Cancer Screening in the Primary Care Setting

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DIALOGUE FOR ACTION™ ON CANCER SCREENING
prevent cancer FOUNDATION

Dialogue for Action 2015

Cancer Screening in Primary Care

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2015

Outline

1. Make a plan
    - Establish baseline measures
    - Determine screening strategy
2. Build a team to deliver screening
3. Get patients screened
4. Coordinate care across the continuum
    - Consider navigation
    - Emphasize quality

#1: MAKE A PLAN

Who Needs Cancer Screening?

- Most providers and their medical teams already have a framework for identifying patients eligible for screening
- Determined by
  - Gender
  - Age
  - Risk factors –
    1. behaviors (smoking),
    2. family history of cancer
- Depends on updating chart data

KEY PLAN ACTIVITY:
Define Baseline Screening Rates:

- Individual level: identify patients
  - Age
  - Risk level
  - Due/overdue
  - Completed (date-test-result)

- Practice level: must assess baseline screening rates

  (Determine where you are before know where you can go)
- Establish a goal

The Baseline is Often Hard to Define

- The exact percentage screening rate may be difficult to identify:
  - Charts may lack test type, date, result
  - EMR may complicate this rather than clarify
  - Improving the use of the EMR to strengthen measurement capacity will help with assessing cancer screening but will help with many other aspects of quality measurement
    - Smoking history, Family history
  - Helps identify/improve processes that are weak (overlaps with aspects of becoming a PCMH)

Performance Measures

"Percentage of patients at average risk aged x to y who had appropriate screening ."

This is calculated according to definitions:

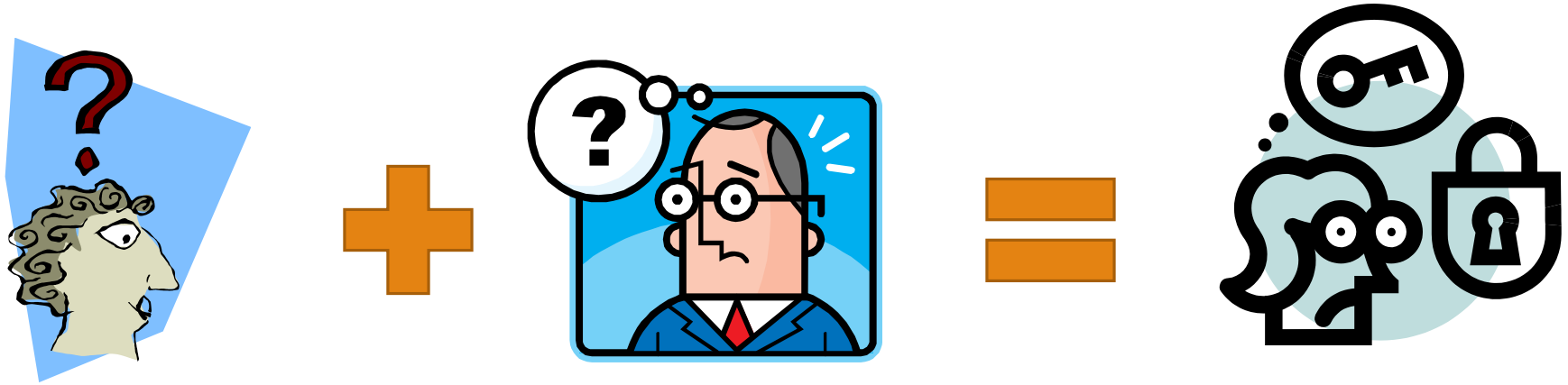
- **Numerator**: Number of patients aged X through Y (with Z history) with appropriate screening for _____ cancer
- **Denominator**: Number of patients who were aged X through Y at some point during the measurement year(s).
- Measure definition often provided by insurers, funders

Measurement of Baseline and Screening Rates Over Time Serves Multiple Purposes

- **Empanelment:**
  - Providers want to know the rate for their own patients
  - Assigning patients to physicians can be based on visit frequency; i.e., which clinician they saw most, or the last visit
  - Once assigned, this can help improve continuity (and movement toward PCMH status)
- **Quality Improvement:**
  - Establishing a starting point may strain credibility; but will provide impetus to standardize and improve the quality of chart data

Key Plan Activity: Design a workable screening strategy

- Consider
  - Guidelines
  - Patient engagement, choice, shared decision making
  - Realistic options in your medical neighborhood (Medicaid)
  - Your peace of mind as a provider



Practice Screening Strategies

- Once strategy decided, team must be informed

✓For cervical cancer

✓For CRC, every practice needs to offer colonoscopy and stool (FIT) testing

✓For breast cancer

✓For prostate cancer

✓For lung cancer

Strategy for Lung Cancer, USPSTF December 2013

- Targets 30 pack year smokers, aged 55-80
- No more than 15 years since quitting
- Only where life expectancy is possible with curative surgery
- Annual screening
- Use Low Dose CT scanning; not CXR
- Not all medical associations are ready to recommend this.
- Informed decision making is key

US Preventive Services Task Force
Final Recommendations for Lung Cancer Screening
December 31, 2013

Grade B Recommendation

The USPSTF has found moderate level evidence for moderate level benefit for lung cancer screening with CT

Coverage Decisions

Affordable Care Act Identified Plans:

- Coverage without a deductible, start January 2015

Medicare final rule February 2015

- NLST criteria ages 55 – 77
- Written order following shared decision making visit
- Radiologist and imaging center criteria
- Submit data to CMS-approved national registry

http://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?NCAId=274

Organization	Type of Statement	NLST Like Subjects?	Other Changes?
ACCP/ ASCO/ ATS endorsed	Evidence based guideline	Suggest it be offered	No
ACS	Guideline	May be considered	No
ALA	Guidance	Recommended	No
NCCN	Consensus guidelines	Recommended	Yes, for some individuals
AATS	Guideline	Recommended	Age 50-79; 20 pack years and five year cumulative risk of 5% or more; lung cancer survivors
AAFP	Clinical Recommendation	Insufficient evidence	Paucity of high-quality evidence with only one study at major medical centers and strict nodule evaluation

Screening Strategies

The evidence offers choices for patients and providers:

- Cervical cancer
  - ≥ age 30: continue cytology q 3 years (if normal) OR co-testing (cytology + HPV test) q 5 years (if normal)
- Breast cancer
  - Age to start screening: Breast (40 vs 50)
  - Frequency of screening: Breast (q 1 vs q 2 years)

Screening Strategy CRC

- Colorectal cancer
  - Colonoscopy q 10 yr OR stool testing q 1 yr OR Flex Sig q 5 yr
  - "One & Done" vs annual repeat (vs every 5 years)
    - Consider risk level
    - Patient preference*
    - Odds of succeeding with repeat testing
  - Stool based test (FIT > FOBT)

*Inadomi JM, et.al. Adherence to colorectal cancer screening: A randomized clinical trial of competing strategies. *Arch Intern Med*. 2012;172(7):575-582

Stool Tests Present a Choice

- Stool tests should be either immunochemical (FIT tests) or high sensitivity guiac tests (HSgFOBT)
- HSgFOBT/FIT are more sensitive/specific than older tests
- FIT advantages*
  - More specific for human blood than guiac-based
  - No worry of false positive due to diet/medicine
  - More user friendly (require fewer samples/less feces contact)
  - Slightly more expensive ($20 vs $3) but Medicare reimburses
  - Patient return rates are higher
  - "Poop on Demand" (N.B. In-office fobt NOT recommended)

*Clinician's Reference: Fecal Occult Blood Testing (FOBT) for Colorectal Cancer Screening Web site. http://nccrt.org/wp-content/uploads/FOBTCliniciansReferenceFinal.pdf. AND Levin TR. Optimizing colorectal cancer screening by getting FIT right. *Gastroenterology*. 2011;141(5):1551-1555.

Other issues to consider

Risk level

- If increased risk or high risk on personal/family history: genetic screening ?

Age to STOP screening…..or individualize

- Breast: ≥ 40 forever (ACS) or 50-74 (USPTF)
- Cervical: age 65 unless prior abnormal or cervix removed
- CRC: 50-75 (USPTF) or individualized based on comorbidities
- Lung: age 80

Patient preferences/limitations

- Self breast exam
- Culture, philosophy
- Access (geography, insurance)

#2 To Deliver this Build a Responsible Team

Your **team** can succeed

- Have a policy that reflects your strategy
  - Display it (algorithm), have protocol, train everyone
  - Make sure protocol includes:

1. Clarify who is responsible for what
2. Assure risk assessment & prior screening documentation
3. Consider standing orders
4. **Deliver the recommendation** to every eligible patient
   (NB: evidence base for this is strong)
5. Make sure patient has instructions (use teach back)
   Note cultural, linguistic, literacy appropriateness

#3 Get Patients Screened

Be Mindful of Patient Barriers:

Consider socioeconomic status, education level, literacy level

- Options: Find the best materials and approach for your patients. Physician recommendation: You should get screened. “CRC may have no symptoms; but it’s preventable, treatable, beatable” with screening.

Consider language barriers

- Option: Translate materials into Spanish, etc.

Consider if there are high rates of behavioral health issues

- Option: Navigation is key—ongoing contact to help get through the maze and complete the process

Shared Decision Making

- Colorectal cancer
- Lung

Practice policy facilitates efficiency/measurement

- Breast
- Cervical

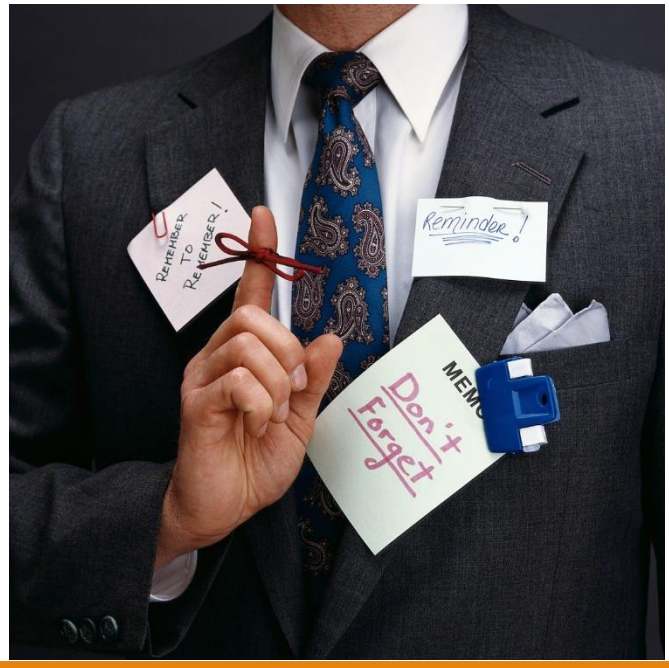
#4 Coordinate Care Across the Continuum

Use Tracking, Follow-up*

- Positive screens must be followed up
- Results must go to patients
- Test and Referral Tracking (and follow up)
  - Track all screening tests results, all referrals
  - Reschedule missed referrals
  - Define the communication gap between the primary care & specialty provider and close it

Use reminders*

- Evidence is very strong - patients & providers
  - In person, by phone, by mail
    - Best reminder is a human voice
    - But all are shown to work
  - Reminders before the visit also
  - Remind again if necessary
    - 3rd reminders for stool test returns, mammograms



*Sarfaty M, Wender R, Smith R. Promoting Cancer Screening in the Patient Centered Medical Home. Ca Cancer J Clin Nov-Dec 2011: 61 (6): 397-408.

Emphasize Quality

Ensure Continuity and Quality

- Navigators key role in follow-up of abnormal findings and hand-off to treatment team
- Maximize FIT/FOBT return rates
- Guaranteeing that all abnormal screening tests lead to a diagnostic procedure

There is evidence that links 'higher touch' medical homes with better screening rates

- Ferrante, et. al. analyzed primary care practices for traits of the patient centered medical home (PCMH)
- Measured up-to-date preventive services(CA screening too)
- Those with higher medical home scores had greater receipt of preventive services, especially:
  - Continuity with the same provider
  - A well visit within prior 5 years
  - More chronic diseases and more visits per year
  - Decision support and links to community resources

* Ferrante, et.al. Annals of Family Medicine. Mar/Apr 2010; 8(2)

The Geisinger Health System*

- 74% improvement in preventive care with nurse care managers ("*Proven Health Navigators*").
- EMRs identify patients who need care
- Increased access-after hours care, internet scheduling
- Physician incentives to deliver evidence-based care
- Geisinger ROI ('06-'10) of 1.7 from PCMH model

- *pcpcc.net

Here is one practice example that worked*

Care team all trained guidelines

Created standing orders

Transferred responsibility for reviewing charts to nursing staff who offered tests to unscreened patients

Added coaching for patients on “how to do it”

Nurses flagged charts for MD where patients declined

Tailored print-outs for linguistic/low literacy patients

* Presentation, Dr. Golden, NCCRT Annual Meeting, 2010.

Conclusion

- To succeed on cancer screening in primary care
  - Plan a **realistic** screening program
  - Assemble a functioning team
  - Get patients screened
  - Coordinate care across the continuum
  - **Attend to quality**

Thank You!