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In the News

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With CRC Screening Rates on the Rise, Quality Control Becomes Center of Attention

by Monica J. Smith

New York—In just the past year, New York City has increased its colorectal cancer (CRC) screening rate by 6% and also has eliminated screening disparities between whites, blacks and Hispanics. But after acknowledging these accomplishments, the primary focus of the Sixth Annual Citywide Colon Cancer Control Coalition (C5) Summit, which took place in June, was assuring that these examinations are high quality as well as numerous.

“As clinicians, we all want to provide quality care to our patients and believe we do this every day,” said Felice Schnoll-Sussman, MD, director of research, Jay Monahan Center for Gastrointestinal Health at New York–Presbyterian Hospital/Weill Cornell Medical Center, New York City, before the 250 people gathered for this year’s summit. “But it’s not until you take a really careful look at your practice that you recognize there is always room for improvement.”

In 2008, according to a survey administered by the New York City Department of Health and Mental Hygiene (DOHMH), 66% of the city’s citizens aged 50 years or older had been screened in the previous 10 years—a marked jump from 42% in 2003 and a few steps closer to meeting the screening rate goal of more than 80% by 2012.

This achievement is the result of a multipronged approach.

“Someone said many years ago that to achieve success at screening, it takes a village. One person, one project, one message at a time is not sufficient,” remarked Sidney Winawer, MD, Paul Sherlock Chair in Medicine, Memorial Sloan–Kettering Cancer Center, New York City. “So what the New York City campaign and C5 have done is mounted multiple programs with repetitive messages by various methods over the years.”

Those methods have included intensive public education campaigns, advertisements atop New York taxis, an annual footrace in Central Park and the inclusion of CRC screening information through 311, the same number New Yorkers call to report a pot hole or find a beach.

Outreach to physicians is equally important.

“We’ve incorporated something about C5 each year at the [New York Society for Gastrointestinal Endoscopy] course, and many of us have given medical Grand Rounds about CRC screening at various hospitals,” Dr. Winawer said. Additionally, many New York hospitals have established patient-navigator programs, and the pilot program for direct referral is beginning to have an impact (see “Skipping the Middle Consult: Direct Referral Program Dramatically Improves Colonoscopy Wait-Times and No-Show Rates,” page 24).

The success of C5’s work has been emulated by other areas in the United States. For example, Louisville, Ky., has been working on a C5-type program for a few years now, and physicians in Houston and Las Vegas have inquired about or have initiated similar programs.

“So C5 is becoming a model,” Dr. Winawer said. “We’re very proud of it.”

Not Just About the Numbers

“We have, we hope, an unrelenting focus on finding strategies that will get people screened,” said Marian S. Krauskopf, MS, director, Cancer Prevention and Control Program, DOHMH. “But simultaneously, because we have so many people being screened, we increasingly feel that we want to pay attention to the quality of those procedures, not just to the numbers being done.”

Quality hinges on several variables, Dr. Winawer explained. “Part of that is outcome, in terms of performance, preparation and completeness of the colonoscopy, and also indicators of the quality of the colonoscopy, primarily the mean adenoma detection rate by the individual and by the endoscopic unit in nontherapeutic and therapeutic colonoscopies.”

“Quality” seems to be the buzzword of the year, partly because of patient concerns since the lay press reported on studies suggesting that endoscopists may not be finding polyps during colonoscopy. In particular, Canadian study that found a high rate of missed polyps caused quite a stir in the patient population (Baxter NN et al. *Ann Intern Med* 2009;150:1-8).

“The patients … come into your office and say, ‘Are you going to find my right colon polyps, and how much time do you take on your withdrawal?’ They ask, and they are the big driver of this system that will keep this moving forward,” said Jonathan Cohen, MD, clinical professor of medicine, New York University Medical Center, New York City.

There are limitations in the Baxter study, such as the fact that only 30% of the examinations were performed by highly trained gastroenterologists. But less publicly high-profile (i.e., not covered by *The New York Times*) tandem studies have long documented inconsistencies in finding lesions (Hixson LJ et al. *J Natl Cancer Inst* 1990;82:1769-1772; Rex DK et al. *Gastroenterology* 1997;112:24-28).

“There’s a paradox when it comes to care, and specifically when it comes to colonoscopy,” Dr. Schnoll-Sussman said. Colonoscopy may be the most effective method for CRC screening, but there can be a wide variation in performance that can affect outcomes, she said.

Another paradox is that the most commonly studied quality indicator for colonoscopy is the cecal intubation rate, Dr. Schnoll-Sussman added. “When a gastroenterologist is in training as a fellow, one of the things that they take pride in is if they made it to the cecum.” Making it to the cecum is important, but it doesn’t guarantee a quality examination of the mucosa. Other quality indicators need to be documented as well. If they are performing quality examinations every time, for example, gastroenterologists should detect adenomas more than 25% of the time in men and more than 15% of the time in women over the age of 50.

“This seems like an easy thing to look at; but the fact is, gastroenterologists don’t usually ask themselves, ‘How often am I finding polyps?’ ” Dr. Schnoll-Sussman said. This reflection on one’s practice and the rate at which polyps are found often can be lost in the day-to-day routine.

“So, if we’re missing lesions, the next question is, ‘Why?’ ” That point of pride, the cecal intubation rate, is indeed a factor. “An effective endoscopist should be able to intubate the cecum more than 95% of the time” and document visualization of the ileocecal valve and the appendiceal orifice, she said.

But no matter how perfect the intubation, an ideal exam can be thwarted by visual obstruction.

“Poor bowel prep is a major impediment to the effectiveness of colonoscopy,” Dr. Schnoll-Sussman said. “I know patients try their best to do a good job at prep, but that is the hardest part of the procedure.” Despite improvements in some preparations, they are all difficult.

Split dosing seems to improve preparation, as does consumption of a lot of fluids. “That’s important because it enhances the purge,” Dr. Winawer said.

Practitioners can take steps to increase the likelihood of patients achieving a good prep, such as reviewing instructions in detail and providing them written take-home materials. It also is important to mentally prepare patients for the work involved with an adequate preparation. Dr. Schnoll-Sussman recommends discussing ways to make the preparation easier, such as preparing Jell-O and broths ahead of time and having tasty juice ice pops

and comfortable toilet paper in the house. “If they are aware of how the prep can make or break the exam, they are more motivated to comply completely,” she said.

Adenoma detection also may be contingent on the length of time of colonoscope withdrawal. As a measure of quality, withdrawal time is a changing concept. Early reports suggested a withdrawal time of six minutes or more; later reports indicated eight minutes as a minimum.

“More recent studies indicate that withdrawal per se is not important by itself, but seems to correlate with the nature of the examination or endoscopist,” Dr. Winawer said. “People who have longer withdrawal times appear to have a more meticulous examination and a higher rate of adenoma detection.”

In addition to variations in bowel preparation quality, cecal intubation and examination time, another quality issue recently reported in the literature is the potential for missing polyps. “One important consideration is that not all the lesions endoscopists find are like little mushrooms or big pedunculated polyps,” Dr. Schnoll-Sussman said. “Endoscopists also need to be vigilant in detecting lesions that are flat or depressed, some of which may harbor greater risk for cancer progression.”

With reimbursements on the wane, practitioners might attempt to make up for that loss by seeing more patients, which would dictate spending less time with each one.

“In this setting, it is especially important for gastroenterologists to ensure that the appropriate time is taken for each individual procedure and patient,” Dr. Schnoll-Sussman said.

Also important is the time *between* examinations—that is, surveillance.

“Multiple surveys indicate that post-polypectomy surveillance colonoscopy in the United States is frequently performed at shorter intervals than what are recommended in the guidelines,” Dr. Schnoll-Sussman said. “For colonoscopy to be cost-effective, and to minimize the risk, the interval between exams should be optimized.”

Quality-Control Initiatives

With that broad understanding of quality in CRC screening, C5 is moving forward with goals that stress quality measures as they apply to New York City.

“Our goals were to better understand the current environment in New York City,” said Dr. Schnoll-Sussman, including reviewing the established quality measures set out by various organizations, deciding which of those measures would apply to New York City and devising a plan of action to implement those measures.

C5 established a Quality Task Force that affirmed the C5’s commitment to launching a quality initiative in New York City and agreed that measuring a few key quality outcomes is

the best approach. The key outcome measures recognized as specifically important are as follow:

- patient consent;
- ensuring that patients have written instructions they can understand;
- quantification of type and quality of bowel preparation;
- assessment of American Society of Anesthesiologists status;
- photo documentation of cecal intubation;
- measurement of withdrawal time; and
- measurement of adenoma detection rate.

“For New York, we recognized that quantifying demographics—including gender, race, ethnicity and insurance status—was very important,” Dr. Schnoll-Sussman said.

Among the next steps for C5 is identifying ways for New York City to systematically collect data on quality measures (see “Nationwide Benchmarking Pilot Program Drives Participants To Improve Quality,” page 18).

“It’s nice to have an increase in screening colonoscopy, but we want to be sure we’re finding more of the important lesions,” Dr. Winawer said. “We didn’t discuss [outcomes] that much at the summit—we’ll probably discuss it more next year when we have more data.”

Next year’s summit will be another critical landmark for C5 as the coalition examines the results of its initiatives—the expanded patient-navigator program, quality indicators, the direct referral pilot program and an analysis of colonoscopy findings.