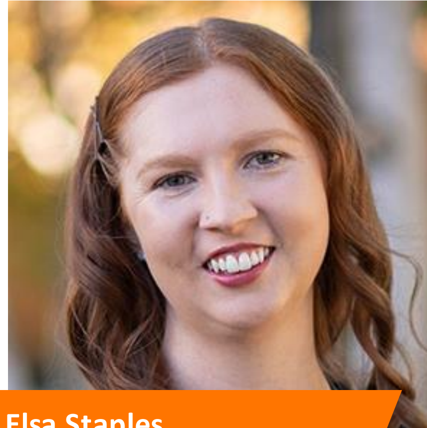
Concurrent Session C

Colorectal Cancer Screening Navigation in Action: Local Successes and Lessons Learned

3:30 PM to 4:45 PM

Colorectal Cancer Screening Navigation in Action: Local Successes and Lessons Learned

Moderator
Heather Dacus
DO, MPH



Elsa Staples
MPH

Jessica Spencer

Beth Wrobel
BSME

Heissel Herrera

Implementing Evidence-Based Strategies for Colorectal Cancer Screening in CO

Elsa Staples, MPH
Senior Program Manager, Colorado Cancer Screening Program - University of Colorado Cancer Center, Colorado School of Public Health
2023 80% in Every Community National Achievement Award Honoree

Implementing Evidence-Based Strategies for Colorectal Cancer Screening in CO

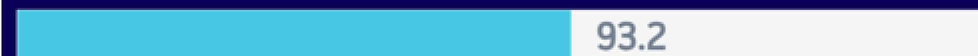
Elsa Staples, MPH – Senior Program Manager
University of Colorado Cancer Center & Colorado School of Public Health

Top Cancers in Colorado

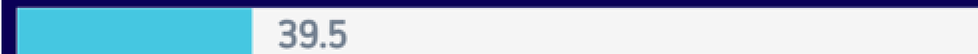
Incidence rates, 2015-2019
by cancer type, for Colorado

Breast (female)

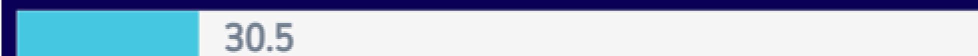
Prostate



Lung and bronchus

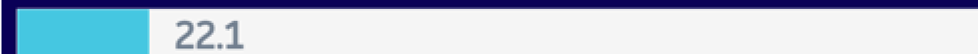


Colorectum



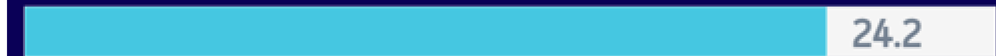
Uterine corpus

Melanoma of the skin



Death rates, 2016-2020
by cancer type, for Colorado

Lung and bronchus

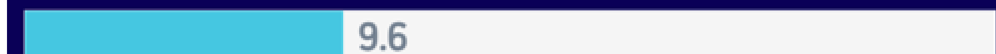


Prostate

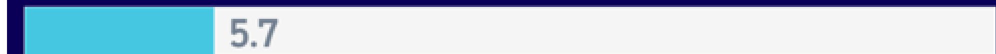
Breast (female)

Colorectum

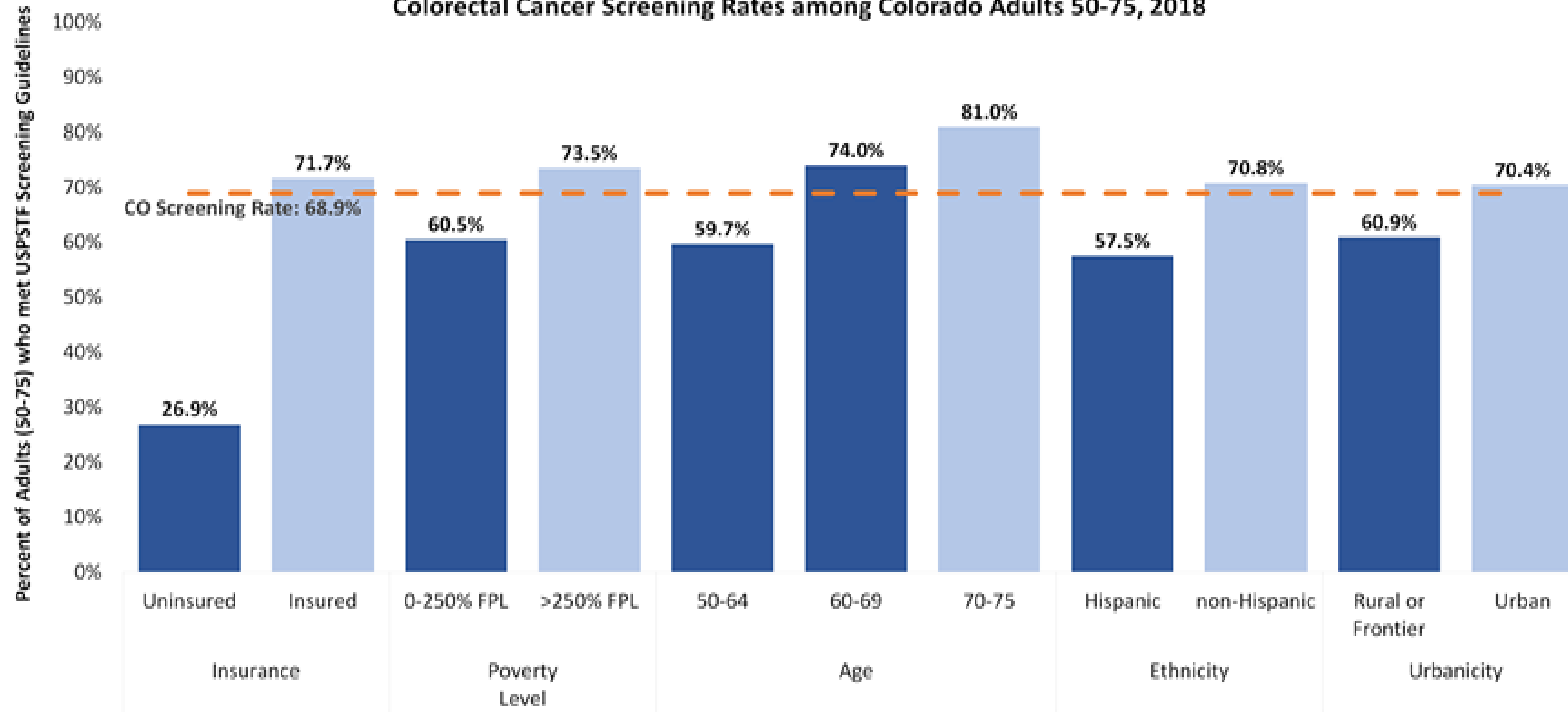
Pancreas

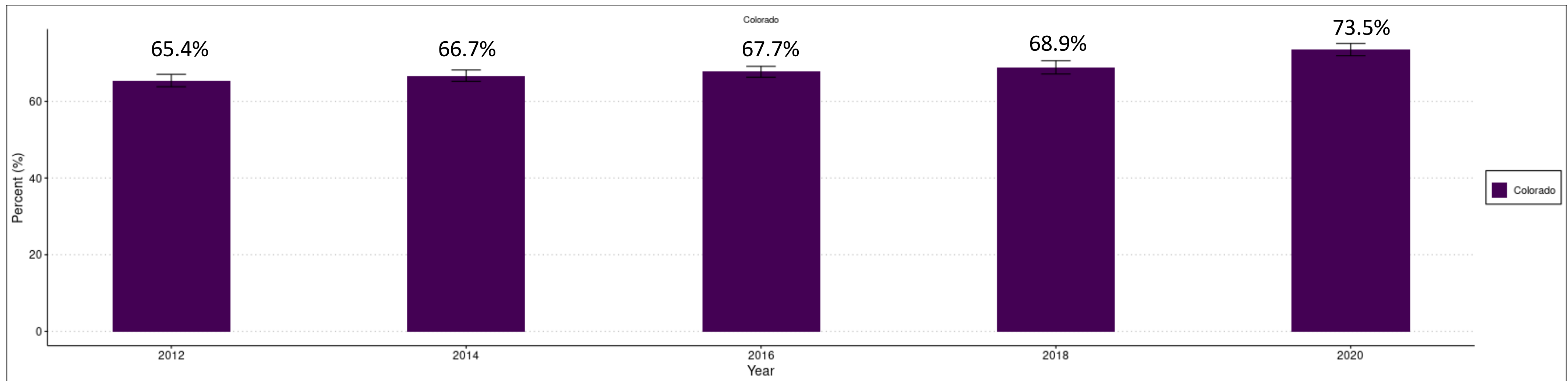


Liver and intrahepatic bile duct



Source: ACS Cancer Statistics Center


Colorectal Cancer Screening Rates among Colorado Adults 50-75, 2018
Percent of Adults (50-75) who met USPSTF Screening Guidelines
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
CO Screening Rate: 68.9%
26.9%
71.7%
60.5%
73.5%
59.7%
74.0%
81.0%
57.5%
70.8%
60.9%
70.4%
Uninsured
Insured
0-250% FPL
>250% FPL
50-64
60-69
70-75
Hispanic
non-Hispanic
Rural or Frontier
Urban
Insurance
Poverty Level
Age
Ethnicity
Urbanicity
Data Source: CO Behavioral Risk Factor Surveillance System, 2018
Target Population
69% Colorado CRC Screening Rate


Colorado
65.4%
66.7%
67.7%
68.9%
73.5%
Percent (%)
60
40
20
0
2012
2014
2016
2018
2020
Year
Colorado

Colorado Cancer Screening Program

COLORADO
CANCER
SCREENING
PROGRAM

Mission of CCSP:

- Partner with local, state, and national clinical and community partners to implement evidence-based interventions and population-based research in cancer prevention and control in order to promote health equity.
- Facilitate training and technical assistance for healthcare teams to implement cancer prevention and control initiatives aimed at reducing barriers and increasing access to care.
- Convene partners at the local, regional, and national level with a shared interest in cancer prevention and control to align efforts for increased reach and effectiveness.

Colorado Cancer Screening Program: A Snapshot

Primary funding by the Cancer Cardiovascular and Pulmonary Disease Grants Program (CCPD) – state tobacco tax revenue

Statewide cancer screening technical assistance program that partners with safety net clinics/hospitals – FQHCs, rural health clinics/hospitals, other safety net clinics

2006-2013: Direct services for colonoscopic colorectal cancer (CRC) screening and patient navigation. (patient eligibility ≤250% FPL)

2014-2023: Following ACA expansion – patient navigation reimbursement and support (patient eligibility ≤400% FPL)

2018-present: Capacity building for patient navigation sustainability and CRC, Lung, and Hereditary Cancer Screenings

July 2023-June 2026+: Implementation of select Evidence-Based Interventions for CRC screening (team-based care approach; all pts eligible)

Identifying Roles and Responsibilities for Cancer Screening Navigation in Your Clinic

Navigation Service	Clinic Staff Member	Partner Organization
Program LIAISON - individual who understands clinic, provider, and specialty care systems involved in providing cancer screening and patient navigation		
In-Reach/Outreach		
• Identification of clinic patients in need of screening		
• Contact and educate eligible patients about cancer screening(s)		
• Educating individuals who are current clinic patients as well as the community the clinic serves about cancer screening(s)		
Education		
• Explain the screening procedure and its preparation to patients, ensuring they understand the screening process and necessary preparation		
• Explain anatomy of appropriate bodily systems		
• Emphasize the medical need for screening method (colonoscopy, LDCT, etc.)		
Referral and Insurance Coverage		
• Facilitate and ensure the appropriate screening Referral/Order is completed by a Primary Care Provider		
• Verify patient income and insurance status per routine clinic policy		
• Help patient apply for other financial assistance programs for patients such as Medicare, Medicaid and SSDI		
Barriers		
• Ensure patients have transportation to and from screening and supportive care after		
• Work with patients to overcome common barriers (education, financial, logistic) using motivational interviewing skills and resource directories		
Reminders		
• Place 1-2 reminder calls before the screening appointment to decrease no-show rates (start prep, appointment date)		
• Utilize reminder system through EHR for surveillance and annual screening		
Care Coordination		
• Ensure follow-up of cancer screening results delivered by provider regardless if abnormal or normal screen - liaison between providers and patients		
• Follow-up with patients to ensure they understand the exam/test results and when they should be re-screened, or how to access additional care		
• Assist the patient with setting appointments for follow up care		
• Inform patient about who is the primary contact person if there are questions about eligibility, screening, post screening - including who to contact if patient is diagnosed with cancer or an adverse event occurs		
Program Reporting and Training Activities		
• Collection of data points for evaluation - outcomes and navigation services (how patient heard about program, time from diagnosis to treatment start, and rates of: 1) no-shows, 2) appropriate prep 3) complete follow-up)		
• Maintain files with patient specific data and records for fiscal and evaluation audits		
• Provide CCSP with monthly colonoscopy navigation and barrier reduction invoices for payment for services		
• Attend training sessions and participate in CCSP skills building opportunities		

Patient navigation definition: CDC defines patient navigation for CRC screening as individualized assistance offered to patients to help address barriers and facilitate timely access to quality screening and follow-up, as well as initiation of treatment services for people diagnosed with cancer (DeGroff et al, 2018)

Resources:

- Patient Navigation Roles and Responsibilities Checklist
- CCSP training and webinar recordings/materials

Patient Navigation competencies:

- PONT Standards
- Colorado lay navigator competencies & registry

Reach & Outcomes of CCSP Screening Navigation Efforts

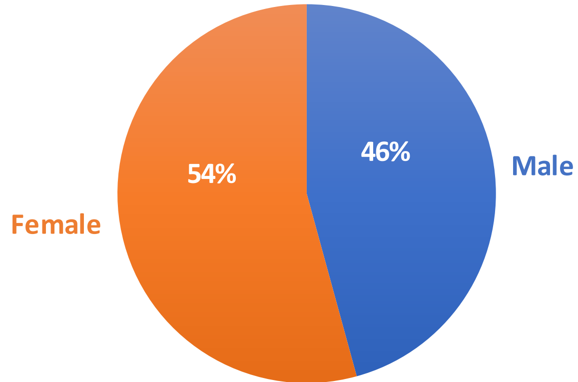
Program To-Date (2006-2023)

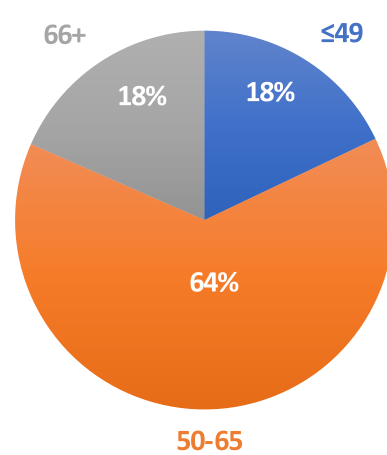
- 40+ clinic systems; 100+ clinic sites
- CCSP eligible patients successfully navigated into colonoscopy: **39,349**
  - Rural: **17%;** Urban: **83%**

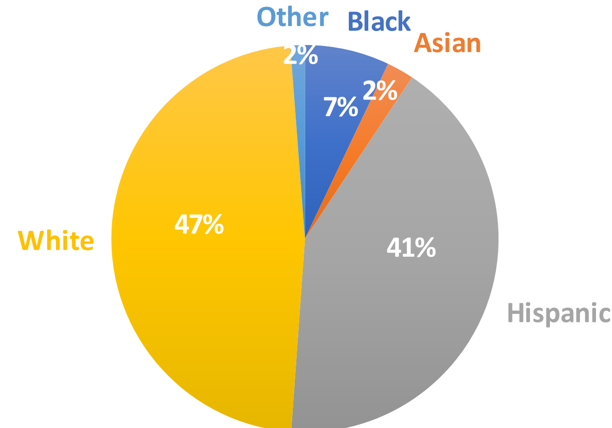
July 2018-June 2023 Grant Cycle

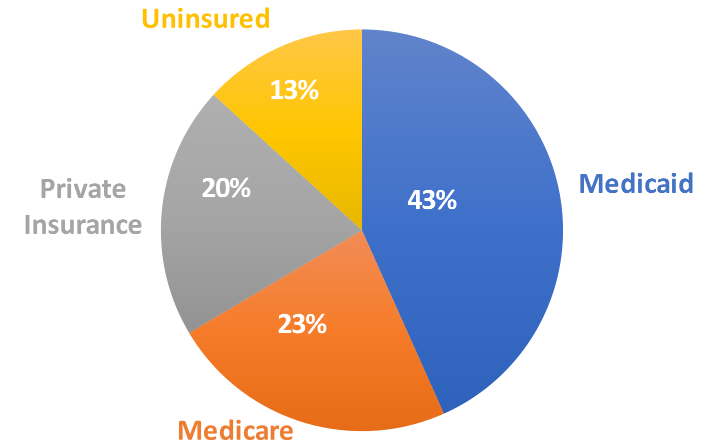
- 13-24 clinic systems per year
- CCSP eligible patients successfully navigated into CRC screening: **12,122**
  - Rural: **12%**; Urban: **88%**
- Stool tests administered: **8,326**
- Stool tests returned: **3,852***
- Hereditary cancer risk assessments completed: **1,330**
- Lung cancer screenings completed: **397**

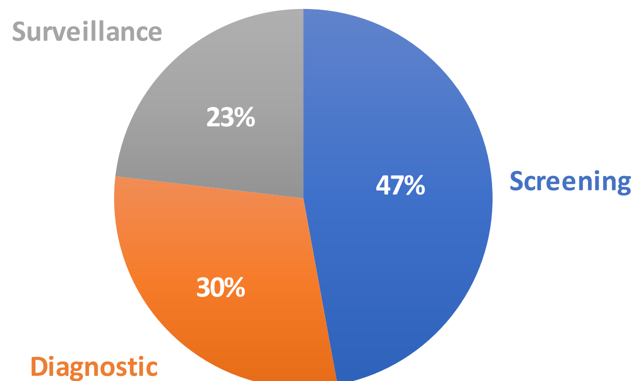
FY19-23 CCSP Colonoscopy Navigation Highlights

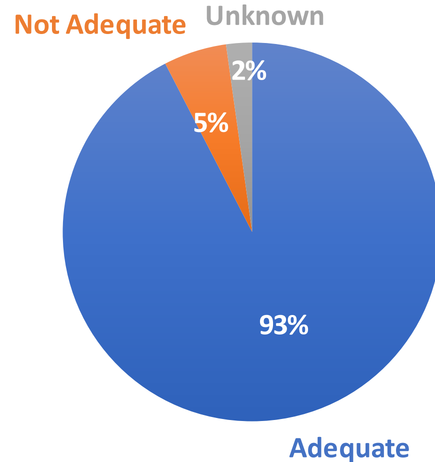


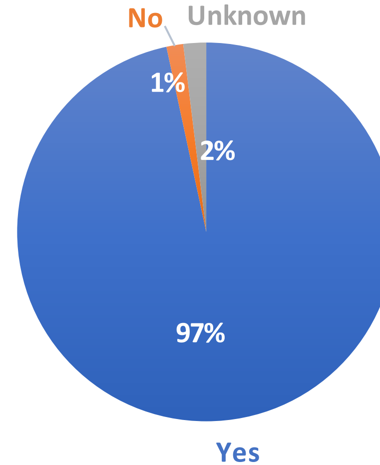


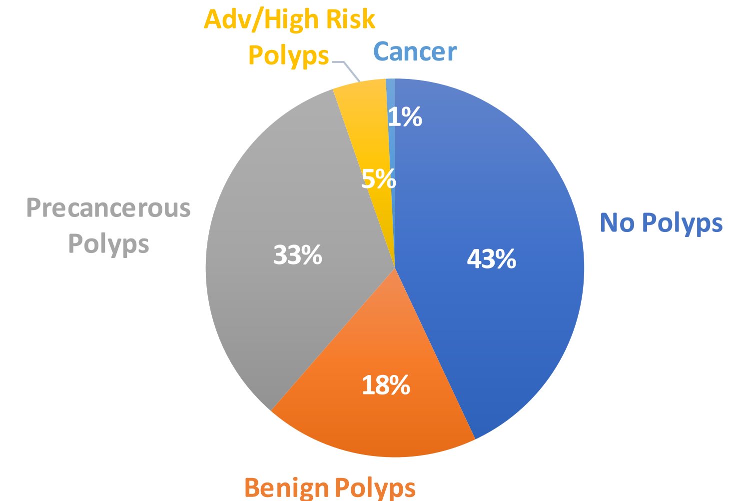












"The improved colorectal screening rates PCHC achieved were due to teamwork and our dedication to making sure our patients are well-served. The fact that we overcame barriers unique to the pandemic is a testament to the staff's loyalty to our mission – to provide quality primary care to those in need."
– Donald Moore, PCHC CEO

Case Study: Pueblo Community Health Center

The National Colorectal Cancer Roundtable honored PCHC for increasing their colorectal cancer screening rate from 54% in 2018 to 62% in 2021.

Achievements through CCSP support 2018-2023:

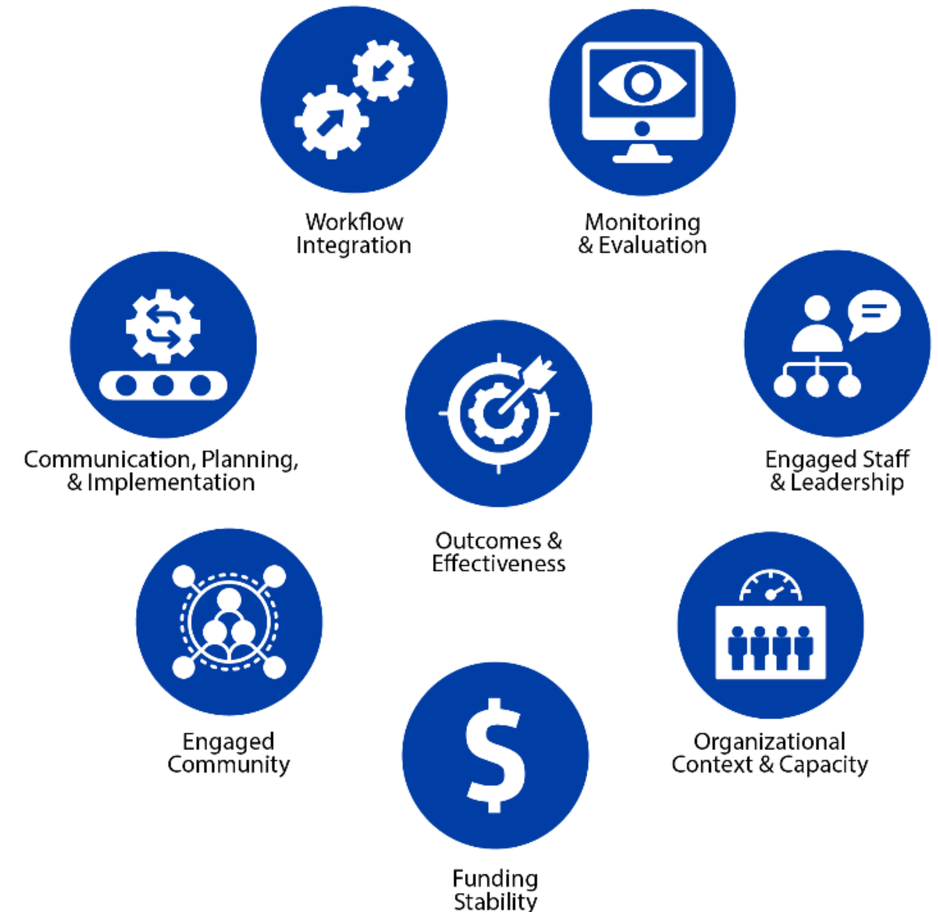
- Updated workflow with warm handoffs between navigation team for stool-based testing and colonoscopy navigation, and designated lead for population management and evaluation reporting
- CRC screening champions: leadership, navigators, providers
- 1,759 CCSP eligible patients successfully navigated into colonoscopy
- 1403 stool-based tests administered and 591 (42.1%) returned (2021-2023)

Sustainability of Patient Navigation Practices

Clinical sustainability capacity: the ability of an organization to maintain structured clinical care practices over time and to evolve and adapt these practices in response to new information (Washington University in St. Louis, 2018)

CCSP PN Sustainability Planning Process:

- CCSP adapted Washington University's Program and Clinical Sustainability Assessment Tools into a hybrid tool
- Each CCSP clinic system assessed sustainability capacity and developed a sustainability plan using the Patient Navigation Sustainability Action Tool
- Examples of activities supporting sustainability: job descriptions with key roles/responsibilities; ensure navigator role documented in clinic workflows
- Clinic systems completed the PNSAT three times between 2019-2023. Average score increased from 5.2 to 5.6 (out of 7-point scale)
- CCSP shortened the PNSAT in Spring 2023 to improve ease of use and expand focus to all PN practices



Technical Assistance Provided by CCSP and Partners

- Statewide partnerships to align efforts and initiatives
  - Primary Care Associations for FQHCs and rural health clinics/hospitals
  - Patient Navigation & Community Health Worker Training Program (PNCT)
  - American Cancer Society
  - Colorado Cancer Coalition
  - Subject matter experts
- Training, education, skills-building sessions for clinic teams on foundations in CRC screening, patient navigation, QI
  - Support for completion of training curriculum and assessment to be listed on Colorado's Health Navigator Registry
- Technical assistance, coaching and facilitation:
  - Workflow development, data management and reporting
  - Sustainability planning for patient navigation
  - Development and implementation of an EBI Action Plan using quality improvement processes
  - Quarterly calls for discussion of progress, successes, barriers
- Connections to external resources: patient education materials, barrier reduction services, professional development opportunities

Implementation of EBIs: July 2023-June 2026

EBIs of focus:

- Client reminders
- Provider reminders and recall systems
- Provider assessment and feedback
- Standing orders by healthcare providers

Technical Assistance Delivery:

- Quarterly learning collaborative meetings (all participating systems)
- Monthly to quarterly 1:1 technical assistance calls with clinic system, CCSP, TA partners

Planning and Implementation Process:

15-20 participating clinics

- Baseline assessment of current CRC screening infrastructure and capacity
- Identify and document existing CRC screening workflow and key roles
- Root cause/gap analysis (fishbone diagram)
- Develop AIM statement and select EBIs
- Create quality improvement plan (PDSAs)
- Finalize and implement EBI action plan
- Monitor CRC screening rate and EBI process measures

Lessons Learned

1. Authentic partnership and listening to the needs of the clinics and community is critical.
2. Meet them where they are at: If there are established efforts and relationships, strengthening those established efforts is a better use of time versus recreating or trying to establish something entirely new
3. No two systems or programs work the same but utilizing common metrics & tools to support systems is helpful. There can be adaption but stay true to the spirit of the evidence-based interventions.
4. It is never too early or too late to consider sustainability
5. Access to colonoscopy remains a barrier for under-resourced communities including uninsured, Medicaid, rural. Need for coordination of efforts.

Thank you!

COLORADO
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PROGRAM

- Elsa Staples, MPH – Senior Program Manager, CCSP

Elsa.staples@cuanschutz.edu

- Andrea (Andi) Dwyer – Director, CCSP

Andrea.dwyer@cuanschutz.edu

Resources:

- CCSP Website - Information and Educational Resources for Clinics and Navigators: https://sites.google.com/view/colorado-cancer-screening-prog/
- Patient Navigation Sustainability Assessment tool: https://sites.google.com/view/pnsat

Thank You

nccrt.org @NCCRTnews #80inEveryCommunity

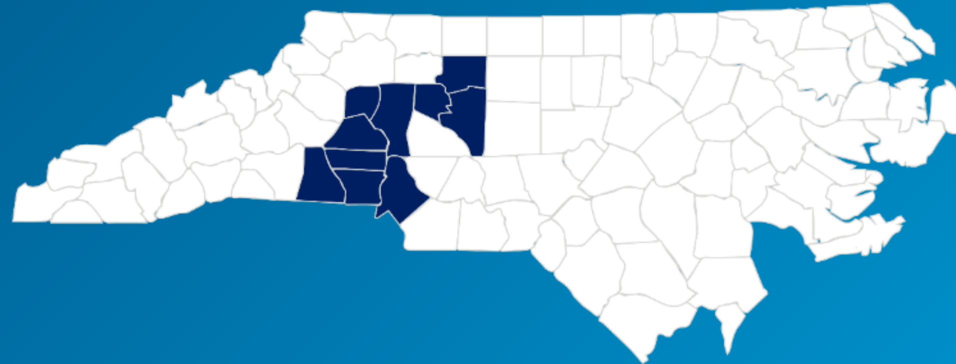
Collaborative Partnership with NC PICCS

Jessica Spencer
Health Promotion Program Manager, Kintegra Health
2023 80% in Every Community National Achievement Award Honoree

Collaborative Partnership with NC PICCS

October 2023
National Colorectal Cancer Roundtable

Jessica Spencer
Health Promotion Program Manager



Our **Mission**

Kintegra Health is a community sponsored, family-centered provider of health care, health education and preventive care services **without regard for the ability to pay.**

Collaborative Partnership with the NC PICCS program

- North Carolina Partnership to Increase Colorectal Cancer Screenings (NC PICCS) is a Centers for Disease Control and Prevention-funded grant aimed at using evidence-based interventions to increase colorectal cancer screening and improve quality of screening and follow-up testing.

- NCPICCS Partners include:
  - American Cancer Society
  - NC Division of Public Health’s Cancer Prevention and Control Branch
  - University of North Carolina at Chapel Hill Lineberger Comprehensive Cancer Center.

North Carolina Partnership to Increase Colorectal Cancer Screenings (NC PICCS)

THE UNIVERSITY *of* NORTH CAROLINA *at* CHAPEL HILL

Program Services
Focused on Priority FQHC Populations

Get Connected 1

Connected NC PICCS with Kintegra's primary care clinics to implement EBIs recommended in the Community Guide

Learn Best Practices 2

Worked with ACS partners to support participating clinics - QI Boot Camp and monthly Learning Collaborative calls

Monitor Quality Improvements 3

Planned and monitored quality improvement activities monthly through PDSA cycles and then tracking screening data

Evaluate Progress 4

Kintegra collected and submitted clinic-level data for baseline, monthly, and annual surveys.

NC PICCS Program Participating Clinics

Cohort 1

Kintegra Family Medicine:
Hickory & Lincolnton Clinics

Cohort 2

Kintegra Family Medicine:
Hudson & Highland Clinics

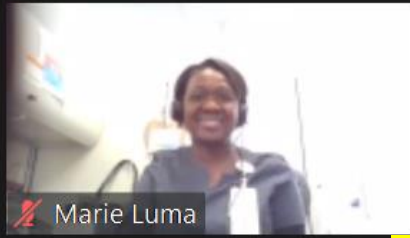
2 More in 2024!

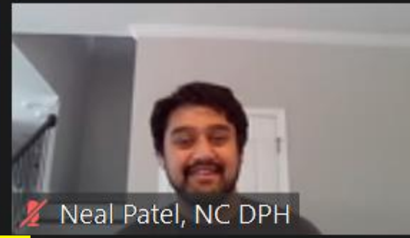
Cohort 3

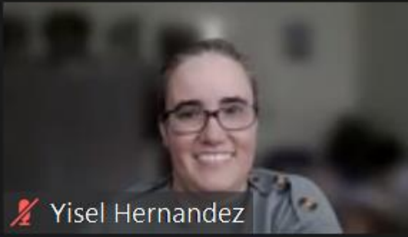
Kintegra Family Medicine:
Statesville & Lexington Clinics

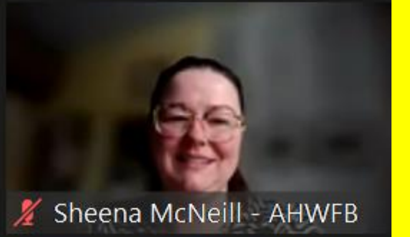
Cohort 4

Kintegra Family Medicine:
X-ray Drive & Third Ave. Clinics

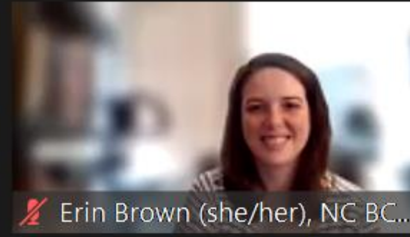


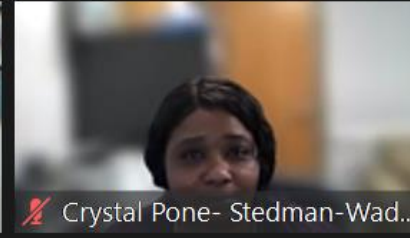






2023 American Cancer Society's Quality Improvement Bootcamp Training!

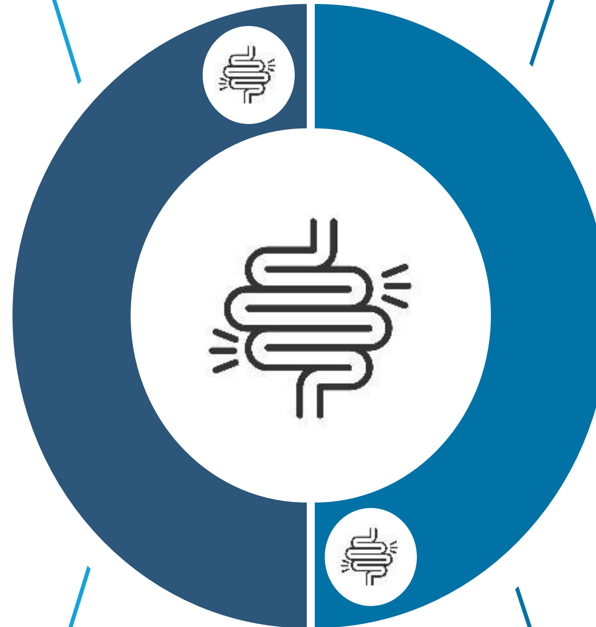




Kintegra Health Participating Clinics EBIs

Provider Focused

- Provider Assessment and Feedback
  - Screening Challenge
  - Provider Competition
  - Monthly Quality Updates
- Provider Education
  - Self-Directed Training
  - Provider Rounding



Patient Focused

- Patient Reminders
  - Tracking log
  - Phone calls
  - Postcards
- Reducing Structural Barriers
  - Postage to Return Kits by Mail
  - Offering Cologuard
- Patient Education
  - Small Media
  - Use of Tablets
  - FIT Kit Instruction Video
  - Step-by-Step Toolkits

Patient Education Toolkits

Kintegra Health

@kintegrahealth · 39 subscribers · 25 videos

Kintegra Health is a community sponsored, family-centered provider of health care, health ...

kintegra.org

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Instructional Video

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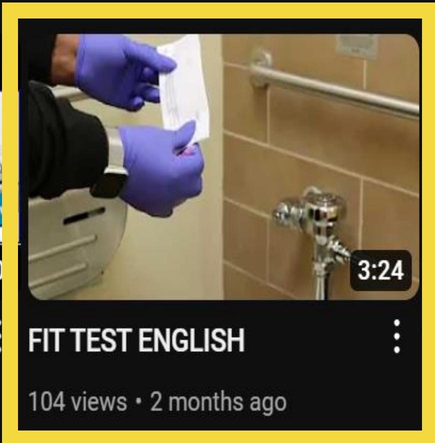
Why Kintegra: Marvin Allen

117 views • 2 months ago



FIT TEST ENGLISH

104 views • 2 months ago

Why Kintegra: Cayla Price

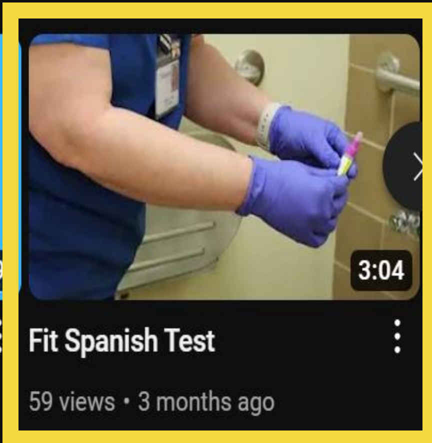
03 views • 2 months ago

Why Kintegra: LaTonka Love

112 views • 2 months ago

Health Fest Post Video Social Media

152 views • 3 months ago



Fit Spanish Test

59 views • 3 months ago

English & Spanish

Personalized Outreach

Colorectal Cancer Education

Kintegra Clinical Staff

Cómo completar un kit Hemosure.

Instructional Video Patient Handout

Did you know that colorectal cancer is the 2nd deadliest cancer in the US?

At-Home Colorectal Cancer Screening

Scan to review step-by-step instructions on how to complete your FIT kit.

Kintegra Family Medicine - Hickory
828-994-4544
Monday – Friday: 8:00am – 5:00pm
(Closed Daily: 12:30pm – 1:30pm)
133 1st Avenue SE, Hickory, NC 28602

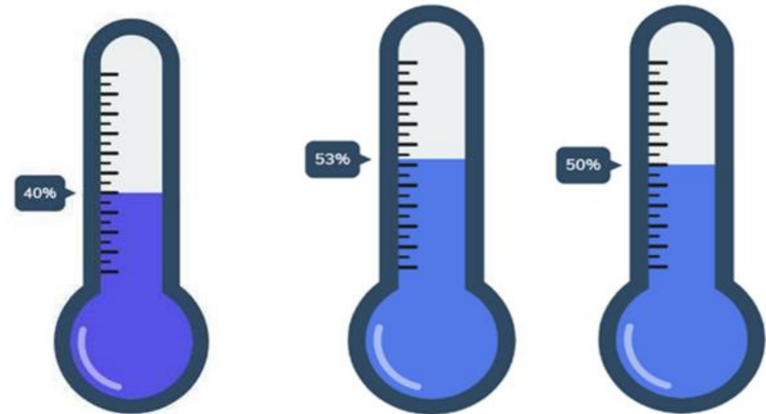
¿Sabías que el cáncer colorrectal es ¿El segundo cáncer más mortal en Estados Unidos?

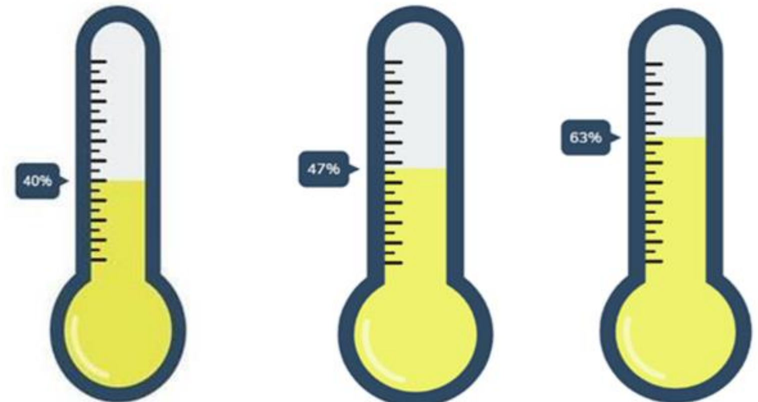
Colorrectal en casa La detección del cáncer

Escanee para revisar las instrucciones paso a paso sobre cómo completar su kit FIT.

Kintegra Family Medicine - Hickory
828-994-4544
Monday – Friday: 8:00am – 5:00pm
(Cerrado Todos Los Días : 12:30pm – 1:30pm)
133 1st Avenue SE, Hickory, NC 28602

Provider Screening Challenge Tracking & Updates





Screening Champions

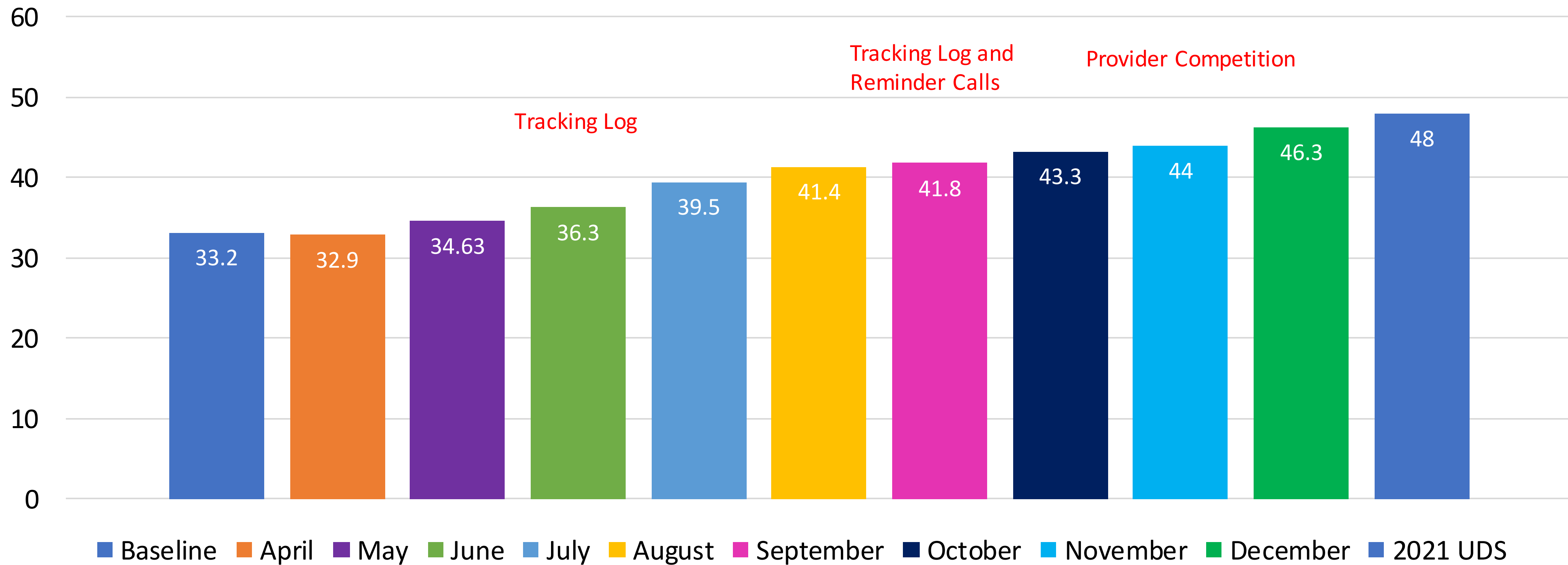
2021 ‘Provider Screening Challenge’

- Provider A had the largest CRC screening rate increase during the year (15% increase)
- Provider B ended the year with the highest CRC screening rate (52%)

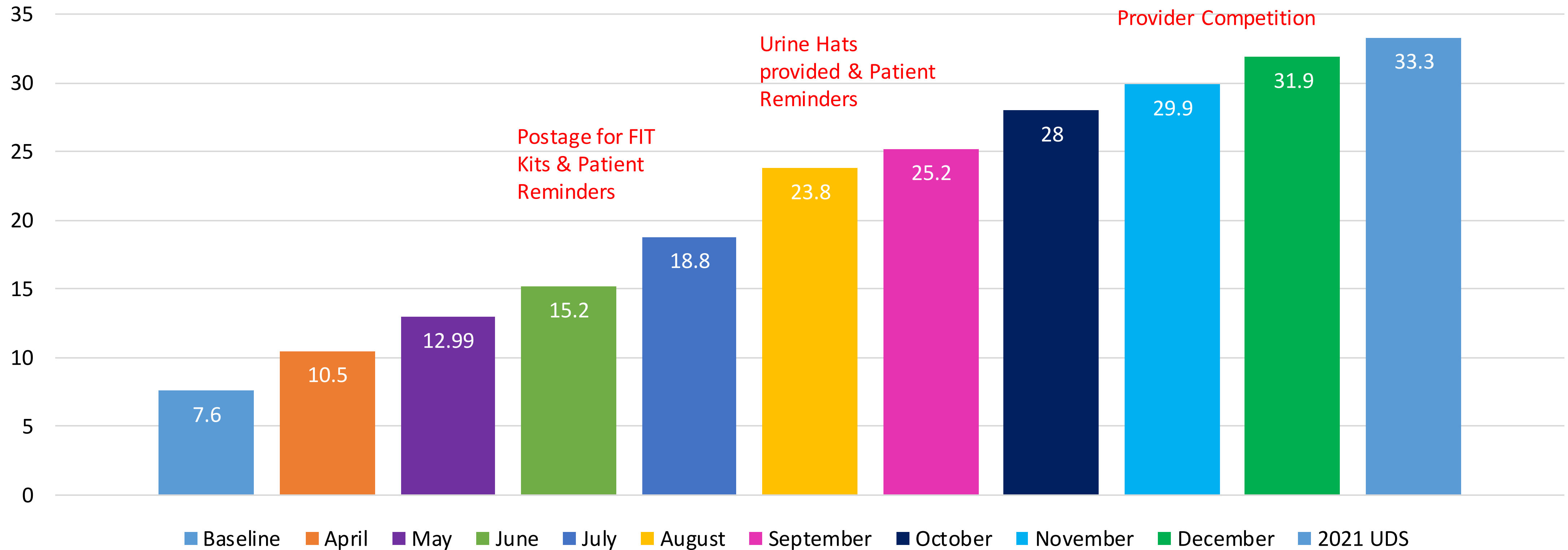
Program Coordination & Patient Navigation via Community Health & Prevention

We are committed to providing Case Management, Education, Health Promotion and Linkage to Care to those experiencing health disparities for the diverse communities that Kintegra Health serves.

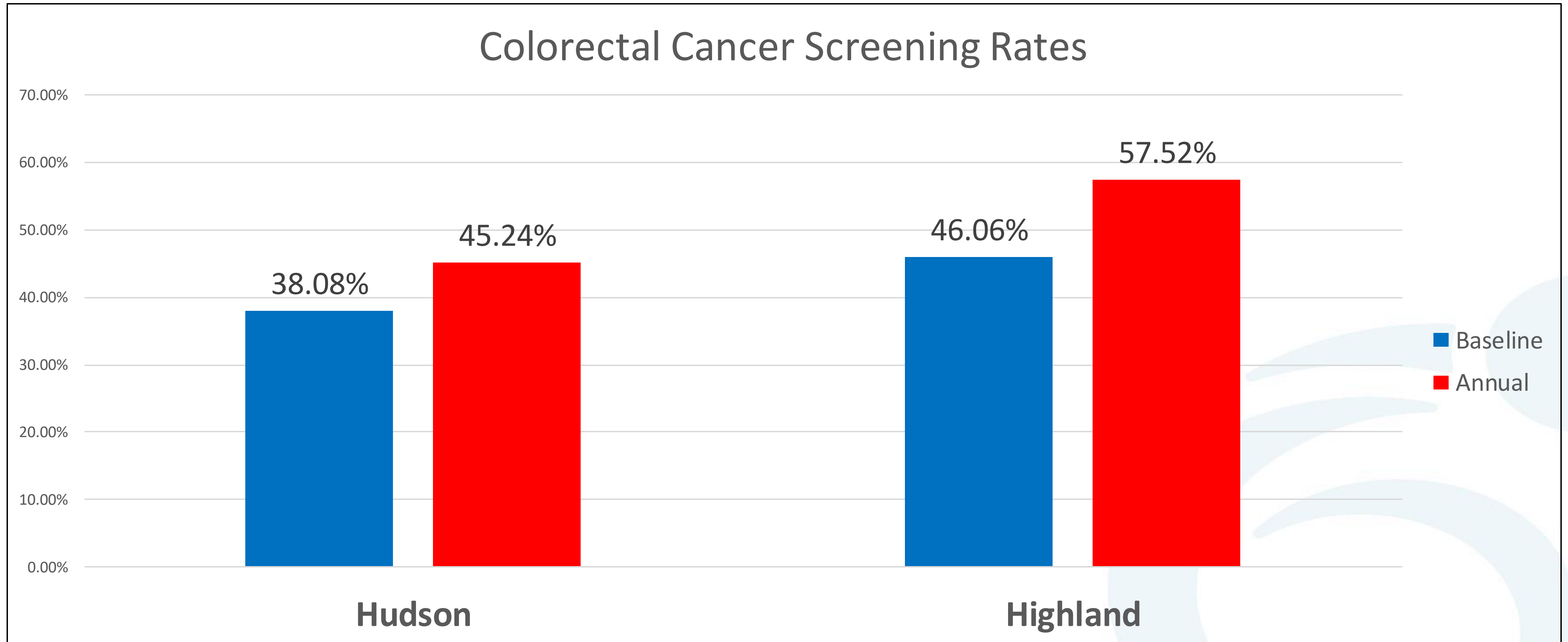
Lincolnton improved their CRC screening rate by 14.8%



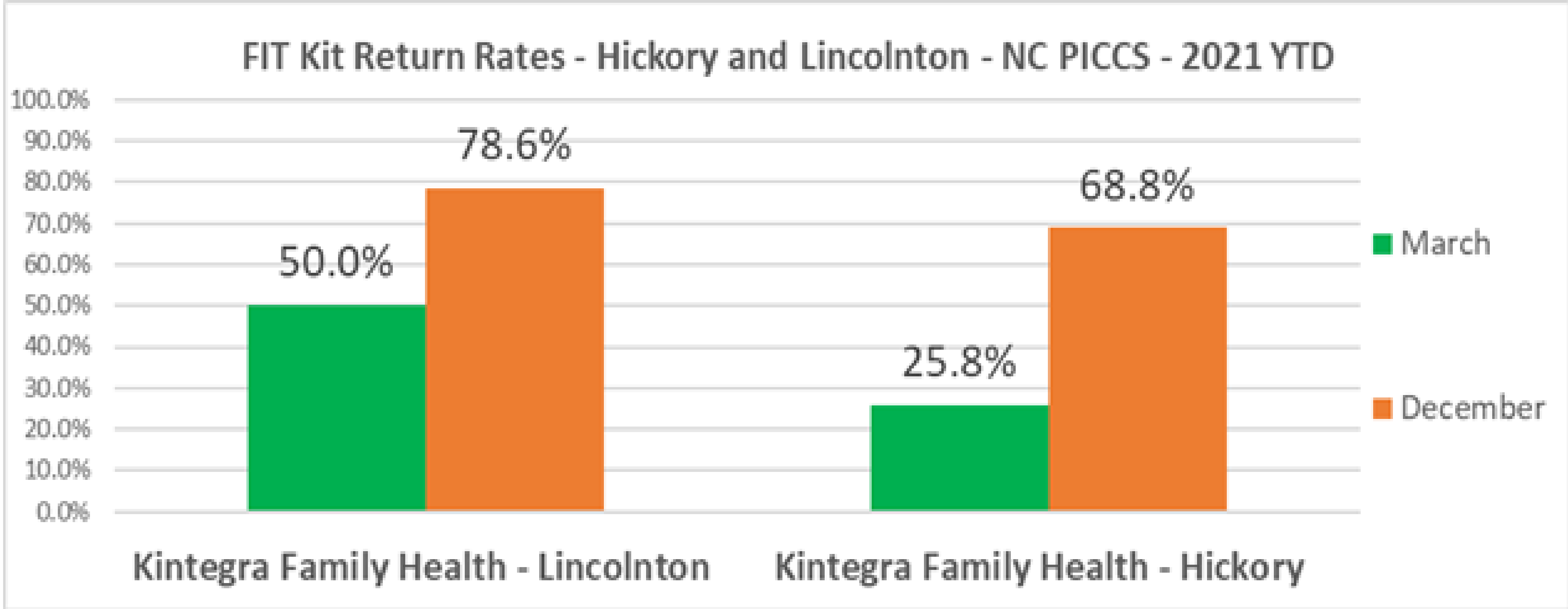
Hickory improved their CRC screening rate by 25.72%



Kintegra CRC Screening Rates (Baseline - Annual)



FIT Kit Return Rate Increases



NC PICCS Colonoscopy Outcomes Report

152 patients with a positive stool-based test

15 patients decline/cancelled appointment or were no show

12 patients with appointments scheduled in the future

66 patients completed follow-up colonoscopy

*Notes- Colonoscopy data for August 2021-May 2023. For patients who were not eligible to be funded by NC PICCS, the Colorectal Cancer Coalition provided funding for follow-up colonoscopies.

NC PICCS Colonoscopy Outcomes Report

Of the 66 patients who received a CDC-funded follow-up colonoscopy:

- **45 POLYPS**
- **4 PRECANCEROUS**
- **10 ABNORMAL**
- **2 NO ABNORMALITIES**
- **4 PENDING RESULTS**
- **1 RESCHEDULED**

*Notes- Colonoscopy data for August 2021-May 2023. For patients who were not eligible to be funded by NC PICCS, the Colorectal Cancer Coalition provided funding for follow-up colonoscopies.

NC PICCS Colonoscopy Outcomes Report - Demographics

53 years old is the average age

53% Hispanic patient population

74% patients had polyp removed

88% patients had abnormal colonoscopy result

Barriers and Solutions

Barriers	Solutions
Transportation	Clinics are working on transportation options (i.e. Uber Health, Gas Gift Cards, Cab Rides) and providing options to mail stool tests back
Cost of Follow-Up Colonoscopy	NC PICCS covered qualifying patients' colonoscopies Kintegra negotiated lower rates with partner GI clinics for uninsured and underinsured patients Future collaboration with the Colon Cancer Coalition
Patient Knowledge	Clinic staff attended Motivational Interview training
Scheduling Follow-Up Colonoscopies	Providers are looking into risk stratifying patients so patients with high risk or need have a priority scheduling for a follow-up colonoscopy.
Staff Turnover	Quality Improvement Team developed process maps and workflows to help address short staffing and trainings for new hires
Staffing Shortage	Created workflows and process maps Working to automate processes through EHR Worked with 3rd parties to help with reminder calls

SUMMARY REPORT

Highlighting Organizational Success!

- Provider and Leadership Support during Project & Beyond, Motivated Staff to Work Towards Goals of Improving Screening Rates
- Established Partnerships with GI Providers to Provide Colonoscopies at Reduced Rates
- Clinic Staff Actively Engaged in the Learning Activities throughout their time with the ACS Learning Collaborative and NCPICCS Program.
- Had Sites Surpass their Goals of Increasing their Screening Rates by 15% and 26%
- Referral Process has Improved
- Identified Screening Champions!

- Cologuard Completion and Return Rates have Improved
- Implemented Standing Meetings with the Marketing Department which will Speed up the Ability to Create and Distribute Patient Education Materials
- Increased Staff Education

Jessica Spencer

Kintegra Health
Health Promotion Program Manager
704-772-4697
jspencer@kintegra.org

Erin Hultgren, MPH, CHES

Kintegra Health
Director of Community Health & Prevention
704-772-4701
ehultgren@kintegra.org

Thank You

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American Cancer Society: Colorectal Cancer Screening

Beth Wrobel, BSME
Chief Executive Officer
HealthLinc

American Cancer Society: Colorectal Cancer Screening

Beth Wrobel
CEO

HealthLinc Map

HealthLinc: We create healthy communities.

- Serving Northern Indiana since 1996
  - Obtained full FQHC status in 2006
- Patient-centered whole-person care model
- 12 Sites, 2 School Based Telemedicine locations
- Mobile Medical/Dental Clinic
- 42k+ patients served per year
- 500 Employees
- Multi-Specialty integrated care

Valparaiso, Indiana Headquarters

MEDICAL
Primary and preventive care, physical examinations, immunizations, pediatrics, women's health including obstetrics, MAT, podiatry and more

DENTAL
Examinations, X-rays, treatment planning, cleanings, extractions, fillings, patient education and more

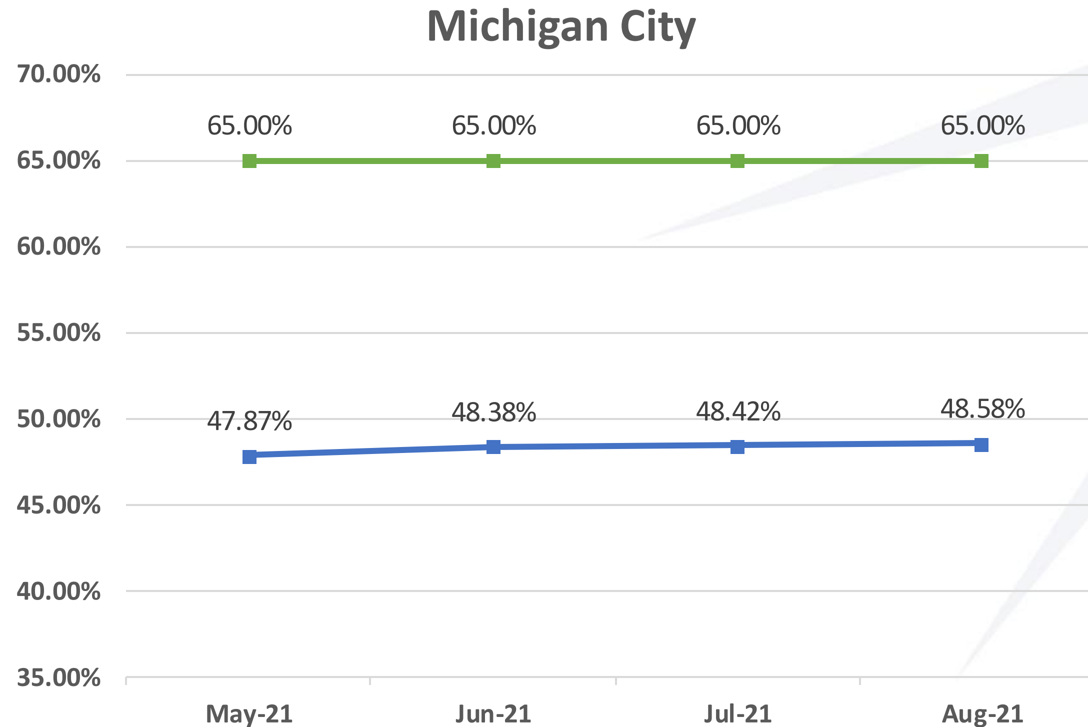
BEHAVIORAL HEALTH
Healthy lifestyle choices, stress reduction, anxiety and depression management, goal setting and more

OPTOMETRY
Eye examinations, dilated retinal evaluations for diabetes, cataract and glaucoma screenings, eyeglass prescriptions and more

HEALTHLINCCHC.ORG

EAST CHICAGO | KNOX | LA PORTE | MICHIGAN CITY | MISHAWAKA | SOUTH BEND | VALPARAISO

Baseline Data



Goal: 65%

2022 Data

Michigan City

	TY 01/22	TY 02/22	TY 03/22	TY 04/22	TY 05/22	TY 06/22	TY 07/22	TY 08/22	TY 09/22	TY 10/22	TY 11/22	TY 12/22
Michigan City	50.3%	51.3%	52.8%	54.3%	54.9%	54.6%	55.6%	55.9%	57.5%	58.8%	59.2%	58.8%

Legend: Michigan City; Michigan City Goal

Y-axis: 0.0%, 10.0%, 20.0%, 30.0%, 40.0%, 50.0%, 60.0%, 70.0%

Goal: 65%

Project Roles

Participant	Roles and Responsibilities
Health System Leadership (Site Leadership)	Involved in cancer prioritization but generally not involved in day-to-day implementation efforts
Health System Core Team Clinical Champion (FNP) Clinical Champion (CTN) Quality Improvement Department Site Support Staff ACS Staff	Spend 5-10 hours each month on the project, including monthly meetings to carry out quality improvement and lead staff trainings. Responsibilities include: • Submit data • Create aim and action plan together • Carry out quality improvement methods and execute evidence-based interventions • Coordinate staff trainings • Create clear communication methods to share plan and feedback with individual clinic sites • Participate in monthly meetings and contribute to agenda
ACS Staff	Support and participate in the core team as they carry out the planning and implementation of the program. • Serve as liaison between GHQ and health system partner • Review progress and financial reports and stay abreast of report deadlines and other action items due • Provide guidance to partner on QI and EBI implementation • Identify opportunities for recognition and sustainability
Clinic Specific Champions • PSR • Community Health Worker	Represent their peers and culture. They should be involved in selecting interventions, designing the action plan and: • Disseminate and customize information • Implement quality improvement plan at their site • Assist with coordinating staff training • Motivate staff and advocate for importance of issue
All Health System Staff Includes providers, nurses, medical assistants and front desk (team that has day-to-day responsibility for serving target population)	Participate in trainings and customize action plan, as needed. Responsibilities include: • Contribute to understanding current state processes, share thoughts on gaps and opportunities for improvement • Work as a team to design/customize selected interventions • Implement interventions and review data

Current QI Activities

Pre-visit

- Utilizing Azari PVP
- Identifying patients to for CRCS
- If either iFOBT or colonoscopy referral already exists for screening, encourage patient to complete and mail back in

Visit

- If order is placed, encourage patient to complete and mail in "poop card" that is looking for blood that you can't see
- If order is closed (per standing order), order a new one. Do not re-order if order is still open
- Provide education on preventive screenings
- CHW consultation for addressing SDOHs
  - Task CHW with due date of task being the date of next appointment, and Denise can see the patient to address SDOHs during their next appointment
- CRCS bathroom stall
  - Bathroom in use sign to provide complete privacy
- Provide kit return deadline and write it on the kit

Post Visit

- Medumo texts
- Utilization of Referral Module in Azara to monitor referrals and orders
- Collaboration with CTN and QI Specialist to follow through on abnormal/inadequate specimens, and non-returned kits
- Receiving regular referral reports for colonoscopies; MA recalls patients
- Patient Navigator to follow-up with Quest and track results for proper disposition (in hiring process)
- Mailer project: reprint orders/put in new orders for patients seen within a year; include infographics, letter, FIT kit, and order; request patient to mail back completed kit with order with pre-paid postage envelope

HealthLinc
YOUR COMMUNITY HEALTH CENTER
FQHC

Background

12 Clinics, 5 Counties
Corporate Headquarters: Valparaiso, IN

Project Aim: *To increase screening rates for colorectal cancer.*

Project Activities:

Mail-FIT campaign	Text Reminders
Patient Navigation	Colonoscopy MOUs
Calling gaps/deficiencies	Patient Incentives

QI Team, Grants, Site Leadership and Care Team Nurse

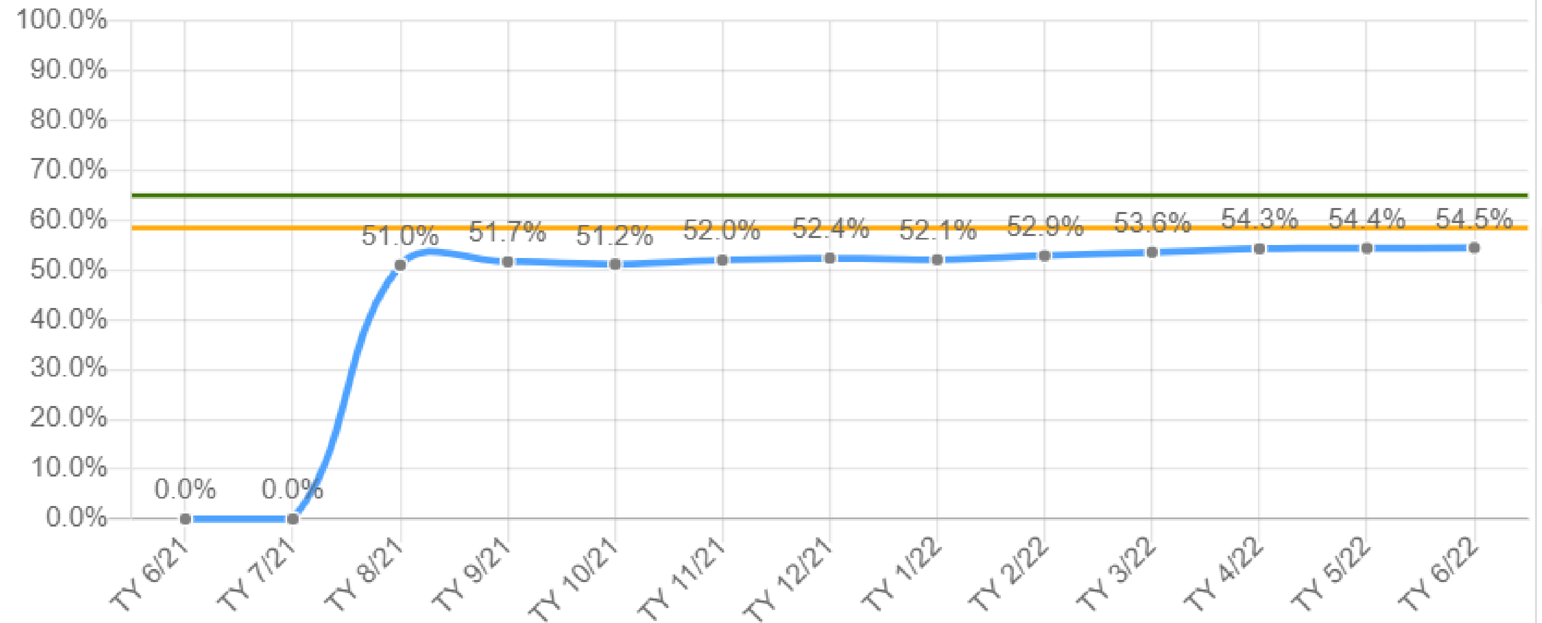
QI Tools used:
Azara DRVS (pre-visit planning, referral management, alerts and reminders), PDSAs

Collaborated with:
Methodist Hospital (colonoscopies)
Franciscan Hospital (colonoscopies)
University of Chicago (Medumo text reminders)

HealthLinc Michigan City

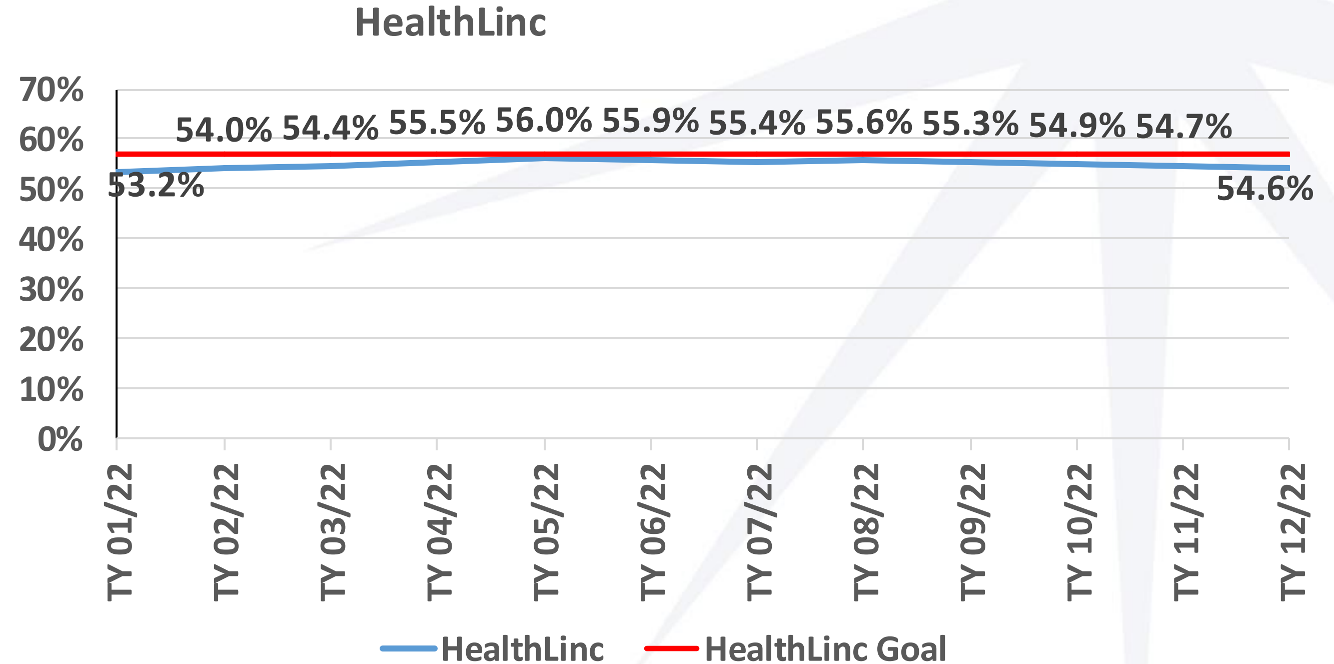
Data

PERIOD	RESULT	NUM	DENOM	EXCL
TY 6/22	**55.0%**	667	1223	24
TY 5/22	**54.0%**	664	1220	26
TY 4/22	**54.0%**	669	1231	26
TY 3/22	**54.0%**	662	1234	24
TY 2/22	**53.0%**	654	1236	23
TY 1/22	**52.0%**	644	1236	23
TY 12/21	**52.0%**	638	1218	23
TY 11/21	**52.0%**	633	1217	21
TY 10/21	**51.0%**	626	1222	20
TY 9/21	**52.0%**	625	1210	18
TY 8/21	**51.0%**	608	1192	17



Data, cont'd

PERIOD	RESULT	NUM	DENOM	EXCL
TY 01/22	**53.2%**	4845	9112	115
TY 02/22	**54.0%**	4933	9131	117
TY 03/22	**54.4%**	4981	9152	116
TY 04/22	**55.5%**	5081	9161	109
TY 05/22	**56.0%**	5176	9241	113
TY 06/22	**55.9%**	5131	9179	111
TY 07/22	**55.4%**	5098	9195	110
TY 08/22	**55.6%**	5167	9296	109
TY 09/22	**55.3%**	5145	9296	113
TY 10/22	**54.9%**	5180	9432	115
TY 11/22	**54.7%**	5167	9447	114
TY 12/22	**54.6%**	5176	9480	118



Results

Successes:

- *7.8% change – increase in colorectal cancer screening*
- *Collaborations and partnerships with other organizations*
- *Increased staff awareness and education (the WHY)*
- *Multi-disciplinary team collaboration – provider, CTNs, MAs, operations, and quality department*
- *Increased patient awareness and education on importance of preventive screenings*
- *Provider and leadership buy-in*
- *Increase distribution of kits in-office or through mail-in campaign*
- *Increase in supply of kits due to collaboration with Quest*
- *Decrease of non-compliance due to cost (MOUs and mail-FIT campaign for no-charge screening)*
- *Increased patient navigation to provide additional education and patient outreach*
- *Corrected documentation of Cologuard screenings in EHR*

Challenges:

- *Patient non-compliance*
- *Patient fear*
- *SDOHs including transportation, insurance, homelessness/housing, education*
- *Patient return rate of FIT kits*
- *Collaborating provider no longer with HealthLinc*

Next Steps:

- *Continue patient navigation and outreach with inclusion of Community Health Workers to address SDOHs*
- *Referral procedure revamp- tracking screenings, diagnostic testing, and abnormal results*
- *Potential Addition of Patient Active Measure (PAM) Score*

Data TY 12/2022

Site	Measure
Michigan City	58.8%
Corporate	54.6%

Michigan City has surpassed the overall Corporate measure since starting this grant.

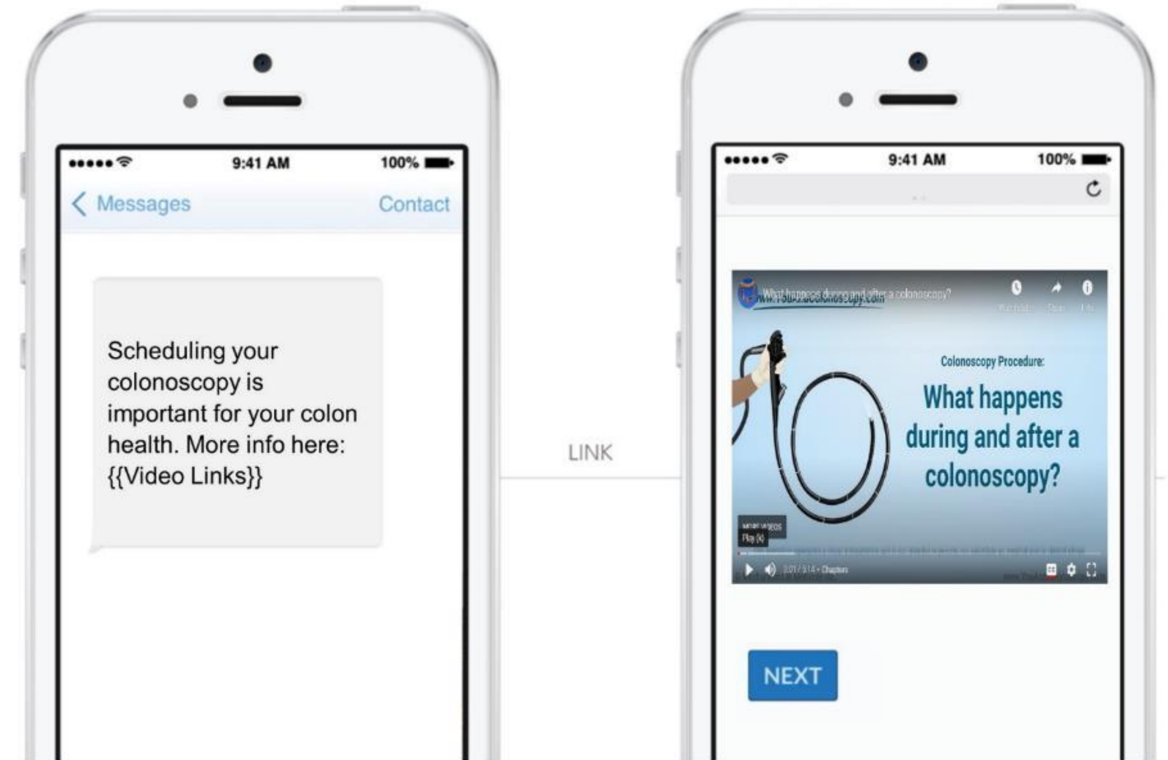
Project with University Of Chicago

2021- 2023

ACCSIS-Chicago Project Component

Short Message Service (SMS)

- FIT Program → Remind to return FIT kit
- Colonoscopy Program
  - ➢ Pathway 1 → Remind to make an appointment
  - ➢ Pathway 2 → Educate on bowel pre|
- Started on June 15, 2021



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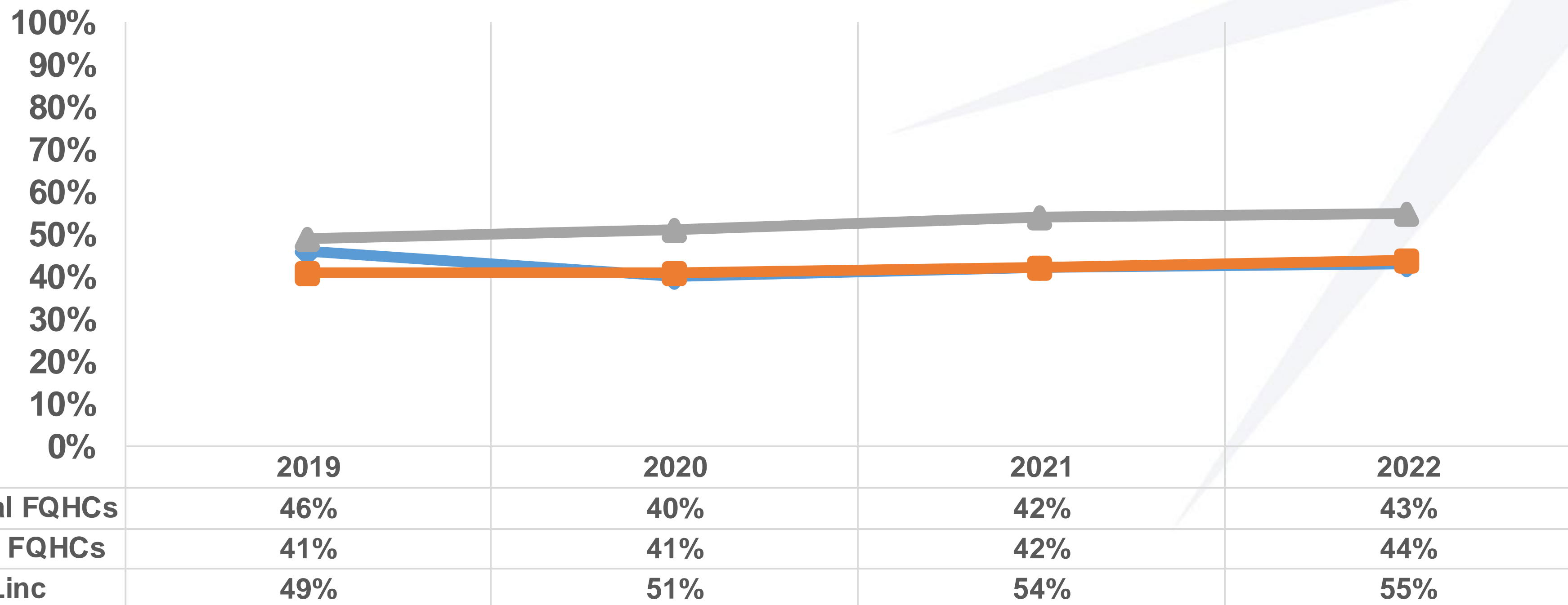
ACCSIS-Chicago Project Component, cont'd

Patient Navigation (PN)

The Patient Navigator's role is to
help increase CRC screening and abnormal FIT follow-up

- Started on June 15, 2022

UDS – Screening Rates



	2019	2020	2021	2022
National FQHCs	46%	40%	42%	43%
Indiana FQHCs	41%	41%	42%	44%
HealthLinc	49%	51%	54%	55%

Thank You!

Questions?

Thank You

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American Cancer Society | National Colorectal Cancer Roundtable

Confessions of a Patient Navigator

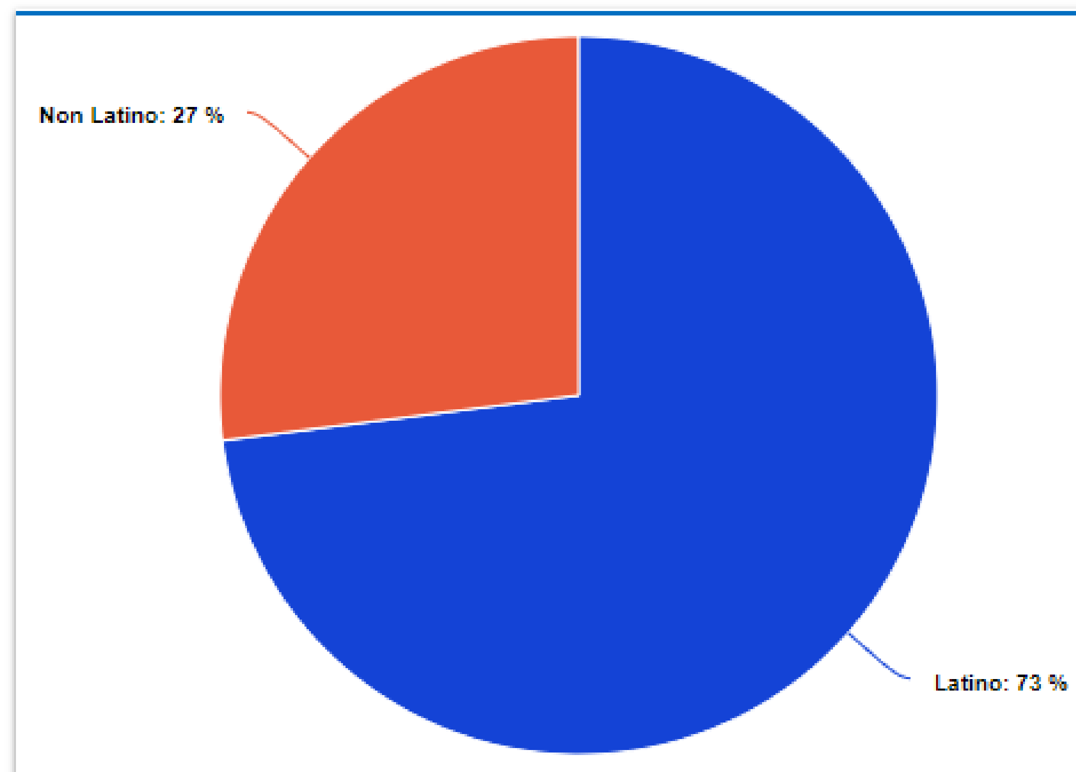
Heissel Herrera
Cancer Prevention Patient Navigator
CommUnityCare and the University of Texas at Austin Dell Medical School
2023 80% in Every Community National Achievement Grand Prize Recipient

Confessions of a Patient Navigator

Heissel Herrera, LMSW
Cancer Prevention Patient Navigator

Our FQHC

Largest safety net provider of primary care in Travis county, Austin.



Navigation Workflow

Receive +FIT

- Call to notify patient of result and assist scheduling GI Consult
  - **If unable to make contact, send a certified letter
- Send result letter: includes colonoscopy education material and appt details

GI Appt Scheduled

- Send reminder text or call for appt
- Send CPRIT coverage registration form to clinic prior to patient appt. It will notify the hospital to flag patient for program funding
- Colonoscopy is usually scheduled during consult, bowel prep instructions reviewed

Colonoscopy procedure

- Call patient a week before, check if patient has:
  - Bowel prep
  - Instruction sheet
  - Need a ride
- Review any questions or concerns

Colonoscopy completed

- Look for hospital record to upload in chart
- Call to follow up with patients who were diagnosed with cancer to provide any additional support

Colonoscopy After Positive FIT

Outcomes of Positive FITs (as of 10/27/2023)	
Colonoscopy Completed	598
Evaluation Scheduled	8
Colonoscopy Scheduled	7
Referred to PCP/Other Provider	18
Pending/Rescheduling	9
Refused/Difficulty Contacting	130
Deceased	9
TOTAL	779

Total "On Track" 613 (79%)

Case Studies

Patient A | Can I Just Repeat the FIT?

- Patient denial and lack of education
- Collaboration is Key
- 28 polyps removed!

Patient B | I am Embarrassed.

- Patient hesitancy and lack of follow up
- Don’t underestimate follow up calls
- Removed 3 precancerous polyps

Patient C | I Need Cardio Clearance

- Complicated health care system and fragmented care
- Collaboration, learned to be a detective
- Cleared to proceed and scheduled

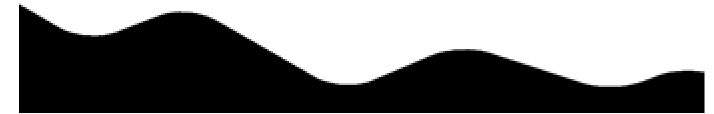
Patient D | They found cancer…

- Fear from their diagnosis
- To comfort without promising anything
- The cancer was caught early

Lessons Learned

- Collaboration is crucial
- Learn to be a detective
- Motivational interviewing is key
- Accessibility
- Patients' health is ultimately their sole responsibility

"Continuous learning is the minimum requirement for success in any field."
—Brian Tracy



Thank you!

Heissel Herrera, LMSW
Heissel.Herrera@communitycaretx.org

Thank You

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