



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

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 navigation program plan for sustainability and find ways to seek reimbursement for colorectal cancer screening navigation. Of course, we want to keep top of mind that colorectal cancer screening navigation 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.

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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 and the framework for the toolkit.

- Patient Navigation is a model of care that aims to reduce an existing health disparity as defined in a particular community.
- Patient Navigation addresses a patient's individual barriers to care by linking them to existing local and regional resources, not by creating new resources or services.
- Patient Navigation 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
- Patient Navigation promotes system-level change to ensure connectivity between the need for screening, screening, and any necessary follow-up services

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

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 a colorectal cancer screening Patient Navigation can be sustainable.
- Provide examples of evidence-based strategies and quality standards for colorectal cancer screening navigation.
- Strategize for whom and how you will prioritize colorectal cancer screening navigation and priority populations for screening.
- Examine programs and approaches to colorectal cancer screening Patient Navigation throughout the U.S. and learn from their work to understand payment models and methods for sustainability.
- Analyze the direct payment methods to pay for colorectal cancer screening Patient Navigation and think about how to apply to your setting.
- Explore making the business case for colorectal cancer screening Patient Navigation - including patient outcomes, quality measures, and cost analysis. Understand the prime components and resources necessary to undertake this work, and apply what's already been achieved in the field.
- Based on your setting, critically review the accreditation and quality measures that might be met with colorectal cancer screening navigation in a variety of health care settings.
- Educate about the types of policy initiatives which have been utilized to help ignite or bolster work for colorectal cancer screening Patient Navigation.
- Evaluate Patient Navigation 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 navigation programs. Like a physical toolkit, you may not need to use every tool, or even read every chapter or section, you'll use only the tools you need for your specific situation. Thus, we encourage you to begin by scanning each volume's 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 support¹.

Please note, that 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 DO IT

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 - good to go back and examine the components of the sustainability framework

Patient Navigation as a Model



The momentum that Patient Navigation 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. Below are

listed the Principles of Patient Navigation that have been developed and vetted for more than 20 years through Dr. Harold Freeman's experience.²

1. Patient Navigation is a patient-centered health care service delivery model. The focus of navigation 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. Patient Navigation 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. Patient Navigation 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 Patient Navigation 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. Patient Navigation 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 Patient Navigation 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 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 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 and 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. Patient Navigation can serve as the process that connects disconnected health care systems.

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

Care Coordination and Patient Navigation

Care coordination is often referenced when speaking about Patient Navigation. The Agency for Healthcare Research and Quality, note 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.³

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.⁴

Patient navigators often deploy the core elements of care coordination and are part of the healthcare redesign.

Development of the Toolkit

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

- 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

There are a variety of resources and toolkits that have been developed to help with designing navigation programs, training, and evaluating Patient Navigation efforts. This Toolkit is dedicated to exploration of the factors that will promote reimbursement and paying for and sustaining navigation. This Toolkit will be a living document, with continuous updates as the science of Patient Navigation and the methods to sustain colorectal cancer screening navigation evolve. We hope that you find this toolkit to be a great resource to further your efforts to sustain Patient Navigation, to make it a standard part of your practice and workforce.

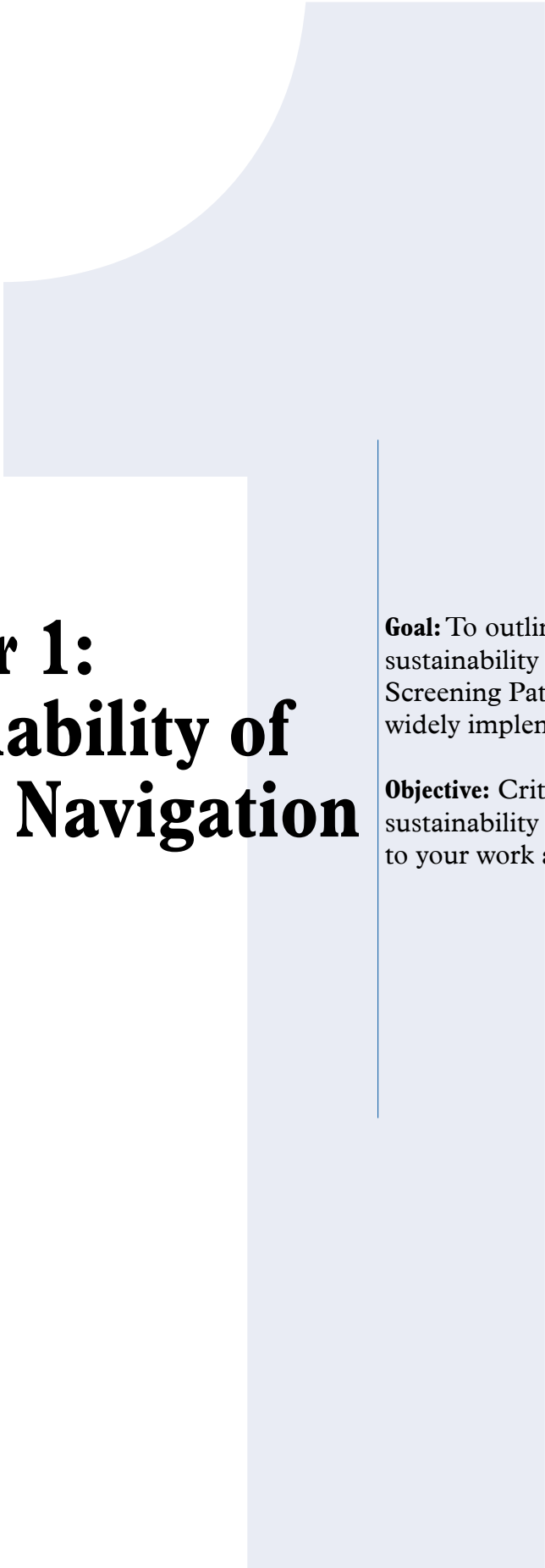


Visit Chapter 9 to learn more about the additional resources and toolkits that might help in further examining Patient Navigation implementation and additional topics in further sustaining systematic approaches to implementation of colorectal cancer screening initiatives and Patient Navigation.

We need your feedback on the toolkit!
<https://www.surveymonkey.com/r/CRCPayPNTK>

Sources

1. The Boston Medical Center Patient Navigation Toolkit. Accessed November, 2015.
2. Freeman HP, Rodriguez RL. History and principle of patient navigation. *Cancer* 2011; 117 (15, supplement)
3. <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html>
4. <http://www.integration.samhsa.gov/workforce/care-coordination>



Chapter 1: Sustainability of Patient Navigation

Goal: To outline the most important aspects of sustainability that will allow Colorectal Cancer Screening Patient Navigation 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 colorectal cancer screening Patient Navigation 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 colorectal cancer screening navigation will not be integrated into the workforce. Stable funding is going to take a dedicated approach.

Let's explore the central tenants 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 domains²:



• **Funding Stability** = making long-term plans based on a stable funding environment

• **Partnerships** = the connection between program and community

• **Organizational Capacity** = the resources needed to effectively manage the program and its activities

• **Program Evaluation** = monitoring and evaluation of process and outcome data associated with program activities

• **Program Adaptation** = the ability to adapt and improve in order to ensure effectiveness

• **Communications** = the strategic dissemination of program outcomes and activities with stakeholders, decision-makers and the public

• **Public Health Impact** = the program's effect on the health attitudes, perceptions and behaviors in the area it serves

• **Strategic Planning** = the process that defines the program direction, goals and strategies

• **Political Support** = the internal and external political environment which influences program funding, initiatives and acceptance



Based on where you are with implementation of colorectal cancer screening navigation, do you feel that you have all nine components established to sustain your program?

Are there specific areas you need more work or to strategize 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 BunkerPublic health program capacity for sustainability: a new framework. Implementation Science20138:15

Chapter 2: Evidence and Patient Navigation

Goal: Provide information on Colorectal Cancer Screening Patient Navigation as an evidenced-based intervention to ensure Patient Navigation is paid for and a sustainable intervention to increase colorectal cancer screening rates.

Objectives:

Critically Examine:

- Why Patient Navigation for Colorectal Cancer Screening is needed.
- The background and definitions of Patient Navigation and evidence for how/why Patient Navigation ‘works’.
- Review the many title of those who serve in the role of care coordination for colorectal cancer screening navigation.
- Why does this all matter when thinking of paying for colorectal cancer screening and Patient Navigation?

Background

Evidence for Patient Navigation in Colorectal Cancer Screening:

There are a host of papers and reviews regarding the effectiveness and efficacy of colorectal cancer screening Patient Navigation.



Later in this Toolkit in Chapter 5, we will explore the agencies who use accreditation and credential aims for colorectal screening that might be helpful in thinking about sustaining colorectal cancer screening Patient Navigation 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 colorectal cancer screening Patient Navigation has the rigor to improve health outcomes as much as many clinical interventions.

Colorectal Cancer Screening Patient Navigation 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.

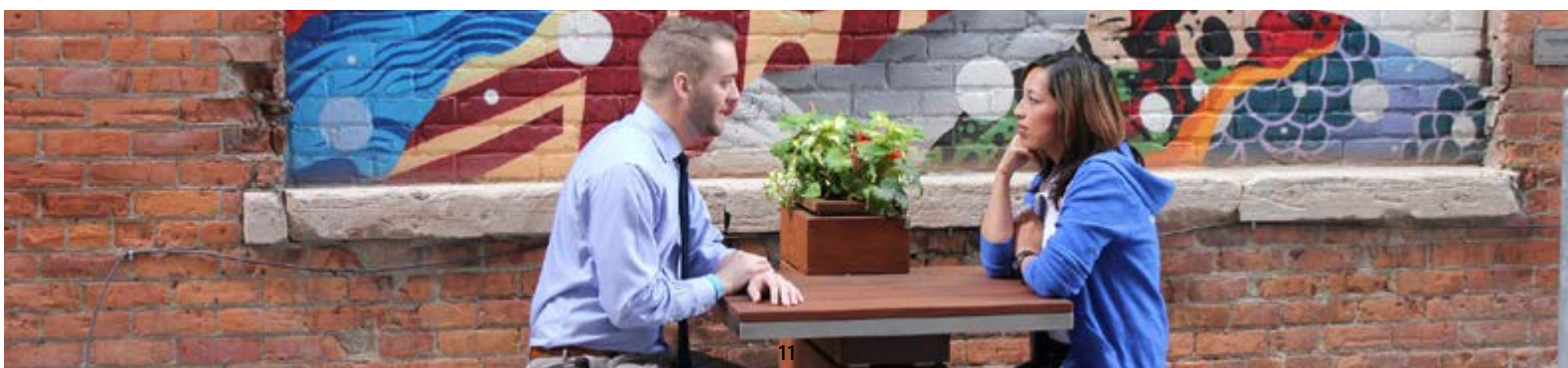
Sources of Evidence The Community Guide and Colorectal Cancer Screening

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/>



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

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 patient navigators and colorectal cancer screening 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 colorectal cancer screening Patient Navigation 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 been utilized.



<http://www.hrsa.gov/quality/toolbox/measure/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 Patient Navigation.



<http://www.cancer.gov/about-nci/organization/crhd/disparities-research/pnpr>

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 (colon) 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 CRC 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 base under your belt, how can you use this information for receiving funding and sustaining colorectal cancer screening navigation?



Food for Thought

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

Use this evidence in grant applications and in proposals to secure grant funding for colorectal cancer screening Patient Navigation.

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?

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/ethnic minorities due to¹:

- No insurance or insufficient insurance
- Cultural influences or previous bad experiences that lead to distrust of the healthcare 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 patient navigation 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 country.⁵



To provide navigation, 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 for information about policy strategies and how states and organizations are implementing policy to make the case to secure colorectal cancer screening Patient Navigation.



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

Navigation is a successful intervention for the medically underserved with access to care issues, both from health outcomes and feasibility and fiscal data. Based on the conclusions of the Patient Navigator Research Program (PNRP) funded by the National Cancer Institute, it demonstrated a moderate benefit in improving timely cancer care. These results support adoption of Patient Navigation in settings that serve populations at risk of being lost to follow-up, which primarily include the medically underserved. The PNRP has provided enormous data and resources to help colorectal cancer screening navigators. 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

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

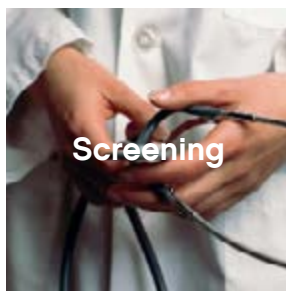


Role of a Patient Navigator

A patient navigator works WITH patients to eliminate real and perceived barriers to health care. The navigation services provided will depend on the barriers that you identify and strategies you use to overcome these obstacles. Often, 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 patients.

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

Cancer Care Patient Navigation⁴



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 those patients who are 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. More information on these issues is available at the Resource section of this Guidebook.

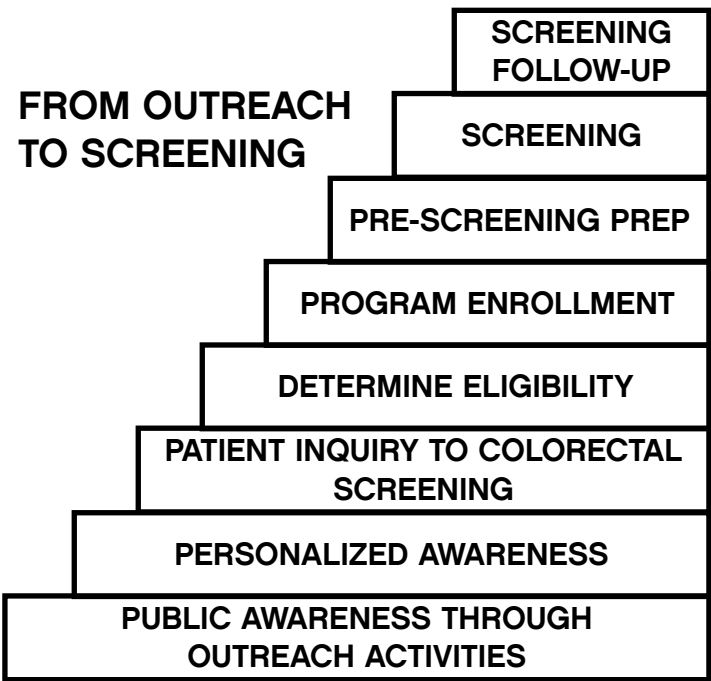
Program Navigation Services

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

Like many Patient Navigation programs in the cancer continuum, colorectal cancer screening navigations might be built differently in many settings, dependent on the health care delivery setting.

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. 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 navigation. Below is an example of what classic colorectal cancer screening Patient Navigation entails⁴.



Interested in all of the very specific elements of Patient Navigation and how to ensure 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 navigation 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 list examples of barriers and potential solutions³.



Evaluating your Patient Navigation 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.

Table 1. Potential Barriers and Possible Navigation Solutions⁴

	Potential Barriers	Possible Navigation Solutions
Health Care System	<ul style="list-style-type: none"> • Patient fails to keep appointment • Patient does not fully understand what the provider says 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Patient speaks a different language than the health care provider 	<ul style="list-style-type: none"> • 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.
Financial	<ul style="list-style-type: none"> • Patient has no insurance • Patient needs help understanding and completing insurance forms 	<ul style="list-style-type: none"> • See if patient qualifies for Medicaid/Medicare. Work with your state health department to see if screening resources for uninsured men and women are available. • AND, Help connect the patient to the state or federal health exchange • Assist patient with completing paperwork/form
Transportation	<ul style="list-style-type: none"> • Patient lives far from clinic and has no means of transportation • Patient cannot afford public transportation 	<ul style="list-style-type: none"> • Assist patient in utilizing the public transportation system • Arrange for community shuttle or volunteer transportation service

Limits of Patient Navigation 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 navigator does and does not do.

Patient navigators do NOT perform the following⁴:

- 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

As a navigator, you will become involved in patients’ lives. However, to be an effective 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 navigator³.

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

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.

The navigator 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 <http://www.hhs.gov/ocr/privacy/hipaa/understanding/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 a lot of consideration and debate about who should serve in the role of a patient navigator. Currently 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 GW University Cancer Center policy resources

<http://smhs.gwu.edu/gwci/>

Perhaps it is best to remember Dr. Freeman’s thoughts⁵:

“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 important to also notice that QUALITY colorectal screening navigation is of the utmost importance. Ensuring that every step of the colorectal cancer screening Patient Navigation process is followed and that there is appropriate and timely follow-up with the patient about surveillance is important. In the event that

there is an adverse event or a cancer diagnosis, a coordinated transfer (warm hand off) to a health care team member is critical.



Building your colorectal cancer screening

Patient Navigation program - what to consider:

- What is the setting in which you will or have implemented your colorectal cancer screening Patient Navigation program?
 - Primary care setting
 - Community setting
 - Regional setting
- Who is the target audience and priority population you are trying to reach with your colorectal cancer screening navigation?
- Will you deliver the colorectal screening Patient Navigation 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 be all of the partners and how will you all work together?



Now! 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 2

Appendix and Tools

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		
Reminders		
Ensure patients have transportation to and from screening and supportive care after		
Work with patients to overcome common barriers		
Perform patient-driven risk stratification		
Barrier Reduction		
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		

Chapter 3: Colorectal Cancer Screening Patient Navigator Programs- City, Regional, and State Based- Networks

Goal: The goal of this chapter is to specifically examine programs that have implemented colorectal cancer screening networks and programs, with Patient Navigation as one of their core tenants. Many of these states and their 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 of this chapter are to provide insight about:

1. A brief description of the aims of the specific colorectal screening program and the role of colorectal cancer screening Patient Navigation.
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 navigation for colorectal cancer screening?

Background:

It is important to know that every colorectal cancer screening program that utilizes patient navigators may choose a different screening modality and number of people they intend to reach and as a result, colorectal cancer screening navigation delivery services may vary greatly for each program. Let's examine several models to explore what and how colorectal cancer screening navigation 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, which included a colonoscopy patient navigator program, within selected public hospitals. Patient navigators are trained to guide individuals through complex clinical settings in order to assist with the scheduling, preparation, and completion of the procedure (See Figure 3.1). It is important to note that New York State also has monies to help support colorectal cancer screening Patient Navigation 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 colorectal cancer screening Patient Navigation.



<https://www1.nyc.gov/assets/doh/downloads/pdf/cancer/cancer-colonoscopy-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 revenue paid for the navigator. It can be harder to make the business case for those PNs who are not part of endoscopy.



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

What Lessons We Can We Learn from New York:

New York had strong champions, 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 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 Patient Navigation'

Two Common and Critical Components from all of 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 link to Patient Navigator Networks who have formed throughout the U.S.

2. Important to keep note that most programs clearly define the scope and practice of the Patient Navigators. Being clear about role and scope of patient navigator, so supervisors understand scope and boundaries and the outcomes help show their role as the PN to sustain their role.



What is the scope of practice for your patient navigators? See Tool 3.1 to think about the scope and who will be serving in what role and how colorectal cancer screening navigation will be delivered in your setting.





Colorado

The Colorado Colorectal Screening Program is a statewide program that partners with the safety net, primary care health care providers to provide no cost colorectal screening to the underserved. The program, coordinated through the University of Colorado Cancer Center, has partnerships with more than 50 community health clinics across Colorado. The program is heavily focused and reliant primarily on Patient Navigation support. Previously the program served patients with community clinics that offer no cost endoscopic screenings (most often colonoscopy). (See Figure 3.2)



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

- **Q:** What do you wish you would have known about sustainability and paying for colorectal cancer screening Patient Navigation?

'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

'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.

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



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



Take a look at Chapter 7 to learn more about the role of training for Patient Navigation. Patient Navigators in the Colorado Colorectal 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.

Testimonials

"I'm a single mom, working a couple part-time jobs, and have had no insurance for 5+ years. Thank you for this Program. It saved my life!"

--- 55 year old Fort Collins woman who had routine screening. Five polyps were found, one of which was cancerous. She had surgery to remove a section of her colon and is now cancer-free.

"I was diagnosed as pre-cancer and had concerns about what would happen. Throughout this process, staff were extremely helpful. They provided guidance and appointments promptly. Susan arranged for my consultation and surgery as well as provided me with emotional support."

"It has taken a weight off my shoulders, as members of my family have died of colorectal cancer. It has been at the back of my mind always but I have not been able to afford the screening."

"May have saved my life, because I had two polyps removed. Thank you for providing this service."

"I feel it was [lifesaving]! The doctor removed a large flat polyp that was pre cancerous. Colon cancer runs in my family. My follow up screening was all clear! I feel a great sense of relief. "

"I am very grateful for this screening because my grandfather and aunt both died from colon cancer, and a first cousin had polyps. It is a relief to have a clean slate!"





South Carolina

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

This program was built with many partnerships aligning and working together to provide CRC screening services. In this program, Free Medical Clinics, FQHC's and safety net organizations refer uninsured and medically underserved patients to colorectal cancer screening with the Colorectal Cancer Prevention Network. Thereafter, patient navigators are responsible to review the patient's 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 CRC and education on endoscopic procedure and colonic preparation. Throughout the process, the navigators are the direct contact with the patients to CRC screening and remain involved as an advocate when patients are referred to specialty care (See Figure 3.3).



Thoughts from Dr. Frank Berger and Team in South Carolina:

- **Q:** What do you wish you would have known about sustainability and paying for Patient Navigation?
- **Q:** Lessons learned:
It was a point of leveraging partnerships, as you can see from the building of resources and timeline to develop a robust screening program with Patient Navigation.
- **Q:** Advice for anyone thinking of what you did to think about sustainability:
Diversification of funding is key; do not rely on one source of funding.



Check out Chapter 7 Case Study to learn how South Carolina partnered with an advocate to help secure funding at the state level to support colorectal cancer screening 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:

- To increase high quality colorectal cancer screening for New Hampshire residents
- 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; 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.

As a result of highly successful outcomes, the NHCRCSP Patient Navigation (PN) model was extensively evaluated by CDC from 2013-2016, including a comparison study of colonoscopy screening and surveillance for navigated vs. non-navigated patients. To enable replication of the navigation model, NHCRCSP and

CDC collaborated to develop a comprehensive Replication Manual that covers detailed planning, implementation, and evaluation of navigation for use by other programs, including the NHCRCSP PN protocol itself as well as staffing and training details.



<https://www.cdc.gov/cancer/crccp/pn-replication-manual.htm>

Patient Navigation has proven highly effective for adherence, provision of high-quality screening, and appropriate and timely follow-up (See Figure 3.4).

Comments from Dr. Lynn Butterly, PI and Medical Director

"Patient Navigation has been shown 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."



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. Visit Chapter 7, Tool 7.1 to read more.

Lessons Learned

Seven core elements form the foundation of the NHCRCSP PN model and were part of its success. One of these, the Six-Topic Navigation Protocol is an established protocol that the NHCRCSP patient navigators followed to deliver six important topics by telephone to patients at defined time intervals in the screening process. The six-topic protocol incorporates comprehensive patient education, assessment and resolution of patient barriers, patient coaching and encouragement, and timely reminders. The seven core elements and the details of the six topic navigation protocol can be found at the link to the NHCRCSP Patient Navigation Model for Increasing Colonoscopy Quality and Completion replication manual.





Alaska

(See Figure 3.5)

Interview with Diana Redwood, ANTHC Program Director:

- **Q:** What do you wish you would have known about sustainability and paying for Patient Navigation?

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 info from the start.



How would you do this? Check out Chapter 6 about Cost Analysis and Making Business Case. You also need to focus efforts on improving the 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
'Patient Navigators can be taught all the information about screening, but it is very difficult to teach people to be extroverted. Important to hire the right personality for the job. The best colorectal cancer screening 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.

Organizations 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 with dedicated time for the Patient Navigator to review and update the medical record so they knew exactly who was due for screening and then called all those people up to encourage them to come in for screening. Very high touch process, but that is what was needed to reach and activate the people that they served.'



- **Q:** Advice For anyone thinking of what you did to think about sustainability.
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 up. Colorectal Cancer Screening Patient Navigators also need to be integrated into the system in an efficient way and be incorporated into the clinical flow. For example, it isn't as effective for a patient navigator to call up patients to get them interested in screening but then not be allowed to schedule those patients.

The Colorectal Cancer Control Program has developed specific guidelines for identifying what specifically is Patient Navigation in terms of roles and criteria, see Tool 2.1 for more information about how this tool works in their setting.



Both Alaska and New Hampshire programs were both 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.



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 are specific resources identified in this chapter that will help you work with partners or your key leadership to inform your efforts?





Chapter 3

Appendix and Tools

Appendix Chapter 3

Chapter 3: Local, Regional and State Programs

Figure 3.1

Name of Program	NYC colonoscopy patient navigator program
Goals of Program	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • In-Person • Phone
Characteristics of Patient Navigators	<ul style="list-style-type: none"> • 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 3.2

Name of Program	Colorado Colorectal Screening Program
Goals of Program	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • In-Person • Phone
Characteristics of Patient Navigators	<ul style="list-style-type: none"> • Primarily Non-Clinical provider (not licensed health professional) <p>To lesser extent:</p> <ul style="list-style-type: none"> • Licensed Practical Nurses • Social Workers • Registered Nurses <p>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.</p>
Initial Funding	Colorado Cancer Cardiovascular and Pulmonary Disease Grants Program (CCPD)
Sustained Funding	CCPD and Institutional Support

Figure 3.3

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	<ul style="list-style-type: none"> • In-Person • Phone
Characteristics of Patient Navigators	<ul style="list-style-type: none"> • 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	<p>Critical Partnerships and Timeline:</p> <ul style="list-style-type: none"> • 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 3.4

Name of Program	New Hampshire Colorectal Cancer Screening program
Goals of Program	Increase high quality colorectal cancer screening for New Hampshire residents with use of colonoscopies.
Setting	Centralized within the NHCRCSP. Navigators worked statewide
Population Focus	<ul style="list-style-type: none"> • The full NHCRCSP program was intended for all appropriate NH residents. • The free colonoscopy and navigation program was intended for Uninsured and underinsured, low Income New Hampshire Residents
Delivery of Patient Navigation Services	<ul style="list-style-type: none"> • Phone Only • 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	<ul style="list-style-type: none"> • Registered Nurses • 1.2 Full Time Employees for navigation
Initial Funding	Colorectal Cancer Control Program (CRCCP)
Sustained Funding	Colorectal Cancer Control Program (CRCCP)

Figure 3.5

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 specialty clinics - 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 patient navigator project in 2007-2008. ANTHC then received CDC funding for the CRC Control Program from 2009-2015.
Sustained Funding	<ul style="list-style-type: none"> • CRCCP Program Not Funded • ANTHC was able to sustain funding of some of the FTE support of the Colorectal Cancer Screening Navigation.

Chapter 4: Payment Approaches and Strategies for Colorectal Cancer Screening Patient Navigation

Goal: This chapter will explore the ways that Patient Navigation 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
 - 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 others have been funded or transitioned from grant to more diversified funding.

Background

Paying for Patient Navigation at this time remains a bit challenging in most states because there is not typically direct reimbursement for colorectal cancer screening navigation.



However, there are strategies that are 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 Patient Navigation funding. While such support may not be sustainable in the long term, its use can allow the opportunity for those working in colorectal cancer screening Patient Navigation to initiate and evaluate efforts that might be grown or potentially 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 the role and scope of both have a lot of overlap. It is important to note that some granting mechanisms that fund cancer prevention, community, and patient driven research have cut back on funding Patient Navigation, as the evidence base is so strong in navigation. But, 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 dollars in the CRCCP pilot program and were also an awardee in the initial round of the CRCCP. However, they were not awardees in the second, most recent 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 Patient Navigation 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?

'We saw the value of the process of colorectal cancer screening navigation and the value of a specific person to carry 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 the 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...

'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:

'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 colorectal cancer screening Patient Navigation.

Grant or Foundation Funding Agencies:

These are specific agencies who have historically supported colorectal cancer screening Patient Navigation 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>

Links of Care Pilot Project

In 2014, the NCCRT awarded special CHANGE grants to three community health centers across the country for the purpose of demonstrating the viability of an effort to improve links of care between community health centers and specialty care in the delivery of CRC screening. The grants were awarded in the summer of 2014 to health centers and partners in Low Country, SC, New Haven, CT and St. Paul, MN. The grants provide support for 18 months and include funding for a community assessment, a stakeholders meeting and technical assistance in each location.



Tool 4.1 Outlines Grantees Progress in Paying for Colorectal Cancer Screening Patient Navigation

Prevent Cancer Foundation

The Prevent Cancer Foundation is a 501(c)3 non-profit that is focused solely on cancer prevention and early detection. The Foundation has invested nearly \$142 million in support of cancer prevention nationwide. The basis of the work comes from four distinct pillars: research, advocacy, education, and outreach. Colorectal cancer screening navigation and evidence based approaches have been an area of funding.



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



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. One specific group who pays in certain situations for the follow-up on the FIT/FOBT and their testing strategies is Exact Sciences. It is key to understand how this might intersect with preventive screening efforts and certain elements of the navigation and tracking process.



<http://www.exactsciences.com/>

Council on Foundations

It is likely that there are regional and state based foundations that might also award support for Patient Navigation. It is essential to think of all partnerships nationally and at the state level and to take time 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 colorectal cancer screening Patient Navigation. 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.



<http://minorityhealth.hhs.gov/>



FUNDED! Beginning in 2015, The Tribal Colon Cancer Collaborative of Inter-Tribal Council is funded for 5 years for colorectal cancer screening patient navigation. One of 2 projects funded under the State Partnership Initiative. Goal of the Project is to Increase the number of American Indians who receive navigation services for colon 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 to the highest level, 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 may include traditional Native concepts in his/her work. CHRP is a unique community-based outreach program, staffed by a cadre of well-trained, medically-guided, tribal and Native community people who provide a variety of health services within AI/AN communities.

However, it is important to note that not all CHRs are funded adequately or have the training to be colorectal cancer screening navigators, but many tribes and territories have devoted additional grant support and dollars to ensure CHRs are utilized to work in the role of colorectal cancer screening Patient Navigation.



<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 where they work, live, and play. One area that CDC has invested monies for colorectal cancer evidence based interventions is the Colorectal Cancer Control Program (CRCCP). In states that received this funding, implementation of navigation efforts 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 colorectal cancer screening navigation has been implemented in certain states.

A fantastic resource within states to consider is the National Comprehensive Cancer Control Program (NCCCP). 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: <http://www.cdc.gov/grants/applying/index.html>

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

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

The Health Resources and Services Administration (HRSA)

HRSA is an agency of 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's programs provide health care to people who are geographically isolated and/or economically or medically vulnerable. HRSA makes grants to organizations 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.



<http://www.hrsa.gov/grants/index.html>

National Cancer Institute

NCI leads a national effort to eliminate the 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 that do develop at the earliest stage, eliminate cancers through innovative treatment interventions, and biologically control those cancers that we cannot eliminate so they become manageable, chronic diseases. Colorectal Cancer Screening Patient Navigation and prevention is an area of interest but the NCI grants are typically more academic and complex in design for research protocols. The Patient Navigator Research Program (PNRP) is one of the largest investments in Patient Navigation research.



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



Much of what the NCI has given thus far in the way of Patient Navigation is through the PNRP. A reminder that the results of the PNRP are critical to help us sustain colorectal cancer screening Patient Navigation. Visit Chapter 2 regarding evidence for colorectal cancer screening Patient Navigation.

The Community Benefit

Not-for-profit 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.

Colorectal Cancer Screening Patient Navigation has been an area that the Community Benefit has helped support!



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

Let's Begin by 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 healthcare worker) each month for each person for whom the provider is responsible for providing services. Per member per month 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 are now using the PMPM payments to pay directly for their Patient Navigation services for colorectal cancer screening, even for those whom 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.



A team is interested in pursuing colorectal cancer screening Patient Navigation for their high risk patients and are trying to understand how to use their PMPM dollars to launch their efforts. How shall you move forward?

Advice from an Interview with a Medicaid Claims Officer:

For those Interested in Wanting to Know More About the PMPM for Medicaid in expansion states:

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



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

- 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 Patient Navigation 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 both 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 who are in ACO's will often receive payments to their facilities to help manage the needs of patients. Patient navigators for colorectal cancer screening are often sustained with these dollars.



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

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



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 can then 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 Colorectal Cancer Screening Patient Navigation.



For many of these areas, it is important to understand what the status of ACA coverage in your state is, 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 colorectal cancer screening navigation.

Potential Medicaid Opportunities to Pay for PN and CHW Work in the Affordable Care Act

The Affordable Care Act (ACA) included a range of provisions that may help enhance the role of patient navigators and community health workers in the U.S. healthcare system. The ACA has provided opportunities for PNs 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., PNs 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 CHWs.

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.

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

1. Opportunities for CHWs and PNs to Provide 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 healthcare 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 PN – 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, and “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 CHW services generally.

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 healthcare 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 Task Force 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 Task Force focuses on are screening tests, counseling interventions, immunizations, and chemoprevention delivered to persons without recognized symptoms or signs of the target condition.¹⁷ The Task Force 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
- Hawaii
- Nevada
- New Hampshire
- New Jersey
- New York
- Washington

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

The following states have expanded Medicaid: 20

- | | |
|------------------------|-----------------|
| • Arizona | • Michigan |
| • Arkansas | • Minnesota |
| • California | • Nevada |
| • Colorado | • New Hampshire |
| • Connecticut | • New Jersey |
| • Delaware | • New Mexico |
| • District of Columbia | • New York |
| • Hawaii | • North Dakota |
| • Illinois | • Ohio |
| • Iowa | • Oregon |
| • Kentucky | • Rhode Island |
| • Maryland | • Vermont |
| • Massachusetts | • Washington |
| | • West Virginia |

CHWs or PNs may be well-suited to provide some of these recommended services. In conjunction with a State Plan Amendment adding CHWs or PNs 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 PNs 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 PNs 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 PNs, and include that information in the State Plan Amendment.

2. Medicaid Health Homes

The Medicaid Health Home is a major opportunity to integrate PNs 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 8 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 | • Ohio |
| • Idaho | • Oregon |
| • Iowa | • Rhode Island |
| • Maryland | • South Dakota |
| • Maine | • Vermont |
| • Missouri | • Washington |
| • New York | • Wisconsin |
| • North Carolina | |

PNs 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.

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/>



Many states are working to embed Patient Navigation for care coordination and are interested in understanding how the SIM dollars can support Patient Navigation for preventive care and whole person care. Part of this is to explore how allowing 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 Patient Navigation and community health worker 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 colorectal cancer screening Patient Navigation 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. These are particularly physician based codes but can integrate the extended care team in service delivery, including patient navigators.

Fee for Service Codes in Medicaid

Beginning in 2013, physicians have new codes to report complex chronic care coordination (“CCCC”) services. Patients needing complex care coordination often have multiple providers treating multiple chronic 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 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 codes for Patient Navigation 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.

The 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!



Are there any specific funding resources that are new to you that you might explore for implementation of Patient Navigation for colorectal cancer screening?

If you are living in an Affordable Care Act 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 4

Appendix and Tools

Tool 4.1

The Links to Care Program has provided pilot dollars to implement or augment work in patient navigations

- Coal Country Community Health Center is a Links to Care partner and examining the return on investment and utilization of Patient Navigation.

“Through the delivery of comprehensive care coordination throughout the medical neighborhood, Coal Country Community Health Center has facilitated an innovative model of patient-centered care focusing on prevention and screening for all ages. The medical home team emphasizes whole person care completing health screenings for all patients age 12 years of age and older with a goal of prevention and wellness for all.”

More detail about the analysis of the sustainability of their care coordination in 2018.

- The West Side Community Health Services has provided a case summary of their work in Links to Care and information about their approach. This support and success from the Links to Care were applied to two local Foundations grants to support Links expansion, both were funded. This totaled around \$140,000 to develop centralized processes and expand Links with Patient Navigation as a central theme from United Family Medicine Health Center in St Paul.

Links to Care: Developing a Medical Neighborhood for Community Health Center Patients

Background

The Affordable Care Act drove enormous transformation in health care. Primary Care practices including Community Health Centers are enhancing health information technology, restructuring their practices as Medical Homes, and joining Accountable Care Organizations to respond to those changes.

The level of transformation is unprecedented, and the need for assistance is great. Community Health Centers in St. Paul and Minneapolis have come together to respond to this rapid change. These health centers are providing health care to their patients by collaborating more extensively with each other, using technology efficiently and working together to increase access, improve quality of care and patient satisfaction while reducing overall health care costs. This partnership has already created an environment that fosters collaboration among health centers not seen in recent years.

The American Cancer Society - Midwest Division has been partnering with West Side Community Health Services, Minnesota’s largest Community Health Center, to pilot a Colorectal Cancer Links to Care project in St. Paul since June 2014. West Side was selected for this pilot project after a highly competitive application process in part because it has the largest uninsured and uninsurable patient population in the Twin Cities and a high proportion of patients that were unscreened for colorectal cancer based on Uniform Data Systems (UDS) 2013 data.



The Need

Community Health Centers in the Twin Cities area are designed to meet the basic health care needs of the patients they serve. But there is a great unmet need to provide access to specialty services for these patients, as well. A recent Commonwealth Fund study found that while health centers have increased their patients' access to primary care, they still struggle to obtain specialty care for their patients, particularly for Medicaid and uninsured patients, who make up nearly three-quarters of the patient population. This is a challenge that almost of all eleven health centers based in the Twin Cities face on a daily basis.

To address this challenge, the American Cancer Society approached West Side Community Health Services, to partner on a national Links to Care pilot project supported by the National Colorectal Cancer Roundtable with funding from Walgreens and the Centers for Disease Control and Prevention.

Links to Care strives to develop care linkages between non-profit community-based health centers and independent provider owned specialty clinics and hospital systems based on a "fair share" model. Links of Care works by relying on strong communication and care coordination; clearly defined, limited, commitments from volunteer medical specialists; donated services from a range of partners; and the long term benefits to communities and business from avoiding high cost late-stage diagnosis.

About West Side Community Health Services

- Largest FQHC in Minnesota
- Over 36,000 unduplicated patients seen annually
- 83% from communities of color
- 97% have income below 200% of FPL
- 53% prefer language other than English
- 36% of West Side patients are uninsured
- Many uninsured are uninsurable
- About one half of the insured are on Medicaid
- 9% have private insurance

Goal

To increase West Side's CRC screening rates by focusing on internal operational improvement, use of screening navigation and providing access to specialty and hospital services for West Side patients.

Baseline 2013

- 12% of Westside's insured patients were up-to-date with CRC screening in 2013
- 4% of uninsured patients were up-to-date with CRC screening in 2013

Strategies

Through the current pilot project at West Side, we are advancing a two-pronged strategy to achieve our goal by ensuring patients have access to colorectal cancer screening, diagnostics and, if necessary, treatment:

Strategy 1: Help support the development of a medical neighborhood around West Side Community Health Services by securing limited, donated services from area endoscopy providers and advancing conversations with hospitals to provide treatment services for under and uninsured when colorectal cancer is diagnosed.

Strategy 2: Focus internally within West Side Community Health Services to strengthen office policies, procedures and protocols to ensure every age and risk eligible patient receives a colorectal cancer screening recommendation, is offered a test and is navigated through screening and diagnostic processes. The very processes that help navigate patients to screening also ensure that patients show up well prepared for donated services, which builds reliability and trust between the clinic and the specialty providers donating care.

Baseline 2013

- 12% of Westside's insured patients were up-to-date with CRC screening in 2013
- 4% of uninsured patients were up-to-date with CRC screening in 2013

Project Progress

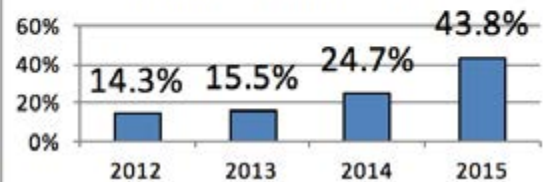
1. Since June 2014, this project has been able to create a referral process for West Side's uninsured patients. We were successful in securing donated colonoscopies from two endoscopy practices, accessing an average of 12 donated colonoscopies a month on an ongoing basis.
2. We have also been able to work with West Side to strengthen their clinical operations:
 - West Side has developed a robust CRC screening policy. The CRC screening policy requires that the Medical Assistants (MA) conduct pre-visit planning, initiate discussions about screening options and offer the iFOB/colonoscopy to patients. This workflow utilizes an EMR pop-up prompt that shows up at the start of the patient visit. Additionally, the MA places the order instead of relying on physicians, thereby reducing the burden on physician workload.
 - iFOB stool testing is now the primary screening modality for average risk patients, thanks to a very effective lab workflow and heavy provider education. By relying on stool testing as the primary screening method, the clinic is better able to manage colonoscopy capacity needs and reserve donated colonoscopy services for those patients who truly need them.
 - iFOB return rates have increased significantly as a result of streamlined processes and active involvement by lab staff, averaging around 74% iFOB return rate. Patients can return kits either by mail or in person.
 - Finally, West Side's referral staff follow the patient and reschedule any missed appointments. Protocol is also in place to have additional patient education through a navigator or an RN, if needed.
3. We have provided recognition of gastroenterology providers and surgeons who are crucial to the project's success. In partnership with ACS CAN, we organized a recognition event for specialty and hospital providers who have been instrumental in solving the access to specialty services. Minnesota Gastroenterology, Colon and Rectal Surgery Associates and Hennepin County Medical Center, Fairview Southdale Hospital and Regions Hospital were recognized for their efforts to provide CRC related specialty and hospital services for the uninsured patients. This event was attended by high-level executives and physicians from specialty practices as well as US Representative Mr. Keith Ellison who recognized the providers.

Progress 2015

- 46% of Westside's insured patients were up-to-date with CRC screening in 2015
- 3 cancers have been diagnosed and 9 individuals had polyps removed preventing potential cancers
- Average wait time for diagnostic colonoscopy reduced from 67 days to 26 days

Eligible Patients Completing CRC Screening at West Side

FOBT in last year or
Colonoscopy in last 10 years or
Sigmoidoscopy in last 5 years



Gastroenterology practice leaders with US Rep. Keith Ellison (MN-5) at an ACS CAN event

Next Steps

Hospital Partnership: Develop partnerships with area hospitals to provide access to treatment for the uninsured and the under-insured including those who have high-deductible health insurance. We continue to meet with hospital leaders to make the business case to provide donated treatment services to West Side's patients. Many of the hospitals are very receptive to this as we have made an effort to highlight that our intent is to share the risk/burden among all participating hospitals.

Gastroenterology Partnership: Continue to support and strengthen gastroenterology partnerships by ensuring effective referrals, minimizing no-shows, avoiding billing challenges and fine-tuning the referral protocol. Additionally, our goal is to add additional gastroenterology partners to the network of providers so the risk and the burden of donating services is shared by an ever wider sample of provider organizations.

Expansion: Our goal is to expand the model to other Health Centers in the Twin Cities metro area. Currently, West Side participates in the Federally Qualified Urban Health Network (FUHN), a collaboration of 10 health centers in the Twin Cities piloting a Medicaid Accountable Care Organization Demonstration Project with the State of Minnesota. We are seeking an initial expansion to 2-3 additional clinics in 2016-2017 with a goal of including all 10 health centers.

Centralized Referral Coordination and Screening Navigation: Since this pilot project is primarily based on developing relationships with specialty providers to secure and expand access to colonoscopies, follow-up testing and, if necessary, cancer treatment, our long term vision is to build the foundation for centralized referral navigation across multiple community health centers. This project has a great potential to save health care dollars in the short and long term. Already, for every dollar invested in this pilot project at one health center, we have coordinated and secured access to \$4 dollars in donated clinical services. The potential for this return on investment is greater as we broaden the scope of this pilot to other health centers. Preventing and finding colorectal cancer early could save thousands of dollars per patient if a cancer is either prevented or found at an earlier stage requiring less intensive treatment.

Partners

- Centers for Disease Control and Prevention (CDC)
- Colon and Rectal Surgery Associates
- Minnesota Department of Health – Sage Scopes Program
- Minnesota Gastroenterology, P.A.
- National Colorectal Cancer Roundtable
- Walgreens
- West Side Community Health Services

Sources

- Establishing a Coalition to Pursue Accountable Care in the Safety Net: A Case Study of the FQHC Urban Health Network http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2013/Oct/1710_Schoenherr_FQHC_case%20study_v2.pdf
- How Strong Is the Primary Care Safety Net? Assessing the Ability of Federally Qualified Health Centers to Serve as Patient-Centered Medical Homes. <http://www.commonwealthfund.org/publications/issue-briefs/2015/sep/how-strong-primary-care-safety-net>

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 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 colorectal cancer screening and Patient Navigation in their practice

Questions to Consider Before Diving In



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

Background



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.

Health systems that fit the Triple Aim construct include the following 5 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.ihl.org/engage/initiatives/tripleaim/pages/default.aspx>

How does Triple Aim tie in with Patient Navigation?

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 CRC Screening PN would address each of the Triple Aim “targets” by providing patient-centered care, improving population health through increased screening and reducing costs.



Flip to Chapter 6 for making the business case for more information on the cost elements. In Chapter 7, we note Patient Navigation Associations who have formed, some note Triple Aim as one of their initiatives to help drive their efforts for Patient Navigation.



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

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 Patient Navigation and support.

STOP CRC, a pilot program offered to patients of CareOregon, 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 5.1)

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 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, and primary care. Recognition of the PCMH standards runs in 3-year increments, requiring re-submission.

The following are PCMH standards achievable with colorectal cancer screening Patient Navigation. Standards noted with * must be adhered to for recognition.



SALUD Family Health Centers runs ten community health clinics in addition to 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 Patient Navigation 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% within 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 improvement of 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 “key to success” in a CoC accredited program:

- 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.
- The cancer committee leads the program through setting goals, monitoring activity, evaluating patient outcomes, and improving care.
- The cancer conferences provide a forum for patient consultation and contribute to physician education.
- The quality improvement program is the mechanism for evaluating and improving patient outcomes.
- 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 a Colorectal Screening Patient Navigator.

(See Figure 5.2)

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:

<https://www.facs.org/quality%20programs/cancer/coc/apply>
<https://www.facs.org/quality-programs/cancer/accredited/about>

II. NON-ACCREDITING ORGANIZATIONS

Centers for Medicare and Medicaid Services - Meaningful Use/Electronic Health Record



<https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2014ClinicalQualityMeasures.html>
<https://www.healthit.gov/providers-professionals/ehr-incentives-certification>

The Centers for Medicare and Medicaid Services is an offshoot of the Department of Health and Human Services, providing Medicaid, Medicare, and the Children's Health Insurance Program (CHIP). Their Clinical Quality Measures (CQMs) identify the quality of services provided by those within the Medicare and Medicaid health care system, specifically with an aim for all affiliated organizations to provide the safest, most effective, patient-centered, and organized care. The measures target hospitals and critical access hospitals (CAHs) who accept Medicaid, Medicare, and the Children's Health Insurance Program (CHIP).

CMS offers a number of incentive programs, offering incentive payment to eligible professionals, hospitals, critical access hospitals, and Medicare Advantage Organizations who utilize Electronic Health Care Record (EHR) technology. The purpose of the incentive is to expand the use of the technology to capture clinical data and health information. The meaningful use of EHRs follows the goals set by the National Quality Strategy, which will be discussed later in this section. (See Figure 5.3)

Those who receive the incentive are required to achieve the following meaningful aspects of care:

- Improve quality, safety, and efficiency and reduce health disparities
- Engage patients and family
- Improve care coordination and population and public health
- Maintain privacy and security of patient health information

To become accepted into any CMS Incentive Programs, organizations and professionals must meet **meaningful use standards**. CMS utilizes a series of CQMs to observe how services are delivered among those within their system, including medical professionals, hospitals, and critical access hospitals.

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 the EHR Incentive Program, hospitals and medical providers must adhere to the clinical quality measures. The measures address the following.

Eligible Professionals

Starting in 2014, the CQMs that are reported by eligible providers are required to select and report on 9 out of 64 measures, covering at least 3 of the NQS areas, as they are considered priorities for health care quality improvement.

Eligible Hospitals

Starting in 2014, eligible hospitals are required to select and report on 16 out of 29 measures in addition to covering at least 3 of the NQS areas, as they are considered priorities for health care quality improvement.

NQS Areas:

- ☐ Patient and Family Engagement
- ☐ Patient Safety
- ☐ Care Coordination
- ☐ Population/Public Health
- ☐ Efficient Use of Healthcare Resources
- ☐ Clinical Process/Effectiveness

Centers for Medicare and Medicaid Services –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 (ACO) are often rewarded should 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 a CRC Screening PN tool within an organization or clinic (See Figure 5.4).

National Quality Strategy

Guided by the Agency for Healthcare Research and Quality, the National Quality Standard 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) which are achieved by applying six priorities addressing health care concerns in the United States.

The six priorities are:

- ☐ Making care safer by reducing harm caused in the delivery of care
- ☐ Ensuring that each person and family is engaged as partners in their care
- ☐ Promoting effective communication and coordination of care
- ☐ Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- ☐ Working with communities to promote wide use of best practices to enable healthy living
- ☐ 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 CRC PN. 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, CRC screening.

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.

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 CRC PN Toolkit. While implementing PN for CRC patients, 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 colorectal cancer screening (See Figure 5.5).

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 5.6).

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

Joint Commission on Accreditation of Healthcare Organizations



The Joint commission on Accreditation of Healthcare Organizations 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 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.

The extensive list of standards set by JCAHO represents some of the leading standards for improving health care delivery (See Figure 5.7).

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.



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.



To learn more, visit: <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 could be used to reach the URAC PCMH Certification:



https://www.urac.org/wp-content/uploads/STDGlance_PCMH_v2-01.pdf

(See Figure 5.8)

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://accc-cancer.org/publications/
CancerProgramGuidelines-4.asp#section10](https://accc-cancer.org/publications/CancerProgramGuidelines-4.asp#section10)

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 #9).

QOPI - Quality Oncology Practice Initiative

The Quality Oncology Practice Initiative 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.institutequality.org/qopi/measures>

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 #10)



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 be to help in exploration or implementation?

Sources

1. Care Oregon. <http://www.careoregon.org/>. Accessed December 2015.



Chapter 5

Appendix and Tools

Appendix Chapter 5

Chapter 5: Accreditation and Quality Standards – Colorectal Cancer Screening Patient Navigation

Figure 5.1

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	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 5.2

Standard
Continuum of Care Services <ul style="list-style-type: none"> • 3.1. Patient Navigation Process • 3.2. Psychosocial Distress Screening • 3.3 Survivorship Care plan
Patient Outcomes <ul style="list-style-type: none"> • 4.1. Prevention Programs • 4.2. Screening Programs • 4.8 Quality Improvements

Figure 5.3

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

Figure 5.4

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 5.5

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 5.6

Standard	Description	Exclusions
NQF 0034	Percentage of members 50-75 years of age who had appropriate screening for colorectal cancer	Patients with: <ul style="list-style-type: none"> • A diagnosis of colon cancer • A total colectomy

Figure 5.7

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 5.8

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 5.9

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 testing

Figure 5.10

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

Chapter 6: Economic Analysis and Business Case for Colorectal Cancer Screening Patient Navigation

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

Objectives:

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 reimbursement and to improve patient outcomes and survival
2. Understand the different types of economic analyses, when to use a 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 patient navigators in 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—must collect back into clinical quality processes (so not independent of the practice and clinical integration)
5. Be certain to crucially think how to show connection back with 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 analysis 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, meaning it's 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 extremely important to know who you are trying to 'convince' about the value of the PN—this is your audience—and think about 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 Patient Navigation is of value and PN 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 Patient Navigation?

- *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 (common)*
- *Programmatic Cost: Measures the cost of developing, implementing and running the program. These cost are required elements of all economic analyses. (common)*
- *Cost Effectiveness Analysis: Compares relative Total Program Cost to a relative Program Outcome of two or more alternative programs (more common)*
- *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 (not common)*
- *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 (not common)*

The following are the most critical elements to capture to inform the basics of a cost analysis (Figure 2 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, this will determine the type of analysis you will consider either doing directly or conducting in partnership with others. Typically the biggest question for each entity will be:

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 what you really need in order to demonstrate the value of PN 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 a lot of 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 1).

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.*

There is a lot of work and resources that 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 Colorectal Cancer Screening Patient Navigation program?

At a minimum you will need to consider the following; however, for certain types of analysis—you will need to know much more:

- 1. Programmatic Cost Elements (See Figure 2)*
- 2. Patient Outcomes for those Navigated:*
 - a. No Show Rates for colonoscopy exams*
 - b. Bowel Preparation Quality*
 - c. Compelled exams (reached cecum)*

7. In an environment that has limited funding, which population is it suggested that Colorectal Cancer Screening Patient Navigation be directed?



Several research papers have examined this very question and results from studies of Patient Navigation 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 of 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 analyses to explain the outcome associated with a monetary input (described briefly above).



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 Patient Navigation activities and critical information.

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

Program Not Begun:

- Define question/s to be answered
- Define population to target patient navigation, not everyone needs navigation, who are your 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 questions to be answered
- Choose key outcome measures
- 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

Programmatic Cost Analysis: is a required component of all types of economic analyses and it 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 in the program. For Patient Navigation programs, this type of analysis would give the total program cost and is often expressed as the cost per person served by the program.



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.

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

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 compares all benefits and costs in monetary values, cost-effectiveness analyses compares 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 Patient Navigation 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.



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 the 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 Patient Navigation grows and is shown to be effective, there will be an ethical concern about withholding an intervention that has been proven to work.

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

Net Cost:

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

Medical Treatment Costs Saved:

$\# \text{ Patients reach diagnostic resolution} \times \text{Cancer Attributable Treatment Cost}$

Outcome:

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

Return on Investment: 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.



What can a Return on Investment study tell us about a Patient Navigation program? What doesn't it tell us?

Return on Investment data explains what program 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 of preventive health services (of which colorectal cancer screening Patient Navigation 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 CRC screening, a Return on Investment 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 Patient Navigation and care coordination. Additionally, these analyses do not relate non-monetary program outcomes to the monetary investment. For example, a return on investment does not describe extended life-years or productivity gains due to a Patient Navigation 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 Return on Investment study can help to articulate specific information about program costs associated with program outcomes of interest, such as numbers screened and numbers of cancer diagnoses. Even this amount of information can be of interest to key partners and stakeholders.

Sensitivity Analysis: a term to describe 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.

1. What are the economic analysis results for Patient Navigation programs for colorectal cancer screening?

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

- Setting of where the Patient Navigation was housed (hospital, community, clinic system, 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 lessons learned in each



***IDEAL-** do this at the start and plan at start 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 ANTCH comments in Chapter 3.

A review of current literature on cost analyses

of colorectal cancer screening Patient Navigation programs revealed ten publications on program costs and two articles highlighting important considerations and evaluation of undertaking a cost analysis. Figure 1 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 Patient Navigation 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 Patient Navigation 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 navigation process.

Salary data is generally available after a program has completed, so if a program is already collecting time data (i.e., time a 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 navigation services (See Figure 6.1).



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 Patient Navigation 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.

Navigation Program Cost = (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

ICER = (Cost of Navigation-Cost of Status Quo)/(Effect of Navigation-Effect of Status Quo)

Key Take-Aways:

- 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 screened

2. 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, colorectal cancer screening Patient Navigation 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 Patient Navigation.

Clinic Managers

Cost analyses are also relevant to the clinic in which the Patient Navigation 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.



Program Implementers (The Patient Navigator) Program implementers care about cost analyses because the results demonstrate the value of these individuals' 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 navigation 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 shows rather than programmatic costs. Because many CRC Patient Navigation programs exist in primary care settings,

the specialty care group is not spending the money on navigation. However, specialty care groups may select which clinic to work with based upon improvements in no show rates.

Entitlement Pro. & 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 CRC screening Patient Navigation program to be cost-effective, the case can be made for Medicaid (and other entitlement programs) to include Patient Navigation 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.

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

Key Measures

(See Figure 6.2)

Key Considerations (Ramsey et al. 2009)

- Costs are specific to the locale: provide context for generalizability
- Include a sensitivity analysis: shows 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

4. Why are high-rigor cost analyses necessary?



High-rigor cost analyses of Patient Navigation programs focusing on colorectal cancer screening are necessary to make the case to policy, insurance, and entitlement stakeholders that Patient Navigation 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. However, 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.

Limitations Abound in Current Literature

- Using historical comparison data
- Sensitivity analyses are contingent upon assumptions used, and without disease progression data for study sample, there are more assumptions
- Some studies have very specific patient population and/or navigation context and results are not necessarily generalizable to other contexts or patient demographics

5. 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 colorectal cancer screening Patient Navigation program than it is to simply assess the economic, health, and quality of life impacts of the intervention.

6. Who can I partner with to conduct a cost analysis of my Patient Navigation 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 Patient Navigation for colorectal cancer screening 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 Patient Navigation 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 colorectal cancer screening navigation 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



Based on the completed costs analysis 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?



Chapter 6

Appendix and Tools

Appendix Chapter 6

Chapter 6: Economic Analysis and Business Case for Colorectal Cancer Screening Patient Navigation

Figure 6.1

Table 1: Example Economic Analyses of Patient Navigation for Colorectal Cancer Screening

Article	Location	Setting and Context	Evaluation Type	Findings
Lin et al. 2008	Pennsylvania (western)	<ul style="list-style-type: none"> Navigation for cancer diagnosis Community Hospitals (small urban/rural, inner-city, urban) 	<ul style="list-style-type: none"> PN Process 	<ul style="list-style-type: none"> Barriers vary by hospital type and location No requests for cancer information in inner-city 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	<ul style="list-style-type: none"> Community Hospitals 	<ul style="list-style-type: none"> Cost-Effectiveness 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Urban Public Hospitals Lay Navigators 	<ul style="list-style-type: none"> Cost-Effectiveness Cost-Benefit Total Costs 	<ul style="list-style-type: none"> 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 attributed to personnel time and salary differences across sites (contributes to effectiveness differences)
Paksett et al. 2012	Ohio (Columbus)	<ul style="list-style-type: none"> Academic and FQHC clinics Lay Navigators 	<ul style="list-style-type: none"> PN Process 	<ul style="list-style-type: none"> Over half report no barriers and half with barriers report only one PNs spent about 15 minutes per patient navigated Low-income patients used PN more readily during first 6 months
Jandorf et al. 2013	NYC	<ul style="list-style-type: none"> Urban Academic Medical Center 	<ul style="list-style-type: none"> Total Costs 	<ul style="list-style-type: none"> Total Costs (navigation): \$29/completed navigation, \$21/non-completed navigation, \$3/no navigation Total Costs (procedure): screening colonoscopy and with biopsy profitable, non-navigated net negative
Lairson et al. 2013	Texas	<ul style="list-style-type: none"> Call Center-Based PN 	<ul style="list-style-type: none"> Total Costs Sensitivity Analysis 	<ul style="list-style-type: none"> Total Costs: \$35.9/participant in usual care, \$294.9/participant in navigation Sensitivity Analysis
Lairson et al. 2014	Delaware	<ul style="list-style-type: none"> Primary Care 	<ul style="list-style-type: none"> Cost-Effectiveness Sensitivity Analysis 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> University Hospital, Community Inpatient & Outpatient Centers 	<ul style="list-style-type: none"> Cost-Effectiveness Sensitivity Analysis 	<ul style="list-style-type: none"> ICER: All outcomes cost-effective, QALY measure shows greatest ICER Sensitivity Analysis: Current cost of \$4,913/participant can increase 2.5x and remain cost-effective, 18% patients contacted successfully screened for PN to be cost-effective
Gritz & Jones 2015	Colorado	<ul style="list-style-type: none"> Community Health Centers and FQHC's 	<ul style="list-style-type: none"> Total Costs Sensitivity Analysis Return on Investment 	<ul style="list-style-type: none"> Total Costs: vary by clinic volume (range \$280/participant for high volume to >\$1000/participant for low volume), average \$470/participant Sensitivity Analysis examined differences in no-show rate reductions. Return on Investment analysis from perspective of colonoscopy provider suggested a break even cost per completed colonoscopy reimbursed at Medicare rates only at the lower cost clinics.
Ladabaum et al. 2015	NYC	<ul style="list-style-type: none"> Academic Urban Medical Center 	<ul style="list-style-type: none"> Cost-Effectiveness 	<ul style="list-style-type: none"> ICER: \$9800/QALY gained for longitudinal PN over no navigation, >\$110,000/QALY over FBT, longitudinal navigation more costly and less effective than FIT

Figure 6.2

Measure	Definition	• Examples
Program Costs	Costs necessary merely because program exists and does not depend upon program size or reach	
Fixed	Dependent upon frequency, type, and intensity of Patient Navigation activities	
Variable		
Administrative Costs		<ul style="list-style-type: none"> • Scheduling • Referrals • Follow-Up with Patient • Patient Satisfaction • EMT/EHR
Human Capital Costs		<ul style="list-style-type: none"> • Employment • Training • Supervision
Direct Medical Costs		<ul style="list-style-type: none"> • Anesthesia • Procedure cost • Diagnostic procedures • Pathology • Cancer Treatment based on Stage of Diagnosis • Hospice
Direct Non-Medical Costs		<ul style="list-style-type: none"> • Transportation • Parking • Childcare • Eldercare • Homecare • Escort
Indirect Costs	Costs associated with program outcomes, but not actual program activities	<ul style="list-style-type: none"> • Lost productivity due to morbidity and mortality

Chapter 7: Policy and Colorectal Cancer Screening Patient Navigation

Goal: This chapter will examine the impact of policy on Patient Navigation 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 navigation at both the state and federal level are noted throughout.

Objectives and Intent:

- To 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 of Patient Navigation in colorectal cancer screening. Further, 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 colorectal cancer screening navigator as a vital role in the health care team.
- To outline policy strategies, particularly at the state level, to sustain the work of colorectal cancer screening patient navigators, critically examining: Workforce Development, Long-Term Financing, and Occupational Associations. Specific tools and examples from various states are included to allow for application in various regions.
- To highlight the most essential elements of organizational policy to consider when implementing a colorectal cancer screening Patient Navigation program, providing specific tools and considerations that may be adapted in many settings.
- To provide links to specific policy case studies and experiences to highlight the utility and successful implementation of colorectal cancer screening Patient Navigation 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 a report known as 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?? of underserved cancer patients.
- **2005**—In response to Dr. Freeman’s work, the Patient Navigator Outreach and Chronic Disease Prevention Demonstration Program was launched 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” at:



<http://bhpr.hrsa.gov/nursing/grants/patientnavigator.html>

Federal Level Policy Supporting Patient Navigation

Patient Navigation has been 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:



<http://canyonranchinstitute.org/storage/documents/NCTACancer9208.pdf>

The CDC has outlined specific steps to integrate Community Health Workers into colorectal cancer screening navigation 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:

The 2010 Standard Occupational Classification (SOC) system is used by federal statistical agencies to classify workers into occupational categories for the purpose of collecting, calculating, and/or disseminating data.

In 2018, the SOC will be updated and 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 would 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.”

Having an official occupational classification would help to increase the legitimacy of Patient Navigation as a profession while also allowing for the collection of important governmental data on Patient Navigation as this occupation continues to evolve. Additionally, having a recognized, concrete definition of Patient Navigation 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 Patient Navigation funding sustainability in Chapter 1

Currently, many state and local agencies are recommending Patient Navigation 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 “Improving Cancer Prevention and Control: How State Health Agencies Can Support Patient Navigators and Community Health Workers,” that speaks to the sustainability of Patient Navigation and necessary policy component initiatives to bolster Patient Navigation. Some states that have been most effective in sustaining and paying for screening Patient Navigation have used distinct recommendations discussed in this brief to implement and sustain their work.

Explore the full ASTHO full 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/programs currently implementing each of these specific recommendations.

Recommendation	Goal
I. Workforce Development	Support standardized training and certification of PN and 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 PNs and CHWs. Figure I (appendix) provides specific examples and strategies that different states have implemented to standardize training efforts



http://www.cdc.gov/cancer/ncccp/ccc_plans.htm

II. Long-Term Financing: ASTHO provides updates and progress reports for states which have policy and legislative coverage for Community Health Workers 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: There is a growing number of state agencies who have identified opportunities to endorse the work of Patient Navigation and community health work.

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



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

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

Visit their website to learn more about the work that's happening in each state and in their specific cancer plans.



In Chapter 3 Andrea Dwyer from Colorado noted that having a statewide network for Patient Navigation was key to sustain her work for colorectal screening Patient Navigation.

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 can now allow non-licensed providers to provide care coordination—Patient Navigation and Community Health Worker 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/>

II. Colorectal Cancer Screening Patient Navigation Specific Policies

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

Formalizing the role of the colorectal cancer screening navigator to be 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 navigator
 - How the Patient Navigators contributes to the multidisciplinary health care team, with specific attention to be 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 considered 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 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>.



Job descriptions are a MUST!

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

The Colorado Colorectal Screening Program PN team lead received a call from one of their partner clinic's medical directors 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, and without this job description, they would not received accreditation.



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

Colorectal Cancer and Screening Patient Navigation:

Many states and organizations have passed legislation (policy initiatives) to secure funding for colorectal screening Patient Navigation. Specifically, Kentucky, South Carolina, and Colorado have made great strides in Colon Cancer Screening through policy changes.

Explore in detail the steps Colorado, Kentucky and South Carolina have taken at the website University of Colorado has established to help showcase this work:



<http://pn toolkitresources.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 and Screening Patient Navigation:

Many states have noted, it is 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 for his state 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 Davids advocacy work to advance policy change visit:



<http://pn toolkitresources.weebly.com/advocacy-resources.html>.

In addition to Davids' story, you will find links to excellent advocacy resources.

Interested in joining the conversation?

Pose questions and connect with other community members through our blog:



<http://pn toolkitresources.weebly.com/blog>



Chapter 7

Appendix and Tools

Appendix Chapter 7

Figure #1

Training	Format	Website
The GW Cancer Institute's Oncology Patient Navigator Training: The Fundamentals	<ul style="list-style-type: none"> • Online • Self-paced 	http://tinyurl.com/GWOnlineAcademy
Patient Navigator Training Collaborative	<ul style="list-style-type: none"> • In-person • Online • Self-paced • Special topic webinars 	http://patientnavigatortraining.org
Harold P. Freeman Patient Navigation Institute	<ul style="list-style-type: none"> • In-person • Online 	http://www.hpfreemanpni.org
Georgetown University Certificate in Patient Navigation	<ul style="list-style-type: none"> • In-person 	http://scs.georgetown.edu/programs_nc/CE0120/patient-navigation?dID=39
Smith Center Integrative Patient Navigation Training	<ul style="list-style-type: none"> • In-person 	http://www.smithcenter.org/institute-for-integrative-oncology-navigation/our-training.html
Sonoma State University Health Navigator Certificate	<ul style="list-style-type: none"> • In-person • Online 	http://www.sonoma.edu/exed/health-navigator/
The Graduate Institute Certificate in Integrative Health Coaching and Patient Navigation	<ul style="list-style-type: none"> • In-person 	http://www.learn.edu/healthcoaching

Figure #2

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.
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 which evolved to the Office of CHW in 2008 which 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	<p>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.</p> <p>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.</p>

CRCCP Program Policy on Patient Navigation

Effective July 1, 2015

Tool 7.1

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.

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.

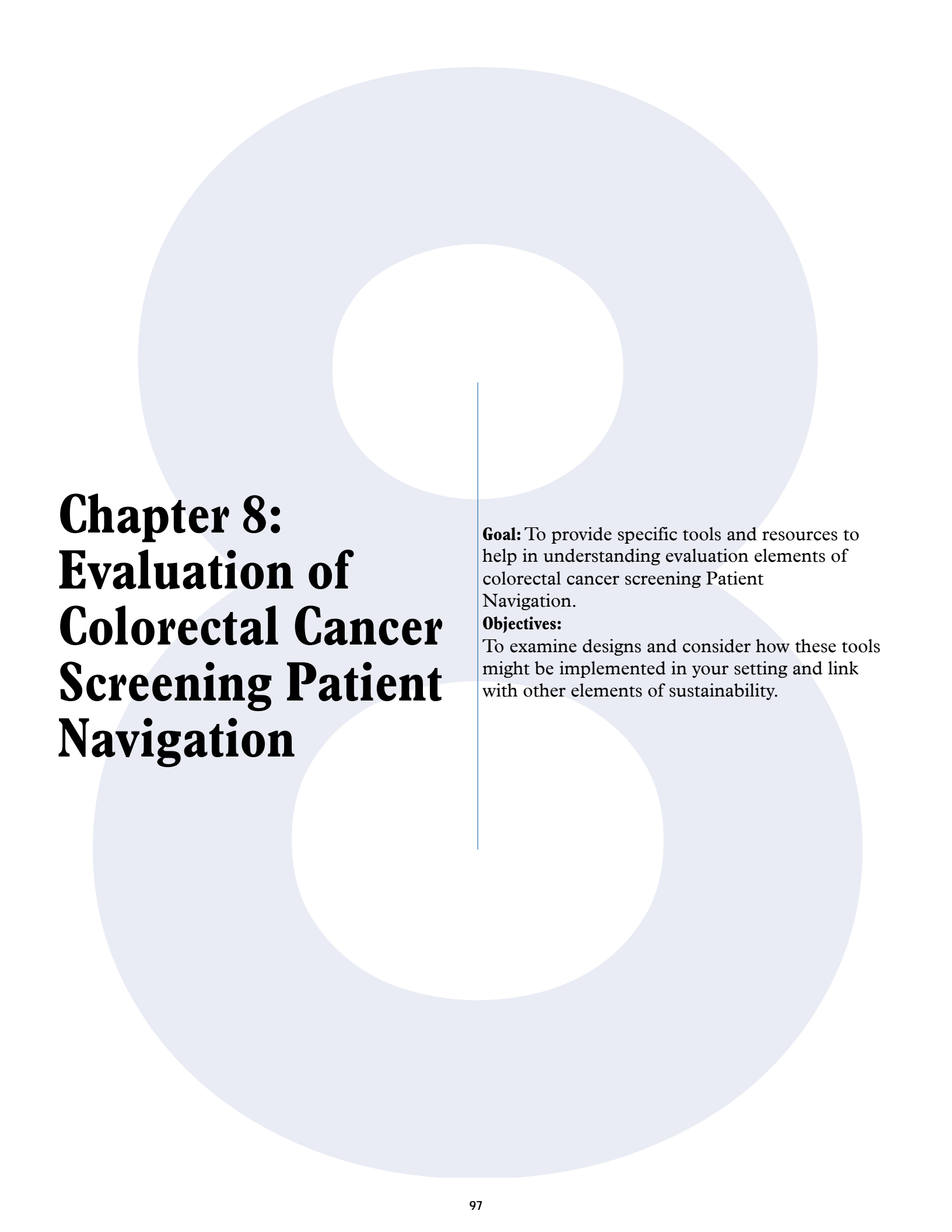
Signature below acknowledges that I have received a copy of my job description and my supervisor has discussed it with me.

Employee Signature

Date

Supervisor Signature

Date



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.

Objectives:

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

Background

The evaluation of Colorectal Cancer Screening Patient Navigation 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.



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 that patients do not show up or attend (or per year)/total number scheduled	<ul style="list-style-type: none"> • Schedulers • Medical Records/EMRs • IT professionals • Navigators • Providers 	Battaglia et al (2011)
Bowel Preparation Quality	Quality Index at time of colonoscopy from endoscopy reports	<ul style="list-style-type: none"> • GI Providers • IT professionals • Navigators 	Johnson et al (2014)
Successful Exam Completion	Number of exams completed/total number of exams started	<ul style="list-style-type: none"> • GI Providers • IT Professionals 	Battaglia et al (2011)
Patient Satisfaction with Navigation	Mean of summary score	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • Providers • Pathology labs • IT professionals 	Rex et al (2015)

II. Implementing Patient Navigation 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 navigation program, you should use a 3 year average to get the best estimate of the pre navigation for all rates
2. When comparing time periods, you should also account for the number of navigators. So for example, if you had 1 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

There are a variety of tools which have been developed to help those in the field design their colorectal cancer screening Patient Navigation evaluation.



These outcomes might be critical in examination of making the business case for colorectal cancer screening, as well as building a policy case for utilization of colorectal cancer screening Patient Navigation. 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 preventive screening navigation, but for those programs in the field—the following have been 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.

Navigation 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 Navigation	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, there were over ten articles published to develop common metrics for patient navigation. 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 colorectal cancer screening navigation, visit Chapter 3 and their toolkit to see how they have provided resources for evaluation.

In addition, the Colorectal Cancer Control Program has developed a specific policy that outlines the required Patient Navigation elements and activities, visit Chapter 7 to learn more about these components.

Thinking about your evaluation and planning how you will implement or augment 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 Patient Navigation evaluation.



<http://patientnavigatortraining.org/wp-content/uploads/2014/07/PN-Evaluation-Toolkit.pdf>

The Centers for Disease Control'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 implementing evaluation-tools that are used in programs implementing colorectal cancer screening? The Colorado Colorectal Screening Program Evaluation Component is available online. Check out Chapter 3 to learn more about Colorado's efforts.

<http://www.ucdenver.edu/academics/colleges/medicalschoo/centers/cancercenter/CommunityAndEducation/colorectal/patientnavigation/program-manual-pn-guidebook-and-forms/Documents/Chapter>

Tracking of your colorectal cancer screening Patient Navigation, and all Patient Navigation is important for process improvements, tracking outcomes and helping overcome barriers, check out the following tools to help you in your search:

Native American Cancer Research Corporation, Linda B and her team have created a robust Patient Navigation tracking databased. 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. Navigation 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.



Are you currently evaluating your colorectal cancer screening Patient Navigation outcomes?

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

Sources:

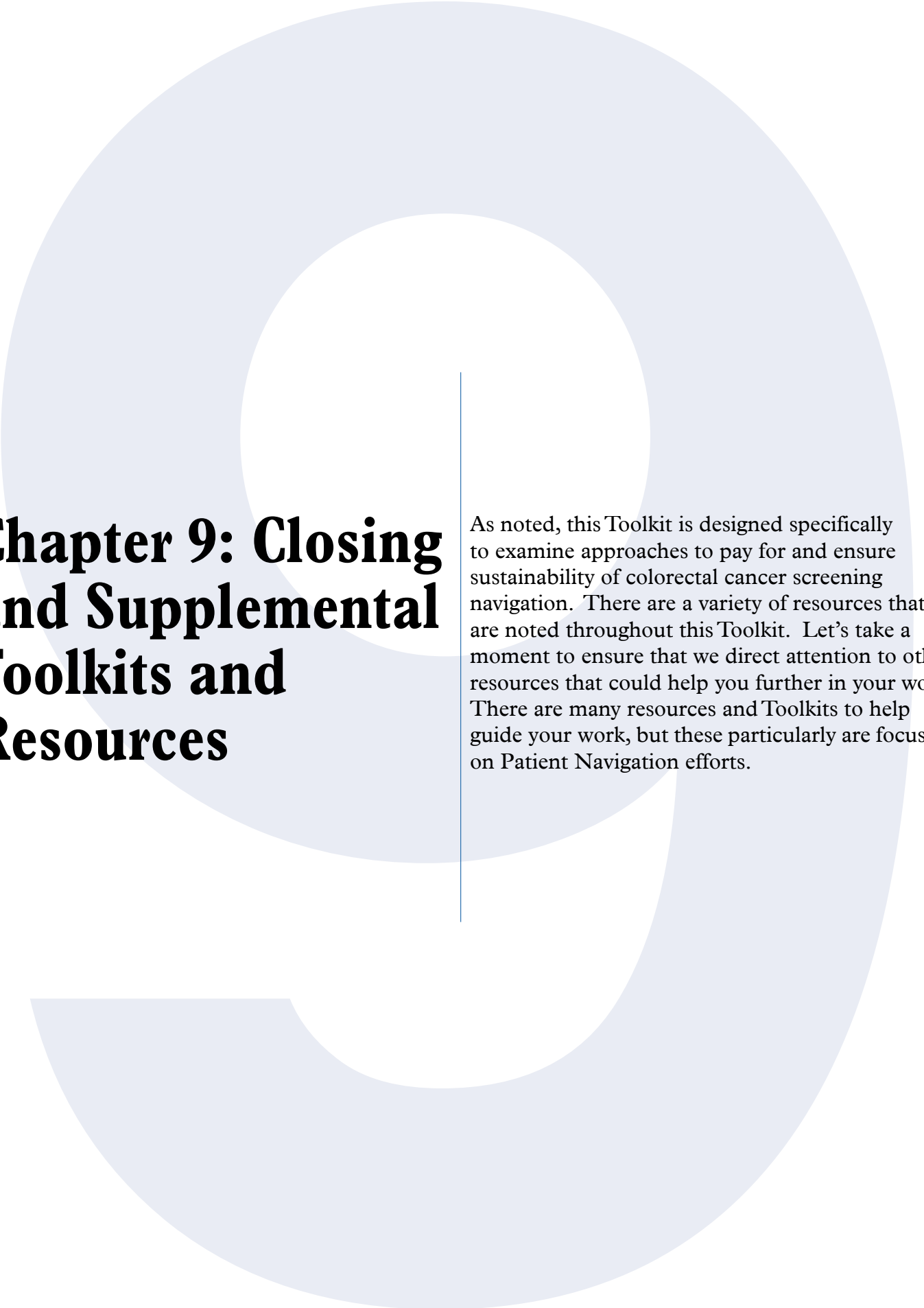
1. Assessing the impact of patient navigation Prevention and early detection metrics Tracy A. Battaglia MD, MPH1,II,*
Linda Burhansstipanov MSPH, DrPH2, Samantha S. Murrell MPH1, Andrea J. Dwyer BS3, and Sarah E. Caron MPH1 and

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 navigation. There are a variety of resources that are noted throughout this Toolkit. Let's take a moment to ensure that we direct attention to other resources that could help you further in your work. There are many resources and Toolkits to help guide your work, but these particularly are focused on Patient Navigation efforts.

The George Washington Cancer Center

The 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/survivorship/casnp>

The Avon and Boston Medical Center Patient Navigation Toolkit

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

<https://www.avonfoundation.org/causes/breast-cancer-crusade/patient-navigation-toolkit.html>

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/>

We need your feedback on the toolkit!

<https://www.surveymonkey.com/r/CRCPayPNTK>

Coming Soon!

Andi Dwyer blogging about experience in developing a cost analysis at the outset of the program for the next grant cycle of the Colorado Colorectal Screening Program.

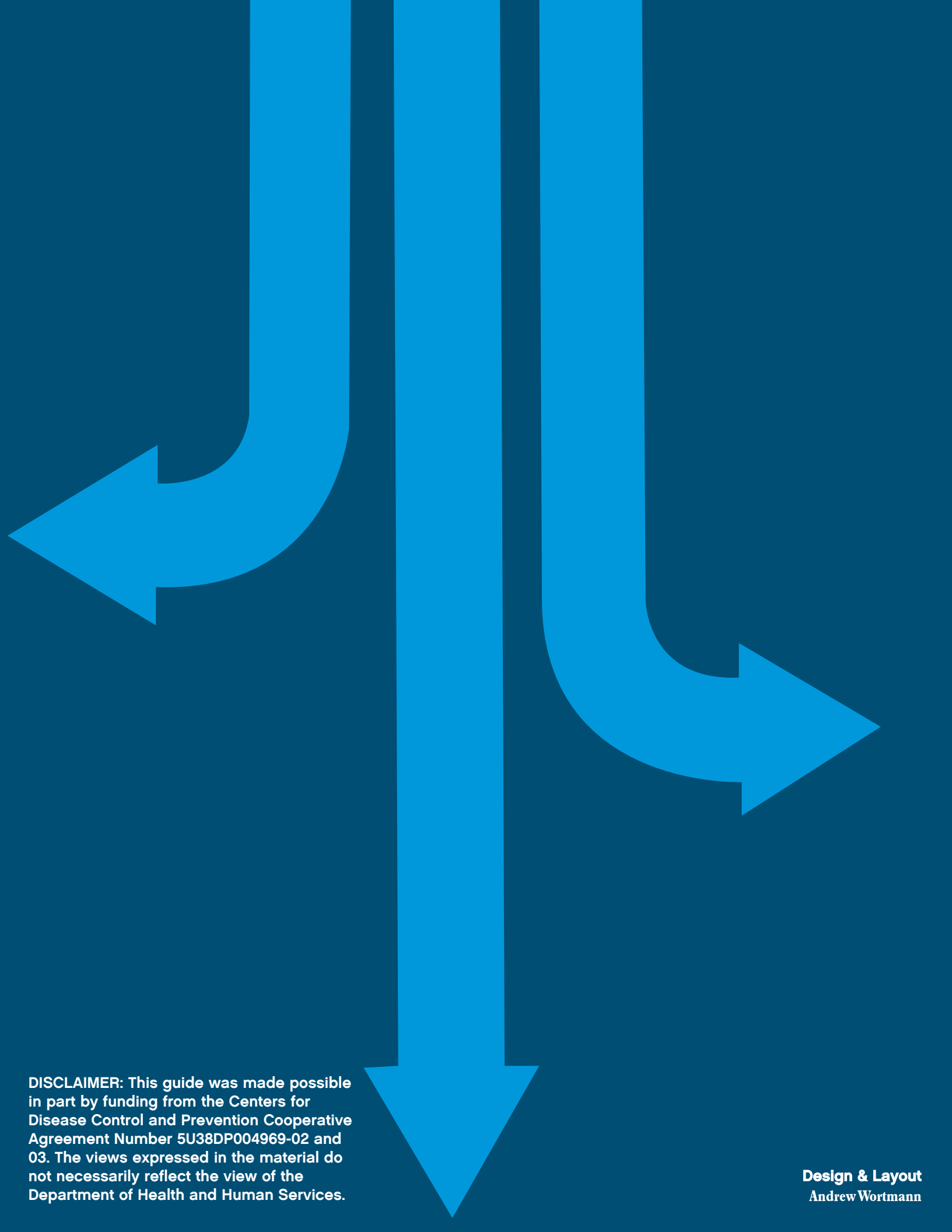
<http://pntoolkitresources.weebly.com/blog>

NCCRT exploring providing a toolkit for in-depth evaluation of Patient Navigation, step-by-step.

The intent is for this Toolkit to be updated as the science and the field in sustainability grows!

<http://nccrt.org/tools/>





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