How to Increase Preventive Screening Rates in Practice:
An Action Plan for Implementing
A Primary Care Clinician’s Evidence-Based Toolbox and Guide
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Medical Center

Name ___________________________ Age _________
Address ___________________________ Date __________

Rx Implement practice changes to achieve the *Four Essentials*.

MD ______________________________________________________
Signature ____________________________________________
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Take steps to identify and screen every age-appropriate patient.

Medical Center

Name ___________________________ Age _________
Address ___________________________ Date ___________

Rx

MD ___________________________
Signature ________________________
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Involve your staff, and put office systems in place.

Medical Center
Name __________________________ Age ________
Address __________________________ Date ________

Rx

MD

Signature __________________________
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Follow a continuous improvement model to develop and test changes.

Medical Center

Name ___________________________ Age _________
Address ___________________________ Date _________

RX

MD _______________________________

Signature __________________________________


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ADJUST

PLAN

STUDY

ACT
**Make a Recommendation**
The primary reason patients say they are not screened is because a doctor did not advise it. A recommendation from you is vital.

**Develop a Screening Policy**
Create a standardized course of action. Engage your team in creating, supporting, and following the policy.

**Measure Practice Progress**
Establish a baseline screening rate, and set an ambitious practice goal. Seeing screening rates improve can be rewarding for your team.

**Be Persistent With Reminders**
Track test results, and follow up with providers and patients. You may need to remind patients several times before they follow through.
Make a Recommendation

**Essential #1**

Determine the screening messages you and your staff will share with patients.

**Essential #1**

Explore how your practice will assess a patient’s risk status and receptivity to screening.
Tools for Your Practice

Essential #1: Make a Recommendation

• CRC Screening Options and Patient Readiness
• Outreach to Underserved Populations
<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Age to Begin Screening</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average risk</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No risk factors</td>
<td>&lt; Age 50</td>
<td>No screening needed</td>
</tr>
<tr>
<td>No symptoms</td>
<td>≥ Age 50</td>
<td>Screen with any one of the following options:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Tests That Find Polyps and Cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FS q 5 yrs*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CS q 10 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DCBE q 5 yrs*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CTC q 5 yrs*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Tests That Primarily Find Cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>gFOBT q 1 yr*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FIT q 1 yr*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>sDNA*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased risk</td>
<td>≥ Age 40 or 10 years</td>
<td>Colonoscopy*</td>
</tr>
<tr>
<td>CRC or adenomatous polyp in a first-degree relative</td>
<td>younger than the earliest diagnosis in the family, whichever comes first</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any age</td>
<td>Needs specialty evaluation and colonoscopy</td>
</tr>
<tr>
<td>Highest risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal history for &gt; 8 years of Crohn’s disease or ulcerative colitis or a hereditary syndrome (HNPCC or, FAP, AFAP)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Sample Tools for Your Practice

### Individual Risk Based on Family History of CRC**

<table>
<thead>
<tr>
<th>Familial Setting</th>
<th>Approximate Lifetime Risk of Colon Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>No history of colorectal cancer or adenoma (General population in the United States)</td>
<td>6%</td>
</tr>
<tr>
<td>One second- or third-degree relative with CRC</td>
<td>About a 1.5-fold increase</td>
</tr>
<tr>
<td>One first-degree relative with an adenomatous polyp</td>
<td>About a 2-fold increase</td>
</tr>
<tr>
<td>One first-degree relative with colon cancer*</td>
<td>2-to-3-fold increase</td>
</tr>
<tr>
<td>Two second-degree relatives with colon cancer</td>
<td>About a 2-to-3-fold increase</td>
</tr>
<tr>
<td>Two first-degree relatives with colon cancer*</td>
<td>3-to-4-fold increase</td>
</tr>
<tr>
<td>First-degree relative with CRC diagnosed at &lt; 50 years</td>
<td>3-to-4-fold increase</td>
</tr>
</tbody>
</table>

* First-degree relatives include parents, siblings, and children.  
  Second-degree relatives include grandparents, aunts, and uncles.  
  Third-degree relatives include great-grandparents and cousins.
Develop a Screening Policy

Essential #2
Create a standard course of action for screenings, document it, and share it.

Essential #2
Compile a list of screening resources and determine the screening capacity available in your community.
Tools for Your Practice

Essential #2: Develop a Screening Policy
• Screening Policy and Office Visits
• CRC Patient Education Materials
Sample Screening Algorithm

Assess Risk: Personal & Family History

Average risk = No family history of CRC or adenomatous polyp

- < 50 years: Do not screen
- ≥ 50 years: Screen

If positive, diagnosis by colonoscopy

Increased or high risk based on personal history

Adenoma → Surveillance Colonoscopy
CRC → Screening colonoscopy, genetic testing, and other cancer screening as appropriate
IBD

Increased or high risk based on family history

High Risk: Germline Syndrome HNPCC or FAP
Adenoma or cancer

Screen with colonoscopy 10 years before youngest relative or age 40

Options

Tests That Find Polyps and Cancer
Flexible sigmoidoscopy every 5 years, or Colonoscopy every 10 years
Double-contrast barium enema every 5 years, or CT colonography (virtual colonoscopy) every 5 years

Tests That Primarily Find Cancer
Yearly fecal occult blood test (gFOBT)*, or Yearly fecal immunochemical test (FIT)*, or Stool DNA test (SDNA), interval uncertain

*The multiple stool take-home test should be used. One test done by the doctor in the office is not adequate for testing. The tests that are designed to find both early cancer and polyps are preferred if these tests are available and the patient is willing to have one of these more invasive tests.
Be Persistent with Reminders

**Essential #3**

Determine how your practice will notify patient and physician when screening and follow up is due.

**Essential #3**

Ensure that your system tracks test results and uses reminder prompts for patients and providers.
Tools for Your Practice

Essential #3: Be Persistent
- Reminder Systems
- Tracking Information
## Internal Practice Questionnaire

### Goals
- Are we functioning in alignment with our greater purpose? Our vision?
- Do we need to reevaluate our goals?
- What is working well? Why?
- What is not working? Why?
- What can be done differently?
- Are we providing the services we said we wanted to provide?
- Should we reevaluate the services we offer?

### Materials
- How do the cancer prevention materials fit our needs?
- Should we modify any of the cancer prevention materials?

### Documentation
- Are we documenting the services we provide?

### Staff Performance and Satisfaction
- How are the staff performing their functions?
- Are staff stepping in where needed?
- Are staff working together as a team?
- Are all staff contributing suggestions?
- How do staff members feel about their work?
- Do staff members feel supported and heard?

### Patients
- How are our patients responding to the change?
Measure Practice Progress

**Essential #4**

Discuss how your screening system is working during regular staff meetings, and make adjustments as needed.

**Essential #4**

Have staff conduct a screening audit, or contact a local company that can perform such a service.
Tools for Your Practice

Essential #4: Measure Progress
• Staff Feedback
• Practice Performance
Click on education drop down box

Then select Maintenance of Certification
Colorectal Cancer (CRC) Screening Module

**Pre-assessment Phase**

**STEP 1**
Enter Patients

You have entered 5 out of the maximum 25 patients you may have in your sample.

Continue

**STEP 2**
Practice Assessment

Continue

**STEP 2**
Interpretation of data

Continue

**STEP 4**
Review QIP

Continue

**Earned CME Information**

This Practice Improvement Program is worth a total of 20 credit hours. You will receive this credit at the completion of the activity.

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Communication

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- Implement practice changes to achieve the Four Essentials.
- Take steps to identify and screen every age-appropriate patient.
- Involve your staff, and put office systems in place.
- Follow a continuous improvement model to develop and test changes to your screening system.
Additional tools to assist practices with increasing colorectal cancer screening can be found in the guide.
The National Colorectal Cancer Roundtable would like to thank everyone who participated in and contributed to making this guide a success.