BREAST HEALTHCARE

IMPROVEMENT IN THE SAFETY-NET

CHANGE PACKAGE

RAPID INNOVATION TO IMPROVE OUTCOMES

DEVELOPED:

The Primary Care Coalition
of Montgomery County, MD
June 2012

TESTED + IMPLEMENTED:

The National Capital Area
Regional Breast Healthcare
Improvement Initiative

FUNDED BY:
Susan G. Komen FOR THE CURE®

Table of Contents

FOR MORE INFORMATION: **Mary Kate Brousseau, Regional Initiative Manager • 301.628.3441 • marykate_brousseau@primarycarecoalition.org**

Acknowledgments

The Breast Healthcare Improvement Initiative Change Package is a result of the drive and desire to facilitate improved outcomes within the safety-net population throughout the National Capital Area. The following organizations and individuals were vital in the development of this tool for expanded use:

FUNDING PARTNER

Susan G. Komen for the Cure

COLLABORATIVE PARTNERS

Primary Care Coalition of Montgomery County, Maryland

Regional Primary Care Coalition

COLLABORATIVE PROJECT TEAM CONSULTANTS

Associates in Process Improvement

Mosaica: The Center for Nonprofit Development and Pluralism

PROJECT TEAM

Mary Kate Brousseau, Project Manager, *Primary Care Coalition*

Steven M. Galen, President and CEO, *Primary Care Coalition*

Leslie Graham, Chief Operating Officer, *Primary Care Coalition*

Mary Jane Joseph, Project Manager, *Primary Care Coalition*

Phyllis Kaye, Director, *Regional Primary Care Coalition*

Naramon Pear Moraras, Project Coordinator, *Primary Care Coalition*

Tom Nolan, Consultant, *Associates in Process Improvement*

Anu Pattabiraman, Senior Project55 Fellow, *Regional Primary Care Coalition*

INITIATIVE ADVISORY COMMITTEE MEMBERS

Sarah Leonhard, *Greater Baden Medical Services, Inc.*

Patricia Mathews, *Northern Virginia Health Foundation*

Kelly Sweeney McShane, *Community of Hope*

Mardell Moffett, *The Morris & Gwendolyn Cafritz Foundation*

Margaret O'Bryon, *Consumer Health Foundation*

Nancy Pallesen, *Northern Virginia Health Services Coalition*

Mindy Rubin, *Kaiser Permanente*

Christina Stevens, *Community Health Care Network, Fairfax County Health Department*

Crystal Townsend, *Healthcare Initiative Foundation*

Gwendolyn Young, *DC Primary Care Association*

PRIMARY CARE SAFETY-NET CLINICS

Community Health Care Network (Molina Healthcare), *Fairfax County, VA*

Community of Hope, *Washington, DC*

Greater Baden Medical Services, Inc., *Prince George's County, MD*

Chinese Culture and Community Service Center (Pan Asian Volunteer Health Clinic), *Montgomery County, MD*

Holy Cross Hospital Health Centers, Montgomery County, MD

Mary's Center, *Montgomery County, MD and Washington, DC*

Mercy Health Clinic, *Montgomery County, MD*

Mobile Medical Care, *Montgomery County, MD*

Muslim Community Center Medical Clinic, *Montgomery County, MD*

The People's Community Wellness Center, *Montgomery County, MD*

Proyecto Salud, *Montgomery County, MD*

Spanish Catholic Center, *Montgomery County, MD and Washington, DC*

HOSPITAL AND BREAST HEALTH PROVIDER PARTNERS

Adventist HealthCare

Capital Breast Care Center

CASA de Maryland

Community Radiology Associates

George Washington University Hospital and Mammovan

Holy Cross Hospital

Howard University Hospital and Cancer Center

Inova Health System

Maryland Department of Health and Mental Hygiene

Montgomery General Hospital

Nueva Vida

Prince George's County Breast and Cervical Cancer Program

Suburban Hospital

Women's Cancer Control Program

Acknowledgments

Introduction

PURPOSE OF THE CHANGE PACKAGE

We all strive to achieve a high quality service delivery system that is seamless to the provider and, most importantly, to the patient.

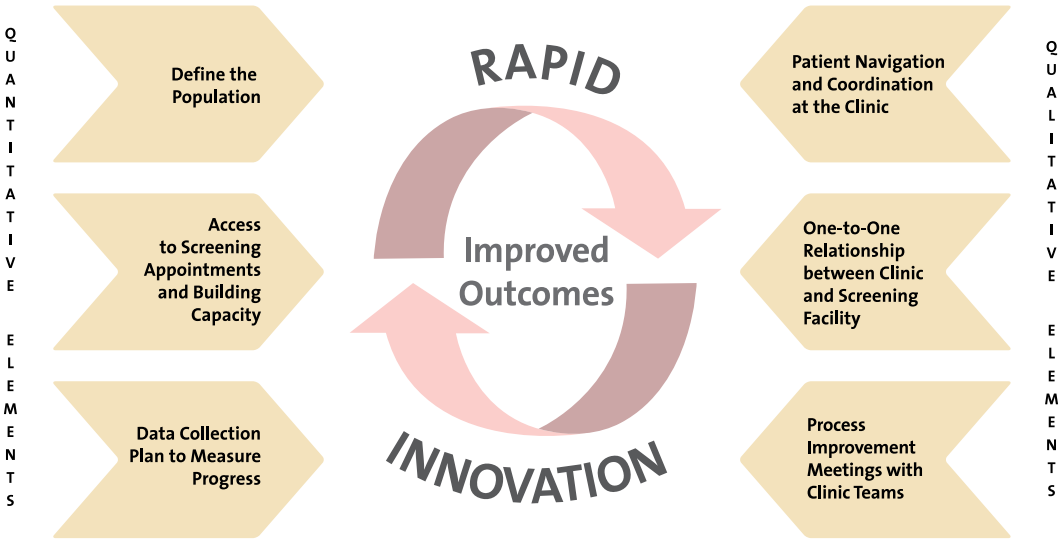
In the National Capital Area (NCA), the Primary Care Coalition (PCC) developed a method to work within the community to build primary care collaboratives and improve mammography screening rates within the safety-net clinic setting. In collaboration with the Regional Primary Care Coalition, regional breast health providers and partners tested and implemented the primary care-based model using the Model for Improvement to improve processes at the micro-system level as well as system design theory to drive larger systems changes.

This Change Package shares recommended interventions and successful strategies that have been tested and documented, and can be used by clinics certified as patient-centered medical homes or in the process of adopting those standards. The package includes step-by-step instructions, examples, and resources to implement breast health process improvement programs for rapid innovation at your primary care clinic. While focused on breast health screening improvement, we encourage you to use these practices with any patient population and preventive screening protocol.

OVERVIEW OF THE CHANGE PACKAGE

The Change Package is a primary care-based model that includes six interventions or "elements" that are employed together to drive rapid innovation to improve breast health outcomes.

THE SIX CRITICAL ELEMENTS OF BREAST HEALTH PROCESS IMPROVEMENT



Element Implementation Checklist

1. DEFINE THE POPULATION

- ☐ Review national guidelines for breast cancer screening with your provider team.
- ☐ Agree upon an evidence-based breast cancer screening guideline for system-wide implementation within your clinic.
- ☐ Define the target population eligible for breast cancer screening according to the adopted guidelines.
- ☐ Determine the demand for mammography services for 100% access, by establishing the number of active, eligible patients seen per year.

2. ACCESS TO SCREENING APPOINTMENTS AND BUILDING CAPACITY

- ☐ Identify all mammography providers for your clinic.
- ☐ Calculate the number of mammograms provided by each mammography facility.
- ☐ Compare this number to the demand as previously assessed in Element 1: Define the Population and determine the need.
- ☐ Strategize ways to fill the gap.

3. DETERMINE A DATA COLLECTION PLAN TO MEASURE PROGRESS

- ☐ Working with the clinic leadership and the project team, identify project outcome measures and benchmarks specific to breast health service delivery.
- ☐ Establish baseline data for each measure through chart review, electronic medical record, or billing database.
- ☐ Compute the exact monthly referral and screening goals using the number of active patients defined as the target population. *(See Element 1: Define the Population).*
- ☐ Use the Breast Healthcare Improvement Initiative's one-page tracking report or develop a breast health tracking tool on your own to report outcome measures on a monthly basis.
- ☐ Review monthly outcome measures with project team to evaluate process improvement activities and identify priority areas for action.
- ☐ Use monthly measures to facilitate and strengthen relationships with partner breast health providers by demonstrating successes and challenges along the continuum of care.

4. PATIENT NAVIGATION AT THE CLINIC LEVEL

- ☐ Designate a staff person to coordinate breast health care services for the patient and to serve as the main point of contact for the mammography facility.
- ☐ Staff personnel must:
  - ☐ Process the mammography screening or diagnostic referral and document it in the medical record system.
  - ☐ Reinforce the need for mammography and answer the patient's questions about the procedure.
  - ☐ Schedule the screening or diagnostic appointment for the patient.

- ☐ Remind the patient of her appointment 1-2 days prior.
- ☐ Maintain contact with the mammography facility to receive the mammography report after the exam is complete.
- ☐ Document the results in the medical record system and follow up with the patient as directed by the medical provider.
- ☐ Have knowledge of resources and requirements to obtain financial support for the patient when needed.

☐ Maintain continuous communication with a contact at the mammography facility (or facilities) as well as with the patient.

5. ONE-TO-ONE RELATIONSHIP BETWEEN CLINIC AND SCREENING FACILITY

☐ Identify priority clinic mammography providers among existing partnerships. Priority setting may depend on several factors including: payment options, geographical location, transportation options, services offered, and existing contracts, if any.

☐ If the clinic does not already have one, establish a point of contact at the mammography facility, preferably someone who is able to make changes in processes.

☐ Set up an initial meeting with the leadership at the mammography facility to discuss the current referral, screening, and follow-up processes. Create a process map or flow chart including current roles of staff members from both institutions.

☐ Use the Model for Improvement to decide on a Plan-Do-Study-Act (PDSA) cycle to improve a priority area of the current process. *(See Element 6: Process Improvement Meetings with the Clinic Project Team)*

☐ Agree upon specific action items to work on and assign roles for team members.

☐ Set up regular meetings to review data and monitor the effectiveness of the process.

☐ *Optional:* Develop and execute a Memorandum of Understanding between the two institutions to document the working relationship.

6. PROCESS IMPROVEMENT MEETINGS WITH THE CLINIC PROJECT TEAM

☐ Engage support from senior leadership to prepare your organization for breast health-focused process improvement.

☐ Educate all staff on process improvement concepts.

☐ Use the Core Project Team Description document to identify members of the Clinic Project Team.

☐ Determine a regular monthly meeting time for Team process improvement activities.

☐ Identify and prioritize areas for improvement, using baseline and monthly data reports.

☐ Plan and implement small tests of change, using PDSA cycles from the Model for Improvement and the PDSA template.

☐ Evaluate test results and plan new tests at each monthly meeting.

☐ Report back to providers, staff and senior leadership regularly, through provider meetings, all-staff meetings, and clinic newsletters. Celebrate success and communicate results throughout clinic.

☐ Work with senior leadership to implement and institutionalize successful tests.

Element 1: Define the Population

ELEMENT DESCRIPTION

Before an organization can begin to improve systems of care for a targeted population, the organization needs to understand and define the population in order to accurately measure and assess the impact of breast health improvement activities. Due to many different national breast cancer screening guidelines, setting up clinic-wide processes can be difficult. Deciding on a clinic-wide referral policy is the first step to help clinics optimize the capacity that they do have; and a clear referral policy helps to establish the demand for mammography services and measuring success.

Establishing the target population enables baseline measurement and goal-setting to assess and drive progress. Defining the population is closely linked with Element 2: Access to Screening Appointments and Building Capacity and Element 3: Data Collection Plan to Measure Progress.

STEPS FOR IMPLEMENTATION

1. Review national guidelines for breast cancer screening with your provider team.
2. Agree upon an evidence-based breast cancer screening guideline for system-wide implementation within your clinic.
3. Define the target population eligible for breast cancer screening according to the adopted guidelines.
4. Determine the demand for mammography services for 100% access, by establishing the number of active, eligible patients seen per year.

EXAMPLES

Establishing Referral Guidelines for the Clinic: Greater Baden Medical Services, Inc., Prince George's County, Maryland

In order to determine the system-wide breast cancer screening referral guidelines, the Greater Baden Medical Services (GBMS) provider team met and discussed each provider's current practices. Some providers used the U.S. Preventive Services Task Force (USPSTF) guidelines, referring women 50 and over, every 1-2 years. Other providers always referred women annually beginning at age 40, and included younger women deemed high-risk according to family history. The GBMS provider team decided that the priority population for mammography screening remains women 50 and over. Therefore, the team decided to adopt the USPSTF guidelines for system-wide implementation and defined their population as women 50 and over to serve as the baseline for tracking and monitoring the referral process for the priority population. Providers still have the clinical discretion to refer women outside the parameters of the guideline, but data on these women are not tracked as part of process improvement activities.

Determining the Demand: Community Health Care Network, Fairfax County, Virginia

The team at Community Health Care Network (CHCN) established a system-wide guideline to refer all women 40 and over every year and defined an "active", eligible patient as a woman, 40 and over, seen at least once over the past year. The clinic team decided to initiate focused breast health process improvement activities at one of their three sites and thus, established the demand at that site. Using data from their practice management system, the team determined that 1,340 active, eligible patients were seen in the previous year. Per their guidelines, that means that 1,340 mammograms are needed each year, or approximately 112 mammograms per month.

FREQUENTLY ASKED QUESTIONS

Q1. With all of the different mammography screening guidelines out there, how do we pick just one for all providers to implement?

A1. Guidelines include recommendations, strategies, or information that assist healthcare professionals and patients to make appropriate clinical decisions, but providers exercise independent clinical judgment specific to individual patients. Providers may refer a patient for a mammogram, whether or not the patient characteristics are within the clinic referral guidelines, especially patients deemed as high-risk. However, the clinic must establish a system-wide guideline for adoption and implementation in order to streamline processes for all staff and enhance the delivery of care to the target population. It may take many meetings with the provider team to discuss the screening guidelines and reach consensus on the system-wide guideline.

Q2. How do you define active patient?

A2. You may define it however you like to best capture the number of women seen and establish your target service population. Some patients may only come in once and never return to the clinic, so you may not want to count those in your active patient population. However, some clinics may want to include patients who visit the clinic just once because you want to make any and all clinic visits an opportunity to refer a patient. The Initiative defines an active patient as "a patient who had two face-to-face encounters with different dates of service – one visit during the past year and the other visit in the measurement period or within two years prior to the end of the measurement period."

Q3. What if our patient population is growing? Do we adjust the number of mammograms needed?

A3. Once you define the population served by your clinic, you may revisit the process to re-establish the target number and the mammography need ("demand"). It must be a data-driven process, which most likely will occur when monthly measures demonstrate significant differences between the true demand and the established monthly goals. (See Element 3: Data Collection Plan to Measure Progress).

USEFUL ATTACHMENTS

- *Summary of Breast Cancer Screening Recommendations*

Element 2: Access to Screening Appointments & Building Capacity

ELEMENT DESCRIPTION

In order to better serve the need in the safety-net population, a clinic must gain an accurate understanding of its access to mammography screening appointments as well as the capacity the screening facility has for mammograms. Transparency in data will allow the clinic to be better positioned to negotiate for access to more mammograms.

STEPS FOR IMPLEMENTATION

1. Identify all mammography providers for your clinic.
2. Calculate the number of mammograms provided by each mammography facility for your patient population.
3. Compare this number to the demand as previously assessed (*see Element 1: Define the Population*) and calculate the remaining need. If the supply does not meet the demand, this shows the gap in mammography services.
4. Strategize ways to fill the gap (funding strategies, strengthening relationships, etc.) and work toward supply matching demand to provide 100% access to the target population.

EXAMPLES

Safety-Net Clinics and Partners Supply and Demand Grid: Montgomery County, Maryland

The *chart on the next page* records an example of the supply and demand for safety-net clinics in Montgomery County. This grid is brought to every breast health improvement partner meeting and shared with primary care safety-net clinics and mammography providers as a tool to facilitate discussion on meeting community need for mammography services.

FREQUENTLY ASKED QUESTIONS

Q1. How do we start tracking number of mammography referrals to different facilities?

A1. Some clinics have built in a drop-down menu in their EMR to document all referral sites. A report can then be generated to track where patients are being referred for mammography. Other clinics use an Excel spreadsheet to track follow-up of services. An example of this spreadsheet can be found under *Useful Tools*.

Q2. What are strategies for negotiating for more slots for mammograms?

A2. An effective strategy for increasing supply is through transparency in data. Demonstrating a low no-show rate and a high need in mammography could result in more slots allotted to your clinic. Continuous communication between the mammography provider and the primary care facility is imperative to overcome barriers and reduce the no-show rate. Using the supply and demand grid to show need can also attract new providers and funders.

Montgomery Cares Clinics: CY 2010	Active Female patients ≥ 40 years of age	65% of total patients ≥ 40 years (HEDIS Medicaid 90th Percentile) Annual Demand	Patients ≥ 40 years enrolled in NBCCEDP	Mammography Supply	Outstanding Need	Mammography Provider
Mercy Health Clinic	785	510	265	250		Shady Grove Adventist Hospital
Proyecto Salud – Olney	249	162		125	37	Community Radiology Associates
Proyecto Salud – Wheaton	1307	850	337	420	93	Community Radiology Associates (300) Holy Cross Hospital (120)
People's Community Wellness Center	248	161	30	130	1	Holy Cross Hospital
Mobile Medical Care – Germantown	706	459		300	159	Community Radiology Associates
Mobile Medical Care – Other	1047	681	193	300	188	Washington Radiology (150)Shady Grove Adventist Hospital (150)
Muslim Community Clinic	658	428	35	350	43	University Imaging (200) Washington Adventist Hospital (150)
Spanish Catholic Center	382	248	56	175	17	Washington Adventist Hospital
Mary's Center	200	130		150		Washington Adventist Hospital
Community Clinic Inc.	1269	825	129	120	576	Holy Cross Hospital
CCACC	137	89		85	4	Shady Grove Adventist Hospital
Holy Cross Health Centers	1063	820		200	620	Holy Cross Hospital
Community Ministries of Rockville	367	239		120	119	Holy Cross Hospital
TOTAL	8418	5602	1045	2725	1857	

- Active Female Patients in Montgomery County is defined as: A patient who had two face-to-face encounters with different dates of service – one visit during the measurement period and the other visit in the measurement period or within two years prior to the end of the measurement period. This is the total eligible population.
- Annual Demand is calculated at the 90th percentile benchmark for the HEDIS Medicaid breast cancer screening. Demand is calculated to be the number of mammograms needed to screen 65% of the eligible population.
- Mammogram Capacity per year is the number of mammograms the mammography facility provides to its "partner" primary care clinic.
- Patients Enrolled in State/County National Breast and Cervical Cancer Early Detection Program (NBCCEDP) – These are patients designated by the NBCCEDP and clinic to have breast health screening services financially covered by the NBCCEDP.
- Outstanding need is calculated by taking the total demand and subtracting the sum of available capacity with the patients enrolled in NBCCEDP. Need shows the current gap and the number of mammograms still required to achieve the targeted access.

USEFUL ATTACHMENTS

- *Sample Patient Referral Tracking Spreadsheet*
- *Sample Health Care Services Agreement*

Element 3: Determine a Data Collection Plan to Measure Progress

ELEMENT DESCRIPTION

One of the fundamental elements behind demonstrating change is the ability to evaluate progress by regularly tracking and monitoring project measures. Data shows whether or not a change is an improvement. If your data are housed in an electronic medical record or in paper charts, your team must establish baseline data to prioritize areas for improvement and to gauge success and continued challenges as the clinic tests new processes. Monthly tracking facilitates efficient assessment of small tests of change and supports data driven decision-making.

Determining the Data Collection Plan relates directly with two other change elements: Element 1: Defining the Population and Element 6: Process Improvement Meetings with the Clinic Project Team. Regularly reported and evaluated measures together with commitment throughout the clinic and organization result in improvement for services to serve the target population.

STEPS FOR IMPLEMENTATION

1. Working with the clinic leadership and the project team, identify project outcome measures and benchmarks specific to breast health service delivery.

EXAMPLES

Measure	Definition	Benchmark
Referral rate	# of active patients receiving referrals in the past two years/ # of active patients eligible for screening	No national benchmark. The Initiative used 95% as the goal.
Screening rate	# of active patients who completed a mammogram in the past two years/# of active patients eligible for screening	65%: 90th percentile benchmark for the HEDIS Medicaid breast cancer screening (2011)
Cycle Time from Referral to Mammography Screening	# of days between date of referral and date of initial mammogram	CDC/NBCCEDP: less than 90 days
Cycle Time from Mammography Screening to Diagnosis	# of days between date of initial mammogram and date of diagnosis	CDC/NBCCEDP: less than 60 days
Cycle Time from Diagnosis to Treatment	# of days between date of diagnosis and start of treatment	CDC/NBCCEDP: less than 60 days
Cancer Diagnoses	# of breast cancer diagnoses	N/A
Cancer Staging	Stage of cancer diagnosis	N/A

Washington, DC has one of the highest breast cancer mortality rates in the country.

The surrounding counties in Maryland and Virginia also experience higher than average breast cancer mortality among certain populations.

(UNITED STATES CANCER STATISTICS (USCS) 2006)

2. Establish baseline data for each measure through chart review, electronic medical record reports, or billing database.
3. Compute the exact monthly referral and screening goals using the number of active patients defined as the target population. (*See Element 1: Define the Population*)
4. Use the Initiative's one-page tracking report (*see attached*) or develop your own breast health tracking tool to report outcome measures on a monthly basis.
5. Review monthly outcome measures with the Project Team to evaluate process improvement activities and identify priority areas for improvement.
6. Share monthly measures among partner breast health providers to facilitate and strengthen relationships by demonstrating successes and challenges along the continuum of care.

EXAMPLES

Establishing Baseline Referral and Screening Rates Using Paper Charts: Community Health Care Network, Fairfax County, Virginia

Community Health Care Network (CHCN) was in the process of transitioning from paper to electronic medical records during baseline data collection. The number of active patients could be pulled electronically; however, referral and screening rates had to be determined by looking for documentation in paper charts. Instead of reviewing each chart for all 1,340 women 40 and over seen over the past year, the team pulled a sample of 134 charts (10%) to gather and record data from referral reports and mammogram results into the chart review template (see attached). The team analyzed the data using Excel spreadsheets. In smaller clinics, the team will have to determine how many charts will constitute a representative sample.

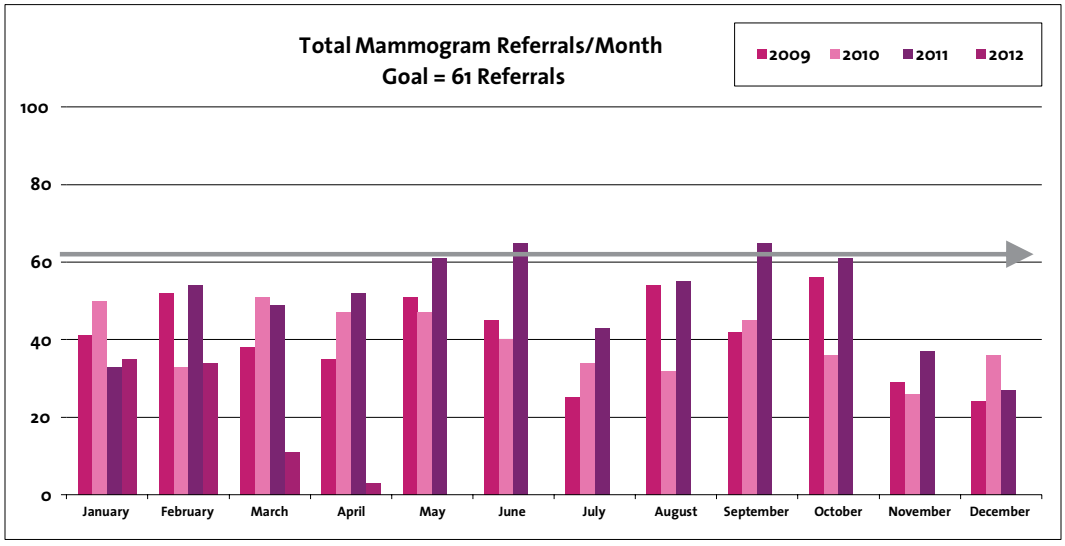
Monthly Report Tool and Goals:
Mercy Health Center, Montgomery County, Maryland

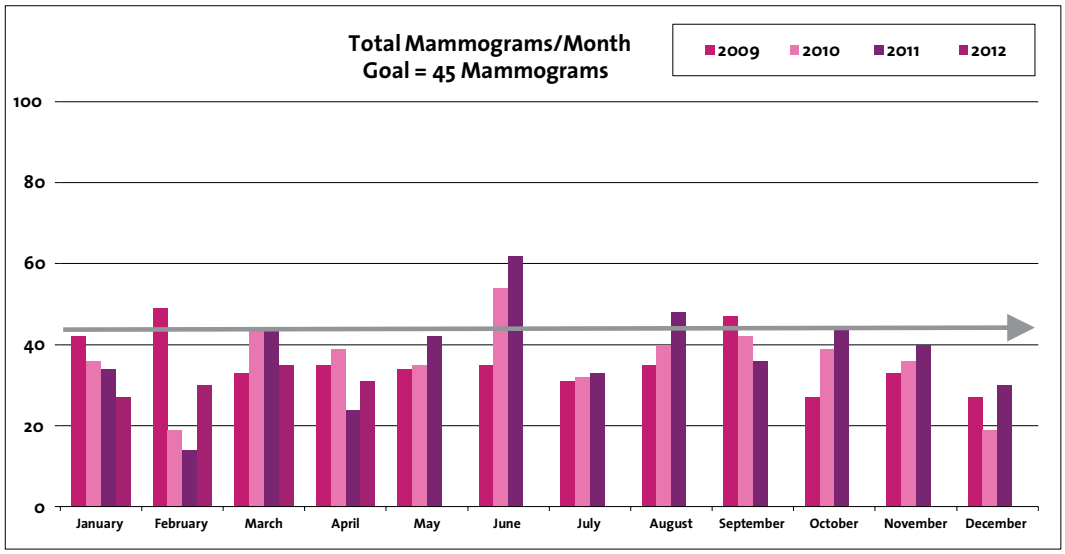
Through the Initiative, Mercy Health Center (MHC) established the following AIM and objectives using baseline data. Then, over the first year, the clinic tracked and reported the following measures using the monthly report template (see attached).

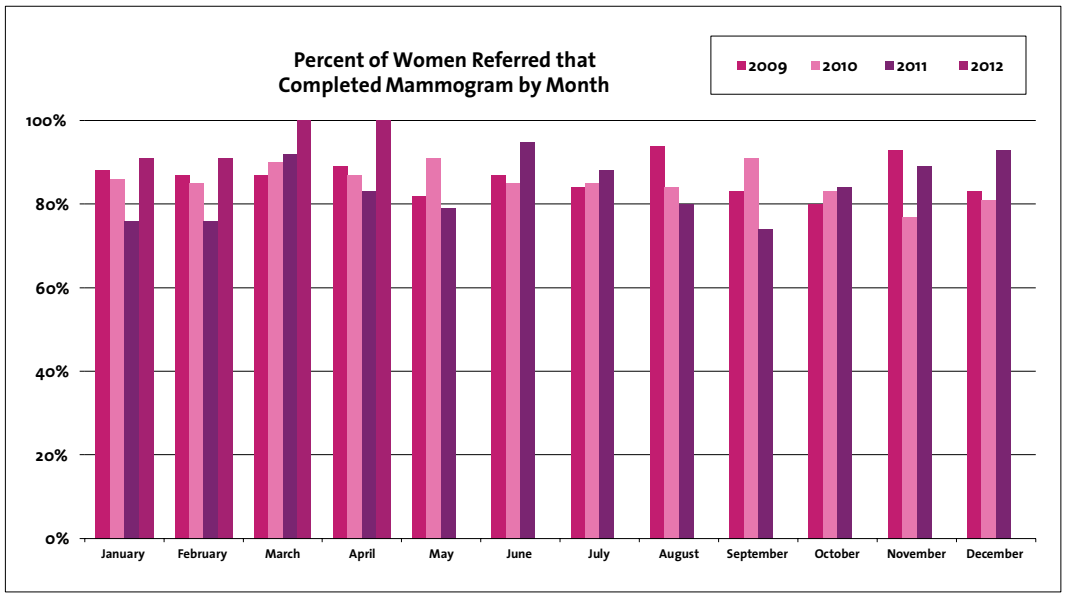
AIM: To provide efficient and evidence-based breast cancer screening services to 45 women per month. (2011 HEDIS Medicaid breast cancer screening benchmark 65%)

Objective 1: Refer 90% (743 annually / 61 monthly) of eligible women for mammography screening.

Objective 2: Screen 65% (536 annually / 45 monthly) of eligible women for mammography screening.


Total Mammogram Referrals/Month
Goal = 61 Referrals
2009
2010
2011
2012
100
80
60
40
20
0
January
February
March
April
May
June
July
August
September
October
November
December


Total Mammograms/Month
Goal = 45 Mammograms
2009
2010
2011
2012
100
80
60
40
20
0
January
February
March
April
May
June
July
August
September
October
November
December


Percent of Women Referred that
Completed Mammogram by Month
2009
2010
2011
2012
100%
80%
60%
40%
20%
0%
January
February
March
April
May
June
July
August
September
October
November
December

FREQUENTLY ASKED QUESTIONS

Q1. How do we prioritize which measures are most important to track?

A1. Various breast health measures are tracked and reported nationally, some of which are required by national certification boards and/or registries. Your facility may already be tracking and reporting some measures, which could be a good starting point. In order to gain support for process improvement, engage your providers and clinic in the decision-making process to capture what is important to them. In the end, you want meaningful measures that will track monthly performance in the delivery of breast health to steer process evaluation as well as quarterly and yearly measures to evaluate overall patient outcomes.

Q2. What measures can we establish that are within the Triple AIM framework?

A1. The Institute for Healthcare Improvement (IHI) asserts that health care system design can and must be developed to simultaneously accomplish three critical objectives, called the "Triple Aim". The objectives are to 1) improve the health of the population, 2) enhance the patient experience of care (including quality, access, and reliability, and 3) reduce, or at least control, the per capita cost of care.

The chart below gives some examples of Triple AIM metrics to evaluate the breast health system:

Patient Experience	Clinical Quality	Cost
Breast cancer screening rates	Recall rate	Per capita cost
Patient reported confusion and anxiety	Cancer rate among abnormal screens	Cancer staging
Cycle times for each aspect of the continuum	Screening detection rate	Reduction in clinical errors
Lost to follow up	Cancer staging	Decrease unnecessary imaging and testing

USEFUL LINKS AND ATTACHMENTS

Breast Health Measures and Benchmarks:

- *National Quality Measures for Breast Centers™ Program (NQMBC)*
- *Healthcare Effectiveness Data and Information Set (HEDIS)*
- *Breast Cancer Surveillance Consortium*
- *Center for Disease Control and Prevention, National Breast and Cervical Cancer Early Detection Program*

- *Chart Review Template*
- *Sample Clinic Monthly Tracking Report*

Element 4: Patient Navigation at the Clinic Level

ELEMENT DESCRIPTION

Patient navigation and care coordination at the clinic level is necessary to provide timely and high quality breast health services through the continuum of care from assessment and screening through diagnosis and treatment. A Patient Navigator is a trained individual who proactively guides patients through and around barriers in a complex cancer care system to decrease fragmentation of care and to coordinate services[1]. Effective patient navigation ultimately enhances the patient's experience of care.

STEPS FOR IMPLEMENTATION

1. Designate a staff person to coordinate breast health care services for the patient and to serve as the main point of contact for the mammography facility.
2. Designated staff personnel:
    a. Process the mammography screening or diagnostic referral and document it in the medical record system.
    b. Clearly reinforce the need for mammography and answer the patient's questions about the procedure.
    c. Schedule the screening or diagnostic appointment for the patient.
    d. Remind the patient of her appointment 1–2 days prior.
    e. Maintain contact with the mammography facility to receive the mammography report after the exam is complete.
    f. Document the results in the medical record system and follow-up with the patient as directed by the medical provider.
    g. Understand resources and requirements to obtain financial support for the patient when needed.
3. The person providing patient navigation services should maintain continuous communication with a contact staff person at the mammography facility (or facilities) as well as with the patient.

We are able to provide more screening to more women in the community.

Patient Navigators serve as key instruments to this success, creating a better connection between patients and the breast health providers.

— INITIATIVE HOSPITAL REPRESENTATIVE

[1] *Source:* Freeman HP. A model patient navigation program. *Oncology Issues*. September/October 2004: 44–46

EXAMPLES

Referral Specialist: Community Health Care Network, Fairfax County, Virginia

CHCN's Referral Specialist (RS) is responsible for processing all radiology referrals at the clinic. The process includes the following steps:

1. The RS receives referral orders from the provider and meets with the patient directly after the provider encounter to schedule the patient's mammography appointment. The patient leaves the clinic with an appointment.
2. The RS faxes the referral and required documents directly to the mammography facility.
3. Two days prior to the scheduled screening exam, the RS calls the patient to remind her of the appointment. If the patient cannot make the appointment the Referral Specialist can reschedule the patient for a new time and also contacts the mammography facility to cancel the appointment.
4. The RS accesses the mammography facility's results portal to review the mammography report within 72 hours of the exam and enters the results into the EMR.
5. If the patient has an abnormal mammogram or requires a follow-up appointment, the RS schedules the necessary follow-up.

The Referral Specialist remains the point of contact for the mammography facility until services are no longer required. In order to keep track of each patient who receives a referral, the RS documents all exams, results, and follow-up information in a protected Excel spreadsheet. Staff also use the spreadsheet for data reporting purposes and in the future plan to build it into the EMR.

Incorporating Patient Navigation Tasks into Current Roles: Greater Baden Medical Services, Prince George's County, Maryland

In order to ensure a sustainable change, the leadership team of Greater Baden Medical Services, Inc. decided to incorporate patient navigation responsibilities into the current roles of the staff members as opposed to creating a new position. The clinic project team of Greater Baden at Capitol Heights integrated the breast health care patient navigation roles into current staff duties at the clinic. Providers process the mammography referral and document it in the EMR. The front desk staff scans in mammography results received at the clinic into the EMR and records the BI-RAD result in a drop-down menu. If results are not received by the clinic within a certain amount of time, Medical Assistants follow up with the patient to determine whether or not she completed the mammogram.

Montgomery County Safety-Net Clinics Breast Health Patient Navigation: Montgomery County, Maryland

While some Montgomery County safety-net clinics have created patient navigator positions, others, similar to Greater Baden, incorporate the responsibilities into current staff positions. The amount of time it takes per week depends on the total number of patients seen at the clinic as well as follow-up required for patients with abnormal results. For some clinics, it may take as little as 4 hours per week and in others, up to 8 hours. In each of the clinics, staff members with multiple responsibilities should set aside a designated time each week to focus only on breast health referral and follow-up. Without that "protected time", navigation responsibilities are easily overwhelmed by direct patient care needs.

FREQUENTLY ASKED QUESTIONS

Q1. Our clinic can't support a new full time Breast Health Patient Navigator, how can we still provide services?

A1. Patient navigation for breast healthcare does not require a full-time position. The responsibility can be incorporated into positions that your clinic has already. For example, some clinics have a Referral Specialist who processes all referrals and follow-up with other facilities. Other clinics have their Certified Medical Assistant (CMA) conduct follow-up calls to ensure that patients keep their appointment or have the opportunity to reschedule an appointment. In these same clinics, the front desk staff is responsible for documenting the mammography results.

Q2. If the hospital or radiology provider has a nurse navigator, do we still need one?

A2. Yes, it is important that there is a designated person at the clinic level to be the point of contact between the primary care provider, the patient, and the diagnostic services and treatment provider. The nurse navigator at the hospital may help with coordinating services at the hospital level, but he/she will also need someone at the clinic to help keep the providers and the patient in the loop as the patient receives care. It is important to clearly define roles and responsibilities of the hospital, radiology, and clinic staff in order to avoid duplication of effort while ensuring high quality integrated care.

USEFUL LINKS AND ATTACHMENTS

Patient Navigation Guides:

- *Primary Care Coalition of Montgomery County*
- *Maryland Affiliate of Susan G. Komen for the Cure:* Teaching Providers, Reaching Women *Toolkit*
- *Harold P. Freeman Patient Navigation Institute*
- *Colorado Patient Navigator Training*

- *Referral Tracking Spreadsheet*
- *Patient Navigation Pre-Assessment Tool*
- *Patient Navigator Position Description (Sample)*

Element 5: One-to-One Relationship Between Clinic and Screening Facility

ELEMENT DESCRIPTION

An established partnership between the primary care medical home and the mammography provider is critical to delivering quality breast health care. A one-to-one relationship between the two organizations will facilitate continuous communication between two single points of contact. The resulting relationship can improve handoffs, decrease cycle times, provide a quick turnaround for mammogram reports, and improve overall efficiency.

STEPS FOR IMPLEMENTATION

1. Project Team members (see Element 6: Process Improvement Meetings with Clinic Project Team) identify priority clinic mammography providers among existing relationships. Priority setting may depend on several factors including: payment options, geographical location, transportation options, services offered, and existing contracts, if any.
2. Establish a point of contact at the mammography facility if the clinic does not already have one. The point of contact should be someone who can make changes in processes; this person may be the head of the radiology department, the lead mammography coordinator, the community health director, etc.
3. Set up an initial meeting with the leadership at the mammography facility to discuss the current referral, screening, and follow-up processes. Create a process map or flow chart including current roles of staff members from both institutions.
4. Use the Model for Improvement to decide on a Plan-Do-Study-Act (PDSA) cycle to improve a priority area of the current process. (See Element 6: Process Improvement Meetings with the Clinic Project Team)
5. Set up regular meetings with the mammography facility to review data and PDSA results and to continue to enhance the partnership. (See Element 3: Data Collection Plan to Measure Progress).
6. *Optional:* Develop and execute a Memorandum of Understanding between the two institutions to document the working relationship.

EXAMPLES

Block Scheduling: Community Health Care Network – Inova Fair Oaks Hospital, Fairfax County, Virginia

The Community Health Care Network (CHCN) wanted to test block scheduling with their sole mammography provider, Inova Health System. CHCN leadership decided to test the process at the North County site, which refers all patients to Inova Fair Oaks Hospital (FOH). Staff from CHCN and FOH gained support from senior leadership and after three meetings, the partners developed a proposed process for block scheduling and set a start date. The partners met bi-weekly during the testing phase to promptly address concerns with scheduling and no-shows. After initial success, the partners increased the block of weekly appointments from 9 slots to 19. The partners continued to check in at least monthly to monitor results and solve problems. After eight months, results demonstrate:

- Cycle time from referral to mammogram decreased to 18 days.
- Mammography completion rate increased to 80% from a baseline screening rate of 55%
- No-show rate decreased from 27% to 6%.
- The streamlined process reduced the amount of staff time spent by both partners on scheduling.
- The partners are working together to spread block scheduling to other sites.

Note: While the majority of patients received mammograms through the block appointments, FOH allowed for patients to schedule outside the block when necessary.

1 in 8 women are diagnosed with breast cancer – a treatable and curable disease.

Breast cancer – the most commonly diagnosed cancer – is also the second leading cause of cancer death in US women. Regular screening leading to early diagnosis and treatment allows many women to become breast cancer survivors rather than victims.

Streamlined Appointment Scheduling to Increase Screening Rates: Community of Hope – George Washington University Hospital, District of Columbia

A portion of COH's clinic population receives mammography screening services at George Washington University (GWU) Hospital. Prior to establishing a relationship between the two facilities, patients often had trouble making appointments through the hospital's central scheduling system. When patients had the responsibility to make their own appointments, data showed a low completion rate. Of the 37 patients with outstanding mammograms and were referred to GWU Hospital between July 2010 and August 2011, 31 never made an appointment.

To improve patient follow-through, the Referral Specialist at COH met with the Manager of GWU Hospital's radiology department to examine the process and establish a contact to better resolve issues. As a result, the Referral Specialist now calls GWU's central scheduling the day of the clinic appointment to schedule a screening mammogram before the patient leaves the clinic. The Specialist faxes the referral directly to the radiology department and the patient then leaves the clinic with an appointment. Knowing of the exact date and time of the appointment allows the clinic to provide prompt follow-up and ensure procedure completion.

FREQUENTLY ASKED QUESTIONS

Q1. What is a Process Map?

A1. A Process Map is an effective tool used to identify opportunities for improvement in clinic flow. To create a Process Map, the staff works together to understand, examine, and visually represent all the steps a patient must go through in order to receive care. The activities generates a flow chart which allows the clinic team to pinpoint specific steps or parts of the process that may be problematic for the patient or staff member. Also, the exercise promotes a better understanding of roles and responsibilities within the clinic to eliminate duplication of efforts and streamline communication.

Q2. What if we refer to multiple mammography providers?

A2. While we recognize that there are variations in clinic models and some clinics and patients face limits in facility options due to multiple insurers or geography, a one-to-one partnership is ideal. A simplified one-to-one relationship streamlines communication and processes and facilitates matching supply with demand for mammography services, enhancing systems to better serve patients. Managing care when patients are sent to multiple providers becomes more difficult because the clinic must track multiple processes, forms, contacts, and possibly sources of funding. We recommend identifying a priority provider, which may be a facility taking all payers, offering interpretation options, and/or transportation, and focusing process improvement efforts with that facility first. If your clinic has no alternative but to utilize more than one mammography provider, there should be clear criteria to determine who is referred to each provider, and the same activities (process mapping, regular communication) are required with each.

Q3. What if we select the Breast and Cervical Cancer Program (BCCP) to be our priority partner? Is it different from selecting a mammography facility?

A3. As with a mammography facility, the clinic needs to set up a system with the BCCP to make sure that patients enrolled in the program get the referral, screening, and diagnostics as needed. The clinic should establish a contact and begin regular meetings to discuss and agree upon a process for the partnership, including transparency around patient referral and follow-up. In general, the BCCP does not offer direct services (i.e. mammograms, sonograms). BCCP differs from a mammography facility because it is a referral to a facility; however, this may be the best way to meet patient need and a clear, streamlined process with regular communication will improve outcomes.

USEFUL LINKS AND ATTACHMENTS

Process Improvement Tools:

- *IHI Model for Improvement*
- *Scotland Government: Understanding the Patient Journey – Process Mapping [PDF]*

- *Sample Clinic Process Map*
- *Sample Memorandum of Understanding for Block Scheduling*
- *Timeline and Time Commitment*

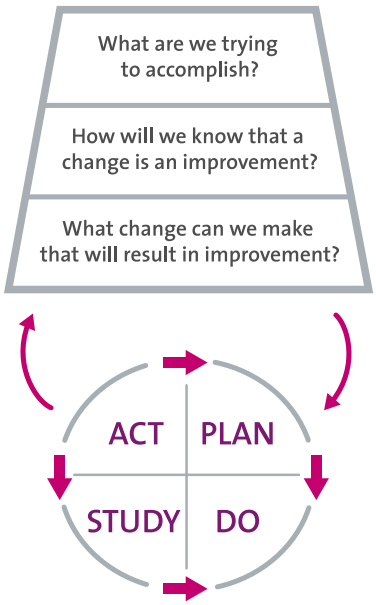
Element 6: Process Improvement Meetings with the Clinic Project Team

ELEMENT DESCRIPTION

This element includes two parts: The first establishes a culture of continuous process improvement throughout the entire clinic system. The second develops a Clinic Project Team, comprised of clinical and non-clinical staff who are dedicated to improving the quality of breast health care. The NCA Regional Breast Healthcare Improvement Initiative used the Model for Improvement framework to assist teams in testing and adopting changes in the delivery of care and to foster continuous improvement.

Strong support from leadership and a foundation of process improvement knowledge empowers the Clinic Project Team to make effective improvements and facilitates all other elements of the Change Package.

Model for Improvement



The Improvement Guide, 2nd Edition
Langley, Nolan, et al., Jossey-Bass 2009

STEPS FOR IMPLEMENTATION

1. Engage support from senior leadership to prepare your organization for process improvement focused on breast health.
2. Educate all staff on process improvement concepts.
3. Use the Core Project Team Description document (attached) to identify members of the Clinic Project Team, which should include staff who represent each step of the clinic breast health process and are committed to driving and championing breast health improvement throughout the clinic.
4. Determine a regular monthly meeting time for Team process improvement activities.
5. Identify and prioritize areas for improvement, using baseline and monthly data reports, process mapping, and the Know Your Processes Questionnaire (attached).
6. Plan and implement small tests of change, using Plan-Do-Study-Act (PDSA) cycles from the Model for Improvement and the PDSA template (attached).
7. Evaluate test results and plan new tests at each monthly meeting.
8. Celebrate success and communicate results throughout the clinic. Report back to providers, staff and senior leadership regularly, through provider meetings, all-staff meetings, and clinic newsletters.
9. Work with senior leadership to implement and institutionalize changes that demonstrated success when tested.

EXAMPLES

Identifying the Clinic Project Team: Greater Baden Medical Services, Prince George's County, Maryland

The Project Team met with GBMS leadership three times to discuss specifics of project implementation. After agreeing to participate, GBMS leadership determined that focused process improvement would begin at the Capitol Heights site with the plan to spread successful practices to the other four GBMS sites.

The Clinic Project Team included the following:

- Sponsors: The Executive Director and the Vice President of Development. The Sponsors did not attend monthly meetings; however they received regular updates and participated in larger quarterly administrative oversight meetings to assist with spread and institutionalization.
- Provider Champion: Family Practice Physician at the Capitol Heights site.
- Key Contact: GBMS Quality Coordinator. The Quality Coordinator for GBMS is also a practicing Nurse Practitioner. She generated monthly reports and communicated measures and updates with the provider teams, both at the site and system-wide.
- Other Members:
  - Capitol Heights Clinic Manager, who drove processes with non-clinical staff as well as partnership development with the mammography provider.
  - Additional Clinical Providers at Capitol Heights, who regularly reviewed referral and screening metrics and brainstormed ideas for PDSAs.

PDSA Cycle: Scheduling a Mammography Appointment: Community of Hope, District of Columbia

After reviewing baseline data, the Team at Community of Hope decided to focus on activities to increase their screening rate and decrease cycle time from referral to mammography screening. The Team, including one physician provider and the Referral Specialist, evaluated current processes and decided on a small test of change. Instead of leaving without a referral in hand or a scheduled mammography appointment, the provider ordered the referral within the EMR and then asked the patient to wait in the lobby. The Referral Specialist retrieved the referral order and met with the patient to schedule a mammography appointment. The patient left with an appointment and referral in hand. Not only did this ease the process for the patient, but assisted with follow-up on no-shows, receiving results, and overall communication with the mammography provider and patient. The Team tested this with referrals and scheduling at one mammography facility and plans to spread the approach to others.

FREQUENTLY ASKED QUESTIONS

Q1. Can the Clinic Project Team be smaller or be just one person?

A1. Ideally, the Clinic Project Team will include representatives of all types of staff members that have a role in patient care, and more specifically a role in the breast health screening, referral, and follow-up process. The wider representation facilitates testing at each step as well as communication of results to other staff.

Q2. How do we spread successful changes to other providers or sites?

A2. Working with your Clinic Project Team and senior leadership, identify 2-3 tests resulting in demonstrated improvements. Report these best practices to the entire staff and/or staff who will be involved in implementation at other sites. For example, a best practice may be to have CMAs document mammography history within the medical record as a prompt to providers to issue a referral when necessary. All CMAs and providers should be trained on this new clinic protocol and any concerns addressed as a part of spread activities.

USEFUL LINKS AND ATTACHMENTS

Online Resources:

- *Health Resources and Services Administration (HRSA) Cancer Collaborative Toolkit*
- *IHI Model for Improvement*

- *Members of the Core Project Team Description*
- *Process Improvement Concept Overview (Slides)*
- *PDSA Worksheets and Example*
- *Sample Clinic Process Map*
- *Know Your Processes Questionnaire*
- *Activities to Support Reliable Screening*

End Note

This Change Package is a guide that we encourage you to pick up and use within your clinic and community to continue to drive breast health improvement throughout the National Capital Area and beyond. While differences in health care delivery systems exist in each jurisdiction, the elements and interventions have proven successful across borders and within many provider models.

The Initiative continues to work toward improving breast health outcomes by spreading best practices and there is still room to improve! Strategies to bring us closer to a high quality breast health system include the following:

- Further test and adapt interventions to apply to all preventive screening and referral coordination. Gather examples of successful implementation.
- Enhance regional data collection and sharing activities:
  - Include more diagnosis and treatment metrics. The Initiative Team focused primarily on data and partnership development to enhance referral to mammography screening processes during the first year and is now gathering data on cycle times from mammography screening to diagnosis and diagnosis to treatment.
  - Enhance the data management system to facilitate information exchange between clinics, mammography providers, and other breast health providers along the continuum of care.
  - Establish a disease registry for each jurisdiction, comparing data and setting benchmarks for the region.
- Expand the regional learning system. The Initiative convenes a Cross-Jurisdiction Learning Collaborative on a regular basis to share best practices and learnings. The learning community should continue to grow by developing a stronger collaborative governance structure to promote data sharing, to address regional systems issues, and to work to replicate breast health improvement activities in other regions.
- Research and test methods to incentivize improved breast health care delivery.

We welcome your feedback on the Change Package and areas for growth and partnership. We look forward to continued collaboration for improve all health care outcomes for the safety-net community.

> *Through this Initiative,* Shady Grove Adventist and Mercy Health Clinic developed a great working relationship to better serve the women of the community.
>
> — ADVENTIST HEALTHCARE REPRESENTATIVE

PCC Breast Health Initiatives

Regional Primary Care Coalition. January 2009

NCA SAFETY-NET OVERVIEW

In the Washington, DC Metropolitan Area, some 120,000, or 15% of the region's population of women 40-64 are low-income. Of these, almost 39% are uninsured. The region has 31 safety-net clinics that serve as medical homes to women 40 and older. Clinics are spread almost equally among Washington, DC (10), Northern Virginia (11), and Suburban Maryland (10). Together they operate 92 facilities providing primary health care services to individuals who might otherwise be unable to obtain them. In 2009, these clinics provided care to an estimated 59,800 women aged 40 and over, about 55,650 (93%) of whom are low-income[2].

The safety-net clinics in the District are serving about 8,000 low-income uninsured women 40 and over, the Northern Virginia clinics about 16,050, Prince George's County's one clinic about 1,300, and Montgomery County clinics about 8,650.

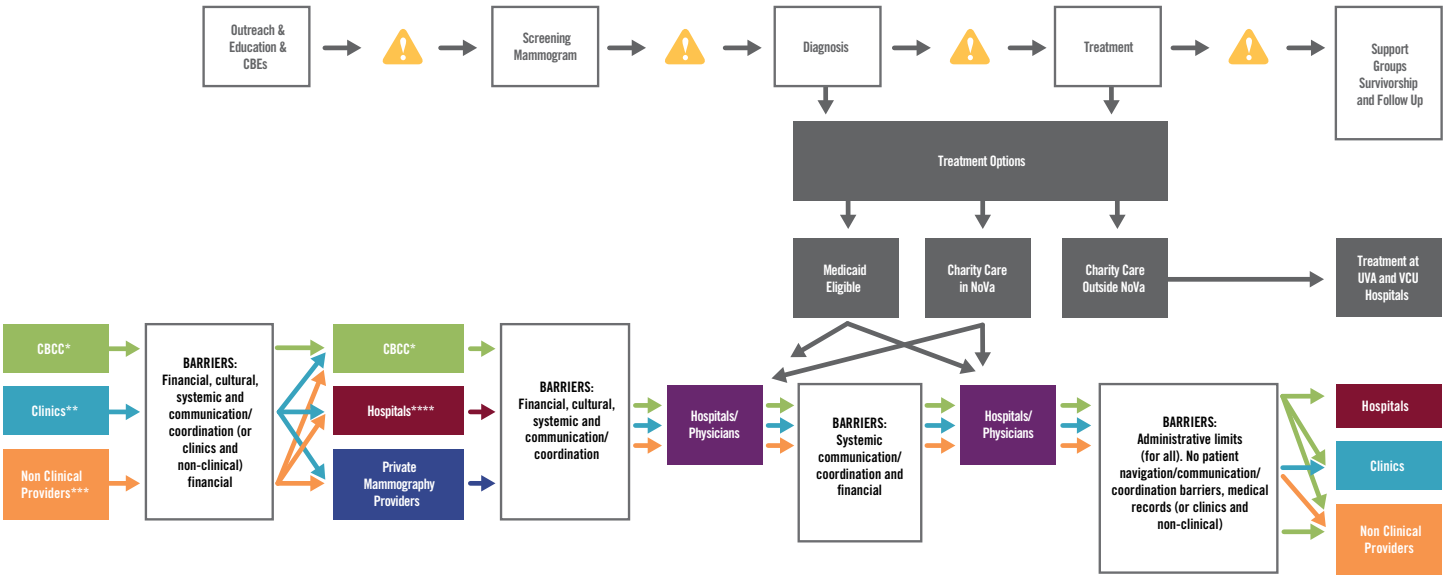
HEALTH ISSUE

Washington, DC has one of the highest breast cancer mortality rates in the country. The surrounding counties in Maryland and Virginia also experience higher than average breast cancer mortality among certain populations. Annual screening rates in the District, Maryland, and Virginia vary between 62% and 64%, all slightly above the national average of 59.7%. However, data from the American Cancer Society show that the aggregate screening rate among uninsured women (34.9%) is far lower[3].

[2] *Source:* Clinic surveys and follow-up communications, supplemented by data from websites and clinic reports (2009).

[3] *Source:* *ACS, 2009

FIG 1. A CLOSER LOOK AT THE FRAGMENTED BREAST HEALTH CONTINUUM OF CARE



Mosaica: The Center for Nonprofit Development and Pluralism: State of the Region Breast Health Care Assessment. Jan. 2011

In 2011, the State of the Region Breast Health Care Assessment, researched and produced by Mosaica: The Center for Nonprofit Development and Pluralism, identified additional challenges to timely and high quality breast health care for low-income women 40 and over, including:

- Limited service coordination between breast health services providers along the continuum of care, including outreach, primary care, mammography screening, diagnostics, and specialty care providers.
- Lack of access to breast health services along the continuum.
- Inconsistent and limited data collection to document outcome measures and need for services.
- Systemic issues throughout the region, including jurisdictional differences in access to medical homes and breast health care services, and limited integration and coordination beyond borders.

Due to the fragmented and uncoordinated delivery system, the quality of care remains inadequate and ultimately compromises outcomes for women. See Figure 1.

MONTGOMERY COUNTY AND NCA BREAST HEALTH IMPROVEMENT INITIATIVES

Since 2007 with grants from Susan G. Komen for the Cure, the Prevent Cancer Foundation, the American Breast Cancer Foundation, and the Maryland Department of Health and Mental Hygiene, PCC has worked as a systems integrator within Montgomery County, Maryland building collaborations to provide coordinated breast health care services to low-income, uninsured women. PCC piloted referral/ screening projects, and then supported wider partnerships among nine safety-net clinics, the Women's Cancer Control Program and Cancer Crusade, five Montgomery County hospitals, and private breast health providers.

These efforts increased screening rates threefold from 20% to 60%, doubled mammography capacity from 1,700 to 3,400, and decreased cycle time from referral to mammography screening by 70% from 100 days to less than 30 days.

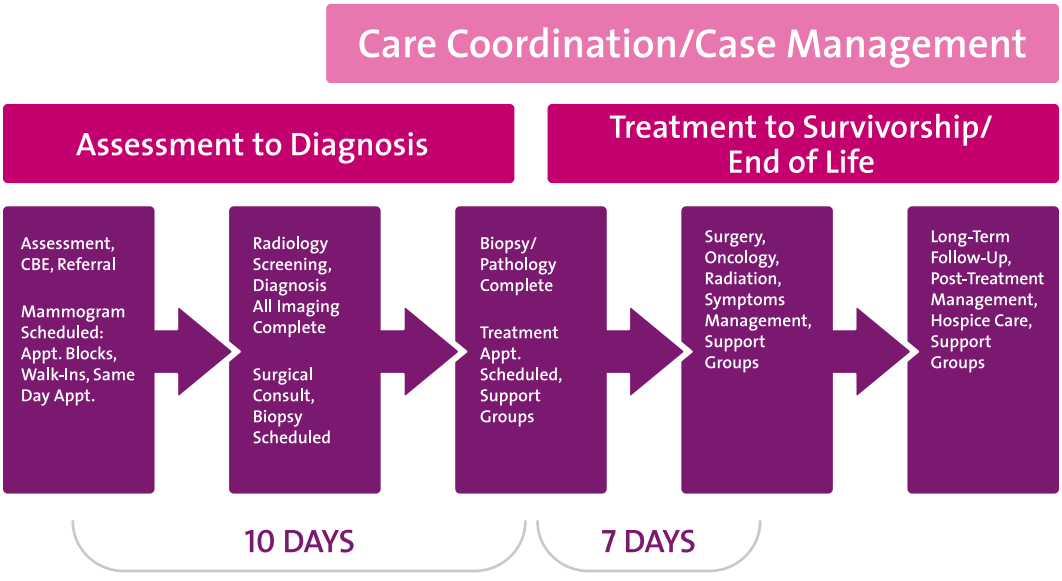
Beginning in 2010, PCC in collaboration with the Regional Primary Care Coalition and with funding from Susan G. Komen for the Cure, launched the NCA Regional Breast Healthcare Improvement Initiative. The Project Team began to test the successful Montgomery County primary care-based model in three adaptation sites in Prince George's County, Washington DC, and Northern Virginia. In addition, the Project Team created a regional learning community including a Cross-Jurisdiction Learning Collaborative, which brings representatives from each jurisdiction together to share breast health measures, success stories, and plan/discuss process improvement activities from a regional perspective.

After a year of focused process improvement, partnership development, and data collection, initial analysis demonstrates:

- *All three adaptation sites show increased screening rates approaching 65%. This represents the 90th percentile performance in the Healthcare Effectiveness Data and Information Set (HEDIS) for Medicaid breast cancer screening.*
- *At one site, cycle time between referral and mammography screening decreased from 48 to 27 days.*
- *Another site worked closely with one mammography provider to decrease the no-show rate for mammography appointments from 26% to 6%.*

Regional Initiative partners continue to collaborate to strengthen the breast health system and spread best practices to engage additional safety-net clinics and breast health providers. The goal is to achieve a high quality breast health system, in which women receive timely services and the continuum of care is seamless from assessment to diagnosis, and treatment to survivorship or end-of-life care. Below is a diagram of such a system.

HIGH QUALITY BREAST HEALTH SYSTEM

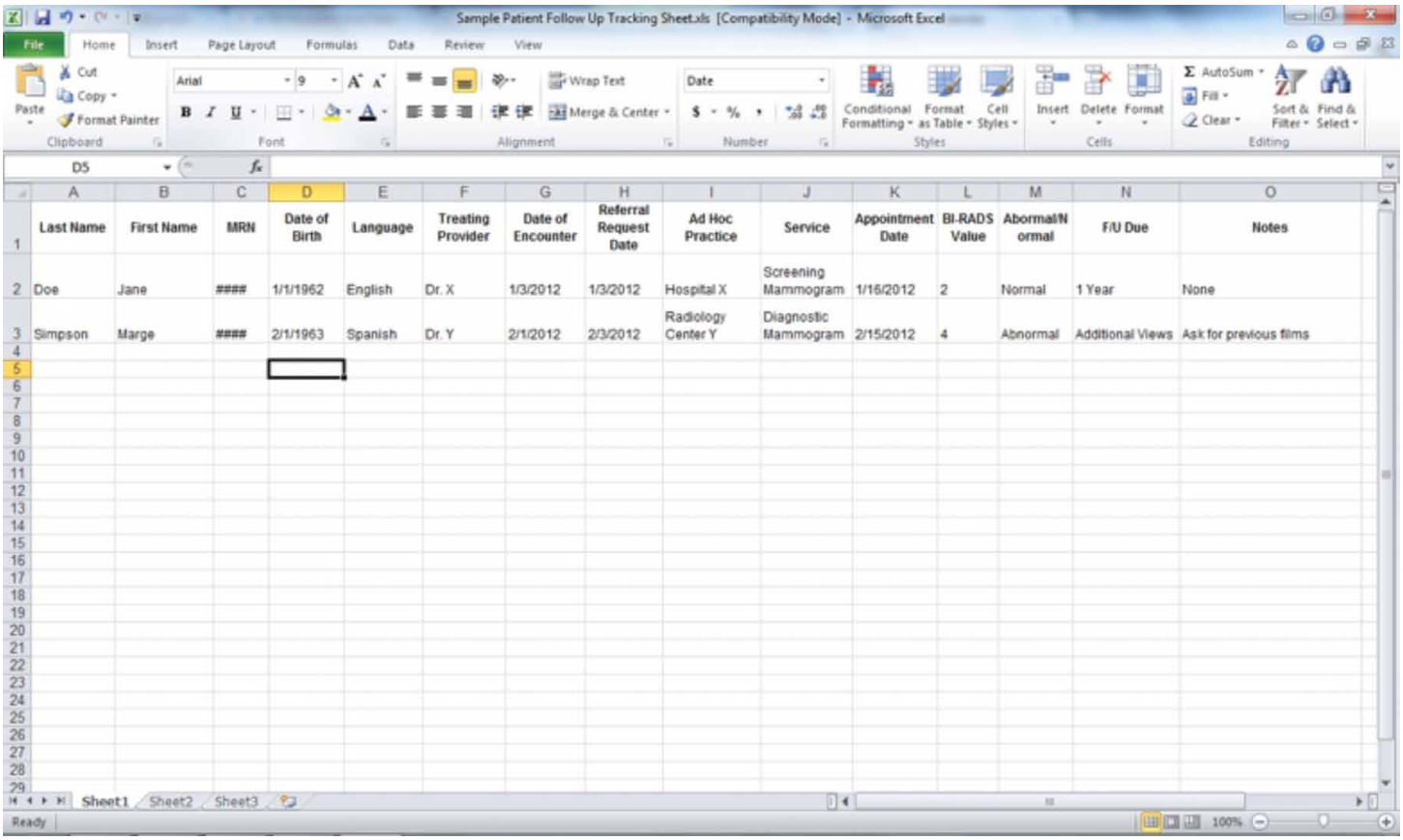


Summary of Breast Cancer Screening Recommendations for Low-Risk Patients

MEDICAL ORGANIZATION	BREAST CANCER SCREENING RECOMMENDATIONS (MAMMOGRAPHY)
American Academy of Family Physicians (AAFP)	Every 1 to 2 years, ages 50 to 69; counsel women ages 40 to 49 about potential risks and benefits of mammography and clinical breast examination.
American College of Obstetricians and Gynecologists (ACOG)	Every 1 to 2 years starting at age 40, yearly after age 50
American Cancer Society (ACS)	Annually after age 40
American Medical Association (AMA)	Every 1 to 2 years in women ages 40 to 49; annually beginning at age 50
Canadian Task Force on Preventive Health Care (CTFPHC)	Every 1 to 2 years, ages 50 to 59
National Institutes of Health (NIH)	Data currently available do not warrant a universal recommendation for mammography for women in their 40s; each woman should decide for herself whether to undergo mammography.
U.S. Preventive Services Task Force (USPSTF)	Every 1 to 2 years, ages 50 to 69

Sample Patient Referral Tracking Spreadsheet

PATIENT REFERRALS, RESULTS, AND FOLLOW-UP



Sample Health Care Services Agreement – for Negotiating Fees and Lump Sum Payment

This Health Care Services Agreement (the "Agreement") is made this ___*date*___, by and between *Radiology Provider* ("Provider") and *Primary Care Provider* ("Client").

1. PURPOSE

The purpose of this Agreement is to establish a framework for radiologic breast health screening services, which eliminates risk of non-payment to Provider and ensures access for needed radiologic services for Patients, without delay. This Agreement is intended to serve as an addendum to a contract for services between Provider and Client.

2. DEFINITION OF RESPONSIBILITIES

Provider shall provide or cause to be provided both the professional and technical components of radiology services indicated below ("Radiology Services"). Radiology Services may be rendered by Provider directly or indirectly through independent contractors selected by Provider. (*Check all that apply.*)

- ☒ Ultrasound
- ☒ Mammography
- ☐ Other: _____

Client shall define a referral process such that Provider is clear which patients are to be served under the terms of the Agreement. This may include a list of specific providers or clinic sites from which the referrals originate.

Client will assign a contact person to communicate with provider on reimbursement issues.

3. FUNDING AND REPORTING

Provider and Client agree to the following rates:

Code	Service	Rate
G0202	Bilateral Screening Mammogram	$_____
G0204	Bilateral Diagnostic Mammogram	$_____
G0206	Unilateral Diagnostic Mammogram	$_____
76645	Breast Ultrasound	$_____

Client will create a credit on their account with Provider through a lump sum payment of $_____ to Provider. This serves as a credit for drawdown upon provision of the above radiology service to referred Patients. Provider will submit to Client a monthly list of all patients screened and any additional testing for reconciliation.

Both Provider and Client agree that additional diagnostic tests are typically covered by the State Breast and Cervical Cancer Diagnosis and Treatment Program, once application to that program is completed and accepted for an individual Patient. To prevent delays in diagnostic work-ups, Client guarantees payment for additional diagnostic tests in the event that the Patient is not accepted into the State Breast and Cervical Cancer Diagnosis and Treatment Program. Provider guarantees it will credit back to the Client account any amounts reimbursed under the State BCCP program for Patients.

Provider is not responsible for Patient applications to State BCCP. This is the responsibility of the clinics and patients. To ensure that Provider is aware of the application status of individual patients to State BCCP, Client will submit to provider the following information on patients who have completed state applications on a bi-weekly basis:

- Patient Name
- Patient DOB
- Date Application Submitted
- Application status
- Approval Number

4. MUTUAL AGREEMENTS

It is mutually understood and agreed between the parties that:

- Continuation: This Agreement shall be in effect until the account credit is depleted. This Agreement may be extended at any time by the provision to Provider of additional lump sum payment as credit on the Client account.
- Termination/Expiration: This Agreement may be ended by either party with thirty (30) days written notice to the other party for any reason. In the event the Agreement is terminated, to Client's Patients, Provider shall return the amount of the credit on Client's account to Client after processing all outstanding payments.
- Rates: The rates defined in this Agreement may be changed through written agreement and with ninety (90) days written notice from Provider to Client.
- Client is under no obligation to refer any or all Patients to Provider.

5. AUTHORIZED INDIVIDUALS

CLIENT	PROVIDER
_____	_____
Signature	Signature
_____	_____
Name	Name
_____	_____
Date	Date

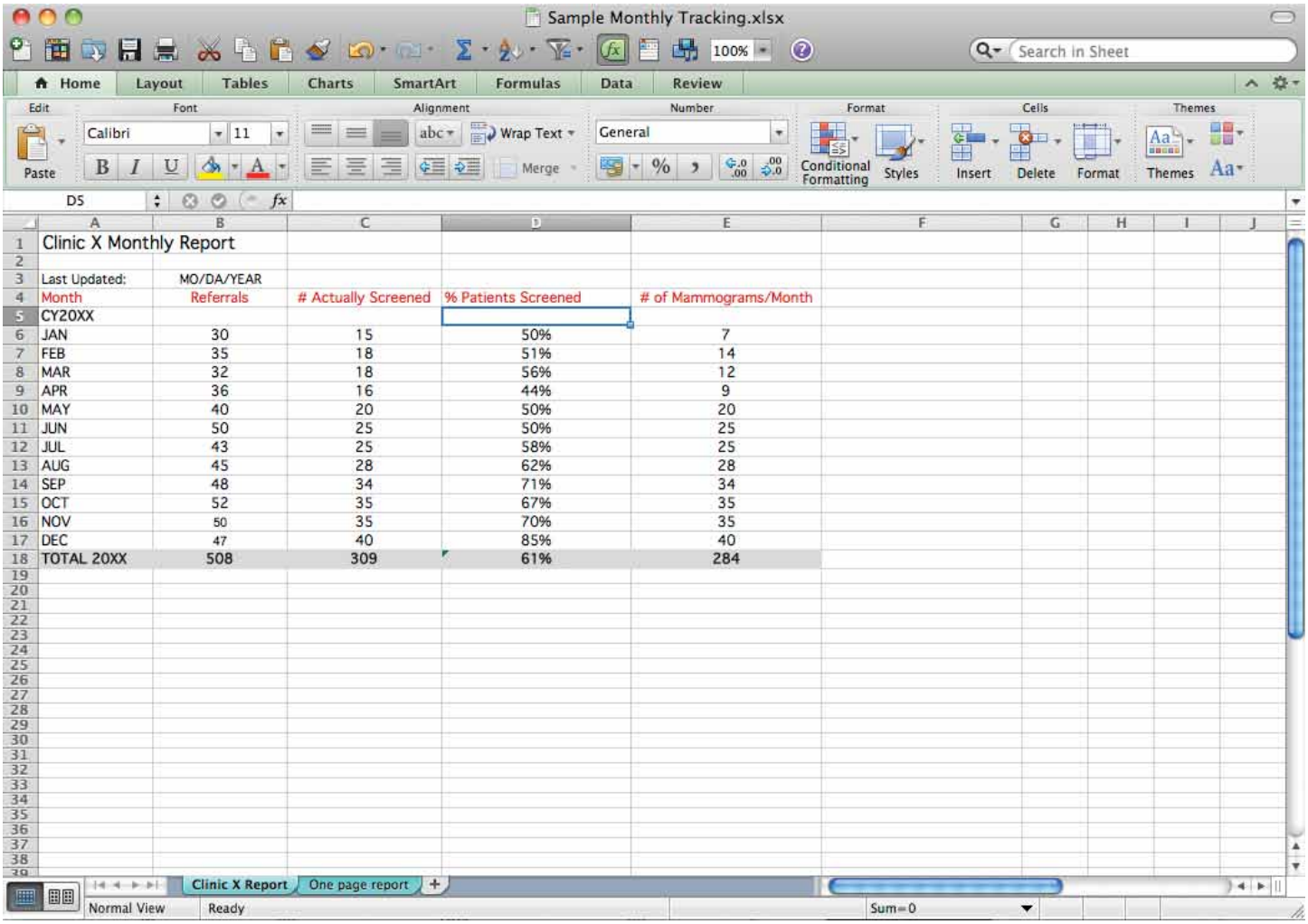
Chart Review Template

Clinic: _____ Date: _____ Auditor: _____

	CHART 1	CHART 2	CHART 3
Patient Name			
Medical Record #			
DOB			
Breast Health Study in past 24 months?	☐ Yes Date: _____ ☐ No	☐ Yes Date: _____ ☐ No	☐ Yes Date: _____ ☐ No
Referral in the past 12 months?	☐ Yes Date: _____ ☐ No	☐ Yes Date: _____ ☐ No	☐ Yes Date: _____ ☐ No
Type of Study	☐ Screening Mammogram ☐ Diagnostic Mammogram ☐ Sonogram ☐ Other _____	☐ Screening Mammogram ☐ Diagnostic Mammogram ☐ Sonogram ☐ Other _____	☐ Screening Mammogram ☐ Diagnostic Mammogram ☐ Sonogram ☐ Other _____
Report in chart?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, Radiology Center/Hospital	☐ Facility A ☐ Facility B ☐ Facility C ☐ Other _____	☐ Facility A ☐ Facility B ☐ Facility C ☐ Other _____	☐ Facility A ☐ Facility B ☐ Facility C ☐ Other _____
If Yes, Results	☐ BI-RADS 0 ☐ BI-RADS 3 ☐ BI-RADS 1 ☐ BI-RADS 4 ☐ BI-RADS 2 ☐ BI-RADS 5	☐ BI-RADS 0 ☐ BI-RADS 3 ☐ BI-RADS 1 ☐ BI-RADS 4 ☐ BI-RADS 2 ☐ BI-RADS 5	☐ BI-RADS 0 ☐ BI-RADS 3 ☐ BI-RADS 1 ☐ BI-RADS 4 ☐ BI-RADS 2 ☐ BI-RADS 5
If Yes, F/U Recommendations	☐ None ☐ 6 months ☐ 1 year ☐ Other: _____	☐ None ☐ 6 months ☐ 1 year ☐ Other: _____	☐ None ☐ 6 months ☐ 1 year ☐ Other: _____
Additional Tests	Test: _____ Date: _____ Location: _____ Result: _____ _____ Test: _____ Date: _____ Location: _____ Result: _____ _____	Test: _____ Date: _____ Location: _____ Result: _____ _____ Test: _____ Date: _____ Location: _____ Result: _____ _____	Test: _____ Date: _____ Location: _____ Result: _____ _____ Test: _____ Date: _____ Location: _____ Result: _____ _____
Other Comments			

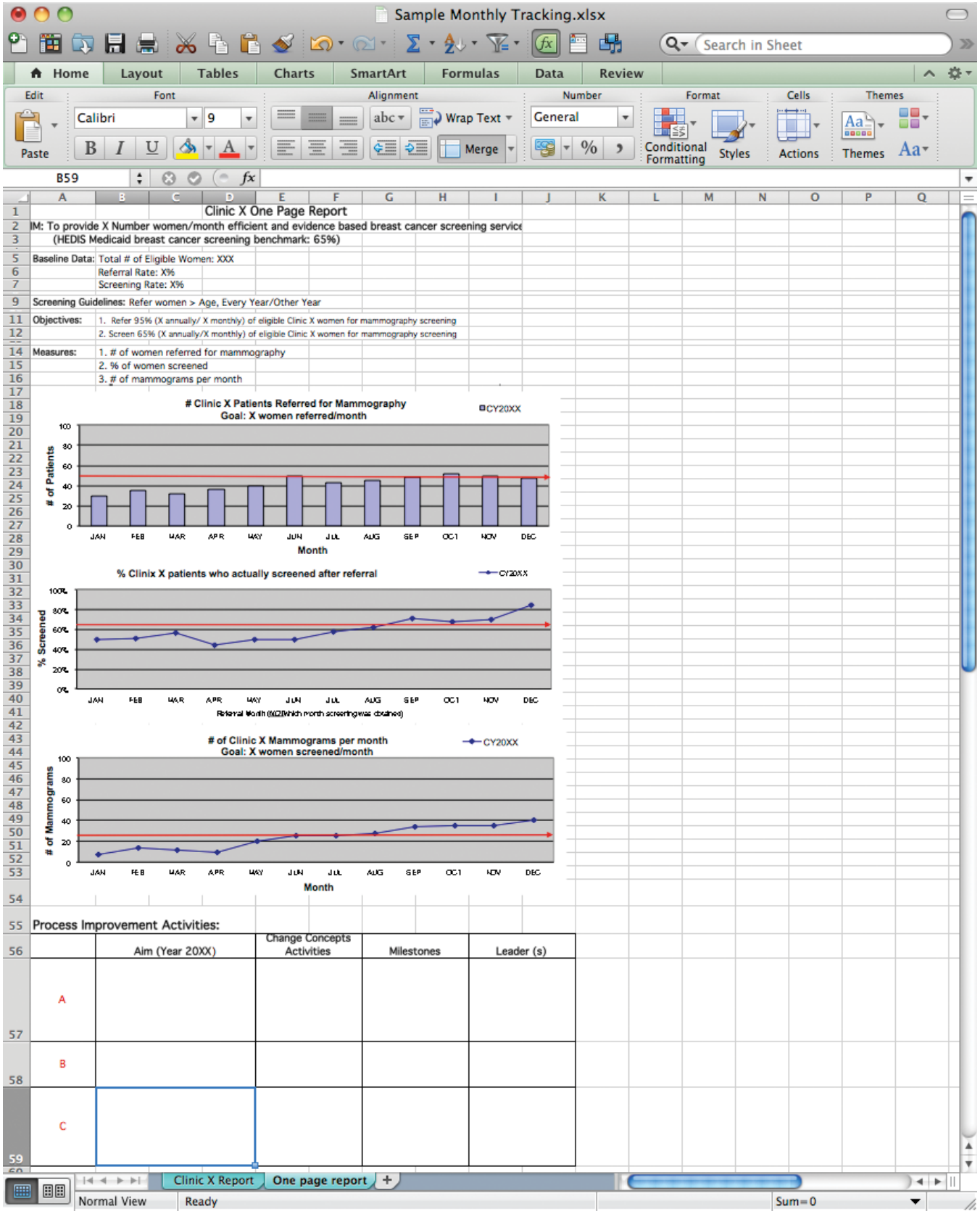
Sample Clinic Monthly Tracking Report

WORKSHEET 1: CLINIC X REPORT



	A	B	C	D	E
1	Clinic X Monthly Report				
2					
3	Last Updated:	MO/DA/YEAR			
4	Month	Referrals	# Actually Screened	% Patients Screened	# of Mammograms/Month
5	CY20XX				
6	JAN	30	15	50%	7
7	FEB	35	18	51%	14
8	MAR	32	18	56%	12
9	APR	36	16	44%	9
10	MAY	40	20	50%	20
11	JUN	50	25	50%	25
12	JUL	43	25	58%	25
13	AUG	45	28	62%	28
14	SEP	48	34	71%	34
15	OCT	52	35	67%	35
16	NOV	50	35	70%	35
17	DEC	47	40	85%	40
18	TOTAL 20XX	508	309	61%	284

WORKSHEET 2: ONE PAGE REPORT



Patient Navigation Pre-Assessment Tool

GOALS

1. What is the goal(s) of your navigation program?

☐ Improved Health Outcomes ☐ Better Patient Experience ☐ Improved Quality Measures

☐ Accreditation ☐ Grant Fulfillment ☐ Other: _____

OPERATIONS

1. What kind of patient navigation is being planned for your practice/ facility?

Patient Navigation	Specific Diagnostic Group (ie. Breast Cancer)			
Outreach				
Cancer screening				
Cancer				
Chronic Illness				
Complex Medical				
Pre-Natal				
HIV				
Behavioral Health				
Other				

2. Who is on the program team?

Physician champion: _____

Administrator: _____

Providers: _____

Nursing staff: _____

Social Services: _____

Patient Navigators): _____

Other(s):_____

3. On a scale of 1-5 with one being the lowest, what is the perceived team commitment? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

4. How will the program be funded?

☐ Grants ☐ Insurance ☐ County/State Funding ☐ Patient Self-Pay ☐ Other: _____

5. Which salaries will be supported by the program budget?

Position	Full time/Part Time	Number of Hours
Patient Navigator		
Outreach Worker		
Administrative Support		
Provider Champion		
Nurse		
Social Worker		
Other		
Other		

6. What additional expenses will be supported by the budget?

☐ Educational Materials ☐ Training ☐ Travel Expenses ☐ Computers ☐ Software ☐ Other: _____

7. Where will the Navigator be housed? _____

8. What equipment will the Navigator need?

☐ Telephone ☐ Computer ☐ Fax ☐ Printer ☐ Other: _____

9. What is the timeline for implementation?

Start Date: _____ Projected Implementation Date: _____

Task	Responsible Person	Date Due	Progress	Date Completed

10. How will patients be identified as eligible for the program?

☐ Provider Referral ☐ Pathology/Radiology/Surgical Reports ☐ Lab Value Parameters
☐ Hospitalizations/ER Visits ☐ Patient Non-adherence to Treatment Plan ☐ Disease State Specific
☐ Preventive Health Needs ☐ Self-Referral ☐ Other: _____

11. What is your anticipated number of patients for patient navigation? _____

12. What is your anticipated patient to navigator ratio? _____

PATIENT NAVIGATOR ROLE

1. Who do you envision in the role of the patient navigator?

   ☐ Nurse ☐ Social Worker ☐ Medical Assistant ☐ Lay-Person ☐ Other: _____

2. What are the primary functions you would like the patient navigator to fulfill?

   ☐ Community Outreach and Education ☐ Care Coordination ☐ Patient Education/Support
   ☐ Financial Counseling ☐ Other: _____

3. What additional activities would you like the patient navigator to be involved in?

   ☐ Quality/Process Improvement ☐ Staff Education Programs ☐ Support Groups
   ☐ Reporting ☐ Health Fairs/Screening Programs ☐ Other: _____

4. Where will the patient navigator document patient interventions?

RESOURCES

1. What internal resources do you currently have in place?

   ☐ Financial Counseling ☐ Social Services ☐ Dieticians ☐ Home Care ☐ Palliative Care
   ☐ Genetic Counseling ☐ Behavioral Health ☐ Hospice ☐ Chaplin Services ☐ PT/OT
   ☐ Pharmacy ☐ Support Groups, Specify: _____
   ☐ Other, Specify: _____

2. What community resources do you currently have relationships with?

   ☐ Health Department ☐ Department of Social Services ☐ Food Banks ☐ Transportation Services
   ☐ Translation Services ☐ Support Groups, Specify: _____
   Other, Specify: _____

OTHER CONSIDERATIONS

1. How will you measure the effectiveness of the program?

   ☐ Patient Health Outcomes ☐ Patient Costs ☐ Patient Experience Surveys ☐ Screening Rates
   ☐ Diagnostic Follow-up Rates ☐ Other: _____

2. Will you need staff training prior to starting the program? ☐ Yes ☐ No

   If yes, who will provide training? _____

3. Do policies and procedures need to be created and/or updated to support the program? ☐ Yes ☐ No

4. Based on your patient population are there any special considerations to meet their needs? _____

_____

_____

FACILITY/PRACTICE DEMOGRAPHICS	
Total Population	
% Female	
% Male	
% 0-18	
% 19-39	
% 40-65	
% 65+	
% White	
% African-American	
% Asian, Pacific Islander	
% American Indian	
% Other	
% Private Insurance	
% Medicaid	
% Medicare	
% Uninsured	
% Hispanic	
% Non-Hispanic	
% Unknown	

5. Is there anyone else needed at the table? ☐ Yes ☐ No If yes, who?

6. What are the challenges/barriers to a successful program? _____

_____

_____

_____

Completed by: _____ Date: _____

Patient Navigator Position Description (*Sample*)

Position Title:	**Patient Navigator**
Supervisory Responsibilities:	
Budget Responsibilities:	
Reports to:	
FLSA:	
Date:	

POSITION SUMMARY

Patient Navigator is self-directed and interacts professionally with a variety of people across multiple disciplines. He/she will demonstrate actions and attitudes that contribute to the critical success factors of patient navigation in a community setting. The position calls for effective communication with safety net clinic staff, providers, community organizations, and patients. It requires knowledge of the environment and system through which a patient must move in order to obtain care.

The Patient Navigator must be able to track and trend clinic progress and effectively communicate findings to clinic management and staff to promote screening services and follow-up to clinic patients.

PRIMARY RESPONSIBILITIES

1. Assist in the identification of clinic patients eligible for navigation.
2. Assess patient's ability to navigate through the healthcare system and identify possible barriers to diagnosis and treatment.
3. Provide patient/family with appropriate educational materials
4. Assist patient in scheduling appointments for routine, diagnostic and/or follow-up care.
5. Assist patient in overcoming financial barriers to obtaining appropriate screening/diagnostic testing and treatment.
6. Contact patients prior to appointments as needed.
7. Monitor the receipt of testing and consult results.
8. Follow-up with patient on results as directed by the provider.
9. Document significant patient navigation activities into the medical record.
10. Ensure coordination of care among treatment providers

SECONDARY RESPONSIBILITIES

1. Develop relationships with personnel and entities providing diagnostic and treatment services to the patient.
2. Participate in Quality Improvement activities as assigned.
3. Provide assistance to spread the learnings of patient navigation to other preventative and disease state patient navigation initiatives.
4. Assist in the training of co-workers.
5. Perform other duties as assigned.

EDUCATION AND EXPERIENCE

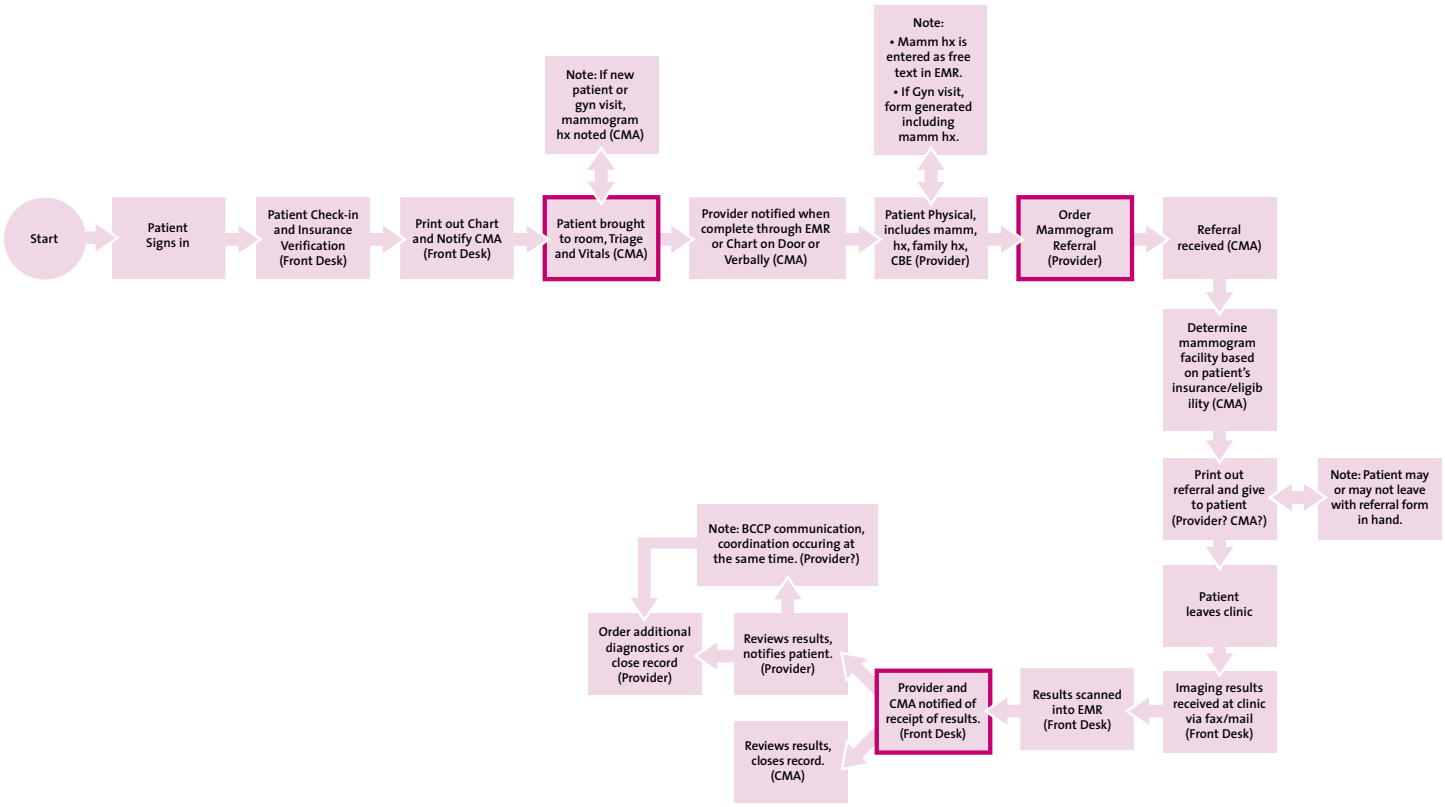
1. Associates degree or equivalent experience in human service fields.
2. Minimum of 1 year experience in working with patients in a clinic setting.
3. Experience working with a diverse, multicultural population

SKILLS AND ABILITIES

1. Bilingual English and Spanish preferred
2. Critical thinking and problem solving skills
3. Ability to communicate clearly and concisely, orally and in writing.
4. Good organizational and time management skills.
5. Ability to maintain composure in stressful situations.
6. Competent in Microsoft Office and applicable software programs.
7. Demonstrate an understanding of and an appreciation for the physical, social and psychological needs of the population served.
8. Demonstrate a positive attitude.

Sample Clinic Process Map

WALKER MILL BREAST HEALTH PROCESS MAP – MARCH 2011



Areas identified for improvement

Sample Memorandum of Understanding for Block Scheduling

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding is entered into this _____ day of MONTH, YEAR, by and between MAMMOGRAPHY PROVIDER. ("Provider") and PRIMARY CARE CLINIC ("Clinic").

BACKGROUND

Provider and Clinic are partnering to improve and expedite access to breast care, including screening and diagnostics, for the low income and underserved. To improve mammography screening rates and reduce the number of patients "lost" along the continuum of breast care, Provider and Clinic are instituting a "block scheduling" program. The benefits of "block scheduling" are:

- The Patient can be scheduled for a mammography appointment by the Clinic, at or near the time of the Clinic visit in which the mammography referral was made. This eliminates a step for the Patient (calling the mammography provider for an appointment), and reduces tracking burden for the Clinic (the Clinic knows the date and time of Patient's mammography appointment).
- The mammography Provider benefits from a Clinic partner that shares a process improvement focus on "no-show' reduction, and simplification of documentation and information exchange.

DEFINITION OF RESPONSIBILITIES

CLINIC RESPONSIBILITIES

The Clinic will be responsible for performing or ensuring performance of the following:

a. Assuring that Patients in need of a mammogram have a referral from an appropriate health provider.

b. Scheduling Patients according to established block times.

c. Filling block times at least 3 business days prior to scheduled date; communicating with Provider to release or hold unfilled slots.

d. Providing appropriate medical information for registration in the format and timeframe requested by Provider.

e. Assisting Patients with requests for prior mammography films.

f. Support Patients that need diagnosis and treatment navigation, by scheduling appointments, finding providers and assisting qualified Patients with completion of public and/or charitable diagnosis and treatment applications.

PROVIDER RESPONSIBILITIES

Provider will be responsible for performing or ensuring performance of the following:

a. PROVIDER will provide Patients with _____ Screening _____ Diagnostic mammograms.

b. PROVIDER will supply mammogram results to Clinic within 5 business days of the mammogram; those with abnormal results will be faxed or electronically transmitted within 3 business days.

c. PROVIDER will ensure Clinic is allotted at least _____ appointment slots per month.

d. Provider will, at least monthly, send a list of "no shows" to Clinic for tracking and follow-up.

MUTUAL RESPONSIBILITIES:

a. Provider and Clinic will each assign a point of contact for scheduling and for process improvement.

b. Provider and Clinic will participate in monthly process improvement meetings/calls as scheduling process is being developed and refined.

c. Provider and Clinic agree to inform the other party at least 30 days in advance, by written notice, if mammography slots are no longer going to be filled (by Clinic) or offered (by Provider).

d. The parties acknowledge and agree that any public information or news release regarding the contents of this MOU, or any promotional or public relations activity regarding any services, programs or facilities established under or arising out of the services provided hereunder shall be undertaken only in a manner which is mutually acceptable, in advance, to each party and upon their respective express, prior written approval.

AUTHORIZED INDIVIDUALS

By signing below, the parties to this MOU certify they are authorized to act for their respective organizations for matters related to this MOU.

CLINIC

By: _____

Name: _____

Title: _____

PROVIDER

By: _____

Name: _____

Title: _____

Timeline and Time Commitment

ACTIVITY	EXPLANATION	TIME COMMITMENT PER YEAR
Project Management	Coordination of activities and monitoring timeline, deliverables, and reporting	8 hours/week (*416 hours*)
Data Collection	Baseline data gathering/Chart review (*500 charts*)	7 days (*56 hours*)
	Baseline data entry (*500 charts*)	5 minutes per entry (*per CHLCare*)
	Report development and regular generation, data cleaning	4 hours/month (*48 hours*)
	Staff training	2 hours
	Chart concordance	Quarterly, 8 hours total
Patient Navigation	Assessment of current navigation activities for breast health.	2 hours
	Patient Navigator training	12 hours
	Patient Navigator	.25 FTE (*salary and benefits*)
Identify and define service population	Breast cancer screening guidelines agreed upon by clinical team.	4 hours
	Determine target population for breast health screening and determine mammography need.	2 hours
Building mammography and breast health resource capacity	Meet with radiology center, develop referral and reporting process with clinic	10 hours
	Create and execute contract/MOU for screening services	3 hours
	Meetings with clinics and other breast health providers to finalize and continue to enhance processes	Quarterly, 4 hours total
Clinic Breast Health PI Activities	Work-plan and timeline development	2 hours
	Process mapping and workflow analysis	12 hours
	Clinic priority setting	2 hours
	PDSA	Ongoing
	Monthly meetings to review data/trends	Monthly, 24 hours total

Members of the Core Project Team Description

CORE PROJECT TEAM

A. Senior Leader/Board Sponsor: _____

The ideal senior leader has ultimate authority to allocate time and resources needed to achieve the team's aims. In addition, this individual has administrative authority over all areas affected by the changes the team will test, can remove barriers to success and will champion the spread of successful changes throughout the organization.

B. Key Contact/QI Manager: _____

A Key Contact/Quality Improvement Manager (QI Manager) is the critical driving component of the project, ensuring that changes are implemented and overseeing data collection. The QI Manager needs to be able to work effectively with the Provider Champion and other clinic staff, and will be the **"Key Contact"** at your organization for the Project.

C. Provider Champion: _____

It is critical to have at least one provider champion on the team. The champion should have a good working relationship with colleagues and should be interested in driving change in the system. Look for a provider who is an opinion leader in the organization, who others go to for advice, and who is not afraid to implement change.

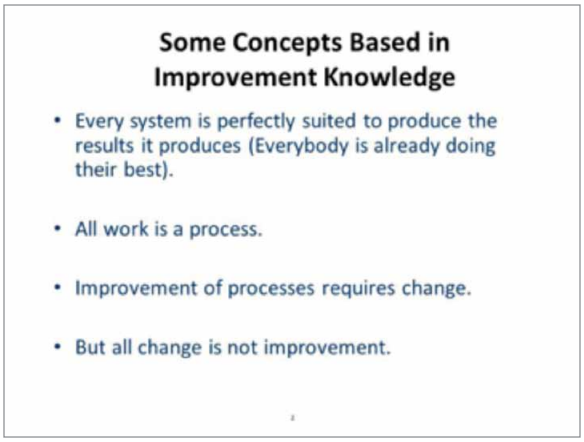
D. Other Team Members *(eg. Case Manager, MA, receptionist, etc.)***:** _____

_____

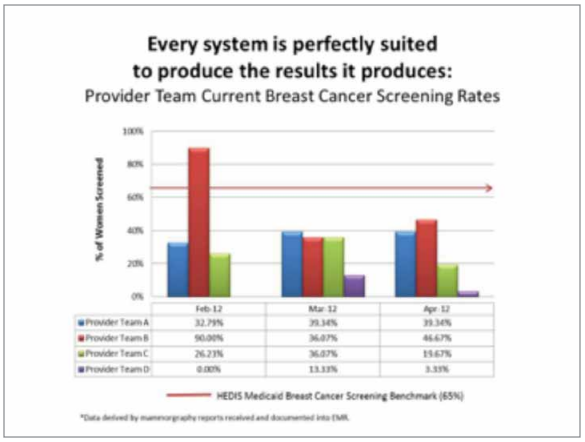
Much of the innovation work in the Project will be focused on the design of new processes. Other persons who are integrally involved in the current processes within the organization should be considered for participation on the improvement team. We recommend that the team include the perspectives of diverse roles. The Project Team should not be predominantly managers.

Process Improvement Concept Overview (*Slides*)

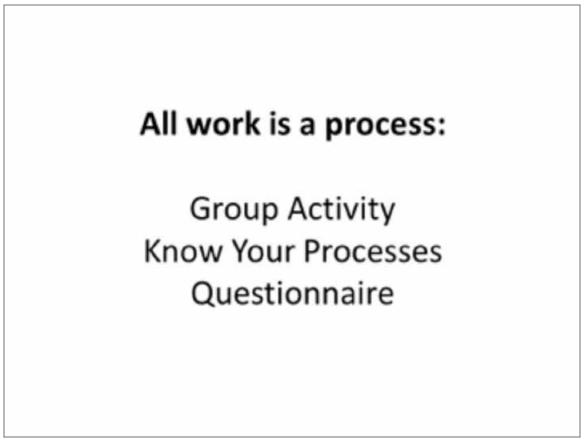
1



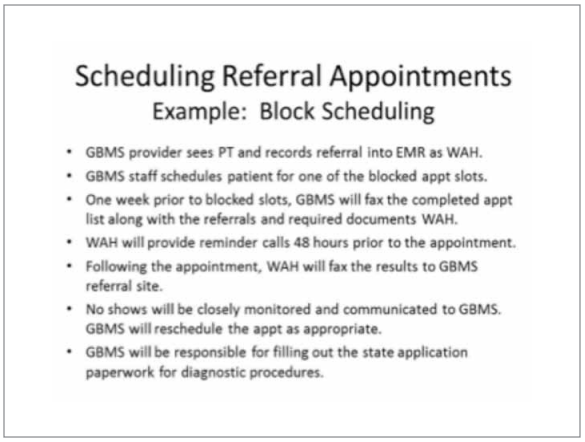
2



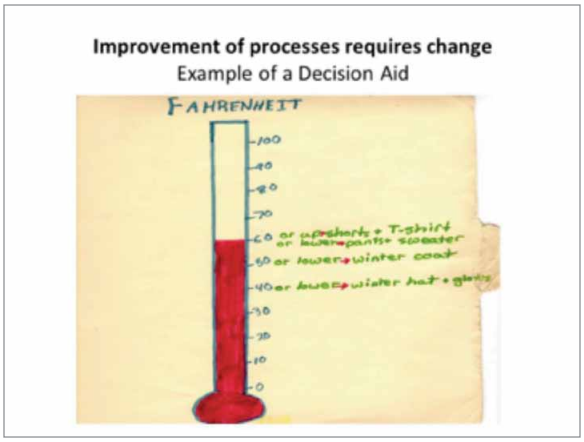
3



4



5



6

Reliable Screening: Identified Best Practices

Process to:	Examples
Identify women for screening	• Flag Charts • EMR Visit Planner Tool • CMA documents during triage
Schedule referral appointment	• Same day walk-in appointments • Block Appointments with partner facility • Centralized appointment system, PT calls from clinic
Getting screening accomplished	• Quick turnaround between referral and screening • PT reminder via phone • Obtaining previous records prior to screening visit • PT education about procedure
Receiving and Acting on results	• Establishing relationships/Improving communication and handoffs • Standardized protocol for follow-up for abnormal results

7

But all change is not improvement:

Planning a Small Test
PDSA Worksheet

8

Model for Improvement

What are we trying to accomplish?

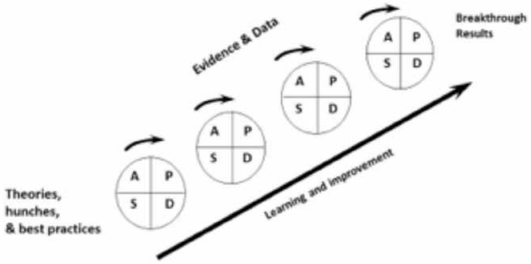
How will we know that a change is an improvement?

What change can we make that will result in improvement?

The Improvement Guide, 2nd Edition, Langley, Nolan, et.al., Jossey-Bass 2009

9

Sequential Building of Knowledge: Include a Wide Range of Conditions in the Sequence of Tests



The Improvement Guide, 2nd Edition, Langley, Nolan, et.al., Jossey-Bass 2009

10

Thank you!

primary care coalition of Montgomery County, Maryland
susan g. komen for the cure
RPCC

11

PDSA Worksheet

Name: _____

Cycles:

1 2 3 4 5 6 7 8 9 10

What do I want to do better?

I. Plan:

What small steps will we take in the next two weeks? (*When? How many times a week?*)

_____

_____

Level of confidence:

1 2 3 4 5 6 7 8 9 10

(*Not Sure*) (*Very Sure*)

II. Actions (Doing):

	April 23-27	**April 30-May 4**
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

III. Studying what we've done:

_____

_____

IV. Reflecting and Acting on what we've done:

_____

_____

Name: Jane Smith **[EXAMPLE: Diabetes Management]**

Cycles:

(1) 2 3 4 5 6 7 8 9 10

What do I want to do better?

- Exercise - Take my Medicine - Self-Monitor - Eat Healthy Foods - Something Else [?]

I. My Plan:

What small steps will I take in the next two weeks? (*When? How many times a week?*)

Instead of having rice every day as part of lunch and dinner, I will stop eating it for a couple of weeks.

My level of confidence:

1 2 3 4 5 6 (7) 8 9 10

(Not Sure) *(Very Sure)*

II. My Actions (Doing):

	March 26 – April 1	**April 2 – April 8**
Monday	No rice	Rice
Tuesday	No rice	Rice
Wednesday	Rice	Rice
Thursday	Rice	Rice
Friday	No Rice	No Rice
Saturday	No Rice	No Rice
Sunday	No Rice	No Rice

III. Studying what I've done:

While I tried to stop eating rice all together, it was too difficult. There was rice at every meal and it was hard to not take.

IV. Reflecting and Acting on what I've done:

This cycle, I will limit my rice to 5 days a week.

ORGANIZATION

Date: _____ Initiated by: _____ Cycle #_____

Purpose of this cycle: _____

PLAN: THE CHANGE, PREDICTION(S) AND DATA COLLECTION

THE CHANGE	
What are we testing?	
On whom are we testing the change?	
When are we testing?	
Where are we testing?	
PREDICTION(s)	
What do we expect to happen?	
DATA	
What data do we need to collect?	
Who will collect the data?	
When will the data be collected?	
Where will data be collected?	

DO: CARRY OUT THE CHANGE/TEST, COLLECT DATA, AND BEGIN ANALYSIS

What was actually tested?	
What happened?	
Observations	
Problems	

STUDY: COMPLETE ANALYSIS OF DATA. SUMMARIZE WHAT WAS LEARNED AND COMPARE TO PREDICTION (USE BACK OF FORM TO ELABORATE).

ACT

What adjustments to the change or method of test should we make before the next cycle?

Are we ready to implement the change we tested?

What will the next test cycle be? (*use back of form to elaborate*)

Institute for Health Improvement (*www.ihi.org*)

Know Your Processes Questionnaires

BREAST HEALTHCARE PROCESSES

Please evaluate the CURRENT state of these processes. Rate each process by putting a tally mark under the heading which most closely matches your understanding of the process. Also mark if the process is a source of patient complaints.

PRIMARY CARE PRACTICE KNOW YOUR PROCESSES – CORE AND SUPPORTING PROCESSES

Processes	Works Well	Small Problem	Real Problem	Totally Broken	Cannot Rate	We're Working On It	Source of Patient Complaint
Answering Phones							
Appointment System							
Messaging to Patients							
Process to indicate when patient due for mammogram screening?							
Risk/History Assessment							
Performing the Clinical Breast Exam							
Ordering mammogram							
Completing the referral							
Scheduling Screening Mammograms							
Scheduling Diagnostic Mammograms							
Receiving Mammogram Results							
Documenting Results in the EMR							
Communication/Relationship with Providers/Radiology centers							
Making Referrals for Re-screenings							
Billing/Coding							
Phone Advice							
Orientation of Patients to Your Practice							
Education for Patients/Families							
Cancer Management/Palliative Care							
	Front Desk	**AMA**	**CMA**	**Nurse**	**Case Manager**	**Provider**	**Other**
Your Role							

CLINIC PROCESSES

Please mark the role or multiple roles that are responsible for each of the following areas as it relates to patient care at your clinic. Please put a tally mark under the heading which most closely matches your understanding of who does what in the process currently.

PRIMARY CARE PRACTICE KNOW YOUR PROCESSES – CORE AND SUPPORTING PROCESSES

Processes	AMA	CMA	Nurse	Case Manager	Provider (MD/NP)	Patient	Other
Answering Phones							
Scheduling Clinic Appointments							
Scheduling Referral Appointments							
Registering the Patient at the Clinic							
Ordering Screening/ Diagnostic Testing							
Receiving Screening/Diagnostic Test Results							
Documenting Screening/Diagnostic Test Results in the EMR							
Renewing Prescriptions							
Contacting Patients about Results							
Following-up with Patients on Outstanding Referrals							
Providing Pre-authorization for Services							
Billing/Coding							
Providing Phone Advice							
Taking Vitals							
Performing Patient Health History and Risk Assessment							
Identifying Women Eligible for Screening							
Documenting History and Assessment Data in EMR							
Performing Patient Exam							
Performing Treatment, Including Minor Procedures							
Providing Health Education for Patients/Families							
Other							

Activities to Support Reliable Screening

PROCESS TO	EXAMPLES
Identify women for screening	• Flag Charts • EMR Visit Planner Tool • CMA documents during triage
Schedule referral appointment	• Same day walk-in appointments • Block Appointments with mammography facility • Centralized appointment system, PT calls from clinic
Getting screening accomplished	• Quick turnaround between referral and screening • PT reminder via phone • Obtaining previous films prior to screening visit • PT education about mammogram procedure
Receiving and Acting on results	• Establishing relationships/Improving communication and handoffs • Standardized algorithm for abnormal results

BREAST HEALTHCARE IMPROVEMENT IN THE SAFETY-NET

Change Package: Rapid Innovation to Improve Outcomes

FUNDED BY:

Susan G. Komen FOR THE CURE®

primary care coalition
of Montgomery County, Maryland

8757 Georgia Avenue, 10th Floor
Silver Spring, MD 20910
www.primarycarecoalition.org

RPCC

1400 16th Street NW, Suite 710
Washington, DC 20036
www.regionalprimarycare.org

FOR MORE INFORMATION: Mary Kate Brousseau, Regional Initiative Manager • 301.628.3441 • marykate_brousseau@primarycarecoalition.org