Establishing Health System Partnerships for Success:

Assessing Clinic Readiness for Enhanced Colorectal Cancer Screening

GET SCREENED SD
COLORECTAL CANCER PROGRAM

SOUTH DAKOTA DEPARTMENT OF HEALTH

Introduction

The Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion released funding for *"Changing Health Systems Using Evidence-based Interventions to Increase Colorectal Cancer Screening."* Funding was awarded to 38 state health departments, tribal organizations, universities & academic medical centers, and other non-profit, hospital & health networks to partner with health systems and primary care clinics to use evidence-based interventions (EBIs) to increase colorectal cancer (CRC) screening in people aged 45 to 75 years old. The focus is on populations that have low screening prevalence and clinic sub-populations who may need more support to complete the screening process or who experience barriers to screening.

Award recipients were provided funding to:

- Establish partnerships with health systems and primary care clinics to implement multicomponent interventions that combine EBIs recommended in *The Community Guide.* The EBIs of priority for this work include: patient reminder systems, provider reminders and feedback, reducing structural barriers, and patient navigation.
- Establish partnerships with organizations that support implementing EBIs, improving data collection, and enhancing use of electronic health records (EHRs) in primary care clinics to increase CRC screening.
- Conduct formal readiness assessments of each partner clinic's capacity to implement EBIs and use this information to select EBIs that will support improved CRC screening.
- Ensure clinics have a CRC screening champion in the clinic.
- Use a limited amount of funding to pay for stool-based testing in partner clinics and ensure follow-up colonoscopies occur after a positive or abnormal screening test, as a payor of last resort.
- Submit high-quality, clinic-level data, including baseline and annual CRC screening prevalence, aggregate data on stool-based tests provided to and returned by patients, and aggregate data on follow-up colonoscopies including those supported by the program.
- Ensure health systems and clinics develop the capacity to collect data and track the entire CRC screening process patients undergo.
- Submit one success story every six months.
- Plan and complete an evaluation of program activities and submit an annual evaluation report.

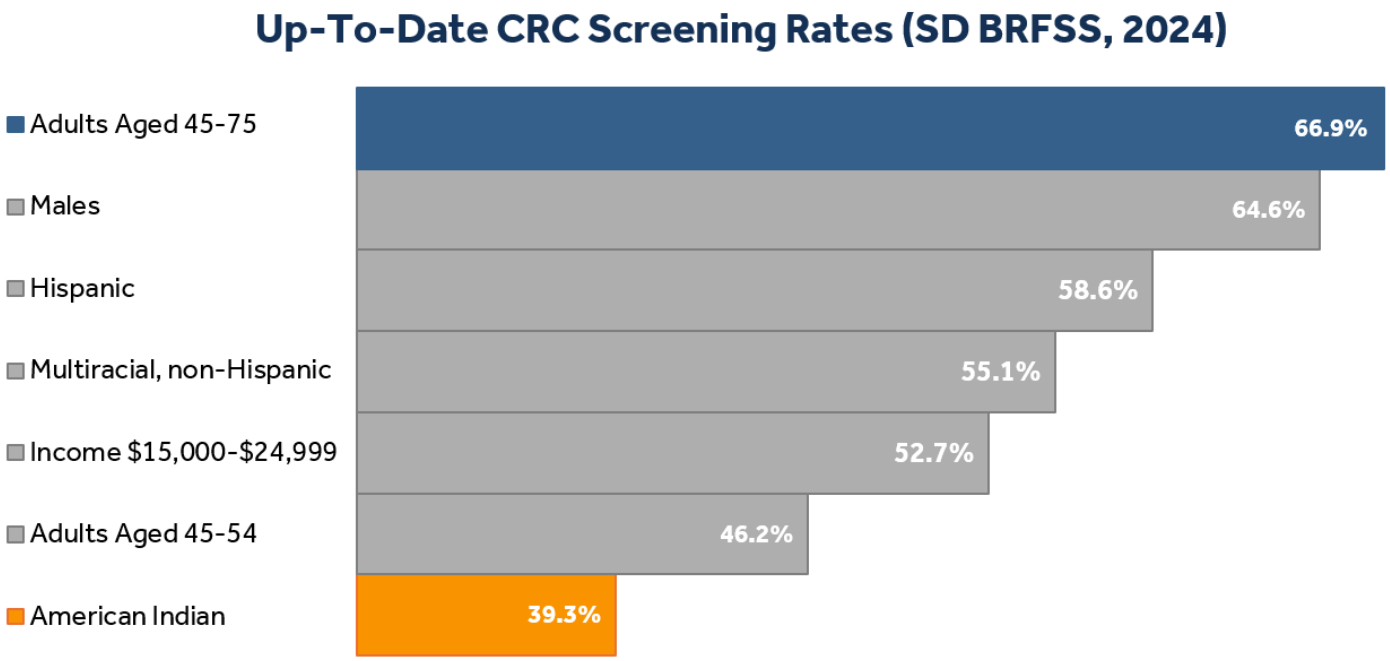
The remainder of this report outlines how one funded state, South Dakota, prepared clinic partners for success by utilizing clinic readiness assessments, selecting appropriate EBIs to implement, and devising supportive technical assistance to enhance the implementation process among the partner clinic locations.

Colorectal Cancer In South Dakota

In 2022, CRC was the second leading cause of cancer-related deaths and the fourth most diagnosed cancer among men and women in South Dakota. From 2019 to 2023, 2,168 new cases of CRC were diagnosed, resulting in an incidence rate of 40.5 per 100,000 people, compared to the national rate of 38.0 per 100,000 in 2023. During 2020-2024, the state recorded 821 deaths from CRC, with a mortality rate of 14.0 per 100,000 residents, which is similar to the national rate of 13.0 in 2024.

The program goal of reduced CRC incidence and mortality is hindered by many barriers in SD. The state encompasses over 75,000 square miles with an average density of 11.7 people per square mile, making it the fifth least densely populated state in the United States. South Dakota's only two urban counties are located on opposite sides of the state, requiring many residents to travel long distances for cancer screening and treatment. An estimated 12.4% of SD residents live below the Federal Poverty Level, with poverty rates reaching 22-42% in counties near American Indian reservations. Moreover, two-thirds of SD is federally designated as a Health Professional Shortage Area, underscoring geographic and income-related differences in healthcare access. Addressing these barriers is critical to reducing the burden of CRC in SD.

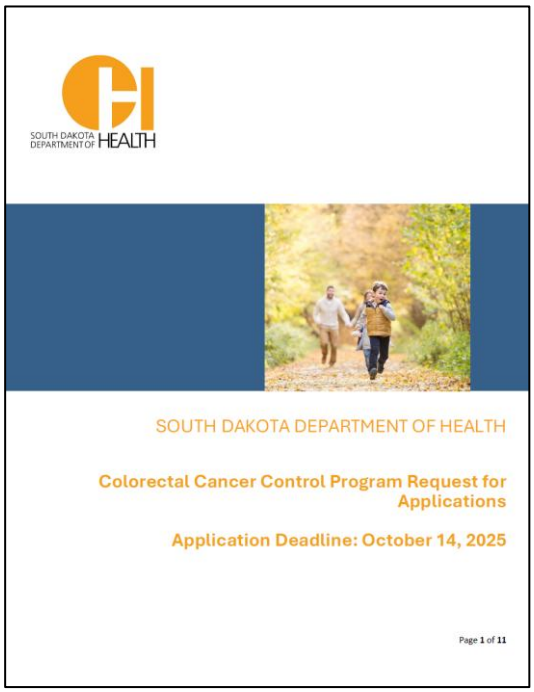
In light of the rurality and socioeconomic factors, 66.9% of the eligible population in SD is up to date on CRC screening, falling below the Healthy People 2030 target of 68.3% (SD BRFSS, 2024). Screening rates are lowest among American Indians (39.3%). Other groups with notably lower screening rates include those who are male (64.6%), Hispanic (58.6%), multiracial, non-Hispanic (55.1%), income $15,000 to $24,999 (52.7%), and adults aged 45-54 (46.2%).



Colorectal Cancer Control Program

The SD Colorectal Cancer Control Program (SD CRCCP), housed within the SD DOH, was funded by the CDC through the outlined funding mechanism. The SD CRCCP aims to increase CRC screening among underserved populations, including low-income individuals, American Indians living on- and off-reservation, residents in rural and frontier areas, and those with inadequate insurance coverage for screening.

Building on lessons learned from previous grant cycles and leveraging data from BRFSS, UDS, GPRA, and other national, tribal, state, and local datasets, the SD Department of Health (DOH) identified key Federally Qualified Health Centers (FQHC's) and American Indian-serving clinics to reach the target population for the project. The SD CRCCP reached out to eight health systems in December 2024 to gauge interest in partnering on the project and to request letters of support for SD's NOFO submission. After SD was awarded the cooperative agreement, the SD DOH opted to release a Request for Applications (RFA) in Fall 2025. SD DOH followed up with the original eight health systems to send personalized thank-you notes and encourage them to apply for the RFA. The RFA was also shared broadly through email listservs, newsletters, and postings on multiple websites. The funding opportunity was offered as a way to help clinics increase CRC screening rates through evidence-based interventions proven to boost screening, access to stool-based tests and follow-up colonoscopies, and support to strengthen systems of care.



Through the RFA, the SD DOH requested and reviewed data from health system applicants including a description of the health system/clinic, current barriers to CRC screening, EHR system specifications, populations served, patient insurance coverage, proposed partnering clinic sites, clinic CRC champions, CRC policies/protocols/workflows, CRC screening rates, available services, and willingness to participate in project activities. Five health systems applied for the funding and four were selected for CRCCP partnership in program year one. These four health systems represent twelve individual clinic locations. Partnerships have now been established with the twelve primary care clinic sites and four additional supporting partners to implement EBIs that will enhance CRC screening efforts. Given the vast rural and frontier nature of SD and noted disparities, these health system partners and associated primary care clinics were strategically chosen as they best serve the identified target populations the program hopes to impact.

Selected Clinic Partners

SD has four FQHC health system networks, which deliver care to the most vulnerable individuals in SD, including uninsured, rural, racial and ethnic minorities, and those with lower annual household income and lower educational attainment. The SD DOH is partnering with three of the four FQHC networks in SD. Partnering FQHCs include: Falls Community Health Center (1 clinic), Horizon Health Care, Inc. (5 clinics), and South Dakota Urban Indian Health (2 clinics). To extend additional reach in rural areas, the SD CRCCP is also partnering with Mobridge Regional Hospital and Clinics (4 clinics).

Four additional collaborating partners were identified to provide technical assistance and guidance to the identified partner clinics, including the American Cancer Society (ACS), Black Hills Special Services Cooperative (BHSSC), South Dakota State University Population Health Evaluation Center (SDSU PHEC), and Community Healthcare Association of the Dakotas (CHAD). These partnerships underscore a shared commitment to reducing barriers, advancing early detection, and improving colorectal cancer outcomes across South Dakota. The state plans to utilize data-driven outcomes and quality improvement efforts to guide programmatic decision making and ensure they promote an optimal level of health for all, especially for those at greatest risk.

Clinic Readiness Assessments

The SD DOH partnered with the BHSSC to complete a clinic readiness assessment tool with each clinic site. Upon clinic partner selection, BHSSC staff scheduled meetings to complete a baseline assessment with key staff from each of the participating clinic sites. The baseline data was utilized to select appropriate priority EBIs to implement at each site. This assessment included:

Baseline CRC screening protocols

- Is there a CRC screening policy in place?
- What national screening guidelines are utilized? (ACS, CDC, USPSTF, etc.)
- Are there standing orders in place for CRC screening tests so non-providers can place the order for stool-based tests?
- Which screening options do you offer patients? (Colonoscopy, Cologuard, Sigmoidoscopy, CT Colonography, High Sensitivity iFOBT/FIT)
- Is this based on provider preference or shared decision-making with patient?
- What does CRC screening assessment look like within each partner site?
- Do you collect patient and family history?

Primary Care Clinic Partners' Patient Population Demographics

- Are there health literacy concerns for your patients?
- What are the typical patient barriers to screening adherence?
- Do you have language translation services available? What specific translation service do you use?
- Which languages do you have translation services for?
- Are there any sub-populations that should be targeted?

Clinic Environments

- How many care teams are at the clinic?
- Is the clinic fully staffed?
- Is there a clinic quality champion?
- How often does the clinic hold staff meetings?
- What is the best method to deliver professional education to your staff?
- Are CNEs, CMEs needed by staff?
- How do the health system/clinics/providers learn about updates to screening guidelines or new processes?
- Are patients assigned a PCP or are they seen by whomever is available?
- What factors support/impede the CRC screening process for staff?
- Are there any competing priorities? What are they and why are they competing?
- Are there incentives tied to the competing priorities?

Evidence-Based Interventions and Supporting Strategies

Provider Assessment and Feedback

- Do you evaluate provider performance in delivering or offering screening to clients (assessment) and present providers with information about their performance in providing screening services (feedback)?
- Does feedback describe the performance of a group of providers or an individual provider? Is feedback compared with a goal or standard and/or used to foster competition and quality improvement?
- Is feedback reported in the form of provider scorecards or in quality reports?

Provider Reminder System

- Are reminders in place to inform health care providers it is time for a client's cancer screening test (reminder) or that the client is overdue for a screening (recall)?
- Can reminders be provided in different ways such as in a client's chart or by email?

Patient Reminder System

- Do you use written (letter, postcard, email, text) or telephone messages advising people that they are due for screening?

Reducing Structural Barriers

- Are there structural barriers and non-economic burdens or obstacles that make it difficult for people to access cancer screening?
- Do you offer interventions designed to reduce these barriers to facilitate access to cancer screening services, such as:
    - Reducing time or distance between service delivery settings and target populations?
    - Modifying hours of service to meet client needs?
    - Offering services in alternative or non-clinical settings?
    - Eliminating or simplifying administrative procedures and other obstacles
    - Language translation services? Transportation assistance? Dependent care assistance?

Patient Navigation

- Do PNs typically assist clients in overcoming barriers to cancer screening? This includes assessment of client barriers, client tracking, and follow-up.
    - Do PNs involve multiple contacts with a patient?

Small Media

- Do you have materials that are used to inform and motivate people to be screened for cancer, including videos and printed materials (e.g., letters, posters, brochures, newsletters)?

Community-Clinical Linkages

- Do you have connections between community and clinic sectors to improve population health?

Health Information Technology

- Do you utilize the health information and technology resources available to the clinic to improve screening rates?

Professional Development

- Is there professional education provided to clinic staff based on their learning needs and methods?

Referral Process

- If a patient chooses colonoscopy, what is the referral process?
- How is the colonoscopy provider/clinic chosen?
- Who schedules the appointment?
- What documentation is sent to this provider?
- What is communicated to the patient?
- Who reviews prep instructions with the patient?
- Following the procedure, when are results expected back?
- How are results documented in the EHR?
- Does anyone follow up on outstanding results/pathology reports?
- Is there a different process if this is an initial colonoscopy vs. follow-up from a positive FIT/iFOBT?
- What happens when patients are uninsured or underinsured?
- What is the typical wait-time for receiving the colonoscopy?
- What happens when a colonoscopy is abnormal?
- What type of communication goes to the patient? (phone, letter, email, patient portal)
- What is the clinical workflow?
- Does the clinic have a referral network to help uninsured patients who need a colonoscopy?

Quality Improvement Efforts

- What are the clinic's general QI efforts?
- What CRC QI efforts are happening in the clinic?
- Have you successfully implemented CRC EBIs/SSs and are they still being implemented?
    - What were the results?
- Who is responsible for analyzing QI data?
- Does the clinic use any clinical data associated with UDS, eCQM, HEDIS, GPRA, or other measures to plan/implement QI activities?
- How do you verify the validity of screening rates and other data?
- When and how frequently does this occur?
- Who conducts the validation?

Educational Materials

- What CRC patient education materials are available in the clinic? (brochures, posters, decision support tools, etc.)
- Does the clinic have restrictions on educational materials such as only using health system materials?
- Are educational materials available in multiple languages that reflect the patient population? What languages?

Clinic Workflow

- Map out the patient workflow for patients 45-75 years old.
- Who shares guidelines/information about necessary screenings/options, and when?
- Who offers and who orders the screening test?
- Who provides education on FIT/Cologuard test completion and return?
- Is there an algorithm/decision tree to determine which is the best test for the patient?
- How is the decision documented?
- Do staff ask about previous CRC screening if status is unknown or not documented?
- What is the process and who is responsible for obtaining previous screening results?
- Are family history/personal history/symptoms assessed for CRC?
- How often is the assessment updated and who does the updating?
- Do providers review their patients' charts for the day before they are seen?
- Does the care team complete a daily huddle?
- What types of appointments are most common?
- What is the process and who is responsible for tracking outstanding FIT/iFOBT/Cologuard return?
- Is this tracked in the EHR?
- What is the process for following up with a patient who did not schedule or complete their colonoscopy?

IT/Admin/EHR

- How long has the EHR been in place?
- Who can run reports from the EHR?
- What is the clinic capacity to set alerts for patient or provider reminders?
    - Can this be done by clinic staff?
- Is clinic able to run reports for CRC screening completion rates by provider, care team, and/or aggregate clinic?
    - If not, what would be necessary to modify this?
- What is the frequency in which screening rates can be generated (monthly, quarterly, annually)?
- What does the chart review process look like?
- What challenges are associated with the EHR system? Is it meeting your needs? If not, what would you change?
- Can the EHR provide a list of patients who are overdue or due for CRC screening and who can run these lists?
- Can the EHR system report/query the patients who need follow-up due to a positive FIT/iFOBT or Cologuard and who can run these reports?
- Does the EHR system list the most recent type of CRC screening test that was used and date completed? Is this in a traceable field or is it in a free text field?
- How is a patient notified that they are due for CRC screening?
- Is there a report available to track CRC tests ordered/referred and completed?

EBIs and Supportive Strategies

Four EBIs identified by *The Community Guide* were deemed priority by the CDC, including:

Provider Reminder and Recall Systems	Provider Assessment and Feedback	Patient/Client Reminder Systems	Reducing Structural Barriers
These reminders inform health care providers it is time for a client's cancer screening test (called a "reminder") or that a client is overdue for screening (called a "recall").	Interventions that evaluate provider performance in delivering or offering screening to patients (assessment) and presentation of information to providers about their performance in providing screening services (feedback).	Written (letter, postcard, email, text) or telephone messages (including recorded/automated messages) advising people that they are due for screening. Client reminders can be general to reach the overall target population or tailored with the intent to reach one specific person based on characteristics unique to the person, related to the outcome of interest, and derived from an individual assessment.	Structural barriers are non-economic burdens or obstacles that make it difficult for people to access cancer screening (e.g., inconvenient clinic hours, lack of transportation). Activities to address these barriers include providing evening clinic hours, transportation services, or other interventions that make it easier for patients to be screened.

In addition to using selected EBIs to promote CRC screening, participating primary care clinic sites also incorporated supportive strategies and activities into their programs, including:

Patient Navigation	A service that assists clients in overcoming barriers to cancer screening and includes assessment of client barriers, client tracking and follow-up. Usually involves multiple contacts with a patient.
Small Media	Small media includes materials that are used to inform and motivate people to be screened for cancer, including videos and printed materials (e.g., letters, posters, brochures, newsletters).
Community-Clinical Linkages	Connections between community and clinic sectors to improve population health.
Health Information Technology	Health information technology (HIT), particularly the electronic health record (EHR), is a critical tool in the identification and management of health system populations that are due or overdue for CRC screening. EHR and HIT utilizes the health information and technology resources available to the clinic to improve screening rates and can be used to support the implementation of EBIs.
Professional Development	Professional education provided to clinic staff based on their learning needs and methods.

SD CRCCP primary care clinic partners were asked to select at least three priority EBIs for implementation at their site. Through the remainder of the report, each clinic partner is highlighted with a summary of the information gathered through the clinic readiness assessment and how that information was utilized to inform the development of their individualized plan.

Falls Community Health Center (Sioux Falls, SD)

Falls Community Health (FCH) is an urban FQHC. Patients of FCH have direct access to culturally appropriate primary and preventive health care, diagnostic and treatment services, behavioral health services, oral health care, and enabling services on a sliding fee scale.

In addition, a health care for the homeless program provides services to homeless persons throughout the community. There are approximately 2,314 patients who meet the age criteria for CRC screening at FCH, 30% are uninsured and most live in poverty. Most patients cannot afford the CRC screening or follow-up testing and treatment that may be needed.

While some patients accept that screening for CRC is important for their preventive health, they are concerned with the findings. If a diagnostic colonoscopy is indicated, many of the patients refuse or fail their scheduled appointment because they do not have the financial resources to pay for the procedure.

In addition to cost, language and health literacy can be significant barriers as well as transportation and a companion to accompany them for a colonoscopy. The FCH patient population is quite diverse with 51% white, 22% black or African American, 3% Asian, 12% American Indian, 16% Hispanic and 4% of multiple races. 20% of all patients are best served in a language other than English. There are over 3 different languages utilized to serve the patients, with Spanish being the most frequent.

FCH utilizes eClinical Works (eCW) for their EHR as well as Azara, a population health tool. The 2024 UDS screening rate for CRC was 35.6%. FCH has strong leadership support for this project in addition to three clinic champions. FCH has the ability to reach the target priority populations of men, minorities, individuals ages 45-49, and uninsured.

The health system will be implementing patient navigation, patient reminder systems, reducing structural barriers and provider assessment and feedback.

Site Quick Stats

Baseline CRC Screening Rate

(UDS, 2024) 35.6%

Target Populations Served

Men
Minority Populations
Individuals ages 45-49
Uninsured

Clinic Challenges

Transient Patient Population
Multiple Languages Among Patients

Patient Challenges

Lack of health coverage
Poverty, lack of financial resources
Language and health literacy barriers
Transportation to Appointments
Companion for colonoscopy

EBIs or Process Changes Selected

Provider Assessment & Feedback
Patient ReminderSystems
Reducing Structural Barriers
Patient Navigation

Horizon Health Clinics
(Aberdeen, Eagle Butte, Huron, Mission, Yankton)

Horizon Health clinics are FQHCs serving both rural and urban communities with established CRC screening workflows and experience implementing quality improvement activities. All Horizon clinics follow USPSTF CRC screening guidelines beginning at age 45 and utilize eClinicalWorks to support patient identification, tracking, and follow-up. These shared capabilities provide a strong foundation for implementation of CRCCP-supported EBIs.

Horizon Health Aberdeen is an urban FQHC serving a diverse and underserved patient population and has an identified CRC champion to lead clinic-level screening improvement efforts. In calendar year 2024, the clinic had 335 patients eligible for CRC screening. The clinic's current CRC screening rate is 35%, with key challenges related to insurance coverage and language access. Approximately 34% of patients are uninsured, and 26% do not speak English as their first language. Aberdeen serves a larger Hispanic population than other Horizon sites, making Spanish-speaking and uninsured patients key target populations. Recommended EBIs include provider assessment and feedback, patient reminder systems, and patient navigation to address language, insurance, and follow-up barriers and improve screening completion.

Horizon Health Eagle Butte is a rural FQHC serving a predominantly American Indian patient population and has an identified CRC champion to lead screening efforts. In calendar year 2024, the clinic had 256 patients eligible for CRC screening, with a current CRC screening rate of 37%. Approximately 68% of patients seen were American Indian. The clinic faces challenges related to rural access, transportation, and continuity of preventive care. American Indian adults in rural settings are a key target population for screening improvement. Recommended EBIs include patient navigation to support screening completion and follow-up, patient reminder systems to reinforce screening outreach, and provider assessment and feedback to support consistent screening performance.

Horizon Health Huron is an urban FQHC serving a community with a significant Karen-speaking population and has an identified CRC champion to support ongoing screening efforts. In calendar year 2024, the clinic had 942 patients eligible for CRC screening, representing a large screening-eligible population within the Horizon system. The clinic's current CRC screening rate is 48%, reflecting a strong screening foundation while still allowing room for improvement. Language and cultural barriers remain key challenges, with Karen-speaking patients identified as a primary target population. Recommended EBIs include provider assessment and feedback, patient reminder systems, and patient navigation to reinforce screening, support patient understanding, and improve follow-through.

Horizon Health Mission is a rural FQHC serving a predominantly American Indian patient population and has an identified CRC champion to lead clinic-level screening improvement. In calendar year 2024, the clinic had 467 patients eligible for CRC screening. In 2024, approximately 84% of patients seen were American Indian, and the clinic's current CRC screening rate is 39%. Key challenges include transportation barriers, limited access to specialty care, and fragmented care for patients who also utilize nearby Rosebud IHS services. American Indian adults in rural settings are the primary target population. Recommended EBIs include patient navigation, patient reminder systems, and reducing structural barriers, particularly related to transportation and access to screening services.

Horizon Health Yankton is an urban FQHC with an identified CRC champion supporting clinic-level screening improvement efforts. In calendar year 2025, the clinic had 369 patients eligible for CRC screening and a current CRC screening rate of 46%, reflecting an established screening foundation with opportunity for continued improvement. Key challenges include maintaining consistent screening follow-up and engaging patients who may delay preventive care. Target populations include screening-eligible adults who are overdue or intermittently engaged in care. Recommended EBIs include provider assessment and feedback to support consistent screening performance, patient reminder systems to encourage timely screening completion, and patient navigation to assist patients with test completion and follow-up.

Horizon Clinic Partner Quick Stats

ABERDEEN

Baseline CRC Screening Rate
(UDS, 2024) 35%

Priority Populations Served
Minorities
Uninsured
Rural Patients
Hispanic

Clinic Challenges
High uninsured patient population
Language barriers

Patient Challenges
Lack of health coverage
Language barriers
Health literacy barriers

EBIs or Process Changes Selected
Provider Assessment & Feedback
Patient Reminder Systems
Reducing Structural Barriers
Patient Navigation

EAGLE BUTTE

Baseline CRC Screening Rate
(UDS, 2024) 37%

Priority Populations Served
Rural patients
American Indian

Clinic Challenges
Rural access
Transportation
preventive Care Continuity

Patient Challenges
Transportation

EBIs or Process Changes Selected
Provider Assessment & Feedback
Patient Reminder Systems
Patient Navigation

HURON

Baseline CRC Screening Rate
(UDS, 2024) 48%

Priority Populations Served
Karen-speaking patients

Clinic Challenges
Language and cultural barriers

Patient Challenges
Language barriers
Health literacy barriers

EBIs or Process Changes Selected
Provider Assessment & Feedback
Patient Reminder Systems
Patient Navigation

Horizon Clinic Partner Quick Stats

Mission

Baseline CRC Screening Rate
(UDS, 2024) 39%

Priority Populations Served
American Indian
Rural patients

Clinic Challenges
Transportation barriers
Limited access to specialty care
Fragmented care for IHS patients

Patient Challenges
Transportation
Fragmented care for IHS patients

EBIs or Process Changes Selected
Patient Navigation
Patient Reminder Systems
Reducing Structural Barriers

Yankton

Baseline CRC Screening Rate
(UDS, 2025) 46%

Priority Populations Served
Overdue eligible adults
Adults intermittently engaged in care

Clinic Challenges
Consistent screening follow-up
Patients who delay preventive care

EBIs or Process Changes Selected
Provider Assessment & Feedback
Patient Reminder Systems
Patient Navigation

South Dakota Urban Indian Health (Sioux Falls and Pierre, SD)

South Dakota Urban Indian Health (SDUIH) has two locations in Pierre and Sioux Falls, SD. Patients of SDUIH have direct access to culturally appropriate primary and behavioral health care. Services are provided on a sliding fee schedule.

The SDUIH clinics are urban FQHCs that report UDS measures and serve American Indian/Alaska Native populations who often experience gaps in preventive care outside of tribal or IHS service areas. Across both clinics, 69% of patients served are American Indian/Alaska Native , with 33% enrolled in Medicaid and 25% uninsured. These clinics have established screening workflows and are well positioned to implement CRCCP-supported interventions focused on patient support, follow-up, and access.

SDUIH – Sioux Falls is an urban FQHC serving a predominantly American Indian/Alaska Native population and has an identified CRC champion to lead screening activities. In calendar year 2024, the clinic had 250 patients eligible for CRC screening. Approximately 86% of patients served are American Indian/Alaska Native, with 46% enrolled in Medicaid and 22% uninsured. The clinic's current CRC screening rate is 23.47%, reflecting significant opportunity for improvement. Challenges include insurance instability, competing social needs, and historical under-screening of urban American Indian/Alaska Native populations. Recommended EBIs include provider assessment and feedback, patient reminder systems, and patient navigation to improve screening performance, support completion, and address access barriers.

SDUIH – Pierre is a Rural FQHC serving an American Indian population with substantial barriers to preventive care and has an identified CRC champion to support screening improvement efforts. In calendar year 2024, the clinic had 375 patients eligible for CRC screening. Approximately 57% of patients served are American Indian/Alaska Native, with 25% enrolled in Medicaid and 26% uninsured. The clinic's current CRC screening rate is 14.8%, indicating a high level of unmet screening need. Challenges include insurance coverage gaps, limited access to specialty care, and low baseline screening rates. Recommended EBIs include patient navigation, patient reminder systems, and reducing structural barriers to improve screening access and completion.

Both partnering clinics have strong leadership support for this project through SDUIH, along with clinic champions identified at each site. The clinic champions will work collaboratively with other staff to implement CRC screening activities. The identified CRC activities also align with the breast and cervical cancer quality improvement activities implemented by clinic staff. With leadership and staff support, these sites have ample improvement opportunities for successful implementation of EBIs to increase CRC screening.

SDUIH Clinic Partner Quick Stats

SIOUX FALLS

Baseline CRC Screening Rate

(UDS, 2024) 23.47%

Priority Populations Served

American Indians
Uninsured
Medicaid

Clinic Challenges

Insurance Instability
Competing Social Needs
Under-screening of Urban AI/AN populations

Patient Challenges

Lack of Insurance
Gaps in preventive care

EBIs or Process Changes Selected

Provider Assessment & Feedback
Patient Navigation
Patient Reminder Systems
Reducing Structural Barriers

PIERRE

Baseline CRC Screening Rate

(UDS, 2024) 14.8%

Priority Populations Served

American Indians
Uninsured
Medicaid

Clinic Challenges

Insurance Coverage Gaps
Limited Access to Specialty Care
Low Baseline Screening Rates

Patient Challenges

Lack of Insurance
Gaps in preventive care
Substantial barriers to preventive care

EBIs or Process Changes Selected

Patient Navigation
Patient Reminder Systems
Reducing Structural Barriers

Mobridge Regional Hospital and Health Services (Mobridge, McLaughlin, Timber Lake, and Selby, SD)

Mobridge Regional Hospital and Health Services was selected as a successful applicant and has not previously participated in the SD CRCCP. The Mobridge Health System includes a 25-bed critical access hospital in Mobridge, SD, four rural health clinics (**Mobridge, McLaughlin, Timber Lake, and Selby, SD**), an in-hospital CLIA-certified lab, 24/7 ambulance service, infusion center (now offering infusion-based chemotherapy), on-site PT/OT and cardio-pulmonary rehab, and a 24-bed assisted living facility.

Mobridge Health System utilizes Cerner as their EHR as well as i2i, a population health tool. At the time of their application, Mobridge Health System had 2,125 patients between the ages of 45-75. The overall health system screening rate is 56.6% and individual rates for the four rural clinics is as follows: Mobridge 64.7%; Selby 38.7%; Timber Lake 34.5% and McLaughlin 19.3%. Three percent of patients are uninsured.

Target populations for the health system include uninsured, low income, rural and American Indian patients. The health system will be implementing patient navigation, patient reminder systems, provider assessment and feedback and reducing structural barriers.

Site Quick Stats

Baseline CRC Screening Rates

Overall: (UDS, 2024) 56.6%
Mobridge: (UDS, 2024) 64.7 %
Selby: (UDS, 2024) 38.7%
Timber Lake: (UDS, 2024) 34.5%
McLaughlin: (UDS, 2024) 19.3%

Target Populations Served

Uninsured
Low Income
Rural
American Indian

Clinic Challenges

Health Insurance Coverage
Rural Access

Patient Challenges

Lack of insurance
Lack of financial resources
Transportation

EBIs or Process Changes Selected

Provider Assessment & Feedback
Patient Reminder Systems
Reducing Structural Barriers
Patient Navigation

Technical Assistance

Monthly meetings are held with all twelve SD CRCCP primary care clinic partners, of which implementation guidance and continuous quality improvement are a core focus. The results of the clinic readiness assessments and workplans are utilized as guides for individualized technical assistance. Across the primary care clinic partner locations, additional technical assistance may focus on refining CRC screening protocols and clinic workflows, enhancing quality improvement efforts within unique EHR systems, and assisting sites in addressing gaps in preventive care.

Sustainability Planning

As the SD CRCCP partnering primary care clinic teams work on implementation activities for their selected EBIs and supporting strategies, the CRC Partnership Facilitator is focusing efforts on institutionalizing system changes through process improvement and utilization of Health IT tools. The development of standard workflows, policies, and incorporation into practice for CRC screening will assist with sustainability once the implementation period is complete.

Summary and Lessons Learned

The SD CRCCP prepared for successful primary care clinic partnerships by assessing clinics' readiness to implement EBIs for enhanced CRC screening. As the new SD CRCCP primary care clinic partners are in the early implementation phase, reportable system-level changes resulting from the partnership have not yet been assessed.

The SD CRCCP devised supportive technical assistance to enhance the EBI implementation process among the individual primary care clinic partner locations. Overall, releasing an RFA for clinic funding served as a way to utilize applications as a comprehensive clinic screening process, allowing the SD CRCCP to establish partnerships with primary care clinics well-suited to reach the identified target populations with enhanced CRC screening efforts. The information gathered through the RFA application allowed the SD CRCCP to better understand each partnering clinic's unique barriers and challenges which allowed staff to fine-tune the EBI selection and implementation process, as well as devise supportive technical assistance to enhance outcomes. The outlined steps may be applied in similar settings within and beyond the state's borders to establish health system partnerships for success in implementing enhanced CRC screening efforts.

COLORECTAL CANCER SCREENING PROGRAM IN SOUTH DAKOTA

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