IMPLEMENTATION GUIDE
Community Cancer Screening Program (CCSP)

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

<u>Note:</u> Refer to "Putting Public Health Evidence in Action". Review the appropriate Modules and 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 Function Needed)

Senior Administrator
- Develops partnership agreements with hospitals, cancer centers, and primary care providers
- Negotiates reduced professional fees for gastroenterologists and pathologists and hospital waivers for colonoscopies for uninsured patients
- Ensures program staff's training on and compliance with the Health Insurance Portability and Accountability Act (HIPAA)
- Manages organizational resources (i.e., finances, staffing) to support program activities
- Oversees program evaluation

Physician Champion/Medical Advisor
- Assists senior administrator in recruiting hospital and cancer center partners
- Promotes benefits of screening the uninsured among health care decision makers

Program Manager
- Trains and supervises health navigators
- Maintains quality control of program implementation
- Recommends and/or facilitates systems changes with primary care settings to facilitate colorectal cancer screening
- Serves as primary liaison among health care providers and program staff

Health Navigator (Requirements: bachelor's or master's degree in a social science, such as psychology or social work, and experience in case management)
- Receives 16 hours of training and coaching on the implementation of CCSP
- Conducts chart audits to identify patients who are eligible for colorectal cancer screening
- Maintains physician reminder systems
- Supports patient recall systems
- Enrolls patients in CCSP
- Schedules screening and follow-up appointments
- Conducts patient education and reminder calls

- Assists patients in overcoming screening barriers
- Documents case management activities
- Coordinates outreach mailings (reminders) to primary care patients
- Prepares patient education packets

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 RTIPs Products Page)*****:**

- **CCSP Navigator Training Manual:** This 111-page training manual describes the 3 modules to be used across 13 sessions to provide health navigators with tools and information to help patients overcome colorectal cancer screening barriers.

- **CCSP Navigator Training Workbook:** This 90-page training workbook follows the organization of the CCSP Navigator Training Manual and includes worksheets for the trainees to complete (e.g., quizzes, evaluation forms).

- **Cancer Coalition of South Georgia CCSP Quality Assurance Checklist for Colonoscopy Screening Navigation:** This 1-page checklist is designed to be used by the individual responsible for overseeing a new health navigator weekly for the first 3 months and monthly thereafter to monitor navigation quality control.

B. Program Implementation:

The steps used to implement CCSP are as follows:

Step 1: The senior administrator (1) establishes written agreements with hospitals and cancer centers willing to provide services at no cost to uninsured patients, (2) creates partnerships with gastroenterologists willing to provide services for uninsured patients at reduced cost or provide in-kind support for CCSP, (3) obtains agreements with surgeons who will provide pathology services for uninsured patients at reduced cost or as in-kind support, (4) partners with primary care centers that provide care for uninsured patients, and (5) establishes screening policies within the primary care setting (i.e., monitoring patient screening status, establishing and maintaining reminder systems, tracking provider performance, providing routine feedback on referral patterns).

Step 2: The program manager prepares and provides progress reports for the senior administrator and referring physicians that describe referral patterns, number of patients who completed screening, and challenges (e.g., referral numbers slowing down).

Step 3: The health navigator works within the primary care system to reduce cancer screening disparities. Tasks include:

- Conducting weekly chart audits of patients with scheduled clinical visits
- Entering provider reminder prompts into the electronic health record system to encourage screening referral
- Processing referrals, conducting patient intake, and scheduling colonoscopy appointments
- Educating patients on the importance of colorectal cancer screening and instructing them in bowel preparation
- Providing culturally sensitive support and information to help patients overcome barriers to screening
- Supplying patients with bowel cleansing products
- Arranging transportation if needed
- Conducting at least three reminder calls per patient to ensure adequate bowel preparation and compliance with provider's screening recommendation
- Updating medical records, including entering recall schedule as recommended by gastroenterologists

Step 4: The senior administrator oversees program evaluation by establishing the baseline screening rate within the primary care setting prior to delivery of the intervention. Ongoing data tracking may include the number of patients identified for screening, the provider referral rate, and the patient compliance rate. The senior administrator conducts chart audits twice annually to measure progress in increasing screening rates.

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/

For further assistance in designing and conducting an evaluation, consider communicating with members from NCI's Research to Reality (R2R) community of practice who may be able to help you with your research efforts. Following is a link to start an online discussion with the R2R community of practice, after completing registration on the R2R site: https://researchtoreality.cancer.gov/discussions.