

## **Increasing Preventive Screening in Community Health Centers (CHC):**

### *Focus on Colorectal Cancer Screening*

**June 13<sup>th</sup> – Washington, DC**

#### **I. Background on the Community Health Center Summit**

The National Colorectal Cancer Roundtable (“Roundtable”) has prioritized working with Community Health Centers (CHC) to increase colorectal cancer screening rates in the CHC setting and decrease screening disparities. In 2011 the Roundtable established a task group specifically to address this issue. During the task group’s planning session at the 2011 Roundtable Annual Meeting, participants proposed a thorough examination of colorectal screening in CHCs. Thought leaders from CHCs, the colorectal cancer world, health systems, and governments would be asked to determine how leaders might work together to improve screening rates.

A confluence of factors made this effort extraordinarily well timed. In early 2012, the Health Resources and Services Administration (HRSA) began requiring CHCs to track and report colorectal cancer screening rates in the Uniform Data System (UDS). The UDS is HRSA’s core tracking system for reviewing the operation and performance of health centers.

Simultaneously, experts began encouraging CHCs to become recognized as patient-centered medical homes (PCMH). CHCs are going through a period of major transformation, experiencing significant growth, and installing new systems at a time when the new UDS requirements are motivating them to improve the delivery of quality colorectal cancer screening. These factors constitute an ideal opportunity to influence the delivery of colorectal cancer screening in the community health center setting.

The purpose of the Summit was to create a strategy for integrating colorectal cancer screening into the community health center setting that would assist CHCs in adopting an effective and efficient screening program. Lessons learned from the Summit could also be leveraged to improve other preventive services in the CHC setting by using colorectal cancer screening as an example.

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A fourteen-member planning committee worked together over the course of four months to prepare for the Summit and identify strategic discussion topics. The committee was instrumental in setting the stage for the session.

Summit goals as defined by the planning committee were as follows:

1. Examine the opportunities and barriers related to delivering quality cancer screening and follow-up care in the community health center setting, using colorectal cancer screening as an example.
2. Begin to refine a strategic plan that can be used as a model for the delivery of effective, efficient cancer screening in community health centers.

The plan should include:

- Integrating with existing structures
  - Aligning resources in the public and private spheres
  - Strengthening channels of communication
  - Working across goals and agencies
3. Examine the existing tools that support cancer screening in practice and identify dissemination strategies and additional needs.

In tandem with the CHC Summit, Alan Balch of the Preventive Health Partnership, led a separate meeting the day before the Summit with NACHC leadership and technical staff on The Guidelines Advantage (TGA), a data-mining software program for quality improvement developed through a partnership between the American Cancer Society, the American Heart Association and the American Diabetes Association. The outcome of this meeting was an agreement to investigate a potential pilot study of TGA in a few select CHC networks and to discuss possible joint research opportunities.

## **II. Overview of Community Health Centers**

There are over 8,000 health centers around the country serving approximately twenty million people. The different types of health centers, consolidated through legislation,

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include the following: community centers, migrant health centers, healthcare for the homeless centers, and primary care in public housing centers.

Community health centers are funded under Section 330 of the Public Health Service Act. In general, federal grants account for 17 to 18 percent of a health center’s budget, while Medicaid comprises 38 to 39 percent of the overall budget, with the balance of funding coming from other grants, state and local indigent care programs, Medicare, and in some instances commercial insurers. CHCs are led by community boards and by statute, not less than 51% of board members must be patients of the health center. To improve access, CHCs are required by law to be located in or adjacent to medically underserved areas.

Nationwide, sixty-seven percent of those served in CHCs are members of racial and ethnic minority groups. The services provided include primary care, pediatrics, OB/GYN, and dental care, as well as diagnostic and laboratory services. CHCs typically have minimal laboratory services on site and some may or may not have radiology services.

Following is a table summarizing the case studies on colorectal cancer screening programs that were shared during the Summit. A brief description of the program and key lessons learned are presented.

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**III. Community Health Center Case Studies**

Presentation	Program	Key Messages
<p><u>Collaboration Between Community Health Centers and the Cancer Coalition of South Georgia</u> Dr. Jim Hotz, National Association of Community Health Centers</p>	<p>This case study described the importance of collaboration among healthcare providers and the incorporation of professional navigation services to reduce cancer-related disparities in rural South Georgia.</p>	<p><u>Lessons Learned</u></p> <ul style="list-style-type: none"> <li>- Acting in isolation and using practice management tools alone, the CHC could not reach its screening goals</li> <li>- A neutral, committed process that included coordinating cancer care, partnership development, patient recruitment, and evaluation was needed</li> <li>- Resources were necessary to employ a Health Navigator to provide patient-centered assistance in overcoming barriers to screening</li> <li>- A commitment from local healthcare providers (hospital, specialists, lab) to provide service regardless of a patient’s ability to pay was critical</li> <li>- Defining a finite number of colonoscopies needed can help GIs commit to delivering a limited number of low- or no- cost colonoscopy; as an added incentive, CHCs can also refer Medicare patients for colonoscopy</li> </ul>
<p><u>Increasing Colorectal Cancer Screening in North Carolina Community Health Centers</u> Dr. Catherine Rohweder, North Carolina TraCS Institute</p>	<p>This case study addressed the extent of office systems’ changes, the costs of integrating and maintaining those changes, and the resulting change in screening rates when North Carolina CHCs worked with the CHC-focused version of the NCCRT’s colorectal screening toolkit and an outreach</p>	<p><u>Lessons Learned</u></p> <ul style="list-style-type: none"> <li>- Chart audits, in combination with staff reports, are helpful in identifying areas of need</li> <li>- Clinics are more open to engaging if quality improvement coordinators are viewed as assisting rather than evaluating or judging</li> <li>- Sites need to be encouraged to take ownership and help execute project plans</li> </ul>

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Presentation	Program	Key Messages
	specialist.	<ul style="list-style-type: none"> <li>- Start with products that are already tailored to CHCs</li> <li>- Research team should invest first by providing initial incentives such as complimentary Fecal Occult Blood Tests (FOBT) or Fecal Immunochemical Tests (FIT) and financial support</li> </ul>
<p><u>The New Hampshire Colorectal Cancer Screening Program</u> Dr. Lynn Butterly, Dartmouth-Hitchcock Medical Center</p>	<p>This case study described the New Hampshire Colorectal Cancer Screening Program, which is funded by the Centers for Disease Control and Prevention. The study addressed the program’s strategies to increase colorectal cancer (CRC) screening statewide, which included practices for increasing referrals for screening, education interventions, and cultivating partnerships and collaboration.</p>	<p><u>Lessons Learned</u></p> <ul style="list-style-type: none"> <li>- Implement evidence-based strategies, including appropriate screening strategies, education interventions, interventions to address barriers, and tracking screening rates</li> <li>- Establish shared responsibility and communication between endoscopists and primary care providers</li> <li>- Maximize partnerships and collaboration</li> <li>- Utilize internal champions</li> <li>- Use patient navigators to reduce no show rates and improve long term relationships with GIs</li> </ul>
<p><u>The Colorado Cancer Screening Program</u> Dr. Holly Wolf, University of Colorado</p>	<p>This case study described the CDC-funded Colorado Colorectal Cancer Screening Program, which is a partnership between the community clinics and the coordinating center at the University of Colorado.</p>	<p><u>Lessons Learned</u></p> <ul style="list-style-type: none"> <li>- The development of partnerships with specialty providers, both on the screening and treatment sides, was critical</li> <li>- Patient navigation in the primary care setting was a substantial benefit to the program</li> <li>- Embedding the whole screening process within the existing health care system was valuable</li> <li>- Establish an organized program with baseline screening rates, policies, outreach to eligible</li> </ul>

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Presentation	Program	Key Messages
<p><u>Colorectal Cancer Screening: Reaching Culturally and Linguistically Diverse Patients</u></p> <p>Dr. Shin-Ping Tu, Cancer Prevention and Control Research Network (CPCRN), Seattle, WA</p>	<p>This case study described the integration of CRC screening into existing CHC systems and the adaptation of interventions for other cultural and linguistic groups to enhance effectiveness and reach.</p>	<p>populations, tracking, and evaluation</p> <p><u>Lessons Learned</u></p> <ul style="list-style-type: none"> <li>- Successes included the following: 1) achieved adaption; 2) developed close partnerships; 3) broadened reach; 4) had a clinic-wide impact</li> <li>- Challenges included the following: 1) staff turnover; 2) challenges using electronic medical records; 3) resource limitations</li> </ul>
<p><u>The Health Literacy and Cancer Screening Project</u></p> <p>Dr. Terry Davis, Louisiana State University Health Sciences Center in Shreveport</p>	<p>This case study described a randomized controlled trial that tested a health literacy intervention designed to increase initial and regular CRC screenings in FQHCs in Northern Louisiana. A secondary aim was to explore patient, provider, and system factors that facilitate or impede screening.</p>	<p><u>Lessons Learned</u></p> <ul style="list-style-type: none"> <li>- Including providers and patients in development of materials is essential</li> <li>- Clinic-wide CRC in-service and study orientation helps inform and enlist all staff</li> <li>- Giving recommendation and the test before the primary care visit is feasible and well received by providers and patients</li> <li>- Simplified information with FOBT demonstration and teach back improves initial screening</li> <li>- Nurse follow-up call to motivate and problem-solve FOBT completion effective but costly</li> <li>- More robust strategies are needed to sustain screening</li> </ul>

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#### **IV. Strategic Framework for Delivery of CRC Screening in CHCs**

In conjunction with the Summit, the Roundtable commissioned a team from Thomas Jefferson University to draft a strategy document that will provide guidance to organization interested in assisting CHCs with their efforts to increase colorectal cancer screening rates. Participants reviewed the paper prior to the meeting and agreed that it was well organized, comprehensive, and balanced between research and practice.

Participants further noted that the paper provided a good opening context with respect to colorectal cancer screening rates, challenges, and opportunities in Federally Qualified Health Centers (FQHCs) and the transformation currently taking place in health centers. Other topics that participants noted were well addressed included the following: 1) the overview of the patient-centered medical home; 2) identifying and managing populations; 3) practice improvement strategies; 4) linkages to the health care system; and 5) the collaborative approach to practice improvement.

During the Summit, participants discussed additional topic areas related to the paper. Recommendations were made regarding the paper's approach, implementation tools, screening strategies, population management, specialists, patient navigation, literacy, and culture. These recommendations are addressed by topic in the sections that follow.

#### Audience and Approach

The audience for the paper is intended to be organizations currently working with community health centers on cancer screening issues (NACHC, CDC, ACS, NCCRT, HRSA, CoC, GI professional societies and others). The paper will focus on strategies for these organizations to pursue and assist in the delivery of effective, efficient colorectal cancer screening in CHCs. The paper will also make important connections to broader preventive services.

The paper will be disseminated and promoted by NACHC and the Roundtable. It will serve as a call to action regarding what these and other collaborating organizations intend to make happen. Working in concert, NACHC and NCCRT have the infrastructure to facilitate

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implementation of next steps and can play a critical role as conveners and coordinators. Other partnering organizations can take the lead, according to their strengths, to carry out key strategies.

#### CRC Resources and Tools

Community health centers need action steps and tools they can implement immediately. Demonstrating the connection between the concepts in the strategy paper and available resources and tools is critical. *Options for Increasing Colorectal Cancer Screening Rates in Community Health Centers* offers recommendations and tools to help CHCs improve screening rates. The Roundtable has additional resources related to screening, including a clinician's guide to FOBTs and FITs, a guide to assess patient risk, recommendations for setting an office policy, a screening algorithm, audit and tracking sheets, and patient reminder letters and postcards. The Roundtable has capacity and resources to work with NACHC and other organizations on the development of new tools, as needed. Attendees did underscore the need for a practical guide to assist health centers in increasing CRC screening

Language and cultural barriers are also important to address if screening rates are to improve. Tools noted by participants include the following: a YouTube colonoscopy prep video, *The Guide to Community Preventive Services*, and MIYO—a web-based system to create customized, culturally appropriate patient education materials for cancer screening and other health issues.

CHCs need easy access to links and tools on multiple sites. The NACHC, the Roundtable and their partners can organize and facilitate the dissemination of tools and resources and can provide additional support to CHCs through webinars, conference calls, and peer-to-peer interactions.

#### CRC Screening Strategies

Defining a screening policy appropriate to the populations being served, including what screening tests are going to be used, is an essential first step. Providing guidance to health centers on how to establish this policy based on their site-specific resources and capabilities will

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determine many of the additional next steps for a practice to ensure implementation of a high-quality screening program.

There are benefits and drawbacks to designing CRC screening programs around both stool-based tests and colonoscopies as the test of choice. Health Centers need to take into account their own resources, population needs, capacity issues and potential adherence issues, as they design their screening program. There are excellent examples of systems-based approaches where very high screening levels have been achieved using both annual stool blood testing and screening colonoscopy. The Roundtable has made it a priority to ensure that clinicians understand the strong evidence base supporting quality stool-based and has resources to inform clinicians that underscore the valuable role that stool-based testing can play in quality CRC screening delivery.

#### Population Management and Registries

HRSA now requires community health centers to track and report colorectal cancer screening rates in the Uniform Data System (UDS). This is the first year that many health centers will collect data, and they will need to establish effective protocols. While eighty percent of FQHCs use electronic medical records, they may or may not have the functional capacity to track all steps in the CRC screening process.

The need for electronic record systems with a quick search entry format is clear. However, if such functionality is not included at the beginning, the IT costs for adding it may be a barrier, as many CHCs are under-resourced.

CHCs cannot accurately track and measure their screening rates if they do not know who in their population has been screened. The entire information chain of screening and results must be standardized. A patient may be screened with stool blood test and tracked internally, or referred to another provider for screening with other tests, typically colonoscopy. The CHC must record the test or the referral, and have a mechanism in place to retrieve the screening results.

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CHCs need support regarding the use of registries for quality improvement purposes. CHCs require information on what registries are available and what types of output reports are available. Once a CHC has a report in hand, they may require guidance on how to interpret and use the data.

#### Referrals to Specialists

Each region or state needs a champion gastroenterologist or surgeon who can galvanize other endoscopists and enlist their support for partnering with CHCs. CDC grantees, for example, can draw from the gastroenterologists or surgeons on their medical advisory boards. When considering specialists to be engaged, it is also important to include surgeons and pathologists.

The case studies presented demonstrate that there are people with the knowledge, experience, and tools to assess the availability colonoscopy resources in their area and establish agreements to provide services. CHCs can look to examples of excellent referral processes in New Hampshire and New York. CHCs need additional information on the specific steps to enlist the support of hospitals and specialists and address the challenges of referring patients when malignancies are found. The case studies from New Hampshire and Albany, GA may be able to serve as models for ways to develop productive relationships with GIs and other parts of the health system.

#### Patient Navigation

There is evidence that patient navigation increases screening rates, and some form of navigation is necessary to achieve optimal program outcomes. Dedicated staff (community health workers/lay health advisors/navigators) can help patients overcome cultural, social, and economic barriers to care. In the CHC setting, this person acts as a health coach, has a varied day, and has to manage the day-to-day realities in a CHC. How do CHCs find these people, train them, pay them, sustain them, and maintain quality? Patient navigation models exist; for example, the ACS and the National Cancer Institute have navigation programs.

#### Literacy, Language, and Cultural Barriers

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We know the biggest potential for compliance with screening lies with the provider making the recommendation for screening. However, attention to literacy, language, and cultural barriers are also critical.

As demonstrated in Dr. Terry Davis' case study, maintaining focus on what patients need to know and what they need to do is essential. Providers should use everyday language rather than medical jargon, be positive and stress the benefits of the test, and limit information to three to five key points. In addition, providers can demonstrate what the patient needs to do, use teaching tools, and ask patients to teach-back to confirm their understanding.

#### Policy Issues for Future Consideration

- Consider sharing case studies with Area Health Education Centers (AHECs) and thereby perhaps influence their implementation strategies.
- Are there ways to begin leveraging Medicaid programs and Medicaid data to determine what is happening with those people and how we can feed some of those people into the community health care system?
- Create linkages to CDC Comprehensive Cancer Control (CCC) programs. There are 69 CCC coalitions nationwide that have both state and local level implementation strategies.
- Need to prepare for the impact of the Affordable Care Act, including what issues and which populations will not be addressed.
- Define roles of various Summit partners in order to create a unified strategy to increase CRC screening.

The Roundtable's Summit on Community Health Centers led to a fruitful discussion on best practices for implementing colorectal cancer screening programs that will serve a culturally and socioeconomically diverse population. After a review of relevant case studies that demonstrate the successes and challenges of various programs, the Roundtable has compiled strategic suggestions and lessons learned that can be applied in CHCs across the country. With these

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tools in hand, CHCs and their advocates should be able to take advantage of the current opportunity for increasing screening services efficiently and with care. The next section will review the Roundtable's vision of appropriate next steps for continuing to facilitate the implementation of CRC screening in CHCs.

#### **Next Steps**

1. Modify the pre-meeting paper based on the meeting discussions to create a strategy document outlining the challenges to screening, highlighting successful programs and processes as case studies, and recommending ways in which the American Cancer Society, the Roundtable, CDC, Commission on Cancer hospitals, the national GI professional societies, HRSA, NACHC, and other organizations can assist health centers in achieving their cancer-screening goals.
2. Provide practical, educational resources for health center clinicians and staff (i.e. webinars, PowerPoint presentations and links to existing tools, and resources such as the CRC Toolbox for CHCs or the one-page guide to FOBTs and FITs for clinicians).
3. Develop an inventory of existing patient materials that address non-English speaking and low literacy patients.
4. Work with the National Association of Community Health Centers (NACHC) and state Primary Care Associations to disseminate existing tools and resources and present findings from the summit.
5. Create guidance, recommendations and new tools where necessary. Identified topics include: a) recommendations on developing relationships with local specialists, endoscopy centers, and hospitals to provide follow-up care; and b) guidance for establishing navigators and/or community health workers.
6. Explore the potential for the American Cancer Society or the Roundtable to serve as the convener to assist in developing local relationships among care systems and providers.
7. Investigate a potential pilot study of TGA in a few select CHC networks and to discuss possible joint research opportunities.

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