PCC’s July Lunch and Learn

July 21, 2022 | 11:00 AM - 12:00 PM ET
Primary Care: A Key Lever to Advance Health Equity:

Register Here:
https://attendee.gotowebinar.com/register/6156454100344638220
Lunch and Learn Co-Chairs

Irene Dankwa-Mullan, MD, MPH
Jack Westfall, MD, MPH
Don't miss THE LIST!

Two Dozen Curated Articles to Shape Primary Care Policy & Practice
Implementing the community resource specialist (CRS) role in primary care

*Learnings from the LINCC project*

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Clarissa Hsu, PhD
Kaiser Permanente Washington Health Research Institute
Presenting at:
PCC’s Lunch and Learn Discussion, July 21, 2022
**Project components**

**Collaborative design**
- Patients & staff create clinic-community liaison role

**Clinic-community linkage pilot**
- Linking patients to community resources
- Action planning and motivational interviewing

**Evaluation**
- Of community resource specialist (CRS) role
- Patient co-investigators

**Delivery system + research team**
Patient and community engagement strategies

- Patient co-investigators
- Collaborative care design process
- Community advisory panels
- Patient survey
- Observation and focus groups
CRS job description and requirements

Qualifications

• No college degree required
• No prior health care experience required
• Understanding and sensitivity to how socioeconomic, environmental, cultural, and other factors influence health
• Computer literacy
• Collaboration in team settings
• Strong communication and organizational skills

Job description

• Coaching patients & referring to resources (60%)
• Developing contacts in the local community (30%)
• Working with the primary care team (10%)
Key lessons learned: Role Implementation

- Role clarity
- Visibility of CRS
- Long ramp up period
- Need for a screening tool
- System level changes
### CRS Spread
- Hiring began in Fall 2017
- 25-30 CRS’s in clinics (most full time)
- Based on 1 CRS/20,000 members
- Covering 34 medical centers
- Recently unionized
- Under Mental Health and Well-being

### CRS Training
- State CHW certificate
- Motivational Interviewing and Trauma Informed Care approaches
- Implementation support and evaluation via KPWA Learning Health System Program

### Patient Interactions
- Seeing almost 1600 unique patients a month
- Over 3000 encounters per month
- 68% of encounters are telephone based
Key lessons learned: Policy & Practice

- Importance of patient voice
- Ensure local ownership
- The role of serendipity
- Need a team care model
- New mechanisms for sustainability
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Preventing Colon Cancer vs. Early Diagnosis, Which is Best?

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Dept of Family Medicine and Population Health
Virginia Commonwealth University SOM
Our team re-analyzed the 2016 U.S. Preventive Services Task Force Evidence Report (USPSTF-ER) meta-analysis for Colorectal Cancer Screening and showed that flexible sigmoidoscopy (FS) reduces all-cause mortality compared to usual care in clinical trials.¹ The current study performs correlation and regression analyses and found that prevention of CRC is most likely the sole mechanism of action for this finding.²

• After more than fifty years of cancer screening trials, FS is the first and only screening modality to demonstrate decreased all-cause mortality.

• The purpose of this study was to test the hypothesis that flexible sigmoidoscopy’s unique reduction in all-cause mortality may be more attributable to colorectal cancer prevention than to early diagnosis.

• Data was extracted from the original USPSTF-ER articles for total deaths, CRC incidence, and deaths attributed to CRC.
DEATH ATTRIBUTED TO COLORECTAL CANCER

**Screening**

<table>
<thead>
<tr>
<th>Study (trial, flu duration)</th>
<th>CRC Deaths</th>
<th>Total</th>
<th>CRC Deaths</th>
<th>Total</th>
<th>Weight</th>
<th>RR [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. FLEXIBLE SIGMOIDOSCOPY (10.5-11.9y)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schoen 2012 (PLCO,11.9y)</td>
<td>252</td>
<td>77445</td>
<td>341</td>
<td>77455</td>
<td>10.9%</td>
<td>0.74 [0.63, 0.87]</td>
</tr>
<tr>
<td>Segnan 2011 (SCORE,10.5y)</td>
<td>65</td>
<td>17136</td>
<td>83</td>
<td>17136</td>
<td>3.8%</td>
<td>0.78 [0.57, 1.08]</td>
</tr>
<tr>
<td>Ablin 2010 (UKFSGT,11.2y)</td>
<td>221</td>
<td>57099</td>
<td>637</td>
<td>11939</td>
<td>11.8%</td>
<td>0.69 [0.59, 0.80]</td>
</tr>
<tr>
<td>Holme 2014a (NORCAP [50-54],11.2y)</td>
<td>12</td>
<td>6920</td>
<td>87</td>
<td>37131</td>
<td>1.2%</td>
<td>0.74 [0.40, 1.35]</td>
</tr>
<tr>
<td>Holme 2014b (NORCAP [55-64],11.2y)</td>
<td>59</td>
<td>13652</td>
<td>243</td>
<td>41089</td>
<td>4.8%</td>
<td>0.73 [0.55, 0.97]</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>609</strong></td>
<td><strong>172252</strong></td>
<td><strong>1391</strong></td>
<td><strong>285750</strong></td>
<td><strong>32.5%</strong></td>
<td><strong>0.72 [0.65, 0.80]</strong></td>
</tr>
</tbody>
</table>

Heterogeneity: \( \hat{\tau}^2 = 0; \chi^2 = 7.6, df = 4 (P = 0.14); I^2 = 0\%
Test for overall effect: \( Z = -4.49 (P = 5.6 \times 10^{-11})\)

2. FOBT (11.0-30.0y)

<table>
<thead>
<tr>
<th>Study (trial, flu duration)</th>
<th>CRC Deaths</th>
<th>Total</th>
<th>CRC Deaths</th>
<th>Total</th>
<th>Weight</th>
<th>RR [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shaukat 2013 (Minnesota,30.0y)</td>
<td>437</td>
<td>31157</td>
<td>295</td>
<td>15394</td>
<td>12.3%</td>
<td>0.73 [0.63, 0.85]</td>
</tr>
<tr>
<td>Scholefield 2012 (Nottingham,19.5y)</td>
<td>1176</td>
<td>76056</td>
<td>1300</td>
<td>75919</td>
<td>20.9%</td>
<td>0.90 [0.84, 0.98]</td>
</tr>
<tr>
<td>Lindholm 2008 (Gotteborg,15.6y)</td>
<td>252</td>
<td>34144</td>
<td>300</td>
<td>34164</td>
<td>10.5%</td>
<td>0.84 [0.71, 0.99]</td>
</tr>
<tr>
<td>Kronborg 2004 (Furen,17.0y)</td>
<td>362</td>
<td>30967</td>
<td>431</td>
<td>30966</td>
<td>13.1%</td>
<td>0.84 [0.73, 0.96]</td>
</tr>
<tr>
<td>Faivre 2004 (Burgundy,11.0y)</td>
<td>254</td>
<td>45642</td>
<td>304</td>
<td>45557</td>
<td>10.6%</td>
<td>0.83 [0.71, 0.98]</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>2481</strong></td>
<td><strong>217966</strong></td>
<td><strong>2630</strong></td>
<td><strong>202000</strong></td>
<td><strong>67.5%</strong></td>
<td><strong>0.84 [0.78, 0.91]</strong></td>
</tr>
</tbody>
</table>

Heterogeneity: \( \hat{\tau}^2 = 0; \chi^2 = 6.38, df = 4 (P = 0.17); I^2 = 37\%
Test for overall effect: \( Z = -4.47 (P = 7.8 \times 10^{-11})\)
Test for subgroup differences: \( \chi^2 = 5.62, df = 1 (P = 0.018)\)

\( flu = \text{follow-up duration}; RR = \text{relative risk}; SJ = \text{Sidik-Jonkman random-effects estimator}; CI = \text{confidence interval}; \text{FOBT} = \text{fecal occult blood test}; y = \text{years}. \) The FOBT analysis for CRC incidence (1.0.1) uses the outcomes at 18.0y follow-up from Mandel 2000 because Shaukat 2013 does not report CRC incidence.
Correlation and Regression Analysis of the Relationship Between Observed Reductions of CRC and Death in RCTs

CRC = colorectal cancer, RR = relative risk, FS = flexible sigmoidoscopy, FOBT = fecal occult blood test, y = years, RCT = randomized controlled trial. A. RCT’s of flexible sigmoidoscopy. B. RCT’s of fecal occult blood test results are added. For the Minnesota FOBT trial, the 30 year study (Shaukat 2013) does not report CRC incidence, therefore both CRC incidence and death are at 18 years follow-up (Mandel 2000 and Mandel 199945).

Key to trials/studies: a = NORCAPP [age 50-54](Holme 2014a+b), b = UKFSST(Atkin 2010), c = PLCC(Schoen 2012), d = SCORE(Segnan 2011), e = NORCAPP [age 55-64](Holme 2014a+b), f = Minnesota(Mandel 199945 + 2000), g = Funen(Kronborg 2004), h = Nottingham(Scholefield 2012), i = Goteborg(Lindholm 2008).
• FS uniquely and consistently reduced death across all RCTs included in our re-analysis of the USPSTF-ER meta-analysis.

• Regression analysis indicates that prevention of CRC is most likely the sole mechanism of action, potentially indicating that early diagnosis of CRC did not have an effect on all-cause mortality
Key Take-aways