Improving Colon Cancer Screening Rates

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Presenters

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This webinar is sponsored by:

• Stratis Health
• American Cancer Society
• Minnesota Community Measurement
• Aligning Forces for Quality Improvement

Objectives

Participants will learn how to:
• Extract data (including baseline) from their electronic health record (EHR)
• Use data to improve colorectal cancer screening rates in their clinic(s)
• Develop a plan to meaningfully use the data for patient care
EVIDENCE BASED INTERVENTIONS

What Works?

Effectiveness of Interventions to Increase Screening for Breast, Cervical, and Colorectal Cancers
Nine Updated Systematic Reviews for the Guide to Community Preventive Services
Susan A. Schembri, MD, MPH; Rachel Hensley, MPH; and Shilpa M. Rana, MD, MPH; Sarah E. B. Mann, MPH; Robert W. McDonald, MD, MPH; Lisa M. B. Nance, MPH; Karen G. McDonald, MD, MPH; and Stephen D. Wise, MD, MPH.

Citation: Schembri SA, Hensley R, Rana SM, Mann SEB, McDonald RW, Nance LM, McDonald KG, Wise SD. Effectiveness of interventions to increase screening for breast, cervical, and colorectal cancers. Nine updated systematic reviews for the Guide to Community Preventive...
Educate and Remind

- One-on-one Education: Sufficient Evidence
- **Client Reminders: Strong evidence**
- Mass Media, Group Education and Client Incentives: Insufficient Evidence

Brochures

They know how to prevent colon cancer – and you can, too.

Take a look inside.
Postcard

Pre or Post Appointment Letter

Letter to Patient at Average Risk

Date

Name
Street
City

Dear [Name]:

Our office has made a commitment to promote the health of its members, and to provide education regarding preventive health measures that you can take to maintain a healthy lifestyle. Our records indicate that you are either overdue for the colorectal cancer screening test, or that you have never had a colorectal cancer screening test.

I am writing to ask you to call our office today to schedule a colorectal cancer screening appointment. By getting colorectal cancer screening tests regularly, colorectal cancer can be found and treated early when the chances for cure are best. Many of these tests can also help prevent the development of colorectal cancer.

The American Cancer Society recommends that average-risk individuals choose one of the following options for colorectal cancer screening. Screening should begin at age 50.
Birthday Message

A world with less cancer is a world with more birthdays.

You have the power to stop colon cancer before it starts. If you are 50 or older you need to get tested for colon cancer.

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Phone Call

FOBT/FIT Follow-up Phone Script for Average-Risk Individuals

Introduction:
Good Morning/Afternoon, May I speak with ____________________________?

[Name] (as received by the patient, the colon cancer screening test) and I am calling from ____________________________.

You recently received a stool blood test for colon cancer screening. Did you have any questions about the test?

We are calling everyone who received one of these to see if there is any way we can help you complete the test.

1. “Have you had the chance to complete and mail your kit?”

If the answer is YES, get the approximate date to ensure that the test will be valid, and get the approximate date of receipt. Thank the participant and let them know that you will send them their results.

If the answer is NO, ask the following question:

Mr./Mrs. ____________, is there any reason why you have not completed your kit?

(Document reason; possible reasons are listed below.)

- Diet and Drug Restrictions
- Test is difficult and disgusting
- Other ____________________________
Be Persistent

- Determine how your practice will notify patients when screening is due
- You may need to remind patients several times before they follow through
- Create a simple tracking system that will help you follow-up as needed

What could you do in the office?

- How could you identify patients who are not up-to-date while they are in your office?
- What could you do to encourage them to schedule a follow-up appointment?
How could you remind clinic staff?

- Behavioral (i.e. reminders, office prompts)
- Cognitive (i.e. Audits)
- “Sociologic” (i.e. better use of nurses)
- Combination of approaches

Build Out Your Office Plan
Measure Results and Discuss

• Make sure you have a plan to review how well your reminders work

• Share these results with office staff to get feedback on what should be continued and what should be discontinued

• Brainstorm new ideas to seek continuous improvement

Web Resources

ACS Colon Materials
www.cancer.org/colonmd

CDC Screen For Life
http://www.cdc.gov/cancer/colorectal/sfl/
DATA ENTRY

EHR Features

- The most important features of an EHR can impose the greatest change:
  - Discrete data collection
  - Point of care charting
  - Clinical decision support (CDS)
Data Capture in EHRs

• Data is captured in EHRs using four methods:
  – Entering data directly, including templates or screens completed by the user
  – Scanning handwritten documents
  – Transcribing text reports created by using dictation or speech recognition
  – Interfacing or feeding data from other information systems such as laboratory systems, radiology systems, blood pressure monitors, or electrocardiographs

Improving Data Entry

• Ensure that data reflects services rendered
  – At check-in ask patient if they have had tests ordered or completed by other providers
• Capture data in appropriate data location
  – Health Maintenance section of EHR = Good
  – Free text in progress note = Not so Good
• Ensure that scanned reports are “filed” or results are entered in discrete data fields
• Perform data clean-up as appropriate
Data Entry Tips

• Consider:
  – Is the information available to providers and staff that will be doing future screening?
  – Is the information available within the EHR to generate reminders?
  – Is the information available to report on overall clinic performance and queries of patients due for screening?
Determine Staff

- Who needs to be involved in report generation?
- Generally…
  - Staff who have reporting background
  - Staff with a good understanding of the EHR system
  - Staff who know where the data resides in the EHR system

Determine Staff (cont.)

- If staff member understands the EHR system but is not skilled in reporting, team the staff member up with a data analyst
  - If a data analyst is not available, working with a third party is an option
- If staff member has the reporting skills but is unfamiliar with the EHR system, work with the reporting staff member on entering data into the EHR to understand the system
Determine the Technology

• What technology is needed to generate the reports?
  – Find out what reporting tools are available with your EHR system
    • Excel
    • Access
    • SQL
    • Crystal reports
  – Use report format that you’re most comfortable with
  – Don’t limit yourself to what is packaged with your EHR system

Analyze the Specifications

• Determine how to identify the EHR data that meets the criteria specified in the denominator and numerator
• Step through each field in the report specifications and document where the data exists on both the appropriate EHR screen and in what table it resides in the database
  – As you step through the specifications, build temporary reports or perform temporary (ad-hoc) queries to analyze the existing data
  – Look for data anomalies or inconsistencies
Generate the Report

• Utilize the data analysis and documentation you took from the specifications
• Build the report
• Document the report process/steps as you go along
• Don’t get hung up trying to pull everything into one report or query
  – Sometimes creating multiple reports and then combining them could be easier
  – Break out complex fields into their own report or temporary table and then bring it all back together once you have all fields accounted for
• Pay close attention to the specifications where certain field values need to be coded appropriately

Test the Results

• Make sure the data is formatted properly as required by the specifications
  – Dates are formatted correctly, codes are properly assigned, etc.
• Test the final results
  – Take a sampling of some records of the report
Utilize the Report Inventory

• A report inventory ensures that all reports currently required can be generated by the EHR
  – Is every report generated actually needed?
  – Would it be more efficient for users to query the system when a report is needed?
• Reports may not be generated from the EHR with precisely the same appearance
  – Will alternative formats be acceptable to those requiring them?
  – Reports should include (and promote) electronic communications

WHAT THIS ALL MEANS
Quality Documentation for Patient Care

- Health information’s primary use is in providing quality patient care
- EHR has the ability to facilitate quality care through the use of accurate documentation
  - The absence of complete and relevant documentation in the EHR makes it impossible to take advantage of CDS
  - If adequate clinical information is not entered into the EHR to satisfy built-in assessments, alerts will trigger more easily and frequently, resulting in “alert fatigue”
- Documentation at the point of care must be of sufficient quality to support healthcare decisions

Data at the Point of Care

- Summary Tool
  - Ensures all the appropriate information is readily available at the time of the encounter
  - Saves time
  - Can be used to provide reminders
  - Facilitates a productive interaction
- Individual Care Planning
  - Provides tools to create and track treatment plans for both clinical and patient self management
  - Ensures that all appropriate care is delivered at the appropriate time
Practice Guidelines and Evidence-based Medicine

• Practical implementation issues
  – Compare practice guidelines already being used with templates developed by vendor
  – Identify practice guidelines currently being offered by specialty societies and health plans. Reach consensus on modifying vendor templates to fit such evidence-based guidance
    • Avoid making too many changes in templates until they have been tried
  – Continuously review templates and guidelines for updating

Public Reporting Measures

• Centers for Medicare and Medicaid Services (CMS)
• Meaningful Use (MU)
• Physicians Quality Reporting System (PQRS)
• Minnesota Community Measurement (MNCM)
SUMMARY

Data Integrity

• Data Entry is as important as Data Extraction and Data Utilization
  (The data pulled is only as good as the data entered)
  – Accuracy
  – Consistency
  – Comprehensiveness
  – Timeliness
  – Accountability

• Educate & Re-Educate Staff
  – Standards of Practice should include Standards for Documentation
  – Educate on how to read/interpret data
Data Use

Goal: People are appropriately screened for CRC

- Develop, Implement, Evaluate an Action Plan
  - Team Approach
    - Make process enjoyable time of working together
  - Be thoughtful, deliberate & reasonable
  - Plan for success!
  - Start with areas of opportunity for improvement
  - Draw on what has worked with other improvement activities
  - Tap into external resources (ACS, Stratis Health, Other Sources)
  - Monitor along the way & adjust as necessary
    - Set threshold & benchmark goals against self and others
    - Acknowledge lessons learned & make adjustments
    - Celebrate successes!
    - Communicate using evidence found in data as a starting point
- Most important........
  
  *Keep your patients & the goal front & center!*

QUESTIONS?
Thank You!

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