Population Health: Colorectal Cancer Screening: Success Stories

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Objectives

- Describe the “Four Essentials” to improve colorectal cancer screening rates
- Explore implementation of community-based programs to improve colorectal cancer screening rates
“The barrier to reducing the number of deaths from colorectal cancer is not a lack of scientific data, but a lack of organizations, financial, and societal commitment.”

Daniel K Podolsky, MD (NEJM 7/20/2000)
The Pledge is Just the First Step

The nation has become energized by the goal of “80% by 2018”.

• Signing a pledge is easy
• Action after signing the pledge

What is it really going to take?
Give me three good reasons...

1. 4\textsuperscript{th} most common cancer and 2\textsuperscript{nd} most common cause of cancer incidence and death in North Dakota

2. 42\% of North Dakota CRC cases diagnosed at late stage

Survival Rates by Disease Stage*

- 90.3\% for Local
- 70.4\% for Regional
- 12.5\% for Distant
North Dakota Colorectal Cancer Screening Rates

Medicare Claims Data (Age 50-75): 4Q2015 through 3Q2016

*Screening tests included: Colonoscopy, Sigmoidoscopy, FOBT, Barium Enema

*Lowest Group

*Middle Group

*2nd Group

State Rate – 45.7%
Four Essential Steps to Improve Screening Rates

- Develop a Screening Policy
- Be Persistent with Reminders
- Measure Practice Progress
- Make a Recommendation

Communication

How to Increase Cancer Screening Rates in Practice
#1: Make a Recommendation

Assess a patient’s risk status and receptivity to screening.

Determine screening messages you and your staff will share with patients.

Be clear that screening is important. Ask patients about their needs and preferences.

1. Make a Recommendation

The primary reason patients say they have not gotten screened is because a doctor did not advise it. A recommendation from you is vital.

Brooks, Durado. 04/12/2017. Improving colorectal cancer screening rates through systems change [PowerPoint].
#2: Develop a Screening Policy

- Involve your staff to make screening more effective.
- Create a standard course of action for screenings, document it, and share it.
- Ensure patient education & follow-up

Brooks, Durado. 04/12/2017. Improving colorectal cancer screening rates through systems change [PowerPoint].
#3: Be Persistent with Reminders

Determine how your practice will notify patient and physician when screening and follow up is due.

Ensure that your system tracks test results and uses reminder prompts for patients and providers.

Brooks, Durado. 04/12/2017. Improving colorectal cancer screening rates through systems change [PowerPoint].
#4: Measure Practice Progress

Discuss how your screening system is working during regular staff meetings and make adjustments as needed.

Have staff conduct a screening audit.

Measure your progress to tell if you are doing as well as you think.

Brooks, Durado. 04/12/2017. Improving colorectal cancer screening rates through systems change [PowerPoint].
Potential Barriers to Screening*

1. Affordability
2. Lack of symptoms
3. No family history of colon cancer
4. Perceptions of the unpleasantness of the test
5. Doctor didn’t recommend it
6. Priority of other health issues

“I fear it will be uncomfortable. My doctor had never mentioned it to me, so I just let it go.”

Based on 2014 Consumer Surveys (Nationwide)
Why Colonoscopy is NOT Gold Standard

- Evidence does not support “best test” or “gold standard”
  - Wide variation in quality (when data is captured and available)
  - Access
  - Patient preference
  - Potential for patient injury
Making the Best Use of Scarce Resources: Screening colonoscopy vs. FIT

- Represents 20 patients

Screening colonoscopy (refer 1000 patients)

- Eligible population, referred
- Patient refusal, no shows
- 20 cancers found in 400 colonoscopies

FIT Testing (2,000 patients)

- Eligible population
- Patients with a positive FIT
- 80 cancers in 160 colonoscopies

*Slide courtesy of Dr. G. Coronado*
It's a beautiful day to save lives.
Implementation of a Colorectal Cancer Screening Program in a Rural Upper Midwest Federally Qualified Health Center: An Evidence Based Project

Kayla M. Abrahamson, RN, BSN, FNP-S & McKenzie R. Peterson, RN, BSN, FNP-S

University of Mary
Project Chair: Dr. Billie Madler
2nd Reader: Dr. Annie Gerhardt
Problem Identification

- Colorectal cancer (CRC) - 2nd leading cause of cancer-related deaths
- Risk starts increasing at age 40 and drastically rises at age 50
- Healthy People 2020 goal: >70% screening for those eligible
- ND ranked 42nd out of 51 in CRCS rates
- CRC is preventable with routine screening
- Estimated 50,000+ deaths a year related to CRC
- >60% are preventable
Literature Findings

• Themes
  – Colorectal Cancer
  – Colorectal Cancer Screening (CRCS) Methods
  – Barriers to CRCS
  – CRCS screening program recommendations
Project Recommendation #1

• Clinical policy and procedure development and implementation
• Includes a screening algorithm
• “Academic Detailing”

Cole et al., 2015; Corey et al., 2009; Davis et al., 2013; Sarfaty, 2008
Project Recommendation #2

- Optimize the EMR to support improved CRCS rates
  - Documentation protocol
  - Patient reminder system
  - Clinical Decision Support Rule
  - Surveillance Protocol

Atlas et al., 2014; Berkowitz et al., 2015; Cole, Esplin, & Baldwin, 2015; Geller et al., 2008; Green et al., 2013; Kern, Edwards, & Kaushal, 2014; Levy et al., 2013
Project Recommendation #3

• Clinical Navigation
  – Workflow analysis to identify staff available to assist in navigation
  – Navigation involves tracking CRCS
  – Patient reminder letter

Green et al., 2013; Levy et al., 2013
Project Recommendation #4

• CRCS Outreach Events
  – Patient outreach letters
  – Flu/FIT campaign
  – FIT cards in place of FOBT
Implementation & Engagement

• Institutional Review Board Obtained

• Threats and Barriers
  – High staff turnover
  – Change in routine
  – Increased workflow expectations
Project Results

Colorectal Cancer Screening Rates

- 2015: 22%
- 2016: 27.90%
Project Results

CRCS Methods Utilized

- Colonoscopy: 24
- FIT Card: 89
Lessons Learned

• Process Improvement Data
  – Staff needed for Clinical Navigation
  – Improved EMR optimization
  – Continued Staff Education on Documentation Requirements
Sustainability of Interventions

• Future Directions
  – Continue Flu/FIT
  – Expand FIT card dissemination to lab-only encounters.
  – Further efforts to improve documentation standardization.
Conclusion

• CRC is 2nd leading cause of preventable death in the U.S. (ACS, 2014a)
• The CRCS program improved CRCS rates
• Project Interventions:
  – Policy & Procedure
  – EMR Optimization
  – Patient Navigation
  – Outreach Efforts
• Strategies have potential to improve healthcare quality and outcomes
References


References


References


It's a beautiful day to save lives.
Northern Plains Comprehensive Cancer Control and Great Plains Mini Grant

- ✔ UR :
- Strategies to Improve Colorectal Cancer Screening

Donna Lunday- Tribal Health Educator
Marianne Young Eagle, MSN/MHA BSN RN
GOAL:

1. Increase access to CRC Screening
2. Increase the number of Tribal members that receive CRC screening through use of the Fecal Immunochemical Blood Test (FIT)

OBJECTIVES:

1. Increase the number of tribal members who receive CRC screening through FIT test from 0 to 300
2. Increase the number of tribal members who receive information about CRC screening, through education and screening events, from 0 to 500
What is GPRA

- The Government Performance and Results Act (GPRA) is a Federal Law
- It requires IHS to demonstrate funds are used effectively to meet their mission
- GPRA is a critical part of the annual budget request for IHS.
- There are annual performance measures with specific targets
- IHS reports 20 clinical GPRA measures; *one being Colorectal Screening*. 
Colorectal Cancer Screening

• **Denominator:**
  Active Clinical patients ages 50 through 75 without a documented history of colorectal cancer or total colectomy

• **Numerator:**
  1. Patients who have had any Colorectal Cancer (CRC) Screening, defined as any of the following:
     • Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT) during the report period
     • Flexible sigmoidoscopy in the past 5 years.
     • Colonoscopy in the past 10 years
  2. Patients with FOBT or FIT during the report period.
Tribal Health Education Grant

• Tribal Health was awarded a Grant, part of which was used to assist Indian Health Services (IHS) to increase their GPRA numbers
• THE purchases Gift cards with a portion of the grant money.
  • Gift cards were $25.00, (with a $2.00 processing fee). One grant used 54% for gift cards and another grant used 96% for gift cards.
  • Sponsored Events include:
    March 2016-Community CRC Screening a the Sky Dancer Casino
    • Presentation on Colorectal Cancer
    • Colorectal Bingo with prizes
    • Rollin Color-inflatable colon
    • Door Prizes
Key Players

- Community Health Representatives (CHR’s)
- Tribal Health/Public Health Nurses
- Lab
- Primary Care Providers (MD, Surgeon, PA)
Function of Community Health Representatives (CHR’s)

- Educated the individuals about CRC Screening using the Colorectal Health Flip Chart. Provided by the American Indian Cancer Foundation. The CHR’s were trained by Joy Rivera to provide CRC Screening.
Function of Public Health Nurses/Tribal Health Educator

- Combined the FluFIT test
- Demonstrated on how to use the FIT test.
- Patient were asked if they wanted a flu shot
- An incentive card was provided to patient to bring back to Lab
- PHN would provide the PCP with Names and DOB of individuals who were screened with the FIT Test individuals who received the FIT test.
Function of Lab

- Lab provided the FIT Test to the patient to take home, after receiving a lab order from the PCP
- Patient returned the FIT Test specimen, and Lab signed off on the card for the incentive.
- The signed card was returned to Tribal Health Education
- Tribal Health provided the $25.00 Gift card
- Test results were available in the Electronic Health Record (EHR) for PCP to review.
Function of the Primary Care provider

- PCP would write an order in the Electronic Health Record (EHR) for the Lab to run the FIT Test.
- Lab results were returned to the PCP
- Every patient receives a letter to inform them of the results of the FIT test, whether it was positive or negative.
- If the patient had a positive result, a referral was initiated for further work up. A Surgeon is on staff to do colonoscopies, if needed.
- If the colonoscopy showed evidence of cancer, the patient is referred to a higher level of care.
# MEASURE

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<th>Measure</th>
<th>2017 Target</th>
<th>2017 Q4</th>
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<tbody>
<tr>
<td>Colorectal Cancer Screening</td>
<td>40.2%</td>
<td>41.9%</td>
<td>1.7%</td>
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Results

- **Northern Plains (NP) Mini grant - $5000.00**
- $2700.00 incentive cards (100 cards) - 54%
- Purchased items, FIT Test kits, door prizes, Bingo prizes
- 193 participants
  - 109 returns
  - 73 Female
  - 36 male

**Great Plains Grant (GP) - $9000.00**

- 415 Participants
- 313 returned FIT Test
- Gender results not available at this time.
Conclusion-Key to success

Collaborating- with Key Players
Prevention- Patients are aware and know that Cancer is a silent killer, the test is easy and is done in the privacy of their home.

Education- used of the visual flipcharts is a great tool for culturally sensitive information.

Easy Access- Providing an incentive so individual are able to spend it at the local stores.
QUESTIONS
## Contact Information

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