How to Increase Cancer Screening Rates:
A Quality Improvement Toolkit for Busy Office Practices

American Cancer Society

Iowa Get Screened

Iowa Cancer Consortium

Upper Midwest Public Health Training Center

Introduction

Purpose of the Toolkit

Working in a busy office clinic, you may ask, *Why do we need to use this toolkit? What's in it for us?* The answer? **Quality improvement.**

The purpose of this toolkit is to provide you with evidence-based action steps and tools you can implement to increase cancer screening rates in your practice. By making some of the changes recommended in the toolkit, you can help move your practice to a higher level of performance.

Why Cancer Screening Is Important

Screening is the process of looking for cancer in people who have no symptoms of the disease. As a clinician, you know the importance of screenings in preventing cancer and finding it early. Encouraging patients to be screened, however, can be a challenge. That's why it's important to have a screening policy that engages staff in the process of offering screenings and delivering reminders at opportunistic times.

Toolkit Formats

This toolkit is provided in two formats: CD and printable (hard copy).

Toolkit Components

There are three main components of this toolkit:

1. The Four Essentials and Related Tools to Improve Cancer Screening Rates (Tabs 1–4)
2. Clinic Self-Assessment Using the Four Essentials (Tab 5)
3. Guidance and Tips for Effective Office Training (Tab 6)

Goal

The goal of this training is to improve quality performance measures by increasing cancer screening rates in your practice.

Intended Audience

The intended audience for this toolkit is health care providers, including physicians, office managers, nurses, nurse practitioners, and physician assistants.

Learning Objectives

At the end of the training, you should be able to implement the essentials relevant to your practice (Make Recommendations, Develop a Screening Policy, Be Persistent with Reminders, and Measure Practice Progress).

How to Use This Toolkit

Four Essentials

This section presents the Four Essential elements for improving cancer screening rates. Each Essential addresses the strategies and includes the tools to facilitate successful implementation. The Four Essentials are:

1. Make Recommendations
2. Develop a Screening Policy
3. Be Persistent with Reminders
4. Measure Practice Progress

Clinic Self-Assessment

In this section, you will be able to evaluate your needs, priorities, and readiness to apply the Four Essentials. Once you've reviewed the Four Essentials, use the Clinic Self-Assessment to identify your strengths and determine areas where you feel improvement is needed.

Guidance and Tips for Effective Office Training

This section offers some tips and recommendations of how you can fit this toolkit training into your busy work schedule.

Tools

While the specific examples presented in this toolkit relate to colorectal cancer, many of the tools and resources provided are adaptable to screening for other cancers or chronic diseases.

Included in the toolkit are the American Cancer Society Screening Guidelines for breast, cervical, colorectal, and prostate cancer (Appendix A).

Improve Cancer Screening Rates

USING THE FOUR ESSENTIAL STRATEGIES

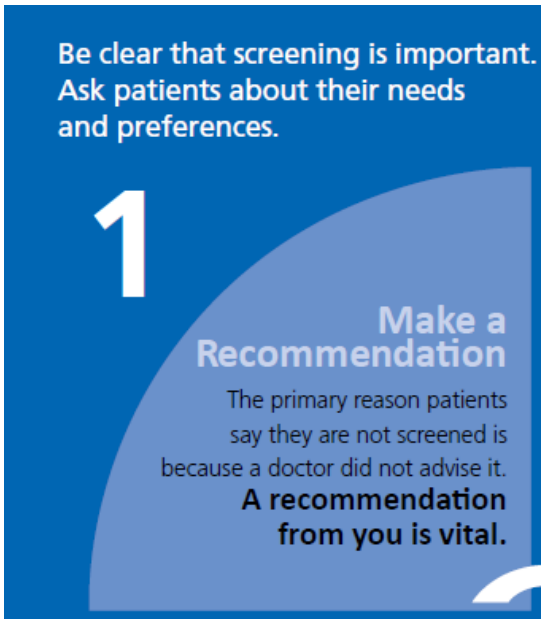
Essential 1: Make a Recommendation

The primary reason patients say they are not screened is because a doctor did not advise it.

Actions Related to Your Office Practice

A recommendation from a doctor is the most powerful single factor in a patient's decision to be screened for cancer. Your actions include:

1. Determine the screening messages you and your staff will share with patients.
2. Explore how your practice will assess a patient's risk status and receptivity to screening.
3. Consider insurance coverage and individual preferences.



Actions Related to Your Patients

Assess your patient's risk status, discuss needs, and offer several screening test options to increase the likelihood that your patient will get screened. At a minimum, offer a choice between a high-sensitivity, multiple sample stool blood test (guiac Fecal Occult Blood Test or Fecal Immunochemical Test, gFOBT/FIT), and a colonoscopy.

Take steps to identify and screen every age-appropriate patient. Start with patients who are easiest to reach and incrementally incorporate less accessible groups, listed here from most to least accessible:

- Patients who appear for regular check-ups;
- Patients who receive regular care for chronic conditions;
- Patients who come in only when they have a problem; or
- Patients who are part of your practice, but almost never come in.

Racial and ethnic minorities and the medically underserved are less likely to be given a screening recommendation. Devote particular attention to screening these groups. Recommendations that are sensitive to specific health belief systems and practices, to linguistic needs, and to economic circumstances can improve receptiveness to screening.

Essential 1 Tools

Screening Options and Patient Readiness

- Understand Colorectal Cancer (CRC) screening options:
  - *Common Sense Cancer Screening*
  - *Cancer Screening in the United States, 2012*
  - *High Quality Stool Blood Tests*
- Assess a patient's risk: *CRC Risk Based on Family History*
- Assess a patient's readiness:
  - *Decision Stage Questionnaire*
  - *Decision Stage Flow Chart*

Outreach to Underserved Populations

- Use culturally and linguistically appropriate educational materials.

Common Sense Cancer Screening

Common Sense Colorectal Cancer Screening Recommendations at a Glance			
Risk Category	**Age to Begin Screening**	**Recommendations**	**Notes**
Average Risk[1] No risk factors No symptoms[2]	**≥ Age 50**	**Screen with any one of the following options:** Tests That Find Polyps and Cancer[3] ✓ Flexible sigmoidoscopy q 5 ✓ Colonoscopy q 10 yrs ✓ Double contrast barium enema q 5 yrs* ✓ Computed tomography colonography q 5 yrs* OR Tests That Primarily Find Cancer ✓ Guaiac-based fecal occult blood test q 1 yr *,** ✓ Fecal immunochemical test q 1 yr *,** ✓ Stool DNA test ***	[1] The American Cancer Society and the US Multi-Society Task Force on Colorectal Cancer view a patient as being at average risk for the purpose of screening if only one first degree relative (FDR) > age 60 is affected. If the FDR is < 50, or affected, also check for a history consistent with hereditary non-polyposis colorectal cancer HNPCC. [2] Patients with symptoms merit an evaluation of their condition to precede screening. [3] 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. *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.

Common Sense Colorectal Cancer Screening Recommendations at a Glance			
Risk Category	**Age to Begin Screening**	**Recommendations**	**Notes**
Increased Risk CRC or adenomatous polyp in a first-degree relative (FDR)[4]	**Age 40 or 10 years younger than the earliest diagnosis in the family, whichever comes first**	**Colonocopy**[5]	[4] Patients with a personal history of CRC or adenomatous polyp require a surveillance plan not screening. [5] Colonoscopy for persons at increased risk is the recommendation of the American Cancer Society and the US Multi-Society Task Force on Colorectal Cancer. The US Preventive Services Task Force (USPSTF) does not specifically recommend colonoscopy, but notes that colonoscopy is the most sensitive and specific modality.
Highest Risk Personal history for > 8 years of Crohn's disease or ulcerative colitis or a hereditary syndrome (HNPCC[6] or, FAP, AFAP)	**Any age**	**Needs specialty evaluation and colonoscopy**	[6] The criteria (Revised Amsterdam) for HNPCC are that there should be at least three relatives with HNPCC-associated cancers (colorectal, endometrium, small bowel, ureter, renal pelvis) and all of the following criteria must be met: 1) One should be a FDR of the other two, 2) At least two successive generations should be affected. 3) At least one cancer should be diagnosed before age 50. 4) Familial adenomatous polyposis should be excluded in the CRC case. 5.) Tumors should be verified by pathological examination.

Cancer Screening in the United States, 2012

"Cancer Screening in the United States, 2012, A Review of Current American Cancer Society Guidelines and Current Issues in Cancer Screening" is a 14-page document that provides a summarization of 2012 American Cancer Society Cancer screening guidelines using the latest data from the National Health Interview Survey. You can access the document by using the accompanying CD.

High Quality Stool Blood Tests

This 30-page document, developed by National Colorectal Cancer Roundtable, American Cancer Society, and Centers for Disease Control and Prevention, provides more information about High Quality Stool Blood Tests. You can access the document by using the accompanying CD.

Assess a patient's risk: *CRC Risk Based on Family History*

Individual Risk Based on Family History of CRC	
Familial Setting	**Approximate Lifetime Risk of Colon Cancer**
No history of colorectal cancer or adenoma (General population in the United States)	6%
One second[1]- or third-degree[2] relative with CRC	About a 1.5-fold increase
One first-degree[3] relative with an adenomatous polyp	2-to-3 fold increase
Two second-degree relatives with colon cancer	About a 2-to-3 fold increase
Two first-degree relatives with colon cancer	3-to-4 fold increase
First-degree relative with colorectal cancer diagnosed at < 50 years	3-to-4 fold increase

[1]Second-degree relatives include grandparents, aunts, and uncles.
[2]Third-degree relatives include great-grandparents and cousins.
[3]First-degree relatives include parents, siblings, and children.

Assess a patient's readiness: *Decision Stage Questionnaire*

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 , CT colonography (CTC), or colonoscopy (CS), etc.

1. Have you ever heard of a (stool blood test, CTC, CS)?
   Yes – Go on
   No – Stop (Stage 1)

2. Are you thinking about doing a (stool blood test, CTC, CS)?
   Yes – Go on
   No – Stop (Stage 2)

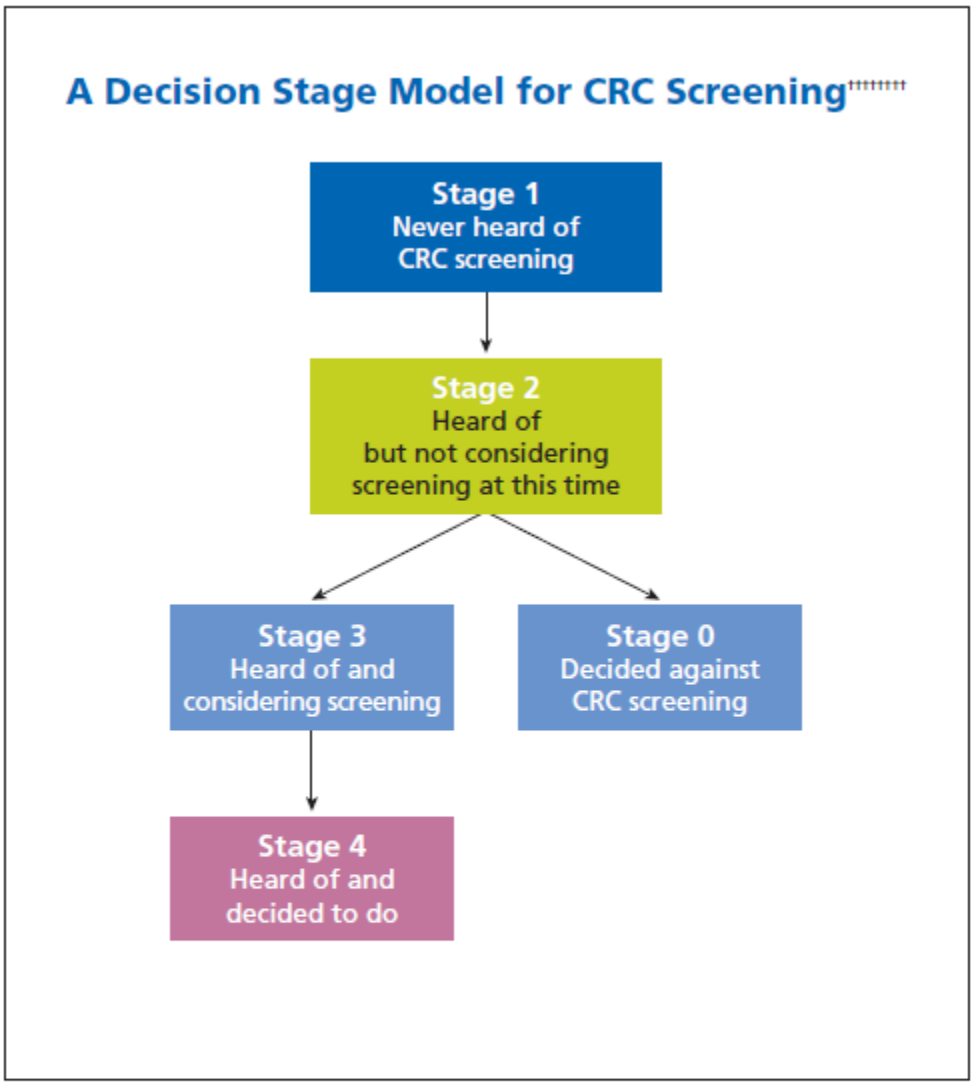
3. Which of the following statements best describes your thoughts about doing a (stool blood test, CTC, CS) in the future?
   a. I have decided against doing a (stool blood test, CTC, CS). (Stage 0)
   b. I'm thinking about whether or not to do a (stool blood test, CTC, CS). (Stage 2 or 3)
   c. I have decided to do a (stool blood test, CTC, 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

****** Source: Adapted from RE Myers, 2003

Assess a patient's readiness: *Decision Stage Flow Chart*



†††††††† This version of stage theory was adapted from the work of by RE Myers.

Culturally and Linguistically Appropriate Educational Materials

The Asian and Pacific Islanders Materials webpage provides downloadable cancer information in Chinese, Korean, and Vietnamese: http://www.cancer.org/AsianLanguageMaterials/index

For Spanish Information, please visit: http://www.cancer.org/espanol/cancer/colonyrecto/

For other CRC related publications materials that include Fact Sheets, Brochures, Brochure Inserts, Posters, Postcards, Print Ads etc. please visit: http://www.cdc.gov/cancer/dcpc/publications/colorectal.htm

Essential 2: Develop a Screening Policy

Create a standardized course of action.

Actions Related to Your Office Practice

Create a standardized course of action for screenings. Document it, and share it with everyone in your practice. Compile a list of screening resources, and determine the screening capacity available in your community.

Consider the following when developing your screening policy:

- national screening guidelines;
- realities of your practice;
- patient history and risk level;
- patient preferences and insurance coverage; and
- local medical resources.

As part of a high-quality screening program for your practice, develop a policy for distribution, tracking and follow-up of annual take-home stool blood tests (FOBT/FIT). Remember that performing an in office digital rectal exam or a single stool blood test is not evidence based and should not be used for colorectal cancer screening.

Take steps to identify and screen every age-appropriate patient.

Actions Related to Your Patients

For patients, the most effective cues to action are those delivered actively through dialogue with a health care provider, initially in person, and subsequently through follow-up by telephone. Educate patients, and help them take necessary next steps before and after they leave your office to increase the likelihood that they will obtain screening.

Essential 2 Tools

Screening Policy and Office Visits

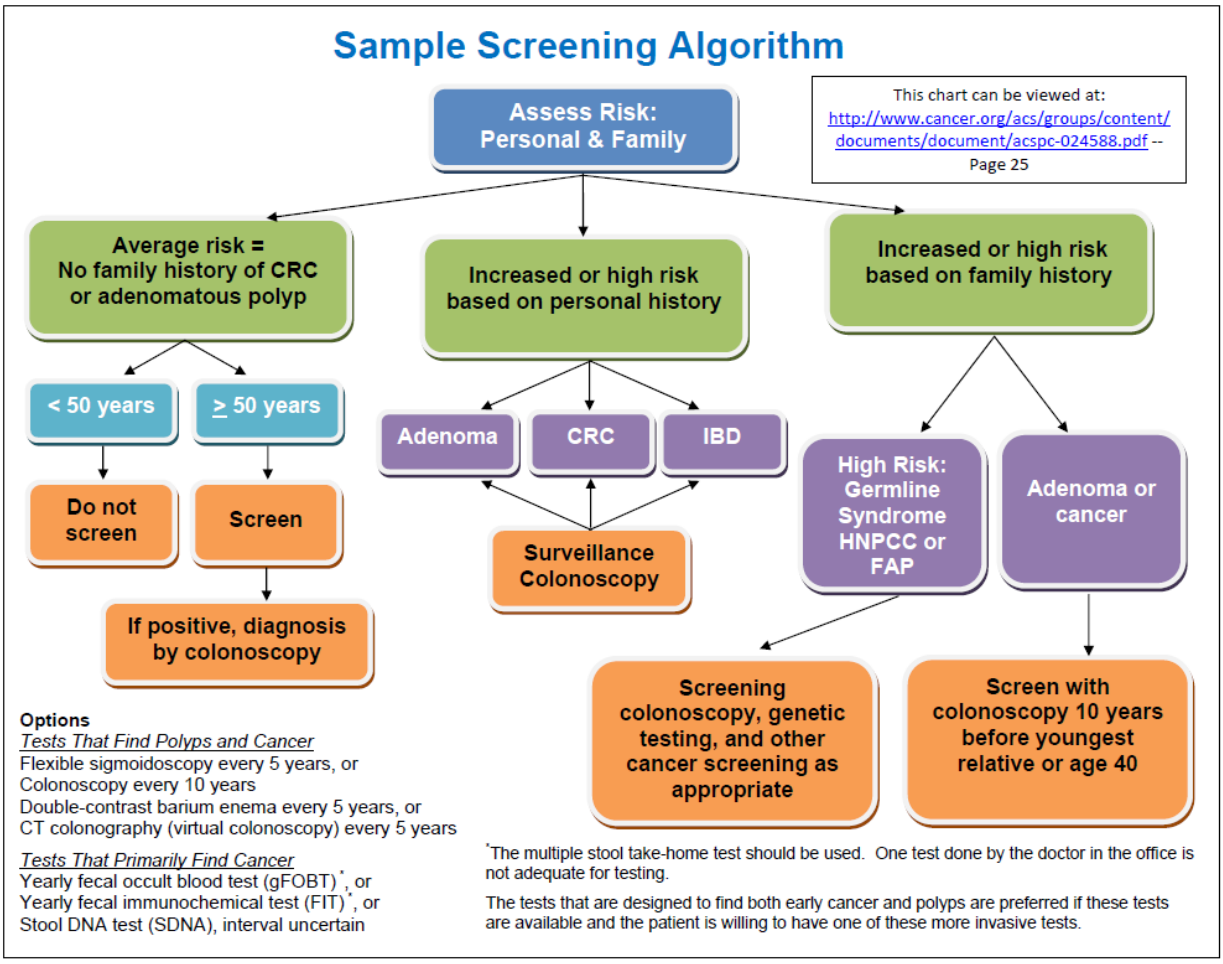
- Use these sample CRC screening policies as a starting point:
  - *Sample CRC Screening Algorithm*
  - *New Mexico Sample CRC Screening Algorithm*
  - *Sample FOBT Flow Chart*
- Enhance a standard office visit: *Office Policy Worksheet*
- View how one office tracked available resources for individuals in need: *Tiered Covered Services for Eligible Adults*
- Develop a quality colonoscopy referral system: *Developing a Quality Screening Colonoscopy Referral System in Primary Care Practice*

Patient Education Materials

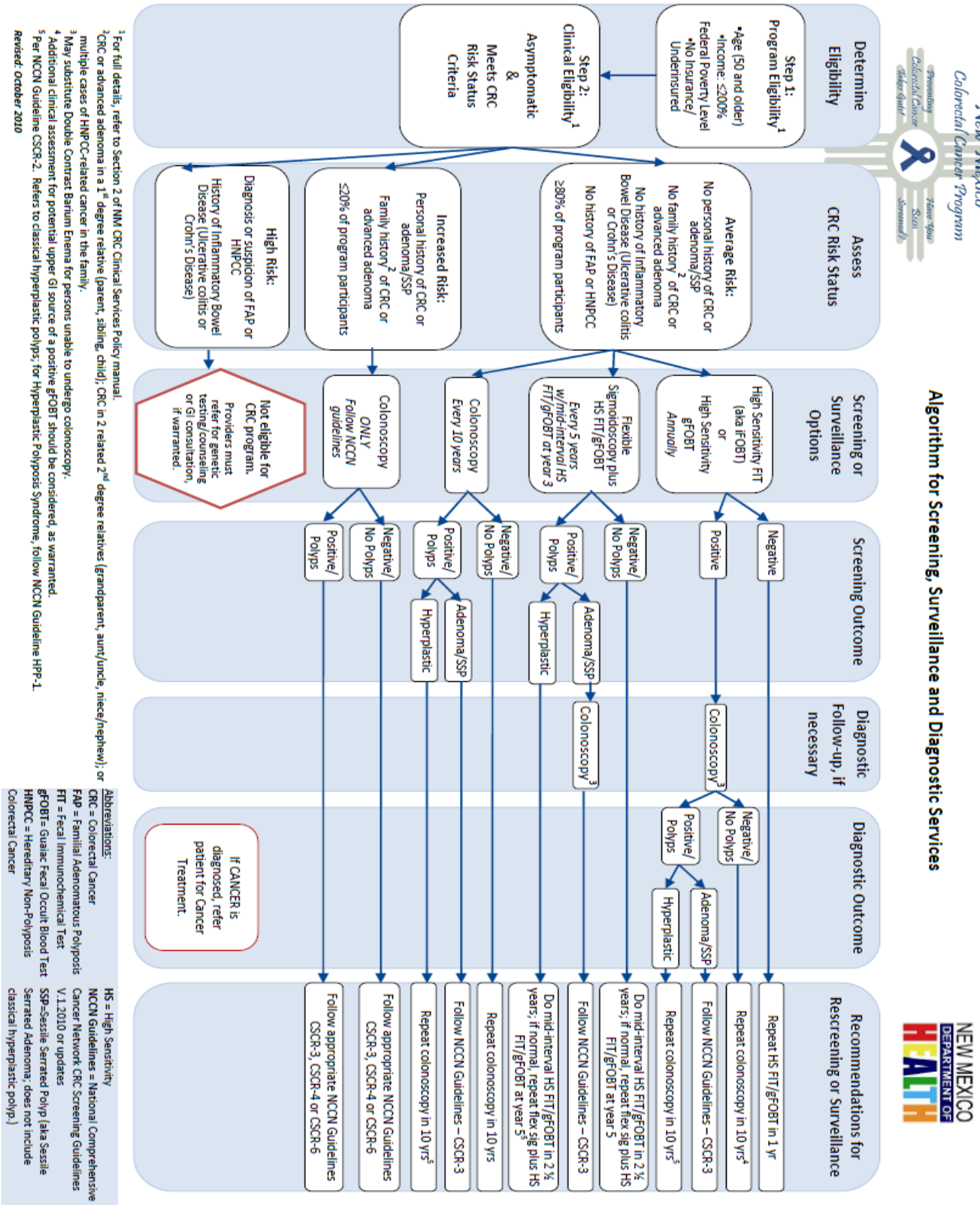
The resources below offer free materials to help you continue encouraging cancer screening among your patients.

- Sample brochures, letters, pamphlets, and videos for patients
- ACS also provided a video of how to get tested for Colon Cancer
- Screening Guidelines Wall Chart (Spanish and English) [http://www.cancer.org/Healthy/InformationforHealthCareProfessionals/ColonMDClinicansInformationSource/EducateYourPatients/index]

Sample CRC Screening Algorithm



New Mexico Sample CRC Screening Algorithm



[1] For full details, refer to Section 2 of NM CRC Clinical Services Policy manual.

[2] CRC or advanced adenoma in a 1st degree relative (parent, sibling, child); CRC in 2 related 2nd degree relatives (grandparent, aunt/uncle, niece/nephew); or multiple cases of HNPCC-related cancer in the family.

[3] May substitute Double Contrast Barium Enema for persons unable to undergo colonoscopy.

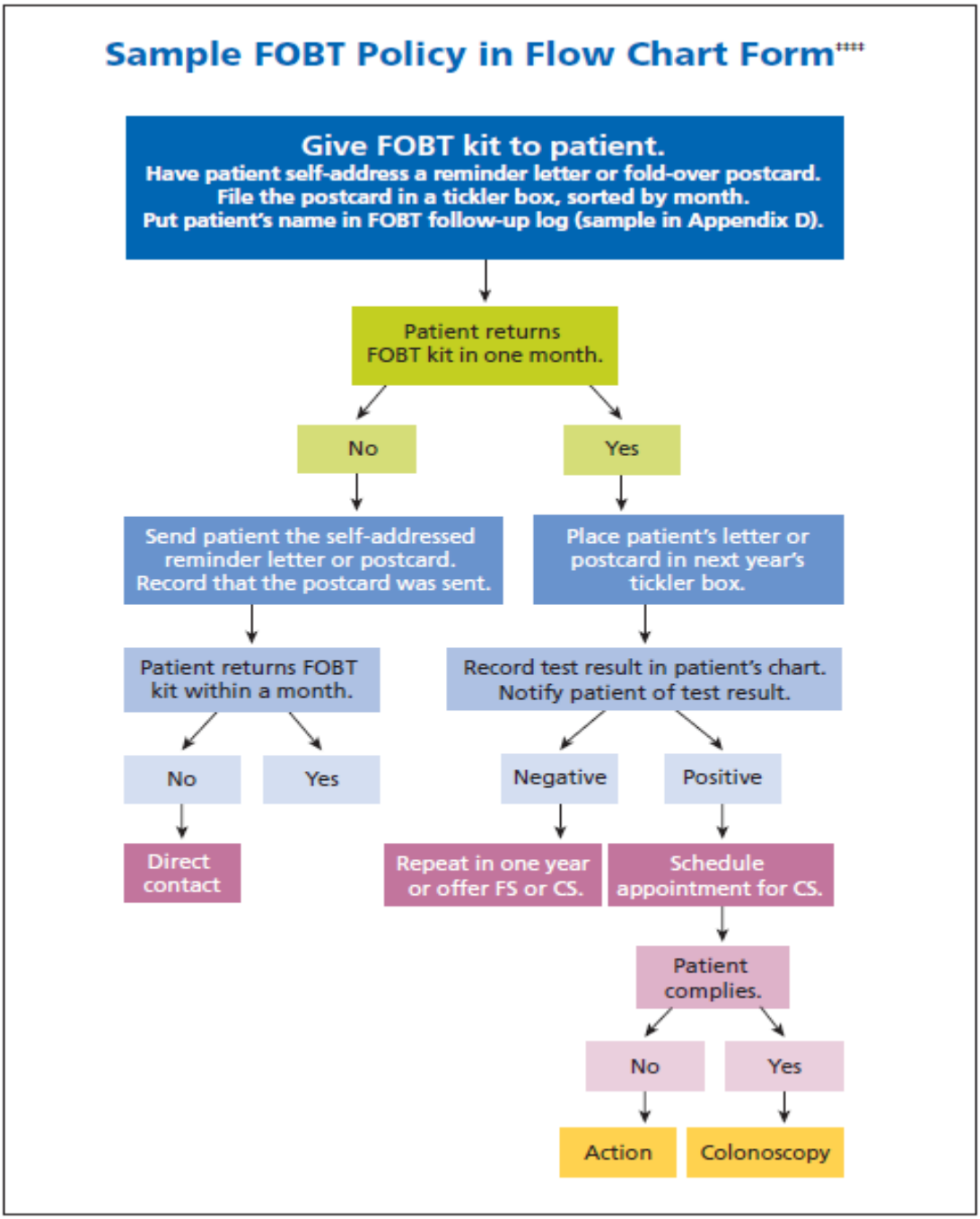
[4] Additional clinical assessment for potential upper GI source if a positive gFOBT should be considered, as warranted.

[5] Per NCCN Guideline CSCR-2. Refers to classical hyperplastic polyps; for Hyperplastic Polyposis Syndrome, follow NCCN Guideline HPP-1.

Revised: October 2010

Abbreviations:
CRC = Colorectal Cancer
FAP = Familial Adenomatous Polyposis
FIT = Fecal Immunochemical Test
gFOBT= Guaiac Fecal Occult Blood Test
HNPCC = Hereditary Non-Polyposis Colorectal Cancer
HS = High Sensitivity
NCCN Guidelines = National Comprehensive Cancer Network CRC Screening Guidelines V.1.2010 or updates
SSP=Sessile Serrated Polyp (aka Sessile Serrated Adenoma, does not include classical hyperplastic polyp.)

Sample FOBT Flow Chart



†††† From Seabury J. Tools and Strategies to Increase Colorectal Cancer Screening Rates: A Practical Guide for Health Plans. Harvard Center for Prevention and American Cancer Society, 2004. Approach reprinted from procedures of Dartmouth Medical School, 2003.

Enhance a Standard Office Visit: *Office Policy Worksheet*

While in the Waiting Room

- Ask the patient to complete a questionnaire to provide information on risk, status, screening history, and attitudes.
- Place informative and attractive posters or fliers in the waiting room or exam rooms as an expression of your own policy and as cues to action.
- Customize the use of educational instructional materials, and reminder tools to suit your practice needs.

Enter staff responsible here: _____

At Patient Check-In

- Have staff ask about preventive care and highlight services that are needed or past due.
- Use preventive care flow sheets and reminder chart stickers.

Enter staff responsible here: _____

During the Visit

- Ask patients about family history and previous screening.
- Let your patients know that getting CRC screening can prevent cancer and save lives.
- Schedule screening before the patients leaves the office.

Enter staff responsible here: _____

Enhance a Standard Office Visit: *Office Policy Worksheet (Continued)*

At Checkout

- Have patients fill out reminder cards. File reminder cards by the month and year of planned notification.

Enter staff responsible here: _____

Communication Beyond the Office

- Contact patients in need of preventive services for the following month.
- Send patients a stool blood test in the mail in anticipation of a visit.

Enter staff responsible here: _____

Tracking Patient Compliance

Assure that changes to an office visit achieve what is intended by tracking patient compliance. Here are suggestions for techniques:

- On a periodic basis, pull charts of patients in the "screening completed" file to see if results are on the chart.
- Track patient compliance by phone to verify screening or provide a reminder for those who were given a referral. If screening is already done, mark this on the tracking sheet or place a copy of the results in a "screening completed" file.
- Perform ongoing preventive service assessments at the time of the visit and document them.
- Use patient personal health record booklets and encourage all patients to bring their records to every visit.

Enter staff responsible here: _____

View How One Office Tracked Available Resources for Individuals in Need: *Tiered Covered Services for Eligible Adults*

NEW MEXICO DEPARTMENT OF HEALTH

TIERED COVERED SERVICES FOR ELIGIBLE ADULTS

REIMBURSABLE UP TO THE LOCAL MEDICARE RATE PER CRC PROGRAM POLICY
(EFFECTIVE JULY 1, 2010)

New Mexico Colorectal Cancer Program

ELIGIBILITY	SCREENING AND SURVEILLANCE TESTS AND PROCEDURES			DIAGNOSTIC FOLLOW-UP IF NECESSARY	TREATMENT
	High-Sensitivity FIT or gFOBT	Flexible Sigmoidoscopy	Colonoscopy	Colonoscopy	
• Men and women • Ages 50+ • Income ≤200%Federal Poverty Level • No insurance/underinsured **AND** • Asymptomatic	+Annually +Office Visit	+ Every 5 years w/high sensitivity FIT/gFOBT at year 3 + Bowel Prep + Biopsy, Polypectomy + Pathology Fees + Office Visits	+ Every 10 years + Bowel Prep + Biopsy, Polypectomy + Moderate Sedation + Pathology Fees + Office Visits	+ Bowel Prep + Biopsy, Polypectomy + Moderate Sedation + Pathology Fees + Office Visits Double Contrast Barium Enema may be substituted for persons unable to undergo colonoscopy.	NOT PAID BY CRC PROGRAM
Average Risk (≥80% of clients) • No personal hx of colorectal cancer (CRC) or adenoma/sessile serrated polyp (SSP) • No family hx[1] of CRC or Advanced Adenoma • No hx of Inflammatory Bowel Disease (Ulcerative Colitis or Crohn's Disease). • No hx of FAP or HNPCC	✓	✓	✓	✓	NOT PAID BY CRC PROGRAM
Increased Risk (≤20% of clients) • Personal hx of CRC or adenoma/SSP • Family hx[1] of CRC or Advanced Adenoma	NOT PAID BY CRC PROGRAM		✓	NOT APPLICABLE	NOT PAID BY CRC PROGRAM
High Risk (Not Eligible for CRCP) • Diagnosis or suspicion of FAP or HNPCC • Hx of Inflammatory Bowel Disease (Ulcerative Colitis or Crohn's Disease).	NOT PAID BY CRC PROGRAM Providers must refer for genetic testing/counseling or GI consultation, if warranted.			NOT PAID BY CRC PROGRAM	NOT PAID BY CRC PROGRAM

CRC= Colorectal Cancer
SSP= Sessile Serrated Polyps
FAP= Familial Adenomatous Polyposis
HNPCC= Hereditary Non-Polyposis Colorectal Cancer
FIT= Fecal Immunochemical Test
gFOBT= guaiac Fecal Occult Blood Test

[1]CRC or advanced adenoma in a 1st degree relative (parent, sibling, child); CRC in 2 related 2nd degree relatives (grandparent, aunt/uncle, niece/nephew); or multiple cases of HNPCC-related cancer in the family.

Develop a Quality Colonoscopy Referral System: *Developing a Quality Screening Colonoscopy Referral System in Primary Care Practice*

This ten-page report from the National Colorectal Cancer Roundtable provides information about developing a quality screening colonoscopy referral system in primary care practice. You can access the document by using the accompanying CD.

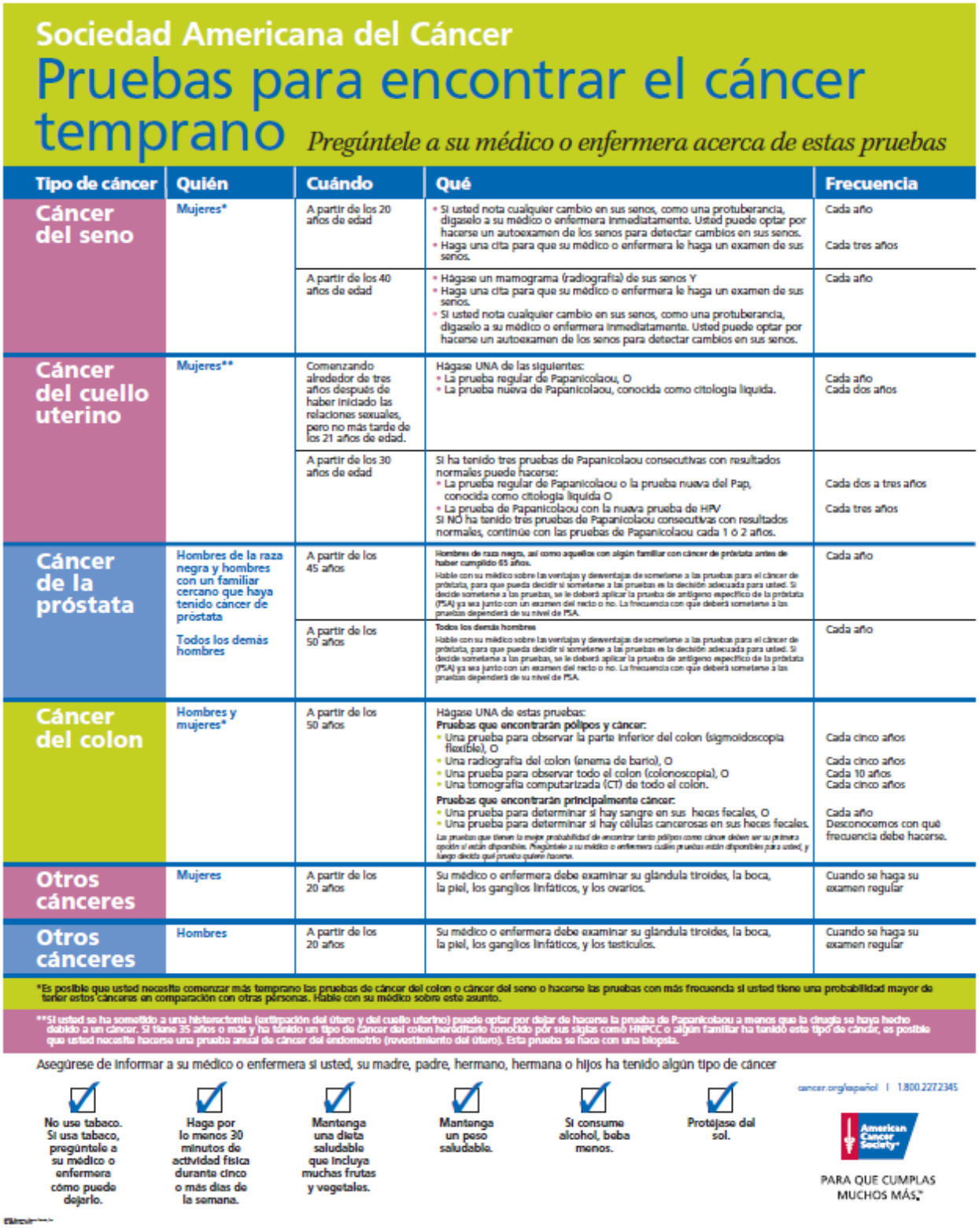
Patient Education Materials

The resources below offer free materials to help you continue encouraging cancer screening among your patients (these resources can also be found on the accompanying CD):

- http://www.cancer.org/Healthy/InformationforHealthCareProfessionals/ColonMDClinicansInformationSource/index

- ACS also provided a video of how to get tested for Colon Cancer: http://www.cancer.org/Healthy/ToolsandCalculators/Videos/get-tested-for-colon-cancer-english (you will need an internet access to view the video)

Guidelines Wall Chart (Spanish and English):



Sociedad Americana del Cáncer

Pruebas para encontrar el cáncer temprano

Pregúntele a su médico o enfermera acerca de estas pruebas

Tipo de cáncer	Quién	Cuándo	Qué	Frecuencia
Cáncer del seno	Mujeres*	A partir de los 20 años de edad	• Si usted nota cualquier cambio en sus senos, como una protuberancia, dígaselo a su médico o enfermera inmediatamente. Usted puede optar por hacerse un autoexamen de los senos para detectar cambios en sus senos. • Haga una cita para que su médico o enfermera le haga un examen de sus senos.	Cada año Cada tres años
		A partir de los 40 años de edad	• Hágase un mamograma (radiografía) de sus senos Y • Haga una cita para que su médico o enfermera le haga un examen de sus senos. • Si usted nota cualquier cambio en sus senos, como una protuberancia, dígaselo a su médico o enfermera inmediatamente. Usted puede optar por hacerse un autoexamen de los senos para detectar cambios en sus senos.	Cada año
Cáncer del cuello uterino	Mujeres**	Comenzando alrededor de tres años después de haber iniciado las relaciones sexuales, pero no más tarde de los 21 años de edad.	Hágase UNA de las siguientes: • La prueba regular de Papanicolaou, O • La prueba nueva de Papanicolaou, conocida como citología líquida.	Cada año Cada dos años
		A partir de los 30 años de edad	Si ha tenido tres pruebas de Papanicolaou consecutivas con resultados normales puede hacerse: • La prueba regular de Papanicolaou o la prueba nueva del Pap, conocida como citología líquida O • La prueba de Papanicolaou con la nueva prueba de HPV Si NO ha tenido tres pruebas de Papanicolaou consecutivas con resultados normales, continúe con las pruebas de Papanicolaou cada 1 ó 2 años.	Cada dos a tres años Cada tres años
Cáncer de la próstata	Hombres de la raza negra y hombres con un familiar cercano que haya tenido cáncer de próstata Todos los demás hombres	A partir de los 45 años	**Hombres de raza negra, así como aquellos con algún familiar con cáncer de próstata antes de haber cumplido 65 años.** Hable con su médico sobre las ventajas y desventajas de someterse a las pruebas para el cáncer de próstata, para que pueda decidir si someterse a las pruebas es la decisión adecuada para usted. Si decide someterse a las pruebas, se le deberá aplicar la prueba de antígeno específico de la próstata (PSA) ya sea junto con un examen del recto o no. La frecuencia con que deberá someterse a las pruebas dependerá de su nivel de PSA.	Cada año
		A partir de los 50 años	**Todos los demás hombres** Hable con su médico sobre las ventajas y desventajas de someterse a las pruebas para el cáncer de próstata, para que pueda decidir si someterse a las pruebas es la decisión adecuada para usted. Si decide someterse a las pruebas, se le deberá aplicar la prueba de antígeno específico de la próstata (PSA) ya sea junto con un examen del recto o no. La frecuencia con que deberá someterse a las pruebas dependerá de su nivel de PSA.	Cada año
Cáncer del colon	Hombres y mujeres*	A partir de los 50 años	Hágase UNA de estas pruebas: **Pruebas que encontrarán pólipos y cáncer:** • Una prueba para observar la parte inferior del colon (sigmoidoscopia flexible), O • Una radiografía del colon (enema de bario), O • Una prueba para observar todo el colon (colonoscopia), O • Una tomografía computarizada (CT) de todo el colon. **Pruebas que encontrarán principalmente cáncer:** • Una prueba para determinar si hay sangre en sus heces fecales, O • Una prueba para determinar si hay células cancerosas en sus heces fecales. *Las pruebas que tienen la mejor probabilidad de encontrar tanto pólipos como cáncer deben ser su primera opción si están disponibles. Pregúntele a su médico o enfermera cuáles pruebas están disponibles para usted, y luego decida qué prueba quiere hacerse.*	Cada cinco años Cada cinco años Cada 10 años Cada cinco años Cada año Desconocemos con qué frecuencia debe hacerse.
Otros cánceres	Mujeres	A partir de los 20 años	Su médico o enfermera debe examinar su glándula tiroides, la boca, la piel, los ganglios linfáticos, y los ovarios.	Cuando se haga su examen regular
Otros cánceres	Hombres	A partir de los 20 años	Su médico o enfermera debe examinar su glándula tiroides, la boca, la piel, los ganglios linfáticos, y los testículos.	Cuando se haga su examen regular

*Es posible que usted necesite comenzar más temprano las pruebas de cáncer del colon o cáncer del seno o hacerse las pruebas con más frecuencia si usted tiene una probabilidad mayor de tener estos cánceres en comparación con otras personas. Hable con su médico sobre este asunto.

**Si usted se ha sometido a una histerectomía (extirpación del útero y del cuello uterino) puede optar por dejar de hacerse la prueba de Papanicolaou a menos que la cirugía se haya hecho debido a un cáncer. Si tiene 35 años o más y ha tenido un tipo de cáncer del colon hereditario conocido por sus siglas como HNPCC o algún familiar ha tenido este tipo de cáncer, es posible que usted necesite hacerse una prueba anual de cáncer del endometrio (revestimiento del útero). Esta prueba se hace con una biopsia.

Asegúrese de informar a su médico o enfermera si usted, su madre, padre, hermano, hermana o hijos ha tenido algún tipo de cáncer

- ☑ No use tabaco. Si usa tabaco, pregúntele a su médico o enfermera cómo puede dejarlo.
- ☑ Haga por lo menos 30 minutos de actividad física durante cinco o más días de la semana.
- ☑ Mantenga una dieta saludable que incluya muchas frutas y vegetales.
- ☑ Mantenga un peso saludable.
- ☑ Si consume alcohol, beba menos.
- ☑ Protéjase del sol.

cancer.org/español | 1.800.227.2345

American Cancer Society

PARA QUE CUMPLAS MUCHOS MÁS.

American Cancer Society

Tests to Find Cancer Early

Ask your doctor or nurse about these tests.

Cancer Type	Who	When	What	How Often
Breast cancer	Women*	Starting at age 20	• If you notice any change in your breasts, such as a lump, tell your doctor or nurse right away. You may choose to do BSE (breast self-exam) to find breast changes. • Have an exam of your breasts by a doctor or nurse.	Every year Every 3 years
		Starting at age 40 and older	• Have a mammogram (x-ray) of your breasts AND an exam of your breasts by a doctor or nurse. • If you notice any change in your breasts, such as a lump, tell your doctor or nurse right away. You may choose to do BSE (breast self-exam) to find breast changes.	Every year
Cervical cancer	Women**	Starting about 3 years after you start having sex but no later than age 21	Have ONE of the following: • The regular Pap test OR • The newer liquid Pap test	Every year Every 2 years
		Starting at age 30	If you have had 3 normal Pap tests in a row, you may have: • The regular or liquid Pap test OR • A Pap test with the new HPV test If you have NOT had 3 normal Pap tests in a row, then continue with your Pap tests every 1 or 2 years.	Every 2 to 3 years Every 3 years
Prostate cancer	African American men and men with a close family member with prostate cancer	Starting at age 45	**African American men and men with a close family member with prostate cancer before age 65** Talk to your doctor about the pros and cons of prostate cancer testing so you can decide if getting tested is the right choice for you. If you decide to be tested, you should have the PSA blood test with or without a rectal exam. How often you are tested will depend on your PSA level.	Every year
	All other men	Starting at age 50	**All other men** Talk to your doctor about the pros and cons of prostate cancer testing so you can decide if getting tested is the right choice for you. If you decide to be tested, you should have the PSA blood test with or without a rectal exam. How often you are tested will depend on your PSA level.	Every year
Colon cancer	Men and women*	Starting at age 50	Have ONE of these tests: **Tests that will find polyps and cancer:** • A test to look into the lower part of the colon (flexible sigmoidoscopy), OR • An x-ray of the colon (barium enema), OR • A test to look into the entire colon (colonoscopy), OR • A CT scan of the entire colon **Tests that will find mainly cancer:** • A test to check for blood in your stool, OR • A test to check for cancer cells in your stool *Tests that have the best chance of finding both polyps and cancer should be your first choice when possible. Talk with your doctor or nurse to find out which tests you can get and then decide which test you want to have.*	Every 5 years Every 5 years Every 10 years Every 5 years Every year We don't know how often it should be done.
Other cancers	Women	Starting at age 20	Your doctor or nurse should check your thyroid gland, mouth, skin, lymph nodes, and ovaries.	Whenever you have your regular checkup
Other cancers	Men	Starting at age 20	Your doctor or nurse should check your thyroid gland, mouth, skin, lymph nodes, and testicles.	Whenever you have your regular checkup

*You may need to begin testing for colon cancer or breast cancer earlier or be tested more often if you are more likely than other people to have these cancers. Talk to your doctor about this.

**If you have had a hysterectomy (your uterus and cervix have been removed), you may choose to stop having the Pap test, unless the surgery was for cancer. If you are 35 or older and have had an inherited type of colon cancer called HNPCC or someone in your family has had this type of cancer, then you may need to be tested each year for cancer of the endometrium (lining of the uterus). This testing is done with a biopsy.

Be sure to tell your doctor or nurse if you have had any type of cancer or if your mother, father, brother, sister, or children have had cancer.

- ☑ Don't use tobacco. If you do, ask your doctor or nurse about quitting.
- ☑ Get at least 30 minutes of physical activity on 5 or more days of the week.
- ☑ Eat a healthy diet with plenty of fruits and vegetables.
- ☑ Maintain a healthy weight.
- ☑ Drink less alcohol, if you drink at all.
- ☑ Protect yourself from the sun.

cancer.org | 1.800.227.2345

American Cancer Society

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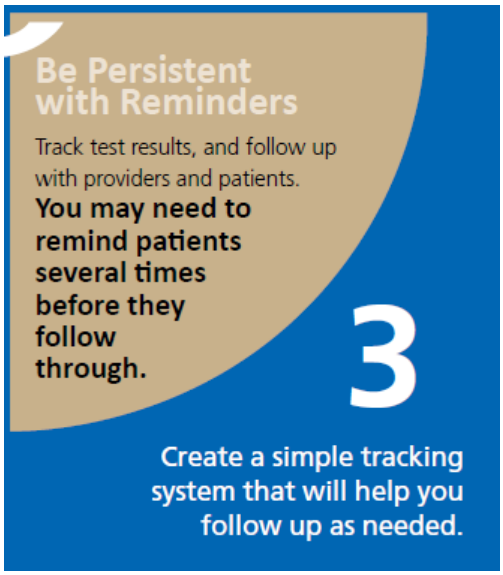
Essential 3: Be Persistent With Reminders

You may need to remind patients several times before they will follow through.

Actions Related to Your Office Practice



1. Determine how your practice will notify the patient and physician when screening and follow-up is due.
2. Put office systems in place that track test results and use reminder prompts for patients and providers, and follow-up on all positives.
3. Involve your staff in reminding both clinicians and patients of upcoming screenings. Chart prompts, ticklers and logs, and electronic medical records can all provide cues for physicians and their teams to take action.
4. Record when a recommendation was given, the type of test recommended, and the test results. If additional follow-up was needed, track and record whether a referral was made and what follow-up tests were performed.
5. Actively monitor whether screening and all necessary follow-up tests are completed in a timely manner.

Actions Related to Your Patients

Encourage patients to follow through with screening by using the following:

1. Postcards
2. Letters
3. Prescriptions
4. In-person conversations
5. Emails
6. Text messages
7. Phone calls

To achieve high screening rates with take-home stool blood tests, reminders and tracking systems are essential.

In the case of a positive stool blood test, do not repeat the test, and always refer a patient for colonoscopy.

Essential 3 Tools

Reminder Systems

- Information about Electronic Health Records*:*
  - ACP Center for Practice Improvement and Innovation
  - AAFP Center for Health IT
  - Purchasing an EHR System
- View sample chart prompt: *Sample Chart Prompts*
- *View sample reminder tools: http://www.cancer.org/Healthy/InformationforHealthCareProfessionals/ColonMDClinicansInformationSource/ForYourClinicalPractice/colonmd-sample-reminder-letters.*

Tracking Information

- View a sample CRC tracking log: *CRC Tracking Template*

Information about Electronic Health Records: *ACP Center for Practice Improvement and Innovation*

The following website provides resources for EHR system selection/implementation. This website will help you compare certified EHR systems to find the system that best suits your needs. http://www.acponline.org/running_practice/technology/ehr/

Information about Electronic Health Records: *AAFP Center for Health IT*

The following website provides five steps for your EHR guide, which includes the preparation, selection, implementation, maintenance, and meaningful use. http://www.centerforhit.org/online/chit/home.html

Information about Electronic Health Records: *Purchasing an EHR System*

Purchasing an Electronic Health Record System

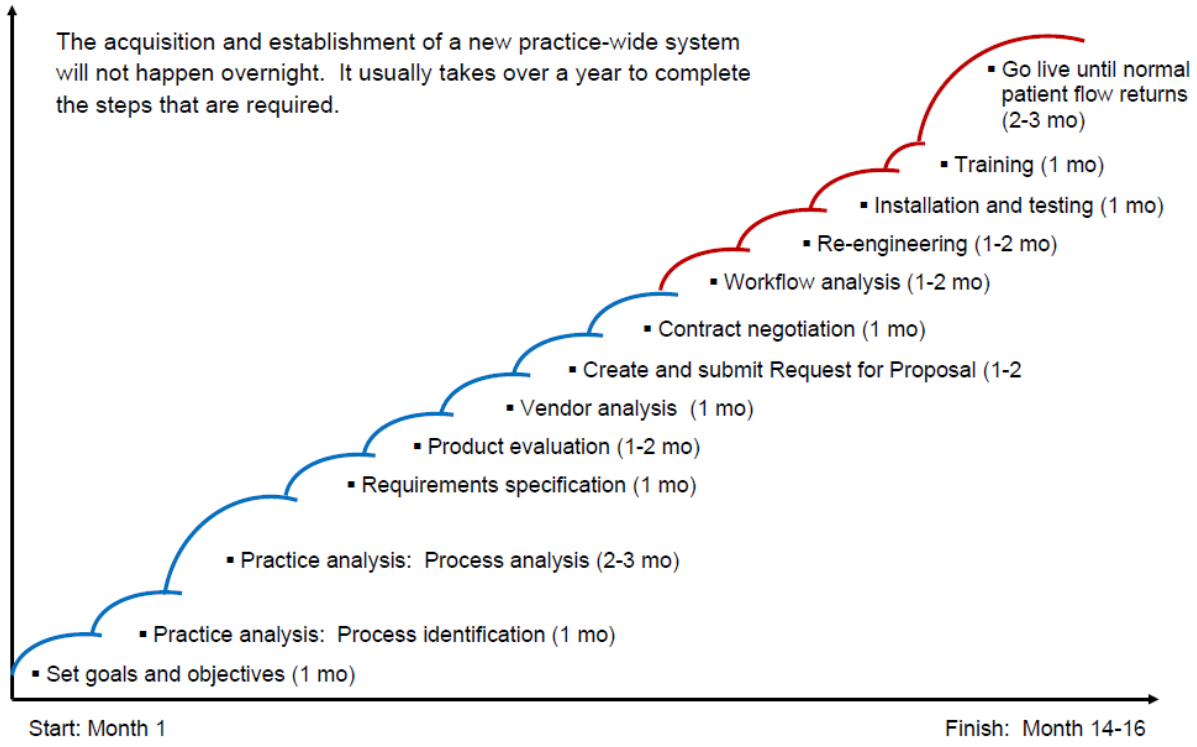
Optimizing CRC Screening Performance Using the EHR

- ✓ EHRs must have the capacity to receive results from other EHR systems, using searchable data fields. For this reason, providers should be wary of purchasing a stand-alone EHR system.
- ✓ When trying to optimize colorectal cancer screening performance, certain functional criteria should be included in the RFP. All of the criteria listed are also included in the CCHIT 2009 Ambulatory criteria, so any system with CCHIT certification should have the functionality to maximize CRC screening.
- ✓ The online tool, called My Family Health Portrait, allows the patient to collect information in a standard way that is easy for family members to share and for providers to use. It can be accessed at www.familyhistory.hhs.gov, and has the potential to be shared electronically with EHRs and personalized health record systems. Vendors should be asked about the potential to interface with this tool.

Reliable Sources of EHR Ratings		
Source of HER Ratings	**Type of Access Available**	**Website**
CCHIT	Free Public Access	www.cchit.org
AAFP	Membership required for selected links	www.centerforhit.org
AC Group	Purchasable reports	www.acgroup.org
ACP	Membership required for selected links	http://www.acponline.org/running_practice/technology/ehr/partner_program/
KLAS	Purchasable reports	www.klasresearch.com/EHR_software
CTS Guides	Registration required	www.ctsguides.com/practicepartner.asp

Information about Electronic Health Records: *Purchasing an EHR System (Continued)*

A Typical Timeline for Selecting and Installing an Electronic Health Records System



Adapted from *The Use of Electronic Health Records in Optimizing the Delivery of Colorectal Cancer Screening in Primary Care* by Randa Sifir, MD; Mona Sarfaty, MD; Smiriti Sharma

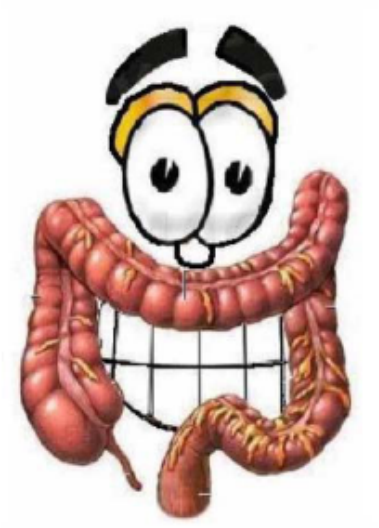
View Sample Chart Prompt: *Sample Chart Prompts*

Sample Chart Prompts
Creating Action Cues

Chart flags or chart prompts serve as visual reminders or "cues to action." Clinicians can have both electronic and paper charts prepared to flag the following:

- **A need for preventive services,**
- **Any indications of increased risk for colorectal cancer,**
- **Age, risk or gender-appropriate screening schedules.**

The visuals below can be used as chart prompts for offices with paper-based records. They can be turned into laminated cards that staff paper clip to a record as a reminder to a physician that the patient needs a screening recommendation.



Adapted from How to Increase Colorectal Cancer Screening Rates in North Carolina Community Health Centers DRAFT 6/1/10.

Cartoon colon chart prompt from the Mountain Park Health Center, Phoenix, AZ.

View the sample reminders for your practice at the link below:
http://www.cancer.org/Healthy/InformationforHealthCareProfessionals/ColonMDClinicansInformationSource/ForYourClinicalPractice/colonmd-sample-reminder-letters

This link provides sample reminders that include patient letters and phone scripts for your practice. All of the following is provided in Word and PDF versions in the accompanying CD. You can take and modify the Word document to be used for other cancers as well.

Patient Letters:

- Letter to patient at average risk
- Letter to patient at increased or high risk
- Letter to patient with positive screening result

Phone Scripts:

- Fecal Occult Blood Test (FOBT) follow-up phone script for average risk individual
- Follow-up phone script for increased risk individual

Sample CRC Tracking Log

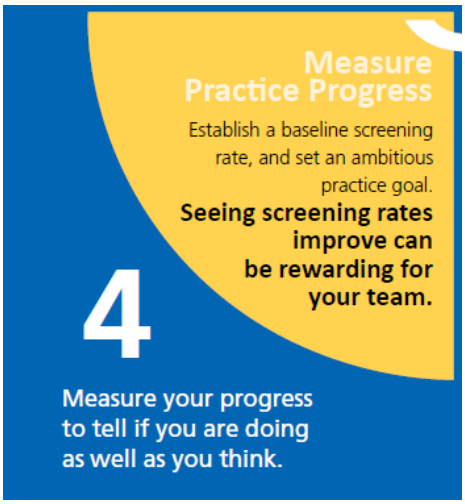
Colorectal Cancer Screening - Tracking Template*

Checklist	***Date***
1. a. **At home FOBT/FIT kit given**	a.
b. FOBT/FIT test completed	b.
c. Results received	c.
d. If no completion or results, reminder card/letter sent	d.
e. Patient notified of finding	e.
f. Referred for Colonoscopy (CS) if positive	f.
g. **Placed in tickler file if negative for next year**	g.
2. a. **Referred for Flexible Sigmoidoscopy (FS)**	a.
b. FS scheduled	b.
c. FS test completed	c.
d. FS results received	d.
e. If no completion or results, FS reminder card/letter	e.
f. FS patient notified of finding	f.
g. FS placed in tickler file if negative	g.
h. **Scheduled for CS if positive**	h.
3. a. **Referred for CS**	a.
b. CS scheduled	b.
c. CS test completed	c.
d. CS results received	d.
e. If no completion or results, CS reminder card/letter	e.
f. CS patient notified of finding	f.
g. **CS placed in tickler file if negative**	g.
4. a. **Referred for CT Colonography (CTC)**	a.
b. CTC scheduled	b.
c. CTC test completed	c.
d. CTC results received	d.
e. If no completion or results, CTC reminder card/letter	e.
f. CTC patient notified of finding	f.
g. CTC placed in tickler file if negative	g.
e. **Scheduled for CS if positive**	h.

This chart can be viewed at:
http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf -- Page 106

Essential 4: Measure Practice Progress

Establish a baseline screening rate, and set an ambitious practice goal.



Establish the Baseline

Identify target population (for example, patients that have never been screened) to establish the baseline screening rate and set the goal to be achieved.

It is essential to complete one review that will serve as a baseline of comparison for all future audits. An initial audit can be completed simultaneously with the baseline review. Audits are not complicated, and the simplest audit involves reviewing a specified number of patient records and documenting key elements. Have staff conduct a screening audit, or contact a local company that can perform such a service.

Collect and Utilize Data

During staff meetings, allow time for your team to report what is working well with your screening system, what can be done differently, whether documentation procedures need improvement, and if there are additional ways to support members of the team.

Elicit feedback from your team and your patients to learn valuable information about opportunities to improve your system.

In Summary

Follow a continuous improvement model to develop and test changes.

1. Develop Your Plan: In cooperation with your staff, develop a screening system based on the Four Essential Strategies. If you already have a system, review your approach and identify opportunities for improvement. Establish a baseline screening rate before implementing changes.
2. Do Your Plan: Engage your staff in the plan, and make sure everyone on your team knows their role.
3. Study Your Results: Measure your screening rates, and meet with your staff regularly to review progress.
4. Act on Your Results: Based on your results, identify opportunities for further improvement. When you are ready, build on your plan and consider including harder-to-reach patient groups.

For best results, continue to repeat this model.

Essential 4 Tools

Staff Feedback

- Consider using a staff meeting questionnaire to guide discussion: *Internal Practice Questionnaire*

Practice Performance

- *8 Steps to a Chart Audit for Quality*
- *"How To" for Performance Improvement*

Internal Practice Questionnaire

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?

Source: Agency for Healthcare Research and Quality.

Eight Steps to a Chart Audit for Quality

The following link provides a full version of the Eight Steps to a Chart Audit for Quality: http://www.aafp.org/fpm/2008/0700/pa3.html.

A simple chart review can help your group answer the question on everyone's mind: "How are we doing?"

Barbara H. Gregory, MPH, MA, Cheryl Van Horn, RN, and Victoria S. Kaprielian, MD

Why a chart audit?
The most beneficial use for a chart audit is to measure quality of care so that you can improve it. Chart audits are often used as part of a quality improvement initiative. For example, a practice might review charts to see how often a particular vaccine is offered, given or declined. If the audit determines that a vaccine is not being offered or given as recommended, then there is room for improvement.

Step 1: Select a topic. The focus of your audit must be clear, neither too narrow nor too broad, and measurable using data available in the medical record. Your topic should also be of interest to the practice, perhaps a problem or aspect of care that the providers have identified as needing improvement. The Joint Commission recommends studying issues that are high frequency, high risk, or both.

Example: Your practice wants to measure how well it's doing on meeting recommendations for preventive care. Since the insurance carriers in the area are focusing heavily on women's health, the group might decide to focus their chart review on screening for breast cancer (mammography).

Step 2: Identify measures. Once you're set on a topic, you need to define exactly what you will measure. Criteria must be outlined precisely, with specific guidelines as to what should be counted as a "yes" (criteria met) and what should be counted as a "no" (not met).

Example: For your audit on breast cancer screening, the group considers several measures, including the following:

- time since last mammogram,
- mammogram completed within last year, and
- mammogram ordered within last year.

After considerable discussion, the group decides to measure whether a mammogram was completed or recommended within the last 24 months.

Step 3: Identify the patient population. To determine which records to review, you need to define the population you want to assess. Characteristics to consider may include age, gender, disease status, and treatment status. In many cases, the focus of the audit and even the measure itself will help to define the population. You'll also need to develop specific inclusion or exclusion criteria.

Example: In keeping with the HEDIS breast cancer screening measure that your group decided to follow, your patient population will be women age 40 to 69. Because you'll be looking for evidence of a mammogram in the past 24 months, the lower age limit for the sample will be 42. Only those patients with at least three visits in the last two years and one in the last 13 months will be included. You decide to exclude women who have had bilateral mastectomies or are terminally ill.

Step 4: Determine sample size. A manual audit of all charts meeting your inclusion criteria will not be feasible in most situations. That's where sampling comes in. For an informal, or "quick and dirty," audit designed to give you a sense of whether a more sophisticated audit is warranted, you may find it useful to sample a minimum of 20 charts. For better results, a common rule of thumb is to try for 10 percent of the eligible charts. Or you may choose to use a convenience sample: the patients from a single day or all the charts on a single shelf in the records room.

Example: Using the process outlined below, your group determines that its sample should total 81 charts.

1. Estimate the expected proportion within the population that will have the measure of interest.
2. Specify the width of the confidence interval you wish to use.
3. Set the confidence level.
4. Use the nomogram to estimate sample size.

Step 5: Create audit tools. To complete your chart audit, you will need instruments on which to record your findings. How they are structured and the details they include will affect the analysis you can do and the eventual usability of your findings. Data should be collected in a format that keeps all individual records separate, but allows for easy compiling.

Creating clear, simple audit tools will make it possible for nonclinical staff to perform many audits effectively. Once you've developed the forms, if someone other than you will be doing the actual chart reviews, go over a

few examples together to be sure the reviewer understands the criteria exactly as you intend.

Example: Your group decides to use paper forms for the chart audit.

Step 6: Collect data. Select the date or dates on which you will collect data. Be sure to coordinate the specifics (date, time, and number of charts to be pulled) with the medical records staff. Review each chart to determine if the patient meets the selection criteria. The reviewer should complete one audit tool (paper form or row in the electronic spreadsheet) for each patient that meets the criteria. To protect patient confidentiality, patient names should not be included on the review forms.

Example: You instruct your office staff to pull the charts of roughly 100 adult female patients. Once you've identified 81 that meet the selection criteria, your nursing supervisor fills out the audit tool for each one, reserving questionable cases for physician review.

Step 7: Summarize results. Summarizing the data is a little more complex than just counting up all the data sheets. You must consider how the data will be used and make sure the information is presented in a way that will make it meaningful. Inconsistencies here can produce data that can't be interpreted.

Example: Your breast cancer screening audit results show that 57 percent of your sample received mammograms.

Step 8: Analyze and apply results. Once you have compiled your data and calculated the results, you can compare them to local or national benchmarks. There may be multiple benchmarks, depending on your topic and the performance measure you calculated. You should take into account the differences between your population and those you're comparing it with, as appropriate. If the measure is truly important to the group, you may wish to set a performance goal based on what the group feels is appropriate and reasonable and make it the focus of a quality improvement initiative.

Example: At 57 percent, your group's breast screening rate is less than the national benchmark of 68.9 percent. This benchmark is the mean for commercial HMO patients, according to the *HEDIS 2007 Audit Means, Percentiles and Ratios*, the NCQA's annual report of health plan performance data (view it at http://www.ncqa.org/tabid/334/default.aspx). Of the 35 patient charts that had no documentation of a mammogram, only 10 records showed that the physician had discussed the need for a mammogram with the patient. The challenge is now to drill down to figure out whether the

issue was discussed but not documented in those other charts or whether it was simply overlooked. Telephone contact with the 25 identified patients might help you begin to clarify this so that an appropriate intervention can be designed.

"How To" for Performance Improvement

Below is a link to a Maintenance of Certification Tutorial. You will need internet access for this.

http://fammed.buffalo.edu/physicianeducation/

Clinic Self-Assessment

The purpose of this assessment is to give your clinic an opportunity to review the Four Essentials and to identify your strengths and determine areas where you feel improvement is needed.

Essential 1: Make a Recommendation

1. Does my practice provide a recommendation for screening to every appropriate patient?

   ☐Yes

   ☐No

   ☐Unsure

2. Has my practice identified patient education screening messages?

   ☐Yes

   ☐No

   ☐Unsure

3. Does my practice share the screening messages with our patients?

   ☐Yes

   ☐No

   ☐Unsure

4. Does my practice assess patient's risk status to screening?

   ☐Yes

   ☐No

   ☐Unsure

5. Does my practice assess patient's receptivity to screening?

   ☐Yes

   ☐No

   ☐Unsure

Essential 2: Develop a Screening Policy

6. Does my practice have an office policy on preventive cancer screening?

   ☐Yes

   ☐No

   ☐Unsure

7. Does my practice actively engage in supporting and following the office policy?

   ☐Yes

   ☐No

   ☐Unsure

8. Does my practice have a compiled list of screening resources?

   ☐Yes

   ☐No

   ☐Unsure

Essential 3: **Be Persistent with Reminders**

9. Does my practice utilize a reminder system?

   ☐Yes

   ☐No

   ☐Unsure

10. Does my practice track orders for screening to see whether patients completed their screening?

    ☐Yes

    ☐No

    ☐Unsure

11. Does my practice track patients to determine whether patients who had a positive screening test received a complete diagnostic evaluation?

    ☐Yes

    ☐No

    ☐Unsure

Essential 4: **Measure Practice Progress**

12. Does my practice establish a baseline and set a goal for cancer screening?

    ☐Yes

    ☐No

    ☐Unsure

13. Does my practice collect data regarding documentation procedures or systems that need improvement?

    ☐Yes

    ☐No

    ☐Unsure

14. Does my practice follow a continuous improvement model to develop and test changes?

    ☐Yes

    ☐No

    ☐Unsure

Assessment Results

Based on the Four Essentials assessment findings please use the following questions to help you determine your clinic next steps.

1. What are your clinic's strengths?

2. What are areas where you feel improvement is needed within your clinic?

3. Which essential(s) does your clinic need to implement, based on the assessment findings?

Next Steps

1. Identify the cancer screening you would like to increase.

   ☐Breast

   ☐Colorectal

   ☐Cervical

   ☐Prostate

   ☐Other

2. Identify your target audience (e.g. age range, those who have never been screened, are behind or over-due for rescreening, etc).

3. Establish your clinic's baseline (current) screening rate for the cancer type and target audience you've identified above (e.g. percentage or number).

4. Identify your clinic's screening goal.

5. Identify a target timeframe for achieving this goal?

Tips for Fitting the Cancer Screening Toolkit Training into a Busy Work Schedule

The purpose of *Tips for Fitting the Cancer Screening Toolkit Training into a Busy Work Schedule* is to offer some tips that you can utilize in your busy office clinic practice. We hope that this will improve your learning, help you with implementation, and eventually improve your cancer screening rates.

Here we offer some tips for fitting implementation of the cancer screening toolkit into your busy work schedule. Implementation might take the form of self-directed training, group training of office colleagues, or some combination of methods. Whatever method you choose, these five tips will help facilitate the learning process:

1. Make learning a top priority.
2. Find a time to learn that works for you.
3. Create a space conducive to learning.
4. Manage learning by "chunking."
5. Above all, learn by doing.

---

1. Make learning a top priority.

- Say it out loud: We are committed to improving cancer screening rates.
- Tell your health care team about the cancer screening toolkit and ask for their involvement.
- Set "doable" goals–by the week, month, and year–for implementing the Four Essentials of preventive cancer screening.
- Identify milestones for accomplishment and rewards for reaching those milestones.

2. Find a time to learn that works for you.

- Avoid choosing times when more urgent activities are likely to push learning out of the way.
- Set aside time for learning sessions that fit your workplace routine. Should training happen:
    - Earlier or later in the day?
    - Earlier or later in the week?
    - In short bursts or in longer, more concentrated sessions?
- Set time limits for each session.

3. Create a space conducive to learning.

- Associate a time of day and specific location for learning.
- Create a checklist of needs for your "learning-ready" environment, such as:
    - Reserving a room where you are less likely to be disturbed.
    - Making training materials available.
    - Notifying others of your schedule.
    - [Add your needs here].
- Say "No!" to distractions by turning off your:
    - Email.
    - Cell phone.
    - Internet browser.
    - [Add your own distractions here].

4. Manage learning by "chunking."

Chunking means dividing a complicated problem into smaller bits and solving those bits one by one.

- "Divide and conquer" the work of learning.
    - Consider forming small groups of learners to share assignments.
    - Offer each participant a chance to take the lead in learning.
- Devote each learning session to a small "bit" of the toolkit. For instance, what do we need to think about for our office policy on cancer screening?
- Choose a preferred point of attack: Should we tackle the more challenging questions first, or pick some "low-hanging fruit" as a way to get started?

5. Above all, learn by doing.

The toolkit is designed to help you implement practice changes to achieve the Four Essentials of preventive cancer screening.

- Plan to adapt the Four Essentials to your office setting and patient populations.
- Be prepared to learn by practice. For instance, repeatedly reminding patients to get screened is a habit developed over time.
- Expect a few bumps in the road as you put the toolkit into practice and you won't be frustrated.
- Give yourself time for implementation. For example, multi-step activities, such as developing and testing a reminder system, may take longer to implement than one of the other essentials.

Additional Screening Resources

Appendix A: American Cancer Society Screening Guidelines

The American Cancer Society recommends these screening guidelines for most adults.

Type of Cancer	Guidelines
Breast Cancer	• Yearly mammograms are recommended starting at age 40 and continuing for as long as a woman is in good health. • Clinical breast exam (CBE) about every 3 years for women in their 20's and 30's and every year for women 40 and over. • Women should know how their breasts normally look and feel and report any breast change promptly to their health care provider. Breast self-exam (BSE) is an option for women starting in their 20's. Some women–because of their family history, a genetic tendency, or certain other factors–should be screened with MRI in addition to mammograms. (The number of women who fall into this category is small: less than 2% of all women in the US) Talk with your doctor about your history and whether you should have additional tests at an earlier age. For more information on breast cancer screening, call the American Cancer Society (1-800-227-2345) and ask for the document titled, *Breast Cancer: Early Detection*.

Type of Cancer	Guidelines
Colorectal Cancer	Beginning at age 50, both men and women should follow one of these testing schedules: **Tests that find polyps and cancer** • Flexible sigmoidoscopy every 5 years*, or • Colonoscopy every 10 years, or • 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) every year**, or • Stool DNA test (sDNA), interval uncertain** * 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. A colonoscopy should be done if the test is positive. The tests that are designed to find both early cancer and polyps are preferred if these tests are available to you and you are willing to have one of these more invasive tests. Talk to your doctor about which test is best for you. Some people should be screened using a different schedule because of their personal history or family history. Talk with your doctor about your history and what colorectal cancer screening schedule is best for you. For more information on colorectal cancer screening, please call the American Cancer Society (1-800-227-2345) and ask for the document titled: *Colorectal Cancer: Early Detection*.

Type of Cancer	Guidelines
Cervical Cancer	• **Cervical cancer screening (testing) should begin at age 21.** Women under age 21 should *not* be tested. • **Women between ages 21 and 29** should have a Pap test every 3 years. Now there is also a test called the HPV test. HPV testing should *not* be used in this age group unless it is needed after an abnormal Pap test result. • **Women between the ages of 30 and 65** should have a Pap test plus an HPV test (called "co-testing") every 5 years. This is the preferred approach, but it is also OK to have a Pap test alone every 3 years. • **Women over age 65** who have had regular cervical cancer testing with normal results should *not* be tested for cervical cancer. Once testing is stopped, it should not be started again. Women with a history of a serious cervical pre-cancer should continue to be tested for at least 20 years after that diagnosis, even if testing continues past age 65. • **A woman who has had her uterus removed (and also her cervix)** for reasons not related to cervical cancer and who has no history of cervical cancer or serious pre-cancer should *not* be tested. • **A woman who has been vaccinated against HPV** should still follow the screening recommendations for her age group. Some women – because of their history – may need to have a different screening schedule for cervical cancer. For more information on cervical cancer screening, please call the American Cancer Society (1-800-227-2345) and ask for the document titled: *Cervical Cancer: Prevention and Early Detection*.

Type of Cancer	Guidelines
Prostate Cancer	The American Cancer Society recommends that men make an informed decision with their doctor about whether to be tested for prostate cancer. Research has not yet proven that the potential benefits of testing outweigh the harms of testing and treatment. The American Cancer Society believes that men should not be tested without learning about what we know and don't know about the risks and possible benefits of testing and treatment. Starting at age 50, men should talk to a doctor about the pros and cons of testing so they can decide if testing is the right choice for them. If they are African American or have a father or brother who had prostate cancer before age 65, men should have this talk with a doctor starting at age 45. If men decide to be tested, they should have the PSA blood test with or without a rectal exam. How often they are tested will depend on their PSA level. For more information on prostate cancer screening, please call the American Cancer Society (1-800-227-2345) and ask for the document titled: *Prostate Cancer: Early Detection*.

Appendix B: The Quality of Colonoscopy Services-Responsibilities of Referring Physicians (Get this 5 page document in the accompanying CD)

Appendix C: Clinician's Reference - Fecal Occult Blood Testing (FOBT) for Colorectal Cancer Screening (Get this two pages document in the accompanying CD)

Appendix D: Iowa's Cancer Plan:
http://www.canceriowa.org/IowaCancerPlan.aspx

Acknowledgements

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