

# Enhanced Access to Cancer Screening (EACS): Evaluation Summary<sup>1</sup>

## Project Focus

The Enhanced Access to Cancer Screening (EACS) project was a two-year initiative that brought together federal, provincial, zone and community partners to increase access to cancer screening. The initiative was co-funded by the Public Health Agency of Canada (PHAC) and Alberta Health Services. It was based on the premise that integrating screening services may be more successful in addressing clients' needs and at increasing access to care (Leatt, Pink & Guerriere, 2000; Canadian Nurses Association, 2013; Eamons et al., 2011; Druss et al., 2010; WHO, 2008).

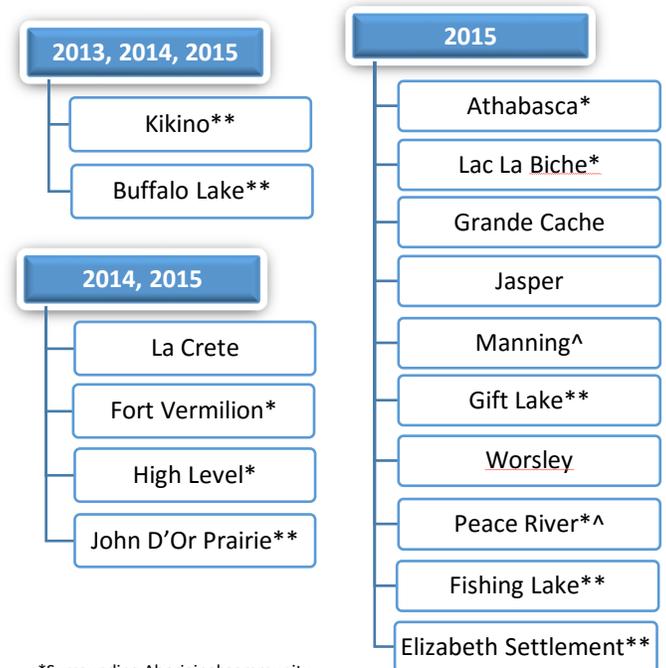
A service delivery framework to guide the integration of cancer screening in public health was developed and validated through the experience of implementing 24 EACS clinics at 16 sites in the North Zone. EACS built on the success and existing capacity of established Screen Test mobile mammography services. When Screen Test, as part of their annual schedule, visited a selected site to offer breast cancer screening, nurses from the community had the opportunity to offer cervical and colorectal cancer screening at the same time.

## Evaluation Approach

The evaluation was conducted between September 2013 and October 2015 and was a collaborative effort among provincial and zone partners. The approach was based on a blending of two context sensitive approaches: developmental evaluation and the RE-AIM framework. This report provides highlights of methods and key findings. A full description of methods and results are available in the final report. The evaluation had three main objectives:

- to document the planning and delivery of integrated cancer screening clinics (project implementation),
- to identify key principles and practices that can be adapted to communities across the province and beyond (service delivery framework), and

## Clinic Sites by Year



\*Surrounding Aboriginal community.

\*\*Aboriginal community.

^Surrounding Hutterite community.

- to begin to assess the public health impact of the framework in the short-term (implications for making a difference).

Data collection methods included clinic debrief sessions, client and staff surveys,<sup>2</sup> and review of project records, including data collected on the day of the clinic.

A consultant, hired towards the end of the project, determined screening uptake related to EACS by comparing women who were up-to-date for all eligible screens in two groups: Screen Test clients screened at EACS sites and clients screened at regular Screen Test visits across the North Zone (control). EACS related screening included any screening that occurred within six weeks before the clinic and up to three months after the clinic (EACS related screening).

<sup>1</sup> The final evaluation report and interim clinic evaluation reports are available upon request from Screening Programs, Alberta Health Services.

<sup>2</sup> The response rate for the client survey was 57% (911 of 1596) and for the staff survey 96% of clinic staff (44 of 46) and 80% of booking clerks (8 of 10) responded.

*Evaluation Challenges*

- Inability to create an accurate baseline for all EACS participants within a defined geographic area.
- Variable data collection at the local level.
- Full engagement of physicians in the project.
- Inability to assess long term outcomes -- outside project timelines.

## Key Findings

*Clinic Implementation*

The *Integrated Screening Guide*<sup>3</sup> (the *Guide*) was developed early in the project. New practices and tools were added to the *Guide* after they were validated at clinics. Starting in 2015, the *Guide* was used to facilitate planning, training and clinic delivery. Use of the *Guide* dramatically streamlined planning. Staff reported that it was user-friendly and useful for information about delivering a clinic and for colorectal training needs.

*Implementation Challenges*

- Coordinating staff availability with the Screen Test schedule at some sites.
- Variation in clinic attendance due to factors outside the control of the project (e.g., recall schedules, weather, or a death in the community).
- Establishing thorough and efficient follow up processes for colorectal cancer screening and incorporating these into existing practices used with other tests.

*Lessons Learned*

For each clinic delivered, key successes and learnings were documented. The lessons learned represent validated practices that include associated tools for integrating cervical and colorectal cancer screening with breast cancer screening. The focus of the lessons learned is on the provision of cervical and colorectal cancer screening in public health and the coordination of these services with breast cancer screening. Lessons learned addressed the concept of integrated screening, community assessment, clinic preparations, physician engagement, clinic promotion, staffing and coordination as well as the follow up of abnormal results.

*Implications for Making a Difference*

The evaluation also included an initial consideration of short-term outcomes. Given the developmental nature of

the project, the level of this data is more suggestive than definitive.

Increased capacity

- To provide colorectal cancer (FIT) screening.
- To offer cervical and colorectal cancer screening in conjunction with the Screen Test mobile unit visit.

Adoption

- The majority of staff (90%) were very or somewhat interested in delivering more clinics and looking for other ways to integrate screening.
- All staff (clinic and Screen Test) felt that clinics are feasible if they are well coordinated and organized.

Increased knowledge and awareness

- Almost three quarters (72%) of surveyed clients reported that they knew more about cancer screening after the clinic than before.

Reach (Access)

- The results focus on attendance data rather than participation rates because of difficulties establishing the eligible population for EACS clinics.
- 1596 clients screened and 67 communities served (see below for more detail).

### Clinics by the Numbers

Number of clinics delivered: 24
Number of Screen Test sites: 16
Communities that had access to clinics: 67
Clinics offering 3 cancer screens: 19
Clinics offering 2 screens (colorectal & breast): 5
Number of clients screened: 1,596
Number with more than one screen: 374 (17%)
Women screened for breast cancer: 1463
Abnormal breast screens: 60 (4%)
Women screened for cervical cancer: 238
Women between the ages of 21-49: 71
Women with abnormal Paps (ASC-US): 5
Women with inadequate samples: 3
Women screened for colorectal cancer: 252
Men screened for colorectal cancer: 44
FITs returned to the lab: 206 (69%)
Positivity rate: 8%

<sup>3</sup> The Integrated Screening Guide is available on request from Cancer Screening Programs, Alberta Health Services.

- Eleven clinics were held in Aboriginal (First Nations or Métis) communities and seven were held in locations with Aboriginal communities in the catchment area. Two locations had Hutterite populations in the surrounding communities (see *Clinics by Site*).

Increased Access

- The majority of clients surveyed reported that wait time for their appointments was reasonable (92%) and were interested in seeing more integrated cancer screening clinics in their communities (91%). Common reasons for wanting more clinics included the increase in access, the convenience, and the importance of early detection.
- Screen Test technologists reported that their clients were positive about the clinics, liked not having to drive far for colorectal and cervical cancer screening and liked being able to do all three screens at once. Clinic staff rated the clinics successful in terms of clients screened, clients with more than one screen, and client feedback.

Screening Uptake due to EACS

- EACS related screening uptake was the proportion of all eligible women who are screened for breast, cervical and colorectal cancers (aged 50-69) and the proportion screened for breast and colorectal (aged 70-74) within six weeks before the clinic and up to three months after the clinic. This time accounted for promotional efforts before the day of the clinic and for the effect of increased knowledge and awareness after the clinic. These results are conservative and will underestimate the true effect of EACS.<sup>4</sup>
- Figures 1-3 show the added value of EACS in increasing the proportion of women up-to-date with screening is around 15% for cervical and 16% for colorectal cancer screening among women 50-69 years. Among women 70-74 years, the added value of EACS for colorectal screening is 19%. Although the results are promising, caution is warranted as the analysis is preliminary.

Project Level Sustainability

- Sustainability was viewed as a process and revisited often in the context of team and stakeholder meetings.
- A list of actions to support sustainability was drafted early in the project and, as a result, steps have been taken to refine the role of Aboriginal health workers in relation to cancer screening, to increase Aboriginal resources, and to develop a clear scope of practice for public health nurses. The North Zone continues to work

**Screening Related Uptake due to EACS Among Screen Test Clients<sup>5</sup>**

Figure 1: Cervical Cancer Screening, Women Aged 50-69

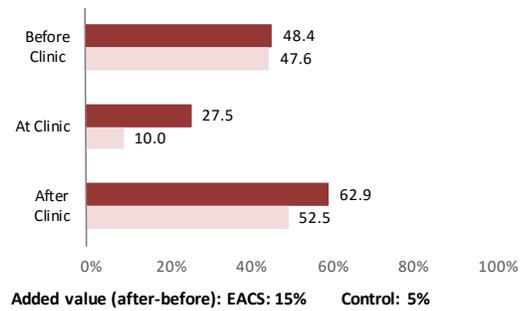


Figure 2: Colorectal Cancer Screening, Women Aged 50-69

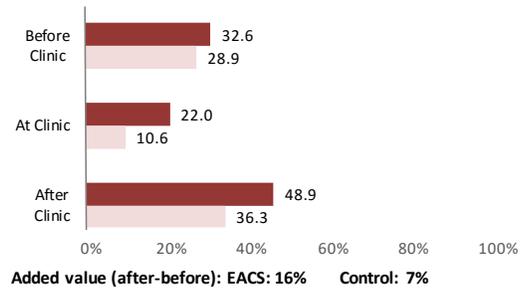
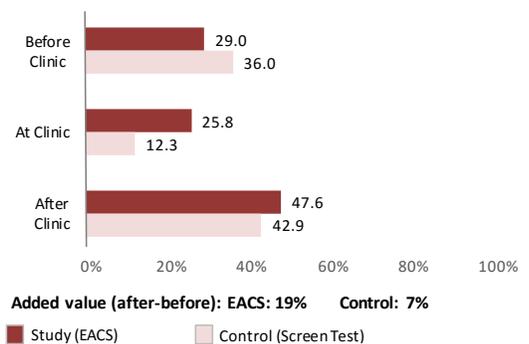


Figure 3: Colorectal Cancer Screening, Women Aged 70-74



on these and other areas that will continue to support the sustainability of integrated screening.

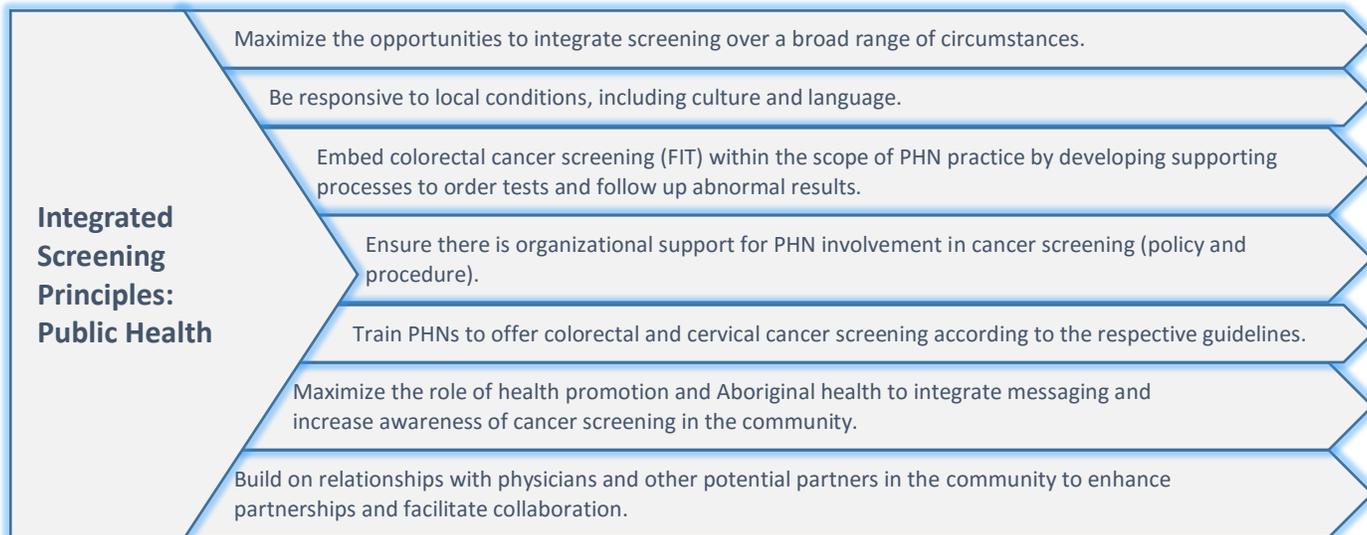
The Integrated Screening Framework Principles

- Taken together, the set of principles and the *Integrated Screening Guide* provide the framework for guiding practice around integrated screening.
- The principles are based on actionable knowledge gained from implementing the clinics in a variety of communities (i.e., lessons learned).
- The principles are all focused on public health and are organized in two main sections: integrated screening in public health overall and integrating with a mobile mammography unit.

<sup>4</sup> A more comprehensive report detailing the method, analysis and full results will be available after the study period is complete (April 2016).

<sup>5</sup>This analysis excludes men and women who were not clients of Screen Test.

## Integrated Screening Framework Principles



## Conclusion and Next Steps

A service delivery framework to guide the integration of cancer screening in public health has been developed and validated through the experience of implementing EACS clinics in the North Zone between September 2013 and October 2015. The results from the evaluation have supported the development of the framework by providing iterative and ongoing data in real time. Preliminary results from a supplementary analysis support the added value of offering cervical and colorectal cancer screening in conjunction with the breast cancer screening offered through the mobile mammography unit. Ongoing evaluation is required to develop an indicator of integrated screening participation (i.e., to determine the proportion of women who have been screened for all the cancers for which they are eligible), an associated target and to assess the effects of the framework in the long term.

Although there are encouraging signs of the growing support for an integrated approach to cancer screening, there are a number of system level changes that need to occur to support the sustainability of the approach developed through the EACS project. These include:

- Addressing the training capacity issues identified through the project (competency guidelines for maintaining FIT screening and more nurses trained in cervical cancer screening).
- Organizational support for PHNs to order FIT tests either directly or in collaboration with a physician.
- A clearly established process for PHNs to follow up abnormal results within their normal scope of practice.
- Acknowledging that integration is not a cure for inadequate resources (WHO, 2008). If PHNs are to screen for cervical and colorectal cancers, resources need to be allocated to support this work within their current roles and responsibilities.
- Ongoing evaluation is required to monitor and evaluate the impact of integrated screening and the implementation of the framework in other communities across the province.



## References

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