

***Dialogue for Action*<sup>TM</sup> on Colorectal Cancer Screening: Today's Progress, Tomorrow's Challenge**  
**Friday Concurrent Conversations**

This report captures the main ideas discussed during six concurrent conversations that took place at the conference on Friday, March 23, 2011, 10:00 – 11:30 AM.

**Conversation 1: Keeping Quality Up and Costs Down: Preparing for Tomorrow's Challenge to Increase CRC Screening Rates**

Facilitator: Catherine Knowles, JD  
Resource Person: Mona Shah, MPH  
Scribe: Stephanie Guiffre

**What practical actions can you take to increase screening rates while keeping quality up and costs in check?**

- Bring the IT and EMR companies to the table; invite them to the Dialogue to discuss how the system needs to change to achieve the goal of increasing screening and reducing costs.
- Medicare will suffer by this flawed system; transform the payment system. As long as payment is tied to visits, we can't accomplish our goal
- Primary care ratio to specialty ratio needs attention because in the new system primary cares won't be able to handle capacity.

1) What tools do you use in your work setting to increase CRC Screening Rates?

- Robust EMRs (Epic)
  - Kaiser's version of add-on to Epic is a registry of those who need screening
  - All care gaps that the patient has are addressed during every visit
  - FIT tests are sent to all those who have not been screened or are due for screening (15-25% return rate)
- Local coalitions across the state (NE) that do FOBT
  - Majority are in rural areas
  - The state pays for the FOBT kit; they then follow up
  - Distribute FOBT kits through a coupon system. Once FOBT is distributed and sent back, a nurse follows up with the patients, if positive, and refers them for further screening (Colonoscopy).
    - There is a nurse on call that can answer questions about how to conduct the FOBT
    - A recall mechanism is also put in place
    - Use radio advertising to get people to get their FOBT kits
- Speakers bureau where nurses go out to work sites to deliver message of screening
- Physician Learning collaboratives to meet quarterly to educate them on the screening guidelines and use this as an assessment tool to judge readiness and screening modalities
- Working with workplace programs to have reminder programs for people 50+
- Small MIYO (Make it your own); Using model programs to build your own program.

- 2) How do these tools affect cost?
  - Get in-kind donations
  - Plug survivors into media
  - No additional cost to run the screening registry because the data system was already in place
- 3) Are these tools helping to get underserved or hard to reach populations screened?
  - A more uniform system could help
  - A clinic at a homeless shelter is distributing FOBT kits
  - Community health centers are helpful in distributing FOBT kits. They are also helpful in educating and spreading the word
  - Redeveloped the ACS toolkit for community health centers
  - Working with health departments and hospitals to decrease the number of people going to ERs as a source of healthcare; redirect patient to a medical home
- 4) Provide examples of current strategies/what is working in your community
  - Workplace wellness programs
  - Creating a coupon program for FOBT (one-on-one discussion) through the pharmacists
  - Ambassador training program (E.g. Training minority volunteers in their church)
  - Educational database
    - Public
    - Trainers and educators
    - Healthcare providers
- 5) Brainstorm of ideas to achieve the goal-what is working
  - Innovative programs that increase screening and primary care and keep people out of ER
  - In rural and city areas they are providing gas cards, transportation and hotel stays to get them to the primary care clinics. This happens through partnerships
  - FIT tests will work much better when people have a medical home (primary care). They will be much easier to track
  - Change doctors' hours to accommodate patients' schedules
  - Provide funding for transportation, decreased no-show rates by 50%
- 6) Discuss implications for cost and quality within the changing health care system and health care reform. How will these implications affect screening rates?
  - Reimbursement rates that are adequate for physicians to take patients
  - Making sure the provider is also adequate
  - Tool kits that guide practices on how to pick the proper EMR system; ones that have a good health maintenance and reminder systems so that we can keep screening rates up
  - EMR and registry should be combined
  - Set up a system that has pre-visit planning so that you make the best use of time with the patient
  - Have the patient fill out information in the system before the visit
  - How do we assist practices to set up this system?
  - Looking at the tool kit and what works
  - Every specialty should have their own EMR that then comes together will all of the patients information. Instead we have a flawed system that doesn't serve the provider's needs

## **Conversation 2: Keeping Quality Up and Costs Down: Preparing for Tomorrow's Challenge to Increase CRC Screening Rates**

Facilitator: Diane Dwyer, MD

Resource Person: David Haggstrom, MD, MAS

Scribe: Dorothy Jean Abernathy

### **What practical actions can you take to increase screening rates while keeping quality up and costs in check?**

- Communication
- Collaboration
- Standard data elements/systems
- Cross communication
- Cloud of information exchange
- Thoughtful of what you do to reach patients
- Capacity issues—keep quality up
- More providers to provide quality service
- Quality standards
- Political Actions
- Extenders
- More representation of insurers

### **1) What tools do you use in your work setting to increase CRC Screening Rates?**

- Media
  - TV, radio, Twitter, social networking
- Websites
  - Pledge cards, brochures
- Health Fairs—Super Colon
- Data-analysis (BRFSS)
  - Feedback to programs
  - Reminders
  - Comparisons to peers
- Offer multiple tests
- Other office staff
- Clinic IT
- In-reach
- Create legislation
- Advocacy
- Navigation—culturally/language appropriate
- Direct/open access
- Bring service to the people

- Have insurer send letter and kits to patients
  - System change—FQHC, insurance providers
  - Private campaigns—Ride for Life
  - Information on how genetic diseases are related to CRC
  - Single fee for all colonoscopy
  - Free colonoscopy
- 2) How do these tools affect cost?
- Single fee decreases cost per person
- 3) Current strategies that are working in your community to get underserved or hard to reach populations screened
- Door to door
  - Utilization and benefits
  - Insurers covering procedure
  - Pay for screening
  - Call list of physicians who take patients with low income/no insurance
- 4) Brainstorm examples of what could work in your community to increase quality and decrease cost
- Expand insurance coverage
  - Increase primary care providers
  - Collaboration between physicians and insurance companies
  - Measuring wait list
  - New test (blood test) with lower costs
    - Cost will come down with wider acceptance
  - Better measurement of the denominator to get rates
  - Numerator—better measurements of who gets a colonoscopy
  - Participating in health information exchange
  - Standard data elements for capturing information
- 5) Discuss implications for cost and quality within the changing health care system and health care reform. How will these implications affect screening rates?
- More Access
  - Basic benefit package

### **Conversation 3: “The Best Screening Test is the One That Gets Done:” Putting the Stool-Based Testing Discussion Between Primary Care Physicians and Patients Back on the Table**

Facilitator: June E. Ryan, MPA

Resource Person: James E. Allison, MD, FACP, AGAF

Scribe: Meghan Keane

#### **What practical actions can you take to insure the visibility of stool-based testing as a screening option and as part of a discussion between primary care physicians and patients?**

- Arrange for FIT to be used
- Double check compliance with annual screening
- Talk to patients about different tests to select best test for individual
- Get more informed
- Find passionate providers to team up with
- Patient navigation
- Connect across states
  - Physician to physician
  - BCBS

#### **1) Discuss current strategies/programs that are working**

- Easy Detect Kit
  - More cost effective
- Getting FOBT patients to follow-up
  - First in a series of potential steps
- More education needed on screening guidelines
  - Take hemo cards out of the exam room
  - GPs need to remind patients about screening needs
  - Partner with healthcare providers to inform patients about health maintenance
- Multi-lingual videos that patients see before they visit so they can be informed → gives a baseline of information
- Need to get medical advisory committee on board with FIT and FOBT
- Rewrite Instructions
- Negotiate (with who?) maybe only pay for returned kits
- Make informational DVDs for physicians
- Get Gastroenterologists on board and have them speak to other doctors
- Policy
- Annual Reminders
- Insurance Companies

- 2) Discuss implications for stool-based testing within the changing health care system and health care reform.
  - Find non-healthcare entities to sponsor/offer stool-based tests
  - Improved and more organized system should leave us in a better place to do annual tests
  - More people will be connected to a health care system
  - New partnerships will need to be created between hospitals, community organizations and private entities.
- 3) What are some challenges?
  - Cultural barriers
  - Unreturned kits
  - Who decides what test to use?
  - Need more education on screening guidelines
  - Increase education—CRC screening is not a one time thing
  - Not everyone sees health care as a right
  - Obtain accurate screening rates

#### **Conversation 4: Today's Progress: Applying What We Know about Language, Health Literacy and Culture in Clinical Care to Increase CRC Screening**

Facilitator: Lina Jandorf, MA

Resource People: Cathy D. Meade, PhD, RN, FAAN and Rena J. Pasick, DrPH

Scribe: Sarah Abou-El-Seoud

##### **Using literacy and cultural tools, what practical actions can you take to increase screening rates in underserved communities?**

- Provider communication (use of tools like the one Dr. Pasick presented)
- Rely on advocacy community—collaboration
- Issue of screening becoming diagnostic
- Not focusing on the “best” test, but on getting people screened
- Groups of trained lay advisors

##### **1) What literacy and cultural tools have you used in your work setting to increase CRC screening rates?**

- Over-the-phone interpretation program
- Interpretation in the community, but not as successful because people prefer talking to people outside of their community (privacy and confidentiality)
- Computer-based health literacy program to help improve print materials
- Teach/describe/define difficult medical terms to make them more understandable
- Translation issues because oftentimes there is not an equivalent word in the language you are translating to, so forced to use the English term
- Literacy tools published over the last few years (TOEFLA); single item literacy tools
  - Do they have a place
  - 2-3 questions you can integrate into assessment forms
- Stressful situations (doctor visit, hospital/emergency room) impacts literacy
  - Timing of intervention is important—during a general wellness visit vs. acute visit
- Oftentimes in phone interaction it is difficult to determine when it is appropriate to discuss literacy issues (determining the literacy level of the patient you are speaking with). Do not want to stop the conversation awkwardly to ask whether he/she needs help understanding the materials
  - Do it first: “I want to make sure I’m giving you information in the best way for you” –give them permission to stop you with questions
- Include images with race and ethnic diversity throughout office and materials
  - Images like these often cost more because not usually common “stock photos”
- Teach back method (provider training to use this with patients)
- Medical librarians are a great resource
- Navigators who have had a colonoscopy can share their personal experiences to help encourage patients and allay fears. They can also answer questions and provide a first hand account

- Culturally target the message—make it personal
  - Flu/FIT model—combining preventive wellness; if people care about one form of preventive health, likely to care about others, too
  - System and organizational view of health literacy—evaluate your environment (signage, translators)
    - E.g.: valet service offered at cancer centers—patients are often unsure if there are costs associated with the service so they do not use it. Also, some patients are not familiar with the service and are afraid because they don't know where their car is going
- 2) Have these tools been effective in reaching underserved populations? Have you seen an increase in screening as a result?
- Harvard has some excellent health literacy materials on their website (include URL here)
  - Use of celebrity role models is effective
    - E.g.: Utah's use of news person known for being active and "outdoorsy" who passed away suddenly from CRC. Gender was really important. He resonated with men because of his love of nature and the outdoors.
    - E.g.: Use of role models who have been screened or who have had cancer
  - Use of multiple channels and customized messaging for a multi-population outreach
  - Diverse staff
  - Testing materials after translation
  - Patient navigator (oral, face-to-face, verbal instruction)
  - Finding the balance between verbal, visual (images) and written
  - Long-term trusting relationships patients have with their primary care provider
- 3) What is your current experience with how health care reform is impacting screening rates in underserved communities?
- NYC has a free colonoscopy program for under and uninsured populations
    - FIT used for statewide program
    - Hospitals involved come up with some extra funding once the state funding has been used up for a given year.
  - FOBT or FIT vs. colonoscopy—use of multiple modalities
  - Maryland—provides money to counties for screening, some also have money for treatment
  - Nebraska—uses FOBT (no fee); state pays for lab processes
  - Alaska—Use to be able to provide FOBT for free, now moved to a sliding fee scale (\$100 w/processing fee); unsure of outcome because a lot of people cannot afford it
- 4) Discuss the implications for program support of language and culture within the changing health care system and health care reform. How will these implications effect screening rates in underserved communities?
- Training aspect
  - A lot of states waiting to see what the Supreme Court decision will be before they do anything
  - Pre-existing condition health plans—coming in w/acute needs (less worry about screening); does the federal government have information about this population? Are screening rates similar to Medicaid population?



- Produce materials in multiple languages to meet the needs of current populations; languages needed may change with the influx of newly insured
- Some states have free breast and cervical screening programs; can this somehow be combined to include CRC screening?
- Have preventive health conversation instead of just CRC alone—present package as a whole part of standard practice of care
- Possible communication issue with understanding what health care reform will mean for individuals and their families
- Insurance will not be free, will still have to pay and barriers will still be a problem. Could the \$295 fine be seen as cheaper?

#### 5) Brainstorm of Ideas to Achieve the Goal

- Ingrate within chronic diseases and other grants—ARRA
- Engage the faith-based community

## Conversation 5: Strengthening Cancer Screening and Awareness Programs

Facilitator: Michelle Tropper, MPH

Resource Person: Sanja Percac-Lima, MD, PhD

Scribe: Kerry McAuliffe

### What practical actions can you take to strengthen screening and awareness programs in your community?

- Structure program that reaches referred patient from GI and self-referred
- Evidence-based strategies to get patient to come to screenings
- Patient—having patient notify provider
- Discussions on national level to discuss local issues—additional conversations, more funding
- Navigator programs do work—before only 42% completion. After 96% complete program
- No competition—sharing resources for outreaching into community—strength in numbers
- Go out into community
- Checklist for process/screening—map out process; policy manual

- 1) Provide examples of screening and awareness programs in your community, including those for underserved and hard-to-reach populations
  - CDC funded CRCPP Program
    - Goal: To increase screening to 80% over age 50 by population strategy
      - Provide 400 free screenings for low income population (underserved)
    - Results: First outreach was through breast and cervical program
      - Less than 1% failed to have adequate prep for screenings and there were no no-shows
      - Strong patient navigation program (Strength)
  - Community: Village based health care professionals (Alaska) engage people; connection through stories to get people to act; told by community health provider (aide)—listening to overcome barriers
  - Family PLZ! Campaign
    - Targets young people based on family history
    - Campaign-in-a-box (online materials)
    - Not specifically targeting the uninsured
  - MD-Komen Grant-volunteer training
  - Office managers: great for outreach to hard-to-reach populations (Strength)
  - Use media to reach underserved (Strength)
  - Community health fairs
    - Screening cards
    - Super Colon (Washington State)
    - Navigator nurses
  - South Carolina Colon program

- Screenings by CDC guidelines
- Partner with free clinics (Strength)
- Community coalitions—grant funded (Strength)
- Community health centers—federally certified, evidence-based strategy

2) Identify what makes the program strong and what current gaps you see. Brainstorm ways to close the gaps.

- Gap 1: How to more easily partner with GIs
  - Capacity problems
  - Fix: Tried a mail campaign to partner with GIs to offer free screenings (they could pay the GIs through funding they had. They sent out 300-400 brochures to GIs and only received 10 responses! Then made personal visits to GIs and their staff. This was much more effective in garnering support for a partnership.)
  - Develop personal relationships with GIs and their office managers
  - Get GIs on medical advisory board
  - Community/program would pay for screenings
- Gap 2: GI will see you if you come; if no-show rate is high, less chance GI will see you over time
  - Ways to have nurse navigators help with no-show rate—enrollment process:
    - o PCP referral form done by telephone, 6-8 calls per patient
    - o If they already have symptoms, don't qualify for free screening
    - o Nurse navigator calls to discuss prep, transportation, where to go, call night before and morning of
- Gap 3: Not knowing what all screening programs in the state are doing—silos—more of the small community programs
  - Fix: Resolve to close gap; take inventory of what is available in state
  - Educate general public on what programs are available (database on progs)
  - Programs for the homeless that will pay for night before in hotel to do prep
  - Partner with breast and cervical programs, family planning
  - CCA Undy 5000 series give portion of proceeds to local community partners in participating states to help fund colon cancer services.
- Gap 4: More integrative care; more of a connection to patient
- Gap 5: Not enough help to make program known (staff resources); when asked for help from program, they are turned away (see also fixes under Gap 3)
- Gap 6: Proper prep can be an issue
- Gap 7: Underinsured—working poor and low middle class
  - What will happen with deductibles in 2014?
- Gap 8: Google “cheap colonoscopy”
  - Less expensive prep that is just as effective as the more expensive brand

3) Discuss implications for strengthening cancer screening and awareness programs within the changing health care system and health care reform.

- Mass General—now being held accountable for all benefits for programs; programs might be able to get more money (i.e. from insurance) since programs will help hospitals help all as required
- Work with insurance companies through changes

- CDC programs—collaborating with issues regarding current system—ensure everyone knows about modifications
- Implementing patient navigator programs
- Discussing barriers; not only about money (e.g. logistics of prep)

**Conversation 6: Strengthening Cancer Screening and Awareness Programs**

Facilitator: Eileen K. Steinberger, MD

Resource Person: Marcus Plescia, MD, MPH

Scribe: Susan Giardina

**What practical actions can you take to help get 80% rates in your program or practice?**

- Include adoption of cancer plan (clinical guidelines in statewide plan)
- Encourage CDC and CMS—CDC to provide guidance and assistance to FQHCs so they are prepared for the increase in Medicaid patients
- Early messaging before 50—in reach programs
- Utilize the worksite for education opportunities
- Continue education—reach out to spouses

**1) Describe the “parts of the buffalo” that you are using**

- Outreach
- Patient Navigators (paid for through CDC grants and for profit)
- FQHC/EMRs to capture data
- Small media-postcards/direct mail
- Advocacy to obtain funding/state and local level
- Using variety of tests, not just one screening method
- Encouraging groups to apply for grants
- Education of providers and lay people/PCP
- Work with employer groups

**2) Brainstorm additional tools and strategies to use to get 80%**

- Provider Education
- Include OB/GYNs
- Development of clinical guidance
- PCP make it easier for them to remind patients of CRC screening and educate office/medical staff
- CDC to work more with CMS
- Patient navigators to help patients who are new to the health care system.

**3) Barriers to Screening**

Insured vs. uninsured—barriers faced by the insured vs. uninsured are different and strategies to increase CRC screening in the two groups will be different. It is important to remember that the insured may face co-pays and deductibles which might make a colonoscopy out-of-reach.

- Problems working with federally qualified health centers-get backed up with uninsured or under insured

- Problems with low screening rates w/Medicaid patients. This will increase as Medicaid rates get higher.
- If more adults come into the insured rolls (as we are hoping they will through increased Medicaid coverage and the Affordable Care Act), the community health centers and FQHC will be enrolling a large number of new patients and possibly be overwhelmed with providing/recommending services for their new patients. This is the basis for the suggestion (below) that CDC work with CMS to help address this potential problem.

4) Brainstorm of Ideas to achieve goal

- CMS to provide incentives for screening
- CDC and HRSA work together on data measures
- Work to decrease no-show rates
- Targeting 65+ population
- More use of social media and technology
- More education of systems
- Start message earlier than 50, so by 50 they are ready to be screened
- Promote multiple screening methods. Identify champions for all screening methods
- Need more data to give to providers
- Use nurses, MAs and other staff

5) Discuss implications for adopting new tools and strategies for CRC screening within the changing health care system and health care reform.

- Electronic medical records provide “pop up” reminders
- Collaborate with Medicaid
- Will have Medicaid patients and will need to work with more FQHCs
- Collaborate with other cancer groups when asking for funding
- Need to work towards quality guidelines
- Make sure managed care organizations are included in education
- Major call to Actions to get FQHC ready for increase in Medicaid population; they must be ready to serve this population
- Private sector needs to promote other methods –get the public asking for it.
- How do we draw attention to other screening methods?
- Patient assessment
- Work with providers to help them to understand other options—help them put systems in place
- Follow up
- Use data in professional literature so that the policy can be changed to include multiple methods