

CANCER CHANGE PACKAGE

Community	Clinical Information Systems	Delivery System Design	Decision Support	Self Management Support	Organization of Healthcare
<p>Evaluate and promote community awareness and receptivity to screening through networking, education and collaboration</p> <p>Develop partnerships with community organizations in an effort to understand community perceptions and promote screening in target populations</p> <p>Develop/work with community advocacy group to create understanding of need for follow-up care</p> <p>Look to community agencies to help decrease barriers to the evaluation of abnormal screens</p> <p>Increase access to diagnostic services</p> <p>Build capacity and expand the cancer care team into the community</p> <p>Maintain a resource database on support services available to people diagnosed with cancer</p>	<p>Develop query capability and/or automated identification of high-risk or relevant subgroups</p> <p>Develop a registry query to identify patients due for screening</p> <p>Develop a registry query to identify patients with an abnormal screening test</p> <p>Create automated reminders for screening</p> <p>Make data entry a part of clinical care at the time of screening</p> <p>Create a tracking system that identifies abnormal screening, follows their referral progress, and/or sends reminders</p> <p>Make the tracking system relevant to the diagnostic work-up of all three cancers</p> <p>Improve communication between care providers across the continuum of care</p> <p>Make provider performance feedback available</p>	<p>Identify people at risk through queries of data system and identification of relevant populations</p> <p>Put Proactive management and reminder systems in place and clarify use of outreach, in reach or both for each cancer</p> <p>Redesign care roles to create planned and coordinated care that assures the patient timely complete screening and diagnostic evaluation and follow-up</p> <p>Develop a standardized referral plan for diagnosis and treatment</p> <p>Design communication and follow-up systems to meet patient and provider needs</p> <p>Standardize specialty feedback after a diagnostic workup</p> <p>Care planned and coordinated with patient assured of timely complete diagnostic evaluation and follow-up</p> <p>Make notification of results a routine part of care</p> <p>Offer work place screening</p>	<p>Provide ongoing educational opportunities for providers regarding screening</p> <p>Create mechanism to obtain feedback from referral specialty groups and facilitate consultation with same specialists</p> <p>Develop collaborative relationships to augment decision making</p> <p>Create a mechanism to facilitate knowledge about outside efforts and requirements</p> <p>Facilitate provider access to guidelines</p> <p>Ensure that treatment decisions and care processes are based upon proven guidelines and/or expert opinion</p>	<p>Assist patients to set and achieve personal goals and given aids to assist in changing behavior</p> <p>Provide patient with culturally and literacy appropriate educational resources needed to evaluate their screening and treatment options</p> <p>Empower patient s to pursue results and provide feedback to the providers</p> <p>Include family, care givers, etc. in educational skills training and decision making regarding need for diagnostic work-up</p> <p>Create mechanisms for patient peer support and behavior change programs</p> <p>Provide access to alternative and traditional treatment modalities if needed</p>	<p>Assess and develop the health care service delivery system to meet the needs of the population</p> <p>Provide culturally competent staff for the patient population</p> <p>Regularly update Board, senior leadership, staff, and community on progress</p> <p>Allocate resources and remove barriers for improving cancer screening</p> <p>Develop partnerships with other community and health care organizations to insure that adequate screening capacity exists.</p> <p>Integrate cancer screening and follow-up into the Business and Performance Improvement Plan</p> <p>Clarify referral relationships for relevant diagnostic services</p> <p>Create availability of patient advocacy expertise</p> <p>Survey patients and staff for satisfaction with services</p> <p>Identify relevant treatment services</p>

Cancer Change Package Specific PDSA ideas for each change concept

Community

1. Evaluative and promote community awareness and receptivity to screening through networking, education, and collaboration

- Use public health outreach programs for professional education
- Host regular town meetings in the community to provide medical updates, get ideas, and ask what the community needs and wants
- Hold annual health fairs, inviting community members to attend and participate as providers and patients
- Billboards, ads, and features on cable access TV.
- Use students in healthcare programs to be used as outreach workers and educators
- Promote the importance of preventative health
- Use flea market/craft day for opportunity to instruct on SBE and cervical cancer screening; encourage follow-up appointments

2. Develop partnerships with community organizations to understand perceptions and promote screening in target populations

- Engage community faith-based organizations to become involved in cancer care outreach and education
- Encourage faith-based groups to develop cancer support groups in their parish
 - Use parish nurses to do lay health education and follow-up
 - Educate and engage faith based partners in African American and Hispanic communities
 - Have health fairs on site
- Community advocacy forum that includes representatives from groups and meets with providers regularly to review screening and follow-up delivery.
- Partner with the local university for cancer screening projects and screening at the clinics
- Strengthen partnership with NCI cancer information service outreach capacity to aid cancer-relevant resources.
- Partnerships with women's groups, clubs, Elks club, YMCA, ACS, Komen foundation, etc.
- Partner with informal care giver groups to assure increased quality of care services for patients requiring long term care services.
- Collaborate with state BCCP.
- Work with community networks with an interest in health to decide how to use their networks to reinforce screening messages.
- Use traditional healers in the community and develop approaches to work toward complimentary approach.

3. Develop/work with community advocacy group to create understanding of need for follow-up care

- Formalize an advocacy team involving the practice site's board of directors, political and religious leaders and the media to build capacity for change
- Engage advocacy function in the state legislature as they implement the Breast and Cervical Cancer Treatment Act
- Use community leaders as role models to minimize the stigma and fears of pap exams, mammograms
- HEDIS requirement (relating to colorectal CA screening) legislation to mandate payment for CRCS
- Engage local businesses in the promotion of a healthy community (good health means good business). Local business should:
 - Promote screening of employees
 - Explore health coverage and improve to allow screening per guidelines
 - Provide incentives for getting screening completed
 - Support special projects

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4. Look to community agencies to help decrease barriers to the evaluation of abnormal screens

- Ask for vouchers, discounts for transportation and child care so that patients can attend screening and treatment activities
- Use of block monitors, with web TV, in the home to get health information from the web
- Get county funding in order to make appoints and screen families that use the web TV
- Mobile vans to do outreach in community
- Convene focus groups to gather input on community needs and assistance with program development at health fair or in waiting rooms

5. Increase access to diagnostic and treatment services

- Link with larger health systems, hospitals, comprehensive cancer centers to provide services (screening, diagnostic, follow-up care)
- Link with community policy makers to address apparent barriers to screening
- Link with statewide breast and cervical cancer screening programs such as BCCCP, Komen, etc, providing more diagnostic and treatment services.

6. Build capacity and expand the cancer care team into the community

- Offer expert/technical assistance for presentations, educational materials, and health fairs to advocacy groups that help to educate patients in the community
- Outside support for providers to help decrease the burden of patient education (handouts should include websites). CRC screening video via high speed internet.
- Develop a referral and feedback process with community specialists. Review referral specialist's chosen algorithm for treatment.
- Identify community agencies also serving clients and use them for recruitment and to improve follow-up adherence by using their current case management systems

7. Maintain a resource database on support services available to people diagnosed with cancer

- Develop a directory of local resources to give the patient (including pharmacy programs, transportation, financial assistance)
- Use cancer information services to highlight local services
- Work with local agencies to develop e-tool data base and make it available to patients
- Provide information on professional case managers to assist with resource allocation and referral
- Identify cancer resources in the area
- Create a calendar of routine community events relating to cancer and have the practice promote the activities.

Clinical Information Systems

1. Develop query capability and/or automated identification of high-risk or relevant subgroups

- Capture history of cancer and other risk factors that may alter timing and/or frequency of screening. Note the importance of family histories that identify first and second degree relatives with cancer diagnoses especially whose ages at diagnoses precede routine screening ages.
- Develop a system for selecting patients for screening based on demographic profiles (age, sex).
- Identify women who have missed screening by 12 months and one day so they can be contacted via phone, visit, and/or letter.
- Identify persons >50 years old living at the same address and invite them to visit together and attend education or screening events.
- Flag for women turning 40 years of age to invite them to have 1st mammogram (make it a special event with a gift as incentive).

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2. Develop a centralized source of information (registry) of patients due for screening or with abnormal screening test

- Develop registry, computer-based, like PECS.
- System should identify patient when registering for appointment if due for test.
- System should print reminder list of all patients who have not had screening or follow-up within a prescribed period.
- Build centralized information systems across groups of practices to make it affordable.
- Generate aggregate and patient-specific reports of timely screening and follow-up.
- Generate system that captures stage of cancers at diagnosis.
- Use standardized terminology in an information system that is considered consistent with national guidelines.
- Obtain feedback from providers as to what type of data to collect and which reports would help screening process.
- Create a centralized database for tailoring letters and reminders to patients.

3. Create automated reminders for screening and follow-up

- Make a decision regarding whether outreach (reminders to women outside of regular visits) and/or in reach (reminders to women in the course of usual care) will be used.
- For in reach, create automated reminders in an electronic record or on encounter forms.
- Develop mechanism to identify patients needing follow-up on diagnosis.
- Automatic reminders to providers for patients who are due for screenings based on demographics.
- Screening updates by birth date.
- Automatic notification of providers for positive cancer screening (Pap, Mammo).
- Generate automatic e-mail and telephone reminders of follow-up for patients.

4. Create a tracking system that identifies abnormal screening, follows their referral progress, and/or sends reminders

- Reminder mechanism to identify patients monthly who have been referred out to make sure they have accessed treatment.
- Develop electronic patient records that identify risk factors and track screening activities.
- Utilize electronic tracking system for patient referrals in which pop-up features would alert clinical staff if patient does not keep follow-up appointment.
- Include date of results, date of communication with patient, what type of communication was used.
- Monitor time between screening, result notification, and diagnostic result by referral provider.
- Real time tracking so that the practice can assess progress towards goals. See NC Cancer Plan and NC CDMC Cancer Measures for goals.
- Automatically enter screening data and follow-up health data from patient records to a Clinical Information System to track follow-up

5. Make the tracking system relevant to the diagnostic workup of all three cancers

6. Improve communication between care providers across the continuum of care

- Empower team to pull information from system (not to go to IS).
- Electronic feedback from specialist to PCP.
- Have system that provides referral source with positive screening information and other information that may be helpful in diagnosis like MMG images and interpreted results, Pap readings and factors that may contribute to interpretation (ie. + infection status at the time of Pap, prior Pap results, prior CRC screening results).

7. Provider specific performance feedback

- Automated report formats that provide monthly summary of the percent of

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- i. Referral to date of screening
 - ii. Number of days from abnormal test to diagnosis
 - iii. Diagnosis to initiation of treatment
- Provide feedback to clinicians in terms of adequacy of test (i.e., PAP).
 - Report practice statistics on a periodic basis to clinicians.

Delivery System Design

1. Identify people at risk through queries of data system and identification of relevant populations

- Workplace screening
- Outreach to young adults and college campuses
- Female adolescent education on breast and cervical cancer screening
- Promote CRC screening around men, using events designed for them
- Consider a group class on using FOBT, maybe as a part of a “Now that you are 50” special educational event (or health fair) or CRC screening day

2. Proactive management and reminder systems in place

- Summary form on patient record so clinician can quickly see what test patient is due. Send parallel reminders to patients.
- Contact patients to schedule and remind of appointments.
- Integrate delivery cancer screening with other preventative health services.
- Generate automatic mail (e-mail, telephone) reminders for patients to let them know when they are due for screening.

3. Redesign care roles to best meet the patient needs

- Case management and community health educator
- Follow-up case-management with computerized tracking and specialized nurse practitioner
- Nurse, peer educator, and soap opera style video
- Redesign the office roles to identify a prevention champion who coordinates activity around screening (from checking patient status to outcomes of follow-up)
- Self-management screening provider (not necessarily a physician) should have training skills on patient/physician communication about screening options.
- Cross train staff to expand capability.
- Develop peer resources/ counselors (like for HIV) to educate regarding the importance of screening.
- Identify nursing staff responsible to identify and make referrals for screening.
- Use volunteers to talk with reluctant patients.
- Develop care teams that include staff relevant to all aspects of identifying and tracking necessary programs.
- Use medical assistant to hand out and teach appropriate FOBT procedure and arrange counseling for patient.

4. Develop a standardized referral plan for diagnosis and treatment

- Contractual relationship with specialty groups with agreement on communication format and timelines
- Tell patient who they have been referred to and that it is their responsibility to make sure follow up appointments are made and kept.

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- Know your referral specialists. Meet with them to explain your efforts, get buy-in and cooperation, and agree on an action plan desired by both parties. Make referral sources aware of cancer goals with emphasis on notification of results, procedure intervals, and cancer stage to primary care center.
- Make sure referral provider has necessary screening information before the visit. Have patient hand carry a copy of the original result.

5. Design communication and follow-up systems to meet patient and provider needs

- Designate specific team members responsible to communicate with patients, specialists, and providers about abnormal test results.
- Use of patients as a second line of information source (voices of experience; peer support).
- Wrap a set of helpful services into the referral process for diagnosis (transport, social services, child care, etc.).
- Develop method of reporting normal results and emphasize continued screening behaviors. Let patient know they are expected to call for results if they are not informed by a specified time. Document this expectation.
- At initial service visit, provide verbal and written information about screening tests, possible results, and their meaning.
- Consider providing pre-paid phone cards for follow-up needs.
- Have patient fill out card and address it to self and put in tickler file to mail when appropriate.
- Ensure that a recall system for short-term follow-up is in place (i.e.; a repeat CBE in 3 months).

6. Standardize specialty feedback after a diagnostic workup

- Set up a referral loop from the practice, to the patient, to the specialist, and back to the practice through letters, phone calls, and faxes.
- Use appropriate and faxable referral form.
- Timely electronic feedback from specialist to the PCP and PCP to specialist.

7. Care planned and coordinated with patient assured of timely complete diagnostic evaluation and follow-up

- Devote a day to screening/Same day screening.
- Develop multimedia system to answer questions quickly (e-mail access to providers and staff).
- Investigate delays in scheduling diagnostic exams (availability of appointments) and encourage setting aside appointments for your patients.
- Have staff available for culturally competent and relevant patient education and referrals.
- Case management of test results, including education, testing procedure, and follow-up into the health care system
- Provide translation for common second language.
- Scan the chart at each clinical visit to verify screening requisites have been fulfilled: if not, do at the time of visit or schedule it for another time.
- Review the charts of all patients appointments the day before or that morning to include the need for screening or follow-up.
- When patient has a screening result, consider standardized telephone assessment of the patient's ability to adhere to follow-up process/ protocols.
- Develop a patient visit form that summarizes for the clinic and referral staff of patient specific needs (interpreter, sedation).

8. Make notification of results a routine part of care

- Use multimedia channels to inform patients of positive and negative results (mail, e-mail, fax, phone, etc.). Provide goal time interval from notification to diagnostic evaluation in correspondence to patient.
- Call patients with results. Encourage appointments to discuss positive screening results.
- Set up counseling sessions to explain results of screening and follow-up for consumers. Clarify relevant medical history and review referral source's treatment algorithms at this appointment. Clarify importance of patient's role in providing screening information to referral source.
- Create standardized methods for mailing results (positive or negative) with educational materials as deemed necessary.
- Set up system to ensure that patients know they will receive notification whether normal or not and that they must follow-up if they do not hear results.

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9. Offer Work place screening

Decision Support

1. Provide ongoing educational opportunities for providers regarding screening

- Provider education in the form of skills training regarding patient/physician communication of positive test results.
- Educate patients and healthcare providers about recommendations for persons with conditions like polyps, family history or other risk factors that puts them at risk.
- Train providers to counsel patients and help them make good informed decisions.
- At least one member of team (and ideally all members) trained in risk communication (what does positive or negative results mean in regards to screening vs. diagnostic testing?).
- Web based CME education for physician and other practitioners on screening and follow-up.
- Yearly seminars for providers on health maintenance.

2. Create mechanism to obtain feedback from referral specialty groups and facilitate consultation with same specialists

- Contractual relationship with specialists.
- Consider the following when considering various specialty groups/specialists: Is follow-up appropriate and streamlined? Is there good feedback loop and collaboration? Do the specialists accept insurances or uninsured patients?
- Establish a pathway for the PCP to direct questions about equivocal test results.
- Have specialty care providers come to practices annually/semi-annually to talk with teams and patients. Make practices aware of guidelines used by specialty care provider.
- Keep an up to date list of providers in diagnostic and surgical referral centers.

3. Develop collaborative relationships to augment decision making

- Members of care team should meet periodically as a quality improvement committee to examine results of screening and screening rates.
- Develop a listserv for exchange of questions, good ideas, best practices.

4. Make relevant information available at the time of the visit

- Develop mechanisms that provide immediate results to prevent loss of follow-ups.
- Standardize flow for review of positive results.
- List cancer screening dates as vital statistics in the front of the medical chart, (as is done for immunizations).
- Develop a system for acquiring test results done outside the delivery system and link it to the primary health system.
- Use simple, culturally appropriate educational information on positive outcomes of early detection
- Cross check pap summaries provided by pap labs with follow-up reminder log, card file, or computer data system.

5. Facilitate provider and patient access to guidelines

- Guidelines on posters in exam rooms, waiting rooms and restrooms.
- Pocket and wallet card reminders for providers and patients (perhaps refrigerator magnets for the patients).
- Develop low literacy materials in different languages that can help patients with decision making about evidence-based options.

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- Provide computer-based system for patient informed decision making about screening and diagnostic testing.
- Guidelines embedded into flow sheet used at the front of chart to allow team to easily identify when the patient is due for screening test or follow up.
- Have clear result interpretation guidelines for providers.

6. Ensure that treatment decisions and care processes are based upon explicit proven guidelines

- Develop pathways of care for patient needs and expectations.
- Automated guidelines where consensus exists.
- Develop and use a high-risk assessment tool based on guidelines.
- Describe results and treatment options and identify resources where providers can acquire rapidly available detailed information.
- Develop a clear “if...then” table regarding results through next steps (esp. for cervical cancer).

Self Management Support

1. Patients are helped to set and achieve personal goals and given aids to assist in changing behavior

- Tailored reminder messages delivered to consumers to encourage appropriate self-management (delivered by phone, mail, e-mail, etc.)
- Follow-up with patient
- Reminder wallet card for re-screening or other summary screening record that the patient keeps
- Use therapeutic communication tools: Ask rather than tell: Ask patients about their commitment to participate in screening and their beliefs and perception of both benefits and barriers; respond empathically to patients' beliefs, concerns and feelings; Use the NURS approach (Name, Understand, Respect, Support); use problem-solving to increase acceptance of screening; seek agreement that leads patient and clinician through action plan and that specifies goals, barriers and next steps.
- Define screening as an informed choice that is an easy and effective way to maintain wellness, in context with other behaviors.
- Develop a wellness self-management contracts with patient (“you do X and we will do Y”).
- Create workbook to track patient and family members' health (immunizations, screenings, diagnoses, treatment, and medications).
- Provide relevant/simple information to patients to help achieve their stated goals.

2. Provide patient with culturally, linguistically and literacy appropriate education and resources needed to evaluate their screening options

- Provide at-risk patients with educational materials emphasizing benefits, limitations and risks of screening.
- Tailor information to the beliefs, values and barriers of the patient.
- Give culturally, linguistically and literacy level appropriate instructions including information describing what the test is about, why it is important, where to get treatment.

3. Empower patient to pursue results and provide feedback to the providers

- Seek feedback from patients (on-line, mail, phone) about experience with screening, self-management, questions, and issues.
- Empower patients to ask and know about the risks of screening, including the possibility of a false positive. Educate patients on limitations of a screening test and that a positive screen only means that a follow-up plan is necessary not that a disease is definitely diagnosed.

4. Include family/care givers in training and decision-making regarding need for diagnostic work-up

- Provide materials that identify how family might support patient to address barriers and participate in the screening and follow-up diagnostic process

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5. Create mechanisms for patient peer support and behavior change programs

- Link with culturally sensitive groups, community resources, other patients and/or promotoras for both outreach and support.
- Add patient representative to the team.

6. Create a clearinghouse for a variety of alternative and traditional treatment modalities

- Develop a directory of local resources to give the patient, including pharmacy programs, transportation, financial assistance and insurance coverage options for evaluation and diagnosis.
- Provide complementary alternative medicine resources if patient desires; consider using NCI Office of Complimentary and Alternative Medicine as a resource.

Organization of Healthcare

1. Assess and develop the health care service delivery system to meet the needs of the population

- Patient vouchers or incentives for screening

2. Provide culturally competent staff for the patient population

- Ensure that someone indigenous to the patient population review the versions of “result communicated” for language and cultural issues.
- Provide translation services at the time of care delivery and notify referral provider of this need.

3. Regularly update Board, senior leadership, staff, and community on progress

- Charts or graphs depicting progress toward screening goals should be readily visible to staff and patients.
- Report the progress achieved in cancer at the regular medical staff meetings.
- Identify community leadership and advocacy groups that will support and advocate for resources. Keep them informed of progress and challenges.

4. Allocate resources and remove barriers for implementation of improving cancer screening and follow-up

- Create designated meeting time for the staff to share progress toward goals.
- Give the team the time to meet and plan as well as the autonomy to test and implement changes.

5. Integrate cancer screening and follow-up into the Business and Performance Improvement Plan

- Institute incentives (financial and other for patients and staff) for documenting patient informed decision-making about screenings and self-management.
- Incorporate cancer screenings a quality management committee.
- Provide performance reports on adherence to guidelines, perhaps graphical representation distributed on a monthly basis and provide as feedback to the provider and to medical staff meetings.

6. Clarify referral relationships for relevant diagnostic services

7. Create patient advocacy expertise

- Each practice should have at least one person trained to assist with financial management, insurance coverage, and finding social support.
- Include recommendations for screening needs in communications with new patients.

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8. Survey patients and staff for satisfaction with services

- Provide feedback forms in the outer office for those who want to comment or make suggestions
- Collect provider, staff and specialist satisfaction on the referral and feedback process

Effective “Kitchen Sink” Interventions

- Reminder flow sheets for patients and providers, audit with feedback, provider educational workshop
- Chart reminders, exam room prompts, in-service meetings, patient-directed literature, community outreach with educational sessions, literature distribution, community events, media, and church programs
- Development of community based provider advisory committee, small group provider training session, provider newsletters, television and radio targeted to community, development of minority task force to encourage screening with screening discounts and billboard advertising
- Patient educational brochures, physician reminders including chart stickers and flow sheets, audit with feedback
- Educational materials, provider presentation, small group discussions with role modeling, free screening for un/under-insured, physician reminders
- Provider education and prompts, integration of a project nurse, patient education, video with role model in talk show format, and reminders, transportation vouchers

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