Paying for Colorectal Cancer Screening Navigation Toolkit
Strategies for Payment and Sustainability

Updated June 2019

NATIONAL
Colorectal
Cancer
ROUNDTABLE

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The Toolkit is divided into distinct chapters. These chapters are based on the specific focus areas that are most central to paying for and sustaining colorectal cancer screening patient navigation.

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COLORECTAL CANCER SCREENING PATIENT NAVIGATION TOOLKIT: INTRODUCTION

The *Paying for Colorectal Cancer Screening Patient Navigation Toolkit* is designed to help health care professionals, at every stage of a patient navigation program, plan for sustainability and find ways to seek reimbursement for colorectal cancer screening patient navigation (CRCS PN). We must keep top of mind that CRCS PN is designed to reduce health disparities and improve health outcomes for your patients. In our case, this means increasing colorectal cancer screening rates, and reducing death and suffering from colorectal cancer.

Definition of Patient Navigation

To maximize the usefulness of the toolkit, we have adopted the following general concepts to provide a working definition for patient navigation (PN) and the framework for the toolkit.

- PN is a model of care that aims to reduce an existing health disparity as defined in a particular community.

- PN addresses a patient's individual barriers to care by linking them to existing local and regional resources, not by creating new resources or services.

- PN is not just a patient navigator; navigation requires a team approach: administrators to champion the program, supervisors to provide clinical and administrative support, and patient navigators with a defined role within the healthcare team[1].

- PN promotes system-level change to ensure connectivity between the need for screening, screening, and any necessary follow-up services

For CRCS PN, these primary elements are critical. We will examine how these fundamental aims are integrated to ensure quality. The examples provided primarily focus on PN into endoscopic screening but also include examples of PN for stool based testing (FIT and FOBT). The following chapters will present evidence for CRCS PN as an intervention. It is our deliberate intention to recommend this strategy to increase colorectal cancer screening rates.

Care Coordination and Patient Navigation:

Often, care coordination is referenced when speaking about PN. The Agency for Healthcare Research and Quality notes that care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care[1].

Care coordination is the cornerstone of many healthcare redesign efforts, including primary and behavioral healthcare integration. It involves bringing together various providers and information systems to coordinate health services, patient needs, and information to help better achieve the goals of treatment and care. Research shows that care coordination increases efficiency and improves clinical outcomes and patient satisfaction with care.

Patient navigators often deploy the core elements of care coordination and are part of the health care redesign[2].

This toolkit contains evidence-based and experience-based examples, case studies, practical tools, and resources to help you:

- Describe and connect how the necessary components for CRCS PN can be sustainable.

- Provide examples of evidence-based strategies and quality standards for CRCS PN.

- Strategize for whom and how you will prioritize CRCS PN and priority populations for screening.

- Examine programs and approaches to CRCS PN throughout the U.S. to understand payment models and methods for sustainability.

- Analyze the direct payment methods to pay for CRCS PN and think about how to apply to your setting.

- Make the business case for CRCS PN. This includes patient outcomes, quality measures, and cost analysis. Understand the prime components and resources necessary to undertake this work, and apply what has already been achieved in the field.

- Critically review the accreditation and quality measures that might be met with CRCS PN based on your setting.

- Discover the types of policy initiatives that have been utilized to help ignite or bolster work for CRCS PN.

- Evaluate CRCS PN programs with the aim of continuous quality improvement.

Audience

The toolkit was designed for a variety of health care professional including:
- Administrators in primary care settings, gastroenterology centers, and community settings.
- Program planners
- Patient navigators
- Policy advisors
- Researchers
- Business Managers
- Insurers
- State and National Program Planners

Using the Toolkit

As the name implies, the toolkit provides a selected set of tools and resources that are useful in different phases and aspects of PN programs. You may not need to use every tool, or even read every chapter or section. You will use only the tools you need for your specific situation. Thus, we encourage you to begin by scanning the list of chapters in order to see what will be most relevant to your situation and need.

Each chapter focuses on the key elements of sustainability relevant to its audience. You may choose to read our toolkit straight through, or pick out the chapters relevant to your cause and start from there to then further examine themes of sustainability in subsequent chapters. In some ways, this might be like a 'Choose Your Own Colorectal Cancer Screening Navigation Adventure.'

The design of this toolkit is very similar to the use of icons and themes utilized in the Boston and Avon Toolkit, based on positive feedback from the patient navigation community. Special thanks to Dr. Tracy Battaglia and team for their support[3].

Please note, because of the volume of information, many of the resources included are found online.

Each chapter is organized into printed resources, online resources, tasks, tools, templates, and case studies so that you can:

Read more about it – *Recommended published materials* that address patient navigation in more depth or from other perspectives than those presented in the toolkit, including scientific articles, books, journal articles, training curricula, and websites

Find it online – *Recommended online materials* that supplement reading resources with free online information, tutorials, and other navigation program websites

Stop and Reflect – *Interactive tools* where you will be asked to complete a task, reflect, or answer questions to guide learning and decision-making processes, such as checklists and Q&A sections

Use it "as is" or adapt to your needs – *User-friendly instruments* that are adaptable, task-specific, and linked to evidence-based recommendations, such as diagrams, monitoring and evaluation tools, case, and other practical materials that you can use without alteration

Customize for your needs – *Easy-to-adapt structured document* that you can use for your own purposes as a tool to generate ideas, or a template to mold to your needs, including blanks, 'fillable' forms, and example protocols

See it in action – *Case studies and descriptions based on true stories* that illustrate a concept, explain how a tool is used, or identify pitfalls and solutions using lessons learned from our experience as well as observational research conducted on navigation programs

Frequently Asked Questions – It's all in the Title!

Redirect – go to another chapter and check out a related topic in another section of the toolkit

Sustainability in Action – *Special themes in sustainability* that are good to revisit and examine the components of the sustainability framework

Development of the Toolkit

The content of this toolkit is drawn from published and public information about patient navigation. Its sources include:

- A literature review of relevant scientific articles
- Review of existing patient navigation programs and services
- Exploration of online patient navigation resources
- Key informant interviews and focus groups with stakeholders such as patient navigators, supervisors, clinicians, medical directors, program coordinators, and investigators
- The experiences and expertise of the:
    - University of Colorado Cancer Center
    - The Colorado School of Public Health
    - The National Colorectal Cancer Roundtable Patient Navigation Toolkit Advisory Committee
    - Over 75 people and organizations who shared their time and expertise

Final Thoughts

Varieties of resources and toolkits have been developed to help design CRCS PN programs, create trainings, and evaluate PN efforts. This toolkit is dedicated to exploring the factors that will promote reimbursement, paying for, and sustaining PN. This toolkit will be a living document, with continuous updates as the science of PN and the methods to sustain CRCS PN evolve. We hope that you find this toolkit to be a great resource to further your efforts to sustain PN, to make it a standard part of your practice and workforce.

Visit Chapter 9 to learn more about the additional resources and toolkits that might help in further examining PN implementation and additional topics in further sustaining systematic approaches to implementation of colorectal cancer screening initiatives and PN.

Sources:

1. http://www.integration.samhsa.gov/workforce/care-coordination
2. http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html
3. The Boston Medical Center Patient Navigation Toolkit. Accessed May 15, 2019.

CHAPTER 1: SUSTAINABILITY OF PATIENT NAVIGATION:

Goal: To outline the most important aspects of sustainability that will allow colorectal cancer screening patient navigation (CRCS PN) to be paid for and be widely implemented for long-lasting impact.

Objective: Critically examine the fundamentals of sustainability to consider how this will be applied to your work and setting.

Background: A word about sustainability. For the purposes of this Toolkit, we will define sustainability capacity as the existence of structures and processes that allow a CRCS PN program to leverage resources to effectively implement and maintain evidence-based approaches and quality.

Sustainability capacity is a critical element of a public health program. Savaya et al. (2008) estimated that up to 40% of all new programs do not last beyond the first few years after the end of initial funding. The high costs of program termination further highlights the need to understand which factors contribute to sustainability and how they can be measured and improved[1].

Sustainability is a lot about paying for the work and salaries of patient navigators; but if there aren't other supporting measures to help ensure patient navigators are fully integrated into the fabric of the medical and community setting, quality CRCS PN will not be integrated into the workforce. Stable funding is going to take a dedicated approach.

Let's explore the central domains of sustainability and just a few words to help us set the stage. In public health and implementation science there are various frameworks to explore sustainability, but most reflect the following key domains[2]:

1. **Funding Stability** = making long-term plans based on a stable funding environment
2. **Partnerships** = connection between program and community
3. **Organizational Capacity** = resources needed to effectively manage the program and its activities
4. **Program Evaluation** = monitoring and evaluation of process and outcome data associated with program activities
5. **Program Adaptation** = ability to adapt and improve in order to ensure effectiveness
6. **Communications** = strategic dissemination of program outcomes and activities with stakeholders, decision-makers, and the public
7. **Strategic Planning** = process that defines the program direction, goals, and strategies
8. **Environmental Support** = internal and external political environment which influences program funding, initiatives, and acceptance

Stop and Reflect:

Based on where you are with implementation of CRCS PN, do you feel that you have all nine components established to sustain your program?

Are there specific areas you need more work on, or need to strategize more about your approach?

SOURCES:

1.   SAVAYA R, SPIRO S, ELRAN-BARAK R. SUSTAINABILITY OF SOCIAL PROGRAMS: A COMPARATIVE CASE STUDY ANALYSIS. AM J EVAL. 2008, 29: 478-493.

2.   SARAH F SCHELL, DOUGLAS A LUKE, MICHAEL W SCHOOLEY, MICHAEL B ELLIOTT, STEPHANIE H HERBERS, NANCY B MUELLER AND ALICIA C BUNGER. PUBLIC HEALTH PROGRAM CAPACITY FOR SUSTAINABILITY: A NEW FRAMEWORK. IMPLEMENTATION SCIENCE. 2013, 8:15. HTTPS://SUSTAINTOOL.ORG/UNDERSTAND/

CHAPTER 2: EVIDENCE AND PATIENT NAVIGATION

Goal: To provide information on colorectal cancer screening patient navigation (CRCS PN) as an evidenced-based intervention to ensure patient navigation (PN) is a paid for and sustainable intervention to increase colorectal cancer screening rates.

Objectives: Critically Examine:

1. Why CRCS PN is needed.
2. The background and definitions of PN and evidence for how and why PN 'works.'
3. The many titles of those who serve in the role of care coordination for CRCS PN.
4. Why does this all matter when thinking of paying for CRCS PN?
5. Background: Evidence for patient navigation in colorectal cancer screening:
6. There are a host of papers and reviews regarding the effectiveness and efficacy of CRCS PN.

LATER IN CHAPTER 5, WE WILL EXPLORE THE AGENCIES WHO USE ACCREDITATION AND CREDENTIAL AIMS FOR COLORECTAL CANCER SCREENING THAT MIGHT BE HELPFUL IN THINKING ABOUT SUSTAINING CRCS PN IN YOUR SETTING.

It is important to note that a number of interventions have demonstrated effectiveness in increasing colorectal cancer screening, such as a medical provider recommending screening, general reminder systems, and health promotion strategies. The data suggest CRCS PN has the rigor to improve health outcomes as much as many clinical interventions.

CRCS PN is a health care strategy and intervention that has proven to be effective when integrated in the health care setting. There are many examples that provide this evidence. Below is one such article.

Personal navigation increases colorectal cancer screening uptake. Ritvo PG1, Myers RE2, Paszat LF3, Tinmouth JM4, McColeman J5, Mitchell B5, Serenity M6, Rabeneck L7. Cancer Epidemiol Biomarkers Prev. 2015 Mar;24(3):506-11.

The following agencies have included colorectal cancer screening as a proven strategy and listed it as an approved strategy based on a systemic review of the literature.

Patient Navigation as a Model

The momentum that PN has received as a community-based intervention (which has expanded and been transformed into a nationally recognized model) has stimulated the need to define principles and standards for patient navigation. Listed below are the "Principles of Patient Navigation" that have been developed and vetted for more than 20 years through Dr. Harold Freeman's experience[1].

1. PN is a patient-centered health care service delivery model. The focus of PN is to promote the timely movement of an individual patient through an often complex health care continuum. An individual's journey through this continuum begins in the neighborhood where he or she lives to a medical setting where an abnormality is detected, a diagnosis is made, and then treatment rendered. The journey continues from rehabilitation and survivorship to the end of life.

2. PN serves to virtually integrate a fragmented health care system for the individual patient. As patient care is so often delivered in a disjointed manner, particularly related to those with chronic diseases, patient navigation has the potential of creating a seamless flow for patients as they journey through the care

continuum. PN can be seen as the guiding force promoting the timely movement of the patient through a complex system of care.

3. The core function of PN is the elimination of barriers to timely care across all phases of the health care continuum. This function is most effectively carried out through a one-on-one relationship between the navigator and the patient.

4. PN should be defined with a clear scope of practice that distinguishes the role and responsibilities of the navigator from that of all other providers. Navigators should be integrated into the health care team to promote maximum benefit for the individual patient.

5. Delivery of PN services should be cost-effective and commensurate with the training and skill necessary to navigate an individual through a particular phase of the care continuum.

6. The determination of who should navigate should be based on the level of skill required at a given phase of PN. There is a spectrum of PN extending from services that may be provided by trained lay navigators to services that require navigators who are skilled professionals, such as nurses and social workers. Another consideration is that health care providers should ideally provide patient care that requires their level of education and experience and should not be assigned to duties that do not require their level of skills. Ideally everyone should be functioning at the top of their licensure.

7. In a given system of care there is the need to define the point at which navigation begins and the point at which navigation ends.

8. There is a need to navigate patients across disconnected systems of care, such as primary care sites and tertiary care sites. PN can serve as the process that connects disconnected health care systems.

9. PN systems require coordination. In larger systems of patient care, this coordination is best carried out by assigning a PN coordinator or champion who is responsible for overseeing all phases of PN activity within a given health care site or system. It is important to distinguish a system of PN from the patient navigator(s) who work within the system.

Sources of Evidence

The Community Guide and Colorectal Cancer Screening:

The Guide to Community Preventive Services is a free resource to help you choose evidence-based programs and policies to improve health and prevent disease in your community. The information gleaned through systematic reviews are used to answer these questions:

*   Which program and policy interventions have been proven effective?
*   Are there effective interventions that are right for my community?
*   What might effective interventions cost and what is the likely return on investment?

https://www.thecommunityguide.org/findings/cancer-screening-multicomponent-interventions-colorectal-cancer

What the Community Guide Says about Colorectal Cancer Screening:

The Community Guide notes that there is sufficient evidence to suggest that Reducing Structural Barriers for Clients is a proven strategy to effectively increase colorectal cancer screening rates.

Structural barriers are non-economic burdens or obstacles that make it difficult for people to access cancer screening. Interventions designed to reduce these barriers may facilitate access to cancer screening services by:

- Reducing time or distance between service delivery settings and target populations
- Modifying hours of service to meet client needs
- Offering services in alternative or non-clinical settings (e.g., mobile mammography vans at worksites or in residential communities)
- Eliminating or simplifying administrative procedures and other obstacles. Specific examples are: scheduling assistance, patient navigators, transportation, dependent care, translation services, limiting the number of clinic visits.

Research-tested Intervention Programs (RTIPs) and Colorectal Cancer Screening Patient Navigation (CRCS PN):

RTIPs is a searchable database of evidence-based cancer control interventions and program materials and is designed to provide program planners and public health practitioners easy and immediate access to research-tested materials.

At least one program, which focuses on utilization of CRCS PN, is featured in RTIPS:

Program Title	Culturally Tailored Navigator Intervention Program for Colorectal Cancer Screening
Purpose	Designed to increase colorectal cancer screening among low-income adults. (2009)
Program Focus	Awareness building and Motivation
Population Focus	Un- and/or Under-screened Individuals
Topic	Colorectal Cancer Screening
Age	Adults (40-65 years), Older Adults (65+ years)
Gender	Female, Male
Race/Ethnicity	Asian, Black, not of Hispanic or Latino origin, Hispanic or Latino, White, not of Hispanic or Latino origin
Setting	Clinical, Urban/Inner City
Origination	United States

Health Resources and Services Administration (HRSA):

Critical Pathway: Colorectal Cancer Screening - Appendix with Supporting Tools

HRSA provides strategies that highlight CRCS PN in their Patient Changes critical pathways. Their star rating system included within the appendix indicates to the user the level to which a tool or resource has be utilized.

http://www.hrsa.gov/quality/toolbox/measures/colorectalcancer/colorectalpathwayappendix.html

Patient Navigator Research Program:

The National Cancer Institute addressed unequal patterns of standard health care access through a multisite Patient Navigation Research Program (PNRP). The PNRP focused on developing and testing interventions for follow-up and treatment initiation of four cancers with significant disparity: breast, cervical, prostate, and colorectal. Many publications and data sources exist for colorectal cancer prevention efforts, including PN.

http://www.cancer.gov/about-nci/organization/crchd/disparities-research/pnrp

Cancer Prevention and Control Research Network – Colorectal Cancer Control Program – funded by Centers for Disease Control (CDC):

CDC's Colorectal Cancer Control Program (CRCCP) funds states and tribes across the United States. The CRCCP's goal is to increase colorectal cancer screening rates among men and women aged 50–75. Higher screening rates will reduce illness and deaths from colorectal cancer. The CRCCP has two components: screening promotion and screening provision. In survey analysis from investigators, grantees of the survey used PN for screening provision and screening promotion. Conclusion: This survey provides insights into PN across a federally funded colorectal cancer program. Results suggest that PN activities may be instrumental in recruiting people into cancer screening and ensuring completed screening and follow-up.

Escoffery C1, Fernandez ME, Vernon SW, Liang S, Maxwell AE, Allen JD, Dwyer A, Hannon PA, Kohn M, DeGroff A. Patient Navigation in a Colorectal Cancer Screening Program. J Public Health Manag Pract. 2015 Sep- Oct;21(5):433-40.

Stop and Reflect:

With good evidence under your belt, how can you use this information for receiving funding and sustaining CRCS PN?

Food for Thought:

Ensure that the decision makers and champions in your organization are aware that CRCS PN is a recommended strategy and there is sufficient evidence to support the role and function of a patient navigator.

Use this evidence in grant applications and in proposals to secure grant funding for CRCS PN.

Include this information in policy discussions with your organization's leadership.

Is there a way to use the Community Guide to understand and look at the cost perspective of health interventions?

What are your thoughts?

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Raising the Standard of Care for All

In the United States, the burden of disease is distributed unequally among those living in poverty, and underserved racial and ethnic minorities due to[2]:

- No insurance or insufficient insurance
- Cultural influences or previous bad experiences that lead to distrust of the health care system
- Logistical barriers such as lack of transportation or child care services
- Language or cultural differences with health care providers
- Limited knowledge about health care issues

Because these barriers exist, patients may not receive preventive health care services or may delay care until they are very ill. Therefore, these populations tend to present to clinics with advanced stage disease.

Being diagnosed at a late stage is especially detrimental for cancer, because successful treatment is often dependent on beginning at an early stage.

Patient Navigation: Promoting Equal Opportunities for Health

To improve health care delivery to those living in poverty and minority populations, the role of a patient navigator was created to help eliminate the above barriers and to guide patients through the medical system. Patient navigators work to identify health care obstacles and help patients get the best possible care.

The concept of PN started at the Harlem Hospital Center in New York City by Dr. Harold P. Freeman. The Harlem program aided low-income and minority breast cancer patients through the cancer care process from identification of a suspicious finding to diagnosis and treatment. These navigators effectively diminished barriers to ensure adequate follow up and treatment. In light of this success, cancer patient navigator programs are now being created across the country5.

To provide PN, you and your staff need to identify potential barriers to health care, and how you can address these issues with creative solutions. Your work can help save lives and improve a patient's experience in the health care system. Visit Chapter 7 to think about how policy strategies might help in making the case to secure colorectal cancer screening endeavors in your work setting.

Who Is the Priority Population to Focus Patient Navigation Resources for Colorectal Cancer Screening Towards?

PN is a successful intervention for the medically underserved with access to care issues, both from health outcomes, feasibility, and fiscal data.

Based on the conclusions of the Patient Navigator Research Program (PNRP), PN demonstrates a moderate benefit in improving timely cancer care. These results support adoption of PN in settings that serve populations at risk of being lost to follow-up, which primarily includes the medically underserved. The PNRP has provided enormous data and resources to help CRCS PN. Read this specific article as it's free to the public3:

Freund KM, Battaglia TA, Calhoun E, et al. Impact of Patient Navigation on Timely Cancer Care: The Patient Navigation Research Program. JNCI Journal of the National Cancer Institute. 2014;106

PN has been implemented in a variety of settings with those who are privately insured, publicly insured, and uninsured. It has proven to be effective for many patients with barriers, regardless who is paying for the exam. However, in a resource-taxed environment, CRCS PN makes the most sense for those who are medically underserved.

Role of a Patient Navigator

A patient navigator works WITH patients to eliminate real and perceived barriers to health care. The PN services provided will depend on the barriers that you identify and strategies you use to overcome these obstacles. Often, patient navigators play a reactive role by trouble-shooting problems as they arise. This manual includes the common barriers; however, many additional barriers will emerge as you interact with your patients.

The chart below illustrates the roles of a patient navigator in cancer care. How your clinic, program, or community addresses these areas will depend upon the barriers identified and available resources.

Cancer Care Patient Navigation[3]

Outreach
Utilize educational materials to educate patients about cancer prevention, cancer risk factors, and the need for cancer screening. Outreach is defined as connecting with patients that are not actively engaged with a health care setting

In-Reach
Identify patients within your organization in need of cancer screening. Contact these patients to inform them of their need of screening and educate them about the importance of cancer screening.

Screening
Often, misunderstandings about cancer screening exist that need to be overcome. Identify patients' barriers to receiving screening services and work with patients to eliminate them.

Diagnosis
With detection of a suspicious lesion, ensure access to a timely follow up appointment to find out if it is cancer. Work with patients and providers to make sure the patients understand instructions and follow up.

Treatment
For patients diagnosed with cancer, ensure they receive all follow up appointments and treatment as needed and in a timely manner. Work with patients one-on-one to determine possible barriers to diagnosis and treatment and

find solutions to these problems. Work with patients to assign a "treatment partner," someone trusted by the patient who can accompany them during appointments and assist with questions and medications. Work with patients on issues such as advance directives, pain management, and emotional support.

Program Navigation Services

Patient Navigator (the noun) and Patient Navigation (the verb)

Like many patient navigation (PN) programs in the cancer continuum, CRCS PN may look different in many settings, depending on the health care delivery setting.

PN services can be provided by one designated person, or shared by several people. For example, the pharmacist may explain screening preparation procedures to the patient, while a second person in the clinic takes care of barriers to transportation to and from screening, and a third is responsible for data collection. However, it is important that each clinic designate a Program LIAISON who coordinates the navigation, workflow and data collection.

The following services are essential parts of PN. Below is an example of what classic CRCS PN entails3.*
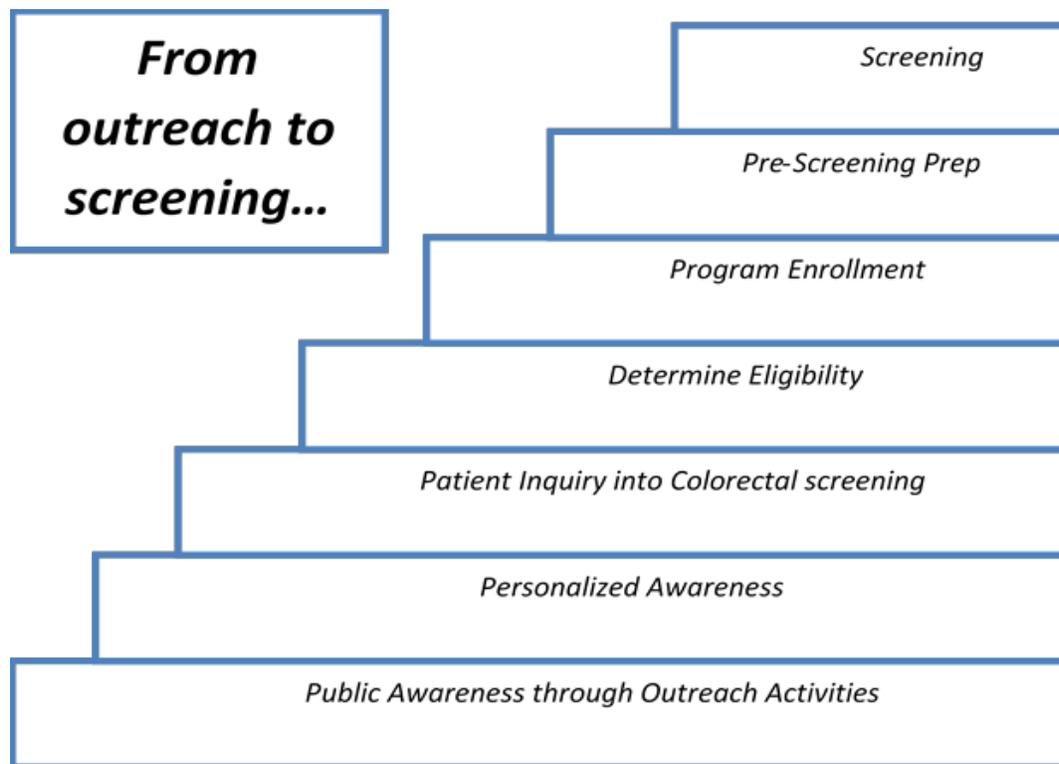
Interested in the very specific elements of PN, and ensuring that you have all of the bases covered, from education and awareness to follow-up after a colonoscopy? Check out Tool 2.1.

Identifying Barriers and Creating Solutions

The most important PN service is to identify barriers to health care. Before interacting with patients, sit down with your health care team and discuss previous problems and obstacles experienced by patients in the past. This meeting will help you identify barriers and solutions. However, you should be prepared to address additional obstacles as you interact with patients. Table 1 lists examples of barriers and potential solutions[3].

Table 1. Potential Barriers and Possible Navigation Solutions4

	Potential Barriers	**Possible Navigation Solutions**
Health Care System	Patient fails to keep appointment Patient does not fully understand what the provider says	• Ensure a reminder call system exists • Follow up with patients who miss appointments • Explain the reason for the appointment and why it is important to attend • Inquire what the patient understands and clarify any misconceptions
Language	Patient speaks a different language than the health care provider	• Arrange for a certified medical translator for each appointment when available • Arrange for a bilingual medical staff person in your clinic to translate • Discuss having your clinic obtain a subscription to a telephone language line • Obtain education materials in several languages • Consult with patient and family to discuss potential community-based resources they may have access to. However, do not ever utilize a family member for interpretation. • Acknowledge that you empathize with the language difficulty. Reassure that this is nothing to be ashamed or uncomfortable about and that you will work with them to overcome these barriers.
	Potential Barriers	**Possible Navigation Solutions**
Financial	Patient has no insurance Patient needs help understanding and completing insurance forms	• See if patient qualifies for Medicaid/Medicare. Work with your state health department to see if screening resources for uninsured men and women is available. • AND, Help connect the patient to the state or federal health exchange • Assist patient with completing paperwork/form

Transportation	Patient lives far from clinic and has no means of transportation Patient cannot afford public transportation	• Assist patient in utilizing the public transportation system • Arrange for community shuttle or volunteer transportation service

Evaluating your PN program is essential to monitoring outcomes and making improvements over time as necessary. Visit Chapter 8 to learn more about how to evaluate these specific measures.

Limits of Patient Navigation

It is important to understand the scope of your role as a patient navigator. You need to understand both what a patient navigator does and does not do.

Patient navigators do **NOT** perform the following[4]:

- Provide direct "hands-on" patient care
- Provide physical assessments, diagnoses, or treatments
- Offer opinions about a diagnosis, treatment, or health care service
- Give information about treatments other than approved basic information from medical sources

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As a patient navigator, you will become involved in patients' lives. However, to be an effective patient navigator you need to set clear boundaries when dealing with patients. It is important for you to define these boundaries before you begin. The following are some examples of actions beyond the scope of a patient navigator[3].

- Giving your own money to patients
- Personally driving patients to and from appointments
- Personally visiting patients in their homes

Patient Confidentiality

As a part of the health care system, the patient navigator must respect laws about a patients' privacy. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states that all medical records and other health information about a person should be kept confidential.

You will be keeping files and forms on patients, which need to be stored properly. Discussing patient information with people not involved in the medical care of that patient is a violation of the patient's rights and in violation of HIPAA. For more information about patient privacy issues, please consult your supervisor.

You can learn more about HIPAA at https://www.hhs.gov/hipaa/index.html

Who Serves in the Role of a Patient Navigator and What About the Other Roles?

There are currently 60 different names and associations with 'community health worker and patient navigator' noted by the Centers for Disease Control and Prevention. There remains much consideration and debate about who should serve in the role of a patient navigator. Currently, both licensed and non-licensed professionals serve in this role. Depending on the orientation of the organization, patient population, among other factors, it is the responsibility of the organization to consider who should serve in this role.

To learn more about the titles, roles, and further information visit George Washington University Cancer Center policy resources: https://smhs.gwu.edu/gwci/

Perhaps it is best to remember Dr. Freeman's thoughts[1]:

> *"The determination of who should navigate should be based on the level of skill required at a given phase of navigation. There is a spectrum of navigation extending from services that may be provided by trained lay navigators to services that require navigators who are professionals, such as nurses and social workers. Another consideration to take into account is that health care providers should ideally provide patient care that requires their level of education and experience and should not be assigned to duties that do not require their level of skills."*

It is also important to notice that QUALITY colorectal cancer screening patient navigation is of the utmost importance. Ensuring that every step of the CRCS PN process is followed and that there is appropriate and timely follow-up with the patient about surveillance is key. In the event of an adverse event or a cancer diagnosis, a coordinated transfer (warm hand off) to a health care team member is critical.

Stop and Reflect:

Building your CRCS PN program – what to consider:

- What is the setting in which you will or have implemented your CRCS PN program?
  - o Primary care setting
  - o Community setting
  - o Regional setting
- Who is the target audience and priority population you are trying to reach with your CRCS PN program?
- Will you deliver the CRCS PN in-person? Will the program be only via phone? Will it be a mixture?
- Who will serve as the patient navigators: lay patient navigators, nurses, others?
- What will your entire colorectal cancer screening program/navigation team 'look like'? Who will all of the partners be and how will you all work together?

Let's take your responses to see what others have done at the city, state, and regional level in Chapter 3.

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CHAPTER 3: COLORECTAL CANCER SCREENING PATIENT NAVIGATOR PROGRAMS – CITY, REGIONAL, AND STATE-BASED NETWORKS

Goal: To specifically examine programs that have implemented colorectal cancer screening networks with patient navigation as one of their core tenants. Many of these programs have embodied several themes of sustainability that we will examine further in the subsequent sections, which is a great framework to set the stage.

Objectives: To provide insight about:

1. The aims of specific colorectal screening programs and the role colorectal cancer screening patient navigation (CRCS PN) plays.
2. Who their programs serve, specifically in terms of demographics and target audience.
3. What is the setting, background, and context of where the programs are implemented?
4. What are the characteristics of people who are serving as the patient navigator for these colorectal cancer screening programs?
5. What are the lessons learned, case studies, examples, and tools that can be helpful for those who are interested in implementing, augmenting, or learning to sustain CRCS PN?

Background: It is important to know that every CRCS PN program may choose a different screening modality and number of people they intend to reach. As a result, CRCS PN delivery services may vary greatly for each program. Let's examine several models to explore what and how CRCS PN programs were launched and have been sustained. We will explore this theme based on city, regional, and state based programs.

Program Examination:

New York City: In 2003, the Commissioner of the New York City Department of Health and Mental Hygiene (NYC DOHMH) launched a colorectal cancer screening initiative in selected public hospitals which included a colonoscopy patient navigator program. The patient navigators were trained to guide individuals through complex clinical settings in order to assist with scheduling, preparation, and completion of the procedure. (See Figure #1) It is important to note that New York State also has money to help support CRCS PN and explore cost analysis.

 The New York team has put together an amazing resource that can be incredibly helpful to those who are interested in design, implementation, evaluation, and many additional aspects of CRCS PN.
https://www1.nyc.gov/assets/doh/downloads/pdf/cancer/colonoscopy-patient-navigator-guide.pdf.

Critical Insight about New York Programs for Background:

As noted in their publications, New York has demonstrated a cost benefit and business case in the endoscopy setting. They started with housing the patient navigators in the endoscopy unit. This was beneficial as it improved quality and increased volume. The increased revenue paid for the patient navigator. It can be harder to make the business case for patient navigators who are not part of the endoscopy unit.

 Visit Chapter 6 to learn about economic impact and how cost analysis and societal benefit can help you make the business case for CRCS PN. Elkin et al. provided input about the economic impact of this specific program.

What Lessons We Can We Learn from New York:

New York had strong clinical champions in their efforts but also engaged their business and financial institutions. The patient navigators were hired through the hospital. The hospital was able to sustain patient navigation (PN) efforts after only one year of funding with grant support.

Champions and partnership are core to sustaining colorectal cancer screening, and understanding the key components of sustaining PN.

Two Common and Critical Components from all the states and Programs:

1. Most states have a regional or statewide network for patient navigators and this entity helps provide the networking for sharing of best practices, training, networking and keeping the movement alive.

Visit the Chapter 7 for a list of Patient Navigator Networks whom have formed throughout the U.S.

2. It is important to note that most programs clearly define the scope and practice of their patient navigators. This allows supervisors to better understand role, boundaries, and outcomes to help sustain the role of PN.

What is the scope of practice for your patient navigators? See Tool 1.1 to think about the scope, who will be serving in what role, and how CRCS PN will be delivered in your setting.

Colorado: The Colorado Cancer Screening Program (CCSP), formerly the Colorado Colorectal Screening Program, is a statewide program that partners with safety net hospitals and clinics to offer no-cost patient navigation services for colorectal cancer screening and other preventive screenings to the medically underserved. The program, coordinated through the University of Colorado Cancer Center, has partnerships with more than 50 community health clinics across Colorado. CCSP is heavily focused and reliant primarily on patient navigation support. Previously the program served patients from community clinics that offered no cost endoscopic screenings (most often colonoscopy). (See Figure #2)

Interview with Andrea (Andi) Dwyer and Dr. Holly Wolf of the Colorado Cancer Screening Program:

Q// What do you wish you would have known about sustainability and paying for colorectal cancer screening patient navigation?

A// 'In retrospect, we would have started evaluating the use of accreditation and quality metrics to have a better idea of how this work was sustainable in clinical settings and helped disseminate this information more quickly.'

Q// Lessons Learned

A// 'Identify the champion early and ensure they help continue to share the message and communicate the value of colorectal cancer screening patient navigation.'

Q// Advice for anyone thinking of what you did to think about sustainability.

A// Know your population! To really connect people to the care and services, ensuring your colorectal cancer screening navigators are truly integrating in the right setting is key!

Tool 1.1 Given that colorectal cancer screening patient navigators are delivering PN in a variety of settings (some frontier and rural communities, others in urban communities), and that the division of the PN services can vary, it is important to understand who is delivering the different components of PN and to ensure there is a 'keeper of the process.'

Visit Chapter 5 to see how clinic systems participating in the Colorado Cancer Screening Program have been able to achieve Patient Centered Medical Home Status and other accreditation measures with the implementation of PN to sustain the work.

See Chapter 7 to learn more about the role of training for PN. Patient Navigators in the Colorado Cancer Screening Program have the opportunity to receive training through the Colorado Patient Navigator Training Collaborative.

Read More About It. Partnerships with safety net primary care and trade organizations in Colorado were key to establishing good partnerships.

Wolf HJ, Dwyer A, Ahnen DJ, Pray SL, Rein SM, Morwood KD, Lowery JT, Masias A, Collins NJ5, Brown CE, DeMaio Goheen CA, McAbee KE, Sauaia A, Byers TE. Colon cancer screening for Colorado's underserved: a community clinic/academic partnership. Am J Prev Med. 2015 Mar;48(3):264-70. doi: 10.1016/j.amepre.2014.09.016. Epub 2014 Dec 26.

South Carolina: Since 2007, South Carolina has steadily built and improved its program to bring together a majority of South Carolina counties to provide endoscopic screening to the uninsured and medically underserved. PN is an integral portion of this work that has played a crucial role in ensuring that patients are up to date and compliant with screening recommendations.

This program was built with many partnerships aligning and working together to provide colorectal cancer screening services at no cost to the patient. In this program, free medical clinics, federally qualified health centers and safety net organizations refer uninsured and medically underserved patients to colorectal cancer screening with the Colorectal Cancer Prevention Network (CCPN). Thereafter, patient navigators review patient medical history to ensure the appropriateness of the referral to the screening program. Based on their eligibility to be screened, patients then meet with a patient navigator for a comprehensive education session on colorectal cancer and education on how to complete screening. Specifically, during the navigation, patients who are directed to open-access colonoscopy, or in need of a diagnostic colonoscopy from a positive fecal immunochemical test (FIT) are educated on the importance of compliance to the endoscopic procedure and colonic preparation to maximize the preventive benefits of the screening. Throughout the process, patient navigators are in direct contact with the patients and remain involved as an advocate when patients are referred to specialty care. (See Figure #3)

While several studies have shown the benefits of patient navigation on cancer screening rates, important gaps remain to address how to provide this service to patient. Given the absence of direct cost billing associated with patient navigation, the CCPN navigation program solely relies on external grant funding source. While the CCPN has, thus far, been successful in leveraging funds from various funding agency, there is a significant need to identify recurrent source of funding for patient navigation. To garner national recognition of the benefits of patient navigation that could lead to sustainable funding, all screening programs must incorporate patient navigation and measure the outcome impact it has on overall screening rates and compliance.

Lessons learned:

'Identify partnerships and building relationships with leadership is key to the development and implementation of a strong program that is sustainable.

> Continuously assess and evaluate the benefits of patient navigation in terms of screening rates, compliance, screening quality on incidence and mortality of the disease.

For anyone thinking of implementing similar strategies for sustainability:

Each state has unique barriers and political climate that drives sustainability. However, developing services and measurable outcomes provide opportunities for future government assistance as well as private funding.

Check out Chapter 7 Case Study to learn more about the utilization of an advocate to help secure funding at the state level to support colorectal cancer screening patient navigation and support.

New Hampshire: The New Hampshire Colorectal Cancer Screening Program (NHCRCSP) is a statewide program developed in 2009 through a CDC CRCCP grant in collaboration with the New Hampshire Department of Health and Human Services (NH DHHS), for which the Mary Hitchcock Hospital was the bona fide agent. The goals of the program were two-fold:

3. To increase high quality colorectal cancer screening for New Hampshire residents
4. To address disparities through the provision of free colonoscopies for low-income, uninsured and underinsured NH residents

As part of the provision of free colonoscopies, the NHCRCSP developed and implemented a patient navigation program and all NHCRCSP patients were navigated. Since the program was statewide, the NHCRCSP used telephonic navigation through a centralized model in which navigators worked within the NHCRCSP infrastructure. They were mentored and supported by a Medical Director and Program Director. (See Figure #4)

As a result of highly successful patient outcomes, the NHCRCSP patient navigation model was extensively evaluated by CDC from 2013-2016, including a comparison study of colonoscopy screening and surveillance for navigated vs. non-navigated patients.

Snapshot of NHCRCSP Patient Navigation Success

1. 2 colonoscopy no-shows per 2,000 patients = 0.1% no-show rate
2. Less than 1% inadequate bowel preparation in 2,000 patients
3. 100% of patients received their test results and endoscopists' follow-up recommendations

To enable replication and dissemination of the navigation model, NHCRCSP and CDC collaborated to develop a comprehensive manual, *"NHCRCSP Patient Navigation Model for Increasing Colonoscopy Quality and Completion, A Replication Manual"*.

The manual covers rationale for patient navigation, case for colorectal cancer screening, barriers to screening, details of NHCRCSP PN model, planning including budgeting and staffing, implementation including navigator training, and evaluation including necessary data to collect, for replication of the successful navigation intervention by other programs,

https://www.cdc.gov/cancer/crccp/pdf/nhcrcsp_pn_manual.pdf

Patient navigation has proven highly effective for adherence, provision of high-quality screening, and appropriate and timely follow-up.

Thoughts from Dr. Lynn Butterly, PI and Medical Director and NHCRCSP team.

'Patient navigation has been shown by the NHCRCSP PN model to be extremely effective in addressing disparities and overcoming both individual and system barriers to healthcare. Colorectal cancer is one of the few cancers that can be prevented, and navigation can have a tremendous impact on increasing high-quality CRC screening, thereby decreasing incidence and mortality from CRC and improving public health. Building trust with patients, educating them about the rationale of screening, and navigating them to and through CRC screening completion leads to success in a medically underserved population.'

Alaska: (See Figure #5)

Interview with Diana Redwood, Alaska Native Tribe Health Consortium (ANTCH) Program Director:

Q// What do you wish you would have known about sustainability and paying for patient navigation?

A// 'You need to provide organization leaders with a business case (economic benefit or net neutral cost) of having patient navigators, which means you need to collect that kind of economic information from the start.'

How would you do this? Check out Chapter 6 about Cost Analysis and Making Business Case. Focus efforts on improving Electronic Health Record reminders, and correct data in the Electronic Health Record so providers can participate more fully in the screening outreach process.

Q// Lessons learned

A// 'Patient Navigators can be taught all the information about screening, but it is very difficult to teach people to be extroverted. It is important to hire the right personality for the job. The best colorectal cancer screening patient navigators are outgoing, understand that outreach includes cold calls to people to persuade them to do something they might not be interested in, enjoy talking to people about health, are gently persistent, and care about helping their people be healthier.

The organization needs to be upfront with navigators before they are hired that the job will involve outreach, and explain what outreach entails. The programs which had the highest increase in screening rates were ones in which staff had dedicated time for patient navigators to review and update the medical record so they knew exactly who was due for screening and then called all those people to encourage them to come in for screening. It's a very high touch process, but that is what was needed to reach and activate the people that they served.'

Q// For anyone thinking of implementing similar strategies for sustainability?

A// 'Make sure leadership is on board to support outreach and make sure you have capacity to support increased screening once patient navigators start calling patients. Colorectal cancer screening patient navigators also need to be integrated into the system in an efficient way and be incorporated into the clinical flowsheet. For example, it makes no sense for a patient navigator to call patients to get them interested in screening but then not be allowed to schedule those patients.'

Tool 1.2: As the CDC has invested in colorectal cancer screening patient navigation in such a dedicated way, they have specifically provided detail about the scope of practice and outlined what quality patient navigation means on behalf of their program.

The Colorectal Cancer Control Program has developed specific guidelines for identifying what specifically is patient navigation in terms of roles and criteria, see Tool 1.2 for more information about how this tool works in their setting.

Both Alaska and New Hampshire's programs were at least initiated with support from CDC and to some extent the Colorectal Cancer Control Program (CRCCP). Visit Chapter 4 to learn a bit more about this as a funding mechanism.

Stop and Reflect:

Based on the examples provided, which of the Programs might be best for you to sustain a colorectal cancer screening navigation program/navigator?

With the information provided, what specific resources identified in this chapter will help you work with partners or your key leadership to inform your efforts

CHAPTER 4: PAYMENT APPROACHES AND STRATEGIES FOR COLORECTAL CANCER SCREENING PATIENT NAVIGATION

Goal: Explore the ways that patient navigation (PN) might be paid for through several approaches, based on the current state of health care.

Objectives:

- Examine funding strategies to think about how to start or sustain funding.
- Specifically outline:
  - Grant opportunities that will support colorectal cancer screening patient navigation (CRCS PN)
  - Potential insurance, Medicaid, and Medicare Avenues for Payment
    - Quality and Accountable Care Payments
    - Opportunities through the Affordable Care Act
    - Potential Opportunities for Coding and Billing Beyond the Affordable Care Act
- Identify if you have appropriate capacity to undertake necessary steps to ensure Medicaid and Medicare funding.
- Explore examples of how other programs have been funded or transitioned from grant to more diversified funding.

Background: Paying for PN at this time remains a bit challenging in most states because there is not typically direct reimbursement for CRCS PN.

However, there are strategies underway, and opportunities that allow patient navigators to be paid for their services by making the business case and supporting patient navigators with institutional support (to be explored further in the Return on Investment/Business Case Chapter). In states where there is Medicaid expansion, there might be an opportunity for patient navigators to be supported with Medicaid. Private insurance companies should further explore this potential. It is important to note that policy will help shape and influence if some of the strategies mentioned are implemented.

Grants and foundational support remain a staple for PN funding. While such support may not be sustainable in the long term, its use can allow the opportunity for those working in CRCS PN to initiate and evaluate efforts that may potentially be used to help show proof of concept to allow for more sustainable efforts.

In this chapter, patient navigators and community health workers are both referenced, as their role and scope have a lot of overlap. Some granting mechanisms that fund cancer prevention, community, and patient driven research have cut back on funding patient navigation because the evidence base is so strong in navigation. However, we will highlight several that continue to support patient navigation and community health work.

Let's Begin with a Case Study-Alaska!

Alaska and the American Native Tribal Health Consortium group received CDC funding in the CRCCP pilot program, and were an awardee in the initial round of the CRCCP. However, they were not awardees in the second five-year funding cycle. Despite their primary funding stream going away, they retained one of their patient navigators and ensured that the duties and roles of the PN process were deployed with other team members.

Check out Chapter 3 to learn more about American Native Tribal Health Consortium.

Interview with the American Native Tribal Health Consortium Team

Q // How did you maintain services after grant support?

A// 'We saw the value of the process of colorectal cancer screening navigation and the value of a specific person carrying out the patient navigation. When we lost our CRCCP grant support, it was important for us to retain what we could. We were able to sustain two of the three navigators in the short term. We now have only one of the initial navigators, and have transitioned the duties and roles of colorectal cancer screening patient navigation to medical assistants. Part of our challenge is we don't have funds to train a patient navigator in colorectal cancer.'

Q// Let's Talk Funding…

A// 'We were able to make the business case to our medical decision makers, noting efficiencies in the system, to have our surgery center maintain the support for our patient navigators and colorectal cancer screening activities. Colorectal cancer screening patient navigation just makes good business sense; the value they bring to ensure patient education and compliance is worth their salary support.'

Q// Future:

A// 'We would have gladly filled the positions with colorectal cancer screening patient navigators vs. another type of medical professional. However, we decided to transition duties to a medical assistant since we lacked support for training a newly hired patient navigator. We did implement the process of colorectal cancer screening navigation amongst our current health care team and have sustained this activity without grant funding.'

Visit Chapter 7 to see how programs and funders are making the business case for CRCS PN.

Grant or Foundation Funding Agencies: Specific agencies who have historically supported CRCS PN in the way of grant or foundation dollars.

American Cancer Society

As the nation's largest private, not-for-profit source of funds for scientists studying cancer, the American Cancer Society focuses its funding on investigator-initiated, peer-reviewed proposals. This process ensures that researchers propose projects they believe are ready to be tackled with available knowledge and techniques. This intellectual freedom encourages discovery in areas that scientists believe are most likely to solve the problems of cancer. The American Cancer Society also offers grants that support the clinical and/or research training of health professionals.

These Health Professional Training Grants promote excellence in cancer prevention and control by providing training or incentive and support to highly qualified individuals in outstanding training programs.

http://www.cancer.org/research/index

Prevent Cancer Foundation

The Prevent Cancer Foundation is a 501(c)(3) nonprofit organization focused solely on cancer prevention and early detection. The foundation has invested nearly $142 million in support of cancer prevention nationwide. The basis

of their work comes from four distinct pillars: research, advocacy, education, and outreach. CRCS PN and evidence-based approaches have been an area of funding.

http://preventcancer.org/our-work/grants-fellowships/

For example..

FUNDED! In 2016, Organization Upstate Foundation was funded by the Prevent Cancer Foundation, this is what they are doing:

Upstate Foundation will pilot the "WE MATTER" project to demonstrate the effectiveness of using trained Resident Health Advocates (RHAs) to reduce colorectal cancer disparities and increase colorectal cancer screening in low-income, primarily African American men and women through peer outreach, education, screening and navigation. The target population is 803 residents, ages 30 – 75, of three low-income public housing developments in Syracuse, New York.

Industry Partners

There might be an opportunity to work with specific pharmaceutical partners who have funding opportunities. For example, Exact Sciences is a pharmaceutical company that pays in certain situations for the follow-up on the FIT/FOBT and their testing strategies. It is key to understand how this might intersect with preventive screening efforts and certain elements of the patient navigation and tracking process.

http://www.exactsciences.com/

Council on Foundations

There are likely regional and state based foundations that might also award support for PN. It is essential to think of all partnerships, both nationally and at the state level, and to find out the strategies for these funding agencies.

http://www.cof.org/about

The Office of Minority Health (part of the Department of Health and Human Services)

Tribal communities and their partners have received considerable funding for research/service projects for CRCS PN. Check out this potential funding source as it is a great opportunity. In the State Partnerships Initiative, the Office of Minority Health partners with communities and organizations in the public and private sectors to offer financial assistance in support of efforts to eliminate health disparities among racial and ethnic minority populations. These entities include state offices of minority health, multicultural health, and health equity; community and faith-based organizations and institutions of higher education; tribes and tribal organizations; and other scientific and research organizations dedicated to improving the health of these targeted groups.

https://minorityhealth.hhs.gov/

For example.. FUNDED! Beginning in 2015, The Tribal Colon Cancer Collaborative of Inter-Tribal Council is funded for 5 years for colorectal cancer screening patient navigation. It is one of two projects funded under the State Partnership Initiative. The goal of the Project is to Increase the percent of American Indians who receive patient navigation services for colorectal cancer screening and treatment services.

Indian Health Services (IHS)-Community Health Representatives

As part of the IHS mission to raise the physical, mental, social, environmental, and spiritual health of American Indian and Alaska Native (AI/AN) individuals and communities, the IHS Community Health Representative Program (CHRP) aims to create a workforce that improves health across the communities they serve. Funded with IHS-CHR appropriations, the Community Health Representative (CHR) is a well-trained, medically guided tribal or Native community-based health care provider who includes traditional Native concepts in their work. CHRP is a unique, community-based outreach program, staffed by a cadre of well-trained, medically guided, tribal and Native community members who provide a variety of health services within AI/AN communities.

It is important to note that not all CHRs are funded adequately or have the training to be colorectal cancer screening patient navigators. However, many tribes and territories have devoted additional grant support and funding to ensure CHRs are utilized to work in the role of CRCS PN.

https://www.ihs.gov/chr

Centers for Disease Control and Prevention General Grants Programs

The Centers for Disease Control and Prevention (CDC) uses grants and cooperative agreements to fund research and non-research public health programs that advance the Agency's public health mission domestically and abroad to keep Americans safe and healthy. The Colorectal Cancer Control Program (CRCCP), housed within the CDC, has invested funding for evidence-based colorectal cancer interventions. In states that received this funding, implementation of PN programs might be among the efforts included in the work.

Check out Chapters 2 and 3 to learn more about the evidence from these programs and how CRCS PN has been implemented in certain states.

The National Comprehensive Cancer Control Program (NCCCP) is a fantastic resource to consider. It involves state and local health departments, state, local, and community organizations, researchers, health care providers, decision makers, cancer survivors, and their families, and many others who all come together to find and agree upon ways to address cancer concerns in their communities.

CDC: https://www.cdc.gov/stltpublichealth/GrantsFunding/opportunities.html

CRCCP: www.cdc.gov/cancer/crccp/

NCCCP: www.cdc.gov/cancer/ncccp/

The Health Resources and Services Administration (HRSA)

HRSA is an agency within the U.S. Department of Health and Human Services, and is the primary federal agency for improving health and achieving health equity through access to quality services, a skilled health workforce, and innovative programs. HRSA programs provide health care to people who are geographically isolated and/or economically or medically vulnerable. HRSA creates grants to improve and expand health care services for underserved people, focusing on the following program areas: Health Workforce, HIV/AIDS, Maternal & Child Health, Office of the Administrator, Primary Health Care/Health Centers, Rural Health, Healthcare Systems, and Organ Donation.

 https://www.hrsa.gov/grants/index.html

National Cancer Institute (NCI)

The National Cancer Institute leads a national effort to eliminate suffering and death due to cancer. Through basic and clinical biomedical research and training, NCI conducts and supports research that will lead to a future in which we can prevent cancer before it starts, identify cancers at the earliest stage, eliminate cancers through innovative treatment interventions, and biologically control cancers that we cannot eliminate so they become manageable, chronic diseases. CRCS PN and prevention is an area of interest. However, NCI grants are typically more academic and complex, and designed for research protocols. The Patient Navigator Research Program (PNRP) is one of the largest investments in PN research.

 http://deainfo.nci.nih.gov/funding.htm

 Much of what the NCI has given thus far in the way of funding for PN is through the PNRP. The results of the PNRP are critical to help sustain CRCS PN. Visit Chapter 2 regarding evidence for CRCS PN.

The Community Benefit

Community benefit describes the activities and initiatives that are provided by nonprofit healthcare organizations in order to improve health and access to care for the entire community that they serve. Nonprofit health care organizations demonstrate their commitment to community service through organized and sustainable community benefit programs providing:

- Free and discounted care to those unable to afford health care.
- Care to low-income beneficiaries of Medicaid and other indigent care programs.
- Services designed to improve community health and increase access to health care.

CRCS PN is an area that the community benefit has helped support. In order to receive tax-exempt status, the IRS requires that non-profit hospitals report on their community benefit activities and initiatives.

 https://www.irs.gov/pub/irs-tege/rr69-545.pdf

Let's Begin Talking About: Potential Insurance, Medicaid, and Medicare Avenues for Payment

Per Member Per Month – Hospital and Facility Setting

Per member per month (PMPM) refers to the dollar amount paid to a provider (hospital or health care worker) each month for each person for whom the provider is responsible for providing services. PMPM forms the basis upon which managed care organizations pay providers under capitation revenue stream or cost for each enrolled member each month. PMPMs are often paid for by Medicaid and often by other private insurance companies.

There are hospital and facility-based programs that use the PMPM payments to pay directly for their CRCS PN services, even for those who are not licensed individuals. This might further provide the opportunity for team-based care and for licensed health professionals to function at the top of their licensure.

FAQs **A team is interested in pursuing CRCS PN for high-risk patients, and is trying to understand how to use PMPM money to launch these efforts. How shall they move forward?**

Advice from an Interview with a Medicaid Claims Officer:

For those Interested in wanting to know more about PMPM for Medicaid in expansion states:

- Visit your state Medicaid home page to learn about what the state provides in the PMPM reimbursement for those who treat Medicaid patients.

For those interested in wanting to know more about how to use the PMPM that is already being awarded to your hospital or clinic system: Meet with hospital and accounting executives and ask how the PMPM is utilized in your facility. Check out Policy Chapter 7 to learn more about this approach.

- Understand if colorectal cancer prevention might be in alignment with the health priorities.
- Identify solutions for barrier reduction for colorectal cancer screening and discuss the potential role for PN with your health care champions and policy decision makers.

Centers for Medicare and Medicaid Services (CMS): Accountable Care Organizations

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

Those in ACOs often receive payments to their facilities to help manage the needs of patients. This is how CRCS PN often is sustained.

For example..

At Salud Family Health Centers in Colorado, while patient navigators are currently funded through an admixture of state grant funds and private foundations, the PMPM and ACO payments have allowed Salud to employee patient navigators. Colorectal Cancer Screening is one of the areas for which they specifically provide navigation and is a priority in their center. To staff their colorectal cancer patient navigator position at 1.0 Full Time Equivalent (FTE), the funding distribution is allocated in the following manner:

Funding Source	%FTE
PMPM	30%
ACO	40%
Colorado Colorectal Screening Program Grant Support	30%
1.0 FTE	100%

CMS offers incentive payments through their Quality Payment Program. Providers and clinical practices can receive incentive pay for collecting and reporting on a variety of quality measures, including many that CRCS PN can help support. For more on the Quality Payment Program, see Chapter 5.

At Colorado Access, one of Colorado's regional Accountable Care Organizations, PMPM and ACO payments allows the agency to implement population-based programs that focus on engaging members in completing preventive cancer screening services. Through proactively outreaching to populations, Colorado Access care coordinators engage in targeted interventions to ensure the appropriate coordination and navigation of care for the most vulnerable, high-risk members. Take a trip back to the Introduction and Chapter 1 to think about who might be the priority population for CRCS PN.

For many of these areas, it is important to understand the status of ACA coverage in your state, the number of Medicare and Medicaid patients, and if you receive the PMPM and any Accountable Care payments. Chapter 7 outlines policy strategies that have been implemented by a number of states and organizations to help pay for CRCS PN.

Potential Medicaid Opportunities to Pay for Patient Navigators and Community Health Workers (CHWs) in the Affordable Care Act

The Affordable Care Act (ACA) includes a range of provisions that may help enhance the role of patient navigators and community health workers (CHWs) in the U.S. health care system. The ACA has offered opportunities for patient navigators and CHWs, and provided insight into how each state is implementing certain activities:

1. ACA has increased access to preventive health services under Medicaid, and implementing regulations have clarified that states may designate non-licensed providers (i.e., patient navigators and CHWs) to provide preventive services.
2. ACA offers state Medicaid programs the opportunity to create "Health Homes" for beneficiaries living with chronic illness, and several states have taken the opportunity to design plans that explicitly include or refer to community health workers.
3. ACA creates funding for State Innovation Models, which are intended to help states improve health outcomes and quality of care while slowing growth in health costs.

Medicaid is a health insurance program funded jointly by the federal and state governments. The amount of federal funding varies by state, eligibility category, and type of service. Federal law forms the backbone of the Medicaid program in all states. States participating in the Medicaid program must write State Plans describing their programs, and the federal Centers for Medicare and Medicaid Services (CMS) must approve these plans, ensuring that they comply with federal Medicaid rules. When states wish to change their Medicaid programs, they generally must file a State Plan Amendment with CMS, which must approve any changes.

Federal law identifies a set of "mandatory services" that states must cover for the traditional Medicaid population. Most Medicaid beneficiaries are entitled to receive these mandatory services subject to a determination of

medical necessity by the state Medicaid program or a managed care plan under contract with the state. The required services include:

- Physician services
- Hospital services (inpatient and outpatient)
- Early and periodic screening, diagnostic, and treatment services for individuals under age twenty-one
- Federally-qualified health center (FQHC) and rural health clinic services
- Nursing facility services for individuals twenty-one and over
- Home health care for persons eligible for nursing facility services
- Transportation services

States have flexibility to cover additional services that federal law designates as optional. Examples include prescription drugs—which all states cover—personal care services, rehabilitation services, and habilitation services. Other optional services include: clinic services, dental services, prosthetic devices, eyeglasses, case management, home and community-based services, personal care services, and hospice services. Note that the category of benefits called "other diagnostic, screening, preventive, and rehabilitative services" is also optional.

Let's Breakdown the 3 Potential Opportunities for ACA Payment for PN and CHW Work:

1. Community Health Workers and Patient Navigators Providing Preventive Care

As part of a regulation implementing ACA requirements regarding health benefits in both private and Medicaid plans, CMS made an important change to its previous regulations defining preventive health care services in Medicaid.

The Social Security Act, the federal statute authorizing and defining Medicaid, had always defined preventive services as those "recommended by a physician or other licensed practitioner," yet the CMS regulation had defined these services as those "provided by a physician or other licensed provider." In a regulation effective January 1, 2014, CMS amended the regulation to match the statute, so that preventive services recommended by a physician or licensed provider – but possibly provided by a non-licensed provider like a CHW or patient navigator – could be reimbursed. In order to take advantage of this change, states must file a State Plan Amendment that describes what services will be covered, who will provide them, any "required education, training, experience, credentialing, or registration" of these providers, the state's process for qualifying providers, and the reimbursement methodology. A policy brief produced jointly by the Trust for America's Healthy and Nemours identified a wide range of preventive services that states can now allow non-licensed providers to provide. The list includes home visiting, group health education, care coordination, and general CHW services.

The Limited State Plan Amendment rule change is an exciting opportunity for employers, medical and policy decision makers within your state, to engage with Medicaid offices to develop these state plans.

The ACA creates new insurance coverage requirements affecting Medicare, Medicaid, and the private insurance market. One of these requirements pertains to preventive health care services, requiring that Medicare and non-grandfathered individual and small group insurance plans cover, without cost-sharing, all preventive services recommended with an "A" or "B" grade by The United States Preventive Services Task Force (USPSTF). Within Medicaid, plans designed for the expansion populations must also cover these services without cost-sharing, while for traditional Medicaid populations, states can choose to cover these services without cost-sharing. If states do cover these services without cost-sharing, the federal government will pay for an additional one percent of the cost.

The USPSTF is an independent, volunteer panel of national experts in prevention and evidence-based medicine. The USPSTF works to improve health by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. The Agency for Healthcare Research

and Quality (AHRQ) within the Department of Health and Human Services is charged with supporting and funding the USPSTF. The preventive services that the USPSTF focuses on are screening tests, counseling interventions, immunizations, and chemoprevention delivered to persons without recognized symptoms or signs of the target condition. The USPSTF does not typically make recommendations aimed at preventing complications from a disease, but it does make recommendations for preventing morbidity or mortality from a second condition among those who have a different established disease. See the appendix for a list of USPSTF recommendations with an "A" or "B" grade.

The ACA has given states the opportunity to receive an extra one percent in federal funding for these services if they agree to provide all of them free of cost-sharing to beneficiaries in traditional Medicaid. As of this writing,

seven states have filed State Plan Amendments to provide these services and receive the additional federal funding:

California	Arizona
Hawaii	Nevada
New Jersey	New Hampshire
New York	Connecticut
Washington	District of Columbia

As mentioned above, the ACA required states to include these services in Medicaid plans designed for "expansion populations." This means each state that expanded Medicaid will cover these recommended services without cost-sharing for the expansion population. The following states have expanded Medicaid:

Alaska	Iowa	New Jersey
Arizona	Kentucky	New Mexico
Arkansas	Louisiana	New York
California	Maine	North Dakota
Colorado	Maryland	Ohio
Connecticut	Massachusetts	Oregon
Delaware	Michigan	Pennsylvania
District of Columbia	Minnesota	Rhode Island
Hawaii	Montana	Utah
Idaho	Nebraska	Vermont
Illinois	Nevada	Washington
Indiana	New Hampshire	West Virginia

CHWs or patient navigators may be well-suited to provide some of these recommended services. In conjunction with a State Plan Amendment adding CHWs or patient navigators as authorized Medicaid providers for certain preventive services, the addition of more preventive services to Medicaid plans can greatly enhance the role of CHWs.

However, no state can take advantage of this ACA provision to increase the role of CHWs or patient navigators until it submits and receives approval for a State Plan Amendment. Therefore, the next step in all states will be for CHW and PN organizations to collaborate with state Medicaid offices to design State Plan Amendments adding patient navigators and CHWs to the list of Medicaid providers in the manner that will best suit the states' needs. It will make sense to identify which recommended preventive services can be provided by CHWs and patient navigators, and include that information in the State Plan Amendment.

https://www.kff.org/health-reform/state-indicator/premium-and-cost-sharing-requirements-for-selected-services-for-medicaid-expansion-adults

2. Medicaid Health Homes

The Medicaid Health Home is a major opportunity to integrate patient navigators and CHWs into whole-person care teams under the ACA. States have the option to establish "health homes" to coordinate care for Medicaid beneficiaries living with chronic conditions. Medicaid Health Homes must provide six core services, including: comprehensive case management; care coordination; health promotion; comprehensive transitional care and follow-up; patient and family support; and referrals to community and social support services. For the first eight quarters the program is effective, the federal government will pay for 90% of the cost of the six core services provided through the program.

Just as states must file State Plan Amendments to change their Medicaid programs to add CHWs as providers of preventive services, they must also file State Plan Amendments to add the Medicaid Health Home to their Medicaid program. The following states have filed and received approval for Medicaid Health Home State Plan Amendments:

Alabama	Michigan	Rhode Island
California	Minnesota	South Dakota
Connecticut	Missouri	Tennessee
District of Columbia	New Jersey	Vermont
Illinois	New Mexico	Washington
Iowa	New York	West Virginia
Maine	North Carolina	Wisconsin
Maryland	Oklahoma	

Patient navigators and CHWs are particularly well positioned to provide four of the six core Health Home services: health promotion; comprehensive transitional care and follow-up; patient and family support; and referrals to community and social support services.

https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/state-hh-spa-at-a-glance-matrix.pdf

3. State Innovation Models

The State Innovation Models (SIM) Initiative is providing financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries – and for all residents of participating states.

See where innovation is happening! https://innovation.cms.gov/initiatives/state-innovations/

For example.. Many states are working to embed patient navigation in care coordination and are interested in understanding how SIM dollars can support patient navigation for preventive care and whole

person care. Part of this is to explore how the addition of a patient navigator will allow other licensed health care professionals to function at the top of their licensure and increase efficiency and business practices allowing unlicensed individuals to work within the care team.

Medicaid Coding and Billing Beyond the Affordable Care Act

Beyond ACA institutions that are affiliated with a medical setting that allows for Medicaid billing, Medicaid has two codes that might be used for PN and CHW services. These are particularly for the most high risk populations which, as identified at the outset of the chapter, are those who are typically the best candidates and priority populations for CRCS PN and care coordination.

Medicaid coding and coverage of benefits is driven on a state-by-state case, so no two states are the same. These codes are potential resources that might be used in care coordination. They are particularly physician based codes but can integrate the extended care team in service delivery, including patient navigators.

Fee for Service Codes in Medicaid

Since 2013, physicians now have new codes to report complex chronic care coordination (CCCC) services. Patients needing CCCC often have multiple providers treating multiple medical conditions and may have significant functional deficits. In addition to psychiatric and behavioral co-morbidities such as dementia or substance abuse, access-to-care challenges and lack of social support may complicate the care of these patients.

Care coordination codes were created so physicians and other qualified health care professionals could bill for time spent coordinating different services and medical specialties needed to manage the complex nature of the patient's medical condition, psychosocial needs, and activities of daily living.

- 99487 Complex chronic care management services with the following required elements:
  - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; establishment or substantial revision of a comprehensive care plan; moderate or high complexity medical decision making. 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
- 99489 Complex chronic care management services, with the following required elements:
  - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; establishment or substantial revision of a comprehensive care plan; moderate or high complexity medical decision making. Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)

Wondering if your state allows for these PN codes, and if this might be applied for care coordination for colorectal cancer screening?

The best way to find out is:

- Online search
- Insert 'State Name' Fee Schedule
- Make contact with your state Medicaid office to better understand the codes and what's covered for care coordination.

Medicaid billing can be particularly complex. Above was adapted from the Affordable Care Act Opportunities for community health workers.

For more in-depth review take a look online: http://www.chlpi.org/wp-content/uploads/2013/12/ACA-Opportunities-for-CHWsFINAL-8-12.pdf

Opportunity Perhaps on the Horizon:

At this time, fee for service remains the reality for most commercial and public insurance plans, in the future, with global billing, there might be a means to directly support patient navigators, in a team based care approach!

Stop and Reflect:

Are there any specific funding resources that are new to you that you might explore for implementation of CRCS PN?

If you are living in an ACA expansion state, which of the outlined opportunities might work for you? What are the specific next steps you can take to explore this opportunity? What partners might you reach out to?

Regardless of which state you live in, what might be a two year plan to consider moving from only supporting positions with grant funding to a mixed approach or more sustainable funding?

CHAPTER 5: ACCREDITATION AND QUALITY STANDARDS – COLORECTAL CANCER SCREENING PATIENT NAVIGATION

Goal: This section highlights a variety of accreditation organizations and programs dedicated to advancing care delivery.

Objectives: Identification and Implementation
- Description of accrediting organizations and leaders in cancer care
- Specific criteria and examples of standards that colorectal cancer screening patient navigation (CRCS PN) efforts might help achieve
- General guidelines about approaches and information to explore for implementation
- Examples of hospitals, clinics, or other medical professionals who have achieved standards or accreditations by implementing CRCS PN in their practice

Questions to consider before diving in:

- Are you currently an accredited organization?
- Are you interested in accreditation from leaders in the cancer prevention field?
- How might advancing your patient care measures benefit your practice?

Background: What is accreditation?

Accreditation is a program, usually voluntary, in which trained peer reviewers from external organizations evaluate a healthcare organization's compliance and compare it with pre-established performance standards.[1]

What are the benefits of following quality standards or seeking accreditation?

The impact of accreditation and standard adherence on quality of care has been noted in many studies and has been shown to improve facility processes of care delivery, follow up, and health records.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3156520/

These benefits are then reflected in overall patient satisfaction and positive impacts on the community. Healthcare providers, including hospitals, cancer centers, primary care providers, and community centers can all benefit from joining an accreditation program, or at least following standards set by recognized organizations dedicated to health care improvement. Because accreditation is generally done voluntarily, providers that follow through with them show dedication to improvement and gold standards.

What can accreditation do for me? In a nutshell…it will provide:

- Professional recognition as a top provider
- Access to resources for professional organizations and bodies
- Organization Improvement
- Reduction of Medical Error
- Decrease Costs
- Maintenance of patient safety

I. Accrediting Organizations

Triple Aim

The Institute for Healthcare Improvement (IHI) is an organization dedicated to improving the medical field, as noted by their creation and implementation of the IHI Triple Aim. They target **three dimensions** by identifying populations in need, creating systems and means of evaluation, creating documents to support system-level results, and providing flexibility to adapt systems to fit local populations and demographics. The framework places accountability on primary care providers, as they often are in contact with patients throughout the lifecycle.

The IHI Triple Aim

Population Health

Experience of Care   Per Capita Cost

Health systems that fit the Triple Aim construct include the following five components:

- Focus on individuals and families
- Redesign of primary care services and structures
- Population health management
- Cost control platform
- System integration and execution

http://www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx

How does Triple Aim tie in with patient navigation (PN)?

Triple Aim focuses on patient-centered care and utilizing a patient navigator for cancer diagnosis, treatment, and survivorship because these additions to care have been shown to improve patient outcomes. Implementing CRCS PN would address each of the Triple Aim targets by providing patient-centered care, improving population health through increased screening and reducing costs.

For example..

CareOregon was one of the first 15 sites to work with the IHI from September 2007 to May 2009, and they continue to utilize Triple Aim to ensure their patients receive quality care. Recent action has been taken to explore colorectal cancer screening as Kaiser Center for Health Research has worked to create and pilot the Screen to Prevent Colon Cancer (STOP CRC) project to increase screening among patients who visit CareOregon's Federally Qualified Health Centers (FQHS).[2]

Patients utilizing FQHS are often low-income individuals who experience health inequity and often report low screening rates.

STOP CRC uses fecal immunochemical testing (FIT) for screening. The kits are mailed out to eligible populations who then mail it back to their clinic. The first step of the intervention is to identify the target demographic. Then the FIT tests are mailed with easy to read and understand instructions. These are concepts embedded in PN and support.

STOP CRC achieves the recommendations of Triple Aim in the following ways:
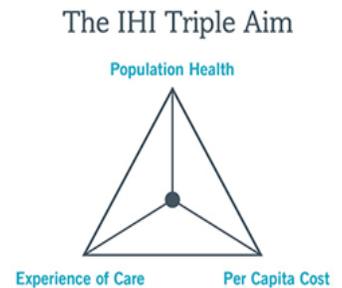
- Cost: Offers screening at a much lower cost
- Barriers: Provides an easy way to get screened by minimizing barriers of travel
- Cultural Barriers: The project team consulted a patient advisory group in the creation of instructions that met the needs of various cultures
- (See Figure #1)

Improvements: Some clinics have enhanced their patient navigation efforts by including outreach calls and group discussions.
www.ihi.org/resources/Pages/CaseStudies/PursuingtheTripleAimCareOregonCaseStudy.aspx

Is the Triple Aim right for you?

IHI provides an assessment for you to explore if you are ready to pursue the Triple Aim!

http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/TripleAimReady.aspx

Patient Centered Medical Home

Patient Centered Medical Home (PCMH), sometimes referred to as the primary care medical home, aims to improve how primary care is delivered. It is a model that incorporates comprehensive care, patient-centeredness, coordinated care, accessible services, quality, and safety. PCMH has built off of work done by the Agency for Healthcare Research and Quality (AHRQ) and the standards are also recognized and used by the National Committee for Quality Assurance (NCQA).

These standards have been shown to save money by reducing emergency room visits, improving patient outcomes, and reducing health disparities through patient relationships and culturally appropriate care.

https://pcmh.ahrq.gov/page/defining-pcmh

Those eligible for recognition by PCMH include outpatient primary care practices, and all eligible clinicians must apply together. Patients make visits to these providers as first contact for care, continuous care, and primary care. Recognition of the PCMH standards runs in three-year increments, and require re-submission.

The following are PCMH standards achievable with CRCS PN. Standards noted with * must be adhered for recognition.

For example..

Salud Family Health Centers runs ten community health clinics and one mobile unit to all community members, specifically the medically underserved, migrant, and seasonal farmworker population. They provide primary healthcare that is integrated, patient-centered, and population based. In addition to being recognized by PCMH, they are also accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and their services range from patient education, pharmacy, care management, diabetic retinopathy screening, and preventive screening services, among other offerings.

They first achieved PCMH accreditation in December 2012, using PN to do recalls and reminders to patients for preventive screening, which is a focus of PCMH. The screening

efforts of this organization are sustained through regular recall of patients, follow up with all patients, frequent training of staff, and the use of a provider reminder system: AZARA.

For Salud, PCMH was a goal to achieve for the purpose of recognition. There are no direct funds attached to PCMH, but the organization believes that it provides leverage with other funding sources like HRSA to have a standardized level of certification. In addition, their UDS screening rate has gone up 20% in the last year with the redesign of their program and additional patient navigation done within the colorectal cancer program.

Commission on Cancer

Developed by the American College of Surgeons (ACoS), The Commission on Cancer (CoC) focuses on improving patient-centered care to cancer patients, caregivers, and family members. Through the application of their standards, research efforts, and advancements in care, the CoC aims to improve overall survival rates and quality of life for cancer patients.

The organization offers various tools to help cancer centers track and advance their programs, in addition to providing advocacy education, training materials, and guidelines. With over 1,500 accredited cancer programs (hospitals, treatment centers, and other cancer facilities) around the United States, the CoC directly affects the way patient-centered care is delivered.

The 5 elements, or "key to success," in a CoC accredited program:

1. The clinical services provide state-of-the-art pretreatment evaluation, staging, treatment, and clinical follow-up for cancer patients seen at the facility for primary, secondary, tertiary, or end-of-life care.
2. The cancer committee leads the program through setting goals, monitoring activity, evaluating patient outcomes, and improving care.
3. The cancer conferences provide a forum for patient consultation and contribute to physician education.
4. The quality improvement program is the mechanism for evaluating and improving patient outcomes.
5. The cancer registry and database is the basis for monitoring the quality of care.

The CoC announced several patient-centered requirements for accreditation to be phased in by 2015, and standard **3.1 requires a patient navigation process**. In addition to 3.1, there are specific standards that could easily be met by implementing CRCS PN.
(See Figure #2)

There are many benefits of becoming a CoC-Accredited program, and often patients look to CoC programs knowing that they will be receiving the highest quality of care.

To learn more about the benefits of becoming CoC accredited, visit:
https://www.facs.org/quality-programs/cancer/coc/apply/benefitscoc
https://www.facs.org/quality-programs/cancer/coc/apply/how

Ii. Non-Accrediting Organizations

Centers for Medicare and Medicaid Services – Quality Payment Program

https://qpp.cms.gov/

The Centers for Medicare and Medicaid Services (CMS) is an offshoot of the Department of Health and Human Services, overseeing Medicaid, Medicare, and the Children's Health Insurance Program (CHIP). Over time, CMS has instituted a variety of payment models based upon quality and performance as well as the Sustainable Growth Rate formula. The Medicare Access and CHIP Reauthorization Act (MACRA) that went into effect January 1, 2017 ended the Sustainable Growth Rate formula and helps practices receive payment based upon quality of care and health of their population. MACRA also restructured the Meaningful Use standards and rolled them into the Quality Payment Program (described below).

Program Eligible Professionals (EPs) and Eligible Clinicians as well as hospitals, including critical access hospitals (CAHs), who accept Medicaid, Medicare, and the CHIP are eligible for payment under the Quality Payment Program. Practices and providers have two options for participation: MIPS (Merit-Based Incentive Payment System) which rolls together Meaningful Use, the Physician Quality Reporting System, and the Value-Based Payment Modifier to provide incentive or Advanced APM (Alternative Payment Model) which provides lump-sum incentive pay for those participating in shared risk programs (like Accountable Care Organizations).

To be accepted into the Quality Payment Programs (QPP), organizations and professionals must meet **meaningful use standards**. CMS utilizes a series of Clinical Quality Measures to observe how services are delivered among those within their system, including medical professionals, hospitals, and critical access hospitals. The electronic Clinical Quality Measures (eCQMs) identify the quality of services provided by those within the Medicare and Medicaid health care system with an aim for all affiliated organizations to provide the safest, most effective, patient-centered, and organized care. eCQMs support the achievement of health care goals related to better health, better health outcomes, and lower cost. These CQMs and eCQMs are based upon the six National Quality Strategy areas:

1. Patient and Family Engagement
2. Patient Safety
3. Care Coordination
4. Population/Public Health
5. Efficient Use of Healthcare Resources
6. Clinical Process/Effectiveness

These measures must be submitted yearly to continue receiving incentives, and in most years, the measures change. Similar to other organizations identified in this section, CMS is concerned with delivering patient-centered, culturally appropriate, safe, effective care. In order to be considered for MIPS or Advanced APM, hospitals and medical providers must adhere to and report upon a range of clinical quality measures. The basic outline of these reporting requirements are described below, but the QPP will be rolling out through 2019, so check the CMS QPP website for updates (https://qpp.cms.gov/).

MIPS
Practice groups and providers choosing to participate in MIPS will receive a Medicare payment adjustment based upon evidence-based and practice-specific quality data that demonstrates the practice has provided high quality, efficient care across four categories. These categories include Quality, Improvement Activities, Advancing Care Information, and Cost. Payment adjustments in the first year (2019) are up to 4% positive or negative, and they increase to 9% in 2022. These adjustments are determined based upon a total MIPS score, which is calculated from the quality of data submitted under each category.

MIPS Quality Measures

Quality Measures account for 60% of the total MIPS score (85% if the practices chooses not to participate in Advancing Care Information category). The quality measures specific to gastroenterology and CRC screening patient navigation are listed in Figure 3.

MIPS Improvement Activities
Improvement Activities account for 15% of the total MIPS score. There are three subcategories that apply to CRCS PN: Care Coordination, Population Management, and Achieving Health Equity. See Figure 4 for details on the specific measures applicable to patient navigation.

MIPS Advancing Care Information
The Advancing Care Information category replaces Meaningful Use.

Advanced APM
Practice groups and providers choosing to participate in Advanced APM will receive a 5% lump sum incentive payment each year from 2019 through 2024. Individual providers and group practices are eligible to participate in Advanced APM if 1) the practice receives 25% of its Medicare Part B payments through and Advanced APM or 2) the practice sees 20% of its Medicare patients through an Advanced APM. Participation is an alternative to the MIPS program that requires practices to use certified EHR technology and operate under a CMS-approved model (i.e.: Comprehensive Primary Care Plus Model, Medicare Shared Savings, Next Generation Accountable Care Organization Model).

Medicare Shared Savings Program
The Medicare Shared Savings Program was established as part of the Affordable Care Act and was created to help coordinate the quality of care for Medicare "fee-for-service" beneficiaries. The program is appropriate for eligible hospitals, providers, and suppliers and aims to create better care for individuals, better population health, and a decrease in the growth in expenditures.

Accountable Care Organizations (ACOs) are often rewarded if they lower their growth in health care costs while meeting quality care standards. There are 33 quality measures addressing the following categories: "patient/caregiver experience, care coordination, patient safety, preventive health, and at-risk populations."

Of the thirty-three measures, eight measures of patient/caregiver experience are collected via the CAHPS survey, seven are calculated via claims, one is calculated from Medicare and Medicaid EHR Incentive Program data, and seventeen are collected via the Group Practice Reporting Option (GPRO) Web Interface. The following specific measures could be reached by incorporating CRCS PN within an organization or clinic. (See Figure #6)

Next Generation ACO Model
CMS has a variety of accountable care models it is testing (all of which are included in the Advanced APM). The Next Generation ACO Model tests whether or not strong financial incentives for ACOs improve health outcomes and lower Medicare fee-for-service expenditures. This Model differs from other ACOs by providing greater reward for greater risk by rewarding quality performance, attainment of and improvement in cost containment, and transition away from reference to historical expenditures. Additionally, this Model allows from transition away from fee-for-service to population-based payment.

The quality measures and performance standards included in the Next Generation ACO Model are aligned with the Shared Savings Program and other CMS quality measurement programs (See Figure 6). With regard to the quality measures, the Next Generation ACO does not use the EHR measure.

National Quality Strategy

Guided by the Agency for Healthcare Research and Quality, the National Quality Standard (NQS) first made an appearance in March 2011. It was created in response to the Affordable Care Act to measure quality and improvement. The NQS has three aims (better care, healthy people/healthy communities, and affordable care). They are achieved by applying six priorities addressing health care concerns in the United States.

The six priorities are:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

The goals of the NQS are easily achievable through the implementation of a colorectal cancer screening patient navigator. Specifically, ensuring that each person and family is engaged in care-making decisions, promoting effective communication, and working with communities to promote best practices, in this case, colorectal cancer screening. The measure specific to CRCS PN is included in Figure 7.

US Department of Health and Human Services

The standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) were first developed in 2000 by the Office of Minority Health. The standards set the framework for health care organizations to better serve minority groups who often receive neither culturally, nor linguistically, appropriate care.

"By tailoring services to an individual's culture and language preference, health professionals can help bring about positive health outcomes for diverse populations."

CLAS standards target all medical centers, organizations, physicians, and medical providers. By implementing these standards, professionals can be confident in their ability to provide equitable care and help reduce health care disparities.

Specifically, the two listed CLAS standards noted in this document apply to the Patient Navigation for Colorectal Cancer Screening Toolkit. While implementing CRCS PN these standards should be adhered to in order to provide culturally appropriate care for patients. One of the cornerstones of colorectal cancer screening is to break down barriers. Culture and language are two of the most common elements of overcoming these barriers. Visit Chapter 2 to learn more about the role of the patient navigator in addressing these issues in CRCS PN. (See Figure #8)

National Quality Forum

The National Quality Forum (NQF) is a non-profit organization comprised of stakeholders from all over the healthcare industry who share the aim of healthcare improvement. By listening to the needs of their partners and engaging stakeholders, NQF is able to improve healthcare in the following ways: create safer patient care, reach better health outcomes, and reduce healthcare costs, among other goals.

NQF endorses measures and standards that are evidence-based and supported by input from patients – the endorsements are done so that providers know what to do in order to provide the best health care.

NQF focuses on person and family centered care measures, along with others. By constantly updating measures and standards that are meaningful for patients and policymakers, healthcare will improve. The NQF targets health professionals, community health agencies, along with medical suppliers. The NQF has endorsed the following standard, which has been used by the Centers for Medicare and Medicaid Services in their Shared Savings Program. (See Figure #9)

Joint Commission on Accreditation of Healthcare Organizations

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredits over 20,000 health care organizations throughout the nation, setting a quality standard in the eyes of the field. Hospitals, doctor's offices, nursing homes, surgery centers, and other health care centers are able to achieve accreditation through the Joint Commission.

In addition, certifications by the Joint Commission can be achieved within a health care organization as well, so there are many options for individuals throughout the healthcare field.

Mission: To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

The extensive list of standards set by JCAHO represents some of the leading standards for improving health care delivery. (See Figure #10)

URAC

URAC accredits many health care organizations such as hospitals, provider groups, and primary care physicians. Their process for accreditation takes four steps: applying, remote review by URAC review staff, on-site review by accreditation team, and committee review as performed by URAC's Accreditation and Executive Committees. The URAC's Patient Centered Medical Home program is one of their top programs in care integration and coordination, and URAC provides a PCMH certification to organizations who meet their standards of quality care.

Learn more here: https://www.urac.org/accreditation-and-measurement/accreditation-programs/all-programs/patient-centered-medical-home/

Primary care practices, specialty groups, outpatient clinics, ambulatory clinics, and pediatric practices may apply for achievement of PCMH by URAC if they aim to:

- Increase access to services
- Support care coordination across the continuum
- Improve patient accountability through information and active decision-making
- Drive efficiency and effectiveness

The following is a list of standards that can be used to reach the URAC PCMH Certification: https://www.urac.org/sites/default/files/standards_measures/pdf/STDGlance_AC_0.pdf (See Figure #11)

Iii. Specific To Cancer Centers

Association of Community Cancer Centers (ACCC)
The Association of Community Cancer Centers (ACCC) is a well-known leader in education and patient advocacy in the field, and many look to their recommendations in order to stay up to date on care delivery, in addition to staying on top of transitions that occur in the field. ACCC has made patient

navigation for cancer care a priority in its ACCC Cancer Program Guidelines to reduce the amount of stress and confusion, often resulting from cancer diagnosis. In the ACCC Cancer Program Guidelines, Patient Navigation Series is listed in section 4.10 and is mentioned as a priority.

https://www.accc-cancer.org/docs/Documents/publications/cancer-program-guidelines-2012

Although accreditation is not offered by this organization, ACCC members have access to the most up to date education materials and resources geared towards providing optimal care along the cancer continuum. (See Figure #12)

Quality Oncology Practice Initiative
The Quality Oncology Practice Initiative (QOPI) is a voluntary improvement program developed by the American Society of Clinical Oncology (ASCO) in 2006. It was designed to assist hematology-oncology and medical-oncology practices to improve patient care. The organization is oncologist-led in order to promote self-assessment, growth, and recognition in the growing field. ASCO has more than 28,000 members and uses science, education, and peer-reviewed journals as means to improve cancer care.

QOPI specifically targets medical, surgical, and radiation oncologists, along with primary care providers, and currently has 935 US based practices and thirty international based practices. Although voluntary, the QOPI does offer a Certification Program (QCP) which has been in existence since January 2010.

http://www.instituteforquality.org/qcp/measures-and-standards

America's Essential Hospitals (Previously: National Public Health and Hospital Institute)

America's Essential Hospitals provide evidence based care to patients using a linguistically and culturally appropriate method. Offering high-quality care to the most vulnerable populations is the top priority of this organization, which supports members involved in policy development, education, research, and advocacy. The following recommendations are listed as a means of providing optimal care:
(See Figure #13)

Stop and Reflect

With examination of the described standards and the Appendix measures, which are applicable to me?

Do they all help me achieve the following?
- Professional recognition as a top provider
- Provide access to resources for professional organizations and bodies
- Organization Improvement
- Reduce medical errors
- Decrease costs
- Maintain patient safety

What will be my next step to help in exploration or implementation?

V. Sources:

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CHAPTER 6: ECONOMIC ANALYSIS AND BUSINESS CASE FOR COLORECTAL CANCER SCREENING PATIENT NAVIGATION

Goal: After completing this chapter, you will have an understanding of different types of cost analyses to help make the business case for colorectal cancer screening patient navigation (CRCS PN). You will also be able to identify if and when undertaking a cost-effectiveness study is a valuable use of your time, or if a previously conducted cost analysis of CRCS PN might be better utilized to make the business case. For those who wish to undertake an economic analysis, the measures necessary to complete several types are described, including measures required to speak to various stakeholders. You will also find a list of resources for applying what's been learned through previously conducted cost analysis, or how to go about it yourself.

Objectives for Audiences:

Program Planners
1. Understand importance of incorporating cost data collection at program inception
2. Appreciate future programmatic value of incorporating cost data and economic analysis

Evaluators
1. Identify appropriate type of economic analysis for program
2. Choose appropriate measures for data collection

Policy Advocates
1. Educate other stakeholders about the use of cost data and economic analysis to make the case for patient navigation (PN) reimbursement and to improve patient outcomes and survival
2. Understand the different types of economic analyses, when to use each type of analysis, and what the results indicate

Clinic Managers
1. Understand importance of incorporating data collection into workflow
2. Use economic analysis data to advocate for incorporating patient navigators into the clinic
3. Work with analysts to ensure costs are tracked and made available for program evaluation
4. Ensure that economic and outcome evaluation are integrated back into the clinical practice—it must circulate back into clinical quality processes and not be independent of the practice and clinical integration
5. Be certain to think critically about how to show connection between cost and analytical tools for future reporting

Background and Considerations:

Let's start out with a discussion about considerations for performing an economic analysis for some good grounding.

A couple things to make clear at the outset—cost analyses are complex, nuanced, and messy!

- If there are already cost studies and analyses complete that are representative enough of your setting, population, or needs, don't try to replicate the effort—use what's already been done.
- You should consider planning your cost analysis prospectively and building it into your program. It is easier and more accurate if you start the planning in advance versus doing it after-the-fact.
- Unless you are skilled and trained in this area, it is not wise to go it alone!

FAQ Answered by a Health Economist
Before you begin a cost analysis, what are the biggest considerations for getting started? It is very important to think about WHOM and why you are trying to make a case for patient navigation.

It is exteremely important to know who you are trying to 'convince' about the value of PN—this is your audience—and consider what about the value of PN would be convincing from their perspective .

Critical Questions to Ask Before You Start A Cost Analysis:

1. **Who do I need to convince that PN is of value, and that it should be implemented and sustained in a specific setting?**

    You need to know your audience. This will often answer your question about why you might need to perform a cost analysis.

    The most common stakeholders are:
    - *Administrators and System Level Decision Makers*
    - *Payors/Insurers*
    - *Policy Makers/Regulators*

2. **In a nutshell, what are the most common types of approaches to thinking about making the business and monetary case for PN?**

    - ***More Common Approaches***
        - *Return on Investment (ROI): Compares the magnitude and timing of financial returns to the magnitude and timing of investments in a program, which is often measured by Total Program Cost*
        - *Programmatic Cost: Measures the cost of developing, implementing and running the program. These cost are required elements of all economic analyses*
        - *Cost-Effectiveness Analysis: Compares relative Total Program Cost to a relative Program Outcome of two or more alternative programs*

    - ***Less Common Approaches***
        - *Budget Impact Analysis: estimates financial impact of implementing a program or intervention; commonly accompanies a cost-effectiveness analysis*
        - *Cost Benefit Analysis: Compares Total Program Costs to Total Program Benefits monetizing both pecuniary (requires placing a monetary value on all benefits and costs)and non-pecuniary benefits*
        - *Cost Utility Analysis: A special case of Cost-Effectiveness Analysis where Program Outcomes are measured in terms of Quality Adjusted Life Years (QALYs) or Disability Adjusted Life-Years that includes both the quality and the quantity of life lived*

    The following are the most crictical elements to capture to inform the basis of a cost analysis (Figure 1 goes into greater detail about these specific costs):

    At a Glance-Micro costing framework:
    - *Patient Navigator Labor Costs*
    - *Supervision & Administrative Support*
    - *Hiring and Training Costs*
    - *Other Direct Program Costs*
    - *Facility and other Indirect Program Costs*

3. Why Is This Important… Where is the Value?

When you know your audience, you can determine the type of analysis you will consider doing either directly, or conducting in partnership with others. The most pressing and important question will be based on perspective:

Based on what's important from the perspective of your target audience, you will need to choose the type of analysis that gives the information you really need in order to demonstrate the value of patient navigation to that audience!

- Return on Investment (ROI): Might be most important to administrators and system level decision makers and most likely important to payors and insurers
- Cost Benefit Analysis: This type of analysis is not as widely used to make the strongest business case. It looks beyond pecuniary benefits and costs that requires placing a monetary value on all benefits and costs, so it is not as widely implemented because of its complexity and it raises deeper issues including societal benefits that are harder to calculate

4. Are economic analyses hard to do?

The short answer is YES! If you are not trained in this area, do not go it alone! There are many factors to consider and perhaps you need to work with a formally trained academician or researcher with a health economics background. But, before you take that leap, it's important to take a step back and consider what's already been done in the field and how you can take advantage of this information. (See Figure 2)

5. Yes, it's clear I really need to do an economic analysis myself. I know my audience and I have ideas about partnerships to help me perform this analysis. Now what?

Before you get started, you need to ensure that you have the buy-in from key champions in your organization to

1. perform the programmatic cost analysis and
2. invest in PN services if the results from the economic analysis demonstrate value.

A lot of work and resources will need to be applied to make progress with an economic analysis – make sure you have the champions in place to get this work done!

6. What are the key elements that we will need to consider to demonstrate the value of a CRCS PN program?

At a minimum you will need to consider the following; however, for certain analyses, you will need to know much more:
1. *Programmatic Cost Elements (See Figure 1)*
2. *Patient Outcomes for those Navigated:*
   a. *No Show Rates for colonoscopy exams*
   b. *Bowel Preparation Quality*
   c. *Completed exams (reached cecum)*

7. In an environment that has limited funding, which population is it suggested that CRCS PN be directed?

Several research papers have examined this very question, and results from studies of PN for many disease types across the care continuum note that patient navigation should most often be directed to the medically underserved as a priority population. See Chapter 1, the Freundy citation for more detail.

Let's Now Review Cost Analysis More Deeply!

Economic analysis is a general term that has slightly different meanings to different people. Broadly, "economic analysis" is an assessment in which monetary or somehow tangible outcomes are associated with an investment. Terms such as cost-benefit, cost-effectiveness, and return on investment are all specific types of analyses to explain the outcome associated with a monetary input (described briefly above). This section will dive into the details and provide specific examples for those ready to consider conducting their own analysis.

There is a lot of overlap in collection of information for overall evaluation and cost analysis. Visit Chapter 8 to learn more about overall evaluation metrics and tools to help capture essential PN activities and critical information.

1. **How do I initiate an economic analysis of my program? (Seems like Strategic Planning is a good idea!)**

    Program Not Begun:
    - Define question/s to be answered
    - Define PN target population (not everyone needs navigation, who is least likely to be screened?)
    - Determine limitations of data collection due to program context and resources
    - Choose key outcome measures (e.g., # of patients navigated, # of navigated patients screened)
    - Assess evaluation capacity of your team and recruit partners if necessary (e.g., a local school of public health or academic institution)
    - Consider evaluation burden of program staff (navigators, clinic staff)
    - Allocate additional evaluation staff within program plan (if necessary)
    - Develop data collection instruments (use what others have used when possible)
    - Incorporate economic data collection into routine program data collection

    Program Already Begun:
    - Identify limitations of retrospective data collection
    - Determine limitations of data due to program context
    - Define question/s to be answered
    - Choose key outcome measures (e.g., # of patients navigated, # of navigated patients screened)
    - Assess evaluation capacity of your team and recruit partners if necessary
    - Understand adding additional reporting requirements of program participants may change program structure, so provide adequate training to ensure program fidelity
    - Develop data collection instruments (use what others have used when possible)

2. **What types of analyses are appropriate to assess the economic benefit of CRCS PN?**

    Programmatic Cost Analysis: a required component of all types of economic analyses that measures the dollar amount of the resources required to develop, implement, and operate the program. It is often referred to as the dollar amount investment by the organization implementing the program. For PN programs, this type of analysis would give the total program cost and is often expressed as the cost per person served by the program.

    For example..

    CASE STUDY:
    What is one example of a cost analysis for patient navigation programs?

    Elkin et al. (2012) performed a cost analysis as part of their economic evaluation of the New York City patient navigator program at three NYC public hospitals. Learn more about them in Chapter 3. Data for the cost analysis was obtained primarily through interviews with program staff and hospital administrators with program databases providing procedure and appointment information. The major outcome is cost per patient referred to navigation. These costs were assessed for program initiation, end of program, and overall referral rates, giving a range of cost estimates.

$$\text{Cost per patient referred: } \frac{Total\ Program\ Costs}{\#\ Patients\ Referred\ to\ Program}$$

Cost-effectiveness: another common economic analysis that is often confused with cost-benefit. The difference between a cost-effectiveness analysis and a cost-benefit analysis is in the type of outcome assessed. Whereas cost-benefit analyses compare all benefits and costs in monetary values, cost-effectiveness analyses compare a measurable outcome that is not necessarily easily expressed in monetary terms to the monetary investment in the program and any difference in direct medical costs with and without the program. For a PN program, these outcomes could be number of patients successfully navigated, number of cancers prevented, or increase in screening rate for the population.

Cost-effectiveness is often reported as an incremental cost-effectiveness ratio (ICER). An ICER is a measure to describe the ratio of the increased cost of an intervention over the standard of care versus the monetary benefit of the intervention over the standard of care. Often, the ICER uses the difference in quality-adjusted life-years (QALY) associated with the intervention over the standard care as the outcome, which is a cost utility analysis.

For example..   *CASE STUDY:*
How does a program collect data to conduct an incremental cost-effectiveness ratio?

Determining incremental cost-effectiveness requires data both on the intervention program and on the usual care condition. Usual care condition data can come from literature or historical data, but the best-case scenario is to set up a program to have a comparison usual care group (i.e., a control group). However, as the field of PN grows and is shown to be effective, there will be an ethical concern about witholding an intervention that has been proven to work.

A multi-site breast and colorectal cancer patient navigation study conducted by Donaldson et al. (2012) determined cost-effectiveness by calculating the net cost of navigation alternatives.

Net Cost:

$$(Cost\ of\ Program\ Implementation) - (Medical\ Treatment\ Costs)$$

Medical Treatment Costs Saved:

$$\#\ Patients\ reach\ diagnostic\ resolution * Cancer\ Attributable\ Treatment\ Cost$$

Outcome:
Measures of the number of patients navigated, time to diagnostic resolution, and cancer stage diagnosis data were collected through aggregate patient data collection. PN program cost data was calculated retrospectively by surveying the PN supervisor. Program cost numbers included direct, nonmedical operating costs, but excluded program start-up costs.

Return on Investment (ROI): a term to describe the net monetary gain after accounting for programmatic costs. Cost-benefit analyses are also used to describe return on investment when including monetized values for non-pecuniary benefits.

For example..   *CASE STUDY:*
What can a ROI study tell us about a PN program? What doesn't it tell us?

ROI data explains what funders get for their monetary investment. The term comes from the investment literature and translates in a similar way: what is the long-term monetary gain for the current monetary investment? These analyses answer the question "How much can I save by investing an upfront cost now?" This question gets at the heart of the argument for preventive health services (of which CRCS PN is an example). By investing in programs and interventions now, the health care organization will save money in the long run. In the context of colorectal

cancer screening, a ROI analysis reveals the savings in cancer-related costs by paying for preventative screening services.

The outcomes are all economic, so these studies do not capture the "intangibles" of PN and care coordination. Additionally, these analyses do not relate non-monetary program outcomes to the monetary investment. For example, an ROI does not describe extended life-years or productivity gains due to a PN program preventing morbidity and mortality. It does not allow for what many see as the 'feel good' benefits from the multi-dimensional components that result in improved care for patients. That said, a basic cost analysis or ROI study can help articulate specific information about program costs associated with program outcomes of interest, such as numbers of patients screened and numbers of cancer diagnoses. Even this limited amount of information can be of interest to key partners and stakeholders.

Sensitivity Analysis: a term describing the extent to which results from an analysis are sensitive to variation in key elements of the analysis. Most economic analyses include sensitivity analyses.

For example, cost-benefit analyses require monetary values for non-pecuniary benefits, and one common sensitivity analysis examines the extent to which findings vary if different values are placed on these intangible benefits. Other types of sensitivity analyses include examinations of variations in programmatic cost estimates, variations in outcomes, and variations in interest rates that are used to calculate the present discounted value of future monetary benefits.

3.   What are the economic analysis results for CRCS PN programs?

When reviewing this section, it is critical to ensure that you understand that each of the examples are provided to exemplify several key elements:

- Setting of where the patient navigation was housed (hospital, community, clinic sysemt, GI Center)
- Who is serving as the patient navigator
- Geographic representation
- The role of the patient navigator or patient navigation in screening, resolution of abnormal finding, and access to treatment
- How the economic analysis was approached – understanding that there are lesssons learned in each

* IDEAL: Do this at the start, and plan at the outset rather than retrospectively. You need to identify the purpose of why you are doing this and who your audience is in order to make the 'business case' and policy case. Sound familiar? Check out Diana Redwood and Alaska Native Tribe Health Consortium (ANTCH) comments in Chapter 3.

A review of current literature on cost analyses of CRCS PN programs revealed ten publications on program costs, and two articles highlighting important considerations and evaluation of undertaking a cost analysis. *Figure 2* details the findings of these studies. The program costs studies included four studies of total costs, three assessments each of an incremental cost effectiveness ratio (ICER), cost-effectiveness, sensitivity analysis, and two evaluations of the PN process (time spent, frequency of barriers).

Process evaluations were included in this table to show outcomes that have a cost associated with them although the evaluation does not include the economic impact. The PN programs examined were predominately based in community health centers, urban hospitals, or Federally Qualified Health Centers (FQHCs).

Although a process evaluation is not an economic analysis, two process evaluation studies were included because the methods are sound and if additional measures were included, the authors could have reported cost analysis outcomes. For example, Paskett et al. (2012) included measures of time spent per patient. If data were collected on patient navigator salary, this measure could have been converted to a cost measure by assigning a personnel cost to the PN process.

Salary data is generally available after a program has completed, so if a program is already collecting time data (i.e., time a patient navigator spends on particular activities over a defined period of time), additional retrospective data collection could provide the details necessary to assign a monetary value to PN services.
(See Figure #1)

For example..

<u>CASE STUDY:</u>
Cost-Effectiveness and Sensitivity Analysis of University Hospital System-Based Patient Navigation Program

The Colorectal Cancer Male Navigation Program, developed by the University Health System in San Antonio, Texas, provides no-cost screening colonoscopies for Hispanic men with a bilingual patient navigator and provider. Researchers at partner institutions conducted an economic analysis including cost-effectiveness and sensitivity analysis.

Cancer-related costs were obtained from the literature (see resources for this reference list) and navigation program costs were determined from the program itself. Major outcome measures include per PN program cost, per patient status quo cost, quality-adjusted life-years (QALYs), life-years (LYs), and life expectancy. The ICER summarizes the effectiveness of the navigation program.

$$\text{Navigation Program Cost} = \frac{Total\ cost\ of\ navigation}{number\ patients\ screened} + colonoscopy + polypectomy$$

QALYs = Utility Weights: 1.0 for normal mucosa/polyps
.74 localized cancer
.61 regional cancer
.26 distant cancer

$$\text{ICER} = \frac{Cost\ of\ Navigation - Cost\ of\ Status\ Quo}{Effect\ of\ Navigation - Effect\ of\ Status\ Quo}$$

<u>Key Take-Aways:</u>
- Sensitivity analysis is contingent upon assumptions made about disease progression because comparison data is collected retrospectively
- Program is cost-saving with only 18% patients contacted by the patient navigator successfully completing a screen

4. **Which stakeholders care about cost analyses?**

Cost analysis results can help make the case for continued funding or sustainability to funders, program implementers, and program beneficiaries. Often, CRCS PN programs are grant funded through government agencies or non-profit organizations and are time limited. Demonstrating cost-effectiveness to these funders will bolster grant renewal applications or perhaps lead to an institution or other payor sustaining funding of this work.

Additionally, in order to move from grant funding to a sustainable program (funded directly from the state or an insurer), an economic argument must be presented to insurers or entitlement program directors in order to maintain funding for PN.

- *Clinic Managers*
  Cost analyses are also relevant to the clinic in which the PN program is implemented. Clinics must dedicate valuable personnel and staff time to execute these programs, so clinic directors want to be sure staff efforts are being dedicated to the most worthwhile programs. Cost analyses provide

evidence of effective and cost-reducing programs. Clinic managers can allocate additional personnel to exceptional programs while identifying programs that need reworking in order to be more effective.

In a case study project to make the case for sustaining a CRCS Patient Navigator within the primary care setting, clinic leadership from a mulit-site FQHC in Colorado cited the information on PN workflow, cost, and FTE as important in determining additional staffing needs and streamlining the navigation process.

-A Community Health Center in Northern Colorado

- *Program Implementers (the patient navigator)*
  Program implementers care about cost analyses because the results demonstrate the value of their efforts. Knowing a program has true benefit to patients, clinics, and providers can help validate an individual patient navigator's efforts to perform high-quality PN to all patients. See Chapter 8 on Evaluation.

- *Funders*
  Funders will look favorably on grant renewal requests if the submissions include cost and sustainability data. Funding agencies want to ensure their money is used wisely and effectively, and this can be demonstrated through cost analysis and cost-effectiveness studies.

- *Specialty Care Providers (The GI Doctor)*
  Specialty care providers are interested in cost data for similar reasons to clinic managers. However, they tend to be more interested in the costs associated with decreased no show rates rather than programmatic costs. Because many CRCS PN programs exist in primary care settings, the specialty care group is not spending the money on patient navigation. However, specialty care groups may select which clinic to work with based upon improvements in no show rates.

- *Entitlement Program & HMO Administrators (Medicaid, Medicare, and CHP+)*
  Entitlement program administrators can use cost data as the reason for changing billable services policies. If data shows a CRCS PN program to be cost-effective, the case can be made for Medicaid (and other entitlement programs) to include PN in their billable services since it would directly effect their bottom line. Similarly, HMOs (Health Maintenance Organizations) would want to encourage cost-saving programs since their insurance pool and provider pool encompass the same patient population.

5. **What are the necessary measures for conducting a high-rigor cost analysis? What are important considerations when designing a cost-analysis study?**

   <u>Key Measures</u>
   (See Figure #1 for additional detail)
   - Program Costs (fixed & variable)
   - Administrative Costs
   - Human Capital Costs
   - Direct Medical Costs
   - Direct Non-Medical Costs
   - Indirect Costs

   <u>Key Considerations</u> (Ramsey et al. 2009)
   - **Costs are specific to the locale**: provide context for generalizability
   - **Include a sensitivity analysis**: show program's ability to accept changing constraints, but be careful of assumptions in the comparison group
   - **Include the common metrics**: cost per QALY, ICER, diagnosis and treatment delays, patient satisfaction, survival, percent receiving and completing therapy

- **Acknowledge challenges**: non-linear relationship between PN efforts and endpoints measured; consistent data collection across program sites is difficult; modest decreases are difficult to detect

6. **Why are high-rigor cost analyses necessary?**

High-rigor cost analyses of CRCS PN programs are necessary to make the case to policy, insurance, and entitlement stakeholders that PN is a cost-effective component of the patient-centered medical home. The literature does not currently include many high-rigor analyses. Aside from the realities of resource constraints, this fact is largely due to program planners not building in sufficient data collection methods from program inception. This problem can be solved with additional research and publication using the guidelines described throughout this chapter. Check out Chapters 5 and 7 to see how this all applies!

Current limitations include studies with purely retrospective data collection and analysis, comparison groups of historical data rather than simultaneous data collection, a lack of generalizability, and no calculation of the economic impact of improved no-show rate. Generalizability is an issue for two reasons:

- Sensitivity analyses are contingent upon the asumptions used, and collecting less data on the sample leads to more assumptions
- Some studies have very specific patient populations or PN context

7. **How do we measure intangible benefits to society and systems?**

It is much more complicated to assess the larger societal and health system impacts of a CRCS PN program than it is to simply assess the economic, health, and quality of life impacts of the intervention.

The downstream effects of cancer screening and early detection include saved lives, reduced morbidity, and fewer treatment costs. In addition to these patient-centered effects, there are effects of PN that are difficult to measure accurately. An individual's successful navigation experience can lead to increased connection to the medical home, including increased utilization of preventative services. and referral of other family members to the medical home for preventative services and routine care. These effects impact not only the family members' in terms of their overall health and quality of life, but also the medical home in which they interact because the clinic is able to bill for these services and provide lower-cost preventive care rather than higher-cost treatment of preventable conditions.

8. **Who can I partner with to conduct a cost analysis of my CRCS PN program?**

It is imperative to know that the vocabulary used in cost analysis, public health, and academia might be different when referring to key concepts or variables. It's important to understand the definitions of the cost analysis constructs to be able to provide sufficient and reliable information.

It is not expected that all organizations coordinating CRCS PN have the in-house expertise to conduct a high-rigor cost analysis. However, resources exist. Organizations can tap into these local resources to conduct high-rigor cost analyses. Partnering with academic research centers, health research organizations, or local schools of public health in the planning and evaluation stages is critical to implementing a program that includes the requisite data collection and evaluation components.

Consulting with experts when planning the PN program will ensure there are adequate data collection procedures in place at program inception to gather appropriate data. Additionally, discussing the evaluation needs before implementing the program may lead program planners to alter certain aspects of the program to facilitate data collection. To get a good grasp on the CRCS PN evaluation metrics, visit Chapter 8.

It should go without saying that including experts in the evaluation phase of a program will aid in conducting the cost analyses. If an organization does not have the capacity to take on a cost analysis evaluation on their own, contracting a health economist researcher to conduct the analysis will ensure the evaluation is thorough

and accurate. Ideally, the same expert should be consulted during program planning and evaluation to provide consistency in measures and language.

Types of Organizations to Partner With:

- Local university
  - Cancer research center
  - Health care administration academic program or researchers
  - Public health program evaluators
  - Business school

- Non-academic research organization
  - Non-profit health research groups
  - Research organizations

The Colorado Cacncer Screening Program (CCSP) partnered with two clinic systems to conduct case study evaluations of the data needed to make the case for sustainability of CRCS PN in the primary care setting. The clinic systems involved cited the advantage of having "another set of eyes reviewing the program" as a benefit of working with a university entity to conduct the evaluation. The full results of this project are available at http://pntoolkitresources.weebly.com.

Stop and Reflect:

Based on the cost analyses already completed, is there specific information that might help inform your efforts?

Are there specific partnerships you should consider before you move forward with implementation of a cost analysis examination?

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CHAPTER 7: POLICY AND COLORECTAL CANCER SCREENING PATIENT NAVIGATION

Goal: This chapter examines the impact of policy on patient navigation (PN) with the intent to preview policy initiatives that have helped to further the role of both the patient navigator and the patient navigation movement. Policy examples that have driven PN at both the state and federal level are noted throughout.

Objectives:

- Give historical background and description of federal policy initiatives and recommendations for patient navigation. This key information is helpful in demonstrating efficacious policies that support the use colorectal cancer screening patient navigation (CRCS PN). For sustaining the work and role of the patient navigator, this evidence may be helpful in justifying to funders the need for compensated patient navigation while demonstrating the CRCS patient navigator as a vital role in the health care team.

- Outline policy strategies, particularly at the state level, to sustain the work of CRCS PNs. Critically examine: Workforce Development, Long-Term Financing, and Occupational Associations. Specific tools and examples from various states are included to allow for application in various regions.

- Highlight the most essential elements of organizational policy to consider when implementing a CRCS PN program, providing specific tools and considerations that may be adapted in many settings.

- Provide links to specific policy case studies and experiences to highlight the utility and successful implementation of CRCS PN programs in various states.

Contextual Policy Background:

As the founder of patient navigation, Dr. Harold Freeman ignited the movement for policy implementation, resource development and systems-wide support for patient navigation. Below are a few of the key initiatives that helped to bolster this movement.

- **1989:** As President of the American Cancer Society, Dr. Freeman created the *Report to the Nation on Cancer in the Poor* – one of the first reports to link poor health outcomes and low socioeconomic status.

> *"Access-related factors may be the most significant barriers to equitable care and must be addressed as an important 1st step toward eliminating health disparities"*
>
> *- Dr. Freeman*

- **2001:** Dr. Freeman served on the 2001 President's Cancer Panel to help inform efforts to improve health outcomes for underserved cancer patients.

- **2005:** The Patient Navigator Outreach and Chronic Disease Prevention Demonstration Program was launched in response to Dr. Freeman's work with a policy initiative entitled "*Patient Navigator Outreach and Chronic Disease Prevention Act of 2005*: *To amend the Public Health Service Act to authorize a demonstration grant program to provide patient navigator services to reduce barriers and improve health care outcomes, and for other purposes.*"

 For additional information on the specific legislative language, please visit:
https://www.govtrack.us/congress/bills/109/hr1812/text

Explore the details of the "Patient Navigator Outreach and Chronic Disease Prevention Demonstration Program."
http://bhpr.hrsa.gov/nursing/grants/patientnavigator.html

Federal Level Policy Supporting Patient Navigation:

PN is identified as a critical component to cancer care by several influential national organizations:

In 2008, a U.S. Surgeons General collective issued a National Call to Action on   Cancer Prevention and Survivorship, with one of the four priority goals being to"ensure that all people can navigate through the health care system."

To read more about the 2008 National Call to Action visit:

The Centers for Disease Control and Prevention (CDC) has outlined specific steps to integrate community health workers into CRCS PN activities through their Policy and Systems-Level Approach.

To view these steps visit: http://www.cdc.gov/dhdsp/docs/chw_brief.pdf

For more information about these specific organizations and their standards, flip back to our quality and accreditation standards, Chapter 5.

National Occupational Standards:

Federal statistical agencies use the 2010 Standard Occupational Classification (SOC) system to classify workers into occupational categories for the purpose of collecting, calculating, and/or disseminating data. The SOC was updated in 2018. The George Washington University Cancer Institute, along with many partnering agencies submitted documentation for the consideration of 'patient navigation' to be included as an occupational category. Under the proposed definition, a patient navigator will be defined as:

"A healthcare expert who reduces and eliminates barriers to accessing care, empowers patients and their families and facilitates timely access to high-quality medical care across the healthcare continuum. Patient navigators work with medically underserved individuals, populations and communities to reduce disparities in health care."

Unfortunately the decision was to **not** include patient navigation as its own job code. This will be an area of continued work, to have an official occupational classification will help increase the legitimacy of PN as a profession while also allowing for the collection of important governmental data on PN as this occupation continues to evolve. A recognized, concrete definition of PN may both improve funding opportunities and support further national research efforts on the role of patient navigators in improving health outcomes.

Review the most important aspects of PN funding sustainability in Chapter 1

Currently, many state and local agencies are recommending PN initiatives beyond the scope of those currently initiated at the federal level. Below we will explore several initiatives currently underway.

Policy Strategies Outlined for States and Territories:

The Association of State and Territorial Health Officials (ASTHO) released an issue brief, titled "Improving Cancer Prevention and Control: How State Health Agencies Can Support Patient Navigators and Community Health

Workers." This brief speaks to the sustainability of PN and necessary policy component initiatives to bolster PN. Many states that have been most effective in sustaining and paying for screening PN have used distinct recommendations discussed in this brief to implement and sustain their work.

Medicaid reimbursement for patient navigation under the Affordable Care Act:

The Affordable Care Act (ACA) has greatly enhanced the potential role of patient navigators and community health workers in state Medicaid plans. Currently, Minnesota is the only state allowing Medicaid reimbursement for CHW care coordination and patient education services. However, with encouragement from state PN and CHW organizations, it is both hopeful and likely that additional states will explore new regulations allowing Medicaid reimbursement for patient navigators and other non-licensed providers providing preventive health services.

Explore the full ASTHO brief: http://www.astho.org/Programs/Prevention/Chronic-Disease/Cancer/Materials/Improving-Cancer-Prevention-and-Control/

Outlined below are the three specific recommendations put forth in "Improving Cancer Prevention and Control: How State Health Agencies Can Support Patient Navigators and Community Health Workers," with examples of states and programs currently implementing each of these specific recommendations.

Recommendation	*Goal*
I. Workforce Development	Support standardized training and certification of PN and Community Health Workers (CHWs).
II. Long Term Financing	Support standard reimbursement for PN and CHW services
III. Occupational Associations	Create occupational networks to strengthen PN and CHW effectiveness in the workforce.

I. *Workforce Development*: support standardized training and certifications of patient navigators and CHWs. **Figure 1 (appendix)** provides specific examples and strategies that different states have implemented to standardize training efforts.

II. *Long-Term Financing:* ASTHO provides updates and progress reports for states which have policy and legislative coverage for CHWs and patient navigators.

http://astho.org/Public-Policy/Public-Health-Law/Scope-of-Practice/CHW-Certification-Standards

Visit Chapter 4 to consider funding strategies

Figure II (appendix) highlights those states that have approached workforce development, typically with state-level policy initiatives. Examine their work and approaches.

III.   *Occupational Associations:* a growing number of state agencies have identified opportunities to endorse the work of PN and community health work.

- The George Washington University Cancer Center Institute has developed a comprehensive list of networks to help advance the area of PN.

> **Collaboration to increase Medicaid Reimbursement**
>
> The ACA has created significant incentives and opportunities to increase the role of patient navigators in state Medicaid programs. In order to fully benefit from these opportunities, PN and CHW professional associations collaborate with states networks and leaders to define the patient navigator role in the state and identify patient navigator workforce supports. To the extent that some opportunities require states to define patient navigator skill and training requirements, patient navigators must be included at the table to participate in these decisions.

http://smhs.gwu.edu/gwci/reports

See Table 2C: State Navigation Networks and Contacts**.**

- Statewide Cancer Coalitions and Comprehensive Cancer Control Programs may also have networks, roundtables or task forces currently considering how to build occupational associations to advance the work of CHWs and patient navigators.

Visit their website to learn more about the work that is happening in each   state and in their specific cancer plans. http://www.cdc.gov/cancer/ncccp/ccc_plans.htm

In Chapter 3, Andrea Dwyer noted that having a statewide network for PN was key to sustain her work for CRCS PN.

A policy brief produced jointly by the Trust for America's Health and Nemours (a children's health system operating in the Delaware Valley) identified a wide range of preventive services that states for which non-licensed providers can now provide care coordination. PN and CHW services are generally included. Additionally, the Trust for America's Health created a questionnaire, which provides education about how to move ahead.

http://www.astho.org/Community-Health-Workers/Medicaid-Reimbursement-for-Community-Based-Prevention/

Colorectal Cancer Screening Patient Navigation Specific Policies:

For many patient navigators working in a hospital, clinic, or other institutional setting, it will be crucial to ensure policies are in place to describe their role and scope.

Formalizing the role of a colorectal cancer screening patient navigator as a member of the care team is necessary to sustain the position. There are two distinct places this should be reflected in organizational policy:

1.   A job description which outlines the following is critical:

- A clear scope of practice and role of the patient navigator
- How the patient navigator contributes to the multidisciplinary health care team, with specific attention made to outline expectations, limitations and overlap in roles of the patient navigator.

2.   Ensuring that the role of the patient navigator is outlined within the organizational charts, and reflected in the roles and positions of the hospital, clinic, or other institution.

It is also important to know that the CDC's Colorectal Cancer Control Program (CRCCP) has a defined policy about what colorectal cancer screening means for those who are grantees. These can be crucial resources for your work. See Tool 7.1.

The Alaska Native Tribal Health Consortium team shared their job description for their colorectal cancer screening patient navigator. See Tool 7.2.

Chapter 3 provides some great resources for ensuring this is established. Take a spin back and look at NYC's resources.

You can also download a sample job description template with a slightly different format adapted from Denver Health medical center at: http://patientnavigatortraining.org/wp-content/uploads/2014/07/Patient-Navigator-II-Job-Description-Denver-Health.pdf

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Job descriptions are a MUST!

Let's take a look at this scenario that highlights the importance of the job description:

The Colorado Cancer Screening Program patient navigation team-lead received a call from the medical director of one of their partner clinics requesting immediate assistance to help create a job description for a colorectal cancer screening patient navigator. The clinic's Joint Commission on Accreditation of Healthcare (JCHO) visit was scheduled and they noted they did not have a job description in place for their colorectal cancer screening navigators. Without this job description, they would not have received accreditation.

Not sure what JCHO is? Visit Chapter 5 to learn more about accreditations and standards.

Colorectal Cancer Screening Patient Navigation:

Many states and organizations have passed legislation (policy initiatives) to secure funding for CRCS PN. Specifically, Kentucky, South Carolina, and Colorado have made great strides in colorectal cancer screening through policy changes.

Explore in detail the steps that Colorado, Kentucky and South Carolina have taken at the website that University of Colorado has established to help showcase/highlight this work: http://pntoolkitresources.weebly.com/case-studies.html

To learn more about the specifics of each state program and characteristics, turn back to Chapter 3.

Advocacy for Colorectal Cancer Screening Patient Navigation:

Many states have noted, an important piece of implementing policy change is understanding how best to advocate for your cause and community. Perhaps one of the best change makers has been David Wright of South Carolina who, as a colon cancer survivor himself, has worked to advocate for cancer awareness and education.

To learn more about David's advocacy work to advance policy change visit: http://pntoolkitresources.weebly.com/advocacy-resources.html. In addition to David's story, you will find links to excellent advocacy resources.

Appendix

Figure 1. State Specific strategies to standardize training efforts

Training	Format	Website	
The GW Cancer Institute's Oncology Patient Navigator Training: The Fundamentals	• Online • Self-paced	**http://tinyurl.com/GWOnlineAcademy**	
Patient Navigator Training Collaborative	• In-person • Online • Self-paced • Special topic webinars	**http://patientnavigatortraining.org**	
Harold P. Freeman Patient Navigation Institute	• In-person • Online	**http://www.hpfreemanpni.org**	
Smith Center Integrative Patient Navigation Training	• In-person	**http://smithcenter.org/institute-for-integrative-oncology-navigation/our-training/**	

Figure II. State Specific Strategies for approaching workforce development

State	Activities for Workforce Sustainability
Alaska	Extensive credentialing program for its workforce and training programs, which were established as part of rural health efforts in the 1950s in concert with the Indian Health Service and the Community Health Aide Program.
Colorado	Colorado implemented a voluntary credentialing process and registry to support the preparation, growth and sustainability of the unlicensed health navigator workforce in Colorado. Although noted as 'voluntary'', several departments have noted this a required
Massachusetts	Among the longest running programs, with a statewide workforce coalition established since the 1990s. Linkage to healthcare enrollment has been a major route to program sustainability. The Department of Health is also the largest contractor for CHW/PN services in the state, which was supported initially by an extensive credentialing system that has now become a licensure program for its workforce.
Minnesota	Passed a provision for CHW certification in 2007 which allowed approved services to be covered under state Medicare/Medicaid funds. The state also established a Healthcare Education Industry Partnership for workforce training between state colleges, universities and a coalition of payers including rural and urban health care systems, BlueCross/Shield, and Robert Woods Johnson.
New Mexico	Established an Advisory Committee. It evolved to the Office of CHW in 2008 and reports to the Department of Health. This committee conducts public health campaigns, workforce assessment, funding, and competency-based training, and oversees voluntary certification. Funding in New Mexico is diversified among Medicaid Managed Care Organizations, a healthcare system, and Medicaid/Medicare.
Ohio	Developed a voluntary certification; however, it is operated with combined oversight of the Ohio Board of Nursing, Community Health Access Program (CHAP), and Office of Minority Health.
Oregon	In 2011, the legislature passed House Bill 650 to inform the development of an integrated healthcare delivery system. As a result, recommendations were made to certify training programs for non-traditional health workers and require oversight of training programs and registration of participants to build incentives for payers to utilize certified workers and deliver bundled payments.
Texas	Texas passed House Bill 1964 in 1999, and established a Promotore Development Committee. In 2001, Senate Bill 1051 directed the Department of Health to develop training and certification program for CHWs.

CHAPTER 8: EVALUATION OF COLORECTAL CANCER SCREENING PATIENT NAVIGATION

Goal: To provide specific tools and resources to help in understanding evaluation elements of colorectal cancer screening patient navigation (CRCS PN).

Objective: To examine designs and consider how these tools might be implemented in your setting and linked with other elements of sustainability.

Background:

The evaluation of CRCS PN has largely been connected to:

- No show rates
- Bowel preparation quality
- Successful completion of screening exam
- Patient satisfaction
- Timeliness

In order to implement evaluation of patient navigation it is critical to think about the specifics of what you need to collect, who you should be thinking of engaging in the work, and specific data.

Overview of CRC Navigation Measures, Variables, Data Collection and Source Information

Navigation Measure	Variables to measure	Stakeholders in Data Collection	Source Information and Tools
No show rates	**Number of scheduled colonoscopy or sigmoidoscopy appointments per month (or per year) that patients do not show up or attend /total number scheduled**	**Schedulers Medical Records/EMRs IT professionals Navigators Providers**	**Battaglia et al (2011)**
Bowel Preparation Quality	**Quality Index at time of colonoscopy from endoscopy reports**	**GI Providers IT professionals Navigators**	**Johnson et al (2014)**
Successful Exam Completion	**Number of exams completed/total number of exams started**	**GI Providers IT Professionals**	**Battaglia et al (2011)**
Patient Satisfaction with Navigation	**Mean of summary score**	**Patient Navigators Quality Improvement Teams Schedulers or Medical Assistants (to administer tool)**	**Jean-Pierre et al (2012)**
Timeliness	**Mean time between abnormal test result and resolution (diagnosis or follow-up recommendations)**	**Providers Pathology labs IT professionals**	**Rex et al (2015)**

Implementing Patient Navigation (PN) Evaluation in Your Practice:

Below are the two key indicators which have truly shown improvement with inclusion of a patient navigator and are commonly used as the clinical outcome measures to show success.

1. When comparing the above measures pre vs. post PN program, you should use a three year average to get the best estimate of the pre PN for all rates.
2. When comparing time periods, you should also account for the number of patient navigators. So for example, if you had 1 patient navigator in year 1 and 2 in year 2, divide the no show rate in year 2 by 2 to compare the relative impact across years

A variety of tools have been developed to help those in the field design their CRCS PN evaluation.

These outcomes might be critical in examination of making the business case for CRCS PN, as well as building a policy case for utilization of CRCS PN. Chapters 6 and Chapters 7 illustrate the connection to evaluation.

Measures for Successful Navigation:

There is debate, and at this time no specific and defined measure of the standards for CRCS PN. However, for those programs in the field, the following are noted as general benchmarks. This is an area for further study and specific guidance by professional organizations, perhaps for internal review within organizations and programs.

CRCS PN Measure	Benchmark
No show rates	**Less than 10%**
Bowel Preparation Quality	**Reporting greater than 95% reported as good or excellent**
Successful Exam Completion	**Reporting 95% of time ability to reach cecum**
Patient Satisfaction with PN	**Patients reporting over 90% in satisfaction field**
Timeliness	**Patient Navigator following up with patient within 1 week of exam to ensure the surveillance and follow-ups are clear**

The Patient Navigation Leadership Summit was held in 2011. From this Summit, over ten articles were published to develop common metrics for PN. For the purposes of prevention and early detection, the following article might be helpful in examining these efforts:

Tracy A. Battaglia, Linda Burhansstipanov, Samantha S. Murrell, Andrea J. Dwyer, and Sarah E. Caron and on behalf of The Prevention and Early Detection Workgroup from the National Patient Navigation Leadership Summit. http://onlinelibrary.wiley.com/doi/10.1002/cncr.26267/abstract

Find the entire Supplement: National Patient Navigation Leadership Summit (NPNLS): Measuring the Impact and Potential of Patient Navigation. http://onlinelibrary.wiley.com/doi/10.1002/cncr.v117.15s/issuetoc

New York has provided fantastic tools to outline evaluation of CRCS PN. Visit Chapter 3 and their toolkit to see how they have provided resources for evaluation.

Additionally, the Colorectal Cancer Control Program has developed a specific policy that outlines the required PN elements and activities. Visit Chapter 7 to learn more about these components.

How you implement or augment your evaluation and planning can take some advanced thinking. Check out these resources to consider how!

The Patient Navigator Training Collaborative has a great resource to help in thinking about PN evaluation. **http://patientnavigatortraining.org/wp-content/uploads/2014/07/PN-Evaluation-Toolkit.pdf**

The Centers for Disease Control and Prevention (CDC)'s Program Performance and Evaluation have Step-by-Step Manuals, Logic Models and Data Collection Methods and Sources, which serve as resources, take some time to review the constructs that might be of help or interest. http://www.cdc.gov/eval/resources/index.htm

Interested in how others are applying evaluation tools used by programs implementing colorectal cancer screening? The Colorado Cancer Screening Program's Evaluation Guide is available online in Part V of the Program Guidebook. Check out Chapter 6 to learn more about Colorado's efforts. https://drive.google.com/file/d/1NHiHXCk7rHDs7UT7alBKyK0_N1PVbjgB/view

Tracking of CRCS PN, and all PN is important for process improvements, tracking outcomes and helping overcome barriers. Check out the following tools to help you in your search:

The Native American Cancer Research Corporation, has created a robust PN tracking database. Screening is a big part of this resource. http://natamcancer.org/fmi/iwp/res/iwp_auth2.html

Username: train
Password: choochoo

The George Washington University (GW) Cancer Institute's Patient Navigation Barriers and Outcomes Tool (PN-BOTTM) is a free, Excel-based data entry, data management and reporting product designed for oncology patient navigation programs. PN programs can use the PN-BOTTM to document, track and generate simple reports on information such as:

- Patient volume
- Patient demographic profiles
- Cancer treatment profiles
- Timeliness of cancer care
- Barriers to care
- Navigator caseload and time
- Navigation services provided
- Patient outcomes

http://smhs.gwu.edu/gwci/BarriersTool

Tool 8.1 provides the basic elements for a screening program for colorectal cancer, which incorporates patient navigation. Adapt this tool in your planning or evaluation data gather.

Stop and Reflect:

Are you currently evaluating your CRCS PN outcomes?

Are you collecting all of the outcomes and have a process or system in place to gather all of the critical information?

Sources:

1. Assessing the impact of patient navigation Prevention and early detection metrics Tracy A. Battaglia MD, MPH1,ǁ,*, Linda Burhansstipanov MSPH, DrPH2, Samantha S. Murrell MPH1, Andrea J. Dwyer BS3, and Sarah E. Caron MPH1 and on behalf of The Prevention and Early Detection Workgroup from the National Patient Navigation Leadership Summit.

2. Optimizing adequacy of bowel cleansing for colonoscopy: recommendations from the US multi-society task force on colorectal cancer. Johnson DA, Barkun AN, Cohen LB, Dominitz JA, Kaltenbach T, Martel M, Robertson DJ, Boland CR, Giardello FM, Lieberman DA, Levin TR, Rex DK; US Multi-Society Task Force on Colorectal Cancer. Gastroenterology. 2014 Oct;147(4):903-24.

3. Jean-Pierre P, Fiscella K, Winters PC, Paskett E, Wells K, Battaglia T; Patient Navigation Research Program Group. Cross-cultural validation of a Patient Satisfaction with Interpersonal Relationship with Navigator measure: a multi-site patient navigation research study. Psychooncology. 2012 Dec;21(12):1309-15.

4. Quality indicators for colonoscopy. Rex DK, Schoenfeld PS, Cohen J, Pike IM, Adler DG, Fennerty MB, Lieb JG 2nd, Park WG, Rizk MK, Sawhney MS, Shaheen NJ, Wani S, Weinberg DS. Gastrointest Endosc. 2015 Jan;81(1):31-53.

CHAPTER 9: CLOSING AND SUPPLEMENTAL TOOLKITS AND RESOURCES

As noted, this toolkit is designed specifically to examine approaches to pay for and ensure sustainability of colorectal cancer screening patient navigation (CRCS PN).

We hope that this toolkit has provided you with the information and resources to assist in your CRCS PN efforts. A reminder that the Toolkit is meant to be a 'choose your own adventure' and living document, dig into the Toolkit in a place that makes sense for your and pick it up again when the need arises, no need to read from front to back!

A variety of resources are noted throughout this toolkit.

Let's take a moment to ensure that we direct attention to other resources that can help you further in your work. There are many resources and toolkits to help guide your work, but these in particular are focused on patient navigation efforts.

The George Washington Cancer Center provides leadership in patient navigation for many initiatives. Take a look at specific toolkits for:

- Patient Navigation Policy Initiatives
- Education and Training
- Survivorship and Navigation

https://smhs.gwu.edu/gwci/reports

The Avon and Boston Medical Center Patient Navigation Toolkit
This is a three-volume toolkit designed to plan and implement a patient navigation program. The toolkit offers case studies, tools, and resources from cancer care patient navigation that can be applied by program planners, supervisors of navigators, and patient navigators.

https://nciphub.org/resources/1600/download/BMC_Patient_Navigation_Toolkit_-_Vol_1.pdf

The National Colorectal Cancer Roundtable
The diversity of the Task Groups allows the Roundtable to address colorectal cancer from many different fronts. We focus on working together to improve general public awareness, educate providers, better inform policy makers, address quality issues and share information about key policy issues.

http://nccrt.org/tools/

APPENDIX CHAPTER 3

Chapter 3: Local, Regional and State Programs

Figure 1

Name of Program	NYC colonoscopy patient navigator program
Goals of Program	Address health disparities in an urban community Increase screening colonoscopy volume Improve patients' understanding of colonoscopy Decrease "no show" rates and "poor bowel prep" Eliminate barriers to care
Setting	The pilot of the NYC colonoscopy patient navigator program was implemented at 3 hospitals in 3 of the 5 boroughs of New York City
Population Focus	Medically Underserved
Delivery of Patient Navigation Services	In-Person Phone
Characteristics of Patient Navigators	Non-clinical provider (not licensed health professional) Bi-lingual Effective at managing in complex systems Strong at connecting with diverse populations Competent health educators Problem solvers Full Time PN at Each Site
Initial Funding	Grant supported for first year of program. Hospitals sustaining salary for patient navigators.
Sustained Funding	Pilot hospitals retained the navigators after the grant funding ended for the salary.

Figure 2

Name of Program	Colorado Cancer Screening Program (formerly Colorado Colorectal Screening Program)
Goals of Program	Address health disparities statewide Increase colorectal cancer screening and awareness Provide navigation support to those who are uninsured, Medicaid, Medicare and privately insured. Improve patients' understanding of colonoscopy Decrease "no show" rates and "poor bowel prep" Eliminate barriers of care Improve partnerships with other chronic disease prevention programs through patient navigation

Setting	Primary Care Safety Net Clinics and Hospitals
	    • Federally Qualified Health Centers
	    • Rural Health Centers
	    • Critical Access Hospitals
	    • Residency Clinics
	    • Faith and Religious Non-Profit Clinics

Population Focus	Medically Underserved Navigated over 2,000 since 2006
Delivery of Patient Navigation Services	In-Person Phone
Characteristics of Patient Navigators	Primarily Non-Clinical provider (not licensed health professional) To lesser extent: Licensed Practical Nurses Social Workers Registered Nurses

	Based on the culture of the clinic, the appropriate navigators who can culturally connect with the patient population are matched to serve as the CCSP PN.
Initial Funding	Colorado Cancer Cardiovascular and Pulmonary Disease Grants Program (CCPD)
Sustained Funding	CCPD and Institutional Support

Figure 3

Name of Program	Colorectal Cancer Prevention Network for uninsured and medically underserved individuals in South Carolina
Goals of Program	To reach those who are the most medically underserved in South Carolina and provide them with resources for CRC screening
Setting	38 counties of South Carolina's 46 counties
Population Focus	Asymptomatic Patients, who live at or below 150% of the FPL, who are Medically Underserved patients, and who have never been screened for colorectal cancer
Delivery of Patient Navigation Services	In-Person Phone
Characteristics of Patient Navigators	6 PNs FTES who are contracted for a total of seeing 600 medically underserved patients. Center for Colorectal Cancer Research hires and funds PNs through University of South Carolina. The PNs vary in age, gender and race/ethnicity and live and connect with patients and medical providers in the community that they serve
Initial and Sustained Funding	Critical Partnerships and Timeline: Prevent Cancer Funds Dialogue Action monies to start discussion 2007 CRC Task Force for South Carolina Alliance: Scope managed by department of health for just basic services. 2008 Blue Cross Blue Shield Foundation (only for direct services) 2011 Duke Endowment Foundation (only for support of direct services) Two Grants complimented way-leverage each way. 2013 through lobbying by for state dollars by a colorectal advocate to get state assembly to be a line item budget funding received. Each year requires a renewal. Center for Colorectal Cancer Research takes the place of the state cancer coalition to help lead efforts for use of patient navigation and CRC screening delivery To sustain efforts, yearly or every several years, need to reapply.

Figure 4

Name of Program	New Hampshire Colorectal Cancer Screening Program (NHCRCSP)
Goals of Program	Increase high quality colorectal cancer screening that improves completion of colonoscopy and follow-up, increases patients' knowledge about their tests and results, and improves overall screening quality and patient satisfaction. NHCRCSP also addressed disparities through the provision of free colonoscopies for the New Hampshire medically underserved populations. All patients in the free colonoscopy program were navigated, in order to address individual patient barriers as well as decrease "no-shows" and patients with poor prep quality.
Setting	Statewide, free colonoscopies provided at 12 endoscopy centers throughout the state, to reach both rural and urban underserved population.
Population Focus	Uninsured or underinsured, low income, less than 250% of Federal Poverty Level, first time colorectal cancer screening or due for CRC screening or surveillance.
Delivery of Patient Navigation Services	Seven Core Elements form the foundation of the NHCRCSP PN model and are crucial to its success. The Core Elements provide the infrastructure and support needed by the Navigators to help patients complete colonoscopy successfully and can be found in the *"NHCRCSP Patient Navigation Model for Increasing Colonoscopy Quality and Completion, A Replication Manual".* Because the program was statewide, navigation was done telephonically. NHCRCSP PN outcomes include: 2,000 screened with 0.1% no- show rate, < 1% had inadequate colonoscopy preparation

	100% patients received follow-up recommendations from endoscopist
Characteristics of Patient Navigators	Registered nurses with clinical expertise, psychosocial assessment skills, who are trained on the NHCRCSP PN model, which was specifically developed to recognize and resolve patient barriers to all aspects of colonoscopy. The Navigators "meet patients where they are," demonstrating respect and empathy, and are sensitive to unique cultural issues for individual patients. Ability to engage patients to build meaningful and trusting relationships in a very short time, communicate effectively with patients, assist with problem solving to overcome identified barriers, and highly organized to deliver the six-topic protocol consistently while juggling many patients at different stages of the navigation process.
Initial Funding	Centers For Disease Control and Prevention Colorectal Cancer Control Program (CRCCP)
Sustainability	NHCRCSP is working to disseminate and sustain patient navigation nationwide through consultation and technical assistance on implementation of the NHCRCSP PN model with dissemination and support from the comprehensive "*NHCRCSP Patient Navigation Model for Increasing Colonoscopy Quality and Completion, A Replication Manual".*

Figure 5

Name of Program	Alaska Native Tribal Health Consortium (ANTHC)-CRCCP Program
Goals of Program	Increase health promotion and screening rates in the Alaska Native and American Indian Community
Setting	Patient Navigators were working in the primary care clinics and the Surgery Center-predominantly in-person interaction.
Population Focus	Alaska Native and American Indian Community
Delivery of Patient Navigation Services	Under this funding ANTHC hired 3 PNs, as well as provided financial support to regional tribal health organizations who hired PNs in 6 regional hub communities
Characteristics of Patient Navigators	3 Full Time Lay Patient Navigators
Initial Funding	ANTHC received funds from CDC through an inter-agency agreement with Indian Health Services which included a pilot colorectal cancer screening project in 2007-2008. ANTHC then received CDC funding for the CRC Control Program from 2009-2015..
Sustained Funding	CRCCP Program Not Funded ANTHC was able to sustain funding of some of the FTE support of the Colorectal Cancer Screening Navigation through making the business case for inclusion of patient navigation.

Appendix Chapter 5

Figure 1

Standard Area	Standard Name	Description
PCMH 2: Team-based Care	B: Medical Home Responsibilities	1: The practice is responsible for coordinating patient care across settings 4: The care team provides access to evidence-based care, patient/family education and self-management support 6: The practice provides equal access to all patients regardless of source of payment.
PCMH 2: Team-based Care	C: Culturally and Linguistically Appropriate Services (CLAS)	3. Providing interpretation or bilingual services to meet the language needs of its population. 4. Providing printed materials in the languages of its population.
PCMH 3: Population Health Management	D: Use data for population management*	
PCMH 4: Plan and Manage Care	B: Care Planning and Self-Care Support*	
PCMH 4: Plan and Manage Care	E: Support Self-Care and Shared Decision-Making	2. Provides educational materials and resources to patients. 6. Maintains a current resource list on 5 topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates.
PCMH 5: Track and Coordinate Care	A: Test tracking and Follow-up	1: Test Tracks lab test orders, flags/follows up on overdue results 2: Tracks imaging test orders, flags/ follows-up on overdue results 3: Flags abnormal lab results 4: Flags abnormal imaging results 5: Notifies patients of normal and abnormal lab/imaging results
PCMH 5: Track and Coordinate Care	B: Referral Tracking and Follow-Up*	
PCMH 5: Track and Coordinate Care	C: Coordinate Care Transitions The Practice	6: Obtains proper consent for release of information (ROI) and has process for secure exchange of info & coordination of care w/community partners 7: Exchanges clinical information with facilities; provides electronic summary of care for > 50% patient transitions
PCMH 6: Measure and Improve Performance	A: Measure Clinical Quality Performance	2. At least annually the practice measures or receives data on at least two other preventive care measures
PCMH 6: Measure and Improve Performance	C: Implement Continuous Quality Improvement*	1. Practice conducts survey measuring experience on at least three of the following: access, communication, coordination, whole person care/self-management

Figure 2

Standard
Continuum of Care Services • 3.1. Patient Navigation Process • 3.2. Psychosocial Distress Screening • 3.3 Survivorship Care Plan
Patient Outcomes • 4.1. Prevention Programs • 4.2. Screening Programs • 4.8 Quality Improvements

Figure 3: MIPS Quality Measures

Quality ID	Measure Name	Description
439	Age Appropriate Screening Colonoscopy	% patients >85 years who received a screening colonoscopy during the reporting year
320	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	% patients aged 50-75 years who received colonoscopy w/o biopsy or polypectomy who have follow-up interval of 10 years documented in colonoscopy report
374	Closing the Referral Loop: Receipt of Specialist Report	% patients with referrals for which referring provider received report from provider to whom patient was referred
185	Colonoscopy Interval for Patients with History of Adenomatous Polyps – Avoidance of Inappropriate Use	% patients ≥18 years receiving surveillance colonoscopy, with history of prior adenomatous polyp(s) in previous colonoscopy findings, which had interval ≥3 years since last colonoscopy
343	Screening Colonoscopy Adenoma Detection Rate	% patients ≥50 with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy

Figure 4   MIPS Improvement Activities

Subcategory	Activity ID	Activity Name	Description
Care Coordination	IA_CC_12	Care coordination agreements that promotes improvements in patient tracking across settings	Establish effective care coordination and active referral management, including: establish care coordination agreements with consultants, provide patients clear expectations, track patients referred to specialists throughout process, or systematically integrating referral information into care plan
	IA_CC_8	Implementation of documentation improvements for practice/process improvements	Implementation of practices/processes that document care coordination activities such as documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for procedure through day of procedure
	IA_CC_2	Implementation of improvements that contribute to more timely communication of test results	Timely communication of test results defined as timely indication of abnormal test results with timely follow-up care
	IA_CC_1	Implementation of use of specialist reports back to referring clinician to close referral loop	Performance of regular practices that include providing specialist reports back to the referring clinician to close the referral loop OR when referring clinician initiates inquiries of the specialist report
	IA_CC_13	Practice improvements for bilateral exchange of patient information	Ensure there is bilateral exchange of necessary patient information to guide patient care that could include: participation in a Health Information Exchange or using structured referral notes
	IA_CC_7	Regular training in care coordination	Implementation of regular care coordination training
	IA_CC_6	Use of QCDR to promote standard practices, tools, and processes in practice for improvement in care coordination	Participation in a Qualified Clinical Data Registry, demonstrating performance of activities that promote use of standard practices, tools, and processes for quality improvement (i.e.: documented preventative screening and vaccinations that can be shared across clinicians or groups)
Population Management	IA_PM_13	Chronic care and preventative care management for empaneled patients	Proactively manage chronic and preventive care for empaneled patients, including: provide patients annually with opportunity to develop/adjust individualized plan of care; use pre-visit planning to optimize preventive care; use panel support tools (registry functionality) to identify services due; use reminders and outreach to alert and educate patients about service due
Achieving Health Equity	IA_AHE_1	Engagement of new Medicaid patients and follow-up	Seeing new and follow-up Medicaid patients in a timely manner, including dually eligible patients
	IA_AHE_2	Leveraging a QCDR to standardize processes for screening	Participating in a QCDR, demonstrating performance of activities for use of standardized processes for screening for social determinants of health such as food security, employment, and housing. Use of supporting tools that can be incorporated in to the certified EHR technology.

Figure 5   MIPS Advancing Care Information

Measure ID	Objective Name	Description
ACI_HIE_1	Health Information Exchange	Clinician transitions or refers patient to another setting of care or health care provider and 1) creates summary of care record using EHR and 2) electronically exchanges summary of care record

ACI_HIE_2	Health Information Exchange	For newly encountered patient, clinician receives or retrieves and incorporates into the patient's medical record an electronic summary of care document
ACI_HIE_3	Health Information Exchange	For a transition of care, referral, or patient encounter of new patient, clinician performs information reconciliation
ACI_PEA_2	Patient Electronic Access	Clinician uses clinically relevant information from EHR to identify patient-specific educational resources and provide electronic access to materials
ACI_CCTPE_2	Coordination of Care Through Patient Engagement	Secure message sent to patient using EHR electronic messaging
ACI_CCTPE_3	Coordination of Care Through Patient Engagement	Patient-generated health data or data from non-clinical setting incorporated into EHR for patient seen by clinician
ACI_PHCDRR_5	Public Health and Clinical Data Registry Reporting	Clinician is active in engagement to submit data to a clinical data registry

Figure 6

Category and ACO #	Measure Steward	Measure Title/Description
Patient/caregiver experience ACO #5	CMS	CAHPS: Health promotion and education
Patient/caregiver experience ACO #6	CMS	CAHPS: Shared decision making
Preventive health ACO #19	NCQA	Colorectal Cancer Screening (NQF#0034)

Figure

CQM that could be used with CRC PN	Description	NQS Area
CMS90v1: Closing the referral loop: receipt of specialist report	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Care Coordination

7

Figure 8

Standard	Description
Principal Standard	1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
Communication and Language Assistance	5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. 6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. 7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

Figure 9

Standard	Description	Exclusions
NQF 0034	Percentage of members 50-75 years of age who had appropriate screening for colorectal cancer	Patients with: •A diagnosis of colon cancer •A total colectomy

Figure 10

Standard	Description
LD.04.04.01: Performance Improvement	EP 5. Ongoing performance improvement occurs organization-wide for the purpose of demonstrably improving the quality and safety of care, treatment or services EP 24. Leaders involve patients in performance improvement activities
PC.01.03.01: Plan Patient's Care	EP 44. Patient self-management goals are identified, agreed upon with the patient, and incorporated into the patient's treatment plan
PC.02.01.21: Effective Communication with Patients	EP 1. The primary care clinician and the interdisciplinary team identify the patient's oral and written communication needs, including the patient's preferred language for discussing health care. EP 2. The primary care clinician and the interdisciplinary team communicate with the patient during the provision of care, treatment, or services in a manner that meets the patient's oral and written communication needs
PC.02.02.01: Coordination Based on Patient's Needs	EP 25. Primary care clinician and interdisciplinary team incorporate patient's health literacy needs into patient education EP 24. The interdisciplinary team identifies the patient's health literacy needs.
PC.02.03.01: Patient Education	EP 28. The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient's individual needs.
PC.02.04.03: Accountability	EP 1. The organization manages transitions in care and provides or facilitates patient access to care, treatment, or services.
PC.02.05.05: Continuous, Comprehensive, and Coordinate Care	EP 2. Members of the interdisciplinary team provide comprehensive and coordinated care, treatment, or services and maintain the continuity of care. Note: The provision of care may include making internal and external referrals EP 6. When a patient is referred to an external organization, the interdisciplinary team reviews and tracks the care provided to the patient EP 13. The interdisciplinary team actively participates in performance improvement activities
PI.01.01.01: Data Collection to Monitor Performance	EP 42. The organization also collects data on the following: patient experience and satisfaction related to access to care, treatment, or services, and communication
RC.02.01.01: Clinical Record	EP 28. The clinical record contains the patient's race and ethnicity. EP 29. The clinical record includes the patient's self-management goals and the patient's progress toward achieving those goals
RI.01.01.03: Respect Patient's Right to Receive Information in a Manner He/She Understands	EP 2. The organization provides interpreting and translation services, as necessary

Figure 11

Category	Standard
Core Quality Care Management	PCMH 3: Patient Empowerment and Engagement PCMH 4: Health Literacy
Access and Communications	PCMH 7: Patient Access to Services and Information PCMH 11: Tracking and Follow-Up of Community Resource Referrals
Testing and Referrals	PCMH 14: Tracking and Follow-Up on Clinical Referrals
Care Management and Coordination	PCMH 15: Promoting Wellness and Comprehensive Health Risk Assessment PCMH 16: Wellness Information and Materials PCMH 17: Patient Reminders PCMH 18: Ongoing Care Management Protocols – All Patients PCMH 19: Informed Decision Making with Patients PCMH 21: Coordination of Care PCMH 22: Coordinating Care Transitions and Written Plans
Quality Performance Reporting and Improvement	PCMH 39: Performance Improvement

Figure 12

Standard Title	Description
Colorectal 63	Complete family history documented for patients with invasive colorectal cancer (defect-free measure, 63a-63c) (**Test Measure**)
Colorectal 63a	Presence or absence of cancer in first-degree blood relatives documented (Test Measure)
Colorectal 63b	Presence or absence of cancer in second-degree blood relatives documented (Test Measure)
Colorectal 63c	Age at diagnosis documented for each blood relative noted with cancer (Test Measure)
Colorectal 64	Percentage of patients with invasive colorectal cancer with positive family history of colorectal cancer (Test Measure)
Colorectal 64a	Percentage of patients with invasive colorectal cancer tested or referred for genetic testing (Test Measure)
Colorectal 65	Genetic testing addressed appropriately for patients with invasive colorectal cancer (Test Measure)
Colorectal 65a	Genetic counseling, referral for counseling, or genetic testing for patients with invasive colorectal cancer with increased hereditary risk of colorectal cancer (Test Measure)
Colorectal 65c	Patient with invasive colorectal cancer counseled, or referred for counseling, to discuss results following genetic testin

Figure #13

Standard Title	Description
4. Establish Measures for Equitable Care	Compare the hospital's service population by race, ethnicity, and language data with those of the catchment community to identify disparities in access or accessibility
5. Communicate in the Patient's Language	Understand and be Responsive to Cultural Needs/Expectations

APPENDIX

Chapter 6: Cost Analysis

Figure #1

Measure	Definition	Examples
Program Costs	Sum of all costs required to operate the program	
Fixed	Costs necessary merely because program exists and does not depend upon program size or reach	Rent Computers, IT Maintenance
Variable	Dependent upon frequency, type, and intensity of patient navigation activities	Payroll Consumable Supplies (office equipment) Printing
Administrative Costs	Cost of supporting the systems that enable PN to operate	Scheduling Referrals Follow-Up with Patient Patient Satisfaction EMR/EHR
Human Capital Costs	Costs of pay employees/staff, their supervisors, and training for these employees	Employment Training Supervision
Direct Medical Costs	Costs of medical care	Anesthesia Procedure cost Diagnostic procedures Pathology Cancer Treatment Hospice
Direct Non-Medical Costs	Costs associated with receiving medical care that are in addition to the medical services themselves	Transportation Parking Childcare Eldercare Homecare Escort
Indirect Costs	Costs associated with program outcomes, but not actual program activities (the "unintended consequences")	Lost productivity due to morbidity and mortality

Figure #2

Example Economic Analyses of Patient Navigation for Colorectal Cancer Screening

Article	Location	Setting and Context	Evaluation Type	Findings
Lin et al. 2008	Pennsylvania	Navigation for cancer diagnosis Community Hospitals (small urban/rural, inner-city, urban)	PN Process	Barriers vary by hospital type and location Most requests, most time per request at inner city hospitals Fewest requests, least time per request at small urban or rural hospitals
Donaldson et al. 2012	Washington, D.C., Kentucky, Louisiana	Community Hospitals	Cost-Effectiveness	ICER: cost saving over standard care, best, and worst case Cost-Savings Threshold: Program must prevent 3.5 CRC deaths per year

Elkin et al. 2012	NYC	Urban Public Hospitals Lay Navigators	Cost-Effectiveness Cost-Benefit Total Costs	Cost-Effectiveness: $199-708 per additional *scheduled* screen, $254-1434 per additional *completed* screen Cost-Benefit: Ratio ranges .3 to 1.2 Total Costs: Variation due to personnel time and salary differences across sites, contributing to wide range in effectiveness
Paksett et al. 2012	Ohio	Academic and FQHC clinics Lay Navigators	PN Process	Over half report no barriers; 25% report only 1 barrier PNs spent about 15 minutes per patient navigated Low-income patients used PN more readily during first 6 months
Davis et al. 2013	Louisiana	Safety-Net Clinics	Cost-Effectiveness	ICER: $250/participant for literacy-informed educational materials and $1337 for nurse navigation plus educational materials Save 33% by using less expensive, non-nursing staff
Jandorf et al. 2013	NYC	Urban Academic Medical Center	Total Costs	Total Costs (navigation): $29/completed navigation, $21/non-completed navigation, $3/non-navigated Total Costs (procedure): screening colonoscopy with biopsy profitable, non-navigated patients net negative
Lairson et al. 2013	Texas	Call Center-Based PN	Total Costs	Total Costs: $35.90/participant in usual care, $294.90/participant in navigation
Lairson et al. 2014	Delaware	Primary Care	Cost-Effectiveness Sensitivity Analysis	ICER: $906 for standard intervention over usual care, $1958 for tailored PN over usual care Sensitivity Analysis: Willingness to pay of $1200 cost effective for standard intervention, $1600 for tailored navigation intervention
Wilson et al. 2014	Texas	University Hospital, Community Inpatient & Outpatient Centers	Cost-Effectiveness Sensitivity Analysis	ICER: All outcomes cost-effective, QALY measure shows greatest ICER Sensitivity Analysis: Cost of $4,913/participant can increase 2.5x and remain cost-effective; need just 18% patients contacted to be successfully screened for PN to be cost-effective
Bensink et al. 2015	National	Clinics Serving the Medically Underserved	Economic Evaluation Total Costs	Navigation costs $275/pt compared to no navigation PN only cost-effective if pt experiences improved diagnostic resolution
Gritz & Jones 2015	Colorado	Community Health Centers and FQHC's	Total Costs Sensitivity Analysis Return on Investment	Total Costs: vary by clinic volume (range $280 to >$1000/participant), average $470/participant Sensitivity Analysis examined differences in no-show rate reductions ROI analysis from colonoscopy provider's perspective: break even cost per completed colonoscopy reimbursed at Medicare rates only at lower cost clinics
Ladabaum et al. 2015	NYC	Academic Urban Medical Center	Cost-Effectiveness	ICER: $9800/QALY gained for longitudinal PN over no navigation, >$110,000/QALY over FOBT Longitudinal navigation more costly and less effective than FIT

Meenan et al. 2015	Washington	Non-profit HMO	Cost-Effectiveness Micro-costing Sensitivity Analysis	ICER: $65 for nurse navigation Sensitivity Analysis: Navigation cost-effective at up to $500 per additional CRC screen
Shokar et al. 2015 Kim et al. 2017	Texas	Community-Based	Micro-costing Budget Impact Analysis Sensitivity Analysis	Incremental 3-yr cost for 10,000 pts: $1.74 million Budget Impacts: mostly due to cost of colonoscopy for high-risk Most impactful parameters: 1) cost of colonoscopy 2) proportion of average risk pts 3) proportion of positive FIT results 4) adherence to returning FIT
Buscemi et al. 2017	Chicago	University Hospital; Community Clinics	Comparative Effectiveness Research	*No findings – describes approach and rationale Compare effectiveness of various navigation approaches across various clinic settings Major outcome of completed screens with effect modifiers of CRC screening uptake patient- and facility-level factors

PROGRAM NAVIGATION SERVICES FOR COLORECTAL CANCER SCREENING (ENDOSCOPY)

Navigation services can be provided by one designated person or shared by several persons. For example, the screening preparation procedures may be explained to the patient by the pharmacist, while another person in the clinic takes care of barriers to transportation to and from screening, and another is responsible for data collection. There might be specific departments or specific outside agencies and institutions that are partners in this effort. It is critical to document the overall workflow of patient navigation and understand whom is doing what for each component of the screening patient navigation process.

The following services are essential parts of navigation. Each clinic should complete below detailing who is in charge of each component to avoid missing components of the navigation process. The following are usual components, but each clinic may add or modify these components to serve their needs better.

Table: Patient Navigation Services

Navigation Service	Person Responsible	Department and/or Name of Facility
Program LIAISON - individual who understands clinic, provider, laboratory, endoscopy, pathology and other systems involved in providing navigation-related services		
In-Reach/Outreach		
• Identification of clinic patients in need of screening		
• Contact and educate eligible patients about screening		
• Educating individuals who are current clinic patients as well as the community the clinic serves about colorectal screening		
Determine Insurance Coverage		
• Verify patient income and insurance status per routine clinic policy		
• Help patient apply for other financial assistance programs for patients such as Medicare, Medicaid and SSDI		
Education		
• Explain the endoscopic procedure and its preparation to patients, ensuring they understand the importance of an adequate preparation		
• Explain GI system anatomy		
• Emphasize the medical need for colonoscopy		
Barrier Reduction		
• Ensure patients have transportation to and from screening and supportive care after		
• Work with patients to overcome common barriers		
• Perform patient-driven risk stratification		
Reminders		

• Reminder calls to decrease no-show rates (start prep, appointment date)		
• Reminder/tickler system for surveillance and follow-up		
Care Coordination		
• Ensuring follow-up of colorectal screening results regardless if abnormal or normal screen - liaison between providers and patients		
• Follow-up with patients about results of the procedure and be sure they understand the results and when they should be re-screened or how to access additional care		
• Assist with setting appointments		
• Inform patient about who is the primary contact person if there are questions about eligibility, screening, post screening - including who to contact if patient is diagnosed with cancer or adverse event		
Program Reporting Activities		
• Collection of data points for evaluation - outcomes and navigation services (how patient heard about program, time from diagnosis to treatment start, and rates of: 1) no-show, 2) appropriate prep 3) complete follow-up)		
• Maintain files with patient specific data and records for fiscal and evaluation audits		
• Attend training sessions and participate in Program teleconferences for navigation		

CRCCP Program Policy on Patient Navigation
Effective July 1, 2015

Defining Patient Navigation
Clients often face significant barriers to accessing and completing cancer screening and diagnostics. Patient navigation is a strategy aimed at reducing disparities by helping clients overcome those barriers. For purposes of the CRCCP, patient navigation is defined as, "Individualized assistance offered to clients to help overcome healthcare system barriers and facilitate timely access to quality screening and diagnostics as well as initiation of treatment services for persons diagnosed with cancer."

Required Patient Navigation Activities
Although patient navigation services vary based on an individual client's needs, at a minimum, patient navigation for men and women served by the CRCCP **must** include the following activities:
- Written assessment of individual client barriers to cancer screening, diagnostic services, and initiation of cancer treatment
- Client education and support
- Resolution of client barriers (e.g., transportation, translation services)
- Client tracking and follow-up to monitor client progress in completing screening, diagnostic testing, and initiating cancer treatment
- Reminder calls/contacts to return FOBT/FIT tests and/or bowel prep and endoscopy appointments
- Given the centrality of the client-navigator relationship, patient navigation must include a minimum of two, but preferably more, contacts with the client
- Collection of data to evaluate the short-term and intermediate outcomes of patient navigation – number of clients navigated and screening completion rate; FOBT/FIT return rate; colonoscopy completion rate; number of screenings with cancers detected and with adenomas detected.

Priority Populations for Patient Navigation
Navigation is an individualized intervention, intensive in nature, and potentially costly; therefore, priority should be given to navigate clients who otherwise would **not** complete the screening process. Patient navigation services may be provided to clients enrolled in the CRCCP (Component 2) as well as those who have other resources (e.g., insurance) to pay for screening and diagnostic services (Component 1). Clients who receive navigation through the CRCCP as part of Component 1 activities, must be low-income and be of appropriate age per USPSTF screening guidelines. For example, a grantee could support a patient navigator position in a clinic or hospital that serves low-income populations. ***Grantees must collect data to monitor the short-term and intermediate outcomes noted above.***

Clients screened by the CRCCP (Component 2) who are subsequently insured may continue to receive patient navigation services. In such instances, grantees are encouraged to continue navigating clients to ensure diagnostic procedures are completed, and if cancer is diagnosed, that treatment is initiated. Navigators should also assist in obtaining complete CCDE data.

Terminating Patient Navigation
Depending on screening and diagnostic outcomes, patient navigation services are terminated when a client (1) completes screening and has a normal result; (2) completes diagnostic testing and has a normal result; (3) initiates cancer treatment or refuses treatment. When a client concludes his/her cancer treatment and has been released by the treating physician to return to a schedule of routine screening, and continues to meet CRCCP eligibility requirements (Component 2), he/she may return to the program and receive all its services, including patient navigation.

Name of Organization
(Example Tribal Health Group)

PATIENT NAVIGATOR	
Approved Date:	**ICPA Level:**
Job Code:	**FLSA:**

JOB SUMMARY: Under clinician direction, this position provides patient navigation services to guide patients through the colorectal cancer screening process by assisting them with access issues, developing relationships with service providers, conducting internal and external outreach, and tracking follow-up and outcomes.

The following duties are intended to provide a representative summary of the major duties and responsibilities and ***ARE NOT*** *intended to serve as a comprehensive list of all duties performed by all employees in this classification. Incumbent(s) may not be required to perform all duties listed and may be required to perform additional, position-specific duties.*

REPRESENTATIVE DUTIES

Guide patients through the CRC screening testing cascade and help patients arrive at scheduled appointments on time and prepared.

Facilitate interaction and communication with health care staff and providers.

Provide colorectal cancer screening outreach education to patients. Make sure patient education materials are distributed in the clinic and other cancer screening and treatment clinics.

Refer patients to hospital financial department, if necessary. Help arrange patient transportation and housing as needed.

Identify and develop relationships with personnel in departments involved in the care of CRC screening patients (i.e., physicians, surgeons, nurses, radiology staff, social services staff, radiation oncology staff, hematology/oncology clinic staff); offer educational sessions to inform practitioners of the Patient Navigator's role and services and to encourage referrals.

Train other Patient Navigators and build relationships with other Patient Navigators.

Track patient follow-up and outcomes of colorectal cancer screening.

Maintains appropriate records and prepares reports as required.

Performs other duties as assigned.

Example KNOWLEDGE and SKILLS
- Knowledge of Alaska Natives and Alaska Native cultures.
- Knowledge of rural Alaska and the Alaska Tribal Health System
- Skill in patient education and outreach
- Skill in computer use
- Skill in working with a clinical care team
- Skill in working with and communicating effectively with a variety of professional and skill levels; such as medical providers, case managers, health educators

MINIMUM EDUCATION QUALIFICATION
A Bachelor's degree in a discipline or field related to programs the incumbent is responsible for. An equivalent combination of relevant education and/or training may be substituted for experience.

MINIMUM EXPERIENCE QUALIFICATION
Non-supervisory – Three (3) years relevant professional work experience.

PREFERRED EXPERIENCE QUALIFICATION
Experience in the Alaska Tribal Health System. Training or experience specific to the scope of position and responsible programs is highly preferred.

ADDITIONAL REQUIREMENTS
May travel within Alaska on small airplanes.

MINIMUM PHYSICAL REQUIREMENTS
The following demands are representative of those that must be met by an employee to successfully perform the essential functions of this job. This position requires: the ability to lift approximately 20 pounds; persistent repetitive movements of the hands, wrists and fingers; and the ability to sit for long periods of time.

This job description is not an employment agreement or contract. Management has the exclusive right to alter this job description at any time without notice.

Signature below acknowledges that I have received a copy of my job description and my supervisor has discussed it with me.

_____   _____
Employee Signature   Date

_____   _____
Supervisor Signature   Date