How to Get Your Whole Population Screened

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Outline

I. Design a **realistic** screening program

II. Apply capacities of the **medical home model** known to **improve cancer screening**

III. Improve links with facilities and specialists

IV. Identify and apply what is known to improve quality

I. Design a realistic screening program

- Screening modalities
  - Cervical cancer
    - > age 30, cytology q 3 yr OR cytology+HPV q 5 yr (co-testing)
    - Periodicity q 3 or q 5 yrs (if both) (assuming normal)
  - CRC screening
    - One and done colonoscopy (CS)(under-served too)
    - Stool test based (FIT vs FOBT)
    - (Flex sig q 5 years)
    - FIT + CS (high risk or positives)
- Age to start screening: Breast, CRC

Consider

- Risk level
  - Increased risk (family hx, STI's, smoking, weight)
  - High risk? Genetic screening?
- Age to stop screening or individualize
  - Cervical
  - CRC
- Patient preferences
  - Culture
  - Other considerations
  - Example: self breast exam
- Access limitations
  - CRC

Role for Practice Leadership

- Develop a screening policy
- Utilize a protocol
  - Deliver the recommendations to every eligible patient (NB: evidence base is strong)
  - Every patient needs risk assessment and documentation of prior screening
  - Who (exactly) is responsible for what
  - Patient instructions (with teach back)
  - Note cultural, linguistic, literacy appropriateness

Use Reminders, Tracking, Follow-up*

- Evidence for patients and providers is strong
  - Modalities: in person, by phone, by mail
  - Consider reminders Before the visit
  - Remind again if needed
    - 3rd reminder for stool test returns, ? missed mammos
- Track test results and follow up
  - Track all referrals, all screening tests results
  - Reschedule missed referrals
    - Define the crack between the primary care & specialty

* *How to Increase Colorectal Cancer Screening Rates in Practice: An Evidence Based Toolbox and Guide* (nccrt.org/about/provider-education/crc-clinician-guide/)

One Practice Example

- Care team 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

II. Apply Capacities of the Patient Center Medical Home (PCMH)

- Patient Centered Medical Home:
  - According to reports, medical homes are raising screening rates
  - Vulnerable low-income populations (insured) with a medical home achieve higher screening rates than those unaffiliated with a medical home (52 % vs. 44%)*
  - Why?
  - One important reason is that medical homes are the province of primary care clinicians; the role of primary care clinician as champions of screening is critical.

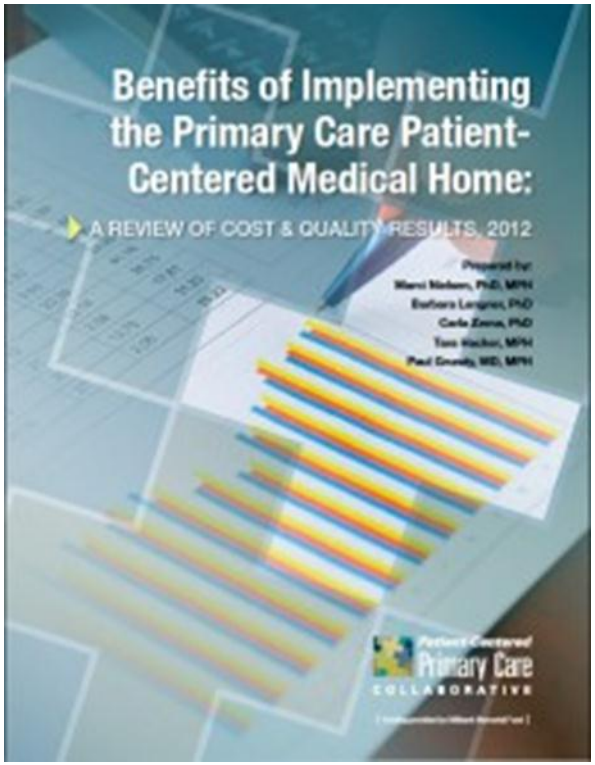
*Berenson, 2012

Primary Care Clinicians: Champions of Prevention

- Most preventive services are administered in the primary care setting:
  - Formerly as part of the "check-up" visit
  - Increasingly on 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 provider of care
  - Place of care too.

Evidence on PCMH & Cancer Screening: (New PCPCC Publication, 2012*)

- Provides nationwide results from 34 recent reports, benefit for:
  - health care costs
  - quality
  - groups burdened with disparities
  - **cancer screening**



* 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 Eligibles	• 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.

- Their goal was to keep patients healthy and in their homes.
- 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.

The Geisinger Health System:

- 74% improvement in preventive care with nurse care managers (*Proven Health Navigator*).
  - EMRs records identify patients who need care
  - Increased access by after hours care, internet scheduling
- Physician incentives to deliver evidence-based care
- Geisinger estimated a ROI of 2 to 1 from PCMH model

Medical Homes & Screening, cont'd

- Community Care of North Carolina (CCNC): statewide medical home, >1 million patients: primary care in 14 community care networks (Medicaid and SCHIP)*.
- Impressive record on prevention (Steiner).
- Improved health outcomes, lower emergency room visits and hospitalizations, increased delivery of preventive services and reduced costs (Ricketts, 2004, Lodh, 2005).

  - * ALSO INCLUDED PHYSICIAN INCENTIVES

What Accounts for Improvement

- Two explanations
  - 1. Payment models that encourage and do not discourage preventive care
  - 2. Capacities of the medical home are selected from evidence as those shown to improve outcomes, including preventive care
- Some capacities are more significant….

Capacities

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

1. Enhance Access and Continuity

- No access no screening
- Approaches
  - Open access scheduling
  - After-hours care
  - Weekend care
  - 24-7 coverage
  - Linguistic/cultural/literacy access
    - WA health center-CRC screening instructions-22 languages
- Continuity builds relationship; sway; ownership
  - Empanelment creates motivation-Who are MY patients?

2. Identify and Manage Populations

- Age, gender, risk status define cancer screening needs:
  - Breast
    - Screening advice (gender),age,risk determined
      - Greater than 20% risk MRI indicated
  - Cervical
    - Varies by age: 21-30, >30, ≥65
    - Varies by risk determined by cytology or cotesting (add HPV)
  - Colorectal
    - Age
    - Risk- personal, family
- **Updated risk status (personal/family history) yearly**

Identify and Manage Populations

- NHIS data shows variation in rates based on:
  - Insurance coverage
  - Education
  - Ethnicity
  - Length of time since immigration to U.S.
  - Language and culture
- Can these things be identified from practice records: age, risk (personal/family), race/ethnicity

Registries, Navigators

- Registries
  - Identify all patients due for screening
  - Allows systematic targeted outreach
  - Reminders/alerts potentiate opportunist contact
- Navigator programs
  - Evidence accumulating-breast and CRC
    - With CRC, even showing that it pays for itself
  - Usually nurses or community health workers
  - Linguistic and cultural matching
  - Training defined
  - Training manuals now available

3. Plan and Manage Care

- Preventive services as well as chronic care
- Evidence based guidelines
- Screening policy
  - Who are we trying to reach?
  - What tests are available to our patients?
  - Support with center-wide teams
    - Standing orders?
  - Measure by center-wide rates
  - Algorithms
  - Protocols

4. Track & Coordinate Care

- Track and follow-up
  - Tests AND Referrals
- Follow-up can be a weak point
  - Positive stool blood tests
  - Cytologies that are not normal
  - Mammograms that need additional films
- All patients deserve a result on their screening
- Unresolved referrals need resolution
  - Better communication with specialty offices (regular reviews?)

Recording Results

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

5. Provide Self Care & Community Resources

- Language, culture, literacy affects outcome
- Patient handouts available (Toolbox&Guide)
- Referral network is community resources

6. Measure/Improve Performance

- Measurement—process improvement—remeasurement
- No other way to see improvement
- CME for clinical staff
- Pay for performance incentives are helping–can provide funding for additional staff for outreach, navigation, etc.

Capicities Mean Better Office Systems

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

III. Improve Links with Facilities, Specialists

- Increasing publications about this.
  - Health Affairs special issue on PCMH 2010
    - SFGH created mechanism for pre-discussion of referrals with specialists
      - Made some unnecessary

IV. Apply Evidence on Improving Quality

- Summary
  - Access, Continuity
  - Policies based on Guidelines
  - Recommendations to Every Patient
  - Reminders for Clinicians and Patients
  - Team based care: Physicians can't do everything
  - Identify & manage populations of patients (outreach)
  - Track and follow-up
- Can this be done?
- Medical homes are doing it

Conclusion

- To move forward successfully with screening for breast, cervical, and colorectal cancer
- Design a **realistic** screening program
- Apply capacities of the **medical home model** known to **improve cancer screening**
- Improve links with facilities and specialists
- Identify and apply what is known to improve quality