FLORIDA CANCER SPECIALISTS & Research Institute

Case Study:

Removing Barriers & Improving the Experience of People With Cancer

Florida Cancer Specialists & Research Institute Optimizes Patient Navigation Services

FLORIDA CANCER SPECIALISTS & Research Institute | 40TH ANNIVERSARY

Many of the more than 18 million Americans with cancer face multiple barriers during their cancer journey. Transportation issues, housing, food insecurity and cultural differences can complicate the patient experience, causing serious delays in accessing treatment and negatively impacting outcomes and overall quality of life.

Patient and clinical navigation services aim to address these barriers by providing personalized care coordination from diagnosis through survivorship. Services range from helping patients manage referrals and follow-ups and scheduling appointments to providing links to vital social support programs.

President & First Lady Biden's Cancer Moonshot Initiative has championed the importance of patient navigation services and prioritized payment for these services so that "patients and their families don't have to navigate their cancer journeys alone."

On January 1, 2024, the Centers for Medicare & Medicaid Services (CMS) enacted Principal Illness Navigation (PIN) billing codes so that oncology practitioners can document and receive payment from Medicare and several of the nation's leading health care insurers followed suit, connecting patients to navigation services performed by certified or trained personnel.

Drawing on experience as a leader in value-based oncology care

Florida Cancer Specialists & Research Institute, LLC (FCS) is proud to be among the 40 community oncology practices and comprehensive cancer centers that have committed to providing personalized patient navigation services to the nearly 100,000 new cancer patients it serves annually at nearly 100 locations statewide.

As the largest community-based oncology provider in Florida with a reputation for providing exceptional care during its 40-year history, FCS has the singular goal of providing the best patient-centric care possible to positively impact quality, access and patient outcomes and reduce health care costs.

In joining this groundbreaking effort, FCS draws upon its success as a top-performing participant in the multi-year Oncology Care Model (OCM) sponsored by the Centers for Medicare & Medicaid Innovation (CMMI), which was launched in 2016. Throughout the entirety of the program, with a focus on the patient experience and maintaining the highest quality patient care and access, efforts by FCS resulted in a reduction of expenditures amounting to more than $210 million, and more than $98 million in net savings to the Centers for Medicare/ Medicaid Services (CMS).

"By implementing PIN codes, we've streamlined patient care coordination processes within our practice. This innovation has not only enhanced efficiency but also deepened trust between patients and providers. We've seen a measurable reduction in emergency department visits as patients receive timely interventions, avoiding complications. As a result, we've not only improved patient outcomes but also significantly reduced the cost of care."

- David Wenk, MD
  FCS Assistant Managing Physician

Pioneering patient navigation

A critical component of FCS participation in the OCM was the establishment of a care management program to address the full, comprehensive needs of patients and ensure continuous, high-quality care throughout all phases of treatment and beyond. Patients and their families were provided with 24/7 access to an oncology-certified nurse to assist with the coordination of care and symptom management. These efforts effectively reduced inpatient admissions, observation stays and unnecessary ED visits throughout the duration of the OCM, with high marks from patients.

As the OCM concluded in June 2022, FCS worked to further refine its patient navigation initiatives to align with Cancer Moonshot goals. Specifically, to focus on improving health equity by screening for and addressing health-related social needs.

Today, these efforts have evolved into a comprehensive care coordination program that aligns with the needs of both patients and payers. Under this newly reorganized program, all FCS patients receive specialized support from the FCS Care Coordination team, regardless of their health care benefit plan. A specialized team consisting of the patient's FCS physician, a nurse navigator, a nutritionist, a behavioral health therapist and other providers are available to the patient, as needed. These skilled professionals work together to help patients manage physical, psychosocial and emotional needs and effectively remove barriers to care. Nurse navigators remain a critical center point and provide:

- Education
- Symptom management
- Access to care assessments
- Referrals to FCS dietitians and behavioral health therapists
- Referrals and care coordination with external providers
- Medication education, side effects management and refill assistance
- Advance care planning
- Supportive care

Oncology Navigation Services

Clinical Navigation Services

- Focus on clinical care, coordination, and education
- Typically provided by licenced clinical staff or qualified health professional (QHPs)

Patient Navigation Services

- Focus on improving access to care related to social determinants of health
- May be provided by individuals who may or may not have clinical training

Taking action to build an effective coding system

Once CMS finalized coding and reimbursement for Principal Illness Navigation (PIN) services, FCS moved quickly to ensure compliance with reporting and documentation requirements. A multidisciplinary team reviewed available training materials and documentation guidelines and built customized workflows within the FCS electronic medical record system. The process rolled out in February 2024.

> ***"As we were already doing the work here at FCS, we were able to quickly align our program with the newly established CMS directive, which was helpful when it came to fulfilling the requirements of a navigator, accurately documenting the crucial details and submitting for reimbursement."***
>
> - Danielle Brown
> FCS Senior Director of Care Coordination

The main objective of the CMS PIN services program, and also that of the FCS nurse navigation program, is to provide a patient-centered approach, catering to the unique needs of the individual being treated to ensure their timely access to appropriate care and resources while preventing unnecessary hospitalizations and emergency room visits.

To meet the PIN code requirements, leaders of the FCS Care Coordination team worked closely with the FCS Informatics team create a custom PowerBI nurse navigation dashboard to track the details from the patient assessments and identify those qualifying for the CMS PIN services program.

To meet the PIN code requirements, FCS established a series of data points that would be used to evaluate and determine the level of preventable hospitalization risk, basing the criteria for eligible patients on defined risk cohorts, stratification groups and clinical risk stratification factors. Factors such as labs, PHQ-9 (mental health) and ECOG (self-care capability) scores, recent hospitalization and cancer staging all help to assign FCS patients into stratification groups based on their risk for preventable hospitalization. Patients presenting with high and moderately high risk for hospitalization based on these determinants, who also met other qualifiers including fulfilling their annual deductible and maximum out-of-pocket expenditures, were then included in FCS' PIN code program.

Preventable Hospitalization Risk Stratification

With the new dashboard implemented, FCS nurse navigators were able to quickly identify and address barriers to care. Of the qualifying high-risk or moderately high-risk patients, FCS found that the top three barriers to care were related to transportation (36%), finance (32%) and nutrition (27%).

By recognizing these distinct barriers to care, the FCS navigation team could then appropriately direct the patient to the best-suited service(s) or provider(s). The result: 185 referrals to FCS Behavioral Health, 59 to an FCS patient financial counselor, 296 to an FCS registered dietitian nutritionist, 333 to FCS supportive services (transportation, housing, clinical forms, home health, durable medical equipment (DME)) and 107 to the FCS Foundation for non-medical financial assistance.

In its first six months, FCS' navigation program was able to identify a cohort of 195 high-risk patients who had 35 or more ED visits prior to intervention from the FCS navigation team. This same cohort experienced zero visits to the emergency department after meeting with a member of the FCS navigation team. These promising results reflect the impact of personalized navigation when directed toward a high-risk group of cancer patients and are encouraging for future consideration of the program.

Risk Cohort

- Basic inclusion criteria
- Basic exclusion criteria

Stratification Groups

- High risk
- Moderate high risk
- Moderate risk
- Moderate low risk

February–August 2024 PIN Data*

58 Patients identified with **food insecurity**

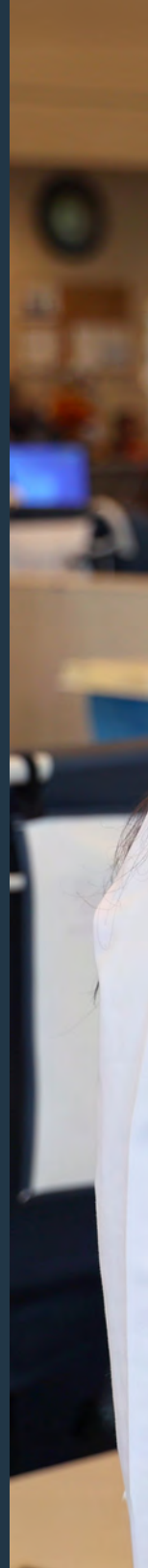
48 Patients needing **housing assistance**

375 Patients provided with **additional education**

318 Patients with **nutritional needs** identified

257 Patients identified with **transportation needs**

**commercial payers*



Leading the Charge in Navigation

As an early adopter of the PINS services program, FCS is working closely with the Cancer Moonshot initiative at the White House. In sharing these initial findings and implementation tactics, FCS hopes to encourage practices across the country to also enlist in the program.

Decrease in emergency department (ED) visits*

195 **unique patients with G0023 code billed**
February–August 2024**

35 **5+** ED visits pre-G0023

14 **0** ED visits post-G0023

** No noted ED visit post-G0023/initial navigation activity*
*** N = 195 patients*

FCS medical oncologist and hematologist Liliana Bustamante, MD with patient Marta.

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