



HOW WE LEVELED THE CRC SCREENING PLAYING FIELD



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At DDW® last May, Howard Koh, MD, MPH, the assistant secretary of health for the U.S. Department of Health and Human Services gave a luncheon. He talked about access and equality of care. Though the Affordable Care Act (ACA) has led to many uninsured obtaining health-care insurance, there remains a great divide between the haves and the have-nots. New York City has been on a quest to improve access and equality to care especially when it comes to colon cancer screening. In 2003, the Department of Health (DOH) created a public-private task force called Citywide Colon Cancer Control Coalition (C5). At its inception, New York City's colon cancer screening rate was 42 percent, and there were significant ethnic and racial screening disparities. Through the coalition's efforts, the screening rates have risen to 69 percent in 2012. Racial and ethnic screening disparities have been eliminated [Figure 1]. The story of our endoscopy center is but one part of a successful endeavor to level the playing field, bringing screening exams to everyone, regardless of their socioeconomic or ethnic background.

When Carnegie Hill Endoscopy (CHE) opened its doors in March of 2012, it had been three years in the making. A 15,000 square-foot center with five procedure rooms, 15 recovery bays, the largest commercial blanket warmer

available and 22 doctors performing 13,000 procedures a year. Located on the Upper East Side of Manhattan, CHE immediately became one of the busiest endoscopy ambulatory surgery centers in the northeastern U.S.

The no-show rate for charitable care patients is almost zero.

All of the founding physicians came from private practices with office-based endoscopy suites. In the State of New York, DOH had mandated that all offices that provided moderate to deep sedation be accredited by JCAHO, AAAASF or AAAHC. However, the state legislature declined a request from the medical society to mandate increased third-party reimbursement for offices that fulfilled these requirements. The cost to maintain accreditation coupled with the lack of improved reimbursement ultimately led to the demise of office-based endoscopy in New York. At the same time, DOH had become more open to granting ASC licenses, referred to as Article 28s in New York. Historically, ASC licensure in the state was in perpetuity. Richard Daines, MD, DOH commissioner in 2009, loosened the approval process for ASCs, placing a limited life on the licenses for five years.

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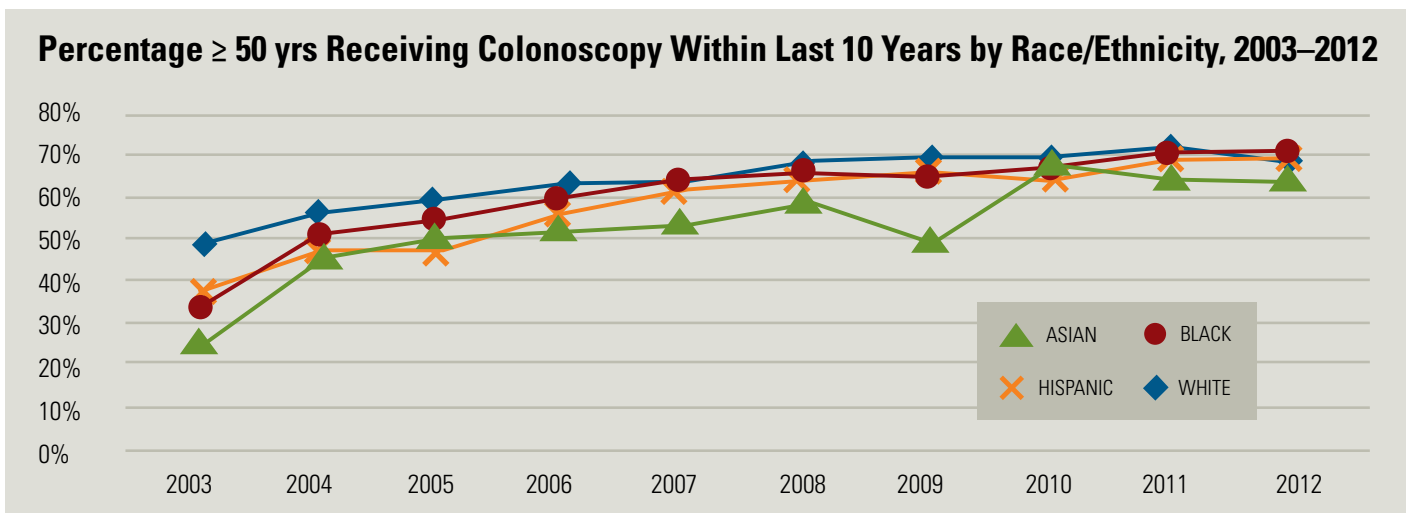


Figure 1: New York City colon cancer screening rates by race. Courtesy of the New York City Department of Health.

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ASCs were now required to provide DOH their payor mix, level of charity care and Medicaid, adverse events, and nosocomial infection rates in order to renew their licenses. DOH wanted to encourage charitable care and Medicaid as part of its goals to eliminate all barriers to health care, and take a more active role in monitoring quality of non-hospital based endoscopy procedures.

Prior to applying for Article 28 status, the partners at CHE developed a relationship with a local federally qualified health center (FQHC) promising to provide free screening colonoscopies to their clients. The facility fee and the professional fees (GI and anesthesiology) would all be waived. Our affiliated hospital, Beth Israel Medical Center (BIMC), agreed to provide free pathology services as part of its charitable mission. BIMC was also amenable that any charitable patient requiring hospitalization following the procedure due to a complication or a finding on the procedure could be admitted to the facility. With this arrangement and despite the objections of other nearby hospitals, Carnegie was granted its initial license.

Many times in life, the greatest failures are born from good intentions. We were committed not to allow this to happen to our charity-care program at CHE. What on the surface seemed like a very easy program to initiate, presented many layers of small nuanced steps to insure success. Educating the FQHC physicians to refer patients for screening required the development of tools to describe the preparation, which were translated into several languages. Industry partners were asked to provide free preparation kits for the patients.

The FQHC needed a system to directly refer patients and properly relay all medical histories to avoid inappropriate screenings at the center. We adopted the direct referral form created by the New York City DOH for their C5 project. CHE's medical directors review all histories and approve the exams. We also had to create methods for (1) getting reports back to the FQHC, (2) immediately notifying them of any significant findings, and (3) establishing the

appropriate recall interval. In addition, we assigned one of our own administrative staff to be a navigator to answer any questions concerning the exam and the preparation to the patient.

The process began two years ago. It started as a mandatory task/burden created by DOH to allow us to maintain our license, yet it has now become fully integrated as part of CHE's mission. It is among the leading agenda items at our monthly board meetings. Charitable-care patients in our community are, for the most part, just another classification for the working poor. They work very hard to house, feed and clothe their families. These individuals do not make enough to afford health care, and their employers do not provide health insurance. They may also not be legal immigrants and thus are not covered under ACA. But as a group, they are responsible, very respectful and thankful for the care we provide.

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We have set aside one half-day block in one room every week for these cases. The no-show rate for this group is almost zero. The support staff and physicians at CHE have come to embrace this program as an important part of who we are. Doctors volunteer their time to provide care on a rotating basis, and has never been a problem getting coverage. The nursing staff, technicians and administrative staff all take great pride in our community service and responsibility. It has become one of the important elements that provide CHE with an *esprit de corps*, reminding us why we became health-care professionals. Our success has led DOH to develop the Community Cares Project to encourage other centers to have charitable arms, and several other endoscopy centers have adopted our program. We would like to extend our thanks to the New York State Department of Health for providing us with an opportunity to become re-grounded. ■