

2018 *Dialogue for Action*[®]: Poster Abstracts

Listed in alphabetical order by poster name. The bolded names are the in-person presenters.

BOARD 1: *Human Papillomavirus Prevention in North Dakota's Youth: Early Results of an HPV Educational Project Targeted at Health Care Professional Communication*



Danielle Pinnick, MPH¹ and Paul J. Carson, MD, FACP¹

1. North Dakota State University Center for Immunization Research and Education

Background: Human papillomavirus (HPV) is a common infection that is easily transmitted and can cause cancer in a number of anatomical sites in both males and females. Despite the availability of an extremely safe and effective vaccine for over a decade, HPV immunization rates remain low in North Dakota and throughout the United States in both boys and girls. In adolescents, HPV series initiation and completion rates are consistently below that of Tdap and MCV-4 – vaccines also administered at the 11-12 year-old medical encounter – indicating both parental refusal of series initiation, as well as provider reluctance to discuss or recommend the vaccine. A strong provider recommendation at the medical encounter is known to be a major predictor of vaccination acceptance for all vaccines, particularly HPV.

Goals and Objectives: The project aim is to increase awareness and knowledge in medical providers throughout the state on HPV infection and HPV-related cancers, to increase provider confidence in and communication about the vaccine. This will translate into improved HPV vaccination rates in North Dakota adolescents.

Methods: A one-hour presentation on HPV was developed by North Dakota State University Center for Immunization Research and Education, including disease epidemiology, vaccine safety and efficacy, and evidence-based communication strategies for discussing immunizations. Trained physicians and public health professionals delivered this presentation in person to clinics throughout the state in a luncheon format.

Clinics were selected to receive HPV education intervention based upon low HPV immunization percentage in their 13-year-old patient population and/or relatively large adolescent patient population. Patient attribution is determined by the most recent immunization administered that is not an influenza vaccine. Eligible clinics included North Dakota Vaccines-for-Children Program participants.

BOARD 1 (Continued)

Clinic-specific data were collected from the North Dakota Immunization Information System prior to each visit, and re-assessed 6 months post-visit. These data were presented to medical staff during the presentation, in informational folders, and emailed to clinic coordinators both at the initial and follow up visits.

Results: In the first year of the project, 534 medical professionals throughout the state received this education, 176 of which were medical providers. Visit attendance is a considerable improvement over typical AFIX visits, which very rarely include physicians or mid-level providers.

Preliminary follow-up assessments are ongoing. As of January 2018, clinics which have received their follow up have shown an HPV up-to-date rate increase from 47.9% to 58.8%. Processed data also show a consistent decrease in the number of missed opportunities to initiate or continue the HPV series in patients at intervention clinics.

Conclusions: Peer-to-peer training with CME and food incentives was significantly more successful than standard AFIX at reaching providers with education. Initial reviews of vaccination rates and missed opportunities in intervention clinics suggest significant improvements in promoting HPV vaccination.

BOARD 2: 2,000 Miles Closer to Our Goal - Montana Colorectal Cancer Roadshow

Courtney Buys¹

1. Montana Primary Care Association

Background: Montana Primary Care Association (MPCA) is an association of Community Health Centers (CHCs) in Montana who last year provided primary care to over 100,000 patients. MPCA provides training and technical assistance to CHCs across the state. These non-profit clinics are in medically underserved areas and do not deny services to anyone. Serving such vulnerable persons along with working in a health care environment with limited resources is challenging, resulting in the Montana CHC colorectal cancer screening rate being 32%, far below the goal of 80%, and far below current state and nationwide data. There are low-cost screening options available that are viable screening tools for all populations, but especially CHC populations that are often overlooked by medical providers due to old habits, however these low-cost options are USPTF recommend and evidence based. Increasing the use of low cost screening options will increase CHC screening rates.

Goals and Objectives: The goal of the training was to increase the percentage of community health center providers who have confidence in and recommend colorectal cancer screening tests other and including the standard colonoscopy; that due to financial, travel, and cultural barriers some patients will choose not to do, therefore increasing colorectal cancer screening rates by using non-invasive tests.

The objective of the training was to have learners leave the meeting with a knowledge of the current screening practices and rates in the state of Montana.

Methods: Instead of the traditional centralized training, which are difficult to get clinicians to attend. The trainers, American Cancer Society physicians, went to nine health centers across the state. Health centers were encouraged to block off their clinicians' schedules so that entire care teams could attend. The target audience was multi-disciplinary health care providers that provide primary care at CHCs and other clinics who serve the underserved. A pre-test was administered to all participants that asked clinicians what their confidence levels were in various colorectal cancer screening tools and what test they most often recommend to patients. Two months after the training a post test was administered to participants.

Results: Pre-Test data indicate that 44% of clinicians recommended FIT/FOBT tests primarily to patients; 53% of clinicians recommended a colonoscopy. Post-test data indicate that 61.54% of clinicians recommended FIT/FOBT tests primarily to patients; 31% of clinicians recommended a colonoscopy.

BOARD 2 (Continued)

Conclusions: The results of the post-test indicated that clinicians became more receptive to other methodologies of colorectal cancer screening after attending the training. Given the rural nature of the state, it is often difficult to get clinicians to attend centralized trainings because of the time to travel. Going to the clinics to provide the training greatly increased the participation and effectiveness.

BOARD 3: A Multi-Faceted, Intensive Approach to Facilitate System Change for Colorectal Cancer Screening

Stephenie Kennedy, EdD, MA¹, Adam Baus, PhD², **Mary Ellen Conn, MS¹**, Susan Eason, MA¹, Taylor Daugherty¹ and Cecil Pollard, MA²

1. Cancer Prevention and Control, West Virginia University Cancer Institute
2. Social and Behavioral Sciences, West Virginia University

Background: Colorectal cancer (CRC) in West Virginia is a significant health problem being the third most common and second most deadly cancer among men and women. Between the years 2010-2014, more than half of all patients with CRC were diagnosed at regional (31%) or distant (20%) stages when cancer is more difficult to treat and cure. Improvements in early detection through screening is vital to reducing mortality from this disease.

Goals and Objectives: Evidence-based interventions (EBIs) have been shown to increase CRC screening. Implementing EBIs in the primary care setting is challenging with time constraints and competing health priorities. The WV Program to Increase Colorectal Cancer Screening facilitates practice-based change in health systems with the goal of increasing their screening rate to 80% or at least 10% over baseline.

Methods: 16 Federally Qualified Health Center clinics participated in a two-year, two-phase partnership. Year one provided intensive technical assistance to implement 2-3 EBIs and supportive activities. All providers received quarterly provider assessment and feedback reports to illustrate their CRC screening rates and that of their peers. An enhanced telephone client reminder system using Stages of Change health theory called patients to provide tailored messaging for them to complete a fecal immunochemical test (FIT). Small media materials were developed for each clinic's population. Additional program support was provided through professional education of providers and staff on CRC screening guidelines, EBIs, and motivational interviewing. In year two, clinics continued implementing EBIs with reduced technical assistance.

Results: CRC screening rates increased among all clinics. Mean screening rates increased from 28% to 51%. 81 providers received quarterly provider assessment and feedback reports. Mean provider screening rates increased from 30% to 50%. The enhanced FIT reminder calls with tailored messaging resulted in a 34% return rate. Training both providers and staff increased CRC knowledge and buy-in support by the entire practice and not just providers.

Conclusions: Conducting multiple EBIs in an intensive time-frame is an efficacious method of adopting practice change in primary care health systems.

BOARD 4: Community-Based Hepatitis C Testing within Philadelphia Senior Centers – “C a Difference”

Lora Magaldi, MS¹, **Alexandra Ripkin, MSW¹**, Dina Zaret¹, Jay Kostman, MD¹ and Stacey Trooskin, MD, PhD, MPH¹

1. Philadelphia FIGHT

Background: Hepatitis C (HCV) is the most common blood-borne infection in the US with a prevalence of 1.6%. CDC guidelines recommend high-risk individuals and individuals born between 1945-1965 (the baby boomer birth cohort) be tested for HCV. Individuals may not be tested due to lack of access to primary care or because providers may not routinely screen for HCV. We aimed to provide community-based rapid HCV testing to individuals born in the birth cohort who attend Community-based Senior Centers in Philadelphia.

Goals and Objectives: Philadelphia FIGHT’s “C a Difference” HCV testing and treatment program aimed to test 500 individuals and educate 4000 baby-boomers about HCV and the increased risk of liver cancer in those infected with HCV. All those testing positive for HCV were eligible for no-cost linkage to subspecialty services.

Methods: HCV education and testing events were held at Philadelphia Senior Centers. Programming was implemented in English and Spanish. “Internal champions” were identified within the sites to promote events and ensure there were adequate spaces for education and testing. The Center members attended our presentations and, in most settings, the administration required the staff to attend so they were able to provide information to others.

Results: Education via classroom-style presentation, newsletters and handouts were provided to 4200 unique individuals within 59 education sessions at 37 different sites. 534 participants were tested via rapid testing technology. Eight antibody-positive individuals were found (1.5% antibody seroprevalence). Of these, one had successfully cleared the virus on his own and five were linked to subspecialty care for treatment. Of those individuals linked to care, one was identified as having cirrhosis and will be referred for liver cancer screening. Two patients are lost to follow-up.

BOARD 4 (Continued)

Conclusions: Many Senior Center members did not know they were at risk for HCV due to the stigma and perception of HCV being a disease primarily affecting those who use intravenous drugs or engage in high-risk sex. Additionally, many attendees were aware of their positive HCV status, but were unaware that they are eligible for treatment or unwilling to undergo treatment due to misinformation about hepatitis C drug cost, availability, and side effects. Through the experiences of our testing staff, we believe that our educational program may have driven patients to seek care, who were already aware they were chronically infected with HCV and did not undergo repeat testing.

Although the seroprevalence of HCV among those who were tested was lower than expected, we believe our program had a significant impact on the attendees of the community centers.

BOARD 5: Economic Assessment of CDC's Colorectal Cancer Control Program: Findings from Colorado, University of Chicago and Washington State

Florence Tangka, PhD, MS¹, Sujha Subramanian, PhD², Sonja Hoover, MPP², Christen Lara³, Karen Kim, MD⁴, Kathryn Kemper⁵ and Casey Eastman, MPH⁶

1. Centers for Disease Control and Prevention
2. RTI International
3. Colorado Department of Public Health and Environment
4. University of Chicago Medical Center
5. Health Point
6. Washington State Department of Health

Background: The Centers for Disease Control & Prevention (CDC) funded 30 states, universities and Native American tribes through its Colorectal Cancer Control Program (CRCCP) to increase colorectal cancer screening uptake among individuals aged 50-75. To increase uptake grantees implemented evidence-based interventions (EBIs) found in *The Community Guide*, such as provider and patient reminders, provider assessment and feedback (PAF) and reducing structural barriers, as well as supporting activities (SAs), such as, small media and patient navigation. A sample of the 30 grantees participated in a cost-effectiveness analysis (CEA) of their programs.

Goals and Objective: The goal of the CEA is to understand the value of investments made by CDC's CRCCP Grantees and their partners in improving CRC screening through health system changes and implementation of EBIs and SAs.

Methods: CDC and RTI International collected cost and effectiveness data from participating grantees [Colorado Department of Public Health and Environment (CO); University of Chicago Medical Center (UCMC); Washington State Department of Health (WASDOH) and HealthPoint]. We designed and tailored a cost data collection tool for each grantee to collect time and resources expended by activity and phase of the project (e.g., development and implementation). We also collected time and resources expended for administration, evaluation and data quality assessment. Because each grantee implemented EBIs differently and had different outcome measures, the analyses differed for each grantee.

Results: CO worked with two health systems. From 2012-2015 Health System 1 increased screening rates from 21.1% to 39.2% through patient and provider reminders, availability of FIT/FOBT kits and PAF, as well as SAs and data quality improvement activities. The incremental cost per screen ranged from \$7.24 to \$23.78. For Health System 2, the screening rate increased from 25.7% in 2013-2014 to 35.4% in 2016-2017. Health System 2 implemented similar EBIs (except for provider reminders), SAs and data quality improvement activities as Health System 1. The incremental cost per screen was \$8.21 in 2014-2015 and \$29.16 in 2016-2017.

BOARD 5 (Continued)

UCMC implemented a non-nurse patient navigator program. The CRC screen completion rate of patients navigated was 85.1% compared to 73.4% for patients not navigated. Assuming a no-show rate of 0-50% and utilizing only implementation costs, the cost per patient successfully navigated to complete colonoscopy screening is estimated between \$88.29-\$214.61.

WASDOH/HealthPoint implemented a number of EBIs: MailedFIT, MammoFIT and FluFIT and birthday card reminders. The overall FIT return rate was 31% with the average cost of \$18.76 per FIT kit returned (calculated utilizing only implementation costs).

Conclusion: CRCCP grantees implemented different combinations of EBIs and SAs. All three programs analyzed experienced an increase in their screening uptake, which is likely due to the implementation of the interventions. The intervention cost per person successfully screened varies across the programs and these differences will be explored in future research.

BOARD 6: *Expanding Access to Colorectal Cancer Screening Services in Texas*

Carlton Allen, MS, CHES¹, Gabriela Orsak, PhD¹ and Paul McGaha, DO, MPH¹

1. University of Texas Health Science Center at Tyler

Background: In the US, colorectal cancer (CRC) is the fourth most frequently diagnosed cancer. In 2013, 136,119 people were diagnosed with CRC, with 51,813 dying from the disease. Compared to Texas as a whole, East Texas has higher incidence and mortality rates from CRC. CRC screening rates are lowest among the uninsured. East Texas is highly rural and low-income, with many uninsured, and with limited access to public transportation. We initiated a CRC screening program in East Texas, focusing on the un- and under-insured. The screening project, funded by the Cancer Prevention Institute of Texas (CPRIT), encompasses 19 counties in East Texas. CRC screening saves lives, yet screening rates among underserved populations, such as the uninsured and minorities, are low. CRC screening in asymptomatic patients can reduce the incidence and mortality of CRC as it: 1) Prevents CRC by polypectomy, 2) Finds early-stage cancers, leading to treatment with a high chance for long term survival, and 3) Identifies families at increased risk.

Goals and Objectives: Our goals included 1) Increasing CRC screening education and access by providing CRC screening risk-benefit education to individuals in the area, and 2) Increasing the rate of CRC screening services by at least 10%, by tailoring support for CRC screening to the individual's intention.

Methods: We provided a coordinated screening program to increase access to and delivery of CRC services (Fecal Immunochemical Test (FIT) and Colonoscopy) where patients had the choice to elect which test they would like to receive. Multiple partnerships were established with existing community programs and clinical colleagues in primary care were engaged to assist with recruitment. Participants with a negative FIT or whose colonoscopy revealed no/benign polyps were scheduled for follow-up. Participants with a positive FIT were scheduled for a colonoscopy. Participants with a colonoscopic biopsy demonstrating a precancerous polyp or cancer were scheduled for appropriate clinical procedures.

BOARD 6 (Continued)

Results: For Year 1, 1,337 screenings were performed with 8.2% screened through FIT, and 91.8% screened through colonoscopy. For year 2, 2,409 screenings were performed with 26.9% screened through FIT, and 72.6% screened through colonoscopy. Between September 1, 2016 and August 31, 2017 (Year Three) there were 3,374 screenings through this CPRIT grant, a 39.6% increase from Year Two. During Year Three the majority of records indicate individuals who had no insurance (n=2,089; 61.9%), or were underinsured. CPRIT funded these screenings. These clients were 65.1% females with an overall mean age of 56.9 years.

Conclusions: We believe that our approach to patient recruitment, which includes population outreach and clinician participation, combined with strategies to overcome barriers to participation such as provision of transportation to participate in CRC screening and/or treatment could be implemented by other health systems and lend to the future sustainability.

BOARD 7: Improving Cervical Cancer Screening and Prevention by Increasing Provider Capacity in Low-Resource Settings in the US and Globally

Mila Pontremoli Salcedo¹, Melissa Lopez², Ellen Baker², Cesaltina Ferreira Lorenzoni³, Elvira Luis³, Kathleen Doughtie², José Humberto Fragnani⁴, Georgia Fontes Sintra⁴, Renato Moretti⁵, Sonia Parra⁶, Rebecca Richards-Kortum⁶, Maurício Maza⁷, Leticia Maricela López-Orellana⁷, Maria Daher⁸, Anthony Ogburn⁹, Rose Gowen¹⁰, Andrea Milbourne², Ana Rodriguez¹¹, McLain Mallory¹⁰, Laura Guerra¹⁰, Paul Toscano¹², Natalie Burkhalter¹³, Eduardo Robles¹⁴, Elena Marin¹⁰ and **Kathleen Schmeler**²

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|---|---------------------------|
| 1. UFCSPA/Hospital Santa Casa de Porto Alegre | 8. Harris Health |
| 2. MD Anderson Cancer Center | 9. UTRGV |
| 3. Hospital Central de Maputo | 10. Su Clinica Familiar |
| 4. Hospital de Cancer de Barretos | 11. UTMB |
| 5. Hospital Albert Einstein | 12. UT Houston |
| 6. Rice University | 13. Mercy Clinic |
| 7. Basic Health International | 14. Gateway Health Center |

Background: Cervical cancer is preventable, yet globally 266,000 women die annually from this disease. Eighty-five percent of cervical cancer cases and deaths occur in low- and middle-income countries (LMICs), particularly in Latin America and sub-Saharan Africa. However, medically underserved regions of the United States also have high rates, such as the Rio Grande Valley (RGV), an area along the Texas-Mexico border where cervical cancer incidence and mortality rates are 30% higher than the rest of the state. These disparities are often due to a combination of a lack of access of care as well as a limited number of trained providers to perform the necessary procedures to treat and manage cervical dysplasia and therefore prevent cervical cancer.

Goals and Objectives: To increase local provider capacity to screen for, diagnose, and manage cervical dysplasia.

Methods: We implemented a cervical cancer prevention program for providers in medically underserved regions that includes: 1) hands-on training to teach colposcopy, cervical biopsy, cryotherapy and loop electrosurgical excision procedure (LEEP) and 2) ongoing telementoring using Project ECHO® (Extension for Community Health Outcomes). The hands-on training is held locally and uses innovative simulation models developed by bioengineers at Rice University. The courses are supplemented with regularly held Project ECHO videoconferences to reinforce skills and knowledge. This telementoring model connects specialists at academic centers with providers in lower resource regions and uses a case-based learning format.

BOARD 7 (Continued)

Results: In 2017, we held five hands-on training courses: two in the RGV of Texas (Harlingen and Laredo), two in Mozambique and one in El Salvador. An average of 25 participants attended each course including physicians, nurse practitioners, physician assistants and nurses. In addition, Project ECHO videoconferences are held regularly with the RGV (bi-weekly, English), Mozambique (monthly, Portuguese) and Latin America (monthly, Spanish). There are approximately 15 to 25 participants in attendance per session. Participants report high levels of satisfaction with the conferences and more than 80% report increases in self-confidence and self-efficacy.

Conclusions: Our initial experience suggests that a multi-pronged approach to training that includes education, mentoring and skills development is well accepted by providers and results in improved provider self-efficacy and confidence. Future courses are planned for these three regions in 2018 and will include more structured assessments and a formal requirement for mentoring. The outcomes of this program will help support an expansion initiative to deliver similar programs in other sites.

BOARD 8: Lessons From the Field: Implementing Evidence Based Interventions to Increase Colorectal Cancer Screening Rates in Community Health Centers

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1. Center for Urban Population Health
2. University of Wisconsin Health
3. University of Wisconsin School of Medicine and Public Health
4. Wisconsin Comprehensive Cancer Control Program
5. UW Carbone Cancer Center

Background: In 2014, the National Colorectal Cancer Roundtable (NCCRT) established a goal to screen 80% of adults, ages 50-75 for colorectal cancer (CRC) by 2018. In that year, 74% of Wisconsin adults, ages 50-75 were “up-to-date” on their CRC screening compared to only 30% of Milwaukee-area Federally Qualified Health Center (FQHC) patients. Created in 2015, *Wisconsin’s Collaborative Approach to Increase Colorectal Cancer Screening* has been funded through the CDC’s Colorectal Cancer Control Program (CRCCP) to support FQHCs in screening underserved Wisconsin adults 50-75 years old for CRC through the strategic implementation of evidence based interventions (EBIs).

Goals and Objectives:

Goal: Support Wisconsin FQHCs to increase CRC screening rates by implementing EBIs to support the national screening goal of 80% by 2018.

Objectives: Describe the process and reason for creating site-specific EBI implementation plans; describe the importance of an internal CRC quality improvement team and the role of a CRC champion; explain the importance of ongoing data collection and validation to support EBI implementation; and share challenges, successes, and lessons learned by CHCs that impact implementation of a quality improvement project.

Methods: In-depth clinical/environmental assessment including a review of baseline data, policies/procedures, and process mapping to guide EBI selection, in-depth and ongoing technical assistance to support implementation, ongoing data collection and validation and biannual data debrief sessions, and peer learning collaborative sessions (in-person and via webinar) to support the sharing of best practices and quality improvement failures and successes.

BOARD 8 (Continued)

Results: Baseline screening rate range: 11-70%, average 34% (7 CHCs, 13 clinics). After one year of funded partnership, the screening rate range was 12-77%, average 42% (7 CHCs, 13 clinics). After two years of funded partnership, the screening rate range was 15-82%, average 49% (6 CHCs, 11 clinics). Initial success of funded FQHCs allowed the project to expand and include three additional FQHCs, thus expanding the scope of this work across Wisconsin to include both rural and urban examples of how strategic EBI implementation can increase CRC screening in the FQHC setting.

Conclusions: CHCs play an important role in our healthcare system and are an integral partner to consider in achieving the national goal of screening 80% of the eligible population by 2018. By focusing on strategic EBI implementation and receiving ongoing programmatic support, CHCs can improve their internal processes and create or strengthen existing clinical policies to ensure that eligible patients receive their recommendation for CRC screening and that the patients have the necessary support to follow through to be screened for colorectal cancer.

BOARD 9: Multi-Faceted Approach to Increasing Lung Cancer Screening in West Virginia

Stephenie K. Kennedy-Rea, EdD¹, **Jenny R. Ostein, MS¹**, Amie Muraski, MPH¹ and Shonta Chambers, MSW²

1. West Virginia University Cancer Institute
2. Patient Advocate Foundation

Background: The West Virginia University Cancer Institute in partnership with the Patient Advocate Foundation, established the West Virginia (WV) Lung Cancer Project, to address lung cancer disparities in WV. According to the WV Cancer Registry and Health Statistics Center lung cancer is the leading cause of cancer deaths (nearly 1 in 3) in WV and cancer is the leading cause of overall deaths in the state. Lung cancer is the most frequently diagnosed cancer in men and women combined and half of all people diagnosed with lung cancer in WV will have distant metastasis.

Goals and Objectives: Decrease lung cancer mortality by increasing early diagnosis through increased knowledge of and access to lung cancer screening, especially among underserved populations.

Methods: The WV Lung Cancer Project (WVLCP) surveyed 633 providers to obtain data on their knowledge, attitudes, beliefs, and current practices surrounding lung cancer screening. Academic detailing sessions were conducted at nine different facilities. The WVLCP partnered with three Medicaid Managed Care Organizations (MMCO) to pro-actively encourage their members to get screened. Public education activities were conducted in the state through a combination of health fairs, community events, newspaper advertisements, Lung Cancer Awareness Month toolkit dissemination, and public services announcements. In addition, the WVLCP collaborated with the state's cancer coalition, Mountains of Hope, to develop and disseminate a Lung Cancer Screening CME webinar to providers.

Results: Data collected from the provider survey indicated that 77.7% of providers were incorrectly screening patients for lung cancer and almost 80% were either incorrect or unsure of CMS coverage for the screening. Seventeen providers have completed the lung cancer CME webinar that was launched in November 2017. Antidotal evidence from community outreach is that the general public is still unaware that lung cancer screening is available. Through pro-actively contacting members, MMCOs were able to determine lung cancer screening eligibility for almost five-hundred members and navigate forty to their PCP for the shared decision making visit.

BOARD 9 (Continued)

Conclusions: It is evident that provider education is a crucial component of increasing lung cancer screening in West Virginia and educational encounters will continue in 2018. Because of the WVLCSP, almost five-hundred Medicaid members were pre-screened for lung cancer screening who otherwise would not have initiated on their own. This multi-faceted approach to improving lung cancer screening in WV is proving effective in increasing knowledge and utilization of the screening in a way that is sustainable and beneficial to providers, the MMCOs, and the people they serve.

BOARD 10: Patient Navigation as a Catalyst for Cancer Screening Quality Improvement

Megan Loucks, MS¹, Brie Garner¹ and Inna Scurtu¹

1. District of Columbia Primary Care Association

Background: Cancer continues to present a major challenge in the Washington, DC metro area. In 2014, only 23% of eligible patients seen at a FQHC were screened for colorectal cancer (HRSA UDS). To improve access to cancer screenings and treatment for colorectal, breast, and cervical cancer, DC Primary Care Association (DCPCA) has developed a health-center-driven program that leverages federal, state, and private partnerships and supports patient navigators as a catalyst for quality improvement.

Goals and Objectives: DCPCA, in partnership with MedStar Georgetown University Hospital, employs two full-time Navigators that are each based in a DCPCA-affiliated FQHC. DCPCA has strategic partnerships in cancer programming with the DC DOH, hospitals, and health plans. Through this collaborative approach, Patient Navigators have access to best practices training, peer sharing opportunities, and, of crucial importance, a direct avenue for communicating feedback on the most complex systems-level barriers to those stakeholders who can best effectuate change.

Methods: Navigators at the clinic work to ensure the patient is referred to appropriate cancer screening and, as needed, diagnosis and treatment. The program is in the process of expanding to include an additional Navigator.

Results:

- **Improved cancer screening rates and navigation services far exceeding target of 500 patients.** Between October 1, 2016 through December 31, 2017, two Navigators provided a comprehensive array of navigation services to 1,623 patients, representing 2,007 cases. A total of 61% of patients referred to the Navigators received a screening. The clinics saw an overall increase in cancer screening rates of 5 and 10%.
- **Creation of new clinic-based screening workflows, using best practices from cancer-focused private facilities, national bodies, and other navigators in DC.** Navigators established a daily screening and follow-up workflow for the clinic. The navigators worked collaboratively to develop an EHR-based system that allows for documentation of key navigation information to monitor progress and impact. This new system would work effectively regardless of unique clinic workflow and will be shared with additional clinics.

BOARD 10 (Continued)

- **Data from navigation services identified key challenges in the DC system.**
Currently, many screening and diagnostic reports are not received automatically into the HIE. Instead, navigators must call screening referral facilities to request records. This results in critical lapses in care, delayed care, and inaccurate reporting. Additionally, through documentation of barriers to care, transportation costs was identified as a key issue. Despite the perceived availability of reduced cost transportation, this challenge remains a barrier. These two issues have been communicated to the DC DOH and area providers and these stakeholders are working with DCPCA to develop a long-term solution to this problem.

Conclusions: By leveraging the resources and strategic partnerships of a PCA, clinic-based patient navigators become a catalyst for positive system-wide change to increase cancer screening and improve access to treatment.

BOARD 11: Patient Navigation Program for Korean Patients with Chronic Hepatitis B Infection

Sara Kim, MPH¹ and Okhyun Ko¹

1. Korean Community Services of Metropolitan New York, Inc.

Background: Hepatitis B (HBV) is a blood-borne, perinatally and sexually transmitted viral infection that can lead to liver disease, liver cancer and premature death. There is an effective vaccine to prevent HBV, and antiviral treatment can slow or prevent liver disease progression. Over 100,000 persons are infected in New York City (NYC). Approximately 2.2 million people in the US Korean immigrants, at high risk for hep B, face numerous cultural, social, and economic barriers to diagnosis and treatment.

Goals and Objectives:

Goal: To provide culturally sensitive patient navigation services for chronic hep B patients who are not treated.

Objective: Screen approximately 240 residents at risk by hosting 15 community screening events at religious based organizations, community institutions, and commercial areas.

Methods:

1. Identify patients from free, on-sites screening events throughout five boroughs of New York City and Korean populated areas in New York State.
 - Test approximately 240 residents at risk by hosting 15 community screening events at faith-based based organizations (FBOs), community institutions, and commercial areas.
2. Provide educational activities to raise awareness and reduce stigmas.
 - Host annual liver cancer forum in collaboration with hepatitis B partner organizations and local Korean hepatologists
3. Conduct media campaign:
 - Post all events on media stations.
 - Purchase advertisements, public service radio announcements 3 days a month for 12 months, TV station panel advertisements for 6 months, 6 placements in daily newspapers
 - Utilize social media and networking tool like 'Kakao Talk', the most popular app among Korean immigrants
4. Produce educational materials for patients and marking/promotional items to be used during community outreach events.

BOARD 11 (Continued)

Results: In 2017, Korean Community Services of Metropolitan New York has hosted around 10 free screening events where more than 100 individuals were tested and utilized traditional media outlets to educate the general public that chronic hepatitis b should be checked and cared regularly although no symptoms are indicated. Through a mix of activities, we identified 25 new patients who were not engaged in any types of medical treatments or needed our free supports due to temporary loss of health insurance. We provided them with medical assessment and care coordination to get free or low-cost advanced treatments such as DNA viral load tests and other liver function tests. Currently provide 78 chronic Hepatitis B patients in total between the ages of 20 and 70. From the group of infected patients, we found that 58% were male, 42% female and 66% of patients were currently on medication. The median age of our patients is 54, with the youngest patient at 24 years old and oldest at 75 years old. 24% of the patients were in the age range of 25-39, 38% were in the range of 40-56, 34% between ages 57-72 and 4% of patients over 72. 80% of infected patients had no health insurance and only 20% of infected patients had health insurance including Medicaid, Medicare, HIP, Oxford and Fidelis. Majority of infected patients resided in Flushing, Queens, the most frequent zip code listed as “11354”.

BOARD 12: Patient Navigation Training for Diverse Communities: A Qualitative Analysis of Barriers to Timely Colorectal Cancer Screening Among Low-Income and Medically Underserved Coloradans

Kirstin Le Grice, MPH¹, Nicole Harty, MPH¹ and Andrea Dwyer¹

1. University of Colorado Cancer Center

Background: The Colorado Colorectal Screening Program (CCSP) is a statewide patient navigation and technical assistance program that partners with safety-net hospitals and clinics to offer evidence-based, no-cost patient navigation services for colorectal cancer screening to the medically underserved. Since 2007, CCSP has navigated nearly 30,000 Coloradans through endoscopic screening.

Despite Medicaid expansion through the Affordable Care Act, colorectal cancer screenings rates have not seen a statistically significant change, with Medicaid rates remaining at approximately 55%. Additionally, patient navigators (PNs) cite challenges in meeting their communities' specific needs. Therefore, increasing screening rates will require thorough comprehension of, and strategies to address, the barriers impeding access to care.

Goals and Objectives:

Goal: Understand shared and unique barriers to care faced by patients and PNs in a geographically and culturally diverse state in order to develop tailored training resources.

Objectives: 1. Identify major patient- and system-level barriers to colorectal cancer screening throughout Colorado. 2. Create tailored training to help PNs overcome their community's specific barriers.

Methods: CCSP clinic leadership and PNs were invited to participate in focus groups and roundtable discussions on four separate occasions. Detailed notes were taken during these conversations for later thematic analysis. Themes were identified and categorized according to particular populations or regions.

Results: 30 PNs and 10 leadership representatives participated in 2 focus groups and 3 roundtable discussions. Eleven themes emerged, with some common to more than one region or population. Themes of Rugged Individualism and Cowboy Mentality were prevalent in northeastern Colorado while the Opioid Epidemic was a major challenge in southeastern Colorado. Low Health Prioritization was common across the state, but manifested differently. Northeastern and western Coloradans, placed priority on *Farming*; in southeastern Colorado, the priority was *Family Finances*; among undocumented and migrant communities, *Anonymity* was prioritized. Among PNs

BOARD 12 (Continued)

working with undocumented and migrant populations, a predominant theme was Distrust of Government. Within metro Denver, Access to Care and Patient-Provider Contact emerged as prominent themes. Broader themes throughout the state include Low Value of Prevention, Limited Specialty Access, Language and Transportation.

Conclusions: Medically underserved Coloradans of low income experience shared and unique barriers to receiving timely colorectal cancer screening based upon their community context. A statewide need exists for education about screening best practices, patient-specific screening methods, and resources. Level 1 motivational interviewing (MI) training and skills in PNs has proven insufficient to meet the complex needs of Colorado's medically underserved. Tailored web-based MI series will provide the necessary tools and skills for PNs to better meet the needs of their community, contributing to an increase in colorectal cancer screening rates. Patient navigators must be trained swiftly to address these challenges so that communities experiencing barriers to care can receive this important preventive service while coverage exists.

BOARD 13: *PDSA: Tracking Completion of Positive (Abnormal) FIT Result to Outcome of Cancer/No Cancer in a Large Federally Qualified Health Center System*

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1. Washington State Department of Public Health, Breast, Cervical and Colon Health Program
2. Cancer Prevention Program, Sea Mar Community Health Centers
3. Washington State Department of Public Health, Washington State Cancer Registry
4. Alliance for Reducing Cancer Northwest, Health Promotion Research Center, University of Washington

Background: Sea Mar Community Health Centers, a Federally Qualified Health Center (FQHC) in Washington (WA) State with 34 clinics, has experienced challenges with:

- Determining if patients with positive (abnormal) FIT results have completed colonoscopy, and
- Quantifying the impact of the FIT program on detection of cancer and polyp removal to secure internal funding for sustainability after CRC grant ends

To address these challenges, Sea Mar and WA State Department of Health have collaborated on a pilot project to track patients with abnormal FIT results through referral to colonoscopy and finding of ‘cancer/no cancer’ and ‘polyps removed.’ Collaboration was funded as part of the CDC CRC grant (NU58DP006101) to implement evidence-based interventions (EBIs).

Goals and Objectives:

Overall Goal: Improve Coordination of Care by tracking patients from abnormal FIT to diagnosis for colorectal cancer screening and closing gaps in patient records in EHR.

Objective 1: Using current staffing and funding within Sea Mar’s centralized Cancer Prevention Program (CPP) unit, create a workflow to track referrals to GI and outcome of cancer/no cancer and polyps removed.

Objective 2: Update patient records in Sea Mar’s EHR and send colonoscopy reports to Health Information Management (HIM) system.

Objective 3: Evaluate effectiveness and implement as part of CPP’s regular activities and document revised workflow.

Methods: From Oct 2017 to Jan 2018, Sea Mar conducted a ‘Plan-Do-Study-Act (PDSA)’ cycle to determine if the CPP unit could successfully track patient GI referrals due to abnormal FIT results to outcomes of cancer/no cancer and polyps removed (yes/no).

BOARD 13 (Continued)

Partners collaborated to create and test workflow and tools:

- Sea Mar Community Health Centers implemented pilot and tracked results
- WA State Cancer Registry aided in creating table to code colonoscopy results
- Alliance for Reducing Cancer, NW/Univ of WA adapted the FIT Tracking Tool
- Additional TA provided by Dr. Gloria Coronado, Senior Investigator, Mitch Greenlick Endowed Scientist for Health Disparities, Kaiser Permanente Center for Health Research
- WA DOH's Breast, Cervical, and Colon Health Program staff coordinated development of workflow and tools

Results: (note: preliminary data—will be finalized in poster)

Table with results for PDSA period will include:

Results: (for Sea Mar patients):

- 24 colonoscopies completed (due to abnormal FIT results) of which 16 patients had polyps removed and 2 patients were diagnosed with cancer

Evaluation & Validation:

- WA State Cancer Registry to validate that coding outcome from colonoscopy reports (sample)

Conclusions:

- Tracking status of referrals to GI and outcomes of cancer/no cancer and polyps removed (yes/no) can be achieved using a centralized process.
- Staff time required to verify referral outcome is minimal.
- Colonoscopy outcome tracking allows FQHC to quantify impact of FIT program.
- Next steps include sharing results with other FQHCs via WA State's Primary Care Association.

BOARD 14: *The Triple Crown: Achieving Screening Rates of 80% for Breast, Cervical and Colorectal Cancer in Southwest GA*

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1. Mercer University School of Medicine
2. Wake Forest University

Background: A new era, focused on quality improvement and preventative medicine, has begun in healthcare. This study utilizes the analytical tool “Population Manager” in conjunction with patient navigators to increase cancer screening rates.

Goals and Objectives: The goal of this study was to demonstrate the possibility of achieving the “triple crown” of cancer screening at Baker County Primary Health Care, a rural clinic in southwest Georgia with a high risk patient population. The triple crown is defined as reaching screening rates of 80% for breast, cervical and colorectal cancer.

Methods: The analytics tool Population Manager was used to identify patients needing cancer screening and to monitor the screening rates throughout the duration of the study. During office visits, patient navigators had direct interactions with patients focused on education, ordering screening tests, and identifying any potential barriers to screening. Patients without a scheduled appointment were contacted via phone. The patient navigators followed up with patients to ensure that their screening had been completed and fixed any documentation errors within the EHR system.

Results: The study took place over a six month period, from July 2017 to the end of December 2017. Over the course of the study, colorectal cancer screening increased from 71.6% to 76.2%. Cervical cancer increased from 58.1% to 67.3%, and breast cancer increased from 65.0% to 80.0%.

Conclusions: Although 80% was only reached for breast cancer, there were also significant increases in the cervical and colorectal cancer screening rates. The results indicate that the combination of patient navigators and an analytical tool is an effective way to increase cancer screening rates, even within a high risk patient population.

BOARD 15: *The Use of Population Health Specialists, Care Managers and Population Health Software to Increase Cancer Screening Rates*

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1. Albany Area Primary Health Care

Background: Albany Area Primary Health Care (AAPHC) is a Federally Qualified Health Center in Albany, Georgia, committed to value based quality patient care. They have been able to achieve this in some of their health centers with the aid of an analytical tool known as the “Population Manager” and the use of Population Health Specialist and a Care Manager. The Population Manger software is implemented during the pre-visit planning of patients to identify deficient cancer screenings. As a result, a remarkable increase in screening rates for breast, cervical and colorectal cancer has been achieved.

Goals and Objectives: The goal of the Population Health specialist is to increase preventive screening mainly breast, cervical and colorectal cancers to 80% in all Albany Area Primary Health Clinics.

Methods: The goal can be reached by the Population Health Specialist with the targeted use of the Population Manager software to generate a list of non-compliant patients in need of the deficient health screenings. Using this list of targeted patients, a focused outreach to such patients is then carried out. Charts are regularly audited to ensure proper documentation of medical records and recall reminders are placed in structured fields in the electronic medical record.

Results: Within a six-month period, there has been a significant increase in the screening rates of about 20% for breast, cervical and colorectal cancer in the targeted population (CDC group) of high risk patients who were targeted by the Care Manager in Lee Medical Arts, compared to the other Lee Medical Arts Center patients that were not. By June 2017, the screening rates for Breast, cervical and colon cancer screening rates in the targeted (CDC group) were 78%, 79% & 81% versus Lee Medical Arts; 66%, 68%, & 68%. Presently, as of December 2017, the rates are CDC group; 82%, 92% & 90% versus Lee Medical 65%, 72% & 77%.

Conclusion: Based on the results, it is evident that implementing Population Health Specialists in all Albany Area Health Centre clinics, the 3 Triple Crown goal (80% screening rate for breast, cervical and colorectal cancer) can be achieved.

BOARD 16: *Transitioning Colorectal Cancer Screening and Patient Navigation from a Closed System Within a Safety-Net Health Setting to an Open System in Collaboration with Community Clinics and Federally Qualified Health Centers*

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2. JPS Health Network Department of Family Medicine
3. University of Texas Southwestern Medical Center - Moncrief Cancer Institute, Department of Clinical Sciences, and the Harold C. Simmons Cancer Center
4. San Diego Veterans Affairs Healthcare System, University of California San Diego, Department of Internal Medicine, Division of Gastroenterology and the Moores Cancer Center

Background: Screening reduces colorectal cancer (CRC) incidence and mortality. System-level mailed outreach using fecal immunochemical test (FIT) has demonstrated effectiveness for increasing screening completion in underserved populations (PP100039), particularly when widely implemented among the diverse patients served by the safety-net health system for Tarrant County (PP120229). To more broadly serve North Texas, the program has been transitioned from a closed system to an open system (PP150061), requiring an expansion in partnerships to include community health clinics, health departments, and Federally Qualified Health Centers (FQHCs).

Goals and Objectives: The overarching goal is to increase colorectal cancer screening participation among the underserved through expanded availability across a 35 county service area. Using organized outreach methods, the program will be able to evaluate the effectiveness of referral to mailed outreach versus from community partners as compared to invitation from the safety-net system.

Methods: Uninsured individuals age 50 to 74 not current with screening are identified and invited to participate in colorectal cancer screening using mailed FIT. Outreach efforts include: 1) a 1-page bilingual invitation letter, 2) a FIT kit, 3) 2 automatic and up to 2 “live” reminder phone calls, and 4) telephone-based navigation to colonoscopy after positive FIT. The program team includes two nurses and four medical assistants, and is supported by the community outreach team. This team not only raises awareness for the program and the services available, but also work with the nurse manager to identify providers within the community to collaborate with for clinical service delivery, including pre- and postoperative appointments and diagnostic colonoscopy.

BOARD 16 (Continued)

Results: The program team has received referrals for 3,934 and invited to participate in CRC screening using organized outreach patients. Similarly, 15,017 were invited through the safety-net system, again using organized outreach. Currently, only about a quarter of patients (23.28%) referred and invited have completed the FIT screening, while about one-third (36.59%) of patients invited through the county safety-net completed FIT screening. However, 65% of patients referred who were FIT positive, have gone on to complete colonoscopy, while only 54% of patients invited through the county safety-net and were FIT positive have gone on to complete colonoscopy.

Conclusions: Program success must balance screening completion with diagnostic follow-up after an abnormal result. As the program continues to grow both in volume and geography, the team will continue to work with community partners on how to best engage and education patients in colorectal cancer screening. The next steps will focus on improving screening participation, while maintaining or improving follow-up completion for those patients receiving abnormal results.

BOARD 17: Utilizing Health Information Technology (HIT) as a Means of Overcoming Barriers to Cancer Screenings

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1. Community Health Care Association of New York State

Background: Over 25,000 New York State residents are diagnosed with breast, cervical, or colorectal cancer each year, which accounts for 20% of the overall cancer mortality rate. With funding from the Centers for Disease Control and Prevention and in partnership with the New York State Department of Health (NYSDOH), the Community Health Care Association of New York State (CHCANYS) implemented a demonstration project to improve breast, cervical and colorectal cancer screenings in Federally Qualified Health Centers (FQHCs) statewide.

Goals and Objectives: The overarching goals of the Cancer Screening Registry Project were to create a data warehouse for FQHCs to monitor cancer-screening rates and address patient care gaps; connect 75% of all NYS FQHCs to the data warehouse; and improve breast, cervical, and colorectal cancer screening rates by 10% over baseline among FQHC project participants.

Methods: In partnership with Azara Healthcare, the Center for Primary Care Informatics (CPCI), a cloud-based data warehouse with reporting and analytics capabilities, and clinical decision support tools was developed for FQHCs to improve data monitoring and team-based care and population health management process improvement.

From April 2016 through March 2017, 11 FQHCs received monthly on-site coaching from CHCANYS project managers and received training and technical assistance to overcome barriers to cancer screenings. FQHC staff often report an inefficient means to identify patient care needs prior to provider visits. To overcome this barrier, Medical Assistants' (MA) were trained to use the CPCI's Pre-Visit Planning (PVP) Report to identify patients with care gaps and lead care team huddles, and provide more advanced clinical functions to the top of their licenses to ensure screenings were initiated.

To monitor improvement, CHCANYS project managers extracted the 11 FQHC's breast, cervical, and colorectal cancer screening rates on a monthly basis and submitted them to the NYSDOH for analysis.

Results: From March 2016 to March 2017, the FQHCs collectively saw a relative increase in their breast cancer screening rate by 15.1%, a relative decrease in their cervical cancer screening rate by 0.7%, and a relative increase in their colorectal cancer screening rate by 11.4%. The FQHCs saw a relative increase in their utilization of the PVP report by 110.9% over the same time period.

BOARD 17 (Continued)

Conclusion: Access to data monitoring and clinical decision support tools alone does not guarantee improvement on clinical quality measures, but in combination with on-site practice coaching, CHCANYS project managers supported FQHC project teams in transforming clinical processes through enhanced staff roles and more efficient workflows. Huddling with the PVP Report allows FQHC staff to proactively identify and prioritize patients' multiple health care needs at their visit. Not only does the CPCI help FQHCs improve health outcomes of their patients, it assists them in meeting requirements for enhanced payment programs, ensuring their financial stability.

BOARD 18: *Vaccination as Cancer Prevention: Barriers and Facilitators of a Quality Improvement (QI) Intervention to Improve HPV Vaccination Rates Among Adolescents*

Nikie Sarris Esquivel, MPH¹, Mahima Ashok, PhD, MS¹, Marcie Fisher-Borne, PhD, MSW, MPH² and Alexander Preiss, MA²

1. RTI International
2. American Cancer Society

Background: The human papillomavirus (HPV) vaccine is a safe and effective way to protect individuals from diseases caused by HPV, including precancers and cancers. In 2014, the Centers for Disease Control and Prevention awarded the American Cancer Society (ACS) a 5-year cooperative agreement to expand its HPV vaccination efforts. As a part of this award, ACS is working closely with Federally Qualified Health Centers (FQHCs) and community health centers in the United States to increase HPV vaccination rates through improved provider awareness, education, and system-wide processes. In 2016, ACS partnered with Boston University's School of Medicine to launch a Maintenance of Certification (MOC) pilot, where providers participating in a HPV vaccination quality improvement project receive MOC Part IV credit and Continuing Medical Education Credits. In May 2017, ACS awarded RTI International a contract to conduct a process evaluation of the MOC pilot.

Goals and Objectives: To implement the MOC pilot to increase provider recommendation and vaccination rates for the HPV vaccine.

Methods: RTI conducted site visits at two MOC pilot sites, which included observational assessments of the clinic space (e.g., placement of HPV materials) and interviews with clinic and ACS staff. Qualitative data were cleaned and a thematic analysis was conducted. RTI abstracted common themes from MOC Learning Collaborative calls held monthly with ACS staff in charge of co-implementing the MOC pilots with FQHCs.

Results: Strong support and training from ACS and a local champion were primary drivers of success. Staff buy-in was critical, and can be achieved by the visible commitment of senior leadership as well as staff participation in creative training sessions (e.g., role-playing parental concerns). Parental resistance to the HPV vaccine, in part attributed to materials written at high literacy levels and English-only text, was a major barrier. The disconnect between clinics' electronic health records and the statewide immunization registry made data collection challenging.

BOARD 18 (Continued)

Conclusions: The MOC pilot was successfully implemented as a systems change intervention to promote cancer prevention. Developing and creatively placing materials that address parental concerns in other languages (e.g., Spanish), at lower literacy levels, and with graphics/pictures may help reduce parental resistance to the HPV vaccine. Data-related issues posed challenges but staff are willing to spend time and resources to address these. Technical assistance should be provided to address these needs. Ultimately, system change interventions targeted at cancer prevention may benefit from strong champions, tailored education materials, and substantive investment to address data challenges.

BOARD 19: We Matter: Increasing Colorectal Cancer Screening in Public Housing Residents

Linda Veit, MPH¹, Leslie Kohman, MD¹, Rachel Rudich¹, Rachel Ryan, MS¹, Liz Fuertes-Bender¹ and Aldrine Ashong-Katai, MS¹

1. Upstate Medical University

Background: Colorectal cancer (CRC) can be prevented by screening and removal of pre-cancerous polyps. African Americans and lower socio-economic groups have a disproportionate CRC burden with a higher incidence, later stage at diagnosis, and increased mortality compared to national averages. We must create a pro-active community approach with education about prevention and early detection of CRC and increased screening to reduce mortality disparities.

Goals and Objectives:

Goals: The aggressive national goal of having 80% of eligible people screened for CRC by 2018 requires communities and healthcare agencies to work collaboratively and use creative approaches.

We demonstrated that a partnership between a public housing authority (Syracuse Housing Authority) and an academic medical center (Upstate Medical University) using a nontraditional health education model can increase CRC screening in individuals ≥ 50 years old and raise awareness in a hard to reach, low socio-economic status population.

Project Objectives:

- 1) Increase knowledge about CRC and the importance of screening
- 2) Increase the rate of CRC screening in the targeted population
- 3) Provide navigation for patients with suspicious findings

The target population included 803 residents of three low-income, public housing complexes.

Methods: Health professionals at Upstate trained four Resident Health Advocates (RHAs) who live in the target community about CRC and screening methods. The RHAs educated their peers and neighbors about CRC risks and the importance of early detection during monthly education sessions and through direct outreach. Residents were given the opportunity for screening via fecal immunochemical testing (FIT) or colonoscopy. The RHAs were able to address barriers to access, racial biases, misinformation and fear with culturally appropriate outreach and education in order to change behaviors and make CRC screening a priority among residents of their community.

BOARD 19 (Continued)

Results: Between June 30, 2016 and June 29, 2017, 780 people (≥ 50 years of age) were informed about CRC screening by the RHAs through education sessions, tabling events and door to door encounters. Seventy-six FIT kits were distributed to residents of public housing 21 were returned for processing. Four colonoscopies were performed. One cancer was prevented by polyp removal and no cancers were detected.

Conclusions: The **WE MATTER** project demonstrated a unique collaboration between a healthcare institution and a public housing authority to work towards better health outcomes in a disadvantaged population. The project also demonstrated the effectiveness of using trained RHAs to increase CRC awareness and screening in low income, primarily African American men and women through peer outreach, education, and encouragement. This has the potential to increase screening and reduce cancer disparities. It is important to engage people in their own surroundings, to offer culturally appropriate material and language and to engage community members with the goal of increasing screening rates.