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Bringing It to the Community: Successful Programs That Increase the Use of Clinical Preventive Services by Vulnerable Older Populations

Janet C. Frank, Kathryn G. Kietzman, and Steven P. Wallace

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SUMMARY: This policy brief reports the findings of a systematic review conducted by the Community Health Innovations in Prevention for Seniors (CHIPS) project. The project identified successful programs for increasing the use of two or more clinical preventive services for vulnerable, underserved populations ages 50 years and older within community settings. The CHIPS project also used the RE-AIM Framework[1] to evaluate the readiness and feasibility of implementing these programs within real-world settings. Policy recommendations focus on expanding and sustaining clinical preventive services in the community and reaching diverse populations, bridging the traditional silos of clinical care and community-based services, and providing financial incentives to clinical providers and community-based organizations to support preventive services coverage.

Clinical Preventive Services (CPS) for Older Adults: A Missed Opportunity

Clinical preventive services such as colorectal cancer screening and pneumococcal immunization can help reduce rates of premature death and disability. Yet, many older adults are not receiving the full set of clinical preventive services that have been proven effective and are considered "high value" in terms of their costs per life saved (Exhibit 1).

Rates are particularly low among racial and ethnic minority older adults (Exhibit 2) compared to national goals.[2,3] Sustained efforts are needed to increase the use of these services for all older adults, and especially for racial and ethnic minority older adults.

Exhibit 1

High-Value CPS Relevant to Healthy Persons Ages 50+

- Influenza Immunization
- Pneumovax
- Mammography
- Colorectal Cancer Screening
- Cholesterol Screening
- Bone Density Screening
- Smoking Cessation Counseling

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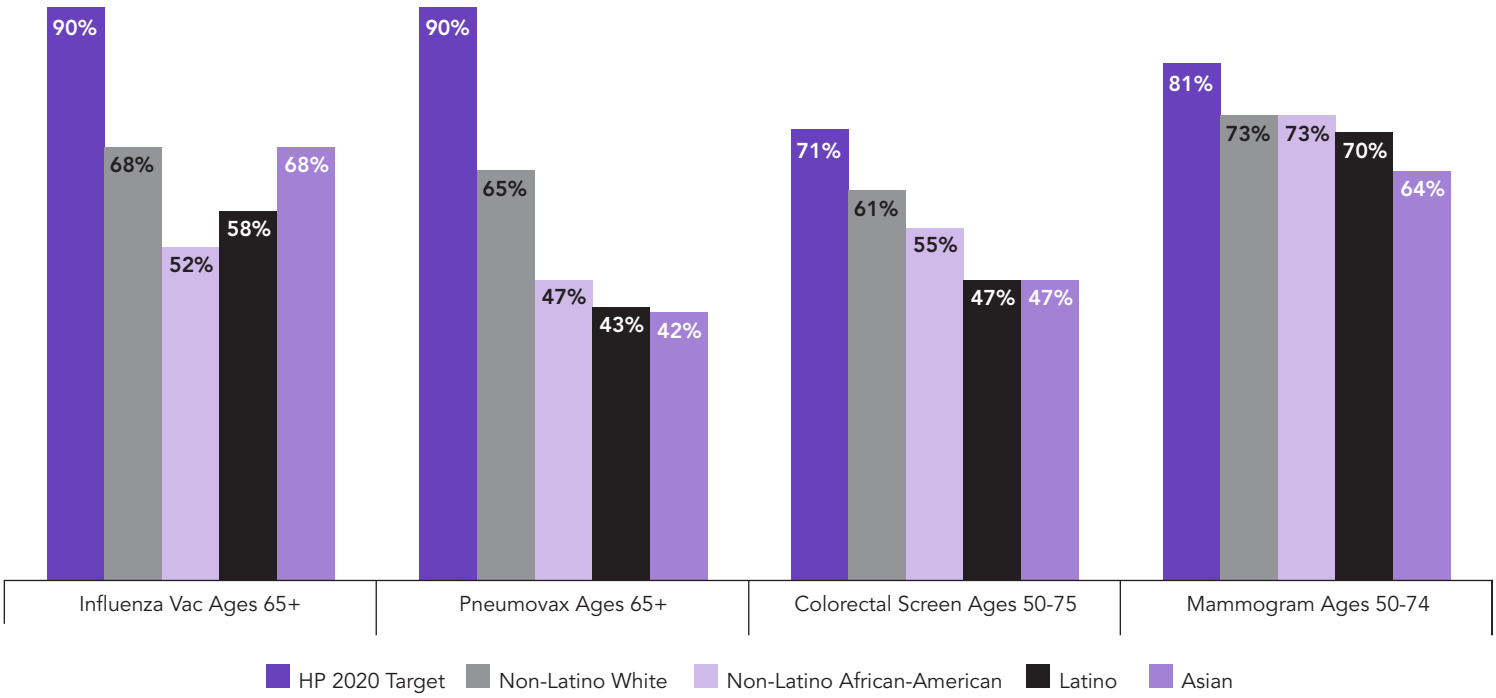
Exhibit 2 **Healthy People (HP) 2020 Goals and Reality: Gaps and Disparities in CPS Receipt**



Source: National Health Interview Survey[4]

The Need for Increasing Community Access to Clinical Preventive Services

Health professionals and/or specialized medical equipment are often required in order to provide clinical preventive services (e.g., mammography),[5] which limits access for those who do not seek preventive care within medical care settings. However, there is increasing evidence that multi-component programs delivered in the community that promote clinical preventive services are among the most effective. For example, *The Guide to Community Preventive Services: What Works to Promote Health?*[6] documents the merits of preventive services for the 50+ population that combine multiple strategies at different community entry points. Our review expands existing reviews by looking at programs that also target multiple preventive services simultaneously.

For decades, public health efforts have tested ways to bring clinical preventive services to the places where people live, work, and congregate. This push to bring such services to people within their community settings is essential, since many in need of services will never access them through a medical care setting.[5] A number of novel programs focus on the three stages necessary for clinical preventive services: engagement, delivery, and follow-up. These effective programs "bundle" clinical preventive services so that multiple services are offered to the person at the same time, enhancing their reach and efficiency. Community-based organizations—for example, faith, service, professional, and recreational organizations—that serve populations ages 50+ can play a critical role in reaching the "hard to reach" older adult population.

"Effective programs 'bundle' clinical preventive services so that multiple services are offered to the person at the same time."

Characteristics of Effective, Bundled Community-Based Clinical Preventive Services Programs

Programs were included in the CHIPS review if they increased the use of clinical preventive services and promoted, delivered, and/or followed up on two or more clinical preventive services in community sites, such as churches, businesses, community organizations, and park and recreation facilities.

Of the 142 programs with outcome data reviewed, 20 met these criteria (Exhibit 3). All 20 programs used educational strategies to increase the uptake of clinical preventive services, but many also incorporated behavioral change (7), service delivery (7), referral linkages (7), or instrumental supports (2) such as transportation assistance and/or navigation assistance (for example, accompanying the client to the service delivery site to assure that s/he could receive the service).

The 20 programs included activities and components such as interpersonal and mass communication, systems navigation (for example, providing transportation to screening appointments), and/or reminders that served as triggers to action. The programs were delivered by both lay health workers and professionals. Priority populations for clinical preventive services included diverse and underserved people ages 50 and older, including African-Americans, Hispanics, Native Hawaiians, Vietnamese, Cambodians, and Filipinos (Exhibit 3). Several of the programs targeted low-income populations, and many were focused on rural communities. Most programs utilized cultural tailoring to assure that the program was appropriate for the priority audience(s).

The CHIPS Project review also assessed the programs using the RE-AIM Framework.[1] This evaluation framework focuses on five dimensions: how well the program *reaches* its intended audience (R), the *effectiveness* of the program in providing the desired benefits (E), the *adoption* of the program by host agencies or organizations (A), systematic program *implementation* that included attention to fidelity to the intended program delivery design (I), and *maintenance* of the program beyond developmental funding (M).

Program information about these dimensions varied considerably. For the most part, reviewed programs provided substantive information to document target population reach, and all were selected because of demonstrated effectiveness in increasing uptake of clinical preventive services. Certain types of programs, such as those using media-based strategies, were not appropriate for assessing organizational adoption; for some others, no information was available. Program implementation was described in great detail for some but not all programs. A good example of detailed information on program implementation is provided by Pathways, which increased breast and cervical cancer screening among Vietnamese-American women.[7]

Even though all of the bundled clinical preventive services programs were effective in increasing uptake, very few provided any information on whether they were maintained after initial funding. A notable exception is ENCORE*plus*,[8,9] which continues to provide breast cancer prevention services and, at some local sites, has added blood pressure screenings. Within 18 months of initiating the program, the local YWCAs implementing it had raised $3.9 million to supplement the initial core grants provided by the YWCA Fund for Women's Health in order to maintain the program and expand it to new areas.

The challenges noted above in the application of the RE-AIM framework to the programs reviewed in CHIPS are likely due to several factors. By design, a number of the programs were planned, delivered, and evaluated with no intention of integrating the program into the host organization (Adoption) and/or continuing it after the initial intervention was completed (Maintenance). Grant funding is often available to develop and test an intervention, but not to continue it. Unless there is an eye to sustainability at the outset, even the most effective programs may not be continued. Implementation science and sustainability are relatively new foci for research, but they have been rapidly gaining popularity in order to promote a better understanding of how to capitalize on effective interventions by ensuring they can be readily implemented, maintained, and disseminated.[10]

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Exhibit 3 Community Health Innovations in Prevention for Seniors (CHIPS) Programs

Name	Description	Location	Priority Population	Setting
Daniels Bay Area[11]	A faith-based program that used educational group sessions and on-site vaccinations to increase uptake of pneumococcal and influenza vaccinations among church members.	San Francisco Bay Area, California	Low-income African-American and Latino	
ENCORE*plus*[8]	A national program to increase breast and cervical cancer screening. Central management provided a standard set of program guidelines, quality standards, and options for activities and methods, while allowing local YWCA sites flexibility and autonomy in the implementation of outreach, education, navigation, provider networking, and linkage strategies.	78 locations in 30 states	Ethnic minority, low-income, and medically underserved women	
Forsyth County Cancer Screening (FoCaS)[12]	This program used a variety of clinic (in-reach) and community-based (outreach) strategies to increase the uptake of breast and cervical cancer screening among women 40 years of age and older residing in low-income housing communities.	Winston-Salem and Greensboro, North Carolina	Low-income African-American women	
Gotay Oahu[13]	This program employed Native Hawaiian paraprofessional health educators who hosted and delivered culturally appropriate group education sessions aimed at increasing breast and cervical cancer screening.	Oahu, Hawaii	Rural and Native Hawaiian women	
Juntos en la Salud[14]	This program compared the effectiveness of two different delivery methods of lay health educators (promotoras de salud) – social support group and individual – to increase breast, cervical, and colon cancer screening behavior. Latinas were identified and recruited through the Hispanic Advisory Board of lay and community-based leaders, as well as through networks of the promotora staff.	Phoenix, Arizona	Medically underserved and low-income Latinas	
Kelly Olmsted County[15]	A culturally appropriate intervention to increase breast and cervical cancer screening rates. Cambodian women were hired to invite women to small informational meetings held in private homes or churches. Educational, behavioral, instrumental, and navigational strategies were used.	Olmsted County, Minnesota	Cambodian women	
Maxwell Los Angeles[16]	This program used an educational strategy to increase breast and cervical cancer screening. Educators were physicians or nurses from the Philippines and fluent in both English and Tagalog. The group sessions lasted 60–90 minutes and were typically conducted in "Taglish," a mix of English and Tagalog.	Los Angeles County, California	Filipino-American women	
Mooney Little Rock[17]	A team of pharmacists and pharmacy students used educational/informational and delivery strategies at community health fairs, screening for blood pressure, cholesterol abnormalities/lipid profile, blood glucose, and body mass index and evaluating participants' knowledge of coronary heart disease risk factors.	Little Rock, Arkansas	All	
Ohana Day[18]	A one-day community celebration and screening event included breast, cervical, colorectal, prostate, testicular, oral, and skin cancer screening. Culturally tailored strategies included educational/informational, delivery, and referral/linkages.	Molokai, Hawaii	Native Hawaiian and medically underserved	
Pathways[7]	This program recruited Vietnamese lay health workers to conduct culturally tailored health education seminars with small community groups of women in neighborhood homes. In addition, Vietnamese "Neighborhood Assistants" conducted sessions on general health behaviors and breast and cervical screening information.	San Francisco, California	Vietnamese	

Community Health Innovations in Prevention for Seniors (CHIPS) Programs

Exhibit 3 (continued)

Name	Description	Location	Priority Population	Setting
Potter San Francisco[19]	This program utilized educational/informational, delivery, and referral/linkages strategies to promote colorectal cancer screening among participants recruited at influenza vaccination clinics in select San Francisco pharmacy locations. The intervention compared providing home colorectal cancer screening (CRCS) test kits with providing CRCS education only.	San Francisco, California	All	
Seattle Senior Immunization[20]	This senior center–based program promoted pneumococcal and influenza vaccinations among adults 65+ using educational/informational strategies. The program relied on peer-to-peer outreach by volunteers who used a script to encourage receipt and address specific barriers to immunization.	Seattle, Washington	Low-income	
Shah Livingston County[21]	This program used emergency medical services (EMS) in two rural communities in upstate New York to screen older adults during emergency responses to evaluate the risk of falling and the need for pneumococcal and influenza vaccines.	Geneseo and Groveland, New York	Rural	
Shenson Dutchess County[22]	This program combined influenza and pneumococcal immunization efforts at community-based flu clinics and included full-scale social marketing activities to promote pneumococcal vaccination with flu vaccine. Marketing strategies, devised by a steering committee, emphasized the use of screening messages by local, well-known health care leaders and elders.	Dutchess County, New York	All	
SPARC Improving Access[23]	The SPARC model involves building coalitions among local public health agencies, hospitals, social service organizations, and advocacy groups in a collaborative effort to improve and provide community-wide delivery of clinical preventive services. This SPARC program provided breast cancer screening referrals to women waiting to get their flu shots.	Litchfield County, Connecticut	Rural	
Sung Atlanta[24]	This breast and cervical cancer screening intervention used lay health workers to provide culturally appropriate in-home educational sessions on breast and cervical cancer.	Atlanta, Georgia	Low-income, African- American, inner-city women	
Targeting Cancer in Blacks[25]	This program was concerned with knowledge, attitudes, beliefs, and behaviors related to breast, cervical, and colorectal cancer screening and tobacco use counseling. The program used mass communication strategies and a community-based participatory research model to develop culturally appropriate intervention materials. Strategies included the use of slogans such as "Get a pap smear once a year" and "Have no regrets, give up cigarettes."	Atlanta, Georgia and Nashville, Tennessee	African-American	
Witness Project[26]	Local African-American breast and cervical cancer survivors referred to as "witness role models" presented motivational personal testimonies about cancer, focusing on the need for early detection and treatment, all within a spiritual context. The "witnessing" intervention was mostly provided to women of all ages in churches and community centers.	Phillips and Monroe counties, Arkansas	Low-income, African-American women	
Woman to Woman[27]	This program aimed to increase breast and cervical cancer screening rates among women employees at 26 worksites in Massachusetts. Peer health advisors (PHAs) were trained and led a variety of activities, including six small-group discussion sessions, one-on-one counseling, and attendance and presentations at health fairs.	Massachusetts	Employees	
Women's Health Alliance[28]	A county-based and coalition-led educational intervention to increase breast and cervical cancer screening compliance rates among women living in rural communities. Coalition members were professional and lay volunteers who implemented public education/ outreach activities to message the importance of breast and cervical cancer screening.	North Central Wisconsin	Rural	

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Policy Recommendations

Evidence from the CHIPS program review shows that community organizations are able to increase access to and receipt of clinical preventive services by diverse, and often underserved, older adults. Now we need policies to support effective program models. Four policy changes would strengthen the delivery and expansion of clinical preventive services:

- First, funding priorities need to include not only projects that focus on intervention development, but also projects that focus on intervention integration into existing organizations and intersectoral systems. One way to achieve this is through research and demonstration funding that supports implementation science and sustainability research, with a goal of embedding the new models of clinical preventive services delivery into the fabric of the host organization. Effective programs should not "come and go" with funding that is available only for program development. Instead, they should be entrenched in the mission and process of the organization and become a routine part of how it serves the community.

- Second, funders should be encouraged to promote the dissemination, replication, and expansion of successful clinical preventive services programs, especially for older ethnic and racially diverse populations and for programs found effective in diverse geographic areas, so that more individuals in vulnerable populations can benefit. To achieve this, funders need to support published work (and access to it) that includes manuals of procedures, implementation guidelines, and other materials so program planners will have the roadmaps they need to assure successful replication. These types of materials should routinely be components of final progress reports to funding agencies and should be made available in the public domain. Funding should also be provided to bridge successful programs from one priority audience (e.g., Hispanics) to another (e.g., African-Americans) and to test the effectiveness of programs with different age subgroups of people 50 and over (e.g., ages 75 and older). Cultural adaptations should be documented and tested for efficacy with the new populations and partners.

- Third, an expanded integration of community and clinic locations is needed to promote the uptake of clinical preventive services, especially among vulnerable populations. A framework proposed by Krist and colleagues[5] outlines key expansions of the Chronic Care Model[29] to promote the integration of community-based locations with the clinical delivery of services and follow-up. A more proactive approach such as this is required to bring clinical preventive services to places where people live, work, and play, rather than waiting for them to come into health care settings.[5]

- Fourth, financial incentives to clinical providers and community-based organizations must be put in place to assure the feasibility and expansion of the delivery of clinical preventive services within community settings. Expanding community availability of clinical preventive services may be more feasible with new policies, such as those within the 2010 Patient Protection and Affordable Care Act (ACA), that remove financial barriers to such services by eliminating deductibles and copayments. Efforts to increase clinical preventive services use within health care systems must be complemented by community-based public health programs that encourage older adults to use these benefits and help to facilitate that use. Reducing individual financial barriers is only one step, although an important one, in the quest to reach Healthy People 2020's goals. With new opportunities for innovation and systems change provided by the ACA and philanthropic organizations, clinical and community integration efforts to support

collaborative programs that promote clinical preventive services uptake should be a top priority.

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