



Improving Colorectal Cancer Screening Rates in North Dakota

Practical Policy



Quality Health Associates
of North Dakota

4 Essentials of Improving CRC Rates

Improve Cancer Screening Rates

USING THE FOUR ESSENTIAL STRATEGIES



Definitions

Bottom line, what is the message of a standing order?

We believe strongly that this screening test is so important that we want to assure that every single one of our patients who meet the screening criteria is offered the test.

- **Policy:** A deliberate system of principles to guide decisions and achieve rational outcomes; it is a statement of intent and implemented as a procedure or protocol
- **Protocol:** Standard that includes general and specific principles for managing certain patient conditions
- **Standing Order:** Allow patient care to be shared among non-clinician members of the care team, such as medical assistants and nurses. Often based on national clinical guidelines but customized for the clinic's patient population and care environment.



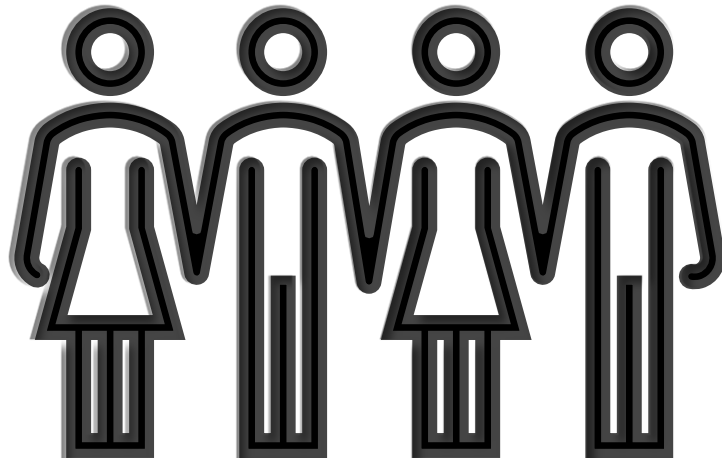
***How has having a screening policy
made a difference in your
screening rates?***

Dr. Jeff Hostetter

Monica Paczkowski

UND Center for Family Medicine

What is Team-based Care?



A group of healthcare professionals coordinating actions for a common purpose

Collaboration to prevent and/or treat disease and promote health

Actively engaging patients as full participants in their care

Encouraging all team members to work to the full extent of their education, knowledge, skills, and abilities

Practice Benefits of Team-Based Care

Increased efficiency
decreases team member
workload

Improve care quality

Improved patient outcomes

Decreased clinician
burnout/turnover

Importance of Providing Care in Teams



Deliver high value care



**Reduce duplication or redundancy
of services**



Prevent medical errors



Improve patient safety

What is Good Policy?

Template:

- ✓ Purpose
- ✓ Definitions
- ✓ Policy
- ✓ Procedures
- ✓ References

Consider:

- National screening guidelines
 - [USPSTF](#)
 - [American Cancer Society](#)
- Realities of your practice
- Patient history and risk level
- Patient preferences and insurance coverage
- Local medical resources
- Include guidance for distribution, tracking and follow-up of take-home test (FIT/iFOBT or mts-DNA)
- Documentation

Realities of your Practice

- Waiting room/exam rooms
- Patient Check-in
- During the Visit
- At Checkout
- Communication outside the office
- Tracking patient compliance

Why Standing Orders?

Problem

- Medical practice is demand (patient) driven
- Practice demands are numerous/diverse
- Few practices currently have mechanisms to assure that every eligible patient gets a recommendation for screening
- Screening rates are less for persons with less education, no health insurance, lower socio-economic status

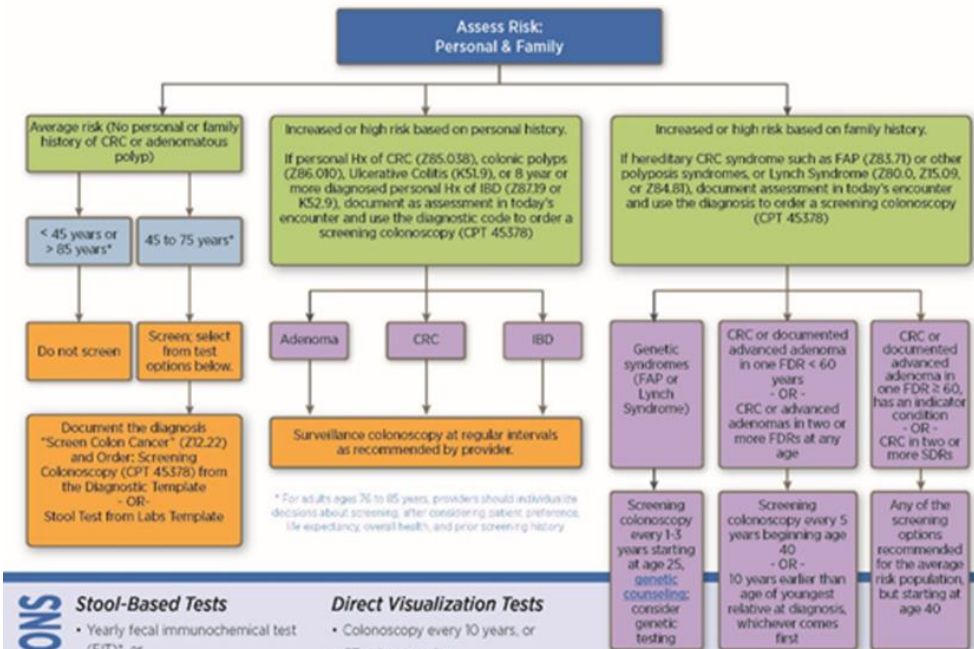
Solution: Standing Orders

- Divide the work
- Assures screening of all eligible patients
- Improve rates

A picture is worth 1000 words!

Sample Colorectal Cancer Screening Algorithm

Per the June 2021 USPSTF and May 2018 American Cancer Society Guidelines



SCREENING OPTIONS

Stool-Based Tests

- Yearly fecal immunochemical test (FIT)*, or
- Multi-target stool DNA (FIT-DNA) every three years, or
- Yearly high-sensitivity guaiac test (HS-gFOBT)*

* Stool samples obtained by digital rectal exam (DRE) have low sensitivity for cancer (missing 19 of 21 cancers in one study) and should **never be used for CRC screening**.

All patients who undergo a test other than colonoscopy as a first-line screening exam and receive a positive test result must follow up with a colonoscopy to complete the screening process.

Direct Visualization Tests

- Colonoscopy every 10 years, or
- CT colonography (virtual colonoscopy) every 5 years, or
- Flexible sigmoidoscopy every 5 years

For Medicare patients, use G codes:

- G0105** – Colonoscopy (high risk)
- G0121** – Colonoscopy (not high risk)
- G0328** – Fecal Occult Blood Test (FOBT), immunoassay, 1–3 simultaneous
- G0464** – Colorectal cancer screening: stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3)

DEFINITIONS

- IBD:** inflammatory bowel disease
- CRC:** colorectal cancer
- FDR:** first-degree relative
- SDR:** second-degree relative
- CTC:** computed tomographic colonography
- FAP:** familial adenomatous polyposis
- FIT:** fecal immunochemical test
- Hx:** history
- Screening colonoscopy** is performed on asymptomatic patients due for colorectal cancer screening because of age or familial risk indicators such as a family history of CRC or adenomatous polyps.
- Surveillance colonoscopy** is performed when a patient has an indicator condition or has had a personal malignancy or premalignancy that needs follow up and requires colonoscopy at more frequent intervals. Examples are Personal History of CRC (Z85.038) or Personal History of Colonic Adenomatous Polyps (Z86.010).
- Diagnostic colonoscopy** is performed when a patient has indicator condition requiring diagnostic workup that includes consideration of colon cancer as a potential diagnosis (i.e. persons with a history of rectal bleeding, anemia, or unexplained weight loss).
- An **advanced adenoma** is a lesion ≥1 cm in size or having high-grade dysplasia or villous elements.

NO Digital Rectal Exam Samples!

Use of DRE to collect a stool sample should NEVER be used.

Missed 19 of 21 cancers in largest study

- Dr. Durado Brooks, ACS (2016)

No guidelines recommend FOBT obtained by digital rectal examination as an adequate colorectal cancer screening test.

- Thad Wilkins, MD/ Peter L. Reynolds, MD; AAFP.org (2010)

“Screening for colorectal cancer following digital rectal exam **is not recommended and should not be done.**”

- Ang et al., The diagnostic value of digital rectal examination in primary care for palpable rectal tumour, Colorectal Disease, Volume 10, Number 8, October 2008 (UK)

Stool samples obtained by digital rectal exam (DRE) have a low sensitivity for cancer ...an should **never** be used for CRC screening.

- ND Colorectal Cancer Roundtable

A provider's guide to colorectal cancer screening - NCCRT

Option to cobrand the flyer with your logo!

A PROVIDER'S GUIDE TO COLORECTAL CANCER SCREENING



Do

- ✓ **Do** make a recommendation! Be clear that screening is important. Ask patients about their needs and preferences. The best test is the one that gets done.
- ✓ **Do** use the American Cancer Society or the USPSTF recommendations for colorectal cancer screening in average-risk adults, starting no later than age 50.*
- ✓ **Do** assess your patient's family history, medical history, and age.
- ✓ **Do** be persistent with reminders.
- ✓ **Do** develop standard office operating procedures and policies for colorectal cancer screening, including the use of EHR prompts and patient navigation.

** The American Cancer Society recommends starting colorectal cancer screening at age 45, while the USPSTF recommends starting at 50. Patients under age 50 should talk to their insurance provider about their coverage.*

Don't

- ✗ **Do not** use digital rectal exams (DREs) for colorectal cancer screening. In 1 large study, DREs missed 19 of 21 cancers.
- ✗ **Do not** repeat a positive stool test. Any abnormal finding should be followed up with a colonoscopy.
- ✗ **Do not** use stool tests on those with a higher risk. A colonoscopy must be performed.
- ✗ **Do not** minimize or ignore symptoms in patients younger than screening age. Evaluate and refer symptomatic patients to colonoscopy as needed, regardless of age.
- ✗ **Do not** forget to use non-clinical staff to help make sure screening gets done. They can hand out educational materials and schedule follow-up appointments.
- ✗ **Do not** forget to coordinate care across the continuum.

For more tools and resources, please visit nccrt.org or contact Kelly Durden, Georgia Colorectal Cancer Roundtable (GCCRT) project manager, at kelly.durden@cancer.org.



Peer Sharing

- What key points in your policy would you recommend to others?
- Did you find weaknesses in your policy that you would like to improve on?

Review your initial assessment:
Consider addressing the gaps in your policy!

Part VI: Rescreening					
	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
The clinic tracks when patients are due for regular CRC screening.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Staff ask about previous CRC screening if none are known or documented.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staff have a process for obtaining past screening results if unknown.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Resources for the Journey Ahead

Resources

- [USPSTF: CRC Guidelines](#)
- ScreenND.org:
 - ICC Screening Toolkit
 - QHA CRC Screening Policy Example
 - CRC Scening Standing Order Policy
 - Sample CRC Screening Algorithm
 - Sample Screening Algorithm
 - A Providers Guide to Colorectal Cancer Screening

Next Steps

- Action Plan: Policy Development or Review
- Evaluation (required for CEUs):
<https://screend.org/eval/c4m2>

**Next collaborative call: December 13th,
Matter of Choice**

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