



Cancer Prevention and Early Detection Clinical Liaison Project

Comprehensive Cancer Final Report June 2017

Prepared for:



Prepared by:
Tia Rudd, MPH, RN

Table of Contents

Preface.....	p. 3
Executive Summary.....	p. 3
Objective.....	p. 4
Deliverables and Scope of Work.....	p. 4
Methodology.....	p. 5
Observations.....	p. 5
Summary and Recommendations.....	p. 11
Appendices.....	p. 16
1. Clinical Liaison Assessment Questionnaire.....	p. 16
2. Feedback to CRC and/or WHC programs.....	p. 18
3. Sample checklist for staff when rooming patients.....	p. 19

Preface

The Cancer Prevention and Early Detection Clinical Liaison Project is a comprehensive review and assessment of colorectal, breast, and cervical cancer screening, and HPV vaccination systems and practices in primary care clinical settings. The project reflects an understanding that systems and practices for increasing rates in each program area are similar to one another in many ways. For this, the Nevada Cancer Coalition gratefully acknowledges the important joint financial support of the Comprehensive Cancer Control, Colorectal Cancer, Women's Health Connection, and Immunization programs.

Executive Summary

Cancer control stakeholders from across Nevada have recognized a need for direct assistance in identifying missed opportunities, implementing evidence-based systems changes, and improving standards in HPV vaccination, breast, cervical, and colorectal cancer screening practices in primary care clinics. The overall goal of this project in quality improvement is to improve Nevada's primary prevention, early detection, and screening rates as outlined in the Nevada State Cancer Plan.

The clinical liaison (RN) performed the pilot study, a baseline assessment of 17 providers in three health care organizations. The survey, an hour-long interview with each provider, was implemented over five months in Spring 2017. It included questions on their:

- 2016 quality measures for HPV vaccinations and cancer screening
- Current HPV vaccination and cancer prevention/screening goals and practices
- EMR systems
- Use of clinical champions
- Use of and access to technical training and educational materials
- Individual attitudes, needs, and wants in these areas.

An analysis of the qualitative data spotlighted providers' deep commitment to cancer screenings' and vaccinations' roles in saving lives, but also various frustrations in carrying out those commitments. Many of the identified missed opportunities and program barriers appear to stem from dysfunctions in systems: EMRs, understanding of staff roles, poor communication, lack of knowledge of organizational goals and policies.

Recommendations for improvement include:

- Fixing or replacing some systems—at the very least, ensuring that all users understand the systems and how to use them.
- Taking advantage of the many free or local training opportunities available.
- Developing or strengthening their clinical champion positions.
- Strengthening community engagement in screening programs by removing barriers to participation and strengthening clinic-to-client communications and education.

The following phase of this project will address the Nevada Cancer Coalition's ideas for helping these three health care organizations to identify their own QI goals relative to this project and map out processes for reaching them.

Objective

The purpose of this project was to pilot a clinical (nursing) liaison relationship with primary care providers and clinics to improve those clinics' prevention and screening practices in colorectal, breast, and cervical cancers, and HPV vaccination rates. This was to be accomplished through:

- the development and administration of a qualitative assessment to capture current cancer prevention, screening, and HPV vaccination practices in participating clinics
- summaries of providers' observations
- recommendations for improvements, including system changes, evidence-based interventions, and policy changes as appropriate.

Observations and recommendations are considered in the context of the overall (and where practical, the specific) clinics' 2016 baseline screening and missed opportunity rates, included in the appendix of this report.

Deliverables and Scope of Work

Initially, the project scope of work was for the period September 2016 to July 31, 2017. However, as the funding was not fully realized until January 2017 and this contractor was not hired until February 2017, the "due by" dates of the deliverables could not be adhered to. The original deliverables are as follows:

- Conduct in-person assessments with at least 15 primary care providers/clinics, of whom at least 15 must be Women's Health Connection participants; and 8 must be Colorectal Cancer Program participants. Provide detailed record of those visits and the data acquired.
- Identify participating clinics' 2016 baseline screening rates and missed opportunity rates for breast, cervical, and colorectal cancer; and HPV vaccination initiation, completion, and missed opportunity rates.
- Consult with Nevada Immunization Program Adolescent Immunization Coordinator for in-services on HPV vaccinations and other resources.
- Working with various levels of provider clinics, identify areas for improvement, develop clinic-specific goals, and provide recommendations for improvement.
- Provide technical assistance on best practices; provider/staff education and training as needed.
- Follow up with participating providers/clinics at intervals to measure progress toward goals.
- Provide final report to NCC and clinic/providers, to include: participants' assessment input, the changes recommended and/or implemented, and outcomes. Include detailed record of all resources provided.

The original contract also called for the contractor to engage the participation of at least two provider/clinics who would serve as pilot project clinics. However, NCC and contractor later agreed that every participating clinic would be considered as a pilot location in this project.

Methodology

Providers were identified from lists of current participants in Women's Health Connection programs, cross-referenced with current participants in the Colorectal Cancer program providers. Personal visits and phone calls from the contractor to the qualifying clinic directors engaged their assistance in promoting the project; the same methods were employed to build relationships with individual providers, culminating in hour-long appointments with each to conduct the assessments. Interviews with providers in Elko and Las Vegas were conducted by phone because of their distance from Reno; otherwise all interviews were conducted in person. In all, I interviewed 17 providers in three separate clinical systems. In addition, I interviewed seven program support staff, including administrators from Access to Healthcare and the Susan G. Komen foundation for background on how these programs provide assistance to clients.

Observations

This summary of Providers' responses follows the outline of the Clinical Liaison Assessment Questionnaire (see Appendix). Note that not all providers answered every question. Where applicable, I state the total number of respondents to those particular questions.

Patient Access

All clinics and providers participate in the Women's Health Connection (WHC) and Colorectal Cancer Program (CRC). All but one, an outreach clinic, were also Vaccines for Children (VFC) providers.

HPV Processes

Overall, providers expressed satisfaction with their medical staff's knowledge of ACIP guidelines for HPV vaccinations as well as their competence in administering the injections. Only half the providers believed their clinic has and uses a system to schedule wellness visits for patients when they turn 11 years old, (with the intent to begin offering HPV vaccination). Seventy percent reported that their "front office" probably does not call patients within a few days following a missed well-child visit. There were no standing orders enabling medical assistants to give HPV vaccinations to "walk-ins" although two providers explained that staff only needs to check with provider before administering the first dose in that series. Vaccine refusals (by parents) were always documented, although not always the reason why.

Although 65% of the respondents said their staff does provide at least "a little" education to parents about HPV and the vaccination, most of those expressed some doubt about their medical assistants' licensure, competence, and/or confidence in that area. As one doctor said,

"We need to do a better job with all our MAs. The more experienced ones are better at it, of course. We don't have a protocol in place that they do automatically. I use "same day, same way" approach, but the MAs do not."

Staff Education and Communication

Providers followed the recommended screening guidelines promoted by their clinical administrations: Advisory Committee on Immunization Practices (ACIP) for HPV vaccinations; American Congress on Obstetricians and Gynecologists (ACOG) for breast and cervical cancer;

and either American Cancer Society (ACS) or US Preventive Task Force (USPSTF) for CRC, cervical or breast cancer. One provider did not know if her practice had a consistent screening policy; however, she did appear to be following the same guidelines as others under that administration.

Only three providers acknowledged the presence of organized screening policy adherence standards within their own practices. These respondents attributed this to the fact that they worked in small, tight-knit practices with a strong lead provider promoting adherence to screening standards.

Responses regarding the presence of an identified champion for cancer screening and vaccinations were mixed. Out of 16 respondents, five providers named themselves as their own champion, and nine others identified the same individual (shared among clinics), a care coordinator, and/or the organization's administrator as the champion. There was no consistent use of the shared champions, often only an acknowledgement that there was one who was available for some functions but not others. Three reported a perceived lack of access to and rapport with the champion because he/she worked at a different site than the provider. Only one respondent (out of 10) thought there was a plan for replacing a champion who might move into a different position or leave the organization, but he didn't know what it was.

In addition to providers, I interviewed two care coordinator/champions and an LPN for background information on their roles in screening/vaccination promotion. The champions for two clinics expressed frustration, feeling stretched beyond their limits to provide the level of support that was needed and for which they had been trained. They delegated when they could, but the staff under them had varying degrees of certification and were themselves shared between clinical sites, which further strained the system of referrals and navigation. Said one,

“I wish there were three of me!”

One provider (out of 15) said she personally trained her own staff in regard to cancer screening and HPV vaccination. The others stated that new staff received all their training in a general orientation in which they were not involved. By and large, refreshers and reminders regarding organizational screening policies are not routinely presented at staff meetings. It is one organization's policy that providers and staff in each practice meet briefly each morning, referred to as the “morning huddle.” But, this is the only time providers and staff meet together. Providers hold their own meetings separately; other staff meet monthly, usually under a non-clinical lead. Commented one:

“If there was to be any medical content, we would need an outside speaker.”

One MD said he provides a yearly training to all his staff on the importance of screenings. The shared champion also provides a thorough training in CRC screening practices for new and current staff, described by another respondent as “well-organized.”

Three-quarters of the providers stated that nonclinical staff with patient contact (such as front desk, scheduling, or billing departments) are not routinely educated on the clinic's screening policies and are not expected to participate in promoting their importance to patients.

Data and Program Monitoring

Three different EMR systems are in use at the three participating organizations. There were no positive comments among the 17 respondents in regard to their EMR's system for alerting them to pending or overdue screenings, vaccinations, or results. Providers' comments ranged from "I don't know if our EMR has flags or automated reminders," to mild criticism, "It's not user-friendly; it's a hindrance!" to the unequivocal:

"The reminders are there but the provider has to go looking for them. It's like a scavenger hunt. It's exhausting."

Providers in two of the three organizations were aware that administrators regularly shared reports on company-wide screening and vaccination rates. However, only four (of 17) providers were aware of their individual rates. Seven said that they had no idea what their personal rates were, nor where to find them. Several knew that there were bonuses for providers with the highest numbers but because the bonuses were also tied to other measures not necessarily under their personal control, they were not eligible for the incentives.

"We have to try to meet five quality measures, and on top of that, bonuses are based on how many patients you see."

"There are monetary incentives, something like 2-10% of your quarterly salary. But half the time, I can't figure out if I've made it or fallen below. I don't ever make it. It's a complicated system. I've been moved around, and when I start at a new place, I don't have the patient load...but that's scheduling. They're re-evaluating the percentages. But why try, if I'm never going to make it?"

A provider who runs his own reports was frustrated:

"We don't know how to use them. It's a new system and I haven't had time to sit down with the reps to learn how the reports are generated. We need help."

Another said that although their IT department did provide two-to-four full-day trainings yearly on how to use their EMR better, there was no reinforcement of the take-aways, and no forum for sharing and addressing problems they might be having with the system.

Many providers referred to their company's screening rates and goals when asked about individual or practice screening goals. Of 12 respondents, nine reported no personal goals other than to fall within the ranges of the organizational goals; or cited general goals to increase mammograms, FIT test compliance, vaccinations, even tobacco screening. Two had not set goals either because they didn't know what their individual baseline was, or because they were not aware of organizational screening goals. Only one provider specifically tied her screening goals to her individual screening rates.

Patient Education and Communication

Just over half (53%) of the respondents said their practice did use some form of communication (usually a combination of phone calls and letter) to remind patients when they are due for screenings or vaccinations (separate from systems to follow up on missed appointments discussed in an earlier section).

One organization runs an annual postcard campaign where patients are rewarded for showing up at the clinic with the postcard to attend a scheduled screening. Another organization relies on its MAs or student interns to comb lists of clients and call all those due for a screening/vaccination. Another provider said he has tried to work out a system with care coordinators and schedulers in his organization, but so far, “It’s not a robust system.” Two reported that their system consisted of the reminders printed on patients’ discharge papers. Asked one doctor,

“But do they ever look at it again?”

Providers’ descriptions of the systems they used to track patients’ compliance with referrals and recommendations were as diverse as the reporters. In summary, it appears that each relied on specific people, either themselves or another whose role it was to track these one-by-one. Some of these people were shared between clinics, which providers noted, was an impediment to efficient communication. Lab results were sent automatically by some labs but not by all. Finally, there appeared to be little to no built-in EMR support. Said one,

“This is a huge failure of our EHR system.”

Providers reported satisfaction with the quality and amount of patient HPV education materials they are provided by Immunize Nevada. Some used and appreciated their organization’s video regarding the FIT test, available in English and Spanish. Beyond that, none were enthusiastic about how well their educational materials met their clients’ or their own needs, for that matter. They reported that although their organization did supply some stock materials on cancer screenings, most preferred educational materials they could download from internet sources such as Medline, FamilyDoctor.org, CDC, kidshealth.org, and UpToDate.com (because they were up-to-date, available in other languages, or of higher quality). Others acknowledged the existence of many excellent resources online but said they simply didn’t have the time to go searching for them.

Providers overwhelmingly expressed an interest in acquiring attractive and up-to-date informational posters about the various cancers and screening/vaccination options for their reception and waiting rooms. Specifically, they reported that their patients are most responsive to posters that remind them to ask their provider about screenings. Some of the providers said that the posters were effective in reminding them, as well.

Special promotions to encourage screenings included Mammo Mondays, the postcard campaign described earlier, and awareness month promotions organized by their companies. At least one clinic maintains a Facebook page on which they advertise screening and vaccination events. For example,

“When we know a doc will be away and the MA doesn't have much to do, we'll promote flu shots for those days and let people know thru our Facebook page.”

Successes

In response to the question, “If you feel your current cancer screening program is successful, to what do you attribute its success?”, eight (of 13) respondents attributed success in their screening practices to the personal efforts of the provider.

“Any success I have is due to the effort I make in creating awareness in my patients of the importance of these screenings.”

“I attribute it to me. It's just known that I strongly recommend them and I lay it out for all my patients. I give them the choice; they almost always pick the correct one.”

“I have a template that I follow for wellness visits. And I go through every single question every year.”

Others attributed their success to:

- Staff's ability to keep patients' records up-to-date and in the exam room when the provider arrives.
- Time and effort spent building and maintaining a clinical team who are all dedicated to the same screening goals.
- Organizational leadership's willingness to hire people exclusively to cover screenings.
- “Morning huddles.”
- Immunize Nevada's resources.

Barriers

Barriers to success were

- Lack of time and personnel for querying and updating records.
- Lack of time for thorough patient interaction.
- The provider's inability to remember to ask about screenings, in the absence of visual alerts to remind him/her.
- EMR difficulties, including providers' lack of understanding how to use them efficiently.
- Limited financial resources (several mentioned running out of Susan G. Komen funds early this past year).
- Failure to involve all staff in screening efforts. Some failure was attributed to providers not understanding the limits of staff's licenses and certifications, creating concerns about extending staff duties beyond legal limits.
- Social factors pertinent to their client population: poor mental health, poverty, unstable residency, fear and mistrust, name overlap (difficulties in identifying and linking patient records).
- Problems with inter-agency communications: between providers and labs, funding programs, and other providers.
- Lack of easy access to transportation to referral clinics, etc.

In response to the question regarding “missed opportunities,” most providers named areas in which they felt they personally could do better (covered under “barriers to success”), rather than more systematic “failures to screen” (the intent of the question).

One systematic missed opportunity is the clinical lack of systems for scheduling wellness visits for patients turning 11-12 years of age. After pre-school years, many children only visit the doctor when they are ill, thus providers are missing opportunities to begin education and promotion of HPV vaccine with pre-teens and parents.

Of the eight respondents who answered, two mentioned chronically insufficient funding for mammograms. CRC screenings were also mentioned as problematic, given patients' unease with both the FIT test and colonoscopy process (described by one provider as “the ‘ick’ factor”). One

doctor noted his failure to take advantage of the frequent contact he had with diabetic patients (every three months) to also address screenings as a missed opportunity.

The care coordinators also expressed frustration with missed opportunities posed by their scopes of work (defined by their supporting grants):

“I’m a MA, but in this role, my scope is as Patient Care Coordinator. So, I may have a patient on my private line for something but I can’t give them their lab results and I can’t answer their questions. I have to tell people to call back on the main line and ask for their MA.... And I can’t help male patients, because they don’t come under the WHC grant.”

Providers’ suggestions for overcoming barriers (Needs and Wants):

All providers in one organization anticipate that the planned installation of a supplementary program in their system’s EMR would fix the current “flagging and alerts” deficiencies.

Others suggested:

- Longer appointment times (20 minutes) or extra “admin time” daily to prepare for or follow up on patient encounters.
- The institution of one annual, billable 20-30 minute appointment dedicated to discussing screenings with patients.
- A system ensuring that all relevant information regarding a patient’s screening status is available when the provider begins the encounter. This could include more training and a checklist of questions for MAs to cover when rooming patients.

“I’m not perfect; I see my weaknesses, but I would like to find a way around them. Instead of me digging around in the computer, have someone TELL me what the patient is due for. It’s housekeeping stuff I don’t have time for.”

- A dedicated transport to give patients better access to referral appointments.
- Ongoing training in EMR use.
- Inclusion of a preventive care template in their EMR.
- A system for rewarding patients for completing screenings.

“If we could pay people or give them a \$10-20 gift card for each returned FIT test...they might get done. And that should offset the huge costs of treating patients with colorectal cancer.”

- Poster-size screening reminders, in each exam room--for both provider and patients.
- Cancer screening checkboxes on the encounter page, (like the “smoking cessation checkbox” that’s already there).
- Quarterly “Women’s Health Days” where a provider in each practice does Pap smears and referrals all day.
- A staff member whose primary (or sole) duty is to comb charts for patients’ screening status and following up with providers, patients as necessary.
- Training all staff to participate in screening promotion.

“If everyone on my team, at every point of contact, would say something to patients, each time, I think they would get the message better.”

Feedback to CRC and/or WHC programs is included in the Appendix.

Summary and Recommendations

Overview

It was clear to me that the people I interviewed are dedicated professionals who want to do their best for their patients and their organizations. Despite individual strengths and good intent, impediments to robust screening and vaccination programs still exist, many the result of multi-level **system failures**. The fact that some providers were uncertain about their organization’s screening systems, policies, and goals represents a foundational “missed opportunity” to build a team who pulls together, in the same direction, and at the right time. Even small differences, such as whether or not providers document reasons why parents refuse the HPV vaccine, create a missed opportunity to identify and address an issue in totality.

Recommendations:

- Clinical administrations should establish screening policies, systems, and key messages that are clear and consistent across all clinic locations and providers—including consistency in documentation. Make it a goal to engage everyone in vaccine and screening promotion at some level.

Clinical Champions

The use of champions to shepherd innovations through organizations is a decades-old practice with proven positive effects on healthcare.¹ Champions are point people for innovations: promoting, educating, navigating, connecting, and supporting both patients and co-workers through processes.

While it was clear that the clinical champions in these organizations have executive and managerial support, several factors undermine their potential to advance their cancer screening programs: poor communication channels with off-site clinicians; confusion in regard to their roles; demand for assistance exceeding champions’ ability to respond appropriately, etc.

Recommendations:

- Define, document, promote, and communicate the role and responsibilities of clinical champions to all staff. Repeat annually.
- Analyze and resolve the providers’ logistical difficulties communicating with the champions.
- Consider creating separate champions for each cancer program: breast, cervical, colorectal.
- Create or strengthen system to replace clinic champions on leave with specifically trained peers so providers can rely on consistency in interactions with temporary replacements.
- Create a transition plan to replace champions who move on.
 - Include tools for the champion to transfer knowledge/expertise to ensure program continues uninterrupted.

HPV Processes

Some providers specifically expressed doubts about their staff's competence in promoting and educating clients/parents regarding HPV vaccinations. Many excellent HPV training resources exist and are readily available online and in person. All providers were notified of at least one such training opportunity offered by High Sierra Area Health Education Center (AHEC) at Northern Nevada HOPES on May 23 (also online) and of another [opportunity](#) on July 25, 2017. AHEC and Immunize Nevada also offer [visual aids](#) on the current timing and dosing recommendations as well as [tips for providers](#) for achieving high HPV vaccination rates.

Recommendations:

- Take advantage of HPV training resources to engage and empower **all** staff in promoting and educating patients. This includes educating staff how to answer vaccine skeptics' concerns.
- Promote the “same way-same day” approach to HPV vaccinations when discussing childhood vaccines with parents. Recommend all routine adolescent vaccines—Tdap, meningococcal, and HPV—at the same time without singling out HPV vaccine or presenting the vaccine as optional.
- Because research has shown that clinical recommendation is the number one reason why parents decide to vaccinate, providers are their own best advocates when they promote HPV vaccination through personal stories, clear recommendations, and open, ongoing communications with parents.
- Develop a system to identify patients entering pre-teen years and schedule them for wellness visits.

Staff Roles

Confusion about the actual limits of staff's scopes of work leads to some missed screening opportunities. Failure to use staff to the full capacities of their licenses is a waste of resources. Staff who are empowered by training and supportive supervisors to initiate patient education add value to the organization as they take on ownership and responsibility for improving screening programs.

Recommendations:

- Clinical directors: Educate staff on the limits of everyone's licenses, certifications, and job descriptions. Clarity on this issue should eliminate some hesitancy to delegate (or assume) stronger educational and support roles in promoting screenings.
- As described elsewhere, many excellent educational opportunities exist to train staff in cancer screening and vaccine promotion. Supervisors can stay on top of training opportunities through local institutions such as [Immunize Nevada](#) and [AHEC](#). (NCC is also in the process of developing videos for this purpose.)
- Consider offering incentives/rewards to providers based solely on their screening rates, detached from other quality measures.

Data Systems/ Program Monitoring

That respondents expressed strong complaints about their EMRs was not unexpected. EMRs are widely reviled, and not without good reason, in many cases. We noted that plans were underway to install a “flagging and alert” system within the EMR at some clinics. It will be interesting to check in on this in a year to see if it has brought about the desired changes.

Recommendations:

- Make sure everyone on staff knows how to use the features built into their EMR. Find out what people are having problems with; respond by offering in-service trainings and regular refreshers for providers/MAs/care coordinators.
- Create an EMR champion to assist others as needed.
- Install flagging and tracking systems in the EMR if these do not already exist.
- Clinical directors: Analyze your clinic's screening/vaccination practices baseline to understand where you are now, and revisit it regularly to mark progress. The simple [checklist](#), "Suggestions to Improve Your Immunization Services", could be easily adapted to cancer screening. The checklist could be completed with other staff members at an annual meeting.
- Run EMR reports on a regular basis (such as monthly or quarterly) and share individual vaccination and cancer screening rates with providers. (This will only be effective if EMRs are being used efficiently to track screening.)
- Explore issues of missed opportunities and lower rates with staff individually or in groups to learn where barriers exist and to facilitate appropriate solutions. Engage the IT department to establish a process to store rates privately but easily accessible to individual providers.
- IT personnel: Create a report in the EMR that pulls all or nearly all patient information needed to submit to WHC or CRC screening programs for enrollment, eliminating the need for a separate form or re-entry of data.
- If EMR systems can't be improved at this time, consider creating a full- or part-time position dedicated to searching charts for upcoming or overdue screenings/vaccinations and alerting the appropriate others to follow up.
- Create manual systems for reminders, alerts, tracking:
 - MAs, LPNs: Check for and alert providers to patients' immunization/screening statuses ahead of encounters. Develop and use standing orders where possible.
 - Non-clinical staff: Create a process and standards for sending out reminders and recalls (for missed appointments). A staff member with strong organizational skills may be useful to help integrate this (or any new system) into office routines.
 - Note: The Community Preventive Services Task Force [website](#) is an excellent source of information on best-practices in cancer screening reminder/recalls, among other topics.

Patient Education and Communication

The standout learning from this section of the assessment was the providers' wish for current, attractive, and bilingual visual/other media aids to educate patients and remind themselves about cancer screenings. Providers are well aware that these resources exist; procuring them, on the other hand, seems to be a question of time and occasionally, finances.

Recommendations:

- Create an educational resource center focused on the needs and interests of the particular population served by the clinic. Ensure that awareness months and other health-related activities are well advertised in the waiting rooms, in English and Spanish. Use the young energy on staff to create eye-catching displays of educational materials. (Balloons may seem gimmicky, but they do attract attention!)

- For resources going beyond visuals and videos, we refer providers, champions and organizational leadership to The Community Preventive Services Task Force [website](#) for information on a wide variety of evidence-based strategies for educating and promoting cancer screening with patients. [Their research](#) shows strong evidence in favor of small media (posters and videos) combined with one-on-one education as the most effective intervention for increasing mammography and Pap test screenings.
- Organizational leadership should collaborate with providers, NCC, Immunize Nevada, and others to identify and procure low/no cost small media materials that meet providers' and patients' needs. This will be covered in a report on "next steps" for the NCC (to follow).

In the meantime, a variety of posters currently on hand at NCC will be displayed for feedback and offered to interested providers until the supply is exhausted.

Structural Barriers

To the extent possible, organizations should consider ways to address some of the barriers impeding patients' engagement in and access to cancer screening opportunities in this community. Transportation and "fear" are two issues of concern to low income clients, according to their providers.

Recommendations:

- Collect and "tell" the stories (during encounters, on websites, Facebook page, or other outreach materials) of patients who have overcome their individual fears to complete screenings and resolve a health issue. This could also be developed into a peer-to-peer engagement program.
- Track and address transportation barriers for patients. Possibilities include gas cards, bus passes, or acquiring a grant-funded dedicated transport/shuttle to increase patient compliance with screening referrals.
 - Engage the Regional Transportation Commission (RTC) to provide multi-day bus passes to patients who return completed FIT tests.
- Create standing orders for MAs, LPNs to give 2nd HPV vaccinations if they are due. Advertise and offer these on Vaccine Days when there's no need for an appointment.
- Institute "Flu-FIT days for patients to walk in (no appointments necessary) for flu shots and pick up a FIT test as well. A staff member could offer hourly FIT test instructions in the waiting room all day.
- Institute Women's Health Days: "All Paps, All day!" Schedule them to coincide with Mammovan stops at the clinic as well.
- If there seems to be a need, consider offering extended clinic hours or Saturday hours once a month, to give patients more scheduling flexibility.

¹ Shaw, E. K. et al. (2012, September). The role of the champion in primary care change efforts. *Journal of the American Board of Family Medicine*, 25(5), 676-685. doi:10.3122/jabfm.2012.05.110281

Appendix 1.

Clinical Liaison Assessment Questionnaire

Patient Access

Which of the following programs do you participate in, either through Access to Healthcare Network/State of Nevada or another grant? (Select all that apply)

- o Women's Health Connection – Pap testing
- o Women's Health Connection - Breast Screening
- o Colorectal Cancer Screening Program
- o VFC Provider for HPV vaccination

Do you use additional safety-net type programs/services to provide cancer screening or HPV vaccination to patients who are not eligible for one of the state programs? (List below)

HPV Processes

Is your immunization staff knowledgeable and comfortable with current ACIP recommendations, including minimum intervals, contraindications, etc.?

Is your immunization staff knowledgeable and comfortable with administering all recommended vaccinations to patients at every visit?

Do you have a system in place to schedule wellness visits for patients at 11-12 years of age?

Do you offer walk-in or "immunization only" visits?

Do you schedule the next vaccination visit before the patients/parents leave the office?

Do you contact patients/parents within 3-5 days when a "well-child" or "immunization only" visit is a "no show" and reschedule it for as soon as possible?

Do you regularly document vaccine refusals and the reasons for the refusal (parent choosing to delay, parent has vaccine safety concern, medical contraindication, etc.)?

Does your immunization staff educate parents about immunizations and the diseases they prevent, even when the parents refuse to immunize? If yes, please describe:

Staff Education and Communication

Please identify the established recommendations for HPV vaccinations; breast; cervical; and/or colorectal cancer screening currently in use in this clinic. Do these exist as standing orders for RNs, MAs, PAs, etc.?

If you have established a clinic-wide policy on cancer screenings and HPV vaccination to engage your team (from front office to physicians) in supporting and following the policy, please describe.

Does your clinic have an identified champion(s) for cancer screening and HPV vaccination, someone who focuses on QI measures, reducing barriers, and improve screening/coverage levels?

If "yes" who is that person(s), and which programs are they responsible for?

Do you have a plan to replace your champion, should he/she leave the organization or move to another position? If "yes" what is that plan?

Please describe any tools you have for creating multiple champions.

How do you orient and train new staff whose roles include patient contact to your clinic's cancer screening and HPV vaccination recommendations?

Are non-clinical staff, such as front desk, scheduling, or billing departments, also educated on the clinic's screening policies so they are part of the team, knowing for example when it's time to schedule immunizations, make screening referrals, or simply to avoid inadvertent sabotage by saying negative things about vaccination or their own screening experiences?

If "yes" please describe.

Do you include refreshers/reminders on your clinic's recommendations and policy during staff meetings or continuing education opportunities? If yes, please describe.

Data and Program Evaluation

Does your clinic use an EMR to manage patient files and data? If "yes" please identify it here. Within your EMR system, do you use flags or automated reminders to signal providers that a service is due? Breast, CR, cervical cancer screenings, or reminders regarding adolescent/pediatric pts?

If you do not use flags or automated reminders, do you have an alternate system to indicate when a patient is due for screening or vaccination? If "yes," please describe.

Do you run reports to evaluate provider/team effectiveness in screening/vaccination? (to see if screening/vax rates are improving, to see how individual providers are doing with their rates, etc.)

If "yes" how often?

How do you use those reports? (Do you share them w/ your staff?)

If you and your team set goals for cancer screening, please describe something about this process.

Patient Education and Communication

Do you use reminder-recalls, such as postcards, letters, emails, or phone/text message systems to remind patients they are due for screening or vaccination services?

Please describe any navigation or tracking system you use to ensure patient compliance with screening and vaccination recommendations/referrals.

Do you have and use patient education materials such as brochures or decision aids to encourage or discuss cancer screening or HPV vaccination? If "yes," please describe.

How well do these materials meet your needs or the needs of your patients? Please describe.

Please suggest/describe additional materials for patient education and communication that you may not have access to but would use if they were available.

Please describe any special promotions your clinic uses to encourage screening (such as flu shot / FIT testing clinics, promos, or awareness month campaigns).

General Information

If you feel your current cancer screening program is successful, to what do you attribute its success?

What do you see as the most significant barriers in your clinic's cancer screening system?

How would you suggest these barriers could be overcome?

Can you identify significant missed opportunities in this clinic's screening programs?

What goals would you like to set for this QI project in cancer screening?

What other feedback would you like to give about the CRC and/or WHC programs?

Appendix 2.

Feedback to CRC and/or WHC programs (Quotations from the providers)

The forms for providing free FIT tests to patients who don't have insurance--I don't have any, don't know where they are, and filling them out is difficult.

The WHC programs are really nice, but sometimes the paperwork can be a headache. There are a lot of restrictions. If we refer a patient for a mammo and she gets a cancer diagnosis, we can't help her. We have to send her to Access to try to figure that out. It's not right that the patient's doctor can't keep working with her on that.

We need a WebIZ for Paps--to keep women on schedule. Then we probably would have cervical cancer nailed. To avoid repeat Paps, too. When I get a new patient, and she can't remember when the last one was, we waste resources. Because if I don't know, I'm going to do it--not assume it was done.

Honestly, given the history of the resources we didn't have and that we now have, I'm grateful. Since we became a FQHC we've become much more effective than when we were a "mission clinic."

I appreciate their efforts; both programs are really good.

I'm grateful to these programs for their resources and their creation of a gateway for patients to access the healthcare they need.

We get a lot of emails about how this money is available, and then more saying, "Now it's not available, but this is instead..." It's always changing. I can't keep track of them all.

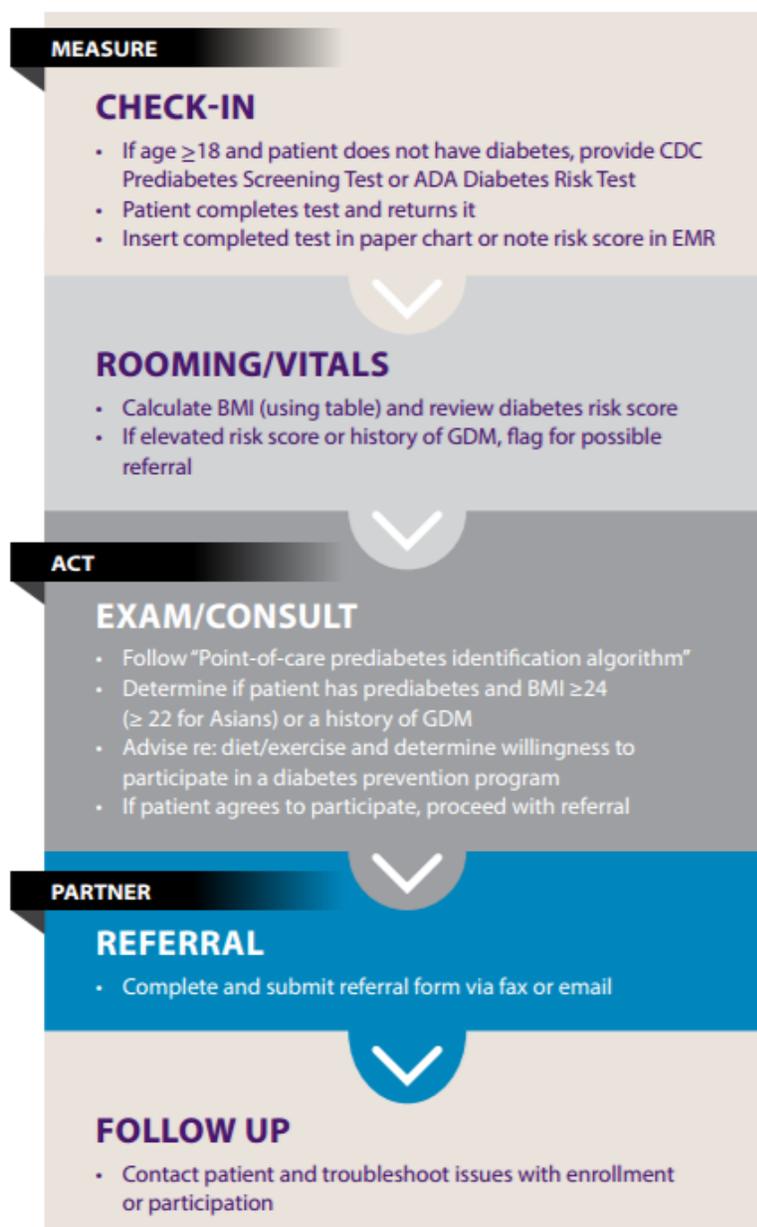
Do you have anything in place to remind YOUR patients? We need that. Also, there's a disconnect: most providers screen for breast cancer at age 40, but WHC doesn't do it until age 50. So, if you get a patient who's over 40 but under 50 from a WHC provider, they likely haven't had a mammo. They need to close that disconnect.

Appendix 3.

Sample checklist for staff when rooming patients

This flowsheet from Nevada Wellness was designed for diabetes, but could be easily adapted to cancer screening processes.

Sample patient flow process



† Use handouts included in this toolkit or request brochures from your local diabetes prevention program provider.