Simple Steps, Significant Impact

Early detection is arguably one of the best tools physicians have to fight potentially devastating conditions. This is especially true for diseases that typically have few early-stage symptoms, including colorectal cancer, breast cancer, and diabetes-related retinopathy.

Colorectal cancer is the second leading cause of cancer-related death in the U.S., but colonoscopies can effectively detect and treat precancerous polyps and early-stage cancer.[1] Likewise, deaths from breast cancer—one of the most commonly diagnosed cancers in women—drop by 26% when women aged 50–74 receive recommended mammograms every two years.[2] Finally, although diabetes is the leading cause of new cases of blindness in adults aged 18–64, annual diabetic retinopathy exams (DREs) can aid in early detection and the implementation of sight-preserving treatment.[3]

However, as with most family medicine physicians, my colleagues and I at General Practice Associates (GPA) can't

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A manageable approach to improve preventive screening compliance

By Larry Doroshow, DO

perform screening colonoscopies, mammograms, and DREs ourselves. We can educate our patients about the recommended clinical guidelines, and then we must refer them to specialists for screening completion.

Unfortunately, some research suggests that about one-third of patients fail to follow up on referrals.[4] This referral problem may play a role in another statistic that indicates 65% of American adults are not current on at least one routine cancer screening.[5]

Therefore, referrals alone are not enough. A referral process that helps ensure patients follow through with their screenings is also essential for early disease detection. Recently, GPA was honored to receive a 2024 KLAS Points of Light award for work to improve our referral process for breast cancer, colorectal cancer, and diabetic retinopathy screenings.[6] We believe that this initiative, and the lessons learned along the way, can help other practices implement new approaches to improve their referral processes.

Lesson 1: Take a deeper dive into the data

As physicians, we recognize how crucial it is to close gaps in care. The question is always, "What is within our power to fix?"

As a starting point, our practice elected to start with reviewing colonoscopies, mammograms, and DREs, and identifying where there were gaps. We turned to value-based management services partner CareAllies for help gathering, reviewing, and analyzing data to understand why eligible patients weren't receiving these three crucial preventive exams. We did not just use our internal data, but also worked with CareAllies to ensure we layered on payer data to ensure a holistic view. A closer look showed a consistent theme: Lack of a referral resulted in a significant portion of patients not receiving their screenings. Specifically, this common issue was found in:

- 75% of noncompliant breast cancer screening patients
- 33% of noncompliant colorectal cancer screening patients
- 100% of noncompliant DRE patients

By looking a little deeper at the data, we recognized the opportunity to focus on enhancing our referral workflows. Still, while data revealed the opportunity, it was a process mapping exercise that helped us pinpoint the fixes we could make.

Lesson 2: Build a multifaceted team

We wanted to identify potential solutions and close the gaps in care quickly. Yet, given all the daily responsibilities of staff and physicians, we also aimed for minimal disruption to day-to-day patient care. Pulling together the right team was imperative.

We needed people from all perspectives to paint the complete picture of the current state of our referral workflows, as well as to weigh in on the future state. Although our internal team could provide a 360-degree view of our practice, we lacked critical data, analytics, and process improvement expertise.

Therefore, we deliberately structured the project team to ensure everyone involved could contribute meaningfully to a well-rounded view of practice workflows—including clinical, operational, and patient outreach perspectives. CareAllies collaborated on process mapping and restructuring and assisted with data and analytics. In addition to a process improvement expert from CareAllies and myself, the project team included:

- Two medical assistants
- Two front office staff members
- A billing staff member

Collectively, all of these different perspectives were essential to ensure we could seamlessly implement the new processes we ultimately developed. The team-based approach also helped strengthen enthusiasm for the project, although GPA's long history of quality improvement initiatives meant there was very little need to generate internal buy-in. Our physicians and staff alike readily embraced the idea.

Lesson 3: Take a hands-on approach

Once the team members were identified, we used a common five-step progression to arrive at potential solutions:

1. Define the problem (gaps in care caused by lack of referrals) and the goal (an increase in completed preventive screenings).
2. Measure patient compliance vs. noncompliance for each type of referral.
3. Analyze why patients weren't completing screenings.
4. Improve practice workflows to address the identified issues.
5. Control by measuring compliance once again—after the workflow improvement.

Our team held dedicated lunchtime meetings once every two weeks for three months. During one of the earliest meetings, our current-state referral workflows were mapped out using a collaborative, hands-on, and low-tech method.

Specifically, the process improvement expert used sticky notes and the meeting room wall like a giant whiteboard as the team reviewed our referral workflows. By the end of the meeting, our existing referral process—including all steps, decision points, documents involved, and potential challenges—was clearly visible.

During other meetings, we:

- Analyzed potential root causes of the care gaps.
- Brainstormed how to address the root cause.

The end result was a massive, fully documented future-state referral process map. Furthermore, it enjoyed immediate buy-in because the team ensured the new process was as simple and low-tech as possible and would fit into existing practice workflows. A pilot of the new referral process quickly confirmed its ability to close the desired care gaps.

Lesson 4: Leverage sustainable solutions

Today, several years after implementation, anyone at GPA can still use the documentation we created to train staff, answer questions, and maintain consistency in the referral process. But much of the process's beauty is its simplicity. We didn't have to invest in new tools or staff to accomplish our goal. Any practice could easily duplicate our solutions.

For example, staff members now generate patient outreach alerts using our shared digital calendar. The team created a visual aid for anyone unfamiliar with the technology to walk them through the steps. However, the process is pretty straightforward. Staff input a patient's name, visit date, referral type, and other details into the calendar. Staff then set a reminder to call the patient two weeks after their visit or four weeks after the referral appointment to ensure they made and followed through with the appropriate colonoscopy, mammogram, or DRE appointment.

We soon appreciated how effective a simple phone call between providers and patients can be. We didn't need a high-cost, high-tech intervention to help close the referral gaps. All it took was a dedicated process to help keep patients' referral appointments from falling through the cracks.

Two other low-tech solutions we have implemented to strengthen preventive screening referrals include:

- An easy-to-use checklist for clinical staff that notes which patients should receive which preventive screenings, how often, whether they require a referral, and other information.
- A transportation benefits flyer to help patients who may not have transportation get to appointments. The flyer tells them where to call to access their transportation benefits.

Lesson 5: Enjoy the results

Our goal was to achieve measurable improvements in the referral rates for all three preventive screenings within six months. Data indicate that referral rates have increased and have continued to improve. Metrics gathered in 2023 suggest that only:

- 16% of noncompliant breast cancer screening patients lacked a referral, an improvement of 59%.
- 21% of noncompliant colorectal cancer screening patients lacked a referral, an improvement of 12%.
- 11% of noncompliant DRE patients lacked a referral, an improvement of 89%.

As the referral process continues, we believe it will improve our patients' access to preventive care over the long term.

Better together

The entire GPA team experiences immense satisfaction from our role in elevating the health and well-being of our community. Looking back, the lessons we learned were both foundational and powerful:

- Utilize data
- Work together
- Keep it simple

How our team collaborated from the start to devise new workflows that fit logically into existing daily routines made it easier for us to embrace the change. As providers, we know we can't do everything ourselves. This initiative was an excellent example of how working with collaborative partners can improve care quality. We hope and believe that our collective work to bolster referrals for these three preventive exams will help patients live better and healthier lives for years to come. GPJ

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