I. Background

Since 1991, the Michigan Department of Community Health (MDCH) has implemented a comprehensive breast and cervical cancer control program (BCCCP), through a multi-year grant from the U.S. Centers for Disease Control and Prevention. The program goal is to reduce breast and cervical cancer mortality in uninsured or underinsured Michigan women by providing quality screening and diagnostic services to promote early detection of breast and cervical cancer.

In 2014, as a result of the Affordable Care Act (ACA), some women who once were eligible for the BCCCP are no longer eligible. Some of these women are now eligible for Medicaid via the Healthy Michigan Plan (HMP), and some women have purchased insurance through the Marketplace. These changes in eligibility requirements have adversely affected the BCCCP caseload since at least 60-70% of women previously eligible to receive services through the program are now eligible to enroll in the HMP. The remaining women with incomes > 139% ≤ 250%, who have purchased insurance, now may receive both breast and cervical cancer screening services, without co-pays, through their individual health plans. As a result, the BCCCP’s longstanding, primary focus as a cancer screening program is transitioning to a program that will have a dual focus on screening and follow-up diagnostic services especially for women with inadequate insurance coverage for diagnostic services.

These changes have prompted the BCCCP to modify current requirements and add a formalized patient navigation component (PN) to the program. Current outreach and recruitment strategies needed to be modified to assist agencies in identifying both eligible uninsured women who require screening services and underinsured women who require assistance with paying for diagnostic services. Utilizing patient navigation strategies will assist BCCCP agencies to adapt to this change. Patient navigation will not replace the current case management (CM) component of the program but will assist eligible women in accessing needed services and ongoing follow-up care as they navigate the health care system.

II. Patient Navigation Compared to Case Management
A. Patient Navigation

Patient navigation shares characteristics with the current BCCCP case management model. Many BCCCP agencies have been performing some patient navigation duties but have not labeled it as patient navigation because of the overlap with case management. The purpose of this document is to distinguish, from a BCCCP perspective, the differences between navigating a client through the health care system and providing case management for that client based on an identified screening abnormality.
1. **Definition of Patient Navigation**
   The BCCCP defines patient navigation as an intervention or a process that addresses specific barriers to obtaining timely, quality, health care related to breast or cervical cancer screening and early detection.

2. **Goals of Patient Navigation**
   The goals of the BCCCP Patient Navigation Program are to:
   a. Identify eligible uninsured/underinsured clients through implementation of targeted outreach and recruitment strategies and then enrolling them in the program to receive appropriate services.
   b. Develop and implement a plan to reduce barriers (Table 1) that prevent women from keeping breast and cervical cancer screening and/or follow up appointments.
   c. Inform community providers (current and new) of the availability, through BCCCP, of payment for breast/cervical diagnostic services for women with abnormal screening results who have inadequate insurance coverage for follow-up care.

Table 1: Barriers to Receiving Healthcare

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Community Guide Recommendation</th>
<th>Ideas for Coordinating Agencies</th>
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<tbody>
<tr>
<td>System Barriers</td>
<td>- Location of healthcare facility</td>
<td>- Recruit additional providers to cover unserved areas</td>
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<td>- System problems with scheduling convenient screening or diagnostic services</td>
<td>- Refer client to health care facilities in a neighborhood or near public transportation whenever possible</td>
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<td>- Communication of BCCCP services to client’s provider responsible for ongoing care</td>
<td>- Encourage providers to expand clinic schedules to meet client’s needs (example: late hours, evenings, weekends).</td>
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<td>- Work with providers (PCPs) to develop a process to refer clients to the BCCCP for screening and diagnostic testing.</td>
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<td>- Develop a process for referring clients back to PCPs</td>
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<tr>
<td>Financial Barriers</td>
<td>- Insurance Issues</td>
<td>- Refer eligible clients to Health Navigators, HMP and the Marketplace</td>
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<tr>
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<td>- Transportation</td>
<td>- Promote outreach for underinsured clients requiring diagnostic testing.</td>
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<td></td>
<td>- Employment Issues</td>
<td>- To facilitate screening completion, assist clients to identify transportation and childcare options, including friends, family, church and other community organizations.</td>
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<tr>
<td></td>
<td>- Childcare issues</td>
<td>- Consider providing help (example: bus passes) with transportation</td>
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B. Case Management
Over the last 15 years, the BCCCP has successfully implemented a case management program. Women identified with breast or cervical cancer screening abnormalities are case managed according to the BCCCP medical protocol until all diagnostic work-up is completed and a final diagnosis is obtained. The current procedures for implementing case management in the program will not change. Adding a structured patient navigation component will enhance the overall effectiveness of the BCCCP in identifying and providing needed services to eligible women.

1. Definition of Case Management
The BCCCP defines case management as planning and implementing diagnostic interventions for a woman when an abnormal breast or cervical cancer screening test result is identified (Table 2).

- Provision of case management continues until all diagnostic services are completed and a final diagnosis is obtained that either confirms or rules out cancer.
- Case management ends when the final diagnosis is obtained.

| Psychosocial Barriers | • Perception or beliefs about tests or treatment  
|                       | • Trust: Attitudes towards medical system/personnel  
|                       | • Fear of procedure or diagnosis  
|                       | • Fatalistic view of cancer: cultural and personal beliefs  
|                       | • Delay in receiving care due to personal issues  
|                       | • Lack of knowledge about cancer screening and follow-up  | • Assess client beliefs about cancer and the tests/treatment associated with it.  
|                       |                                                        | • Provide education aimed at increasing trust and decreasing fears.  
|                       |                                                        | • Collaborate with community health worker (CHW) or trusted members of the community to increase trust about test/treatments.  
|                       |                                                        | • Educate staff and providers about the cultural beliefs common to the women served. Educated providers are better able to provide culturally appropriate care and client education.  
|                       |                                                        | • Provide education to BCCCP clients regarding cancer screening and follow-up care  | • Communication Barriers | • Non-English speaking or need for Interpreter  
|                       | • Literacy issues  
|                       | • Communication concerns with medical personnel  | • Identify and meet the needs for client education of non-English speaking and/or low literacy clients: screening materials in various languages, pictures, video, interpreters  
|                       |                                                        | • Provide staff education on literacy issues, including plain language; assess client literacy. Written educational materials may not be of use to clients with limited literacy  |
• Women diagnosed with cancer are assisted with obtaining treatment services either through the BCCCP Medicaid Treatment Act (MTA) or an alternate way if ineligible for MTA.

Table 2: Abnormal Screening Results Requiring Case Management Services

<table>
<thead>
<tr>
<th>CBE Results</th>
<th>Abnormality: R/O cancer (includes findings of: dominant mass, nipple discharge, asymmetrical thickening, skin changes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammogram Results</td>
<td>ACR 0: Assessment Is Incomplete and biopsy is performed, ACR 4: Suspicious Abnormality, ACR 5: Highly Suggestive of Malignancy;</td>
</tr>
<tr>
<td>Pap test Results</td>
<td>ASC-US with + HPV, ASC-H, AGC, HGSIL, Squamous Cell Carcinoma or Adenocarcinoma</td>
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2. **Goal of Case Management**
   The goal of the BCCCP Patient Case Management Program is to deliver timely and appropriate breast and cervical diagnostic services according to the BCCCP medical protocol and the CDC Clinical Performance Indicators of timeliness and completeness. Refer to **BCCCP Case Management Documentation/Reimbursement Guidelines**.

III. **BCCCP Patient Navigation Responsibilities**

A. **Staff Requirements for Patient Navigation**
   Navigation services can be provided by one person or shared by several individuals. The Patient Navigator does not need to be a health care professional to provide non-clinical services to enrolled women. Different program components can be shared among different staff members.

B. **Components of the BCCCP Patient Navigation are as follows:**
   1. **Identifying Eligible Women/Appropriate Referrals**
      Goal: Identify Program Eligible women and refer ineligible women to the appropriate agency
      a. **UNINSURED WOMEN (stated income ≤ 138% Federal Poverty Level) (FPL)**
         • Verify that the woman does not have Medicaid or the Healthy Michigan Plan.
         • Enroll the woman first in BCCCP to receive screening and/or diagnostic services.
         • At the time of enrollment, explain to the woman that she may be eligible for HMP (based on her income) and provide HMP program information.
         • Refer the woman to a certified health insurance enrollment counselor at ENROLL MICHIGAN (http://enrollmichigan.com/) OR the website www.michigan.gov/mibridges
b. **UNINSURED WOMEN (stated income is > 138% but ≤ 250% FPL)**
   - Enroll the woman in BCCCP to received screening and/or diagnostic services
   - Explain to the woman that she may be eligible to enroll in a health plan during open enrollment for the Health Insurance Marketplace.
   - Refer the women to a certified health insurance enrollment counselor at Enroll Michigan (http://enrollmichigan.com/) or give information on enrollment dates for health insurance through the Marketplace.

c. **UNDERINSURED WOMEN (stated income is > 138% but ≤ 250% FPL)**
   - Women with insurance may be eligible for the BCCCP if they are identified with a breast or cervical abnormality requiring diagnostic follow-up AND have a high deductible that must be met and/or inadequate coverage for diagnostic tests.
   - Enroll women and document services provided as described in the Patient Navigation Documentation Guideline.

**NOTE:** Undocumented women (non-citizens), ≤ 250% FPL, are ineligible for HMP or Health Insurance Marketplace. For these women, enroll in BCCCP and provide needed services.

2. **Targeted Provider Outreach**
   Goal: Build upon existing relationships agencies have cultivated through the program as well as promote BCCCP services to providers not familiar with the program. Providers include: Primary Care Providers, Gynecologists, Surgeons, Hospitals, Social Workers, Patient Navigators, Community Health Workers, Clinics, Health Systems, FQHC’s, Mammography Facilities, etc.

   a. Develop/modify a current process within your agency to:
      - Contact current providers to inform them of BCCCP program changes in enrolling uninsured and underinsured women.
      - Identify new providers/agencies that potentially could become bi-directional referral resources for uninsured and underinsured women.

   b. Maintain contact with providers throughout the year in order to obtain screening/diagnostic test results, and communicate any changes in program requirements.

3. **Targeted Recruitment Aimed at Eligible Women:**
   Goal: Promote changes in BCCCP services by building upon existing relationships or establishing new relationships with community organizations.
a. Develop a current process to:
   - Contact community agencies and/or organizations (churches, migrant organizations, Komen, ACS, Michigan Works!, etc.) and provide information on BCCCP services available to uninsured/underinsured women.
   - Streamline client referrals from community agencies/organizations to the PN to facilitate enrollment in the BCCCP.

b. Resolve barriers (Table 1) for underinsured women to receive diagnostic services or uninsured women to receive both screening and diagnostic services, (if needed)

IV. BCCCP Case Management Activities
A. Staff Requirements for Case Management
   Case Management services are provided by a health care provider (RN, Nurse Practitioner, Physician, Physician Assistant) to assure timely and appropriate delivery of diagnostic services for an abnormal breast or cervical screening abnormality.

B. Specific responsibilities
   1. **Arranges** necessary follow-up according to BCCCP Medical Protocol based on screening abnormality (Table 2).
   2. **Communicates** diagnostic follow-up results (and any need for additional follow-up) to the client and the client’s provider.
   3. **Assists** client with obtaining cancer treatment (if diagnosed) through the BCCCP Medicaid Treatment Act (MTA), or other appropriate treatment if not eligible for MTA.
   4. **Documents** case management services and follow-up care provided in the client’s medical record. This should include a client-centered plan of care, and addresses assessment, planning, implementation, provision of client education and support, coordination, monitoring and evaluation.
   5. **Assures** all clinical services are documented in the Michigan Breast and Cervical Information System (MBCIS) according to program procedures.
   6. **Refers** client either for treatment or back to primary care provider for follow-up. If 6-month follow-up is required the agency will work with the woman to schedule the test or refer the client back to her primary for follow-up.

V. Patient Navigation Documentation Requirements for Reimbursement
A. Reimbursement for Patient Navigation
   Each agency will be given $30.00 per caseload woman for patient navigation services. These funds are in addition to $95.00 per caseload woman for coordination. Funds will be allocated at the same time as coordination dollars.
   (NOTE: Case management funds will be reimbursed separately for clients completing diagnostic work-up for an abnormal screening result).
B. Documentation Requirements for Patient Navigation Reimbursement
The following MUST be completed and submitted by the required due dates as a requirement for the continued allocation of the $30.00 for patient navigation. (Refer to Patient Navigation Documentation Guidelines)
1. Completion of FY15 Outreach and Recruitment Plan to Increase Caseload
   Submission of plan is due to E.J. Siegl by 12/1/14.

2. Documentation in MBCIS and BCCCP Enrollment Form of required information on UNINSURED women referred to the Healthy Michigan Plan

3. Documentation of the following for each quarter on the Patient Navigation Quarterly Report:
   a. Patient Navigation Services
      - # of Title X/Family Planning women < age 40 enrolled in BCCCP for follow-up of abnormal CBE result
      - # of women with stated incomes < 138% FPL referred to HMP
      - # of women with stated incomes 139%-250% FPL referred to Health Navigators at Enroll Michigan to obtain Marketplace Insurance
      - # of women in the community, regardless of insurance status, and whom may or may not be eligible for BCCCP, referred for appropriate services
      - # of women with breast/cervical cancer diagnosis referred to ACS
   
   b. Outreach/Recruitment Strategies to identify eligible uninsured/underinsured women
      - # of UNINSURED eligible women enrolled in BCCCP
      - # of UNDERINSURED eligible women enrolled in BCCCP
   
   c. Provider Outreach to increase client referrals
      - # current/new providers contacted/informed of diagnostic services available through BCCCP

VII. Case Management Documentation Requirements for Reimbursement

A. Reimbursement for Case Management
   Upon completion of diagnostic testing and determination of a final diagnosis, including treatment disposition and treatment start date (if cancer diagnosed) Local Coordinating Agencies will be reimbursed $95/screening cycle for BCCCP clients.

B. Documentation Requirements
   Refer to information specified in the BCCCP Case Management Documentation Guidelines for specific information to document in MBCIS.