STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor -- Joshua M. Sharfstein, M.D., Secretary

Family Health Administration
Russell W. Moy, M.D., M.P.H., Director

CCSC HO Memo #11-21

MEMORANDUM

To: Health Officers
CRF/CPEST Program Directors, Coordinators, and Staff
SAHC Program Directors, Coordinators, and Staff

From: Diane Dwyer, MD, Medical Director, CCSC

Date: March 22, 2011

Re: **Maryland Colonoscopy Quality Assurance Program,**
REVISED: CRF Program Colonoscopy Feedback Reports, and
New Contract Template for Endoscopy Providers

I. Maryland Colonoscopy Quality Assurance Program

The Center for Cancer Surveillance and Control is establishing the Maryland Colonoscopy Quality Assurance Program (CQAP) to measure and improve quality of colonoscopy in Maryland. As a start, on January 12, 2011, I presented information at the Health Officers' Roundtable about colonoscopy performed in the Cigarette Restitution Fund (CRF) Program and the variation seen in colonoscopy "indicators" such as adequacy of bowel preparation, intubation of the cecum, biopsy rates, and adenoma detection rates.

CDB Reports: Programs may look at information for their jurisdiction associated with these indicators by running the following reports or downloads in the Client Database:

Adenoma detection rates—C-CoPD;
Adequacy of exam, bowel prep, and cecal intubation rates—C-IC (by county)
List of inadequate colonoscopies—C-LLIC (list of inadequate cols by provider); and
For your jurisdiction's line list of patient information—Use the Download feature in the Client Database

II. REVISED Colonoscopy Feedback Reports

We have **revised the information provided to you in Health Officer memo #11-20.**

Because of the issues raised on the teleconference our new plan is the following:

- We have computed the data for the Colonoscopy Feedback Report for the Maryland CRF Program as a whole for the period 7/1/2006 and 12/31/2010 (Attachment 1).
- We are preparing a Colonoscopy Feedback Report **for each provider** who has performed one or more colonoscopies in this period.
- We will provide the reports for each provider to the Health Officer of the jurisdiction(s) where the provider has contract(s) with a LHD. If a provider has contracted with more than one program, we will produce ONE report for the provider, but we will share it with each Health Officer who holds a contract with that provider.

Each local Health Officer will decide how s/he chooses to handle these reports. Options that have been mentioned include, but are not limited to:

- Telling the providers that the reports are available and that s/he may request a copy of the provider's individual report if they are interested. The health department would provide a copy of the provider's report and a copy of the statewide report (Attachment 1) for comparison if interested.
- Sending the provider-specific Colonoscopy Feedback Report to providers with a cover memo from the local Health Officer and a copy of the statewide report (Attachment 1) for comparison.

We have spoken to Dr. Watkins and he has revised his Dear Colleague letter in line with the comments that we had on the teleconference on March 16, 2011 (Attachment 2). Feel free to use this letter in your discussion or mailings with providers.

In a hard copy, separate mailing, we will send the provider-specific Colonoscopy Feedback Reports **directly to the Health Officer**. Please recognize that this is potentially sensitive information and handle appropriately.

Please let me know how you are handling these reports in your jurisdiction.

III. Endoscopy Provider Contract Template

For your use when generating your 2011 provider contracts, we have prepared a contract template specific for those providers who perform colonoscopy and sigmoidoscopy. This template (Health Officer Memo #11-18) has additional language regarding 1) reporting of colonoscopy findings, and 2) quality assurance of the reporting through colonoscopy feedback reports.

Many thanks to those at DHMH and in the local programs who have helped make these feedback reports a reality, especially Dr. Eileen Steinberger, Annette Hopkins, Barbara Andrews, Carmela Groves, and **all of the local program staff** who enter data into the CDB and who help assure quality data!

If you have any questions, please e-mail me at ddwyer@dhmh.state.md.us or call 410-767-5088.

Attachments e-mailed to Health Officers and CRF program staff; packets mailed to Health Officers

cc: Russell Moy, M.D., M.P.H. Donna Gugel, M.H.S.
Courtney Lewis, M.P.H. Kelly Sage, M.S.

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March 22, 2011

Dear Colleague,

Maryland is a leader in colorectal cancer (CRC) screening. Maryland is now 5th in the nation, with **72.7% up-to-date with CRC screening** (either FOBT in past year or endoscopy within the past 10 years)[1]. With your help, Maryland public health programs funded by the Cigarette Restitution Fund (CRF), since 2001, have completed **16,844 colonoscopies** on low income uninsured or under-insured Marylanders and have identified **186 cases of CRC and 73 cases of high grade dysplasia**.

Maryland also wants to be a **leader in the quality of colonoscopy**.

The CRC Medical Advisory Committee has formulated and updated the Minimal Elements for CRC Screening, Diagnosis, Treatment, and Education.[2] As Chairman of the CRC Medical Advisory Committee, I have written to you about colonoscopy quality improvement: in 2005, regarding adequacy of bowel prep, cecal intubation, and the need to biopsy all lesions; in 2007 regarding the Colonoscopy Reporting and Data System (CO-RADS) that provides national standards for quality assurance activities in colonoscopy and for colonoscopy reporting[3]; in 2009, providing the latest Minimal Elements and program statistics for bowel prep adequacy in the program; and in 2009, providing data on a review of a sample of Maryland CRF program colonoscopy reports from 2004-2005 using CO-RADS as a benchmark—and showing that not all reports documented the recommended items.[4]

The Maryland CRF Program has now begun a **Colonoscopy Quality Assurance Program (CQAP).** As a first step, the DHMH is generating a **Colonoscopy Feedback Report** for each colonoscopist. The Feedback Report will be sent to the local Health Officer in the local health department who contracted with the endoscopist to provide colonoscopies for the program on or after July 1, 2006.

Thank you again for your participation as a colonoscopist in the Maryland CRF Program. If you have questions or comments, please call your local Health Officer or contact Diane Dwyer, M.D., at 410-767-5088.

Sincerely,

Stanley Watkins, M.D.
Chairman, Medical Advisory Committee

[1] Colorectal Cancer Screening---United States, 2002, 2004, 2006, 2008. MMWR Supplement 60(01); 42-46
[2] http://fha.maryland.gov/pdf/cancer/ccsc09-19_att_crc_min_el.pdf
[3] Lieberman, et al. Standards for colonoscopy reporting and data system: Report of the Quality Assurance Task Group of the national Colorectal Cancer Roundtable. Gastrointestinal Endoscopy 2007;65:757-766.
[4] Li, et al. Quality assessment of colonoscopy reporting: Results from a statewide cancer screening program. Diag and Thera Endoscopy 2010, Article ID 419796.

Maryland Cigarette Restitution Fund Program
Colonoscopy Quality Assurance Program
Colonoscopy Feedback Report
July 1, 2006--December 31, 2010

The report below is derived from data submitted by the local health department colorectal cancer screening program to the Maryland Department of Health and Mental Hygiene, Center for Cancer Surveillance and Control on **colonoscopies performed between July 1, 2006 and December 31, 2010**.

	CRF Program			National Standards or Expected Number~
	N	**%**	**Range##**	
Total Number of Colonoscopies	7650			
Number (%) with Adequate Exam*	6960	91.0%	77.1-100%	
Number (%) with Adequate Bowel Preparation#	7109	92.9%	77.1-100%	
Number (%) with Cecum Reached	7393	96.6%	88.1-100%	
Number (%) with Cecum Reached among those with adequate bowel prep	6960	97.9%	91.0-100%	90-95%
Number of first colonoscopies**	6036			
Number of first colonoscopies in patients 50+ years of age without bleeding symptoms (at average OR increased risk)	4534			
Biopsy rate on this group (regardless of adequacy of colonoscopy)	2307	50.9%	8.3-97.3%	
Total adequate colonoscopies on patients 50+ who did NOT have bleeding symptoms	4103			
Findings				
Any Cancer detected (adenocarcinoma, carcinoid, lymphoma, rectal or anal squamous cancer)	17	0.4%		
Adenocarcinoma	12	0.3%		
Suspected cancer	7	0.2%		
High grade dysplasia	20	0.5%		
Any adenoma	997	24.3%	8.9-68.6%	
Advanced adenomas (>=1cm, or any villous histology)	261	6.4%	1.3-20.3%	
Other adenomas, not advanced	736	17.9%	2.2-60%	
Other findings or normal	3062	74.6%		
Neoplasia detection rate on first colonoscopies^		25.3%	4.4-68.6%	
Neoplasia detection rate-men^		31.8%		>=25%
Neoplasia detection rate-women^		22.1%		>=15%
Mean size of largest adenoma (mm) on colonoscopies where any adenoma was found and size was documented	8.3			

* **Adequate exam** is defined as a colonoscopy in which the bowel prep was adequate and the cecum was reached.

Bowel preparation is considered **Adequate** if the terms such as "excellent," "good," "very good," or "fair" were used in the colonoscopy report to describe the bowel preparation AND the recall interval was 10 years for an average risk patient with no findings. If the provider's recall interval was **less than 10 years for an average risk patient with no findings and the prep was "fair," the CRF Program coded the prep as NOT adequate.**

** **Number of first colonoscopies** is the number of colonoscopies that were the first colonoscopy in the CRF Program on an individual patient. This number excludes repeat colonoscopies performed as follow-up to findings on the first colonoscopy or for recall surveillance colonoscopies.

^ **Neoplasia detection rate** include adenocarcinomas, suspected cancer, high grade dysplasia, and adenomas of any size or histology in first colonoscopies on patients 50+ without bleeding symptoms.

~ Rex DK, Petrini JL , Baron TH, et al. ASGE/ACG Taskforce on Quality in Endoscopy, Am J Gastroenterol 2006;101:873–885.

Range is the minimum and maximum value among providers in the CRF Program who did >= 30 colonoscopies during this period.

Data Source: Client Database as of March 1, 2011