Paps, Colos, and FITS... Oh My!
Addressing Cancer Screening Disparities in Homeless Populations

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Learning Objectives

1. Identify strategies for improving colorectal and cervical cancer screening rates for a population experiencing homelessness

2. Describe opportunities and challenges of inter- and intra-agency collaboration in providing preventive health care

3. Recognize the importance of including clients in Quality Improvement work
Health Care for the Homeless Baltimore

- Care with dignity for **10,000 people/year**
- 3 main clinic sites, mobile van, respite care
- Services include medical, behavioral health, psychiatry, dental, case management, community health workers, & housing
- NCQA Level III PCMH offering co-located, integrated care teams
- Advocacy for quality health care, affordable housing and livable incomes for all
- 2020 Strategic Goal: **As a result of our care, the health outcomes of our clients will rival the health outcomes of a stably housed population**
Cancer Screenings & Our Population

• Cancer is common, but even more common in the homeless population. Cancer-related death is twice as common for people experiencing homelessness as it is for the average for the adult U.S. population\(^1\)

• Significant barriers to screening in our population:
  – Lack of insurance; competing priorities; lack of knowledge about importance or process; anticipated discomfort or misperceptions\(^2\)

• Cancer screenings detect, prevent, and can cure cancer when caught early

• Our screening rates were low compared to other FQHCs, so we prioritized improving colorectal cancer screening in 2016 and cervical cancer screening in 2017

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Overview of Initiatives

• Clinical Leadership buy-in
• Performance improvement goal and staff involvement across disciplines/roles

Setting the Culture

• Preventive Health Tracker
• Registries (for calling clients past due for CA screenings)
• Standard CMA, RN, and CHW workflows
• Preventive needs addressed first
• Standing orders
• 1:1 Cancer screening competencies

Developing Tools + Training

• Follow-up visits for paps
• Preventive Health Education at groups
• Women’s Health Day
• Choice between FITs and colonoscopies
• Calls to clients past-due for screenings

Improving Access

• Gift card incentives
• FIT mail-ins
• Colonoscopy Prep Bags
• Comfort kits for paps
• Patient Navigation Program
• Community Health Workers

Addressing SDoH

• Client voice throughout this change process

Engaging clients
Spotlight: Community Health Workers + GI Clinic Partnership

Problem: 60 - 70% no-show rate to GI clinic for colonoscopy consult

Change idea: Have CHW team assist with navigation to GI clinic appointments
Spotlight: Patient Navigation for Colonoscopies

Problem:
Our external partnership for providing patient navigation for colonoscopy completion was failing

Change Idea:
Utilize our internal resources to supply client navigation. Nurses screen and identify barriers, then address needs

Provider refers client to RN for colonoscopy navigation

RN consult prep visit. RN assesses barriers.

Client goes to GI specialist

RN Colonoscopy prep visit. RN Assesses barriers.

Client completes colonoscopy

CHW support if needed

CHW/CCP support if needed
Results of our efforts: Colorectal Cancer Screening

HCH Colorectal Cancer Screening Rate
July 2016 - April 2019

- Average = 54%
- 58%

- Staff Competition
- Client Incentives
- Outreach Calls
- Preventive Health Tracker
- Mailing FITs
- Competency Testing
- Patient Navigation; CHW GI escorts

Standing order added
Results of our efforts: Cervical Cancer Screening

HCH Cervical Cancer Screening Rate
November 2016 - April 2019

- Began PI Project
- EHR training
- Preventive Health Tracker
- Balt Co & Mobile intervention

Baseline = 50%

Average = 62%
Results of our efforts: Federally-Qualified Health Center (FQHC) Comparison

HCH Cervical Cancer Screening Rate

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
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<tbody>
<tr>
<td>2016</td>
<td>41%</td>
</tr>
<tr>
<td>2017</td>
<td>44%</td>
</tr>
<tr>
<td>2018</td>
<td>57%</td>
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2017 National Average\(^1\) = 56%

HCH Colorectal Cancer Screening Rate

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<tbody>
<tr>
<td>2016</td>
<td>35%</td>
</tr>
<tr>
<td>2017</td>
<td>42%</td>
</tr>
<tr>
<td>2018</td>
<td>47%</td>
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2017 National Average\(^1\) = 42%

\(^1\)HRSA 2017 National Health Center Data (UDS): https://bphc.hrsa.gov/uds/datacenter
# Lessons Learned

<table>
<thead>
<tr>
<th>Make it easy to do the right thing</th>
<th>It’s ok to fail</th>
<th>Acknowledge/capitalize on our strengths</th>
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<td>Break the work up into short-term and long-term goals</td>
<td>See through the eyes of the clients</td>
<td>Create a culture of prioritizing preventive care</td>
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<tr>
<td>Provide ongoing trainings</td>
<td>Try Pilots</td>
<td>Persist</td>
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Continued Challenges

**Internal**
- Implementing workflows across sites
- Making sufficient time for training
- Prioritizing preventive care for clients with competing priorities
- Referral & scheduling workflows

**External**
- Fragmentation of the US Healthcare system:
  - Lack of EHR interoperability, timely access to colonoscopies, co-pays/insurance barriers
  - Unique population barriers:
    - Client mistrust of the medical community
    - Undocumented clients fear presenting to medical services
Questions
Discussion

1. What strategies/tools does your clinic use to ensure your clients receive cancer screenings?

2. What opportunities and/or challenges do you have with improving cancer screening for your clients?
Thank you!

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