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/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

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 discrepancies 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 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