Dialogue for Action 2014
Cancer Screening in Primary Care
How the Medical Home Can Help You Screen Your Entire Population

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Outline

I. Design a workable screening program--

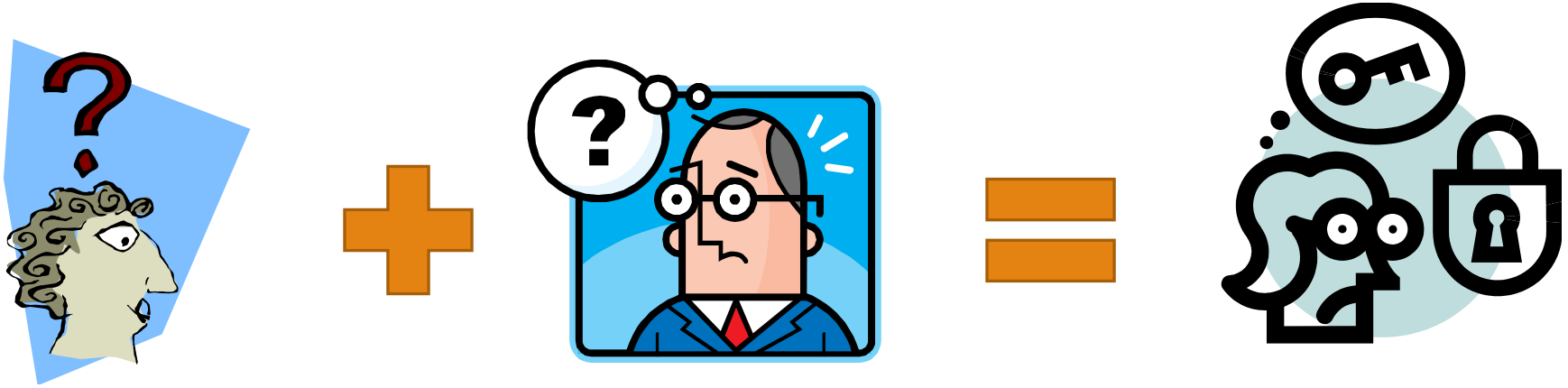
(a strategy)

II. Plan to deliver it as a team

III. Use the features of the medical home model that are supported by evidence

Design a workable strategy

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



Design a workable strategy, cont'd

The evidence offers choices for patients and providers:

- Cervical cancer
  - ≥ age 30: 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)

Design a workable strategy, cont'd

- 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 vs FOBT)
  - In-office fobt NOT recommended

*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

*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.

For your individual patient, 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

Patient preferences, limitations

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

To Deliver this Build a Responsible Team

Your **team** can succeed

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

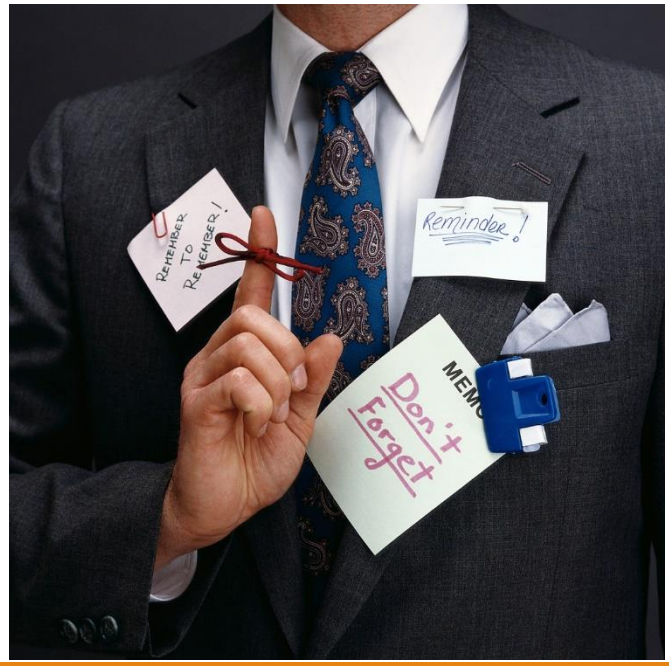
1. Clarify who is responsible for what
2. Assure risk assessment & prior screening documentation
3. Consider standing orders
4. Deliver the recommendation to every eligible patient
   (NB: evidence base for this is strong)
5. Make sure patient has instructions (use teach back)
   Note cultural, linguistic,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

You can make this work

- A champion
  - A cheer leader
- Discuss at meetings
- Measure
  - Discuss
  - Tweak
- Measure again
- Consider PDSA cycles, rapid cycle improvement (IHI)

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.

Use Tracking, Follow-up*

- Positive screens must be followed up

  * *How to Increase Colorectal Cancer Screening Rates in Practice: An Evidence Based Toolbox and Guide*

    (nccrt.org/about/provider-education/crc-clinician-guide/)

- 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

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

The Capacities of the Patient Center Medical Home (PCMH) Can Help

- According to reports, medical homes are raising screening rates
- Vulnerable low-income populations with medical homes have higher screening rates than those without medical homes (52 v 44%)*
- One important reason is that medical homes are the province of primary care clinicians, who have a critical role as champions of screening.

*Berenson, 2012:insured low income individuals

Primary Care Clinicians: Champions of Prevention

- Most preventive services are administered in the primary care setting:
  - Formerly as part of the "check-up" (wellness) visit
  - Increasingly on an opportunistic basis
- Primary care clinicians see prevention as part of "core mission"
- 1^{o} care residency graduates are schooled in prevention
- Likelihood of a patient getting screened relates directly to whether they have a regular primary provider of care
  - Place of care too.

Patient Centered Medical Home (PCMH) (Medical Home) (Health Home)

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

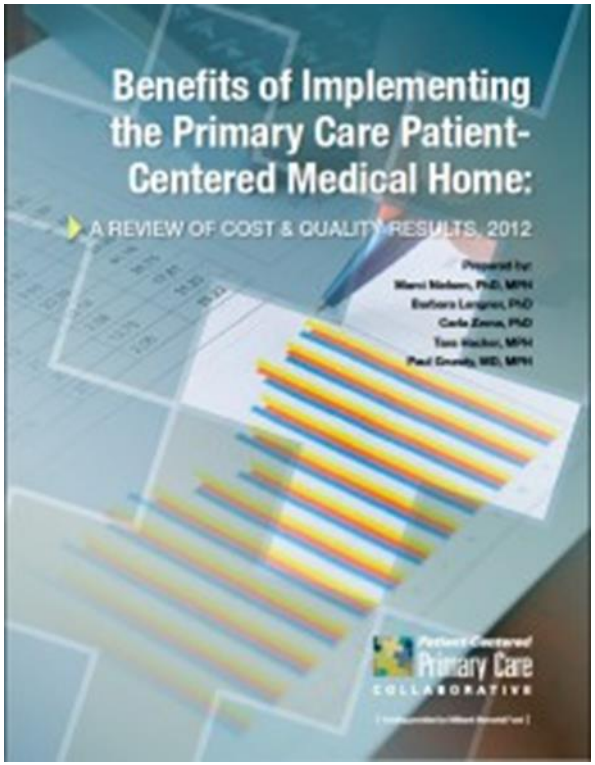
- Ferrante, et. al. analyzed primary care practices for traits of the patient centered medical home (PCMH)
- Measured up-to-date preventive services(CA screening too)
- Those with higher medical home scores had greater receipt of preventive services, especially:
  - Continuity with the same provider
  - 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)

There is evidence from the Patient Centered Primary Care Collaborative (pcpcc.org)

2012 Summary provides nationwide results from 34 reports, showing benefits on:

- **cancer screening**
- disparities
- quality
- health care costs



*** www.pcpcc.net**

PCMH Initiative	Description of Program	Prevention Measures
Senior Care Options program, affiliated with the Common-wealth Care Alliance (MA)	Community–based team care including nurse practitioners and geriatric social workers focused on Dual Eligible	• Mammography screening rates increased among women ages 65-69 years by 75 -79 % from 2005-2011; • Colorectal cancer screening rates increased from 30-51% from 2005 to 2011;

Senior Care Options, cont'd.

- Influenza immunization rates also increased from 65 to 77%.
- Hospital readmission rates decreased by 2% in one year. (Nielsen M, 2012) .
- They created web-based patient records with access from multiple points and multiple providers.
- Payment was on a capitated basis with financial incentives for keeping patients healthy.
- Their goal was to keep patients healthy and in their homes.

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

Other medical homes show screening increases.

- Community Care of North Carolina: statewide medical home, >1 million patients offering primary care in 14 community care networks (Medicaid and SCHIP)*.
- Impressive record on prevention (Steiner).
- Improved health outcomes, lower emergency room visits/hospitalizations, increased delivery preventive services, reduced costs (Mahoney, 2011; Steiner, et.al.,'08).

* ALSO INCLUDED PHYSICIAN INCENTIVES

What Accounts for Improvement

Two explanations

- 1. Payment models encourage and do not discourage preventive care (incentives)
- 2. Capacities of the medical home are selected from evidence, i.e. shown to improve outcomes, include preventive care

Some capacities are more significant….

Medical home features make the difference (NCAQ)

1. Enhance Access and Continuity
2. Identify and Manage Populations
3. Plan and Manage Care
4. Track and Coordinate Care
5. Provide Self Care & Community Resources
6. Measure & Improve Performance

1st PCMH - Enhance Access and Continuity

- No access--no screening:
  - Commonwealth Fund surveyed 715 patients twice: before/after medical home recognition & highest access rating increased 61 to 69%
  - BCBS Michigan 60% increase 24/7 access - 5% higher preventive
- Approaches: open access, after-hours (nights/weekends), 24-7
- Linguistic/cultural literacy (WA CHC had CRC-22 languages)
- Continuity builds relationship and sway
- Empanelment creates motivation–Who are MY patients?

2nd PCMH - Identify and Manage Populations

- Screening needs defined by age, gender, risk status*
  - Breast
    - Screening advice based on gender, age, risk
    - Greater than 20% risk MRI indicated
  - Cervical
    - Varies by age: 21-30, >30, ≥65 and risk
  - Colorectal
    - Age, Risk (personal, family)
- Potential of information technology - find age/risk groups and make contact easier

Specific IT features include registries

- Registries
  - Identify all patients due for screening
  - Can do systematic targeted outreach
  - Reminders/alerts to potentiate opportunist contact
- Navigator programs
  - Evidence accumulating (Breast/CRC) - revenue neutral
  - Nurses or community health workers
  - Concordance language and cultural
  - Training manuals now available

3rd PCMH - Plan and Manage Care

- Evidence based guidelines (and quality measures)
  - BCBS New Jersey (Horizon): 6% increase breast/cervical cancer screening
- Screening policy
  - Who are we reaching?
  - What tests are available to our patients?
  - Uniform policy allows for center-wide playbook- teams, standing orders, algorithms, protocols
  - Measurement by practice-wide rates

4th PCMH - Track & Coordinate Care

- All patients deserve screening results
- Follow-up can be a weak point
  - Positive stool blood tests especially
  - Cytologies that are not normal
  - Mammograms that need additional films
- Track and follow-up tests AND referrals
- Unresolved referrals need resolution
  - Better communication with specialty offices; improve links to other facilities

Improve Links to Facilities & Specialists

- Health Affairs special issue on PCMH 2010
  - SFGH created mechanism to pre-discuss referrals with specialists
    - Made some unnecessary
    - Increased likelihood that results returned

Record results properly

- EMR data should include (all searchable):
  - The test
  - Date it was performed
  - The results
  - Follow-up recommendations
  - Dates follow-up or contact was attempted

5th PCMH - Self Care & Community Resources

- Language, culture, literacy appropriateness affect outcome
- Patient handouts available (Toolbox & Guide)*
- Practice network of community resources

* cancer.org OR nccrt.org

6th PCMH - Measure to Improve Performance

- Measurement—process improvement—remeasurement
  - Know if there is improvement
  - CME/CE for clinical staff
- Pay for performance incentives are helping- can provide funding for additional staff for outreach, navigation, care management, etc.

Better Office Systems=Better Capacity

- Easier to implement new guidelines
- Achieve efficiency
- Achieve benefits of teamwork

Medical home features apply the evidence on improving outcomes

- Summary
  - Create Access, Continuity
  - Identify & manage your populations (outreach)
  - Manage Care with screening based on Guidelines
    - Recommendations to Every Patient
    - Reminders for Clinicians & Patients
    - Team based care: Physicians can't do everything
  - Track and coordinate (follow-up)
  - Provide self care guidance and links to community resources
  - Measurement and improvement

Pre-conclusion

Q: Can this be done?

A: Medical homes are doing it!

Conclusion

- To succeed on cancer screening in primary care
  - Design a **realistic** screening program
  - Apply the evidence-based capacities of the **medical home model**
  - Remember: Rome was not built in a day

Proceed inch by inch and row by row and sure as I am standing here your screening rates will improve!