NCCRT Steering Committee Visit
Baltimore Medical System Notes
Wednesday, July 25, 2007

Meeting Goal: The purpose of the visit was to help the National Colorectal Cancer Roundtable (NCCRT) to get a better understanding of issues faced at the local level in delivering CRC screening. This is the first of a series of visits to advance the Roundtable's understanding of real world barriers and real world solutions in screening delivery at the local level in order to identify research areas that need additional Roundtable attention and identify practical interventions that can be promoted among NCCRT members.

Summary:

The visit to Baltimore Medical Systems, a Federally Qualified Health Center serving over 42,000 patients in Baltimore City and Baltimore County, illustrated several challenges faced in delivering colorectal cancer screening at the local level. Key issues are health literacy, accountability (ie who is responsible for ensuring a patient is aware of a positive result), the completion of referrals (providers with sliding pay scales changes constantly), copays as a barrier, transportation barriers, the difficulty of data tracking, the performance of in office FOBTs, and the ease of securing mammograms vs. the struggle with getting colonoscopies.

NCCRT also wants to follow up on several key ideas:

1. Tracking key indicators
2. Inviting the National Assn. of County and City Health Officials (NACCHO) and the Assn of Clinicians for the Underserved to serve as Roundtable Members
3. Exploring FIT as a screening option at BMS
4. Follow up on data around copays as a barrier (JHU)
5. Ensuring that there is a "Cheat Sheet" version of the CRC Clinician's Guide
6. Seeing if NCCRT members have Low Literacy Level materials to share and post on www.nccrt.org

Opening:

Dr. Weber opened by expressing the Roundtable's desire to be realistically informed.

-What are the problems specific to Baltimore?
-What can NCCRT do?
-NCCRT needs to better understand populations, disparities, etc.

Dr. Smith shared that public health is something that needs to be confronted at the local level. What can NCCRT do to make your work easier?

BMS Overview

Dr. Rhee talked about the important role that community health centers play in providing cost effective care in the community. They play a crucial role in addressing health disparities and place an emphasis on screening and prevention. Their screening rates exceed those of the general population. They face a constant challenge of delivering care with operations budget of less than 1%. Collaborations are crucial to their success.

They are a Federally Qualified Health Center, so they receive federal funding by meeting five qualifications: located in a high need area, provide comprehensive health care, open to all residents, governed by a community board (patients/users of facilities), and follow performance and accountability requirements. This also gives them certain advantages, such as being protected from malpractice and access to discounted drugs.

Specifically with respect to CRC screening, some of the challenges are health disparities, systems issues (particularly those without a health care home), provider-level issues (cultural disconnect, lack of guideline awareness, lack of time for in depth discussions with patients and lack of time to follow through with referrals), and patient-level issues (poor literacy and mistrust).

Solutions include: collaborations, a CRC "movement," access to health care "homes," cultural competency, community health workers, team approach, info systems, P4P, support/reimbursement for nontraditional encounters and low literate, culturally appropriate materials.

Key Issue Discussion:

Health Literacy

Dr Rhee stressed the problem of health literacy. Colonoscopy is expensive, but there are challenges ensuring FOBTs are done correctly. BMS faces a constant pressure to do whatever they can do to be more cost effective. Almost all providers are doing FOBT or colos. (Flex sigs seem to be on the way out.)

Meseret Bezuneh with the University of Maryland School of Medicine also stressed the need for low literacy materials and the need to keep things simple. Many patients operate on a 3rd grade reading level; many materials are at an 11th grade reading level and won't be used. Washington, Grant and Mack also seconded the problem of FOBTs being done incorrectly.

A low literacy CRC specific piece would be helpful, particularly low literacy level FOBT directions. Most households do have DVDs and a growing number have access to the internet. Can the Roundtable help find low literacy materials that have already been developed? Preferred means of outreach messages: television, radio, audio/visual, though there is not a lot of money for radio and tv promos

Logistic/Cost Issues

Washington, Grant and Mack talked about barriers to screening, such as transportation, childcare, eldercare, and costs and the difficulty of securing care on front lines. They try to find providers who offer sliding fees, but this is securing care by the ones and can change at any moment. There are also strong cultural barriers; many individuals do not speak English. Also, a patient may have to go all the way across town to find a provider with a sliding scale, so this raises transportation, child care and elder care issues.

They also compared the ease of securing mammograms with the difficulty in securing CRC screening. They can tap Avon, Komen, CDC and CRF for breast cancer screening; CRC is much more limited. Some places offer same-day diagnostic mammograms, which takes away a barrier.

Mollie Howerton described the JHU intervention to target African Americans 65 or older living in Baltimore City to test the efficacy of community health workers to that of a less intensive intervention in adherence to several cancer screening tests, including CRC. She talked about the barrier of the 20% copay for those in the population (20%) on a fixed income. Electricity and gas bills have gone up substantially – they will have to see how those affect health care choices. There is also a great difference in cost for hospital based care and tests conducted in a doctor's office that create differences in the copay. Mollie has data on how copays are a barrier that she is willing to share.

The policy mechanisms of reimbursement are tricky. Providers do not give upfront estimates of patient cost, because if a screening tests turns into a diagnostic test, the patient's responsibility can jump. If one person has a bad experience and gets a colonoscopy with $600 bill, then none of their friends will get screened.

Additional cost barriers arise because some doctors require pre-screening tests, such as EKGs, blood work, or they want to see the patient, though the literature shows these are not necessary. This patient population may have other illnesses or they may be drug users, which makes it more complicated to ensure that prep is right. There are certain issues that must be taken into account for diabetics. Nurses are helpful at working through these issues.

Need for Screening Messages to Come from Community

Washington, Grant and Mack stressed the need to have representatives of the community to get messages out to the public. Morgan Freeman, Denzel Washington type of person for a radio announcement/PSA works to reach African American community. They do not have a lot of money for recruitment workers, but "Follow up, follow up, follow up" is key to success. They've also had good success working with churches in the same neighborhoods as the community health centers with a "whole body" message. Family members and neighbors begin to hear the messages.

Both patient incentives and community health worker incentives could help. They've educated over 250,000 people with one on one interventions (You have to talk to people at the health fare, not just go to the health fare). Males are more challenging than females. One outreach effort that is effective is getting help from patients who are already educated.

Bo Aldige shared that CRPF may have grant money to help. Erica Childs is the contact at CRPF. The goal of the Cancer Prevention and Early Detection Community Grants Program is to support education or services in cancer prevention and early detection, especially to underserved communities, across the United States. They have small grants, typically in the amount of $15,000 (though they can be more) that can be used to hire community workers to help communities with cancer screening. The program has one funding cycle per year, with two types of awards: one-year development grants and two-year enhancement grants.

Marian Krauskopf talked about some successes that C5 had in NY. They introduced a screening navigator program. For a $35,000 investment in an outreach worker, one hospital saw a $300,000 return in both reduced no shows and improved prep. NYC initiatives have contributed to reducing racial disparities. In NYC African Americans and Caucasians have almost equal colonoscopy screening rates. Asian and Latino rates have increased as well. Screening rates have increased from 42% of eligible New Yorkers 50 and over in 2003 to almost 69% in 2006. The group discussed the benefit of screening navigators. They help connect the dots for people to navigate our fragmented health care system. People need coaching to help them get through the system.

Baltimore has had success with their automated phone reminder system that targets patients over 50 who are due for screening. System is very cost effective. Typically, about 10% of those called, make an appointment. They check one month out to see if appointment was kept. Could increase this part of the intervention. Total intervention costs are about $25,000 for outreach, screening, phone calls, staff time and incentives.

Best Practices must be Community Specific

Currently, outreach training comes from conferences, but every community is different and must be tailored to local needs. What works for Harold Freeman in NY, won't necessarily work for Baltimore. There are local issues, and workers need to know the target screening population. For example, the CMS study looks at Baltimore city-wide, but East Baltimore and West Baltimore have different issues.

Sustainability/awareness/nuances of Grants

David Silver shared that he mostly treats a geriatric population. He seems to being seeing progress. He can ask, "When was your last colonoscopy," not "Have you ever had one?" They also seem to be seeing fewer cases of CRC in the mortality reports. There are some issues with communication and being sure that those in need have access to the few

services available. Those at the frontline may not be aware of all the grants out there. The biggest frontline frustration is the lack of money.

Hutchison talked about how the sustainability of a program is very important. Often because of funding issues, programs will be eliminated just as the community has begun to trust the program. When margins are so slim, loosing one grant can be devastating and makes it hard to plan.

Diane Dwyer discussed the MD screening program and shared statistics. The statewide program is funded by Maryland's cigarette restitution fund. Baltimore receives funding through the CDC demo. It's a health care success story. Having a health care home (community health centers) has been important to their success. They've screened over 14,000 individuals, though many more are eligible. She stressed the need for patient management; colonoscopy is a complicated procedure and there is the need for proper prep and post colonoscopy instructions.

In addition, she cautioned that under the CDC screening demonstration program, those with a positive FIT/FOBT are not eligible for a colonoscopy under the CDC demo. People who are positive would have to get their colonoscopies outside of the reimbursement program. This is one of the CDC rules for eligibility, not Baltimore's. Also, some doctors like to be more aggressive than the National Guidelines. If a doc wants more aggressive follow up, they have to send a letter saying that your doctor may want this, but the CDC won't pay for it. In some instances, what will be paid for also varies by grant. The CRF will pay for a treadmill test, but the CDC won't. There also may be fees associated with post-screening care. On the plus side, they've been able to demonstrate that you can take funds and build a successful program. On the other hand, there is a certain amount of angst about the CDC demo. What will happen when the demo is over? Even the B&C program took a hit this year.

Accountability

There are some real world communication issues between PCs and gastros. Who has the responsibility? If a colonoscopy is not completed or a polyp not tattooed, how should the case be managed and who should follow up with the patient? If a chart is flagged, who is responsible for following up? Staff may be aware of incomplete tests, or incorrect procedures, but are in an uncomfortable position. They have medical knowledge in a different way than doctors do. This is a national issue.

Pay for Performance is also useful. There is a slightly different approach in that incentives go to teams, not just physicians. Recommendations don't have to solely come from physicians. They do not have EMR data on how effective this is as of yet. While BMS is moving to EMR, only 8% of CHCs have them. They do use their EMR to collect data, but cautioned that providers must balance many other demands, and this is secondary to delivery of care. This makes research harder. They have looked at measures that focus on processes and are now shifting to outcomes. Realistically, they do

not deliver patient-centered care. Providers must do a lot in the shortest amount of time possible.

FIT

Smith talked about some of the challenges with screening. With virtual colonoscopies, you face the difficult decision of ignoring small polyps. It's a hard decision, as lesions are often measured incorrectly, but with every polypectomy comes the risk of perforation. It also does quite well in a center of excellence, but it's unclear how well it will do in the real world. Some doctors don't like that there is a permanent record of the screen. FIT may be a good option. It's a more expensive test, but prep is easier and you only need two samples. Dr. Rhee agreed that FIT is an interesting option to explore. There is the challenge of sending the test outside of the system for reading. They like to keep costs down by keeping things in the health care "home." Dr. Rhee talked about how many docs in BMS conduct in-office FOBT, even though that may been an empty exercise. Docs are constantly weighing the pressure to do more with less. ACS conducted a study with Lewin that showed colos and FOBTs could be performed for less than 60 cents pmpm costs; however, this did not include costs of outreach. It would be interesting to see how much cost of outreach increases the cost of FOBT.

Rhee talked about how they only get 20-30% of FOBT results back. There is no reimbursement for cards that are not returned. There is a sliding charge for readings. If the focus is on getting FOBTs for 10,000 patients; 1,200 have positive FOBT. They will need 1,200 colonoscopies. They find it better to push resources for 1,200 colonoscopies instead of 10,000. The colos could not be funded through the CDC, but perhaps through academic institutions.

Academia funding vs. Community Funding

They wrestle with funding issues in Baltimore. Funding often goes to academic institutions, and then is subcontracted to community health centers to reach patients. Community is reluctant to use JHU even though it is right next store because of lack of trust and communication issues. Howerton mentioned that the CMS grant initially proposed funding for outreach, but the funding was eventually cut.

Tour of the Belair-Edison Family Health Center

The group toured Belair-Edison Family Health Center, led by Dr. Erica Isles. The center is one of BMS's seven full-service primary care health centers, where they offer Internal Medicine (adults), Pediatrics, Family Practice (all ages), and OB/GYN services. Each site is different. The center serves patients on a sliding scale and work with an "in house" radiology facility, pharmacy and lab. 80% of revenue comes from visits. They've consciously worked to create the atmosphere of a quality health care facility.

This particular site converted to EMR over a year ago. The transition was time consuming, but providers are beginning to see the benefit in both care, ease of follow-up

and the amount of space freed up from the physical presence of records. Provider buy-in was important for "culture shift." New patients do not have patient charts. Old records are scanned in. The conversion to EMR was a big investment, particularly given how tight their operating costs are. It was about a million to start up and $250,000 to maintain. Screening reminders show up on the screen (there is a preventive health maintenance section), as well as flags about allergies, recent immunizations, cardiology referrals, language spoken, etc. At some point, the lab, radiology and pharmacy will be able to interface with EMR system.

The facility includes 23 rooms, 8 clinicians, 2 nurse practitioners, and has ob/gyn 3 days a week and a general surgeon every other week. Patients are on Medicaid, insured or uninsured. The facility also has a Health Benefits Managers who work with patients to secure care. They issue 92,000 referrals a year. It is difficult to follow up to make sure those happen, and it is on the patient to make the appointment. Can do same day, referrals, but is the exception. When GIs do the report, it's scanned in so the doctor can see it within 24 hours. If it's not completed, doctor can talk with patient about why not. The physician then determines when the next screening should be. With GIs, they typically don't take a sliding scale and some don't have payment plans. Transportation is also an issue. For patients without insurance, BMS tries to make patients aware of city and state screening programs.

The new technologies allows BMS to do a report showing who of their over 50 population has had CRC screening. Their project for the summer is to track outcomes. There is some issue of accountability that was discussed earlier in the day. GIs are supposed to notify the PCP if there is a serious issue, but they do not always do that (try to call once, don't call again). Ultimately, BMS needs to "own" it. Not sure why, but many providers moved to in-office FOBT a few years ago, likely because it was hard to make sure that patients followed up on referrals.

Closing Discussion Session

Key issues of importance:

- financial and logistical issues
  -transportation
  -childcare, eldercare
  -copays
  -difficulty in telling patients costs upfront
- ease of mammography delivery vs. colonoscopy
- benefit of navigators, community-based outreach workers
- health literacy
- accountability
- in office FOBT
- difficulty of tracking data in underserved areas, given provider time and financial pressures

Possible new partners for NCCRT:

- National Association of Community Health Centers (NACHC)
  -lobbying organization, worked on SCHIP bill
  -community health centers need to work together

- Association of Clinicians for the Underserved (ACU) www.clinicians.org
  -focus on issues of importance to these clinicians
  -Rhee is a board member
  -*Journal for Healthcare of Underserved*

- HRSA

Possible next steps for NCCRT to explore:

- assist with sharing best practice (telephone reminder system); must be tailored to community
- assist with sharing low literacy materials
- explore case patient/outreach worker incentives
- explore immunochemical tests for colorectal cancer (FIT) as an option for BMS
  -research to see that this is cost effective as opposed to FOBT
  -other partners?
- Clinicians Toolkit:
  -possibly have longer version online, shorter print version for physicians
  -create simple laminated tool kit, one page card for frontline physicians
- Identify specific CRC measures; better way for data for research and P4P measures
- share ACS patient education DVDs; could Quest send out?
- share online CME for physicians
- ACS is focusing attention on research funding for the underserved; funding option for BMS?
- Share copay barrier data from JHU
- Reach out to potential new partners