2022 NCCRT Annual Meeting

FOLLOW UP TO ABNORMAL NON-COLONOSCOPY TESTING

American Cancer Society | National Colorectal Cancer Roundtable | 80% In Every Community

Follow Up to Abnormal Non-Colonoscopy Testing

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Director of Advocacy Fight Colorectal Cancer

David Lieberman
MD
Professor of Medicine Oregon Health and Science University

Elizabeth Ciemins
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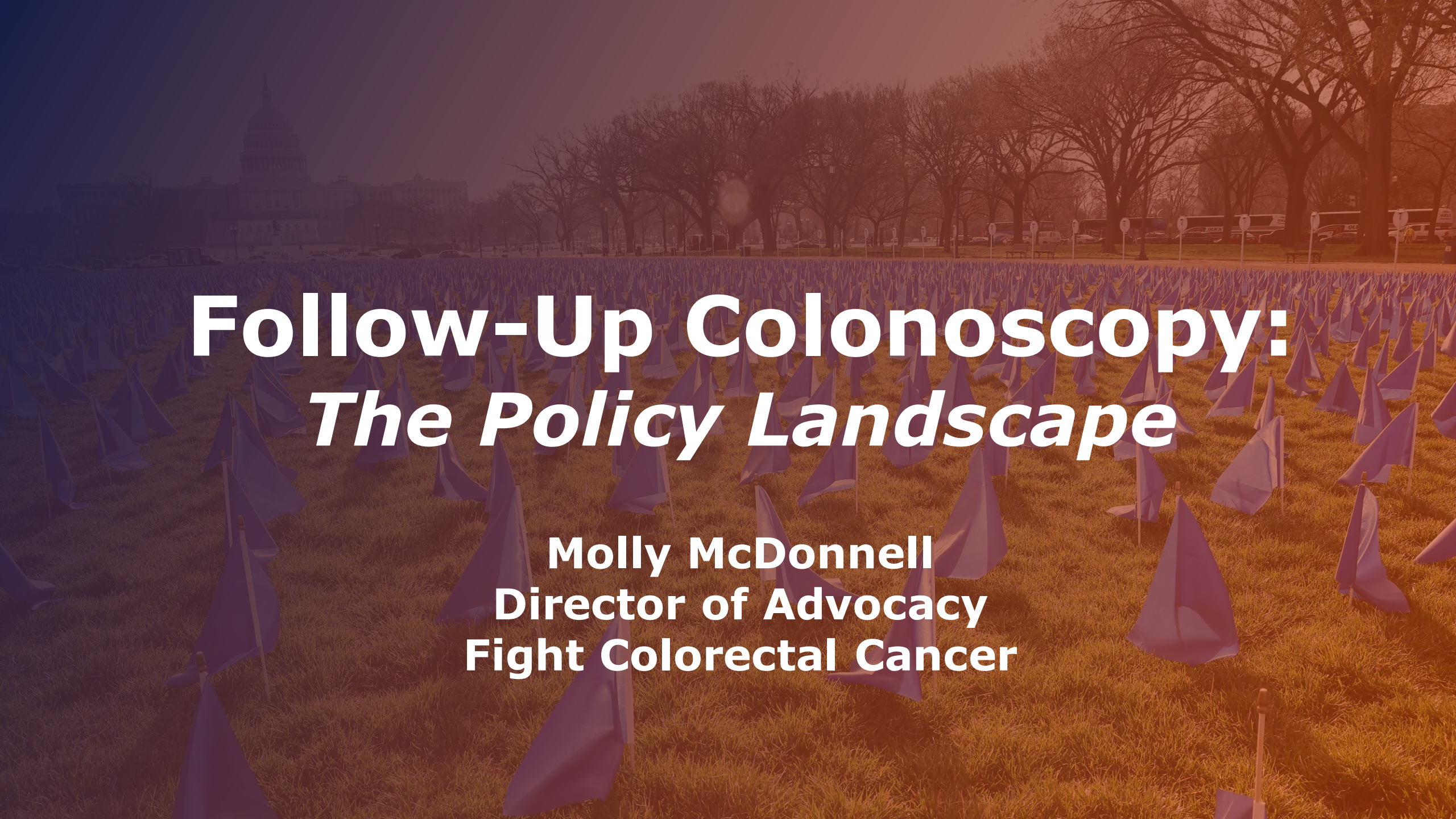
Vice President, Research & Analytics, AMGA

The Policy Landscape

Thursday, November 17, 11:00 AM

American Cancer Society | National Colorectal Cancer Roundtable | 80% In Every Community



Follow-Up Colonoscopy: *The Policy Landscape*

Molly McDonnell
Director of Advocacy
Fight Colorectal Cancer

F!GHT COLORECTAL CANCER™

Patient Support

A cancer diagnosis is scary. We believe no one fights alone.

Whether you're a patient, caregiver, or friend, we're here for you.

Policy Change

The key to changing cancer is through advocacy, policy and research.

From day one the focus of Fight CRC has been to get the voices of advocates heard.

Research Endeavors

It takes thought leaders, experts, and advocates working together to move research forward.

We're focused on funding promising, high-impact research.

Catalyst State-by-State Advocacy Program

Fight CRC's Catalyst Program aims to accelerate progress toward turning aspirational colorectal cancer screening goals into reality by increasing access and reducing barriers to colorectal cancer screening. Specifically,

- Remove patient cost-sharing for follow-up colonoscopies following a positive non-invasive CRC screening test for insured populations.
- Ensure coverage for insured populations to include 45-49 years old, as is now recommended through American Cancer Society & USPSTF guidelines.

FUNDING

Fight CRC provides grant funding of up to $50,000 to state coalitions and provides a facilitator to carry out a robust action planning process

ASSISTANCE

Fight CRC provides funding and technical assistance to support grassroots activities and coalition-building at the state level

MODEL FOR CHANGE

Grantees will serve as a model and offer lessons learned for other communities looking to organize coalitions to advance policies and advocate around the issue of CRC screening.

STATES

Our grantees include **Arkansas**, **California**, **Colorado, Indiana, Kentucky, Louisiana, Nebraska, New Jersey, New York, Rhode Island, Texas and Virginia**.

Catalyst Advisory Council

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

American Cancer Society Cancer Action Network

prevent cancer FOUNDATION

Strategic Partners & Sponsors

ACHI
INSPIRING HEALTHY ACTS

NO SHAVE NOVEMBER

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EXACT SCIENCES

Genentech

Bristol Myers Squibb

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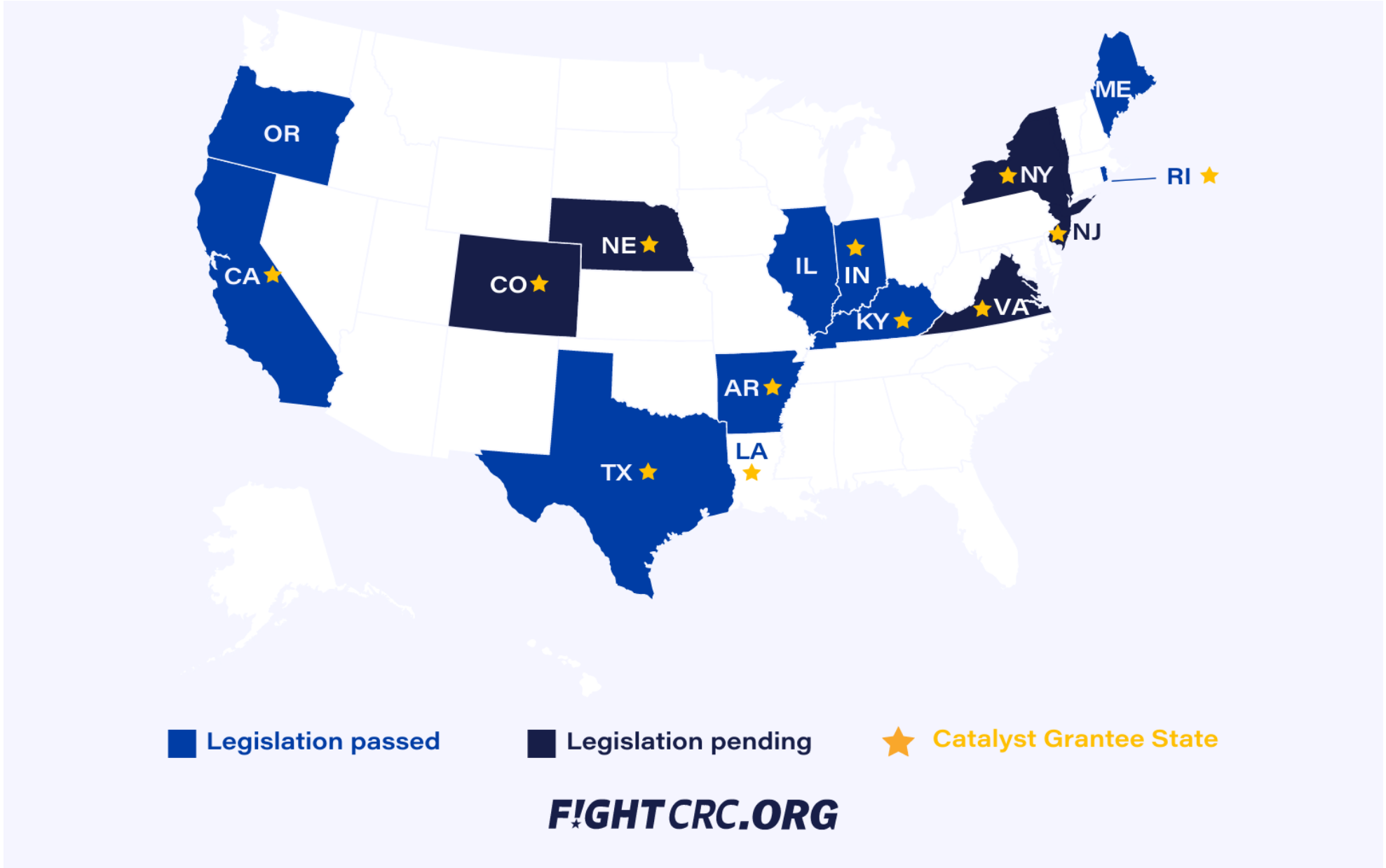
State Follow-Up Policy Landscape



Follow-Up Colonoscopy Policy Efforts

2012

Medicare Loophole Bill First Introduced

States Advance Follow-up Legislation

2015-2022

December 2020

Medicare Loophole Bill Signed into Law

Commercial Plan Guidance on Follow-up Colonoscopy

January 2022

July 2022

CMS Proposed Rule on Follow-up Colonoscopy

CMS Final Rule on Follow-up Colonoscopy

November 2022

FIGHT COLORECTAL CANCER

Follow-Up Colonoscopy Coverage

- ✓ ACA Compliant Plans
- ✓ Medicare
- ✓ Medicaid Expansion Population
- ? Traditional Medicaid Population
- ✗ Grandfathered Plans
- ✗ Uninsured

FIGHT COLORECTAL CANCER

Looking Ahead: Implementation

Over the past two years we've seen incredible policy wins, now it's our job to ensure that patients actually benefit.

Patients

Physicians

Health Insurers

Coders/Billing Depts

Looking Ahead: State Work

New Jersey

Advancing **legislation to remove patient cost-sharing** for colonoscopy following a positive non-invasive screening test.

Virginia

Introducing and advancing legislation to **remove out-of-pocket costs for colonoscopy** following a positive non-invasive screening test.

Your State?

Fight CRC will be awarding a limited number of smaller grants in 2023 for states interested in building capacity for policy work around colorectal cancer screening.

Looking Ahead: Federal Work

Expand the CDC Colorectal Cancer Control Program

Build on Existing Success

Increase funding for the CDC's Colorectal Cancer Control Program so it can expand to all 50 states

Leverage Successful Models

Provide eligibility for treatment through Medicaid for those diagnosed through the CRCCP as the Breast & Cervical Cancer Prevention & Treatment Act did

Thank You!

molly@fightcrc.org
www.fightcrc.org

Thank You!

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Closing the Screening Continuum: Updates from the American Gastroenterological Association

Thursday, November 17, 11:00 AM

American Cancer Society | National Colorectal Cancer Roundtable | 80% in every community

AGA CRC Screening Initiative

David Lieberman
Professor of Medicine; Division of Gastroenterology
Oregon Health and Science University

aga American Gastroenterological Association

AGA Screening Initiative Task Force

Launched Executive Committee on CRC Aug. 2021

Published AGA Policy Statements on CRC Screening in *Gastroenterology* June 2022

Defined the continuum of CRC screening which includes:

Identification of high-risk patients	**Follow-up of non-invasive screening tests**	**Follow-up of high-risk patients after colonoscopy**

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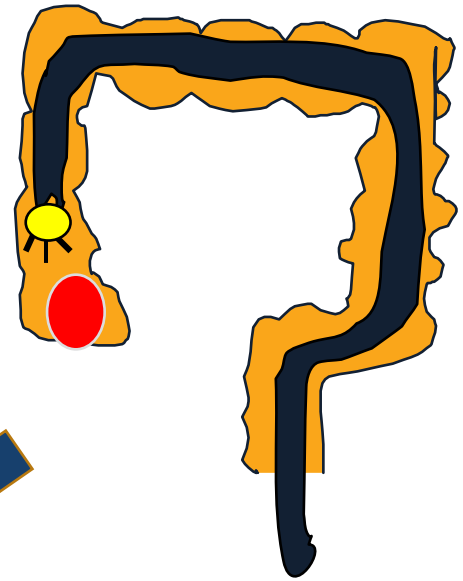
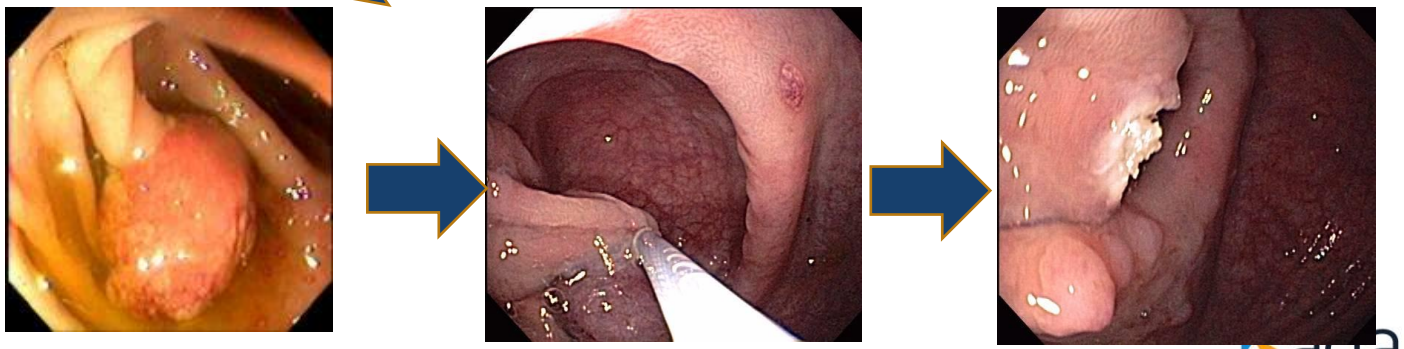
Continuum of CRC screening

Non-Invasive
Test completed

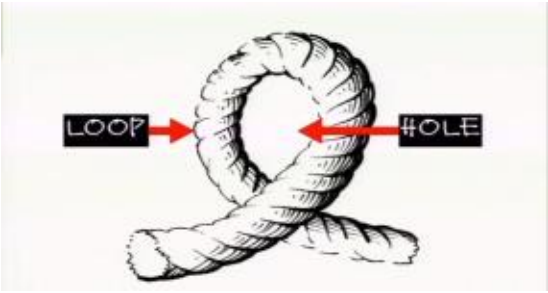
(+) Test



Primary Screen
With Colonoscopy



Closing Financial Barriers to Screening



Biden Administration Issued Guidance requiring **private health plans** to cover the follow-up colonoscopy necessary after a non-invasive screening

2020

Jan. 2022

July 2022

Medicare & private payers must cover screening colonoscopy resulting in polypectomy- phase-in

CMS proposed covering the follow-up colonoscopy after a positive stool-based CRC screening test

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Phase II Screening Initiative

Improving Adherence

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Vision, hopes, dreams

Table 4. Estimated Impact of Increasing Population-Wide Colorectal Cancer Screening Uptake in the United States, Based on Mean Results From 4 Established Screening Models

Total CRC screening uptake in the population	Colonoscopy uptake (absolute rate),[a] %	FIT uptake (absolute rate),[a] %	CRC cases averted, %	CRC deaths averted, %
65%[b] **65%**	55	10	47 **47%**	53 **53%**
75%	55	20	53	61
75%	65	10	55	61
85% **85%**	55	30	60 **60%**	68 **68%**
85%	65	20	61	69
85%	75	10	62	70

[a]Assuming that those taking up screening do so with full participation over time with screening, follow-up, and surveillance.
[b]Approximate current prevalence of screening among age-eligible individuals aged 45–75 years.

Lieberman, Ladabaum et al; Gastroenterol 2022; 163(2):520-526

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Challenges to Screening

- Education/awareness
- Access to initial screening
- Adherence when screening offered
- Disparities
- Barriers
  - Socio-economic
  - Access to health care
  - Transportation if colonoscopy needed
  - Time away from work
  - Childcare and elder care responsibilities
  - Disparities

Successful Screening Models

Successful programs

- Kaiser, California – achieved >80% adherence with subsequent reduction in CRC incidence, mortality and elimination of disparities (Doubeni, 2022)
- C-5 in NYC – achieved high levels of adherence in diverse populations

Lessons from successful programs

- Create access
- Develop effective education/communication
- Provide **navigation**

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What is navigation?

- **Education; answer questions**
- **Provide access to test**
- **Reminders to complete test**
- **Navigate to colonoscopy if non-invasive test is (+)**
- **Help with barriers such as**
  - Transportation
  - Time off work
  - Child-care, elder care

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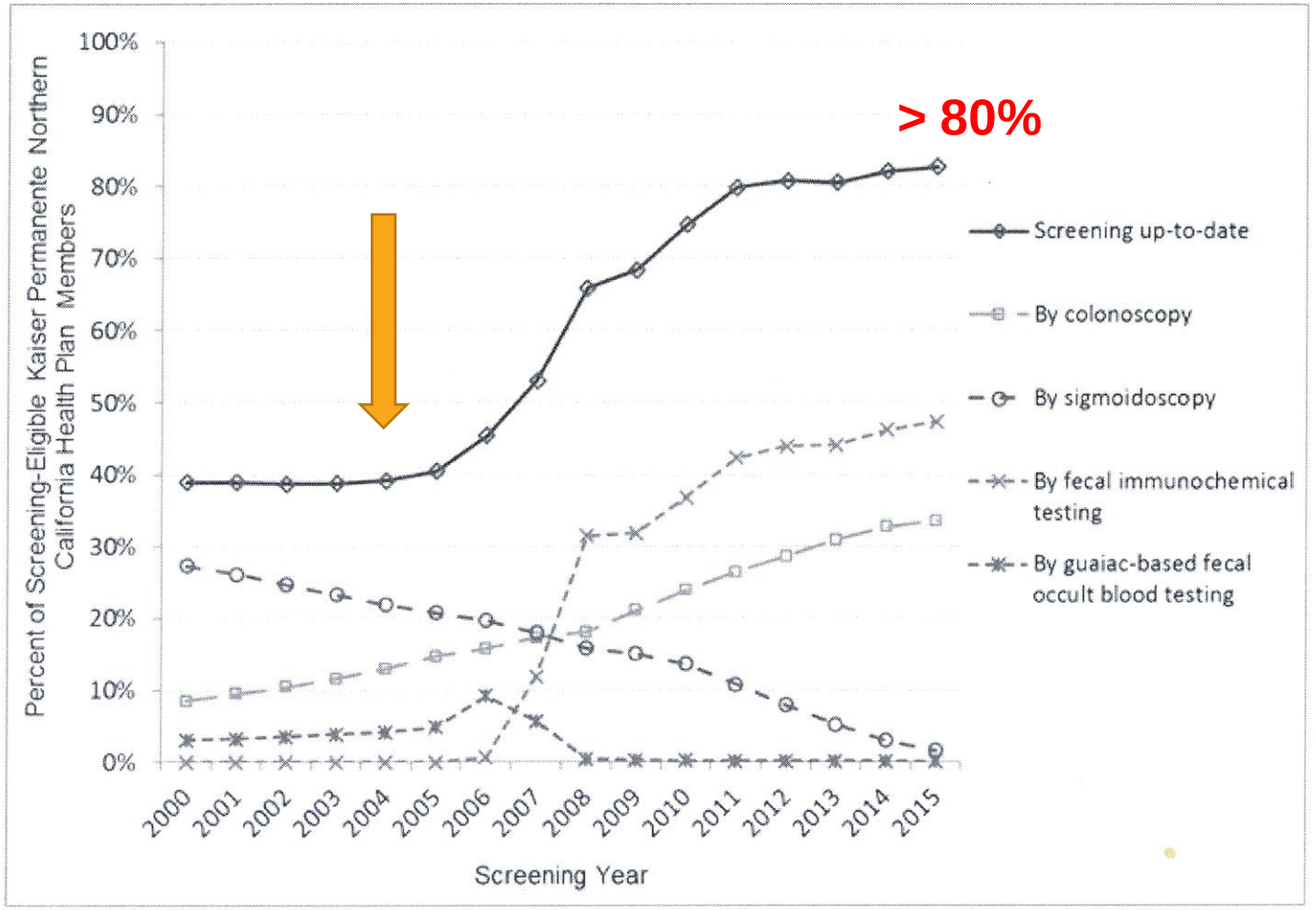
CRC Screening Rates

American Cancer Society Goal: 80% by 2018



Levin et al; Gastroenterol 2018; DOI 10.1053/j.gastro.2018.07.017

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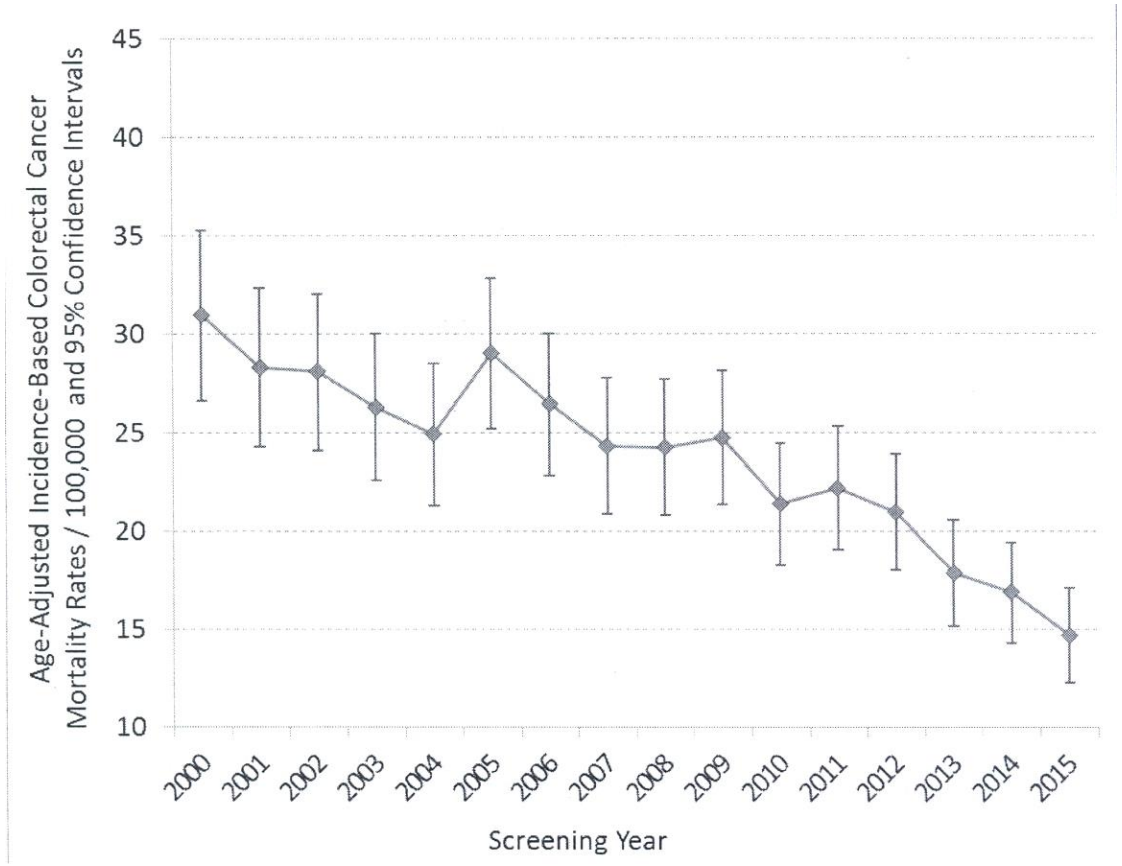
CRC Mortality



Levin et al; Gastroenterol 2018; DOI 10.1053/j.gastro.2018.07.017

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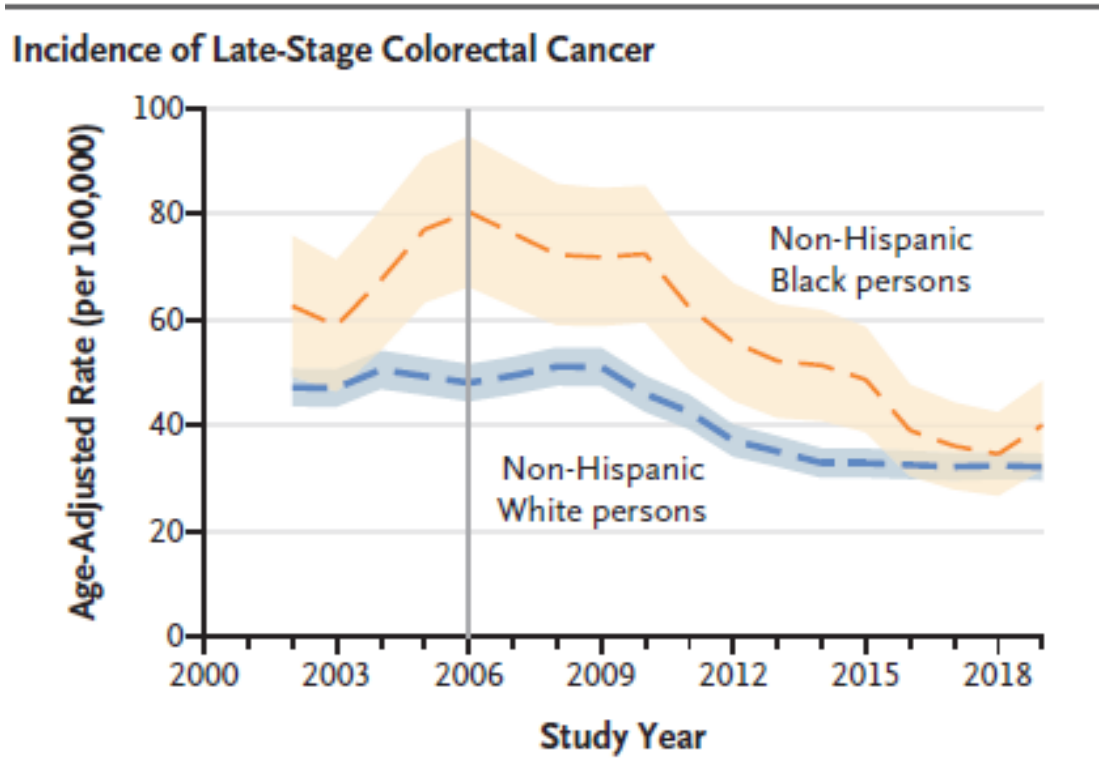
CRC Incidence- Late Stage CRC



Doubeni et al; NEJM 2022; 386:796-9

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Piloting success

Proposed approach

Develop pilot framework

Screening continuum

Access and coverage

Navigators

Partner with health care stakeholders

Industry
- Non-invasive screening test companies
- Endoscopy companies

Payers
- Preventive benefits
- Health equity officers

Patient & provider diversity
- COCCI
- ABGH

Work with consumer-facing partners

Retail health
- Walmart, Amazon, Walgreens, CVS, etc.
- Provide key preventive health services
- Expand Flu/FIT model
- Identify high risk patients

Transportation Apps
- Uber/Lyft
- Collaborate on transportation
- Key barrier to care

Activate patients & providers

Patients
Grassroots campaign to reach black patients and underserved populations

Endoscopists
Work with pilot project coordinators and navigators to provide colonoscopy for positive non-invasive tests

It takes a village

Education + Access + Navigation = ↑ Adherence


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Thank You!

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Work Toward a HEDIS Measure

Thursday, November 17, 11:00 AM

American Cancer Society | National Colorectal Cancer Roundtable | 80% in every community

CRC follow-up screening measure

Elizabeth L. Ciemins, PhD, MPH, MA

National Colorectal Cancer Roundtable Meeting

November 17, 2022

Presentation Outline

- AMGA overview
- Measure specification
- Measure exploration
- Reliability testing
- Feasibility testing
- Face validity and qualitative insights
- Future directions

AMGA: What we do

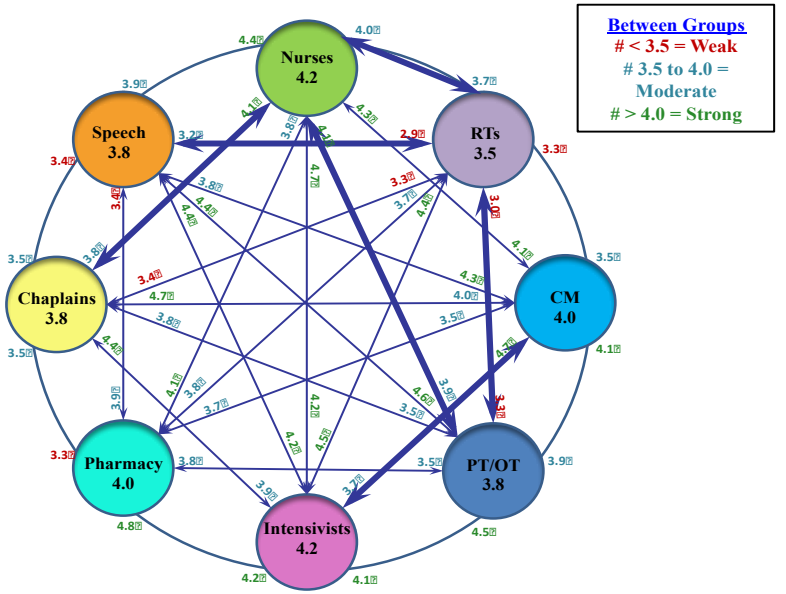
+

T2DM Obesity

Immunizations

HTN ASCVD

+



AMGA Research

Leveraging Evidence to Advance Practice

Integrating Evidence

Studying methods for integrating evidence-based practice into routine health care

Fostering Innovation

Discovering innovations originating in clinics that are responding to real-world challenges

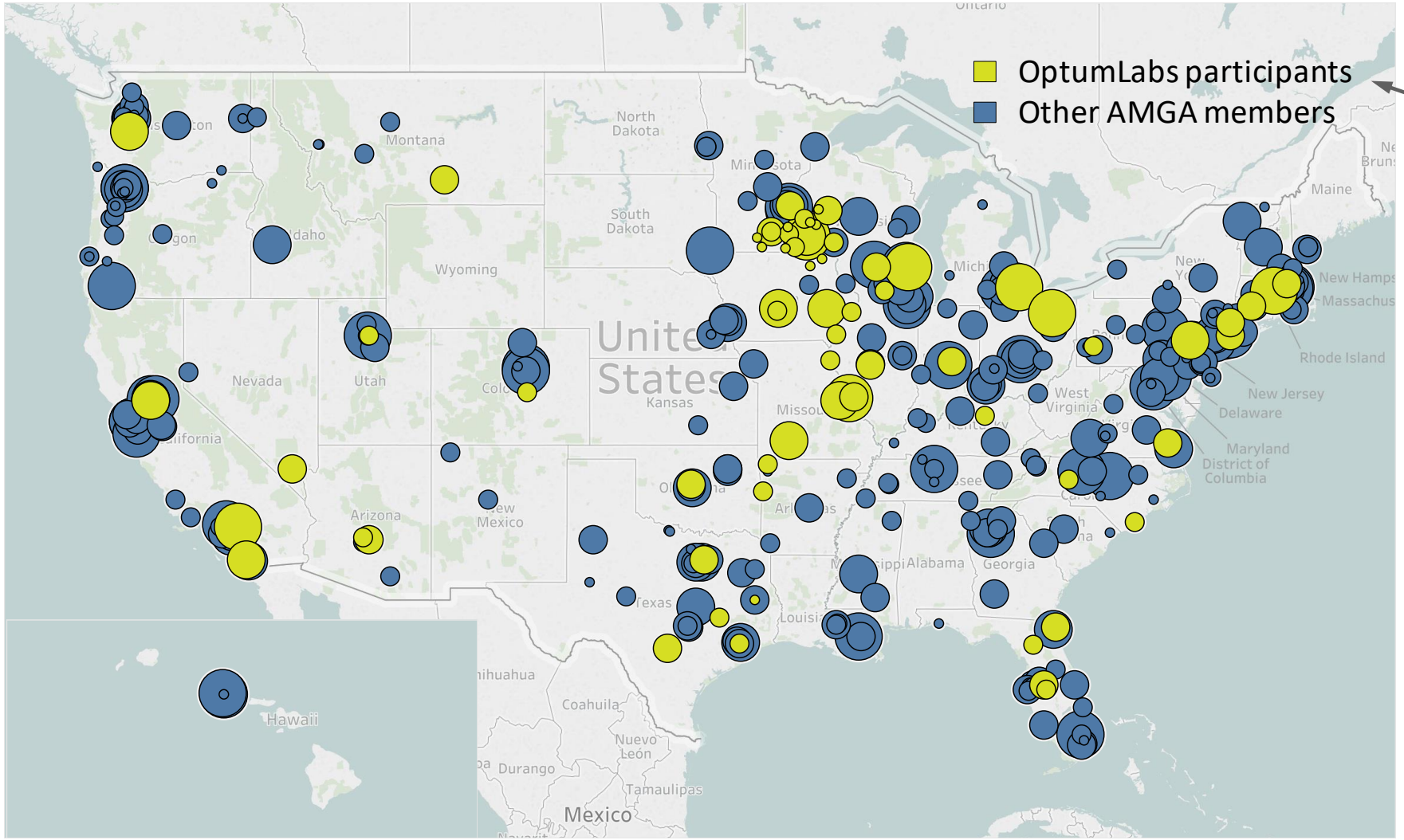
Driving Change

Uncovering hidden meanings in data and the reasons driving behavior and process changes

More information at: research@amga.org

https://www.amga.org/performance-improvement/best-practices/research-analytics/

AMGA Membership



Representative AMGA Members

AMGA Analytics

Measure Development Project

Collaboration

Advisors

- **Mary Barton**, MD, Vice President, NCQA
- **Frank Colangelo**, MD, MS-HQS, FACP, Director, Outcomes Office, Allegheny Health Network; CQO, Premier Medical Associates, National Colorectal Cancer Roundtable
- **Robert Smith**, PhD, Sr. Vice President for Cancer Screening, American Cancer Society
- **Richard Wender**, MD, Chair Family Medicine and Community Health at University of Pennsylvania School of Medicine

Objective

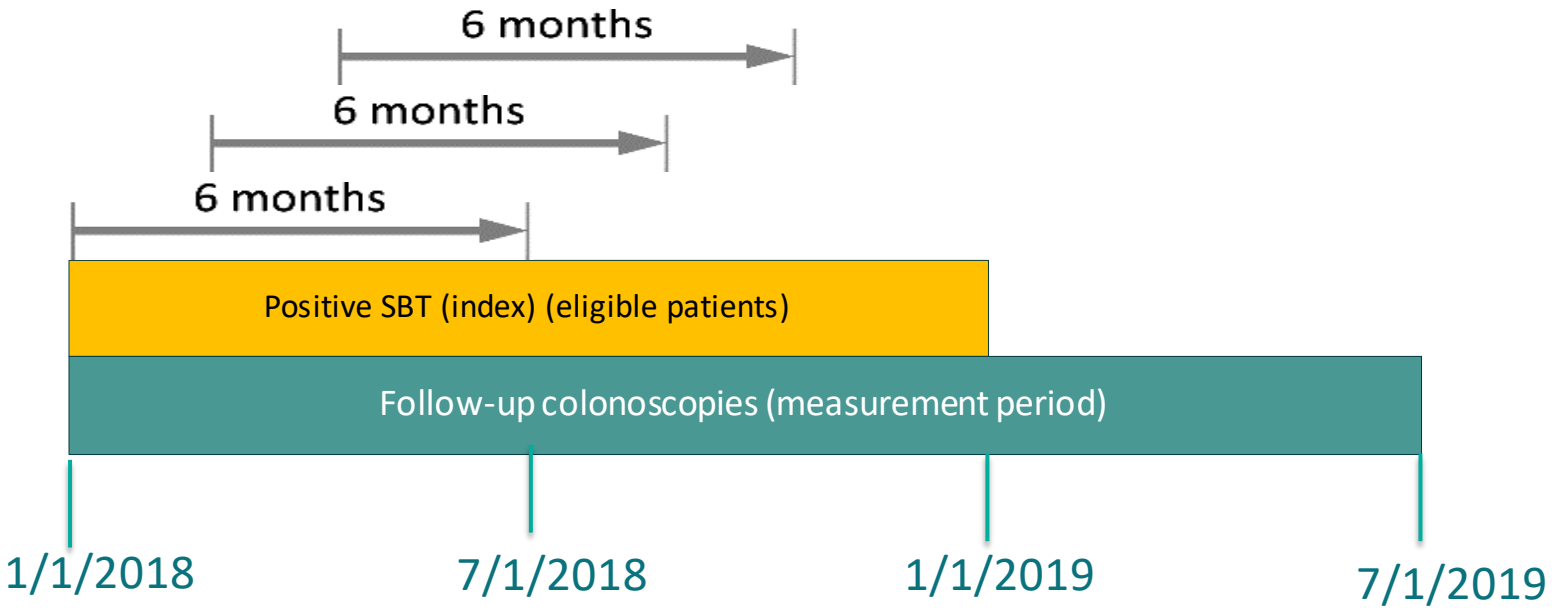
To develop and test a *Colorectal Cancer (CRC) Screening Follow-Up Measure* that measures the receipt of timely follow-up with a colonoscopy after a positive stool-based screening test (fecal immunochemical test (FIT) or multitarget stool DNA test (mt-sDNA)) for colorectal cancer.

Current HEDIS Measure

Assesses adults 45–75 who had appropriate screening for CRC with any of the following tests:

- fecal immunochemical test (FIT) (annually);
- FIT + multi-target stool DNA (mt-sDNA) (past 3 years);
- computed tomographic colonography (past 5 years);
- flexible sigmoidoscopy (past 5 years); and
- colonoscopy (past 10 years).

Measure: Colorectal Cancer Screening Follow Up within 6 months after Positive Stool-based Test (SBT)



- Index positive SBT (denominator)
- Numerator compliant (measurement period)

Measure description

- The percentage of adults ages 45 through 75 who receive a diagnostic colonoscopy within 180 days following a positive stool-based screening test (SBT) for colorectal cancer (CRC) within the eligibility year.

- **For the purposes of measure testing based on the available data (2016–2020), we will follow 2016 guidelines and test the quality measure among adults ages 50-75.**

AMGA Analytics

Measure testing population

Description of data

- Data for this study was obtained from the Optum Labs Data Warehouse, a database* of de-identified healthcare claims, clinical, demographic and other data elements
- De-identified EHR data (including outbound billing claims) sourced from 38 health care organizations (HCOs)
  - May not include treatment, i.e., colonoscopy, performed outside the contributing HCO (8.6% difference in sub-analysis)

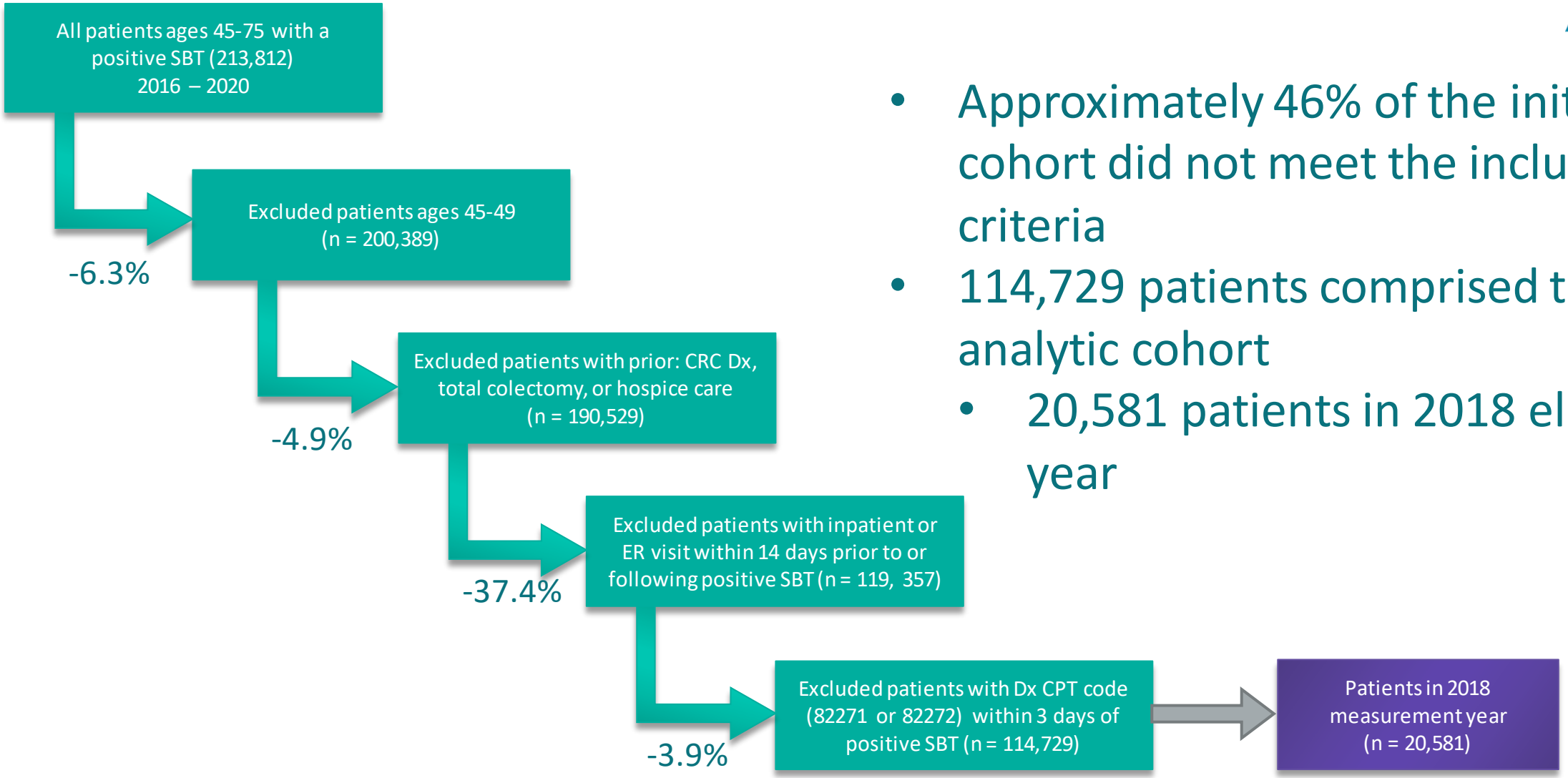
*Study data were accessed using techniques compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and, because this study involved analysis of pre-existing, de-identified data, it was exempt from Institutional Review Board approval

Exclusion criteria

- Age <50 years
- History of malignant CRC diagnosis, total colectomy, or hospice care*
- To isolate “screening” population by eliminating presumed diagnostic SBT:
  - Hospitalization or ER visit within 14 days of a positive test
  - Diagnostic SBT per CPT code within 3 days prior to positive test result

*based on HEDIS measure

Attrition table for exclusion criteria



- Approximately 46% of the initial cohort did not meet the inclusion criteria
- 114,729 patients comprised the analytic cohort
  - 20,581 patients in 2018 eligibility year

Patient characteristics, measurement year, 2018

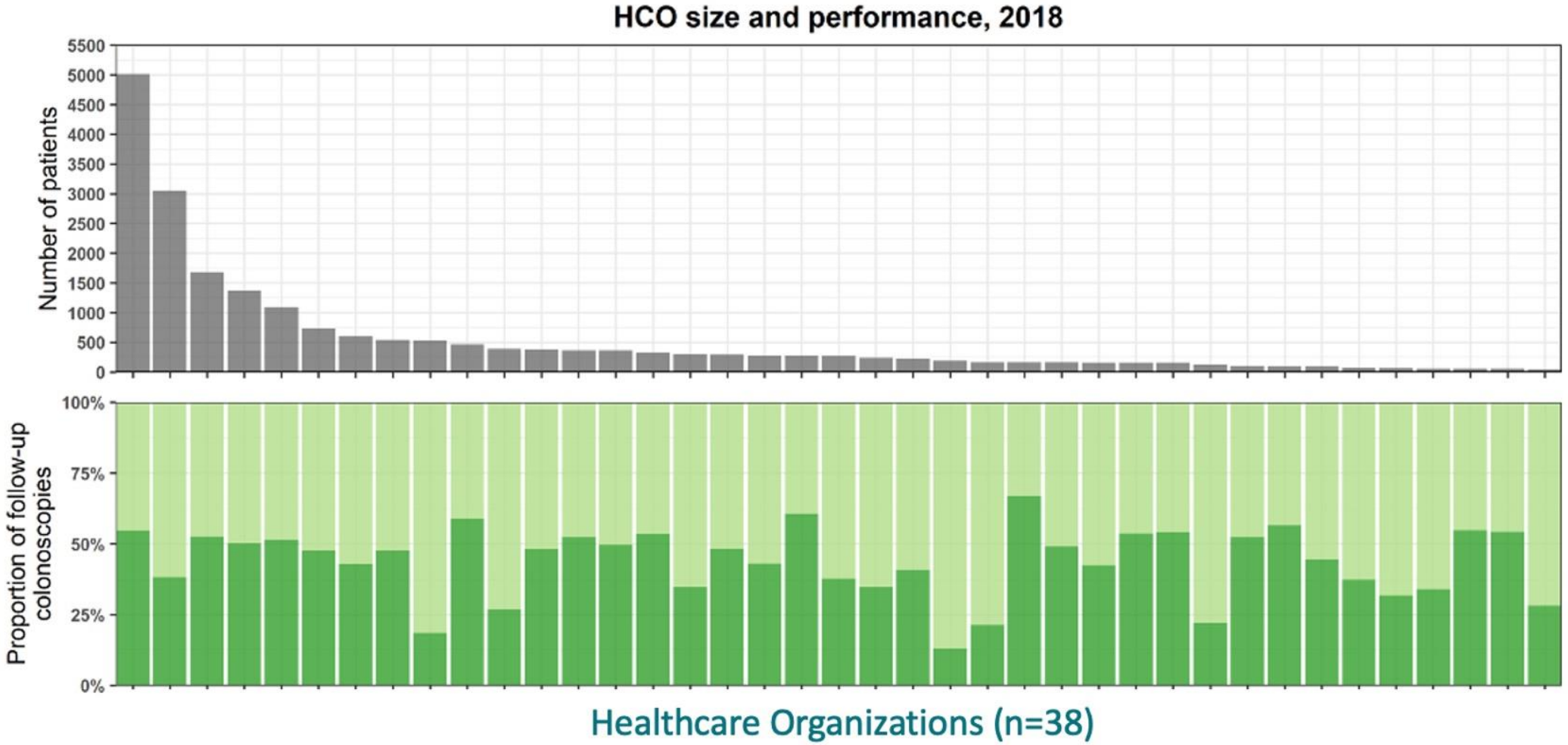
Table 1. Patient characteristics, 2018 (n = 20,581)

Index age (Mean, (SD))	63.6 (7.1)	**Insurance type (%)**	
Sex, Male (%)	10,009 (48.6)	Commercial	13,138 (63.8)
Race (%)		Medicaid	1,056 (5.1)
African American	1,492 (7.2)	Medicare	4,733 (23.0)
Asian	307 (1.5)	Other or Unknown	1,654 (8.0)
Caucasian	17,705 (86.0)	**RUCA (%)**	
Other/Unknown	1,077 (5.2)	Metro UA	2,069 (10.1)
Ethnicity (%)		Large UC	165 (0.8)
Hispanic	644 (3.4)	Small UC	86 (0.4)
Not Hispanic	18,612 (90.4)	Rural	45 (0.2)
Unknown	1,325 (6.4)	Unknown	18,216 (88.5)
Education (%)		**Smoking status (%)**	
High School Diploma or less	1,932 (9.4)	Never smoked	6,692 (32.5)
Associates or Bachelors	3,858 (18.7)	Not currently smoking	1,235 (6.0)
Higher than Bachelors	712 (3.5)	Previously smoked	6,019 (29.2)
Unknown	14,079 (68.4)	Current smoker	3,763 (18.3)
Household income (%)		Unknown	2,872 (14.0)
<$40,000	1,156 (5.6)	**Charlson index (%)**	
$40,000-$74,999	1,482 (7.2)	0	11,423 (55.5)
$75,000-$124,999	1,595 (7.7)	1-2	5,900 (28.7)
$125,000-$199,999	606 (2.9)	3-4	1,687 (8.2)
$200,000+	263 (1.3)	5+	778 (3.8)
Unknown	15,479 (75.2)	Unknown	792 (3.9)

Measure performance: percentage of patients with positive SBT who received a colonoscopy within 180 days

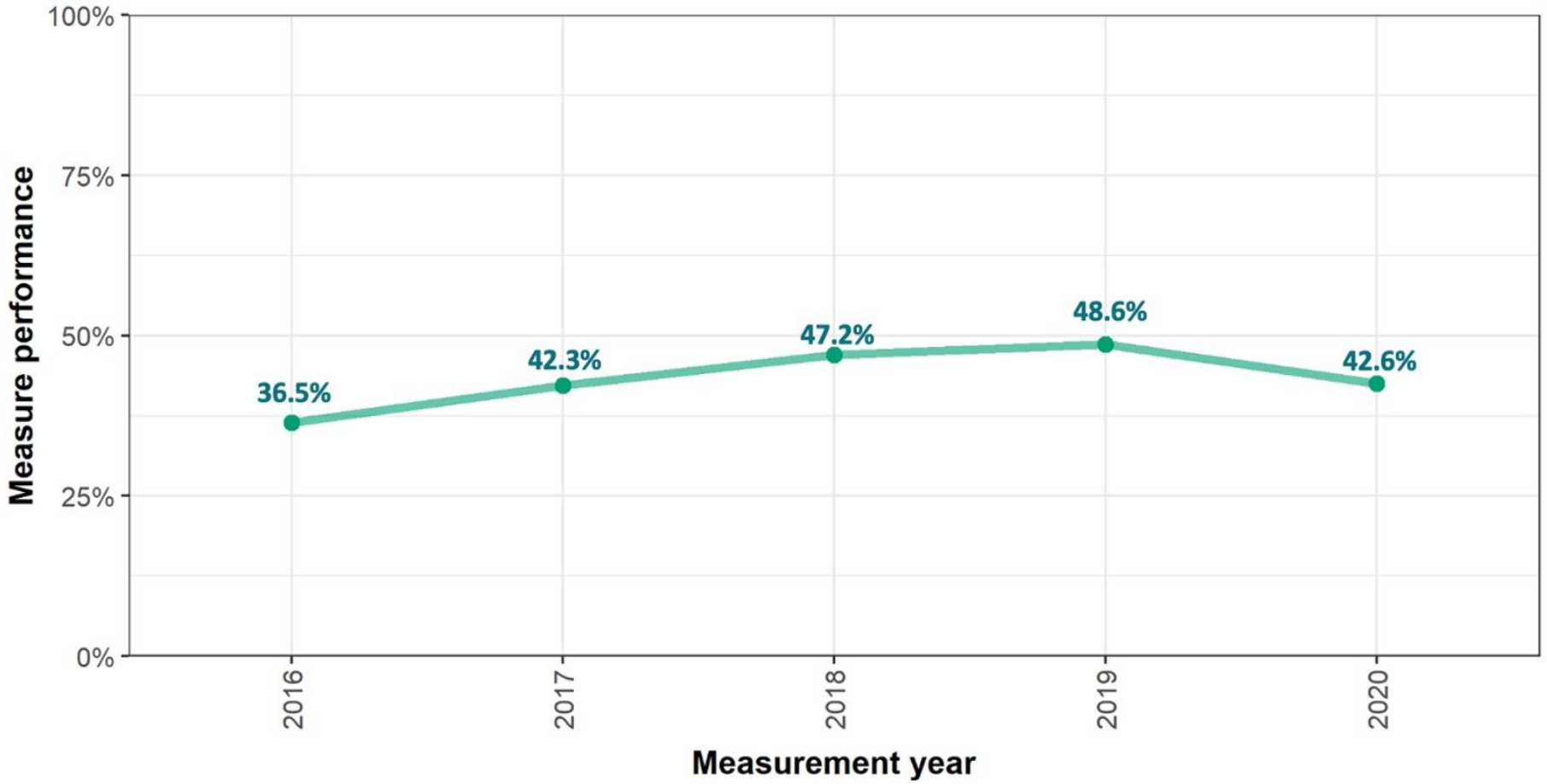
Measure performance, 2018 (n=38 HCOs)

Measure: percentage of patients with positive SBT who received a colonoscopy within 180 days

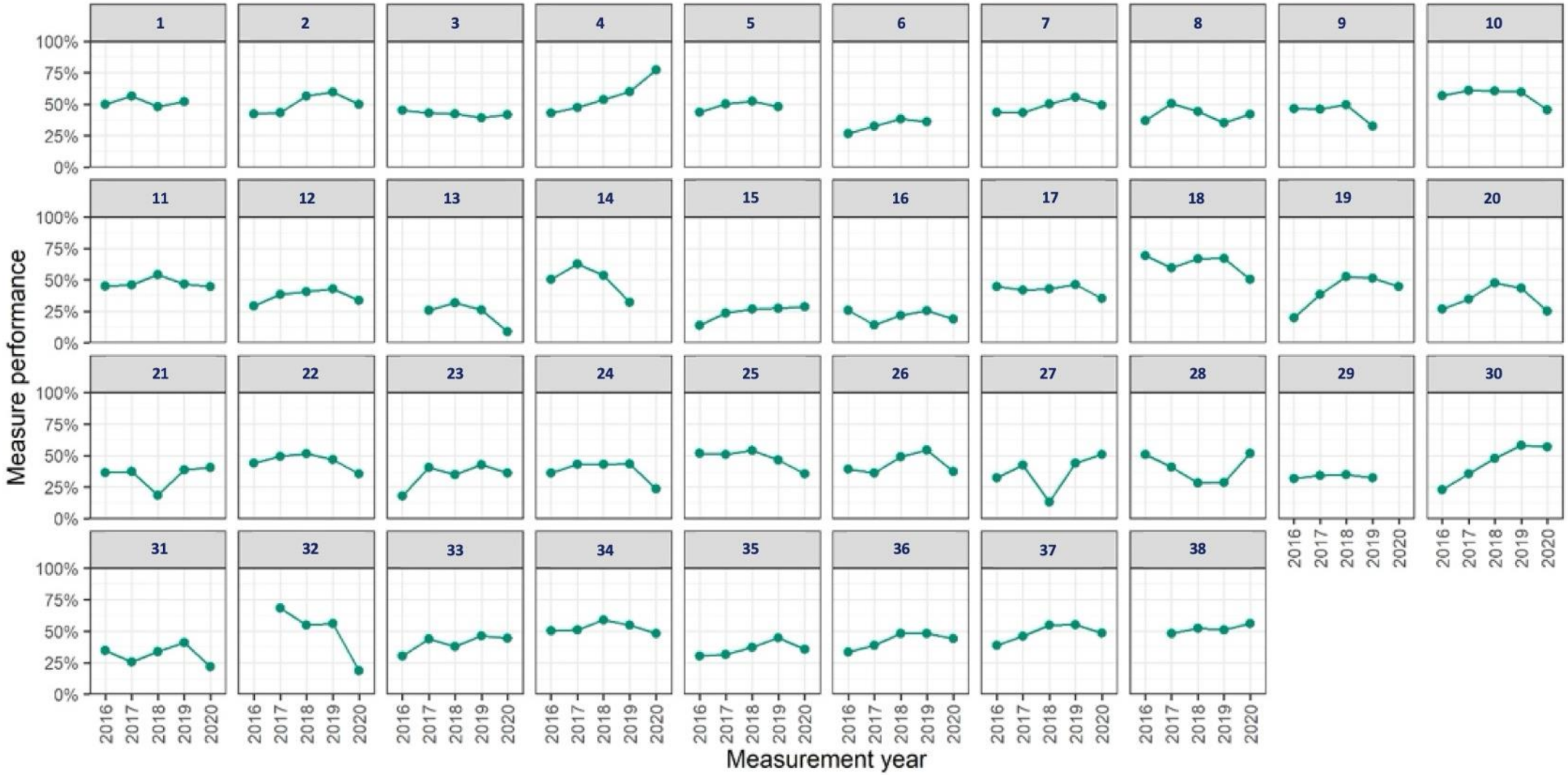


Median: 48% , Range: 13% - 67%

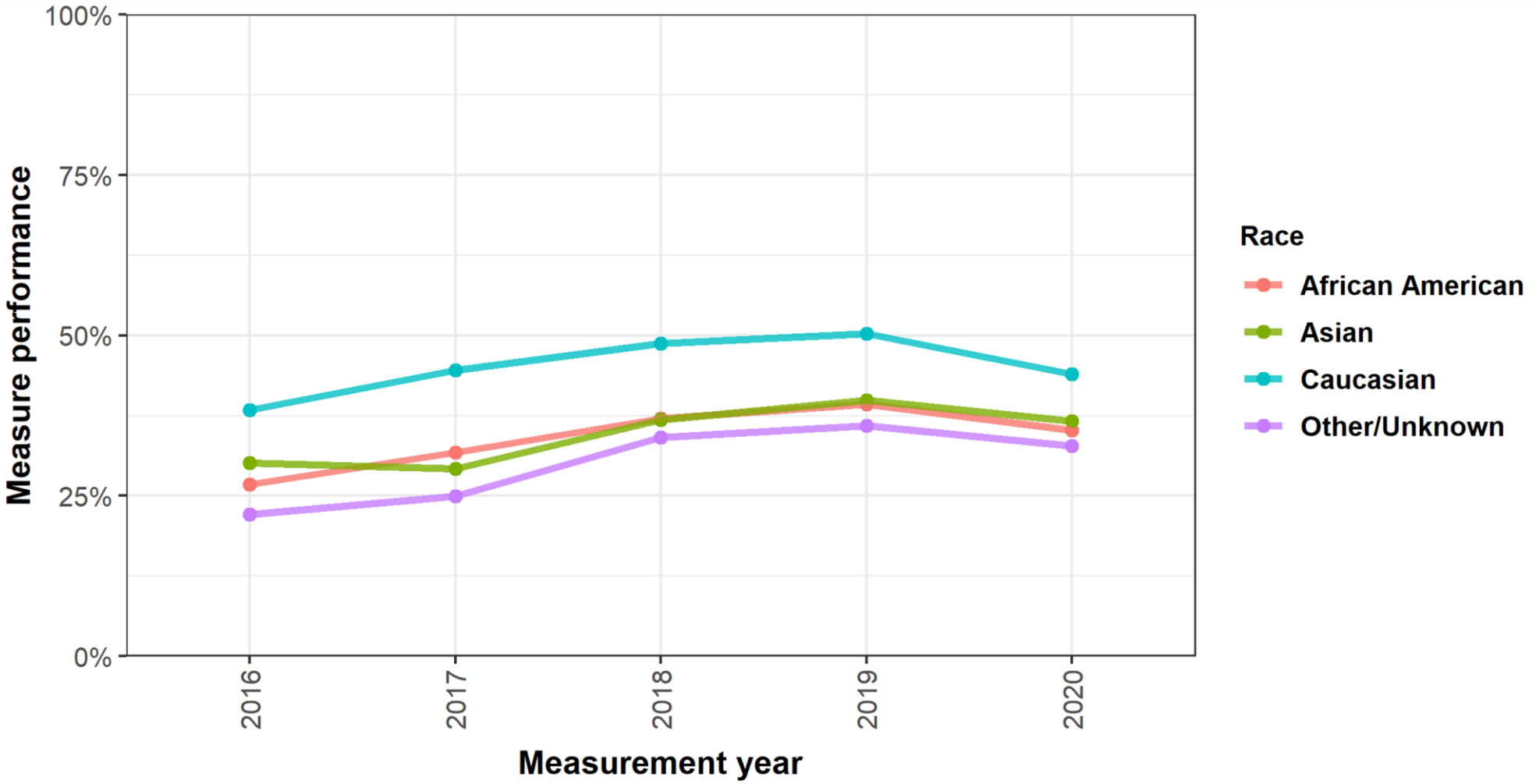
Measure performance over time, overall



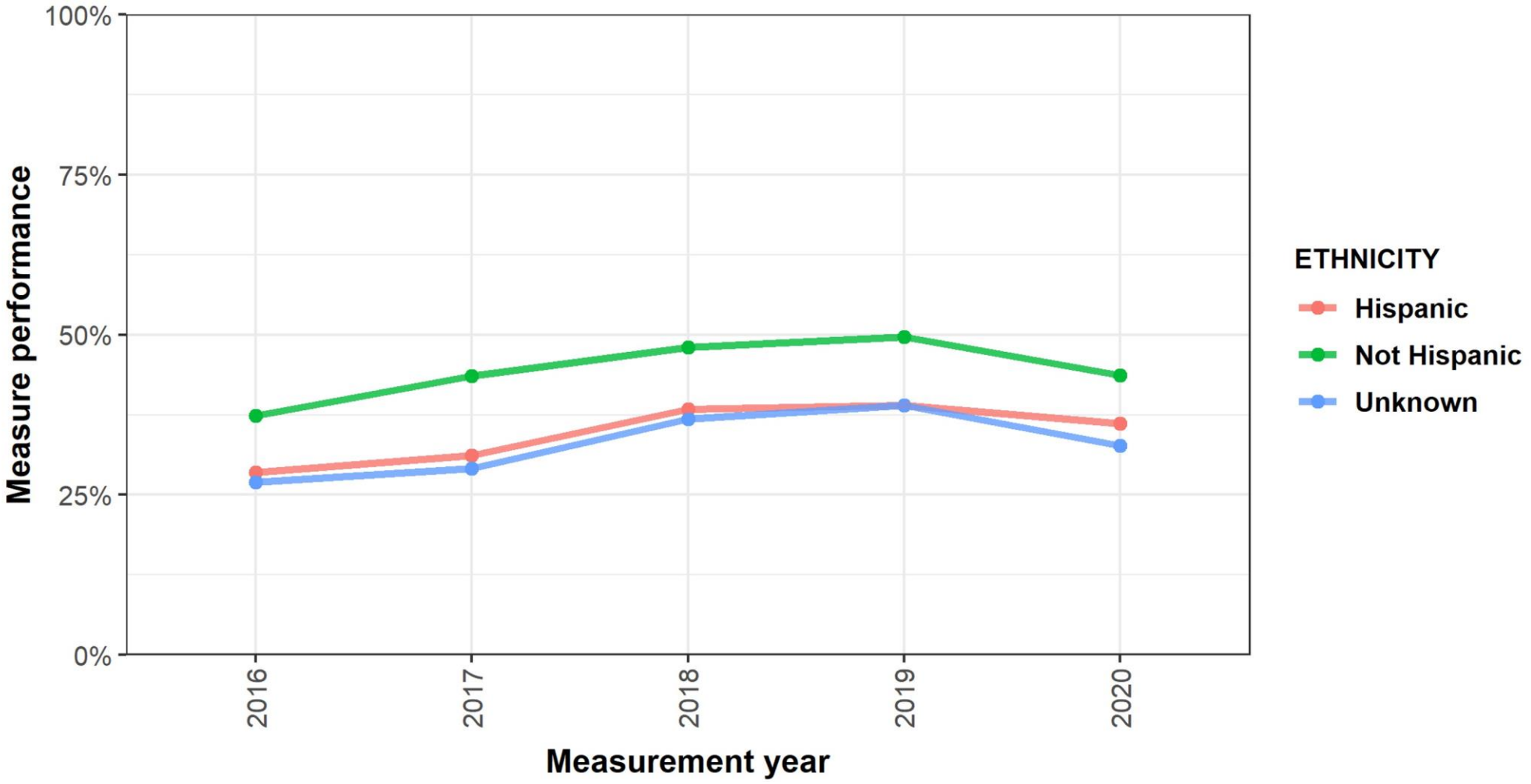
Performance over time, by HCO



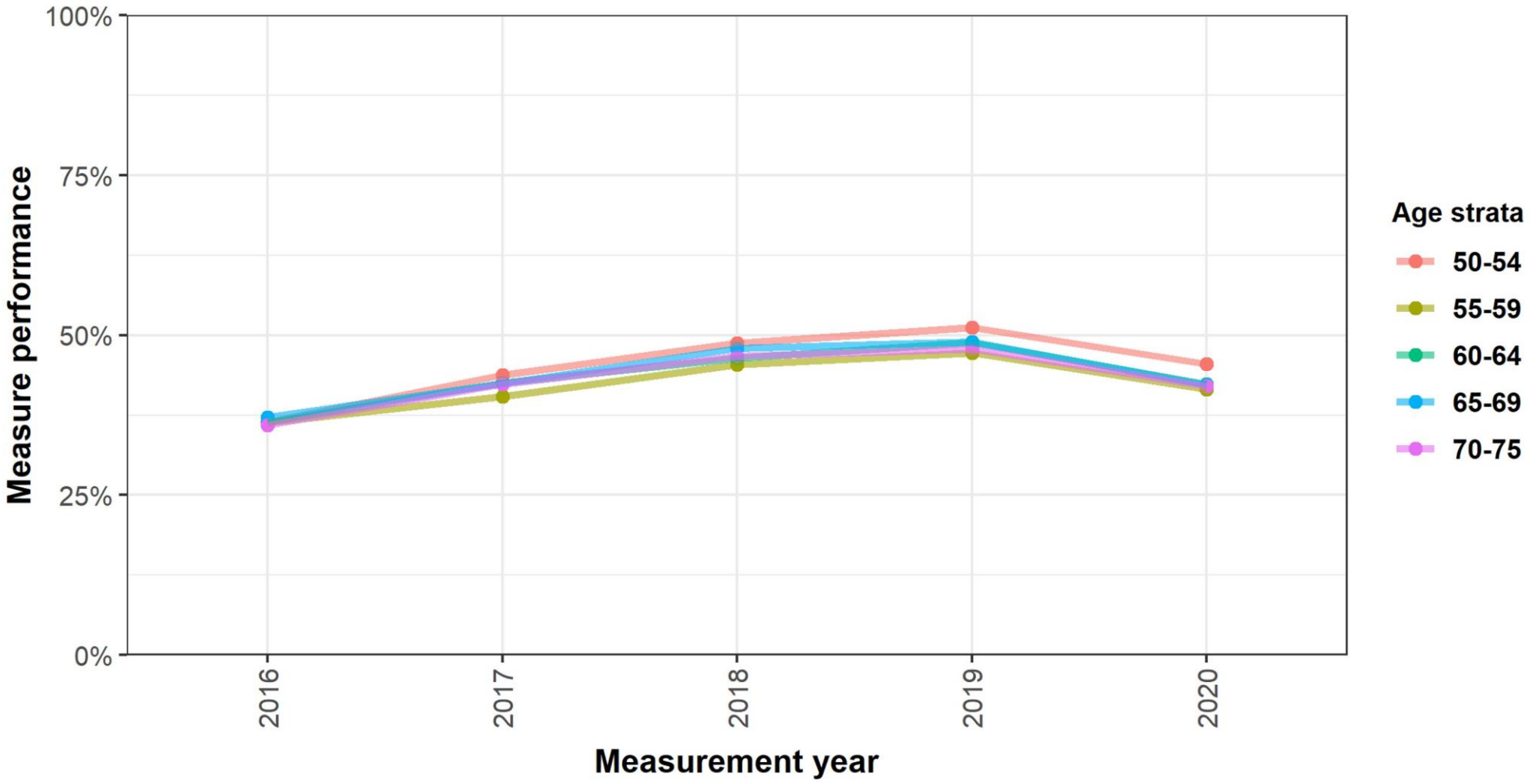
Performance over time, by race



Performance over time, by ethnicity



Performance over time, by age



AMGA Analytics

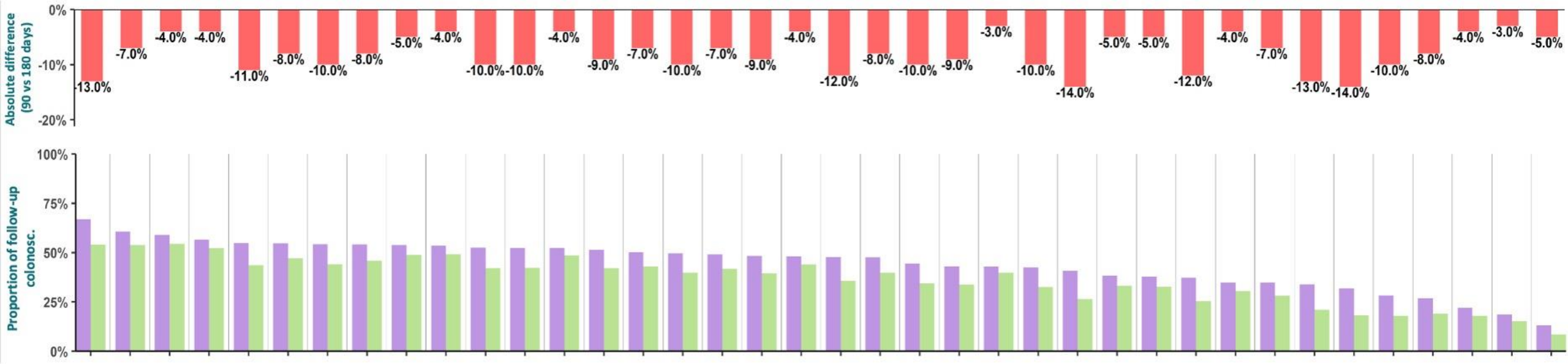
Measure evaluation

Evaluation

- Sensitivity analysis
- Reliability testing
- Feasibility testing
- Face validity

Sensitivity Analysis

Absolute difference in follow-up colonoscopy rates between 90 vs 180 days (2018) (n=38)



Proportion of follow-up colonoscopies across 38 HCOs, 2018:

- 90-day follow-up:
  - Mean: 36%
  - Median: 40%
  - Min: 8%
  - Max: 54%
- 180-day follow up:
  - Mean: 44%
  - Median: 48%
  - Min: 13%
  - Max: 67%

Reliability testing

- Signal-to-noise testing
  - Methods
    - Beta-binomial model
    - By healthcare organization, race, measurement year
  - Formula

$$\frac{\text{Between-group variance}}{\text{Between-group variance + group-specific or sampling/measurement error}}$$

  - Good reliability:
    - 90% for individuals
    - 70–80% for groups

Reliability testing: Results

RELIABILITY				
Race (mean)	98%		Year (mean)	99%
Black	98%		2016	99.2%
Asian	95%		2017	99.3%
White	99%		2018	99.4%
Other	98%		2019	99.4%
Ethnicity (mean)	98%		2020	99.2%
Hispanic	97%		HCO (mean)	96%*
Non-Hisp.	99.8%			Range: 88–99%

*Interpretation: 96% of variance in the measure was due to between-system differences

Feasibility testing

- Three health systems conducted feasibility assessment
  - Evaluated data elements
    - Data Availability – data readily available in a structured format
    - Data Accuracy – data element >90% accurate under normal conditions
    - Data Standards – data element coded using nationally accepted terminology standard, e.g., CPT, HCPC, LOINC, etc.
    - Workflow – data captured during the routine course of care; how is workflow impacted?

Feasibility testing: data elements

#	Data Element
1	Patient age
2	Date and result of CRC screening SBT
3	Encounter: Identification of prior CRC diagnosis
4	Encounter: Identification of prior total colectomy
5	Encounter: Initiation of hospice or palliative care within 12 months of positive
6	Encounter: Identification of inpatient visit within 14 days of positive SBT
7	Encounter: Identification of ER visit within 14 days of positive SBT
8	Follow-up colonoscopy date
9	Race
10	Ethnicity

Feasibility testing: partial results

	EHR #1	Allscripts Touchworks version 20.1.2		
Data Element	**DATA AVAILABILITY**	**DATA ACCURACY**	**DATA STANDARDS**	**WORKFLOW**
Patient age	1	1	1	1
Date and result of CRC screening SBT	1	1	1	1
Encounter: Identification of prior CRC diagnosis	1	1	1	1
Encounter: Identification of prior total colectomy	1	1	1	1
Encounter: Initiation of hospice or palliative care within 12 months of positive SBT	1	0	1	1
Encounter: Identification of inpatient visit within 14 days of positive SBT	0	0	0	0
Encounter: Identification of ER visit within 14 days of positive SBT	0	0	0	0
Follow-up colonoscopy date	1	1	1	1
Race	1	1	1	1
Ethnicity	1	1	1	1
SUMMARY				
Data Elements Scoring 0 within Domain	2	3	2	2
Total data elements	10	10	10	10
% of data elements requiring review within domain	20%	30%	20%	20%

Feasibility testing: partial results

5	Encounter: Initiation of hospice or palliative care within 12 months of positive SBT		data can be entered with a date and ICD-10 code but this is not captured >90% of the time
6	Encounter: Identification of inpatient visit within 14 days of positive SBT		inpatient stays are on different EHRs from different orgs; CCDAs are received but are not structured/searchable data
7	Encounter: Identification of ER visit within 14 days of positive SBT		ER visits are on different EHRs from different orgs; CCDAs are received but are not structured/searchable data

AMGA Analytics

Face Validity and Qualitative Insights

Qualitative Theme 1

<u>Lack of knowledge about failure to follow-up</u>

All providers expressed surprise at the low follow-up rates.

"Until we had this conversation, I assumed [the follow-up rate] was 100%."

Qualitative Theme 2

Patient hesitancy around colonoscopy

- Not all patients are willing to have a follow-up colonoscopy even after a positive test.
- Discomfort with the colonoscopy preparation and procedure as a main concern of patients.
- Cost: follow-up colonoscopies after a SBT may be billed at a higher rate, or not covered (prior to 2021 change).

"Something as simple as the prep [for a colonoscopy] makes a big difference to patients. That's the biggest thing that patients don't want to go through"

Qualitative Theme 3

<u>Trust and communication</u>

Potential need for follow-up is regularly discussed at the time of ordering stool-based tests. Discussions with patients are the biggest facilitator to completing follow-up.

"As a provider, they trust you and your recommendations"

Facilitators and barriers

Facilitators of follow-up

- Integration with EHR
- Transparent reporting
- Ease of referral
- Dedicated staff
- Anticipatory guidance

Barriers to follow-up

- Lack of integrated gastroenterology
- Breakdown in communication of results, follow-up scheduling
- No typical “process”

“I think sharing data is excellent, I wish we were doing more”

Summary

- The CRC follow up measure meets the criteria for a quality performance measure submitted by health systems:
  - Variation in measure performance
  - Reliable
  - Feasible
    - May need to simplify exclusion criteria by removing inpatient and ED visit with SBT requirement
  - Face validity

AMGA Analytics

Questions & Discussion

Thank You!

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Q&A

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