Dialogue for Action
Prevent Cancer Foundation

Dialogue for Action on Colorectal Cancer Screening **Prevention Now for a Healthier Tomorrow**
Thursday Concurrent Conversations

This report captures the main ideas of the six concurrent conversations that took place at the conference on Thursday, March 24, 2011, 3:30-4:40 PM.

Conversation 1A: Utilizing Electronic Health Records for the Promotion of Screening

Facilitator: Jasmine Greenamyer, MPH
Resource Person: Donald Nease, MD
Scribe: Meriam Driss

1) As a health care professional or as a patient, what is your experience with EHRs as part of medical care?
   - Very efficiently capture what doctors and other medical staff are doing with patients
   - iPad—doctors quickly grabbing onto new technology
   - Using some EHRs are problematic at point of care
   - EHR = all encompassing
   - EMR = electronic medical record
     - Basic
     - Meds
     - Progress notes

2) What have been the challenges?
   - New technologies
   - "Kicking and screaming"
     - Having to pull people into embracing new technology, unwillingness
   - Public health data—meaningful use?
   - Consistency of definitions
   - Half information
     - Silo effect- e.g. in different division of a hospital people were using different databases
     - With patient records some departments were adding fields that other departments were not adding
     - Strive for good information in, good information out
   - Just because you build it doesn't mean they'll use it
     - Incentives for using
     - Training needs
   - What do you need? Workflow
     - Software decisions not taking into account those on the ground
   - Checks not fully received
   - Public health—don't really need EHRs

- How to use for cancer screening
- Fear of change
- Bad ingrained doc training
- Have to rely on previous docs to click

3) What have been the successes?
   - VA system really worked (EHR) and outside of VA system can also be scanned in
   - Reduced medical errors
   - Need system-wide adoption
   - Comprehensive systems:
     - Labs
     - Pathology
   - Info portable
   - Common format for patient records (write in 1 of 2 standards, but read out in both)
   - Must provide to patient electronically—can transport to new doctor
   - Legible record
   - Logistics = no paper charts
   - Instantaneous
   - After hours access

4) What practical actions can you take to ensure the success of medical homes and health care reform.
   - Guidance on how to choose system
     - What will be used?
     - What do we want to get out?
     - Custom building—work with vendor to change/build-ons (extremely expensive)
     - Avoid planned obsolescence
   - Training/phase-in/timing
   - Multi-disciplinary team
   - Those using involved in choosing
   - EMR navigators
   - Get creative
   - Dialogue among those using EHRs and those interested in using them
   - Clearing-house for best practices
   - National conversation on findings funded through various groups coordinating federal grants
   - Chronic disease model
     - If sending letter as a reminder for one thing—see what else patient needs
     - Piggyback prevention part

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Conversation 1B: Medical Homes Now and Implications for the Future Practice

Facilitator: Diane Dwyer, MD
Resource People: Richard Wender, MD
Joseph Mambu, MD
Scribe: Meghan Keane

1) Facilitate and open discussion on medical homes and the impact of preventive services and primary care
   - Definition: optimal performing primary care
   - Enhanced access
   - Engaged, coordinated care
   - Patient-oriented
   - Physician leading a staff (team)
   - No medical home pilot dedicated to cancer
     - Mostly dedicated to heart disease and diabetes

2) Have you worked in a medical home setting or have you been a patient with a medical home?
   - Comprehensive medical group
     - Team always available
     - Knows your medical background

3) What have been the challenges?
   - Facilitating a successful, cohesive team
   - Providing a neutral forum
   - Thinking in terms of "team"
   - Hospitals use incentives to get more patients into medical homes
   - Cost
     - Need a 30-40% increase in revenue
     - Need outside sources to fund pilots
   - EMR accuracy
   - Health reform is moving faster than medical homes can be established

4) What have been the successes?
   - Satisfaction in better patient care
   - Smaller burn-out rate for doctors in medical homes
   - Prevention is cost-effective in the long run
   - Best possible care

5) Discuss implications for medical homes within the changing health care system and health care reform.
   - Long-term reduction in medical costs
   - Cost-effective

    - Decrease hospitalization and ER visits
    - Increase outpatient management
- Need for more primary care medics—fast to implement health care reform and increase patient load
    - Infrastructure to do this
    - Outside entities to provide training to patient navigators (partnership)
- Medical schools and residency programs need to grow
- Need to improve transitions

6) What practical actions can you take to ensure the success of medical homes and their role in the delivery of preventive services?

- Work with more nurse practitioners, physician assistants and doctors
- Other medical industries will need to get paid less
- Need to form partnerships among different fields
    - Insurance companies would be a good place to start (not with the doctors)
    - Insurance companies—pay for performance—drive measurement with incentive pay
- Funding for public health and the collaboration between public health and medical homes

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Conversation 1C: Ensuring the Success of Community Health Centers (CHC) in 2014 and Beyond

Facilitator: Patricia Bonifer-Tiedt
Resource People: Jim Hotz, MD
Denise Ballard, MEd
Scribe: Sarah Abou-El-Seoud

1) Facilitate an open discussion on participants' experiences with community health centers and the impact on preventive services and primary care.
    - CHCs are part of large practices (45+ doctors) and smaller practices
    - Part of coalitions working with community health centers
    - Community outreach
    - Federally Qualified Health Center—contract to different CHCs
    - Individuals with roles in state-level health departments—working with local CHCs (for example one individual works in the policy and advocacy department and is working on outreach grants that connect with community health centers)

2) What have been the challenges?
    - Specialists know very little about CRC screening
    - Going back to case managers versus the doctors
    - Insurance-If a patient has a positive Fecal Immunochemical Test (FIT) it become diagnostic and is therefore not funded anymore. It is really hard to find alternate sources of funding for follow-up testing/procedures.
    - CRC screening is not a required reportable item according to Health Resources and Services Administration (HRSA). There are several other things that are required to be reported on; if there is a push, CRC screening as a requirement is possible.
    - Turnover rate of providers and staff
    - Reaching patients-especially males (most CHC patients who come in tend to be females) and the uninsured
    - People do not know what colorectal cancer is; they've never seen the blue star (unaware)
    - Physicians are busy and distracted by other problems patients have. CRC needs to become a priority within CHCs.

3) How were the challenges overcome?
    - Increase awareness through announcements in public places such as on buses
    - Conversation/open dialogue with specialists to increase knowledge
    - Use of cancer registries
    - Assign a long-term staff member to the sites to continually educate new staff (there was a lot of instability within the centers, so there needed to be a stable staffer who was responsible for CRC awareness)
    - Funding affordable tools (FIT test-example from California)

- Negotiate with stable executive director when possible
- Work with local hospitals at public events like health fairs
- Make phone calls to men who had abnormal screenings to set up appointments. Did this through "coaches" in the community; individuals developed relationships with their "coach."

4) What have been the successes?
   - Teaming up with hospitals, health fairs, barber shops and churches
   - Outreach (get the word out in public places)
   - 1-800 service that directs you to closest location to get screened
   - Coaching program
     - Contacting/following up with patients with abnormal tests to ensure additional testing and treatment (when needed)

5) Discuss implications for community health centers within the changing health care system and health care reform.
   - If we now have funding, what do we need to increase CRC screening?
     - Patient navigator programs
       - Infrastructure to do this
       - Outside entities to provide training to patient navigators (partnership)
   - Issues with capacity (even with health reform)
     - Not enough doctors and with colonoscopies; there are not enough specialists
   - With diagnostics people are still not covered
     - We want people to get screened, but what about when the screen is positive?
   - We need to stay on top of new legislation and make noise about where the gaps are!

6) What practical actions can you take to ensure the success of community health centers?
   - Get CRC screening to be a required reporting topic for HRSA and National Association of Community Health Centers
     - NACHC quality center
     - Make noise
     - (ACS, CDC) Use the association (NACHC) as a catalyst
       - Handouts/information at all conferences and get it out to health centers (Blue star as a start)
   - Ensure the 1-800 numbers have all CHCs included/listed on the information given out on the call
   - Adopt a CRC screening collaborative
     - Getting different silos in public health together for CRC screening as a priority
   - Push for Granger bill

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Conversation 1D: Strengthening Relationships Between Primary Care Providers and Medical Specialists

Facilitator: Erica Childs Warner, MPH
Resource People: Timothy Munzing, MD
Edward J. "Joe" Eyring, II, MD
Scribe: Stephanie Guiffré

1) Facilitate an open discussion on the relationships between primary care providers and medical specialists and the impact on preventive services.
    - Medical Specialists: Endocrinologist, radiologist, etc.
    - Primary Care Physicians: Internist, Family doctor, OB/GYN

2) If you are not a health care provider, what has been your experience with regard to the relationships between primary care providers and medical specialists?
    - Teams: nurses, patients, doctors (many doctors serve as specialists even if they are in primary care given their area of concentration. Quality is most important).
    - Kaiser System: Electronic records that are linked between primary care doctors and sub-specialist makes it easy to access information.
    - Information going from a specialist to a primary care can be difficult unless the two are in the same system and the systems talk to one another.
        - EHRs are the key to communication.
        - Need to take the time to review records (re: where the patient has been and what he/she saw a specialist for).

3) In your experience, what steps have been taken to strengthen these relationships?
    - Kaiser System: Electronic records that are linked between primary care doctors and sub-specialist make it easy to access information.

4) What are the challenges?
    - Moving from one state to another made it difficult to transfer information to a new PCP (8 year cancer survivor). Her oncologist needed to communicate proper information to new PCP
    - Recognize the waste in our current system before we can improve the system
    - Cultural differences in specialties create unnecessary attitudinal barriers
    - Competitive barriers
    - Incompatibility of the EHRs; how do we bridge the gap if the systems don't speak to each other
    - Situation change (behavior dynamics)
    - Sifting through the amount of information in the health record
    - The amount of time that you have to wait to be seen (challenge for the Indian Health Service)

5) What are some of the success stories related to strengthening relationships and the promotion of screening?

- American Congress of Obstetricians and Gynecologists (Consultation document)
- Letter from state level to section level chairs that reminds them of screening guidelines and when it is appropriate to refer a patient to a specialist for screening
- Integrated system that captures information about what the patient needs and it red flags screenings that are needed.

6) Discuss implications for the relationships between primary care providers and medical specialists within the changing health care system and health care reform.
    - Health Information Technology Act and Affordable Care Act
        - Need to understand the terminology
        - Take things that work and use them as models for care

7) What practical actions can you take to ensure that the relationships between primary care providers and medical specialists are strengthened?

- Direct booking (eliminates steps)
- Co-develop education materials (specialists and primary care groups sit down and decide how the materials should be created and what they should say)
- Improving the connection between specialist and PCP
- Develop a system that keeps the patient at the center (focus on evidence-based medicine)
- Don't rely just on the written communication, but make a direct call to the specialist and vice versa
- Standardize communication
- If the PCP doesn't get what he/she wants from specialist, stop referring patients to that specialist

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Conversation 1E: Ready, Set, Go: Nursing Professionals and New Ways to Deliver Preventive Services

Facilitator: Lina Jandorf, MA
Resource Person: Marilyn Schaffner, PhD, RN, GCRN
Scribe: Susan Giardina

1) How are nursing professionals being utilized to deliver preventive services?
    - Health coaches (Iowa/Nebraska)
    - Parish nursing
    - Nursing case managers
    - Nurse educators
    - Nurse navigators
    - Nurse endoscopists

2) What challenges has the nursing profession faced with regard to the delivery of preventive services and primary care?
    - Money for implementation
    - Nurses need to become more business focused
    - Need for greater training of nurses and managers in leadership roles
    - Acceptance and payment/malpractice of nurse endoscopists
    - Bundle preventive services
    - Develop collaborative quality nursing services
    - Development of research protocols

3) What solutions have been used to address the challenges?
    - Need for collaboration w/American Gastroenterological Association (AGA), American Society for Gastrointestinal Endoscopy (ASGE) and Society of Gastroenterology Nurses and Associates (SGNA) at national level
    - Major nursing and local orgs need to develop a business model of preventive services
    - Understand value of CTP codes
    - Role for doctor of nursing practice DNP in preventable care
    - Develop power nurse lobby; state and especially federal lobby

4) What are some of the success stories?
    - Pay for performance
        - Developing evidence-based research (published)
        - Physicians actively seeking collaboration with nurses organizations (being asked to join the table)

5) Discuss implications for nursing professionals in the delivery of preventive services and primary care within the changing health care system and health care reform.
    - Broader models of care
    - Nursing shortage

6) What practical actions can you take to ensure the success of medical homes and their role in the delivery of preventive services and primary care?
    - Broader model of care
    - Emergency management
    - Clearer definition of patient navigation for all preventive services
    - Strategic plan for the delivery of preventive services by nurse professionals including definition of preventive services (IOM report)
    - Raising awareness of nursing shortage
    - Educating legislature about nursing shortage

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Conversation 1F: Primary Care at the Community Level: Evidence-Based Practices

Facilitator: Michelle Tropper, MPH
Resource Person: Mona Sarfaty, MD
Scribe: Suzette Smith

1) Facilitate an open discussion on the adoption of evidence-based practices within primary care and the impact on preventive services.
    - Most doctors feel they DO use evidence-based practice, but there is much variability in *what* is evidence-based.
    - Different ideas about what CRC screening is appropriate.
    - Combo of researcher, MD and patient, the combination becomes very complex
    - Examples of Evidence-based practices
        - Positive impact of MD recommendations
        - Community Guide — is a good resource
        - Patient Reminders
        - Small media — i.e. brochures

2) In your experience how have evidence-based practices been utilized in primary care at the community level?
    - FOBT cannot be used in Alaska— not accurate; usually use flex sig because it's transportable; sometimes colonoscopy in Anchorage.
    - Kaiser has good system — "bright spot"

3) What have been the challenges?
    - Reminder systems require organization and many resources
    - Limited funds and resources hard to integrate into other systems such as breast/cervical screening
    - Charts do not contain all information needed "in one place"—hard to know who is up to date
    - No system or poor system for uninsured or undocumented
    - Limited time—hard for doctors to find/take time to care and to discuss
    - Rural areas—getting patients where they need to be

4) What have been the successes?
    - Small media—low hanging fruit
    - Reminders—in some areas this is successful
        - Flagging charts = possibility
    - Lower barriers
        - Relationships with doctors
        - Speak their language
        - Night clinics
        - Hospital close by

5) Discuss implications for adopting evidence-based practices in primary care at the community level within the changing health care system.
    - Success will depend on education
        - Work with public need
        - Communication will be needed, especially rural communities, to understand health care reform
    - Different implications for different areas and needs—what works for one does not work for another

6) What practical actions can you take to ensure that evidence-based practices are implemented in primary care at the community level?
    - Continue to advocate for EMRs that work
        - Including accommodating small practices
        - Ensure that prevention is built in
    - Engage with other community orgs to reach goals with EMRs
        - Build partnerships.
        - "Strength in numbers"
    - Work with cancer coalitions to mobilize community
    - Small media use to educate and communicate health care reform
    - Website to education and communicate health care reform
    - Keep a whole perspective—give info on exercise, diet, stress, sleep—don't just talk CRC screening
    - Providers to hire a health educator
    - Recruit, visit, recall
    - Empowering communities for life
    - Ask your coalition to apply evidence to community
    - Patient navigators becoming more powerful force—and then give power to patients
    - Doctors need to "own it"
    - Evaluate/modify implementations
    - Re-evaluate "colonoscopy only" i.e., California is unable to provide for all
    - There are other screening methods on landscape