Improving CRC Screening Rates: The Role of Patient Navigation and Strategies to Sustain Improvement

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Lincoln, NE

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Sioux Falls, SD

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Coal Country Community Health Center
Beulah, ND
Welcome

- Welcome!
- Q & As at end of the presentations
- Slides and recording will be available on the GPQIN website: Calendar > Past Events
  http://greatplainsqin.org
- Utilize chat for questions and sharing throughout
Patient Story

- Lon Sorenson, Lincoln, NE
The Role of the Patient Navigation and Strategies to Sustain Improvement

Sara Romeo, RN, BSN
CRC Navigator
Falls Community Health
Falls Community Health
Sioux Falls, SD

► Our Clinic
  ► We are a Federally Qualified Health Center
  ► We serve approximately 13,000 pts a year
  ► Around 22% of our pts are best served in another language other than English
  ► Sliding Fee Scale used with 50% of our patients

► We are also a recognized level 3 Patient Centered Medical Home
Know the Facts!

- Colorectal Cancer is the second-leading cause of cancer death in the United States\(^{(1)}\).
- In 2017, South Dakota expected 410 new colorectal cancer cases and 160 deaths to this cancer. It is estimated 135,430 newly diagnosed colorectal cancer cases and 50,260 deaths are projected within the United States\(^{(2)}\).
- Screening adults ages 50-75 yrs allows for early detection and will most likely lower cost of treatment and save their life.
- If we achieve the 80% goal, we could prevent 277,000 new cases and 203,000 deaths over the next several years\(^{(1)}\).
FCH Screening Improvement Strategies

► In 2010 FCH partnered with the South Dakota Department of Health (SDDOH) to improve CRC screening rates
  ► Implemented patient navigation, tracking system, covered cost of screenings for qualifying patients
► Rates improved from the low teens to nearly 30% over the course of 5 years
► When the grant cycle ended mid-year 2015 our rates plateaued
CRC Screening Improvement Strategies

- In 2016 the SDDOH had another grant opportunity.
- This has allowed us to hire a part-time nurse navigator as a supporting strategy to implement evidence-based interventions.
- Nurse Navigator Role including, but not limited to:
  - Education and Reduction of Barriers
  - Screening with iFOBT kits
  - Colonoscopy Appointments
  - Continuous Yearly Screening Follow-up
  - Research for funding Colonoscopies
Improving Cancer Screening Rates Using Four Essentials

At FCH we have implemented this evidence-based practice from American Cancer Society into our daily work to increase screening rates amongst our patients

1. Make a Recommendation
2. Develop a Screening Policy
3. Be Persistent with Reminders
4. Measure Practice Progress
Four Essentials to Screening

1. Make a Recommendation
   - Education is Key to patients ages 50-75 and those with a family history
   - Discuss the importance of being screened

2. Develop a Screening Policy
   - Engage your team!
   - CRC Screening form
   - Screen everyone ages 50-75 yrs
Four Essentials to Screening

3. Be Persistent with Reminders
   - Phone Call or letter to patient 1\textsuperscript{st}, 2\textsuperscript{nd}, and 4\textsuperscript{th} week or until specimen is received
   - Annual Reminders
   - Sorry We Missed You

4. Measure Practice Progress
   - Excel Spreadsheet
     - Distributed & Received iFOBTs
     - Annual Reminders, Turned 50, New Patient
     - Positive Results and Colonoscopy Follow-Ups
Distributed iFOBT Kits

<table>
<thead>
<tr>
<th>Month</th>
<th>2016</th>
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<tbody>
<tr>
<td>JAN</td>
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<td>NOV</td>
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RETURNED iFOBT KITS

% OF RETURNED iFOBT KITS

2016  2017

Jan    Feb    Mar    Apr    May    Jun    July    Aug    Sep    Oct    Nov    Dec
2016 CRC Screening Rates

% OF PATIENT'S SCREENED

Jan  Feb  March  April  May  June  July  Aug  Sept  Oct  Nov  Dec

28  30  29  31  32  33  34  35  36  37  38
Navigation through Colonoscopies

- In 2016, of the 208 Returned iFOBT Kits, 21 were positive
  - 9 Completed Colonoscopies (1 Clear Finding)
  - 12 No appointment/No Funding/Barriers

- In 2017, of the 261 Returned iFOBT Kits, 42 were positive
  - 24 Completed/Pending Result Colonoscopy-(1 Clear Finding)
  - 2 Refused
  - 16 No appointment/No Funding/Barriers
Navigation through Colonoscopies

- In April 2017, FCH received a grant to fund colonoscopies
- New Hampshire Colorectal Cancer Screening Program
- Six Topic Navigation Protocol:
  - Engagement & Barrier Assessment
  - Prep Education & Barrier Resolution
  - Prep Review and Re-addressing Barriers
  - Assessment of Prep and Confirmation of Test Day Details
  - Day of Colonoscopy
  - Follow-Up and Patient Understanding of Results
- 11 out of 12 Patients completed their Colonoscopy
- All but 2 Colonoscopies had findings
Benefits to the Navigator Position

- Increased patient compliance
- Increased screening rates
- Increased return rates
- Greater compliance with colonoscopy completions
References

(1) 80% Screening Goal. http://cancer.org/colon. The American Cancer Society, the National Colorectal Cancer Roundtable. 2017


Coal Country Community Health Center (CCCHC)

Beulah, Hazen, Killdeer, and Center, North Dakota

Chastity L. Dolbec, RN, BSN, Director of Patient Care & Innovation
Coal Country Community Health Center (CCCHC) Background

2016 Patient Demographics

- 10,052 unique patients
  - 61% Private Insurance
  - 18% Medicare
  - 21% Uninsured / Medicaid

- 39,050 visits
CCCHC’s Medical Home Team

- Physician/Mid-Level Provider Lead
- Provider Nurse (RN, LPN, RMA)
- RN Care Coordinators / BHCC / Community Care Coordinator
- Certified Nursing Assistants
- Support Staff – lab, radiology, reception, med recs, certified coders and billers, behavioral/mental health
Our Medical Neighborhood

Coal Country Community Health Center (FQHC)
✦
Sakakawea Medical Center (CAH)
✦
Mercer County Ambulance
✦
Beulah Drug and Hazen Drug
✦
Knife River Care Center (Skilled LTC)
✦
Custer Health (Public Health)
Preparing the Foundation for Screening Navigation

One Step at a Time…
Laying the Foundation...

- **BCBS – MediQhome** *(2010–2011)*
  - Care Management Fees for PCMH principles
  - Population Health Management – Chronic/Preventative
    - Addition of RN Care Coordinator – Initial step taken

- **CMS FQHC APCP (Advanced Primary Care Practice) PCMH Demonstration** *(2011–2014)*
  - 500 FQHCs awarded – PCMH transformation *(NCQA)*
  - PMPM incentive for achieving PCMH recognition
    - Educational resources to guide transformation
    - Addition of support staff (certified nursing assistants) and RN Care Coordinators (Patient Navigators)
Building Upon the Foundation...

- Expanded Services – Increase in demand = Increase in Provider teams (2012 to current)
  - 23.04 FTE in 2012 compared to 35.95 FTE in 2016
- HRSA PCMH Supplemental Funding (2011 – 2012)
  - Patient engagement and outreach
- HRSA Quality Improvement Funding (2015 – 2017)
  - Patient engagement and outreach
  - FluFIT campaign – Community approach
  - Expanded Care Coordination throughout all four clinics
  - Addition of Administrative Position – Community and Patient Engagement Director
Continued Reinforcement to Pay for Screening Navigation

- CMS AIM Funding – Caravan Health (2016 – current)
  - MSSP – Track 1 Accountable Care Organization
  - Additional reimbursement for services provided (prepaid shared savings)
    - Revenue generated through Annual Wellness Visits (W2M, IPPE, Subsequent)
    - TCM, CCM services

- National Colorectal Cancer Roundtable (2016)
  - 80% by 2018 National Achievement Grand Prize Award
    - Continued work with outreach and engagement
    - FluFIT, Colorectal Cancer Screening projects
Expanding Screening Navigation through Funding Sources (2016 – Current)

- DSHII (Delivery System Health Information Investment) Funding (2016–2017)
  - Population Management Software purchase
  - Improved efficiencies of navigation overcoming EMR challenges

- PCMH QI Supplemental Funding (2017 & Beyond)
  - Further funding supporting navigation efforts

- ND DoH – Division of Cancer Prevention & Control
  - Electronic Health Record Project Grant
  - ECHO Project – Extension for Community Healthcare Outcomes

- PCMH QI Supplemental Funding (2017 & Beyond)
  - Further funding supporting navigation efforts
How did we step off the curb?

Team Approach EQUALS Sustainability
Team Approach to Paying for Screening Navigation

- Administrative Support
  - BOD, Admin Team including Medical Director

- Medical Home Team Engagement
  - Provider-led
  - **RN Care Coordinators ~ Patient Navigators** (dual role)
  - RN/LPN/MA
  - Support staff

- Quality Champion
  - Innovative QI Projects
  - Tracking
Collaboration = Success in Improving Patient Outcomes
Medical Neighborhood Collaboration ~ Links of Care

- **Medical Neighborhood**
  - FQHC (four clinics) Comprehensive Care Coordination
    - In-reach / Out-reach
    - Screening
    - Diagnose
    - Refer & Treatment
    - Transitions in Care
  - Critical Access Hospital (CAH)
    - Direct Link to Colonoscopy Referrals
    - On-site surgeon, CRNA, visiting surgeons
    - Transitions in Care
  - Public Health
    - Preventative screening, FluFIT
    - Transitions in Care
  - Pharmacy
    - FluFIT
  - Long Term Care – Skilled Nursing Facility
    - Comprehensive Care Coordination
    - Transitions in Care
Comprehensive Care Coordination within the Medical Neighborhood

- **Navigation EQUALS Improved Health Outcomes**
  - 100% review of all patients – yearly at a minimum (most often 2X/year)
    - CRCS – Feb and Sept review for Innovation projects in March and October
    - Recall protocol – three attempts over 4 months (letters and phone calls)
  - Tracking of referrals/consults (colonoscopy)
  - Direct link to referring surgeon (local CAH)
    - Care Coordination / Navigation closes the loop
  - Innovative approaches to patient engagement
    - Social media
    - Newspaper
    - Community Engagement
Partnership with local American Cancer Society Chapter
  ◦ North Dakota Colorectal Cancer Roundtable
    • Clinical Expertise
      • 80% by 2018 Initiative
    • Toolkits and Resources
      • Flufit.org
        • Annual Flu FIT campaign within Medical Neighborhood
          • FQHC, CAH–RHC, Public Health, Pharmacy

Emphasis on Team Based Care Through the Delivery of...
  • Evidence–based Clinical Guidelines
    • Sharing of Best Practices – CCCHC presentations
  • Standardized Job Descriptions
    • Clearly defined responsibilities for navigation
    • Team approach – all share in responsibility of navigation
Cancer Screening
Innovative Improvement Strategies
Collaborative Partnerships

- Partnership with PCA, NDDoH, & ACS – EQUIP (ECHO Collaborative Quality Improvement Project for Cervical Cancer Screening
  - Interactive Distance Learning series to develop QI plan
  - ACS Representative – Shannon Bacon (Coach)
- Partnership with NDDoH and QIO (Quality Health Associates of ND)
  - Electronic Health Record Enhancements to Improve Cancer Screening Rates
    - Lab information system interface
    - Staff hours for training – new population health management software
- CCCHC Local Partnerships
  - Local Business Employee Health and Wellness programs
  - FluFIT
  - Get Your Pink On – Mammo Marathon
  - Pap & Pamper – Cervical Cancer Awareness Month
    - Community Supported Event
  - 1st Annual Women’s Day – Fall 2017
    - Focus on all three cancer screening measures with community support
CCCHC’s Baseline and Improved Cancer Screening Rates

Slight decline noted in 2016–2017 – addition of 3,000 new patients
Evaluation – Return on Investment

- MSSP – ACO Quality measures
  - CRC screening
  - Decrease in Potentially Preventable ER Visits (PPEV)
  - Decrease in Potentially Preventable Admits (PPA)
  - Shared Savings

- UDS measures
  - CRC – continued improvement

- BCBS Blue Alliance – Rural ACO
  - Improvement in WCC completion rates
  - Decrease in PPEV
  - Decrease in PPA
  - Shared Savings

- NCQA Patient Centered Medical Home recognition
- Improved Patient Satisfaction
Challenges

- **Screening**
  - Two office visits for colonoscopy
  - Transportation for colonoscopy – Identified through our CHNA

- **Grant Expenditures**
  - Notice of Grant Award – Not clearly defined
  - Change mind – Mid cycle of grant award
  - Time commitments for reporting requirements
  - Too short of turn around from notice of grant to implementation/finalization of project
  - Smaller health centers – Rural America – QI staff wear multiple hats

- **Similar QI projects from competing organizations**
  - Improve Alignment with other organizations for mutual outcome
Coal Country Community Health Center
(Beulah, Hazen, Center, and Killdeer, ND)
## Progress

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<tr>
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<th>2014 BRFSS Data</th>
<th>2016 BRFSS Data</th>
<th>Relative Improvement Rate</th>
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<tbody>
<tr>
<td><strong>Kansas</strong></td>
<td>68.5%</td>
<td>69.2%</td>
<td>1.0%</td>
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<tr>
<td><strong>Nebraska</strong></td>
<td>62.9%</td>
<td>65.2%</td>
<td>3.7%</td>
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<tr>
<td><strong>North Dakota</strong></td>
<td>63.7%</td>
<td>67.4%</td>
<td>5.9%</td>
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<tr>
<td><strong>South Dakota</strong></td>
<td>68.6%</td>
<td>69.7%</td>
<td>1.6%</td>
</tr>
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<td><strong>Great Plains QIN</strong></td>
<td>65.3%</td>
<td>67.5%</td>
<td>3.3%</td>
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<td><strong>National excluding Great Plains QIN</strong></td>
<td>69.76%</td>
<td>71.36%</td>
<td>2.29%</td>
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Questions

You may ask questions as follows:

- Post your questions in “Chat” in WebEx
- Dial *5 on your phone keypad to be placed in the queue for questions
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