

Cancer Screening in Primary Care: Lessons from Community Health Centers

Dialogue for Action

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Health Center Mission

Improve the health of the Nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services



What is a “Community Health Center”?

Local, non-profit, community-owned health care providers serving low income and medically underserved communities.

Characteristics of federally funded centers:

- Funded through grants from the Health Resources and Services Administration (HRSA)
- Located in medically underserved area or serve a medically underserved population
- Governed by a community board
- Provide comprehensive primary health care
 - Primary & Preventive Care
 - Culturally and linguistically competent care
 - Enabling Services (translation, transportation,...)
- Provide services available to all with fees adjusted based on ability to pay (“sliding scale”).

What is a “Community Health Center”?

Health Center characteristics (continued):

- Meet other performance and accountability requirements regarding administrative, clinical, and financial operations
- Often provide on-site dental, pharmaceutical, and mental health and substance abuse services
- Report quality data to HRSA annually using measures defined in the Uniform Data System (UDS)
- Synonyms: Federally Qualified Health Center (FQHC), Community Health Center (CHC), Section 330 Health Center



Health Center Statistics

In 2016:

- 1,400 health center organizations
- 10,400 sites
 - every U.S. state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin
- Nearly 26 million patients served
 - 1 in 12 people nationwide rely on a health center for their preventive and primary health care needs
 - 1 in 10 children
 - 1 in 3 people living in poverty
- More than two-thirds of health centers are recognized as Patient Centered Medical Homes (PCMH)



Challenges faced by many CHC patients

Patient-related:

- Financial barriers (esp. lack of insurance)
- Access issues – lack of transportation, ability to take time off work
- Poor health literacy
- Fear/Distrust of medical system
- Cultural issues
- Language barriers
- High no-show rate for appointments, tests

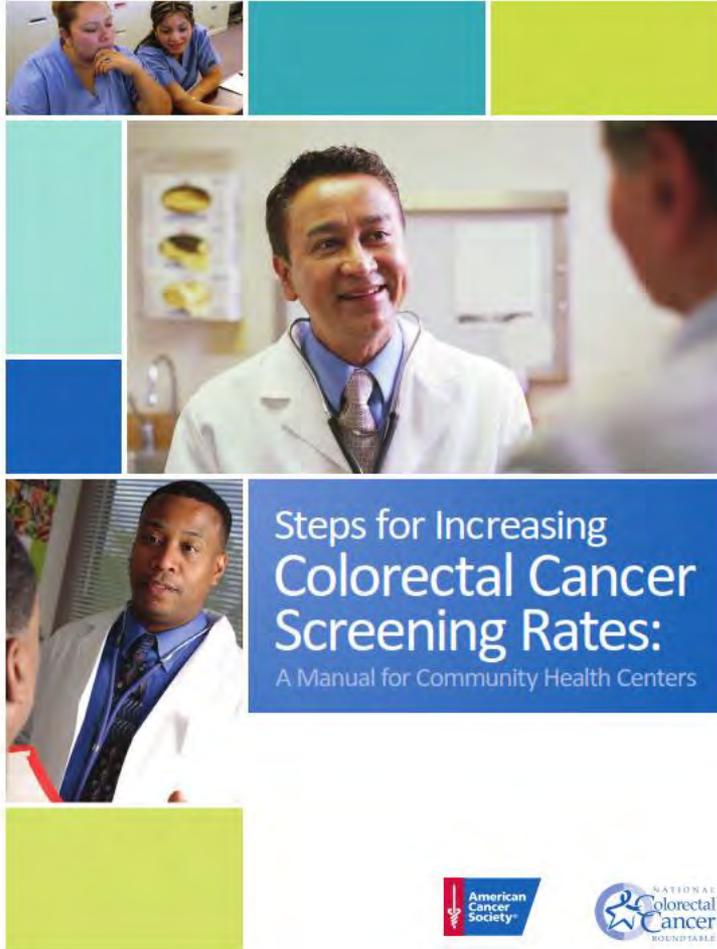


Challenges faced by many CHC patients

Systems-related:

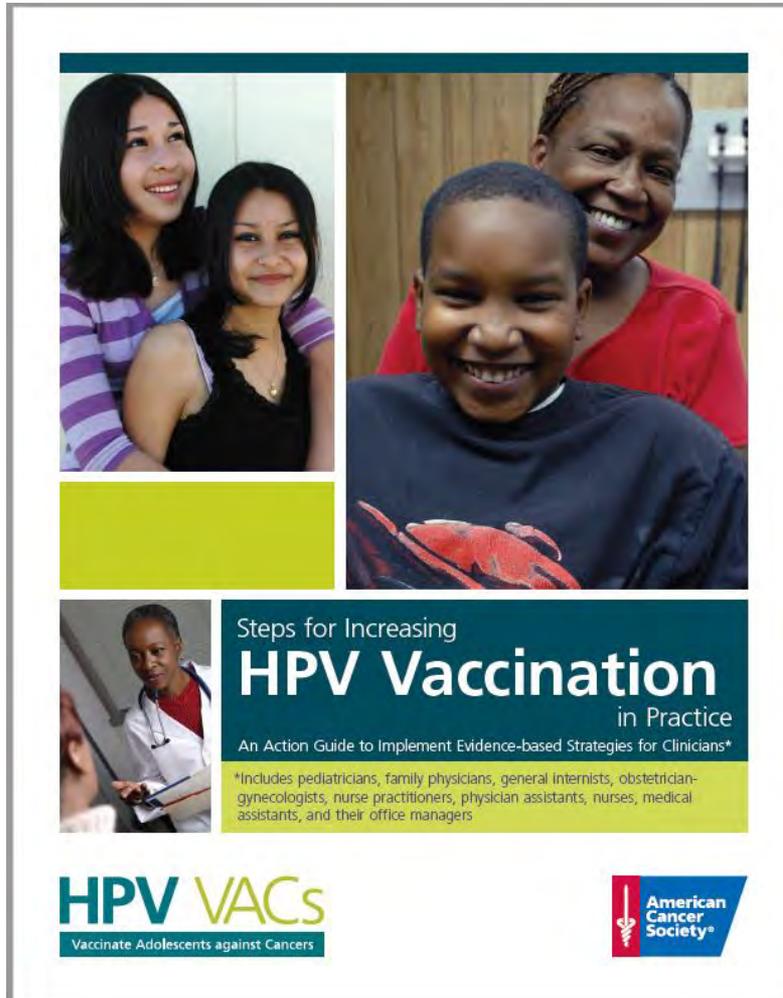
- Costs along the entire care spectrum (e.g. fees for imaging, pathology, anesthesia, hospital/facilities, ...)
- Cost of follow-up treatment if needed
- Indirect costs of screening (time off work, post-treatment care, etc.)
- Lack of structures and processes in specialty practices and referral facilities to address patient barriers

CRC “Steps” Manual



- Step-by-step instructions to help primary care practices implement team-based, systematic processes to increase CRC screening.
- Developed with input from NACHC, HRSA, CDC and CHC clinicians and staff
- Most information relevant to wide range of primary care practices (not just CHCs), and to screening and follow-up of other cancer types

HPV “Steps” Manual



- Provides step-by-step instructions to help primary care implement team-based, systematic processes to increase HPV vaccination.
- Many concepts and techniques similar to those described in the CRC manual.

Step #1: Baseline Data

Guidance on how to determine accurate baseline screening rate



Cancer-related Health Center Data

What about UDS Quality Measures?

Childhood Immunization Status	Cervical Cancer Screening	Tobacco Use Screening and Cessation Intervention	Use of Appropriate Asthma Medications
Screening for Clinical Depression and Follow-up	Controlling High Blood Pressure	Early Entry to Prenatal Care	Diabetes: HbA1c > 9%
Weight Assessment and Counseling for Children and Adolescents	Low Birth Weight	Body Mass Index Screening and Follow-up Plan for Adults	Ischemic Vascular Disease: Use of ASA or Another Antiplatelet
Colorectal Cancer Screening	Dental Sealants for children aged 6-9	HIV Linkage to Care	CAD and Lipid Therapy

Determining Screening Rates

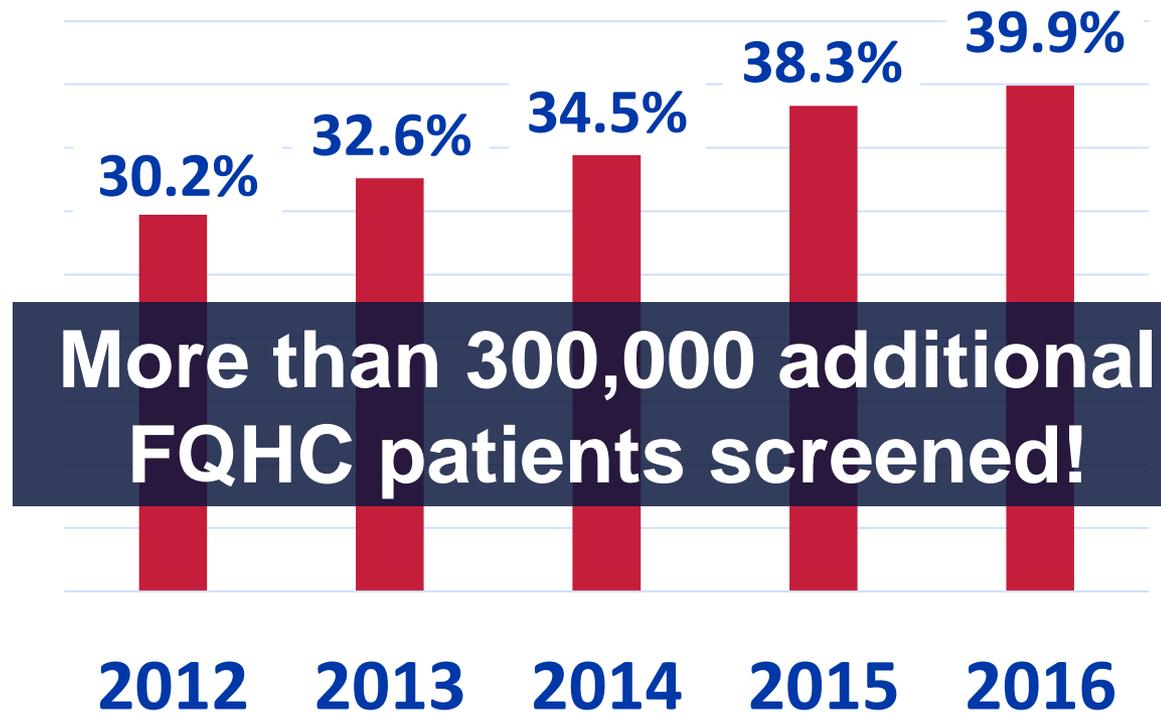
- Identify correct patient populations required to calculate a colorectal cancer screening rate
- Identify the numerator and denominator for your baseline screening rate using [Health Resources and Services Administration \(HRSA\) Recommendations](#)
 - Denominator
 - Patients 50-75 years of age with a visit during the measurement period
 - Numerator
 - Patients with one or more screenings for CRC, defined by any one of the following:
 - Fecal occult blood test (FOBT) during the measurement period (MP)
 - Flexible sigmoidoscopy during MP or the four years prior
 - Colonoscopy during MP or the nine years prior
 - **FIT-DNA during MP or the two years prior**
 - **CT Colonography during MP or the four years prior**

New in 2018

FQHC Screening Rates Are Rising

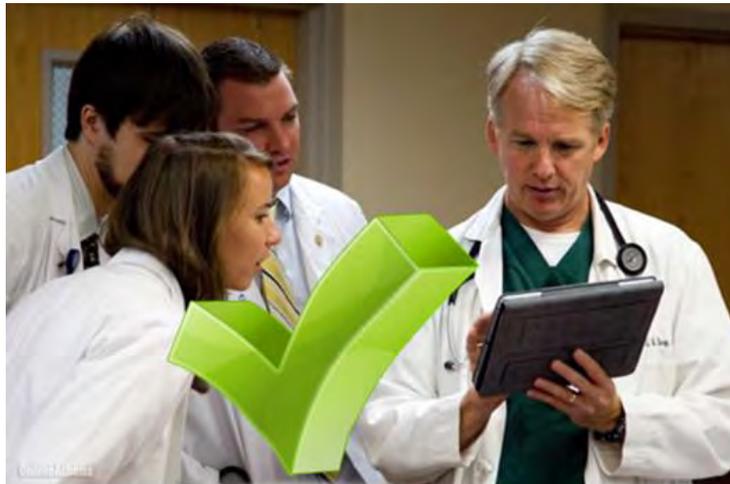
CRC Screening Rate

*ALL FQHCs
(UDS)*



Step #2: Create a Team

- Engage staff at multiple levels with focus on quality and process improvement
- Identify champions who can ingrain new processes into practice
- Integrate screening navigation





Patient Navigation

Navigator models may include:

- Outreach
- Assistance with scheduling lung CT
- Appointment reminders
- Track screening completion
- Ensure that screening results reach PCP and are entered into medical record
- Monitor follow up of abnormal findings

CRC Screening Navigation – Rural GA

Screening Navigation

Intervention patients were:

- 4 times more likely to be up to date with CRC screening (43% vs 11%)

Original Article

Evaluation of a Patient Navigation Program to Promote Colorectal Cancer Screening in Rural Georgia, USA

Sally Honeycutt, MPH¹; Rhonda Green, BS²; Denise Ballard, MEd²; April Hermsstad, MPH¹; Alex Brueder, MD³; Regine Haardörfer, PhD¹; Jennifer Yam, MD⁴; and Kimberly J. Arriola, PhD, MPH¹

BACKGROUND: Colorectal cancer (CRC) is a leading cause of cancer death in the United States. Early detection through recommended screening has been shown to have favorable treatment outcomes, yet screening rates among the medically underserved and uninsured are low, particularly for rural and minority populations. This study evaluated the effectiveness of a patient navigation program that addresses individual and systemic barriers to CRC screening for patients at rural, federally qualified community health centers. **METHODS:** This quasiexperimental evaluation compared low-income patients at average risk for CRC ($n = 809$) from 4 intervention clinics and 9 comparison clinics. We abstracted medical chart data on patient demographics, CRC history and risk factors, and CRC screening referrals and examinations. Outcomes of interest were colonoscopy referral and examination during the study period and being compliant with recommended screening guidelines at the end of the study period. We conducted multilevel logistic analyses to evaluate the program's effectiveness. **RESULTS:** Patients at intervention clinics were significantly more likely than patients at comparison clinics to undergo colonoscopy screening (35% versus 7%, odds ratio = 7.9, $P < .01$) and be guideline-compliant on at least one CRC screening test (43% versus 11%, odds ratio = 5.9, $P < .001$). **CONCLUSIONS:** Patient navigation, delivered through the Community Cancer Screening Program, can be an effective approach to ensure that lifesaving, preventive health screenings are provided to low-income adults in a rural setting. *Cancer* 2013;000:000-000. © 2013 American Cancer Society.

KEYWORDS: cancer screening; colorectal cancer; colonoscopy; program evaluation; community health centers; community health workers; rural health.

INTRODUCTION

Colorectal cancers (CRCs) are the third leading site of cancer diagnosis and death among males and females in the United States and the state of Georgia.¹ Because early detection is associated with more successful treatment and better prognosis, several national organizations have issued screening guidelines for people at average risk for developing CRC.²⁻⁵ Screening options include tests that can prevent and detect cancer and those that can detect, but not prevent, cancer.⁶

The US Preventive Services Task Force (USPSTF) recommends CRC screening using colonoscopy, flexible sigmoidoscopy, or fecal occult blood test (FOBT) for most adults aged 50 to 75 years.² Because detection and removal of precancerous polyps can prevent CRC, organizations including the American Cancer Society and American College of Gastroenterology recommend colonoscopy or other cancer prevention tests as the preferred CRC screening method.³⁻⁵ Colonoscopy is the most sensitive test for detecting CRC, and promoting colonoscopy as the preferred screening method may increase the likelihood of referral and allow for greater detection of adenomatous polyps.^{2,4}

In 2010, only 58.6% of adults aged 50 to 75 years were current on any modality of CRC screening according to USPSTF guidelines.⁶ Screening rates are particularly low among minorities, low-income populations, individuals who are uninsured or lack access to quality health care, and rural populations.⁷⁻¹¹ Barriers to colonoscopy screening include not receiving a provider referral for screening, inadequate health insurance, not having a medical home, health systems barriers (eg, scheduling challenges), logistic obstacles (eg, cost, transportation, time commitment), cognitive-emotional factors (eg, fear of procedure, disagreeable preparation, embarrassment), and lack of information about risk factors and

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DOI: 10.1002/onco.28033. Received: October 23, 2012; Revised: December 19, 2012; Accepted: February 12, 2013. Published online in Wiley Online Library (wileyonlinelibrary.com).

CRC Screening Navigation - NYC

Screening Navigation

Intervention patients were:

- 59% more likely to be screened

ORIGINAL INVESTIGATION

HEALTH CARE REFORM

Colorectal Cancer Screening Among Ethnically Diverse, Low-Income Patients

A Randomized Controlled Trial

Karen E. Lasser, MD, MPH; Jennifer Murtillo; Sandra Lisboa, BA; A. Naomie Cassmir, BA; Lita Valley-Shah, RN, BSN, MM, CGRN; Karen M. Emmons, PhD; Robert H. Fletcher, MD; John Z. Ayanian, MD, MPP

Background: Patient navigators may increase colorectal cancer (CRC) screening rates among adults in underserved communities, but prior randomized trials have been small or conducted at single sites and have not included substantial numbers of Haitian Creole-speaking or Portuguese-speaking patients.

Methods: We identified 465 primary care patients from 4 community health centers and 2 public hospital-based clinics who were not up-to-date with CRC screening and spoke English, Haitian Creole, Portuguese, or Spanish as their primary language. We enrolled participants from September 1, 2008, through March 31, 2009, and followed them up for 1 year after enrollment. We randomly allocated patients to receive a patient navigation-based intervention or usual care. Intervention patients received an introductory letter from their primary care provider with educational material, followed by telephone calls from a language-concordant navigator. The navigators offered patients the option of being screened by fecal occult blood testing or colonoscopy. The primary outcome was completion of any CRC screening within 1 year. Secondary outcomes included the propor-

tions of patients screened by colonoscopy who had adenomas or cancer detected.

Results: During a 1-year period, intervention patients were more likely to undergo CRC screening than control patients (33.6% vs 20.0%; $P < .001$), to be screened by colonoscopy (26.4% vs 13.0%; $P < .001$), and to have adenomas detected (8.1% vs 3.9%; $P = .06$). In prespecified subgroup analyses, the navigator intervention was particularly beneficial for patients whose primary language was other than English (30.8% vs 18.6%; $P < .001$) and black patients (30.7% vs 16.7%; $P = .004$).

Conclusions: Patient navigation increased completion of CRC screening among ethnically diverse patients. Targeting patient navigation to black and non-English-speaking patients may be a useful approach to reducing disparities in CRC screening.

Trial Registration: clinicaltrials.gov Identifier: NCT01141114

Arch Intern Med. 2011;171(10):906-912

COLORECTAL CANCER (CRC) is the second leading cause of cancer death in the United States and is preventable through screening.^{1,2} Nevertheless, approximately 40% of eligible adults in the United States and more foreign-born US residents³ are overdue for CRC screening.³ Patients at greatest risk

See Invited Commentary at end of article

for not being screened include racial minorities,⁴ patients with Medicaid or no health insurance coverage,⁵ those who are foreign born,⁶ and patients with low socioeconomic status.⁸ Factors that may contribute to low screening rates among the urban poor with health insurance coverage and access to health care include lack of trust in physicians, an absence of symp-

toms, fatalistic views regarding cancer,¹⁰ and the lack of a recommendation from a physician for screening.¹⁰

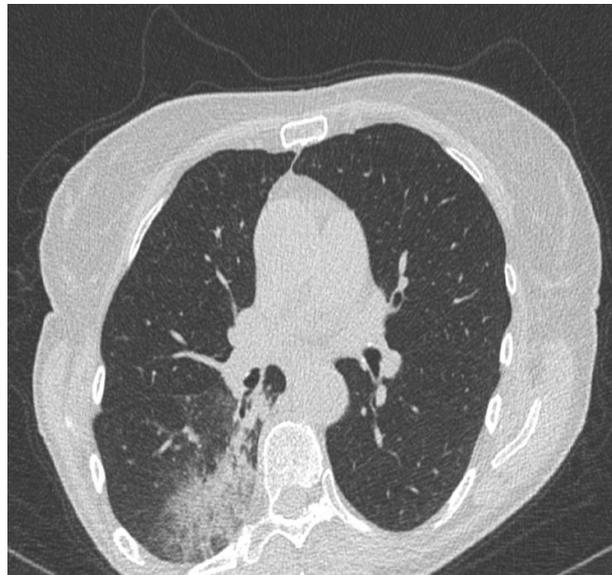
Patient navigation is a way to address these barriers to screening. Patient navigators are laypersons from the community who guide patients through the health care system so that they receive appropriate services.¹¹ The navigators perform a wide range of advocacy and coordination activities, such as assisting patients in obtaining health insurance coverage or transportation to appointments.¹² Using flexible problem solving (rather than provision of a discrete set of services), patient navigators educate patients regarding the disease in question and address the needs of the individual patient. Finally, patient navigators provide social and emotional support to patients.

Several nonrandomized studies,¹³⁻¹⁷ including our own,¹¹ have shown that patient navigation can increase rates of CRC

Author Affiliations are listed at the end of this article.

Step #3: Get Patients Screened

- Ensure high-quality screening, as well as diligent tracking of test completion and follow-up
- Develop and implement measurement and feedback to PCPs and other team members





Standing Orders

- Standing orders that allow nursing staff, medical assistants or navigators to discuss cancer screening and submit referrals for screening have been demonstrated to increase screening rates
- Staff training on risk assessment, components of the screening discussion, ... is essential for a successful program.
- Know your state – rules vary regarding use of standing orders

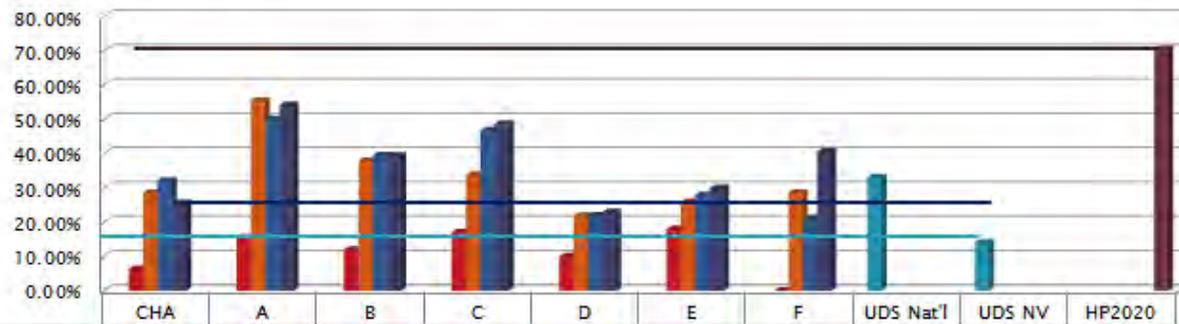


Outreach

- Addresses individuals who may not have frequent visits to the health center, or may not have received information on screening during recent visits
- Multiple modalities available
 - Telephone
 - Text
 - Email
 - Snail mail

Regular Reporting of Screening Performance

% of patient 50-75yo who have received appropriate colorectal cancer screening



	CHA	A	B	C	D	E	F	UDS Nat'l	UDS NV	HP2020
2013								33.00%	14.00%	
2013	6.36%	15.54%	12.00%	17.02%	10.00%	17.95%	0.00%			
4th qtr, 2014	28.56%	55.45%	37.88%	33.72%	21.82%	25.93%	28.57%			
1st qtr, 2015	32.15%	50.00%	39.44%	46.75%	22.00%	27.87%	21.21%			
2014 YTD	25.50%	54.20%	39.31%	48.73%	22.88%	29.85%	40.58%			
2020										70.50%

Name	Description	Numerator	Denominator	Source	Reference
Colorectal Cancer Screening	Percentage of adults 50-80 years of age who had an appropriate screening for colorectal cancer	Patients in the denominator who received one or more screenings for colorectal cancer	All patients 51 to 80 years of age during the measurement year	NCQA/NQF PQRS/PCPI	National Committee for Quality Assurance 📄



Electronic Medical Records

- Studies have demonstrated significant improvement in screening and outcomes with effective use of EMRs
- Tremendous potential...
 - Registry functions
 - Population management tools/resources
 - Reminders
- *However* the potential is often not met

EMRs and Cancer Screening

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SUMMARY REPORT:

USE OF ELECTRONIC MEDICAL RECORDS TO FACILITATE COLORECTAL CANCER SCREENING IN COMMUNITY HEALTH CENTERS

Prepared for:

National Colorectal Cancer Roundtable
American Cancer Society, Inc.
National Association of Community Health Centers

Submitted by:

Aeffect, Inc.
Deerfield, IL

September 2013

This project was supported by CDC Cooperative Agreement Number U50/DP001863. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention (CDC).



- Surveyed CHC clinicians, QI and IT staff (including “super-users”)
- Identified multiple barriers to effective use
 - EMR system issues
 - CHC staff and resources
 - Organizational issues
- Report also describes high performing models and best practices
- A number of findings relevant to all types of cancer screening

<http://nccrt.org/wp-content/uploads/NCCRT-Summary-EMR-Report-Final.pdf>

Step #4: Coordinate Care

Suggestions on **creation of a medical neighborhood** to coordinate the care of patients beyond the walls of the health center



Includes the hospital, radiology, anesthesia, pathology, surgery and oncology



Creating Medical Neighborhoods: Key Characteristics of Model Programs

1. Strong Leadership
2. Focus on Care Coordination
3. Effective Use of Data
4. Clarity of Expectations and Fair Division of Labor
5. Standardization for Efficiency



IMPROVING LINKS TO CARE IN THE DELIVERY OF COLORECTAL CANCER SCREENING AND FOLLOW UP

A funding opportunity through the American Cancer
Society's CHANGE Program



Issue: Limited Access to Specialty Care

Accessing specialty care, including screening and follow up colonoscopy, is a major challenge for many FQHC patients.

- Appropriate screening not available for patients at increased risk
- Follow up colonoscopy not available for patients with positive FIT or guaiac test results
 - Delay or failure to obtain follow up colonoscopy is associated with increased risk of CRC and late-stage dx
 - Studies from safety net settings find follow up rates < 50%
- Lack of access makes some clinicians reluctant to recommend screening



Links of Care Pilot Project

Grant funding to FQHCs and local partners to stimulate collaboration and support development of the long-term structures and relationships needed to improve access to specialists in the community in the delivery of cancer screening and follow up, using CRC as the model.

Pilot FQHCs:

- West Side Community Health Services, Saint Paul, MN
- Beaufort-Jasper-Hampton Comprehensive Health Services, Port Royal, SC
- Fair Haven Community Health Center New Haven, CT



The Goals

Primary goal:

- Increase timely access to specialists for FQHC patients after a positive colorectal cancer screening result.

Secondary goals:

- Advance evidence-based strategies to increase colorectal cancer screening rates within primary care systems.
- Develop processes, tools and templates to promote replication of this work in other communities and for other types of cancer screening and follow-up.

Lessons Learned

- **Effective patient navigation is essential**
 - Proactively addresses anticipated barriers
 - Increases adherence with screening
 - Protects good relationship with hospital and specialists by effectively addressing concerns about no shows, follow up of abnormal screens, other challenges.
- **Agreement on expectations**
 - Defined number of screenings per month
 - Clear role delineation re: f/u of abnormalities, annual reminders
- **Ensure program efficiency**
 - Use consistent protocols that reduce the burden on health center and screening center staff while ensuring that all needed medical information is transmitted (e.g. standardized referral forms).
 - Agreement on billing procedures, management of inaccurate billing,...



Lessons Learned

- **Form and leverage the right partnerships**
 - Regular communication between health center staff and the screening site at multiple levels regarding what is working and what needs to be improved
- **When things go wrong (and they will):**
 - Joint problem-solving
 - Accept the blame (no finger pointing)
 - ...but share the credit