Purpose of Today's Discussion

- Overview of the National Colorectal Cancer Roundtable (NCCRT) and 80% by 2018
- State of colorectal cancer (CRC) screening and the 80% by 2018 campaign
- New tools and resources
- Q&A

National Colorectal Cancer Roundtable

NCCRT is a national coalition of public, private, and voluntary organizations whose mission is to advance CRC control efforts by improving communication, coordination, and collaboration among health agencies, medical-professional organizations, and the public.

- Co-Founded by ACS and CDC in 1997
- Collaborative partnership of 100+ member organizations
- Includes many nationally known experts, thought leaders, and decision makers on CRC
- Work is conducted throughout the year through various Task Groups and Special Topic Meetings
- Annual Meeting addresses important topics and sets the following year’s agenda
NCCRT Member Organizations

**Founding Organizations:**
- American Cancer Society
- Centers for Disease Control and Prevention

**Members:**
- Government agencies
- Medical professional societies
- National non-profits
- Academic Institutions
- Cancer Centers
- State coalitions
- Survivor-based organizations
- Health departments
- Advocacy Groups
- Health plans
- Employers
- And many more

NCCRT Task Groups

- Community Health Centers
- Evaluation & Measurement
- Policy Action
- Public Awareness & Social Media
- Professional Education & Practice Implementation
- Family History & Early Onset CRC
- Quality Assurance

NCCRT Tools, Resources & Publications

Available at: nccrt.org

80% by 2018

80% by 2018 is a movement in which more than 1,500 organizations have committed to substantially reducing colorectal cancer as a major public health problem and are working toward the shared goal of reaching 80% screened for colorectal cancer by 2018.

Add your organization’s name to the list today: nccrt.org/80by2018
Why 80% by 2018?

- Screening works.
- 80% is doable.
- Potential to prevent 277,000 cases and save 203,000 lives, all by 2030.

When we launched this campaign, we never imagined it would capture the attention of the nation like it has.

Our initial goal was to have 50 organizations pledge... As of June 2017, we have 1,500...

80% by 2018

1,500+ pledges from community health centers, medical professional societies, hospitals, government agencies, survivor groups, health plans, employers, and more.

- 19 cities
- 4 governors
- 2 mayors

Former West Virginia governor Earl Ray Tomblin became the first US governor to sign the 80% by 2018 pledge in 2015!
80% by 2018 Pledges from West Virginia

**73 and counting!**

- Appalachia Community Cancer Network
- Appalachian Glass
- Barbour County Health Department
- Belington Medical Center
- Bonnie’s Bus Mobile Mammography
- Broadus Hospital
- Bruce McDonald Memorial United Methodist Church
- Cabell-Huntington Health Department
- Camden Clark Hospital Medical Center
- Charleston Area Medical Center WV
- City National Bank
- City of Summersville
- City of Weston
- Clay Pool United Methodist Church
- Community Care of West Virginia
- Coventry
- Cox Landing United Methodist Church
- Edwards Comprehensive Cancer Center
- Davis Cancer Center
- Fairmont General Hospital
- First Christian Church of Logan
- Governor Earl Ray Tomblin
- Harrison County Health Department
- Harrison County Senior Citizens Center
- Health Access
- Homer Laughlin China Company
- Huntington Internal Medicine Group
- Jane Lew Truck Stop and Robin’s Nest Travel Center
- Jefferson Asphalt Products
- Lewis County Health Department
- Lewis County Senior Center
- Lincoln County Board of Education
- Lincoln Primary Care Center
- Logan Cancer Center
- Marion County Family Resource Network
- Marion County Senior Center
- Mary Babb Randolph Cancer Center at WV University

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**Four Strategic Plan Goals to Achieve 80% by 2018**

**Consumers**

*Move consumers to action*

**Systems**

*Use providers, payers, and employers to support screening*

**Policy**

*Increase access and remove barriers to screening*

**Process**

*Maintain momentum*

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**80% by 2018 Progress**

We’re tracking all major measures – BRFSS, NHIS, HEDIS, UDS – and there are strengths and limitations of each.
From 2013 to 2015, screening increased from 59% to 63%.

This rise, which follows a plateau in screening between 2010 to 2013, translates to an additional 3,785,600 adults (>50 years) screened in 2015.

If screening prevalence remains at the 2015 rather than the 2013 level, an estimated 39,700 additional CRC cases and 37,200 deaths will be prevented through 2030.

Percentage of Adults Aged 50-75 Years Up-to-Date with CRC Screening, by Race/Ethnicity, NHIS, US, 2000-2015

CRC Screening in West Virginia FQHCs, UDS

Resources & Tools to Reach 80% by 2018

New Tools Available

- 2017 80% by 2018 Communications Guidebook
- Updated guidebook designed to help understand and communicate colorectal screening options to core audiences.

Guidance on what hospitals, employers, primary care physicians, communities, insurers, GIs and endoscopists, radiologists, women's health providers, survivors and families, and state coalitions can do to advance 80% by 2018.
New Tools Available

New guidance on engaging celebrities, tips on earning earned media and tools to evaluate your 80% by 2018 messaging efforts

New Tools Available

• Asian Americans Companion Guide
• Subpopulations included are: Cambodian, Chinese, Filipino, Korean, Laotian, Southeast Asian, and Vietnamese.

New Tools Available

• Paying for Colorectal Cancer Screening Navigation Toolkit
• Provides advice on paying for and sustaining CRC screening patient navigation to help health care professionals get their navigation programs on sustainable footing.

New Tools Available

• CRC Screening Best Practices Handbook for Health Plans
• Includes benefit to health plans of focusing on CRC screening, best practices, case studies, lessons learned, sample templates and tools.
New Tools Coming Soon

Tools in the pipeline include:
- Expanded Evaluation Toolkit (webinar on June 27)
- Hospitals/Health Systems Change Package
- Updates to the FOBT Clinician’s Reference Resource
- CRC Practices Workflow for NextGen
- Familial and Early Onset CRC module for primary care
- Redesigned NCCRT website, including a searchable database of NCCRT and external partner tools

Learn More About 80% by 2018

Visit our website to find 80% by 2018 videos, resource packets, webinars, and more:
www.nccrt.org/80by2018

If we can achieve 80% by 2018, 277,000 cases and 203,000 colorectal cancer deaths would be prevented by 2030.

Thank You!

emily.butler@cancer.org
www.nccrt.org

Twitter: @NCCRTnews and tweet with #80by2018
Facebook: www.facebook.com/coloncancerroundtable
Incorporating stool DNA testing into practice

Francis R Colangelo, MD, MS-HQS, FACP
Chief Quality Officer
Premier Medical Associates

Outline

- The impact of colorectal cancer
- General introduction of PMA
- Overall 80% by 2018 efforts
- Background of stool DNA testing
- Description of pilot
- Future plans

Conflicts of Interest

I have none to report
THE IMPACT OF COLORECTAL CANCER

Burden of Colon Cancer
• Of cancers that affect both men and women it is the second leading cause of cancer related deaths
• Per ACS estimates in 2017 (nationally)
  • 95,520 new cases of colon cancer
  • 39,910 new cases of rectal cancer
  • 50,260 deaths

http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-key-statistics

The News Is Not All Bad
• Screening rates have been increasing steadily since the 1990s
• There has been a 30% reduction in colon cancer mortality in the last 10 years
• Estimates that 65% of individuals aged 50-75 have been screened (but still 23 million to go)
• If adults are screened for colon cancer, the disease can be detected at an early stage and/or polyps can be removed
Premier Medical Associates

- Formed 1993
- 100 providers
- 23 specialties
- 1:1 ratio PCPs to specialists
- Part of Highmark Health
- Member of the Allegheny Health Network

2015 360,000 patient visits
All adult and pediatric offices have level 3 PCMH certification
AMGA Analytics for Improvement member
EHR and Registry

- Allscripts
- Touchworks
- CQS (Clinical Quality Solutions)
- registry

PMA 80% BY 2018 EFFORTS

Colon Cancer Screening Efforts

- Campaign kicked off 12/13/12
- 57.5% practice wide screening rate 1/1/13
- Provider and staff education
- Prominently displayed marketing materials
- Emphasized importance of FIT
Colon Cancer Screening Efforts

We hit 80% 12/31/15

No, we didn’t…

77.6% 5/31/16

Yes, we did!

80.2% 10/24/16
Colon Cancer Screening Efforts

1st Runner Up Recipient of the 80% by 2018 National Achievement Awards

STOOL DNA TESTING

Multitarget stool DNA test assay

- Aberrantly methylated BMP3 and NDRG4 promoter regions
- Mutant KRAS
- β-actin
- Immunochemical assay for human hemoglobin

Study Design

- 12,776 participants across 90 centers
- 50 to 84 years old
- Average risk patients who were already scheduled for colonoscopy
- Multitarget stool DNA test with a commercial FIT then colonoscopy within 90 days
- 9,989 were eventually included in analysis


Study Results

<table>
<thead>
<tr>
<th></th>
<th>sDNA</th>
<th>FIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity colon cancer (n=85)</td>
<td>92.3%</td>
<td>73.8%</td>
</tr>
<tr>
<td>Sensitivity advanced precancerous lesions (n=757)</td>
<td>42.4%</td>
<td>23.8%</td>
</tr>
<tr>
<td>Specificity-normal colon on colonoscopy (n=4457)</td>
<td>89.8%</td>
<td>96.4%</td>
</tr>
</tbody>
</table>


Regulatory and Guideline approval

- FDA approved Cologuard for colorectal cancer screening August 2014
- CMS announced a national coverage determination for Cologuard October 2014
- ACS included in early detection guidelines November 2014

PILOT AND RESULTS
Pilot and Results

There was still a need…

Spring 2015 803 patients aged 50 to 75 with Medicare insurances either had yet to be screened or were 6 months or more late for next FIT or colonoscopy per internal registry.

Outreach/Intro Letter

Next

- Orders faxed to Exact Science in two cohorts
  - May 2015 patients with traditional Medicare
  - Sept 2015 patients with Medicare Advantage

- 3 call attempts/voicemail every three days

- Once kit was shipped compliance call made 8 days after
After 13 days

A REMINDER ABOUT YOUR COLOGUARD TEST

Your doctor has ordered a Colguard™ test for you. Based on this order, we sent you a collection kit more than 14 days ago.

- Taking the Colguard test involves collecting a stool sample in the privacy of your own home, and sending it to our laboratory for analysis via prepaid UPS shipping.
- Everything you need to collect this sample is contained in the simple white box that was delivered to the address provided by your doctor.
- If you did not receive this white box, or if you have other questions, please call us back at the number below. Our specialists are available 24 hours a day, 7 days a week.

Please return your sample as soon as possible, so we can help you get screened.

Thank you.

Sincerely.

Exact Sciences
Patient Support Center

1-844-670-8878

<table>
<thead>
<tr>
<th>Details</th>
<th>n =</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total identified</td>
<td>803</td>
</tr>
<tr>
<td>CTB</td>
<td>1</td>
</tr>
<tr>
<td>Exclusion total colectomy</td>
<td>1</td>
</tr>
<tr>
<td>Declined by patient-prior colonoscopy</td>
<td>7</td>
</tr>
<tr>
<td>Completed stool DNA test</td>
<td>154</td>
</tr>
<tr>
<td>Negative stool DNA test</td>
<td>135</td>
</tr>
<tr>
<td>Positive stool DNA test</td>
<td>19</td>
</tr>
</tbody>
</table>

Closing the loop

- Individual patient results sent back to practice
- Weekly order status reports in first 30 days sent to quality department
- Bi-weekly order status reports days 30-60 sent to quality department
- Final status of orders at day 60 sent to quality department

???

- 43 returned the kit empty to Exact Science via UPS
- 1 was rejected because the kit was too full!!
### Analysis of negative stool DNA patients
- 59 had never been screened before
- 45 had done FIT before but were tardy for follow up
- 31 had done colonoscopies at outside providers and were current with screening (lack of data point)

### Follow up of 19 positive stool DNA patients
- 15 had never been screened before
- 1 CTB before colonoscopy scheduled
- 16 had follow up colonoscopies
- 2 refused colonoscopy in spite of vigorous efforts

### Findings on 16 colonoscopies
- 6 no significant findings
- 5 had adenomatous polyps
- 3 had advanced precancerous lesions
- 2 had colon cancers
  - One stage I resected
  - One stage IV

### Celebrating Successes and Future Plans
...offering choice in colorectal cancer screening strategies may increase screening uptake. As such, the screening tests are not presented in any preferred or ranked order; rather, the goal is to maximize the total number of persons who are screened because that will have the largest effect on reducing colorectal cancer deaths.

Future

- Because of coverage issues, local insurer P4V programs and lack of USPSTF guidance (until now) providers were discouraged from offering test routinely after pilot was completed
- As of 1/1/17, providers will be free to order as an option as part of a shared decision making process for Medicare patients
- Working on commercial insurers patients to cover sDNA testing
Wise Saying

“The best screening test is the one that gets done…”

Dr. Sidney Winawer

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Melinda Kling Smith
Abdominal Radiology
West Virginia University

Outline
- Introduction
- Insurance Coverage
- Comparison with Other Screening Tools
- Who Should be Screened?
- Indications/Contraindications
- Patient Preparation/Exam Protocol
- Interpretation/Cost Effectiveness
- Images
Introduction

- **CT COLONOGRAPHY**
  - Minimally invasive imaging exam of the large intestine
  - CT Colonography (CTC) is a modified CT exam in a patient that has undergone bowel preparation and subsequent colonic distention.
  - Images are then interpreted using 2D and 3D techniques

- CT Colonography should not be viewed as a replacement for optical colonoscopy but rather as an additional option to increase overall compliance rates for screening.

*CT Colonography: Principles and Practice of Virtual Colonoscopy* Perry Pickhardt and David Kim

Equipment

- Multidetector CT scanner
- Software (Numerous packages)
- Automated CO2 delivery device
- Integrated PACS (3D) workstation
- Trained personnel

Natural history of CRC is transition of normal epithelium into adenoma and then eventually adenocarcinoma

- 80-90% of CRC developed from adenomas
- Time frame is approximately 5-15 years
Colonic adenoma progression

<table>
<thead>
<tr>
<th>Small adenomas</th>
<th>Advance colonic adenomas</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5mm</td>
<td>&gt;10mm</td>
</tr>
</tbody>
</table>

Dysplasia Cancer

Averages over 5 to 15 year course

Introduction

- Screening methods include colonoscopy, barium enema, sigmoidoscopy, FOBT, FIT, Stool DNA
- More than 40 million Americans have not undergone recommended screening for colorectal cancer
  - By comparison, compliance with breast cancer screening in women >40 yrs old is 67-85%.

Introduction

- CT colonography (aka virtual colonography)
  - In March 2008, multiple societies including American Cancer Society, American Gastroenterological Association, and US Task Force on CRC endorsed CTC as acceptable screening option
  - Age 50 with repeat every 5 yrs (avg risk pt)

Insurance Coverage

**Private Payer Coverage**
- United States Preventive Services Task Force (USPSTF) colorectal cancer (CRC) screening recommendations assigned an “A” grade to USPSTF-recognized CRC screening exams - including CT colonography (virtual colonoscopy). Until and unless the Affordable Care Act (ACA) is repealed, the ACA would now require private insurers to fully cover (with no co-pay) these USPSTF-recognized screening exams – including CTC.
Coverage (ACR Website)

Summary of Private Policies in CTC
- Anthem Blue Cross and Blue Shield (CA, CO, CT, IN, KY, ME, MO, NV, NH, OH, VA, WI)
- Blue Choice (SC)
- Blue Cross and Blue Shield (GA, TN, TX)
- Cigna
- Empire (NY)
- Excellus (NY)
- Humana
- Independence Blue Cross
- Kaiser Permanente (MD, DE, PA, NJ, NY)
- Priority Health (MI)
- United Healthcare (UHC) River Valley (AR, GA, IL, IA, NC, OH, SC, TN, VA)
- Unicare

Insurance Coverage (ACR)

Medicaid plans would also be required to cover CTC screening for Affordable Care Act “expansion adult” enrollees [6] and for all enrollees if the state has an extra federal match for USPSTF preventative services [7]. While Medicare often follows USPSTF’s lead, Medicare is not required to cover USPSTF A and B services and may make its own coverage decision [8].

What colorectal cancer screening tests does Medicare cover?
- Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) every year for all Medicare beneficiaries 50 years and older.
- Stool DNA test (Cologuard) every 3 years for Medicare beneficiaries 50 to 85 years old who do not have symptoms of colorectal cancer and who do not have an increased risk of colorectal cancer.
- Flexible sigmoidoscopy every 4 years for those 50 years and older, but not within 10 years of a previous colonoscopy.
- Colonoscopy every 2 years for those at high risk (regardless of age) and every 10 years for those who are at average risk 4 years after a flexible sigmoidoscopy for those who are at average risk.
- Double-contrast barium enema if a doctor determines that its screening value is equal to or better than flexible sigmoidoscopy or colonoscopy:
  - Once every 2 years for those 50 years and older who are at high risk.
  - Once every 5 years for those 50 years and older who are at average risk.
- At this time, Medicare does not cover the cost of virtual colonoscopy (CT colonography).

Detection
- Based on studies, CT colonography has a sensitivity ranging from 75-100% for detection of polyps greater than 10 mm in size.
- Specificity >95% with thin-section MDCT for lesions >10 mm.
- Per-polyp sensitivity for medium polyps (6-9 mm) ranges from 47-82%.
Detection (CTC vs OC)


Landmark study examining CTC versus OC

Sensitivity of CTC for polyps ≥ 10 mm = 92.2%

Polyps ≥ 8 mm = 92.6%; Polyps ≥ 6 mm = 85.7%

OC sensitivities were 88.2, 89.5, and 90%, respectively

Cost (Optical Colonoscopy)

Who should be screened with CT colonography?

- Asymptomatic adults of average risk
- Asymptomatic patients with positive family history (excluding polyposis or nonpolyposis syndromes)
- Asymptomatic patients at increased risk of colonoscopy
Diagnostic Indications

- Following incomplete optical colonoscopy
- Evaluation of suspected submucosal lesions
- Surveillance of unresected 6-9 mm polyps detected on prior CTC
- Unexplained GI bleed, iron deficiency anemia or other GI symptoms
- Symptomatic patients at increased risk for colonoscopy
- Surveillance following resection of polyps or cancer

Contraindications for CTC

- Fulminant colitis
- Any symptomatic acute colitis
- Acute diarrhea
- Acute diverticulitis
- Pregnancy
- Recent colorectal surgery
- Colon containing inguinal hernia
- Recent deep endoscopic biopsy or polypectomy
- Known or suspect colonic perforation
- Symptomatic or high grade bowel obstruction
- Routine follow up of IBD
- Polyposis or nonpolyposis syndromes

Dose Considerations

- Low dose CTC performed on Multidetector scanner associated with up to 45% less radiation burden compared to 64-slice scanner

Safety Considerations

- Concerns include risk of radiation-induced cancer, perforation, and workup of extracolonic findings
  - Most reported cases of perforation occur in the setting of pre-existing colonic disease such as IBD or recent polypectomy
### Additional Limitations

- Flat lesions are difficult to detect on 3D imaging
- No information regarding hyperemia, inflammatory infiltration, and mucosal erosion
- No specimen obtained

### Table 1: Computed tomographic colonography: advantages and disadvantages

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimally invasive&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Requires bowel preparation and distention</td>
</tr>
<tr>
<td>Typically examines entire colon</td>
<td>Radiation exposure&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Typical examination is brief (&lt;30 min)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Relatively limited availability&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>No sedation (need for enema) or recovery time&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Relatively expensive</td>
</tr>
<tr>
<td>Extrabucal pathology (benefit)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Interpreter dependent</td>
</tr>
<tr>
<td>Accurate in medium to large polyp detection</td>
<td>Relatively frequent need for subsequent colonoscopy</td>
</tr>
<tr>
<td>Can be used in colonic obstruction&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Extrabucal findings of not beneficial—generates anxiety and additional tests&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup>Advantage over optical colonoscopy.
<sup>b</sup>Disadvantage with optical colonoscopy.

### Bowel Preparation

- Three major approaches
  - Cathartic
  - Fecal Tagging-only
  - Complete cathartic/tagging
Patient Preparations

- Multiple preparations
- One example: VA protocol
  - 1 bottle of Magnesium Citrate
    - Polyethylene glycol is alternative in severe renal/cardiac dx, but more prone to leave retained fluid in colon
  - 4 tablets of Bisacodyl
  - Oral Contrast
    - 60 mL Tagitol stool tagging agent
    - 120 mL MD Gastroview (diatrizoate meglumine)

Patient Preparations

- "Wet" agents consist of different preparations of PEG
  - Higher volume iso-osmolar lavage (OK for renal/liver insufficiency, CHF, fluid restriction)
  - Polyethylene Glycol-based (PEG)
  - 4L (high volume)
  - 2L (low volume) NOTE: High vol no better than low

- Wet and Dry Agents

- Wet and Dry Agents

- Wet and Dry Agents

- Wet and Dry Agents

- Wet and Dry Agents
Patient Preparations

- “Dry”
  - Lower volume hyperosmolar – better tolerance, less residual fluid
  - Mg-citrate: OTC
  - Na-picosulfate
  - Na-phosphate: Renal risks (off US market)
- Senna: high dose- more cramps/pain, or lower dose combined with other cathartic

Patient Preparations

- “Electronic” cleansing
  - Software algorithm which subtracts high-density tagged material
    - Possibility of oversubtracting polyps associated with stool
    - Heterogeneous fecal tagging or volume averaging

Patient Preparation

- 2 days before exam
  - Low fiber diet. Stop all fiber supplementation.
  - No beans, nuts, seeds, whole grains
  - Monitor glucose levels if diabetic (no meds if glucose level <120 mg/dL)
- Day before exam
  - Clear liquid diet (broth, applesauce, rice, strained fruit juices, popsicles, lemonade, coffee, tea)
  - No red, purple, or blue colored substances →can simulate blood during passage from bowel

Patient Preparation

- Day before exam
  - 1 bottle of Tagitol (20 mL) with breakfast, lunch, and dinner
  - Dulcolax (bisacodyl) pills at lunch
  - Magnesium citrate taken at 6pm
  - ½ bottle of Gastroview at 9pm
  - 8 oz glass of water hourly 2-8 pm
Patient Preparation

- Post-exam
  - Bloating and cramping may occur for 24 hrs after exam

Same Day Tagging

- Same Day Incomplete Colonoscopy
  - 2 hour iodine tagging with 30 mL diatrizoate meglumine and diatrizoate sodium
  - Iodinated contrast reached the distal colon in 71.5% of patients*

Exam Protocol

- Numerous positioning techniques

Exam Protocol

- 1.5 L CO2 bilateral decubitus positioning
- 1.0 L CO2 supine position
- Insufflation at 20-30 mm Hg
- Room air used at some institutions
- CO2 reportedly causes less discomfort as it is rapidly absorbed into the bloodstream
Insufflation

- Colonic distention
  - Automated low pressure instillation of carbon dioxide (CO2)

Potential clinical problems (Colonic Distention)

- Poor distention on images
  - Machine not frozen; CO2 infusing
  - Scout often okay
  - Scan shows poor distention
  - Reasons
    - Low CO2 tanks
    - Volume cut-offs
    - Retained colonic fluid/stool
    - Obesity/High BMI
    - Hernia related
    - Diverticulosis/myochosis
Interpretation

- Readers should interpret at least 45-50 cases
- National CT Colonography Trial participants required to have read 500 studies and undergo qualifying exam of 20 cases
- Multiple training courses offered through professional societies, universities, and ACR training facility

Interpretation

- Polyps are ovoid/rounded homogeneous soft tissue densities with fixed location
  - Radiologists should not mention polyps ≤ 5 mm in diameter – ACR Guidelines
    - Not cost effective given workup cost on what is most likely a benign lesion
  - Residual stool often mobile and heterogeneous density
  - Flat lesions more difficult to detect

Interpretation

- 1-7% of patients with CRC will have a synchronous cancer
- Distal colonic stenosis may prevent OC from evaluating proximal colon
- CTC can be used to evaluate proximal colon

Interpretation

- Extracolonic findings
  - Many incidental findings are benign and of no clinical consequence
  - With dose reduction techniques, may be more difficult to detect due to increased noise
  - Found in 41-69% of patients (9-14% of which are clinically significant)
  - Cost of additional workup for incidentals
**Interpretation**

- **Extracolonic findings**
  - Common findings needing more urgent tx include malignancies and aortic aneurysm
  - Pickhardt et al detected previously unknown malignancy in 0.56% of asymptomatic pts during CTC (sample size >10,000)
  - Detection rate of malignancy is 1 per 200 asymptomatic adults (1 colorectal cancer per 500 cases and 1 extracolonic cancer per 300 cases)

**Cost Effectiveness**

- FOBT most cost effective due to low cost per testing unit
  - Cheap and noninvasive
- CTC not cost effective if every polyp detected is followed by subsequent optical colonoscopy

**Interpretation**

- **Extracolonic findings**
  - Most common extracolonic malignancy
  - Renal cell carcinoma (RCC)
  - Most common benign finding was renal cyst

**Cost Effectiveness**

Vogelaar et al (2009) simulated different screening strategies for CTC with OC followup

1) Any size polyp,
2) Polyps 6 mm or larger, or
3) Polyps 10 mm or larger

Different screening intervals of 20, 15, 10, 5 yrs

16 total scenarios with optical colonoscopy alone included
Cost Effectiveness

- Life years gained, cost, and number of screening tests calculated for each scenario
- Results:
  - CTC should be offered at intervals of 5 yr screening with followup for only polyps 6 mm or greater in size (with cost threshold less than 43% of screening OC)

Imaging

POOR Distention

GOOD Distention

POOR Distention/poor prep

GOOD Distention/clean
Thank you for your time.
If you have any questions please feel free to email me at Melinda.Smith@hsc.wvu.edu

West Virginia Colorectal Cancer Screening Summit
June 14, 2017
Fairmont, WV
COLON CANCER IN KENTUCKY
PARTNERSHIPS & POLICY FOR SUSTAINABILITY
June 14, 2017

Katie Bathje
Program Director
Kentucky Cancer Consortium

Jason Baird
Contract Lobbyist
Limestone Group

HOW FAR WE’VE COME
HAPPY GRAPHS

PROGRESS IN KENTUCKY: CRC INCIDENCE
PROGRESS: A 17% reduction from 2004-2014

PROGRESS IN KENTUCKY: CRC MORTALITY
PROGRESS: An 18% reduction from 2004-2014
KENTUCKY VS. WEST VIRGINIA?

**Incidence** rate: most recent 5-year trend
- #1 -- Kentucky (falling trend)
- #5 -- West Virginia (stable trend)

**Mortality** rate: most recent 5-year trend
- #2 -- West Virginia (falling trend)
- #5 -- Kentucky (falling trend)

HOW DID KENTUCKY MAKE PROGRESS?

PARTNERSHIPS, PLAN, POLICY,
PUBLIC AWARENESS, PATIENT NAVIGATION

LAYING THE FOUNDATION: PARTNERSHIPS

- Identify dedicated staff who can be neutral conveners
- Gather partner organizations who share similar goals, but have clearly identified roles
  - Ex.: ACS CAN, Regional cancer control org, 501c3 CRC-only org, HD
- Create a specific non-profit that can lobby and advocate specific to Colon Cancer Policy Prevention Change, Ex: Colon Cancer Prevention Project
- Convene partners regularly, focused on mutually agreed upon objectives
  - KY Dialogue for Action, monthly meetings hosted by KCC, regular ongoing communication
  - Providers, Public, Advocacy

PARTNERSHIP DEVELOPS A PLAN

- Identify resource gaps and areas of greatest need
  - Uninsured not getting screened, BRFSS question about barriers ($); Appalachian data abysmal, identified HDs amenable to pilots
- Prepare for planned and unexpected opportunities to request and acquire resources: “What would you do with a million dollars?”
- KCC revised the Resource Plan to be less “public health lingo” and more “business/funder-friendly”
PARTNERSHIP DEVELOPS A PLAN

• Plan objective: “Educate healthcare decision makers, elected officials, funders and interested Kentuckians on the potential to decrease the cancer burden in Kentucky through supporting cancer prevention and early detection.”
• Partners meet and communicate regularly to own parts of plan, create action steps, and report progress

What Can We Do for Kentucky?

For every $100,000 invested in cancer prevention and screening…

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking cessation medications*</td>
<td>666</td>
</tr>
<tr>
<td>Lung cancer screening**</td>
<td>135</td>
</tr>
<tr>
<td>Colon cancer screening</td>
<td>246</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>403</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>450</td>
</tr>
</tbody>
</table>

* Nicotine replacement therapy
** For those at high risk and screened for the first time

What Can We Do for Kentucky?

For every $500,000 invested in cancer prevention and screening…

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking cessation medications*</td>
<td>3,333</td>
</tr>
<tr>
<td>Lung cancer screening**</td>
<td>675</td>
</tr>
<tr>
<td>Colon cancer screening</td>
<td>1,229</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>2,016</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>2,102</td>
</tr>
</tbody>
</table>

* Nicotine replacement therapy
** For those at high risk and screened for the first time

What Can We Do for Kentucky?

For every $1,000,000 invested in cancer prevention and screening…

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking cessation medications*</td>
<td>6,666</td>
</tr>
<tr>
<td>Lung cancer screening**</td>
<td>1,350</td>
</tr>
<tr>
<td>Colon cancer screening</td>
<td>2,457</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>4,032</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>4,504</td>
</tr>
</tbody>
</table>

* Nicotine replacement therapy
** For those at high risk and screened for the first time
PLAN GETS “WORKED” BY POLICY LEVEL PARTNERS

- During this time, a three-time cancer survivor and professional fundraiser who wanted to make a difference in cancer...found KCC cancer plan online
- KCC convened fundraiser, coalition chair, and physician champion who has his own 501c3.
  - Colon Cancer Prevention Project (501c3) hires a lobbyist
- Made in-roads with Lieutenant Governor – a colon cancer survivor and Kentucky Cancer Foundation Board Member
- Made the case to Administration that CRC screening saves live AND money
- Keep. Meeting. Regularly.

PLAN GETS “WORKED” BY PUBLIC AWARENESS PARTNERS & PROVIDER PARTNERS

- Partners agree on a unified message for public awareness campaign (small media, radio, billboards, newspaper)
- Colon Cancer Prevention Project provides direct focused colon cancer prevention lobbying efforts, coordinates with other groups
- ACS CAN continually communicating with advocacy volunteers

PLAN GETS “WORKED” BY PUBLIC AWARENESS PARTNERS & PROVIDER PARTNERS

- Testify at state health and welfare legislative hearings
- Primary care provider trainings on best practice office policy for CRC screening uptake at both the state and regional levels
- All regional cancer coalitions (14+) choose to focus on CRC screening as their “issue” and utilize campaign materials
- Still. Meeting. Regularly.

PARTNERSHIPS + POLICY = PROGRESS

- Screening program for the UNinsured (2008)
  - Established, but not funded
- Colorectal cancer screening insurance mandate (2008)
  - All Kentucky insurers required to cover ACS recommended colon cancer screening tests
- Coal severance funds allocated for CRC screening (2010)
  - Used funds to pilot KCCSP at Health Departments in 5 Eastern Kentucky counties!
PARTNERSHIPS + POLICY = PROGRESS

- Needed a home for funds: Public/private partnership developed through founding of “Kentucky Cancer Foundation” (2012)
  - Governor allocates $500,000 in Executive Budget to be matched by Kentucky Cancer Foundation’s $500,000 – all to fund the Kentucky Colon Cancer Screening Program

POLICY PARTNERS

- House and Senate Leadership
- Appropriations Committee Chairs
- Health and Welfare Committee Chairs
- Health Budget Sub-Committee Chairs
- Other legislators who have a genuine interest
  - Executive Branch, Governor, Lt. Governor, Health Cabinet Secretary, Commissioner Public Health, Medicaid Commissioner
- State Medicaid Leadership can spearhead Managed Care Companies utilization of CRC screening rates as a performance rating measure EVERY year

THE MOTHER OF ALL POLICY CHANGE: MEDICAID EXPANSION

- 2014: Medicaid expanded to adults earning up to 138% of the federal poverty level.
  - $33,465 for family of four
- Establishment of a Kentucky-run insurance exchange
- More than 310,000 people enrolled in the first year, more than double the original estimate.
WHAT DID MEDICAID “DO” TO KCCSP?

Number of Colonoscopies by Calendar Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>532</td>
</tr>
<tr>
<td>2014</td>
<td>172</td>
</tr>
<tr>
<td>2015</td>
<td>76</td>
</tr>
<tr>
<td>2016</td>
<td>49</td>
</tr>
</tbody>
</table>

Pushed FIT first

KY CRC SCREENING IN MEDICAID
% SCREENED FOR CRC ONE OF 8 QUALITY METRICS TIED TO REIMBURSEMENTS

<table>
<thead>
<tr>
<th>Date of service calendar year</th>
<th>Total Spent</th>
<th>Claim count</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>$18,685,114</td>
<td>63,204</td>
</tr>
<tr>
<td>2014</td>
<td>$16,000,160</td>
<td>58,034</td>
</tr>
<tr>
<td>2013</td>
<td>$6,397,554</td>
<td>28,371</td>
</tr>
</tbody>
</table>
WHAT IS THE KY COLON CANCER SCREENING PROGRAM (KCCSP)?

- State-wide colon cancer screening program for the uninsured and underinsured, low income population
  - Housed within Kentucky Cabinet for Health and Family Services, Kentucky Department for Health
    - Provides funding and administration to sites
    - Includes an outreach/awareness campaign
    - Government appointed KCCSP Advisory Committee
- KCCSP enacted into law (KRS 214) in 2008 by the KY General Assembly

HOW DID WE DISPENSE FUNDS?

- KY Department for Public Health released a Request for Applications (RFA) distributed to local health departments.
- Each application was by a panel of 6 DPH staff and advisory committee members.
- Funds awarded to 14 sites, covering 48 counties.

KCCSP ELIGIBILITY

- Low income uninsured adults aged 50 to 64
  - Aged 45-64 if African American
  - Regulation passed in 2016 extended coverage to the UNDERinsured
    - Medical expenses are 5% or more of the applicant’s individual annual income
  - US Citizen & KY Resident
  - 250% at or below the poverty Level
  - Lack of up to date CRC screening

WHAT DID WE ASK OF THE LOCAL HEALTH DEPARTMENTS?

- Act as fiscal agent (receives and distributes funds)
- Convene local partners to determine how to best deliver the program in its area
- Utilize Kentucky Cancer Program (regional comprehensive cancer control program) when developing community awareness, identifying eligible patients etc.
- Determine the best setting for patient navigators and ensured they had tools necessary to support the program.
WHAT DID WE ASK OF THE LOCAL HEALTH DEPARTMENTS?

• Identify providers to serve as medical home and to clear patients for colonoscopy.
• Identify Colonoscopy providers at the agreed rate.
• Developed plan for connecting patients to treatment in case of complications or cancer diagnosis (KCCSP funds did not cover these outcomes)

FIT FIRST

• Anticipate that 75% of the screenings will be FIT
  • Anticipate that 25% of screenings will be colonoscopy
• OC-Light Point of Service test was used
• To receive patient navigation fee ($50), FIT KIT must:
  • Be mailed back to navigator by patient
  • Resulted and patient notified of results
• Data on patient and FIT result entered into state lab database

Comparison of FIT and gFOBT

<table>
<thead>
<tr>
<th></th>
<th>FIT</th>
<th>gFOBT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Samples Needed</td>
<td>Varies depending on brand; 1 or 2 samples</td>
<td>3 samples from 3 days</td>
</tr>
<tr>
<td>Results effected by diet</td>
<td>No</td>
<td>Yes – red meat, cruciferous vegetables, beets, radishes, turnips</td>
</tr>
<tr>
<td>Results effected by medication</td>
<td>No</td>
<td>No NSAIDS for 7 days prior; No vitamins with Vitamin C 2 days prior</td>
</tr>
<tr>
<td>Source of blood detected</td>
<td>Colon</td>
<td>Full digestive system – Gums to Rectum</td>
</tr>
<tr>
<td>Test Analysis</td>
<td>Varies – point of care or machine analyzed</td>
<td>Point of Care</td>
</tr>
<tr>
<td>Sensitivity for Adenomas</td>
<td>87-98%</td>
<td>Up to 50%</td>
</tr>
<tr>
<td>Specimen Container</td>
<td>Most are closed system</td>
<td>Open system – risk of exposure</td>
</tr>
<tr>
<td>Collection of Sample</td>
<td>Less subject to patient error</td>
<td>More subject to patient error</td>
</tr>
</tbody>
</table>

KCCSP FIT SERVICES

• 1159 FITs entered in system
  • 15 Kits expired on return
  • 143 – canceled/not returned
  • 1001 – Resulted – 74% Female
  • 922 – Negative
  • 79 – Positive for occult blood – 7.8%
COLONOSCOPY

• Provided to those with Positive FIT – or at increased risk for CRC based on patient and family history.
• KCCSP provides reimbursement - $1,000
  • Covers: colonoscopy provider, facility, anesthesia, any polyps removed, and/or pathology testing
• LHD established contracts with colonoscopy providers and/or facilities
• Contract included language requiring reporting of certain items including reaching cecum, polyp pathology and any complications

COLONOSCOPY RESULTS – INCEPTION THROUGH JUNE 30, 2016

<table>
<thead>
<tr>
<th>Final Diagnosis</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRC Diagnosed</td>
<td>14</td>
<td>1.8%</td>
</tr>
<tr>
<td>Adenomatous - high grade</td>
<td>13</td>
<td>1.6%</td>
</tr>
<tr>
<td>Adenomatous - no high grade</td>
<td>222</td>
<td>26.8%</td>
</tr>
<tr>
<td>Final diagnosis pending other procedure</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Hyperplastic polyp</td>
<td>130</td>
<td>15.7%</td>
</tr>
<tr>
<td>Incomplete procedure (followed by DCBE)</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Normal/Negative</td>
<td>448</td>
<td>54.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>829</td>
<td></td>
</tr>
</tbody>
</table>

KEY TO KCCSP SUCCESS: PATIENT NAVIGATORS

• LHD identified staff to serve as patient navigator at each site
  • This was almost always one of MANY hats the staffmember wore
• Help increase awareness of need for colon cancer screening
• Verify participants meet program eligibility
• Assist in linking patients with abnormal screening results or colon cancer diagnosis to additional services/ navigators
• Ensure that referrals, procedures, communications and follow-up occur in a timely fashion
• Record and report required data

BENEFITS OF PATIENT NAVIGATION

• Linking patients to resources and services
• Contacting patients to confirm or reschedule appointments
• Helping patients make follow-up appointments
• Conducting outreach to non-adherent patients
• Tracking interventions and outcomes
• Enhancing access to care and services
• Reducing barriers to care
WHAT NOW?
SCREENING PROGRAM MOVING FORWARD

THE LAY OF THE LAND

• 2016-2018 legislative budget: legislators approved $500,000 to be kept in budget for colon cancer screening
  • Governor line item vetoed this allocation
  • Massive heroin epidemic reprioritized public health in KY
  • Ideological change in executive branch
  • $250,000 in carry forward funds available for utilization
• KCCSP Advisory Committee and KCC Colon Cancer Committee continue To. Meet. Regularly.
  • Scaling back program, focus on Appalachia

IN SUMMARY
LESSONS LEARNED

Appalachia vs. Non-Appalachia Colon and Rectum Cancer Mortality Rates 2000-2013
WHAT STRATEGIES ARE MOST USEFUL?

- Identify a neutral convener of partners (in KY, comp cancer)
  - Administrative, communication, mediator
- Clearly identify roles each partner can play
  - **POLICY**, educational, financial
- Build partnerships with business, health care systems, health economists and others who see the world through $
- Collaboratively develop target objectives: PLAN
- Clearly outline the resources necessary to reach your objectives
- Share your plan with key decision makers & advocates
  - Share it again, and again, and again...

KEEP THE END IN MIND

- Continue to focus on mutually agreed upon goals that improve the health of the population
  - Increase screening rates
  - Reduce morbidity and mortality
- 80% by 2018!

LET US BE A RESOURCE!

- Strong sense of camaraderie
- Barriers are opportunities
- Sense of humor
- Connections at every level
- Open handed with resources (program manuals, legislative language, etc)

We’ll leave you with a message from our Governor!

https://www.facebook.com/GovMattBevin/videos/1674943162805570/

CONTACT

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Kentucky Cancer Consortium
katie@kycancerc.org

Jason Baird
Limestone Group
jason@limestonegrp.com
Learning Objectives

- Role and Scope of Practice for Patient Navigators in Colorectal Cancer Screening (and ancillary team)
- Step-By-Step CCSP Patient Navigation
- Importance of CRC Screening
- Thinking about Sustaining the Role and Scope

SETTING EXPECTATIONS

- We only have 1.5 hours
- The goal is to make sure you think about all of the steps and information to be considered for patient navigation for colorectal cancer screening.
- Dedicated time for you to review and discuss information with team and consider who this might work in your setting or practice.
- Think about longer term sustainability and where you are and where do you need to go?
- This is food for thought.
Why is Patient Navigation Important?

- The patient encounter is crucial
- Eliminates barriers to care
- Improves bowel prep outcomes
- Provides individual assistance across the cancer care continuum of care

Primary Activities of a CCSP Patient Navigator

- In-reach/Outreach
- Education
- Communication
- Barrier Reduction
- Reminders
- Care Coordination
- Determining Insurance Coverage
- Data Collection and Reporting

Colon Cancer At-A-Glance*

Colon cancer is the second leading cause of cancer-related death in the U.S.

On average, your risk is about 1 in 20, although this varies widely according to individual risk factors.

90% of new cases occur in people 50 or older.

People with a first-degree relative (parent, sibling or offspring) who has colon cancer have two to three times the risk of developing the disease.

There are currently more than 1 million colon cancer survivors in the U.S.

Why is Patient Navigation Important?

- Increases patient follow through with screening appointments
- Decreases patient anxiety
- Improves patient satisfaction and experience with the health care system
- Allows all the partners and health care team to work at the top of their scope!
In-Reach and Outreach

**In-Reach:** Targeting current clinic patients who are in need of CRC screening for at least CCSP (beyond in some clinics)

**Outreach:** Raising awareness throughout your community about the importance of CRC screening

**Goals:** To increase awareness and CRC screening rates

---

Determine Insurance Coverage

- **Clinic Enrollment Plan:** Identify who in the clinic will help enroll patients in insurance programs
- **Check Coverage:** Work with patient to determine what his/her insurance will cover
- **Copays and Additional Care:** Identify what patients costs will be for screen and if follow-up is needed
- **Determine if patient is eligible for CCSP navigation reimbursement**

---

In-Reach

- **Identify eligible clinic patients**
  - BMIR Queries
  - Chart reviews
  - Tickets in BMR
- **Connection with other programs that share same general eligibility criteria**
  - Help ensure that clinic staff speak about screening rates
- **Spread awareness at your clinic**
  - Display posters
  - Display and provide brochures
- **Educate your clinic patients**
  - Targeted mailings; postcards or letters from clinic physicians
  - Targeted phone calls

---

Patient Navigation Services (expanded)

---

**PATIENT NAVIGATION SERVICES EXPANDED**

---

**Determine Insurance Coverage**

- **Clinic Enrollment Plan:** Identify who in the clinic will help enroll patients in insurance programs
- **Check Coverage:** Work with patient to determine what his/her insurance will cover
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In-Reach

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  - Display posters
  - Display and provide brochures
- **Educate your clinic patients**
  - Targeted mailings; postcards or letters from clinic physicians
  - Targeted phone calls
Educate Clinic Patients On...

- The importance of CRC screening
- CRC Risk level
- Family History and Genetic Syndromes
- Recommended screening modalities
- Screening recommendations
- The bowel preparation process and instructions
- The screening process and instructions

Increased Risk

- Individuals with a family history of colorectal cancer or adenomatous polyps in a 1st degree relative
  - Mother
  - Father
  - Brother
  - Sister
- Individuals with a personal history of colorectal cancer or adenomatous polyps

Average Risk

- Asymptomatic individuals who are not in the increased or high risk categories
- Age to begin screening for colorectal cancer = 50
- Colonoscopy every 10 years
- Sigmoidoscopy every 5 years
- FIT/FOBT every year

Know Who to Talk to

- Does your clinic have a marketing department?
- Does your clinic circulate a newsletter?
- Who can you contact for promotional materials?
- What has been done in the past?
Outreach and Public Awareness

- Raise community awareness
- Health fairs
- Social events
- Mailings
- Posters
- Brochures

Know Who to Talk to

- Who is your audience?
- Who runs the health fairs in your community?
- Informal Opinion Leaders?
- CRC Champions in your community
- Shop owners who might let you advertise?
  - Grocery store
  - Post Office
  - Library
  - Radio Hosts
  - Local TV networks
  - Local Journalists

Educate the Community On...

- The importance of CRC screening
- Risk level
- Family History and Genetic Syndromes
- Screening modalities available at your clinic
- Screening intervals
- Healthy Lifestyle

GI Anatomy

- Cecum
- Ascending Colon
- Transverse Colon
- Descending Colon
- Sigmoid Colon
- Rectum
- Anus
Communication

• Communicate with the patient and the care team
• Develop a rapport and establish trust with patient
• Ensure you have a strong capability statement
• Define expectations and boundaries
• Devise follow up strategies that work with the patient
  • When to contact (day, time)
  • How to contact (landline, cell, email, mail)

Communication Techniques

• Motivational Interviewing
  • Goal oriented, client centered questioning
  • Encourages collaborative partnership between you and patient
• Open-Ended Questions
  • Encourages patient to think and reflect
  • Requires more than “yes” or “no”

Barrier Reduction

• Facilitates patient access and utilization of care
• Assists with patient and provider interaction
• Helps ensure that patients find and access the services they need
• Increases patient self-efficacy

Cultural Barriers

• Is someone on your staff bi-lingual?
• Will your clinic need a translator?
• Is your material printed in that language?
• Can staff relate to the various cultures, health beliefs, and stigmas that may be associated with patients being navigated?

Think about who is on your staff who it is appropriate that may assist patient navigators in handling these cultural barriers
Logistical Barriers

- Transportation
- Elder care
- Child care
- Getting and/or paying for PREP
- Time
  - Time off from work, time away from caring for family
- Built environment
  - Where you live, work, access, habits

Reminders

- Ensure that patients have transportation to and from the screening and supportive care after
- Work with your patients to overcome common barriers
- Remind patients of proper prep procedure

Reminders

- Evidence-based interventions help improve CRC screenings rates
  - Reminder Calls
    - Colonoscopy: 1-3 days before appointment
      - Improves bowel prep & reduces no-shows
  - Patient reminders (In-Reach)
    - Inform patients when they are due for screening
      - Postcards, letters, phone calls, etc.

Bowel Preparation

- Many CRC screening methods require bowel prep:
  - Colonoscopy
  - Flexible Sigmoidoscopy
  - Computed Tomographic (CT) Colonography
- Necessary in order to be able to see the colon and find abnormalities and/or polyps
- Requires diet and/or fluid restrictions but will vary according to the screening provider’s instructions
Bowel Preparation

What Bowel Prep are you using at your clinics?

PREP Instructions

One Week Before Colonoscopy

- Patient navigator places reminder call to patient
- Follow physician instructions for blood-thinner medications such as Coumadin and Heparin
- Have power prep solution at home
- Read through the bowel prep instructions

Two Days Before Procedure

- Drink plenty of water
- Eat lightly
- Avoid bulky, fibrous foods such as
  - Raw veggies, beans, peas, lentils
  - Wheat bran cereals and breads
  - Sweets
  - Fatty meats
- Bottom line: on the day before your colonoscopy, EVERYTHING in your colon must come out

The Day Before Colonoscopy

- Follow a clear liquid diet
  - Water
  - Clear broth
  - Clear fruit juice
  - Coffee or tea — no cream!
  - Plain gelatin
  - Popsicles
  - Soda
  - Sports drinks
- Do NOT drink red, blue, or purple liquids
PREP Instructions

The Following are NOT clear liquids

- Milk
- Cream
- Pudding
- Apple sauce
- Orange juice
- Coffee with cream

Do NOT drink red, blue, or purple liquids

Care Coordination

- Assist with appointment setting
- Ensure F/U of colorectal screening results regardless if abnormal or normal
  - Patient navigators are the liaison between patients and providers
- F/U with patients about results of procedure
  - Be sure they understand the results and when they should be re-screening
- Provide treatment navigation or facilitate transfer of care for treatment services
- Be sure to know who does what!

CCSP Reporting Activities

- Collection of data points for evaluation-outcomes and navigation services
  - Rates of
    - No show
    - Appropriate prep
    - Complete follow-up
CCSP Patient Navigation Activities

- Monthly teleconference calls on the first Tuesday of every month
- Large trainings
- Regional trainings
- Webinars
- Site visits

Outcomes to Evaluate Patient Navigation

- No-show rates
- High Quality Bowel Preparation
- Exam Completion (Ability to Reach Cecum)
- Complete follow-up

Let's Discuss!

Breakout into Groups of 2-3
- People who are part of the same systems
- People who are in different systems but want to learn from each other

Review the one pager about role and scope!
- Patient Navigation and Patient Navigator…sometimes not everyone does everything but the process to navigate relies of several people and several institutions! Who does what is important.
Now Let’s Talk About How to Make It Stick!

WHERE CAN YOU FIND THE PAYING FOR COLORECTAL CANCER SCREENING NAVIGATION TOOLKIT

- Microsite Supported by University of Colorado
  - [http://pntoolkitresources.weebly.com/](http://pntoolkitresources.weebly.com/)
- The Toolkit is formatted in initial draft in PDF Format
- Save To Your Device, Active Links
- Print Out
- Evaluate!!! PLEASE!

PREVIEW: PAYING FOR COLORECTAL CANCER SCREENING NAVIGATION TOOLKIT

Lead Developer: Andrea (Andi) Dwyer
Co-Director: Colorado Colorectal Screening Program
Steering Committee Member CCRT
The University of Colorado Cancer Center
Spend 5 Minutes and Talk to a Neighbor....

When you think about CRC Patient Navigation and the Sustainability Constructs Just Described:

What's Going Well?
What's Not Going Well?

Each chapter is organized into printed resources, online resources, tasks, tools, templates, and case studies so that you can:

- READ MORE ABOUT IT
- FIND IT ONLINE
- E-MAIL MORE ABOUT IT
- SHARE MORE ABOUT IT
- SEE IT IN ACTION
- FREQUENTLY ASKED QUESTIONS
- SUSTAINABILITY IN ACTION

A Bit of A
Use Front to Back OR Back to Front
or Jump In ‘Where You Are!’
Chapter 1: Let's Dig In!

Chapter 2: Evidence and Patient Navigation

Chapter 3: States, Cities, Regions and Tribal Programs

So... What Are the REAL opportunities to really Pay??

To Get Started:

Grants and foundational support might be a means to begin.
There are possible methods for payment through accountable care opportunities, the ACA and perhaps allowable codes for care coordination.

Making the business case can also be a viable and sustainable approach. Chapter 6 can tell you how!
Chapter 5: Accreditation and Quality Standards – Colorectal Cancer Screening Patient Navigation

Questions to Consider

Chapter 6: Economic Analysis and Business Case for Colorectal Cancer Screening Patient Navigation

Chapter 7: Policy and Colorectal Cancer Screening Patient Navigation
Chapter 8: How Will You Know If You Are Successful and How to Make the Case for Future Funding?

Take 5 Min and Share With Your Neighbor Your Next Step

This Toolkit Will:
- Help people in different settings and different phases think about payment and sustaining patient navigation
- Give examples of what programs and initiatives have worked with patient navigation at the core
- Additional Resources WILL:
  - Provide greater insight about how to initiate specific programs
  - Inform how to manage and supervise patient navigators
  - Many other opportunities

(See Chapter 9)

Thank You!
Co-Director Colorado Colorectal Screening Program
Andrea Dwyer
Andrea.Dwyer@ucdenver.edu
303-724-1018
Learning Objectives

- Understand the Quality Payment Program (QPP) Requirements for 2017
- Understand rewards and penalties in 2017
- Identify practical strategies to thrive under the Merit-Based Incentive Payment System (MIPS)

Icebreaker

- Describe the Quality Payment Program in one word

“___________________”
SGR & THE “DOC FIX”

The Sustainable Growth Rate
Medicare payment prior to 2019 – Fee-for-service payment system, where clinicians are paid based on volume of services not value
Established in 1997 to control the cost of Medicare payments to physicians

IF

- Overall physician costs
- Target Medicare expenditures
- Physician payments cut across the board

Each year, Congress passed temporary “doc fixes” to avert cuts (no fix in 2015 would have meant a 21% cut in Medicare payments to clinicians)

The Quality Payment Program (QPP)
• A payment system that rewards value and outcomes
• Key point: We are all part of the QPP
  - Clinicians
  - Patients and family members
  - Office staff
  - CMS
  - EHR vendors
  - Quality Insights QIN

We all share a similar goal to improve patient outcomes
What is MIPS?

- Streamlines three legacy programs (PQRS, MU, VM) into one and adds a fourth component to promote improvement and innovation in clinical activities
- Allows clinicians flexibility to choose measures and activities that are most meaningful to their practice

Two Tracks in the QPP

- In 2017, clinicians and groups are "graded" based on performance in 3 categories
- MIPS score determines Medicare Part B reimbursement in 2019
- Participant in programs that have shared risk, such as ACOs
- Qualified participants avoid MIPS penalties and receive a 5% payment increase

Most Clinicians Will be Subject to MIPS

- All clinicians/groups must report MIPS in 2017
- CMS cannot determine qualifying advanced APM participants until 2018

Who is a MIPS Eligible Clinician in 2017?

- "Physician" includes:
  - MD (doctor of medicine)
  - DO (doctor of osteopathy)
  - DDS (doctor of dental surgery)
  - DDM (doctor of dental medicine)
  - DPM (podiatrist)
  - OD (optometrist)
  - DC (chiropractor)
Clinician Eligibility Requirement

- Must bill > $30,000/year to Medicare Part B AND see > 100 Medicare patients/year
- NPs, PAs, and other clinicians who do not bill under their NPI are not eligible

Non-Patient Facing Clinicians

- A non-patient facing MIPS EC is an individual who bills ≤ 100 patient-facing encounters (including Medicare telehealth services) during one of the determination periods
- A non-patient facing group is when > 75 percent of the NPIs billing under the group’s TIN meet the definition of a non-patient facing individual MIPS eligible clinician during one of the determination periods

Non-Patient Facing Clinicians

- The two determination periods when CMS will identify non-patient facing individuals and groups are:
  - 9/1/15 to 8/31/16
  - 9/1/16 to 8/31/17

Who is Excluded from MIPS?

- Enrolled in Medicare for the first time during the performance period. New ECs are exempt until the following performance year.
- Medicare Part B allowed charges ≤ $30,000/year OR See ≤ 100 Medicare Part B patients/year
- Receive 25% of Medicare payments
- Enrolled in Medicare for the first time during the performance period. New ECs are exempt until the following performance year.
- Medicare Part B allowed charges ≤ $30,000/year OR See ≤ 100 Medicare Part B patients/year
- Receive 25% of Medicare payments
- Enrolled in Medicare for the first time during the performance period. New ECs are exempt until the following performance year.
- Medicare Part B allowed charges ≤ $30,000/year OR See ≤ 100 Medicare Part B patients/year
- Receive 25% of Medicare payments
‘Pick Your Pace’ Participation in 2017

**Test Pace**
- Submit Something
  - Submit some data
  - Neutral or small positive payment adjustment

**Partial Year**
- Submit a Partial Year
  - Report data for 90 days
  - Small positive payment adjustment

**Full Year**
- Submit a Full Year
  - Report data for full year
  - Modest positive payment adjustment

Non-participation in the QPP in 2017 will result in a negative 4 percent payment adjustment in 2019.

Select Individual OR Group Reporting

- Practices must decide whether to report data at the individual clinician level or as a group
- All MIPS categories must be reported the same way
- If practice is in an ACO, group reporting must be: done

**OPTIONS**
- Individual
- Group

Under an AIN number and TIN where they reassign benefits
1) As a group with 2-2 clinicians (RPIs) who have reassigned their billing rights to a single TIN
2) As an AIN entity, i.e. ACO

Group Registration Requirements

- Group registration is required for two circumstances:
  - The group wants to report using the CMS Web Interface
  - The group wants to report the CAHPS for MIPS survey as one of their six quality measures
- June 30, 2017 is the registration deadline

Quality Category

- Replaces PQRS
- Select six quality measures, including one outcome measure or high priority measure
- 271 quality measures are available

<table>
<thead>
<tr>
<th>Submission Method</th>
<th># of Available Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>271</td>
</tr>
<tr>
<td>EHR</td>
<td>53</td>
</tr>
<tr>
<td>Registry</td>
<td>243</td>
</tr>
<tr>
<td>CMS Web Interface</td>
<td>15</td>
</tr>
<tr>
<td>CSV (CAHPS survey)</td>
<td>1</td>
</tr>
</tbody>
</table>
Quality Scoring in 2017

- 3 points are awarded for each measure (up to 6) that is successfully submitted
- If a measure cannot be “reliably scored” against a benchmark, 3 points will be awarded
- If a measure can be “reliably scored” against a benchmark, 3-10 points will be awarded
- There are separate benchmarks for the quality measures based on the data submission method
- All measure reporters (individuals and groups) are combined into one benchmark

Reliable Scoring

- Reliable scoring requires the following:
  - A benchmark must exist
  - There is sufficient case volume (≥ 20 cases for most measures)
  - Data completeness is met (≥ 50% of possible data is submitted)
  - All payor’s patients for the following submission methods:
    - Registry
    - QCDR
    - EHR
  - Only Medicare patients for the following submission methods:
    - Claims
    - CMS Web Interface
    - CAHPS Survey

MIPS: “Quality” and Colorectal Screening

- Colorectal Cancer: Rectal Pathology Reporting in Category (Primary Tumor) and in Category Regional Lymph Nodes with Histology Grade
- Colorectal Cancer Screening
- Colorectal Cancer: Mutation Testing for Patients with Metastatic Colorectal Cancer who receive Anti-epidermal Growth Factor Receptor Therapy
- Patients with Metastatic Colorectal Cancer and BRAF Gene Mutation Sporadic Treatment with Anti-epidermal Growth Factor Receptor Biologic Monoclonal antibody
- Screening Colonoscopy/Adenoma Detection Rate

Most Common Colorectal Screening Measure
Bonus Points for the Quality Category

- **Two bonus points** are awarded for each additional outcome or patient experience measure reported in addition to the one required outcome measure.
- **One bonus point** is awarded for each additional high-priority measure reported in addition to the one required outcome/high-priority measure.
- **One bonus point** is awarded for each quality measure submitted electronically end-to-end using CEHRT.

Maximum Quality Score

- The maximum number of points available for the quality category is based on the submission method and whether the readmission measure was calculated.
- CMS calculates the readmission measure for groups with > 15 ECs that have more than 200 cases.

Maximum Quality Score (cont.)

For groups with complete reporting (no readmission measure):
- 60 points
- 6 measures (readmission measure does not apply)

For groups with complete reporting plus readmission measure:
- 120 points
- 6 measures plus readmission measure
Calculating the Quality Score

\[
\text{Total Quality Performance Category Score} = \frac{\text{Points earned on required 6 quality measures}}{\text{Maximum number of points}^*} + \text{Any bonus points}
\]

Quality Submission Methods

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>QCDR (Qualified Clinical Data Registry)</td>
<td>QCDR (Qualified Clinical Data Registry)</td>
</tr>
<tr>
<td>Qualified Registry</td>
<td>Qualified Registry</td>
</tr>
<tr>
<td>EHR</td>
<td>EHR</td>
</tr>
<tr>
<td>Claims</td>
<td>Administrative Claims</td>
</tr>
<tr>
<td></td>
<td>CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td></td>
<td>CAHPS for MIPS Survey</td>
</tr>
</tbody>
</table>

The CAHPS for MIPS Survey counts as 1 patient experience measure. Five other measures must be submitted using a different reporting method.

Registry and QCDR Reporting

- CMS released the list of 2017 Qualified Registries and Qualified Clinical Data Registries (QCDRs)
- Registries can report data for the Quality, Advancing Care Information, or Improvement Activity categories
- The lists are located on the QPP website at:
  - https://qpp.cms.gov/docs/QPP_2017_CMS_Approved_QCDRs.pdf

Advancing Care Information Category

- Replaces Meaningful Use
- In 2017, the ACI category is optional for these ECs:
  - Nurse practitioners
  - Physician assistants
  - Clinical nurse specialists
  - Certified registered nurse anesthetists
  - Non-patient facing clinicians
  - Hospital-based physicians (≥ 75% of Part B services performed inpatient, in the ER, or in an on-campus outpatient department)
Optional Clinicians for ACI in 2017

- Optional ECs qualify for **automatic re-weighting**
- CMS will re-weight the ACI category to 0% and increase the Quality category to 85% (MIPS score = 85% Quality + 15% IA)
- If ACI data is submitted, CMS will score the ACI measures

Are Hardship Exceptions Available for ACI?

- MIPS ECs can apply for an ACI category hardship exception on an annual basis
- Applications will be approved for the following three reasons:
  - Insufficient Internet activity
  - Extreme and uncontrollable circumstances
  - Lack of control over the availability of CEHRT
- If the application is accepted, CMS will re-weight the ACI category to 0 and increase the Quality category weight to 85%

Certified EHR Technology Required

- In order to report measures for the ACI category and/or receive the electronic reporting bonus point for the Quality category, you must use an EHR certified as:
  - 2014 Edition, OR
  - 2015 Edition, OR
  - A combination of 2014 and 2015 editions (i.e., EHR is upgraded during the reporting period)
- Everyone must upgrade to 2015 CEHRT prior to January 1, 2018

2017 ACI Requirements

- **Testing option**: Submit all base score measures (4 or 5 depending on measure set selected)
- **Partial and full participation**: Submit more than the base score measures

A full list of ACI measures is located at: [www.qpp.cms.gov](http://www.qpp.cms.gov)
Two ACI Measure Sets

2017 Transition Measures
Select if one of the following was used during the reporting period:
• 2014 Edition
• 2015 Edition
• Combination of 2014 and 2015 Editions

ACI Measures
Select if one of the following was used during the reporting period:
• 2015 Edition
• Combination of 2014 and 2015 Editions

ACI Base Measures

• In order to receive any points for the ACI category, a Privacy & Security Risk Assessment must be done during the calendar year AND the remaining base score measures must have at least a 1 in the numerator

ACI Performance Measures

Performance Score
2017 Transition ACI Measures
1. Provide Patient Access
2. Health Information Exchange
3. View/Download/Transmit
4. Patient Education
5. Secure Messaging
6. Medication Reconciliation
7. Immunization Registry Reporting

Performance Score
ACI Measures
*Requires 2015 or 2014/2015 combination CEHRT
1. Provide Patient Access
2. View/Download/Transmit
3. Patient Education
4. Secure Messaging
5. Patient Generated Health Data
6. Send a Summary of Care
7. Request/Accept Summary of Care
8. Clinical Information Reconciliation
9. Immunization Registry Reporting

Differences in the ACI Measure Set

• Base measure added:
  – Request and Accept a Summary of Care electronically *New

• Performance measures added and/or revised:
  – Patient Education: Must provide materials electronically
  – Clinical Information Reconciliation: In addition to reconciling meds, med allergies and problem list must be reconciled
  – Patient Generated Health Data: Incorporate data from patient or non-clinical setting into EHR *New
  – Request and Accept a Summary of Care: Electronically *New

• All performance measures worth 10 points (none worth 20 points)
ACI Bonus Points

**5 Bonus Points**

If you report to one of the following:
- Clinical Data Registry
- Specialized Registry
- Public Health Registry
- Syndromic Surveillance
- Electronic Case Reporting

**10 Bonus Points**

If you utilize CEHRT to complete one of the 18 Improvement Activities that is designated as an ACI bonus activity

ACI Scoring

\[
\text{ACI Score} = \text{Base Score} + \text{Performance Score} + \text{Bonus Points}
\]

- 155 ACI points are available, but only 100 ACI points are needed to earn full credit for this category
- Full credit will add 25 points to the MIPS score

ACI Submission Methods

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attestation</td>
<td>Attestation</td>
</tr>
<tr>
<td>Registry</td>
<td>Registry</td>
</tr>
<tr>
<td>EHR</td>
<td>EHR</td>
</tr>
<tr>
<td>CMS Web Interface (groups of 25 or more)</td>
<td></td>
</tr>
</tbody>
</table>

Improvement Activities (IA)

- There are 92 improvement activities, grouped into categories
- Each activity must be completed for a minimum of 90 days
- The max score for full credit for the IA category is 40 points
- If full credit is earned, 15 points will be added to the MIPS score
- Points are awarded based on the weight of the activity
- AND the number of clinicians in the practice, the location of the practice, and if a clinician is a non-facing clinician

**15% of MIPS score in 2017**
Improvement Activities Eligible for ACI Bonus

- 18 of the 92 Improvement Activities (IA) award 10 bonus points to the ACI category if the IA is completed for 90 days
- Additional bonus points cannot be earned for completing more than one ACI bonus designated activity
- Six of the 18 activities directly relate to a 2017 ACI Transition measure
- All activities are medium weight

IA Categories

High Weight and Medium Weight Points

- HIGH weight = 40 points and MEDIUM weight = 20 points
  - If your practice has ≤ 15 clinicians
  - If your practice is located in a rural zip code
  - If your practice is located in a health professional shortage area (HPSA)
  - If you are a non-facing eligible clinician
- HIGH weight = 20 points and MEDIUM weight = 10 points
  - If your practice has > 15 clinicians

Special Considerations

- These participants earn full credit for the IA category (40 points):
  - Certified Patient Centered Medical Home (PCMH)
  - Comparable specialty practices
  - APM designated as a Medical Home Model
- Medicare Shared Savings Program Track 1 or the Oncology Care Model automatically receive points based on the requirements of the APM
  - All current APMs under the APM scoring standard will earn full credit for the IA category (40 points)
  - All future APMs under the APM scoring standard will receive at least half credit for the IA category (20 points)
Colorectal Care Coordination IA

<table>
<thead>
<tr>
<th>ACTIVITY ID</th>
<th>SUBCATEGORY NAME</th>
<th>ACTIVITY WEIGHTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA_OCC_6</td>
<td>Care Coordination</td>
<td>Medium</td>
</tr>
</tbody>
</table>

IA Credit for Working with the QIN

- Several IAs are aligned with physician office projects that Quality Insights offers
- If you participate in any of these projects, you will earn points toward your IA score

Colorectal Test Results IA

<table>
<thead>
<tr>
<th>ACTIVITY ID</th>
<th>SUBCATEGORY NAME</th>
<th>ACTIVITY WEIGHTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA_OCC_2</td>
<td>Care Coordination</td>
<td>Medium</td>
</tr>
</tbody>
</table>

QIN-Related Activities

- Some examples include:
  - Referring Medicare patients with diabetes to diabetes self-management classes
  - Receive education about antibiotic stewardship
  - Participate in the Transforming Clinical Practice Initiative (TCPI)
  - Report high blood pressure outcome measures and Million Hearts® measures
  - Improve adult immunization rates
  - Increase Annual Wellness Visits
Activities Supported by Quality Insights

- IA_BE_3: Beneficiary Engagement
- IA_CC_3: Care Coordination
- IA_CC_4: Care Coordination
- IA_EPA_4: Expanded Practice Access
- IA_PM_5: Population Management
- IA_PM_6: Population Management
- IA_PSPA_19: Patient Safety & Practice Assessment

IA Submission Methods

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<td>Qualified Registry</td>
</tr>
<tr>
<td>EHR Vendor</td>
<td>EHR Vendor</td>
</tr>
</tbody>
</table>

Calculating the MIPS Score

- The MIPS Score is calculated by adding the Quality, ACI, and IA scores together

<table>
<thead>
<tr>
<th>Quality Score</th>
<th>ACI Score</th>
<th>IA Score</th>
<th>MIPS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 possible points</td>
<td>25 possible points</td>
<td>15 possible points</td>
<td>= 100 possible points</td>
</tr>
</tbody>
</table>

2017 Payment Adjustments

<table>
<thead>
<tr>
<th>MIPS Score</th>
<th>Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 points</td>
<td>4% negative payment adjustment</td>
</tr>
<tr>
<td>3 points</td>
<td>No payment adjustment</td>
</tr>
<tr>
<td>4-69 points</td>
<td>Positive payment adjustment up to 4%</td>
</tr>
<tr>
<td>≥ 70 points</td>
<td>Eligible for exceptional performance bonus with minimum of additional 0.5%</td>
</tr>
</tbody>
</table>
**Bonus for Exceptional Performers**

- Clinicians/groups with a MIPS score of at least 70 points are eligible to receive an additional positive payment adjustment funded from a pool of $500 million.
- The exceptional performer bonus is available for the first 6 years of the program (2019-2024).
- The bonus percent is determined so that clinicians/groups having higher final scores above the additional performance threshold receive higher additional MIPS payment adjustments.

**Future MIPS Payment Adjustments**

- The potential maximum adjustment to Medicare Part B payments will increase each year from 2019 through 2022.

**Prepare to Participate**

- Consider your practice readiness – have you previously participated in PQRS or MU?
- Choose data submission method(s) you want to use, verify capabilities, and confirm that methods are approved by CMS and/or ONC.
- Determine if you want to report as individuals or a group.

**Prepare to Participate (cont.)**

- Review and select measures and activities – consider the following:
  - Your patient population and conditions you treat
  - Your practice location
  - Quality data you may submit to other payers
  - QRUR results
Assistance to Providers

- Practice Transformation Services
  - Patient Centered Medical Home
  - Accountable Care Organizations
  - Affiliation with a healthcare system
- Transforming Clinical Practice Initiative
- QPP assistance to all practices
- Access the Health Care Payment Learning and Action Network (forum to discuss, track, and share APM best practices)
- State Innovation Models

Contact Us

- Practices with 15 or fewer clinicians
  - Email qpp-surs@qualityinsights.org
- Practices with 16 or more clinicians
  - Email dhennen@qualityinsights.org