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Colorectal Cancer Screening, 80% Goal: A Comprehensive, Team-Based Approach

Colorectal Cancer Screening, 80% Goal: A Comprehensive, Team-Based Approach

Nicole L. Trieste, RN, M.B.A., Director, Ambulatory Care Gaps & Best Practices, Geisinger Health System

Webinar, February 17, 2021

> *"At the end of the day, the best option [for colorectal cancer screening] is the one that actually gets completed and gets the patients screened."*
>
> — **Nicole L. Trieste, RN, M.B.A.**, Director, Ambulatory Care Gaps & Best Practices, Geisinger Health System

Colorectal cancer is treatable in 90% of patients when caught in early stages[1], so getting providers, system staff, and patients to buy into the importance of colorectal cancer (CRC) screening is an important step in keeping patients healthy. Ensuring screenings continue in the age of COVID-19 can be a challenge, but it is not insurmountable.

Nicole L. Trieste, Director of Ambulatory Care Gaps & Best Practices at Geisinger Health System, shared her experience with Geisinger's CRC screening initiative, which has resulted in an 8% increase in CRC screening over the past five years. Ms. Trieste shared her tips and tools for increasing staff buy-in and patient participation, with a focus on overcoming barriers to CRC screening, leveraging technology, shared decision-making tools, and the use of analytics. She also shared how the COVID-19 pandemic helped Geisinger launch some creative solutions to keep patients on schedule for cancer screening.

Background

Geisinger Health System, with a primary footprint in Pennsylvania, spans three areas of the state, each with very different populations. Altogether, Geisinger serves over 300,000 attributed patients across these hubs, which include 45 family practice and internal medicine practice sites and just over 250 primary care providers.

Trieste noted that, excluding skin cancers, CRC is the third most common cancer diagnosed in men and women in the U.S.[1] Five-year survival rates indicate that CRC is treatable in 90%[1] of patients when caught in early stages. Thus, timely screening/rescreening can impact early detection, survival, and costs. Screening for CRC is especially important in Pennsylvania because the state exceeds the national average in both the incidence of CRC and mortality from it. The national average for incidence of CRC is 38.7 per 100,000 people, but in Pennsylvania, it's 41.9 per 100,000.[2] The national average for CRC mortality is 14.2 per 100,000, while Pennsylvania is at 15.3. "So," noted Trieste, there is "certainly opportunity to improve in both of these areas."

[1] ACS. Colorectal cancer facts and figures 2020-2022. Atlanta: American Cancer Society; 2020.

[2] NIH. State Cancer Profiles; Quick Profiles: Pennsylvania. Updated March 18, 2021. Accessed March 18, 2021. *https://statecancerprofiles.cancer.gov/quick-profiles/index.php?statename=pennsylvania*.

Focused on value-based care, Geisinger knows that "prevention is key in being successful in a value-based care model." For CRC screening, Geisinger utilizes the U.S. Preventive Services Task Force (USPSTF)[3-4] recommendations to identify eligible CRC screening and rescreening patients, which include patients who are between 50[5] and 75 years old and have:

- Not had a colonoscopy in the last 10 years or
- Not had a flexible sigmoidoscopy in the last five years or
- Not had a Cologuard® completed in the last three years or
- Not had a fecal occult blood test [FOBT] or fecal immunochemical test [FIT] kit completed in the last year.

The challenge is making sure that patients meeting these criteria actually get CRC screening. Trieste said there are two primary types of barriers to CRC screening. This first type are patient-driven. These relate primarily to educational needs insofar as patients have misconceptions regarding preparation for a colonoscopy and the time involved, fear of a procedure, lack of awareness of the various screening options and the ease of using them, including those that can be done at home. Patients also have concerns about the cost of screening and/or don't consider it important when they are asymptomatic or there is no family history.

The second type of barrier is what Trieste called "system-driven." For Geisinger, these include issues with access to the gastrointestinal (GI) department for colonoscopies and patients getting into GI in a timely manner in some transportation-challenged areas, ease of scheduling, and "then, certainly," said Trieste, "patient and staff education on the importance of colorectal cancer screening, the significance, the various options, etc." Of course, Trieste also noted, "COVID has impacted CRC screening in a number of ways." She then shared several methods Geisinger has used to address these challenges.

Using Technology to Close Gaps in Care

To address challenges related to CRC screening, Geisinger has used internally developed tools and made use of best practice functions in its electronic health record system (Epic®). "Leveraging technology has truly been crucial in the success of our colorectal cancer screening improvement," said Trieste.

Geisinger's internally developed Ambulatory Management Program, or AMP Report "enables folks at all levels of patient care to see the open gaps that the patient has." The report can be used in pre-visit planning, at point of care, and as a "follow-up or what we would call a 'close the loop' tool. The AMP report (see Figure 1) contains basic patient demographic information, followed by appointment information, and then a list of the open gaps in care, which are based on standards from the National Committee for Quality Assurance (NCQA) as well as internal quality metrics. The AMP report also identifies what Geisinger calls the nursing responsibility—items that nurses can address when they're rooming the patient, hierarchical condition category (HCC) coding information, and information about future and previous appointments. "The goal to show both future and previous appointments," said Trieste, is to help "eliminate any unnecessary appointments," help with schedule smoothing, and help "ensure that patients have the appropriate follow-up."

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[3] Bibbins-Domingo K, Grossman DC, Curry SJ, et al. Screening for colorectal cancer US Preventive Services Task Force recommendation statement. *JAMA*. 2016;315(23):2564-2575. doi:10.1001/jama.2016.5989.

[4] United States Preventive Services Task Force. Colorectal Cancer: Screening. Accessed March 25, 2021. *https://uspreventiveservicestaskforce.org/uspstf/draft-recommendation/colorectal-cancer-screening3*.

[5] Trieste noted that the 2020 USPSTF draft CRC screening recommendation decreased the starting age for screening to 45 and Geisinger will be following that recommendation when it is issued.

Figure 1: AMP Report

[redacted] Open Gaps: 5 Risk Adm/ED: 16% 6/22/20 8:00

Patient Information

Name: [redacted] MRN: [redacted] Sex: M Birth Date: [redacted] Phone: [redacted]

Address: [redacted] Age: 57

Insurance: GHP FAMILY PLAN

GHP Case Managed: No *Recommend Mail Order*

Appointment Information

Date: [redacted] Length: 20 MIN Provider: [redacted]

Last CMSL Appt: 12/20/2019 Next CMSL Appt:

Comments: Type: COMPLETE PHYSICAL

Open Gaps

*Colorectal Cancer Screening order needed	No Colorectal Cancer Screening Ordered in the past year
Lung Cancer Screen order needed	No Lung Cancer Screen Ordered in Past Year
*O2 Sat needed	No Oxygen Assessment in past year
*Shingles vaccine needed	No Shingles Vaccine administered

Previous Diagnoses
Not previously reviewed

Diagnosis Suggestion	Previous diagnosis of Major Depressive, Bipolar, or Paranoid Disorders - due for assess, plan and encounter dx in calendar year

Supporting evidence: *Diagnosis of Moderate episode of recurrent major depressive disorder (HCC) (F33.1) most recently on 2019-12-20 at Family Practice Gray's Woods, State College (Office Visit) per EPIC Encounter.*

Diagnosis Suggestion	Previous diagnosis of COPD - due for assess, plan and encounter dx in calendar year

Supporting evidence: *Diagnosis of COPD, severity to be determined (HCC) (J44.9) most recently on 2019-11-18 at Family Practice Gray's Woods, State College (Office Visit) per EPIC Encounter.*

Diagnosis Suggestion	Previous diagnosis of Congestive Heart Failure - due for assess, plan and encounter dx in calendar year

Supporting evidence: *Diagnosis of Heart failure, systolic, due to CAD (HCC) (I50.20, I25.10) most recently on 2019-12-20 at Family Practice Gray's Woods, State College (Office Visit) per EPIC Encounter.*

Bundles: PROCESS RELIABILITY, COPD, ADULT PREVENTION, PERSISTENT_HCC

*= Nursing Responsibility

Future Appointments

Date/Time	Dept	Provider
[redacted]	Pharmacy, Gray's Woods, State College Family Practice Gray's Woods, State College Pharmacy, Gray's Woods, State College Cardiology, Gray's Woods, State College Pulmonary Medicine, Gray's Woods, State College	[redacted]

Previous Visits

Appt Date/Length	Visit Type	Dept	Provider	Primary Diagnosis	Disposition Date
[redacted]		Family Practice Gray's Woods, State College Family Practice Gray's Woods, State College	[redacted]	R73.03-Prediabetes F43.22-Adjustment disorder with anxious mood	6/20/2020

"So, when you think about pre-visit planning," said Trieste, "if I see that Betty Boop is coming in for her appointment next week and she's overdue for colorectal cancer screening, I can call Betty in advance of her appointment," and review the clinically appropriate CRC screening. "Ideally, it helps to have this completed prior to the visit. So, when the patient does come in, it's the most effective and efficient use of everybody's time to be able to review those results with the patient."

The Epic® electronic health record (EHR), which includes best practice alerts, comes into play when patients come in for appointments. If the patient is overdue for screening, an automated CRC screening alert displays for the nursing staff when the patient is being roomed. If the nurse ignores or declines the alert, the alert will then fire again during the provider visit. Geisinger has an associated smart set with the documentation tools and order that's attached, to ease the process of enduring the patient gets scheduled for screening.

Technology has also helped Geisinger facilitate communication outside the point of care. In particular, they have instituted "happy birthday" and "chronic disease" letters, which are sent electronically to patients who are active on the health portal and via U.S. mail to patients who are not (as well as to those active portal patients who do not appear to have read the electronic letter within seven days). The letters go to discrete subsets of patients, which are defined by specific criteria for each letter. The point is to help the patient close gaps in care. So, for example, the birthday letter begins on a celebratory note, followed by a suggestion that birthdays are also "a time to remember and talk, and it discusses the importance of preventive care." Below that message is the patient's health calendar showing gaps in care that are either overdue, due now, or due in the upcoming months. Said Trieste, "This really helps the patient plan and schedule as appropriate." The chronic disease letters go out six months after the patient's birthday for qualifying patients, such as those with diabetes, chronic kidney disease, coronary artery disease, hypertension, etc.

Trieste later noted that keeping patients up to date on screening is a daily challenge. "That's really the reason we have so many modalities and avenues of communication to patients regarding their open gaps in care, to help ensure that proactive communication about their healthcare needs."

People-Centered Approaches

Geisinger has also engaged in several CRC screening "Close the Loop" initiatives that are driven more by personnel than technology, and Trieste focused on three of them.

The first two utilize Geisinger's "Care Gaps Health Coordinators." These coordinators are assigned to primary care sites, with each coordinator responsible for four to six of Geisinger's community medicine sites. The Care Gaps Coordinators are responsible for the entire panel at those sites, but, noted Trieste "really, it's shared accountability and responsibility with operational and site leadership for helping to improve our quality metrics." The first Close the Loop initiative the Care Gaps Coordinators work on is outreach to patients who had a Cologuard® ordered within the last 60 to 90 days but have not returned the kit. The care gaps staff contacts the patients, encourages them to return the kit, and answers any questions they may have.

The second Close the Loop initiative for Care Gap Coordinators is outreach to patients who have positive Cologuard® or FIT tests but have not had a follow-up colonoscopy scheduled or completed. "So," explained Trieste, "our care gap staff will outreach to those patients, provide the necessary education around the importance of the follow-up screening and having a colonoscopy, and then get that scheduled for the patient while they have them on the phone."

The final Close the Loop initiative involves the GI team, which conducts outreach to patients who've canceled or "no showed" their colonoscopy appointment. They work to get the patient rescheduled, answer any questions or concerns the patient has, and again, said Trieste, "really just try to make sure that we get our patients the appropriate care that they need."

Several other people-centered processes have helped address some of the educational barriers to CRC screening. Trieste noted that "shared decision making is truly a key component in patient centered health care. It's truly the clinicians and the patients working together to make those critical healthcare decisions and select the appropriate test, treatments, etc., for that particular patient."

To help facilitate this process, Geisinger has partnered with Exact Sciences, whose representatives provide on-site education for staff and answer questions around Cologuard®. They've also provided demo kits to all of Geisinger's sites. So, as nursing staff discuss CRC screening, they can do a hands-on demo with the patient if that's the method they choose to use for screening. "So when they do receive the kit," said Trieste, "it's not foreign to them. They've seen it in the office. They know what it looks like. They know how to utilize it and how to how to complete it when they do get it at home." As well, Geisinger has incorporated motivational interviewing education at the site level. Geisinger educators go on-site and provide education to the site staff to help improve patient engagement when addressing preventive screenings, "especially," said Trieste, those patients "who are more resistant or difficult to engage."

Geisinger has also developed a shared decision making (SDM) tool, "Fast Facts About Colon Cancer & Screening," designed to facilitate CRC screening engagement and discussion (see Figure 2).

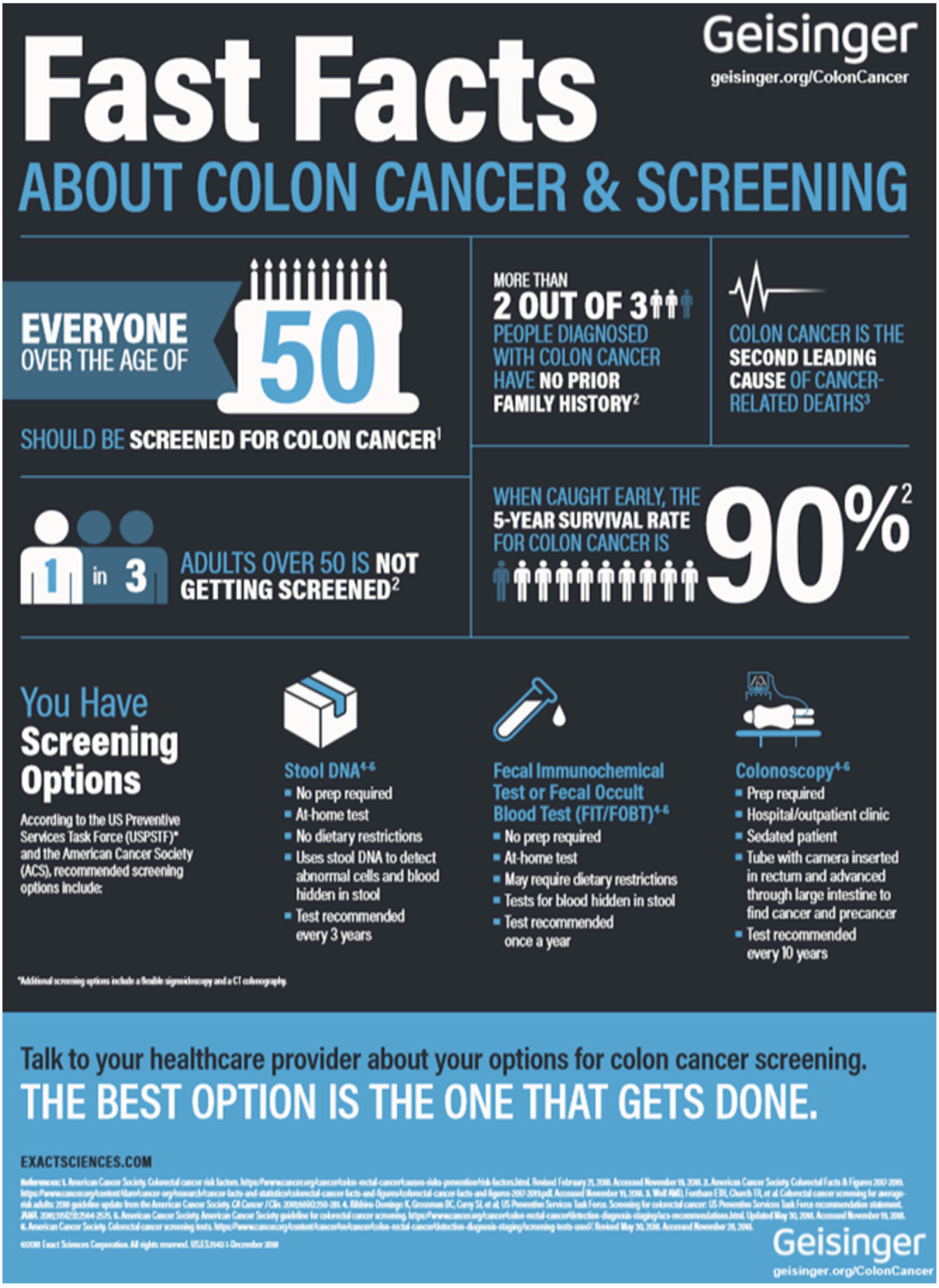
"So you'll see," said Trieste, "it's bright." It shows high-level colorectal cancer screening stats, graphics, and "certain stats that jump out at you that we want patients to notice quickly. But most importantly," Trieste noted, "it really discusses the three screening options that are available to patients with brief explanations of each." Geisinger promotes colonoscopies as the reference standard for colorectal cancer screening, but, Trieste acknowledged, "at the end of the day, the best option is the one that actually gets completed and gets the patients screened."

She later noted that prepping staff for all these discussions "did not happen overnight." Geisinger spent several years focused on educating nursing staff and providers on CRC screening so "they're much more comfortable now talking about and discussing CRC screening options with patients than ever before."

Making the Most of Colorectal Cancer Awareness Month

In addition to all its individual patient-directed approaches, Geisinger has made the most of Colorectal Cancer Awareness Month to facilitate interest in CRC screening. Last year, it had the Colossal Colon (a large inflatable colon) displayed for a day at each of its hospital campuses. "We had great patient interest in it," said Trieste. "Patients were super intrigued when they would see it, wanted to check it out." They even took pictures with it. Geisinger also had quite a bit of local media coverage publicizing the importance of CRC screening, and did a lot of its own marketing on internal and external social media platforms, on the patient portal, and in newsletters sent through the system and partner Geisinger Health Plan. They engaged both inpatient and outpatient staff with a CRC bulletin board contest, and its school of medicine partnered with local nursing schools to create a number of internal educational videos.

Figure 2: SDM Tool



Using Analytics to Track Progress

"We really needed to be able to measure what we were doing," said Trieste, to evaluate the effectiveness of their efforts on CRC screening. "There's significant importance in being able to measure the value of the processes." Number one, she said, is "being able to collect your baseline data and being able to compare that over time and seeing either the improvement or, you know, maybe it's not improved." If not, she said, then you circle back and see what you can do better. Geisinger utilizes several dashboards and metrics for this processes.

"This is really critical to understand where you're at in the process," Trieste explained. "What are your colorectal cancer screening rates? What percentage is being screened by what method? What patients need what follow-up if anything is positive or abnormal?" Geisinger's screening dashboard helps answer these questions. "This really looks at and gives us the ability to drill down to the patient level and provider level data within each screening method to aid in closing the loop on those gaps." Care gap coordinators and GI departments also use this dashboard report as part of their Close the Loop efforts.

Another primary analytics tool is Geisinger's internally developed Primary Care Quality and Disease Management Dashboard. It tracks a number of metrics, but Trieste focused on the CRC information. This dashboard provides a year-over-year, month-over-month comparison. It allows the user to drill down by the individual metrics, the individual scores by the site, and by the provider. It also provides graphs, which Trieste noted, "often help to tell that quality story over time." As a result, this dashboard gets much use from all Geisinger's sites and providers "to see where they're at for all of our priority metrics." (See Figure 3)

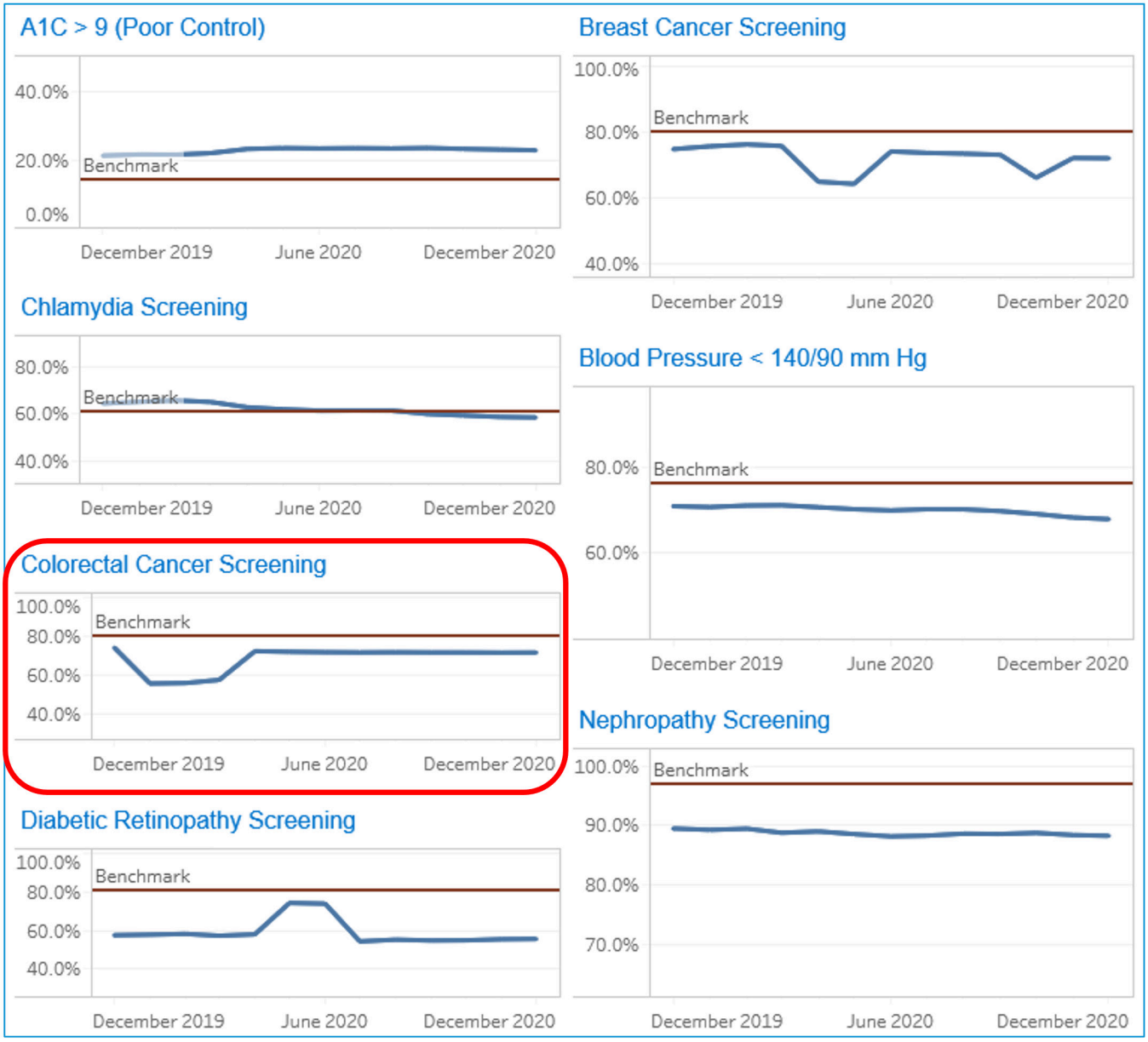
The Provider and Nurse Scorecard, another internally developed tool, reports on metrics related to Geisinger's pillars of care, including patient satisfaction, emergency department and inpatient utilization, various screenings, access, etc. The scorecard also has the ability to drill down to the site provider and nursing staff levels, so it is "highly utilized by our operational insight leadership" to identify who's doing really well, as well as "areas of opportunity and where can we improve."

Finally, there is the Best Practice Alert Dashboard, which provides a trending view of the acknowledgment reasons for our best practice alerts (i.e., when screening orders are placed, canceled, or declined and, if declined, for what reasons). Again, this allows "operational staff to identify who's doing really well. And then again," said Trieste, "where do we have opportunities for improvement?"

Trieste stressed that accountability is an essential element of any quality initiative, "whether it's colorectal cancer screening, breast cancer screening, getting hemoglobin A1Cs on our diabetics, it really doesn't matter. Accountability is key." She emphasized that no one person is responsible for this. "Everybody that touches the patient," every part of the care team, plays a role in the success of screening. "And so it really starts with leadership," said Trieste, and "their commitment to achieving our screening goals." From there it works its way down to the site level where, Trieste noted, "having those champions on the front line has been a critical part of our success."

She connected this to Geisinger's 2017 promotion of the care team approach, "moving away from the provider having the sole responsibility for that patient and everybody else kind of being the helpers to the provider," to a "we" and "they" environment. Patients have contact with multiple members of the care team, who all share responsibility, whether they be the provider, pharmacist, community health assistant, case manager, care gaps nurse, social worker, etc. The approach, says Trieste, "moved away from *my* patients to *our* patients and having concern for the entire panel of patients at that site."

Figure 3: Quality Metric Trending



Data through 1/3/21

Lessons Learned and Future Goals

All of these activities have culminated in Geisinger reaching a CRC screening rate of about 71%, which is a significant improvement over the 63% rate it began with five years ago. Trieste acknowledged the process has not been perfect: "We've had stumbling blocks." There have been successes, "but we haven't gotten to 80% yet, so we certainly have some more opportunity to get there." She said one of the key lessons was to ensure reliable, consistent, and efficient workflows. "We certainly want to have the least amount of clicks. We want it to work every time, and we want it to be reliable. We want to make sure we're identifying the right population when they come in and getting them the most appropriate screening."

Next, "communication, communication, communication," from the executive level to the front line, it's important to make sure "everybody—from your

nurse to your provider to your social worker to your case manager, to your operations manager—understands the significance and importance of colorectal cancer screening. Why are we doing it? What are the options? What is clinically appropriate? And then how are we doing measuring, measuring that success? Are we improving? Are we not? If we're not, where can we you know, where can we do better?" It also helps to be sure there is transparency in sharing of the data. Trieste emphasized that all the metrics dashboards discussed in her presentation are accessible "to anyone in our primary care departments, from providers to nursing to operations to medical assistants." So, everyone has the same access and the same information on outcomes and progress.

Trieste noted that patience is necessary. "You're not going to see that improvement overnight." It can take months to years to truly see a significant impact, which is why, she said, "I think it's so important to celebrate those small wins when you have them." Geisinger has implemented quality awards across its community medicine sites, including quarterly awards for those with the highest quality scores, as well as those deemed "best in class," and "most improved." Trieste says these help "drive that momentum and keeps folks going. It really promoted, what I would say, healthy competition among our sites to improve."

Moving forward, Trieste noted that, while COVID "has thrown a wrench into many things for our health system," it also provided opportunities to be creative, and she expects some of the innovations to continue in the post-COVID world. Geisinger's first positive COVID-19 case was identified on March 17, 2020, and by March 25 they had stopped all non-urgent and emergent appointments and procedures and closed or consolidated a number of community medicine and primary care sites. These facilities did not open until June 1. Thus, there was a period of longer than two months with minimal care gap closure. Although Geisinger did transition to telemedicine, Trieste indicated it's more difficult to address care gaps under those circumstances. She said, "We needed to get creative. We needed to think outside the box. And we had to figure out how to get care to our patients instead of having our patients come to us in the traditional ways."

One exciting innovation was Geisinger's "2020 On the Road to a Healthier You" initiative. Within weeks of the pandemic shut down, a partnership between care gap teams and members of the best practice team adapted Geisinger's mobile health services bus to serve primary care diabetic patients with open gaps in care. In keeping with pandemic social distancing guidelines, patients were scheduled one every 10 minutes. They soon expanded beyond diabetic-specific gaps to include CRC screening, breast cancer screening, and cervical cancer screening. They visited 16 sites over 20 days in the summer of 2020, seeing 611 patients, completing almost 1500 labs, and conducting almost 500 retinal scans. "And the patient feedback was overwhelmingly positive," said Trieste. Geisinger considered this a "huge success" and expects to expand mobile care service in 2021. As they were not set up to track cancer screenings as part of the 2020 initiative, capturing those metrics as part of the 2021 expansion is something they are looking to do. As well, with mobile options that include a mobile DEXA [dual-energy X-ray absorptiometry] unit, a mobile mammogram unit, and a mobile dental unit, they hope to provide multiple units at each location to try to close as many gaps as possible at one time. They are also looking into providing vaccines and Cologuard® screening on the mobile care bus.

The pandemic also prompted a campaign for Geisinger's Medicare population, which got FIT kits by mail this past summer. A letter outreach campaign to primary care patients overdue for CRC screening is scheduled for early 2021 and will encourage patients to contact care gap staff to identify the best screening method for each patient. The letter uses graphics and easy-to-read text

to explain and promote the various screening methods, including the ease of at home test kits, which, Trieste noted "during these times is very appealing to patients." She also noted, however, that for patients who do need to come in for a visit, they've stressed educating patients about safety measures in place to protect them, such as screening for symptoms at all clinic and hospital entrances, social distancing, masking practices, etc. Trieste expects to check results about 60 days after the letter campaign to measure the success of the outreach.

Looking ahead, Trieste also expects 2021 to bring in more CRC screening patients once the age 45 standard is formally endorsed by the USPSTF. "Sadly, we're not going to have the Colossal Colons at our site and be promoting in-person activities" for CRC Screening Awareness Month this year, but, said Trieste, "there's certainly a lot of things we can do outside of being in person." They will continue to promote the bulletin board contest, have display boards in all in- and outpatient facilities, utilize both internal and external social media, newsletters, and the patient portal, "and then really partnering with our local news stations to get the word out about the importance and significance of colorectal cancer screening."

Trieste ended her program with an inspiring message for these difficult times. "Really, what COVID has shown us," she said, is "we cannot solve problems with the same thinking we used when we created them. And so we needed to think more critically and creatively."

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