No One Left Behind: The Road to 80% by 2018

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Vice President Hubert Humphrey once said “The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy, and the handicapped.” As gastroenterologists, we are dedicated to reducing the burden of colon cancer in this country by increasing screening rates to 80% by 2018. We will not reach that goal without attacking the problem of access to preventive care for those without adequate insurance. This month, Suzanne P. Lagarde, MD, MBA, FACP, a gastroenterologist and CEO of a large New Haven Federally Qualified Health Center, provides us with a “how-to manual” for providing colonoscopy to some of the most challenged patient populations.

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Despite widespread availability of colorectal cancer (CRC) screening techniques that are proven to reduce both incidence and mortality of CRC, colon cancer remains the second leading cause of cancer deaths in the United States. As reported by the Centers for Disease Control (CDC) in November 2013, only 65% of Americans are up-to-date on CRC screening, although rates of CRC screening among uninsured or underinsured people are significantly lower.1 The CDC has announced a goal of “80% by 2018”—an ambitious plan because a majority of patients not screened are minority, low-income, and historically uninsured. With the arrival of the Patient Protection and Affordable Care Act containing provisions for universal coverage of preventive screenings, some current barriers may be reduced,2 but numerous studies have underscored nonfinancial barriers to screening including factors such as lack of trust, language barriers, and health illiteracy that continue to play important roles in keeping screening rates at unacceptably low levels.

A growing body of published data supports the role of patient navigation in improving CRC screening rates.3 What has not been widely reported is what constitutes best practice in the field of CRC patient navigation.

As noted by Lee et al4 in the March 2013 issue of Clinical Gastroenterology and Hepatology, current trends in healthcare delivery are shifting away from fee-for-service reimbursements to a value-based system where providers will be rewarded for enhancing the health of “accountable” populations. CDC publications suggest that our chance of successfully achieving 80% by 2018 will be highly dependent on our ability to successfully engage the currently underserved population. Our challenge as medical professionals will be to help practicing gastroenterologists to overcome barriers, both financial and societal, and reduce the cancer burden among Medicaid and uninsured patient populations.

The Connecticut Experience

In 2008–2009, the Connecticut Department of Public Health funded a statewide screening colonoscopy program for the uninsured. Seventeen endoscopists were recruited from across the state, and patients were referred from 9 of Connecticut’s 13 federally qualified health centers. By using an open access model of screening colonoscopy and relying heavily on lay patient navigators (PNs), 263 screening colonoscopies were successfully completed during a 12-month span. Twenty-three patients failed to keep their appointments for an 8% “no-show” rate, which is well below national rates in comparable patient populations. Only 3 patients had a suboptimal bowel prep precluding effective screening.5

Abbreviations used in this paper: CDC, Centers for Disease Control; CRC, colorectal cancer; PN, patient navigator.
Before the start of the program, commitment for providing all immediate procedural and downstream services (anesthesia, pathology, and hospital-based services) was obtained from associated hospitals and professionals to manage the full spectrum of colon cancer prevention and potential treatments.

Free Screening Colonoscopy Program in Southern Connecticut

On the basis of lessons learned from the Connecticut-sponsored free screening colonoscopy program, the program was continued on a limited scale once funding from the state had stopped by recruiting providers to offer subsidized or pro bono care. One gastroenterology practice (Connecticut Gastroenterology Consultants, New Haven, CT) with 10 partners agreed to provide 10 free screening colonoscopies monthly or 1 “no cost” colonoscopy per gastroenterologist per month. Because this group of gastroenterologists performed approximately 1000 colonoscopies annually by each physician, their donated exams were 12 screening procedures for each physician or 1.2% of their overall volume. An ambulatory endoscopy center (Shoreline Endoscopy Center, Guilford, CT) jointly owned by Connecticut Gastroenterology Consultants and Yale New Haven Hospital, with capacity for 600–700 procedures per month, agreed to provide 10 free procedures/month or 1.6% of the total capacity. A private anesthesiology group employed by the ambulatory endoscopy center also donated services of its partners, and the surgical pathology department of Yale New Haven Hospital provided free processing and interpretation of pathology specimens.

Between May 2010 and May 2013, two hundred thirty-two “no cost” colonoscopies were performed on uninsured patients referred from 2 local federally qualified health centers. The overall no-show rate was 9%. Adenoma detection rate was 40%, and advanced adenoma detection rate was 5%. Suboptimal bowel prep requiring repeat examination was identified in 4 patients.

Lessons Learned

Because the program operated out of a single private gastroenterology practice, operational inefficiencies and problems were quickly identified. Not surprisingly, it became clear that the single event that most threatened the viability of the program was a no-show. No-shows were (often mistakenly) interpreted by participating gastroenterologists to be indicative of “failure” of the open access, heavily navigated program, and each patient who did not follow through with the procedure commitment threatened the ongoing participation by the private gastroenterology group. When systems were carefully scrutinized to identify factors that contributed to a no-show, it became clear that 3 factors were the most impactful contributors to the no-show rate.

1. Length of time between initial face-to-face visit with navigator and date of scheduled colonoscopy. When this interval period extended beyond 4 weeks, the no-show rate rose significantly.

2. The number of contacts, either face-to-face visits or phone calls, between navigator and patient. This number correlated directly with the probability of a patient arriving on time and well-prepped for a scheduled screening colonoscopy appointment.

3. Lack of contact in the week preceding the scheduled colonoscopy. When communication between navigator and patient failed to occur during the 7 days before the scheduled appointment, there was a significantly greater risk of no-show.

The second most common complaint from participating gastroenterologists was inadequate and/or inaccurate patient information around the medication list and the indications for the screening. Missing or inaccurate information about medications, in particular antiplatelet agents, diabetes medications, and anti-hypertensive therapy, was deemed to be a significant barrier to safe medical care. Similarly, occasional patients arrived prepped for a colonoscopy, and it was discovered that indications for the procedure did not comply with current guidelines.

By the end of the first year of the program, these problems had been identified, changes were implemented, and outcomes were tracked.

Best Practices

On the basis of our experiences with the No Cost Colonoscopy program for screening of uninsured Connecticut patients, we would offer the following recommendations for sites considering adoption of a similar program. The recommendations run across 3 broad categories: provider engagement, guidelines, and navigator training.

Engagement of providers. To engage providers, one must demonstrate that the financial impact on their individual practices is minimal and the gain in CRC prevention is substantial. Acceptance of the program by providers, including gastroenterologists, anesthesiologists, pathologists, and the endoscopy center, was accomplished easily once we quantified the financial
impact on each participant as compared with their annual production. Continued participation in the program by providers required close attention to factors that contributed to poor patient compliance: no-shows and poor bowel preparations.

We quickly determined that when open lines of communication between providers and navigators were maintained, we were able to resolve problems when they arose. Providers need to understand that PNs are an integral part of the medical team. As coordination of care becomes increasingly important and rewarded via alternative payment methodologies, the importance of PNs on the healthcare team becomes increasingly clear.

Guidelines. Table 1 lists key features essential to a successful program of CRC screening in an underserved population. Guidelines are reinforced by use of checklists (Figure 1).

Navigator training. For this program to be effective, PNs must be trained and supervised closely by a physician champion. In the Connecticut program, we partnered with a local community college to create a training program for PNs. The certificate program consists of 20 hours of didactic instruction coupled with another 20 hours of shadowing. Although the overall content of training focuses on generic patient navigation, the college also offers modules focused on a particular disease or disease group. We have created a CRC screening module that reviews topics such as CRC, bowel preps, and checklists (available on request by the author). Plans are underway to supplement in-person lectures with on-line training.

The Road Ahead

What lies ahead will very much depend on the speed with which healthcare reimbursement shifts from fee-for-service to value-based payment. Although the model put forth in this article has been shown to be effective, we believe that its scalability will be favorably impacted when payers incorporate value into reimbursement. Current Medicaid reimbursement in Connecticut for screening colonoscopy is virtually identical to Medicare reimbursement, yet access for Medicare patients is easier than access for Medicaid patients. Clearly, factors other than reimbursement rates impact the ease that underserved populations gain access to screening colonoscopy. In addition, up to 25% of the underserved population in need of CRC screening are undocumented immigrants who to date have had added barriers to basic healthcare and thus are at increased risk to develop CRC and other potentially preventable diseases. Patient navigation provides the value to overcome procedural barriers such as inadequate bowel preparation and completion of appointments. Unfortunately, services provided by PNs are not reimbursed in Connecticut and most other states. Despite published data demonstrating the benefit of CRC screening and prevention, process barriers continue to compromise our nation’s stated commitment to reduce CRC annual incidence and death.

On the basis of our experience during the past 3 years, it is clear that with rigorous patient navigation,
uninsured patients from lower socioeconomic backgrounds can be motivated to accept the importance of CRC screening and be successfully supported throughout the multistage and difficult process of colonoscopy preparation and procedure. Although it seems likely that a similar program can be used successfully in a Medicaid population, this remains to be demonstrated.

The program outlined in this article has outlined a best (and successful) practice that uses patient navigation to enhance results for colonoscopy-based CRC screening. A number of other programs in the country have used this model or other CRC screening modalities (including fecal immunochemical testing based screening) to provide needed preventive services to populations challenged by financial and access barriers to healthcare—something that most of us take for granted. We have learned that the biggest threat to sustaining a CRC screening program for underserved populations is a no-show. It is critical to put in place measures that maximize the likelihood that a patient referred for screening colonoscopy will in fact keep the appointment. Using checklists and trained PNs who have ongoing supervision appears to be critical for a successful program to deliver needed services.

As the healthcare of the United States evolves into a more cost-effective and higher-quality delivery system, population health management and payment methodologies will change in ways that will challenge traditional gastroenterology practices. It falls to us to ensure that our patients receive the quality care that we believe should be a fundamental human right irrespective of social status. The current goal of 80% by 2018 CRC screening is achievable if, and only if, we can engage significant numbers of low-income, underserved patients to understand the lifesaving impact of CRC screening and help them navigate the significant barriers to successful preventive care. Engaging a cadre of well-trained, highly supervised, accountable PNs in the effort will bring us closer to our vision.

References

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Conflicts of interest
The author discloses no conflicts.