NAPCRG
International Conference on Practice Facilitation

Effective Communication and Coordination for a Multi-Level Collaborative Intervention

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JENNIFER COURY
We should get started and people might trickle in and if it's a small group, that's great because we're gonna talk to each other about things. So that's fun. So, our title I'm realizing after being at the conference for two days, is really long. "Effective communication and coordination for a multilevel, collaborative intervention." This is what happens when you let the scientists get involved with naming things. I'm Jennifer Coury and I am a senior project manager at the Oregon Rural Practice Research Network. I work for Melinda Davis. And I've been working in the gap between research studies and clinical practices for over 15 years, which means I get to take what the research team thinks is easy and bring it into real clinical practices and bridge that gap. And so what we're gonna talk about today is an example of one of those research projects where we brought things into real clinical practices and settings.

BRITTANY BADICKE
And I'm Brittany Badicke I am a research project manager with the Oregon Rural Practice Based Research Network also work with Melinda. So I've been there for about three years. My first two years was as a practice facilitator and then the last year has been as a project manager. And before that I was a clinic supervisor at a primary care clinic.

JENNIFER COURY
It's not working, make sure it's on, it's working like just a few seconds ago, a minute ago. Here we go. So, I mean, so I don't move this anymore. So we're gonna talk to you about a study called Smarter CRC, which is a regional and national collaboration. It stands for screening more patients for CRC through adapting and refining targeted evidence based interventions in rural settings. And it's co-led by Doctor Melinda Davis and Doctor Coronado at Kaiser Center for Health Research. So it was a collaboration between both organizations and we're also part of a national collaboration and funded by the National Cancer Institute. And what it's looking at is building the evidence base for multilevel interventions. So a lot of different levels that you can work with to increase rates of colorectal cancer screening, follow up, and referral to care. And why is this important? Sorry, let's see if this works. Now? Brittany fixed it. So colorectal cancer screening is extremely, extremely effective and the earlier you catch it, the more, I mean, basically the more likely people are to live, it's really dramatic. But it's also really complicated and most people know about colonoscopy because it's pretty invasive process, it's hard to get to

centers, especially we're working with rural clinics, colonoscopy centers are really far away. So we talk a lot about fecal immunochemical tests, FIT tests. These are things that patients can do in their home, in the privacy of their own home, and they can actually be mailed to patients. So talk about equity, you can reach people who don't actually come into the clinic, right? So we know there's a lot of people out there who really just don't see their provider, they don't have a relationship. And so our program was really focused on researching how to do a mailing program with fecal immunochemical tests tests or FITs in real world clinical practices. There's a lot of barriers at the patient, provider, health system levels and it involves primary care, specialty care labs, possibly vendors for mailing: all of these different organizations. And so what a great opportunity for practice facilitation. And so what we're gonna talk about today is some real world scenarios we came up with doing this work and how a facilitator might have conversations with all these different parties. So just to give you background, but I'm not gonna go into a super big depth. We had a three phase study. First, we adapted these materials for rural practice settings. So we did focus groups with rural clinicians and also patients to say what would speak to you and what are your barriers. And then we did a pragmatic randomized control trial with 28 rural and frontier clinical practices in Oregon and three associated health plans that worked with those clinics. In 2021, we delivered the program to half the clinics. In 2022, we delivered the program to all of the clinics. So we compared the first year to...in the first year, we compared those that did the program and those that didn't do the program. And then we expanded it and what the program was, I'm gonna go into a little bit more depth on the last one, but basically, it was a collaborative mail FIT program that worked with both the health plans and the clinical practices. And then we combined it with navigating patients to colonoscopy if they got an abnormal result on their FIT. And then we're now in phase three, actually expanding this program to more clinical practices and more organizations. We're gonna focus today on that middle part, the pragmatic trial work that we did. And this is just an overview of kind of how we, how we did things. So the very first step was identifying who is even due for colorectal cancer screening, which is very complicated, it turns out. And the health plan list of Medicaid patients that they thought was due may or may not have matched the clinical practice list. So there was a whole validation to even identify who we wanted to outreach to. Then what we did was we prompted patients before they got the FIT in the mail to say this is colorectal cancer screening. This is why it's important. This is why it affects you. The health plans contracted with vendors to actually mail the FITs. The patients, received the FITs and then the clinical practices reminded patients in all different ways, phone, text, sometimes MyChart messages, and then we navigated patients to follow up colonoscopy. So we trained navigators at each of the clinical practices to actually call patients with an abnormal FIT and go through motivational interviewing and do all of that navigation to get them in for a colonoscopy. And all of this was supported throughout by practice facilitators and by training of the clinical practices, providers, health plans. I'm gonna turn over to Brittany.

BRITTANY BADICKE
Ok. So we know, we know that practice facilitators are very skilled in developing relationships, listening active, actively to their partners, meeting them where they are,

coordinating effective meetings, and then tracking progress along the way. And we know that historically, practice facilitators worked mainly with primary care clinics, but as health care continues to get more complex, we've realized that facilitators are really needed to kind of bridge between all of the different systems that work together. And so they're able to utilize all of these same skills to really bridge that gap between all of these organizations and to support these multi-level multi component interventions. And what we've learned about this is that organizations are more likely to succeed at implementing practice change with the help of these highly skilled facilitators. OK. So Jen just went over this a bit and I'm gonna talk about how we used facilitation throughout each of these steps and pay attention because these will be related to the scenarios we're gonna hand out shortly. So when it came to identifying eligible patients, there was a lot of data support needed. As we know, there is often a discrepancy between what the health plan thinks their patient lists are and what the clinical practice says their patients lists are. So we had practice facilitation support that was really helping have those discussions between the health plan and the clinical practice and then teaching clinical practices who is eligible for screening. What does this look like? We created a lot of handouts, we did a lot of trainings and then there was a lot of one on one support of. Let's look at this chart together, let's indicate how you might choose whether this patient is eligible or not. We also had a lot of communication on the timing of these things. There's a lot of evidence that shows when you should be reaching out to patients to let them know that this is coming. You don't want it to be too far in advance because by the time they get it, they don't remember that they had a conversation with you. But you also don't want it to be too soon so that they may be already received it and threw it in the garbage or it ended up in a, a giant pile of mail that they're never going to look at. We also worked to develop different types of call scripts and outreach letters. So using language that has been proven to be effective to get patients engaged in this type of work and getting different people within the practice, so that could be front office, staff could be medical assistant, community health workers, nurses. So just kind of getting comfortable with using that language to get people, I guess, accepting of the fact that they're about to receive something in the mail. Then they would receive their FIT kits. And we then did patient reminders again, really important to remind them of the timing of this. You don't want to make that phone call or send that text or letter more than has been received. If they get it after that, they think it's, what we've heard is that the patients don't think it's as important if they receive it and then they hear nothing. And by that time, they may have thrown it away or again, it's in a giant stack of mail that is long forgotten. Then we also have...we did extensive workflow mapping with all of these practices. And so that was to figure out--we did a lot of swim lane diagrams--that was really to figure out who's the best person to do each of these steps and what supports do they need to be successful in this? And then we provided expert advice along the way. And then Jen had mentioned the patient navigation. We had some of our partners from the Kaiser Permanente team that delivered a really excellent patient navigation training. We did...as facilitators, we did workflow mapping to identify who in your practice can do this work. And what that communication would look like and then we were available as needed to help them through that. So, what we'll be doing today is handing out some scenarios and I think we have...did I count 15?

JENNIFER COURY
Yeah.

BRITTANY BADICKE
So we'll do...we'll do 3 scenarios. We'll start to pass these out and I'll--go ahead.

AUDIENCE MEMBER
Well, I had a quick question.

BRITTANY BADICKE
Yeah. Sure.

AUDIENCE MEMBER
In the last slide, did you run any into any trouble with the patients not receiving the kits as far as postal service?

BRITTANY BADICKE
Yeah. So no, that's a great question.

JENNIFER COURY
We, that's one of the things we had to actually facilitate was some of our rural post offices had had problems in the past where let me, let me phrase it differently. The clinical practices had tried to mail FITs in the past and had been told no, by their post offices. Like, no, we can't mail this. It's a biohazard. It's just all kinds of things. And so we had to go in and say no, no, this is really ok. We've done this before. It meets regulations. And we worked with clinical practices and we actually worked with, in some cases, the, the liaison to the post office at the medical practice and we gave them wording and said this is done before this is, you know, and, and all of that stuff. So we did have to, we did have to facilitate that as well.

AUDIENCE MEMBER
And then I...in follow up to that like address verification because I've, I've known that a lot of addresses over the years, you know, they're not correct.

BRITTANY BADICKE
Workflow facilitated that.

JENNIFER COURY
Yeah, so that was so part of our workflow. I know this is a great question. So part of our workload was that the clinical, the the health plan addresses were verified at the clinical practice level and then the health plans ran it through a process of the USPS. You can send a list to the USPS and they'll verify it and tell you who's moved based on their database and which addresses are invalid. And so those addresses were pulled out before mailing. But

then we had to communicate, we had to make sure that that information got back to the clinical practices. So the health plans had that information in their system. But then we had to make sure that the lists got back to the actual clinical practices because there were so many parties involved. But yeah, the USPS will verify a mailing list and it's a small fee, but it is a fee, which is why we had to health plan to do it rather than the clinical practices because they had, they had the funding to do that.

AUDIENCE MEMBER
Thank you.

JENNIFER COURY
Are there other questions about the study or what we did? It was pretty complicated.

AUDIENCE MEMBER
You said you did swim lanes, did that involve the facilitators, the managers, project managers, facilitators?

BRITTANY BADICKE
Yeah. So all of the practice facilitators were trained in workflow mapping. And then we had an interview guide that we went through a workflow assessment interview guide that we went through with all of the different practices, asking very detailed questions, digging into what their current practices are and then how they wanted to fit the implementation of this program into their current workflow.

JENNIFER COURY
And we did two things we---because it was a research study, all of the interactions with the clinical practices were...we did detailed field notes for qualitative analysis later and store that in a RedCap tracking system. But we also, for the clinical workflows in specific, did a workflow diagram in what's...LucidChart, we use LucidChart to, to draw the workflow and we gave that back to the clinical practices [inaudible].

BRITTANY BADICKE
It very handy to have though because they'll say we didn't talk about this and it's like, oh, well, here's when this decision was made and then we could reference that and then kind of work through that. You know, this is why the decision was made and you know, we can always change it if it no longer makes sense. But saying, you know, they were, they were part of the decision making. It wasn't just here's the intervention and how you do it.

JENNIFER COURY
Yeah, and it was down to like Sally at the front desk is going to receive the mailed FITs back back and put them in the lab box. Like it was really very, very structured.

MELINDA DAVIS

The only thing I'd briefly just like back up and add is part of the reason we partnered with the health plan and didn't just get the list of eligible patients from the practice is because in prior work, we had found it's really hard for clinics to generate that list. And so, and it could also be hard financially for them to fund the cost of mailing. And so that partnership with the health plan was a strategy to try to get a more accurate list of eligible patients and to overcome some of those administrative burdens. The health plans also partnered with third party vendors who did a lot of the actual stuffing of the envelopes and doing the mailing with that information. I think the team might have some feedback about what clinics like, what are the benefits of that partnership versus when might you want to work directly with the clinic to implement these programs? But it was really designed because of just the challenges and identifying that eligible population and a goal of addressing inequities in Medicaid compared to commercial members because those screening rates tend to be 15 to 20% lower in those populations in general.

AUDIENCE MEMBER
Ok.

BRITTANY BADICKE
Are there other questions?

JENNIFER COURY
I bet you guys all have questions once we hand these out. Yeah. So what we were hoping to do was a little group, small group exercises where we have a scenario that names have been changed for privacy purposes. No, there are actually no fake names in here. But, we have a few scenarios and a few things to consider and we would love for, folks to maybe...let's just do three groups because it's not a big group here. And so maybe here you guys can all take one of these. This is scenario one.

AUDIENCE MEMBER
Do I need to read them out?

JENNIFER COURY
You guys can read them in your small groups and then sort of brainstorm, take some time to brainstorm on what you would do if you were in this situation. And we have some guiding questions for you. So maybe you want another group and then you guys call me here. Linda knows the answers.

AUDIENCE MEMBER
Yes.

JENNIFER COURY
So why don't we split up? Why don't we split up you guys and doing this? So maybe two of you can come back here and do scenario three. Is that gonna mess?

BRITTANY BADICKE
So there's some suggested timing on there. We were thinking about 15 minutes to brainstorm and then 10 minutes to think of what your potential solutions would be.

JENNIFER COURY
But if folks are done sooner, just let us know and there's room for you to jot down notes on your scenarios.

JENNIFER COURY
Let's come back together. Great conversations! I mean, I got to hear all of them and just, it was really exciting. So we're gonna just talk, I mean, share out what your group came up with as sort of your, your go to answers overall. Oh, not, not here. I'm gonna take this too much pressure. So we're gonna start with group one. And I'm gonna read out the scenario since you all didn't have their scenario in front of you. Scenario one was about the member patient list review and they're working, you're working with a health plan and clinical practice to implement a collaborative colorectal cancer screening program using a mail FIT. The health plan has a list of members who are not current with screening and at which clinical practices they receive care discrepancies between the health plan generated member list and clinic generated member list are found, including who is an active patient of that clinic and if they are due for CRC screening. So the question is, how should the health plan and clinical practice collaborate to refine the list to ensure the correct patients are reached for colorectal cancer screening? And how does the practice facilitator help? So what did you guys talk about? What did you come up with?

AUDIENCE MEMBER
Oh, I we had, we talked about lots of things but we, we broke it down. So we would first get an onboard meeting, right? What we would say, let's have an onboard meeting to see who the practice is gonna commit to work with the health plan to start looking at this data. That'd be the first thing. Then we would, once we get the meeting, say the meeting is underway, then we would send a secure email like a spreadsheet of the patients, you know, encrypted email just so that, because it's PHI, of course, and then we believe like we have to give a deadline, right? So like, so who would send the email?

JENNIFER COURY
Who's the "we"?

AUDIENCE MEMBER
So we...the email would come from a clinical practice I almost, well, I almost wanna say the health plan and the, and the clinical practice Robin here has some good knowledge because he said, Well, I worked inside a health plan and took care of a large Medicaid managed care population. And we could always count on the data. The closer it was to the where the patient was being taken care of, the more accurate it was and that was usually not the health plan. And so the idea was to engage someone at the practice that has

access and cares about this. And often it was a quality team. If, if a quality team existed or whoever the individuals and stakeholders that were engaged in quality could usually lead to the right place. But then yes, that file, it ultimately comes down to kind of a download and a patient by patient scrubbing that you have to find the resources that don't exist to dedicate to, to doing that. And sometimes the health plan could actually have somebody on the team that was collaborative would be a community health worker, for instance, that could engage virtually. And once they got access approved to the clinic's plan, because often the clinics, if they were small, didn't have any resources to, to offer. It was hard enough to engage much less sort of ask them to do anything. So it was more about getting the access and the and then validating the results because I think you brought up the point that if the patient has switched coverage, they may have had a colonoscopy or a screening previously and the result is not gonna show up at all to the health plan. And maybe to the practice, then there's the whole cohort of patients that say they're assigned to a practice, but they've never been there, they've never engaged. And, and that, that was trickier. Yeah, that was really hard to sort of figure out

JENNIFER COURY
I couldn't have written those points better.

AUDIENCE MEMBER
We had an asthma incident because in Massachusetts we're waived and they have the, the capitated stuff and so the quality actually affects the reimbursement.

JENNIFER COURY
Yep, and the health plan gets their list from the state Medicaid agencies. So those are updated like they can't even. Yeah, I mean, it's just...

AUDIENCE MEMBER
And they're often late. In Massachusetts, the Medicaid list overrides whatever the health plan has in their system, you can, you can correct it with the state. The member has to call.

JENNIFER COURY
Were there other things?

AUDIENCE MEMBER
Oh yeah, we talked, we talked about...and if someone didn't know, like at the practice level, they didn't know how to extract with like in Michigan, we, we have, we've been fortunate because we were the REC for

JENNIFER COURY
the for implementing EHR across Michigan. So we have a lot of experience dealing with, EHRs, right? I wanna connect with you.

AUDIENCE MEMBER

Yeah, we could help them, you know, to extract a list because a lot of times, you know, inside but don't always know how to run a patient list out their EHR but it is there. You could do it. They all have the capability.

JENNIFER COURY
I mean, yeah. So those are so far.

AUDIENCE MEMBER
And then we give a deadline. Always give a deadline, always do a deadline that's ahead of your deadline because they're gonna surpass that deadline, right? You have your soft deadline and your hard telling you.

SPEAKER

JENNIFER COURY
Exactly.

AUDIENCE MEMBER
Trying to find a word for that.

JENNIFER COURY
So I wanna make sure everybody has a chance to, to put other thoughts on this scenario from the, from the rest of the folks who maybe didn't have it on there. I know you were only asked to think about yours. Did we cover everything?

AUDIENCE MEMBER
Yeah, I mean, for the most part.

JENNIFER COURY
Let's give everybody else time. All right. All right, Brittnay. How do we do? Ok. Did we, did we get these? Facilitate agreement for a standard definition of what do for colorectal cancer screening needs. So, lots of times we had to give actual procedure codes to either the health plan or the clinical practice and then sometimes they followed them and sometimes they didn't follow them. But this was really important to explain what it means to do for screening, who is considered a current patient. So what you were saying is some of the, the health plans said this patient goes here, but they haven't been in in 18 months or a year or whatever. And each clinical practice defined it a little bit differently. Developed a standard operating SOP for a list review at the clinical practice. So, scrubbing, right? These, these patients have to be scrubbed individually and reviewed. Lot of times the health plan generates and sends a monthly gap list to the clinical practice as a way of saying these are who we think are due and then two way communication between the health clinic and the plan. So I think they covered. Yeah, that's yeah, great work.

BRITTANY BADICKE
Yeah. And the facilitator really helps with every step of this and makes sure that when decisions are made, that everybody agrees that that's the decision so that that can move forward as the new process.

JENNIFER COURY
OK. Alright, scenario 2. FIT decision. So you're working with the health. Oh, well, the first sentence is always the same. You're implementing a collaborative FIT mail program. The health plan has contracted with a vendor to conduct the FIT mailing. You're assisting in the development of a comprehensive workflow that includes the health plan clinical practice mailing vendor and processing lab. In order for the collaborative screening program to work, it is critical that each partner understands their role and that each has the information necessary to be successful. When you reach this step for lab processing, you learn that the FIT the health plan is using cannot be processed at your regularly contracted lab. So there are hundreds of types of FITs. There are varying reliability. They are processed differently and some labs process a subset of FITs other labs are processed actually at the clinic. So it really can depend on it. And the FIT in our case is being mailed by the health plan. So the question is how do you engage the health plan, clinical practice, and processing lab to decide which FIT should be mailed for the program and where and how can it be processed? So, before you mail out FITs, you wanna make sure that they can be processed.

AUDIENCE MEMBER
So well, first they had to clarify for me that there are hundreds of types of FIT tests because I'm like, well, if they can't do the FIT test and then we were done. But, ok, so, we know that we need to involve, like everybody who's listed here: the health plan, the mailers, and the practices and it, it's asking us like, who has the authority to make that final decision. We feel like it's probably the health plan, like for the final final because they are ultimately gonna pay for whatever fit test is selected if we continue to work with this lab. And, so we kind of talked about doing swim lanes, looking at the process, you know, starting from the beginning, like hey, you guys following your process essentially, like identifying the patient and, you know, communication and all that, and then, you know, getting it done. So we wanted to talk to them about the contracts because we don't know everybody's contract. So what is the lab contract? Is it, you know, like we're stuck in it for the next five years? But we know that it's probably, that's a change that might be needed is, or it might be the easiest change is to change the lab as opposed to whatever FIT test was selected. And I say that because a conversation we had here is a side thing like, you know, people are using FIT test. I'm like, no, we won't change because it may be related. Like if this practice is in a health system, that's what they use and that's the final decision, right?

SPEAKER

AUDIENCE MEMBER

Yeah, I think we brought, talked about this is ideal for a practice facilitator to do process mapping and bring the parties together. And this is what practices sometimes are. This is the last thing they wanna do because it's tedious, but this is the most helpful thing that they can have. And then that really reveals a lot of these potential things where you can improve or change so forth.

JENNIFER COURY
Do other other folks have thoughts or? And yeah, so we said, you know, building understanding across all of the partners about which FITs can be processed with the regularly used lab. So this is like what you were saying, right, what can we, what can we do like is there are there other FITs with our lab? Establish the costs. Make sure the lab manager....and make sure the lab manager is involved in conversations early. So one of our health systems--we randomized--and one of our health systems, we had three clinics in the study. Two of the clinics did the program the first year and there was no problem at all. They mailed the FIT that was used by the health plan. Absolutely a breeze. Lovely. They had great response rates. We had such buy-in from the clinical practice. It was awesome. And then we added the third clinic in the second year when we expanded it and their entire, and I mean entire, program broke down. And what happened was the lab manager didn't even know this program was happening. And when we added the third clinic, it bumped their volume up high enough that he saw the costs. I was on so many calls with this lab manager, we had to go from start one, we had to explain the program. We had to, we had to pick a new FIT for the program. They changed their FIT in the second year of the program. This did not happen in the first year of the program. So involve all the parties in any practice change as early as you can, even if they say they're busy, even if they say they don't have time. Oh, yeah, thank you. It's been the clinic and lab capacity to receive the volume of fits. The the aforementioned example was it was fine until we bumped it up to a larger amount of FITs. Agree on a FIT that can be mailed. They can't all be mailed and can be processed at the lab and is effective, and confirm that the workflow.

AUDIENCE MEMBER
You changed the FIT. We were trying to change the lab.

BRITTANY BADICKE
It's a little easier to change the FIT, but you want to get, you want to make sure that everybody agrees with that decision. And that they agree with however reliable that test is because you might be changing to one that can be mailed, but maybe isn't the best option for what can be processed in the lab.

JENNIFER COURY
Yeah. All right. Let's get to the third scenario. So who wants to talk? You guys talked about such great things. Do you wanna read it? I don't have it. Yeah, I swear, I presented one more. Multipart patient outreach. So if you're working on a collaborative FIT mail program, the clinical practice is part of a large health system that centralizes many patient outreach efforts. The FITs have been mailed and it's time to begin reminder outreach, phone calls or

texts or messages in the EHR to remind patients to complete their FITs. This health system has an outreach department that will lead this effort. However, they are not clinically trained and are unable to answer patient questions about the FIT. How should the outreach department and clinical practice work together to ensure that all the patient outreach has occurred and all patient questions have been answered? Oh, I heard, I heard such great things I want you to share.

AUDIENCE MEMBER
I said in terms of who should be involved, it should be the outreach department. To be on board about what they're available for. I think one of the questions we had is we know that the department isn't clinically trained, but like what, what are they able to do? And so what to what level can they? So if we provide training and scripting and like FAQs-- can they deliver that information? And then what kind of escalation plan for when they're getting questions that they're not being answered? Especially if there's multiple sites, we need to make sure they know who to escalate to, depending on what location the patient is in. And then like some key things: like what do we want to make sure that we're getting across to the patients? And we like, here's this, is it gonna cost you or it, is it this much? How are you gonna get your results? Like making sure that key things are kind of shared out. And then I think, so we talked about so, examples that were given were like phone calls, text messages or EHR reminders that maybe it'd be a good idea to start with like text, text messages are relatively universal now, starting there and kind of having a tracking system and maybe some automated responses that people can send back. It could be a phone call or like some sort of way to kind of see who are the key people that we should start with. And then go from there and then in terms of documentation, I was like lots of documentation is needed. And maybe in multiple places. But making sure that the clinic and the outreach center all access documentation. Similarly, some patients might call the clinic when they get the test if they're confused or like to make sure that we're not crossing paths. What have I missed? We talked about like how many calls and like the timing, the timing and how many calls. Yeah, and having an actual text message that went out saying that the FIT kit was coming, so they had warning it was coming in the mail first and then we did have a...she brought up that there is a Youtube video that you can send people to on how to actually use the test. Yeah, so giving them that QR code to be able to easily access that from home.

JENNIFER COURY
Yeah, great, great suggestions. Sure. Let me talk about this?

BRITTANY BADICKE
Ok.

JENNIFER COURY
Sure. So yeah, so great. Yeah, developing documentation, right? For all the parties communicating between departments, looking at how do you do electronic health record messages or flags to facilitate the communication between the clinical side of things and

the outreach department. Dveloping a tracking mechanism that can be viewed by both departments so that everybody can see the population that's being outreached to. Scripting. So what you were saying, like automated messages, texts, the QR code is a great idea, having a little video that can explain things so that outreach department doesn't have to have all that information. And then, I would just add organizing a training session with academic experts. So or a link to recorded training. So we also brought in experts to those departments and they would present either to the provider groups or directly to the outreach department, at least to increase their knowledge of the ways of screening for colorectal cancer. Yeah. So do we wanna go forward to?

BRITTANY BADICKE
Yeah.

JENNIFER COURY
Ok. So I just we're kind of out of time but I did want to share that we have a lot of tool kits available that we've created as part of this. In particular, we have a facilitation guide that's written for organizations, implementing a mail FIT program and patient navigation program. So definitely check it out and there, there's a website called mailFIT.org that has a lot of patient-facing...population-facing materials. So call scripts and fact sheets and also tracking documents. So some of the tools that we've talked about like tracking between organizations and even down to, here's what a a list of eligible for CRC patients looks like to be reviewed. So we have all of those materials on mailFIT.org And we had two scientific publications, but the this is our study protocol and then the data challenge is all about the challenges in EHR. So we, we wrote a paper about it. So final questions?

AUDIENCE MEMBER
I do have one. Just, just a thought like in my brain, on this, did you guys drill down? Like did you just do like anybody that needed a colorectal cancer screening? Like to do the like people that have a history in their family of colon...colorectal cancer?

BRITTANY BADICKE
You don't. Yeah, there's, there's criteria for being eligible for a FIT. And so if you have a family history, if you've ever been symptomatic. Any of those things, then you get excluded and that's in that initial identifying the patient population. That's what facilitators worked with the clinics to say here's the people that you would exclude from this. And we actually had a separate protocol where we would say they had the option to then enroll them in patient navigation to colonoscopy if they needed to go straight to that rather than doing the FIT first.

AUDIENCE MEMBER
Perfect.

JENNIFER COURY
It's only for average risk.

AUDIENCE MEMBER
Great, great. All right. Thank you everybody.

JENNIFER COURY
We're out of time.ollaboration.