IMPLEMENTATION GUIDE

Multilevel Follow-up of Cancer Screening (mFOCUS)

Using an Evidence-Based Program to develop
a process model for program delivery in the practice setting

Note: Refer to "Putting Public Health Evidence in Action". Review the appropriate Modules and the handouts provided in each, in order to modify and evaluate this program to meet the needs of your organization and audience.

"Putting Public Health Evidence in Action" is available online at:
http://cpcrn.org/pub/evidence-in-action/

I. Program Administration (Type of Staffing and Functions Needed)

Study Coordinator [Recommended: administrative staff]
- Coordinates setting up EHR system with IT department.
- Completes study coordinator training.
- Screens patients for eligibility.
- Conducts outreach with patients by sending portal message reminders, sending mailed reminders, and making phone calls.

Patient Navigator [Recommended: clinic staff]
- Completes patient navigator training.
- Contacts patients via phone.
- Conducts social determinants of health screener with patients over the phone.
- Assists with scheduling recommended follow-up.

IT Staff [Recommended: IT professionals]
- Establishes the coding for the EHR reminders and to identify patients overdue for follow-up care due to abnormal screening results following breast, cervical, colorectal, and lung cancer screening.
- Creates external database to track and monitor patient eligibility and outreach.

II. Program Delivery

For additional information on modifying program materials, refer to the appropriate Module(s) for program adaptation from "Putting Public Health Evidence in Action".

A. Program Materials ***(All listed materials can be viewed and/or downloaded from the Products Page)*****:**

The EHR intervention includes the following written materials and graphic images:

- **Navigator and Study Coordinator Training Book:** A training manual for the study coordinator and patient navigator.

- **Navigator Script:** A phone script that patient navigators follow when calling patients to help schedule overdue appointments and that addresses patient barriers to scheduling.

- **EHR Alert Example in Online Portal:** Screengrabs of an example EHR alert.

- **Patient Outreach Letter:** An example letter that is mailed to patients overdue for follow-up care.

B. Program Implementation:

The steps used to implement this program are as follows:

Step 1: IT staff develops, tests, and implements the EHR tools to identify patients overdue for follow-up care due to abnormal results following breast, cervical, colorectal, and lung cancer screening tests.

Step 2: The study coordinator and patient navigator complete training.

Step 3: Patients identified as overdue for follow-up care due to an abnormal cancer screening test result have a reminder added to the patient record that can be accessed in the EHR by the primary care provider and in the patient portal by the patient.

Step 4: The study coordinator follows up with patients that remain overdue for follow-up care by sending the outreach letter and calling patients to inform them of the test result and provide contact information to schedule recommended follow-up.

Step 5: The patient navigator follows up with patients that remain overdue for follow-up care by calling patients following the navigator script. The patient navigator tracks the patient until follow-up care is scheduled.

III. Program Evaluation

For additional information on planning and adapting an evaluation, review the appropriate Modules for program implementation and evaluation from "Putting Public Health Evidence in Action".
http://cpcrn.org/pub/evidence-in-action/