Links to Care
Building Specialty Care Linkages for FQHC Patients

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Links to Care Pilots Seek to Improve:

• CRC screening and follow up care for uninsured, underinsured and uninsurable patients

• Strengthening relationships between community health centers and specialty providers based on a fair distribution of donated services

What is Links to Care?
Solve the Access to Specialty Care for CRC

• Uninsured, underinsured and uninsurable patients at FQHCs face barriers to specialty care

• Patients who complete take-home stool tests don’t have a way to get follow-up colonoscopy and treatment, if necessary

• Providers unwilling to offer stool testing options if no follow-up available
3 Pilot Sites

• Pilot Projects started in mid-2014

• Supported by: NCCRT, ACS & CDC

  ▪ Low-Country, SC
  ▪ New Haven, CT
  ▪ Saint Paul, MN
Why West Side Community Health Services?

- Largest FQHC in Minnesota
- Over 36,000 patients seen annually
  - 36% of West Side patients were uninsured in 2014
  - About one half of the insured were on Medicaid
  - Significant number of under-insured with high out-of-pocket deductibles making colonoscopy unobtainable
  - Many uninsured are uninsurable
  - Over 3,700 patients age 50 and older
  - About 17% screening rate June 2013
Challenges at West Side in 2014

• Stool tests under-utilized
  - Follow-up colonoscopy not available for uninsured patients if test was positive
• No formal screening navigation and colonoscopy referral process
• No patient registry
Challenges at West Side

- Unmet need for follow-up, diagnostic and treatment for uninsured, under-insured, and uninsurable patients
- West Side’s patients had no access to routine specialty care

Root Cause: Lack of Access to Specialty Care
Solution: Finding solutions that works for West Side’s patients
Our Strategies

• Develop a FIT based program
• Improve MA / provider workflow
• Screening navigation
• Staff education

• Relationship/Linkages with GI Groups
Our Approach

1) Conduct Community Assessment
2) Convene Stakeholder Group
3) Studied and Shared High Performing Models
4) Made a case for donated care
5) Distributed the burden of providing donated care
6) ACS staff served as conveners and catalysts
7) Trained staff on pre-visit planning process
8) Educated providers on efficacy of stool testing
9) Trained and placed Screening Navigators
10) Stool testing --primary screening modality

6) Referred positive stool testing for follow-up colonoscopy
7) Endoscopy relationship management
MN State CRC Roundtable

- Convened Executive Leaders from Minnesota’s largest Health Systems (i.e. Hospitals, Specialty Practices, Public Health)
- Recruited key decision-makers
- Incorporated the *Links to Care* into the agenda to create momentum
Successful Partnership Development

• Engagement from many angles
  - Community Clinical Champions
  - MDH support and engagement
  - American Cancer Society Health Systems and Advocacy Staff
Partnerships developed for diagnostic colonoscopy for uninsured, uninsurable patients

- Two GI partners committed to donating free colonoscopies plus additional services
- Initial commitment of about 16 donated colonoscopies per month
Changes in Workflow

- Increased focus on stool testing; very quickly transitioned to stool testing as primary screening modality
- Provider and clinical staff education to order stool test
- Hire patient navigator
- Work with GI partners to complete colonoscopy
- 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 direct-mail campaign
- Educate patient about screening options
- Walk along side patient for colonoscopy referral, prep, and completion to minimize no show
Preliminary Analysis: Polyps Removed

**Tubular Adenomas**
- Uninsured
- Private
- Medicare
- Medical Assistance
- MSHO

**Adenomatous / Advanced Adenoma**
- Uninsured
- Private
- Medicare
- Medical Assistance
- MSHO
Preliminary Analysis: Polyps Removed

Serrated & Tubulovillous Polyps

- Uninsured
- Private
- Medicare
- Medical Assistance
- MSHO

Combo of Tubular & Hyperplastic Adenomas

- Uninsured
- Private
- Medicare
- Medical Assistance
- MSHO
Lessons Learned

- Stool testing to average risk patients as first line of screening
- Colonoscopy still an option if stool testing was positive or if providers elected due to risk factors
- Must be part of daily process – Team Visit Planning
- Patient incentives are effective
- Unscreened population = increased cancers diagnosed
Lessons Learned

• GIs groups are often willing to provide donated services and care if **expectations are clear** (i.e. a defined number of colonoscopies per week or month), **business case is clear** (fulfill Community Benefit; reduce downstream ER use of CRC patients) and **burden is clearly shared** among local providers or systems.

• Volume can be managed if **all parties work collaboratively** and there is effective coordination/distribution of cases.
Advancing Policy Solutions

- Building on ACS CAN policy work in MN
- Highlight successes of Links to Care with State & Federal legislators
- Build Congressional champions for and raise visibility of this public-private partnership
- State funding for centralized referral coordination and screening navigation
What’s Next

• Focus groups – patients who decline recommendations
• Develop partnerships with hospitals for gap coverage
• Continue to support and develop community and GI partnerships. Add additional GI partners
• Spread program to additional FQHC clinics
• Develop centralized referral coordination and screening navigation