Improving Colon and Breast Cancer Screening Rates: A Public Health Improvement Initiative

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September 25, 2017
“80% by 2018”
Goals of the Initiative

1. Increase the percentage of people aged 50-75 eligible for colorectal cancer screening who have been adequately screened to >65% by December 2016 as defined by National Quality Forum measure #0034.

2. Increase the percentage of women aged 50-74 eligible for breast cancer screening who have received mammograms to >65% by December 2016 as defined by National Quality Forum measure #2372.
Then 80% by 2017!
Funding From

BlueCross BlueShield Nebraska
An independent licensee of the Blue Cross and Blue Shield Association

CHI Health
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COPIC
Better Medicine • Better Lives

Nebraska Medical Association
Advocating for Physicians and the Health of all Nebraskans
2014 Medicare Shared Savings Program ACOs

% of Patients Receiving Colorectal Cancer Screening (ACO 19)

Number of MSSP ACOs

% of Patients Receiving Colorectal Cancer Screening

Bob Rauner MD MPH

N=334, Average 56.2%
Practice Heterogeneity Challenge

- Practice Sizes from 1 to 11 providers.
- Independent, Employed, FQHC, Residency Program
- Family Medicine, Internal Medicine, OB/GYN
- 8+ EHRs (3 clinics changed EHRs during project)
- 49,000+ Patients
Nebraska Colorectal Cancer Screening Rates by Public Health District

Medicare Claims Data (Age 50-75): 3Q2015 through 2Q2016

*Screening tests included: Colonoscopy, Sigmoidoscopy, FOBT, Barium Enema

- Lowest Group
- 2nd Group
- Middle Group: State Rate – 44.4%
- 4th Group: Highest Group

Analysis provided Great Plains Quality Innovation Network • December 2016
Motivating Physicians: Cowboys & Herding Cats
What Kind of an Idiot Tries to Herd Cats?
Motivating Practices/Physicians

“Multiple Hooks” Approach

1. It’s best for our patients
2. It aligns with multiple payers (e.g., MSSP, BCBS, UDS/HRSA).
3. CME and Part IV Maintenance of Board Certification
4. Something good to compete on (style points, professional satisfaction)
5. It’s best for our community.
DMAIC – Six Sigma

Communicate
POINT/COUNTERPOINT

Point: How Quality Reporting Made Me a Better Doctor

David R. Scrase, MD
Internal Medicine and Geriatrics, The University of New Mexico Medical School,

Figure 1. Model to improve quality of patient care.

Step 1: Agree on the standard of care

Step 2: Collect and provide initial reporting of the data

Step 3: Argue about the data

Step 4: Improve the data

Step 5: Provide actionable data

Step 6: Improve care and outcomes
COLORECTAL CANCER SCREENING - ROUND 3 DATA
Initial Planning Worksheet

Clinic Name: ___________________________ Date: ___________________________

1) We aim to increase the percentage of patients aged 50-75 who have recommended colorectal cancer screening from ____% (numerator_____ / denominator_____ ) to _____% by Nov 15, 2017. (NQF 0034)

2) We will increase the percentage of patients aged 50-74 who have recommended breast cancer screening from ____% (numerator_____ / denominator_____ ) to _____% by Nov 15, 2017. (NQF 2372)

Describe our change:

<table>
<thead>
<tr>
<th>What process issue(s) did we identify?</th>
<th>What are our proposed solution(s) for improvement?</th>
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What is our action plan for carrying out your proposed solution?

<table>
<thead>
<tr>
<th>What needs to be done?</th>
<th>Who will do it?</th>
<th>By when?</th>
<th>Completed?</th>
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Possible Interventions

1. Team Huddles
2. Provider Feedback
3. Standing Orders
4. Involving Community Health Workers
5. Reminder Systems (EHR alerts, patient reminders)
6. Health Promotion or Marketing
7. Working With Other Agencies (e.g., Ethnic Community Center)
Smart Draw

Colonoscopy - Patient over 50 years of age
(Clinical Alert Note will prompt all team members to mention colon cancer screening to patient)

Exception Report
- Report generated quarterly by IT
- Report who have not had FOBT past year, Yes
- Sigmoidoscopy past 5 years, Colonoscopy past 10 years

Point of Care
- Provider
- Clinical Staff
- Front Office

Patient Initiated Contact/Recall
- Did patient receive letter about colon cancer screening
  - Yes
    - Refer to send letter and educational material
    - Any questions
      - Yes: Defer to send letter and educational material
      - No
  - No

Colonoscopy/Endoscopy to patient above 50 years of age
- Ask if patient received brochure
  - Yes
    - Provide brochure if missed
  - No
    - Ask if any questions
      - Yes: Schedule endoscopy
        - Add patient to recall
      - No: Answer questions or defer to provider

If patient requests:
- Defer to clinical staff or schedule appointment with provider
- Which option would patient prefer for screening
Mammogram

- Goal: 65
- Clinic: 54

Amy: 61 → 64
Dr. B: 62 → 68
Mindy: 50 → 58
Tara: 53 → 51
Heidi: 43 → 53
Tess: 0 → 0

Colonscopy

- Goal: 65
- Clinic: 55

Amy: 57 → 60
Dr. B: 71 → 53
Mindy: 50 → 51
Tara: 31 → 41
Heidi: 29 → 32
Tess: 0 → 0

At each visit:

Check health maintenance.
If RED check face sheet. If patient marked then put date or approximate date in health maintenance. If marked NO then order the test.
Colorectal Cancer Screening
Patients 50-75 with a documented colorectal cancer screening

- Provider A: 29.7% (101/340)
- Provider B: 57.1% (605/1060)
- Provider C: 65.8% (480/730)
- Provider D: 51.9% (467/899)
- Provider E: 9.1% (91/1005)
- Provider F: 53.0% (371/700)
- Provider G: 63.5% (724/1140)
- Clinic Total: 48.3% (2839/5874)

70th Percentile: 61%
90th Percentile: 67%
Best Practices
Standardized Processes
Data Availability
Role Differentiation

Key Lessons
Teamwork
The importance of data
“For me it was very shocking to see the numbers and important to realize how much improvement was needed to be done. I feel very confident now to make those changes in our team.”
“All providers were involved in this initiative, so from the get-go the entire practice was involved. But more that just colonoscopy, we also were able to get data on DEXA, immunizations, mammography etc. so were able to involve these other screenings even though our task was colonoscopy.”
“This process allowed us to critically look at strategies to improve care. Some were successful and some were not and we learned about the best methods that were efficient and cost effective.”
“Small relatively easy changes can significantly affect patient care.”
“I feel like we can continue to succeed in being leaders of the community and leading our patients to quality healthcare.”
92% of physicians would do this process again.
Lessons Learned

1. Physician leadership is key
   1. Lead Physicians need to be present and involved
   2. Lead physicians need to delegate appropriately
2. Measure, but keep it simple
3. The whole team needs to be involved – physicians, office manager, care coordinator, nurses, front desk, back office
4. The team needs planning time – weekly meetings for small team, monthly for staff/physician meetings
“If you want to build an organization that is fearful, angry, cynical, and full of resistance to change, dump in data without explanation and start ranking and spanking.”

Thom Walsh, Ph.D.
Staffing for Quality Improvement

Adapted from: “How Physicians Can Fix Health Care: One Innovation at a Time”, by Chris Trimble
Slack Time

Part Time: Lead Physician

Full Time: Care Coordinators

Ongoing Operations

Fraction of Time vs. People

Staffing For Quality Improvement
Next Steps

• Middle of Year 2 – Nebraska Physicians Cancer Screening Initiative
• Expansion to all Nebraska FQHCs
• Middle of Year 1 Lincoln Community HPV Vaccination Initiative
• Diabetes Initiative for 2018?
  • Lines up with diabetes measures for MSSP, BCBS, CPC+, UDS/HRSA
  • Biggest cost bucket for ACOs & Employers