Patient Navigation: A Catalyst for Quality Improvement in Cancer Screening

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Background

Cancer remains a focus area for improvement in Washington, D.C. DC's Healthy People 2020 plan included goals to increase early detection for all cancers and to reduce racial gaps in cancer incidence and death rates. In 2014, only 23% of eligible patients seen at District FQHCs were screened for colorectal cancer (HRSA UDS). To improve access to cancer screenings and treatment for breast and colorectal cancers, DC Primary Care Association (DCPCA) developed a health-center-based patient-navigation program that leverages federal, state, and private partnerships to drive quality improvement.

Goals

DCPCA, in partnership with MedStar Georgetown University Hospital, sought to create an evidence-based intervention to improve access to cancer screenings.

Our goal was to **increase screening rates for breast and colorectal cancers** for patients seen at community health centers in Wards 5, 6, and 8, using a clinic-based patient-navigation strategy.

Methods

In Fall 2016, DCPCA hired two full-time Patient Navigators, who are each based in a DCPCA-affiliated FQHC.

- **Community of Hope (COH):** FQHC in Wards 5 and 8 serving **10,800 patients** annually. Navigator began in **January 2017.**
- **Bread for the City (BFC):** FQHC in Ward 6 serving **2,700 patients** annually. Navigator began in **September 2016.**
- 75% of patients have incomes below the federal poverty line.

Navigators provide the following comprehensive support to patients to access cancer screening, diagnostics, and treatment:

- Scheduling and attending appointments for cancer screenings, diagnostic testing, and treatment.
- Assessing barriers to care (e.g., transportation, language, insurance) and coordinating support services.
- Communicating with patients to educate and to reduce anxiety.
- Ensuring that all patients receive their screening results and that the reports are documented in the EHR.
- Helping patients with cancer diagnoses transition into treatment.
- Working with clinical staff to improve workflows.

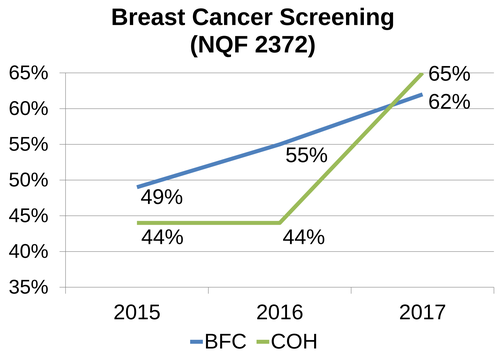
Results (Part 1)

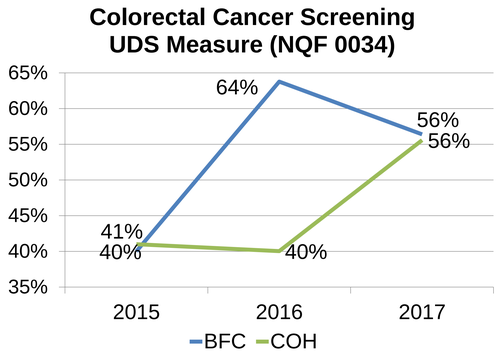
Provision of navigation services to patients, far exceeding target of 500 patients per year.

- Between October 1, 2016 and December 31, 2017, two navigators provided navigation services to **1,623 patients**, representing 2,007 cases. "Cases" are unique referrals for screening (breast or colorectal).

Improved cancer screening rates.

- 61% of patients referred to the navigators received a screening *and* the result was received.
- Between 2015 and 2017, breast cancer screening rates for the clinic population **increased by 48% at COH and by 27% at BFC.**





- Between 2015 and 2017, colorectal cancer screening rates for the clinic population **increased by 36% at COH and by 41% at BFC.** The rate decreased by 12% between 2016 and 2017 at BFC. HRSA UDS measure specifications define up-to-date as up-to-date by the end of the calendar year. This definition is a strict criterion for screenings done via FIT, which requires re-testing after one year. The chart below shows the percentage of patients up-to-date *by the time of their most recent visits*.
- Navigators monitor screening rates on an ongoing basis, communicate results to staff, and adjust interventions as needed, as was done with a revised process for returning FIT samples.

Colorectal Cancer Screening Measure Dashboard - BFC

2015				2016				2017			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
56%	51%	50%	58%	61%	64%	65%	73%	69%	68%	71%	65%
				^ CRC QI Project			^ Navigation begins. Request old records.			Failed intervention: Mailing FIT	^

Results (Part 2)

Creation of new, clinic-based screening workflows, using best practices from cancer-focused private facilities, national bodies, and other navigators in DC.

- Navigators established daily screening-and-follow-up workflows for the clinic. Navigators also worked collaboratively to develop an EHR-based system that allows for documentation of navigation activities, to monitor progress and impact.

Identification of key challenges in the health care system that present barriers to effective cancer screening.

- **Information exchange:** An estimated 75% of colorectal cancer screening results and 10% of breast cancer screening results are not received automatically, either by fax or within the HIE. Navigators must call referral facilities to request records. This results in lapses in care, delayed care, and inaccurate reporting.
- **Transportation**: Through documentation of barriers to care, transportation cost and convenience were identified as key issues for patients. Despite the perceived availability of reduced-cost transportation, this challenge remains a barrier.
- DCPCA is working with government agencies, providers, and HIE leaders to develop a sustainable solution to these challenges.

Conclusion

By leveraging the resources and strategic partnerships of a PCA, clinic-based patient navigators become *catalysts* for system-wide improvements to cancer screening and access to treatment.

As next steps:

- Hire a third navigator to be placed at an additional FQHC.
- Address non-clinical barriers, particularly transportation.
- Improve information exchange for cancer screening results.
- Advance data analytics in EHR and drive improvement.
- Continue to support patients on their paths to health!