St. Luke's: Improving Preventive Cancer Screenings in Routine Care

Our clinic identified a significant gap in preventive health screenings, particularly for cancer, which was affecting patient outcomes. By integrating screening discussions into routine assessments, using new tools like Cologuard tear-off sheets, and optimizing our electronic health record (EHR) system, we were able to better track and address the gaps in our care. The addition of motivated providers and ongoing efforts to prioritize screenings during every patient visit has led to improved patient outcomes, with many cases of potential cancers being detected and treated early.

Challenge:
Our clinic recognized a significant deficit in preventive health screenings, particularly related to cancer detection. Many patients, especially those at higher risk, were not regularly being screened, and this was often overlooked during routine appointments. We realized there was an urgent need to make screenings a priority and integrate them into patient care to close these gaps.

St. Luke's Clinic Team Members: Dr. Benjamin Krogh, Natasha Gjovig, Sarah Thomte, Brenda Casteel, Lexie Harms, Rita Grote
Not pictured: Sommer Nelson, Roxanne Fortier, Janie Sova, Christine Knudsvig and

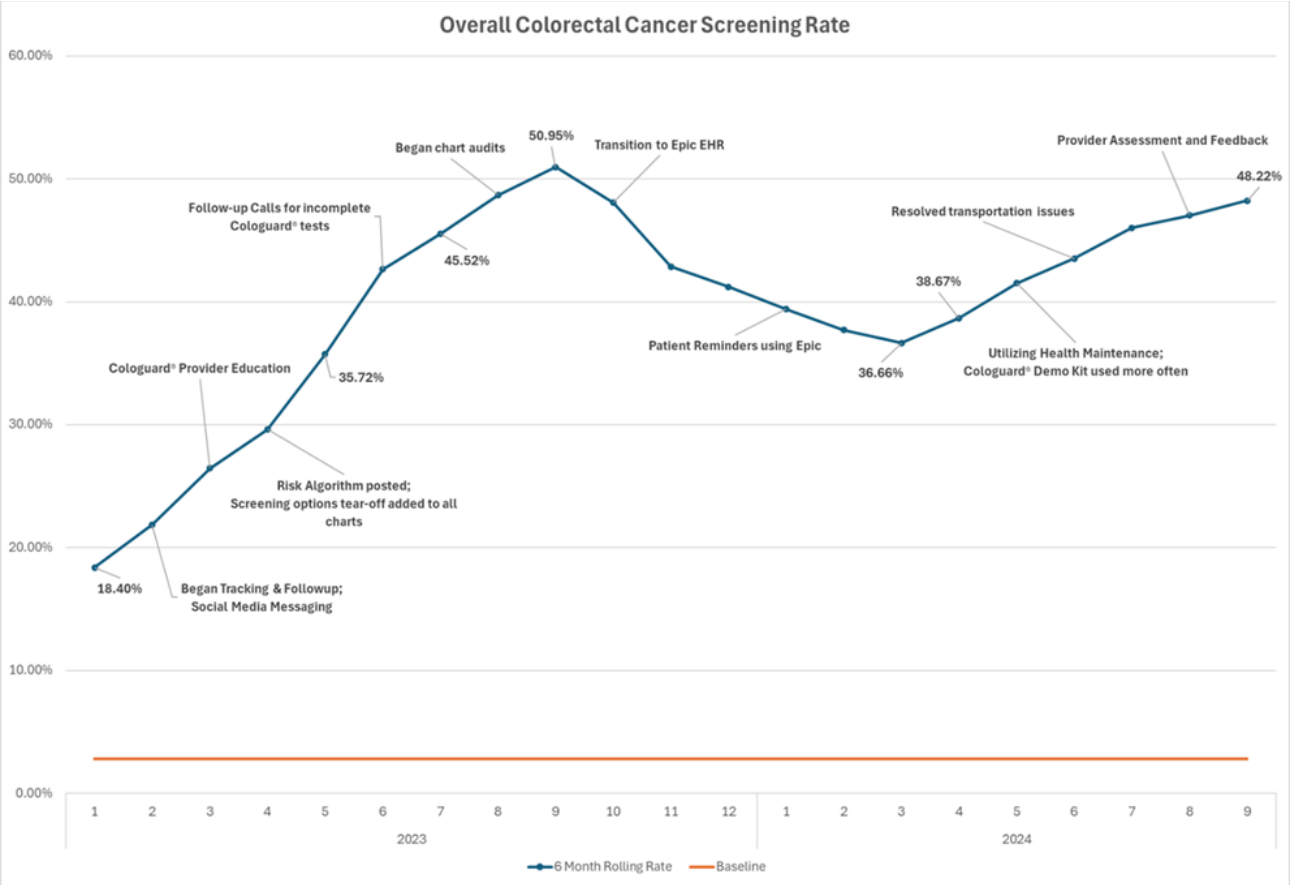
Action:
We decided to incorporate cancer screenings into the initial assessment at each appointment. To facilitate this, we introduced Cologuard tear-off sheets to guide conversations with patients about screening options, helping them understand which tests would be most appropriate based on their medical history. We also onboarded new providers who were enthusiastic about improving patient outcomes. These providers quickly embraced the focus on preventive care and began seeing patients regularly to address health maintenance.

We paid closer attention to care gaps using our new electronic health record (EHR) system, Epic, which we adopted 10 months ago. As our team grew more accustomed to the system, we identified features we liked and optimized them for tracking patient screenings. These care gap conversations became a standing item in our team meetings, ensuring they were always made a priority.

Results:
Our clinic saw substantial improvements in patient outcomes. One example is a 55-year-old male patient who visited us for an upper respiratory illness. His blood pressure was slightly elevated, and he was due for prostate-specific antigen (PSA) screening, given his family history. After discussing health maintenance, we asked him to return for lab work, and upon his return, we identified that he was overdue for colorectal cancer (CRC) screening. He was scheduled for a colonoscopy, during which eight polyps were removed, including one that was large enough to require further intervention. Fortunately, all pathology reports came back benign, but the screenings likely prevented more serious health issues.

Additionally, every patient who had a positive Cologuard result, except one who declined, was scheduled and completed a follow-up colonoscopy within the same month. By bringing these screenings into routine check-ups, we consistently identify care gaps, resulting in more preventive care being delivered. Brenda Casteel, RN commented, "CRC screening has been quite a journey, going from 2% to 58%. The providers have been closing care gaps, the nurses provide education to the patients and Natasha is keeping our data in check. Together our numbers have improved and for our patients, I can happily say they are reaping the benefits."

St. Luke's Medical Center Data on Timeline



Sustainability:

To ensure continued success, we are committed to addressing care gaps at every patient encounter, not just during annual wellness visits. Providers and nurses are reminded to use every face-to-face meeting to evaluate health maintenance needs. We also standardize our intake protocols to ensure screenings are addressed consistently.

We have integrated follow-up systems within our EHR, using tools like REDCap to track data and send reminder letters to patients who are due for screenings. Tools like Slicer Dicer also allow us to run reports on patient data to target those who are overdue.

To keep this momentum going, we plan to regularly share data with staff, fostering a sense of competition to drive further improvements. Additionally, we will continue promoting screenings through social media and newspaper ads to keep the community informed and engaged.