

Clinical Directors Network (CDN)

Implementing Patient Navigator Programs in Medicaid Health Plans To Increase Colorectal Cancer Early Detection





CLINICAL DIRECTORS NETWORK


www.CDNetwork.org
www.eClinician.org

Implementing Patient Navigator Programs in Medicaid Health Plans To Increase Colorectal Cancer Early Detection
Jonathan N. Tobin, Ph.D.
PRESIDENT/CEO
CLINICAL DIRECTORS NETWORK (CDN)
DIRECTOR OF EDUCATION & TRAINING
INSTITUTE FOR PUBLIC HEALTH SCIENCES
YESHIVA UNIVERSITY
PROFESSOR OF HEALTH PSYCHOLOGY
ASSOCIATE PROFESSOR
OF CLINICAL EPIDEMIOLOGY
DEPARTMENT OF EPIDEMIOLOGY &
POPULATION HEALTH
ALBERT EINSTEIN COLLEGE OF MEDICINE
OF YESHIVA UNIVERSITY

**5th Annual C5 Summit
Eliminating Barriers to Colonoscopy
Screening in New York
New York, NY
June 5, 2008**




**Clinical
Directors
Network**
**A Practice-based
Research
Network
(PBRN)**



www.CDNetwork.org

**CDN:
Past, Present & Future**

- An informal network of clinical leaders who practice as primary care clinicians in low-income and minority communities
- A research and educational organization
- A means to translate clinical research into clinical practice



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JONATHAN N. TOBIN, Ph.D.
CLINICAL DIRECTORS NETWORK, INC.
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CDN's Primary Activities

- Practice-based Research
- Education and Training
- Professional Development

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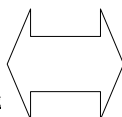
CDN'S RESEARCH PORTFOLIO → MIXED MODEL	
HIV/AIDS	NIAID, NIMH, HRSA, AmFAR, BMS, DMP, Roche
CANCER CONTROL	NCI AHCPR
DEPRESSION	NIDA, SAMHSA,
STRESS MANAGEMENT	NIMH
HYPERTENSION	NHLBI
DIABETES	HRSA
IMMUNIZATIONS	CDC, HRSA, Pharma
MIGRAINE/HEADACHE	Merck
ANEMIA	Ortho Biotech
ASTHMA	EPA, DEP, HRSA
HPV	NYC DOHMH
TEENSCREEN	Columbia University
PALLIATIVE CARE	NCI
NUTRITION/PHYS. ACTIV.	RWJ, NYS Atty Gen
PERIODONTAL DISEASE	NIDCR
GENETICS	March of Dimes
PREGNANCY/PRENATAL	NIMH

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ACADEMIC PARTNERS & PROJECTS

- YALE SCHOOL OF PUBLIC HEALTH
- DARTMOUTH MEDICAL SCHOOL
- COLUMBIA UNIVERSITY
 - College of Physicians and Surgeons (P&S)
 - Mailman School Of Public Health (MSPH)
- RAND CORP & UCLA
- UNIVERSITY OF MICHIGAN
 - School of Dental & Oral Surgery
 - School of Public Health
- UNIVERSITY OF MIAMI
 - Miller School Of Medicine
- Centering Pregnancy (NIMH)
- Cancer Control (NCI)
- Hypertension in African Americans; BP Adherence (NHLBI)
- Cancer Caregiver Support (NCI)
- A Web-based Rx Support Tool for HIV (HRSA)
- PTSD Among Refugees (NIMH)
- Periodontal/Diabetes (NIDCR)
- Stress Management/HIV (NIMH)

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CDN RECRUITMENT EXPERIENCE 1992-Present

52,465 Patients enrolled

69 % Female

49 % African-American

34 % Latino/a

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Training: Conferences, In-Services & Webcasts = ONSITE & ONLINE

WELCOME TO CDN
 Clinical Directors Network, Inc. (CDN) is a not-for-profit network of primary care clinicians in Community Health and Health Centers. CDN's mission is to provide and improve comprehensive and accessible community-oriented primary and preventive health care services for poor, minority, and underserved populations. CDN's overall goal is the translation of clinical research into clinical practice, now.

RESEARCH
 CDN is the only practice-based research network in the USA devoted to providing primary care and research opportunities to medically underserved populations. [more>](#)

UPCOMING WEBCASTS
Hypertension: Monitoring and Medication Adherence
 Presented by: George Ogedegbe, MD, MPH, MG
 Columbia University College of Physicians & Surgeons
 Wednesday, March 08, 2006 1:00 PM
[more>](#)

WEBCAST LIBRARY

<ul style="list-style-type: none"> Asthma Diabetes/Disaster Planning Cardiovascular Disease/Prevention Clinical Leadership Dental/Oral Medicine Geriatric Medicine WOUNDS Infectious Diseases Meet the Author 	<ul style="list-style-type: none"> Adolescent Health Cancer Prevention and Early Detection Clinical Informatics Clinical Research Training Depression/Mental Health Diabetes/Prevention Health Disparities Collaborative Immunizations Minority Health
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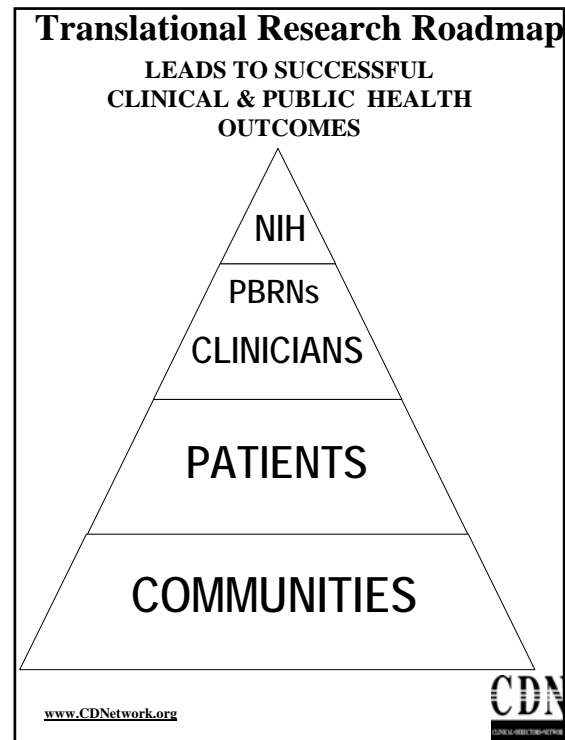
[Click here for other Webcast Categories \(page 2\)](#)

WHAT WE DO

- Office Systems Consultation
- Educational and Training Activities

BECOME A CDN MEMBER
 In order to encourage and support current and future Clinical Leaders, CDN membership is open to all primary health professionals in health care facilities in New York, New Jersey, Puerto Rico, the US Virgin Islands, and

www.CDNetwork.org/webcast_library.html
CME accredited through AAFP



Patient Navigator Overview

IAF Institute for Alternative Futures

THE DRA PROJECT
Accelerating Disparity Reducing Advances

Source: Institute for Alternative Futures – Disparity Reducing Advances (DRA) Project – See www.altfutures.com

Patient Navigation

- **Patient Navigators help patients navigate the health care system**
- **Services provided:**
 - Facilitating communication among patients, family members, survivors and health care providers
 - Coordinating care among providers
 - Arranging financial support and assisting with paperwork
 - Arranging transportation and child care
 - Facilitating follow-up appointments
 - Community outreach
 - Ensuring that appropriate medical records are available at appointments
 - Ensuring access to clinical trials

Source: Institute for Alternative Futures, Patient Navigator Program Report, April 13, 2007

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Evolution of Patient Navigator Programs

- American Cancer Society (ACS) introduced the first Patient Navigator program (1990) in conjunction with Dr. Harold Freeman for cancer patients.
- Launched Patient Navigator program (2005). There are currently 60 ACS programs in the U.S.
- Received \$10 million gift from AstraZeneca to expand the Patient Navigator program (2007)
- National Cancer Institute (NCI) provided funding (2002) to evaluate the efficacy and cost-effectiveness of Patient Navigation
- The Center for Medicare and Medicaid Services (CMS) started 6 demonstration sites (2006) to study whether Patient Navigators improve care for minorities.

Source: Institute for Alternative Futures, Patient Navigator Program Report, April 13, 2007

Current Patient Navigation Programs

Comparison Chart

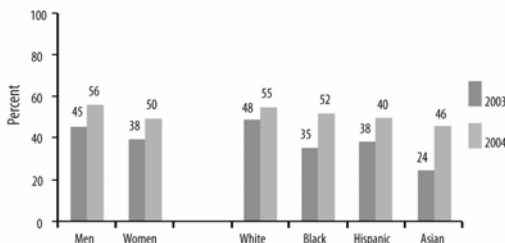
Patient Navigation Program Overview

Name	Target Population	Sites	Focus Area	Navigator Type
ACS Patient Navigator Program	Mostly Medically Underserved	Over 50 sites	Cancer (various types)	Trained Patient Navigators
Medicare Cancer Prevention and Treatment Demonstration for Racial and Ethnic Minorities	Minority Medicare fee-for service beneficiaries	6 sites	Breast, Cervical, Colorectal & Prostate Cancer	Community Health Workers Supervised by Nurses or Medical Social Workers
CRCHD Patient Navigator Research Program	Racial/Ethnic Minorities, Low Income & Underserved	9 sites	Breast, Cervical, Colorectal & Prostate Cancer	Various (see table 2)
Clinical Directors Network	Underserved Women	11 sites	Screening for Breast Cancer	Trained Care Managers
Harlem Cancer Education and Demonstration Project	Mostly Underserved African American	1 site	Breast Cancer	Trained Patient Navigators
Breast Health Navigation Project	Various	1 site	Breast Cancer	Trained Patient Navigators
Men as Navigators for Health	African American & Latino Men	1 site	Chronic Disease & Sexual Health	Lay Health Advisor
NASW Collaborating to Conquer Cancer Toolkit	Organizations & Communities	Online	Cancer (various types)	Toolkit
Nova Scotia Breast Screening Program	Various	3 sites	Breast Cancer	Trained Patient Navigators
Cancer Care: Guiding Patients to Quality Outcomes	Patient Navigators & Program Champions	Online	Cancer (various types)	Toolkit

Source: Institute for Alternative Futures, Patient Navigator Program Report, April 13, 2007

Colon Cancer in NYC

- Every year, colon cancer kills about 1,500 New Yorkers¹
- In the 2006 NYCDOHMH Community Health Survey, only 59% of those 50 and older have had a colonoscopy in the last 10



*Colonoscopy in the last 10 years among adults age 50 and older; age adjusted
Source: NYC Community Health Survey, 2003 and 2004

Sources:
1. Summary of Vital Statistics 2005 Bureau of Vital Statistics, NYC Department of Health and Mental Hygiene.
2. The New York City Community Health Survey (CHS) 2006. Bureau of Epidemiology Services, NYC Department of Health and Mental Hygiene.
3. The New York City Community Health Survey (CHS) 2003-2004

Implementing Patient Navigation Programs Through Practice-Based

Research

CDN

CLINICAL DIRECTORS NETWORK

NY Prevention Care Management (PCM) Projects I, Transl, II

Allen Dietrich, MD – PI (Dartmouth)
Jonathan N. Tobin, PhD – Co-PI (CDN)

NCI

NCI R01-CA-87776

Carrie Klabunde, PhD - NCI Project Officer




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- **Prevention Care Management (PCM) Projects I, T, II**
NCI R01-CA-87776
- **Norris Cotton Cancer Center**
Dartmouth:
Allen Dietrich, MD – PI
Michael Beach, MD, PhD
Christina Robinson, MS
Mary Ann Greene, MS
Elaine Livingston
Carol Sox, ENGR
Cheryl Lofgren
- **CDN**
Jonathan N. Tobin, PhD – Co-PI
Andrea Cassells, MPH – Proj Dir
Richard G. Younge, MD MPH – Med

PCMI Participating Community Health Centers:

BROOKLYN

- Bedford Stuyvesant FHC
- Brownsville Multi-Service FHC
- Sunset Park FHC
- Park Ridge HC
- Family Physician HC

BRONX


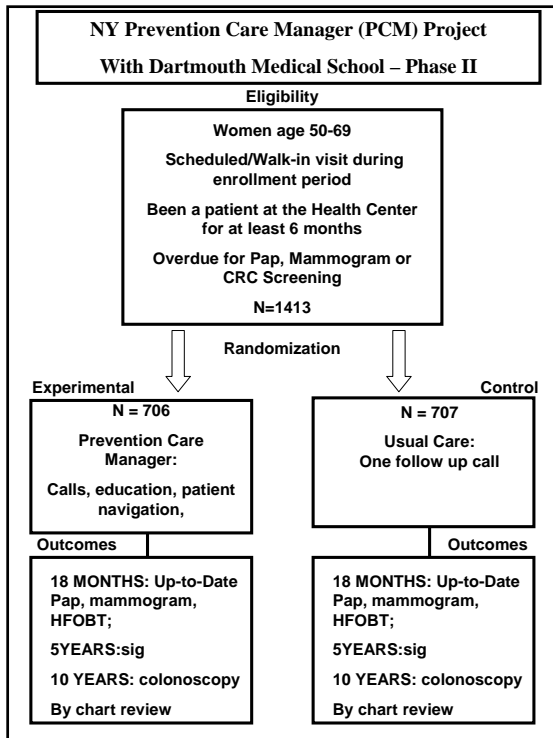
- Montefiore Comprehensive Family Care Center
- Morris Heights Health Center
- Urban Health Plan

MANHATTAN

- Ryan-NENA CHC
- William F. Ryan CHC
- Betances Health Center
- Boriken Community Health Center



QUEENS

- Joseph P. Addabbo Family Health Center

NY Prevention Care Manager Project (PCM1)

- N = 11 NYC CHCs
- n = 1413 women aged 50-69 years
- Women were Randomized (RCT) to:
 - EXP: PCM Telephone support
 - CON: Usual Care (UC)
- Assessed cancer screening barriers perceived by women
- Provided Telephone Prevention Care Management to overcome barriers
- Outcomes: Up-to-date (USPSTF) status at 18 months for cancer screening for:
 - Breast
 - Cervical
 - Colorectal

NY Prevention Care Manager Project (PCM1) PCM Approach:

- Assessed and removed patient-perceived barriers to screening
- Prevention Care Managers provided telephone support and assistance toward achieving up to date status;
- Provided needed education and motivational support;
- Helped patients to access services
- Provided follow-up support including:
 - scheduling appointments
 - reminder calls and letters
 - help with transportation
 - directions to screening facilities



PCM1 Outcomes: All 3 Cancer Screening Rates Improved Significantly

(N=1390)

	<u>PCM</u> all p<0.05	<u>Usual Care</u> not significant
Breast	58% → 68%	60% → 58%
Cervix	71% → 78%	70% → 70%
Colorectal	<u>39% → 63%</u>	39% → 50%

Dietrich, Tobin, Cassells, et al Annals of Internal Medicine 14(8): 563-571, 2006



Clinical Benefits to Practices, Providers & Patients


- Identification of patients in need of clinical preventive services
- Standardized coaching scripts
- Patient Telephone Outreach
- Performance Measures & Feedback
- CME for clinicians
- Staff Education & Training



Biggest Challenge?

- How to spread this innovation to the entire patient population (or to the entire community/population) ?
- How to sustain these efforts over time?
- Who will pay for the PCMs?





PCM TRANSLATION PILOT STUDY (PCMT)

FOCUS ON INCREASING CRC SCREENING

PCM TELEPHONE SERVICES PROVIDED BY MCO STAFF



Participating Managed Care Organization

BRONX

- Affinity Health Plan

Participating Community Health Centers

- Jacobi Health Center at Tremont
- Martin Luther King Jr. Health Center
- Montefiore Comprehensive Family Care Center
- Morris Heights Health Center
- Soundview Community Health Center
- Urban Health Plan

PCMT Outcome:



CRC Screening Rates Improved Significantly

(N = 1316)

Cancer screening rates among patients reached by phone



	PCM	Usual Care
Breast (N=539)	41% → 72%	49% → 71%
Cervix (N=539)	58% → 77%	59% → 72%
Colorectal (N=312)	16% → 34%	17% → 28%
	[< p=0.04 >]	

Dietrich, Tobin, Cassells, et al., Annals of Family Medicine, 2007

Comparison of PCM1 and PCMT Outcomes: Colo-Rectal Cancer

	Usual Care	PCM	OR	95% CI	P-value
PCM1 (CHC)	205/542 42.4%	279/528 57.6%	1.84***	(1.44 , 2.35)	<0.001
PCMT (MMCO)	78/309 49.4%	103/317 56.9%	1.43*	(1.01 , 2.02)	.046
Interaction			0.77	(0.51 , 1.18)	.24
Power			0.21		






Prevention Care Manager-Managed Care Organization Project (PCM-MCO)

A collaboration among:

- NY Metropolitan Managed Care Organizations (MCOs)
- HRSA Community Health Centers (CHCs)
- NYC Health & Hospitals Corporation (HHC)
- Diagnostic and Treatment Centers (D&TCs)
- National Cancer Institute (NCI)
- New York State Department of Health – Office of Medicaid Managed Care
- Island Peer Review Organization (IPRO)
- Clinical Directors Network (CDN)
- Dartmouth Medical School (DMS)/Norris Cotton Cancer Center

Funded by NCI Grant RO1-CA119014-01

PCM-MCO Research

Team

- **Dartmouth**

- Allen Dietrich, MD
- Christina M. Robinson, MS
- Mary Ann Greene, MS
- Ann Barry Flood, PhD
- Mike Beach, MD, PhD

- **CDN**

- Jonathan N. Tobin, PhD
- Andrea Cassells, MPH
- Richard G. Younge, MD, MPH
- Camille Wood, MA
- TJ Lin



Participating MMCO

Health Plans

- **Health Plus**

- Eric Wentz
- Richard Weinberg
- Dr. Arthur Levin
- Claribel Estrella-Blake
- Rosanna Quezada
- Chris Persaud

- **MetroPlus:**

- Maurice Sahar
- Tania Gordon
- Miguel Negron
- Jahnho Smith
- Karen Miller

- **AmeriChoice**

- Dr. Pankaj Gupta
- Doreen Cornelisse
- Patricia Miller
- Jan Perry
- Mabel Vasquez
- Daisy Huang
- Catherine Lopez



PCM-MCO Project Timeline

- Preparation and Background
Fall 2006-Fall 2007
- Barriers Interviews
Fall/Winter 2007
- Pilot of PCM-MCO Intervention
Spring 2008
- Randomized Control Trial of PCM-MCO Intervention
Summer 2008-Winter 2009 (NEXT PHASE)



PCM-MCO Pilot Methods

- Nine Community-based Practices
 - Three Diagnostic and Treatment Centers (MetroPlus)
 - Three Community Health Centers (Health Plus)
 - Three Private Community Providers (AmeriChoice)
- Thirty Patients (N = 10 per MCO)
- Intervention Delivered By Phone In English And Spanish
- Three To Four Calls Per Patient
- Time Frame – Three Months

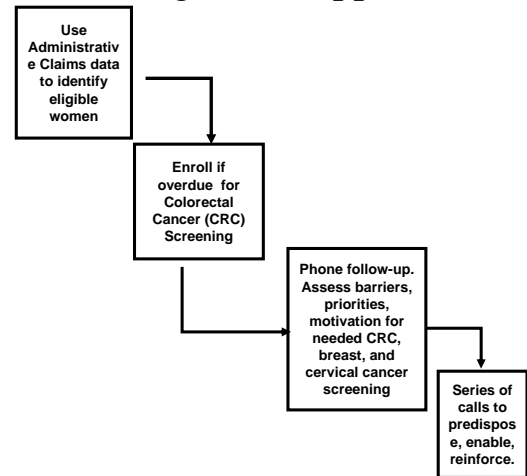


PCM-MCO Pilot Methods

- Patient Eligibility
 - Female
 - At least 50 and not older than 64 during Pilot period
 - No History of Colon Cancer
 - Continuous enrollment with MCO for at least 12 months
 - Receive care at a participating CHC, D&TC or Private Community Provider



The Prevention Care Management Approach



PCM-MCO

Pilot Intervention Steps

- Health Plan staff conducts initial and follow-up telephone calls to member using PCM Scripts and Forms
 - Describes program, confirms or corrects screening data from Administrative database
 - Assesses barriers for overdue tests, asks patient if she is ready to schedule an appointment
 - Schedules appointment
 - Sends educational materials
 - Feedback letters (to patients / to providers)
 - Reminder calls
 - Personalized follow-up to ensure that patient obtained screening tests



PCM-MCO Project Update: Barriers Interviews

- 133 completed in English and Spanish
- Conducted Feedback session with each Health Plan
- Findings shared at PCM-MCO “All Partners Meeting” (3/27/08)
 - Health Plus, MetroPlus, Americhoice
 - Health and Hospitals Corporation (HHC)
 - NYSDOH, Office of Medicaid Managed - Performance Improvement Project (PIP)
 - Island Peer Review Organization (IPRO)



The Interviews

- Demographics
 - Race and languages
 - Education
- Health Status
 - Height and weight to calculate BMI
 - Smoking status
 - Family cancer history
- Health Care Utilization
 - Time since most recent routine checkup
 - Proportion of healthcare received from assigned primary care site
- Cancer Early Detection History
 - Self report of most recent screening date
 - Barriers and facilitators



Pilot Barriers

Interviews: Process

- 1240 calls made to complete 133 interviews
- Variation across MCOs
 - Language barriers
 - Completion rate ranged from 11% to 20%
- M and F callers well received
- **RESOURCE-INTENSIVE:** Significant efforts and resources will be required to reach all at-risk participants



Pilot Barriers Interviews: Findings (n=133)

- Demographics:
 - 73% of women born outside USA
 - Race/ethnicity vary across 3 MCOs
- Utilization:
 - Attendees: 85% report routine checkup within 2 years
 - Non-attendees: varied from 10-35% across MCOs
 - Lower screening rates for all three cancers
 - Longer time since routine checkup
 - 68% report no primary care provider (vs. 15% of attendees)
- Claims-based cancer screening rates:
 - **Colorectal: 23%** (vs 59% NYC)
 - Breast: 68%
 - Cervical: 73%



Pilot Barriers Interviews: Findings (n=133)

- **Most mentioned barrier and facilitator**
 - “ recommendation from my doctor or nurse”



Screening Guidelines for Colorectal Cancer

USPSTF (2002)

“The U.S. Preventive Services Task Force strongly recommends that clinicians screen men and women 50 years of age or older for colorectal cancer. Rating: A Recommendation.”

ACS, ACR, US Multi-society Task Force on Colon Cancer (3/08)

- Polyps and cancer
 - SIG
 - Colonoscopy
 - DCBE
 - CT colonography (CTC)
- Primarily Cancer
 - Home FOBT*
 - FIT*
 - sDNA

*Recommended interval: Annual



New Developments

- Importance of colonoscopy procedure time (SLOW DOWN)
- Other clinician variations
- Importance of NP-CRN (flat polyps)
- Colon cancer prevention is primary goal of screening tests:
 - primarily detect cancer
 - detect cancer and adenomatous polyps



New USPSTF Recommendations

- Expected 2008
- Continued support for established methods
- New support for FIT
- “I” recommendation for CTC



DRIVERS OF CHANGE

- Quality Metrics
 - HEDIS
 - JCAHO
 - Pay for Performance
 - HRSA UDS
- Reimbursement for
 - Tests/Procedures
 - Support Services



Conclusions

- Colon Cancer Screening using PCM is effective in the Health Center setting
- Screening Using PCM can be translated from the Health Center to the Health Plan setting
- Translation effectiveness is test-specific



Considerations

Many reasons explain differences

- Baseline CRC screening rates are lower
- CRC Tests are more difficult for patients to undergo

Requires

- Clinician Recommendations
- MMCO Partners
- Medicaid Regulation



Next Steps

- More extensive RCT
- Profit and Non-profit Health Plans
- Wider variety of Care Delivery Settings
 - HRSA Health Centers
 - Diagnostic/Treatment Centers
 - Physician Group Practices
 - Community Hospital Out-patient practices
- Generalizability to other
 - Clinical Preventive Services
 - Behavioral Interventions
 - Disease Management Services



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Jonathan N. Tobin, PhD

President/CEO

CDN

5 West 37th Street - 10th Floor
New York City NY 10018 USA

Tel (212) 382-06-99 ext 234

Tel (212) 382-06-99 ext 227

Fax (212) 382-06-69

JNTobin@CDNetwork.org

www.CDNetwork.org

www.eClinician.org

