80% by 2018: Maximizing the Potential with Colorectal Cancer Screening

Strategic Advice from the Michigan Forum Experts
Colorectal Cancer Facts, Figures and Issues: A Look at Michigan 2015

- 4,190 new cases of colorectal cancer (CRC) will occur
- 1,670 Michigan men and women will die from CRC
- Michigan screening rate (as a state) is currently 72%
  - Screening rates are increasing over time
  - Disproportionate rates of CRC incidence and mortality in Michigan
Michigan FQHC’s CRC Screening Rates

<table>
<thead>
<tr>
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<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>23.4%</td>
<td>26.6%</td>
<td>30.5%</td>
</tr>
</tbody>
</table>

American Cancer Society (ACS) Facts & Figures 2015
MI Behavioral Risk Factor Survey (MiBRFS), 2014
2014 Health Resources and Services Administration – Health Center Profile
In Michigan – Colorectal Cancer

CRC Death Rates 2008-2012

Age-Adjusted Death Rates for Michigan, 2008 - 2012
Colon & Rectum
All Races (includes Hispanic), Both Sexes

CRC Mortality 1975-2012

Historical Trends (1975-2012)
Mortality, Michigan
Colon & Rectum, All Races (incl. Hisp)
Both Sexes, All Ages

Key Mortality Michigan
Colon & Rectum All Races (incl. Hisp)
Both Sexes All Ages

Source: Death data provided by the National Vital Statistics Systems public use data file. Death rates calculated by the National Cancer Institute using SEER*Stat. Death rates (deaths per 100,000 population per year) are age-adjusted to the 2000 US standard population (19 age groups: <1, 1-4, 5-9, ... 80-84, 85+). Population counts for denominators are based on Census populations as modified by NCHS. The state populations included with the data released have been adjusted for the population shifts due to hurricanes Katrina and Rita for 12 counties and parishes in Alabama, Mississippi, Louisiana, and Texas. 1990-2011 US Population Data. HCC is used with mortality data.
Screening

Appropriate Colorectal Cancer Screening Among Adults Aged 50 Years and Older by Race/Ethnicity, Michigan, 2013
Launched in 2014: The Healthy Michigan Plan

Over 600,000 enrolled in the Healthy Michigan Plan (HMP).

Good News!
- **455,000 people** – had at least one primary care visit
- **174,179** had preventive care visits
- **27,000** colonoscopies completed

BUT

- **40,000** people between **138-250%** of the federal poverty line remain uninsured, the majority live in Wayne County

*Department of Health and Human Services, 9/1/2015*
2012 CDC Vital Signs

Many adults are not being tested

- 65% Up-to-date CRC testing
- 28% Tested but not up-to-date
- 7% Never tested
- 24% Insurance status of never tested adults aged 50–75 years
- 76% Total never tested adults aged 50–75 years

U.S. Preventive Services Task Force – Screening for CRC

- Men and women 50-75 should be screened for CRC
- People with a personal or family history should be screened earlier than 50 for CRC
- The decision to screen for CRC in adults ages 76-85 should be an individual one, taking into account the patient’s overall health and screening history
# Draft: Recommended Screening Strategies for CRC (USPSTF)

## Draft: Table. Recommended Screening Strategies for Colorectal Cancer

<table>
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<tr>
<th>Screening Modality</th>
<th>Frequency</th>
<th>Other Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIT or high-sensitivity gFOBT</td>
<td>Every year</td>
<td>Requires the fewest lifetime colonoscopies (a proxy for harms). Does not require bowel cleanout, anesthesia, or transportation to and from the screening examination (test is performed at home).</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy with FIT</td>
<td>Flexible sigmoidoscopy every 10 years plus FIT every year</td>
<td>Potentially attractive option for persons who want endoscopic screening but wish to limit exposure to colonoscopy. May also be useful when access to colonoscopy is geographically limited.</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Every 10 years</td>
<td>Requires less frequent screening. Screening and diagnostic followup of positive results can be performed during the same examination.</td>
</tr>
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</table>

* Applies to persons with negative screening tests (including hyperplastic polyps) and is not intended for those in surveillance programs.

**Abbreviations:** FIT = fecal immunochemical test; gFOBT = guaiac-based fecal occult blood test.
CRC Screening Recommendations: Other Organizations

- American College of Gastroenterology (ACG)
- American Gastroenterological Association (AGA)
- American Society for Gastrointestinal Endoscopy (ASGE)
- American College of Physicians (ACP)
- American Cancer Society (ACS)
Average Risk for CRC – (75% of the Population)

May choose any **recommended** CRC screening test at **appropriate** intervals

**Options Increase Screening**

Increased or High Risk for CRC

(Lynch Syndrome, FAP, other Polyposis Syndromes, History of polyps/CRC, Strong Family History or IBD)

*Colonoscopy Required*

Clinician’s Reference: Fecal Occult Blood Testing (FOBT) for Colorectal Cancer Screening
Arch Intern Med/Vol. 172, APR, 9, 2013
2015 UDS Appropriate CRC Screening

- Colonoscopy within 10 years
- Flexible sigmoidoscopy within 5 years
- FOBT or FIT during the measurement year

Data collection excludes patients who have had or have CRC
2015 Clinical Performance Measures: Uniform Data System (UDS)

Percentage of patients ages 50-75 who had appropriate CRC screening.

- **Numerator:**
  - Number of patients aged 51-74 with appropriate screening for CRC.

- **Denominator:**
  - Number of adults aged 51-75 years who had at least one medical visit during the reporting year.

Know Your Numbers!
Community Outreach

- Health Fairs, Super Colon, Churches
- Public Speaking through Community Organizations
  - Visually Impaired People for Progress
  - Deaf and Hard of Hearing Services
- Physical Activities
- 5K Run/Walk
March Colon Cancer Awareness Month
Distribution of MCRCEDP baskets
TV/Radio Spots
Health Center Visits/LIFE EMS
Make it Your Own mailings to fit your demographic need

www.miyoworks.org
Barriers

- Transient population
- Use of multiple clinics (difficult to get current and accurate medical records)
- Language and Cultural Barriers
- Lack of literacy skills
- Fearful of Government involvement (Big Brother, Undocumented population)
Navigation Challenges

- Lack of transportation
- Unable to obtain preparation
- Obtaining laxative and clear liquids
- Location to prep
- Embarrassment about being socioeconomically disadvantaged
Insurance Reimbursement

- Be familiar with insurance companies
- G Codes or 45378
- Not all policies cover screenings
- Be aware of insurance jargon
  - Screening vs Diagnostic
  - Low risk vs High risk
  - Preventative vs Symptoms
  - Referral discrepancies
    - Referral indicates screening but medical records note symptoms
Medical Insurance Enrollment

www.healthcare.gov
1-800-318-2596 open 24/7

Michigan Insurances:
Enrollmichigan.com/healthy-michigan-plan/
QI PLANNING PROCESS

- Annual Board-Approved Quality Improvement
- Identified significant opportunity to improve CRC screening rates
- Especially iFOBT due to low utilization and return
- Workgroup identified internal and external resources
- Initiated PDSA cycle
PLAN
Goal: Increase CRC Screening
Incorporate FOBT utilization
Develop Workflow

DO
Train/Implement workflow

STUDY
Track CRC Rates
Track FOBT Use/Return
Staff Reception

ACT
Standardize and apply to all practices
PRINCIPLES OF WORKFLOW DEVELOPMENT

• Identify Barriers
  ◦ Missing CRC discussion opportunities with patients
  ◦ Only offered colonoscopies
  ◦ If iFOBT given, no process to track if returned
  ◦ Returned iFOBT not logged or billed appropriately
  ◦ Patient barriers: Cost for CRC screening and transportation.
PRINCIPLES OF WORKFLOW DEVELOPMENT, Con’t

• Incorporate the EHR
  Capture for billing
  Capture for tracking and reporting
  Achieve uniformity for all practice locations
  Medical Records retrieval system
FOBT Take Home Kit
Getting Started with the Workflow

FOBT WORKFLOW CHART

- Clinical Staff Check CDS Alert when Rooming Pt for Missing Screening
- Put "Colon CA Screening" Reminder Document on Counter for PCP to See
- If instructed, Give FOBT Kit to Patient + Education to RETURN SAMPLE "WITHIN 7 DAYS"
- Put Patient's Name in FOBTCLIA
- PCP documents in TEC Section "FOBT given today;"

Did Patient return FOBT kit within 7 days? (Check FOBTCLIA Log "Weekly" for Overdue FOBTs)

NO

- Patient Engagement Call required by Day 14 by Case Mgt Nurse
- Note contact date in FOBT Log
- After 2 contact attempts, make note in FOBT Log and document in EHR

Did patient receive FOBT kit within 7 days?

YES

- Create Nurse Visit + FOBT lab order in Treatment Section and drop appropriate billing charge
- Notify pt of results

Patients with FOBT:

NEGATIVE

- Tell pt: - Repeat FOBT in One Year - OR Pt May Choose Colonoscopy Next Time - Update FOBT Log

POSITIVE

- Assign Lab to PCP for further instruction

Patient Complies with Colonoscopy Order

NO

- If FU not done, make referral to Nurse Case Manager to make engagement call
- Case Manager to call patient for education or to identify barriers and document

YES

"Receive" results of Colonoscopy in DI section, scan documents
Workflow, Step-By-Step

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“Receive” results of Colonoscopy in DI section, scan documents
Ongoing Process

- **Perform Weekly:**
  - Check iFOBT Log
  - Case Management Engagement Calls
  - Feedback to Staff Units

- **Perform Monthly:**
  - Utilize EHR to Track and Graph Data
  - Share and Encourage Clinical Staff Teams
  - Report Data to QI Team Monthly
Looking Forward

- Keep the momentum going
- Look for ways to be creative
- Think ahead for campaign ideas
- Align with partners and resources
- Ongoing education

Colon Cancer Awareness
Steps for Increasing Colorectal Cancer Screening Rates

1. Make a Plan
2. Assemble a Team
3. Get Patients Screened
4. Coordinate Care across the Continuum

Taken from: Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers
Step #1: Make a Plan

Determine Baseline Screening Rates
• Identify your patients due for screening.
• Identify patients who received screening.
• Calculate the baseline screening rate.
• Improve the accuracy of the baseline screening rate.

Design your Clinic’s Screening Strategy
• Choose a screening method.
• Use a high-sensitivity-stool based test.
• Prioritize patients for screening.
• Understand insurance complexities.
• Know community resources.
• Calculate the need for colonoscopy.
Step #2: Assemble a Team

- **Form an Internal Leadership Team**
  - Identify an internal champion.
  - Define roles of the internal champion.
  - Educate the team.
  - Insure the team understands the plan.
  - Utilize patient navigators.
  - Define the roles of the patient navigators.
  - Agree on team tasks.
  - Identify a physician champion (GI/colonoscopist)
Step #3: Get Patients Screened

- Prepare the Clinic
- Communicate the Need
- Prepare the Patient
- Ensure Quality
- Measure and Improve Performance
- Make a Recommendation
- Address Barriers

Prepare the Clinic

Communicate the Need

Ensure Quality

Measure and Improve Performance

Make a Recommendation

Address Barriers

Prepare the Patient
Step #4: Coordinate care across the continuum

- Coordinate Follow-Up after test
- Establish a medical neighborhood
- Educate patient on next-steps, and update record in EHR
Resources

- Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers

- 80% by 2018 Communications Guidebook: Effective messaging to reach the unscreened

- What can primary care doctors do to advance 80% by 2018?
Resources, Continued

- National Colorectal Cancer Roundtable
- CRC Resources for Providers and Patients
- American Cancer Society (ACS)
- Make It Your Own (MIYO)
- CDC Screen for Life Campaign
- Enroll Michigan – Certified Navigators
SAVE THE DATE(S)

- January 11, 2016 will be an all-day Colorectal Cancer In-Service hosted at MPCA – think of team members you’d like to bring and plan to join! An invite will be coming to you shortly….

- In the event of a “snow day” on 1/11, our alternate date is February 1, 2016. Stay tuned!
Questions?

For more information, please contact:

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