Quick Guide to Planning and Implementing Selected Activities to Increase Breast, Cervical, and Colorectal Cancer Screening

National Breast and Cervical Cancer Early Detection Program
Colorectal Cancer Control Program

Centers for Disease Control and Prevention

SCREENOUTCANCER
Advancing Cancer Prevention Nationwide

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About This Guide

This guide was developed to support awardees and partners of CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and Colorectal Cancer Control Program (CRCCP), who conduct community-based and health system interventions to improve cancer outcomes. The guide begins with an overview of steps involved in selecting and implementing *any* of the selected activities. It goes on to describe critical elements, key concepts, and resource needs to inform planning, implementation, monitoring, and evaluation for *each* activity.

The activities included are some of those contained in CDC's frameworks for implementing NBCCEDP and CRCCP. Awardees identified these activities as areas where more technical assistance is needed.

Activities include:

- Partnering for health systems change.
- Community health worker programs.
- Patient navigation.
- Evidence-based interventions recommended in the Community Guide:
  - Client reminders.
  - Provider assessment and feedback.
  - Provider reminders.
  - Reducing structural barriers.

Lay the Foundation for Successful Implementation

For each activity, remember:

- **Get to know and engage the intended audience, community, or health system.** Perform a needs assessment and include discussions with stakeholders who will implement the strategy and members of the intended audience. Include stakeholders in assessment and throughout implementation and evaluation to ensure success.

- **Match activities to the identified screening barriers and the needs of the intended audience.** It is critical to determine a strategy's suitability. Learn factors to consider when adapting a strategy to suit the intended audience. For more information, visit www.astho.org/Programs/Access/Community-Health-Needs-Assessments/.

- **Integrate evaluation from the beginning.** Create a logic model to describe your program. This will inform other evaluation planning steps, including formulating evaluation questions and identifying indicators of success and data sources. Remember to allocate resources to monitoring and evaluation and to share findings with stakeholders throughout implementation—not just at summation. Engage outside expertise, if you do not have capacity within your organization. Consider the resources of local universities. For help developing logic models, visit www.cdc.gov/eval/tools/logic_models.html. For more information, visit www.cdc.gov/eval/framework/.

- **Plan for sustainability.** To achieve lasting impact, design activities to continue long-term. Activities like engaging stakeholders for input and buy-in; integrating activities into existing processes; developing and documenting policies and protocols; and attaching responsibilities to roles—instead of individuals—can help to institutionalize activities.

Basic Steps for Selecting and Implementing Activities

Choosing a Strategy

1. Establish your clinic's baseline screening rate.

   - Choose the indicator to use. For example, see indicators from the National Quality Forum (www.qualityforum.org/measures_reports_tools.aspx), Uniform Data System (www.bphc.hrsa.gov/datareporting/reporting/), and Healthcare Effectiveness Data and Information Set (www.ncqa.org/hedis/measures/).

   - Choose a measurement time frame with start and end dates. For NBCCEDP and CRCCP, it is 12 months.

   - Determine the number of patients who are up-to-date with screening, and the total number of patients who are eligible for screening based on their age and sex. Divide the number of patients who are up-to-date by the total number of eligible patients, and multiply the result by 100 to get your baseline screening rate.

     For example, if 3,274 patients were eligible for screening during the selected time frame and 813 were up-to-date with screening, the baseline screening rate is 813 ÷ 3274 = 0.248 × 100 = 24.8%.

   For more details, see CDC's guide to establishing and verifying a baseline clinic screening rates for breast, cervical, and colorectal cancer screenings at www.cdc.gov/cancer/nbccedp/measuring-cancer-screening-rates.htm.

2. Identify which patients are not getting screened and try to determine why.

   - Review your screening data to see if certain groups are less likely to be screened and explore the barriers they may encounter.

   - Map your screening process and assess where breakdowns may be occurring. For example:
     - Do providers and staff members know which patients are due for screening?
     - Are providers and staff members knowledgeable about cancer screening recommendations?
     - Do patients believe that cancer screening is important to their health?
     - For mammograms and colonoscopies, are patients referred to specialists and are they keeping their scheduled appointments? For stool test kits, are patients receiving the tests, completing the tests when received, and returning the screening tests? If not, why?
     - Are providers available to do colposcopies, mammograms, or diagnostic colonoscopies?

3. From the Community Guide (www.thecommunityguide.org/topic/cancer), choose one or more activities that address barriers to screening. Match activities to your patient population and setting and include stakeholders in the selection process.

Before Implementation

1. Engage staff members.

   - Identify one or two staff members who are particularly dedicated to increasing cancer screening and early detection. They will help lead your efforts and are called *champions.*

- To gain buy-in, invite input from everyone who will play a role in your activities.
- Ask clinic leadership to publicly endorse the importance of screening and the improvement activities.

2. Set a target screening rate.

Engage staff members, providers, and other stakeholders to set a realistic and attainable goal. For example, *By July 2020, increase our clinic's colorectal cancer screening rate from 35% to 40%*.

3. Create a workflow that includes the selected activities.

- Update your process map to include the steps required to implement the activities you chose.

- Conduct brief Plan-Do-Study-Act cycles of the new processes. For example, test a new approach for flagging patients with one provider for a week, so you can see how well it works and refine the process as needed.

- Finalize your process map and develop a plan for full-scale implementation.

4. With input from staff members, develop a plan for monitoring and evaluation.

- Identify measures that will allow you to determine if the new processes are implemented as intended. Specify who will collect the process measures and how and when they will do so.

- Outcome measures include the screening completion rate, with special attention on groups identified as having low rates.

    For more details, see CDC's Framework for Program Evaluation at www.cdc.gov/eval/framework/.

5. Train providers and staff members on the new processes and workflows.

- Clarify roles and responsibilities.
- Identify people who will answer questions about the new processes.
- Explain how the processes will be monitored to evaluate success.

Implementation

1. Execute your implementation plan.

- Communicate the start date to all providers and staff members.
- Keep everyone engaged by providing progress reports regularly.

2. Monitor and adjust.

- Monitor process measures from the beginning.

- When process measures indicate problems, assess and address their cause. Test any process changes quickly before full-scale implementation.

- Document process changes and inform providers and staff members.

3. Plan for sustainability and maintenance.

- Include key process and outcome measures into your clinic's quality monitoring plan.
- Establish protocols as part of your office policy.
- Maintain adequate staff members and resources to support the new processes.

Monitor and adjust activities to fit changes in the health system, such as new staff members and changes in the availability of specialists. Be flexible and adapt as needed.

Resources

- Guide for Measuring Cancer Screening Rates in Health System Clinics (CDC) www.cdc.gov/cancer/crccp/guidance_measuring_crc_screening_rates.htm Guidance for measuring baseline and annual breast, cervical, and colorectal cancer screening rates in participating health system clinics.

- Putting Public Health Evidence in Action Training Workshop. Cancer Prevention and Control Research Network. www.cpcrn.org/training

Partnering for Health Systems Change

Partnering for health systems change involves developing relationships with organizations that deliver health care—hospitals, clinics, health maintenance organizations (HMOs), and community health centers—with the goal of making lasting changes. In this case, the goal of partnership efforts is to improve cancer screening for patients in these health care systems.

Before You Start

- Know the status of previous and existing relationships with the partner.
- Establish a common goal.
- Define your role and your partner's role, including resource commitments.
- Make sure your partner is committed to working together over a sustained period.

Budgeting Staff, Time, and Money

Partnership is "people" work. Assemble a team with good communication skills, knowledge of health systems, and expertise in technical areas that support EBI implementation and evaluation (e.g., workflows, EHR, quality improvement). Budget to hire contractors for technical expertise beyond your internal team capacity (e.g., EHR). Allocate time to establish and maintain partnerships, make site visits, conduct training, and evaluate, as well as time to routinely assess and improve implementation.

Funds may also support direct assistance to health systems efforts. These resources should be short-term, since the goal is to work with health systems to implement sustainable change. Work with health systems to determine the level of financial assistance needed to get started; for example, staff members' time and the cost of electronic health record overlay. Be clear about the conditions of funding, including when it will end, and expectation that they plan for continuing without it.

Deeper Dive into Implementation

Convene Key Stakeholders and Identify Potential Health System Partners

1. Invite a small group of key community stakeholders to help you identify health system partners in your area. Stakeholders could include the cancer control coalition in your state, tribe, or territory; the American Cancer Society; and large employers or medical professional organizations, such as a primary care association.

2. Identify health systems in your area. Consider partners such as federally qualified health centers, physician groups, local health departments, and community-based organizations.

3. Determine the cancer screening rate for each health system clinic and identify those that could benefit most from your support. For example, which systems could:

   - Improve their cancer data-tracking methods most?
   - Improve their cancer screening rates most?
   - Benefit from using reminder systems for providers, patients, or both?
   - Benefit from creating or enhancing clinic workflows and policies for cancer screening?
   - Most likely improve cancer screening rates because of their reach in the community?
   - Have the biggest impact on improving health equity due to the populations they serve?

4. Find out if any key stakeholder has worked on a successful project in the past with any of the health systems identified. If so, leverage the pre-existing relationship to get started more quickly.

5. Identify health systems that are ready and eager to partner.

6. Make a list of priority health systems to contact.

Educate Health System Partners about the Need to Increase Cancer Screening Rates

1. Identify a champion within the health system—someone who has a relationship with you or other key stakeholders and who can make decisions or influence the decision-makers within the health organization.

2. Appeal to their interest in improving health and business outcomes by improving their cancer screening rates. Link to their existing quality improvement programs and other activities.

3. Help health systems collect and analyze data to find out how they are doing with their cancer screening rates.

| Problems and Solutions: Working with Health Systems to Collect Data ||
PROBLEM	SOLUTION
EHR data to determine baseline screening rates are not readily available.	• Conduct manual chart review to determine baseline screening rates. • Follow instructions for conducting chart review outlined in the CDC's *Guide for Measuring Cancer Screening Rates in Health System Clinics*.
Health system leaders or decision makers are not comfortable sharing CDC-required data with you.	• Explain that CDC does <u>not</u> require health systems to report personally identifiable information. • Describe the data that *are* collected (e.g., clinic characteristics, EBI implementation, clinic-level screening rates). • Discuss the importance of collecting data to document the work they are doing and the progress they make in improving screening rates.
EHR baseline screening rate data are flawed or incomplete.	• Conduct manual chart review to determine baseline screening rates. Follow instructions for conducting chart review outlined in CDC's *Guide for Measuring Cancer Screening Rates in Health System Clinics*. • Conduct an assessment of the EHR to identify problems (e.g., improper data entry, colonoscopy reports not received, reporting FIT tests distributed as FIT tests completed). • Provide support for addressing assessment results (e.g., training providers on proper data entry, developing protocol to receive colonoscopy reports and enter data correctly in EHR, developing appropriate data queries to calculate numerator and denominator for screening rate calculation)

4. Educate health systems on ways to improve their screening rates, such as:

- Using reminder and recall systems for health care providers and electronic medical records to improve the delivery of cancer screening services.

- Following evidence-based recommendations for cancer screening.

- Promoting practice-based system changes to increase primary care referrals for cancer screening.

- Promoting the use of assessment and feedback for health care providers to improve the delivery of cancer screening services.

- Offering and promoting alternative clinic hours.

- Simplifying administrative procedures.

Develop an Action Plan with Your Partner

1. Identify a goal, such as increasing the partner's cancer screening rate by a certain percentage.

2. Choose an evidence-based strategy. Help your health system partner choose the best strategy to use.

3. Identify methods, processes, and programs you can build on. For example, if your partner has a patient reminder system for mammograms, can a colon cancer screening reminder be added?

4. Determine how progress will be tracked. Decide what data will be collected, how, and how often; the reporting methods you will use; and who will receive the information.

5. Implement the action plan.

Monitor and Adjust

- Assess your relationship with the health system partner.
- Assess your partner's progress on improving cancer screening rates.
- Discuss progress. Address challenges. Build on strengths.
- Share and celebrate successes.

Sustain

Implement activities that meet identified needs. When this is done in ways that are acceptable to stakeholders and the activities are integrated into current practices and systems, they are more likely to continue. Continue the relationship by identifying additional activities that are needed or by expanding into more clinics.

If you plan to provide short-term funding to the health system, discussions about sustainability should take place prior to award. You should have a written agreement about the amount and duration of funds and plans for how the health system will continue efforts after funding ends.

Resources

- Guide for Measuring Cancer Screening Rates in Health System Clinics (CDC)
  www.cdc.gov/cancer/crccp/guidance_measuring_crc_screening_rates.htm
  Guidance for measuring baseline and annual breast, cervical, and colorectal cancer screening rates in participating health system clinics.

- Increasing Colorectal Cancer Screening and Promoting Screening Quality: An Action Guide for Engaging Employers and Professional Medical Organizations (CDC)
  www.cdc.gov/cancer/crccp/pdf/employersguidefinal.pdf (PDF-6.1MB)
  Helps CRCCP awardees work with specific types of partners to promote policies, programs, and practices to increase colorectal cancer screening rates and promote high-quality screening services at the community level.

- A Guide to Facilitating Health Systems Change (CDC)
  www.cdc.gov/dhdsp/programs/spha/guide_facilitating_hs_change.htm
  Helps states facilitate changes in health care systems to improve prevention and management of heart disease and stroke and their risk factors.

- Colorectal Cancer Screening Best Practices Handbook for Health Plans (National Colorectal Cancer Roundtable)
  https://nccrt.org/resource/handbook-health-plans/
  Best practices, case studies, templates, and tools to help health plans prevent more cancers.

- Manual of Intervention Strategies to Increase Mammography Screening Rates (CDC and The Prudential Center for Health Care Research)
  www.cdc.gov/cancer/nbccedp/pdf/pruguide.pdf (PDF-613KB)

Community Health Worker Programs

Community health workers (CHWs) create or strengthen connections between health care providers, community organizations, and public health agencies to improve patients' access to preventive and chronic care services. As members of the community they serve, they have unique credibility. CHWs build individual and community capacity to improve health outcomes by increasing health knowledge and self-sufficiency through activities such as outreach, community education, informal counseling, social support, and advocacy. CHWs are also known as community health advisors, outreach workers, community health representatives, or *promotores*.

Before You Start

- Gain community support and provider buy-in for the program.
- Make sure cancer screening and treatment services are available.
- Determine how to integrate the CHWs into the health care team.
- Identify who will supervise the CHWs.
- Partner with CHWs to identify community resources to address common barriers to screening, such as transportation and child care.
- Make a list of social service resources to support referrals for other patient issues that may surface, such as housing.
- Identify and collaborate with other chronic disease and public health programs that link people in the community to clinical services.

Budgeting Staff, Time, and Money

Resource needs to establish and implement a CHW program will vary depending on your implementation model. Consider the following items across models.

- Invest staff and time to establish the program infrastructure (policies, guidelines, supervision, and job descriptions); recruit, train, and manage CHWs; and ensure adherence to policies and guidelines.

- Allot enough time for CHWs to conduct outreach and other activities based on your program model. Consider piloting your model to gain a sense of how much time should be allocated.

- Budget for items to support CHW work—like, work space, office equipment, and mobile devices.

- Budget for resources to address patient barriers, if CHWs will conduct navigation activities.

Devote staff, time, and money to evaluation activities that document processes and assess outcomes.

Deeper Dive into Implementation

Engage Stakeholders

- Review the community assessment to identify key gaps, resources, strengths, and challenges. Keep these results in mind throughout the development of your program.

- Use the assessment results to obtain commitments and support for the CHW program from the community and clinical organizations.

- Develop specific objectives and activities for the program with your stakeholders.

Develop Program Infrastructure and Materials

Develop the CHW program infrastructure and all necessary documents and forms to standardize and guide implementation, monitoring, and evaluation. Some key needs include:

- Infrastructure: Policies, guidelines, communication, and record keeping.
- Documents: Job descriptions and training materials.
- Forms: Activity logs and referral sheets.

Recruit and Train CHWs

- Incorporate established CHW competency standards and certification requirements into job descriptions. For more information, visit www.astho.org/Community-Health-Workers/.

- Recruit and hire CHWs based on job descriptions. Some states have certification programs at local community colleges. Others provide state-level training or certification through the health department.

- Implement a standardized CHW training program (many exist). Content for the training should include the evidence-based findings, recommendations, and interventions for the cancer screenings related to your CHW program's focus. Customize it to the communities that you serve. It should also include training on collection of monitoring and evaluation data. For resources and programs, visit www.cdc.gov/dhdsp/programs/spha/chw_training/.

- CHWs need a supervisor who can help them manage the issues that can accompany this highly personal and relationship-driven work; help CHWs establish healthy boundaries and prevent compassion fatigue.

Develop a Monitoring and Evaluation Plan

Develop a plan that will tell you whether the CHW activity led to completed screening.

- Develop a logic model to illustrate how implementation leads to outcomes. Use this model to guide your monitoring and evaluation.

- Evaluate the objectives and activities you identified with your stakeholders, especially completed screenings that result from CHW efforts. Include CHWs in evaluation planning and train to collect data.

- Establish quality assurance measures as the basis for monitoring implementation.

Operationalize and Manage the CHW Program

- CHWs should meet with community and clinical representatives to establish relationships, discuss the program goals and objectives, and develop strategies for working together.

- Be consistent with communications. Adhere to the process you established—when and how CHW communication will occur and with whom (community members, clinical staff members, or program managers). If the process needs to change, document the changes and inform all involved.

- Monitor records such as completed forms, activity logs, contacts, and referrals.

- Implement quality assurance measures (e.g., data tracking, patient confidentiality measures, follow through, and follow up).

- Create opportunities for professional development and training.

Monitor and Adjust

- Monitor implementation of the CHW program (process measures) from the beginning.

- Identify implementation issues such as training, retention, community-clinical linkages, and communication with stakeholders.

- Adjust as needed and document changes in protocol.

Evaluate

- Carry out the evaluation plan.

- Document the number of people who completed screening as a result of CHW contacts and referrals. Calculate the screening rate at least quarterly to monitor trends.

- Share the evaluation results with CHWs and stakeholders to get input on areas that need improvement.

- Document and share promising practices to advance the field.

Sustain

- Explore long-term payment options such as private or public insurance.

- Consider sharing CHW staff members across programs.

- Consider engaging CHW staff members affiliated with community-based programs.

- To increase reach and save on costs, use existing social service resources that can help you address barriers to screening and care.

Resources

- Highlighted Best Practices and Insights from Community Health Worker (CHW) Literature Review (Maine Center for Disease Control and Prevention)
www.mechw.org/docs/resources/rfp/Best%20Practices%20Recommendations%20Lit%20Review%20for%20ME%20CHWI%202_26_2016%20FINAL.pdf (PDF-396KB)

- National Community Health Advisor Study (The University of Arizona)
http://crh.arizona.edu/publications/studies-reports/cha
Provides guidance to policymakers and practitioners on areas that could improve the overall status of the community health advisor field.

- Community Health Worker Resources (Association of State and Territorial Health Officials)
www.astho.org/Community-Health-Workers/
Resources related to financing, certification, and licensure and examples of work in states to support CHWs.

- Promising Approaches to Integrating Community Health Workers into Health Systems: Four Case Studies (Urban Institute)
  www.urban.org/research/publication/promising-approaches-integrating-community-health-workers-health-systems-four-case-studies/view/full_report
  Interventions that illustrate the challenges and opportunities for integrating CHWs into health systems in specific state and local contexts.

- Rural Community Health Workers Toolkit (Rural Health Information Hub)
  www.ruralhealthinfo.org/toolkits/community-health-workers
  Helps you evaluate opportunities for developing a CHW program and provides resources and best practices developed by successful CHW programs.

- Community Health Workers in Rural Settings (Rural Health Information Hub)
  www.ruralhealthinfo.org/topics/community-health-workers/
  An introduction to community health workers and resources.

- Community Health Worker Assessment and Improvement Matrix (United States Agency for International Development [USAID])
  www.who.int/workforcealliance/knowledge/toolkit/CHWAIMToolkit_Revision_Sept13.pdf?ua=1 (PDF-2.4MB)
  Helps ministries, donors, and non-governmental organizations assess and strengthen their community health worker programs.

- Evaluation Toolkit for *Promotor(a) de Salud* Programs (MHP Salud)
  http://mhpsalud.org/wp-content/uploads/2013/11/Evaluation-Toolkit-for-Promotora-Programs.pdf (PDF-1.7MB)
  Recommended for organizations that implement *promotor(a)* or CHW programs and have little or no evaluation experience or limited evaluation resources.

Patient Navigation

Patient navigation is a strategy designed to increase access to timely screening, diagnosis, and treatment of cancer and other chronic diseases by eliminating barriers to care.[1] For cancer screening and early detection, navigation focuses on helping patients overcome personal and health care system barriers to understand and access screening and follow-up.

Patient navigation is often associated with reducing structural barriers. Patient navigation can be part of a comprehensive approach to reducing structural barriers. Examples of potential barriers include:

- Lack of transportation.
- Lack of childcare.
- Lack of knowledge about benefits of screening.
- Language barriers.
- Mistrust of the health care system.
- Fear of the procedure.

To ensure a comprehensive service delivery approach, CDC developed six requirements for implementing patient navigation in our cancer screening programs. They are:

- An assessment of patient barriers.
- Patient education and support.
- Resolution of barriers.
- Patient tracking and follow-up.
- A minimum of two contacts.
- Data collection to evaluate screening outcomes.

Before You Start

Develop Partnerships

- Identify internal and external partners such as clinics and community-based organizations that may have a role in providing services and support, like transportation or other resources to address barriers.

- Enlist the support of partners and involve them in the planning process.

- Identify a key contact in each organization or department.

Budgeting Staff, Time, and Money

Staffing

- Patient navigation staff members should include a supervisor, patient navigators, and staff to answer medical or clinical questions. Staff may be full-time, part-time, contract, or consult as needed.

- Relationship building is central to effective patient navigation. When hiring navigators, look for an effective communication style and other interpersonal skills that are needed for effective patient engagement.

- Consider competencies needed for the navigators based on the range of services they will provide; for example, clinical expertise or fluency in a language.

- Develop a navigator job description. For more information, visit www.cdc.gov/cancer/crccp/pn-replication-manual.htm and https://smhs.gwu.edu/cancercontroltap/resources/advancing-field-cancer-patient-navigation-toolkit-comprehensive-cancer-control.

Budget for:

- Time and resources to hire, train, and supervise navigators.
- Time and staff to assess patient and system barriers to screening.
- Time and staff to develop, implement, and maintain a system to track contacts, patients navigated, and screening adherence and outcomes.
- Time and staff to monitor implementation and provide feedback.
- Time and staff to identify community partners that can share or provide resources,
- Technology needed by navigators
- Resources to address barriers such as bus passes if you do not have a partner to provide transportation.

Deeper Dive into Implementation

Identify Services

Assess the needs of the patient population. You or your partners may have this information already from community needs assessments, clinic surveys, or other sources. Hospitals, in particular, are required to conduct community assessments. You can also engage your own sample of patients and other stakeholders.

If you do not have access to existing data, you can conduct your own community assessment. For more information, visit https://cancercenter.gwu.edu/sites/default/files/coc_navigation_standard_road_map.pdf (PDF-1.2MB).

Services to include will depend on the identified needs of the population and the resources available. Some examples of patient navigation services include:

- Outreach or in-reach to promote screening.
- Assessment of patient and caregiver needs.
- Education about screening.
- Transportation services
- Child or elder care support.
- Language translation services.
- Eligibility determination or payment source identification.
- Paperwork completion.
- Appointment scheduling.
- Resolution of other barriers.
- Education about colorectal screening bowel preparation.
- Appointment reminder calls.
- Patient tracking, including post-screening tracking and follow-up.

Plan the Program Components

Decide:

- The type of navigator that would best fit your model based on patient needs, such as a community health worker, patient navigator, nurse, or social worker.

- If navigation will be delivered in person, by telephone, or online.

- Where navigators will be located: within the health system or centralized within the health department.

- How navigators will be supervised.

Integrate patient navigators into the health care team if they are in a health system or clinic setting.

Develop a Patient Navigation Protocol and Process Manual

The patient navigation protocol and process manual will guide navigators through their daily operations and ensure consistent delivery of navigation services. Important information to include:

- When navigation begins and ends.

- The types of services navigators should offer.

- Clear guidance on the types of activities navigators should perform, and those they should refer to more appropriate staff members such as a clinician or social worker.

- Important resources and contact information, such as transportation and translation services.

Develop a Patient Tracking System

The system should be able to track patients and collect data needed to assess processes and outcomes. Patient records should contain navigation information. The Patient Navigation Barriers and Outcomes Tool (PN-BOT) is an example of a tracking system. Navigation programs can use this tool to document, track, and generate simple reports. For more information, visit https://smhs.gwu.edu/gwci/BarriersTool.

Launch the Program

- Begin offering patient navigation services according to your protocols.
- Plan regular patient navigation staff meetings to review progress and solve problems.
- Provide appropriate support to patient navigators and ensure appropriate supervision.

Monitor and Adjust

- Generate and review reports from the patient tracking system regularly to monitor process and outcomes. Calculate the screening rate at least quarterly to monitor trends.

- Monitor process data and use results for continuous quality improvement.
  - Sample process indicators include priority populations reached, barrier assessment completed, and adherence to navigation protocols.
  - Sample outcome indicators include screening completion rate, rate of patients with adequate preparation for screening (endoscopy), missed appointments, and late cancellations.

  - Consider frequency of data collection—daily, weekly, or another time period? If you wait too long, navigators may forget some services they provided. But aggregating information too often may result in an over-count of patients served.
  - Monitor and provide feedback and support to navigators.

- Adjust the program as needed. Document changes in your patient navigation protocol manual.

Sustain

Sustaining patient navigation typically requires resources to support navigators. Consider additional funding options. Some programs provide seed funding to health systems to support patient navigation initially, with a commitment from the health system to pay for the service after funding ends if it is shown to be successful.

- In some clinics, navigators pay for themselves by saving the health system money by reducing the number of late cancellations and no-shows.

- Potential funding sources include federal grants; private foundations; non-federal grant support; state health departments; academic, institutional, or medical society grants; and private philanthropy. For more information, visit https://nccrt.org/resource/paying-colorectal-cancer-screening-patient-navigation-toolkit/.

Resources

- Guide for Measuring Cancer Screening Rates in Health System Clinics (CDC)
  www.cdc.gov/cancer/crccp/guidance_measuring_crc_screening_rates.htm
- New Hampshire Colorectal Cancer Screening Program Patient Navigation Model Replication Manual (CDC)
  www.cdc.gov/cancer/crccp/pn-replication-manual.htm
- Advancing the Field of Cancer Patient Navigation: A Toolkit for Comprehensive Cancer Control Professionals (GW Cancer Center)
  https://smhs.gwu.edu/cancercontroltap/resources/advancing-field-cancer-patient-navigation-toolkit-comprehensive-cancer-control
- Core Competencies for Non-Clinically Licensed Patient Navigators (GW Cancer Center)
  https://smhs.gwu.edu/cancercontroltap/resources/core-competencies-non-clinically-licensed-patient-navigators
- Executive Training on Navigation and Survivorship (GW Cancer Center)
  https://smhs.gwu.edu/cancercontroltap/resources/executive-training-navigation-and-survivorship
- Guide for Patient Navigators – A Supplement to the Oncology Patient Navigator Training: The Fundamentals (GW Cancer Center)
  https://smhs.gwu.edu/cancercontroltap/resources/guide-patient-navigators-supplement-oncology-patient-navigator-training-fundamentals
- Implementing the Commission on Cancer Standard 3.1 Patient Navigation Process: A Road Map for Comprehensive Cancer Control Professionals and Cancer Program Administrators (GW Cancer Center)
  https://smhs.gwu.edu/cancercontroltap/resources/implementing-commission-cancer-standard-31-patient-navigation-process-road-map
- GW Cancer Center's Online Academy
  http://gwcehp.learnercommunity.com/cancer-institute
- Patient Navigation Barriers and Outcomes Tool (PN-BOT) (GW Cancer Center)
  https://smhs.gwu.edu/gwci/BarriersTool

- Paying for Colorectal Cancer Screening Patient Navigation Toolkit (National Colorectal Cancer Roundtable)
  https://nccrt.org/resource/paying-colorectal-cancer-screening-patient-navigation-toolkit/
- Key Considerations in Designing a Patient Navigation Program for Colorectal Cancer Screening (CDC)
  www.ncbi.nlm.nih.gov/pmc/articles/PMC4618321/

Reference

[1]Freeman HP, Rodriguez RL. History and principles of patient navigation. *Cancer* 2011;117(15 Suppl):3539–3542.
www.ncbi.nlm.nih.gov/pmc/articles/PMC4557777/

Client Reminders

Client reminders are messages to clients informing them that they are due or overdue for a screening service. Client reminders can be delivered as:

- Written messages (a letter, postcard, email, or a message in a health systems' patient portal).
- Telephone messages, such as direct calls to a patient, texts, or automated messages.

Before You Start

- Gain staff members' buy-in and input throughout planning and implementation of the strategy. For example, consider multiple types of reminder systems and get input on the pros and cons of each.

- Choose a mode of communication that is appropriate for the priority population. For example, if phone numbers change often, phone reminders may not be very effective.

- Tailor the client reminder message to your patient population and clinic setting.

- Discuss how you will integrate reminder protocols into daily clinic workflow to avoid creating inefficiencies.

    o Determine if your electronic health record (EHR) system can generate reports on completed screenings, which will be linked to the reminders.

- Update charts to make sure only the correct patients are flagged to receive reminders.

- Create a process to ensure screening tests are recommended according to appropriate intervals, as indicated in U.S. Preventive Services Task Force (USPSTF) screening recommendations for breast,[2] cervical,[3] or colorectal[4] cancer.

Budgeting Staff, Time, and Money

- Allot staffing resources and time to develop the new client reminder system and screening referral protocol, test, train staff, and implement it.

- Funds may be needed for translation services, printing, and mailing. Look into bulk mailing to decrease costs, if necessary.

- Build in time to document and reconcile undeliverable reminders. It will take extra effort to acquire updated contact information for patients.

Deeper Dive into Implementation

Establish Criteria for Reminders

- Establish patient criteria (age, sex, date of last screening, active patient status) for reminders based on USPSTF screening recommendations.

- If you include risk assessment in your process, set criteria for what constitutes average and high risk for the types of cancers you address. This information can be used to tailor the reminders.

Create a Workflow that Includes the Reminder Process

- Ask staff members to assess the current workflow to inform the new system.

- Choose a client reminder method that is best suited for the clinic and its patients. Examples include reminders generated and delivered through an EHR system to a patient portal, automated or live telephone reminders, texts, emails, and printed and mailed reminders.

- Set up the reminder system based on the client reminder method (manual or electronic).

    – Determine how lists of those due for screening will be generated (using manual chart auditing or automated system) and determine parameters for who should be included.

    – Decide who will send the client reminders and how they will be sent. Make sure roles and tasks are defined clearly.

    – Navigators may supplement the reminder system, or they may be the reminder source, if they deliver reminder calls in addition to helping patients overcome screening barriers.

    – Decide if enhanced reminders will be incorporated into the system. *Enhanced reminders* follow the first reminder and provide more information about screening, ways to overcome barriers to screening, and help with scheduling appointments.

    – Decide follow-up and resolution steps for undeliverable reminders.

    – Decide how patient response will be documented.

    – Decide follow-up for scheduled appointments that are missed.

- Develop forms or other tools to help with workflow.

- Train staff on client reminder protocols.

Tailor the Client Reminder (Optional)

Tailor the reminders based on characteristics of the priority population that you identify. The reminder message should indicate that the recipient is due for a specific screening test.

- If you can extract information about risk from the EHR system, you can include this information.

- Try tailoring messages based on gender, ethnicity, language, insurance status, literacy level, and age.[5]

    o Make It Your Own (MIYO) (http://www.miyoworks.org/login/auth) offers messages that can be used for this purpose.

    o Outside vendors may be needed.

Generate the List of Patients Who Should Receive a Reminder

- If you are using a manual chart auditing method, create a list of patients who are due for screening based upon the audit.

- If you are using an automated system, apply eligibility criteria to generate a list of patients who are due for screening through the EHR system.

Send Reminders to Clients Who are Due (or Past Due) for Screening

- Send client reminders manually or through the EHR system if available and effective for the audience.

- Make sure follow-up on the reminder is also done. This might include an enhanced reminder. Set a time frame for its completion.

- Note in patient's file that a reminder was sent.

Schedule and Complete Cancer Screening Tests for Those Who Respond

- Schedule or refer for screening, as appropriate.
- In the patient record, document whether a test was ordered, conducted, or refused.

Monitor and Adjust

Document whether there is an increase in screening compared to the period before you implemented or improved upon your client reminder system. Are clients who received reminders getting screened? Calculate the screening rate at least quarterly to monitor trends.

Use your process measures to monitor implementation of the system from the beginning. Adjust as needed and document changes in protocol.

- Confirm that patients were identified appropriately.

- Identify issues such as information technology, clinic flow, generation of reminders, or training.
  - Make sure client reminders are generated and followed up as intended.
  - Make sure scheduled and completed tests are documented using checklists or electronic entry.
  - If you receive little or no response to reminders, identify patient barriers or the breakdown in the reminder system.

Process Evaluation Questions

- Are clients receiving reminders? Is a mechanism in place to assess delivery?
- Are reminders consistent with screening recommendations?
- Do patients understand the reminders? Do the reminders motivate them to get screened?
- Are patients scheduling and completing recommended screenings?
- What barriers are interfering with successful implementation of the reminder system?
- Be flexible and adapt as needed.

Sustain

- Choose a client reminder method that is best suited for the clinic and integrate reminder protocols into daily clinic workflow to create efficiencies.

- Maintain adequate staff members and resources to support the processes over time. Make sure roles and tasks are defined clearly and documented.

- Track costs and other resources associated with activities to help inform decisions about replication.

Resources

- CDC's guide for establishing and verifying baseline and annual screening rates is available at www.cdc.gov/cancer/crccp/guidance_measuring_crc_screening_rates.htm.

Community Guide Recommendations and Findings

- The Community Guide's systematic review with information specific to client reminders is available at www.ncbi.nlm.nih.gov/pubmed/22704754.
- The Community Guide's systematic reviews of client reminders for specific cancer screenings are available at www.thecommunityguide.org/findings/cancer-screening-client-reminders-breast-cancer, www.thecommunityguide.org/findings/cancer-screening-client-reminders-cervical-cancer, and www.thecommunityguide.org/findings/cancer-screening-client-reminders-colorectal-cancer.

Research-Tested Intervention Programs (RTIPs)

The National Cancer Institute's RTIPs website is a searchable database of evidence-based cancer control programs.

- Programs using client reminders to increase breast cancer screening: http://rtips.cancer.gov/rtips/rtips_search.do?topicid=4&cg=5&choice=cguide

- Programs using client reminders to increase cervical cancer screening; http://rtips.cancer.gov/rtips/rtips_search.do?topicid=5&cg=5&choice=cguide

- Programs using client reminders to increase colorectal cancer screening: http://rtips.cancer.gov/rtips/rtips_search.do?topicid=6&cg=5&choice=cguide

Make It Your Own (MIYO)

A resource for designing products with research-tested messages, available at www.miyoworks.org.

Examples of Reminders

- An example of a mailed letter is available at https://rtips.cancer.gov/rtips/viewProduct.do?viewMode=product&productId=25965553. (PDF-73KB)
- An example of a mailed patient brochure is available at https://rtips.cancer.gov/rtips/viewProduct.do?viewMode=product&productId=292687. (PDF-343KB)
- An example of a telephone script is available at www.cancer.org/content/dam/cancer-org/cancer-control/en/worksheets/fobt-fit-follow-up-phone-script-average-risk-individuals.pdf (PDF-16KB). (PDF-410 KB)
- An example of an automated phone script is available at https://rtips.cancer.gov/rtips/viewProduct.do?viewMode=product&productId=1952668.

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[2]Final Update Summary: Breast Cancer: Screening. U.S. Preventive Services Task Force. February 2018. www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening1

[3]Final Update Summary: Cervical Cancer: Screening. U.S. Preventive Services Task Force. August 2018. www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening2

[4]Final Update Summary: Colorectal Cancer: Screening. U.S. Preventive Services Task Force. June 2016. www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening2

[5]*80% by 2018 Communications Guidebook: Recommended Messaging to Reach the Unscreened.* National Colorectal Cancer Roundtable. 2017. http://nccrt.org/resource/2017-80-2018-communications-guidebook-recommended-messaging-reach-unscreened/

Provider Assessment and Feedback

Provider assessment and feedback evaluates provider performance in recommending screening to eligible patients (assessment), and present providers with information about their performance (feedback). Feedback may describe the performance of a group of providers or an individual provider.

Provider assessment and feedback consists of:

- Collecting data on screening for a defined time-period for one provider or a group of providers. Data can include screening recommendations, distribution of stool test kits, screening referrals, and completed screening tests.

- Synthesizing data in a graphic or report.

- Presenting data to providers in the context of a quality improvement initiative that helps determine barriers and facilitators and develop policies and procedures to increase screening completion.

Before You Start

- Determine current practices, preferences, and policies for how providers recommend and refer eligible patients for screening.

- Get buy-in on increasing screening from staff members and providers and encourage input on the process. Provider buy-in is critically important. Conduct an in-service to describe the strategy. Discuss the basis for assessment.

- Invest in education and tools to help providers increase screening rates.

- Identify a champion to explain the importance and usefulness of provider assessment and feedback and help address provider concerns or lack of enthusiasm.

Budgeting Staff, Time, and Money

- Staff members will be needed to plan and monitor this strategy, particularly to generate feedback reports and communicate with providers.

- Allocate time to educate providers and help them with screening reminders and support, such as chart stickers and continuing education credits.

- You may need to purchase tools to extract screening data from the EHR. Also, budget for costs associated with generating feedback reports.

- If you will use professional education to support this strategy, budget for training.

Deeper Dive into Implementation

Engage Providers, Staff Members, and Leadership

- Include everyone—clinical, administrative, and information technology staff—in development.

- Decide the basis for the assessment. For example:
  - screenings recommended (if this is tracked),
  - stool test kits distributed,
  - screening referrals, and
  - screenings completed.

- Decide with providers how feedback will be shared. Feedback should be provided in a way that is motivating, not demoralizing.
  - Report options
    - de-identified individual provider comparisons
    - individual comparison to clinic or system screening rate or average
    - compare to a standard, such as UDS or HEDIS.
    - clinic to clinic comparisons.
  - Delivery setting
    - group discussion setting
    - one-on-one
  - Results can be shared by
    - organizational leadership
    - quality improvement staff
    - an outside entity

Determine How Assessment Data Will Be Gathered

- If an electronic health record will be used, identify the data elements to query.

- If a manual chart review is needed, develop a chart review tool. For more information, visit www.aafp.org/fpm/2008/0700/pa3.html.

- When your chart review tools and processes are complete, run a pilot test to see how they work. Adjust forms, processes, and allocation of time as needed.

Train Providers and Other Staff Members

- Train staff members on the assessment and feedback process. Specify roles and responsibilities.
- Identify staff members who will answer questions and provide technical assistance.
- Review how the feedback will be delivered.
- Explain the measures that will be monitored and how success will be defined.

Implement the Strategy

- Conduct the assessment using the parameters you chose before implementation.

- Summarize and analyze the results. Make sure the information is complete and presented in a meaningful way that shows clearly how the provider is doing relative to the measure.

- Provide feedback on a regular basis and allot time to discuss ways to improve screening rates.

Provide Tools to Help Providers Improve

- Make sure all providers have a written plan for using the results, including how they can work to improve their screening rate.

- Give providers tools such as screening recommendations, algorithms, flow charts, and decision-making aids, as well as messages they can deliver to encourage patients to be screened.

- Provide prompts such as provider reminders in patients' charts.

- Offer educational opportunities to help providers better understand screening recommendations and ways to increase screening.

- Offer providers other resources to help them better connect with their patients to increase screening rates, such as motivational interview training or posters in the exam rooms.

Monitor and Adjust

- Monitor the process from the beginning.

- Assess implementation, including challenges encountered by staff and the ability to complete the chart reviews or run computer queries in a timely manner.

- Assess the provider feedback process. Simple evaluation questions after a feedback session can help identify challenges, such as:
    - Are the data you received about your screening performance presented in a way that is understandable and helpful? How could it be presented in a more useful way?

    - Do you have unanswered questions about the feedback? If so, what are they?

    - Was the information about how to increase screening rates helpful? Do you need other information or tools to help increase screening among your patients?

- Adjust as needed and document process changes.

- Calculate the screening rate at least quarterly to monitor trends.

Sustain

- Build provider assessment and feedback processes into the practice's routine operations. This may mean including a review of screening rates on the agenda of standing care team or quality improvement meetings or posting screening rates in staff areas.

- Allow time for improvement between assessments.

- If you have an office policy regarding screening, make sure screening eligibility criteria and assessment targets are included.

- Maintain adequate staff members and resources to support the processes over time

- Track costs and other resources associated with activities to help inform decisions about replication.

Resources

- 8 Steps to a Chart Audit for Quality (American Academy of Family Physicians) (www.aafp.org/fpm/2008/0700/pa3.html

- Guide for Measuring Cancer Screening Rates in Health System Clinics (CDC) www.cdc.gov/cancer/crccp/guidance_measuring_crc_screening_rates.htm Guidance for measuring baseline and annual breast, cervical, and colorectal cancer screening rates in participating health system clinics.

- Increasing Colorectal Cancer Screening: An Action Guide for Working with Health Systems (CDC) www.cdc.gov/cancer/crccp/pdf/colorectalactionguide.pdf (PDF-4.6MB)

- How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's Evidence-Based Toolbox and Guide 2008 (National Colorectal Cancer Roundtable) https://nccrt.org/resource/steps-increasing-colorectal-cancer-screening-rates-manual-community-health-centers-2/

- Colorectal Cancer Screening Best Practices: A Handbook for Hospitals and Health Systems (National Colorectal Cancer Roundtable) https://nccrt.org/resource/colorectal-cancer-screening-handbook-for-hospitals-and-health-systems/

Provider Reminders

Reminders, also known as *recalls,* are prompts that tell providers that it's time or past time for a patient to be screened. Reminders can be delivered as flags in patient charts, by email, or as electronic health record alerts.

Before You Start

- Gain buy-in and input from staff members and providers throughout planning and implementation. Consider different kinds of reminder systems and get their input on the pros and cons of each.

- Determine whether your electronic health record system can generate reports on completed screenings. This capability will cue reminders.

Budgeting Staff, Time, and Money

- Resource needs will vary based on the reminder system you choose, and the staff members involved.
- Budget for items to support the reminder system selected.
- Identify needs, such as information technology, flags for charts, training.
- Determine if additional staff or staff time is needed.
- Allot time to design workflows and policies, train implementers, pilot test, and adjust your strategy.

Deeper Dive into Implementation

Create a Reminder Process Workflow

- Ask staff members to assess the current processes and workflow.

- Choose the provider reminder method best suited for the clinic (manual or electronic).

- Identify staff members who will receive and respond to reminders. Make sure roles are clearly defined.

- Train staff members on how to respond to reminders.

- Set up the reminder system.

- Conduct quality assurance checks on the reminder system to make sure the correct patients are flagged. Set protocols for reporting inaccuracies or other problems with the reminders, and for fixing them.

- Determine how providers will order screening tests, and how this will be documented in the patient's record. Will client reminders be generated?

- Establish a quality assurance process to make sure screening tests are ordered and completed as recommended by the U.S. Preventive Services Task Force.
  - Develop checklists, forms, or other tools to document preparation (if applicable), completed screening, and update of the reminder.

Generate the List of Patients Who Should be Screened

Establish criteria for reminders based on USPSTF screening recommendations for breast cancer (www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening1), cervical cancer (www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening2), or colorectal cancer (www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening2).

- If charts will be flagged manually, generate a list of eligible patients who are due for screening and have an upcoming appointment.

- If you are using an automated system, apply eligibility criteria to create electronic flags or to generate a list of patients who are due for screening and have an upcoming appointment.

Alert Providers About Patients Who Are Due or Past Due for Screening

- Make sure providers or other staff members who are responsible for ordering or recommending tests know which patients need to be screened.

- Flagging can be done manually on a paper chart, or electronically with an email alert or a pop-up message. This may be a 1-step process included in generating the list if the EHR has that capability.

- Providers who receive the reminder should recommend or order the screening test, as appropriate, and document in the patient record if the test was recommended, ordered, conducted, or refused.

Monitor and Adjust

- Get input from staff on a monitoring and evaluation plan.
  - Indicators might include appropriate provider responses to the reminders and reminders programmed correctly according to eligibility criteria.
  - The screening completion rate is an outcome indicator.
- Monitor implementation.
- Determine if eligible patients were identified appropriately.
- Make sure alerts are being issued as intended.
- Use a checklist or electronic entry to make sure tests that are conducted or ordered are recorded.
- If there is no response to flags, determine barriers to acting on the prompt.
- Calculate the screening rate at least quarterly to monitor trends.

Process Evaluation Questions

- Are providers receiving reminders?
- Are reminders consistent with screening recommendations?
- Are providers making screening recommendations to their patients?
- Are providers documenting tests ordered in patient records?

Sustain

- Identify issues and adjust as needed; document changes in protocol.
- Share the clinic's screening rates to motivate staff members. See the Provider Assessment and Feedback strategy summary for information on how to apply findings to improve patient care.

Resources

- Guide for Measuring Cancer Screening Rates in Health System Clinics (CDC)
  www.cdc.gov/cancer/nbccedp/measuring-cancer-screening-rates.htm

- Cancer Screening: Provider Reminder and Recall Systems – Breast Cancer (Guide to Community Preventive Services)
  www.thecommunityguide.org/findings/cancer-screening-provider-reminder-and-recall-systems-breast-cancer

- Cancer Screening: Provider Reminder and Recall Systems – Cervical Cancer (Guide to Community Preventive Services)
  www.thecommunityguide.org/findings/cancer-screening-provider-reminder-and-recall-systems-cervical-cancer

- Cancer Screening: Provider Reminder and Recall Systems – Colorectal Cancer (Guide to Community Preventive Services)
  www.thecommunityguide.org/findings/cancer-screening-provider-reminder-and-recall-systems-colorectal-cancer

- Manual of Intervention Strategies to Increase Mammography Screening Rates (CDC and The Prudential Center for Health Care Research)
  www.cdc.gov/cancer/nbccedp/pdf/pruguide.pdf (PDF-613KB)
  Includes three essential steps and related tools to increase mammography screening rates in clinical settings.

Reducing Structural Barriers

Structural barriers are burdens or obstacles, other than cost, that make it hard for people to get screened for cancer. Activities include:

- Reducing the time or distance between cancer screening services and target populations, for example eliminating the need for multiple visits to complete screening.

- Changing service hours (opening earlier or closing later) to be more convenient for patients.

- Offering screening services in non-clinical or other places, for example, mobile mammography vans at worksites or neighborhood pick-up locations for stool tests.

- Eliminating or simplifying paperwork and other obstacles by providing scheduling assistance, patient navigators, transportation, child or elder care, and translation services.

Before You Start

- Find out which barriers are impeding access to screening for your intended audience. Consider conducting a community assessment.

- Engage members of the target population to make sure the proposed services or resources address the identified barriers and are likely to be used by the intended audience.

- Identify community partners with resources to address barriers; for example, a local church with vans to drive community members to doctor's appointments.

- Secure leadership support. Health system and clinic administrators must support any new activities or processes and be prepared to allocate resources (staff members, money, and time) to support it.

Budgeting Staff, Time, and Money

Resource needs will vary based on the barrier you are addressing and how many patients experience the barrier. For example:

- Extending clinic hours may require more staff members or overtime pay.

- Addressing transportation issues may mean budgeting for gas cards, bus passes, or a contract with a ride-sharing service.

Allot enough time to explore barriers for your intended audience, identify resources to address them, train implementers, run a pilot test, and adjust your strategy.

To make sure you have enough budget, look at local data on patient use of the proposed service. If data are not available, consider running a pilot test.

Deeper Dive into Implementation

Identify Patient Barriers to Screening

- Ask patients and other stakeholders in the clinic and community to discuss why screening rates are low.

- Include individuals who have and have not completed scheduled screenings to gain perspective on both barriers and facilitators to screening completion.

- Engage community health workers, patient navigators, social workers, clinic staff members, and others who can provide insight based on their interactions with patients.

- Consult existing community assessments. If the information is current and credible, you may have what you need to get started.

- Focus groups, one-on-one interviews, and short questionnaires are common ways to gather information. Begin engaging small numbers of people and stop when new barriers have been exhausted.

- Engage a diverse representation of your intended audience so the information you collect shows a full picture of the barriers that affect screening completion. Variation in age, marital status, education, language, location (urban or rural), cultural background, and whether the person has children can create different barriers to screening.

Decide Which Services to Provide

- Ask patients and stakeholders to confirm that the proposed services address the barriers identified, are the ones likely to make the most impact, and are culturally appropriate and acceptable to the intended audience.

- Include clinic management and others who influence use of resources and changes in clinic policies.

- Include partners with insight into your target audience and who may be able to offer resources.

- Determine how you will select services to implement. Will it be by consensus or a decision made by clinic management?

- Include only options that the health system or clinic is willing and able to make and is willing to sustain.

The questions below can help you get started.

- What services do we think will have the greatest impact on our cancer screening rates and why?
- Does it make sense to implement others?
    - Are the services feasible? Too costly? Too resource intensive?
    - What resources (staff members and funds) are available to make the changes?
- Are patients likely to use them?

Plan for Implementation

- Identify a champion to lead integration of the service. If you have engaged stakeholders from the beginning, a natural champion may have emerged. If not, identify someone who is personable, well-respected, and committed to the strategy. For additional information, visit www.health.nsw.gov.au/wohp/Documents/mc3-clinical-champions-mcneil.pdf (PDF-471KB).

- Engage people and systems that will be affected, such as providers, staff members, facility workers, and transportation companies.

- Create an implementation plan that includes all the tasks necessary to make changes to systems, educate and train staff members, promote the changes to patients and partners, and monitor implementation. The plan should include assigned staff members and due dates.

- Document policies and procedures that will guide the strategy.

- Pilot test the structural change, document the results and costs, and calculate the resources needed to scale up.

Implement the Service

Determine how you will introduce the service and educate staff members, patients, and other stakeholders. During orientation, use training methods that reflect how your audience likes to receive information.

Announce the new service:

- Remember to use partners to get the word out.

- Anticipate issues or questions by brainstorming with your key stakeholders and seek solutions beforehand. Document frequently asked questions and adjust protocols and policies.

- Consider conducting a fun, high-visibility kickoff event to create excitement. For example, coincide the kickoff with a community event, or hold at the clinic and send invitations to patients. Be creative.

- Implement the new service.

Monitor and Adjust

- Assigned staff members should monitor implementation to ensure policies and procedures are followed.

- Collect data such as transportation invoices, employee time records, or satisfaction surveys to assess the impact and determine how the change is being used. Use this information to make improvements and make activities and resources more sustainable.

- Document challenges and successes.

- Check the screening numbers and other indicators periodically to see if they are improving.

- Adjust as needed and document any changes.

Process Evaluation Questions

- Did the change happen?
- How many people have used the new resource?
- Are there problems that need to be fixed?
- Are patients completing recommended screening tests?

Sustain

- Keep costs as low as possible. For example:
  - Choose several transportation options. Offer the most cost-effective, like a bus pass, first, and offer more expensive options like taxis or ride-sharing services only when necessary.

  - Share translation staff members with other health department programs or use language lines.

  - Recruit volunteers to work during extended clinic hours.

  - Make sure resources are used only by patients with an identified need, not as incentives offered to everyone regardless of need.

- Partner with community-based organizations that provide patient support services, like transportation and child care, and who are willing to serve as referral resources for your program.

Resources

- *Clinical Champions* NSW Government Health
  www.health.nsw.gov.au/wohp/Documents/mc3-clinical-champions-mcneil.pdf (PDF-471KB).

- Colorectal Cancer Screening Best Practices: A Handbook for Hospitals and Health Systems.
  https://nccrt.org/resource/colorectal-cancer-screening-handbook-for-hospitals-and-health-systems/