Colorectal Cancer Screening Program in South Carolina

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About the CCSPSC:

The Colorectal Cancer Screening Program in South Carolina (CCSPSC) works with eight federally-qualified health center (FQHC) systems in South Carolina and several partners, including the American Cancer Society, South Carolina Primary Health Care Association, and Colorectal Cancer Prevention Network. Together, we work with partnering FQHCs to implement at least two **priority, evidence-based approaches** (provider assessment and feedback, provider reminders and recall, client/patient reminders), **supportive strategies** (professional education and small media), and **additional activities** (standard procedures and 80% by 2018 pledge). Our goal is to help our partner FQHCs increase CRC screening rates by at least 5% annually – **recent data from 2018 show an actual increase of 11% in colorectal cancer screening from 2016 to 2017 (13 FQHC sites) and an actual increase of 18% from 2015 to 2017 (8 FQHC sites)**. Evaluation is an important element of the program, and the Core for Applied Research and Evaluation (CARE), led by Dr. Lauren Workman at the University of South Carolina, leads evaluation activities.

The purpose of the Colorectal Cancer Screening Program in South Carolina (CCSPSC) is to increase participation in CRC screening by working *with* partner health systems to implement priority evidence-based strategies.

The CCSPSC is guided by an iterative, adaptive, and flexible phased-approach to implementation that includes:

- Phase 1: Building Partnerships
- Phase 2: Collecting Baseline Data and Planning
- Phase 3: Implementing Evidence-based Approaches
- Phase 4: Supporting and Monitoring Implementation
- Phase 5: Cultivating Sustainability and Maintaining Progress

About the CDC CRCCP:

The CCSPSC is a Centers for Disease Control and Prevention (CDC) Colorectal Cancer Control Programs (CRCCP). The goal of the CDC CRCCP is to increase colorectal cancer screening rates among people between 50 and 75 years of age to implement evidence-based interventions and other supporting strategies in partnership with health systems {Component 1} and provide CRC screening and follow-up services for a limited number of eligible people {Component 2}. The CDC CRCCP grantees include 23 state health departments, 1 American Indian tribe, and 6 universities. Learn more about the CDC CRCCP at https://www.cdc.gov/cancer/crccp/.

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Site:_____ **Team Member:**_____ **Implementation Phase:**_____
Date:_____

Provider Assessment and Feedback Observation Form

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 services (feedback). Feedback may describe the performance of a group of providers (e.g., mean performance for a practice) or an individual provider, and may be compared with a goal or standard[1,2].

Feature[3]
Provider Assessment and Feedback Implementation Team
Who are the Providers? (select all that apply)? ☐ MD/DO ☐ NP ☐ Nurses ☐ Other:_____
Who on the team is responsible for conducting the assessment/pulling assessment data? ☐ Front desk staff ☐ CRCS Coordinator ☐ Quality Management Staff ☐ Providers ☐ Other:_____
Who on the team is responsible for providing feedback to providers? ☐ Chief Medical Officer (CMO)/Lead Provider/Medical Director ☐ Practice Manager ☐ CRCS Coordinator ☐ Quality Management Staff ☐ Other:_____
Implementation: Provider Assessment
Is the EBI currently being implemented? ☐ Yes ☐ No
Type of Provider Assessment (select all that apply) ☐ Percentage of patients from schedule that were ordered a CRCS ☐ Percentage of providers who ordered CRCS ☐ Percentage of patients who completed CRCS by provider ☐ Percentage of CRCS for providers ☐ Other:_____
Source of Assessment Data

[1] Sabatino SA, Lawrence B, Elder R, Mercer SL, Wilson KM, DeVinney B, Melillo S, Carvalho M, Taplin S, Bastani R, Rimer BK, Vernon SW, Melvin CL, Taylor V, Fernandez M, Glanz K, Community Preventive Services Task Force. Effectiveness of interventions to increase screening for breast, cervical, and colorectal cancers: nine updated systematic reviews for The Guide to Community Preventive Services. *Am J Prev Med* 2012;43(1):765-86.

[2] Community Preventive Services Task Force. Updated recommendations for client- and provider-oriented interventions to increase breast, cervical, and colorectal cancer screening. *Am J Prev Med* 2012;43(1):760-4.

[3] Adapted from Partnership for Prevention. Healthcare Provider Reminder Systems, Provider Education, and Patient Education: Working with Healthcare Delivery Systems to Improve the Delivery of TobaccoUse Treatment to Patients—An Action Guide. The Community Health Promotion Handbook: Action Guides to Improve Community Health. Washington, DC: Partnership for Prevention; 2008.

Site:_____ **Team Member:**_____ **Implementation Phase:**_____
Date:_____

- ☐ Clinic Schedule/Patient Lists
- ☐ EHR Data
- ☐ Paper Chart Data
- ☐ Reports of completed screenings
- ☐ Other:_____

Frequency of Assessment

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Inconsistent
- ☐ Other:_____

Implementation: Provider Feedback

Format of Provider Feedback

- ☐ EHR chart/graphs
- ☐ Paper reports (charts, graphs, tables)
- ☐ Report cards
- ☐ Email
- ☐ Other:_____

Method of Presenting Provider Feedback

- ☐ Office display of data
- ☐ All staff/group/provider team meetings
- ☐ Individual meetings with provider
- ☐ Other:_____

Frequency of Provider Feedback

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Inconsistent
- ☐ Other:_____

Is Provider Assessment & Feedback data identifiable (by provider)?

- ☐ Yes
  - o By name
  - o Coded
- ☐ No
- ☐ Other:_____

Site:_____ **Team Member:**_____ **Implementation Phase:**_____
Date:_____

Monitoring and Evaluation
What procedures are in place to track the delivery of provider assessment and feedback? ☐ Standard of Practice/Protocol ☐ Tracking orders/referrals for colonoscopy ☐ Tracking distribution of FIT/FOBT ☐ Tracking completed screenings (return of FOBT/FIT/colonoscopy results) ☐ Other:_____
Are goals set for each provider? ☐ Yes, same for all providers o Goal:_____ ☐ Yes, different by provider ☐ No ☐ Other:_____
Who is responsible for monitoring this process? ☐ Name:_____ ☐ Position:_____
Who is responsible for addressing needed follow up for providers who fall below their goal? ☐ Name:_____ ☐ Position:_____

Colorectal Cancer Screening Program in South Carolina Readiness Assessment

The Colorectal Cancer Screening Program in South Carolina (CCSPSC) **initial readiness assessment** is administered during the implementation team's second visit to the center and the **annual readiness assessment** is administered at each annual review meeting following the initiation of implementation activities.

Initial Readiness Assessment: Typically, the second site visit includes a meeting with several center staff. This readiness assessment should be completed by all FQHC staff present in the meeting to capture a variety of perspectives on the organization's readiness to implement the colorectal cancer screening program. For each site, at least three and no more than five site representatives should complete the assessment for the initial process.

The Implementer explains the initial readiness assessment:

> *"Hello everyone, we are asking our sites to complete a readiness assessment, which will help us better understand how ready your site is to implement the Colorectal Cancer Screening Program in South Carolina. Your response to these questions will not prevent your site from being able to participate in the program."*

The Implementer then asks all staff present to complete a readiness assessment. Each center staff at the meeting is given a readiness assessment form (paper/pencil) and asked to complete the survey independently.

> *"I'm going to pass out a quick assessment for each of you to complete. There are no right or wrong answers; we are just looking to get a sense of how ready your organization is with this assessment. Your responses will be confidential. If you have any questions about the assessment please feel free to ask me."*

The CCSPSC team collects all completed assessment forms and saves to the shared drive (Folder: Readiness Assessment Initial). The information is used to inform the development of the implementation plan and approach for implementation training, which is tailored to the current environment (based on the Organizational and Environmental Assessment) and readiness of the FQHC site.

Annual Readiness Assessment: The annual assessment will occur approximately one year after the site initiated implementation of evidence-based approaches. The annual assessment will be repeated each year. For each site, at least three and no more than five site representatives should complete the assessment. The same general process as for the initial assessment will be used.

The Implementer explains the annual readiness assessment:

> *"Hello everyone, we are asking our sites to complete a readiness assessment as part of the annual review process. The repeat readiness assessment will help us recognize if your site's preparation and ability to implement evidence-based approaches as part of the Colorectal Cancer Screening Program in*

South Carolina have changed since the initial assessment. Your response to these questions will not prevent your site from being able to continue with the program."

The implementation staff then asks all staff present to complete a readiness assessment. Each center staff at the meeting is given a readiness assessment form (paper/pencil) and asked to complete the survey independently.

"I'm going to pass out a quick assessment for each of you to complete. There are no right or wrong answers; we are just looking to get a sense of how ready your organization is with this assessment. Your responses will be confidential. If you have any questions about the assessment please feel free to ask me."

The CCSPSC team collects all completed assessment forms and saves to the shared drive (Folder: Readiness Assessment Annual). The information is used to inform the potential modifications to the implementation plan and technical assistance needs.

FQHC Readiness Criteria

We will utilize the R=MC^2 framework to systematically assess each FQHC's readiness to implement evidence-based strategies for colorectal cancer screening (Dymnicki, 2014). The framework below distinguishes three major components to measure organizational readiness: 1) Motivation, 2) General capacity, and 3) Intervention-specific capacity. In addition, it provides examples of the types of information that will be collected during the interviews and document reviews. The evaluation and program teams will collect information from each FQHC on the three readiness components. Information will be collected through in-person meetings between CCSPSC Program Staff and FQHC leadership.

Component 1. Motivation
A. Relative Advantage • Current use of CRCS promotion strategies • Importance of CRCS as it relates to other public health issues that affect the populations the FQHC serves
B. Compatibility • Fit of CCSPSC with existing programs at the FQHC • Level of FQHC leadership commitment integrating this new program into existing programs
C. Complexity / Doability • Feasibility of implementing this new program • Difficulty of the CCSPSC intervention approach
D. Trialability • Ability of FQHC to pilot implementation of CCSPSC
E. Observability • CRCS rates (as key outcome) are regularly assessed and shared to determine program progress.
G. Priority • Perceived importance of this new program relative to other FQHC programs
Component 2. General Capacity
A. Culture/Innovativeness • Current process/stakeholders for deciding what programs to offer • Current process/stakeholders for implementation of existing programs • General receptiveness of employees to change
B. Resource Utilization • Current resources for implementation of existing programs and process/stakeholders for deciding resource allocation for programs • Process/stakeholders for communicating information on program implementation
C. Structure/Staff Capacity • Process/stakeholders for monitoring implementation of existing programs • # staff, staff expertise available to implement existing programs
Component 3. Intervention-specific Capacity
A. Intervention specific knowledge, skills, and abilities
B. Program Champion
C. Specific-Implementation Climate Supports • Resources ($, # staff, staff expertise) available to implement this new program • Process/stakeholders for supporting implementation of this new program
D. Inter-organizational Relationships • Partnerships to support implementation of this new program • Referral networks for CRCS to support this new program • Process/stakeholders for monitoring implementation of this new program

CCSPSC Readiness Assessment Tool

The CCSPSC Implementer will complete the top part of this form prior to administering.

Date:	**CCSPSC Implementer:**
FQHC System:	**FQHC Site:**
GO LIVE! Date (for Annual only):	**Annual Review Date:**

Type of assessment: ☐ Initial assessment ☐ Annual review 1 ☐ Annual review 2 ☐ Annual review 3

1. Our FQHC site has a current lab agreement for stool-based testing (fecal testing, such as FOBT, FIT).

☐ Yes ☐ No ☐ Don't Know

2. Our FQHC site has a referral network to help patients who need a colonoscopy.

☐ Yes ☐ No ☐ Don't Know

3. Our FQHC site has an established medical network or resources to help uninsured patients who need a colorectal cancer screening.

☐ Yes ☐ No ☐ Don't Know

Characteristic of Readiness	Strongly Agree	Agree	Disagree	Strongly Disagree	Do Not Know
4. Promoting colorectal cancer screening is a priority for our FQHC.	SA	A	D	SD	DK
5. FQHC leadership is committed to promoting colorectal cancer screening.	SA	A	D	SD	DK
6. Given our current initiatives and priorities, implementing the Colorectal Cancer Screening Program in South Carolina (CCSPSC) is feasible.	SA	A	D	SD	DK
7. CCSPSC fits well with the mission (or values) of our organization.	SA	A	D	SD	DK
8. I understand what is required to implement the CCSPSC program.	SA	A	D	SD	DK
9. We regularly assess our site's colorectal cancer screening rates.	SA	A	D	SD	DK
10. We make decisions based on our site's colorectal cancer screening rates.	SA	A	D	SD	DK

Characteristic of Readiness	Strongly Agree	Agree	Disagree	Strongly Disagree	Do Not Know
11. Our staff and providers are receptive to implementing new initiatives.	SA	A	D	SD	DK
12. We have successfully implemented evidence based interventions in the past.	SA	A	D	SD	DK
13. Our FQHC site has sufficient resources (including funding, time, and staff) to implement the CCSPSC program.	SA	A	D	SD	DK
14. Our FQHC data systems can track colorectal cancer screening rates among eligible adults aged 50-75.	SA	A	D	SD	DK
15. Our EHR is easily modifiable to extract and report data we need.	SA	A	D	SD	DK
16. It is a challenge for our FQHC to recruit and retain senior leadership.	SA	A	D	SD	DK
17. Our FQHC engages in specific activities to improve colorectal cancer screening.	SA	A	D	SD	DK
18. Our FQHC's colorectal cancer screening referral network is adequate for our patient population.	SA	A	D	SD	DK
19. Our FQHC has partnerships in place (American Cancer Society, SC Primary Health Care Association, etc.) to support implementation of the CCSPSC program.	SA	A	D	SD	DK
20. Our FQHC has the capacity to sustain its initiatives and processes with evidence-based strategies implemented for colorectal cancer screening.	SA	A	D	SD	DK

21. How are decisions related to new programs and initiatives made at this FQHC site?

22. How are those decisions about new programs and initiatives communicated with staff and providers?

Thank you for taking time to complete this assessment!

Overview of Site Visits, Follow-up Visits, Technical Assistance Sessions

UNIVERSITY OF SOUTH CAROLINA
Arnold School of Public Health

POWERED BY CDC SCREENOUTCANCER
Colorectal Cancer Control Program

This table provides an "at-a-glance" overview of in-person meetings or formal contact with partner FQHC sites across all phases of the CCSPSC as of 12April19 (DRAFT VERSION – FOR INTERNAL REVIEW).

Phase 1: Building Partnerships

- Initial Site Visit

Phase 2: Baseline Data and Planning

- 2nd Site Visit

Phase 3: Implementation

- Pre-visit for Initial Professional Education
- Initial Professional Education
- Initial Implementation Training
- Follow-up Implementation Training (may be more than one meeting)
- Pre-GO LIVE
- GO LIVE

Phase 4: Supporting and Monitoring Implementation

- Follow-up Visit #1 (1 mo post-GO LIVE)
- Follow-up Visit #2 (2 mo)
- Follow-up Visit #3 (3 mo)
- TA Session #1 (4-6 mos)
- TA Session #2 (7-9 mos)
- TA Session #3 (10-12 mos)
- Annual Review Meeting
- First Annual Professional Education

Phase 5: Sustainability and Maintenance

- *4 quarterly TA sessions (in development)*
- *Followed by 2nd Year Annual Review*
- *Internal Path Forward Planning Meeting*
- *Path Forward Meeting*
- *Subsequent TA sessions*

In-person Meeting(s) or Contact with Partner FQHC Sites (time)	Purpose	Main Activities	Outcomes / Products	Who / Roles and Responsibilities	Materials Needed	Other Information
Phase 1 **Initial Site Visit** (with newly enrolled FQHC sites)	Introduce CCSPSC and site primary contacts, review MOA, discuss partnerships, introduce evidence-based approaches, discuss general process	• Complete site visit summary form • Give contact information to sites	• Establish and confirm partnerships • Collect information for implementation plan	UofSC Team UofSC Program Coordinator and Program Implementer lead meeting. ACS present to explain their role in CCSPSC and other related activities.	• Agenda • Initial site visit worksheet • CCSPSC logic model • CCSPSC contact list • Copy of MOA • CCSPSC one-page handout • Site visit summary form	*ACS expertise and history of working with FQHC system/site. ACS welcome to attend any in-person meeting and will continue to be included on communication regarding in-person visits.
Phase 2 **2nd Site Visit** (with newly enrolled FQHC sites)	Complete readiness and organizational assessments to inform development of implementation plan	• Obtain contextual information influencing implementation • Develop implementation Plan • Complete second site summary visit	• Completed implementation plan • Completed readiness assessment • Completed organizational assessment	UofSC Team ACS UofSC Program Implementer leads meeting.	• Agenda • Readiness assessment • Organizational assessment • Second site visit summary form • Implementation plan template	
Phase 3 **Pre-visit for Initial Professional Education**	Assess preparation for the initial professional education session and drop-off professional education session pre-test evaluation forms	• Complete checklist for initial professional education session • Drop off initial professional education pre test • Address any outstanding issues associated with preparation	• Completed checklist	UofSC Team	• Agenda • Checklist for initial professional education session • Initial professional education pre-test evaluation forms	

In-person Meeting(s) or Contact with Partner FQHC Sites (time)	Purpose	Main Activities	Outcomes / Products	Who / Roles and Responsibilities	Materials Needed	Other Information
Phase 3 Initial Professional Education	Conduct "all staff" initial professional education session	• Conduct all-staff initial professional education session • Collect pre-test evaluation forms • Administer post-test evaluation forms	• Increased staff awareness of CRC screening and the CCSPSC at the site	UofSC Team ACS CCSPSC and ACS jointly present initial professional education session.	• Agenda • Initial professional education session PPT • Laptop, projector, and screen (as needed) • Packets for attendees • Post-test evaluation forms	*ACS topic expertise and history of conducting professional education sessions.
Phase 3 Initial Implementation Training	Provide effective implementation training on evidence-based approaches at site to prepare for implementation of approaches (GO LIVE).	• Review implementation training binder materials • Determine issues associated with implementation to be addressed • Decide on small media • Administer pre- and post-implementation training evaluation forms	• Updated implementation binder • Assigned tasks for site staff and CCSPSC staff between training sessions	UofSC Team UofSC Program Implementer leads training.	• Agenda • Implementation training binder (implementation plan, organizational assessment, baseline CRCS data, info on evidence-based approaches selected) • Pre-test for implementation training • Post-test for implementation training	

In-person Meeting(s) or Contact with Partner FQHC Sites (time)	Purpose	Main Activities	Outcomes / Products	Who / Roles and Responsibilities	Materials Needed	Other Information
Phase 3 **Follow-up Implementation Training**	Follow-up on assigned tasks to be completed before determining a GO LIVE date	• Review assigned tasks • Begin development of SOP	• Finalize plans to GO LIVE • Determine GO Live date	UofSC Team ACS Site Implementation team decides final process. UofSC Program Implementer leads meeting.	• Agenda • Implementation training binder (implementation plan, organizational assessment, baseline CRCS data, info on evidence-based approaches selected) • Small media examples	
Phase 3 **Pre-GO LIVE Visit**	Drop off small media and implementation training follow-up evaluations forms	• Drop off implementation training follow-up evaluation forms • Supply small media	• Ensured final plans in place to GO LIVE	UofSC Team	• Small media • Small media tracking sheet • Implementation training follow-up evaluations forms	
Phase 3 **GO LIVE Events** (optional)	Support site with GO LIVE event	• Take pictures • Bring CRC program identity items • Provide support, as needed, for GO LIVE event	• Took pictures for newsletter • Celebrated GO LIVE event	UofSC Team ACS	• Camera • Program identity items	*ACS involvement in work with site, participate in celebration
Phase 4 **Follow-up Visit #1** (Month 1 post-GO LIVE)	Follow-up with site about implementation of evidence-based approaches and identify elements of the process requiring attention.	• Discuss successes, challenges, and adjustments • Discuss other applicable activities • Collect follow-up evaluation forms • Monitor small media supply	• Completed observation forms • Addressed any current needs associated with implementation	UofSC Team	• Agenda • Observation forms	*ACS expertise and history of working with FQHC system/site and "trouble shooting." ACS team could attend any of the three follow-up visits during the first three months post-GO LIVE.

In-person Meeting(s) or Contact with Partner FQHC Sites (time)	Purpose	Main Activities	Outcomes / Products	Who / Roles and Responsibilities	Materials Needed	Other Information
Phase 4 **Follow-up Visit #2** (Month 2 post-GO LIVE)	Follow-up with site about implementation of evidence-based approaches.	• Discuss successes, challenges, and adjustments • Discuss other applicable activities	• Completed observation forms • Addressed any current needs associated with implementation	UofSC Team	• Agenda • Observation forms	
Phase 4 **Follow-up Visit #3** (Month 3 post-GO LIVE)	Follow-up with site about implementation of evidence-based approaches.	• Discuss successes, challenges, and adjustments • Discuss other applicable activities	• Completed observation forms • Addressed any current needs associated with implementation	UofSC Team	• Agenda • Observation forms	
Phase 4 **TA Session #1** (Months 4-6 post-GO LIVE)	Discuss implementation of evidence-based approaches and identify any elements of the process requiring attention {Focus on process maps and SOP}	• Begin development of process maps through discussion with the site • Review quarterly data • Review SOP • Monitor small media supply	• Obtained information to inform development of process maps • Revised SOP, as applicable • Identified plans to address challenges	UofSC Team ACS UofSC Program Implementer leads meeting.	• Agenda • Most recent quarterly data collected • Copy of SOP • Examples of process maps	
Phase 4 **TA Session #2** (Months 7-9 post-GO LIVE)	Discuss implementation of evidence-based approaches and identify any elements of the process requiring attention {Focus on process maps and SOP}	• Review site process maps • Review quarterly data • Review SOP • Develop follow-up process map	• Updated process maps • Revised SOP, as applicable • Identified plans to address challenges	UofSC Team	• Agenda • Most recent quarterly data collected • Copy of SOP • Site process maps	

In-person Meeting(s) or Contact with Partner FQHC Sites (time)	Purpose	Main Activities	Outcomes / Products	Who / Roles and Responsibilities	Materials Needed	Other Information
Phase 4 **TA Session #3** (Months 10-12 post-GO LIVE)	Discuss implementation of evidence-based approaches and identify any elements of the process requiring attention {Focus on process maps and SOP}	• Review site process maps • Review site follow-up process map • Review quarterly data • Review SOP	• Updated process map • Revised SOP, as applicable • Identified plans to address challenges	UofSC Team	• Agenda • Most recent quarterly data collected • Copy of SOP • Site process maps	
Segue to Phase 5 **Annual Review Meeting** (one-year post-GO LIVE)	Assess progress and document changes to organization that have occurred in the past year to inform necessary modifications to implementation	• Review and edit readiness assessment, organizational assessment, and implementation plan • Discuss success, challenges, and solutions	• Revised readiness assessment, organizational assessment, and implementation plan	UofSC Team ACS UofSC Program Implementer leads meeting. ACS attends to provide input on annual review and in preparation for the one-year professional education session.	• Agenda • Annual readiness assessment • Organizational assessment • Implementation plan	*ACS expertise and history of working with FQHC system/site.
Segue to Phase 5 **One-year Professional Education Session**	Provide a refresher on CRC screening, celebrate success and achievements over the past year since GO LIVE, and describe next steps	• Conduct all-staff initial professional education session • Administer post-test evaluation forms	• Increased staff awareness of CRC screening and the CCSPSC at the site • Increased understanding of site progress over past year	UofSC Staff ACS UofSC and ACS jointly present one-year professional education session.	• One-year professional education session PPT • Laptop, projector, and screen (as needed) • Packets for attendees • Post-test evaluation forms	*ACS topic expertise and history of conducting professional education sessions.

In-person Meeting(s) or Contact with Partner FQHC Sites (time)	Purpose	Main Activities	Outcomes / Products	Who / Roles and Responsibilities	Materials Needed	Other Information
<u>SUMMARY</u> of TA Sessions in Phase 5 (Months 1-12 after annual review; and beyond) The activities in this phase will be guided by the CQI tool offered by CARE or a tool of the sites choice.	Support continued implementation of evidence-based strategies and promote sustainability	• Review process maps • Review SOP • Review quarterly data • Observation forms • CQI sessions • CRCS resources / Continuum of Care • Champion(s) in place	• Site visit summary form • Edited versions of process maps, SOP, quarterly data • Observation forms	UofSC Program Implementer: review of process maps, SOP, quarterly data; complete observation forms ACS: CQI, CRCS resources Other expertise, as needed	• Agenda • Process maps • SOP • Quarterly data • Observation forms • Debrief Survey (QR Code) • Other	*ACS expertise and history of working with FQHC system/site.
Phase 5, TA Session #1 (Months 1-3 after annual review)	Usual check in to ensure implementation is proceeding {UofSC} Begin discussions about collecting metrics and use of CQI data tool for tracking CRCS {ACS} Inform site about the potential for additional staff at future meetings	• Review process maps • Review SOP • Review quarterly data • Explore current processes for tracking CRCS (led by ACS) • Introduce CQI spreadsheet as option – TBD core/common elements if site wants to use own tool (led by ACS) • Plan for CQI spreadsheet (or other) data collection (led by ACS)	• Site visit summary form • Edited versions of process maps, SOP, quarterly data • Observation forms • CQI spreadsheet • Other CQI meetings TBD	UofSC Program Implementer: review of process maps, SOP, quarterly data; complete observation forms ACS: lead CQI, CRCS resources	• Agenda • Process maps • SOP • Quarterly data • Observation forms • CQI spreadsheet • Other CQI materials TBD • UofSC to make copies • Debrief Survey (QR Code)	Sites will continue to email the tool to CARE quarterly.

In-person Meeting(s) or Contact with Partner FQHC Sites (time)	Purpose	Main Activities	Outcomes / Products	Who / Roles and Responsibilities	Materials Needed	Other Information
Phase 5, TA Session #2 (Months 4-6 after annual review)	Brief check in to ensure implementation is proceeding {UofSC} Review CQI data on CRCS {ACS}	• Brief check in items (review process maps, review SOP, review quarterly data – new challenges, etc.) (led by UofSC program implementer) • Review CQI data on CRCS (led by ACS)	• Site visit summary form • Edited versions of process maps, SOP, quarterly data • CQI spreadsheet • Other CQI meetings TBD • Root Cause Analysis (RCA) • Follow-up phone call (30 minutes) to review RCA • Brief Interview process (when information is needed from staff who are unable to attend meeting)	UofSC Program Implementer: review of process maps, SOP, quarterly data ACS: lead CQI, CRCS resources, Brief interview process	• Agenda • Process maps • SOP • Quarterly data • CQI spreadsheet • Other CQI materials TBD • Debrief Survey (QR Code) • UofSC to make copies	"The Doers" ACS to update UofSC Program Implementer of the date/time/duration describing activity(ies) for the next meeting. What staff need to attend and why. UofSC Implemeter can assist with follow-up, as directed by ACS

In-person Meeting(s) or Contact with Partner FQHC Sites (time)	Purpose	Main Activities	Outcomes / Products	Who / Roles and Responsibilities	Materials Needed	Other Information
Phase 5, TA Session #3 (Months 7-9 after annual review)	Brief check in to ensure implementation is proceeding {UofSC} TBD	• Email process maps, SOP to identify changes • Review quarterly data • RCA Findings • Brainstorm about changes that lead to improvement • Plan for PDSA TBD based on TA #1 and TA#2, but will include usual check in items *Should everything be in order with no need for improvement, content will transition to ACS-led work and other QI needs	• Site visit summary form • Edited versions of process maps, SOP, quarterly data • Observation forms TBD	UofSC Program Implementer: Email process maps &SOP for review Review quarterly data; complete observation forms ACS: lead CQI, CRCS resources	• Agenda • Process maps • SOP • Quarterly data • Observation forms • CQI spreadsheet • Other CQI materials TBD • Debrief Survey (QR Code) • UofSC to make copies	ACS to update UofSC Program Implementer of the date/time/duration describing activity(ies) for the next meeting. What staff need to attend and why. UofSC Implementer can assist with follow-up, as directed by ACS

In-person Meeting(s) or Contact with Partner FQHC Sites (time)	Purpose	Main Activities	Outcomes / Products	Who / Roles and Responsibilities	Materials Needed	Other Information
Phase 5, TA Session #4 (Months 10-12 after annual review)	Brief check in to ensure implementation is proceeding {UofSC}	• Email process maps, SOP to identify changes • Review quarterly data • Review outcome for RCA TBD based on TA #1 and TA#2, but will include usual check in items *Should everything be in order with no need for improvement, content will transition to ACS-led work on medical neighborhoods and other QI needs	• Site visit summary form • Edited versions of process maps, SOP, quarterly data • CQI spreadsheet • Other CQI meetings TBD	UofSC Program Implementer: Email process maps &SOP for review Review quarterly data; complete observation forms ACS: lead CQI, CRCS resources	• Agenda • Process maps • SOP • Quarterly data • CQI spreadsheet • Other CQI materials TBD • Debrief Survey (QR Code) • UofSC to make copies	ACS to update UofSC Program Implementer of the date/time/duration describing activity(ies) for the next meeting. What staff need to attend and why. UofSC Implementer can assist with follow-up, as directed by ACS
2nd Year Annual Review	Assess progress and document changes to organization that have occurred in the past year to inform necessary modifications to implementation	• Review and edit readiness assessment, organizational assessment, and implementation plan • Discuss success, challenges, and solutions	Revised readiness assessment, organizational assessment, and implementation plan	UofSC Team ACS UofSC Program Implementer leads meeting. ACS attends to provide input on annual review and in preparation for the one-year professional education session.	• Agenda • Annual readiness assessment • Organizational assessment • Implementation plan	After 2nd Annual meeting UofSC team and designated site ACS primary care member and CARE team member will meet to conduct a SWOT analysis of the sustainment of implementation of the EBI's and develop a plan for the path forward

In-person Meeting(s) or Contact with Partner FQHC Sites (time)	Purpose	Main Activities	Outcomes / Products	Who / Roles and Responsibilities	Materials Needed	Other Information
Internal Path Forward Meeting	To provide feedback for a potential path forward for the site	• Review Internal Planning document • Conduct SWOT analysis	Completed SWOT worksheet	UofSC Team, ACS Primary Care Team Member, CARE team member	• Agenda, • Internal Planning Document for Path Forward • SWOT Worksheet Template • Post-it Notes, Sharpies,	After 2nd Annual meeting UofSC team and designated site ACS primary care member and CARE team member will meet to conduct a SWOT analysis of the sustainment of implementation of the EBI's and develop a plan for the path forward
Path Forward	To update key staff on the success, opportunities, and trends identified at the 2nd Annual Review and data collection process	• Provide hard copies as well and email a handout • The handout will replace the "all staff" professional education session	Increased staff awareness of CRC screening and the CCSPSC at the site Increased understanding of site progress over past year	UofSC Staff ACS UofSC and ACS jointly present 2nd -year	• SWOT material • Packets for attendees	
Sharing Results	To provide the site with a one-page document to highlight key results, successes, and opportunities. The document is intended to be shared with everyone at the site in lieu of the annual professional training.	• Create the one-page document and make copies for dissemination • This document will also be			•	
Phase 5, Additional TA sessions in future years – TBD	TBD	TBD	TBD	TBD	TBD	

******Phase 5: Gray-shaded boxes are in development, in progress***

Note: CCSPSC will include 4 TA sessions, but the work to address QI may require additional visits. We will track the number of additional visits, but ACS will lead.

Colorectal Cancer Screening Program in South Carolina
CRCS Program FQHC Site Visit Summary Sheet

Organizational Information

FQHC System ID#/Site ID#:	CRCSP Staff: ACS:	Date:

FQHC Site Contacts Attending Conference Call Meeting

Purpose of Visit

Topic	Result
Updates:	

Brief Summary of Visit

Action items and questions for follow up

Follow Up Visit/Contact Scheduled

☐ Date: / Time:

Champions for Colorectal Cancer Screening in South Carolina

ACTIVITY 1:

Why am I a champion?

Please take a few minutes to answer the following questions about being a champion before the in-person champions training. At the in-person training, you will work with a partner to share your answers. This will give you time to learn about a fellow champion. When asked, be prepared to provide one sentence about why your partner is a champion for colorectal cancer screening.

How have you acted as a champion in the past? Have you ever been a proponent for a cause or an issue? Have you ever worked to overcome barriers to address this cause or issue? This does not have to be specific to colorectal cancer screening but for any cause or issue.

What are characteristics of someone who is an effective champion for colorectal cancer screening? If you are unsure of specific characteristics related to a champion for colorectal cancer screening, respond generally in terms of characteristics of an effective champion.

What do you see as the main role(s) of a champion for colorectal cancer screening?

For what reasons is colorectal cancer screening important to you? In other words, why does it matter? Why should people be screened for colorectal cancer?

What are three reasons why you are here to learn more about being a champion for colorectal cancer screening?

What is one thing about your interest in being a champion for colorectal cancer screening that you want others to know?

What barriers to serving as a champion do you anticipate and how may you overcome any barriers?

What else about you and your connection to colorectal cancer screening do you think makes you an ideal champion?

Champions for Colorectal Cancer Screening in South Carolina

ACTIVITY 2:

How can I be an advocate?

Hook, Line, and Sinker
Making a Legislative Ask

The Hook: Introduce yourself and give your hometown and county. The hook is being a constituent. You vote in the legislator's district, and legislators work for the people who vote for them. You are why they are in the General Assembly and how they can remain in office.

Line: Tell the legislator why the issue is important to you. The line is your personal connection to the cancer issue. Such as, "I'm here today because I am a six-year colon cancer survivor," or "My father died from colon cancer," or "My sister had a colonoscopy and the doctor found a polyp, and I know firsthand the difficulties of having cancer" or "I work in a FQHC, and I see the need for patients to be screened for colorectal cancer screening."

Sinker: Ask the legislator to support our issues. The sinker is what you want the legislator to do about your concern – ***the ask*** – and the reason for the meeting.

Champions for Colorectal Cancer Screening in South Carolina

ACTIVITY 3:
How will I serve as a champion?

This activity will be used with the CHAMPIONS PLAN (next page) to bring together what has been learned during the training and plan for how to serve as a champion.

Think back to Activity 1. Why are you a champion for colorectal cancer screening? Take a moment to write a statement about why you are an ideal champion for colorectal cancer screening. Consider characteristics of an effective champion.

Think back to Activity 2. How can you be an effective advocate for colorectal cancer screening? Take a moment to write a statement about what you have done in the past or what you want to do in the future to advocate for colorectal cancer screening.

What are the three most important pieces of information you want others to know about colorectal cancer screening?

What are the three most important reasons someone should be screened for colorectal cancer?

What is the most important reason, to you, for people to be screened for colorectal cancer?

What opportunities do you see to increase colorectal cancer screening in South Carolina?

What else do you need to know to be an effective champion for colorectal cancer screening?

Champions for Colorectal Cancer Screening in South Carolina

CHAMPIONS PLAN

Name:

Organization:

Email:

My three colorectal cancer screening talking points.

1.

2.

3.

<u>Tomorrow</u>, I will do the following to serve as a champion for colorectal cancer screening.

In the <u>next six months</u>, I will do the following to serve as a champion for colorectal cancer screening.

In the <u>next year</u>, I will do the following to serve as a champion for colorectal cancer screening.

Please submit this form to Hiluv before leaving. A copy will be provided to you.

Champions for Colorectal Cancer Screening in South Carolina

A Letter to {ME}

Name:

Organization:

Email:

Date of Training:

Dear _____ {Your Name},

On [date of training], I made a commitment to serve as a champion for colorectal screening in South Carolina.

Since the training in [date], in the last six months, I have (what you expect to have done as a champion):

I have made new connections (list those with whom you seek to connect):

A Letter to {ME}, page 2

I have encountered challenges, but I have overcome them (list anticipated challenges and potential solutions):

I have learned new information about colorectal cancer screening (list what you expect to learn):

In the next six months, by July 2019, I will (what will you plan to do for the next six months as a champion):

I have been a champion.

Sincerely,

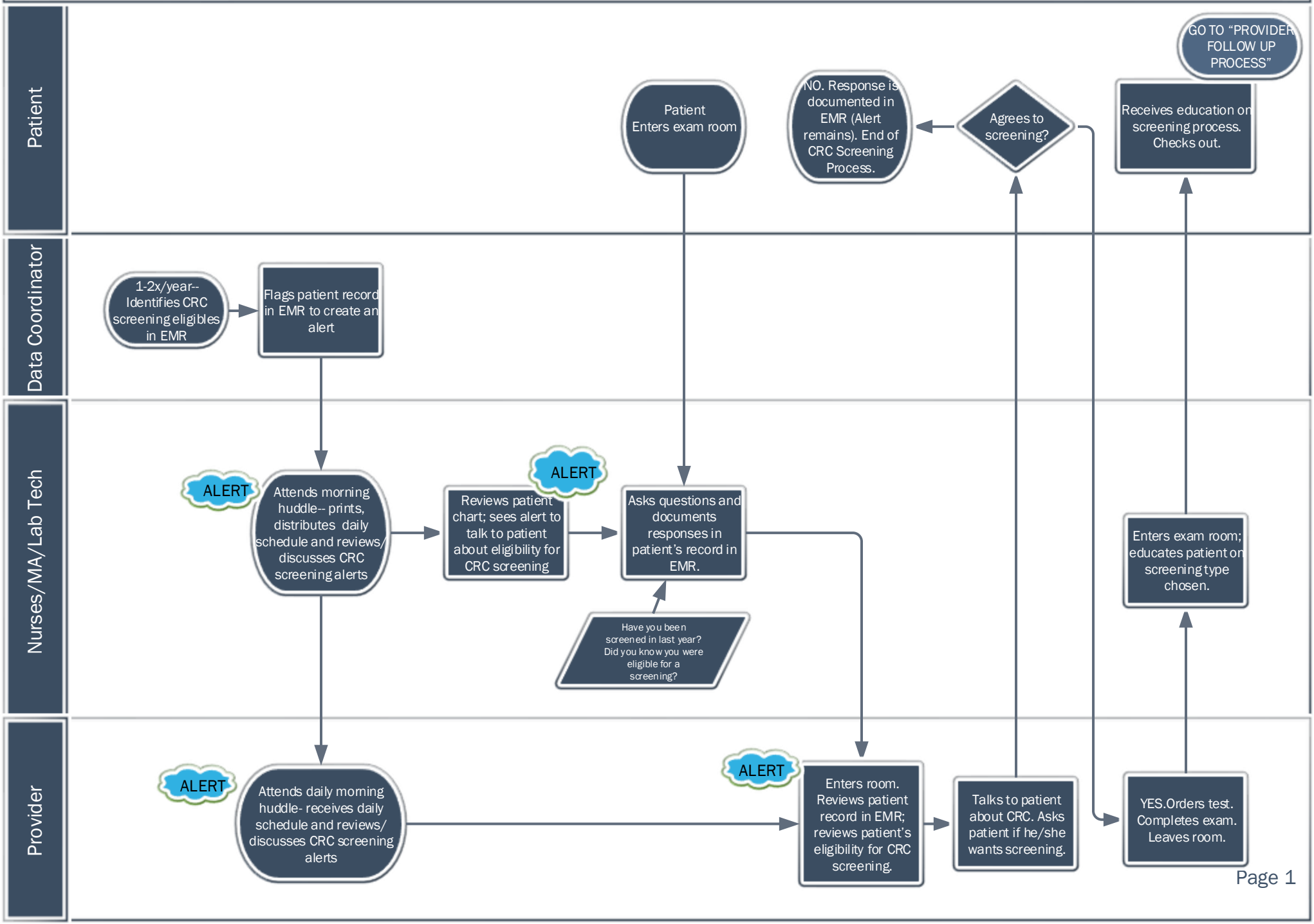
_____ {Your Signature}

Please submit this letter to [facilitator] before leaving. We will send you this letter six months from training - [date].

CCSPSC Phased Approach to Implementation with Partners

SANDHILLS-LUGOFF- PROVIDER REMINDER PROCESS 10.18.18

EMR- Allscripts



Site:_____ **Team Member:**_____ **Implementation Phase:**_____
Date:_____

Provider Reminder Observation Form

Reminders inform health care providers 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 e-mail (Baron, 2010[1]).

Feature[2]
Provider Reminder Implementation Team
Who is on the provider reminder team? ☐ MD/DO ☐ NP ☐ Health Educator ☐ Medical Assistant (CMA/CNA) ☐ Front Desk Staff ☐ Other:_____
Who on the team is responsible for identifying eligible patients? ☐ Front desk staff ☐ CRCS Coordinator ☐ Quality Management Staff ☐ Other:_____
Who is responsible for using the reminder to recommend screening? ☐ MD/DO ☐ NP ☐ Nurse ☐ Medical Assistant ☐ Other:_____
Implementation
Is the EBI currently being implemented? ☐ Yes ☐ No
Type of Reminder Present (select all that apply) ☐ Blue Star magnet ☐ Written notes/sticky note in patient chart ☐ Daily List/Report of eligible patients ☐ Morning Provider/Care Team huddle ☐ Email reports to providers with list ☐ EHR/EMR flags or alerts ☐ Rescreening alert
Source of Provider Reminder (select all that apply) ☐ Daily schedule/appointment list of patients eligible for CRCS

[1] Baron RC, Melillo S, Rimer BK, Coates RJ, Kerner J, Habarta N, Chattopadhyay S, Sabatino SA, Elder R, Leeks KJ, Task Force on Community Preventive Services. Intervention to increase recommendation and delivery of screening for breast, cervical, and colorectal cancers by healthcare providers: a systematic review of provider reminders. [PDF - 452 kB] *Am J Prev Med*2010;38(1):110-7.

[2] Adapted from Partnership for Prevention. Healthcare Provider Reminder Systems, Provider Education, and Patient Education: Working with Healthcare Delivery Systems to Improve the Delivery of TobaccoUse Treatment to Patients—An Action Guide. The Community Health Promotion Handbook: Action Guides to Improve Community Health. Washington, DC: Partnership for Prevention; 2008.

Site:_____ **Team Member:**_____ **Implementation Phase:**_____
Date:_____

- ☐ EHR Prompt to Provider
- ☐ Provider
- ☐ Other:_____

Frequency of Reminder (assessed for <u>each</u> type of reminder)

Type of Reminder__*i.e. EHR Flag*_____

- ☐ Every visit (every day for all clients)
- ☐ Weekly
- ☐ Monthly
- ☐ Inconsistent
- ☐ Other:_____

Type of Reminder__*i.e. Care Team Huddle*_

- ☐ Every visit
- ☐ Weekly
- ☐ Monthly
- ☐ Inconsistent
- ☐ Other:_____

Type of Reminder_____

- ☐ Every visit
- ☐ Weekly
- ☐ Monthly
- ☐ Inconsistent
- ☐ Other:_____

Monitoring and Evaluation

What procedures are in place to track the delivery of provider reminders?

- ☐ Standard of Practice/Protocol
- ☐ Confirmation of provider reminder built into EHR
- ☐ Tracking orders/referrals for colonoscopy
- ☐ Tracking distribution of FIT/FOBT
- ☐ Tracking return of FOBT/FIT/colonoscopy results
- ☐ Other:_____

Who is responsible for monitoring this process?

- ☐ Name:_____
- ☐ Position:_____

Who is responsible for addressing needed changes to the process?

- ☐ Name:_____
- ☐ Position:_____

Site:_____ **Team Member:**_____ **Implementation Phase:**_____
Date:_____

What barriers and/or challenges were observed in the implementation of provider reminders?
Notes:

Arnold School of Public Health

Colorectal Cancer Screening Program in South Carolina
Implementation Tracking
SITE NAME / NUMBER (EXAMPLE ONLY)
CCSPSC: IMPLEMENTER NAME
ACS: NAME

GOAL: Increase CRC screening by X% each year
Baseline CRC screening (DATE): XX%
Annual CRC screening YR1 (DATE): XX%
Annual CRC screening YR2 (DATE): XX%

Implementation Phase	Communication: Types of contact methods and frequency			Process Indicators	Description of Activities	Success	Challenges	Technical Assistance Opportunities
	Via Email	Via Phone	In person					
Phase 1: Building Partnerships December1, 2015- September 22, 2016	33	20	3 Dates: 06/24/16, 09/01/16 , 09/21/16	• MOA (6/23/16) • Site Selected (Lakeview) • Readiness Assessment for Lakeview (09/21/16)	Met with site to build rapport and plan Trusting relationship with CCSPSC team Partnership with ACS Part of CCPN (open access colonoscopy Program and Fit Pilot) Selection of EBIs through 1st and 2nd summary visit forms Readiness Assessment for site	Trust and rapport was built with the site leadership team	Took a long period to establish first visit with this site Patient buy in for FIT testing and transportation for colonoscopies referrals	Tracking CRCS
Phase 2: Baseline Data and Implementation Plan September 22, 2016- November 21, 2016	20	10	1 Dates: 11/15/16	• Org Assess (10/21/16) • Baseline CRC Data (10/21/16) • Implementation Plan (11/21/16)	Joined CCSPSC Evaluation Committee Discuss preferred priority evidence-based strategies to align with current CRCS activities	Solutions to barriers identified	Access for the uninsured	Need for a CRC SOP

Phase 3: Implementation November 11, 2016 -March 21, 2017	10	5	7 Dates: 11/17/16, 12/06/17, 01/12/17, 2/16/17, 03/09/17, 03/14/17, 3/21/17	• Professional Education (11/17/16) • Implementation Training (4 sessions; dates-12/06/17, 01/12/17, 02/16/17, 03/09/17 • GO LIVE (03/21/17)	Developed provider assessment and feedback process for CRCS Developed process for Client Reminder Implementing FIT CRCS program Develop better tracking methods for CRCS CPN open access program participation Increase resources for the uninsured Pre- and post-test evaluation for professional education and implementation training Part of NCRRT 80% by 2018 goal	Site provides incentives for CRCS measures along with all meaningful use measures, Has outreach workers to pick up Fits from patient's homes	Admin not allowing site to develop a CRC SOP Need admin approval before implementing any new process	Feedback on tracking CRCS for providers
Phase 4: Supporting and Monitoring Implementation March 22, 2017- April 19, 2018 (Ongoing)	24	9	9 Dates: 4/25/17, 05/30/17, 06/15/17, 07/20/17, 08/22/17, 10/25/17, 01/25/18, 03/15/18, 04/19/18	• Observation forms completed for 3 f/u drop ins • 1st TA , 2nd TA, & 3rd TA completed • 6 follow ups after going live completed • 1st, 2nd, & 3rd Quarterly data completed • 1st, 2nd, & 3rd Quarterly data completed • Annual review meeting completed • 1st One year Professional training completed	Participating in focus groups Process maps completed for EBIs Completed annual data Participated at the CCPSC CRC training session at SCPHA Annual Retreat in Charleston Completed 3 quarterly data Has developed Follow up of CRC Results Process Maps Completed annual CRC data Annual Review meeting –updated OA, RA, and CDC Implementation Plan 1st Annual professional training completed	Positive feedback and has seen in increase in CRCS since going live CRC increased from 26%-28%	Patients having bad phone numbers and addresses for birthday cards sent out	Process maps Improved process for implementing EBIs Develop process maps for the follow up part in getting results in EMR for CRCS Will be changing EBI (client Reminder to Provider Reminder) due to issues with tracking

Phase 5: Ongoing Monitoring Implementation April 20, 2018- Present	32	15	2 Dates: 06/21/18, 8/30/18	• Completed 1 TAs and 1 extra visits • Observation forms completed • Introduction of CQI • Reviewed 1st submission of CQI data	Review process maps, SOP, and quarterly data Discussed CRCS resources / medical neighborhood Champion(s) in place Identifies loophole on where root cause analysis will be conducted by ACS	CRC screening rate continues to increase conducting provider assessment and feedback for all measures system wide with monetary incentives for providers	Still has not been able to develop a CRC SOP	New CQI tool introduced and completed Review loopholes CQI activities Root cause analysis

Updated by: Date:

CCSPSC Program
Organizational Assessment and Environmental Scan
Winter/Spring 2016

General FQHC Site Information

FQHC System: Number of Clinics in System:	FQHC Clinic/Site:	Street Address:

Primary Contact Person's Information

Name:	Title:
Email:	Phone:

Additional Contacts

Name:	Title:
Email:	Phone:

Name:	Title:
Email:	Phone:

Updated by: Date:

Current Organizational Infrastructure

Staffing

Service Site Staff by Primary Role: How many of the following roles does the clinic employ?

Type of Staff	Total FTE	Number Full Time	Number Part Time	Number Volunteers
Total Number of Primary Healthcare Providers				
Doctors				
Physicians Assistant				
Nurse Practitioners				
Registered Nurse or Licensed Practical Nurse				
Clinic Manager				
Pharmacist				
Certified Nurse Assistant/Medical Assistant				
Counselor				
Educator				
Front Desk Staff				
Patent Navigators				
Community Health Worker				
Other (please specify)				

Leadership

Capacity for implementation	□ Low	□ Medium	□ High
Readiness for implementation	□ Low	□ Medium	□ High
Commitment to implementation	□ Low	□ Medium	□ High

Updated by: Date:

How often does the clinic hold the following meeting types?

Type of Meeting	**Frequency**
All staff meetings	
Huddles	
Visit planning meetings	
Quality Improvement meetings	
Other: Please indicate meeting type or name	

Availability of Services for Target Population

How many days per week is the facility open? _____/7

Hours of Operation	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Administration							
Clinical (all patients)							
Clinical (target population)							

How does an individual enroll as a patient into your clinic? Do you only serve patients who live in a certain county, community, etc.?

Does the clinic offer designated appointments? _____ Yes _____ No

If yes, is an appointment required? _____ Yes _____ No

Does the clinic provide transportation services for patients? _____ Yes _____ No

Patient Population

What is your clinic's total active patient population? _____

How many visits occurred at your clinic in the most recent year? _____

Number of patients by age: 17 or younger_____ 18 to 49 _____ 50 to 75 _____ 76 and up _____

Number of patients by gender: Female _____ Male _____

	African American/ Black	White	Asian	American Indian/ Alaska Native	Native Hawaiian/ Other Pacific Islander

Updated by: Date:

Number of patients by race					

Number of patients by Hispanic/Latino ethnicity: _____

Number of patients who have no health coverage: _____

Any additional information you would like to us to know about your patient population:

Appointment Scheduling

What primary appointment model does the clinic utilize?

- ☐ Traditional (office visit, preventive or yearly appointment made in advance)
- ☐ Advanced access (same day, next day)
- ☐ Hybrid (shared appointments, group appointments, etc) Other (please specify)

Does the RN manage their own separate schedule?

- ☐ Yes
- ☐ No
- ☐ N/A

What is the approximate, current no-show rate (if known)? _____

Updated by: Date:

Current Activities Related to Colorectal Cancer Screening

CRC Screening/Referrals

Does the clinic have any of the following activities in place for colorectal cancer screenings?

- ☐ Patient reminders
- ☐ Provider reminders
- ☐ Provider assessment and feedback
- ☐ Reducing structural barriers
- ☐ Small Media
- ☐ Professional Development and Training (including provider training re: screening modalities)
- ☐ Health Information Technology
  - o Yes? Briefly Describe_____
    _____
- ☐ Community Health Workers
  - o Yes? # of FTE CHWs?_____
- ☐ Patient Navigation
  - o Yes? # of FTE patient navigators?_____

Does the clinic have its own written protocol/practice standard for colorectal cancer screenings?

- ☐ Yes (please obtain a copy of the protocol)
- ☐ No
- ☐ I don't know

Comments/Notes

How does the colorectal cancer screening process currently work in this organization?

Is the process implemented consistently across the entire organization?

Updated by: Date:

How could we assist in improving that process (including efforts to make colorectal cancer screening processes consistent across the practice)?

What type of colorectal cancer screening services do you offer on site or for referral?

Type of Colon Cancer Screenings Offered	**On Site**	**Referral** (describe referral process and sites below)
FOBT Brand?_____ Lab used?_____	□ Yes	□ Yes
FIT Brand?_____ Lab used?_____	□ Yes	□ Yes
Flex Sig	□ Yes	□ Yes
Colonoscopy	□ Yes	□ Yes

If you refer, what is the referral process? (What are the steps?)

Please describe the referral sites:

Facility Name	**Payment Type (Sliding scale, Insurance, Full service charge)**	**Miles from your facility to the referral site**	**Do you follow up referrals to this site? Y/N**	**If Y, list the person responsible for follow up**	**Percentage of patients that reach referral facility**

Updated by: Date:

How do patients referred for flexible sigmoidoscopy or colonoscopy receive their prep medications?

_____On site pharmacy _____Off site pharmacy _____Both _____ Other (Specify): _____

CRC Screening Promotion

Is your organization currently doing any work related to CRC screening promotion? For example, American Cancer Society coaching? Other existing programs aiming to promote CRC screening, navigation, timely treatment, etc.?

Any experience with implementing evidence-based strategies?

Any experience with USC's Center for Colon Cancer Research (CCCR)?

Health Information Technology System

Basic EMR/EHR Information

What is the name of the EMR/EHR system your organization uses? _____

How long has your organization been using this EMR/EHR System? _____

Has the clinic fully transitioned from paper charts to EHR? (Yes/No)

How would you describe the current level of satisfaction (including ease of use) with the EMR/EHR system?

Who is responsible for EHR reporting? _____

Updated by: Date:

Is your EHR capable of running reports or do you have a separate data warehouse to run reports?

_____

Baseline Screening Rate Assessment & CRC Screening Data Collection

In the EHR, do client charts indicate method and date of most recent screening colorectal cancer? If yes, please indicate where it is recorded (text field, checkbox, or structured data field).

Which measures for does the clinic report on for each of the following?

- ☐ UDS
- ☐ NQF
- ☐ PQRS
- ☐ eCQM
- ☐ ACO Other reporting body: (please specify _____)

Does the clinic have the capacity to modify EHR system?

- ☐ Internal
- ☐ External
- ☐ None
- ☐ I don't know

Comments/Notes - please list the staff role who is able to modify the system

Does the EHR system have the ability to produce reports?

- ☐ Yes
- ☐ No
- ☐ Clinic doesn't know (marked "I don't know")

Comments/Notes

Updated by: Date:

Does the EHR have the capacity to find eligible population (based on demographics or exclusions [colectomy/CRC diagnosis]) for colorectal cancer screening?

- ☐ Yes
- ☐ No
- ☐ Clinic doesn't know (marked "I don't know")

Comments/Notes

Does the EHR have the capacity to provide a list of clients who are not up to date with colorectal cancer screening?

- ☐ Yes
- ☐ No
- ☐ Don't know

If yes, where is this information recorded in the EHR? (i.e. text box, open field, record sheet, etc.)_____

What systems are in place for tracking referrals and completion of screening in your data system? For example, are there checkboxes for '*procedure ordered'* or '*screening completed on x date'*?

Does the EHR have the capacity to incorporate a reminder system for clients who are in need of cancer screenings?

- ☐ Yes
- ☐ No
- ☐ I don't know

Comments/Notes

Does your data system have provider reminders or alerts in place? _____

Can you calculate baseline screening rates as required for this project? _____

Updated by: Date:

Experience with Quality improvement and Evaluation

Does your organization have a formal quality improvement process? If so, how well does it function?

Has your organization done any work related to quality improvement or evaluation related to CRC Screening?

How would you describe your current capacity and ability to collect any additional information needed for evaluation of this program?

What QI data is regularly collected? _____

Who is responsible for analyzing QI data? _____

If applicable, does your health system currently use the clinical data associated with UDS, PQRS, and/or NQF measures to plan and implement quality improvement activities for Colorectal Cancer Screening?

_____

General Feedback and Recommendations

Please provide any additional notes:

Deeper Dive Workshop: Evaluating Health Systems Interventions

Amy DeGroff, PhD, MPH
Senior Health Scientist
Centers for Disease Control and Prevention
Email: asd1@cdc.gov

Heather M. Brandt, PhD
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U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Arnold School of Public Health

June 6, 2019

Workshop Plan

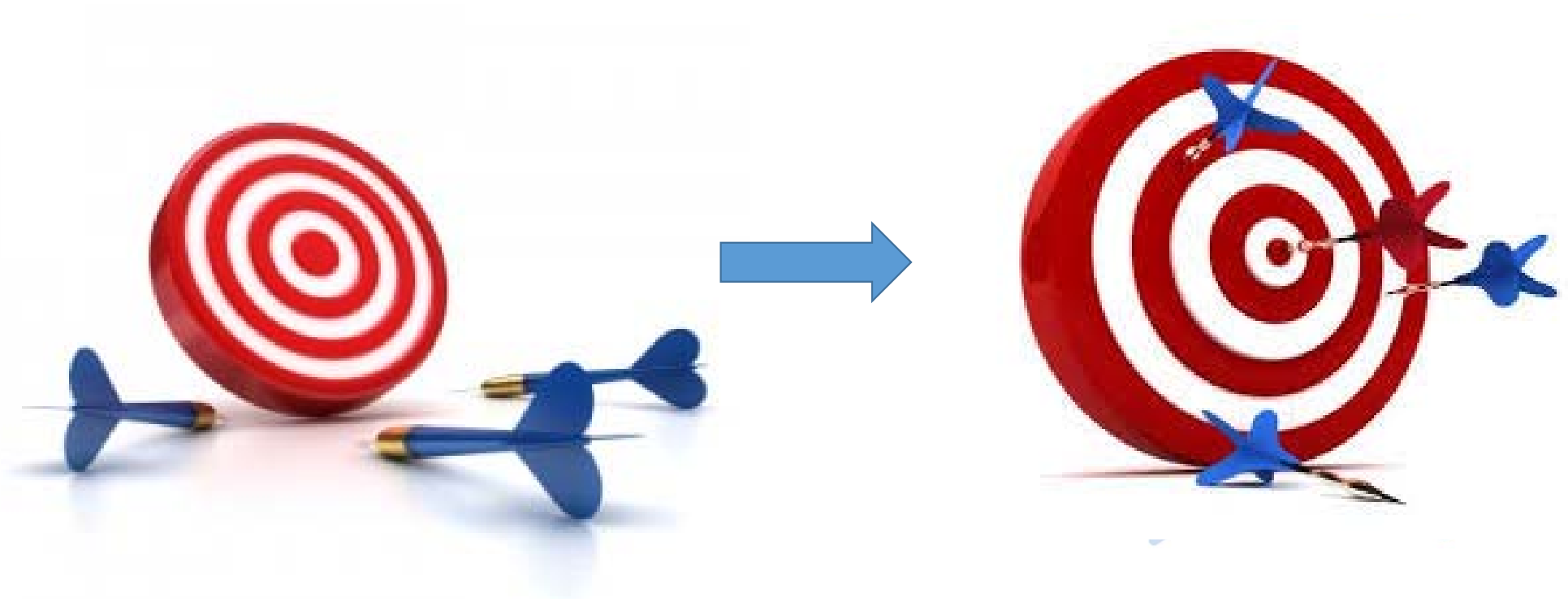
- Brief review of Workshop Training Outcomes
- Introductions
- Initial Activity
- CDC-led Evaluation (Amy)
- Case Study: Colorectal Cancer Screening Program in South Carolina (Heather)
- Questions and Answers

Workshop Training Outcomes

By the end of the workshop, participants will be able to:

- Describe examples of evaluation questions that can guide evaluation of health system interventions.
- Identify evaluation methods for measuring processes of health system interventions and key health outcomes (breast, cervical, and/or colorectal cancer screening)
- Describe different types of evaluation data to measure, monitor, and use for program improvement
- Understand the role of data quality for key health outcomes
- Describe at least one program-specific example of how evaluation data have been used to monitor and modify health systems interventions
- Discuss at least one program-specific example of how to use key health outcomes and process data (including implementation outcomes data) for program improvement

Workshop Training Outcomes: In Sum

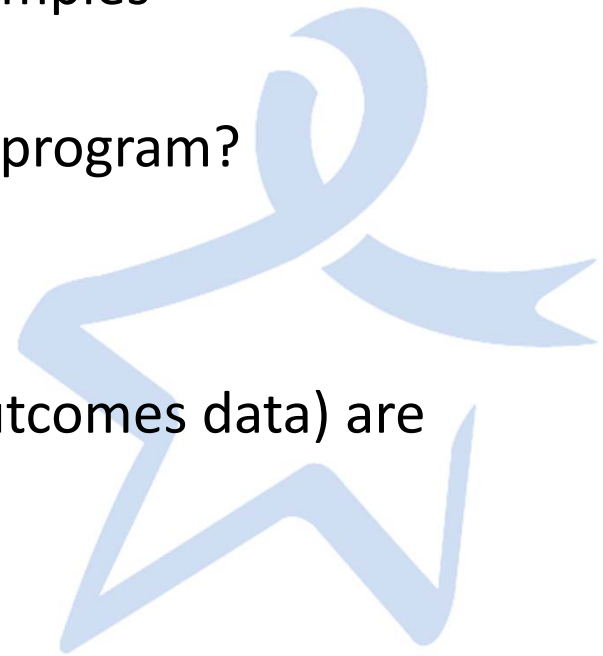


Introductions

- Name
- Program
- Role

Initial Activity

- Indicate program name (or state) by selected examples
- What are your program's **evaluation questions**?
- What **outcomes data** are being collected in your program?
  - Types and sources of data
  - Frequency
  - Uses
- What **process data** (including implementation outcomes data) are being collected in your program?
  - Types and sources of data
  - Frequency
  - Uses



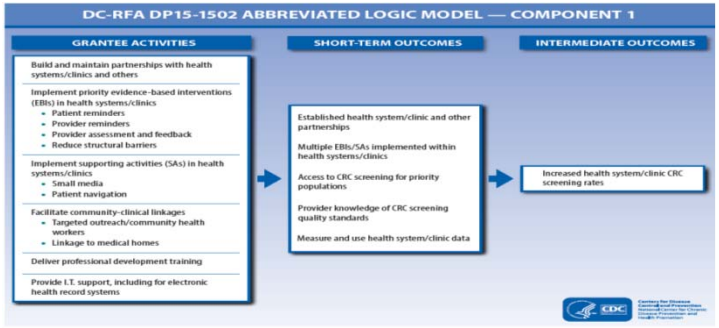
Refer to handouts on tables.

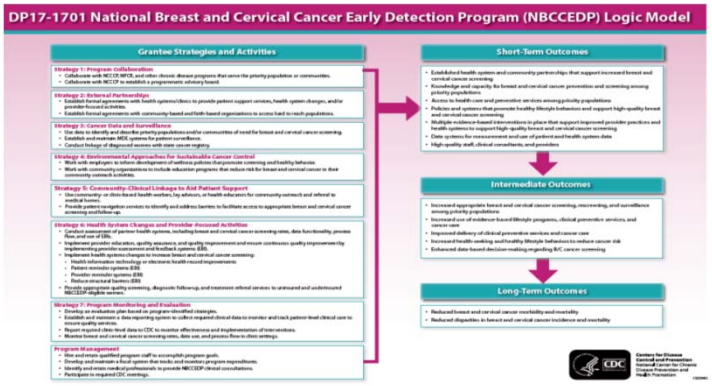
CDC-led Evaluations

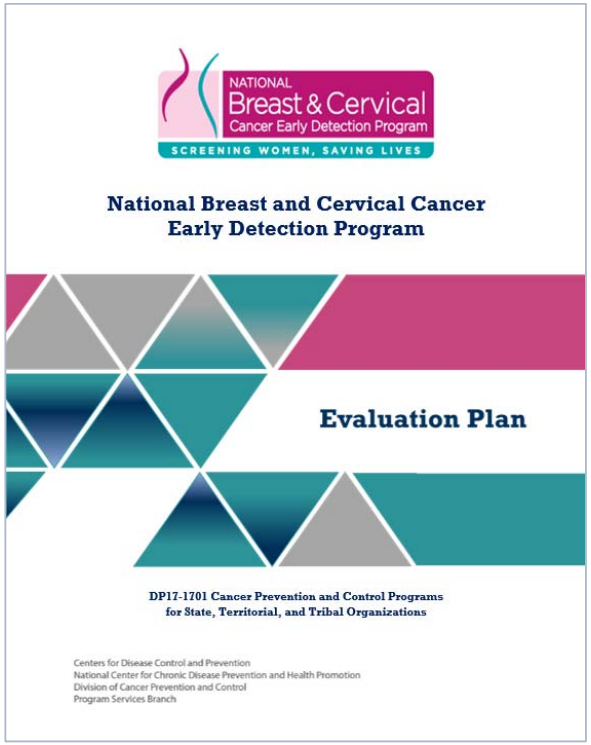
Amy DeGroff, PhD, MPH
Senior Health Scientist
Centers for Disease Control and Prevention
Email: asd1@cdc.gov

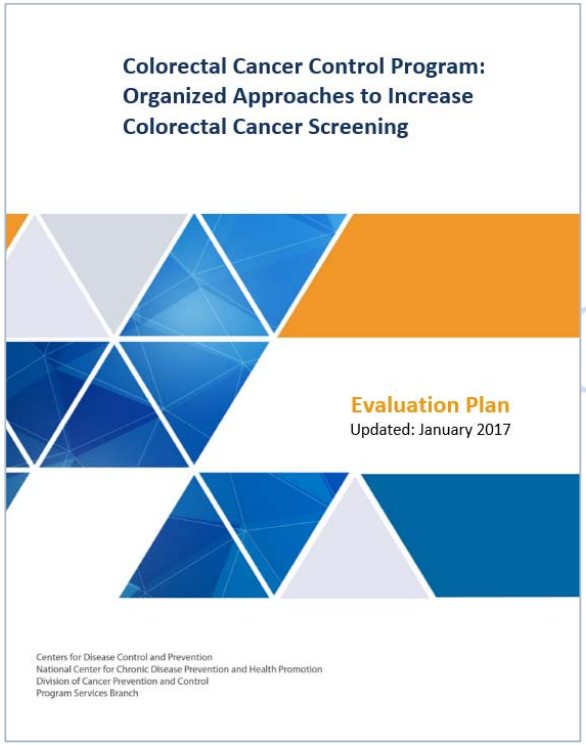
U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

We all need a plan









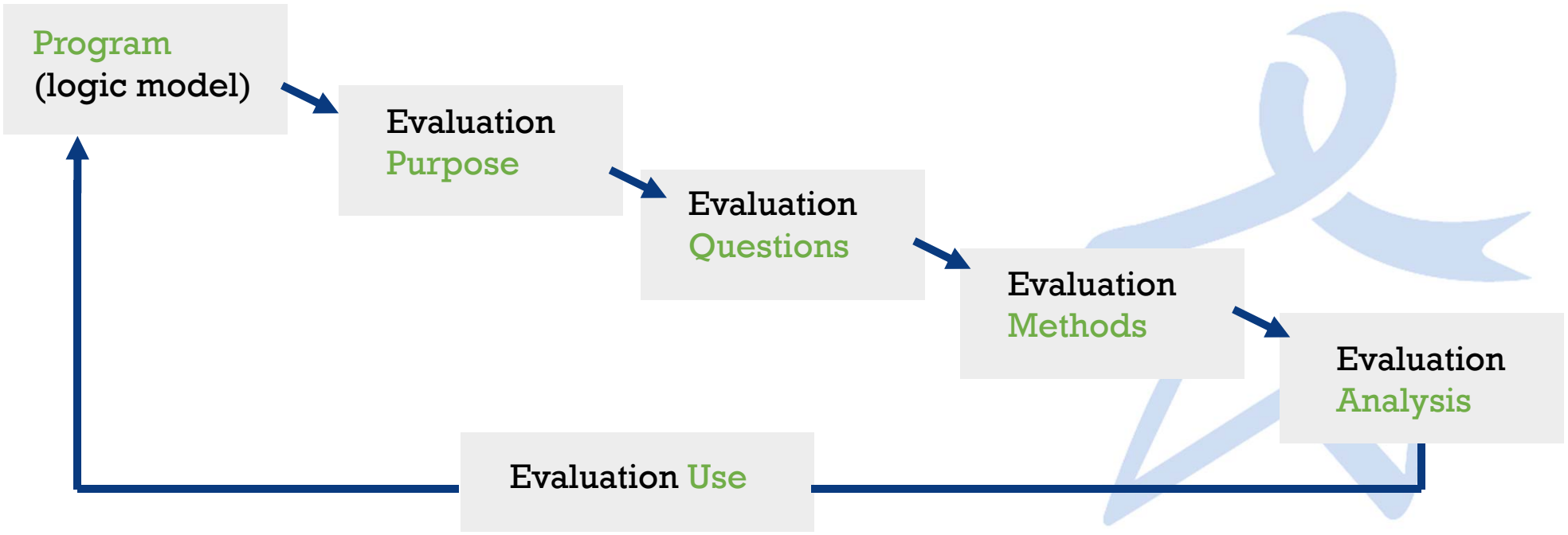
And a purpose…

Accountability to funders (Congress)

Program Improvement

Planning and Decision Making

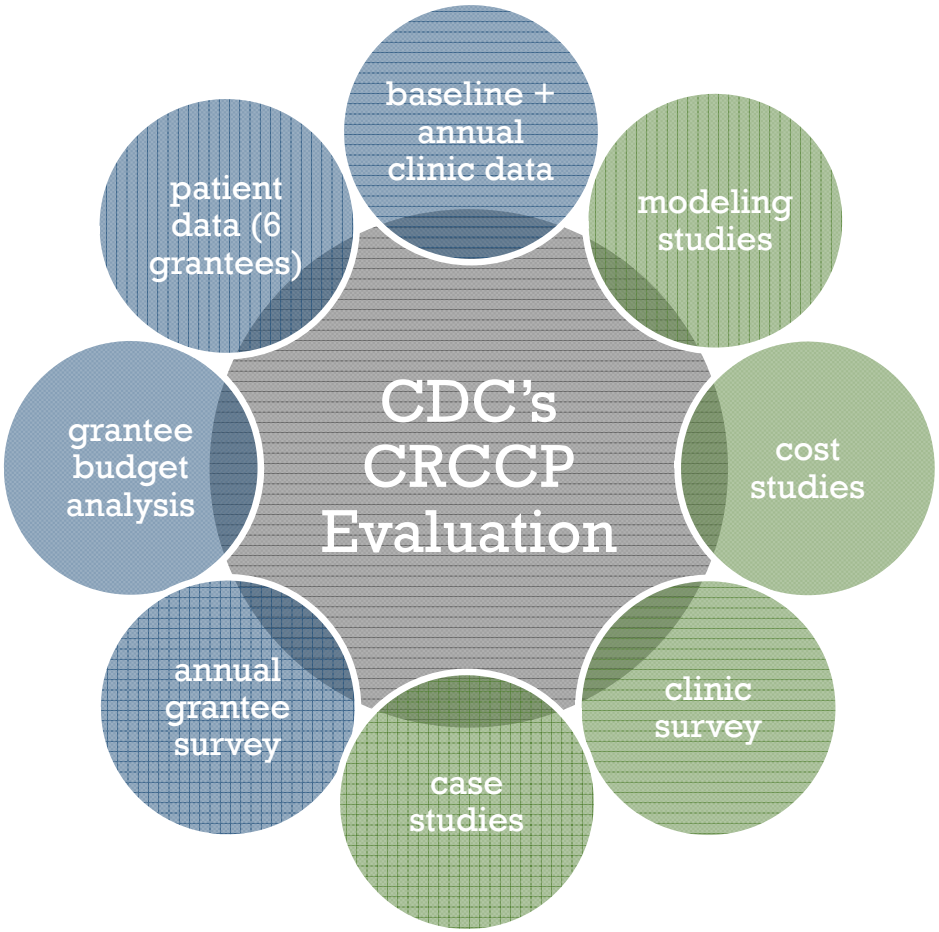
Think “alignment” and focus on USE!



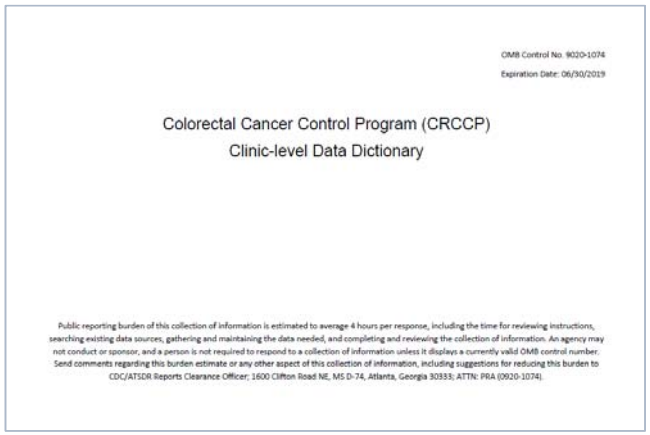
CDC's evaluation questions

Process	Outcomes	Impact
What is the program reach (# clinics)?	Are EBIs cost-effective?	How many deaths are averted?
How do clinics integrate EBIs into workflows?	What factors are associated with increases in SRs?	What is the quality of life years saved?

CDC's CRCCP evaluation involves systematic data collections of all grantees and special studies with subsets of grantees.



Central to the evaluation are CDC's clinic data

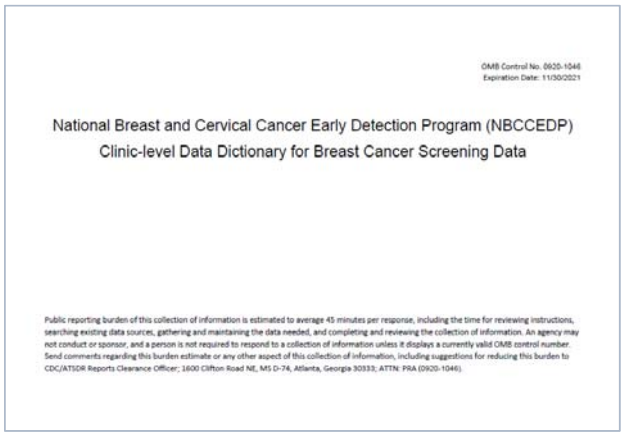


OMB Control No. 9020-1074
Expiration Date: 06/30/2019

Colorectal Cancer Control Program (CRCCP)
Clinic-level Data Dictionary

Public reporting burden of this collection of information is estimated to average 4 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1074).

Clinic data dictionary:
Colorectal

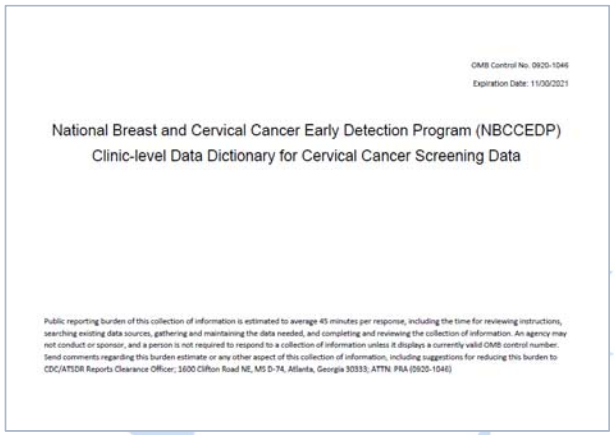


OMB Control No. 0920-1046
Expiration Date: 11/30/2021

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)
Clinic-level Data Dictionary for Breast Cancer Screening Data

Public reporting burden of this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1046).

Clinic data dictionary:
Breast



OMB Control No. 0920-1046
Expiration Date: 11/30/2021

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)
Clinic-level Data Dictionary for Cervical Cancer Screening Data

Public reporting burden of this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1046)

Clinic data dictionary:
Cervical

Purpose of the Clinic Data

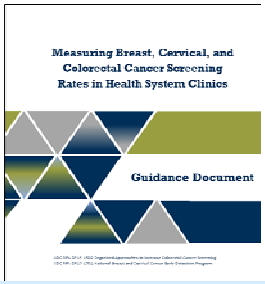
To assess **program reach, clinic characteristics, EBI implementation,** and changes in breast and cervical cancer **screening rates** in NBCCEDP partner clinics.

What data are collected at the clinic-level?

- Record identification
- Clinic and health system characteristics
- Patient population characteristics
- Screening rate
- EBIs
- Monitoring and QI activities
- Patient navigation and community outreach

What other data are you collecting?

Ensuring high quality clinic data

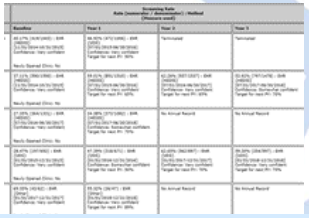


Measuring screening rates guidance document

Data dictionaries-full and abbreviated

Customizable data collection forms

Clinic Baseline and Annual Reporting Systems



TA and Data Quality Review

Common clinic data challenges

EHR systems

Poor data entry, limited functionality, scanned reports, changing systems, (and on and on….)

Issues with screening rate measurement

Using different measure types, changing 12-month measurement periods, assigning wrong baseline or program year, big swings in denominators

How do you ensure high quality data?

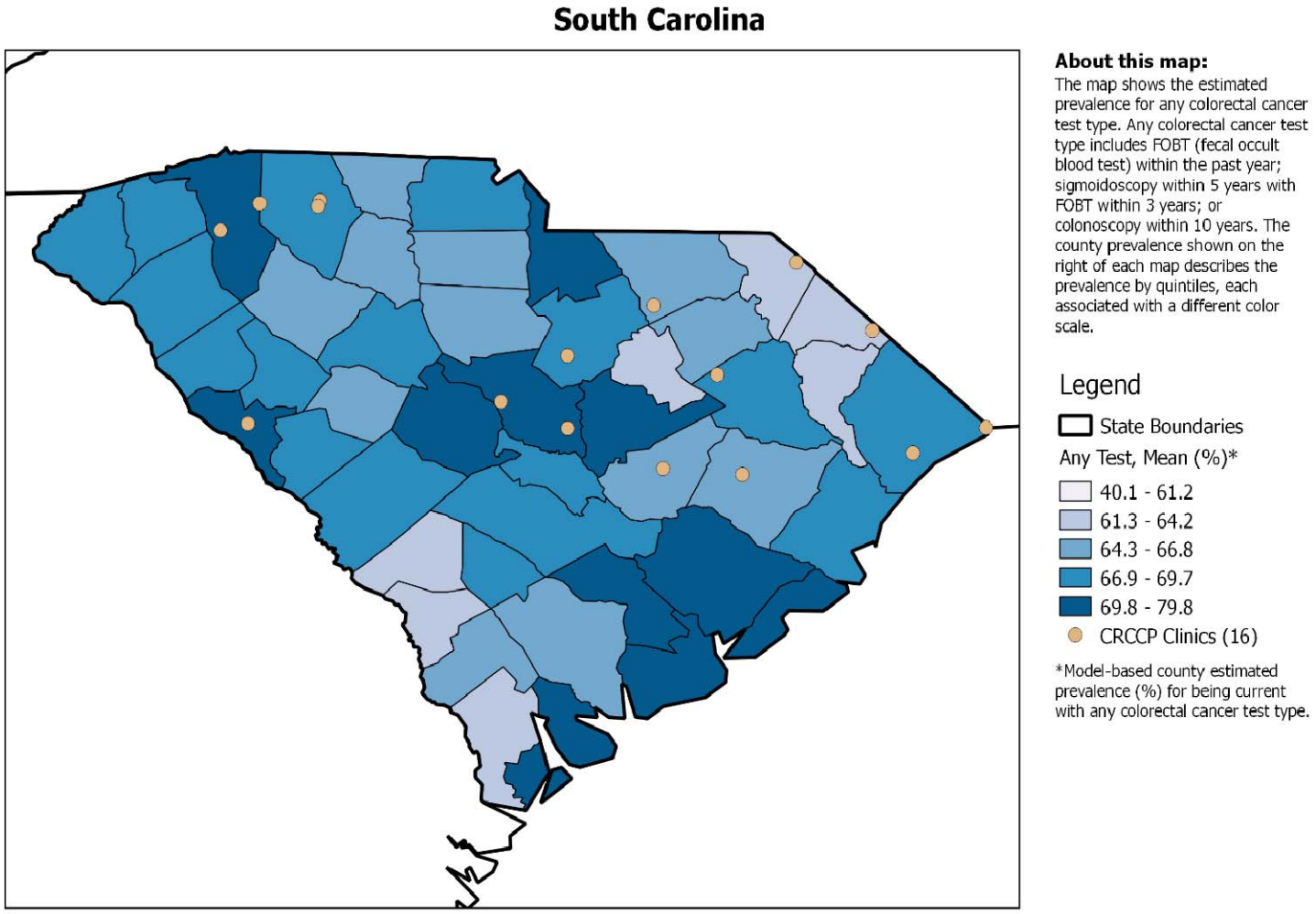
Using clinic data for monitoring progress

- What is the program's reach? Are grantees reaching the intended population?
- Are grantees implementing EBIs in each clinic? Are they enhancing EBIs or implementing new EBIs?
- How much implementation support are grantees providing to clinics?
- Do clinics have a champion?

Using clinic data to examine effectiveness

- Are screening rates increasing and by how much?
- What factors are associated with greater increases in screening rates?
- What factors are associated with high performing clinics in comparison to low performing clinics?
- What is the cost-effectiveness of specific EBIs?
- What is the long-term impact of the program on lives saved?

Using Clinic Data for Planning



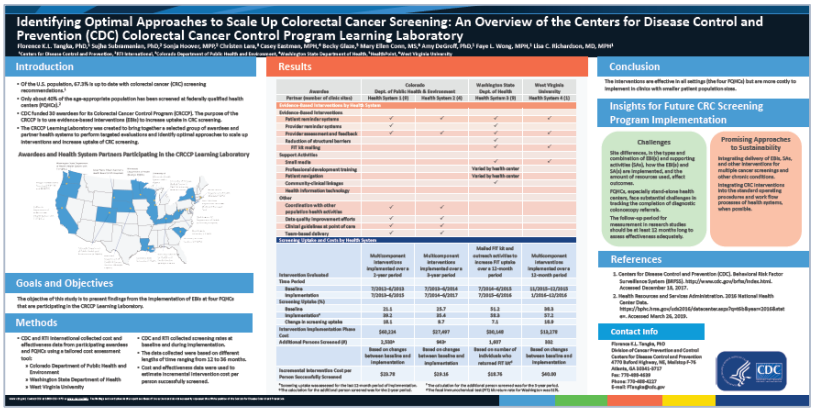
Source: Berkowitz Z, Zhang X, Richards TB, Nadel M, Peipins LA, Holt J. Multilevel small-area estimation of colorectal cancer screening in the United States. Cancer Epidemiol Biomarkers Prev. 2018 Mar;27(3):245-253. doi: 10.1158/1055-9965.EPI-17-0488.

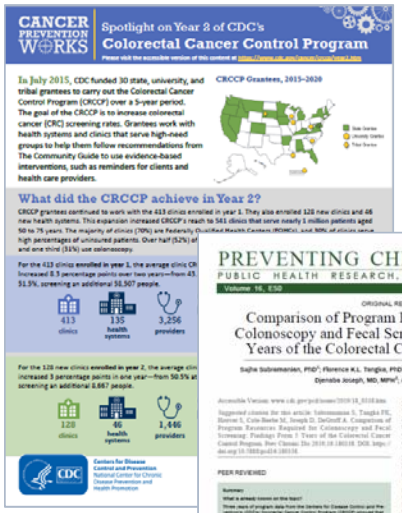
How are you using your data?

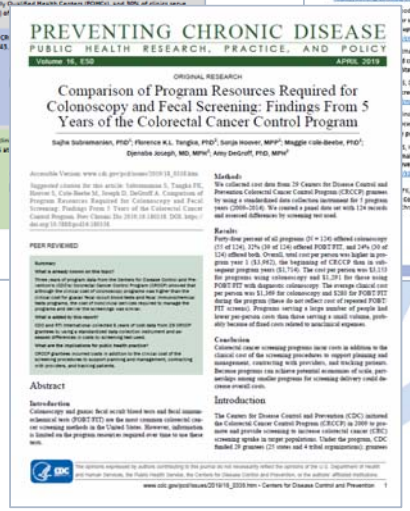
- For monitoring implementation?
- For evaluating effectiveness?
- For planning?

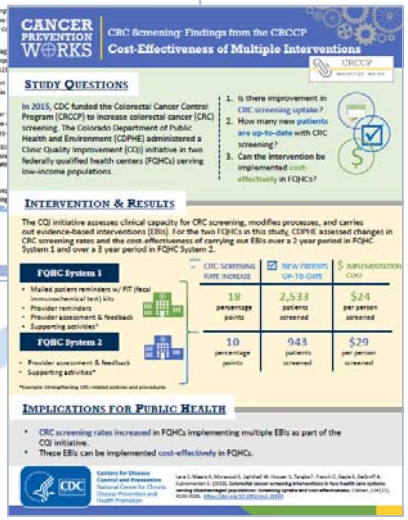
Disseminating program results

Sharing results with stakeholders









Case Study:
Colorectal Cancer Screening Program in South Carolina

Heather M. Brandt, PhD
Associate Dean, Graduate School
Professor, Arnold School of Public Health
University of South Carolina
Email: hbrandt@sc.edu

Arnold School of Public Health

@ChampsforCRC @BlondeScientist

About the Colorectal Cancer Screening Program in South Carolina (CCSPSC)

Access CCSPSC Resources

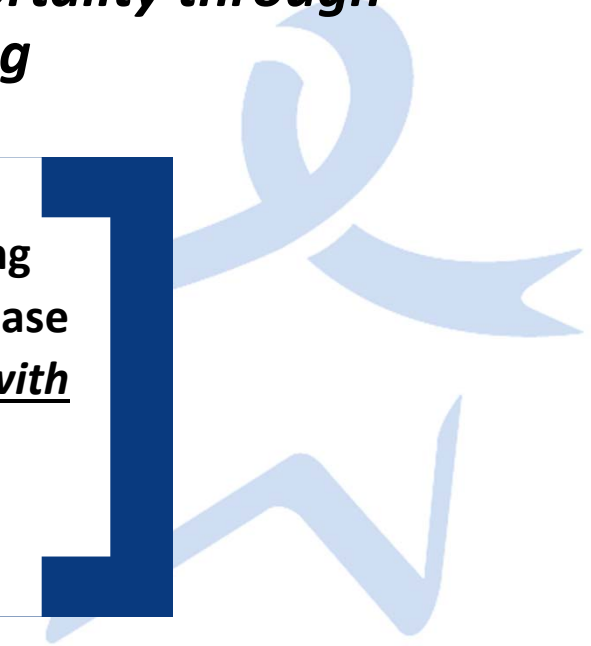
Evaluation Tools: http://bit.do/CCSPSC-Evaluation

Champions Training Program: http://bit.do/CCSPSC-Champions

CCSPSC

Long-term Outcome: Decrease colorectal cancer mortality through increased participation in colorectal cancer screening

The purpose of the Colorectal Cancer Screening Program in South Carolina (CCSPSC) is to increase colorectal cancer screening rates by working *with* partner health systems to implement priority evidence-based strategies.



CDC Colorectal Cancer Control Program:
https://www.cdc.gov/cancer/crccp/index.htm

CCSPSC Partners

- South Carolina Primary Health Care Association
- American Cancer Society
- Colorectal Cancer Prevention Network (CRCfacts.com)
- Eight FQHC systems in South Carolina:
  - CareSouth Carolina
  - Carolina Health Centers
  - Cooperative Health (formerly Eau Claire Cooperative Health Centers)
  - HopeHealth
  - Little River Medical Center
  - New Horizon Family Health Services
  - ReGenesis Health Care
  - Sandhills Medical Foundation
- Advisory Council
- Evaluation Committee
- Other partners, including the South Carolina Department of Health and Environmental Control, South Carolina Cancer Alliance, South Carolina Office of Rural Health, Access Health, South Carolina Hospital Association

CCSPSC Phased Approach to Implementing with Partners

COLORECTAL CANCER SCREENING PROGRAM IN SOUTH CAROLINA

BASELINE DATA SNAPSHOT

PROGRAM REACH

16

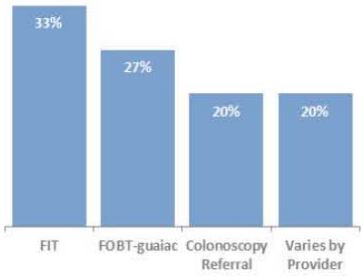
FEDERALLY QUALIFIED HEALTH CARE CLINICS ARE CURRENTLY PARTICIPAING IN THE CCSPSC PROGRAM.

The 16 clinics represent 8 systems.
100% of clinic sites are PCMH certified.

59

PRIMARY HEALTHCARE PROVIDERS SEE PATIENTS IN THESE 16 CLINICS.

PRIMARY TEST TYPE USED



PATIENT POPULATION

23,553

PATIENTS AGED 50-75 RECEIVE CARE AT THE PARTICPATING CLINICS.

Patient populations by clinic ranged from 321-4,625.

26%

OF THE PATIENT POPULATION IS UNINSURED.

Uninsured patient populations in the clinics range from 5-82%.

33%

OF SCREENING ELIGIBLE ADULTS HAVE BEEN SCREENED FOR COLORECTAL CANCER.

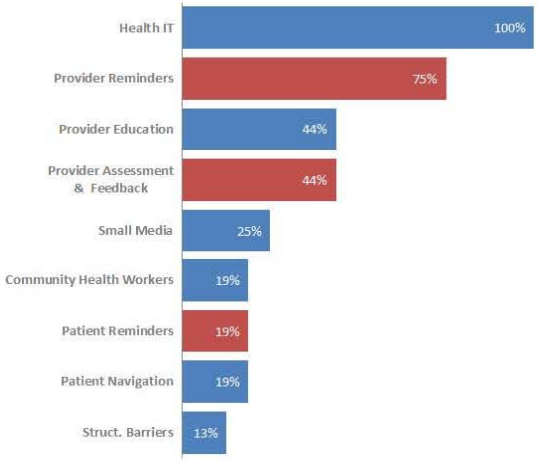
Screening rates ranged from 3% to 73%. The median is 26%.

73%

OF CLINICS USED THE UDS MEASURE TO CALCULATE SCREENING RATES.

Other clinics used HEDIS (20%) and chart review (7%).

EBI & SUPPORTING STRATEGIES IN PLACE AT CLINICS AT BASELINE



REFERRAL NETWORKS FOR COLORECTAL CANCER SCREENING

81%

OF CLINICS REPORTED THAT THEIR CLINIC HAS AN ADEQUATE REFERAL NETWORK FOR COLORECTAL CANCER SCREENING.

February 7, 2019

Implementing Evidence-based Interventions

Select at least two priority, evidence-based approaches:

- Provider assessment and feedback
- Provider reminders and recall
- Client (patient) reminders

Multi-level and multi-component interventions

Supportive activities:

- Professional education
- Small media

Additional activities:

- Standard procedures (policies)
- 80% by 2018 pledge (80 In Every Community)
- Champions training program

Provide "whole office" professional education

Provide tailored implementation training

GO LIVE: Start of implementation

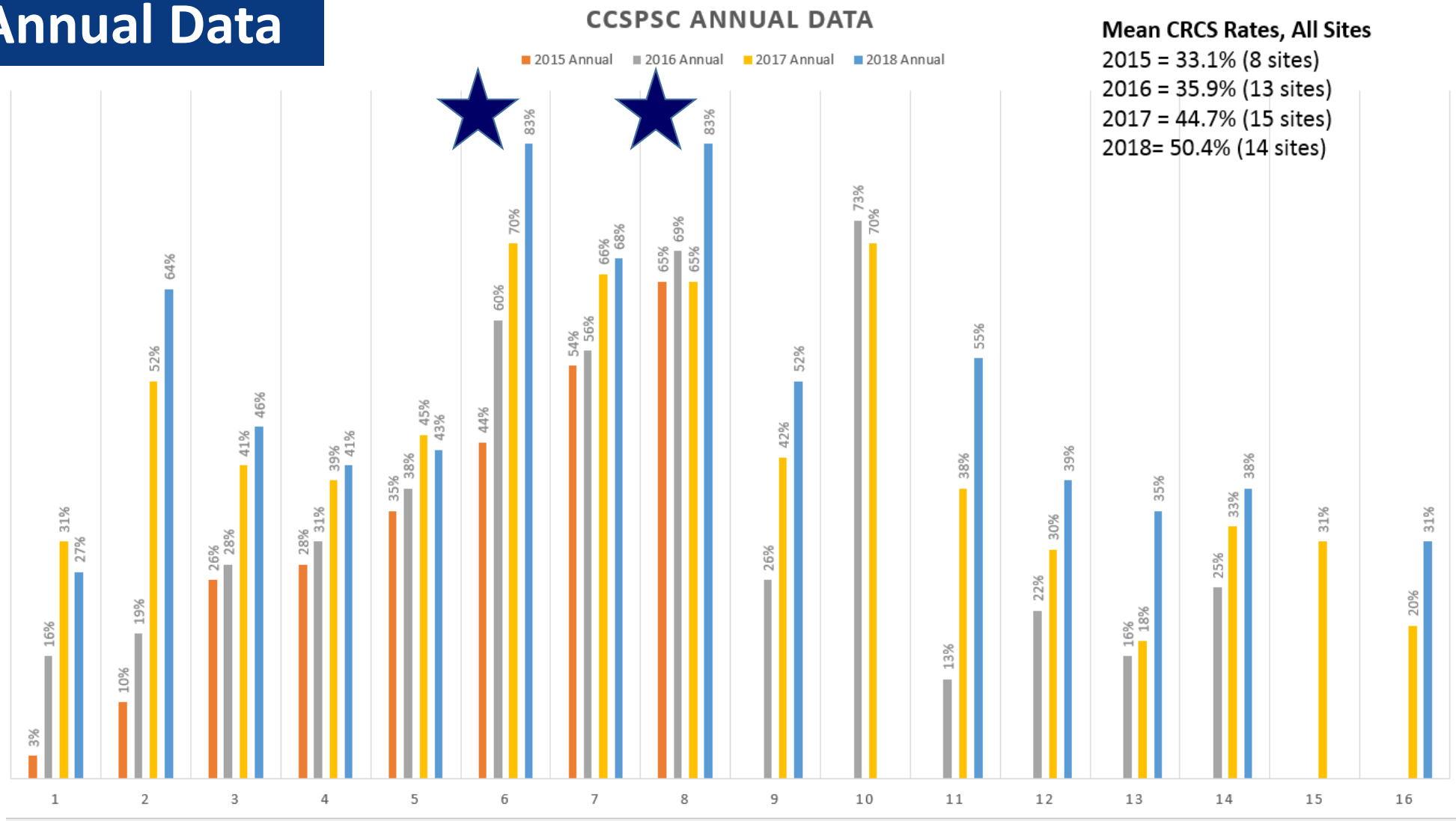
Outcomes Data:
Colorectal Cancer Screening

Access CCSPSC Evaluation Tools at:
http://bit.do/CCSPSC-Evaluation

Evaluation Question

- ***Did we increase colorectal cancer screening among age-eligible, average risk patients in the health center?***
  - Type: UDS measurement at health center (site) level; source is EMR
  - Frequency:
    - Annual
    - Quarterly (not submitted to CDC; use for program improvement)
  - Uses:
    - Annual: Compare to overall health center system data, state (South Carolina) health center system data, national health center system data; Goal setting/targets for next year
    - Quarterly: Guide quarterly technical assistance

Annual Data



Mean CRCS Rates, All Sites

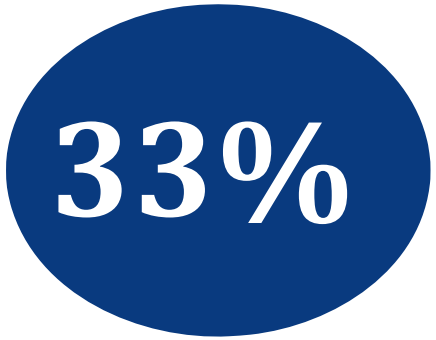
2015 = 33.1% (8 sites)

2016 = 35.9% (13 sites)

2017 = 44.7% (15 sites)

2018= 50.4% (14 sites)

Overall Increases in CRC Screening: 2015 to 2017 (8 sites*)



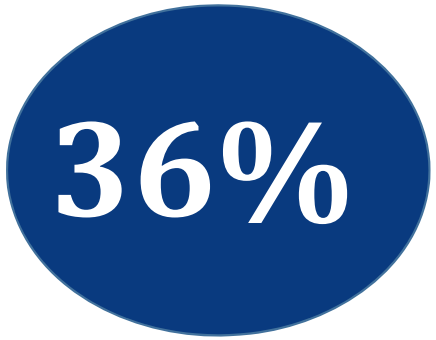
CRC Screening
2015

CRC Screening
2017

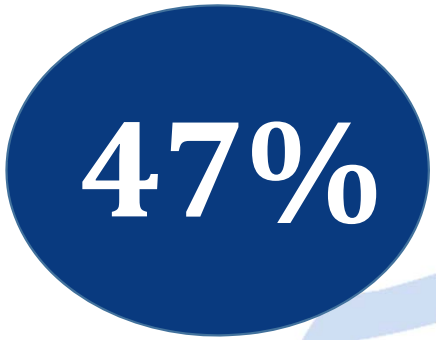
This represents an actual increase of 18%.
State average was +6%. National was +4%.

**Includes data from 8 sites that began implementation in 2015-2016. Note: 2018 UDS data unavailable at this time.*

Overall Increases in CRC Screening: 2016 to 2017 (13 sites*)



CRC Screening
2016



CRC Screening
2017

This represents an actual increase of 11%.
State average was +5%. National was +2%.

**Includes data from 13 sites that began implementation in 2016-2017. Note: 2018 UDS data unavailable at this time.*

Quarterly Data

Health Center Site	GO LIVE Date	2015 Annual	Q3 2016	Q4 2016	2016 Annual	Q1 2017	Q2 2017	Q3 2017	Q4 2017	2017 Annual	Q1 2018	Q2 2018	Q3 2018	Q4 2018	2018 Annual
004-001	Q3 2016	**28%**	23%	29%	**31%**	30%	34%	40%	43%	**39%**	39%	39%	39%	43%	**41%**
006-001	Q3 2016	**3%**	---	6%	**16%**	21%	25%	26%	31%	**31%**	30%	28%	30%	26%	**27%**
005-001	Q3 2016	**35%**	---	---	**38%**	40%	44%	49%	51%	**45%**	59%	46%	48%	47%	**43%**
003-001	Q3 2016	**10%**	---	---	**19%**	8%	14%	48%	59%	**52%**	59%	61%	67%	68%	**64%**
008-001	Q3 2016	**65%**	---	71%	**69%**	68%	69%	70%	69%	**65%**	76%	84%	83%	81%	**83%**
008-002	Q3 2016	**44%**	---	58%	**60%**	61%	57%	67%	70%	**70%**	76%	84%	82%	81%	**83%**
002-001	Q1 2017	**54%**	---	---	**56%**	63%	68%	70%	73%	**66%**	68%	66%	68%	70%	**68%**
001-001	Q1 2017	**26%**	---	---	**28%**	---	27%	30%	34%	**41%**	42%	61%	49%	48%	**46%**

Using Quarterly Data

Health Center Site	GO LIVE Date	**2015 Annual**	Q3 2016	Q4 2016	**2016 Annual**	Q1 2017	Q2 2017	Q3 2017	Q4 2017	**2017 Annual**	Q1 2018	Q2 2018	Q3 2018	Q4 2018	**2018 Annual**
003-001	Q3 2016	**10%**	---	---	**19%**	8%	14%	48%	59%	**52%**	59%	61%	67%	68%	**64%**

Two examples for 003-001:

- Ability to retrieve quarterly colorectal cancer screening data – technical assistance focused on capacity to do this successfully (also had EMR change during this time)
- Tracking return of stool-based tests and closing referral loop in 2017 – technical assistance focused on processes for promoting return, closing referral loop, and ensuring documentation of test results in EMR

Process Evaluation

Access CCSPSC Evaluation Tools at:
http://bit.do/CCSPSC-Evaluation

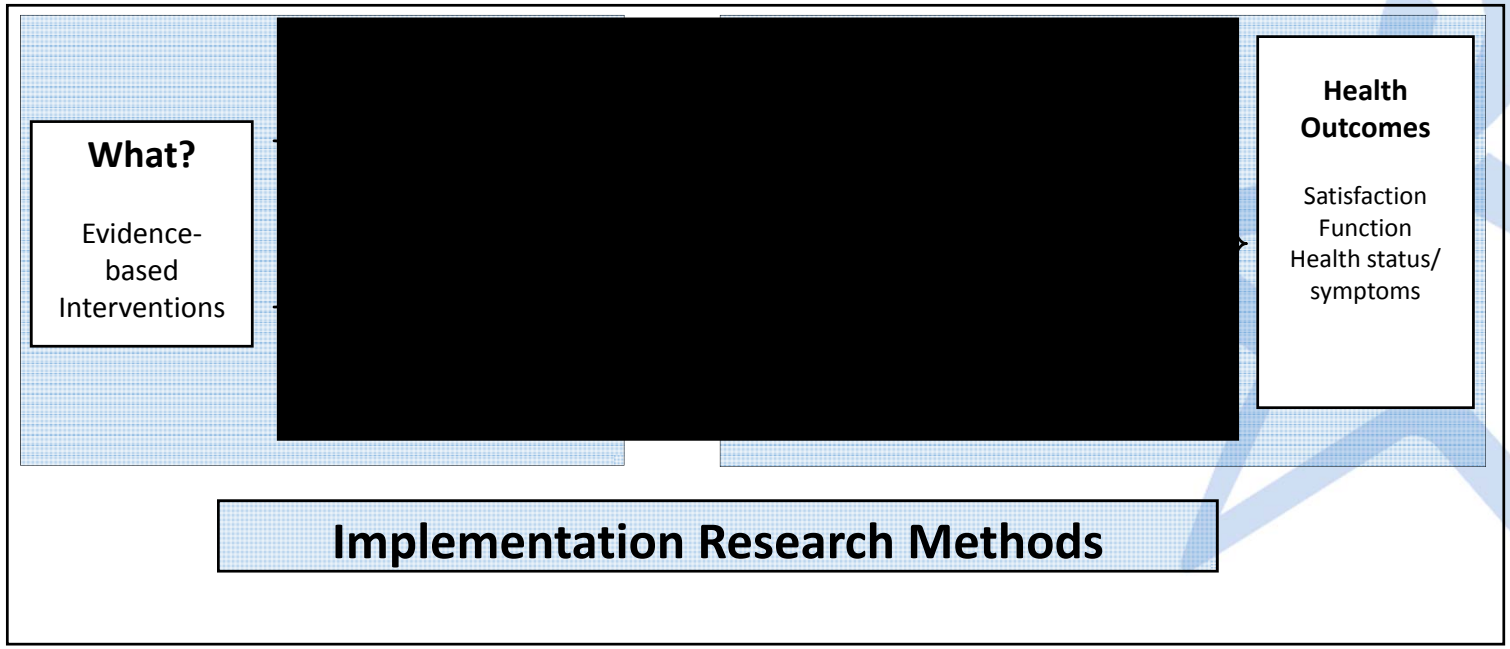
Process Evaluation Tools, selected examples

- Implementation plan (CDC format)
- Status of implementation document
- Overview of site visits document
- Site visit summary document
- Contextual factors: Readiness assessment, organizational and environmental assessment
- Process maps/workflow mapping
- Observation checklists
- Intervention tracking tools
- CQI tool

Access CCSPSC Evaluation Tools at: http://bit.do/CCSPSC-Evaluation

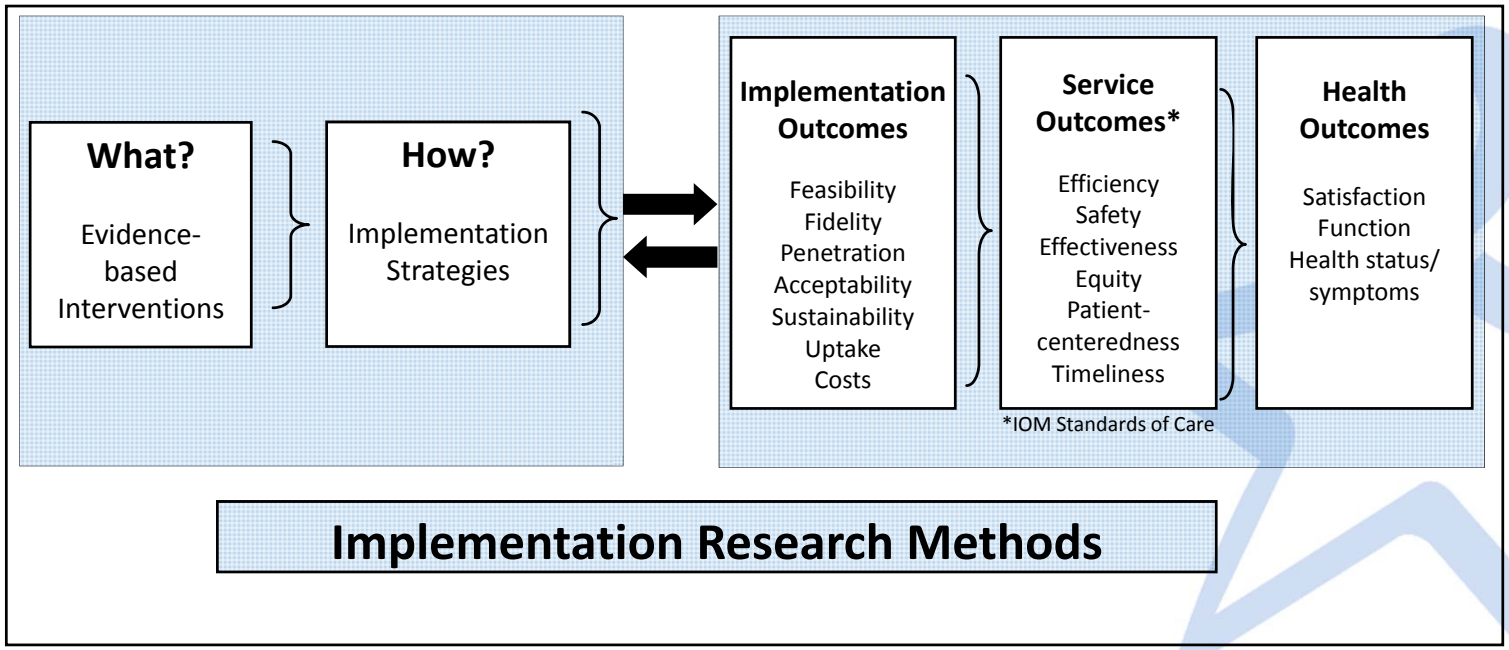
Implementing Evidence-based Interventions

We know <u>what</u> we want to implement, and we know the <u>outcome</u> we want to achieve. But how do we do that? That's what lies behind the black box and is less well understood and studied.



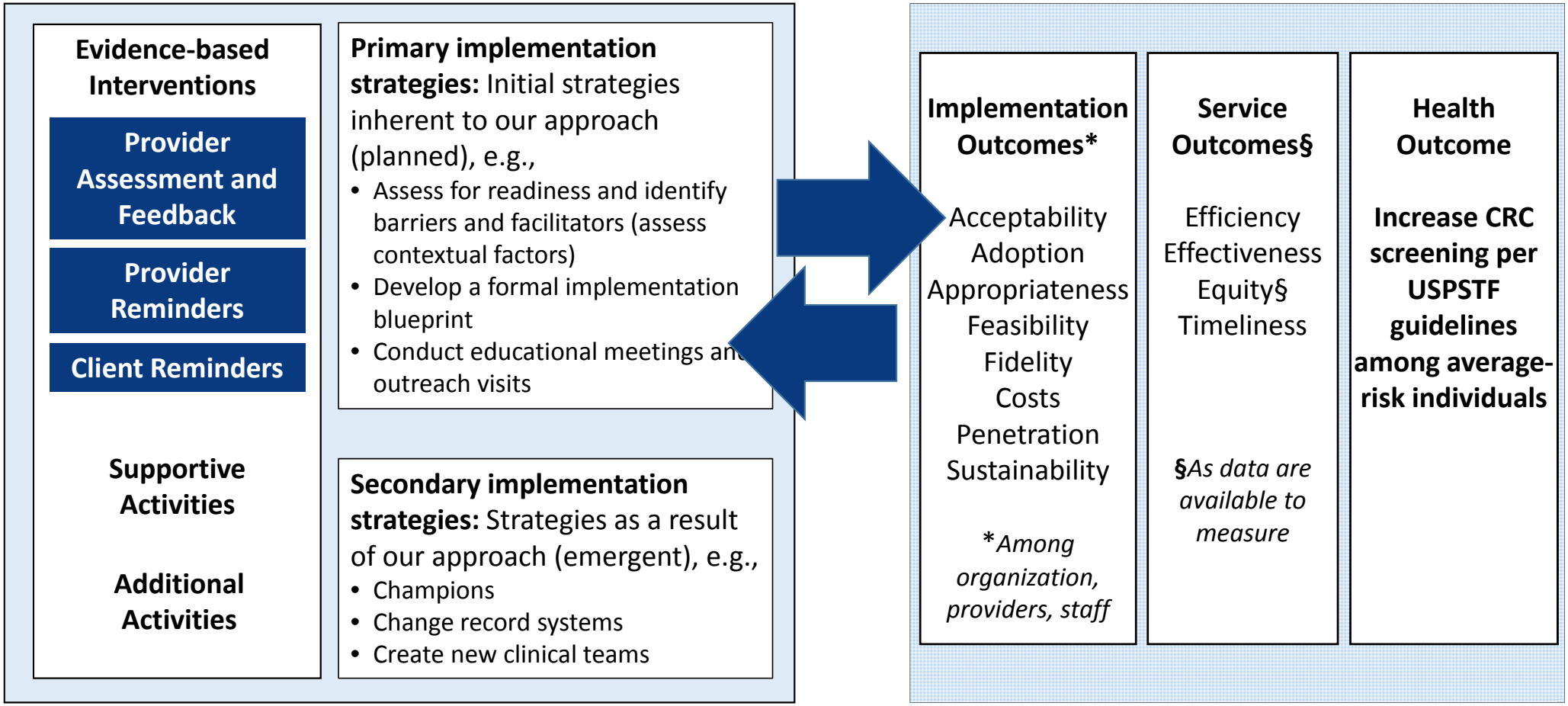
Proctor, E.K., et.al., 2009; Implementation Research Methods slides adapted from a presentation by Dr. Prajakta Adsul of the National Cancer Institute.

Implementing Evidence-based Interventions



Proctor, E.K., et.al., 2009; Implementation Research Methods slides adapted from a presentation by Dr. Prajakta Adsul of the National Cancer Institute.

Colorectal Cancer Screening Program in South Carolina



Colorectal Cancer Screening Program in South Carolina (PI: Heather Brandt) – Application of the Conceptual Model of Implementation Research; adapted from Proctor, E.K., et.al., 2009; Implementation strategies adapted from Powell et al., 2015; evidence-based interventions from The Community Guide for Preventive Services

Implementing Evidence-based Interventions

Select at least two priority, evidence-based approaches:

- Provider assessment and feedback
- Provider reminders and recall
- Client (patient) reminders

Multi-level and multi-component interventions

Supportive activities:

- Professional education
- Small media

Additional activities:

- Standard procedures (policies)
- 80% by 2018 pledge (80 In Every Community)
- Champions training program

Process Evaluation Question: Is implementation of all EBIs the same?

- Provider reminders
- Provider assessment and feedback
- Client reminders

What are the key ingredients of provider reminders?

What are examples of provider reminders?

How can we ensure provider reminders are implemented with quality? (Think: fidelity)

Provider Reminders

- Reminders inform health care providers it is time for a client's cancer screening test (called a "reminder") or that the client is overdue for screening (called a "recall reminder")
- Reminders can be provided in different ways, such as flagged appointment lists, notes in client charts, "blue star" on the exam room, by e-mail, etc.

  Examples of Implementation:
  - Electronic alert (based on record or chart audit)
  - Provider/care team huddle
  - Printed sheet with highlighted names
  - Poop emoji or blue star on door
  - Morning email each day

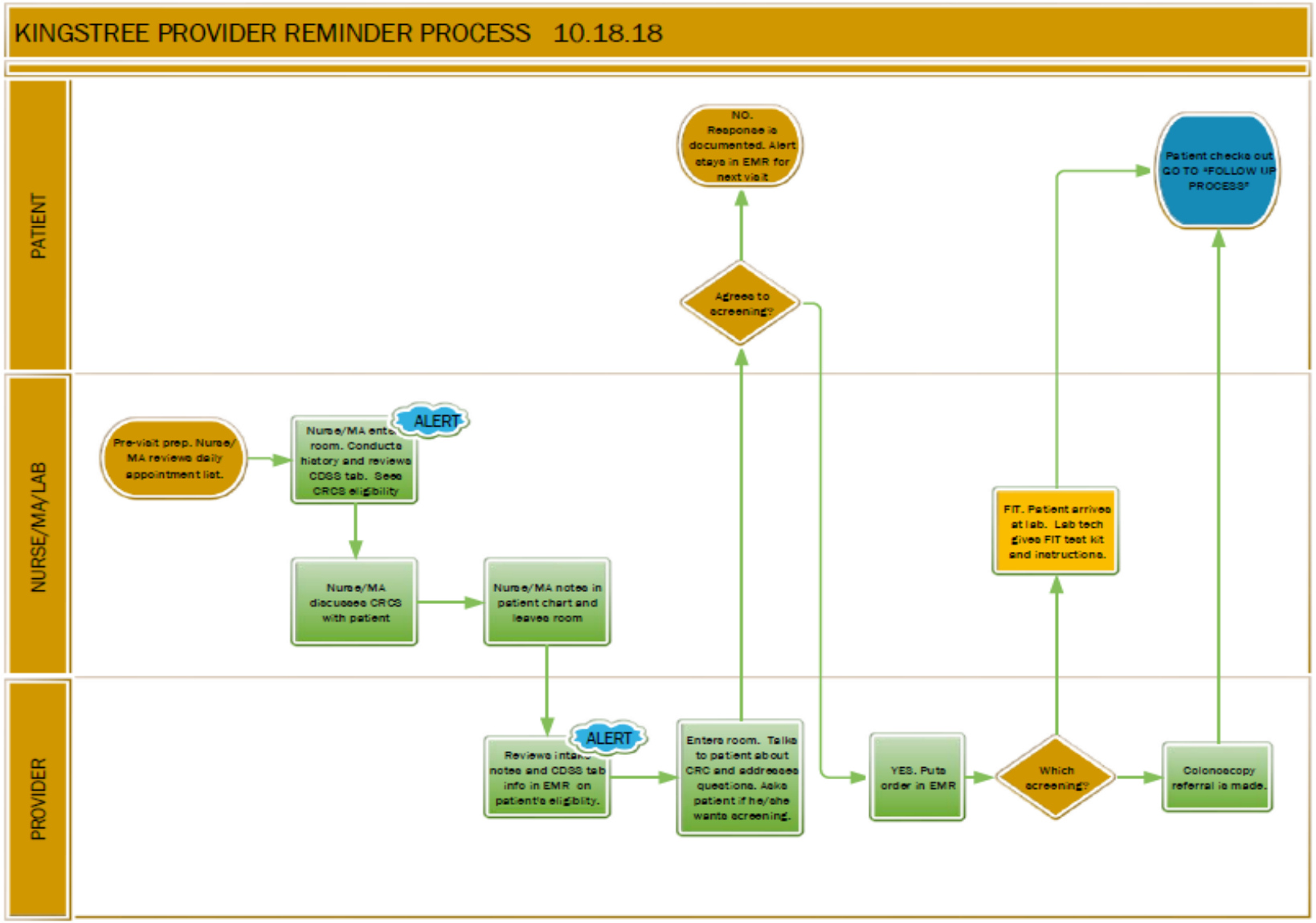
Provider Reminders

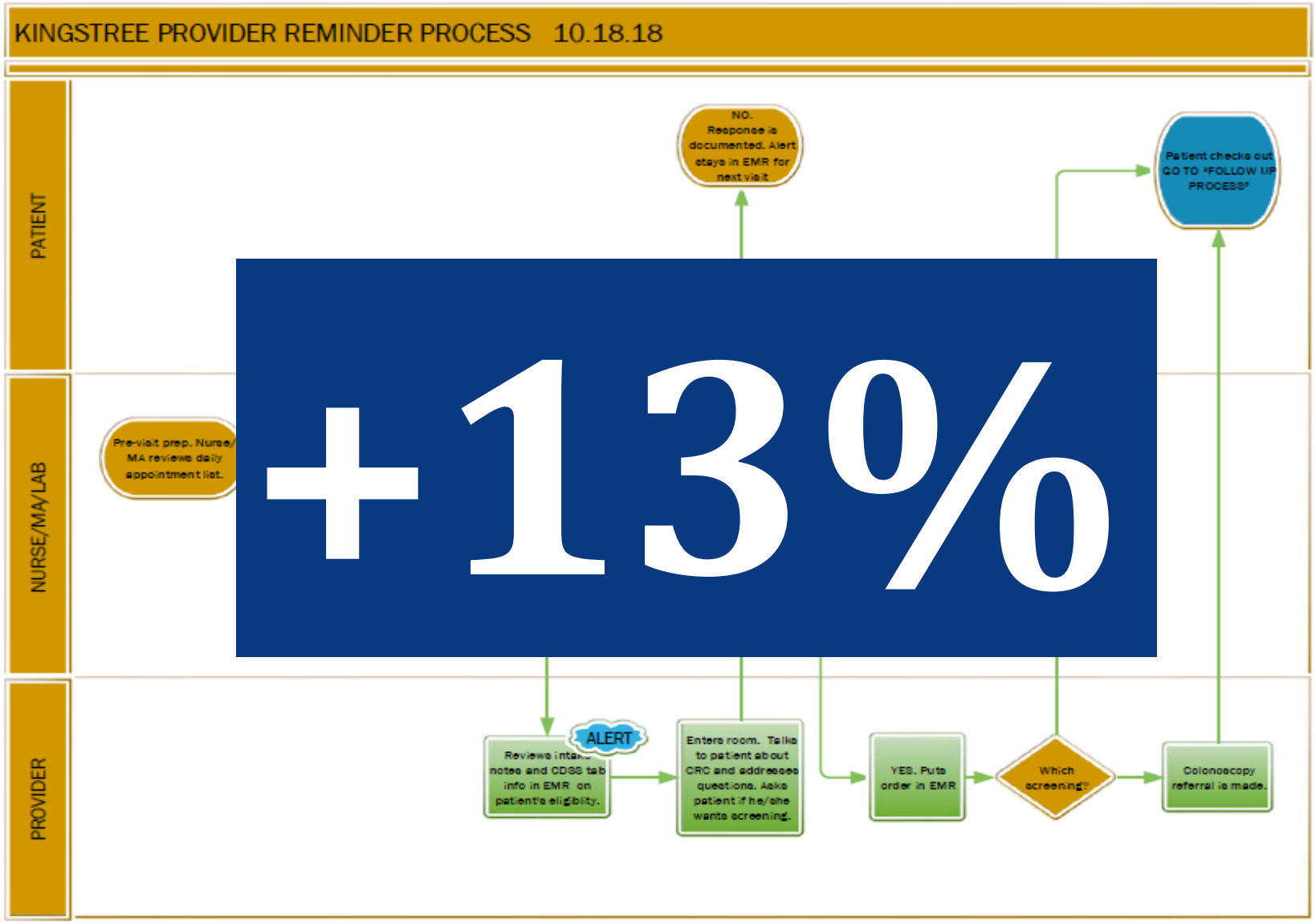
- Begin with a functional definition to set parameters
- Key ingredients
- Track implementation of the EBI – what is being done to implement
- Monitor quality of implementation
- Examine in combination with other interventions and strategies

- ***Do provider reminders increase colorectal cancer screening?***

Kingstree (HopeHealth)

- HopeHealth system serves Williamsburg, Florence, Clarendon, Aiken, and Orangeburg counties
- Kingstree serves 1,125 individuals of screening age
- Priority evidence-based interventions:
  - **Provider reminders (7/2016 to present)**
  - Provider assessment and feedback (stopped 10/2017)
  - Client reminders (10/2017 to present)

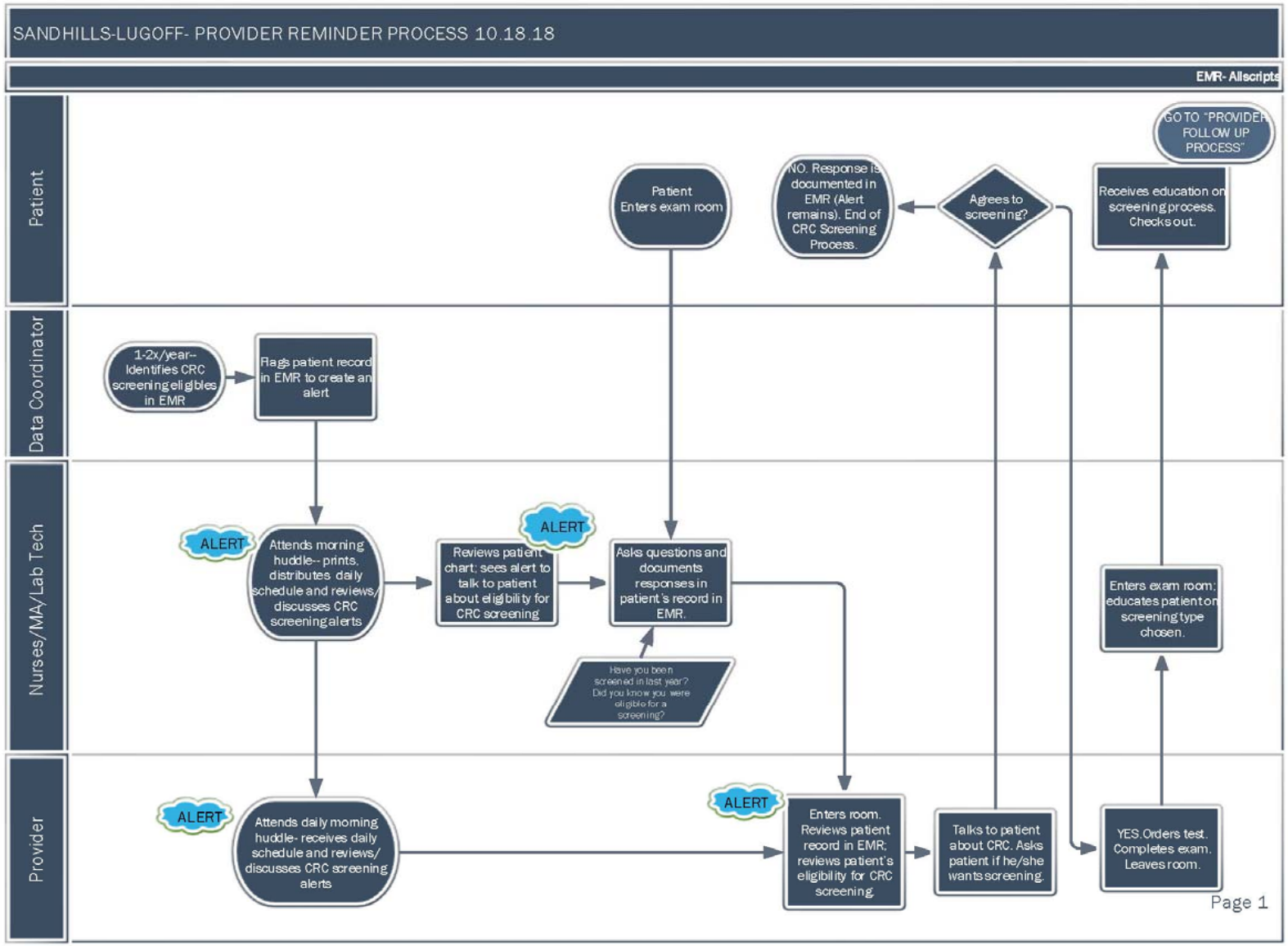

KINGSTREE PROVIDER REMINDER PROCESS 10.18.18
PATIENT
NURSE/MA/LAB
PROVIDER
NO. Response is documented. Alert stays in EMR for next visit
Patient checks out GO TO "FOLLOW UP PROCESS"
Agrees to screening?
Pre-visit prep. Nurse/ MA reviews daily appointment list.
ALERT
Nurse/MA ente room. Conducts history and reviews CDSS tab. Sees CRCS eligibility
Nurse/MA discusses CRCS with patient
Nurse/MA notes in patient chart and leaves room
FIT. Patient arrives at lab. Lab tech gives FIT test kit and instructions.
ALERT
Reviews inta notes and CDSS tab info in EMR on patient's eligibity.
Enters room. Talks to patient about CRC and addresses questions. Asks patient if he/she wants screening.
YES. Puts order in EMR
Which screening?
Colonoscopy referral is made.

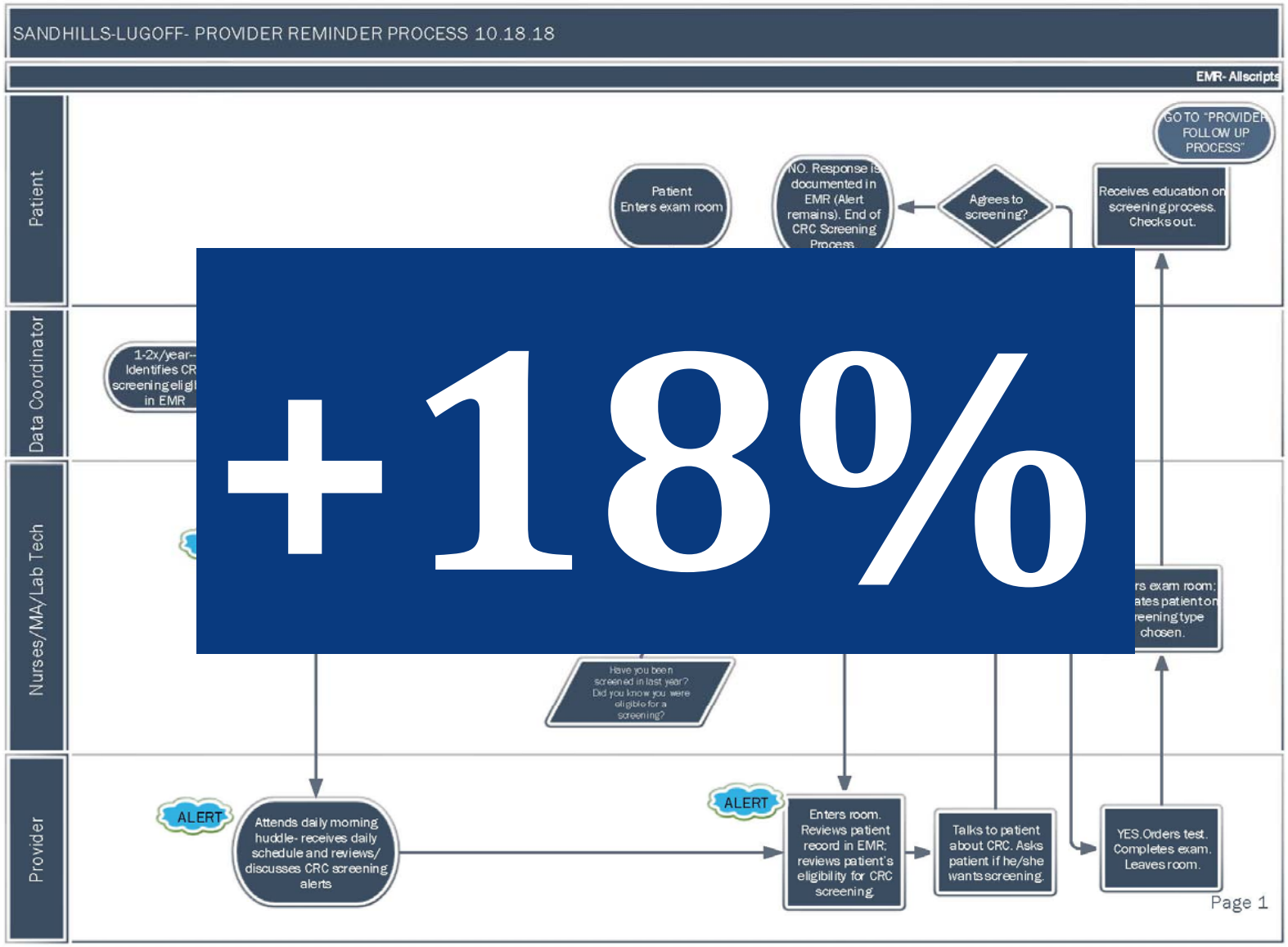

KINGSTREE PROVIDER REMINDER PROCESS 10.18.18
PATIENT
NURSE/MA/LAB
PROVIDER
NO. Response is documented. Alert stays in EMR for next visit
Patient checks out GO TO "FOLLOW UP PROCESS"
Pre-visit prep. Nurse/ MA reviews daily appointment list.
+13%
ALERT
Reviews intake notes and CDSS tab info in EMR on patient's eligibility.
Enters room. Talks to patient about CRC and addresses questions. Asks patient if he/she wants screening.
YES. Puts order in EMR
Which screening?
Colonoscopy referral is made.

Lugoff (Sandhills)

- Sandhills Medical Foundation serves Chesterfield, Kershaw, Lancaster, and Sumter counties
- Lugoff serves 1,425 individuals of screening age
- Priority evidence-based interventions:
  - **Provider reminders (8/2016 to present)**
  - Provider assessment and feedback (8/2016 to present)

Sandhills Medical Foundation, Inc.
WELCOME TO YOUR PATIENT-CENTERED MEDICAL HOME.


SANDHILLS-LUGOFF- PROVIDER REMINDER PROCESS 10.18.18
EMR- Allscripts
Patient
Data Coordinator
Nurses/MA/Lab Tech
Provider
1-2x/year-- Identifies CRC screening eligibles in EMR
Flags patient record in EMR to create an alert
Patient Enters exam room
NO. Response is documented in EMR (Alert remains). End of CRC Screening Process.
Agrees to screening?
Receives education on screening process. Checks out.
GO TO "PROVIDER FOLLOW UP PROCESS"
ALERT
Attends morning huddle-- prints, distributes daily schedule and reviews/ discusses CRC screening alerts
ALERT
Reviews patient chart; sees alert to talk to patient about eligibility for CRC screening
Asks questions and documents responses in patient's record in EMR.
Have you been screened in last year? Did you know you were eligible for a screening?
Enters exam room; educates patient on screening type chosen.
ALERT
Attends daily morning huddle- receives daily schedule and reviews/ discusses CRC screening alerts
ALERT
Enters room. Reviews patient record in EMR; reviews patient's eligibility for CRC screening
Talks to patient about CRC. Asks patient if he/she wants screening.
YES. Orders test. Completes exam. Leaves room.
Page 1

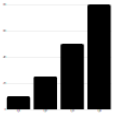

SANDHILLS-LUGOFF- PROVIDER REMINDER PROCESS 10.18.18
EMR- Allscripts
Patient
Data Coordinator
Nurses/MA/Lab Tech
Provider
Patient Enters exam room
NO. Response is documented in EMR (Alert remains). End of CRC Screening Process
Agrees to screening?
Receives education on screening process. Checks out.
GO TO "PROVIDER FOLLOW UP PROCESS"
1-2x/year– Identifies CR screening eligi in EMR
+18%
Have you been screened in last year? Did you know you were eligible for a screening?
ALERT
Attends daily morning huddle- receives daily schedule and reviews/ discusses CRC screening alerts
ALERT
Enters room. Reviews patient record in EMR; reviews patient's eligibility for CRC screening
Talks to patient about CRC. Asks patient if he/she wants screening.
YES. Orders test. Completes exam. Leaves room.
chosen.
Page 1

Evaluation Question

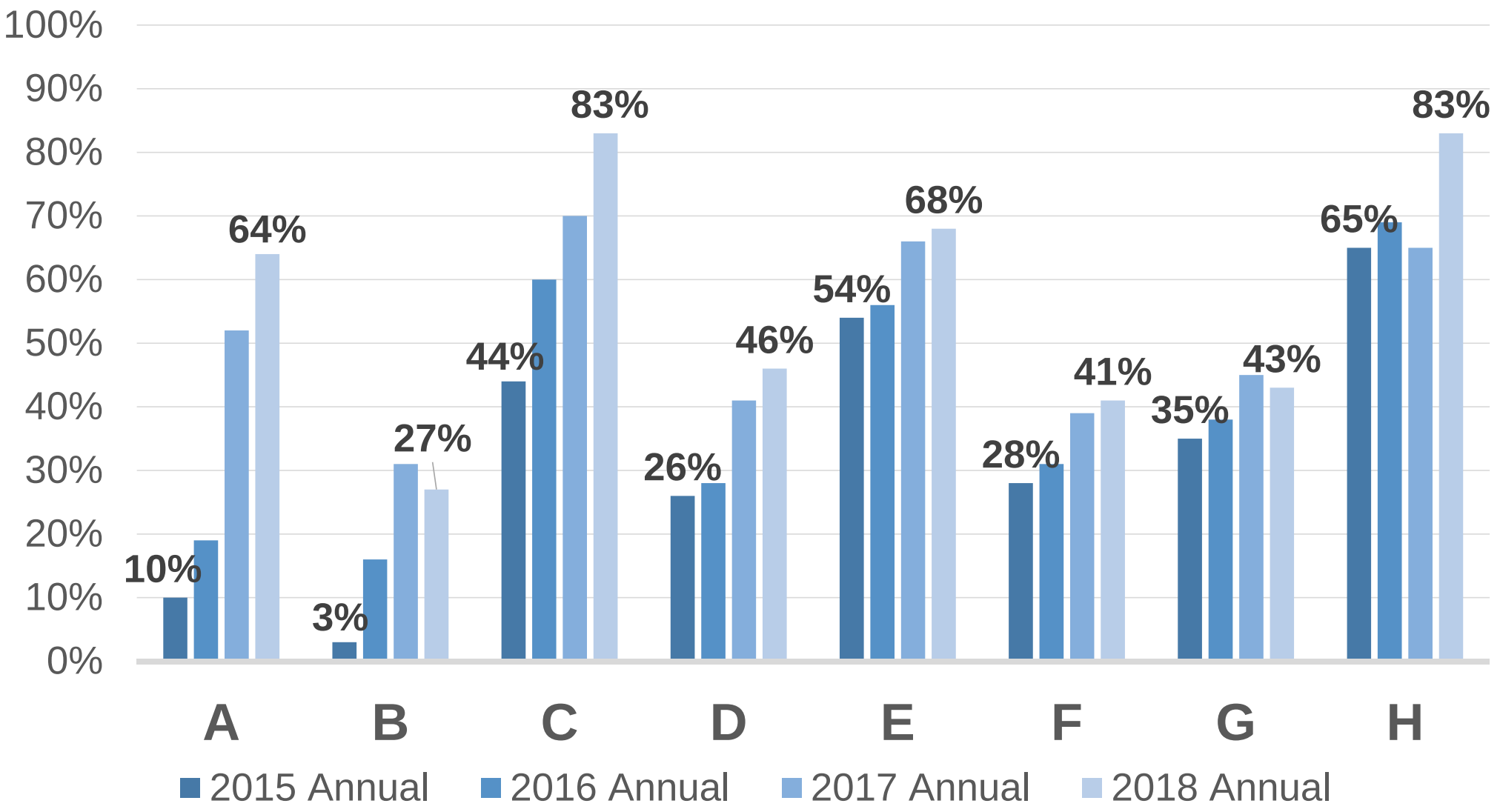
- ***Do selected EBIs in combination yield greater increases in CRC screening rates?***
  - Type: Combination of data (will explain); multiple sources (will explain)
  - Frequency:
    - Quarterly through technical assistance needs
    - Annually through review of composition and combination data in comparison to outcome data
  - Uses:
    - Identify the most effective and efficient composition and combination to enhance implementation
    - Inform replicability and scalability of evidence-based interventions and enhance quality of implementation to achieve outcomes

Health Center Site	*EBIs*	*Composition*
A		PR: Daily list, EHR prompt PAF: Identifiable reports, quarterly
B		PR: Daily huddle, EHR prompt, rescreen alert PAF: Identifiable office display, quarterly
C		PR: Daily list, daily huddle, EHR prompt PAF: Identifiable report cards, monthly
D		PR: Daily huddle PAF: Identifiable report cards, monthly
E		PR: Daily list, EHR prompt, blue star magnet CR: Mailed letter to client
F		PR: EHR prompt CR: Phone calls, text messages, emails
G		PR: Daily list, daily huddle, EHR prompt CR: Birthday cards, EHR notifications
H		PR: Daily list, daily huddle, EHR prompt PAF: Identifiable report cards, monthly


Provider Reminders (PR)


Provider Assessment and Feedback (PAF)

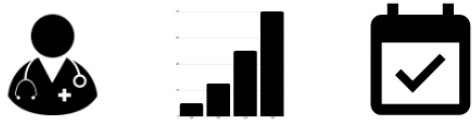

Client Reminders (CR)


100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
10%
64%
3%
27%
44%
83%
26%
46%
54%
68%
28%
41%
35%
43%
65%
83%
A
B
C
D
E
F
G
H
2015 Annual
2016 Annual
2017 Annual
2018 Annual

5 sites +31%*

3 sites +12%*

***Average of actual change in CRCS rates from 2015 to 2018**



Evaluation Question

- ***How does time to "go live" (active implementation) vary by site characteristics? How does time relate to CRC screening rates?***
  - Type: Combination of data (will explain); multiple sources (will explain)
  - Frequency:
    - Quarterly through technical assistance needs
    - Annually through review of time leading up to implementation and progression through phases
  - Uses:
    - Identify the most effective and efficient way to get to implementation and achieve outcomes
    - Inform replicability and scalability of evidence-based interventions and enhance quality of implementation to achieve outcomes

Health Center Site	# Days: Initial Prof Ed to Impl Train Start	# Impl Train Sessions	# Days: Initial Prof Ed to Impl Train Finish	# Days: Start Impl Train and Impl Train Finish	# Days: Initial Prof Ed and Go Live	Baseline 2015	Annual 2016	Annual 2017	Annual 2018	Increase: Baseline to Annual 2018
004-001	2	5	57	84	65	28%	31%	39%	41%	13%
006-001	15	2	31	16	65	3%	16%	31%	27%	24%
005-001	6	3	29	24	39	35%	38%	45%	43%	8%
003-001	12	4	61	49	63	10%	19%	52%	64%	54%
008-001	3	3	59	55	84	65%	69%	65%	83%	18%
008-002	1	3	60	55	82	44%	60%	70%	83%	39%
002-001	14	3	50	36	125*	54%	56%	66%	68%	14%
001-001	19	3	91	72	124*	26%	28%	41%	46%	20%

Prof Ed = Professional Education; Impl Train = Implementation Training

Take Home Messages:

- Collect high quality data – and use it for program improvement.
- Collect data from multiple sources in multiple ways to understand implementation processes and outcomes.
- Use data for program improvement to inform and explain the “what” and the “how” to increase colorectal cancer screening rates.

- *Implementation outcomes matter for replicability and scalability – important to measure and monitor.*

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- American Cancer Society
- Colorectal Cancer Prevention Network (CRCfacts.com)
- Eight federally-qualified health center (FQHC) systems in South Carolina (16 FQHC sites across the eight systems)
- Advisory Council
- Evaluation Committee
- Other partners

Access CCSPSC Evaluation Tools at: http://bit.do/CCSPSC-Evaluation

Deeper Dive Workshop: Evaluating Health Systems Interventions

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