

Supportive Documents
NBCCEDP-DP12-1205
Nebraska Year Five of Five

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Community Health Hub

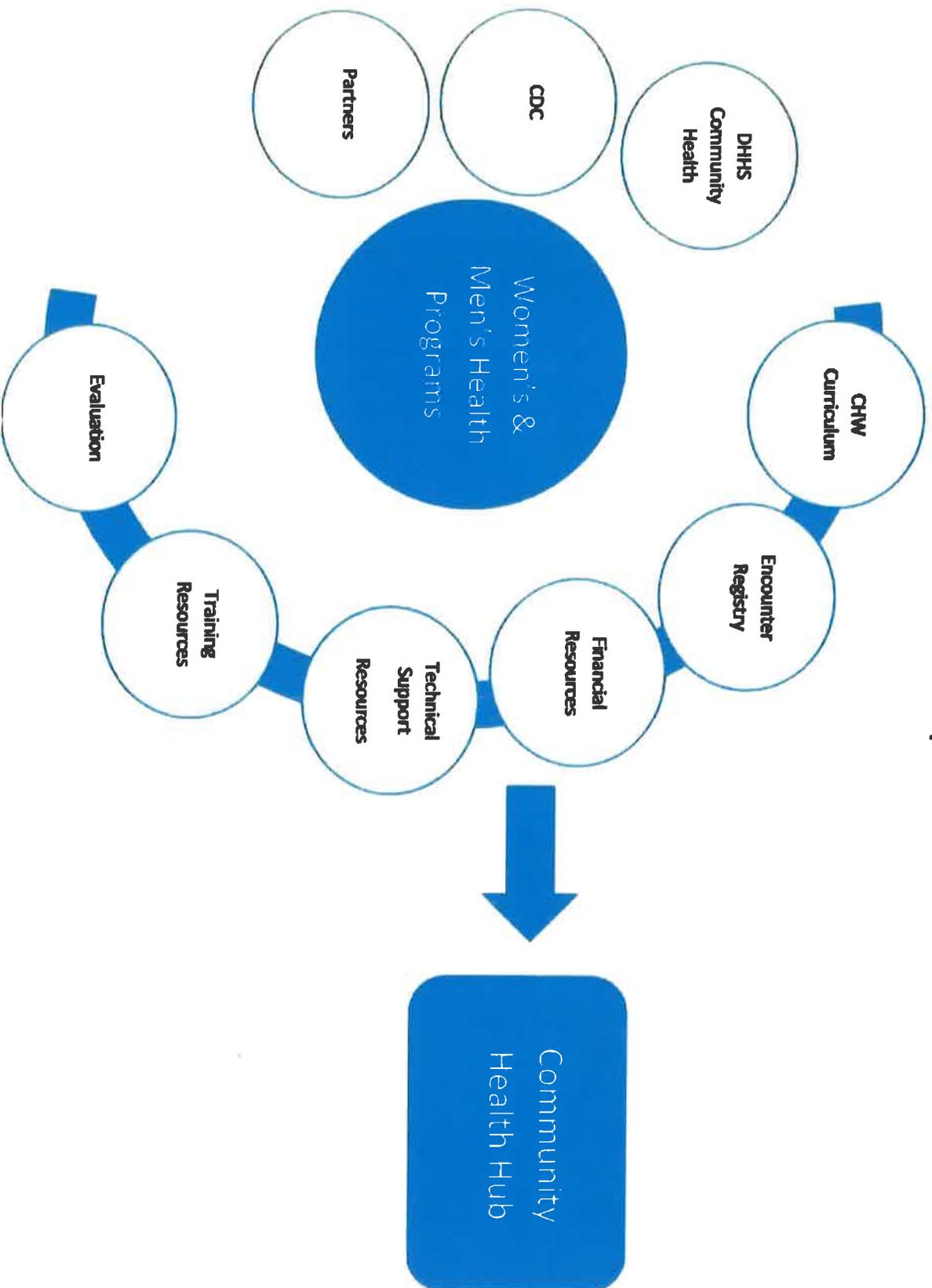
Model

Map-Cohort I & II

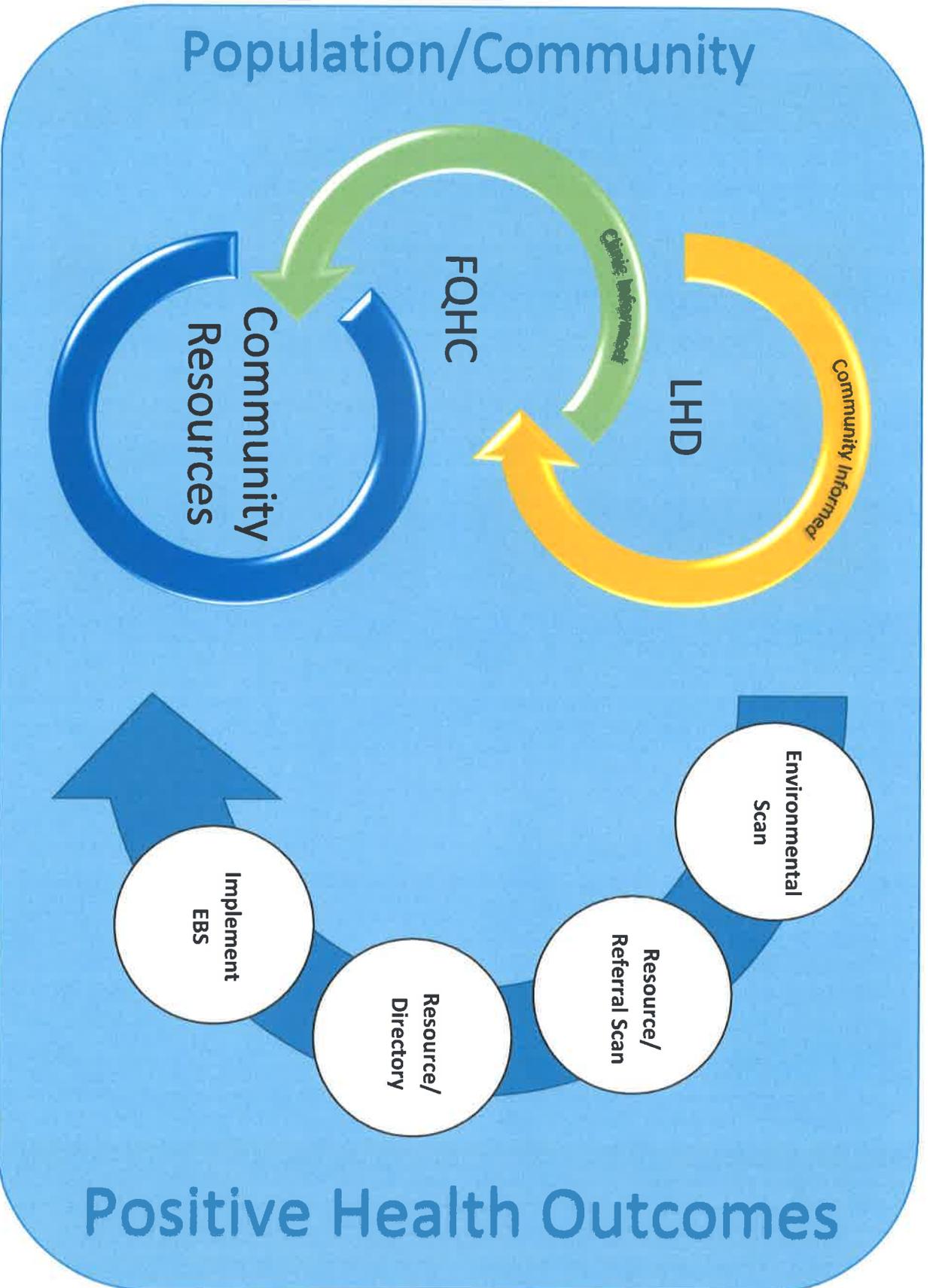
Map –Cohort III

Nebraska Community Health Model

September 2014



Community Health Hub



Community Health Hub Work

**Timeline/Milestone/
Planning Document:**

Leadership Team
DPP and Health
Coaching Roles



Community-Based Environmental Scan

- Demographics especially 40+
- Preventive Screening Rates
- Incidence and Mortality
- Health Systems and Access
- Gaps and needs to improve health status

Environmental Scan of Community Resources

- Available resources related to preventive screening, follow-up, treatment, modifiable risk factors
- Populations served
- Gaps and needs to build capacity, access and

Identify Evidence-Based Strategies to address findings from Environmental Scans

Community Referral/Resource Directory

**Revised
Timeline/Milestone/
Planning Document:**
Measures of Success, Key Staff



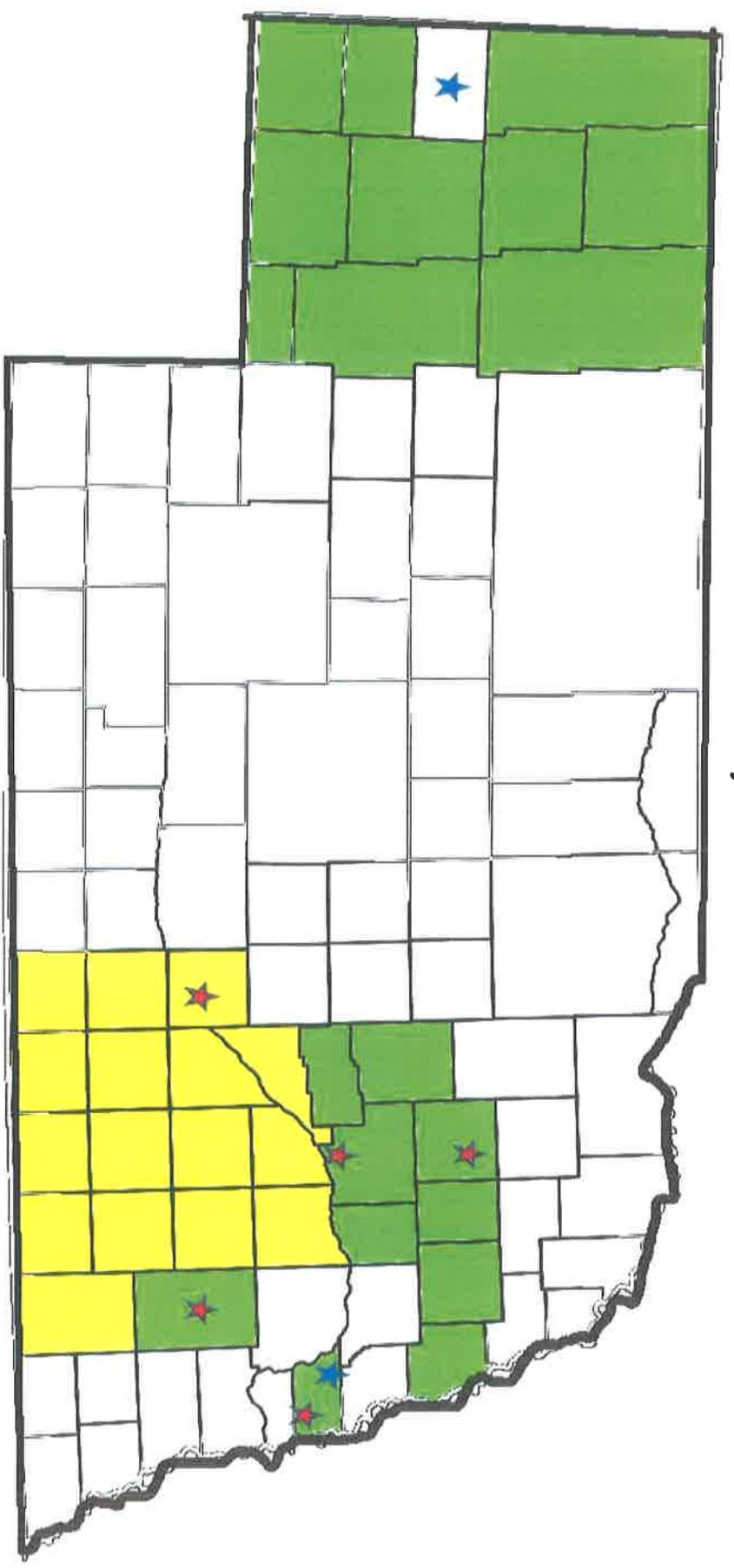
Increase Mammography Rates in Women 50-75
Increase Cervical Cancer Screening Rates in Women 21-75

Increase Colon Cancer Screening Rates in Men and Women 50-75

Decrease rates of uncontrolled hypertension in adults

Increase number of adults assessed for smoking status
Increase number of smokers referred to the quit line

Women's & Men's Health Programs
Community Health Hubs



★	Cohort 1 FQHC
★	Cohort 2 FQHC
■	Local Health Department/District-Cohort 1
■	Local Health Department/District-Cohort 2

**Nebraska Breast Cancer Control Plan
Partnership Network**

Website Resource
Workgroup Logic Models
Workgroup Plans

Nebraska Breast Cancer Control Partnership Network

Strengthening relationships, sharing resources, and celebrating successes



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Welcome

Thank you for joining us as we all work together to conquer breast cancer. We have designed this site to be a “communications hub” for the exchange of information and ideas.

We have included key elements from the 2011-2016 state plan and will keep you posted on activities initiated by work groups formed around the goals and priorities. We will spotlight exciting programs run by dedicated individuals and organizations in their local communities. And we will continue to link you to a library of resources for breast health care providers and public health professionals.

Downloads available:

- [Rev9.20.15BreastHealthResources](#) (PDF)
- [State Plan Highlights](#) (3MB)
- [Full 2011-2016 Nebraska Breast Cancer Control Plan](#) (7MB)

We invite your input through the “Leave a Reply” feature that appears on each page. Please alert us to any errors we make and send us ideas for new resources to share and programs to spotlight. This is YOUR place to connect with others who share your passion... a place where we can all help each other to be more successful. So please sound off... we want to hear from you!

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- [Survivor Celebration Cruise – Jan. 31-Feb. 7, 2016](#)
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• Leadership Team Links

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• Archives

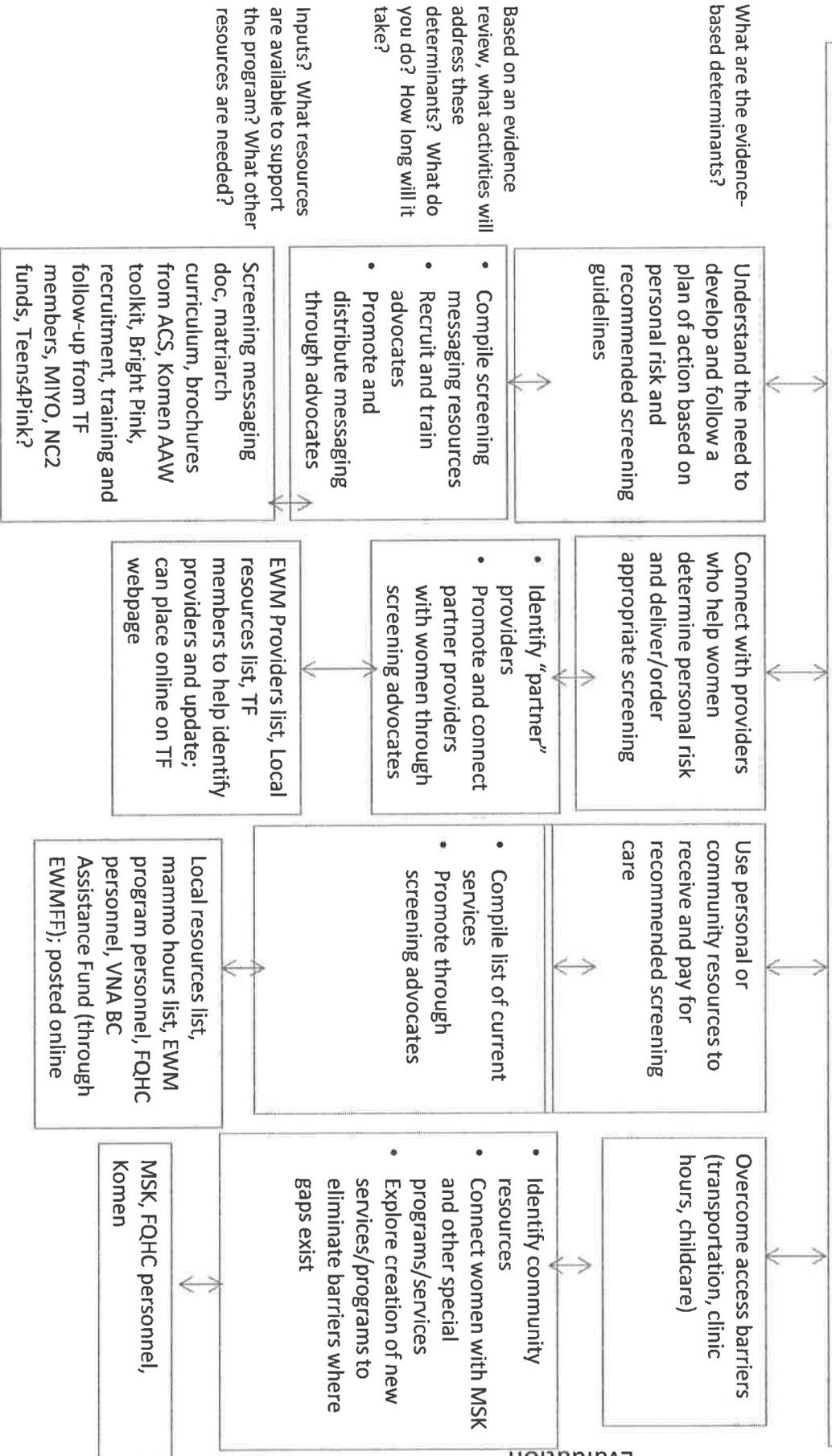
Archives

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Metro African American Breast Cancer Task Force

Goal: Influence at least 200 African American women who are not up-to-date on their breast cancer screening to have screening (CBE or mammogram) between March 1 and October 30, 2015.

Sub Goal: To recruit, train, and equip at least 20 women to become "breast cancer screening advocates" who will each contact 10 friends and family members from the African American community and encourage them to have preventive screenings (and track if they follow-through).



Evaluation
 ↓
 Impact
 ↓
 Outcome
 ↓
 Process

Metro African American Breast Cancer Task Force Bylaws



Article I: Name

The name of this organization shall be the Metro African American Breast Cancer Task Force (MAABCTF). Metro Area includes Douglas, Cass Sarpy, Dodge and Washington counties in Nebraska. Membership is not exclusive to the Metro Area.

Article II: Mission

Metro African American Breast Cancer Task Force's mission is for every African American woman in our community, to be educated and empowered to advocate for herself and receive timely and respectful breast health care and services, according to current guidelines.

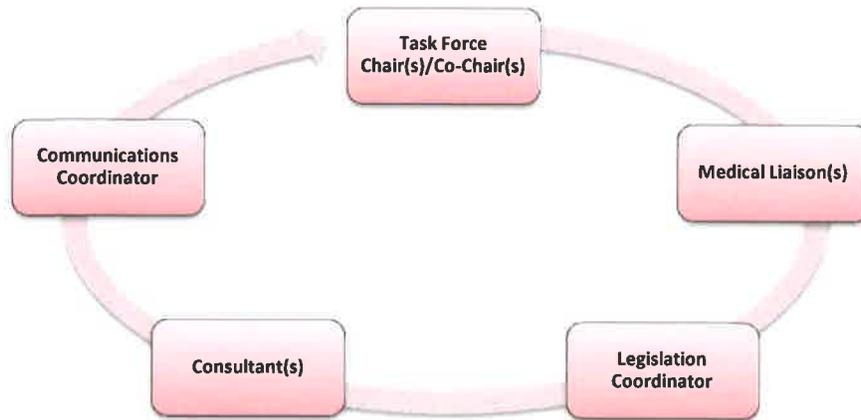
Article III: Goals

The goals of the task force are to:

- Increase opportunities for education, awareness and advocacy.
- Improve patient engagement throughout the continuum of care (prevention, screening, treatment and survivorship).
- Increase access to services throughout the continuum of care.

Article IV: Structure

General Membership



Article V: Membership

The Task Force shall be an organization of volunteers consisting of individuals and organizations from the Metro Area (but are not exclusive to the Metro Area) who are representative of the community. Membership is open to any person, organization or business, interested in furthering and supporting the Task Force mission and goals.

Members will attend meetings and/or community projects. Members must identify one committee to belong to for at least a two year commitment.

Metro African American Breast Cancer Task Force Bylaws

(Continued)



Article VI: Leadership

1. Task Force Leadership

The leadership of the Task Force shall consist of a Chair (co-Chairs). Should the Chair (co-Chairs) step down from their position a list of candidates will be developed by the Task Force.

Article VII: Leadership Responsibility

1. Task Force Chair(s)/Co-Chair(s)

The Chair of the Task Force shall preside over general membership meetings of the Task Force. Co-Chair(s) will assist on those programs or projects and report back to Chair(s).

2. Medical Liaison

When needed or upon request, the Task Force will be advised by a person or persons from a Medical team that addresses Breast Cancer issues.

3. Legislation Coordinator

The Task Force will monitor those issues and laws that impact our targeted population.

4. Consultant

The Task Force will utilize consultants as needed.

5. Communications Coordinator

The Communications Coordinator will maintain records for the Task Force and post them to the Task Force page on the BC Partnership website for easy access. The Chairs of Task Force Subcommittees will maintain individual committee records and turn them into the incoming Chairs within 30 days of the end of the term.

Article VIII: Committees

- Committees will be available as project/programs are developed.

Article IX: Meetings

1. Regular Meetings

Regular meetings for the Task Force shall be held quarterly at a minimum, or as needed.

Regular meetings of the Committees shall be held quarterly at a minimum. Additional meetings will be scheduled by the Committee Chair/Co-Chair as needed to accomplish the work of the group.

All Task Force, meetings shall be open to any interested task force members.

2. Correspondence/Notification of Meetings

The minutes and notification of each Task Force meeting will be distributed to members electronically via the list serve or the website.

Agenda and meeting notices will be e-mailed to all members at least one week prior to that meeting.

Members may submit items for the meeting agenda up to one month prior to each meeting. Request for discussion of "emergency" items can be added until the time the meeting begins. Contact the Task Force secretary with this information. These items will be prioritized by the Task Force Chair(s) based on time.

Metro African American Breast Cancer Task Force Bylaws

(Continued)



Article X: Amendment to Bylaws

These Bylaws may be amended at any regular meeting of the Task Force by a majority vote of the full members present, provided that the amendment has been submitted to the members in writing ten (10) days prior to the meeting.

Leadership Job Descriptions

Chair(s)

- Preside over Task Force meetings.
- Arrange the agenda for Task Force meetings.
- Become familiar with organizations and members within Task Force.
- Provide focus for the Task Force in the community at official functions.
- Consult with members as needed.
- Be accessible by phone to staff and members.
- Deal with members and staff fairly, sensitively, and confidentially.
- Promote collaboration, conflict resolution and decision-making.
- Be open to diverse opinions and points of view.
- Attend quarterly Task Force and NAABCTF Committee meetings and major activities.

Co-Chair(s)

- Responsible to the Task Force Chair. Chair the Task Force in the event the Chair(s) is (are) absent or cannot fulfill his/her duties.

Task Force Medical Liaison or Consultant(s)

- Will be contacted as needed.

Task Force Legislation Coordinator

- Each member is invited to bring to the Task Force any issues or laws to discuss.

These Bylaws will be updated as needed. Last update: 3/5/2015

Lincoln Lancaster Breast Cancer Diversity Outreach Initiative

ACTION PLAN

Goal: Increase number of women by 510 in targeted population of those with income below \$35,000, African American and Latina that receive mammograms/CBEs by 12/31/16.

PROVIDER FOCUS

Sub Goal: Improve provider effectiveness in communication and patient influence with target population through education of 40 providers.

Workgroup #1: Cultural Competence

Leader: Jill Savage

WG Members: Danna Bacon

Ad-Hoc WG Members: Mary Jo Gillespie, Teresa Harms

- Objective: Provide culturally Competent Care (includes health literacy)
 - Education on CLAS Standards training
 - Compile list of agencies/providers willing to be trained on CLAS standards
 - Identify who can provide CLAS Standards training
 - Schedule and provide CLAS Standards training
 - INPUTS: NE Office of Health Disparities & Health Equity
 - Education on Health Literacy
 - INPUTS: Lincoln Literacy Council, Health Literacy NE, Lancaster County Medical Society

Workgroup #2: Community Resources/Access Barriers (provider and community focus)

Leader: Lori Vidlak

WG Members: Roger Garcia, Teresa Harms, Mary Kelly, Janet Goodman-Banks

Ad-Hoc WG Members: Mary Jo Gillespie, Danna Bacon, Jill Savage

- Objective: Increase awareness of community assistance programs
 - Compile list of community assistance programs
 - Breast health education
 - Breast screening referrals
 - Survivorship services
 - Financial assistance
 - Language translation provided (education and/or services)
 - Female healthcare providers for breast health screenings
 - Others?
 - INPUTS: BCCP Partnership, LCMS, EWM
 - Utilize partners' local & social media to increase awareness & use of programs
 - INPUTS: BCCP Partnership, LCMS, EWM
 - Analyze potential need for expanded language translation (education and/or services)
 - INPUTS: BCCP Partnership, LCMS, EWM

- Objective: Address access barriers (transportation, childcare, clinic hours)
 - Explore what financial needs exist that could benefit from fundraising, to include sustainability efforts for such services, determine fundraising opportunities, and executive fundraising initiatives.
 - Explore alternative transportation options such as taxi rides, bike trails, and/or the use of gas cards to help facilitate access to services.
 - Explore bringing programming into communities or w/i specific neighborhoods to reduce distance to service delivery sites and enhance participation. One method to provide alternative service settings may be to use a mobile mammography van.
 - INPUTS: EWM Foundation, EWM Legislation, FQHCs, CHWs, Patient Navigators/SW

Workgroup #3: Provider Education & Patient Utilization

Leader: Tamara Robinson

WG Members: Dr. Carolyn Cody, Denise Logan, Janet Goodman-Banks, Dr. Michelle Ellis

Ad-Hoc WG Members: Mary Jo Gillespie

- Objective: Increase patient f/u & follow through on CBE/mammograms
 - Provider Reminder Systems
 - INPUTS: Community Guide, ACS
 - Provider Assessment and Feedback
 - INPUTS: Community Guide, ACS
 - Client Reminders
 - INPUTS: Community Guide, ACS
- Objective: Increase provider awareness of recommended clinical processes & patient breast health care
 - Compile best practices in clinical processes & patient breast health care
 - This will include getting provider input/buy-in on breast cancer risk assessment tool & breast health care plan
 - INPUTS: CHW, ACS, Bright Pink, Komen, LCMS
 - Provide education to providers on best practices in clinical processes & patient breast health care
 - INPUTS: CHW, ACS, Bright Pink, Komen, LCMS

COMMUNITY FOCUS

Sub Goal: Provide education and support to 2,175 women in targeted population of those with income below \$35,000, African American and Latina to receive recommended preventive screenings for breast cancer by 12/31/16.

Workgroup #4: Community Education & Utilization

Leader: Tamara Robinson

WG Members: Catherine Verplank, Carly Hunt, Jill Weyers, Janet Goodman Banks, Martha Florence, Joey Labadie, Deb Dailey

Ad-Hoc WG Members: Mary Jo Gillespie, Dr. Carolyn Cody

- Objective: Identifying individual breast cancer risk
 - Compile & review current best practices in breast cancer risk assessment tool

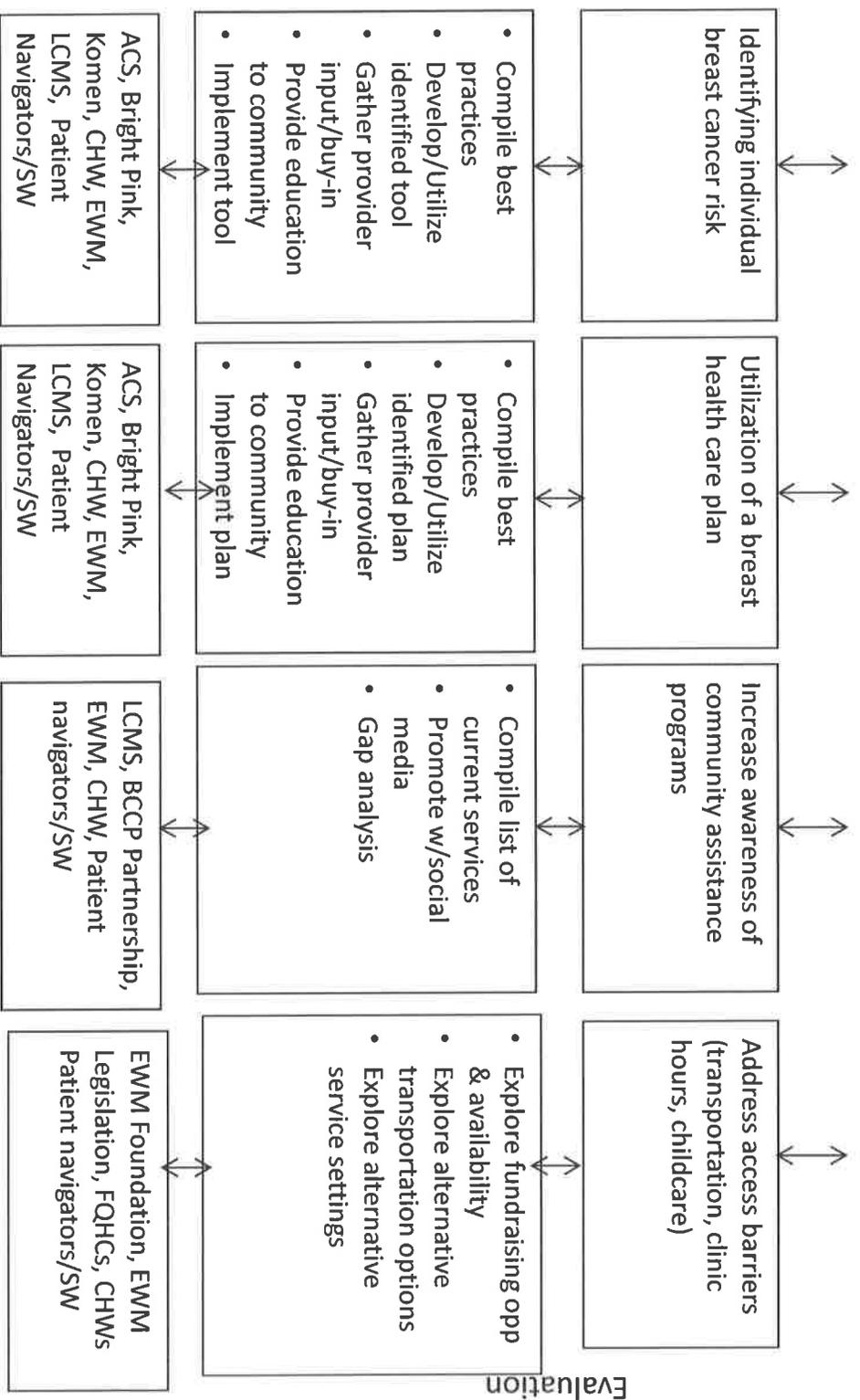
- Develop and/or utilize current best practice breast cancer risk assessment tool
 - Take into consideration language translation and health literacy
 - Teach at a Younger Age: Utilize girl groups and reach out to young women regarding breast health. Explore opportunities to provide breast health education to young girls and women and execute educational presentations and/or activities for this target audience.
- Gather provider input/buy-in on breast cancer risk assessment tool & breast health care plan
- Provide education to community on breast cancer risk assessment tool
- Implement breast cancer risk assessment tool
- INPUTS: ACS, Bright Pink, Komen, CHW, EWM, LCMS
- Objective: Utilization of a breast health care plan
 - Compile & review current best practices in breast health care plans
 - Develop and/or utilize current best practice breast health care plans
 - Take into consideration language translation and health literacy
 - Gather provider input/buy-in on breast health care plan
 - Provide education to community on breast health care plan
 - Implement breast health care plan
 - INPUTS: ACS, Bright Pink, Komen, CHW, EWM, LCMS

Lincoln Lancaster Breast Cancer Diversity Outreach Initiative (Community Focus)

Goal: Increase number of women by 510 in targeted population of those with income below \$35,000, African American and Latina that receive mammograms/CBEs by 12/31/16.

Sub Goal: Provide education and support to 2,175 women in targeted population of those with income below \$35,000, African American and Latina to receive recommended preventive screenings for breast cancer by 12/31/16.

What are the evidence-based determinants?



Based on an evidence review, what activities will address these determinants? What do you do? How long will it take?

Inputs? What resources are available to support the program? What other resources are needed?

Outcome → Impact → Process

Evaluation

Medical Advisory Committee Minutes

Every Woman Matters/Nebraska Colon Cancer Program Medical Advisory Committee

Minutes—September 2015 Web-Based Meetings

Members Present September 14, 6 p.m. Meeting:

Dr. Mary Curtis, Charlene Dorsey, Dr. David Hilger, Dr. David Hoelting, Dr. Ali Khan, Ashley Larson, Dr. Kris McVea, Michelle Malcom, Dr. Kara Meinke-Baehr

Members Present September 23, 8:30 a.m. Meeting:

Heather Blacklidge, Heather Elton, Dr. Kris McVea, Dr. Diana Nevins, Dr. Kelly Nystrom, Joni Pagenkemper, Rachele Sledge

Members Present September 23, 4:00 p.m. Meeting:

Dr. Sam Augustine, Dr. Brian Finley, Dr. David Holdt, Dr. Sonja Kinney, Dr. Susanne Liewer, Dr. Kris McVea, Dr. Steven Remmenga, Carrie Snyder, Dr. Alan Thorson

Members Unable to Attend Meeting Who Completed Feedback Survey

Dr. Syed Mohiuddin

Staff Present at One or More Meetings:

Tracey Bonneau, Deborah Dailey, Michelle Heffelfinger, Melissa Leypoldt, Andrea Riley, Kathy Ward

Welcome by Melissa Leypoldt, Program Director

Melissa thanked the continuing Medical Advisory Committee members and welcomed new members. The Affordable Care Act (ACA) and other activities at the federal and state level have changed the Every Woman Matters and Colon Cancer programs in many ways. It is an important time to bring Medical Advisory Committee members up to date and receive their feedback.

The web-based meetings of the Medical Advisory Committee are an effort to save time for committee members, but we will ask your opinion on their effectiveness, and may still have occasional face-to-face meetings. Between meetings, we will communicate primarily through email. Melissa asked members to let Kathy Ward know if they want the honorarium for meeting participation sent to a different address than the one we were given (most of which were work addresses). Kathy's email is Kathy.ward@nebraska.gov.

Melissa announced that Dr. Kris McVea has agreed to be the new Chair of the Medical Advisory Committee. The previous Chair, Dr. William Minier, has retired.

Welcome by Dr. Kris McVea, Chair of the Medical Advisory Committee

Dr. McVea introduced herself and asked members participating in the meeting to introduce themselves. She discussed the topics that Melissa will address, including several new and emerging issues. She stressed to members the importance of participating in the feedback survey. A link to the survey will be made available at the end of each of the three meetings.

Presentation on Centers for Disease Control and Prevention Feedback Reports and Changes in the Every Woman Matters/Nebraska Colon Cancer Program—Melissa Leypoldt

Melissa reviewed the programs, including the age, income, and citizenship or residency qualifications, the funding, and the services provided. Every Woman Matters is now in its 23rd year. Melissa reminded the group that the programs follow U.S. Preventive Services Task Force guidelines for screening and the American Society for Colposcopy and Cervical Pathology guidelines for management of abnormal cervical screening.

Melissa showed graphs of Nebraska women screened for breast and cervical cancer in Every Woman Matters for the program years from 1991-2015. The number of screenings have decreased considerably since Fiscal Year 2010. Reasons for the decline have included state law that prevents the program from serving women who cannot prove they are in the country legally, changes in screening guidelines, and the increase in the number of women insured through the Affordable Care Act.

Melissa also showed graphs indicating the rate of CIN and invasive cervical cancer and the rate of breast cancer by age group since Every Woman Matters began screening in 1991. Another table showed the number and percent of WISEWOMAN clients who were current smokers (30%), as well as those with hypertension, high cholesterol, obesity, and diabetes. WISEWOMAN clients must also be participants in the Breast and Cervical Program.

For the Colon Cancer Program, Melissa showed a chart with screening outcomes by test—either FOBT/FIT or colonoscopy. Another chart showed estimated costs by colon screening test. Using Behavioral Risk Factor Surveillance System data, Melissa showed colorectal screening prevalence in Nebraska compared with U.S. data. Nebraska's rates for all types of colon screening tests are lower than those of the U.S. as a whole.

Melissa's next presentation involved the many recent program changes. The enrollment process has changed to correspond with new Centers for Disease Control and Prevention (CDC) requirements. Women in the program must complete the healthy lifestyle questionnaire annually, and the program must determine insurance coverage. CDC requires that women with insurance are given information on the preventive benefits available to them. Women without insurance must receive information on obtaining health care coverage through the Federal Health Care Marketplace, and they must be given education on medication access. The CDC-funded programs also must determine smoking status so current smokers can be referred to the Quit Line, whether or not they are eligible for the programs.

While the programs historically enrolled most women through presumptive eligibility by providers, there are too many new requirements to expect providers to meet. As a result, staff in the Every Woman Matters office take care of eligibility determinations. This reduces the burden on providers, but has increased workload at the central office.

Since the Breast and Cervical Cancer Program began, funding has been accompanied with a requirement that at least 60% be spent on direct services such as screening. The law that required this was changed

as of July 1, 2015, to give programs more flexibility for services that are important to women with or without health care coverage. These services include outreach, health navigation, case management, and education.

Prior to the Affordable Care Act (ACA), 20-24% of Every Woman Matters clients had insurance, but needed program assistance because of copays and deductibles. Now that the ACA has eliminated the copays and deductibles for screening, those women no longer need the assistance of Every Woman Matters. Approximately 10-15% of Every Woman Matters clients have been referred to the Federal Health Care Marketplace and are now insured. Approximately 3% of clients have insurance policies that were grandfathered in from a period prior to the Affordable Care Act that do not offer the now-required coverage for preventive services.

CDC has shifted its focus to encourage state programs to increase population-based screening, particularly through systems changes and evidence-based interventions. Population-based interventions address all women in need of screening, regardless of qualifications such as citizenship and residency. The CDC programs are helping people with new insurance coverage learn how to effectively use it. At the same time, there are still clients who need to be screened through the programs.

Melissa said that Nebraska's programs need the assistance of the Medical Advisory Committee to help achieve systems changes and to implement evidence-based interventions. These systems changes must be evidence-based and data-driven. At the community level, the programs are working on outreach, training of community health workers, development of resource directories, and the building of linkages to primary care and medical homes. A web-based encounter registry has been made available for outreach and community health workers to document their activities. It has been operating for six months and has 1,000 people registered.

Some program interventions that CDC encourages are reducing structural barriers and utilizing electronic health record systems to find patients in need of screening and to issue screening reminders. A challenge is finding ways for the programs to collect data to show their impact.

Melissa mentioned again that CDC requires the programs to follow the guidelines of the U.S. Preventive Services Task Force. Dr. Hilger noted the impact on breast cancer screening when these guidelines make some women ineligible. Melissa said that we will soon receive "white papers" addressing the population of women aged 40-50.

Dr. Hoelting asked why women who are non-citizens are now excluded when this eliminates screening for some who need it the most. In the long-run, the costs may be higher when women have later-stage cancers. Melissa said this change came about because of a state law. The exclusion only applies to direct screening through the programs.

For the WISEWOMAN (WW) Program, which addresses risk factors for cardiovascular disease (including diabetes), CDC also encourages population approaches. WW now has fewer data requirements and a particular emphasis on controlling hypertension.

The Colon Cancer Program no longer has CDC funding. Only five programs across the nation received funds on this round of grants. The absence of federal funds presents an opportunity to redefine the program and how its state and cash funds are used. Most current clients are average risk, screening is

done according to an algorithm established by the Medical Advisory Committee, and most clients are screened through Fecal Occult Blood Testing (FOBT). In addition to state funding of \$400,000 annually, the program has accumulated a cash fund of \$300,000 through donations and payment of 10% fees by persons receiving colonoscopies through the program. Colonoscopies are reimbursed at the Medicare rate.

The Colon Cancer Program has made effective use of 20 community coalitions to distribute the screening kits. There is also a new colon cancer stakeholders group developing plans to increase screening in the state. The national goal, which Nebraska hopes to reach, is “80% by 2018”, meaning that 80% of persons aged 50 and older will be screened by the year 2018.

New and Emerging Issues—Melissa Leypoldt

Melissa defined four new and emerging issues—some with more than one question. They are:

1. *Screening methods for the Nebraska Colon Cancer Program*
 - a. *Should the Colon Cancer Program switch from Fecal Occult Blood Testing (FOBT) to Fecal Immunochemical Testing (FIT) as a primary screening method?*
 - b. *If so, is there a preference for a particular brand?*
 - c. *How do we redefine the best use of funds for the screening program?*

Melissa said that while FIT is more expensive, the reduced number of samples needed and the lack of dietary restrictions has the potential to increase the return rate. The cost of FIT is about four times as much as FOBT, and the processing costs are higher.

National studies have shown better return rates for FIT. A project in Nebraska to increase screening rates for rural Hispanics and urban African Americans did not show better results from FIT over FOBT. If the change is made from FOBT to FIT, it will be important to develop the right messages for the populations to be served. The challenge for program staff and the Medical Advisory Committee is to determine the best use of limited funds for colon cancer screening.

Dr. McVea noted that FIT is more sensitive and specific, with the potential of a better completion rate. Melissa noted that the community coalitions working on colon screening with FOBT have varying return rates, all the way up to 75% for the coalition sponsored by the Lincoln Lancaster County Health Department. At the same time, some coalitions have very low rates, so there is an effort to share best practices. The average return is around 50%. One World has a high return rate of 63-65%.

Dr. Nevins said that while FIT has higher costs up front, it may be cheaper if it reduces unnecessary colonoscopies. Heather Elton said the concern about a single sample is that it might be more likely to give a false negative if the polyp or cancer is not bleeding at the time. Dr. McVea said that there is data on FIT comparing it to tests with three samples. Results have been good with the type that has a test tube container and a plastic swabbing tool. The problem with all colon cancer tests is that people don't want to do them, so there has to be education up front as well as follow up. The Kaiser health system has invested a lot of resources into providing motivation up front and following with phone calls.

Dr. Thorson said that the FIT is a slight improvement, but guaiac-based FOBT is still very acceptable. He has a contact that may be able to help provide FIT kits at significant savings and will try to arrange a

discussion. A subgroup may need to be formed to work through this. Melissa said that as in the past, subgroups make recommendations and the entire Medical Advisory Committee will be asked to vote.

Carrie Snyder asked whether someone in a hereditary cancer family who does not meet the age requirement for screening would be considered on a case by case basis. Melissa said that for breast cancer, there are exceptions that are recognized by the U.S. Preventive Services Task Force. MRI may be covered with additional paperwork. There is not a similar provision for colorectal cancer screening.

Dr. Thorson noted that there is criteria for some people to bypass FOBT and go straight to colonoscopy. Melissa stated that a copy of the algorithm for colon cancer screening would be sent to all committee members.

2. *Reducing structural barriers to care and out-of-pocket costs*
 - a. *What structural barriers to care and out-of-pocket costs are most important to Every Woman Matters clients and other low-income women?*
 - b. *How should new funding from CDC to address structural barriers to care and out-of-pocket costs be used most appropriately?*
 - c. *What would be an appropriate data source?*

Melissa said that federal funds are now available that can be used to assist both clients and other low-income women with disparate needs in overcoming structural barriers and out-of-pocket costs. Women do not have to be program eligible or enrolled in the programs to qualify for this assistance. The question that needs to be answered, with the Medical Advisory Committee's help, is how to best do this at a clinic level. An issue for the programs is how to develop a data source without creating paperwork burdens.

3. *Health coaching related to cardiovascular disease and diabetes*
 - a. *How should Every Woman Matters work with clients and other low-income women and their health care practitioners to provide education on self-measured blood pressure monitoring and home blood pressure monitors?*
 - i. *CDC is encouraging use of materials and provider education from The Million Hearts Campaign (millionhearts.hhs.gov)*
 - b. *What procedures should Every Woman Matters use to change diabetes screening from blood glucose to hemoglobin A1C?*

Melissa said that CDC is encouraging the change in diabetes screening to hemoglobin A1C because so many women are not fasting at the time of their appointments. It drives up costs to bring them back, and the data cannot be used if tests are done in a non-fasting state. Hemoglobin A1C testing can be used without regard to fasting, but Melissa asked whether clinics have the equipment needed to do the test.

Comments from members of the Medical Advisory Committee indicated that there was support for moving to hemoglobin A1C testing, and committee members did not think it would be too difficult to implement in clinics. Dr. Hoelting said that A1C is the gold standard for testing, and Dr. Meinke-Baehr felt there was no question that it should be used. She said that primary care clinics have good A1C capability, and it can be done readily and cheaply through regional labs. Joni Pagenkemper said that if there is a cost issue, it might be worthwhile to do random screening and do hemoglobin A1C for women

with blood glucose levels over 200. If not a cost issue, she would support doing hemoglobin A1C for all. Dr. McVea said that costs may be less because there would no longer be the need to bring a woman back for a fasting test.

The WISEWOMAN Program now has the opportunity to provide financial incentives for lifestyle services, including assisting with equipment and education for self-measured blood pressure monitoring. CDC wants programs to coordinate with the Million Hearts Initiative and utilize their resources. Heather Elton said that she works in a home health program that is doing home telemonitoring, including blood pressure. Their patients are happy with this service, they have learned to do monitoring each day, and it has been effective in reducing rehospitalizations.

4. *Collaborations to increase evidence-based screening on a population level in Nebraska*
 - a. *What activities are already occurring in Nebraska to set targets and measure progress for evidence-based screening?*
 - b. *Are there gaps in these activities that could be filled by involvement of Every Woman Matters and the Nebraska Colon Cancer Program, especially with rural clinics?*

Melissa said that there are many clinics throughout Nebraska going through systems changes to increase evidence-based screening. Every Woman Matters can now help with this on a population-based level without worrying that the program is meeting the 60% requirement for direct screening. A question for the Medical Advisory Committee is how best the programs can help fill gaps to increase screening for people with disparate needs. A challenge is collecting data to show the programs can share credit for screening improvements.

Completion of the Feedback Survey—MAC Members

Dr. McVea again urged Medical Advisory Committee members to take a few minutes to complete the feedback survey. She stated that it literally takes only a couple of minutes. The results will provide important information on the four new and emerging issues, will help determine whether specific work groups will be formed, and will give guidance on the effectiveness of the web-based meetings.

The link is:

<https://www.surveymonkey.com/r/MVRXX6F>

Members of the Medical Advisory Committee will be sent a summary of the meeting, compiling the discussion of all three sessions. Workgroups that may be formed as a result of the meeting and survey feedback will meet either through email, web/phone-based meetings, or in-person meetings.

Dr. McVea and Melissa Leyboldt thanked the Medical Advisory Committee members for their participation and assistance.

Professional Education Planning
Community Health Advocate Workshop

Building Strong Patient-Provider Partnerships for Cancer Prevention and Screening



Free Seminar for Primary Care Physicians,
Gynecologists, Oncologists, and Clinical Staff

Thursday, June 9, 2016

7:00-8:30am

**Attend in person or via telehealth
CMEs and CEUs will be available**

Learn how to use tools and techniques that **empower** your patients to share critical information to help you make appropriate recommendations for cancer screening, treatment, and healthy lifestyle choices.

About the Primary Presenter:

Edward T. Creagan, MD, FAAHPM

“Dr. Ed” Creagan is a professor of medical oncology at the Mayo Clinic Medical School. He is the award-winning author of How NOT to Be My Patient: A Physician’s Secrets for Staying Healthy and Surviving Any Diagnosis



- Holds the endowed chair as the John and Roma Rouse Professor of Humanism in Medicine.
- Named Outstanding Educator from the Mayo Clinic School of Continuing Medical Education; received the Distinguished Mayo Clinician Award – Mayo Clinic’s highest honor
- First Mayo Clinic consultant board certified in hospice and palliative medicine
- Associate medical editor for MayoClinic.com where he blogs on stress

Live Seminar Location

Bryan East Campus Plaza Center
Conference Room A,
1600 S. 48th Street, Lincoln

Contact

Lori Vidlak, 402.525.6973
lori@bluesteminteractive.com

Via Nebraska State Telehealth Network

If your hospital or public health department would like to participate in the broadcast, register at www.netelehealth.net

Seminar Sponsors

Nebraska Breast Cancer Control Partnership Network
Lincoln Breast Cancer Coalition
Nebraska DHHS Every Woman Matters Program

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of Nebraska Methodist Hospital and the Nebraska DHHS Every Woman Matters Program. The Nebraska Methodist Hospital is accredited by the Nebraska Medical Association to provide continuing medical education for physicians.

**SAVE
THE
DATE!**

Community Health Advocate Workshop

Learn about new tools and techniques to empower patients to share critical information with healthcare providers that can impact recommendations for cancer screening, treatment, and healthy lifestyle choices.

June 9, 2016

Navigating the Healthcare System

Encouraging Strong Patient-Provider Partnerships

12:00 - 4:00 pm

Lincoln-Lancaster County Health Department
Lower Level Training Room
3140 N. Street, Lincoln

Lunch will be provided and mileage will be reimbursed

Keynote Presenter: Edward T. Creagan, MD, FAAHPM

“Dr. Ed” Creagan is a professor of medical oncology at the Mayo Clinic Medical School. He is the award-winning author of How NOT to Be My Patient: A Physician’s Secrets for Staying Healthy and Surviving Any Diagnosis



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Sponsors

Nebraska Breast Cancer Control Partnership Network
Lincoln Breast Cancer Coalition
Nebraska DHHS Every Woman Matters Program

Evaluation

Poster Presentation

Promoting Cancer Screening Through a Community Health Hub Model: Evidence from Nebraska

Hongmei Wang, PhD¹, Yang Wang¹, Jianping Daniels, PhD², Melissa Leyboldt, RN²
¹ University of Nebraska Medical Center College of Public Health, Omaha, NE
² Nebraska Department of Health and Human Services, Lincoln, NE

Research Objective

The Nebraska Department of Health and Human Services (NEDHHS) adopted a community health hub (CHH) model to improve cancer screening. Starting in November 2012, NEDHHS worked with four local health departments (LHD) and two federally qualified centers (FQHC) in Nebraska to conduct environmental scan to assess the needs and gaps for cancer screenings and to identify and implement appropriate evidence-based strategies to promote cancer screening in the populations and communities they serve.

Evaluation Design

To evaluate the effectiveness of the CHH model, we conducted both process and outcome evaluations at the end of first-year of program implementation. The process evaluation tracked progress in program activities and the successes and challenges experienced during program implementation. The outcome evaluation measured achievement of the program's goals using NEDHHS administrative database. The outcome measures included program enrollment, screening numbers and rate, and follow-up rate for breast, cervical and colon cancer screening.

Process Evaluation Findings

- All six CHH sites completed core program activities including forming project team, completing environmental scan, identifying evidence-based strategies, creating implementation plan, but in varying stage to implement the identified strategies.
- All sites conducted patient navigation and provided case management to new and existing clients. The FQHCs' efforts mostly targeted patients through their electronic medical records by creating new clinical practice protocols. The LHDs reached their target populations by working with health care providers/pharmacies and conducting education/outreach activities in various venues.

Table 1. Preventive Screening Status 2012-2013

	Colon Cancer screening		Breast Cancer Screening		Cervical Cancer Screening	
	N	%	N	%	N	%
Enrollment						
Eligible	1,489		1,113		914	
Screening						
Past due	1,164	78%	279	25%	278	30%
Up to date	325	22%	834	75%	636	70%
Follow up						
Positive	25*		152		51#	
Contacted	25	100%	147	97%	9	100%
Physician visit	25	100%	111	73%	6	67%

* Number of positive results for colonoscopy only.
 # Only 9 of these 51 people with positive results were at CIN III or more severe, which were scheduled to be followed up

Outcome Evaluation Findings

- By the end of the first year, 2,881 women aged 40 years and older and men aged 50 years and older were enrolled.
- About 22% of those 1489 men and women aged 50-74 years eligible for colon cancer screening were up-to-date. About 78% were offered tests but either refused or didn't return the test kits.
- About 75% the 1113 women aged 40-74 years eligible for breast cancer screening were up-to-date.
- About 70% of the 914 women eligible for cervical cancer screening were up-to-date.
- A majority of participants who tested positive on Colonoscopy(100%), breast cancer(97%), or cervical cancer (100%) were followed-up to schedule a physician visit.

Implications for Dissemination and Implementation

- The community health hub model proved to be successful during the first year to promote cancer screening in Nebraska.
- Direct program resources to continue to improve screening outcomes in those areas where screening rates have not met goals.
- Continue evaluation using the administrative data to examine the achievement toward cancer screening outcomes