



Sage Programs | Breast, Cervical & Colorectal Cancer Clinic Systems Change Initiative | Increasing Cancer Screening in Minnesota

CLINIC ORIENTATION MANUAL

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Disclaimer: This is a working program manual. Changes may be made, including but not limited to, updates to best practices, clinical staffing needs, and additional guidance from the Centers for Disease Control and Prevention. In the event that changes are made, an updated version of this document will be sent to the project coordinator

Contents

- Section I: Background.....1**
 - Manual Overview1
 - Goal1
- Section II: Systems Change, Sustainability, and Health Equity Lens2**
 - Systems Change2
 - Sustainability.....3
 - Health Equity Lens.....4
 - Cancer Disparities4
 - What Creates Health?.....7
 - Applying a Health Equity Lens to Practice.....8
- Section III: Program Framework8**
 - Sage Breast and Cervical Early Detection Program (NBCCEDP)8
 - Scopes Colorectal Cancer Control Program (CRCCP)8
 - Partner Roles.....9
 - CDC Role.....9
 - MDH Sage and Scopes Programs Role9
 - Clinics Role10
 - MDH Technical Assistance10
- Section IV: Implementation.....12**
 - Appoint Clinic Champion and Team13
 - Clinic Readiness Assessment.....15
 - Baseline Data Collection16
 - Implementation Planning Summary16
 - Evidence-Based Interventions (EBIs).....17
 - Community Preventive Services Task Force (CPSTF) Findings for Cancer Prevention and Control18
 - Evidence-Based Interventions (EBIs) Definitions21
 - Supporting Activities21
 - Resources22
 - EBI Implementation Checklists.....23
- Section V: Data Reporting and Evaluation.....23**
 - Baseline and Annual Clinic Data.....23
 - Program Evaluation.....24
- Section VI: FOBT/FIT/FIT-DNA Kits and Linkage to Follow-Up Colonoscopy25**
- Section VII: Voter Registration.....25**
- Section VIII: Screening Guidelines.....25**
 - Colorectal Cancer25
 - Breast and Cervical Cancer.....26

Section I: Background

Manual Overview

This manual was developed to support clinics funded by the Minnesota Department of Health's (MDH) Breast and Cervical (Sage) and Colorectal (Scopes) cancer screening programs **to conduct health systems change interventions to improve cancer screening rates and patient outcomes.**

This manual provides the program background, defines clinic systems change and the health equity lens central to this work, and outlines program components. It also provides information on the grant requirements including:

- Assessing clinic needs and readiness for systems change.
- Assessing electronic health record (EHR) use.
- Mapping of clinic workflow processes.
- Implementing evidence-based interventions (EBIs).
- Developing an implementation plan.
- Collecting clinic data and program evaluation.

Partner roles including the type of technical assistance available from MDH is also described.

Goal

Increase breast, cervical, and colorectal cancer screening rates in primary care clinics through sustainable health systems change

For Sage and Scopes, the essential need for the program (to increase screening rates) has already been established, and effective interventions (EBIs) have been identified in the *Community Guide*.¹ Grantee's role will determine how best to implement the identified interventions in their clinic.

Dr. Lisa Richardson, Director of the Center for Disease Control and Prevention's (CDC) Division of Cancer Prevention and Control, highlights evidence-based strategies to help you screen more people and save money for your health clinic in this **one-minute video**:

[ScreenOutCancer "Too Great a Cost" -- Increasing Cancer Screenings, Saving Lives \(https://www.youtube.com/watch?v=uxwWLSL8uPE\)](https://www.youtube.com/watch?v=uxwWLSL8uPE)

¹ The Community Guide to Preventive Services (*The Community Guide*). <https://www.thecommunityguide.org/content/task-force-findings-cancer-prevention-and-control>

Section II: Systems Change, Sustainability, and Health Equity Lens

Systems Change

The Minnesota Department of Health Sages and Scopes Programs adopted the CDC's definition to define systems change. Health systems change is a change in organizational policies, processes, or environmental supports that institutionalize improvements in the screening process and lead to increased screening rates in the health system or clinic and target populations.

Systems Change Using Evidenced-based Strategies Benefits Clinics

Increases overall number of adults screened.

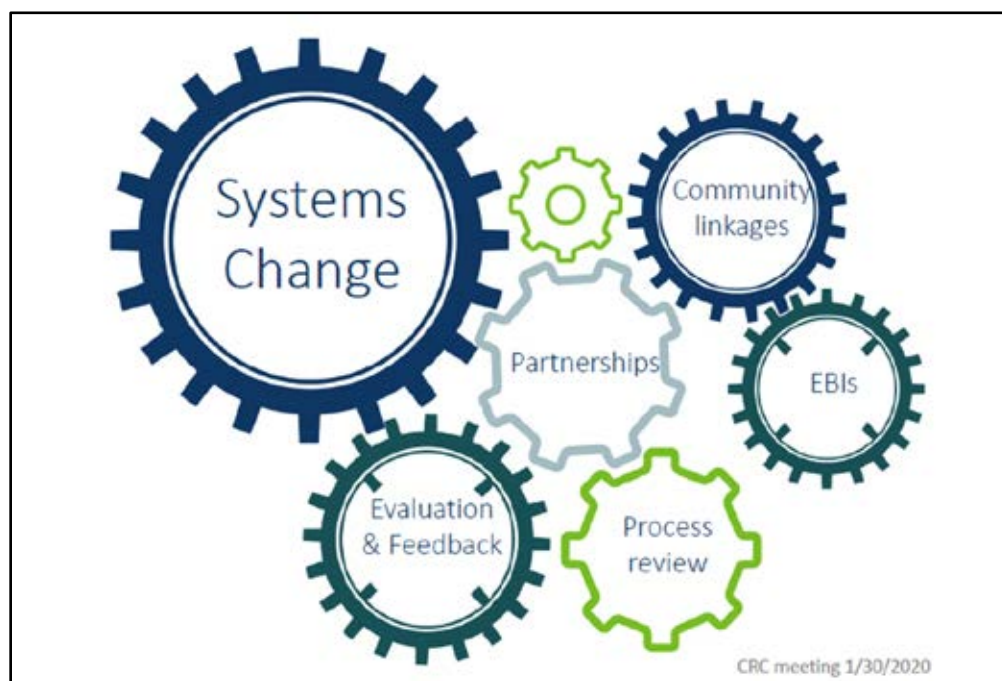
Increases clinic screening rates.

Improves patient outcomes by finding cancer early when treatment works best.

Enhances cancer screening clinical service delivery.

Advances health equity and reduces health disparities.

Figure 1: Components of systems change



As illustrated by the gears in figure 1, for systems change to be effective and sustainable, it needs to be grounded in community linkages and partnerships; be based on evidence-based interventions; include process review; and be adjusted based on evaluation and feedback. All of the gears must move together!

Systems change in clinics results from initiatives and strategies that improve one or more functions of the clinic and lead to better health outcomes through sustainable improvements in access, coverage, quality, or efficiency. It is about making changes to the collective activities in the clinic that guide daily operations (i.e., service delivery) and the implementation of EBIs to improve outcomes and efficiency.

Implementing new or enhancing existing EBIs can support individuals getting screened regularly. A first step might be to change the clinic's EHR to identify patients that are due or overdue for screening or re-screening. Then, having a patient reminder system in place will help ensure that people are re-screened at the appropriate interval. These changes will lead to increased clinic cancer screening rates.

Institutionalization of EBIs and other process improvements will help establish more organized approaches to breast, cervical and colorectal cancer screening in the clinic. A systems change approach reaches more people while assisting in getting them what they need to be healthy.

Sustainability

Systems change work is most impactful when it is sustainable, as sustainability is key to community relationships and long-term change. This is especially true in the case of cancer screening as changes made to clinic processes need to support individuals repeating the health behavior of getting screened on a regular schedule.

For this grant, examples of changes sustainable through institutionalization might include:

- Efforts to automate tasks through Health IT/EHR.
- Implementing new or improved protocols and staff training processes.
- Moving activities to non-grant funding sources.

For these reasons, the MDH Sage program will work with your clinic to institutionalize EBI implementation so that improved outcomes will persist, and community relationships will be maintained.

Health Equity Lens

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity².

Advancing Health Equity in Minnesota: Report to Legislature, 2014³

Health Disparity: A population-based difference in health outcomes (e.g., women have more breast cancer than men).

Health inequity: A health disparity based in inequitable, socially determined circumstances (for example, American Indians have higher rates of diabetes due to the disruption of their way of life and replacement of traditional foods with unhealth commodity foods). Because health inequities are socially determined, change is possible.

Health equity: When every person has the opportunity to realize their health potential—the highest level of health possible for that person—without limits imposed by structural inequities. Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health.

Structural inequities: Structures or systems of society—such as finance, housing, transportation, education, social opportunities, etc.—that are structured in such a way that they benefit one population unfairly (whether intended or not).

Structural racism: The normalization of an array of dynamics—historical, cultural, institutional, and interpersonal—that routinely advantage White people while producing cumulative and chronic adverse outcomes for people of color and American Indians.

Cancer Disparities

Cancer inflicts enormous suffering, death, and financial hardship. In Minnesota (MN), cancer is a leading cause of mortality, with breast and colorectal cancers being some of the most common. Longstanding disparities in cancer incidence and mortality outcomes exist for breast, cervical and colorectal cancer. Minnesota has these health disparities because the opportunity to be healthy is not equally available everywhere or for everyone in the state.

The 2014 landmark report from the Minnesota Department of Health [Advancing Health Equity in Minnesota: Report to the Legislature](https://www.health.state.mn.us/communities/equity/reports/ahe_leg_report_020114.pdf) identified the social determinants of health (e.g. , income, education, housing, etc.) as well as systemic issues such as structural racism, discrimination, and conscious and unconscious racism that are deeply engrained in all of our systems and benefit some populations while having an adverse impact on others. These

² World Health Organization, Ottawa Charter for Health Promotion 1986.

³ Advancing Health Equity in MN, Report to the Legislature, 2014

https://www.health.state.mn.us/communities/equity/reports/ahe_leg_report_020114.pdf

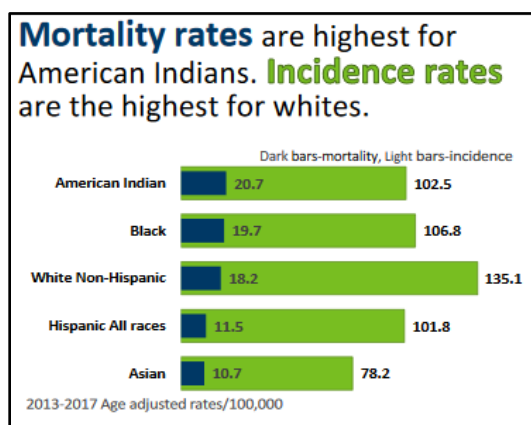
inequities and health disparities are evidenced in health outcomes. In addressing screening disparities, we can address disparities in cancer incidence and mortality outcomes.

Sage and Scopes' efforts are based on the understanding that health results not only from individual behaviors but also from access to quality health care and wellness services, healthy and thriving communities, access to jobs, housing, education, paid sick leave, and more.

The disparities noted below are an indication of deep systemic inequities that exist to prevent some communities from thriving and achieving optimal health.

Breast cancer is MN's most common invasive cancer diagnosis in women across every racial and ethnic group. Compared to women of other races and ethnicities, White women have higher breast cancer incidence rates but lower mortality rates. American Indian and Black women have the highest mortality rates, followed by White women. American Indian women are most likely to die from breast cancer.⁴

Figure 2: Mortality rates for breast cancer



MN Breast Cancer Disparities³

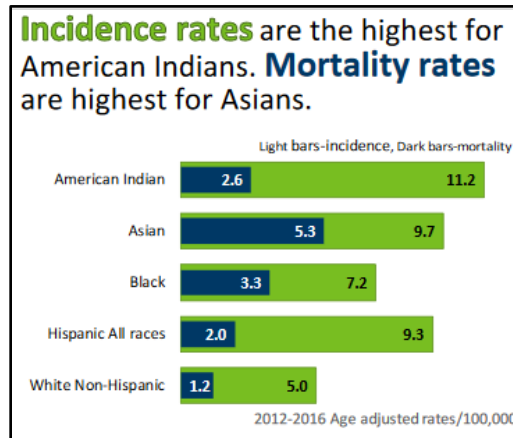
Cervical cancer disproportionately affects Minnesota's people of color and American Indian women are the most likely to develop cervical cancer in Minnesota. From 2012-2016, they were twice as likely to be diagnosed with this cancer as non-Hispanic White women. Asian women were more than four times as likely to die from cervical cancer as non-Hispanic Whites. Additionally, Asian women were the least likely to report having a Pap test screening in the past three years, followed by Black women. The likelihood of having a Pap test in the past three years is strongly associated with education. Only 78 percent of women who didn't complete high school reported being screened while 86 percent of college graduates were screened.⁵

⁴ *Breast Cancer Disparities in Minnesota women* fact sheet. MDH 7/17/2020 <https://www.health.state.mn.us/data/mcrs/docs/breastfs.pdf>

³ MDH, *Breast Cancer*

⁵ *Cervical Cancer in Minnesota* fact sheet. MDH 1/28/20 <https://www.health.state.mn.us/data/mcrs/docs/cervicalfs.pdf>

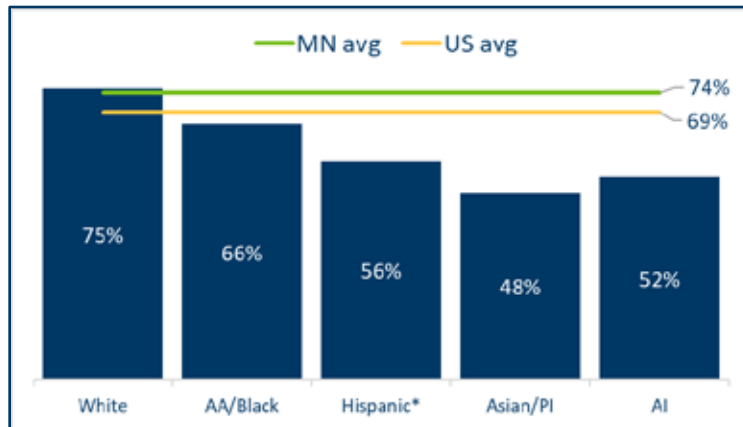
Figure 3: Mortality rates for cervical cancer



MN Cervical Cancer Disparities⁴

Colorectal Cancer (CRC) is the third most common cancer diagnosis and second leading cause of death in Minnesota for both men and women.⁶ Colorectal cancer incidence and mortality is highest among American Indians, who experience CRC mortality rates more than twice as high as non-Hispanic Whites (27.6 per 100,000 versus 12.6, respectively).⁷ In 2020, an estimated 2,320 Minnesotans will be newly diagnosed with **colorectal cancer**, and 790 people will die from it.⁸ Yet, over half of all CRC cases are preventable, and screening alone can prevent more than 60% of CRC deaths.

Figure 4: MN CRC screening rates by race/ethnicity. BRFSS 2018.



MN CRC screening rates overall are 74% (Figure 4). This state-level success obscures substantial screening disparities.⁹ Only 46% of uninsured, 59% of Medicaid, and 58% of populations of color

⁴ MDH, Cervical Cancer

⁶ "Colorectal Cancer: Facts & Figures." MN Public Health Data Access. Minnesota Department of Health. Web. https://data.web.health.state.mn.us/cancer_colorectal

⁷ MN Cancer Registry System 2012 – 2016.

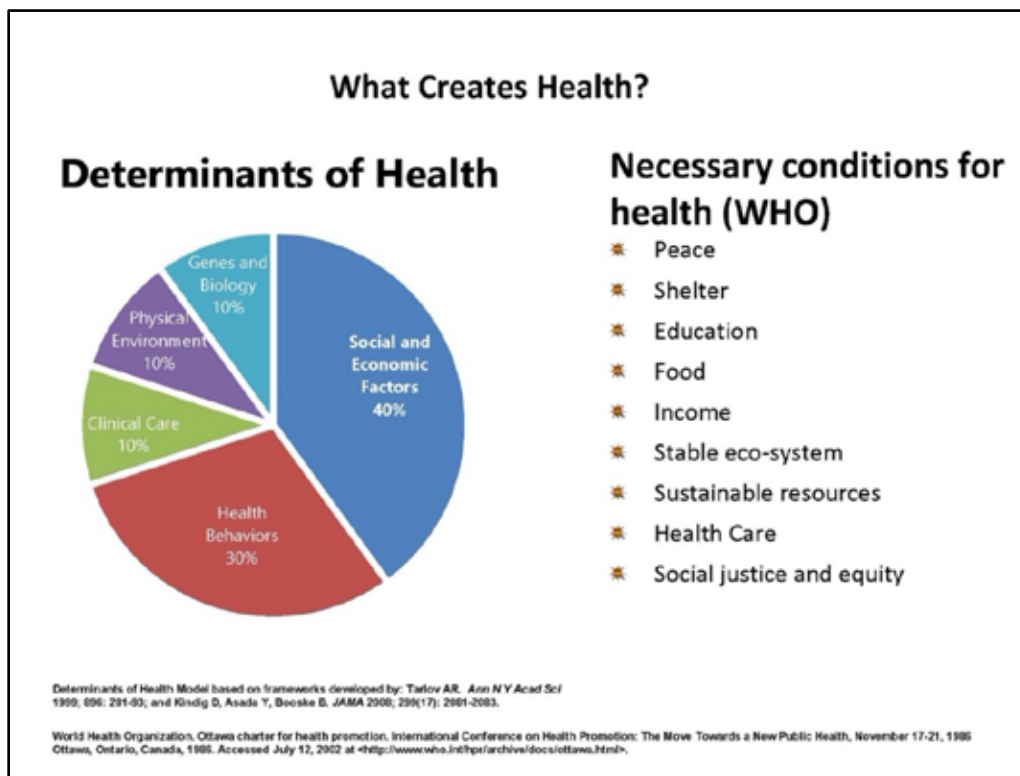
⁸ American Cancer Society, 2019. Cancer Facts and Figures 2020.

⁹ Behavioral Risk Factor Surveillance System (BRFSS) 2014, 2016, and 2018

and American Indians are up to date with appropriate colorectal cancer screening. Rural populations are screened at a lower rate (69%) than the state average. Only 52% of American Indians are up to date with CRC screening.

What Creates Health?

Figure 5: What creates health?



As shown in figure 5, the social determinants of health are: social and economic factors (40%), health behaviors (30%), clinical care (10%), physical environment 10%, and genes and biology (10%). The necessary condition for health as defined by the World Health Organization are:

- Peace
- Shelter
- Education
- Food
- Income
- Stable ecosystem
- Sustainable resources
- Health care
- Social justice and equity.

Applying a Health Equity Lens to Practice

The work that clinics do translates the theory of health equity into practice by implementing proven, game-changing innovations. Using a health equity lens means health systems and clinics will change their ways of working so that everyone has a fair and just opportunity to be as healthy as possible. This may involve changing clinic operations and creating interventions designed to reduce structural barriers that make it difficult for people to access and complete appropriate cancer screenings and diagnostic care. Examples might include patient navigation, flexible clinic hours, referrals to needed social services, and addressing structural racism.

This work is transformative work because it goes beyond the individual needs to address the structural and systemic causes of health inequities. By improving the health of those experiencing the greatest disparities, this work will improve the health of all Minnesotans.

Section III: Program Framework

Sage Breast and Cervical Early Detection Program (NBCCEDP)

The Minnesota Breast and Cervical Program (Sage) aims to increase cancer screening among low-income, underserved women ages 40 to 64 throughout the state. Within this broader mission, Sage is primarily supported through MN State and federal funds through the National Breast and Cervical Early Detection Program (NBCCEDP) and has been active since 1991.¹⁰

Scopes Colorectal Cancer Control Program (CRCCP)

The Minnesota Department of Health Scopes Program was awarded a 5-year grant that began in June 2020—*Public Health and Health System Partnerships to Increase Colorectal Cancer Screening in Clinical Settings*—from the Centers for Disease Prevention and Control (CDC) Colorectal Cancer Control Program (CRCCP). The purpose of this grant is to increase colorectal screening rates among people between 45 and 75 years of age.¹¹

The Sage and Scopes programs prioritize identifying, naming and addressing racial, ethnic, and economic disparities in breast, cervical, and colorectal cancer screening, incidence, and mortality. These programs work to increase clinics screening rates by:

- Implementing sustainable health systems changes.
- Implementing EBIs described in *The Community Guide*¹² and other supporting strategies in partnership with health systems or primary care clinics serving high-need populations using a health equity lens.
- Providing follow-up services for a limited number of program-eligible people.

¹⁰ CDC NBCCEDP, <https://www.cdc.gov/cancer/nbccedp/>

¹¹ CDC CRCCP, <https://www.cdc.gov/cancer/crccp/>

¹² The Community Guide, <https://www.thecommunityguide.org/topic/cancer>

Partner Roles

Figure 6: Roles of partners

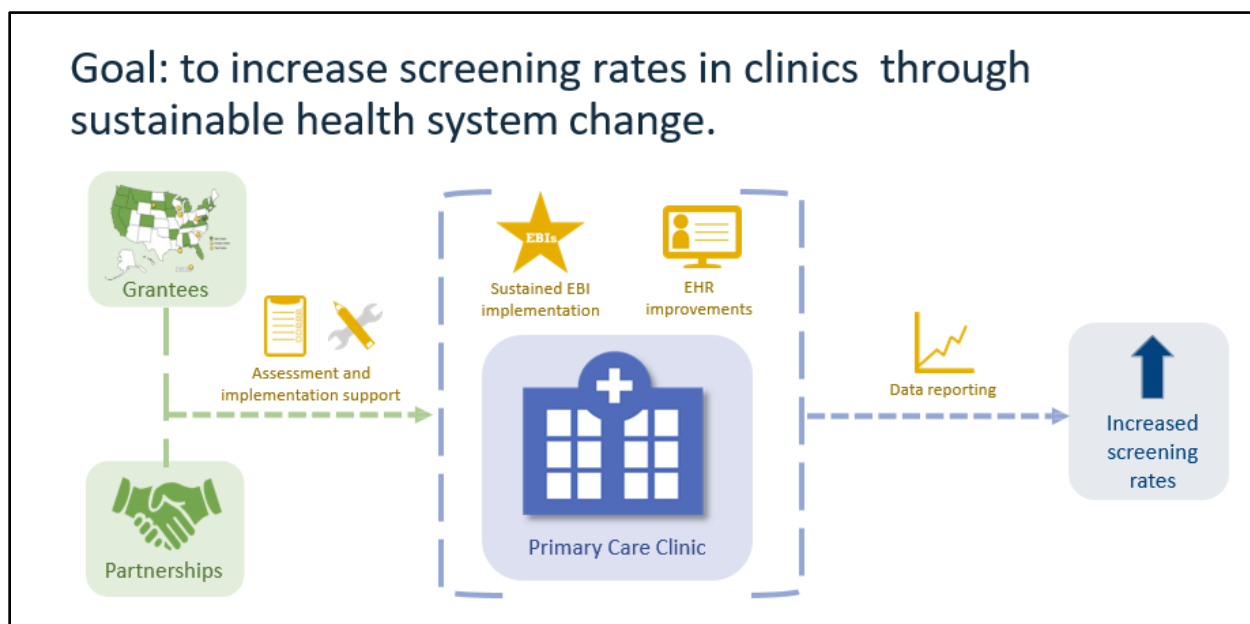


Figure adapted from the Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control

Figure 6 illustrates how the goal to increase screening rates in clinics through sustainable health systems change will be met through the efforts of partners. CDC provides grants to states to form partnerships with primary care clinics. The clinics implement EBIs and EHR improvements. The following are the roles of partners in this project.

CDC Role

- Provide a grant to MDH through a competitive process.
- Share requirements for program implementation and data collection.
- Provide technical assistance to MDH.

MDH Sage and Scopes Programs Role

- Receive and administer a competitive grant from CDC.
- Form partnerships with organizations such as the American Cancer Society, the University of Minnesota School of Public Health, and the American Indian Cancer Foundation to support program implementation.
- Form new or strengthen existing partnerships with primary care clinics or health systems by providing grants to implement the program in Minnesota.
- Provide coverage for follow-up diagnostic colonoscopies to patients who are low-income and uninsured or under-insured at the system change partner clinics.

- Assist the clinic staff with connecting to treatment resources for patients with a diagnostic colonoscopy that resulted in a cancer diagnosis or those needing additional evaluation or treatment.
- Provide technical assistance including assessment and implementation support to clinics.
- Focus on priority populations of uninsured, Medicaid, populations of color and American Indians, or rural populations.

Clinic Role

- Implement and sustain EBI's.
- Implement EHR improvements.
- Report data to MDH and use the data for program improvement and performance management.

MDH Technical Assistance

The Minnesota Department of Health will engage regularly with you to ensure the clinic has sufficient guidance, oversight, and support to implement the selected EBIs.

This support can be provided through phone calls, video communications, and on-site visits once restrictions due to the pandemic are lifted.

Figure 7: Technical Assistance



Figure adapted from the Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control

MDH will provide the following technical assistance to the clinic:

- Support for the completion of grant program requirements.
- CDC resources such as *The Community Guide's* EBIs for cancer screening.¹³
- Support for EBI implementation.
- Quality improvement resources including use of data for continuous QI.
- Assist with facilitation of linkages to follow-up colonoscopies.
- Assess clinic data quality and reports on an ongoing basis.
- Share evaluation results.
- Patient Navigation training.
- Technical assistance as requested.

¹³ The Community Guide, <https://www.thecommunityguide.org/topic/cancer>

Section IV: Implementation

Figure 8: Steps for successful program implementation

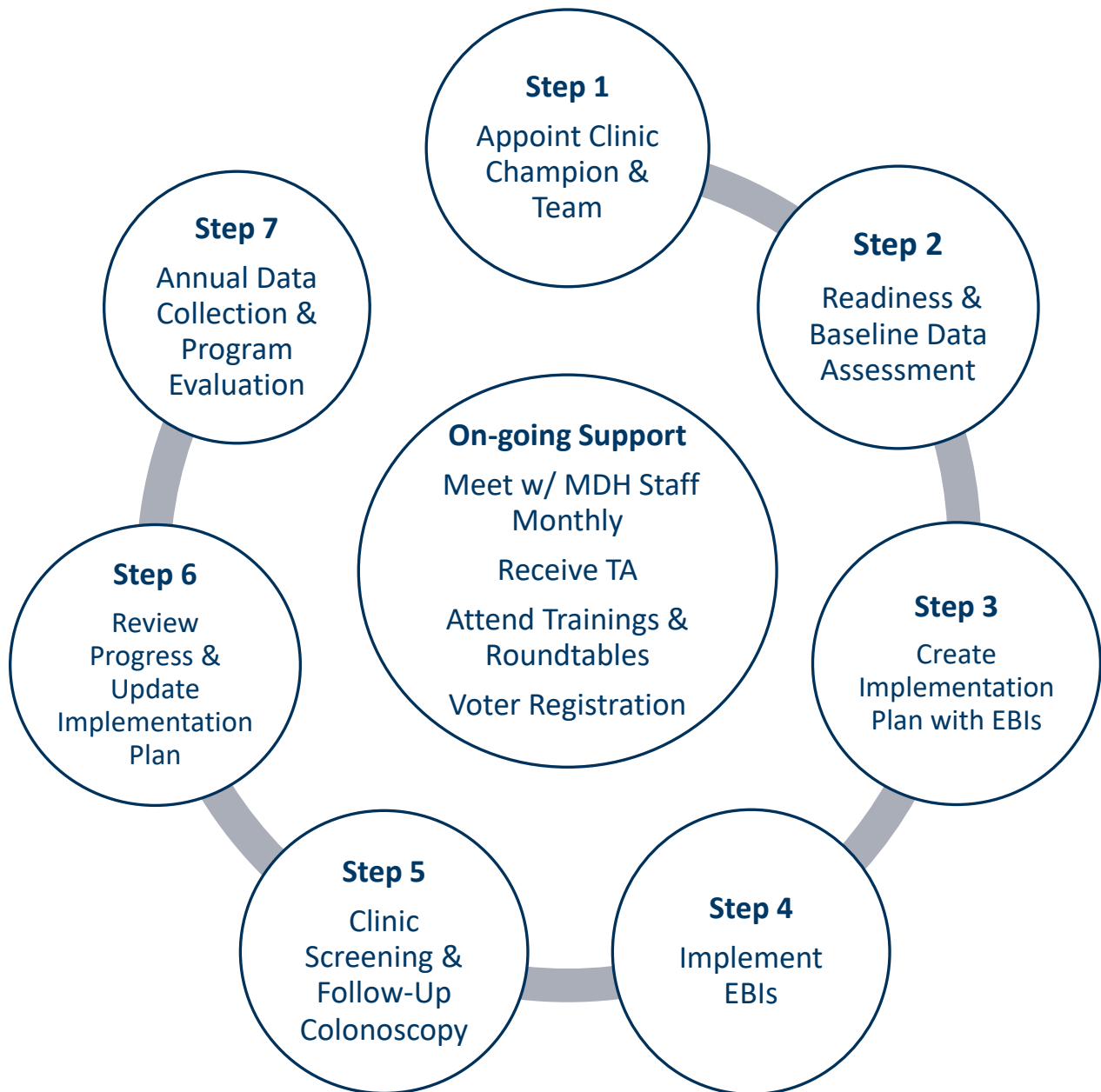


Figure 8 shows in circles the steps to be completed for successful program implementation: appoint clinic champion and team; complete readiness assessment and collect baseline data; create an implementation chart with EBIs; implement EBIs; participate in program evaluation and annual data collection; review progress and update implementation chart; provide clinic screening and follow-up colonoscopy as appropriate; meet with MDH staff monthly; attend trainings and roundtables; and engage in voter registration.

Appoint Clinic Champion and Team

Champion

A project champion can be appointed by senior leadership/management or self-appointed in a volunteer basis and is responsible for coordinating the project. Clinic champions can be in roles of clinic leadership, quality improvement managers, and/or health care providers.

The champion:

- Is the main point of contact with MDH.
- Is particularly dedicated to increasing cancer screening and early detection.
- Is responsible for representing the project.
- Can make decisions or influence the decision-makers within the clinic.
- Monitors and documents progress.
- Is responsible for recruiting team members and the communication and coordination of team activities.

Team

A clinic team must be identified to ensure the cancer screening initiative can be appropriately and effectively embedded into practice and be successful.

The team members:

- Attend scheduled meetings.
- Contribute knowledge and resources.
- Implement or supervise the EBI improvements.
- Participate in evaluation and provides feedback on improvements.

The core team members should be recruited from each relevant area of care and administration that has a part in cancer screening. The core team can start small. During the workflow analysis and subsequent meetings, additional “resource” members can be added to the team to answer specific questions, provide guidance, or implement processes.

Creating a clinic team that reflects a collaborative approach within the clinic is important to implementing successful new clinic processes. A few examples of possible members to include in your team are:

Core Members

- Administrators
- Quality Improvement Staff
- Providers - physicians, nurse practitioners, physician assistants, etc.
- Lab Coordinator

- Cancer Screening Lead

Others as needed

- Community Health Workers/Patient Navigator/Health Educator/Coach
- IT
- Receptionist/Front desk
- Social Worker
- Pharmacy
- Other

Patient Perspective

It is important to find a way to obtain input from patients on changes that will impact their care. If possible, include a “customer” on your project team. It may not be realistic to include a patient or family member on every quality improvement activity, but there are other ways to include the patient voice and gather feedback. For example, presenting project plans to a patient/family clinic advisory board if one exists, or asking several patients for input as projects unfold.

Foundation for Successful Implementation

Get to know and engage the intended audience, community, or clinic. 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.

Integrate evaluation from the beginning. The MDH evaluation team has designed a participatory evaluation to help your program be successful and sustainable. They will work with you to formulate evaluation questions and identify indicators of success and data sources. They will need your assistance for monitoring and evaluation, and they will share findings with the clinic throughout implementation.

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.

Tips for Selecting and Implementing Activities

Chose a strategy

- Obtain your clinic's baseline screening rate.
- Identify which patients have not received screening and try to determine why.
- From *The Community Guide*, 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

- Engage staff members.
- Set a target screening rate.
- Create a workflow that includes the selected activities.
- With input from staff members, develop a plan for monitoring and evaluation.
- Train providers and staff members on the new processes and workflows.

Implementation

- Execute your implementation plan.
- Plan for sustainability and maintenance.
- Monitor and adjust activities in the implementation plan to fit changes in the clinic, such as new staff members and changes in the availability of specialists.
- Be flexible and adapt as needed.

Clinic Readiness Assessment

The Clinic Readiness Assessment documents current breast, cervical, and colorectal screening processes in the clinic, the quality of screening data, and resources available in the clinic. The findings of the clinic readiness assessment should inform the selection of Evidence-Based Interventions (EBIs) and process improvements.

Clinics will partner with the Minnesota Department of Health to complete this assessment **before** implementation of the evidence-based interventions (EBIs).

Below are examples of what you will find in the Clinic Readiness Assessment Tool. The tool will be provided to clinics by MDH Systems Change Coordinator.

Examples: What You Will Find in the Clinic Assessment Tool

Clinic

- Type of facility
- Leadership support

- Quality improvement projects
- CRC / Breast and Cervical cancer champions

Patients

- Number of patients
- Break-down by age, sex, race/ethnicity
- Screening rates

Workflow

- Process mapping for how patients move through their appointment
- Staff processes identifying patients due for screening and tracking their results
- Screening policy and protocols

Health Information Technology

- EHR system used
- Report-running abilities
- Data entry staff responsibilities and flow

Existing EBIs

- Any current activities that fall into one of the four EBIs
- Extent/quality of implementation

Information adapted from the Centers for Disease Control and Prevention National Center for Chronic Disease and Health Promotion, Division of Cancer Prevention and Control

Baseline Data Collection

The purpose of baseline data collection is to establish a standardized record of clinic data prior to the implementation of activities. This, combined with the standardized annual clinic data, will allow for program evaluation including changes in breast, cervical, and colorectal screening rates over the project period. The data collection assesses health system clinic and patient population characteristics; monitoring and quality improvement activities; EBI-implementation practices; and cancer screening rates. The baseline data collection will occur simultaneously with the readiness assessment.

To learn more about baseline data collection, please visit Section VI: Data Reporting and Evaluation of this manual.

Implementation Planning Summary

The implementation planning summary tool will guide the clinics program implementation in concert with MDH. The completed form will help clinics plan the implementation of their

evidence-based interventions (EBIs) and help MDH provide useful technical assistance to promote program success.

The tool summarizes the results of the clinic’s readiness assessment, and this information can be used for selecting EBIs. A part of this document is an implementation chart (also may be called a work plan). The chart addresses the gap/issues/problems identified through the readiness assessment, what EBI or process change (i.e., quality improvement) the clinic selected to address the gap, and the implementation details. Completing this chart and reviewing it throughout the project will improve the likelihood of achieving desired outcomes.

A draft tool will be completed by MDH based on clinic input and provided to the clinic for review and input before finalizing and submitting to CDC for approval.

Implementation Chart for EBI Selection - Example

Issue/Problem	EBI or Process Change Selected	Implementation Details
Clinic not assessing provider performance in delivering or offering screening to clients and not presenting assessment results to providers	Provider Assessment and Feedback	<p>EHR will be used to gather data on provider performance in delivering or offering screening for clients</p> <p>Feedback reports for providers on their individual performance and compared to other providers will be developed and shared with them</p> <p>The use of feedback reports by providers will be assessed</p>

Evidence-Based Interventions (EBIs)

Clinics must implement at least two EBIs that address gaps and barriers that are identified in the clinic readiness assessment. Evidence suggests that combining two or more strategies increases community demand for, and access to, cancer screening and lowers costs. For example, strategies such as reminders and reducing structural barriers can be used together to increase provider delivery of services, as explained in the **following 30-second video**:

[ScreenOutCancer “Too Great a Cost”—Reminders and Reducing Structural Barriers \(www.youtube.com/watch?v=pv6ADVPhNJA\)](http://www.youtube.com/watch?v=pv6ADVPhNJA)

Effective EBIs that address many barriers to breast, cervical, and colorectal cancer screening are identified in [The Community Guide](#). This manual focuses on the EBIs described below.

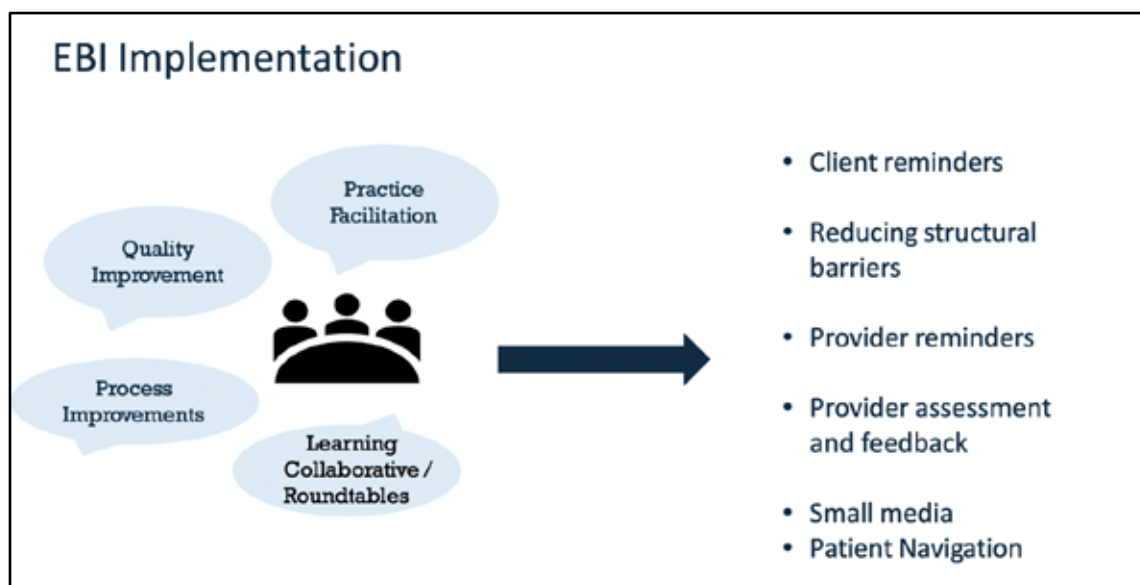
Figure 9: EBI implementation

Figure by the Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control

As noted in figure 9, practice facilitation, quality improvement, process improvements, and learning collaborative or roundtables are all activities provided by a trained individual or team of individuals to build the internal capacity of a clinic to engage in practice improvement activities overtimes. This is beneficial in reaching incremental and transformative improvement goals. In the case of this program, they can be used to guide and measure the implementation of the EBIs; client reminders, reducing structural barriers, provider reminders, provider assessment and feedback and supporting activities of small media and patient navigation.

Community Preventive Services Task Force (CPSTF) Findings for Cancer Prevention and Control¹⁴

The Community Guide is a resource that holds the official recommendations of the Community Preventive Services Task Force (the Task Force). 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.¹⁵ The Community Guide has identified effective EBIs that address many barriers to breast, cervical, and colorectal cancer screening.

¹⁴ The Community Guide.

¹⁵ Centers for Disease Control and Prevention, *Colorectal Cancer Control Program: Public Health and Health Systems Partnerships to increase Colorectal Screening in Clinical Settings Program Manual, Part I Implementation*, 2020.







The following tables include alphabetized lists of intervention approaches reviewed by the CPSTF with summaries of the findings for each intervention ([definitions of findings](#)). Links to the evidence can be found at: [The Community Guide: CPSTF Findings for Cancer Prevention and Control \(https://www.thecommunityguide.org/content/task-force-findings-cancer-prevention-and-control\)](https://www.thecommunityguide.org/content/task-force-findings-cancer-prevention-and-control).

 Recommended

- The systematic review of available studies provides strong or sufficient evidence that the intervention is effective. The categories of "strong" and "sufficient" evidence reflect the Task Force's degree of confidence that an intervention has beneficial effects.

 Insufficient Evidence

- The available studies do not provide sufficient evidence to determine if the intervention is, or is not, effective. This does **NOT** mean that the intervention does not work. It means that additional research is needed to determine whether or not the intervention is effective.

Increasing Cancer Screening Intervention	Breast Cancer ¹⁶	Cervical Cancer ¹⁷	Colorectal Cancer ¹⁸
Interventions Engaging Community Health Workers			
Multicomponent Interventions			

¹⁶ Breast and cervical cancer systems change grant recipients must provide patient navigation and EBIs recommended in the *Community Guide*. The EBIs for breast and cervical cancer are noted above.

¹⁷ If an intervention is recommended for one cancer (breast or cervical) but has insufficient evidence for the other cancer, CDC will allow the intervention to be implemented for both cancers.

¹⁸ Colorectal Cancer Grant recipients must implement at least two of four required EBIs: 1) Provider Assessment and Feedback, 2) Provider Reminders, 3) Client (or Patient) Reminders, 4) Reducing Structural Barriers. In addition, they may use patient navigation to support delivery of EBIs. Existing small media materials may be used or adapted for use to support implementation of patient navigation and client reminder system.

SAGE PROGRAMS CLINIC SYSTEMS CHANGE

Client-Oriented Interventions	Breast Cancer ¹⁹	Cervical Cancer ²⁰	Colorectal Cancer ²¹
Client Reminders	●	●	●
Group Education	●	◆	◆
One-on-One Education	●	●	●
Reducing Client Out-of-Pocket Costs	●	◆	◆
Reducing Structural Barriers	●	◆	●
Small Media	●	●	●
Client Incentives	◆	◆	◆
Mass Media	◆	◆	◆

Provider-Oriented Interventions	Breast Cancer ²²	Cervical Cancer ²³	Colorectal Cancer ²⁴
Provider Assessment and Feedback	●	●	●
Provider Reminder and Recall Systems	●	●	●
Provider Incentives	◆	◆	◆

¹⁹ Breast and cervical cancer systems change grant recipients must provide patient navigation and EBIs recommended in the *Community Guide*. The EBIs for breast and cervical cancer are noted above.

²⁰ If an intervention is recommended for one cancer (breast or cervical) but has insufficient evidence for the other cancer, CDC will allow the intervention to be implemented for both cancers.

²¹ Colorectal Cancer Grant recipients must implement at least two of four required EBIs: 1) Provider Assessment and Feedback, 2) Provider Reminders, 3) Client (or Patient) Reminders, 4) Reducing Structural Barriers. In addition, they may use patient navigation to support delivery of EBIs. Existing small media materials may be used or adapted for use to support implementation of patient navigation and client reminder system.

²² Breast and cervical cancer systems change grant recipients must provide patient navigation and EBIs recommended in the *Community Guide*. The EBIs for breast and cervical cancer are noted above.

²³ If an intervention is recommended for one cancer (breast or cervical) but has insufficient evidence for the other cancer, CDC will allow the intervention to be implemented for both cancers.

²⁴ Colorectal Cancer Grant recipients must implement at least two of four required EBIs: 1) Provider Assessment and Feedback, 2) Provider Reminders, 3) Client (or Patient) Reminders, 4) Reducing Structural Barriers. In addition, they may use patient

Evidence-Based Interventions (EBIs) Definitions

Provider assessment and feedback (Breast, Cervical and Colorectal Cancer screening) — evaluating provider performance in delivering or offering screening to clients (assessment) and present providers with information about their performance in providing screening performance (feedback).

Provider reminders (Breast, Cervical and Colorectal Cancer screening) — informing 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”).

Client reminders (Breast, Cervical and Colorectal Cancer screening) — written (letter, postcard, or email) or telephone messages (including automated messages) advising people that they are due for screening.

Reducing structural barriers (Breast and Colorectal Cancer screening only) — Identify and address obstacles that prevent people from getting screened. Facilitate access to cancer screening services via:

- 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).

Supporting Activities

Patient navigation (Breast, Cervical and Colorectal Cancer screening) — a strategy designed to increase access to timely screening, diagnosis, and treatment of cancer and other chronic diseases by eliminating barriers to care.

MDH role in patient navigation:

- Technical Assistance to help clinics develop a clinic-based patient navigation program.
- Facilitate completions of follow-up after a positive or abnormal screening test.

For cancer screening and early detection, patient navigation focuses on helping patients overcome personal and health care system barriers to understand and access screening and follow-up. It can be used to:

- Reduce barriers to access and use of cancer screening services.

navigation to support delivery of EBIs. Existing small media materials may be used or adapted for use to support implementation of patient navigation and client reminder system.

- Support the implementation of EBIs (e.g., support functions to remind people they are due or overdue for screening).
- For the CRC systems change program, facilitate completions of follow-up colonoscopies performed after a positive or abnormal CRC screening test. MDH will provide this service and it can be provided regardless of whether CDC funds are used to pay for the follow-up colonoscopy (visit [Section VI](#) for more information).

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, but are not limited to:

- Lack of transportation.
- Lack of childcare.
- Lack of knowledge about the benefits of screening.
- Lack of responsible driver to drop off and pick up patient for their colonoscopy appointment.
- Language barriers.
- Mistrust of the health care system.
- Fear of the procedure.

Priority should be given to navigate clients who otherwise would not complete the screening process. Clients who receive navigation through Sage and Scopes cancer screening programs must be low-income and meet United States Preventive Services Task Force (USPSTF) screening guidelines.

CDC has strict guidelines and reporting that needs to be completed if their funds are used for patient navigation. ***Additional information will be provided to clinics before MDH approves the use of funds for patient navigation.***

Small media (Breast, Cervical and Colorectal Cancer screening) — materials that can be used to inform and motivate people to be screened for cancer.

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 general audiences.

Because many high-quality small media materials already exist, such as [Screen for Life](#), grantees should use existing materials, such as [Cancer Screening: Small Media Targeting Clients—Colorectal Cancer](#), in implementing small media interventions to support implementation of patient navigation and client reminder interventions.

Resources

- CDC ScreenOutCancer: Evidence-based Intervention. Guidance on the use of evidence-based interventions and supporting activities to improve the quality of cancer screening and

increase the number of people screened.

<https://www.cdc.gov/screenoutcancer/interventions/index.htm>

- Evidence-Based Intervention Planning Guides. Tips on implementing evidence-based interventions to increase screening for breast, cervical, and colorectal cancer. <https://www.cdc.gov/screenoutcancer/ebi-planning-guides/index.htm>
- Centers for Disease Control and Prevention. *Quick Guide to Planning and Implementing Selected Activities to Increase Breast, Cervical, and Colorectal Cancer Screening*. Atlanta: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2019. <https://www.mchevidence.org/documents/Guide%20to%20Planning%20and%20Implementing%20Strategies%20to%20Increase%20Cancer%20Screening%20September%202019.pdf>

EBI Implementation Checklists

The EBI implementation checklists can be found in *Appendix A: EBI Implementation Checklists*.

Section V: Data Reporting and Evaluation

The purpose of data reporting and evaluation is to demonstrate the progress the clinic has made towards achievement of the project outcomes; build a stronger evidence base for specific interventions; clarify applicability of the evidence base to different populations, settings, and contexts; drive continuous improvement; determine if the intended populations are reached and program impact is achieved. It will also be used to determine the likelihood the program activities will be sustainable over time.

MDH Evaluation staff will be partnering with you to collect required datasets, to assist with technical assistance needs related to electronic health records, and to support evaluation of your breast, cervical, and colorectal systems change work. MDH staff will analyze the information collected and provide a summary to the clinic.

Baseline and Annual Clinic Data

The purpose of Baseline and Annual Clinic Data forms are to collect standardized, longitudinal datasets from each participating clinic in order to answer many of MDH's and CDC's evaluation questions, including those related to implementation of program activities (e.g., EBIs) and changes in clinic-level screening rates over time. The data include but are not limited to items in the following areas:

- Health system, clinic, and patient characteristics
- Baseline and annual screening rates
- Screening practices and completion of follow-up care if needed
- Monitoring and quality improvement activities
- EBIs and other clinic activities
- COVID-19 effects on clinic activities

Program Evaluation

Program evaluation should be meaningful to your clinic. It can help monitor and improve your program (e.g., EBI implementation), demonstrate program effectiveness in increasing screening rates, and support program sustainability. It is the systematic collection of information about the implementation of your program.

The MDH Evaluation team will work with clinic staff to collect process evaluation information through your quarterly progress reports, interviews, or survey.

Program Reporting Schedule

Timeline	Activity
Within 1 month of starting project	Complete one-time baseline data form and Screening rates - Utilize the same metrics for the upcoming MNMCM guidelines or UDS if possible. For dates January 1, – December 31)
Annual data form	Complete annual data collection form
Annual screening rates	Submit Years 2+) with Numerator/Denominator
Quarterly progress reports	Complete and submit quantitative information as requested on form and qualitative data
Quarterly data measures	Utilize an existing report run quarterly or monthly, just share the parameters. This will be utilized to show and inform progress
Quarterly invoice	As noted in the grant agreement
Implementation Plan/Work plan	As noted in the grant agreement

Meetings	
Monthly	MDH Systems Change Coordinator Meeting and Clinic Champion
Quarterly	Systems Change Coordinator and Clinic Team meetings
Quarterly	Roundtable

Section VI: FOBT/FIT/FIT-DNA Kits and Linkage to Follow-Up Colonoscopy

The MDH cannot pay for the purchase or processing of guaiac fecal occult blood tests (FOBTs)/fecal immunochemical tests (FITs) or FIT-DNA tests (Cologuard). The clinic will have to bear the cost of these tests.

Patients with abnormal (or positive) FOBT, FIT, or FIT-DNA tests will need a diagnostic colonoscopy. The MDH Scopes program may be able to help pay for this diagnostic colonoscopy for adults ages 45 to 75 who are asymptomatic, low income and uninsured, or underinsured, and are screened by a systems change partner clinic.

The intent of providing coverage for follow-up colonoscopies is to:

1. Facilitate the development of partnerships between the clinic and endoscopy providers that can be leveraged once direct funding ends.
2. Facilitate the development of partnerships between the Minnesota Department of Health and the clinic by reducing barriers such as the cost of follow-up colonoscopy that may hinder the clinic participation in efforts to increase CRC screening rates.
3. Ensure the patient screening process is completed.
4. Patient navigators at MDH might provide navigation services when received calls from patients at the call center.

ALL recipients must ensure linkage to follow-up colonoscopy.

For more information, please contact Michelle Brasure at michelle.brasure@state.mn.us

Section VII: Voter Registration

A clinic receiving a grant from the State is required to provide voter registration services for its employees and the public served by them. Voter registration materials can be found at the Secretary of State's office at <https://www.sos.state.mn.us/elections-voting/get-involved/state-agencies/> or by contacting the Voter Outreach team at 1-877-600-VOTE (8683) or secretary.state@state.mn.us.

Section VIII: Screening Guidelines

Screening means checking a person's body for cancer before they have symptoms. Getting screened regularly may find breast, cervical, and colorectal cancers early, when treatment is likely to work best.

Colorectal Cancer

There is substantial evidence that screening for Colorectal Cancer (CRC) reduces the incidence of and death from this disease. Screening for CRC can 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 years.²⁵

The USPSTF released new guidelines for CRC screening on May 18, 2021. The new guidelines recommend screening of non-symptomatic, average-risk adults ages 45-75 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.²⁶

Breast and Cervical Cancer

CDC supports screening for breast and cervical cancer as recommended by the U.S. Preventive Services Task Force. Mammograms are the best way to find breast cancer early when it is easier to treat. The USPSTF recommends that women who are 50 to 74 years old and are at average risk for breast cancer get a mammogram every two years. Women who are 40 to 49 years old should talk to their doctor or other health care professional about when to start and how often to get a mammogram. Women should weigh the benefits and risks of screening tests when deciding whether to begin getting mammograms before age 50.²⁷ The Breast Cancer Screening Guidelines for Women Chart compares recommendations from several leading organizations. <https://www.cdc.gov/cancer/breast/pdf/breast-cancer-screening-guidelines-508.pdf>

Two screening tests can help prevent cervical cancer and find it early. When cervical cancer is found early, it is highly treatable and associated with long survival and good quality of life. The Pap test can find abnormal cells in the cervix which may turn into cancer. The HPV test looks for the virus (human papillomavirus) that can cause these cell changes. Pap tests also can find cervical cancer early when the chance of being cured is very high. The USPSTF recommendations for screening vary by the woman's age.²⁸

²⁵ Division of Cancer Prevention and Control, Centers for Disease Control and Prevention, *Colorectal Cancer Control Program: Public Health and Health Systems Partnerships to Increase Colorectal Screening in Clinical Settings Program Manual, Part I Implementation*. Atlanta: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2020.

²⁶ U.S. Preventive Services Task Force, *Colorectal Cancer: Screening*, <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening>

²⁷ U.S. Preventive Services Task Force, *Breast Cancer* <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening>

²⁸ U.S. Preventive Services Task Force, *Cervical Cancer* <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening>