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

Concurrent Session C

3:30 PM to 4:45 PM
Colorectal Cancer Screening Navigation in Action: Local Successes and Lessons Learned

Moderator
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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

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast (female)</td>
<td>130.4</td>
</tr>
<tr>
<td>Prostate</td>
<td>93.2</td>
</tr>
<tr>
<td>Lung and bronchus</td>
<td>39.5</td>
</tr>
<tr>
<td>Colorectum</td>
<td>30.5</td>
</tr>
<tr>
<td>Uterine corpus</td>
<td>22.9</td>
</tr>
<tr>
<td>Melanoma of the skin</td>
<td>22.1</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung and bronchus</td>
<td>24.2</td>
</tr>
<tr>
<td>Prostate</td>
<td>21.9</td>
</tr>
<tr>
<td>Breast (female)</td>
<td>18.7</td>
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<tr>
<td>Colorectum</td>
<td>11.3</td>
</tr>
<tr>
<td>Pancreas</td>
<td>9.6</td>
</tr>
<tr>
<td>Liver and intrahepatic bile duct</td>
<td>5.7</td>
</tr>
</tbody>
</table>

Source: ACS Cancer Statistics Center
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)**
### 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**

### Identifying Roles and Responsibilities for Cancer Screening Navigation in Your Clinic

<table>
<thead>
<tr>
<th>Navigation Service</th>
<th>Clinic Staff Member</th>
<th>Partner Organization</th>
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</thead>
<tbody>
<tr>
<td>Program LIAISON - individual who understands clinic, provider, and specialty care systems involved in providing cancer screening and patient navigation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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
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

**GENDER**
- Male: 54%
- Female: 46%

**AGE AT SCREENING**
- ≤49: 18%
- 50-65: 64%
- 66+: 18%

**RACE/ETHNICITY**
- White: 47%
- Hispanic: 7%
- Asian: 2%
- Other: 41%

**PAYER SOURCE**
- Medicaid: 43%
- Medicaid: 13%
- Medicare: 20%
- Private Insurance: 23%
- Uninsured: 4%

**SCREEN REASON**
- Surveillance: 23%
- Screening: 47%
- Diagnostic: 30%

**PREP QUALITY**
- Adequate: 93%
- Not Adequate: 5%
- Unknown: 2%

**CECUM REACHED**
- Yes: 97%
- No: 1%
- Unknown: 2%

**SCREEN OUTCOME**
- No Polyps: 43%
- Precancerous Polyps: 5%
- Adv/High Risk Polyps: 5%
- Cancer: 1%
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)

“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
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
• 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!

- 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
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.
# Program Services
## Focused on Priority FQHC Populations

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<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Connected NC PICCS with Kintegra’s primary care clinics to implement EBIs recommended in the Community Guide.</td>
</tr>
<tr>
<td>2</td>
<td>Worked with ACS partners to support participating clinics - QI Boot Camp and monthly Learning Collaborative calls.</td>
</tr>
<tr>
<td>3</td>
<td>Planned and monitored quality improvement activities monthly through PDSA cycles and then tracking screening data.</td>
</tr>
<tr>
<td>4</td>
<td>Kintegra collected and submitted clinic-level data for baseline, monthly, and annual surveys.</td>
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NC PICCS Program
Participating Clinics

Cohort 1
Kintegra Family Medicine: Hickory & Lincolnton Clinics

Cohort 2
Kintegra Family Medicine: Hudson & Highland Clinics

Cohort 3
Kintegra Family Medicine: Statesville & Lexington Clinics

Cohort 4
Kintegra Family Medicine: X-ray Drive & Third Ave. Clinics

2 More in 2024!
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
Personalized Outreach

Kintegra Health

Colorectal Cancer Education

Kintegra Clinical Staff
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
828-596-4544
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 mortífero 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
828-596-4544
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%

Lincolnton Colorectal Cancer Screening (CRC) Rates, Baseline through Learning Collaborative and NC PICCS program

Tracking Log

Provider Competition

Baseline April May June July August September October November December 2021 UDS
Hickory improved their CRC screening rate by 25.72%
Kintegra CRC Screening Rates (Baseline - Annual)

Colorectal Cancer Screening Rates

- Hudson: 38.08% Baseline, 45.24% Annual
- Highland: 46.06% Baseline, 57.52% Annual
FIT Kit Return Rate Increases

FIT Kit Return Rates - Hickory and Lincolnton - NC PICCS - 2021 YTD

- Kintegra Family Health - Lincolnton:
  - March: 50.0%
  - December: 25.8%

- Kintegra Family Health - Hickory:
  - March: 78.6%
  - December: 68.8%
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

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

nccrt.org  @NCCRtnews  #80inEveryCommunity
American Cancer Society: Colorectal Cancer Screening

Beth Wrobel
CEO
• 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
Baseline Data

Goal: 65%
Goal: 65%
<table>
<thead>
<tr>
<th>Participant</th>
<th>Roles and Responsibilities</th>
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</thead>
<tbody>
<tr>
<td>Health System Leadership (Site Leadership)</td>
<td>Involved in cancer prioritization but generally not involved in day-to-day implementation efforts</td>
</tr>
</tbody>
</table>
| 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
12 Clinics, 5 Counties
Corporate Headquarters: Valparaiso, IN

Project Aim: To increase screening rates for colorectal cancer.

Project Activities:
- Mail-FIT campaign
- Patient Navigation
- Calling gaps/deficiencies

- Text Reminders
- Colonoscopy MOUs
- 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)
<table>
<thead>
<tr>
<th>PERIOD</th>
<th>RESULT</th>
<th>NUM</th>
<th>DENOM</th>
<th>EXCL</th>
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<td>667</td>
<td>1223</td>
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<td>664</td>
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<td>51.0%</td>
<td>626</td>
<td>1222</td>
<td>20</td>
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<td>625</td>
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<td>TY 8/21</td>
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### HealthLinc

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<td>9112</td>
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<td>TY 02/22</td>
<td>54.0%</td>
<td>4933</td>
<td>9131</td>
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<td>TY 03/22</td>
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<td>4981</td>
<td>9152</td>
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<td>TY 04/22</td>
<td>55.5%</td>
<td>5081</td>
<td>9161</td>
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<tr>
<td>TY 05/22</td>
<td>56.0%</td>
<td>5176</td>
<td>9241</td>
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<tr>
<td>TY 06/22</td>
<td>55.9%</td>
<td>5131</td>
<td>9179</td>
<td>111</td>
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<tr>
<td>TY 07/22</td>
<td>55.4%</td>
<td>5098</td>
<td>9195</td>
<td>110</td>
</tr>
<tr>
<td>TY 08/22</td>
<td>55.6%</td>
<td>5167</td>
<td>9296</td>
<td>109</td>
</tr>
<tr>
<td>TY 09/22</td>
<td>55.3%</td>
<td>5145</td>
<td>9296</td>
<td>113</td>
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<tr>
<td>TY 10/22</td>
<td>54.9%</td>
<td>5180</td>
<td>9432</td>
<td>115</td>
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<tr>
<td>TY 11/22</td>
<td>54.7%</td>
<td>5167</td>
<td>9447</td>
<td>114</td>
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<tr>
<td>TY 12/22</td>
<td>54.6%</td>
<td>5176</td>
<td>9480</td>
<td>118</td>
</tr>
</tbody>
</table>

![HealthLinc Graph](image-url)

**HealthLinc Goal**

- TY 01/22: 54.0%
- TY 02/22: 54.4%
- TY 03/22: 55.5%
- TY 04/22: 56.0%
- TY 05/22: 55.4%
- TY 06/22: 55.6%
- TY 07/22: 54.9%
- TY 08/22: 54.7%

**HealthLinc**

- TY 01/22: 53.2%
- TY 02/22: 54.0%
- TY 03/22: 54.4%
- TY 04/22: 54.4%
- TY 05/22: 54.4%
- TY 06/22: 54.6%
- TY 07/22: 54.6%
- TY 08/22: 53.2%
- TY 09/22: 55.5%
- TY 10/22: 54.7%
- TY 11/22: 54.6%
- TY 12/22: 54.6%
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
Michigan City has surpassed the overall Corporate measure since starting this grant.

<table>
<thead>
<tr>
<th>Site</th>
<th>Measure</th>
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</thead>
<tbody>
<tr>
<td>Michigan City</td>
<td>58.8%</td>
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<tr>
<td>Corporate</td>
<td>54.6%</td>
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</table>
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 prep
- Started on June 15, 2021
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

Level 1 Navigation
Short Message Service
• Newly receive screening order
• Reminder message every 7 days
• Links to written education materials and videos

Level 2 Navigation
PN Service
• Haven’t completed routine or follow-up screening 30 days after receiving an order
• Focused education
• Barriers and social needs assessment
• Barrier reduction and resolution

Outreach
Education
Barrier Reduction
Reminder
Care Coordination
Program Reporting

• Started on June 15, 2022
UDS – Screening Rates

UDS: CRC SCREENING RATES 2019 - 2022

<table>
<thead>
<tr>
<th></th>
<th>National FQHCs</th>
<th>Indiana FQHCs</th>
<th>HealthLinc</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>46%</td>
<td>41%</td>
<td>49%</td>
</tr>
<tr>
<td>2020</td>
<td>40%</td>
<td>41%</td>
<td>51%</td>
</tr>
<tr>
<td>2021</td>
<td>42%</td>
<td>42%</td>
<td>54%</td>
</tr>
<tr>
<td>2022</td>
<td>43%</td>
<td>44%</td>
<td>55%</td>
</tr>
</tbody>
</table>
Thank You!

Questions?
Thank You
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

<table>
<thead>
<tr>
<th>Outcomes of Positive FITs (as of 10/27/2023)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy Completed</td>
<td>598</td>
</tr>
<tr>
<td>Evaluation Scheduled</td>
<td>8</td>
</tr>
<tr>
<td>Colonoscopy Scheduled</td>
<td>7</td>
</tr>
<tr>
<td>Referred to PCP/Other Provider</td>
<td>18</td>
</tr>
<tr>
<td>Pending/Rescheduling</td>
<td>9</td>
</tr>
<tr>
<td>Refused/Difficulty Contacting</td>
<td>130</td>
</tr>
<tr>
<td>Deceased</td>
<td>9</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>779</strong></td>
</tr>
</tbody>
</table>

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

nccrt.org   @NCCRTnews   #80inEveryCommunity