Operationalize a FIT Kit/Follow Up Process to Improve Colon Cancer Screening Rates and Reduce Disparities

· PREVENTIVE ·

PARTNERS IN EXCELLENCE

North Memorial Health Care

PROVIDER

North Memorial Healthcare

CHALLENGE

Increase our overall colon cancer screening rates by reducing financial, transportation, language and cultural barriers.

PROCESS FOR CHANGE

We implemented a FIT Kit/Follow Up Process with tremendous success. Our approach mirrored a process described in a JAMA Internal Medicine study (press release 6/16/14). We operationalized a robust standardized process to offer the less invasive fecal immunochemical test (FIT) kit. This is used when a patient declines scheduling the "gold standard" colonoscopy. We follow up via phone call and letter to encourage the sample return for testing. This has markedly increased the sample return rate percentage for testing.

RESULTS

- Our overall colon cancer screening rates have increased, especially for underserved patient populations. We predict that this approach has saved lives due to early detection of colon cancer.
- Prior to implementation of our FIT kit/Follow Up Process, patients returned an average of 10% of FIT kit samples for testing. One year after operationalizing our process, we see an average of 55-85% sample return rate across the 16 primary care clinics.
- We achieved a 74% colon cancer screening rate in 2015.

ADOPTION CONSIDERATIONS

- Understand the barriers preventing patients from following through with recommended colon cancer screening tests.
- Develop methods to reduce those barriers.

RECOMMENDATIONS FOR SUSTAINING GAINS

- Conduct quarterly spot checks of the FIT kit/Follow Up Process Tracking Tools to sustain sample return rate.

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Integrated Depression Care Management Grant

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PARTNERS IN EXCELLENCE

St. Luke's Pediatric Associates

PROVIDER

St. Luke's Pediatric Associates

CHALLENGE

Many of our pediatric patient visits were for social-emotional or behavioral concerns. Our pediatricians desired more guidance when prescribing and managing psychotropic medications. We did not have access to a child psychiatrist, so many patients had to seek care elsewhere – often with long wait times.

Recognizing these concerns, we obtained the Integrated Depression Care Management Grant to develop better mental health screening for pediatric and adolescent patients.

PROCESS FOR CHANGE

St. Luke's hired a mental health care coordinator and created a model of care coordination and psychiatric consultation. We established clinical processes to screen children ages 6-17 with the Pediatric System Checklist. Additionally, we established a bi-monthly "curbside consultation" to assist providers.

RESULTS

- Pediatric mental health screening is now implemented in all of the St. Luke's Primary Care and Pediatric Clinics throughout the St. Luke's system.
- We increased the number of screenings completed by 20%. As a result, we improved identification of behavioral health concerns.
- We improved psychoeducation in the clinic setting and improved more timely access to mental health services.

ADOPTION CONSIDERATIONS

- Accessible database or EMR that can track screens.
- Physician champion and provider buy-in.
- Care coordination that has experience in mental health.

RECOMMENDATIONS FOR SUSTAINING GAINS

- Expanded and continued monitoring of screening practices, including care coordination support to other clinics who may not be as familiar with pediatric mental health concerns.
- Continued and additional training opportunities for staff.
- Continued and sustained community mental health relationships.

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Decreasing Fall Risk with BE-SAFE Program

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PARTNERS IN EXCELLENCE

Park Nicollet® HealthPartners®

PROVIDER

Park Nicollet Physical Therapists

CHALLENGE

Too many of our aging adults are falling and getting injured. Every year more than one in three people over the age of 65 years falls. Among older adults, falls are the leading cause of fractures, loss of independence, hospital admissions and deaths.

PROCESS FOR CHANGE

Physical therapists (PTs) developed the BE-SAFE (Balance, Endurance, Strength and Function Evaluation) Program to better assess and treat our aging patients and prevent falls. All of our PTs can perform the following standardized tests: Gait Speed, Timed Up and Go, Single Leg Stance, 30 Second Sit to Stand, Four Square and 2 Minute Step.

RESULTS

- PTs are quickly identifying fall risk in patients.
- Patients are being prescribed appropriate treatment and exercises.
- On a case by case basis, patients have shown statistical improvement in their scores when retested which decreases their likelihood of falling.

ADOPTION CONSIDERATIONS

- Ensure that all of our adult PTs were trained in the BE-SAFE Program and acknowledge the great impact we can have in our patients' lives.

RECOMMENDATIONS FOR SUSTAINING GAINS

- Created a resource webinar for information on aging and standardized testing procedures, created a cheat-sheet with normative data, streamlined the evaluation form for easy capturing of test results and developed a competency assessment tool.

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Immunization Initiative

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PARTNERS IN EXCELLENCE

HudsonPhysicians

PROVIDER

Hudson Physicians

CHALLENGE

We strongly believe patient immunizations are important. We set the goal to increase our immunization rates of patients 11 years and older by 5% over a 6 month period.

PROCESS FOR CHANGE

We implemented our Immunization Initiative on Feb. 2, 2016. We focused on six selected immunizations: Menactra, Boostrix, Pneumovax, Prevnar 13, Gardasil 9 and Flu. We selected seven provider/clinical assistant teams to start the initiative. In May, we added six more providers, for a total of 13 providers. Our Care Coordinators at each station reviewed the selected provider's schedules each morning. Then, they consulted the EMR, WIR, MIIC and our clinic immunization schedule to identify which vaccinations the patients (11 years and older) were due to receive at their non-illness visits.

The Care Coordinators printed out provider schedules and indicated recommended immunization(s). The clinical assistants reviewed the recommendations with patients during their intake. The provider/clinical assistant teams educated the patients and encouraged receiving the vaccines during the appointments. At the end of the day, the clinical assistants highlighted all patients on the printed schedule that received immunizations and gave the results to our Clinical Services Purchaser who kept the formal tally.

RESULTS

- We increased our immunization rates by 14% over a 3 month period.
- We increased patient understanding of the importance of immunizations.
- We began a new process for patient reminders for immunizations.

ADOPTION CONSIDERATIONS

- You must have provider and clinical staff buy-in.
- You must have the staffing resources to take on the new workload.
- You must have the financial ability to purchase considerably more vaccines up front.

RECOMMENDATIONS FOR SUSTAINING GAINS

- This process has become the standard workflow for the Care Coordinators.
- We perform immunization audits every 2 weeks which are reported to the QA team.
- Providers and clinical assistants are shown their audit results on a monthly basis.

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Reducing the Incidence of Unmanaged Diabetes in the Latino and East African Patient Population

· PREVENTIVE ·

PARTNERS IN EXCELLENCE

CentraCare Clinic

PROVIDER

CentraCare Health

CHALLENGE

CentraCare Health believes that community-based health education and community health workers can play an integral role in raising the level of health care obtained by the East African and Latino populations. This project focuses on providing the Somali and Latino populations with a community health worker who represents the cultural background of the population.

PROCESS FOR CHANGE

Utilizing a home visit model, CentraCare identifies patients for community care coordination via diabetes registries at its Melrose and Family Health Center locations. Next, a community health worker, one representing the Latino population or another representing the East African population, visits patients in their homes and provides support for navigation of the health care system.

The community health workers also coordinate care between the primary care provider, diabetic educator, pharmacist and the health care home coordinator. The team functions through warm handoffs, as well as utilizing the electronic medical record to stratify patients and document patient encounters. This way, all members of the team are able to provide consistent and coordinated care. We collect client feedback via intake forms, phone calls, focus group discussion and word of mouth.

RESULTS

- Reduction in no-shows at the clinic.
- Built relationship within the community and the clinic.
- Lowered A1c.

ADOPTION CONSIDERATIONS

- Community needs to be involved in the problem solving and solution design.
- Relationships are key to our health.
- Partnership and collaboration are essential in improving health.

RECOMMENDATIONS FOR SUSTAINING GAINS

- Retain the community health workers.
- Look for other sources of funding.

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