Public Health and Health Systems Partnerships to Increase Colorectal Cancer Screening in Clinical Settings in New York State

Project Packet

November 2021 – April 2023

Table of Contents

Background and Goals

Introduction

The purpose of the *Public Health and Health System Partnerships to Increase Colorectal Cancer Screening in Clinical Settings* project is to support primary care clinics to implement and/or improve evidence-based interventions (EBIs) identified in the Community Guide aimed at increasing colorectal cancer (CRC) screening rates. This work is funded by the Centers for Disease Control and Prevention (CDC) and administered by the New York State Department of Health (NYSDOH). Clinics participating in the project receive support from the NYSDOH, CDC and other experts to increase CRC screening rates and improve the quality of screening and follow-up testing. The materials in this packet outline the project expectations, timeline and key deliverables as established by the CDC and NYSDOH (Appendix A:).

Background

CRC is the second leading cause of death from cancer in the United States and the third leading cause of cancer death for New York State adults. There are approximately 9,027 new cases of CRC diagnoses about 3,060 adult death from this disease annually in NYS. Early detection of CRC, through regular screening, can improve survival rates. In some cases, screening can prevent the development of CRC through detection and removal of adenomatous polyps before they become cancerous. Of individuals diagnosed with early-stage CRC, more than 90% live for five or more years.

The U.S. Preventive Services Task Force recommends screening average risk adults age 45-75 years old for CRC with either: 1) fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually, 2) multi-target stool DNA (also referred to as FIT-DNA) every 1 or 3 years, 3) colonoscopy every 10 years, 4) computed tomographic colonography (CTC) every 5 years, 5) flexible sigmoidoscopy every 5 years, or 6) flexible sigmoidoscopy every 10 years with FIT annually.

Despite strong evidence that screening for CRC is effective, the percentage of NYS adults ages 50 to 75 years who report a CRC screening history adherent with current USPSTF recommendations was 71.5 in 2019. This is below both the Healthy People 2030 objective of 74.4% and the National Colorectal Cancer Roundtable's goal of 80% screened for CRC in every community.

Adults ages 50 to 64 years are significantly less likely to report having received recommended CRC screenings than adults ages 65 years and older. Adults ages 50 to 75 years without health insurance are significantly less likely to be adherent (50.9%) compared to those with any health insurance (73.1%). Moreover, NYS adults ages 50 to 75 years without a regular health care provider are also significantly less likely to be adherent (41.3%) compared to those with a regular health care provider (75.2%). Lower rates of screening directly contribute to disparities in CRC morbidity and mortality.

Project Expectations

In order to ensure that the clinics participating in this project receive the greatest benefit, clinic level staff are expected to be actively involved in the work. Primary project contacts at each clinic will communicate with NYSDOH on a regular basis about project activities. In addition, robust engagement is also needed from other staff at the clinic and center level during project meetings and collaborative learning sessions. Specific expectations and responsibilities for both clinic and NYSDOH staff are outlined further in each topic area.

Project Structure

This project consists of a clinic assessment, development of a quality improvement (QI) plan, implementation of that QI plan, participation in a learning collaborative, CRC screening rate data validation, and participation in ongoing evaluation. NYSDOH may engage partners to support clinics in completing some of these activities. NYSDOH and its partner/s are collectively referred to as NYSDOH throughout this document.

Clinic Assessment

The intent of the clinic assessment is to collaboratively identify and document the clinic's current CRC screening processes, workflows, data, and available resources. The assessment may identify gaps in clinic workflow and opportunities for improvement. Results from the clinic assessment are used to inform the next step in the project, development of a QI plan.

The assessment collects a set of 'baseline' data elements that capture clinic activities prior to assessment. This enables clinic staff, the NYSDOH, and, ultimately, the CDC to assess improvements over time.

Assessment also includes data collection and discussion about the clinic's processes in the below topic areas:

- ✓ FQHC and clinic characteristics
- ✓ Quality Improvement
- ✓ Health Information Technology (HIT)
- ✓ CRC Screening Workflow
- ✓ Status of EBIs
- ✓ Barriers to Screening
- ✓ Impact of COVID-19 on screening

NOTE: NYSDOH and CDC appreciate that the recent COVID-19 pandemic has impacted clinic operations and that clinic activities during the time period since March 2020 likely do not reflect 'normal' operations. NYSDOH will work with the clinic to develop a picture of both 'normal' clinic operations as well as the impact the COVID-19 pandemic has had on clinic operations. To that end, NYSDOH may request some specific data regarding clinic screening rates and activities prior to March 2020.

Each clinic assessment will consist of an electronic survey followed by *at least* one meeting (either virtual or in person). At this meeting the team will review the survey results and discuss clinic CRC screening workflow and existing clinic activities that support CRC screening. This will inform development of a process map and identification of areas ripe for improvement through EBI implementation and other systems changes.

Clinic Responsibilities:

- Ensure clinic staff are available to participate in all live and written assessment activities.
  - This includes the designated clinic team as well as other staff in the clinic who represent those with specific responsibilities around CRC screening (e.g., patient navigators/advocates, patient care technicians, laboratory staff or any others with responsibility for mailing fecal test kits, tracking referrals, and making reminder calls, public affairs staff responsible for developing patient-facing materials, messaging and reminders, mid-level practitioners with any responsibility for educating patients, QI staff who develop and monitor assessment reports and others).
- Respond to requests for meetings and required deliverables in a timely manner.
- Engage openly and honestly about current clinic operations.

NYSDOH Responsibilities

- Respond to questions and requests for technical assistance in a timely manner.
- Provide guidance on all aspects of the clinic assessment.
- Engage respectfully with clinic staff.

Outcome: At the close of the assessment process, clinic teams and NYSDOH will have developed a mutually agreed upon process map (and or value stream map) of the patient flow for CRC screening as well as individual workflows for each existing EBI the clinic has in place (e.g., provider reminders, patient reminders, etc.).

Quality Improvement (QI) Plan Development

As described above, the clinic assessment process will enable the clinic, in partnership with NYSDOH, to identify EBIs and other systems changes to include in of a QI Plan to be implemented in the next phase of the project. At least two EBIs must be included as part of each clinic's QI Plan.

Using information gathered from the clinic's assessment, each clinic will develop a QI Plan that demonstrates how the clinic will both implement and evaluate selected systems changes, including at least two priority EBIs towards achieving improvement in the clinic CRC screening. This plan is a 'living' document to be reviewed regularly and revised as needed based on outcomes of implementation.

The QI plan development process is multifaceted and involves the following stages:

QI Plan Orientation: This session will include all participating clinics and consist of two parts. The first is an introduction to the project QI plan template, QI plan development guide (Appendix B:) and QI monitoring and technical assistance process. NYSDOH will review the various sections of the QI plan template and expectations for plan completion. This will include a focus on identifying appropriate interim process measures for each activity. The second part provides a brief review and discussion of general QI concepts, tools and techniques that may be of use during QI plan development and implementation. All clinic team members should attend this session.

QI Plan Development/Review Meeting: Once the QI orientation session is complete, each individual clinic will participate in at least one meeting with NYSDOH to review the tools, discuss questions and/or concerns, and discuss which EBIs/systems changes the clinic will include in the QI plan. At this meeting NYSDOH and clinic staff will discuss proposed process measures, data sources, and implementation timeline. Each clinic must participate in *at least* one live (in person or virtual) meeting regarding QI Plan development. NYSDOH will conduct periodic phone and/or email check-ins to assess progress and provide technical assistance, and clinic staff are encouraged to reach out with questions or ideas. Each clinic will be assigned a specific NYSDOH team member to be the primary contact during QI plan development. A draft QI plan will be due by December 31, 2021 with the final plan completed by January 31, 2022.

QI Plan Approval: Upon the clinic and NYSDOH agreeing on a QI plan that meets all requirements, NYSDOH will submit the plan to CDC for review and approval. CDC may respond with questions or suggestions, and NYSDOH will work with the clinic to develop responses and, as necessary, amend the QI plan to address CDC comments.

Evidence-Based Interventions

As part of this project, the CDC requires clinics to select at least two different priority EBIs to either implement or enhance as part of the QI plan. The CDC bases its priority EBIs on Community Guide recommendations.

The Community Guide is a resource that shares the official recommendations of the Community Preventive Services Task Force and, through review of evidence identifies effective EBIs that address many barriers to CRC screening. The four priority Community Guide-recommended EBIs for increasing CRC screening are: Patient Reminders, Provider Reminders, Provider Assessment and Feedback, and Reducing Structural Barriers.

Descriptions and more detail on these EBIs can be found in Appendix C:. Additionally, the Community Guide has identified that multi-component interventions have the most impact on screening rates, meaning that no one EBI used alone is sufficient to improve cancer screening rates.

Clinic Responsibilities

- Attend all required meetings during this phase.
- Review all guidance and communicate and work with NYSDOH to address any concerns or questions.
- Ensure appropriate clinic staff are engaged in QI Plan development and selection of EBI/systems changes.
- Submit a completed QI Plan for review by the established date.
- Ensure adequate process measures are identified and that the clinic can collect data to monitor these measures.
- Respond to questions or feedback from CDC (through NYSDOH) in a timely manner.

NYSDOH Responsibilities

- Provide thorough guidance and technical assistance throughout the QI plan development process.
- Respond to questions and requests for technical assistance in a timely manner.
- Summarize and submit QI plan to CDC for approval.
- Ensure questions or feedback from CDC are transmitted to the clinic, develop responses in tandem with clinic, and submit responses to CDC in a timely manner.

Outcome: At the close of the QI plan development process, clinic teams and NYSDOH will have developed a mutually agreed on QI plan that encompasses implementation and/or enhancement of at least two priority EBIs and may also include other systems changes that are expected to increase clinic CRC screening rates.

QI Plan Implementation

Once CDC approves the QI plan, implementation can begin! Depending on the QI proposed plan timeline and when CDC approves it, slight adjustments may need to be made.

It is important to communicate with NYSDOH about progress, challenges and successes, as well as any changes made during implementations. There are two primary methods of communicating with NYSDOH about project activities.

- Clinics must submit a monthly reporting tool that collects clinic monthly screening rate data as well as narrative text describing QI implementation activities during the month such as outcomes and achievements, challenges, and plans for the next month. Clinics can also submit questions or requests for technical assistance using this monthly survey. The survey questions and guidance can be found in Appendix D:.
- Clinic teams will also participate in meetings with NYSDOH at least every other month during implementation. These meetings will be an opportunity to review monthly report submissions, discuss any successes and challenges, and follow-up on technical assistance requests.

NYSDOH will provide additional technical assistance and resources beyond these scheduled meetings, either upon request or upon review of each monthly report submission. Each clinic will be assigned a specific NYSDOH team member to be the primary contact during implementation.

Clinic Responsibilities:

- Implement approved QI plans with fidelity.
- Document any QI plan adjustments that are made.
- Submit monthly reporting tool according to the agreed upon submission schedule
- Participate in regular project meetings.
- Identify successful activities (through PDSA cycles, ongoing review of data and process measures, and use of other QI tools) and expand or sustain these activities to increase usage across the clinic.

NYSDOH Responsibilities

- Provide timely technical assistance to ensure clinic has access to the most up-to-date resources and information on best practices.
- Support clinics in identifying successful activities and developing plans for expanding and sustaining activities.
- Engage with clinics with understanding and awareness of competing priorities and unexpected barriers.

Outcome: At the end of the implementation period, it is expected that QI plans will have been followed or, if adjustments made, those adjustments were documented. Implementation of QI plans is expected to increase clinic CRC screening rates.

Learning Collaborative

Throughout QI plan implementation, all participating clinics will join live learning collaborative sessions, held every other month from March through November 2022. The intent of these sessions is to support improvement through collaborative learning across varied clinic sites. Clinic team staff will discuss high priority topics, share barriers to screening and strategies to overcome challenges. Through these discussions, it is expected that new approaches and ideas for overcoming barriers to screening will be developed. Clinic team staff will learn from each other, NYSDOH and other topic experts.

Potential learning collaborative session topics include: patient education and messaging, maximizing workflows and reducing structural barriers, closing the referral loop, and leveraging HIT to improve CRC screening compliance. For each session, NYSDOH will make recommendations as to which staff, beyond the clinic team, should attend each session.

To complement the live collaborative learning, prior to each session clinic staff will review one or more recorded trainings that relate to the session topic. Discussion questions will be shared at the end of each recording, and clinics will come to live sessions prepared to discuss these

clinic activities related to the topic area. Course materials will be accessed on the BCPC's Project Intranet site. More information on site access and use of this site will be provided prior to the first session.

Clinic Responsibilities:

- Identify appropriate staff to be invited and attend each session, based on topic, ensuring that the core clinic team is always in attendance.
- Ensure staff complete the requisite recorded course prior to each live session.
- Ensure staff are prepared to participate in collaborative sessions by sharing best practices, successes, and challenges.

NYSDOH Responsibilities

- Identify session topics that correlate to clinic needs as identified during clinic assessments.
- Facilitate open and respectful dialogue among all clinic and NYSDOH participants during live discussions and on discussion boards.

Outcome: Clinics participate in collaborative learning and learn strategies to overcome barriers to QI Plan implementation.

Data Validation

Between January and March 2022, as the QI plan is being finalized for CDC approval, clinics will work with NYSDOH to assess the quality of screening data reported by the clinic's electronic health record (EHR), a process referred to as data validation.

A functional EHR system is integral to building an organized screening system. The accuracy of data extracted from EHRs can vary for many reasons, including how data are documented and entered into the EHR. As described in the National Colorectal Cancer Roundtable's (NCCRT) summary report, "Use of Electronic Medical Records to Facilitate Colorectal Cancer Screening in Community Health Centers," problems with EHR screening rates include; the system is not optimized to track cancer screening easily, poor documentation of previous screening received outside of the health system, lack of staff training, and family history data are not easily accessible.

Validation is an important step in determining the accuracy of the EHR-generated screening rate. Given the EHR issues described above, EHR-generated screening rates may not be accurate. To validate the accuracy of an EHR-generated CRC screening rate, clinics will complete a written assessment of their ongoing or latest data validation activities. Clinics will then complete a manual chart review and compare that chart review with an EHR generated screening rate for the same period (December 2021 trailing year). Clinics will report on any findings and actions taken to address issues. NYSDOH will provide guidance on completing and reporting on this manual chart review.

Clinic Responsibilities:

- Respond to data validation assessment and any follow-up questions.
- Complete data validation as per minimum project specifications. Clinics may complete validation activities beyond minimum project specifications.

NYSDOH Responsibilities:

- Review data validation survey and provide feedback in a timely manner.
- Support clinic manual chart review efforts with guidance and technical assistance.

> ***Outcome:*** Consistent and accurate CRC screening rate data collected and reported throughout the project to ensure data integrity and support practice improvement

Evaluation

So far we've outlined data collection activities that support project evaluation and performance management. This section describes all of the elements included in overall project evaluation.

Evaluation and performance management help demonstrate achievement of project outcomes; build a stronger evidence base for specific interventions; clarify applicability of the evidence base to different populations, settings, and contexts; and drive continuous improvement. Evaluation and performance measurement also determine if the intended populations are reached, if activities are implemented as planned, and whether project impact is achieved.

Data collected and monitored throughout this project will be used by CDC for overall project evaluation, NYSDOH for state-level and clinic-specific evaluation and to provide technical assistance and develop best practices, and by participating clinics to monitor progress toward stated goals.

Baseline Data Collection: During the clinic assessment process described earlier, NYSDOH collects baseline data about the clinic and CRC screening that is reported to CDC and used to understand how the clinic functions, what roles various staff have in the CRC screening process, how CRC screening rates are monitored and common barriers to screening among the patient population.

Monthly Data Collection: As described in the QI plan implementation section, during implementation each clinic will complete a monthly survey reporting on activities and progress. The survey collects monthly screening rates and narrative text describing QI implementation activities during each month Appendix D.

Annual Data Collection: Between August and October of each year the NYSDOH will collect clinic-level data to meet CDC requirements for data submission. Data elements include annual screening rates and progress on implementing QI plans. CDC will review the submission and may ask for additional or clarifying information. NYSDOH will work with clinics to develop responses as necessary.

Success Story: In the second contract period (in or around May 2023) NYSDOH will work with each clinic to develop a success story related to project activities. Additional guidance will be provided as this date approaches.

Ad Hoc Surveys/Evaluation: NYSDOH may ask the clinic to complete additional surveys throughout the project period. Surveys may be for NYSDOH use (e.g., evaluation project implementation and the quality of educational materials) or may be CDC-developed surveys around specific activities.

Clinics may also be asked to participate in additional research projects through CDC collaborations with research partners. Participation is voluntary and optional and may be funded or unfunded.

Clinic Responsibilities:

- Provide accurate and timely data and reports to support individual clinic and overall project level progress towards evaluation efforts.
- High-quality clinical data available and routinely used to monitor improvement in screening metrics such as fecal test return rate, screening colonoscopy completion rate and timely follow-up of positive screening tests.

NYSDOH Responsibilities:

- Oversee project evaluation and performance management, providing useful tools and technical assistance to clinics as well as timely data submissions to the CDC.
- Support clinics in understanding data submission and reporting requirements.
- Provide clinics with clear feedback on data and reports received.

Outcomes:

Clinic Level Outcomes:

- Sustained clinic support for improvements in cancer screening related clinical care
- Increased clinic-level cancer screening-related rates
- Increased number of patients that return completed FIT kits
- Improved colonoscopy completion rate
- Increased number of eligible patients up to date with CRC screening

Population-Level Impact

- Increased percentage of adults that are up to date with colorectal cancer screening
- Increased early detection of cancer
- Decreased colorectal cancer incidence and mortality

Appendix A: Project Activity Overview and Timeline

Colorectal Cancer Screening Project Activity Overview and Timeline

Key Deliverable	Timeframe	Description		
Kickoff Meeting	11/3/2021	Clinic teams participate in project kickoff meeting		
Clinic Assessment Survey	11/8 - 11/22/21	Collects data and information on existing clinic processes and activities related to CRC screening, to be distributed 11/8/21, due 11/22/21		
Clinic Assessment Meeting/s	11/8 – 11/30/2021	Review assessment survey results and map out clinic processes ○ One meeting with HIT/QI staff to review HIT tools and existing QI processes ○ At least one meeting with clinic staff to review clinic workflows and develop process map		
QI Plan Development	12/1 – 12/31/21	Clinic team meets with NYSDOH to review QI plan template and receive guidance on completing the QI plan. Consider gaps identified during assessment when identifying potential activities. ○ One project-wide QI plan training between 12/1 and 12/15/21 ○ Submit draft QI plan by 12/31/21		
Final QI Plan Submission Approval	12/31/21 - 1/31/22	Complete a QI plan to improve clinic CRC screening rates ○ Clinic team participates in at least one technical assistance meeting to review draft plan ○ Submit final plan by 1/31/22		
Data Validation	1/1/22 – 3/31/2022	Complete data validation of CRC screening measure. ○ Complete survey of current data validation activities ○ Complete manual chart review		
QI Plan CDC Approval	2/1 – 2/28/22	CDC approves QI plan, Clinic begins implementation		
QI Plan Implementation Period		**Reporting**	**Learning Collaborative**	**Meetings**
		Clinic submits monthly progress reports and screening rates via reporting template	Clinic team and other clinic staff actively participate in learning collaborative sessions every other month.	Clinic team meets with NYSDOH at least every other month to discuss progress and receive technical assistance
	March 2022		Learning Collaborative Session #1 March 16, 2022	Implementation Meeting
	April 2022	March Narrative & January Data due 4/30/22		
	May 2022	April Narrative & February Data due 5/31/22	Learning Collaborative Session #2 May 18, 2022	Implementation Meeting
	June 2022	May Narrative & March Data due 6/29/22		

Key Deliverable	Timeframe	Description		
		Reporting	**Learning Collaborative**	**Meetings**
QI Plan Implementation and Evaluation	July 2022	June Narrative & April Data due 7/31/22	Learning Collaborative Session #3 July 20, 2022	Implementation Meeting
	August 2022	July Narrative & May Data due 8/31/22		
	September 2022	○ Annual assessment due 9/15/22 ○ August Narrative & June Data due 9/30/22	Learning Collaborative Session #4 September 21, 2022	Implementation Meeting
	October 2022	September Narrative & July Data due 10/31/22		
	November 2022	○ Annual Screening Rate due 11/15/22 ○ October Narrative & August Data due 11/30/22	Learning Collaborative Session #5 November 16, 2022	Implementation Meeting
	December 2022	November Narrative & September Data due 12/31/22		
	January 2023	December Narrative & October Data due 1/31/23		Implementation Meeting
	February 2023	January Narrative & November Data due 2/28/23		
	March 2023	Success Story due 3/2023		Implementation Meeting
	April 2023			
Evaluation & Sustainability	September 2023	Annual assessment due 9/15/23		
	November 2023	Annual Screening Rate due 11/15/23		

Appendix B: QI Plan Template and Completion Guide

QI Plan Template

Implementing Quality Improvement Activities to Increase Colorectal Cancer Screening

QUALITY IMPROVEMENT ACTION PLAN **(**Complete either electronically or via a print copy.)
SECTION 1:
Date
Organization Name/Site Location
Team Lead(s) and Contact Information

SECTION 2:
Sample Area Identified for Improvement
Process or problem identified for improvement *While processes are in place to identify patients coming in for appointments who are due for screening and processes are in place to recommend screening to these patients, patients not scheduled for visits are notified only once per year. In depth patient education may not be available for all patients depending on staff schedules on patient's appointment date. Screening rates vary across age and race/ethnicity, targeted messaging may be needed for different populations/age groups. Regular reminders with targeted messaging may support increased screening rates among target populations.*
Background leading up to need for this action plan (include findings from clinic readiness assessment) *Clinicians recommend screening and refer patients to pt advocate appointment, pending PA schedule availability. Some patients may leave without in-depth education and may not return for this education/appointment. Patients who do not have scheduled appointments may not respond to once per year message regarding screening, messaging may not be targeted to specific populations. This is especially necessary for Hispanic/Latinx patients aged 50-54, who clinic date show have the lowest screening rates.*

SMART Goals (Specific, Measurable, Attainable, Realistic, Time-Bound)	**Process Measures** (For each SMART Goal, identify a corresponding measurement)
1. Increase the number of times patients receive screening reminders in 2022 from one reminder in March to monthly reminders. Reminders sent until screening complete. *2. Increase the variety of screening messages available to utilize for varied patient populations*	*1. Unscreened patients receive up to 12 screening reminders per year. Reminders sent until screening complete.* *2. Number of different messages available, Number of kinds of messaging methods available, Number of targeted messages available to Hispanic/Latinx patients aged 50-54.*
Scope of the Intervention	**Resources Needed**

(boundaries for where project begins and ends)	
Identify target population. Develop/find tested messages promoting CRC screening. Assess messaging for use with target population. Develop plan for managing patient referral to screening post-reminder. Implement reminders among patient population. Monitor responses/outcomes and assess changes to be made.	*Data identifying demographic most in need of increased attention/targeted messaging.* *Data identifying preferred method of contact of these patients.* *Existing tested messaging from external agencies/partners. Input from PFAC or other patient group to ensure messaging resonates and identify additional barriers to be addressed in communications.*
Potential Barriers & Strategies to Mitigate Barriers	**Sustainability Plan (Proposed)**
Barrier: *Identifying specific messaging for target population* Mitigation: *Utilize existing messaging as tested by the American Cancer Society, National Colorectal Cancer Roundtable, and/or Centers for Disease Control and Prevention*	*Develop communications/messaging plan with target dates for a reminder to be sent each quarter. Embed new messaging into EHR or other campaign software to be utilized as per messaging/ communications plan.* *Educate clinic staff on tested messages to be used consistently with patients in the target demographics.*
Barrier: Mitigation:	
Barrier: Mitigation:	

Categories of Intervention. Select all that apply

☐ Closing the Loop (Improving referral or resulting process with GI)	☒ **Patient Reminders (i.e. phone calls, emails, postcards, text messages)**	☐ **Provider Reminders (i.e. EMR reminders, client charts, e-mails)**
☐ Data Sources and Utilization (RHIOs, etc.)	☐ Paying for CRC Screening or Diagnostics/ Enrolling in Health Plans	☐ **Reducing Structural Barriers, select all that apply: ☐reducing time/distance to services, ☐transportation, ☐childcare, ☐extending clinic hours, ☐non-clinical setting, ☐simplifying procedures**
☒ Disparate/Hard to Reach Population/s	☐ Policy Development & Change	
☐ Electronic Health Records/Health Information Technology	☐ Professional Development Training	
☐ Improving Service Delivery (screening, diagnostics)/Workflow Development or Change	☐ **Provider Assessment and Feedback (i.e. performance reports)**	☒ Small Media (i.e. Brochures, flyers, digital/social media)
☒ Outreach and Education (i.e., group, one on one, events)/Community Health Workers	☐ Provider Champion	☒ Sustainability
☐ Patient Navigators	☐ Other: Click or tap here to enter text.	☐ Other: Click or tap here to enter text.

First Area Identified for Improvement

Process or problem identified for improvement

Background leading up to need for this action plan (include findings from clinic readiness assessment)	
SMART Goals (Specific, Measurable, Attainable, Realistic, Time-Bound)	**Process Measures** (For each SMART Goal, identify a corresponding measurement)
1. 2.	1. 2.
Scope of the Intervention (boundaries for where project begins and ends)	**Resources Needed**
Potential Barriers & Strategies to Mitigate Barriers	**Sustainability Plan (Proposed)**
Barrier: Mitigation:	
Barrier: Mitigation:	
Barrier: Mitigation:	

Categories of Intervention. Select all that apply

☐ Closing the Loop (Improving referral or resulting process with GI)	☐ **Patient Reminders (i.e. phone calls, emails, postcards, text messages)**	☐ **Provider Reminders (i.e. EMR reminders, client charts, e-mails)**
☐ Data Sources and Utilization (RHIOs, etc.)	☐ Paying for CRC Screening or Diagnostics/ Enrolling in Health Plans	☐ **Reducing Structural Barriers, select all that apply: ☐reducing time/distance to services, ☐transportation, ☐childcare, ☐extending clinic hours, ☐non-clinical setting, ☐simplifying procedures**
☐ Disparate/Hard to Reach Population/s	☐ Policy Development & Change	
☐ Electronic Health Records/Health Information Technology	☐ Professional Development Training	
☐ Improving Service Delivery (screening, diagnostics)/Workflow Development or Change	☐ **Provider Assessment and Feedback (i.e. performance reports)**	☐ Small Media (i.e. Brochures, flyers, digital/social media)
☐ Outreach and Education (i.e., group, one on one, events)/Community Health Workers	☐ Provider Champion	☐ Sustainability
☐ Patient Navigators	☐ Other: Click or tap here to enter text.	☐ Other: Click or tap here to enter text.

Second Area Identified for Improvement

Process or problem identified for improvement	
Background leading up to need for this action plan (include findings from clinic readiness assessment)	
SMART Goals (Specific, Measurable, Attainable, Realistic, Time-Bound)	**Process Measures** (For each SMART Goal, identify a corresponding measurement)

1. 2.	1. 2.
Scope of the Intervention (boundaries for where project begins and ends)	**Resources Needed**
Potential Barriers & Strategies to Mitigate Barriers	**Sustainability Plan (Proposed)**
Barrier: Mitigation:	
Barrier: Mitigation:	
Barrier: Mitigation:	

Categories of Intervention. Select all that apply

☐ Closing the Loop (Improving referral or resulting process with GI)	☐ **Patient Reminders (i.e. phone calls, emails, postcards, text messages)**	☐ **Provider Reminders (i.e. EMR reminders, client charts, e-mails)**
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☐ Electronic Health Records/Health Information Technology	☐ Professional Development Training	
☐ Improving Service Delivery (screening, diagnostics)/Workflow Development or Change	☐ **Provider Assessment and Feedback (i.e. performance reports)**	☐ Small Media (i.e. Brochures, flyers, digital/social media)
☐ Outreach and Education (i.e., group, one on one, events)/Community Health Workers	☐ Provider Champion	☐ Sustainability
☐ Patient Navigators	☐ Other: Click or tap here to enter text.	☐ Other: Click or tap here to enter text.

Third Area Identified for Improvement

Process or problem identified for improvement

Background leading up to need for this action plan (include findings from clinic readiness assessment)

SMART Goals (Specific, Measurable, Attainable, Realistic, Time-Bound)	**Process Measures** (For each SMART Goal, identify a corresponding measurement)
1.	1.

2.	2.
Scope of the Intervention (boundaries for where project begins and ends)	**Resources Needed**
Potential Barriers & Strategies to Mitigate Barriers	**Sustainability Plan (Proposed)**
Barrier: Mitigation:	
Barrier: Mitigation:	
Barrier: Mitigation:	

Categories of Intervention. Select all that apply

☐ Closing the Loop (Improving referral or resulting process with GI)	☒ **Patient Reminders (i.e. phone calls, emails, postcards, text messages)**	☐ **Provider Reminders (i.e. EMR reminders, client charts, e-mails)**
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☐ Patient Navigators	☐ Other: Click or tap here to enter text.	☐ Other: Click or tap here to enter text.

Implementing Quality Improvement Activities To Increase Colorectal Cancer Screening

QUALITY IMPROVEMENT PLAN COMPLETION GUIDE

This guide provides explanations for how to complete each section of the Quality Improvement (QI) Plan, including the companion Plan Do Study Act (PDSA) cycle log excel spreadsheet. The QI Plan is to be used to document proposed QI interventions and progress implementing them. Within the QI plan and PDSA cycle log, each clinic will identify each intervention selected for improvement, and develop a plan for implementation. The QI plan may be completed electronically or via a print copy.

Section 1:
Date: Provide the date that this plan is created.

Organization/site Location: Name of the organization or health system and clinic site/location. Name, address, telephone number of the organization or health system and clinic site/location.

Team Lead(s): Name, email and telephone number of team lead/s for this site.

Section 2:
Section 2 consists of a sample *Area Identified for Improvement* plus three fillable *Areas Identified for Improvement* to complete with descriptions of the discrete processes or problems identified through assessment and plans for implementation. Each *Area Identified for Improvement* includes sections to fill in that identify the intervention/process designated for improvement, at least one SMART goal, and at least one corresponding process measure for tracking progress.

Not all *Areas Identified for Improvement* must be completed, though the overall plan **must** include implementation or improvement of at least two evidence-based interventions (EBIs). While work on EBIs is required, there may be other system improvements necessary to support achievement of a goal.

> EBIs have been documented empirically as having evidence of effectiveness in creating QI change. The Centers for Disease Control and Prevention (CDC) has identified four domains that, when they are implemented individually and especially in combination, are effective in increasing the rate of colorectal cancer (CRC) screening.
>
> System improvements may include: amending existing processes or protocols, developing new workflows (such as ensuring diagnostic follow up/closing the loop after a positive stool-based test, monitoring and tracking screening recommendations to completion), Health Information Technology (HIT) improvements or upgrades, development or modification of patient education materials, increasing or changing staff roles, or using a team-based approach.

The clinic will identify each intervention and develop a plan for implementation using the QI plan document and accompanying PDSA cycle log.

Section 2 contains the following elements to complete:

Process or problem identified for improvement
- In this section, provide the reason(s) that led to participating in this QI CRC Screening Project.

Background leading up to need for this action plan (includes findings from the clinic readiness assessment)
- Provide a short summary of supplemental information that supports the process or problem that is identified in the section above. This section may include clinic specific data, anecdotal/clinical observations, and/or regional population health information.

SMART Goals: The QI plan includes the use of SMART goals, corresponding process measures that will document the change, and a PDSA cycle log documenting the progress of the EBI.
- For this section, document the SMART goal the clinic will seek to achieve in response to the process or problem area identified for improvement. The statements should be specific, measurable, achievable,

relevant, and time-bound. To be measurable, the action must inherently be able to be documented or counted. Include as many SMART goals as necessary.

Process measures: Include at least one corresponding measure for each SMART goal. Process measures are:

- Statements of the action that will be counted or documented as evidence of change related to the SMART goal.
- The process measure is intended to produce the evidence to understand whether change has occurred and should be applicable to the SMART goal and the intervention.
- Included with this document is an appendix that contains a list of sample process measures that may be used as the measures that apply to SMART goals.

Scope of the Intervention: Provide information in this section regarding the improvement activity, including timing and any additional detail such as the specific, target patient population, and/or number of clinicians or process that will participate.

Resources Needed: List the resources (of all types) needed to carry out the improvement effort.

Potential Barriers & Strategies to Mitigate Barriers:

- Identify the obstacles that might need to be addressed during the planning and implementation of the interventions.
- Identify methods and approaches for removing the potential barriers.

Sustainability Plan: Identify a plan for permanently integrating the intervention once the desired outcome/goal has been reached.

- How will sustainability be built into implementation? Describe efforts to institutionalize changes, gradually moving activities to other funding sources, efforts to automate tasks through Health IT, and implementing new or improved protocols and staff training processes, etc.

Categories of Intervention: Select the categories the intervention supports/falls under. Please note that the four EBIs are in bold, as a reminder that at least two of these interventions must be selected for improvement work. Select all categories that apply to each Area of Improvement.

- **Closing the Loop:** Improving referral or resulting process with specialists. This may include activities related to patient referral and scheduling as well as timely receipt of complete results of procedures.

- **Data Sources and Utilization:** Utilizing or improving processes related to Regional Health Information Organization (RHIO) data or other external data sources to identify patients in need of screening or dates and results of prior procedures.

- **Disparate/Hard to Reach Populations/s:** Improving or implementing work related to specific, target populations in need of more specialized outreach, messaging, or barrier reduction service.

- **Electronic Health Records/Health Information Technology**: Improving HIT system to better identify patients in need of screening, monitor screening activities (from referral to scheduling/kit distribution), and improve receipt and storage of results in structured fields.

- **Improving Service Delivery/Workflow Improvement:** Improving processes to increase screening recommendation and monitoring of screening completion. Also includes maintenance of a network of providers and partnerships with health care organizations to guarantee timely access to screening and diagnostic services.

- **Outreach and Education/Community Health Workers:** Improving community-level outreach and educational activities. May also include improving screening messages provided to patients in one on one or group settings.

- **Patient Reminders: Written (letter, postcard, email) or telephone messages (including recorded/automated messages) advising people that they are due for screening. Client reminders can be general to reach the overall target population or tailored with the intent to reach one specific person based on characteristics unique to that person, related to the outcome of interest, and derived from an individual assessment.**

- **Paying for CRC Screening or Diagnostics/ Enrolling in Health Plans:** Improving patient access to screening through programs such as the Cancer Services Program, charity care or enrollment in health insurance.

- **Policy Development and Change:** Developing or improving policies related to CRC screening

- **Professional Development/Training:** Instituting or improving clinic staff/clinician training related to CRC screening, including education on new policies or resources available.

- **Provider Assessment and Feedback: Interventions that evaluate provider performance in delivering or offering screening to patients (assessments) and presentation of information to providers about their performance in providing screening services (feedback).**

- **Provider Reminders: Reminders inform health care providers it is time for a client's cancer screening test (called a "reminder") or that a client is overdue for screening (called a "recall").**

- **Reducing Structural Barriers: Structural barriers are *non-economic* burdens or obstacles that make it difficult for people to access cancer screening.**
  Examples of structural barriers include but are not limited to:
  - **Schedule limitations/inconvenient hours**
  - **Transportation barriers/lack of transportation**
  - **Language/translation barriers**
  - **Patient engagement**

- **Small Media:** Developing or utilizing materials such as videos or printed materials like letters, brochures, and newsletters. These materials can be used to inform and motivate people to be screened for cancer. They can provide information tailored to specific individuals or targeted to general audiences

- **Sustainability:** Permanently integrating an intervention. Institutionalizing changes, automating tasks through Health IT, and implementing new or improved protocols and staff training processes

- **Other:** Please add category titles that relate to the planned intervention
- **Recommendations & Next Steps**
  Suggestions for additional QI activities based on findings and lessons learned.

<u>Sample Process Measures for Selected Evidence-Based Interventions (EBIs) and Supportive Strategies</u>
QI plans must include interim process measures for each intervention and corresponding SMART goal(s). Clinics will monitor and report on progress using these process measures, which will assist in identifying whether interventions are heading towards or meeting stated goals.

The suggested process measures included below are provided to assist in identifying clinic-specific measures. These maybe used as is or modified or new measures can be identified depending on the goals and interventions selected.

INTERVENTION	POTENTIAL PROCESS MEASURE
EVIDENCE-BASED INTERVENTIONS	
CLIENT REMINDERS	Percent of / number of patients sent reminders to be screened for CRC that are coming due in the next 60 days
	Percent of / number of patients sent reminders to be screened for CRC that are 60 days past due

	Percent of / number of specific patient population such as: men, women, patients 50-64 years of age sent reminders to be screened for CRC that are coming due in the next 60 days
	Percent of / number of specific patient population such as: men, women, patients 50-64 years of age sent reminders to be screened for CRC that are 60 days past due
	Number of attempts or number of times a patient is sent a client reminder before attempts stop
	Number of different types of delivery for client reminders (automated message vs tailored message, personal call, letter, text, patient portal)
PROVIDER REMINDERS	Percent of / number of providers that are reminded each day that their scheduled patients are due/past due for CRC screening.
	Number of X delivery type for provider reminders (e.g., huddle, EHR alert, paper note, other…)
	Monitor alert fatigue (are alerts ignored, is there a work around to stop the alerts, do providers need to provide a response in the EHR to satisfy the alert)
PROVIDER ASSESSMENT AND FEEDBACK	Factors to consider when assessing the use of provider and assessment feedback reports:
	Frequency of provider assessment and feedback reports given staff.
	Measures selected (e.g. CRC screening rate, number of patients referred to screening, number of fecal screening test kits handed out to patients, number of patients referred to colonoscopy, etc..)
	Who receives the reports
	How the reports are distributed
	Blinded or unblinded reports
REDUCING STRUCTURAL BARRIERS	Number of different barrier reductions services offered
	Percent of / number of patients offered assistance with CRC screening
	Percent of/ number of patients with completed barrier assessment
	Percent of/ number of patients assigned a navigator (or similar role) to address barriers
OTHER SYSTEMS IMPROVEMENTS/SUPPORTIVE STRATEGIES	
	Number of patients who had orders or referrals for GI/Colonoscopy
	Number of patients with completed colonoscopy

IMPROVING COLONOSCOPY REFERRAL PROCESS	Number of missed colonoscopy/GI appoints without prior cancellation
	Number of cancellations less than 24 hours before the scheduled colonoscopy appointment
	Number of patients who received screening results
	Number of results that were sent to the primary care provider
	Number of patients offered assistance with obtaining prep items
IMPROVING FIT DISTRIBUTION AND RETURN PROCESS	Number of FIT/iFOBT kits: ordered, handed out to patients, returned, sent to and processed by the laboratory
	Number of test results returned to the clinic
	Number of test results communicated to patients
	Number of reminder calls resulting in returned kits
IMPROVING FOLLOW-UP OF ABNORMAL RESULTS	Number of positive CRC screening results communicated to patients
	Number of diagnostic colonoscopies completed after positive stool-based test results
IMPROVING HIT PROCESSES TO SUPPORT IMPROVED CRC SCREENING	Number of colonoscopy reports returned from specialist with pathology report

Appendix C: Priority Evidence-Based Interventions

Although there are several Evidence-Based Interventions (EBIs) identified by the Community Guide as effective at increasing CRC screening (What works), the CDC focuses on the four 'priority EBIs' defined below, as well as promoting the implementation of more than one EBI, as evidence suggests multicomponent interventions lead to greater impact than a single EBI alone.

Provider assessment and feedback

Provider assessment and feedback interventions both evaluate provider performance in delivering or offering screening to patients (assessment) and present providers with information about their screening performance (feedback). Feedback may describe the performance of a group of providers (e.g., mean performance for a clinic) or an individual provider (e.g., performance compared to peers in a clinic), and may be compared with a goal or standard.

Examples of provider assessment and feedback interventions include:

- Within a clinic, assessing individual provider performance for appropriately recommending CRC screening and notifying providers how they compare to one another.
- Among clinics, assessing CRC screening rate adherence to current guidelines and publishing the results in comparison to a target rate.
- Fostering competition by periodically publishing the screening rates of "competing" providers or clinics.

Provider Reminders

Reminders inform healthcare providers that it is time for a patient's cancer screening test or that the patient is overdue for screening. The reminders can be provided in different ways, such as in patient charts or by e-mail.

Examples of provider reminder interventions include:

- Activating/Utilizing the provider reminder function in an EHR to remind providers that the patient is due or overdue for screening. Reminders could include information about USPSTF recommendations for CRC screening.
- Creating a system where clearly visible reminders are placed on paper charts prior to a patient's office visit with the providers.

Patient Reminders

Patient reminders are written (letter, postcard, e-mail or text) or telephone messages (including automated messages) advising people that they are due for screening. Patient reminders may be enhanced by one or more of the following:

- Follow-up written or telephone reminders
- Additional text or discussion with information about the indications for, the benefits of, and ways to overcome barriers to screening.
- Assistance in scheduling appointments.

These interventions can be untailored to address the overall clinic population eligible for screening or tailored with the intent to reach one specific person, based on the characteristics unique to that person, related to the outcome of interest, and derived from an individual's risk assessment.

Examples of patient reminder interventions include:

- Utilizing the EHR to identify the population potentially eligible for screening and those due for screening and mailing a postcard or letter with information that they are due for screening. This would include a process to monitor responses to the reminder and providing another reminder as appropriate.

Reducing structural barriers

Structural barriers are non-economic burdens or obstacles that make it difficult for people to access cancer screening. Interventions designed to reduce these barriers may facilitate access to cancer screening services by:

- Reducing the time or distance between service delivery settings and target populations.
- Modifying hours of service to meet patient needs.
- Offering services in alternative or non-clinical settings (e.g., mobile medical vans)
- Eliminating or simplifying administrative procedures and other obstacles (e.g., scheduling assistance, patient navigators, transportation, dependent care, translation services, limiting the number of clinic visits).

Such interventions often include one or more secondary supporting measures, such as:

- Printed or telephone reminders
- Education about cancer screening
- Information about screening availability (e.g., group education, pamphlets, brochures)
- Measures to reduce out-of-pocket costs to the patient

Examples of reducing structural barrier interventions include:

- Direct referral to colonoscopy
- Offering screening in conjunction with other preventive services visits (e.g., visits for influenza or COVID-19 vaccines).
- Assessing clinic workflow to streamline processes for patient identification, test provision or referral, tracking, and follow-up

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The CDC has also developed Evidence-Based Intervention Planning Guides for each of the four priority EBIs. These are brief yet comprehensive overviews of the primary components of each intervention and include sample process flows.

Appendix D: Monthly Reporting Template and Guidance

Each month beginning in March 2022 each clinic will receive a link to complete an online report on the prior months project activities and progress. A draft of the report questions is included below:

Colorectal Cancer Screening Rate:

Monthly screening rates should be submitted with a 60-day lag. For example, when submitting the screening data for February 2022, the data should be run after April 30, 2022. The 60-day lag allows time for records to come in and be attached in the EHR correctly.

- Please report the numerator, denominator and screening rate in the designated fields.
- Please report using the same criteria each month. Any changes in the way the data is run should be described in the narrative.

Screening rate definitions are as follows:

- Denominator: patients 50-75 years of age that had a clinic visit in the one-month period being assessed. Applicable exclusion criteria based on measure should be applied (e.g. do not include long-term care residents, patients with a history of total colectomy or colorectal cancer [CRC]).
- Numerator: of the patients in the denominator those that are up to date on (CRC) screening recommendations. Typical recommendations are:
  - FIT/FOBT/iFOBT: 12months
  - FIT DNA/Cologuard: 36 months
  - Sigmoidoscopy: 60 months
  - Colonoscopy: 120 months

Screening Rate Narrative

- Please describe any contextual factors that are important to understanding reported data, such as significant shifts in denominators due to changes in clinic operations or staffing. Be sure to indicate if any changes were made in how the monthly data is run.

Monthly Narrative Reporting:
This section includes a narrative description of quality improvement (QI) plan implementation during the reporting period, including describing key progress towards implementing work outlined in the QI plan and achieving project goals.

Respond to the following questions for each of the evidence-based interventions (EBIs) being implemented: Provider Reminders, Provider Assessment and Feedback, Patient Reminders, Reducing Structural Barriers, Other EBI/Systems Change Activity:

- Activities - Briefly describe what was done to plan for, implement or enhance this activity this month? Include interim process measure data as available.
- Outcomes/achievements - What were the most important outcomes that resulted from project work on this activity this month? How did this activity impact patients and/or screening rates? Please include anything learned that may have a positive impact on patients and/or screening rates in the future.
- Challenges- What challenges or obstacles were identified in implementing this activity this month?
- Plans - What are the clinic's plans for this activity in the next month? Include 3-5 important things to get done on this activity.

Do you have any questions or requests for support or technical assistance?

If there is anything else to report or share about clinic or center operations or colorectal cancer screening please note it here.

Appendix E: Select Resources

Small Media Materials:

New York State Department of Health

- Get the Facts about Colon Cancer (PDF)
  - Spanish (PDF)
  - Haitian Creole (PDF)
  - Italian (PDF)
  - Korean (PDF)
  - Russian (PDF)
  - Chinese (PDF)
- Get Tested for Colon Cancer (PDF)
  - Spanish (PDF)
  - Haitian Creole (PDF)
  - Italian (PDF)
  - Korean (PDF)
  - Russian (PDF)
  - Chinese (PDF)
- GET FIT! Ask your doctor about FIT, a colorectal cancer test (brochure) (PDF)
  - Spanish – ¿Tiene 50 años o más? ¿Alguna vez se hizo alguna prueba para el cáncer colorrectal? (PDF)
  - Chinese (PDF)
  - Russian (PDF)
- GET FIT! Ask your doctor about FIT, a colorectal cancer test (poster) (PDF)
  - Spanish (PDF)
- 50 or Older? Get Screened for Colon Cancer (African American couple) (PDF)
  - Spanish (PDF)
- 50 or Older? Get Screened for Colon Cancer (Hispanic male) (PDF)
  - Spanish (PDF)

The Make It Your Own (MIYO)system can be used to create customized health information for the specific populations they serve. MIYO assures high quality by standardizing the look and feel of materials and using evidence-based strategies recommended by the U.S. Centers for Disease Control and Prevention. MIYO delivers industry-standard, production-ready files for print, web and interactive applications.

Mailed Fecal Test best practices and pictorial instructions for completing FIT tests from the Kaiser Permanente Center for Health Research: Program Materials (kpchr.org)

Colonoscopy Preparation Information:

- 60434-How-Do-I-Prepare-For-My-Colonoscopy_English_Spanish.pdf (kpchr.org)
- Colonoscopy Prep | Colonoscopy Richmond VA | CRS (crspecialists.com)