0:0:0.0 --> 0:0:3.630
Nikki Medalen
Well, welcome to the first module of the screen Rapid Action Collaborative.

0:0:4.600 --> 0:0:8.140
Nikki Medalen
My name is Nikki Medalen and I will be facilitating these calls.

0:0:13.90 --> 0:0:13.520
Kari Novak
OK.

0:0:21.370 --> 0:0:21.690
Kari Novak
Just.

0:0:21.760 --> 0:0:21.980
Kari Novak
OK.

0:0:11.320 --> 0:0:23.470
Nikki Medalen
I am a quality improvement specialist with Quality Health Associates of North Dakota and my background is in public health nursing. I was the McHenry County nurse for a decade or so and then taught public health nursing at mine at state for about 10 years.

0:0:25.860 --> 0:0:38.500
Nikki Medalen
And then came to Quality Health associates to work on some population health initiatives that were being promoted at that time. This is actually the second colorectal cancer project that I've worked on and it is truly a subject that is near and dear to my heart.

0:0:39.740 --> 0:1:4.410
Nikki Medalen
Shortly after we were married, my husband actually was diagnosed with an early stage colon cancer at the age of 27, and luckily we were able to migrate it, mitigate it fairly quickly, but it wasn't eye opener at an early age that cancer is not just a disease of older adults, and while it can be absolutely devastating, prevention and treatment can absolutely save lives. And so I'm very glad to be working on this program.

0:1:5.350 --> 0:1:12.340
Nikki Medalen
John Gardner is my partner in the technical consistent technical assistance component. John, would you introduce yourself?

0:1:13.320 --> 0:1:42.940
Jonathan Gardner
Yeah, absolutely. Thanks, Nikki. So I'm Jonathan Gardner or John, I'm a network administrator with Quality Health Associates of North Dakota. I've been with Quality Health Associates now for about 11

years and specialize in IT. Before that, I worked in health IT at an Air Force Base hospital. It's my pleasure to be providing technical assistance with data collection instruments and maximizing your use of the electronic health record to support scan.

0:1:43.490 --> 0:1:46.10
Jonathan Gardner
Cancer screening initiatives such as this.

0:1:47.440 --> 0:1:48.150
Nikki Medalen
Thank you, John.

0:1:49.470 --> 0:1:57.770
Nikki Medalen
Carolyne Tufte is a new quality improvement specialist at QHA and she will be joining us in this work as well. Carolyne, would you introduce yourself?

0:1:59.390 --> 0:2:10.500
Carolyne Tufte
Hi everybody. My name is Carolyn Tufte. I am a nurse by background. I'm with my experience being in a critical access hospital, real health clinic.

0:2:11.160 --> 0:2:20.750
Carolyne Tufte
Umm I joined QHA in June of this year and it was about two years ago. I was in your guys's shoes.

0:2:22.110 --> 0:2:28.20
Carolyne Tufte
Working on the screened program with our clinic and doing the Rapid Action Collaborative.

0:2:29.960 --> 0:2:30.830
Nikki Medalen
Thank you, Carolyn.

0:2:32.260 --> 0:2:40.30
Nikki Medalen
So the three of us welcome you to this series of calls. This is the 4th cohort of participants in the screen program.

0:2:41.800 --> 0:2:44.380
Nikki Medalen
So we're we're feeling a little more.

0:2:45.410 --> 0:3:16.430
Nikki Medalen
Experienced, I guess, in delivering some of this information and in being able to share with you some of the experiences we've had with other clinics. We do offer CEUS for participating in the rapid Action Collaborative. And so I would appreciate it if you would put your name, credentials and title in the chat

so that we can make sure that we have you on the list for those CPU's, how that will be managed is that we will track who participates in each of these calls.

0:3:16.600 --> 0:3:27.890
Nikki Medalen
And then at the end of the series, those hours will be logged and you will receive a certificate with the number of hours that you actually participated.

0:3:30.320 --> 0:3:39.70
Nikki Medalen
If you have any one in the room with you that isn't isn't separate and we wanna make sure you put their name and credentials in in the chat as well.

0:3:41.70 --> 0:3:48.380
Nikki Medalen
We want to thank you for your commitment to the screen program and to the Rapid Action Collaborative. We don't consider the rapid action collaborative.

0:3:49.130 --> 0:3:54.640
Nikki Medalen
Optional. This is really all the information that you need to know that.

0:3:55.460 --> 0:4:4.240
Nikki Medalen
Allows us to utilize the time that we have with you in your individual TA calls to work on what's very specific to your clinic and your community.

0:4:5.50 --> 0:4:34.980
Nikki Medalen
We do have high expectations for interaction with your teams through these events, so please do use the chat and the discussions to ask questions or share your concerns or best practices. We really want you to feel comfortable sharing with us and with your peers. Today's event is scheduled for about 45 minutes. Is this is the first event and we wanted a little more time, but the remaining 5 events in the series will each be 30 minutes long. The purpose for our meeting today is to Orient you to the screened program so that you're clear about our expectations.

0:4:35.80 --> 0:4:53.350
Nikki Medalen
To share some data with you in regard to why this project is so important and then to help you become comfortable with the data that that we're asking you to collect and to help you see the value in collecting it and being able to use it to enhance your work. So with that John, I'm going to turn it over to you.

0:4:54.400 --> 0:4:54.970
Jonathan Gardner
Thanks Nikki.

0:4:56.970 --> 0:5:18.730
Jonathan Gardner
So for to start, we'll do a little bit of housekeeping. If you're joining from a web browser such as Chrome, Firefox or Edge, Your view of the teams meeting might look something like this so you can use the camera button to turn on your webcam if you have one. We love to see everyone if you're able, but if not, that's OK.

0:5:19.560 --> 0:5:28.810
Jonathan Gardner
The microphone will mute or unmute yourself. We can strongly encourage discussions, so don't be shy to unmute.

0:5:28.980 --> 0:5:29.300
Jonathan Gardner
Uh.

0:5:31.120 --> 0:5:36.160
Jonathan Gardner
The uh raise hand button if you'd like to speak, or if you have a question but you don't want to interrupt.

0:5:37.440 --> 0:5:43.50
Jonathan Gardner
This is a small group though, and we won't be offended if you do interrupt us with a question.

0:5:44.90 --> 0:5:54.540
Jonathan Gardner
You can use the chat box button to show the chat. Occasionally we'll have a polls, attachments, or answer questions in the chat, so you might want to keep that open.

0:5:56.280 --> 0:6:2.120
Jonathan Gardner
You can also page through the slides on your own if you'd like using the pager buttons on the left hand side.

0:6:3.620 --> 0:6:18.110
Jonathan Gardner
And depending on your organization's security settings, it's sometimes necessary to give teams additional permissions in your web browser. In most browsers, that can be done from that site settings button to the left of the address bar on the top.

0:6:22.930 --> 0:6:36.470
Jonathan Gardner
Well, as you know, the goal of this initiative is to improve colorectal cancer screening rates in North Dakota, focusing on rural frontier and tribal populations, you may be wondering what that assistance will look like from us.

0:6:37.720 --> 0:6:48.10
Jonathan Gardner

Will it assist participating clinics by facilitating completion of a comprehensive readiness assessment and we really like to do this in person if possible.

0:6:49.570 --> 0:6:59.280
Jonathan Gardner
We'll provide individual technical assistance to the clinics. Uh, this may be in an online format such as a teams meeting like this or in person.

0:7:0.410 --> 0:7:10.90
Jonathan Gardner
We lead uh, this rapid action collaborative with small groups for sharing information and ideas that transcend everyone's action plan.

0:7:12.20 --> 0:7:32.510
Jonathan Gardner
We will conduct site visits and coaching calls on a regular basis with each of your teams to assess progress, identify barriers, develop strategies to meet any challenges you are having and to assist you in developing new goals and interventions as you determine that you're initial interventions are either in place or not meeting your needs.

0:7:34.500 --> 0:7:42.710
Jonathan Gardner
Will guide the development of clinic specific action plans for implementing evidence based interventions to address colorectal cancer screening.

0:7:43.430 --> 0:8:4.820
Jonathan Gardner
When we have completed your detailed assessment, will provide feedback to you with suggestions for evidence based interventions, but ultimately your action plan is yours, so you can choose whether to use our feedback or create an entire delete entirely different plan. Either way, we'll do our best to assist you in the implementation of that plan.

0:8:6.590 --> 0:8:15.270
Jonathan Gardner
We advise and support leveraging your electronic health records to collect and report colorectal cancer screening program measures wherever possible.

0:8:16.190 --> 0:8:21.90
Jonathan Gardner
And of course, we make resources, tools and materials available to you.

0:8:26.540 --> 0:8:38.450
Jonathan Gardner
As a method to gauge your progress through the screened program, we have designed a milestone program based on a 3 year plan. This information has been provided to you in the recruitment documents.

0:8:39.100 --> 0:8:49.110
Jonathan Gardner
You will note that the levels of accomplishment are based on moving through required steps of the program in a chronological manner and include requirements for submitting data.

0:8:49.850 --> 0:9:8.720
Jonathan Gardner
We know that data can be a real challenge for some clinics, particularly if you're if you're using centric platform or other older EHR's. But we're confident that once you are armed with the information from today's meeting and with the technical assistance that we can provide, this is not going to be a problem for anyone.

0:9:11.850 --> 0:9:21.540
Jonathan Gardner
As as I mentioned, this is a three-year plan. If you remain committed in one year's time, you should be able to achieve the silver milestone.

0:9:22.990 --> 0:9:27.970
Jonathan Gardner
Gold by the end of year 2, platinum by the end of year 3.

0:9:28.960 --> 0:9:37.390
Jonathan Gardner
The copper phase includes all of the items needed to get off to a good start, including assigned commitment letter or participation agreement.

0:9:38.270 --> 0:9:41.330
Jonathan Gardner
Forming a multidisciplinary innovation team.

0:9:42.720 --> 0:9:50.570
Jonathan Gardner
Completing the clinic readiness assessment, let's both the initial and the detailed assessments, which includes the workflow diagrams.

0:9:52.670 --> 0:9:59.990
Jonathan Gardner
Completing the introductory meeting, uh, which is often done prior to or along with your detailed clinic readiness assessment.

0:10:1.210 --> 0:10:3.460
Jonathan Gardner
Uh, setting a goal for first year?

0:10:4.330 --> 0:10:6.340
Jonathan Gardner
And submitting baseline data.

0:10:8.590 --> 0:10:19.50
Jonathan Gardner
The bronze level assures that your data submission is current, that you are active in your action plan, and that you have developed or reviewed your clinic policy for CRC screening.

0:10:21.420 --> 0:10:31.650
Jonathan Gardner
The silver level is awarded at the end of the first year when your team has been consistent with participation and coaching calls and run, and the rapid action collaboratives.

0:10:32.530 --> 0:10:34.630
Jonathan Gardner
You implemented your action plan.

0:10:35.380 --> 0:10:46.30
Jonathan Gardner
You have achieved your first year goal or made significant progress towards it and you can share evidence that you are sharing this performance with your clinic board or leadership.

0:10:47.460 --> 0:10:52.870
Jonathan Gardner
The goal and platinum levels simply continue this work to assure sustainability.

0:10:54.530 --> 0:10:57.330
Jonathan Gardner
This project is funded by the CDC.

0:10:58.50 --> 0:11:16.300
Jonathan Gardner
Uh funding and this funding allows us to provide incentives, so we're providing a monetary award of $1000 per milestone to support staff time and activities related to implementing evidence based interventions to improve colorectal cancer screening rates.

0:11:22.400 --> 0:11:29.20
Jonathan Gardner
We do have a website where all of the resources that we share in these meetings can be found and and many more.

0:11:29.890 --> 0:11:55.370
Jonathan Gardner
The website looks something like this. You can see four tabs at the top program resources, rapid Action, collaborative and news events. These buttons seem fairly self-explanatory, but I'll point out that under the rapid Action, Collaborative button is where you'll find that the recordings of these events, a link to the evaluations and any resources that we talk about in each event.

0:11:56.730 --> 0:12:2.540
Jonathan Gardner

We are continually working on the news and events section as there are some great success stories to share.

0:12:4.180 --> 0:12:15.890
Jonathan Gardner
We hope that it'll be very assertive in letting us know when you have something to share, as we would love for this section to help us document the great work that you are all doing to improve colorectal cancer screening rates.

0:12:20.300 --> 0:12:43.150
Jonathan Gardner
In addition to our website, we deliver a monthly newsletter by e-mail containing tips, tools, and updates for colorectal cancer screening, improvement, as well as sharing the successes of you and your peers. Everyone we currently have on our list should have received the one e-mail last week on Thursday. Let us know if you have not received it or would like to be added to our list.

0:12:44.790 --> 0:12:50.520
Jonathan Gardner
Are there any questions about the screened program at this time before we move on?

0:12:53.40 --> 0:12:55.810
Jonathan Gardner
Feel free to unmute or chat what you do.

0:13:4.850 --> 0:13:18.970
Jonathan Gardner
All right. Well, before we move on, this is a snippet of a conversation with the Undd Center for Family Medicine, one of the other clinics participating in the screened program. Nikki asked them how participating in screened has helped their clinic.

0:13:19.820 --> 0:13:21.0
Jonathan Gardner
Let me hit play here.

0:14:28.400 --> 0:14:36.310
Jonathan Gardner
A big thanks to you ND Center for family medicine. That's doctor Hostetter and and Jody who were.

0:14:38.330 --> 0:14:39.60
Jonathan Gardner
Contributed.

0:14:40.760 --> 0:14:46.60
Jonathan Gardner
Contributed to that question and allowed themselves to be played at the Rapid Action Collaborative.

0:14:51.30 --> 0:15:18.280
Jonathan Gardner
I wanna make sure that we have a common set of facts to understand why this work of cancer screening

is so important and why it is so important for our patients to understand why they should be screened. We do know that one in about 24 people in the US developed colon cancer. If you've been in healthcare for long, you also know that cancer has long been considered a silent killer. But it is insidious and often doesn't have symptoms until it's too late.

0:15:18.850 --> 0:15:45.390
Jonathan Gardner
We need to use that information to encourage our patients to be screened. We know that symptoms of colorectal cancer screening include blood in the stool, unexplained weight loss, change in bathroom habits, persistent cramps or low back pain, fatigue of feeling bloated and anemia. But it's in its early stages when it is easiest to treat. It may not have no symptoms at all.

0:15:47.520 --> 0:16:0.40
Jonathan Gardner
Half of all new colorectal cancer diagnosis are in people 66 or younger. In fact, if you were born in the 90s, we're talking about people now in their 20s thirty years old.

0:16:1.40 --> 0:16:9.170
Jonathan Gardner
You have the you have two times the risk of colon cancer and four times the risk of rectal cancer than those born in the 50s.

0:16:11.260 --> 0:16:24.930
Jonathan Gardner
We know that CRC is the 2nd deadliest cancer when colorectal cancer is detected in its early stages. It is more likely to be cured. Treatment is less extensive and the recovery is much faster.

0:16:26.770 --> 0:16:57.0
Jonathan Gardner
The five year survival rate for stage one and stage 2 colon cancer is 90%. The five year survival rate for patients diagnosed at stage three is 71% and stage four only 14%. So obviously screening and catching it at an early stage is absolutely essential to survival. This is an especially important fact to consider following 2020 where so much of our healthcare system was shut down.

0:16:57.320 --> 0:17:11.70
Jonathan Gardner
Due to COVID and people not getting screened now, how many people who would have been diagnosed in 2020 but may not be diagnosed until much later are now at a later stage of cancer than they might have been earlier.

0:17:17.490 --> 0:17:33.780
Jonathan Gardner
For those who are motivated by economic data, the total annual medical cost of colorectal cancer care is $14.1 billion in the United States, with the total reaching 158 billion for all cancer combined.

0:17:35.820 --> 0:17:41.150
Jonathan Gardner
11% of all cancer treatment costs in the United States are colorectal cancer.

0:17:42.510 --> 0:17:47.780
Jonathan Gardner
Colorectal cancer has the second highest cost of any cancer in the United States.

0:17:48.820 --> 0:17:59.470
Jonathan Gardner
The average Medicare spending for patients with newly diagnosed colorectal cancer ranges from 40 to $80,000, depending on the stage.

0:18:1.660 --> 0:18:14.730
Jonathan Gardner
In addition, on average, cancer survivors have annual losses in work, productivity, missed work days and employment disability. There are about $1000 higher compared to people without cancer history.

0:18:15.450 --> 0:18:24.340
Jonathan Gardner
Some survivors are not able to return to work, while others report not being able to perform all of their tasks because of illness or distress.

0:18:26.810 --> 0:18:45.700
Jonathan Gardner
And of course, there are many other costs related to cancer, such as additional care outside the hospital, rehabilitation, missed work, an increase in health insurance premiums, transportation costs for outpatient services.

0:18:46.720 --> 0:18:48.440
Jonathan Gardner
Child care, elder care.

0:18:49.980 --> 0:18:50.610
Jonathan Gardner
And.

0:18:51.440 --> 0:18:54.20
Jonathan Gardner
You know, personal care associated with cancer.

0:19:2.80 --> 0:19:11.190
Jonathan Gardner
Pre COVID 33%, approximately 33% of eligible adults in North Dakota are not up to date with colorectal cancer screening.

0:19:12.180 --> 0:19:22.370
Jonathan Gardner
Uh, 41% of of colorectal cancer cases are diagnosed at a late stage, with only 13% reaching A5 year survival rate.

0:19:24.30 --> 0:19:32.240
Jonathan Gardner

Priority populations in North Dakota are males, American Indians, and individuals without post high school education.

0:19:34.220 --> 0:19:42.530
Jonathan Gardner
Uh, the current screening rate and this is a little dated and I apologize from 2018 is about 67%.

0:19:45.200 --> 0:19:49.420
Jonathan Gardner
The screening rates in tribal communities tends to be a little bit lower.

0:19:54.890 --> 0:20:18.690
Jonathan Gardner
It is estimated that there were 380 new cases of colorectal cancer in 2019, and as we shared on the previous slide, we cannot help be concerned help but be concerned that in the years following the pandemic, there would likely have been additional cases of colorectal cancer in North Dakota. How many of them did not get diagnosed because of the pandemic?

0:20:19.850 --> 0:20:24.860
Jonathan Gardner
And and now when they are found, we'll be at an even later stage.

0:20:31.310 --> 0:20:58.560
Jonathan Gardner
So our goal is to help you use data in a way that is meaningful to your team and to help you recognize the data does not have to be difficult, but a way to help understand why we're choosing to work on this project and and then as we move through the implementation of our action plans to help us see if our interventions are working or not, we often talk about data as numerators and denominators, but on their own, these numbers are not really impactful.

0:20:59.80 --> 0:21:7.550
Jonathan Gardner
The stories that go with those numbers is information that can be used. Please keep in mind how important it is that you.

0:21:10.670 --> 0:21:25.200
Jonathan Gardner
Uh, keep in mind how important it is that you turn data into information that your staff, leadership, board, patients, whoever your audience is, can really wrap their minds around what it means and understand what you expect them to do with it.

0:21:26.790 --> 0:21:47.720
Jonathan Gardner
So polling question. Uh, your clinics have been asked to complete an action plan and the very first item in that action plan was to set a goal for your clinic. How much you were going to improve your colorectal cancer screening rate. So what goal did your organization set for itself? You should see a pop up where you can choose.

0:22:2.870 --> 0:22:7.150
Jonathan Gardner
I got two responses so far.

0:22:14.180 --> 0:22:19.610
Sarah Thomte
I'm not sure on ours, to be honest. I'd have to check with Brenda the lead on it.

0:22:20.320 --> 0:22:20.670
Jonathan Gardner
OK.

0:22:26.460 --> 0:22:46.770
Jonathan Gardner
So it's important that you know your current rate before you set this goal. So it may seem kind of crazy to set a goal at 100% improvement, but a few years ago in our experience, there have been clinics that simply have not focused on prevention in the past and they're screening rates were very low like one or 2% of their eligible population.

0:22:47.540 --> 0:23:5.290
Jonathan Gardner
For them, improving 100% may have only mean screening 2 to five more people in a whole year's time. So even though it sounds lofty, the reality is it's not as lofty as someone who is currently at 55% wanting to improve to 65%.

0:23:9.720 --> 0:23:15.730
Jonathan Gardner
In this work, we encourage you to set a goal that is at least 15% higher than your current rate.

0:23:16.780 --> 0:23:27.890
Jonathan Gardner
We want to set the bar at a level that requires attention. Note that the colorectal Cancer Roundtable has set a goal of 80% in any every community in the United States.

0:23:29.40 --> 0:23:40.300
Jonathan Gardner
The goal that you set for yourself should really be considered in light of this national goal. Think about where you are now and where you want to be a year from now. Two years from now, three years from now.

0:23:41.140 --> 0:23:46.960
Jonathan Gardner
You have also done your clinic readiness assessments and should have a pretty good idea of where some of your biggest challenges are.

0:23:51.640 --> 0:24:4.160
Jonathan Gardner
One thing that may help you set a goal is to figure out what it actually means in terms of work that

needs to be done to see that it is reasonable and easy way to do that is to figure out what that means for staff.

0:24:5.370 --> 0:24:8.270
Jonathan Gardner
For instance, if I see 1000 patients.

0:24:8.920 --> 0:24:17.390
Jonathan Gardner
And have a current screening rate of 25%, it means that 250 of my thousand patients are up to date on screening.

0:24:18.450 --> 0:24:23.940
Jonathan Gardner
We have 52 weeks in a year. That means we're screening five of my patients per week.

0:24:26.670 --> 0:24:36.470
Jonathan Gardner
If I set a goal 15% higher to 40%, that means I would need to screen 400 patients per year, or 8 patients per week.

0:24:37.270 --> 0:24:42.410
Jonathan Gardner
That's only three more than what we are currently screening. Does that seem doable?

0:24:44.620 --> 0:25:5.790
Jonathan Gardner
So you can see how I've taken a piece of data and applied a story behind the numbers to provide information that my staff can really use and understand in their work. It seems like it would be a lot easier to ask them to screen three more people a week than it is to just give them a target rate. That may seem overwhelming.

0:25:13.20 --> 0:25:38.410
Jonathan Gardner
One of the most important tasks associated with this, or any quality improvement project is of course data collection, data collection for this project can be completed on a monthly basis, so each month you'll use your electronic health records system or other data sources to pull reports and then log into redcap and complete a form very much like the one that you see here.

0:25:39.760 --> 0:25:47.600
Jonathan Gardner
She there's only a few data points, including your overall colorectal cancer screening rate, your fecal kit return rate.

0:25:48.330 --> 0:25:52.370
Jonathan Gardner
And screening and diagnostic colonoscopy completion rates.

0:25:53.770 --> 0:26:2.100
Jonathan Gardner
The monthly values reported here are used to complete the annual aggregate uh data record for your clinic for the CDC.

0:26:6.610 --> 0:26:29.60
Jonathan Gardner
We recognize that the electronic medical records are not always complete or the data may be entered in different ways. This may cause your electronic reports to be inaccurate. As a result, we ask that you validate your rates with some simple chart reviews. We recommend approximately 10 charts per reporting month to reach about 100 charts over a year.

0:26:30.870 --> 0:26:35.680
Jonathan Gardner
We have designed the chart review to require as little data entry as possible.

0:26:36.580 --> 0:26:55.90
Jonathan Gardner
Uh, only the patients age or date of birth is required, otherwise the chart review follows a a simple algorithm consisting of up to 8 yes or no questions that determine whether the chart is included in the denominator and whether any screening results have been documented appropriately.

0:26:55.990 --> 0:27:6.960
Jonathan Gardner
This will not only validate your EHR generated to screening rates, but can also help you identify charts that may not be properly documented in the electronic medical record.

0:27:14.30 --> 0:27:16.520
Jonathan Gardner
Baseline. So your baseline timeframe.

0:27:17.290 --> 0:27:27.320
Jonathan Gardner
Must be prior to implementing any interventions for the screened project. It will determine your monitoring time frame that you'll use for the remainder of the project.

0:27:28.590 --> 0:27:36.520
Jonathan Gardner
The measure definition should be one of the four recognized measure definitions if possible, or maybe defined separately.

0:27:38.490 --> 0:27:49.160
Jonathan Gardner
It is important that you that the measure definition you use for your baseline is the same As for your monthly monitoring data collection and the remainder of the project.

0:27:51.240 --> 0:27:58.470
Jonathan Gardner

If you're unable to pull a baseline rate from your electronic medical record, you can use chart reviews to determine your baseline rate.

0:28:6.120 --> 0:28:24.530
Jonathan Gardner
There are several methods to determine screening rates within a provider practice and might include the your electronic medical record data, which we recommend billing data, chart audits, or even outside sources like the burqas data.

0:28:26.760 --> 0:28:34.470
Jonathan Gardner
For the electronic metal medical record, we're looking for active patients who are ages 50 and up.

0:28:35.240 --> 0:28:40.30
Jonathan Gardner
Active can be defined as a visit within the last, uh, last year.

0:28:41.120 --> 0:28:47.330
Jonathan Gardner
Usually ages uh, 76 to 80 are used as a cutoff point.

0:28:48.610 --> 0:28:53.630
Jonathan Gardner
Clients with a diagnosis of colorectal cancer should be excluded and.

0:28:55.260 --> 0:29:0.690
Jonathan Gardner
And so your result is you're looking at patients 50 to 75.

0:29:2.480 --> 0:29:9.510
Jonathan Gardner
Without a diagnosis of colorectal cancer or total colectomy, and that's your denominator for your screening rate.

0:29:11.400 --> 0:29:19.410
Jonathan Gardner
For your numerator, uh, you're looking for those clients that have had either a a fit or FOBT in the last year.

0:29:20.150 --> 0:29:21.780
Jonathan Gardner
Flexible sigmoidoscopy.

0:29:22.970 --> 0:29:24.130
Jonathan Gardner
In the last five years.

0:29:25.580 --> 0:29:28.60
Jonathan Gardner
Uh, or colonoscopy? In the last 10 years.

0:29:30.340 --> 0:29:35.780
Jonathan Gardner
Those that decline screening should not be in the numerator, and those that might have had.

0:29:37.280 --> 0:29:42.390
Jonathan Gardner
Had an in office FOBT generally are also not included.

0:29:44.910 --> 0:29:47.720
Jonathan Gardner
Now if you use billing data, UM billing data.

0:29:48.370 --> 0:29:59.730
Jonathan Gardner
Can be used to collect your rates only if the the data contains primary care billing information, lab test and endoscopy procedures.

0:30:0.560 --> 0:30:7.600
Jonathan Gardner
In that case, data is extracted for new or existing patients ages 51 uh to 75.

0:30:9.80 --> 0:30:17.150
Jonathan Gardner
CRC screening percentages are based on the number of patients in the file versus the number who had a procedure in that set time frame.

0:30:21.700 --> 0:30:36.670
Jonathan Gardner
Uh Perfis is the behavioral risk factor surveillance system, the world's largest ongoing telephone health survey system tracking health conditions and risk behaviors in the United States since 1984.

0:30:38.130 --> 0:30:45.80
Jonathan Gardner
Data is collected in all 50 States and is on a county basis.

0:30:46.870 --> 0:31:3.440
Jonathan Gardner
For colon cancer, uh specifically, there are three questions that are asked every year. Uh, the first asks of those that are over age 50 if they have had a blood stool test in the last two years and the 2nd if they have ever had a colonoscopy or sigmoidoscopy.

0:31:5.20 --> 0:31:14.430
Jonathan Gardner
Uh, they added a third question that asks those who had answered that they had not had screening, why they had not been screened.

0:31:15.880 --> 0:31:31.490
Jonathan Gardner
So, uh, you can if you, if you can closely compare your your patience to accounting or or even multiple counties, you might be able to use Beerfest data to to monitor screening rates.

0:31:34.90 --> 0:31:43.740
Jonathan Gardner
From here, though, I'll turn it over to Nikki to talk about the value of Previsit prep as it relates to screening and prevention and how it can even affect the accuracy of your data.

0:31:55.610 --> 0:31:56.480
Jonathan Gardner
You're on mute, Nikki.

0:31:59.450 --> 0:32:0.900
Nikki Medalen
I think this is still your.

0:32:2.230 --> 0:32:5.140
Nikki Medalen
Your slide for a couple more slides.

0:32:6.690 --> 0:32:7.40
Jonathan Gardner
Is it?

0:32:7.500 --> 0:32:9.130
Nikki Medalen
Yeah, to slide 19.

0:32:13.780 --> 0:32:17.280
Jonathan Gardner
The slide that you're seeing on the screen, is it Previsit Prep is a day to dig.

0:32:24.380 --> 0:32:24.600
Jonathan Gardner
Yep.

0:32:17.390 --> 0:32:27.10
Nikki Medalen
Ohh, maybe you intended to? Yeah. Originally it wasn't. It was slide 16, which I think we had hid anyway. So I will take over from here. Sorry about that.

0:32:27.730 --> 0:32:28.280
Nikki Medalen
UM.

0:32:29.680 --> 0:32:35.920
Nikki Medalen

I think that everyone's struggles with thinking about data. I'm gonna take control here again. Sorry about that.

0:32:37.500 --> 0:32:57.50
Nikki Medalen
But it doesn't have to be complicated and I really think if we turn our attention to thinking about how a pre visit prep something that we probably do with every patient is really a data dig and how you can use that data to improve your rates, one patient or one clinic day at a time. It makes this idea of data collection a little bit easier.

0:32:58.180 --> 0:33:13.350
Nikki Medalen
The American Medical Association estimates that revisit planning can actually save 30 minutes of both physician time and staff time per day and save about $26,400 a year. And that's in an average size rural clinic.

0:33:14.640 --> 0:33:15.640
Nikki Medalen
Umm so.

0:33:16.340 --> 0:33:23.450
Nikki Medalen
Whether we're already doing a pre visit prep or you might consider it in your future, there are some key things to consider.

0:33:24.310 --> 0:33:54.340
Nikki Medalen
The first is using a visit planning checklist that is specific to your facility. We wanna make sure that this list includes any screening exams or labs that are priorities for your facility. So if you already have a checklist to make sure that it is up to date with the initiatives that your clinic is currently working on by using a checklist, you'll be aware to arrange for lab work to be completed before the next visit. And that way when the physician sees the patient, they already have the information that they need to make decisions.

0:33:54.420 --> 0:33:55.250
Nikki Medalen
With the patient.

0:33:56.800 --> 0:34:2.990
Nikki Medalen
In our next slide or slide or two down, we will share a link to some examples for those.

0:34:4.40 --> 0:34:5.70
Nikki Medalen
Planning checklist.

0:34:6.940 --> 0:34:37.930
Nikki Medalen

The next thing to remember is to review notes from the patients last visit and ensure that notes from other physicians such as specialists who've delivered care since the last visit are in the record. Make sure to complete appropriate dates, check boxes or discrete data fields to assure that the test results are the lab results when entered, are put in a way that they can be pulled into it. Report during this review, you might identify gaps in care such as preventative and chronic care needs. Some nurses find it's very helpful.

0:34:38.30 --> 0:34:49.230
Nikki Medalen
To make a pre visit phone call or send the patient to an e-mail or a text to confirm their appointment and perhaps complete a medical record, medication reconciliation, or just set the agenda for the appointment.

0:34:50.70 --> 0:35:1.770
Nikki Medalen
This can really help patients come prepared for their appointment with the questions or concerns that they have and help move that appointment along more efficiently. It also has been noted to reduce no show rates.

0:35:2.720 --> 0:35:11.130
Nikki Medalen
Some organizations have a patient complete the pre appointment questionnaire so that they can be better prepared to respond to patient concerns when they come in.

0:35:13.240 --> 0:35:18.400
Nikki Medalen
To improve teamwork, many clinics find that a morning team huddle is helpful.

0:35:19.960 --> 0:35:50.850
Nikki Medalen
This is a time used to alert the team to any last minute changes in the schedule or to alert them to any special patient needs. While we think of Previsit Prep as something that is done the day before the visit, the process really continues on through the patients visit and helps you get a little more upstream with the patient by setting up the next appointment at the conclusion of a current visit. Maybe arranging for lab tests to be completed so that their next visit can be used more efficiently. And it also has an opportunity to make.

0:35:51.100 --> 0:35:55.200
Nikki Medalen
Wellness suggestions for patients who are currently visiting with an acute condition.

0:35:55.920 --> 0:36:20.170
Nikki Medalen
How easy would it be to say to the patient who's in the clinic for an ear infection? We're glad you could help us with this infection today, but we'd really like to see you again when you're feeling better and help you get caught up on your screening exams. Would you like to make an appointment for an annual

exam where we can talk about that and just by directing them back to the front desk or the registration desk to make that appointment can really help boost?

0:36:20.540 --> 0:36:22.260
Nikki Medalen
Umm your?

0:36:23.220 --> 0:36:40.570
Nikki Medalen
Quality measures in across all screening exams, so if you're interested in taking your revisit, prep up a notch. I did include a link at the bottom of the screen here to a really simple article called 10 Steps to Previsit planning that can produce big savings.

0:36:44.290 --> 0:36:47.100
Nikki Medalen
Here's a piece of information that everyone should take note of.

0:36:47.970 --> 0:36:59.840
Nikki Medalen
A few years back, the American Cancer Society surveyed patients who were not up to date on their screenings, and they learned that the primary reasons that patients say they're not screened is because their doctor did not recommend it.

0:37:0.740 --> 0:37:6.310
Nikki Medalen
And that should really make us think about our previsit prep and how we use that data to find.

0:37:7.400 --> 0:37:31.430
Nikki Medalen
Umm the to determine what screening exams the patient is due for and how we can thread that conversation into our patients visits on every single visit. Obviously some exams are due every 135 or 10 years, so it isn't that we talk about the same thing every time, but just that we're aware of what the patient may be do for and assuring that those recommendations are made appropriately.

0:37:34.740 --> 0:37:40.270
Nikki Medalen
So now we ask you, what are your concerns about reporting or using data in your practice?

0:37:51.50 --> 0:37:55.600
Nikki Medalen
Go ahead and take yourself off of mute if you'd like to add to this conversation.

0:37:59.210 --> 0:38:28.400
Merideth Bell
This is Meredith Bell. I don't think and I'm speaking for Carrie and she can she can weigh in too, but I don't think that I think our providers like competition and they like to know where they're where they're sitting and they wanna do the right thing. So I don't foresee any major concerns about sharing data like that in the practice. My only hesitancy is that I wanna make sure that it's.

0:38:29.160 --> 0:38:29.880
Merideth Bell
Sistant.

0:38:30.980 --> 0:38:40.990
Merideth Bell
And and as close to correct as we can get with, you know, the EHR and making sure we have all the right filters and all of that so.

0:38:43.30 --> 0:38:47.770
Merideth Bell
As long as it's I, that's my biggest concern is just making sure that we share.

0:38:49.310 --> 0:38:55.210
Merideth Bell
The right thing and then be consistent about sharing those numbers throughout the course of the project.

0:38:57.580 --> 0:38:57.870
Kari Novak
This.

0:38:57.240 --> 0:38:58.180
Nikki Medalen
You make a great point.

0:38:58.590 --> 0:39:29.140
Kari Novak
This is Carrie. And I also agree with that and it also makes a difference that we have two of our family practice providers that do the colonoscopies in House. So that makes a huge difference. It's just a lot more readily available and we can get them in quickly. So it's not like they have to sit on and go. Ohh. I guess I really don't wanna do that. And all of a sudden, you know, a month down the road, two months down the road going, I'm gonna just cancel it for now. So I think we see a better rate because we can get them in sooner too.

0:39:30.960 --> 0:39:31.910
Nikki Medalen
Right, I agree.

0:39:32.490 --> 0:39:33.760
Merideth Bell
You don't give him time to think.

0:39:35.260 --> 0:39:36.850
Merideth Bell
You can schedule your next week.

0:39:38.840 --> 0:39:55.250
Nikki Medalen

You know, we have been working with 15 clinics over the last couple of years. And Meredith, I think you're right on point when you talk about the consistency in your data. And one of the outcomes that we have seen from this project is that in.

0:39:56.540 --> 0:40:9.830
Nikki Medalen
Past years prior to their work with this program, they haven't looked at the data as closely as we kind of were, but we'll be forcing you to look at it now and they realized.

0:40:10.350 --> 0:40:11.960
Nikki Medalen
Umm, some of the.

0:40:12.730 --> 0:40:16.950
Nikki Medalen
Inconsistencies in data reporting in how?

0:40:17.710 --> 0:40:37.300
Nikki Medalen
Umm the information is logged into the EHR across providers and so forth, and so hopefully just using this data on a monthly basis as you will be with us when you recognize those problems, you can address them. And so one of the cute in several of our clinics.

0:40:39.10 --> 0:40:57.900
Nikki Medalen
Their data actually was showing them at a lower rate than they actually were because of those inconsistencies, and once those were corrected, we could see those rates improve just by improving how the data is input. So I I love that point and I appreciate that because.

0:40:58.750 --> 0:40:59.690
Nikki Medalen
That has been.

0:41:0.910 --> 0:41:4.640
Nikki Medalen
A truly significant part of the improvement that some of our clinics have made.

0:41:8.560 --> 0:41:10.720
Nikki Medalen
Sarah, do you have anything to add?

0:41:13.20 --> 0:41:17.780
Sarah Thomte
No, I don't think so. I agree. I think we're kind of on a similar page.

0:41:20.310 --> 0:41:24.960
Nikki Medalen
So our next question, how does CRC screening compare with other preventive screening rates in your system?

0:41:26.550 --> 0:41:34.750
Nikki Medalen
Thinking about breast or cervical cancer screening or blood pressure under control or some of those other quality measures that you're working on?

0:41:36.850 --> 0:41:37.460
Kari Novak
So I know.

0:41:36.540 --> 0:41:37.530
Nikki Medalen
Do you think you're doing?

0:41:38.140 --> 0:41:58.530
Kari Novak
Out. Go ahead. So I know with like our blood pressure screening, we're probably right around that 8788% goal for us is 90%. And then with the breast cancer screening with the Blue Cross Blue Shield, they've got us at about a 767% completion rate, so.

0:41:59.400 --> 0:42:1.420
Kari Novak
The last time I had data from them.

0:42:4.790 --> 0:42:5.390
Nikki Medalen
That's great.

0:42:7.670 --> 0:42:23.620
Nikki Medalen
You may have noticed that earlier in the slide, we didn't update the births data to the latest the latest version right now in North Dakota, the births data says this is the latest that just came out. Did it come out last fall?

0:42:24.340 --> 0:42:30.640
Nikki Medalen
Umm, that North Dakota is at about 72% for colorectal cancer screening, but we think that that's a little bit.

0:42:32.10 --> 0:42:32.780
Nikki Medalen
Not accurate.

0:42:34.330 --> 0:42:38.120
Nikki Medalen
We have a lot of questions about this last survey in terms of.

0:42:38.800 --> 0:42:46.510
Nikki Medalen

Just having been done during COVID and the way that people answered might have been what they wanted to do, but maybe.

0:42:47.290 --> 0:42:49.50
Nikki Medalen
Didn't follow through so.

0:42:50.370 --> 0:43:0.820
Nikki Medalen
We just really hesitate to use this latest source and you know we we utilize births data for a lot of things and we find it very valuable, but we just.

0:43:2.170 --> 0:43:12.960
Nikki Medalen
Just have a lot of questions about the validation for the data this time, so you may find that we use a little bit older data as we talk about this because we're more confident in it.

0:43:17.100 --> 0:43:41.250
Nikki Medalen
So this slide just has some resources for this work that we're talking about, data about previsit planning and you can see that there are four documents linked here. We will also include those on the screen website along with the recording from this event as soon as that's available and we will let you know when that's available. It should be in the next couple of days.

0:43:41.820 --> 0:44:0.980
Nikki Medalen
Umm, the next steps of course, if you haven't already completed your action plan and we're traveling to to Crosby tomorrow, so don't worry, Sarah, we have not asked you to start that action plan yet until we've completed your detailed assessment. We do have that back from you. Meredith, thank you very much. You did a great job on it.

0:44:2.720 --> 0:44:16.620
Nikki Medalen
Another next step is to disseminate your goal to the entire staff, so we'll be working with you on that in, in your first TA call. But at that point, we'll want you to make sure that you share that information with your staff.

0:44:17.590 --> 0:44:36.990
Nikki Medalen
Also, review your current policies around colorectal cancer screening or screening improvement and identify areas for improvement on our next rapid action collaborative call on the 8th of November, we will be talking about policy. So you'll kind of want to know what you have in place in terms of CRC policy or if you don't have anything at all.

0:44:39.110 --> 0:44:58.20
Nikki Medalen
And then our final ask of you is that you complete the evaluation and we will send an e-mail following

this call to make sure that you have the link to that evaluation which is required in order to receive your CEOs. So please do complete that for us. John, do you wanna put that link in the chat also?

0:44:59.600 --> 0:45:0.530
Jonathan Gardner
Yep, absolutely.

0:45:2.880 --> 0:45:5.580
Nikki Medalen
Oh, and I didn't add Carolyne to this. I apologize Carolyne.

0:45:7.80 --> 0:45:35.150
Nikki Medalen
This is the contact information for both John and myself. You certainly can reach out to us at any time. We will be scheduling our monthly TA calls with your facilities as well. And so you'll have lots of connection to us, but we are totally available to you. So please, please do use our e-mail or phone numbers, whatever is your most comfortable way to contact us and we if we can't take your call immediately, we'll get back to you just as soon as we can.

0:45:36.710 --> 0:45:40.450
Nikki Medalen
Does anyone have any questions, comments, any concerns?

0:45:48.500 --> 0:45:57.790
Nikki Medalen
Well, hearing none, I just thank you for joining today. We hope that you have a very productive rest of your day. Thank you.

0:45:59.830 --> 0:46:0.390
Sarah Thomte
Thank you.

0:46:0.150 --> 0:46:0.810
Merideth Bell
Thank you.

0:46:1.180 --> 0:46:1.660
Jonathan Gardner
Thank you.