Editorial

Title: Translating the ADR Quality Measure for Endoscopists to a Public Health Approach to Screening Underserved Patients for Colorectal Cancer

Short Title: Improved CRC screening at FQHC by integrating endoscopic ADR quality measures

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Grant Support: Dr. Hitchcock has no financial support related to this commentary.

Disclosures (financial, professional, or personal) relevant to manuscript: M. Hitchcock: no financial disclosures relevant to this editorial. Opinions expressed in this editorial are mine alone.

Key Words: Adenoma Detection Rate, Colorectal Cancer, Quality Measures, Normal Risk, High Risk, Federally Qualified Health Centers, Colonoscopy

Abbreviations:


Word Count (main body and table/figure legends): 1,163 words - Main Body, No Tables or Figures are included

References: 14
Images: None

Author Involvement: MEH was involved with conceptualization and design; analysis and interpretation of data; drafting of the manuscript; critical revision of the manuscript for important intellectual content.

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In this issue of *Gastroenterology*, Shaukat et al. present data characterizing the adenoma detection rate (ADR) for a 5-year cohort (2015-2019) of 159,817 patients with normal or average risk for developing CRC, including 4,841 patients 45 – 49 years of age who had colonoscopies performed by 99 endoscopists in metropolitan Minnesota. The authors aimed to establish endoscopic standards for ADR when scoping normal risk younger patients. ADR is a validated endoscopy quality measure with 25% overall ADR (30% for men and 20% for women) the accepted benchmark for all endoscopists doing colonoscopies on normal risk patients aged 50-75 years of age. When possible, colonoscopy exams with an indication of family history of CRC or advanced polyps were excluded. The authors suggest that if an endoscopist’s patient cohort is trending to patients younger than age 50 years in accordance with the new USPSTF guidelines, a 1-3% drop in ADR can be anticipated if 10-25% of all colonoscopies performed are on patients 45-49 years of age. However missing cohort data on family cancer history or racial/ethnic characteristics raises concerns that individuals younger than 50 years of age in this cohort represent a group at higher risk of CRC than the older age groups.

This editorial suggests how data from Shaukat et al can be used to improve underserved patients of both normal and increased risk for CRC cared for by Federally Qualified Health Centers (FQHC). The question arises whether these data can be used to improve CRC risk stratification and provision of care, taking into account the need for better cohort characterization, paired with ADR benchmarks for endoscopists completing colonoscopies through outsourced specialty referrals. FQHC have screening programs in place to comply with UDS reporting requirements aligned with USPSTF screening guidelines. As clinics adapt to the new age guidelines, the question remains as to whether FQHC staff correctly identify patients at increased risk needing direct referrals to high quality endoscopists, rather than including them in their normal risk screening programs.

FQHC need to standardize risk assessment and document the results prior to making screening recommendations to their eligible patients. We know that many cohort studies
incompletely exclude patients with known genetic mutations, such as Lynch Syndrome (LS),
because the number of patients excluded does not approach the expected proportion, based on
the known LS mutation frequency in the general population (1 in 279). Encouraging better use
of CRC risk assessment tools in FQHC patients will help to increase applicability for
racial/ethnic groups currently under-represented in those tools, and allow for more accurate
analysis of care delivered to patients, in both integrated and fragmented care delivery systems.

The USPSTF guidelines lowering the screening to 45 years of age for normal risk
patients put additional pressure on resource-limited FQHC. Specifically, FQHC provide care
for patients of which 91% are low income and 63% are racial or ethnic minorities, with frequent
movement of patients between FQHC systems not connected via EHR complicating the tracking
of preventive services. This is further compounded by the Covid-19 pandemic, which caused
significant changes to clinic operations, clinicians, and staff with added practice demands.
In 2020, almost 28.6 million patients were cared for by FQHC. Many of these systems have mail
out FIT CRC screening campaigns in place to meet the 80% in Every Community national goal
but patients are triaged to FIT screening primarily based on age in accordance with USPSTF
guidelines. For colonoscopy screening needs, FQHC experience fragmented specialty care
since many outsource their colonoscopies and struggle to migrate results of those
colonoscopies back into structured data fields that can be readily queried for quality
improvement purposes. The NCI-funded consortium, Accelerating CRC Screening and Follow-
up through Implementation Program (ACCSIS) has a framework in place to address improved
risk assessment and triage to the appropriate CRC screening modality at FQHC. As these
implementation strategies become generalizable, FQHC can commit to documenting risk
assessment and colonoscopy results in structured data fields in their electronic health records,
including a flag if high risk patients are triaged inappropriately to FIT rather than colonoscopy.

The next step in the process is to then to hone the referral process of FQHC patients to
endoscopists depending on patient risk and ADR quality measures of individual endoscopists.
Pairing the Shaukat et al. study with one by Wieszczy et al. linking ADR to subsequent post-colonoscopy CRC (PCCRC) suggests some additional improvements in the CRC risk stratification process may better identify those patients at increased risk who need a referral for colonoscopy, versus normal risk FQHC patients who should be offered FIT with follow up colonoscopy for abnormal results as the primary screening modality. As Toyoshima et al. indicate, referring higher risk patients to endoscopists meeting high ADR quality benchmarks may improve cancer outcomes for these patients. In addition, several national organizations have set colonoscopy reporting standards linked to patient risk assessment and potential integration with data systems. However, the integration of results within FQHC from outsourced colonoscopies is less clear.

While integrated health systems have internal tracking that can link colonoscopy reports to the ADR of individual endoscopists, FQHCs without direct EHR linkages to the outsourced endoscopy service may not be able to document the equivalent standard of care. To ameliorate this, some incremental steps are suggested to help promote more health equity for those receiving care at FQHCs, including: 1) tasking the endoscopy service doing the outsourced colonoscopies to be proactive in assigning patients identified as higher risk to endoscopists meeting higher ADR standards within their endoscopy practice, which is feasible if the clinics improve their risk stratification process by identifying patients at higher risk for developing CRC prior to the colonoscopy referrals; 2) gaining commitment by the endoscopy practice to offer the same standard of care of an ADR of 25% for endoscopists performing colonoscopies for patients at normal risk for developing CRC but being referred because of abnormal FIT results, with adjustments made for those scoping a larger percentage of younger patients as Shaukat et al. suggest; and 3) commitment by the endoscopy service to report the ADR of the person completing the colonoscopy with the information transmitted back to the referring FQHC.
According to NCI, their CRC risk assessment tool is less accurate for Blacks/African Americans, Asian Americans/Pacific Islanders, or Hispanic/Latinos because of missing data.\textsuperscript{12} Given the higher percentage of patients served by FQHC who are racial or ethnic minorities, FQHCs that consistently include valid risk assessments using a standardized tool, may also help increase representation by racial/ethnic groups currently underrepresented in those tools. With risk stratification that is more inclusive of all people receiving colonoscopies, cohorts may then be more clearly defined as normal or high risk and then linked to colonoscopy outcomes that also consider ADR quality measures of the endoscopists.\textsuperscript{12} Ultimately, this may help reduce structural barriers for more racial/ethnic groups \textsuperscript{13}, and may improve care delivered throughout the screening continuum for all patients \textsuperscript{14} independent of where they receive care.
References


Author names in bold designate shared co-first authorship.