Barriers for getting evidence-based practices adopted by primary care providers

2011 Dialogue for action on CRC screening – Baltimore

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Why is CRC screening important?

- "…declines in CRC death rates are consistent with a relatively large contribution from screening and with a smaller but demonstrable impact of risk factor reductions and improved treatments."*
- "colorectal cancer is one important disease in which racial and socioeconomic disparities in outcomes can most readily be eliminated by ensuring that all eligible adults are effectively screened and abnormal findings are fully treated."‡

Laiyemo AO, et al. JNCI. 2010; *Edwards BK, et al. 2010; ‡Ayanian JZ. JNCI. 2010

Objectives

- Discuss the barriers for use of evidence-based practices by community-based primary care providers
- Discuss strategies to overcome barriers
- Describe how health care reform impacts the adoption of evidence-based practices in primary care

Evidence, clinical judgment, advocacy, preferences

WHAT IS EVIDENCE?

What is evidence?

- "Evidence-based medicine is the conscientious, explicit and judicious use of current **best evidence** in making decisions about the care of individual patients."
- "Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough."

www.cebm.net/?o=1914

*Sackett. BMJ 1996; 312 : 71-2

What is the evidence for CRC screening?

- Well done controlled trials and meta-analyses/systematic reviews?
  - Fecal Occult Blood Tests (guaiac-based tests)
  - Flexible Sigmoidoscopy
- Well done observational studies?
  - Controversial
- Expert opinions?
- Advocacy/Celebrity?
- Guidelines?

*BMJ 1996; 312 : 71-2; **BMJ. 1996; 313(7050): 169–171.

From the Frontlines….

<u>Perspectives of primary care clinicians</u>

- "It is not lack of knowledge about the guidelines. It is about how to make all happen – consistently"
- "We know what to do. We don't seem to be able to do it consistently, … it is in fits and starts"
- **Clinicians do not have time during their usual care visits to complete all the necessary education**

Yarnall, AJPH 2003
Quotes are personal communications from colleagues

"You are given 20 minutes to see a patient. Just think for a minute, that I'm seeing you today for the 1st time, you are 53 years of age, you have two other different co-morbidities, but I also want to talk to you about colon screening."

"You have to come to some agreement with the patient, with what are they willing to do…it's not the provider or the patient, but it's kind of coming together with the patient to help them to understand the importance of this, but they ultimately make the decision."

"The reality is that I am not going to have time to give you enough time so you can understand and appreciate and be motivated by that."

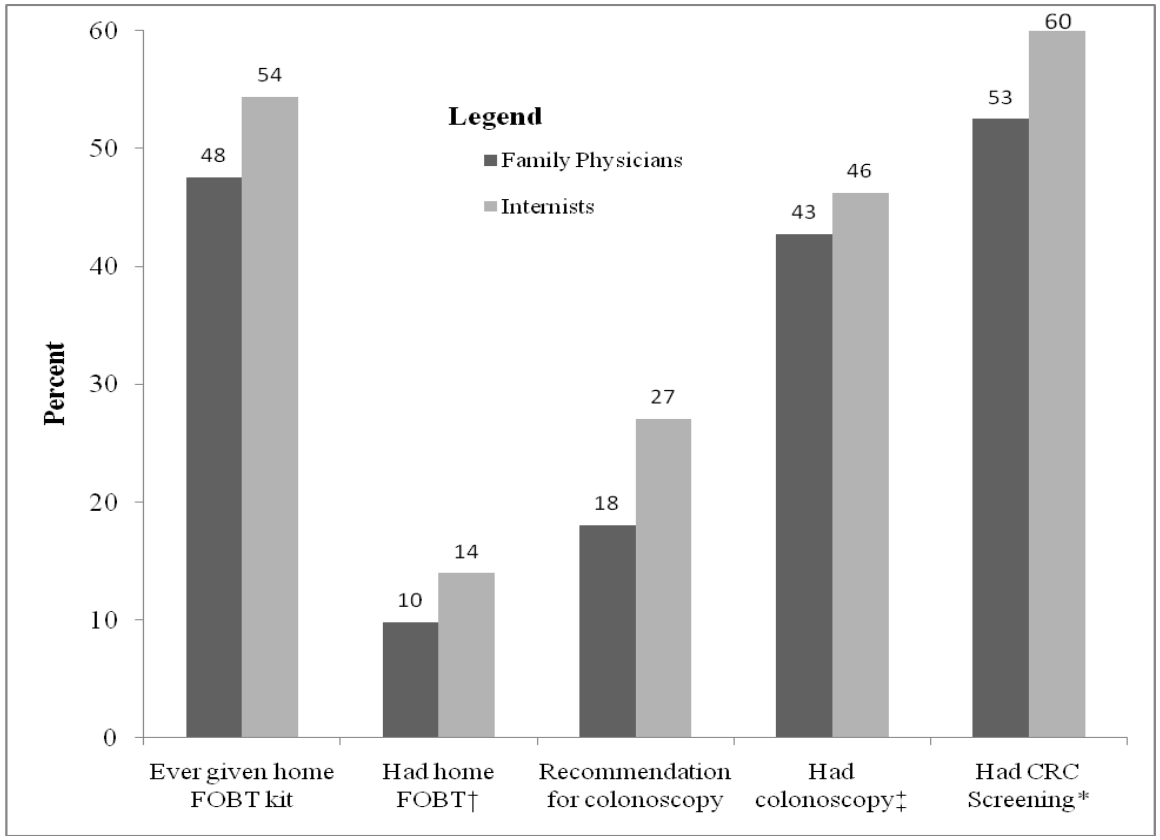
Findings from key informant interviews of clinicians, managers and staff at 2 CHCs in Central Massachusetts on a CBPR Project in 2010

Percentage CRC Screening Knowledge and Awareness among Medicare Beneficiaries, MCBS 2007

Outcome, %	Internists, n=1,624	FPs, n=1,652
Previously heard of colon cancer	86.6	86.4
Previously heard of colonoscopy	**76.6**	**82.1***
Previously heard of home FOBT kit	50.1	54.4
Returned most recent FOBT kit	94.9	93.5

Age 50-75
Medicare Current Beneficiary Survey
*P-value <0.05

CRC Screening According to PCP Specialty, 2007



CRC Screening rates

- Disabled beneficiaries receiving care from FPs - 34%
- Higher income beneficiaries receiving from internists - 68%

- Medicare Enrollees, n=3,276
- 50-75 years of age, interviewed 2006 & 2007

Medicare Current Beneficiary Survey
All p-values <0.01

Underuse, overuse and misuse

- … along with **substantial variations** among clinicians even in similar settings.

  What makes some clinicians more effective than others?

  How have those overcome the **time and organizational barriers**?

Three groups of patients on prevention

- Group 1: Eager to be screened
  - Challenge is preventing overuse and misuse
- Group 2: Need a little nudge
  - Physician **recommendation** is sufficient
- Group 3: Unwilling or unable
  - Complex multilevel interventions may be necessary – reminder and tracking systems and community-based approaches
  - Will challenge the **resources** of the average practice!

Stages of change paradigm alone is inadequate

Doubeni. Ann Fam Med. eLetters , Jul 22, 2010

Cuzick J, et al. Statistics in Medicine. 1997;16(9):1017-29

CBPR Project and more…

- “The difficulty of achieving buy-in from patients for a screening test as unpleasant as the colonoscopy – it’s a tough sell”

- “extensive preparation, need for anesthesia, inherent risk, invasive nature, and sensitive body area involved. It is a resource-intensive endeavor, requiring the patient to have time to prepare the day before, take time off the day of the procedure, and find transportation to and from the test.”

Technological advancements leave some behind

- “I guess in the past they used to do the sigmo something and they don’t do that anymore, and I guess people used to like that, I hear patients talking about that.” – pt navigator

Lag between recommendation and testing

- “We like to think of ourselves as one stop shopping because we do provide so many services to our clients right there at [CHC] but colonoscopy is not a procedure that we do here.” -executive
- “On-site, easy access, walk-in, open access schedule and all the other modifications we have made to make it easier for women to actually keep their appointments will be lost, when people will need to find transportation to another site.” -executive

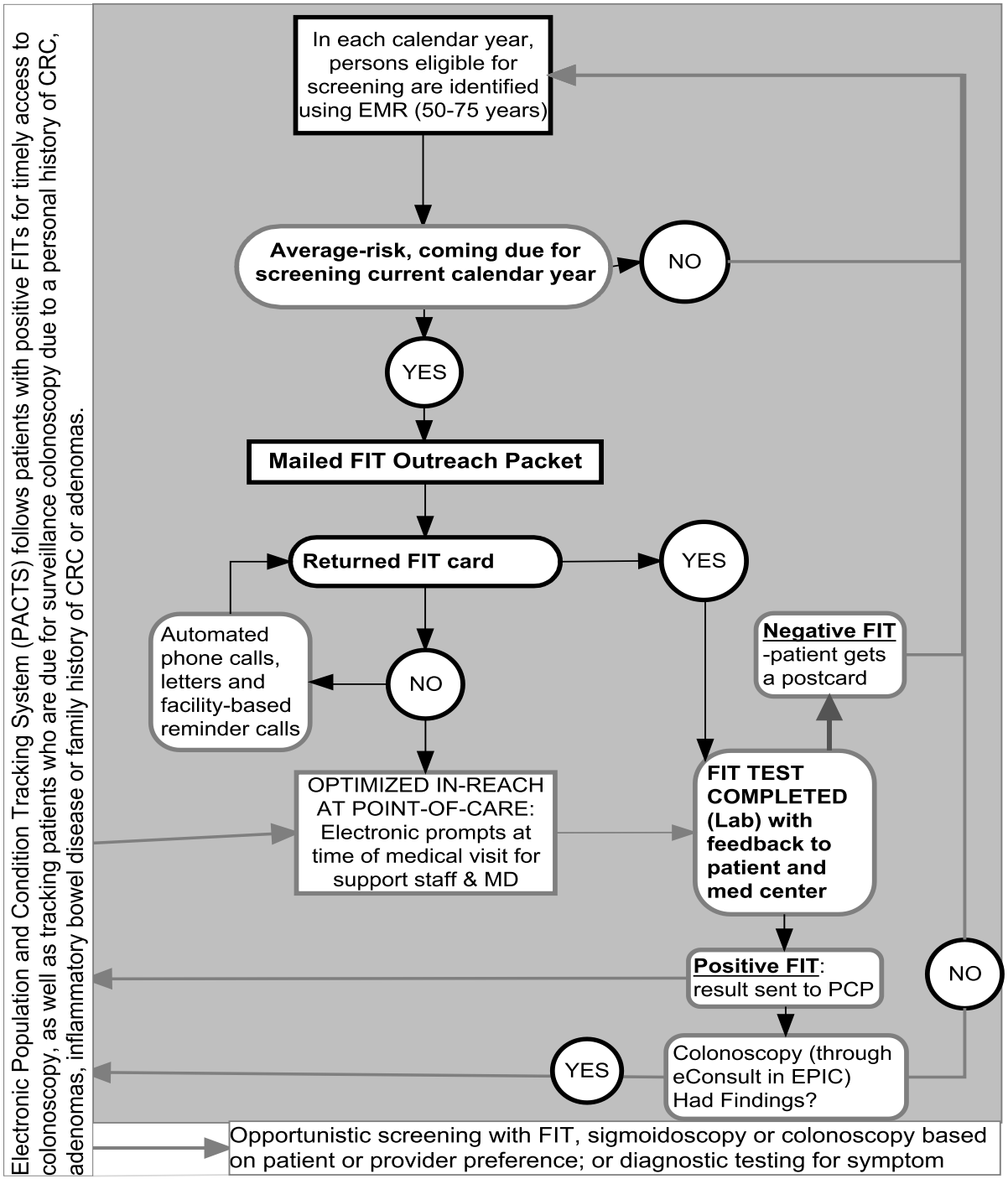
- All CRC screening tests entail a lag and at least parts of it are outside the control of PCPs

Clinicians know what to do but appear unable to do it. Why?

STRATEGIES TO OVERCOME BARRIERS

Kimberly Yarnall, AJPH 2003

Developing and sustaining a robust tracking and reminder system is beyond most community-based primary care practices



Kaiser Permanente Northern California's Organized Screening Program. Courtesy – T.R. Levin

Strategies to improve the delivery of evidence-based preventive services

- Know who is due for screening (registry/reminders/clinical decision support)
- Recommend screening
- Assist patients to complete screening
  - Assign ownership and share responsibility – everyone in a practice
  - Exploit every opportunities – make it part of every visit
  - Standing orders for FOBT/endoscopy
  - Protocols for follow-up of abnormal tests

Ivory tower

Improving delivery of preventive services on the frontlines

- Many practices are under-**resourced**
- Prevention is **competing** with overwhelming demands of chronic disease and psychosocial needs of the populations most in need of screening
- **“Preventive medicine is something that is put on the back burner because there are so many struggles that have to be dealt with on a daily basis.” –provider***

Resources for identifying those eligible for screening and their risk status

- Reminder systems
  - EMR with clinical decision support tools
  - Patient registries
  - Develop office procedures and tracking systems
- Participation in community coalitions or networks for prevention
  - Example - diabetes collaborative/C5
  - Share cost of registries
  - Shared goals
  - Learning communities, clinical detailing

Time for prevention

- Make prevention part of every visit
- Develop enabling office procedures and tracking systems
- Not just clinicians, but anyone that comes into contact with patient

Role of a prevention medicine specialist

- Develop a culture of prevention
- Comprehensive **personalized suite of preventive services**
- Group visits with multidisciplinary teams
- Partner with practices of varying sizes
- Apply guidelines & appropriateness criteria
- Monitor progress/adapt
- Integrate community assessments

The Affordable Care Act and Prevention

- "Refocus" primary care on prevention
- Coverage of Preventive Health Services (USPSTF Grade A recommended services)
    - New employer and private health plans
    - No cost-sharing
- Covered Medicare Annual Personalized Wellness Visit
- Reduce financial barriers for Medicaid
- CHC demonstration projects
- Community transformation grants
- National strategy
    - Quality and health promotion, coordination

Koh & Sebelius. Promoting Prevention through the Affordable Care Act. NEJM. 363;14

Some Resources

- Research-tested Interventions Programs
  - http://rtips.cancer.gov/rtips/topicPrograms.do?topicId=102265&choice=default
- European Panel on the Appropriateness of Gastrointestinal Endoscopy II (EPAGE II)
  - www.epage.ch/EPAGE_ADM/start2.html
- How to Increase Colorectal Cancer Screening Rates in Practice
  - www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf
- Enhancing Use and Quality of Colorectal Cancer Screening
  - http://consensus.nih.gov/2010/colorectal.htm
- NCCRT & ACS Resources
- NCI
  - http://www.cancer.gov/cancertopics/pdq/screening/colorectal/Patient/page3

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