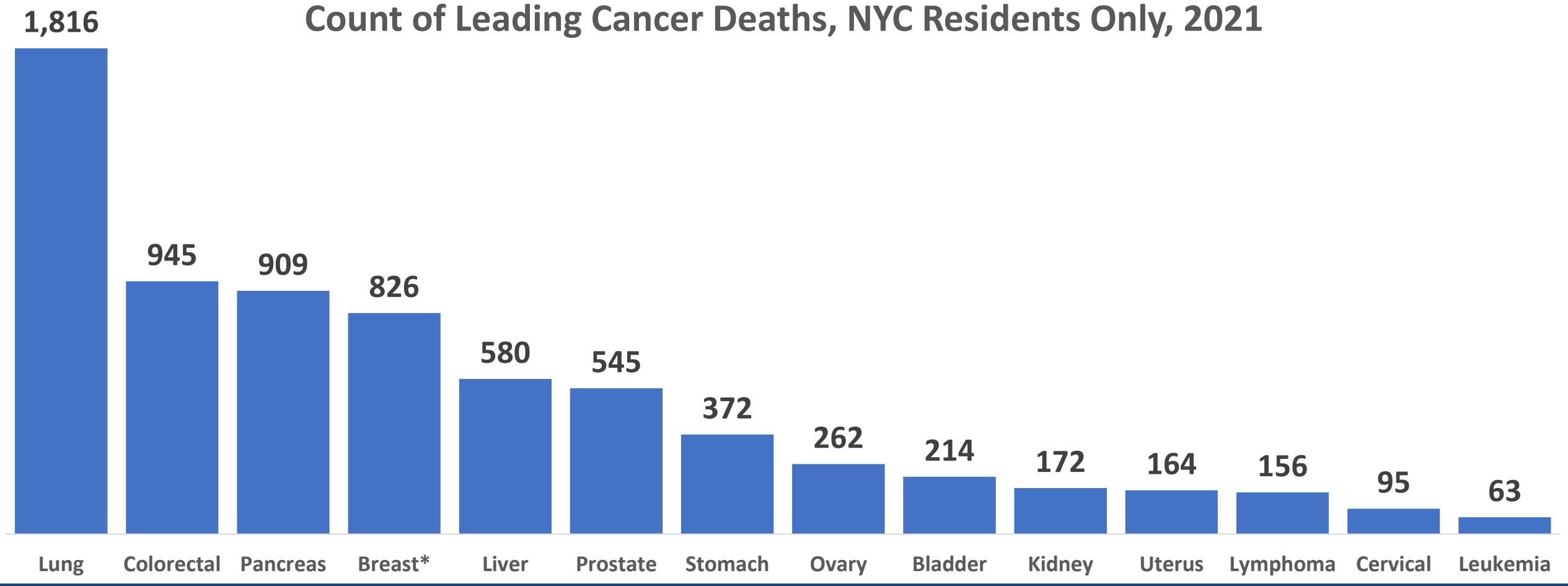
NYC COMMUNITY CARES PROJECT

Project Update as of August 2024

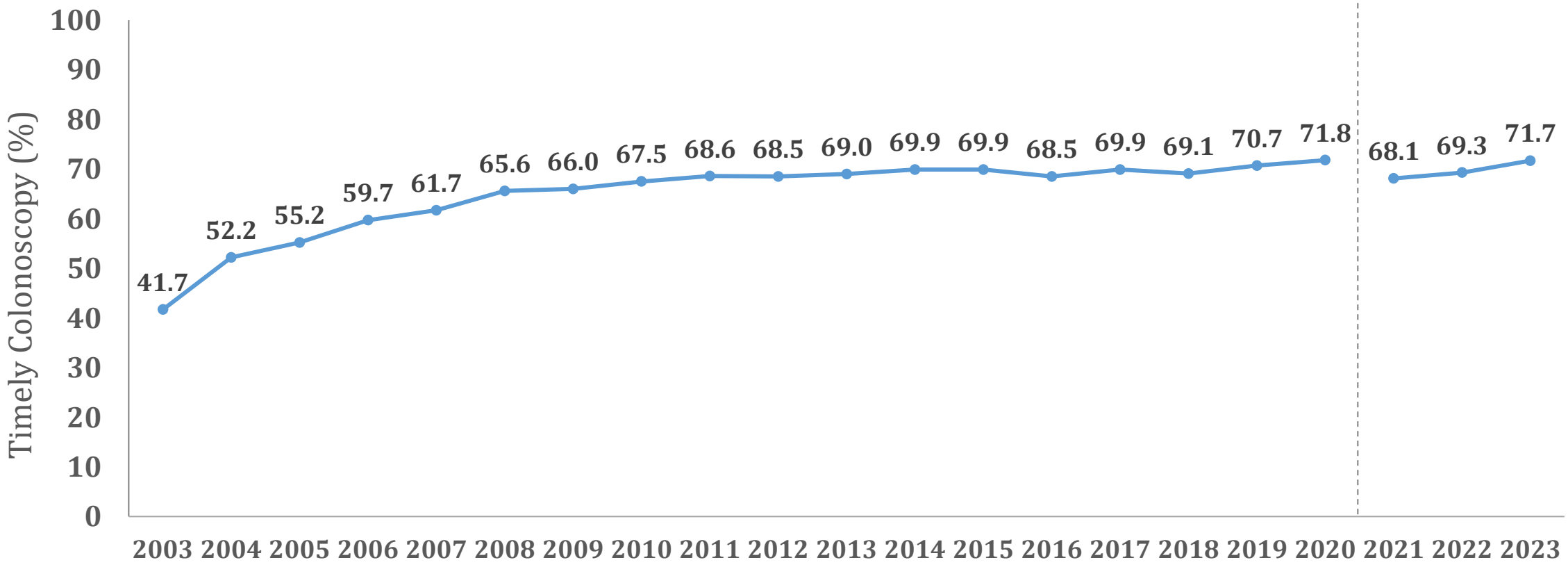
A Leading Cause of Cancer Death in NYC



Source: NYC Office of Vital Statistics, 2021

NYC Health

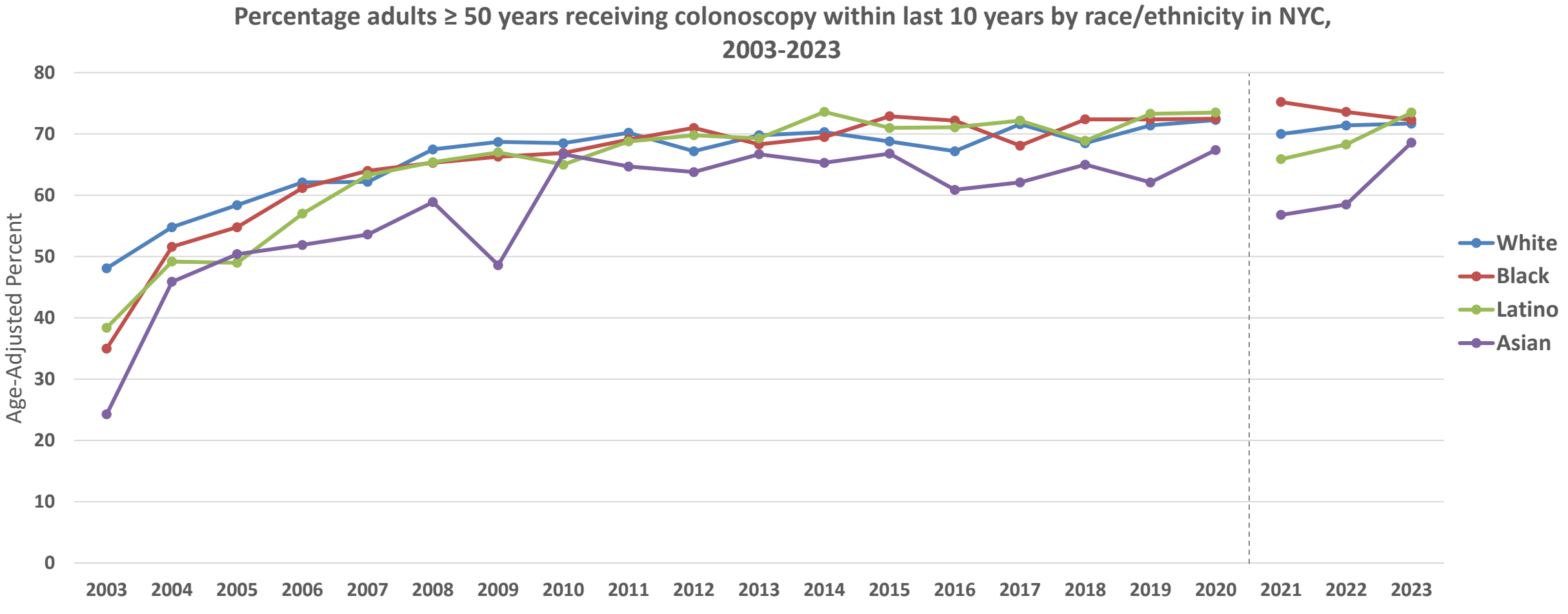
Timely Colonoscopy among NYC Adults Ages 50+ Years, 2003-2023



*Note that the American Cancer Society changed the recommended age for colorectal cancer screenings to 45+

Data Source: NYC Community Health Survey, 2003-2023. CHS has included adults with landline phones since 2002 and, starting in 2009, has also included adults who can be reached by cell phone. In 2021, CHS shifted to Address Based Sample (ABS) in which respondents primarily participate by taking the survey on the web, with phone and paper options also available.
Data are age-adjusted to the US 2000 Standard Population.

Gaps in NYC Screening Colonoscopy Adherence by Race/Ethnicity

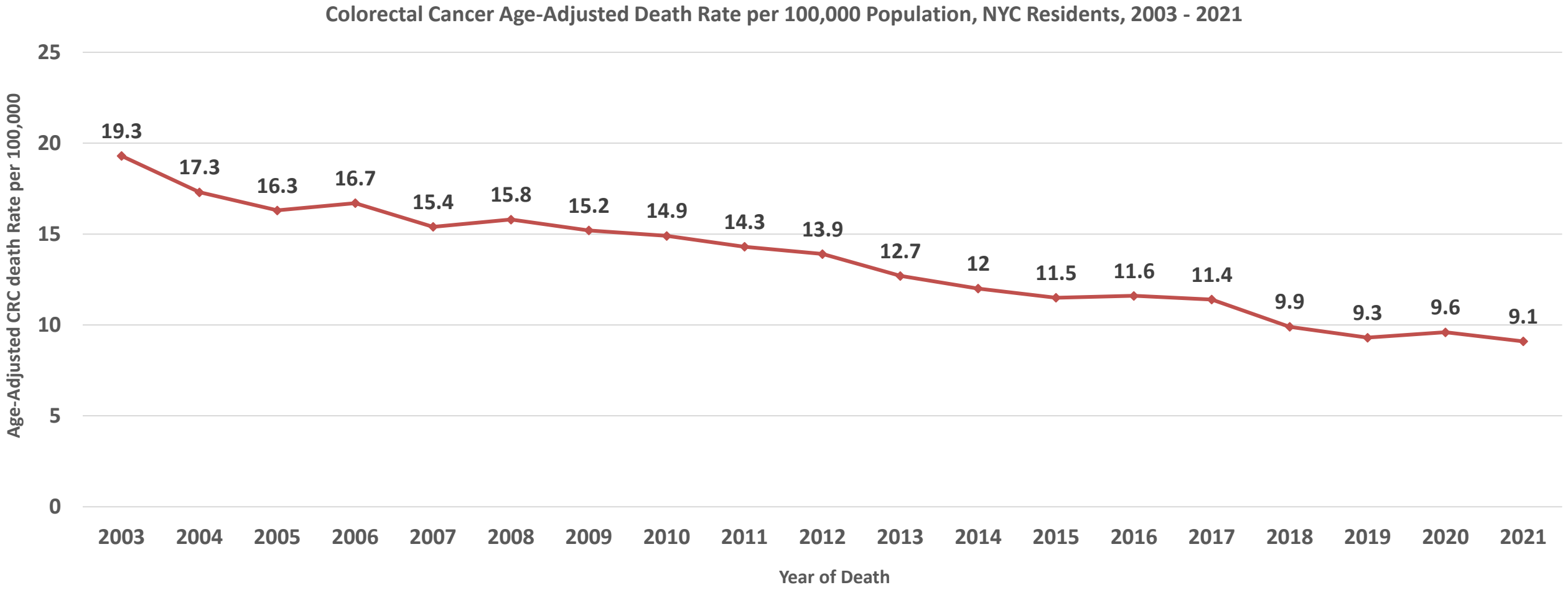


Data Source: NYC DOHMH Community Health Survey, 2003-2021. CHS has included adults with landline phones since 2002 and, starting in 2009, has also included adults who can be reached by cell phone. In 2021, CHS shifted to Address Based Sample (ABS) in which respondents primarily participate by taking the survey on the web, with phone and paper options also available.

Trend for each race/ethnicity is significant at $p < .001$.

NYC Health

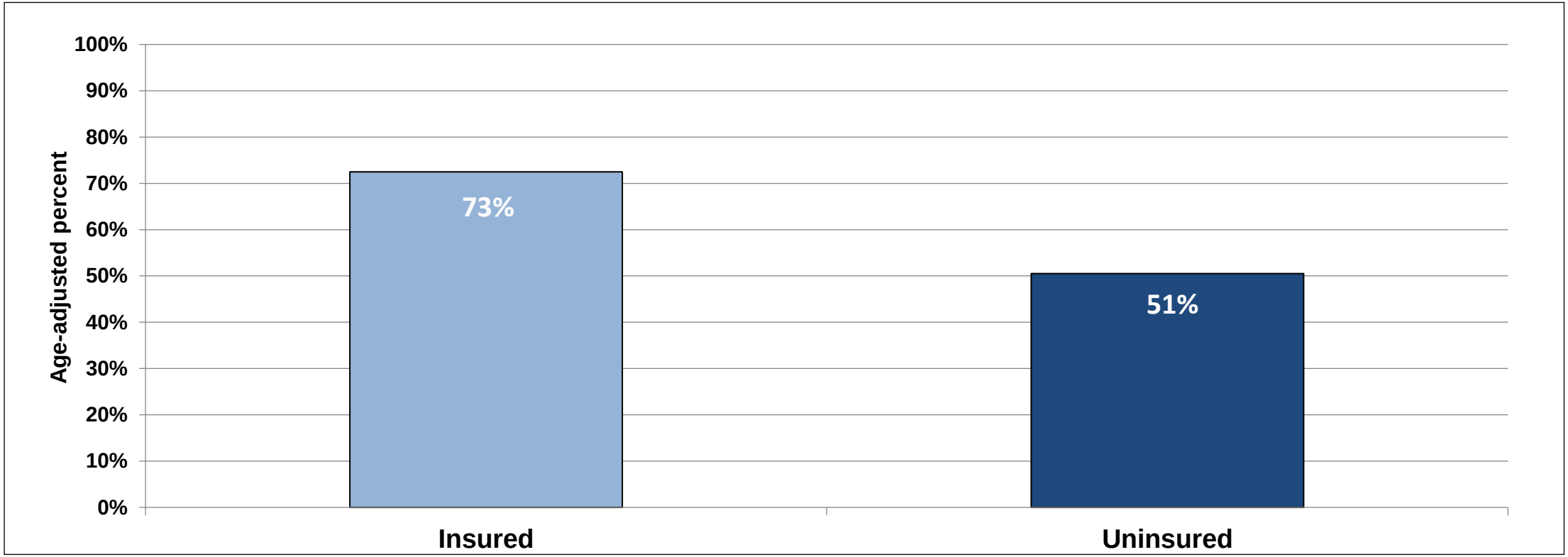
Colorectal Cancer Age-Adjusted Death Rate per 100,000 Population, NYC Residents, 2003 - 2021



Source: NYC Department of Health and Mental Hygiene. Vital Statistics. Death/Mortality Data 2003-2020. Rates are age adjusted to the 2000 US Standard Population (modified from US Census Bureau interpolated intercensal population estimates, 2000-2020)

Colonoscopy Adherence Lower for Uninsured New Yorkers

Percentage NYC adults aged ≥ 50 years receiving colonoscopy in past 10 years, by insurance status, 2023

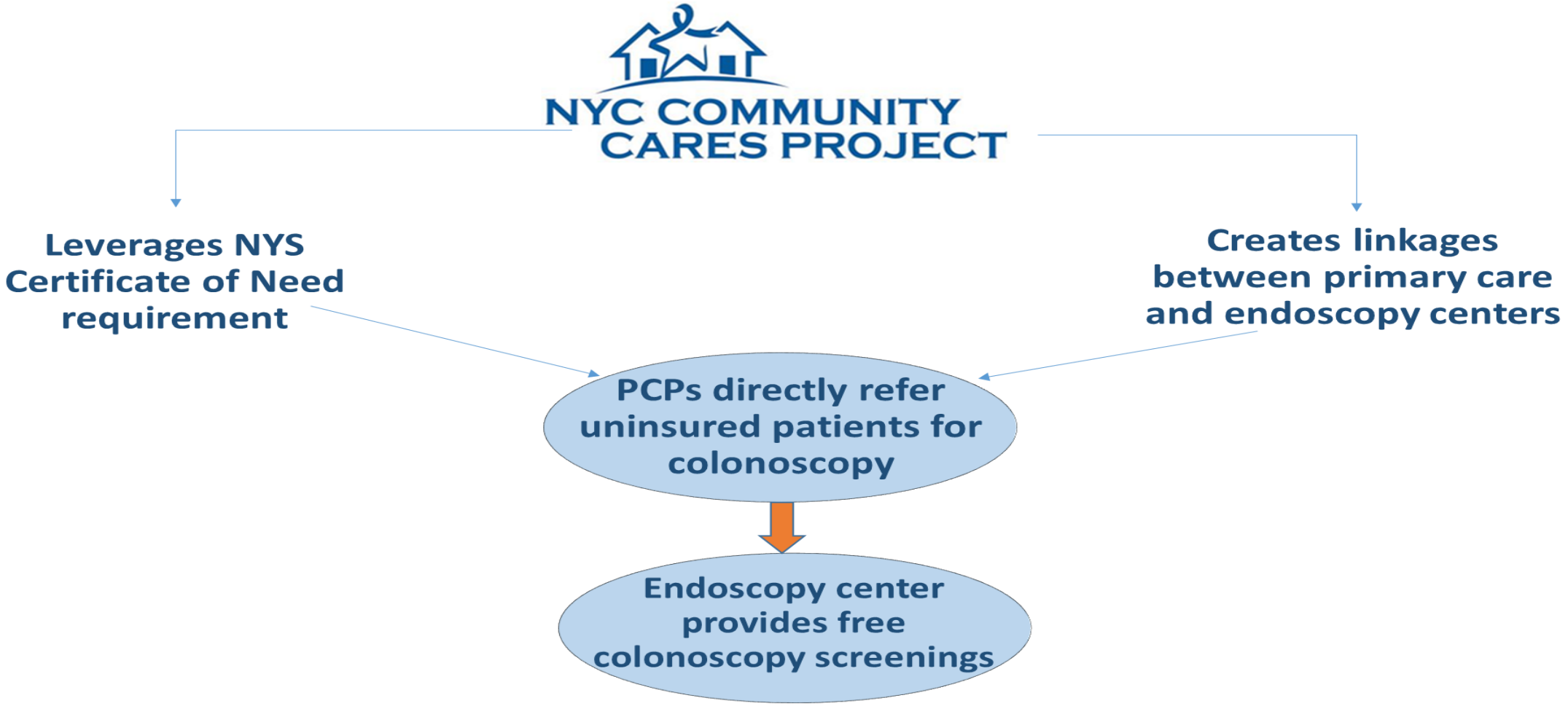


Data Source: NYC DOHMH Community Health Survey, 2023.

Addressing Disparities in Care: Colonoscopy for the Uninsured in NYC

- Interventions are needed to assist uninsured people and those without a PCP
- Community Cares Project (CCP), established in 2013, is a DOHMH intervention
  - Aims to reduce inequity between the insured and uninsured
  - Links uninsured New Yorkers from Community Health Centers to participating Endoscopy Centers
  - They provide colonoscopy, anesthesia and pathology free of charge
- From 2013 to the present day, the total number of patients screened through CCP is 5,308

NYC Community Cares Project (CCP) Model Links Uninsured Patients to Care



The NYC Community Cares Project is a collaboration supported by the C5 Coalition, the NYS Department of Health and the NYC Department of Health and Mental Hygiene.

NYC Health

NYC CCP Referring Primary Care Sites, 2024

Primary Care Networks and Sites

- Charles B. Wang Community Health Center
- Community Healthcare Network
- Family Health Centers at NYU Langone
- Flushing Hospital Medical Center
- Institute for Family Health
- Jamaica Hospital Medical Center
- Ryan Health Network

Health + Hospital Primary Care Sites

- NYC Health + Hospitals/Gotham Health, East New York
- NYC Health + Hospitals/Gotham Health, Gouverneur
- NYC Health + Hospitals/Gotham Health, Morrisania

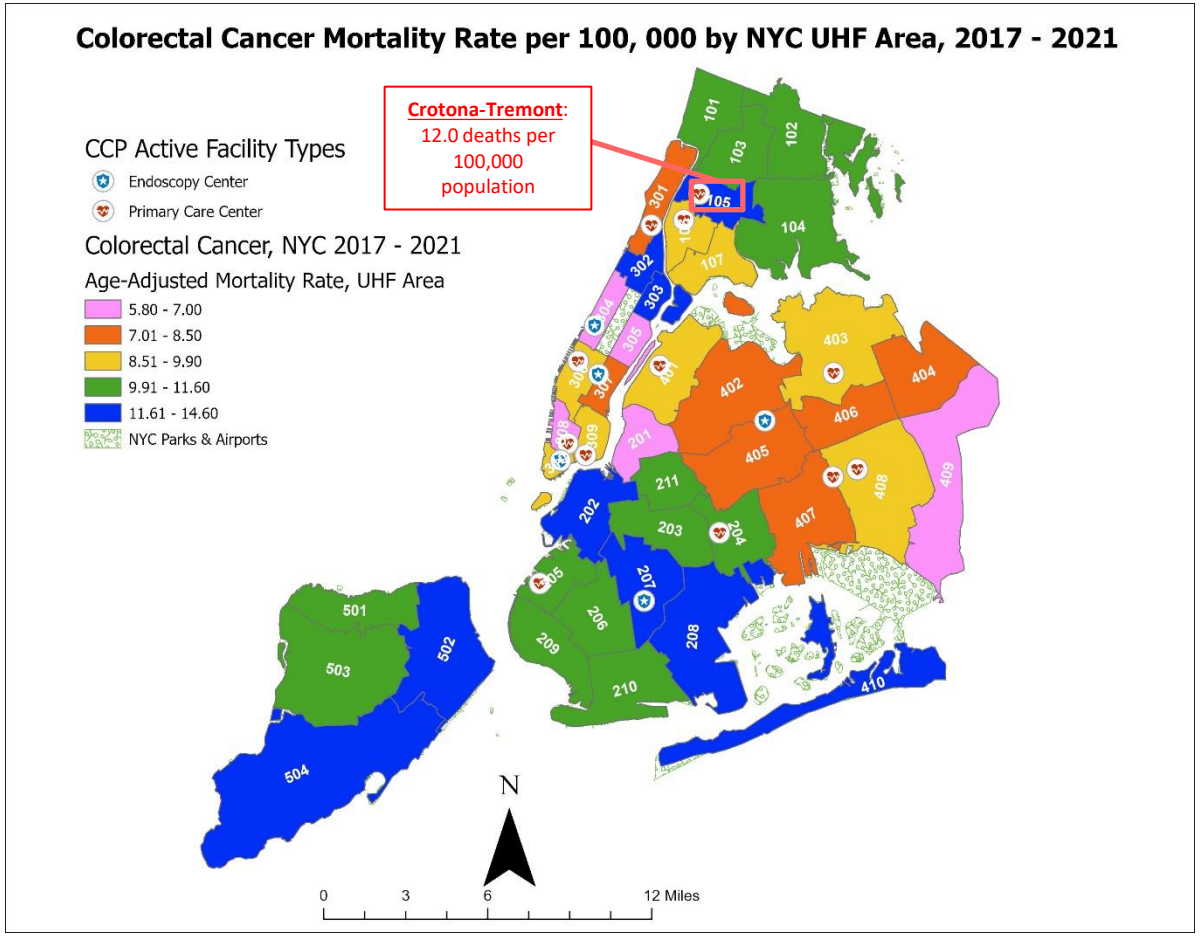
Active participating sites as of August 2024.

NYC CCP Participating Ambulatory Surgery Sites, 2024

- Goldstep Ambulatory Surgery Center
- Liberty Endoscopy Center
- Manhattan Endoscopy Center
- Queens Boulevard Endoscopy Center
- Mount Sinai CHOICE Program
  - Mostly via Upper Westside Endoscopy

Active participating sites as of August 2024.

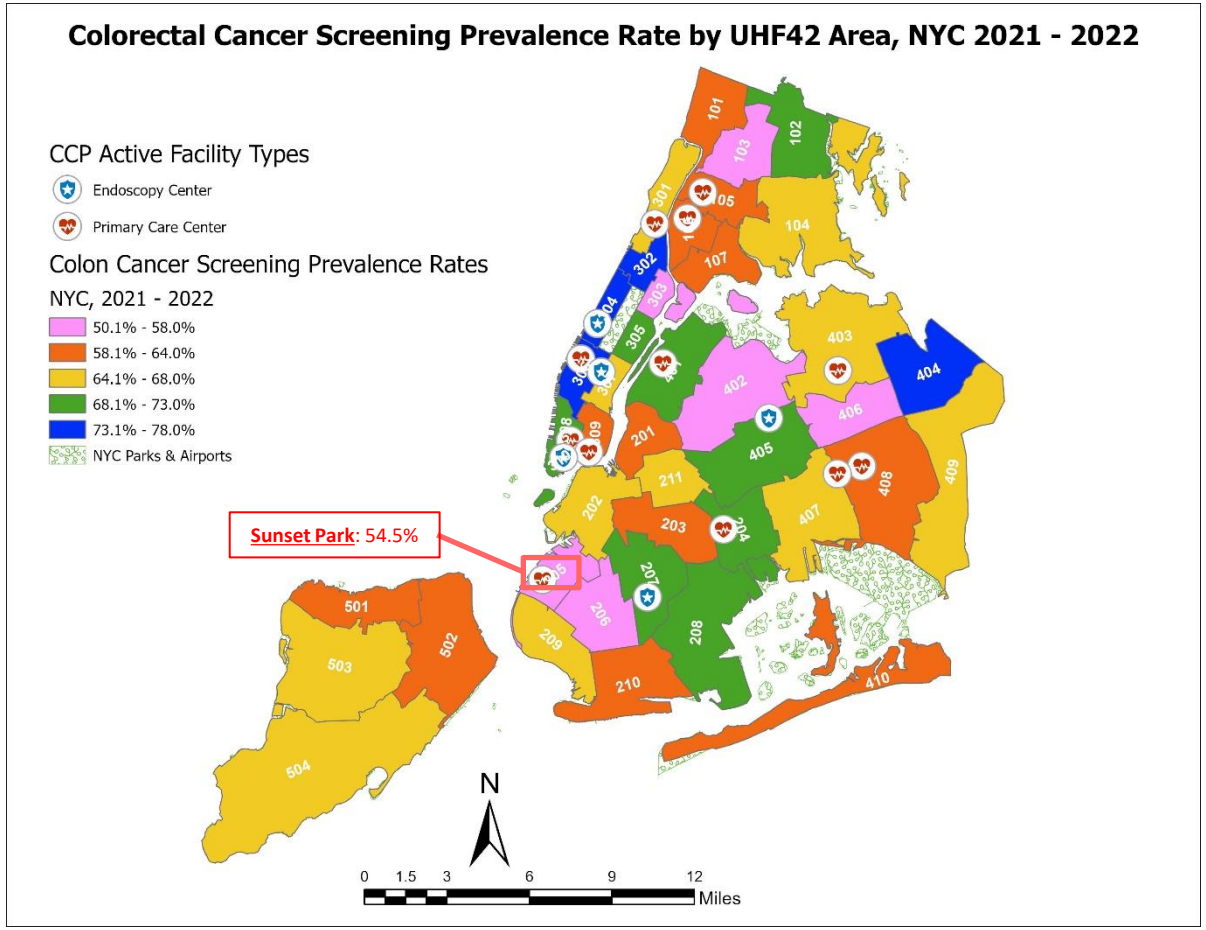
CCP Participating Sites Across the City and Colorectal Cancer Mortality Rates



*Neighborhoods on the map are United Hospital Fund (UHF) Neighborhoods

Source: NYC Department of Health and Mental Hygiene. Vital Statistics. Death/Mortality Data 2017-2021.

CCP Participating Sites Across the City and Colonoscopy Screening Rates



*Neighborhoods on the map are United Hospital Fund (UHF) Neighborhoods

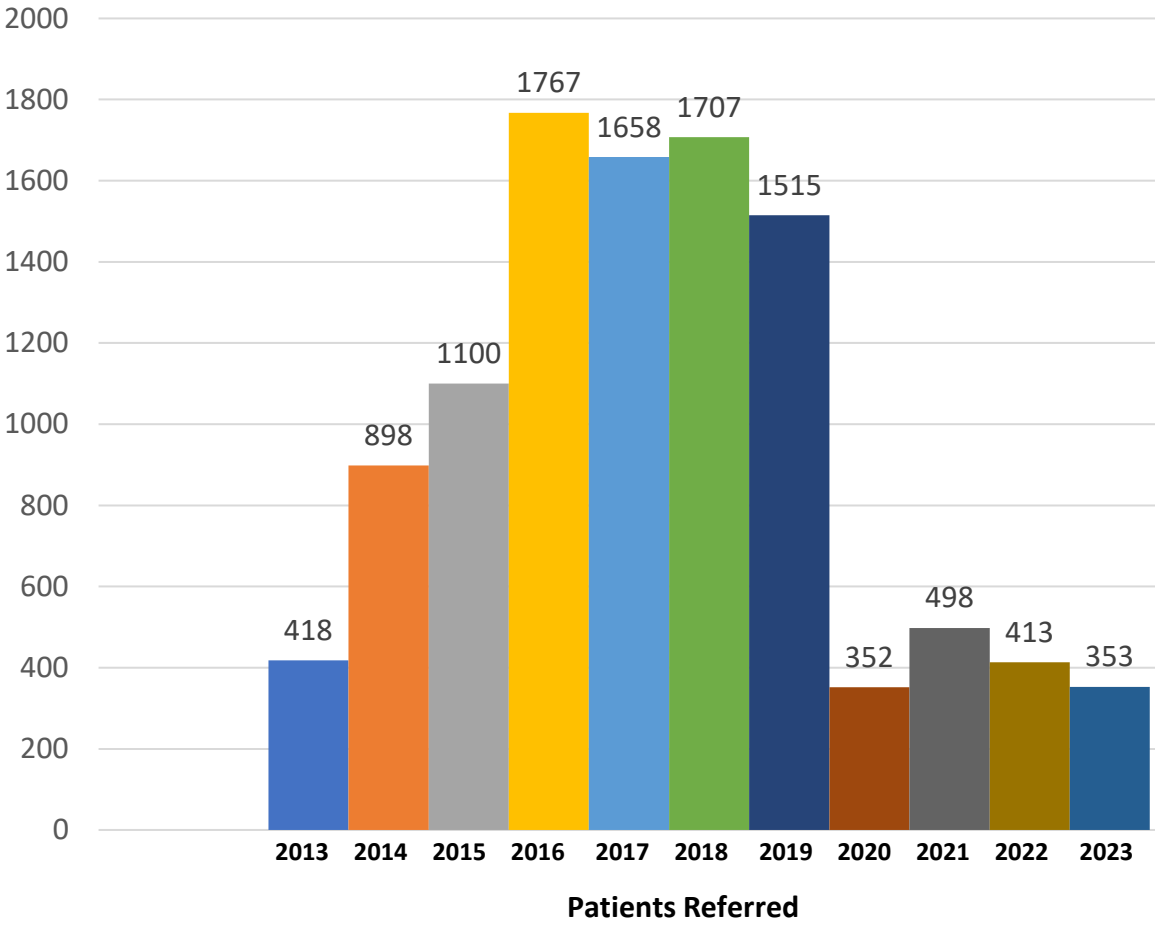
Source: NYC Community Health Survey, 2021-2022. Data are age-adjusted to the US 2000 Standard Population.

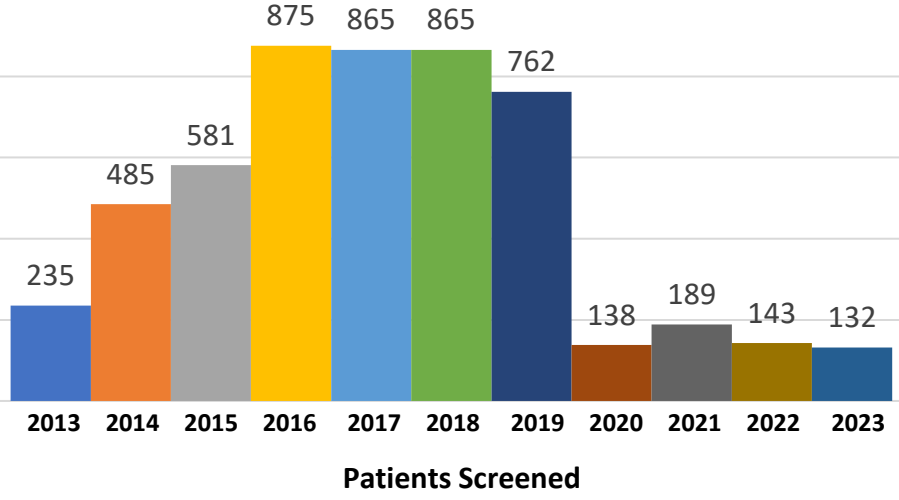
NYC CCP Data Collection

From all participating sites DOHMH collects:

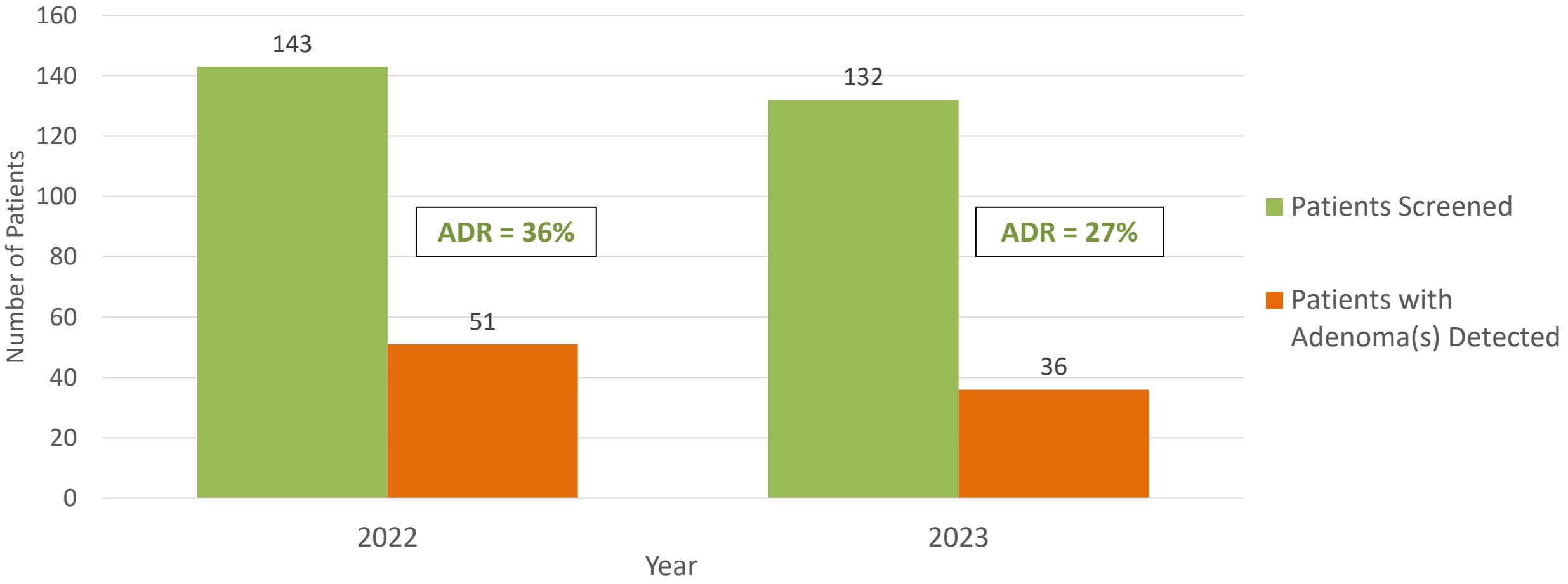
- Number of colonoscopy referrals received from primary care centers
- Number of patients scheduled for colonoscopy
- Number of patients screened by colonoscopy, no-shows, cancellations
- Number of patients with adenomas detected during colonoscopy
- Number of patients with a colon cancer diagnosis

Year over Year Comparison, Uninsured Patients Served 2013 - 2023



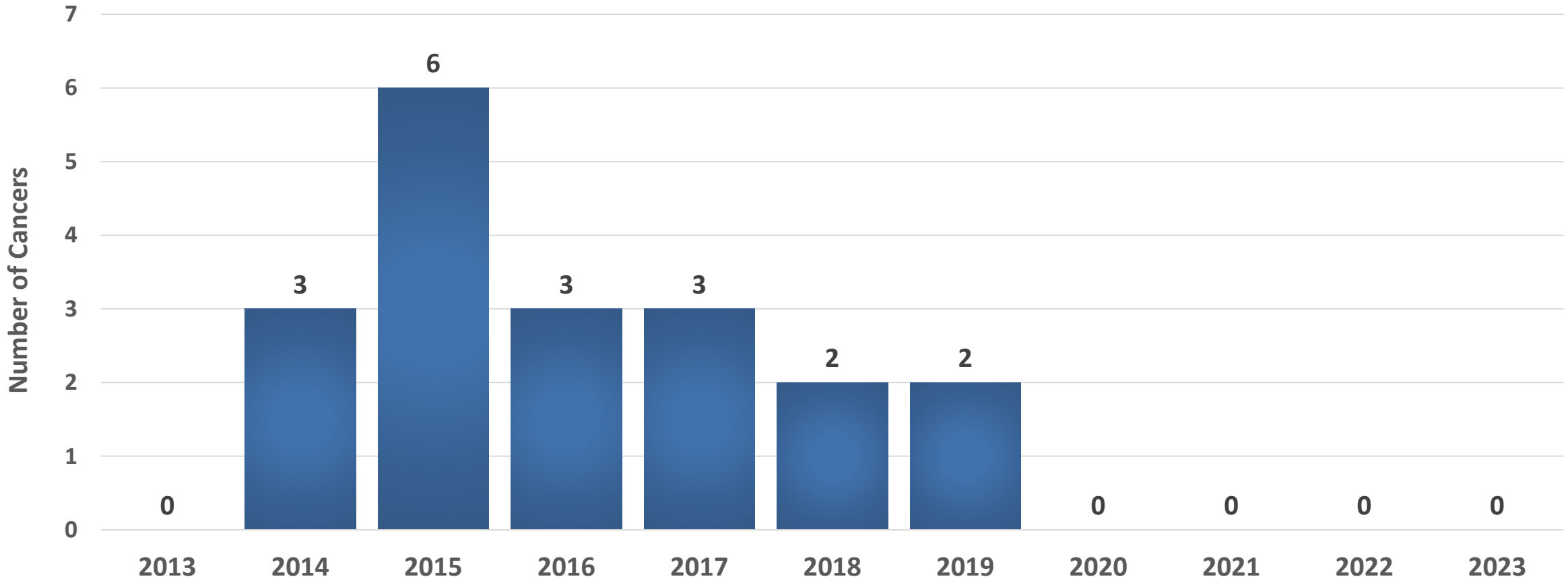


Potential Cancer Prevented Among the Uninsured: CCP Site Adenoma Detection, 2022-2023



ADR = *Adenoma Detection Rate*, which is the proportion of individuals who had a complete screening colonoscopy and had one or more adenomas divided by the total number of patients screened

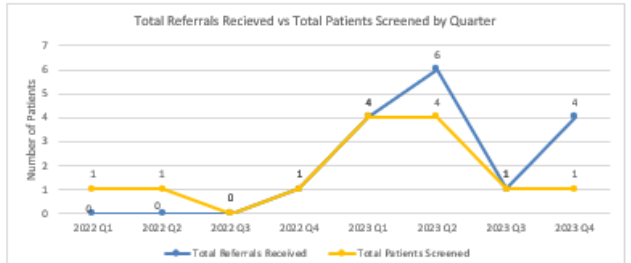
Year over Year comparison, Number of Cancers Detected Among Uninsured Patients Served, 2013-2023



NYC CCP Provides Feedback Reporting to Participating Sites

NYC Community Cares Project
Colonoscopy Screenings for the Uninsured

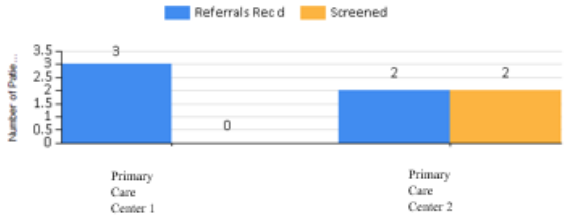
Endoscopy Center A: Q3 & Q4 2023 Feedback Report



Graph I: Total Referrals Received vs. Total Patients Screened by Quarter

- During Q3 and Q4 2023, Endoscopy Center A (EC A) received a total of five referrals and screened two patients. This led to a screening completion rate of 40%, which was lower than the screening completion rate among the referred in the first half of the year (80%).
- Between Q3 and Q4 2023, the number of referrals EC A received increased by 300%, from one to four.
- Between Q3 and Q4 2023 there was no difference between the number of patients EC A screened.

Referrals & Screenings for Partnering CHCs



Graph II: Referrals & Screenings for Partnering CHCs

Community Health Center (CHC)	Number of Referrals Generated by CHCs	Number of Referrals Received by KBEC	Patients Scheduled	Patients Screened	Cancellations	No Shows
Primary Care Center 1	13	3	0	0	0	0
Primary Care Center 2	3	2	2	2	0	0

Table 1: Referrals & Screenings for Partnering CHCs

Graph II shows the number of referrals received and patients screened by EC A for each of their partners within the second half of 2023.

Table I displays referral and scheduling outcomes for each partnered CHC. This includes the number of referrals sent by each CHC, the number of referrals received by EC A, as well as the number of patients scheduled, screened, cancellations, and no shows.

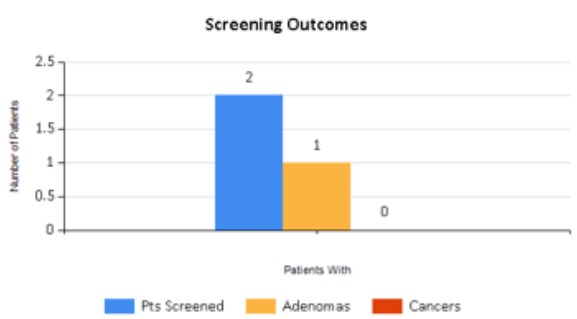
1. Sites that sent more referrals than EC A received

The below CHCs sent more referrals than EC A received. This is likely due to EC A's inability to process all referrals.

- **Primary Care Center 1 (PCC 1)**
  - Although PCC 1 reportedly sent EC A 13 referrals, EC A received three referrals. This is because PCC 1sent referrals to EC A's email, which is not checked regularly.
  - Despite receiving three referrals, EC A did not schedule or screen any patients. This is due to EC A's limited charity care capacity.
- **Primary Care Center 2 (PCC 2)**
  - Although PCC 2 reportedly sent EC A three referrals, EC A received two referrals.

NYC CCP Feedback Tracks Colonoscopy Completions and Cancer Diagnoses

- All the referrals received by EC A were scheduled for appointments.
- Among the two patients scheduled, both patients, or 100%, were screened.



Graph III: Screening Outcomes
Among the two patients screened, 50%, or one, had at least one adenoma removed. This translates to one life possibly saved from colorectal cancer. Furthermore, EC A's adenoma detection rate (ADR) of 50% was above the national average of 25%, which is the benchmark for quality colonoscopies. There were no cancers reported within Q3 or Q4 2023.

Conclusion

Within Q3 and Q4 2023, the number of uninsured patients screened by EC A decreased by 75% compared to the first half of 2023 (2 vs 8). The decrease can mostly be attributed to logistical issues, as well as limited capacity.

One of the logistical issues involved PCC 1's referrals. In December 2023, CCP learned that PCC 1 sent referrals to EC A, but they were not being processed. CCP's program manager spoke with EC A and learned that the referrals were sent to EC A's email, which is not checked regularly. The issue was resolved by advising PCC 1 to send referrals via secure fax, since that is checked daily.

Another logistical issue involved PCC 2, which reported that one of their patients was billed for pathology. After many follow-ups, pathology lab voided the bill in February 2024. To avoid further lab issues, CCP asked EC A to pause their charity care program until they find a new lab for charity care. Additionally, CCP's program specialist shared a pathology lab representative's contact information with EC A's manager. It is CCP's hope that the center will collaborate with that pathology lab to resume their charity care program.

Overall, CCP wants to acknowledge EC A's commitment to screening uninsured New Yorkers.

Thank You!

Evidence-Based Multicomponent Interventions CCP Uses to Increase Screening

Increase Community Demand

- Group education
- 1 on 1 education
- Client reminders
- **Client Incentives**
- **Mass media**
- **Small media**

Increase Provider Delivery

- Provider reminders
- Provider incentives
- **Provider assessment and feedback**

Source: Community Preventive Services Task Force. The Community Guide, Increasing Cancer Screening: Multicomponent Interventions – Colorectal Cancer. July 2017

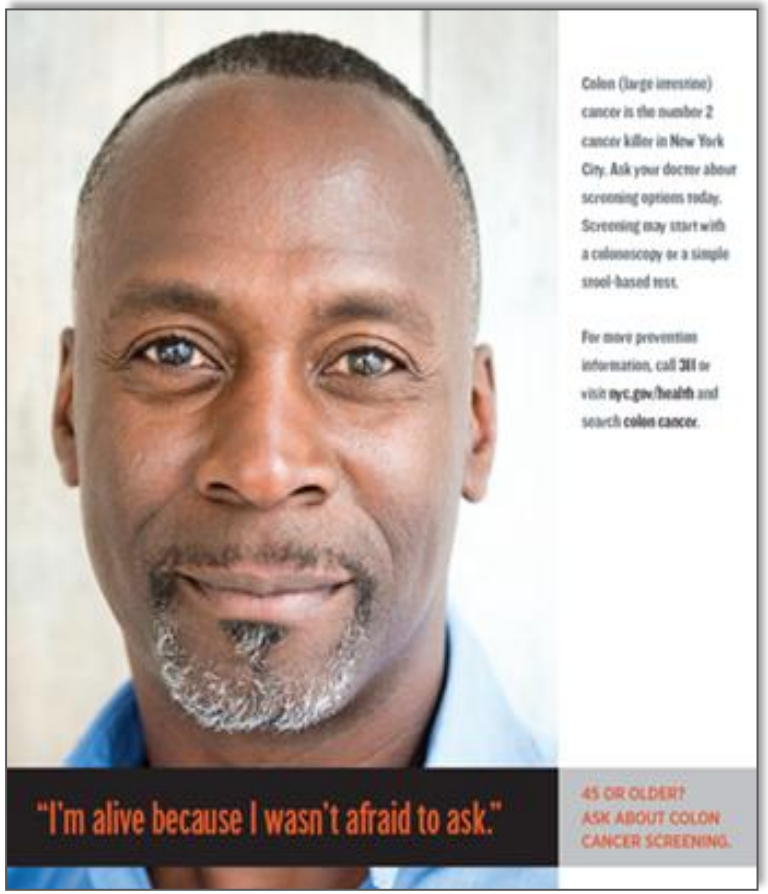
Evidence-Based Multicomponent Interventions CCP Uses to Increase CRC Screening, Cont.

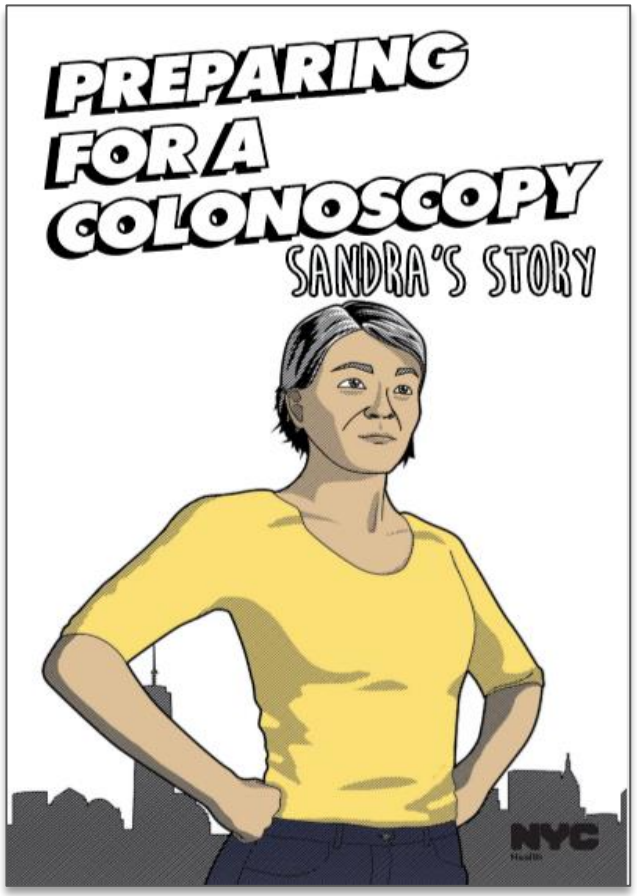
Increase Community Access

- **Interventions to reduce client out of pocket costs**
- **Interventions to reduce structural barriers (ex: patient navigation)**
  - Reducing administrative barriers
  - **Providing appointment scheduling assistance**
  - **Using alternative screening sites**
  - **Alternative screening hours**
  - Providing transportation
  - **Providing translation**
  - Providing childcare

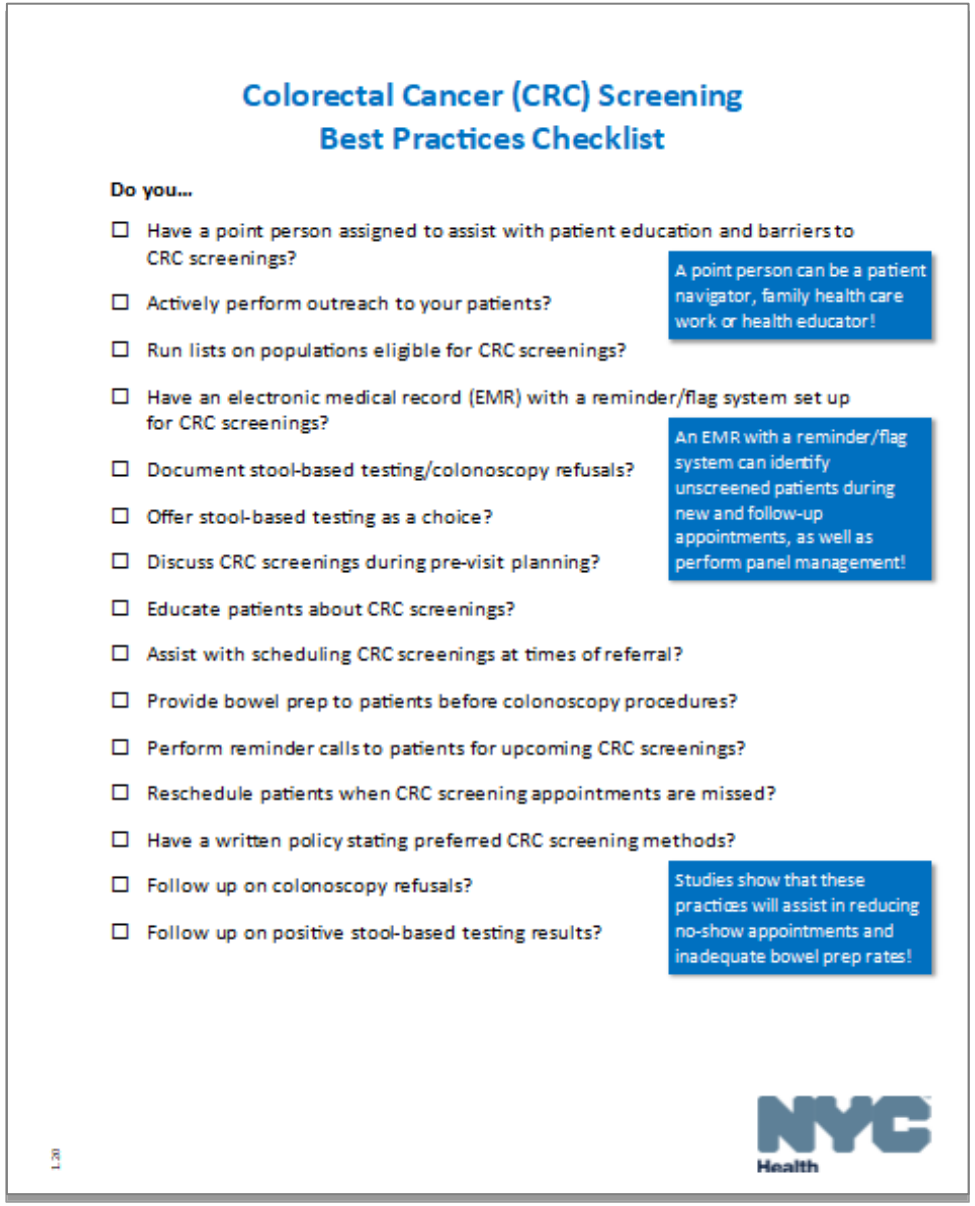
Source: Community Preventive Services Task Force. The Community Guide, Increasing Cancer Screening: Multicomponent Interventions – Colorectal Cancer. July 2017

Examples of Mass Media and Patient Educational Materials Used by DOHMH to Help Increase CRC Screening Rates





CRC Screening Best Practices Checklist



Colorectal Cancer (CRC) Screening Best Practices Checklist

Do you…

- ☐ Have a point person assigned to assist with patient education and barriers to CRC screenings?
- ☐ Actively perform outreach to your patients?
- ☐ Run lists on populations eligible for CRC screenings?
- ☐ Have an electronic medical record (EMR) with a reminder/flag system set up for CRC screenings?
- ☐ Document stool-based testing/colonoscopy refusals?
- ☐ Offer stool-based testing as a choice?
- ☐ Discuss CRC screenings during pre-visit planning?
- ☐ Educate patients about CRC screenings?
- ☐ Assist with scheduling CRC screenings at times of referral?
- ☐ Provide bowel prep to patients before colonoscopy procedures?
- ☐ Perform reminder calls to patients for upcoming CRC screenings?
- ☐ Reschedule patients when CRC screening appointments are missed?
- ☐ Have a written policy stating preferred CRC screening methods?
- ☐ Follow up on colonoscopy refusals?
- ☐ Follow up on positive stool-based testing results?

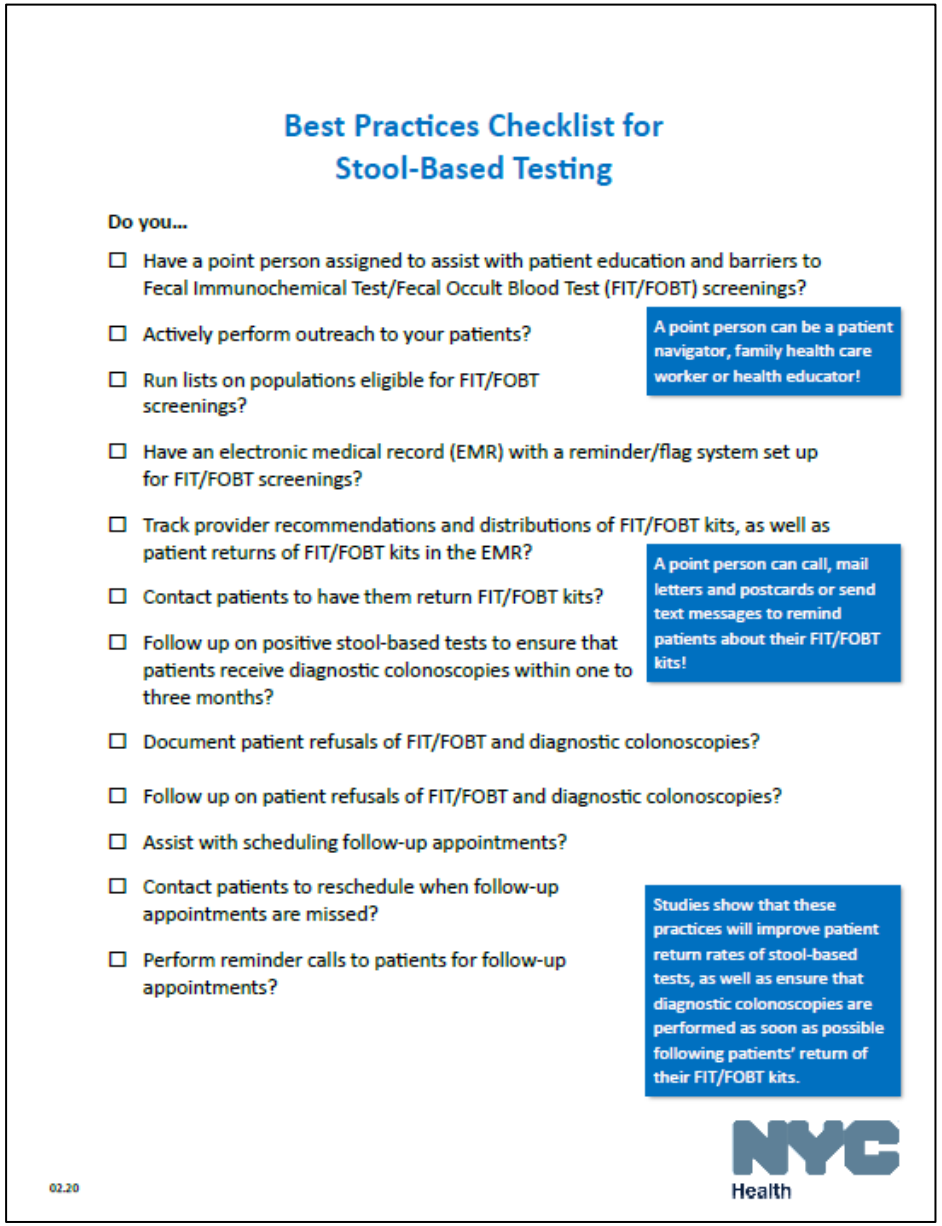
A point person can be a patient navigator, family health care work or health educator!

An EMR with a reminder/flag system can identify unscreened patients during new and follow-up appointments, as well as perform panel management!

Studies show that these practices will assist in reducing no-show appointments and inadequate bowel prep rates!

1.20

Best Practices Checklist for Stool-Based Testing



Best Practices Checklist for Stool-Based Testing

Do you...

- ☐ Have a point person assigned to assist with patient education and barriers to Fecal Immunochemical Test/Fecal Occult Blood Test (FIT/FOBT) screenings?
- ☐ Actively perform outreach to your patients?
- ☐ Run lists on populations eligible for FIT/FOBT screenings?

A point person can be a patient navigator, family health care worker or health educator!

- ☐ Have an electronic medical record (EMR) with a reminder/flag system set up for FIT/FOBT screenings?
- ☐ Track provider recommendations and distributions of FIT/FOBT kits, as well as patient returns of FIT/FOBT kits in the EMR?
- ☐ Contact patients to have them return FIT/FOBT kits?
- ☐ Follow up on positive stool-based tests to ensure that patients receive diagnostic colonoscopies within one to three months?

A point person can call, mail letters and postcards or send text messages to remind patients about their FIT/FOBT kits!

- ☐ Document patient refusals of FIT/FOBT and diagnostic colonoscopies?
- ☐ Follow up on patient refusals of FIT/FOBT and diagnostic colonoscopies?
- ☐ Assist with scheduling follow-up appointments?
- ☐ Contact patients to reschedule when follow-up appointments are missed?
- ☐ Perform reminder calls to patients for follow-up appointments?

Studies show that these practices will improve patient return rates of stool-based tests, as well as ensure that diagnostic colonoscopies are performed as soon as possible following patients' return of their FIT/FOBT kits.

02.20

NYC Health

Thank You!