



**Webinar: Colorectal Cancer (CRC) Screening and the Patient Centered Medical Home**  
**Additional Questions & Answers**  
**July 28th, 2016**

Robert A. Smith, PhD and Suzanne Lagarde, MD, MBA, FACP  
Webinar replay: <http://nccrt.org/webinars/>

- 1. Is it sufficient for a health center to address and meet a PCMH standard only with relationship to one disease, like CRC? Or do these standards need to be incorporated into a variety of disease types in order to secure accreditation?**

[Dr. Smith] In principle, a PCMH will address the full range of an individual's preventive health and chronic care needs. Accreditation under NCQA requires evidence that the practice is using data for population management on an annual basis for at least two preventive care services, at least two immunizations, three chronic or acute care services, and medication monitoring and alert, including patients not recently seen in the practice. The details are available on the NCQA website.

- 2. How is the decision of colonoscopy vs FIT modality included? Are there any conditions (diabetes) that would exclude screening via colonoscopy?**

[Dr. Lagarde] We use patient navigation only with ASA I and II (anesthesiology classifications which stratify risk of the procedure). Patients who are ASA III are referred for a GI consult first, to ensure that the GI doc is comfortable putting the patient through prep and procedure. For patients with a higher risk of complications from procedure, might choose to do FIT. There are many conditions that make colonoscopy more risky, but that's a question for another hour discussion.

- 3. Are there any methods to address cultural challenges to CRC discussions/screenings/education for patients not originally from the US (culturally competent methods for CRC)?**

[Dr. Lagarde] If you are in a community with a predominant culture, it is definitely a good idea to use a patient navigator from the community who is from the same culture and is bilingual (assuming a language other than English is preferred). There is a myriad of published material in

many different languages. Written material should be provided in patient's language of choice. Sometimes it is difficult to match literacy level and language of choice, when this happens you may need to use local resources to create appropriate materials.

[NCCRT] NCCRT's June 29, 2016 webinar on implementing FIT-based programs shared a link to wordless instructions that are available for public use: [www.kpchr.org/stopcrc](http://www.kpchr.org/stopcrc) (under the Materials tab).

**4. For Dr. Smith; I saw that electronic reminders were separate from the patient and physician reminders, what exactly are these?**

[Dr. Smith] Reminders can come in all shapes and sizes. Patient reminders typically are mailed or telephone reminders, whereas physician reminders generally refer to reminders that are placed in the day's charts, or pop-up in the electronic health record. Reminders for the clinical staff may be electronic or paper-based. Electronic health records also may be programmed to list patients who are due for preventive services, so that they may be sent reminders, and they also can be used to identify patients who are non-adherent with recommendations or referrals. Finally, reminders may be additive, i.e., a patient may be sent a letter, which is then followed up with a phone call, and the patient's chart may also include a flag to alert the clinician.

**5. Is the Project Access federally funded?**

[Dr. Lagarde] No. It currently receives a small amount of state funding. Other support includes grants (e.g. Komen) and local support primarily from our local hospital.

**6. How were negative FIT tests handled? Did you send postcards, make calls, or not address them? How did you schedule them for follow-ups in a year?**

[Dr. Lagarde] Negative FITs are recorded in the EMR and the Health Maintenance Portal is updated to indicate patient due for repeat CRC screening in one year. At one year, process is repeated, i.e. patient gets letter/call from patient navigator and/or PCP makes another referral to navigator.

**7. Have you had any challenges in getting patients screened with colonoscopy, specifically, if the patient does not have insurance or cannot afford it? Providers continue to share with me how this a challenge and may even consider not screening with FIT.**

[Dr. Lagarde] I know that we are extremely fortunate in that our local hospital is very generous and allows us to perform free screenings. Also, the faculty of the local medical school donates their time. I know that most areas are not as fortunate. Of course, if the number of uninsured was very large, this could be a problem. We were pleasantly surprised to find out that the number of uninsured going through our screening process is lower than we expected. In our health center, the uninsured rate is 27% yet to date, only 9% of patients referred for colonoscopy are uninsured. We think that this is due to the older age of patients, but not sure.

**8. What are your suggestions for a community cancer center that utilizes a private practice physician model in a geographic area where there are no gastroenterology providers who will see uninsured patients?**

[Dr. Lagarde] If you can find just one GI “champion” you might be able to build a program. Before I started working at our health center, when I was still in private practice, I created a program we call “No Cost Colonoscopy” where we asked GI docs to provide one “no cost” colonoscopy per month. As a fraction of their overall colonoscopy volume, this is miniscule. We then worked very hard with our patient navigator to ensure that these patients kept their appointments (see attached article in Clinical Gastroenterology and Hepatology), were well prepped and after the procedure, we provided the patient with a thank you note to send to the GI. Word got out that this was a good program and we gradually got other GIs to donate “one no cost colonoscopy per month”. Key is ensuring that there are very few no-shows (there are ways to do this, see article) and patients are compliant with good prep. No-shows rapidly kill a program.

**9. What is the most appropriate way to demonstrate ROI for the resources used for CRC screening (such as navigation, etc.) to justify additional staff/resources and how can you demonstrate overall impact to the hospital bottom line?**

[Dr. Lagarde] We’ve actually done the ROI and it is very convincing. The vast majority of insured patients who are referred for colonoscopy are referred to the GI for a “pre-procedure” visit. For ASA I or II patients that is not needed and the PCP can provide the needed Cardiopulmonary exam, medication and allergy lists, etc. See slide below which shows ROI. Despite this convincing argument, in Connecticut I have thus far been unable to convince our state Medicaid agency to pay for patient navigation for CRC screening.

**Economic argument for Patient Navigation #1**

- Can navigate 8 to 10 patients/day
- With open access, for ASA I and II patients, visit to GI is not needed. Hence insurer is spared the cost and SHOULD apply it to reimbursing navigation

Cost of 99213	# Patients seen by PN/day	Savings/week	Savings/year	Average PN salary + fringe
\$66 (Medicaid)	8-10	\$2640 – \$3300	\$121,000 – \$152,000	\$45,000 – \$50,000