80% by 2018: FQHC Colorectal Cancer Screening Workshop

Creating a plan with the Michigan Forum experts

2.22.2016
CRC Forum Overview and Goals

- Introduction of 80% by 2018 Michigan forum
- A snapshot of the work we’ve done thus far, and our goals in the next two years
  - National forum meeting in Atlanta (Sept. 2015)
  - Focus on increasing MI’s screening rates from approximately 70% statewide to 80% (*FQHCs average 30%)
  - Developed plan to implement statewide
  - Using the CRC toolkit and creating PDSA
  - Funding 2 MI FQHCs currently with the CHW Cancer project, focusing on CRC screening
<table>
<thead>
<tr>
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<th>Recommendation</th>
<th>Grade</th>
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<td>The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. The risks and benefits of different screening methods vary.</td>
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<td>Adults ages 76 to 85 years</td>
<td>The decision to screen for colorectal cancer in adults ages 76 to 85 years should be an individual one, taking into account the patient's overall health and prior screening history. • Adults in this age group who have never been screened for colorectal cancer are more likely to benefit. • Screening would be most appropriate among adults who: 1) are healthy enough to undergo treatment if colorectal cancer is detected, and 2) do not have comorbid conditions that would significantly limit life expectancy.</td>
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## CRC Screening Tests

**Table: Recommended Screening Strategies for Colorectal Cancer**

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<th>Frequency*</th>
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<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>
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* 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.

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DRAFT: U.S. Preventive Services Task Force, CRC Screening Recommendations, October 2015
Average Risk for CRC
May choose any recommended CRC screening test at appropriate intervals

Increased or High Risk
(Personal or 1st Degree Family History of CRC or Adenomas, Lynch, etc.)
Colonoscopy Required
High-Sensitivity FOBT Recommended for CRC screening

- At-home, multiple sample test – stick or brush for collection

- Hemoccult II SENSA® (Beckman Coulter, Inc.)

DRAFT: U.S. Preventive Services Task Force, 1/2015
Fecal Immunochromatographic Test
At-Home Tests
Best Test Performance

Of the FITs that are cleared by the U.S. Food and Drug Administration (FDA):

- OC-Light® Test
- OC FIT-Chek® family of FITs (Polymedco)

U.S. Preventive Services Task Force, 1/2015
Tests No Longer Recommended (Not High-Sensitivity)

- Hemoccult (Smith Kline and French Laboratories) 1970
- Hemoccult II (SmithKline Diagnostics)
- Seracult and Seracult Plus (Hardy Diagnostics)
- Coloscreen (Helena Laboratories)
### Draft: Table. Recommended Screening Strategies for Colorectal Cancer

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Digital Rectal Exam (DRE)

- A digital rectal exam (DRE) is **NEVER** acceptable for CRC screening
  - Misses 95% of advanced neoplasm
  - False sense of security

Clinician’s Reference: FOBT for CRC Screening
Colonoscopy

**Polyp** – growth inside the lining or outside of the colon (large bowel)

**Shape:**
- Pedunculated (mushroom like)
- Sessile (flat)
Polyps: Come in Different Shapes
Type of Polyp - Affects Interval Screening

- **Adenomas** (pre-cancerous)
- **Non-adenomas**
- **Cancer**
  - **Adenocarcinoma**
Colorectal Cancer (CRC)
Adenomas (Pre-Cancerous)

- Tubular
- Mixed
- Villous
- Serrated*

*note old terminology SSP is now Sessile Serrated Adenoma
Non-Adenomatous (Bumps)

- Hyperplastic polyps
- Benign mucosal polyps
- Polypoid granulation tissue
- Prolapsed mucosal polyps
- Inflammatory polyp
- Transitional mucosal polyp
- Lipoma
- Gangleioneuroma
- Neuroma
- Hamartomatous polyp*if >5
High Risk Adenomas

- Adenoma with high grade dysplasia
- 3 or more adenomas
- > 1 centimeter in size
- Piecemeal removal
Reducing Barriers (Surgeon’s Tips)

- Reduce fear - Pediatric scope
- 1:1 Education
- Nausea with the prep
  - Zofran 4 mg every 4-8 hours
- Type of prep
  - Split dose
  - Miralax/Gatorade (needs normal renal function and no CHF)
  - Osmo Prep (32 pills)
- Transportation
The colorectal cancer measure is based on several organizations’ clinical guidelines:

- U.S. Preventive Services Task Force (USPSTF)
- American Cancer Society (ACS)
- Agency for Healthcare Research and Quality (AHRQ)
- American Gastroenterological Association (AGA)
What are the Measures?

- **Uniform Data System (UDS) 2015 Quality of Care Measures**
  - Percentage of patients aged 50 to 75 who had appropriate screening for colorectal cancer
    - **Numerator:** Number of patients aged 51 through 74 with appropriate screening for colorectal cancer
    - **Denominator:** Number of patients who were aged 51 through 74 at some point during the measurement year, who had at least one medical visit during the reporting year
What are the Measures?

- **HEDIS 2015 “Effectiveness of Care” Prevention and Screening**
  - Percentage of patients 50 to 75 years of age who had appropriate screening for colorectal cancer.
    - **Denominator:** Patients age 51 to 75 years as of December 31 of the measurement.
    - **Numerator:** One or more screenings for colorectal cancer. Any of the following meet criteria:
      - Fecal occult blood test (FOBT) during the measurement year. For electronic data, assume the required number of samples were returned regardless of FOBT type.
      - Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
      - Colonoscopy during the measurement year or the nine years prior to the measurement year.
What are the Measures?

- CMS’ Meaningful Use (MU) and Physician Quality Reporting Program (PQRS): Clinical Quality Measure (CQM) Clinical Quality Colorectal Cancer Screening, (NQF #0034)
  - **Denominator:** Patients 50-75 years of age with a visit during the measurement period.
  - **Numerator:** Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria below:
    - Fecal occult blood test (FOBT) during the measurement period
    - Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
    - Colonoscopy during the measurement period or the nine years prior to the measurement period
What are the Measures?

- Patient-Centered Medical Home (PCMH):
  - Standard 6
    - Element A
      - Factor 2:
        - At least two preventive care measures relative to the practices’ entire patient population.
# What are the Guidelines?

**United States Preventive Services Task Force (Healthy People 2020)**

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<td>Screen with high sensitivity fecal occult blood testing (FOBT), sigmoidoscopy, or colonoscopy. Grade: A</td>
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For all populations, evidence is insufficient to assess the benefits and harms of screening with computerized tomography colonography (CTC) and fecal DNA testing.

Grade: I (insufficient evidence)

**Screening Tests**

High sensitivity FOBT, sigmoidoscopy with FOBT, and colonoscopy are effective in decreasing colorectal cancer mortality.

The risks and benefits of these screening methods vary.

Colonoscopy and flexible sigmoidoscopy (to a lesser degree) entail possible serious complications.

**Screening Test Intervals**

Intervals for recommended screening strategies:

- Annual screening with high-sensitivity fecal occult blood testing
- Sigmoidoscopy every 5 years, with high-sensitivity fecal occult blood testing every 3 years
- Screening colonoscopy every 10 years
What are the Guidelines?

- **Michigan Quality Improvement Consortium (MQIC) Adult Preventive Services Age >50.**
  - Screen for colorectal cancer using high-sensitivity FOBT, sigmoidoscopy, or colonoscopy, in adults (excluding those with specific inherited syndromes - Lynch syndrome and familial adenomatous polyposis, and IBD) beginning at age 50 years and continuing until age 75 years.
  - Screening intervals assuming 100% adherence to the regimen: Annual FOBT, sigmoidoscopy every 5 years combined with high-sensitivity FOBT every 3 years, or screening colonoscopy every 10 years. Recommend against routine screening for colorectal cancer in adults age 76 to 85 years, and recommend against screening for colorectal cancer in adults older than age 85 years.
What are the Guidelines?

- American Cancer Society: Starting at age 50, men and women at average risk for developing colorectal cancer should use one of the screening tests below:

  - Tests that find polyps and cancer
    - Flexible sigmoidoscopy every 5 years*
    - Colonoscopy every 10 years
    - Double-contrast barium enema every 5 years*
    - CT colonography (virtual colonoscopy) every 5 years*

  - Tests that mainly find cancer
    - Guaiac-based fecal occult blood test (gFOBT) every year*,**,***
    - Fecal immunochemical test (FIT) every year*,***
    - Stool DNA test every 3 years*

*Colonoscopy should be done if test results are positive.

** Highly sensitive versions of these tests should be used with the take-home multiple sample method. A gFOBT or FIT done during a digital rectal exam in the doctor’s office is not enough for screening.
What are the Guidelines?

- **American Gastroenterological Association**
  
  Screening tests for CRC broadly fall into two categories:

  - Fecal tests (ie, gFOBT, FIT, and sDNA)
  
  - Partial or full structural exams (ie, FSIG, CSPY, DCBE, and CTC) which are tests that are effective at detecting cancer and premalignant polyps.
How to Align Measures and Select Guidelines?

- Several different measure definitions and benchmarks for CRC
- Differences in payers and entities
- Can be frustrating
How to Align Measures and Select Guidelines?

- Stick with the UDS definition for the measure
  - Annual Reporting
  - EHR capability
- Build awareness of various measures
- CMS’ Consensus Core Set: ACO and PCMH / Primary Care Measures Version 1.0
Words of Advice...

- All efforts you make on processes for improvement will help you improve regardless of which measure you refer to, so just start with the evidence-based recommendations for improving rates, (e.g. ACS guide), pick a definition you are going to use, and begin with your improvement efforts.

- Using payer reports can be an easy way to target patients due for screening- this has worked for health centers in West Virginia.

- Important reminder: look for improvement within your system. Some of the national goals may be unrealistic but internal improvement is still a big accomplishment.
15 MINUTE BREAK
Opportunity for Improvement

- Review baseline data
- Identified significant opportunity to improve CRC screening rates
- Annual Board-Approved Quality Improvement Plan
- Identify a framework and assemble a team
PDSA

PLAN
- Goal: Increase CRC screening rates
- Incorporate iFOBT utilization
- Develop Workflow

DO
- Train/Implement workflow

Study
- Track CRC Rates
- Track iFOBT Use/Return
- Staff perception

Act
- Standardize and apply to all practices
Interdisciplinary Work Team

- Medical Director
- Quality Improvement Coordinator
- Clinical Case Manager
- Information Technology Support
- Accounts Receivable Manager
- Medical Records
- Data Analyst
Identify the Barriers

- Missing CRC discussion opportunities with patients
- Only offered colonoscopies
Barriers, cont’d

- Lacked system to track iFOBT return
- Lacked developed billing plan for the iFOBT
- Overhaul Clinical Education
- Medical Records Retrieval
- Electronic Health Record (EHR) must contain all capabilities
GETTING STARTED WITH THE WORKFLOW

FOBT WORKFLOW CHART

- Clinical Staff Check CDSS Alert when Rooming Pts 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 FOSTICLIA
- PCP documents in T3 Section "FOBT given today"

Did Patient return FOBT kit within 7 days? (check FOSTICLIA Log weekly for overdue FOBT)

- 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

NEGATIVE

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

POSITIVE

- Assign Lab to PCP for further instruction

- Patient Complies with Colonoscopy Order

- 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

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

**FOBT WORKFLOW CHART**

- Clinical Staff Check CDSS Alert when Rooming Pts 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 FOBT/CLIA
- PCP documents in Tx Section “FOBT given today”

---

**Did Patient return FOBT kit within 7 days?**
(Check FOBT/CLIA Log Weekly for Overdue FOBTs)
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- Create Nurse Visit + FOBT lab order in Treatment Section and drop appropriate billing charge
  - Notify pt of results

NO

YES

NEGATIVE

POSITIVE
Note in FOBT Log and document in EHR

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

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

Patient Complies with Colonoscopy Order

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

Assign Lab to PCP for further instruction

**NO**

**YES**
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
Set a CRC Goal
Clinical 2-Colorectal Cancer Screening, Ages 50-75 (Colonoscopy + FOBT Trend – Rolling 12 months)

Goal = 32.6% (2013 UDS Nat’l Ave) by 12-31-16

- 20.5%
- 24.0%
- 25.9%
- 28.0%
- 27.9%
- 28.3%
- 28.8%
- 29.9%
- 31.2%
- 31.5%
- 32.5%
ENJOY LUNCH BACK AT 12:45
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

Ensure Quality

Step #3: Get Patients Screened

Prepare the Clinic

Ensure Quality

Measure and Improve Performance

Make a Recommendation

Address Barriers

Communicate the Need

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

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

For more information, please contact:

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