Cancer Screening

10 MINUTES | SEPTEMBER 13TH, 2022

NATIONAL ASSOCIATION OF Community Health Centers

Microlearning Modules

MODULES	ACTION STEPS	RESOURCES
WHAT? **WHY?** **HOW?**	1 ***ENGAGE*** leadership 2 ***APPLY*** population health management strategies 3 ***DESIGN*** models of care 4 ***CREATE/UPDATE*** clinical policies and standing orders 5 ***DEPLOY*** care teams in new ways 6 ***OPTIMIZE*** health information systems 7 ***ENGAGE*** patients and support self-management 8 ***DEVELOP/ENHANCE*** community partnerships 9 ***TAILOR*** treatment for social context 10 ***MAXIMIZE*** reimbursement	VTF VTF Resources NACHC Cancer Screening Action Guide

Cancer Screening

WHAT?

WHY?

HOW?

WHAT are the clinical guidelines for colorectal cancer screening?

Clinical guidelines recommend screening men and women at average risk for colorectal cancer aged 45-75 years

Average risk individuals have no:

- ✓ Personal or family history of adenomatous polyps or colorectal cancer.
- ✓ Personal history of inflammatory bowel disease such as Crohn's disease or ulcerative colitis.
- ✓ Genetic syndrome such as familial adenomatous polyposis or hereditary non-polyposis colorectal cancer.

Adults 76-85 years of age may be screened depending on their overall health and personal preferences.

WHAT are CRCS testing options?

Stool-based tests

- Fecal Immunochemical Tests (FIT) - **every year**
- High-sensitivity Guaiac Fecal Occult Blood Tests (gFOBT) - **every year**
- FIT-DNA - **every 1 or 3 years**

For average risk adults

Visual tests

- Colonoscopy - **every 10 years**
- CT colonography - **every 5 years**
- Flexible sigmoidoscopy - **every 5 years**
- Flexible sigmoidoscopy with FIT - **Flexible sigmoidoscopy every 10 years plus FIT every year**

Annual, high-quality stool-based screening is comparable to a high-quality colonoscopy-based screening program when positive stool tests are followed by colonoscopy (see NACHC Cancer Screening Action Guide for relevant references).

Achieving high CRCS rates requires use of **both** stool-based and visual tests to balance logistics, patient preference, staffing, and availability of providers who can perform colonoscopies.

WHAT are 3 types of stool-based tests?

Type	Brand	Manufacturer	Sensitivity*	Specificity*	# Stool Samples
FIT *(CLIA-waived)*	OC Light iFOB Test	Polymedco	78.6%-97.0%	88.0-92.8%	1
	QuickVue iFOB	Quidel	91.9%	74.9%	1
	Hemosure One-Step iFOB	Hemosure, Inc.	54.5%	90.5%	1 or 2
	Insure FIT	Clinical Genomics	75%	96.6%	2
	Hemoccult-ICT	Beckman Coulter	23.2%-81.8%		2 or 3
HSgFOBTs+	Hemoccult II SENSA	Beckman Coulter	61.5%-79.4%	86.7%-96.4%	3
mt-sDNA	Cologuard	Exact Sciences	92.3%	89.8%	1

http://nccrt.org/wp-content/uploads/dlm_uploads/IssueBrief_FOBT_CliniciansRef-09282019.pdf
*Direct comparison between tests is not possible; consult original studies for additional information.
+High-sensitive guaiac-based FOBT; Hemoccult II and generic guaiac-based tests should not be used.

WHAT are the clinical guidelines for cervical cancer screening?

All major screening guidelines recommend starting cervical cancer screening at age 21.

The two screening tests for prevention of cervical cancer include:

1. Pap test – which looks for changes in cells on the cervix that, if not treated, can become cancer (cervical cytology)

2. HPV test – which looks for a virus (human papillomavirus) that can cause cell changes in the cervix that become cancer

WHAT are the clinical guidelines for cervical cancer screening?

Age 21-29

- Screen every 3 years with cervical cytology alone

Age 30-65

- Screen every 3 years with cervical cytology alone, OR
- Screen every 5 years with high-risk human papillomavirus (hrHPV) testing alone, OR
- Screen every 5 years with hrHPV testing in combination with cytology (co-testing)

Do Not Screen

- Patients who have had a hysterectomy with removal of the cervix and no history of a high-grade precancerous lesion or cervical cancer
- Patients with a cervix younger than 21 years
- Patients with a cervix older than 65 years with adequate screening history and not otherwise at risk for cervical cancer

Cancer Screening

WHAT?

WHY?

HOW?

WHY is attention to cancer screening so important?

Improve Population Health

Nearly 53,000 adults in the United States (U.S.) are expected to die from colorectal cancer in 2022, the third leading cause of cancer related death.

Approximately 14,000 adults in the U.S. will be diagnosed with cervical cancer in 2022, and roughly 4,280 will die.

Screening to detect polyps or cancer at an early stage has been proven to save lives.

https://www.cancer.org/cancer/colon-rectal-cancer/about/key-statistics.html
https://www.cancer.org/cancer/cervical-cancer/about/key-statistics.html

WHY is attention to cancer screening so important?

Improve Quality

- HRSA Uniform Data Systems (UDS)[+]
  - Colorectal Cancer Screening, national rate 42%
  - Cervical Cancer Screening, national rate 53%
- HEDIS & other Health Plans performance measures
- Factored into value-based care payments

Improve Health Equity

Cancer screening rates are lower for: older patients; patients with no usual source of care, no health insurance, or public insurance only; patients with less than a high school education; non-Hispanic Asian patients; and patients who were US residents for less than 10 years.

Deliver as a Patient-Centered Medical Home (PCMH)

A component within PCMH competencies:

- Knowing and Managing Your Patients
- Care Coordination and Care Transitions
- Performance Measurement and Quality Improvement

Provide Evidence-Based Care

- United States Preventive Task Force Recommendations (USPSTF)
- American Cancer Society (ACS)

[+]https://data.hrsa.gov/tools/data-reporting/program-data/national

Cancer Screening

WHAT?

WHY?

HOW?

Action Guides:

Cancer Screening
Diabetes Control
HTN Screening & Control

- Synthesis of the evidence-base
- Guidelines and recommendations
- Sample clinical policies
- Sample standing orders
- Care team training resources
- Links to documentation guides for leading EHRs
- Links to patient educational resources
- Links to guides supporting community partnerships
- Reimbursement and payment strategies

2022 Update
Cancer Screening
coming in Sept

https://bit.ly/VTF_ActionGuides

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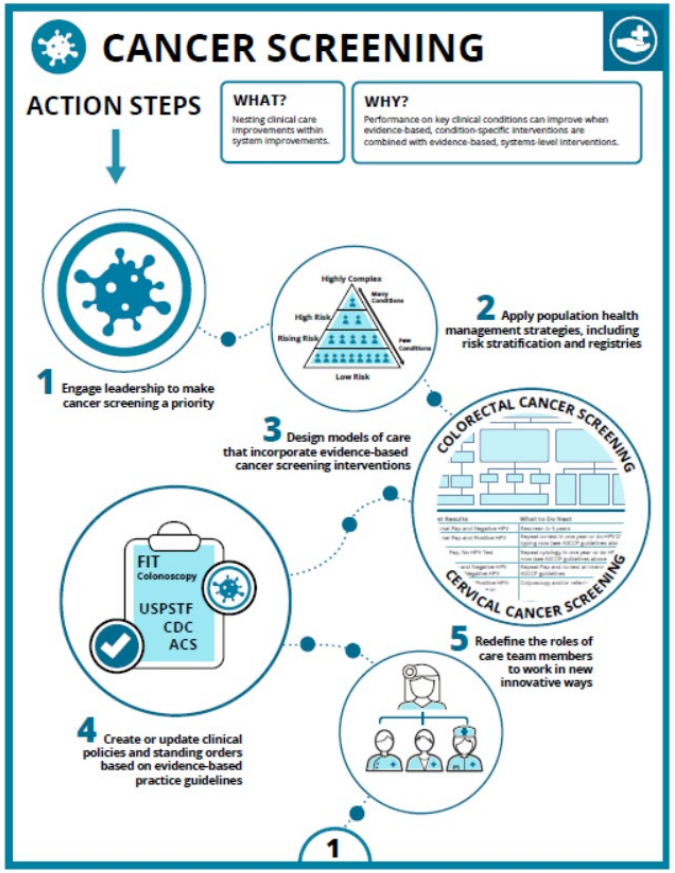
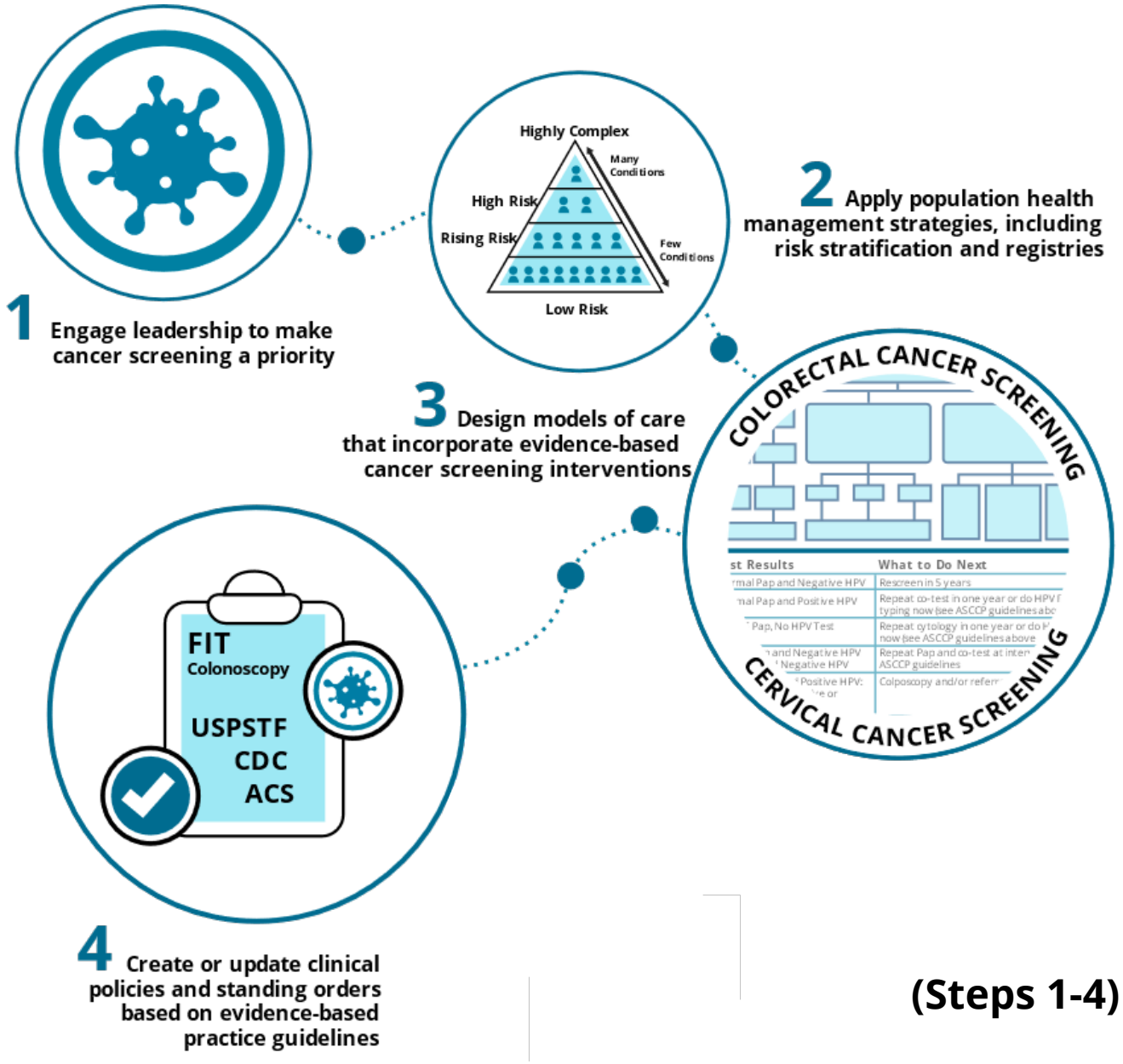
10 Action Steps for Cancer Screening

NACHC Infographic





https://bit.ly/VTF_EBC_Cancer-graph

(Steps 1-4)

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STEP 1

ENGAGE LEADERSHIP

Set cancer screening as a top **organizational priority**.

Leadership, in partnership with staff, should set short and long-term **targets for improvement**

Identify cancer screening **champion(s)**; consider a network of clinical champions (cancer screening, diabetes, hypertension, etc.) all working together to impact systems change

Provide **performance data and feedback** to staff as this has been shown to improve performance.

Join state, regional, or national initiatives (American Cancer Society's National Colorectal Roundtable Initiative's goal to achieve a CRCS rate of 80% or higher across the nation)

Helpful Resource: NACHC Leadership Action Guide

STEP 2

APPLY POPULATION HEALTH MANAGEMENT STRATEGIES

- **Empanelment**: ensure every patient is matched to a provider and care team
- **Risk Stratification**: segment your patient population to identify the right level of care and services
- **Registries & Care Gap Reports**: identify and target patients for cancer screening within each subgroup
- **Health center, local, and national data**: to drive clinic-based quality improvements

CDC's U.S. Cancer Statistics Data Visualizations Tool: compares cancer rates at the county level as well as at the congressional district, state, and national levels.

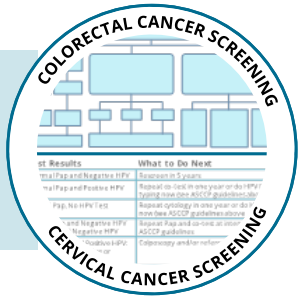
CDC's Quick Facts, CRCS: shows CRCS trends by year, state, race/ethnicity, insurance status, sex, and age.

Agency for Healthcare Research and Quality (AHRQ)'s National Healthcare Quality and Disparities Reports: show each state's performance rates for a portfolio of measures, benchmarked against data from top-performing states.

Helpful Resources: NACHC Empanelment Action Guide; NACHC Risk Stratification Action Guide

STEP 3

DESIGN MODELS OF CARE



USPSTF RECOMMENDATIONS: GRADE A+	
Women age 21-29	• Screen with cervical cytology alone every 3 years.
Women age 30-65	• Screen every 3 years with cervical cytology alone. OR • Screen every 5 years with high-risk human papillomavirus (hrHPV) testing alone. OR • Screen every 5 years with hrHPV testing in combination with cytology (co-testing).
Do NOT screen:	• Women who have had a hysterectomy with removal of the cervix and no history of a high-grade precancerous lesion or cervical cancer. • Women younger than 21 years. • Women older than 65 years with adequate screening history and not otherwise at risk for cervical cancer.

USPSTF RECOMMENDATIONS	
Screen average-risk adults **age 45-75** for colorectal cancer.	
Stool-based tests	• High-sensitivity Guaiac Fecal Occult Blood Tests (gFOBT) - **every year**. • Fecal Immunochemical Tests (FIT) - **every year**. • FIT-DNA - **every 1 or 3 years**.
Visual tests	• Colonoscopy - **every 10 years**. • CT colonography - **every 5 years**. • Flexible sigmoidoscopy - **every 5 years**. • Flexible sigmoidoscopy with FIT – **Flexible sigmoidoscopy every 10 years plus FIT every year**.

+https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/cervical-cancer-screening2

A comparison of major cervical cancer screening guidelines: https://www.cdc.gov/cancer/cervical/pdf/guidelines.pdf

https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2#tab.

https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html.

STEP 3

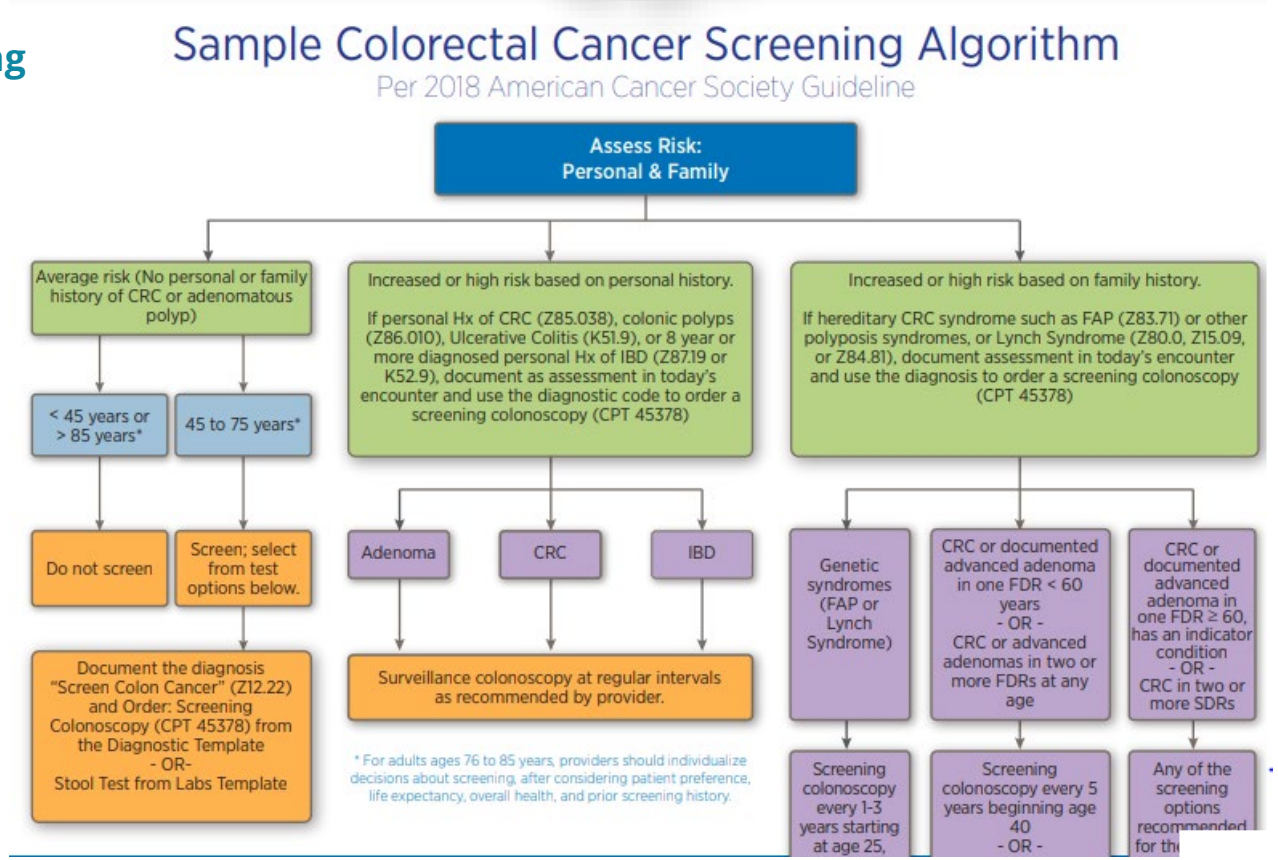
DESIGN MODELS OF CARE (cont'd)

Incorporate standardized workflows in care models
Whole-person prevention/care, including cancer screening

Before the visit
- Empanelment
- Risk Stratification/Segmentation
- Managed Care Reports
- Health Information Exchange (HIE) Data
- Registries & Care Gap Reports

During the visit
- Care team roles
- Clinical protocols
- Standing orders
- Provider recommendation* (can be thru standing orders)
- Patient self-care guides/prevention checklists
- HIT/EHR clinical decision support; alerts

After the visit
- Referral and follow-up; closing the loop
- Documentation



https://nccrt.org/resource/sample-risk-assessment-screening-algorithm/

STEP 4

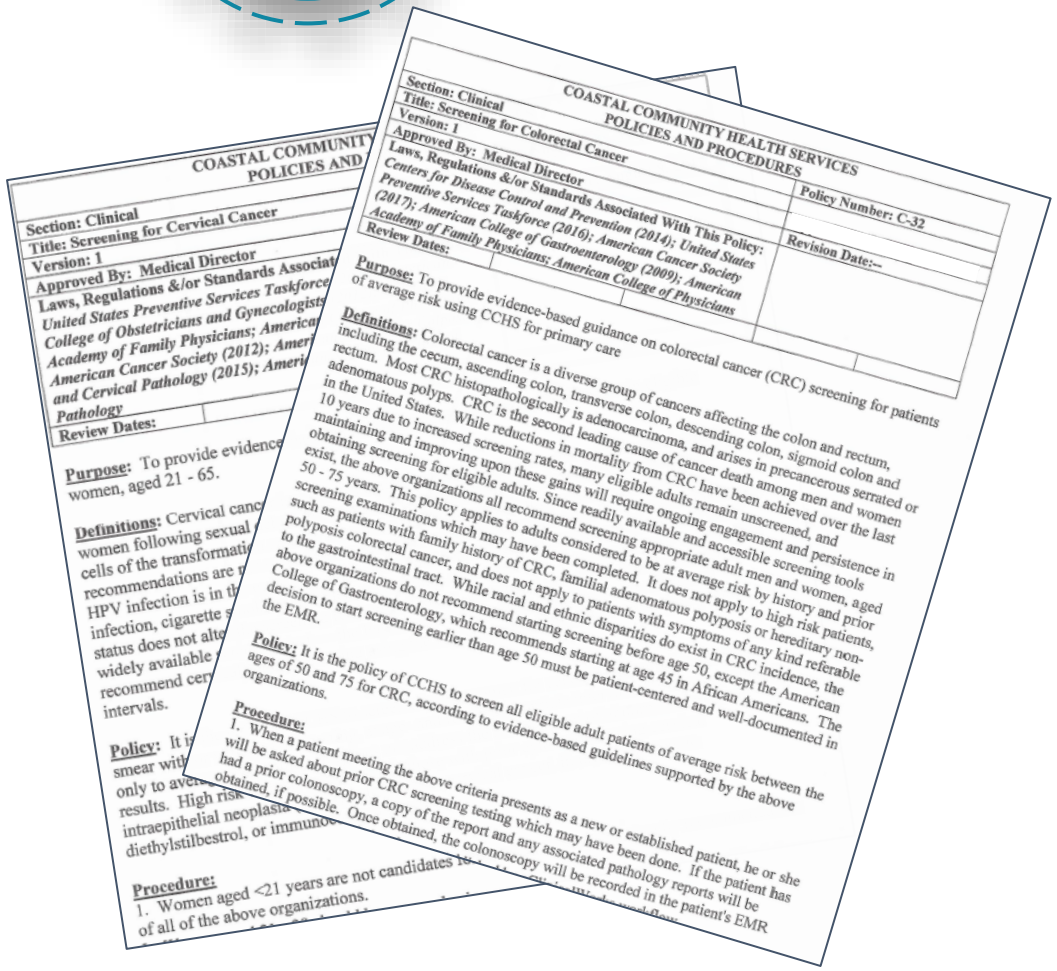
CREATE/UPDATE CLINICAL POLICIES AND STANDING ORDERS

Evidence-Based Care

Policies should:
- ✓ Reflect current clinical guidelines
- ✓ Utilize evidence-based cancer screening tests
- ✓ Be constructed to address different risk levels

Standing orders can authorize certain staff to carry out medical orders (e.g., FIT test) per practice-approved protocols without a clinician's examination and can improve clinical measures.

Cancer Screening Guidelines include:
U.S. Preventive Services Task Force
American Cancer Society


COASTAL COMMUNITY HEALTH SERVICES
POLICIES AND PROCEDURES

Section: Clinical
Title: Screening for Colorectal Cancer
Version: 1
Approved By: Medical Director
Laws, Regulations &/or Standards Associated With This Policy: Centers for Disease Control and Prevention (2014); United States Preventive Services Taskforce (2016); American Cancer Society (2017); American College of Gastroenterology (2009); American Academy of Family Physicians; American College of Physicians
Policy Number: C-32
Revision Date:--
Review Dates:

Purpose: To provide evidence-based guidance on colorectal cancer (CRC) screening for patients of average risk using CCHS for primary care

Definitions: Colorectal cancer is a diverse group of cancers affecting the colon and rectum, including the cecum, ascending colon, transverse colon, descending colon, sigmoid colon and rectum. Most CRC histopathologically is adenocarcinoma, and arises in precancerous serrated or adenomatous polyps. CRC is the second leading cause of cancer death among men and women in the United States. While reductions in mortality from CRC have been achieved over the last 10 years due to increased screening rates, many eligible adults remain unscreened, and maintaining and improving upon these gains will require ongoing engagement and persistence in obtaining screening for eligible adults. Since readily available and accessible screening tools such as patients with family history of CRC, familial adenomatous polyposis or hereditary non-polyposis colorectal cancer, and does not apply to patients with symptoms of any kind referable to the gastrointestinal tract. While racial and ethnic disparities do exist in CRC incidence, the above organizations do not recommend starting screening before age 50, except the American College of Gastroenterology, which recommends starting at age 45 in African Americans. The decision to start screening earlier than age 50 must be patient-centered and well-documented in the EMR.

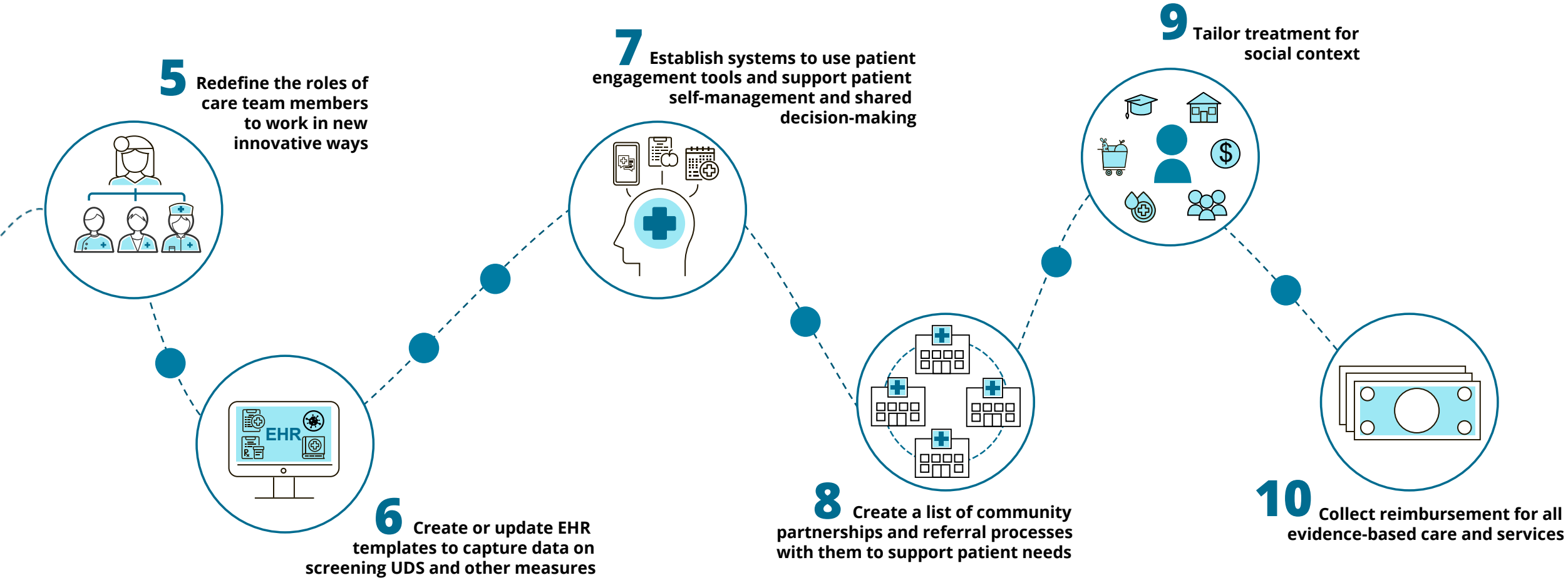
Policy: It is the policy of CCHS to screen all eligible adult patients of average risk between the ages of 50 and 75 for CRC, according to evidence-based guidelines supported by the above organizations.

Procedure:
1. When a patient meeting the above criteria presents as a new or established patient, he or she will be asked about prior CRC screening testing which may have been done. If the patient has had a prior colonoscopy, a copy of the report and any associated pathology reports will be obtained, if possible. Once obtained, the colonoscopy will be recorded in the patient's EMR

Procedure:
1. Women aged <21 years are not candidates

10 Action Steps for Cancer Screening

NACHC Infographic



(Steps 5-10)

STEP 5

DEPLOY CARE TEAMS IN NEW WAYS

- ✓ **Expand staff roles**; utilize navigators, community health workers, care managers and others in team-based care
- ✓ Create a cancer screening **proficiency checklist** for key care team positions; evaluate staff proficiency and address gaps.
- ✓ Create **exam room tools that summarize key care parameters** (e.g., recommended ages for all priority screenings, such as colorectal and cervical cancer screening, blood pressure parameters, glucose levels, depression screening scale).
- ✓ Provide **staff instructional tools and resources** to support communication with patient around need for test and instruction on how to complete test (e.g., FIT instructional documents)
- ✓ Design **integrated workflows** that incorporate the provider's recommendation for screenings around not only cancer screening, but also other preventive and chronic disease management guidelines.
- ✓ Use **daily huddles** that incorporate pre-visit planning (e.g., identifying care gaps in advance of patient visit, including cancer screening, reminding patients of visit).
- ✓ Create processes for **tracking, referral, and follow-up** of cancer screening and other preventive/chronic conditions.

STEP 6

OPTIMIZE HEALTH INFORMATION SYSTEMS

Create guidance on how to document cancer (and other) screenings within **structured fields** in the EHR.

Documentation should include components for:

- ✓ Tests/screenings that were performed
- ✓ Referrals made
- ✓ Tracking test results and follow-up

If your EHR does not allow you to track test distribution and returns, set up a simple tracking log, and assign staff to regularly review and recall patients who have not completed a screening test.

Configure your EHR/PHM system to create Gap Reports – to identify needed preventive health screenings.

Implement automated reminders in the EHR to prompt the clinical team.

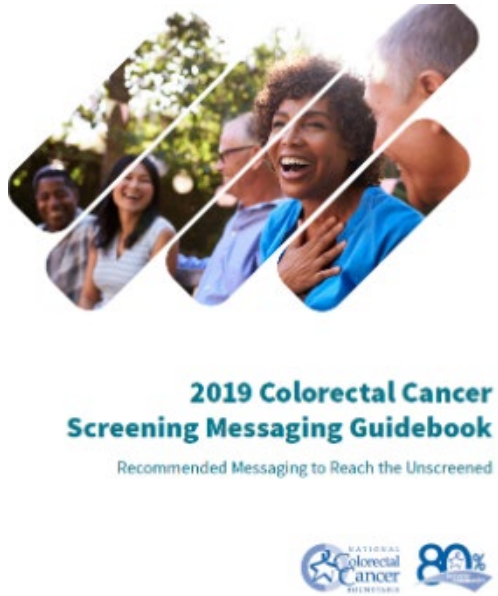
Helpful Resources:

1. Colorectal Cancer Screening and Risk Assessment Workflow: Documentation Guide for Health Center NextGen Users developed by NACHC
2. EHR Best Practice Workflow And Documentation Guide To Support Colorectal Cancer Screening Improvement With EClinicalWorks developed by the Health Center Network of New York with support from NACHC, ACS, and the National Association of Chronic Disease Directors

STEP 7

ENGAGE PATIENTS AND SUPPORT SELF-MANAGEMENT

- ✓ Engage and educate patients about the importance of regular cancer screening.
- ✓ Offer patient education materials in multiple languages, at appropriate literary levels, with translators available, as needed.
- ✓ Provide materials that use pictures and visuals, rather than words, is also important.
- ✓ For CRCS, consider creating a mock stool test demonstration that can be used to instruct patients and for patients to demonstrate the technique via teach-back.
- ✓ Use telephone and text messaging systems to emphasize provider recommendations and remind patients



Resource: [NACHC Patient Engagement Action Guide]

STEP 7

ENGAGE PATIENTS AND SUPPORT SELF-MANAGEMENT

Patient engagement tool

Patient:_____ Date: _____

IMPORTANT

As a ***woman aged 50-75 years of age***, your doctor wants you to receive the following screenings based upon the *BEST MEDICAL information. Be sure to ask your doctor, nurse practitioner or physician assistant at today's visit to check if you need the tests which can ***save your life*** ☺.

ROUTINE CARE:

- Blood Pressure
- Depression screening
- Weight screening and counseling for better weight control
- Screening for use of aspirin or a cholesterol lowering medication to prevent heart disease

CANCER SCREENINGS:

- Breast cancer (mammogram every 1-2 years)
- Cervical cancer (Pap test every 3 years for women aged 21-65 years or every 5 years for women aged 30-65 who get an HPV test alone or HPV test in combination with Pap test).
- Colon cancer (women aged 45-75 years; FIT test annually or other screening/ diagnostic tests and frequencies depending on risk. 75+ depending on provider recommendation and provider preference).

BLOOD TESTS:

- HbA1c for diabetes
- Hepatitis C screening
- HIV
- Diseases transmitted through sexual activity

LIFESTYLE:

- Tobacco use
- Alcohol use
- Relationship violence

***BEST MEDICAL INFORMATION/RESEARCH: US Preventive Services Task Force (USPSTF):**

- Aspirin Use in some adults 50-59 years can lower your risk for heart attack, stroke and colorectal cancer. Drugs that lower cholesterol may be used in some adults 40-75 years of age with risk factors to prevent cardiovascular disease. Check with your doctor before taking aspirin or any medication
- Cervical Cancer screening recommended through age 65 years.
- Blood glucose monitoring recommended in overweight adults 40-70 years of age.
- Hepatitis C one-time monitoring or additional screening as needed.
- HIV Screening through 65 years of age.

STEP 8

DEVELOP/ENHANCE COMMUNITY PARTNERSHIPS

HRSA Form 5A **outlines service requirements for various types of partnerships in support of cancer screening and other services.**

Requirements include **screening for breast, cervix, and colorectal cancers (e.g., mammography, Pap testing, fecal occult blood testing, sigmoidoscopy, colonoscopy)**.

Health centers utilize one or more of the following three delivery methods to provide a service:

1. **Direct (Health Center Pays):** Services provided directly by the health center and for which the health center pays and bills.

2. **Formal Written Contract/Agreement (Health Center Pays):** Services provided on behalf of the health center by another entity via a formal written contract/agreement, where the health center is accountable for paying and/or billing for the direct care provided via the agreement.

3. **Formal Written Referral Arrangement (Health Center Does NOT Pay):** Services provided by an entity other than the health center, with which the health center has a formal written referral arrangement (e.g., MOU, MOA, or other formal written arrangement). The actual service is provided and paid/billed for by the other entity (the referral provider).

https://bphc.hrsa.gov/compliance/compliance-manual/chapter4

STEP 8

DEVELOP/ENHANCE COMMUNITY PARTNERSHIPS

Use Formal Referral Arrangements to create colonoscopy referral network:

Calculate the health center's need for colonoscopy

- American Cancer Society Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers, page 17 provides calculation assistance

Identify area endoscopists

Reach out to area endoscopists; request partnerships

- Consider direct referral agreements

Formalize endoscopist partnership agreements and expectations

- Standardized Colonoscopy Reporting and Data System (CO-RADS) Recommendations: pre-, intra-, and post-procedure elements to be documented in colonoscopy report.
- Evidence-based colonoscopy follow-up: results and any implications, next steps/treatments, timing of next screening based upon results.
- Monitor colonoscopy procedure quality: adenoma detection rate (≥30% male screening; ≥20% female screening), cecal intubation rate, quality of bowel prep, use of appropriate intervals for screening and surveillance.

STEP 9

TAILOR TREATMENT FOR SOCIAL CONTEXT

- ✓ Assess patients' potential food insecurity, housing instability, financial and other social drivers of health (SDOH)
- ✓ Apply information to treatment decisions
- ✓ Link to more targeted services, such as care coordination, care management or other follow-up services
- ✓ Refer patients to community resources, as appropriate.
- ✓ For patients diagnosed with cancer, develop an inventory of community resources that may provide assistance during treatment such as familyreach.org, which serves patients facing hardship after a cancer diagnosis.

STEP 10

MAXIMIZE REIMBURSMENET

Reimbursement opportunities exist outside of the prospective-payment system (PPS), including:

Medicare Care Management Services

- NACHC Reimbursement Tip Sheet: Chronic Care Management, Complex Chronic Care Management, & Principal Care
- NACHC Reimbursement Tip Sheet: Behavioral Health Integration
- NACHC Reimbursement Tip Sheet: Initial Preventive Physical Exam & Annual Wellness Visits
- NACHC Reimbursement Tip Sheet: Psychiatric Collaborative Care Model
- NACHC Reimbursement Tip Sheet: Transitional Care Management

Additional reimbursement may also be available in your state from Medicaid, health home initiatives, or other payers.