

Executive Summary

The Colorectal Cancer Quality Enhancement Research Initiative (CRC QUERI) mission is to promote the translation of research discoveries and innovations into patient care and systems improvements in order to reduce the incidence, late detection, suffering, and mortality from colorectal cancers among all veterans. Success at achieving this mission is defined as creating measurable, rapid and sustainable improvements in colorectal cancer prevention, early detection, treatment, supportive care, palliative care, and patient-centered outcomes. The CRC QUERI is funded jointly by VA and the National Cancer Institute; thus, unlike other QUERI Centers, we have both non-VA and VA executive committee members and are advancing our goals through projects both inside and outside of the VA.

Colorectal cancers (CRC) rank second among causes of cancer deaths, account for approximately 11% of all new cancer cases, and are the third most common cancers among men and women in the U.S. The 5-year survival rate is over 90% for people whose colorectal cancer is found and treated in Stage I and 5% for people with Stage IV disease. Only one third of colorectal cancers are found at an early stage, in large part due to low rates of screening and complete diagnostic evaluation (CDE). Furthermore, screening and CDE rates are unequally distributed by race/ethnicity and SES, with African Americans at greatest disadvantage. These figures are especially tragic given the *strong evidence base* that colorectal cancer screening (CRCS), followed by CDE and treatment, can substantially lower incidence and mortality rates.

The complete process of CRCS, CDE, and treatment is necessary for any benefit to occur. While the VA Office of Quality and Performance (OQP) reports that FY 2003 compliance with the CRCS performance measure averaged 67%, findings from CRC QUERI studies over the past two years indicate that 54% of veterans with positive screening results fail to receive CDE within six months. Since CDE rates are lower than screening rates, and screening is useless without CDE, **our first goal is to improve the rate of CDE following a positive initial screening test.** Data from our Colorectal Cancer Screening and Follow-up Event data system (CRC SAFE) indicate that the reasons for CDE failure vary by facility. Thus, there is no “one size fits all” intervention. The low CDE rate in some facilities is due to lack of provider referral to CDE while in another it is primarily due to lack of appointment completion. In the past year we have used Center resources to make significant progress toward understanding factors contributing to CDE deficits and developing an integrated, conceptually driven approach to improving CDE rates. We have recruited a network of researchers interested in diverse aspects of CDE, we have implementation projects underway, and are developing more to be proposed over the next two years. These projects include efforts to increase communication of screening

results among patients, primary care, laboratory, and GI providers, efforts to improve and streamline referral processes, identify patients at risk for CDE non-completion, improve patient compliance with CDE prep, and improve patient adherence with CDE appointments.

Our second goal is reducing variation in, and improve CRC guideline-adherent screening rates. OQP reports FY 2003 compliance with the CRCS performance measure averaged 67% ranging from 57% to 74% at the VISN level and 38% to 88% at the facility level. CRC QUERI is committed to reducing this variation and raising performance levels at all VHA facilities. Our current activities involve in-depth diagnosis projects intended to guide implementation strategies to increase CRCS in facilities that have high CDE rates and adequate capacity to support the increased demand for CDE that will accompany higher CRCS rates. Projects include qualitative analysis of audiotaped CRC screening discussions between patients and providers, examination of organizational factors associated with rates, development of the CRC SAFE data system, and patient and provider surveys.

Our third goal is to improve the quality of cancer care and reduce suffering and mortality among CRC patients. Unfortunately, there are major gaps in the evidence base for colon and rectal cancer treatment depending on stage, treatment goals (cure or palliation) and other clinical factors (e.g., location of malignancy, effect on symptoms and functioning). When the CRC QUERI was funded three years ago, we identified a strong need for improved understanding of the relationship between processes of care and outcomes, as well as for insight into existing variations in care in VA. With the funding and inception of the VA Cancer Care Outcomes Research Consortium (VA CanCORS) we are making significant progress toward this goal. VA CanCORS will provide a rich set of data from patient survey, provider survey, and medical records, allowing for a number of important ancillary studies, in addition to testing the main hypotheses. We expect CanCORS to provide the foundation for targeting, conducting, and evaluating quality improvement strategies.

To sustain our momentum and leadership in cancer care quality enhancement efforts, we are proposing to establish a Co-Clinical Coordinating center for CRC treatment in Durham, under the direction of Dawn Provenzale, M.D.

In the meantime, we are focusing on developing quality enhancement interventions in cases where there is sufficient evidence of best practice recommendations and performance gaps. As there is considerable evidence both that cancer pain is under-treated, as well as of significant race/ethnicity disparities in pain treatment, we recruited an investigator with a focused interest in this area. We are planning projects intended to improve our understanding

of factors contributing to variation in pain treatment, as well as an intervention research study with a factorial design testing patient-directed and provider-directed interventions.