Improving Colorectal Cancer Screening Rates in a Primary Care Center Clinic
Team #1

CS&E Participants
- Dr. Carlos Jaén, MD, PhD
  - Department Sponsor and Chair, Family & Community Medicine; Interim Director, Primary Care Center
- Tamara Heflin, RN
- Antonio Serna, BS
- Daniel Prather, Capt, USAF
- Christina Lumba, RN, LCDR, USN
- Sherry Martin (Facilitator)

Ad Hoc Team Members
- M. Akram, MD
- Jose De La Cerda, PA-C
- Linda McFarlin, RN, MAM
- Crystal Cruz, MA
- Lorrie Groesbeck, LVN
- Lea Rongey, LVN
- Shannon Nunnelly, RN
- Nazneen Ali, Analyst
Image retrieved from https://news.uthscsa.edu/take-a-stroll-through-a-giant-colon/
BACKGROUND

Colorectal cancer, the second leading cancer killer in the US, causes over 51,000 deaths annually (www.cdc.gov).

A study by Meester, et al (2015), estimates that raising the level of colorectal screening in the general population from 58% to 80% by 2018 would produce:

- A short-term 20% increase on colorectal cancer incidence rates
- A long-term 22% decrease in colorectal cancer incidence rates by 2030
- A long-term 33% decrease in colorectal cancer mortality rate by 2030

These impacts translate into the prevention of 21,000 colorectal cancer deaths per year.

PROBLEM STATEMENT

The current colorectal cancer screening rate for the Medical Arts and Research Center (MARC), Primary Care Clinic, is 50%. Improving this measure to 72% by June 2016 would put the PCC on path to achieve 80% by 2018; ultimately leading to a 33% decrease in colorectal cancer mortality in the Primary Care Clinic patient population.
The aim of this project is to increase the rate of colorectal cancer screenings among MARC Primary Care Clinic (PCC) patients from 50% to 72% during fiscal year 2016 (September to August).

The process starts when an eligible patient presents to the MARC PCC and ends when the report/result is scanned into the patient’s record.

This is necessary to improve the overall health of our population and to the successful delivery of value-based care within UT Medicine.
Referral Process Flowchart

Primary Care Clinician/Clinic Staff

1. Order falls into MARC PCC Benefit Coordinator (BC) pending Queue
   - BC reviews INTERNAL eligibility based on insurance
     - Yes → Patient eligible for internal referral
     - No → Patient eligible for external referral

   2. BC refers patient to appropriate specialist
   - BC notifies patient of approved facility

   3. Patient keeps appointment and completes nurse visit

   4. Patient proceeds to follow-up in primary care

Benefit Coordinator

Specialty Clinic (GI/Surgery)

1. Specialist verifies patient's benefits
   - Specialist contacts patient to schedule nurse visit
     - Yes → Does patient schedule nurse visit appointment?
     - No → Specialist contacts patient to discuss options

   2. Does patient decide to have procedure?
     - Yes → Colonoscopy procedure with specialist is scheduled
     - No → Specialist cancels procedure appointment and colonoscopy is completed

   3. Patient keeps procedure appointment and colonoscopy is completed
     - Does specialist forward colonoscopy results back to PCC?
       - Yes → PCC reviews results and updates health maintenance
       - No → Patient shows up for care gap report

   4. Patient shows up for care gap report

   5. PCC care team continues tracking referral order

Specialty Clinic for Procedure, then Follow Up in Primary Care
Our Team In Action
Mapping out the Driving Elements
AIM Statement:
The aim of this project is to increase the rate of colorectal cancer screenings among MARC Primary Clinic patients from 50% to 72% during fiscal year 2016.

GOAL

PRIMARY DRIVERS

Remove Patient Barriers

Identify Insurance and Payment Issues

Reduce Primary Care Physician (PCP) Barriers

Increase Procedure Capacity

INTERVENTIONS

Research and coordinate potential transportation services for patients on procedure day

Increase patient outreach through phone calls, letters, and patient portal (MyChart)

Research potential payment plans (facility dependent)

Research options for using Fecal Occult Blood Test (FOBT) cards, which patient takes home and returns for testing

Develop educational materials (pamphlets, digital media, screensavers, etc.) for patients.

Reduce reliance on clinician by transferring administrative tasks to support staff

Provide Epic training for providers and LVNs on how to enter an order for colonoscopy (screening)

Improve capacity with new provider starting in June 2016. One provider is increasing clinical time. (GI Clinic)

Send patients to alternate sites for colonoscopy (General Surgery, Robert B. Green, Hospital for critical patients, or Dr. Kumar (excluding Community First))
Current Interventions

- **Intervention 1**: Increase patient outreach through phone calls, letters, and patient portal (MyChart)

- **Intervention 2**: Send patients to alternate sites for colonoscopy (General Surgery, Robert B. Green, Hospital for critical patients, or Dr. Kumar (excluding Community First))

- **Intervention 3**: Develop educational materials (pamphlets, digital media, screensavers, etc.) for patients.
Colorectal Cancer Screening

Are You at High Risk?
Your risk for colorectal cancer may be higher than average if:

- You or a close relative have had colorectal polyps or colorectal cancer.
- You have inflammatory bowel disease.
- You have a genetic syndrome such as familial adenomatous polyposis (FAP) or hereditary nonpolyposis colorectal cancer.

People at high risk for colorectal cancer may need earlier or more frequent tests than other people. Talk to your doctor about when to begin screening and how often you should be tested.

Screening Saves Lives
If you’re 50 or older, getting a colorectal cancer screening test could save your life. Here’s how:

- Colorectal cancer usually starts from polyps in the colon or rectum. A polyp is a growth that shouldn’t be there.
- Over time, some polyps can turn into cancer.
- Screening tests can find polyps, so they can be removed before they turn into cancer.
- Screening tests also can find colorectal cancer early. When it is found early, the chance of being cured is good.

Colorectal Cancer Can Start With No Symptoms
Precancerous polyps and early-stage colorectal cancer don’t always cause symptoms, especially at first. This means that someone could have polyps or colorectal cancer and not know it. That is why having a screening test is so important.

Screening Tests at-a-Glance

The U.S. Preventive Services Task Force (USPSTF) recommends colorectal cancer screening for men and women aged 50–75 using high-sensitivity fecal occult blood testing (FOBT), sigmoidoscopy, or colonoscopy. The decision to be screened after age 75 should be made on an individual basis. If you are older than 75, ask your doctor if you should be screened.

The benefits and potential harms of the recommended screening methods vary. Discuss with your doctor which test is best for you. Getting screened could save your life.

<table>
<thead>
<tr>
<th>Name</th>
<th>Preparation</th>
<th>What happens?</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>High-Sensitivity Fecal Occult Blood Test (FOBT) or Sigmoid Test: Fecal Immunochemical Test (FIT)</td>
<td>Your doctor may recommend that you follow a special diet before taking the FOBT.</td>
<td>You receive a test kit from your health care provider. At home, you use a stick or brush to obtain a small amount of stool. You may be asked to do this for several bowel movements in a row. You return the test to the doctor or a lab, where stool samples are checked for blood.</td>
<td>This test should be done every year. (If anything unusual is found, your doctor will recommend a follow-up colonoscopy.)</td>
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<td>Flexible Sigmoidoscopy (Flex Sig.)</td>
<td>Note: this is sometimes done in combination with High-Sensitivity FOBT.</td>
<td>Your doctor will tell you what foods you can and cannot eat before the test. The evening before the test, you use a strong laxative and/or enema to clean out the colon.</td>
<td>During the test, the doctor puts a short, thin, flexible, lighted tube into the rectum. This tube allows the doctor to check for polyps or cancer inside the rectum and lower third of the colon.</td>
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<tr>
<td>Colonoscopy</td>
<td>Note: Colonoscopy is also used as a followup test if anything unusual is found during one of the other screening tests.</td>
<td>Before this test, your doctor will tell you what foods you can and cannot eat. If you use a strong laxative to clean out the colon, some doctors recommend that you also use an enema. Make sure you arrange for a ride home, as you will not be allowed to drive.</td>
<td>You will receive medication during this test, to make you more comfortable. This test is similar to flex sig, except the doctor uses a longer, thin, flexible, lighted tube to check for polyps or cancer inside the rectum and the entire colon. During the test, the doctor can find and remove most polyps and some cancers.</td>
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For more information, please call 1-888-CDC-INFO (1-888-232-4636) or visit www.cdc.gov/screenforlife
Next Steps

- **Intervention 4**: Reduce reliance on clinician by transferring administrative tasks to support staff.

- **Intervention 5**: Research options for using Fecal Occult Blood Test (FOBT) cards, which patient takes home and returns for testing.
Statistical Process Control Chart
Statistical Process Control Chart
Value Added

- Cost of prevention vs. Cost of treatment
- Patient activation
  - Patients request procedure
- Enhancing the patient/clinician relationship
  - Reduce clinician time to explain procedure
- Identified unused capacity to deliver colonoscopies
  - Added general/colorectal surgery services
Conclusion

- Our interventions to date have been evidence-based and by early measurement are working.
- As a team we believe we should look to implement these interventions across the other Primary Care Center clinics.
- Additionally, some of these interventions should be reviewed for other screening applications including mammography and pneumococcal vaccine.
THE ROAD TO HEALTH IS PAVED THROUGH GOOD INTESTINES