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Maine Quality Counts

Increasing Colorectal Cancer Screening Rates: Steps to Success

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Maine Colorectal Cancer Learning Collaboratives

American Cancer Society-WellPoint Foundation Change Grant

- Maine Cancer Screening Initiative 12/2/2013-11/28/2015
- In collaboration with Maine Primary Care Association
- 5 Federally Qualified Health Centers (FQHC's) participated Year 1 and 6 FQHC's Year 2; including Penobscot Community Health Center

Maine Colorectal Cancer Learning Collaboratives

American Cancer Society New England Colorectal Cancer Learning Collaborative

- June 2015 thru June 2016
- Maine: 3 FQHC's, including Penobscot Community Health Center
- Total of 11 Community Health Centers (CHC) across New England
- Aggregate Colorectal Cancer (CRC) screening rate increased 6.3%; highest increase at one CHC=25%

The First Step:

Encourage a positive quality improvement culture in your organization!

- Part of what you do every day - not just one more thing on your plate
- Improved quality of patient care is the reason and focus of this QI work

Build the Quality Improvement Foundation

- **Increase Knowledge**: On-Site Education for Providers and Clinical Staff – CRC screening/Fecal Immunochemical Test (FIT Test)
- **Baseline Assessment:** review current processes and identify both strengths and opportunities to improve
- **Electronic Health Record (EHR) Capabilities:**
  - Panel Management
  - Patient lists for outreach, provider prompts ("Pop-ups"), can EHR pull baseline data, practice and provider level data

Build the Quality Improvement Foundation

- **Data:** Use of data in quality improvement is important

- **Evidence-based interventions:** patient and provider/clinical team focused
    - Patient Reminders – practice outreach
    - Provider/Clinical Team Reminder/Recall (prompts)
    - Provider/Clinical Team Assessment and Feedback

Build the Quality Improvement Foundation

- **Process Mapping** (current state – time well spent)
  - Brainstorm together around the process of each new intervention (engage staff in this process)
  - Workflows create responsibility = accountability
  - Make sure people are working to the highest level of their licensure - Who is the most appropriate for the task?
  - Minimizing redundancy = improves efficiency

Build the Quality Improvement Foundation

- **PDSA Cycles:** The Plan-Do-Study-Act (**PDSA**) cycle is part of the Institute for Healthcare Improvement's Model for Improvement (developed by Associates in Process Improvement)
    - Plan
    - Do
    - Study
    - Act
- Not every change is an improvement!

Increasing Colorectal Cancer Screening Rates: Steps to Success

- Important to have a structured timeline in a QI Project
- Monthly Coaching Calls with Peers – Now use videoconferencing (Zoom, Skype Platforms)
- At least one in-person Peer to Peer Learning Session
- QI Support with Practice Facilitator with monthly on-site meetings

Increasing Colorectal Cancer Screening Rates: Steps to Success

Once you have built the Quality Improvement Foundation, implementing new interventions (processes) is next…

Practice Outreach: Patient Reminders

- Hired outreach medical assistants (3 for the organization)
  - Maine Cancer Foundation Grant
- Types of outreach
  - Postcards for those turning 50 in 3 months
  - Letters/phone calls to patients overdue for colorectal cancer screening (focus on those that have had CRC screening in past)

Practice Outreach: Patient Reminders (cont.)

- Types of outreach (continued)
  - Letters to patients who have had CRC screening in the past and will be due in 3 months
  - Calls to patients who have cancelled or no showed for colonoscopy
  - Follow-up with patients 1wk after sending out FIT kits to answer questions/identify barriers or concerns
  - Permission to schedule

Increase Knowledge

- Developed most common “reasons for not screening”
  - -Developed scripts to combat these concerns/myths
  - -Development of scripting for outreach medical assistants
- Adoption of standing orders
- Enhanced training on FIT for medical assistants
- Lab staff orienting new providers on difference between occult stool cards and FIT testing
- Continuing Medical Education (CME) for medical providers for CRC/FIT Educational Training
- Use of pooh-doh for training for FIT kits
- Simplifying instructions for staff and patients

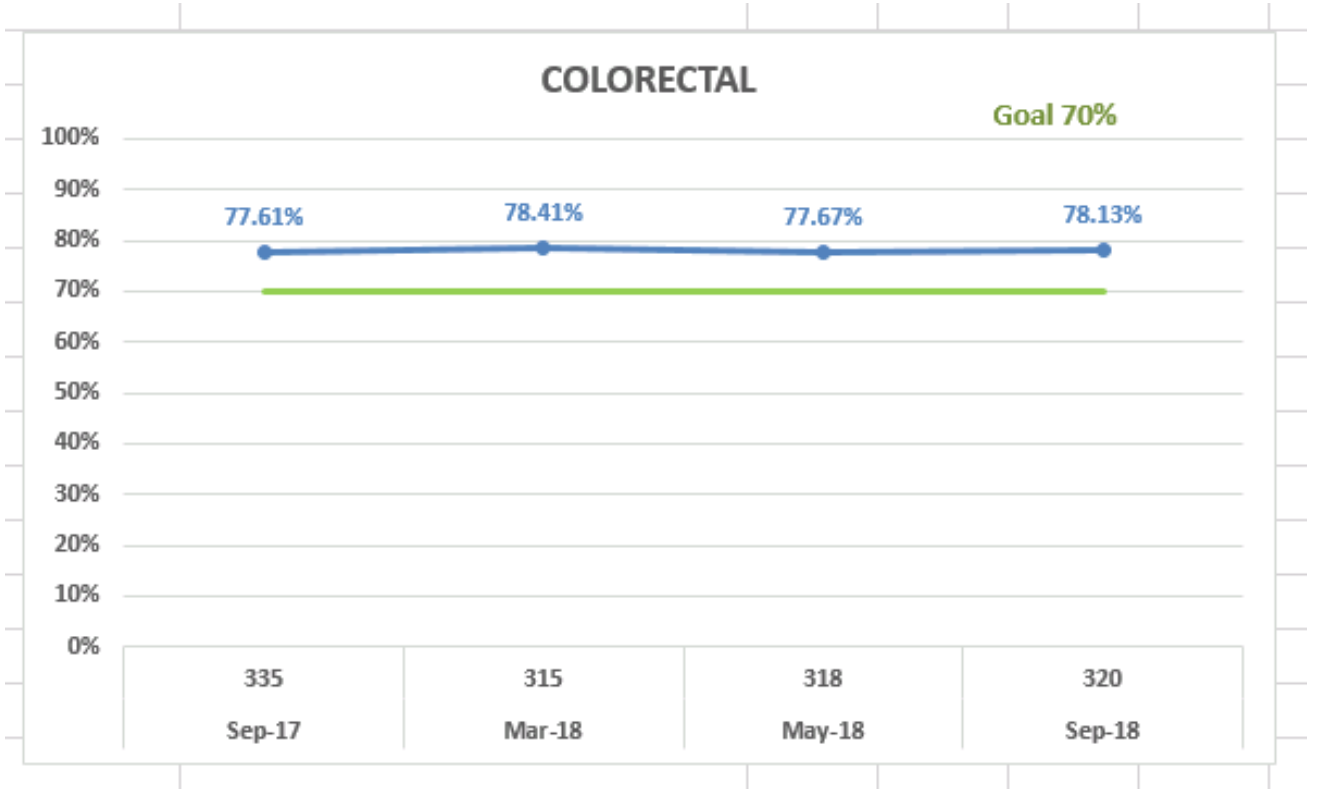
Including Other Members of the Team

- Reports from data team looking for colonoscopy documents in the EMR and data not put in discrete field
- Ask that medical records staff begin “flow-sheeting” colonoscopy data in discrete fields
- Ensure medical records staff enter discrete data into report fields for new patients
- Empaneled medical assistants identify pts due through pre-visit planning

Use of Data

Dashboards with CRC screening rates

SUSAN CHEFF, MD	Flu	BP Control	Colorectal	Mammo	A1C<9	PAPS	Depression Screening	IVD with Antithrombotic	CAD with Lipid Lowering Therapy
YOUR RESULT	N/A	95%	78%	76%	88%	80%	N/A	98%	80%
GOAL	90%	80%	70%	70%	88%	75%	0%	90%	80%
Number of Pts to Reach Goal	N/A	0	0	0	0	0	N/A	0	0
PRACTICE AVERAGE	N/A	90%	70%	71%	80%	72%	N/A	94%	83%
Organizational Average	N/A	85%	65%	67%	78%	61%	N/A	90%	81%



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Use of Data (Continued)

Testing Accuracy of FIT

Out of 114 patients that had a positive FIT and went on to have a colonoscopy…

58/114 (50.9%): Adenomatous Polyp(s)
14/114 (12.3%): Hemorrhoids
12/114 (10.5%): Diverticulosis
8/114 (7%): Hyperplastic polyp
4/114 (3.5%): Cryptitis/Colitis
3/114 (2.6%): Adenocarcinoma
9/114 (7.9%): Normal
6/114 (5.3%): Colonoscopy not performed

Addressing Provider Concerns: ? need for scheduling colonoscopy if only one FIT test (of 2 samples) is positive. Out of 59 patients with an adenoma/carcinoma found on colonoscopy, 27 patients had only 1 positive FIT (45.7%).

Collaboration with Other Organizations

- Maine Cancer Foundation, American Cancer Society, Maine Primary Care Association, St. Joseph's Hospital, HealthInfoNet, other FQHC's
- Use of another anesthetic for patients without someone to accompany them home after procedure
- No longer requesting a consult prior to the colonoscopy

Collaboration with Other Organizations (Continued)

- Switching of prep back to one that is more tolerated
- Re-instituting calls prior to the procedure
- Encourage local pathologist to send all pathology to HIE

Most Helpful in the CRC Learning Collaboratives:

Most Useful:

Collaboration

- To learn what other practices are doing to improve CRC screening rates
- To share barriers and work on solutions/work arounds as a group
- Identifying best practices
- In-person learning sessions most useful

Least Useful:

The learning calls were difficult to engage in but the content was helpful

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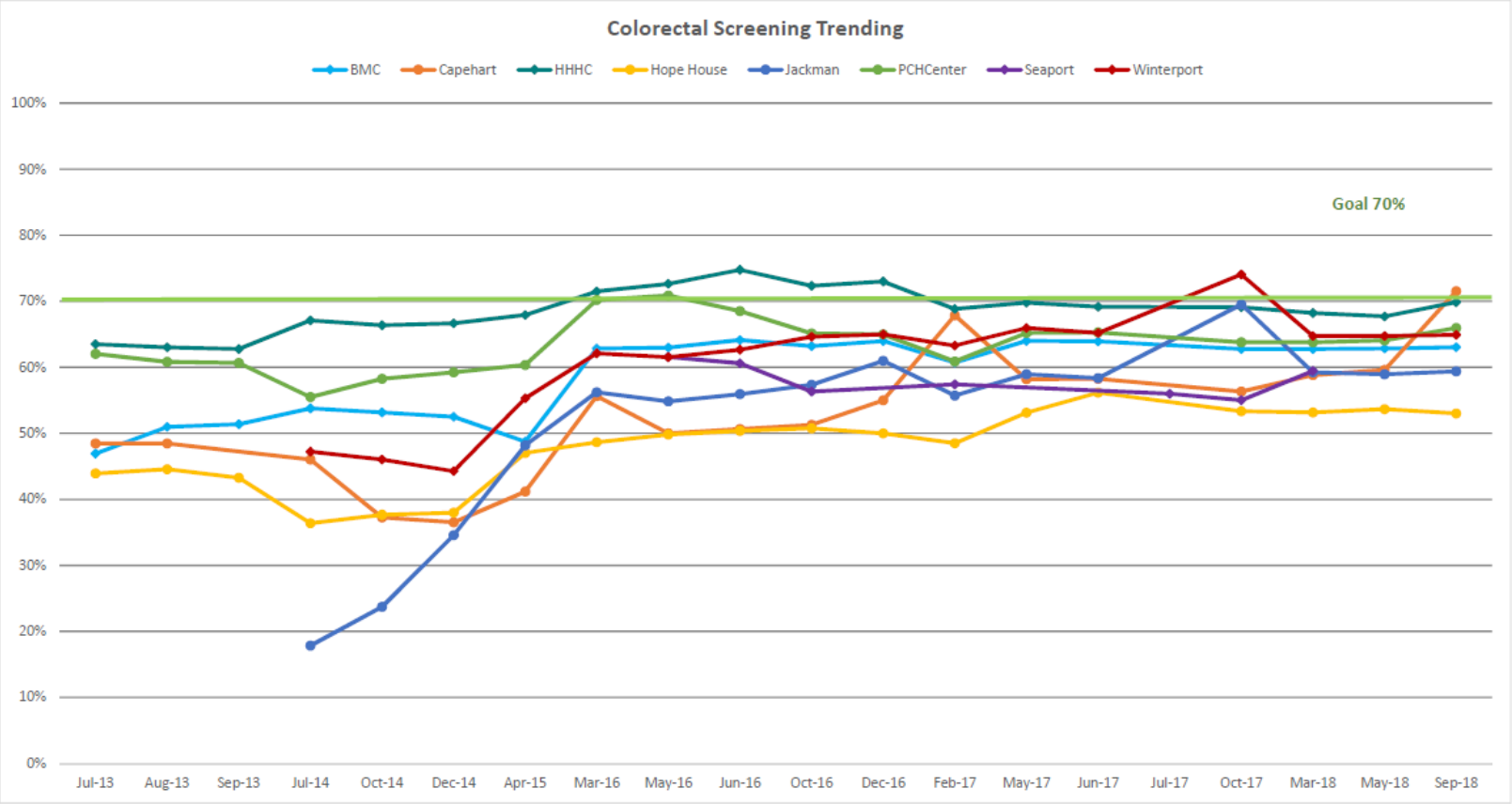
Oct. 2012- June 2015- Sept. 2018

38.85%→57.69%→65% *Provider Range 43%-82%*



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