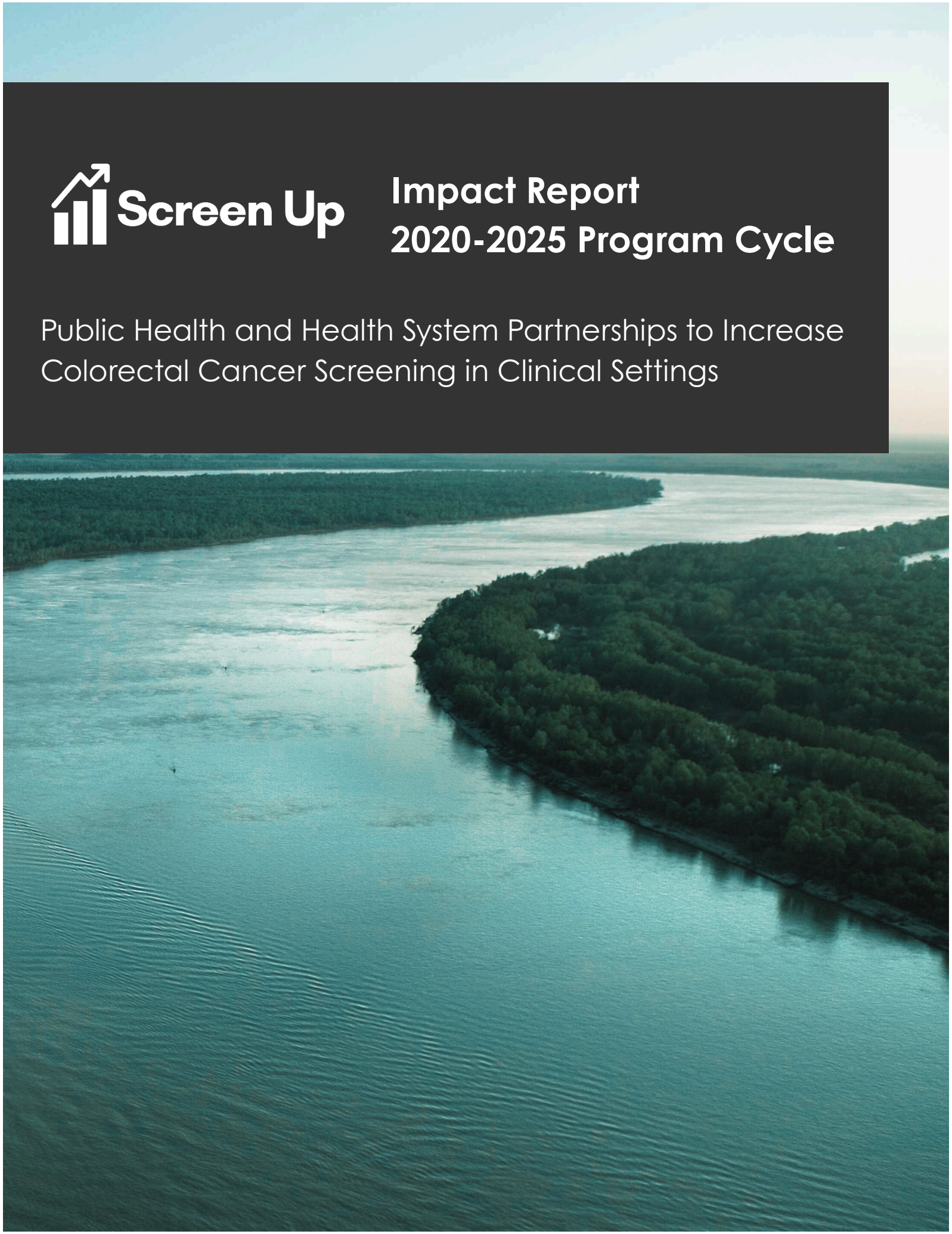
Screen Up

# Impact Report
# 2020-2025 Program Cycle

Public Health and Health System Partnerships to Increase Colorectal Cancer Screening in Clinical Settings



# Acknowledgements

## Screen Up Clinic Participants

Screen Up's success is entirely due to the dedication and participation of the participating clinics & partner organizations. Their staff dedicated time and energy to every aspect of the program, demonstrating a consistent level of engagement throughout. This success is a true reflection of their commitment to improving the health of their communities.

### Participating Clinics

- Access Health Louisiana
- Baptist Community Health Services
- Baton Rouge Primary Care Collaborative
- CareSouth Medical & Dental
- Common Ground Health Clinic
- Iberia Comprehensive Community Center
- InclusivCare
- Open Health Care Clinic
- Plaquemines Primary Care
- Start Corp. Community Health Center

### Partner Organizations

- American Cancer Society (ACS)
- Azara Healthcare
- Cancer Association of Louisiana (CALA)
- Centers for Disease Control and Prevention (CDC)
- Exact Sciences
- Louisiana Cancer Prevention and Control Programs (LCP)
- Louisiana Colorectal Cancer Roundtable (LCCRT)
- Louisiana Department of Health (LDH)
- Louisiana Primary Care Association (LPCA)
- Louisiana Public Health Institute (LPHI)
- Louisiana Tumor Registry
- LSU Health New Orelans School of Public Health
- Taking Aim at Cancer Louisiana (TACL)

This program is supported in large part through a five-year cooperative agreement from the Centers for Disease Control and Prevention (CDC) DP20-2002: Public Health and health systems partnerships to increase colorectal cancer in clinical settings. Screen Up would like to acknowledge the support of our CDC program officer for guidance throughout the 5-year program cycle.

# Contents

# Executive Summary

The Screen Up Program supports health systems, community health centers, and Federally Qualified Health Centers (FQHCs) in Louisiana in implementing evidence-based interventions (EBIs) to increase cancer screening rates. Participating clinics are required to implement at least two of the following in their first year in the program: 1) patient reminders, 2) provider reminders, 3) provider assessment and feedback, or 4) reducing structural barriers.

Between 2020 and 2025, Screen Up enrolled ten clinics and provided ongoing support to help them implement proven EBIs that enhance colorectal cancer screening efforts. All participating clinics were Federally Qualified Health Centers (FQHCs) that served 203,722 patients and identified 50,158 eligible patients for cancer screening.

Clinics achieved notable early successes in colorectal cancer screening after enrolling in the program:

- Each clinic increased the number of EBIs in place.
- Average colorectal cancer screening rates increased by 8 percentage points after two years in the program.
- 100% of clinics reported a very high level of confidence in applying the knowledge and skills through the program in other clinic sites.

Screen Up has fostered measurable improvements in cancer screening rates by equipping clinics with the necessary quality improvement tools and resources to address challenges in cancer screening workflows.

Screen Up

**For more information about the Screen Up program, our history, and our impact in the community, contact:**

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Phone: 504-568-5893

# Cancer in Louisiana

Louisiana carries a higher cancer burden than the national average, ranking 4th in overall cancer incidence and 7th in overall cancer mortality. Colorectal, breast, and cervical cancers contribute significantly to these rates, and importantly, all three are detectable through effective screening.

- Colorectal cancer (CRC) is the 2nd leading cause of cancer death among Louisiana residents. Louisiana has the 5th highest death rate and the 3rd highest incidence rate for CRC in the United States. Because CRC is highly treatable when diagnosed early, timely screenings can greatly improve survival rates. Screening can also prevent cancer through the detection and removal of pre-cancerous polyps.

- Breast cancer is the most frequently diagnosed cancer among women in Louisiana. In Louisiana, significant geographic disparities in breast cancer deaths exist, with death rates in 33 out of 64 parishes far exceeding the state rate of 20.3. When caught at an early stage, breast cancer has a nearly 100% survival rate. If found at Stage III, the survival remains at 86%. Regular screenings are the most effective strategy to prevent breast cancer deaths.

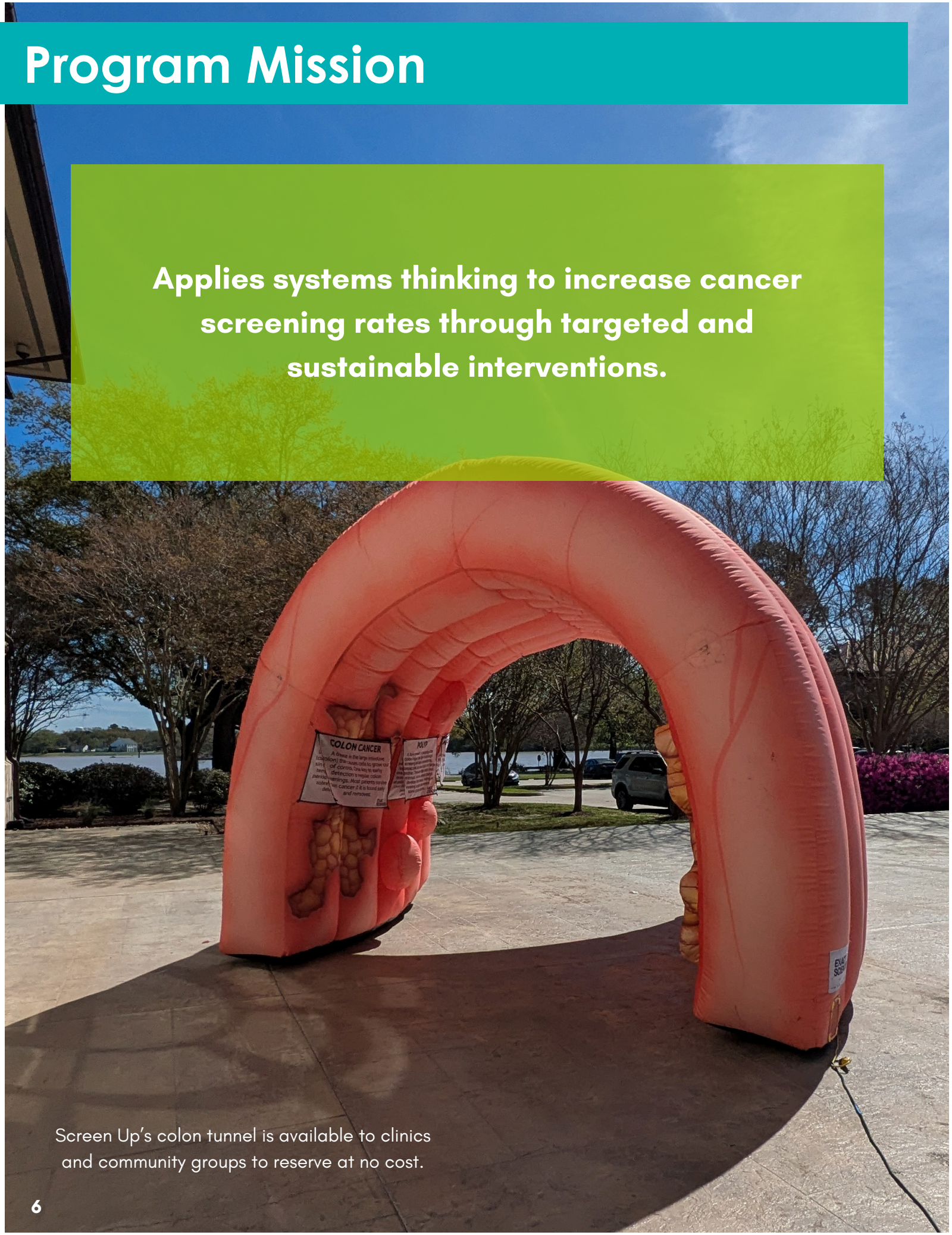
- Louisiana has one of the highest cervical cancer rates in the U.S. Cervical cancer is now largely preventable due to the human papillomavirus (HPV) vaccine and can often be detected in its early (precancerous) stage through screening. Regular screening is the most effective way to detect cervical cancer early, and when combined with vaccination of both men and women, it has the potential to virtually eliminate cervical cancer.

In July 2015 and 2020, 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). This program was subsequently implemented on a state level as Screen Up.

Screen Up conducted a mixed-methods evaluation to assess the program's impact on participating clinics working to increase colorectal cancer screening rates. This report presents the findings from the 2020-2025 program period.

# Program Mission

**Applies systems thinking to increase cancer screening rates through targeted and sustainable interventions.**




Screen Up's colon tunnel is available to clinics and community groups to reserve at no cost.

# Program Description

Screen Up applies evidence-based implementation science strategies to deliver tailored quality improvement support to primary care clinics in Louisiana. By systematically integrating proven interventions and optimizing workflow processes, Screen Up enhances the adoption, fidelity, and sustainability of cancer screening practices. This targeted approach addresses patient-level and system-level barriers to screening, ultimately driving measurable increases in preventable cancer screening rates and contributing to reductions in cancer incidence, suffering, and mortality.

In the program cycle 2020-2025, Screen Up established partnerships with 14 clinics that collectively serve 203,722 patients in primary care settings. Screen Up selects clinic partners based on two criteria:

- those that provide services to underserved populations in primary care settings
- those with a breast, cervical, or colorectal cancer screening rate below 60%

Additionally, Screen Up collaborates with external organizations that support medically underserved populations. Key partners include US Centers for Disease Control and Prevention (CDC), the American Cancer Society (ACS), Louisiana Department of Health (LDH), Louisiana Public Health Institute (LPHI), Azara Healthcare, Louisiana Primary Care Association (LPCA), Louisiana Tumor Registry (LTR), Taking Aim at Cancer Louisiana, and the Louisiana Comprehensive Cancer Control Program (LCCCP).

Once a clinical partner is enrolled in the Screen Up program, practice facilitators work with the clinic team to implement evidence-based interventions (EBIs) to enhance screening efforts. Screen Up provides clinics with:

- A no-cost practice facilitator to provide technical assistance
- Funding to support implementation of EBIs
- Electronic Health Record (EHR) support
- Technical assistance for collecting and using data and reporting
- Promotion of success and services
- Professional development and training
- Supporting webinars and continuing education opportunities

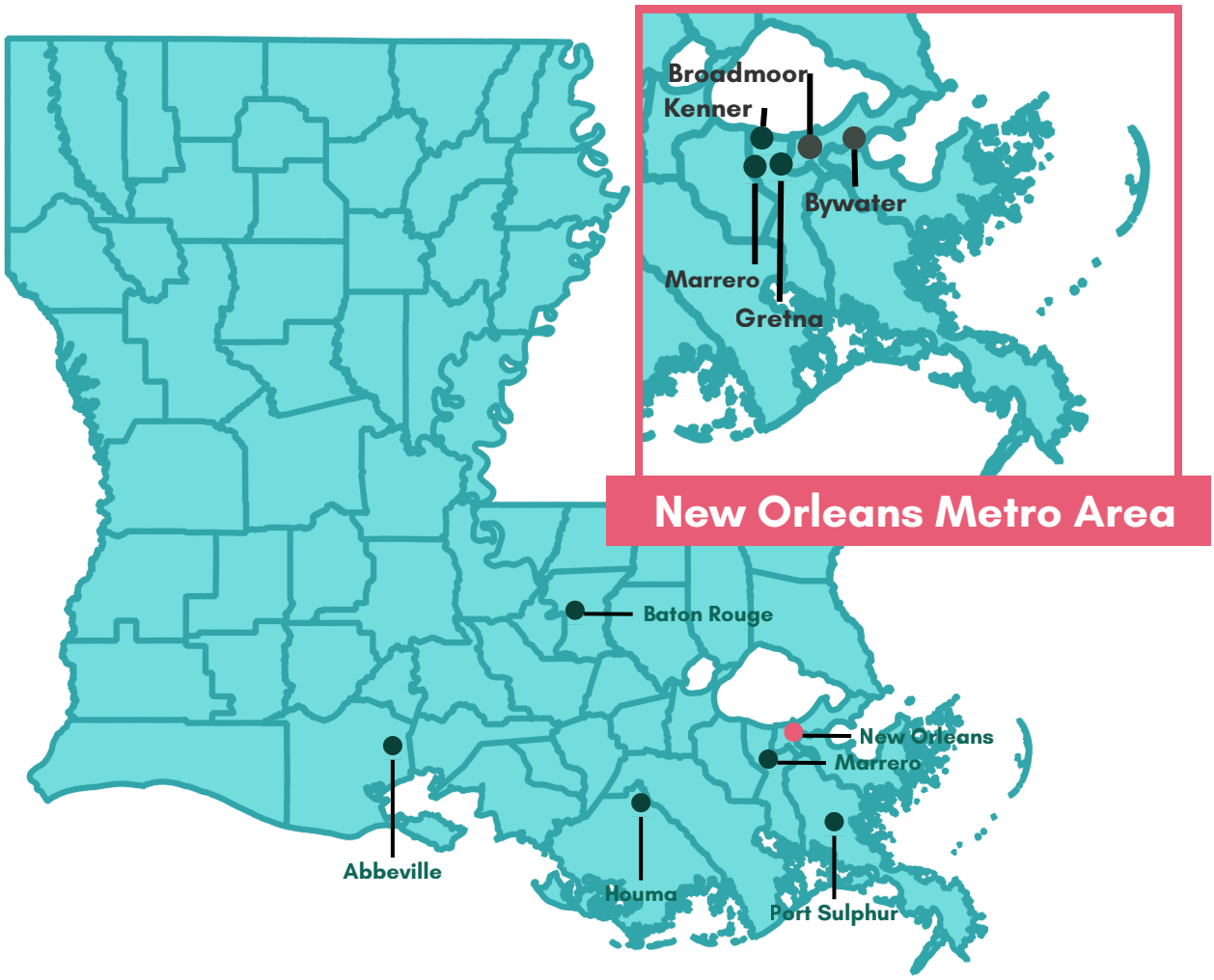
# Program Description

Screen Up's logic model provides a visual framework that outlines its intended impact on cancer screenings, while systematically organizing key components and anticipated outcomes. Within the model, particular emphasis is placed on the relationships between CDC strategies and the activities implemented by the program.

| CDC STRATEGIES | 01 | 02 | 03 | 04 | 05 | 06 |
|---|---|---|---|---|---|---|
| | ESTABLISH CLINIC PARTNERSHIPS | ESTABLISH COMMUNITY PARTNERSHIPS | CONDUCT CLINIC ASSESSMENT | IMPLEMENT EBIs | FACILITATE LINKAGES | DATA QUALITY, MONITORING & EVALUATION |
| ACTIVITIES | • Use data ta select clinics In high-need areas<br>• Establish formal agreements with clinics<br>• Identify clinic-level team to lead systems change | • Recruit partners with experience in systems change<br>• Establish formal agreements with partners<br>• Collaborate to support EBI Implementation | • Conduct assessment of readiness, workflows, & data quality<br>• Analyze results to identify gaps and opportunities<br>• Use results to prioritize 2 EBIs for implementation | • Provide mini-grants to support implementation<br>• Provide practice facilitation to guide implementation<br>• Monitor progress on Clinic Action Plan<br>• Facilitate provider training and education | • Assess capacity to navigate referrals to specialists<br>• Identify resources & improvements to facilitate linkage | • Plan and conduct monitoring and evaluation<br>• Collect clinic data on process and outcomes<br>• Use data for program Improvement |
| OUTPUTS | • MOU's & contracts executed<br>• Communication Plan disseminated<br>• Kick-Off Meetings complete<br>• Team Roles & Responsibilities on File | • MOUs/Contracts executed<br>• Communication Plan disseminated<br>• Partnership Roles & Responsibilities on file | • Readiness results, baseline & workflows on file<br>• Summary of Gaps & Opportunities on file<br>• Clinic Action Plan with AIM statement and<br>• priority EBIs on file | • EBI-driven Budget Narrative on file<br>• Data Tracker/Dashboard routinely updated<br>• Annual Site Visit complete and summary on file<br>• Calendar for webinars and trainings on file | • Process map for patient referrals on file<br>• Strategy to improve navigation/referral<br>• coordination detailed In Clinic Action Plan | • Evaluation Plan on file and disseminated<br>• Chart Review / Data Assessment on file<br>• Quarterly Progress Reports disseminated<br>• Baseline & Annual Data recorded in CDC C-BARS |
| SHORT-TERM OUTCOMES | • Effective collaboration to Increase cancer screening | • Policies and processes in place to systematically identify and refer patients to cancer screening | • Improved provider knowledge and adherence to guidelines | • Increased provider recommendation of screening (provider reminders, provider assessment & feedback)<br>• Increased patient demand for screening (small media, patient reminders) | • Increased patient access to screening (reducing structural barriers, patient navigation) | • Enhanced data-based decision on programming and screening delivery |
| TARGET OUTCOMES | INCREASED CANCER SCREENING RATES | | | | | |

# Five-Year Program Reach

Screen Up partnered with ten Federally Qualified Health Centers (FQHCs) to increase colorectal screening rates between 2020 and 2025. Seven of the 10 clinics were located in metropolitan areas, while the other three were in non-metropolitan areas.




**10**
NUMBER OF CLINICS PARTICIPATED BETWEEN 2020-2025

**74**
NUMBER OF PROVIDERS ACROSS ALL CLINIC PARTNERS

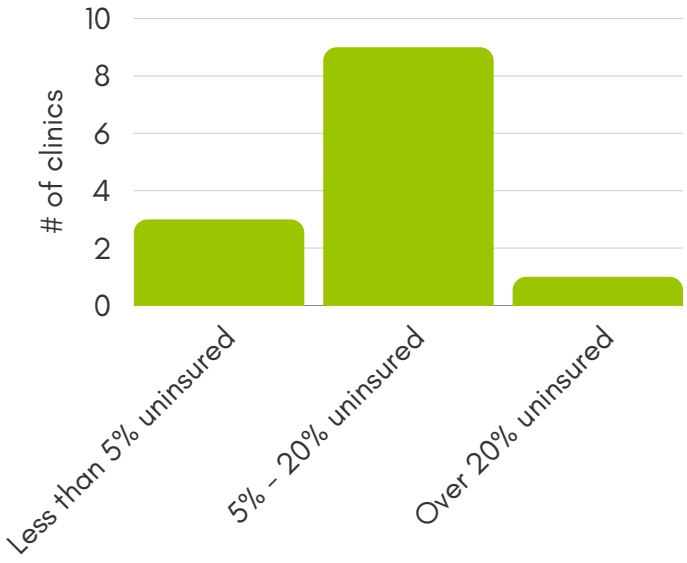
**203,722**
NUMBER OF TOTAL PATIENTS SERVED

**50,158**
NUMBER OF ELIGIBLE PATIENTS SCREENED

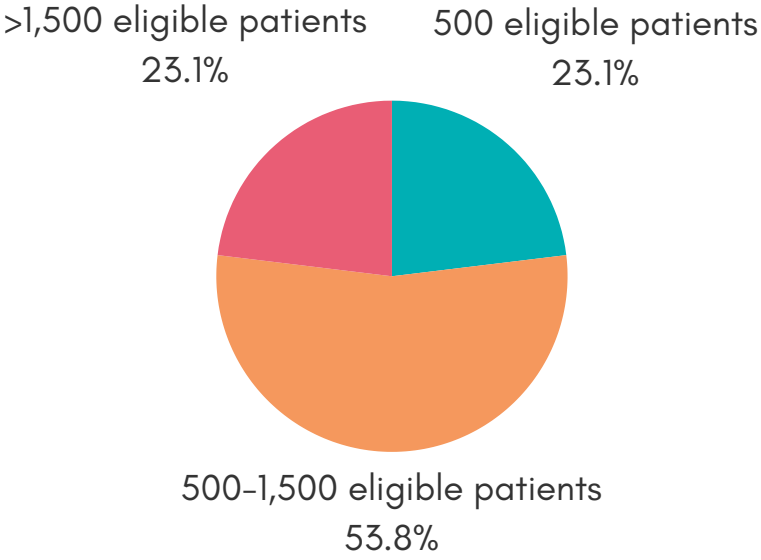
# Clinic Characteristics at Baseline

Screen Up clinics serve high-need populations

## The Percent of Uninsured Population the Clinic Serves

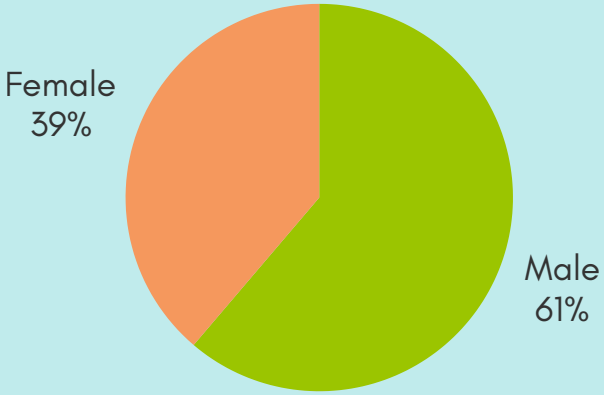



## Clinic Size

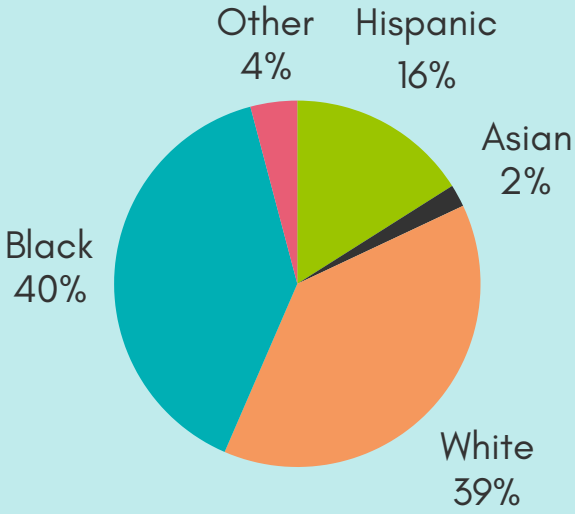



*Eligible refers to individuals who meet the criteria for the specific cancer screening the clinic is aiming to improve

## Demographic Breakdown of All Participating Clinics




### Average Percent for Gender Across All Clinics



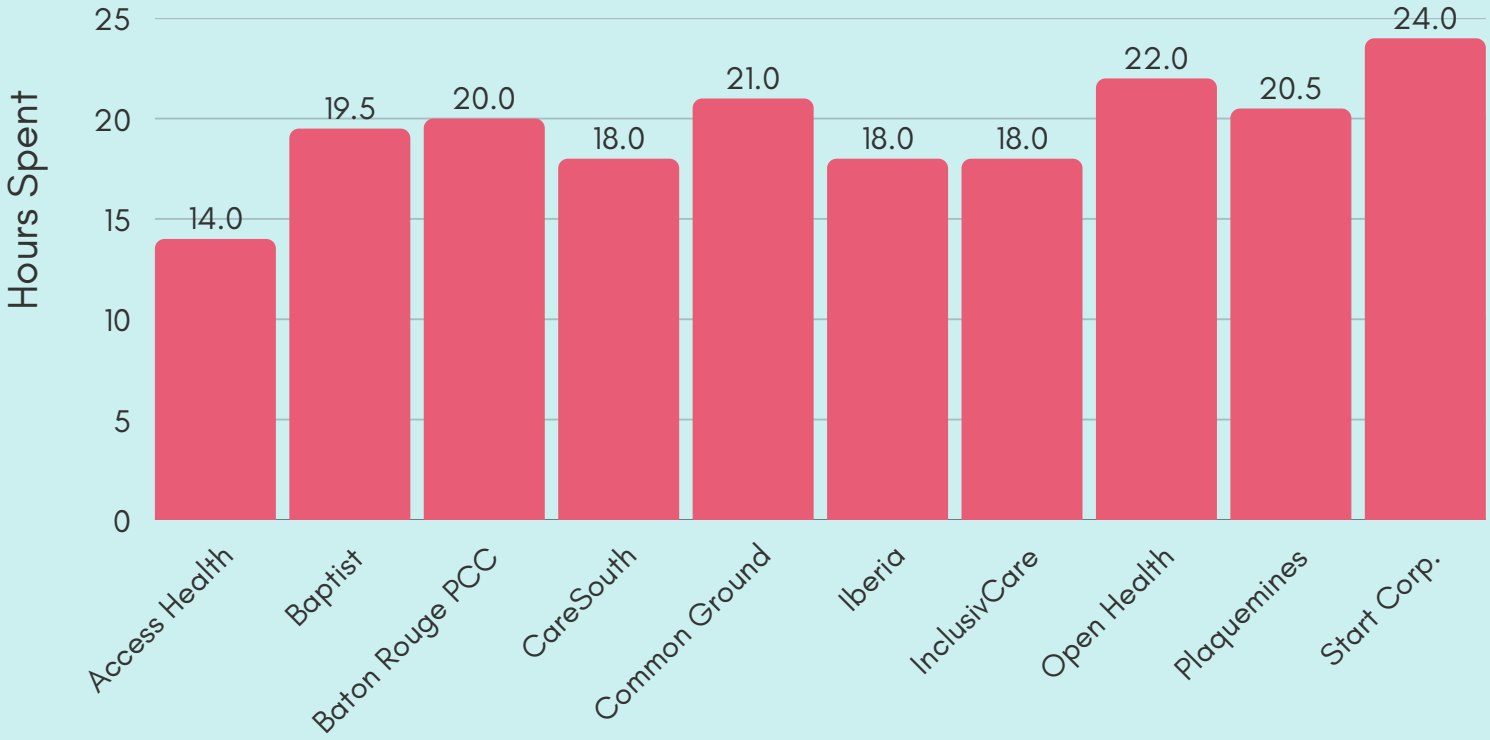

### Average Percent for Race and Ethnicity

# Evidence-Based Interventions (EBIs)

Screen Up practice facilitators work with clinic staff to improve cancer screening rates in accordance with the US Preventive Services Task Force (USPSTF) guidelines. Two of the following Evidence-Based Interventions (EBIs) are chosen and implemented by the clinics in their first year, with the other being implemented in subsequent years:

1) Patient reminders
2) Provider reminders
3) Provider assessment and feedback
4) Reducing structural barriers.

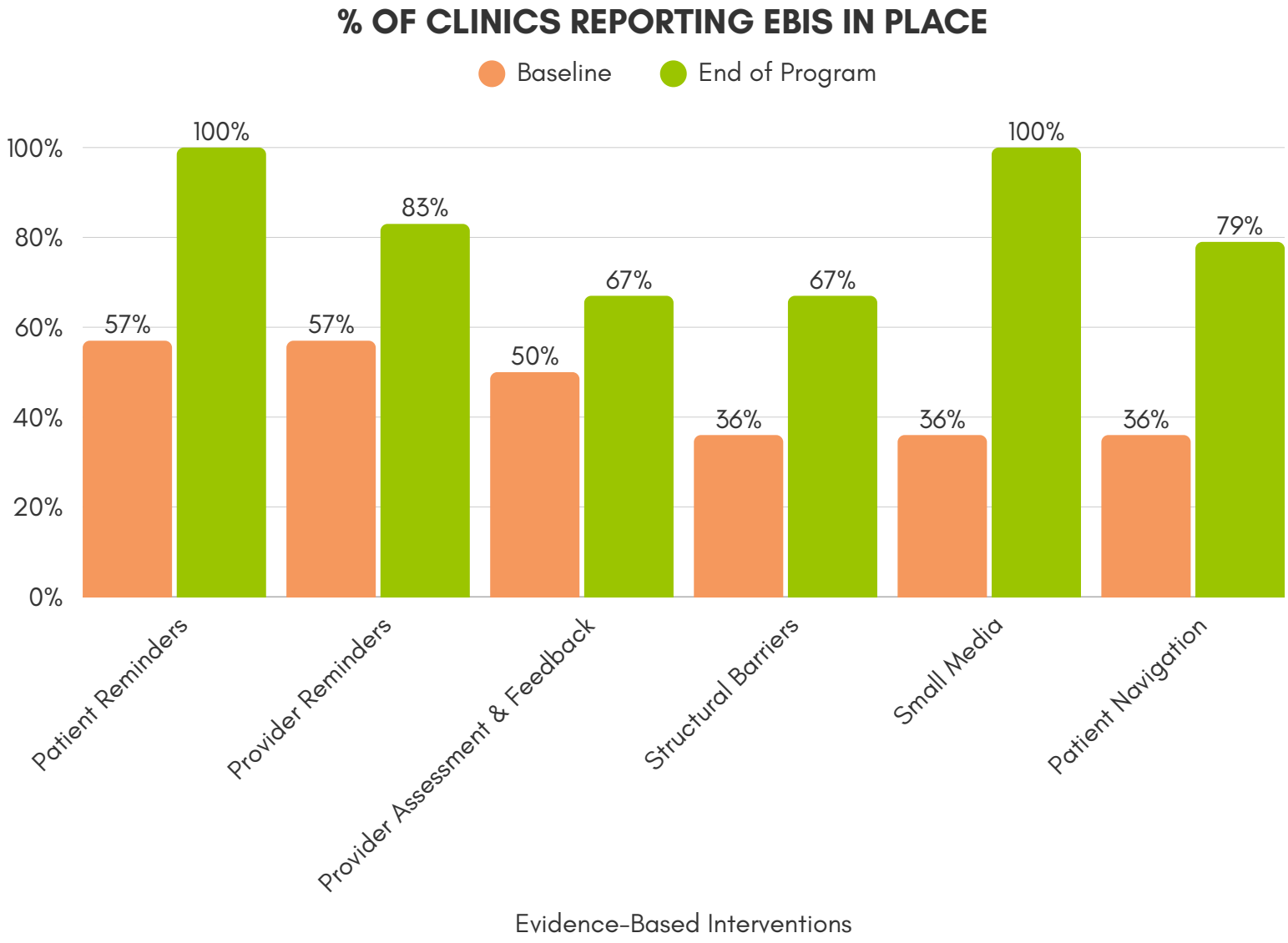
Other supporting strategies are implemented to enhance EBIs, such as health informatics support, professional development, technical assistance on patient navigation, and support for print and digital media.




Clinics received an average of 19.5 hours of EBI implementation support during their first year.

# PROGRAM IMPLEMENTATION

Most clinics reported having patient and provider reminders at baseline. A few clinics also had supporting activities in place.




**After 1 year in the program, we saw:**

**50%**
OF CLINICS IMPLEMENT PATIENT REMIDNERS

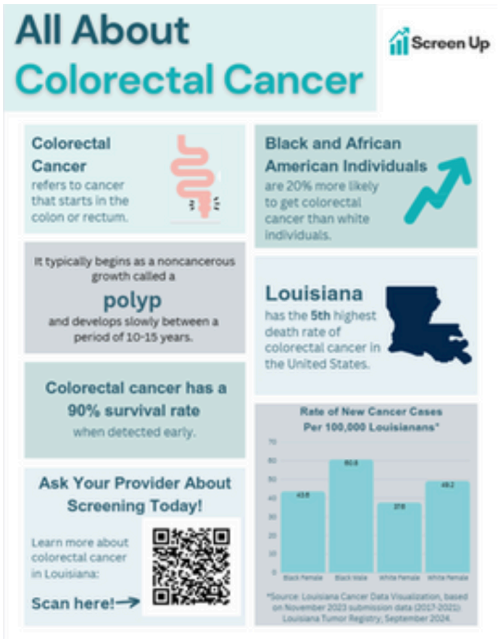
**79%**
OF CLINICS IMPLEMENT POVIDER REMIDNERS

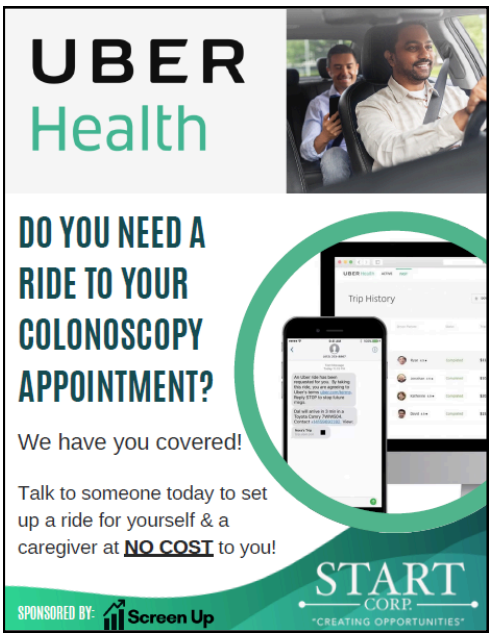
**43%**
OF CLINICS IMPLEMENT PATIENT NAVIGATION

# Communication Strategies to Increase Screening Rates

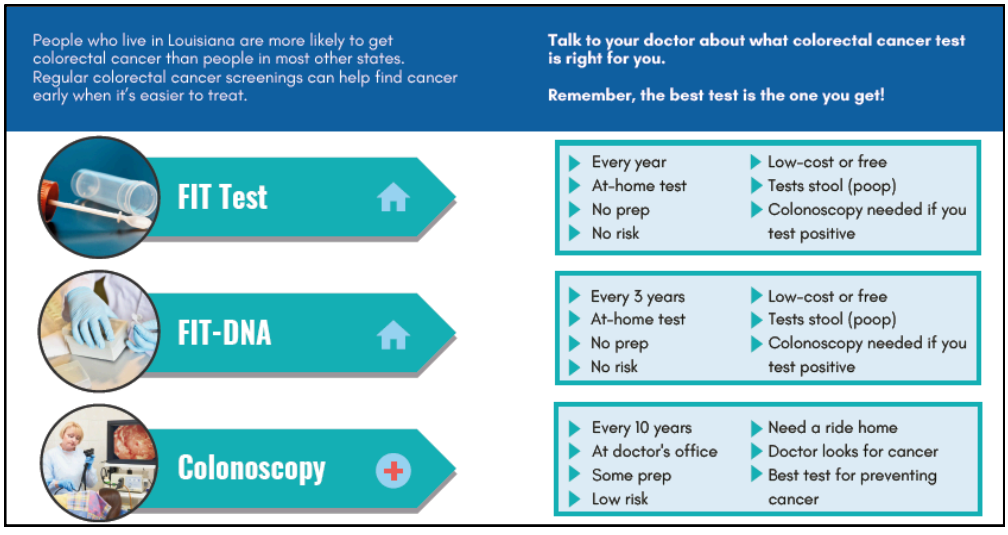
To utilize social media and other communication channels, Screen Up created educational materials for clinics to share on their social media platforms and distribute in clinic waiting rooms.

In addition, Screen Up and CareSouth produced a video to play in their waiting room, highlighting their efforts and processes related to cancer screening.







# Leveraging Health IT Systems

Partnering clinics complete a baseline data form as part of their initial assessment and submit monthly or quarterly data trackers throughout their participation in the program. These assessments help validate screening rates and identify gaps or challenges in collecting the required program measures, including screening data.

Screen Up assisted multiple clinics with chart reviews to confirm the accuracy of their reported screening rates. Additionally, Screen Up worked with clinics' Electronic Health Records (EHR) systems and the EHR overlay, Azara, to resolve mapping issues that led to inaccurate screening data.

**Partnership Spotlight**

Screen Up partnered with Azara to help clinic partners effectively use the EHR overlay to track cancer screening rates. Clinics focused on improving colorectal cancer (CRC) screening worked with Azara to enable tracking of FIT kit return rates and completed colonoscopy rates throughout the grant cycle. In program year 3, Screen Up hosted two webinars to support clinics in troubleshooting data issues and using Azara to analyze structural determinants of health within their patient populations.

azara healthcare

# Professional Development

Screen Up hosts Quality Improvement Webinar Series from content experts to support clinical partners. These virtual webinars also offer no-cost continuing education (CME and CNE) credits to physicians and nurses.

**24**

NUMBER OF WEBINARS FROM 2020-2025

**755**

NUMBER OF TOTAL PARTICIPANTS

**18.5**

MOUNT OF CE CREDITS OFFERED

## Webinars Hosted

- CRC Screening Tips & Tricks
- Key Steps to Improving CRC Screening in FQHCs
- Developing an Aim Statement to Target Screening Rates
- Process Mapping to Identify Workflow Gaps
- Motivational Interviewing
- Huddling for Cancer Improvement
- Six Sigma Boot Camp
- Improving Patient Outcomes Through Data Tracking
- Patient Navigation: The Secret Sauce to Improving CRC Screening
- Using Social Determinants of Health Data in Cancer Screening Workflows
- Building Partnerships to Increase Cancer Screening Rates
- The Power of Patient Choice
- How to Reduce Clinic No-Show Rate
- Turning Cancer Awareness into Action
- HPV Self-Sampling: What Clinics Need to Know
- Louisiana Resources for Facilitating Cancer Screening and Follow-Up
- Blood-Based CRC Screening Test

## Thank you to our speakers

- Dr. Angie Wood, Southeastern Louisiana University
- Carrie Taylor, Azara Healthcare
- Cecilia Saffold, HealthTeamWorks
- Harpreet Sanghera, Coleman Associates
- Dr. Keith Winfrey, NOELA
- Dr. Mike Hagensee, LSU Health New Orleans
- Ray Arce, Exact Science
- Taffy Morrison, Navigators for Health, Louisiana
- Tammy Swindle, CALA
- Victoria Raymond, Guardant Health

# Colorectal Cancer Screening

Ten clinics focused on increasing colorectal cancer (CRC) screening rates among adults aged 50 to 75. In 2022, Screen Up expanded the target age range to include individuals aged 45 to 49, in alignment with the updated 2021 U.S. Preventive Services Task Force (USPSTF) colorectal cancer screening guidelines. We collected annual measurements to assess the impact of the interventions on clinic CRC screening rates. We observed the following outcomes across our 10 clinics:

**28,253**
NUMBER OF ELIGIBLE PATIENTS FOR CRC SCREENING

**3,474**
NUMBER OF ELIGIBLE PATIENTS FOR CRC SCREENING

**1,525**
NUMBER OF COLONOSCOPIES PERFORMED

**85**
NUMBER OF FOLLOW-UP COLONOSCOPIES PERFORMED

**8**
**PERCENTAGE POINTS INCREASE**

After **1 year** in the program, the average clinic CRC screening rate increased by **8 percentage points**.

# Colorectal Cancer Screening

The impact of Screen Up was evidenced by consistently remarkable increases in screening rates across clinics during their initial years of implementation.

**11** PERCENTAGE POINTS INCREASE

After **2 years** in program, Plaquemines Primary Care CRC screening rates increased by **11 percentage points**.

**7** PERCENTAGE POINTS INCREASE

After **2 years** in program, Baptist Community Health Services CRC screening rates increased by **7 percentage points**.

**18** PERCENTAGE POINTS INCREASE

After **3 years** in program, Baton Rouge Primary Care Collaborative CRC screening rates increased by **18 percentage points**.

**28** PERCENTAGE POINTS INCREASE

After **4 years** in program, CareSouth Medical & Dental CRC screening rates increased by **28 percentage points**.

**21** PERCENTAGE POINTS INCREASE

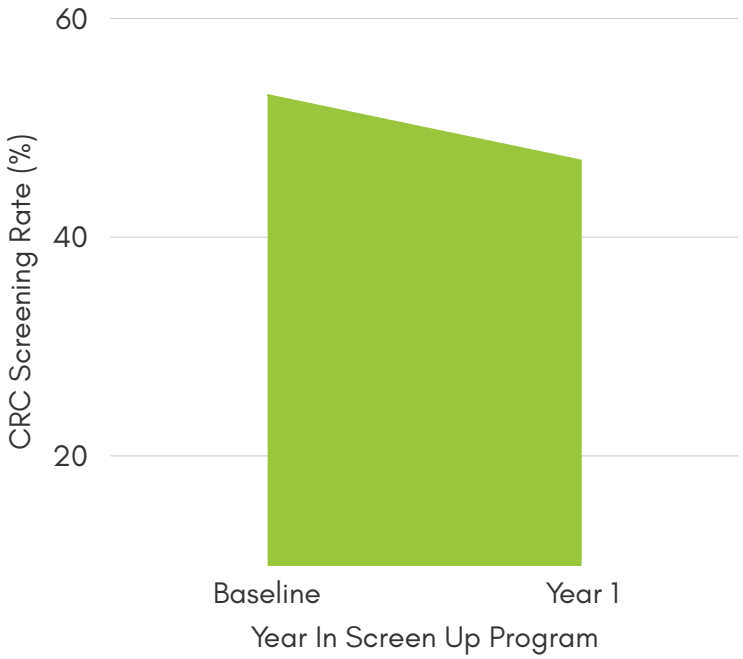
After **4 years** in program, InclusivCare CRC screening rates increased by **21 percentage points**.

**40** PERCENTAGE POINTS INCREASE

After **5 years** in program, Start Corp. CRC screening rates increased by **40 percentage points**.

# Access Health Louisiana

Access Health Louisiana (AHL) in Belle Chasse, had been part of Screen Up for 4 years and in 2020 had a colorectal cancer (CRC) screening rate of 53%. Due to significant challenges from the pandemic i.e. reduced clinic hours, staffing shortages, and fewer patients coming to the clinic, the CRC screening rate decreased to 47%. AHL also monitored the FIT return rate, which increased from 57% to 58%, and the colonoscopy completion rate decreased from 22% to 13%.




## EBIs Implemented

### Removing Structural Barriers

Work with insurance payers to address barriers to screening and assess other potential interventions such as mailing FITs & patient reminders.

### Provider Assessment & Feedback

Enhanced monthly provider assessment & feedback with additional CRC screening data to include: FIT return rate, colonoscopy completion rate, and follow-up rate for individual providers.

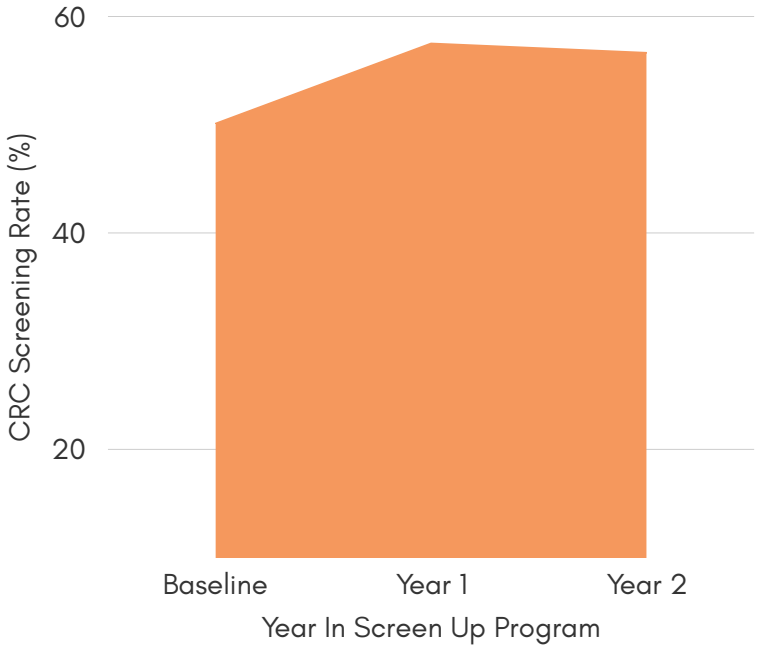
AHL worked with WellCare, an insurance payer, to find resources to connect patients to gastroenterologists to reduce these structural barriers. Using the custom dashboard built in Azara, AHL provided healthcare providers monthly assessments and scorecards, that included their current CRC screening rate, FIT return rate, colonoscopy completion rate, colonoscopy return rate. AHL also used morning huddles to provide updates to providers on CRC screenings.

**Program Wrap-Up**

Clinic graduated in 2021, as they worked with Screen Up during the previous 5-year program cycle.

# Baptist Community Health Services

Baptist Community Health Services, in New Orleans, joined Screen Up in 2023 with a baseline CRC screening rate of 50%. After one project year, its screening rate increased to 57.5%. In their 2nd year, they maintained their initial increase and prioritized addressing patient barriers by offering Uber Health rides for eligible patients. Additionally, they began offering Cologuard as an additional screening option.




## EBIs Implemented

### Patient Reminders

Reminders are sent to patients with open FIT and Follow-Up Colonoscopy orders. Medical assistants remind patients of upcoming screening appointments during annual appointment reminders.

### Reducing Structural Barriers

Provide no-cost transportation via Uber Health for colonoscopy to uninsured patients and patients with Medicaid. Coordinate UMC Financial Assistance for those needing help paying for colonoscopy services.

### Provider Assessment & Feedback

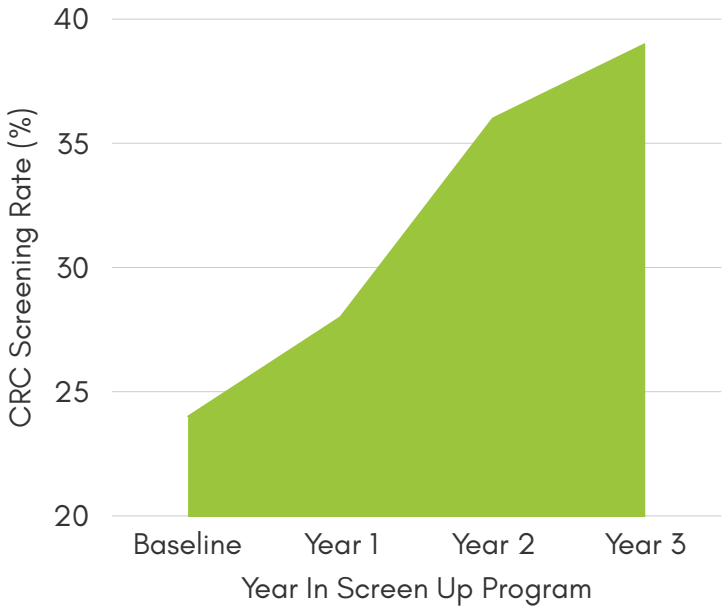
Providers receive quarterly UDS metrics regarding their CRC screening reports. Additionally, they can view & track their individual Cologuard screening metrics on a monthly basis.

**Quote from the Clinic Team**

"Screen Up is an excellent program and helped us grow as an organization. Overall, the ideas and education provided are so helpful - along with the support to try new things!" - Hannah Pounds, Chief Medical Officer

# Baton Rouge Primary Care Collaborative

Baton Rouge Primary Care Collaborative (BRPCC), in Baton Rouge, joined Screen Up in 2021. Their baseline CRC screening rate was 24%. In 3 years of partnership, they have increased their screening rate to nearly 40%. BRPCC implemented three evidence-based interventions that influenced their success.




## EBIs Implemented

### Patient Reminders

Navigator made outreach phone calls to patients due for screening or who needed to return the FIT test. Additionally, patients are educated, and barriers to completing the screening test are addressed.

### Provider Assessment & Feedback

Providers received monthly scorecards via email, which are reviewed during provider meetings and follow-up meetings.

### Provider Reminders

Azara pre-visit planning reports are reviewed daily with the team, as well as a general chart prep.

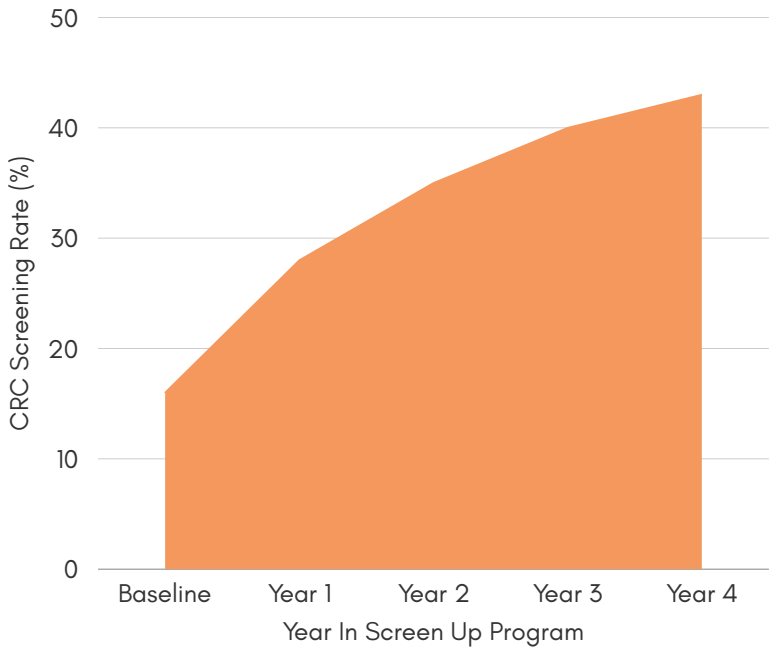
**Quote from the Clinic Team**

"Having the LCP [Nurse] Navigator to assist with patient reminders has been extremely successful... just having that extra layer of support for our patients and staff is great!"

– Rachel Gray, APRN, FNP-C

# CareSouth Medical & Dental

CareSouth Medical & Dental, located in Baton Rouge, began its partnership in 2021 with a CRC screening rate of 16%. After 4 years, their CRC screening rate was 43%. This improvement was made by improving clinic workflows, utilizing a reminder messaging system, and onboarding a patient navigator who prioritized CRC screening.




## EBIs Implemented

### Patient Reminders

CareMessager enabled two-way texting, alerting patients about upcoming/overdue screenings and allowing real-time responses from the navigator.

### Provider Reminders

Support staff performed chart prep daily and utilized the Azara pre-visit planning report to determine patients eligible for screening.

### Provider Assessment & Feedback

Provided monthly scorecards to providers and hosting monthly one-on-one follow-up meetings with outlying providers.

### Reducing Structural Barriers

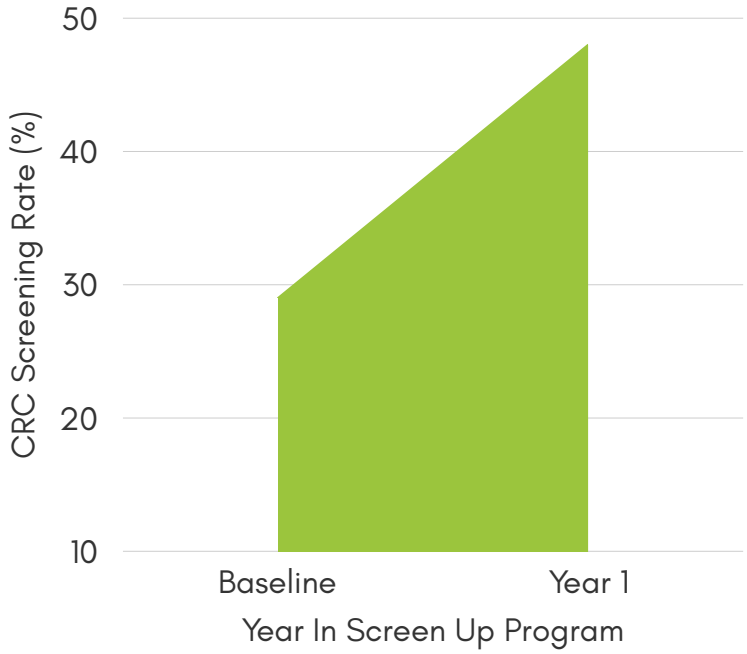
CareSouth curated a strategic partnership with a local GI provider who has a screening day for their patients, specifically to help reduce and eliminate colonoscopy wait times.

**Quote from the Clinic Team**

"Through the work with the colorectal initiative, we have been able to improve workflow processes and impact our patients' outcomes positively through the implementation of the evidence-based interventions!"- Samantha Given-Banguel, Director of Quality

# Common Ground Health Clinic

Common Ground Health Clinic, in Gretna, began with a baseline CRC screening rate of 29%. Throughout their work with Screen Up, Common Ground Health Clinic significantly increased its CRC screening rate to 48%. Common Ground Health Clinic also monitored the FIT return rate, which increased from 29% to 34%, and the colonoscopy completion rate, which increased from 32% to 35%.




## EBIs Implemented

### Patient Reminders

Weekly reminder calls for up to 3 weeks, for patients to return their FIT test. Postcards were mailed to patients due for screening.

### Provider Reminders

Providers were reminded of the CRC screening needs for individual patients during daily morning huddles.

### Provider Assessment & Feedback

One-on-one monthly feedback was given to individual providers regarding their CRC screening rate.

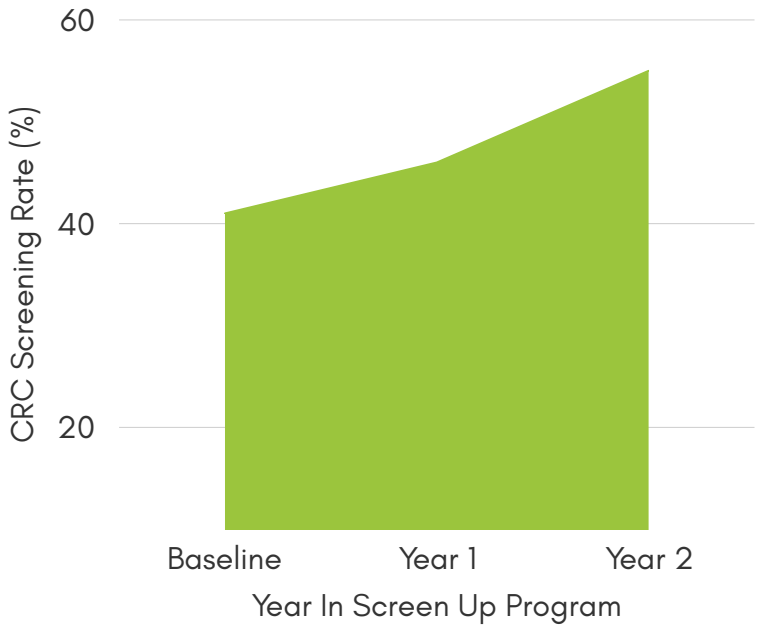
**Program Wrap-Up**

Due to the significant impacts of Hurricane Ida in 2021, Common Ground had to withdraw from the Screen Up program.

# CLINIC IMPACT

# Iberia Comprehesive Community Health Center

Iberia Comprehensive Community Health Center (ICCHC) in Iberia, was a Screen Up partner from 2022-2024. Their baseline CRC screening rate was 41%. After two years in the program, their CRC screening rate increased to 55%. During this time, they worked to streamline workflows & prioritize patient follow-up.




## EBIs Implemented

### Patient Reminders

Quarterly text messages were sent to patients due for CRC screening. Postcards were mailed to patients who could not receive texts.

### Provider Assessment & Feedback

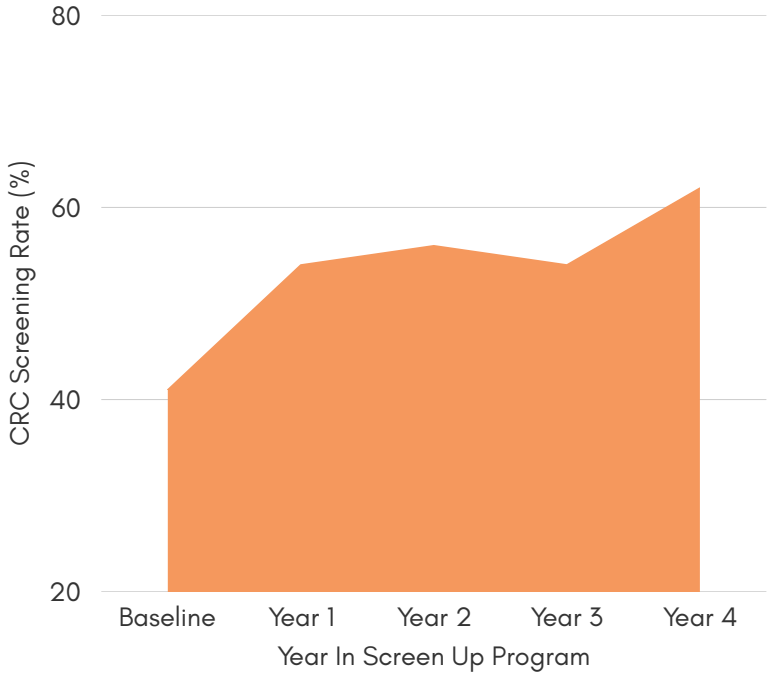
Providers received monthly scorecards via email regarding their CRC screening metrics. In-person meetings were held with individual providers to discuss specifics & strategize improvements.

**Quote from the Clinic Team**

On provider assessment & feedback, "Workflow improvement was such a value-added. We were giving the providers scorecards, but the one-on-one conversations were not being had. Adding that one layer has been a great tool" - Crystsal Armstrong, Project Champion

# InclusivCare

InclusivCare in Marrero began its partnership with Screen Up in 2020. Over 4 years, they increased their CRC screening rates from 41% to 62%. This increase is due to workflow improvements and their dedicated GI Coordinator. In 2024, the clinic implemented a new screening modality, a Blood-Based CRC test. As a team, they are committed to offering their patients choices and providing tailored education that allows for screening autonomy.




## EBIs Implemented

### Patient Reminders

GI coordinator makes outreach calls and sends tailored flyers to patients due for screening. GI coordinator additionally calls patients to return FIT kits.

### Provider Reminders

Azara huddle reports are shared with the clinic site managers daily to be reviewed and utilized for team-based discussion.

### Provider Assessment & Feedback

CRC screening report cards are emailed to providers quarterly & follow-up one-on-one meetings are held for outlying providers.

### Reducing Structural Barriers

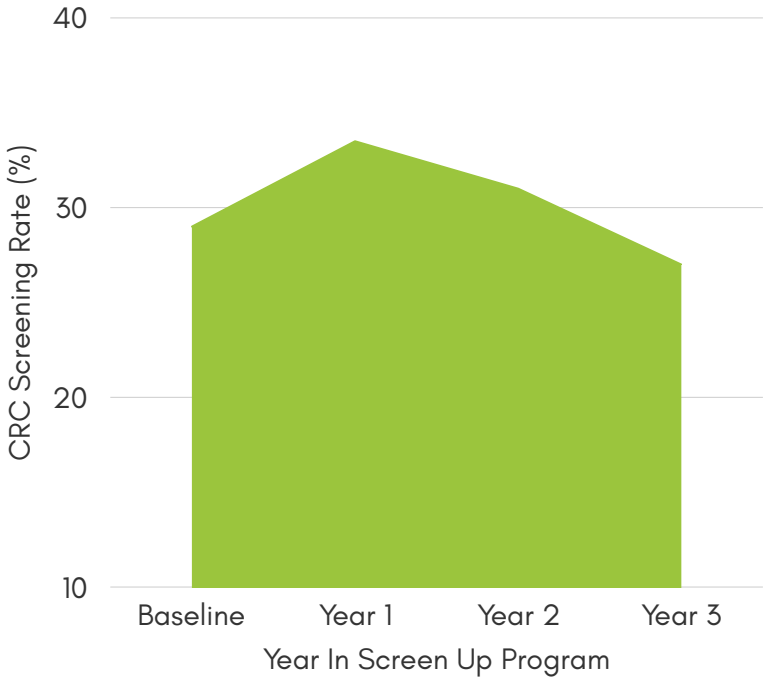
Provided last resort follow-up colonoscopy funding to patients who had a positive FIT-kit and was uninsured.

**Quote from the Clinic Team**

"Being a part of Screen Up has made our overall practice better moving forward."
- Anthony Jase, Chief Medical Officer

# Open Health Care Clinic

Open Health Care Clinic in Marrero, began with a baseline CRC screening rate of 28% which increased to 33%. Open Health Care Clinic also monitored the colonoscopy completion rate, which increased from 27% to 33%, and the colonoscopy follow-up rate, which increased from 18% to 35%. These successes were due to making CRC screening a priority and improving their screening workflows and patient reminder process.




## EBIs Implemented

### Patient Reminders

Pre-visit phone calls were made to remind patients due for screening. Post-visit phone calls were made to remind patients to return their FIT-kit.

### Reducing Structural Barriers

Uber Health rides were offered to patients to return their FIT kits or complete other screening options.

### Provider Assessment & Feedback

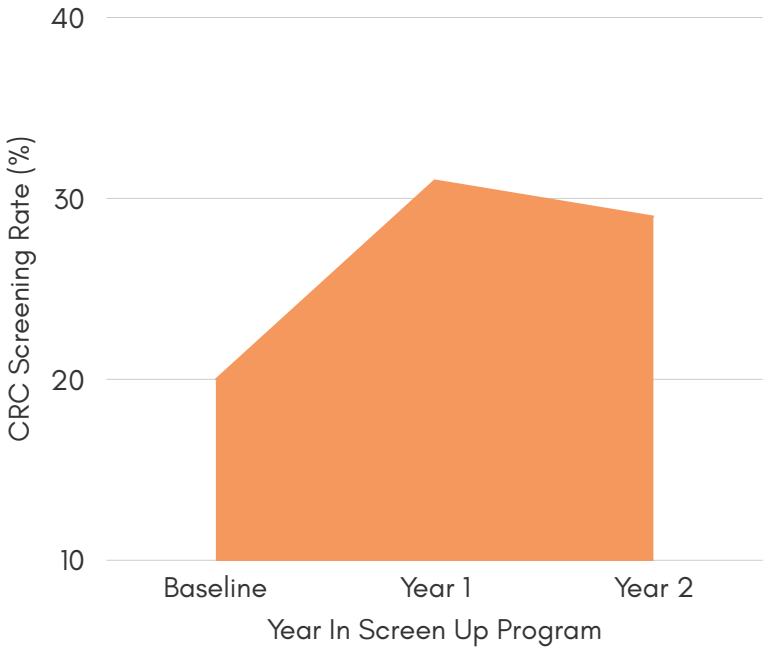
Monthly screening rates were sent to providers via email. Individual and clinic CRC metrics were discussed during monthly QI meetings.

**Quote from the Clinic Team**

This has given providers the opportunity for easy Q&A and increased staff engagement, which has proven fruitful in the increasing numbers of CRC Screening orders."- Savanna Matthews, Quality Nurse

# Plaquemines Primary Care

Plaquemines Primary Care (PPC), in Port Sulfur, began its partnership with Screen Up in 2022. Their baseline CRC screening rate was 20%, which increased to 31% after one year. Due to increasing patient volumes, their annual CRC screening rate decreased to 29% in 2025. To address this new patient volume and better prioritize CRC screenings, they hired a patient navigator to better address their patients' needs.




## EBIs Implemented

### Patient Reminders

Patient Navigator called to remind patients they were due for screening, provided education, and offered to send FIT kits directly to their homes.

### Reducing Structural Barriers

Clinic partnered with Exact Sciences, to offer free Cologuard testing kits to patients who were uninsured or under-insured. Additionally, they setup a Cologuard drop-off site inside the clinic, due to mailing difficulties.

### Provider Reminders

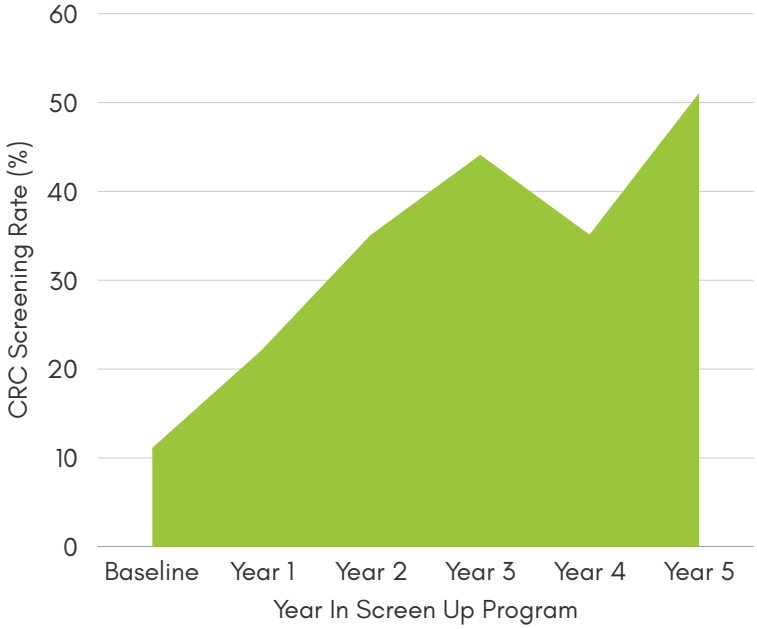
Daily chart prep and team huddles were held between the provider and their designated MA.

**Quote from the Clinic Team**

"This is the most well run grant program that we have ever been a part of.. we are passionate about CRC screening because they are passionate. Ya'll keep us on track, focused, and engaged!" - Jennifer Harris, Chief Executive Officer

# Start Corp. Community Health Center

Start Corporation Community Health Center, located in Houma, began working with Screen Up in 2020, reporting a baseline CRC screening rate of 11%. After their first year with Screen Up, they improved their rate to 22% and by Year 2, they reached a screening rate of 35%. The significant increase was mainly due to prioritizing CRC screenings and improving workflows. By the end of the program, their annual CRC screening rate was 51%.




## EBIs Implemented

### Patient Reminders

Text messages were sent reminding patients to return their stool test. Quarterly calls were made for those who are overdue for screening.

### Provider Reminders

Morning huddles were held daily using the Azara pre-visit planning report to identify patients due for screening.

### Provider Assessment & Feedback

Monthly the providers recieved their individual Cologuard report, which tracks completed & open orders.

### Reducing Structural Barriers

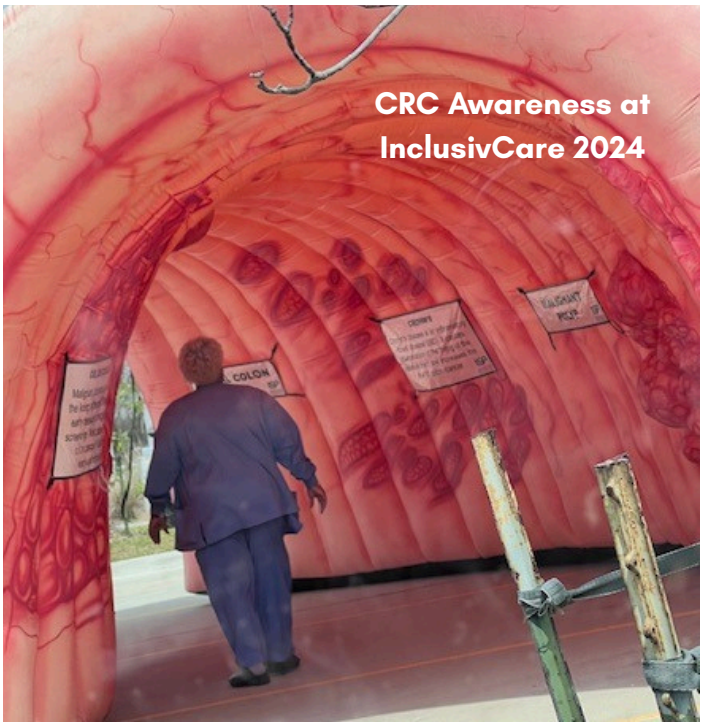
Partered with Uber Health to address transportation barriers to screening. Also, reimplemented low-cost FIT testing for uninsured patients.

**Quote from the Clinic Team**

"Screen Up cares about patients and their well-being. They attempt to overcome any barrier or challenge patients may have that may prevent cancer screenings".

# Community Outreach & Education

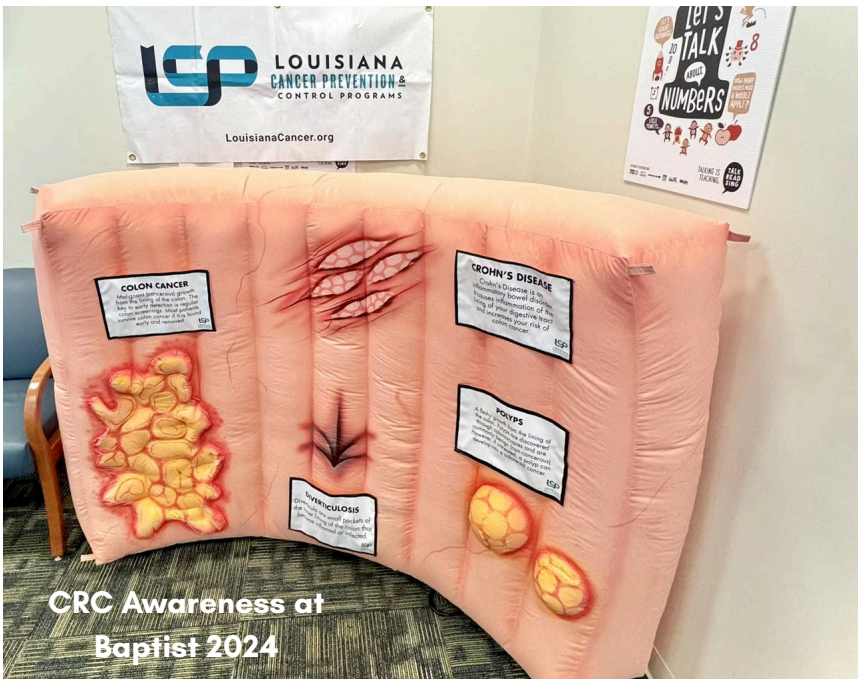
Screen Up clinics host a variety of outreach events to educate and raise awareness about cancer in the community they serve. Screen Up supports these efforts by providing educational materials, such as posters and brochures, and promotional equipment, including two inflatable colon tunnels, two colon walls, for community outreach events at no cost. This offers a fun and engaging way to educate families.




CRC Awareness at InclusivCare 2024

CRC Awareness at START Corp. 2025


CRC Awareness at CareSouth 2023




CRC Awareness at Baptist 2024

# Provider Education

Screen Up provides funding for clinic staff to attend trainings and conferences. For example, Screen Up sponsors one member from each clinic partner to attend the Southeastern Colorectal Cancer Consortium conference every year. The conference brings together CRC stakeholders such as providers, researchers, survivors, and caregivers from 14 Southern states and Puerto Rica to discuss CRC issues.


**2024 Southeastern Colorectal Cancer Consortium**

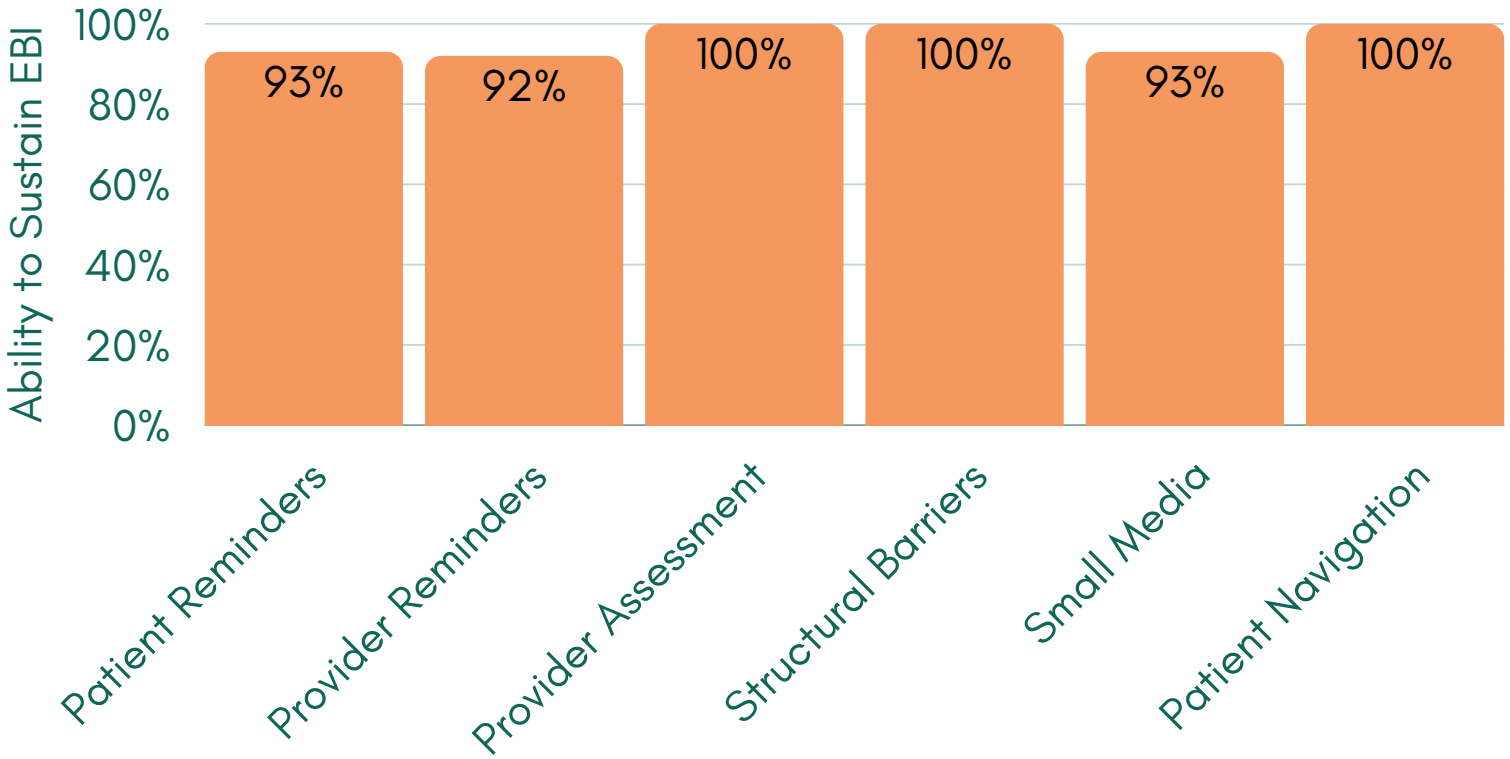
**Clinic providers at the 2023 Colorectal Cancer Day at the Capitol in Baton Rouge**

# Sustainability

An essential component of the Screen Up workflow is ensuring the sustainability of evidence-based interventions (EBIs) in clinics. Clinics were introduced to key factors for sustaining improvements, with an emphasis on building sustainability into the implementation of priority EBIs from the outset. These factors were institutionalizing changes, gradually moving activities to other funding sources, automating tasks through IT systems, and implementing standard staff training protocols.

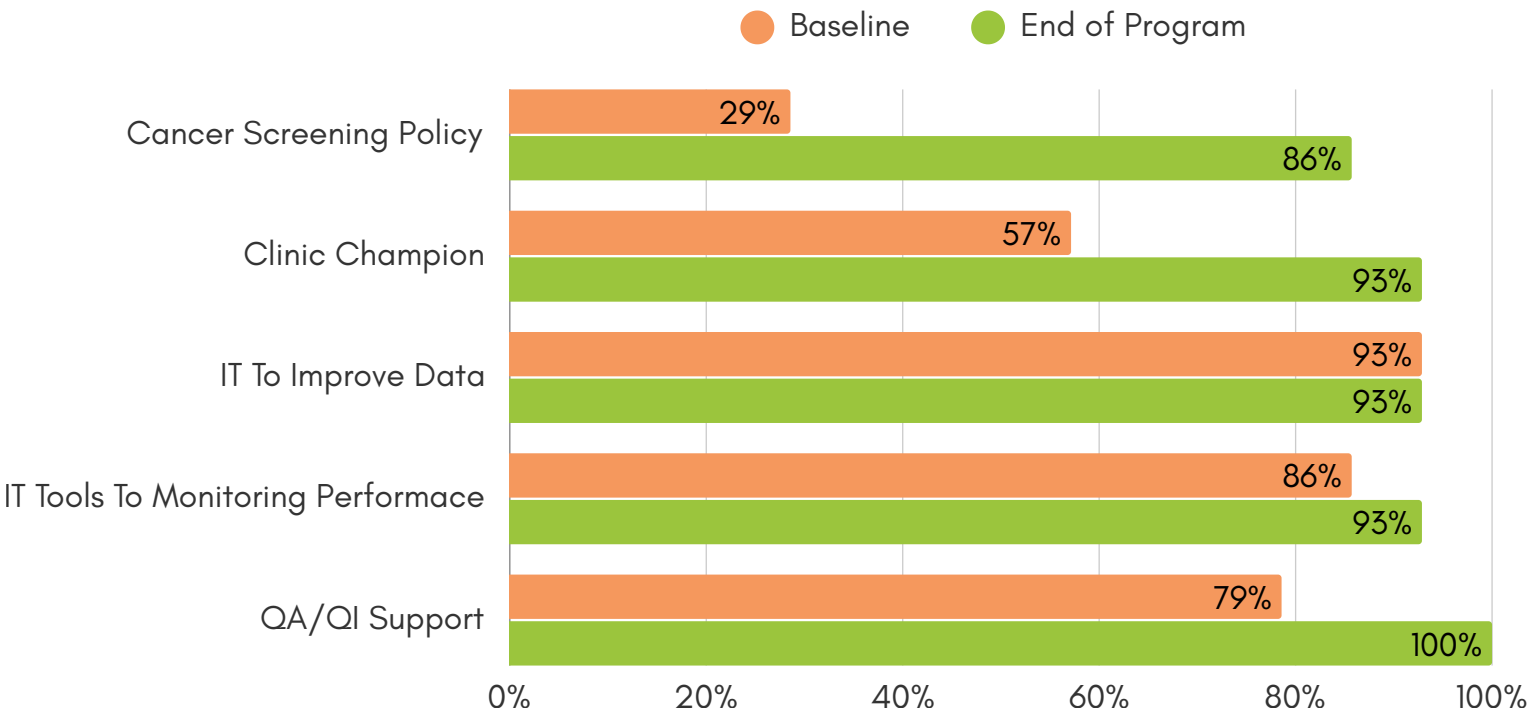
Clinics reflected on which activities had the greatest impact on screening rates, their ongoing priorities, the potential for system-wide implementation of EBIs, future benchmarks, and the resources needed to maintain progress. Most clinics expressed optimism about their ability to sustain improvements and developed sustainability plans that included developing formal cancer screening policies and procedures, expanding provider assessments to incorporate additional data points, and continuing with the EBIs that demonstrated the greatest impact.

When asked about the sustainability of these practices, clinics' responses reflected positive outcomes for the EBIs they implemented.



# Sustainability

The implementation of EBIs and supporting activities was assessed by evaluating the standardization and integration of related policies and procedures in clinics.




**On a scale of 1 to 5 (5 being the highest), how confident do you feel in applying the knowledge and skills you gained in the program?**

**100%**

**REPORTED A CONFIDENCE LEVEL OF 5**

**What challenges do you anticipate moving forward?**

- Patient compliance
- Culture and language
- Colonoscopy completion and transportation
- Increasing stool kit return rates
- Working on screening compliance and keeping patients motivated for screening

# Lessons Learned

## Program Implementation Challenges

Geographic disparities in the distribution of primary care centers and specialists make it difficult for low-income and rural individuals to access cancer screening tests and follow-up appointments.

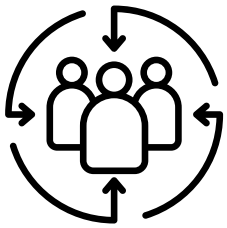
### Findings

This had led to long wait times for colonoscopy appointments, sometimes up to 6 months. This issue is exacerbated in those with Medicaid who have fewer options for providers.

### Key Takeaways

Providers could be incentivized to see Medicaid patients by increasing reimbursement rates. In addition, specialists could designate appointment slots for those with abnormal screening tests who need a follow-up diagnostic test. For example, gastroenterologists could designate colonoscopy appointment slots for those with positive stool-based tests.

## Clinics Participation



Overall, strong leadership buy-in played a crucial role in enabling individual clinics to achieve successful screening rates.

### Findings

Clinics with well-rounded project teams experienced greater overall program impact.

### Key Takeaways

Having representatives from leadership, IT, providers, medical assistants (MAs), and quality improvement ensured successful implementation.

# Lessons Learned

## Barriers to Transportation

Several clinics identified transportation as a barrier to cancer screening. To address this challenge, we partnered with Uber Health to provide patients with rides to and from their screening appointments. Additionally, one clinic received extra support in the form of gas cards and bus tokens to further assist patients with transportation needs.

### Findings

After Uber Health rides were implemented, clinics identified another barrier to completing colonoscopy screening appointments. Patients often did not have a caregiver, who were often required to accompany patients post-anesthesia to appointments.

### Key Take-Aways

While transportation is often identified as a primary barrier to screening, clinics found that additional challenges persisted even after addressing transportation needs.

## Data Collection

Multiple clinics experienced significant deficits in their workflow and data quality when extracting cancer screening rates and other measures for the Screen Up program.

### Findings

Screen Up staff helped identify mapping errors affecting cancer screening rates. They assisted clinics with communication between their EHR providers and the EHR overlay, Azara.

### Key Takeaways

Multiple clinics had to validate their rates through chart reviews, which helped increase their confidence in their processes.

# RECOMMENDATIONS: INITIATIVES FOR PRIMARY CARE CLINICS

## WHAT WORKS BEST?

## INITIATIVES THAT FOCUS ON PATIENTS AND HEALTH SYSTEMS

### Increase Awareness

- Educate providers and patients on tests and recommendations
- Initiate timely screening & screening options, allowing for choice
- Take family history early & act on it
- Prompt evaluation of potential cancer symptoms

### Patient Education for Follow-up Colonoscopy

- Include visuals for test instructions and materials in multiple languages
- Automated reminders for scheduling a colonoscopy, not only the clinic visit

### Patient Navigation After Positive FIT Tests

- Cross site scheduling and reminders
- Tailor support to frequent no-shows - get personal with patients

### Track Data

- Use EHR to identify priority groups
- Identify group with low screening rates
- Monitor completion & next required screening date