0:0:0.0 --> 0:0:13.250
Nikki Medalen
All right. I think we will get started. Welcome to the second module of the screened Rapid Action Collaborative. I think you all probably know me now. I am Nikki Medalen and John Gardner and Carolyn Tufty who also work on this project or here as well.

0:0:13.890 --> 0:0:17.920
Nikki Medalen
And also our colleague Jeff Reddekopp is on the call today.

0:0:19.650 --> 0:0:47.670
Nikki Medalen
John will be taken care of some behind the scenes work, including recording our meeting and putting up polling questions and of course is always available to answer any questions you have about the technology and data collection and those kinds of things. Carolyn will be monitoring the chat and I know we'll help keep us on time and I will be facilitating the call today. And I've also asked Jeff to participate as well. So as always on these calls, if you would please chat in your name, title and.

0:0:47.740 --> 0:0:58.810
Nikki Medalen
Facila facility. This will help us. We'll use that as our sign in sheet for the CEO's that will be available at the end of of our rapid action collaborative.

0:1:0.750 --> 0:1:2.920
Nikki Medalen
So please go ahead and chat that in the chat.

0:1:7.240 --> 0:1:36.170
Nikki Medalen
And in the meantime I will get started. So as you know today our topic is practical policy. So we do require that everyone who is working on the screen project develop a policy, but we want to make that as easy for you as possible. And so I'm going to share with you today some things we really want you to think about as you're developing your policy. But we will also share a template of a policy that.

0:1:37.290 --> 0:1:40.150
Nikki Medalen
Kind of helps you say you don't have to reinvent the wheel.

0:1:42.950 --> 0:1:45.850
Nikki Medalen
I'm going to mute a couple of people who I can hear.

0:1:47.680 --> 0:1:48.170
Nikki Medalen
Umm.

0:1:49.230 --> 0:2:20.40
Nikki Medalen

And if at any time you want to ask a question, please do feel free to unmute yourself and ask. But we should have some time at the end of our call today to also have some Q&A. So to begin in 2008, the American Cancer Society and the national Colorectal Cancer Roundtable published a guide called how to increase colorectal cancer screening rates and practice. And that included the four essentials that you see on the screen. This document was reviewed more recently in 2017.

0:2:20.130 --> 0:2:40.200
Nikki Medalen
And confirmed these 4 essentials and we have kind of used this document to build our plan around. So like we talked about last week, the number one essential is to make the recommendation. Remember that we said that the primary reasons patients say that they are not being screened is because the doctor didn't advise it.

0:2:40.990 --> 0:2:49.990
Nikki Medalen
The second is to develop a screening policy and this really creates a standardized course of action so that everyone on your team knows their role.

0:2:50.700 --> 0:2:59.420
Nikki Medalen
And policy is also so necessary to sustainability when something occurs in a policy, it becomes the how we do it here.

0:3:1.560 --> 0:3:24.770
Nikki Medalen
3rd is be persistent with reminders and you know that we'll be talking a lot over the next couple of years on provider reminders, patient reminders. We know that patients might need to hear things, something multiple times before they're ready to follow through. And then of course, the 4th is measure, practice progress. So we talked about this last week and we'll talk about it again in the last module of the rapid Action Collaborative.

0:3:26.420 --> 0:3:32.850
Nikki Medalen
Once you know what your current rate is, you can set that practice goal and share progress with your entire team.

0:3:34.160 --> 0:3:40.770
Nikki Medalen
Every screened participating clinic will develop a policy and this will be the focus of our event today.

0:3:41.850 --> 0:3:45.820
Nikki Medalen
So just to make sure that we're all on the same.

0:3:46.820 --> 0:3:55.990
Nikki Medalen
Wavelength, so to speak. It seems like the terms policy and protocol are used interchangeably and standing orders becomes a subset of those. So I just want to be clear.

0:3:56.470 --> 0:4:24.440
Nikki Medalen
Umm and run through these definitions with you so policy is a deliberate system of principles to guide decisions and achieve rational outcomes. It is a statement of intent and implemented as a procedure or a protocol. A protocol is a standard that includes general and specific principles for managing certain patient conditions, and is standing order allows patient care to be shared among non clinician members of the care team, such as medical assistants and nurses.

0:4:25.240 --> 0:4:36.970
Nikki Medalen
Often based on national clinical guidelines but customized for the clinics, patient population and care environment, standing orders enable all members of the care team to function at their fullest capacity.

0:4:40.20 --> 0:4:56.380
Nikki Medalen
Think about the tasks or conditions for the standing orders that you currently have in your facility. It may include orders for medication refills, treatment for uncomplicated Utis, mammograms, fluid pneumonia vaccinations, or ordering lab tests for certain chronic disease patients.

0:4:58.40 --> 0:5:14.510
Nikki Medalen
But when you think about how a patient interprets a standing order, what you're really saying to them is that we believe strongly that this screening test is so important that we want to assure that every single eligible patient who meets the screening criteria is offered the test.

0:5:15.760 --> 0:5:31.890
Nikki Medalen
One of the real benefits of having a standing order with the clinic is that it spreads the burden of care across the entire team. I wanna share a short clip from our clinic partners at UCSD Medical Center, doctor Jeff Hostetter, and Monica Ciskowski regarding policy. I'll share that on this next slide.

0:6:40.660 --> 0:6:51.420
Nikki Medalen
I've really appreciated that they shared those sentiments with us and I think it's a nice segue into a few words about team based care. So Jeff, I'm gonna turn it over to you for the next couple of slides.

0:6:52.780 --> 0:7:26.870
Jeff Redekopp
Next, Nikki. Ohh, I do quite a bit of work for QHA around. Patient centered medical home and I appreciate what Doctor Hostetter just said and then appreciate and agree with you. As far as being able allowing patient care to be shared among non clinician members of care teams such as medical assistant or a nurse. According to the Agency for Healthcare Research and Quality, the primary goal of medical teamwork is to optimize the timely and effective use of information, skills and resources by teams of healthcare professionals.

0:7:27.350 --> 0:7:44.120
Jeff Redekopp

The purpose of enhancing the quality and safety of patient care and a team based approach really can provide proactive and timely access to colorectal screening, which ultimately improves the outcomes for the patients that you are working with. Next slide please.

0:7:46.600 --> 0:7:53.960
Jeff Redekopp
And when you develop A-Team based structure, your patients will have a greater continuity with their practitioner or cure team.

0:7:55.420 --> 0:8:14.90
Jeff Redekopp
And integrating nurses and allied health professionals, as well as other non clinical staff can enhance clinical administrative supports for providers and improve practice efficiency and that results in higher clinician and staff satisfaction and work life balance and really prevents a lot of that burnout that we're seeing.

0:8:15.350 --> 0:8:46.160
Jeff Redekopp
Team members can help providers by working to their license or certification capacity and an example here is having the front desk staff provide the patients with the questionnaire, not analyzing it, and then nurses using that information to be able to determine, determine the risk and then order stool tests for average risk clients. And that workflow really is going to allow the provider to focus on acute issues.

0:8:46.260 --> 0:8:52.370
Jeff Redekopp
And she complaints and only have to have the screening discussion for patients with questions.

0:8:53.10 --> 0:8:59.580
Jeff Redekopp
Any who are unsure which test is best, or those who actually need to have colonoscopy?

0:9:0.670 --> 0:9:30.640
Jeff Redekopp
And as the example I just shared shows, maximizing team member roles ultimately helps share the load, which decreases not only provider burnout again, but also increases job satisfaction and those other roles other than clinicians in the clinic because they can see that their full skills and abilities are being used and also helps the team members develop new knowledge and abilities and can motivate them to pursue any types of further education.

0:9:30.720 --> 0:9:32.770
Jeff Redekopp
And training next slide please.

0:9:36.200 --> 0:9:49.350
Jeff Redekopp
And research has found that health care teams that communicate effectively and work collaboratively reduce the potential for air, which results in enhancing patient safety and also improved clinical performance.

0:9:50.90 --> 0:9:54.870
Jeff Redekopp
And teams that are more responsive to changes as they occur as they occur.

0:9:56.230 --> 0:10:3.840
Jeff Redekopp
They're able to react and respond accordingly, and in a high functioning team setting, trust develops.

0:10:4.550 --> 0:10:12.20
Jeff Redekopp
Which increased his confidence in your coworkers knowing that they're going to be able to perform their duties in times of crisis.

0:10:13.310 --> 0:10:34.200
Jeff Redekopp
Multiple rules that work together also make fewer mistakes, which leads to better overall care for the patient and can also help reduce those care costs. Team based care and the contest of colorectal screening also helps increase screening rates, builds wholistic care and improve the overall patients experience.

0:10:35.540 --> 0:10:38.450
Jeff Redekopp
Thanks for that time, Nikki. And I'll turn it back over to you.

0:10:40.250 --> 0:10:40.920
Nikki Medalen
Thank you, Jeff.

0:10:42.740 --> 0:11:2.610
Nikki Medalen
So as we start talking about policy, I want to share some considerations for developing or reviewing your screening policy. You might already have something in place so we can build on that or review that, and maybe it's just fine the way that it is. But here's some things I want you to think about if you haven't already developed.

0:11:3.670 --> 0:11:33.480
Nikki Medalen
A policy. The first is, of course, the national screening guidelines, so you can see here that we have links to the USPSTF, the United States Public Health Service Task Force and the American Cancer Society. And those links are linked directly to the guidelines that they have around colorectal cancer screening. Both of these organizations now recommend screening to begin at age 45. And you know, when we think about what are we really looking for here, I want you to think about all the ways that the procedures.

0:11:34.60 --> 0:12:2.870
Nikki Medalen
Might be impacted in your policy in terms of thinking about flags in your electronic health record, parameters of the reports that you might be able to pull, thinking about small media or messaging, patient reminders, provider reminders, those kinds of things. I also want you to think about the realities

of your practice and this really speaks to the workflows of your clinic and the flow of patients through their visit. And we'll actually talk more about this one on the next slide.

0:12:4.680 --> 0:12:20.870
Nikki Medalen
Patient history or risk level. So here you'll want to include decision making tools that provide options for average risk patients so that you can optimize the availability of colonoscopy for your highest risk patients. We'll show you an example algorithm in an upcoming slide.

0:12:22.300 --> 0:12:39.870
Nikki Medalen
Also, patient preferences and insurance coverage, we know that not all patients have the same options available to them. And so we'll have to provide options for screening that are appropriate to their risk level and that might also be more manageable to them. Note that the best screening test is the one that the patient will actually complete.

0:12:41.400 --> 0:12:56.380
Nikki Medalen
Also, local medical resources. Of course you need to take into considerations what resources you have and when. We're talking about colorectal cancer, a lot of times we're talking about whether or not you have colonoscopy on site. Do you have that on site at all of your clinics? If you've got multiple clinics?

0:12:57.570 --> 0:13:26.850
Nikki Medalen
And even where you do, it's unlikely that you have the capacity to screen every eligible patient with colonoscopy. Nor is it appropriate. Even if you did, your policy should include guidance for distribution tracking and follow up of the take home test to be sure that the patient receives the support, encouragement and instruction that they need to complete the test and to be able to be sure that it's accurately documented in the EHR in a manner that can be retrieved into a report. And of course, that leads us to documentation.

0:13:27.430 --> 0:13:33.780
Nikki Medalen
In our experience and our last three cohorts, this is probably the area that we've been able to identify most clearly.

0:13:34.360 --> 0:13:38.890
Nikki Medalen
Umm. And we're talking about things like documenting their risk level.

0:13:39.760 --> 0:13:43.10
Nikki Medalen
Distribution of the tests or orders that have been.

0:13:43.330 --> 0:14:12.680
Nikki Medalen
Ohh that have been made follow up calls the results of those tests when a patient was notified, and I'd also documenting any follow up that's needed in a manner that can be pulled into a report. That's kind

of the key to this. It's not enough anymore to just scan in a document. We need to be able to pull that result into a report when you're asked for it. This is really important for any MIPS measures that you might be reporting or any quality measures that you're reporting to.

0:14:13.370 --> 0:14:18.660
Nikki Medalen
Maybe. Maybe Medicaid and ACO Blue Alliance, all kinds of programs like that?

0:14:20.460 --> 0:14:29.810
Nikki Medalen
I said that we'd talk about the realities of your practice, and so I want you to consider or reflect on some of these as you consider what your policy and procedures would would look like.

0:14:31.360 --> 0:14:33.720
Nikki Medalen
In your waiting room or your exam rooms.

0:14:34.830 --> 0:14:58.770
Nikki Medalen
Oftentimes we find media there, such as posters, Flyers, handouts. You might have good health TV or an electronic messaging system in your you're waiting room that can be customized to express your policy and queues to action. There are certain materials that you may want to make sure are there, so you'll want to know who is responsible to order those and make copies and make sure that they're in those spaces.

0:15:0.460 --> 0:15:21.170
Nikki Medalen
In terms of patient check in, do you have a questionnaire that patient should complete regarding their risk, their screening status or history and their preferences? Do staff ask about preventive care and highlight services that are needed or past due and if their status has changed, is there an opportunity to flag the chart or preventive care flow sheet?

0:15:22.350 --> 0:15:32.590
Nikki Medalen
During the visit, I'm thinking about making the recommendation, completing the algorithm to determine risk level and select the most appropriate tasks. Tests. Excuse me.

0:15:32.790 --> 0:15:50.290
Nikki Medalen
Umm, documenting their risk, low level and exploring options or preferences with the patient and assuring that that's that schedule can't talk right now, assuring that their appointment is scheduled before they leave the office.

0:15:51.720 --> 0:15:57.790
Nikki Medalen
At checkout has the patient filled out a reminder card with the date and of their.

0:15:59.710 --> 0:16:5.840
Nikki Medalen
Of their appointment and when they would like you to notify them or include their contact preferences.

0:16:6.920 --> 0:16:23.770
Nikki Medalen
And then, of course, there's communication beyond the office, so it might be helpful to include in the policy how and when patients who are due for screening will be contacted. Some of you have great access to tools within your EHR that can help you with that and some don't. So those may look very different from one another.

0:16:25.460 --> 0:16:37.910
Nikki Medalen
Also, tracking patient compliance assure that changes to an office visit achieve what is intended by tracking patient compliance through chart reviews or keeping a list of referrals and checking for results in a timely manner.

0:16:41.890 --> 0:17:10.500
Nikki Medalen
Why would we want a standing order? Well, in this work, we will strongly encourage you to have standing orders for colorectal cancer screening. We know that medical practice is changing from a fetus service mechanism to reimbursement based on quality. But regardless, as we also push for patients to become engaged in their care and as long as their television commercials and radio ads for everything from the latest miracle drug to surgical procedures, we know that medical practice will remain.

0:17:10.580 --> 0:17:12.790
Nikki Medalen
At least in some part demand driven.

0:17:13.410 --> 0:17:27.570
Nikki Medalen
We also know that practice demands our numerous and diverse we've had, we've been practicing individual patient care for so long that we often forget that there are some things that apply to everyone, things we consider to be standards of population health practice.

0:17:28.310 --> 0:17:58.700
Nikki Medalen
Few practices currently have mechanisms to assure that every eligible patient gets a recommendation for screening, and we also know that screening rates are less for persons with lower, less education or no health insurance and lower socioeconomic status. So standing orders kind of provide the solution to many of these issues. Standing orders allow nursing staff or medical assistants to discuss CRC screening options, provide fit or multi target stool DNA tests and instructions.

0:17:58.910 --> 0:18:6.380
Nikki Medalen
And submit referrals for screening colonoscopy and all of these have been demonstrated to increase colorectal cancer screening rates.

0:18:9.390 --> 0:18:26.540
Nikki Medalen
Your procedure should also include an algorithm or a decision tool, and this assures that the same criteria is being used by all of the staff consistently. This algorithm that we are showing you here is actually from the national Colorectal Cancer Roundtable, and we've also kind of.

0:18:28.360 --> 0:18:48.750
Nikki Medalen
Compared it or reconciled it with the American Cancer Society guidelines. So this is to start screening at age 45, and this algorithm is actually appropriate for most clinics. In fact, we haven't run into one yet that this has not been probably the best algorithm that we've found.

0:18:51.690 --> 0:19:14.650
Nikki Medalen
The purpose of it, of course, is to assess risk. So patients with average risk that you see on the left side. I know this is hard to see. These are patients who are 45 to 75 years of age with no history of adenomatous polyp, no history of inflammatory bowel disease and no family history of colon cancer. Based on those findings, there are instructions for the appropriate types of screening which really can be any of the screenings.

0:19:16.250 --> 0:19:27.770
Nikki Medalen
Based on average risk, if the patient is younger than 45, we don't screen. If the patient is greater than 45, we screen with a stool test or colonoscopy. And note that.

0:19:28.470 --> 0:20:2.540
Nikki Medalen
Umm, you know, colonoscopy is always available to patients, but we find that in the younger age groups, it's often more difficult for them to have the multiple office visits that are required. So you have an office visit for where the order is made. You have a separate office visit for a pre op and then the day of the colonoscopy, of course. And in addition to that Prep while Prep is required as well as requiring a driver because they will be sedated. And so there's a lot of barriers actually to colonoscopy, particularly for people who are still of working age.

0:20:2.710 --> 0:20:10.100
Nikki Medalen
And so we want to take those things into consideration, but it is always a shared decision between the provider and the patient.

0:20:11.310 --> 0:20:37.100
Nikki Medalen
In the middle and on the right sides of this algorithm, you know that if the patient has an increased risk based on personal history of an adenoma colorectal cancer or irritable bowel disease, then they should have a colonoscopy. A surveillance colonoscopy allows a little bit more flexibility in terms of the interval and always gives the physician control of screening if they would like to screen more often, per their knowledge of the patient's condition.

0:20:41.880 --> 0:20:59.520
Nikki Medalen
Umm, I hope that this goes without saying, but I always want to bring it up that digital rectal exam samples are absolutely not acceptable. I've listed or found four articles here from totally different sources that support that.

0:21:0.40 --> 0:21:4.860
Nikki Medalen
Umm digital rectal exam is absolutely not not a screening tool.

0:21:6.90 --> 0:21:14.820
Nikki Medalen
And so I'm just gonna leave this at that. I hope that this is something that is not being done in your clinics. If it is, we need to discuss it a little bit further, but we can do that in your.

0:21:15.170 --> 0:21:24.430
Nikki Medalen
Umm. In your TA calls. If anyone has questions about why this is unacceptable, I will find and provide these resources for you.

0:21:27.360 --> 0:21:55.260
Nikki Medalen
This is a document the the provider guide to colorectal cancer screening was some dues and don'ts. This one page flyer may be used to remind clinicians about some of the dos and don'ts when it comes to colorectal cancer screening. And you, as our partners have the option to Co brand this flyer with your organization's logo. I would encourage you to contact the American Cancer Society to learn more about utilizing this. If you do want to brand it for yourself, but go ahead and use it as you see fit.

0:21:56.720 --> 0:21:59.310
Nikki Medalen
So I wanna take a little time for some peer sharing now.

0:22:1.80 --> 0:22:6.600
Nikki Medalen
Do you currently have a policy and what key points of your policy would you recommend to others?

0:22:14.160 --> 0:22:14.970
Nikki Medalen
Don't be shy.

0:22:29.890 --> 0:22:30.670
Nikki Medalen
Anybody.

0:22:44.760 --> 0:22:50.640
Nikki Medalen
I'm I'm expecting from the silence that maybe you don't have a policy yet, and that's perfectly OK.

0:22:51.740 --> 0:22:55.200
Nikki Medalen
I put it in this slide one of the.

0:22:57.80 --> 0:22:59.750
Nikki Medalen
Findings. I guess that we've had from some of our.

0:23:2.860 --> 0:23:34.230
Nikki Medalen
Experiences with our other clinics is that there is not a process for obtaining screening results if they're unknown, so that is also another consideration. I did see that there was a message in the chat from Meredith, she said. We've not had ours approved yet and I would just encourage you, Meredith, to hold off on that until we've had our TA call and just have a little conversation about it. There might be some things that we can help you with or help make more concise. I know that this sounds like a lot to think about, but it's really.

0:23:34.570 --> 0:23:41.90
Nikki Medalen
Important that you think about it before the policy is written, although we consider a policy to be a live document, they can always be updated.

0:23:44.130 --> 0:23:59.790
Nikki Medalen
So some resources for the journey ahead, we've talked about quite a few things and referred you to some resources in this topic. All of them are listed under the resources section. If you go to thescreen.org website.

0:24:0.450 --> 0:24:0.940
Nikki Medalen
Umm.

0:24:1.960 --> 0:24:18.550
Nikki Medalen
Under the Rapid Action Collaborative, you will see a module 2 and all of these resources are available there in links so the USPSTF CRC screening guidelines. I believe the American Cancer Society guidelines are there also.

0:24:19.690 --> 0:24:32.840
Nikki Medalen
The screening, a screening toolkit, the policy example that we like to give you as a starting point. What we have there is not considered ideal by any means. We just want to make sure that.

0:24:33.540 --> 0:24:44.190
Nikki Medalen
You're not having to reinvent the wheel. Umm. Also the example CRC screening algorithm and the providers guide to colorectal cancer screening. That dues and don'ts page.

0:24:45.260 --> 0:24:53.630
Nikki Medalen
Our next step, of course, will be in terms of our action plan will be developing that policy and we'll be talking about that in your next TA calls.

0:24:54.300 --> 0:24:54.850
Nikki Medalen
Umm.

0:24:55.900 --> 0:25:9.450
Nikki Medalen
And then we also ask that you complete an evaluation for today. Of course, that's evaluation is required for your CEUS. So we will put this link into the chat.

0:25:10.250 --> 0:25:26.600
Nikki Medalen
John oh, I don't. I can't seem to collect it. But if you would put that in the chat, John, I'd appreciate it. And our next collaborative call will be on December 13th and that will be on the matter of choice. So we'll be discussing all of the screening options available.

0:25:27.830 --> 0:25:34.120
Nikki Medalen
And as always, here is our contact information. If you have any questions, feel free to reach out to us at anytime.

0:25:36.490 --> 0:25:39.970
Nikki Medalen
Does anyone have any any questions or anything they want to bring up today?

0:25:49.500 --> 0:25:54.280
Nikki Medalen
All right. Well, hearing none, we will let you go and have a very productive day. Thank you.