One Colonoscopy – One Phone Call
Making Open Access Colonoscopy a Reality!

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Disclosure: Partner, Hershey Endoscopy Center

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Objectives: Open Access Endoscopy (O.A.E.)

1. Rationale behind open access colonoscopy for colorectal cancer screening
2. “Nuts and bolts” of O.A.E.
3. Lessons from NYC

O.A.E.- Key Points

- Direct access to endoscopic procedure without a prior office visit to gastroenterologist
- Procedure, not a consultation
- “One stop shopping”
- Takes a system to do correctly

Historical Perspective:

Mid 1990’s
AGA manpower assessment
“too many GI docs”!
“retrain for internal medicine”?
ACGME increased GI training from 2 to 3 years plus increased training requirements

Result → Decreased training slots ~ 40%
Historical Perspective:
1997, CMS* provided coverage for CRC screening colonoscopy in average risk individuals
Private insurers followed suit
Routine pre-procedure visits not covered
*Balanced Budget Act, 1977

Historical Perspective
U.S. Preventive Services Task Force 1996
GI Consortium 1997
American Cancer Society
“Screening for colorectal cancer and adenomatous polyps should be offered to all men and women without risk factors beginning at age 50.”

USPSTF 2002
“strongly recommends that clinicians screen all men and women 50 years of age or older for colorectal cancer. This is a grade A recommendation.”
“The benefits from screening substantially outweigh potential harm.”
“Colorectal cancer screening is likely to be cost-effective (<$30,000 per additional year of life gained) regardless of the strategy chosen.”
A/M 2002;137:129-131
Average Risk Screening for Colorectal Cancer

All males and females above 50 years of age without high risk factors

CRC SCREENING EARLY DETECTION & PREVENTION

Early Detection ➔ Decreased Mortality

Prevention = adenoma removal ➔ Decreased Incidence

USPSTF 2008 : CRC Screening Tests / Intervals

• Annual screening with high-sensitivity FOBT
• Sigmoidoscopy every 5 years, with high-sensitivity FOBT every 3 years
• Screening colonoscopy every 10 years
### Sensitivity of One-Time CRC Screening Tests

<table>
<thead>
<tr>
<th>Stool-Based Tests</th>
<th>Cancer %</th>
<th>Advanced Adenoma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitive guaiac (FOBT)</td>
<td>50 – 75 %</td>
<td>20 - 25</td>
</tr>
<tr>
<td>Fecal immunochemical</td>
<td>60 – 85 %</td>
<td>20 - 50</td>
</tr>
<tr>
<td>Stool DNA</td>
<td>80 %</td>
<td>40</td>
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<table>
<thead>
<tr>
<th>Structural Exams</th>
<th>Cancer %</th>
<th>Advanced Adenoma</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT colography</td>
<td>&gt; 90</td>
<td>90 (≥ 10mm)</td>
</tr>
<tr>
<td>Sigmoidoscopy</td>
<td>&gt; 95 (distal)</td>
<td>70</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>&gt; 95</td>
<td>88 - 98</td>
</tr>
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Adopted from Lieberman. NEJM 2009 361:1179-1187

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### POLYPECTOMY REDUCES INCIDENCE OF CRC IN STANDARD CLINICAL PRACTICE

<table>
<thead>
<tr>
<th>Gender</th>
<th>RR (95% CI)</th>
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<tbody>
<tr>
<td>Males</td>
<td>0.31 (0.20-0.69)</td>
</tr>
<tr>
<td>Females</td>
<td>0.41 (0.22-4.00)</td>
</tr>
<tr>
<td>Total</td>
<td>0.34 (0.23-0.63)</td>
</tr>
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(1015 subjects underwent polypectomy, 1980-87) compared with expected age and sex-specific incidence (1996) reported in population.


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### Risk of CRC After Negative Colonoscopy

<table>
<thead>
<tr>
<th>Time (yrs.)</th>
<th>Reduced RR CRC</th>
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<tbody>
<tr>
<td></td>
<td>Right-sided</td>
</tr>
<tr>
<td>1-2</td>
<td>0.28</td>
</tr>
<tr>
<td>3-4</td>
<td>0.25</td>
</tr>
<tr>
<td>5-9</td>
<td>0.40</td>
</tr>
<tr>
<td>10-19</td>
<td>0.29</td>
</tr>
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</table>

"...declines in CRC death rates are consistent with a relatively large contribution from screening and with a smaller but demonstrable impact of risk factor reductions and improved treatments." *

"colorectal cancer is one important disease in which racial and socioeconomic disparities in outcomes can most readily be eliminated by ensuring that all eligible adults are effectively screened and abnormal findings are fully treated."‡


### Colorectal Cancer Screening Percentages

**Demographic and Access**

<table>
<thead>
<tr>
<th>Demographic/Access</th>
<th>Overall</th>
<th>58.6 (57.3 - 59.9)</th>
<th>White</th>
<th>59.8 (58.4 - 61.2)</th>
<th>Black/African American</th>
<th>55.0 (51.7 - 58.2)</th>
<th>American Indian/Alaska</th>
<th>49.5 (35.3 - 63.8)</th>
<th>Chinese</th>
<th>41.3 (28.8 - 55.0)</th>
<th>Hispanic</th>
<th>46.5 (42.9 - 50.2)</th>
</tr>
</thead>
</table>

**National Health Interview Survey, United States, 2010**
Colorectal Cancer Screening Percentages
Demographic and Access
National Health Interview Survey, United States, 2010

Education
Less than high school  44.6  (41.5 - 47.7)
High school graduate  53.6  (51.4 - 55.9)
College graduate  67.3  (65.0 - 69.5)

Usual source of care
Health insurance  58.7  (57.4 - 60.0)
Private / Military  65.0  (63.4 - 66.5)
Uninsured  20.7  (17.9 - 23.8)

CRC Screening :
What’s being done ?

CRC Screening Strategies
One Stage  Two-Stage
Colonscopy  FOBT  Flex. Sig.
            CTC  Stool DNA

Colonscopy
Open Access Colonoscopy

Advantages:
- PCP - simplifies / increases CRC screening
- Patient - 1 instead of 2 or 3 visits
- GI Providers - increases endoscopy time

Disadvantages
- PCP - appropriate referrals ?
  eliminates CRC screening choices?
- Patient - lacks patient-physician relationship
- GI Provider - poorly-referred, informed, and prepped patients

Open Access (OA) Endoscopy

Benefits:
- Reduces costs/inconvenience

Requires:
- Trained and dedicated staff to avoid inappropriate procedures and bridge loss of physician/patient dialogue
Successful Open Access Colonoscopy

Patient arrives well-informed, confident, and well-prepped

Keys to success for OAE

• Educate referring providers and their office staff
• Develop a written screening checklist for scheduling
• Use a dedicated OA scheduler
• Send letters to non-responders
• Give clear instructions for bowel preparations
• Send thorough and clear educational materials to patients
• Being comfortable with your informed consent

Open Access Colonoscopy Scheduling Form

- procedure, indication, time frame
- medical issues
- CRC risk factors
  age, family history, IBD
Pre-Endoscopy Evaluation Required

- Age > 75 years
- MI / Stents / CABG
- Dialysis
- Can’t climb 1 flight steps / angina
- Antiplatelet* / coagulation agents
- COPD (FEV1 < 10)
- Defibrillator / pacer
- Sleep apnea on CPAP
- IDDM
- HCT < 30 %

*ASGE Guideline: Aspirin and/or NSAIDs may be continued for all endoscopic procedures.

Dedicated OA Scheduler (RN, Mid-Level)

- Phone Contact
- Provides information, instructions, pre and post expectations, preparation
- Reviews medical history
- Mails educational material, prep instructions, schedule
- Okay for OA?
Mailing information

- Time and date
- Educational materials
- Pre-op instructions
- Bowel prep
- Map to endoscopy center
- Contact information; 24/7
O.A.E.

Contraindications:

- Not routine screening or surveillance procedures
- Medical issues
  - Anticoagulation
  - Implantable intracardiac devices
  - Tenuous cardiopulmonary status (ASA Class)
- Personal issues
  - Desire to meet endoscopist prior to procedure

O.A.E.

Responsibility of the endoscopy center

- Appropriate indications
- Educated / assured patients
- Financial clearance
- High quality endoscopy
- Follow-up communication to PCP and patient
- Recommendation for further screening / surveillance
- Continued quality improvement
Open Access Endoscopy

Is it safe?

PA Safety Reporting System
Hershey Endoscopy Center, 2011

- Open Access 0.74% (13 events/1745 procedures)
- Clinic Patients 1.28% (7 events/548 procedures)
- All Patients 0.95% (25 events/2634 procedures)

Central PA
Open Access Endoscopy

8 GI Practices contacted

2 No (1 will start 2012)
4 Yes*
2 No response

*Larger practices

Notes:
Direct phone line staffed for open access
Dedicated outreach program
EMR—“One-click GI referral”

New York City

Citywide
Colon Cancer Control Coalition

Department of Health and Mental Hygiene
2003
CRC Screening: The NYC Experience “C5”

In 2003, recommended colonoscopy as preferred screening test with FOBT as alternative

- Patient navigators
- Direct endoscopy referral
- C5 visited doctors’ offices, and public education (radio, subway ads), also civic groups and churches
- Funds for un- and under-insured

GOAL: By 2010, 80% of eligible New Yorkers will be screened for colorectal cancer

Need to increase referrals coming from the primary care office

NYC C5

Barriers to CRC screening
The primary care perspective

- Time, Time, Time
- Clinician education
- Primary care office supports
- Patient resistance

NYC C5
Time facts

- Pap smear takes 5 minutes to perform
  - 5 minutes / year x 10 years = 50 minutes

- Mammogram takes 3 minutes to order
  - 3 minutes / year x 10 years = 30 minutes

- Colonoscopy takes 10 minutes to explain options, order test, prescribe prep and instructions
  - 10 minutes every 10 years = 10 minutes

What takes time:

- Educating patients about need for screening
- Explaining options for screening
- Providing more detailed explanation of chosen option
- Prep instructions and prescriptions
- Insurance and authorizations
- Uniform referrals / prep forms simplify process
- Need the referral process to become “second nature” to all involved staff

Patient convenience

- Open access colonoscopy eliminates barrier of a separate office visit; saves time and money!
- **Physician recommendation is a key**

NYC C5
Hospital Reimbursement and a Requirement

- Reimbursement rate: $600 per screening colonoscopy
- All participating hospitals agree to provide treatment services to any patient diagnosed with cancer through this program

American Cancer Society, NYC C5

GI Practice Implementation

- Intake form
- Scheduling
- Prior authorization / insurance clearance
- Reporting of results (referring provider, patient, research database)
- Referrals (cancers, incidental findings)
- Follow-up intervals, call back system

NYC C5

NYC Approach

- Open Access Endoscopy
  - Direct referral form faxed by Primary Care Provider
  - Reviewed by Gastroenterologist
  - Appropriate cases given to Patient Navigator

- Patient Navigator does the following:
  - Step 1: Scheduling Phone Call
  - Step 2: Reminder Postcard
  - Step 3: Two Week Reminder Call
  - Step 4: Three Day Reminder Call

NYC C5
Colonoscopy in NYC
Progress Toward 2012 Goal

*New Yorks 50+ who report having had a colonoscopy in the past 10 years. Source: NYC Community Health Survey 2005-2009. Results are age-adjusted. CHS has included adults with landline phones since 2002 and, starting in 2009, also has included adults reachable only by cell phone.

Assessment: Survey

- Most patients who agree to undergo colonoscopy are amenable to direct referral
- The referral form was helpful in identifying which patients should be referred directly
- Overall the referral process was user-friendly
- Having this option available increased the number of colonoscopy referrals I make
- The direct referral from improved patient care
- Materials for bowel preparation and liquid diet were sufficient

NYC C5

Referring Provider Survey

NYC C5
Patient Survey

Endoscopist Survey

Colonoscopy Trends
NYC vs. U.S.
Patient Navigator

- 64% of patients would not have completed colonoscopy without the assistance of the Patient Navigator
- Felt the procedure had been explained:
  - by PCP: 84.2%
  - by PN: 92.1%
- Understood bowel prep:
  - by PCP: 34.9%
  - by PN: 58.5%
- Satisfied with bowel prep explanation:
  - by PCP: 83.0%
  - by PN: 99.1%

Technical Issues Improved by Navigation

- Prep Quality: Inadequate or Poor
  - Pre-Navigation: 12%
  - Post-Navigation: 4.7%
- No-Show Rates
  - Pre-Navigation: 40%
  - Post-Navigation: 15%

Patient Navigator: Impact of Improved No-Show Rate

- Assuming 2,500 colos per year:
  - 40% no-show without PN: 1,000
  - 15% no-show with PN: -375
  - More complicated colos: 625*

Revenue from facility fees:
- @ $700 per case: $437,500

*14 more cases / week
**Why the Uninsured?**
Access and Cancer Screenings

<table>
<thead>
<tr>
<th>Test</th>
<th>uninsured</th>
<th>underinsured</th>
<th>insured</th>
<th>regular provider</th>
<th>not both</th>
<th>neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pap, past 3 yrs (all women)</td>
<td>83</td>
<td>60</td>
<td>78</td>
<td>63</td>
<td>41</td>
<td>21</td>
</tr>
<tr>
<td>Mamm, past 3 yrs (women 45+)</td>
<td>56</td>
<td>43</td>
<td>58</td>
<td>42</td>
<td>21</td>
<td></td>
</tr>
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Percents are age-adjusted
Source: NYC DOHMH Community Health Survey 2004-2005
American Cancer Society

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**Program Purpose**

- Provide screening colonoscopies to uninsured and underinsured New Yorkers;
- Provide colonoscopy screening navigators through NYC DOHMH Program
- Provide ACS patient navigation services to cancer patients

American Cancer Society, NYC C5

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**NYC C5 Project Summary**

- Open access colonoscopy has increased screening rates in institutional settings
- Aim to reproduce that success by facilitating open access colonoscopy in community settings where most colonoscopy takes place
- C5 can develop partnerships with outside organizations to facilitate referrals and measure outcomes
Blue Ridge Regional Colonoscopy Initiative
Health Net Federal Services, LLC
TRICARE® North Region

About Health Net Federal Services, LLC and the Colorectal Cancer Screening Initiative

- Heath Net Federal Services, LLC (Health Net) is the managed care support contractor for the TRICARE North Region, partnering with the Military Health System and civilian network providers to offer health care to over 3 million military beneficiaries.
- TRICARE provides coverage for colonoscopy screening without a referral or copayment/cost-share.
- Rates of colorectal cancer screening in the North population are just slightly lower than the national average (est. 61%).

Stay Healthy With Health Net Key Steps

- Partnered with seven endoscopy centers in the Blue Ridge area.
- Faxed notifications of the initiative to 468 primary care managers (mostly physicians) who had overdue patients.
Stay Healthy With Health Net Key Steps

- Mailed letters to 2,868 TRICARE beneficiaries:
  - Alerted them to overdue status and the benefit coverage.
  - Included general information about colorectal cancer screening.
  - Listed information about local endoscopy centers, including hours and phone numbers.

Summary

Colorectal Cancer Screening
Open Access Endoscopy
Increases access and convenience for patients and providers

As a practitioner, your recommendation is the single most influential factor whether a person receives screening!

Thank you!

Questions?

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