IDENTIFYING & TARGETING AGE-RELATED CRC SCREENING RATE DISPARITIES IN FAMILY MEDICINE RESIDENCY CLINICS

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PROBLEM
• CRC is a national health care priority
• CRC is an Aurora Health Care (AHC) Quality Metric and a care gap per AHC’s Community Health Needs Assessment (CHNA)
  • Our residency clinics face challenges associated with urban underserved populations
  • These clinics are currently not a goal for the CRC screening quality metric
• Addressing clinical care gaps without identifying specific at risk populations limits the ability to identify and implement targeted improvements
• AHC does not routinely provide data on at risk and/or disparities within a clinical quality metric

BACKGROUND
• Nationally studies have identified disparities in CRC screening with screening less prevalent among patients who are A.K.C  
  • Uninsured and/or lower socioeconomic status
  • African-American/Black, Asian, Non-English speaking Hispanic patients
  • Local variations do exist/differ from national experiences
• Age related disparities in CRC screening rates among eligible patients is limited/not reported in literature

OBJECTIVES
• To identify REAL-GI disparities (race, ethnicity, age, preferred language, gender and insurance) in care to patients ≥50 who are eligible for colorectal cancer (CRC) screening in two family medicine residency clinics
• To develop, implement, and evaluate progress towards increasing CRC screening targeted disparity gap population

METHODS
IHI IMPROVEMENT MODEL
• A team of residents/faculty framed our approach using the IHI Model’s for Improvement
• Providers at 2 family medicine clinics identified barriers to CRC screening using a fishbone approach to engage them in the improvement process

POPULATION DATA
• A retrospective analysis of all patients eligible for CRC screening at 2 targeted clinics, a control clinic (residency clinic in same zip code), and our care region during a 12 month period (Dec-Nov 2015) was completed in collaboration with AHC quality improvement specialists
• Ninety (90) patients achieving CRC screening metric was reported by REAL-G & insurance
• Categories with an N < 25 were omitted
• Criterion for disparity within a category was identified as ≥10%
• Analysis was repeated in Jan 2017 for intervention period (Jan-Dec 2016)

RESULTS
IDENTIFIED DISPARITY GAP FOR CRC SCREENING
• The largest CRC screening disparity was associated with age
• Screening gaps ranging from 13-15% between populations aged ≥65 vs age 50-54
• CRC Screening Rate disparities by race, ethnicity, and gender were <10%

BASELINE CRC SCREENING X AGE DISPARITY

CONCLUSIONS
• Identifying a specific disparity group provided a focus for improvement (beyond the monthly quality metrics received by each clinic)
• Increased CRC screening rates appear to be influenced by:
  • Improved CRC ordering workflows
  • Clinic provider/staff education
  • Staff champions who are CRC advocates and implement changes
• Project created dialogue about CRC screening rates in several Aurora-wide groups, which may have encouraged change in our care region

BARRIERS/LIMITATIONS
• Age 50-54 as a disparity group was an atypical “frame” potentially limiting provider/staff engagement and buy in
• CRC screening rates may be influenced by clinic size
• Need to investigate differences in insurers’ coverage of CRC and clinic specific perceptions re: coverage; identify/implement strategies to address

REFERENCES

Aurora Health Care