Funded by:
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
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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

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Associates in Process Improvement
Mosaica: The Center for Nonprofit Development and Pluralism

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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

HOSPITAL AND BREAST HEALTH PROVIDER PARTNERS
Adventist HealthCare
Capital Breast Care Center
CASA de Maryland
Community Radiology Associates
George Washington University Hospital and Mammovian
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

Mary’s Center, Montgomery County, MD and Washington, DC
Merry 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
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   - Holy Cross Hospital Health Centers, Montgomery County, MD

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   - Adventist HealthCare
   - Capital Breast Care Center
   - CASA de Maryland
   - Community Radiology Associates
   - George Washington University Hospital and Mammovian
   - Holy Cross Hospital
   - Howard University Hospital and Cancer Center
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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.
THE SIX CRITICAL ELEMENTS

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 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

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Active Female Patients ≥ 40 years of age</th>
<th>65% of total patients ≥ 40 years of age (HEDIS Medicaid 90th Percentile) Annual Demand</th>
<th>Patients ≥ 40 years enrolled in NBCCEDP</th>
<th>Mammography Supply</th>
<th>Outstanding Need</th>
<th>Mammography Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercy Health Clinic</td>
<td>785</td>
<td>510</td>
<td>265</td>
<td>250</td>
<td></td>
<td>Shady Grove Adventist Hospital</td>
</tr>
<tr>
<td>Proyecto Salud – Olney</td>
<td>249</td>
<td>162</td>
<td>125</td>
<td>37</td>
<td></td>
<td>Community Radiology Associates</td>
</tr>
<tr>
<td>Proyecto Salud – Wheaton</td>
<td>1307</td>
<td>850</td>
<td>337</td>
<td>420</td>
<td>93</td>
<td>Community Radiology Associates (300) Holy Cross Hospital (120)</td>
</tr>
<tr>
<td>People’s Community Wellness Center</td>
<td>248</td>
<td>161</td>
<td>30</td>
<td>130</td>
<td>1</td>
<td>Holy Cross Hospital</td>
</tr>
<tr>
<td>Mobile Medical Care – Germantown</td>
<td>706</td>
<td>459</td>
<td>300</td>
<td></td>
<td>159</td>
<td>Community Radiology Associates</td>
</tr>
<tr>
<td>Mobile Medical Care – Other</td>
<td>1047</td>
<td>681</td>
<td>193</td>
<td>300</td>
<td>188</td>
<td>Washington Radiology (150)Shady Grove Adventist Hospital (150)</td>
</tr>
<tr>
<td>Muslim Community Clinic</td>
<td>638</td>
<td>428</td>
<td>35</td>
<td>350</td>
<td>43</td>
<td>University Imaging (200)</td>
</tr>
<tr>
<td>Spanish Catholic Center</td>
<td>382</td>
<td>248</td>
<td>56</td>
<td>175</td>
<td>17</td>
<td>Washington Adventist Hospital</td>
</tr>
<tr>
<td>Mary’s Center</td>
<td>200</td>
<td>130</td>
<td></td>
<td></td>
<td></td>
<td>Washington Adventist Hospital</td>
</tr>
<tr>
<td>Community Clinic Inc.</td>
<td>1269</td>
<td>825</td>
<td>129</td>
<td>120</td>
<td>576</td>
<td>Holy Cross Hospital</td>
</tr>
<tr>
<td>CCACC</td>
<td>137</td>
<td>89</td>
<td>85</td>
<td>4</td>
<td></td>
<td>Shady Grove Adventist Hospital</td>
</tr>
<tr>
<td>Holy Cross Health Centers</td>
<td>1063</td>
<td>820</td>
<td>200</td>
<td>620</td>
<td></td>
<td>Holy Cross Hospital</td>
</tr>
<tr>
<td>Community Ministries of Rockville</td>
<td>367</td>
<td>239</td>
<td>120</td>
<td>119</td>
<td></td>
<td>Holy Cross Hospital</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>8418</strong></td>
<td><strong>5602</strong></td>
<td><strong>1045</strong></td>
<td><strong>2725</strong></td>
<td><strong>1857</strong></td>
<td>****</td>
</tr>
</tbody>
</table>

- 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.

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**USEFUL ATTACHMENTS**

- Sample Patient Referral Tracking Spreadsheet
- Sample Health Care Services Agreement
THE SIX CRITICAL ELEMENTS

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

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

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.
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:

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

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
THE SIX CRITICAL ELEMENTS

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
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.

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.

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.
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](#)
THE SIX CRITICAL ELEMENTS

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.

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
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
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.

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.

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

<table>
<thead>
<tr>
<th>MEDICAL ORGANIZATION</th>
<th>BREAST CANCER SCREENING RECOMMENDATIONS (MAMMOGRAPHY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Academy of Family Physicians (AAFP)</td>
<td>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.</td>
</tr>
<tr>
<td>American College of Obstetricians and Gynecologists (ACOG)</td>
<td>Every 1 to 2 years starting at age 40, yearly after age 50</td>
</tr>
<tr>
<td>American Cancer Society (ACS)</td>
<td>Annually after age 40</td>
</tr>
<tr>
<td>American Medical Association (AMA)</td>
<td>Every 1 to 2 years in women ages 40 to 49; annually beginning at age 50</td>
</tr>
<tr>
<td>Canadian Task Force on Preventive Health Care (CTFPHC)</td>
<td>Every 1 to 2 years, ages 50 to 59</td>
</tr>
<tr>
<td>National Institutes of Health (NIH)</td>
<td>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.</td>
</tr>
<tr>
<td>U.S. Preventive Services Task Force (USPSTF)</td>
<td>Every 1 to 2 years, ages 50 to 69</td>
</tr>
</tbody>
</table>
Sample Patient Referral Tracking Spreadsheet

**PATIENT REFERRALS, RESULTS, AND FOLLOW-UP**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MRN</th>
<th>Date of Birth</th>
<th>Language</th>
<th>Treating Provider</th>
<th>Date of Encounter</th>
<th>Referral Request Date</th>
<th>Ad Hoc Practice</th>
<th>Service</th>
<th>Appointment Date</th>
<th>BI-RADS Value</th>
<th>Abnormal</th>
<th>FU Due</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Doe</td>
<td>Jane</td>
<td>####</td>
<td>1/1/1982</td>
<td>English</td>
<td>Dr. X</td>
<td>1/3/2012</td>
<td>1/3/2012</td>
<td>Hospital</td>
<td>Mammogram</td>
<td>1/18/2012</td>
<td>2</td>
<td>Normal</td>
<td>1 Year</td>
<td>None</td>
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<tr>
<td>Simpson</td>
<td>Margie</td>
<td>####</td>
<td>2/1/1963</td>
<td>Spanish</td>
<td>Dr. Y</td>
<td>2/7/2012</td>
<td>2/3/2012</td>
<td>Radiology Center</td>
<td>Mammogram</td>
<td>2/15/2012</td>
<td>4</td>
<td>Abnormal</td>
<td>Additional Views</td>
<td>Ask for previous films</td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Service</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0202</td>
<td>Bilateral Screening Mammogram</td>
<td>$____</td>
</tr>
<tr>
<td>G0204</td>
<td>Bilateral Diagnostic Mammogram</td>
<td>$____</td>
</tr>
<tr>
<td>G0206</td>
<td>Unilateral Diagnostic Mammogram</td>
<td>$____</td>
</tr>
<tr>
<td>76645</td>
<td>Breast Ultrasound</td>
<td>$____</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CLIENT</th>
<th>PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Signature</td>
</tr>
<tr>
<td>Name</td>
<td>Name</td>
</tr>
<tr>
<td>Date</td>
<td>Date</td>
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</table>
## Chart Review Template

<table>
<thead>
<tr>
<th>Clinic: _____________________________________________</th>
<th>Date: __________________</th>
<th>Auditor: __________________________________________</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>CHART 1</th>
<th>CHART 2</th>
<th>CHART 3</th>
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</thead>
<tbody>
<tr>
<td><strong>Patient Name</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Medical Record #</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DOB</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Health Study in past 24 months?</td>
<td>□ Yes Date: ____________</td>
<td>□ Yes Date: ____________</td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td>□ No</td>
</tr>
<tr>
<td>Referral in the past 12 months?</td>
<td>□ Yes Date: ____________</td>
<td>□ Yes Date: ____________</td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td>□ No</td>
</tr>
<tr>
<td>Type of Study</td>
<td>□ Screening Mammogram</td>
<td>□ Screening Mammogram</td>
</tr>
<tr>
<td></td>
<td>□ Diagnostic Mammogram</td>
<td>□ Diagnostic Mammogram</td>
</tr>
<tr>
<td></td>
<td>□ Sonogram</td>
<td>□ Sonogram</td>
</tr>
<tr>
<td></td>
<td>□ Other: ______________</td>
<td>□ Other: ______________</td>
</tr>
<tr>
<td>Report in chart?</td>
<td>□ Yes</td>
<td>□ Yes</td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td>□ No</td>
</tr>
<tr>
<td>If Yes, Radiology Center/Hospital</td>
<td>□ Facility A</td>
<td>□ Facility A</td>
</tr>
<tr>
<td></td>
<td>□ Facility B</td>
<td>□ Facility B</td>
</tr>
<tr>
<td></td>
<td>□ Facility C</td>
<td>□ Facility C</td>
</tr>
<tr>
<td></td>
<td>□ Other: ______________</td>
<td>□ Other: ______________</td>
</tr>
<tr>
<td>If Yes, Results</td>
<td>□ BI-RADS 0</td>
<td>□ BI-RADS 0</td>
</tr>
<tr>
<td></td>
<td>□ BI-RADS 1</td>
<td>□ BI-RADS 1</td>
</tr>
<tr>
<td></td>
<td>□ BI-RADS 2</td>
<td>□ BI-RADS 2</td>
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<td></td>
<td>□ BI-RADS 3</td>
<td>□ BI-RADS 3</td>
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<tr>
<td></td>
<td>□ BI-RADS 4</td>
<td>□ BI-RADS 4</td>
</tr>
<tr>
<td></td>
<td>□ BI-RADS 5</td>
<td>□ BI-RADS 5</td>
</tr>
<tr>
<td>If Yes, F/U Recommendations</td>
<td>□ None</td>
<td>□ None</td>
</tr>
<tr>
<td></td>
<td>□ 6 months</td>
<td>□ 6 months</td>
</tr>
<tr>
<td></td>
<td>□ 1 year</td>
<td>□ 1 year</td>
</tr>
<tr>
<td></td>
<td>□ Other: ______________</td>
<td>□ Other: ______________</td>
</tr>
<tr>
<td>Additional Tests</td>
<td>Test: ___________________</td>
<td>Test: ___________________</td>
</tr>
<tr>
<td></td>
<td>Date: ___________________</td>
<td>Date: ___________________</td>
</tr>
<tr>
<td></td>
<td>Location: ___________________</td>
<td>Location: ___________________</td>
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<tr>
<td></td>
<td>Result: ___________________</td>
<td>Result: ___________________</td>
</tr>
<tr>
<td>Test: ___________________</td>
<td>Test: ___________________</td>
<td>Test: ___________________</td>
</tr>
<tr>
<td>Date: ___________________</td>
<td>Date: ___________________</td>
<td>Date: ___________________</td>
</tr>
<tr>
<td>Location: ___________________</td>
<td>Location: ___________________</td>
<td>Location: ___________________</td>
</tr>
<tr>
<td>Result: ___________________</td>
<td>Result: ___________________</td>
<td>Result: ___________________</td>
</tr>
<tr>
<td>Other Comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Sample Clinic Monthly Tracking Report

WORKSHEET 1: CLINIC X REPORT

<table>
<thead>
<tr>
<th>Month</th>
<th>Referrals</th>
<th># Actually Screened</th>
<th>% Patients Screened</th>
<th># of Mammograms/Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>JAN</td>
<td>30</td>
<td>15</td>
<td>50%</td>
<td>7</td>
</tr>
<tr>
<td>FEB</td>
<td>35</td>
<td>19</td>
<td>57%</td>
<td>13</td>
</tr>
<tr>
<td>MAR</td>
<td>32</td>
<td>18</td>
<td>56%</td>
<td>12</td>
</tr>
<tr>
<td>APR</td>
<td>36</td>
<td>16</td>
<td>44%</td>
<td>9</td>
</tr>
<tr>
<td>MAY</td>
<td>40</td>
<td>20</td>
<td>50%</td>
<td>20</td>
</tr>
<tr>
<td>JUN</td>
<td>50</td>
<td>25</td>
<td>50%</td>
<td>25</td>
</tr>
<tr>
<td>JUL</td>
<td>43</td>
<td>25</td>
<td>58%</td>
<td>25</td>
</tr>
<tr>
<td>AUG</td>
<td>45</td>
<td>28</td>
<td>62%</td>
<td>28</td>
</tr>
<tr>
<td>SEP</td>
<td>48</td>
<td>34</td>
<td>71%</td>
<td>34</td>
</tr>
<tr>
<td>OCT</td>
<td>52</td>
<td>35</td>
<td>67%</td>
<td>35</td>
</tr>
<tr>
<td>NOV</td>
<td>56</td>
<td>35</td>
<td>70%</td>
<td>35</td>
</tr>
<tr>
<td>DEC</td>
<td>47</td>
<td>40</td>
<td>85%</td>
<td>40</td>
</tr>
</tbody>
</table>

TOTAL 20XX: 508 | 309 | 61% | 284
Worksheet 2: One Page Report

Clinic X One Page Report

| Int: To provide X number women/month efficient and evidence-based breast cancer screening services |
| Breast Health Care Improvement Initiative (HCBCI) |
| Baseline Data: Total # of eligible women: XXX |
| Referral Rate: X% |
| Screening Rate: X% |

Screening Guidelines: Refer women 2 Age, Every Other Year |

Objectives:
1. Refer 95% or annually/6 months of eligible Clinic X women for mammography screening |
2. Screen 65% (X annually)/6 months of eligible Clinic X women for mammography screening |

Measures:
1. % of women referred for mammography |
2. % of women screened |
3. % of mammograms per month |

# Clinic X Patients Referred for Mammography
Goal: X women referred/month

% Clinic X patients who actually screened after referral

# of Clinic X Mammograms per month
Goal: X women screened/month

Process Improvement Activities:

<table>
<thead>
<tr>
<th>Aim (Year 20XX)</th>
<th>Change Concepts Activities</th>
<th>Milestones</th>
<th>Leader(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>C</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
# 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?

<table>
<thead>
<tr>
<th>Patient Navigation</th>
<th>Specific Diagnostic Group (ie. Breast Cancer)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach</td>
<td></td>
</tr>
<tr>
<td>Cancer screening</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Chronic Illness</td>
<td></td>
</tr>
<tr>
<td>Complex Medical</td>
<td></td>
</tr>
<tr>
<td>Pre-Natal</td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Position</th>
<th>Full time/Part Time</th>
<th>Number of Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Navigator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Champion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: _______________

<table>
<thead>
<tr>
<th>Task</th>
<th>Responsible Person</th>
<th>Date Due</th>
<th>Progress</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Total Population</th>
<th>% Female</th>
<th>% Male</th>
<th>% 0-18</th>
<th>% 19-39</th>
<th>% 40-65</th>
<th>% 65+</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

% 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)

<table>
<thead>
<tr>
<th>Position Title:</th>
<th>Patient Navigator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisory Responsibilities:</td>
<td></td>
</tr>
<tr>
<td>Budget Responsibilities:</td>
<td></td>
</tr>
<tr>
<td>Reports to:</td>
<td></td>
</tr>
<tr>
<td>FLSA:</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>

**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.
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

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

2. Some Concepts Based in Improvement Knowledge
   - Every system is perfectly suited to produce the results it produces (Everybody is already doing their best).
   - All work is a process.
   - Improvement of processes requires change.
   - But all change is not improvement.

3. Every system is perfectly suited to produce the results it produces:
   Provider Team Current Breast Cancer Screening Rates

4. All work is a process:
   Group Activity
   Know Your Processes Questionnaire

5. Scheduling Referral Appointments
   Example: Block Scheduling
   - GBMS provider sees PT and records referral into EMR as WAH.
   - GBMS staff schedules patient for one of the blocked apt slots.
   - One week prior to blocked slots, GBMS will fax the completed apt list along with the referrals and required documents WAH.
   - WAH will provide reminder calls 48 hours prior to the appointment.
   - Following the appointment, WAH will fax the results to GBMS referral site.
   - No shows will be closely monitored and communicated to GBMS.
   - GBMS will be responsible for filling out the state application paperwork for diagnostic procedures.

6. Improvement of processes requires change
   Example of a Decision Aid
Reliable Screening: Identified Best Practices

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

But all change is not improvement:
Planning a Small Test PDSA Worksheet

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?

Act  
Study  
Plan  
Do

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

Thank you!
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):

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<thead>
<tr>
<th></th>
<th>April 23-27</th>
<th>April 30-May 4</th>
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<tbody>
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<td>Friday</td>
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</table>

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):

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<thead>
<tr>
<th></th>
<th>March 26 – April 1</th>
<th>April 2 – April 8</th>
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<tbody>
<tr>
<td>Monday</td>
<td>No rice</td>
<td>Rice</td>
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<tr>
<td>Tuesday</td>
<td>No rice</td>
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<td>Saturday</td>
<td>No Rice</td>
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<tr>
<td>Sunday</td>
<td>No Rice</td>
<td>No Rice</td>
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</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>What are we testing?</th>
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<tbody>
<tr>
<td>On whom are we testing the change?</td>
</tr>
<tr>
<td>When are we testing?</td>
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<tr>
<td>Where are we testing?</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Processes</th>
<th>Works Well</th>
<th>Small Problem</th>
<th>Real Problem</th>
<th>Totally Broken</th>
<th>Cannot Rate</th>
<th>We’re Working On It</th>
<th>Source of Patient Complaint</th>
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<tbody>
<tr>
<td>Answering Phones</td>
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<td>Messaging to Patients</td>
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<td>Process to indicate when patient due for mammogram screening?</td>
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<td>Risk/History Assessment</td>
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</table>
## 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

<table>
<thead>
<tr>
<th>Processes</th>
<th>AMA</th>
<th>CMA</th>
<th>Nurse</th>
<th>Case Manager</th>
<th>Provider (MD/NP)</th>
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<td>Receiving Screening/Diagnostic Test Results</td>
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<td>Performing Treatment, Including Minor Procedures</td>
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<td>Providing Health Education for Patients/Families</td>
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# Activities to Support Reliable Screening

<table>
<thead>
<tr>
<th>PROCESS TO</th>
<th>EXAMPLES</th>
</tr>
</thead>
</table>
| 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](logo.png)

**Primary Care Coalition**
of Montgomery County, Maryland

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Silver Spring, MD 20910
www.primarycarecoalition.org

**RPCC**
1400 16th Street NW, Suite 710
Washington, DC 20036
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For more information: Mary Kate Brousseau, Regional Initiative Manager • 301.628.3441 • marykate_brousseau@primarycarecoalition.org