



Dialogue for Action™ on Cancer Screening: Hitting the Targets **Friday Concurrent Conversations**

This report captures the main ideas discussed during six concurrent conversations that took place at the conference on Friday, March 22, 2013, 10:00 – 11:30 AM.

Conversation 1: Hitting the Targets for Cancer Prevention and Screening: Strategies for Patient Engagement

Facilitator: Eileen Steinberger, MD, MS

Resource People: Lillie D. Shockney, RN, BS, MAS

Jennifer S. Smith, PhD, MPH

Scribe: Erica Childs Warner, MPH

Practical actions to use effective patient engagement strategies to increase screenings

- Reach and educate women
- Address barriers: clinic hours
- Use humor
 - “I got my tailpipe checked”
- Utilize innovative venues (community gatherings and bathrooms) and products (coasters and toilet paper)
- Use clear messaging
- Address pride issues
 - Collect voluntary \$ contributions
- Bundle screenings
- Provide assistance with signups for Medicaid
- Patient navigation
- Promote healthy lifestyles
- Tailored messaging and programs

1) What patient-engagement strategies have you used in your work setting to increase screening rates?

- Home screening kits
- Mobile mammography units
- Healthy behaviors and cooking events
 - With incentives
 - Free activities
- Engage survivors
- Incentives for completion of colonoscopy
- Incentives for mammography
 - Small gifts for completion of screening
- Voluntary monetary contributions to screening programs, asking participants to pay even a small amount increases ownership/engagement and value of program

- Coverage of travel and screening costs
- Involve community members
 - Signage on buses
 - At various venues: churches, bars, farmers' markets
- Educate about insurance benefits
- Peer-to-peer education: pass along screening messages
- Patient navigation for diagnostic procedures

2) What have been Challenges?

- Fear
- Unknown family history
- Distance
- Confusion over guidelines
- Mixed messages from providers
- Adoption lag time for guidelines from providers
- Influx of Medicaid
- Cultural barriers
 - Women only seeing female providers
 - Lack of acknowledgement of cancer

3) Describe ways to overcome challenges?

- Go to men
- Address fear
- Use visuals
- Meet with providers (go over guidelines and barriers)
- Comment on HEDIS guidelines (submit public comments)

Conversation 2: Increasing Access and Quality and Reducing Cost in Health Care: Opportunities in the Private Sector

Facilitator: Laura S. Benson, RN, MSN, CPHQ

Resource Person: Richard Wender, MD

Scribe: Kerry McAuliffe

For people who work in the private sector, what practical actions can they take to increase access and quality while reducing costs? (This group focused on Colorectal Cancer (CRC) screening)

- Quality emphasis – reportable measures/data
- State-based registry – National database
- Certification of screening centers
- Better communication to patient on result/meaning
- Better follow-up on pathology report
- Colon focused – unified message on rectal exam
- Roundtable – Patient question list for insurance questions
- Bundled payment – some success
- Adhere to E-B guidelines
- Determine if patients need pre-visit vs. colonoscopy
- Eliminate waste in the system (i.e. putting stool cards in better locations – easy to see)
- System to link together what types of screenings a patient is due for
- Reduce duplication of services – issue of not having records of patient
- Open access centers for patients to call up
- Blend claims and clinical data
- Pay for screenings regardless of risk; more payment for patient if diagnosed

- 1) If you work in the private sector, what tools have you used in your work setting to increase access, and quality, while reducing costs?
 - One sheet of questions to ask for consumer
 - Standard list of questions for consumer to know what is/isn't covered
 - Quality is key
 - A standard database of screenings to use to analyze future screenings
- 2) How have these tools helped to keep costs down without sacrificing quality?
 - One of the standard questions should be asking about type of anesthesia, as there are differences in time, cost and amount needed
 - Training, certification and norms in practice would enhance quality of colonoscopies
 - It is important to keep costs down, while not sacrificing quality
 - Kentucky has a program that allows patients to pay as a bundle when a procedure is complete

3) What have been challenges?

- Screening vs. diagnostic coding and its impact on charges to the consumer
- Affordable Care Act (ACA) confusion
 - Coverage
 - Questions to ask (consumer)
- Insurance companies have different modifiers
- A rectal exam does not count as CRC screening, but some providers think it does
- For patient, knowing going in what screening procedure will entail (i.e. what type of anesthesia)
 - Patient doesn't know type of anesthesia is available
 - Cost of anesthesia – if a polyp is found and is removed while patient is out this becomes a diagnostic procedure with added costs (not just a screening)

4) Describe ways you overcame challenges?

- Educational tools – consumers (RE: ACA, coverage)
- Insurance rates will go up, but doesn't sacrifice quality to reduce costs; allow for sustainability in costs and quality
- Paying for withdrawal/prep time
- Don't know how to ask about cecum
- Need to empower consumers to be informed
- Healthcare is treated as an economic driver – driving costs up – profit seeking
- Some doctors base patients next screening on guidelines strictly, instead of personal history
- Screening – one is prevention/ one is clearly detection

5) Examples of what's working in the private sector?

- KY – bundled payment for colonoscopy
- Not sending polyps to pathology
- Bundled approach with providers (because colonoscopy costs were \$2K - Eastern Shore, MD)
- Potential in the private sector for increasing access and quality while reducing costs within the healthcare system
- Need excessive surveillance – happening on primary care side: calling patients, asking for family history, asking for history of personal screenings
- Adherence to E-B Guidelines
- Revisit guidelines
- Get path report – more detail on polyps, etc.

6) What is your current experience with how healthcare reform is impacting rates?

- There is a lot of unknown with what will/will not be covered with the Affordable Care Act
- Overall confusion
 - What is covered?
 - What applies to the individual?
 - Patient does not know what to ask
- Reimbursements are lowering, which is causing concern
 - The only way to reduce costs is to pay docs less – this will happen

- Foreign doctors are surprised by how much US doctors make
- Screenings are coming from primary care
- Knowledge of comorbidities

Conversation 3: Increasing Access and Quality and Reducing Cost in Health Care: Opportunities in the Public Sector

Facilitator: Donald Nease, Jr., MD

Resource Person: Diane M. Dwyer, MD

Scribe: Sarah Abou-El-Seoud

For people who work in the public sector, what practical actions can they take to increase access and quality while reducing costs?

- Push for someone who translates USPSTF guidance into practical implementation
- Experts from different areas (coders) who set up processes to help explain (AMA changes codes, currently if come in for CRC screening and someone else comes in with rectal bleeding and gets screened – the code is the same if polyp is found – both considered diagnostic even though one was simply a preventive screening test)
- However, if we cover everything, we aren't going to cut costs
- Education
 - 1) Standardized CHW training
 - 2) Consumer education (more care is not always better, reduce TV drug ads and start doing public service messages)
 - 3) Educate consumer on how to use their doctor, primary care, etc.
- MD – access to tax records so people do not have to go home and find records (eligibility)

1) If you work in the public sector, what tools have you used in your work setting to increase access, and quality, while reducing costs?

- Community health coalitions – information sharing, access, assistance/resource sharing
- This was originally focused on cancer control, but now have expanded to wellness focus
- Most helpful when health officer within local jurisdiction sets up the coalition – starts the conversation
- Colorado group held a health fair offering cancer screenings, information, blood pressure tests, etc.
 - Created their own FIT test instruction form (6th grade level, images)
 - No copays
 - Provide transportation
 - Hold health fairs and other screening events on Saturdays so people can come when they are not working
 - Limit the population you invite (example – Medicare patients due for screenings)
 - Large portion of population has low literacy – health fair setting allowed for every patient to be paired with a trained volunteer to help navigate the screenings offered and provide info
 - Incentives for attending – food, prizes
 - They had a 30% return on FIT test
 - Going forward will do reminder calls to increase return of FIT tests
- Disorganization within CHCs

- State primary care associations (Different levels of support depending on the state – the Michigan Primary Care Association helps with EHR support)
- Health education – evaluation workshop – incorporating evaluation, starting to think more about the evaluation side
- Working with private entities, universities and other public organizations to figure out what is working
 - How do we meet standards, what are best practices within other FQHCs
- Importance of managing resources well
- New York – state and federal dollars used to follow patients – case managers, lay health educators (have a lot of resources)
- Colorado is training public health staff at the local level – toolkit that can be used in other areas, but able to tailor the kit to match different community needs
- VA model – national system, works well, using a single data system
- Importance of EHR systems that can talk to each other
- Need for coordination/integration between public health and data at the primary care level
 - Ensure not duplicating efforts
 - Comorbidity

2) How have these tools helped keep costs down without sacrificing quality?

- Quality review at clinical level (feedback to providers)
- Direct Access Colonoscopy – NYC
- Reduction in duplication efforts – if public health and primary care collaborate
- Need to change patient perception of “more is better”
- Expansion of childhood cancer registry to include others
- Flu/Fit model with breast and cervical cancer screening programs
- Reduce unnecessary colonoscopies and increase quality of colonoscopies
- Procedures based on guidelines - CO-RADS

3) Have these tools been effective in reaching underserved and underinsured populations?

- Denver Health – health fairs
- Undocumented individuals – how do we reach them?
- How do we get quality reviews in clinics that serve under and uninsured?
- Health facilities in some Walmarts and Targets
- Reaching out to undocumented parents whose children were born in the US and are eligible for Medicaid – went to consulate (CO); enrolled 1-6 people per day

4) What have been the challenges?

- How do you measure cost savings of prevention?
- Educating public on benefits and harms – more is not always better
- Policies that match guidelines – dealing with changing guidelines
- Follow through – diagnostic piece and treatment
- Am I going to get enough information to assess quality? Know what information you want out of a system before looking at EHRs

- If people work until late , regular physician offices are closed whereas ERs are open 24 hours
- Need to come up with strategies for engaging patients
- HEDIS measures don't match up with guidelines
- Not hitting quality measures = not getting funding

5) Describe ways you overcame these challenges

- In NY, provide feedback to providers – letter with recommendations (Clinical Quality Committee – adenoma detection rate – through University not statewide practice)
- Have them ask those that they contract with for feedback – need to be at both clinical and provider level
- Should look at VA model, as they have been using EHRs for years
- Educate people that health is consumer driven
 - Can choose your doctor
 - Need to communicate with physician
- Better communication between people doing quality measures and providers

6) Provide examples of what's working in the public sector in your community

- See Question 1

7) Discuss the potential in the public sector for increasing access and quality while reducing costs within the changing health care system, including challenges related to health care reform implementation.

- How do we motivate people to make health a priority?
 - Preventive care vs. waiting until sick and going to the ER
 - For some, fears such as deportation make this difficult
 - Accessibility – have to work, watch kids, etc., which makes medical appointments difficult to schedule
- In CO, CHW training integrated into college system
- More people with access – huge opportunity, but need solid funding structure, CHWs
- Patient Navigation Network – a start, but not all are certified or trained the same
- Need a curriculum for CHEs – standardized
- Some states such as FL and MN have a certification model
- Promotora training (standardized)
- Combine roles – have patient navigators who can discuss prevention and chronic disease management

8) What is your current experience with how health care reform is impacting screening rates?

- MD – gave people access that they never had – getting access to screening for the first time
- Payments for screening, but billed if biopsied (also sometimes anesthesia is not covered)
- Getting patients a PCP who makes referrals
- Increased capacity – in the past we have been giving a lot of care to only a few people
- Concern about states not getting on board with Medicaid

- OK – State money for cancer screening – part of contract with University to do follow up if positive screening test
- USPSTF makes recommendations, but needs an arm that deals with implementation
- Want to avoid the “Welcome to Medicare” failure – It was not explained to PCPs how it worked – had to bill a certain way
- Not hitting quality measures = not getting funding

Conversation 4: Reconciling the Benefits and Harms of Cancer Screening

Facilitator: Michelle Tropper, MPH

Resource Person: Jocelyn Rapelyea, MD

Scribe: Pamela Nwoji, MPH

What practical actions can your workplace take to minimize the impact of divergent screening guidelines with different ways to assess benefits and harms?

- Data – can we measure the harms of divergent guidelines?
- Important to understand what patients understand about harms
- Giving information about harms themselves can cause anxiety/stress
- There is a fine line – physician has the responsibility to create the relationship with patients and exercise judgment
- Need consensus about how to approach risk. Standardization for recommendations and how to approach it
- Macro guideline for micro decision
- Needs to pen up recommendations to have the voice of those who are involved (i.e. Radiologist needs to be part of the review for breast cancer screening. To assume they will be biased is not right)
- Involve clinicians directly – ACS does this

- 1) How has cancer screening been impacted by divergent guidelines with different ways to assess the benefits and harms of screening?
 - Negative impact – “they don’t get screened”
 - Not quantifiable – not easy to measure
 - Need consistency in how to approach this
 - Harms measured against incorrect benefits
 - Concise messaging to eliminate confusion
 - Discussions with providers aren’t happening
 - Problems with interpretation of results – public health vs. individual
 - Take what has been done and use it in an appropriate way
 - Assess risk individually
- 2) How has your workplace reacted to divergent screening guidelines with different ways of assessing benefits and harms? What have been the challenges? How have you overcome them?
 - Open communication between USPSTF, ACS and other guideline making organizations improves outcome
 - Share evidence table before first draft
 - Need better messaging through media
 - Desire for transparency when developing guidelines

- 3) What new tools and strategies would help your workplace resolve these issues of divergent screening guidelines with different ways to assess benefits and harms?
- See article Bob Smith referred to in presentation about how women view harms view harms (<http://www.bmj.com/content/320/7250/1635>)
 - But this is subjective – varies
 - These become clinical decisions and the guideline organizations have no business telling people what to do. State the harms and benefits and let individuals have conversation with their doctors
 - Public Health vs. Individual
 - Don't skew information and limit individual choice
 - Physicians should tell patients the facts about screening (including risks and harms) – not influenced by money
 - Guidelines could be divided into risks and benefits by subcategories in population
 - Issue with creating recommendations for the population based on individual
- 4) Discuss implications for cancer screening given the controversies surrounding the benefits and harms of certain screening modalities.
- Media knowledge – how it effects patient decisions
 - Pharma advertising and influence
 - How to make the decision for PSA screening
 - Again – public vs. individual debate
 - Those who can pay will and those who can't won't be able to benefit
 - Is it better to screen more and not have money to follow up or is it better to screen less and follow up – controversy and questions are taking up more money
 - With the ACA are diagnostics covered?
 - Colon only or others as well?
 - Copay?



Conversation 5: Effective Strategies for Cancer Screening in Clinical Practice and Public Health Programs

Facilitator: Elizabeth Westbrook, MCHES

Resource People: Laurie Fenton Ambrose

Jonathan N. Tobin, PhD

Scribe: Maria Byers

What practical actions can your workplace take to ensure the use of effective strategies for cancer screening?

- Partner with community health centers who will get the attention of the consumer
- HMO used personal story about screening in letter to their consumers
- Phone calls to 50+ community to check if they are getting screened “Oh, by the way” calls
- Paid incentives to participants worked for some (drawings for gas cards, groceries, etc.)
- Looking at wellness programs at worksites – someone else can provide incentive
- In CT, state employees get \$ incentives if they follow requirements. If they do not meet requirements their premiums increase
- Work with program to provide free transportation to screening appointments
- Use worksite (peer pressure your colleagues) – wellness competition for 100% participation
- Evaluation of where current practices are and how their programs are running – important to know challenges in advance/identify challenges in advance
- In uninsured populations – patient navigators to provide information, get patients to agree to screening, assist in making appointments, help with transportation needs and follow patients throughout the process
- Partner/collaborate with coalition (hospitals, providers, etc.) working towards same goals. Allow each to do their part
- Collaborative effort of everyone involved in network (influence each other, physician to physician)
- Group evaluation – nurse practitioner bingo style program to deliver message. Each person has to answer questions
- Presentations – collaborating across programs
- Develop software to increase screenings, determine patient needs
- Gather data via pilot programs to figure out why patients are not getting screened
- Community Champion
- Worksite wellness

1) What strategies have you used to increase mandated guidelines driven screening (breast, cervical, colorectal) in clinical practice and public health programs?

- Partner with community centers, conduct interventions with community health systems
 - Outreach, education, screening, leverage support with volunteers, host trainings
- Co-training in community, promote screenings, community health, and testing with diverse community partners

- Used many strategies at HMO – rates for screening are low – used system reminders with limited success. Not talking directly with physicians. Suggestion: communications directly from health worker/centers (incentives, follow-up – biannual incentive), systems change)
- Partnering with physicians, documenting screening/reporting back to physicians
- Everyone is interested in implementing tools, but data is the problem. Suggestions: meaningful use incentive for colorectal screening for 50-75 year olds
- Materials given to front desk/office staff to educate patients
- Toolkit – screening “champion” within health system office. Trained in toolkit. Visits to best practice office to see what works. Visits to less successful offices as well
- Toolkit training (voluntary) in community with overall increase in practices in NJ – listening to their peers about what is/is not working
- Face-to-face relationship based encouragement. Visit with physicians and office managers
- Talking with corporations about importance of prevention/screening. Find one person in the community to help spread the word – someone with wide network/following, celebrity? (Exp: Doug Miller in Utah)
- Media outreach – personal stories are most effective – TV, radio, print, digital personal messages/families ties – show on TVs in physician offices. Campaigns in community
- Specific module/curriculum for specific culture/groups/areas – story telling (relatable)
- In Montgomery County, diverse community education targeted to specific community group. Health promoters trained to educate specific to each group. Great response. Free colonoscopies provided to uninsured w/community health groups as partner

2) How effective have these strategies been with underserved and underinsured populations?

- Screening Days – usually on Saturdays
 - Partner with providers to provide free mammograms, and education about other screenings
 - Physicians donating their time so cost is free to individuals
- Packaging services together/delivered together
- When patients go for one screening, refer them for the other – if effective in getting someone to get one screening, they are more likely to get another
- Referrals/ cross-training – educate patients on the importance of screening, so they go when they are referred
- Confusion regarding guidelines on the part of patients – important to build long-term relationships and enable patients to know what services are available and to help them understand screening guidelines
- If patients participate in annual visits – look at data and base services on behavior – every visit should include prevention
- Data-based approaches/ follow – up
- Educate providers re: what is effecting life of patient

3) What have been the challenges?

- Clinics/offices over taxed, not able to capture/maintain data
- Problem with switching systems (tech)

- Frustrations with getting other federally funded programs on board with programs that are working within same community
- Providers must be aware of what is happening in patients' lives (childcare, transportation)
- Structural barriers – after-hour clinics (available services)
- Private practices do not have access to enabling service funding
- High unemployment rates (uninsured) not getting treatment once diagnosed
- Challenges with following up on colonoscopies
- Health providers may not know what FIT test is
- Minimize communication with providers - prioritize messages
 - Too many messages; not enough time for providers
- Physicians frustrated with patients who have diagnosis but are not following/learning treatment plan
- Need resources to learn about treatment
 - Patients need menu of resources, free education
- Helping people change their behavior
 - Provide direct service providers with training

4) Provide examples of what is working in your work setting.

- Education (health fairs, schools churches) and outreach
- Baseline audits of providers EMRs
- Education based on what resonates with population
- Provide resources/deliverables to identify what their needs are (in systems)
- Education to providers (something patients can be given to change/impact their situations)
- Find trusted people in community- build in all different areas/keep connected with each other
- Networking – linking medical and community
- Toolkits/EMR trainings for better understanding
- Collaborations among organizations doing the same work
- Bundle/package services (flu/fit)
- Learn from what works – messaging, key informants, focus groups to provide feedback
- Improve records – for cancer screening data
- Make information available on patients side (itouch given to patients – they can access their medical records and monitor exercise, etc.)
- Patient navigator that helps patients get through the system
- Collecting data/family history to determine what screenings are a priority
- Leverage funding and referrals - cross navigations to achieve mutual goals
- Relationship building before education. Cultural competence, trust building

Conversation 6: Communicating the Message of Cancer Screening in the Digital Age

Facilitator: Jim Wood

Resource Person: Katie Matusik

Scribe: Ashley Boggs, MA

What practical actions can you take to effectively communicate the message of cancer screening in the digital age (or traditional)?

- Make it funny – YouTube parodies on colon cancer screening or CRC Harlem Shake
- Getting village/community health aides more involved
- Providing guidance on digital media to local affiliates
- Don't always reinvent the wheel
- Get social media experts who know best practices and metrics
- Find support for distribution

1) Which “traditional” and new tools and strategies have you used to communicate screening messages?

- Theater scripts for community
- Posters
- Calendar
- PSAs – with celebrities
- Birthday cards (reminders)
- Bus ads
- Provider signatures – good assessment
- Newspaper ads
- Radio (no way of tracking)
- Billboards
- TV and movie ads
- Film screening
- Text messaging – challenges with consent, good opportunity for low-income minorities
- Facebook – challenges with censorship and access
- Health fairs and state fairs
- Digital tool opportunity for measurement
 - Google analytics
 - Need metrics for sponsors

2) What have been the challenges?

- IT – Facebook access at work
- Measuring reach with traditional media
- Getting people to fill out data
- Community and staff unaware of digital media

- Restricted access
- Perception that digital is only for youth
- Encouraging participation of social media – link traditional with new – give guidance
- Transient communities – tracking people
- Manpower – competing with other priorities
- Using web tools – i.e. Hoopsuite and Buffer
- Procedures and guidelines – have strategic plans
- People only have personal accounts on digital media sites such as Facebook and therefore using it at work – even for work purposes – is considered personal use and must be done out of the office
- Lack of money
- Inter-office politics
- Noise – competing with all that is out there in the social media world

3) How were challenges overcome?

- Mix the media messages
- Thank supporters
- Rebranding social media as a valuable health tool
- Retweet – saves time, builds relationships, and enables sharing of info
- Finding the right people to follow
 - Ask them to participate

4) Provide examples of what is working in the community

- Word of mouth
- Flyers and brochures
- Targeted messages
- Direct people to digital media
- Resource packets – listing a variety of resources
- Giving more choices for how people can receive the message
- Put it online – to track resources

5) How can these “traditional” and new tools and strategies help you communicate your screening messages to underserved populations?

- Use zip codes to track populations
- Culturally appropriate messages
- Translate into other languages
- Faith-based interventions
- Community venues – i.e. barbershops
- Calendar of recipes
- Recipe videos on YouTube
- Email campaigns – interaction
- Low tech meets high tech
 - Use poster to promote Facebook page