Steps for Increasing Colorectal Cancer Screening Rates:
A Manual for Community Health Centers

September 11, 2014
Presenters:

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Chair, National Colorectal Cancer Roundtable

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Objectives of Today’s Webinar

- Important role of reaching underserved through CHCs in 80% by 2018
- The national picture of CRC screening in CHCs
- How CHCs might benefit from manual
- How to use the manual
  - Key steps and points to keep in mind
  - Ready to use tools, templates and resources
- Questions
Richard Wender, MD
Chief Cancer Control Officer, American Cancer Society
Chair, National Colorectal Cancer Roundtable
The nation has become energized by the goal of 80% colon by 2018.

So what will it really take to achieve this goal?
10 Steps to Achieving 80% by 2018

1. Increase the percentage of Americans with health insurance.
2. Find strategies to reach newly insured Americans.
3. More effectively engage the payers.
4. Find new ways to communicate with the insured, unworried well.
5. Make sure that colonoscopy is available to everyone.
10 Steps to Achieving **80% by 2018**

6. Ensure everyone can be offered a **stool blood test** option.
7. Create powerful, reliable, committed **medical neighborhoods** around Federally Qualified Health Centers.
8. Recruit as many **partner organizations** as possible.
9. Implement intensive efforts to reach **low socio-economic populations**.
10. **Believe** we will achieve this goal!
Key Step: Implement Intensive Efforts to Reach the Populations Confronting the Greatest Barriers to Care

✓ Poverty, lack of insurance, low education level, lack of a regular source of primary care are all associated with very low screening levels, under 30%.

✓ Many Native American tribes and Hispanics have very low screening rates and some groups have very high mortality rates.
What Will It Take To Reach These Groups?

✓ Support of FQHCs, Indian Health Service, and other safety net practices
✓ Willingness to donate some services
✓ Near universal sharing of the responsibility
✓ Innovative models to simplify the process
  ▪ Navigators
  ▪ Community health workers recruited from these vulnerable communities
Key Step: Create Medical Neighborhoods around Federally Qualified Health Centers

- These centers provide care to more than 20 million people; more than two-thirds are uninsured or have medical assistance.
- Engaging primary care clinicians in these and other settings is critical.
- One of their greatest barriers is finding specialty networks to provide colonoscopy and treatment services.
The NCCRT, through the American Cancer Society and Centers for Disease Control and Prevention, is funding the Links of Care program.

Grants go to FQHCs or comparable care settings to promote CRC screening.

Requires formation of a care network, a medical neighborhood, to guarantee patients receive all aspects of care, from screening through treatment and survivorship care.
Key Step: Ensure Everyone Can be Offered a Stool Blood Test Option

✓ Some people will not or cannot have a colonoscopy
✓ Anyone who hesitate should be offered a Fecal Immunochemical Test
✓ In some settings, FIT needs to be offered as the primary screening strategy
Meta-analysis of FIT vs. Hemoccult Sensa

<table>
<thead>
<tr>
<th></th>
<th>FIT</th>
<th>Hemoccult Sensa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity:</td>
<td>73-89%</td>
<td>64-80%</td>
</tr>
<tr>
<td>Specificity:</td>
<td>92-95%</td>
<td>87-90%</td>
</tr>
</tbody>
</table>

Conclusion: **FIT is a superior option** for annual stool testing.

Mounting evidence supports using FIT’s rather than guaiac based options

- Demonstrate superior sensitivity and specificity
- Are specific for colon blood and are unaffected by diet or medications
- Some can be developed by automated readers
- Some improve patient participation in screening

Many Patients Prefer FOBT

Randomized clinical trial in which 997 patients in the San Francisco PH care system received different recommendations for screening:

<table>
<thead>
<tr>
<th>Recommended Test</th>
<th>Completed Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>38%</td>
</tr>
<tr>
<td>FOBT</td>
<td>67%</td>
</tr>
<tr>
<td>Colonoscopy or FOBT</td>
<td>69%</td>
</tr>
</tbody>
</table>

Many patients may forgo screening if they are not offered an alternative to colonoscopy.
Key Step: **Believe We Will Achieve this Goal!**

- CRC screening rates increased 10% in 10 years, from 2000 to 2010.
- We are now striving to increase screening rates by **15%** in 5 years.
- Signing a pledge is not enough.
- **Every organization** has to dedicate thought, time, and passion.
If 80% by 2018 is a slogan, we have no hope of achieving this goal.

If 80% by 2018 is a call to action, it can be done.
Mary Doroshenk, MA
Director, National Colorectal Cancer Roundtable
American Cancer Society
The national picture of CRC screening in CHCs
Strategies for Expanding Colorectal Cancer Screening at Community Health Centers

Mona Safaty, MD, MPH¹; Mary Doroshenk, MA²; James Hotz, MD³; Durado Brooks, MD, MPH⁴; Seiji Hayashi, MD, MPH, FAAFP⁵; Terry C. Davis, PhD⁶; Djenaba Joseph, MD, MPH⁷; David Stevens, MD⁸; Donald L. Weaver, MD⁹; Michael B. Potter, MD¹⁰; Richard Wender, MD¹¹

Community health centers are uniquely positioned to address disparities in colorectal cancer (CRC) screening as they have addressed other disparities. In 2012, the federal Health Resources and Services Administration, which is the funding agency for the health center program, added a requirement that health centers report CRC screening rates as a standard performance measure. These annually reported, publicly available data are a major strategic opportunity to improve screening rates for CRC. The Patient Protection and Affordable Care Act enacted provisions to expand the capacity of the federal health center program. The recent report of the Institute of Medicine on integrating public health and primary care included an entire section devoted to CRC screening as a target for joint work. These developments make this the ideal time to integrate lifesaving CRC screening into the preventive care already offered by health centers. This article offers 5 strategies that address the challenges health centers face in increasing CRC screening rates. The first 2 strategies focus on improving the processes of primary care. The third emphasizes working productively with other medical providers and institutions. The fourth strategy is about aligning leadership. The final strategy is focused on using tools that have been derived from models that work. CA Cancer J Clin 2013;00:000-000. ©2013 American Cancer Society, Inc.

Keywords: colorectal cancer screening, community health centers, strategies or strategic planning, public health, quality/quality improvement, Patient Centered Medical Home
How to Increase Colorectal Cancer Screening Rates in Practice:
A Primary Care Clinician’s* Evidence-Based Toolbox and Guide
2008

*Including Family Physicians, General Internists, Obstetrician-Gynecologists, Nurse Practitioners, Physician Assistants, and their Office Managers

Mona Sarfaty, MD

EDITORS
Karen Peterson, PhD
Richard Wender, MD

http://nccrt.org/about/provider-education/crc-clinician-guide/
How might a Community Health Center benefit by using this manual?

1. Helps practices increase CRC screening rates through a team-based, systematic approach
2. Helps increase rates for UDS measure
3. Trains staff on a quality improvement processes that apply to other preventive services
4. Implements field-tested processes created by experts
5. Strengthens relationships with other community partners
Steps for Increasing Screening Rates

1. Make a Plan
2. Assemble a Team
3. Get Patients Screened
4. Coordinate Care across the Continuum
Step #1 Make A Plan
Determine Baseline Screening Rates
- Identify your patients due for screening
- Identify patients who received screening
- Calculate the baseline screening rate
- Improve the accuracy of the baseline screening rate

Design Your Practice's Screening Strategy
- Choose a screening method
- Use a high sensitivity stool-based test
- Understand insurance complexities.
- Calculate the clinic's need for colonoscopy
- Consider a direct endoscopy referral system

Step #2 Assemble A Team
Form An Internal CHC Leadership Team
- Identify an internal champion
- Define roles of internal champions
- Utilize patient navigators
- Define roles of patient navigators
- Agree on team tasks

Partner with Colonoscopists
- Identify a physician champion

Step #3 Get Patients Screened
Prepare The Clinic
- Conduct a risk assessment

Prepare The Patient
- Provide patient education materials

Make A Recommendation
- Convince reluctant patients to get screened

Ensure Quality Screening for Stool-Based Screening Program

Track Return Rates and Follow-Up

Measure and Improve Performance

Step #4 Coordinate Care Across The Continuum
Coordinate Follow-Up After Colonoscopy
- Establish a medical neighborhood
Maria Syl D. de la Cruz, MD
Instructor, Department of Family & Community Medicine
Jefferson Medical College/Thomas Jefferson University
How do I use this manual?
Organized into three primary sections

- **Introduction**
- **Steps to Increase Cancer Screening Rates**
- **Appendices**

The manual can be used in segments

Use live links to navigate throughout the manual:
- "Alt+Left Arrow" on PC
- "Command+Left Arrow" on Mac
Step #1: Baseline Screening Rates

- CHCs need to determine where they are before they can determine where to go
- Encourage all CHCs to assess or re-assess their baseline screening rate
Steps #1: Screening Strategy

There is no evidence from randomized controlled trials that one screening method is the “best”

Years of life saved through an annual high-quality stool blood screening program are COMPARABLE to a high-quality colonoscopy-based screening program when positive stool tests are followed by colonoscopy.
Choosing the right test

Do You Have:
- Family history of colorectal cancer or polyps?
- Personal history of colorectal cancer or polyps or inflammatory bowel disease?

Yes

Colonoscopy
Provider and patient determine if testing should be started before age 50.

No

Are you:
- Age 50 – 75 years old?

Yes

Provider and patient decide which test is preferred.* (see table below)

No

Younger than 50 years
Testing is not recommended.

Older than 75 years
Provider and patient decide if testing is needed.

FOBT/FIT†

Key facts
- Reduces death from colorectal cancer
- Safe, available, and easy to complete
- Done on your own at home and returned
- Finds cancer early by finding blood in the stool
- Finds most cancers early when done every year

Colonoscopy

Key facts
- Reduces death from colorectal cancer
- Can prevent cancer by removing polyps (or abnormal growths in the colon) during test
- Examines entire colon
- Finds most cancers or polyps that are present at the time of the test
- Done every 10 years if no polyps are found
Steps #1: Screening Strategy

Traditional stool guaiac tests such as the Hemoccult II (TM) and its generic equivalent Seroccult, are no longer recommended! In-office stool testing and digital rectal exams are not appropriate methods of screening for colorectal cancer.

It is important to recognize that not all FITs are created equal.
Step #2: Create a Team

- **Find your internal and external champions!**
- Your champions can help you establish links of care.
Step #3: Get Patients Screened

A recommendation from the provider is the most influential factor on patient screening behavior
CRC = colorectal cancer
HSGFOBT = high-sensitivity fecal occult blood test
FIT = fecal immunohistochemical test

*Note: Additional recommendations for screening exist by ACS, which are available at: www.cancer.org/Healthy/FindCancerEarly/CancerScreeningGuidelines
CRC = colorectal cancer
HNPCC = Hereditary non-polyposis colorectal cancer
FAP = Familial adenomatous polyposis
IBD = Inflammatory bowel disease

*Note: Additional recommendations for screening exist by ACS, which are available at:
www.cancer.org/Healthy/FindCancerEarly/CancerScreeningGuidelines
Step #4: Coordinate Care

The creation of a medical neighborhood will be critical in coordinating the care of patients.

Includes the facility, pathology, anesthesia, back up surgery, radiology, hospital, and possibly oncology.
Tools, Templates and Resources

- Appendix A
  - Work Sheets for Completing the Action Steps

- Appendix B
  - Electronic Health Record Screen Shots

- Appendix C
  - Program Tools and Materials

- Appendix D
  - Resources
### Appendix A-7: Action Plan

#### Action Plan Work Sheet

<table>
<thead>
<tr>
<th>Name of Health System:</th>
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<table>
<thead>
<tr>
<th>Colorectal (CRC) screening goal:</th>
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</table>

<table>
<thead>
<tr>
<th>Existing methods, processes, and programs that can be used to achieve the goal:</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>How will progress be tracked and how often?</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence-Based Strategies Chosen</th>
<th>Major Tasks to Implement Strategy</th>
<th>Expected Outcomes</th>
<th>Challenges and Potential Solutions</th>
<th>Person(s) Responsible</th>
<th>Due Date</th>
<th>Information or Resources Needed</th>
</tr>
</thead>
<tbody>
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**Increasing Quality Colorectal Cancer Screening: An Action Guide for Working with Health Systems**

## Appendix A-8: Tracking Template

### Colorectal Cancer Screening – Tracking Template

<table>
<thead>
<tr>
<th>Checklist</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Stool-Based Test</strong></td>
<td></td>
</tr>
<tr>
<td>1. Home HSgFOBT/FIT kit given</td>
<td></td>
</tr>
<tr>
<td>2. HSgFOBT/FIT test completed</td>
<td></td>
</tr>
<tr>
<td>3. Results received</td>
<td></td>
</tr>
<tr>
<td>4. If no completion or results, reminder call/text/letter sent</td>
<td></td>
</tr>
<tr>
<td>5. Patient notified of finding</td>
<td></td>
</tr>
<tr>
<td>6. Referred for colonoscopy if positive</td>
<td></td>
</tr>
<tr>
<td>7. Placed in tickler file if negative for next year</td>
<td></td>
</tr>
</tbody>
</table>

| **B. Colonoscopy** | |
| 1. Referred for colonoscopy | |
| 2. Colonoscopy scheduled | |
| 3. Colonoscopy test completed | |
| 4. Results received | |
| 5. If no completion or results, reminder call/text/letter sent | |
| 6. Patient notified of finding | |
| 7. Placed in tickler file if negative | |
Appendix B-1: Electronic Health Records

Sample NextGen Screenshot
How to Order Colonoscopy in EHR

Colonoscopy Protocol Report Build Tool

Memorized report build for KBM 7.9 and 8.0 or other KBMs that utilize protocols template.

1. NextGen EHR → File → Reports → Generate Report → By Practice
2. Select “Templates” in Setting List.
3. Locate “order” and select.
4. Indicate to pull “Latest Value By” by “Encounter Date”.
5. Select listed fields to pull for report.

Select these fields for report in “Select Field” options.
Appendix B-2: Electronic Health Records

Sample E Clinical Works Screen Shot
How to Generate a Report on Colonoscopies Ordered

Building reports on Colonoscopy in the Registry section
This query is for ordering the colonoscopy (V76.51). This does not include completed orders or patients that refuse or don’t see the specialty provider.

This query will search for instances the provider used the V76.51 code in their progress note.
*This will not show completed orders.
*This will not show all eligible patients due for colonoscopy.
Appendix C-1: Sample Screening Policy

ATTACHMENT 1 (CRCs Initiative)

IV. PROCEDURE

1. POPULATION
   Target population: Number of patients at average risk between age 50 through 75.
   UDS standard of care screening options:
   - Colonoscopy conducted during the reporting year or previous 9 years (total = 10 years)
   - Flexible sigmoidoscopy conducted during reporting year or previous 4 years (total = 5 years)
   - Guaiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) during the reporting year

2. Interim GOALS
   X by 20XX

3. EXCLUSION
   Patients who have or who have had colorectal cancer
   *may want to consider excluding patients receiving end of life care*

4. DATA ENTRY
   Practice managers will assure that new employees are oriented to this initiative and are provided with adequate orientation for data entry and appropriate scanning of documents.

V. DATA ABSTRACTION AND REPORTING

A. REPORTS
   1. Report parameters: Number of active patients aged 51 through 74
   2. Exclusions: Patients who have or who have had colorectal cancer
   3. Reporting Frequency: Quarterly
   4. Data Calculation:

\[
\text{Total \# of active patients who were aged 51 through 74} = \frac{\# \text{ of active pts aged 51 through 74 who have had gFOBT/FIT < 1 yr, flexible sigmoidoscopy < 5 yrs, or colonoscopy < 10 yrs}}{\text{Total \# of active patients who were aged 51 through 74}}
\]

Source: Adapted from the New Hampshire Colorectal Cancer Screening Program
Appendix C-6: Preparation Checklist

<table>
<thead>
<tr>
<th>Colonoscopy Screening</th>
<th>1\textsuperscript{st} meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Telephone #1:</td>
<td></td>
</tr>
<tr>
<td>Telephone #2:</td>
<td></td>
</tr>
<tr>
<td>Referring clinician/address:</td>
<td></td>
</tr>
</tbody>
</table>

Initial face-to-face meeting (1-5 weeks before appointment) 
- Discussion of importance of colonoscopy
- Provide educational literature?

Does patient meet screening criteria? Yes/No
- >50 yrs old and >10 yrs since last colonoscopy
- >40, first degree relative colon Ca and >5 yrs since last colonoscopy
- Proven adenomatous polyp, >5 yrs since last colonoscopy

Medication Review

<table>
<thead>
<tr>
<th></th>
<th>STOP</th>
<th>Don’t STOP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin, Plavix (clopidogrel) *need MD clearance, ideally stop 5 days</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Plavix (clopidogrel)</td>
<td>Effient</td>
<td></td>
</tr>
<tr>
<td>Coumadin (warfarin)</td>
<td>*need MD clearance, ideally stop 4 days</td>
<td></td>
</tr>
<tr>
<td>Xarelto</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Diabetes meds</td>
<td>Metformin, Januvia, glyburide *need MD clearance, usually hold oral agent morning of test</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Insulin *need MD clearance, usually half dose insulin night before and morning of test</td>
<td></td>
</tr>
<tr>
<td>Anti-hypertensives (BP meds)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Iron and iron-containing vitamins</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>ALL other meds can be held on the day of appointment</td>
<td>1 week before</td>
<td></td>
</tr>
<tr>
<td>Patient given written instructions about medications? (Yes/No)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Colonoscopy Preparation Navigator Checklist from New Haven CHC
# Appendix C-6: Preparation Checklist

## Bowel Prep
- Provide copy of bowel prep in native language
- Review bowel prep (in native language, if possible)
- Review with patient specific times to take laxative
- Review with patient “Clear liquid diet,” provide patient with diet list

## Appointment
- Date and Arrival time
- Estimated departure time (usually ~3 hrs after arrival)
- Appointment card given to patient?

## Transportation
- Review need for driver (if public transportation, must be accompanied)
- Patient’s transportation plans (who, how): Name:
  Phone:
Appendix C-6: Preparation Checklist

<table>
<thead>
<tr>
<th>Colonoscopy Screening</th>
<th>1-3 weeks before</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Second face to face meeting mandatory if initial meeting &gt; 5 weeks before colonoscopy</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Bowel Prep</strong></td>
<td></td>
</tr>
<tr>
<td>• Provide copy of bowel prep in native language</td>
<td></td>
</tr>
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<td>• Review bowel prep (in native language, if possible)</td>
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<td></td>
</tr>
<tr>
<td><strong>Appointment</strong></td>
<td></td>
</tr>
<tr>
<td>• Date and Arrival time</td>
<td></td>
</tr>
<tr>
<td>• Estimated departure time (usually ~3 hrs after arrival)</td>
<td></td>
</tr>
<tr>
<td>• Appointment card given to patient?</td>
<td></td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td></td>
</tr>
<tr>
<td>• Patient’s transportations plans (who, how):</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
</tbody>
</table>

Source: Colonoscopy Preparation Navigator Checklist from New Haven CHC
## Appendix C-6: Preparation Checklist

### Screening Colonoscopy – Telephone Calls

#### One week before appointment
- Remind patient of date and arrival time
- Confirm transportation plans
- Brief review of bowel prep
- Review clear liquid diet
- Review medication list

#### One day before appointment
- Ask how prep is going
- Remind importance of increased fluids - **Must drink “beyond thirst”** At least extra ¼ gallon over 24 hours
- Remind importance of two doses of prep, separated by at least 4-6 hours

<table>
<thead>
<tr>
<th>Record of additional phone calls</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient concern/question:</td>
<td></td>
</tr>
<tr>
<td>Resolution:</td>
<td></td>
</tr>
<tr>
<td>Patient concern/question:</td>
<td></td>
</tr>
<tr>
<td>Resolution:</td>
<td></td>
</tr>
</tbody>
</table>
Appendix D – Additional Resources

1 - Patient Education Materials
2 – Guidelines on CRC Screening (ACS, USPSTF)
3 - Patient Navigation (Training Programs)
4 - Electronic Health Records
5 - Practice Management
Appendix D-1: Resources

Centers for Disease Control and Prevention
cdc.gov/cancer/dcpc/publications/colorectal.htm
(Materials available in Spanish) Screen for Life Campaign Materials • Fact Sheets, Brochures, Brochure Inserts, Posters, Print Ads

National Cancer Institute
cancer.gov/cancertopics/pdq/screening/colorectal/Patient Patient information about colorectal cancer, colorectal cancer screening, and other topics

National Colorectal Cancer Roundtable
nccrt.org/tools/
Tools and Resources
Appendix D-1: Resources

**Prevent Cancer Foundation**
preventcancer.org/colorectal3c.aspx?id=1036
(Materials available in Spanish): Fact Sheet: Colorectal Cancer 2009 Fact Sheet

**American Cancer Society**
cancer.org/colonmd
(Materials available in Spanish and Asian languages):
ColonMD: Clinicians • Information Source Videos, Wall Charts, Brochures, Booklets • Guidelines, Scientific Articles, Presentations, Sample Reminders, Toolbox, CME Course, Medicare Coverage, *Facts & Figures, Journals*
The national goal is to increase the colorectal screening rate to 80% by the year 2018

We believe that CHCs can also work toward that goal!
We gratefully acknowledge the contributions of the following individuals:

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This project was supported in part by CDC Cooperative Agreement Number U50/DP001863. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention (CDC).