



Advancing High Performance Health

Colorectal Cancer Screening

*Quality and Innovation
Collective (QuIC)*

Phase 3 Meeting Summary





AMGA Quality and Innovation Collective (QuIC) Colorectal Cancer Screening

CRC Screening: An Urgent Imperative for a Highly Preventable Disease

Colorectal cancer is the third-leading cause of new cancer cases and cancer deaths in the United States, with the American Cancer Society estimating 151,030 new cases and 52,580 deaths for 2022 alone.

Phase 3 Meeting Summary

In September 2021 at the Phase 2 virtual meeting of the Colorectal Cancer Quality and Innovation Collective (CRC QuIC), AMGA Foundation President and AMGA Chief Medical Officer John Kennedy, M.D., opened a virtual gathering with an appeal to participants. He urged them to implement the new screening guidelines for people aged 45-75 and close health equity care gaps in CRC screening exacerbated by the pandemic.

In April 2022, he and Dr. Durado Brooks, deputy chief medical officer, screening, at Exact Sciences, welcomed participants back to report on their work since the Phase 2 meeting, including highlights from their targeted interventions, best practices, lessons learned, and what's next for improving screening rates.

During the time between these meetings, participants submitted goals and plans for tailored interventions, followed by full quality improvement documentation. These submissions informed the meeting's agenda.

The April 26-27 meeting was the collective's third and final gathering. Using AMGA's new QuIC format, the three meetings enabled participants to:

- Listen to high level discussions
- Share current care practices through collaborative meetings
- Create new models and care paths through interactive workshops

Keynote: Colorectal Cancer Screening: 80% in Every Community

Keith Winfrey, M.D., Chief Medical Officer, New Orleans East Louisiana Community Health Center

Moderator: Frank Colangelo, M.D., M.S.-HQS, FACP, Allegheny Health Network and Chief Quality Officer, Premier Medical Associates

New Orleans East (NOELA) Community Health Center (CHC) achieved 80% CRC screening in 2018, a journey which began six years before spurred by new reporting guidelines and a new electronic health record

CRC QuIC Participants

- Carle Physician Group
- Geisinger
- INTEGRIS Medical Group
- Intermountain Healthcare
- Kelsey-Seybold Clinic
- Lehigh Valley Physician Group
- Maury Regional Medical Group
- Prevea Health
- Privia Health
- Summit Medical Group
- Sutter Medical Foundation
- Utica Park Clinic



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(EHR). When NOELA CHC's new system showed only 3% of eligible patients as having been screened for colorectal cancer, Winfrey thought, "That had to be impossible." After investigating, he discovered his hunch was correct. "It was a whopping 11%."

Winfrey acted at once, determining, "Here's where we are, here's what we need to do to improve." This involved using the new EHR to introduce data into the practice and seizing every opportunity to incorporate screening into patient interactions. "No matter who or why people were coming to the clinic, we had a conversation about screening."

As for the screening tactics themselves, NOELA CHC found success by taking a "FIT first" approach. "That's when we really started seeing improvement in screening rates," Winfrey said. "And the success of this approach has been beneficial over time, especially recently when we didn't experience much of a drop-off during the COVID-19 pandemic. Because our staff was very familiar with the process, we were able to pivot very quickly to mailing FITs [fecal immunochemical tests] out to patients, and tracking the returns."

Partnerships for open access endoscopies also yielded encouraging results. NOELA CHC worked with a safety net hospital that allowed direct access to patient scheduling and a private practice, with a focus on making sure patients followed through with appointments at both sites.

Other tactics in 2012-2018 included patient and provider incentives, EHR training, including importance of choice of screening modality discussions, and the addition of a new patient navigator and quality improvement director (See Figure 1). Throughout, NOELA CHC used frequent staff meetings, provider assessments and feedback, and health coaching about CRC screening "to drive it into our systems' DNA and to make the screening process more consistent," Winfrey said.

Figure 1: Summary of NOELA CHC's EBIs and PDSAs

2012-14

- Provider Reminders & Feedback
- Provider recommendation
- EHR training
- Assessment & Feedback

2014-15

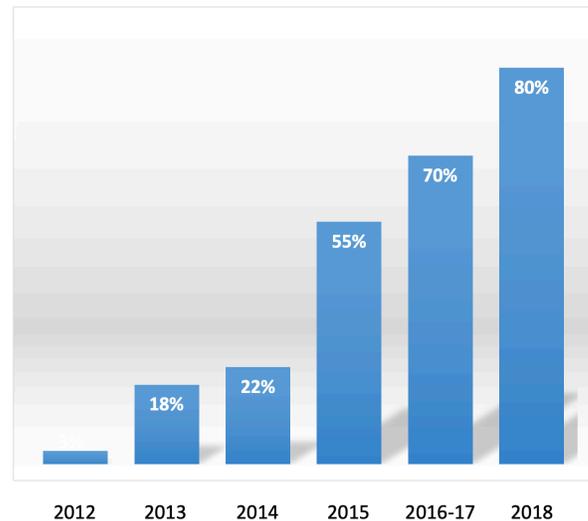
- Hired new Patient Navigator and QI Director
- "FIT first" strategy
- "FluFIT" initiative

2016-17

- Opportunistic Approach
- Patient incentive, Provider incentive
- OAE partnerships

2018

- All of the above engaged beginning in January





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Winfrey also talked about collaborative and community-based efforts to improve CRC screening rates. “We need everybody to do their part both within their own system and collaboratively with other systems,” he said.

Winfrey began this discussion with the group that inspired NOELA CHC’s 80% screening goal: the National Colorectal Cancer Roundtable (NCCRT). In 2014, NCCRT launched its “80% by 2018 Initiative” with the goal of activating organizations to invest in colorectal cancer screening. Out of 1,800 participating organizations, more than 350 reported reaching the 80% goal and hundreds of others reported increasing CRC screening rates.

The NCCRT’s efforts have had a ripple effect, with organizations, collaborations, and state roundtables nationwide now addressing CRC screening in a more coordinated fashion and with an explicit goal of achieving an 80% rate. Winfrey cited the South Carolina Colorectal Cancer Prevention Network, which helps uninsured patients access screening; Surgery on Sunday in Kentucky, which provides medically necessary procedures at no cost; and the fully navigated CRC screening program at Advocate Illinois Masonic Medical Center, where direct referrals and Saturday screenings significantly reduced screening wait times.

Winfrey emphasized the power of regional collaboratives. “Through regional consortia that have similar socioeconomic demographics and risk factors, we’re able to share unique challenges and discuss best practices within our region to be more impactful,” he said.

Moderator and Audience Q&A

How do you overcome barriers like language at NOELA CHC?

NOELA CHC has a diverse patient population, with significant Vietnamese, African American, and Latinx representation, and two-thirds of patients speak languages other than English. When reaching out to patients with a variety of cultures and ways of interacting with health systems, “employ staff that reflect your population,” Winfrey advised. “And really work on consistent messaging so the importance of screening resonates.”

Whether dealing with language barriers and messaging or any other aspects of screening, “learning to identify your unique challenges and barriers will be key to your success,” he said.

How does staff know who’s due for screening?

NOELA CHC uses daily huddle sheets to show care teams which patients are due for preventive services such as screenings. “Each team gets a printout at the start of the day, so they know which specific conversations need to be had during a patient’s visit,” Winfrey said.

How do you make sure patients with a positive stool test complete screening?

Often patients who have chosen a stool test just aren’t ready for a colonoscopy, even when they learn of a positive result, Winfrey observed. Compounding this challenge, Louisiana’s health systems are still working through a backlog of appointments due to COVID-19 and hurricane-related disruptions. NOELA CHC has responded by maintaining registries and reporting systems, Winfrey said, “so coordinators are able to monitor and stay on top of patients’ needs.”



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CRC QuIC Quality Improvement Report

Earlean Chambers, RN, M.S., CPHQ, Director of Clinical and Quality, Population Health Initiatives, AMGA Foundation

CRC QuIC has been an incremental journey of increasingly targeted focus, with participants moving from collaborative discussions to specific interventions. With the initiative now in its third phase, Chambers walked through the process leading groups up to this point, including the pivotal work participants did on their own in the months before the April 2022 meeting.

In Phase 1, participants ranked lack of patient awareness and education as their top problem related to colorectal cancer screening, followed by the new screening guidelines, disparities in care, and clinical workflows. Phase 2 confirmed these priorities and added a few new ones: Lack of screening for average-risk and high-risk patients, inadequate clinical decision support tools, and the need for more uptake in provider education and communication.

Then participants used the Quality Improvement Documentation Tool to set a goal and craft a corresponding intervention for each's individual organization. "Goals had to be specific to a targeted population, measurable, achievable, relevant, and time-specific," Chambers said.

Interventions toward these SMART goals addressed a variety of issues: Closing gaps in CRC screening, educating patients and providers, strengthening outreach, and more. Chambers highlighted the range of tactics that emerged, from scripting for front desk staff and screening for social determinants of health (SDOH) to developing frameworks for clinical pathways and distributing FIT and Cologuard packets in exam rooms.

While staffing shortages, COVID-19 priorities, time constraints, and IT/EHR difficulties presented obstacles along the way, "there was success in each project," Chambers said.

Group Interventions and QuIC Tips

In five-minute spotlights, groups presented their interventions and their "QuIC Tips" for success.

Carle Physician Group implemented a policy that allows nurses and certified medical assistants (CMAs) to order CRC screenings, including fecal immunochemical test-immunochemical fecal occult blood test (FIT-FOBT) or Cologuard—a change driven by the nurses and CMAs themselves. Carle created a new infographic and adjusted its electronic medical record (EMR) to support the new policy and is now cascading the protocol through the organization.

QuIC Tip: *Find a change agent within the clinical staff to promote the policy change and share success.*

Geisinger is addressing disparities in care through more efficient screening for and collection of data on SDOH. The organization created a SDOH questionnaire, launched through Epic and currently sitting on the Neighborly platform, for primary care providers to walk through during patient visits. The team is using dashboards to combine this data and leverage it to close care gaps. One way that they are closing gaps is to move Cologuard kits into the number one slot in the dashboard, where medically appropriate, to get those patients screened sooner, rather than later.

QuIC Tip: *An efficient process for SDOH screening and collecting results data can help you identify your vulnerable populations.*



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INTEGRIS Medical Group created a handout to educate patients on how helpful and simple screening is and how CRC is largely preventable with the screening process. When COVID-19 precluded distribution via front desk staff, nurses handed the flyer to patients during the rooming process. INTEGRIS supplemented the flyer with provider education in various standing meetings and information on its portal connecting patients to care coordinators who could schedule them for the screening method of their choice. These materials have educated 96% of patients to date, and INTEGRIS is currently expanding its efforts to text messages.

QuIC Tip: *Make screening education standardized, physician-driven, and available in multiple formats.*

Intermountain Healthcare's rural communities have been challenged by a lack of screening awareness, poor access to care, and siloed systems. Improving access and closing the performance gap involves a mix of standardization and site-specific customization, with an emphasis on shared learning, iterative improvement, and involvement of each team member—from GIs to primary care providers to surgeons—in localizing the program. They are also partnering with public health departments and payers.

QuIC Tip: *Co-design initiatives and plans together to better understand specific needs of care teams and communities.*

Kelsey-Seybold Clinic integrated clinical decision support tools into its EHR to increase screening compliance and follow-up, including an automated outreach system via MyChart. Reminders give patients the opportunity to request a FIT kit, providers a chance to close the loop when tests yield abnormal results, and more. Kelsey-Seybold also used the new system to update Epic maintenance for all CRC screenings and its health maintenance plan.

QuIC tip: *Data analytics and reporting can help pinpoint struggling populations that need more targeted outreach and help addressing barriers.*

Lehigh Valley Physician Group has created a CRC clinical pathway that extends through screening and diagnosis to cancer treatment and survivorship, age 45 to 75. One pivotal step was working out the data needed to build a robust dashboard, such as who gets screened and how. The pathway is now in the queue for final development, with Lehigh Valley obtaining the network capacity and resources to extend it firm-wide and embedding parts of the pathway into the EMR to guide screening reminders and assessments.

QuIC Tip: *It's a collaboration, all the parts—clinicians, clinical operations—have to flow together to get the work done.*

Maury Regional Medical Group has been expanding its marketing while consolidating patient outreach. Starting in March, Colorectal Cancer Awareness Month, the organization launched ads across newspaper platforms, social media, billboards, internet, and LOOMA TV. Concurrently, the organization collaborated across departments to streamline patient outreach: Conducting in-depth chart reviews, assigning patients color-coded categories for calls or referrals, and consolidating this information into a report, updated monthly, that care teams can pull from the EMR.

QuIC Tip: *Classifying patients during phases of outreach helps to group patients together for more focused follow-ups. It also gives the quality team the opportunity to re-review the patients who do not have results on file.*



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Prevea Health is improving screening rates for patients with average risk through FIT kit mailings and “any screening is better than none” messaging. The organization mailed FITs with postage-paid envelopes directly to patients in rural communities, where patients don’t have as easy access to care. Patients can complete the tests in the comfort of home without having to take time off work. For next steps, Prevea is developing new processes to handle positive test results and screenings that fall outside of its system and exploring options with Cologuard.

QuIC Tip: *Ensure you have a good process in place for record collection, especially from outside systems.*

Privia Health has been grappling with insufficient screening documentation, such as incomplete EMR entries and results not being recorded as searchable data. Interventions include data mining to determine if a missing entry is due to a patient not completing screening or a clinician not inputting results. Teams have also been manually reviewing charts and claims where discrete data is missing and examining the best pathways for getting data into discrete fields so it can be extracted and searched. This process also enables the team to follow up after screening.

QuIC Tip: *Educating the team on documentation specifics is essential for getting information into the EHR in a way that you can get data out.*

Summit Medical Group rescheduled its staff and patient education intervention planned for 4Q 2021 to 2Q 2022 due to barriers such as staffing shortages, climbing COVID-19 positivity rates, and evolving guidance from Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention (CDC). At present, the team has readied its documents and selected several standardized Exact Sciences tools.

QuIC Tip: *Readiness is key to a successful intervention. Competing priorities can derail plans and cause unnecessary frustration.*

Utica Park Clinic has been engaging advanced practice registered nurses (APRNs) in outreach to eligible patients, many of whom are hesitant and resistant and/or challenged by social and economic barriers. An APRN hungry to take on new activities worked with Utica Park’s quality manager to pull quality reports, then started making phone calls: Talking to patients about the importance of screening, assessing individual needs, and addressing hesitations and fears. APRNs order Cologuard and partner with Cologuard navigators to ensure address and demographic information is captured correctly.

QuIC Tip: *Find more time and use trained clinical staff and conversations for those patients who need more than a screening reminder.*



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Care Coordination and Clinical Workflow Panel

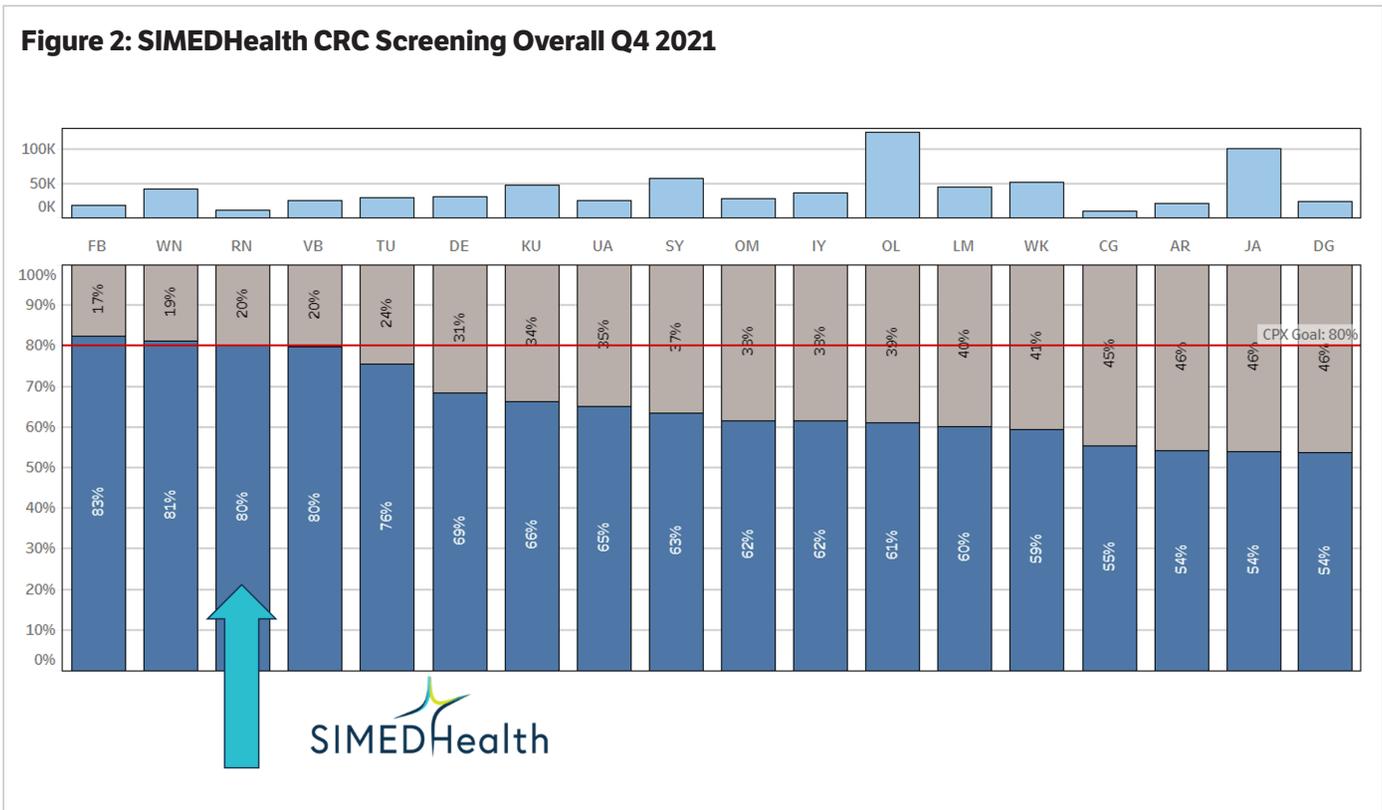
Manish Naik, M.D., Chief Medical Officer/Chief Medical Information Officer, and **Anas Daghestani, M.D.**, Chief Executive Officer, Austin Regional Clinic; **Beth Keane**, Chief of Population Health, SIMEDHealth; **Megan Romine, D.O., M.H.A., FACP**, Medical Director Population Health, UnityPoint Clinic and UnityPoint Accountable Care

Moderator: Annie Sy, Pharm.D., M.H.S.A., Sutter Valley Medical Foundation

In this interactive panel discussion, participants learned how three peer organizations are addressing challenges in care coordination and strengthening their clinical workflows.

SIMEDHealth rallied its efforts around an employee-named campaign, “Don’t Be in the Dark: Know What Grows,” and focused on its EHR, adding a structured datapoint for screening decliners and creating a centrally managed account for Cologuard. “We quickly moved from 37% into the 50 percents just by capturing more people for screening,” Keane said (see Figure 2).

Another critical element was improving follow-up for positive FIT and Cologuard results—“going beyond check the box,” in Keane’s words. In the old workflow, SIMEDHealth’s GI partners typically reached out three times to patients then reached back to PCP. Referrals were getting lost.





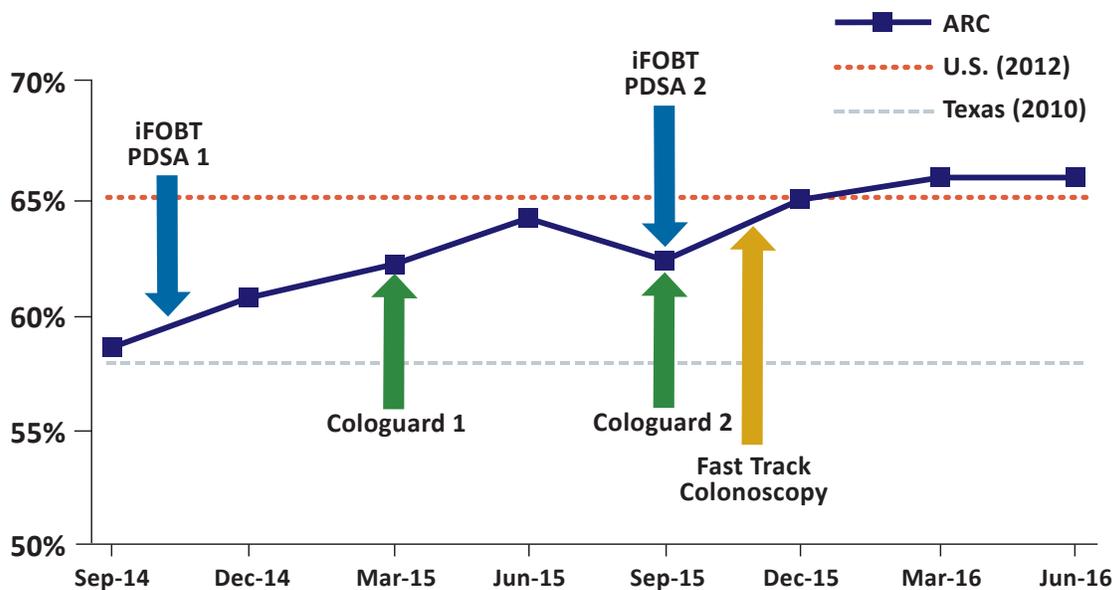
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Under the new system, a primary care physician's initial notification for a GI referral triggers up to six months of outreach. Escalating tactics include gentle reminder emails about the importance of screening, to certified letters to patients' homes that might also get the attention of loved ones, to phone calls that address questions and obstacles. The last attempt captures the reason for resistance to guide conversations at the patient's next primary care visit. This campaign has enabled SIMEDHealth to achieve an 80% screening rate.

Austin Regional Clinic conducted a similar multichannel outreach campaign, including web ads with direct scheduling and patient newsletters. The organization concurrently enhanced Epic's health maintenance section for more integrated information. "This really helped us improve data capture and tracking," Naik said. It previously was hard to tell if a patient's record was up-to-date or if a test was Cologuard or fecal occult blood test (FOBT). Now care teams receive a current, integrated view, with the ability to order all three of the test types from the same screen.

The organization is currently working to close the screening gap for patients with positive stool-based test and exploring tactics like artificial intelligence (AI)-enabled appointment scheduling via text.

Figure 3: Austin Regional Clinic: Overall CRC Screening Rate



At UnityPoint, having 30% of patients cared for by independent providers adds complexity to care coordination and clinical workflows. "That's over 20 EHRs and pen and paper," in Romine's words. The organization is tackling these challenges through having a centralized group aggregate and verify this information, giving care and outreach teams a pathway to check off throughout the year, and making health maintenance capabilities as "smart" as possible, for a shared understanding of a patient's screening.

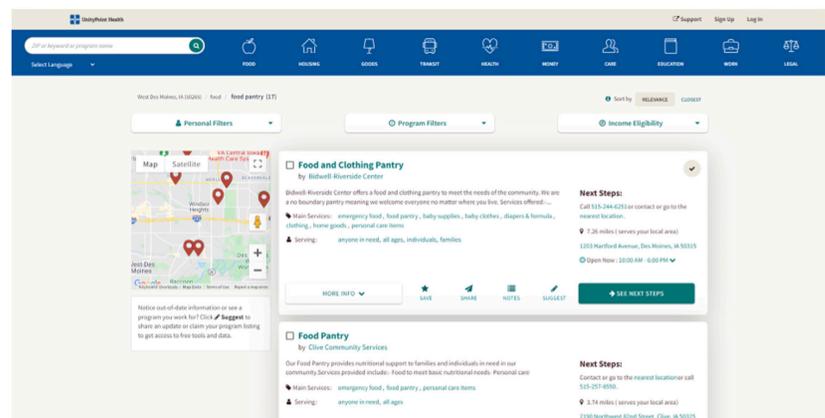


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Recently, the organization has been collecting data related to equity and social determinants of health and getting information out on community resources and condition-specific programming. They learned that terminology matters and changed from “colonoscopy” to “colon cancer screening” in the portal and EMR (see Figure 4). This change encourages shared decision-making.

Figure 4: UnityPoint Accountable Care: Health Equity

- Organizational emphasis on health equity to improve health outcomes for patients and communities
- Data collection and discovery
 - Accurate Demographics including location, race, language, and sex and gender identity
 - SDOH Screening
- Connection to community resources (partnership with findhelp.org)
- In the near future, planning for condition specific programming based on community needs



Moderator and Audience Q&A

How do you incorporate medical assistants (MAs) in the process?

At Unity Point, MAs are able to start conversations about screening and tee up either an order or a discussion with a physician, who now has more time to spend on these talks. MAs and the full care team receive education on CRC screening. It’s about “giving people the ability, making sure it’s an all-for-one effort, and being aligned in the message,” Romine said.

At Austin Regional Clinic, nurses give patients a heads-up about screening—for example, “I notice that you’re overdue. The doctor’s going to talk to you about that today,” Daghestani said. Keane discussed SIMEDHealth’s team approach, “not just your MAs but the front desk, everyone’s aware that this is something we’re focusing on, and everyone’s helping to get the patient ready.”

How do you engage younger (age 45-50) patients?

While panelists noted some lags between the updated guidelines and health plan adoption, “for most part, it’s not an issue anymore,” Daghestani noted. Austin Regional Clinic started with conversations, and “once we had confidence of coverage, we built in the alerts,” he said.

SIMEDHealth similarly focused on conversations while the insurance aspect of screening was getting lined up. “We started talking to our physicians,” Keane said, advising that organizations “start talking to your patients now—it might take a couple conversations.” Since then, SIMEDHealth has made adjustments in its EMR and is “treating younger patients just like all other eligible patients,” Keane said.



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“The change was made for a very valid scientific reason, but the message got lost during the pandemic a little bit. We personally had to get people up to speed in the clinic,” Romine said, detailing UnityPoint’s education for patients, providers, and teams to help them understand the change, craft messaging, and incorporate the new age group into the workflow.

What barriers are you seeing?

“GIs have been very busy,” Romine observed. “Delays in care from the pandemic have really impacted them.” Keane talked about how she has seen patients “not defiant but just really busy. This is where our calls are helpful and show how important this is.”

Meanwhile, SIMEDHealth is addressing “simple gaps in the referral process—maybe the patient didn’t get a call from GI”—with calls that put all three parties on the line for screening, and Austin Regional Clinic has started efforts to enable patients to book directly into a GI’s schedule.

Are you offering Saturday screenings?

“We’re not, but I love the idea,” Keane replied. Daghestani noted that one of Austin Regional Clinic’s specialists offers Saturday screening clinics. “It’s always 100% booked with no cancellations,” he said. While the clinic is popular with younger and employed patients, “it’s a harder sell to ask specialists to give up a Saturday,” so they’re looking into a rotation schedule.

What’s the best form of screening outreach?

Panelists all cited a variety of tactics. “The more you talk about it, the more you increase awareness and the chance that someone gets screened,” Keane said. Daghestani recommended different solutions for different people and different times of day, with a balance so patients aren’t overwhelmed. Austin Regional Clinic uses alerts for nurses to start that discussion and has seen success with text messages that allow patients to book appointments directly through a single action.

Breakout Sessions

In three concurrent breakout sessions, participants held round-robin discussions on the current status of their interventions, barriers they experienced, strategies to overcome, best practices, lessons learned, and plans for sustainability and scaling up.

Breakout Topic: Disparities in Care

Geisinger, Intermountain Healthcare, Kelsey-Seybold Clinic

What’s standing in the way of screening for CRC QuIC participants? How are organizations finding out what patients need? This session’s participants shared their stories, challenges, and plans for the future around addressing disparities in care in CRC screening.

Intermountain Healthcare talked about its rural hospital colonoscopy program and developing a questionnaire to better understand patient barriers, such as a lack of transportation, and close care gaps at every visit. Geisinger is also working



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with questionnaires, adding a SDOH survey to its Cerner Population Health Dashboard, comparing questionnaire answers to screening rates. The goal is to identify and address needs related to transportation, social support, and financial security. For some patients, the cost involved in preparing for a colonoscopy can be prohibitive.

Kelsey-Seybold shared that its IT team has been working with Exact Sciences to integrate Cologuard results into the EMR. Breakout session participants said that this was an easy process and very beneficial.

Many of participants' challenges involve resources—or the lack thereof. How do you develop IT tools when IT departments are understaffed and playing catch-up? How do you encourage busy front-line staff to walk through questionnaires and talk through concerns? Even with provider incentives, it's difficult to get buy-in, especially from primary care staff with 40 other things to manage and monitor.

Breakout Topics: Patient Awareness and Education about Colorectal Cancer, Screening, and Prevention; Provider Education and Communication Uptake ***Carle Physician Group, INTEGRIS Medical Group, Summit Medical Group***

Outreach at INTEGRIS Medical Group spans the range of channels: Patient education through huddles, a “portal push” which was successful, emails that were considered bombardment, and a text messaging campaign that will soon go live. But one of the biggest success stories involved *where* care teams distributed their materials.

Patient education materials used to be handed out at the front desk, breakout participants explained. But when COVID-19 protocols eliminated traditional front desk check-ins, this distribution moved to the rooming process, with several benefits. CRC screening materials escaped the information overload that frequently occurred around the check-in desk, and having physicians hand the materials over and talk about them reinforced their importance.

Carle Physician Group encouraged patient communication and education through developing a nurse protocol for ordering FITs, FOBTs, and Cologuard tests. When the organization tested it at a pilot location, a certified nurse assistant (CNA) had a conversation with a reluctant patient that led to screening—and identified stage 3 colorectal cancer. The organization is now exploring more touchpoints for the protocol.

How do you engage leadership and staff in screening when “no one reads emails?” Summit Medical Group responded through technology, launching standardized education with a CRC algorithm and another tool for decision-making across patient options, as well as reviewing email readership to identify champions. Other tactics range from centralized scheduling to ease the administrative burden and a “friendly practice challenge” with transparent monthly reports.

Participants shared multiple lessons learned, including the importance of trial and error. Leverage your CNAs by empowering them to deliver the CRC screening message and order tests. Get the most of your EHR but realize that it won't do everything. Involve leadership in your strategies so they buy in and see the outcomes. And critically, make sure your audiences are ready to receive your messages; otherwise much of your efforts will be wasted.



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Breakout Topics: Screening and Identification of Patients at Average and High Risk; Clinical Workflow/Pathways for CRC Screening

Lehigh Valley Physician Group, Maury Regional Medical Group, Prevea Health

To improve clinical workflows and pathways for screening, Prevea Health piloted a FIT/FOBT kit mailing for average- and high-risk patients, addressing that many do not have good access to care. The organization is currently measuring conversion rates and rolling the campaign out to other locations.

Because many patients don't have information or education on their CRC screening options, Maury Regional Medical Group developed a screening improvement plan for patient education, supported by efforts toward one common report for outreach. The aim is to use tactics like color-coded groups within the list to identify screening preferences and narrow down to high-risk populations.

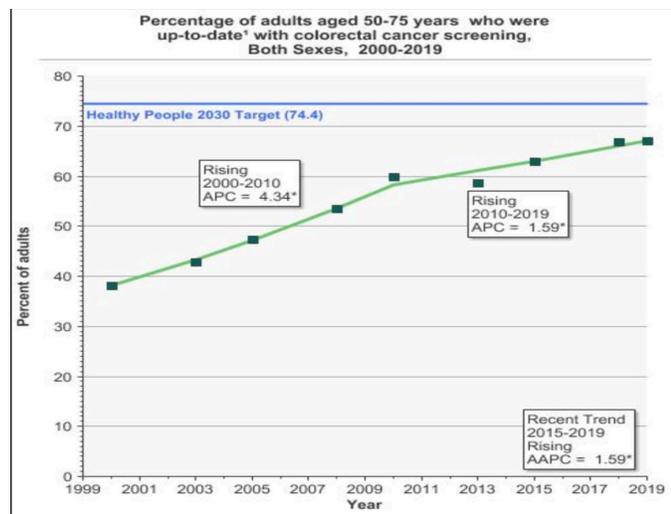
Lehigh talked about its experiences developing a comprehensive CRC pathway from screening to cancer survivorship. Collaboration made the design process straightforward, participants said, while challenges tended to revolve around technology, such as integrating disparate data/data from different sources and getting a CRC tool/pathway into the organization's overall IT queue.

In Conclusion

Colorectal cancer screening rates have been steadily and significantly improving, from less than 40% of adults aged 50-75 in 1999 to just under 70% two decades later (see Figure 5). However, reaching 80% in every community is going to take continued, collaborative effort from every health system.

Figure 5: CRC Screening

- Colorectal Cancer Screening rates are improving.
- However, it's going to take effort from every health system in order to reach 80% in every community.



AMGA and the AMGA Foundation would like to thank our participants and sponsors for their contributions to the CRC QuIC. We encourage further sharing, discussion, and engagement toward our goals—and toward lowering mortality from this highly preventable disease.

The CRC QuIC is sponsored by Exact Sciences.

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