**Participating Health Centers:**

- Family Practice and Counseling Services Network
- Esperanza Health Center
- Philadelphia Department of Public Health, Ambulatory Health Services
- Spectrum Health Services
- Delaware Valley Community Health
- Greater Philadelphia Health Action
- African Family Health Organization

**AFAHO**

**Background**:
The African Family Health Organization (AFAHO) is a community-based organization serving African and Caribbean immigrants and refugees in the greater Philadelphia area. AFAHO uses a culturally rooted peer support model to leverage shared language, lived experience, and system navigation to help individuals and families overcome social barriers, access resources, improve health and education outcomes, and build pathways to integration and self-sufficiency.

AFAHO seeks to increase breast health knowledge, expand access to screening, and ensure follow-up care for African and Afro-Caribbean women to reduce late-stage diagnoses. Their "Me First" breast cancer program will provide individualized outreach, education, and barrier reduction to help close these gaps in care.

**Goals for ReSET:**

- Engage 200 women in outreach and education.
- Conduct one-on-one breast health sessions with 100 women.
- Provide free mammogram referrals to 50 women, ensuring 100% completion.
- Support navigation and follow-up for all abnormal results.

**Proposed Plan:**
AFAHO navigators will conduct outreach and education in community settings such as braiding salons, churches, mosques, and associations. Navigators will also provide culturally and linguistically tailored materials, including distribution through WhatsApp. For screenings, navigators will schedule mammograms, coordinate mobile van events with Jefferson in Southwest and Northeast Philadelphia, and ensure follow-up for abnormal results. Navigation support includes appointment scheduling, reminders, interpretation in multiple languages (French, Haitian Creole, Swahili, Mandingo, Bambara, Fulani), medical accompaniment, insurance assistance, behavioral health referrals, and transportation via SEPTA passes when needed. Program management will focus on partnership development, supervision of navigators, data tracking, and adherence to reporting protocols.

**DVCH**

**Background**:
Delaware Valley Community Health (DVCH) is a community-focused nonprofit providing culturally responsive, evidence-based primary and preventive care to low-income, uninsured, and underinsured populations across Philadelphia, Montgomery, and Delaware counties. DVCH offers a broad range of primary and preventive services, including adult and pediatric medicine, obstetrics and gynecology, behavioral health, dentistry, podiatry, and optometry.

DVCH seeks to strengthen tracking, follow-up, and care coordination for breast and colorectal cancer screening, aiming to reduce disparities in preventive care and improve outcomes in underserved populations.

**Goals for ReSET:**

- Track and follow up on abnormal colorectal and breast cancer results.
- Ensure timely diagnostic follow-up and surveillance for high-risk patients.
- Use data to identify gaps and improve outreach strategies.

**Proposed Plan:**
DVCH will implement the Azara Abnormal Tracking Module within their EHR to streamline identification and management of abnormal results. Population Health Specialists will monitor screening completion, FIT return rates, and mammogram recalls, integrating high-risk alerts into Patient Visit Planning (PVP) to prompt providers. Care coordination includes managing follow-up for patients with positive FITs, coordinating increased surveillance for patients requiring more frequent colonoscopy, and ensuring timely follow-up for recalled mammograms. DVCH will conduct continuous quality improvement through regular data review, technical assistance from Azara, and adjustments to outreach and navigation workflows to ensure equitable access and reduce late-stage cancer diagnoses.

**Esperanza**

**Background**:
Esperanza Health Center (EHC) is a faith-based FQHC serving a medically underserved, predominantly Latino and African-American population in Philadelphia neighborhoods including Kensington, Hunting Park, Juniata, Harrowgate, Feltonville, and Fairhill. EHC has over 15 years of experience using lay community health educators to strengthen connections between the health system and the community.

EHC seeks to improve breast and colorectal cancer screening rates, expand patient outreach, and increase abnormal cancer screening follow-up rates across its patient population.

**Goals for ReSET:**

- Increase CRC and breast cancer screening rates by 5% in one year.
- Ensure follow-up for abnormal results reaches 100% compliance.
- Apply equity-focused outreach to underserved subpopulations.

**Proposed Plan:**
EHC will expand patient outreach to all individuals due for screenings, prioritizing those experiencing disparities while offering services to all. A team of three Care Gap Specialists and one CRC Screening Navigator will coordinate care for patients with abnormal results, ensuring completion of diagnostics and connection to treatment. Clinical workflows will be refined for outreach, abnormal screening follow-up, and care coordination with HFP Cancer Navigators. Staffing will be strengthened by hiring an additional Care Gap Specialist to support outreach across EHC's three locations.

**FPCSN**

**Background**:
Family Practice and Counseling Services Network (FPCSN), formerly FPCN, is a nurse-managed network of community health centers delivering integrated primary care, behavioral health, dental, and preventive services. FPCSN has served marginalized communities for over 33 years.

FPCSN seeks to enhance colorectal cancer screening through centralized outreach, patient engagement, and navigation strategies, with the goal of expanding to additional health centers and screening types.

**Goals for ReSET:**

- Reach at least 2,000 patients due for colorectal cancer screening.
- Expand screening strategies to additional centers over time.
  Provide enhanced navigation and follow-up support for patients with abnormal results.

**Proposed Plan:**
FPCSN will launch centralized outreach campaigns using Azara Population Health tools and CareMessage automated texting to reach patients due for CRC screening. Standing orders will facilitate referrals for GI/colonoscopy, and patient data will be used to prioritize outreach. Patients with positive FIT results will be enrolled in abnormal screening follow-up via AthenaPractice EMR forms and Azara's tracking module. Enhanced navigation services will provide transportation support and behavioral health assistance to increase follow-up adherence.

**GPHA**

**Background**:
Greater Philadelphia Health Action, Inc. (GPHA) is a nonprofit, community-based FQHC founded in 1970. Accredited by the Joint Commission, GPHA operates 12 health centers, delivering over 85,000 annual visits for medical, dental, behavioral health, pharmacy, and child development services.

GPHA seeks to reduce breast cancer disparities by identifying women ages 40-74 overdue for mammography and providing outreach, education, and support to ensure timely screening and follow-up.

**Goals for ReSET:**

- Outreach to 100% of 4,794 eligible female patients.
- Reduce patients with no mammogram on record by 25%.
- Reduce overdue mammograms (>1 year) by 50%.

**Proposed Plan:**
GPHA will hire a full-time Breast Health/Population Health Technician (PHT) and onboard a Vista to lead outreach and coordination. Patient outreach will include phone, email, text, and mailed educational campaigns. Screening events will be hosted in partnership with Fox Chase and Sidney Kimmel Cancer Center, and assistance provided to uninsured/underinsured patients via University of Pennsylvania and Solis Mammography. Education will cover breast health, mammography importance, and breast self-exam techniques, while social determinants of health such as transportation and food insecurity will be addressed. Follow-up will ensure PCPs receive results and patients with abnormal findings receive navigation to diagnostic or specialist care. GPHA's self-scheduling platform will facilitate expedited diagnostic appointments.

**PDPH/AHS**

**Background**:
The Philadelphia Department of Public Health's Ambulatory Health Services (PDPH/AHS) operates eight health centers in medically underserved communities. For over 50 years, these centers have served as the city's lead safety net provider, delivering critical comprehensive care and specialized services to individuals regardless of their insurance status, ability to pay, or legal status. Five centers are FQHCs, and three are FQHC Look-Alikes.

PDPH/AHS seeks to expand breast and colorectal cancer screening and follow-up at Health Center #9, targeting African American and uninsured patients.

**Goals for ReSET:**

- Increase screening compliance to 70-75% for breast cancer and colorectal cancer.
- Ensure timely follow-up and treatment for abnormal results.
- Address barriers to care and improve progression from screening to treatment.

**Proposed Plan:**
A part-time Patient Navigator will manage outreach, follow-up, and care coordination. Screening outreach includes identifying eligible patients, scheduling appointments, and educating on early detection. Follow-up ensures results are uploaded to records, providers are alerted, and appointments for abnormal results are scheduled promptly, aiming for HEDIS compliance within 90 days. Navigation addresses barriers including transportation, language, and fear, implements the Core 5 SDOH tool, and collaborates with behavioral health and benefits counselors. Coordination with hospitals will ensure timely consults and follow-up documentation.

**Spectrum Health Services, Inc.**

**Background**:
Spectrum Health Services, Inc. is a FQHC serving 14,000 patients across West, North, South, and Northeast Philadelphia. Founded in 1967 to address family planning access, Spectrum expanded to primary care, dental services, and recently opened a site for immigrant and refugee populations in 2023.

Spectrum seeks to expand cancer screening and patient navigation to reduce disparities in breast and colorectal cancer care, increase screening rates, reduce delays in diagnosis, and improve outcomes.

**Goals for ReSET**:
- Increase colorectal cancer screening from 18.9% to 40% (~550 care gaps).
- Increase breast cancer screening from 34.5% to 50% (~265 care gaps).
- Ensure all patients with abnormal results enter navigation workflows for timely follow-up.

**Proposed Plan:**
Two Population Health Specialists will review charts to identify missing or undocumented screenings, collaborating with Epic analysts and consultants for EHR optimization. Specialists will conduct monthly outreach via phone and mass text, coordinating onsite mammograms, mailed/pickup FIT/Cologuard kits, and offsite screenings, while addressing transportation barriers. CRC education sessions with demonstrations will be held monthly. Provider engagement includes quality bonuses, quarterly gamification competitions, and ongoing reminders to discuss and order screenings. Abnormal results will be referred via EHR orders to Population Health Specialists, who will track results, coordinate appointments, assess social determinants of health, provide transportation, and follow up, in collaboration with GI, radiology, oncology, and Health Federation resources.