NATIONAL ASSOCIATION OF
Community Health Centers®

Best & Promising Health Center Practices Driving Transformation

A Systems Approach to Improved Cancer Screening

Health centers across the country are making meaningful system-level changes to improve health outcomes, patient and staff experiences, costs, and access to care. System-transformations drive care improvements, including preventive services like cancer screening. In an effort to capture and share the many great examples of health center transformation in action, the National Association of Community Health Center's (NACHC), with support from the American Cancer Society (ACS) and the Centers for Disease Control and Prevention (CDC), launched a national call for 'Best and Promising Practices' in health center transformation.

Over one hundred health centers responded to the call. This document summaries stories from just over two dozen top examples of health centers testing new approaches, strengthening internal systems and processes, and reimagining how alternate models of teamwork can enhance care. Many of the health centers highlighted participate in NACHC's Elevate national learning forum, which uses an organizing framework called the Value Transformation Framework (VTF) to drive transformation efforts. This summary is organized using the VTF's focus on Infrastructure, Care Delivery, and People. These health center examples show how taking a systems approach to transformation can have far reaching impacts, including improved preventive care and cancer screening.

INFRASTRUCTURE

Data Management and Integration

- **The Asian American Health Coalition (AAHC)** of Houston, TX significantly enhanced the accuracy and usability of its cancer screening data through focused data hygiene and staff education efforts. Early on, AAHC discovered discrepancies between cancer screening reports from different data systems, which raised concerns about the reliability of outreach and improvement efforts. To address this, the Health Informatics Analyst initiated a monthly data review process targeting one or two UDS measures at a time. These reviews clarified reporting logic and identified gaps in documentation, electronic health record (EHR) setup, and vendor configurations. Correcting missing LOINC codes in lab results, for example, led to a 5% improvement in screening compliance. As staff deepened their understanding of electronic clinical quality measures, outreach efforts became more precise, avoiding redundant follow-up with already-screened patients. This ongoing process boosted confidence in quality reporting, including Uniform Data Systems (UDS) and Healthcare Effectiveness Data and Information Set (HEDIS) reports and established a sustainable, team-driven approach to continuous data quality improvement with a smarter foundation for cancer screening performance and more effective patient engagement.
- **El Centro de Corazón** of Houston, TX significantly boosted colorectal cancer screening rates from 13.2% in 2023 to 48.6% by July 2025 through targeted improvements in data management, testing methods, and staff engagement. The clinic began by auditing and correcting EHR data to address underreporting of FIT and colonoscopy results. They then transitioned from traditional FIT tests to the more effective FIT-DNA (Cologuard), increasing completed screenings to 20–25 per week. Using bulk texting to 30 patients at a time and follow-up calls, patients overdue for screening were actively engaged and supported in

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completing mailed Cologuard kits. Medical Assistants led outreach efforts and ordered tests with standing orders, maximizing existing staff capacity without adding new hires. A partnership with Houston Methodist brought GI fellows onsite monthly for timely follow-up of positive results, ensuring colonoscopies and additional treatment would be provided if necessary. Building on this success, El Centro is now adapting these strategies to improve breast cancer screening by training Medical Assistants to order mammograms and streamline patient access. This integrated approach has helped El Centro de Corazón make major strides in colorectal cancer screening and sets the stage for expanded cancer prevention efforts.

- **La Familia Medical Center** of Santa Fe, NM improved cancer screening by applying successful team-based, data-driven systems that boosted their patient's diabetes outcomes. After reducing uncontrolled A1c rates from 33% to 21% between 2020 and 2024, La Familia adapted strategies such as EMR alerts, monthly scorecards, and targeted outreach for cancer prevention. Screening rates rose substantially: breast cancer from 51% to 66%, cervical from 60% to 72%, and colorectal from 37% to 46%. La Familia partnered with the New Mexico Department of Health and Cologuard to expand access for uninsured patients and used data to guide outreach for underserved groups, including adults ages 45–55 and people experiencing homelessness. This culture of continuous improvement focuses on closing gaps and strengthening early detection across the board.

Quality Improvement Commitments

- **Legacy Community Health** in Houston, TX boosted cancer screening by embedding quality improvement into daily workflows across its 60+ clinics. They replaced top-down reporting with real-time dashboards and clinic-owned scorecards, enabling frontline teams to spot gaps and act quickly. Interdisciplinary workgroups redesigned EMR templates and standing orders, making it easier for MAs, nurses, and providers to flag and complete overdue screenings during visits. Targeted outreach prioritized high-risk patients, while 140+ "Quality Champions" helped spread innovations clinic-wide. As a result, even clinics with the lowest screening rates saw early gains, demonstrating how shared ownership of quality improvement efforts combined with data transparency and team-driven solutions can accelerate cancer screening.

- **City of Cincinnati Primary Care (CCPC)** in Ohio reduced poorly controlled diabetes rates by 36.7% using a system-wide quality improvement approach that now informs CCPC's cancer screening work. Starting with a pilot at one health center, CCPC implemented a care bundle for diabetes that included point-of-care A1C testing, guideline-based medication adjustments, and timely follow-ups. This bundle was then scaled across the system with support from QI specialists at Cincinnati Children's Hospital. The effort was reinforced through weekly care team huddles, data transparency, and leadership engagement. Ultimately, performance for the UDS measure for poorly controlled diabetes dropped from 30% to 19% between 2020 and 2024 and other performance and measure gaps narrowed. The same culture of continuous improvement now supports CCPC's initiatives focused on cancer screening and mental health.

- **Bay Community Health (BCH)** of West River, MD successfully closed care gaps in diabetes management by integrating point-of-care A1C testing into routine visits, strategies for delivering immediate results and timely clinical action that are now being applied to cancer screening. By adopting technology that uploads results directly into the EHR, BCH reduced documentation errors from 12.5% to 0.9%, and decreased the percent of patients with uncontrolled or undocumented A1Cs from 26% to 17% within one year. Continuous improvement was driven through repeated Plan-Do-Study-Act (PDSA) cycles, staff retraining, and monthly quality audits to sustain accuracy and adherence. Building on this success, BCH is now applying these strategies to cancer screening: piloting in-visit FIT testing and same-day mammography scheduling to minimize missed opportunities and enhance preventive care access.

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CARE DELIVERY

Access Models and Point-of-Care Improvements

- **Northern Nevada HOPES** of Reno boosted the ability for people experiencing homelessness to receive cancer screening and prevention services by developing a transitional housing community with easy access to primary care. Hope Springs created a 30-unit tiny-home community directly across from the clinic where residents, previously experiencing homelessness, participate in a free six-month program that includes mental health counseling, peer-led recovery meetings, life skills training, and on-site support. The housing site enables residents to attend same-day health services without transportation barriers and with hope to rebuild their lives. The intake process flags overdue cancer screenings such as Pap tests and colorectal cancer checks which are then prioritized by care teams. Paired with consistent peer support and care coordination, this proximity-based model led to dozens of first-time or long-overdue cancer screenings, with multiple early detections and follow-up treatments. The program is a powerful example of how stable housing and trusted, coordinated care can re-engage marginalized individuals in preventive health.

- **Southwest Community Health Center** in Bridgeport, CT significantly improved colorectal cancer screening by implementing an innovative Cologuard Kits On-Site Program led by Community Health Workers (CHWs). By distributing Cologuard kits directly during patient visits and having CHWs trained to provide personalized education and follow-up support, the program nearly doubled kit return rates to 74% compared to traditional ordering. This effort boosted the center's overall colorectal cancer screening rate from 34% to 40% within eight months. Leveraging EHR tools, CHWs could identify eligible patients, track kit distribution and results, and coordinate follow-up. Southwest CHC plans to continue operating effective data-driven, patient-centered approaches to care that can reduce barriers and increase cancer screening participation.

- **Ryan Health** in New York, NY partnered with Cologuard to develop an onsite colorectal cancer screening kit distribution program that helped boost return rates and overcome patient barriers. This effort was initiated when low return rates from faxed Cologuard orders were an obvious obstacle. One clinic, as a result, launched a pilot program where patients received kits onsite directly after education from LPNs. Patients were given the chance to register for the Cologuard program in the Exact Sciences portal in real-time, during a clinic visit. Every step of the process was improved: the clinic manager coordinated staff training, the quality director and medical director led workflow design and provider engagement, UPS pickups from the clinic removed mailing barriers (patients were concerned about package theft). In the first month, return rates rose to 45% for onsite kits compared to 38% for faxed orders. Providers appreciated knowing patients received education and the kit in real time, and patient feedback was notably positive.

- **Uncompahgre Medical Center (UMC)** in Norwood, CO launched a free, patient-centered mobile van service to overcome transportation barriers faced by patients in geographically isolated areas of Norwood and West Montrose County. Operating twice weekly, the van improves access to in-person care, especially for follow-up and chronic disease management visits. This service, combined with standardized clinical protocols aligned with Patient-Centered Medical Home (PCMH) standards, has led to reduced no-show rates and increased patient adherence to preventive services, including timely pap smears and colorectal cancer screenings. Early outcomes show improved appointment attendance and higher patient and staff satisfaction, directly supporting care coordination and value-based care goals. UMC continues to refine this model with plans to expand service days and integrate technology solutions to improve scheduling efficiency and further enhance transportation access for services like breast cancer screenings.

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- **Migrant Health Center, Western Region** of Sur Mayaguez, Puerto Rico expanded cancer screening access in Puerto Rico through a pioneering mobile telehealth model. Using the island's first 5G-enabled mobile fleet that includes six MedPods and two Telehealth Vans, the health center can now bring virtual care directly to rural, low-income, and homeless communities. These mobile units allow staff to collect vitals, lab samples, and screening specimens (e.g., Pap smears, HPV tests) while connecting patients to remote providers in real time. Cancer screening education, scheduling, and follow-up counseling are all integrated into mobile visits, improving patient engagement and adherence. Over 1,000 individuals have been served, including high-risk groups like people living with HIV, as screenings are now embedded into routine care. By combining high-tech tools with culturally responsive outreach, Migrant Health Center is breaking down barriers to early detection and delivering preventive care where it is needed most.

- **Evara Health** of Clearwater, FL used home-based care and tech-enabled workflows to close cancer screening gaps and reach underserved patients. Evara improved colorectal cancer screening by combining technology-enabled outreach with home-based care. With screening rates stuck at 33% from 2022–2023, Evara partnered with Exact Sciences in 2023 to implement a centralized program prioritizing the Cologuard® test for average-risk patients. Using Epic Aura™ and EpicCare Link™, the team streamlined patient identification, bulk test ordering, and result tracking which led to over 12,000 kits mailed in 2024. Language-specific outreach via text, calls, mail, and in-person engagement helped overcome connection barriers. Screening rates rose 52% in one year, reaching 50%. Of 3,700 completed tests, 453 were positive (103 among uninsured patients), all referred for colonoscopy through patient navigation and grant-funded support. Evara also expanded access through its Medical Home at Home (MH@H) program, which delivers care and cancer screening directly to patients' homes. A mobile team offered chronic disease management, at-home screening kits, telehealth, and remote monitoring. Together these steps addressed transportation barriers and broadband gaps. The approach led to a 12-point improvement in diabetes control, a 16-point gain in hypertension management, and better adherence to preventive care. These two strategies show how integrating technology, outreach, and home-based care can drive better access and boost early detection.

Care Navigators, Ambassadors, and Community Health Workers

- **East Hill Family Medical** of Auburn, NY transformed cancer screening and primary care for patients with complex needs in 2024 by redesigning its care navigation model. Clinical leadership led a new department to establish dedicated care navigator roles that could be integrated with provider teams and equipped with SDOH screening tools within the EMR. Navigators were empowered in their role to build trusting, long-term relationships with patients, identify social barriers like housing and literacy, coordinate diagnostics and specialty care, and support chronic disease management. This patient-centered approach has closed persistent care gaps, boosting colorectal cancer screening to 74.9%, and breast cancer screening to 77.8%. These rates are the highest in the state. Additionally, no-show rates dropped and over 3,000 SDOH screenings were completed within six months. East Hill's model demonstrates how innovative, integrated navigation can improve preventive care while fostering deeper patient trust.

- **Lincoln Community Health Center** in Durham, NC brought blood pressure care into the community and is now using the same model to promote cancer screenings. To tackle hypertension, Lincoln launched a creative initiative that included monthly BP education classes, off-site "BP Blitz" events, and one-on-one coaching from trained Student Health Ambassadors. This outreach reached over 1,000 patients and contributed to a 10-point increase in hypertension control rates, rising from 59.3% to 68.9%. Students from Duke and North Carolina Central University delivered motivational interviewing and follow-up calls/texts, building both patient engagement and student public health interest. These trusted, community-centered

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strategies are now being extended to raise awareness and uptake of cancer screenings through similar events at churches, schools, libraries, and local fairs; ensuring preventive care conversations reach people where they are.

- **Clínica Monseñor Oscar A. Romero** of Los Angeles, CA improved cancer screening access for Latino communities by embedding trained Promotoras (trusted community health workers) into both clinic workflows and community outreach. These Promotoras provided culturally tailored education on breast, liver, and lung cancer, helping patients navigate referrals, follow-up appointments, and insurance challenges. The team led 30 cancer education workshops and reached more than 1,500 individuals through outreach events, resulting in over 200 mammograms, 150 liver fibroscan screenings, and multiple referrals to Cedars-Sinai's Clinical Trials Campaign. With just $30,000 in funding, the program boosted early detection, improved patient trust and self-efficacy, and demonstrated the power of culturally grounded approaches. The model is now being scaled to strengthen cancer literacy and prevention in other underserved communities.

- **Siloam Health** of Nashville, TN developed an accredited, evidence-based Community Health Worker (CHW) program to improve chronic disease outcomes in hard-to-reach communities in central Tennessee, with implications for preventive care, including cancer screening. Partnering with IMPaCT (a Community Health Worker program), they recruited CHWs from the communities they serve and trained them in behavioral health, motivational interviewing, and health coaching, delivering culturally tailored care in Spanish and Arabic. The program includes quality standards, fidelity monitoring, and biweekly data-driven learning sessions to optimize workflows. Serving over 600 patients annually, Siloam's CHW program has driven significant improvements in A1c, blood pressure, weight, and care goal achievement. Though focused on chronic disease, these trusted CHWs assist patients through cancer treatment and are well positioned to expand their work to preventive care and cancer screening navigation in underserved populations that face greater barriers of trust and access.

Care Management Improvements

- **CHC of North Country** in Canton, NY improved cancer screening by building a robust case management program for high-need patients, and embedding screening checks into all encounters, whether medical, dental, or behavioral health. They use standing orders so any team member could initiate screening. They also deployed a mobile unit to bring preventive care including at-home CRC screening kits directly to rural communities and individuals with transportation barriers. Each case manager reaches 30 patients per month who are on Medicaid and Medicare, have substance use disorders, overuse the emergency department, or have missed appointments. The team developed a robust follow-up call system and participates in Transition of Care and Chronic Care Management. Screening for non-clinical impacts on health using the NYS tool is standard practice, and patients are routinely connected to resources outside the health center through "Unite Us." By integrating screening reminders for colonoscopies, Pap tests, and lung CTs into these outreach efforts, nurse care coordinators ensure patients complete preventive care promptly. This patient-centered, high-touch approach has helped CHCNC address complex needs, remove barriers to preventive care for hard-to-reach populations, and close cancer screening gaps.

- **Mountain Valley Health Center (MVHC)** in Zanesville, OH developed a comprehensive Care Management Program centered on a dedicated team of Care Managers using an Azara data dashboard to track quality metrics site-by-site, including cancer screening adherence. Care Managers are more informed about when to offer timely follow-up after hospitalizations and emergency visits, personalized outreach calls to reduce readmissions, and improved care continuity. Importantly, the Care Management

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program is set up to integrate proactive cancer screening outreach through quarterly Azara reports that identify patients overdue for colorectal, cervical, and breast cancer screenings. Care Managers reach out to patients that require screening via phone calls and text reminders to encourage scheduling. This data-driven, patient-centered model has contributed to MVHC's recognition as a national quality performer and a high achiever in value-based care. Patient outcomes and preventive care adherence have improved, and emergency department utilization has decreased with their strengthened approach to care management.

PEOPLE

Expanded Care Teams, Leadership, and Training

- **San Fernando Community Health Center** of San Fernando, CA redirected outreach efforts to the lab and doubled colorectal cancer screening rates. The idea began when San Fernando CHC identified high lab utilization and decided to engage patients during their lab visits rather than during busy clinical appointments. An outreach coordinator from the Lab educated patients about the importance of colorectal cancer screening on-site, providing them with a kit to take home, while a case manager followed up within three days to encourage kit return. The outreach coordinator also tracked completions and flagged results for providers. This lab-based approach led to a sustained 75% screening completion rate, which was more than double the 35% rate under the previous method of discussing screening during a routine clinic visit. San Fernando CHC witnessed a significant increase in colorectal cancer screening uptake for at-risk populations.
- **Saban Community Clinic** of Los Angeles, CA launched the Target BP program in 2024, which included a multidisciplinary, pharmacist-led team using telephone consultations, home BP monitors, and coordinated workflows to improve blood pressure control among patients with uncontrolled hypertension. The program enrolled 26% of eligible patients in just three months, achieving a 71% reduction in systolic BP rates among participants and increasing overall BP control from 58.7% to 61% in its first year. Saban also added a Robotic Process Automation (RPA) system to streamline and standardize their referral process, reducing cycle times and staff burden while ensuring timely updates. With the use of RPA, staff could automatically track completed cancer screenings, especially mammograms, and close care gaps. By integrating pharmacists into medication management, offering flexible telehealth visits, and streamlining referral processes, the clinic is improving care coordination, reducing provider burden, and enhancing patient access to preventive screenings and follow-up.
- **Promise Community Health Center** of Sioux Center, IA used a team-based model originally built to boost hypertension control to also increase cancer screening rates. After retraining medical assistants and embedding standardized follow-up protocols for high blood pressure, the clinic integrated pharmacists and nurse health coaches resulting in a jump in BP control from 73% to 84% and the elimination of performance gaps across race, ethnicity, and language. This same approach was adapted for cancer screening by launching a data-driven campaign that included monthly dashboards, provider huddles, and real-time patient lists. Screenings were embedded into routine visits, while at-home FIT kits and no-cost mammogram navigation increased accessibility. These actions resulted in more patients reached, more screenings completed, and more preventive care gaps closed, especially for underserved populations.

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- **CommWell Health** of Four Oaks, NC improved cancer screening rates with a multi-pronged approach centered around their Culture Transformation Blueprint and Leadership Excellence Operational System (LEOS). The Culture Transformation Blueprint uses the power of mentorship and team development programs for staff, and LEOS serves as a unified framework organizing work into four pillars all staff can relate to: Culture, Quality, Finance, and Governance. This system aligned staff from all levels around shared goals which fostered leadership growth, smoother workflows, and a unified focus on data to more easily track preventive care including breast, cervical, and colorectal screening metrics. CommWell Health also conducted a major financial overhaul including the modernization of their sliding fee scale processes, steps to make auditing more transparent, and optimizing Good Faith Estimates and front desk collections. These steps helped improve collections by $30,000 monthly while ensuring eligible patients had clear access to discounts and reduced financial barriers to screening. Additionally, ComWell Health's SweetHearts program addressed chronic disease disparities through a comprehensive, multidisciplinary focus on diabetes and hypertension management. This patient-centered effort, which includes community engagement, offers a replicable model to support cancer screening by tailoring outreach and improving care coordination based on the SweetHearts program success. Together, these initiatives strengthened staff engagement with over 91% recommending CommWell as a workplace, and elevated patient satisfaction beyond 90%, creating a more reliable care environment that supports higher screening rates and better health outcomes all around.

- **Community Health Centers, Inc. (CHC)** of Winter Garden, FL faced workforce shortages that strained capacity, increased patient wait times, and heightened staff burnout. To respond, CHC partnered with St. Petersburg College to launch a 12-week customized Medical Assistant (MA) training program, offered in a hybrid format at CHC's Forest City Health Center. This program allows employees to maintain their jobs while completing rigorous clinical and administrative training, leading to certification and a two-year employment commitment with CHC. By graduating an estimated 20 new Certified Medical Assistants each year, CHC has expanded its workforce with staff who are equipped to support patient education and outreach for cancer screenings, including colonoscopies, pap tests, and lung CTs. As MAs are trained to conduct follow-up calls, provide screening reminders, and address social needs that may be barriers to preventive care, nurses and providers have more time to focus on complex clinical tasks. This workforce model has increased timely access to preventive services and ensures more patients, including underserved patients, receive the screenings needed to detect cancer early.

- **Lynn Community Health Center** of Lynn, MA redesigned its care team workflows to improve access and increase cancer screening. By introducing Medical Assistant (MA) visits for lower-complexity needs and training MAs and RNs to manage routine follow-up care, the clinic allowed primary care physicians to focus on complex cases while still increasing patient volume by 10%. New workflows included standing orders for FIT screening and MA-led cancer screening support. These workflow changes have been well received by staff. As a result, FIT screening orders have risen, blood pressure and A1c control have improved, and cancer screening is expanding to include mammography and lung cancer assessments. Lynn's Access Model 2.0 proves that rethinking roles and workflows can boost team satisfaction and preventive care outcomes.

Population Health Outreach and Cultural Connections

- **Heart City Health** of Elkhart, IN is streamlining preventive care and improving cancer screening rates through smarter pre-visit planning. They use a population health tool to identify patients due for screenings ahead of appointments, allowing teams to prep charts, flag needed tests, and reduce duplicative services. The Patient Visit Planning (PVP) tool enables medical assistants and community health workers to discuss screenings at the start of the visit, increasing patient awareness and uptake. Starting with colorectal cancer, the team quickly saw positive results. Patients' screenings are now captured and documented, or if patients face barriers, they are guided through alternative screening options. This approach has since expanded to include mammograms and cervical cancer screenings, improving workflow efficiency, patient education, and screening completion.
- **Seattle Indian Health Board (SIHB)** in Seattle, WA developed the Indigenous Knowledge Informed Systems of Care (IndigiKnow), a culturally grounded framework that integrates Traditional Indian Medicine into holistic healthcare. By embedding traditional practices alongside behavioral, dental, and medical services including cancer screening, SIHB honors Indigenous worldviews that emphasize balance and community wellness. SIHB pioneered the creation of billable CPT codes for Traditional Medicine and customized EHR systems to support its integration, demonstrating systemic innovation. Preliminary outcomes show that patients engaging with Traditional Medicine experience lower rates of depression, anxiety, and suicidality, and exhibit higher medical compliance, including better appointment adherence and participation in preventive care like cancer screenings. This approach leverages cultural motivation where healing is connected to family and community wellbeing resulting in more engaged patients and a model that bridges Indigenous and Western medicine.
- **La Clínica del Pueblo** in Washington D.C, transformed its approach to community engagement and improved health access through a Participatory Rapid Appraisal (PRA) process that centers patient voices in organizational planning and care design. The PRA was conducted in Spanish with affinity groups organized by age, geography, and health status. They used participatory tools to uncover challenging barriers such as food insecurity, housing instability, and chronic stress to define patient priorities. This process informed redesigns of social needs screenings, guided grant development, and strengthened community advocacy efforts. Importantly, the PRA fostered a cultural shift by positioning patients as experts and co-designers of care. This method offers a powerful foundation for improving cancer screening by revealing the real-world obstacles patients face like work schedules, transportation, and mistrust, and enabling health centers to tailor screening strategies that are more accessible and integrated into patient empowerment plans for better primary care.

These 27 examples represent the exceptional commitment health centers across the nation demonstrate as they deliver high-quality patient care and cost-saving preventive care. The National Association of Community Health Centers is dedicated to supporting this great work, offering national programs such as Elevate to bring health centers together and support transformation, and sharing best practices like these among health centers, primary care associations, health center controlled networks and training partners throughout the United States.

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