

CASE STUDY SPOTLIGHT

NOELA Community Health Center – Mary Queen of Vietnam (MQVN) Community Development Corporation



Type

Federally Qualified Health Center

Location

New Orleans, LA

EHR

Athena Health

4,904
patients

- 94.0% of patients at or below 200% Federal Poverty Guideline
- 63.2% of patients are best served in a language other than English
- 36.0% of patients are uninsured



Patient Strategies

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



Clinician/Staff Strategies

- Provider assessment & feedback
- Provider reminder or recall
- Provider education
- Care team/team-based approach
- Clinical champion
- HIT interventions dashboard



Reducing Structural Barriers

- Mailed FIT

Background

NOELA's initial review of colorectal cancer (CRC) screening rates in 2013 revealed a rate of 3%, prompting them to make increasing CRC screening a priority. By 2014, NOELA started work with the American Cancer Society and signed the 80% by 2018 pledge (a commitment to strive toward reaching an 80% screening rate). In 2016, their rates had increased to 70.4% and they were working to further increase their rates.

Results

NOELA's UDS CRC screening rate increased to 80% in 2018, achieving the above-mentioned goal. In 2019 their rate was 73.4% and in 2020 it was 75.5%, remaining consistently high across time, including during the COVID-19 pandemic.

Evidence-based Strategies and Interventions

NOELA employed several different strategies to boost their already high CRC screening rates, including implementation of a mailed fecal immunochemical test (FIT) intervention, patient navigators educating patients about CRC screening, providing training to all staff on how to distribute FIT kits to patients, and use of provider dashboards to promote screening within the practice. NOELA provided the following solutions and lessons learned:

Share Data and Feedback with all Staff

The quality improvement director runs monthly reports on the health center's CRC screening data and conducts provider feedback sessions. During the sessions, the staff review test results and ensure that patients are receiving appropriate follow-up. They also look at missed opportunity reports to understand the number of patients that have completed CRC screening and those that have not, and then try to focus on how to improve their screening rates.

- **CRC data and reports shared with all staff:** cancer screening rates comparison (year-to-date); CRC screening – monthly comparison; CRC screening – trailing year comparison; CRC screening – missed opportunity report; colonoscopy vs. FIT.
- **Data and reports shared with patient navigators:** CRC screening trend report; care coordination – client reminders/patient navigation; FITs distributed vs. FITs returned; FITs distributed tracker.
- **Data and reports shared with providers:** daily huddle notes; provider scorecard; cancer screening provider comparison; data discussed during QI meetings.

Patient Navigators

- Navigators go through the registry of existing patients that are due for FIT and contact them by phone. If they have an upcoming appointment, the navigator informs the patient that during their upcoming appointment they can pick up an FIT kit.
- After distributing the FITs, the navigator calls the patient to remind them to bring back the test within a week or two of giving it out, and then reminds them monthly until the test is returned.
- NOELA found they have a better FIT return rate when the patient navigator distributes the FIT than when the provider gives it out. They found this had more to do with the follow up provided by the patient navigator handing it out as opposed to lack of a consistent follow up when the provider gives it out.

Mailed FITs

During the height of the COVID-19 pandemic, patients often didn't want to come into the health center. When reaching out to remind patients, navigators would ask if patients preferred to pick up or receive mailed FIT kits. If mailed a kit, patients would either return them in the mail or bring them back to the health center, as most do not live very far away.

Mail Postcards to Patients Who Don't Respond to Phone Calls

Reminder postcards are mailed to patients who are not available by phone, asking them to call to schedule an appointment. For patients reached by phone, if they are unable to come into the clinic, they're offered the opportunity to receive the FIT kit by mail.

Train Clinical and Non-clinical Staff to Communicate with Patients About FIT

NOELA trained most staff in the clinic on how the test is performed. Whether it's front desk staff or medical assistants, they all know how to explain the process to patients. If the medical assistant did not cover it with the patient by the time the provider gets in the room, the provider will make the recommendation and then either the provider will give the FIT kit to the patient, or at checkout, they ask the front desk staff to explain to patients how to complete it before they leave. Most of the staff are familiar with the test, how it's conducted, and how to explain it to patients.

More Visits per Year = Better Screening Percentage

NOELA found a strong correlation between the number of visits patients have per year, and whether they were up to date with their screenings or not. Patients who tend to complete the FIT kits are the ones who have at least three or more visits throughout the year.



Interviewee

Keith Winfrey, MD

Chief Medical Officer

New Orleans East Community Health Center