

# **Clinical Quality Improvement for Cancer Screening**

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# A few acronyms to get us started..

- BRFSS: Behavioral Risk Factor Surveillance System
- FIT: Fecal Immunochemical Test
- FOBT: Fecal Occult Blood Test
- NCCRT: National Colorectal Cancer Roundtable
- USPSTF: United States Preventive Service Task Force

# POPULATION BASED SCREENING

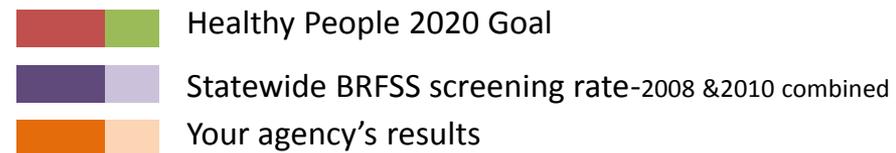
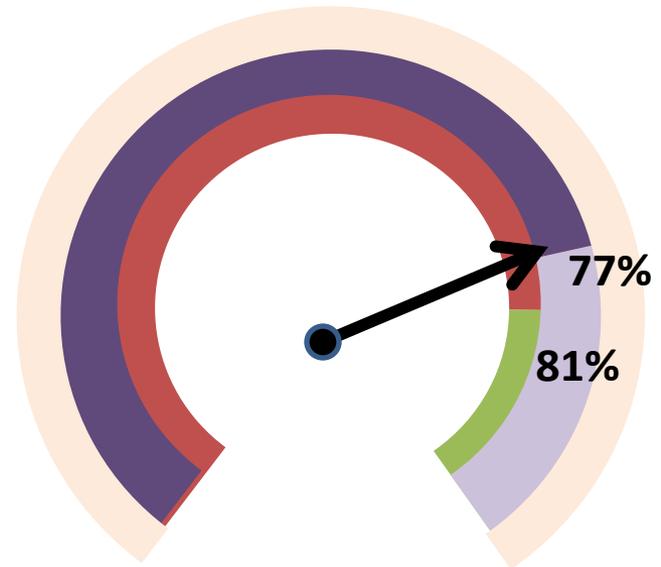


# Breast Cancer 101

## FACTS (2009)

- Most common cancer in women
- Death rates have been steadily **decreasing** since 1990
- **3,441** women were diagnosed with breast cancer in Colorado

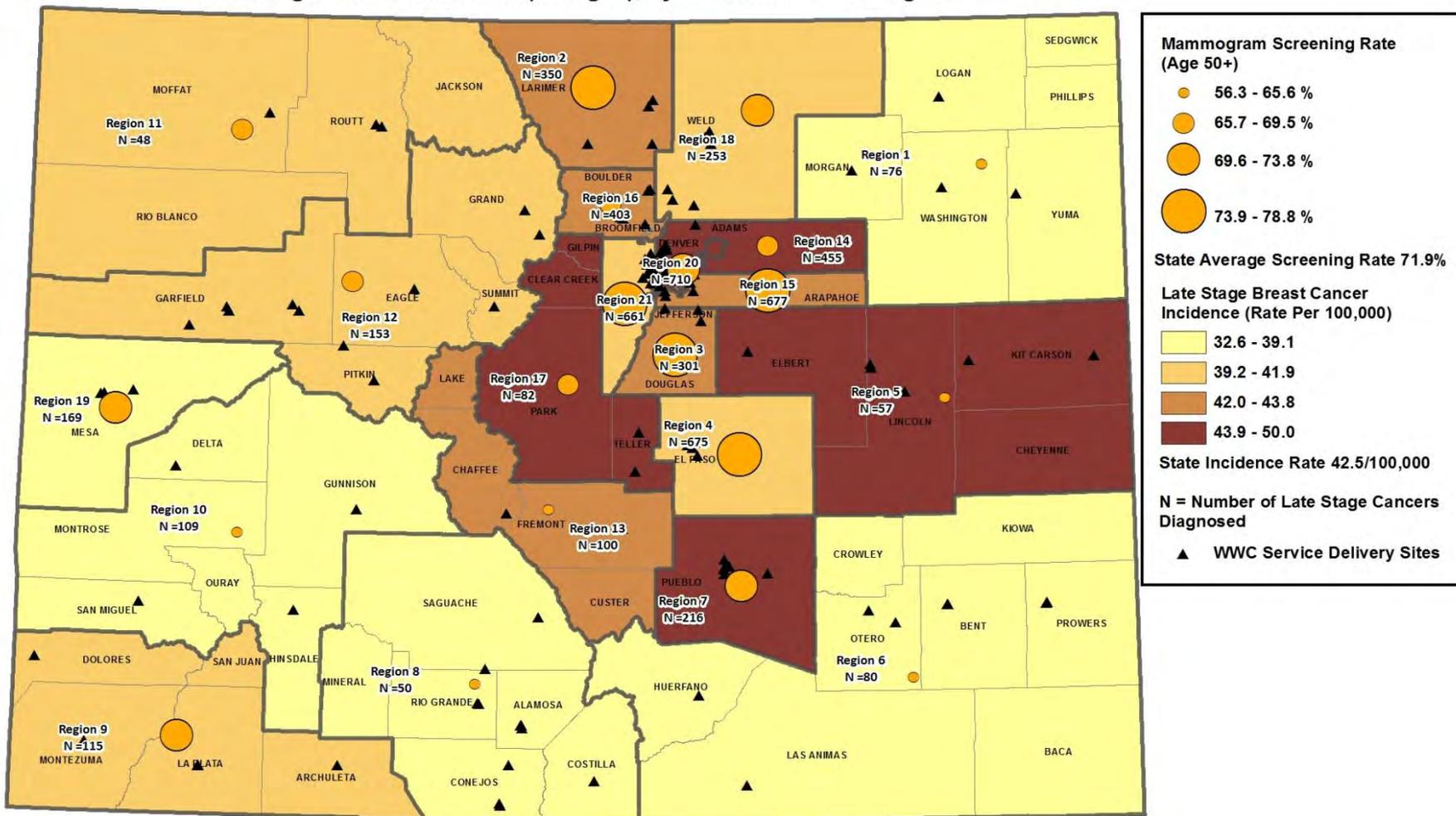
*If diagnosed early on, almost  
98% of women will  
survive breast cancer*



# Breast Cancer in Colorado

## Mammogram Screening Rate Among Women (Age 50 and Over)

### Late Stage Cancer Incidence (All Ages), by Health Statistics Region



**Data Sources and Notes:**

Mammogram Screening Rate - Percent of females aged 50+ who have had a mammogram in the past 2 years, 2012, Colorado BRFSS, Health Statistics and Evaluation Branch, Colorado Department of Public Health and Environment.

Late Stage Breast Cancer Incidence: 2008-2012 Age-adjusted incidence rates for cervical cancer diagnosed in late stage only, Colorado Cancer Registry, CDPHE.

Number of Diagnosed (Breast Cancer Diagnosed in Late Stage), 2008-2012, Colorado Cancer Registry, CDPHE.

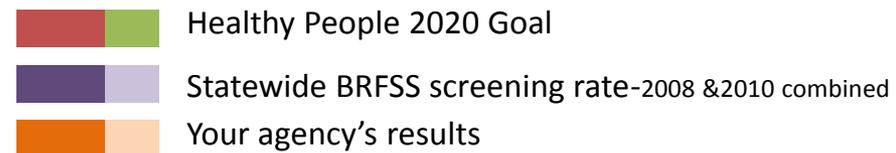
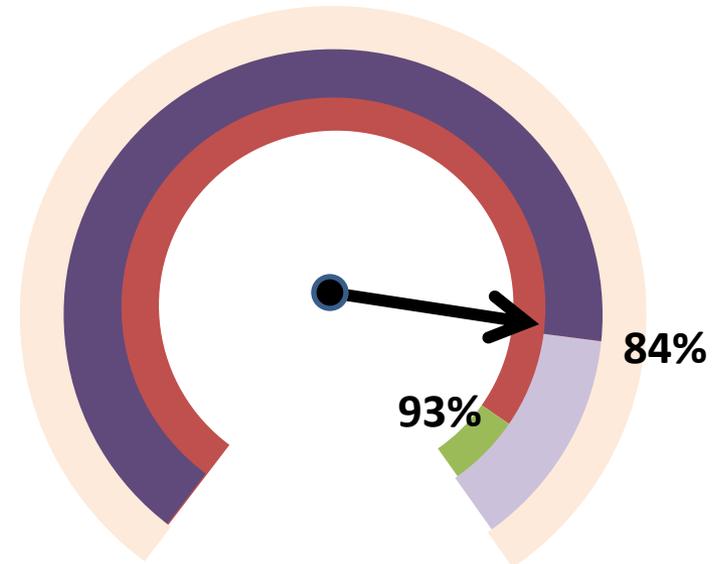


# Cervical Cancer 101

## FACTS

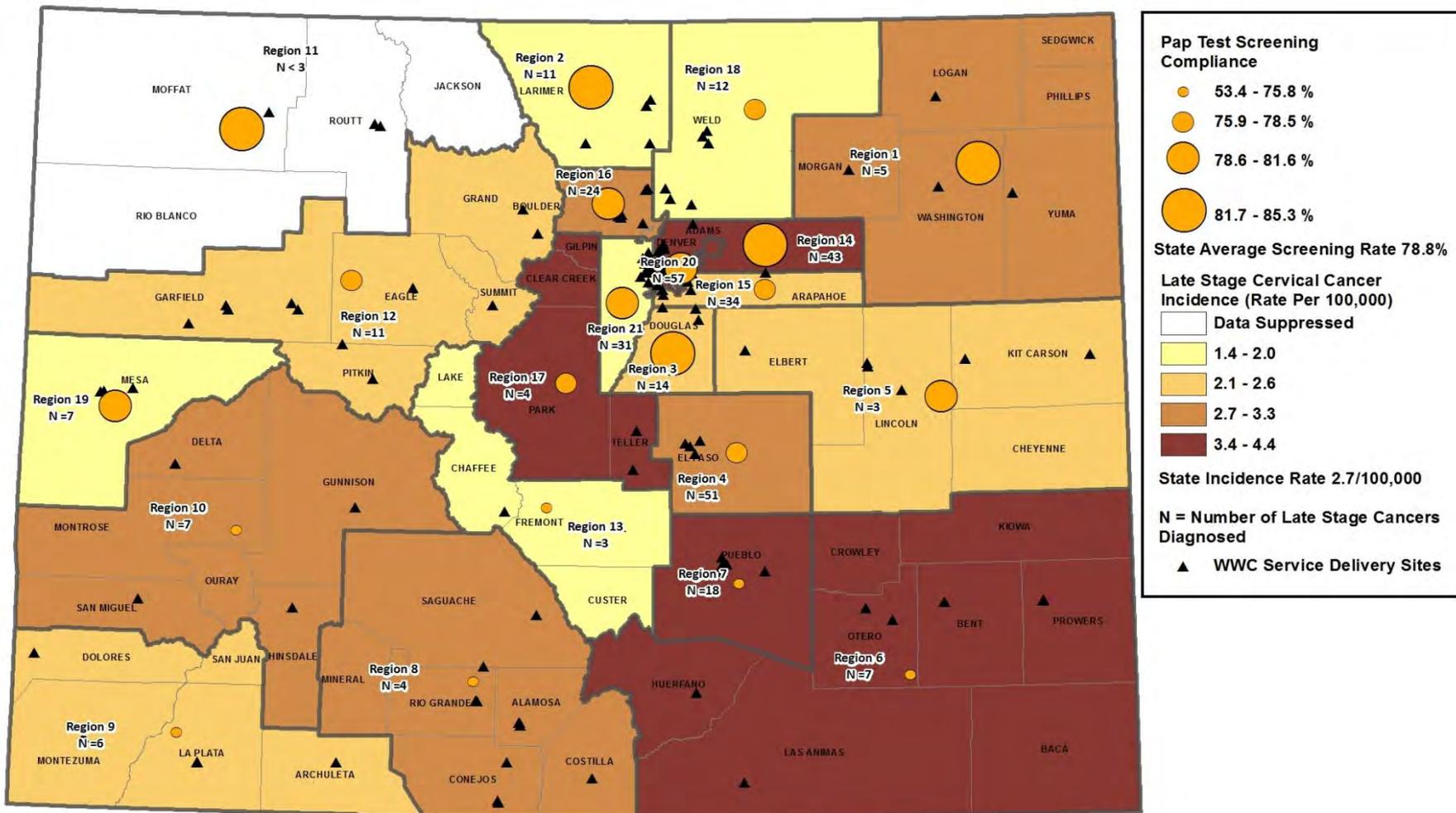
- **149** women were diagnosed with invasive cervical cancer in Colorado. (2009)
- Cervical cancer was once one of the most common causes of cancer death for American women— increased use of pap test caused the death rate to decline by **~70%**

*Cervical cancer can take years to develop, but is preventable if caught early*



# Cervical Cancer in Colorado

## Pap Test Compliance and Late Stage Cancer Incidence, by Health Statistics Region



**Data Sources and Notes:**

Pap Test Screening Compliance - Percent of females aged 18+ who have had a Pap test in the past 3 years, 2012, Colorado BRFSS, Health Statistics and Evaluation Branch, Colorado Department of Public Health and Environment.

Late Stage Cervical Cancer Incidence: 2008-2012 Age-adjusted incidence rates for cervical cancer diagnosed in late stage only, Colorado Cancer Registry, CDPHE.

Number of Diagnosed (Cervical Cancer Diagnosed in Late Stage), 2008-2012, Colorado Cancer Registry, CDPHE.

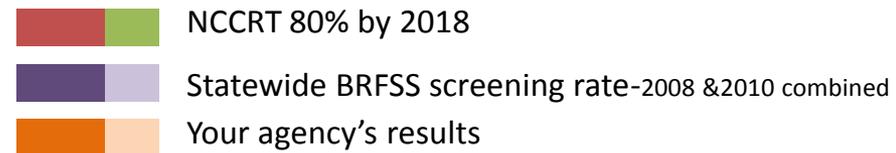
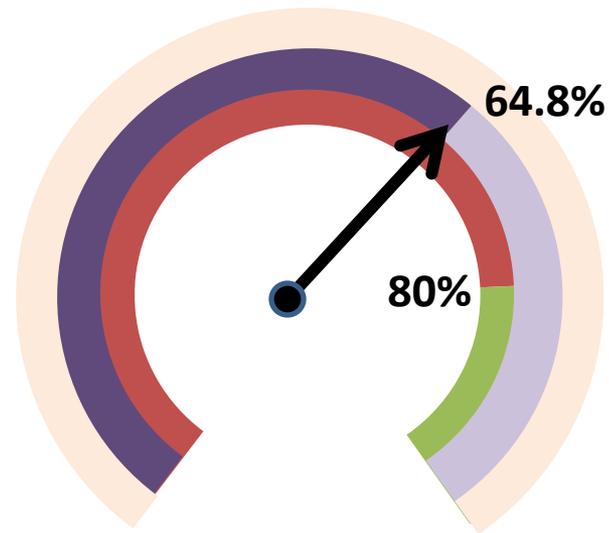


# Colorectal Cancer 101

## FACTS

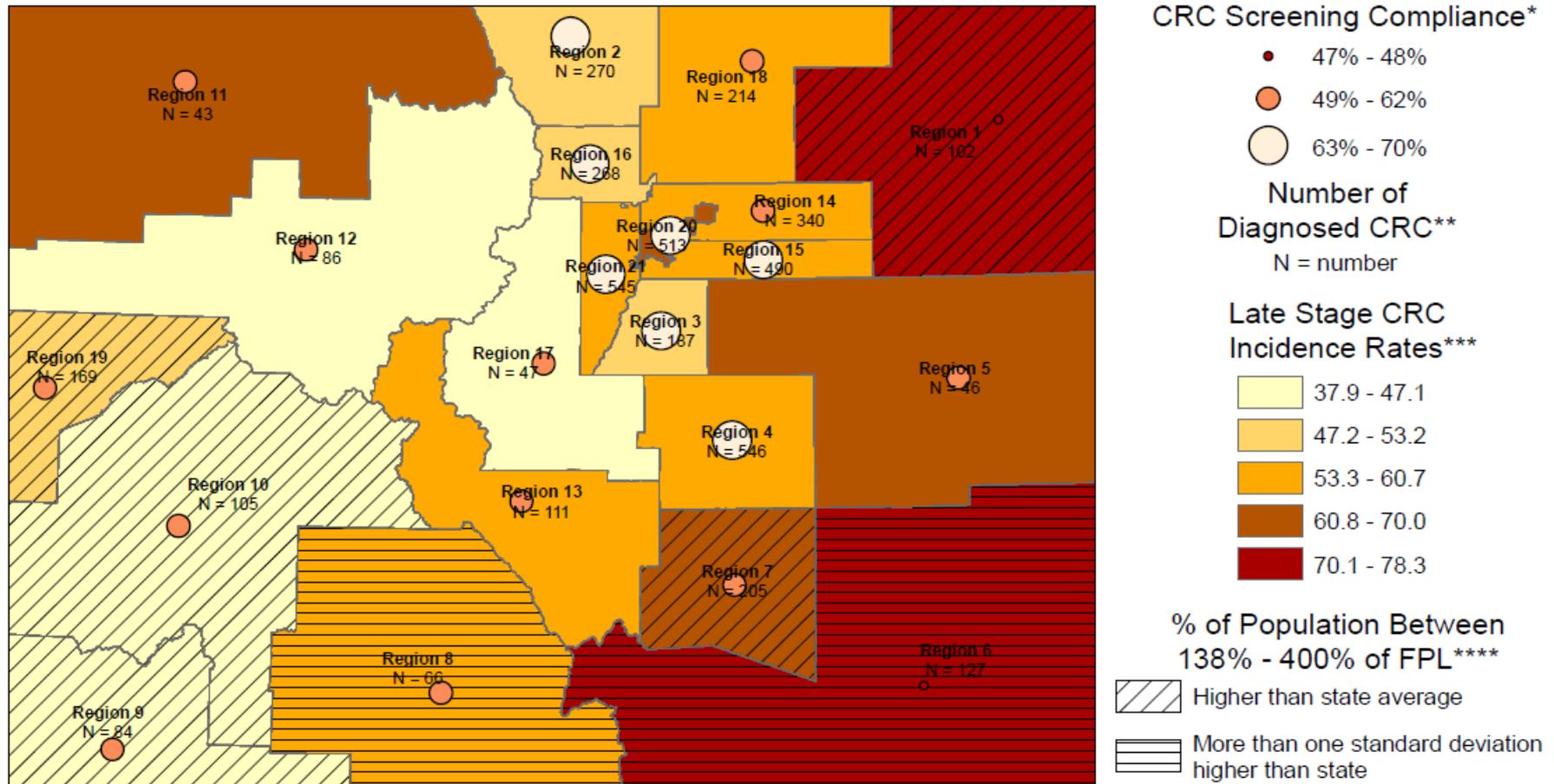
- 2<sup>nd</sup> leading cancer cause of death (men & women combined)
- The estimated direct medical cost of CRC care in 2010 was **\$14 billion**

*50% of the expected new CRC cases and deaths were prevented between 2003-2007 because of screening*



# Colorectal Cancer (CRC) in Colorado

## Screening Compliance, Number Diagnosed, Late Stage Incidence, and Poverty by Health Statistics Region



### Data Sources and Notes:

\* CRC Screening (colonoscopy in 10 yrs; sigmoidoscopy in 5 yrs and FOBT in 3 years; FOBT in 1 year), ages 50-75, 2010 and 2012 combined, Colorado BRFSS, Health Statistics and Evaluation Branch, Colorado Department of Public Health and Environment.

\*\*Number of diagnosed CRC, ages 50+, 2010-2012, Colorado Cancer Registry, CDPHE.

\*\*\* Age-adjusted incidence rates per 100,000 population for late stage CRC diagnosed in Regional or Distant stage only, ages 50+, 2010-2012, Colorado Cancer Registry, CDPHE.

\*\*\*\* Percent of population 138%-400% of the Federal Poverty Level, ages 40-64, 2012, Small Area Household Income Estimates, U.S. Census.



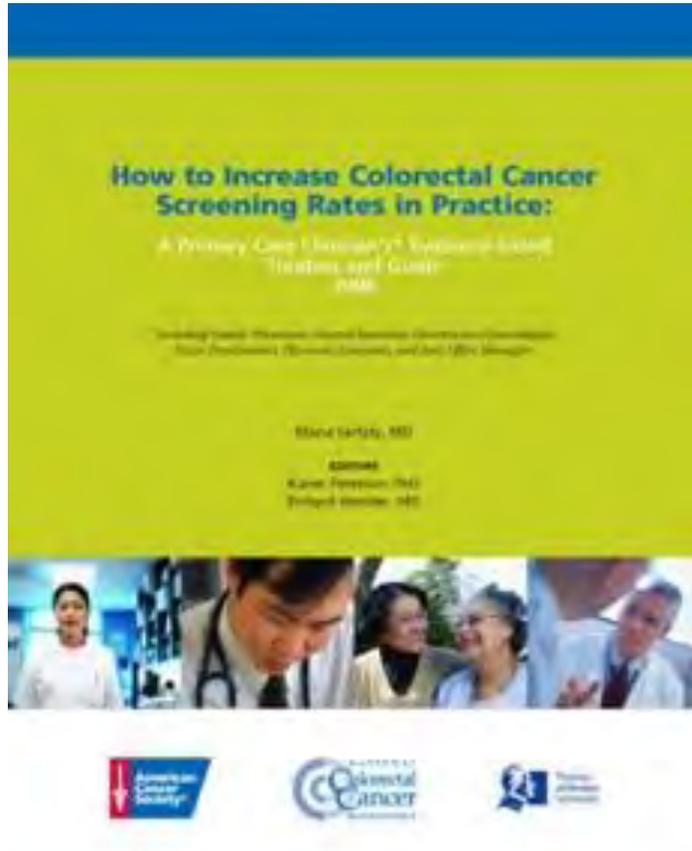
*"I'd have been here sooner if it hadn't been for early detection."*

# Clinical Quality Improvement: Cancer Screening

- **Establish Foundational & Sustainable Practices**
- Reach your **entire clinic population systematically** to ensure every client is touched and followed up on
- Enable all clinic staff to understand and participate in cancer screening activities
  - Change of social norms regarding who does what, how, and why

**Managing & improving work processes to streamline clinic operations and deliver optimum care**

# Cancer QI Components



- Ensure different screening options are available
- Baseline Assessment
- Infrastructure Review
- Resource Review
- Clinic Policy Creation/Modification
- Staff Training
- EHR modifications
- Clinic Champion

\*Clinics without an EHR can, and should, still participate in systems change activities

## Part 1: Conduct a Baseline Screening Assessment

***Provider assessment and feedback is an evidence-based strategy to increase cancer screening rates***

- Basis of an internal gauge towards improvement or maintenance of preventive screenings
- Establishes the process for future assessments, and also provides guidance for other screening assessments that can be completed and tracked (ex: breast & cervical)



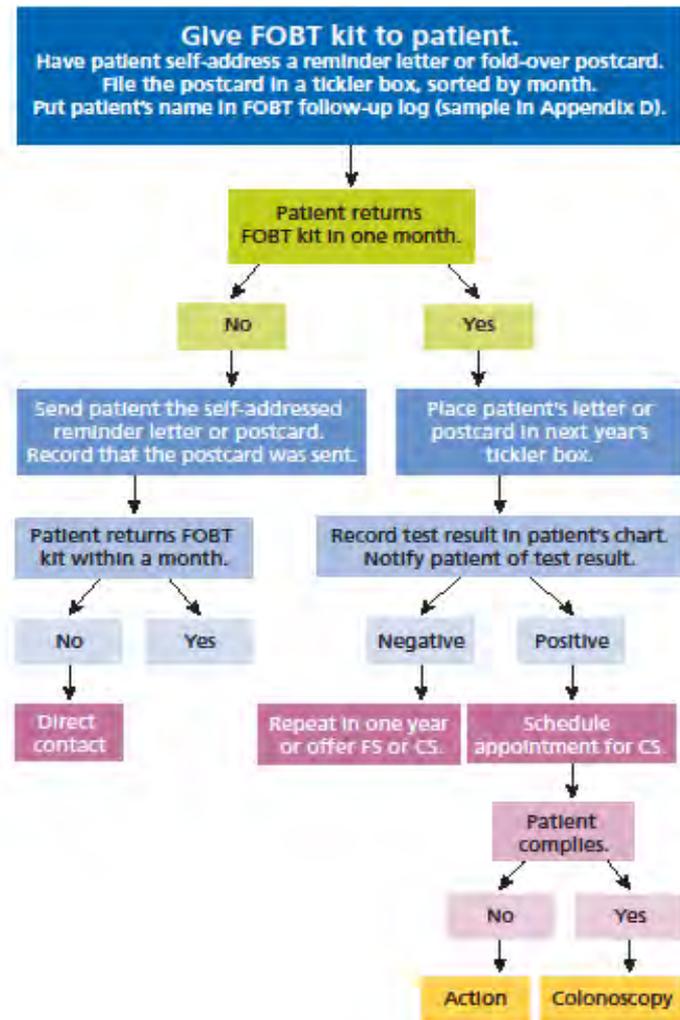
***Provides quantitative and qualitative data to inform systematic changes***

***Used to build reporting capacity (NQF/UDS)***

## Part 2: Infrastructure review & development

Developing an *office policy and workflow* is an evidence-based strategy to increase cancer screening rates

- Design process to fit the way people function
- Provide tools/reports to facilitate workflow
- Identify steps to implement policy



## Part 2 (cont.) More infrastructure!

Developing an *office reminder system* is an evidence-based strategy to increase cancer screening rates.

### For Physicians:

- Chart prompts
- Ticklers and logs
- EHR reporting
- Staff assignment

### For Patients

- Education
- Posters/Brochures
- Reminder postcards, letters or calls



## Part 2 (cont.) Communication

Developing an *effective communication system* is an evidence-based strategy to increase cancer screening rates.

### For Office:

- Clear roles and responsibilities
- Ensure family history is collected in a meaningful way

### For Patients:

- Stage-based communication
- Shared decisions, informed decisions, and use of decision aids



# Where can you start?

**Adhere to appropriate screening guidelines and ensure all screening options are available for your patients**

- Breast: Beginning at age 40 or 50
  - Biennial screening mammography for women aged 50-74 (USPSTF) OR
  - Annual mammograms starting at age 40 and continuing as long as a woman is in good health (ACS)
  
- Cervical : Beginning at age 21
  - Pap test in past 3 years
  - Pap and co-HPV test in past 5 years (after age 30)
  
- Colorectal: Beginning at age 50 or earlier if personal/family history
  - FIT/FOBT within 1 year
  - Colonoscopy within 10 years
  - Flexible sigmoidoscopy or double contrast barium enema (DCBE) within 5 years

# FIT/FOBT 101

FOBT/FIT is a low cost, easily accessible option

- **Used Annually, has excellent comparison to colonoscopy in reducing mortality of CRC**
  - If high sensitivity FOBT or FIT
- Identify your current FOBT/FIT
  - Is it a low-sensitivity FOBT?
    - These are no longer deemed clinically appropriate
  - Is it a high-sensitivity FOBT? Is it a FIT?
- FOBT/FIT should be done *ANNUALLY*
- *\*\*Digital Rectal Exam or DRE is no longer acceptable for CRC screening*

## Types of FOBT and Sensitivity for Cancer or Adenomas

FOBT version	Sensitivity for Cancer	Sensitivity for Adenomas
Hemoccult II Sensa (guaiac based-high sensitivity)	50%-79%	21%-35%
Fecal Immunochemical Test or FIT (high sensitivity)	55%-100%	15%-44%
Hemoccult II (guaiac based-low sensitivity)	13%-50%	8%-20%

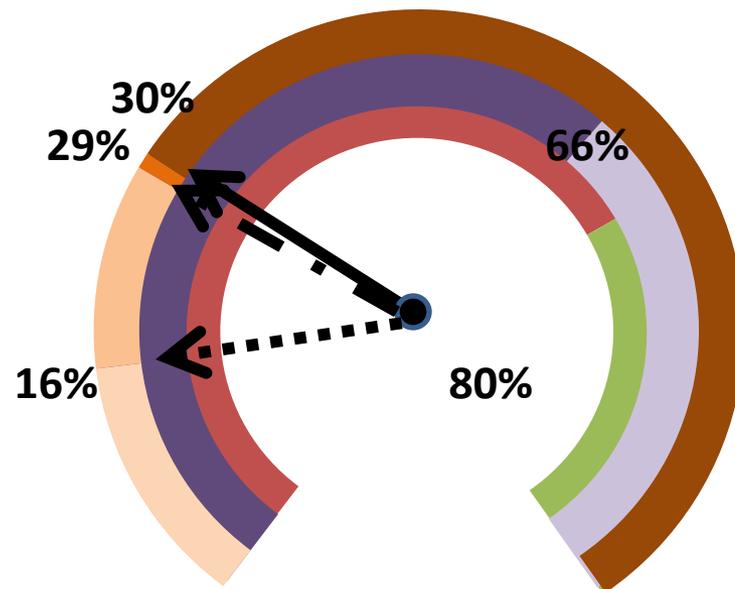
NOTE: High quality CRC screening programs don't use in-office FOBT at the time of digital rectal exam as screening for colorectal cancers

**WILL THESE CHANGES REALLY HELP  
OUR SCREENING RATES??????**

# Success: High Plains Community Health Center

➤ The **overall CRC screening compliance rate nearly doubled** (16% to 30%)

➤ The **total volume** of clients screened for CRC **increased**, from 348 to 726 clients



Clinic Results (P1, P2, P3)

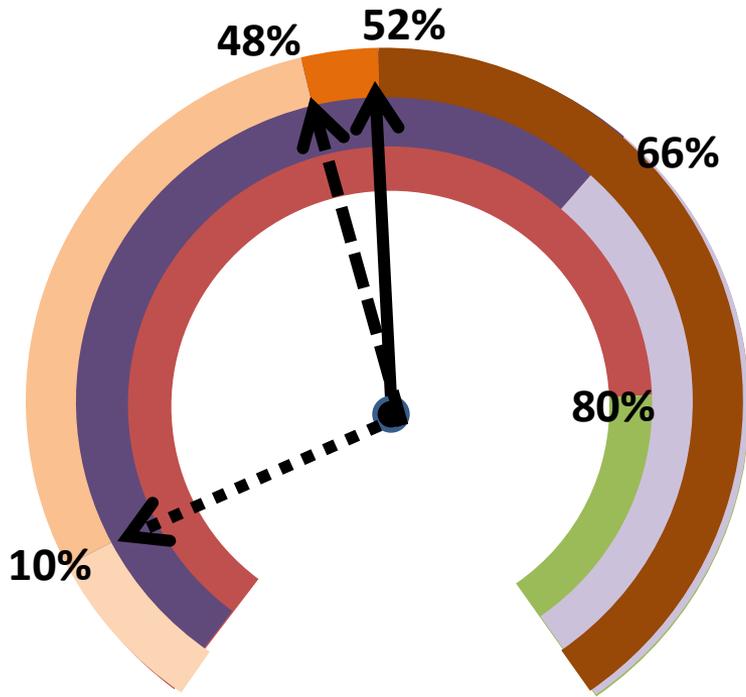


Statewide BRFSS Screening Rate (2008 & 2010 combined)



NCCRT Screening Goal

# Success: Summit Community Care Clinic



Clinic Results (P1, P2, P3)



Statewide BRFSS Screening Rate (2008 & 2010 combined)

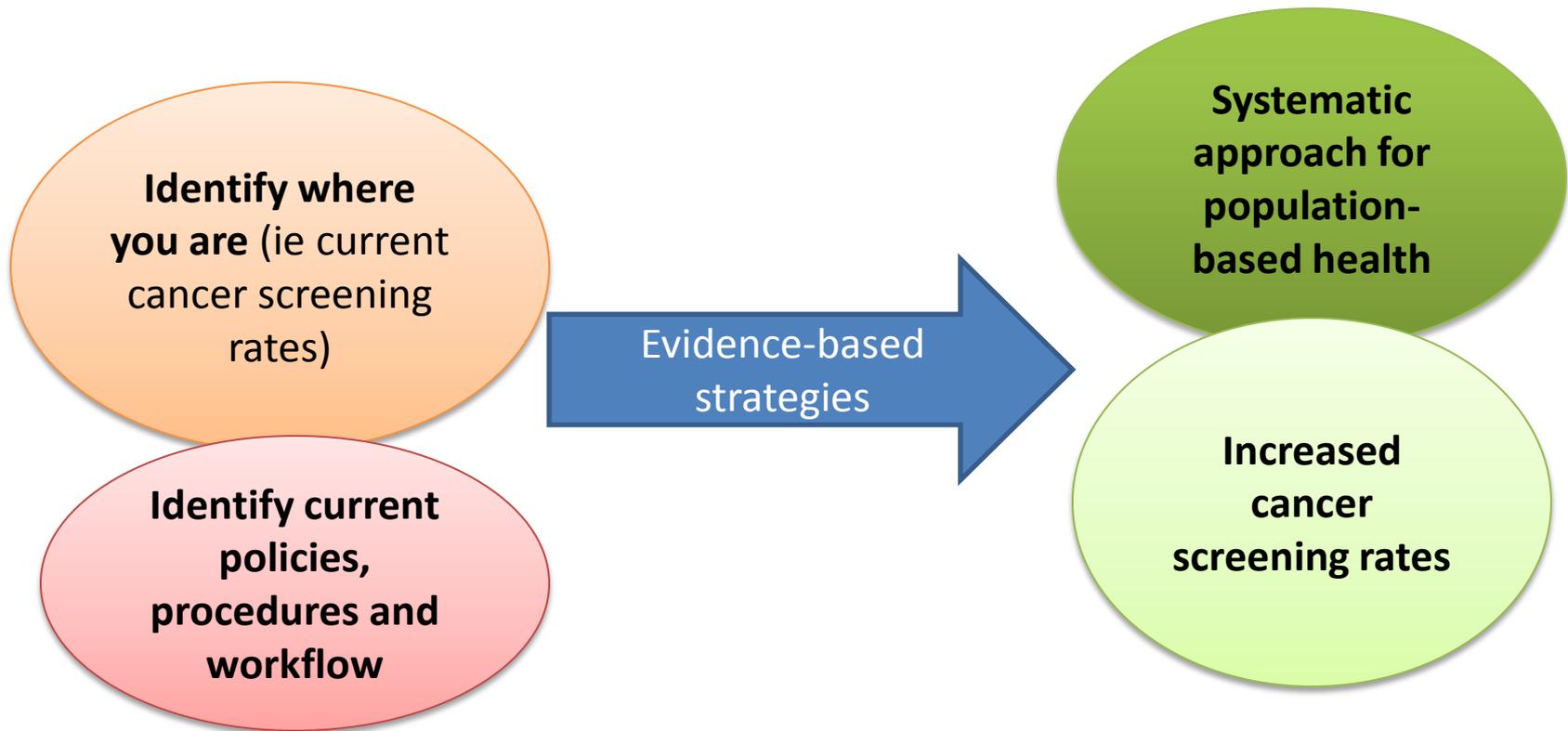


NCCRT Screening Goal

- The **overall CRC screening compliance** rate **quadrupled** (10% to 52%)
- The percent of clients receiving a **colonoscopy** **increased** (4.4% to 13.4%)
- The percent of clients receiving **FIT kits** **increased** (5.7% to 38.7%)

# In Summary...

Clinical quality improvement helps



# Benefits for YOUR clinic

- Good patient care and cancer screening resources
- Increase clinic reimbursements
- Reimbursement for staff time
- Technical assistance
- EHR modifications for improvement in reporting and data measurement
- Replicate process for other diseases...

# How I can help.....

- Identify areas of **clinical quality improvement** and **evidence-based strategies** to increase cancer screening rates **at YOUR clinic!**
  - Identify resources to help your clinic switch to a high-sensitivity FOBT/FIT
- **Promote cancer month awareness**, prevention and early detection



# **THANK YOU FOR YOUR TIME TODAY!**

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