Original Article

Fostering Partnerships and Program Success

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BACKGROUND: Fostering partnerships was critical to the success of the Colon Health Program (CHP) in Greater Seattle. The CHP was built on the Breast and Cervical Health Program (BCHP) framework. A replicable system to provide quality colorectal screening services for individuals with limited incomes and no health insurance was developed. **METHODS:** Partners were recruited and engaged during 3 programmatic phases: 1) development and start-up, 2) implementation, and 3) sustainability planning. Several tactics were used to develop trust and build bridges among the partners and to create an effective work group. **RESULTS:** The partners were critical to developing clinic policies, procedures, and systems to increase colorectal screening and improve follow-up; expanding access to colonoscopies; and initiating statewide dissemination of training and systems as well as policy change. The fecal occult blood test completion rate was 61%, and the colonoscopy completion rate was 78%. The colonoscopy navigation system was effective with a low "no show" rate (8%). The partners were instrumental in helping Washington State obtain funding from the Centers for Disease Control and Prevention to continue the CHP statewide. **CONCLUSIONS:** During implementation, key elements for success included: building the project on the successful BCHP framework, meticulous training of clinic staff about colorectal cancer and screening methods, frequent consultation to identify and solve problems, active support of the clinic administration, and the presence of a CHP champion in the clinic. Institutionalization of the CHP depended on: assessing progress after the first year, documenting experience with the program, disseminating lessons learned, engaging new partners, and determining steps to expand the program. ***Cancer*** **2013;119(15 suppl):2884-93.** © *2013 American Cancer Society.*

KEYWORDS: partnerships; colorectal cancer; clinic policies, procedures, and systems to increase screening and assure follow-up; expand access to colonoscopies; program dissemination.

INTRODUCTION

In this report, we describe how fostering partnerships led to the successful development of the Colon Health Program (CHP) in Greater Seattle. The CHP, as 1 of 5 Centers for Disease Control and Prevention (CDC)-funded Colorectal Cancer Screening Demonstration Programs (CRCSDPs), was built on the framework of the Breast and Cervical Health Program (BCHP), which provides quality breast and cervical screening and diagnostic services for women with limited incomes and no health insurance. The BCHP is administered by the Washington State Department of Health (DOH) and is a population-based program intended to reduce mortality and morbidity from breast and cervical cancers through early detection with screening and diagnostic services and through prompt access to cancer treatment. The BCHP is funded by the CDC (National Breast and Cervical Cancer Early Detection Program), Susan G. Komen for the Cure (Puget Sound, Eastern Washington, and Portland Affiliates), the Breast Cancer Prevention Fund, and the American Cancer Society (ACS) (Great West Division). Public Health-Seattle & King County (Public Health) manages the BCHP in a 4-county service area. Public Health contracts with local agencies and health care providers for outreach and clinical services. Public Health, BCHP contractors, and partners developed the CHP in King, Clallam, and Jefferson Counties.

Problem Statement

Colorectal cancer is the second leading cause of cancer-related death in the United States and in Washington State. Screening for colorectal cancer is 1 of the most effective clinical preventive services for reducing morbidity and mortality from

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the disease.[1] The US Preventive Services Task Force recommends screening adults ages 50 to 75 years who are at average risk using fecal occult blood testing (FOBT), sigmoidoscopy, or colonoscopy.[2]

In 2004, the Behavioral Risk Factor Surveillance Survey reported that the colorectal cancer screening rate was 57% among adults aged ≥50 years in King County. Screening was defined as having an FOBT within 1 year, a sigmoidoscopy or colonoscopy within 5 years. Because of the Behavioral Risk Factor Surveillance Survey questions for 2004 and prior years, we were unable to separate colonoscopy from sigmoidoscopy to define colonoscopy within 10 years. Among uninsured adults ages 50 to 64 years, the screening rate was only 23%. These relatively low screening rates contributed to a higher mortality from colorectal cancer.[3]

In 2005, 65% of new cases of colorectal cancer in King County were diagnosed at a late stage. African Americans, American Indians, and Alaska Natives had higher poverty rates, lower rates of health insurance coverage, and lower colorectal cancer screening rates than Caucasians. The 2005 age-adjusted colorectal cancer death rates for African Americans (24.2 of 100,000) and for Native Americans (25.2 of 100,000) were substantially higher than the rate for Caucasians (16.4 of 100,000).

The priority population identified by the CDC for the demonstration project (low income, uninsured and under-insured adults aged ≥50 years) was consistent with the established need in our community. Greater Seattle also prioritized African American and Native American populations. We used evidence-based approaches to promote colorectal cancer screening. This included the approaches recommended by the Task Force on Community Preventive Services (eg, client reminders, small media, and reducing structural barriers to screening)[4] and those in the review by Morrow et al[5] of community-based colorectal cancer screening interventions for underserved populations (eg, community education and telephone outreach).[5] The CHP provided the opportunity to: 1) increase screening among the priority populations; 2) increase awareness about screening in the total population; 3) develop a comprehensive screening system, including community outreach and public education, primary care services, patient navigation, gastroenterologist specialty services, case management and patient support; and 4) replicate the screening system statewide.

The purpose of this report is to describe the tactics used to foster partnerships that led to successful implementation of the CHP. In developing the CHP, partnerships were critical, providing essential support during 3 programmatic phases: 1) development and start-up, 2) implementation, and 3) sustainability planning. By describing how our partnerships were forged and maintained, we hope to facilitate other programs' partnership efforts.

Below, we review the literature relevant to our program model. Next, we describe how partners were engaged and recruited at each of 3 programmatic phases. We describe our efforts to maximize the benefits of collaboration and minimize the costs throughout the partnership process. Then, we provide examples of key achievements. Finally, we discuss how fostering partnerships with enhanced collaborations contributed to the development of an effective model program that is now being implemented statewide.

Literature Review

We conducted a review of the literature relevant to our program model and the role of partnerships. First, we present literature that provided the basis for the framework we used to establish partnerships supporting the CHP. Then, in Table 1, we describe the relevant literature on key elements of collaborative partnerships and their impact on community health, particularly cancer screening.

Although we built the CHP on the existing BCHP, lessons from our literature review required that we incorporate significant changes in the established procedures of both Public Health and the participating clinics. From the onset, we prioritized partnerships as central to the success of the CHP, including modifying BCHP procedures. Consequently, we applied the Stage Theory of Organizational Change and prior community coalition and partnership efforts to inform our partnership development. Both are described below.

Framework: Stage Theory of Organizational Change

The Stage Theory of Organizational Change describes how a coalition of complex organizations makes change to implement a new program[12,13] and provides a framework for understanding the role of partnerships in that process. The framework demonstrates how organizations working together in a community are able to address an issue beyond the capacity of any single organization. The theory also describes the benefits and costs of collaboration; awareness of and addressing these benefits and costs are key to building strong partnerships. Benefits of collaboration include access to new information, ideas, materials, and resources as well as the potential to maximize use of scarce resources. Costs associated with collaboration include diversion of resources, dilution of an

TABLE 1. Literature Review Summarizing Key Elements of Collaborative Partnerships and Their Impact on Community Health

Author/Study	Outcome/Key Factors
Roussos & Fawcett 2000[6] (reviewed 34 studies describing the effects of 252 partnerships)	Partnerships contributed to population-level health improvements, community-wide system changes. and health behavior change; key factors: clear vision and mission, develop action plan and effective leadership (communication, meeting facilitation, negotiation, and networking skills), ongoing feedback on progress, technical assistance and support, securing financial resources, and making outcomes matter
Lasker & Weiss 2003[7] (presents a multidisciplinary model with processes that lead to more effective community problem solving and improved community health)	Develop bridges and social ties that connect individuals and organizations; create broad-based control and influence; select leadership that believes in the capacity of diverse individuals and organizations to work together to identify, understand, and solve problems
Mays 1998[8] (studied health alliances from 60 communities in the United States and described the public health role)	Public health role in partnership is "boundary spanner": secure buy-in from stakeholders, respond to constraints, keep structure simple, ensure effective communication, develop explicit evaluation strategy, and maintain momentum
Kluhsman 2006[9] (documented the impact of 11 rural community cancer coalitions in Appalachia)	Documented 15 sustainable community changes; 49% of individuals reached through the coalitions completed the cancer screening services
Ward 2006[10] (compared dissemination of Screen for Life, National Colorectal Cancer Action campaign materials among 450 randomly selected organizations affiliated with cancer coalitions to 450 organizations not affiliated with coalitions)	Seventy-five percent of organizations in the coalition were positively influenced by the coalition to use materials, 29% of organizations in the coalition group participated compared with 8% of the noncoalition group
DeGroff 2008[11] (case study evaluation of program start-up for the 5 Colorectal Cancer Screening Demonstration Program sites)	Partnerships provided critical resources from initial grant application through program development, implementation, and sustainability planning

organization's position on an issue, possible incompatible positions and policies and delays in taking action because of time spent developing consensus.

Mays et al[8] described key elements for successful partnerships during the implementation phase, including training and process consultation, consultation after training, and active support of an administrator and champion at the implementation level. Key elements for institutionalization were to assess the first year experience with the program and determine the necessary steps to maintain and increase its use. We attempted to address each of these key elements during the implementation and sustainability phases of the CHP.

Program Planning and Development

The partners were engaged and recruited at each of the 3 CHP phases: 1) development and start-up, 2) implementation, and 3) sustainability planning. Some partners had a long history of working together in the BCHP or the Colorectal Cancer Task Force, whereas others, like the gastroenterologists, had no experience with either group. Partners were comprised of a diverse group by race, ethnicity, and professional roles. Key partners were primary care center staff, gastroenterologists, Medical Advisory Board members, staff from the Washington State Department of Health, and members of the Colorectal Cancer Task Force and the Washington CARES (Community, Action, Research and Evidence based Systems) About Cancer Partnership.

To develop trust and build bridges linking the partners, Public Health used several tactics. From the onset, Public Health staff set a tone of inclusion, respect, and acceptance. Being positive, supportive, and flexible while recognizing there were many effective approaches to understanding and solving problems was critical. Another important practice intended to facilitate partnerships was the open, fair, and equitable distribution of resources, including CDC funds, materials, staff support, and client incentives. By applying procedures used in the BCHP, Public Health staff shared the budget allocation plan with all involved and made changes as needed to address needs identified by partners.

It was important to acknowledge the challenges as we started working on the demonstration project: colorectal cancer screening is more complicated than breast or cervical cancer screening because of the multiple screening modalities, their different time intervals, and the complexity of the tests. The CHP partners had to learn a lot of new information about colorectal cancer screening tests and protocols and had to gain experience communicating this information effectively to clients. It was uncomfortable for partners, who were accustomed to being experts in

implementing the BCHP, when some of our strategies failed or client enrollment did not meet expectations. Public Health staff expressed strong support for the partners and was confident that, by working together, an effective system to increase colorectal screening would be developed and lives would be saved. For the gastroenterologists who had never worked with Public Health or BCHP, barriers included wariness about involvement in a special project, lack of capacity, and concerns about the contract or reimbursement rate.

By the end of the first year, effective work relationships were established between Public Health, local partners, and national partners, including the other CDC-funded demonstration project sites. Table 2 summarizes key partners at each program stage along with their contributions to the CHP. Figure 1 illustrates the partnership structure at the end of project start-up.

To engage new clinical partners, representatives from Public Health met with medical and management staff from the BCHP primary care centers and multiple gastroenterology groups to discuss the CHP. We shared progress reports and program materials and invited their participation in the CHP. With the gastroenterologists, we emphasized the successful client navigation procedure

TABLE 2. Colon Health Program Key Partners

Partner	Contribution to Program
Phase 1: Development and start-up	
Colorectal Cancer Task Force, Washington CARES About Cancer Partnership	Identified CDC's CRCSDP funding opportunity; selected applicant for grant, developed strategic approach, and helped write the grant; served as CHP Advisory Committee; funded CHP activities: translated brochures, client incentives, database, and additional BRFSS questions about colorectal cancer screening
American Cancer Society, Great West Division	Contributed community and provider education materials, including copies of "Complete Guide to Colorectal Cancer" for all partners
BCHP contractors: Ten primary care centers and 1 referral agency	Developed effective procedures for client recruitment, enrollment, education, clinical care, and follow-up, navigating to gastroenterologist and cancer treatment and data collection that met or exceeded the CDC CRCSDP program requirements and quality measures
Two gastroenterologist practices	Provided colonoscopies
Medical advisory board: Primary care and gastroenterologist physicians, nurses, nurse practitioners, and researchers	Provided expertise in medical practice, program evaluation, and colorectal cancer model screening systems
Cancer Information Service	Assisted in locating education and community resources
CDC staff	Provided technical assistance and encouragement
Phase 2: Implementation	
Twenty additional BCHP primary care centers and 5 outreach agencies	Further tested and enhanced methods for client services; expanded screening capacity; initiated community education and outreach to promote screening
Two additional gastroenterologist practices	Increased access to colonoscopy services, which a key reason why more BCHP primary care centers decided to participate
BCHP community partners	Shared information about colorectal cancer screening with their agencies and networks
American Cancer Society Cancer Action Network	Led policy and advocacy efforts in the Washington state legislature; organized educational proclamations sponsored by members; helped pass legislation mandating the inclusion of colorectal cancer screening in health insurance plans
Pacific Rim resources	Evaluated CHP education materials and messages
Phase 3: Sustainability planning	
Washington state legislature	Allocated state funds to expand CHP statewide
Washington State DOH	Applied for CDC grant to plan and implement a Dialogue for Action statewide effort to develop a working plan to increase colorectal cancer screening; coordinated statewide expansion of the CHP and integration with BCHP; applied for new CDC funds to implement colorectal cancer screening program
BCHP prime contractors	Planned and implemented CHP in their service area
Colorectal Cancer Task Force, Washington CARES About Cancer Partnership	Planned and implemented (with DOH) the Washington State Dialogue for Action on Colorectal Cancer to develop statewide agenda; created a nonprofit organization to develop new resources to address colorectal cancer (Washington Colon Cancer STARS)

Abbreviations: BCHP, Breast and Cervical Health Program; BRFSS, Behavioral Risk Factor Surveillance System; CDC, Centers for Disease Control and Prevention; CHP, Colon Health Program; CRCSDP, Colorectal Cancer Screening Demonstration Program; DOH, Department of Health; STARS, Support, Treatment, Awareness, Resources, and Screening.

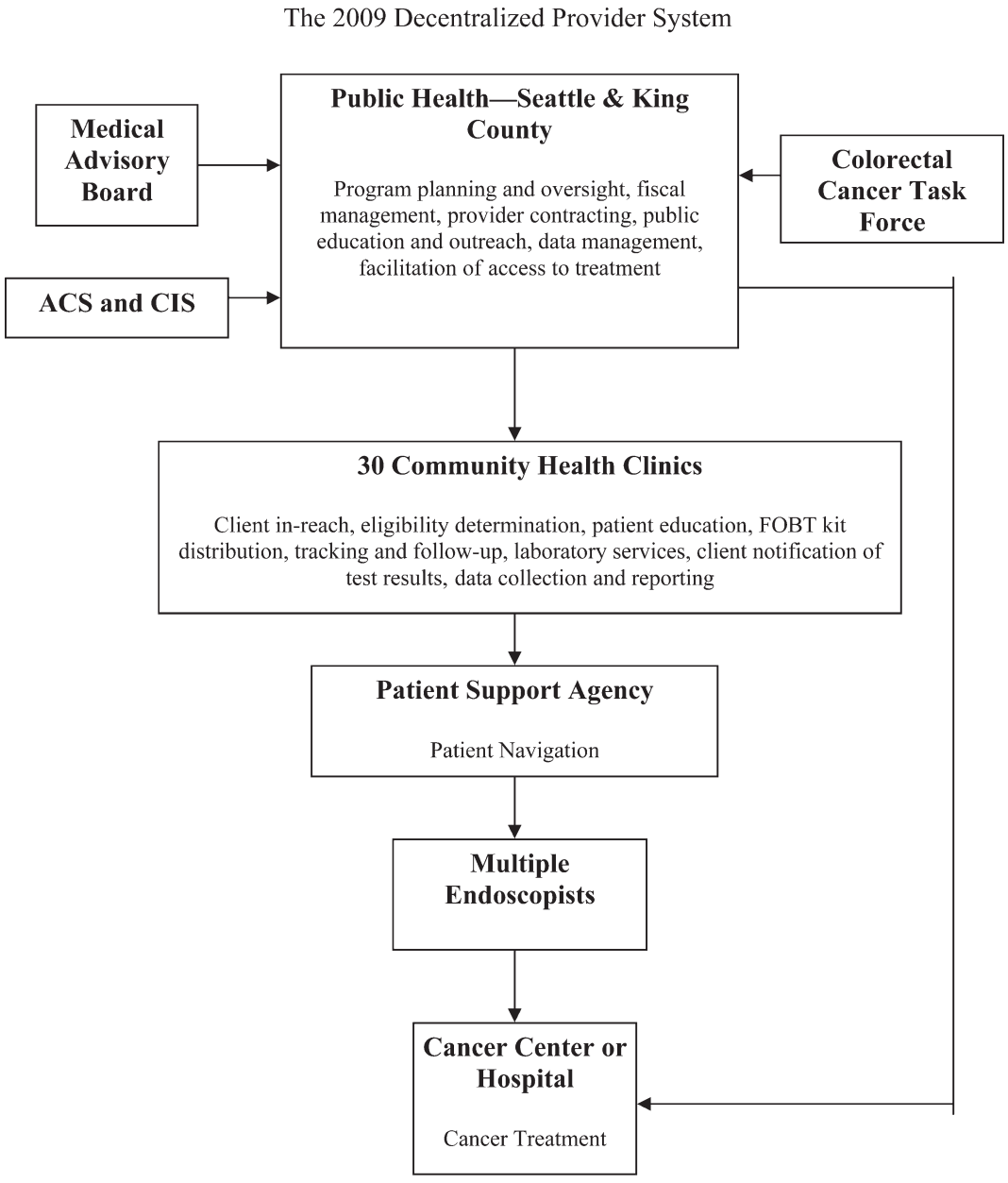

Figure 1. The decentralized provider system for the Colorectal Cancer Screening Demonstration Program in the State of Washington is illustrated. The Colorectal Cancer Task Force is a subcommittee of statewide Comprehensive Cancer Control (CCC), which was established to address colorectal cancer issues. ACS indicates American Cancer Society; CIS, Cancer Information System; FOBT, fecal occult blood testing.[11]

and the low "no-show" rate. We negotiated a limited number of client visits and assured that the CHP would not overload their clinic or management capacity. With the BCHP primary care centers, we promoted funding support for agency planning needs, Public Health's training and technical assistance and the resources already developed, such as medical protocols, client education materials, and a template that drew data from the electronic medical record system, used by several agencies.

To engage new community partners, Public Health staff presented CHP progress reports and information about colorectal cancer screening to the BCHP partners and the ACS Cancer Action Network (ACS CAN). We discussed our mutual interests and identified opportunities for

collaboration, such as a legislative effort to obtain funding for statewide expansion of the CHP and educating BCHP partners so they could share information about colorectal cancer screening within their agencies and networks. Public Health contracted with a communications firm (Pacific Rim Resources [PPR] Communications) to evaluate the CHP education materials and messages. Public Health, ACS CAN, and the Colorectal Cancer Task Force worked with the new partners to address access to colorectal cancer screening for insured and uninsured populations statewide.

Program Implementation and Operation

Examples of key achievements at each project phase that were facilitated by our partnerships are described below and include many of the achievements that reflect our partners' collaborative efforts to overcome unexpected barriers, tailor activities for priority populations, and assure quality services.

Phase 1: Development and start-up

In the first 6 months, Public Health staff and a physician from the clinic trained all staff at the 10 clinical sites about colorectal cancer screening and follow-up and the CHP procedures. Training included in-depth information about colorectal cancer and prevention, approved screening methods, reimbursement, client education, how to make gastroenterology referrals, follow-up to increase FOBT returns, and strategies for helping clients who were diagnosed with cancer access treatment services. Through this process, Public Health staff discovered a remarkable range of knowledge about prevention and detection of colorectal cancer among clinic staff. In addition, most clinic staff offered screening opportunistically when a client came into the clinic and if the provider remembered. None of the clinics had a reliable system to track FOBT returns or colonoscopy completion. The CHP elevated systematic colorectal cancer screening as a priority in the clinics. Consequently, clinic staff developed systems to offer screening, educate clients, track test completion, and follow-up on test results. Two important improvements included identifying clients at increased or high risk and assuring they were referred for colonoscopy and eliminating the practice of in-office FOBT, which is not an effective method to screen for colorectal cancer.[14]

Public Health staff formed a CHP Committee comprised of a manager and screening coordinator from each primary care clinic, the referral agency, and a gastroenterologist to manage the detailed planning and implementation for the project. They developed systems for the project and for each participating organization to educate and recruit clients, offer colorectal cancer testing, remind clients, track tests, assure follow-up for clients with abnormal results, and navigate clients to colonoscopy services.

After approximately 6 months of program operations, the CHP partners made several important changes:

1. Reimbursement for start-up costs

The clinic staff needed more time than anticipated to set up the program because of the complexities of program eligibility, instructing clients on how to complete FOBT tests, and completing a complex data reporting and reimbursement form. Consequently, managers and clinical coordinators had to spend significant time troubleshooting and developing internal clinical systems.

2. Simplified client enrollment

Enrollment was challenging, because it involved documenting eligibility for CHP, determining whether the client was at increased risk or average risk for colorectal cancer, and assuring the appropriate test recommendation. The different age range from BCHP, developing strategies to include men, and not enrolling high-risk clients or clients with symptoms also proved problematic. Public Health staff produced a protocol sheet to help clinic staff quickly determine eligibility and identify the appropriate test.

3. Gastroenterology appointment follow-up

Clinic staff wanted to know the status of clients who were referred to gastroenterology providers and how many clients missed appointments for colonoscopy. This resulted in an extensive redevelopment of the gastroenterology referral and navigation procedure to communicate with the referring provider if a client missed or did not schedule an appointment.

4. Incentives for fecal occult blood test completion

Another frequent concern was client completion of FOBTs. Each clinic developed a system to remind clients to complete FOBTs. Usually, this included 2 telephone calls and a letter spread over 3 weeks. Public Health staff created a flyer that visually demonstrated how to complete an FOBT and mailed a $10 grocery store gift card and flyer encouraging healthy eating, physical activity, and tobacco cessation to further reduce cancer risks to clients who completed the test.

Phase 2: Implementation

Improved colorectal cancer screening system

The CHP developed effective systems to offer colorectal cancer screening, educate clients about the tests,

provide follow-up to increase returns, and assure that clients with abnormal tests were referred for a follow-up test (colonoscopy). Client characteristics are described more fully in the article by Seeff et al in this supplement to *Cancer*.[15] Public Health monitored effectiveness through the data reporting system, which tracked enrollment, screening tests, test completion, timeliness of follow-up, and test outcomes.

Increased colorectal cancer screening rates

In total, 2679 clients were enrolled. The FOBT completion rate was 61%. Of those tests, 17% were positive. The average FOBT return time was 20 days, and the median was 12 days. It was unclear how much the gift cards contributed to the improved FOBT return rate. For clients who had a positive FOBT or who were at increased risk for colorectal cancer, the colonoscopy completion rate was 78% (see Fig. 2). The colonoscopy completion rate for average risk clients who were initially referred for screening colonoscopy was 50%. Fifty percent of average-risk clients who were referred for colonoscopy refused to return calls to the navigator to schedule an appointment or refused the screening test once they understood what the procedure involved. Of the 728 colonoscopies completed, the average time to completion was 108 days, the median was 96 days, and 227 colonoscopies (31%) detected 1 or more adenomatous polyps. Two clients were diagnosed with colorectal cancer during the CHP demonstration project. One client was diagnosed with stage IIA colorectal cancer, and 1 client was diagnosed with high-grade dysplasia during the CHP demonstration project.

Successful outreach to priority populations

Clinic in-reach, small group, and 1-to-1 outreach has worked well in BCHP recruitment and was effective in recruiting clients for the CHP. The BCHP outreach workers provided colorectal cancer screening messages to individuals they encountered. Incentives, such as blue star pins or blue wristbands, which represent colon cancer and screening awareness, were used to support the education encounter. To augment the outreach worker activities, Public Health staff implemented a mass media campaign promoting colorectal cancer screening and a targeted media campaign through local community newspapers and radio stations that served priority populations.

The CHP exceeded its goals of reaching: 25% men and 40% people of color. Of the 2679 clients enrolled in the program, 29% were men, 59% were people of color, 40% spoke a language other than English, and 85% were King County residents. Client characteristics are described more fully in the article by Seeff et al.[15] Only 6% of clients had been previously screened at the recommended intervals. About 5% of clients were at increased risk because of a family history of colorectal cancer or polyps.

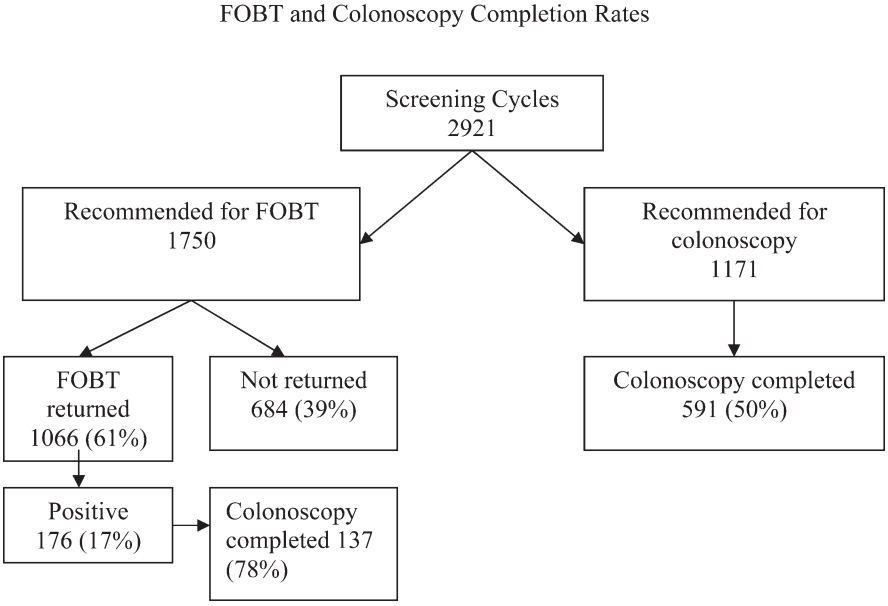

Figure 2. The fecal occult blood test (FOBT) and colonoscopy completion rates are illustrated.

Identifying and addressing client barriers to colorectal cancer screening.

PRR Communications conducted focus groups to test the messages used in educational and promotional materials and to explore barriers to screening. Four focus groups were held: 2 with women and 2 with men. Participants were uninsured, they ranged in age from 50 to 64 years, and most had not been screened for colorectal cancer.

Through the focus groups, PRR Communications learned that cost was the major barrier to colorectal cancer screening. Free screening was recommended as the strongest incentive for taking the test. These findings were reinforced by our CHP clients, who repeatedly stated they would not have been screened if the service had not been free. This was an important concern, even for clients who were screened by FOBT, because colonoscopy is required to follow-up a positive test.

In addition to cost, many focus group participants had reservations about FOBT and colonoscopy tests. For those who had never been screened, lack of knowledge about how to perform the FOBT and confusion and "mystery" about colonoscopy were major concerns. Clients wanted a lot of education, including talking to someone who had been screened to dispel the mystery. Those who had a prior colonoscopy expressed concerns about the bowel-cleansing preparation and feared embarrassment during the procedure. Those who had a prior FOBT expressed concerns about putting fecal matter in the mail. The educational messages developed by the CHP tested positively. The main feedback were suggestions to replace the colonoscopy illustration with one that was less scary, to identify key messages more prominently, and to make the design more contemporary and colorful (copies of the educational materials are available at the website: www.kingcounty.gov/health; accessed May 6, 2013). There was mixed feedback about whether offering a gift card would increase colorectal cancer screening. Some participants said it seemed like a bribe and was not necessary.

Client navigation

The CHP developed effective navigation systems to assure that clients kept gastroenterology appointments. The gastroenterology providers expressed a high level of satisfaction working with the CHP, because clients had excellent bowel preparation, there was a low "no-show" rate (8%), and they enjoyed contributing to a valuable program.

Lessons learned about clinic-based screening programs

By the end of the third year, several key elements of a successful primary care, clinic-based colorectal cancer screening program became apparent: 1) *clinic champion*, defined as a provider site staff person, usually a medical assistant or nurse, who ensures that the program operates efficiently; 2) *staff training* to ensure that providers understand the eligibility criteria for screening and how to refer clients at increased risk (those with a primary relative who had a diagnosis of colorectal cancer or precancerous polyps before age 60 years or with $\geq$2 relatives who were diagnosed with colorectal cancer at any age) and clients with a positive FOBT for colonoscopy and to ensure that providers and their staff can describe for the clients the logistics of both performing an FOBT and completing a colonoscopy; 3) *clinical systems*, designated staff and management provide support to develop clinical systems that ensure all eligible clients are screened and that clients with positive tests have follow-up; and 4) *community outreach* is used to inform the community about the importance of screening and where to receive it.

The challenges were: 1) promoting the CHP to busy clients and clinic staff, because few individuals deny the benefits of colorectal cancer screening, but busy clients and staff find many reasons not to complete recommended screening tests or even promote them; and 2) implementing special projects and reporting on their outcomes, because publicly funded clinics operate several projects targeted at special populations, such as those related to breast and cervical cancer, human immunodeficiency virus/acquired immunodeficiency syndrome, diabetes, and obesity prevention, and specially funded projects with reporting requirements can seem overly burdensome considering the income generated for the clinical site.

Phase 3: Sustainability planning

ACS CAN, Colorectal Cancer Task Force, and Washington State legislature

ACS CAN and the Colorectal Cancer Task Force members educated Washington State legislative members about colorectal cancer screening and prevention in Washington State. During the 2006, 2007, and 2008 legislative sessions, members read proclamations from the floor of the House and Senate and participated in "Dress in Blue" Day for colorectal cancer awareness in March. These actions raised awareness about colorectal cancer and the potential for prevention with routine screening. The state legislature passed a law requiring insurance plans to cover colorectal cancer screening and created a budget proviso allocating new state funds to expand the CHP statewide. State funding also allowed the evaluation of clients who had symptoms of colorectal cancer.

Washington State Department of Health and statewide expansion

The Department of Health (DOH) used new state funds to expand the CHP across the state. Public Health staff transferred the CHP policies, procedures, forms, data system, educational materials, training modules, and resources to the DOH and the BCHP prime contractors from around the state. The DOH assumed management of the CHP.

This work positioned the DOH to be successful in their application to the CDC for the "Integrating Colorectal Cancer Screening within Chronic Disease Programs" funding opportunity announcement. Although state funding was eliminated in 2009 because of the financial crisis, the CHP continues with federal funding, assuring the sustainability of colorectal cancer screening for individuals with low incomes and no health insurance and improving education and outreach efforts to screen the insured. The BCHP and CHP were fully integrated, becoming the Breast, Cervical, and Colon Health Program (BCCHP). By June 2010, the DOH expanded colorectal cancer screening to approximately 127 clinics and 25 endoscopy sites/surgeons.

In summary, the CHP partners increased client services and staff training; developed clinic policies, procedures, and systems to increase screening and improve tracking and follow-up; expanded access to colonoscopies; and initiated statewide dissemination of training and systems as well as state-level policy changes. Finally, the CHP partners were successful in helping the DOH obtain competitive funding from the CDC to integrate colorectal cancer screening into the BCHP state wide over the next 5 years.

Timeline

The CHP timeline is detailed in Table 3.

Conclusion

In conclusion, Public Health's tactics to develop trust and build bridges that linked partners formed an effective work group that was comfortable sharing information, ideas, and resources. This greatly enhanced collaboration and contributed to the program's success. Training, frequent process consultation, and active support of clinic managers and champions were critical to the partnership's success during the start-up and implementation phases. During the first few months of screening, Public Health recognized early milestones, such as the first 100 clients enrolled, the first adenomatous polyps removed, the first client diagnosed with colorectal cancer, increased FOBT return rates, and low colonoscopy "no-show" rates. Although client enrollment numbers were relatively small, it demonstrated that the partners had developed a successful system for educating clients, offering screening, tracking, and follow-up that would increase screening and contribute to the goal of reducing colorectal cancer incidence and mortality. Clients highly valued the CHP services, and their positive feedback to clinical staff motivated the partners.

The partnership continuously improved and refined the CHP. Thus, as problems were identified by reviewing data or noticing trends at agencies or questions posed by

TABLE 3. Colon Health Program Timeline and Major Milestones

Date	Major Milestone
June 2005	Partners decide to submit grant application
September 2005	Grant awarded
February to June 2006	Train 300 clinical staff at 10 clinics
September 2005 to June 2006	Recruit and contract with gastroenterologist
July 2006	Start screening
April 2007	State law passed mandating colorectal cancer screening inclusion in insurance plans
June 2007	Awarded Dialogue for Action on Colorectal Cancer grant from the Prevent Cancer Foundation
September 2007	Contracted with Seattle gastroenterology group
November 2007	Started "opt in" colonoscopy
March 2008	State legislature allocated $965,000 to expand CHP and serve clients with colorectal cancer symptoms
April to June 2008	Plan statewide expansion
September 2008	Colon STARS nonprofit organization incorporated; Washington Dialogue for Action on Colorectal Cancer conference set statewide priorities
July 2009	State funding eliminated; stopped "opt-in" colonoscopy and enrolling symptomatic clients
July 2009	Conclusion of CHP demonstration project; DOH awarded CDC-funded "Integrating Colorectal Cancer Screening within Chronic Disease Programs" project
August 2009	Transition to state-managed program and integration of BCHP with CHP-BCCHP

Abbreviations: BCCHP, Breast, Cervical and Colon Health Program; BCHP, Breast and Cervical Health Program; CDC, Centers for Disease Control and Prevention; CHP, Colon Health Program; DOH, Department of Health; STARS, Support, Treatment, Awareness, Resources, and Screening.

clinical coordinators, solutions were developed. The Medical Advisory Board members, Colorectal Cancer Task Force members, and CDC program and medical consultants frequently consulted on program issues. Public Health staff coordinated in-person meetings with clinical coordinators quarterly during the first year and then twice a year after the system was operating effectively.

When it became evident that the partners had developed an effective model program, Public Health staff began work on institutionalization. This involved assessing partners' first year involvement with the CHP and determining necessary steps to maintain the work. Not only did we focus on maintaining activities in the initial partnership, we also developed a strategy to spread the CHP across the remainder of our service area and statewide through the recruitment of new partners.

In conclusion, the CHP partners increased access to colorectal cancer screening services, especially access to colonoscopy. Key elements for successful implementation of the CHP demonstration project were: building the project on the successful BCHP framework, detailed training and retraining of provider site staff about colorectal cancer and screening methods, frequent consultation to identify and solve problems, and active support of administration and champion at the clinic. Institutionalization of the program depended on: assessing progress after the first year, documenting experience with the program, disseminating learning, engaging new partners, and determining steps to maintain and expand the program. These efforts enhanced community systems and policies for colorectal cancer screening in Greater Seattle and ultimately throughout Washington State.

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