

Improved Adherence to Colorectal Cancer Screening Recommendations for First-Degree Relatives of Patients with Advanced Adenomas

Organization	Family History	Recommendatio
omprehensive Cancer Network	 1 FDR with CRC at <60 y or; ≥2 FDR with CRC at any age 1 FDR with CRC at ≥60 y 1 SDR at <50 y 1 FDR with advanced adenoma 	 Start colonoscopy at 40 y or 1 earliest CRC (whichever is every 5 y. Start colonoscopy at 50 y or 1 earliest CRC; repeat every Start colonoscopy at 50 y, repeat Start colonoscopy at 50 y or at adenoma (whichever is earliest earl
y Task Force on CRC (AGA, ACS, R, ASGE, etc)	 FDR with CRC or adenoma at <60 y or ≥2 FDRs at any age FDR with CRC or adenoma at ≥60 y or ≥2 SDRs with CRC at any age 	every 5–10 y Start colonoscopy at 40 y or 1 earliest CRC (whichever is e every 5 y Start screening at 40 y (any mo as average risk
College of Gastroenterology	1 FDR with CRC or advanced adenoma at <60 y or \ge 2 FDRs with CRC or advanced adenoma 1 FDR with CRC or advanced adenoma at \ge 60 y	Start colonoscopy at 40 y or 1 earliest CRC; repeat every Start colonoscopy at 50 y; rep
inadequate s	Creening of their FDR. Patient Providers	
	edge of findingsPractice variation per guidelinesareness of findingsEducation/knowledge of guidelinese of health informationVariability in endoscopy reportingLanguage barriersLimited time availabilityLoss-to-follow-up	
C	Limited time availability Difficulty locating procedure and/or linical staff knowledge pathology recommendations	
Clinical staff Available appoin	f awareness/trainingElectronic health record reminderstment/scheduleResource for patient education	
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Available appoin	tment/schedule Resource for patient education	UCSF Cuality Improvement Improving Colorecta Screening Recomm
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Data was collected by chart review of the endoscopy report and post procedure pathology follow up letters.

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- at 40 y or 10 y before hichever is earlier); repeat
- at 50 y or 10 y before epeat every 5-10 y at 50 y, repeat every 5-10 y at 50 y or at the age of hever is earlier); repeat
- at 40 y or 10 y before hichever is earlier); repeat

DS

- 40 y (any modality); repeat
- at 40 y or 10 y before ed epeat every 5 y at 50 y; repeat every 10 y

risk leading to



provement Project: Colorectal Cancer (CRC) Recommendations in ee Relative(s) (FDR) of sath Gvanced Adenoma

f CRC screening in FDR of patients with

G 2021 guideline by using an automate e uniform screening recommendatio



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Interventions

Interventions included:

- 1. Surveying faculty/fellows to identify barriers in knowledge and adherence to guidelines
- 2. Developing patient educational material in various languages about AA and importance of FDR screening (Figure 2)
- 3. Developing an automated prescriptive template in endoscopy report writer (EndoPRO) to standardize screening recommendations (Figure 3)
- 4. Educating providers and nurses (Figure 4)
- 5. Compiling quarterly compliance report cards





- Prior to the intervention, only 7% (11 of 166) with AA received appropriate CRC screening recommendations for their FDR.
- On the pre-intervention survey (n=38), suboptimal adherence was due to:
 - \bigcirc Low familiarity with guidelines (47%) Overlapility in delivery of screening recommendations Limited time available to communicate recommendations and provide patient education resources

Figure 2. Sample patient education/informational material about AA. Figure 3. EndoPro documentation Template. Figure 4. Education flyer for providers

Results



- individuals.



Figure 5. Adherence rate of recommendations for CRC screening in firstdegree relative of patients with AA

Monthly rates of adherence to recommendations increased, from a baseline of 7%, to 50% (after automated endoscopy report implemented), 56%, 74%, 77% and 80%, respectively (Figure 5)

Discussion

Earlier and more intensive screening of FDRs in those with AA is considered an untapped opportunity with a potential to substantially reduce the burden of CRC.

Here we propose a multifaceted intervention with stakeholder and patient education and automation of the process to improve compliance with the recommendations.

 Such novel workflows can play a key role in reducing the burden of CRC by targeting high risk individuals for CRC screening.

Conclusion

• Our QI interventions led to a 73% improved rate in appropriate guideline-based CRC screening recommendations for high-risk