Colorectal Cancer Screening:
Tools for Your Practice
and the Evidence for Them

Mona Sarfaty, MD MPH FAAFP
Thomas Jefferson University
February 2011

Outline

- Current physician practices
- Importance of a doctor's recommendation
- Getting a recommendation to each patient
- Evidence for effective strategies
- Address common barriers to screening

Q: Do Physician Screen Their Patients for CRC?

- A: Yes, 98% already do.
  (Klabunde, et. al., Prev Med 2003)

Why Do Physicians Screen for CRC?

- It reduces the incidence and mortality of CRC
- CRC Screening is a HEDIS measure as of 2003
  - HEDIS=nationally accepted quality measure
  - Now part of pay for performance (Medicare)
- CRC malpractice cases are costly and rising ("failure to screen" now common complaint)
- CME credit is now available for practice improvement: AAFP, ABIM, AMA (20 cr)

5

What is the Problem?

- Screening rates are lower than expected
- Medical practice is demand (patient) driven and practice demands are numerous/diverse
- < 25% of PCP's nationwide think 75% of their eligible patients are screened (Klabunde, op cit)
- Screening rates are less for persons with less education, no health insurance, lower SES.

6

Q: Why focus on primary care practice? What can we do about it?

- We have it in our power to improve the screening rate. 'This is our sphere of influence.'
- Majority of people >age 50 see a 1°MD q year (BRFSS, CDC)
- Few practices currently have mechanisms to assure that every eligible patient gets a recommendation for screening.

7

Case Study

- A 45 year old man goes to the doctor for a sore shoulder. The history form collected at the front desk reveals that his 55 year old brother had an adenomatous polyp found recently.

8

What is the man's risk of CRC?

- A. Average Risk
- B. Increased Risk
- C. High Risk

Would you recommend screening to this man?

- A. No, because it is not his check up?
- B. Yes, because you can't raise screening rates without taking every opportunity to screen.
- C. Yes, because he is at increased risk and could be screened 10 years earlier than his youngest family member with CRC.

What screen do you recommend?

- A. Stool Blood Testing (SBT)
- B. Flexible Sigmoidoscopy (FS)
- C. SBT + FS
- D. Colonoscopy
- E. Any of the tests preferred by the patient

2008 CRC Screening Guidelines:

- Exams that are designed to detect both early cancer and precancerous polyps should be encouraged if resources are available and patients are willing to undergo an invasive test
- If the full range of screening tests are not available, physicians should make every effort to offer at least one test from each category

2008 CRC Screening Guidelines

Average risk adults age 50 and older

- Tests that detect adenomatous polyps and cancer
  - **Flexible sigmoidoscopy (FSIG) every 5 years*, or**
  - **Colonoscopy every 10 years, or**
  - Double contrast barium enema (DCBE) every 5 years*, or
  - CT colonography (CTC) every 5 years*

*Note: All positive screening tests should be followed up with colonoscopy **Must detect at least 50%

2008 CRC Screening Guidelines

- Tests that primarily detect cancer **
  - **Annual guaiac-based fecal occult blood test (gFOBT)* with high test sensitivity for cancer, or**
  - **Annual fecal immunochemical test (FIT)* with high test sensitivity for cancer, or**
  - Stool DNA test (sDNA)*, with high sensitivity for cancer, interval uncertain

*Note: All positive screening tests should be followed up with colonoscopy **Must detect at least 50%

If tests that can prevent CRC are preferred, why not recommend them alone? 3 Reasons

- 1. Greater patient requirements for successful completion
  - Endoscopic and radiologic exams require a bowel prep and an office or facility visit
- 2. More invasive than fecal testing, therefore higher potential for patient injury
  - Risk levels vary between tests, facilities, practitioners
- 3. Patient preference
  - Many individuals don't want an invasive test or a test that requires a bowel prep
  - Some prefer to have screening in the privacy of their home
  - Some may not have access to the invasive tests due to lack of coverage or local resources

Other Stool Test Cautions

- ONLY AT-HOME TEST ACCEPTABLE
- Positive FOBT should not be repeated
  - Should be followed with a **colonoscopy**

Screening Options: Can We Get to 80%

- **What are the benchmarks for the main screening tests?***

Endoscopy (over 50, ever)

- Delaware.....74.3 %
- Maine.....72.6 %
- Maryland.....71.3 %

Stool Blood Tests (over 50, last 2 years)

- Florida.....29 %
- California.....27.8%
- Maine.....27.7%

*BRFSS, CDC, 2008.
N.B. This does not mean up to date.

17

How Can We Get to Goal of 80% Patients Screened?

18

Q: Is a Doctor's Recommendation Really That Useful?

- **A: Yes. Unequivocally!**

The physician's recommendation is the most consistently influential factor in cancer screening!

EBM CME

The evidence for this is based on analysis of large data bases from population based surveys, specifically the National Health Interview Surveys in 2000 & 2003, statewide cancer surveys from two states (California, Maryland), practice based interventions, and qualitative research.

19

KEY POINT: Most Influential Factor: Recommendation from a Physician (Clinician)

- Although other factors, such as health insurance status play a role, the evidence supporting the role of a physician's recommendation derives from many types of research-based and population sources and is geographically constant.
- A recommendation from a primary care clinician has been identified most consistently, directly and indirectly, as the factor of prime influence.

20

Q: How do we know this?

- **A:** This conclusion has an evidence base from research on breast, cervical, and colorectal cancer screening.

21

Evidence from Screening for Breast and Cervical Cancer

- A doctor's recommendation is the single most important motivator for mammogram & pap smear screening (#41-46)
- Further, it shows that the lack of a recommendation is experienced as a barrier (#47)

22

Evidence from Research on Screening for Colorectal Cancer

- Receiving FOBT cards from a doctor is a strong predictor of screening status (#49)
- Ever receiving a flex sig recommendation increases the likelihood having flex sig (#48)
- Seeing a doctor within the prior year is a strong predictor of screening status (#49)
- More preventive health visits increases odds of having been screened (#50)

23

What is the Evidence from Statewide Surveys?

- Pennsylvania: 90% of those who reported a recommendation vs. 17% of those who did not were screened (#51)
- Maryland: 67% of those who reported a recommendation the last year vs. 5% of those who had not completed FOBT* (26% received the rec)
- *MD Cancer Survey, 2006

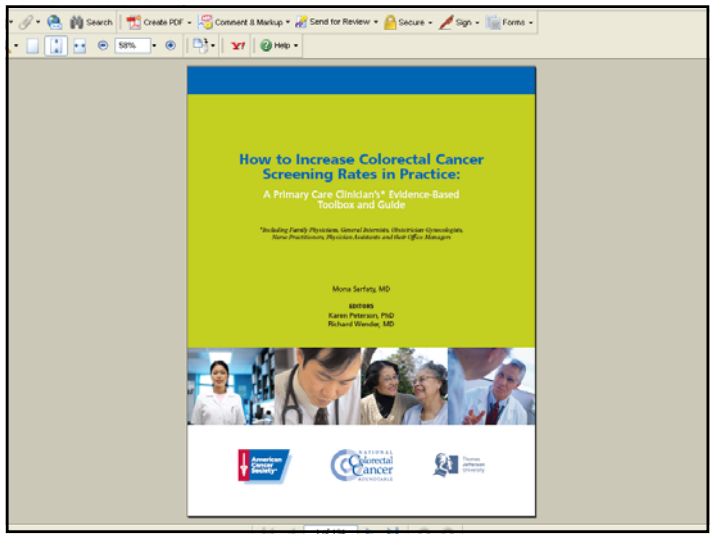
24

What is the Evidence from Statewide Surveys, cont'd

- Maryland: 85% of those who reported a recommendation for endoscopy vs 25% who did not had an endoscopy(73% ever rec rec)
- Those with screening endoscopy not up-to-date when asked "why", said:
  - 23% "doctor didn't order it, or didn't say I needed it.* (most common single reason)

What is the Evidence from Statewide Surveys, cont'd

- Those with no FOBT (last year/ ever) when asked "why", replied:
  - 29% "doctor didn't order it, or didn't say I needed it.* (most common reason)
- *Ibid



How Can We Increase CRC Screening Rates in Practice?*

4 Essentials:

#1 A Recommendation to every patient

#2 An Office Policy

#3 A Reminder System

#4 An Effective Communication System

*** www.cancer.org**

Essential #1: Screening Recommendation

Goal = recommendation to each eligible patient

- Requires an opportunistic/global approach*
  i.e. don't limit efforts to "check-ups"
- Requires a system that doesn't depend on the doctor alone.

***N.B. An opportunistic approach doesn't justify an in-office FOBT which has negative evidence.**
(Collins, et. al. *An Int Med*)

How to involve staff who work in the practice?

Essential #2: An Office Policy

- States the intent of the practice.
  - tangible, maintains consistency,
  - prerequisite for reliable, reproducible practice
- Algorithms easiest policies to follow.
- Beware: one size does not fit all practices!
- Beware: one size does not fit all doctors!
- Beware: one size does not fit all patients!

Factors to Consider in Your Office Policy

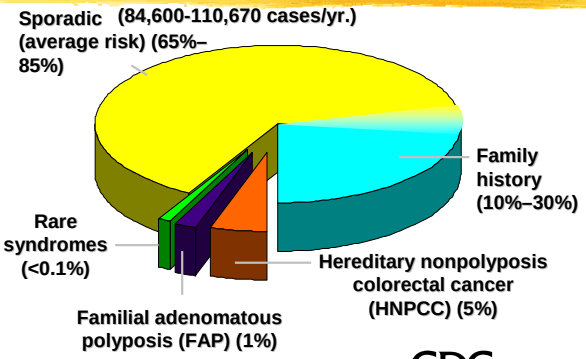
- 1.Individual Risk Level ("risk stratification")
- 2. Medical resources (endoscopy available?)
- 3. Insurance (insured? covered? deductible? copay?)
- 4. Patient Preference
  - Patients do have preferences (#128, #129)
  - We often neglect to ask about them (#127)
  - We won't know unless we ask

The Central Question: Risk Level

Individual Risk Levels?

- Average
- Increased
- High

Colorectal Cancer Cases



Individual Risk Based on Family History of CRC[1]

Familial Setting	Approximate lifetime risk of colon cancer
No history of colorectal cancer or adenoma (General population in the U.S.)	6%
One second or third-degree relative with CRC	About a 1.5 fold increase
One first-degree relative with an adenomatous polyp	About a 2 fold increase
One first-degree relative with colon cancer*	2-3 fold increase
Two second-degree relatives with colon cancer	About a 2-3 fold increase
Two first-degree relatives with colon cancer*	3-4 fold increase
First-degree relative with CRC diagnosed at < 50 years	3-4 fold increase

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

Risk of Colorectal Cancer

- **An individual's risk of colorectal cancer is elevated if:**
  - **There is a first degree relative with CRC or an adenomatous polyp under age 60**
  - **There are two relatives of any age with CRC or with an adenomatous polyp**
  - **There is a history of chronic inflammatory bowel disease for > 8 years or a hereditary syndrome.**

EB CME

The evidence for this assessment of risk comes from a meta-alaysis of 27 studies back to 1966 that assessed familial risk of colorectal cancer and adenomatous polyps. (Johns LE, Houlston RS. A systematic review & meta-analysis of familial colorectal cancer risk. Am J Gastroenterol 2001; 96: 2992-3003.)

Q: How Many at Increased Risk?

- **A:** Many more than we usually think.
- Too much emphasis in the past on the "average risk" person, assumed to represent the vast majority.
- In fact, with CRC, 15-35% of the population is at increased risk.

Questions to Determine Risk

- Have you or any members of your family had colorectal cancer?
- Have you or any members of your family had an adenomatous polyp?
- Has any member of your family had a CRC or adenomatous polyp when they were under the age of 50? (If yes, consider a hereditary syndrome.)
- Do you have a history of Crohn's Disease or Ulcerative Colitis (more than eight years)?
- Do you or any members of your family have a history of cancer of the endometrium, small bowel, ureter or renal pelvis? (If yes, consider HNPCC. Check the criteria.)

Case Study

- A 40 year old woman comes in for heartburn.

The waiting room history reveals that her mother and her sister both had colorectal cancer. Her mother was diagnosed at age 50 and her sister had uterine cancer at age 50.

What is her risk level?

- A. She is at average risk.
- B. She is at increased risk
- C. She is at high risk.
- D. It is impossible to define her risk level based on the information provided.

What action will be indicated?

- A. Colonoscopy
- B. Genetic Testing
- C. Referral to a gastroenterologist.
- D. All of the above

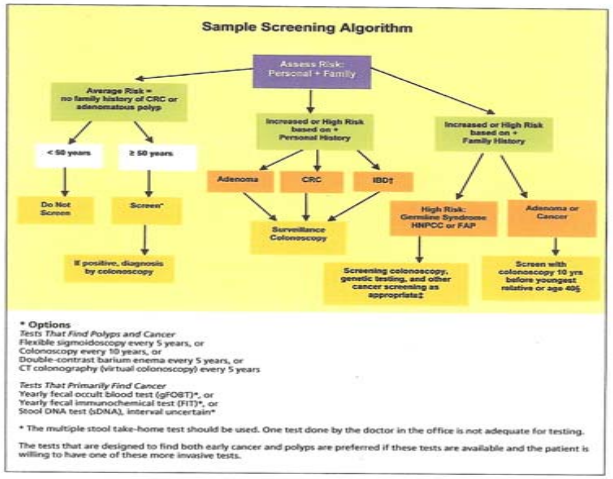
- See *Screening Recommendations at a Glance also*, *Toolbox and Guide* (p 63), for another approach to visualizing this policy.

Common Sense Colorectal Cancer Screening Recommendations at a Glance

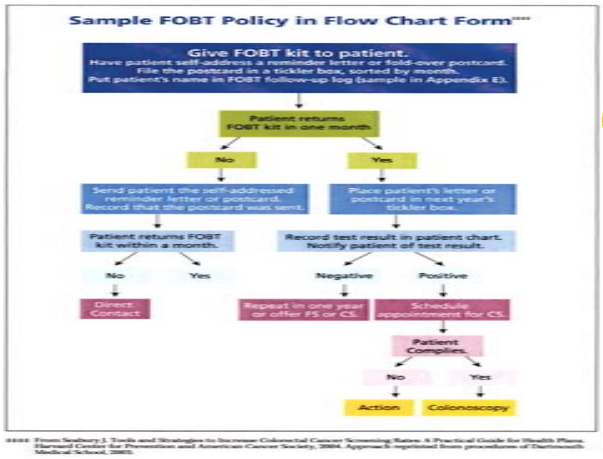
Risk Category	Age to Begin Screening	Recommendations
Average Risk No risk factors No symptoms*	< Age 50 > Age 50	No Screening Needed Screen with any one of the following options: *Tests That Find Polyps and Cancer* FS q 5 yrs* CS q 10 yrs DCBE q 5 yrs* CTC q 5 yrs* OR *Tests That Primarily Find Cancer* gFOBT q 1 yr*,** FIT q 1 yr*,** sDNA***
Increased Risk CRC or adenomatous polyp in a first degree relative*	Age 40 or 10 years younger than the earliest diagnosis in the family, whichever comes first	Colonoscopy*
Highest Risk Personal history for > 8 years of Crohn's Disease or Ulcerative Colitis or a hereditary syndrome (HNPCC or, FAP, AFAP)	Any age	Needs specialty evaluation and colonoscopy

* If the test is positive, a colonoscopy should be done.
** The multiple stool take-home test should be used. One test done by the doctor in the office is not adequate for testing.
*** Interval uncertain.

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.



An Algorithm Pertaining Strictly to Stool Blood Testing



Barriers to Physician Practice

Inadequate follow up of positive FOBT

- Approximately 30% of patients told they had a positive FOBT reported that this test was either followed up with a repeat FOBT, or no diagnostic work up. Every positive FOBT should lead to a diagnostic work-up.

EBM CME

This finding is based on two cross sectional surveys: the first is of 1147 physicians who responded to the National Survey of Colorectal Cancer Screening Practices, the second was based on the responses of 11,365 individual respondents to the NHIS. The physicians survey indicated that nearly 30% of positive FOBT's were followed up with another FOBT rather than used as the basis for a complete diagnostic work-up. The NHIS survey had an identical result, with 30% of individuals indicating they did not get a diagnostic exam after a positive FOBT.*

**Nadel et al, Annals of Int Med Jan 2005*

Essential #3: A Reminder System

- Two types:
  - Physician Reminders
  - Patient Reminders
- There is evidence for effectiveness of both

Physician Reminder Types

- Chart Prompts
  - Problem lists
  - Screening schedules
  - Integrated summaries
- Alerts - placed in chart
- Follow-Up Reminders
  - Tickler System
  - Logs and Tracking
- Electronic Reminder Systems (HER)

Evidence on Physician Reminders

	% Improved
Meta-analysis #1	**13.2%**

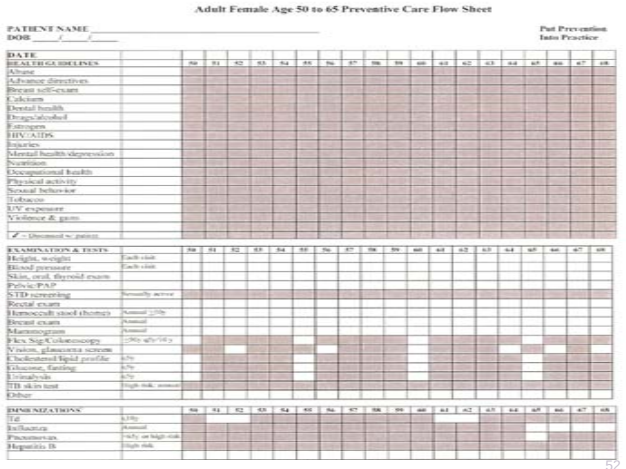
35 RCT's- on mammogram rates-prompts, staff roles, logs
(Mandelblatt, Yarbroff,Ca Ep.Biom. Prev 1999)

- **Meta-anlaysis #2** **13.1 (5.8-18%)**

33 RCT's-on approaches to increase preventive service use (inc. fobts) - prompts, alerts, ticklers
(Balas EA, et. al. Arch Int Med 2000)

How Include Reminders?

- Advanced Preparation
  - Chart reviews before the visit with alert
  - Staff can ask the patient with give you an alert
- Audits – reminders after the fact
  - Referred to as "Cognitive" approach (#89)
    - 18.6% improvement
    - 21% when combined with other reminders
- Logs/Ticklers
  - Maintained for follow-up


Adult Female Age 50 to 65 Preventive Care Flow Sheet

FOBT Tracking

Date

a. At home FOBT Kit Given
b. FOBT Test Completed
c. Results Received
d. If No Completion or Results, Reminder Card/Letter Sent
e. Patient Notified of Finding
f. Referred for CS if Positive
g. Placed in Tickler File if Negative for next year

a. Referred for FS if FOBT Negative
b. FS Scheduled
c. FS Test Completed
d. FS Results Received
e. If No Completion or Results, FS Reminder Card/Letter Sent
f. FS Patient Notified of Finding
g. FS Placed in Tickler File if Negative
h. Scheduled for CS if Positive

a. Referred for CS
b. CS Scheduled
c. CS Test Completed
d. CS Results Received
e. If No Completion or Results, CS Reminder Card/Letter Sent
f. CS Patient Notified of Finding
g. CS Placed in Tickler File if Negative

Checklist for Follow Through: Screening to Complete Diagnostic Evaluation

FOBT Screening	date	FS or CS Screening (circle one)	date
1. FOBT Given		1. FS/CS Ordered (circle)	
2. Provider Notified re: FOBT Result		2. FS or CS Scheduled	
3. Non-responder-Contacted (Back to 2)		3. No Show Identified	
4. If FOBT +, Referral Given		4. Rescheduled	
5. Colonoscopy Scheduled		5. Results Reviewed	
6. Show/No-show		6. Results on Chart for Endoscopy/Pathology	
7. No-show Rescheduled		7. If FS +, Referral for Colonoscopy	
8. Results Reviewed		8. Show/No-Show	
9. Results on Chart		9. No-Show Rescheduled	
		10. Results Reviewed for Endoscopy/Pathology	
		11. Results on Chart	

Chart Audit Template

				FOBT			Flexible Sigmoidoscopy			Colonoscopy			
Name ID	Date	Gender Race Ethnicity	Screen Choice FOBT FOBT-FS FS or CS DCBE	FOBT Return Y/N	Result	Result Date	Flex Sig Y/N	Result	Result Date	CS Y/N	Result	Result Date	Diagnosis

Chart # and Phone #	Name	Sex	Race/Ethn.	DOB	Risk A/I/H	FOBT Distrib. date	FOBT Result	FS Referral date	CS Referral date	Needs FOBT FS, CS, None	Reminder Written/ Telephone Date(s)	Test Result & Notification Date	Comment (other CA screening needed)

What About Patient Reminders ?

- Two types
  - 1. Cues to action
  - 2. Education
- The evidence on Reminders for CRC screening
  - Increased return of Stool Blood Tests (SBT) ±
  - Increased screening with SBT or Endoscopy §

± Myers, et. al., Medical Care, 1991.
§ Myers, et. al., CA, 2007.

Evidence on Patient Reminders for Mammograms

- A Meta-analysis of 45 RCT studies on Mammography *
  - Letters, phone reminders, Rx's
  - 13-17.6% screening improvement
  - Two options work better than one

*Yabroff KR, Mandelblatt JS. Cancer Ep Bio Prev 1999.

Reminder Fold-Over Postcard

Date

Dear (Name):

Colon cancer is the second leading cause of cancer-related deaths in the United States, and men and women are equally at risk. The good news is that colon cancer can be prevented or detected early and death from colon cancer can be prevented if screening is done on a regular basis.

Our records indicate that it is time for your annual physical and cancer screening. Please call your primary care physician, at XXX-XXX-XXXX so that you can schedule an appointment at your earliest convenience.

Sincerely,

Increased Risk Letter

Date

Dear_____

According to our records, you indicated that either you or a family member who is under age 60 has a history of colorectal polyps or cancer. This medical history places you at increased risk for colorectal cancer. Because of this, it is advisable that you have a colonoscopy now.

If you had a negative FOBT test, you still need a colonoscopy.

A colonoscopy is a procedure that must be done by a gastroenterologist or a surgeon at an endoscopy center or hospital. This test will allow a doctor to look inside the entire colon (large intestine) to check for a polyp or cancer.

If you do not have health insurance, please do not let this keep you from getting a colonoscopy. We can assist you with scheduling a colonoscopy or finding a doctor who will see you. Please call _____to set up an appointment if you have questions.

If you have health insurance (or Medicare/Medicaid), our office will refer you for a colonoscopy. To obtain the referral call or take this letter with you to your next doctor's appointment.

Thank you for taking care of your health and following through on this important test.

Sincerely,

Medical Director

Average Risk Reminder

Date

Name
Street
City

Dear (Name):

Colorectal cancer is the second leading cause of cancer death among men and women in the United States. The good news is that this disease can be prevented. Screening tests are vital to preventing colorectal cancer because they can detect pre-cancerous polyps that can be removed easily with routine procedures. Lifestyle changes, such as improving diet and increasing physical activity, can also reduce the risk of cancer.

Like many people, you are at risk for colorectal cancer. I am writing to remind you to call your primary care physician today to schedule a colorectal cancer screening appointment. By getting colorectal cancer screening tests regularly, colorectal cancer can be found and treated early when the chances for cure are best.

Please read the enclosed brochure to learn about colorectal cancer screening. If you'd like to know more about colon cancer and the testing process, I would be happy to talk with you about it further. You can also call the American Cancer Society at 1-800-ACS-2345 or visit www.cancer.org. Whatever your next step, I hope you'll schedule your next screening test soon. It just might save your life.

Sincerely,

Enclosure: *Colon Testing Can Save Your Life brochure*

61

FOBT Positive Letter

Date

«FirstName» «LastName»
«Address»
«City», «State» «Zip»

Dear «FirstName» «LastName»,

We wanted to congratulate you on successfully completing the Fecal Occult Blood Testing (FOBT). The results of your FOBT test for colon and rectal cancer screening showed that you may have blood in your stool and that further testing is needed.

You now need a colonoscopy to look for a possible source of the bleeding and to determine if a polyp or cancer is present. Usually there is no serious problem, or if a precancerous growth is found, it can be removed to prevent cancer. However, cancer is one of the potential causes for your bleeding; we want to be very careful to rule out this possibility. A colonoscopy is a procedure that must be done by a doctor at an endoscopy center or a hospital. This test will require that you have anesthesia and will allow a doctor to look inside your entire large intestine to check for a growth or a polyp or cancer. The doctor will explain the colonoscopy results to you after the test.

We can assist you with scheduling a colonoscopy. Please call or visit our office. Please call _____ to obtain a referral or set up an appointment. Also, please take this letter with you to your next doctor's appointment.

Thank you for following up on your healthcare needs. I am enclosing a brochure that describes colonoscopy. We have a video tape available if you would like to view it.

Sincerely,

Medical Director

62

Essential #4: An Effective Communication System

- Better communication has many benefits.
- Communication with patients
- Within the practice
- How to improve interior communication?
  - Staff involvement
  - Decision aids
  - Theory-based approaches
- Among the parts of the system (primary practice and specialists)

63

An Effective Communication System

- Meta-analysis of patient interventions for mammography - education and communication strategies*
  - Theory based communication was more effective
  - 24% improvement in screening rates vs 0% for generic education

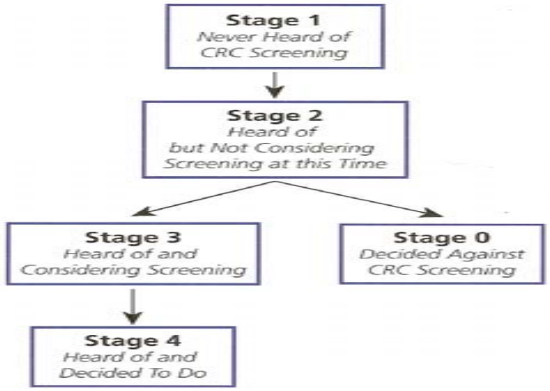
* Yabroff and Mandelblatt, op cit

64

An Effective Communication System

- Examples of theory-based communication:
  - Communication based on behavior models
    - Health Belief Model
    - Social Cognitive Theory
    - Theory of Reasoned Action
    - Theory of Planned Behavior
    - Stages of Decision Making

A Decision Stage Model for CRC Screening



Brief Questionnaire to Identify Decision Stage*

Use this questionnaire when starting a conversation with a patient about screening. It will help you identify the readiness of the patient for screening.

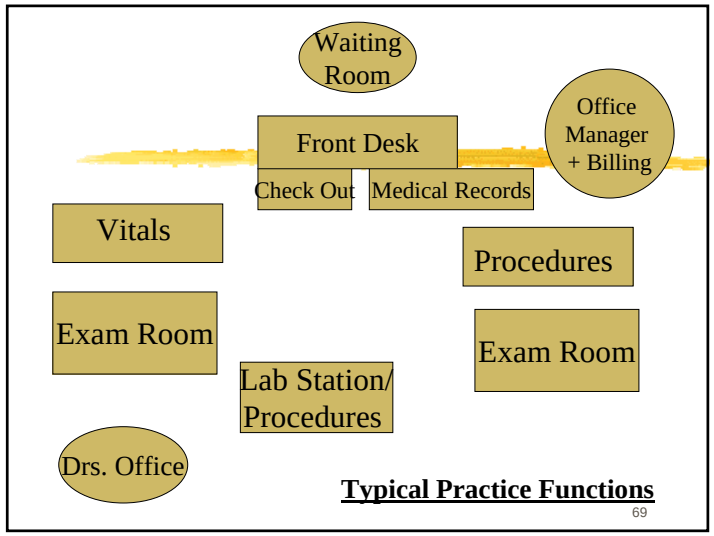
Describe the specific screening test, e.g. stool blood test (FOBT), flexible sigmoidoscopy (FS), or colonoscopy (CS), etc.

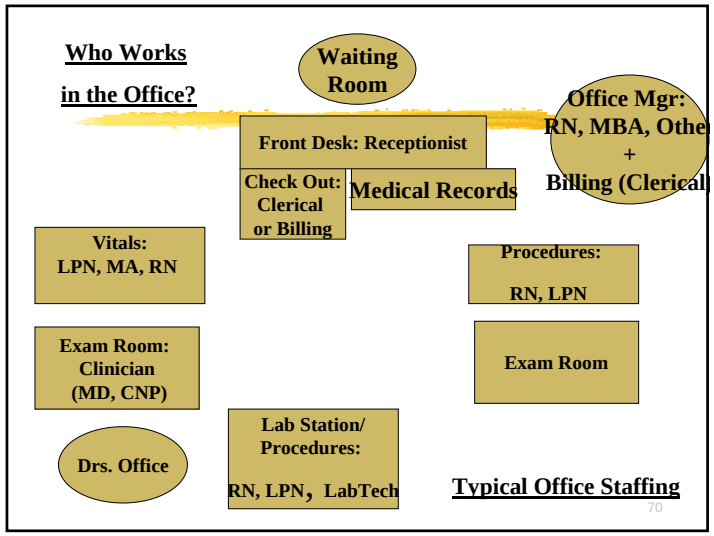
1. Have you ever heard of (FOBT, FS, CS)?
   - Yes – Go on
   - No – Stop (Stage 1)
2. Are you thinking about doing a (FOBT, FS, CS)?
   - Yes – Go on
   - No – Stop (Stage 2)
3. Which of the following statements best describes your thoughts about doing a (FOBT, FS, CS) in the future?
   - a. I have decided against doing a (FOBT, FS, CS). (Stage 0)
   - b. I'm thinking about whether or not to do a (FOBT, FS, CS). (Stage 2 or 3)
   - c. I have decided to do a (FOBT, FS, CS). (Stage 4)

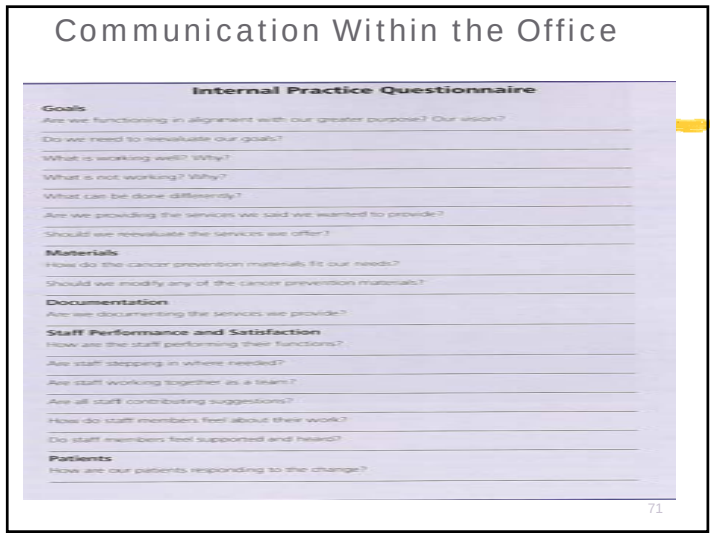
Responses place the individual in a decision stage related to screening test use:

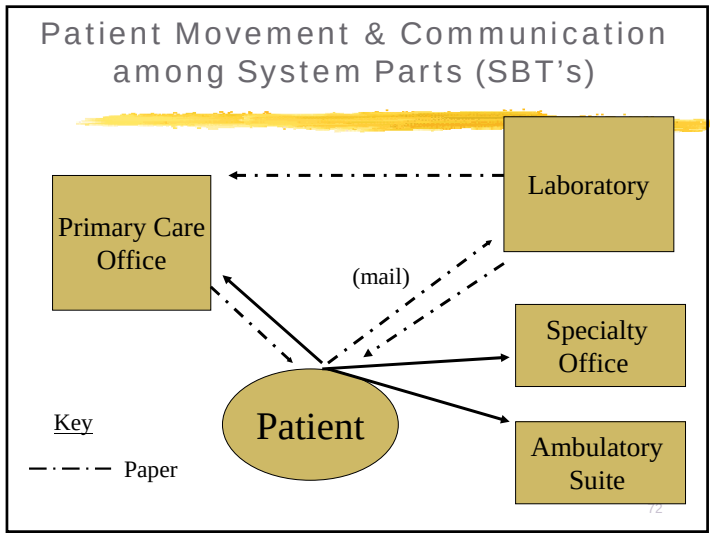
Stage 0:	*Decided Against*
Stage 1:	*Never Heard Of*
Stage 2:	*Heard of – Not Considering*
Stage 3:	*Heard of – Considering*
Stage 4:	*Heard of – Decided to Do*

How to involve staff who work in the practice?

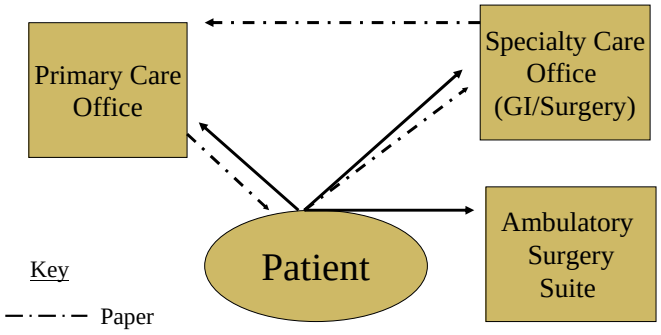

Waiting Room
Office Manager + Billing
Front Desk
Check Out
Medical Records
Vitals
Procedures
Exam Room
Exam Room
Lab Station/ Procedures
Drs. Office
Typical Practice Functions
69


Who Works in the Office?
Waiting Room
Office Mgr: RN, MBA, Othe + Billing (Clerical)
Front Desk: Receptionist
Check Out: Clerical or Billing
Medical Records
Vitals: LPN, MA, RN
Procedures: RN, LPN
Exam Room: Clinician (MD, CNP)
Exam Room
Drs. Office
Lab Station/ Procedures: RN, LPN, LabTech
Typical Office Staffing
70


Communication Within the Office
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?
71


Patient Movement & Communication among System Parts (SBT's)
Laboratory
Primary Care Office
(mail)
Specialty Office
Patient
Ambulatory Suite
Key
Paper
72

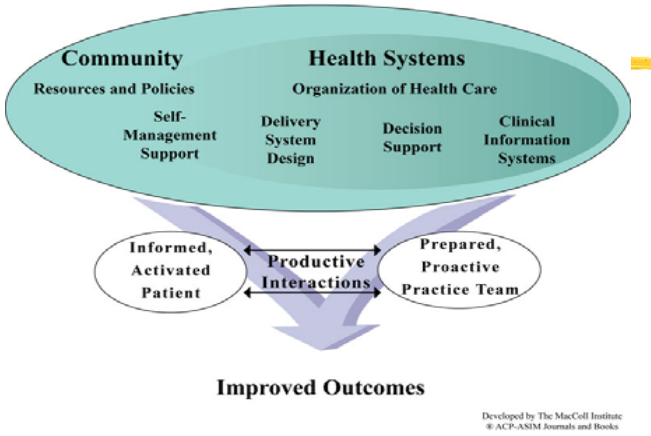
Patient Movement & Communication among System Parts (colonoscopy)



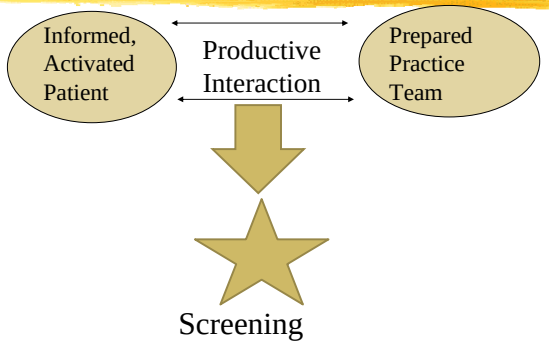
Can Models Help?

- Two models in use
- 1. Patient Centered Medical Home
- 2. Chronic Care model

The Chronic Care Model



Patient – Provider At the Center



Focus on the Provider

Prepared Team

- ❑ Ready to educate the patient
- ❑ Screening policy, i.e. based on guidelines ("Decision Support")
- ❑ Staff roles/office flow/equipment (Referrals, FOBTs)
- ❑ Plan communications with the patient
  - ❑ Who will discuss the options?
  - ❑ Who will discuss logistics/answer questions?
  - ❑ Who will do follow-Up, and discuss results?
- ❑ Coordination (Tracking System)

Focus on the Patient

Patient
Informed, Engaged
Activated

- ❑ Are patients aware CRC screening? (waiting room brochures, posters, outreach letters, etc.)
  - ✓ Do they know they are susceptible to CRC*?
  - ✓ Do they know the benefits of screening*?
  - ✓ Do they face barriers*?
  - ✓ Do they know how to do it*? Do they know they have screening choices? ("self-efficacy")

* Health Belief Model (theory based model)

NCQA Criteria for PCMH

- PPC – PCMH: Standards:
  - PPC 1: Access and Communication
  - PPC 2: Patient Tracking and Registry Functions*
  - PPC 3: Care Management
  - PPC 4: Patient Self-Management and Support*
  - PPC 5: Electronic Prescribing
  - PPC 6: Test Tracking*
  - PPC 7: Referral Tracking*
  - PPC 8: Performance Reporting and Improvement*
    - Reminders in the pcpcc.net principles version
  - PPC 9: Advanced Electronic Communications
  - ***Must Pass**

The Four Essentials: A Review

- A recommendation to every eligible patient
- An office policy
- A reminder system
- An effective communication system

In Conclusion

- Screening reduces incidence & mortality
- Physician Recommendation has the largest influence on screening rates
- Physicians can improve their office effectiveness through use of these essentials
- The Toolbox and Guide is designed to provide what you need for your practice.

Thank You

Toolbox and Guide

cancer.org/colonmd

(see list on the right)

"For Your Clinical Practice"

Mona.Sarfaty@jefferson.edu