Expanding Access: Leveraging Patient Support Services to Increase Cancer Screening Rates

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March 5th, 2026 | 3 pm EST

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NNCC National Technical Assistance Program (NTAP)

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Today's Agenda

5 min - Welcome

- **20 min – Lightning Perspective**

  Suzanne Cohen, MPH

  Health Federation of Philadelphia
  - HIT + Population Health Infrastructure

  Elsa Staples, MPH, and Andi Dwyer, MPH

  University of Colorado Anschutz Cancer Center
  - CHW/Navigation Implementation & Sustainability

- **20 min – Moderated Discussion**

10 min - Questions & Wrap-Up

Panel Learning Outcomes

- Identify common breakdowns in the colorectal cancer screening-to-resolution pathway, including follow-up to abnormal results and diagnostic completion.
- Describe patient navigation and community health worker (CHW) strategies that improve screening completion and timely follow-up in medically underserved populations.
- Discuss operational and sustainability considerations for integrating navigation and patient support services into health center workflows.

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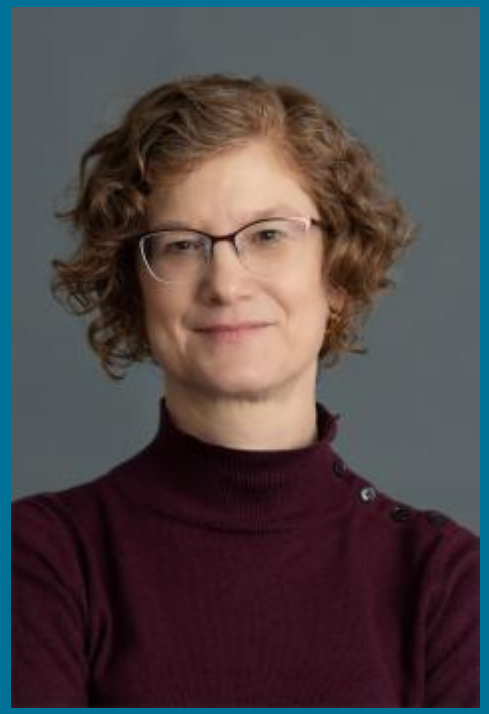
Subject Matter Expert



Suzanne Cohen, MPH

Senior Director of Population Health

Health Federation of Philadelphia

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Health Federation of Philadelphia (HFP) History with Cancer Related Work

- Health Center Controlled Network has focused on quality improvement for cancer screening statewide (colorectal, breast, cervical)
- Supported program planning and implementation with a health center and a cancer center for AxCS HRSA funding focused on colorectal cancer
- Re-SET - foundation funded initiative to support a community-wide effort in Philadelphia to increase screening and address gaps in the continuum from screening outreach through diagnosis, treatment and survivorship for breast and colorectal cancer.

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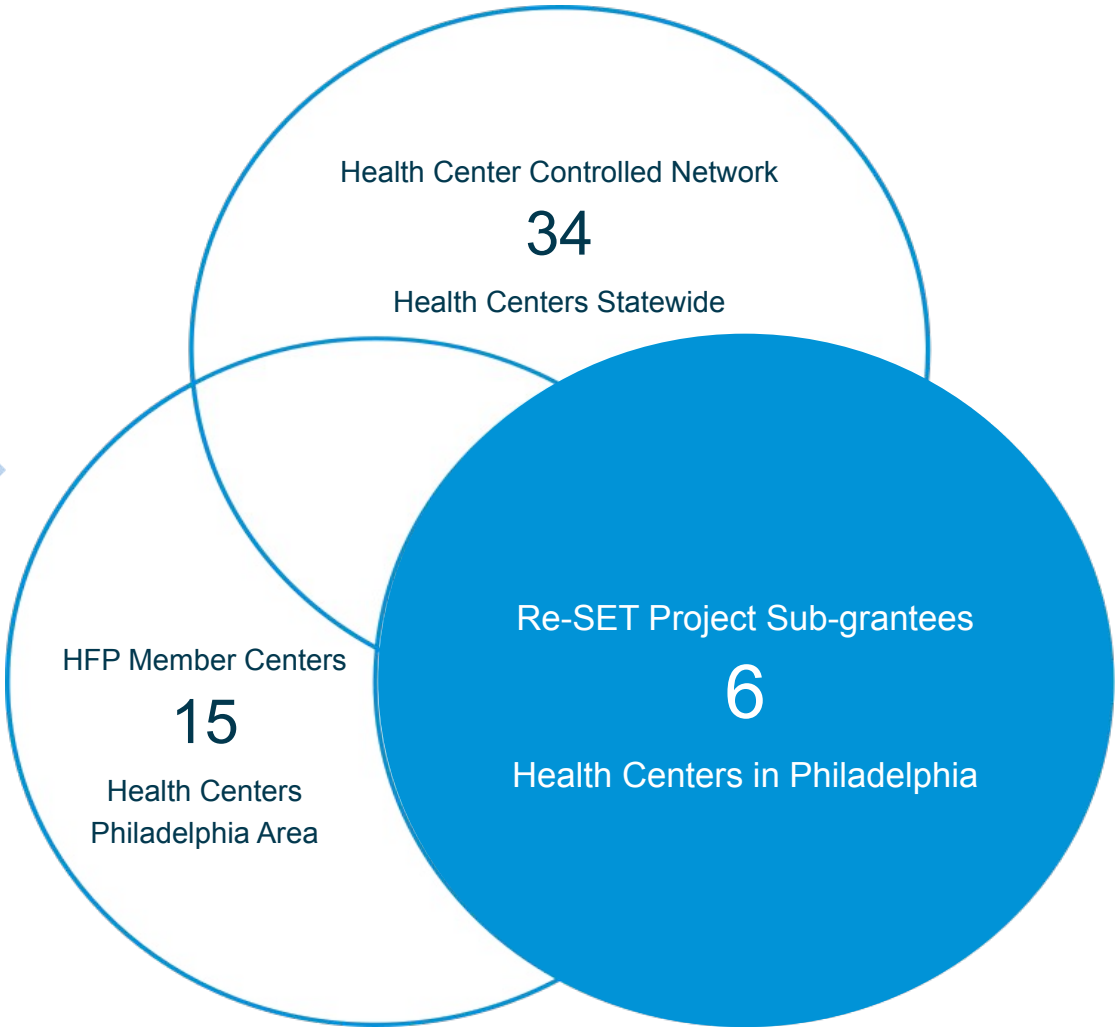

- Foundation-funded
- Focus on breast and colorectal cancer
- Baseline screening rates of
  - CRC: 25.6% - 55.8%
  - Breast: 35% - 62%
- Goal: to increase screening rates and follow-up to positive screens (connection to diagnostic testing and treatment)

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Strategies Based on Needs Assessment

People

- Dedicated staffing at the health center level for screening, outreach and follow-up
- Connecting people doing this work across organizations
- Centralized resource for the most complex cases

Process

- Do as much as possible at the health center FIT or FIT-DNA first
- Orders and results - reducing friction for health center patients (and staff)
- Addressing health system fragmentation
- Transportation infrastructure

Technology

- Azara Population Health - abnormal results module
- Text messaging for mailed FIT campaigns
- HIE for orders/results

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Subject Matter Experts

Andrea (Andi) Dwyer

Program Director, Colorado Cancer Screening Program

University of Colorado Anschutz Cancer Center

Elsa Staples, MPH

Sr. Program Director, Colorado Cancer Screening Program

University of Colorado Anschutz Cancer Center

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colorado school of public health

UNIVERSITY OF COLORADO
COLORADO STATE UNIVERSITY
UNIVERSITY OF NORTHERN COLORADO

Andrea (Andi) Dwyer, MPH
Director, CCSP

Elsa Staples, MPH
Senior Program Manager, CCSP

Cancer Center
NCI-DESIGNATED COMPREHENSIVE CANCER CENTER

COLORADO CANCER SCREENING PROGRAM

Patient Navigation and Cancer Screening Implementation Approaches in Colorado

Funding: CCPD Grants Program

History of CCSP's Structure and Focus

Primary funding by the Cancer Cardiovascular and Pulmonary Disease Grants Program (CCPD) – state tobacco tax revenue

Statewide cancer screening technical assistance program that partners with safety net clinics/hospitals – FQHCs, rural health clinics/hospitals, other safety net clinics

2006-2013: Direct services for colonoscopic colorectal cancer (CRC) screening and patient navigation. (patient eligibility ≤250% FPL)

2014-2023: Following ACA expansion – patient navigation reimbursement and support (patient eligibility ≤400% FPL)

2018-present: Capacity building for patient navigation sustainability and CRC, Lung, and Hereditary Cancer Screenings

July 2023-June 2026+: Implementation of select Evidence-Based Interventions for CRC screening (team-based care approach; all patients eligible)

Implementation of CRC Screening EBIs

Current EBIs of Focus:

- Client reminders
- Patient navigation
- Provider reminders and recall systems
- Provider assessment and feedback
- Standing orders by healthcare providers

Technical Assistance Delivery:

- Quarterly learning collaborative meetings (all participating systems)
- Quarterly technical assistance calls with clinic system, CCSP, TA partners

Access CCSP EBI Implementation Resources

Planning and Implementation Process:

Currently 19 participating clinic systems

1. Baseline assessment of current CRC screening infrastructure and capacity
2. Identify and document existing CRC screening workflow and key roles
3. Root cause/gap analysis (fishbone diagram)
4. Develop AIM statement and select EBIs
5. Create quality improvement plan (PDSAs – 2 per year)
6. Implement EBI action plan through QI approach
7. Monitor CRC screening rate and EBI measures

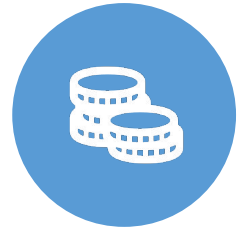
CCSP Participating Clinic System	2025 CRC Screening Rate	2024 CRC Screening Rate	2023 CRC Screening Rate	2022 CRC Screening Rate
Avg CRC Screening Rate of CCSP Clinic Systems	**44.3%**	**40.9%**	**33.3%**	**28.8%**

Patient Navigator/Community Health Worker Sustainability Initiatives and Resources

PN/CHW MEDICARE REIMBURSEMENT: PHY SICIAN FEE SCHEDULE – PRINCIPAL ILLNESS NAVIGATION/ COMMUNITY HEALTH INTEGRATION CODES

PN/CHW MEDICAID REIMBURSEMENT: BEGINS IN COLORADO IN 2028

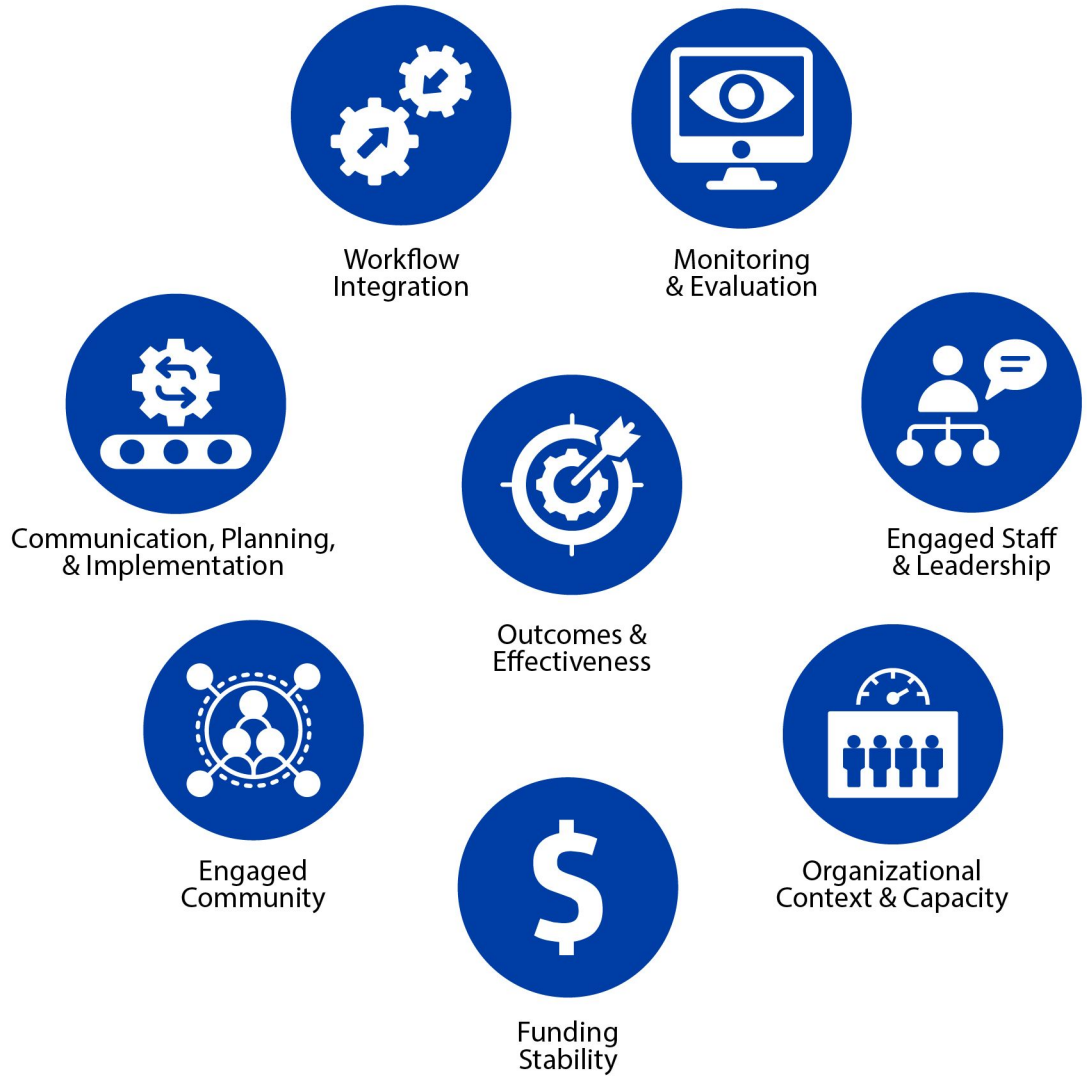
PN/CHW TRAINING AND CREDENTIALING INITIATIVES



QUALITY BASED PAYMENT STRATEGIES

PN/CHW SUSTAINABILITY CAPACITY ASSESSMENTS AND PLANNING

Patient Navigation Sustainability Assessment Tool
PNSAT



PNSAT Domains	Definition
Engaged Staff & Leadership	Having frontline staff & management within the organization who are supportive of the PN practice
Organizational Context & Capacity	The PN practice has the internal support & resources needed to effectively navigate patients/clients
Funding Stability	The PN practice has established a consistent financial base
Engaged Community	The PN practice has external support & engagement (beyond the clinical navigation team)
Communication, Planning, & Implementation	Using processes that guide the direction, goals, & strategies of the PN practice
Workflow Integration	Designing the PN practice to fit into existing processes, policies, & technologies
Monitoring & Evaluation	Assessing the PN practice to inform planning & document results
Outcomes & Effectiveness	Understanding & measuring practice outcomes and impact of the practice

Staples ES and Dwyer AJ. (2023). Patient Navigation Sustainability Assessment Tool – Short Version. Colorado School of Public Health and University of Colorado Cancer Center, Aurora, CO.

Identifying Roles and Responsibilities for Cancer Screening Navigation in Your Clinic

Navigation Service	Clinic Staff Member	Partner Organization
Program LIAISON - individual who understands clinic, provider, and specialty care systems involved in providing cancer screening and patient navigation		
In-Reach/Outreach		
• Identification of clinic patients in need of screening		
• Contact and educate eligible patients about cancer screening(s)		
• Educating individuals who are current clinic patients as well as the community the clinic serves about cancer screening(s)		
Education		
• Explain the screening procedure and its preparation to patients, ensuring they understand the screening process and necessary preparation		
• Explain anatomy of appropriate bodily systems		
• Emphasize the medical need for screening method (colonoscopy, LDCT, etc.)		
Referral and Insurance Coverage		
• Facilitate and ensure the appropriate screening Referral/Order is completed by a Primary Care Provider		
• Verify patient income and insurance status per routine clinic policy		
• Help patient apply for other financial assistance programs for patients such as Medicare, Medicaid and SSDI		
Barriers		
• Ensure patients have transportation to and from screening and supportive care after		
• Work with patients to overcome common barriers (education, financial, logistic) using motivational interviewing skills and resource directories		
Reminders		
• Place 1-2 reminder calls before the screening appointment to decrease no-show rates (start prep, appointment date)		
• Utilize reminder system through EHR for surveillance and annual screening		
Care Coordination		
• Ensure follow-up of cancer screening results delivered by provider regardless if abnormal or normal screen - liaison between providers and patients		
• Follow-up with patients to ensure they understand the exam/test results and when they should be re-screened, or how to access additional care		
• Assist the patient with setting appointments for follow up care		
• Inform patient about who is the primary contact person if there are questions about eligibility, screening, post screening - including who to contact if patient is diagnosed with cancer or an adverse event occurs		
Program Reporting and Training Activities		
• Collection of data points for evaluation - outcomes and navigation services (how patient heard about program, time from diagnosis to treatment start, and rates of: 1) no-shows, 2) appropriate prep 3) complete follow-up)		
• Maintain files with patient specific data and records for fiscal and evaluation audits		
• Provide CCSP with monthly colonoscopy navigation and barrier reduction invoices for payment for services		
• Attend training sessions and participate in CCSP skills building opportunities		

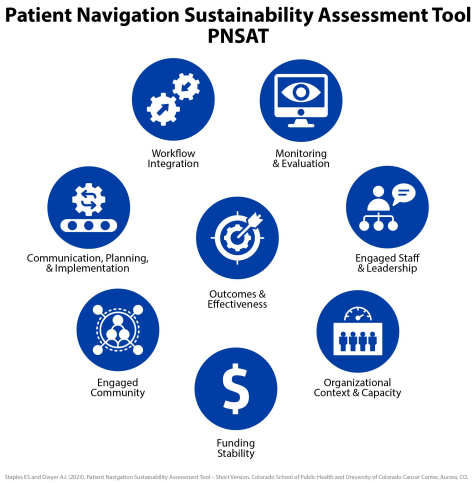
Patient Navigation Standards:

- Oncology Navigation Standards of Professional Practice
- Colorado CHW/PN Core Competencies
- NNRT Patient Navigation Job Roles by Levels of Experience

CCSP PN Resources:

- Patient Navigation Roles and Responsibilities Checklist
- CCSP PN Guidebook
- CCSP Webinar Recordings

PNSAT Implementation Resources



https://sites.google.com/view/PNSAT

PSAT Program Sustainability Assessment Tool

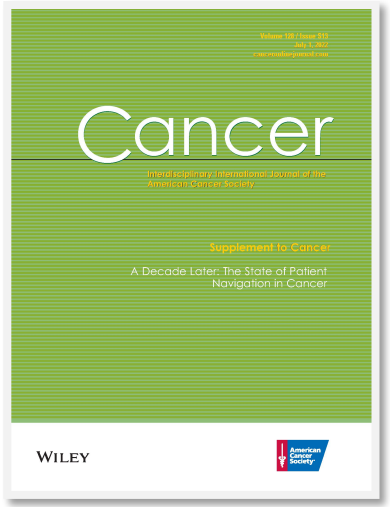
CSAT Clinical Sustainability Assessment Tool

sustaintool.org

Washington University in St. Louis Sustainability Assessment Tools

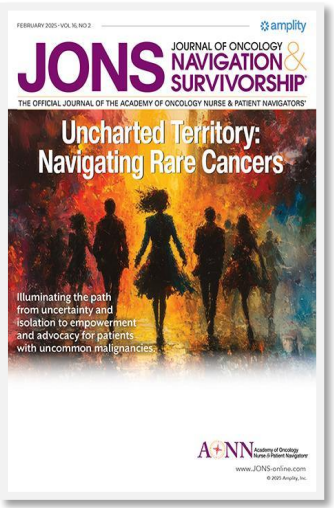
https://sustaintool.org/

PNSAT Implementation Resources



Dwyer AJ, Staples ES, Harty NM, LeGrice KE, Pray SLH, Risendal BC. What makes for successful patient navigation implementation in cancer prevention and screening programs using an evaluation and sustainability framework. *Cancer*. 2022;128 Suppl 13:2636-2648. doi:10.1002/cncr.34058.

ACS NNRT and ACS LION. Promising Practices Supporting the Sustainability of Patient Navigation: An Implementation Guide. 2025.



Fleisher L, Staples ES, Gentry SS, Chappell M, Lighthall W, Dwyer AJ. Enhancing sustainability in patient navigation programs: Perspectives from the field. *JONS.* 2025;16(2):46-58.

Staples ES, Dwyer AJ. Sustainability planning for patient navigators: best practices. *JONS*. 2025;16(2):59-60.

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Moderated Panel Discussion

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Open Discussion

Please feel free to come off mute to ask your question

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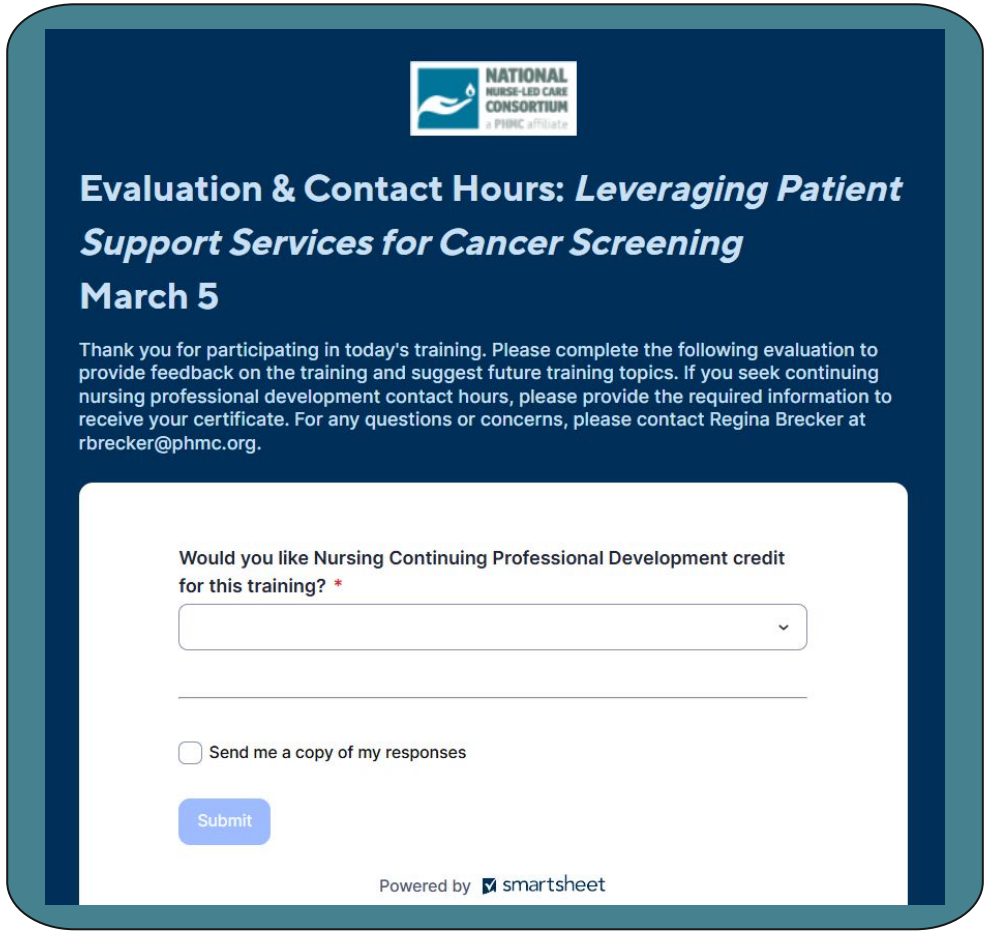

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Evaluation & Contact Hours: *Leveraging Patient Support Services for Cancer Screening*

March 5

Thank you for participating in today's training. Please complete the following evaluation to provide feedback on the training and suggest future training topics. If you seek continuing nursing professional development contact hours, please provide the required information to receive your certificate. For any questions or concerns, please contact Regina Brecker at rbrecker@phmc.org.

Would you like Nursing Continuing Professional Development credit for this training? *

Send me a copy of my responses

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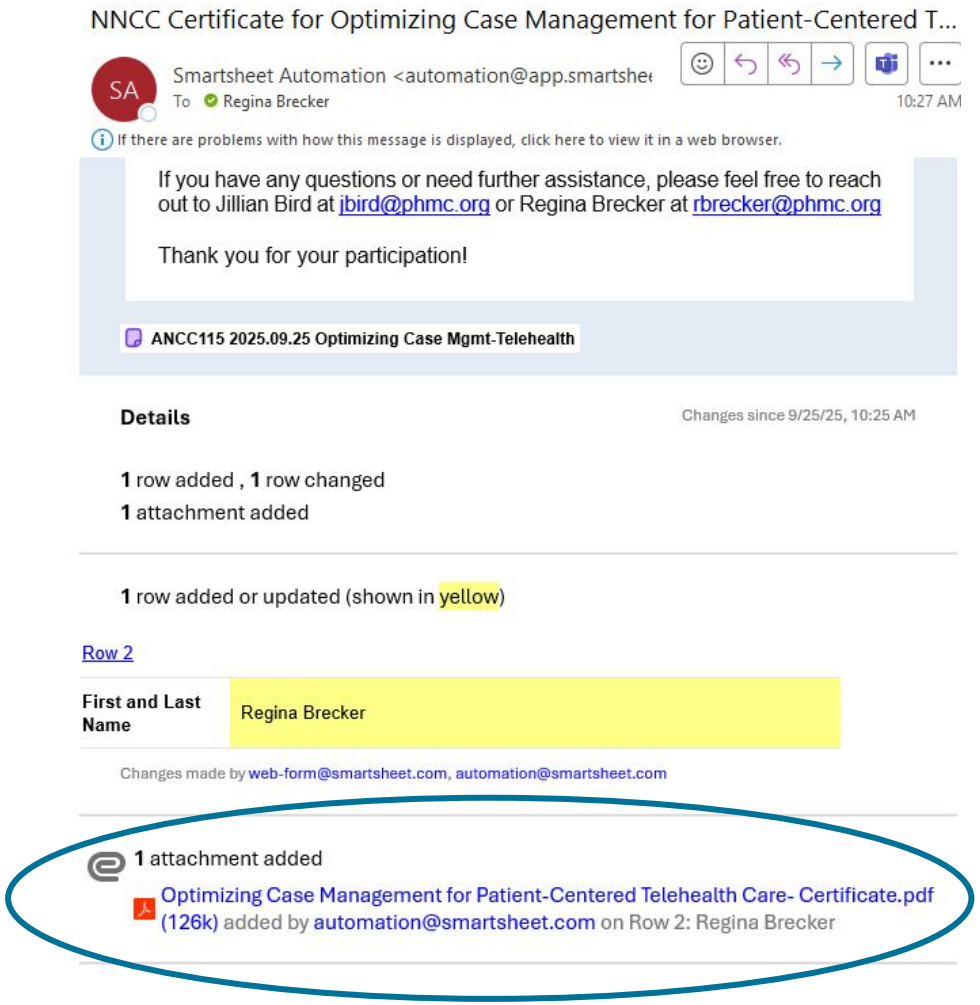
Once you submit the evaluation, please wait approximately **20 minutes** for your certificate to arrive. It will come from “Smartsheet Automation,” and be linked at the **very bottom of the email** (as seen below). You will not need to request access.


NNCC Certificate for Optimizing Case Management for Patient-Centered T...

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To Regina Brecker 10:27 AM

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If you have any questions or need further assistance, please feel free to reach out to Jillian Bird at jbird@phmc.org or Regina Brecker at rbrecker@phmc.org

Thank you for your participation!

ANCC115 2025.09.25 Optimizing Case Mgmt-Telehealth

Details Changes since 9/25/25, 10:25 AM

1 row added , **1** row changed

1 attachment added

1 row added or updated (shown in yellow)

Row 2

First and Last Name	Regina Brecker

Changes made by web-form@smartsheet.com, automation@smartsheet.com

1 attachment added

Optimizing Case Management for Patient-Centered Telehealth Care- Certificate.pdf (126k) added by automation@smartsheet.com on Row 2: Regina Brecker

Access Health Center Resources

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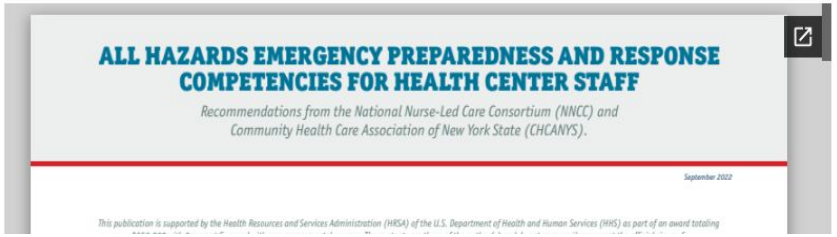
All Hazards Emergency Preparedness and Response Competencies for Health Center Staff

To successfully perform their assigned emergency/disaster roles, health center staff must understand how their organization will respond to hazards, including the use of altered management structures and modified operations. The National Nurse-Led Care Consortium (NNCC) and the Community Health Care Association of New York State (CHCANYS) created a set of competencies to improve the emergency and disaster preparedness of all health center staff. This publication provides a comprehensive overview of those competencies and sub-competencies, as well as a description of their development process. The competencies are intended to form the foundation of health center staff education and preparedness for all-hazards emergency and disaster response and will allow health centers to direct their limited training time and resources to cover the most essential preparedness aspects.



Upcoming Trainings

Improving Access: A Training Series on Cervical Cancer Screening and Prevention for Health Centers - 3PM EST

Registration: https://us02web.zoom.us/webinar/register/WN_Bs53T-k4S_C_LeRlXOQpUQ

- **March 10 -** Session 2: Breaking Down Barriers – Improving Access to Cervical Cancer Screenings
- **March 17 -** Session 3: Patient-Directed Approaches to Cervical Cancer Screening
- **March 24 -** Session 4: Strengthening Follow-Up – Care Coordination and Linkages to Support Services

The Community Health Management Task Force - Treating More than the Disease: Whole Person Approaches to Managing Chronic Conditions - Learning Series

Registration: https://us02web.zoom.us/webinar/register/WN_wvZhXfg_RImOTI02fyUdfA

- **March 18 -** Session 1: Clear Communication, Better Outcomes: Universal Health Literacy Strategies for Chronic Condition Management

Thank You!

If you have any further questions
or concerns please reach out to
Regina Brecker at rbrecker@phmc.org

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