NAPCRG
International Conference
on Practice Facilitation

Practice Facilitation to Improve CRC Screening in Rural Clinics in Missouri

Presented by Nuha Wareg, MBBS, MPH, Nursing PhD Candidate; Jane McElroy, PhD; Alicia Vaca, BSN, MPH, RN; Brandon Spratt; Kevin Everett, PhD

NUHA WAREG, MBBS, MPH, Nursing PhD Candidate
Hi, everybody. My name is Nuha Wareg. I'm one of the practice facilitators on the MPICS project, which stands for Missouri Partnership to Improve Colorectal Cancer Screenings. So just like an overview of the importance of colocancer screenings to you right there. It's just like it's one of the top four cancers in the US. And then we have the CRC deaths associated with failure to screen is 76% of CRC deaths occurred in patients who are not up to date with the screenings. So it's very important and it's one of the most preventative cancers if we do the screenings. To your left, left here, it shows our map in Missouri and most of our Missouri countings unfortunately fall below the, the state average of 62%. This is also a continuous overview that screening methods. We have multiple screening methods and that's sometimes add to the complexity of CRC screening for the practices. In comparison with breast cancer, for example, they only have mammograms to stick with. This one, they have different methods; they need to talk with patients more and just like talk with them what's available and what's the difference is. So we have at home screening tests, you may be familiar with Fit or FOBT. And there is Cologuard, that's done every 1 to 3 years, and there is a colonoscopy, which is the gold standard for the screening and this is done every 10 years if it's normal. Barriers to screening we face in rural areas, you may be familiar or feel familiar with these ones. Lack of insurance, cost, transportation. It's a big issue in our Missouri rural areas as well. Other challenges: access to health centers. It's typically over 30 miles away or more. For the rural clinics we work with. Limited colonoscopy facilities availability. So they don't have a lot of facilities close by that offer colonoscopies. And also resources, other educational resources and other resources that are limited to their location. Before I start with our practice facilitation: we are a part of the CDC Colorectal Cancer program. So it's our first round, five year round, with the CDC. This is our first time to get funded and we are in the program year four and going strongly. So just like background for where our funding is coming from. So our model: we kind of like started with the NOW model when we wrote the grant, but then we kind of like pivoted and created and make it our own model. So we focus on and out and bidirectional partnership. We would tell our clinics, our partners, "we are partners in this, we need to hear from you." It's not just like they are where they're coaching you, but it's bidirectional. So you and us. We form a team with strong, our team of practice faciliators. We have strong clinical background. I'm a physician from Libya and I have my MPH here in the States. We have two nurses with nursing backgrounds. So our clinical experience adds to this. We know the clinical work flow, we know what that looks like to the practices we work with. We are able

to speak the language of clinicians, when they say something, we understand that. We have acknowledgement of, like, our respectful acknowledgement of their challenges they face on day to day, like a fast pace, like clinics work. And we have an emphasis on shared problem solving with collaborations with our team. So we have our program directors, and epidemiologists, a psychologist. And we have a gastroenterologist on our team to, to just give us, to consult her on the areas that we cannot solve. We do also additional trainings. We go a lot of conferences like this one and other conferences to add to our skills. So this is the timeline that we work with. So we do readiness assessment. We use some of the tools from CDC and other tools to do readiness assessment with our practices. And once they complete that, we start baseline data collection and then we do facilitation ongoing with them to choose evidence based interventions, implement them, and then look for ways to sustain them even after the funding will be gone. So, like I said, we have three full FTE practice facilitators. We have a project coordinator, communication outreach specialist. We have GRA with us. And then we have an evaluator, family physician with us who is an EHR expert (he's in informatics) and we have a gastroenterologist also. So a little bit about our clinics: We partnership with nine Health Systems, eight FQHCs and one free community clinic: total of 34 clinics, 20 out of those 27 in rural counties. And it's just like for data that CDC wanted us to collect by clinics. So that's why we don't look at them as a system, we look at them as individual clinics. Our demographics, we have 84% white, only 4% Black and 6% Hispanic, 28% uninsured, and we have 7% non-english speakers. Those are an overview of the evidence based interventions that CDC recommends. They're based on the EvidenceNOW. So we have patient reminders, provider reminders, a provider, assessment and feedback, structural barriers, and then supportive activities like patient navigators. For structure barriers, just now CDC, they're very like, they're not like you can choose this for transportation, you can't use this. So we're mainly focusing on workflow and how to remove these barriers, sometimes transportations, but we will need to talk with CDC before they use the funding. So it's called structure barriers. We thought it's outside of that, but it's, it's, it's a little tricky to manage. So the innovation....the innovation and technology. So what we use: we do a lot of tailored communication; we do our data analysis by our own by ourselves. We also create our tailored educational materials and this is based after we talk with clinics; we assist them and we see like what are their needs, and we tailor that. So for the communication, we always try to have the nonjudgmental tool. Like we're not here to audit you when we go to our clinics, we're here to partner, we're here to help, we're here, we are here to hear from you. We utilize different modalities for meetings, including in-person. Just an FYI, this grant started in COVID, so we started doing Zoom building this partnership, which was very hard. But then we use the chart or EHR review as an opportunity for us to go there visit even during COVID. And then after COVID is mostly gone, hopefully, we started to do more in person visits. Our emails: we try to make them very personalized, texts and phone calls, we needed. We get a lot of their phone calls sometimes. We're busy, we're out in the field: "here's my phone number, just text me when, when you send any important emails." So we do that. Site visits: We recently also did like shadowing site visits. So we go there like we're not here for a meeting or anything. We're just here to observe how you're doing things and we just talk with you whenever you have like two or three minutes. So I'm gonna focus more on data analysis in the next slide. So

this is just a mock data that what we get from them. Just we don't want to burden them. We ask them, "don't clean data, don't do anything. Just give us the Excel sheet." "We'll, we'll deal with it." So you can see like some of the variables we get from them and then we'll work on, on this data. We clean it, analyze it. The second phase is like I said, data cleaning and and analysis. And then how we share the data: we create these infographics. So you see like this is the annual data summaries. So we give this to them. after each, the end of each calendar year (it has two pages). The first page, it has some demographics and the screening rates. And then the second page, we give them screening rates by clinic and then also the chart review that we did like what, what, what did we find in their chart review. So you see more like this is the first page. We have by screening rates by age groups, gender and then race and ethnicity. And then we discuss that with them. If we see something lower, we discuss like what's happening like your Hispanic population. Do you need more interpreters? Do you need something in their language? So we use this tool to discuss with them. This is in the second page. So you see screen rates by clinic and we give them comparison what from the baseline year and the the the next year. So they see where they were and where they're at. This is just a chart review. So the chart review we do is select 10% of the full sample they give us and we go there and we look into their charts, we see the data they give us. Sometimes it says this patient, Patient A has been screened, but when we go into the chart, we cannot find any documentation for that. So it helps us identify if there is any mapping issues, like any documentation issues that they may, they may have and then we discuss with them. OK. This is not getting captured in your quality measures because of 123, documentation or mapping. So that's how we do this. This is quarterly. So we also get data from them quarterly and we give them another infographic for their quarterly data. The first page you see also their screening rates by quarter and then in the little box, I think, I have here with 5 6 patients, we do an analysis and calculation and we show them, we give them a goal like something that they can look forward. So you have to do 5 to 6 patients additionally per week to add 10% to your screening rates. And they love this because it's like just a goal for them to follow. The second page is also by clinic, their screening rates by quarter. So they see like, "oh, what's happening in this quarter?" Why we dipped down? And we...it's like just sparkles the discussion between us and we can like, look at different areas to improve. This is a provider assessment and feedback. We also create this for each provider care team and we show them, you see like Doctor Sullivan, she's over: she's at 70% screening rates. And it compares her with other providers in her system. And it also give her a goal here: like "you will need to screen an additional three patients per month to add like 10% to your screening rates." And we just give them an overview of the evidence based interventions because sometimes we cannot meet with meet with all providers. So this will give them an idea, "this is what we're doing in your system." "Those are the EBIs." So they have this quarterly. Educational materials also based on the clinic and their needs, their population they serve. So we tailor those. So, to your left here, this is what it is after a lot of feedback, we hear like patients when they do. They're scared to do a FIT test or at home stool testing because they think if it's positive, it means they have a cancer. So we created this infographic and this is also available in Spanish, Dari and Pashto. And this is because of our partners, they requested those languages. So we translated those and we give that to them. The one to the right: This was created for one

of our clinics at MU. The physician, she was very adamant about the colors; she wanted this color and she wanted a little questionnaire on the top and then just screening rates. So the one to the right, she wants to give it to her patients in the waiting room so they can answer those questions before they enter the exam room. This is a provider pocket card. We also created these, we have two of them and I have examples in my bag if you want to look at them later. This is a detailed one. So this is for MDs, DOs, and nurse practitioners, because it's very detailed. It shows them for average risk persons for high risk colonoscopy, like findings how long you need to wait to do the other colonoscopy. Very detailed one. We have another one that's very simple. Those are for RNs for MAs, to just like help them to talk with, with their patients. This is another infographic. We created one of our clinics they wanted, "ok, like we're having troubles with our male populations. We can't get them to get screened." So we created this truck education infographic that's next to them. And they, they really loved it. So we have different table stands, FIT instructions, birthday cards. We created a lot of, of these stuff. I'm just gonna go through this really quick. You can see and you can find them on our website. Those are FIT instructions. We went to each clinic, we looked at their FIT instructions. Some of them are clear. Some of them, they're very hard to understand. We give them to our families to read them like, "you understand it?" and like they say "no", so we created our own instructions: English, Spanish version and we give them to our clinics depending on the brand of the stool tests that they're using. So not all of them will be the same. There are like some exam room stands also English and Spanish. They use them. The last thing we created is safety net resources for colonoscopy. So we look out at the catchment areas of our clinics. What are the facilities around them that offer colonoscopies? We call these facilities. We conducted meetings with them. We understood, "ok, like how much is the colonoscopy? Like out of pocket for an insured person?" "Do you have any charity care?" "Do you have any discounts?" We put all of these informations in one document for each clinic and we give that to them. So CHWs, case managers, can use that when talking with their patients. We also talked with UberHealth. And if they are in our areas and the the prices to the facility, we also provided that to our clinics, just more resources for them to make it easier so they can they can serve their patient population better. So the conclusion: our implementations, we implemented our practice delegation model to utilize technology, innovative strategies will change and improve the quality of our patients care. Our outcome: we had an average 10% increased screening rates over three years (for health system with three data points) because we have a system that just joined us a year ago. So we couldn't put them in there, in the average there, but we're proud of, of the other systems. The impact: So we're hoping to improve like patient outcomes, quality of care, and close care gaps, not just for CRC screening. So what we are implementing there, we're hoping that our clinics, they can use them for other quality measures as well. And this is our team: I have Alicia, one of the practice facilitators, with me today here. These are our partners. We really want to thank them so much. We wouldn't be able to make a change without them being like very understanding partners and wanted to change and make a change in our rural communities. That's our email. Please email us if you have any questions [or] wanted any of these resources. And I think I have. Ok. Yeah, I have the…our website and MPICCS website also, and you can find these resources and download them. So, thank you.

STEPHANIE KIRCHNER
Do you have a couple minutes if anyone has any questions? Two questions.

SPEAKER 6
How did, what was the procedure or the process for doing the chart reviews?

SPEAKER 6
Did you go to the clinic?

NUHA WAREG
Yes

SPEAKER 6
And did you, did you sign like a data use agreement or how did you, how did you facilitate that process?

NUHA WAREG
Yeah. Thank you for your question. So, so it depends on the clinic. Some of them, they have a HIPAA form, some of them, they have something called VAA to let you go to there. So it depends on them. We discussed that with them at the beginning of the grant. So it's recommended by CDC, but we highly recommend this for us to see. And we just sign them and they give us access and we go to clinics. One of the clinics they allowed us to do it virtually because it was like a very high COVID. So like we signed two forms, I think one of each of our team members who are doing the chart review and one from our program directors, they need to sign that. And we just...yeah, yeah, we learned a lot about EHRs.

SPEAKER 6
Yeah, I'm curious about that really. I, I'm sitting with the whole talk just about that topic alone. so I won't though. I'll ask you my next question. What was the response on the pocket card? What's the feedback then? On, on those?

NUHA WAREG
Like, I'm gonna be honest here, the ones who got them, they love them, some of them, they really, they didn't really get. Because we sent them to the leadership and obviously the leadership didn't do the education. So when we did our site visits, we asked like, did you get a pocket card? And some of them are just like what did it look like? Like, it's a small card. "Oh, they give it to me and it's here in my drawer." They didn't know about them. So that's when it was like, "oh, ok, we need to do more education." So we started to have an educational with go with them. So if the leadership, we give them the pocket card, they didn't know anything, was like, "here it is. here's the explanations," but it's just like this is...you need to be careful. If you give it to someone, you need to be sure that they, they know how to educate about it.

SPEAKER 6
You guys create a lot of collateral like that. I mean, so many documents. So I'm curious about what the return on investment is and who did it? Who did all that design work?

NUHA WAREG
We did that.

SPEAKER 6
Wow.

NUHA WAREG
We, we had like our program director. She is like, you need to learn Illustrator, all of you.

SPEAKER 6
And you said that's free on your website?

NUHA WAREG
Yes. You'll find them on our website, like the educational materials and you can download them and brand them. It's like they're available for you. Should we take another question or?

STEPHANIE KIRCHNER
Yeah, just one more and then we'll move on to

SPEAKER 6
My name is Bo Kim. I'm from the VA Boston Health Care System. Thank you for your wonderful talk and the visuals are just stunning. So downloading them, you mentioned how for data analysis that you ask them to give you the data and then you're able to do all the analytics for.

JESSICA REED WILLIAMS
So down the road, I was wondering what your team's thoughts were on kind of building capacity at the sites themselves to be able to continue to monitor some of these things that they're doing, once you are not working with them as regularly in the future?

NUHA WAREG
Yes. Thank you. So we're doing with them something they're not gonna do analysis like we do because I, I work on SAS we do like a deeper dive in the analysis. But for them, a lot of our FQHCs, they use something called the DRVS. It's a software by Azara Health and our team also went to the conference of the Azara to, to learn more like about the tools. So some of our system, they build their own provider assistant and feedback reports now in their Azara and we are just looking at it and how to make the goal that we are creating in there to do like the calculations so the providers can get that. So we're working with them

to use different tools than what we have. But hopefully they'll have the same reporting like quarterly, and annually.

STEPHANIE KIRCHNER
Yeah, thank you so much. I'm sure she's gonna be around if there's a lot of questions.