Links of Care

August 17th, 2015
3:00pm EST
National Colorectal Cancer Roundtable Webinar
Purpose of Today’s Webinar

• Examine common features of model programs that have demonstrated success in securing follow up care in the delivery of colorectal cancer screening for uninsured, underinsured, and low-income adults

• Understand elements crucial to success in building strong relationships with gastroenterologists, hospitals, and other specialists

• Q&A
Presenters

Mary Doroshenk (Moderator)
Director, National Colorectal Cancer Roundtable (NCCRT)

James Hotz, MD
Medical Director
Cancer Coalition of South Georgia
NCCRT Steering Committee
Co-Chair, NCCRT Community Health Centers Task Group
National Association of Community Health Centers

Jason Beers
President and CEO
Operation Access
NCCRT Member

Lynn Butterly, MD
Director, Colorectal Cancer Screening
Dartmouth – Hitchcock Medical Center
NCCRT Steering Committee
Background

**June 2012** – The NCCRT co-hosted a meeting with the National Association of Community Health Centers to identify strategies for improving colorectal cancer in community health centers.

**February 2013** – Then Assistant Secretary for Health Dr. Howard Koh convened a group to advance work on colorectal cancer screening rates, particularly among the underserved.

**June 2013** – Strategy paper published. Need to improve access to specialty care after CRC screening highlighted as a major barrier.

**September 2013** – Leaders of professional societies along the care continuum met to review model programs.

**May 30th, 2014** – Three pilot sites were selected.
Financial Challenges

• Cost constraints, even for insured patients (high deductibles)
• Costs along the entire care spectrum (e.g. hospital fees, pathology fees, anesthesia fees)
• Cost of follow-up treatment if needed
• Indirect costs of screening (time off work, post-treatment care, etc.)
• Lack of reimbursement for care coordination/patient navigation
Health Partner/Provider Recruitment

- Lack of providers who accept uninsured, underinsured or Medicaid patients
- Lack of specialists, especially in rural and low income communities
- Limited access to safety net providers
- Long wait times (for both screening and follow-up care), especially for Medicaid patients
- Liability concerns
Patient Related

- Poor care coordination/patient navigation
- Language barriers
- Cultural issues
- Access issues – lack of transportation, ability to take time off work
- Poor health literacy
- Fear of screening
- Poor patient prep
- Hi no-show rate
Effective Models

James Hotz, MD, Medical Director, Cancer Coalition of South Georgia

Colleen Schmitt, MD, Project Access/Founding Physician of Volunteers in Medicine, Chattanooga, TN

Jason Beers, CEO, Operation Access, San Francisco and the Peninsula

Lynn Butterly, MD, Principal Investigator and Medical Director, New Hampshire Colorectal Cancer Screening Program

Dave Greenwald, MD, New York Citywide Colon Cancer Control Coalition

Carla Ginsburg, MD, MPH, AGAF, Chair, Public Affairs and Advocacy Committee, American Gastroenterological Association
James Hotz, MD
Medical Director
Cancer Coalition of South Georgia
NCCRT Steering Committee
Co-Chair, NCCRT Community Health Centers Task Group
National Association of Community Health Centers
The Case for Upstream Investment

If too many people are drowning in the river, it’s not enough to fish them out. We must look upstream and find out why they are falling in in the first place.

The Case for Upstream Investment

If too many people are drowning in the river, it’s not enough to fish them out. We must look upstream and find out why they are falling in in the first place.

Phoebe Serves High Needs Region in SW Georgia

- Five hospitals; 691 beds at regional tertiary center
- Cancer services extend to citizens in a 100-mile radius
- One of the 10 poorest Congressional Districts
- Double state average of Medicaid recipients - state 19% vs. region 33% eligibility
- Overall highest cancer incidence in Ga. Terrell is No. 1
Population by Ethnicity

2011 ESTIMATED POPULATION
178,350

2017 Projected Population
183,855

Data source: Georgia Department of Public Health, Oasis 2013

Nielsen-Claritas Data Set, December 2012 Build
# Demographics

<table>
<thead>
<tr>
<th></th>
<th>Dougherty</th>
<th>Lee</th>
<th>Mitchell</th>
<th>Terrell</th>
<th>Worth</th>
<th>Georgia</th>
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<tbody>
<tr>
<td>Population, 2012</td>
<td>94,501</td>
<td>28,746</td>
<td>23,144</td>
<td>9,045</td>
<td>21,741</td>
<td>9,919,945</td>
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<tr>
<td>Persons 65 years and older</td>
<td>12.4%</td>
<td>8.7%</td>
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<td>15.25</td>
<td>15.1%</td>
<td>11.0%</td>
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<tr>
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<td>30.4%</td>
<td>76.0%</td>
<td>50.0%</td>
<td>37.4%</td>
<td>69.0%</td>
<td>63.2%</td>
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<td>% Black</td>
<td>67.1%</td>
<td>20.0%</td>
<td>47.9%</td>
<td>60.6%</td>
<td>29.2%</td>
<td>31.0%</td>
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<tr>
<td>High graduate or higher, persons age 25+</td>
<td>80.0%</td>
<td>83.7%</td>
<td>68.1%</td>
<td>63.9%</td>
<td>73.2%</td>
<td>84.0%</td>
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<tr>
<td>Median household income, 2007-2011</td>
<td>$32,364</td>
<td>$58,252</td>
<td>$37,597</td>
<td>$38,336</td>
<td>$49,736</td>
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</tr>
<tr>
<td>Persons below poverty, 2007-2011</td>
<td>28.7%</td>
<td>10.3%</td>
<td>24.1%</td>
<td>22.6%</td>
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</table>
# Serving a High-Needs Population

<table>
<thead>
<tr>
<th>Incidence Rate</th>
<th>Age-Adjusted Death Rate</th>
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</thead>
<tbody>
<tr>
<td><strong>U.S. : 39.7 (2010)</strong></td>
<td><strong>U.S &amp; Georgia: 16.4</strong></td>
</tr>
<tr>
<td><strong>Georgia : 44.3 (2006- 2010)</strong></td>
<td><strong>Georgia : 16.4</strong></td>
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<table>
<thead>
<tr>
<th>Primary Service Area</th>
<th>Cases/100000</th>
<th>Status</th>
<th>Cases/100000</th>
<th>Status</th>
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<td>Dougherty</td>
<td>47.3</td>
<td><img src="#" alt="Green" /></td>
<td>16.0</td>
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<tr>
<td>Lee</td>
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<td>Mitchell</td>
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<td><strong>Terrell</strong></td>
<td><strong>68.5</strong></td>
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<td><strong>32.7</strong></td>
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<tr>
<td>Worth</td>
<td>39.6</td>
<td><img src="#" alt="Green" /></td>
<td>13.3</td>
<td><img src="#" alt="Green" /></td>
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Terrell County has the highest annual incidence rate in Georgia for all cancers: 562.7. Lee and Mitchell are 8th and 9th respectively.
Are we doing right by our community?

STRATEGIES for Improving Access to Care

• Invest Upstream
• Partner Across the Community and Providers
• Build Community Capacity
• Advocate for Change
• Lead Innovation

In 1986, the Foster G. McGaw Prize was created to recognize hospitals that have distinguished themselves through efforts to improve the health and well-being of everyone in their communities. Today, despite sweeping changes in the way health care is delivered, hospitals and their communities continue to forge strong partnerships to promote a healthier America.

The Baxter Allegiance Foundation and the American Hospital Association founded the Foster G. McGaw Prize on the belief that the relationship between a hospital and its community is unique.
Collaborative Model Distributes Responsibilities to Improve Care

• Formation of the Cancer Coalition of So Ga. to address a region
  — providers were also competitors who came together to fund the effort for coordinated care
• Albany Area Primary Health Care – Medical Home and link to patient recruitment
• GI practice
• Navigators working through the Coalition
• Surgical Oncologist/Scholar
Navigator is at the intersection of health and healthcare delivery

- Identifies patients and implements reminder system.
- Eliminates barriers to care — transportation, education, cost, support
- Improves compliance with process and procedure preparation
- Reduces overall program costs through change in care delivery processes
Health disparities develop because transforming technologies are not distributed.

**SOLUTIONS**

- Adopt a Primary Care Strategy to deliver care closest to home.
- **Advocate Community Benefit** as a sound business strategy that is as much an indicator of success for a hospital as admissions, financial statements, quality care indictors and revenue streams.
- Form *and leverage* the right partnerships
- Link the hospital to a primary care delivery system [Phoebe and AAPHC]
Elements for Success in a Colorectal Screening Program

- The Hospital – provides transforming technologies and specialists
- AAPHC – the appropriate primary care setting
- Cancer Coalition of South Georgia – navigators identify patients, bring them into care for screening and other primary care needs
Program Outcomes: 2008 to June 2013

- **1,815 colonoscopies** in 1,714 patients
  - *Seven (7) Cancers* detected and treated
  - ~ *35% of all patients had adenomatous (high-risk, precancerous) polyps removed*

Note: Number of colonoscopies has increased each year, with
- **567 completed July 1, 2012 – June 30, 2013 (FY13)**

- Patient **“No Show” Rate = 2%** (i.e., 98% of navigated patients show as scheduled for colonoscopy appointments)

- Bowel prep is “good, adequate or excellent = **96% of navigated patients**
Lessons Learned

• The collaborative program is a **cost effective** way to reach the target population
• Through navigators, **patients come into primary care** services along with screening
• There is great **need to expand** programs
• Resources are limited, so **the burden must be shared** among primary care groups, hospitals and other providers

• **Navigators create the seamless transitions and are key to efficiency and effectiveness**
Strategies for Expanding Colorectal Cancer Screening at Community Health Centers

Mona Safaty, MD, MPH; Mary Doroshenk, MA; James Hotz, MD; Durado Brooks, MD, MPH; Seiji Hayashi, MD, MPH, FAAFP; Terry C. Davis, PhD; Djenaba Joseph, MD, MPH; David Stevens, MD; Donald L. Weaver, MD; Michael B. Potter, MD; Richard Wender, MD

Community health centers are uniquely positioned to address disparities in colorectal cancer (CRC) screening as they have addressed other disparities. In 2012, the federal Health Resources and Services Administration, which is the funding agency for the health center program, added a requirement that health centers report CRC screening rates as a standard performance measure. These annually reported, publically available data are a major strategic opportunity to improve screening rates for CRC. The Patient Protection and Affordable Care Act enacted provisions to expand the capacity of the federal health center program. The recent report of the Institute of Medicine on integrating public health and primary care included an entire section devoted to CRC screening as a target for joint work. These developments make this the ideal time to integrate lifesaving CRC screening into the preventive care already offered by health centers. This article offers 5 strategies that address the challenges health centers face in increasing CRC screening rates. The first 2 strategies focus on improving the processes of primary care. The third emphasizes working productively with other medical providers and institutions. The fourth strategy is about aligning leadership. The final strategy is focused on using tools that have been derived from models that work. CA Cancer J Clin 2013;000:000-000. ©2013 American Cancer Society, Inc.

Keywords: colorectal cancer screening, community health centers, strategies or strategic planning, public health, quality/quality improvement, Patient Centered Medical Home
Special Theory of Relativity #2

\[ E^T = mc^2 \]

Endoscopy (timely) = My Colon Cancer Control and Cure
Original Article

Evaluation of a Patient Navigation Program to Promote Colorectal Cancer Screening in Rural Georgia, USA

Sally Honeycutt, MPH; Rhonda Green, BS; Denise Ballard, MEd; April Hermstad, MPH; Alex Brueder, MD; Regine Haardörfer, PhD; Jennifer Yam, MD; and Kimberly J. Arriola, PhD, MPH

BACKGROUND: Colorectal cancer (CRC) is a leading cause of cancer death in the United States. Early detection through recommended screening has been shown to have favorable treatment outcomes, yet screening rates among the medically underserved and uninsured are low, particularly for rural and minority populations. This study evaluated the effectiveness of a patient navigation program that addresses individual and systemic barriers to CRC screening for patients at rural, federally qualified community health centers. METHODS: This quasi-experimental evaluation compared low-income patients at average risk for CRC (n = 809) from 4 intervention clinics and 9 comparison clinics. We abstracted medical chart data on patient demographics, CRC history and risk factors, and CRC screening referrals and examinations. Outcomes of interest were colonoscopy referral and examination during the study period and being compliant with recommended screening guidelines at the end of the study period. We conducted multilevel logistic analyses to evaluate the program’s effectiveness. RESULTS: Patients at intervention clinics were significantly more likely than patients at comparison clinics to undergo colonoscopy screening (35% versus 7%, odds ratio = 7.9, P < .01) and be guideline-compliant on at least one CRC screening test (43% versus 17%, odds ratio = 5.9, P < .001). CONCLUSIONS: Patient navigation, delivered through the Community Cancer Screening Program, can be an effective approach to ensure that lifesaving, preventive health screenings are provided to low-income adults in a rural setting. Cancer 2013;000:000-000. © 2015 American Cancer Society.

KEYWORDS: cancer screening; colorectal cancer; colonoscopy; program evaluation; community health centers; community health workers; rural health.
Evaluation Findings

*What is the degree of CCSP effectiveness towards improving colonoscopy screening behavior?*

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Odds Ratio</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had colonoscopy referral during study (among due)</td>
<td>4.260^</td>
<td>&lt; .0001*</td>
</tr>
<tr>
<td>Had colonoscopy exam during study (among due)</td>
<td>7.708†</td>
<td>&lt; .0001*</td>
</tr>
<tr>
<td>Compliant on any test</td>
<td>6.013†</td>
<td>&lt; .0001*</td>
</tr>
</tbody>
</table>

*p-values are based on Wald ($\chi^2$) Statistic

^ Controlling for Race (Black)

† Controlling for Race (Black) and Age (50-59 and 60-64)
Goal 80% CRC Screening in CHCs

“We can try with a little help from our friends”

“We will get by 80% with a little help from our friends”

Thank You
Jason Beers
President and CEO
Operation Access
NCCRT Member
Operation Access

*Bridging the Healthcare Gap*

- Founded by surgeons in 1993 to create a way to volunteer in their community to reduce health disparities

- Eligible patients are low-income, uninsured and unable to qualify for public insurance, referred by a community health center
How does OA work?

**Patients**

**Community Clinics**
- FIT screening
- Medical home
- H&P/labs

**Operation Access**
- Eligibility screening
- Referral to specialist and case management
- Prep assistance and Interpretive services
- Provider recruitment and engagement
- GI session coordination

**GI Volunteers**
- Colonoscopy

**Hospitals & Endoscopy Centers**
- GI suites, supplies
- Lab and pharmacy

**Other Clinical Volunteers**
(Unless provided by facility)
- Pathology
- Nurses, techs, anesthesia

**Donated Colonoscopy**
- Procedure, pathology report sent to the community clinic

**How does OA work?**

1. **Patients**
2. **Community Clinics**
   - FIT screening
   - Medical home
   - H&P/labs
3. **Operation Access**
   - Eligibility screening
   - Referral to specialist and case management
   - Prep assistance and Interpretive services
   - Provider recruitment and engagement
   - GI session coordination
4. **GI Volunteers**
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6. **Other Clinical Volunteers**
   (Unless provided by facility)
   - Pathology
   - Nurses, techs, anesthesia
7. **Donated Colonoscopy**
   - Procedure, pathology report sent to the community clinic
Criteria for Colonoscopy

Must be above-average risk, such as the following:

**FIT** or **FOBT+**
Unexplained blood in stool (not from hemorrhoids)
Unexplained change in bowel habits
Unexplained weight loss/gain
Iron deficiency anemia
Personal history of CRC or adenomatous polyps
1st degree relative diagnosed with CRC

*No routine screenings provided by OA*
Network

- Procedures are provided in endoscopy centers and hospitals, both for profit and non-profit
- All care is donated by the providers
- Program infrastructure (forms, protocols, navigation) allow GIs to focus on the procedure
- Integrated services and Saturday GI clinics
- 200 donated colonoscopies per year
Developing your Network

- Ask representatives from the entire universe of providers to participate
- Institutional commitments are key
- Get GI champions early, have them recruit peers
- Solicit feedback and use it to improve
- Manage your “slots” thoughtfully
- Recognize volunteers in simple & personal ways
Patient navigation adds value

Culturally competent case management leads to high quality care and happy volunteers

- intake and adherence to referral criteria
- appointment scheduling and management
- letters, maps, reminder calls
- diagnosing & removing barriers to follow through

OA patient compliance is 97% (1% not prepared, 1% no show, 1% cancel without 48 hours notice)
Recruiting Navigators

Mastery of key languages and cultural competency more important than advanced education.

Ability to develop and follow systems is key.

Interpreter / Community Health Worker skills are a great match.

Each OA navigator is bilingual and attends an interpreter training.

Navigators are conduits to the specialists; coordinating access to scarce GI resources.
Why Screen for CRC?

To prevent cancer

Care coordination programs make it easy for me and my staff, and I know patients will show

When my colleagues and I join forces, we share the duty equitably

To save money

You will save lives
Goals of the NHCRCSP
Statewide CDC Funded CRCCP

- Increase CRC screening for all NH individuals over age 50 to **80%** (80% by 2018 Initiative)
- Address Disparities: Offer *high quality* free **colonoscopies** to 350-400 low income, uninsured or underinsured individuals/year
- NHCRCSP works with NH community health centers (**CHCs**), in order to reach the 80% goal
NHRCSP CRC Screening for CHCs

Central Organization: NH CHCs refer to NHRCSP

- For those CHCs, NHRCSP referred to 12 endoscopy sites (hospital-based and ASCs) for colonoscopies, selected by their geographic proximity for the CHC patients

- Endo sites have hospital affiliations and all hospitals agreed (NHRCSP policy) to cover cost of care for CRCs found through the program, and colonoscopy complications
NHRCRCSP CHC COLLABORATION: General Approach and Groundwork

- Get CHC and endo unit leadership commitment
- Identify and train internal champions
- Agree on health center screening policy
  - Incorporate CRC screening education
  - Recognize specific barriers for underserved:
    - Language, cultural, travel, missed work time, etc
- Identify appropriate endoscopy sites and establish policies and procedures
Key Elements of Delivering CRC Screening Continuum of Care To CHCs

- **Central infrastructure** (NHRCRCSP) connects CHC patients to needed venues of CRC screening and cancer care.

- NHRCRCSP establishes **referral policies and procedures** with CHCs, endoscopy sites, and hospitals.

- Must also establish **agreements and/or contracts** if needed with PCPs and endoscopy sites (pathology, anesthesia).

- Maximize **partnerships** that support the process.
Efficiency Elements of Delivering CRC Screening Continuum of Care To CHCs

- Established procedures to provide medical clearance and relevant patient information to endoscopists (appropriate referrals save time and money) and other medical caregivers (including patient consent to release information); all referrals appropriate

- Standardized forms for medical and patient history, referral, colonoscopy results, etc. are efficient

- Communication Policies are critical
Key Elements of High Quality Screening:  

*Shared Responsibility Approach:*

**Communication** between endoscopists and PCPs:
- PCPs *receive* colonoscopy reports
- Colonoscopy reports must be *complete*
- PCPs receive endoscopist’s *f/u recommendation*
- PCPs familiar with CRC screening *guidelines*
- Both GIs and PCPs actively ensure that patient care and follow-up is appropriate

*The Quality of Colonoscopy Services: Responsibilities of Referring Clinicians. A Consensus Statement of the Quality Assurance Task Group, National Colorectal Cancer Roundtable*  
Fletcher RH, Nadel MR, Allen JI et. al.  
*Journal Gen Intern Med* 2010;25(11):1230-4
Partnerships and Collaborations:
- Internal champion(s) critical to success
- CDC CRCCP in applicable states, DHHS
- NCCRT, ACS, CDC, NCI, GI Societies (AGA)
- Comprehensive Cancer Control (CCC) groups
- EMR system leaders and experts (FQHC CHAN)
- Insurers (address barriers together)
- Endoscopists (“in-kind” colonoscopies)
Patient Navigation

- Navigation Outcomes:
  - Almost 2000 high-quality colonoscopies
  - Two No-Show patients
  - < 1% Inadequate Preparations
  - 100% of patients received follow up recommendations; PCPs also notified
  - Extremely high patient satisfaction
OTHER NHCRCSP STRATEGIES TO INCREASE HIGH QUALITY CRC SCREENING for CHCs

- NHCRCSP prep video on YouTube
- DHHS - Provider Health Alert Network (HAN) message
- Provider recognition for donated (free colo) services
- Prep instructions translated into 26 languages
The Compelling Case

- Second most common cause of ca death in US
- Providing CHC patient with high-quality CRC screening will improve health, and lower (huge) health care costs
- Colorectal cancer, a preventable disease, has an estimated annual national cost of $14 billion
- Success benefits everyone
**Key Characteristics**

- **Expectations are clear** (defined number of colonoscopies per month), **business case is clear** (fulfill Community Benefit; reduce ER use of CRC patients) and **burden is shared** among local providers or systems.

- A **strong physician champion** can help coordinate high level institutional commitment from GIs and hospitals/health systems.

- High value is placed on **program efficiency** and **consistent protocols** that reduce the burden on physicians, while ensuring doctors have needed medical information (e.g. **standardized patient info forms**).

- Use of **patient navigators protects good relationship with GIs** by effectively addressing concerns about no shows, prep, other barriers.

- Form and leverage the right partnerships; understand what motivates each partner; **share the credit**.
## Replicating in pilot locations

<table>
<thead>
<tr>
<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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<tbody>
<tr>
<td>St. Paul, MN</td>
<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>New Haven, CT</td>
<td>Fair Haven Community Health Center</td>
<td>Bella Vista Clinic</td>
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<td>N/A</td>
<td>Community Health Center Association of CT</td>
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<tr>
<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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</table>
Thank You!

• Today’s speakers
• Cancer Coalition of South Georgia
• Operation Access
• Dartmouth – Hitchcock Medical Center
• NCCRT Community Health Centers Task Group

This webinar series was made possible in part by funding from the Centers for Disease Control and Prevention Cooperative Agreement Number 5U38DP004969-02. The views expressed in the materials and by speakers and moderators do not necessarily reflect the official policies of the Dept. of Health and Human Services.
Join us for the following upcoming webinars:

Thursday, September 10th at 1:00pm EST – 80% by 2018 Exemplary Program Series: What Health Plans Can Do to Achieve 80%
Save the Date -- Registration not yet opened

Monday, September 21st 1:00pm EST – Evaluating Systems Change focused on Colorectal Cancer Screening
Save the Date -- Registration not yet opened
For more information contact:
Mary Doroshenk, MA
Mary.doroshenk@cancer.org

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