INTRODUCTION/HISTORY OF PROJECT

Colon cancer is easily treated and often cured when caught in the early stages. Yet, it remains the number two cancer killer in the United States. A collaborative was created in July 2011 with representatives from the Institute for Clinical Systems Improvement (ICSI), the American Cancer Society (ACS) and the Minnesota Department of Health (MDH). The purpose of the collaborative was to increase usage of the ICSI Colorectal Cancer Screening guideline in primary care settings, using quality improvement tools to raise screening rates from 66 percent to 80 percent. The ICSI guideline aims to increase the rates of patients who are up-to-date with screenings and who have had a shared decision-making conversation about screening. The collaborative also aimed to use learnings from the 2010 Colon Cancer Roundtable.

Over 14 months, ending in August 2012, teams from primary care medical groups and integrated care delivery systems met via webinars, conference calls and periodic telephonic one-on-one sessions, sharing progress reports at several intervals. Each team received three readiness assessments to identify gaps in implementation of the guideline: one before implementation, one at six months post-implementation and one at the end of the collaborative.

Teams participating in the collaborative were required to have a clinician champion to lead changes on-site, a team leader to serve as the contact for progress reports and logistics, and a data management or quality professional.

PROJECT GOALS AND OBJECTIVES

In addition to the general goals of increasing patient awareness and provider promotion of colorectal screening recommendations, the collaborative had four project objectives:

1. To help clinics increase their screening rates and perform better against Minnesota Community Measurement assessments.
2. To meet the Triple Aim goals of improving population health, improving the patient experience and reducing per capita costs.
3. To support Cancer Plan Minnesota 2011-2016 to reduce the cancer burden by focusing on the continuum of care.
4. To implement the ICSI Colorectal Cancer Screening guidelines in primary care.
Topics addressed during the collaborative included:

• How to establish aims and measures
• An overview of ICSI’s revised Colorectal Cancer Screening guideline
• An update on Minnesota Community Measurement screening outcome measures
• A review of medical groups’ best practices
• Setting up and using a patient registry
• Using shared decision-making to increase appropriate screenings
• Linkages to other projects, such as health care homes and accountable care organizations
• Sustaining success and spreading best practices within and between clinics

The learning collaborative was virtual to enable providers from across Minnesota to participate. Sessions were delivered via WebEx or conference call. Content was structured to deliver the evidence and measurement behind Colorectal Cancer Screening first, followed by quality improvement tools to make the necessary process changes. The midpoint of the collaborative had content related to specific components necessary to improve Colorectal Cancer Screening, such as shared decision making and registries. The collaborative also tied Colorectal Cancer Screening into larger initiatives at the state and national levels.

To hold groups accountable, ICSI collected monthly progress reports and three readiness assessments during the collaborative. ICSI built in two 1:1 consulting calls with groups, which enabled participants to ask questions and receive ongoing support.

ICSI conducted a readiness assessment survey three times during the learning collaborative: prior to the start, in the middle and at the end. The assessment, done via Survey Monkey and sent to each team lead, was structured with key points necessary to improve the process for Colorectal Cancer Screening.

Nine of the 12 participating clinics completed the first readiness assessment. All groups reported prior change experience and the capacity to undertake the change. Opportunities existed in all categories for groups to move to a standard process across their organization. Four of the 12 participating clinics completed the second and third readiness assessment.
Three groups completed all three readiness assessments and reported many functions becoming standardized. Two of groups reported a change from “partial” to “standardized” for screening criteria incorporated into systems and known by staff. Two groups moved from “none” to “standardized” and one from “none” to “partial” for a registry to track patients who have been tested or when they are due. One clinic reported a change from “partial” to “standardized” and one from “none” to “partial” for having increased risk criteria available. One organization reported moving from “none” to “standardized” for receiving feedback from a specialty clinic if the patient were referred out. All three clinics moved to “standardized” for communication and marketing materials on Colorectal Cancer Screening.

### ACTIVITIES AND ACCOMPLISHMENTS OF PARTICIPATING CLINICS

#### Mankato Clinic
There are 6 family practice and internal medicine sites and an endoscopy center. The hospital is owned by Mayo.

In an effort to standardize the messages about colorectal screenings, the Mankato Clinic is in the process of creating a single brochure to replace multiple versions. It uses a third party vendor to call patients overdue for screenings and reports a call back rate as high as 47 percent. In addition, the clinic is developing an electronic preventative services preventive service registry that will utilize the EHR to its maximum capability and offers the fecal immunochemical test (FIT). Colorectal cancer screening rates are currently at 77 percent.

#### Mayo Clinic Health System – Faribault
This system consists of 20 physicians, 2 clinic sites and one hospital.

Focusing on accurate data collection, patient follow-up and increased awareness of the guidelines, Mayo Clinic Health System – Faribault distributes patient materials and posters, trains its nurses and implements reminder systems for patient follow-up. The clinic also now offers a fecal occult blood test (FOBT), changed its colonoscopy screening prep to a Gatorade-based product and plans to begin FIT in the future.

#### Mayo Clinic Health System – Owatonna
There is 1 clinic that provides primary care and specialty care services.

In addition to raising public awareness of the need for screening, Mayo Clinic Health System in Owatonna is focused on enhancing patient ownership of his or her care. 50th Birthday greeting cards are sent to applicable patients as a reminder for screening, patient education sessions are held throughout the community, and pre-visit planning has been implemented. The clinic also offers FIT, with care coordinators following up on all outstanding FIT and FOBT patients.
Mayo Clinic Franciscan HealthCare – LaCrosse
In the LaCrosse system, there are 13 primary care sites and 2 hospitals.
This health care organization is updating its data and implementing a new EMR tool. At the same time, it is working through process measures and quality procedures, especially related to how patients make appointments and how referrals are made. In addition, birthday cards are sent to patients 50 and older, and monthly reminder letters go to all overdue for screening. Currently, it has a screening rate of 66 percent.

Sanford Health Bemidji
There are more than 35 physicians and a hospital in this health care system.
Sanford Health Bemidji has conducted numerous promotions to increase patient and provider awareness, including posting ACS “Tests to Find Cancer Early” fliers in exam rooms, elevators and waiting rooms; handing out pamphlets to patients 50 and older receiving flu shots; giving physicians the ICSI screening guidelines and laminated algorithms; holding a conference on colorectal screening and colon cancer; and speaking at a Women’s Expo on the topic of “Colon Cancer: Silent, Common and Preventable.” In addition, the medical staff chose a day to wear blue uniforms and buttons that said, “Ask me why I’m wearing blue” to share screening education. Health coaches have been hired to follow up on screenings. The organization also has engaged in several publicity efforts, including radio interviews, newspaper articles, letters to the editor and participation in a health fair. Screening rates grew from 68.9 percent to 71 percent between Q3 and Q4 of 2011. Internally, Sanford Health Bemidji has a robust EMR, enabling it to pull reports quarterly and track screening results by physician. These data are shared, and physicians with good results are congratulated in a weekly newsletter. In addition, eight patients are scheduled to participate in the Minnesota Department of Health free SAGE scope program.

Mayo Clinic Health System – Wisconsin
There are 12 family medicine sites and 3 on-site GI practices for colonoscopy referrals.
These sites worked on creating accurate data and a standard work document, as well as updating data sets, by making their EMR tracking system more robust to track when a patient is at risk or has opted for a non-colonoscopy screening method. Birthday card reminders are being sent, and colonoscopy referral forms are being added to a patient’s chart and sent electronically to the GI department. The sites are rolling out a protocol for independent testing, enabling nurses to schedule screens without patients seeing a clinician. In addition, a reminder system for FIT is being developed.

Mayo Clinic – South Region
This includes 13 clinics and 5 hospitals. Flexible sigmoidoscopies and colonoscopies are referred to Mayo Clinic in Rochester.
This clinic is focusing on capturing existing colonoscopy data and customizing its EMR for follow-up. Soon, it will be able to track results by provider when a PCP has been designated. The data sharing is transparent. Using a red, yellow and green tracking
system, users know that red means a patient is overdue, yellow means a screening is upcoming, and green means the screening has been completed.

A key point in the Colorectal Cancer Screening learning collaborative was that the best test for the patient was a completed test. A goal was to make providers aware that colonoscopies are not the only choice for patients. Throughout the collaborative, many groups explored the option of the FIT and developed education material for patients.

Although the evidence does not support group education for colorectal cancer, many clinics held education sessions for the public during March. These events were very well received.

Accurate data is key to tracking and measuring when people are due for screening. Several organizations worked throughout the collaborative to ensure their data were up to date. Groups then began implementing a registry.

**General Awareness:**

- Creating materials and finding appropriate ways to display them take time and money.
- One clinic is trying to facilitate meetings with local leaders of the Somali population to educate them on the importance of health maintenance.
- Engaging those 65 and older is difficult.

**Data Collection:**

- Several clinics mentioned the challenge of ensuring accurate data.
- Some clinics struggle with what information needs to be collected (i.e. type of polyp, size, risk status) and who should be responsible for entering the data into a system.
- When working with outside providers, clinics need to create a process to ensure results are sent to the right place.
- It can be a challenge to share data between a clinic and a hospital, especially when they do not belong to the same health care system.
Provider Engagement:
- Some physicians requested a condensed version of the ICSI guideline. Others asked for visual cues for prompting a discussion with a patient. Clinics are trying to make the ICSI algorithm more user friendly.
- Physicians may question the reporting method and its accuracy.
- Physicians can easily be overwhelmed with measures.

Patient Compliance:
- Some patients object to a pre-colonoscopy physical.
- Patients are often not eager to talk about screening.
- Patient follow-up is time consuming, whether conducted via telephone calls, cards sent to individuals or reminders posted in the EMR.

Process Issues:
- Concerns were raised over the colonoscopy prep. Some clinics switched to a Gatorade-based prep, which was less costly, but convincing physicians to switch was difficult.
- It is a challenge for providers and nurses to know when a patient is due for screening. Sometimes, staff can highlight the service needed on a rooming sheet.
- Having the ability to process FIT results on-site can be difficult.
- In some cases, there is not adequate availability of physicians to perform colonoscopies.
- It is time consuming for providers and nurses to track fecal occult blood test results.

PROJECT OUTCOMES

Colorectal Cancer Screening Results
Colorectal Cancer Screening Collaborative data are reported using the Minnesota Community Measurement annual data on Colorectal Cancer Screening Rates. Data are split into two periods: 1) prior to the start of the collaborative (baseline data July 2010-June 2011) and compared to 2) the screening rates during and at the end of the collaborative (July 2011-June 2012 data). The colorectal cancer screening rate for the collaborative at baseline was at 73% compared to the state rate at 64%. The collaborative screening rate during and at the end the collaborative remained at 73%, but was still higher than the overall state rate at 68%.

While the overall collaborative rate during and at the end did not change from the baseline, the results by some individual clinics did change. Out of 18 clinics who participated and submitted data for period during and at the end of the collaborative (July 2011-June 2012), the colorectal cancer screening rate remained almost the same or increased for 11 clinics. Mayo Clinic Health System-Faribault Clinic had the highest percentage point increase in its screening rate from the baseline by 28 points or almost a 50% increase from the baseline, from 57% from July 2010-June 2011 vs. 85% from July 2011-June 2012.
Organizational Readiness Assessments
Organizational Readiness Assessment surveys were conducted before implementation, six months post implementation and at the end of the collaborative. Highlights are available in the attachments.

Lessons Learned
Lessons were learned along the way that are guiding a second learning collaborative. Face-to-face sessions will help to engage organizations. Process measures and outcomes throughout will help groups be more accountable and show progress throughout the learning collaborative. In addition, the order of the content could be moved around to help with the flow of the collaborative.

NEXT STEPS

Going forward, ICSI will share results with collaborative participants and report results on the ICSI website, in the ICSI newsletter and internally at ICSI, ACS and MDH. General publicity will highlight results to external audiences. Support from the ACS and MDH was acknowledged at all planning meetings and has been an integral part of the structure of this collaborative. Experience with this collaborative, and the involvement of the American Cancer Society and the Minnesota Department of Health, has already influenced the structure of a second collaborative.