2020 - 2021 Annual Colorectal Cancer Clinic Readiness Assessment/QI Plan

Submit Form and Invoice To mjgillespie@healthylincoln.org **Date**

Secton 1: Health System Profile

Health System Name

Health System Street

Health System City **Health System Zip**

Health System County

Total # of Primary Care Clinics in System **Total # of Primary Care Providers in System**

PCMH recognize, certified, or accredited? **Yes** **No** **Pending**

Section 2: Clinic Profile

Clinic Name

Clinic Street

Clinic City **Clinic Zip**

Clinic County

Title	Name	Phone	Email
Lead Physician			
Care Coordinator Name			
Quality Improvement Coordinator			
Other			

Do you have a clinic champion for colorectal cancer screening? **Yes** **No**

Title	Name	Phone	Email
CRC Champion			

Physicians	#	FTE
Family Physician		
General Practitioners		
Internists		
OB/GYN		
Pediatricians		
Other Specialty		
Total Physicians		

Mid-Levels and Nursing Staff	#	FTE
Nurse Practitioners		
Physician Assistants		
Certified Nurse Midwives		
Nurses		
Other Medical Personnel		
Laboratory Personnel		
X-Ray Personnel		

Outreach Staff	#	FTE
Community Health Worker		
Care Coordinators		
Navigators		

Section 3: Electronic Health Record Overview

Primary EHR Vendor at Selected Clinic

Primary EHR Home: **Health System Wide EHR** ☐ **EHR Specific to Clinic** ☐

Section 4: Current Colorectal Cancer Screening Practices

FIT	**Yes** ☐	**No** ☐	**Primary CRC Screeening Method** ☐		
FIT-DNA (Cologuard)	**Yes** ☐	**No** ☐	**Primary CRC Screeening Method** ☐		
FOBT	**Yes** ☐	**No** ☐	**Primary CRC Screeening Method** ☐		
Colonoscopy	**Yes** ☐	**No** ☐	**Primary CRC Screeening Method** ☐		
Other:	**Yes** ☐	**No** ☐	**Primary CRC Screeening Method** ☐		
Attach Policy for CRC Screening	**Yes** ☐	**No** ☐	**Do Not Have** ☐		
Attach Standing Orders	**Yes** ☐	**No** ☐	**Do Not Have** ☐		

Section 5: Description of Community/Clinic Characteristics

Include variables that describe clinic and patient characteristics and demographics, including:

*** Currently planned or initiated quality improvement initiatives**

*** Current policies or standing orders in place regarding CRC screening**

*** Training and reinforcements practices that support standing orders**

*** Leadership support of preventive care generally and prioritization of CRC screening specifically**

*** Presence of absence of a designated staff membe or administrator championing CRC screening initiatives**

Describe barriers experienced to receiving/completing CRC screening for patients

Section 6: Workflow Assessment

Include variables that describe clinic workflows, including:
***Patient Identification: Protocol used to determine patient's eligibility and those due for screening, e.g.**
***Patient Flow: Processes while patient is in office for screening/education, decision making, test return or prep, e.g.**
***Screening and Results Tracking Follow-Up: Process to determine if tests are returned, informing of test results, specialty care referrals, e.g.**
***Rescreening Patients: Process for tracking when patients are due, e.g.**

Attach clinic workflow for patients identified due for CRC screening	**Yes**	☐	**No**	☐	**Do Not Have**	☐
Attach patient workflow related to visit, education, referrals, screening instructions	**Yes**	☐	**No**	☐	**Do Not Have**	☐
Attach clinic workflow for screening, results tracking and follow up	**Yes**	☐	**No**	☐	**Do Not Have**	☐
Attach clinic workflow for rescreening patients	**Yes**	☐	**No**	☐	**Do Not Have**	☐

Note: PHL and Women's/Men's Health Programs will be supporting clinics with scheduled webinars and resources regarding workflow development/enhancements

Section 7: CRC Priority Evidenced Based Interventions

In the table below, check items you are currently doing. Please explain items selected in the space provided below or attach another sheet. Please share any tools you are currently using.

Primary Evidence Based Strategies

1. Provider Assessment	*Currently Doing*	*Describe the frequency for each select intervention*		
☐ ***Dashboards***	☐	Weekly ☐	Monthly ☐	Quarterly ☐
☐ ***Data-sharing***	☐	Weekly ☐	Monthly ☐	Quarterly ☐
☐ ***Benchmarking***	☐	Weekly ☐	Monthly ☐	Quarterly ☐
☐ ***Provider Compare***	☐	Weekly ☐	Monthly ☐	Quarterly ☐

Intervention Descriptions (Enter Detailed Description Below)

2. Provider Reminders	*Currently Doing*	*Describe the frequency for each select intervention*		
☐ ***Chart***	☐	Weekly ☐	Monthly ☐	Quarterly ☐
☐ ***Email***	☐	Weekly ☐	Monthly ☐	Quarterly ☐
☐ ***EHR Trackers***	☐	Weekly ☐	Monthly ☐	Quarterly ☐
☐ ***Other:***	☐	Weekly ☐	Monthly ☐	Quarterly ☐

Intervention Descriptions (Enter Detailed Description Below)

3. Patient Reminders	*Currently Doing*	*Describe the frequency for each select intervention*		
☐ ***Mail***	☐	Weekly ☐	Monthly ☐	Quarterly ☐
☐ ***Text***	☐	Weekly ☐	Monthly ☐	Quarterly ☐
☐ ***Phone***	☐	Weekly ☐	Monthly ☐	Quarterly ☐
☐ ***Patient portal***	☐	Weekly ☐	Monthly ☐	Quarterly ☐
☐ ***Other:***	☐	Weekly ☐	Monthly ☐	Quarterly ☐

Intervention Descriptions (Enter Detailed Description Below)

4. Reducing Structural Barriers	*Currently Doing*	Intervention Descriptions (Enter Detailed Description Below)
☐ ***FIT Tests at Flu Shot Visit***	☐	
☐ ***Extended Hours***	☐	
☐ ***Walk-in Appointments***	☐	
☐ ***Patient Navigation***	☐	
☐ ***Reducing out of Pocket Cost*** *(Gas Card, Vouchers, Patient Assistances Programs)*	☐	

Support Activities

	Currently Doing	*Describe the frequency for each select intervention*					
☐ *Patient Navigation*	☐	< 15min	☐	30min-1hr	☐	2-3hrs	☐
		15-30min	☐	1-2hrs	☐	3hrs	☐

Intervention Descriptions (Enter Detailed Description Below)

	Currently Doing	*Describe the frequency for each select intervention*
☐ *Small Media*	☐	Weekly ☐ Monthtly ☐ Quarterly ☐

Intervention Descriptions (Enter Detailed Description Below)

Section 8: Implementation Factors

1. Description of Intervention Needs

Briefly describe the health system policies and practices that require intervention and/or could be improved upon in order to increase screening rates. Describe how these interventions and/or improvements will be implemented at your clinic site and the person(s) responsible for implementation.

2. Implementation Resources Available
List or summarize the resources available to facilitate successful implementation (e.g. EHR system, clinic-based patient navigators). Will the program be using Patient Navigators or Community Health Workers to support implementation of Evidence-Based interventions? Also, note any community agencies you use for educational classes, or resources. Also describe the financial assistance programs awarded to patients you serve, if any.
3. Potential Barriers or Challenges
Briefly describe any anticipated potential barriers or challenges to implementation.