Colorectal Cancer Screening Quality Improvement Practices
Josh Kellems, CHES
Health Systems Manager,
Primary Care Systems
What We’ll Cover

• Colorectal Cancer (CRC) Quality Improvement Overview
• Global aim statements and activity
• Process mapping – current and ideal states
• Gap analysis
• PDSA cycles and data evaluation
• Evidence-based interventions
• Helpful tools and resources
History of ACS Colorectal Cancer Resources

- Materials/Brochure Delivery
- Evidence-Based Interventions
- Grant Funding
- Capacity-Based Quality Improvement
Colorectal Screening Initiatives Are Working!

Indiana FQHC CRC Screening Rates*

~30%  40.6%

2012  2018

QI Strategies Should Be Based On:

- Health system needs
- Capacity of resources
- Staff capacity
- Validity and accuracy of data (baselines)
The Quality Improvement Process

- Agree On the Need
- Team Identification and Formation
- Aim or Goal Setting
- Process Mapping – Current State
- Process Mapping – Ideal State
- Gap Analysis
- Plan Do Study Act (PDSA) Cycles
- Data/process evaluation
Forming The Team

Potential Team Members

• Leadership or Administration
• QI or QA Lead
• Provider Champion
• MA Champion
• Clinical Director
• IT/HIT or EMR Expert
• Do-it-all (organizer)
Global Aim Statement

The first step to organizing around an area of focus

Use S.M.A.R.T. Language

Specific goal
Measurable outcome
Attainable and
Realistic
Timeframe makes sense
Global Aim Statement

We aim to improve: (name the process)
   In: (target location or patients)

The process begins with: (specific process beginning)
The process ends with: (specific process ending)

By working on the process, we expect to: (list benefits)
It is important to work on this now because: (list imperatives)
Global Aim Statement: Example

We aim to improve: CRC screening rates from 42% (2017 UDS) to 50% by the end of CY 2018

In: Clinics system-wide

The process begins with: Analyzing the current CRC screening process and mapping the ideal screening process

The process ends with: The implementation of the ideal, sustainable CRC screening process

By working on the process, we expect to: 1. Identify current screening inconsistencies/gaps, and 2. improve upon the existing process

It is important to work on this now because: 1. The CRC screening rate fell 4% with the last year, and 2. Screening more people will help to decrease late-stage diagnosis of CRC
Global Aim Statement Activity

At your table:

1. Discuss your practice’s CRC screening needs
2. Decide what you want to improve
3. Complete the Global Aim Statement Worksheet as a group
4. Remember to keep it S.M.A.R.T.
Process Mapping (Current State)

Pre-visit

Visit

Post-visit
Gap Analysis

What factors are contributing to the problem?

FIGURE 3: Fishbone diagram for root cause analysis.
PDSA Cycles

- Make changes
- Next Cycle

- Objectives
- Predictions
- Plan for implementation
- Who should be involved

- Analyze data
- Compare to prediction or baseline
- Summarize learnings

- Carry out the plan
- Document findings
- Report problems or successes
Screening Process Considerations

- Evidence-based interventions
  - Reminder system
  - 1:1 education with patient
  - Patient navigation
  - Barrier reduction
  - Small media
  - Provider assessment and feedback
  - Provider reminder and recall systems

- EMR data entry
- Policy (standing orders)
Data Evaluation

Goal = >90%

Median = 68%

Percent Compliance

Week number

Improvement team formed
Testing and adapting changes
Changes implemented
Tools and Resources

• Your friendly neighborhood ACS representative
• Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers (ACS)
• ACS Small Media – Brochures and info sheets
• ACS Flu FIT guide
• Cancer.org
  • Presentations
  • Guidelines
  • Statistics
• NCCRT Resource Center (www.nccrt.org)
  • Webinars
  • CMEs
  • Info sheets
ACS Health Systems Managers

Northern Indiana Primary Care
Josh Kellems – josh.Kellems@cancer.org
(574) 780-6512

Central Indiana Primary Care
Andrea Radford – andrea.Radford@cancer.org

Southwest Indiana Primary Care
Caleb Nehring – caleb.nehring@cancer.org
(404) 417-8096

Statewide State-Based Systems
Katie Crawford – Katherine.Crawford@cancer.org
(317) 344-7823
Q&A