LINKS OF CARE UPDATE: SUCCESSES AND LESSONS LEARNED FROM THREE PILOT SITES

JULY 27TH, 2017
1:00 PM ET
Purpose of Today’s Webinar

• Understand what we’ve learned so far from the Links of Care pilots, including:
  – An overview of each pilot site,
  – How the project was implemented
  – Workflows
  – Key partnerships and “asks” of partners
  – Successes
  – Lessons learned and remaining challenges

• Q&A
The Problem

• Federally Qualified Health Centers (FQHCs) serve low-income, uninsured/underinsured populations
• CRC screening can be provided at low cost through stool testing
• Lack of access to follow up colonoscopy needed, if stool test abnormal
• Need to create a more cohesive Medical Neighborhood to provide care across the continuum
Presenters

• **Moderator: Kara Riehman, PhD**
  Strategic Director, Evaluation & Research, American Cancer Society, Inc.

• **Suzanne Lagarde, MD, MBA, FACP**
  Chief Executive Officer, Fair Haven Community Health Center, Connecticut

• **Julia Williams, RN**
  Chief Nursing Officer, Beaufort Jasper Hampton Comprehensive Health Services, Inc., South Carolina

• **Chris Singer, RN, CPHQ**
  Chief Operating Officer, West Side Community Health Services, Minnesota
The Opportunity:

Three grants in the amount of $150,000 each over 30 months have been awarded to Federally Qualified Health Centers (FQHCs) networks and local system partners to decrease colorectal cancer mortality rates.

Three sites were selected on May 30\textsuperscript{th}, 2014 and are implementing the project through 2017.

The grant funding is intended to stimulate collaboration among local partners and support development of the long-term structures and relationships needed to improve access to specialists in the community in the delivery of colorectal cancer screening.
Pilot Site Support

- Pilot sites received $150,000 for the 30 month pilot; $125,000 went to FQHCs primarily as compensation for the reporting requirements; $25,000 went to the partner applicant

- NCCRT assisted pilot sites in conducting a community assessment

- NCCRT and ACS helped coordinate a stakeholders meeting to design a plan to improve care delivery

- NCCRT, ACS & Partners spurs involvement of additional physician leaders

- Partnering community receives technical assistance throughout the assessment and planning phase, as needed

- Partnering community receives coaching on high performing models and other support throughout the implementation phase, as needed
The Goal:

Primary goal:
• Increase timely access to specialists after a positive screening result.

Secondary goal:
• Advance evidence-based strategies to increase colorectal cancer screening rates within primary care systems.
# Pilot Sites

<table>
<thead>
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<th>City</th>
<th>Lead FQCH</th>
<th>FQHC #2</th>
<th>FQHC #3</th>
<th>FQHC #4</th>
<th>Partner Applicant</th>
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<tr>
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<td>La Clinica</td>
<td>East Side Family Clinic</td>
<td>McDonough Homes Clinic</td>
<td>N/A</td>
<td>Minnesota Dept. of Health Sage Program</td>
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<td>Bella Vista Clinic</td>
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<td>Community Health Center Association of CT</td>
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<td>Port Royal, SC</td>
<td>Beaufort-Jasper-Hampton Comprehensive Health Services, Leroy E. Browne Medical Center</td>
<td>Ridgeland Family Medical Center</td>
<td>Port Royal Medical Center</td>
<td>Ruth P. Field Medical Center</td>
<td>South Carolina Primary Health Care Association</td>
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Evaluation Questions

• How have FQHC partners implemented the links project?
  • How did they build external collaborations with GIs/Hospitals?
  • How did they implement internal processes?

• What is the role of ACS staff in project implementation?

• What did we learn from this pilot that will help us sustain and expand Links of Care?
Building Partnerships: Strategies

• Identified GI champions who:
  • Are committed to public health and social justice
  • Recognize importance of colon cancer screening

• Emphasized role of navigator
  • Ability to decrease no-show rates, ensuring donated time is well-spent

• Built on existing relationships between FQHC and hospital
  • FQHC clinical staff sit on hospital committees
  • FQHC CMO and hospital CMO relationship
Role of Patient Navigator

• Education on FIT and colonoscopy
• Refer for colonoscopy
• Schedule colonoscopy
  – Depends on GI/hospital partner process
• Reminders
• Ensure prep, transportation
• Track results in EHR/tracking system
• Inform patients of results
• Follow-up on no-shows
• Refer to follow-up/treatment
Role of ACS

- Reputation enhanced legitimacy
- Instrumental in partnership building
- Viewed as independent third party
  - Have separate conversations with FQHCs and partners ‘behind the scenes’
- Support and reassurance
  - ‘We’re not out there fighting this alone’
- Problem-solving
Keys to Successful Implementation

• Start with the right partners
• Ensure partner leadership at the table initially
• Patient navigator
• Passionate staff
• FQHC Leadership involvement
• Use data to demonstrate progress, challenges
• Celebrate successes
Fair Haven Community Health Center

- New Haven Connecticut
- 18,000 patients
- 72% Hispanic-majority monolingual Spanish
- 25% uninsured
- 58% Medicaid, 11% private insurance, 6% Medicare
Fair Haven Community Health Center--Program

Links to Care Program
• Partnered with members of the department of Digestive Diseases at Yale University School of Medicine
• Colonoscopy-based program; FIT for patients refusing or at high risk for colonoscopy
• Open access endoscopy, **high intensity patient navigation**
Patient Navigation

- Most of Links to Care funding went to support PN salary and fringe
- Bilingual, from community, passion for work
- Trained to use checklist, follow guidelines, track outcomes
Guidelines or “Rules of engagement” for PN

- Face to face encounter with Patient Navigator (PN)
- Patient education—importance of procedure, dispel “urban myths”
- Procedure scheduled within 4 weeks, usually within 2 weeks
- Confirm transportation, including contact info for transporter
- Review bowel prep in native language, verbal & written, appropriate literacy level
- PN provides bowel prep. In CT, Golytely fully covered by Medicaid.
- Addresses key meds: anti-platelet agents, anti-coagulants, insulin, DM meds, BP meds
- **Patient told must make contact within 7-10 days before scheduled appointment or canceled**
- All patients called day before to encourage prep, push fluids, etc
Referrals June 2014 – June 2017

- Colonoscopy Referrals: 1469
  - Performed: 741 (50%)
  - Not Performed: 504 (34%)
  - Advanced Lesions: 17 (2.3%)
  - Tubular Adenoma: 261 (35%)
  - Cancer: 4 (0.5%)
  - Advanced Lesions: 17 (2.3%)
  - No Show: 22 (2.9%)
  - Poor Prep: 21 (0.3%)

- FIT test given: 354 (70%)
- FIT test returned: 245 (69%)
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<th>Year</th>
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<th>2015</th>
<th>2016</th>
<th>2017 (7/1/16-6/30/17)</th>
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<tr>
<td></td>
<td>43.66%</td>
<td>44.12%</td>
<td>50.1%</td>
<td>54.9%</td>
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Cost Analysis over first two years of Program

- 3 cancers: 2 early stage
- Cost analysis showed estimated savings of $263,450 from early detection of cancers
- Cost analysis showed small savings ($36,340) from decreased no show rates
- BUT, low reimbursements from Medicaid and self pay resulted in overall NET LOSS of $558,246
Lessons Learned

- Key role of navigation—3% no-show rate, critical to maintaining commitment of gastroenterologists
- Cost of navigation currently not reimbursed
- Over first two years, not cost effective
- Colonoscopy capacity of participating GIs is rate limiting factor—approximately 250/year
- Attempts to engage more GIs in private practice failed. One private practice working with us, but many limitations
Response to Challenges

Capacity limitations
• Change program to FIT for average risk population, colonoscopy for high risk.
• Continue to try to engage private practice GIs,

Sustainability
• Transition to FIT for average risk population
• Part of State pilot looking at Value Based Payments. Colon cancer screening currently not part of the Quality Metrics. With advanced payments, able to hire PN.
THANK YOU AMERICAN CANCER SOCIETY AND LINKS TO CARE!!
Speaker: Julia C. Williams

Chief Nursing Officer & Director of Quality Assurance
Beaufort Jasper Hampton
Comprehensive Health Services, Inc.

July 27, 2017
• **Beaufort Jasper Hampton Comprehensive Health Services, Inc. (BJHCHS)** was organized to deliver comprehensive health services to the socially and economically deprived residents of Beaufort, Jasper & Hampton Counties.

• **BJHCHS was incorporated in 1969, and added Hampton County in 1998.**

• One of twenty FQHCs located in the rural Low Country of South Carolina.

• **Nine centers and eight school base programs.**

• **Beaufort County is made up of Sea Islands connected by bridges**
Lowcountry – Finding Intestinal Troubles (L-FIT)

Our organization represented the rural community.

The program was a FIT to colonoscopy program.
The purpose of the Links of Care pilot was to stimulate collaboration among local partners and support development of long term structures and relationships needed to improve access to specialists in the community in the delivery of colorectal cancer screening for community health centers.

- Reach out into our rural communities and perform colorectal screenings on our patients.

- Encouraging and providing patients a cost-effective means for CRC screening by providing FIT testing versus screening colonoscopies.
Overview - continued

• Adding a patient Navigator to staff in order to coordinate the CRC program and actively work with patients and staff.

• Utilizing our community partners to conduct community assessments with residents and gastroenterologists to address the barriers and unmet needs of the uninsured and underinsured to alleviate disparities in care.
Implementation

Policy and Procedures
- Letter to all age appropriate patients (50-75)
- Developed tracking log for navigator
- Educated Providers and staff
- Discussion with local Gastroenterologists to seek collaboration
- Discussions concerning cost of FIT tests and cost negotiation
- Met with South Carolina Primary Health Care Association to coordinate community assessment
- Initially four centers only with staggered starts
Workflows

- Identification Process
  - Initial request to screen, notification of screening time and place
  - Notification of screening results
- Positive diagnostic- follow-up and treatment
- Negative- letter sent to patient
Workflows

- Referral to surgeon/oncology
- Patients referred to Beaufort Memorial Hospital
- Referred to Keysering Cancer Center in Beaufort or Hollings cancer Center in Charleston
Beaufort Jasper Hampton Comprehensive Health Services * Colorectal Screening Process

Patients are triaged and identified for FIT Program

- Discuss program with pt and offer
- Patient agrees to testing
- Patient instructed on use & process
- Nurse fills out order & puts hard copy in kit
- Navigator pulls FIT test results daily

- Positive results identified
  - Patient refuses
  - Navigator documents results on CRC log & EHR

- Negative results identified
  - Navigator calls to notify pt - pt is notified or no answer
  - Navigator notifies pt of results
    - Navigator documents on CRC log & EHR
    - Pt receives letter & calls for results
      - Pt is scheduled for colonoscopy
        - Navigator Contacts pt w/ apt for colonoscopy
        - Pt instructed on bowel prep/ pt specific instructions
        - Navigator sends script to preferred pharmacy
        - Navigator ensures that pharmacy sent prep to pt
        - Navigator notifies pt of results
          - Navigator documents in EHR & pt notified in 1 yr for f/u

- No answer - navigator mails pt letter to contact office
  - If no response, navigator sends certified letter
    - No response to certified letter, Pt marked as "lost to f/u" in EHR & CRC log

- If no results reported, navigator contacts patient for reminder.
  - Discuss reason for not having test yet & wants to have done
  - Navigator documents on CRC log patient response

- Pt changed mind & does not want to participate
  - Navigator documents in EHR & pt notified in 1 yr for f/u

- Patient refuses
  - Navigator contacts nurse to reinforce instruction on pick up
  - Pt contacted 1 week out to reinforce apt
  - Post colonoscopy - Nav pulls results/ pathology and scans into EHR

- Pt has done or has agreed to proceed with taking the test
  - Pt contacted the day before regarding day of preparation
  - Copy of prep instructions mailed to patient

DONE
Key Partners

- National Partners
  - National Colorectal Roundtable
  - CDC
  - American Cancer Society
  - Walgreens
- Dr. Montenegro and staff
- Beaufort Memorial Hospital
- AccessHealth Lowcountry- Debbie Slazyk
- Beaufort Memorial Hospital (BMH)
- Dr. Crisologo
Key Partners

- Pathology services of Beaufort and Charleston - Dr. Collins
- Keyserling Cancer Center - Dr. Chahin
- Low Country Anesthesia - Dr. Bell
Asks

Initially asked Dr. Montenegro

AccessHealth Lowcountry coordinated meeting to “ask” BMH for free Colonoscopies
  Free = $250,120 donated services from BMH (52 Colonoscopies)

CEO, CMO and key staff from BJHCHS and ACS staff

Initial ask was for 4 donated colonoscopies per month and received 8 per month

Keyserling Cancer Center agreed to provide treatment to any patient diagnosed through the project regardless of insurance status and ability to pay (3 patients have been diagnosed)
Successes

Percentages CRC Screening Rates

- 2011: 26%
- 2014: 38%
- 2015: 38%
- 2016: 55%

2011 26%
2014 38%
2015 38%
2016 55%
Successes - continued

- FIT kit return rate 59% consistent over time
- 100% of the 67 patients that were scheduled for colonoscopies kept their appointment
- 99.9% were adequately prepped
- Ability to provide patients with an efficient means of testing and receiving follow-up care that had not been available due to cost
- Improved communication between the hospital and BJHCHS
Lessons Learned

- Assistance from National organizations valuable to create dialogue/interest in addressing public health issues
- Communication/coordination needs to be done prior to implementing change and on-going
- Importance of navigation
- Importance of calculating need in order to make the ask
Remaining Challenges

- Sustainability
- Continue to work with BMH scheduling department
- Continue to look for funding opportunities
- Increase public awareness and media buy in
Links to Care:
West Side Community Health Services
Project Overview

West Side Characteristics: Largest FQHC in Minnesota; over 36,000 unduplicated patients seen annually; 35% remain uninsured; high incidence of language barriers

Goal: Implement medical neighborhood to facilitate colorectal cancer screening for all patients regardless of ability to pay

Stakeholders: GI partners, ACS, state health department

Strategies: primary FIT program, leverage free colonoscopies from partners, improve MA/provider workflow, provide staff education
About West Side

• Largest FQHC in Minnesota
• Over 36,000 unduplicated patients seen annually
• Serve those who have the greatest barriers
  • 35% remain uninsured
  • 97% have income below 200% of FPL
  • 53% prefer language other than English
Low improvement trend - Barriers

• IFOB kits underutilized
  - Follow-up colonoscopy not available for uninsured patients if test was positive
  - Providers perceived colonoscopy as superior

• No formal process for walking alongside patients during colorectal cancer screening process or colonoscopy referral

• No registry tracking system to know individual patient outcomes

• Tremendous need for follow-up, diagnostic and treatment for uninsured, under-insured, and uninsurable patients

• Community assessment showed that community providers willing to donate services.
Partnerships developed for free colonoscopy testing for uninsured patients

- MN Colorectal Roundtable pulled stakeholders together to plan strategies
- Stakeholder meeting to discuss need in January 2015
- Two GI partners committed to donating free colonoscopies plus additional services
  - Minnesota Gastroenterology
  - Colorectal Surgical Associates
Successful Partnership Development

- Engagement from many angles
  - Community Clinical Champions
  - State support and engagement
  - American Cancer Society
  - Engagement among many disciplines
- Both partners agreed to free colonoscopies (Total of 16/month)
Changes in Workflow

• Began project planning to increase number of colonoscopies vs iFOB; very quickly transitioned to primary iFOB campaign
• Provider and clinical staff education to order iFOB first
• Work with GI partners to complete colonoscopy for patients whether (un)insured
• Hire patient navigator
• Formalize and standardize workflows for all staff
• Integrate into daily flow
Role of Patient Navigator

- Maintain patient registry
- Contact patients if in-clinic appointment did not result in screening order
- Manage incentivized mailing campaign
- Educate patient about screening options
- Walk along side patient for colonoscopy referral, prep, and completion to minimize no show
As additional resources become available, workflow adapts to bring more patients into screening compliance. (SAFE, Links)
Eligible Patients Completing Colorectal Screening at WSCHS

FOBT in last year or
Colonoscopy in last 10 years or
Sigmoidoscopy in last 5 years

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<th>Percentage</th>
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<td>2016</td>
<td>43.8%</td>
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<tr>
<td>2017</td>
<td>62.0%</td>
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From 268 colonoscopies,

- 95% of patients had at least one polyp removed
- Total of 697 polyps removed
  - 128 tubular adenoma
  - 21 advanced adenoma
Lessons Learned

• IFOB offered to all patients as first line of screening is a must

• Colonoscopy still an option if IFOB was positive or if providers elected due to risk factors – performed fewer colonoscopies with Links

• Must be part of daily process – Team Visit Planning

• Patient incentives are effective

• Unscreened population = increased cancers diagnosed
What’s Next

• Develop partnerships with ‘treatment’ partners
• Continue to support and develop community and GI partnerships = medical neighborhood
• Add additional GI partners
• Spread program to additional FQHC clinics
• Further develop patient navigator role
• Support daily workflow
Questions?

Chris Singer, MAN, RN, CPHQ
West Side Community Health Services

cjsinger@westsidechs.org
Thank You!

- Suzanne Lagarde and Fair Haven Community Health Center
- Julia Williams and Beaufort Jasper Hampton Comprehensive Health Services, Inc.
- Chris Singer and West Side Community Health Services
- The GI practices, hospitals, and local American Cancer Society health systems staff partnered with each site
- The NCCRT Community Health Centers Task Group
- The American Cancer Society, the Centers for Disease Control and Prevention, the National Association of Community Health Centers, and the many contributors who have helped in these efforts!

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Upcoming Webinars

80% by 2018 Progress
Tuesday, September 26th, 1:00pm ET

Save the date:
nccrt.org/webinar-80by2018-progress/
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