Collaborative Return to Screening PDSA
Quality Improvement and Clinical Study

Speakers:
Dr. Heidi Nelson
Dr. Rachel Hae Soo Joung
Dr. Laura Makaroff

Moderator: Dr. Laurie Kirstein
Webinar Logistics

• All participants are muted during the webinar

• Questions – including technical issues you may be experiencing – should be submitted through the question pane

• Questions will be answered as time permits; additional questions and answers will be posted on the website

• Please complete the post-webinar evaluation you will receive via email
Introducing Our Moderator

Laurie Kirstein MD, FACS
Attending Breast Surgeon
Memorial Sloan Kettering Cancer Center
Associate Professor
Cornell University Medical College
Middleton, NJ
Introducing Our Presenters

**Heidi Nelson MD, FACS**  
Medical Director, Cancer Programs  
American College of Surgeons  
Chicago, IL

**Hae Soo (Rachel) Joung, MD**  
Ruth L. Kirschstein Postdoctoral Fellow  
Surgical Outcomes and Quality Improvement Center  
General Surgery Resident, PGY-4  
Northwestern University  
Chicago, IL

**Laura Makaroff, DO**  
Family Physician and Senior Vice President of Prevention and Early Detection at the American Cancer Society  
Washington DC
Updates on Return to Screening PDSA and Clinical Study

Outline of Topics

**Review**  Dr. Heidi Nelson
- Key objectives
- Logistics for PDSA QI Project
- Logistics for Clinical Study
- Q&A

**Report**  Dr. Rachel Joung
- Documentation and Forms
- Early Results from Enrollment Phase
- Q&A

**Introduce**  Dr. Laura Makaroff
- Interventions
- Q&A

**Panel**
- Moderator: Dr. Kirstein
- Speakers: Dr. Makaroff, Dr. Joung, Dr. Nelson
KEY OBJECTIVES

Close 2020 Screening Deficit (9 million)

3 KEY OBJECTIVES:
- Restore Screening
- Prevent Unnecessary Cancer Deaths

Sharpless: COVID-19 expected to increase mortality by at least 10,000 deaths from breast and colorectal cancers over 10 years
Goal: Accelerate Return To Screening

Collaboration

American Cancer Society
Commission on Cancer (CoC)
National Accreditation Program for Breast Centers (NAPBC)
PDSA STEP ONE – PLAN

A. Select one or more target screening focus
B. Assemble a team of key, diverse stakeholders (QI team)
C. Follow national guidelines and protocols:
   ➢ American Cancer Society screening toolkits were available
     Evidence-Based Interventions for Cancer Screening from the Community Guide
   ➢ A PDSA and Clinical Study protocol was drafted collaboratively
     Project and Clinical Study Details
D. Draft the Rationale and Problem Statement for your program
E. Complete Enrollment Form (REDCap Form A)
PDSA STEP TWO – DO

a) Review the American Cancer Society toolkit
   • Select a return to screening approach
   • Present plan to CoC Cancer Committee or NAPBC Breast Program Leadership Team
   • Document in minutes
   • Submit REDCap FORMS for the study
   • Complete on-line FORMS for submission to PRQ
   • Activate the plan no later than June 1, 2021, to be in compliance

b) Consider implementing more than one intervention in sequence or in parallel
   • Increase Community Demand
   • Increase Provider Delivery
   • Increase Community Access
PDSA STEP THREE – STUDY

Monitor and Document monthly screening rates and interventions

How to monitor your progress:
• Monitor screening activities every month
• Document monthly screening in the on-line or REDCap FORMS
• Modify or intensify interventions if screening rates are declining or not increasing
• Project will be compliant when your screening rates have returned to pre-Covid rates and you have increased screening by 10%
• Extensions may be granted beyond 2021

DOCUMENT…. DOCUMENT…. DOCUMENT... to secure standards compliance
Important instructions for achieving and documenting compliance

- May 31 - Form A (baseline application) was due
- June 1 - First intervention was to be implemented

- June 1 to November 31 - Record interventions
- June 1 to November 31 – Record screening rates and increase interventions as needed

- December 31 - Form B (data collection log) is due
- December 31 - Form C (intervention log) is due

- Keep these records available for PRQ and accreditation survey for standards credit
- Submit REDCap FORMS for clinical research accrual credit
Q&A
## Form A: Breast Cancer Screening Enrollment and Baseline Data Collection

<table>
<thead>
<tr>
<th>Pre-Pandemic Rate of Breast Cancer Screening</th>
<th>Average monthly pre-pandemic rate (September '19 + January '20 rates/2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pandemic Rate of Breast Cancer Screening</td>
<td>Average monthly pandemic rate (September '20 + January '21 rates/2)</td>
</tr>
<tr>
<td>Pandemic Screening Gap</td>
<td>Screening Gap calculated for you as: Pre-Pandemic minus Pandemic Screening Rates</td>
</tr>
<tr>
<td>10% Increase in Screening</td>
<td>10% Increase calculated for you as: 10% over the Pandemic Screening Rate</td>
</tr>
<tr>
<td>Post-Intervention Monthly Breast Cancer Screening Target</td>
<td>Target calculated for you as: Screening Gap or 10% Increase (if gap is less than 10%)</td>
</tr>
<tr>
<td>Source of Information for Breast Cancer Screening Rate</td>
<td></td>
</tr>
</tbody>
</table>

- Breast Cancer Screening Test (select all that apply)
  - [ ] Screening Mammograms
  - [ ] Screening MRIs (for high-risk women)
  - [ ] Other
Form B/C: Post-Intervention Monthly Data Collection and Intervention Log (Breast)

Thank you for enrolling in the Return to Cancer Screening Clinical Study (Breast) by completing Form A.

- Use this REDCap form:
  - To monitor and record monthly screening rates from April 1st, 2021 and continue through November 30th, 2021. (Form B)
  - As an activity tracker to keep a running log of interventions (Form C)
- At the end of each month, please document the number of screenings for the month, and check (select) the interventions that were implemented during the month.
- When you scroll to the bottom of this form, you will find a Summary Table that shows a tally of the number of interventions performed each month and the number of screenings per month.
  - Use this table as a reference to see if you are getting closer to your target monthly screening rate.
  - If your monthly screening rate is not improving, consider implementing more interventions or switching to different interventions.

You can open this form as often as you wish, save your answers by clicking [Save & Return Later], and return to this form at any time before final submission.
# Form B: Monthly Screening Log

**Breast Cancer Screening Test (select all that apply)**

*must provide value*

- [ ] Screening Mammograms
- [ ] Screening Breast MRI (for high-risk women)
- [ ] Other

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Screening per Month (please record at the end of each month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td></td>
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<td>July</td>
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<td>August</td>
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<td>September</td>
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<tr>
<td>October</td>
<td></td>
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<tr>
<td>November</td>
<td></td>
</tr>
</tbody>
</table>
FORM C: INTERVENTION LOG

Instructions:

- Please note the **start date** of the FIRST intervention that was implemented at your institution.
- At the end of each month, please return to this form to **check (select)** which interventions were implemented/performed during that month.
- *Note: Interventions need to be implemented by June 1st. You **do not** need to have had interventions implemented prior to June 1st.*

You can find detailed information about the following evidence-based interventions here: Evidence-Based Interventions for Increasing Cancer Screening from the Community Guide.

Intervention Start Date

*must provide value*

Please note the start date of the FIRST intervention that was implemented at your institution.
### A. Patient Reminders

<table>
<thead>
<tr>
<th></th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Individual patient reminder/outreach by healthcare providers (e.g., phone calls, text, email, EMR messaging, letters)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Facility/institution-wide patient outreach (e.g., automated notifications to eligible patients within health system)</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### B. Patient Education

<table>
<thead>
<tr>
<th></th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. One-on-one education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4. Group education</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### C. Media

<table>
<thead>
<tr>
<th></th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Dissemination of guideline/messaging information to patients across the hospital system (e.g., banners/posters, pamphlets, hospital website)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6. Dissemination of guideline/messaging information across community sites (e.g., vaccination sites, pharmacies, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The table below auto-calculates (tallies) the number of interventions performed per month, from the selections you made above. It also shows you the monthly screening you entered above in Form B.

Please use this as a reference when comparing the number of interventions implemented to your monthly screening rate.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Interventions Performed per Month (this is auto-calculated)</th>
<th>Number of Screenings per Month (this is auto-inserted from above Form B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>0</td>
<td></td>
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<tr>
<td>June</td>
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<td>July</td>
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<td>August</td>
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<td>September</td>
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<td>October</td>
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</tr>
<tr>
<td>November</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
TARGET GOALS

- **BREAST**
  - Restore Screening: 26%
  - Close 2020 Screening Deficit: 74%

- **LUNG**
  - Restore Screening: 35%
  - Close 2020 Screening Deficit: 65%

- **COLORECTAL**
  - Restore Screening: 37%
  - Close 2020 Screening Deficit: 64%

- **CERVICAL**
  - Restore Screening: 48%
  - Close 2020 Screening Deficit: 52%
## Screening Deficits and Potential Impact

856 enrollments completed; 814 validated

<table>
<thead>
<tr>
<th></th>
<th>Breast Cancer</th>
<th>Colorectal Cancer</th>
<th>Lung Cancer</th>
<th>Cervical Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimate of Potential Monthly Increases</td>
<td>57,141</td>
<td>6,079</td>
<td>1,744</td>
<td>4,280</td>
</tr>
<tr>
<td>Restore screening increase</td>
<td>21,684</td>
<td>5,159</td>
<td>900</td>
<td>2,101</td>
</tr>
<tr>
<td>Close 2020 screening deficit increase</td>
<td>35,456</td>
<td>920</td>
<td>844</td>
<td>2,180</td>
</tr>
</tbody>
</table>

489 CoC-accredited programs
260 NAPBC-accredited programs
749 unique programs

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Interventions Chosen by Participation Programs

1. Social Media Posts and/or Press Releases (63%)
2. Dissemination of guideline/messaging information to PCPs (49%)
3. Individual Patient Reminder/Outreach by Healthcare Providers (49%)
4. Facility-wide Patient Outreach (34%)
5. Dissemination of guideline/messaging to patients across the hospital system (30%)
6. Dissemination of guideline/messaging to specialists (23%)
7. Dissemination of guideline/messaging across community sites (23%)
8. Provider reminder/recall (18%)
9. One-on-one patient education (17%)
10. Collaboration with local TV/radio/news (16%)
Q&A
Agenda

Overview of Evidence-Based/Informed Interventions

How the evidence is generated

Advantages of using EB/Is

Using your data for EB/I Selection

Interventions by Strategy

Resources/Questions
Evidence-based interventions

are practices or programs that have peer-reviewed, documented empirical evidence of effectiveness. Evidence-based interventions use a continuum of integrated policies, strategies, activities, and services whose effectiveness has been proven or informed by research and evaluation.

Evidence-informed practices

use the best available research and practice knowledge to guide program design and implementation. This informed practice allows for innovation while incorporating the lessons learned from the existing research literature. Ideally, evidence-based and evidence-informed programs and practices should be responsive to cultural backgrounds, community values, and individual preferences.
Evidence Derived from Research

- Interventions that have been tested in a research study
- Systematic review of multiple interventions
- Policy analysis

Evidence Derived from Practice

- Intervention developed, implemented and evaluated in an organization, community or geographic region
Advantages of using EB/I Interventions

Success

- Increases likelihood of a successful initiative

Resource Conservation

- Increase cost benefit by saving time and resources, including during planning and implementation phases

Value

- When describing your program and sharing your plan with various partners

Evaluation Focus

- Defines what to evaluate and where you are looking for impact
Data Theory

There is a knowledge gap in our community when discussing colorectal cancer screening options—by both patient and provider.

Who is Impacted

Individual:
- Hesitant to screen
- Unaware of options

Provider:
- Does not recommend
- May not support all screening options

Organization:
- Lacks accessible hours
- Difficult to return stool kits

Community:
- GI not available to do diagnostic tests
- Lack of clinics in this area

Intervention Strategies

Increase Community Demand

Increase Provider Delivery

Increase Community Access

Intervention Selection: EXAMPLE
Recommended Evidence-Based/Informed Interventions by Strategy

Increase Community Demand
- **CLIENT REMINDERS**
  - Breast, Cervical, Colorectal, HPV Vaccination
- **CLIENT INCENTIVES**
  - Colorectal
- **SMALL MEDIA**
  - Breast, Cervical, Colorectal
- **PATIENT EDUCATION**
  - Breast, Cervical, Colorectal, HPV Vaccination

Increase Provider Delivery
- **PROVIDER REMINDERS/RECALL**
  - Breast, Cervical, Colorectal, HPV Vaccination
- **PROVIDER ASSESSMENT & FEEDBACK**
  - Breast, Cervical, Colorectal, HPV Vaccination
- **PROFESSIONAL EDUCATION**
  - Breast, Cervical, Colorectal, HPV Vaccination
- **PROVIDER INCENTIVES**
  - Colorectal
- **STANDING ORDERS**
  - HPV Vaccination

Increase Community Access
- **REDUCE BARRIERS**
  - Breast, Cervical, Colorectal, HPV Vaccination
- **REDUCE OUT-OF-POCKET COSTS**
  - Breast, Colorectal
Interventions are MOST effective when done in combination

**MOST Effective**
- All 3 Strategies

Multicomponent interventions that used all three strategies increased cancer screening by a median of 24.2 percentage points

- Interventions to increase community demand
- Interventions to increase provider delivery
- Interventions to increase community access

**Effective**
- 2 Strategies

Multicomponent interventions that used strategies to increase community demand and community access increased cancer screening by a median of 11.2 percentage points

- Interventions to increase community demand
- Interventions to increase community access

**NOTE for HPV VACCINATION**
A strong provider recommendation from a child’s healthcare provider is the most significant factor in a parent’s decision to vaccinate their children

1Opel et al. 'Presumptive Recommendation
Lung Cancer Screening

USPSTF Recommended Screening Guideline- as of March 9, 2021

Adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years

According to the USPSTF:

Increasing lung cancer *screening discussions* and *offering screening* to eligible persons who express a preference for it is a key step to realizing the potential benefit of lung cancer screening.

*Although there is very little evidence that aligns to a proven intervention, based on this statement, focusing in these areas would provide guidance on how your project may begin.*

Increase Community Demand

PATIENT EDUCATION

Increase Provider Delivery

PROFESSIONAL EDUCATION

Q&A
Return to Screening PDSA and Clinical Study

PANEL

Moderator:
Dr. Kirstein

Speakers:
Dr. Makaroff
Dr. Joung
Dr. Nelson
Panel Discussion Topics

Expected Outcomes:

➢ Restore screening rates and address 2020 screening deficit

➢ Determine if the # of interventions lead to quicker improvements in screening
   Is there a threshold; is there linear or logarithmic improvement?

➢ Identify which types of interventions are the most effective at improving screening rates
   Passive vs. active; patient-directed; physician-directed; community-directed

Potential Next Steps After Study Completed:

➢ Consider changes to “best practices” for CoC and NAPBC screening standards

➢ Consider future national quality improvement projects
https://www.facs.org/quality-programs/cancer/coc/resuming-care
Upcoming Webinars

CAAnswer Forum LIVE – August 2021
Topic: Quality Improvement and Standard 7.3
Question submission open now until August 2, 2021
Wednesday, August 18, 2021, at 12 pm CDT

Assisting Centers with Meeting the Special Needs of Patients with Metastatic Breast Cancer Webinar
Wednesday, September 8, 2021, at 12 pm CDT

Pelvic MRI for Rectal Cancer: Tips on Interpretation
Tuesday, September 14, 2021, at 5 pm CDT

CAAnswer Forum LIVE – October 2021
Topic: Rapid Cancer Reporting System and more on the STORE.
Evaluating registry data – Understanding class of case and other data items
Wednesday, October 13, 2021, at 12 pm CDT

Webinar information and registration is located:
https://www.facs.org/quality-programs/cancer/events

Cancer Programs Newsletter - Register
https://www.facs.org/quality-programs/cancer/news