

Improving Patient Engagement Boosts Colorectal Cancer Screening Rates

BY MOHINI SINHA, MD

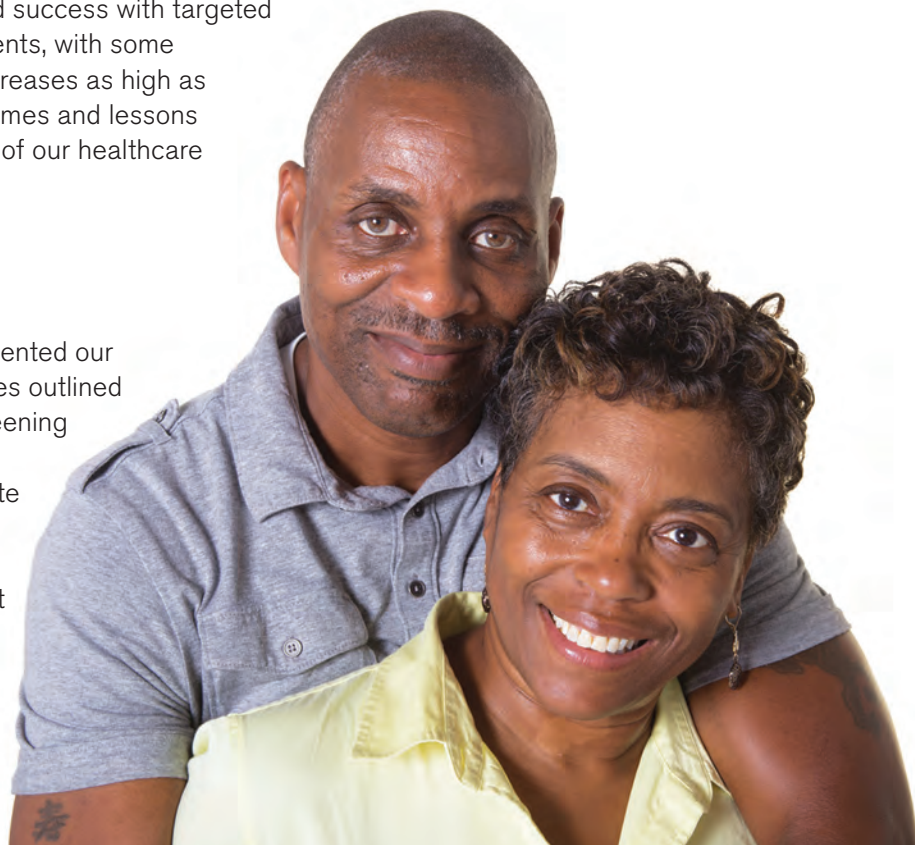
Today's emphasis on quality is driving a renewed focus on prevention and early detection of disease—including colorectal cancer (CRC), which is the second-leading cause of cancer-related death in the United States, with annual treatment costs totaling more than \$14 billion.^{1,2} Screening procedures play a critical role in helping to prevent CRC and to detect precancerous polyps so they can be removed. According to the American Cancer Society, 90 percent of CRC deaths can be prevented with early screening.³

Rates of recommended screenings in people aged 50 to 75 have been increasing but still lag behind goals set by the National Colorectal Cancer Roundtable (NCCRT).⁴ In order to raise these rates, healthcare efforts must include a strategy to motivate difficult-to-engage patients to complete their screening. Monarch HealthCare, an independent physician association and part of OptumCare®, piloted an innovative colorectal screening program in 2016 in which we sought to eliminate barriers to screening in this population.

Other healthcare organizations have found success with targeted efforts to activate difficult-to-engage patients, with some approaches resulting in screening-rate increases as high as 15 percent.⁵ In this article, we share outcomes and lessons learned from our pilot, conducted at three of our healthcare practices in Orange County, California.

GUIDED BY BEST PRACTICES

In partnership with Genentech, we implemented our initiative using resources and best practices outlined in Genentech's Love Your Colon CRC screening program (www.loveyourcolon.org). This program contains tools designed to activate patients, along with an associated guide for health systems to consider when developing their own processes for patient outreach and screening.⁶ Genentech was responsible for the creation of the Love Your Colon tools, while Monarch practices were fully accountable for implementation of the program.



We knew that a successful screening program deploys the right interventions at the right time. At each of the three pilot offices, we made observations about primary care authorization processes, timing of referrals, and workflow efficiency. These reviews enabled us to optimize a cancer screening process flow and develop standard operating procedures for documenting screening information in the electronic health record.

Monarch HealthCare's central office identified screening candidates, with patient eligibility determined according to American Cancer Society colorectal cancer screening criteria.⁷ Identified candidates received a letter from Monarch's quality medical director, informing them they were due for screening. The letter contained key messages—based on work by the NCCRT, a coalition of colorectal cancer screening experts⁴—designed to help patients understand the need for screening, anticipate objections, and motivate them to get screened. In addition to the letter, candidates also received a graphically driven educational brochure that employed the same core messages.

With consent from their primary care providers (PCPs), candidates were preauthorized for a colonoscopy and directed in the letter to schedule a consultation with a gastroenterologist (GI). Our hope was that this “fast-track” approach, bypassing the PCP, would remove a time-related barrier to adherence.

After the mailing, all screening candidates who had not scheduled an appointment within two weeks received a phone call from Monarch's central program coordinator, who used a patient-navigation call script to answer questions and address objections to CRC screening. The goal was to ensure that the patient either scheduled a screening consultation or consented to complete a fecal occult blood test (FOBT) kit. Candidates who did neither within three months of program initiation automatically received an FOBT kit in the mail.

The central program coordinator also informed provider staff members of patients' CRC screening preventive care gap. Providers were given the educational brochure and the patient-navigation call script to use in conversations with screening

candidates who came into the office for an unrelated illness or to discuss colorectal screening with their PCP.

POSITIVE OUTCOMES

By the end of the program, the combined screening rate at the three pilot sites rose from 51 percent at baseline to 68 percent. At the onset, 219 patients had been identified as eligible for screening but nonadherent; by the end, 32 percent of them completed either an FOBT or a colonoscopy (Table 1). Among patients completing colonoscopies, polyps were removed in 17 and none were found to be malignant.

Table 1. Outcomes at end of pilot

Number of identified screening candidates (SCs)	219 (100 percent)
Number of SCs who followed up with a PCP or GI	119 (54 percent)
Number of SCs who completed screening	69 (32 percent)
Completed screenings: type of screening tests	Colonoscopy = 28 (41 percent) Flex sigmoidoscopy = 0 (0 percent) FOBT = 41 (59 percent)
Number of SCs who had polyps removed	17
Number of SCs with positive FOBT tests	0
Number of SCs diagnosed with colorectal cancer	0

Although it is difficult to attribute the increase in average screening rate to any single intervention, information gathered through formal surveys after the pilot completion gives us some clues. First, pilot site providers and staff reported that the outreach tools were highly effective at increasing patient

awareness and activating them to get screened. Providers also reported having more frequent screening conversations with patients during the pilot.

Second, patients reported that the outreach tools were more effective at motivating them to receive screening than information they had received in the past. Finally, given the limited use of FOBTs in pilot sites (from January through June 2016, only 0 percent to 2 percent of patients completed FOBTs), it stands to reason that the availability and promotion of the FOBT during the pilot may have been one of the key drivers in increasing screening rates.

LESSONS LEARNED

We also attribute the higher screening rate in part to best practices that were built into the program. Those practices, and the valuable operational lessons that emerged, include:

Best practice 1: Establish measurable goals. At the three pilot sites, we sought to bring screening rates closer to the NCCRT goal of 80 percent of eligible patients screened by 2018.⁴ This was a patient-centered, aspirational goal, rather than one based on meeting requirements of a quality measure.

Best practice 2: Provide screening candidates with all available testing options. At-home testing kits for patients who did not want to complete a colonoscopy removed a significant barrier for difficult-to-engage patients, leading to higher screening rates.

Best practice 3: Analyze workflows and establish formal processes. Prior to this pilot, we did not have oversight over the patient screening journey (i.e., identifying eligible patients and following them through to completion of screening). This exercise enabled us to codify a workflow, integrate it into each office's processes, and close a fundamental gap in quality of care.

Best practice 4: Use a centralized patient navigator. By moving the burden of patient outreach and follow-up to the central office, provider staff

could devote more time to patient care, allowing us to use our patient navigator to fullest capacity.

Through a concerted effort to motivate difficult-to-engage patients, colorectal cancer screening rates meaningfully improved by the end of the pilot. We believe that the Love Your Colon program tools and suggestions for workflow optimization effectively contributed to this outcome. Genentech plans to expand the program tools from the pilot into additional Love Your Colon program resources. The activities we undertook are applicable across health systems. Our next step will be to test this program at other sites, removing a few of the manual outreach steps that would cause significant hurdles to scalability. ○

Mohini Sinha, MD, is Quality Medical Director at Monarch HealthCare in Irvine, California.

References

1. American Cancer Society: *Cancer Facts & Figures 2017*. . <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2017/cancer-facts-and-figures-2017.pdf>. Accessed April 13, 2017.
2. Mariotto AB, Yabroff R, Shao Y, Feuer EJ, Brown ML. Projections of the cost of cancer care in the United States: 2010-2020. *J Natl Cancer Inst*. 2011;103(2):117-128.
3. American Cancer Society: *Can colorectal polyps and cancer be found early?* <https://www.cancer.org/content/cancer/en/cancer/colon-rectal-cancer/detection-diagnosis-staging/detection.html>. Revised March 2, 2017. Accessed March 31, 2017.
4. National Colorectal Cancer Roundtable: *Tools & resources: 80% by 2018 communications guidebook: recommended messaging to reach the unscreened*. <http://nccrt.org/tools/80-percent-by-2018/80-by-2018-communications-guidebook>. Accessed April 4, 2017.
5. Arif K, Hufford D, Debose R. *Colon cancer screening: home testing increases patient activation*. *CAPG Health*. 2016;10(2):30-31.
6. Love Your Colon. <http://www.loveyourcolon.org>. Accessed April 4, 2017.
7. American Cancer Society: *Recommendations for colorectal cancer early detection*. <https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html>. Revised March 1, 2017. Accessed April 4, 2017.