CASE STUDY SPOTLIGHT

Coal Country Community Health Center

Type
Federally Qualified Health Center

Location
Beulah, ND

EHR
Epic

8,685
patients

4
locations

- 28.4% of patients at or below 200% Federal Poverty Guideline
- 0.5% of patients are best served in a language other than English
- 8.1% of patients are uninsured

Patient Strategies

- Patient reminder or recall/in reach
- Patient education
- Small media
- Navigator/Community Health Worker

Clinician/Staff Strategies

- Provider reminder or recall
- Care team/team-based approach
- Clinical champion
- HIT interventions dashboard
- Shared decision-making model
- Follow up to abnormal (positive) FIT

Reducing Structural Barriers

- Transportation
- Community outreach
- Expanded office hours

Background

Coal Country Community Health Center (CCCHC) provides colorectal cancer (CRC) screenings for patients in rural and remote areas. These patients have unique challenges and access issues and in 2012, CCCHC had a CRC screening rate of 29%.

Results

By January 2018, CCCHC had increased its CRC screening rate to 68% through the implementation of several innovative quality improvement projects. Their 2019 screening rate dipped to 56% but increased to 59% in 2020 despite challenges posed by the COVID-19 pandemic.

Evidence-Based Strategies and Innovations

CCCHC saw opportunities to strengthen its collaborative relationship with the local critical access hospital and tertiary hospitals to increase screening rates, as well as make improvements to their own internal CRC screening process. For patients, they focused on education, reminders, small media, and navigation. With a clinical champion, they created a team-based approach, dashboards, reminders, shared decision-making, and improved process on follow-up after a positive or abnormal fecal immunochemical test (FIT). Lastly, they conducted community outreach, provided transportation to appointments, and expanded office hours to reduce structural barriers.

Furthermore, under the direction of Dr. Aaron Garman, Medical Director, the health center's healthcare delivery transformed from an acute care model, where they focused on sick visits, to a prevention and wellness model, where they are proactively working to keep their patients well. CCCHC shared the following solutions and lessons learned from their CRC screening interventions:

Distributing FIT

The health center provides FITs to patients while they are in the practice. Patients are then able to return kits to the health center in-person or by mail.

Referrals and Preferred Partnerships

- The health center has a strong relationship with the local critical access hospital in the area, which allows them to schedule colonoscopies relatively easily and have a seamless process for closing the referral loop. The critical access hospital has their own surgeon on staff, and the health center has a clinic in it. Before the patient leaves for the visit, they will have their colonoscopy appointment scheduled with the local critical access hospital.
- The health center also has an established relationship with each of the two tertiary hospitals about 80 miles away for patients who prefer to travel to one of the two facilities.
- The health center utilizes the same EHR as the critical access hospital and both tertiary hospitals, making it easy to share patient records.
- Incomplete referrals are sent from the medical records team to the nurse to perform follow-up. The reason is then documented in the EHR as to why the colonoscopy was not completed, canceled, or rescheduled.

Existing Patient Outreach

The health center does a 100% recall for all patients who are not up to date on their CRC screening every six months. Quarterly reminders are also sent through the patient portal automatically for preventive screenings.

Historical Test Result Data

When reviewing the medical record to see if a patient has completed their screening, any missing historical test records are requested from the entity that performed the screening. Once the historical results have been received, the medical records department sends the historical results to the nurse to update the medical record.

EHR-based Best Practice Advisories

Within the EHR there are best practice advisories to guide the providers to perform preventive screenings. The health center can also submit requests to the EHR vendor to customize these alerts. The practice also uses order sets customized to the type of screening ordered.

Three-Step Recall Process

The health center utilizes the dashboards within the EHR.

- When an order is noted as delinquent in the EHR, the health center first mails a letter to the patient. The practice then contacts the patient via phone if the screening has not been completed within two weeks, then lastly the practice sends another letter.
- The health center also uses text messages for reminders.
- Reminders are also sent through the patient portal via the EHR.

Patient Education

- The health center uses the patient education module within the EHR to print education for patients. The practice also works with the North Dakota Colorectal Cancer Roundtable to develop messages and education for patients. Additionally, the health center works with other health centers and the state primary care associations in North and South Dakota to share patient education resources for CRC screenings.
- The health center provides services and education through numerous community health fairs.
- The health center uses social media platforms to provide education to the community.

Structural Barriers

- The health center provides transportation services for patients to their practice. The practice and the critical care access hospital are working jointly to overcome patients' transportation barriers for colonoscopies.
- The health center provides after-hours services for patients unable to come between 8am–5pm.

Outreach and Follow-up

- The health center uses a team-based approach with RN care coordinators to assist with closing loops and gaps in care.
- The day before the visit the care coordinator performs pre-visit planning and reviews the charts for any gaps in care. If any gaps are noted, it is communicated to the patient's care team via "huddle notes" within the EHR.
- During the visit, the care team reviews and provides the FIT if appropriate, along with education on how to complete the screening.
  - For normal FIT results, a letter is sent to the patient or a message is sent through the patient portal. All normal/negative results are automatically published to the patient portal.
  - The health center follows up with patients immediately upon receiving positive or abnormal FIT results. The patient is contacted by the nurse via phone and the care team determines if the patient must come in for a follow-up appointment. If the health center has been unsuccessful in reaching the patient by phone, a certified letter is mailed to the patient.
  - Kits that have not been returned are identified within the EHR as orders without results, and the nursing staff follows up. Positive or abnormal results are flagged to the provider and are scheduled for a follow-up appointment.
- If a colonoscopy is the appropriate screening method, the provider performs the history and physical at that visit to prevent the patient from having to return for another visit. The appointment is made for the patient's colonoscopy and the bowel prep instructions are given to the patient at that visit. A staff member from the critical access hospital performs a reminder call the day before the scheduled colonoscopy to review steps with the patient. After the colonoscopy, the results are sent back to the health center with the recommended screening frequency, the reason for increased screening frequency, and the health maintenance module within the EHR is updated.

Navigation for Patients with Positive or Abnormal Results

The care coordinator for each care team navigates patients with positive or abnormal results. The care coordinator is also responsible for updating the patient's medical record if information was received by an interface, and the provider signs off on it.

Interviewee

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