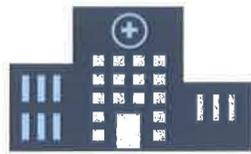


The goals of this strategy are to reach high-need individuals in the community, facilitate their access to clinical services, and ensure screening completion.

Use data to identify people:



Where do they
work?



Where do they
access care?



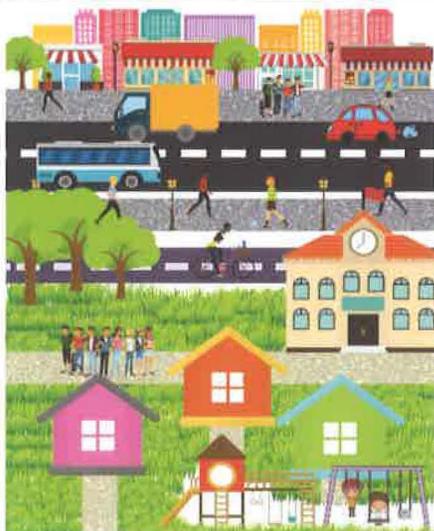
Where do they
live?



What community
resources do they use?

Then meet them where they are

Connecting Communities to Clinical Services



Inform

Individuals and community partners about your program (e.g., what it covers, screening sites, referral process).



Educate

Individuals and community partners about cancer screening.

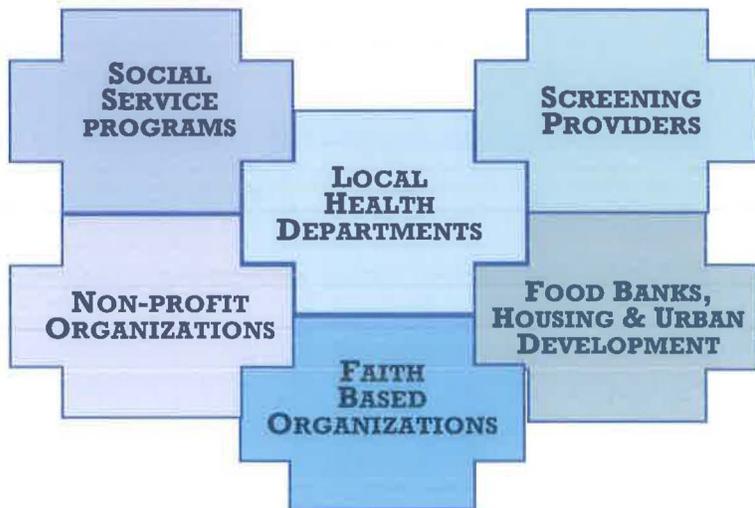
Link

Individuals to health systems through community-based referrals.

Community Clinical Linkages work when grantees

- **Use data** to identify high-need individuals and **focus** where there is highest potential impact.
- **Partner** with organizations that have access to low income, underserved individuals.
- Work with partners to **employ community-based strategies** to educate, inform, and link to screening.
- **Expand access** by engaging new clinics to provide screening services.
- **Facilitate** partnerships between public health, health systems, and community-based organizations.

Choose the Right Partners



- Does the partner have access to and provide reliable services to women who are low income, underserved, and unscreened?
- Does the partner have the capacity to expand your program's reach?
- Will the partner agree to specific recruitment/outreach goals?
- Can the partner provide data for program planning and/or monitoring and evaluation?

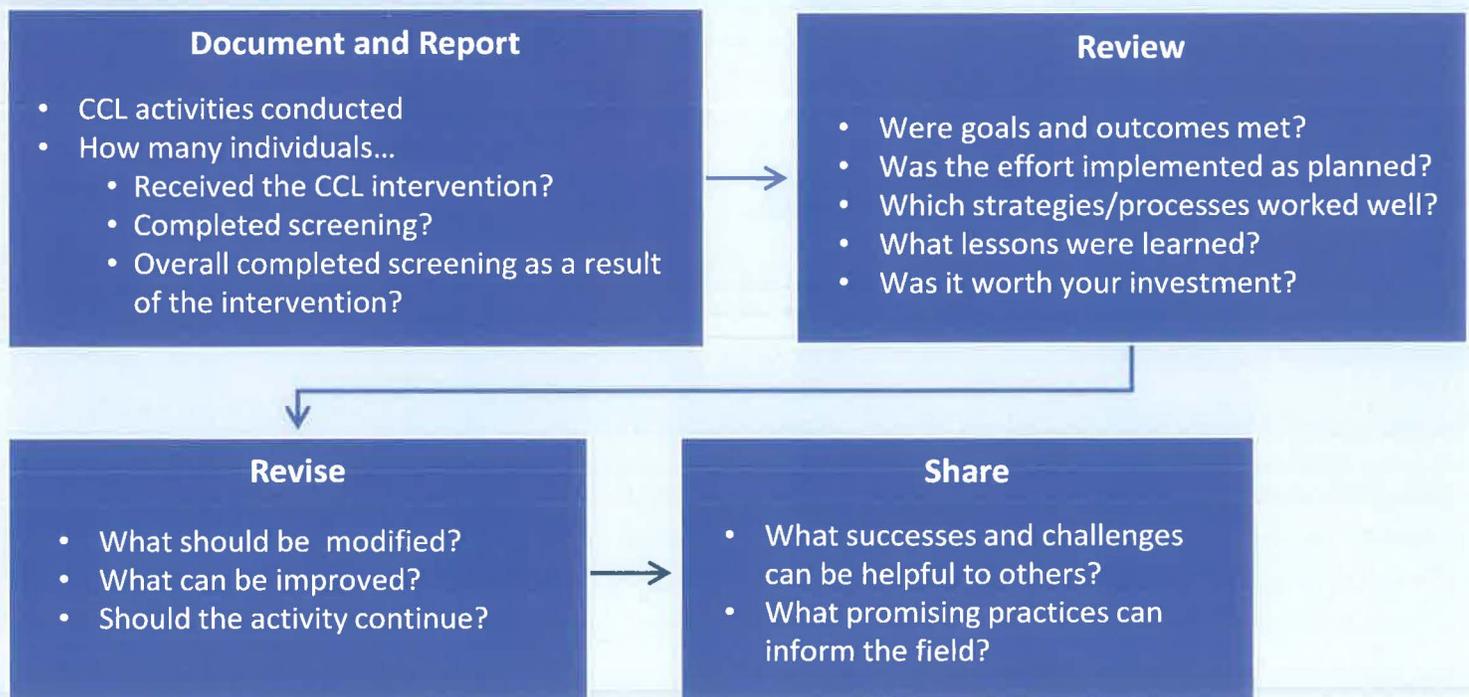
The **RIGHT** partners will have

- ❖ Access to the priority audience
- ❖ Sufficient Reach
- ❖ Compatible Goals
- ❖ Commitment to Outcomes

Establish Partnerships and Provide Technical Assistance

1. Assess community access to screening and form clinical partnerships to support service delivery.
2. Work with partners to set objectives and determine strategies to link people to clinical services.
3. Establish an agreement defining roles, responsibilities, and commitments.
4. Provide resources and technical support for implementation and evaluation.
5. Establish an agreement to collect and share data on individuals served and completing screening.

Monitor and Evaluate



This document builds on the community-clinical linkage (CCL) infographic. You will find:

- Guidance on applying an evaluation approach to your planning
- Information on reporting to CDC about CCL activities

Evaluation Guidance

The strategy goals are to reach high-need individuals in the community, facilitate their access to clinical services, and ensure screening completion. At the time of initial outreach, individuals may or may not be affiliated with a health system. CCL activities should be designed to link individuals to primary care for healthcare needs, including screening. You should aim to design activities so that screening completion can be confirmed using medical records.

Evaluation-Centric Program Planning

In planning, consider these questions to ensure that you will be able to evaluate your CCL activities:

- How will we follow/track the individuals reached in the community and confirm screening completion verified by medical records?
- What data can be collected to monitor how CCL activities are delivered (e.g., number of individuals reached, number of individuals referred for clinical services)?
- Will individuals reached through CCL activities receive CDC-funded screening and/or CDC-funded navigation? If so, are processes in place to collect Minimum Data Elements (MDEs)?
- How will we obtain confirmation of screening completion for individuals who do not receive CDC-funded screening or navigation?

As you explore CCL strategies, consider:

- Developing agreements between all involved organizations (e.g., your program, community-based partner, and health system/clinic) that support linking individuals to clinical services (screening), sharing client information for referral purposes, and collecting evaluation data.
- Collecting reliable evaluation data that will support continuous feedback for program improvement and help to demonstrate outcomes (e.g., screening completion).

Review the peer reviewed and grey literature to identify model CCL strategies and inform your planning and evaluation. The following resource provides criteria for identifying organizations to work with and sample elements for evaluation:

Centers for Disease Control and Prevention. *Community-Clinical Linkages for the Prevention and Control of Chronic Diseases: A Practitioner's Guide*. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2016.

Reporting to CDC

Continuing Application and Evaluation Reports

Your CCL plans should be reflected in your reporting to CDC. Below are some examples, and there may be other opportunities. Work with your CDC Program Consultant to discuss your plans and ensure you are including the right information.

- Workplan – As you plan for each program year, *set an annual target for the number of individuals to be screened due to your CCL efforts*. Goal setting can help keep the focus on your outcome of getting individuals from the community to clinical services and ultimately to **complete screening**. The workplan template includes a column for baseline and target values. As you plan your CCL activities and set targets, consider how you will collect reliable data to assess progress in meeting your targets.
 - ❖ State your objective and target for the number of individuals to complete screening based on CCL. Screening completion should be verified by medical records.
 - ❖ Include other objectives for your CCL activities and include targets where appropriate, whether performed by a contractor or grantee personnel. For example, if you propose:
 - Group education and navigation for individuals participating in the groups - set targets for the number of individuals educated, navigated, and screened.
 - A partner refers and tracks individuals into clinical services - set targets for the number of individuals referred, followed-up, and screened.
 - ❖ Indicate your plans for monitoring, evaluation, and oversight, including training and technical assistance for your partners and staff.
- Budget – The contractual elements “scope of work,” “itemized budget and justification,” and “methods of accountability” can be used to specify what CCL activities a contractor will do (scope of work), the payment structure (itemized budget and justification), and the processes that you and the contractors will perform to evaluate the contracted work (method of accountability that is outcome driven and has clear deliverables). Note: This aligns with the CDC Budget Preparation Guidelines which you should review and use.

- NBCCEDP Service Delivery Projection Worksheet – If your CCL plans include CDC-funded navigation from the community to the health system or through completed screening, account for this as you prepare this worksheet. Additional details are included in the section below on MDEs.
- Progress Reports and Evaluation Reports – These reports should include a summary of the CCL activities conducted and related evaluation data, including whether targets were met. If targets were not met, describe barriers to meeting the targets and proposed changes to your CCL activities to improve program efforts. These reports should also document process measures or information lessons learned, and challenges.

Annual NBCCEDP Grantee Survey*

Types of CCL information that you can anticipate being collected include:

- Description of your CCL activities
- CCL activities conducted by partners
- Use of patient navigators or community-based workers (e.g., health educator, community health worker, community nurse, promotora)
- Whether individuals reached through CCL activities were tracked through the completion of screening
- Numbers of individuals reached through CCL activities that completed screening/diagnostics
- Data source used to confirm screening completion for individuals participating in CCL activities
- Planning activities regarding future CCL efforts
- Where individuals were identified for patient navigation (in the community and/or in a clinic/hospital)
- *The survey will be fielded in 2019.

Minimum Data Elements (MDEs)

As part of CCL activities, individuals may be identified in the community, linked to clinical services, and navigated to or through screening. If CDC funds are used to pay for an individual's navigation/or clinical services, an MDE record should be reported. See the NBCCEDP policy and manual on patient navigation posted at www.nbccedp.org.

This document accompanies two others, the CCL strategy infographic and *Applying an Outcomes Driven Approach to Community-Clinical Linkages: Guidance for Grantees*. It includes grantee examples that align with CDC guidance, specifically:

- 1) Identifying high-need individuals in the community, facilitating their access to clinical services, and ensuring screening completion.
- 2) Focusing on meeting individuals through community outreach and partnership.
- 3) Evaluating through screening completion, using medical records.

It is important to emphasize that these examples are promising, not perfect. Most are in the early stages of implementation or evaluation, or both. Hopefully they can stimulate thinking about how you might implement CCL strategies. So you can learn more, we have included grantee contact information.

We encourage you to leverage the experiences, expertise, and resources of others in your state, tribe, territory, or jurisdiction. This may lead to a more cost-effective approach to CCL. During planning and assessment, identify potential collaborators. That is, collaborators from other programs, organizations, or groups that are both experienced and effective in the community-clinical linkage arena.

CHWs at Health Department Conduct Community Outreach and Refer Women - Nebraska

The Nebraska program conducts statewide outreach through a network of 19 “Community Health Hubs,” which are mostly local health departments. Community Health Workers (CHWs), funded through the hubs or local health departments, connect with women in the community and navigate them to more than 400 screening providers. They document contacts and risk assessments for each woman in an electronic *CHW Encounter Registry*. If a woman is deemed eligible for Nebraska’s program, the CHW assists her in completing an enrollment form, which is then sent to the program for review and follow-up. The program uses the *Encounter Registry* data to assess the type of outreach or navigation provided to non-program eligible women and determines if they complete screening at one of their provider sites. The program has a CHW training curriculum for program-affiliated CHWs and manages the *Encounter Registry* to monitor community outreach progress. To learn more: Melissa.Leypoldt@nebraska.gov

Grantee Staff Conduct Outreach and Navigation at Community-Based Organization - Louisiana

The Louisiana State University program partners with six *Second Harvest Food Bank* pantries in New Orleans. The program's navigator and nurse practitioner conduct outreach and education, navigating eligible women to four breast and cervical cancer screening providers in the area. Methods for education and outreach depend on the pantry's food distribution operations and may include group and/or 1:1 education activities, stationed in or near the waiting area. The program initially conducted an assessment at each pantry. Among the information collected was the number of women and federal poverty level served, the best days to conduct outreach, the availability of space (for education and outreach), and whether the women had a primary care provider. Since grantee personnel are providing the navigation, they are able to enter data into the program's data management system, Catalyst, used to report MDEs and PN-Only MDEs. The community navigation program will be expanding to additional parishes in 2019. To learn more: Jasmine Meyer, jmeyer6@lsuhsc.edu

Tribal Health Educator Conducts Outreach and Clinic-Based Navigators Follow-Up - Cherokee Nation

The Cherokee Nation program serves a 14-county area in Oklahoma. The tribe manages their own health system consisting of nine facilities. Their public health educator conducts outreach at community venues in the 14-county area, including at clinics. She provides the names of women she has met in the community to the clinic-based case managers. The case-managers follow-up with the women to schedule their screening. To learn more: Andrea-Carpitcher@cherokee.org

External Partner, YWCA, Conducts Outreach and Navigation - New Mexico

In the last grant cycle, the New Mexico program implemented a community outreach and navigation program, funding multiple contractors. During this time, the program developed standardized reporting processes, policies, forms, and a short training for these contractors. Among them was the YWCA. Many of the women navigated by the "Y" were identified through their own 20-year database which included over 3,000 women. The New Mexico program and providers could refer women for navigation as well. The "Y" used a voucher/coupon system to determine if women were screened by their screening providers and reported this data to the program. To learn more: Beth.Pinkerton@nm.state.us

Navigators Housed at Program Screening Providers Conduct Outreach, Follow-up, and Navigation - Wisconsin

The Wisconsin program currently supports three navigators that are housed at three health systems including the largest health system in Wisconsin; a health system focusing on rural communities; and the University of Wisconsin's Cancer Center Health Disparities initiative. In addition, another navigator, based at the City of Milwaukee Health Department, serves both NBCCEDP and WISEWOMAN clients. The program also supports a community health worker at the Milwaukee Consortium for Hmong Health. The navigators and community health worker conduct community outreach, follow-up, and navigation. To learn more: Gale.Johnson@dhs.wisconsin.gov

Partnering with the Hepatitis C Program to Schedule Screening at their Outreach Event - Cherokee Nation

The Cherokee Nation program is in the early phases of partnering with the Hepatitis C Program. The latter program is piloting a project to provide education and screening at food distribution centers. Referred to as “food warehouses”, low-income people shop for free at these grocery-like stores. The breast and cervical program’s health educator and clinic-based case manager will work alongside the Hepatitis program staff. While screening will be provided on-site for various health maintenance screenings such as HbA1c, cholesterol, Hepatitis C, and HIV, the breast and cervical program will schedule appointments on the spot for cancer screening. To learn more: Andrea-Carpitcher@cherokee.org

Facilitating Referrals through Direct Mailings to Women Denied Medicaid - Maine

In Maine, individuals who are denied Medicaid receive an automated letter that identifies alternate state Department of Health and Human Services resources. Monthly, the breast/cervical program receives a list of the denied women, ages 40-64 years, and sends them “direct mail”. Approximately 50% of the program’s new enrollees identify “direct mail” as the reason they enrolled. This is a low-cost strategy for Maine. While this strategy is not community-based in a physical sense, they are still reaching their eligible population. Please consider this “systematic referral” strategy with community-based partners or those serving your priority populations. To learn more: Maryann.M.Zaremba@maine.gov

Using Non-Traditional Partners, such as Emergency Medical Services.

We heard through the grapevine of an effort with Emergency Medical Services (EMS). On their “down time,” EMS workers conduct outreach for the program. If this is your program, tell us about it, so we can learn about your successes and challenges and how women are connected to screening.

KEEP IN MIND...

We hope these examples are helpful to your planning efforts. As you explore these and other strategies, it may be fruitful to consider:

- Developing a three-way agreement between your program, community-based partner, and health system/clinic to link women to screening, and share data and referral information. Public health is a valuable partner to healthcare systems by helping communities access needed care.
- These three-way partnerships may offer a mechanism for continuous feedback and demonstrating outcomes (i.e. obtaining requisite data on screening outcome) and the importance of such partnerships.