A Report on Efforts to Increase Appropriate Screening For Colorectal Cancer in Minnesota

Background
Improving colorectal cancer screening rates has been one of the top priorities of the Minnesota Cancer Alliance, a coalition of more than 100 organizations working together to reduce the burden of cancer in Minnesota.

In March 2009 the Minnesota Cancer Alliance and the American Cancer Society (ACS) co-sponsored a roundtable discussion entitled “Colon Cancer Prevention: The Next Quantum Leap.” A broad group of stakeholders attended, including representatives from care delivery systems, health plans, the Institute for Clinical Systems Improvement (ICSI), MN Community Measurement (MNCM), the Minnesota Department of Health (MDH), and ACS.

The goal of this roundtable was to explore how care delivery systems could help reduce deaths from colorectal cancer (CRC) in Minnesota from its current rate of about 800 annually. Key strategies arrived at were: 1) motivate patients age 50 and older at average risk for CRC to opt for screening; 2) identify and screen people under age 50 at higher risk for CRC; 3) address geographic and other disparities in CRC screening; and 4) ensure high-quality colonoscopy in Minnesota.

Following the March roundtable a Colorectal Cancer Advisory Council was formed which divided its work into three subgroups. The Communications/Messaging subgroup focused on clarifying the screening message for average risk individuals to the public and providers. The High Risk subgroup worked with ICSI to update ICSI’s CRC Screening Guideline to address screening for people at elevated risk. The Payment subgroup addressed the complexities of billing and payment for CRC screening.

Roundtable II
In October 2010, stakeholders reconvened (participants listed in Appendix A) to highlight work accomplished since the first roundtable and to determine how to further leverage health systems to achieve a population-wide screening rate of 80%

Brian Rank, MD, Medical Director for HealthPartners Medical Group, and Matt Flory, Minnesota Director of Health Care Partnerships for the American Cancer Society, provided an update on the progress of the work to date. This included:
• Formation of the Colorectal Cancer Advisory Council (membership list, Appendix B).
• Use of the new ICSI guideline for CRC screening (http://bit.ly/9KPkC0) to serve as a state evidence-based standard. Some additions to this revised guideline are: recommended routine screening for individuals at average risk for CRC; quality indicators for appropriate use of colonoscopies; additional considerations for informed decision-making, and adding American Indians, 45 years or older, to the average risk screening category.
• A change in how CRC screening measurement data is collected and reported by MNCM to provide greater public accountability and transparency (http://bit.ly/hvUC4S).
• Implementation of numerous communications strategies.
• Clarification of billing and coding practices for screening procedures.
• Completion of an Advisory Council membership survey that showed an increase in screening rates and/or indication of CRC screening as a top priority for work in the next two years.
• Decisions by five health plans in Minnesota to work with their provider groups to improve colorectal cancer screening for their performance improvement project for the Minnesota Department of Human Services for 2011.
• Assistance from Stratis Health, through a mini-grant from the Minnesota Cancer Alliance, to help clinics with public reporting on CRC screening measures.
• The development of new colonoscopy quality measures and direct data submission for CRC screening through MNCM (www.mnhealthscores.org).

Jim Chase, President of MN Community Measurement, described the 2010 results for colorectal cancer screening in MNCM’s Health Care Quality report (below).
The data for the CRC screening measure used for this report were collected from health plan claims data and medical record review. The bars in the chart show the percentage of patients age 51-75 who had appropriate screening. Data for 2010 are not directly comparable to those for earlier years due to the fact the age limit was lowered to include patients only 75 years or younger. Chase also noted that of the 61 medical groups included in the report on this measure there was significant variation in screening rates—from a high of 92% to a low of 15%.

With new MNCM Colorectal Cancer Screening Direct Data Submission and Colonoscopy Quality & Surveillance measures put in place in the summer of 2010, the data for these measures as of August 2011 will be collected directly from medical groups and will include additional information on patient’s race, ethnicity and primary language. Also for future consideration will be measures that will attempt to evaluate the quality of the screening, not just whether or not a screening was completed. According to Chase, these measures will include the volume of procedures performed, completion rate, adenoma detection rate, and a measure of the appropriate interval between screenings.

**Quality of Screening**

John Allen, MD, Medical Director for Quality from Minnesota Gastroenterology, PA, provided a perspective on colonoscopy. Dr. Allen noted that many resources could be wasted if the work of the group focused only on the rate of screening and not also on the effectiveness and quality of screening exams. He explained that while colonoscopy is the most invasive, dangerous and costly population screening procedure approved by the U.S. Preventive Services Task Force there is not currently an effective measure for quality outcomes and cost of this procedure.

Dr. Allen indicated that colonoscopy procedures account for approximately 70% of a gastroenterology practice’s income and that this powerful economic influence should be acknowledged as the stakeholders seek to improve screening rates and reduce cancer deaths.

In addition Dr. Allen presented some of the work Minnesota Gastroenterology has done to collect data and improve the effectiveness of their group’s colonoscopies. As is typical with clinical quality improvement efforts, Minnesota Gastroenterology found that sharing relevant quality data directly with physicians and providing a transparent means of comparison is a powerful motivator for improvement.

**Sharing Success Stories**

A panel of representatives from organizations that showed remarkable improvement in their own screening rates from 2008 to 2009 shared their success stories at the roundtable. Larry Morrissey, MD, Stillwater Medical Group, Jim Gwost, CentraCare, and Loriann Lane, CMA, and Carli Palmer, RN, from HealthEast Care System listed the following as key factors that helped these organizations improve their screening rates:
Plan Ahead
• Standardize the screening protocols and the providers performing colonoscopies
• Build a quality improvement and communications infrastructure “behind the scenes” without adding extra burden to the patient/physician interaction

Identify Patients/Engage Providers
• Develop a process for targeted medical chart review—figuring out which patients were most likely to be in need of a screen and reviewing those charts
• Make information on physician screening rates transparent within the organization—this adds a little “friendly competition” between colleagues

Reminders for Providers and Patients
• Improve documentation and prompts—both electronic and paper
• Improve or initiate patient outreach—simple postcards and letters work

The panelists also noted common challenges they encountered in their work. These included:
• Trying to ensure patient follow-up for screening and results. Often patients seek other providers for the procedures. It is important to get this information back to the original clinic and documented in the medical record.
• Needing to track CRC screenings other than colonoscopies. Some information systems are not set up to track additional CRC screening methods.
• Patient confusion regarding insurance coverage for colonoscopy. Some insurance companies will change coverage from 100% covered preventive screen to a diagnostic test (involving a deductible and/or co-pay) if a polyp is detected. This is often a surprise to patients and creates friction between patient and provider group.
• Difficulty with patient preparation for a colonoscopy procedure and the need to have patient questions regarding prep addressed in a timely manner prior to the procedure.

Ideas to increase CRC screening were generated by the participants at both the March 2009 and the October 2010 roundtable discussions. The lists below outline their ideas and are divided into three general categories: 1) Communication and information exchange, 2) System improvements, and 3) Public policy and regulatory tactics. Those in italic were identified during the first roundtable. Those not italicized were generated during the October roundtable. Participants at the second roundtable were asked to identify which tactics generated from roundtable one they found to be useful; the number in parentheses after a tactic represents the number of participants indicating they used the tactic and found it to be useful.
**Tactics to Increase Screening**

**Communication and Information Exchange Tactics - Within provider groups**

- Customise EMR with prompts for screening (14)
- Provide feedback to provider on their performance (measure and report) (11)
- Clearly communicate guidelines and standards of care to all providers (14)
- Hard wire one set of guidelines into the EMR (8)
- Leverage EMR for point-of-care prompts

**Communication and Information Exchange Tactics - Between provider groups**

- Clearly communicate guidelines and standards of care to all providers (14)
- Work on methods to share patient data between systems (5)
- Get retail clinics to encourage CRC screenings
- Inform other specialists regarding CRC prevention and screening
- Report rates back to provider (from GI providers)
- Collaborate with those providing screening to get information
- Optimize tracking of data through the creation of a statewide registry for information exchange

**Communication and Information Exchange Tactics - Physician/Clinic to patient**

- Incorporate questions about CRC screening into other health care encounters (e.g. mammograms, flu shots, etc.) (9)
- Generate a print-out for patients with last preventive exams and what is recommended for their age/gender (5)
- Develop “action plan” print-outs (2)
- Develop a pamphlet for use at appropriate appointments (standard communications) (7)
- Get info on colorectal cancer screening when patient gets vaccinated for the flu
- Provide all screening choices to patients (not just colonoscopy)

**Communication and Information Exchange Tactics – Population-wide communications**

- Develop marketing campaign specific to high-risk individuals (9)
- Develop an interactive website/videos to engage public (6)
- Provide all screening choices to patients (not just colonoscopy)
- Gain acceptance of all screening types
- Increase use of free screens – FOBT, FIT
- Get info on colorectal cancer screening when patient gets vaccinated for the flu
System Improvement Tactics

✓ Standardized screening questions for high-risk patients to flag in system by age 40 (5)
✓ Provide incentives to high-risk patients to get screening (1)
✓ Reduce or eliminate insurance barriers for individuals (cost sharing, etc.) (6)
✓ Hard wire one set of guidelines into the EMR (8)
✓ Schedule screening before patient leaves office (12)
✓ Have systematic process at primary care clinic to schedule patient for screening
✓ Emphasize team approach at the provider level
✓ Make CRC screening a strategic quality improvement goal at the Board/Senior Leadership level for all providers, systems, and plans
✓ Achieve consistent preparations to avoid variances in outcomes
✓ Ensure document screening is done
✓ Reduce complexity of coverage, waive co-pay, and determine cost to patient before they have the test

Public Policy and Regulatory Tactics

✓ Reduce or eliminate insurance barriers for individuals (cost sharing, etc.) (6)
✓ Offer patients incentives to be screened (2)
✓ Expand efforts to the broader community (faith community, social service agencies, etc.)—too focused on providers
✓ Develop a statewide screening (and cancer) registry to optimize tracking of data for information exchange
✓ Create consistent benefit coverage/reimbursement—diagnostic vs. screening reimbursement varies
✓ Simplify billing, coding, and benefits—Need uniformity among payers (based on procedure, not findings)
✓ Reduce complexity of coverage, waive co-pay, determine cost to patient before they have the test
✓ Develop measurement and reporting systems to encourage transparency with reporting rates

In addition to the list of tactics, there was engaged discussion among participants regarding the need for some type of statewide screening and/or cancer registry. Many participants mentioned the effectiveness of the statewide immunization registry and would like to have something similar for colorectal cancer screening. Current barriers to forming such a registry listed by participants included the need to identify people who haven’t been screened and are at the appropriate screening age/interval, that it requires multiple inputs from payers and providers, and its formation must deal with different vendors, HIPAA and financial issues. Working with vendors and collaboration among committed stakeholders on a product was discussed as a
possible solution. The group believed such a registry would be a very useful tool to achieve many of the tactics listed above.

Another area of discussion focused on insurance coverage for colonoscopies. The Colorectal Cancer Advisory Council Payment subgroup did work prior to the October roundtable to help clarify billing and coding practices for screening procedures by various health plans. The subgroup created a grid of codes used by the various health plans that qualify their beneficiaries for coverage of colonoscopy as a preventive benefit.

The participants felt more needed to be done to distinguish in advance when colonoscopies would be considered preventive tests and when they would be considered diagnostic tests. They indicated that the uncertainty and higher cost sharing when the tests were coded and/or billed as a diagnostic test provided a significant disincentive for patients to get screened.

Finally, there was acknowledgement of the need to focus on the goal of reducing deaths from colorectal cancer, not only to increase screening rates. This requires additional attention to the quality and effectiveness of current screening procedures with an eye to new screening innovations that may be more cost effective, less invasive and help detect more early cases of colorectal cancer.

As the discussion roundtable drew to a close the participants were unanimous in their agreement that additional work was needed on the strategies and tactics identified by the group. Participants encouraged ICSI to partner with the Minnesota Cancer Alliance and the stakeholder participants of the roundtable to convene a CRC screening collaborative to enhance clinic systems to improve colorectal cancer screening rates.

For more information, contact:
- www.mncanceralliance.org
- www.icsi.org
- www.mncm.org

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Appendix A

Organizations Represented at Roundtable II

Allina Medical Clinic
American Cancer Society
Avera
BlueCross BlueShield of MN
Colon and Rectal Surgery Associates, Ltd.
Essentia Health (formerly SMDC)
Fairview Health Services
HealthEast Care System
HealthPartners Medical Group
HealthPartners Health Plan
HealthPartners Research Foundation
HHH Cancer Center
Institute for Clinical Systems Improvement

Mayo Health System
Medica Health Plan
MN Community Measurement
Minnesota Department of Health
Minnesota Gastroenterology
NWFS
Park Nicollet Health Services
PreferredOne
Stillwater Medical Group
StratisHealth
UCare
University of Minnesota
VPCI

Appendix B

Colorectal Cancer Advisory Council Members

John Allen, MD, Minnesota Gastroenterology
Barry Bershow, MD, Fairview Health Services
Heather Clark, Preferred One
Matt Flory, American Cancer Society
Jim Gwost, CentraCare
Mary Hermann, Park Nicollet Health Services
Ken Joslyn, MD, University of Minnesota
Steve Kolar, MD, HealthEast Care System
Jane Korn, MD, MN Department of Health
Barb Kunz, HHH Cancer Center

Kathy Kupfer, UCare
Melissa Marshall, Institute for Clinical Systems Improvement
Mary Mercil, Patient Representative
Brenda Paul, MN Community Measurement
Brian Rank, MD, HealthPartners Medical Group
Kari Retzer, ICSI
Angie Rolle, American Cancer Society