

Practice Workshop: Streamlining the Patient Screening and Follow-up Process

As part of Colorectal Cancer Awareness Month, the American Society of Colon and Rectal Surgeons (ASCRS) is working to help its members improve the accuracy and efficiency of their colorectal cancer screening and follow-up efforts. The following is an overview of a "Best Practices" model developed by colorectal surgeon Michael Spencer, MD, and colleagues at Colon and Rectal Surgery Associates, in St. Paul, Minnesota. You may wish to consider adapting and implementing it in your own practice.

Overview

Colorectal cancer remains largely preventable. Screening rates for America's number two cancer killer, however, remain poor. Surveys report screening rates at 20 to 40 percent throughout the country. Unfortunately, these figures are dramatically less than the accepted screening standards for colorectal cancer and far less than those for breast and prostate cancer. Perhaps one of the principal reasons for this variance is public awareness and expectations that lag behind those for other more publicized diseases. Additionally, many physicians and health systems have failed to adopt published guidelines. Surveillance, while more usually accepted as a quality care indicator, remains quite variable in most healthcare systems.

To ensure compliance with published guidelines and to improve screening and surveillance within our practice, my partners and I instituted a series of activities to better screen our patients. Our practice consists of 17 physicians, all of whom are subspecialists in the field of colon and rectal surgery. The practice serves a diverse population as we see patients from the entire Twin Cities metropolitan area. The need to institute a simple yet effective screening initiative was seen as vital to our patients as well as to the viability of our practice. In 1998, shortly after the national recommendations from the American College of Surgeons and the American College of Gastroenterology were published, the practice instituted a series of steps to help improve our screening compliance. Largely, this involved creating new templates for our computerized record system that would promote a unified approach by the physicians in their discussions for screening with their patients and ensure proper follow-up of patients being screened for colorectal cancer.

Partners Assisting with Implementation

The partners involved were all internal to our practice including all the physicians, our business office staff, and those involved with the oversight committee. Additionally, we work with the Minnesota Colorectal Cancer Initiative, an organization that tracks familial colorectal cancer in a registry, as a referral site

for those patients with a high risk or a family history of colorectal cancer or for those patients we recommend a genetic counselor.

As the activity was carried out primarily within our private practice, we did not require buy-in from other groups or health systems. Records of prior screening and family history, however, did require information transfer from additional health systems. As our practice works within the university training center and veteran's hospital, some adaptation or integration of our data with these institutions was required. The principal players, however, were the group of physicians within our practice who had to commit the time and finances to implement of the program.

Steps in Implementation:

Preparation:

- Obtain consensus from partners around the screening project. All needed to agree that this was a viable activity they could support and would subsequently change their practice patterns if they were found to be at variance with the accepted published guidelines.
- Review and accept the consortium guidelines published in *Gastroenterology*, 1997, 112:594-642.
- Appoint an administrative team to provide oversight for the implementation. This group provides ongoing surveillance and ensures appropriate screening practices are being utilized; team members will meet with individual physicians when variances are discovered.

Clinical Implementation:

- New data templates are created for all patients seen by the group's physicians. Physicians have to fill in the appropriate responses or the chart is returned as incomplete. Specific templates are designed for new patients, routine follow-up cases, and post-procedure patients. Each group is queried as to their chief complaint, past medical history (including personal and family history of colorectal cancer, breast cancer, gynecologic cancer or other cancers, other diseases which may increase their risk of colorectal cancer) and any clinical symptoms.
- Patients are then risk stratified as low, moderate, or high according to guidelines and based on the findings from physician queries.
- Appropriate screening and/or surveillance is then undertaken. High-risk patients as well as those with presumed genetic predisposition according to their family history are referred to a colorectal cancer registry.

- Charts are randomly reviewed by the oversight committee for completion, appropriate risk stratification, and proper intervention. All physicians are given group and individual statistics on the appropriateness of recommended intervention.

A computer registry provides a systematic recall of patients at each of the risk categories. This system keeps track of the time of last intervention and the date of the next needed screening or follow-up exam. This automated recall is provided for those patients at low risk and consists of a recommendation for a flexible sigmoidoscopy at 5-year intervals as well as reminders for annual stool hemacults. All patients at high risk and those scheduled for surveillance endoscopy have their reminders reviewed by their physician prior to the scheduling of an appointment to ensure the appropriateness of the intervention planned for the visit.

These measures have facilitated effective screening and surveillance for the majority of patients, and periodic monitoring has assured a high level of compliance amongst the physician group. This project has greatly enhanced the practice's risk assessment and colonoscopy rates for patients at increased risk. Documenting risk status also has minimized insurance rejections for those patients in need of colonoscopy.

Factors that facilitated implementation:

- Increased patient recognition of the importance of screening
- Quality mandate of health organizations
- Computerized record system already in existence
- Increasing medical legal risk of not documenting accurate screening
- Close working relationship with genetic counselor and colorectal cancer registry

Factors that hindered implementation:

- Costs, specifically time to design the data templates; physician time in monitoring the patients for appropriate care; and the cost of information systems where none exist.
- Low reimbursement for this type of activity.
- Public perception of screening still poor, including fear of testing.

Evaluation or Monitoring Methodology:

- Create oversight team to ensure appropriate screening practices are being utilized. Physicians are given group and individual statistics on the appropriateness of their intervention recommendations. Prior to implementing the system, we found that the appropriate screening recommendation was given approximately 80 percent of the time, and now it's given 95 percent of the time. We are now in the process of evaluating the system after six months.
- Meet with individual physicians when variances are discovered and discuss agreed-upon practice parameters for screening. We found the group to be almost evenly divided between recommending a program for their patients that was too aggressive and not aggressive enough. Often after discussion, most physicians understood how to improve their accuracy on recommendations by referring to the agreed-upon standards.
- Charts are randomly reviewed by the oversight committee for completion, appropriate risk stratification, and proper intervention. Charts are returned to physicians if all screening information is not completed in full. Before implementing this project we had strong concerns that charts were not being completed properly. In order to affect dramatic improvement, a policy was instituted that mandates a chart is fully completed before the patient is billed for services rendered. We continue to monitor the appropriateness and completeness of the physician's recommendations. The group awaits any changes or new recommendations on intervention by the American Cancer Society and others before reviewing our strategies.