**Community Health Hub/Coalition**

**Community Based FIT Screening Plan for Adults 45-74**

* Return rates for FIT kits distributed by Community Health Hubs (CHH) and Cancer Coalitions contracted with the Nebraska Colon Cancer Program range from 32%-70%.
* Reviewing previous return rates and submitted distribution plans four practices were identified as increasing the likelihood of FIT kits being returned.
* All contractors distributing FIT kits through the NCP must include one or more of the four strategies to increase FIT rates.

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| --- | --- | --- | --- |
| **CHH or existing cancer coalition with 501c3 status** |  | **Date Submitted for approval:** | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| **Contact Name:** |  |
| **Type and Brand of FIT Kit:** | ** OC-Light S FIT ** ** Other (Please List): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **FIT Kits Provided By:** |  |
| **Please select the boxes indicating which strategies will be included in the Community Based FIT Screening Plan:** |
| ****Recommendations by Local providers to encourage and promote FIT screening and efficacy of FITs. | **Narrative description of how CHH/Coalition will implement this strategy:** |
| ****Plan for education to FIT distribution sites such as pharmacies, clinics, and other partners distributing FIT kits for contractor. Education and training should include: how to select age appropriate participants, how to complete FIT, importance of colorectal cancer screening, efficacy of screening with FIT, and appropriate monitoring of FIT kits.  | **Narrative description of how CHH/Coalition will implement this strategy:** |
| ****1:1 education to men and women 45-74 years of age regarding importance of colorectal screening, efficacy of FIT screening, *commitment of individual to complete*, how to complete FIT.  | **Narrative description of how CHH/Coalition will implement this strategy:** |
| **Direct Mail Distribution of FIT kits as a supportive strategy. (Must be paired with an approved EBI)** | **Narrative on justification and need for supportive strategy:** |
| ****Timely follow up of non-returned kits within 3 weeks of distribution of kit at minimum by mail.  | **Narrative description of how CHH/Coalition will implement this strategy:** |
| **Goal 1 - Projected number of kits that will be distributed:** |  | **Goal 2 – Projected number of kits that will be returned/completed:** |  |
| **Actual amount of kits a Hub has currently (non-expired):** |  | **Number of kits Hub has currently (Expired):** |  |
| **Number of kits Hub is Requesting from WMHP:** |  |  |
| **Description of CHH/Coalition Distribution Process:** |  |
| **Age of Distribution****45-74 Specific plan for addressing younger population.** |  |
| **Timeframe for distribution** | **Date of start and finish** |
| **Description of CHH/Coalition Process for Follow Up of Non-Returned FIT Kits:** |  |
| **Description of CHH/Coalition Coordination with Processing Lab:** |  |
| **Name of Lab or Labs processing FITs:** | **Lincoln-Lancaster Co. Health Department****Attn: Laboratory****3130 0 Street** **Lincoln, Ne 68510** |
| **Description of CHH/Coalition Follow up for Positive FIT:** |  |
| **Process for referring potential eligible Nebraska clients to NCP for colonoscopy:** |  |
| ** Copy of Enrollment/Intake/Demographic Form Collected from FIT Recipients provided to DHHS for review** |
| **Primary Person for FIT Registry Data Entry:** | **Address of Health Hub:** | **Primary Phone:** (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_ |
| **Primary Fax:** (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Primary E-mail:** |
| **Secondary Person for FIT Registry Data Entry:** | **Secondary Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_** |
| **Secondary Fax: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Secondary E-mail:** |
| **List of In Kind Activities/Services:** | **Estimated Value of In Kind:** |
| **HUB Signature:**  | **Date of Signature: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_** |
|  |
| **DHHS Response/Plan Feedback:** | **Date:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| **CHH/Coalition Response to DHHS Feedback:** | **Date:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| **DHHS Approval:** |  Yes No Pending | **Reason:** |
| **DHHS Signature:** | **Date of Signature:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ |
| **Checklist for Hub for Completion of FIT Process** Screening Template Completed with Hub’s SignatureDistribution List Submitted Enrollment Form Submitted and ApprovedBUDGET REQUEST IF APPLICABLE |  |

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