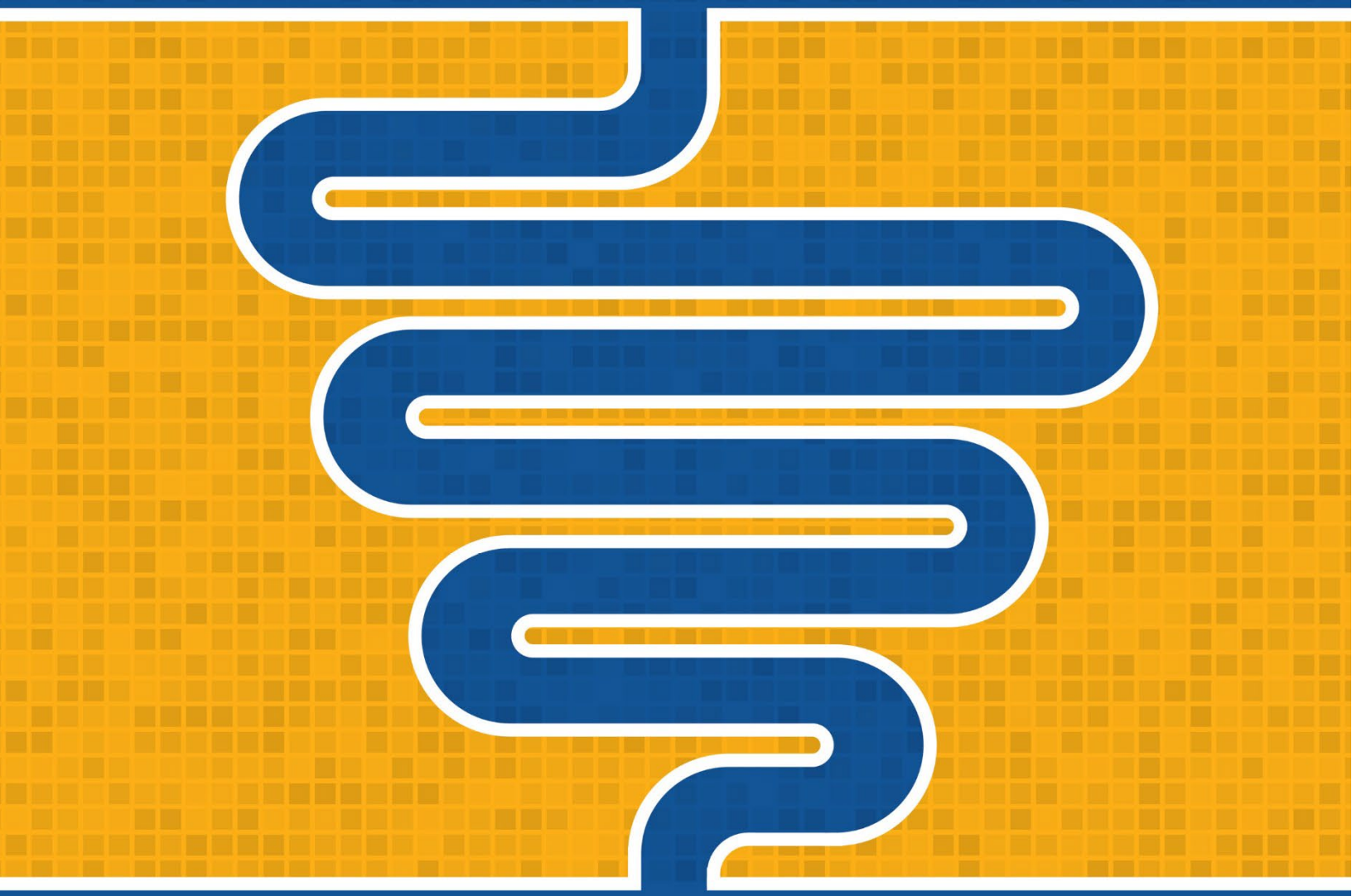
Testimonial Transcript
UNC SCORE Project



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Narration

Scaling Colorectal Cancer Screening through Outreach, Referral, and Engagement or SCORE was a partnership between the Lineberger Comprehensive Cancer Center at the University of North Carolina at Chapel Hill and two community health centers that serve rural North Carolina communities.

The two community health center partners were Blue Ridge Health in the western part of the state and Roanoke Chowan Community Health Center in the northeastern part of the state.

SCORE is a demonstration project funded by the National Cancer Institute Cancer Moonshot Initiative, Accelerating Colorectal Cancer Screening and Follow-Up Through Implementation Science program.

The goal of SCORE was to reduce colorectal cancer mortality rates by increasing the screening rates among patients in the two community health centers.

The project used mailed fecal immunochemical tests or FITs, which are stool-based screening tests that patients can receive by mail and complete at home.

This video tells the story of SCORE and the project's interim results.

We hope that this information can help you to create successful partnerships to implement and operate a successful mailed FIT outreach program.

Community health centers are non-profit organizations that provide health care to medically underserved populations throughout the United States.

In North Carolina, community health centers serve patients in all 100 counties.

Blue Ridge Health in western North Carolina provides care to many temporary agricultural workers that do not have medical insurance.

Roanoke Chowan Community Health Center in northeastern North Carolina serves rural medically underserved counties where 88% of people report incomes below 200% of the federal poverty level. The map shows counties where the SCORE project mailed FITs to patients of Blue Ridge Health and Roanoke Chowan Community Health Center.

The Blue Ridge Health population is about 29% Hispanic and 66% non-Hispanic White.

The Roanoke Chowan Community Health Center population is about 56% Black or African American and 41% non-Hispanic White.

About 30% of Blue Ridge Health patients are covered by Medicare or Medicaid, and 51% do not have health insurance.

About 61% of Roanoke Chowan Community Health Center patients are covered by Medicare or Medicaid, and 31% are privately insured.

Only about 13% do not have health insurance.

A key goal of SCORE was to increase colorectal cancer screening without increasing the workloads of busy clinical care providers and staff.

To accomplish this goal, the SCORE team delivered mailing and navigation services from one central location to patients of both community health centers.

The University of North Carolina Lineberger Comprehensive Cancer Center served as the central location for mailing FITs and providing navigation.

The SCORE organized mailed FIT outreach intervention had three main components: a colorectal cancer screening registry, centralized mailed FIT outreach, and a patient navigator.

The SCORE team started a new mailing cycle every four to six weeks.

Between 50 and 200 kits were sent out in each cycle.

The colorectal cancer screening program included the following steps.

Select eligible patients: The clinic teams ran a query on their electronic health record (EHR) system to identify patients who were eligible for a FIT kit.

Patients who were eligible were entered into a registry.

For organizations that are implementing this program in the future, such a registry could be maintained within the EHR system or outside the system in a database.

Mail out FIT kits: The SCORE team used the registry to schedule and mail out FIT kits and reminder letters and track FIT completion rates.

The SCORE team also responded to patient calls from patients about the FIT kit.

Process FIT results: Patients mailed their completed kits to a designated lab for processing.

The lab reported test results to the clinic and the SCORE team.

Refer and navigate to follow-up colonoscopy: The clinics referred patients with abnormal FIT results to colonoscopies.

The SCORE patient navigator provided telephone support to help patients complete colonoscopies.

The navigator explained the colonoscopy process to patients, offered emotional support, answered questions, and coordinated financial and transportation assistance.

Between July 2020 to September 2021, SCORE mailed 1,961 FIT kits.

The mailed FIT return rate was 25%.

Forty-three patients (9%) had an abnormal FIT and were referred to the SCORE navigator and follow-up colonoscopy.

84% of those patients completed follow-up colonoscopies.

One cancer was detected and treated.

It is important to set aside enough time, months, not weeks, to develop and test your plan for adapting this program to fit your EHR system and clinic workflows.

Doing this will help you to reach more patients, including patients who may have barriers to in-person healthcare visits.

Before your clinic can schedule mailed FIT outreach cycles for large patient groups, you will need to:

- Develop and test an EHR population query to identify patients who are eligible and due for FIT screening.
- Develop and test a registry to manage and track the organized mailed FIT outreach services that you provide to eligible patients.

It may be possible to maintain the registry inside your EHR system.

The SCORE project developed a HIPAA-compliant registry outside the EHR systems of our partner community health centers.

The registry is essential for keeping track of when patients:

- receive annual mailed FITs and reminder letters,
- complete their mailed FIT,
- receive notice of their results,
- receive a referral for a follow-up colonoscopy after an abnormal result,
- are contacted by the patient navigator, and
- complete a follow-up colonoscopy after an abnormal result.

Document and pilot test your mailed FIT outreach and navigation protocols to make sure they do not impede or duplicate clinic workflows.

Determine how many patients your program will serve and create a schedule for mailing FITs to groups of patients on a monthly, quarterly, or twice-yearly cycle.

Please see the example detailed workflow document on the NACDD mailed FIT online course web pages.

An overall challenge was developing a centralized mailed FIT outreach program that worked in coordination with the EHR systems and unique workflows of different clinics.

To help manage this challenge during the program development phase, the SCORE team created workgroups that included SCORE and clinic staff for each intervention component. The three components included the EHR query and screening registry, centralized mailed FIT outreach, and follow-up patient navigation.

For patients with abnormal results and particularly for those without health insurance, another challenge was addressing the affordability of follow-up colonoscopies.

The patient navigator played a key role in linking patients to needed financial and transportation services.

In partnership with Blue Ridge Health, Roanoke Chowan Community Health Center, and the National ACCSIS Consortium, the University of North Carolina UNC Lineberger Comprehensive Cancer Center is evaluating the SCORE program's effectiveness, cost-effectiveness, and implementation processes.

The evaluation includes manual review of patient charts to compare screening completion rates in the intervention and control arms, time and motion study to compare personnel and materials costs in the intervention and control arms and calculate the cost-effectiveness of SCORE, surveys, interviews, and focus groups to evaluate implementation processes.

The team used patient and provider comments as indications of interim progress.

Patients appreciated the convenience of being able to complete the test at home and mail their samples to the lab.

"It was definitely the way to go for me, not coming into the doctor's office. That's always a pain in the neck."

Patients who completed the navigation also liked the process.

"I'm grateful that the navigator called me. He gave me the feeling that I was not doing this on my own and that he understood the process a lot better than I did."

The providers liked the program because patients received screening recommendation through the program, the mailed FIT workflow did not interfere with clinic workflows, and the SCORE patient navigator provided one on one support for follow-up colonoscopies.

"I don't think there's a downside to implementing a program like this."

The entire mailed FIT program does not have to be wholly contained at one location or implemented by a single team.

Instead, the three main components of the system – the screening registry component, the mailed FIT component, and the follow-up navigation component can be managed by different teams.

Communication across teams is essential.

The screening registry component of the program required team members with EHR expertise to develop an EHR query to accurately identify patients and program the EHR or an external HIPAA-compliant database to track mailings and screening results.

Training and technical assistance would be beneficial.

The mailed FIT component of the program required technical assistance to set up workflows for assembling and mailing kits, tracking screening completion, notifying patients of results, and updating the EHR.

The centralized patient navigation component of the program required access to each clinic's EHR system to monitor colonoscopy referrals and communicate directly with providers and staff.

The navigator did not need a clinical background but did require training and good interpersonal skills to connect with patients and healthcare teams.

Navigation programs can reduce the time delay between receiving an abnormal result and completing a follow-up colonoscopy.

For patients who speak languages other than English, consider hiring a bilingual navigator or linking to interpreter services and using communication materials in the languages they speak.

Thank you for watching this video about the SCORE mailed FIT outreach program.

We hope that our story gave you some ideas to start or deliver organized mailed FIT outreach to your clinic patients.

Resource Links

Mailed FIT Implementation Guide

https://chronicdisease.org/wp-content/uploads/2023/01/60851-Mailed-FIT-Guide-v50.pdf

Mailed FIT Implementation Workbook

https://chronicdisease.org/wp-content/uploads/2023/01/Mailed-FIT-Course-Workbook-v05FF.pdf