Colorectal Cancer Control Program:

Public Health and Health System Partnerships to Increase Colorectal Cancer Screening in Clinical Settings
DP20-2002

Program Manual, Part I
Implementation

September 2021, v1.1

Centers for Disease Control and Prevention
Program Services Branch
National Center for Chronic Disease Prevention and Health Promotion
Division of Cancer Prevention and Control

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Chapter 1: Program Policies and Data Requirements

Requirements Based on Federal Regulations

The Notice of Award (NOA) is the official document, signed (or the electronic equivalent of a signature) by a Grants Management Officer that: (1) notifies the recipient of the award of a grant, (2) contains or references all terms and conditions of the grant and Federal funding limits and obligations, and (3) provides the documentary basis for the recording of the obligation of Federal funds in the U.S. Department of Health and Human Services (HHS) accounting system. A grantee's activities are governed by the provisions of its NOA.

For information about requirements based on federal regulations, please visit https://www.cdc.gov/grants/welcome-packet/index.html for the most recent guidance regarding contractor and consultant approval processes, the annual Federal Financial Report (FFR), the Annual Performance Report (APR) and other requirements and regulations.

Program Policies

P1. Target Population

Recipients must identify a target population/geographical area based on need (e.g., population or geographical area has a colorectal cancer (CRC) screening rate lower than that of the rest of the state).

P2. Partnership with primary care clinics and/or health system(s)

Recipients must partner with primary care clinics/health systems that serve the target population/geographical area and have a CRC screening rate of <60% to implement priority evidence-based interventions (EBIs). Recipients may partner with health systems that are comprised of several primary care clinics but should implement program strategies and activities at the clinic level.

P3. Partnership agreements

Recipients must establish a partnership agreement with the partner primary care clinics and/or health system(s) (e.g., memorandum of understanding [MOU]/memorandum of agreement [MOA]). The agreement should clearly define the goals of the partnership, activities that will be conducted (including reporting of data), and the responsibilities of each partner (see **Appendix A: Memorandum of Understanding/Memorandum of Agreement Requirements**).

P4. Clinic readiness assessment

An implementation readiness assessment must be completed for each clinic prior to implementation of evidence-based interventions (EBIs). Recipients will be required to 1) submit their clinic readiness assessment tool to CDC for review and approval and 2) complete a clinic implementation planning summary for each clinic/site prior to EBI implementation (see **Appendix B: Clinic Readiness Assessment Guidance and Appendix C: Clinic Implementation Planning Summary**)

P5. Evidence-based interventions (EBIs)

Recipients must implement at least two EBIs in the partner primary care clinics health system(s). Recipients may choose at least two of the following EBIs recommended in The Community Guide (https://www.thecommunityguide.org/):

1. Provider assessment and feedback
2. Provider reminders
3. Client reminders
4. Reducing structural barriers

The EBIs chosen for a particular clinic should address gaps and barriers identified in the clinic readiness assessment.

P6. Patient navigation

Recipients who implement patient navigation activities must do so in accordance with the Colorectal Cancer Control Program (CRCCP) Program Policy on Patient Navigation, including the collection of data on specific processes and outcomes (see **Appendix D: CRCCP Patient Navigation Policy**).

P7. Small media

Recipients who implement small media interventions must maximize use of existing small media materials to support implementation of patient navigation and client reminder interventions.

P8. Implementation support

Recipients must provide substantive implementation support (e.g., technical assistance) to partner primary care clinics. Recipients must describe a plan or protocol for how implementation support will be provided to primary clinics for data system improvements, EBI implementation, and data monitoring and submit it to CDC for approval (see **Appendix E: Technical Assistance Plan**).

P9. Clinic implementation planning summary

Grantees must complete a clinic implementation planning summary with each participating clinic/site. These plans should be submitted to your CDC program consultant for review and approval *prior to*

initiating program activities with your clinic partner. Program consultants are always available to provide technical assistance on implementation plans (see **Appendix C: Clinic Implementation Planning Summary**).

P10. FOBT/FIT/FIT-DNA kit purchase, processing, and mailing

Program funds **may not** be used to purchase or process guaiac fecal occult blood tests (FOBTs)/fecal immunochemical tests (FITs) or FIT-DNA tests (Cologuard). Program funds **may** be used to pay for packaging and mailing of kits.

P11. Follow-up colonoscopy

Recipients may use limited funds with CDC approval to pay for follow-up (e.g., diagnostic) colonoscopies for asymptomatic uninsured or underinsured adults age 45-75 years who are screened for CRC by their partner clinics (e.g., clinics in which the recipient is partnering to implement EBIs).

1. Funds may not be used to pay for colonoscopies to evaluate or diagnose symptomatic patients.
2. Reimbursement for colonoscopy may not exceed the Medicare rate.
3. The Federal government is the payor of last resort; funds may not supplant other available sources of payment for colonoscopy.

Evaluation, Data, and Reporting

E1. Staffing

Recipients must have, or have access to through partner organizations:

1. Staff with expertise in evaluation, data collection, data management, analysis, and data reporting.
2. Staff with expertise to extract population health data from electronic health records (EHRs) and improve the quality of EHR data.

Program Policy, Part II: Evaluation and Performance Measurement provides additional information and resources related to evaluation staff and consultants.

E2. Evaluation and performance measurement requirements

Recipients must:

1. Develop an Evaluation and Performance Measurement Plan within 6 months of award and submit it to CDC by December 31, 2020;
2. Implement an evaluation consistent with their Evaluation and Performance measurement Plan, including process and outcome evaluation to assess all major program activities over the course of the 5-year project period.

Program Manual, Part II: Evaluation and Performance Measurement includes additional information and resources to support development of the required evaluation and performance measurement plan and for conducting evaluation activities.

E3. CDC-led evaluation

Recipients must take part in the CDC-led evaluation of the overall CRCCP, including participating in three unique data collections: CRCCP quarterly program update, CRCCP annual awardee survey**,** and CRCCP baseline and annual clinic data records.

Program Manual Part II: Evaluation and Performance Measurement provides additional information on each data collection, including submission due dates.

E3.a Quarterly program update (QPU)

Recipients must participate in the Quarterly Program Update (QPU). This data collection of all recipients collects information about spending, staffing vacancies, successes/challenges, and technical assistance. The Web-based survey is administered quarterly. See Program Manual, Part II: Evaluation and Performance Measurement for additional information on the QPU.

E3.b Annual awardee survey

Recipients must participate in the Annual Awardee Survey. This annual survey of all recipients collects data about program management, clinic assessment, data management, technical assistance, partnerships, and COVID effects on program management. The Web-based survey will be administered every July following each program year. See Program Manual, Part II: Evaluation and Performance Measurement for additional information on the annual awardee survey.

E3.c Baseline clinic data

Grantees must collect CRCCP baseline clinic data records for all clinics where CRCCP activities will be implemented. Baseline clinic data records must be clinic-level, not health system-level. All data reported in the baseline clinic data record represent activities in place prior to implementing CRCCP activities. Baseline data include information about the clinic and its parent health system, patient characteristics, baseline screening rates, and EBIs existing prior to implementation of CRCCP activities. See Program Manual, Part II: Evaluation and Performance Measurement for additional information on the baseline clinic data, including details on reporting deadlines.

Special Note: For clinics enrolled under DP15-1502 and continuing as part of DP20-2002, new baseline clinic data records are required given that CDC has revised the clinic dataset to include new data items. Recipients may use clinic data collected for the DP15-1502 PY5 annual data record for this baseline record.

E3.d Annual clinic data

Grantees must collect CRCCP annual clinic data records for all clinic where CRCCP activities are implemented. Annual clinic data records must be clinic-level, not health system-level. Annual clinic data records reflect program activities for the program year and include updated information about the clinic and its parent health system, annual screening rates, and EBIs implemented during the program year. Annual clinic data records are reported following the end of each program year from June 30 to September 30. See Program Manual, Part II: Evaluation and Performance Measurement for additional information on the annual clinic data, including details on reporting deadlines.

Chapter 2: Background and History

Introduction

The purpose of the Colorectal Cancer Control Program (CRCCP): Public Health and Health System Partnerships to Increase Colorectal Cancer Screening in Clinical Settings (DP20-2002) is to implement evidence-based interventions (EBIs) to increase and improve the quality of CRC screening and follow-up testing in primary clinics and health systems serving high-need populations.

Background

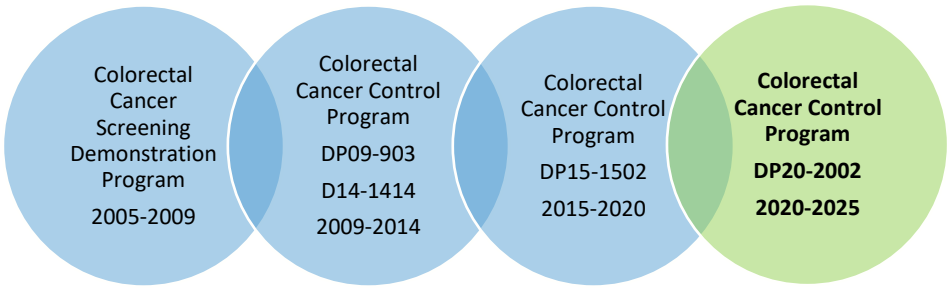
Colorectal cancer (CRC) is the second leading cause of death from cancer in the United States. There is substantial evidence that screening for CRC reduces the incidence of and death from this disease. Screening for CRC can both detect disease early when treatment is more effective and prevent cancer by finding and removing precancerous polyps. Of individuals diagnosed with early stage CRC, more than 90% live five or more years5

The U.S. Preventive Services Task Force recommends screening average risk adults age 45-75 years for CRC with either: 1) fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually, 2) multi-target stool DNA (also referred to as FIT-DNA) every 1 or 3 years, 3) colonoscopy every 10 years, 4) computed tomographic colonography (CTC) every 5 years, 5) flexible sigmoidoscopy every 5 years, or 6) flexible sigmoidoscopy every 10 years with FIT annually.

Despite strong evidence that screening for CRC is effective, only 68.8% of adults age 50-75 years reported being up-to-date with CRC screening in 2018. Approximately 22 million adults have never been screened or are not up-to-date with screening. Individuals age 50-64 years, men, racial and ethnic minorities, those who do not live in a city, and people with lower educational attainment and annual household income are less likely to be screened. Lower rates of screening directly contribute to disparities in CRC morbidity and mortality.

Program History

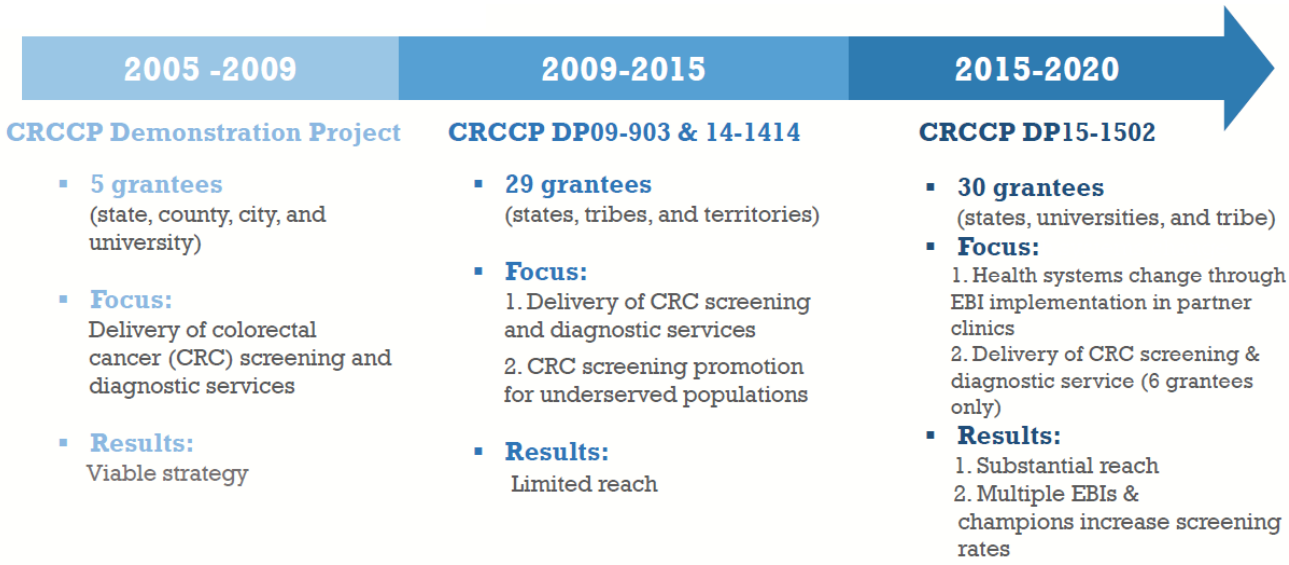
The Centers for Disease Control and Prevention (CDC) has almost 30 years of experience supporting the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) for the medically underserved population. The NBCCEDP uses a comprehensive approach to breast and cervical cancer control, including providing early detection services, educational activities, public and private partnerships, and quality assurance measures. To better understand how to structure and implement population-level CRC screening, primarily by providing direct screening services, the CDC conducted a 4-year CRC screening demonstration program from 2005 through 2009. Five sites were competitively selected to participate in the demonstration program. The program provided USPSTF-recommended CRC screening tests to low-income men and women who were uninsured or underinsured for CRC screening services.



Following the successes and lessons learned from the CRC screening demonstration program, the CDC received additional funding to support the Colorectal Cancer Control Program (DP09-903 and DP14-1414) in 22 states and 4 tribal organizations effective fiscal year 2010. A new focus for the CRCCP was the promotion of CRC screening to all people over the age of 50 with the goal of increasing the percentage of people who had been screened for CRC, regardless of income or health insurance status. Grantees aimed to increase CRC screening in the population by implementing the EBIs recommended in *The Community Guide*. Up to 30% of awarded funds were allocated for the provision of CRC screening to the priority population of low-income men and women who were uninsured or underinsured for CRC screening services. While grantees achieved successes in partnering with healthcare systems to implement EBIs and increased screening rates in a variety of settings, measuring success in a way that reflected the entire scope of the program proved to be challenging. Many grantees did not have sufficient resources or reach to impact a large portion of the potentially screen-eligible population, and quantitative measures reflecting successes achieved on a smaller scale were not systematically collected across all grantees.

In 2015, CDC funded 30 recipients to implement DP15-1502 Organized Approaches to Colorectal Cancer Screening. Based on lessons learned from DP09-903 and DP14-1414, this version of CRCCP had a narrower focus on increasing screening in targeted populations served by implementing priority EBIs from The Community Guide. This approach allowed grantees to implement targeted activities within a feasible scale and allowed for the systematic collection of data that showed the impact of the program.

Recipients focused on four priority EBIs from The Community Guide (client reminders, reducing structural barriers, providers reminders, provider assessment and feedback) and several supporting activities (small media, patient navigation, provider education, health information technology). Six recipients received funding to provide direct screening services to average-risk, low income, uninsured and underinsured people. Over the course of DP15-1502 recipients partnered with nearly 700 clinics reaching more than one million patients. Factors associated with higher clinic screening rates over time included implementing three to four EBIs, implementing new EBIs rather than enhancing EBIS that were already in place, having a CRC screening champion, and having a CRC screening policy. Barriers to increasing screening rates included insufficient resources for follow-up colonoscopy after a positive or abnormal screening test, using electronic health record (EHR) systems for population management, and competing priorities in clinics.



DP20-2002: Public Health and Health System Partnerships to Increase Colorectal Cancer Screening in Clinical Settings continues to focus on implementing EBIs in partnership with primary care clinics serving targeted populations or geographic areas. This iteration of the CRCCP places additional emphasis on using data to identify target populations and partner primary care clinics; conducting a thorough assessment of clinic readiness to prior implementation of EBIs to identify and address gaps, barriers, and needed data system improvements; provision of sufficient technical assistance from recipients to clinics; facilitation of linkages to follow-up colonoscopy; and data quality and program evaluation.

Program Planning

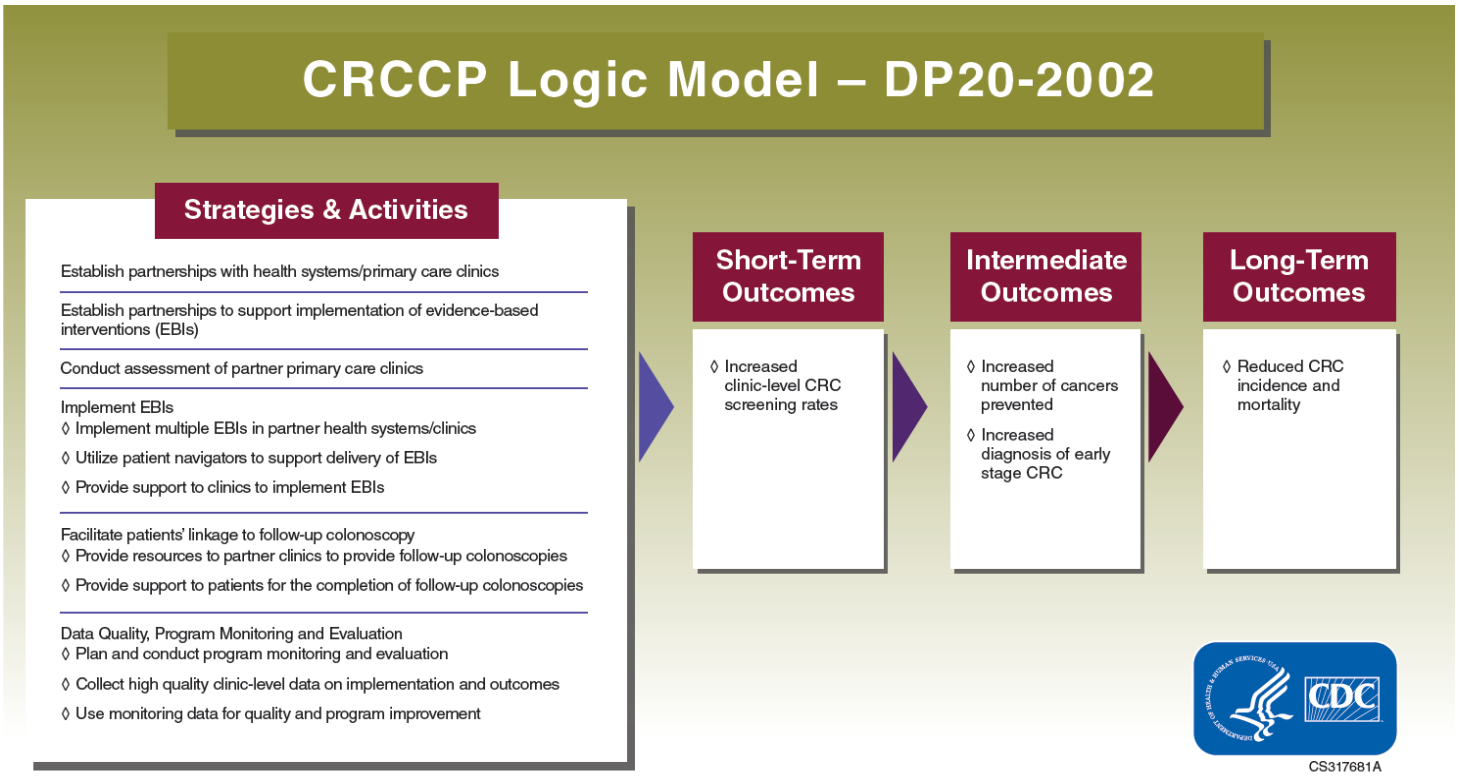
Successful public health programs:

1. Carefully assess the public health problem (or the essential need for the program);
2. Develop measurable process and outcome objectives to assess progress in addressing the issue;
3. Select interventions to help achieve these objectives;
4. Implement the selected interventions;
5. Monitor and evaluate selected interventions based on the objectives;
6. Use monitoring and evaluation data to improve the program.

For the purposes of the CRCCP, the essential need for the program (to increase CRC screening rates) has already been established, and effective interventions (EBIs) have been identified. Grantees should determine how to define the specific essential need in their community/state and how best to implement the identified interventions. As described in the funding opportunity announcement, grantees should:

1. Identify the area/community/population with the greatest need (e.g., lower screening rates than other areas/communities/populations in the state).
2. Identify and partner with primary care clinics that serve the identified area/community/population.
3. Carefully assess the problem in the health system/clinic setting.
4. In partnership with the health system, select the interventions that best meet the needs of the clinic and target areas/community/population.
5. Implement the selected interventions.
6. Evaluate the interventions to determine whether objectives have been met; assess progress accomplishments, and challenges; and assess any unintended consequences.
7. Make program adjustments and improvements.

A program logic model can assist programs in visualizing how selected partnerships and interventions will support and lead to program objectives and outcomes. The CRCCP logic model describes how grantee activities lead to desired short-, intermediate-, and long-term outcomes.



Over the course of the program period, recipients may add partners (e.g., primary care clinics, implementation support partners) and/or interventions (e.g., EBIs, small media, patient navigation) to increase CRC screening in the target area/community/population. Prior to adding partners, interventions, or activities, grantees should carefully consider how the proposed partnership/intervention/activity will fit into the overall program plan relative to other ongoing interventions and activities, and how it will lead to established program objectives. Recipients should ensure adequate capacity to provide the necessary implementation support/technical assistance when considering expansion. Long term sustainability of the implemented EBIs in participating primary care clinics is a priority that should be considered throughout the 5-years

Health Systems and Organized Cancer Screening

Partnerships with primary care clinics/healthcare systems and other entities are foundational to the CRCCP. Grantees are expected to partner with health systems and primary care clinics that serve their target geographical area/community/population to implement EBIs within individual clinics.

A *health system*, or *healthcare system*, is an organization of people, institutions, and resources that deliver healthcare services to meet the needs of the target population. The World Health Organization (WHO) defines a health system more broadly as consisting of "all organizations, people, and actions whose primary intent is to promote, restore, or maintain health. This includes efforts to influence determinants of health as well as direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. A health system includes, for example, a mother caring for a sick child at home; private providers; behavior change programs; vector control campaigns; health insurance organizations; and occupational health and safety legislation. It includes inter-sectorial action by health staff, for example, encouraging the ministry of education to promote female education, a well-known determinant of better health" (*Everybody's Business—Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*).

Health system change results from initiatives and strategies that improve one or more functions of the health system and that lead to better health outcomes through sustainable improvements in access, coverage, quality, or efficiency. Given how broadly health systems can be defined, a single definition of health system change can be challenging. For the purposes of the CRCCP, health system change is a change in organizational policies, processes, or environmental supports that institutionalize improvements in the CRC screening process and lead to increased CRC screening rates in the health system and target population.

Implementation and institutionalization of EBIs and other process improvements will help to establish more organized approaches to CRC screening in partner health systems. Most cancer screening in the United States is opportunistic; patients are offered a screening test when they come to the doctor's office for another reason. Organized cancer screening systems have the following characteristics:

1. An explicit policy with specified age categories, method, and interval for screening;
2. A defined target population;
3. A management team responsible for implementation;
4. A healthcare team for decisions and care;
5. A quality assurance structure;
6. A method for identifying cancer occurrence in the population.

Relative to opportunistic screening, organized screening places a greater emphasis on reaching the entire population of those eligible to be screened (rather than those who happen to come to the healthcare system) and on the quality of the screening process, particularly on follow-up for additional testing or rescreening. Use of EBIs calls attention to the entire screening process and promotes CRC screening among those who do not regularly have contact with the healthcare system.

Partnerships

By definition, a partnership is a relationship between two or more parties that involves close cooperation between parties that have specified joint rights and responsibilities. The basic assumption of a partnership is that when individuals or organizations join together, they will be more successful in their collective efforts than they could be as individual participants—making the best use of different but complementary expertise and resources. To be successful, partnerships should have clear purpose, add value to the work of the partners, and should be carefully cultivated and evaluated. The strongest partnerships occur when both mutual and individual goals are served.

The primary focus of the CRCCP is on partnerships with health systems, particularly primary care clinics to implement EBIs. These partners (both primary care clinics and implementation support) can include, but are not limited to, the following:

1. Community Health Centers (CHCs)/Federally Qualified Health Centers (FQHCs);
2. Other publicly funded entities that provide primary care services;
3. Insurers, including self-insured employers;
4. Healthcare networks;
5. Hospitals;
6. Primary care associations;
7. Regional medical associations;
8. Professional organizations.

Grantees should consider the following in selecting a health system partner to implement priority EBIs and supporting strategies:

- Target population:
  - Does the health system serve primarily, or in part, the target geographical area/community/population?
- Services provided:
  - Does the health system provide direct primary care services to the target population, or have access to organizations that provide these services?

- Data:
  - Does the health system have access to/the ability to share data on the CRC screening rate in the population targeted by the intervention? This includes a numerator (the number of people who received a CRC screen), a denominator (the total number of adults who were eligible for a CRC screen), and a CRC screening rate for a given time period. The data should be provided at the clinic level.

The CDC has several resources on developing and sustaining partnerships with health systems and other organizations. The following resources may assist grantees in developing successful health system partnerships (available at https://www.crccp.org):

1. *Increasing Quality Colorectal Cancer Screening: An Action Guide for Working with Health Systems*
2. *Increasing Quality Colorectal Cancer Screening and Promoting Screen Quality: An Action Guide for Engaging Employers and Professional Medical Organizations*
3. *Engaging, Building, Expanding: An NBCCEDP Partnership Development Toolkit*

Program Implementation

Once an overarching program plan (developed in the program planning phase) and appropriate health system partnerships have been established, recipients are ready to conduct *Clinic Readiness Assessments* for each partnering clinic, complete and submit a *Clinic Implementation Planning Summary* for each clinic that summarizes the findings of the assessment and the rationale for selecting a given EBI to implement in that clinic, and implement EBIs in clinics based on that clinic's assessment (**Appendices B and D**). Recipients must also complete a *Technical Assistance Plan* describing how they will provide technical assistance to clinic partners (see **Appendix E: Technical Assistance Plan**). *The Clinic Readiness Assessment* and the *Clinic Implementation Planning* form must be completed **prior** to implementing EBIs in partner clinics.

The intent of this implementation process is to:

1. Assess the current CRC screening practices and processes, including current use of EBIs or other strategies and data quality (e.g., accuracy of CRC screening rates derived from the EHR);
2. In partnership with the clinic, describe the issue or problem, select interventions that address the issue or problem, and provide details on how the intervention will be implemented;
3. Assess the availability of and access to services across the screening continuum (e.g., follow-up colonoscopy and treatment services);
4. Consider and incorporate sustainability into EBIs that are implemented;
5. Assess potential technical assistance needs and describe how technical assistance will be provided.

Clinic Readiness Assessment

Once an overarching program plan has been established, recipients are required conduct a readiness assessment of each partnering clinic or FQHC site. The purpose of the *Clinic Readiness Assessment* is to document the current CRC screening process in the clinic, the quality of CRC screening data, and resources available in each clinic. The *Clinic Readiness Assessment* should identify gaps and opportunities in the clinic's CRC screening process and any needed quality improvement activities prior to EBI implementation, such as improving the quality of electronic health record (EHR) screening data. The results of the *Clinic Readiness Assessment* should guide the selection of EBIs to address any identified gaps and opportunities.

CDC has provided guidance for conducting and developing a *Clinic Readiness Assessment* tool **(Appendix B**). Recipients are expected to develop their own CRA tool to use with their partnering clinics. Recipient specific *Clinic Readiness Assessment* tools must be submitted to CDC for review and approval prior to use.

Clinic Implementation Planning Summary

The *Clinic Implementation Planning Summary* is a management tool for planning the implementation of EBIs and other activities within partner clinics. A *Clinic Implementation Planning Summary* should be completed in

collaboration with each partner clinic. The *Clinic Implementation Planning Summary* is intended to promote program success by ensuring that clinics are selected based on data and readiness, a thorough assessment of current clinic data and processes, selection of EBIs and process improvements that match identified issues, and incorporation of sustainability as a part of implementation. A well-constructed *Clinic Implementation Planning Summary* demonstrates your readiness for implementation and the likelihood of achieving outcomes. The Plan may be useful as a reference to identify what worked and what was less productive once implementation begins.

The CDC has provided a *Clinic Implementation Planning Summary* tool that must be completed for each partner clinic and submitted to your CDC program consultant for review and approval prior to implementation of EBIs **(Appendix D).**

Technical Assistance Plan

CDC expects recipients to provide substantive technical assistance (TA) to primary care clinic partners to support the effective implementation of EBIs. Recipients should plan to engage regularly with clinic partners to assess progress towards EBI implementation goals, assess and address barriers to implementation, collect and use data for continuous quality improvement, and assess clinic data quality on an ongoing basis. Recipients will complete the *Technical Assistance Plan* to provide details about how they will provide TA to clinic partners **(Appendix E).** The plan reflects how recipients will provide TA to all clinic partners including who will provide TA (the recipient or contracted partners), how TA will be provided (by phone, in person, or other mechanism), what TA will provided (workflow mapping, EHR data quality improvement, practice facilitation, etc.), and when TA will be provided (bi-weekly, monthly, etc.).

The Technical Assistance Plan must be submitted to CDC for review and approval and should be updated annually and revised as needed.

Evidence-Based Interventions

The Community Guide is a resource that holds all the official recommendations of the Community Preventive Services Task Force (the Task Force)

(http://www.thecommunityguide.org/index.html). The Task Force was established in 1996 by the U.S. Department of Health and Human Services to identify population health interventions that are scientifically proven to save lives, increase lifespans, and improve quality of life. The Task Force produces recommendations (and identifies evidence gaps) to help inform the decision making of Federal, state, and local health departments; other government agencies; communities; healthcare providers; employers; schools; and research organizations.

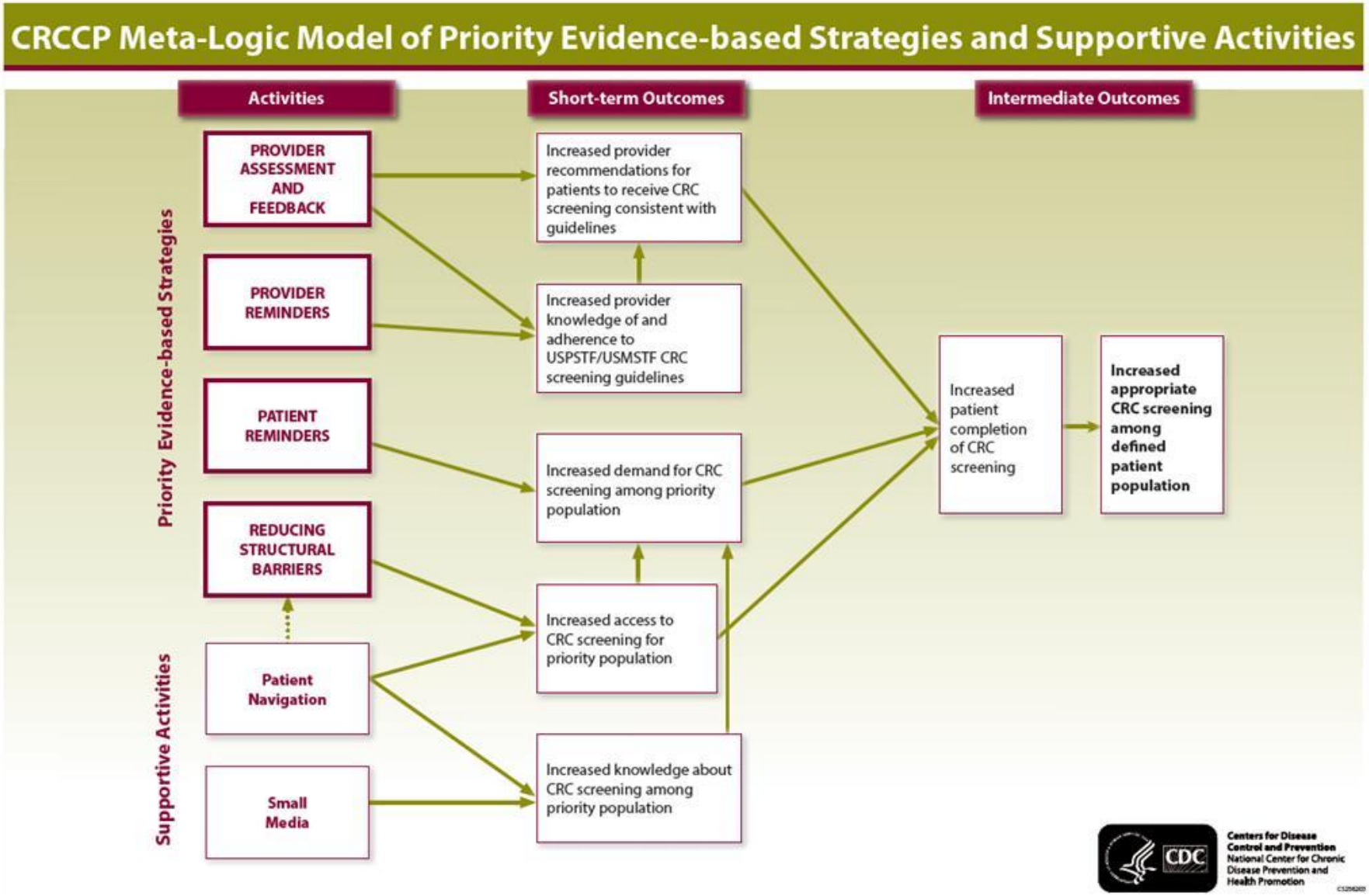
The Community Guide has identified effective EBIs that address many barriers to CRC screening. The CRCCP has chosen the following EBIs to be implemented by grantees within their partner primary care clinics:

1. Provider assessment and feedback;
2. Provider reminders;
3. Client reminders;

4. Reducing structural barriers.

The CDC has created a series of logic models specific to the CRCCP that depict how EBIs and supporting strategies such as patient navigation and small media can help achieve program goals and desired outcomes. Below is a "meta-logic model" that shows how the various interventions could work together to increase CRC screening rates.

Grantees must implement at least two of the four EBIs in their partnering primary care clinics. Research, including evaluation studies of the CRCCP DP15-1502, have shown that implementing multiple EBIs can increase the screening rate more than implementing a single EBI strategy. In selecting EBIs to implement, grantees should consider the needs of the health system and the target population, and the environment in which the interventions will be implemented (see Program Planning).


CRCCP Meta-Logic Model of Priority Evidence-based Strategies and Supportive Activities
Activities
Short-term Outcomes
Intermediate Outcomes
Priority Evidence-based Strategies
Supportive Activities
PROVIDER ASSESSMENT AND FEEDBACK
PROVIDER REMINDERS
PATIENT REMINDERS
REDUCING STRUCTURAL BARRIERS
Patient Navigation
Small Media
Increased provider recommendations for patients to receive CRC screening consistent with guidelines
Increased provider knowledge of and adherence to USPSTF/USMSTF CRC screening guidelines
Increased demand for CRC screening among priority population
Increased access to CRC screening for priority population
Increased knowledge about CRC screening among priority population
Increased patient completion of CRC screening
Increased appropriate CRC screening among defined patient population
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National Center for Chronic Disease Prevention and Health Promotion

Provider Assessment and Feedback

Provider assessment and feedback interventions both evaluate provider performance in delivering or offering screening to clients (assessment) and present providers with information about their performance in providing screening performance (feedback). Feedback may describe the performance of a group of providers (e.g., mean performance for a practice) or an individual provider (e.g., performance compared to peers in a practice), and may be compared with a goal or standard (https://www.thecommunityguide.org/findings/cancer-screening-provider-assessment-and-feedback-colorectal-cancer).

Examples of provider assessment and feedback interventions include:

1. Within a clinic, assessing individual provider performance for appropriately recommending CRC screening and notifying providers how they compare to one another.

2. Among clinics, assessing CRC screening rate adherence to current guidelines and publishing the results in comparison to a target rate.

3. Fostering competition by periodically publishing the screening rates of "competing" providers or clinics.

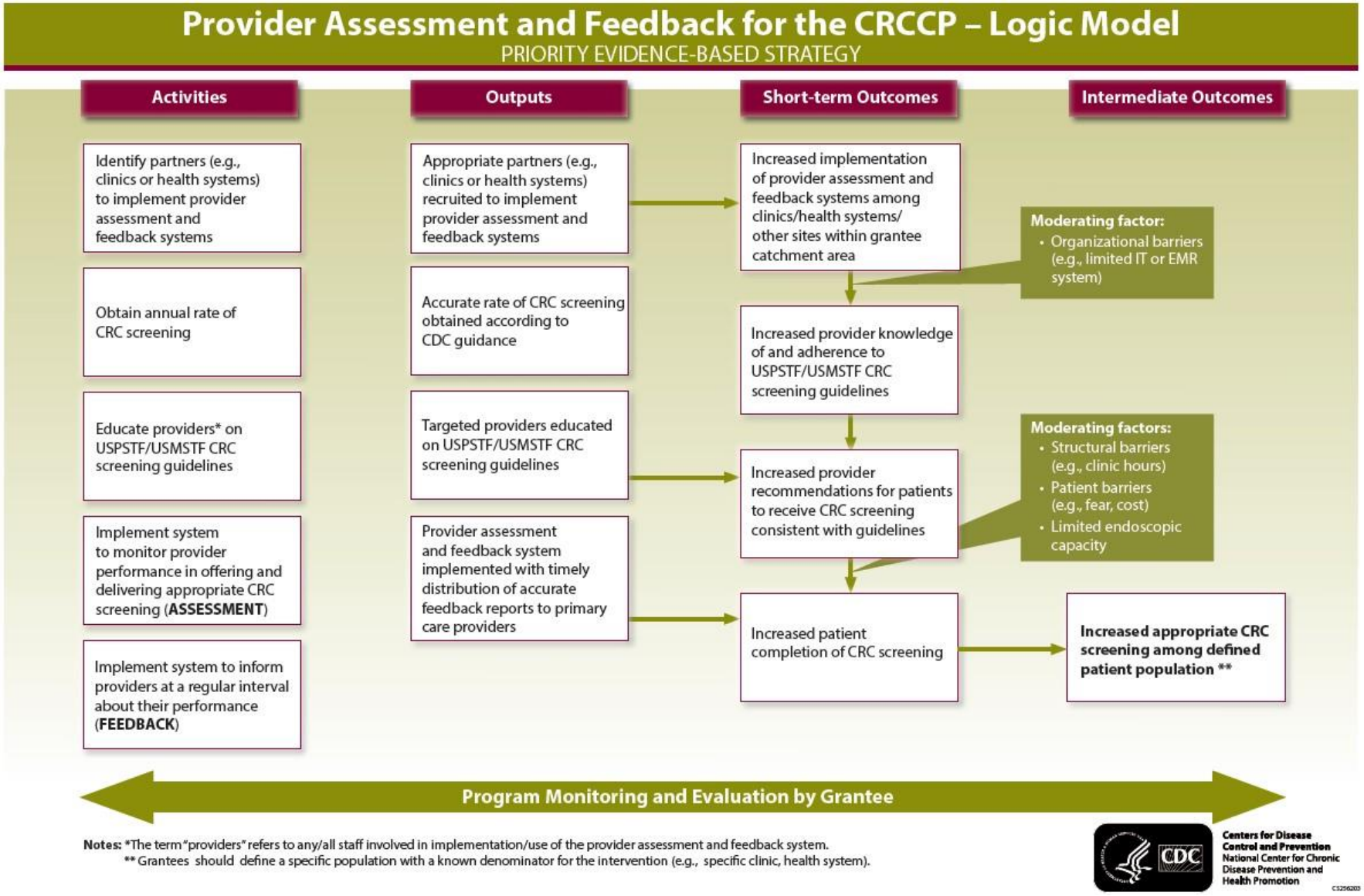
To successfully implement and evaluate provider assessment and feedback interventions, grantees should:

1. Have access to information about provider performance in offering CRC screening (e.g., the total population eligible for screening assigned to the provider, the proportion of the population that was offered a screening test as documented by a chart or EHR order, the proportion of the population that was offered a screening test that engaged in informed decision making).

2. Have access to information about provider performance in delivering CRC screening (e.g., the proportion of the eligible population that was offered and completed a screening test, follow-up of incomplete or abnormal tests, follow-up of tests that were ordered but not performed).

3. Have access to information to create feedback reports for providers about their performance (e.g., the proportion of the eligible population that is up-to-date with CRC screening, the ability to compare performance to other providers or practices).

4. Have a method to assess the use of provider feedback reports by targeted providers or practices.


Provider Assessment and Feedback for the CRCCP – Logic Model
PRIORITY EVIDENCE-BASED STRATEGY
Activities
Outputs
Short-term Outcomes
Intermediate Outcomes
Identify partners (e.g., clinics or health systems) to implement provider assessment and feedback systems
Obtain annual rate of CRC screening
Educate providers* on USPSTF/USMSTF CRC screening guidelines
Implement system to monitor provider performance in offering and delivering appropriate CRC screening (ASSESSMENT)
Implement system to inform providers at a regular interval about their performance (FEEDBACK)
Appropriate partners (e.g., clinics or health systems) recruited to implement provider assessment and feedback systems
Accurate rate of CRC screening obtained according to CDC guidance
Targeted providers educated on USPSTF/USMSTF CRC screening guidelines
Provider assessment and feedback system implemented with timely distribution of accurate feedback reports to primary care providers
Increased implementation of provider assessment and feedback systems among clinics/health systems/ other sites within grantee catchment area
Moderating factor:
• Organizational barriers (e.g., limited IT or EMR system)
Increased provider knowledge of and adherence to USPSTF/USMSTF CRC screening guidelines
Increased provider recommendations for patients to receive CRC screening consistent with guidelines
Moderating factors:
• Structural barriers (e.g., clinic hours)
• Patient barriers (e.g., fear, cost)
• Limited endoscopic capacity
Increased patient completion of CRC screening
Increased appropriate CRC screening among defined patient population **
Program Monitoring and Evaluation by Grantee
Notes: *The term "providers" refers to any/all staff involved in implementation/use of the provider assessment and feedback system.
** Grantees should define a specific population with a known denominator for the intervention (e.g., specific clinic, health system).
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Provider Reminder and Recall Systems

Reminders inform healthcare providers that it is time for a client's cancer screening test (called "a reminder") or that the client is overdue for screening (called "a recall"). The reminders can be provided in different ways, such as in client charts or by email

(https://www.thecommunityguide.org/findings/cancer-screening-provider-reminder-and-recall-systems-colorectal-cancer).

Examples of provider reminder interventions include:

1. Activating/Utilizing the provider reminder function in an EHR to remind providers that the patient is due or overdue for screening. Reminders could include information about USPSTF recommendations for CRC screening.

2. Creating a system where clearly visible reminders are placed on paper charts prior to a patient's office visit with the provider.

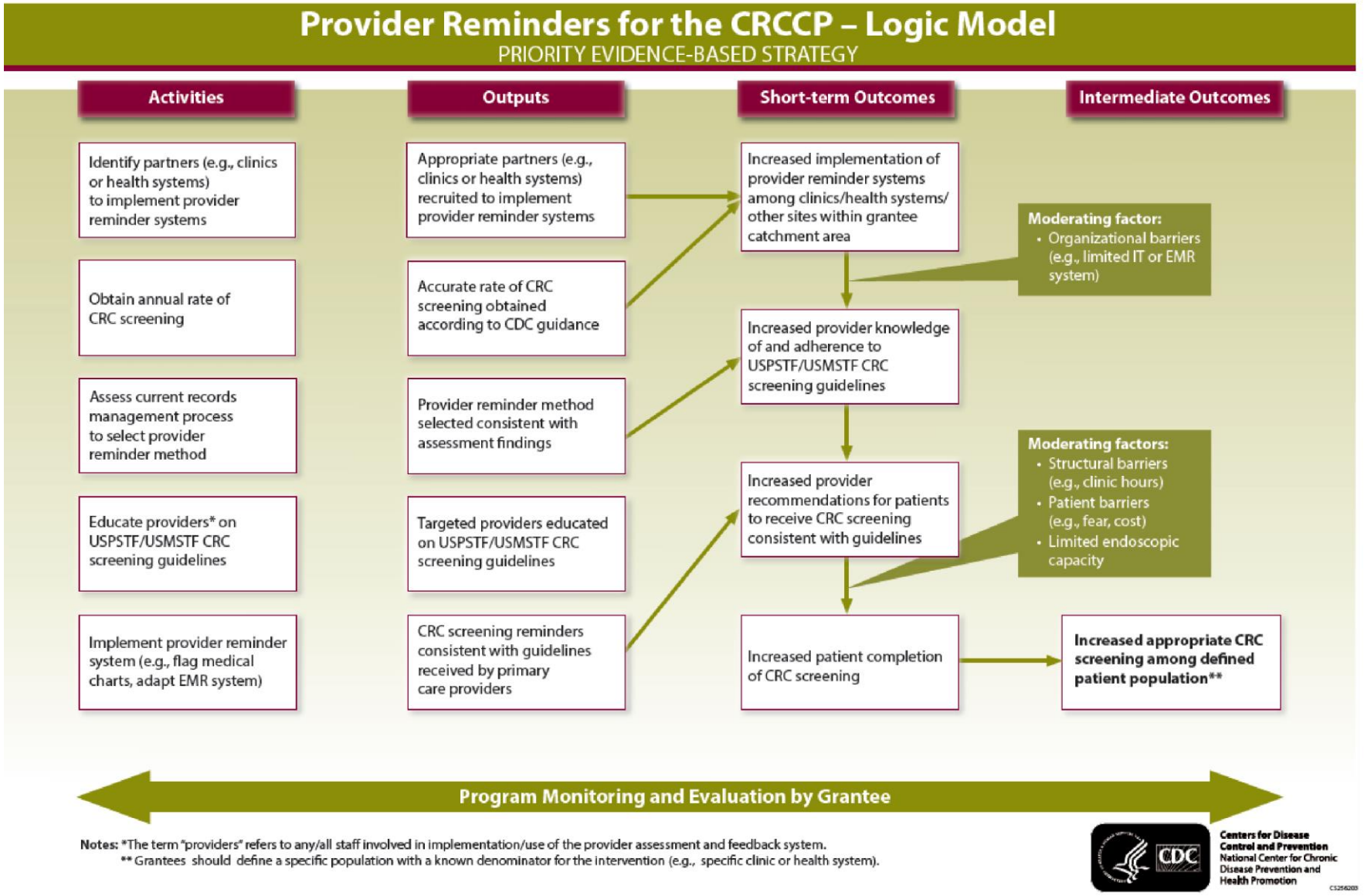
To implement and evaluate provider reminders effectively, grantees should be able to:

1. Track the number of provider orders or referrals for CRC screening tests.

2. Track the number of completed CRC screening tests.

3. Assess the use of reminders by providers.

4. Monitor the CRC screening rate in the eligible population.


Provider Reminders for the CRCCP – Logic Model
PRIORITY EVIDENCE-BASED STRATEGY
Activities
Outputs
Short-term Outcomes
Intermediate Outcomes
Identify partners (e.g., clinics or health systems) to implement provider reminder systems
Obtain annual rate of CRC screening
Assess current records management process to select provider reminder method
Educate providers* on USPSTF/USMSTF CRC screening guidelines
Implement provider reminder system (e.g., flag medical charts, adapt EMR system)
Appropriate partners (e.g., clinics or health systems) recruited to implement provider reminder systems
Accurate rate of CRC screening obtained according to CDC guidance
Provider reminder method selected consistent with assessment findings
Targeted providers educated on USPSTF/USMSTF CRC screening guidelines
CRC screening reminders consistent with guidelines received by primary care providers
Increased implementation of provider reminder systems among clinics/health systems/ other sites within grantee catchment area
Increased provider knowledge of and adherence to USPSTF/USMSTF CRC screening guidelines
Increased provider recommendations for patients to receive CRC screening consistent with guidelines
Increased patient completion of CRC screening
Moderating factor:
• Organizational barriers (e.g., limited IT or EMR system)
Moderating factors:
• Structural barriers (e.g., clinic hours)
• Patient barriers (e.g., fear, cost)
• Limited endoscopic capacity
Increased appropriate CRC screening among defined patient population**
Program Monitoring and Evaluation by Grantee
Notes: *The term "providers" refers to any/all staff involved in implementation/use of the provider assessment and feedback system.
** Grantees should define a specific population with a known denominator for the intervention (e.g., specific clinic or health system).
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Client Reminders

Client reminders are written (letter, postcard, or email) or telephone messages (including automated messages) advising people that they are due for screening. Client reminders may be enhanced by one or more of the following:

- Follow-up printed or telephone reminders
- Additional text or discussion with information about the indications for, the benefits of, and ways to overcome barriers to screening
- Assistance in scheduling appointments

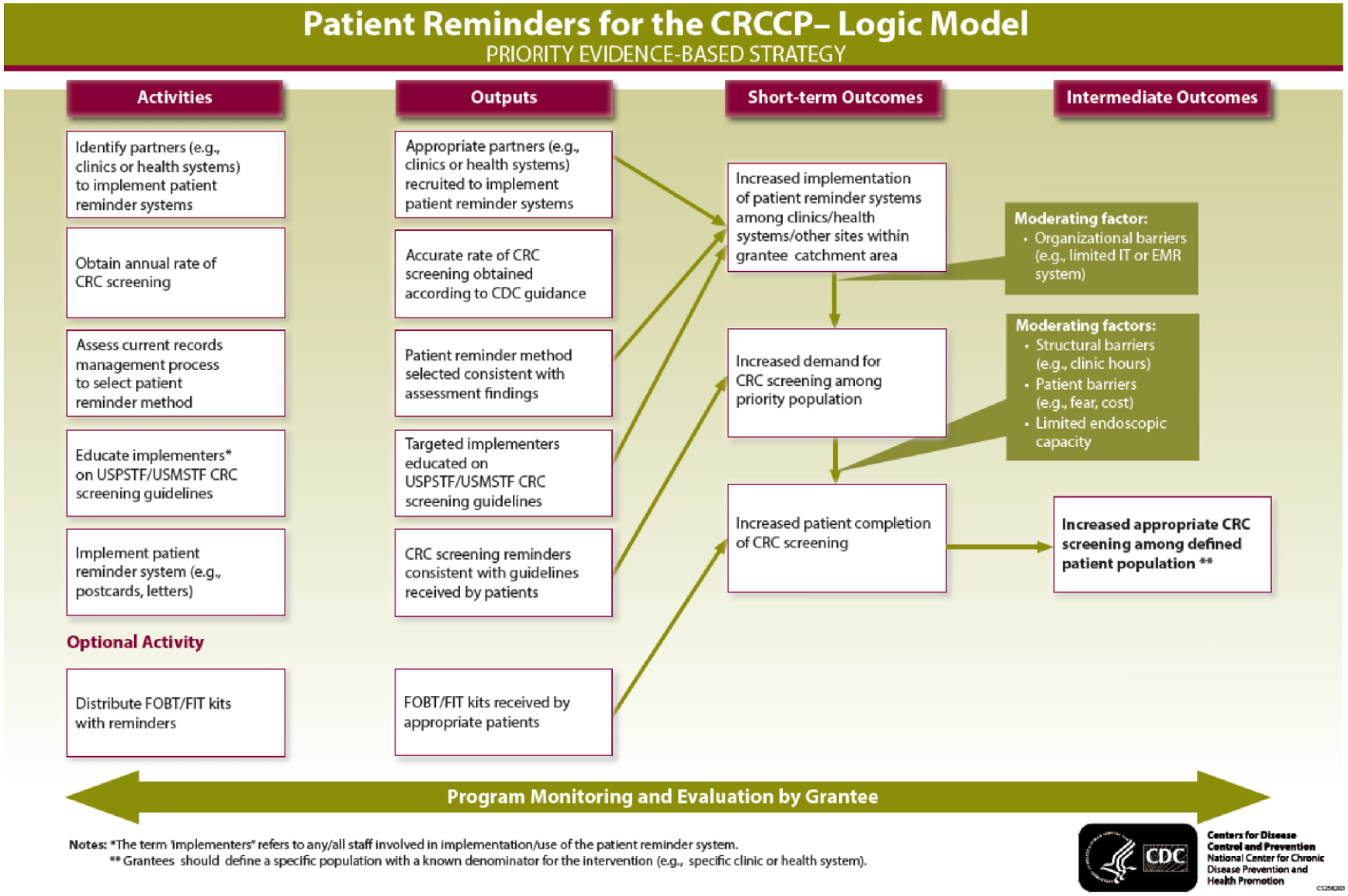
These interventions can be untailored to address the overall target population or tailored with the intent to reach one specific person, based on the characteristics unique to that person, related to the outcome of interest, and derived from an individual assessment (https://www.thecommunityguide.org/findings/cancer-screening-client-reminders-colorectal-cancer).

Examples of client reminder interventions include:

1. Utilizing the EHR to identify the population potentially eligible for screening and those due for screening, and mailing a postcard or letter informing the client they are due for screening. This would include a process to monitor responses to the reminder and providing another reminder as appropriate.

To implement and evaluate client reminders effectively, grantees should be able to:

1. Identify the population eligible and due for screening.
2. Track responses to reminders (e.g., client completed an office visit, completed screening, refused screening, did not respond).
3. Monitor the CRC screening rate in the eligible population.


Patient Reminders for the CRCCP– Logic Model
PRIORITY EVIDENCE-BASED STRATEGY
Activities
Outputs
Short-term Outcomes
Intermediate Outcomes
Identify partners (e.g., clinics or health systems) to implement patient reminder systems
Obtain annual rate of CRC screening
Assess current records management process to select patient reminder method
Educate implementers* on USPSTF/USMSTF CRC screening guidelines
Implement patient reminder system (e.g., postcards, letters)
Optional Activity
Distribute FOBT/FIT kits with reminders
Appropriate partners (e.g., clinics or health systems) recruited to implement patient reminder systems
Accurate rate of CRC screening obtained according to CDC guidance
Patient reminder method selected consistent with assessment findings
Targeted implementers educated on USPSTF/USMSTF CRC screening guidelines
CRC screening reminders consistent with guidelines received by patients
FOBT/FIT kits received by appropriate patients
Increased implementation of patient reminder systems among clinics/health systems/other sites within grantee catchment area
Moderating factor:
• Organizational barriers (e.g., limited IT or EMR system)
Increased demand for CRC screening among priority population
Moderating factors:
• Structural barriers (e.g., clinic hours)
• Patient barriers (e.g., fear, cost)
• Limited endoscopic capacity
Increased patient completion of CRC screening
Increased appropriate CRC screening among defined patient population **
Program Monitoring and Evaluation by Grantee
Notes: *The term 'implementers' refers to any/all staff involved in implementation/use of the patient reminder system.
** Grantees should define a specific population with a known denominator for the intervention (e.g., specific clinic or health system).
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Reducing Structural Barriers

Structural barriers are non-economic burdens or obstacles that make it difficult for people to access cancer screening. Interventions designed to reduce these barriers may facilitate access to cancer screening services by:

- Reducing the time or distance between service delivery settings and target populations.
- Modifying hours of service to meet client needs.
- Offering services in alternative or non-clinical settings (e.g., mobile mammography vans at worksites or in residential communities).
- Eliminating or simplifying administrative procedures and other obstacles (e.g., scheduling assistance, patient navigators, transportation, dependent care, translation services, limiting the number of clinic visits).

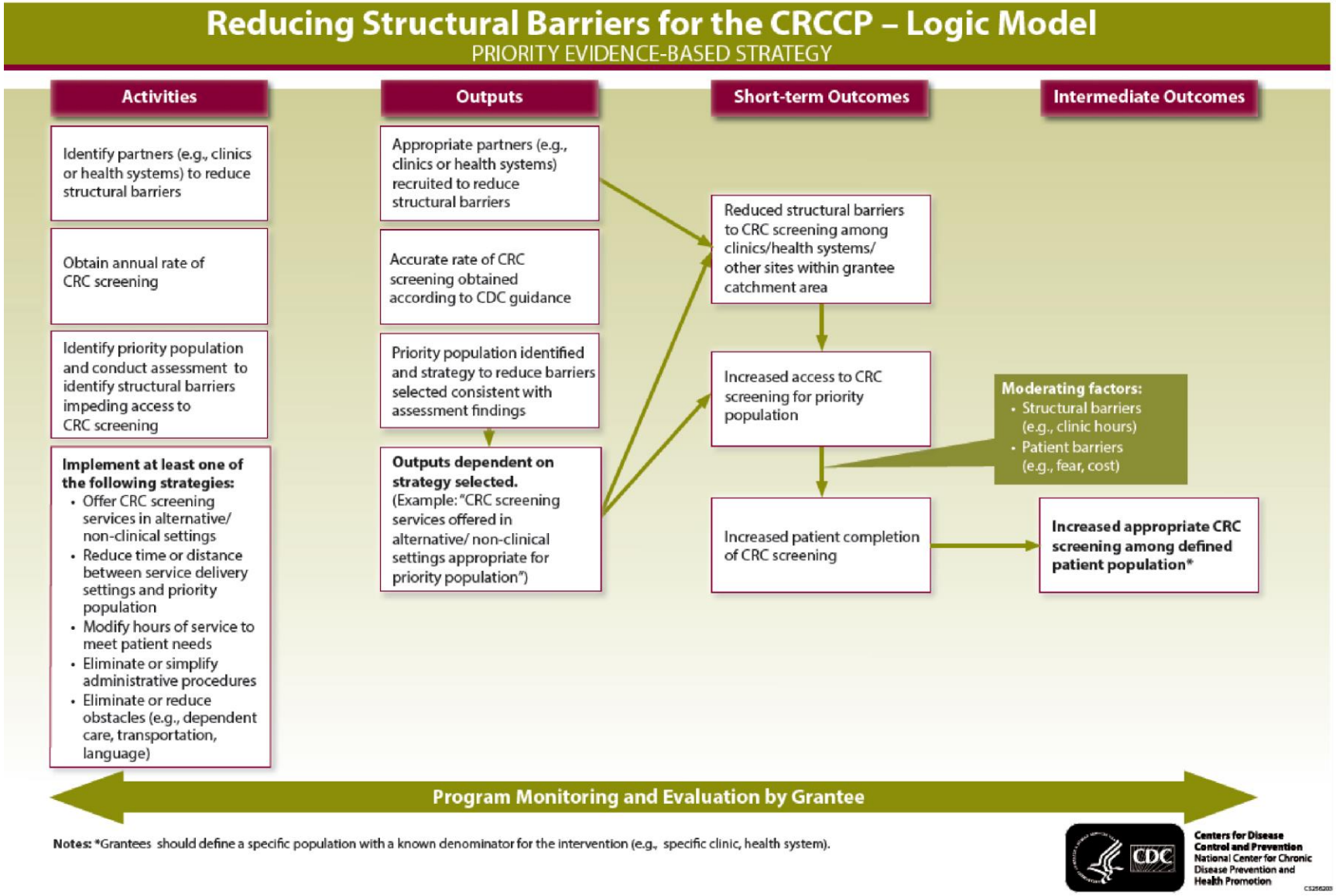
Such interventions often include one or more secondary supporting measures, such as:

- Printed or telephone reminders
- Education about cancer screening
- Information about screening availability (e.g., group education, pamphlets, brochures)
- Measures to reduce out-of-pocket costs to the client (although interventions principally designed to reduce client costs are considered to be a separate class of approaches) (https://www.thecommunityguide.org/findings/cancer-screening-reducing-structural-barriers-clients-colorectal-cancer).

Examples of reducing structural barrier interventions include:

1. Direct referral to colonoscopy.
2. Offering screening in conjunction with other preventive services visits (e.g., visits for influenza vaccines).
3. Assessing clinic workflow to streamline processes for patient identification, test provision or referral, tracking, and follow-up.

Evaluation of these interventions will vary by activity; however, monitoring the CRC screening rate in the eligible population is the primary outcome.


Reducing Structural Barriers for the CRCCP – Logic Model
PRIORITY EVIDENCE-BASED STRATEGY
Activities
Outputs
Short-term Outcomes
Intermediate Outcomes
Identify partners (e.g., clinics or health systems) to reduce structural barriers
Obtain annual rate of CRC screening
Identify priority population and conduct assessment to identify structural barriers impeding access to CRC screening
Implement at least one of the following strategies:
• Offer CRC screening services in alternative/ non-clinical settings
• Reduce time or distance between service delivery settings and priority population
• Modify hours of service to meet patient needs
• Eliminate or simplify administrative procedures
• Eliminate or reduce obstacles (e.g., dependent care, transportation, language)
Appropriate partners (e.g., clinics or health systems) recruited to reduce structural barriers
Accurate rate of CRC screening obtained according to CDC guidance
Priority population identified and strategy to reduce barriers selected consistent with assessment findings
Outputs dependent on strategy selected. (Example: "CRC screening services offered in alternative/ non-clinical settings appropriate for priority population")
Reduced structural barriers to CRC screening among clinics/health systems/ other sites within grantee catchment area
Increased access to CRC screening for priority population
Increased patient completion of CRC screening
Moderating factors:
• Structural barriers (e.g., clinic hours)
• Patient barriers (e.g., fear, cost)
Increased appropriate CRC screening among defined patient population*
Program Monitoring and Evaluation by Grantee
Notes: *Grantees should define a specific population with a known denominator for the intervention (e.g., specific clinic, health system).
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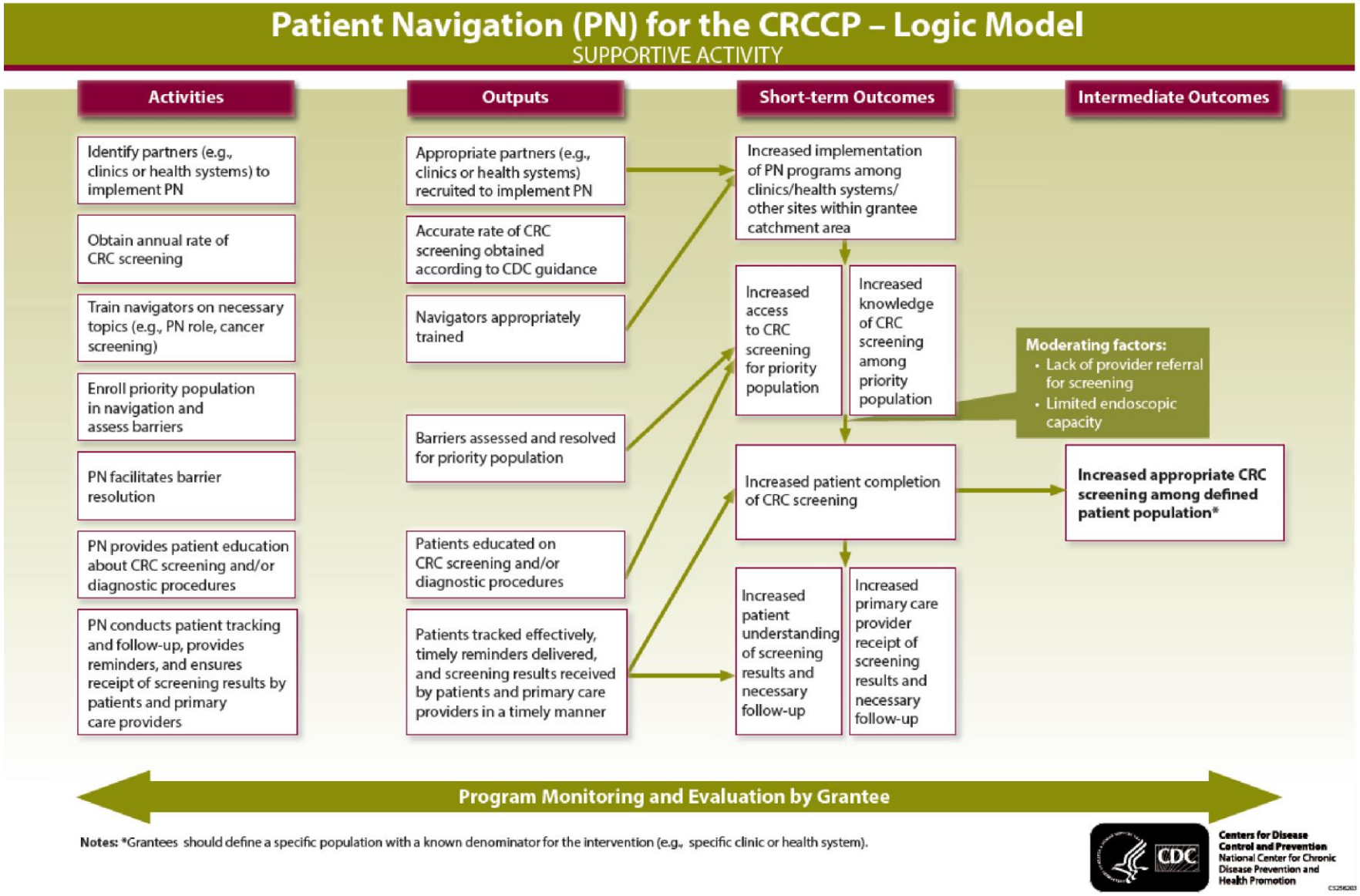
Interventions to Support Implementation of EBIs

Patient Navigation

Patient navigation may be used by partnering clinics as an approach to reduce barriers to access and use of cancer screening services, and to support implementation of EBIs (e.g., support functions to remind people they are due or overdue for screening). Patient navigation may also be used to facilitate completion of follow-up colonoscopies performed after a positive or abnormal CRC screening test; this support may be provided regardless of whether CDC funds are used to pay for the follow-up colonoscopy.

The CDC's program policy on patient navigation requires the following activities be conducted by partnering clinics:

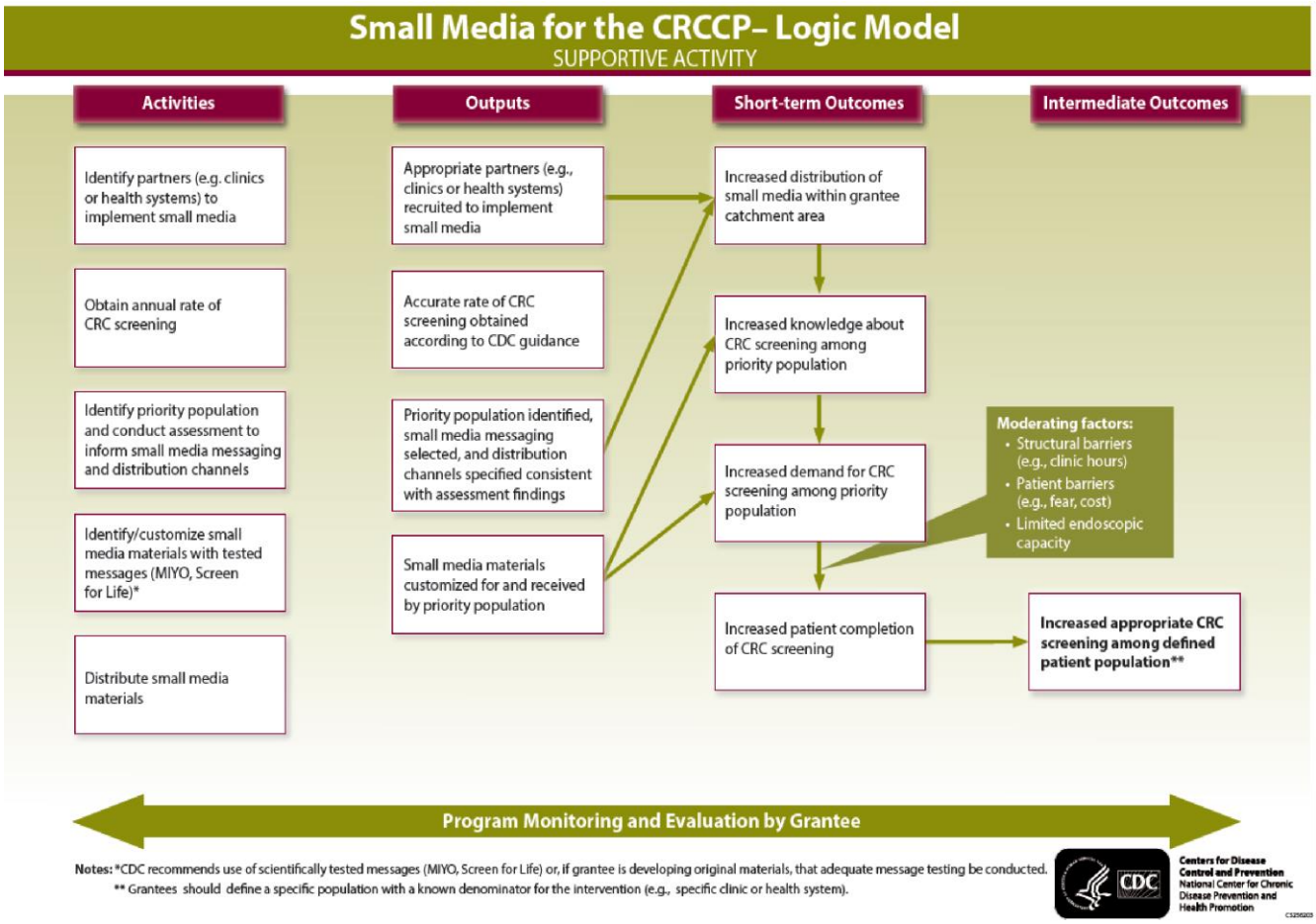
1. Written assessment of individual client barriers to cancer screening, diagnostic services, and initiation of cancer treatment
2. Client education and support
3. Resolution of client barriers (e.g., transportation, translation services)
4. Client tracking and follow-up to monitor client progress in completing screening, diagnostic testing, and initiating cancer treatment
5. Reminder calls/contacts to return FOBT/FIT tests and/or bowel prep and endoscopy appointments
6. Given the centrality of the client-navigator relationship, patient navigation must include a minimum of two, but preferably more, contacts with the client
7. Collection of data to evaluate the short-term and intermediate outcomes of patient navigation: the number of clients navigated and screening completion rate, FOBT/FIT return rate, colonoscopy completion rate, and number of screenings with cancers detected and with adenomas detected. See **Appendix D**: CRCCP Program Policy on Patient Navigation.


Patient Navigation (PN) for the CRCCP – Logic Model
SUPPORTIVE ACTIVITY
Activities
Outputs
Short-term Outcomes
Intermediate Outcomes
Identify partners (e.g., clinics or health systems) to implement PN
Obtain annual rate of CRC screening
Train navigators on necessary topics (e.g., PN role, cancer screening)
Enroll priority population in navigation and assess barriers
PN facilitates barrier resolution
PN provides patient education about CRC screening and/or diagnostic procedures
PN conducts patient tracking and follow-up, provides reminders, and ensures receipt of screening results by patients and primary care providers
Appropriate partners (e.g., clinics or health systems) recruited to implement PN
Accurate rate of CRC screening obtained according to CDC guidance
Navigators appropriately trained
Barriers assessed and resolved for priority population
Patients educated on CRC screening and/or diagnostic procedures
Patients tracked effectively, timely reminders delivered, and screening results received by patients and primary care providers in a timely manner
Increased implementation of PN programs among clinics/health systems/ other sites within grantee catchment area
Increased access to CRC screening for priority population
Increased knowledge of CRC screening among priority population
Moderating factors:
• Lack of provider referral for screening
• Limited endoscopic capacity
Increased patient completion of CRC screening
Increased patient understanding of screening results and necessary follow-up
Increased primary care provider receipt of screening results and necessary follow-up
Increased appropriate CRC screening among defined patient population*
Program Monitoring and Evaluation by Grantee
Notes: *Grantees should define a specific population with a known denominator for the intervention (e.g., specific clinic or health system).
CDC
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

Small Media

Small media include videos and printed materials such as letters, brochures, and newsletters. These materials can be used to inform and motivate people to be screened for cancer. They can provide information tailored to specific individuals or targeted to general audiences (https://www.thecommunityguide.org/findings/cancer-screening-small-media-targeting-clients-colorectal-cancer).

Because many high-quality small media materials already exist, such as *Screen for Life,* grantees should use existing materials in implementing small media interventions (See Program Policy P7).



Linkage to Follow-Up Colonoscopy

Screening for CRC is a process that may involve more than one test. If someone is screened with a test other than colonoscopy such as fecal occult blood test (FOBT), fecal immunochemical test (FIT), multi-target stool DNA (mts-DNA or FIT-DNA), computed tomographic colonography (CTC or virtual colonoscopy), or flexible sigmoidoscopy, and has a positive or abnormal result, a follow-up (e.g., diagnostic) colonoscopy **must** be obtained to complete the screening process.

Recipients may use a limited portion of awarded funds to pay for follow-up colonoscopies. The intent of providing limited funds to pay for colonoscopies is to:

1. Facilitate the development of partnerships between primary care clinics and endoscopy providers that can be leveraged once direct funding ends;
2. Facilitate the development of partnerships between recipients and primary care clinics by reducing barriers such as cost of follow-up colonoscopy that may hinder clinics' participation in efforts to increase CRC screening rates.

The intent of this activity is not to support or establish a traditional recipient led and managed "screening" program with infrastructure that exists outside of partner primary clinics. Implementation of this activity should minimize the use of contracts between the recipient and endoscopy providers; centralized, recipient supported patient navigation services; contracted billing and payment services; or other recipient supported infrastructure that partner primary care clinics would not have access to once the recipient's partnership with a given clinic ends.

Recipients that do not use CDC funds to pay for follow-up colonoscopies are still required to ensure that their partnering primary care clinics have access to follow-up colonoscopy to complete the screening process.

CDC funds may be used to:

1. Pay for follow-up colonoscopies for asymptomatic, uninsured or underinsured adults age 45-75 years who are screened for CRC by their partner clinics (e.g., clinics in which the recipients are implementing EBIs).
2. Pay for a colonoscopy following a positive or abnormal
    a. Fecal Immunochemical test (FIT);
    b. Fecal occult blood test (FOBT);
    c. Multi-target stool DNA test (FIT-DNA or Cologuard);
    d. Flexible sigmoidoscopy;
    e. Computed tomographic colonography (CTC or virtual colonoscopy).

Reimbursement for colonoscopy may not:

1. Exceed the Medicare rate;
2. Supplant other available sources of payment for colonoscopy (the Federal government is the payor of last resort.

Recipients who use CDC funds to pay for follow-up colonoscopy must report aggregate data on the results and final diagnosis as specified in the CRCCP Clinic Data Dictionary.

Program Evaluation and Performance Measurement

Evaluation and performance measurement help demonstrate progress towards achievement of project outcomes; build a stronger evidence base for specific interventions; clarify applicability of the evidence base to different populations, settings, and contexts; and, drive continuous improvement. Evaluation and performance measurement can also determine if the intended populations are reached and program impact is achieved. CDC's goal is to work with recipients to conduct meaningful program evaluation activities that can be used to monitor and improve programs and demonstrate program effectiveness in increasing CRC screening rates in partner clinics. For more information about evaluation and recipient evaluation requirements, please see Program Manual, Part II: Evaluation and Performance Measurement.

CDC-Led Evaluation

The CRCCP's purpose is to increase CRC screening rates among an applicant-defined target population of persons ages 45–75 within a partner health system, defined geographical area, or disparate population. Together, grantees and the CDC will be held accountable in demonstrating success in increasing clinic CRC screening rates—our primary outcome of interest reflected in the CRCCP logic model (see Chapter 2, Program Planning). As required in DP20-2002, the CDC must evaluate the overall CRCCP, as well as individual grantee performance. To guide our evaluation efforts, the CDC has developed its own evaluation plan that includes a listing of key stakeholders; a program description; process and outcome evaluation questions; the evaluation design, including data collection and analysis methods; and a planned use for the findings and dissemination efforts. Recipients are required to participate in CDC data collections to support the CDC-led evaluation. For more information about the CDC Evaluation Plan and required data collections, please see Program Manual, Part II: Evaluation and Performance Measurement.

Appendix

Appendix A: Memorandum of Understanding/Memorandum of Agreement Requirements

Memorandum of Understanding/Memorandum of Agreement Requirements

The purpose of each Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA) is to define the mutual goals and the working relationship between partners clearly. Further, it outlines the responsibilities of the recipient and each participating health system clinic or other entity to conduct work directly funded by this funding opportunity announcement. The MOU/MOA must be between the recipient and the partner. A separate, additional agreement or contract is required between the recipient and any intermediaries. The MOU/MOA must be detailed, specific, and binding and outline who, what, and when.

The MOU/MOA must include:

1) Names of parties, agencies, or organizations entering into the agreement.

2) An effective **date range** that spans the length of the proposed project.

3) Commitment of the participating partner to work with the recipient and other collaborative partners to address program requirements and implement project activities. **Must delineate the partner's specific roles in achieving the goals of the FOA.**

4) Commitment to collaboratively
   - **Assess the needs and existing capacity** to achieve goals.
   - **Select and implement activities** described in the FOA.
   - **Monitor implementation progress.**
   - **Evaluate outcomes and success** of the partnership.
   - **Participate in data reporting and evaluation activities** required by CDC.

5) Commitment of the recipient to work with the partner and other partners to address project requirements, including the **designation of point(s) of contact** within the recipient organization and the partner **with authority to make program-related decisions** and dedicated to the implementation of the proposed applicant activities.

6) While this is not a contract, if an exchange of funds is involved, the budget and justification should be outlined along with deliverables or services to be provided. Do not insert the contract.

7) Countersignatures for both parties by authorized representatives.

The MOU outline may include sections describing its purpose, background and objectives, terms of the memorandum including dates, responsibilities of the recipient, responsibilities of the partner health system, funding, authorized representatives, and the process for amending or terminating the agreement.

Appendix B: Clinic Readiness Assessment Guidance

CLINIC READINESS ASSESSMENT GUIDANCE

This guidance can help you design your program-specific assessment tool by providing a list of key elements to include.

The purpose of the clinic readiness assessment is to document the current CRC screening process, the quality of CRC screening data, and resources available in each clinic to guide the selection of EBIs to address identified gaps and opportunities and identify and conduct any needed quality improvement activities prior to EBI implementation, such as improving the quality of electronic health record (EHR) screening data. Clinic readiness assessments should be conducted with each clinic **before** EBI implementation occurs. CDC will review assessment results in the Implementation Clinic Planning Summary with you and approve or make recommendations regarding your EBI selections prior to implementation.

1) Include variables in your clinic readiness assessment that describe clinic and patient characteristics and demographics. Patient demographic data will be used in determining baseline CRC screening rates for the clinic.

   Collect at minimum, the following information on **clinic characteristics and demographics**.

   - Type of facility, such as a Federally Qualified Health Center (FQHC) or a community health center being assessed and the number of facilities within the larger health system (if applicable).
   - Type and number of providers and other office staff.
   - Community characteristics (urban, suburban, or rural).
   - Currently planned or initiated quality improvement initiatives.
   - Current policies or standing orders in place regarding CRC screening.
   - Training and reinforcement practices that support standing orders.
   - Leadership support of preventive care generally and prioritization of CRC screening specifically.
   - Presence or absence of a designated staff member or administrator championing CRC screening initiatives.

   Collect at a minimum, the following information on **patient characteristics**. These should align with baseline data collection for submission through CDC's clinic data collection system (CBARS).

   - The total number of patients aged 50 to 74 years with at least one medical visit during the designated reporting year. (This age group will change to include patients aged 45-49 years once the national measures (i.e., UDS, HEDIS) have been updated.)
   - The number of active patients by sex and race/ethnicity.
   - The number of active patients by insurance type (including uninsured).
   - The number of patients who are up to date with CRC screening according to U.S. Preventative Services Task Force (USPSTF) guidelines.
   - Relevant patient population characteristics (average income, health literacy, typical barriers faced to adhering to care).
2) Include a clinic workflow assessment as part of your overall Clinic Readiness Assessment Tool. A workflow assessment seeks to identify existing practices and missed opportunities for patient identification (due for screening), education, recommendation for screening, and follow-up.

Collect information on how patients are **identified as due for CRC screening**.

- What protocol is used to determine a patient's eligibility for CRC screening? Does it include age, risk, and last completed screening result? Is it actively used?
- Staff member(s) responsible for identifying patients due for screening and the process for noting this in their files, alerting the patients that they are due, and/or flagging their files for a provider reminder.

Consider how you will map clinic processes in terms of **patient flow**.

- Identify the physical spaces the patient encounters during a visit and the different staff who interact with the patient in each space or step. Describe what processes take place; for example, in the pre-exam area, the nurse takes the patient's height, weight, and blood pressure.
- Identify educational materials visible or provided at each step of patient flow.
- Identify if, when, and how in the workflow and protocol a staff member discusses CRC screening with the patient. Address related issues such as shared decision-making for test selection, refusal to be screened, and insurance status as a financial barrier to screening completion.
- Identify which staff member orders the screening test.
- Describe any measures taken to ensure a patient has received a recommendation/referral during their visit and before leaving the clinic. For example, catching a missed opportunity before the patient leaves.
- Describe the process for educating the patient on how to complete the screening test. This includes how to complete and return a Fecal Immunochemical Test (FIT) to the lab, who to contact to schedule a colonoscopy, information about colonoscopy prep, and next steps in case of an abnormal result). Include information on when this occurs during a patient visit and which staff member is responsible for this task.

Consider how you will map clinic processes in terms of **screening and results tracking and follow-up**.

- Identify the clinic process and staff responsible for determining if and when a FIT kit was returned or a colonoscopy completed and how the information is documented.
- Identify the protocol for contacting a patient who has not completed an ordered or scheduled screening test.
- Describe the process for informing a patient of negative (normal) results, including documentation.
- Describe the process for informing a patient of positive (abnormal) results, including documentation.
- Describe the process and staff responsible for working with a patient to arrange for follow-up testing. Include information on who schedules the colonoscopy, who reviews prep instructions with the patient, what happens when patients are uninsured or underinsured, the specialist providers to which the patients are referred, and the typical wait time for receiving the colonoscopy, etc.
- Describe the process and staff responsible for following up with specialty care to ensure that the patient received the scheduled test and to obtain the results for further follow-up or documentation.
- Describe the process for following up with a patient who did not show up for their scheduled appointment.

Consider what information you will collect on clinic processes for **rescreening patients**.

- Describe the clinic's process for tracking when patients are due for regular CRC screening.

- Determine if staff ask about previous CRC screening if none are known or documented.
- Determine if staff have a process for obtaining past screening results if unknown.

3) Review and assess your clinic partner's data collection and monitoring system to determine how they will obtain accurate data to calculate reliable CRC screening rates. There is some overlap in the suggested variables mentioned below and the previous section.

   Consider how you will collect information to **document patient data**.

   - Note which kind of electronic health record system is being used and any other important information about the product, modules, or population management tools used with the system.
   - Identify past systems used and discuss plans to change products in the future.
   - Identify how patient data related to CRC screening are documented in the EHR or manually during the patient visit and for tracking and follow-up. Include how previous screening results, referrals, current results, patient refusal, and follow-up needed is documented. Document whether data are entered into a structured field or as free text, and whether data are entered manually, scanned, or imported.
   - Identify whether documentation practices are standardized across staff and consistently communicated during training.

   Consider how you will collect information on the current capacity to **use EHR data for process improvement**.

   - Identify if and how reports are generated using the EHR and who handles this task (internal, vendor, which staff if internal). Note whether reports are used to identify patients due for screening or to pre-screen patient records to facilitate provider recommendations.
   - Assess the clinic's capacity to modify their EHRs to generate specific reports as needed.
   - Assess the clinic's capacity to set up alerts for patient or provider reminders and whether this is currently done.
   - Assess whether the clinic can generate reports for CRC screening completion rates by provider, care team, and/or aggregate clinic.
   - Identify the quality standards reporting system(s) to which the clinic submits data, such as the Uniform Data System (UDS) or the Healthcare Effectiveness Data and Information Set (HEDIS). Also identify the metric the clinic uses to report CRC screening data, such as the National Quality Forum (NQF) or UDS, and how these data affect their quality improvement activities.

4) Determine the degree to which the following Community Preventive Service Task Force (CPSTF) recommended strategies (listed in The Community Guide) are in place at the implementation site or clinic.
   - Provider assessment and feedback
     - Describe who is being assessed (individual providers, pods, clinic teams, clinics).
     - Describe the metric used (such as the number of eligible patients who receive a CRC screening recommendation or the number who complete a CRC screening test).
     - Describe the format used for providing feedback (provider score cards, rankings, competition, comparison to a target rate).
     - How are the results discussed with the providers and clinic staff (written report, interactive meeting)?

    - Is competition among providers encouraged? How is improvement incentivized?
- Provider reminders
    - Describe any alert to clinic staff that a patient is due or overdue for CRC screening.
    - Describe who receives the alert.
    - Describe the format (EHR, manual flag or note) and how it is delivered.
    - Describe any action required to close out the alert/tracking.
- Patient reminders
    - Describe how a patient is alerted when due or overdue for CRC screening (phone, letter, text).
    - Describe how this was determined and what information is relayed.
    - Describe any additional information provided (educational, next steps).
    - Describe how the patient response is tracked.
    - Describe the reminder process (How many alerts will the patient receive? At what interval? When will they stop?).
- Reducing structural barriers
    - Describe how obstacles to screening completion are identified (individual and community needs).
    - Describe what these obstacles or barriers are.
    - Describe the ways in which transportation challenges, the need for alternative clinic hours, FIT kit return challenges, and other barriers are addressed by the clinic.

Appendix C: Clinic Implementation Planning Summary

Clinic Implementation Planning Summary

INSTRUCTIONS: Complete this form for each clinic partner. Submit to your CDC Program Consultant for review and approval before proceeding with activities with your clinic partner. In our review, CDC will look for evidence of thorough assessment, clinic selection based on data and readiness, EBI selection and process improvements that match identified issues, and sustainability as part of implementation.

This form should be completed by the CRCCP recipient—not the clinic partner or technical assistance partner(s). However, the content of this summary should have been reviewed and agreed upon by all partners involved in the planning and implementation of activities at the clinic described here.

Before completing, make sure a formal agreement with the partner clinic is in place, a thorough clinic readiness assessment using your CDC-approved tool has been conducted, and planning meetings have been held using assessment results to inform decision-making.

PARTNER INFO	
Name of Clinic: Click or tap here to enter text.	
Name of Health System: Click or tap here to enter text.	
Name of Person Completing This Form: Click or tap here to enter text.	Role: Click or tap here to enter text.
Date: Click or tap to enter a date.	
ENGAGEMENT	
1. Briefly describe how you engaged or recruited this clinic partner to be part of CRCCP efforts. Include any relevant information about working with partners and whether this clinic is part of a larger health system, etc. Click or tap here to enter text.	
FIT	

2. Describe why this partner is a good fit for this project. Provide information on patient population and clinic characteristics, baseline CRC screening rates, the use of an EHR system, leadership support, clinic champions, and how this project aligns with other quality improvement initiatives.

Click or tap here to enter text.

WORKFLOW

3. Summarize existing screening processes, including current EBI activities (if any) and the quality and consistency of implementation. Attach a completed process map. Include their patient navigation process, if applicable.

Click or tap here to enter text.

EBI SELECTION AND IMPLEMENTATION

4. Based on your assessment results, in the chart below describe critical issues, the activities and EBIs you and your partners have selected for implementation or enhancement, and how they will implemented.

Issue/Problem	EBI or Process Change Selected	Implementation Details
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

DIAGNOSTIC COLONOSCOPIES

5. Describe how this clinic covers diagnostic colonoscopies. Will CDC funds be used? If so, include documented assessment of barrier and how the clinic will meet reporting and other requirements.

Click or tap here to enter text.

SUSTAINABILITY

6. How will sustainability be built into implementation? Describe efforts to institutionalize changes, gradually moving activities to other funding sources, efforts to automate tasks through Health IT, and implementing new or improved protocols and staff training processes, etc.)

Click or tap here to enter text.

TECHNICAL ASSISTANCE

7. **<u>If applicable</u>**, what additional technical assistance will this clinic need that may not be described in your Technical Assistance Plan? Describe how you will provide different or additional technical assistance for this partner.

Click or tap here to enter text.

APPROVAL

To be completed by CDC

☐ CDC has reviewed the information provided and the recipient should proceed with implementation as described here.
☐ This form is NOT approved due to the issues described in the Comments box. Please work with your PC to address outstanding issues and resubmit for review and approval before moving forward with implementation.

Name of Approver	
Comments and feedback for the recipient.	

Appendix D: CRCCP Patient Navigation Policy

Defining Patient Navigation

Clients often face significant barriers to accessing and completing cancer screening and diagnostics. Patient navigation is a strategy aimed at reducing disparities by helping clients overcome those barriers. For the purposes of the CRCCP, patient navigation is defined as, "individualized assistance offered to clients to help overcome healthcare system barriers and facilitate timely access to quality screening and diagnostics as well as initiation of treatment services for persons diagnosed with cancer."

Required Patient Navigation Activities

Although patient navigation services vary based on an individual's needs, at a minimum, patient navigation for men/women served by the CRCCP must include the following activities:

1. Assessment of individual patient barriers to cancer screening, diagnostic services, and initiation of cancer treatment
2. Patient education and support
3. Resolution of patient barriers (e.g., transportation, translation services)
4. Patient tracking and follow-up to monitor patient progress in completing screening, diagnostic testing, and initiating cancer treatment
5. A minimum of two, but preferably more, contacts with the patient, due to the centrality of the patient-navigator relationship.
6. Collection of data to evaluate the primary outcomes of patient navigation -- cancer screening and/or diagnostic testing, final diagnosis, and treatment initiation if needed.

Terminating Patient Navigation

Depending on screening and diagnostic outcomes, patient navigation services are terminated when a client (1) completes screening and has a normal result; (2) completes diagnostic testing and has normal results; (3) initiates cancer

Priority Populations for Patient Navigation

Navigation is an individualized intervention, intensive in nature, and potentially costly; therefore, priority should be given to navigate clients who otherwise **would not** complete the screening process. Clients who receive navigation through the CRCCP activities must be low-income and be of appropriate age per USPSTF screening guidelines. For example, a grantee could support a patient navigator position in a clinic or hospital that serves low-income populations. ***Grantees must collect data to monitor the short-term and intermediate outcomes noted above.***

Appendix E: Technical Assistance Plan

Technical Assistance Plan

CDC expects recipients to engage with their clinic partners actively to implement the CRCCP, including supporting evidence-based interventions (EBIs). The purpose of this Technical Assistance Plan is to ensure that all DP20-2002 recipients thoughtfully consider **who** will provide it (such as the recipient or a contracted partner), **what** TA will be provided, **how** TA will be delivered (such as in person or by phone), and **when** (with what frequency) TA will be delivered. The plan should also document how TA delivery will be monitored.

Complete this TA Plan by describing your strategy for providing technical assistance to your partner clinics. Include details for working with clinics to identify a clinic champion, establish a CRC screening policy, address electronic health record (EHR) issues, implement practice improvements, implement evidence-based interventions, collect and use data, and support activities leading to long-term sustainability of CRCCP activities in your partner clinics. Provide this plan to your CDC Program Consultant no later than **October 30, 2020** and review it at least annually.

The plan should represent your approach for working with your partners on a routine basis. If you change the way you will provide technical assistance based on lessons learned, improvements, or other circumstances, please update this document and provide a copy to your PC. If you have a clinic that requires an alternative to this plan, please note that information in their Implementation Readiness Summary.

1. **Complete the Table Below**
   - List all staff and partners (internal or external to your organization) who will deliver TA support to your partner clinics in column 1 of the table below.
   - Describe their role in column 2.
   - Describe the focus of their TA in column 3 (for example, health information technology, clinic quality improvement, or evaluation).
   - Note if the partner is receiving grant funding.

Person/Partner Delivering TA	Role	TA Focus	Funding Provided (Y/N)
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	☐
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	☐
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	☐
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	☐
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	☐
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	☐

Provide details about your overall TA approach related to question 1 below

2. **Describe How and When TA Is Delivered**
    - Describe methods used to deliver TA (such as in person or by telephone).
    - Describe the frequency of TA delivery. We recognize that this will vary depending on assessment results for individual clinics but describe your general approach.
    - If providing TA or other support to a group of clinics at the same time, describe how such support will be provided and the frequency.
    - Will you develop action plans that specify TA for each clinic? If so, describe.
    - How will you use strategies in Plan-Do-Study-Act (PDSA) or another quality improvement framework to monitor new processes that are implemented?

3. **Monitoring Partners That Are Delivering TA to Partner Clinics**
    - If partners (contractors or consultants) are involved in delivering TA to clinics, describe how you will monitor their activities and ensure accountability (such as regular reports from partners or regular calls with partners).
    - Describe any deliverables required from your partners related to their TA provision.
    - Describe how you will monitor the TA that is delivered (quality of TA delivered, amount of TA delivered, types of TA delivered)