



American Indian Cancer Foundation

IMPROVING COLORECTAL SCREENING (INPACS)

American Indian Cancer Foundation

# INPACS Project Report

*Improving Northern Plains American Indian Colorectal Cancer Screening*



May 2013



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Dear Colleague:

Thank you for participating in the “Improving Northern Plains American Indian Colorectal Screening” (INPACS) project.

Enclosed is a report summary of the INPACS project discussing colorectal cancer screening best practices and overall findings of participating clinics from the Northern Plains.

A few resources to help support colorectal cancer screening at your clinic:

- The report “*How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician’s Evidence-Based Toolbox & Guide 2008*” identifies areas where to help improve colorectal cancer screening and is highlighted within this report. Visit: <http://nccrt.org/about/provider-education/crc-clinician-guide>
- Visit Native CIRCLE at <http://www.nativeamericanprograms.org/index-circle.html> for cancer information resources and patient materials.
- By request, we will mail the video presentation of an update of current colorectal cancer screening practices by Dr. David Perdue.

We hope you and your clinic found your participation in the INPACS project useful. Each clinic contributed valuable feedback on the state of colorectal cancer in Indian Country. We look forward to pursuing next steps addressing the issues discussed and identifying possible solutions and/or resources to support colorectal cancer screening in your community.

If you would like to further discuss these findings, we are happy to set up a conference call to review your results and discuss opportunities addressing colorectal cancer screening rates.

Thank you for all that you do to promote the health of the American Indian community. We look forward to collaborating on future projects.

Best Regards,

David, Anne, Brandie and Kris

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Stronger Nations through prevention, early detection, and access to quality care.



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## Acknowledgements:

We would like to acknowledge all of the I.H.S., tribal health and urban health clinics that participated in the "Improving Northern Plains American Indian Colorectal Cancer Screening" (INPACS) project. A special thank you and appreciation to all tribal health directors, CEOs, clinic directors, providers and clinic staff that contributed their time to support the work in reducing the impact of cancer in American Indian communities.

## Project Summary:

The project "Improving Northern Plains American Indian Colorectal Cancer Screening" (INPACS) recruited 54 I.H.S., tribal health and urban health clinics within MN, WI, ND, SD, NE, MT, and WY. INPACS project goals were to better understand successes and challenges for colorectal cancer (CRC) screening and to collaboratively develop strategies to improve cancer screening rates.

## Colorectal Cancer in Northern Plains American Indians:

- Colorectal cancer is the second most common cancer in American Indians (following lung cancer).
- In the Northern Plains, the incidence of colorectal cancer is 39% higher for American Indians compared to non-Hispanic Whites.
- Colorectal cancer screening has a tremendous impact on both incidence and mortality.
- Less than half of Northern Plain American Indians ages 50 years and older are current with CRC screening, though rates are improving.

**Table 1: GPRA CRC Screening Rates by IHS Area**

	2007	2012
Aberdeen	16.0%	34.3%
Bemidji	26.0%	47.2%
Billings	16.0%	43.5%
All Areas	26.0%	46.1%

## Northern Plains American Indians:

About 96,000 American Indians ages 50 - 74 years old live across the Northern Plains (MN, WI, ND, SD, NE, MT, and WY).



### **INPACS Methods:**

Data was collected by INPACS staff during visits to each participating site. Clinic administration shared clinical system-level information on CRC screening practices. Clinical providers participated in a 90-minute program which included a survey, discussion of CRC screening challenges, and an educational program that provided CME/CEU credit.

Nearly 350 health care professionals participated in the education session for CME/CEU credit including 145 health care providers from the 40 IHS, tribal health and urban health clinics that participated in the INPACS project.

### **INPACS Project Findings:**

The INPACS project focused on CRC screening practices within I.H.S., tribal health and urban clinics in American Indian communities across the Northern Plains. Multiple components of the project comprehensively assessed quality assurance measures at both the provider-level and the systems-level such as CRC policies and clinic systems for provider and patient reminders. A clear, overarching finding of this project is that system-level strategies are needed to impact CRC screening rates in clinics across Indian Country.

In order to make the INPACS findings relevant and useful to the participating clinical systems, this summary is presented within the framework of the “four essentials” for improving CRC screening rates listed in “*How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician’s Evidence-Based Toolbox & Guide 2008*”. (<http://nccrt.org/about/provider-education/crc-clinician-guide>)

These evidence-based essentials are:

- 1) Provider recommendation
- 2) A clinic policy on CRC screening
- 3) Clinic reminder system
- 4) Effective communication system



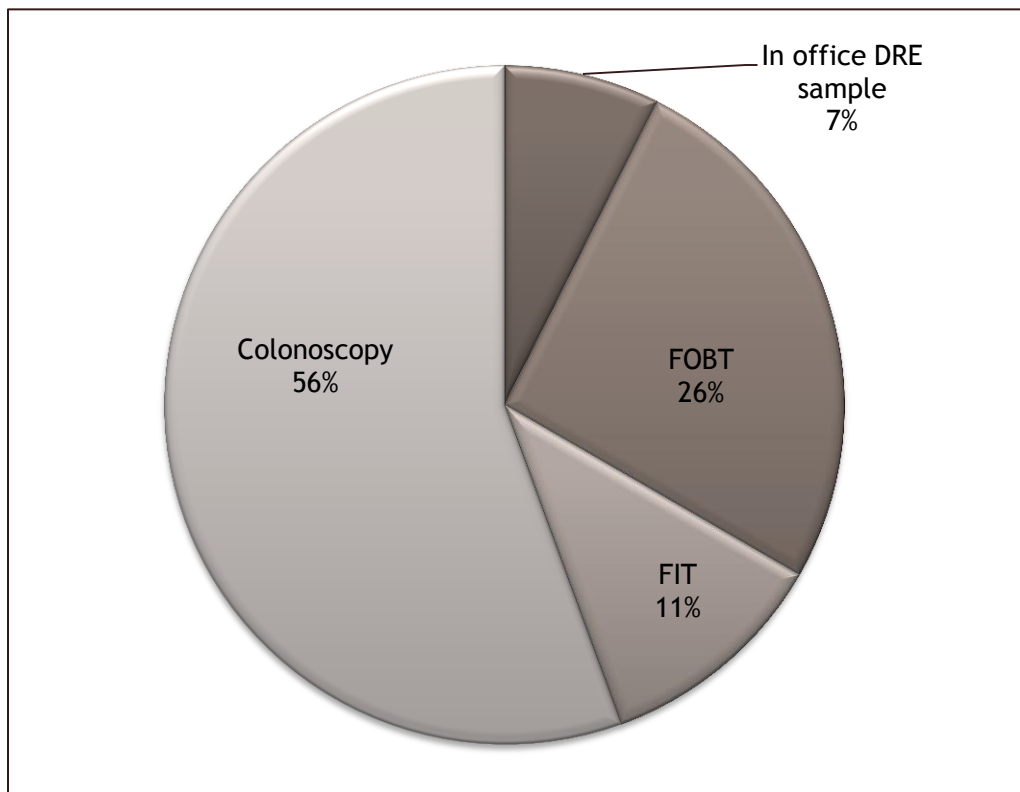
### PROVIDER RECOMMENDATION:

*A provider who recommends screening is the most influential factor in patients completing CRC screening. Providers must understand and follow national screening guidelines.*

### Who in the clinic should discuss CRC screening with patients?

- Over 80% of health care professionals identified providers to be responsible for counseling patients about CRC screening.

### What CRC screening option is recommended most by clinic health care providers?



Provider recommendations of specific CRC screening options varied across clinics. Screening recommendations are often based on availability, cost, ease of use, and other contributing factors that may limit options to recommend to patients.



### ***Colorectal Cancer Screening Options***

***Colonoscopy is an accepted screening method that should begin at 50 years and as early as 45 years due to increased risk factors for American Indians. If no polyps are found, the test interval is every 10 years.***

- Almost all (98%) of providers recommend colonoscopy for patients 45 - 50 years old.

***Flexible sigmoidoscopy is another accepted screening method that should begin at 50 years and as early as 45 years due to increased risk factors for American Indians. If no polyps are found, the test interval should be every 5 years along with FOBT every 3 years.***

- Even though it is an acceptable screening method, *flexible sigmoidoscopy* was rarely (17%) recommended by providers to their patients.

***Stool tests include Fecal Occult Blood Testing (FOBT) and Fecal Immunochemical Testing (FIT) are accepted screening methods that should begin at 50 years and as early as 45 years, due to increased risk factors for American Indians.***

***The test must be done annually to reduce CRC mortality. It should not be used in individuals with a family history of CRC or in those with previous adenomatous polyps.***

- Eight out of 10 providers recommend FOBT to their patients of which two-thirds of these providers begin screening at ages 45 - 50 years old.

**A positive FOBT/FIT test should not be repeated but referred for a colonoscopy.**

- Almost all (96%) clinics follow-up positive FOBT/FIT tests with a recommendation for a colonoscopy.

***In office digital rectal exam (DRE) sample testing with FOBT or FIT is not a recommended screening method because it misses up to 95% of colorectal cancer.***

- 65% of providers still use in office DRE sample testing, mostly based on providers' concern as the only opportunity to screen patients that are unwilling to complete other CRC screening.



### CLINIC POLICY ON CRC SCREENING:

*Established clinic CRC screening policies provide a systematic approach to support effective CRC screening practices and system flow with each patient.*

***Policies must include:***

- 1) A determination of individual risk level based on family and personal health history;*
- 2) Identifying local medical resources;*
- 3) Assessing insurance/payor coverage;*
- 4) Incorporating patient preferences, while adhering to national guidelines as appropriate.*

- The majority of clinics visited (89%) do not have their own written CRC protocol. Most rely on national guidelines such as those from the American Cancer Society or U.S. Preventive Services Task Force.
- 90% of providers reported routinely assessing CRC family history with their patients.

Common insurance/payor coverage issues are:

- 1) Insurance often covers colonoscopy for preventive screening but if a polyp is found it may result in unexpected out-of-pocket costs for the patient.
- 2) Contract Health Services funding is limited and therefore is not a reliable source of funding for colonoscopies.





**CLINIC REMINDER SYSTEMS:**

*Clinic systems with paper chart prompts, or automated electronic medical record (EMR) reminders identify due, overdue or increased risk patients. These allow providers to be efficient and effective in addressing CRC screening.*

- Almost half (47%) of clinics report a system in place to remind *providers* when their patients are due for CRC screening.
- While over 85% of clinics have an EMR system in place, only 37% use their EMR system to help track when their patients are due for initial CRC screening.
- Nearly 75% of the providers inform their patients when they are due for initial CRC screening during a clinic visit.

***Provider feedback via chart audits or registries track practice improvements, and are helpful tools for measuring progress while improving CRC screening rates.***

- Just over half (55%) of clinics give providers feedback on their rates of CRC screening.

***Patient reminders encouraging screening has been shown effective in increasing CRC screening uptake. Examples include postcards, letters, or phone calls.***

- Only 17% of clinics visited remind *patients* when they are due for CRC screening outside of clinic visits.

***Mailed reminders, plus personal phone calls, significantly increased the return of stool blood tests cards.***

- Only 27% of clinics follow-up to remind their patients to return FOBT/FIT kits.

***Advance mailing of FOBT/FIT kits with accompanying letters before clinic appointments has been shown to significantly increase FOBT/FIT return rates.***

- This is a promising approach that has not been attempted within the participating clinics.





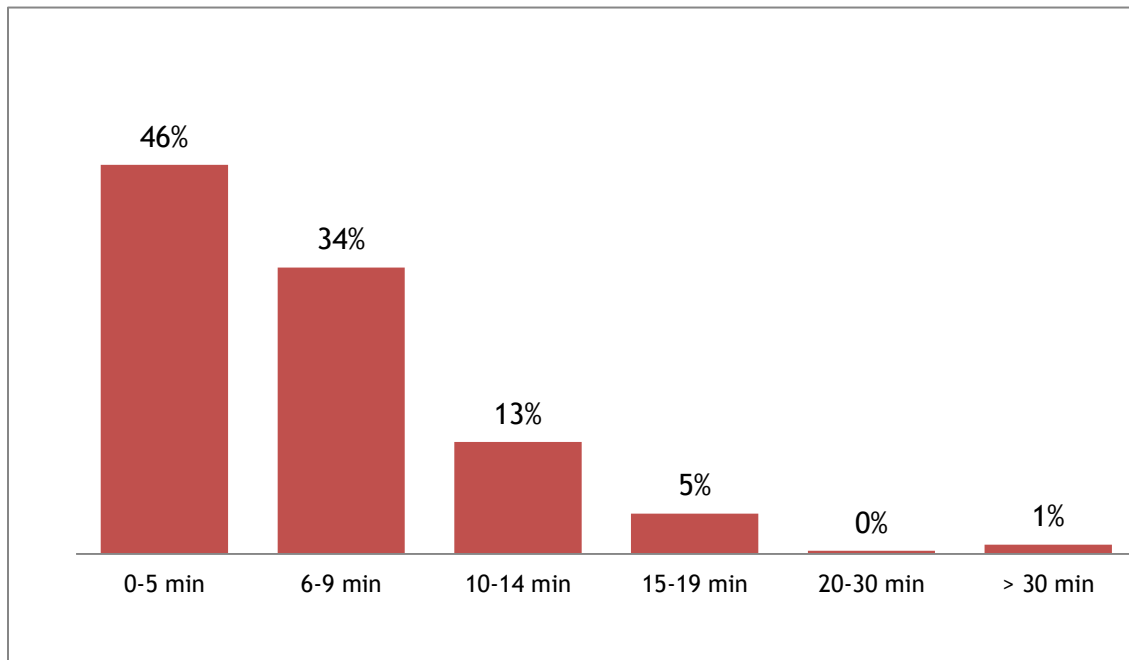
### EFFECTIVE COMMUNICATION SYSTEMS:

*It is critical that patients be fully aware of their screening options along with the risks and benefits of each option. Screening choices are then based on a patient's preference and guided by patient risk factors as determined by the provider.*

*Tracking provider rates of CRC screening achievement among patients helps to identify successes and areas in need of improvement within the clinic system.*

- 75% of providers (“usually” or “sometimes”) present more than one option when discussing CRC screening with their patients.

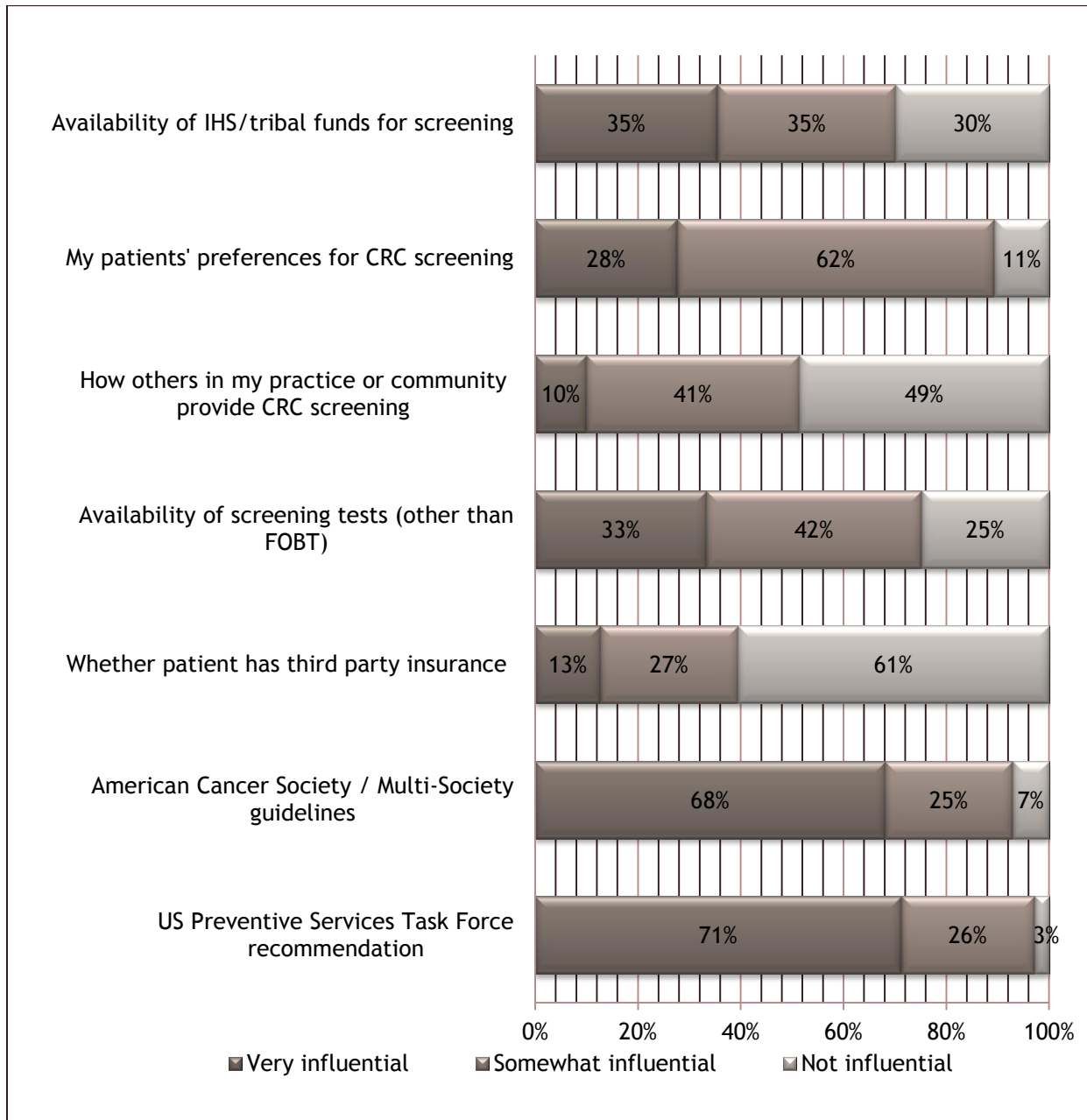
**How much time on average do you believe it takes to adequately discuss CRC screening with your patients?**



- Most (83%) providers believe that patients prefer their provider to pick a CRC screening option for them.
- Nearly 40% of providers believe clinic time demands limits their ability to adequately discuss CRC screening options with patients.
- Over half (55%) of clinics have a system in place to distribute provider feedback on their rates of CRC screening achievement.



To what extent do the following influence provider recommendations for CRC screening with patients?





### HIGHLIGHTS FROM PROVIDER DISCUSSIONS:

*The purpose of the provider discussions was to identify challenges and possible solutions in moving more patients towards CRC screening completion. A total of 145 providers from 40 clinics participated.*

Individual or Community Barriers and Solutions for CRC screening	
<i>Barriers</i>	<i>Possible solutions</i>
<i>“With no symptoms, patients do not see the benefits to screening.”</i>	<ul style="list-style-type: none"> <li>• <i>“Talk about the high risk to Natives and spread word of the need to address CRC, it can be prevented and treated.”</i></li> <li>• <i>“Digital stories could be displayed on TV in waiting room.”</i></li> </ul>
<i>“Patients have competing priorities in their daily life that keeps them from coming into the clinic and getting screened. High risk patients don’t come to the clinic for check-ups.”</i>	<i>“(Offer) incentive to completing colonoscopy.”</i>
<i>“Fear of procedure, findings.”</i>	<ul style="list-style-type: none"> <li>• <i>“Community cancer champion to spread (the) message... someone the community can identify with.”</i></li> <li>• <i>“Positive stories need to get out more than the negative.”</i></li> </ul>
<i>“Patients have distrust about the procedure, doctors, the healthcare system, and the local hospitals where the procedure gets done.”</i>	<i>“Patient navigator can address multiple issues to help patients make appointment, coordinate their visit, transportation.”</i>
<i>“Patients don’t want to handle their stool (for FOBT/FIT).”</i>	<i>“Return mailing address and postage on FOBT/FIT envelope to make it easy. Also, need follow-up about a week later.”</i>



<b>Financial Barriers and Solutions for CRC Screening</b>	
<b>Barriers</b>	<b>Possible solutions</b>
<i>“Transportation to the colonoscopy can be an issue. Transportation expenses include a vehicle, gas, and in some cases, food and lodging for an overnight stay. Weather can also be prohibitive.”</i>	<i>“A system in place to coordinate transportation, reminders and prep education.”</i>
<i>Contract health service dollars are limited and because colonoscopies are done off-site they are limited.</i>	<i>“National resources need to be available. Diabetes has a large highlight within IHS but since CRC is such a predominant issue, it does not get the same resources, or attention.”</i>
<i>“Time off of work, for both self (patient) and support person.”</i>	<i>“Prep on Sunday, colonoscopy on Monday.”</i>
<i>“Many patients are uninsured or underinsured, which is a barrier because the procedure is expensive. If they have Medicare, it does not cover all services 100% and insurance coverage carries high co-pays for colonoscopies.”</i>	<i>“Medical Social Workers to help patients get signed up for insurance.”</i>
<i>“IHS does not pay for any screening [colonoscopy] unless symptomatic (at our site).”</i>	<i>“Work with I.H.S. area office for increasing priority level for CRC screening.”</i>

<b>Health Care Provider Barriers and Solutions to CRC Screening</b>	
<b>Barriers</b>	<b>Possible solutions</b>
<i>“Providers already have a large workload, so preventive screening brings on another task to an already busy schedule.”</i>	<ul style="list-style-type: none"> <li>• <i>“Develop a team approach.”</i></li> <li>• <i>“Encourage I.H.S. and Improving Patient Care Initiative to make CRC a priority to increase screening.”</i></li> <li>• <i>“Improve relationship between Clinic and Public Health and work with them to improve screening rates.”</i></li> </ul>
<i>“Lack of recognition of screening rates among providers. Often times, the data is not reliable.”</i>	<ul style="list-style-type: none"> <li>• <i>“Need tracking/follow-up to continue the increase of CRC rates. A list to highlight patients eligible to get screening would need staff to follow-up.”</i></li> <li>• <i>“Rearrange system to improve rates; we need a systems change.”</i></li> </ul>



<b>Health System Barriers and Solutions to CRC Screening</b>	
<b>Barriers</b>	<b>Possible solutions</b>
<i>“Staff turnover causes a lack of continuity of care.”</i>	<ul style="list-style-type: none"> <li>• <i>“Consistency. Everyone gets the same message and guidelines.”</i></li> <li>• <i>“Need cultural training for cancer programs.”</i></li> </ul>
<i>“Most clinic facilities are not equipped to provide colonoscopies for their patients.”</i>	<i>“Get a provider credentialed to do colonoscopy. An employed endoscopist in the clinics saves CHS money.”</i>
<i>“(Many clinics) still having paper charts.”</i>	<i>“Electronic medical record system.”</i>
<i>“Limited outreach and community education tools at the clinic.”</i>	<i>“Provide community patient education.”</i>
<i>“Not having a process to identify patients in need of CRC screening.”</i>	<i>“Developing a process to assess clients (who are in need of CRC screening).”</i>
<i>“No tracking for FOBT/FIT tests for reminders.”</i>	<i>“Add component to EHR system to have an alert/reminder system.”</i>
<i>“No policy in what to do with a positive FOBT test.”</i>	<i>“Develop a clinic policy for the steps to follow when test is positive, (including) a procedure: call/form letter/visit and what to include in discussion with patient.”</i>

<b>What have clinics tried to increase cancer screening rates among patients?</b>
<i>“Reminder systems in the EMR.”</i>
<i>“Teams get reports on their screening rates.”</i>
<i>“Meeting Government Performance and Results Act (GPRA) standards.”</i>
<i>“Offering incentives for patients to get screened. Positive reinforcement works.”</i>
<i>“Partnerships with cancer screening navigators or state screening programs.”</i>
<i>“Coordination with Community Health, which creates wrap around care for patients.”</i>



**LESSONS LEARNED FROM THE INPACS PROJECT:**

*After visiting 40 clinics in the Northern Plains, the INPACS project identified areas of possible interventions to support the increase of CRC screening in future projects.*

**Provider recommendation:**

Current practices demonstrated the importance of provider recommendation as a predictor of patient screening completion. This was reflected by the information gathered in the facility assessment and was part of the feedback received in provider discussions.

Future projects could support provider education and resources to encourage provider discussions of CRC screening options and recommendations with patients of screening age.

**A clinic policy on CRC screening:**

Although most clinics did not have an identified written CRC screening policy, there was often support from clinic leadership to pursue the development of such a clinic policy.

Future projects could focus on clinic policy development and enforcement to ensure a system change within clinics in order to increase screening.

**Clinic reminder system:**

Many of the participating clinics had an EMR system in place with a basic reminder set up to alert providers to offer CRC screening for their patients. In most cases, these systems were not set up to prompt patient reminders before the CRC screening was due or outside of the clinic visit.

Poor communication on CRC screening tests results and follow-up recommendations between the participating clinics and the endoscopy facilities was another common concern among providers.

Future projects could support clinics in navigation of their EMR systems to systematically use patient and provider reminder tools, including follow-up. Clinics that have already developed these techniques in effectively communicating patient follow-up with referral facilities could serve as role models.

**Effective communication system:**

In most instances, providers felt they could adequately discuss CRC screening with their patients in less than 10 minutes. Although, providers commonly shared concerns that clinic time demands sometimes limited their ability to have this discussion with patients.

Some clinics had an established system where providers received feedback on their rates of CRC screening achievement with patients.

Future trainings could emphasize shared decision making techniques to use with patients when discussing CRC screening options and the role of clinic staff to intervene. Developing systems for both providers and health care staff will help reinforce what is working and highlight areas in need of improvement where it can support overall clinical practices.





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