NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Making Change Based on Program Evaluation Data! The What, Who, and When

Lessons Learned from Southeastern NBCCEDP and CRCCP Awardees

April 24, 2024 3:00-4:30 p.m. EDT

The “Enhancing Cancer Program Grantee Capacity through Peer-to-Peer Learning” project is supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $400,000 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.

Agenda

- Introduction and Setting the Stage
- The What: Data – South Carolina CRCCP
- The Who: Partnerships – North Carolina CRCCP
- The When: Integration – Tennessee NBCCEDP
- Polls and Q&A

Upcoming Opportunities

Save the Date!

Peer-to-Peer Learning Webinar
Sustainability
June 3, 2024 3:00-4:30 p.m. ET

PEER —TO— PEER LEARNING | Call SERIES APRIL-MAY 2024

The How: Diving Deeper on Making Change Based on Program Evaluation Data

Call I
April 29, 1:00 p.m. ET

The How: Data
Kick-off Speaker: Lisa Scott, South Carolina

Call II
April 29, 3:00 p.m. ET

The How: Partnerships
Kick-off Speaker: Jennifer Park, North Carolina

Call III
April 30, 5:00 p.m. ET
The How: Integration
Kick-off Speaker: Elizabeth Berardi, Tennessee

Call IV
May 1, 11:00 a.m. ET
Office Hour with Karin Hohman and Leslie Given

PEER —TO— PEER LEARNING | Webinar
APRIL 2024

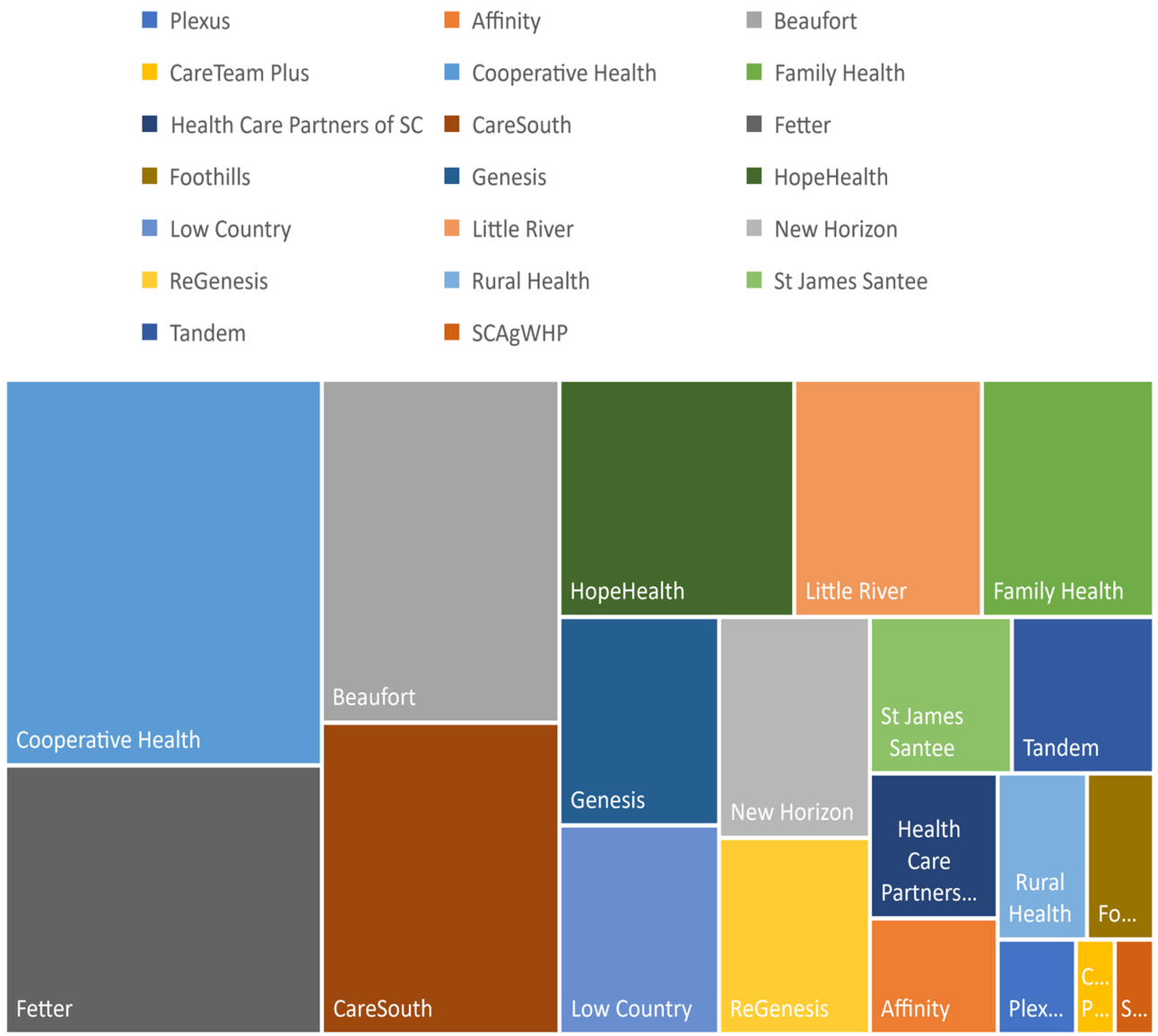
South Carolina

Learning Objective 1:
Discuss how the implementation of Azara (Population Health Platform) in South Carolina has impacted data utilization with FQHCs across the state. Specific to CRCCP, this includes customized automatic monthly reports and annual reporting outcomes for colorectal cancer screening rates.

Learning Objective 2:
Demonstrate how Azara data reports along with information collected in interactive technical assistance and project team interviews has driven evaluation for the SC CRCCP program, allowing for continuous quality improvement to drive sustainable clinic workflows and successful quality measure outcomes.

South Carolina Health Center Controlled Network (SCHCCN)

SCHCCN Network



What is an HCCN?

HRSA defines a HCCN as “a group of safety net providers collaborating horizontally or vertically to improve access to care, enhance quality of care, and achieve cost efficiencies through the redesign of practices to integrate services, optimize patient outcomes, or negotiate managed care contracts on behalf of the participating members”.

Patient Engagement

Patient Privacy and Cybersecurity

Social Risk Factor Intervention

Disaggregated Patient Level Data

Interoperable Data Exchange and Integration

Data Utilization

Leveraging Data Health Tools

Health IT Usability and Adoption

Health Equity

Improving Digital Health Tools

What is Azara?

Azara DRVS (Data Reporting & Visualization System) is a comprehensive healthcare analytics platform designed to empower health centers with actionable insights derived from their data. It offers a range of benefits tailored to the needs of healthcare facilities:

Data Integration
Advanced Analytics
Customizable Dashboards
Quality Improvement
Population Health Management
Financial Performance Optimization
Regulatory Compliance
Decision Support

Project Data Support

Colorectal Cancer Prevention Network
at the University of South Carolina
SC Communities Unite to Increase CRC Screening

Azara CCPN UDS CRCS dashboard - assist clinics with implementation and monitoring of EBIs

- Annual CRCS data by clinic for CDC required reporting
- Monthly CRCS clinic data for EBI implementation.
  - Automatically emailed 1st of each month to CCPN and clinic project team.
  - Includes demographic and SDOH breakdown to monitor gaps in care.

Azara Cohort development - assist clinics in data reporting and identifying gaps

Breakdown by age/gender/race/ethnicity/sexual orientation/insurance:

- *CRC Screening Modality*
- *FIT return rate*
- *Cologuard return rate*
- *Colonoscopy Completion rate*
- *FIT+ to Colonoscopy completion*
- *Cologuard+ to Colonoscopy completion*

Azara data support from the SCPHCA has impacted clinic staff's knowledge and usage of Azara CRCS reports.

Here is the project feedback CCPN has received:

"Pulling the 'open referral' to review colonoscopy referrals helped us to realize that we should be pulling 'open labs' also."

"We use Azara for data collection and perform regular audits and data validation to ensure accuracy and integrity of our data."

"With the help of the data we are able to increase screening."

"Azara allows nurses to pinpoint specific patients who need to be screened."

Monthly Clinic-level DRVS Report for CRCS

CRC Screening Total Count for TY

672

Pts w/ Colorectal Cancer Screening

-25% ▼ TY 10/23

CRC Deminator

1,881

Pts w/ Qual Visit

CRC Screening Rates for Network-Level Averages

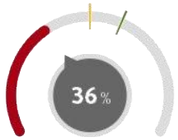
Network Average

44%

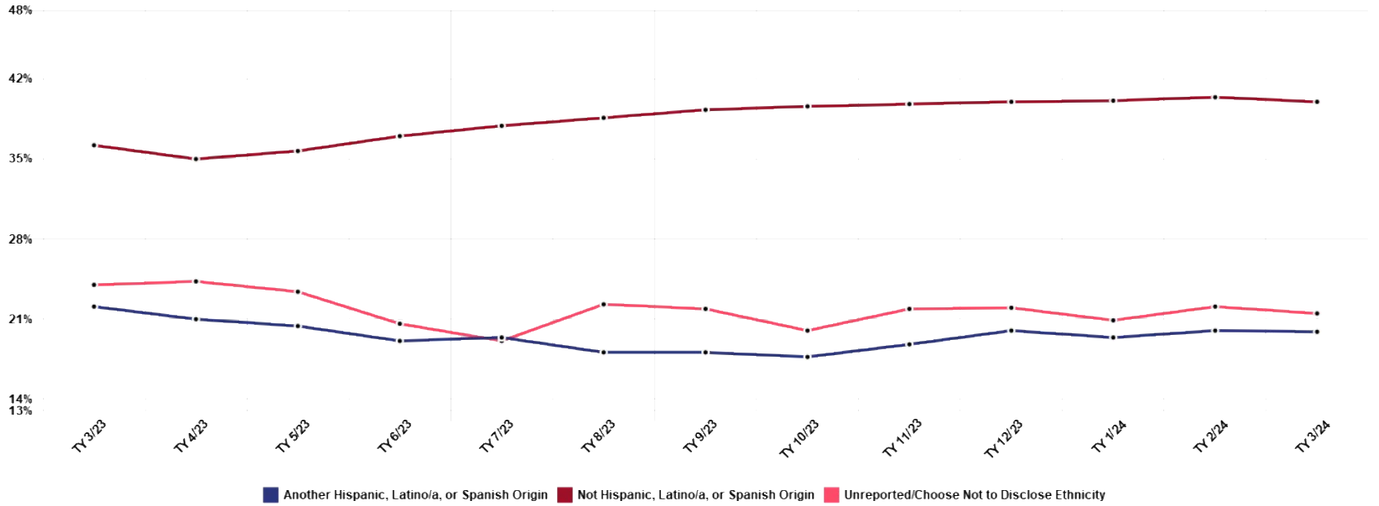
Best Center

66%

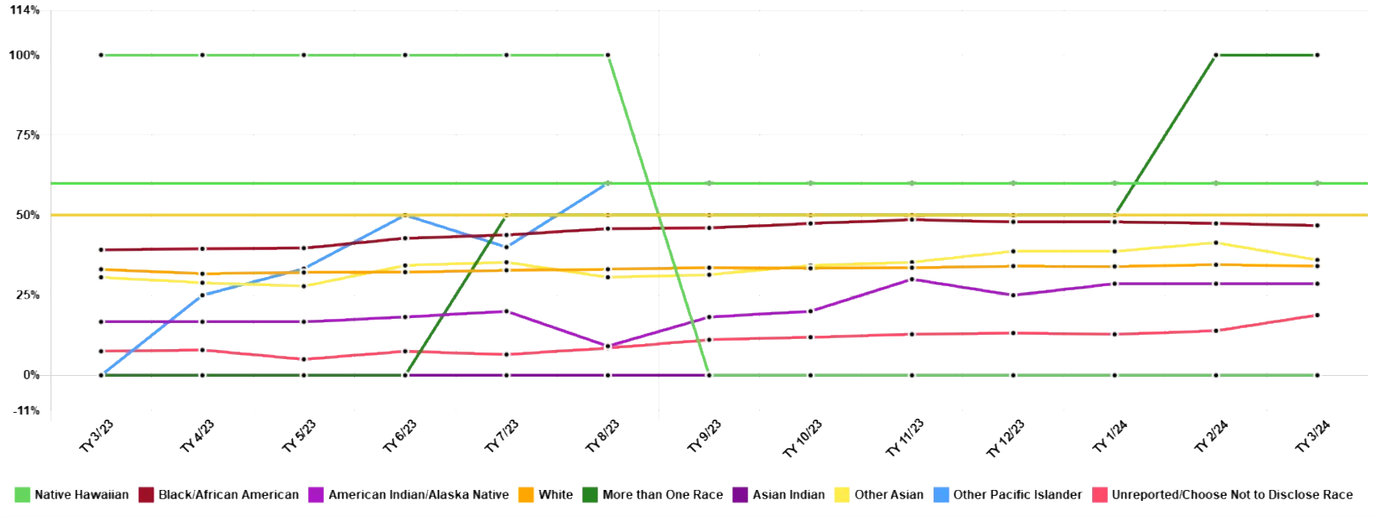
CRC Screening Gauge for Trailing Year



CRC Screening by ETHNICITY for the Trailing Year



CRC Screening by RACE for the Trailing Year



CRC Screening by FEMALES and AGE

AGE	RESULT	NUMERATOR	DENOMINATOR	EXCL	GAP	TO TRGT
<= 44	0.0%	0	0	0	0	0
45-49	26.2%	33	126	0	93	43
50-54	25.3%	47	186	0	139	65
55-59	36.7%	73	199	0	126	47
60-64	38.5%	84	218	1	134	47
65-69	50.5%	109	216	5	107	21
70-75	52.5%	83	158	3	75	12
76 +	0.0%	0	0	0	0	0

CRC Screening by MALES and AGE

AGE	RESULT	NUMERATOR	DENOMINATOR	EXCL	GAP	TO TRGT
<= 44	0.0%	0	0	0	0	0
45-49	18.1%	19	105	0	86	44
50-54	24.8%	35	141	1	106	50
55-59	28.8%	45	156	2	111	49
60-64	32.7%	53	162	1	109	45
65-69	42.4%	59	139	4	80	25
70-75	42.7%	32	75	6	43	13
76 +	0.0%	0	0	0	0	0

CRC Screening by OTHER GENDER and AGE

AGE	RESULT	NUMERATOR	DENOMINATOR	EXCL	GAP	TO TRGT
<= 44	0.0%	0	0	0	0	0
45-49	0.0%	0	0	0	0	0
50-54	0.0%	0	0	0	0	0
55-59	0.0%	0	0	0	0	0
60-64	0.0%	0	0	0	0	0
65-69	0.0%	0	0	0	0	0
70-75	0.0%	0	0	0	0	0
76 +	0.0%	0	0	0	0	0

CRC Screening by PAYOR

UDS FINANCIAL CLASSES	RESULT	NUMERATOR	DENOMINATOR	EXCL	GAP	TO TRGT
Medicare	49.4%	326	660	17	334	70
Dual Eligible Medicare and Medicaid	47.3%	95	201	8	106	26
Private Insurance	30.8%	188	610	5	422	178
Medicaid	29.9%	49	164	0	115	50
Unmapped	26.0%	19	73	0	54	25
Uninsured	24.1%	90	374	1	284	135

CRC Screening by SEXUAL ORIENTATION

SEXUAL ORIENTATIONS	NUMERATOR	DENOMINATOR	EXCL	GAP	TO TRGT
Unknown	5	12	0	7	3
Straight (not lesbian or gay)	530	1,384	18	854	301
Choose not to disclose	111	381	4	270	118
Don't know	20	77	0	57	27
Lesbian or gay	6	24	1	18	9
Bisexual	0	2	0	2	2
Something else	0	1	0	1	1

CRC Screening by RACE, ETHNICIY

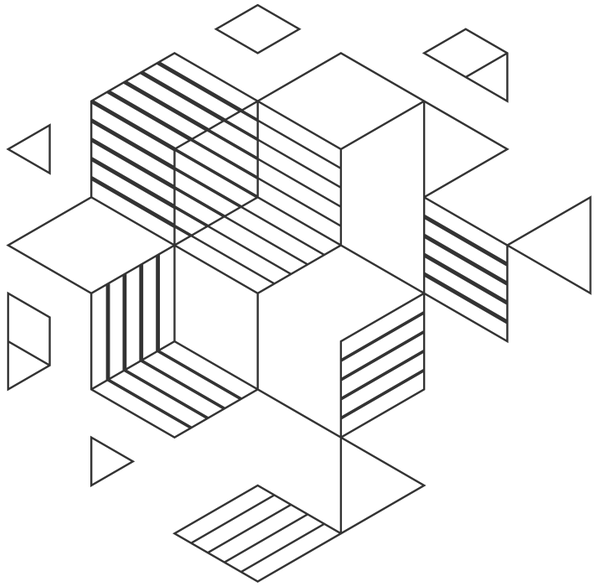
RACES AND ETHNICITIES	RESULT	NUMERATOR	DENOMINATOR	EXCL
American Indian/Alaska Native/Not Hispanic, Latino/a, or Spanish Origin	33.3%	2	6	0
American Indian/Alaska Native/Unreported/Choose Not to Disclose Ethnicity	0.0%	0	1	0
Asian Indian/Not Hispanic, Latino/a, or Spanish Origin	0.0%	0	1	0
Black/African American/Another Hispanic, Latino/a, or Spanish Origin	42.9%	3	7	0
Black/African American/Not Hispanic, Latino/a, or Spanish Origin	47.6%	120	252	5
Black/African American/Unreported/Choose Not to Disclose Ethnicity	25.0%	2	8	0
More than One Race/Another Hispanic, Latino/a, or Spanish Origin	100.0%	1	1	0
Other Asian/Not Hispanic, Latino/a, or Spanish Origin	39.1%	9	23	1
Other Asian/Unreported/Choose Not to Disclose Ethnicity	0.0%	0	2	0
Other Pacific Islander/Another Hispanic, Latino/a, or Spanish Origin	100.0%	1	1	0
Other Pacific Islander/Not Hispanic, Latino/a, or Spanish Origin	50.0%	2	4	0
Unreported/Choose Not to Disclose Race/Another Hispanic, Latino/a, or Spanish Origin	16.7%	3	18	0
Unreported/Choose Not to Disclose Race/Not Hispanic, Latino/a, or Spanish Origin	33.3%	2	6	0
Unreported/Choose Not to Disclose Race/Unreported/Choose Not to Disclose Ethnicity	12.5%	1	8	0
White/Another Hispanic, Latino/a, or Spanish Origin	19.1%	60	314	4
White/Not Hispanic, Latino/a, or Spanish Origin	38.5%	455	1,183	13
White/Unreported/Choose Not to Disclose Ethnicity	23.9%	11	46	0

CRC Screening by PREFERRED LANGUAGE

LANGUAGES	RESULT	NUMERATOR	DENOMINATOR	EXCL	GAP	TO TRGT
Albanian	100.0%	1	1	0	0	0
American Sign Language	100.0%	1	1	0	0	0
French	100.0%	1	1	0	0	0
English	38.7%	615	1,591	20	976	340
Vietnamese	20.0%	1	5	0	4	2
Spanish	19.2%	51	266	3	215	109
Portuguese	16.7%	2	12	0	10	6
Chinese, Other	0.0%	0	1	0	1	1
Pohnpeian	0.0%	0	1	0	1	1
Russian	0.0%	0	2	0	2	2

CRC Screening by SDOH for Trailing Year

SDOH	RESULT	NUMERATOR	DENOMINATOR	EXCL	GAP
CHILDCARE	0.0%	0	1	0	1
CLOTHING	50.0%	3	6	0	3
EDU	42.9%	9	21	1	12
EMPLOYMENT	44.5%	57	128	2	71
FOOD	36.4%	4	11	0	7
FPL<200	38.1%	442	1,160	15	718
HISP/LAT	19.9%	68	341	4	273
HOMELESS	33.3%	12	36	0	24
HOUSING	20.0%	1	5	0	4
INCARC	25.0%	1	4	0	3
INSURANCE	38.8%	466	1,200	18	734
ISOLATION	42.9%	9	21	0	12
LANGUAGE	19.7%	57	290	3	233
MED/CARE	12.5%	1	8	0	7
MIGRANT	11.1%	1	9	0	8
PHONE	50.0%	1	2	0	1
RACE	45.8%	140	306	6	166
REFUGEE	0.0%	0	1	0	1
SAFETY	33.3%	3	9	0	6
STRESS	38.9%	65	167	2	102



CARE
CENTER for APPLIED RESEARCH & EVALUATION

April 24, 2024

USING EVALUATION DATA FOR DECISION MAKING

Mark Macauda, PhD, MPH

What We Use Data For

- TRACKING CLINIC PROGRESS
  - HELP US SEE SUCCESSES AND AREAS FOR IMPROVEMENT
- DURING TECHNICAL ASSISTANCE CALLS
  - FACILITATES CLINIC DISCUSSIONS
- UNDERSTANDING CLINIC POPULATIONS
  - ESPECIALLY SINCE AZARA DATA HAS DENOMINATORS

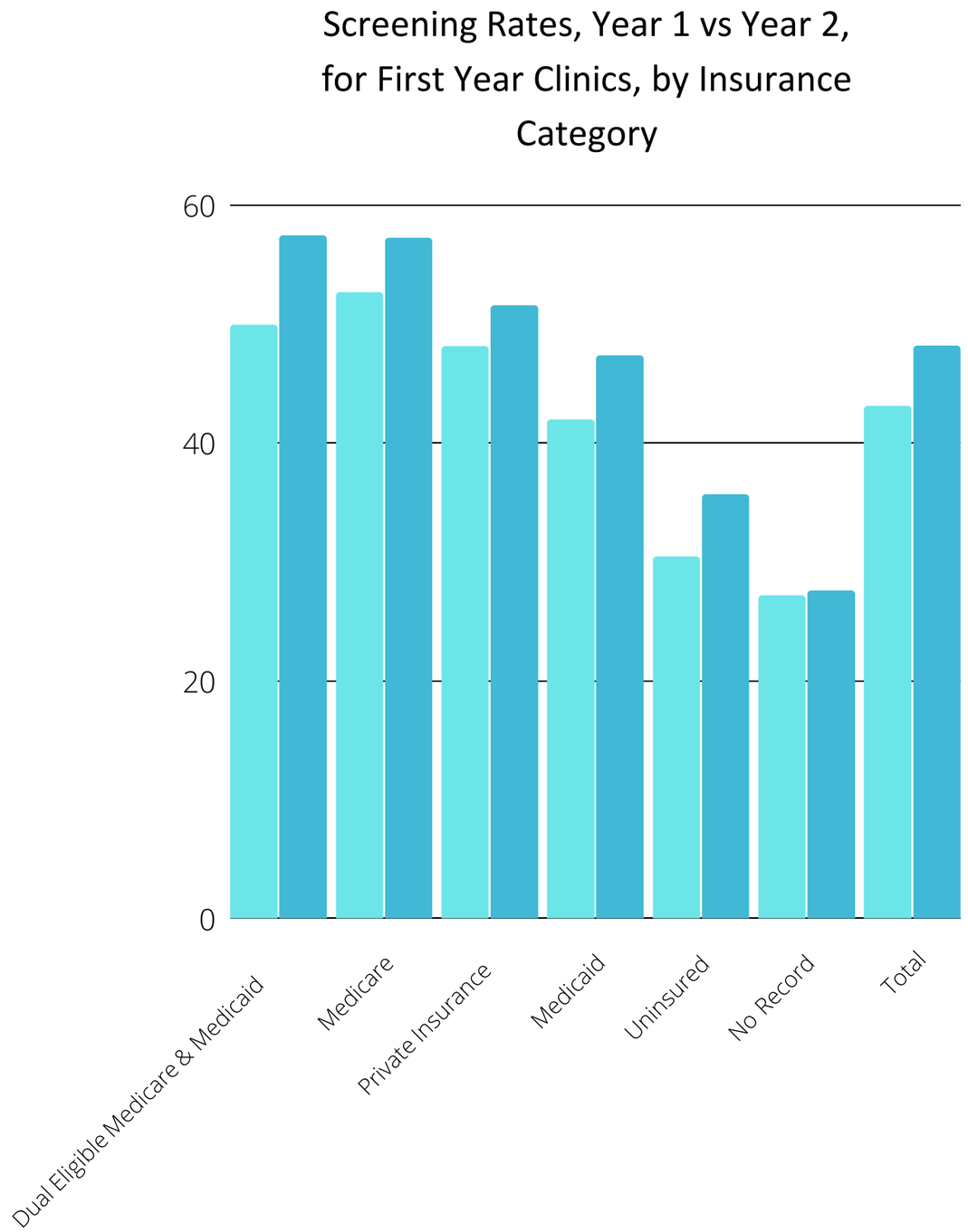
What We Use Data For (Continued)

- UNDERSTANDING PROGRAM TRENDS AND EFFECTIVENESS
- REVIEW OF IMPLEMENTATION AND LESSONS LEARNED
  - QUALITATIVE INTERVIEWS WITH CLINIC STAFF AND PARTNERS

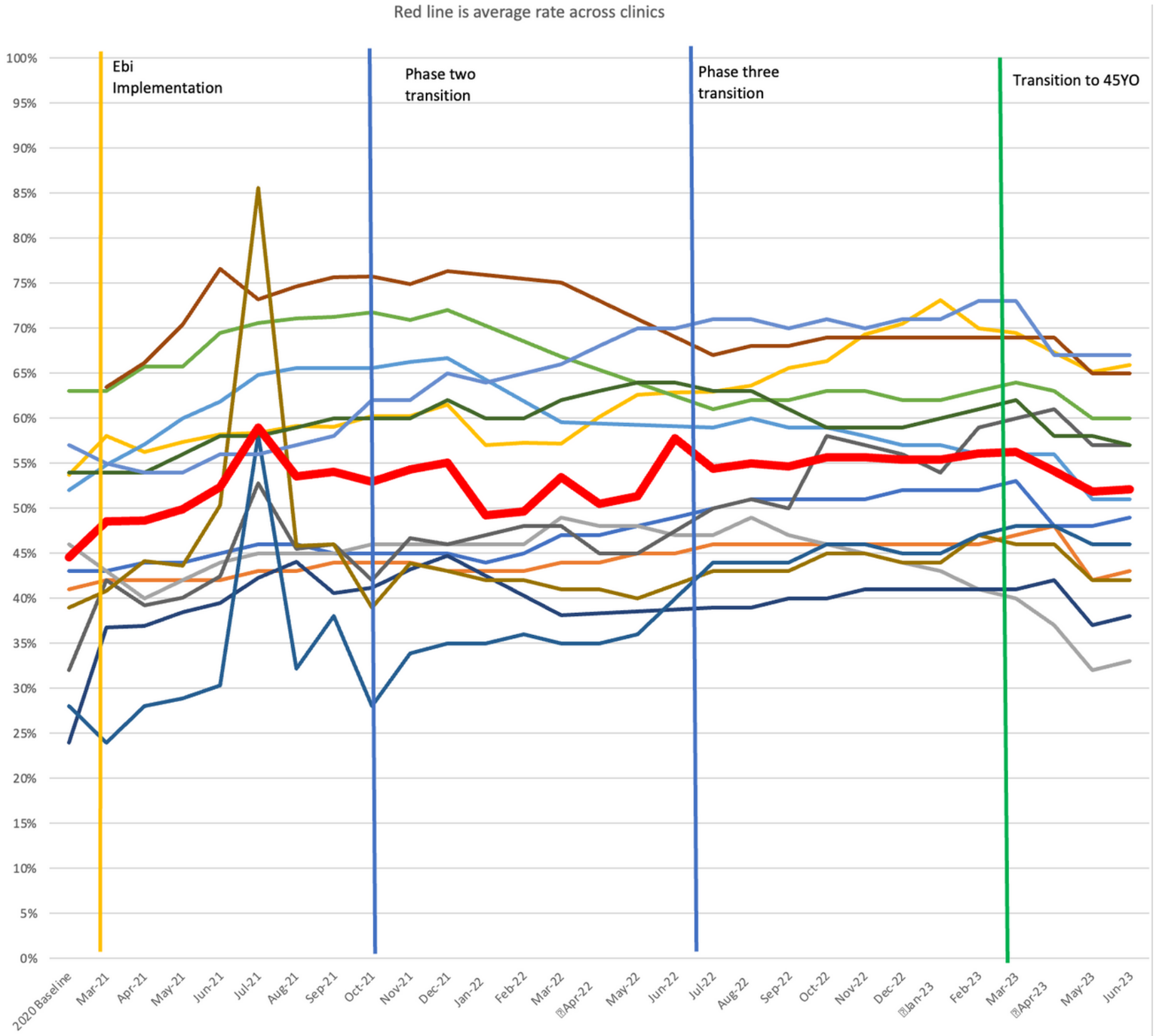
UDS 2021: 21.09%		2022 Goal: 38%
Date	**CRCS Rate**	**Notes**
May 2022		Cooperative Health changing current data feed from Athena (Dataware to Data View) to Azara. Requested Azara to do a "Refresh". Unable to pull monthly data.
June 2022	26%	107/406 Pulled from Azara; trailing year
July 2022	28%	115/409 Pulled from Azara; trailing year
August 2022	34%	April pulled data during TA 8.24.22: 104/262- 39.7% (Odette only- some patients may still be listed under previous provider) 129/394 32% (other providers) 128/411 pulled from Azara trailing year; pulled 9.14.22
September 2022	35%	137/396 Pulled from Azara;trailing year Notes: Clinic pulled Azara report on 9/28/2022- 46.2% (pulled from Azara trailing year)
GOAL MET! October 2022	38%	143/399 Pulled from Azara;trailing year Clinic has been working on getting reports into system and reaching out to patients that have not been to see a provider in a while.
November 2022	38%	145/387 Pulled from Azara; trailing year.
December 2022	40%	153/383 Pulled from Azara; trailing year.

One way we use the Azara data is to help clinics understand their progress over time

Data is documented/tracked in LucidChart



We also use the Azara data to look at the effects of different demographic factors on screening rates



We have also been using Azara data to understand the trends in clinic screening rate over time.

These are our first-year clinics with the project phases marked.

The red line is the average rate across clinics

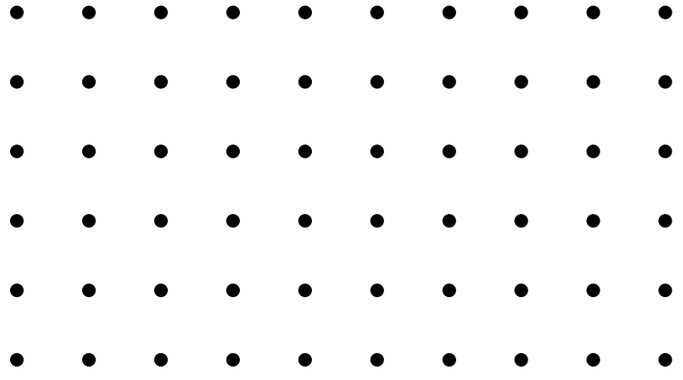
Results

INTERVIEW 1: YEAR 1 LEARNING COLLABORATIVE PARTICIPANTS

Six Learning Collaborative participants representing six clinics participated in the group interview. The purpose of the group interview was to understand their experience of the learning collaborative process. Conversation focused heavily on a) participants' expectations of the process prior, b) the most helpful parts of the learning collaborative so far, and c) current and anticipated barriers to colorectal cancer screening. Below are the major takeaways from this conversation:

- Clinics came into the project openminded with little to no expectations
- Clinics find having newfound structure and standardization in their screening process valuable
- Clinics appreciated carving out dedicated time to study their processes
- Clinics found the Learning Collaborative most helpful when working 1:1 with Lisa to unpack their processes; clinics found it most challenging to implement the PDSA cycles to improve these processes
- Clinics expect to continue facing the challenges of staffing and improving their FIT return rates

We use yearly interviews with clinic staff to better understand successes and challenges



Using Data

Moving forward we are seeking to understand what makes some clinics more successful than others:

- Patient mix?
  - Insurance
  - SDOH
- Initial readiness?
- Baseline rate?

Questions?

PEER —TO— PEER LEARNING | Webinar
APRIL 2024

North Carolina

Learning Objective 3:
Discuss establishing, evaluating, and strengthening partnerships to benefit patient care and create more effective and efficient systems.

Learning Objective 4:
Explore and evaluate relationships driven by internal and external partners within a colorectal cancer screening program to better understand relational coordination (e.g., communication, shared goals, and mutual respect). This includes sharing plans and processes for evaluating partnerships between participating FQHCs and referral gastroenterology practices to improve colorectal cancer screening programs and cancer care continuum.

SCREENOUTCANCER
Colorectal Cancer

North Carolina Partnership to Increase
Colorectal Cancer Screenings (NC PICCS)

North Carolina P2P Webinar: Partnerships

Jennifer Park, MPH, CHES, Program Director for NC PICCS
North Carolina Partnership to Increase Colorectal Cancer Screenings
Cancer Prevention and Control Branch, NC Division of Public Health
NC Department of Health and Human Services

Dr. Renée Ferrari, PhD, MPH, Lead Evaluator for NC PICCS
North Carolina Partnership to Increase Colorectal Cancer Screenings
Senior Investigator, Lineberger Comprehensive Cancer Center
Adjunct Assistant Professor, Department of Maternal and Child Health,
Gillings School of Global Public Health, University of North Carolina at Chapel Hill

Objectives

1) Discuss establishing, evaluating, and strengthening partnerships to benefit patient care and create more effective and efficient systems.

2) Explore and evaluate relationships driven by internal and external partners within a colorectal cancer screening program to better understand relational coordination.

NC PICCS Partnerships

NC PICCS Program

NC PICCS is a Centers for Disease Control and Prevention funded grant aimed at using evidence-based interventions to increase colorectal cancer screening rates and follow-up colonoscopies at participating NC PICCS clinics.

NC PICCS is a partnership.

American Cancer Society®

THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

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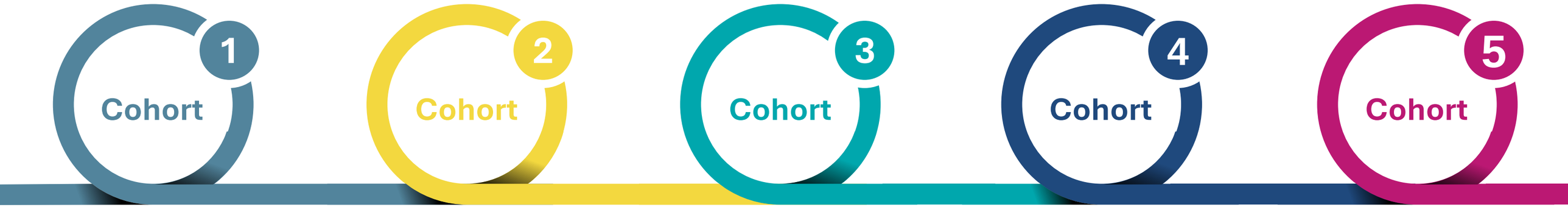
External Health System Partners



Program Year 1:

Kintegra Family Medicine

- Kintegra Clinic 1
- Kintegra Clinic 2

Program Year 2:

Kintegra Family Medicine

- Kintegra Clinic 3
- Kintegra Clinic 4

Opportunities Industrialization Center (OIC)

- OIC Clinic 1
- OIC Clinic 2

Program Year 3:

Kintegra Family Medicine

- Kintegra Clinic 5
- Kintegra Clinic 6

Opportunities Industrialization Center (OIC)

- OIC Clinic 3

Program Year 4:

Kintegra Family Medicine

- Kintegra Clinic 7
- Kintegra Clinic 8

Blue Ridge Community Health Services (BRH)

- BRH Clinic 1
- BRH Clinic 2

Program Year 5:

Kintegra Family Medicine

- Kintegra Clinic 9
- Kintegra Clinic 10

Blue Ridge Community Health Services (BRH)

- BRH Clinic 3
- BRH Clinic 4

Overview of Program Services Focused on Priority FQHC Populations

Get Connected 1	Connect NC PICCS with participating FQHC's primary care clinics to implement EBIs recommended in the Community Guide.
Learn & Implement Best Practices 2	Support participating clinics with QI Boot Camp, monthly Learning Collaborative calls, and monthly TA calls.
Monitor Quality Improvements 3	Plan and monitor quality improvement activities on a regular basis through PDSA cycles, and track CRC screenings and colonoscopies.
Evaluate Progress 4	Collect and submit clinic-level data for baseline, quarterly, and annual surveys.

Components of NC PICCS Work Plan

ID clinics serving communities in greatest need

FQHC partners select two additional primary care clinics/year for NC PICCS program

DPH establishes formal partnerships via RFA and contracts

Develop an evaluation report and integrate findings into CDC reports

Share the data/reports and gather feedback

Use evaluation results for continued program improvement to meet the health needs of the FQHC

Partner with ACS based on agency's expertise to provide technical assistance

Partner with UNC-Chapel Hill for evaluation and data analysis

Connect and commence ACS QI Learning Collaborative

Coordinate collaborative TA to identify and resolve challenges via EBIs

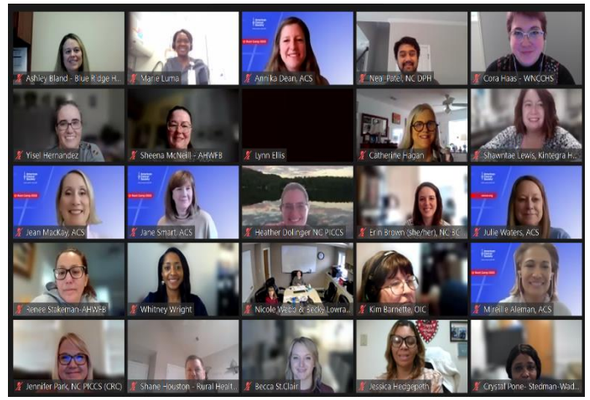
Replicate best practices in other clinic sites

Streamline referral processes and document improvements that facilitate successful patient navigation

American Cancer Society's Quality Improvement Learning Collaborative Model

- Facilitate sustainable implementation of evidence-based interventions and system/policy changes through intentional use of quality improvement tools to increase cancer screening and prevention quality measures

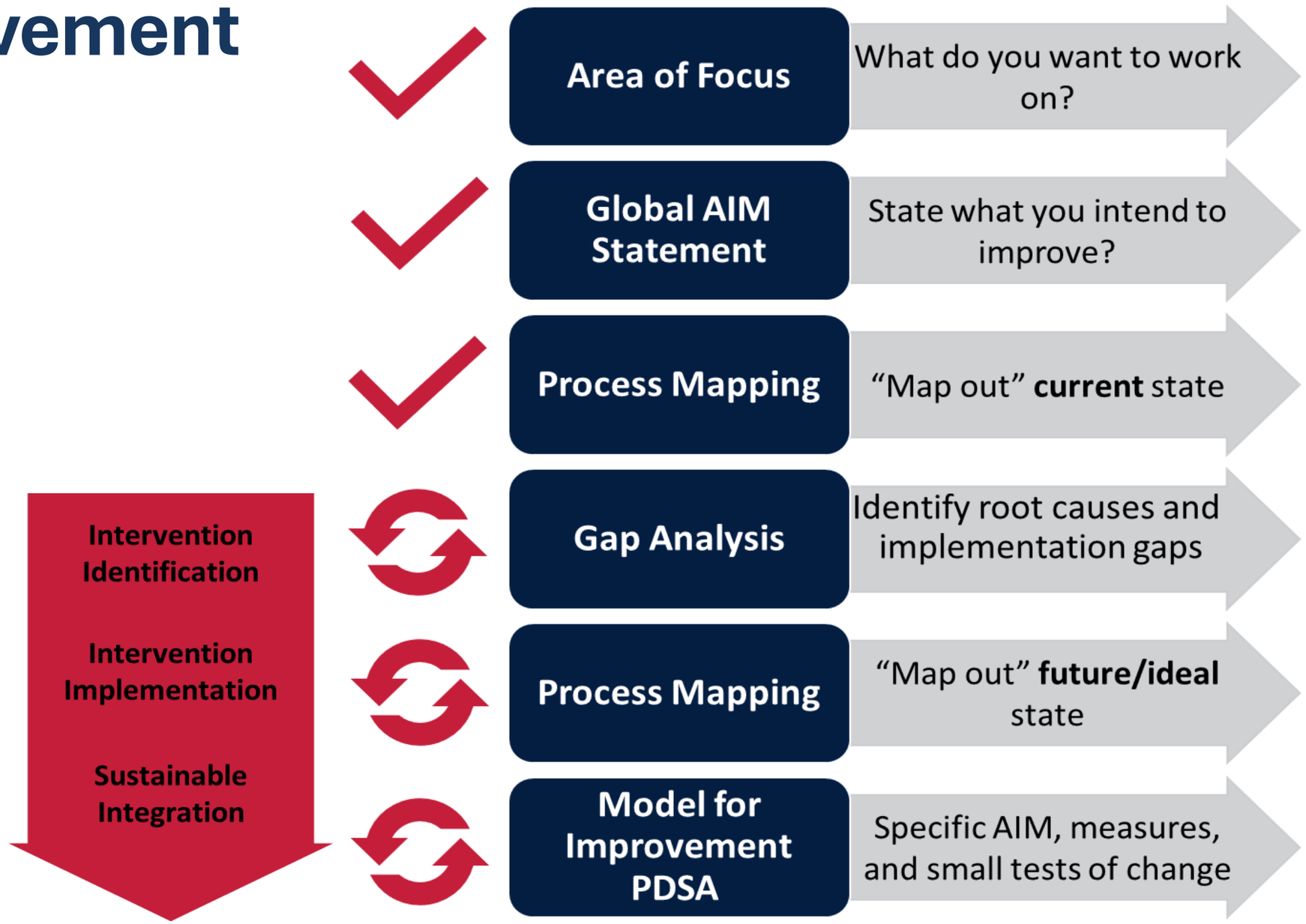
- Share best practices and problem solve among participating clinics



"The education provided really "clicked" and we've seen a ripple effect where the information learned is being applied to other cancer screening areas."

High Engagement and Replication

Quality Improvement Process



NC PICCS Partnerships Evaluation

NC PICCS Evaluation

Refer to logic model

Develop evaluation plan using CDC evaluation framework as guidance

Include dissemination of results to stakeholders/partners

Evaluation Components

- Partnerships and Collaborative Engagement
- Data Capacity
- Quality Improvement Capacity
- CRC Screening Processes
- CRC Screening EBI Implementation
- CRC Screening Outcomes

Evaluation Plan Overview

The North Carolina Partnerships to Increase Colorectal Cancer Screening (NC PICCS) Evaluation Team will conduct a process and outcome evaluation of colorectal cancer (CRC) screening programs at partner Federally Qualified Health Center (FQHC) clinics. The evaluation is guided by the Centers for Disease Control and Prevention's (CDC) Framework for Program Evaluation, which includes six steps: 1) engage stakeholders, 2) describe the program, 3) focus the evaluation design, 4) gather credible evidence, 5) justify conclusions, and 6) ensure use and share lessons learned. This evaluation plan is organized around these steps.

We will evaluate the NC PICCS program on its five programmatic components and outcomes: 1) partnerships and Collaborative engagement, 2) quality improvement capacity, 3) CRC screening processes, 4) CRC screening evidence-based intervention (EBI) implementation, and 5) CRC screening outcomes. In the evaluation of each component, we seek to answer the following evaluation questions. For more detail on how we determined and prioritized these questions, see "Evaluation Design."

1. Partnerships and Collaborative Engagement
   - 1a. Was a partnership established with an FQHC health system / clinic?
   - 1b. Were partnerships established/renewed with ACS and DPH?
   - 1c. Were partnerships established/renewed with UNC Chapel Hill and DPH?
   - 1d. How fully did the clinic engage in the Collaborative?
   - 1e. What were the perceptions of the partnership among its clinic partners?
   - 1f. What were the perceptions of the partnership among CPCB, ACS, and UNC team members?

2. Data Capacity
   - 2a. Was the NC PICCS team able to develop and administer a data capacity tool for the clinics?
   - 2b. How have clinics' data capacity improved from the start of the NC PICCS program to the end of the program year?
   - 2c. What barriers/facilitators and successes/challenges did clinics experience with data capacity?
   - 2d. How confident are clinics with their CRC screening rate data?

3. Quality Improvement (QI) Capacity
   - 3a. What was the clinic's baseline level of readiness and capacity to conduct QI before the Collaborative? After the Collaborative?
   - 3b. How many of the QI tools did clinic teams use and to what extent did they use QI tools as intended?
   - 3c. What were clinic staffs' perception of Collaborative activities and QI tools?
   - 3d. How did clinics capacity to do QI and to improve CRC screening change?

4. CRC Screening Processes
   - 3a. What were clinics' CRC screening processes prior to the Collaborative?
   - 3b. How did clinics change their CRC screening processes during the Collaborative period?

5. CRC Screening EBI Implementation
   - 5a. What EBIs did the clinic choose to implement?
   - 5b. Did the clinics choose at least one patient and one provider EBI?
   - 5c. What barriers did clinics encounter and what facilitators were effective?

6. CRC Screening Outcomes

Evaluation Purpose

The purposes of this evaluation are to 1) improve CRC screening programs at partner clinics, 2) inform future program planning, and 3) facilitate accountability to funders and other programmatic stakeholders. The intended users (stakeholders) of the evaluation results are listed in Table 1. How evaluation results will be communicated and anticipated use of findings by stakeholders are listed in Tables 4 and 5, respectively.

Stakeholders of Evaluation Results

Table 1. Overview of NC PICCS internal and external stakeholders and evaluation activities in which they will be engaged.

		Describe the program	Focus on the evaluation	Collect / report data	Justify conclusions	Disseminate results
Internal Stakeholders (NC PICCS)	NC Division of Public Health (DPH), Cancer Prevention and Control Branch (hereafter CPCB)	X	X	X	X	X
	American Cancer Society (ACS)	X	X	X	X	X
	University of North Carolina (UNC) Evaluation and Technical Assistance Team	X	X	X	X	X
External Stakeholders	CDC Colorectal Cancer Control Program (CRCCP)		X	X	X	X
	Participating Federally Qualified Health Centers (FQHCs) / clinics			X		X
	National partners (e.g., Cancer Prevention and Control Research Network)					X
	State partners (e.g., NC CRC Roundtable (NC CRCRT))					X
	Other audiences with interest in CRC screening					X

NC PICCS Evaluation

Refer to logic model

Develop evaluation plan using CDC evaluation framework as guidance

Include dissemination of results to stakeholders/partners

Evaluation Components

- **Partnerships and Collaborative Engagement**
- Data Capacity
- Quality Improvement Capacity
- CRC Screening Processes
- CRC Screening EBI Implementation
- CRC Screening Outcomes

Evaluation Plan Overview

The North Carolina Partnerships to Increase Colorectal Cancer Screening (NC PICCS) Evaluation Team will conduct a process and outcome evaluation of colorectal cancer (CRC) screening programs at partner Federally Qualified Health Center (FQHC) clinics. The evaluation is guided by the Centers for Disease Control and Prevention's (CDC) Framework for Program Evaluation, which includes six steps: 1) engage stakeholders, 2) describe the program, 3) focus the evaluation design, 4) gather credible evidence, 5) justify conclusions, and 6) ensure use and share lessons learned. This evaluation plan is organized around these steps.

We will evaluate the NC PICCS program on its five programmatic components and outcomes: 1) partnerships and Collaborative engagement, 2) quality improvement capacity, 3) CRC screening processes, 4) CRC screening evidence-based intervention (EBI) implementation, and 5) CRC screening outcomes. In the evaluation of each component, we seek to answer the following evaluation questions. For more detail on how we determined and prioritized these questions, see "Evaluation Design."

1. Partnerships and Collaborative Engagement
   - 1a. Was a partnership established with an FQHC health system / clinic?
   - 1b. Were partnerships established/renewed with ACS and DPH?
   - 1c. Were partnerships established/renewed with UNC Chapel Hill and DPH?
   - 1d. How fully did the clinic engage in the Collaborative?
   - 1e. What were the perceptions of the partnership among its clinic partners?
   - 1f. What were the perceptions of the partnership among CPCB, ACS, and UNC team members?

2. Data Capacity
   - 2a. Was the NC PICCS team able to develop and administer a data capacity tool for the clinics?
   - 2b. How have clinics' data capacity improved from the start of the NC PICCS program to the end of the program year?
   - 2c. What barriers/facilitators and successes/challenges did clinics experience with data capacity?
   - 2d. How confident are clinics with their CRC screening rate data?

3. Quality Improvement (QI) Capacity
   - 3a. What was the clinic's baseline level of readiness and capacity to conduct QI before the Collaborative? After the Collaborative?
   - 3b. How many of the QI tools did clinic teams use and to what extent did they use QI tools as intended?
   - 3c. What were clinic staffs' perception of Collaborative activities and QI tools?
   - 3d. How did clinics capacity to do QI and to improve CRC screening change?

4. CRC Screening Processes
   - 3a. What were clinics' CRC screening processes prior to the Collaborative?
   - 3b. How did clinics change their CRC screening processes during the Collaborative period?

5. CRC Screening EBI Implementation
   - 5a. What EBIs did the clinic choose to implement?
   - 5b. Did the clinics choose at least one patient and one provider EBI?
   - 5c. What barriers did clinics encounter and what facilitators were effective?

6. CRC Screening Outcomes

Process and Outcome Evaluation Plan, December 2022 Version 3.0

Evaluation Purpose

The purposes of this evaluation are to 1) improve CRC screening programs at partner clinics, 2) inform future program planning, and 3) facilitate accountability to funders and other programmatic stakeholders. The intended users (stakeholders) of the evaluation results are listed in Table 1. How evaluation results will be communicated and anticipated use of findings by stakeholders are listed in Tables 4 and 5, respectively.

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	Other audiences with interest in CRC screening					X

Partnerships & Collaborative Engagement: Evaluation Questions, Indicators, Data Sources

Evaluation questions	Indicators	Data sources
1. Was a partnership established with a FQHC health system / clinic?	Completed contract with FQHC health system	Written agreements with FQHC and DPH
2. Was a partnership established/renewed with ACS and DPH?	Formal partnership with ACS to provide technical assistance on clinic quality improvement efforts and to work collaboratively with the NC PICCS team on program development	ACS contract agreement with DPH
3. Was a partnership established/renewed with a UNC Chapel Hill and DPH?	Formal partnership with UNC to provide program evaluation, data analysis and to work collaboratively with the NC PICCS team on program development	UNC contact agreement with DPH
4. How fully did the clinic engage in the Learning Collaborative (“Collaborative”)?	Proportion of calls and meetings attended by team and clinic; composition of team membership, time set aside for QI activities outside learning sessions, leadership buy-in, perception of value of Collaborative	Meeting attendance logs Post-focus groups Call observations
5. What were the perceptions of the partnership among its clinic partners?	Clinics’ subjective evaluation of the support from the NC PICCS team including responsiveness to clinic requests and quality of communication	Post-focus groups
6. What were the perceptions of the partnership among, DPH, ACS and UNC team members?	Team members’ subjective evaluation of the collaboration between DPH, ACS, and UNC	Team discussion/retreat

Q.1-3: Establishing Partnerships

Questions

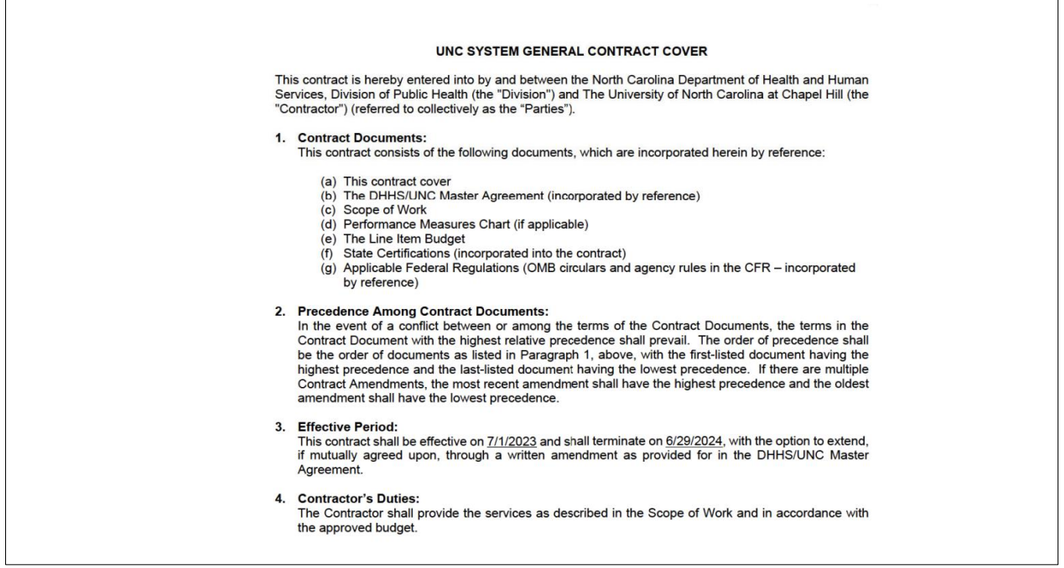
Q1. Was a partnership established with a FQHC health system / clinic?

Q2. Was a partnership established/renewed with ACS and DPH?

Q3. Was a partnership established/renewed with a UNC Chapel Hill and DPH?

Indicators

- Contracts
- Collaboratively-developed SOW & agreed-upon deliverables



UNC SYSTEM GENERAL CONTRACT COVER

This contract is hereby entered into by and between the North Carolina Department of Health and Human Services, Division of Public Health (the "Division") and The University of North Carolina at Chapel Hill (the "Contractor") (referred to collectively as the "Parties").

1. **Contract Documents:**
   This contract consists of the following documents, which are incorporated herein by reference:

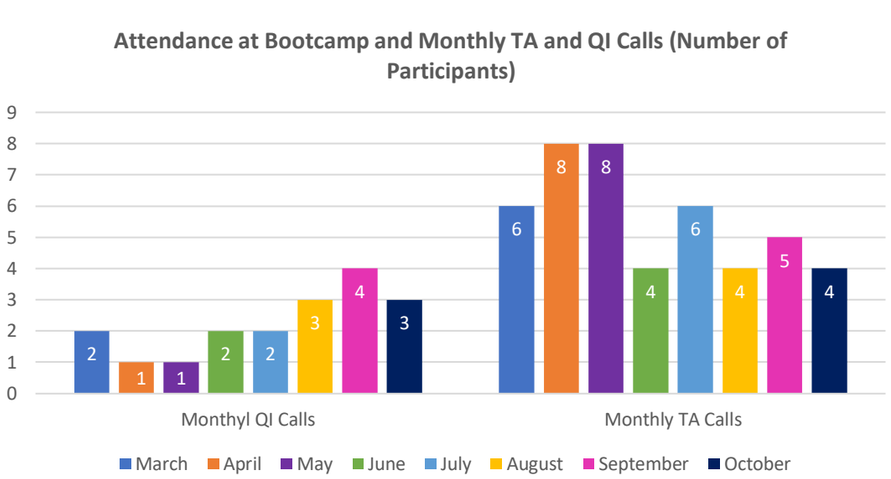
   (a) This contract cover
   (b) The DHHS/UNC Master Agreement (incorporated by reference)
   (c) Scope of Work
   (d) Performance Measures Chart (if applicable)
   (e) The Line Item Budget
   (f) State Certifications (incorporated into the contract)
   (g) Applicable Federal Regulations (OMB circulars and agency rules in the CFR – incorporated by reference)

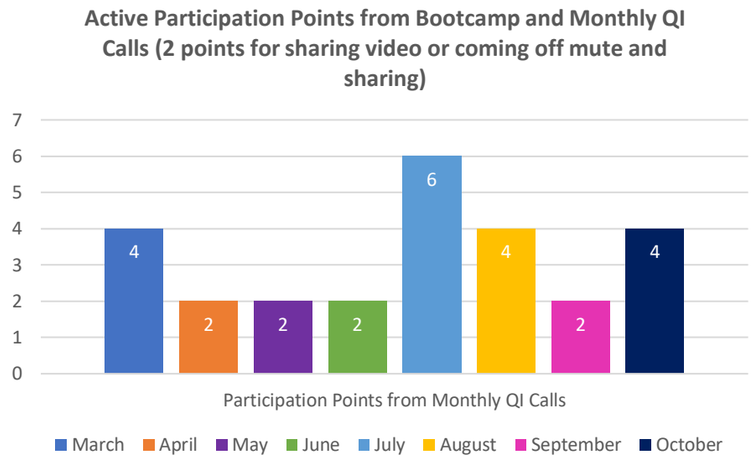
2. **Precedence Among Contract Documents:**
   In the event of a conflict between or among the terms of the Contract Documents, the terms in the Contract Document with the highest relative precedence shall prevail. The order of precedence shall be the order of documents as listed in Paragraph 1, above, with the first-listed document having the highest precedence and the last-listed document having the lowest precedence. If there are multiple Contract Amendments, the most recent amendment shall have the highest precedence and the oldest amendment shall have the lowest precedence.

3. **Effective Period:**
   This contract shall be effective on 7/1/2023 and shall terminate on 6/29/2024, with the option to extend, if mutually agreed upon, through a written amendment as provided for in the DHHS/UNC Master Agreement.

4. **Contractor's Duties:**
   The Contractor shall provide the services as described in the Scope of Work and in accordance with the approved budget.

Q4. How fully did the clinic engage in the Collaborative?





Aim Statement Tracking	Aim Statement	Completed
	Current State Process Map	In progress
	Gap Analysis	Not started
	Future State Process Map	Not started
	PDSA 1	Not started
	Provider and Staff Training	Not started
	PDSA 2	Not started
	PDSA 3	Not started

April — May — June

Survey Data
No June Survey

Survey Data

Question from [OIC Clinic 1] : *"Has anyone had any experience with blood-based CRC testing? What is the reliability of those tests?"*

TA Call Notes

During the last 15 minutes of the call, [OIC Clinic 1 and Clinic 2] would like to...*"Go into breakout rooms and have an open discussion about successes and challenges with other systems working on the same cancer type"*

Survey Data

[OIC Clinic 1 and Clinic 2]

"Appointments for colonoscopies are out for many months. We had 2 providers that left last month, and their focus was on closing open items."

"Are there providers in Eastern NC that offer reduced or payment arrangements for uninsured patients or those with high deductibles?"

TA Call Notes

All 4 clinics said they were very satisfied with the Collaborative.

Q5. What were the perceptions of the partnership among its clinic partners?

Cohort 1

Clinics were asked about satisfaction on a survey, and all four responded that they were extremely satisfied with NC PICCS.

"Anytime that we've reached out to any of you guys that's on the team we've always gotten an answer in a timely manner so that was very helpful."

Cohort 2

During the post-focus group discussion, clinics expressed the support and guidance offered by the NC PICCS team to be very helpful. The clinics mentioned being happy with the communication provided by NC PICCS.

"It was a great collaborative like it always is. You guys are always great."

Cohort 3

Clinic staff said that they have been "more mindful" since joining NC PICCS and have implemented more reviews of screening numbers and patient health maintenance prior to patient visits.

During the post-focus group discussion, clinic staff expressed the support and collaboration offered by the NC PICCS team to be working well.

Q6. What were the perceptions of the partnership among DPH, ACS, and UNC team members?

During a discussion among the NC PICCS team about their partnership, all expressed appreciation for and satisfaction with many aspects of the partnership, mainly centered around working well as a team and improved understanding of reporting requirements and roles as the project has progressed.

The NC PICCS team meets bi-weekly to discuss any challenges and needed supports, including a focus on building team relationships. These regular discussions are collaborative and productive.

Key Takeaways

Evaluation questions	Key Takeaways
1. Was a partnership established with a FQHC health system / clinic?	External FQHC partners were identified through an RFA and contracting process. To address cancer health disparities, existing clinic and county level data were used to ID clinics serving historically marginalized populations. A participating FQHC reported, "This program has initiated conversations and created partnerships that otherwise might not have existed."
2. Was a partnership established/renewed with ACS and DPH? 3. With UNC and DPH?	ACS has always had a good relationship with DPH which was part of the reason why this team came together. However, this project definitely deepened the relationship between the two organizations. UNC is committed to working with DPH state partner for long-term and state-wide efforts. Both ACS and UNC agencies contribute special expertise to the NC PICCS program team.
4. How fully did the clinic engage in the Collaborative?	The clinics were fully engaged in the QI Learning Collaborative - they attended all meetings, interacted with other systems, presented, etc. A good example of this engagement is cohort 3 won the 'Zoomy Award' (an award based on participation and interaction during the calls). The NC PICCS program and Learning Collaborative has required clinic team members from various departments learn and become more involved in QI processes which created a ripple effect where information is applied to CRC screenings and other cancer prevention screenings moving forward.
5. What were the perceptions of the partnership among its clinic partners?	A participating FQHC's internal team improved communication practices, having an informal check-in and then scheduling a formal check-in. They reported it has been great to learn their team members' communication styles. The NC PICCS team discovered that combining "asks" (data requests and # of meetings held) from the NC PICCS team members and having a point person to communicate with the health system are positive approaches to address the FQHC's challenges of limited staff time, workload, staff transitions, and communication.
6. What were the perceptions of the partnership among DPH, ACS and UNC team members?	The NC PICCS team implemented quality improvement strategies around defining roles, responsibilities, and program protocols for engaging with FQHCS, that would address issues with duplicate emails, data collection, and role clarity. A key takeaway is to continuously monitor internal processes for continued program improvement to meet the health needs of the FQHC.

"Absolutely would recommend NC PICCS to other clinics to improve screening rates in our population"

Partnership

"Communication has always been great (with NCPICCS Team) through emails and meetings. (They're) always happy to schedule another meeting if we didn't understand something."

Communication

"Loved QI Bootcamp! I wish I had that training 10 years ago! helps put all the pieces together."

Quality Improvement Learning Collaborative

"Staff education provided by NC PICCS team to staff was great (the motivational Interviewing training); helped convey how to communicate with our patients so they understand the importance of screening."

Learning Together

"How do we get the patient connected [to colonoscopy]? We can identify the patients who have no insurance…but I don't really know what happens after we give the name [to the GI practice] and what we need to do to make sure the patient makes it to the appointment and then follow up. That was the most challenging part."

Address Challenges

Next Steps in Partnership Development and Evaluation

Continuous CRCCP Program Improvement

IDENTIFIED NEED: Through pre- and post-focus group discussions and technical assistance calls, NC PICCS identified a need to address challenges with communication and efficiency between NC PICCS participating FQHCs and partnering GI clinics.

FQHC-GI Challenges

Challenges

- Lack of local GI providers
- Delayed scheduling for their follow-up colonoscopy
- Colonoscopy results not making their way back to the FQHC records
- General difficulties communicating with GI practices

Clinic staff desire stronger linkages:

“Working in rural areas, it’s been difficult to have a local GI provider. There’s not enough local GI providers. Collaborative relationships have been key.”

“I wonder if we were able to get a conversation, for us and [the evaluation team] to meet with those GI practices, and have [FQHC Navigation Coordinator] be a part of them from that navigation perspective…kind of help set the stage for some of that communication, and maybe building that relationship between [FQHC Navigation Coordinator] and the GI practice in a way that we haven't done so far.”

FQHC-GI Linkages: An “Expanded” Evaluation

- The purpose of this extended evaluation is to explore relationships between participating FQHCs and referral gastroenterology (GI) practices to improve CRC screening programs and inform best practices on creating strong partnerships between health centers and gastroenterology practices

- Findings will elucidate barriers and facilitators to FQHC and GI practice linkages, with the aim of strengthening those linkages to benefit patient care and create more effective and efficient systems

FQHC-GI Linkages Expanded Evaluation Questions: Partnerships

Evaluation Component	Evaluation Questions
Partnerships	1. Are there existing partnerships between participating FQHCs and GI clinics? 2. What do those partnerships look like? 3. How were these partnerships achieved? 4. How are they maintained?

Continuous CRCCP Program Improvement: Evaluating FQHC-GI Linkages

IDENTIFIED NEED: Through pre- and post-focus group discussions and technical assistance calls, NC PICCS identified a need to address challenges with communication and efficiency between NC PICCS participating FQHCs and partnering GI clinics.

DEVELOPED PLAN: NC PICCS Evaluation Team developed an evaluation plan using the Consolidated Framework for Implementation Research 2.0 (CFIR) ‘Teaming’ construct in addition to relational coordination concepts to guide our evaluation of the partner linkage between FQHCs enrolled in NC PICCS and their referral GI clinics.

FQHC-GI Linkages Evaluation Plan Concepts

- **Teaming**

  The degree to which individuals join together, intentionally coordinating and collaborating on interdependent tasks, to implement the innovation

- **Relational Coordination**

  Communicating and relating for the purpose of task integration
  - Communication
  - Shared goals
  - Shared knowledge
  - Mutual respect

Damschroder, L.J., Reardon, C.M., Widerquist, M.A.O. et al. The updated Consolidated Framework for Implementation Research based on user feedback. Implementation Sci 17, 75 (2022). https://doi.org/10.1186/s13012-022-01245-0
Relational Coordination Collaborative: https://heller.brandeis.edu/relational-coordination/about-rc/index.html

Continuous CRCCP Program Improvement: Evaluating FQHC-GI Linkages

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DEVELOPED PLAN: NC PICCS Evaluation Team developed an evaluation plan using the Consolidated Framework for Implementation Research 2.0 (CFIR) 'Teaming' construct in addition to relational coordination concepts to guide our evaluation of the partner linkage between FQHCs enrolled in NC PICCS and their referral GI clinics.

GATHERING INFORMATION: The Evaluation Team is holding conversations with FQHC clinics and GI clinics and developing a relational coordination survey. *Goal: Identify and disseminate best practices for strengthening FQHC-GI linkages to benefit patient care.*

Thank you for attending!

Jennifer Park, MPH, CHES

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Cancer Prevention and Control Branch,
NC Division of Public Health
NC Department of Health and Human Services

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PEER TO PEER LEARNING | Webinar
APRIL 2024

Tennessee

Learning Objective 5:

- Discuss ways in which programs can build the foundation for data-driven thinking.

Learning Objective 6:

- Discuss methods of implementing, sustaining, and using efforts for future planning.

"The When"

Integrating Evaluation

Elizabeth Berardi, MPH, BSN, RN | Cancer Programs Administrator | April 2024

TN Department of Health

Learning Objectives

1. Discuss ways in which programs can build the foundation for data-driven thinking.
2. Discuss methods of implementing, sustaining, and using efforts for future planning.

About Tennessee

Tennessee Team

ELLIE BERARDI, MPH, BSN, RN
CANCER PROGRAMS ADMINISTRATOR

CRISSY HARTSFIELD, MBA
SECTION CHIEF, RWH

AUDREY STACH, DVM, MPH
EPIDEMIOLOGIST/DATA MANAGER

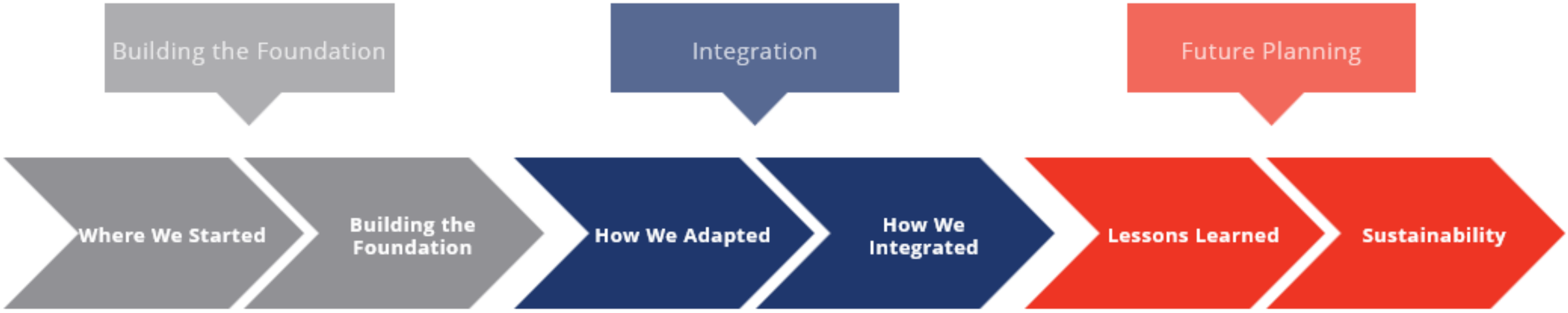
TN Department of Health

Tennessee

- BCCEDP grantee
  - Serve ~17,000+ unique individuals annually
- Non-Medicaid expanded state
- Data-driven history
- Continuously increased screening

TN Department of Health

Our When



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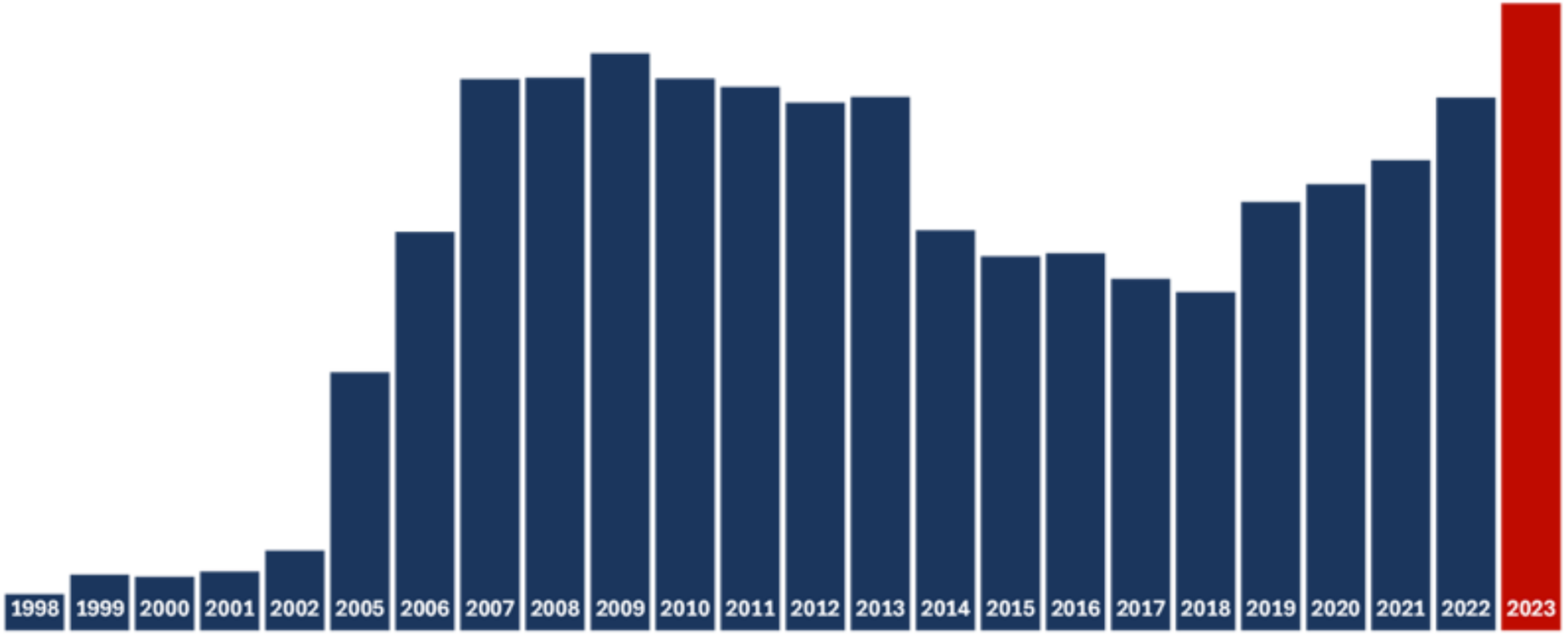
Building the Foundation

Program Services

In **program year 2023**, the TBCSP served approximately 17,000 persons. This was the highest number ever served in a single year since program inception.



TN Department of Health

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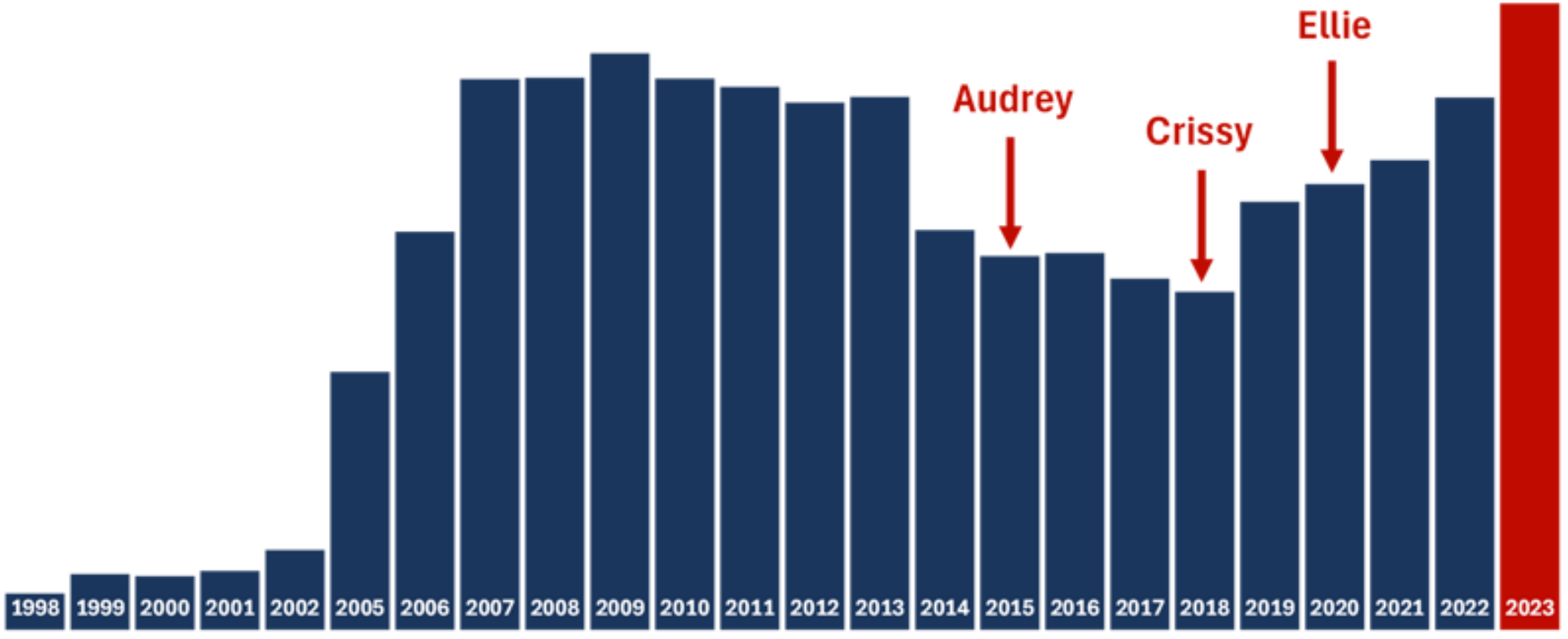

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What Changed?

- Improved epi capacity
  - Less reliance on MDE feedback (e.g., plots and core indicators)
  - Increased, more granular and more timely use of local data
- Stable program staff with an interest in the data
- **Strong partnership between epi and program staff**

“Epidemiology is information for action”

Where We Started

- **Something was missing**
  - Running out of money for services
  - Not screening any Black women in certain geographic areas
  - Decreases in number of women served

Building the Foundation

- **Data wasn't telling the whole story**
- Started data deep dives with data manager
  - Generated more fiscal reports
  - Analyzed county and census tract level rates
  - Expanded program network
- 'Using Data to Reduce Breast Cancer Disparities' Project

TN Department of Health

Integration

How Do We Use Data?

- Quantity of services
- Quality of services and data
- Fiscal considerations
- Populations at risk and/or in need of services

Quantity of Services

- Quarterly data reports
- Screening cycles among racial/ethnic minorities
- Impact of COVID on monthly cycle counts

Quality of Services and Data

- MDE core indicator reports by county and clinic
- Monthly incomplete and pending cycle reports
- Monthly missing data reports

TN Department of Health

Fiscal Considerations

- Annual funding allocations
- Monthly claims paid by staff member
- Times between services, claim submissions, and claims payments

Populations at Risk

- Cancer incidence and mortality
- Cancer screening rates
- Social determinants of health
- Eligible population estimates
- Cancer risk scoring
- Drive-time analyses

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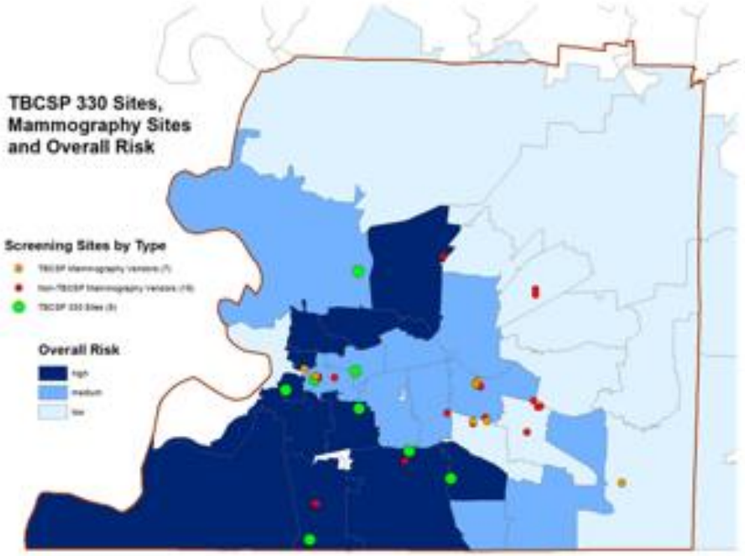
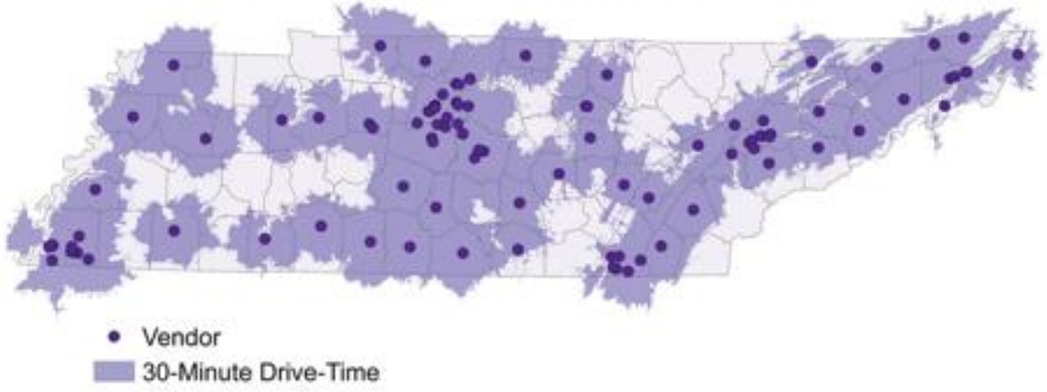
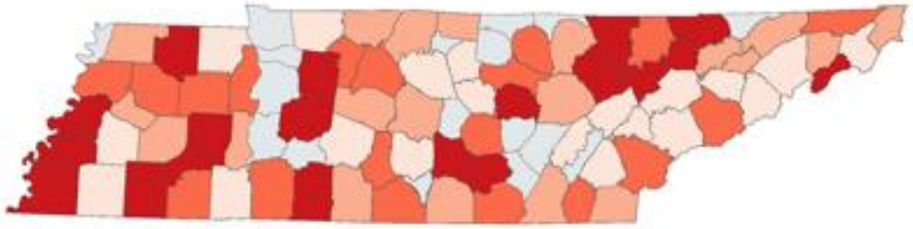
Mapping



Locations of FDA Approved Mammography Facilities TBCSP Vendors with 30-Minute Drive-Times



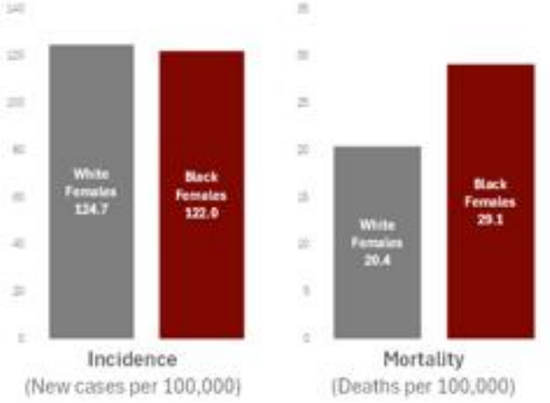
The **breast cancer mortality rate** varies across Tennessee counties. Over half of the counties in the highest breast cancer mortality quartile are in the West and East Regions.



Breast Cancer Mortality (deaths per 100,000)

15.1 - 19.4 | 19.5 - 21.4 | 21.5 - 24.8 | 24.9 - 35.7 | Suppressed

Although the breast cancer incidence rate is similar among white and black females, **black females** have a higher breast cancer mortality rate compared to white females.



Black females are more likely than white females to be diagnosed with breast cancer at late stages of the disease.

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How We Integrated These Methods

ANALYZE

Don't just run and distribute

ASK CRITICAL QUESTIONS

Ask every time: who, what, where, when, why, how

SOLUTIONS-BASED ANSWERS

e.g., Clinic has low uptake - provide TA, find out why, etc.

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Future Planning

What We Learned

STAFF

Staff mindset and stability of positions matter

CAPACITY

Epi capacity influences action

DATA

Data sharing strengthens partnerships

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How We Will Sustain These Efforts

Integration = sustainability

Every major decision is supported by data	Awarding success (e.g., program awards)
Supporting opportunities (e.g., TA for clinics, education for providers)	Strategic planning with the group (e.g., Annual Meeting)

TN Department of Health

Thank You!

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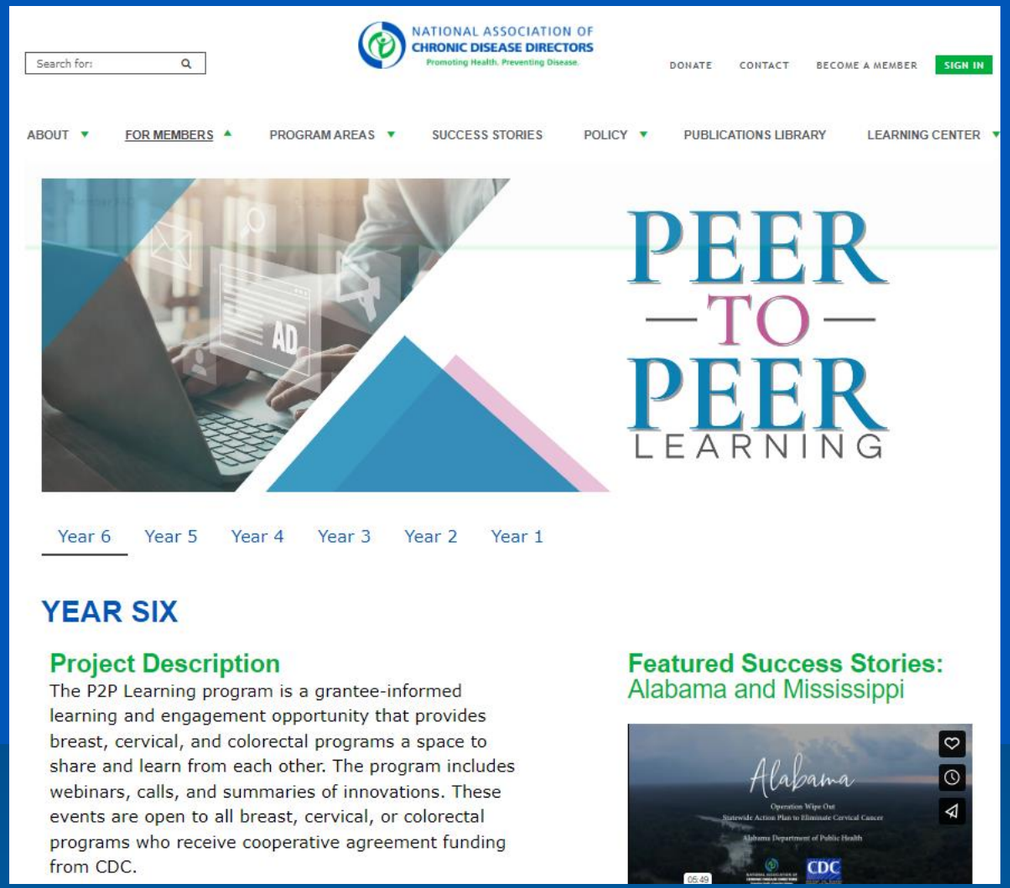
Cancer Programs Administrator

Elizabeth.Berardi@tn.gov
629-230-8561

TN Department of Health

Q&A

P2P Learning Resource Website



www.chronicdisease.org/p2plearning

- Webinar and Call Series Recordings
- Slide Decks
- Resources from Programming
- Summaries of Innovation from Call Series
- Videos
- Access to 30th Anniversary NBCCEDP and CRCCP Virtual Training Content including Virtual Booths

Continuing the Conversation

PEER —TO— PEER LEARNING

Call SERIES
APRIL-MAY 2024

The How: Diving Deeper on Making Change Based on Program Evaluation Data

Call I
April 29, 1:00 p.m. ET

The How: Data
Kick-off Speaker: Lisa Scott, South Carolina

Call II
April 29, 3:00 p.m. ET

The How: Partnerships
Kick-off Speaker: Jennifer Park, North Carolina

Call III
April 30, 5:00 p.m. ET
The How: Integration
Kick-off Speaker: Elizabeth Berardi, Tennessee

Call IV
May 1, 11:00 a.m. ET
Office Hour with Karin Hohman and Leslie Given