**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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