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 <5% 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/deviate 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
  - 96 patients achieving CRC screening metrics 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

`% of Eligible vs. Real GI Followed**

Age: 50-54  Age: 55-59  Age: 60-64
Care Region  77%  76%  77%
Control Clinic  71%  77%  78%
Sm Clinic  68%  74%  77%
Lg Clinic  70%  74%  73%

POST INTERVENTION CRC SCREENING x TARGETED AGE DISPARITY (AGE 50-64)

CRC Screening Pre/Post Age ≥ 50-54

Pre  Post
Care Region  71%  69%
Control Clinic  66%
Sm Clinic  68%
Lg Clinic  65%  66%

CONCLUSIONS
- Identifying a specific disparity group provided a focus for improvement (beyond the monthly quality metrics received by each clinic)
- Increased CRC screening rates appears to be influenced by:
  - Improved CRC ordering workflows
  - Clinic providers/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” possibly 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