Guide to High Performing Models

National Colorectal Cancer Roundtable

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I. High Performing Model Programs

The following programs have been identified as High Performing Models by the National Colorectal Cancer Roundtable (NCCRT), based on their demonstrated success in delivering colorectal cancer (CRC) screening and follow up care to uninsured, underinsured and low-income adults in their respective communities.

	Location	Program Summary	Participating Hospitals and Clinicians	Number of CRC Patients Served Annually
Cancer Coalition of South Georgia	South Georgia (32 county service area)	Provides free screening for CRC and other types of cancer for the uninsured	3 hospitals, 3 outpatient and hospital-based endoscopy centers, 9 gastro-enterologists	More than 500 free colonoscopies annually
New Hampshire Colorectal Cancer Screening Program	New Hampshire (statewide)	Provides free screening colonoscopies to low-income uninsured and underinsured through a CDC grant	14 community health centers; 12 endoscopy centers; 10 hospitals	350–400 free colonoscopies annually
Operation Access	San Francisco/ Bay Area (six county service area)	Provides free access to diagnostic colonoscopies and other surgical care for low-income uninsured people, particularly undocumented immigrants	10 hospitals; 4 endoscopy centers; 50 gastroenterologists	More than 200 free GI procedures annually
Volunteers in Medicine (in collaboration with Project Access)	Hamilton County, TN	VIM is a medical home clinic for low-income residents of Hamilton County. Project Access provides access to advanced hospital procedures.	5 hospitals; 700+ volunteer physicians	Not available

Some of the programs profiled in this guide have a broad health care focus, delivering care that extends well beyond CRC, while others have a more narrow focus, delivering only cancer screening in general or CRC screening in particular. When possible, discussion of their activities throughout this guide will attempt to focus on efforts and resources specific to CRC screening. However, readers should note that the scope and scale of these model programs vary considerably.

This guide is organized around the following tasks and potential barriers that new community coalitions may face in developing a program to improve access to colorectal cancer screening:

- Start Up
- Recruiting Health Partners and Providers
- Management, Roles and Responsibilities
- Coordination of Patient Care
- Resources and Funding

In each section, readers will find a discussion of how model programs have addressed barriers and achieved success, as well as specific examples of model programs "in action."

It is important to note that these programs each had different objectives and different resources at their disposal. As such, some of this material may not be as relevant to all readers. At the same time, lessons and learning from previous efforts can be applied or adapted to other situations. In addition, the programs highlighted in this document were "trailblazers" in this area, so new programs may be able to expedite their program by learning from their experiences.

An Appendix appears at the end of the guide, which provides examples of forms, logic models, flow charts, and other materials that further illustrate how the model programs have executed the principles described in this guide.

II. Common Features of High Performing Models

The models discussed in this Guide have many of the following features in common, which program administrators say contribute significantly to their success.

1. **Strong Physician Leadership.** Physician champions are essential for recruiting other providers. Physician leaders are the best resource for communicating with potential volunteers and hospitals to make the case for how long-term costs and medical problems can be avoided by an effective screening program. Further, these physician leaders are often from a neutral entity or organization (not the CHC), which may help with peer to peer recruitment and negotiation.

2. **Focus on Care Coordination.** Patient navigators help ensure that patients are well prepared for their screening. This not only helps make the best use of funds and donated services, but good show rates and good prep elevates the reputation of the program, making continued recruitment and provider participation easier to secure.

3. **Effective Use of Data.** From data to describe and quantify the need in the community to documentation of outputs and outcomes, model programs use data effectively to document their success and engage potential partners, volunteers, and funders.

4. **Clarity of Expectations and Fair Division of Labor.** Navigators and volunteer providers asked to accept low or no cost patients often form the core of these model programs. Other providers are being reimbursed, but are not used to accepting underserved patients from community health centers. For all these audiences, it is critical to be very clear about what they are being asked to do. For navigators, detailed care coordination manuals that prescribe contact points help ensure that patients are well prepared for their procedures. For providers, it may mean asking for a weekly or monthly commitment or defining a finite number of cases they will see. Demonstrating that volume is finite *and* shared amongst several partners is extremely important.

5. **Standardization for Efficiency.** Model programs run efficiently, making maximum use of volunteers' time and limited funds. One key way of achieving this is by standardizing things like referral forms, patient information forms, and communications.

III. Start Up

"If you want to run fast, run alone. If you want to run far, run together."
–African Proverb

Starting from an Informal Network

Model programs often begin with one or more physician champions that take the initiative to solve a problem they have personally observed in their community. What takes them to the next level of success, though, is their ability to develop and sustain a collaboration of providers across the continuum of care. Model programs tell us that for them, this initiative began with an informal network of providers who were already comfortable working together. These providers may have already been volunteering their time, or wanted to, but needed a structure and organizing body to systematize their individual efforts. Typically, they were not directly affiliated with the community health centers they were trying to help, but rather with a "neutral" organizing body, such as cancer coalition, Centers for Disese Control grantee or non-profit.

In some cases, the initial network included more than just health care providers, but also community leaders, the faith community, and other local "visionaries" who had the personal drive and connections to make the program a reality.

In many cases, programs were able to secure volunteer support from a network of providers who were already familiar with each other and working together on referrals for insured patients. Then, once an endoscopist made a commitment to provide free colonoscopy services, he or she could approach referral partners and ask pathologists, surgeons, or other specialists along the continuum to lend their support too. Asking peers to donate a limited number of services to match those provided by the endoscopist proved to be a successful strategy. Successful application for grant support is another successful strategy.

In Action: Start Up

Cancer Coalition of South Georgia

- Began as a collaborative effort by area cancer centers, businesses, religious organizations, academic and community groups.

Volunteers in Medicine

- Began as a faith-based initiative through a local Baptist Church. Start up was supported by other local churches, foundations and individuals.
- Work groups and the executive management committee met weekly for two years before the clinic opened their doors. Their efforts secured in-kind services and equipment from x-ray equipment to exam tables and even an endoscope.
- Individual task forces focused on different aspects of the start up process, including budget, treatment algorithms, fundraising, physical plant, and clinical care.

NHCRCSP

- Initiated under a CDC grant, but was built on a foundation of experience and partnerships with the Department of Health and the pre-existing Comprehensive Cancer Coalition.

Physician Champions

Some of the model programs profiled in this guide began by getting one or more gastroenterologists committed to the program in its earliest stages. He or she then acted as a physician champion for the program, serving as a recruiter, spokesperson administrator, and fundraiser. All model programs emphasize the importance of this type of physician leadership at all stages of development.

Characteristics of effective physician champions for this type of program include: strong connections with other physicians and hospitals, having other community ties (not necessarily clinical, but in the faith or business communities), being articulate and passionate about the benefits of a CRC screening program for the uninsured, and having the ability to devote time to promoting the cause on a regular basis over an extended period of time as the program establishes itself.

In Action: Physician Champions

Operation Access

- Operation Access was founded in 1993 by two surgeons and a hospital administrator. They sought to develop a solution to the surgical needs of the uninsured population in the Bay Area and provide opportunities for physicians who wanted to volunteer in their own community. Operation Access has expanded to include gastroenterology and other diagnostic services in addition to surgery, and partners with a network of 1400 volunteers, 41 hospitals and ambulatory care centers, and 80 clinics.

"This has got to be driven by physician leaders in the community. The sell is easy if it comes from them."

–Volunteers in Medicine

The importance of an enthusiastic physician champion who is willing and able to "sell" the program cannot be overstated. New programs should recognize that it is often not easy for physicians to "cold call" their peers and ask for their volunteer support. As a result, a physician champion with the right personality is a critical resource for coalition building. At the same time, developing a selling story for all members of the executive leadership team and volunteer providers will help everyone make the case, open doors, and garner support.

Model programs also note that the environment for "charity care" is in a state of change with the implementation of the Affordable Care Act and the expansion of Medicaid in many states. These

"We had to negotiate with the pathologists, basically saying, the GI guys are doing it. If they donate their services, will you be willing to donate your services? If you've got an endoscopist who's being very generous in setting the standard, then it's a lot easier to move the stuff behind him."

–Cancer Coalition of South Georgia

changes are impacting the extent to which individuals and organizations are willing to support indigent care programs. Model programs say that physician champions are in the best position to know the limitations of the ACA and fluently address arguments that the law has already addressed the needs of the uninsured.

In Action: Flexible Commitments

Operation Access

- Operation Access allows participants to choose from two different volunteer models. A Saturday model allows an entire surgical team (surgeon/specialist, anesthesia, nurses, tech) to volunteer on one day, seeing multiple patients in a row. A weekday/integrated model allows specialists to see a single patient at a time during their normally scheduled OR times.

Commitments and Expectations

Model programs tell us that getting an early commitment from a member of the local GI community (for example, a single gastroenterologist or a larger GI group) helped them set the stage for recruiting other key participants along the continuum of care. In other words, if they have a GI group on board, it is easier to approach other specialists such as pathologists or surgeons to also contribute their services.

Although informal relationships are often where physician commitments are begun, some model programs do recommend documenting provider agreements in a simple written agreement so that expectations are clear from the beginning and no misunderstandings arise. (See Appendix for one example of a provider participation plan.)

Planning and Structure

As the program gets started, some model programs emphasize the importance of managing the planning process so that a schedule is adhered to and the program can demonstrate constant forward progress toward clearly defined goals. This type of process ensures that everyone in the coalition feels that their contribution is leading to something meaningful. Given that some model programs report a long start up period—up to two years—before they saw their first patient, preliminary goals are important to maintaining partners' enthusiasm and commitment. During this planning and start-up period, the models programs report significant activity establishing their management structure, developing processes and work groups, fundraising and recruiting partners.

"Try to produce tangible results fast…if it's not leading to something that is worth the time that people are devoting to show up to the meetings and to participate in the process, people stop showing up."

–Operation Access

During the planning process, it is important to do the necessary homework to document and demonstrate the needs of the community, including baseline screening rates, the number of uninsured, and demographic characteristics of the target audience. This not only helps secure partners, but establishes a baseline against which future outcomes can be compared to demonstrate the program's success.

Products emerging from the start up and planning process may include the following, depending on the scope and scale of the envisioned program:

- Staffing and recruitment plans
- Budget and list of possible funding sources
- Definitions of roles and responsibilities for key staff
- Board of directors by-laws
- Flow charts to define the care delivery process
- Logic models

In Action: Documenting the Need

Volunteers in Medicine

- In order to document the needs in their community, program managers looked at community data from a range of resources including the Better Business Bureau, the Chamber of Commerce, and the Kaiser Family Foundation. This information helped them describe their audience to funders and volunteers and identify key service gaps. Data from local hospitals on the number of uninsured patients seeking care in their emergency rooms for primary care issues and referral and screening practices at free clinics rounded out the picture.

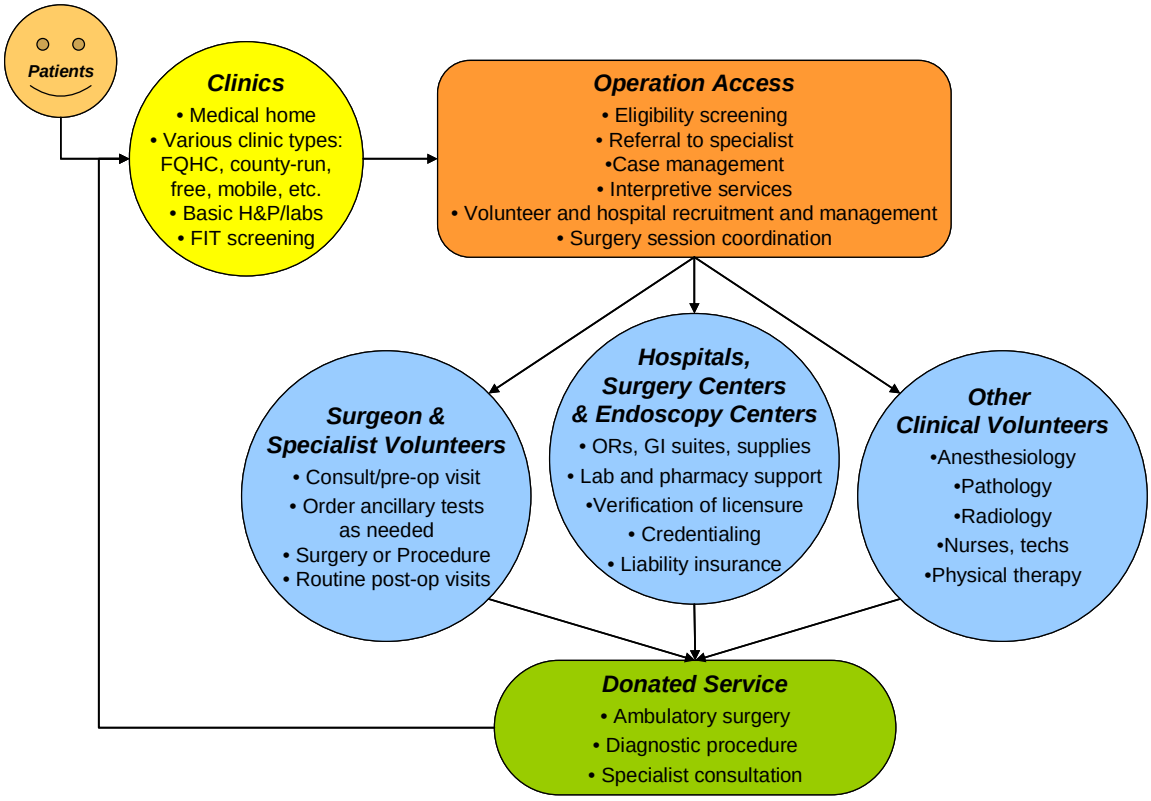


Figure 1: Operation Access "How We Work" Model

IV. Recruiting Health Partners and Providers

Strategies for Recruitment

All model programs indicate that peer to peer recruiting is the most successful method of recruiting new partners—including individual providers, hospitals and health systems. This approach is important because according to one program manager, it is nearly impossible for anyone other than a physician to even get a meeting with a specialist to discuss involvement in a new program. Additionally, programs say that successful peer recruiting builds on itself; word will spread if one specialist gets involved and likes what he or she sees.

> *"The approach that is utilized is peer-to-peer when possible, to try to engage gastroenterologists or other physicians to approach their peers."*
>
> *–Operation Access*

Making the Business Case to Hospitals

Model programs each describe a consistent approach to securing participation from hospital or health system participation in their programs. They say that a physician champion needs to meet with a senior decision-maker at the hospital and make the case that it is in the hospital's best interest to manage and prevent CRC cases before they show up in their emergency rooms.

An important element of any hospital recruitment strategy is to have the right people talking to the right people. Approaching the CEO or CFO of a health system is said to be less fruitful if these top level executives do not have a clinical background. Instead, starting with a

In Action: Partner Recruiting

Operation Access

- Peer to peer recruiting is a successful recruitment strategy, but it works best when based on success. People will want to talk about and recruit their peers to a program if it is well managed and has strong potential for success.

Project Access

- Individual primary care physicians are asked to provide services to at least 10 Project Access patients per year.
- Specialists are asked to provide services to 5 Project Access patients per year.

Cancer Coalition of South Georgia

- Their hospital recruitment strategy includes positioning community benefit as a sound business strategy, and as much an indicator of success as admissions, financial statements, quality care indicators, or revenue.

medical director who understands the clinical case for screening and can present and translate it as a business issue for the hospital is said to be more successful. Model programs say it is often more difficult to get a commitment from hospital staff who make decisions about indigent care programs and how those resources are spent, given that the financial case is not as clear cut to them.

"A doctor can often be the person that gets the CEO to buy in…[by saying] we're a community based hospital; these are people we're going to have to serve anyway, and that it's the right thing to do. But also, that it's a good investment. So it has to be a doctor who knows how to speak both languages, the human side and the financial side."
–Cancer Coalition of South Georgia

In Action: Addressing Liability Barriers

Volunteers in Medicine & Project Access

- In Tennessee, VIM found that some retired physicians wanted to volunteer for the program and give back to their community. However, a key barrier to their participation was the fact that they could not practice without a medical license and liability coverage. To address this, VIM and Project Access worked through the state legislature to facilitate the creation of a volunteer medical license for physicians whose sole practice is rendering professional services without compensation in a free health clinic. They also helped establish an option for liability coverage for retired physicians. At only $100/year, volunteers are willing to pay for their own coverage.

Model programs recommend doing the homework necessary to develop a clear and customized "selling strategy" before approaching a hospital or health system. Examples include researching the backgrounds of the hospital's executive leadership and board members to so that someone can be identified who is likely to be an internal champion for the underserved in their community. They suggest preparing clear data for the needs of the targeted community, so that program managers can make a clear and structured "ask" rather than requesting an open-ended commitment. The argument for prevention versus treatment should be clearly developed and backed up with data.

Another important strategy for securing non-profit hospital participation is to appeal to their community benefit requirements. When approaching potential hospital partners, model programs have outlined exactly how participation can help satisfy these requirements.

"We found a strong champion for this was our oncologists…you get an advanced, a stage four cancer that starts bleeding, having pain, they're going to show up in your emergency room. You're going to get them anyway. So they found this a way of kind of down staging their disease."
–Cancer Coalition of South Georgia

Additionally, hospitals that are Commission on Cancer Hospital Certified must have a health disparity plan, which a CRC screening program can help deliver.

Addressing Provider Concerns about Patient Volume

Model programs vary in the extent to which they request that volunteering physicians commit to a particular number of patients. Some ask for whatever a provider can accommodate, while others ask for a minimum commitment (such as one per month).

An important barrier to recruiting volunteer providers is the misconception that if they agree to participate, they will be overwhelmed with cases. One strategy for addressing this concern is to recruit a broad coalition of providers and clearly communicate how cases will be equitably distributed. Having a larger number of stakeholders means no one provider or hospital has to bear an unnecessary burden.

Another important strategy to address concerns about patient volume is to "do the math" for the targeted community to demonstrate that the level of commitment needed is not as large as they may think. This can be done using publicly available census and insurance data, emergency room data provided by local hospitals, and the known prevalence of colorectal cancer.

Based on the population of uninsured adults between 50 and 64, model programs are able to tell providers approximately how many uninsured patients there are, how many are likely to need CRC screening, and how many colorectal cancer cases are likely in a given year. Depending on the number of endoscopists available, the program can then calculate the number of cases each volunteer would need to accept, or adjust the screening strategy if too few providers are available by using fecal immunochemical testing (FIT) as the primary screening strategy and using colonoscopy for follow up of positive results. These types of calculations are also valuable for demonstrating to hospitals that the level of commitment required to provide follow up care

In Action: Calculating Patient Volume

Cancer Coalition of South Georgia

- Negotiation with potential partners focuses on a limited, finite 'ask' that is based on calculations of the maximum number of uninsured patients that may be seen through the program for a given population.
- The coalition asks endoscopists what they are willing to contribute, ranging from one case a week to one a month. Program managers have determined that once case per month is the minimum number that an provider should commit to in order to remain active in the program.

Operation Access

- Volunteers at Operation Access average six cases per year, but do not have to commit to a minimum number of patients. Volunteers themselves determine how many patients they want to see, how often, and on what schedule. They also have the freedom to turn down any case.

"I don't think physicians are afraid to donate their time, but I think they want to have control over that, and I think many are fearful that floodgates will open."

–Volunteers in Medicine

for cancers detected is extremely small, especially if colonoscopy is the primary screening method being used.

It is important to communicate to providers that their level of commitment is under their control and that the program will carefully manage referrals to assure that no one is asked to do more than they can handle. For larger programs in urban areas and those with many volunteers, it may be important to present volunteers with a written plan for equitable case distribution.

"If they see that your program is successful and they realize it's no big deal to throw in one patient a week, for example…then that adds up to a very substantial commitment…we have to demonstrate that it's not going to be a big deal for them, not going to affect their business adversely."

–Operation Access

TOP 10 REASONS PHYSICIANS PARTICIPATE IN PROJECT ACCESS
1. Project Access allows you and your group to efficiently manage and track the charity care that you have always provided.
2. Project Access allows you to define the amount of charity care that you are able and willing to provide.
3. Project Access creates a whole network of providers and healthcare services that are automatically available to you and your Project Access charity patients.
4. Project Access screens potential charity care patients before they are referred to you, verifying that they meet financial, residential, and healthcare need criteria.
5. Project Access charity care patients are eligible for services for a specific period of time and only as long as the criteria are met.
6. Project Access tracks the dollar value of the charity care that you provide so that your efforts can be appropriately recognized by our community and used as a powerful tool to advance issues of importance to providers.
7. Project Access allows for an equitable distribution of services by physicians, hospitals, and other providers when attending to the needs of the underserved in our community.
8. Project Access prevents any single physician, physician group, hospital or other provider from being asked to provide more than a fair share of charity care.
9. Project Access creates an infrastructure which allows for our entire community, business, city and county governments, media, educational institutions, each to support the provision of charity healthcare services.
10. It's the right thing to do!

OPERATION ACCESS VOLUNTEER RECRUITMENT STRATEGIES

- Compose a letter signed by a distinguished colleague to send out to other providers in the community. Peer to peer recruitment can be more effective than hearing from a unknown person or organization.
- Publicize volunteer opportunities on program website, in newsletters, in staff lounges, hospital publications, and online (e.g. Craig's List, Idealist)
- Cultivate relationships with key people who can help spread the word about volunteer opportunities (e.g. hospital PR and community benefit staff, gatekeepers/office staff, support staff for current volunteers)
- Approach providers who are involved in other volunteer projects (e.g. international medical missions, free clinics)
- Attend employee/volunteer fairs at hospitals
- Make presentations at staff meetings
- Send unsolicited patient referrals ("this patient needs your help")
- Cold call prospects and drop off information packets

Volunteer Engagement and Recognition

Having a volunteer recognition plan is an important way of thanking providers who donate their time and facilities and encouraging ongoing participation. While some model programs have more elaborate volunteer recognition efforts than others, the effort to engage and recognize participants on a regular basis is what is most important.

Model programs use both formal and informal means of recognizing volunteers, ranging from informal lunches or dessert parties to gifts and awards. Other means of recognizing volunteers can be low-cost or no cost, such as publishing stories about volunteer providers in a program newsletter or website (see Appendix), or pitching stories that feature a particular volunteer to local news outlets.

In Action: Volunteer Recognition

Volunteers in Medicine & Project Access

- Project Access hosts an annual picnic to thank volunteers and the local baseball team donates an evening at the park. The organization takes out a full page ad in the newspaper and buys billboards to tell the community about the work of their volunteers.
- VIM also hosts an annual luncheon for lay volunteers, an annual dinner for provider volunteers, and a fund-raising banquet that highlights selected patient success stories.

Cancer Coalition of South Georgia

- The Coalition hosts two appreciation days a year for volunteer doctors and their staff, where a luncheon or desserts are provided.

THE OPERATION ACCESS MODEL APPROACH TO VOLUNTEER RECOGNITION

- **Volunteer awards** given out annually. Winners receive a letter thanking them for their service, and a copy is sent to their supervisor, physician manager or hospital administration. Small gifts may be given at the volunteer celebration, and winners are featured in a year-end newsletter and on the website. **Posters, plaques or certificates** for hospitals when they reach a milestone (e.g. 5 years). **Recognition** (letter, plaque) for volunteers when they reach a milestone. Volunteers may also receive certificates from local elected officials or be nominated for community service awards.
- **Gifts** such as t-shirts and other program-branded materials.
- **Recognition** in newsletters, annual reports, videos, blogs, brochures, and hospital communications. Recognition immediately after surgery sessions.
- **PR** featuring stories and photos of volunteers.
- **Events** such as volunteer celebrations, happy hours, lunches or picnics.
- **Correspondence**, such as thank you cards after a procedure, patient comments, recommendation letters, birthday cards, or holiday letters.
- **Food** provided at surgery sessions
- **Personal thank you** from OA staff and/or patients

Volunteer Spotlight

Jung On Ahn, RN
(San Mateo)

2013 Spirit Award Recipient - Jung On Ahn, RN, Kaiser Permanente Medical Center, South San Francisco

Jung On has been volunteering with OA as an OR nurse from the inception of the program at Kaiser Permanente South San Francisco in 1998. Back in Korea, Jung On always volunteered through her church, but when she came to the United States, she had difficulty finding a way to give back until she found Operation Access a perfect fit. "It was effortless to get involved with OA… (it) was so convenient; it was right under my nose,"

Jung On's work with our patients is infused with her good will. "OA is part of my life. We get our life, health and blessings from the lord. There has got to be a way to give back and share. I have received a lot in my life and I am so grateful for the ability to volunteer."

V. Management, Roles and Responsibilities

Staffing

Each model program operates with a core of paid managers, administrators and clinical staff in addition to volunteer providers, board members, and other uncompensated partners. The number of paid staff needed to run a successful program ranges from just four FTEs to 13.5 FTEs.

Depending on the size of the population being served, key staff needed to manage these programs may include:

- Program director
- Medical director
- Patient navigators
- Data managers
- Clinical secretaries
- Development/fundraising staff
- Communications/marketing staff

Additionally, a board of directors that includes representation from all stakeholders—volunteer specialists, hospitals, primary care physicians, funders, and community organizations—is an important resource.

Responsibilities

A key responsibility of program leadership staff is to initiate and maintain strong relationships with providers. Because so much of recruitment and engagement comes down to personal relationships, these same relationships are needed to keep those commitments going over the long run.

Program managers and paid staff perform a broad range of activities to administer their programs, interact with partners, and document outcomes.

In Action: Management Resources

NHCRCSP

- Operates on five FTE staff, including a medical director, program director, grant administrators, data manager, clinical secretary and patient navigators.
- Meetings are held weekly to cover program management, quarterly for budget issues.
- A dynamic database tool was developed that combines elements of an EHR with billing and patient communication tools. The database tracks all patient demographics, records of calls received, enrollment information, procedure records, and bills received/paid on each patient's behalf.

Cancer Coalition of South Georgia

- Has one full-time manager navigator and 3.5 FTE navigators.
- Work groups are kept small and tightly focused so they are easier to schedule and sessions are more productive.

Volunteers in Medicine & Project Access

- VIM has five FTEs including a clinic director, front-desk staff, volunteer coordinator, nurse, dispensary tech and medical personnel trainer.
- Project Access operates on four FTEs, including a director, full-time care coordinators, an administrator, and a fundraiser.

While the following list is not intended to be exhaustive, it summarizes many of the core activities that paid program staff perform on a regular basis.

- Identify and screen patients
- Establish policies and procedures
- Raise funds and report back to funding agencies
- Publicize the program
- Recruit volunteers
- Develop agreements or contracts with primary care providers, hospitals, endoscopy sites, etc.
- Provide ongoing management of partnerships, including recognition of volunteers, and partner communication
- Manage referrals
- Coordinate care and address patient barriers
- Evaluate and document outputs and outcomes

Given that each model program operates with a minimal number of paid staff, they have been able to achieve greater efficiency in administration by standardizing many documents and protocols. Standardizing practices in the following areas not only helps program staff make the most of their time, but also helps volunteer providers spend less time on addressing or interpreting administrative needs and more on direct patient care:

- referral forms
- volunteer management plan
- case management guidelines
- prep instructions
- presentations about the program
- volunteer recruitment packets and applications
- volunteer communications (e.g. welcome letter, commitment form, thank you/follow-up letters)
- templates for hospital community benefit reports

In Action: Communication with Partners

Volunteers in Medicine & Project Access

- On a monthly basis, representatives from free clinics, FQHCs, VIM, Project Access, and local hospitals meet to discuss and coordinate their efforts. This level of coordination was a new and highly beneficial model for Chattanooga providers who were previously providing uncoordinated and unmeasured levels of free care to the uninsured.

Cancer Coalition of South Georgia

- Hospital partners receive written reports every three months describing the number of patients navigated and screened at their hospitals. Referring primary care providers get monthly reports describing numbers of referrals, screenings, abnormal results and cancers. The report can be used to examine referral patterns and ensure prompts are delivered to patients who are due for them.

NHCRCSP

- NHCRCSP created standardized forms for medical and patient history, referrals, and colonoscopy results. This ensures that providers' time is used efficiently and that everyone involved knows exactly what to expect when they are seeing a patient referred through the program.
- The NHCRCSP created a provider education piece that was featured in the *Healthy Insights* newsletter. The program summarizes important facts about screening recommendations and sets population goals for New Hampshire. (See http://cancer.dartmouth.edu/gi_pancreatic/documents/healthy_insights_mar2011.pdf)

Revisiting Organizational Goals

At the launch of a new program, it is assumed that a mission statement with clear goals and objectives will be established. However, model programs also revisit these goals on a regular basis and reflect on the continuing success of the program from a longer term perspective. In some cases, they have found it necessary or beneficial to adjust their goals based on new information, changes in the community, or funding needs.

In Action: Goals and Objectives

Operation Access

- Operation Access has adopted the CRC goal of 80% screening by 2018, reflecting the NCCRT's national movement to raise the bar for CRC screening. This type of goal is motivating and easy to remember for everyone involved.

Program managers are also encouraged to take time to think about their program wants to be known and viewed in the community. For example, one of the goals of Project Access is to operate seamlessly with local providers. As the proram has matured, they are viewed just like any other payor, and patients referred through the program do not receive differentiated treatment. If all program staff and volunteers are reminded of these types of organizational values, the program's "brand" can be more consistently reflected in every interaction with patients, providers, funders, and the broader community.

"We're known as being responsible, intelligent, professional, and physician or volunteer led."
–Operation Access

Communication Among Partners

Model programs report that it is important to have a broad coalition in order to maximize reach and engage a diverse group of providers. At the same time, large, diverse groups require more management and coordinated communications.

Once volunteers are committed, regular, structured communication helps ensure that everyone is aware of their responsibilities and has adequate notice of key dates. Commitments should be planned in advance and predictable if possible. For example, when Operation Access plans volunteer-staffed surgery sessions at hospitals, they try to do so a year in advance in order to ensure adequate time to recruit volunteer support staff.

"Programs that want to try to set up some sort of infrastructure to deliver this kind of program should understand that the people who are designing it and running it need to be in very close touch with each other on a regular basis. In order to pool the knowledge and the skills, you can't just meet three, four times a year."
–NHCRCSP

Some programs established focused work groups that met frequently (weekly) during their start up phase and less often (monthly) as the program became more established. Work groups may focus on a particular need, such as fundraising, clinical issues, or expanding

services to a new region. Other model programs have a small, core management group that meets weekly and addresses all aspects of program management.

Measuring and Demonstrating Results

Each model program regularly measures both outputs and outcomes in order to demonstrate their value to stakeholders and the broader community. Both types of data need to be collected because they carry meaning to different stakeholders. Data that may be regularly collected include outputs describing activities and volume, such as the amount of funds raised, number of active volunteers, volunteer service hours, value of volunteer services, number of referrals given, patients served or colonoscopies conducted.

Short-term and long-term outcomes focus more on clinical results and population impact, including cancer detection, risk reduction, decreased mortality, reduction in disparities, reduced costs for care, or improved quality of life. Data that documents the number of precancerous polyps removed is often particularly meaningful to physicians, hospitals and health systems who are donating their time and facilities, as it clearly demonstrates the impact of screening programs. Some model programs also conduct regular evaluations to measure satisfaction with the program.

"One of the key successes I think for both models is the leaders realized before either opened their doors that tracking the amount of care given, tracking everything, was going to be fundamental. And it has helped inform every grant application we've ever made since then."

–Volunteers in Medicine

In Action: Demonstrating Results

Operation Access

- Operation Access surveys patients to measure satisfaction, impact of donated procedures on their quality of life, health, and whether they made lifestyle changes as a result of the care they received. Patients are also given the opportunity to provide suggestions for improvement (see Appendix for survey instrument).
- Volunteers and clinics are also surveyed to measure intent to volunteer in the future, satisfaction with their experience, and willingness to recruit others to volunteer.
- Data is provided to participating hospitals that documents program activities and establishes annual goals.

Cancer Coalition of South Georgia

- Selected patients who have benefited from the program have volunteered to be spokespeople for the program. They have been highlighted in newsletters, given media interviews and come to board meetings to put a personal face on the good that the program does in the community. Focusing on individual benefits helps to combat prejudices about the uninsured.
- Recognizing that their audience was very time-pressed when it comes to reviewing reports, the Coalition changed from delivering a detailed, glossy annual report to an abbreviated version of less than 10 pages, and found that partners were more apt to read and actually absorb the information in it. (Link to annual reports: http://www.sgacancer.org/about_us/organization.html)

The results of surveys and data collection efforts are often described in newsletters or annual reports sent to donors, volunteers, and other partners. In some cases, programs collect and report extensive amounts of data in response to the interests of their supporters. Other programs focus on limited, high impact numbers.

In Action: Reporting Program Data

Volunteers in Medicine

- In reporting their impact on the community, VIM breaks down the cost per patient visit ($77.47), value delivered per patient visit ($404 at clinic rates or $1,618 at ER rates) and rate of return on contributions (for every $1 donated, the return was $5.22 at clinic rates or $20.88 at ER rates).

2013 Key data concerning the care area of the clinic:

Category	2012	2013
Patient visits	5,944	5,561
X-rays	333	264
Dental Services	$8,756	$4,950
Optometry Services	$17,100	$15,750
Medical Services provided, X-Ray	$530,893	$634,384
Laboratory Services	$222,469	$215,011
Clinic Dispensary	$65,538	$63,547
PAP meds (90day supply)	$1,577,356	$1,314,640
Total Medical Care Delivered (clinic rates)	**$2,422,112**	**$2,248,282**
Total Medical Care Delivered (ER rates)	**$9,688,448**	**$8,993,128**
Total Expenditures	$446,465	$430,793
Available Counseling Hours*	258.5	195.4
Mammograms Taken - Memorial's Breast Center*	232	199
Referrals - Project Access*	389	292
Total Volunteer Service Hours*	14,318	14,573
Est. Value of Donated Volunteer Hours*	$731,792	$803,981

* Value is not included in Medical Care Delivered

VIM Staff = 5 FTEs

Figure 2: Volunteers in Medicine 2012–2013 Clinic Impact

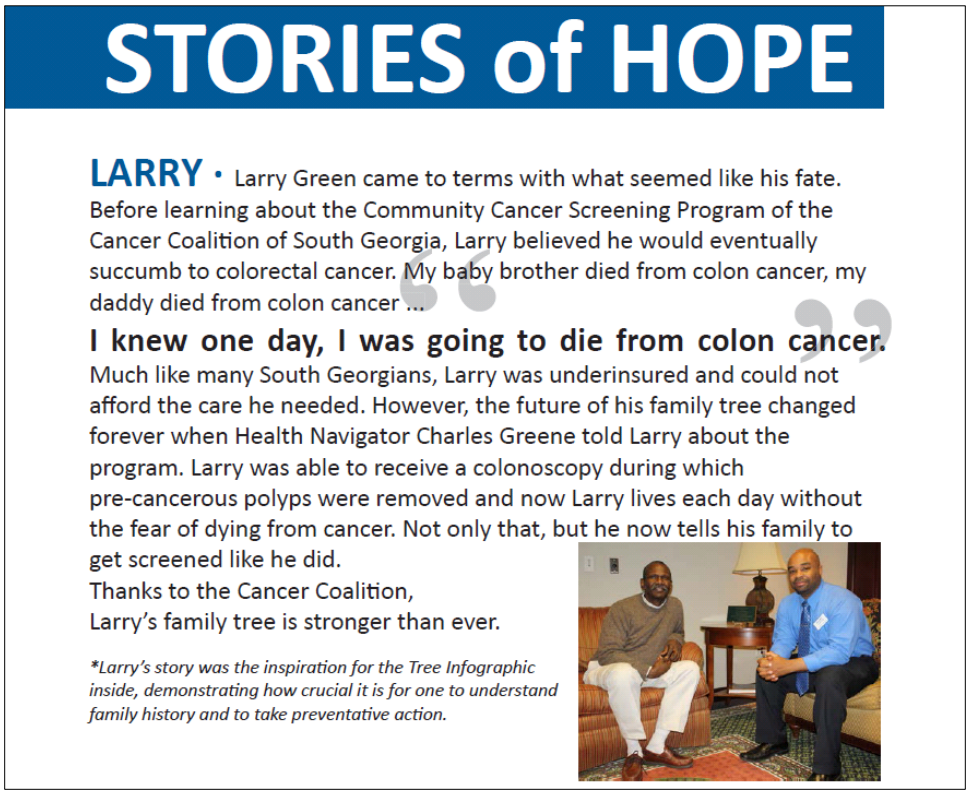
Highlighting outcomes for individual patients through case studies or testimonials is another way that model programs communicate about their results in a very accessible, personal way. Putting a "face" on the beneficiaries of free screening programs is particularly effective at combating stereotypes that some harbor about the types of people that lack insurance and need free care.

In Action: Highlighting Patient Outcomes

Volunteers in Medicine

- VIM created a seven minute You Tube video featuring testimonials from patients about the help that they have received from the program. The video also describes the financial impact of VIM. (see http://youtu.be/zAffMRBHWp8)

"Putting a personal story and a face to the people that we're serving [is important]…when they hear their actual stories, then they seem to care."
–Cancer Coalition of South Georgia



STORIES of HOPE

LARRY · Larry Green came to terms with what seemed like his fate. Before learning about the Community Cancer Screening Program of the Cancer Coalition of South Georgia, Larry believed he would eventually succumb to colorectal cancer. My baby brother died from colon cancer, my daddy died from colon cancer …

I knew one day, I was going to die from colon cancer.

Much like many South Georgians, Larry was underinsured and could not afford the care he needed. However, the future of his family tree changed forever when Health Navigator Charles Greene told Larry about the program. Larry was able to receive a colonoscopy during which pre-cancerous polyps were removed and now Larry lives each day without the fear of dying from cancer. Not only that, but he now tells his family to get screened like he did.

Thanks to the Cancer Coalition,
Larry's family tree is stronger than ever.

**Larry's story was the inspiration for the Tree Infographic inside, demonstrating how crucial it is for one to understand family history and to take preventative action.*

VI. Coordination of Patient Care

Some model programs attribute a large part of their success to their ability to make the CRC screening process as easy as possible for physicians and hospitals that are volunteering their time, or who are participating through a reimbursement model. In essence, they have been able to achieve their goal of making "charity cases" no less desirable than insured cases. A large part of this is due to attention paid to effective patient navigation.

Patient navigators may also be called Program Coordinators, Program Specialists, Assistants, or Managers, but they all perform key care coordination activities that model programs say are essential to ensuring good prep and good show rates. Navigators help patients overcome issues that are commonly identified as key barriers to CRC screening, and are particularly common among low-income and minority targets that are over-represented among uninsured populations:

- Fear of screening
- Lack of primary care/medical home
- Embarrassment about the procedure
- Complicated prep
- Lack of transportation

Navigation in model programs is typically done by phone, and programs operate with as few as 1.5 FTE patient navigators or as many as 6.0. Navigators often place a prescribed number of calls at key points in the process. During each call, navigators may spend as much as 20 minutes with the patient, providing education and responding to individual barriers that the patient may present.

In Action: Patient Navigation

NHCRCSP

- 1.5 FTE patient navigators working centrally serve patients throughout the state to coordinate approximately 350 colonoscopies a year. They are currently at ~1500 colonoscopies with zero no-shows and <2% inadequate prep.
- Navigators use an internally developed policy manual that prescribes at least six key contact points for each patient.
- Created a prep video available on YouTube http://www.youtube.com/watch?v=xd1N0WOcd5A and written instructions in 22 languages.
- Navigators have immediate access to medical expertise to answer patient questions and address barriers.

Cancer Coalition of South Georgia

- Uses 4.5 FTE navigators working out of 9 CHCs to serve patients in 30 counties. Each navigator is responsible for working with patients from 2–3 clinic sites.
- Navigators are from the communities being served, are familiar with the neighborhoods that patients are coming from, and often even have the same acquaintances. This familiarity helps generate patient trust and greater willingness to follow through with the navigator's instructions.
- Navigators review patient charts at the clinics and create prompts in electronic medical records to remind providers about the need for a screening referral.
- Navigators call on patients regularly once a procedure is scheduled to provide culturally appropriate navigation.

Operation Access

- Translation is provided for all patient communications and almost all program staff members are bilingual.

"Most of our patients have limited health literacy…so we knew that we had to be very diligent about this educational process. And because of that, our patients are cleaner, we understand from some of the GI specialists, than some of the people with insurance. And it's because of these reminder calls."

–Cancer Coalition of South Georgia

IN ACTION: Training and Managing Navigators

NHCRCSP

- Patient navigators must make a minimum of six calls to patients over the course of their involvement with the program.
- A detailed policy manual prescribes when calls are made and what topics are covered during each call. Navigators can provide more education or support, but no less than what is described in the manual.

Patient Preparation

A common complaint of volunteer endoscopists is when they have set aside time to volunteer their services and the patient does not show up or is poorly prepped. Screening programs have to work hard to overcome perceptual prejudices in low-income uninsured populations that they are not going to show up or take the prep seriously.

Efforts to address these issues have paid off for the four model programs in this guide. No show and poor prep rates in these programs are reported to be much lower than for a typical insured population. Model programs report no show or late cancellation rates of 0% to 4% and poor prep rates that are typically less than 5%. They say that tracking this type of information is important to demonstrate to new/potential partners that patients in the program will be prepared and represent a good investment of their volunteer time.

Model programs pay special attention to standardizing patient navigation, developing guidelines, models, or training materials that prescribe how patients will be navigated. They also often use a simple, standardized referral form and guidelines that describe criteria for acceptable referrals and patient qualification information (see Appendix for sample patient qualification and enrollment materials).

"Providers in community health centers really have even less time than other providers to go over all the details that you would want a patient to know in order to make sure they're willing to have the test and will be well prepared…and navigation makes up that gap, which can be a gaping hole that allows a lot of screening to fall through the cracks."

–NHCRCSP

Examples of standardized or model materials provided to patient navigators to ensure consistency include:

- Patient qualification questions
- Phone scripts
- Correspondence (content and frequency)
- Reminders
- Education (re: diet, prep)

When navigators can be relied upon to take care of all the details around scheduling, education, bowel prep, etc., all the provider has to do is show up and perform the procedure, making it more likely that they will continue their involvement with the screening program over the long term.

Hiring and Managing Effective Navigators

Model programs emphasize that navigators that are working with the type of populations typically targeted by free screening programs have to have the right personality to overcome the unique barriers of low-income uninsured populations. Some even say they look to hire navigators with personality traits that they have found to be effective at establishing trust and rapport with patients and ensuring effective communication, including:

- Persistence
- Flexibility
- Assertiveness
- Friendliness
- Expertise with CRC screening
- Understanding of public health goals
- Personal roots in the local community

Well Care

A common barrier to screening for low-income and uninsured populations is the lack of a medical home. All four model programs receive referrals from patients at community health centers, including free clinics and federally qualified health centers (FQHCs), ensuring that they will have access to ongoing care. In the case of Volunteers

IN ACTION: Patient Navigation Contact Points

Operation Access

- First call: eligibility and intake (up to 20 minutes)
- Second call: confirmation of appointment and location
- Third call: explanation of prep process
- Fourth call: reminder 2–3 days prior to appointment

Cancer Coalition of South Georgia

- First call: once a primary care doctor gives medical clearance, the patient is handed off to a navigator. The first call is an interview to verify eligibility, gather medical history, provide an overview of what to expect from the procedure and understand potential barriers that the patient may face.
- Second call: confirmation of appointment.
- Third call: after a packet of information is mailed to the patient and he/she has picked up the bowel prep, the navigator calls and spends 20–30 minutes on prep education. The navigator asks the patient to take everything out of the bag and walks through the prep procedure step by step, followed by having the patient explain the steps back to them.
- Fourth call: two days before the procedure, patients are reminded to start their special diet and the navigator once again goes over the prep instructions .
- Final call: patient satisfaction/check in call after the procedure is completed.

in Medicine and NHCRCSP, one of the programs' core goals is to provide patients with a medical home. Patients who have access to primary care providers are able to have a medical clearance before their procedure, as well as follow up care. This service is paid for through the NHCRCSP and is part of the required referral process for colonoscopy. This helps to eliminate the need for the endoscopist to see the patient before the procedure.

Transportation Barriers

Model programs do not typically provide or pay for transportation to and from colonoscopies. In an emergency though, all say that funds can be allocated to make sure a patient can get to and from their appointment. Additionally, navigators may make use of Medicaid transportation or provide gas money for a friend or neighbor to drive a patient that has no other means of getting to their procedure.

For a new program just starting up, it may be important to plan for transportation assistance. For example, anticipating that fact that many low-income patients may not have their own transportation, though, Volunteers in Medicine purposefully selected a clinic site that is on a bus route.

Language and Cultural Barriers

Culturally competent and multi-lingual care coordination is an essential component of model programs that serve diverse audiences. The most successful navigators speak the language of their patients, both literally and figuratively.

Model programs say that it can be important to recruit navigators who come from the community being served. Navigators are going to be spending a significant amount of time on the phone with patients, educating them and helping them address fears and other barriers. A good, culturally competent navigator will form a bond with the patient that will help encourage them to overcome personal barriers, improving show rates and patient satisfaction.

"[The navigators] find out what their issues are, and often it's just fear of the unknown. So they describe the procedure, try to alleviate some of their fears, and tell them that they're going to stick with them through the process."

–Cancer Coalition of South Georgia

IN ACTION: Addressing High Needs Populations

Cancer Coalition of South Georgia

- Culturally competent navigation is critical to serving populations that are low-income, poorly educated, and have limited health literacy. In one Georgia county served by the Coalition, nearly 29% of the population lives below the poverty line. Another county served has the highest cancer incidence in Georgia. Some of these patients live in rural areas where transportation is a challenge and some may not have running water or bathroom facilities. Local navigators are able to empathize with these and other barriers, identify solutions, and help patients develop greater trust and familiarity with the local health care system.

NHCRCSP

- The NHCRCSP uses translation services (language line) and has prep instructions in 20 languages to overcome barriers of language and to assist diverse patients, some of whom are homeless.

Follow Up Support

Navigators may also serve as a resource to patients once their procedure is done. In some cases, they are responsible for entering information into a patient's electronic medical record about follow up screening intervals.

Navigators may also provide administrative support to patients, such as dealing with bills that they may receive in error from providers or facilities that agreed to provide their services at no cost. These types of billing errors may seem like a minor issue to providers, but to a low-income patient who was promised a no-cost procedure, receiving a large medical bill that they cannot pay for can be an extremely scary experience.

VII. Resources and Funding

Paying for the Full Continuum of Care

Potential costs for CRC screening may include a wide range of services and facilities starting with a primary care visit and continuing on to include navigation services, prep, transportation, endoscopy services, facility fees, anesthesiology, surgery, pathology, diagnosis, surgery, and chemotherapy if a cancer is found. Some programs are able to secure volunteer participation across this entire continuum of care. Others obtain volunteer participation from some providers, but reimburse others at Medicare or Medicaid rates.

For example, a program may have endoscopists that volunteer their time, but must pay for pathology or facility fees. If this is the case, participating providers typically agree to Medicaid level reimbursement rates and the program raises funds pay for these services. The NHCRCSP is unique among the four models in that all participating providers are reimbursed at Medicaid rates, through their CDC grant funding.

Though not all model programs provide estimated costs per patient, the costs to provide colonoscopy services (including prep and navigation) is not high, reported to range from $300 to $2000 depending on the area of the country and the patient, with most falling below $1000 each.

Raising Funds

Model programs receive funding from a variety of local, state, federal and private sources, including the following:

- Federal grants
- State or county funding
- CDC
- Individual donors
- Businesses
- Hospital/health system foundations
- Corporate foundations
- Churches and other faith-based organizations

In Action: Costs and Funding Sources

Operation Access

- Provider services are donated, and two thirds of the program funding to support care coordination comes from hospital and health conversion foundations, a reflection of the high value they place on the program.

Cancer Coalition of South Georgia

- Annual program costs total roughly $200,000 (including CRC, breast and cervical screening). Partners contribute an additional $300,000 in in-kind contributions to the CRC screening program.
- Pathology is one part of the continuum of care that is partially paid (at $100 per case) and partially covered by a pre-existing hospital relationship.

NHCRCSP

- Pays for colonoscopy, pathology, anesthesiology when needed, prep, and PCP visit at Medicare reimbursement rates through a CDC grant program. Costs per patient may be around $1000, ranging higher for more complex procedures.

"The main thing is to look for a broad portfolio of funding so that if you lose one funding source, you still have others to fill the gaps."
–Cancer Coalition of South Georgia

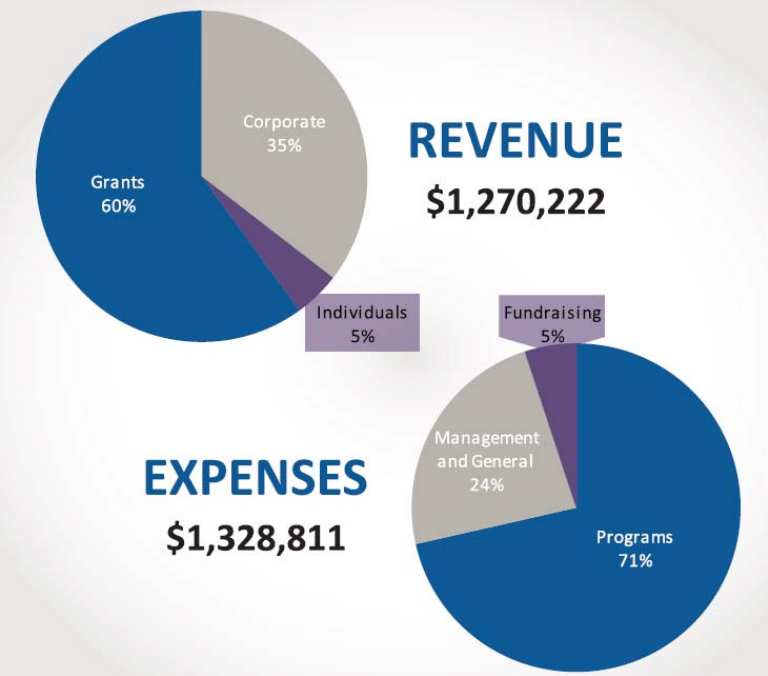


Figure 3: 2013 Financial Summary for the Cancer Coalition of South Georgia

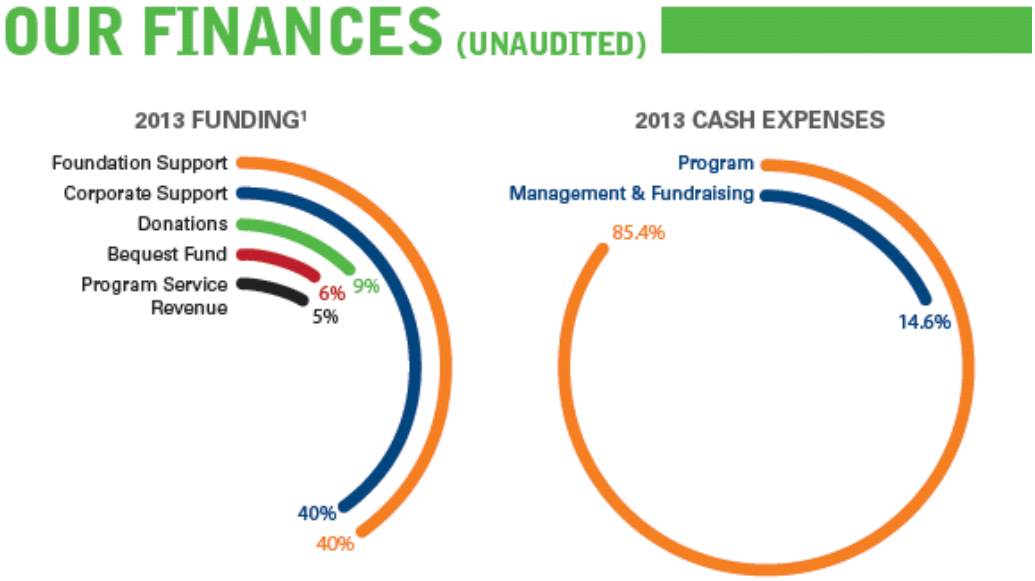


Figure 4: 2013 Financial Summary for Operation Access

Some programs receive a significant portion of their funding from hospitals and health systems that recognize that funding screening programs will positively impact their bottom line through *cost avoidance*. However, they still stress the importance of having a diversified funding base, so that they do not rely too heavily on a small number of funders. Rather, efforts should be ongoing to seek out new sources of funding, as existing sources may need to reduce their level of support due to unforeseen circumstances

Most programs conduct large annual fundraisers to generate donations, boost awareness and celebrate successes with donors and volunteers. Fundraisers include traditional events such as banquets or golf outings.

Funds raised through all development efforts are necessary to pay for services, facilities and staff costs that are not or cannot be donated including:

- Translation
- Patient navigation
- Transportation
- Prep
- Primary care visits
- Facility fees

"The reason hospitals are willing to do this…is [they are] going to pay for free cancer care anyway when unscreened, low income uninsured people show up at their facility with cancer. The more you screen underserved people and prevent cancer from occurring, the lower your costs over time."

–NHCRCSP

In Action: Fundraising for CRC

Cancer Coalition of South Georgia

- When making the case to potential donors that CRC screening is worth funding, the Coalition emphasizes that significant disparities exist in CRC deaths and that an effective screening program can eliminate these disparities. No one deserves to die from colorectal cancer because they could not afford to be screened.

Operation Access

- Operation Access supplements its budget with donations from corporations and individuals. They emphasize that the funding mix is and should be dynamic, as they respond to changes in the community and economy, and identify new sources of support.

VII. Appendix

The following samples are provided as examples of standardized materials, protocols, and reports that model programs have used.

Recruiting Health Partners and Providers

- Physician Recruitment Letter (Operation Access)
- Provider Participation Plan (Project Access)

Management, Roles and Responsibilitiees

- Logic Model (Operation Access)
- Colonoscopy Pilot Clinical Process Map (Operation Access)
- HealthScope Magazine Feature Article on Project Access (provider recognition and patient success stories)
- Patient and Volunteer Outcomes Report (Operation Access)
- Simplified Program Impact Report (Cancer Coalition of South Georgia)

Care Coordination

- Referral Forms (NHCRCSP, Project Access, Operation Access)
- Patient Application (Volunteers in Medicine)
- Patient PCP Referral Form (NHCRCSP)
- Patient Satisfaction Survey (Operation Access)
- Patient Recruitment Card (Cancer Coalition of South Georgia)

RECRUITING HEALTH PARTNERS AND PROVIDERS

OPERATION ACCESS SAMPLE PHYSICIAN RECRUITMENT LETTER

Joe Jones, MD
123 Main St.
San Francisco, CA

Dear Dr. _____:

If you have ever considered donating your time and skills to people who really need your help, but traveling abroad isn't feasible, volunteering with Operation Access is an opportunity to make a difference in the lives of others - right here at home.

Over the past six months, we have seen an increased demand for [***specialty name]*** services, and your participation with OA would make a significant difference in our ability to respond to the community need. The most typical procedures for which we received referrals are: [***list procedures if relevant].*** [***Name of hospital]*** has partnered with OA since ***[year],*** and would support your efforts by donating use of the OR, staff and supplies. Currently, [***number]*** of your colleagues volunteer with us, and I encourage you to speak with Dr. _____ or Dr. _____to learn more.

Volunteering with Operation Access is easy:

- All prospective patients are referred to OA by community clinic physicians
- You determine how many patients you will see and how frequently you will see them
- You schedule OA patients during the week at your convenience
- OA staff works closely with your office staff and manages every patient to assure that they keep their appointments and are properly prepared.

"I have struggled for years (with) balanc(ing) the need for specialty services like GI for folks without the means to pay with the needs of running an office. There is no perfect solution, but Operation Access makes it fairer and easier. The decisions are made by the primary doctor... All of the referrals that I have received have been appropriate. It is a nice way of sharing my skills with a group of patients that truly needs them." Richard Auld, MD

Volunteering with Operation Access is rewarding:

"Thank you for the pro-bono surgery that you provided for me through Operation Access and which I could never have come close to affording on my own. You freed me from a debilitating and worsening condition that was seriously impacting my life and for which I couldn't get help anywhere else. I admire you greatly Dr. Kidd, for offering pro-bono services to people who can't afford to get medical help. There aren't many doctors who will do that."
From patient Lindsay W to her OA physician volunteer

Please contact me if you would like to further discuss this opportunity. . **[OR: I will follow up with you in about a week to discuss this opportunity.]** I look forward to your positive response.

Best regards,

Program Manager/Specialist
phone number
e-mail address

2013 Provider Participation Plan

Please mail or fax back to us: P.O. Box 973, Johnson City, TN 37605; 423.232.6707

***Only one form is necessary for a whole group. Please detail your current providers, specialties, and individual participation levels on page 2. Please notify us when any provider joins or leaves your office so we can update our records accordingly.**

Practice Name:_____(please print)

Practice Address:_____(please print)
Street City State Zip

Main Phone_____ Main Fax_____ Main Email_____

Main Contact:_____ **Preferred Method of Contact**: ___Ph ___Fx ___Email

Practice Administrator:_____ Phone _____

Billing Contact: _____ Phone_____

In 2013, I Will Participate in the following manner:

Primary Care Practice/Group

____As an Individual Practitioner, providing services to 10 approved Project Access patients through my office.

Specialty Care Practice/Group

____As an Individual Practitioner, providing services to 5 approved Project Access patients through my office.

____As a Group Member of 2-3 Providers, providing services to 10 approved Project Access patients through our office.

____ of 4-5 Providers, providing services to 20 approved Project Access patients through our office.

____ of 6-7 Providers, providing services to 30 approved Project Access patients through our office.

____ of 8-9 Providers, providing services to 40 approved Project Access patients through our office.

____of 10+ Providers, providing services to 50 approved Project Access patients through our office.

____Other as defined here _____

_____

Person Completing Form:_____ **Title:**_____

Signature:_____ **Date:**_____

Please Note: Diagnostics AND Initial Specialty Care Appointments MUST be set-up/scheduled by our office.
This is the way we keep track of donated services and resource limitations.
All Diagnostics and Initial Specialty Care Appointments have Authorization Codes. Please do not schedule without one.

Please contact us if you have questions or wish for someone to come speak to your group about Project Access.
Thank you for helping our community in need.

1/2

Project Access
Providers' List and Office Specifications

PROVIDER'S NAME	SPECIALTY(IES) SubSPECIALTIES	INDIVIDUAL PARTICIPATION LEVEL	CREDENTIALS	LICENSE NO. W/ EXPIRATION DATE
John Smith	*Internal Medicine*	*5*	*M.D.*	*23001 12/01/2014*

Specifications

●Diagnoses: Are there certain diagnoses or conditions you wish to see? Any which you prefer not to see?

_____

_____

●Scheduling: How would you like us to schedule with your office?

_____

Do you have a specific internal form you would like completed? _____ [if so, please provide]
Do you want to review records before accepting a patient? _____

●Residency: Do you have any residential restrictions other than by county [our policy is to send Sullivan Co patients to Sullivan Co providers and Washington Co patients to Washington Co providers]?

_____

●Hospital: At which Hospital(s)/Facility(ies) do you have privileges?

_____

●Billing: How do you track the care donated/written off by your office? How do you prefer to communicate that with us? How often?

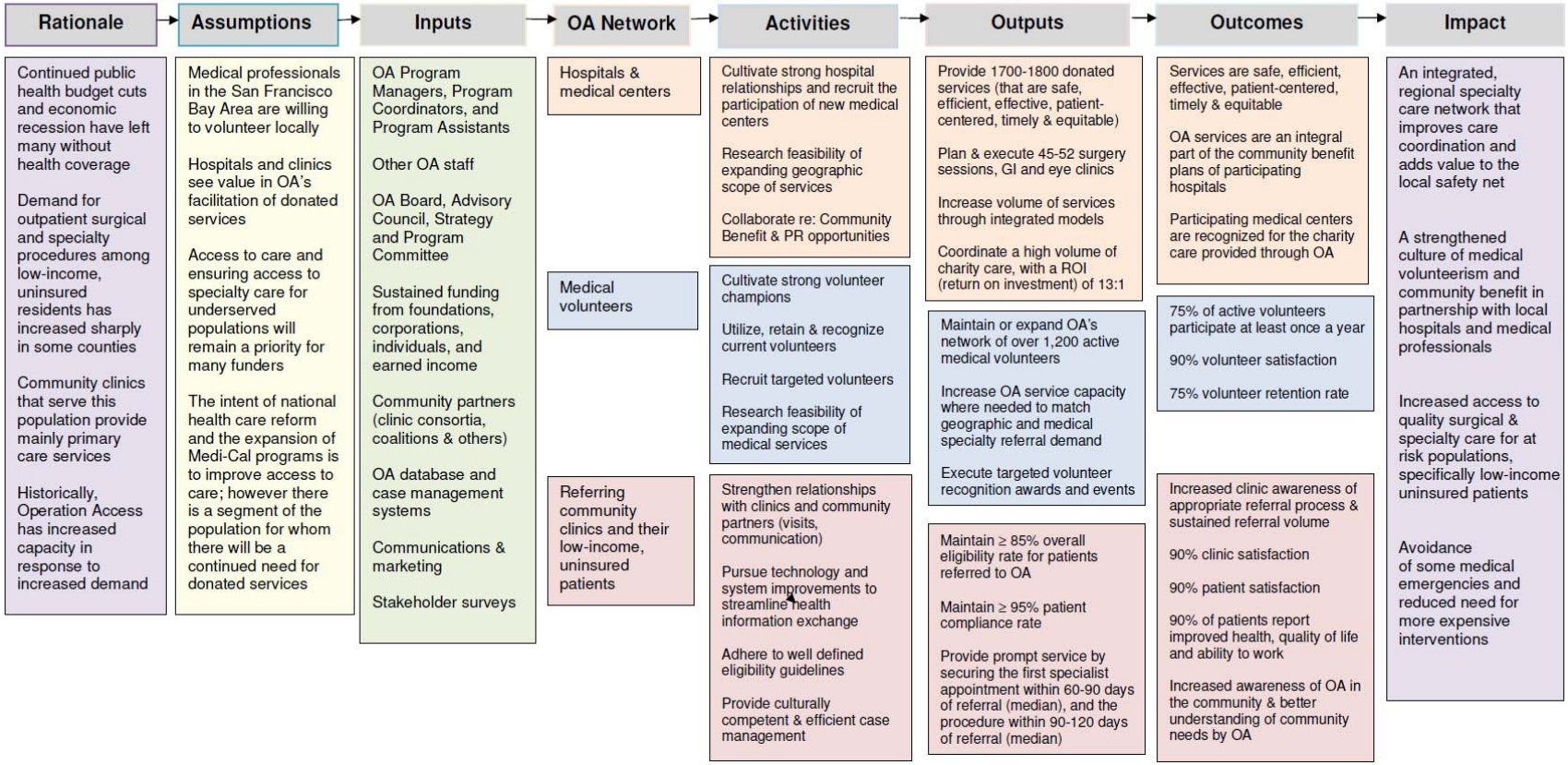
_____

2/2

MANAGEMENT, ROLES AND RESPONSIBILITIES

Operation Access (OA) in the San Francisco Bay Area / Logic Model: Plan and Intended Results for 2013

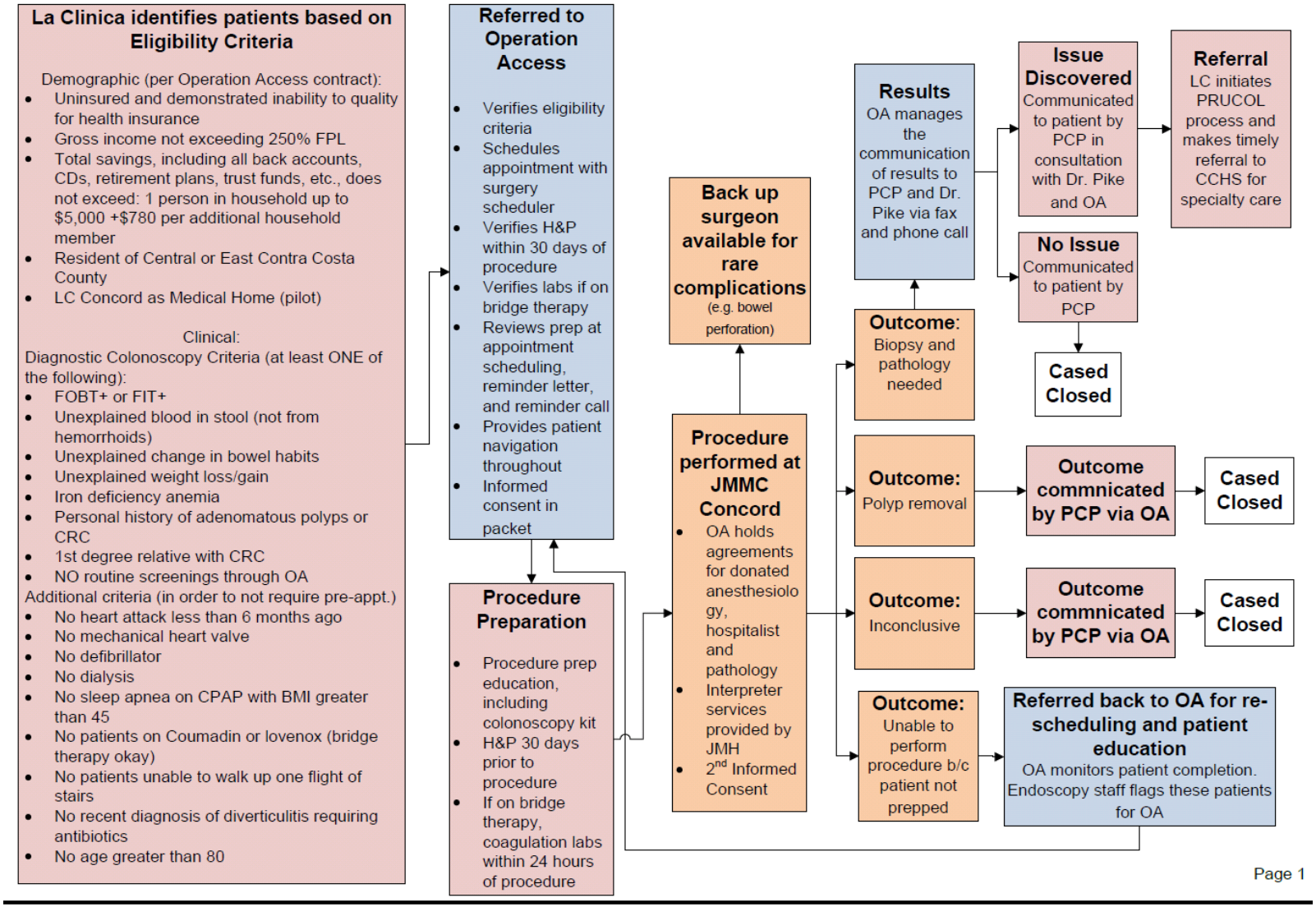
***GOAL**: To sustain a high level of donated surgical and specialty services that responds to the level of referral demand by region & medical specialty, while implementing technology and system changes to increase efficiency & impact.*



La Clinica – Pink
Operation Access – Blue
JMH - Orange

Operation Access Colonoscopy Pilot – Clinical Process

John Muir Health – June 2014



HEALTHSCOPE MAGAZINE ARTICLE ON PROJECT ACCESS

(l to r) Polly Ryan, Memorial North Shore and Westside Health Centers; Sharon Stewart, Volunteers In Medicine; Tammy Burke, Chattanooga-Hamilton County Health Department; William McInnis, Dodson Avenue and Southside Community Health Centers; Rae Young Bond, Chattanooga-Hamilton County Medical Society and Medical Foundation of Chattanooga

Project Access

By Jenna Haines
Photos by Med Dement

Community Partnerships for Compassionate Care

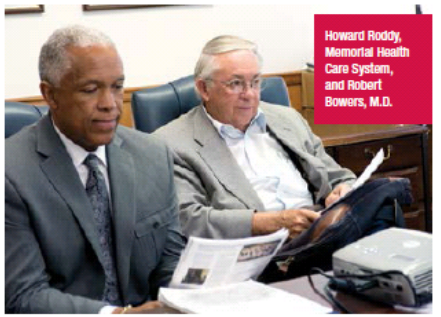
While affordable health care has become a major political issue in just the last few years, Project Access has been helping low-income patients in Chattanooga find the care they need since 2004. Coordinated by the Medical Foundation of Chattanooga in partnership with the Chattanooga-Hamilton County Medical Society, Project Access isn't a health insurance program. Rather, it's a network of doctors, hospitals, medical schools, community clinics, and the Hamilton County Health Department that works to provide access to specialty care for patients with medical needs or conditions that require treatment.

The program is specifically designed for those who have fallen between the cracks: people with low-income jobs who cannot afford health coverage, but make too much to qualify for programs like TennCare. Since its inception, Project Access has donated over $112 million in health care to uninsured Hamilton County residents, and over 700 volunteer physicians currently participate.

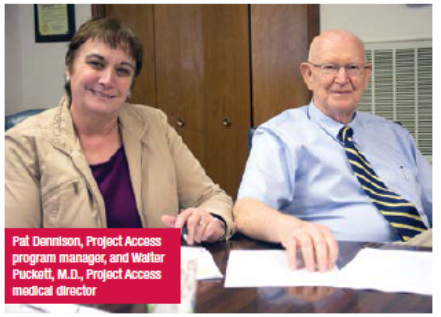
The life-changing impact of Project Access can be best understood through the voices of its patients. Here are three remarkable patient stories.

Ron Holland

After losing his job and health insurance, Ron was admitted to the Volunteers in Medicine medical clinic. A preliminary X-ray revealed a suspicious area in his chest, and he was diagnosed with lung cancer shortly after. Understanding Ron's need for a specialist in the midst of financial hardship, his doctors referred him to Project Access for surgery. In 2007, he underwent a lung resection performed by Dr. Rob Headrick and a round of chemotherapy. By 2008, he was disease-free. But his complications were not over. Ron was working at a new job when bad news struck again. In January of 2013, Dr. Colleen Schmitt, a volunteer gastroenterologist with Volunteers in Medicine, discovered a developing issue that once more required specialist care and referred Ron back to Project Access. After a CT scan discovered signs of esophageal cancer, volunteer surgeons Dr. Headrick and Dr. Charles A. Portera performed an operation to reconstruct his esophagus and save his larynx. Today, Ron is healthy, recovering, still gainfully employed, and thankful for all the



Howard Roddy, Memorial Health Care System, and Robert Bowers, M.D.



Pat Dennison, Project Access program manager, and Walter Puckett, M.D., Project Access medical director

Project Access By the Numbers *(April 2004-November 2013)*

$112 Million
Total value of donated health care provided to uninsured Hamilton County residents through Project Access

51.1 Return of Investment
Each $1 spent to manage the program resulted in $51 of donated care in 2013

13,897
People screened to determine eligibility

9,715
Individuals who have received medical care

375
Average number of patients enrolled in any given month

38% Better Health
Former patients who rated their health status as good, very good or excellent compared to 29% before care

8,670
People who did not qualify for the program but were referred to other appropriate community resources and programs

39% Fewer Physical Restrictions
Former PA patients who said they now have little to no restrictions on activities compared to 26% prior to care

38% No Limitations on Daily Work
Former PA patients who reported little to no limitations on daily work inside or outside the home due to physical problems compared to 30% prior to care

17% Now Insured
The percentage of former PA patients who have obtained health insurance coverage

700+ Volunteer physicians currently participating

Project Access patient Roy with coordinator Dana Brinkman

support he received from the individuals of the Project Access program.

Donna Hassell

Donna Hassell is responsible for more than her own health. In the last five years, she has also taken care of her 24-year-old son who suffered paralysis from the waist down after a 2008 motorcycle accident. In August of 2012, Donna began to experience her own health concerns when she developed pancreatitis. She went to her primary care physician, Dr. Jimmy Davis of Memorial's North Shore Health Center, who recognized her condition required more attention from a GI specialist. So Donna, in dire condition (she had dropped from 110 pounds to 67 pounds) was referred to Project Access, where she was informed by volunteer physician Dr. Louis Lambiase that she needed a feeding tube inserted to save her life. Reluctantly, Donna agreed. Today, Donna still has the feeding tube in place, but she has not used it for six weeks. Her weight has returned to 97 pounds, and she has been able to obtain both disability and TennCare. While still in recovery, Donna is overjoyed. "There are so many angels in Chattanooga, I just don't know where to begin." She hopes to have the feeding tube removed completely before 2014.

Roy

In 2012, Roy began to experience a loss of vision and hypertension and was referred to Project Access by the Dodson Avenue Community Health Center. After a CT scan revealed that he had a pituitary adenoma, Project Access volunteer Dr. Michael Gallagher of Chattanooga Neurosurgery and Spine deemed it was necessary to perform surgery in order to remove the benign tumor pressing against his optic nerve. The adenoma is now gone, and Roy's eye sight and blood pressure have improved significantly.

Partnerships with Clinics

One aspect that makes Project Access distinctive is its extensive network of doctors, hospitals, and medical professionals that makes its mission possible. "I think it's unique that so many physicians—so many specialists—have been willing to give their time at no charge to patients that wouldn't have any other recourse except emergency room management," says Dr. Jimmy Davis, a physician at Memorial North Shore Health Center.

But how does Project Access work with the clinics, exactly? Project Access medical director Dr. Walter Puckett explains that the program acts as a "middleman" of sorts. "If a patient needs specialty care, Project Access facilitates the arrangements to provide that care for that particular patient, who is uninsured and below 150% of the poverty level," he says. "For example, if the patient needs a heart transfer or needs their gallbladder taken out, Project Access facilitates the process for that patient." While Project Access is not intended for primary care, it does provide resources and help to patients needing a primary care home.

> *"There are not many cities like Chattanooga where the medical society is able to pull the hospitals and physicians together and make it work. That's really exceptional. There are just not many programs like it in the country."*
>
> *– Dr. Robert Bowers*

"There are not many cities like Chattanooga where the medical society is able to pull the hospitals and physicians together and make it work," says Dr. Robert Bowers, a retired doctor who worked previously with Project Access as chairman and volunteer physician. "That's really exceptional. There are just not many programs like it in the country."

The Future of Project Access

Despite recent health care reforms, Project Access volunteers say the program will still be necessary and will continue to provide care for those in need. "Since Tennessee has not expanded Medicaid, our poorest citizens—those under 100% of the federal poverty level—will not be eligible for financial assistance to purchase health insurance," says Rae Young Bond, executive director of the Chattanooga-Hamilton County Medical Society and Medical Foundation of Chattanooga. "For many of our patients, health insurance will still be financially out of reach. Project Access will still be needed for the foreseeable future."

Project Access calls itself a "community health partnership," and this couldn't be more true. It's about far more than providing financial resources to support those in medical need; it's about creating a cohesive network of medical professionals and institutions that have a patient's best interest in mind.

When it comes to articulating Project Access' ultimate goal, Dr. Jimmy Davis nails it on the head. "Project Access complements the mission of compassion, the heart and soul of medicine."

HAMILTON COUNTY PROJECT ACCESS
A COMMUNITY HEALTH PARTNERSHIP

Project Access - Sharing the Gift of Healing in 2013

Since 2004, physicians, hospitals, health centers, and other partners have donated their care and services to nearly 9,715 of our uninsured neighbors. Lives have been saved, health has been restored, and many people have been able to continue working and supporting their families because their health crisis was averted.

These wonderful partners have donated more than $112 million of health care services through Project Access. The program has also directed more than 8,200 individuals to other community resources.

We give thanks to these wonderful individuals and organizations who provide direct care to our patients, and to the generous individuals and companies who have supported Project Access program operations.

SPONSORING ORGANIZATION

Chattanooga-Hamilton County Medical Society and Medical Foundation of Chattanooga

1917 East Third Street
Chattanooga, TN 37404
423-826-0269 (Project Access)
423-622-2872 (Medical Society & Foundation)

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Kindred Hospital
Memorial Health Care System
Parkridge Health System
Siskin Hospital for Physical Rehabilitation

PARTICIPATING HEALTH CENTERS

Erlanger Southside and Dodson Avenue Community Health Centers
Memorial North Shore & Westside Health Centers
Hamilton County Health Centers
Volunteers in Medicine
Homeless Health Care Center
Chattanooga CARES
Lone Oak Clinic
Lifespring Community Health
Cherokee Health System

OTHER PARTNERS

Alliance Physical Therapy
Beltone Hearing Aid Center
Chattanooga Homeless Coalition
Dispensary of Hope Pharmacy Program
Eye Surgery Center of Chattanooga
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Patient survey results

OA makes a difference in patients' lives. The respondents to post-procedure surveys indicate that:

96% of patients were "very" or "extremely" satisfied with their overall experience with OA

For patients who had surgical procedures:

98% reported improved quality of life

98% reported improved health

95% reported improved ability to work

94% reported improved mobility

88% of patients having diagnostic and/or non-surgical procedures reported that they made a lifestyle change as a result of the care they received

Volunteer survey results

Volunteers like working with OA. The respondents to our annual volunteer survey indicate that:

95% believe that their volunteer commitment is a "good fit" or they want to do more

94% probably or definitely will be volunteering with OA in one year

94% are "very" or " extremely" satisfied with their overall experience with OA

52% already do or are interested in recruiting others to volunteer with OA

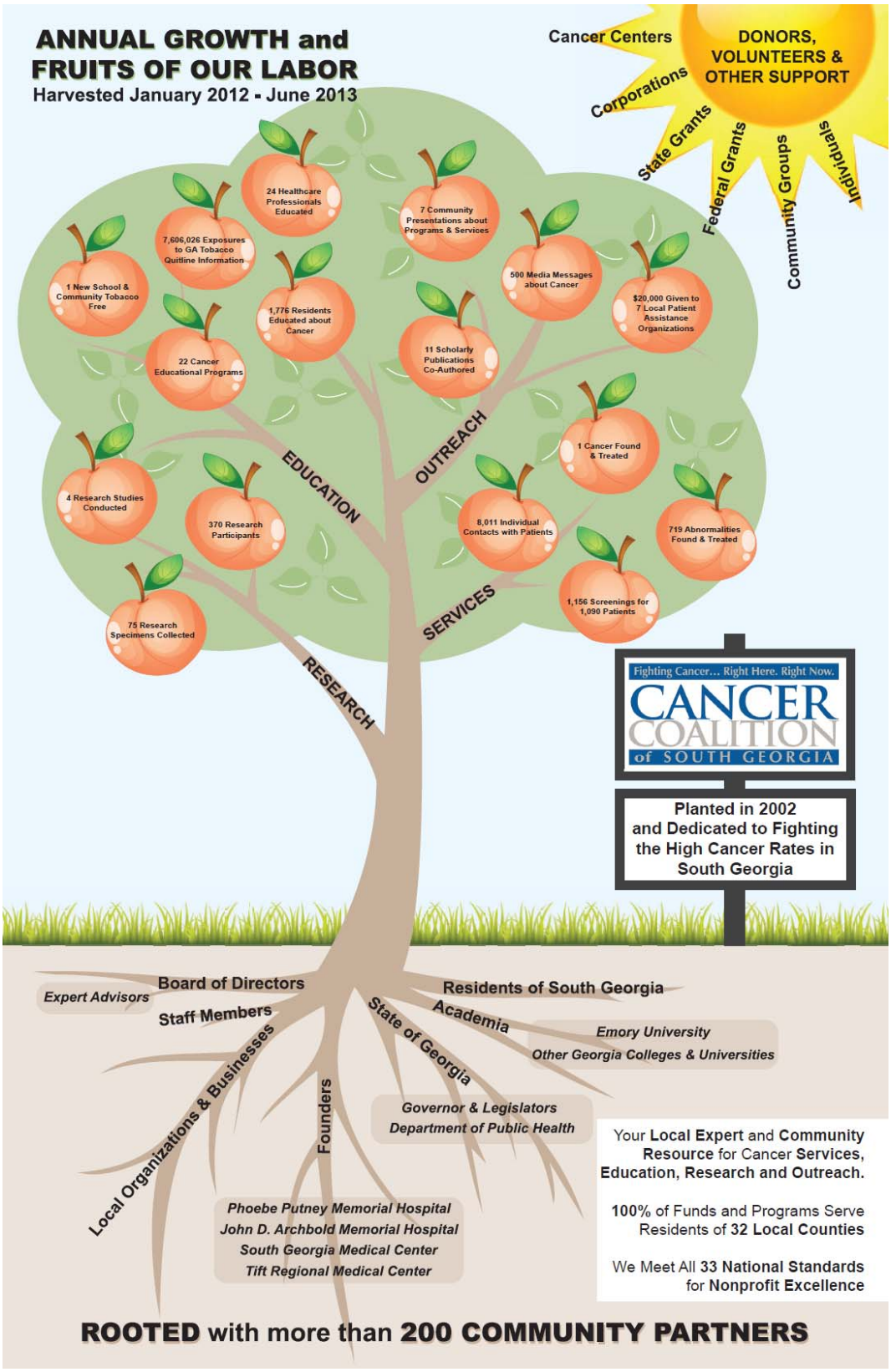
OA Supports Personal Philanthropy

85% see volunteering with OA as an opportunity to help others in the community

75% volunteer with OA because volunteering is part of their value system

Operation Access Annual Report 2013

SIMPLIFIED PROGRAM IMPACT REPORT



CARE COORDINATION

2013 Referral Request Form

423.232.6700 (P)
423.232.6707 (F)
www.ProjectAccessEastTn.org

***This form MUST be accompanied by supportive documentation which is relevant to and demonstrates the need for services being requested.**
Please indicate which of the following are being supplied with this Referral __Medical Records __Office Notes __Diagnostics/Lab Results

Part A: Provider Submitting Referral

Provider: _____ Office Name: _____

Contact Person: _____ Phone: _____ Fax: _____

Email: _____ **Preferred method of Contact**: ___Ph ___Fx ___Email

Part B: Patient Demographics

Patient Name: _____ Sex: ___Male ___Female

Patient's Social Security #: _____-_____-_____ Age:____ Date of Birth: ____/____/_____

Phone (Home #): _____ (Mobile #): _____ (Other#)_____

Address: _____ City: _____ State: _TN_

County: _____ Zip:_____ **Date the patient was first seen in office:**_____

For Part C and Part D Below, use 1,2, or 3 to **Rate Level of Urgency**: _1_ Priority _2_ As soon as Possible _3_ Standard Practice

If requesting a Diagnostic Complete **Part C: Diagnostic Procedure Requested** **This Form is used as an Order**

Diagnostic/Test: _____ __with contrast, __without contrast, __w/ & w/o contrast **Urgency**:___

Diagnosis: _____ **ICD 9/10 Code(s)**: _____

Diagnostic/Test: _____ __with contrast, __without contrast, __w/ & w/o contrast **Urgency**:___

Diagnosis: _____ **ICD 9/10 Code(s)**: _____

For Hospital Diagnostics, Wash Co Residents will be scheduled at JCMC; Sull Co Residents at HVMC or BRMC

If the Patient needs Specialty Care Complete **Part D: Specialty Requested**

Patients are assigned to Specialists on a rotating basis. Please do not request a specific provider.

Specialty Area Requested: _____ **Diagnosis**: _____ **Urgency**:___

Specialty Area Requested: _____ **Diagnosis**: _____ **Urgency**:___

Specialty Area Requested: _____ **Diagnosis**: _____ **Urgency**:___

Specialists previously involved in the Patient's care: _____

Please Note: Diagnostics AND Initial Specialty Care Appointments MUST be set-up/scheduled by our office.
This is how we track the services donated to us each year and prioritize urgency.
All Diagnostics and Initial Specialty Care Appointments have Authorization Codes. Please do not schedule without one.

Authorized Signature: _____ **Date**: ____/____/_____

Operation Access

Patient Referral Form

Fax: 415.733.0019 Ph: 415.733.0052
115 Sansome St., Ste. 1205, San Francisco, CA 94104
Email: info@operationaccess.org Web: www.operationaccess.org

Operation Access office use:

Patient Name:_____

Address:_____

City/State/Zip:_____

☐ Check if Homeless and provide Case Manager info

Best phone #:(_____)_____

Other phone #:(_____)_____

Emergency Contact: _____

Contact phone #: (_____)_____

Language:_____ Ethnicity: _____

English Speaker in household? ☐ Yes ☐ No

Date of birth: _____/_____/_____ Sex: M F

Clinic Contact Info

Referring Clinic: _____

Primary care home (if different): _____

Referring Provider: _____

Ph:(_____)_____ E-mail:_____

Clinic Contact/Case Manager:_____

Ph:(_____)_____ E-mail:_____

Fax:(_____)_____ Referral Date: _____

Eligibility Guidelines

Patients may be referred for ***non-emergency, outpatient* & *elective procedures.*** *Available services depend on availability of volunteer doctors.*

In order to qualify, a patient must:

- Not have health insurance or Worker's Comp. coverage.
- Be currently ineligible for any publicly sponsored insurance including Medi-Cal, Medicare, or Healthy Families.
- Earn less than 250% of the Federal Poverty Level: $28,725 for individual, $58,875 for family of four.
- Not require ongoing care by specialist for successful recovery (referring clinic maintains responsibility for care after procedure and final appointment).

Please fill out completely and fax

Attach Relevant Clinical Information (check off what is included):

- ☐ Progress Notes (if relevant)
- ☐ Most Recent H&P/Medical History
- ☐ Imaging Results
- ☐ Labs
- ☐ Pathology Report
- ☐ Surgical Reports
- ☐ Other _____

Procedure(s) Requested: _____

_____

_____

Diagnosis / Symptoms / Relevant Treatment or Hospitalizations:

_____

_____

_____

Visual Acuity (for eye referrals): _____

Check if a biopsy is being requested: ☐

If a malignancy is detected: the patient will be referred back to you (the medical home) for coordination of follow-up care.
OA's scope of service is limited to the diagnostic procedure.

Body Mass Index:_____

Mental Illness?_____Treated? ☐ Yes ☐ No

Current Medications:_____

_____

Anticoagulants?: ☐ Yes ☐ No

Allergies:_____

_____

Diabetes:_____If yes: Controlled? ☐ Yes ☐ No

Co-Morbidities (circle all existing or past conditions):

Heart Disease Stroke Hypertension Lung Disease
Kidney Disease Diabetes Cancer Family History of Cancer
Active Substance Abuse History of Substance Abuse
Other _____

VOLUNTEERS IN MEDICINE PATIENT APPLICATION

Volunteers in Medicine Chattanooga
5705 Marlin Road, Suite 1400, Building 5900
Chattanooga, TN 37411
Phone (423) 855-8220 Fax (423) 855-8230

Volunteers in Medicine Chattanooga provides medical care for Hamilton County Residents who are uninsured, can prove residency in Hamilton County for a minimum of 90 days, and who meet certain financial guidelines. Income is based on total household income, not on individual income.

We require the following documentation to be considered for acceptance as a patient. Any adult living in your household also must provide this information. Documentation of Social Security benefits for any minor child in the household must be provided.

- **Photo ID drivers license**
- **Piece of mail 90 days old addressed to you at your current home address. The mail should be a utility bill, rent receipt, bank statement. No "junk mail" is accepted.**
- **Copy of 2013 tax return. If you did not file, bring verification of non-filing which is on line at www.irs.gov.**
- **If self employed, provide Schedule C along with your tax return.**
- **Last 4 paycheck stubs of all working adults in your household.**
- **Documentation of alimony/child support you are paying or receiving.**
- **Documentation of food stamps you are receiving.**
- **Documentation of retirement benefits/pension benefits. Bring verification from www.ssa.gov (for social security benefits)**
- **If you were dropped from TennCare within the past 12 months, provide your TennCare drop letter.**
- **If employed, letter from employer stating that you do not receive healthcare coverage/benefits through them.**
- **If you have no income, provide explanation of how you are meeting your living expenses. If someone is helping you with expenses we must have a letter from that person stating what they are providing and their relationship to you.**

Complete the attached forms and return with the above documentation on this date:_____

April, 2013/Rev June 2013/Rev Jan 2014

PATIENT INFORMATION

NAME:_____

HOME ADDRESS:_____

Street City State Zip

HOW LONG HAVE YOU LIVED AT THIS ADDRESS:_____

HOME PHONE:_____ **CELL PHONE:**_____

DATE OF BIRTH:_____ **SOCIAL SECURITY #:**_____

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

Street City State Zip

EMPLOYER PHONE:_____

LENGTH OF EMPLOYMENT:_____

MONTHLY INCOME:_____

YEARLY INCOME:_____

SPOUSE INFORMATION

NAME:_____

SOCIAL SECURITY #:_____

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

Street City State Zip

MONTHLY INCOME:_____

YEARLY INCOME:_____

HOUSEHOLD INFORMATION

LIST ALL PERSONS IN HOUSEHOLD

NAME	DATE OF BIRTH	RELATIONSHIP

MISCELLANEOUS HOUSEHOLD INCOME

UNEMPLOYMENT BENEFITS PER WEEK:_____

FOOD STAMPS PER MONTH:_____

ALIMONY/CHILD SUPPORT PER MONTH:

PAID:_____ **RECEIVED:**_____

SOCIAL SECURITY/DISABILITY BENEFITS PER MONTH:_____

WORKERS COMPENSATION PER MONTH:_____

PENSION INCOME PER MONTH:_____

CHECKING ACCOUNT BALANCE:_____

SAVINGS ACCOUNT BALANCE:_____

April 2013/Rev June 1, '13/Rev June 14, 2013

PATIENT MEDICAL INFORMATION

NAME:_____

WHERE HAVE YOU BEEN RECEIVING MEDICAL CARE PRIOR TO CONTACTING VOLUNTEERS IN MEDICINE:
CLINICS:_____**Memorial Northshore Health Center**
_____**Memorial Westside Health Center**
_____**Erlanger Hospital Clinics**
_____**Dodson Avenue Health Center**
_____**Southside Health Center**
_____**Homeless Health Center**
_____**Cherokee Health Systems**
_____**Fortwood**
_____**Joe Johnson Mental Health Center**
_____**Mental Health Cooperative**
_____**Other/Please List Below**

_____

EMERGENCY ROOMS:_____
DO YOU HAVE TENNESSEE COVER RX DRUG PLAN:
_____**YES** _____**NO**

LIST ALL OF YOUR CURRENT MEDICATIONS AND WHO PRESCRIBED THEM:_____
_____
_____

DO YOU HAVE A MEDICAL HISTORY OF:
HEPATITIS:_____**YES**_____**NO**
HIV/AIDS: _____ **YES**_____**NO**

I affirm that I have answered all questions honestly and completely. I affirm that the documentation that I am providing is honest and complete. I understand that by submitting fraudulent or incomplete information my application will be denied. I understand that if in the future fraudulent or incomplete information is discovered in my application I may be inactivated as a patient.

_____

Signed: **Date:**

April 2013/Rev. May 2013/Rev.6-14-13/Rev. 10-'13/Rev. 11-13

Dartmouth-Hitchcock

New Hampshire Colorectal Cancer Screening Program (NHCRCSP)
Client Enrollment Information

What is the New Hampshire Colorectal Cancer Screening Program (NHCRCSP)?
Dartmouth-Hitchcock in collaboration with the New Hampshire Department of Health and Human Services (NHDHHS) has developed the New Hampshire Colorectal Cancer Screening Program (NHCRCSP), a statewide effort to increase colorectal cancer screening for NH residents.

Who is funding the NHCRCSP?
The NHCRCSP is funded from the Centers for Disease Control (CDC) with in-kind donations from Dartmouth-Hitchcock, Dartmouth-Hitchcock's Norris Cotton Cancer Center, NHDHHS, and others. In order to carry out the program there are eligibility guidelines, both clinical and financial. Not everyone who completes the forms will be eligible.

If I am enrolled into the NHCRCSP what services will I receive?
As a client of NHCRCSP, you have access to free education on colorectal cancer screening, a free colonoscopy screening test and free patient navigation services to assist you with obtaining the test and the preparation for the test.

What services are not covered by the NHCRCSP?
If enrolled in the program, your free colonoscopy can find polyps or cancer. If your colonoscopy finds polyps they may be removed during the procedure. If cancer is found and further treatment or testing is needed, the NHCRCSP cannot pay for these services but will provide you with a timely and appropriate referral to obtain these services.

Who is eligible for the colonoscopy screening services of the NHCRCSP?
You must meet all of the following criteria to be eligible for the screening program:

* Men and women who are 50-64 years of age.
* Average Risk for colon cancer – People who have symptoms suggestive of gastrointestinal disease, inflammatory bowel disease (Crohn's Disease or Ulcerative Colitis), or evidence of genetic syndromes associated with colorectal cancer cannot be enrolled in the program.
* Individuals with a personal or family history of colorectal cancer or polyps will be considered.
* Uninsured or underinsured. Underinsured is defined as having at least a $1,000 deductible, co pay or co insurance.
* Eligible individuals will be at or below 250% of federal income guidelines. Both uninsured and underinsured must meet these income guidelines
* Reside in New Hampshire.
* Be medically cleared by a primary care provider/physician for a colonoscopy (the program will assist you in doing this if needed).

February 2014- INTERNET

Appendix E
Enrollment Packet

How do I register in the NHCRCSP?
You must complete an enrollment form each time you would like to be screened, and follow the "Next steps" mentioned below.

Next steps to enroll in the NHCRCSP:

- ☐ Read the Colorectal Cancer Screening brochure
- ☐ Complete both sides (front and back) of **Form A** (the registration form).
- ☐ Read and sign the **Form B**, the consent for participation in the NHCRCSP. Plan to send a copy of this document to NHCRCSP and keep one for your own file.
- ☐ Please read and complete the **Form C,** the authorization for the use / disclosure of protected health information, by placing the name of your family doctor where indicated. Plan to send a copy of this document to NHCRCSP and keep one for your own file.
- ☐ Mail your complete package (forms A, B and C) to:
  Dartmouth-Hitchcock Medical Center
  NHCRCSP
  One Medical Center Drive
  Lebanon, NH 03756 - 0001
- ☐ Your **completed** forms will be reviewed by NHCRCSP staff, who will only contact you at this point in the process if they have further questions.
- ☐ Your doctor will then contacted to ensure that it is safe and appropriate for you to have a colonoscopy. If you don't have a primary care physician or have not seen a PCP in the last year, you will be assisted by the NHCRCSP staff in scheduling a visit. The visit will be paid by the NHCRCSP.
- ☐ If you are accepted into the program, the NHCRCSP staff will notify you of your registration by mail.
- ☐ After enrollment, a NHCRCSP colonoscopy site will contact you to schedule the procedure.
- ☐ If you need more registration forms for other people in your home or for friends or family members who meet the eligibility guidelines, please call the NHCRCSP Office at (603) 653-3702.

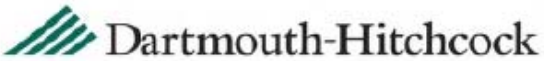
2014 Current Federal Poverty Income Level Guidelines

In January of each year, the federal government releases the Federal Poverty Income Guidelines. To be eligible for the New Hampshire Colorectal Cancer Screening Program your income (before taxes are deducted) must fall at or below 250% of this guideline. The numbers listed below are 250% of the guideline income levels. A pregnant woman counts as two for the purpose of this calculation.

2014 Current 250% Federal Poverty Guidelines		
Family Size	**250% Gross Yearly Income**	**250% Gross Monthly Income**
1	$29,175	$2,431
2	$39,325	$3,277
3	$49,475	$4,123
4	$59,625	$4,969
5	$69,775	$5,815
6	$79,925	$6,660
7	$90,075	$7,506
8	$100,225	$8,352

February 2014- INTERNET

Dartmouth-Hitchcock



Dartmouth-Hitchcock Medical Center
NHCRCSP - Colburn Hill
One Medical Center Drive
Lebanon, NH 03756-0001
(603) 653-3702
Fax (603) 727-7798

Dear Potential Client,

Thank you for your interest in colorectal cancer screening. Dartmouth-Hitchcock in collaboration with the New Hampshire Department of Health and Human Services (NHDHHS) has implemented the New Hampshire Colorectal Cancer Screening Program (NHCRCSP), a statewide effort to increase colorectal cancer (CRC) screening for NH residents. The program will also provide a limited number of free colonoscopies to men and women who are New Hampshire residents and who meet financial and clinical eligibility for the screening program.

Enclosed is information about the early detection of cancer, Client Enrollment Information, an NHCRCSP Enrollment Form, a Consent For Participation in the NHCRCSP Form, an Authorization for Use/Disclosure of Protected Health Information Form, and a business reply envelope. Please follow the instructions contained in the Client Enrollment Information "Next Steps" section to be considered for the free colonoscopy part of the program.

If you have any questions please call us at (603) 653-3702. Again thank you for your interest in the program.

Sincerely,

NHCRCSP

Enclosures:
Brochure
NHCRCSP Client Enrollment Information
FORM A, NHCRCSP Enrollment Form
FORM B, Consent For Participation in the NHCRCSP Form (2)
FORM C, Authorization for Use/Disclosure of Protected Health Information Form (2)
Business Reply Envelope

10-5-10

Form A – Enrollment Form
New Hampshire Colorectal Cancer Screening Program (NHCRCSP)

TO BE COMPLETED BY PATIENT – PLEASE PRINT AND COMPLETE BOTH SIDES

Name: _____ _____ _____ _____
(Last) (First) (MI) (Maiden)

Date of Birth (Month/Day/Year): __ __ / __ __ / __ __ __ __ Gender: ☐ Male ☐ Female

Address: _____ County of Residence: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____ - _____

Other Phone Number: (____) _____ - _____ Email Address: _____

Can we use this email address to contact you? ☐ Yes ☐ No Preferred Contact Time? _____

Mailing Address (if different): _____

City: _____ State: _____ Zip: _____

NAME OF PERSON IN THE EVENT WE ARE UNABLE TO REACH YOU

Name: _____ Relationship to You: _____

Phone Number: (____) _____ - _____

DEMOGRAPHIC INFORMATION

Do you have any needs or disabilities of which we should be aware? ☐ No ☐ Yes, Check all that apply
☐ Hearing Impairment ☐ Speech Impairment ☐ Need help making appointments ☐ Handicap Access
☐ Learning Disability ☐ Need help filling out forms ☐ Other, specify: _____
Race (Check all that apply): ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian or Alaskan
☐ Unknown
Are you of Hispanic origin? ☐ Yes ☐ No
Primary Language: ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other, specify: _____
Is an interpreter needed? ☐ Yes ☐ No
How much is your yearly, household gross income? $_____
Number of people (including yourself) who are supported by this income: _____
Education (highest level): ☐ No High School ☐ Some High School ☐ High School Graduate or equivalent
☐ Some college or higher ☐ Don't Know ☐ Prefer not to answer
Marital Status: ☐ Married ☐ Never Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Living with someone
Do you have health insurance? ☐ Yes ☐ No, if no, are you eligible for Medicaid? ☐ Yes ☐ No
If you have health insurance, please tell us what kind: ☐ Medicare: ☐ Part A ☐ Part B ☐ Medicaid
☐ Private Insurance (such as Anthem or Blue Cross) If private, name: _____
If you have insurance, what is the total amount of your deductible for a colonoscopy? $ _____

FAMILY HEALTH PROVIDER/DOCTOR

Do you have a primary care provider or family doctor? ☐ No ☐ Yes, if yes, please complete the following:

Name of Provider: _____ Name of office or practice: _____

Phone Number: (____) _____ - _____ Fax: (____) _____ - _____

Address: _____

City: _____ State: _____ Month/Year of last visit: __ __ / __ __ __ __

NHCRCSP, DHMC, One Medical Center Drive, Lebanon, NH 03756 Phone (603) 653-3702 Fax (603)727-7798 www.cancer.dartmouth.edu/NHCRCSP

CANCER SCREENING HISTORY

Have you had any of the following colorectal cancer screening tests?

Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT) in the PAST YEAR?

☐ No ☐ Yes, if yes was your test: ☐ Positive or ☐ Negative

Colonoscopy? ☐ No ☐ Yes, if yes, please tell us the year of your last test and name of facility where test was done.

Year: __ __ __ __ Facility: _____

Were there polyps? ☐ No ☐ Don't Know ☐ Yes

If yes, were you told that any of the polyps were "precancerous"? ☐ No ☐ Don't Know ☐ Yes

Sigmoidoscopy in the last five years? ☐ No ☐ Yes, if yes, please tell us the year of your last test and name of facility where test was done. Year: __ __ __ __ Facility: _____

CANCER HISTORY

Have you ever had colon or rectal cancer? ☐ No ☐ Yes

Have you ever had other types of cancers? ☐ No ☐ Yes, if Yes, type of cancer? _____

Have any family members had colorectal cancer? ☐ No ☐ Don't Know ☐ Yes

If yes, please list relationship to you and age at diagnosis of the colorectal cancer.

Relationship: _____ Age at Diagnosis: _____

Relationship: _____ Age at Diagnosis: _____

Relationship: _____ Age at Diagnosis: _____

Have any family members had colorectal polyps? ☐No ☐Don't Know ☐Yes, list relationship to you and age found

Relationship: _____ Age Found: _____

Have any family members had other types of cancer? ☐No ☐Don't Know ☐Yes, if yes, type of cancer(s)?

_____

HAVE YOU EVER HAD OR BEEN TOLD YOU HAVE ANY OF THE FOLLOWING?

Inflammatory Bowel Disease (IBD) (Crohn's Disease or Ulcerative Colitis)	☐Yes	☐No	☐Don't Know
Familial Adenomatous Polyposis (FAP)	☐Yes	☐No	☐Don't Know
Hereditary Non Polyposis Colorectal Cancer (HNPCC)	☐Yes	☐No	☐Don't Know
SIGNIFICANT bleeding from your rectum or bloody stools?	☐Yes	☐No	
RECENT NEW diarrhea or constipation lasting more than 2 weeks?	☐Yes	☐No	
Unexplained weight loss of more than 10% of your body weight?	☐Yes	☐No	

MEDICAL HISTORY

Weight (Pounds): _____

Do you take any blood thinners such as Coumadin or Plavix?	☐Yes	☐No
Do you have any bleeding disorders (difficulty getting your blood to clot)?	☐Yes	☐No
Are you taking daily prescription pain medications?	☐Yes	☐No
Do you use daily supplemental oxygen or a C-Pap Machine?	☐Yes	☐No
Are you aware of any problems with sedation or anesthesia?	☐Yes	☐No
Do you have any allergies to medications or latex?	☐Yes	☐No
If yes, please tell us what your allergies are: _____		
Do you have a pacemaker or defibrillator device?	☐Yes	☐No
Are you a diabetic?	☐Yes	☐No
If yes, do you take any medications for this?	☐Yes	☐No
Would you consider yourself in good health?	☐Yes	☐No
If no, please list your medical problems: _____		
Are you a current smoker?	☐Yes	☐No

How did you hear about the program? ☐Brochure/Poster ☐Mailing (Specify) _____

☐Healthcare Professional (Specify) _____ ☐Friends / Family

☐ TV / Radio / Newspaper (Specify name): _____ ☐ Other (Specify): _____

NHCRCSP, DHMC, One Medical Center Drive, Lebanon, NH 03756 Phone (603) 653-3702 Fax (603)727-7798 www.cancer.dartmouth.edu/NHCRCSP

SAMPLE PATIENT SATISFACTION SURVEY

Operation Access
Bridging the Healthcare Gap

Dear «FirstName»,

You recently received medical care through Operation Access and we hope that your health is improving. We are always working to make sure that every patient has the best experience possible, and to do that we need your help!

-Please tell us about your experience with Operation Access by filling out this short questionnaire and sending it back in the pre-stamped envelope provided with the survey.

Your opinion is important! We will use what you tell us in combination with the information that we get from other patients to continue helping many more people like yourself.

We will not share your name or contact information with anyone.
It is Operation Access' ongoing policy to protect your privacy and personal information.

Thank you for your time,

«PrimaryCaseMgr»

Operation Access
Bridging the Healthcare Gap

This survey pertains to your experience with «DrSurgeon» at «Hospital_Name» and Operation Access.
Please answer all questions thoroughly. Your responses are important to us.

1. How satisfied are you with the service of the Operation Access Staff?

☐ Extremely satisfied
☐ Very satisfied
☐ Somewhat satisfied
☐ Somewhat dissatisfied
☐ Very dissatisfied
☐ Extremely dissatisfied

2. How satisfied are you with the service you received from «DrSurgeon» in the appointment on «ApptDate»?

☐ Extremely satisfied
☐ Very satisfied
☐ Somewhat satisfied
☐ Somewhat dissatisfied
☐ Very dissatisfied
☐ Extremely dissatisfied

3. I feel I benefited from my appointment with «DrSurgeon».

☐ Yes ☐ No

4. The appointment made me feel better informed about the condition for which I was referred.

☐ Yes ☐ No

5. Because of the appointment, I am doing something different now to improve my health.

☐ Yes ☐ No

6. How satisfied are you with your **overall experience** with Operation Access?

☐ Extremely satisfied
☐ Very satisfied
☐ Somewhat satisfied
☐ Somewhat dissatisfied
☐ Very dissatisfied
☐ Extremely dissatisfied

Patient ID:«PatientIntakeID», «County», «Hospital», «DrSurgeon»

Do you have any suggestions for how we can improve our services? Do you have anything else you would like to share with Operation Access?

Do you authorize Operation Access to share your comments and name with its stakeholders and/or the media? Sign below if yes.

- ☐ **Comments ok, no name**
- ☐ **Comments and name ok**
- ☐ **Consent not given**

I give my authorization and consent for my comments and name to be disclosed in marketing materials and communications with volunteers, donors, the press, and other contacts of the organization.

I further acknowledge that I have no right of approval, no claim to compensation, and no legal claim against Operation Access (including, without limitation, claims based upon invasion of privacy, defamation, or right of publicity) arising out of any use of my statements.

I have read and I understand this Authorization and Consent and sign it of my own free will.

Signature: _____ Date: _____

Printed Name: _____

Fighting Cancer ... *Right Here. Right Now.*

CANCER COALITION of SOUTH GEORGIA

Community Cancer Screening Program™

What is Colorectal Cancer?

Colorectal cancer is cancer that occurs in the colon or rectum. The colon is the large intestine or large bowel. The rectum is the passageway that connects the colon to the anus.

Who Develops Colorectal Cancer?

- **Both men and women can develop colorectal cancer.**
- **It is most often found in people 50 years and older.**
- **The chance of cancer increases as you get older.**

Colorectal cancer is the 3rd most commonly diagnosed cancer in Georgia and the 2nd leading cause of cancer death for both men and women - but it doesn't have to be that way.

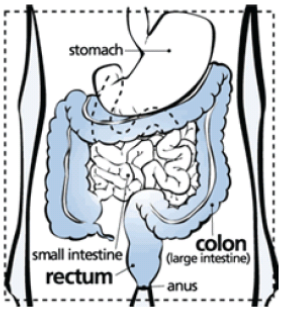
If men and women 50 years and older had regular check-ups, at least 60% of these deaths would not occur.

So if you are 50 or older, start getting your colorectal cancer check-ups now.

What Kinds of Check-Ups Are There?

There are different ways to get checked. One way involves using a home-based stool sample kit. Another test is called a colonoscopy. Your doctor will tell you which test is best for you.

Colon Polyp



What is a Colonoscopy?
A colonoscopy is a test in which the doctor uses a long, thin, flexible, lighted tube to check for polyps or cancer in the rectum and colon.
During the test, the doctor can find and remove most polyps and some cancers.

02212014

Are You At Higher Risk?

Anyone can develop colorectal cancer. However, there are some things that may increase your chances. Having one or more of the factors listed below does not mean that you will definitely develop colorectal cancer.

- Having a personal or family history of colorectal cancer or polyps
- Being 50 years and older
- Being African American or Jewish of Eastern European descent
- Having Type 2 diabetes
- Not getting regular exercise
- Being very overweight
- Smoking for many years
- Drinking alcohol heavily (men: more than 2 drinks a day and women: more than 1 drink a day)
- Having inflammatory bowel disease, including ulcerative colitis and Crohn's disease
- Having certain inherited family health issues

People at high risk for colorectal cancer may need to get tested earlier or more often than other people. Talk with your doctor about your cancer tests.

Remember:
Colorectal cancer can start without any symptoms!

Screening Saves Lives

If you're 50 years or older, getting a colorectal cancer screening test could save your life.

Here's How:

- Colorectal cancer usually starts from polyps in the colon or rectum. A polyp is a growth that shouldn't be there.
- Over time, some polyps can turn into cancer.
- Screening tests can find polyps so they can be removed ***before*** they turn into cancer.
- Screening tests can also find colorectal cancer early. When it is found early, there is a good chance that it can be cured.

The Bottom Line

If you're 50 years or older, talk with your doctor about getting checked for colorectal cancer. Also, be sure to ask your doctor whether you need any other cancer tests.

Early Detection is Your Best Protection!

For more information about the
Community Cancer Screening Program™
call **229-312-1700**

For more information on colorectal cancer screening
visit www.cdc.gov/screenforlife
or call **1-800-CDC-INFO (1-800-232-4636)**

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