This Patient Navigation Guidebook explains the roles and limitations of a Colorado Colorectal Screening Program patient navigator, and provides specific information about the program, colorectal cancer screening, diagnosis, treatment and recovery.
Greetings!

We are thrilled that you have joined us in the movement to increase colorectal cancer screening rates in Colorado through patient navigation. Patient navigation is a research-tested and evidence-based practice that has been shown to increase cancer screening rates among the medically underserved throughout the country. As a result, patient navigation have become an essential role in Federally Qualified Health Centers and Community Health Clinics.

This manual is intended to guide you through the Colorado Colorectal Screening Program’s patient navigation model, and help enhance the patient navigation programs that live within your clinic. You will find resources to help create targeted, colorectal cancer screening-specific messaging for your clinic and community, better implement colorectal cancer screening patient navigation, educate patients, and reduce barriers to care.

Throughout this manual we have inserted one-pagers, or fact sheets for you to print off and utilize within your clinic and your work. These can serve as resources you, your clinic staff, and your patients. Please note that this manual is a living document. We will revise this manual as screening recommendations and best practices are updated.

This manual is strictly a tool—how you choose to implement patient navigation should be determined by what works best within your clinic. It is our hope that this manual will guide you as you navigate patients and help you establish a robust patient navigation system within your clinic.

Kindly,

The CCSP Team
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About the Colorado Colorectal Screening Program

Colorectal cancer (CRC) is the second leading cause of cancer mortality in the United States. CRC differs from most cancers because it is preventable through timely screening. According to the US Preventive Services Task Force (USPSTF) recommendations, CRC screening reduces the rate of late stage CRC diagnoses, and increases survivorship.

The Colorado Colorectal Screening Program (CCSP) is designed to provide free patient navigation services for colorectal screening to medically underserved Coloradans, and to increase the awareness and demand for colorectal screening in throughout the state.

Patient navigators educate patients about screening requirements and the procedure, reduce barriers to care, coordinate care, and help patients understand screening results.

The program focuses on individuals between 50-64, who have an income level at or below 400% of the federal poverty level. CCSP focuses on this particular age group because the USPSTF recommends that screening for CRC begin at age 50 for average risk individuals.

Underserved Coloradans often have difficulty accessing CRC screening due to limited experience navigating the health care system and difficulty understanding materials provided by health care staff.

CCSP is funded by the Cancer, Cardiovascular Disease and Pulmonary Disease Competitive Grants Program (CCPD) at the Colorado Department of Public Health and Environment, from resources available through Amendment 35, a tobacco tax in Colorado dedicated to improving health.

Through its patient navigation services, CCSP has become a critical component of a plan to achieve the Colorado Year 2018 colorectal screening goal of increasing screening rates to 80% among the medically underserved.
Understanding Colorectal Cancer in the United States

⇒ CRC the third most common cancer found in men and women combined, and the second leading cause of cancer death in the United States\(^1,2\).

⇒ Roughly 4.4% of Americans are expected to be diagnosed with CRC in their lifetime\(^3\).

⇒ African Americans are more likely to die of CRC than any other group. Caucasians have the second highest date of death from CRC, followed by American Indian/Alaska Natives, Hispanics, and Asian/Pacific Islanders\(^4\).

⇒ 1 in 3 adults over 65 has colon polyps—these polyps sometimes progress to cancer.

⇒ 80% of CRC is preventable through removal of polyps during endoscopic colorectal screening\(^6,7,8\).

Colorectal Cancer in Colorado:

⇒ Every year, approximately 620 Coloradans die from CRC, over 600 have colostomies, and 1,400 have bowel resections\(^9\).

⇒ Most Coloradans over the age of 50 have not been screened endoscopically for CRC—despite the fact that they get routine breast or prostate screening\(^10\).

⇒ If every Coloradan age 50 and older were screened for polyps, well over half the deaths from colon cancer could be prevented.

Watch this video to learn more about colorectal cancer in the United States!
Outcomes of the 2016 CCSP Needs Assessment

In 2016, CCSP staff conducted a needs assessment highlighting colorectal cancer screening needs across Colorado among men and women between the ages of 50 and 64. The map you see below was created by the Health Statistics and Evaluation Branch of the Colorado Department of Public Health and Environment and overlays three pieces of data: colorectal cancer screening compliance, late-stage incidence rate, and poverty level. This map demonstrates that the Eastern parts of the state have a significant need for increased screening: there is a greater presence of late stage diagnoses, lower screening rates, and substantial poverty burden. Additionally, the mortality rate is high in Northeastern and Southern Colorado. The findings of CCSP’s needs assessment shed light on the need for increased rates of colorectal cancer screening in Colorado. Increased partnerships between local health departments, Regional Care Collaborative Organizations, local screening providers, and other community partners are promising methods to increase screening rates. Collaborations such as these can increase awareness, outreach, and education in areas with the lowest screening rates. For more detailed analysis and results specific to different regions across Colorado, see Appendix C.

* Colorado Central Cancer Registry, 2012-2014, Number of people diagnosed with a colorectal cancer at any age
** BRFSS, 2012 & 2014, Percent of people aged 50 to 75 screened for colorectal cancer (colonoscopy in last 10 years, sigmoidoscopy in last 5 years, or FIT/FoBT in last year)
*** Census Small Area Household Estimates, 2014, Percent of people aged 50 to 64 at or below 250 percent of federal poverty level
**** Colorado Central Cancer Registry, 2012-2014, Age-adjusted incidence rates per 100,000 population for late stage colorectal cancer diagnosed in regional or distant stage only among people aged 50+

Created by: Public Health Informatics Program, October 2016
Part I: Patient Navigation

“Patient navigator programs are improving timely access to diagnosis and treatment, assisting patients and families in managing and coordinating cancer care, decreasing complications from treatment by managing symptoms promptly, and increasing patient quality of life.”

(Wilcox & Bruce, 2010)
An Unequal Healthcare System

In the United States, the burden of disease is distributed unequally among the poor and ethnic minorities due to:

- Lack of, or insufficient, insurance
- Cultural influences or previous bad experiences leading to distrust of the healthcare system
- Logistical barriers such as lack of transportation or childcare services
- Language or cultural differences with healthcare providers
- Limited knowledge about healthcare issues

Because these barriers exist, patients may not receive preventive care services, or may delay care until they are very ill. As a result, many minorities and low-income individuals visit the clinic with diseases that have already progressed into an advanced stage. Late stage diagnosis is especially detrimental for cancer, because successful treatment often depends on beginning at an early stage.

"We all need to use our healthcare resources wisely, but no patient in America with cancer should go untreated, no matter what his or her economic status."

- Dr. Harold P. Freeman
Patient Navigation: A Solution to Inequality

The creation of a patient navigator role has sought to improve health care delivery to medically underserved populations. Patient navigators help eliminate barriers and guide patients through the often-complex medical system, assuring that they get the best care possible.

Dr. Harold P. Freeman, at the Harlem Hospital Center in New York City, created the concept in 1990. His Harlem program aided low-income and minority breast cancer patients through the cancer care process from the first sign of a suspicious finding to diagnosis and treatment.

These navigators effectively diminished barriers, ensuring adequate follow-up and treatment for their clients. In light of this success, cancer patient navigator programs are now being created across the country. As a navigator, you will learn about barriers to healthcare, and how you can use creative solutions to address these issues. Your work will help save lives and improve a patient’s experience in the healthcare system.

If a patient navigation program already exists at your clinic, this guide will help you integrate the Colorado Colorectal Screening Program into your patient navigation curriculum.

Recent Studies Involving Patient Navigation

A study on underserved Koreans in Los Angeles County found that a multifaceted colorectal screening approached increased screening rates. The intervention program included a bilingual cancer educational program and navigation assistance for screening. At the 12-month post-intervention follow-up, 77% of participants in the intervention group had obtained screening, compared to 11% in the control group.

A community-based pilot intervention combined cervical cancer education with patient navigation and raised screening rates among Chinese American women in New York City. The program helped overcome linguistic and access barriers to screening. In the 12-month interval following the program, screening rates were significantly higher in the intervention group (70%) than in the control group (11%).
Role of a Patient Navigator

The primary roles of a patient navigator for colorectal cancer screening are listed below. How your clinic addresses these areas will depend upon barriers identified and resources available. Please refer to the Colorectal Cancer Patient Navigation and Resource sections of this manual for more information and ideas to address these categories.

Outreach
Educate your patients about cancer prevention, cancer risk factors, and the need for cancer screening. Colorectal cancer educational materials are obtainable through CCSP in both Spanish and English and can be tailored to your clinic. CCSP is also able to fund mailings to the patients served by your clinic.

Screening
Identify patients in your organization who need cancer screening. Contact these patients to inform them of their need for screening and educate them about the importance of cancer screening. Misunderstandings about cancer screening often exist and must be addressed. Identify your patient’s barriers to receiving screening and work with the patient to eliminate them.

Barrier Reduction
Patient navigators work with patients to eliminate barriers to care. The services you provide depend on the barriers you identify and the strategies you use to overcome them. Often, navigators play a reactive role by trouble-shooting problems as they arise. This manual discusses common barriers; however, many additional barriers will emerge as you interact with patients.

Diagnosis
If a suspicious lesion is detected, ensure that a follow-up appointment is scheduled to determine if it’s cancer. Work with patients and providers to make sure patients understand these instructions and the need for a follow-up appointment.

Treatment
For patients diagnosed with cancer, ensure that they attend all follow-up appointments and receive treatment as needed. Work with patients one-on-one to determine possible barriers to diagnosis and treatment, and find solutions to these problems. Encourage patients to assign a “treatment partner,” someone the patient trusts who can accompany them to appointments, assist with questions, and help discuss medications with their physician. Work with patients on issues such as advanced directives, pain management, and emotional support. More information on these issues is available in the Resource section of this guidebook.

Rehabilitation
Provide education and support for cancer survivors and emphasize community resources. Some community resources are available in the Resource section of this guidebook.
Identifying Barriers and Creating Solutions

Identifying barriers to care is one of the most crucial services a patient navigator can provide. A patient’s demographics, cultural background, socioeconomic status, and level of trust for the healthcare system can all lead to different barriers that you as a patient navigator will help them overcome.

Patients living in rural areas may experience far different barriers than patients living in urban or suburban settings. Rural areas tend to have less infrastructure. Hospitals and clinics tend to be further away, public transportation is limited, and specialty care is often sparse. Because of these barriers, rural patients are less likely to seek preventive services such as colorectal screening, tend to wait longer before seeking treatment, and thus, often present with more serious illnesses.

Refugees and immigrants may experience their own set of unique barriers. Language and literacy barriers make it difficult if not impossible to understand basic health information, or what their doctor is trying to tell them. Limited health literacy and cultural beliefs may also cause a delay in seeking medical treatment. Before interacting with patients, sit down with your providers to discuss problems and obstacles that patients have experienced in the past. This will help you identify both barriers and solutions.

You will find a variety of tools in the Resources section of this manual designed to help you eliminate barriers that your patients may be faced with. In addition to the tools provided in this manual, you should also become familiar with the Patient Navigator Training Collaborative (PNTC). The PNTC offers trainings throughout Colorado to help enhance patient navigator skills and knowledge. Courses range from beginner to advanced levels and are beneficial to both novice and experienced patient navigators. These courses will provide you with a wealth of barrier reduction techniques and resources.
Identifying Barriers and Creating Solutions

The following barrier reduction best practices can be used as a guide to help you and your fellow patient navigators find solutions to barriers patients may face.

Table 1: Potential Barriers and Possible Navigation Solutions

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Possible Navigation Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Care System</strong></td>
<td></td>
</tr>
</tbody>
</table>
| ⇒ Patient fails to keep appointments | ⇒ Ensure a reminder-call system exists  
  ⇒ Patient does not fully understand what the provider says | ⇒ Follow up with patients who miss appointments  
  ⇒ Explain the reason for the appointment and the importance of attending  
  ⇒ Ask what the patients understands and clarify any misconceptions |
| **Language** | | |
| ⇒ Patient speaks a different language than the provider | ⇒ Arrange for a certified medical interpreter to be present at appointments  
  ⇒ Arrange for a bilingual medical staff member in your clinic to translate*  
  ⇒ Discuss having your clinic obtain a subscription to a telephone language line**  
  ⇒ Obtain educational materials in several languages***  
  ⇒ Consult with patient and family to discuss community-based resources they can access.  
  ⇒ Acknowledge that you empathize with the language difficulty. Reassure that this is nothing to be shameful of, and that you will work with them to overcome these barriers. |
| **Financial** | | |
| ⇒ No insurance  
  ⇒ Patient needs help understanding and completing insurance forms | ⇒ See if patient qualifies for Medicaid or Medicare  
  ⇒ Assist patient with completing paperwork |
| **Transportation** | | |
| ⇒ Patient lives far from the clinic and has no means of transportation  
  ⇒ Patient cannot afford public transportation | ⇒ Assist patient in utilizing the public transportation system  
  ⇒ Arrange for community shuttle or volunteer transportation service. |

* If you use this option, please refer to the Appendix A.  
** Most of these companies offer a fee-for-service option, so you can use it in an emergency; however, the price is usually much higher than the price available with the subscription.  
*** Colon cancer educational brochures are available through the CCSP. For more information, visit the Program website, [http://colonscreen.coloradocancercenter.org](http://colonscreen.coloradocancercenter.org).
# Communication Skills

Effective communication is essential to successful patient navigation. Your ability to listen to and understand a patient’s fears and needs is vital to your role. Through these skills, you will build a relationship based on trust and respect. This manual identifies basic communication skills to help you interact with patients.

## When communicating with patients, remember the four E’s

<table>
<thead>
<tr>
<th>Engagement</th>
<th>A connection between you and the patient that enables a partnership to develop.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>➞ Introduce yourself to the patient</td>
</tr>
<tr>
<td></td>
<td>➞ Show interest in the patient as a person</td>
</tr>
<tr>
<td></td>
<td>➞ Identify the patient’s expectations and prioritize your interaction to address both the patient’s and your agendas</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Empathy</th>
<th>A sincere interaction with a patient, who feels seen, heard, and accepted.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>➞ Be aware of physical barriers such as desks et., which impede empathy</td>
</tr>
<tr>
<td></td>
<td>➞ Encourage the patient to share their thoughts and feelings, then affirm them by using the patient’s own words while reserving judgement</td>
</tr>
<tr>
<td></td>
<td>➞ Allow some self-disclosure, when appropriate</td>
</tr>
<tr>
<td></td>
<td>➞ Use open-ended questions to enhance emotional and social communication</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>An opportunity to provide information and clarify misconceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>➞ Determine the patient’s understanding of the disease by asking, “what do you think is going on?”</td>
</tr>
<tr>
<td></td>
<td>➞ Ask additional questions to discover the patient’s concerns</td>
</tr>
<tr>
<td></td>
<td>➞ Provide information and communicate understanding to decrease the patient’s uncertainty and anxiety</td>
</tr>
<tr>
<td></td>
<td>➞ Have the patient tell you what they know after the discussion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enlistment</th>
<th>Working with the patient to formulate a plan to overcome barriers to care.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>➞ Discuss the barriers identified and potential solutions that will work best for their routine and lifestyle.</td>
</tr>
<tr>
<td></td>
<td>➞ At the completion of the visit, be sure to close effectively by summarizing the agreed-upon plan and discussing next steps</td>
</tr>
<tr>
<td></td>
<td>➞ Try to engage a “treatment partner” who will help the patient ask questions and take notes and appointments, as patients under pressure of a cancer diagnosis are often unable to ask questions or fully understand the treatment plan</td>
</tr>
</tbody>
</table>

The following organizations offer more information on communication skills development:

- American Academy on Communication in Healthcare
- Bayer Institute for Health Care Communication
- Ask Me 3
Limits of Patient Navigation

It is important to understand the scope of your role as a patient navigator. You need to understand what a navigator does, but also, what a navigator should not do. As a navigator you will become involved in your patients' lives. However, to be an effective navigator, you need to set clear boundaries. It is important that you define these boundaries before you begin.

**Patient navigators do not provide direct, hands-on patient care such as**:  
- Providing physical assessments, diagnoses or treatments  
- Offer opinions about a diagnosis, treatment, or healthcare service  
- Give information about treatments other than approved basic information from medical sources.

**It is beyond the scope of a patient navigator to**:  
- Give your own money to patients  
- Personally drive patients to and from appointments  
- Personally visit patients in their homes

**Patient Confidentiality**

As part of the healthcare system, patient navigators must respect laws about patient privacy. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states that all medical records and other health information about a person should be kept confidential.

You will be keeping files and forms on your patients, which need to be stored properly. Discussing patient information with people not involved in the medical care of that individual is a direct violation of HIPAA and the patient’s rights. For more information about patient privacy issues, please consult your supervisor.
Part II: Colorectal Cancer Screening
What is Cancer?

Cancer begins in the cells. Cells are the building blocks that make up tissues. Tissues make up our organs. Cells grow, divide, and die as new ones take their place. Cancer is the result of damage to the cells that causes them to grow out of control and not die off in a way that they normally would.

These abnormal cancer cells stick together and form a tumor—they can grow large, and in places where they interfere with the normal work of other organs. If left untreated, cancer cells can spread to nearby tissues and lymph nodes. Lymph nodes are special areas of the body that help trap things like germs and cancer cells. Cancer cells can also spread to other organs in the body through a process called metastasis (meh-TAS-tah-sis).

Cancer is defined in stages, which depends on the following:

- Tumor size
- If it has spread to neighboring lymph nodes
- If there has been a metastatic spread to other parts of the body

Staging describes how advanced or severe the cancer is, and allows doctors to better plan and determine the best course of treatment.
What is Colorectal Cancer?

In most cases, colon and rectal cancers develop slowly, over a period of several years. Most of these cancers begin as a polyp—a growth of tissue into the center of the colon or rectum.

There are different types of polyps. The most worrisome is an adenoma, because most colorectal cancer comes from adenomatous polyps. Studies have shown that an adenomatous polyp takes approximately 10 to 15 years to develop into cancer. This is why physicians recommend that patients receive colonoscopies every ten years.

Early polyp removal may prevent the development of cancer. Over 95% of colon and rectal cancers are adenocarcinomas: cancers of the cells that line the inside of the colon and rectum. Cancer can start in any area of the large bowel. Different areas may cause different symptoms. However, colorectal cancer usually has no symptoms, which is why screening is so important.

What are the Symptoms of Colorectal Cancer?

The following are some symptoms of colorectal cancer:

- A change in bowel habits such as diarrhea, constipation, or narrowing of the stool that lasts for more than a few days
- A feeling that you need to have a bowel movement that doesn't go away
- Bleeding from the rectum or blood in the stool
- Cramping or steady stomach pain
- Weakness and tiredness
What are the Colon and Rectum?

The colon and rectum are the final part of the digestive system. Together they make up the large bowel. The colon is a muscular tube about five feet long. It absorbs water and nutrients from food and serves as a storage place for waste. Waste moves from the colon into the rectum, which is the final 6 inches of large bowel. From there, it passes out of the body through the anus during a bowel movement.

The colon has four sections: ascending colon, transverse colon, descending colon, and sigmoid colon.
What are the Risk Factors for Colorectal Cancer?

A risk factor is anything that increases a person’s chance of developing a disease. Some things can’t be changed, but others can be modified or avoided to decrease a person’s risk of colorectal cancer. You can’t change the genes you inherited from your parents but you can choose to quit smoking. Patients must be reminded that the most important prevention method for colorectal cancer is colorectal screening.

Avoiding risk factors alone does not guarantee that you’ll be cancer free. Most people with a particular risk factor for cancer do not actually get the disease. On the other hand, some people are more sensitive to risk factors that can cause cancer.

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Decreasing the Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Chance of CRC increases at age 50. Have a colonoscopy every 10 years beginning at age 50.</td>
</tr>
<tr>
<td><strong>Family History of colorectal cancer or familial syndromes</strong></td>
<td>First degree relatives (parent, sibling, child) who have had CRC increase a patient’s risk of developing it themselves. Encourage patients to know their family history and what it means about screening intervals. At what age were family members diagnosed? Knowing this will help physician determine when screening should begin.</td>
</tr>
<tr>
<td><strong>Diet</strong></td>
<td>Diets high in fat, red or processed meat, and low in fiber, vitamin D, calcium and folate Eat a diet that is high in fruits and vegetables, and lower your consumption of red and processed meat</td>
</tr>
<tr>
<td><strong>Exercise and Weight</strong></td>
<td>Sedentary lifestyle and being overweight increase one’s risk of developing CRC Eat a balanced diet and exercise regularly.</td>
</tr>
<tr>
<td><strong>Smoking</strong></td>
<td>Smokers are 30-40% more likely to develop and die from CRC Current smokers should be encouraged to quit, and given resource to help.</td>
</tr>
<tr>
<td><strong>Personal history of bowel disease, adenomatous polyps, or colorectal cancer</strong></td>
<td>Patients with ulcerative colitis are at higher risk of developing colorectal cancer. Adenomatous polyps have the potential to turn into cancer. A personal history of bowel disease, adenomatous polyps, or previous colorectal cancer means you may need to receive colonoscopies more frequently.</td>
</tr>
</tbody>
</table>
## Screening and Surveillance Guidelines

### Table 4: Reimbursable Screening Guidelines for Average, Increased, and High Risk Patients

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Age to Begin Screening</th>
<th>Reimbursable Screening Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average Risk</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asymptomatic individuals who are not in the categories below (including those with a previous hyperplastic polyp as their most advanced lesion)</td>
<td>50 years</td>
<td>Colonoscopy every 10 years OR Flexible Sigmoidoscopy or DCBE every 5 years</td>
</tr>
<tr>
<td><strong>Increased Risk</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual with family history of CRC or adenomatous polyp in a first degree relative diagnosed at age 60 years or older</td>
<td>40 years</td>
<td>Colonoscopy every 10 years OR Flexible Sigmoidoscopy or DCBE every 5 years</td>
</tr>
<tr>
<td>Either colorectal cancer or adenomatous polyps, in any first-degree relative before age 60, or in two or more first-degree relatives at any age (if not a hereditary syndrome)</td>
<td>Age 40 or 10 years before the youngest colon cancer / adenoma in the family, whichever is earlier</td>
<td>Colonoscopy every 5 -10 years Colorectal cancer in relatives more distant than first-degree does not increase risk substantially above the average-risk group</td>
</tr>
<tr>
<td>On previous endoscopic screening, individual with one or two small (&lt;1 cm), adenomatous polyps with only low-grade dysplasia</td>
<td>At initial time of polyp diagnosis</td>
<td>Colonoscopy 5 years after initial polyp removal. If that exam is normal, then colonoscopy every 5 10 years thereafter.</td>
</tr>
<tr>
<td>On previous endoscopic screening, individual with any of the following: - 3 to 10 adenomas or - one large (≥1 cm) adenomatous polyp or - any adenoma with villous features or high grade dysplasia</td>
<td>At initial time of polyp diagnosis</td>
<td>Colonoscopy 3 years (providing that piecemeal removal has not been done &amp; the adenoma(s) are completely removed) If the follow-up exam is normal or shows only one or two small tubular adenomas with low-grade dysplasia, then colonoscopy every 5 years thereafter.</td>
</tr>
<tr>
<td>On previous endoscopic screening, individual with more than 10 adenomas at one examination</td>
<td>At initial time of polyp diagnosis</td>
<td>&lt; 3 years – interval established by clinical judgment</td>
</tr>
<tr>
<td>Personal history of curative-intent resection of colorectal cancer</td>
<td>One year after diagnosis</td>
<td>Colonoscopy one year after resection. If normal, then the interval before next subsequent exam should be 3 years. If normal, then the interval before next subsequent exam should be 5 years.</td>
</tr>
<tr>
<td><strong>High Risk</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual with family history of Familial Adenomatous Polyposis (FAP)</td>
<td>Puberty</td>
<td>Sigmoidoscopy (or colonoscopy) and genetic testing. If polyposis is confirmed by endoscopy and/or if genetic testing is positive, then refer patient to a center with experience in managing FAP.</td>
</tr>
<tr>
<td>Individual with family history of hereditary non-polyposis colon cancer (HNPCC)</td>
<td>Age 21 to 25 years</td>
<td>Colonoscopy and genetic testing*. If genetic test is normal, screen as per average risk. If genetic test is positive or patient has not had genetic testing, then refer patient to a center with experience in managing HNPCC.</td>
</tr>
<tr>
<td>Personal history of inflammatory bowel disease: (Chronic Ulcerative colitis or Crohn’s disease)</td>
<td>Cancer risk begins to be significant 8 years after the onset of pancolitis OR 12 – 15 years after the onset of left sided colitis</td>
<td>Colonoscopy with multiple biopsies every 1 – 2 years, and refer patient to a center with experience in surveillance and management of IBD. Important note: The Program can only cover the costs of colorectal cancer screening in patients with established, long standing disease (&gt;8 years) and not for the diagnosis or symptomatic evaluation of patients with IBD.</td>
</tr>
</tbody>
</table>
Beginning at age 50, both men and women of average risk for developing colorectal cancer should use one of the screening tests below. Tests designed to find both early cancer and polyps are preferred.

**Tests that find polyps and cancer**
- Flexible sigmoidoscopy every 5 years*
- Colonoscopy every 10 years
- Double contrast barium enema every 5 years*
- CT colonography (virtual colonoscopy) every 5 years*

**Tests that mainly find cancer**
- High sensitivity fecal occult blood test (FOBT) every year*,**
- Fecal immunochemical test (FIT) every year*,**
- Stool DNA test (sDNA), every 3 years*

*Colonoscopy should be done if test results are positive
**For FOBT or FIT used as a screening test, the take-home multiple sample method should be used. A FOBT or FIT done during a digital rectal exam in the doctor’s office is not adequate for screening.

People should talk to their doctor about starting colorectal cancer screening earlier and/or being screened more often if they have any of the following colorectal cancer risk factors:

- a personal history of colorectal cancer or adenomatous polyps
- a personal history of chronic inflammatory bowel disease (Crohn’s disease or ulcerative colitis)
- a strong family history of colorectal cancer or polyps (cancer or polyps in a first-degree relative [parent, sibling, or child] younger than 60 or in 2 or more first-degree relatives of any age)
- a known family history of hereditary colorectal cancer syndromes such as familial adenomatous polyposis (FAP) or hereditary non-polyposis colon cancer (HNPCC)
Colorectal Screening Recommendations

Colorectal cancer screening is unique. There are a number of different screening options that patients may choose from. Certain methods even allow cancer screening and prevention to occur simultaneously. These screening tests, which are done endoscopically, not only identify polyps, but can also remove them at the same time. Therefore, you are both screening for cancer and preventing it from developing. The following chart lists the recommended screening methods for colorectal cancer.

<table>
<thead>
<tr>
<th>US Preventive Services Task Force (USPSTF): Standard Screening Tests for Colorectal Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
</tr>
<tr>
<td>Flexible Sigmoidoscopy (Flex Sig)</td>
</tr>
<tr>
<td>FOBT + Flex Sig</td>
</tr>
<tr>
<td>Fecal Occult Blood Test (FOBT)</td>
</tr>
<tr>
<td>Virtual Colonoscopy</td>
</tr>
<tr>
<td>DNA Stool Test</td>
</tr>
<tr>
<td>Fecal Immunochemical Test (FIT Kit)</td>
</tr>
</tbody>
</table>

Learn more about the USPSTF Screening Recommendations by watching this video!

Learn more about colorectal cancer screening guidelines here:

- US Preventive Services Task Force
- US Multi-Society Task Force on Colorectal Cancer
- American Gastroenterological Association

Colonoscopy

Colonoscopies are considered the gold standard for colorectal cancer screening. It is a minimally invasive procedure, done while the patient is sedated. During the procedure, a thin, lighted tube called a colonoscope is inserted in the anus to examine the rectum and colon. This allows the physician to remove and biopsy polyps and tissue samples to evaluate for cancer, if necessary. Because adenomatous polyps take 10 to 15 years to develop into cancer, colonoscopies should be performed every ten years.
Colonoscopy Continued

What preparation is involved?
For an accurate test, patients must undergo preparation which consists of a clear liquid diet plus a bowel prep. All stool must be emptied before the procedure can begin.

- Patients must begin the clear liquid diet in the morning on the day before colonoscopy. Clear liquids have two characteristics – you can see through the liquid, and nothing remains on a fork when lifting the liquid at room temperature. Examples include: water, sodas, popsicles, pulp-free juice, broth fruit-free Jell-O, black coffee, and tea.

- In addition to the clear liquid, patients consume a special bowel prep solution to fully flush out their colon. These solutions do NOT taste good and will cause diarrhea. There are different types of bowel prep solutions, and a few different ways to take them. The exact prep, and manner in which you take it will depend on your physician. Many patients say the preparation process is worse than the procedure itself; however, it is vital that patients complete the preparation as instructed to ensure an accurate and safe exam.

Medications
Most medications can be continued as usual. Patients should discuss the use of blood thinners, aspirin, vitamin D, and non-steroidal anti-inflammatories (NSAIDS) with their physicians before the procedure. If the patient requires antibiotics before dental procedures, they must alert the physician as they may require antibiotics prior to the colonoscopy. During the procedure the patient will undergo light sedation. You will need to ensure that transportation is arranged.

While typically a safe procedure, there are some risks associated with the colonoscopy. These include bleeding or perforation of the bowel wall, which may require blood transfusions or surgery, or an adverse reaction to the sedatives. Additionally, if a patient does not prep properly, polyps may be missed due to limited visibility. After the procedure, the patient should contact their physician if they experience severe abdominal pain. Nausea, fevers, chills, or rectal bleeding equal to more than half of a cup.
Colonoscopy Continued

What can I expect?

- On the morning of the day prior to the procedure, patients must begin a clear liquid diet: only water, soda, popsicles, pulp-free juice, broth and fruit-free Jell-O.
- The evening before your colonoscopy, patients will take medications to clean out the bowels. These medicines do not taste good and will make you have diarrhea. These medicines must be taken as directed to ensure the test is done safely and provides the doctor with accurate results.
- During the procedure, the physician will be passing a thin tube into your rectum and colon.
- On the day of the procedure, patients will have an IV started and monitors in place to measure heart rate and breathing.
- Patients will receive light sedation before the procedure through the IV — they will be awake, but sleepy and relaxed. If needed, they may receive additional doses of medication during the procedure.
- During the procedure, patients will lie on their side.
- Insertion of the scope may be uncomfortable, but not be painful.
- Air will be injected into the rectum and colon to facilitate movement of the scope through the bowel. This may cause a sensation of pressure, gassiness, bloating, or cramping. People tolerate the procedure well and rarely feel pain.
- The procedure typically lasts between 15-60 minutes.
- If the entire colon is not visualized, the patient will need to undergo another bowel prep and colonoscopy.
- The physician will examine the lining of the bowels carefully. If a polyp or suspicious area is identified, the physician can remove the polyp or take a biopsy at this time to determine if it is cancer.
- Because of the sedation, the patient will need someone to help them home.

Patients must contact their physician immediately if they experience severe abdominal pain, abdominal distention, nausea, fever, chills, or rectal bleeding equal to more than half a cup after the procedure.
Fecal Occult Blood Test

All fecal occult blood tests, both guaiac (gFOBT) and immunochemical (FIT) detect blood in the stool that is only visible with a microscope. Blood in the stool may be a sign of polyps, cancer, or another disease process.

The latest guidelines recommend high sensitivity (FOBT or FIT) be used to detect colorectal cancer. While all FIT tests are high sensitivity, it’s important to note that traditional FOBTs are not high sensitivity.

How is it done? How often?

Since colorectal cancer may bleed only intermittently, the FOBT is done over several days on three different bowel movements to increase the chances of detecting blood. The patient will take home a set of three special cards. Small amounts of stool are placed on the cards and returned to the doctor or lab for testing. FOBT must be repeated annually for colorectal screening.

Need to Know!

Proper utilization of fecal occult blood tests have led to a 30% reduction in mortality. However, the follow must be rules must be adhered:

All fecal occult blood tests, both gFOBT and FIT must be done annually for 3-5 consecutive years. If the results are positive, a diagnostic colonoscopy must be completed.
Fecal Occult Blood Test Continued

What preparation is involved?

To improve the accuracy of the test, advise patients to increase the amount of “roughage” in their diet 2-3 days before starting the test, such as raw or cooked carrots, corn, spinach, prunes, bran cereals or popcorn.

Avoid the following, beginning 2-3 days before the test: turnips, beets, radishes, artichokes, mushrooms, broccoli, bean sprouts, cauliflower, apples, oranges, bananas, grapes, melon, red meat, iron supplements, aspirin, NSAIDs, vitamin C supplements, and certain medications (cochicine, iodine, antacids or boric acid). Patients should not perform the test if they are menstruating or have actively bleeding hemorrhoids. These factors may cause a false-positive test.

Pros and Cons

FOBT has proven to reduce the death rate due to colorectal cancer. It is easy to do and there are no risks associated with the procedure. However, FOBT can cause a “positive” result for reasons other than colorectal cancer. If a patient has a “positive” FOBT, he or she must undergo a colonoscopy to evaluate for cancer and determine the reason for the positive result.

What can I expect?

1. Fill out the information on the front of each card.
2. During a bowel movement, collect a small amount of stool on one end of an applicator. Try catching the stool on some plastic wrap draped loosely over the toilet bowl and held in place by the toilet seat. If you use a container to collect the stool, clean and rinse it well to get rid of any substance that may affect the test results.
3. Apply a thin smear of stool inside box A.
4. You can reuse the same applicator to obtain a second sample from a different part of the stool. Apply a thin smear inside box B.
5. Close the cover of the slide.
6. Complete the remaining two cards in the same way during two other bowel movements.
7. Return all slides to your health professional either in person or by mail within 4 days of collecting the samples.
Fecal Immunochemical Test (FIT)

The Fecal Immunochemical Test (FIT) is based on the immunochemical detection of human hemoglobin (Hb) in the stool. The assay uses a monoclonal antibody to capture Hb on a test strip. Since globin does not survive passage through the upper gastrointestinal tract, the presence of globin in the stool indicates bleeding in the colon and rectum.

How is it done? How often?
Since colon cancers may bleed only intermittently, FIT is performed on two different bowel movements. Patients take home a kit with instructions, a collection card that has two flaps, and two brushes. After a bowel movement, patients will gently swab the stool with the brush. Next, the brush is swirled into the toilet water, ridding it of stool. Then, the water on the brush is painted onto the card. After a second sample is collected, the card is returned to the doctor or lab for testing. FIT must be repeated once a year for CRC screening.

What preparation is involved?
There are no dietary or medication restrictions for a FIT.

As with the gFOBT, patients should not perform the test if they are menstruating or have actively bleeding hemorrhoids, as these factors may cause a false-positive test.

Pros and Cons
FITs have been proven to reduce the death rate due to colorectal cancer. A FIT is more sensitive and specific for gastrointestinal blood than a gFOBT, but does not detect upper gastrointestinal bleeding. FIT may also have greater compliance because there is no stool handling. It is easy to do and there are no associated risks from the procedure.

However, like a gFOBT, a FIT can cause a positive result for reasons other than colorectal cancer. If a patient has a positive FOBT, he or she must undergo a colonoscopy to evaluate for cancer and determine the reason for the positive result.
Flexible Sigmoidoscopy

Flexible Sigmoidoscopy (Flex Sig) is a procedure that looks inside the rectum and lower part of the colon for polyps and cancer.

How is it done? How often?
During the procedure, a thin, lighted tube called a sigmoidoscope is inserted in the anus to examine the rectum and lower colon. Flex Sig must be done every five years to screen for colorectal cancer.

What preparation is involved?
To achieve an accurate test, patients must undergo preparation for Flex Sig. The rectum and lower colon must be cleared of all stool before the procedure can begin. This is accomplished via one or two enemas prior to the procedure. Patients must adhere to the recommended preparation plan; otherwise, the test may not be effective.

Most medications can be continued as usual. Patients should discuss the use of blood thinners, aspirin, vitamin E and non-steroidal anti-inflammatories (NSAIDs) prior to the procedure with their physician. If the patient requires antibiotics before dental procedures, they must alert the physician, as they may require antibiotics prior to Flex Sig. Because patients may undergo light sedation, they will need to arrange for someone to help them get home.

Pros and Cons
Flex Sig has been proven to reduce the death rate due to colorectal cancer. Flex Sig enables the physician to examine for colorectal cancer, and approximately 70% of adenomas are seen with Flex Sig. Because however, Flex Sig only examines the rectum and lower portion of the colon, it may miss cancer further up the colon. If the physician identifies a polyp or growth during the procedure, the patient will need to undergo a colonoscopy to remove polyps, take biopsies, and examine the rest of the colon.

While typically a safe procedure, there are some risks associated with Flex Sig. These risks include adverse reaction to sedatives, and bleeding and perforation of the bowel wall, which may require blood transfusions or surgery. Patients should contact their physician if they experience severe abdominal pain, abdominal distention, nausea, fevers, chills or rectal bleeding equal to more than a half cup following the procedure.
Flexible Sigmoidoscopy Continued

**What can I expect?**

- The patient receives one or two enemas before the procedure.
- The patient is awake during the procedure – light sedation may be provided.
- The patient lies on their side during the procedure.
- Insertion of the scope may be uncomfortable, but should not be painful.
- Air is injected into the rectum and colon to facilitate movement of the scope. This may cause a sensation of pressure, gassiness, bloating, or cramping.
- The procedure typically lasts between five and fifteen minutes.
- The physician will examine the lining of the bowel carefully. If a polyp or suspicious area is identified, a colonoscopy will need to be performed for polyp removal and biopsy.
- The procedure may be uncomfortable, but should not be extremely painful. If there is extreme discomfort, you should alert the physician.
- You will need someone to help you home, as you may be groggy from the sedation.
- Patients experiencing severe abdominal pain, abdominal distention, nausea, fevers, chills or rectal bleeding equal to more than a half cup after the procedure, must contact their physician immediately.

**Virtual Colonoscopy**

The patient will undergo a series of x-rays called a computed tomography scan (CT scan) to create an image of the colon. In these images, you can see polyps and masses. While initial studies suggest that this method is good at detecting polyps and masses, patients still need to have a colonoscopy for polyp removal or tissue biopsy if a mass is found.

**DNA Stool Test**

The DNA stool test, Cologuard, was approved by the FDA in August of 2014, and is covered by both Medicaid and Medicare. This non-invasive test examines a sample of stool for traces of blood, abnormal cells and DNA mutations that may be a sign of colorectal cancer. No special diet or prep is involved for this method of screening. If the results indicate cancer or pre-cancer, a colonoscopy will need to be performed.
Paying for Colorectal Cancer Screening*

**Federal Law & Private Insurance**

In accordance with the Affordable Care Act (ACA) all health plans implemented on or after September 23rd 2010 must cover colonoscopies and other colorectal cancer screening tests. However, this rule does not apply to insurance plans that were in place before the ACA. These grandfathered plans may have their own policies in place for covering the cost of colorectal cancer screening. For this reason, it is recommended that anyone with private insurance contact the insurance company directly to learn about their coverage.

**Medicaid**

Colonoscopies are considered part of Medicaid’s Preventive & Wellness Services in Colorado. Medicaid members do not have a copayment for a screening colonoscopy. However, a $2.00 copayment is required if the colonoscopy is performed for diagnostic or treatment purposes. In addition to colonoscopies, Colorado Medicaid covers additional screening options such as sigmoidoscopies and stool-based FIT/FOBT tests.

**Medicare Part B**

Colonoscopies are covered every 2 years for individuals at high risk for CRC. For average risk individuals, colonoscopies are covered once every 10 years, or 4 years after a flexible sigmoidoscopy. Additionally, Medicare will cover a Fecal Occult Flood Test (FOBT) once a year, or a flexible sigmoidoscopy every 4 years (but not within 10 years of a colonoscopy) for anyone 50 and over.

A Multi-target stool DNA test is covered by Medicare if an individual meets all of the following conditions:

1) Between the ages of 50 and 85
2) No signs or symptoms of colorectal disease
3) At average risk for CRC
   - No personal history of adenomatous polyps, colorectal cancer, inflammatory bowel disease, Crohn’s Disease or ulcerative colitis
   - No family history of adenomatous polyps, colorectal cancer, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer

Visit Medicare’s [Coverage](#) page to learn more about your screening options.

*Adapted from the American Cancer Society*
Navigator Checklist: Endoscopy & Pathology Reports

=> Make sure the patient and identification information match.
=> Pathology Report information matches Endoscopy Report information.
=> Direct your attention to the “Findings” section in both reports.
   => Adenoma vs. Hyperplastic/benign Polyp: neither is cancer but an Adenomas may become cancerous and must be removed.
   => Dysplasia: if present, it is an early sign that the polyp is becoming cancerous.
=> Endoscopy Report:
   => Was the entire polyp removed? If not, was a sample taken for a pathology exam?
   => If not removed entirely, was residual left?
   => Some patients may ask about the size of the polyp.
   => If colonoscopy: was the entire colon visualized? If not, ask why.
   => If sigmoidoscopy: was the left/descending colon completely visualized? If not, ask why.

Informing the Patient After Consultation with the Physician Can Include:

=> The number of polyps that were found and either completely or partially removed when no cancer was detected in the pathology report. When this occurs, it is extremely important to reassure the patient that the polyp was not cancerous.
=> When applicable: “but it was an adenoma, which means it could become cancer. Luckily, it was removed before becoming cancer.”
=> If the polyp was not completely removed and an explanation is available in the report, make sure the patient is instructed to follow-up with the physician about the need for other procedures (e.g., surgery).
=> If cancer is diagnosed: explain that a follow-up with their doctor will address the stage (how advanced the disease is), treatment, and continued follow-ups to monitor for other polyps, as they are likely to develop more.
=> If adenoma: “It is important to follow-up sooner than 10 years, probably in 3 years, so please discuss this follow-up with your doctor.”
=> If hyperplastic/benign polyp: “It’s important to follow up within 5 to 10 years, so be sure to discuss this with your physician.”
=> If no polyps: “See you in 10 years, but if you have any symptoms, come see us sooner.”
Diagnosis and Staging of Colorectal Cancer

Colorectal cancer develops from adenomatous polyps and is diagnosed by microscopic evaluation of polyps and tissue biopsies that are removed during a colonoscopy. After colorectal cancer is diagnosed, the patient’s prognosis and treatment options depend on the following:

- Stage of cancer
- Levels of certain cells and hormones in the blood
- Whether the cancer has recurred (i.e., if the cancer has come back)
- The patient’s general health

**Stages of Colorectal Cancer**

Stages of colorectal cancer are determined by how far the cancer has spread. Doctors will use the following tests to determine how far it has spread:

- **CT Scan**
  - Detailed x-ray image of the body that examines the tumor, as well as lymph nodes and other organs like the liver, lungs, and brain for metastases
- **Lymph Node Biopsy**
  - Removal of all or part of a lymph node, which is viewed under a microscope to look for cells
- **Complete Blood Count (CBC)**
  - A blood sample is taken and analyzed for the number of red blood cells, white blood cells, and platelets
- **Carcinoembryonic antigen assay (CEA)**
  - Blood test measuring the level of CEA, a hormone released by cancer cells and normal cells. A high CEA level indicates colorectal cancer
- **Magnetic Resonance Imaging (MRI)**
  - Detailed image of the body using magnetic waves to see the tumor. A substance called gadolinium is given to make cancer cells light up on these scans
- **Chest X-Ray**
  - Used to see if the cancer has spread to the chest bones or organs
- **Surgery**
  - Removal of the tumor and lymph nodes, which are examined under the microscope to evaluate for spread
Diagnosis and Staging of Colorectal Cancer
Continued

Stage 0 (Carcinoma in situ)
⇒ Cancer is only found in the inner most lining of the colon

Stage I
⇒ Cancer has spread to the middle layers of the colon wall

Stage II
⇒ Cancer is split into stages IIA and IIB
  ⇒ Stage IIA: Cancer has spread beyond the middle layers of the colon wall or has spread to nearby tissues of the colon or rectum
  ⇒ Stage IIB: cancer has spread beyond the colon wall into nearby organs and/or through the peritoneum

Stage III
⇒ Cancer is divided into stages IIIA, IIIB, and IIIC
  ⇒ Stage IIIA: Cancer has spread to the middle layers of the colon wall and up to 3 lymph nodes
  ⇒ Stage IIIB: Cancer has spread beyond the middle layers of the colon wall, to nearby tissues or organs and/or through the peritoneum and up to 3 lymph nodes
  ⇒ Stage IIIC: Cancer has spread to or beyond the middle layers of the colon wall and/or to nearby tissues, organs and peritoneum and has spread to 4 or more lymph nodes

Stage IV
⇒ Cancer has likely spread to nearby lymph nodes, and other parts of the body such as the liver and lungs
Part III: Patient Navigation for the Colorado Colorectal Screening Program

This section will pull concepts together to demonstrate how a CRC patient navigation program can work at your facility. You will learn specifics about implementing outreach, organizing screening, facilitating diagnosis and treatment, and transitioning patients into rehabilitation for colorectal cancer.

Certain aspects of patient navigation must be included in your program to provide each patient with the current standard of care. However, many other aspects of this program can be modified to address the needs of your local community. You can also utilize resources that you may already have in place in your clinic as well.
Clinic Enrollment Protocol

Community health clinics and hospitals enrolled in the Colorado Colorectal Screening Program shall provide primary care services to patients who are referred to the program for endoscopic colorectal screening.

The majority of clinics and hospitals enrolled in the program are members of the Colorado Community Health Network (CCHN), or Colorado Rural Health Centers (CRHC). Additionally, CCSP partners with other Federally Qualified Health Centers and charitable organizations who have primary care centers throughout the state.

Clinics who wish to enroll as a program partner will be considered on a case-by-case basis. Inclusion criteria is based on one or more of the following conditions:

1. Clinics and hospitals must provide primary care to clients who are eligible and referred to CCSP.
2. Clinics and hospitals provide care to the medically underserved in geographical regions and communities where a CCHN or CRHC is not currently established.
3. Clinics and hospital systems who provide endoscopic screening services within their system, agree to partner with other participating health clinics to provide screening when capacity is available and the need is identified.

The Program Director will make the final decision about clinic or hospital inclusion into the Program.
CCSP Patient Navigation Eligibility Criteria

The Colorado Colorectal Screening Program (CCSP) is a statewide program that partners with designated safety net hospitals and clinics to offer no-cost patient navigation services for colorectal screening to the medically underserved of Colorado. Patient navigators have become an essential component in preventive services, and especially colorectal cancer screening. Patient navigation for colorectal cancer screening has even been shown to improve bowel preps, which are necessary for an adequate colonoscopy to be performed.

Patient navigators educate patients about screening requirements and the procedure, provide barrier reduction assistance, coordinate care, assist with insurance enrollment; and help patients understand screening results. The program is coordinated through the University of Colorado Cancer Center, with funding support from the Cancer Cardiovascular and Chronic Pulmonary Disease (CCPD) Grants Program.

What services are provided?

- No-cost patient navigation for eligible patients
- Free regional trainings to all patient navigators and community partners
- Clinic outreach and patient support services
- Public outreach and education
- Systems-change assistance for clinics wanting to increase colorectal cancer screening rates

Patient eligibility criteria for no-cost patient navigation for colorectal screens are as follows:

- Lawfully present Colorado residents age 50 or older, or those under 50 with personal family history of colon cancer
- Uninsured, or insured through Medicaid, Medicare, or a private insurance
- Household income at or below 400% of the federal poverty level
- Patient in a partnering clinic
- Patient is symptomatic
CCSP Patient Navigation Eligibility Criteria

<table>
<thead>
<tr>
<th>Age Criteria</th>
<th>Inclusion Criteria</th>
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<tbody>
<tr>
<td>50 years and older (average risk)</td>
<td>Patient of a particular clinic</td>
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<tr>
<td>OR</td>
<td>AND</td>
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<tr>
<td>Younger than 50 with personal or family history of CRC, adenomas or a genetic syndrome</td>
<td>Income at or below 400% of the Federal Poverty Level</td>
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<td>Patient can demonstrate lawful presence in CO</td>
</tr>
<tr>
<td></td>
<td>Patient is eligible for screening according to USPSTF and the USMSTF CRC guidelines for CRC screening</td>
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</table>

Participating clinics are responsible for documenting eligibility information—including lack of coverage of endoscopic colorectal screening, and will be asked to present this information at the time of chart audit by CCSP. Patient of all payer sources (i.e., Medicaid, Medicare, Private Insurance, Self Pay) are eligible for patient navigation services for colorectal cancer screening if they meet the above stated criteria.

### 2017 Federal Poverty Guidelines

<table>
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<tr>
<th>Persons in Household</th>
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The Colorado Colorectal Screening Program uses federal poverty guidelines to determine eligibility. These guidelines are updated annually by the federal government.

*If your family contains more than 8 people, add $4,160 to each additional person*

*Source: [Obamacare.net](http://Obamacare.net)*
CCSP Navigation Services

Scheduling Screenings and Identifying Barriers

The Colorado Colorectal Screening Program reimburses clinics for eligible patients who have been successfully navigated through the colonoscopy screening process. Remember to schedule the screening at a time that allows the patient to complete the prep and procedure without interference in work schedules, important events, and so forth. In addition to scheduling the appointment, identify barriers that may impede either the prep or screening itself. Discuss workplace, childcare, transportation, language/cultural issues with the patient, and create solutions to overcome these barriers.

Pre-Screening Prep

For an accurate test, patients must undergo preparation for colonoscopy – a clear liquid diet plus the bowel prep. As a navigator, making sure the patient understands and complies with the screening prep is one of your most important tasks. Go over both the clear liquid diet and the bowel prep with the patient. After you explain the pre-screening prep with the patient, have the patient describe in their own words what the prep entails and why it is important for them to complete. You may need to further facilitate the prep by utilizing reminder cards or phone calls to increase compliance.

Screening

Depending on the barriers that were identified, your job as a navigator will vary for every screening. Remember to arrange for transportation assistance the day of the procedure as the patient may receive some sedation. Have a friend or family member drive the patient home, help them use public transportation, or arrange for another means of transport.

Post-Screening Follow-up

Contacting the patient after their procedure is important for many reasons. It allows you to confirm that they completed the screening, and gives you the opportunity to discuss any problems they may have encountered. You should also use this opportunity to discuss their results with them. Notifying patients about the result of the procedure is important even if the results are normal. Explain what the results mean, and when their next screening will need to occur.

Data Collection

CCSP uses data collected by patient navigators to show that CRC screening is effective, and that the program is effective in preventing colorectal cancer and saving lives. Each month, patient navigators upload data into a Survey Monkey tool that allows the program to track patient demographics, barrier reduction services offered, and clinical outcomes. It is vital that each clinic have one patient navigator designated to this task, as data collection is an integral component to the future success of CCSP.
Trainings for CCSP patient navigators are conducted through four envisioned modules:

1. Colorectal Cancer Education and Program Information for CCSP
2. Specialized Training about Colorectal Screening and Screening Outcomes
3. From Diagnosis Forward
4. Outreach

If at any time you feel that you and your clinic would benefit from a CCSP training, or if you would like trainings on additional topics, please contact our PN Coordinator, Kirstin Le Grice: Kirstin.LeGrice@ucdenver.edu

Free cultural competency trainings are also offered by the Cultural Competence Curriculum of the University of Colorado School of Medicine. Patient navigators will be informed of upcoming workshops and are always invited to attend them.
CCSP Navigation Services

Patient navigation services can be provided by one, or several people within a clinic. Screening preparation procedures may be explained to the patient by the pharmacist, while another person in the clinic assists with the patient’s transportation barriers. Furthermore, a third individual might be responsible for data collection. However, it is important that each clinic designate a program LIAISON who coordinates the navigation and evaluation activities. The following services are essential to successful navigation. Each clinic should complete this chart to avoid missing components of the navigation process.

<table>
<thead>
<tr>
<th>Navigation Service</th>
<th>Clinic Staff Member</th>
<th>Partner Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program LIAISON</strong> - individual who understands clinic, provider, endoscopy, pathology and other systems involved in providing Program related services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>In-Reach/Outreach</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Identification of clinic patients in need of screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Contact and educate eligible patients about screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Educating individuals who are current clinic patients as well as the community the clinic serves about colorectal screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Determine Insurance Coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Verify patient income and insurance status per routine clinic policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Verify patient lawful presence per routine clinic policy and using Affidavit HB-1023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Facilitate and Ensure the PCP Referral Form is completed by a Primary Care Provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Help patient apply for other financial assistance programs for patients such as Medicare, Medicaid and SSDI</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Explain the endoscopic procedure and its preparation to patients, ensuring they understand the importance of an adequate preparation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Explain GI system anatomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emphasize the medical need for colonoscopy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Barriers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ensure patients have transportation to and from screening and supportive care after</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Work with patients to overcome common barriers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Perform patient-driven risk stratification</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reminders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reminder calls to decrease no-show rates (start prep, appointment date)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reminder/tickler system for surveillance and follow-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Care Coordination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ensuring follow-up of colorectal screening results regardless if abnormal or normal screen - liaison between providers and patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Follow-up with patients about results of the procedure. Be sure they understand the results and when they should be re-screened, or how to access additional care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assist the patient with setting appointments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inform patient about who is the primary contact person if there are questions about eligibility, screening, post screening - including who to contact if patient is diagnosed with cancer or an adverse event occurs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Program Reporting Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Collection of data points for evaluation - outcomes and navigation services (how patient heard about program, time from diagnosis to treatment start, and rates of: 1) no-show, 2) appropriate prep 3) complete follow-up)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provide CCSP with regular “Verification of HB 06-1023 Certification for Payment Request” for payment for services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maintain files with patient specific data and records for fiscal and evaluation audits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Attend training sessions and participate in CCSP teleconferences for navigation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Raising Awareness for Colorectal Cancer Screening

Media

Media can be an effective way to reach out to the community. The extent of your media campaign will depend upon the media opportunities in your community and the budget available. CCSP will work with your clinic to coordinate media marketing efforts. Overall, be creative with the media you choose. This short video, called “JoJo Your Colon and You” is a great example of using media to increase colorectal cancer screening awareness!

In-Reach

It is essential that you use the resources available within your organization to recruit patients for colorectal screening. Make alliances with the providers and other screening programs at your location to ensure that they refer appropriate patients to you. Place your resources in areas where they are easily seen, like waiting rooms and patient examination rooms. For example, send birthday cards to patients who are turning 50 that also remind them to schedule a colorectal screening. Doing this will help increase patient awareness.

Community Outreach and Interaction

You also need to generate the interest of people within the community—so get out there and meet them! Whether you have a booth at a local fair, giver presentations to church groups, or use your media resources to advertise at various places, you need to get the word out. Here are some places to consider:

⇒ Churches
⇒ Community Action Organizations
⇒ Post Offices
⇒ Shopping Centers and Malls
⇒ Community Health Centers
⇒ Salons and Barber Shops

Check it Out!

Make It Your Own (MIYO) is an online tool that organizations can use to create FREE health messaging tailored specifically for their patient populations. With MIYO, your organization can create population specific in-reach and outreach tools like flyers, posters, web banners, and mailing inserts to help educate clinic patients and community members about the importance of timely colorectal cancer screening.
Raising Awareness for Colorectal Cancer Screening

Patient navigators strive to increase awareness of colorectal cancer and the utilization of screening services. This can be achieved through various interventions in your community. Outreach interventions can be large or small, depending on the funding available to you. The most common types of outreach interventions include: media, in-reaching, and community interaction. Key pieces of information you will want to educate your audience about, in both in-reach and outreach activities include:

- Importance of CRC screening
- Family History
- Risk Levels
- Screening modalities
- Screening Process
- Bowel Prep

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Media Education     | Utilize print material or other mechanisms to relay information to patients and generate interest in screening | ➞ Pamphlets, posters, flyers, fact sheets  
 ➞ Radio and TV spots  
 ➞ Newspaper/magazine ads and stories  
 ➞ Billboards, bus placards  
 ➞ Direct mailings sent to patients  
 ➞ Inserts placed into envelopes of other mailings  
 ➞ Materials made available in the community  
 ➞ Websites |
| In-Reach             | Use resources within your organization to increase patient interest in the colorectal screening program | ➞ Physician referrals (talk to your providers about the program, ask them to contact the program staff, or to visit our website)  
 ➞ One-on-one meetings after appointments  
 ➞ Direct telephone calls to patients  
 ➞ Working with other departments:  
   ➞ Breast and cervical cancer programs  
   ➞ Flu-shot clinic  
   ➞ Hypertension/blood pressure clinic  
   ➞ Diabetes clinic  
   ➞ Smoking cessation programs |
| Community Interaction| Placing yourself at locations within the community to provide colorectal cancer education and set up screening opportunities | ➞ Presentations  
 ➞ Interactive health fair displays  
 ➞ Partnership with other local organizations  
 ➞ Health groups  
   ➞ usually gender specific groups facilitated by navigators |
Determining Insurance Coverage

Patient navigation roles and responsibilities will differ by clinic, based on staffing and capacity. Some clinics have enrollment specialists that patient navigators can refer to. In other clinics, the patient navigator must determine a client’s insurance coverage, and help them enroll if they are uninsured. In the event that you must help determine your patient’s insurance coverage, there are three objectives to remember:

1) Help the patient determine what their insurance will cover
2) Identify what, if any, out-of-pocket expenses the patient may incur in regards to the screening and any follow-up that may be needed
3) Based on their insurance and income, determine if the patient is CCSP eligible

The following flowcharts can be used to help you determine insurance coverage and next steps for your patients:

- Insurance?
  - Yes
    - What Kind?
      - Medicare
        - Check for Supplement
          - Help patient check copays
            - Continue with navigation
        - Private Insurance
          - Confirm at or below 400% FPL
            - Help patient check copays
              - Continue with navigation
      - Medicaid
        - Continue with navigation
Education

Education is a critical component of patient navigation, and one of the most essential services a patient navigator can provide. Through proper education, patient navigators have the ability to increase not only awareness, but colorectal cancer screening rates as well.

**Educate your clinic patients and community members on...**
- The importance of colorectal cancer screening
- Colorectal cancer risk levels based on family history and genetic syndromes
- Recommended screening modalities
- Screening recommendations
- Screening intervals
- Bowel Preparation
- Screening process and instructions

**Educate the community about...**
- The importance of colorectal cancer screening
- Screening modalities available at your clinic
- Importance of a Healthy Lifestyle
- Screening intervals

---

**From outreach to screening...**

1. **Public Awareness through Outreach Activities**
2. **Patient Inquiry into Colorectal screening**
3. **Personalized Awareness**
4. **Determine Eligibility**
5. **Program Enrollment**
6. **Pre-Screening Prep**
7. **Screening**

---

Colorado Colorectal Screening Program: 2017 Patient Navigation Guidebook
Education: Bowel Prep

A good bowel prep is indicative of how well a patient was navigated through the colorectal cancer screening. Bowel preparation is a necessary step in the colorectal cancer screening process. A successful prep involves getting everything out of your colon. If a prep is done poorly, and there are traces of fecal matter left in the colon, the specialist will have trouble seeing polyps, and as a result, may miss them altogether.

There are many brands of bowel prep solution—it is your responsibility to know what prep your clinic utilizes, and what specific instructions must be followed. In addition to drinking the prep solution, your patient will need to follow a clear-liquid diet for 24-48 hours leading up to the procedure. It is imperative that you educate your patients on the importance of a good prep, and provide them with the tools they will need to prep successfully.

One week before the colonoscopy, place a reminder call to the patient to …
- Ensure patient is following their physician’s instructions regarding blood thinner medications
- Ensure patient has the bowel prep solution at home
- Read through the bower prep instructions with the patient

Two days before the procedure the patient must…
- Drink plenty of water
- Eat lightly
- Avoid bulky, fibrous foods such as:
  - Raw veggies, beans, peas, lentils
  - Wheat bran cereals and breads
  - Sweets
  - Fatty meats

The day before the colonoscopy the patient must…
- Follow a clear liquid diet:
  - Water
  - Clear broth
  - Clear fruit juice
  - Coffee or tea—no cream!
  - Plain gelatin
  - Popsicles
  - Soda
  - Sports drinks

The bottom line: on the day before a patient’s colonoscopy, EVERYTHING in the colon must come out!

Important!
Patients cannot drink any red, blue, or purple liquids.
**Bowel Prep**

The table below highlights the different bowel preps used for colonoscopies, DCBE, and virtual colonoscopies\(^2\). Before beginning a bowel prep, patients should discuss any existing health conditions with their physicians, as alternative prep techniques may be required. The physician will base the prep method on the patient’s medical history.

<table>
<thead>
<tr>
<th>Bowel Prep</th>
<th>How to use it</th>
<th>Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>Golytely or Colyte</td>
<td>Patients consume up to one gallon of a special salt solution over 4 hours (4 – 8 pm the night before the procedure) by drinking an 8 oz. glass of solution every 10 minutes until the gallon is finished.</td>
<td>Some people find it helpful to drink it chilled or through a straw placed far back in the mouth to minimize the taste</td>
</tr>
<tr>
<td>Magnesium Citrate with Bisacodyl Tablets + MiraLAX®</td>
<td>Patients combine MiraLAX®, an over-the-counter laxative, with 2 quarts of Gatorade. Splitting the does between the night before, and the morning of the procedure.</td>
<td>Patients need to continue to consume plenty of clear liquids during this prep to avoid dehydration.</td>
</tr>
<tr>
<td>MoviPrep</td>
<td>Patients take a PM</td>
<td>AM Split Dosing regimen, in which the first dose is taken the day before the procedure, and the second dose is taken the day of.</td>
</tr>
<tr>
<td>SUPREP Bowel Prep Kit</td>
<td>Patients will take a split dose 2-day regimen, taking the first 6oz bottle in the evening before the procedure at 6pm and the second 6oz bottle exactly 6 hours prior to the procedure.</td>
<td>Patients need to continue to consume plenty of clear liquids during this prep to avoid dehydration.</td>
</tr>
</tbody>
</table>

**Curious to see what a GOOD prep looks like? Click here!**

**Curious to see what a BAD bowel prep looks like? Click here!**
Bowel Prep 101

The day before your colonoscopy, you will need to stick to a strict liquid diet. To make the best out of the situation, be sure to have plenty of the following on hand:

- Water
- Soda (the bubbles trick your body into thinking it's full)
- Gatorade and Powerade
- Clear broth
- Jell-O
- Pulp-free juice
- Coffee & Tea
- Popsicles
- Honey

Avoid...

- Anything dyed red, purple, or blue
- Pulp
- Dairy and Creamers

A Few Tips:

- Have someone do the cooking so you don’t have to while you're taking the prep. That’s just mean!
- Avoid having guests over while you prep.
- Ask for some alone time. Have the kids spend the day at a friend’s house. Ask your husband or wife for privacy

Make Sure to Have:

- Have a book handy. You’ll be spending your day on the porcelain throne so you might as well have some company!
- The softest toilet paper money can buy.
- Baby wipes. Yes, you read that right
- Diaper rash cream. You’ll thank us.

Try Your Prep:

- After putting it in the freezer for 2 hours
- With a straw
- With Gatorade
- With Crystal Lite Powder
- With Sprite or 7-Up

Check it Out!

The Colon Cancer Alliance offers tips and tricks for a successful bowel prep here. Be sure to check out the sample prep guide on their website too!
Sample Bowel Prep Instructions: Denver Health

Getting Ready for Your Colonoscopy - 1 Day Prep

Once your colonoscopy has been scheduled, arrange for a responsible adult to sign you out after the procedure and take you home. You will not be allowed to drive or take public transportation without a responsible adult with you.

If your care provider has prescribed oxygen and you are supposed to wear it, you must bring your tank with you. Please be sure your tank is full or your exam will be cancelled.

- YOU MUST NOT EAT ANY SOLID FOOD THE DAY BEFORE YOUR TEST.
- Pick up a jug of COLYTE at your pharmacy after your exam has been scheduled. You will need a prescription.

How do I prepare?

Medicines: Continue ALL of your medicines except:
- If you take coumadin (Warfarin) ask your provider what you should do at the time the test is discussed.
- If you take iron pills, stop taking them five days before the exam.
- If you have diabetes and take insulin in the morning, give yourself half of your usual dose.
- If you take diabetes pills do not take them.

Bowel Prep: Day Before the Exam

1. Do not eat anything solid the whole day.
2. Start drinking lots of CLEAR LIQUIDS in the morning and all day. You may have any of these:
   - Water, bouillon, soda pop, Kool-aid®, coffee/tea (no milk or creamer), popsicle, Jell-O®, Gatorade®. Do not drink any red liquids.
   - Very important: You may not eat any solid food or drink alcohol for the entire day!
3. In the morning, fill the Colyte jug as written on the jug and place in the refrigerator.
   - At 5:00 pm start drinking a glass full every 15 minutes
   - Drink only 1/2 of the jug. Keep the rest in the refrigerator.
   - You may have explosive diarrhea. BE NEAR A BATHROOM.
   - If you feel sick, slow down drinking but finish 1/2 of the jug of Colyte
   - You should continue drinking clear liquids freely through the evening and night

Bowel Prep: Day of the Exam

- Drink the rest of the Colyte 4 hours before you are to arrive. This should be done within 1 hour.
- You may drink clear liquids until 2 hours before you arrive then stop!
- Take your morning medicines with sips of water 30 minutes after finishing your Colyte

Report to Pavilion M, 725 Delaware Street, at the time instructed.

Who do I call if I have questions or problems?

Call the Denver Health NurseLine at (303) 739-1211 any time day or night.

Special instructions: ________________________________
CCSP Evaluation

Evaluation is a key component of the Colorado Colorectal Screening Program. Consistent evaluation of CCSP’s patient navigation services allows us to ensure that the program is positively impacting its patient population and effective in preventing colorectal cancer. CCSP gathers data on screening population characteristics—namely age, ethnicity, screen reason, results—and data on the barrier reduction methods used by our navigators to ensure that patients complete the screening process. Furthermore, programmatic evaluation of CCSP also allows us to ensure that we are achieving our screening goals.

2016 CCSP Evaluation Results
CCSP Evaluation: Aggregate Data Tool

Figure 1: Evaluation Data Collection Form

<table>
<thead>
<tr>
<th>Month</th>
<th>16-Feb</th>
<th>16-Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # Clients Navigated by Clinic</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td># CCSP Eligible Clients Navigated</td>
<td>22</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>10</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>1</th>
<th>21</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>66+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Eth</th>
<th>18</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
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</table>

<table>
<thead>
<tr>
<th>Payer Source?</th>
<th>22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td></td>
</tr>
<tr>
<td>Private Insurance</td>
<td>0</td>
</tr>
<tr>
<td>Uninsured</td>
<td>0</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Screen Reason</th>
<th>1</th>
<th>21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveillance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptomatic</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Follow-Up to FIT/FOBT</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Screening Only (Asymptomatic)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family History</th>
<th>21</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Known Family Hx</td>
<td></td>
</tr>
<tr>
<td>First Degree History of Adenomatous Polyps</td>
<td>0</td>
</tr>
<tr>
<td>First Degree History of Colon Cancer</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prep Quality</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate</td>
<td></td>
</tr>
<tr>
<td>Not Adequate</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cecum Reached</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Screen Outcomes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients with an adenoma removed</td>
<td></td>
</tr>
<tr>
<td>Clients with cancer detected</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appointment Attendance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment Kept</td>
<td></td>
</tr>
<tr>
<td>Appointment Not Kept (No Show)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referrals</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td># Referred to WWC or CHHS</td>
<td></td>
</tr>
<tr>
<td># Referred to CCSP from WWC or CHHS</td>
<td></td>
</tr>
</tbody>
</table>

Clinical and Process-Related Outcomes

CCSP strives to ensure that Patient navigators are able to collect and submit program data efficiently and hassle free. Recently, the program began utilizing Survey Monkey as its data collection tool, which has been found to be more user friendly and has helped streamline the reporting process for clinics.

Data is to be collected and reported each month. These include:

⇒ Total number of patients navigated for CRC screening
⇒ Total number of eligible CCSP patients navigated
⇒ Client demographics
  ⇒ Age
  ⇒ Race/ethnicity
  ⇒ Payer source
  ⇒ Screen reason
  ⇒ Family history
⇒ Data from exam or pathology report
⇒ Appointment attendance
⇒ Referrals to or from other programs
CCSP Evaluation: Aggregate Data Tool

CCSP will provide a data collection template with all the variables you are asked to report. Your clinic may decide to design your own tracking template, but you will be responsible for a specific set of variables at the time of an audit. Some clinics may need to work with their IT or EMR groups to extract the necessary data.

To count how many clients you are navigating through CRC screening in total

If a client is CCSP eligible you will need the rest of the data points for that client

Screen data to help reporting by month

Client name or HRN for internal clinic use only – this allows you to keep track of individual clients who may need follow-up and will help when the Program does audits. You do not report this column.

CCSP Evaluation: Survey Monkey

Click here to access the FY2018 Survey Monkey form!
## CCSP Evaluation: Survey Monkey

### Screen Reason

**Surveillance:** they’ve been screened and had a precancerous or cancerous finding  
**Symptomatic:** they are being screened because they display any major symptoms indicative of colon cancer  
**Follow-Up to FIT/FOBT:** they had a positive FIT/FOBT  
**Screening Only:** they are truly a screen – no symptoms, no personal history, no previous positive FIT/FOBT

**Family History (FamHx):** a 1<sup>st</sup> degree relative (mother/father, sister/brother, child) of the client has been diagnosed with colorectal cancer or adenomatous polyps. If the client has 1<sup>st</sup> degree relatives with both CRC and adenomatous polyps enter client at FamHx CRC. If no known family history, indicate as such.

### Results

**Prep Quality:** adequate/not adequate as described in the endoscopy report  
**Cecum Reached:** yes/no as described in the endoscopy report. If the report specifies that scope was advanced to the ileocecal valve and/or terminal ilium was visualized indicate *Yes*. If exam was terminated because of poor prep or poor visualization indicate *No*.

**Screen Outcomes:** If a biopsy was taken and pathology came back as adenomatous, indicate Adenomatous polyp. If biopsy was taken and pathology came back as cancerous, indicate Cancer. If both, indicate as Cancer. If pathology came back as hyperplastic or no abnormality, you do not need to report that.

### Referrals

We are tracking how many clients are enrolled in multiple programs through the work of our trained PNs. If you referred a client to WWC, CHHS or DPPE after enrolling them in CCSP, please keep track of that. If a client was referred to CCSP from WWC, CHHS or DPPE, please keep track of that.
Sample Endoscopy Report

You will need to refer to the endoscopy report to find the following data:

- Age
- Family History
- Symptom Status
- Prep Quality
- Secum Reached

Sometimes endoscopy reports contain images. These images should be clearly labeled. Always consult your GI provider if you have questions about the endoscopy report.
Sample Pathology Report

A pathology report will only exist if polyps were removed during the colonoscopy and biopsied. The pathology report will tell you two key pieces of information:

1) Were the polyps adenomatous
2) Were the polyps cancerous?

Always consult your GI provider if you have questions about the endoscopy report.

---

Final Surgical Pathology Report

Accession #: 1
Name: 
DOB: 
MRN: 
Billing No.: 
Collect Date: 03/02/2011

Req. Dr.: 
Att. Dr.: 
Ward: 
Rec'd Date: 03/02/2011

Copy to: BILLING DEPT. SALUD

A) GI BIOPSY
B) GI BIOPSY
C) GI BIOPSY

Final Diagnosis:
A. SIGMOID COLON, POLYPS X 2, POLYPECTOMY:
   - TUBULAR ADENOMAS.
B. ASCENDING COLON, POLYPS X 2, POLYPECTOMY:
   - TUBULAR ADENOMAS.
C. ASCENDING COLON, MASS, BIOPSY:
   - TUBULOVILLOUS ADENOMA (SEE COMMENT).

Comment:
The ascending colon biopsy (C) is fragmented, precluding evaluation of margins. No high-grade dysplasia or invasive component is identified in this biopsy. Clinical correlation is necessary.
CCSP Evaluation: Reporting Results

Adequacy of Colonoscopy
An adequate colonoscopy is defined as reaching the cecum and having colonic preparation sufficient to visualize 90% of the colonic mucosa. The colonoscopy procedure report should detail whether the cecum was reached and whether the endoscopist visualized the colonic mucosa adequately.

Findings of Colonoscopy: The report of optical colonoscopy findings including polyp(s), mass, lesion/tumor, other lesions (hemorrhoids, diverticular disease, varices, inflammatory bowel disease [ulcerative colitis and Crohn’s disease of the colon]). These Include:

- Number of lesions
- Description
  - (e.g., flat, raised, sessile, pedunculated, bleeding, irregular, etc.),
  - size, and location of each lesion seen
- Whether there was:
  - Biopsy during colonoscopy with removal of entire lesion(s);
  - Biopsy without removal of entire lesion(s);
  - No biopsy during colonoscopy;
  - Other management of polyp/lesion (tattoo of site; saline lift prior to biopsy, etc.)
- Whether or not an additional surgery or procedure is needed.

Endoscopist’s recommendation
This includes a recommended date for the next colonoscopy or other testing based on the adequacy of the colonoscopy, optical findings, results of pathology, and the client’s risk category. If the recommendation depends on the results of the histologic evaluation of a polyp, the endoscopist should provide recommendations based on the pathology results. The precise recommendation will sometimes not be available in the colonoscopy report as it is generated prior to the pathology report, so encourage the endoscopist to provide recommendations.

Pathology Report
A polyp or lesion is classified by standard pathologic criteria and should include the following:

- Type of polyp or lesion: tubular adenoma; villous adenoma; tubulovillous adenoma; serrated adenoma; hyperplastic polyp; other (mucosal polyp, inflammatory, pseudopolyp, submucosal polyp [lipoma, carcinoid, metastatic tumor, etc.]).
- Degree of dysplasia: low-grade dysplasia (mild dysplasia, moderate dysplasia), high-grade dysplasia (including severe dysplasia, carcinoma in situ, and intramucosal carcinoma).
- Presence of involvement of stalk/margin: If neoplasia (adenoma or cancer) is present, determine whether the stalk or margin of the specimen is free of involvement.

Note: This applies to larger polyps removed by snare excision. It is often not possible to evaluate the margins of small polyps removed by biopsy alone.
CCSP Evaluation: Reporting Results

An invasive carcinoma on biopsy or polypectomy specimen should be classified as follows:

**Differentiation**
- Note whether the carcinoma is well, moderately, or poorly differentiated
- If carcinoma is arising in adenomatous polyp:
  - Presence or absence of lymphatic/vascular invasion
  - Margins: Note whether the margin is involved; distance of the carcinoma from the margin/stalk, or distance of the carcinoma from the cauterized margin of the specimen.

**Stage of disease**
- Based on biopsy results, diagnostic tests, surgical findings, and pathology, the stage of disease should be determined for the individual patient. This should include the American Joint Committee on Cancer (AJCC) staging by TNM classification of the tumor, nodes, and metastases.

**Treatment**
- Based on the findings on colonoscopy or other screening/diagnostic tests and the further evaluation, the usual and customary treatments are recommended by the medical care provider(s) on a case-by-case basis:
  - No further treatment necessary
  - Ablation or excision of lesions during colonoscopy
  - Surgery
  - Chemotherapy
  - Radiation Therapy

**Follow-up of Colonoscopy and Other Testing:**
- Inadequate Colonoscopy
  - If a provider determines that a colonoscopy is inadequate, the provider should determine if and when additional procedures are necessary to complete screening for CRC (repeat the colonoscopy, do a DCBE, etc.).
- Surveillance Recommendations
  - CCSP, under the recommendation of the [US Multi-Society Task Force on Colorectal Cancer](https://www.cancer.org), has adopted the following surveillance guidelines for colonoscopy surveillance after polypectomy and cancer resection: following a 1-year colonoscopy, the patient should receive a surveillance colonoscopy after 3 years, and another after 5 years (9 years post surgery).
CCSP Billing and Reimbursement

Partner clinics of the Colorado Colorectal Screening Program receive reimbursement for each eligible patient that is successfully navigated through the colorectal screening process.

In order to receive this reimbursement, clinics must submit two things to the program's finance manager:

1) Certification of Verification:
   - This document certifies that the patients navigated are lawfully present in the United States. Every patient submitted on this form must have an affidavit on file.

1) Billing Invoice
   - This document indicates the number of patients for which you are requesting reimbursement from the program

Additionally, clinics may submit barrier reduction reimbursement forms to the program. As of July 1, 2017, clinics are required to submit receipts with their barrier reduction forms. CCSP often reimburses clinics for barrier reduction efforts such as, but not limited to:

- Purchasing bowel prep for patients
- Paying for a patient’s cab fare or gas
- Paying for a hotel room so that a patient has somewhere to stay while doing the bowel prep. *This barrier reduction practice is often used to help homeless patients prepare for the procedure.*
- Paying for child care or elder care so that the patient may complete the procedure
- Paying for a day of missed work if the patient does not receive sick-leave from their place of employment

Forms must be submitted to the program’s finance manager by the 10th of the following month. For example, all June paperwork must be submitted by July 10th, all July paperwork must be submitted by August 10th and so forth.

These forms can be found on the following three pages.
Billing Invoice Form

Provider:
Clinic Name
Address
City, State, Zip

Invoice# ______________________________

Services Provided: **Patient Navigation**

Month Services Provided: ____________________________

Date Submitted: ____________________________

Prepared by: ____________________________

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Description of Services</th>
<th>Rate</th>
<th>Amount Due</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient Navigation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$ -

$ -

TOTAL AMOUNT DUE: $ -

The undersigned hereby certify that pursuant to CRS 24-76.5-103 have verified that pa-
eighteen years of age or older who we are referring for health services to be funded by
appropriated funds (a) have provided appropriate identification (b) have executed the
affidavit, and (c) are lawfully present in the United States, and we are able to supply evi-
of the above if so requested by you or any agency of the State of Colorado

Signed ____________________________

Date ____________________________
Certification of Verification

CERTIFICATION OF VERIFICATION UNDER CRS 24-76.5-103

We, ____________________________, hereby certify that pursuant to CRS 24-76.5-103 have verified that the patients eighteen years of age or older who we are referring for health services to be funded by state appropriated funds (a) have provided appropriate identification (b) have executed the required affidavit, and (c) are lawfully present in the United States, and we are able to supply evidence of the above if so requested by you or any agency of the State of Colorado.

Signature: ____________________________

Date: ______________

Print Name: ____________________________

Signature: ____________________________

<table>
<thead>
<tr>
<th>Patient Encounter ID#</th>
<th>Patient Encounter ID#</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Screening Service Provider(s): ____________________________

Month/Year Service Provided: ____________________________

Number of Patients Certified: ____________________________
## Barrier Reduction Invoice Form

**Provider:** [Clinic Name]  
**Address**  
**CHC:** [Clinic Name]  
**Address**  
**Address**  
**Invoice #**  
**Terms:** Due Upon Receipt

### Dates of Services Provided (mm/dd/yy)

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
</table>

**Date Submitted:** [ ]  
**Prepared:** [ ]

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Description of Services</th>
<th>Rate</th>
<th>Amount Due</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Barrier Reduction (Please check which category)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Bowel Prep</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Lodging</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Co-pays for screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Translation services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All receipts should be kept on file at clinic

**Total Amount Due:** $
Policies and Procedures to Verify Citizenship or Legal Resident Status for Colorado House Bill 10-1023

Figure 3a: HB1023 Affidavit Page 1

HB1023 AFFIDAVIT

I, ______________________, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one):

___ I am a United States citizen, or
___ I am a Permanent Resident of the United States, or
___ I am lawfully present in the United States pursuant to Federal law.

I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

__________________________  ____________
Signature                  Date
The following forms of identification are acceptable for compliance with proof of lawful presence within the United States, effective August 1, 2007. Any document that is presented must have, or be accompanied with, an unexpired state or federal form of photo identification.

For U.S. Citizens and Permanent Residents (check document provided):

__Unexpired Colorado Driver’s License. A valid Colorado driver’s license includes only a current driver’s license, minor driver’s license, probationary driver’s license, commercial driver’s license, restricted driver’s license, or instruction permit. In the case of a resident of another state, the driver’s license or a state-issued identification card from the state of residence, if that state requires that the applicant prove lawful presence prior to issuance of a document. Currently, states that do not require lawful presence checks and are not acceptable: AK, HI, IL, MD, MA, MI, NE, NM, NC, OR, TN, TX, UT, VT, WA, WI.

__Unexpired Colorado Identification Card issued by Dept. of Motor Vehicles.

__Unexpired United States Military Card

__Unexpired United States Military Dependent Identification Card

__Unexpired United States Coast Guard Merchant Mariner Card

__Copy of applicant’s birth certificate from any state, the District of Columbia and all United States territories. U.S. Territories include American Samoa, Federated States of Micronesia, Guam, Midway Islands, Puerto Rico and US Virgin Islands.

__United States Passport, except for “limited” passports issued for less than five years

__Report of Birth Abroad of a US Citizen, form FS-240

__Certificate of Birth issued by a foreign service post (FS-545) or Certification of Report of Birth (DS-1350). These are available from the Department of State.

__Certificate of Citizenship (N-560 or N-561). This document is issued to those persons who derive U.S. Citizenship through a parent. The N-561 is issued upon loss or damage of the original document or following an individual’s name change.

__U.S. Citizen Identification Card (I-97). These were last issued in 1974.
__Northern Mariana Identification Card. Those born in the Northern Mariana Islands prior to November 3, 1986 were collectively naturalized.

__Statement provided by a US consular officer certifying that the individual is a US citizen. (This document is provided to an individual born outside the US who derived citizenship through a parent but does not have form FS-240, FS-545 or DS-1350.)

__American Indian Card with Classification code “KIC” and a statement on the back identifying US Citizen members of the Texas Band of Kickapoo.

__Certificate of Naturalization (N-550 or N-570).

__INS Form I-51 (Alien Registration Receipt Card), commonly called or known as a “green card” or INS Form I-551 (Alien Registration Receipt Card), commonly known as the “Green Card” with the code CB, CU, or CH.

__Unexpired Temporary I-551 Stamp in foreign passport or on INS Form I-94 or

__Unexpired temporary I-551 stamp in foreign passport or on INS Form I-94 with the code CB, CU, or CH.

For those with Immigration Documents (check document provided):

__INS Form I-94 annotated with stamp showing grant of asylum under section 208 of the Immigration and Nationality Act (INA) or

__INS Form I-94 annotated with stamp showing admission under Section 207 of the INA or

__INS Form I-94 with stamp showing admission for at least one year under Section 212(d)(5) of the INA. (Applicant cannot aggregate periods of admission for less than one year to meet the one-year requirement)

__INS Form I-94 with stamp showing admission under Section 203(a)(7) of the INA or

__INS Form I-94 with stamp showing parole as “Cuba/Haitian Entrant” under Section 212(d) (5) of the INA.

__INS Form I-866B (Employment Authorization Card) annotated “274a 12(a)(5)” or

__INS Form I-866B (Employment Authorization Card) annotated “274a 12(a)(3)” or

__INS Form I-866B (Employment Authorization Card) annotated “274a 12(a)(10)” or

__INS Form I-866B (Employment Authorization Card) annotated “A3”

__INS Form I-776 (Employment Authorization Document) annotated “A5” or Grant Letter from the Asylum Office or INS or

__INS Form I-776 Employment Authorization Document) annotated “A10” or

__INS Form I-768 (Employment Authorization Document) annotated “A3”.

__INS Form I-571 (Refugee Travel Document).

__Order from an immigration Judge showing deportation withheld under Section 243(h) of the INA as in effect prior to April 1, 1997, or removal withheld under Section 241(b)(3) of the INA.

Applicant has presented acceptable proof of lawful presence not listed above. Please describe the proof presented here:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________


FOR OFFICE USE ONLY:

1. Make certain type of ID is checked.
2. Provide date of expiration of document:
3. Date form accepted:
4. Accepted by (initials):
Policies and Procedures to Verify Citizenship or Legal Resident Status for Colorado House Bill 10-1023

CCSP provides reimbursement of patient navigation services for completed colorectal screening to lawfully present residents of Colorado ages 50 and older, who are at or below the 400% of the federal poverty level. Funded by money collected from Amendment 35, CCSP is subject to HB 06-1023. This bill provides a state scheme for the verification of citizenship/legal alien status of persons eighteen years of age and older before they receive certain public benefits including the services provided under CCSP. The policy and procedures to carry out this verification for CCSP are outlined below.

Verification and Certification Policy

Community clinics must verify citizenship/legal resident status prior to referring patients for screening and provide CCSP certification of that verification. Community clinics must certify patients’ citizenship/legal resident status prior to CCSP paying for navigation services. The clinic must:

- Review identification in the form of
  - A valid Colorado driver’s license or a Colorado identification card
  - A U.S. military care card or a dependent’s identification card
  - A U.S. Coast Guard Merchant Mariner card or
  - A Native American tribal document

And
- If the patient is a resident of another states, the driver’s license or state-issued identification card from the state of residence. States that do not require lawful presence checks and whose driver’s licenses are not acceptable are:

<table>
<thead>
<tr>
<th>State</th>
<th>State</th>
<th>State</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>Massachusetts</td>
<td>North Carolina</td>
<td>Utah</td>
</tr>
<tr>
<td>Hawaii</td>
<td>Michigan</td>
<td>Oregon</td>
<td>Vermont</td>
</tr>
<tr>
<td>Illinois</td>
<td>Nebraska</td>
<td>Tennessee</td>
<td>Washington</td>
</tr>
<tr>
<td>Maryland</td>
<td>New Mexico</td>
<td>Texas</td>
<td>Wisconsin</td>
</tr>
</tbody>
</table>

Benefit agencies may also accept the listed forms of identification published by the Office of the Federal Register, National Archives and Records Administration, in the full Code of Federal Regulations (CFR) governing the specific services provided. In the absence of specific governing CFR regulations, Benefit Agencies shall accept the listed forms of identification published in Attorney General’s Order Number 2129-97 Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility Under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as issued by the Department of Justice, Federal Register, November 17, 1997, Vol.62, No. 221, and which are incorporated by reference. Attachments A and B provide lists of documents acceptable per this Federal publication.
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- Review identification in the form of
  - A valid Colorado driver’s license or a Colorado identification card
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  - A U.S. Coast Guard Merchant Mariner card or
  - A Native American tribal document

And

- If the patient is a resident of another state, the driver’s license or state-issued identification card from the state of residence. States that do not require lawful presence checks and whose driver’s licenses are not acceptable are:

<table>
<thead>
<tr>
<th>Alaska</th>
<th>Hawaii</th>
<th>Illinois</th>
<th>Maryland</th>
<th>Massachusetts</th>
<th>Michigan</th>
<th>Nebraska</th>
<th>New Mexico</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>Oregon</td>
<td>Tennessee</td>
<td>Texas</td>
<td>Utah</td>
<td>Vermont</td>
<td>Washington</td>
<td>Wisconsin</td>
</tr>
</tbody>
</table>

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- Materials incorporated by reference in this rule do not include later amendments or editions of the incorporated material. These may be obtained by contacting the Director, Motor Vehicle Division of the Department of Revenue. Copies of materials may also be examined at any state publication depository library. Certified copies shall be provided at cost upon request.


Have the patient execute an affidavit that states that they are a U.S. citizen, a lawful permanent resident, or that they are otherwise lawfully present in the U.S. pursuant to federal law. The affidavit does not need to be notarized.

If a patient does not have one of the appropriate forms of identification listed above or in Attachment A or B (See Appendix B), the patient should be instructed to contact the Department of Revenue (DOR) to complete a waiver application. The individual will be required to provide as much proof of identity and lawful presence as they can.

It is not necessary to make or maintain a copy of the identification document provided. However, the clinic must note which form of identification was provided, which note can be made in the space provided on the affidavit form.

Any applicant who indicates on their affidavit that they are an alien lawfully present in the U.S., but is not a U.S. citizen or Permanent resident must be verified through the federal Systematic Alien Verification of Entitlement Program (SAVE program). Each clinic must register and set up an account by going to https://save.uscis.gov/Registration/. For additional information call (202)272-8720 or go to SAVE website. The charge for accessing SAVE is $25.00 per month. Inquiries that exceed the $25.00 limit are $0.26 per inquiry. If no inquiry is completed during the month, there is no charge.

Any individual that presents a clearly fraudulent piece of identification will not eligible to participate in CCSP. If you have any questions regarding the acceptability of any identification document provided to you, please contact CCSP.

The clinic must maintain a list of all patients participating in CCSP who have been verified as legal Colorado residents.

The clinic must retain copies of the signed affidavits in the event it is necessary to demonstrate compliance with provisions of HB 06-1023. Clinics must agree to a review of those records if necessary.

Procedures for Certification of Verification

Clinics will provide a signed Certification of Verification under CRS 24-76.5-103 form for patients enrolled and screened through CCSP to their screening service providers on a monthly basis, or less frequently if only an occasional screen is carried out.

Certification of Verification is used when your clinic also provides the screening services (endoscopy/bowel prep).
Part IV: Resources for Patient Navigation

The following section contains resources which may be helpful for your patients. By no means is this a complete resource. You may be aware of additional resources that are available in your community. Identifying and leveraging resources to help patients is truly a communal effort between the Patient navigator, patient, and community.
# Sample Job Description: Patient Navigator

**Job Description**

**Non-Management (Patient Care)**

<table>
<thead>
<tr>
<th>Job Title:</th>
<th>Patient Navigator II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department:</td>
<td>Community Health Services</td>
</tr>
<tr>
<td>Mgt Approval/Date:</td>
<td>1/11/11 Whitley</td>
</tr>
<tr>
<td>HR Approval/Date:</td>
<td>1/11/11 MV</td>
</tr>
<tr>
<td>Job Code:</td>
<td>DZZC3204</td>
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<tr>
<td>FLSA Status:</td>
<td>Non-exempt</td>
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<tr>
<td>Salary Class:</td>
<td>H - Hourly</td>
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<tr>
<td>EE04 Code:</td>
<td>05-Para-Professional</td>
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<tr>
<td>HR Occ Class:</td>
<td>500 CommHealth</td>
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<tr>
<td>Job Class:</td>
<td>CPT</td>
</tr>
<tr>
<td>Reports To:</td>
<td>Director or Program Manager</td>
</tr>
<tr>
<td>Grade Sch:</td>
<td>NonExempt</td>
</tr>
</tbody>
</table>

The following statements are intended to describe the general nature and level of work being performed by people assigned to this job. They are not intended to be an exhaustive list of all responsibilities, duties, and skills required of personnel so classified.

**JOB SUMMARY:** Under general supervision, provides basic care coordination, identifies and reduces barriers to care, provides referrals to necessary resources.

**MINIMUM QUALIFICATIONS:**

**Education:** High School Diploma or GED.

**Experience:** Typically requires at least one year of community involvement and/or working with clients, or an equivalent combination of education and experience.

**Knowledge, Skills & Abilities:** Knowledge: Basic care coordination, knowledge of community resources.

Skills: Establish and maintain rapport and a therapeutic relationship, Communication and motivational interviewing, Uses computers, including Microsoft Outlook, Word, PowerPoint, Excel, SharePoint, GoldMine, scheduling software as well as perform Web searches for clients, BLS.

Abilities: Bilingual English/Spanish or English/other languages preferred.

**Certificate/License/Registration:** Certificate of completion from the Community College of Denver Community Health Worker program and/or the Patient Navigator Training Collaborative at the University of Colorado, or an equivalent combination of education and experience.

**ESSENTIAL DUTIES & RESPONSIBILITIES:** List each job duty and responsibility that is essential to performing the job successfully, efficiently and safely.

70% Care Coordination
- Follows standard work
- Establishes rapport and therapeutic relationship
- Orient patients to the agency and program
- Communicates in an understandable manner and monitors clients’ understanding
- Assesses patient needs
- Uses knowledge of client’s cultural, ethnic, religious and social system to develop and revise care/action plan
- Identifies and assists clients in reducing barriers to care and implementing and adhering to plan
- Arranges follow-up

10% Communication and participation with Health Care Team
- Communicates client plans and concerns to healthcare providers
- Orders needed labs and tests following protocol
- Participates in clinic/setting specific meetings and initiatives
- Teaches Healthy Living classes

10% Documentation
- Data is accurate, complete and entered within 24 hours of client interaction
Sample Job Description: Patient Navigator

8% Resource referral and acquisition
- Provides clients and families with factual and appropriate information and education in understandable manner
- Refer and assist clients in accessing needed resources to meet identified needs (including grant applications, medication assistance, transportation, behavioral and substance abuse treatment, etc.)
- Promotes positive interpersonal (customer) relationships with fellow employees, physicians, patients and visitors. Treats these individuals with courtesy, dignity, empathy and respect; consistently displays courteous and respectful verbal and non-verbal communications.
- Adheres to, complies with and demonstrates support for the mission and values of Denver Health. Supports and adheres to the Denver Health Dozen.
- Ensures confidentiality of patient information by creating and maintaining a secure and trusting environment by not sharing information learned on the job, except when necessary in the performance of the job responsibilities or to improve a patient’s care.
- Has regular and predictable attendance.

For Patient Care Positions:
- Ensures all duties, responsibilities and competencies are conducted in a manner that is effective and appropriate to patients/clients to whom care/service is being provided.
- Demonstrates knowledge and applicability of the principles of growth and development over the life span, as well as demonstrating the ability to assess data reflecting the patient’s status and interpreting appropriate cultural information of the patient(s) to whom care/services is being delivered/provided.
- Employee has completed and met their clinical competency standards.

NON-ESSENTIAL DUTIES & RESPONSIBILITIES: This section should include any job duties considered marginal or not essential to the purpose of the job.

2% Performs other duties as assigned.

ADMINISTRATIVE RESPONSIBILITIES: Check the item(s) that are administrative responsibilities of this position, if applicable: ☒ Not Applicable ☐ Instructing ☐ Assigning Work ☐ Reviewing Work ☐ Assessing Performance ☐ Hiring/Terminating ☐ Disciplining

DEGREE OF SUPERVISION RECEIVED: ☐ Close ☒ General ☐ Minimal

PERSONNEL SUPERVISED (Titles and Approximate Numbers): ☒ None

INTERNAL/EXTERNAL CONTACTS: Patients, families, providers, administrative staff, community based organizations

POPULATION SPECIFIC STAFF: ☐ Yes ☐ No
(Check YES, if this job requires interaction with patients, families, and/or visitors. If YES, complete the population specific competencies at the employee’s home department.)

ADA CHECKLIST – Select the following requirements that are essential (not marginal) for the incumbent to perform this job successfully, efficiently and safely.

| Physical and Mental Requirements: Place the appropriate “Amount of Time” code for each of the following: | 0 = None; 1 = less than 1/3; 2 = 1/3 to 2/3; and 3 = more than 2/3 |
|---|---|---|---|
| PHYSICAL: 3 Lifting < 10 lbs - Light | 1 Lifting 10 - 20 lbs - Light-Med | 0 Lifting 41 - 80 lbs - Med Heavy | 0 Lifting > 120 lbs - Very Heavy | 0 Pushing/Pulling < 20lbs | 0 Push/Pull 20 - 50 lbs | Other: Describe: |
| ACTIVITIES: 3 Sitting | 1 Standing | 0 Kneeling | 0 Squatting | 1 Walking (Distance) | 1 Climbing (Steps, etc.) | 1 Reaching (overhead, extensive, repetitive) |
| MENTAL/SENSORY: 3 Strong Recall | 3 Reasoning | 3 Problem Solving | 3 Hearing | 2 Seeing/Sight | 3 Talk/Speak Clearly | 3 Write legibly |
| EMOTIONAL: 3 Fast pace environment | 1 Steady pace | 3 Able to handle multiple priorities | 3 Frequent & intense customer interactions | 3 Able to adapt to frequent change | 1 Works under deadlines | 3 Process complex info |
# Sample Job Description: Patient Navigator

## Environmental Requirements
Place the appropriate “Amount of Time” code for each of the following:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Code 0</th>
<th>Code 1</th>
<th>Code 2</th>
<th>Code 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood and body fluids</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Biohazards (e.g., bacteria, funguses, viruses)</td>
<td></td>
<td></td>
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<tr>
<td>Radiation (ionizing, laser, microwave)</td>
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<tr>
<td>Toxins, cytotoxins, poisonous substances</td>
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</tr>
<tr>
<td>Chemicals</td>
<td></td>
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<tr>
<td>Hazardous materials other than blood and body fluids</td>
<td></td>
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</tr>
<tr>
<td>Communicable disease</td>
<td></td>
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</tr>
<tr>
<td>Combative situations</td>
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<td></td>
</tr>
</tbody>
</table>

## Environmental Requirements: Daily Activities

- Continuous keyboard use > 2 hrs or intermittent keyboard use > 4 hrs
- Performance of same motion/motion pattern every few seconds greater than 2 hours at a time
- Vibrating or impact tools/equipment greater than a total of 2 hrs
- Forceful hand exertions greater than a total of 2 hrs

## Type of protective clothing, equipment, hand or power tools, vehicles and machinery used:

## Decision-Making Authority
Check the item below that comes closest to describing the decision-making authority required in this position:

- Decisions are made within limits of clearly established policies, procedures, or instructions.
- Decisions are made requiring limited interpretation of policies, procedures, or instructions.
- Decisions are made requiring broad interpretation of policies, procedures, or instructions.
- Decisions are made which modify previously held or create new policy interpretations.
- Decisions are made on issues that initiate new organization wide policy.

## Provide a signed copy of the Job Description to the employee and place the originally signed copy in the Supervisor’s Desk File.

<table>
<thead>
<tr>
<th>Field</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee’s Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee’s Signature</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor’s Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor’s Signature</td>
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</tbody>
</table>
Patient Navigation Training and Education

The Colorado Patient navigator Training Collaborative offers a full curriculum designed to build Patient navigator skills and knowledge. Courses and workshops relate to issues navigators deal with every day and are taught by patient navigation experts. A variety of formats make it easy to incorporate training into a patient navigator’s busy schedule. Formats include:

- Face-to-face workshops
- Online courses
- Self-paced online tutorials
- Special-topic webinars

The Patient Navigator, Community Health Worker & Promotor de Salud Alliance promotes policies, programs and partnerships that: reduce and eliminate barriers to quality health care both within health systems and the community; reduce disparities in health outcomes; and foster ongoing health equity. The Alliance believes that every Coloradan has an equal opportunity to obtain healthcare that personally addresses their medical, mental, emotional, social determinants, and spiritual health needs. The alliance holds quarterly meetings throughout Colorado, and has created a resource portal to patient navigators to utilize.

The Association of Community Cancer Centers (ACCC) provides an online resource, Cancer Care Patient Navigation: A Call to Action, to assist with patient navigation services, offering a continuing education activity, practical guide for community cancer centers, ACCC guidelines for patient navigation and tools.

The Harold P. Freeman Patient Navigation Institute teaches the skills of successful patient navigation and has serves leading organizations such as the Leukemia and Lymphoma Society, Cleveland Clinic, and the Ralph Lauren Center for Cancer Care and Prevention. The institute provides training programs that increase patient navigation efficiencies, and supports retention rates of patients via patient navigation.

The National Cancer Institute, Center to Reduce Cancer Health Disparities seeks to reduce cancer health disparities by assisting with timely access to cancer care for all Americans.
The American Cancer Society, a CCSP partner, has over 1,800 Colorado resources related to colorectal cancer. To access these resources, call the ACS/CCSP toll-free number:

1-866-227-7914

This may be the easiest way to be made aware of available resources in your local area!

Cancer Related Resources

The Colorado Cancer Coalition is a statewide collaborative working to eliminate the burden of cancer in Colorado. The coalition is made up of multiple task forces, all who work together to improve the life of Coloradan’s touched by cancer. To learn more about their Colorectal Cancer Task Force, click here.

Colorado Department of Public Health and Environment (CDPHE) has up-to-date statistics on colorectal cancer for Colorado on their cancer registry, and listings with links to all county health departments. To visit their Colorado Central Cancer Registry, click here.

Colon Cancer Alliance is on a mission to knock colon cancer out of the top three cancer killers. They are doing this by championing prevention, funding cutting-edge research, and providing the highest quality patient support services.

The Advocacy Connector is an online resource to assist in connection patients/caregivers to groups relevant to a specific need. This site provides national and state level cancer-specific resources regarding various topics including: caregiver support, counseling and therapy, financial assistance, pain management, survivorship, veterans’ services, young adult cancer support, etc.

American Cancer Society (ACS) can provide contact information for the local office serving your area. The ACS offers programs that help cancer patients, family members, and friends cope with the treatment decisions and emotional challenges they face. Some materials published in Spanish. Spanish-speaking staff is available.

⇒ Telephone: 1-800-227-2345

Association of Cancer Online Resources offers cancer-related resources for patients, family members, advocates, professionals, as well as a free online lifeline for anyone affected by cancer.

Be Seen Get Screened offers colorectal cancer-related resources for patients, navigators, clinicians, and advocates. Visit this site for an overview on screening methods, reasons to be screened, and outreach opportunities. This website also features a “Doctor Discussion” page where you can get information regarding colorectal cancer from physicians around the country.
Cancer Related Resources

**Colorectal Care Line** offers case management services, patient resources (temporary housing assistance, transportation, general CRC information, etc.) and links to the Patient Advocate Foundation.

⇒ Telephone: 1-866-657-8634

**Gastroenterology of the Rockies** gives an overview of what to expect during the preparation and colonoscopy procedure.

**Medline Plus** is the National Institutes of Health’s website for patients and their families and friends. Produced by the National Library of Medicine, it brings you information about diseases, conditions, and wellness issues in language you can understand. Medline Plus offers reliable, up-to-date health information, anytime, anywhere and for free.

**National Cancer Institute** (NCI) is a national resource for evidence-based cancer information. They provide information on prevention, screening, diagnosis and treatment. They offer informational pamphlets for patients in English and Spanish – many are contained on the enclosed CD. Additionally, their website has a database of all ongoing clinical trials that you can search by cancer type, treatment and/or ZIP code. Service, in English or Spanish, within the United States.

⇒ Telephone: 1-800-4-CANCER

**Patient Advocate Foundation** safeguards patients through effective arbitration, mediation and negotiation; assuring access to care, maintenance of employment and preservation of their financial stability. Spanish services available.

⇒ Telephone: 1-800-532-5274

**Cancer Care** offers free telephone, online, in-person, and over-the-phone education workshops, support groups, counseling and financial assistance for different types of cancer. Information available in Spanish and English.

⇒ Telephone: 1-800-813-4673
Diagnosis of Colorectal Cancer (CRC)

Patient navigators need to create a system at their site that allows them to identify patients diagnosed with cancer. Physicians diagnose CRC by examining the polyps removed during endoscopic screening. This information is found in the pathology report. If cancer is present, the doctor will bring the patient into the clinic and discuss the results of the pathology report and treatment options with them. Once this occurs, you can contact the patient and offer to help them through the cancer care process. Please discuss how this process will work at your clinic with your provider.

Important Topics to Address after Diagnosis

Social Issues

⇒ A cancer diagnosis adds stress to family and social networks. As a navigator, you should assess the characteristics and quality of the patient’s support network early on. Identify conflicts within the family, as they can negatively affect the patient’s care.

⇒ As the patient’s functional status declines, additional assistance might be required. Knowing their support system will enable you to better identify possible resources within it, or the need for home health care. With the patient’s permission, you can share information with the family about the disease and the treatment plan. Contact with the family can help you arrange for transportation, address patient care issues, and so on.

Financial Issues

⇒ Cancer treatment is expensive. Navigators can make a brief assessment of the patient’s financial status and refer the patient (when appropriate) for social service evaluation to determine if other sources of income are available. Some patients with advanced cancer can file for Social Security or Disability Benefits.

⇒ As a navigator, you should be aware of resources in your community that provide financial assistance, food, housing, energy assistance, and so on. If available, you can refer patients to a social worker or case manager to help enroll them in these types of programs.

Psychological Issues

⇒ Anxiety, depression, marital/partner difficulties, sexual problems, and interpersonal communication issues can occur frequently in cancer patients. These problems fluctuate during the course of cancer – usually most pronounced at diagnosis, with recurrence, with declining functioning, and nearing death.

⇒ Most cancer patients cope successfully with their psychological difficulties, though some will need and benefit from medication, or counseling, or both. Many cultures stigmatize mental health disease, and you may need to work hard to overcome these barriers.
Important Topics to Address After Diagnosis

Sexual Issues

⇒ Sexual problems occur in cancer patients for many reasons. Fatigue from treatment, or from progressive cancer usually leads to a decline in sexual desire. Body image may become distorted by weight loss, hair loss, presence of colostomy and physical scars, leaving patients feeling attractive. As a Patient navigator, you should feel comfortable discussing the potential impact of therapy on sexual interest and activity.

Vocational Issues

⇒ Vocational problems are common among cancer patients. Patients will need a more flexible schedule to make all their appointments, and employers are not always willing to accommodate. Patients may live in fear of losing their job. You can play an important role under these circumstances by educating the employer about the patient's abilities and prognosis.

⇒ Early contact with the employer (with patient consent) can be helpful. Describe the length of time the patient is likely to be disabled, or what accommodations could be made to allow the patient to continue working while receiving chemotherapy or radiation treatments.

⇒ The Federal Rehabilitation Act of 1973 and Americans with Disabilities Act of 1991 provide federal protection to cancer patients. According to these acts, employers must accommodate patients receiving cancer treatment. Consider vocational counseling for individuals who lose their jobs or who are unable to continue in their previous type of employment.

Family Notification

⇒ Once diagnosed with colorectal cancer or adenomatous polyps, the patient should alert their family of their increased risk of colorectal cancer. The patient's parents, siblings, and children need to begin screening earlier—typically at age 40.
Financial Assistance

Cancer treatment is expensive, and has a major impact upon a patient's financial resources. For general information, please visit the Center for Health Progress and Mile High United Way. Patients with, and without insurance, will feel a financial impact from this diagnosis. Tools are available on the web, which allow patients to access financial and basic assistance programs for which they qualify.

**Benefits Check-Up** is a free service for developed for people 50 years and older with and without Medicare. Gives patients help finding financial, basic needs and prescription drugs assistance programs.

**Benefits.gov** is a web-based screening tool to determine eligibility for federal benefits programs including health insurance.

**BEST (Benefits Eligibility Screening Tool)** is a web-based screening tool to determine eligibility for benefits administered through the Social Security Administration.

**The Colorado Consumer Health Initiative (CCHI)** has developed a resource to assist in finding resources for uninsured individuals. Please refer to this guide for more information and talk with your clinic staff.

**Medicaid** is a health insurance program for eligible low-income adults, children, pregnant women, elderly, those with disabilities. Colorado’s Medicaid program is administered by the Colorado Department of Health Care Policy and Financing (HCPF).

**Medicare** provides health insurance to older Americans and the disabled. Eligible individuals include those who are 65 or older, people with permanent kidney failure, and disabled individuals of any age. To receive information on eligibility, explanations of coverage, and related publications, call Medicare at the number listed below or visit their website. Some publications are available in Spanish. Spanish-speaking staff are available. The Medicare Hotline can answer general questions about benefits and coverage. Your clinic staff should also be knowledgeable about Medicare enrollment and benefits.

**Colorado Indigent Care Program** (CICP) is a health insurance program for individuals that are not eligible for Medicaid or Medicare. The program requires a co-pay of participants. Families must be at or below 185% of the Federal Poverty Line. This program is run by the Colorado Department of Health Care Policy and Financing (HCPF).
Financial Assistance

**Cancer Care** is a national nonprofit agency that offers free support, information, financial assistance, and practical help to people with cancer and their loved ones. Oncology social workers provide services in person, over the phone, and through the website. Cancer Care’s reach also extends to professionals by providing education, information, and assistance. Parts of the website and some publications are available in Spanish. Staff can respond to calls and e-mails in Spanish.

**Patient Assistance Program** is a subsidiary of the Patient Advocate Foundation. It provides financial assistance for several healthcare to patients who meet certain qualifications.

**Veterans Benefits** are available for eligible veterans and their dependents to receive cancer treatment at a Veterans Administration Medical Center. Treatments for service-connected conditions are provided, and treatment for other conditions may be available based on the veteran’s financial need. Assistance available in Spanish

⇒ Telephone: 1-877-222-8387

**National Cancer Institute** gives you access to more than 100 organizations nationwide that provide emotional, practical, and financial support services for people with cancer and their families. Available in Spanish

**Friends of Man** is a Colorado organization that provides financial assistance with food, clothing, medical expenses, day care and dental expenses.

⇒ 303-798-2342

**Patient Access Network Foundation** is a nonprofit organization that helps uninsured individuals with life-threatening and chronic disease pay for their medications.

⇒ Telephone: 1-866-316-7263

**American Society of Clinical Oncology** offers timely, comprehensive and oncologist-approved information. This site has multiple trusted resources for managing the cost of care. Available in Spanish

**Cops Fighting Cancer** is a nonprofit that provides individualized financial, practical, and emotional support to Colorado cancer patients and their families.
Financial Assistance

Rocky Mountain Cancer Assistance provides financial assistance to cancer patients receiving treatment in Colorado. Assistance is for basic needs such as rent or mortgage, utilities, car payments and car insurance, health insurance, and other day-to-day expenses.

Cancer Financial Assistance Coalition helps cancer patients experience better health and well-being by limiting financial challenges.

American Cancer Society teaches practical aspects of starting cancer treatment. ACS provides a list of organizations and programs that can help individuals and families having financial difficulties. Churches and local civic organizations, such as the United Way are also good resources to tap into.

Medical costs not covered by insurance policies can sometimes be deducted from annual income before taxes. Tax deductible expenses include mileage to and from appointments, out-of-pocket costs for treatment, prescription drugs, and meals during lengthy medical visits. Internal Revenue Service offices, tax consultants, and certified public accountants can determine medical costs that are tax deductible.

Social Security Administration (SSA) is the government agency that oversees Social Security and Supplemental Security Income (SSI). More information about these and other SSA programs is available by calling the toll-free number listed below. Spanish-speaking staff is available.

⇒ Social Security provides a monthly income for eligible elderly and disabled individuals.
⇒ Supplemental Security Income supplements Social Security payments for individuals who have certain income and resource levels.

LEAP is an energy assistance program that pays a portion of heating costs for low-income individuals. Applications are available at the website below.
Social Security Disability Insurance (SSDI)

Eligibility

Disability is defined as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment[...]which can be expected to result in death or which [has] lasted, or can be expected to last, for a continuous period of not less than 12 months." In the United States, eligibility is based upon work credits, which are determined by the length of time employed and the amount of wages earned.

The number of work credits needed to qualify for benefits increases with age. Some dependents of disabled workers are also eligible for benefits, including children of disabled workers who are under 18 and spouses who are over age 62 or are caring for children (under age 16) of the disabled worker. The SSA publishes eligibility information for the public which can be accessed by calling 1-800-772-1213 or by going to the SSA website.

Disability determination

The process of determination for SSDI begins by submitting an application to the local Social Security office. The initial determination takes 60 to 90 days. Applications should be submitted as soon as the individual becomes disabled.

Medical evidence of impairment needs to be provided once eligibility is confirmed. The state-based Disability Determination Service (DDS) agency gathers the evidence needed to evaluate the claim. Records of previous clinic and hospital visits will be requested. A medical evaluation will either be requested from the treating physician or by a consultative examination provided by a physician who contracts with the SSA.

The initial disability determination is based upon review by a board consisting of medical and non-medical agency personnel. Approximately one-third of applications are approved at this initial stage. Applicants have 60 days to appeal the decision. The decision is reconsidered by another administrative panel within the same agency.

Patients denied at may continue to appeal the decision to the Administrative Law Judge, who is able to consider additional information regarding the claimed disability, including additional medical information. The applicant can also be represented by legal counsel at this phase. Approximately one-half of all claims appealed at this level are reversed in favor of the applicant. If denied, the applicant can appeal decisions through the Social Security Appeals Council and on to Federal court.
Social Security Disability Insurance (SSDI)

Benefits
Recipients of SSDI can begin receiving payments after a six month "grace period" from when the disability was judged to have begun. Payments continue as long as the recipient meets eligibility requirements. The individual becomes eligible for Medicare once disabled for two years under SSDI. A disabled worker whose condition improves is allowed and encouraged to attempt to reenter the workforce and will not lose benefits if the attempt is unsuccessful. Medicare coverage is continued for up to 39 months for those who attempt to return to work.

SSDI Resources
An important resource is the SSA publication, "Disability Evaluation under Social Security," also known as the "Blue Book," which lists the medical criteria (physical examination findings, laboratory studies) the SSA will use to determine impairment and disability for the most common medical conditions. Copies are available online from the Social Security Administration (www.ssa.gov).

Poverty Guidelines
Poverty guidelines change every year. You can find the current guidelines with calculated percentages on page 38. You can also calculate these percentage levels yourself. The current poverty guidelines can be found at http://aspe.hhs.gov/poverty/index.shtml. To determine if patients are eligible for CCSP, you will need to calculate 400% of the poverty line.

To calculate the income for 400% of the poverty line:

Poverty Level x 4 = 400% of poverty line

The current federal poverty level for one adult is $11,880. 400% of this is $47,550. Thus, in order for an individual to qualify for CCSP navigation services, he or she must earn less than or equal to $47,550 annually. Federal poverty guidelines change annually, so you will need to recalculate these values accordingly.
Basic Needs Assistance

Patients may also require assistance with daily expenditures like food, clothing, rent and housing. If available, a social worker or case manager can help you provide these services to your patients. The following are some resources you may find helpful.

**Colorado 211** is a free and confidential call-in service that provides access to assistance for basic needs such as food, housing, rent and utility aid, transportation assistance, legal services and more. You can dial 211 or visit their website to find services and resources in your area.

**Salvation Army** can help with clothing donations and other goods, as well as temporary housing.

**Project Angel Heart** prepares and delivers free, nutritious meals to Coloradans with live threatening illnesses.

**Supplemental Nutrition Assistance Program** helps low income individuals with nutrition assistance. Applications available at your local Social Security office. To determine patient eligibility, go online and use their prescreening tool.

**Catholic Charities of Denver** provides food, clothing, and shelter to all people in need regardless of faith. Catholic Charities operates in Denver, northern Colorado and the Western Slope.

**Loaves and Fishes Ministry** assists with utility, rent and fuel payments for residents of Fremont County.

**Visiting Angels Living Assistance Services** provides non-medical in home care including light housework, laundry, bathing and companionship.
Transportation Assistance

Certain nonprofits arrange free or reduced-cost air and ground transportation for cancer patients going to or from cancer treatment centers. Financial need is not always a requirement. To learn more about these programs, talk with a medical social worker.

<table>
<thead>
<tr>
<th>Ground Transportation</th>
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</thead>
<tbody>
<tr>
<td><strong>American Cancer Society—Road to Recovery</strong></td>
</tr>
<tr>
<td>Address: 2255 Oneida St., Denver, CO 80224</td>
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<tr>
<td>Telephone: 800-227-2345</td>
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<tr>
<td><strong>American Red Cross</strong></td>
</tr>
<tr>
<td>Address: 444 Sherman St., Denver, CO 80203</td>
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<tr>
<td>Telephone: 303-722-7474</td>
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<tr>
<td><strong>Innovage</strong></td>
</tr>
<tr>
<td>Address: Locations in Denver, Aurora, Lakewood, Loveland, Pueblo, Carbondale, and Thornton</td>
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<tr>
<td>Telephone: 888-992-4464</td>
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<tr>
<td><strong>Shuttle Service of Southern Colorado</strong></td>
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<tr>
<td>Address: 215 S. Victoria St., Pueblo, CO 81003</td>
</tr>
<tr>
<td>Telephone: 719-544-9444</td>
</tr>
<tr>
<td><strong>Colorado Non Emergency Medical Transportation</strong></td>
</tr>
<tr>
<td>Telephone: 855-264-6368</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Air Transportation</th>
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</thead>
<tbody>
<tr>
<td><strong>Air Care Alliance</strong></td>
</tr>
<tr>
<td>Email: <a href="mailto:mail@aircarealliance.org">mail@aircarealliance.org</a></td>
</tr>
<tr>
<td>Telephone: 888-260-9707</td>
</tr>
<tr>
<td><strong>Angel Med Flight</strong></td>
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<tr>
<td>Email: <a href="mailto:info@angelmedflight.com">info@angelmedflight.com</a></td>
</tr>
<tr>
<td>Telephone: 844-597-2367</td>
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<tr>
<td><strong>National Patient Travel Center</strong></td>
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<tr>
<td>Telephone: 800-296-1217</td>
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</tbody>
</table>
Prescription Assistance

Patient assistance programs are offered by some pharmaceutical manufacturers to help patients pay for their medications. The following list is a living document and will continue to be updated:

Cancer Financial Assistance Coalition
CFAC is a coalition of organizations that helps cancer patients manage their financial challenges.

Colorado Prescription Drug Discount Resources
Information and links for local, state, and national prescription drug discount programs.

RX Outreach
Telephone: 800-769-3880
Email: questions@rxoutreach.org

Needy Meds Inc.
Telephone: 800-503-6897
Email: info@needymeds.org

RxAssist
Email: info@rxassist.org

Partnership for Prescription Alliance
To contact this organization, visit their website and complete a patient the inquiry form on their contact page.

Together Rx Access
Telephone: 800-444-4106

Health District of Northern Larimer County; Patient Assistance
Telephone: 970-416-6519
Pharmaceutical Company Patient Assistance Programs Continued

**Merck**
Telephone: 800-727-5400

**GlaxoSmithKline**
Telephone: 888-825-8249

**Pfizer**
Telephone: 844-989-7284

**Genentech**
Telephone: 877-436-3683

**Novartis**
Online Contact [Form](#)
Telephone: 800-669-6682

**AstraZeneca**
Telephone: 800-292-6363
## Free and Affordable Medical Equipment

<table>
<thead>
<tr>
<th>Program</th>
<th>Address</th>
<th>Hours</th>
<th>Telephone</th>
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</thead>
<tbody>
<tr>
<td><strong>Assistance League of Denver – Hospital Equipment Lending Program</strong></td>
<td>1400 Josephine Street</td>
<td>T-Th: 9:00am – 1:00pm</td>
<td>303-322-5205</td>
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<tr>
<td></td>
<td>Denver, CO 80206</td>
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<tr>
<td><strong>Dominican Home Health – Durable Medical Equipment Loan Program</strong></td>
<td>2501 N. Gaylord Street</td>
<td>M, W, F: 10:00am – 3:00pm</td>
<td>303-322-1413</td>
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<tr>
<td></td>
<td>Denver, CO 80205</td>
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<tr>
<td><strong>Boulder Elks</strong></td>
<td>3975 28th Street</td>
<td>T, Th: 9:00am – 4:00pm</td>
<td>303-442-5003</td>
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<tr>
<td></td>
<td>Boulder, CO</td>
<td>W, F: 10:00am – 3:00pm</td>
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<tr>
<td><strong>GoodHealthWill</strong></td>
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<tr>
<td></td>
<td>2003 W. 8th Street</td>
<td>M-S: 9:00am – 5:00pm</td>
<td>970-624-6002</td>
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<tr>
<td></td>
<td>Loveland</td>
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<tr>
<td></td>
<td>2611 W. 11th St Road</td>
<td>M-S: 9:00am – 5:00pm</td>
<td>970-515-6935</td>
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<td></td>
<td>Greeley</td>
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<tr>
<td></td>
<td>965 Platte River Blvd.</td>
<td>M-S: 9:00am – 5:00pm</td>
<td>303-558-0671</td>
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<tr>
<td></td>
<td>Brighton</td>
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Mental Health Services

**Clinica Campesina** offers a full spectrum of health care services. Multiple locations. Payment based on income. Accepts undocumented patients. **Spanish services available.**

⇒ Address: 1345 Plaza Court N, Lafayette, CO 80026
⇒ Telephone: 303-650-4460

**St. Mary’s Family Practice Residency** offers mental health counseling by outreach service workers. **Spanish services available.**

⇒ Address: 2698 Patterson Rd. Entrance 43, Grand Junction, CO 81506
⇒ Telephone: 970-298-2800

**AF Williams Family Medicine Center** provides health screening and mental health services to refugees. **Spanish services available.**

⇒ Address: 3055 Roslyn St. Ste. 100, Denver, CO 80238
⇒ Telephone: 720-848-9000

**Mental Health Center of Denver** provides mental health, psychology, psychiatry and counseling. Cost is based on a sliding scale for city and county of Denver residents only. **Spanish services available.**

⇒ Address: 4141 E. Dickenson Pl. Denver, CO 80222
⇒ Telephone: 303-504-7900
⇒ Email: AccessCenter@mhcd.org

**El Centro de Las Familias** provides culturally sensitive psychotherapy, group therapy, family therapy, case management, and medication evaluation and management. **Spanish services available.**

⇒ 75 Meade St. Denver, CO 80219
⇒ Telephone: 303-504-7900
⇒ Email: AccessCenter@mhcd.org

**Servicios de la Raza provides** mental health services to women and children.

⇒ Address: 3131 W. 14th Ave. Denver, CO 80204
⇒ Telephone: 303-458-5851
⇒ Email: info@serviciosdelaraza.org
Legal Assistance

**Patient Advocate Foundation** (PAF) provides education, legal counseling, and referrals to cancer patients and survivors concerning managed care, insurance, financial issues, job discrimination, and debt crisis matters. The Patient Assistance Program is a subsidiary of the PAF. It provides financial assistance to patients who meet certain qualifications.

⇒ Telephone: 800-532-5274

**Colorado Legal Services** provides various civil legal services. No traffic or criminal services on a sliding scale fee system.

⇒ Address: 1905 Sherman St. #400 Denver, CO 80203
⇒ Telephone: 303-837-1313

**Colorado Bar Association** has listings for free legal services in Colorado.

Telephone: 800-332-6736

**Legal Aid Foundation of Colorado** helps insure that free legal services are available to low-income Coloradans.

⇒ Address: 1900 Grant St. Ste. 1112 Denver, CO 80203
⇒ Telephone: 303-863-9544

Immigrant and Refugee Resources

**Colorado Consumer Health Initiative (CCHI)** produced a financial assistance resource guide for Colorado, which includes information for immigrant and refugee populations.

⇒ 1580 Logan St. Ste. 340 Denver, CO 80203
⇒ Telephone: 303-839-1261
⇒ Email: Inform@cohealthiniative.org

**Colorado Trust** is an organization for the advancement of health for all people in Colorado. They have information specific for immigrant and refugee populations.

⇒ Address: 1600 Sherman St. Denver, CO 80203
⇒ Phone: 303-837-1200
Wigs

**Tender Loving Care (TLC)** is a part of the American Cancer Society, and provides wigs, hats, hair pieces, and turbans to women suffering from hair loss due to cancer treatment. TLC allows women to purchase these products and at affordable rate, and from the comfort of their own home.

⇒ Telephone: 800-850-9445

**Hana Designs** is based out of Littleton, CO, and sells both synthetic and human hair wigs, as well as scarves. The owner a cancer survivor herself, has worked in numerous oncology departments throughout the Denver Metro Area, including Children’s Hospital and Rose Medical Center.

⇒ Address: 229 W. Littleton Blvd. Littleton, CO 80120
⇒ Telephone: 866-799-4262
⇒ Email: info@hanadesigns.com

**Headcovers Unlimited** specializes in wigs, scarves, turbans, and hats for cancer patients. This website also provide resources to assist with the loss of eyebrows and eyelashes.

Telephone: 1-800-264-4287

**Godiva’s Secret** has a wide selection of affordable wigs, alopecia products, chemo products for men and women undergoing chemotherapy.
Colostomy Issues

**United Ostomy Association of America** provides a wealth of resources for patients with colorectal cancer, including ostomy support groups, diet and nutrition education, travel tips, and more. Visit their webpage at [www.ostomy.org](http://www.ostomy.org) for ostomy information or to find a support group near you.

Colostomy Manufacturers

- **Coloplast Inc.**
- **Genairex Inc.**
- **Convatec—a Bristol-Myers Squibb Company**
- **Hollister Inc.**
- **Cymed Ostomy Co.**
- **Marlen Manufacturing & Development Co.**
- **EHOB**
- **Nu-Hope Laboratories**
- **Torbot Group**
- **The Perma-Type Company**
End-of-Life Issues

**National Hospice and Palliative Care Organization** (NHPCO) is an association of programs that provide hospice and palliative care. They offer discussion groups, publications, information about how to find a hospice, and information about the financial aspects of hospice. Some Spanish-language publications are available, and staff is able to answer calls in Spanish.

⇒ Telephone: 703-837-1500
⇒ Email: nhpco_info@nhpco.org

**Colorado Center for Hospice and Palliative Care** works to increase access to palliative and hospice services and promote quality standards of care for all Coloradans. The web site has a list of providers throughout the state.

⇒ Address: 2851 S. Parker Rd. Ste. 1210 Aurora, CO 80014
⇒ Telephone: 303-848-2522
⇒ Email: info@coloradohospice.org

**Halcyon Hospice and Palliative Care** offers patient centered hospice and palliative care across the Front Range.

⇒ Address: 9200 E. Mineral Ave. Ste. 1140 Centennial, CO 80112
⇒ Telephone: 877-940-3433
Transitioning Patients Beyond Treatment

Navigating the Maze

Cancer care can be confusing for patients – different doctors, different clinics, too many appointments to keep track of. As a navigator, it is essential that you help patients through this process. The diagnosis of cancer is difficult physically, emotionally and spiritually. Having an ally to rely on during this time, gives patients tremendous support.

Your first mission is to establish a solid relationship with the patient. Gage what they understand about their diagnosis and treatment plan, and how they feel about it. Ask the patient how you can help them and what role would they would like you to play in their care. Start identifying barriers to their care at this time, and begin creating solutions. Create a file on each cancer patient. You will need to keep a record of their primary care physician, oncologist, surgeon, and other healthcare providers.

Encourage patients to keep a journal where they can record the contact information for all their doctors, keep track of appointments, list all their medical history and medications, and document all procedures. Patients may want to keep track of their lab tests as well. Keeping a journal will provide a sense of control and allow cancer them be actively involved in their treatment.

Upon completing treatment, patients enter the rehabilitation phase of their cancer care, which can include physical, emotional, social, and vocational rehabilitation. This section covers some rehabilitation activities you can provide as a navigator for cancer survivors and those patients who will succumb to their disease.

Physical Therapy

Patients suffering from physical problems related to their cancer should be evaluated for physical therapy. For patients with advanced cancer, physical therapy can be used to maintain mobility, improve stamina, and retain control over activities of daily living (grooming, bathing, eating, toileting). Physical therapists can also provide them with walkers and other devices to help improve their quality of life.

Patients with Colostomies

For colostomy patients, there will be a post-operative adjustment. In the hospital, the will be educated on how to care for the colostomy site or stoma, how to use colostomy bags, and how to care for the skin near it. Encourage your patient to view and touch their stoma site. Doing this will help them develop independence and self-confidence regarding their self-care. Periodic home care visits by a nurse or stomal therapist can help the recovery process and increase confidence after surgery.
Transitioning Patients Beyond Treatment

Emotional Support

Patients that complete cancer treatment have just survived an emotional ordeal. Both patients and families can benefit from support groups and/or counseling. The American Cancer Society’s Cancer Support Network and the Colon Cancer Alliance’s “Buddy Program” are two options to discuss. Some local Colorado support groups include:

**Rocky Mountain Cancer Center Coffee and Conversation:** All cancer patients welcome. This support group meets the 2nd and 4th Wednesday of each month from 10:00am – 11:00am in Pueblo at 3676 S. Parker Blvd, Suite 350. Contact Ami Gorsky for more information at 719-296-6000 or click here.

**Rocky Mountain Cancer Center Support Group Mind-Body Fridays** – in Longmont. This group meets the 1st Friday of each month from 3:00pm – 4:00pm at 2030 Mountain View Ave., Suite 210. For more information, call Marianne Stenhouse at 303-684-1843 or click here.

**University of Colorado Hospital Mindful Stress Management Class** – in Aurora. This group meets on the first Tuesday of each month from 12:30 – 1:30. Come learn mindfulness practices that have proven to reduce stress in people with cancer, as well as their families. Classes are located at 12605 E. 16th Ave. Click here to learn more.

**University of Colorado Hospital Nutrition & Cancer Class** – Aurora. These classes take place on the 4th Tuesday of each month from 6:00pm – 7:30pm and are located at 1665 Aurora Court, in the AIP2, Room 11.102. Click here for more information.

**St. Joseph Hospital Coping with Cancer**—in Denver. This support group is open to patients, survivors, caregivers and families. It occurs Wednesday of the month from 3:00pm – 4:30pm in the 1st floor conference room. The hospital is located at 1825 Marion Street. For more information, call 303-318-3449 or click here.

*New cancer support groups continue to be created throughout Colorado. For real-time updates about cancer support groups in your area, please visit the Colorado Cancer Coalition’s support group webpage.*
Appendix A

Effectively Working With a Trained Interpreter in Your Practice: These topics must be defined for using staff members as interpreters before the process is in place:

- How will the staff member be summoned when needed for interpreting?
- How would she/he deal with their regular functions during that time?
- Will patients have their appointments set for a certain time when this person is available?
- Will this new function be compensated financially?
- Will the person be excused of his/her other duties when needed for interpreting?
- Will this role be officially recognized in the clinic?
- How will problems arising from miscommunication during interpretation be handled?
- How will continuing education/training for this person be handled?

Some of the rules that need to be established or, at a minimum, discussed, are in the following TRANSLATE mnemonic.

<table>
<thead>
<tr>
<th>T</th>
<th>Trust</th>
<th>How will trust be developed in the patient-clinician-interpreter relationship? In relationships with the patient's family and other health care professionals?</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Roles</td>
<td>What role(s) will the interpreter play in the clinical care process (e.g., language translator, culture broker/informant, culture broker/interpreter of biomedical culture, advocate)?</td>
</tr>
<tr>
<td>A</td>
<td>Advocacy</td>
<td>How will advocacy and support for patient and family centered care occur? How will power and loyalty issues be handled?</td>
</tr>
<tr>
<td>N</td>
<td>Non-Judgmental Attitude</td>
<td>How can a non-judgmental attitude be maintained? How will personal beliefs, values, opinions, biases, and stereotypes be dealt with?</td>
</tr>
<tr>
<td>S</td>
<td>Setting</td>
<td>Where and how will medical interpretation occur during health care encounters (e.g., use of salaried interpreters, contract interpreters, volunteers, Language Line)?</td>
</tr>
<tr>
<td>L</td>
<td>Language</td>
<td>What methods of communication will be employed? How will linguistic appropriateness and competence be assessed?</td>
</tr>
<tr>
<td>A</td>
<td>Accuracy</td>
<td>How will knowledge and information be exchanged in an accurate, thorough, and complete manner during health care encounters?</td>
</tr>
<tr>
<td>T</td>
<td>Time</td>
<td>How will time be appropriately managed during health care encounters?</td>
</tr>
<tr>
<td>E</td>
<td>Ethical Issues</td>
<td>How will potential ethical conflicts be handled during health care encounters? How will confidentiality of clinical information be maintained?</td>
</tr>
</tbody>
</table>

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Developed by: Robert C. Like, MD, MS Center for Healthy Families and Cultural Diversity
Department of Family Medicine
Appendix A

How to Work Most Effectively with Trained Interpreters

1. **Permission and confidentiality**: Make sure permission from the patient/family is granted for use of an interpreter. When feasible, inquire if there are topics they do not want to discuss in front of this person.

2. **Pre-interview**: Prior to entering the exam room, briefly discuss with the interpreter: the general reason for the visit, known issues, and the goals for the encounter.

3. **Role of the interpreter**: In the pre-interview, discuss with the interpreter the roles he or she will to take. Do you want them to simply interpret the words or do you want the interpreter to assist in better understanding barriers of cultural nature?

4. **Starting**: Ask the interpreter how to say a professional greeting in the family’s native language and use it at the beginning of the visit. You may feel awkward using an interpreter. Say so and encourage the patient to let you know if it is not working well for any reason.

5. **Etiquette**: When possible, try to arrange for you to face the patient, with the interpreter on the side. Ask about the family’s cultural preferences regarding eye contact, closeness of sitting proximity, touching, etc. Talk directly to the patient, in the first person, as you would normally do.

6. **The Dialogue**: Try to use single questions and short phrasing. Attend to the interpreters need to interpret what you are saying, and break long statements and questions down to shorter segments. Periodically check if the patient understands by asking them to repeat what you said. If you wonder about meaning or length of response, ask the patient and interpreter to clarify. Be patient, some phrases in English may require longer sentences in other languages to have the same meaning.

7. **The Story**: In many cultures, there is a tradition of “telling the whole story.” Patients may talk for several minutes and the interpreter may give you a much shorter interpretation. It is important to ask the interpreter to translate verbatim. The degree to which you hear the whole story may influence their level trust and compliance later.

8. **Barriers**: Be sure to ask the interpreter to explore whether there are barriers that might interfere with treatment: monetary, transportation, attitudes, concerns, beliefs or other cultural barriers, as you would with any patient.

9. **Adequate understanding**: In this setting, there is obviously greater chance that the patient will not have a complete understanding. Allow ample time for questions and specifically ask whether they have gotten all of their questions answered. It is particularly encouraging if you learn the word for questions in their language.

10. **Debriefing**: Before leaving the room, ask the patient to provide feedback through the interpreter.
Appendix A

Using Casual Interpreters
(Family members or volunteers)

In some instances, you may not have a formal interpreter available or telephonic voice interpreting. In that case, you may have to use a “casual” or “ad-hoc” interpreter. This might include a co-worker, a family member or community volunteer. Never utilize a child or adolescent.

Using “casual” interpreters, may cause more errors than when using trained interpreters. However, there are times when it cannot be avoided. Be cautious and double check important issues. Patients may feel embarrassed when using relatives or friend to interpret, so always do your best to use a professional or a phone translation service.

Trust your senses: if responses seem inadequately translated, or the history is confusing, insist on getting a trained interpreter or use a phone translation line.
Appendix B

Attachment A & B: Acceptable Proof of Lawful Presence

Attachment A

The following documents are acceptable as proof of lawful presence pursuant to AG Order Number 2129-97 referenced in 2.1.3. of this rule.

A. Primary Evidence (One document is needed): Identity can be proven by these same documents if they bear a picture of the applicant.

1. Copy of applicants birth certificate from any state, the District of Columbia and all United States territories.
2. United States Passports, except for "limited" passports, issued for less than five years.
4. Certificate of Birth issued by a foreign service post (FS-545) or Certification of Report of Birth (DS-1350). These are available from the Department of State.
5. Certification of Naturalization (N-550 or N-570). The N-570 is issued upon loss or damage to the original document or following an individual's name change.
6. Certificate of Citizenship (N-560 or N-561). This document is issued to those persons who derive U. S. Citizenship through a parent. The N-561 is issued upon loss or damage of the original document or following an individual's name change.
7. U. S. Citizen Identification Card (I-97). These were last issued in 1974.
8. Northern Mariana Identification Card. Those born in the Northern Mariana Islands prior to November 3, 1986 were collectively naturalized.
9. Statement provided by a US consular officer certifying that the individual is a US citizen. (This document is provided to an individual born outside the US who derived citizenship through a parent but does not have form FS-240, FS-545 or DS-1350.)
10. American Indian Card with Classification code 'KIC' and a statement on the back identifying US Citizen members of the Texas Band of Kickapoos.

B. Secondary Evidence

If the applicant cannot present one of the documents listed above, the following may be relied upon to establish US citizenship or nationality:

1. Religious records recorded in one of the 50 states, the District of Columbia and U. S. territories, within three months after birth showing that the birth occurred in such jurisdiction and the date of the birth or the individual's age at the time the record was made.
2. Evidence of Civil Service Employment by the US Government before June 1, 1976.
3. Early school records (preferably from the first school) showing the date of admission to the school, the child's date and place of birth and the names' and places of birth of the parents.
4. Census record showing name, US citizenship or a US place of birth or age of applicant.
5. Adoption Finalization Papers showing the child's name and place of birth in one of the 50 states, DC, or US territories or where the adoption is not finalized and the State or other jurisdiction listed above in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency showing the child's name and place of birth in one of such jurisdictions (NOTE: the source of the information must be an original birth certificate and must be indicated in the statement), or
6. Any other documents that establish a US place of birth or in some way indicates US citizenship.
Appendix B

C. If an individual is unable to present any of the above documents the following options are available:

1. Accept a written declaration, made under penalty of perjury, and possibly subject to later verification of status, from one or more third parties, indicating a reasonable basis for personal knowledge that the applicant is a US citizen or non-citizen national.

2. Accept the applicant’s written declaration, made under penalty of perjury and possibly subject to later verification of status that he or she is a US citizen or non-citizen national.

Note: These options (C.1 and C.2) should be used with caution in appropriate circumstances. For example, before using these options a provider might require the applicant to demonstrate why a document evidencing that he or she is a US citizen or non-citizen national does not exist or cannot be readily obtained.

D. Collective Naturalization

If the applicant cannot present one of the documents listed in A or B above, the following will establish US citizenship for collectively naturalized individuals:

1. Puerto Rico (PR):

   Evidence of birth in PR on or after April 11, 1899 and the applicants’ statement that he or she was residing in the US, a US possession, or PR on January 13, 1941 or

   Evidence that the applicant was a PR citizen and the applicant’s statement that he or she was residing in PR on March 1, 1917 and that he or she did not take an oath of allegiance to Spain;

2. US Virgin Islands:

   Evidence of birth in the US Virgin Islands (VI) and the applicant’s statement of residence in the US, a US possession, or the US VI on February 25, 1927;

   The applicant’s statement indicating residence in the US VI as a Danish citizen on January 17, 1917 and that he or she did not make a declaration to maintain Danish citizenship; or

   Evidence of birth in the US VI and the applicant’s statement indicating residence in the US, US Possession or Territory or the Canal Zone on June 28, 1932.

3. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

   Evidence of birth in NMI, TTPI citizenship and residence in the NMI, the US, or a US territory or possession on November 3, 1986 (NMI local time) and the applicant’s statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time);

   Evidence of TTPI citizenship in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant’s statement that he or she did owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

   Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant’s statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

Note: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a US citizen.

E. Derivative Citizenship

If the applicant cannot present one of the above documents you should make a determination of Derivative US citizenship in the following situations:
Appendix B

Applicant born abroad to two US citizen parents:

Evidence of US citizenship of the parents and the relationship of the applicant to the parents, and the evidence that at least one parent resided in the US or an outlying possession prior to the applicant's birth.

Applicant born abroad to a US citizen parent and a US non-citizen national parent:

Evidence that one parent is a US citizen and the other is a US non-citizen national, evidence of the relationship of the applicant to the US citizen parent and the evidence the US citizen parent resided in the US, a US possession, American Samoa or Swains Island for a period of at least one year prior to the applicant's birth.

Applicant born out of wedlock abroad to a US citizen mother:

Evidence of US citizenship of the mother, evidence of the relationship to the applicant and, for births on or before December 24, 1952, evidence that the mother resided in the US prior to the applicant's birth or, for births after December 24, 1952, evidence that the mother has resided, prior to the child's birth, in the US or a US possession for a period of one year.

Applicant born in the Canal Zone or the Republic of Panama:

A birth certificate showing birth in the Canal Zone on or after February 26, 1904 and before October 1, 1979 and evidence that one parent was a US citizen at the time of the applicant's birth;

or

A birth certificate showing birth in the Republic of Panama on or after February 26, 1904 and before October 1, 1979 and evidence that at least one parent was a US citizen and employed by the US government or the Panama Railroad Company or its successor in title.

All other situations where an applicant claims to have a US citizen parent and an alien parent, or claims to fall within one of the above categories but is unable to present the listed documentation:

If the applicant is in the US, refer him or her to the local INS office for determination of US citizenship;

If the applicant is outside the US, refer him or her to the State Department for a US citizenship determination.

F. Adoption of Foreign-Born Child by US Citizen:

If the birth certificate shows a foreign place of birth and the applicant cannot be determined to be a naturalized citizen under any of the above criteria, obtain other evidence of US citizenship;

Since foreign born adopted children do not automatically acquire citizenship by virtue of adoption by US citizens, refer the applicant to the local INS district office for a determination of US citizenship if the applicant provides no evidence of US citizenship [the law changed several years ago to allow such children to obtain automatic citizenship].

G. US Citizenship By Marriage

A woman acquired US citizenship through marriage to a US citizen before September 22, 1922.

Note: If the husband was an alien at the time of the marriage and became naturalized before September 22, 1922, the wife also acquired naturalized citizenship. If the marriage terminated, the wife maintained her citizenship if she was residing in the US at the time and continued to reside in the US.

H. Applicants with Disabilities and Non-discrimination

If an applicant has a disability that limits the applicants ability to provide the required evidence of citizenship or nationality (e.g. mental retardation, amnesia, or other cognitive, mental or physical impairment), you should make every effort to assist the individual to obtain the required evidence. In addition, you should not discriminate against applicants on the basis of race, national origin, gender, religion, age or disability. See Non-discrimination Advisory, Attachment 2 to Interim Guidance.
Appendix B

ATTACHMENT B

For specific detailed descriptions of the Immigration Documents referred to below see Exhibit A to Attachment 5 of US AG Order.

Instructions:

The documents listed below, will, when combined with satisfactory proof of identity (which will come from the document itself if it bears a photograph of the person to whom it relates), establish that an applicant falls within one of the categories of 'qualified alien' for purposes of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996.

Each of the documents listed below will demonstrate lawful status and you should not require presentation of a registration document if the applicant presents one of the other legally acceptable documents that reasonably appears on its face to be genuine and to relate to the person presenting it. However, if the document presented is not a registration document and does not on its face reasonably appear to be genuine or to relate to the person presenting it, it is appropriate to ask the applicant to produce his or her registration document as additional evidence of immigration status so long as the request is not made for a discriminatory reason.

Presentation of a registration document listed below that reasonably appears on its face to be genuine and to relate to the person presenting it (or to satisfy higher applicable standards) will often obviate the need to verify the applicant's immigration status with the INS: if the applicant presents a registration document that does not meet this standard, sending the INS a copy of the document will assist it in verifying the applicants' status quickly and accurately.

Alien Lawfully Admitted for Permanent Residence

1. INS Form I-551 (Alien Registration Receipt Card, commonly called or known as a 'green card')
2. Unexpired Temporary I-551 Stamp in foreign passport or on INS Form I-94.

Asylee

3. INS Form I-94 annotated with stamp showing grant of asylum under section 208 of the Immigration and Nationality Act (INA)
4. INS Form I-688B (Employment Authorization Card) annotated '274a.12(a)(5)'
5. INS From I-776 (Employment Authorization Document) annotated 'A5'
6. Grant Letter from the Asylum Office or INS

Refugee

7. INS Form I-94 annotated with stamp showing admission under Section 207 of the INA
8. INS Form I-688B (Employment Authorization Card) annotated '274a.12(a)(3)'
9. INS Form I-766 (Employment Authorization Document) annotated 'A3'
10. INS Form I-571 (Refugee Travel Document).

Alien Paroled into the US for a Least One Year

11. INS Form I-94 with stamp showing admission for at least one year under Section 212(d)(5) of the INA. (Applicant cannot aggregate periods of admission for less than one year to meet the one-year requirement).

Alien whose Deportation or Removal Was Withheld
Appendix B

12. INS Form I-882B (Employment Authorization Card) annotated 274a.12(a)(10)


14. Order from an immigration Judge showing deportation withheld under Section 243(h) of the INA as in effect prior to April 1, 1997, or removal withheld under Section 211(b)(3) of the INA

Alien Granted Conditional Entry

15. INS Form I-94 with stamp showing admission under Section 203(a)(7) of the INA

16. INS Form I-882B (Employment Authorization Card) annotated 'A3'

17. INS Form I-766 (Employment Authorization Document) annotated 'A3'

Cuban / Haitian Entrant

18. INS Form I-551 (Alien Registration Receipt Card, commonly known as the 'Green Card' with the code CU6, CU7, CH6

19. Unexpired temporary I-551 stamp in foreign passport or on INS Form I-94 with the code CU6, CU7, CH6

20. INS Form I-94 with stamp showing parole as 'Cuba/Haitian Entrant' under Section 212(d)(5) of the INA

Alien Who has Been Battered or Subjected to Extreme Cruelty

See Attachment 5, Exhibit B, at AG Order No. 2129-97.

The documentation for Violence Against Women Act self-petitioners is the INS issued 'Notice of Prima Facie Determination' or 'Notice of Approval'.


## Appendix C

### CO Demographic Breakdown by Health Statistic Region (HSR)

<table>
<thead>
<tr>
<th>HSR</th>
<th>Percent Aged 50-64&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Percent Identifying as Hispanic&lt;sup&gt;b&lt;/sup&gt;</th>
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<tr>
<td>Colorado</td>
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<td>11.83</td>
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</tbody>
</table>

<sup>a</sup> Percent Aged 50-64 = (# Aged 50-64/Total HSR Population), 2014

<sup>b</sup> Percent Identify as Hispanic = (# Aged 50-64 Who Identify as Hispanic/Total HSR Population Aged 50-64), 2010
Appendix C

Figure 2. Percent of Colorado Population Aged 50-64, 2014. Data from US Census, 2014.

Figure 3. Percent of Total Colorado Population Aged 50-64 Identifying as Hispanic, 2010. Data from US Census, 2014.
### Appendix C

<table>
<thead>
<tr>
<th>HSR</th>
<th>Private</th>
<th>Public</th>
<th>Uninsured</th>
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Appendix C

Colorectal Cancer Incidence (2010-14) and Mortality (2011-15), Age 50-64

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References


References

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Image 2:

Image 3:

Image 4:

Image 5: