Louisiana Colorectal Health Project

Performance and Evaluation Report

2015—2020

Contents

Summary

The **Louisiana Colorectal Health Project** recruited clinics across the state to participate in a project aimed at increasing colorectal cancer screening rates. Enrolled clinics were provided ongoing support to implement interventions proven effective at increasing screening rates. Program reach extended to 12 clinics that served 19,872 patients aged 50 to 75 years. All of the clinics were FQHCs providing healthcare to underserved communities.

Clinics made big, early achievements following enrollment in the project:

- Each clinic increased the number of evidence-based interventions in-place.
- Average screening rates jumped by **14 percentage points** during a clinic's first year.
- The average rate had increased by **22 percentage points** over baseline after 2 years.

Clinic gains eventually slowed after a few years in the project, suggesting that impact of future efforts may be maximized by focusing on an intensive, finite period of implementation.

Introduction

Colorectal cancer (CRC) is the 2nd leading cause of cancer death among Louisiana residents. Louisiana has the 4th highest death rate and the 3rd highest incidence rate for CRC in the United States. Because CRC is highly treatable when diagnosed early, timely detection through regular screenings can greatly improve survival rates. Screening can also prevent the development of cancer through detection and removal of pre-cancerous polyps.

In the summer of 2015, Louisiana State University Health Sciences Center in New Orleans (LSUHSC-NO) was awarded a five-year cooperative agreement from the Centers for Disease Control and Prevention (CDC) to implement the Colorectal Cancer Control Program (CRCCP). The program was subsequently implemented on a regional level as the Louisiana Colorectal Health Project (LCHP). Throughout the project period, LCHP leveraged its federal funding to support clinical partners in the implementation of evidence-based interventions (EBIs) to increase colorectal cancer (CRC) screening. The five-year project period concluded at the end of June 2020.

LCHP conducted a multi-method evaluation to address a range of process and outcome-related questions. In this report, we present final evaluation results for the five-year project period including performance data for process and outcome measures. Evaluation findings are ultimately analyzed to offer evidence-based conclusions on project outcomes. At the end of the report, recommendations are listed to support program staff and stakeholders in future planning and program improvement.

Program Description

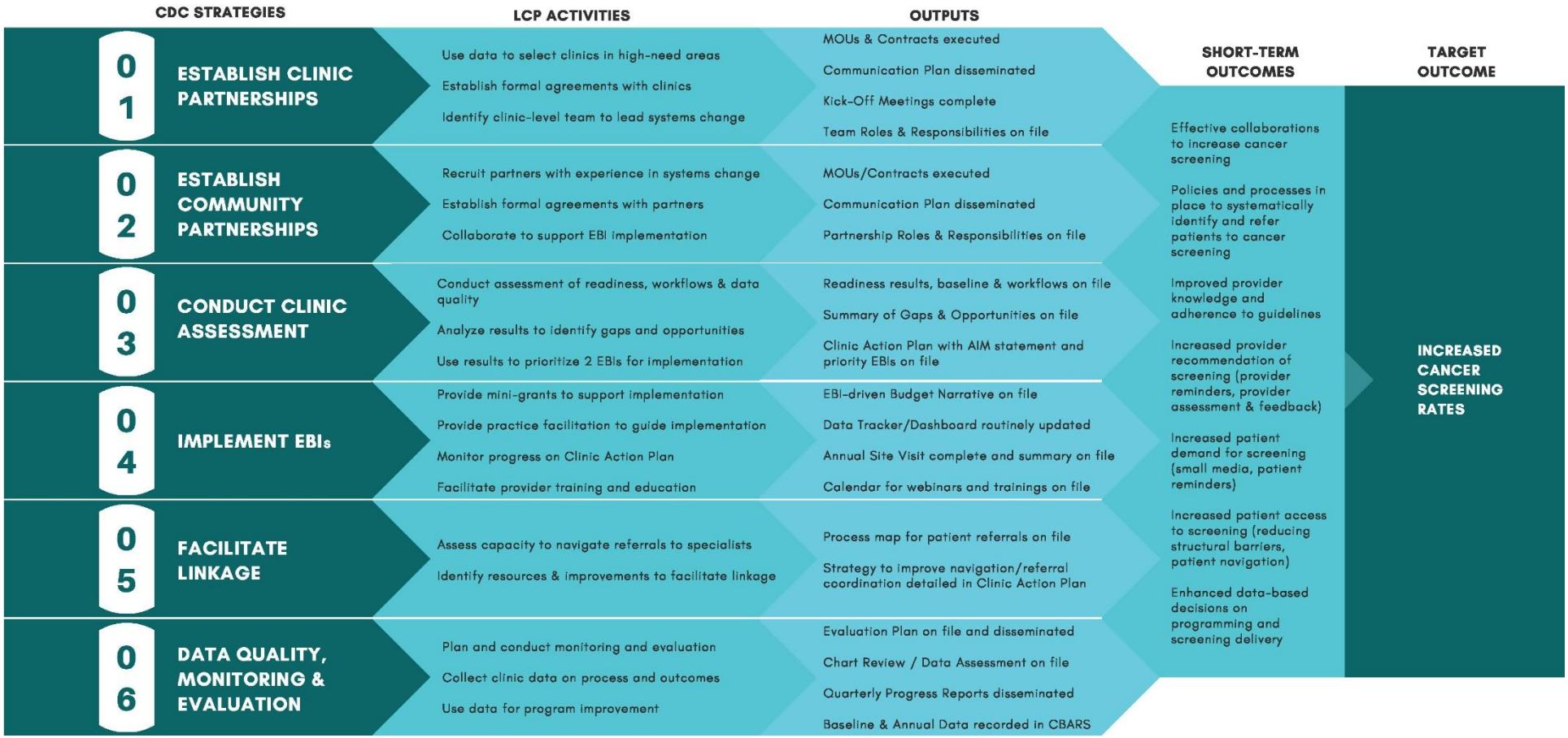
LSUHSC-NO was one of 31 grantees funded by the CDC to implement a statewide model of the CRCCP from 2015 through 2020. The express goal of the CRCCP is to increase CRC screening rates among medically underserved populations. Grantees are specifically funded to partner with clinics and support them in implementing strategies from The Community Guide proven effective at promoting cancer screening. In order to best reach the target population, grantees are encouraged to work with Federally Qualified Health Centers (FQHCs) who provide primary care to underserved communities.

LCHP was established in July of 2015. Along with FQHCs, LCHP partnered with the American Cancer Society (ACS) and the Louisiana Primary Care Association (LPCA) to assist with implementation of clinic-level activities. LCHP also partnered with Azara Healthcare to support participating clinics with data-driven reporting and analytics. On the following page, an updated logic model describes LCHP's activities, outputs and outcomes on the following page.

LCHP recruited clinics with high-need populations and low screening rates to participate. Each clinic's CRC screening process was assessed and results were used to identify care gaps and recommend EBIs. Clinics were required to implement 2 or more EBIs proven to reduce common barriers to screening. Priority EBIs were those proven effective at increasing community demand (patient reminders), increasing community access (reducing structural barriers), and increasing provider delivery of screening services (provider reminders, provider assessment and feedback). Supporting activities (SAs) such as provider education, small media and patient navigation could also be implemented.

After EBIs were selected, 2 key strategies supported their implementation: mini-grants and practice facilitation. The mini-grant program was administered by LPCA to provide clinics with modest financial support to cover start-up expenses related to EBI implementation. Practice facilitation was provided by LCHP and ACS staff trained in quality improvement coaching. Practice facilitators met with clinic staff on a regular basis. LCHP also provided technical assistance and professional education opportunities to partner clinics.

HEALTH SYSTEMS CHANGE TO INCREASE CANCER SCREENING



IV

Evaluation Background

The stated purpose of the CRCCP is to increase CRC screening rates among a grantee-defined target population of persons 50-75 years of age. LCHP aimed its efforts at increasing screening rates in FQHCS located in areas of Louisiana where late-stage diagnosis of CRC was most prevalent. CRCCP grantees such as LCHP were accountable for demonstrating success in increasing screening rates among their target population. Grantees were required to develop and implement an evaluation plan, as well as report final performance data and evaluation results within 90 days following the end of the 5-year project period.

To evaluate LCHP, project staff implemented a plan to answer fundamental questions:

1. Did the program reach its target population?
2. What EBIs and SAs were implemented in clinics?
3. Did clinic-level screening rates increase following implementation of EBIs and SAs?

The answers to these overarching evaluation questions and supplemental inquiries are intended to demonstrate the process and outcomes of the project. Conclusions are expected to inform planning efforts for future program cycles as stakeholders seek to build on project strengths and close gaps.

V

Methods

Multiple methods were deployed to address the evaluation questions. In addition to gathering high quality clinic-level data required by the CDC, LCHP conducted its own monitoring and evaluation activities to support on-going program improvement. The evaluation was an iterative process and some methods developed over time.

➥Data Collection

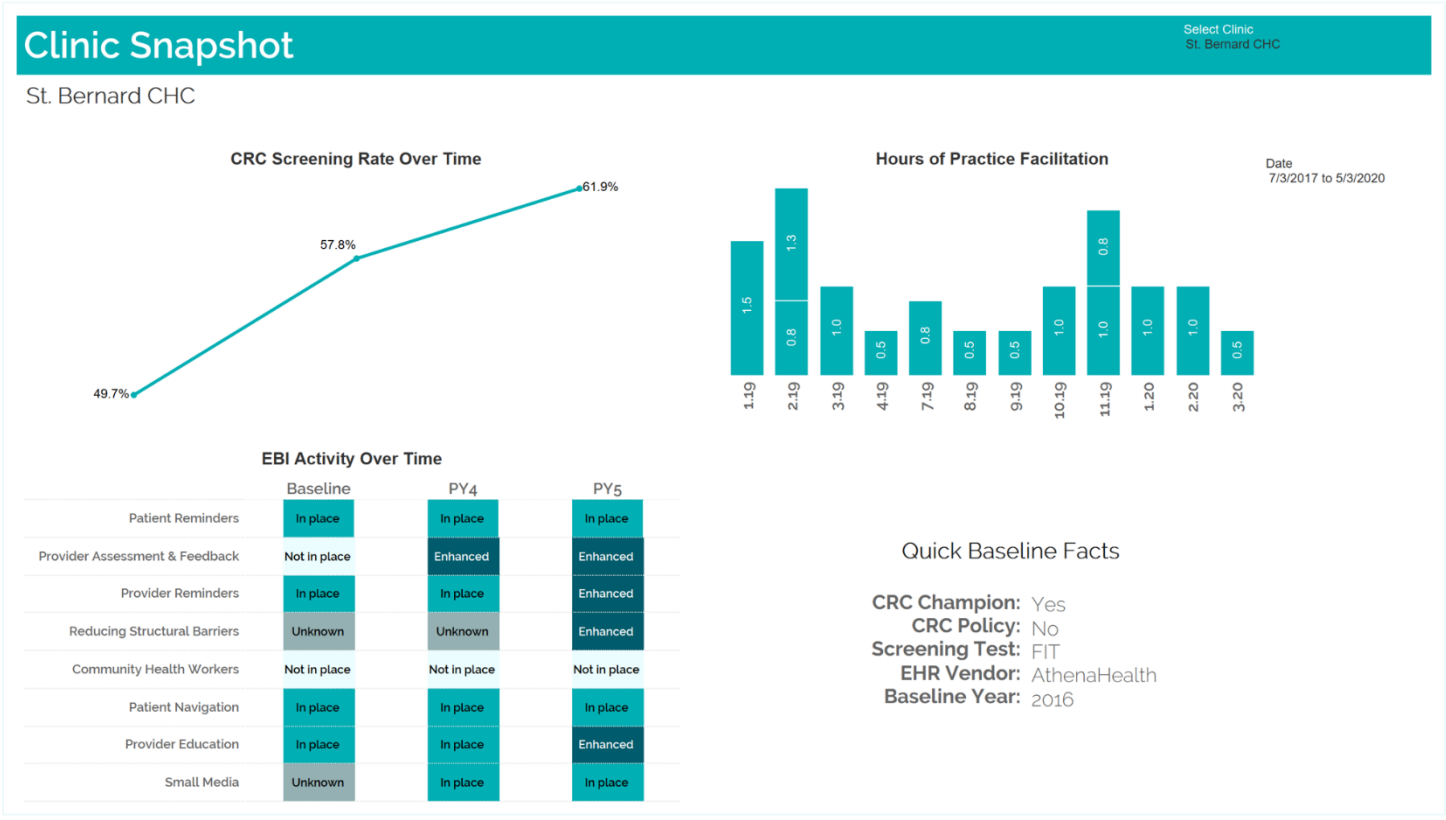
As noted above, primary data collection encompassed all clinic-level data defined by the CDC. LCHP collected baseline data for each clinic before intervention activities were implemented. Baseline data included information to describe the clinic and its patient population, in addition to baseline screening rates and EBIs/SAs in-place prior to intervention activities. Thereafter, structured follow-up data on screening rates and EBIs/SAs was collected on an annual basis to monitor and evaluate project activities and the outcome of interest. The CDC developed spreadsheet-based forms for both baseline and annual clinic data collection. LCHP staff sent the forms to clinic personnel to complete and return. Reponses were reviewed with clinics before the data was recorded in an online database.

LCHP collected additional information on process implementation beyond what was required by the CDC. Principally, practice facilitators would report on the content of recurring meetings with partner clinics. An Excel-based tracking sheet was developed to collect information on dates, duration, and action items. Meeting data was eventually recorded in Podio and later transferred to Microsoft Access. Additional sources of process implementation data included EHR data visualized in Azara DRVS as well as mini-grant narratives submitted by partner clinics. In the final weeks of the project period, LCHP administered a closeout survey among external stakeholders to assess perceived impact and solicit feedback on methods. All survey respondents were invited to participate in a follow-up interview; zero opted-in.

➥Analysis

Descriptive analyses were conducted to summarize information on project reach and process implementation. A Tableau-based dashboard was developed to visualize clinic-level process and outcome data. The interactive dashboard was powered by CDC-defined data and clinic meeting data to generate summary snapshots for quick reference. Following the methods of CDC evaluators, baseline and annual screening rates were weighted according to screen-eligible patient counts. Weighting the clinic-level screening rates was necessary to account for variance in clinic size when assessing screening rate changes in aggregate. Screening rates for one clinic were excluded from aggregate analyses due to clinic erroneously reporting a system-level rate at baseline rather than a comparable clinic-level rate.

A dashboard was developed to quickly analyze clinic data.

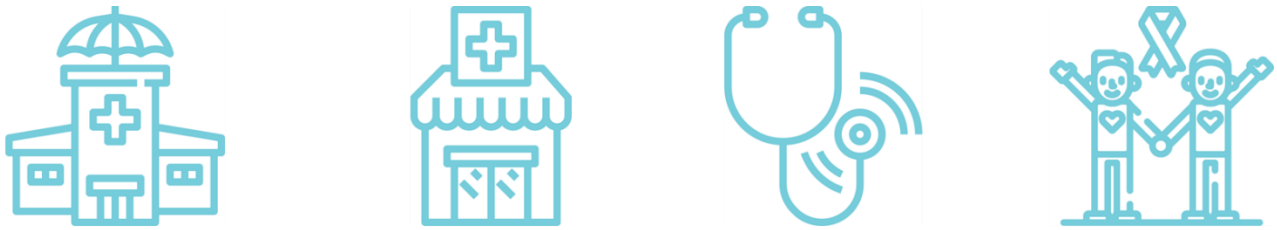


VI

Results

➥Program Reach

Our reach was multi-dimensional…



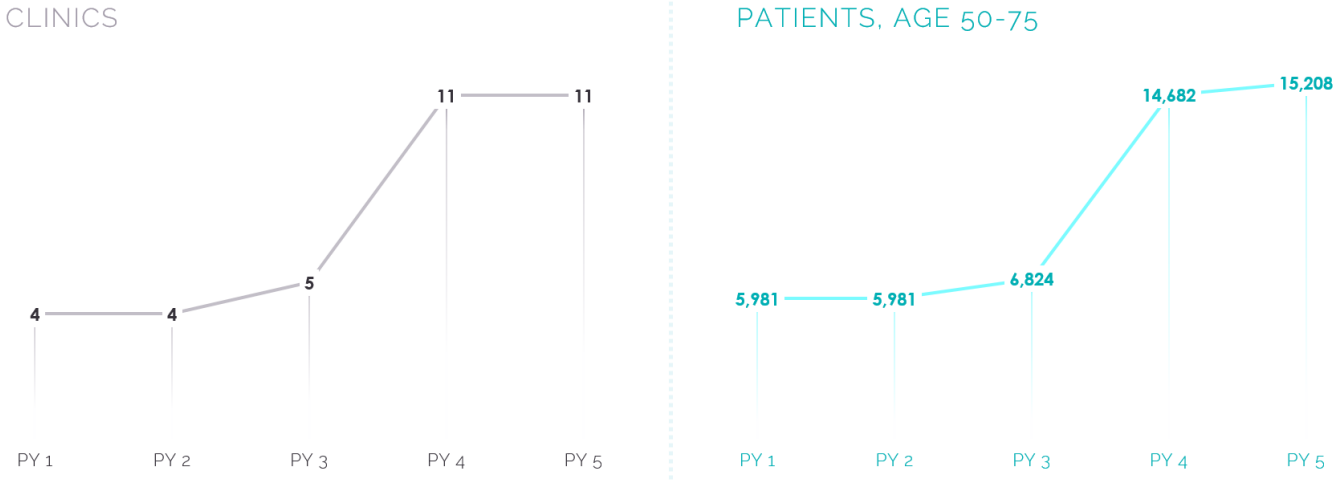
7 Health Systems

12 Clinics

67 Providers

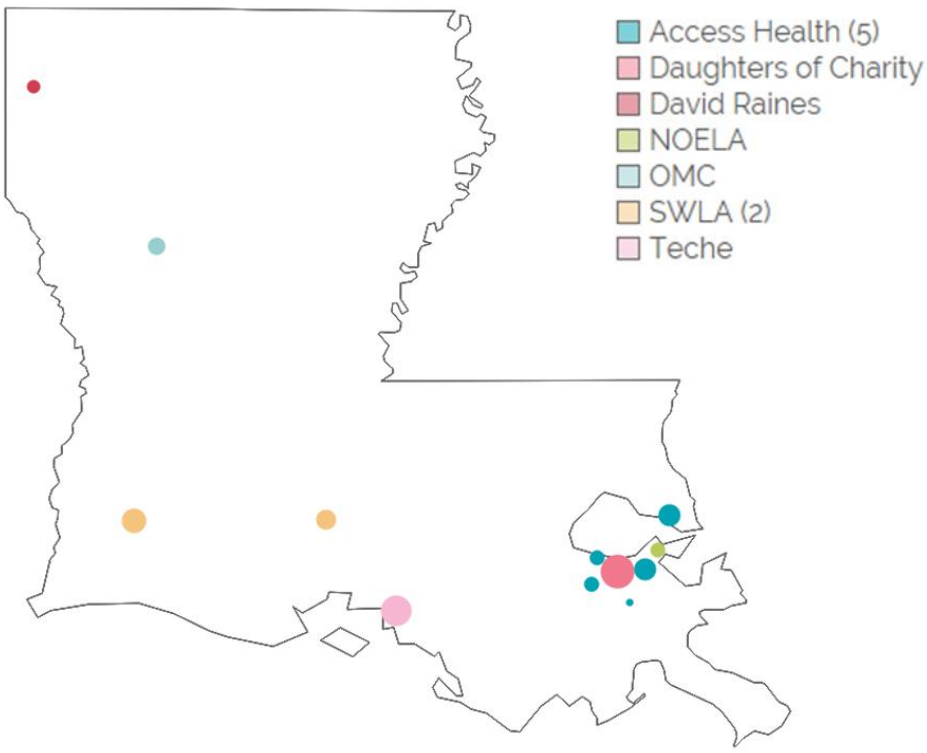
19,872 Patients

And more than doubled over time.



From 2015 to 2020, LCHP partnered with 7 health systems and enrolled 12 clinics in the project. The 12 clinics represented 67 providers serving 19,872 patients aged 50 to 75.

Clinics were spread across the state…



And the target population was engaged.

12 Clinics

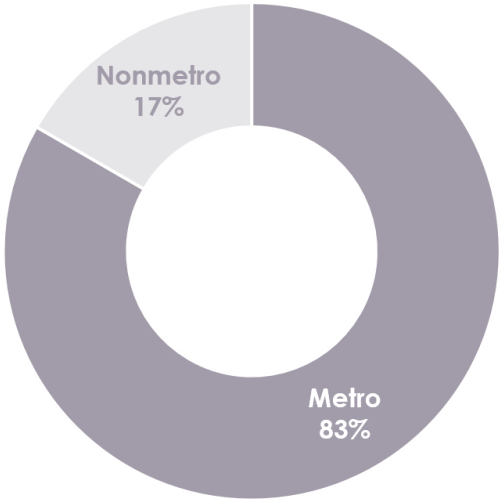
100%
Federally Qualified Health Centers (FQHCs)

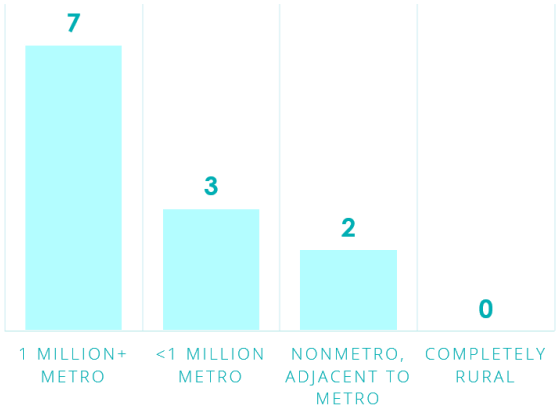
100%
In parishes with majority late-stage diagnosis

31%
average baseline screening rate*

Appropriate, high-need clinics were selected for intervention. All of the enrolled clinics were FQHCs and each was located in a parish with majority late-stage diagnosis of CRC. The average screening rate among clinics (31%) was lower than the 2015 US average (38%).

However, not many rural clinics were enrolled…

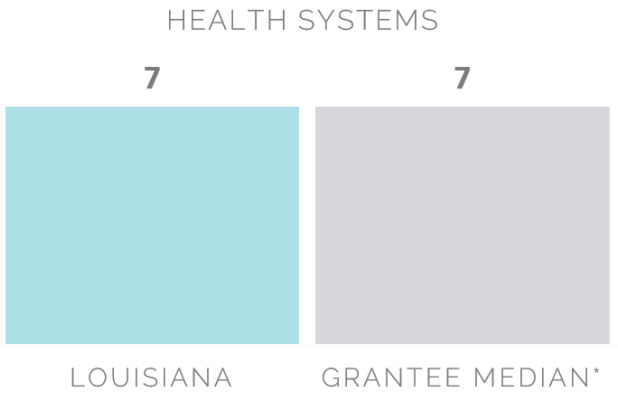


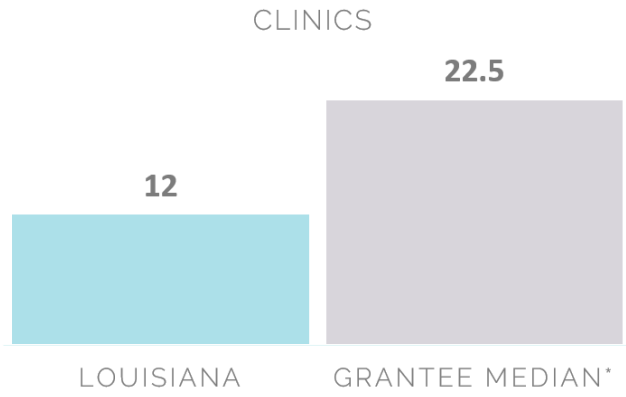


Clinic Locations by USDA Rural-Urban Classification

10 out of 12 clinics were located in a metropolitan area. Just 2 clinics were located in non-metropolitan areas and 0 were located in rural communities, according to USDA data.

And other grantees enrolled more clinics within systems.

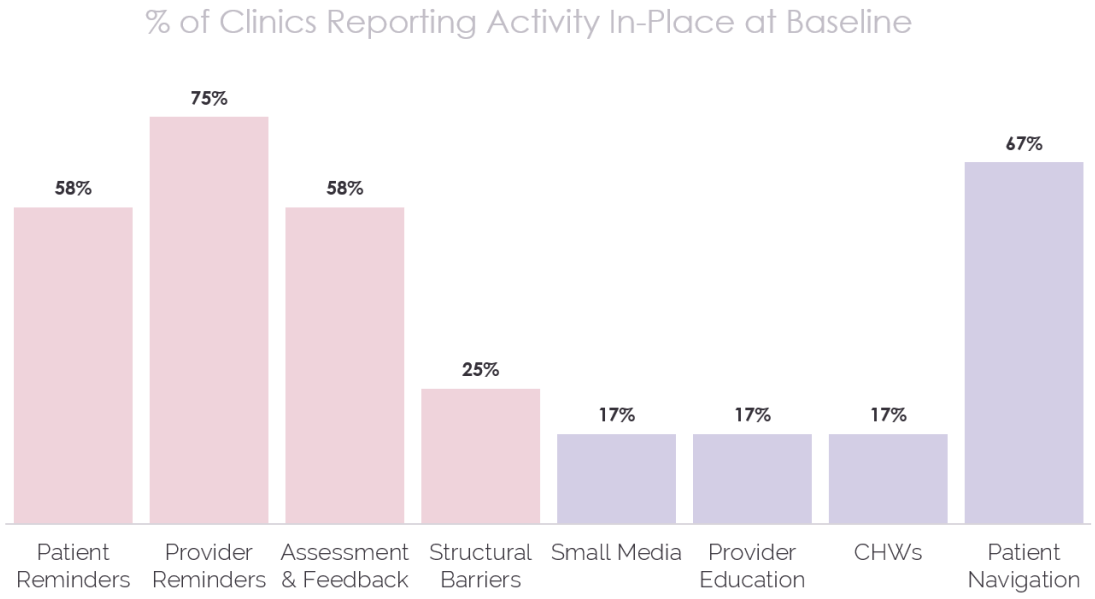




Our number of health system partners was typical for grantees, but other grantees observably enrolled more clinics within partner health systems.

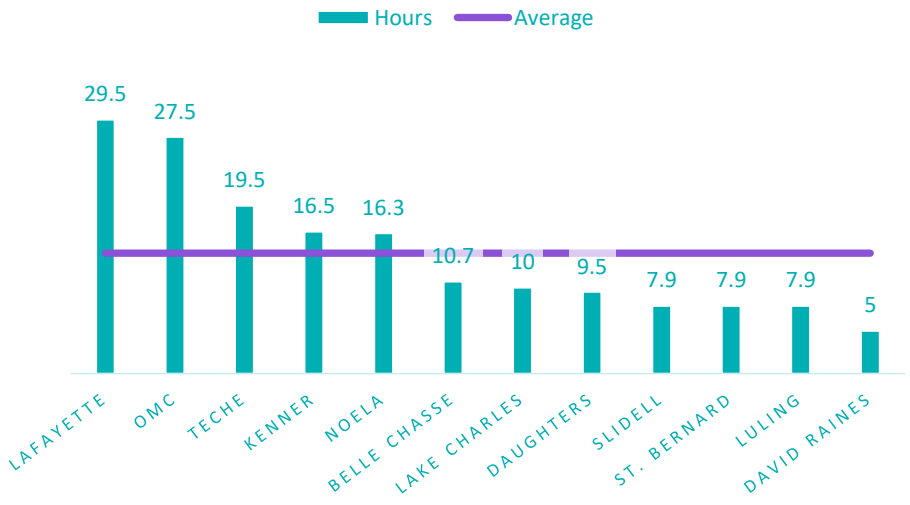
➥Evidence-Based Interventions

Some EBIs and SAs were in-place before implementation.

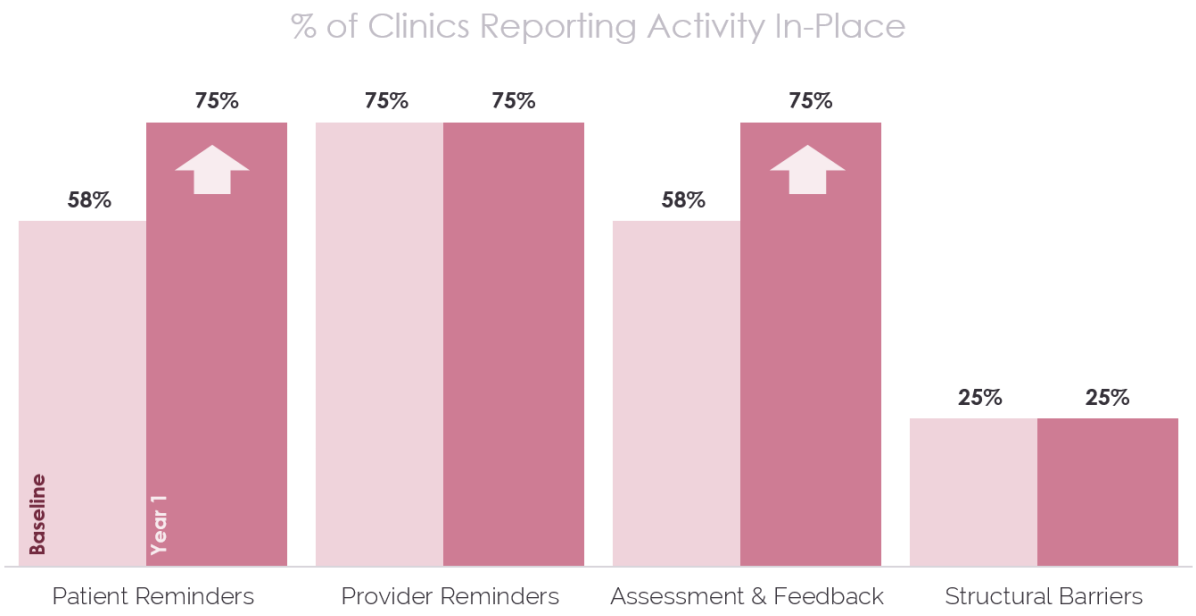


A majority of clinics reported having Patient Reminders, Provider Reminders and Provider Assessment and Feedback in-place at baseline. Few supporting activities were in-place with the exception of Patient Navigation.

Clinics received an average of 14 hours of EBI implementation support during their first year in project.

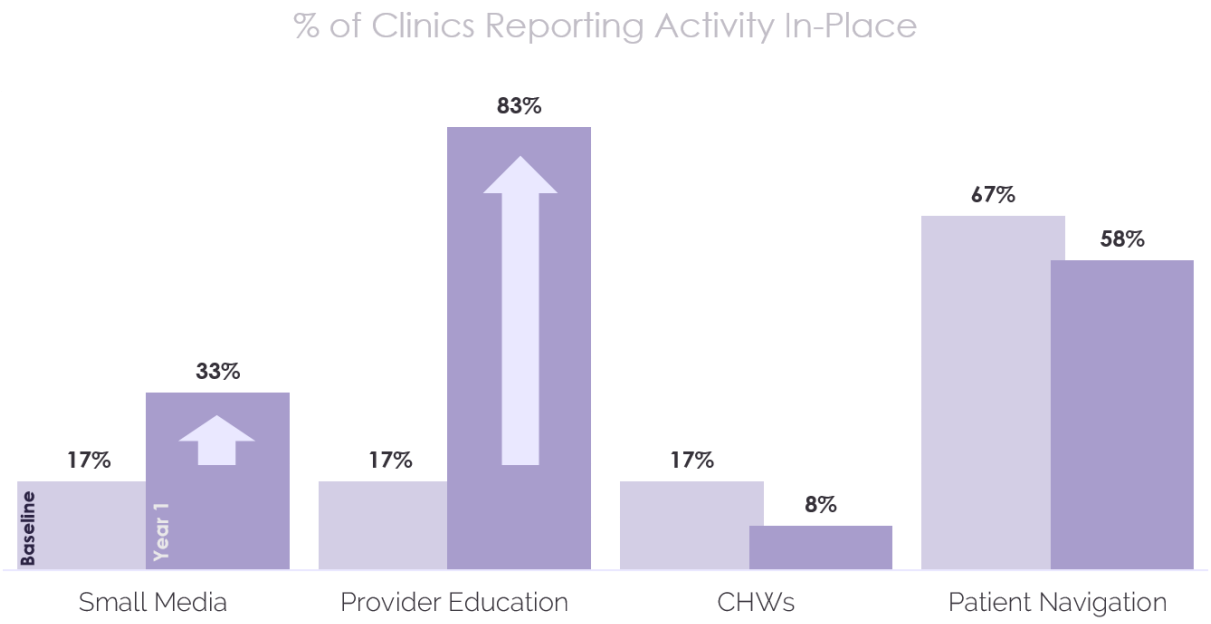


2 EBIs were more likely to be in-place after Clinic Year 1.



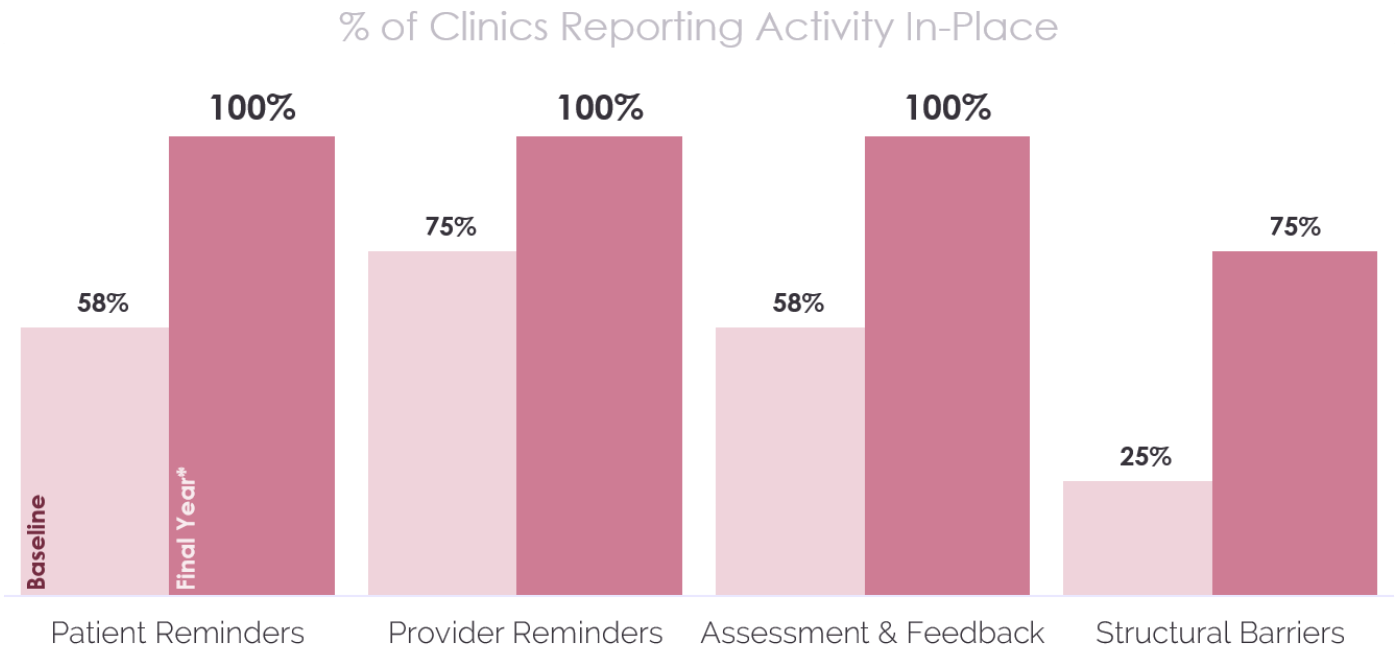
Clinics were most likely to select and implement Patient Reminders and Provider Assessment & Feedback during their first year in the program.

Some SAs saw substantial increases during Clinic Year 1.

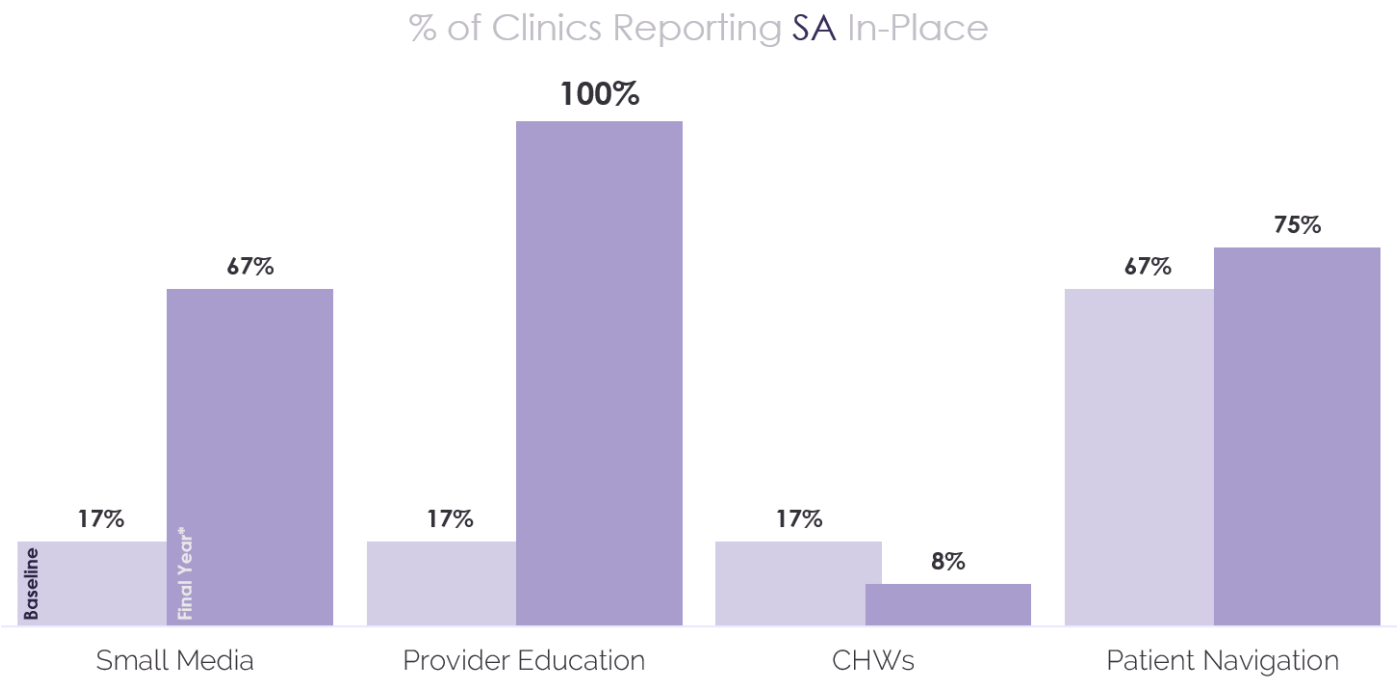


Clinics were far more likely to have Provider Education in-place after Year 1, likely due to trainings and webinars sponsored by LCHP. Small Media also increased among clinics.

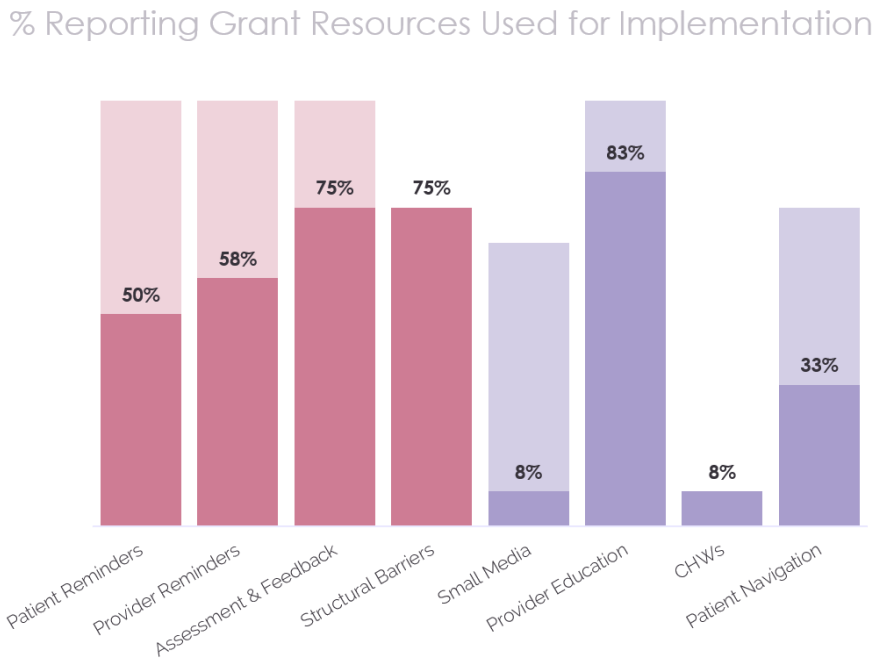
By their final year, 100% of clinics had several EBIs in-place.



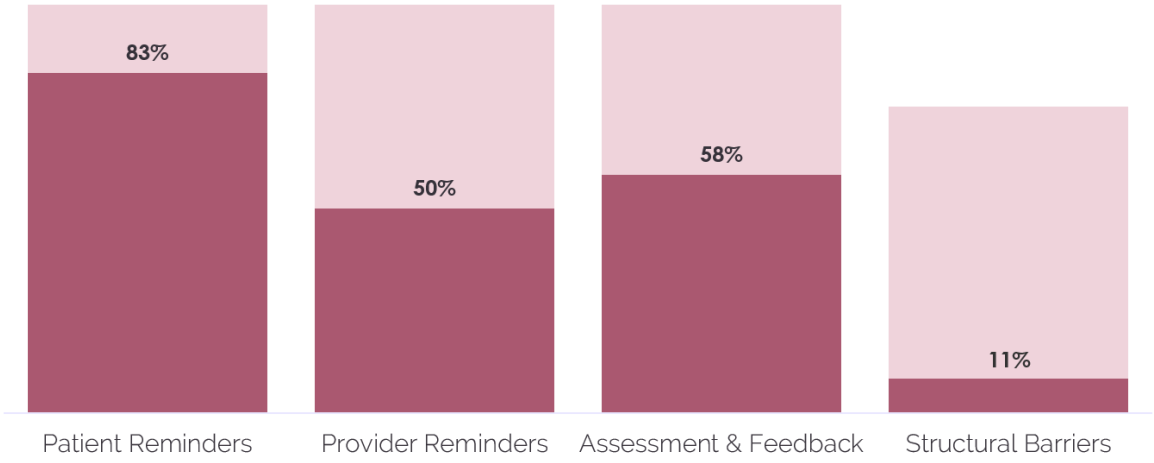
100% reported Provider Education by their final year, too.



Grant resources supported many EBIs and SAs that were in-place by the end of a clinic's final year.



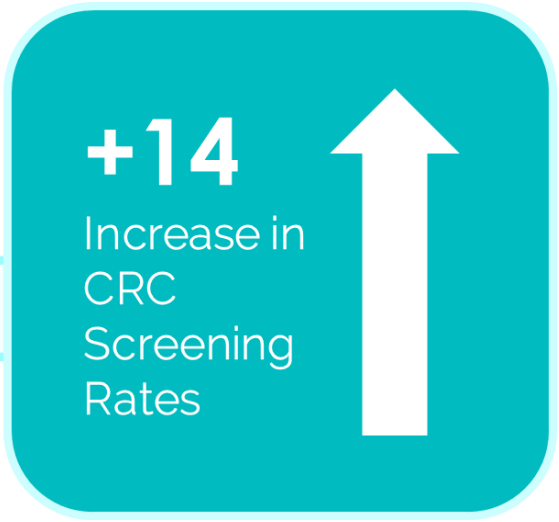
However, not all clinics considered the EBIs sustainable.



➥Screening Rates

After 1 year in program, average screening rates increased by 14 percentage points.

	Baseline Screening Rate	Year 1 Screening Rate
Clinic Average (N=11)*	31%	45%



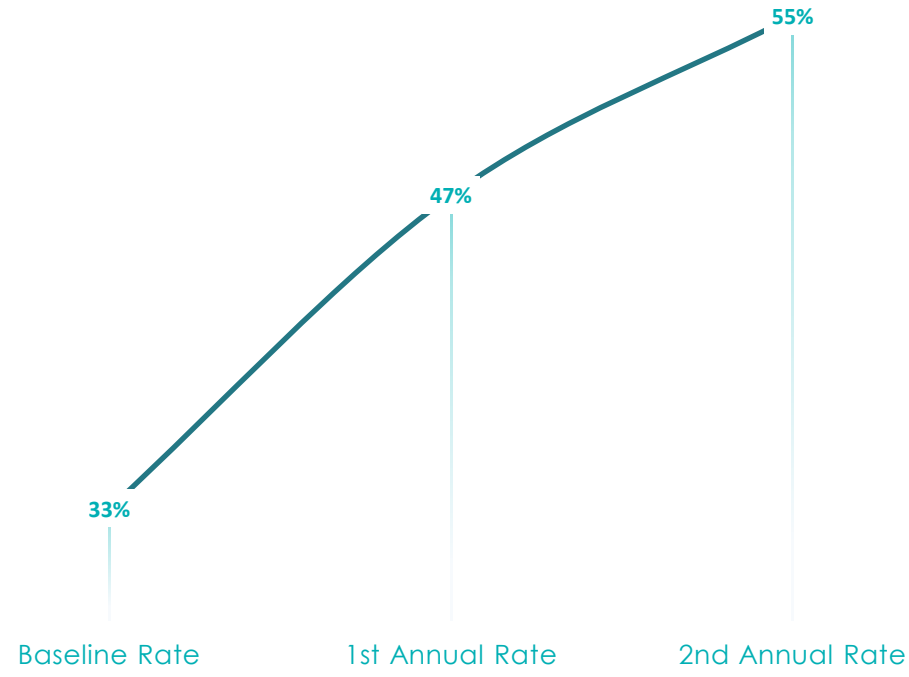
*Excludes SWLA-Lafayette due to incomplete baseline data. Screening rate % reflects weighted rate.

After 2 years in program, screening rates had increased by 22 percentage points.

	Baseline Screening Rate	Year 2 Screening Rate
Clinic Average (N=10)*	33%	54%

*Excludes SWLA-Lafayette due to incomplete baseline data; excludes SWLA-Lake Charles due to insufficient years of participation. Screening rate % reflects weighted rate.

Clinics made big gains across their first 2 years in program.



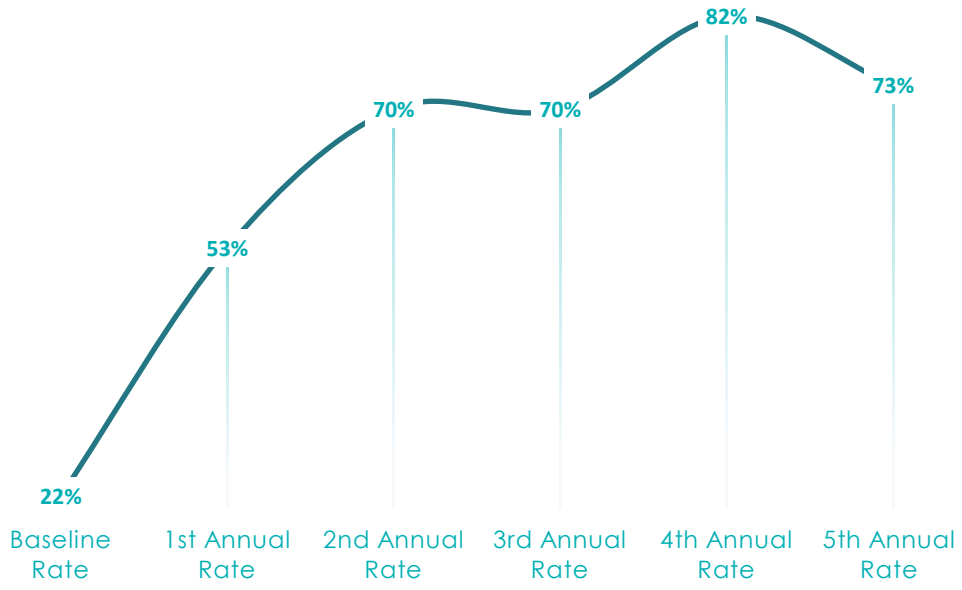
N=10

However, increases eventually slowed among the few clinics enrolled 3+ years.

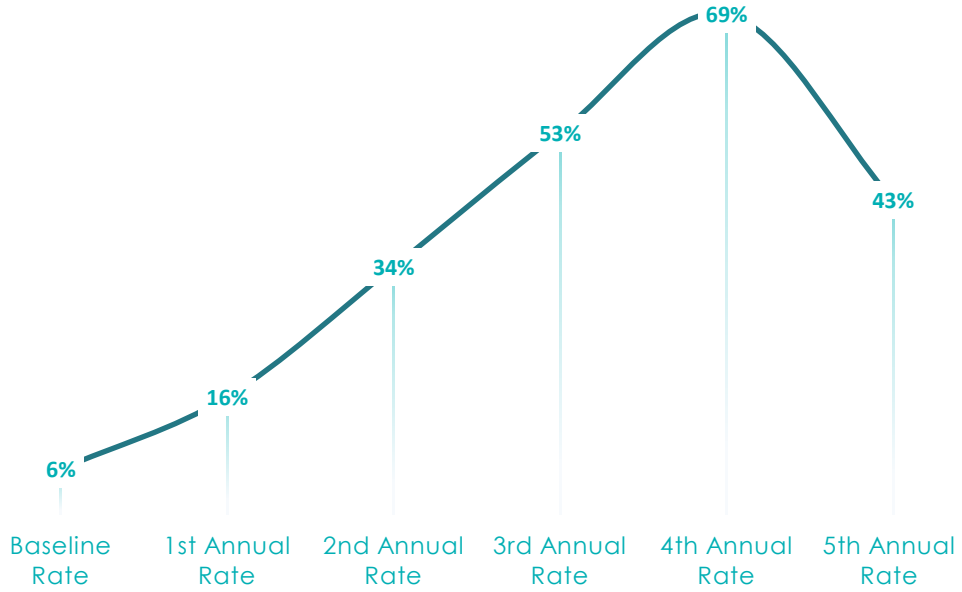
N=4

Clinics enrolled for 5-years shed light on long-term effects.

NOELA made big early gains, then maintained success.



OMC made steady progress, then switched EHRs in final year.



*SWLA-Lafayette not represented due to incomplete baseline data.

➥Conclusions

LCHP partnered with 7 health systems over the 5 years of the performance period. The project reach's extended to 12 clinics that served 19,872 patients aged 50 to 75 years. All of the clinics were FQHCs serving high percentages of uninsured patients.

Partner clinics implemented The Community Guide's EBIs to increase CRC screening. Clinics were more likely to have EBIs in-place after 1 year in the project. Consistent with study results demonstrating strength of multi-component interventions, 100% of enrolled clinics had a minimum of 3 EBIs in-place at the time of their last annual data submission.

Impact of program interventions was evidenced by consistently remarkable increases in screening rates across clinics during their initial years of implementation. On average, clinics increased their screening rates by 14 percentage points during the first year enrolled in the project. After 2 years in the project, the average clinic had increased their screening rate by 22 percentage points over their baseline numbers.

Though achievements were maintained, screening rate increases eventually plateaued for most clinics enrolled long-term. In terms of evaluating outcomes, OMC's transition to new EHR during their 5th year of project participation illustrates a potential pitfall in long-term relationships with clinics. Given strength of early increases, the impact of future efforts may be maximized by focusing resources on intensive early implementation with a clinic. Resources could be shifted to newly enrolled clinics as "legacy" clinics sustain improvements.