

NCCRT

Primary Care Strategy Meeting

*Catalyzing Primary Care to Increase
Colorectal Cancer Screening*

*August 12, 2022
8:30am-3:45pm ET*





The State of Primary Care

Richard C. Wender MD
Professor and Chair
Family Medicine and Community Health
University of Pennsylvania



Penn Medicine



Department of
Family Medicine &
Community Health

The State of Primary Care: The Bottom Line

- Having a primary care clinician is associated with substantial improvements in health and is a public good.
- Family physicians provide most primary care visits. Visits to CRNP's and PA's are critically important. General internal medicine is declining.
- Number and distribution of primary care clinicians is inadequate.
- Primary care clinicians are under stress and at risk of leaving primary care practice.



Higher concentration of and access to primary care improves health.



Primary Care, Health, and Equity

Barbara Starfield,
MD, MPH

Supercourse lecture
September 2004



Primary Care Oriented Countries Have

- Fewer low birth weight infants
- Lower infant mortality, especially postneonatal
- Fewer years of life lost due to suicide
- Fewer years of life lost due to all except external causes
- Higher life expectancy at all ages except at age 80

Starfield 07/07 IC 3762 n

Sources Starfield. Primary Care Balancing Health Needs, Services, and Technology. Oxford U. Press, 1998. Starfield Shi, Health Policy 2002 60201-18.



“Each 10 additional primary care physicians per 100,000 people is associated with a 51.5 day increase in life expectancy.”

JAMA Internal Medicine | Original Investigation

Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015

Sanjay Basu, MD, PhD; Seth A. Berkowitz, MD, MPH; Robert L. Phillips, MD, MSPH; Asaf Bitton, MD, MPH; Bruce E. Landon, MD, MBA; Russell S. Phillips, MD

IMPORTANCE Recent US health care reforms incentivize improved population health outcomes and primary care functions. It remains unclear how much improving primary care physician supply can improve population health, independent of other health care and socioeconomic factors.

OBJECTIVES To identify primary care physician supply changes across US counties from 2005-2015 and associations between such changes and population mortality.

DESIGN, SETTING, AND PARTICIPANTS This epidemiological study evaluated US population data and individual-level claims data linked to mortality from 2005 to 2015 against changes in primary care and specialist physician supply from 2005 to 2015. Data from 3142 US counties, 7144 primary care service areas, and 306 hospital referral regions were used to investigate the association of primary care physician supply with changes in life expectancy and cause-specific mortality after adjustment for health care, demographic, socioeconomic, and behavioral covariates. Analysis was performed from March to July 2018.

[← Invited Commentary page 515](#)

[+ Supplemental content](#)



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“Primary care is a public good.”

Implementing High-Quality Primary Care

SHARE [f](#) [t](#) [in](#) [✉](#)

Implementing High-Quality Primary Care:

Rebuilding the Foundation
of Health Care



What does provision of primary care services look like in the U.S.
today?



Table 1. Number of Office-Based, Direct Patient Care Physicians by Specialty, 2017

Physician Type	Number of Physicians	Percent of Primary Care Physicians	Percent of Total
Total Physicians	699,670	-	100.0%
Non-Primary Care Physicians	476,546	-	68.1%
Total Primary Care Physicians	223,125	100.0%	31.9%
Family Physicians	88,197	39.5%	12.6%
Geriatrics	4,170	1.9%	0.6%
General Practice	6,097	2.7%	0.9%
General Internal Medicine	77,068	34.5%	11.0%
General Pediatrics	47,593	21.3%	6.8%

Source: American Medical Association (AMA) Physician Masterfile (2017)

Exodus of General Internists Adds to Primary Care Shortage

May 12, 2010

PRINT 

Health and Human Services Secretary Kathleen Sebelius wants health care reform to “[usher in a new era for primary care providers](#),” but a new report warns that increasing numbers of general internists are leaving the field.

A [survey](#) conducted by the American College of Physicians (ACP) and the American Board of Internal Medicine (ABIM) found that nine percent of all internists originally certified between 1990 and 1995 are no longer working in general internal medicine or any of its subspecialties. That figure includes both general internists and internal medicine sub-specialists. When the data for general internists is broken out separately, the portion defecting from the field rises to a whopping 17 percent, compared to only four percent for the sub-specialists.

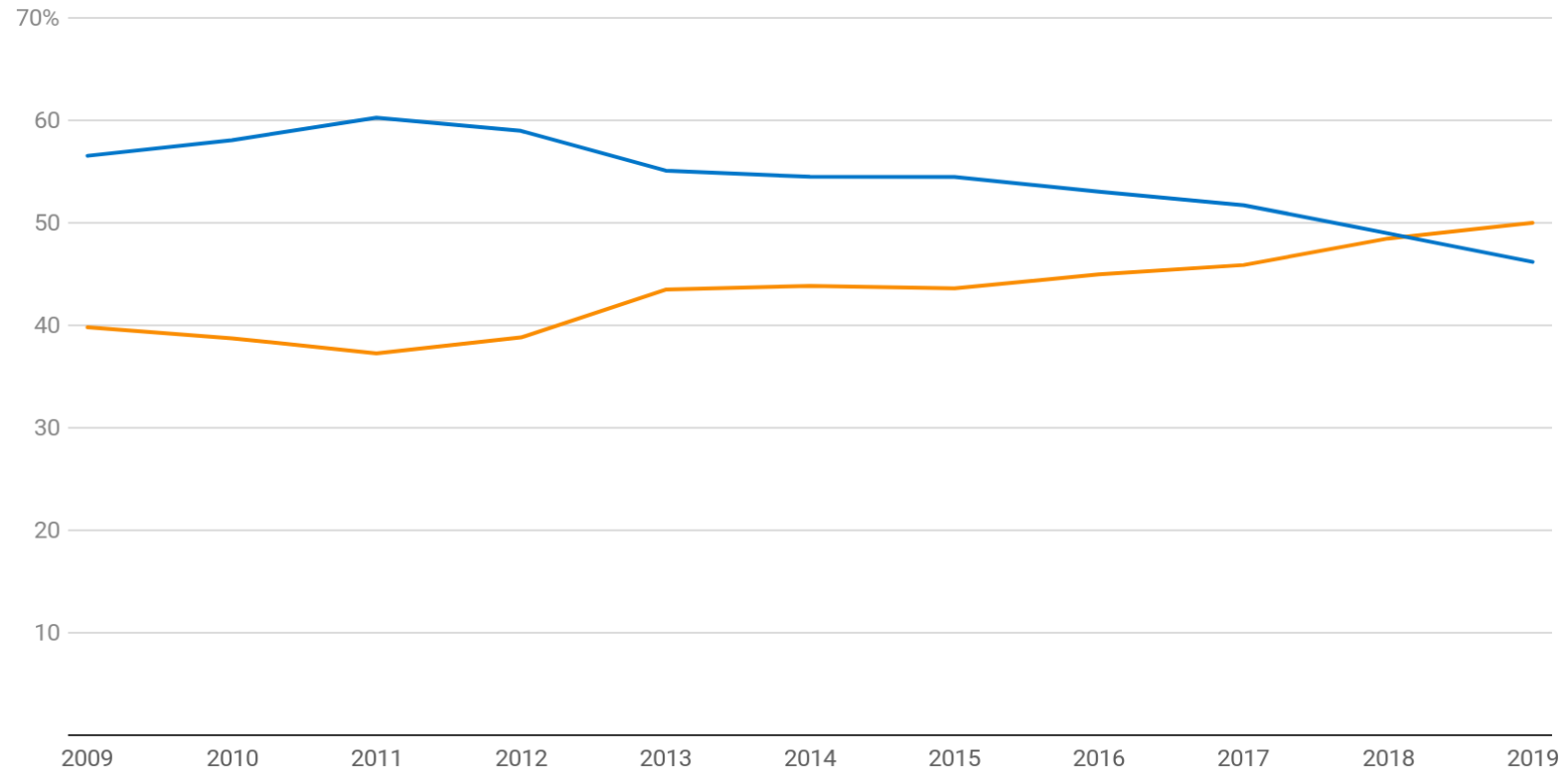


Osteopathic physicians and foreign-trained physicians comprise a rising percentage of the primary care workforce.

Newly Minted M.D.s Less Likely to Seek Careers As Primary Care Physicians

Although the percentage of U.S.-trained M.D.s who seek further training in one of the three primary care residency categories — internal medicine, family medicine and pediatrics — is declining, the percentage of U.S.-trained osteopathic doctors and foreign-trained allopathic doctors desiring jobs in those fields is on the rise.

— U.S.-trained allopathic doctors — Osteopathic and foreign-trained allopathic doctors



Note: The category for U.S.-trained allopathic doctors, or M.D.s, includes both fourth-year medical students and graduates of U.S. medical schools.

Credit: Victoria Knight/Kaiser Health News

Source: [National Resident Matching Program](#)



Visits to primary care physicians are declining.
Visits to NP's and PA's are increasing.

Figure 4: Annual Change in Office Visit Utilization to PCPs and NPs and PAs

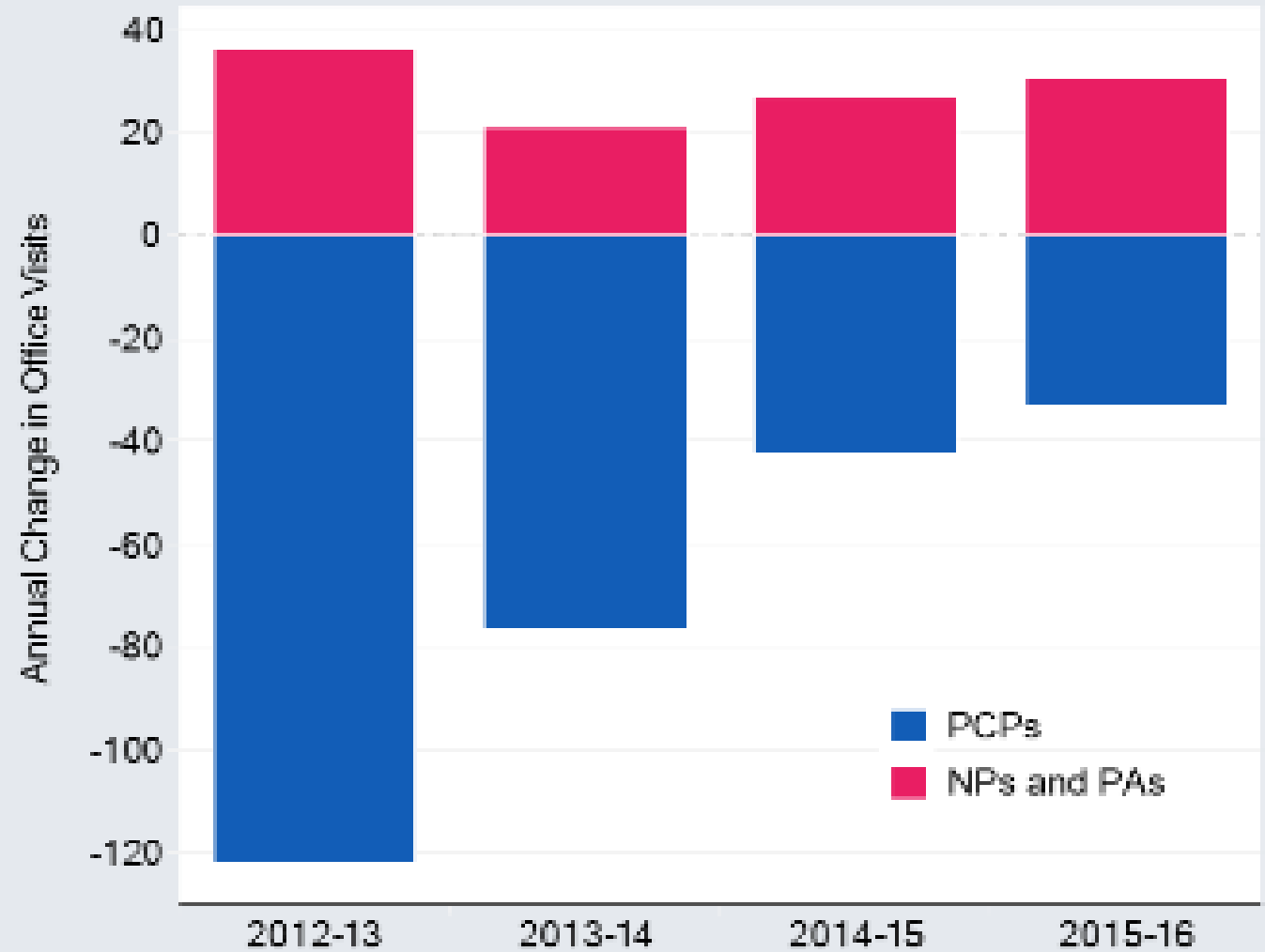
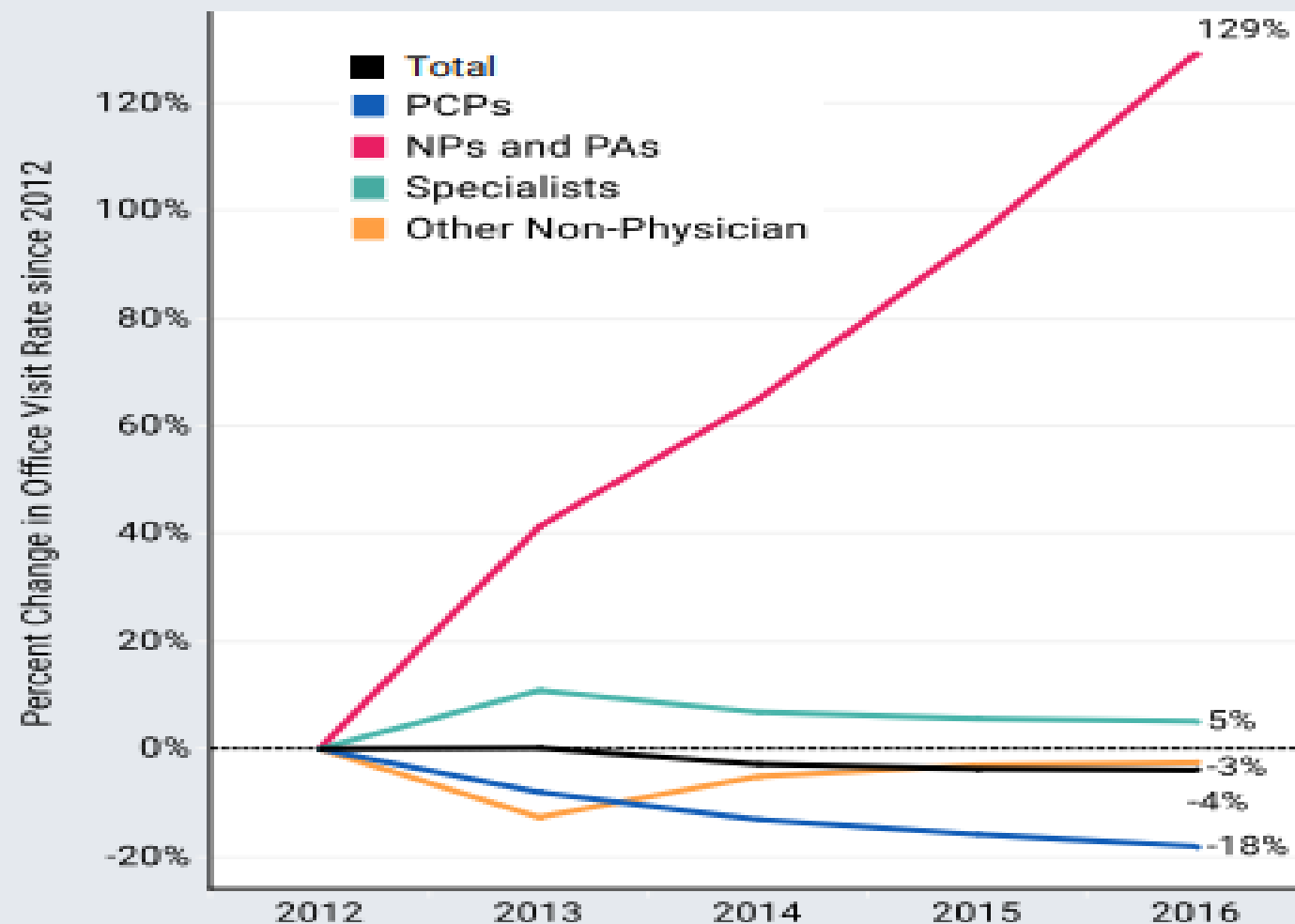
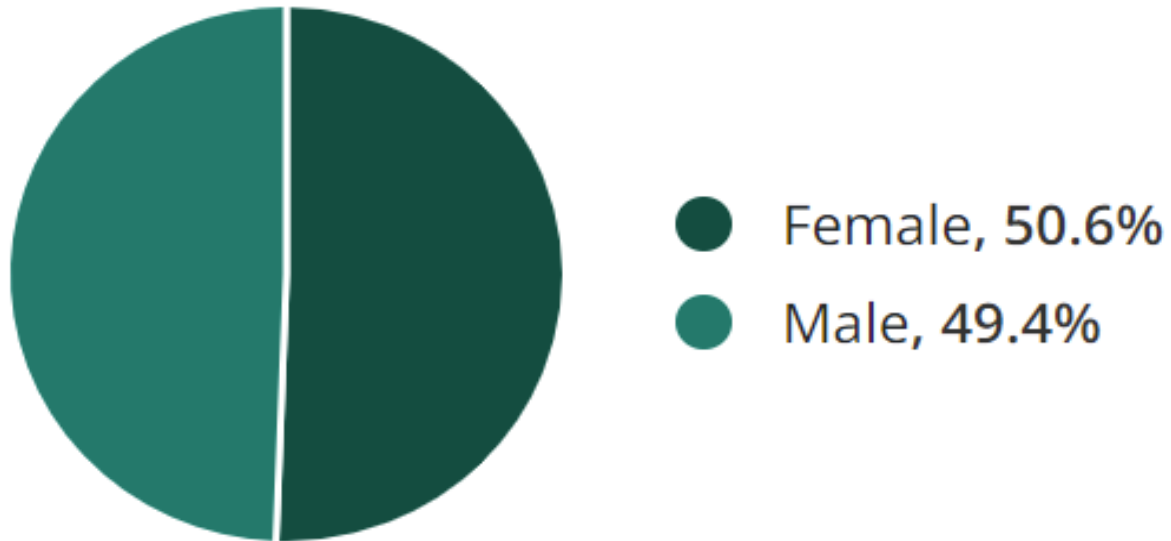


Figure 3: Cumulative Change in Office Visit Utilization, 2012-2016

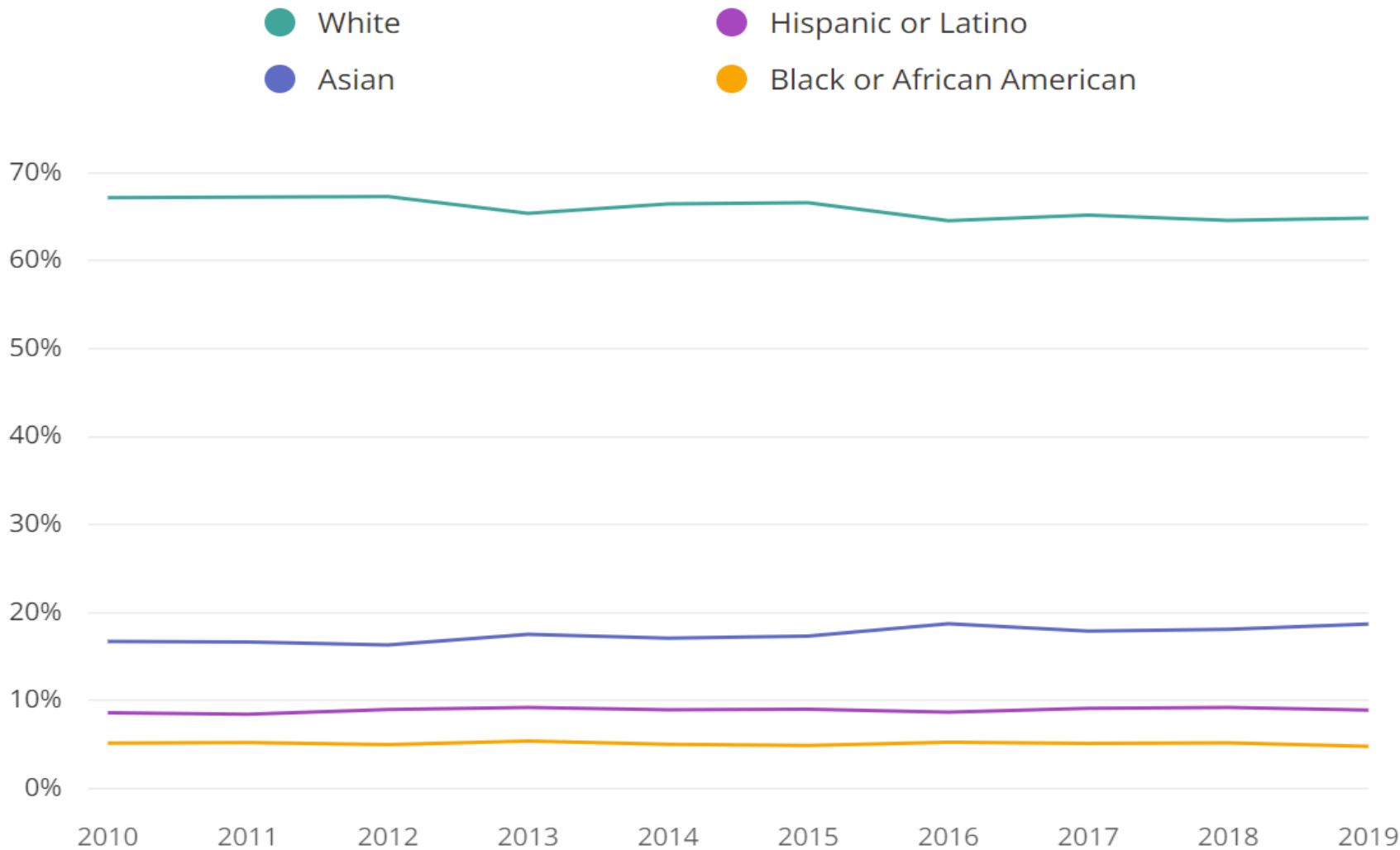


Among primary care physicians, 50.6% of them are women compared to 49.4% which are men.

Job Title ▾

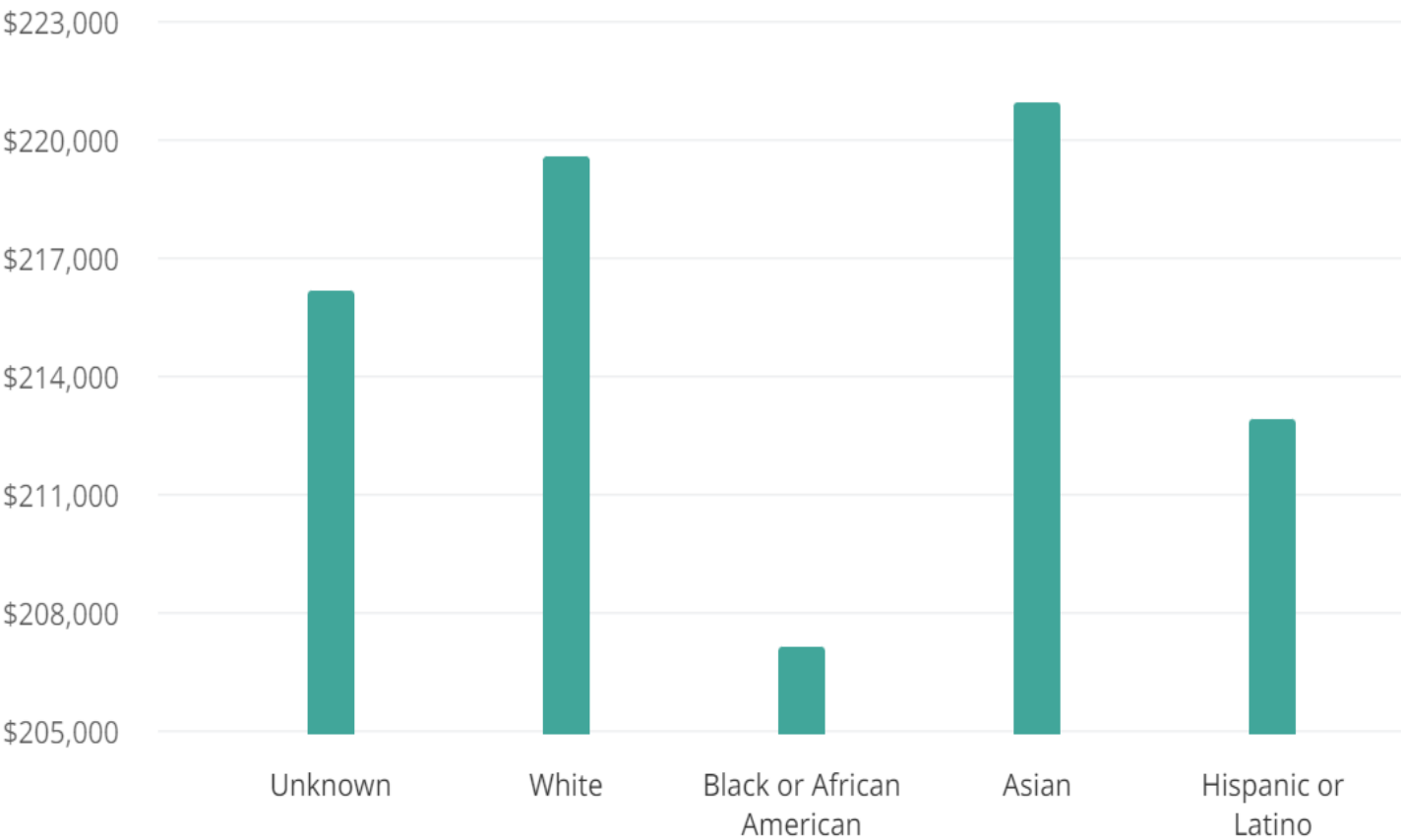


Using the Census Bureau data, we found out how the percentage of each ethnic category trended between 2010-2019 among primary care physicians.



Primary Care Physician Wage Gap By Race

Asian primary care physicians have the highest [average salary](#) compared to other ethnicities. Black or african american primary care physicians have the lowest average salary at \$207,205.



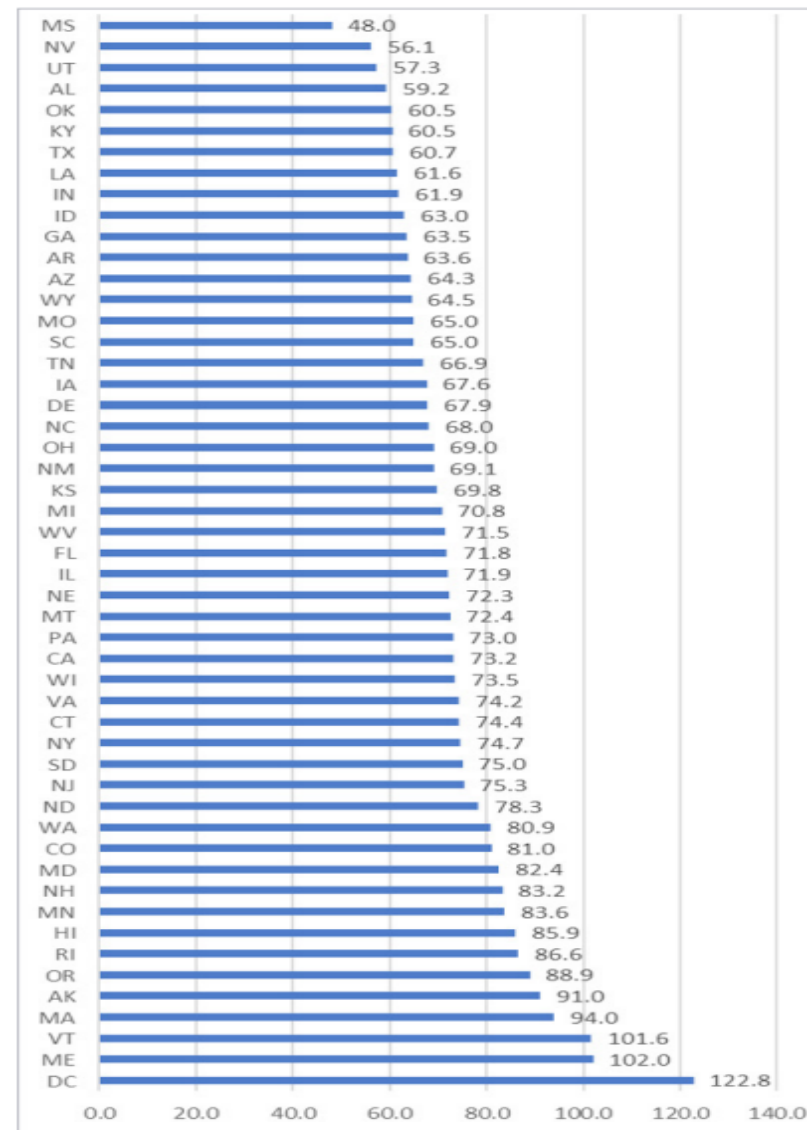
Primary care clinicians are concentrated in larger MSA's. Family physicians are more likely to work in smaller communities and in rural settings.

Table 5. Primary Care Professionals by Metropolitan Statistical Area (MSA) Status

Population Range	Percent of U.S. Population	Non-Primary Care	Primary Care	Family Medicine	Internal Medicine	Pediatrics	General Practice	Geriatrics
MSA								
1,000,000+	54.7%	63.5%	58.2%	48.1%	65.5%	65.9%	46.0%	67.3%
250,000-1,000,000	21.2%	21.1%	21.3%	24.2%	19.6%	19.5%	15.8%	20.8%
< 250,000	9.2%	8.4%	8.6%	11.0%	7.3%	6.9%	7.0%	6.1%
Non-MSA								
20,000+	5.9%	3.4%	4.5%	6.2%	3.4%	3.3%	5.1%	2.2%
2,500-19,999	7.4%	2.1%	4.9%	8.1%	2.7%	2.3%	7.8%	1.9%
< 2,500	1.5%	0.2%	0.7%	1.3%	0.3%	0.2%	1.8%	0.3%



Table 4. Primary Care Physicians per 100,000 Population by State, 2017

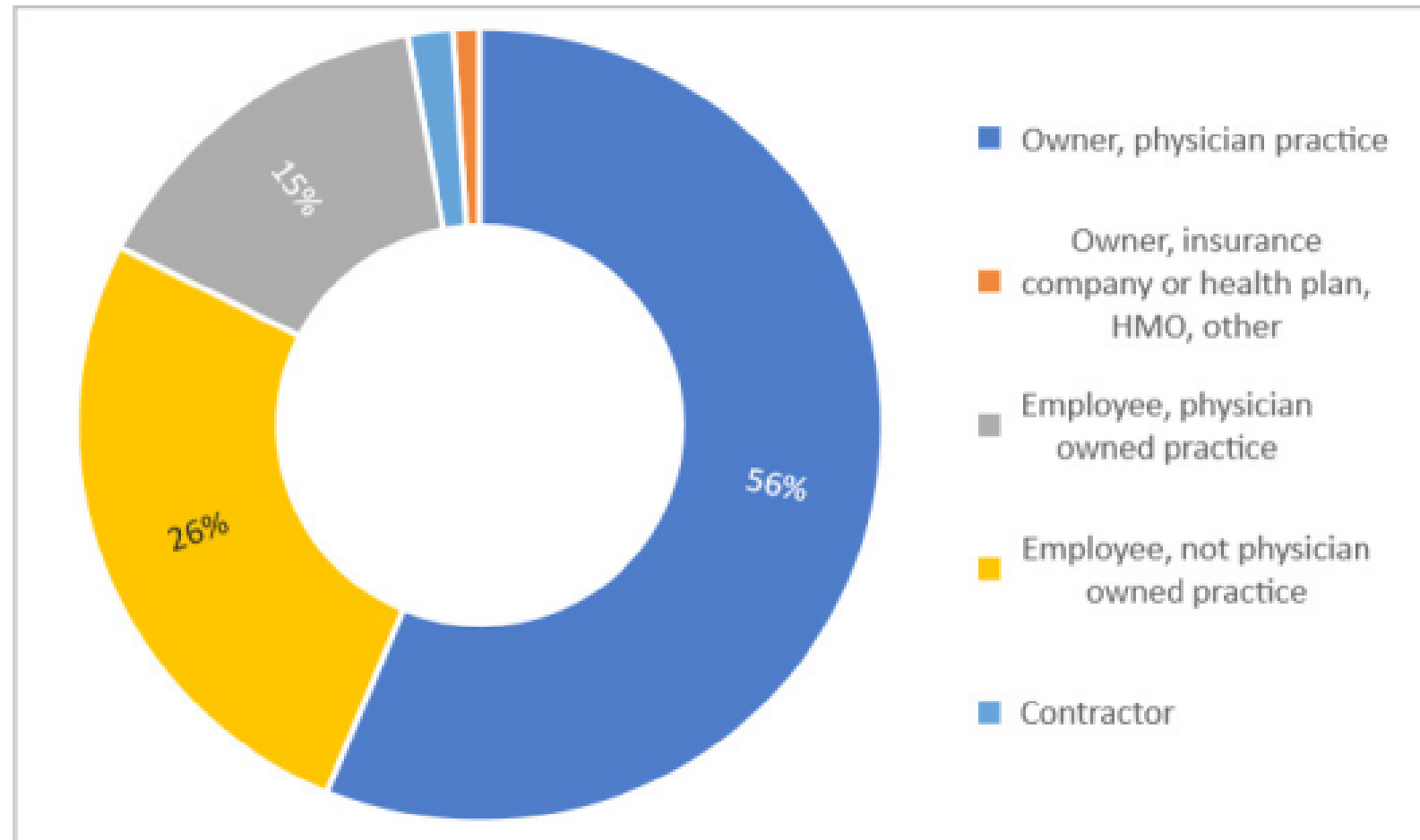


Primary Care Clinician Type in Rural Areas

- Physician assistants are the most likely clinician type to practice in health area shortage areas.
- Nurse practitioners and nurse midwives are also more likely to practice in HPSA's.
- Family physicians are far more likely than other physician types to practice in HPSA's.

**A higher percent
of primary care
physicians own
their practice
than one might
think.**

Figure 5. Primary Care Physicians by Employment Status, 2014



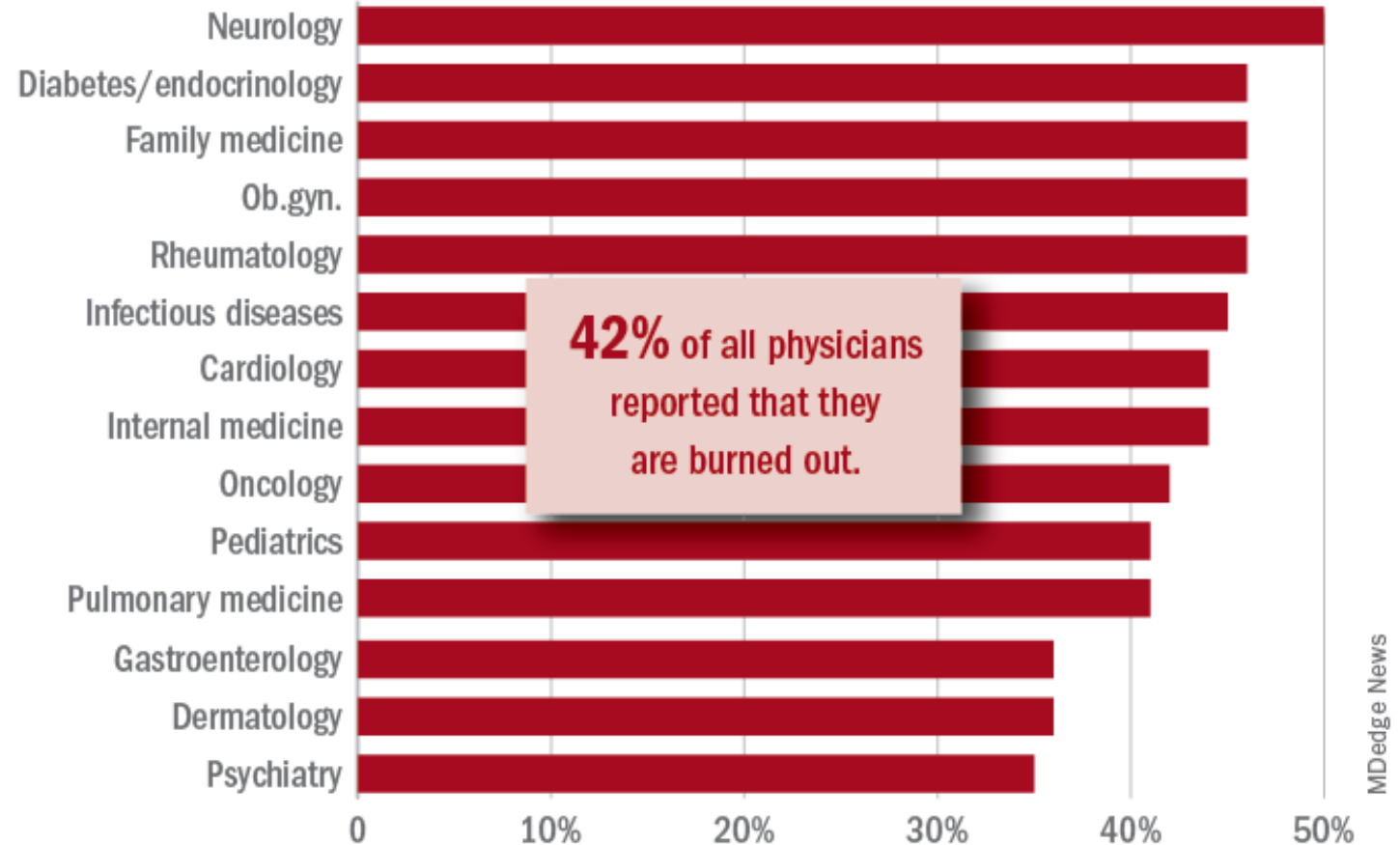
Source: National Ambulatory Medical Care Survey (NAMCS) (2014)

Primary care clinicians are feeling stressed.



Burnout rates among family physicians are high.

Physicians in selected specialties who reported burnout

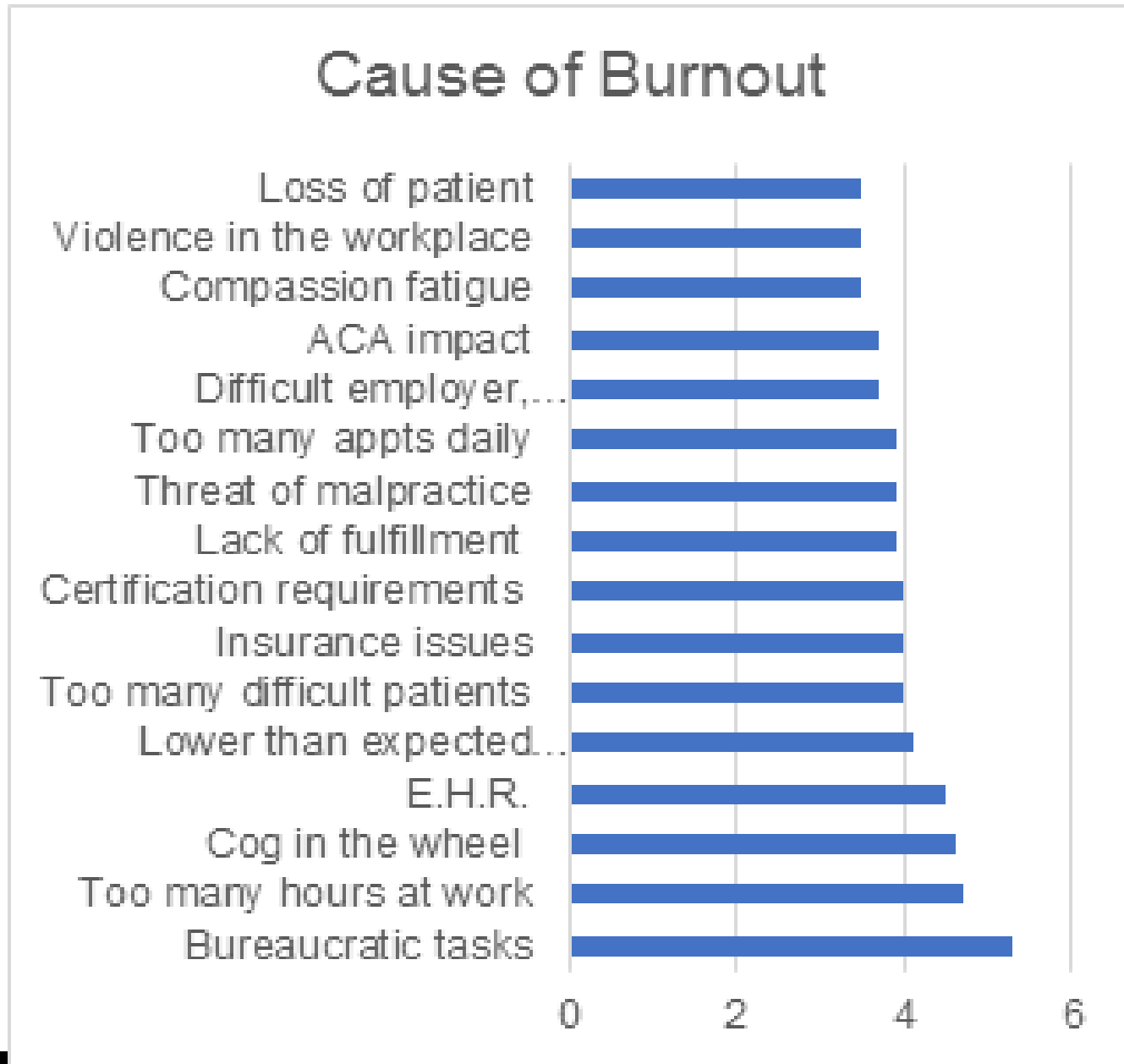


Note: Based on a survey of 15,181 physicians conducted from June 25 to Sept. 19, 2019.

Source: Medscape



**A large array
of factors not
directly
related to
caring for
patients
contributes to
burnout.**



Increased Support Staffing Tops List Of US Physicians' Preferred Methods For Addressing Burnout

Q: Please select the three options which could be implemented by facilities to address burnout.



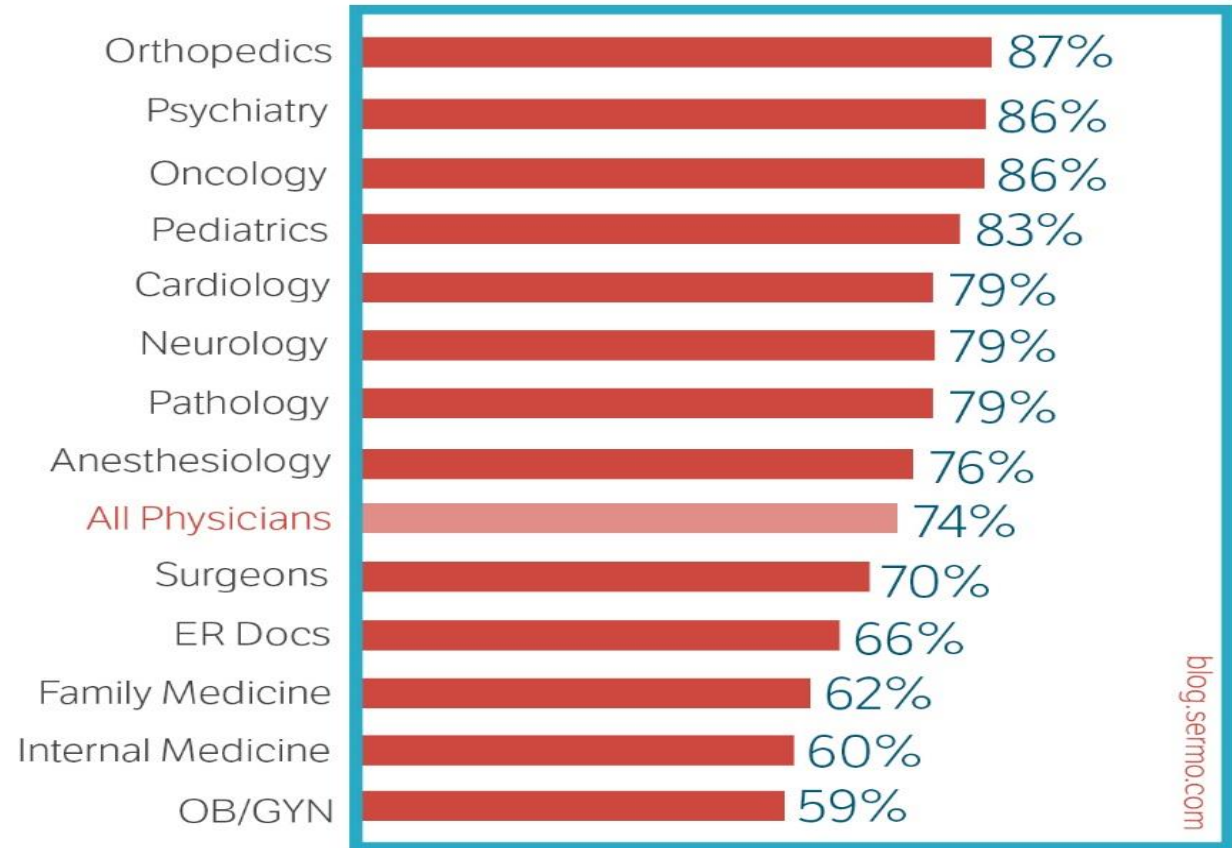
Source: InCrowd, n=612 physicians, 2019

BUSINESS
INSIDER
INTELLIGENCE



**Primary care
practice is not
satisfying
enough.**

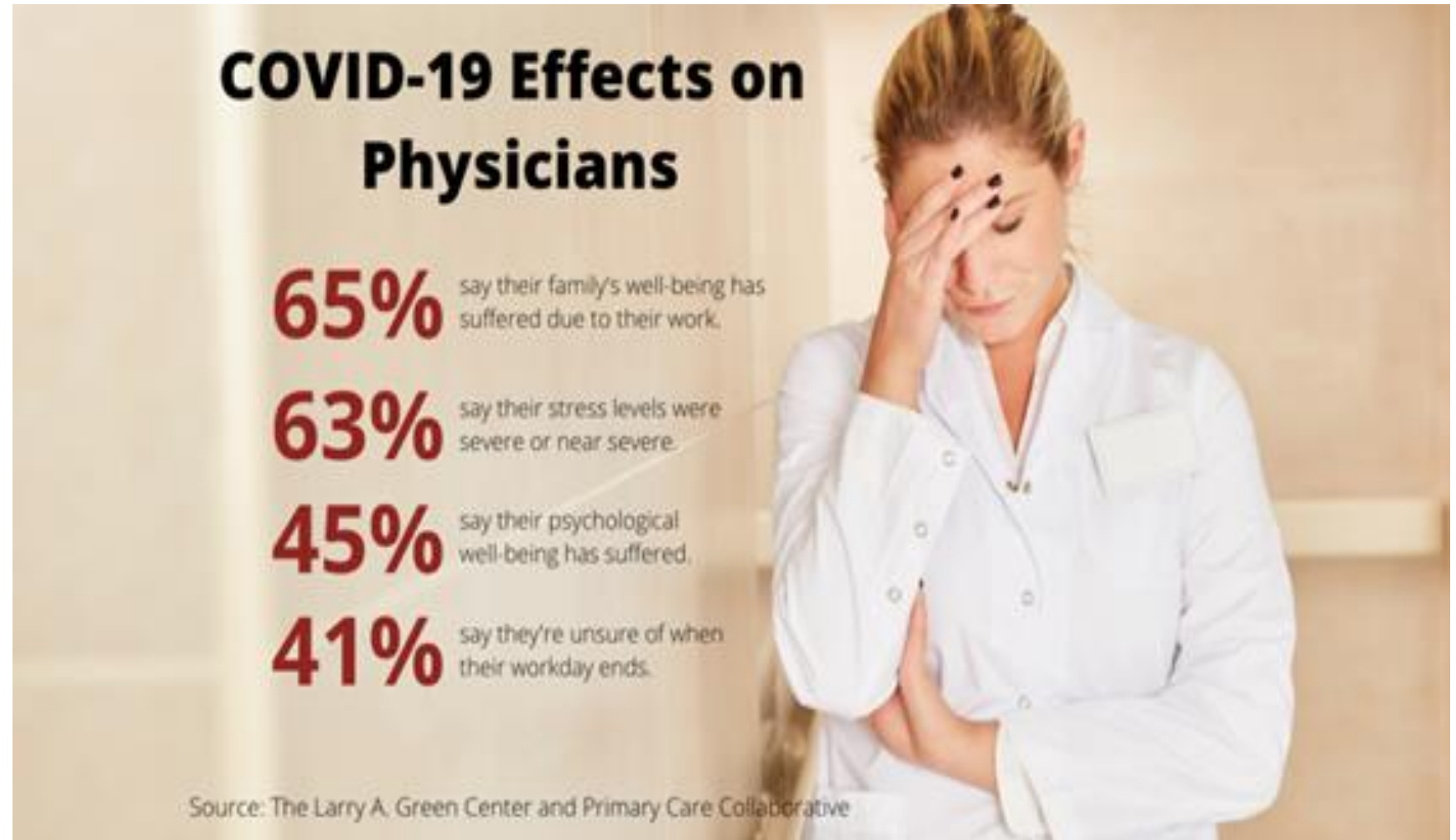
How Many Physicians Would Choose Their Specialty Again?



Sermo Physician Poll • Mar 2014 • 2926 Respondents



**COVID-19
has
exacerbated
stress level.**



Shaping the future of primary care.

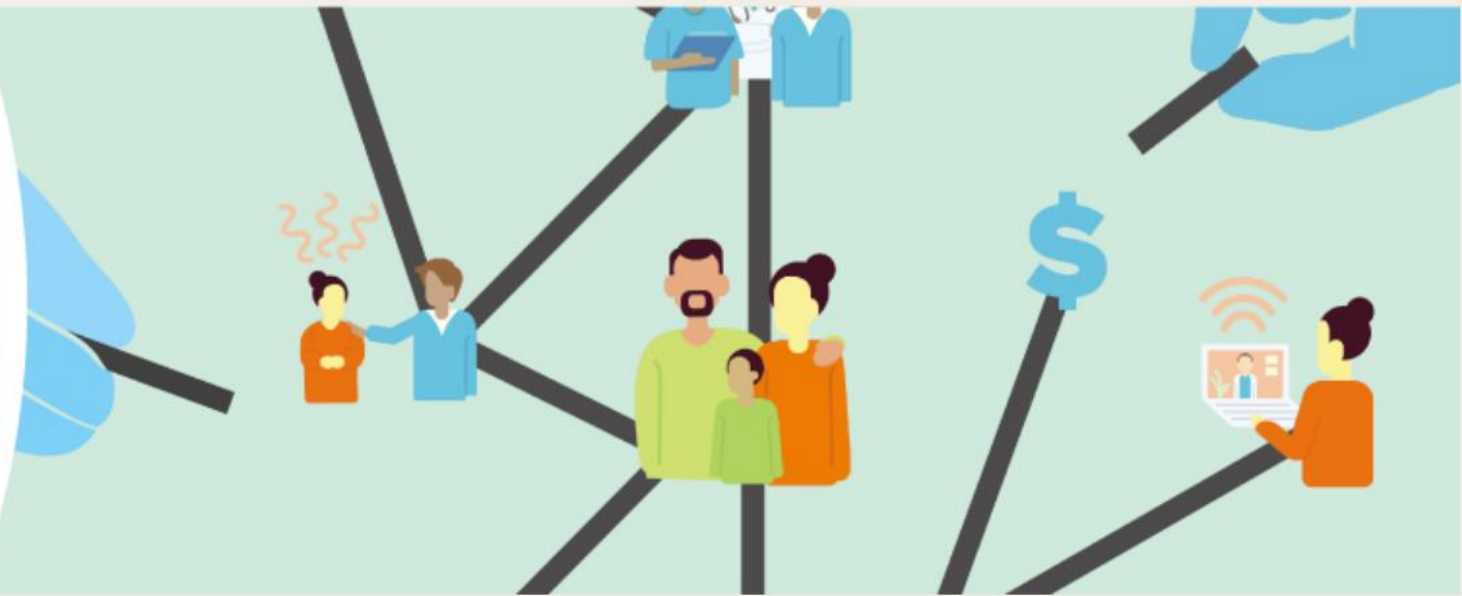


Implementing High-Quality Primary Care

SHARE    

Implementing High-Quality Primary Care:

Rebuilding the Foundation of Health Care



National Academies' Recommendations

1. Pay for primary care teams to care for people, not doctors to deliver services.
2. Ensure that high-quality primary care is available to every individual and family in every community.
3. Train primary care teams where people live and work.
4. Design information technology that serves the patient, family, and the inter-professional care team.
5. Ensure that high-quality primary care is implemented in the United States.



Implications for CRC Screening: Over-Arching Strategies

- Access to primary care is vital. Increasing access to primary care would reduce cancer mortality more substantially than increased access to oncologists . . . I think.
- We need to form stronger bonds with Nurse Practitioner and Physician Assistant leaders and organizations.
- We need more effective ways to partner with physician-owned practices.



Implications for CRC Screening: Office-based Interventions

- Promote participation in value-based payment models that are tied to quality outcomes and support team care.
- Increase linkages between primary care practices and organizations that can aid in population outreach.
- Continue to promote options for CRC screening.
- Engage local partners.



Thank you!



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Improving CRC Screening Rates – Lessons Learned

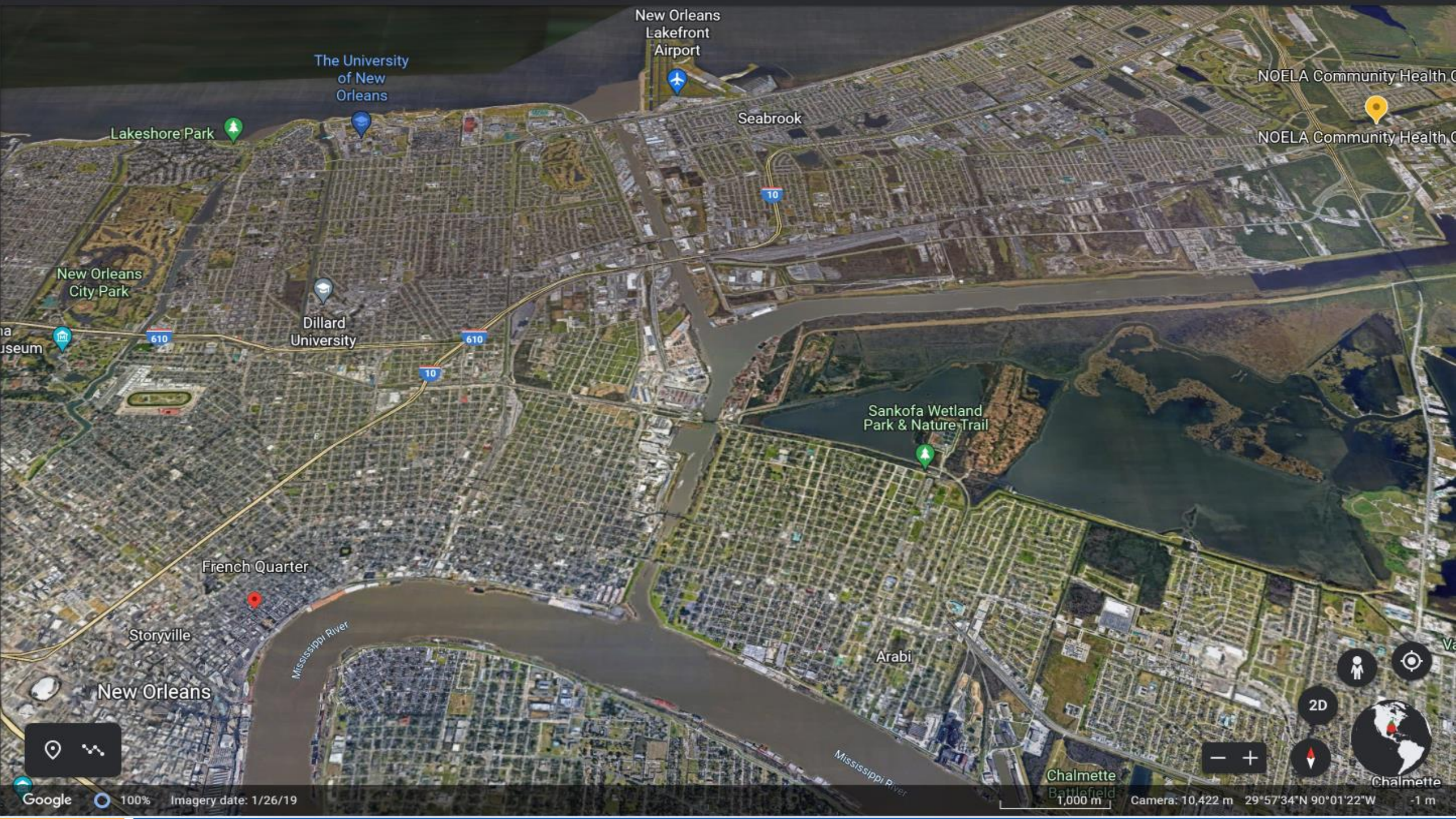
Dr. Keith Winfrey

August 12, 2022



New Orleans





New Orleans
Lakefront
Airport

The University
of New
Orleans

Lakeshore Park

Seabrook

NOELA Community Health C

NOELA Community Health C

New Orleans
City Park

Dillard
University

Sankofa Wetland
Park & Nature Trail

French Quarter

Storyville

New Orleans

Arabi

Chalmette
Battlefield
1,000 m

Camera: 10,422 m 29°57'34"N 90°01'22"W -1 m

Google 100% Imagery date: 1/26/19

NOELA Community Health Center

- **Practice Type:** Federally Qualified Health Center
- **Location:** New Orleans, Louisiana
- **Health System Statistics (2021 UDS Data):**
 - 4,904 unique patients
 - 94% of patients at or below 200% Federal Poverty Guideline
 - 63% of patients best served in a language other than English
 - 36% of patients are uninsured
 - EHR: AthenaHealth



NOELA Community Health Center



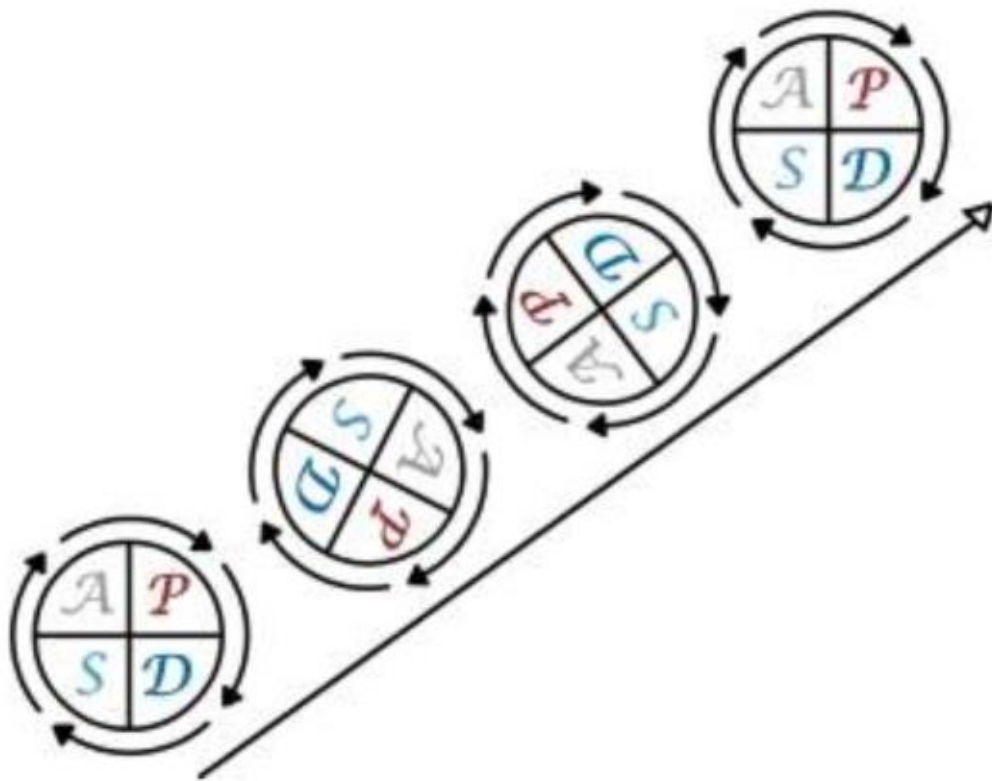
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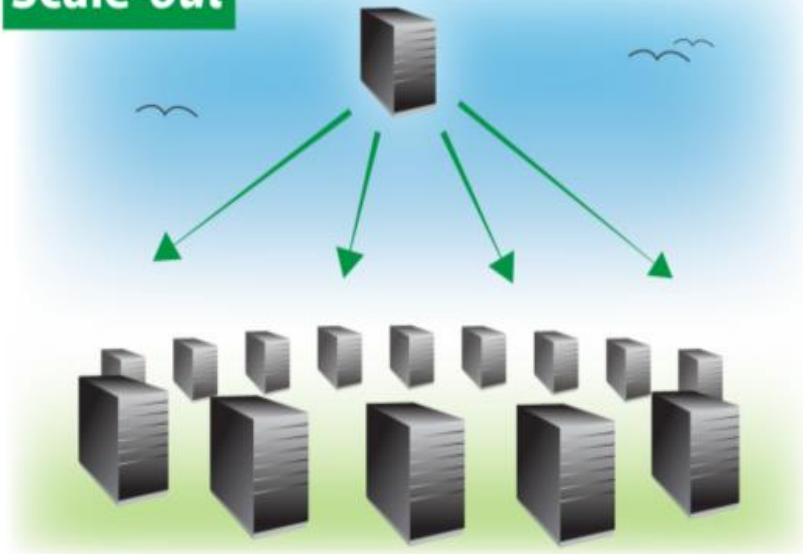
32%



28%



Scale-out





ABOUT ▾

WHAT WE DO ▾

WHAT'S NEW ▾

RESOURCE CENTER

GET INVOLVED

Search

Announcing the 2019 80% by 2018 National Achievement Awards Honorees

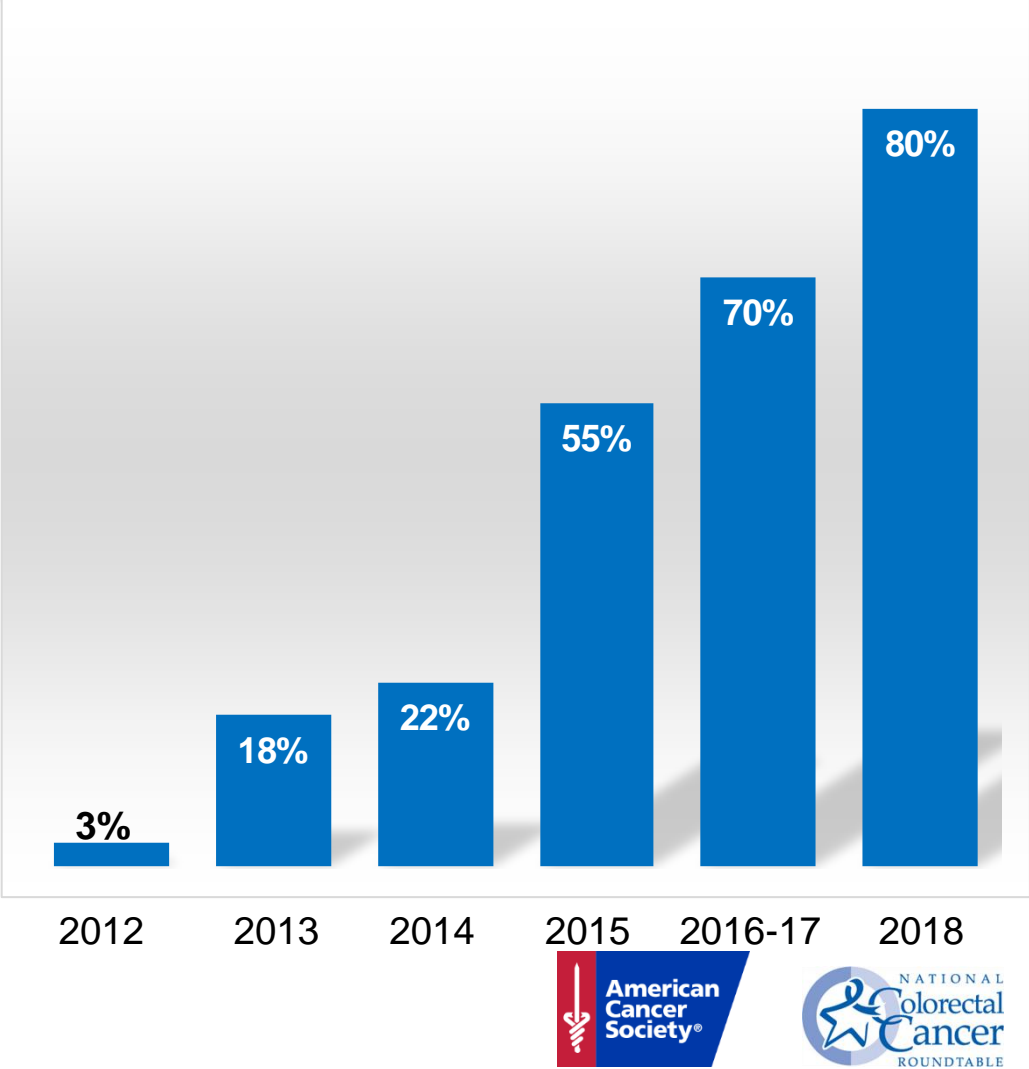
Please join us in congratulating the 2019 80% by 2018 National Achievement Award Honorees!

The 80% by 2018 National Achievement Awards is a program designed to recognize individuals and organizations who are dedicating their time, talent and expertise to advancing needed initiatives that support the shared goal to regularly screen 80% of adults 50 and over for colorectal cancer. [Read more about the awards program.](#)

Grand Prize Winner: NOELA Community Health Center
Category: Community Health Center

NOELA Community Health Center, a nationally recognized Patient-Centered Medical Home, provides comprehensive primary and preventive health care services to improve the health and wellness of the underserved communities in and around the New Orleans East area. After transitioning to a new electronic health record, in 2012, the year that colorectal cancer screening became a reportable measure







Barriers, Missteps, Challenges, and Successes

Screening Barriers

Patient

- CRC screening not a priority
- Lack of awareness of screening options
- Lack of motivation
- Lack of transportation
- Cultural awareness

Organization

- Lack of Provider Recommendation
- No CRC registry available
- Lack of transportation
- No dedicated staff

Medical Neighborhood

- Nearest hospital >20 min from CHC
- Hospital w/backlog of colonoscopy referrals
- “High-Rise” bridge (115 ft., 1.27 miles long)



Image via WWL-TV



Major Ways We Learn

Reading literature

Listening to an expert

Trial and Error



Challenges

Missteps

Barriers

Missteps

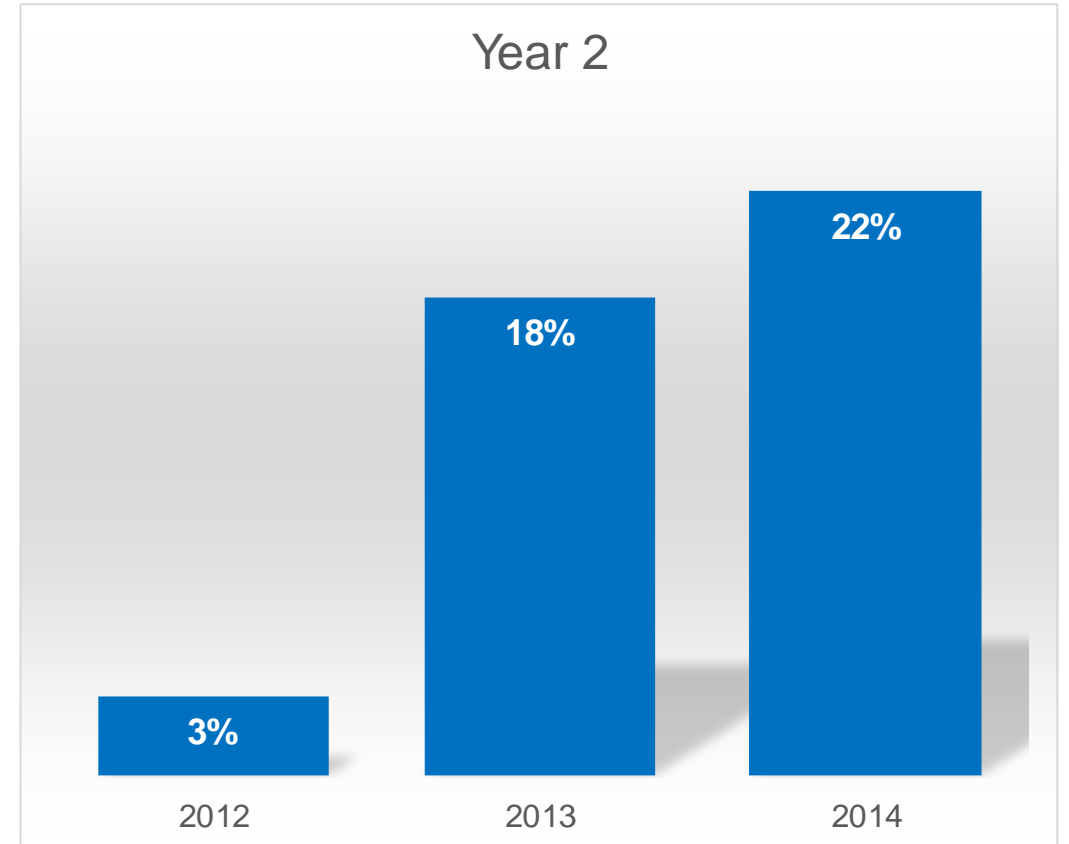
Missteps

- Assumptions

- the process would be easy.
 - Provider focused
 - Completion of stool test
- improvement would be quick.
- “We’re in this alone.”

- Setting the Bar too low

- Implementing individual EBIs one at a time



Strategies for Expanding Colorectal Cancer Screening at Community Health Centers

Mona Sarfaty, MD, MPH^{1*}; Mary Doroshenko, MA²; James Hotz, MD³; Durado Brooks, MD, MPH⁴; Seiji Hayashi, MD, MPH, FACP⁵; Terry C. Davis, PhD⁶; Djenaba Joseph, MD, MPH⁷; David Stevens, MD⁸; Donald L. Weaver, MD⁹; Michael Potter, MD¹⁰; Richard Wender, MD¹¹

Community health centers are uniquely positioned to address disparities in colorectal cancer (CRC) screening, but have not fully addressed other disparities. In 2012, the federal Health Resources and Services Administration, which is the funding agency for the health center program, added a requirement that health centers report CRC screening rates as a standard measure. These annually reported, publically available data are a major strategic opportunity to improve screening rates. The Patient Protection and Affordable Care Act enacted provisions to expand the capacity of the federal health center program. The recent report of the Institute of Medicine on integrating public health and primary care included an emphasis on CRC screening as a target for joint work. These developments make this the ideal time to integrate CRC screening into the preventive care already offered by health centers. This article offers 5 strategies that address the challenges health centers face in increasing CRC screening rates. The first 2 strategies focus on improving the processes of screening. The third emphasizes working productively with other medical providers and institutions. The fourth strategy is a focus on leadership. The final strategy is focused on using tools that have been derived from models that work. *CA: A Cancer Journal of the American Cancer Society* 2013;000:000-000. ©2013 American Cancer Society, Inc.

Keywords: colorectal cancer screening, community health centers, strategies or strategic planning, public health, quality improvement, Patient Centered Medical Home

RESEARCH AND PRACTICE

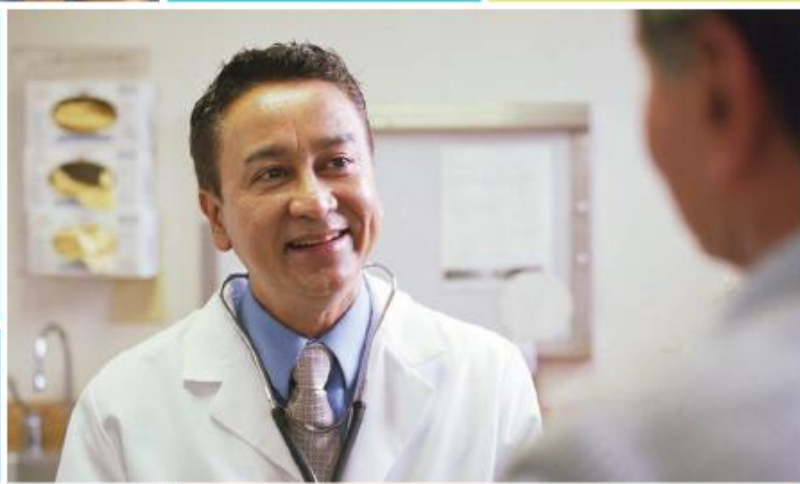
System Strategies for Colorectal Cancer Screening at Federally Qualified Health Centers

Jeanette M. Daly, RN, PhD, Barcey T. Levy, MD, PhD, Carol A. Moss, BS, and Camden P. Bay, MS

Federally qualified health centers (FQHCs) attempt to provide comprehensive, quality primary health care services to medically underserved communities and vulnerable populations. Approximately 1198 centers receive

Objectives. We assessed the protocols and system processes for colorectal cancer (CRC) screening at federally qualified health centers (FQHCs) in 10 states.

Methods. We identified 49 FQHCs in 4 states. In January 2013, we sent medical directors a 40-item questionnaire about policies on CRC



Steps for Increasing Colorectal Cancer Screening Rates:

A Manual for Community Health Centers



How to Increase Colorectal Cancer Screening Rates in Practice:

A Primary Care Clinician's* Evidence-Based
Toolbox and Guide
2008

**Including Family Physicians, General Internists, Obstetrician-Gynecologists,
Nurse Practitioners, Physician Assistants, and their Office Managers*

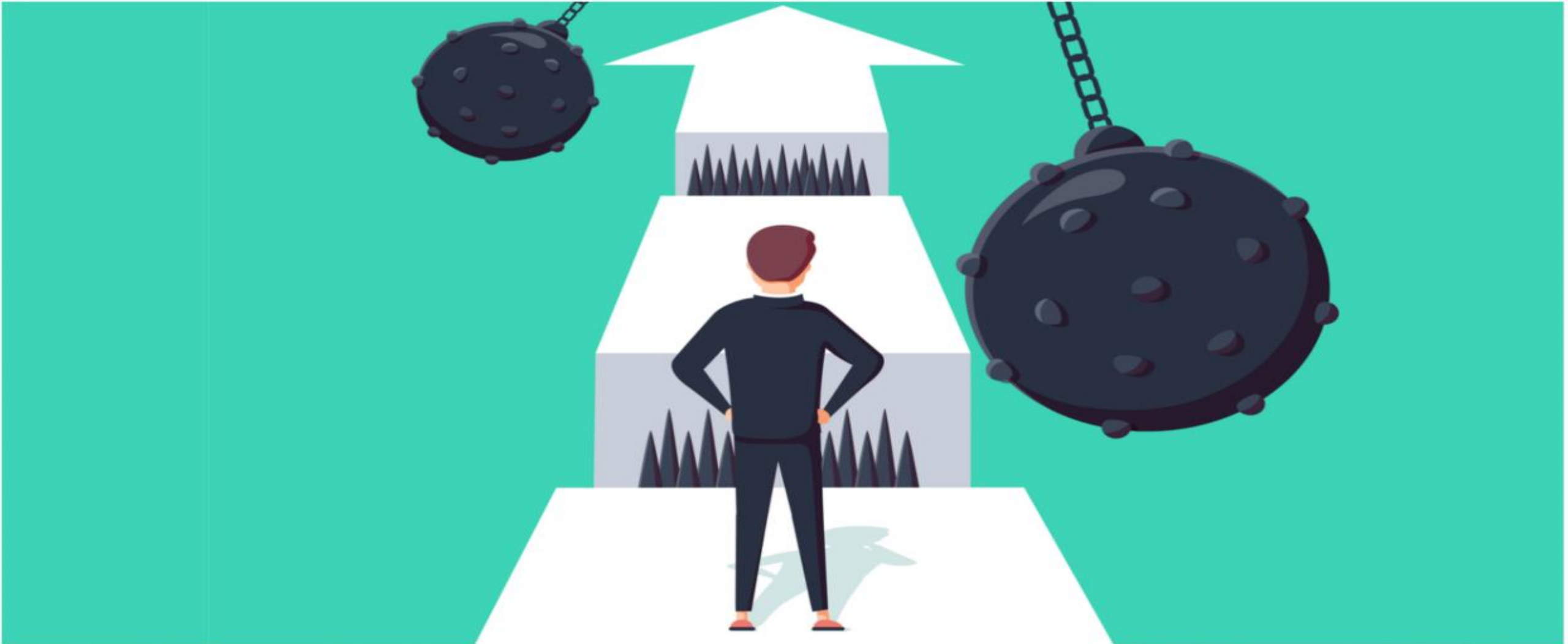
Mona Sarfaty, MD

EDITORS

Karen Peterson, PhD

Richard Wender, MD





Challenges

Major Challenges

- Developing the right screening strategy
- Patient Inertia
- Service Disruptions
 - COVID-19 Pandemic
 - Hurricanes
- Provider /Staff Turnover

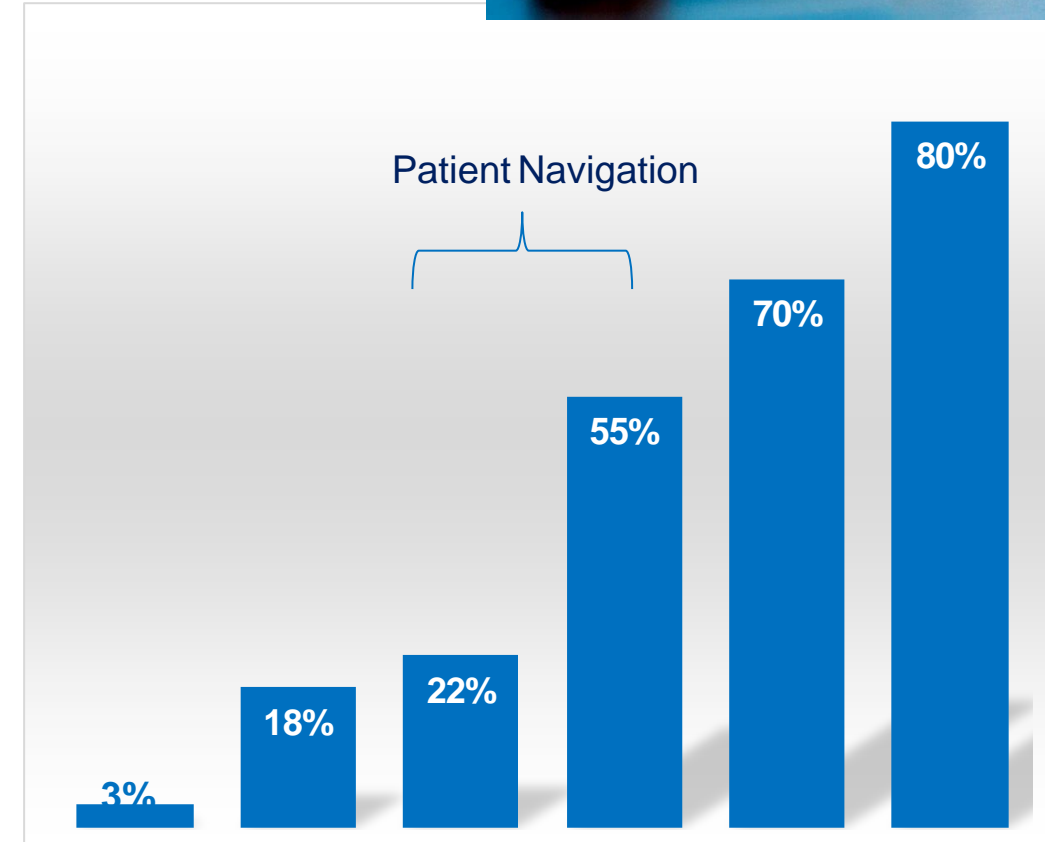


Successes



Successes

- “FIT first” Strategy
- Patient Navigation
- Global / Opportunistic Approach
- Organizational Priority
- Patient Incentives
- Provider & Patient Reminders
- Provider Assessment & Feedback



Pearls of Wisdom

- Avoid assumptions
 - **Process will be easy**
 - **Rates will increase quickly**
- Administrative AND Clinical support is necessary
- “Don’t reinvent the wheel”
- Set “stretch” goals
- Behavioral modification strategies needed





Thank You!



Allegheny Health Network Premier Medical Associates

- **Practice Type:** Multi-specialty physician practice
- **Location:** Greater Pittsburgh area
- **Primary Care System Statistics:**
 - 81,000+ patients
 - 2% (153 patients) are best served in a language other than English
 - 11% (8,939 patients) Black
 - 0.8% (679 patients) Hispanic
 - 1% (1,026 patients) of patients are uninsured
 - EHR: Allscripts



Allegheny Health Network Premier Medical Associates

- **Major Challenge:** Provider preference for colonoscopy
- **Strategies:**
 - Provider education and shift to offering a menu of CRC screening options
 - Transparent data reporting
 - Proactive outreach to patients reaching screening age
 - Automated robocall reminders
 - Test completion tracking with a FIT registry and abnormal FIT registry
- **Results:** CRC increased from **57.5% in 2012 to 80% in 2015.**



Allegheny Health Network Premier Medical Associates

- **Spotlight on Step #3: Get Patients Screened**
- Make a Recommendation
 - Multiple studies have shown that a recommendation from the provider (or a member of the provider's team) is the most influential factor on patient screening behavior.
- Track Return Rates and Follow-up
 - An organized system to track screening tests and follow-up is very important in a screening program.

Patient name	DOB	MRUN	Date of + FIT	Home office	Provider	Action taken	Patient mailing address

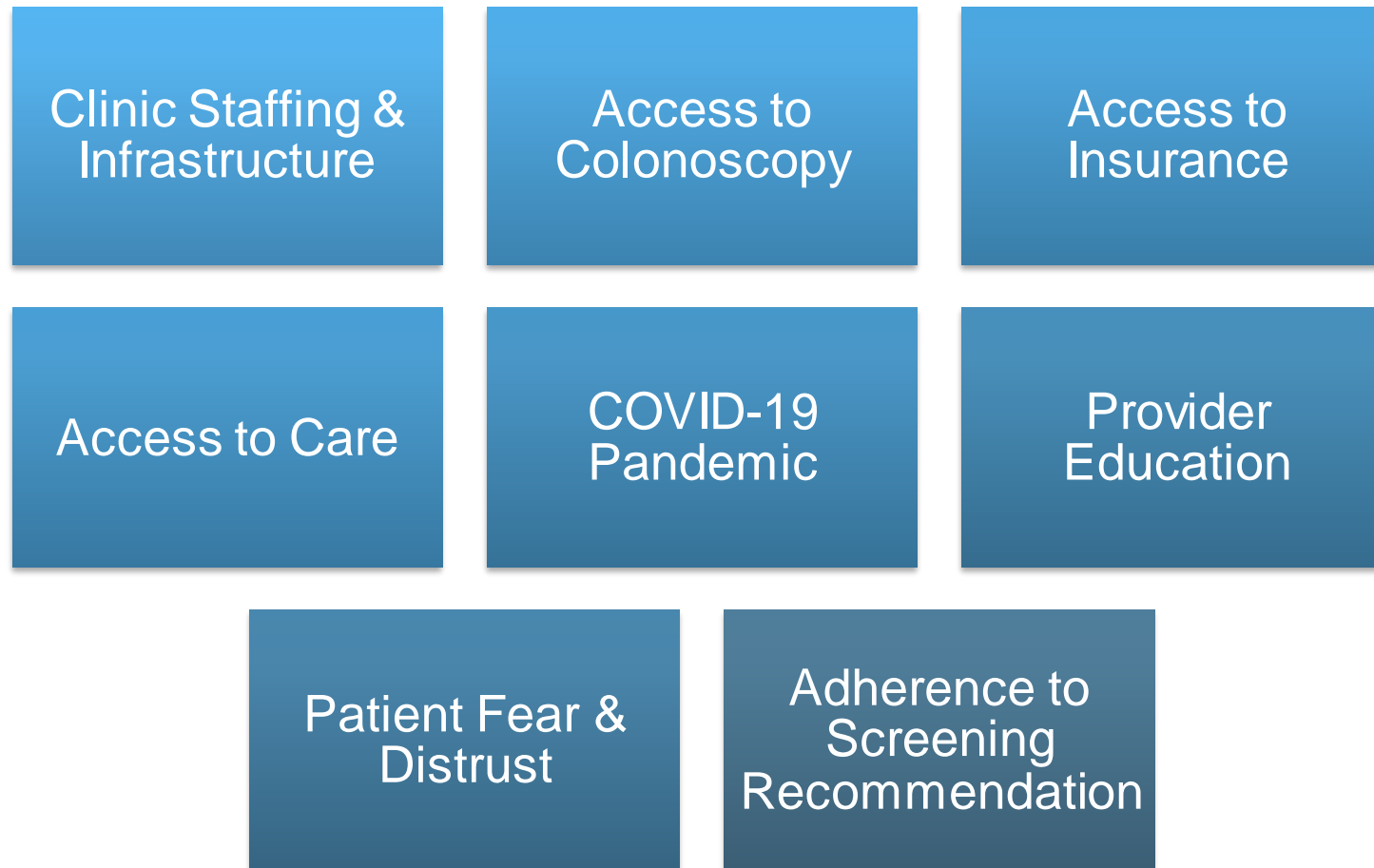




We asked you: *Barriers*



From a provider or practice perspective, what are some of the biggest barriers in providing colorectal cancer screening in primary care?





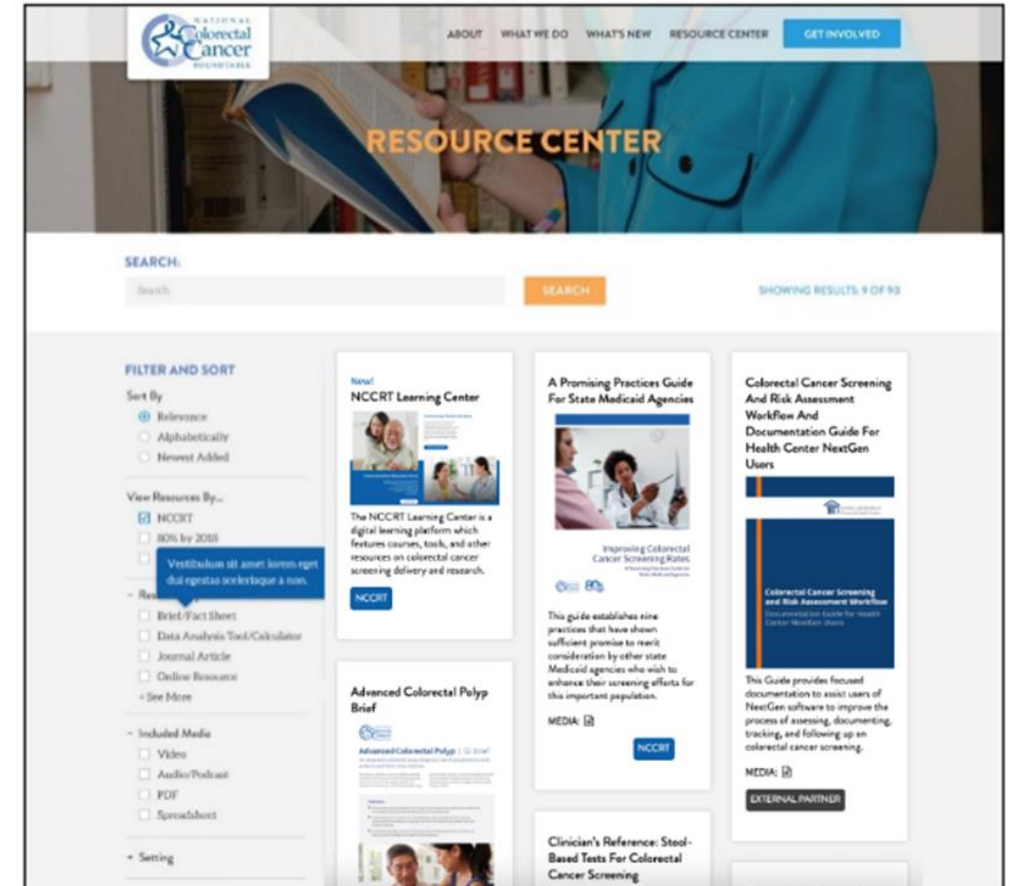
NCCRT Tools & Research



The NCCRT Resource Center

The NCCRT Resource Center contains evidence-based resources and tools to help you increase quality colorectal cancer screening in a range of settings and populations.

nccrt.org/resource-center

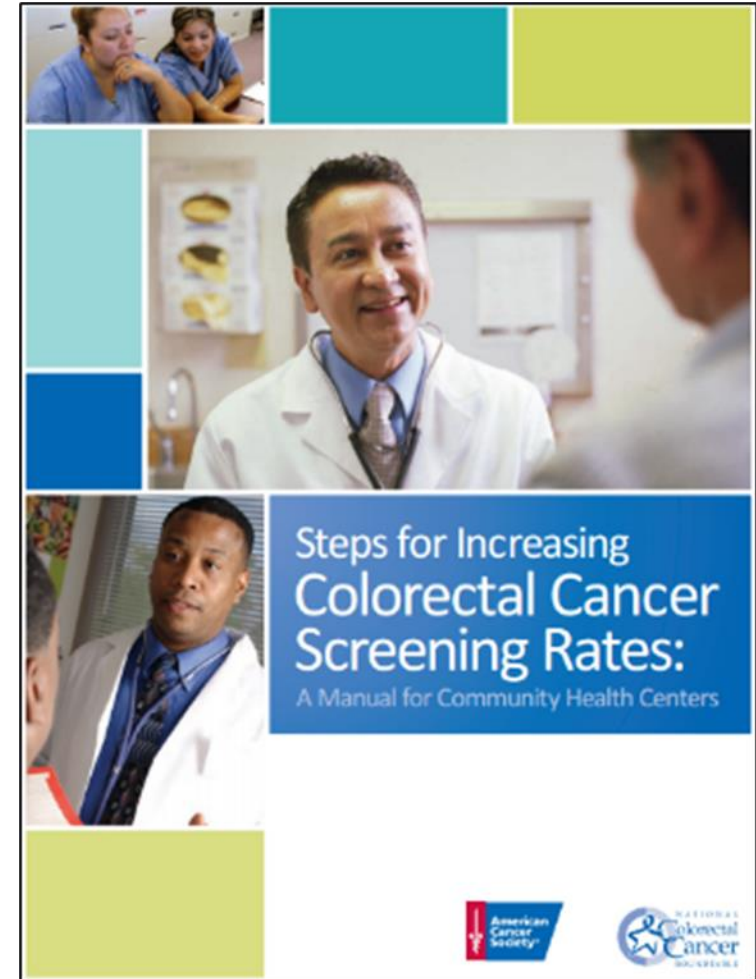


The NCCRT Steps Guide – 2014 Edition

The **NCCRT Steps Guide** provides step-by-step instructions to help health centers implement processes to increase CRC screening.

The 2014 edition has been instrumental in helping numerous health centers achieve improvements in their CRC screening rates.

nccrt.org/resource-center



The NCCRT Steps Guide – 2022 Update

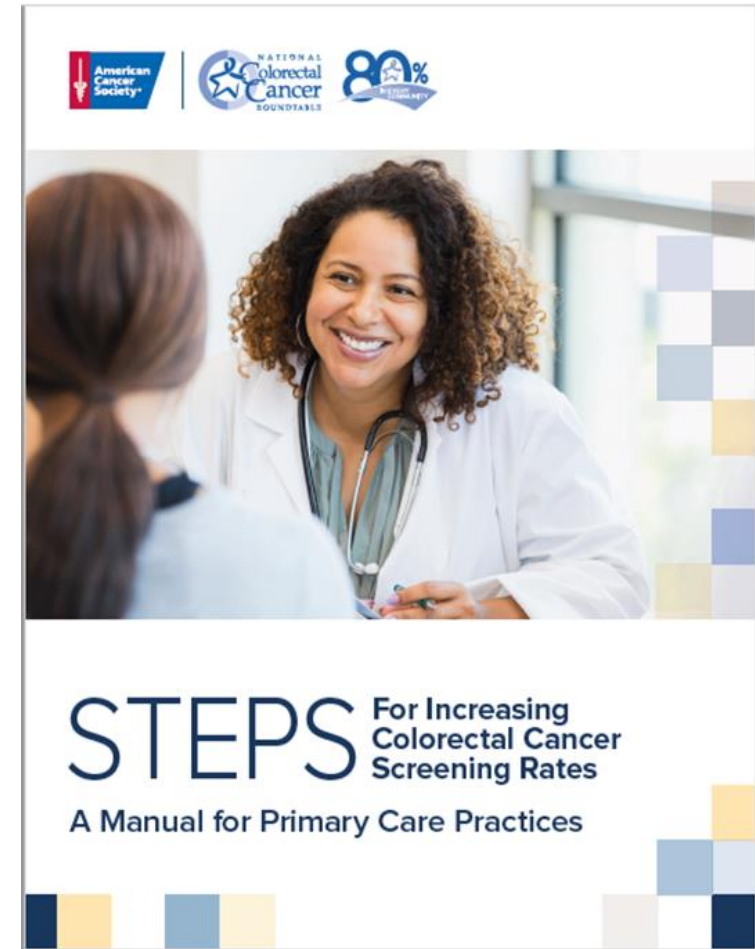
The newly updated Steps Guide includes:

- Expansion to all primary care Latest science and best practices
- Current guidelines and test options
- Expert-endorsed strategies
- 10 case studies of exemplary practice sites
- Samples, templates, and tools

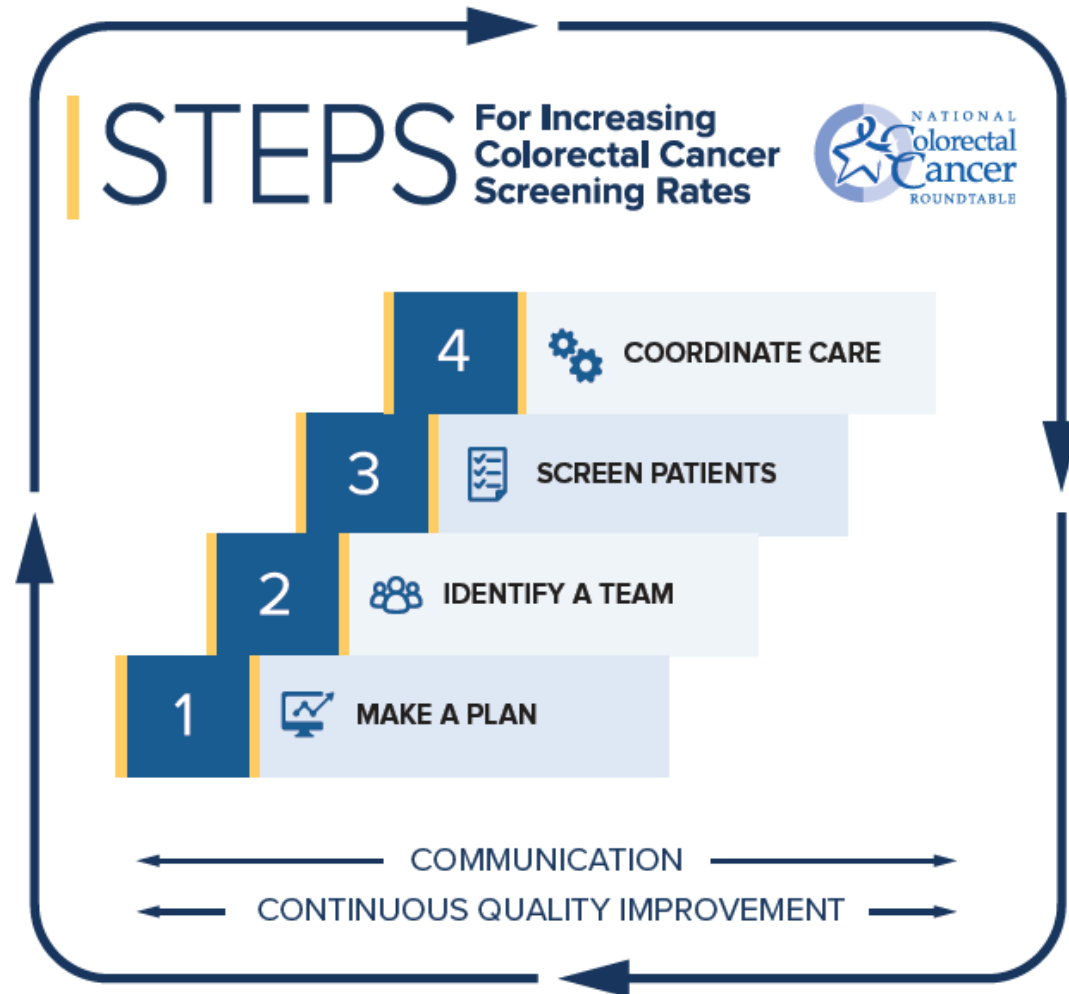
Coming August 2022!

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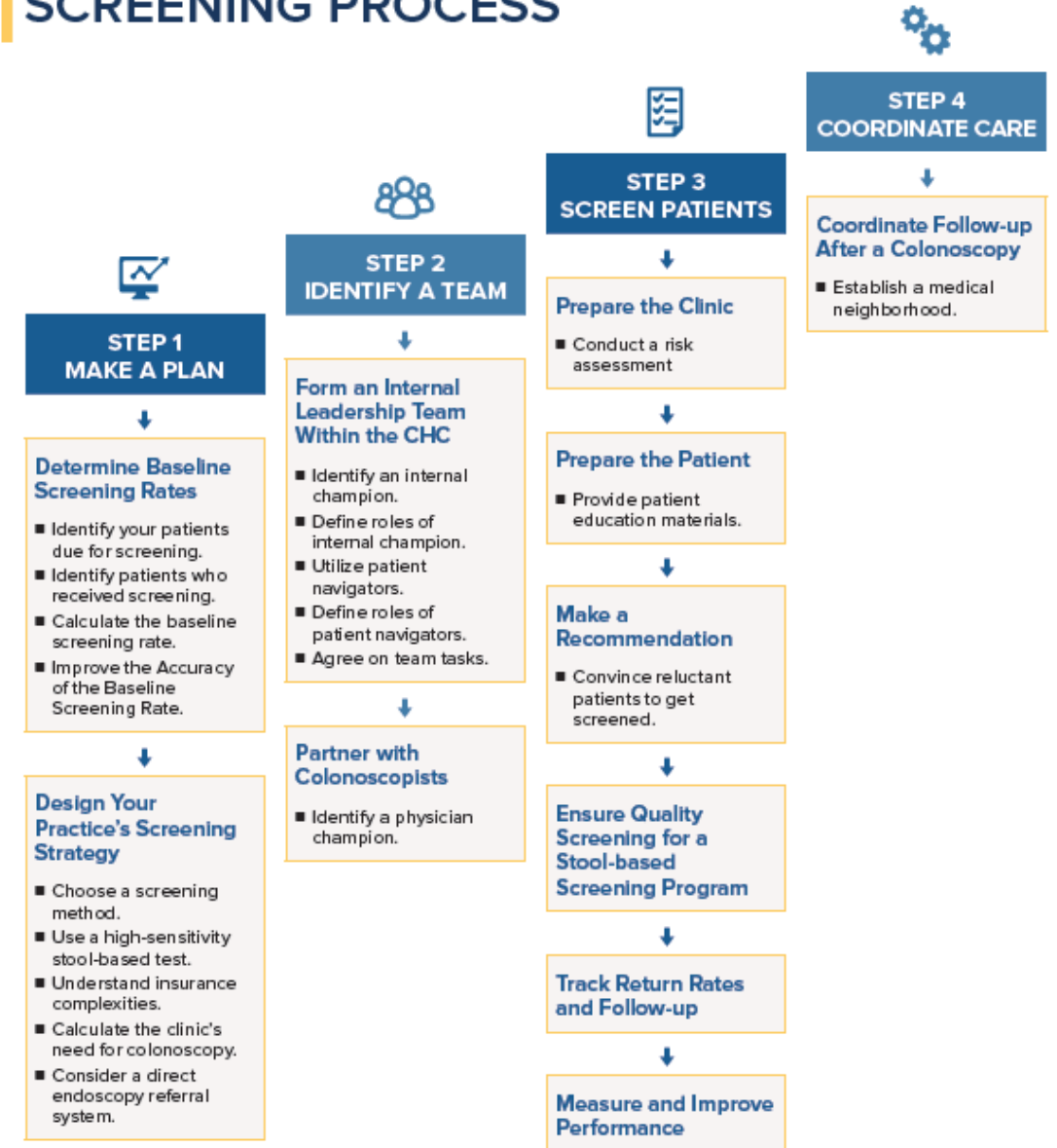
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The NCCRT Steps Guide



OVERVIEW OF THE SCREENING PROCESS



The NCCRT Steps Guide – 2022 Update

Appendices:

- Colonoscopy Needs Calculator
- Readiness Assessment Tools
- FIT/FOBT Sample Workflow Process
- Coding Guidance
- Updated EHR Workflow Documentation Screenshots
- Sample screening reminder and recall letters and call scripts
- And more...

SCRIPT FOR ABNORMAL FIT RESULT



Hi [Patient Name],

This is [Caller's First Name]. I work with Dr. [PCP] at Mercy. You recently completed a Fecal Immunochemical Test (FIT) to check for colon and rectal cancer. The results of your test were **abnormal**, showing **blood in your stool**. Dr. [PCP] would like for you to schedule an appointment to discuss next steps.

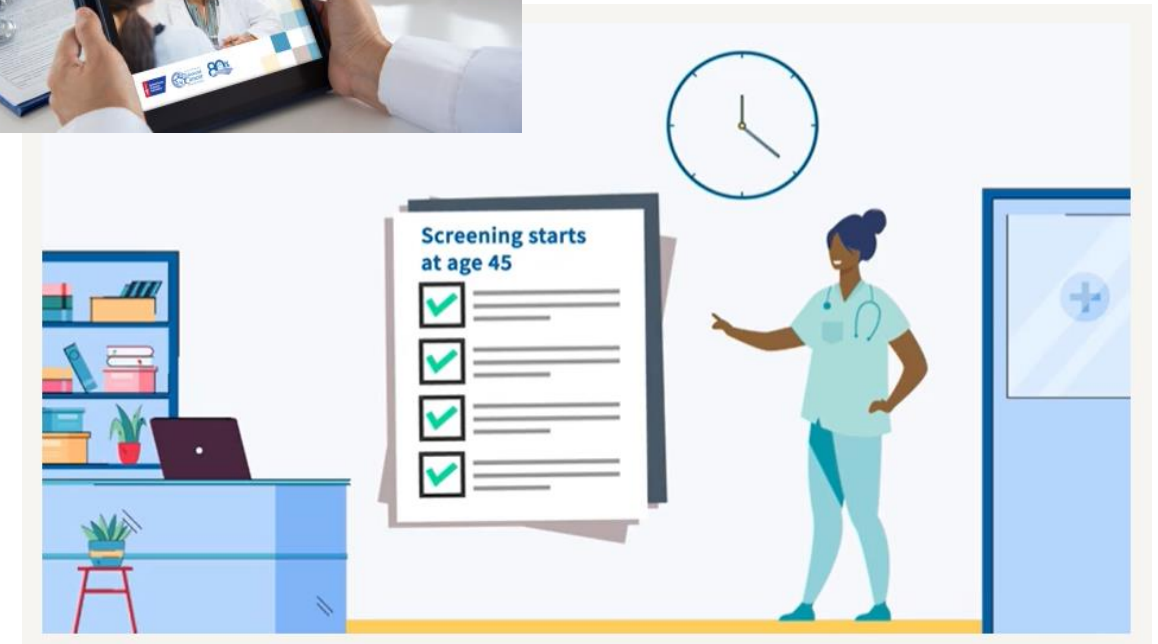
IS NOW A GOOD TIME TO SCHEDULE AN APPOINTMENT?

-
- **“Yes”** → (Book the appointment and confirm.) You are scheduled for ____ day and time with (doctor or APP name). He/she will have a copy of your results and a copy will also be mailed to you.
- **“No”** → I recommend that you _____ the next two weeks. He/she will _____
- **“I’m no longer seeing Dr. [Mercer]”**
- **“Yes”** → Please share a copy of your results and next steps. Call their results and next steps.
 - **“No”** → **Do you need help?**

The NCCRT Steps Guide – 2022 Update

Promotion Tools:

- 45 sec promotional video
- Sample social media posts
- Newsletter blurbs
- Shareable graphics
- Opportunities for co-sponsored articles and webinars (thank you AMGA!)

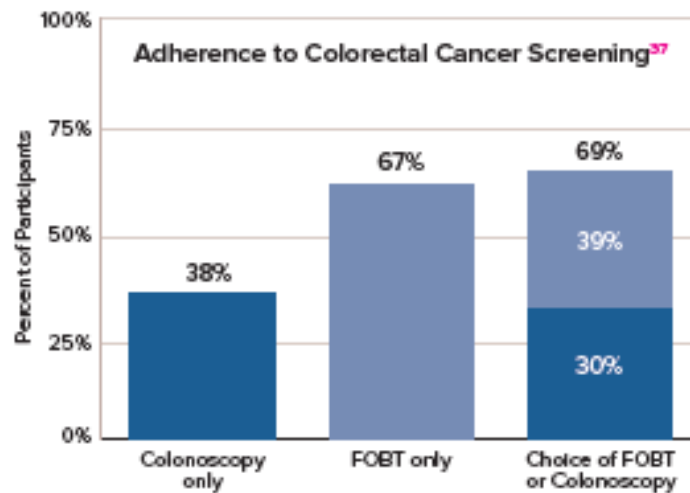


nccrt.org/resource-center

The Clinician's Reference on Stool-based Testing

The Clinician's Reference on Stool Based Tests for CRC explains the different types of stool-based tests and provides guidance on implementing high-quality stool-based screening programs.

nccrt.org/resource-center



Guidelines from the American Cancer Society, the US Preventive Services Task Force, and others recommend Fecal Immunochemical Tests (FIT), High-Sensitivity Fecal Occult Blood Tests (HS-gFOBT) and FIT-DNA testing as options for colorectal cancer (CRC) screening in men and women at average risk for developing colorectal cancer.

This document provides state-of-the-science information about these tests.

Clinician's Reference
STOOL-BASED TESTS FOR COLORECTAL CANCER SCREENING

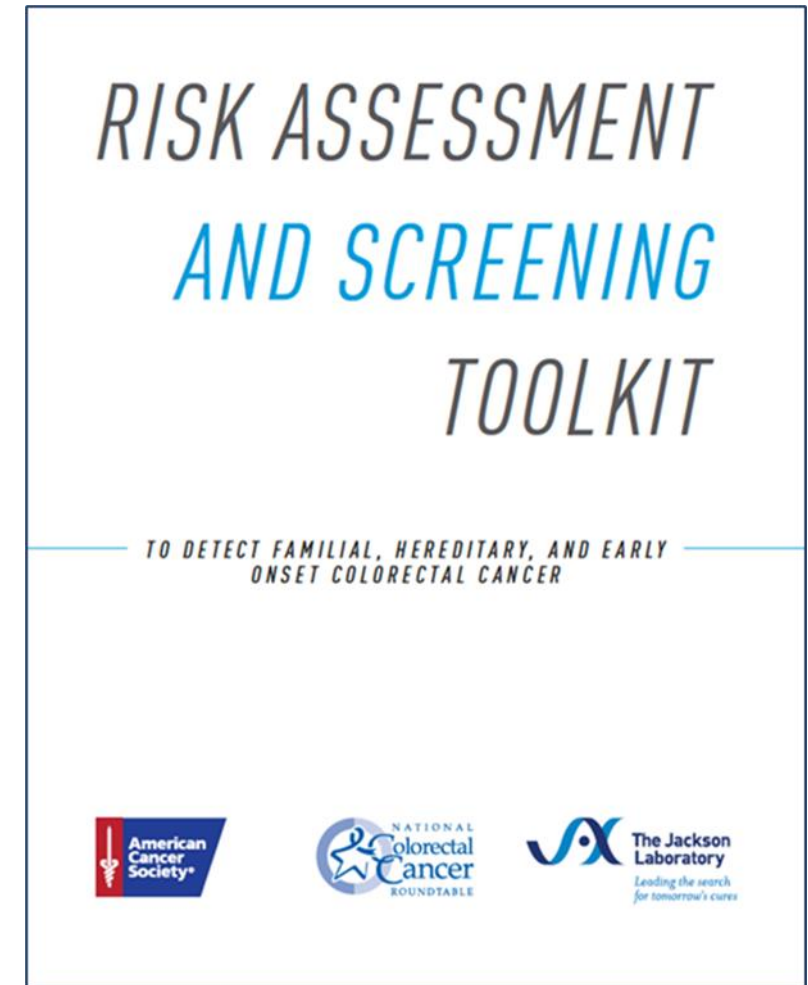
80% IN EVERY COMMUNITY

The number of colorectal cancer cases is dropping thanks to screening. We are helping save lives. We can save more.

The NCCRT Risk Assessment and Screening Toolkit

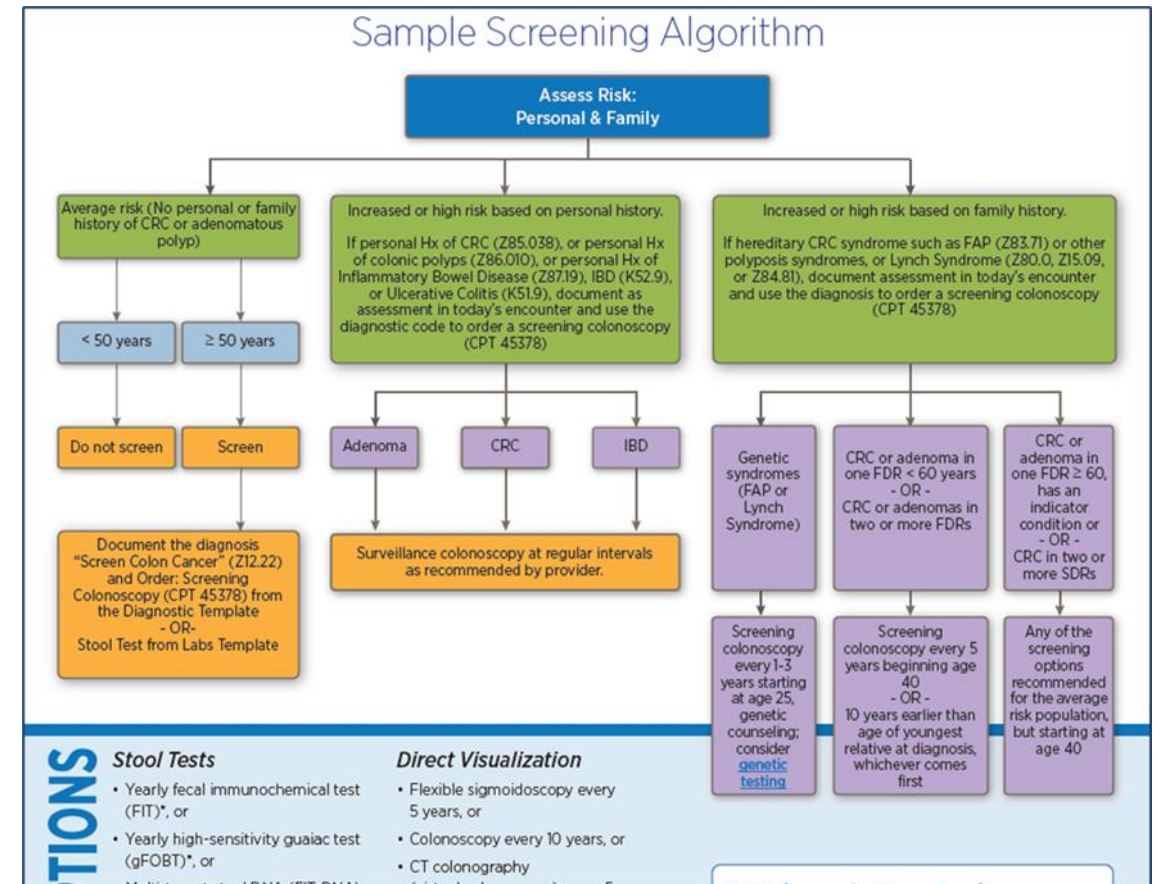
The NCCRT Risk Assessment and Screening Toolkit helps primary care providers systematically collect, document, and act on family history, while also educating clinicians on early-onset CRC and the need for more timely diagnostic testing.

nccrt.org/resource-center



The NCCRT Risk Assessment and Screening Toolkit

The NCCRT Risk Assessment and Screening Toolkit provides screening algorithms in flowchart format for providers.



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NCCRT Briefs for Key Partners

- Primary Care Physicians
- GIs and Endoscopists
- Radiologists
- Hospitals
- Insurers
- Women's Health Providers
- State Coalitions
- LGBTQ Communities
- Survivors and Families
- Communities
- Elected Officials
- Employers

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80% IN EVERY COMMUNITY

How Can Women's Health Providers Save More Lives from Colorectal Cancer?

Learn what you can do to advance the shared goal to reach screening rates of 80% and higher in adults ages 45 and older.

Colorectal cancer is the second-leading cause of cancer-related deaths for men and women combined, yet it is often preventable.

It's now recommended that all men and women at average risk of colorectal cancer start regular screening at age 45. Yet, about 1 in 3 adults ages 50 and older – about 38 million people – is not getting screened as recommended. The shift to screening at age 45 will only add to this deficit.

Fortunately, there are several high-quality screening tests for colorectal cancer. Learn how you can play a role in saving more lives from colorectal cancer.

80% in Every Community is a National Colorectal Cancer Roundtable initiative in which more than 1,800 organizations are working toward the shared goal of reaching colorectal cancer screening rates of 80% and higher in communities across the nation.

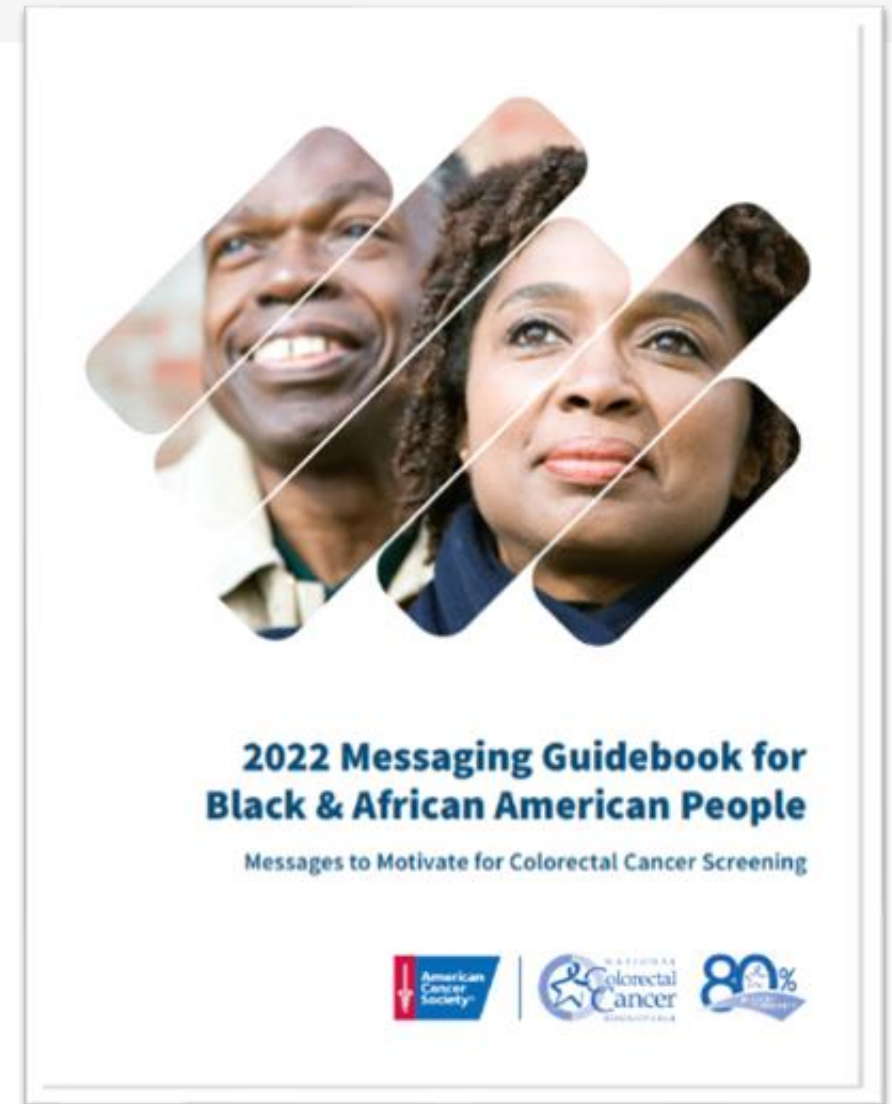
The American College of Obstetricians and Gynecologists (ACOG) is a proud supporter of this effort.



The number of colorectal cancer cases is dropping, thanks to screening. We are helping save lives. We can save more.

NCCRT Market Research & Crafted Messaging

- In 2014, NCCRT conducted its first market research project
- Released the *80% by 2018 NCCRT Communications Guidebook*
- *Companion Guides reflecting market research on messaging to Asian Americans Hispanics/Latinos released in 2015/2016* The NCCRT Colorectal Cancer Screening
- *Messaging Guidebook: Recommended Messaging to Reach the Unscreened* was released in 2019
- Recent release of Messaging Guidebook for Black & African American People



Lead-Time Messaging to Encourage On-Time Screening

Originated from an idea to tailor messaging to the those under 50 years or age, or who had just turned 50

Project goals:

- Find messaging to raise awareness around CRC screening among 20–44-year-olds.
- Better understand perceptions about CRC and likelihood to get screened on-time.
- Develop recommendations for reaching younger audiences with screening messaging (what do they want/need to know, when should it be delivered, and who should deliver the information).
- Determine effective messaging that best resonates with this audience.



Lead-time Messaging: Impact of the Provider Recommendation

- Less than half with a family history have discussed CRC screening with their physician
- Only 20% have discussed CRC screening with a HCP
- ~ 3 in 10 plan to wait for their HCP to bring up screening
- 47% think people should start based on whatever their HCP recommends
- 51% prefer to receive CRC screening information from health care providers
- Doctors (85%) and other HCP (79%) are the most trusted sources for information

Crafted Messages

Themes for messages derived from Phases 1 & 2:

- *Preventable & treatable if caught early*
- *Tied to wellness*
- *Rising rates of CRC in young adults*
- *Family history*

What we want our top messages to ultimately convey to our audience:

- Aged 40+ and average risk: *get screened*
- Younger audience: *Those with a family history motivated to convey that information to their doctors*
- Young & symptomatic: *talk with their doctor ASAP*

The NCCRT Annual Meeting

The NCCRT Annual Meeting
November 16-18, 2022
Baltimore, Maryland

Presentations by nationally known experts, thought leaders, and decision makers on CRC screening policy and delivery, with opportunities to network and learn from each other.

nccrt.org/events



How the AAMA Became a Dedicated Partner of the NCCRT in the “80% in Every Community” Initiative

THE AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS® (AAMA)

DEBORAH NOVAK, CMA (AAMA), VICE PRESIDENT

DONALD A. BALASA, JD, MBA, CEO, LEGAL COUNSEL

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NOVEMBER 2021

Medical assistants and the AAMA

Medical assistants work in outpatient settings and perform both back-office clinical and front-office administrative duties.

60% of CMAs (AAMA) work in primary care.

The American Association of Medical Assistants (AAMA) represents over 90,000 medical assistants throughout the United States.

Why CRC screening?

There are many worthy public health causes (e.g., preventing alcohol-exposed pregnancies and FASDs).

AAMA national and state leaders were encountering a number of tragic colorectal cancer situations in their professional and personal lives.

They realized that medical assistants could make a significant difference in increasing CRC screening rates.

How medical assistants make a difference



**OFTEN MEDICAL ASSISTANTS ARE
“COMMUNICATION INTERMEDIARIES”
BETWEEN PROVIDERS AND PATIENTS.**



**FOR EXAMPLE, MEDICAL ASSISTANTS
ARE OFTEN ASSIGNED PATIENT
EDUCATION.**



**MEDICAL ASSISTANTS ARE ASSUMING
PATIENT NAVIGATOR AND PATIENT
ADVOCATE ROLES.**

Strategies

AAMA continuing education courses and articles in *CMA Today* were geared toward empowering medical assistants to be more effective advocates for CRC screening.

The focus intensified during CRC Awareness Month and Medical Assistants Recognition Week.

Medical Assistants' Role in Improving CRC Screening Rates: Getting to 80%; Durado Brooks, MD, MPH

Results

3,964 health professionals successfully completed the course for AAMA CEU credit.

AAMA posts in Facebook, Instagram, LinkedIn, and Twitter resulted in 183,613 impressions.

AAMA state societies, local chapters, and academic programs created their own CRC screening educational events, thus multiplying the impact.

Partnership with NCCRT

Medical assistant managers used NCCRT materials and information to provide in-service training for staff.

They also used NCCRT materials as a basis for role playing so staff would be more comfortable talking with patients about CRC screening.

Thoughts for other professional societies

Don't underestimate the generosity and commitment of health professionals. They are often motivated by noble challenges.

Ongoing bravery and self-sacrifice in response to COVID-19 pandemic.

Verifying CRC screening should become just as integral a component of primary care practice as verifying patient immunizations.



We asked you: *Overcoming Challenges*



From a provider or practice perspective, what do you recommend for helping overcome challenges in promoting CRC screening in primary care?

Engage/find
CRC champions

Strong Practice
Culture

Better
Infrastructure to
Support
Screening

Clinical
Workflow and
Best Practices

Provider
Education

Building
Partnerships

Community
Education
Outreach

Increase
Resources &
Funding for
CRC Screening



We asked you:
Essential Partners



Which essential partners should be working together to catalyze primary care around CRC screening?

