



Improving Colorectal Cancer Screening Rates in North Dakota

Discovery through Data



Quality Health Associates
of North Dakota

Site Settings

Pager

Quality Health Associates
of North Dakota
Slide 1 of 26

SCREEN AND

Improving Colorectal Cancer Screening Rates in North Dakota

Discovery through Data

Jonathan Gardner

01:33

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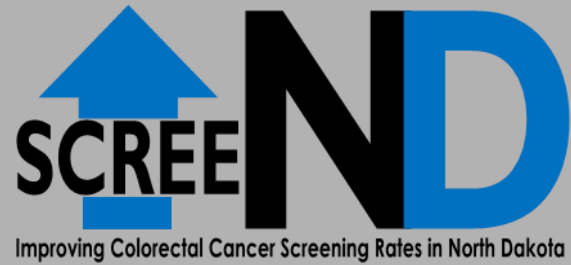
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JG
Jonathan Gardner

Quality Health Associates of North Dakota (QHA) is partnering with ND's primary care clinics to increase colorectal cancer (CRC) screening rates for rural, frontier, and Native American populations.



Assistance from QHA

QHA will assist participating clinics using the following strategies:



✓ Facilitate completion of a comprehensive readiness assessment



✓ Provide individual technical assistance

✓ Lead a rapid-action collaborative structure with small groups to target specific needs

✓ Conduct site visits and coaching calls to assess progress, identify barriers, and develop mitigation strategies



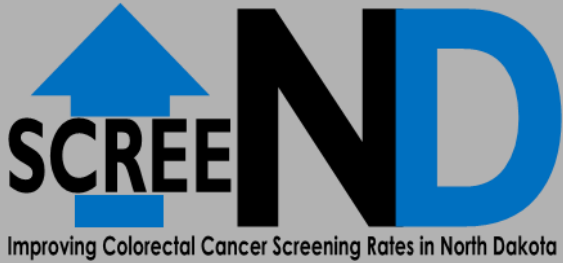
✓ Guide the development of clinic-specific action plans for implementing at least two evidence-based interventions (EBIs) to address CRC screening



✓ Advise clinic staff in leveraging their electronic health records (EHRs) to collect and report CRC screening program measures



✓ Share resources, tools and materials



Milestones Program Cohort 3

SCH: Wishek*
 SCH: Napoleon*
 SCH: Kulm*
 SCH: Gackle*
 JMHCC: Elgin
 Community Clinic
 JMHCC: Richardton
 Clinic
 Southwest Healthcare
 Services - Bowman

COPPER



- Signed commitment letter
- Formed multidisciplinary innovation team
- Completed Clinic Readiness Assessment
- Completed introductory meeting
- Submitted Action Plan and set goal for year 1
- Submitted baseline data

BRONZE



- Data submission is current
- Initiated two (2) evidence-based interventions as defined in Action Plan
- Submitted current clinic policy for CRC Screening

SILVER



- Team members participated in scheduled coaching calls and rapid action collaborative
- Implemented at least two (2) evidence-based interventions specific to improving CRC screening rates
- Achieved 1st year goal for improving CRC screening rate
- Shared SCREEND performance with Clinic Board or Leadership

GOLD



- Reviewed and updated Action Plan annually
- Submitted at least one success story or lesson learned related to the interventions selected
- Achieved 2nd year goal for improving CRC Screening rate
- Distributed clinician level data to medical staff

PLATINUM



- Achieved 3rd year goal for improving CRC Screening rate
- Used EHR to fullest potential to sustain EBIs such as flagging for follow-up, tracking screening results, pulling reports, generating and sending reminders to both providers and patients



Improving colorectal cancer screening rates in North Dakota



Quality Health Associates
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Program



Resources



Rapid Action Collaborative



News/Events

Website: <https://www.screend.org/>



Improving Colorectal Cancer Screening Rates in North Dakota

Get the Facts

COLORECTAL CANCER SYMPTOMS

- 🩸 Blood in your stool
- ⚖️ Unexplained weight loss
- 🚽 Change in bathroom habits
- 👉 Persistent cramps or low back pain
- 🥱 Fatigue
- 🐛 Feeling bloated
- 💧 Anemia

24
1 IN ~~23~~
DEVELOPS COLON CANCER

Get educated Get screened.

THE SYMPTOMS
OF COLORECTAL
CANCER CAN BE
NO SYMPTOMS
AT ALL.

IF YOU WERE BORN
IN THE 90'S...
YOU HAVE **2X** THE
RISK OF **COLON**
CANCER AND **4X**
THE RISK OF **RECTAL**
CANCER THAN
THOSE BORN IN 1950.

COLORECTAL
CANCER
IS THE **2ND**
DEADLIEST
CANCER.

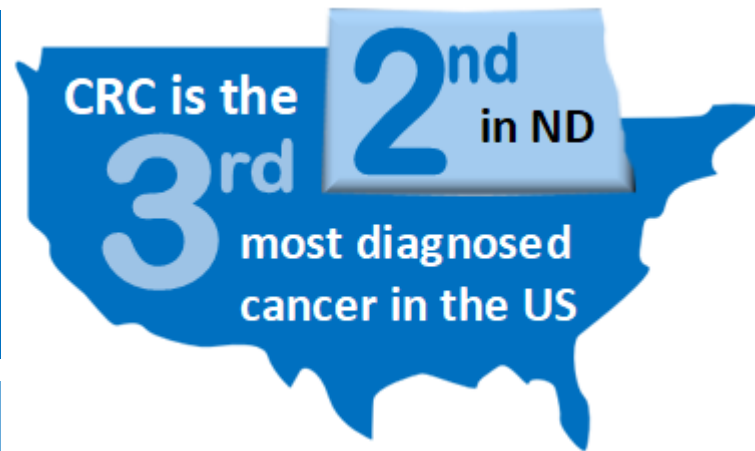


\$14.1 BILLION
total annual
medical cost
of colorectal
cancer care

Economic Data

The High Cost of Colorectal Cancer

- 11% of all cancer treatment costs
- # 2 in cost
- Average cost of new diagnosis of CRC: \$40,000-\$80,000
- On average, cancer survivors have annual losses in work productivity (due to missed workdays and employment disability) that are about \$1,000 higher compared to people without a cancer history.



Polling Question:
How do you think the COVID-19 pandemic has impacted screening and outcomes in your service area?

Where are we now?

- Pre-Covid, 33% of eligible adults in ND are not up to date (today?)
- 41% of CRC cases are diagnosed at a late-stage with only 13% reaching a 5-year survival rate
- Priority Populations:
 - Males
 - American Indians
 - Individuals without post-high school education
- Current ND Screening rate: 67%, Tribal Communities about 52% overall.
- Estimated 380 new cases of CRC in ND in 2019

Setting a Goal

Polling Question:
What goal did your organization set for itself?

- Encourage to set a goal that is at least 15% higher than current rate
- Figure out what that means – Is it 1 more patient screened per week? 1 per day?

1000 eligible patients/year: Current rate is 25%


= 250 patients are up to date/screen 5 patients per week

40%: 400 patients per year would need to be screened

= 8 patients per week (or 3 more than current)



Let's unite to reach our shared goal:
80% in Every Community.

Reporting Period Beginning	Reporting Month	Reporting Year	Reporting Quarter
<input type="text"/>  M-D-Y <input type="checkbox"/> Baseline	<input type="text"/> View equation	<input type="text"/> View equation	<input type="text"/> View equation

Colorectal Cancer Screening Rate (Overall)

Numerator	Denominator	Calculated Rate
<input type="text"/>	<input type="text"/>	<input type="text"/> View equation

Measure Definitions: [HEDIS](#) | [UDS](#) | [GPRA](#) | [NQF](#)

Fecal Kit Return Rate

Number of patients given fecal kits	Number of patients returning fecal kits	Calculated Rate
<input type="text"/>	<input type="text"/>	<input type="text"/> View equation

Measure Definition: [Fecal Kit Return Rate](#)

Screening Colonoscopy Completion Rate

Number of patients referred for colonoscopy	Number of patients completing colonoscopy	Calculated Rate
<input type="text"/>	<input type="text"/>	<input type="text"/> View equation

Measure Definition: [Colonoscopy Completion Rate](#)

Diagnostic / Follow-up Colonoscopy Completion Rate

Number of patients referred for follow-up colonoscopy	Number of patients completing follow-up colonoscopy	Calculated Rate
<input type="text"/>	<input type="text"/>	<input type="text"/> View equation

Measure Definition: [Follow-up Colonoscopy Completion Rate](#)

Data
Collection:
REDCap

Patient Information

Medical Record Number

Optional

Date of Birth

  M-D-Y

Optional

Age

* must provide value

Age at Encounter

 [View equation](#)

Population Criteria

Patient has been diagnosed with colorectal cancer any time

* must provide value

Yes No

[reset](#)

Patient has had a total colectomy

* must provide value

Yes No

[reset](#)

Other criteria will exclude this patient from colorectal cancer screening

* must provide value

Yes No

[reset](#)

Screening History

Patient documentation indicates a completed Fecal Occult Blood Test (iFOBT / HSgFOBT), or Fecal Immunochemical Test (FIT) within one (1) year

* must provide value

Yes No

[reset](#)

Electronic Health Record

The Electronic Health Record (EHR) for this patient is adequately and appropriately documenting colorectal cancer screening for this patient.

Yes No

Optional

[reset](#)

Score

Numerator: 1

Denominator: 1

Data Validation: Chart Review

Data Collection: Baseline Data

- Determine a one-year baseline timeframe
- Select a measure (GPRA, HEDIS, UDS, or NQF)
- Use your Electronic Health Record or another system to generate a baseline CRC rate

Your Tools

Electronic Medical Record

- Numerator: Include those who had FOBT or FIT in last year, FIT-DNA in last 3 years, flexible sigmoidoscopy in last 5 years, or colonoscopy in last 10 years
- Denominator: Active clients age 51 -75 (Exclude those with current CRC diagnosis)

Billing data: Can only be done if billing data contains primary care billing information, lab test and endoscopy procedures

Behavioral Risk Factor Surveillance Survey Data (BRFSS)

Government Performance and Results Act (GPRA)

Pre-visit Prep as a Data Dig

Pre-visit planning can increase efficiency often saving 30 minutes of both physician time and staff time per day and save about \$26,400/year!
(AMA, 2015)

- Use a visit planning checklist
 - What screening exams/labs are priorities for your facility?
 - Arrange for labs to be completed before next visit
- Review notes from the patient's last visit and ensure notes from other physicians who delivered interval care are in the record.
 - Are dates, check boxes or fields completed to assure they are included in the data pulls?
 - Identify gaps in care: preventive and chronic care needs
 - Pre-visit phone call, email or text: medication reconciliation, set the agenda (this also reduced no show rates!)
 - *Pre-appointment questionnaire – responses prepopulate visit notes
- Pre-clinic care team huddle
 - Alert team to last-minute changes or special patient needs

<https://www.ama-assn.org/practice-management/sustainability/10-steps-pre-visit-planning-can-produce-big-savings>

**Did you
know?**

The primary reason patients say they are not screened is because their doctor did not recommend it.

- ACS

Discussion

- What are your concerns about reporting or using data in your practice?

Resources for the Journey Ahead

Pre-visit Planning

- Link 4 documents:
 - Previsit planning implementation checklist
 - Previsit checklist
 - Pre appointment questionnaire
 - Previsit plan order sheet

Next Steps

- Complete Action Plan
- Disseminate goal to your entire staff
- Review your current policies around CRC and/or screening and identify areas for improvement.
- Complete Evaluation:
https://www.surveymonkey.com/r/ScreenD_Module_1_091421

Next RAC call: 10/12/2021, 1:00 pm CT/12:00 MT | Topic: Practical Policy

ScreenND Contact Information

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