FORUM TEAMS REPORT

80% by 2018 Forum
Increasing Colorectal Cancer Screening Rates through Enhanced Partnerships between Comprehensive Cancer Control Coalitions and Federally Qualified Health Centers

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Comprehensive Cancer Control
Collaborating to Conquer Cancer
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In 2015, 11 states applied to participate in the *80% by 2018 Forum: Increasing Colorectal Cancer Screening Rates Through Enhanced Partnerships Between Comprehensive Cancer Control Coalitions and Federally Qualified Heath Centers*. We would like to thank members of the 11 state teams who shared their insights and experiences as they worked to increase colorectal cancer screening rates in their states.

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Introduction

Colorectal Cancer and the Value of Screening

Colorectal cancer (CRC) is the third most commonly diagnosed cancer in the United States and kills more men and women than any other cancer except lung cancer.¹ American men have about a 4.7% risk of developing colorectal cancer in their lifetime, and women have about a 4.4% risk.²

A national study of colonoscopies on 2,602 patients found that patients who had polyp removal had a 53% lower risk of death from colorectal cancer.³ An annual stool-based screening program with multiple randomized controlled trials showed that screened patients had a 25% decrease in mortality from colorectal cancer.⁴

In 2017, an estimated 50,260 people will die from colorectal cancer.¹ Many thousands of lives might be saved with increased screening.

The Challenge: Increase Screening Rates

Nearly 23 million people have never been screened for colorectal cancer. (One in three adults between 50 and 75 years of age).⁵

Screening rates are low among people with lower socioeconomic status, minimal education, and limited or no access to care. Follow-up of screening abnormalities is also lower among racial and ethnic minorities. Screening rates are especially low among Hispanics and recent immigrants.

Community health centers (CHCs) largely serve these populations. In those centers, the average national screening rate for colorectal cancer in 2012 was 30.2%.⁷ Rates ranged from 7.6% in Oklahoma to 52.6% in Vermont.⁸

These regional disparities suggest that CHCs have tremendous potential to improve colorectal cancer-screening rates. They also have the potential to reduce colorectal cancer morbidity and mortality in racially and ethnically diverse, socioeconomically challenged communities across the country.

The Goal: 80% by 2018

The 80% by 2018 initiative is supported by the American Cancer Society® (ACS), the Centers for Disease Control and Prevention (CDC) and led by the National Colorectal Cancer Roundtable (NCCRT, an organization co-founded by ACS and CDC).

These organizations are working toward the shared 2018 goal of regularly screening 80% of adults aged 50 and older for colorectal cancer.

The recommendations are designed to help CHCs to:

- Provide education on appropriate and high-quality screening.
- Screen patients.
- Track follow-up of screening and results.
- Build networks between providers and health systems.
The 80% by 2018 Forum

Teams of stakeholders representing state Comprehensive Cancer Control programs and coalitions, Federally Qualified Health Centers (FQHCs), primary care associations, local health departments and others within the states, were invited to apply to participate in the 80% by 2018 Forum: Increasing Colorectal Cancer Screening Rates through Enhanced Partnerships between Comprehensive Cancer Control Coalitions and Federally Qualified Health Centers.

Comprehensive Cancer Control (CCC) is an approach that brings together diverse partners and organizations to develop and implement plans to reduce the burden of cancer in local communities. CCC programs have been established in all 50 states, the District of Columbia, 7 tribes and tribal organizations, and 7 U.S. territories and Pacific Island Jurisdictions.

The Comprehensive Cancer Control National Partners (CCCNP) is a collaborative group of diverse national organizations working together to build and strengthen CCC coalition efforts across the nation.

The meeting was initiated under the leadership of the Comprehensive Cancer Control National Partners (CCCNP). Meeting sponsors included the American Cancer Society, the Centers for Disease Control and Prevention, National Cancer Institute and the National Colorectal Cancer Roundtable. The Health Resources Services Administration and the National Association of County and City Health Officials were also primary supporters of the meeting.

The 80% by 2018 Forum was designed to enhance the capacity of states to implement evidence-based interventions to increase screening rates for colorectal cancer. The 1½-day event included expert presentations and panels on essential evidence-based strategies and tools, as well as interactive state team action-planning sessions.

The 80% by 2018 Forum was created to:

- Facilitate the creation of evidence-based action plans by the 11 state teams.
- Present proven strategies that advanced local implementation of state cancer plan CRC screening objectives, through the collaboration of stakeholders such as local health departments and Federally Qualified Health Centers.
- Provide training on the use of existing tools and resources designed to help increase CRC screening rates. Training included The Guide to Community Preventive Services and Implementation and Research-Tested Intervention Programs (RTIPS).
- Cultivate new, and strengthen existing, relationships between CRC state and local stakeholders. Stakeholders included Local Health Departments, Federally Qualified Health Centers, Primary Care Associations, and GI Experts.
- Explore how CHCs can integrate evidence-based colorectal cancer screening into practice, with the help of multilevel collaborations. Additionally, inform subject-matter experts about implementation challenges faced by Community Health Centers.
Selection Process

Teams were asked to present an application for consideration by submitting the following information:

- How the teams expected to benefit their states.
- A list of individuals who would represent them at the Forum.
- The state of the collaborative relationships between the organizations represented in their team.
- The current colorectal cancer screening priorities of the partner organizations.
- Past successes of the partner organizations in implementing evidence-based CRC screening interventions.
- Past challenges experienced by partner organizations in implementing CRC screening interventions.

Teams were partially selected based on their level of readiness to develop and implement a plan, as well as their ability to engage full representation throughout their geographic regions. See Appendix 2 for information about the teams prior to the Forum.

The 11 Teams

The 11 teams selected were from: Arizona, California, Florida, Georgia, Michigan, Mississippi, New York, Pennsylvania, South Dakota, Texas, and Vermont. Teams were expected to incorporate the information gained at the Forum into their collaborative action plans before executing the plans.

Technical Assistance Process

A Technical Assistance (TA) process was provided to state teams after the Forum concluded. Bimonthly calls were conducted with each team to help them progress toward implementation of their action plans.

The main objectives of the TA process was to review CRC screening objectives, discuss progress and opportunities, identify barriers and possible options for resolution, and provide resources.

Another key objective was to track and communicate challenges and successes to the CCC National Partners. The results of the TA process are being used to help guide future initiatives.
Action Plans Developed During the Forum

Each Forum team developed a plan of action steps to carry out during 2016. The Technical Assistance process supported them in achieving their plans. Individual team action plans can be found in Appendix 1.

**Arizona**

Arizona’s plan revolved around three main areas:

- Partnership Development and Coalition Building: To successfully convene a state CRC roundtable with a minimum number of partners in attendance; a diversity of backgrounds and skills; and built-in future sustainability.
- Establishment of a Patient Navigation Program: To establish a sustainable CRC screening Patient Navigation Program with the necessary policies to support it and the funding to keep it going.
- Screening Rates: To increase the Uniform Data System (UDS) CRC screening rate.

**California**

California’s plan was divided into quarters. They intended to identify and build regional partnerships throughout the year. In the first half of the year they would assess the feasibility of a grant/pilot project. If feasible, in the second half of the year they would implement the project. They would also work year-round on initiating legislation to support CRC screening and on lowering the cost of FIT testing.

**Florida**

Florida’s plan was focused on building collaborative structures for their statewide CRC screening efforts. Their plan was to organize a steering group to build upon the collaboration started during the Forum. They would then expand that collaboration by identifying additional stakeholders and establishing a business model. Their plan also included “blue sky” goals like establishing a statewide cancer screening registry, telemedicine navigation, mentoring systems, and addressing of financial barriers.

**Georgia**

Georgia’s plan emphasized five areas:

- Pursuing the establishment of state policies to support more widely available CRC screening.
- Engaging the general community, businesses, and corporations to increase employer and employee engagement in CRC screening; and establishing employer policies to support the increased engagement.
- Creating “medical neighborhoods” involving hospitals, endoscopists, and other specialists to increase the availability of screening and care for the uninsured.
- Boosting use of patient navigation and attendance at screening practices through pricing adjustments, business model development, dissemination of educational materials for the public, and training.
- Providing support and training to primary care practices to help them better implement CRC screening-related activities.
Michigan

Michigan set a concrete goal of accomplishing a CRC screening rate of 80% statewide. Other, softer goals for the year included:

- Increasing awareness of **80% by 2018** among partners and the community.
- Gathering actionable data to increase stakeholder buy-in.
- Developing strong, trusted relationships with FQHCs.
- Increasing availability of donated FIT tests.
- Making colorectal cancer a quality measure for Medicaid.

Mississippi

The Mississippi team set out to achieve the following within a year:

- Migrate from fecal occult blood tests (FOBT) to FIT tests in their plan.
- Encourage the GI community to offer free screenings.
- Implement data metrics (UDS) at FQHCs.

Some of the evidence-based interventions (EBIs) they intended to implement included:

- Patient reminder systems.
- Provider education.
- Presentations of data and evidence.
- Developing a small media plan.

New York

The New York team intended to meet on a regular basis and add other members that would help accomplish their action plan goals. Their focus was on three distinct evidence-based strategies to increase cancer screening rates within FQHCs:

- Promotion of FIT testing
- Small media
- Patient navigation

The plan was to target FQHCs, the State Cancer Consortium general membership and quality improvement staff at health plans especially those serving Medicaid clients. The team also intended to survey all 65 FQHCs in the state to assess their needs and inform how best to use the evidence-based strategies to educate and fulfill any gaps.

The New York team intended to develop two distinct models by year-end for their CRC work: one for upstate and one for downstate. Another important objective was to assess what policies were in place in New York to support CRC screening.
Pennsylvania

The main focus of the Pennsylvania team’s plan was coalition-building towards attaining the 80% by 2018 goal. They set out to increase stakeholder engagement by identifying barriers, strategies, and interventions that would engage stakeholders in a statewide plan with a definite timeline.

The EBIs highlighted in their plan included:
- Training and technical assistance.
- Implementation of Patient Navigators and Community Health Workers.
- Implementation of FluFIT screenings.
- Promoting an increased use of EBIs by FQHCs, hospitals, employers, legislators, payers/insurers, and the private sector.

South Dakota

South Dakota divided their plan into quarters.
- During the first quarter, they intended to determine the EBIs to be used; perform gap analysis; identify key partners; and consolidate their plan.
- During the second quarter, they would assess FQHCs through surveys, in-person meetings, and other forms of data collection.
- The third quarter of their plan involved identifying and training FQHC organizational teams, champions, and site leads.
- Finally, in the fourth quarter the team contemplated implementing the EBIs, adjusting the plan as necessary, and evaluating results.

Texas

The Texas team defined three stages for their plan, expressed in very general terms:
- Planning: Complete a needs assessment and environmental scan of programs, populations, and providers in the state.
- Assembling: Create a CRC Screening and Planning Committee, including key organizations and stakeholders.
- Screening: Use each organization’s assets to increase screening within the state, using EBIs.

Vermont

The Vermont team organized their plan around the following strategies:
- Create a strong, statewide network by increasing communications and informing relevant people about the status and progress of CRC screening.
- Create two or three small media pieces on Make It Your Own (MIYO), as well as a distribution plan.
- Train facilitators to implement EBIs in all involved organizations.
- Implement FluFIT screenings by addressing insurance issues, data concerns (Electronic Medical Records [EMRs]), and assessing previous FLU clinics.
- Bring small media to primary care facilities in the form of decision-making aid tools.
Interviews With 11 State Teams

Final project interviews were completed at the end of 2016 to capture each Forum team’s successes, challenges, best practices, and next steps. This section provides an overview of lessons learned and a discussion of the interview findings.

The information in this section is based largely on transcripts from those interviews and team progress reports.

Evaluation Questions

Evaluation questions used during the telephone interviews with each of the 11 teams included:

- What was the role of the CCC program or coalition in planning and implementing your interventions or activities?
- What positive results did your team’s efforts bring about? What were the impacts?
- What didn’t go well? If the team had it all to do over again, what would they do differently?
- What recommendations would you make to others doing similar projects?
- Are there any new best practices you could share?
- What are the next steps in your team’s plan?
- How will you sustain your efforts?

Analysis

All interviews were transcribed and reviewed multiple times. Recurring themes and recommendations were identified and these were grouped according to relevant categories.
Lessons Learned

The following section provides an overview of important themes from the qualitative interviews with representatives of the 11 Forum teams. Areas addressed include: forum benefits, promising practices, challenges, and approaches to support sustainability.

Forum Benefits

Participants reported that the Forum helped them to form, re-energize, and sustain productive partner relationships.

People said the Forum helped them to:

- Form strong partnerships.
- Achieve concrete results.
- Improve sustainability of the project.
- Form new partnerships.
- Re-energize existing partnerships.
- Attain a new level of richness and diversity of collaboration.
- Increase momentum and enthusiasm in the partners.
- Generate new ideas.
- Increase productivity because of personal relationships.
- Identify more realistic goals, with the help of facilitators.

Promising Practices

Forum participants recognized that standardizing processes and utilizing team-based approaches improved outcomes.

The team-based approaches included: engaging appropriate participants; defining clear objectives and developing action plans; and using schedules, agendas, and technologies to promote efficient and effective teamwork.

Team members identified the following best practices:

Partnerships

- Include relevant partners for better problem-solving.
- Broaden team membership to reach new communities and populations, and to access new partnerships and resources.
- Leverage diverse participants to affect different areas of the health system.
- Educate partners to develop more support and commitment.
- Different cancer groups had overlapping functions and responsibilities, which could hinder clear delineation of objectives, participation, and accountability.
Action Plans

- Use the Forum action planning process as a decisive starting point.
- Take specific actions as soon as possible after the Forum.
- Use specific written action plans to gain support from partners.
- Use accountability methods to increase the impact of plans.
- Small-scale interventions should be tested before committing larger resources.

Meeting Practices and Processes

- Create structures for scheduling and tracking recurring meetings.
- Use outside meeting facilitators for improved communication and focus.
- Schedule regular meetings to maintain cohesion among participants.
- Implement regular communication among participants.
- Use clear objectives to focus roundtable meetings.
- Use predetermined agendas to keep meetings short and efficient.
- Support project champions with adequate information and resources.
- Use technology to organize teams, track attendance, and share files.

Sustainability

Participants said that:

- Committed people help projects move forward, regardless of circumstances.
- Including and involving relevant partners increases project sustainability.
- Existing CCC programs and coalitions provided needed infrastructure for the projects.

Challenges

Participants identified several factors that impacted the action plan implementation process:

- Lack of funding for patient screening navigation is a major challenge.
- National education information requires adaptation to local state needs.
- In-person, full-day training is a time burden for some healthcare staff and providers.
- Team members are often very busy people with demanding day jobs and have limited time to devote to additional projects.
- Project goals proposed in team meetings are sometimes too lofty or complex to implement.
- Access to quality data is required to form baselines for EBIs.
**Key Takeaways**

- The Forum helped states coordinate their efforts and resources, develop partnerships, and increase project sustainability.
- The CCC infrastructure increases project sustainability.
- Including and involving key partners increases project sustainability.
- Committed people help projects move forward, regardless of circumstances.
- Standardized processes can increase team productivity.
- Patient navigators are a critical success factor in screening.
- Lack of funding for patient navigators is a major challenge.
Interview Findings

The following section presents information from qualitative interviews with representatives from the 11 Forum teams. The findings highlight important themes; however, they are not meant to reflect the sentiments of all of the Forum teams, state programs, and coalitions.

All teams participating in the Forum process had valuable successes, insights, and best practices to share. In the sections that follow, selected quotes are included to provide context and illustrate key concepts. Not all states are mentioned in all sections.

What Was the Role of the CCC Program or Coalition in Planning and Implementing Your Interventions or Activities?

The role of Comprehensive Cancer Control in the development and implementation of Forum action plans varied from state to state.

Some of the CDC-funded CCC programs had staff changes over the course of the year. At times, when a position was vacant, there was limited or no CCC program staff participation. Following are some selected examples of CCC roles in the action planning process.

The CCC coalition’s participation in South Dakota:

The coalition implemented the action plan and oversaw the strategy for the state cancer plan. The group discussed the best ways to ensure accountability. – South Dakota Team

Florida described a network of organizations and strong relationships. One way the CCC coalition supported Forum activities was by releasing a request for proposal for grants to support community-clinic linkages around CRC awareness and screening:

The south Florida regional collaborative purchased a giant inflatable colon. Four different systems, including hospitals and FQHCs, hosted educational programs featuring the giant colon. A patient navigator was present to sign up eligible participants for their screening. – Florida Team

Pennsylvania expressed that after the summit, the CCC program played an “integral role,” providing infrastructure to maintain momentum.
Georgia expressed this about the role of their CCC coalition:

> CRC and HPV are two active areas of the cancer plan, and there is strong collaboration among coalition partners to implement next steps. – Georgia Team

Vermont stated that the CCC program submitted the team’s original application to the Forum. CCC also collaborated with ACS to facilitate the meetings to push the project forward. They called CCC a “true lead” in their project, with “heavy involvement.”

According to the Michigan team, the CCC program “provided support and coordination” to the Forum team, as well as administrative support. One of their most important initiatives was to create a letter that advocated for making CRC screening a quality measure for Medicaid in their state.

The letter was drafted and reviewed by a workgroup of the *Michigan Cancer Consortium*, and was approved by their board of directors. The team expressed their optimism about the possibility of succeeding at this measure:

> If the group achieves CRC screening as a quality measure, they believe there will be significant progress. When a health plan is incentivized positively, there will be progress. – Michigan Team

California expressed that CCC played a “big role” in planning their CRC screening activities, providing infrastructure for their efforts and assisting in “bringing everybody together.”

**What Positive Results Did Your Team’s Efforts Bring About? What Were the Impacts?**

**Strong Partnerships**

Arizona’s team found success in strong partnerships, achieving concrete results and improving the sustainability of the project:

> The Arizona Alliance for Community Health (AACH) provides technical assistance to FQHCs about the data they should pull. AACH continues to work with the tribes, even though there are no colorectal funds. The partnership continues to grow and develop. – Arizona Team

Through their close relationship with health plan organizations, the Arizona team was also able to implement a statewide cancer screening report card that integrated live data about different types of cancer prevention interventions from multiple partners.
California's experience was similar to Arizona's. They emphasized the benefits of the Forum itself as a catalyst for the formation of new partnerships and for re-energizing existing partnerships. They found the experience to be a real turning point into a new level of richness and diversity of collaboration in their region.

Georgia and New York expressed similar benefits from attending the Forum to solidify partnerships and increase momentum and enthusiasm in the partners.

**The Forum provided an opportunity to continue discussions and determine how to integrate cancer screening as a priority, sustain momentum, and do it feasibly.** – California Team

**The Forum was a great starting point, bringing the team together to generate new ideas. The breakout session on EMRs/EHRs was very important. It was a reminder that what may theoretically seem straightforward is a lot harder to implement.** – Georgia Team

**This was an important opportunity to bring together entities from around the state that are working on a particular initiative, and to advance it.** – New York Team

Florida emphasized the importance of bringing high-level leaders to the table when building partnerships. Their presence made it easier to get actionable commitments to the project:

**The group is bringing healthcare leaders to the table, engaging them and inspiring them to make a commitment. Chief medical officers, CEOs, COOs, gastroenterologists, endoscopists, hospital systems, FQHCs, and health plans are the priority audience.** – Florida Team

Florida also identified ACS as a valuable partner:

**The ACS team of health systems representatives are in the communities, making connections, and providing materials and resources to those individuals within the system, generating great response to the invitation.** – Florida Team
The team also partnered with the *Florida Cancer Data* system to develop statistical analysis tools to help them identify counties that had the greatest number of late-stage CRC diagnoses. Assuming this was an indicator of a higher need for CRC screening, they proceeded to target these counties in their efforts.

Volunteers from the community can create a map and share it with providers who may not know that they’re in a high-risk area for late-stage diagnoses. – Florida Team

Georgia’s team highlighted the importance of developing strong relationships with team members and representatives from partner organizations. The team hosted their first Roundtable in 2016 and are actively planning for the second roundtable to be held March 15, 2017. Team members found that the quality of their personal relationships significantly enhanced their productivity and capacity to move forward with the project.

The Vermont team committed to “creating a strong statewide network” as part of their plan:

The team invited some representatives from the Office of Local Health and from a county FQHC with seven practices that covered 80% of the county. These members enabled the team to connect with offices of Local Health in Vermont to do a colorectal cancer quality improvement project. – Vermont Team

Mississippi said the following about their efforts:

At the state level, there has been considerable support and involvement in the initiative as set forth by the larger 70% by 2020 group. – Mississippi Team

**Creative and Effective Ideas**

Florida collaborated with the CCC program to test an innovative idea that was successful and that will be repeated:

Initially, the Florida regional collaborative purchased a giant inflatable colon for four different healthcare systems to host educational programs. It was so well received that the team has plans to continue using the inflatable colon to increase screenings within different hospital systems to educate patients. – Florida Team

Another innovation from the Florida team was a colonoscopy calculator to help providers more accurately estimate the size of their commitment. Having advance knowledge of the number of potential colonoscopies made it easier for providers to budget their workload and proceed with confidence.
Vermont’s team recommended a similar approach as a best practice. In their experience, having a specific donated care request made it easier for potential donors to decide to participate.

The Mississippi team was involved in creating a CRC public service announcement (PSA) featuring Dak Prescott, former quarterback at Mississippi State (now with the Dallas Cowboys).

The PSAs were aired on several different stations throughout central and northern Mississippi. The hope is that they will be picked up statewide. – Mississippi Team

Education and Awareness

The Michigan team worked on increasing awareness and education. They created a CRC toolkit that was sent to all of their coalition members.

They also created fact sheets with infographics that were featured on the www.michigancancer.org (Michigan Cancer Consortium) website, to increase awareness of the 80% by 2018 initiative.

Another important post-Forum success for the Michigan team was the completion of a CRC screening training, with multiple FQHC partners attending.

Through the training, the team was able to assist FQHCs with clear steps to increase screening rates. The evaluations for the training were very positive, with FQHCs saying it was enjoyable and useful. – Michigan Team

Building on Existing Initiatives

The Mississippi team found success in integrating their project with another significant CRC initiative that already existed in their state. They recognized the potential for collaboration while they were at the Forum and designed their action plan with coordination in mind.

There is a volunteer structure in place for each task force. Each group is implementing evidence-based interventions and focusing on a particular audience that includes state employees, large employers, veterans, and military personnel. – Mississippi Team
Adapting to the Needs of a Target Audience

New York’s team implemented a survey among FQHCs to find out how to assist them in achieving the 80% by 2018 goal. The results of the survey indicated a need for patient education tools.

The team sought input from partners across the state as well as from key stakeholders. They learned that FQHCs wanted patient education materials for their organizations.

We are working with the creators of Make It Your Own (MIYO) on a webinar for FQHCs so that clinics realize that there are resources that are easily accessible and easy to use. – New York Team

Bringing Accountability to All the Partners

The Pennsylvania team developed templates to track goals and action steps, as well as reporting standards to assist their partners. The team will also request partners to commit to action planning in exchange for receiving technical assistance.

Roundtable members will receive technical assistance from experts across the state who have achieved successful outcomes with colorectal cancer initiatives. Members will come with a plan and then refine it, and those that don’t have a plan, will develop one. – Pennsylvania Team

Finding the Right People

The Vermont team was enthusiastic about the opportunity to develop new relationships and strengthen existing ones.

When the team returned from the Forum, everyone was eager to do something, and a year later that is still the case. It was a combination of bringing the right people – a great team – to the table, and an energizing training. – Vermont Team
What Didn’t Go Well? If the Team Had it All to Do Over Again, What Would They Do Differently?

Funding a Patient Navigator

Several teams said that the patient navigator role is a critical success factor in CRC screening, and that lack of funding for patient navigators is a major challenge:

Local FQHCs need patient navigators to help people through the colonoscopy and FIT testing screening processes. – Arizona Team

When recruiting volunteer physicians, it is very important to have patient navigators in place. The team learned that South Carolina was successful in continuing to recruit physicians to provide volunteer colonoscopies because patients were navigated well. They were prepped and always showed up. – Florida Team

Adjusting for Geographical and Cultural Differences

California’s team members experienced a learning curve after the Forum. The education they received was very valuable, but they needed to determine how to adapt the information to their state needs. They noted that the states are likely to have specific challenges that cannot be addressed during a national meeting, so tailored follow-ups would be helpful.

They also noted that not all stakeholders attended the Forum, so some perspectives about what might or might not be feasible, were not addressed. Once they convened the broader group of stakeholders and mapped out what was feasible the target activities for the action plan were changed.

California found it was important to adapt educational efforts to the different needs of the participants. For example, implementing educational efforts that required medical providers to take a whole day for training was a challenge for healthcare providers in some areas.

The team decided to create 15-minute videos to enable physicians and team members to review them at their convenience and progress through the material at their own pace. In other areas of the state this was not an issue so they proceeded with the one-day trainings as originally planned.
Vermont experienced similar challenges with their educational interventions, and is also considering using a webinar format:

The team planned an in-person training with a webinar option, and the healthcare staff chose the webinar. It is challenging to reach the providers and staff to arrange the time for an in-person training. – Vermont Team

Georgia’s team shared that because the Forum was held in their state, they experienced an issue with member participant turnover during the actual event. It was easier for team members to skip parts of the event and get caught up in their day-to-day activities because the Forum was local.

Florida noted that it is challenging to implement systems changes or enhance access to care for the uninsured or underinsured in privately funded hospitals in Miami Dade county. Access and screening costs are barriers for many patients.

Managing Resource Constraints

The Georgia team experienced a significant challenge with losing their CRC funding right before the Forum. Their director for colorectal cancer, who composed their application, was no longer with the team by the time the Forum started. They shared how this affected them before, during, and after the Forum.

The Georgia team found that while the goals they set for themselves during the Forum were “lofty” and inspiring, the realities of managing their day-to-day workload plus trying to accomplish their Forum goals was challenging. They suggested that future Forums might consider using facilitators to emphasize the viability of the ideas being presented, given the operational realities of the team.

The roundtable is a wonderful approach, and the team has accomplished some great work. It is also important to recognize that many members are very busy people who are well-respected within their fields and, while they have a huge passion for colorectal cancer and/or 80% by 2018, they also have demanding day jobs. – Georgia Team

Negotiating Access to Data

Teams also mentioned that access to quality data is required to determine baselines when implementing EBIs. South Dakota directly exemplifies the problem:

It can be challenging at times to obtain the needed data – baseline numbers. The team is working on making population health data more transparent and available. Three or four years down the road, they imagine knowing all the available CRC quality measures for their communities and health systems. – South Dakota Team
What Recommendations Would You Make to Others Doing Similar Projects?

Managing the Complexities of Collaboration

Several states found that the different cancer groups, organizations, task forces, coalitions, and other bodies at times had overlapping functions and responsibilities. Clear delineation of objectives, participation, and accountability can help groups negotiate these challenges.

Arizona recommended clarifying the roles of all participants in meetings so that everyone is clear about their tasks and responsibilities.

Florida also touched on this issue from the perspective of effective collaboration. They emphasized the importance of moving forward while harmoniously coordinating with partners to avoid duplications and inadvertent obstructions of effort.

Testing Before Implementing

South Dakota discussed their experience with successfully implementing EBIs. They believe there is a value to testing interventions at a small scale to ensure that they work before committing larger-scale resources.

When the team started, they were working with a smaller number of clinics that had some funding. Through experience they learned what interventions could have the most impact. They found that provider assessment and feedback was very important. If you haven’t tested the activity or approach before, do a small pilot. – South Dakota Team

Going Straight to the Source

South Dakota shared a lesson learned regarding an assessment of FQHCs that was part of their implementation plan.

When creating a plan for donated colonoscopy services, the team found it can be helpful to ask FQHC leaders/CEOs: “We want to help you get some donated colonoscopies, will you partner with us on a request that would include your data?”
Are There Any New Best Practices You Could Share?

Maintaining Momentum and Accountability

Several teams noted that creating the necessary structures for recurring meetings and tracking their progress with **80% by 2018** were factors for success.

Involving as many relevant partners as possible in these recurring meetings made them more effective at solving problems. Access to resources needed by the team also promoted success. The Arizona team shared their experience with changes in their structure:

> The team decided to transform the colorectal cancer roundtable into a task force that will be meeting quarterly. The chair will be a part of the Arizona cancer coalition steering committee, so they can report on what is happening to the rest of the steering committee. – Arizona Team

The Arizona team also found that another way to support momentum and accountability was to bring in an outside facilitator to run their meetings:

> An outside professional facilitator keeps the room energized, on-task, and moving forward. This enables everyone to participate. – Arizona Team

California's team expressed the importance of communication structure and regular meetings to maintain cohesion among team members, given their many competing priorities. They found the Technical Assistance process beneficial:

> Being able to verbally speak about activities and evaluate next steps for 1-2 hours is helpful. – California Team

The Florida team expressed a similar opinion. They added that discussing improvements and innovations in regular meetings keeps the team engaged.

Vermont also emphasized the importance of regular communication between project partners. They found it valuable to keep partners informed of what is happening in CRC screening statewide and, if possible, nationally.
The Pennsylvania team shared their positive experience of taking action after the Forum and networking widely:

The team left the Forum with an action plan, and a few months later they held a statewide summit with over 160 attendees. Participants broke into specialty groups revolving around health plans, hospital employers, and Federally Qualified Health Centers. Everyone attending the summit built upon the action and provided input into what became a more detailed strategic plan. – Pennsylvania Team

Being Specific and Action-Oriented

The Arizona team also found it easier to gain support from partner organizations by having an action plan with specific goals. They said that well-written action plans that “sit on the shelf” do not have the same impact as plans with built-in accountability:

Another key state partner called because we had developed an action plan. People don’t want to attend meetings that don’t result in action and follow-up. – Arizona Team

The Georgia and New York teams pointed out the importance of being specific about the objectives for a roundtable from its inception. They also recommended inviting people who have a track record of getting things done.

Be specific about the meeting objectives and next steps, whether it is one meeting where people exchange information or an ongoing activity. When bringing people together, consider whether there will be work happening in between, afterwards, and long term and prepare participants as needed. – Georgia Team

Be clear about why people are meeting. A possible approach is having one group for coordination and another for implementation. – New York Team

The Texas team shared a similar idea around keeping coalition meetings as short as possible. They endorsed using a pre-determined agenda to clarify individual roles and responsibilities and to conduct meetings with a clear focus. They favored asking attendees to complete some pre-meeting tasks to keep meetings short and efficient.

The Vermont team agreed that having a specific action plan was very important for moving forward. They found the Forum was a decisive starting point for them:

It was useful to sit down and create an action plan. An action plan provides a clear starting point. The Forum action planning process, in particular, was very helpful. – Vermont Team
Extending the Network

Arizona recommended researching potential attendees and creating invite lists for meetings. The team felt that broadening the base of people involved created opportunities for new partnerships and new resources.

> There are a dozen health plans participating now – a mix of Medicaid and private sector providers. This dialogue between the health plans and the health department is a new step. It took time to find and engage new members, but it was worth it. – Arizona Team

Georgia's team also recommended having a diverse group of steering team members. A diverse team has influence in different parts of the healthcare ecosystem and can leverage their relationships to benefit the project. They stressed the importance of having members from the G.I. community and hospitals.

Working with Committed Partners

Partner buy-in repeatedly surfaced as an important factor for success. Creating committed partnerships required educating partners on the benefits of the 80% by 2018 initiative, and inspiring them to support it.

> What was built through the CDC colorectal cancer control program was essential to moving forward. Partner support was also really important, but the fact that there was a strong foundation built through the program helped the team to keep going even without funding. – Arizona Team

Supporting Champions

The Georgia team highlighted the importance of having champions to promote the mission and goals of the group, and to support those champions with adequate resources:

> Provide support for the champions and leaders. All the teams' work groups have a project manager that helps with the agendas, the Doodle polls, the scheduling of meetings, the meeting notes, and reminders. – Georgia Team
Automating When Possible

Texas compensated for funding and staffing limitations by using technology tools to organize their regional CRC summit after the Forum:

The team used a few systems such as an online RSVP system that made the logistics much easier. There was a link that could be sent out and shared widely. People were able to easily respond, and attendance was automatically tracked.

The team also set up a Box.com account (which is similar to Dropbox). They have a shared repository of alliance documents, and each work group has their own folder. – Texas Team

How Will You Sustain Your Efforts?

Educating for Lasting Momentum

People who are aware of the stakes and understand the impact of the initiatives are motivated to find ways to keep the work moving forward. This information can be the seed of sustainability. Involving all partners in this way can create lasting momentum.

The team is doing all of this because they are committed to the cancer coalition. Even though we have limited funding, we continue to move forward. – Arizona Team

As long as we have a strong group of people who are willing to pool their resources, this group will be sustained beyond just this project. The group has been established as a separate work group of the coalition, so it’s going to be there. – California Team

Developing Rich Partnerships to Promote Longevity

Pennsylvania’s team shared their strategy for sustainability: inclusiveness and involvement of all relevant partners to maximize possibilities for long-term project survival. They organized a regional summit immediately following the Forum.
The team created a summit planning group that was representative of many specialty organizations: groups like the Gastroenterology Association, the Commission on Cancer, Pennsylvania Association of Community Health Centers, and some health plans.

The summit planning partners were the Pennsylvania Department of Health, Comprehensive Cancer Program, and the American Cancer Society. To ensure a level of sustainability going forward, they created infrastructure revolving around the comprehensive cancer coalition. – Pennsylvania Team

The Arizona team also demonstrated resiliency and a commitment to sustainability. Upon finding out they were not receiving the CDC funding they were expecting, they found ways to keep their CRC screening project going, and their partners supported them:

The team committed to ensuring the work would continue, despite funding challenges. Coalition partners agreed to continue coming to the table. One partner paid for a venue for the roundtable. Another partner paid for facilitation. – Arizona Team
Closing Summary

The report summarizes the views of 11 teams that participated in the 80% by 2018 Forum on Increasing Colorectal Cancer Screening Rates. The Forum provided an opportunity for teams to develop new relationships and build on existing ones. Subject matter experts and resources were available to help the teams coordinate their activities and create action plans.

As work on the action plans began, the commitment of partners and their ability to leverage key resources facilitated progress. Standardized processes and technology helped the teams maximize their efforts. All of these factors, as well as existing CCC infrastructure, supported the work and increased the possibility of the teams continuing their activities.
Appendix 1 - State Team Action Plans

**FORUM TEAMS REPORT**

**ARIZONA**

### 80% by 2018 Forum Action Plan

**EBI: PARTNERSHIP DEVELOPMENT/COALITION BUILDING**

**GOALS/OUTCOMES**

- Explore different PN models
- Explore different PN financing mechanisms
- Seek different external funding sources
- Expand partnerships
- Expand use of technology to assume some PN functions (e.g., client reminders)
- Joint grant planning ACS

**RESOURCES**

- Trained PNs
- Funding
- SME/technical support
- Policy support

**RESPONSIBILITIES**

- CHC Qi committee
- Health department
- ACS

**COMMUNICATIONS**

- C-Suite FQHCs/IHS
- Qi staff
- Providers/champion
- Cancer coalition
- Tribal programs/leadership

**SUCCESS**

- Established PN program
- Sustainable funding
- Policies to support PN

---

**EBI: PATIENT NAVIGATION**

**ARIZONA**

**ACTIONS**

- Assemble planning team
- Identify stakeholders
  - Plan for those who need to participate, but may be reluctant
- Obtain ACS elements of a roundtable
- Create timeline
- Assign responsibilities

**RESOURCES**

- Funding (currently available)
- Engaged coalition
- Other state roundtables/peers
- ACS
- Colon Cancer Alliance

**RESPONSIBILITIES**

- Health department
  - Contact, stakeholders, timeline, resources
- ACS
  - Contact, stakeholders, timeline, resources
- Dana
  - IHS

**COMMUNICATIONS**

- Stakeholders
- SMEs/speakers
- Develop communication plan/meeting promotion
- Tribal leaders/IHS/Urban Indian Health

**SUCCESS**

- Roundtable convened
  - # of partners
  - Diversity of participants
  - Sustainability
**80% by 2018 Forum**

**ACTION PLAN**

**GOALS & ACTIVITIES**

1. Identify & build regional partnerships
2. Assess feasibility of potential grant/pilot/project
3. Implement a grant/pilot/project: CRC Screening Improvement Project (CRCSIP)
4. Evaluate grant/pilot/project
5. Legislation – initiate process
6. Promote to distribute discounted arrangement for FIT
80% by 2018 Forum

**ACTIONS**
- Organization of a steering group
  - Follow-up from this meeting
- Develop communication plan
- Build on existing work
- Identify additional stakeholders
- Establish a business model

**COMMUNICATION RESOURCES**
- Condensed electronic resources
  - From this meeting
  - Florida-specific
  - Branded 80% by 2018

**BLUE SKY**
- Statewide cancer screening registry
- Telemedicine navigation statewide
- Systematic mentoring systems by systems of successful models
- Addressing financial barriers
80% by 2018 Forum ACTION PLAN GEORGIA

Primary Care Practice Support
- Practice Facilitation / Detailing
- EHR Use
- Project ECHO
- Internal QI Capability

Policy
- Regional Cancer Coalitions (5)
- Funding
- Other Legislative
- Organizational Insurance/Third Party Payer Coverage

State & Local HDs
- Navigation Models
- Pricing
- Expansion
- Training

Screening, Navigation, Dissemination

Medical Neighborhoods
- Hospitals
- Endoscopists
- Other Specialists
- Links to Care for the Uninsured

Data Support & Surveillance
- Employer & Employee Engagement
- Awareness
- Employer Policies

Community & Corporate
**FORUM TEAMS REPORT**

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**80% by 2018 Forum**

**ACTION PLAN**

**MICHIGAN**

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**STEP 1**
- Make data actionable
- Evaluate communication needs
- Engage marketing people
  - Better characterizing program, including champion fact sheets
  - Start pulling data: 1-2 pager in PowerPoint, 2-3 minute video message
- Schedule follow-up calls one month from now

**STEP 2**
- FQHC training
  - Send to team for input
  - Reach out to UMHS
  - DX vs. screening insurance
  - Address DX colonoscopy billing by getting health plans to change policy voluntarily; or engage insurance commissioner
  - Reach out to ACS-CAN person
- FQHC perspective gained by group

**STEP 3**
- Colon equality
- Medicaid: get colorectal cancer screening as a quality measure
  - Engage ACS-CAN (state)
- Training event at MPCA for all players (clinicians, QI, billing)
  - Programming for training event

**STEP 4**
- 80% by 2018 awareness: getting the governor on board
  - Reach out to the governor’s office

**STEP 5**
- FQHC training - follow-up Task Force
  - Includes evaluation
  - Determine if they want technical assistance

---

**one year from now**

- Public and partners are more aware of **80% by 2018**
- Data is actionable to achieve stakeholder buy-in
- MI Cancer Consortium is a leader in this area
- Barriers reduced for patients receiving services at FQHCs

- MI team has strong, trusted relationships with FQHCs
- Research initiated on FLU/FIT use in FQHC
- Champion identified to donate FITs
- Colorectal cancer is a quality measure for Medicaid
What will be different a year from now as a result of your work?
► Will use UDS data in evaluating/measuring (data/metrics) for use at FQHCs
► Move from FOBT to FIT in the plan
► Involve GI community in solution on providers

What evidence-based strategies will you use?
► Patient reminder systems
► FIT vs. FOBT and increasing FluFIT
► Provider education
► Data/evidence presentations

Are there stakeholders who might resist? Barriers? What barriers can become opportunities?
► Might have provider resistance to seeing patients for screening
► Lack of insurance preventing acceptance of patient ____?____ FIT
► Any stakeholder ____?____ financial interest in providing up-front costs
► Money is a barrier for implementation

What action steps will you take?
► Through 2016 - work through how patients can get tested
80% by 2018 Forum

**New York**

**Action Plan**

<table>
<thead>
<tr>
<th>Organizational Structure</th>
<th>Evidence-Based Strategies</th>
<th>Target</th>
<th>Resources</th>
</tr>
</thead>
</table>
| ▶ Establish 80% by 2018 workgroup under state cancer consortium | ▶ FIT testing  
▶ Small media  
▶ Patient navigation | ▶ FQHCs  
▶ Consortium health plans | ▶ MIYO  
▶ NCCRT  
▶ NY DOH  
▶ NY ASC  
▶ CHCANYS  
▶ ACS |

What will be different a year from now as a result of your work?

Building upon previous NY 80% by 2018 plan

▶ Upstate model
▶ Downstate model

Of the FQHCs who have not adopted FIT testing (~1 yr)

▶ All 65 FQHCs - define a %
▶ First step - assessment: what policies are in place?
  ▸ Protocol for CRC screening
  ▸ Conducted at October 2015 meeting, State Primary Association, captured via Survey Monkey
**80% by 2018 Forum Action Plan**

**EBIs**
- Provide Training & Technical Assistance
- Utilize SLT Cancer Coalition to Continue 80% by 2018 Activities
- Implementation of Patient Navigation and CHWs
- Implement FluFIT
- Implement Strategies to Increase Use of EBIs with the Following Key Constituent Groups:
  - Community health centers/FQHCs
  - Hospitals/health systems
  - Employers
  - Legislators
  - Payers/insurers
  - Private sectors

**Convening Coalition (Stakeholders)**

**Increasing Awareness of CRC Screening Options**

**Increasing CRC Screening Rates in PA**

**Responsibility: ACS/DOH/SLT**
- Utilize December 2015 Summit for stakeholder engagement
  - Identify barriers, effective strategies, and interventions to continue to engage stakeholders in the development of statewide plan to reach the goal of 80% screening by 2018
- Strategic recruitment
  - Who do we need?
  - Identify gaps and stakeholder participation
  - Develop CRC workgroup and subcommittees and identify workgroup leaders and co-chairs of subcommittee
- Develop and implement statewide action plan and timeline
- Ongoing 80% by 2018 initiatives
  - Develop communication strategy
  - Identify program champions
  - Increase use of EBIs

**Resource: Data Advisory Committee**
- Continue to publicly provide region-specific CRC screening rates to monitor progress
- Identify data sources to target populations
- Utilize data to evaluate the impact of cancer interventions and identify the targeted populations and communities where interventions should be focused
80% by 2018 Forum

Build a Consolidated Action Plan (based on existing plans)

POC: Jill - Fall 2015
- Determine EBIs
- Gap Analysis Activity
- Identify Key Partners
- Completed Plan - Output

Implemenatation, Data Tracking & Evaluation

POC: Brooke
- Revisions to Action Plan
- Data Dissemination
- Celebration & Recognition of Partners

FQHC Assessment

POC: Mary - January 2016
- Survey to Collect Data on Current FQHC CRC Practices
- In-person Meetings
- Quarterly CRC UDS Data Collection
- MOUs with Endoscopy Sites to Cover Diagnostic Colonoscopies for FQHC Patients w/Positive FIT

Identify & Train FQHC Organizational Teams, Champions, & Site Lead

POC: Stacie - Timeline TBD
- Health Care Professional Training
- Ongoing Team Support
- Quarterly Data Feedback

SOUTH DAKOTA
Complete a needs assessment and environmental scan of programs, populations, and providers in the state.

Create a CRC Screening Planning Committee, and identify organizations and key stakeholders with common goals to increase CRC screening and decrease mortality.

Meet November 9 at CPRIT meeting to further refine gaps and capacity building.

Utilize each organization’s assets to increase screening within the state using evidence-based intervention resources.

ACS: navigation, client reminders, education, access to care.

TACHC: cancer surveillance data, report cards, provider education, care coordination, evaluation.

TCCCP: small media, facilitation, education, communication.

CPRIT: data communication, dissemination, funding.

TAC: data collection, facilitation, collaboration, implementation of interventions.
## 80% by 2018 Forum

### ACTION PLAN

<table>
<thead>
<tr>
<th>STRATEGIES</th>
<th>ACTIONS</th>
<th>WHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create strong, statewide network</td>
<td>Increase communications about what’s happening at state level/right people become informed&lt;br&gt;Get on facilitator meeting agenda(s)</td>
<td>All of us present&lt;br&gt;KB regarding facilitators</td>
</tr>
<tr>
<td>Create 2-3 small media pieces on MIYO and a distribution plan</td>
<td>Identify specific focus (just CRC or other cancers?)&lt;br&gt;Identify audience(s)&lt;br&gt;Identify locations where pieces would be sent and/or displayed</td>
<td>ACS&lt;br&gt;VDH (DOH VT)&lt;br&gt;80% by 2018 team</td>
</tr>
<tr>
<td>Train facilitators to implement evidence-based CRC activities</td>
<td>Recruit from within our own and partner organizations to sign the 80% by 2018 Pledge (DOH, FQHCs, hospitals, community partners)</td>
<td>All of us and our partners</td>
</tr>
<tr>
<td>Implement FluFIT screenings</td>
<td>Investigate insurance (legal requirements of payers)&lt;br&gt;Explore data concerns – how to ensure clinic data is transferred to EMRs&lt;br&gt;Assess previous FLU clinics – were those who attended appropriate for CRC screening?</td>
<td>Identify specific roles and responsibilities within our group</td>
</tr>
<tr>
<td>Small media to primary care</td>
<td>Identify specific focus – we like decision-making aid tools</td>
<td>Identify specific roles and responsibilities within our group</td>
</tr>
</tbody>
</table>
Appendix 2 - Overview of State Teams Prior to the Forum

The following data tables provide an overview of Pre-Forum information for the 11 teams selected to attend the Forum. The data tables summarize collaborative relationships with partners, previous successes in CRC screening, and previous challenges encountered.

Pre-Forum CRC Roundtables or Workgroups

State teams reported whether they participated in a CRC roundtable, workgroup, task force, or committee, and whether they would like to create one.

<table>
<thead>
<tr>
<th>Team</th>
<th>Pre-existing CRC Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>No</td>
</tr>
<tr>
<td>California</td>
<td>Yes</td>
</tr>
<tr>
<td>Florida</td>
<td>No</td>
</tr>
<tr>
<td>Georgia</td>
<td>Yes</td>
</tr>
<tr>
<td>Michigan</td>
<td>Yes</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Yes</td>
</tr>
<tr>
<td>New York</td>
<td>No</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>No</td>
</tr>
<tr>
<td>South Dakota</td>
<td>Yes</td>
</tr>
<tr>
<td>Texas</td>
<td>No</td>
</tr>
<tr>
<td>Vermont</td>
<td>Yes</td>
</tr>
</tbody>
</table>

State CRC Priorities

Partner organizations were asked what priorities, goals, or objectives their team partners had with respect to CRC prevention. All of the state teams were committed to increase screening rates. State teams were working on CRC interventions that reflected strong collaboration with some or all partners.
Partner Successes

Partner organizations described their prior successes in CRC screening and prevention. Selected successes are summarized in the following table.

<table>
<thead>
<tr>
<th>State Team</th>
<th>Successes</th>
</tr>
</thead>
</table>
| Arizona    | - Collaborating with each other  
|            | - Establishment of CRC screening baselines  
|            | - Collaboration with screening providers |
| California | - Provider education  
|            | - Widespread implementation of screening interventions  
|            | - Measurable increase in screening rates |
| Florida    | - Use of patient navigators and reminder systems  
|            | - Small media campaign  
|            | - Improved adherence in Fecal Immunochemical Test (FIT) testing |
| Georgia    | - Creating the opportunity for a low-cost FIT  
|            | - Implementation of reminders and provider assessment and feedback in FQHCs  
|            | - Increased FIT testing rate from 26% to 73% by 2014 |
| Michigan   | - Increased collaboration and education of partner organizations  
|            | - Sent out screening reminders to more than 90,000 clients over 50 years of age  
|            | - Collaborated with screening providers to reduce colonoscopy cancellation rates |
| Mississippi| - Implemented community clinical linkages and collaborations  
|            | - CRC screening training  
|            | - Increased screening rates in rural populations |
| New York   | - Increased public awareness of CRC  
|            | - Implemented measures to make CRC screening easier for New York State employees  
|            | - Rolled out FIT test in FQHCs |
| Pennsylvania| - Provider education  
|            | - Use of EMR alerts  
|            | - Screened more than 3,000 patients using patient navigation over the last 6 years |
| South Dakota| - Distributed over 8,000 client reminders and recalls  
|            | - FQHC doubled their screening rate using reminder system, provider assessment and FluFIT  
|            | - Hosted a CRC roundtable |
| Texas      | - Improved CRC screening rates at FQHC  
|            | - Awarded 15 grants totaling $28M to CRC programs |
| Vermont    | - Implemented a 9-month collaboration group to teach screening to primary care providers  
|            | - Implemented pre-planned patient visits at FQHCs |
## Partner Challenges

Partner organizations described their prior challenges in CRC screening and prevention. Selected successes are summarized in the following table.

<table>
<thead>
<tr>
<th>State Team</th>
<th>Challenges</th>
</tr>
</thead>
</table>
| Arizona    |  - Staffing requirements  
             - Capacity to meet workload of CRC efforts  
             - Provider education  
             - Client education |
| California |  - Delivering funding to community partners  
              - Education efforts hindered by the size and diversity of California  
              - Lack of insurance coverage for patients with positive diagnosis |
| Florida    |  - Limited resources to go beyond a positive FIT test  
              - Compliance and reimbursement issues hampered successful patient/provider relationships  
              - Lack of patient education necessary for successful completion of FIT tests |
| Georgia    |  - Overcoming perception that colonoscopy is always preferable to a FIT test  
              - Improving FIT return rates  
              - Lack of Medicaid coverage in many areas within the state |
| Michigan   |  - Competing priorities in healthcare and competition for funding  
              - Lack of knowledge about CRC screening options in FQHC staff  
              - Structural, financial, homelessness, and billing barriers |
| Mississippi|  - Uninsured and underinsured, and lack of transportation  
              - Insufficient provider capacity  
              - Educating the lay public |
| New York   |  - Competing priorities and structural barriers  
              - Lack of knowledge of CRC screening methods  
              - Large uninsured and undocumented communities |
| Pennsylvania| - Patient reluctance  
              - Competing priorities at FQHCs  
              - Lack of comprehensive statewide plan for **80% by 2018** |
| South Dakota| - Capturing data for CRC screening and patient compliance  
              - Lack of staff and provider time  
              - High percentage of complex chronic diseases in low-income patients |
| Texas      |  - Limited funding, difficulty of obtaining treatment services when cancer is found  
              - Expansive geography  
              - Large uninsured/undocumented population |
| Vermont    |  - Lack of staff and financial resources for CRC screening  
              - EHR reliability issues  
              - Patient compliance, transportation, and affordability issues |
Sources


