Tips for better screening rates at your facility

1. Recommend CRC Screening to Patients
    - Discuss multiple screening options with patients (not only colonoscopy)
1. Develop a CRC Screening Policy
    - Fit the policy to your practice
        - ♦ Determine patient risk level
        - ♦ Identify local medical resources
        - ♦ Assess insurance coverage
        - ♦ Consider patient preference
        - ♦ Engage your team in following the policy
3. Be Persistent with CRC Reminders
    - Use patient tools:
        - ♦ Education and cues to action
    - Use provider tools:
        - ♦ Chart prompts
        - ♦ Audits and feedback
        - ♦ Ticklers and logs
        - ♦ Staff assignments
        - ♦ Track test results
4. Measure Practice Progress
    - Have staff conduct a screening audit
    - Establish a baseline screening rate
    - Discuss how the screening system is working

Learn more at : http://www.ucare.org/providers/Documents/IncreaseCancerScreeningRates.pdf

Avoid these errors:

- **X** Not assessing a patient's level of risk for developing CRC, based on personal, family, and medical history, to determine appropriate screening approach.
- **X** Screening patients with a digital rectal exam (DRE).
- **X** Screening patients in the clinic with guaiac-based FOBT, using only a single stool sample following a DRE.
- **X** Not ordering diagnostic colonoscopy for patients with a positive gFOBT, iFOBT, or flexible sigmoidoscopy.
- **X** Not following up on patients referred for colonoscopy.
- **X** Recommending screening with colonoscopy at intervals shorter than every 10 years, or flexible sigmoidoscopy at intervals shorter than every 5 years, for average-age-risk persons.
- **X** Starting screening earlier than age 50 for average-risk, asymptomatic individuals.
- **X** Applying recommendations for average-risk persons to patients that are at increased risk for developing CRC.

Adapted from: "How to Increase CRC Rates in Practice: A Primary Care Clinician's Evidence-based Toolbox and Guide, 2008" , available at : http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf

Subscribe to the IHS CRC listserv at:

http://www.ihs.gov/listserver/index.cfm?module=signUpForm&list_id=138

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Colorectal Cancer (CRC) Screening

A Reference Guide for IHS and Tribal Healthcare Providers

May 2013

INDIAN HEALTH SERVICE · PHS · 1955 ·

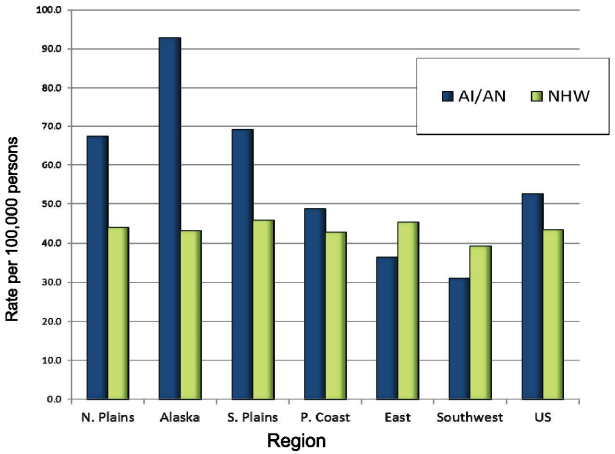
Colorectal cancer in American Indian and Alaska Native (AI/AN) communities

Did you know?

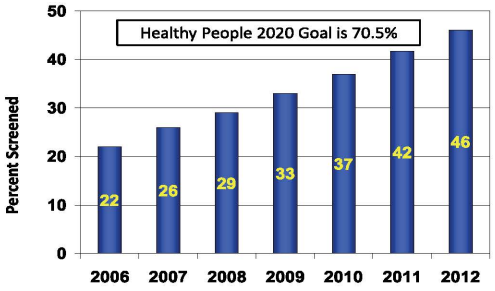
Of all AI/AN men and women who are currently cancer free at age 50, an estimated 4.1% (1 in 24) will develop CRC in their lifetime.

Source: Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov) DevCan database: "SEER 18 Incidence and Mortality, 2000-2009, with Kaposi Sarcoma and Mesothelioma". National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch, released April 2012, based on the November 2011 submission.

Colorectal cancer incidence rates, AI/AN and non-Hispanic Whites (NHW), both sexes, 2005-2009



Colorectal cancer screening trend within the Indian Health Service (GPRA clinical data)



Who, how, and how often to screen for CRC

The United States Preventive Services Task Force recommends :

- Average-risk men and women aged 50-75 should be screened using any of the following:

  YEARLY: Immunochemical fecal occult blood test (iFOBT) or high-sensitivity guaiac-based fecal occult blood test (gFOBT)

  -OR-

  EVERY 5 YEARS: Flexible sigmoidoscopy (along with FOBT every 3 years)

  -OR-

  EVERY 10 YEARS: Colonoscopy

- Routine screening is not recommended for men and women ages 76-85. Decisions about first-time screening in this age group should be made on an individual basis.

- Screening is not recommended for men and women over the age of 85.

Link to USPSTF recommendations:

http://www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm

Ways to encourage patients to get screened

Utilize culturally and linguistically appropriate materials to educate patients. Check the following sites for materials and links to other resources:

- Albuquerque Area Southwest Tribal Epidemiology Center, Tribal Colorectal Health Program— http://aaihb.org/aastec/tchp/

- Alaska Community Health Aide Program—Cancer Education— http://www.akchap.org/html/resources/cancer-education.html

When recommending FOBT, include an option for immunochemical FOBTs, which offer patients several advantages over traditional guaiac-based FOBTs, including:

- No dietary or medication restrictions before or during screening

- Fewer stool samples needed

- Various stool collection methods (less stool handling)

- Detects only colorectal bleeding

Utilize the Guide to Community Preventive Services, which highlights interventions that can increase cancer screening: http://www.thecommunityguide.org/cancer/index.html