Sustainability of Colorectal Cancer Screening Patient Navigation

Case Studies

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INTRODUCTION

MAKING THE CASE FOR SUSTAINABILITY

This report includes four case studies that highlight key components of any plan to sustain colorectal cancer screening navigation within the primary care setting.

Each case study focuses on the unique context of a specific clinic, including its geographic location and relationship with GI providers.

Within each case, different examples of rationale, best practices, and policies necessary to sustain patient navigation are described. Not every example will apply to every clinic, but all clinics should be able to identify a handful of lessons learned that apply in their community's context.

Want to dive into sustainability? Check out the National Colorectal Cancer RoundTable's "Paying for Patient Navigation" Toolkit: https://bit.ly/2EDpStZ

01

Community Health Center, Refers to Stand Alone GI Practice

- Community health center with a single primary care practice location
- Referrals for specialty GI sent to a stand-alone GI practice that is not connected to their clinic or local hospital
- GI/Primary Care partnership established such that GI group will accept 8 patients per month referred from Clinic 1, about equal to the demand from primary care
- Agreement contingent upon PN at Clinic 1 to ensure patients understand procedure, bowel prep instructions, follow-up guidelines, arrive for their appointment on time and well-prepped

Comprehensive Screening Approach

In order to address the needs of all patients and the limited capacity of their screening provider partner, Clinic 1 has instituted a FIT program to screen average-risk individuals. MAs and Providers discuss CRC screening with all patients, including describing the pros and cons of stool-based versus direct screening tests. Providers recommend only colonoscopy for high-risk patients, but offer a FIT kit or colonoscopy to average-risk individuals. For patients who choose a FIT kit, the kit is explained by MA staff and given to patients before they leave the clinic. For patients who choose a colonoscopy, patients are referred to the PN to discuss the screening before they leave the clinic.

Patients referred for colonoscopy meet with the PN, who is responsible for identifying and addressing any barriers preventing the patient from being screened. The PN explains the screening process, the patient's expectations, and refers the patient to the GI group for education on bowel prep and scheduling.

The GI group and PN work together to ensure the patient receives reminders before the procedure and follow-up instructions after the screening. The GI group follows-up with the patient’s results, and the PN calls the patient to confirm they received their results, understand the necessary follow-up, and schedules an appointment with the patient’s PCP as necessary.

Sustaining Leadership Support

Clinic 1 experienced turnover in their leadership about one year ago. The previous leadership team instituted the FIT program and PN role, so there was concern about losing the momentum and progress in increasing screening rates with this change in leadership. Clinic 1 was able to maintain its focus on CRC screening rates because one of the PCPs served as a clinic champion, pushing to maintain the CRC screening workflows and PN role. Because this clinic champion and the care team worked diligently to ensure workflows and the GI specialty partnership remained, the clinic did not experience decreases in screening rates during the transition.

Some key factors that helped ensure PN remained in-tact include:

1. No simultaneous turnover in PN staff (PN and supervisor or PN and back-up)
2. Consistent communication across care teams to work through any challenges
3. Ongoing discussions with GI group to ensure the referral, PN, and screening process was working well for both the PCP and specialty clinics
4. Clinic Champion (PCP) who cited clinic data on effectiveness of PN on CRC screening rates to make the case to the new leadership

Paying for PN

When the PN role was first instituted, it was payed by stitching together funds across multiple grants for cancer screening, care coordination, and chronic disease management. As they implemented these grant-based projects, Clinic leadership saw the effect the PN role was having on increasing screening rates and decreased no-shows and non-compliance. The GI specialty provider that partners with the clinic was an early partner in the clinic's first CRC screening PN grant, and the GI specialty group cited PN as the reason for continuing to partner with Clinic 1 when the grant funds ended. Because of both the quantitative (screening rates, UDS measures) and qualitative (improved partnership with GI specialty) data to support the benefits of PN, Clinic 1 decided to use their "per member per month" (PMPM) dollars to support a cancer screening and preventive services PN role. They continue to see improvements in their screening rates for breast, cervical, and colorectal cancers, which emphasizes the need for this PN role.

FIT Program Best Practices

Clinic 1 has had their FIT program in place for 2 years and plans to continue using FIT kits as part of a comprehensive CRC screening strategy.

The continued use of a FIT kit screening option is important because a population-based screening strategy must use the FIT for three to five consecutive years in order to see declines in CRC mortality.

Incorporating FIT kits was a good fit for Clinic 1 because of their relatively stable and consistent patient population.

Additional FIT Program Best Practices incorporated at Clinic 1 include:

1. Referring all high-risk patients directly to colonoscopy
2. Using Business Intelligence tools (EMR functions, IT support) to identify patients due for screening and track all kits and results
3. Automatic flag and referral to PN for follow-up and navigation into colonoscopy for all positive FIT results
4. Partnership with GI group for direct referral of all positive FIT results

02

Rural Clinic System, Refers to Local Hospital

- Rural clinic system associated with the local hospital
- PN implemented as hybrid PN/CHW role, 1.0 FTE dedicated per clinic
- Colonoscopy-focused approach to screening due to high late-stage incidence and capacity challenges
- Business Intelligence tools and Team-Based Care have been critical in sustaining PN

Business Intelligence and EHR Integration

Clinic 2 has used Business Intelligence (BI) tools to identify and "flag" patients in their EMR who are due for CRC screening. This automated process alerts MAs to patients in need of screening before the patient comes in for an appointment, and sends this alert to the PCP to discuss screening. This same identification process flags patients due for screening who have not been coming into the clinic, generating a call list for the PN/CHW. Other functionality in Clinic 2's EHR allows clinic staff and PN/CHW to identify scheduled colonoscopies, track no show rate, and send staff alerts to conduct reminder calls.

Using technology to assist in care team communication and tracking patients' health needs enables clinic personnel to focus on one-on-one patient interventions of education and barrier reduction.

Clinic 2 experienced some challenges in implementing and sustaining these BI tools due to their rural location. They were not able to institute cloud-based communication across their clinic locations until reliable broadband internet was accessible in their region. The significant up-front equipment and training investment and lack of personnel to manage the system seemed daunting. However, through careful planning and partnership with a variety of funding sources and technical assistance organizations, Clinic 2 was able to secure funding to implement health information technology systems and retain the technical assistance and oversight required to maintain these technologies. Clinic 2 has seen productivity increase and quality measures steadily improve since the implementation of these business intelligence tools.

Adopting a Business Intelligence Tool can take the operational tracking work off the plates of clinic staff, creating more capacity for patient navigation work.

Role of PN in Team-Based Care

The PN/CHW at each clinic is responsible for overseeing all aspects of the PN process, with some clinic staff helping in various navigation activities. Clinic 2 provides direct referral to the hospital for colonoscopies for all patients.

The clinic has opted for a colonoscopy-focused CRC screening approach because they lack the capacity to accurately manage, track, and follow-up on FIT kits and they are in a part of the state with high late-stage cancer incidence. Clinic 2 emphasizes educating and reaching all patients who come into the clinic as well as outreach to community members about the importance of getting screened and talking to their PCP.

Implementing the role of PN across multiple clinic staff persons was seamless for Clinic 2 because they operate under a team-based care model. Team-based care allows Clinic 2 to provide patient-centered care that addresses individual patient's needs, meeting patients at their level.

The PN activities of clinic in-reach are performed by MA staff, identifying patients due for CRC screening who are not coming into the clinic. Using morning huddles, the care team is able to quickly communicate which patients on the schedule are due for various preventive services and ensure the appropriate care team member will address each with patient.

An MA care coordinator serves as the main point of contact for each patient, streamlining patient communication, and providing additional education and barrier reduction to ensure patients are well prepped and understand the importance of their screening.

Team-Based Care

Clinic 2's implementation of a team-based care model allows all care team staff to work to top of their licensure, which has a number of benefits to patients, providers, and the care team. A team-based care approach allows nurses and PCPs to discuss more complex health issues in depth with patients because lower-level staff (i.e. MAs) take notes, chart, and conduct the patient intake and history.

Patient care planning, coordination, and treatment is assigned to the most appropriate care team member, so the team's knowledge and skills to their maximum efficiency. PCPs are granted more time with patients and overall clinic volume increases through a team-based care approach.

03

Large Urban Community Health Center, Refers to Local GI Practice

- Community health center with a single primary care practice location
- Referrals for specialty GI sent to a stand-alone GI practice that is not connected to their clinic or local hospital
- PN implemented as one dedicate person who focuses only on CRC screening navigation
- Clinic recently experienced turn-over in the PN position, but sustained the PN role due to strong institutional leadership support, documented roles and responsibilities, defined PN job description and scope, and cross-training
- PN is a critical component of maintaining their excellent relationship with their GI provider group

Successful Partnership with GI Providers

In the past, Clinic 3 has had challenges in access to screening for their Medicaid patients. They referred almost exclusively to one endoscopy group, and the clinic team was dedicated to ensuring a strong partnership existed and identified strategies to address the endoscopy group's concerns of accepting a large number of Medicaid patients. The endoscopy group was encouraged by the fact that Clinic 3 has a dedicated CRC screening PN to ensure patients arrive for their appointment on time and well prepped. Clinic 3 was able to provide evidence of the decrease in no-show rates associated with their implementation of the CRC screening PN. The endoscopy group agreed to accept more Medicaid patients under an agreement that all of Clinic 3's patients would be scheduled on specific days. Additionally, the medical leadership team and the endoscopists met to determine which aspects of patient education and navigation would be the responsibility of which group. The group instituted a direct colonoscopy referral program for all but high-risk patients with comorbidities so that patients could see their PCP, be navigated by the PN, and then arrive at their screening appointment without a pre-visit consultation. The direct referral program is contingent upon all patients being navigated by the PN at Clinic 3 because the GI group has cited previous challenges in Medicaid patients arriving on time and well-prepped for their procedure. This agreement has led to fewer barriers for patients, increased screening volume for the endoscopy center, and increased CRC screening compliance rates for Clinic 3.

Sustaining PN through Turnover and Transitions

Clinic 3 was able to sustain the PN role through transitions in large part due to dedicated and committed leadership. The PN supervisor and clinic operations team ensured roles and responsibilities were documented for the PN position as well as comprehensive workflow process maps describing how a patient interacts with the care team throughout the navigation process. Documented these processes were crucial in developing the PN position description and scope.

Clinic 3's operations staff cites cross-training staff as a major reason the role was sustained throughout this transition with limited impact on patient care. A referral coordinator was cross-trained on CRC screening PN workflow processes so they could fill in when the PN was on vacation or out sick, and this came in especially handy when the PN transitioned out of their role and a new hire was identified and on-boarded.

Evidence of the Cost-Effectiveness of PN

PN for CRC screening has been shown to be cost-saving as compared to standard care in a variety of settings including community hospitals, primary care, and lay navigators in urban hospitals. These studies have shown that the increased screening volume and well-prepared patients gained as a direct result of PN saves money. Highlights from these studies include:

- A community hospital saw cost savings due to PN because they screened enough additional people to prevent 3.5 CRC deaths each year
- PN cost $9,800 per quality-adjusted life-year gained
- The cost per patient navigated ranges from $280-$1000/patient depending upon volume
- 18% of patients in need of screening need who are contacted for PN need to be navigated for program to be cost-effective

For a more detailed listing of cost-effectiveness studies of PN for CRC screening, see the Chapter 6 Appendix of the Paying for PN Toolkit: https://bit.ly/2EDpStZ

Leadership Support

One of the major factors in Clinic 3's success not only in sustaining the PN role, but also in making significant progress in increasing CRC screening rates, is the strong leadership buy-in to support the program. Clinic 3's leadership team went through a strategic planning process to identify clinic and community needs and prioritize efforts to improve their community's health. Through this process, the clinic identified their region as having significantly high late-stage CRC incidence and low screening rates. Clinic administration was aware of the evidence of the cost-effectiveness of PN and prioritized CRC cancer screening and PN as a major priority in their strategic plan.

Clinic leadership sees the value in supporting PN as long as they continue to see increases in their CRC screening rates, as tracked by UDS measures. The leadership team has seen the benefit of navigating patients, so they pay for these services from their operating budget.

04

Safety-Net Clinic, Contracts for In-House Colonoscopy Provider

- Clinic partners with a GI doctor to come onsite four days per month to provide colonoscopies in-house
- Navigation implemented as a process distributed among many clinic staff
- PN activities funded through various grants focused on care care coordination and cancer screening
- Clinic 4 is in the process of acquiring PCMH accreditation, using PN to meet many standards

Using PN to Meet Quality Standards

Clinic 4 has been in the process of receiving PCMH accreditation for the past year. Clinic leadership has identified the specific PCMH criteria they would like to emphasize and which programs and policies already in place help meet the criteria.

Clinic 4 engaged in a project to track CRC screening quality indicators to demonstrate the value of PN in helping meet UDS measures and acquire PCMH accreditation. They were able to quantify how PN has improved patient satisfaction with

care and timeliness of care, decreased no shows, and improved screening rates. Making the connection between PN and these quality indicators has convinced clinic leadership that PN is an integral part of providing quality care to all patients, and PN is standard of care in their clinic.

PCMH criteria include a range of standards, some of which clinics may select as they see fit while others are required for all clinics seeking accreditation. There are 10 standards directly relatable to PN; 4 of these are requirements to qualify for PCMH accreditation. The key standards Clinic 4 identified that are addressed by PN include medical home responsibilities, test tracking and follow-up, coordinate care transitions, and measure clinic quality performance.

How to Use PN to Meet Accreditation Standards

Patient-Centered Medical Home (PCMH)

2017 PCMH requirements focus on assessing practice transformation and specify goals for improvement based upon the defined concepts, competencies, and criteria. The concepts related to PN include:

1. Team-Based Care and Practice Organization
2. Knowing and Managing Your Patients
3. Care Management and Support
4. Care Coordination and Care Transitions
5. Performance Measurement and Quality Improvement

Triple Aim

The Triple Aim is to improve patient experience (quality and satisfaction), improve population health, and reduce per capita cost of health care. Implementing CRC Screening PN would address each of the Triple Aim "targets" by providing patient-centered care and improving population health through increased screening and reduced cost.

Quality Payment Program

The Quality Payment Program is a payment incentive program clinics are eligible for if they submit and meet various quality measures, improvement activities, and care information reporting measures. Numerous objectives can be met using patient navigation.

For more details on using PN to meet accreditation standards, see Chapter 5 of the Paying for PN Toolkit: https://bit.ly/2EDpStZ

05

Federally-Qualified Health Center, Focused on Population Health

- Clinic refers to outside hospital or specialty provider groups
- Patient Navigation is defined role on the PCMH care team
- PN activities funded through various grants focused on care care coordination and cancer screening
- Clinic 4 is in the process of acquiring PCMH accreditation, using PN to meet many standards

PN as a Part of the Population Health Team

Clinic 5 recently became accredited as a PCMH and has been designated as an FQHC status for three years. In an effort to provide patients with PCMH-appropriate care, Clinic 5 has structured their care teams (or pods) to include a Population Health Team.

This team includes one case manager, RN-level care coordinator, and Patient Navigator per care team. The team is focused on lowering hospital and ER visits and repeat clinic visits with the PN focusing on health care services outside the clinic's walls.

The Business Case for a Population Health Model

Clinic 5 has embraced the Medicare Shared Savings Program approach to value-based payment. Their approach is to be proactive in moving their clinic operations to align with a pay-for-performance structure rather than fee-for-service. In this capitated payment model, there is a need to keep clinic utilization down, especially among high-cost providers.

This Population Health model becomes profitable when there are more patients attributed to Clinic 5 with fewer overall visits. Patient panels among each care team are built around the estimate of a set number of visits per day, per provider, with a predicted no-show rate and predicted return-to-clinic ratio. Continued profitability will occur by adding additional Population Health Team staff as the clinic population grows, while not increasing the number licensed staff.

Clinic 5 is using the Heirarchical Clinical Categories approach of risk-stratifying their patient population to focus on providing necessary resources and services to the highest utilizers. These services include programs that reside in the community, outside the clinic.

Role Definition and Distinction on the Population Health Team

Clarity among the population health team with regard to the specific roles and functions of each team member is critical to the success and sustainability of the Population Health Team, including the Patient Navigator.

Each Population Health Team has a patient panel of approximately 3000 individual, but not all patients need these services.

The Population Health Team's goal is to work with the subset of high-utilizer patients to bring down the return-to-clinic ratio down. To this end, the case manager assists in pre-visit planning to evaluate and follow-up on emergent health issues while the RN Care Coordinator assists patients in receiving appropriate care for multiple chronic conditions.

The PN focused on referrals and connecting patients to specialty care or services outside the clinic.

Sustaining patient navigation within the primary care setting will look different for each clinic.

The data, evidence, and rationale needed to make the case for sustaining CRC screening patient navigation within the primary care setting will vary depending upon an individual clinic's context. The funding available, payer mix, partnerships, and community context will determine which elements of the best practices and examples of sustainability presented in these case studies best suit a particular clinic.

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