Increasing Colorectal Cancer Screening in a Community Clinic Setting

BACKGROUND

According to the Centers for Disease Control and Prevention (CDC), Nevada's colorectal cancer screening rate is 58%[i] for people ages 50-75 who report being "up-to-date" with colorectal cancer screening, far below the Healthy People 2020 goal of 70.5%. This includes having had a fecal occult blood test (FOBT) during the previous year, a sigmoidoscopy within the previous five years and a FOBT within the previous three years, or a colonoscopy within the previous 10 years. It is also important to note that rates decrease as family incomes decrease meaning that eligible adults with lower income are almost two and a half times less likely to be up-to-date on their colorectal cancer screening.[ii]

Community Health Alliance (CHA) is a Federally Qualified Health Center (FQHC) organization providing comprehensive primary and preventive healthcare programs, services, and health education to the low-income, Medicare, Medicaid, and uninsured populations. Four clinic locations serve more than 50,000 children and adults in their respective communities each year. In November 2012, CHA partnered with the Nevada Cancer Coalition, Nevada Colon Cancer Partnership, Access to Healthcare Network, and State of Nevada Cancer Prevention Unit, to improve colorectal cancer screening among its relevant patient population and create sustainability of colorectal cancer screening processes within a clinic setting. This pilot project developed processes to make the Fecal Immunochemical Test (FIT) process more "user friendly," increase colorectal cancer screening among existing clients, and increase provider knowledge.

METHODS

Project partners held preliminary meetings to explore both changes in clinical processes and evidence-based recommendations for patient interventions. To provide context and a baseline, CHA reviewed its past year's screening records which indicated 150 out of 4,657 eligible patients met the screening criteria constituting a 3.22% up-to-date screening rate for the year.

Strategies implemented included the following:

1. **Identify targeted population according to evidence based protocols**
   - CHA identified 5,038 eligible patients from four clinics aged 50-64, average risk and never or rarely screened.
2. **Access to Healthcare Network enrollment**
   - Protocols for application and enrollment were developed with Access to Healthcare Network, a healthcare discount program serving uninsured patients.
3. **Employing a care navigator**
   - Care Navigator began assisting uninsured patients in applying for the free FIT colon cancer screening test offered through Access to Healthcare Network and provided eligible patients with FITs to take home for them to use in collecting the sample for processing.
   - Provided patient education and information on colorectal cancer
   - Provided translation services to patients.
4. **Patient reminders**
   - Postcards were developed, using the CDC Screen for Life Campaign, specific to each clinic location and sent to eligible patient population from each clinic. Cards encourage patients to schedule a colon cancer screening appointment right away if they have not been screened in the past year.

- Telephone appointment schedulers were trained in the colon cancer screening process and given instructions on direct telephone calling to targeted patients.

5. **Medical Provider Detailing**
   - Medical providers of all four clinics were trained in the program protocols and processes.
   - Two webinar sessions were held to provide detailing on colorectal cancer screening options for patients. Webinars were presented by gastroenterological physicians.
   - Medical staff were provided with in-office tools to use when speaking to patients about their screening choices.

6. **Utilization of Electronic Health Records System (EHRs)**
   - Developed and installed "prompts" that pop-up in the patient's EHR at each visit if the patient meets screening criteria. Staff were trained on use of protocols and the EHR prompts.
   - Programmed EHR system to automatically generate appropriate education resources for patients based on inputted data about their screening history or results.
   - Coordination with LabCorp and Quest Diagnostics for reporting of results of FIT tests through electronic population of lab results into the EHRs.
   - Ordered colon cancer screenings through the EHR record so the order can be tracked. This enables CHA care team members to contact the patient if the FIT test sample has not been received by the laboratory and provides the opportunity to reinforce the importance of completing the screening with the patient, thus promoting screening compliance.
   - Prompts and time stamping of orders developed and implemented to facilitate care navigation.

RESULTS

Data is somewhat limited with two months of operation (April and May, 2013). To provide context, CHA had 150 patients screened for colon cancer in the prior year – June 1, 2011 through May 31, 2012. That is out of 4,657 patients meeting screening criteria in that year. This constitutes a 3.22% screening rate in the eligible population. Comparing the same time period of April/May 2012 versus April/May 2013 rates, CHA realized a capture rate for screening increase of 300% within its patient population after implementation of this project.

During the project period, one patient was screened to be positive in the FIT test. That patient was referred and navigated into an appointment with a GI specialist. That specialist appointment was completed with a report received from the treating GI specialist.

CHA is able to sustain the office process and EHR changes implemented during this project. The Care Navigator provides navigation for clients of all four clinic locations and covers all cancer screening needs including cervical and breast. Thus, the Care Navigator has been incorporated into the overall operations of CHA and sustaining this position is easier given the duties covered. Additional patient materials and reminder postcards are obtained through Nevada Cance

[i] 2012 BRFSS Survey Data collected by Behavioral Risk Factor Surveillance System (BRFSS) sponsored by the Centers for Dis
and Prevention.
[ii] HealthyPeople.gov at http://www.healthypeople.gov/2020/topicsobjectives2020/nationalsnapshot.aspx?topicId=5.