



# Lunch & Learn



A forum for researchers and policymakers to translate primary care research into action

# PCC's July Lunch and Learn

July 21, 2022 | 11:00 AM - 12:00 PM ET



July Webinar

Thursday, July 28  
3:00 p.m. ET

## Primary Care: A Key Lever to Advance Health Equity:

### PANELISTS

### MODERATOR



ANN GREINER,  
MCP

President and  
CEO,  
Primary Care  
Collaborative



DOMINIC MACK,  
MD, MBA

Director of the  
National Center  
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Morehouse  
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LOUISE COHEN,  
MPH

CEO,  
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Development  
Corporation  
(PCDC)



DOROTHY  
SIEMON, ESQ.

Senior Vice  
President,  
Office of Policy  
Development and  
Integration  
(OPDI), AARP



Sarah Coombs

Director for Health  
System  
Transformation,  
National Partnership  
for Women & Families

Register Here:

<https://attendee.gotowebinar.com/register/6156454100344638220>



## SPEAKERS



**Clarissa Hsu, PhD**  
Kaiser Permanente  
Washington Health  
Research Institute



**Scott Strayer, MD, MPH**  
Virginia Commonwealth  
University

## REACTOR



**Janice Tufte**  
University of  
Washington

## Lunch and Learn Co-Chairs



**Irene Dankwa-Mullan, MD, MPH**



**Jack Westfall, MD, MPH**



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Two Dozen  
Curated Articles  
to Shape  
Primary Care  
Policy & Practice

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# Implementing the community resource specialist (CRS) role in primary care

*Learnings from the LINCC project*

## LINCC



Learning to Integrate Neighborhoods and Clinical Care

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



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# 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

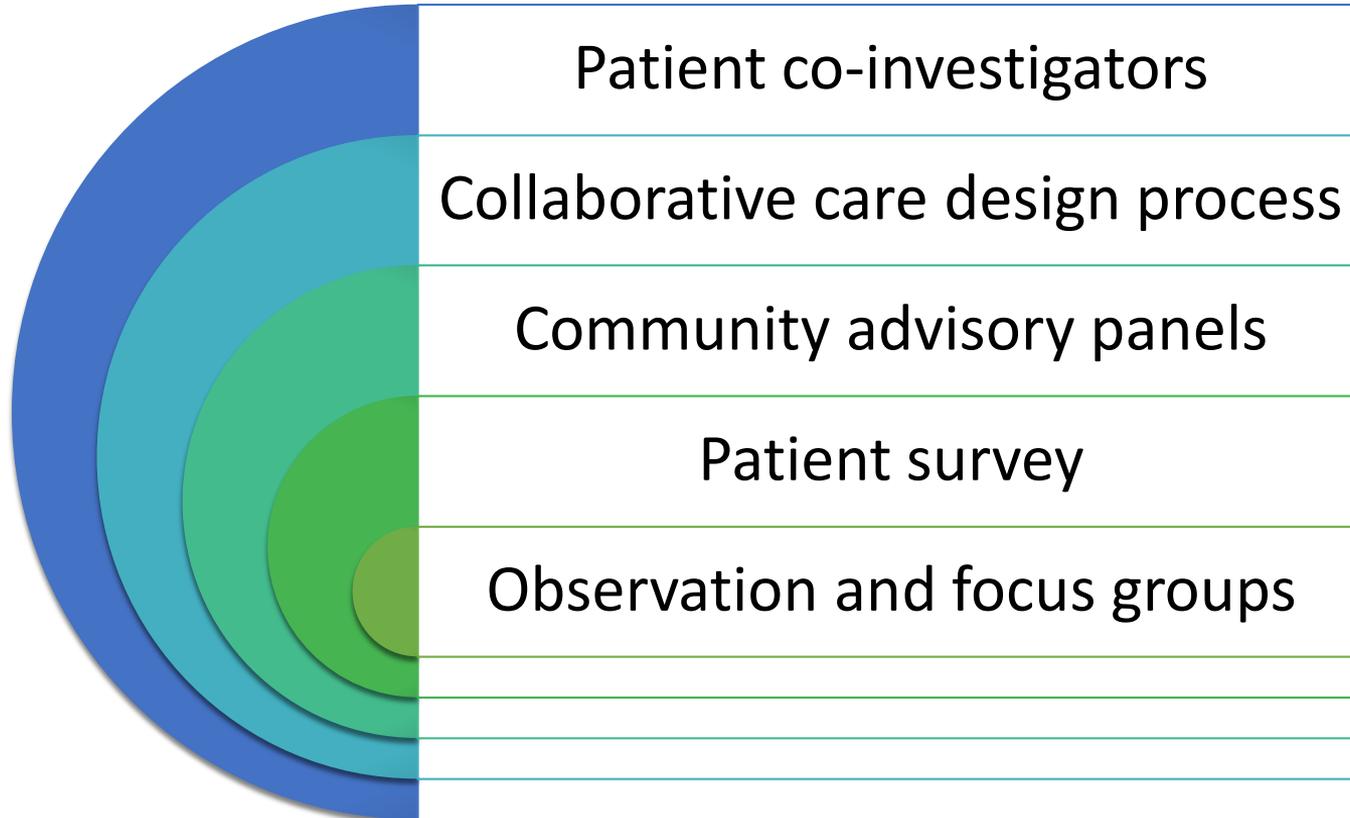


## Evaluation

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

Delivery system + research team

# Patient and community engagement strategies





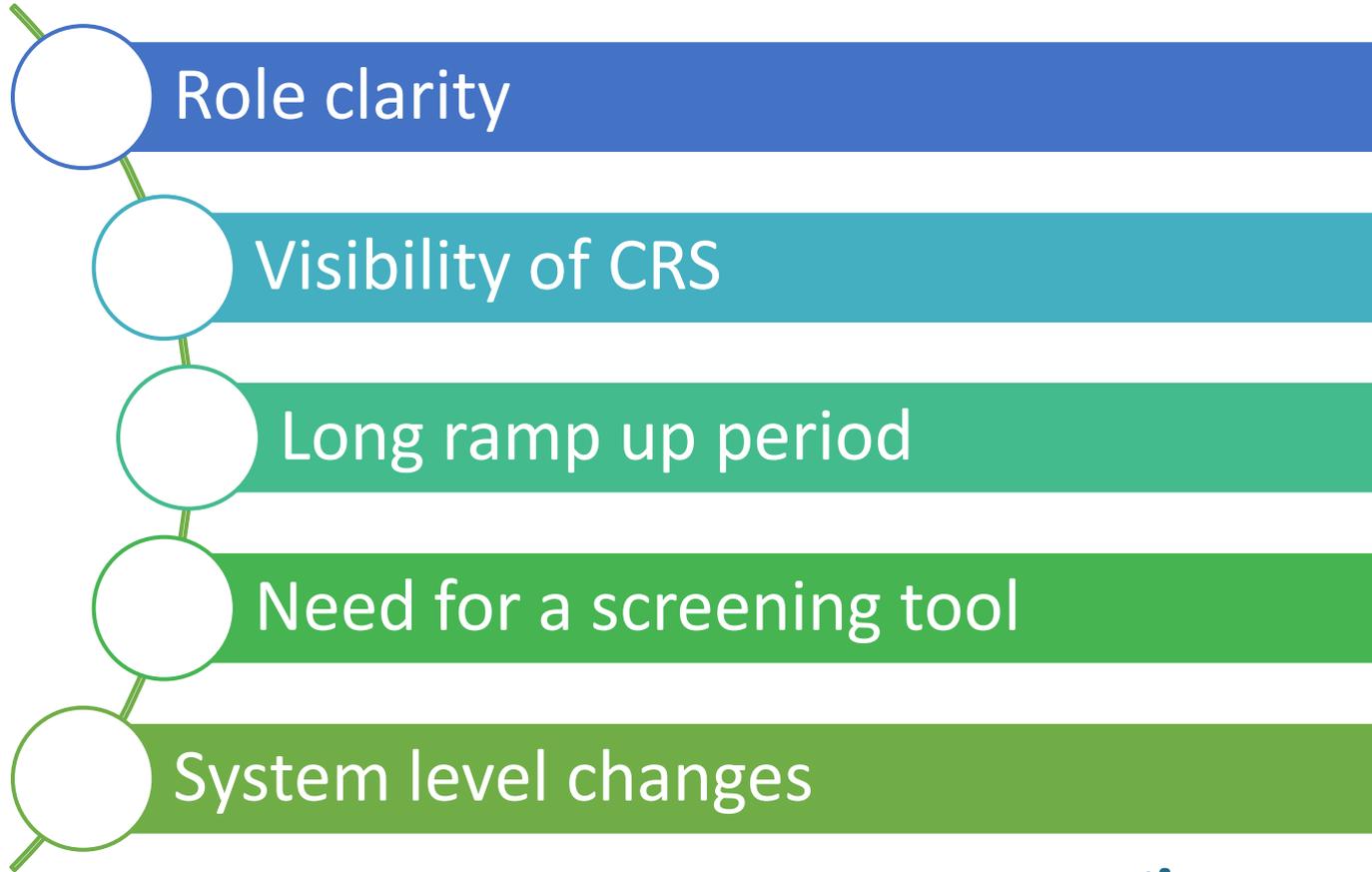
## Qualifications

- 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



# After LINCC: Sustainability/Pre-Pandemic State

## 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



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# Preventing Colon Cancer vs. Early Diagnosis, Which is Best?

Scott M. Strayer, MD, MPH

Harris-Mayo Professor and Chair

Dept of Family Medicine and Population Health

Virginia Commonwealth University SOM



**VCU**

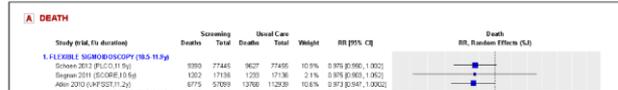
# BLUF

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.<sup>1</sup> 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.<sup>2</sup>

1. *Ann Intern Med. October 2017;167(8):602–603.*
2. *Swartz AW, Eberth JM, Strayer SM. Preventing colorectal cancer or early diagnosis: Which is best? A re-analysis of the U.S. Preventive Services Task Force Evidence Report. Preventive Medicine 118 (2019) 104–112.*

- 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.

Figure 1. Meta-analysis of Death, Colorectal Cancer Incidence, and Death Attributed to Colorectal Cancer



**C DEATH ATTRIBUTED TO COLORECTAL CANCER**

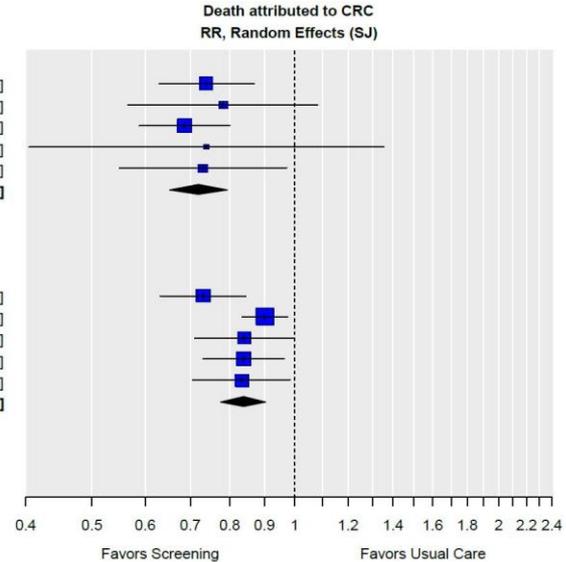
Study (trial, f/u duration)	Screening		Usual Care		Weight	RR [95% CI]
	CRC Deaths	Total	CRC Deaths	Total		
<b>1. FLEXIBLE SIGMOIDOSCOPY (10.5-11.9y)</b>						
Schoen 2012 (PLCO, 11.9y)	252	77445	341	77455	10.9%	0.74 [0.63, 0.87]
Segnan 2011 (SCORE, 10.5y)	65	17136	83	17136	3.8%	0.78 [0.57, 1.08]
Atkin 2010 (UKFSST, 11.2y)	221	57099	637	112939	11.8%	0.69 [0.59, 0.80]
Holme 2014a+b (NORCAPP [50-54], 11.2y)	12	6920	87	37131	1.2%	0.74 [0.40, 1.35]
Holme 2014a+b (NORCAPP [55-64], 11.2y)	59	13652	243	41089	4.8%	0.73 [0.55, 0.97]
<b>Total (95% CI)</b>	<b>609</b>	<b>172252</b>	<b>1391</b>	<b>285750</b>	<b>32.5%</b>	<b>0.72 [0.65, 0.80]</b>

Heterogeneity:  $\tau^2 = 0$ ;  $\text{Chi}^2 = 0.76$ ,  $\text{df} = 4$  ( $P = 0.94$ );  $I^2 = 0\%$   
 Test for overall effect:  $Z = -6.49$  ( $P = 8.6 \times 10^{-11}$ )

<b>2. FOBT (11.0-30.0y)</b>						
Shaukat 2013 (Minnesota, 30.0y)	437	31157	295	15394	12.3%	0.73 [0.63, 0.85]
Scholefield 2012 (Nottingham, 19.5y)	1176	76056	1300	75919	20.9%	0.90 [0.84, 0.98]
Lindholm 2008 (Goteborg, 15.6y)	252	34144	300	34164	10.5%	0.84 [0.71, 0.99]
Kronborg 2004 (Funen, 17.0y)	362	30967	431	30966	13.1%	0.84 [0.73, 0.96]
Faivre 2004 (Burgundy, 11.0y)	254	45642	304	45557	10.6%	0.83 [0.71, 0.98]
<b>Total (95% CI)</b>	<b>2481</b>	<b>217966</b>	<b>2630</b>	<b>202000</b>	<b>67.5%</b>	<b>0.84 [0.78, 0.91]</b>

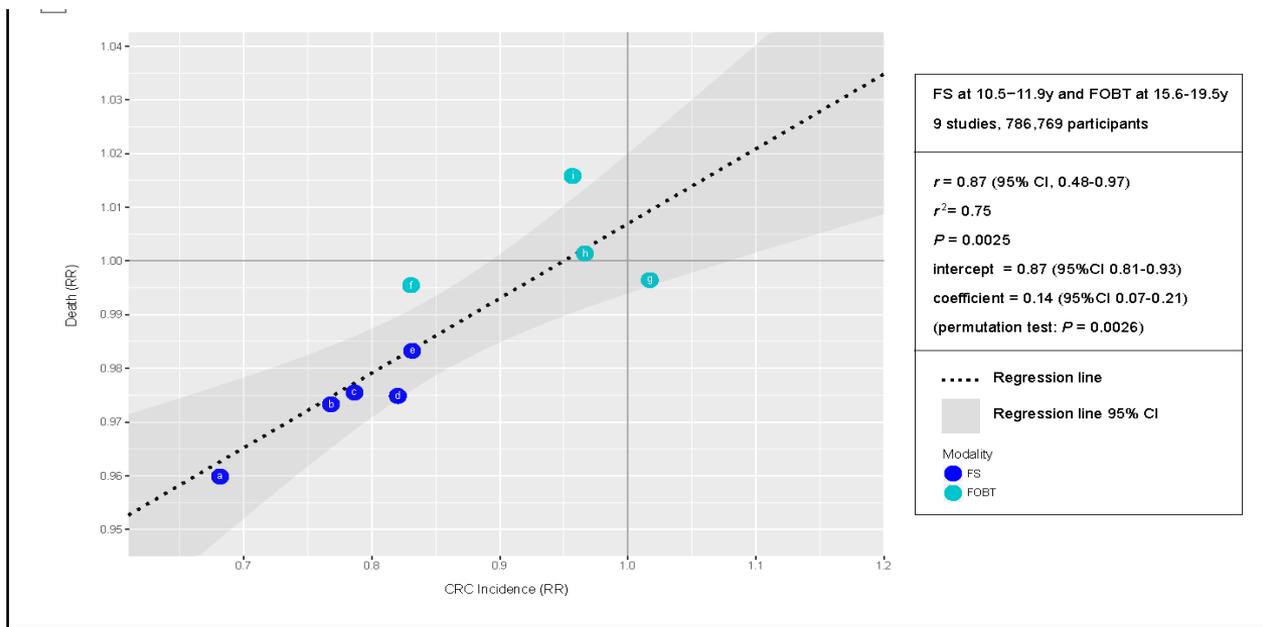
Heterogeneity:  $\tau^2 = 0$ ;  $\text{Chi}^2 = 6.38$ ,  $\text{df} = 4$  ( $P = 0.17$ );  $I^2 = 37\%$   
 Test for overall effect:  $Z = -4.47$  ( $P = 7.8 \times 10^{-6}$ )

Test for subgroup differences:  $\text{Chi}^2 = 5.62$ ,  $\text{df} = 1$  ( $P = 0.018$ )



f/u = follow-up duration, RR = relative risk, SJ = Sidik-Jonkman random-effects estimator, CI = confidence interval, FOBT = fecal occult blood test, y = years. The FOBT analysis for CRC incidence (1 B.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 1999<sup>46</sup>).

**Key to trials/studies:** **a** = NORCAPP [age 50–54](Holme 2014a+b), **b** = UKFSST(Atkin 2010), **c** = PLCO(Schoen 2012), **d** = SCORE(Segnan 2011), **e** = NORCAPP [age 55–64](Holme 2014a+b), **f** = Minnesota(Mandel 1999<sup>46</sup> + 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