



Navigating Colorectal Cancer Doesn't Need to Be A Pain in the Butt

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Background

It is estimated that almost 140,250 new cases of large bowel cancer are diagnosed each year in the United States. Almost 100,000 will be colon and 40,000 will be rectal. Of those diagnosed, over 50,000 Americans will die from large bowel cancers every year. This makes colorectal cancer the third most common cancer death for women and the second leading cause of cancer death in men in the United States.

Once a diagnosis of cancer is made, this can be a very lengthy and consuming process. There are many providers working together to treat the patient. These typically include the PCPs, GI specialists, radiologists, surgeons, and oncologists. For each specialist, certain imaging and labs are important for planning and treatment.

For my surgery practice, the three most important imaging/labs needed were colonoscopy for diagnosing the cancer; CT chest, abdomen, pelvis for staging and surgical planning; and the CEA to help monitor the disease process.

Anytime these are missing from an initial visit, it requires the surgeon to refer the patient out and then the patient returns for additional visits which add more time, energy, and steps before surgery.

Innovation Objectives

- My objective was an aggressive undertaking to find a way to ensure patients entering for their initial encounter with the surgeon had these three components to streamline the process from diagnosis to surgery and in turn help with value care and quality of the experience for the patient.

Program Description

- The first part of the project was gathering the data. We looked at what imaging and labs patients completed before the initial visit. We looked at number of visits with surgeon before surgery. And finally, we looked at time from initial visit to surgery.
- Next we brainstormed possible ways to tackle the issue which included contacting providers who refer the patients in, contacting patients, and changing referral process.
- I worked closely with the scheduler to identify new patients coming in and including a pamphlet in their welcome packet.

Looking at the Evidence

Types of Imaging/Labs Used

CT Chest, Abdomen, Pelvis

MRI

PET Scan

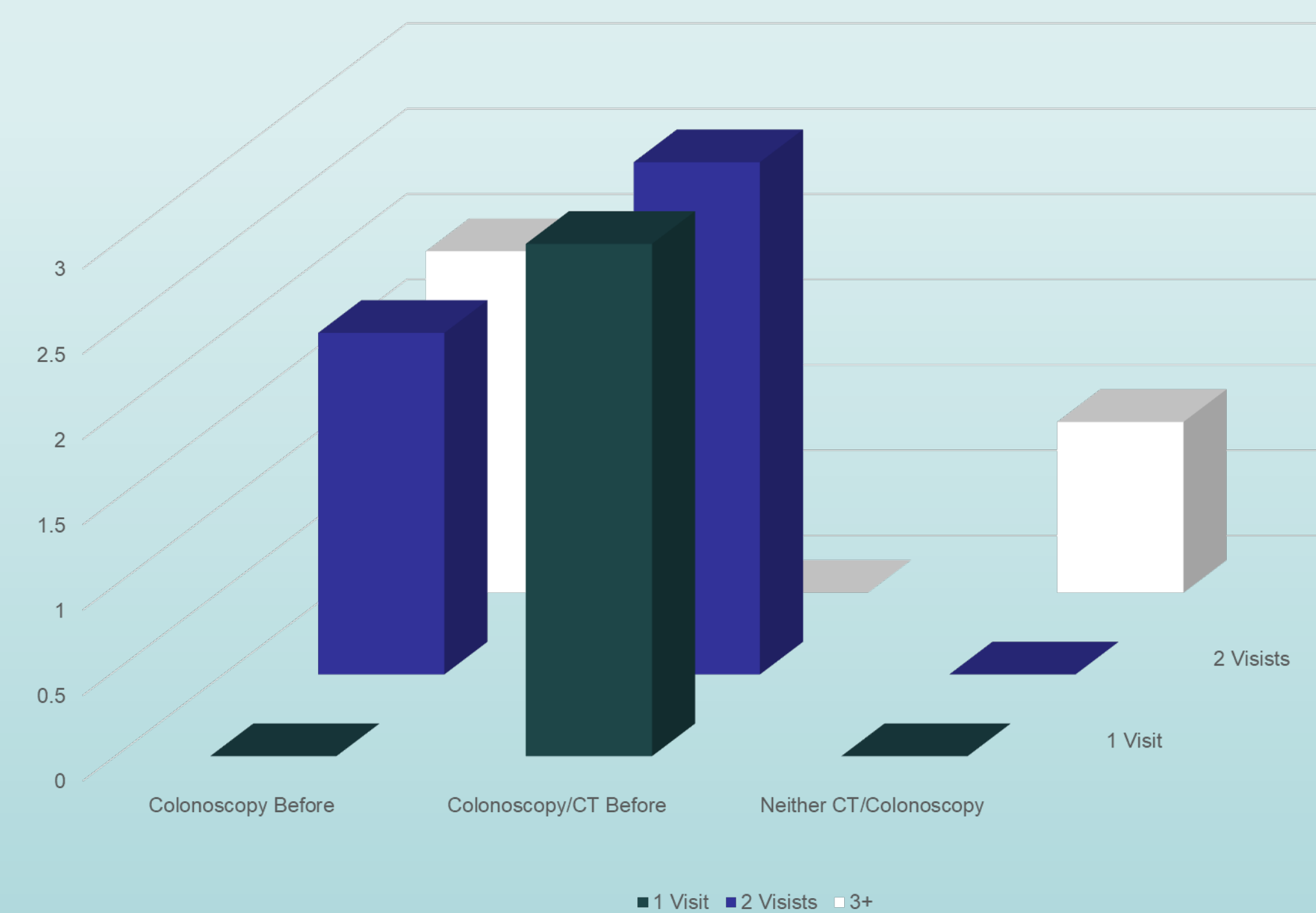
Colonoscopy

Flexible Sigmoidoscopy

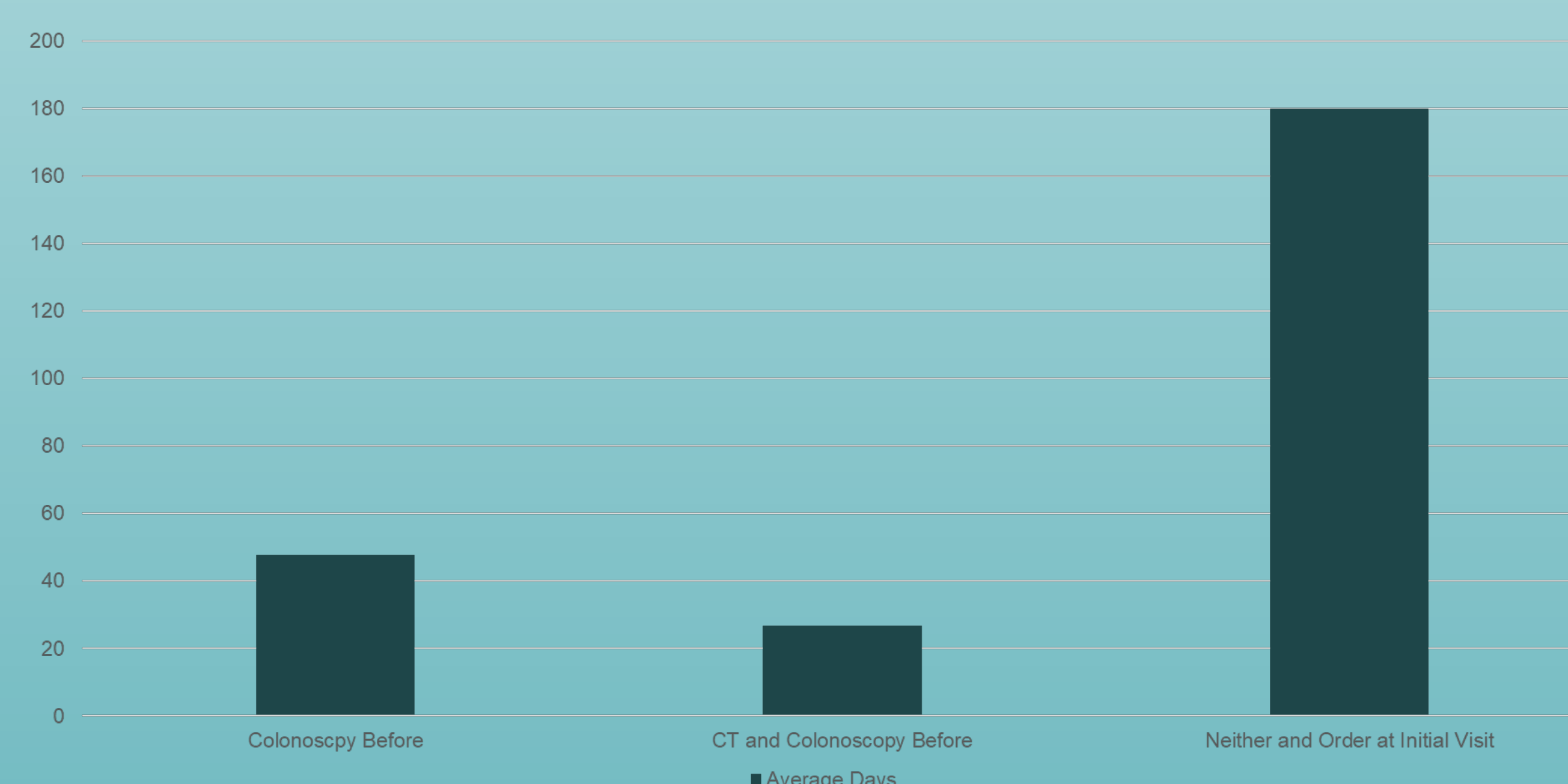
Rigid Sigmoidoscopy

Tumor Markers CEA

Number of Visits Compared to Imaging Completed Before Initial Visit (n = 11)

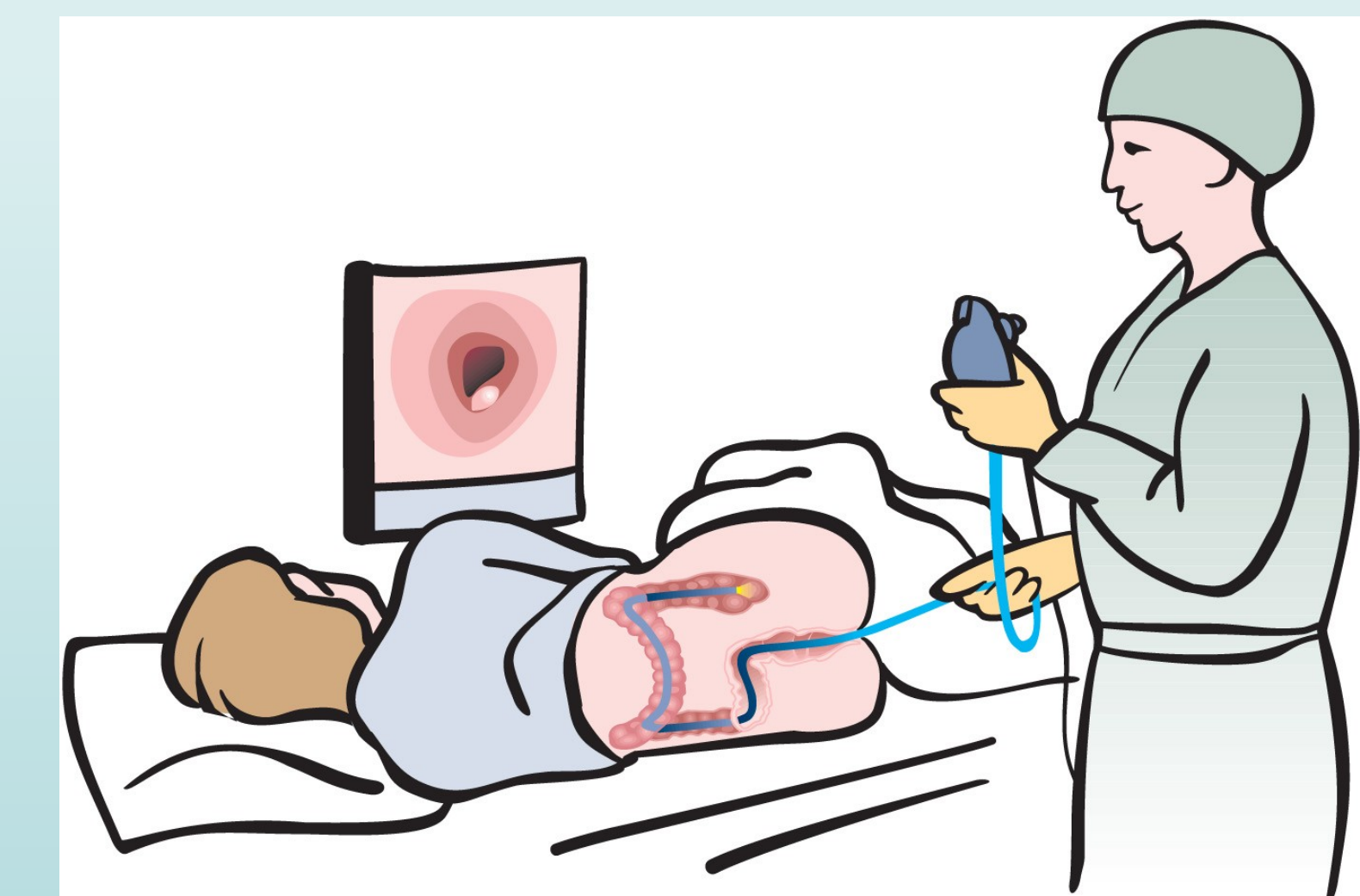


Average Time Between Surgery and Initial Visit (n = 11)



Discussion

- The scope of this QI project was very challenging for several reasons, most notably is the amount of time needed to evaluate the effectiveness of the changes.
- We discovered patients who had completed their CT and colonoscopy before the initial meeting had less visits with the surgeon before surgery and had less days between initial visit and surgery compared to patients who had only completed one or neither.
- We quickly learned, patients are referred in by multiple sources both in the community and regions making contacting them individually inefficient at affecting positive change.
- Our most important lesson learned was patient health literacy limited the effectiveness of asking patients to ensure completed imaging. This led to us modifying our original pamphlet to a helpful informational guide for the new patients to help explain the process.



Conclusion

Targeted improvements should focus on improving the gaps between providers in the community and the surgeon to better serve the patients. The problem with the delay in treatment is a communication error between providers.

References

Kloos, N., Keren, D., Gregg, S., Maclean, A., Dixon, E., Mohamed, R., . . . Ball, C. (n.d.). Can we improve the efficiency of care in patients with colorectal cancer from the time of their initial referral for colonoscopy to surgical resection? *Canadian Journal of Surgery = Journal Canadien De Chirurgie.*, 62(1), E4-E6.