Thank you for joining us!  
We’ll get started in a moment!

Acknowledgements

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Learning Objectives

• Provide a brief overview of colorectal cancer prevention and screening recommendations
• Discuss why CHCs should improve colorectal cancer screening rates
• Discuss how to offer and provide patient education about fecal immunochemical test (FIT)/guaiac-based fecal occult blood test (FOBT) as equally valid screening options for average-risk populations
• Review available resources in Massachusetts and Maine to support community health centers

Today’s Presenters

Kathryn Hollett, MD
Director of Quality Improvement
North Shore Community Health, Gloucester, MA
Community Health Center Speaker’s Bureau Member - a joint project of the American Cancer Society, the National Colorectal Cancer Roundtable and the National Association of Community Health Centers

Rebecca Colella
Quality Improvement Coordinator
Maine Primary Care Association

Antonia Blinn
Project Manager
Cancer Screening Improvement Initiatives
Massachusetts League of Community Health Centers
Improving Colorectal Cancer Screening Rates in Community Health Centers

Kathryn Hollett, MD

Mrs. P
Colorectal Cancer (CRC)

- 3rd most common cancer and the 2nd deadliest
  - 132,700 new cases expected for 2015

- Approximately 50,000 deaths from colorectal cancer in the US every year

- 1.2 million Americans living with CRC (2012)

Why Screen?

There are two aims of screening:

1. Prevention
   Find and remove polyps to prevent cancer

2. Early Detection
   Find cancer in the early stages, when best chance for a cure
Early Detection → Increased Survival

- Colorectal Cancer 5-year survival rates
  - Localized 90%;
  - Regionally-spread 71%.
  - Metastatic 13%.

- Early stage colorectal cancer typically does not have symptoms, which is why screening is usually necessary to detect this cancer early.

- Only 40% of colorectal cancers are diagnosed at an early stage, in part due to the underuse of screening.
Colorectal Cancer Incidence and Mortality

- Declining due to:
  - Changes in risk factors.
  - Improvements in treatment
  - Screening → earlier detection
  - Screening → prevention

- From 2007 to 2011, CRC incidence rates declined by 4.3% per year among adults 50 years of age and older
- The CRC death rate declined by 2.5% per year.
- Screening has prevented more than 500,000 colorectal cancers in the US over the past three decades per recent study estimates.

Colorectal Cancer Risk Factors
Age – the most impactful risk factor.

- CRC usually develops after age 50
- The chance of getting CRC increases as you get older

http://science.education.nih.gov/supplements/nih1/cancer/guide/pdfs/ACT3M.PDF.

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Modifiable CRC Risk Factors

- Physical activity
  - Less active raises risk
- Overweight
  - Obesity raises risk of having and dying from CRC
- Smoking raises risk
- Heavy alcohol use raises risk
- Diet
  - High in red/processed meat raises risk
  - High in fruits and vegetables lowers risk
Non-modifiable risk factors for CRC

- Personal or family history of adenomatous polyps or colorectal cancer
- Certain inherited syndromes
  - Hereditary nonpolyposis colorectal cancer (HNPCC)
  - Familial adenomatous polyposis (FAP)
- Inflammatory bowel disease
  - Crohn’s Disease
  - Ulcerative Colitis
- Type II Diabetes

Who Gets Colorectal Cancer?

- Sporadic (average risk) (65%–85%)
- Family history (10%–30%)
- Hereditary nonpolyposis colorectal cancer (HNPCC) (5%)
- Familial adenomatous polyposis (FAP) (1%)
- Rare syndromes (<0.1%)
Risk Assessment

- 20-25% of the population is at increased risk of CRC.
- Screening strategies differ for high risk individuals.
- Risk assessment is a key step in evaluating patients and deciding which CRC screening test is appropriate.

Screening: How are we doing?
CRC Screening: National Data

In 2012, 65.1% of US adults were up to date with screening.

- The percentages of blacks and whites up-to-date with screening were equivalent.
- Lower rates for Hispanics and Native Americans.
- Lower rates among adults with less than a high school education.
- Lowest rates among the uninsured.

Source: Klabunde et al, Cancer Epidemiol Biomarkers Prev 2011;20:1611-1621
National Health Interview Survey Public Use Data File 2010, National Center for Health Statistics, Centers for Disease Control and Prevention, 2011.
American Cancer Society, Surveillance Research, 2011.

CRC Screening in Community Health Centers

UDS measure - Colorectal Cancer Screening

- 2012 Nationwide Rate for CHCs – 30.2%
  - Slightly increased in 2013

- Measure – Percent of patients in universe who received appropriate screening for colorectal cancer

- Universe is adults who were age 51 through age 74 during the measurement year and seen in the measurement year

- Requires documentation of test performed by grantee or by another care giver
Colorectal Cancer Screening Rates in Health Centers

Data Source: U.S. data 2012.
Adults 50-75 years of age who have received any of the following: colonoscopy during reporting year or previous 9 years, flexible sigmoidoscopy conducted during reporting year or previous 4 years, or FOBT or FIT during reporting year.

Colorectal Cancer Screening Rates - Northeast

Data Source: U.S. data 2012.
Adults 50-75 years of age who have received any of the following: colonoscopy during reporting year or previous 9 years, flexible sigmoidoscopy conducted during reporting year or previous 4 years, or FOBT or FIT during reporting year.
Why are 70% of at-risk CHC patients not screened?

Groups with lowest screening rates include:
- Lower socioeconomic status
- Uninsured
- Racial/ethnic minorities

Why patients aren’t getting screened
(according to physicians)

- Patient reluctance to undergo screening procedures
- Patient fear of procedure or results
- Patient lacks insurance coverage for screening procedure
Why patients aren’t getting screened
(according to patients)

- “My doctor never talked to me about it!”
- Fear of cancer diagnosis
- Lack of symptoms
- Misconceptions about cancer causes and risks
- Perceived discomfort of screening tests
- Embarrassment
- Cultural issues
- Patient preferences

Make a Recommendation

Goal = Recommendation to each eligible patient

- Opportunistic/global approach
  - Don’t limit efforts to “check-ups”
- Team approach: Don’t depend on the provider alone
- Consistent messaging from clinicians and staff, taking into account patient knowledge and concerns
How is CRC screening done?

Types of tests used for CRC screening:

Tests that can find both polyps and colorectal cancer

Tests that mainly find cancer

ACS Colorectal Cancer Screening Guidelines

At age 50, both men and women should begin regular screening and have one of the screening tests listed here or on the next slide:

**Tests that find both polyps and cancer**

- Flexible sigmoidoscopy (FSG) every 5 years*, or
- Colonoscopy every 10 years, or
- Double contrast barium enema (DCBE) every 5 years*, or
- CT colonography (virtual colonoscopy) every 5 years*

*Colonoscopy should be done if anything is found by these tests
Tests that mainly find cancer

- Guaiac-based fecal occult blood test (gFOBT)
- Fecal immunochemical test (FIT)
- Stool DNA tests (sDNA)

All of these test the stool for hidden blood or other changes that may be signs of cancer.
- They are less invasive and easier to do.
- They are less likely to find polyps than the other types of tests.
- Colonoscopy will be needed if results are abnormal.

Recommended Screening Tests
ACS and USPSTF

- Colonoscopy
- High Sensitivity Fecal Occult Blood Testing
  - Guaiac
  - Immunochemical
- Flexible Sigmoidoscopy (FSIG)
  - Recent studies support efficacy
  - Availability extremely limited in U.S.
Hemoccult II (TM) and its generic equivalent Seroccult, are no longer recommended!

In-office stool testing and digital rectal exams are not appropriate methods of screening for colorectal cancer.

NOT APPROPRIATE SCREENING TESTS

Stool Test: Guaiac

- Most common type in U.S.
- Solid evidence (3 RCTs)
- 30 year f/u (NEJM Oct 2013)
- Need specimens from 3 bowel movements
- Non-specific for human blood
- Results influenced by foods and medications
- Better sensitivity with newer versions (Hemoccult Sensa)
- Older forms (Hemoccult II) not recommended!
Fecal Immunochemical Test (FIT)

- Specific for human blood and for lower GI bleeding
- Results not influenced by foods or medications
- Some types require only 1 or 2 stool specimens
- Higher sensitivity than older forms of guaiac-based FOBT
- Costs more than guaiac tests (but higher reimbursement)

CHOOSING A SCREENING TEST
WHICH TEST IS BEST?

- No evidence from randomized controlled trial (RCT) that one method is best.
- Years of life saved through an annual high-quality stool-blood screening program are COMPARABLE to colonoscopy based screening.

Colonoscopy Limitations

Evidence does not support that colonoscopy is the “best test” or “gold standard” for screening

- Colonoscopy misses ~ 10% of significant lesions in expert settings
- More costly on a one-time basis
- Higher potential for patient injury than other tests
- Test performance measurable outcomes vary widely
  - i.e., test performance is highly operator dependent
Quality Issues with Colonoscopy

- no requirements for reporting of endoscopic quality measures
- significant variation among endoscopists in key quality metrics e.g. adenoma detection rate
  - 20% overall detection rate (varied from 7% - 52%)
  - Adenoma detection rates (adr’s) inversely associated with interval cancer (between colonoscopies)

Overutilization of Colonoscopy

- Among 24,000 Medicare beneficiaries who had normal colonoscopy 46.2 percent had a repeat colonoscopy in seven years*
- 24 percent of gastroenterologists and 54 percent of surgeons who performed screening colonoscopy recommended surveillance for a hyperplastic polyp**


Stool Testing Quality Issues

- In-office FOBT is essentially worthless as a screening tool for CRC and should never be used.
- CRC screening by FOBT should be performed with high-sensitivity FOBT - either FIT or a highly sensitive gFOBT (such as Hemoccult SENSA).
  - Older, less sensitive guaiac tests (such as Hemoccult II) should not be used for CRC screening.
- Tests must be completed annually by the patient
- All positive screening tests should be evaluated by colonoscopy

FIT AND FOBT

<table>
<thead>
<tr>
<th>FIT and guaiac-based FOBT</th>
<th>Sensitivity for cancer</th>
<th>Sensitivity for adenoma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunochemical tests (FIT)</td>
<td>55% - 100%</td>
<td>15% - 44%</td>
</tr>
<tr>
<td>High-sensitivity guaiac-based FOBT (Hemoccult Senza)</td>
<td>50% - 79%</td>
<td>21% - 35%</td>
</tr>
<tr>
<td>Hemoccult II</td>
<td>33% - 50%</td>
<td>8% - 20%</td>
</tr>
</tbody>
</table>
Improving Screening Rates

http://nccrt.org/about/provider-education/manual-for-community-health-centers-2/


How might a Community Health Center benefit by using this manual?

1. Helps CHCs increase colorectal cancer screening rates through a team-based, systematic approach
2. Helps increase rates for UDS measure
3. Trains staff on a quality improvement processes that apply to other preventive services
4. Implements field-tested processes created by experts
5. Strengthens relationships with other community partners
Steps for Increasing Screening Rates

**Step #1: Make a Plan**
- Determine Baseline Screening Rates
  - Identify your patients due for screening
  - Identify patients who received screening
  - Calculate the baseline screening rate
  - Improve the accuracy of the baseline screening rate
- Design Your Practice’s Screening Strategy
  - Choose a screening method
  - Use a high sensitivity stool-based test
  - Understand insurance complexities
  - Calculate the clinic’s need for colonoscopy
  - Consider a direct endoscopy referral system

**Step #2: Assemble a Team**
- Form An Internal CHC Leadership Team
  - Identify an internal champion
  - Define roles of internal champions
  - Utilize patient navigators
  - Define roles of patient navigators
  - Agree on team tasks
- Partner with Colonoscopists
  - Identify a physician champion

**Step #3: Get Patients Screened**
- Prepare The Clinic
  - Conduct a risk assessment
  - Establish a medical neighborhood
- Prepare The Patient
  - Provide patient education materials
  - Convince reluctant patients to get screened
- Ensure Quality Screening for Stool-Based Screening Program
  - Coordinate Follow-Up After Colonoscopy

**Step #4: Coordinate Care Across The Continuum**
- Make A Recommendation
  - Establish a medical neighborhood
- Track Return Rates and Follow-Up
  - Measure and Improve Performance
Step #1: Make a Plan
(Determine Baseline Screening Rate)

- CHCs need to determine where they are before they can determine where to go
- Encourage all CHCs to assess or re-assess their baseline screening rate

Step #1: Make A Plan
(Design your Screening Strategy)

There is no evidence from randomized controlled trials that one screening method is the “best”

Years of life saved through an annual high-quality stool blood screening program are COMPARABLE to a high-quality colonoscopy-based screening program when positive stool tests are followed by colonoscopy
Patient Preference

Inadomi, Arch Intern Med 2012

<table>
<thead>
<tr>
<th>FOBT/FIT†</th>
<th>Colonoscopy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key facts</strong></td>
<td><strong>Key facts</strong></td>
</tr>
<tr>
<td>• Reduces death from colorectal cancer</td>
<td>• Reduces death from colorectal cancer</td>
</tr>
<tr>
<td>• Safe, available, and easy to complete</td>
<td>• Can prevent cancer by removing polyps (or abnormal growths in the colon) during test</td>
</tr>
<tr>
<td>• Done on your own at home and returned</td>
<td>• Examines entire colon</td>
</tr>
<tr>
<td>• Finds cancer early by finding blood in the stool</td>
<td>• Finds most cancers or polyps that are present at the time of the test</td>
</tr>
<tr>
<td>• Finds most cancers early when done every year</td>
<td>• Done every 10 years if no polyps are found</td>
</tr>
<tr>
<td><strong>Things to consider</strong></td>
<td><strong>Things to consider</strong></td>
</tr>
<tr>
<td>• May produce positive test results, even when no polyps or cancer are in the colon</td>
<td>• Stomach pain, gas, or bloating is possible before, during or after test</td>
</tr>
<tr>
<td>• When the test is positive colonoscopy is required</td>
<td>• Must be performed at a hospital or clinic, usually with sedation or anesthesia, and someone must go with the person to take him or her home after the test</td>
</tr>
<tr>
<td>• Person testing themselves comes into brief close contact with stool samples on a test kit</td>
<td>• A clear liquid diet is required before test</td>
</tr>
<tr>
<td>† Guaiac Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT)</td>
<td>• Must take medication that will cause loose bowel movements to clean out the colon prior to test</td>
</tr>
</tbody>
</table>

†Flexible sigmoidoscopy may not be readily available and has largely been replaced by colonoscopy in the US.

Many Patients Prefer FOBT

- Diverse sample of 323 adults given detailed side-by-side description of FOBT and colonoscopy (DeBourcy et al. 2007)
  - 53% preferred FOBT
  - Almost half felt very strongly about their preference
- 212 patients at 4 health centers rated different screening options with different attributes (Hawley et al. 2008)
  - 37% preferred colonoscopy
  - 31% preferred FOBT
- Nationally representative sample of 2068 VA patients given brief descriptions of each screening mode (Powell et al. 2009)
  - 37% preferred colonoscopy
  - 29% preferred FOBT

Key Findings

- FOBT used by many, but effectiveness questioned by majority of providers
- Colonoscopy viewed as the best screening test, but a high proportion of patients face barriers
  - Often recommended despite limited access
  - Emphasis on colonoscopy was associated with low screening rates in a number of sites
Step #2: Assemble a Team

- Educate staff
- Post motivating visuals in patient areas
- Keep patient education materials and stool testing kits handy
- Create EMR prompts to identify eligible patients.
- Create team-based processes for documenting and tracking CRC screening
- Create a system for patient notifications and reminders

Staff Involvement

- Key Point.....the clinicians cannot do it all!
- Time that patients spend with non-clinician staff is underutilized
- Standing orders can empower nurses, intake staff, etc. to distribute educational materials, schedule appointments, etc.
- Involve staff in meetings to discuss progress in achieving office goals for improving the delivery of preventive services
Motivating Staff

Step #3: Get Patients Screened
Make a recommendation!

A recommendation from the provider is the most influential factor on patient screening behavior.
Step # 3: Get Patients Screened
Risk Assessment

- Making appropriate screening recommendations requires accurate assessment of each patient’s risk status

- Individual Risk Levels
  - Average
  - Increased
  - High

Sample Screening Algorithm

Assess Risk: Person & Family

- Average Risk = no family hx of CRC or adenomatous polyp
  - < 50 yrs
    - Do Not Screen
  - ≥ 50 yrs
    - Screen*
      - Adenoma
      - CRC
      - IBD**
      - Increased or High Risk = + Family or personal hx of CRC or adenomatous polyp, IBD or HNPCC-related cancer

- Personal History
  - + Adenoma
  - + CRC
  - + IBD**

- Family History
  - + Germline Syndrome
  - + Adenoma

- Diagnosis by Colonoscopy
  - Surveillance Colonoscopy
  - Childhood Screening
  - Screen 10 yrs before youngest relative or age 40

* Options
  - IORT or IMRT
  - Preop or Postop
  - Resection
  - Colonoscopy 40 yrs

** IBD refers to inflammatory bowel disease for 8 yrs.
Choosing the right test

Do You Have:
- Family history of colorectal cancer or polyps?
- Personal history of colorectal cancer or polyps or inflammatory bowel disease?

No
- Are you: Age 50 – 75 years old?
- No: Younger than 50 years: Testing is not recommended.
- Yes: Older than 75 years: Provider and patient decide if testing is needed.

Colonooscopy
- Provider and patient determine if testing should be started before age 50.

Step #3 Get Patients Screened
Patient Education
Step #4: Coordinate Care Across the Continuum

The creation of a medical neighborhood will be critical in coordinating the care of patients. It includes the facility, pathology, anesthesia, back up surgery, radiology, hospital, and possibly oncology.

Reassess your CRC screening data and processes

- Has your screening rate increased?
- Does the team have ideas for improving efficiency and efficacy?
- Does your community health center, PCA or the American Cancer Society have resources or assistance available to help you improve your CRC rates?
Take Home Points

- Provider recommendation
- Stool testing as a valid and convenient screening option
- Teamwork

Teamwork Processes

- Prompts for identifying eligible patients
- Motivating patient education visuals
- Reminder letters
- Documentation and tracking
Questions

Colorectal Cancer Screening

Resources
National Colorectal Cancer Roundtable

- 80% by 2018 Campaign
- Communications Guidebook
  - Effective messages for reaching the unscreened.

“With these messages, we intend to help educate, empower and mobilize three key unscreened audiences:
- The Newly Insured
- The Insured, Procrastinator/Rationalizer
- The Financially Challenged”

http://nccrt.org/about/80-percent-by-2018/

Communications Guidebook Demographics

Demographic Profile
- Age: More likely to be younger than those screened; nearly two-thirds are 50-59 years of age.
- Insurance Status: More likely to be uninsured (nearly one-quarter) than those screened.
- Income: Slightly lower income than those screened, with over one-half earning under $40K per year.
- Race/Ethnicity: More likely to be Hispanic than those screened (nearly five in ten eligible Hispanics are not being screened).
- Education: Slightly more likely (around seven in ten) to have less than a 4-year college degree than those who have been screened.
- Cancer Connection: Less likely to be a cancer survivor (<7%) and less likely to have a close friend/family member with cancer than those screened (just over half).

Emotional Profile
- Think they are taking care of their health already
- Fearful of the unknown
- Fearful of preparation/procedure
- Focused on more immediate health concerns
- Procrastinators
- Rationalize reasons for not being screened
- Lack sense of urgency around the issue
- Have an “I know best” attitude
Steps for Increasing Colorectal Cancer Screening Rates: A Manual for CHCs

http://nccrt.org/about/provider-education/manual-for-community-health-centers-2/

Tools, Templates and Resources

- Appendix A
  - Work Sheets for Completing the Action Steps

- Appendix B
  - Electronic Health Record Screen Shots

- Appendix C
  - Program Tools and Materials

- Appendix D
  - Resources
Appendices: Tools, Templates, and Resources

Appendix A

1 – Collect Health System Data Work Sheet
2 – Chart Audit Sample Template
3 – UDS Definition of Performing a Random Sampling (from the UDS Manual)
4 – Health System Experience with CRC Screening Work Sheet
5 – Health System Intervention Strategies Work Sheet
6 – Interventions for Health Insurance Plans
7 – Action Plan Work Sheet
8 – Sample Tracking Template
9 – Assess Your Progress Work Sheet

Appendix B

1 – NextGen Screen Shots
2 – EClinicalWorks Screen Shots

Appendix C

1 – Sample Screening Policy Template (Adapted from the New Hampshire Colorectal Cancer Screening Program)
2 – Options for Stool-based Tests – Coming Soon!
3 – Standards History and Physical Form with Labs (Operation Access)
4 – Direct Endoscopy Referral (New York Citywide Colon Cancer Control Coalition)
5 – Sample Colonoscopy Appointment Letters in English and Spanish (Operation Access)
6 – Colonoscopy Preparation Navigator Checklists (Fair Haven CHK)
7 – How to Implement a FLL-FIT and FLL-FORT Program (fluft.org)
8 – Sample HsgFORT/FIT Results Tracking Sheet
9 – Sample Reminder Cards
10 – Sample Patient Reminder Letter for Screening
11 – Sample Patient Reminder Letter to Return Test
12 – Sample Patient Letter Regarding a Negative Test
13 – Sample Chart Stickers
14 – Sample Memorandum of Understanding with GI and Other Specialty Providers (Operation Access)
15 – Quality Measures for Colonoscopy Reports

Appendix D

1 – Patient Education Materials
2 – Guidelines
3 – Patient Navigation
4 – Electronic Health Records
5 – Practice Management

References
Clinicians Reference: FOBT

One page document designed to educate clinicians about important elements of colorectal cancer screening using fecal occult blood tests (FOBT). Provides state-of-the-science information about guaiac and immunochemical FOBT, test performance and characteristics of high quality screening programs.

Available at:

Resources – MA Health Promotion Clearinghouse

http://massclearinghouse.ehs.state.ma.us/category/CANCER.html
Test Yourself For Colon Cancer At Home

Why is it important to get screened for colon cancer?
Screening tests can help your doctor find precancerous polyps and detect cancer. When polyps are found and removed, colon cancer can be prevented.

Who needs to be screened?
Men and women who are 50 or older
- If you have a personal or family history of polyps or colon cancer, you may need to begin getting screenings earlier.
- African Americans have a greater risk for colorectal cancer. If you're African American, it's especially important to be screened.

A simple stool test can save your life.
A stool test, or a blood test called FIT, is an easy, one-time screening test that the colon cancer screening test. You take a stool sample and mail it to a laboratory for testing.

What do stool tests look for?
Your doctor or health care team may recommend a stool test if they find blood in your stool.

What if my stool test finds blood?
If your doctor or health care team finds blood in your stool, you will need to come back for an additional test. This could be a colonoscopy.

Make It Your Own (MIYO) Portal

http://miyoworks.org/
FluFIT/FluFOBT PROGRAM

- Combines CRC screening with annual flu shot campaigns
- Practice/Clinic staff provide FOBT/FIT kits to eligible patients when they get their annual flu shot
- Studies show FluFOBT leads to higher CRC screening rates (including studies in community health centers)
See how it works in community clinics

What are FLU–FIT & FLU–FOBT Programs?

FLU–FIT and FLU–FOBT Programs help clinical teams increase access to colorectal cancer screening by offering home tests to patients at the time of their annual flu shots. Successful FLU–FIT and FLU–FOBT Programs have been implemented in public and private clinic settings. They have been pilot tested in commercial pharmacies, too.

These programs were awarded the Annual Prevention Laurel for Innovative Programs by the Prevent Cancer Foundation, the National Colorectal Cancer Roundtable, and the American College of Obstetricians and Gynecologists in 2013. They have recently been recognized as a “Research Testable Intervention Program” (RTIP) by the National Cancer Institute. This fall the program will be featured in the Agency for Healthcare Research and Quality’s Innovations Exchange. The American Cancer Society is currently introducing FLU–FIT Programs in several community health centers across the country.

See how it works at Kaiser Permanente

FLU–FIT or FLU–FOBT

The FLU–FIT and FLU–FOBT Programs were developed with support from the American Cancer Society, the Centers for Disease Control and Prevention, and the U.S. Preventive Services Task Force.

Colorectal Cancer Screening Archived Webinars

- **Webinar #1 – Clinical Guidelines and Evidence-Based Approaches**
  
  [https://communityhealth.adobeconnect.com/p3z8xlnx1r0/](https://communityhealth.adobeconnect.com/p3z8xlnx1r0/)

- **Webinar #2 - Process Effective Improvement Efforts**
  
  [https://communityhealth.adobeconnect.com/p7o6btsx05k/](https://communityhealth.adobeconnect.com/p7o6btsx05k/)

- **Webinar #3: Best Practices in Community Health Centers**
  - Part I-To view the overview: [https://communityhealth.adobeconnect.com/p8m7fy82h58/](https://communityhealth.adobeconnect.com/p8m7fy82h58/)
  - Part II-To view the transition from gFOBT to iFOBT (FIT): [https://communityhealth.adobeconnect.com/p71hoqzx56j/](https://communityhealth.adobeconnect.com/p71hoqzx56j/)
  - Part III-To view the Research Study and evidence based improvement approaches and resources: [https://communityhealth.adobeconnect.com/p8lhwxskakl/](https://communityhealth.adobeconnect.com/p8lhwxskakl/)

- **Colorectal Cancer Screening Guidelines Webinar**
  This CME activity encompasses the most recent guidelines on screening initiation, screening intervals and screening follow-up on colorectal cancer screening led by Paul C. Schroy III, M.D., M.P.H., Professor of Medicine, Boston University School of Medicine Director of Clinical Research, GI Section, Boston Medical Center. CME Credit: 1 AMA PRA Category 1 Credit™, risk management study.
  To view: [www.massmed.org/cme/dphcolorectalscreening](http://www.massmed.org/cme/dphcolorectalscreening)

- **Screening for Colorectal Cancer: Optimizing Quality (CME)**
  This continuing education activity provides guidance and tools for clinicians on the optimal ways to implement screening for colorectal cancer to help ensure that patients receive maximum benefit.
  To view: [www.rdc.gov/cancer/colorectal/quality/](http://www.rdc.gov/cancer/colorectal/quality/)

- **Improving Colorectal Cancer Screening Rates in Community Health Centers***link coming soon***
Complete Our Evaluation

https://www.surveymonkey.com/s/RT8H6M3

Additional Questions?

Antonia Blinn
ablinn@massleague.org
Massachusetts League of Community Health Centers

Becky Colella
rcolella@mepca.org
Maine Primary Care Association