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The Kimmel Cancer Center and the Department of Health Policy Team with Aetna US Healthcare, Inc. and the National Cancer Institute to Define Standard of Care Treatment for Colorectal Cancer

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Colon cancer is a major cause of oncologic morbidity and mortality in the United States. Screening has been shown to detect early malignancy and decrease mortality and morbidity. As well, close follow up after resection of colorectal cancer, especially early stage cancers, has been shown to lead to earlier detection and management of recurrent disease. (1)

In an attempt to identify strategies for limiting the devastating morbidity and mortality resulting from colorectal cancer, The Kimmel Cancer Center and Aetna US Healthcare (AUSHC), through a grant from the National Cancer Institute have established the Health Practices Research Program (HPR). HPR combines the clinical expertise available through Thomas Jefferson University and the Department of Health Policy with the large patient data sets created by AUSHC for the purpose of addressing the many questions concerning best treatment strategies for oncologic disease such as colorectal cancer.

Numerous criteria, such as the MD Anderson Guidelines and the North Central Cancer Treatment Group recommendations, have been established to define treatment algorithms of highest quality for colorectal cancer. Unfortunately, there have been no large-scale randomized trials documenting the efficacy of standardized postoperative monitoring programs. (2) In an attempt to investigate the utility of standardized patterns of care, this important study describes "standard of care" (SOC) treatment for colorectal cancer and utilizes the SOC definition as an internal benchmark against which to compare the treatment received by USHC insured colorectal cancer patients.

After a medical literature review of available guidelines, recommendations and consensus statements regarding the care of patients treated for colorectal cancer, interviews were conducted with TJUH medical, surgical and radiation oncologists. The medical literature and clinical consensus were then combined to develop a list of procedures and the timing of these procedures considered "SOC treatment" for colorectal cancer patients. SOC for the first year after treatment was defined as a history and physical every three months, CEA blood test every three months, liver function tests every three months, CT scans of the abdomen and pelvis every six months, chest x-ray annually, and colonoscopy annually.

Patients were identified for the study from a listing of over 230,000 individuals eligible for fecal occult blood test screening. From this list, 268 individuals were identified with colorectal cancer related colectomy procedure codes from the AUSHC claims database. Of these individuals, 237 were confirmed by chart review to have a diagnosis of colorectal cancer between 1987 and 1990. A total of 222 individuals from this group with complete data was identified for the study. The utilization of procedures considered "SOC treatment" was assessed for these patients using the AUSHC claims and encounters data bases. Overall, the study population was found to be evenly distributed by age, gender and stage of disease.

Analysis of the data showed that during the first year after treatment, 81% of colorectal cancer patients received at least one documented physician encounter related to one or more SOC procedures. Overall, less than half of the study patients received CEA blood tests, liver function tests, chest x-rays, abdominal or pelvic CT scans, or colonoscopy during the study period. Additionally, patients with late stage disease received a statistically greater number of physician encounters and abdominal and pelvic CT scans than their early stage counterparts.

Compared to the SOC, the actual reported receipt of procedures by colorectal cancer patients appears lower than one might expect. It should be recognized, however, that these results have been reached through comparison of the data to a SOC that may not be a completely accurate portrait of the clinical treatment universe. Although it may have limitations, the definition of SOC through the use of administrative data was necessary because, at present, there is no valid clinically derived database from which to create a benchmark for comparison to the study population.

Ultimately, it is this author's belief that, as disease management programs have begun to show, some level of standardized care will likely improve both the process of care and the morbidity and mortality outcomes for patients with colorectal cancer. The question that now remains for TJUH, and healthcare in general, is what level of standardization of care is appropriate to achieve quality outcomes for its colorectal cancer patients? The results of this study underscore the imperative of finding an answer to this question. A critical step in this direction is the establishment of a national, controlled prospective study that explores the efficacy of standardized treatment algorithms for colorectal cancer through valid external benchmarks and standardized patterns of quality care.

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