

80% by 2018 Strategic Mapping Moving Professionals to Action Pre-Meeting Survey Results

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80% by 2018 Strategic Mapping Process

Big Picture Mapping Session – June 10th, 2014

- 23 organizations represented
- Provided input through pre-meeting survey and discussion
- Session used to begin development and prioritization of draft 80% by 2018 strategic plan

Public Awareness Task Group Meeting – July 17th, 2014

- 26 organizations represented
- Provided input through pre-meeting survey and discussion
- Further adjusted 80% by 2018 strategic plan
- Finalizing 80% by 2018 Communications Plan

Professional Education and Practice Task Group Meeting – July 30th, 2014

- 23 organizations representing
- Provided input through pre-meeting survey and discussion
- Further adjust 80% by 2018 strategic plan
- Develop a 2015 provider outreach/systems change plan around 80% by 2018
- Fold 80% by 2018 Communications plan into the work



80% by 2018 Strategic Mapping Moving Professionals to Action Pre-Meeting Survey Results

What:

- Participants took a 15 question on-line survey

Participants:

- 24 individuals took the survey; 21 organizations represented
- 23 organizations represented at the meeting

Purpose:

- To help inform our work to activate efforts around provider outreach and systems change in order to reach 80% screening rate for colorectal cancer by 2018.



Survey Insights

Keys to success:

- Use a multilevel thought process that asks what should be done at the patient, provider, organization, community, and national level.
- Encourage partnerships and collaboration across all relevant organizations that take advantage of each contributors area of expertise (e.g., public health expertise in population management with provider expertise in individual patient management).
- Tailor strategies to the audience and organizations we want engaged in the cause.
- Figure out what the NCCRT can do at the national level to support 50 state strategies.



Survey Insights

What do we have going for us?

- Range of organizations with influence on local, state and national levels
- Successful initiatives implemented through partner organizations to reach physician groups, researchers, health systems and government influencers
- Existing set of tools to promoting systematic screening improvements
- Experience implementing testing options through various avenues and utilizing reminders/patient navigators
- Agreement on the importance of collaboration and partnership
- Resounding support for 80% by 2018



Working with Primary Care Practices

Perceived barriers to success

- Lack of time and resources to dedicate to CRC efforts (i.e. screening reminders, invitations, etc.); competing priorities
- Poor use/underuse of EMRs
- Not enough incentives to increase screening rates
- PCPs lack knowledge about screening options; issues with improper screening
- Issues with securing follow up treatment

What's worked?

- Working through state CCC plans, ACS and state department of health to reach primary care
- Using community health workers/patient navigators to navigate patients through the screening process
- Using EHRs to improve the referral and reminder process through automation
- Keeping providers informed of their screening rates as compared to HP goals and their peers
- Delivering messaging and tools related to CRC screening through quality improvement organizations and initiatives
- Developing better lines of communication with gastroenterologists
- Creating learning communities that PCPs can share best practices for increased CRC rates



Recommendations:

Primary Care Practices

Work with NACHC, ACP, AAFP, ACOG on a national level to legitimize local efforts to improve screening; NP, PA/pharmacist

Work with health systems especially payers to provide data and incentives for PCPs; role of CCC plans and coalitions in PCP

Provide PCPs education about screening guidelines, testing options, achievable first steps and systems change with CME; resident training and MOC

Help practices improve EHR systems to track screenings and automate screening reminders and invitations and how to do pop management with what you have; feedback for docs

Recognize high performing practices

Teaching team based approach to care (possibly to include navigation) as a way to address workload issues

Promote solutions to common barriers; provide “consultations” to help PCPs overcome barriers to screening

Work with AAFP, ACP ACOG and CDC to develop specific tools about talking to patients who are reluctant to be screened

Work with state department of health



Working with CCC Programs & Coalitions

Perceived barriers to success

- State plans are not specific enough
- State officials operate in silos and are not engaged on the issue
- Lack of understanding about the toll of CRC and the economic benefits of screening
- Not enough funds and lots of competing priorities

What's worked?

- Involvement of key leadership in state planning committees and program boards; strong local champions
- CCC workgroups that focus on CRC
- Encouragement of partnership organizations to sign the 80 x 2018 pledge
- Development and distribution of Colorectal Cancer Awareness materials
- Use of NCCRT's CRC Clinician's toolkit



Recommendations:

Cancer Control Programs & Coalitions

Encourage CCC programs and coalitions to adopt 80% by 2018

Promote connection between CCC and primary care – constructive suggestions about what works

Provide them with evidence-based actionable items on a regular basis

Provide forums for sharing between high performers and those new to CRC – CDC

Inventory plans on CRC; identify best practices and help others improve -- CDC

Create resources for development of state level CRC Roundtable with right partners the table – primary care, payers, CoC, academic medical center etc, state health departments

Develop state level data on toll of CRC in both human and economic terms; build proportionality into efforts

Provide guidance on communications strategy using state health director



Working with Payers

Perceived barriers to success

- Payers do not see the ROI in CRC screening tests; resistance to changing rates or coverage
- Cost of anesthesia and facilities charges are driving up the cost of screening
- Inability to change quickly due to contracts and regulations
- Fragmented coding/claims systems that don't align with ACA mandate
- Payers have other health priorities
- Payers are not up-to-date on the latest recommendations or ACA-covered procedures

What's worked?

- Work on CRC awareness
 - Encouraging testing through health plan sponsored worksite wellness programs
 - Working with health plans on patient screening reminders
- Patience and perseverance and a friend on the inside
- Some collaboration with state Medicaid programs
- Lobbying states to make CRC screening a required performance measure
- Collaboration with state policy makers to introduce anti-cost sharing legislation for polyp removal
- Working with state insurance commissioner to formally communicate to plans that there is no cost sharing for polyp removal



Recommendations:

F Speak their language: Make business/ROI case for CRC; stress both paying for good services and ceasing coverage for bad

Do literature review to show what interventions by payers have been effective; do report on best practices; recognize high performers

Do toolkit to help health plans look at how they are doing at each part of the process; recruit payers to help; push for required quality measures on CRC for providers

Pay for performance incentives for providers

Improve payer awareness of proper coding for procedures covered under the ACA

Encourage strategic use of databases to inform clinicians, do patient reminders and target unscreened subpopulations; influence what's in EMR

Use advocacy and legislation changes to influence commercial payers



Quality Stool Blood Testing

Perceived barriers to success

- Colonoscopies are seen as the gold standard
- Lack of education throughout the entire healthcare system, especially as it relates to the existence of stool testing and its effectiveness
- Too many tests out there without data on effectiveness; problems with FDA approval process
- Need to assure adherence to annual testing
- Confusing instructions, not geared toward low literacy levels
- Copays apply to follow up colonoscopy if positive

What's worked?

- Education and outreach efforts
- FluFIT/FOBT promotion
- Use by many CDC CRCCP grantees
- Ensuring its offered as an option to those who can't afford, can't access or refuse colonoscopy



Recommendations: Promote Quality Stool Blood Testing

Educate the public, doctors, clients, physicians on the option, existence and effectiveness of different screening methods

Provide criteria for evaluating test effectiveness; Promote high quality, high value evidence based Fecal Occult products and practices

Find ways to provide valued low cost tests to uninsured

Encourage guideline organizations to define screening continuum to include colonoscopy after positive stool blood test; define quality measures using this definition

Work with vendors to improve literacy levels of patient instructions

Work with the FDA to improve oversight on approved tests