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How to Increase Colorectal Cancer Screening Rates in Practice

January 15 & 28, 2009

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Presenters

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Objectives

- Review current CRC screening rates in Ohio.
- Examine universal guidelines for CRC screening.
- Identify opportunities in primary care setting to prevent CRC.
- Describe strategies to improve CRC screening rates in the primary care setting.

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CRC Rates in Ohio

1.8 million Medicare beneficiaries in Ohio

- 15% disabled
- 95% aged 50-80 years
  - Less than half (48.7%) with CRC screening
- Whites: 48.9% screening rate
- Non-whites: 46.4% screening rate

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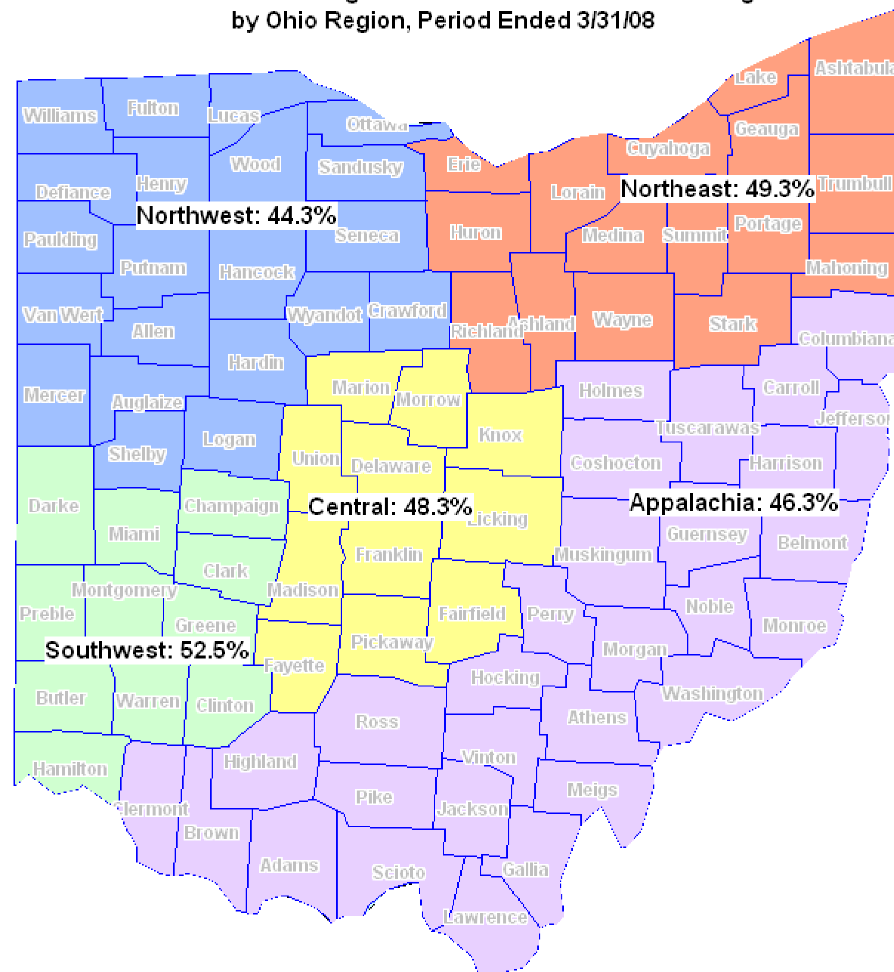
CRC Screening in 5 Ohio Regions



Lowest county rates:

- Fulton: 39.5%
- Morrow: 39.4%

Highest county rates:

- Montgomery: 55.7%
- Warren: 55.9%

CRC Testing Type

Of those beneficiaries undergoing CRC screening:*

- 93% had a colonoscopy (once in prior 10 years)
- 10% had a flexible sigmoidoscopy (once in prior 4 years)
- 13% had a FOBT within the prior year
- 5% had a barium enema (once in prior 4 years)

*Total exceeds 100%, as some beneficiaries will have multiple types of CRC screening.

Source: Centers for Medicare & Medicaid Services (CMS) claims for period ended 3/31/08.

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Facts

Colorectal cancer:

- 3rd most common type of cancer
- 2nd leading cause of cancer deaths
- Preventable
- High rate of late stage diagnosis
- Low screening rates

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Screening Guidelines

Tests that find polyps and cancer:

- Colonoscopy every 10 years
- Flexible sigmoidoscopy every 5 years
- Double contrast barium enema every 5 years
- CT colonography (virtual colonoscopy) every 5 years

Tests that mainly find cancer:

- FOBT every year
- Fecal immunochemical test (FIT) every year
- Stool DNA (sDNA) test, interval uncertain

Source: Levin B, Lieberman DA, McFarland B, et al. Screening and Surveillance for the Early Detection of Colorectal Cancer and Adenomatous Polyps, 2008: A Joint Guideline from the American Cancer Society, the US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology. Published online March 5, 2008. *CA Cancer J Clin*. 2008;58.

Why Focus on Primary Care Practice?

- Sphere of influence: Providers in the PCP setting can dramatically improve screening rates
- 80-90% of people aged 50+ see PCP every year

Source: The Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System

What Can We Do?

- Ensure screening recommendations for all eligible patients
- Adopt a proactive approach to compliance and referral follow-through

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The Four Essentials

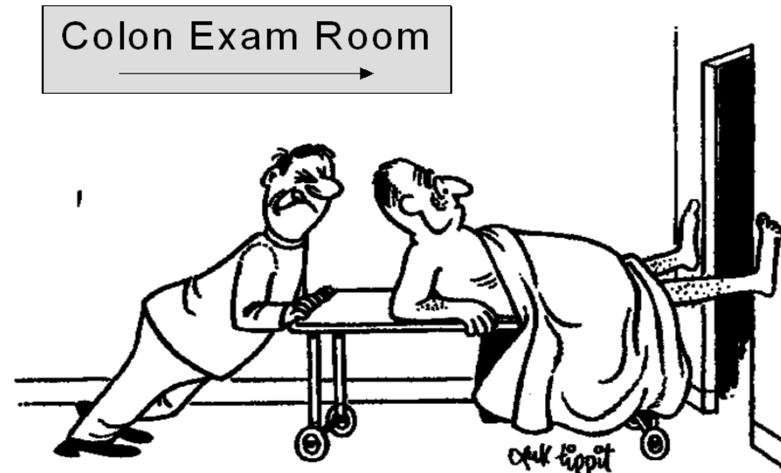
1. **A screening recommendation**
   - For every eligible patient
2. **An office policy**
   - Known to all office staff
3. **A reminder system**
4. **An effective communication system**

Essential #1: Screening Recommendation

A doctor's recommendation is the single most powerful determining factor in a patient's decision whether or not to obtain cancer screening.

Why Focus on Primary Care Practice?

BUT, how useful is a doctor's recommendation?
Aren't we bucking human nature with this one?



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Recommendation Counts!

- Lack of a doctor's recommendation is actually experienced as a barrier to screening
- Most frequently cited reason for not getting tested: "Doctor didn't say I needed it"

Source: Plomer KD and Tenney MJ. Breast and Cervical Cancer Screening: Barriers and Use Among Specific Populations - A Literature Review, Supplement 3. AMC Cancer Research Center, Centers for Disease Control and Prevention publication. January 1995.

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Guidelines and Education

- Physicians and staff must be current on screening guidelines
- Educational materials should be offered to patients (from ACS, generated from EHR, etc.)

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Opportunities

- Recommendation at all types of visits – not just during "check-ups"
- Conversation before physician visit
- Information in patient areas

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Essential #2: An Office Policy

- Vital foundation to ensure that all eligible patients receive a screening referral

"Almost all primary care physicians recommend screening for CRC. Few have systems in place to assure that all eligible patients get the recommendation."

- Richard Wender, MD (2003)

Chair of the Professional Practices Task Force of the National Colorectal Cancer Roundtable and past President of the American Cancer Society

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Fit the Policy to Your Practice

- Policy must reflect local resources, standards and trends
- No single policy will fit all practices
- Consider:
  - Individual risk level
  - Local medical resources
  - Insurance coverage
  - Patient preference
  - Implementation

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Determine Individual Risk Level

- Risk assessment should occur at 1st visit
- Risk may change over time
- Repeat risk assessment regularly
- Risk levels: "average," "increased" or "high" (pp. 21-23*)
- High-risk patients: frequently missed, need extra surveillance and early referrals

* Page numbers in this document refer to the American Cancer Society's Toolkit and Guide (*How to Increase Colorectal Cancer Screenings in Practice*), available at cancer.org/colonmd.

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High-Risk Patients

Q: How many patients are at increased risk?

A: Many more than we usually think.

- 18-20% of general population
- Risk of CRC and polyps increases with age
  - 20-25% of people aged 50 are at increased risk
  - 50% of people aged 75-80 are at increased risk

Source:
Winawer SJ, Shike M. Prevention and control of colorectal cancer. In: Greenwald P, Kramer BS, Weed D, et al. *Cancer Prevention and Control*. New York: Marcell-Dekker;1995:537-60.

U.S. Preventive Services Task Force. Screening for Colorectal Cancer: Recommendations and Rationale. *Ann Int Med.* 16 July 2002;137(2):129-131.

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Risk Awareness

Policy should include:

- Standardized questions to assess family history and personal history (p. 24)
- Documentation of risk level in chart
- Screening recommendations based on risk level
- Method of informing the patient

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Determining Risk

- Personal or family history of colorectal cancer
- Personal or family history of adenomatous polyp
- Personal or family history of CRC or adenomatous polyp under the age of 50
- Personal history of Crohn's disease or ulcerative colitis
- Personal or family history of cancer of the endometrium, small bowel, ureter, or renal pelvis

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Identify Local Medical Resources

- Screening resources vary by region—surplus or shortage
- Policy should consider:
  - Supply of physicians and nurses
  - Number of facilities
  - Distribution of GI practices
  - Insurance coverage
  - Regulatory requirements

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Assess Insurance Coverage

- Insurance coverage is a predictor of screening compliance
- Policy should consider:
  - Coverage for CRC screening is not uniform
  - Coverage may still mean a high deductible or co-pay
  - Patients with no insurance have limited options
- Medicare reimburses for colonoscopy

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Patient Preference

Policy should consider:

- Pros and cons of each screening option
- Outline patient involvement in decision
- Use shared decision-making based on patient's preference and/or constraints, such as:
    - Local medical resources
    - Insurance coverage
    - Privacy concerns

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Implementing the Policy

- Engage staff in policy development
- Create a clear policy
- Define, present and post the policy
- Disseminate the policy throughout the office
- Encourage questions from staff

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Communicating the Policy

- Clarity is key!
- Best practices:
  - Include policy in new hire training
  - Post reminders on bulletin boards
  - Use algorithms (p. 25)
  - Use policy flowchart (p. 30)
  - Use sample scripts (p. 31)

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Essential #3: A Reminder System

Reminders:

- Underutilized
- Lead to more effective office practice
- Few offices use reminders
- Can be directed at provider, patients or both
- Both provider- and patient-directed reminders have demonstrated benefits

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Patient Reminders

Education interventions

1. Theory-based (specific information)
   - Superior option, esp. when delivered in person
2. Generic (general information)

Cues to action

- Phone calls, in-person communication

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Physician Reminders

- Chart prompts
  - Problem lists
  - Screening schedules
  - Integrated summaries
- Alerts (placed in chart)
- Follow-up reminders
  - Tickler system
  - Logs and tracking
- Electronic reminder systems (EHR)

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Strategies for Physicians

Effective strategies:

- Behavioral
  - Reminders and prompts
- Cognitive
  - Audits and feedback
- Sociologic
  - Using office staff in different roles

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Alerts and Reminders

Alerts and reminders: cues to action

- Problem lists
  - Include preventive services and risk assessment
- Screening schedules
  - Office staff can review to see if there has been follow-through for ordered testing
- Integrated summaries
  - EHR can offer an integrated summary with cancer screening and prevention information
- Electronic reminders
  - EHR offers automatic alerts and reminders

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Tickler Files and Logs

- Tickler files and logs: traditional cue action methods
- Effective options:
  - Postcard reminders (filled out by patient)
  - FOBT kit log—as a means to monitor compliance

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Staff Assignments

- EHR • a change in staff roles
- Methods to improve effectiveness and boost screening rates:
  - Staff initiation of screening process
  - Staff encouragement of patient
  - Use existing staff in different roles
  - Changes in workflow
- Models for change (pp. 46-47): Model A and Model B

Model A

Part I

- Ask yourself:
  - What are we trying to accomplish?
  - How will we know if the change is an improvement?
  - What changes can we make that will result in improvement?

Part II

- Follow the PDSA cycle (Plan-Do-Study-Act):
  - Plan a change
  - Try it
  - Observe the results
  - Act on what is learned

Source: The Institute for Healthcare Improvement

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Model B

1. **Plan**
   - Evaluate system
   - Include staff
   - Develop shared goals
   - Determine new procedures
   - Assign roles
2. **Implement**
   - Implement new roles
   - Meet regularly
3. **Follow-up**
   - Track changes

Source: Lumetra

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Essential #4: An Effective Communication System

Benefits of effective communication:

- Facilitate and promote delivery of healthcare messages
- Maximize effectiveness of clinical encounters
- Increase impact of physician and staff
- Strengthen relationships with patients

Improve communication through:

- Theory-based approach
- Decision aids
- Staff involvement

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Types of Communication

- Theory-based communication has defined benefits
- Stage-based communication
  - Defines stages of thinking to guide the message
  - Efficient tools facilitate flow of the right information

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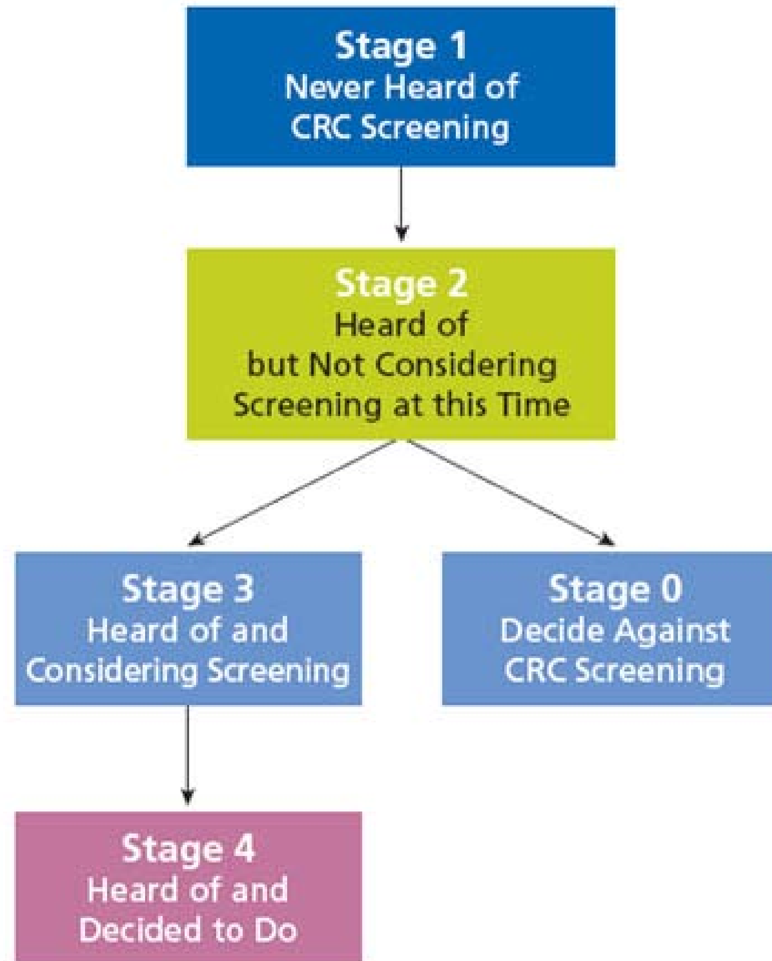
Decision Stage Model



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Decision Aids

Decision aids:

- Help patients make informed decisions
- Brochures, pamphlets, Internet resources:
    - www.healthfinder.gov
    - www.cancer.org
    - www.mayoclinic.com
    - www.webmd.com

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Staff Involvement

Staff involvement:

- Can contribute directly increased CRC screening rates
- Techniques:
  - Distribute patient questionnaires/surveys
  - Share information related to decision stage/risk level
  - Encourage patients to get screened
- Tracking:
  - Use chart audits (p. 107) and patient tracking (pp. 108-109) to track progress

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The Four Essentials: A Review

1. A recommendation to every eligible patient
2. An office policy
3. A reminder system
4. An effective communication system

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Conclusion

- Screening reduces incidence and mortality.
- Physician recommendation has the largest influence on screening rates.
- **You** can increase office effectiveness and screening rates by utilizing the four essentials.

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Thank you!

Electronic version of the Toolbox and Guide available at: **cancer.org/colonmd**

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