

QUALITY IMPROVEMENT PROJECT TO INCREASE BREAST CANCER SCREENING IN AURORA SINAI INTERNAL MEDICINE CLINIC



46th Annual
SCIENTIFIC
DAY 2020

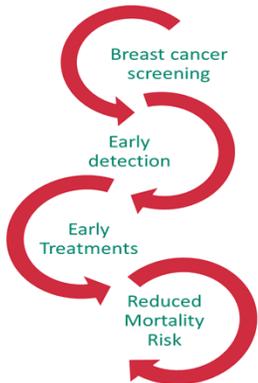
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PROBLEM

In the Aurora Sinai Internal Medicine Clinic, breast cancer screening has been below expectations for years which reflects to under achieved Quality measures.

BACKGROUND

Breast cancer (BC) is responsible for the deaths of over 40,000 women in the USA (1). The United States Preventive Services Task Force (USPSTF) recommends biannual mammogram for all women aged 50-74 years (2). Today, the 5-year survival of BC is almost 90%, compared to 75% in 1975 (3). Breast cancer screening (BCS) leads to earlier detection and treatment, reduced mortality, and reduced need for the toxic treatments. Despite the documented screening benefits, only 64-81% of the population that meets the criteria for regular BCS is regularly screened (1).



OBJECTIVE

The USPSTF guideline for BCS is a Quality Improvement (QI) measure that is tracked for Primary Care Physicians (PCPs) in Advocate Aurora Health. The primary care providers (PCPs) in our clinic had a combined BCS of 67% for Group 1 and 73% for Group 2 for the eligible patient assigned to them at September 2019 (system goal was $\geq 84\%$). We hypothesized that regular BCS has been limited by factors including inadequate emphasis, education, and reminders for BCS. Our goal was to fill these gaps and improve patient outcomes by increasing our BCS by $\geq 10\%$ for Group 1 and $\geq 8\%$ for Group 2 By April 1, 2020.

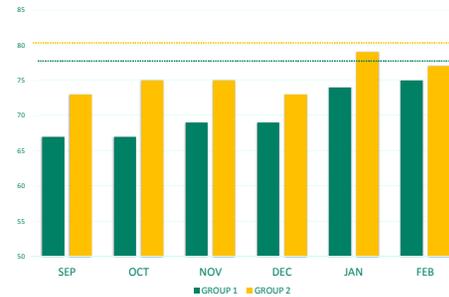
METHODS

The study population included our clinic PCPs from Group 1 (Drs. Sharma, Hunde, and Usmaiel) and Group 2 (Drs. Peliska, Homida, Hamed, Boese, Siyum, and Shethwala) who performed personal outreach to their patients due for BCS. Every month, data was generated through the system's QI process, which included the percentage of eligible BCS patients who are up-to-date and a list of patients who are due. The process for the study was our routine clinic workflow, in addition to dedicated outreach to our patients (the intervention). We called, mailed letters, or messaged through our electronic messaging system (MyAdvocateAurora) to our patients who were due for BCS. We advised our patients to complete a screening mammogram given supporting facts. A screening mammogram was ordered for those who agreed. We provided the patients with a phone number to schedule it. For patients who had BCS in other systems, we collected the results through the usual process and updated them in our system.

RESULTS

At the start of our QI projects, only 67% and 73% of patients of age 50-75 had up to date BCS for Group 1 and Group 2 respectively. By continuous and dedicated outreach, our BCS score has improved to 75% for Group 1 and 77% for Group 2 on February 20, 2020.

Breast cancer screening in women ages 50-74



CONCLUSIONS

To improve the BCS rates and decrease breast cancer-related mortality, we established individualized outreach. Our efforts increased our QI measures. However, our project was not able to continue until April 1, 2020 as planned due to indefinite closure of non-essential clinic visits starting at the end of February 2020, due to the COVID-19 pandemic.

Even though we were not able to continue the project, by continuing these dedicated outreach reminders, we might have been able to reach our BCS rate Goal to $\geq 77\%$ for Group 1 and $\geq 80\%$ for Group 2 if it weren't for COVID-19 Pandemic.

REFERENCES

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