



Options for Increasing Colorectal Cancer Screening Rates

in North Carolina Community Health Centers

US PUBLIC HEALTH SERVICE SCREENING RECOMMENDATIONS

Adults age 50 – 75: Screen with Fecal Occult Blood Test (FOBT) / Fecal Immunochemical Test (FIT), flexible sigmoidoscopy, or colonoscopy.

Adults age 76 – 85: Do not screen routinely.

Adults older than 85: Do not screen.

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<http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf>

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Introduction

In North Carolina in 2007, there were 4,100 new cases of colon/rectal cancer and 1,590 deaths.^{1, 2}

WHY SCREEN FOR COLORECTAL CANCER?

- Colorectal cancer is the nation's second leading cause of mortality for cancers affecting both sexes.³
- Screening prevents colorectal cancer and reduces mortality.⁴⁻⁶
- The long period of transformation from adenomatous polyp to malignancy (5-15 years) gives clinicians a window of opportunity to help their patients prevent colorectal cancer.
- Screening for colorectal cancer is less costly than cancer treatment.
- Colorectal cancer screening rates will be a required element in the Universal Data System.

Community Health Centers should recommend and offer colorectal cancer screening because their goal is to provide preventive care!

HOW CAN THIS GUIDE HELP IMPROVE SCREENING RATES?

- This guide provides tools for delivering colorectal cancer screening recommendations.
- This guide provides guidelines for administrators of CHCs to support screening practices.
- Incorporating these systems changes can help achieve the goal of increasing the national colorectal cancer screening rate from 47% in 2005 to 75% by 2015, as established by the American Cancer Society.⁷

This guide presents three Essential Elements for improving screening rates:

1. Support Screening in Your Clinic Environment
2. Make Your Recommendation
3. Use An Office Reminder System

A brief overview of each Essential Element follows with concrete strategies and tools to facilitate their adoption in North Carolina Community Health Center settings.

Essential Element #1:

Support Screening in Your Clinic Environment

CONDUCT A CLINIC ASSESSMENT

A self-assessment survey such as the one in Tool A can be used to identify necessary resources and mechanisms that are already in place in the practice site and where there might be gaps. This exercise will make it easier to determine which tools in this guide should be implemented.

TOOL A: SELF-ASSESSMENT SURVEY

Yes No

Medical Records

- 1. Do patient charts indicate current CRC screening status?
- 2. Do patient charts indicate method and date of last screening?
- 3. Do patient charts indicate high-risk status due to family history?
- 4. Does your medical record system have the capacity to provide a list of patients ages 50-75 who are not up to date on their screening?

Yes No

Staff Roles

- 5. Is there a designated staff member who *provides information* to patients about CRC screening?
- 6. Is there a designated staff member who *recommends* CRC screening to patients?
- 7. Is there a designated staff member who *follows up* with patients who agree to be tested?

Yes No

Resources

- 8. Are the PHS Clinical Practice Guidelines for CRC screening easily available for clinician reference?
- 9. Does your clinic have free materials available to patients on CRC screening?

Yes No

Follow-Up

- 10. Does your clinic have a process for following up with patients who have not returned their FOBT/FIT kit cards?
- 11. Does your clinic have a process for receiving and documenting test results for patients who choose flexible sigmoidoscopy or colonoscopy?

Yes No

Billing

- 12. Has your clinic's financial administrator identified health plan coverage, diagnosis, and billing codes for CRC screening?

IMPLEMENT CHANGES TO PATIENT VISITS

The clinic's environment, systems, and patient-provider communication can be enhanced to promote colorectal cancer screening.

TOOL B: RECOMMENDED PATIENT VISIT PRACTICES

In the waiting room and exam room:

- Place informative and attractive office posters or fliers in the waiting room to educate about clinic policy and in exam rooms to cue action.
- Offer educational materials, instructional materials, and reminder tools to suit your clinic population.

At lab or triage area:

- Ask patients about family history and previous screening.
- Tag chart if patients are eligible for screening.
- Give standing orders for FOBT/FIT cards to average risk patients who are not up to date with screening.

During the exam:

- Reinforce message for CRC screening and discuss best option for patients (FOBT/FIT, colonoscopy, flexible sigmoidoscopy).

At checkout:

- Schedule screening before the patients leave the office.
- Program patient reminders into the electronic medical record or have patients fill out reminder cards.

After the visit:

- Call patients to remind them of their colonoscopy/flexible sigmoidoscopy appointments.
- Contact patients who do not return FOBT/FIT cards or keep their colonoscopy/flexible sigmoidoscopy appointments.

DETERMINE INDIVIDUAL RISK LEVEL

- The U.S. Preventive Services Task Force recognizes two risk levels: average and higher than average, according to personal history and family history.
- Guidelines suggest that if an individual is high-risk, screening before age 50 with a colonoscopy is reasonable.⁸ Since risk changes over time, an assessment, such as the one in Tool C, should be repeated annually.⁹
- Use algorithms such as the one in Tool D to quickly determine which tests are appropriate for the patient's risk level.

TOOL C: ANNUAL ASSESSMENT TO DETERMINE RISK

These are questions you can ask patients in order to place them in the average-risk or high-risk categories. Then, follow the algorithm in Tool D.

- Have you ever had inflammatory bowel disease (Crohn's disease, ulcerative colitis)?
- Have you ever had a colon polyp?
 - A polyp is an abnormal growth in the inner lining of the colon. These can be harmless (benign), a sign of cancer (precancerous), or diagnosed as cancer (malignant).
- Has any member of your family had colorectal cancer?
- Has any member of your family had a colon polyp?

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photo © National Cancer Institute - Rhoda Baer



TOOL D: SAMPLE SCREENING ALGORITHM

Risk Assessment: Personal History

- Crohn's disease
- Ulcerative colitis
- Previous diagnosis of precancerous polyps > 1 cm

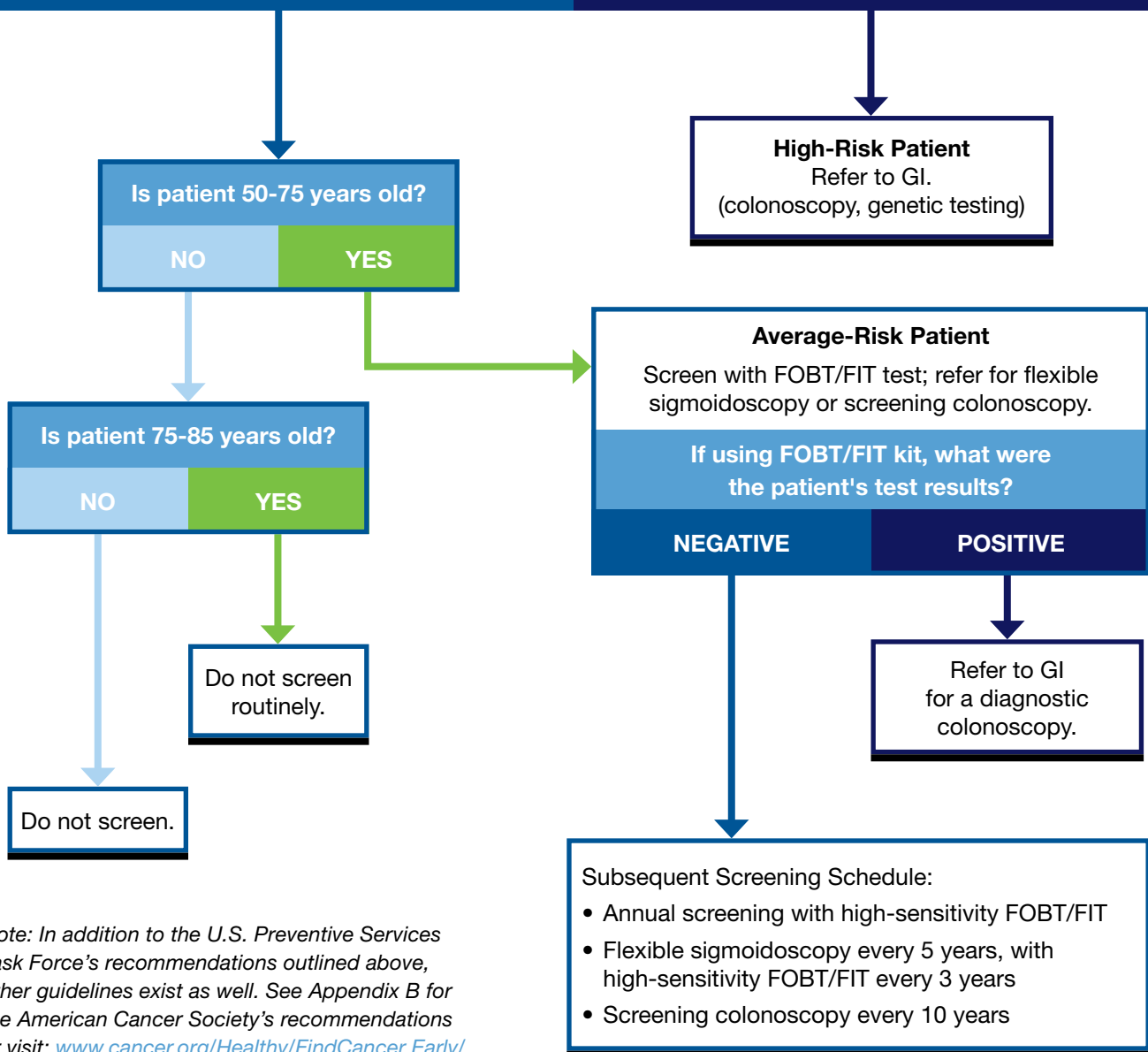
Risk Assessment: Family History

- History of colon cancer
- History of precancerous polyps > 1 cm

Does patient have any conditions outlined in the Personal or Family History Risk Assessments?

NO – Average Risk

YES – Increased Risk



Note: In addition to the U.S. Preventive Services Task Force's recommendations outlined above, other guidelines exist as well. See Appendix B for the American Cancer Society's recommendations or visit: www.cancer.org/Healthy/FindCancerEarly/CancerScreeningGuidelines

IMPLEMENT UNIVERSAL RECOMMENDATION FOR FOBT/FIT

- In a 2004 study, the CDC concluded that there is sufficient capacity to screen the entire eligible population of the nation within one year using FOBT, backed up by colonoscopy for those who screen positive.¹⁰
- Community Health Centers are well-positioned to increase overall screening rates by recommending the FOBT/FIT kit and using standing orders to ensure that all eligible patients are screened.

TOOL E: SAMPLE STANDING ORDER FOR FECAL OCCULT BLOOD TESTING

1. Determine that patients are 50 years of age or older and not in a high-risk category.
2. Establish that patients have not had FOBT or FIT in previous 12 months, colonoscopy in last 10 years, or sigmoidoscopy in last 5 years.
3. Offer FOBT/FIT colorectal cancer screening to patients along with routine lab work.
4. Provide patients the FOBT/FIT kit and instructions for performing and returning the test.
5. Record information in FOBT/FIT tracking log.
6. Follow up on return of FOBT/FIT kit. Ensure that provider and patients are notified of test results and that follow-up is scheduled as needed.

photo © Blue Ridge Community Health Services - Hendersonville



USE HIGH-SENSITIVITY FOBT OR FIT

- Traditional stool guaiac tests such as the Hemoccult IITM should be replaced with higher sensitivity tests such as the Hemoccult SENSATM or a fecal immunochemical test (FIT).¹¹⁻¹³
- Although the FIT is more expensive, there may be advantages to using it, such as the elimination of dietary restrictions and fewer samples needed (for some kits).

KNOW YOUR PATIENT'S INSURANCE COVERAGE

- North Carolina state law mandates that health benefit plans provide coverage for colorectal cancer exams and laboratory tests.¹⁴
- Medicare reimburses for PHS-recommended screenings.
 - Medicare beneficiaries 50 years and older will be reimbursed for an annual stool test, a flexible sigmoidoscopy every 4 years (once every 10 years post colonoscopy), and a screening colonoscopy every 10 years (2 years at high risk).¹⁵
- Medicare beneficiaries can receive any of these screening tests without a deductible or co-pay.¹⁶

DO NOT PERFORM DIGITAL RECTAL EXAMS

- Digital rectal exams (DRE) have not been found to be effective in detecting bleeding from colorectal polyps or cancers and should not be used to replace the at-home FOBT/FIT.^{17, 18}
- Clinicians may continue to perform the exam for other purposes (such as prostate exams) but should not use the DRE as a screening method for colorectal cancer.

DO NOT REPEAT POSITIVE FOBT/FIT

- All patients with a positive stool test for occult blood require colonoscopy follow-up.

ARRANGE FREE OR LOW-COST COLONOSCOPIES FOR PATIENTS WITH POSITIVE FOBT/FIT

- Some CHCs have been able to arrange formal written agreements with local or regional gastroenterologists to provide affordable colonoscopies.
- Other CHC providers have informal verbal agreements with colleagues in their geographic area to perform colonoscopies for uninsured patients with a positive FOBT/FIT.
- The best argument for providing this service is that gastroenterologists will receive very few referrals on an annual basis from CHCs. In a study in High Point, NC approximately 200 people, most of whom were uninsured, were screened with a take-home stool test and only four (2%) required a follow-up colonoscopy for a positive result.¹⁹
- Encourage patients and physicians to request a discount from the gastroenterologists or to explore payment plan options.
- With healthcare reforms scheduled to take place in 2014, more CHC patients will have insurance to cover follow-up colonoscopies.

photo © Blue Ridge Community Health Services - Hendersonville



Essential Element #2:

Make Your Recommendation

RECOMMEND SCREENING FOR ALL ELIGIBLE PATIENTS

- One fact that has remained consistent from community to community is the influence of a physician's recommendation on the cancer screening decisions of their patients.
- Provider recommendation is the leading predictor of patient screening behavior.²⁰⁻²⁴
- To prevent and reduce mortality, the recommendation must include a referral for colonoscopy when other screening tests are positive.

USE AN OPPORTUNISTIC APPROACH

- While many physicians prefer to give recommendations for cancer screening at the time of the annual checkup, this approach will not reach all the patients in the practice who need screening.
- An alternate approach is to recommend screening at all types of visits. This is generally referred to as an “opportunistic approach” or a “global approach.” The opportunistic approach means recommending screening far more frequently.
- Given the many demands on a practitioner's time, an opportunistic approach will only work when office systems function automatically to get a recommendation to every appropriate patient – even if the clinician is not immediately involved.
- An opportunistic approach is not the same thing as conducting a single sample FOBT in the office as a screening test, which is ineffective.^{17, 18}



ASSESS PATIENT'S SCREENING PREFERENCE

A process of shared decision-making involving the clinician and patient should occur. For average and high-risk patients, the conversations could go something like this:

TOOL G1: AVERAGE-RISK COUNSELING SCRIPT

“I would like you to be screened for colorectal cancer because it is recommended for everyone between the ages of 50 and 75. There are two ways you can get screened — you can either do a take-home test (FOBT/FIT) or we can refer you for an internal exam (either flexible sigmoidoscopy or colonoscopy).

The take-home test (FOBT/FIT) looks for blood in your stool. With this test, we can detect cancer at an early stage without the risks of a medical procedure. You'll need a colonoscopy if you have an abnormal finding on the FOBT/FIT. A colonoscopy is when the doctor looks at the inside of your intestine with a small camera.

A colonoscopy (or flexible sigmoidoscopy) allows us to find and remove growths (polyps) in your bowel. By removing these colon polyps, we can decrease your chance of developing cancer. The two main risks are accidentally puncturing your intestine (bowel perforation) and complications from pain medication (anesthesia). Both of these risks are rare.

The least expensive option for most patients is the take-home stool test. If you have Medicare, there is no cost to you for any of these tests. If your test result is positive, then our clinic will work with you to arrange for a follow-up colonoscopy. Results of the colonoscopy will help us know if there is cancer so that you can receive treatment.”

TOOL G2: HIGH-RISK COUNSELING SCRIPT

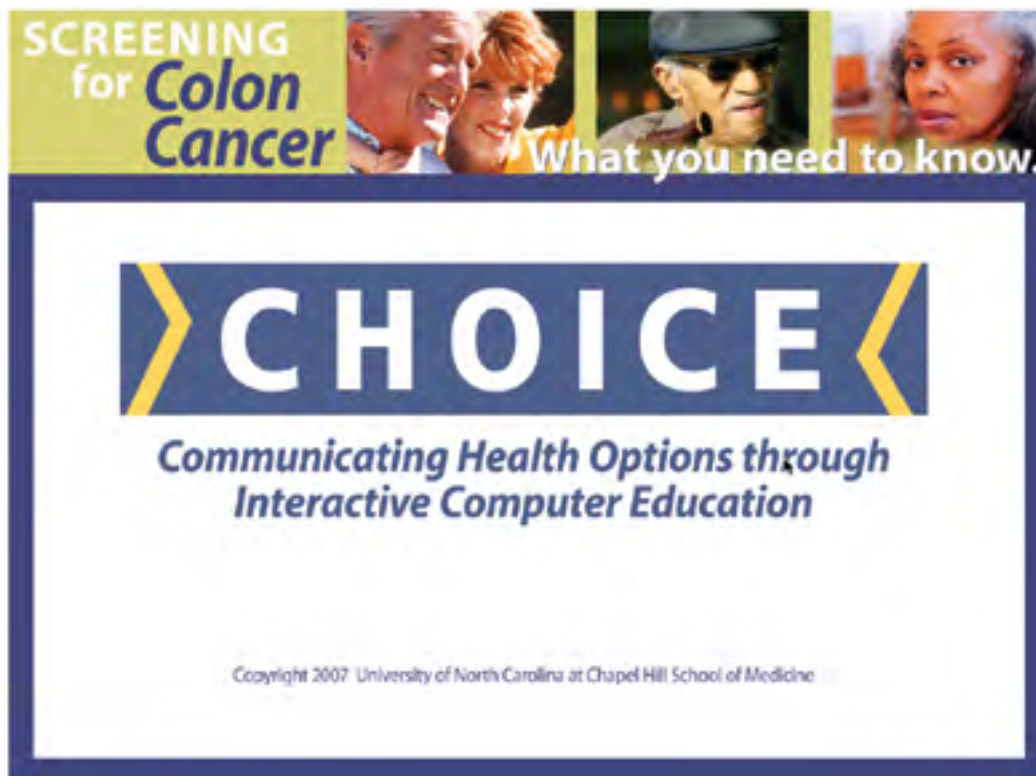
“Because you are high-risk (state the risk factors), I recommend that you have a colonoscopy. A colonoscopy is when the doctor looks at the inside of your intestine with a small camera. Results of the colonoscopy will help us figure out if you have precancerous growths or cancer, and treatment can be planned accordingly.” (If uninsured or cost is an issue): “I realize this procedure costs a lot of money, but I feel this is a very important test for you to have. We'll work with the referral coordinator to get an appointment and talk about payment options.”

USE DECISION AIDS AND OTHER PATIENT MATERIALS

Decision aids help undecided patients identify screening and treatment preferences. One web-based tool, Screening for Colon Cancer: What you Need to Know, is free and can be accessed at: <http://decisionsupport.unc.edu/CHOICE6/entry.php?ac=89309>

TOOL H: DECISION AID

This decision aid helps average-risk patients determine if they are ready for screening and if so, which type of screening they prefer. Individuals can view it at home or Community Health Centers can play it in a private alcove or waiting room. Persons who view this decision aid should not have previously been diagnosed with colorectal cancer or adenomatous polyps (<http://decisionsupport.unc.edu/CHOICE6/choice6.htm>, accessed 4/29/10).



- CDC’s Screen for Life program has a variety of patient materials in English and Spanish including fact sheets, brochures, posters, and print ads (http://www.cdc.gov/cancer/colorectal/sfl/print_materials.htm) that are free of charge.
- These publications and related materials can be ordered directly from the online ordering form of CDC’s Division of Cancer Prevention and Control: <http://wwwn.cdc.gov/pubs/dcpc1.aspx>
- See Appendix C for additional patient materials and resources.

Are you the picture of health?

“Colorectal cancer is the 2nd leading cancer killer. But it doesn’t have to be.”

*Katie Couric, Co-Founder
EIF’s National Colorectal Cancer Research Alliance*

Colorectal cancer and precancerous polyps don’t always cause symptoms. So you can look healthy and feel fine and not know there may be a problem. ■ Screening helps find polyps so they can be removed **before** they turn into colorectal cancer. This is one cancer you can prevent! ■ Screening can also find colorectal cancer early, when treatment often leads to a cure. ■ If you’re 50 or older, make sure you really are the picture of health. Get screened for colorectal cancer.

1-800-CDC-INFO (1-800-232-4636) • www.cdc.gov/screenforlife

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention

CDC

National Colorectal Cancer Research Alliance
EIF ENTERTAINMENT INDUSTRY FOUNDATION

Screen Life
www.cdc.gov/screenforlife

This is personal.

“My mother was the cornerstone of our family. When she was diagnosed with colon cancer, it was like the whole family got cancer. She died when she was only 56. Let my heartbreak be your wake-up call.”

Terrence Howard, actor/musician

Colorectal cancer is the second leading cancer killer in the U.S., but it is largely preventable. If you’re 50 or older, please get screened. Screening finds precancerous polyps, so they can be removed before they turn into cancer. And screening finds colorectal cancer early, when treatment works best. If you’re at increased risk—if you have a personal or family history of polyps or colorectal cancer, or you have inflammatory bowel disease—ask your doctor when to start screening. **Screening saves lives.**

1-800-CDC-INFO (1-800-232-4636) • www.cdc.gov/screenforlife

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention

CDC

National Colorectal Cancer Research Alliance
EIF ENTERTAINMENT INDUSTRY FOUNDATION

Screen Life
www.cdc.gov/screenforlife

Essential Element #3:

Use An Office Reminder System

CREATE ACTION CUES

- Integrated summaries and chart flags serve as visual reminders or “cues to action.” All clinicians can have their clinic charts prepared with these elements, whether they are electronic or paper.
- For integrated summaries, a problem list and screening schedule on each chart should include “preventive services” or an equivalent phrase as a separate item as an ongoing cue to action. Patients who are at increased risk for colorectal cancer should have this fact listed as an item on the problem list. Age and gender-appropriate screening schedules should be easy to find on the chart.
- Electronic or paper chart flags that are HIPAA-compliant can alert office staff when screening is indicated or overdue. Since charts are usually pulled prior to the patient visit, the provider will know ahead of time if colorectal cancer screening is warranted. The same procedures will ensure follow-through for patients with a positive screening who require a complete diagnostic exam with colonoscopy.



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TOOL I: INTEGRATED SUMMARY

ADULT HEALTH PROBLEM LIST AND PREVENTIVE CARE FLOW SHEET: XYZ MEDICAL CENTER

Patient Name: _____

Date of Birth: _____ Medical Record Number: _____

Primary Care Provider: _____ Height: _____

Immunizations and Date

Tdap: _____ Flu: _____ Pneumonia: _____ Shingles: _____ Hep. B: _____

Problem List

Family Medical History

Allergies and Reactions

Prevention Discussion Topics

Advance Directives · Oral Health · Physical Activity · Tobacco Use Cessation
Depression · Substance Abuse · Domestic Violence/Abuse

Cancer Screening

Procedure / Test	Guideline	Date(s) / Result(s)
Mammography	(q 2 yr if 50+)	
Pap Smear	(q 3 yr if 21+)	
FOBT/FIT, flex. sig. or colonoscopy	(age 50-75)*	

* Recommendation varies depending on family and patient history.

TOOL J: SAMPLE CHART STICKER

Is colon cancer screening needed?

Yes No

Recommendation: age \geq 50 years or family history

Type: Colonoscopy FOBT/FIT
Other _____

Referral date: ____/____/____

Results: _____



<http://www.nyc.gov/html/doh/downloads/pdf/csi/coloncancerkit-clin-sticker.pdf>

IMPLEMENT TICKLERS AND LOGS

- Other systems to ensure compliance include ticklers and logs. A tickler system is created when a copy of a lab order, referral, reminder, or tracking sheet is placed in a file box. When results or reports arrive, the copy is pulled from the tickler file, the patient is notified by phone or mail, the results are placed in the chart, and a visit is scheduled if appropriate. Orders with no accompanying results within 30 days require follow-up.
- The patient self-addresses a fold-over reminder that is sent if the stool cards are not returned within a specific time period.
- Another approach to improve patient adherence is to create a single log or tracking sheet of all patients who take home a FOBT/FIT kit. The log can be used to contact patients with test results, send reminders to patients who have not returned their kits, and document follow-up colonoscopies for positive stool blood tests.

INSTITUTE PATIENT REMINDERS (LETTERS, POSTCARDS, AND TELEPHONE SCRIPTS)

- HIPAA-compliant letters and telephone messages can be modified for your specific clinic's needs. There should be three scripts:
 1. A reminder to come in for testing;
 2. A reminder to send in FOBT/FIT cards;
 3. A notification of negative CRC screening results

TOOL L: SAMPLE HIPAA-COMPLIANT POSTCARDS

Outside of Card

The diagram illustrates the layout of a HIPAA-compliant postcard. A horizontal dashed line labeled "Fold Line" is positioned near the top. Below the fold line, on the left side, is the "Return Address" field, which includes the following text: "Return Address", "Practice Name", "Address", "Address", and "City, State, Zip". On the right side, there is a rectangular box labeled "Postage". In the center of the card, there is a rounded rectangular box containing the following text: "Patient Name", "Address", "Address", and "City, State, Zip".

TIME FOR TEST

Inside of Card

Fold Line

Dear _____ ,

It's time for your annual colorectal cancer screening test.

For people over age 50, this simple test saves lives.

Colorectal cancer is a 100% curable cancer when found in the early stages. Having a stool test every year can help find colorectal cancer early.

Remember to have this test every year. Follow up with your doctor any time you have bleeding from your bottom more than once, bloody stools, or a change in bowel habits.

Please call _____ to see your provider and pick up your stool test kit.

Sincerely,

Your healthcare provider

Address

City, State, Zip

Office Main Phone Number

REMINDER TO RETURN TEST

Inside of Card

Fold Line

Dear _____ ,

On your last visit to your healthcare provider, _____ , you were given a test to screen for colorectal cancer.

At this time, we have not received your test back in the mail.

Colorectal cancer is a 100% curable cancer when found in the early stages. Simple tests like having a stool test every year can help find cancer early.

Please return your completed test kit to us as soon as possible.

If you have any questions about your test, please call _____ at _____ .

Sincerely,

Your healthcare provider
Address
City, State, Zip
Office Main Phone Number

NEGATIVE RESULT

Inside of Card

Fold Line

Dear _____ ,

We are pleased to tell you that your stool test came back normal.

Colorectal cancer is a 100% curable cancer when found in the early stages. Simple tests like having a stool test every year can help find early, curable colorectal cancer.

Remember to have this test every year. Follow up with your doctor any time you have bleeding from your bottom more than once, bloody stools or a change in bowel habits.

If you have any questions about your test, please call _____ at _____ .

Sincerely,

Your healthcare provider
Address
City, State, Zip
Office Main Phone Number

POPULATION MANAGEMENT

- For Community Health Centers that have fully implemented opportunistic screening, the next step is to proactively identify all eligible patients who are in need of screening. This can be accomplished in several ways:
 1. Generate a list from the EMR system of all patients between 50 and 75 who are not up-to-date on their screening tests, and send a reminder postcard (see Tool L).
 2. Send a birthday card to every patient who turns 50 to remind them about getting screened.
 3. Include colorectal cancer screening in recalls that are already sent out for mammograms, prostate cancer screening, and other services for patients over 50.

**THE BEST COLORECTAL CANCER SCREENING TEST
IS THE ONE THAT GETS DONE!**

photo © NC Community Health Center Association



APPENDIX A: Screening for Colorectal Cancer

CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

This document is a summary of the 2008 recommendation of the U.S. Preventive Services Task Force (USPSTF) on screening for colorectal cancer. This summary is intended for use by primary care clinicians. Grade definitions are available on page 27.

Population	Adults Age 50 to 75*	Adults Age 76 to 85 years*	Adults Older than 85*
Recommendation	Screen with high sensitivity fecal occult blood testing (FOBT), sigmoidoscopy, or colonoscopy. Grade: A	Do not screen routinely. Grade: C	Do not screen. Grade: D
	For all populations, evidence is insufficient to assess the benefits and harms of screening with computerized tomography colonography (CTC) and fecal DNA testing. Grade: I (insufficient evidence)		
Screening Tests	High-sensitivity FOBT, sigmoidoscopy with FOBT, and colonoscopy are effective in decreasing colorectal cancer mortality. The risks and benefits of these screening methods vary. Colonoscopy and flexible sigmoidoscopy (to a lesser degree) entail possible serious complications.		
Screening Test Intervals	Intervals for recommended screening strategies: <ul style="list-style-type: none"> • Annual screening with high-sensitivity fecal occult blood testing • Sigmoidoscopy every five years, with high-sensitivity fecal occult blood testing every three years • Screening colonoscopy every ten years 		

<p>Balance of Harms and Benefits</p>	<p>The benefits of screening outweigh the potential harms for 50- to 75-year-olds.</p>	<p>The likelihood that detection and early intervention will yield a mortality benefit declines after age 75 because of the long average time between adenoma development and cancer diagnosis.</p>
<p>Implementation</p>	<p>Focus on strategies that maximize the number of individuals who get screened.</p> <p>Practice shared decision making; discussions with patients should incorporate information on test quality and availability.</p> <p>Individuals with a personal history of cancer or adenomatous polyps are followed by a surveillance regimen, and screening guidelines are not applicable.</p>	
<p>Relevant USPSTF Recommendations</p>	<p>The USPSTF recommends against the use of aspirin or nonsteroidal anti-inflammatory drugs for the primary prevention of colorectal cancer. This recommendation is available at: http://www.preventiveservices.ahrq.gov</p>	

*These recommendations do not apply to individuals with specific inherited syndromes (Lynch Syndrome or Familial Adenomatous Polyposis) or those with inflammatory bowel disease.

Internet Citation:

Screening for Colorectal Cancer, Topic Page. March 2009. U.S. Preventive Services Task Force. <http://www.uspreventiveservicestaskforce.org/uspstf/uspscoco.htm>. Accessed April 2010.

GRADE DEFINITIONS AFTER MAY 2007

The U.S. Preventive Services Task Force (USPSTF) has updated its definitions of the grades it assigns to recommendations and now includes “suggestions for practice” associated with each grade. The USPSTF has also defined levels of certainty regarding net benefit. These definitions apply to USPSTF recommendations voted on after May 2007.

WHAT THE GRADES MEAN AND SUGGESTIONS FOR PRACTICE

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small.	Offer or provide this service only if other considerations support the offering or providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

APPENDIX B:

American Cancer Society Guidelines

AMERICAN CANCER SOCIETY RECOMMENDATIONS FOR COLORECTAL CANCER EARLY DETECTION

PEOPLE AT AVERAGE RISK

The American Cancer Society believes that preventing colorectal cancer (and not just finding it early) should be a major reason for getting tested. Finding and removing polyps keeps some people from getting colorectal cancer. Tests that have the best chance of finding both polyps and cancer are preferred if these tests are available to you and you are willing to have them. Beginning at age 50, both men and women at average risk for developing colorectal cancer should use one of the screening tests below:

Tests that find polyps and cancer

- Flexible sigmoidoscopy every 5 years*
- Colonoscopy every 10 years
- Double-contrast barium enema every 5 years*
- CT colonography (virtual colonoscopy) every 5 years*

Tests that mainly find cancer

- Fecal occult blood test (FOBT) every year*,**
- Fecal immunochemical test (FIT) every year*,**
- Stool DNA test (sDNA), interval uncertain*

* Colonoscopy should be done if test results are positive.

** For FOBT or FIT used as a screening test, the take-home multiple sample method should be used. An FOBT or FIT done during a digital rectal exam in the doctor's office is not adequate for screening.

In a digital rectal examination (DRE), a doctor examines your rectum with a lubricated, gloved finger. Although a DRE is often included as part of a routine physical exam, it is not recommended as a stand-alone test for colorectal cancer. This simple test, which is not usually painful, can detect masses in the anal canal or lower rectum. By itself, however, it is not a good test for detecting colorectal cancer due to its limited reach.

Doctors often find a small amount of stool in the rectum when doing a DRE. However, simply checking stool obtained in this fashion for bleeding with an FOBT or FIT is not an acceptable method of screening for colorectal cancer. Research has shown that this type of stool exam will miss more than 90% of colon abnormalities, including most cancers.

PEOPLE AT HIGH RISK

If you are at an increased or high risk of colorectal cancer, you should begin colorectal cancer screening before age 50 and/or be screened more often. The following conditions place you at higher than average risk:

- A personal history of colorectal cancer or adenomatous polyps
- A personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease)
- A strong family history of colorectal cancer or polyps
- A known family history of a hereditary colorectal cancer syndrome such as familial adenomatous polyposis (FAP) or hereditary non-polyposis colon cancer (HNPCC)

For the full set of risk factors and guidelines, please refer to: <http://www.cancer.org/Cancer/ColonandRectumCancer/MoreInformation/ColonandRectumCancerEarlyDetection/colorectal-cancer-early-detection-a-c-s-recommendations>

APPENDIX C: Patient and Provider Materials

CENTERS FOR DISEASE CONTROL AND PREVENTION

<http://www.cdc.gov/cancer/dcpc/publications/colorectal.htm>

(Materials available in Spanish)

Screen For Life Campaign Materials

- Fact Sheets, Brochures, Brochure Inserts, Posters, Print Ads

NATIONAL CANCER INSTITUTE

<http://www.cancer.gov/cancertopics/wyntk/colon-and-rectal/page1>

(Materials available in Spanish)

- Booklet: What You Need to Know About Cancer of the Colon and Rectum

FOUNDATION FOR DIGESTIVE HEALTH AND NUTRITION

<http://www.fdn.org/wmspage.cfm?parm1=210>

- Fact Sheet: Colorectal Cancer Fact Sheet

PREVENT CANCER FOUNDATION

<http://preventcancer.org/colorectal3c.aspx?id=1036> (Materials available in Spanish)

- Fact Sheet: Colorectal Cancer 2009 Fact Sheet

AMERICAN CANCER SOCIETY

<http://www.cancer.org/colonmd>

(Materials available in Spanish and Asian languages)

ColonMD: Clinicians' Information Source

- Videos, Wall Charts, Brochures, Booklets
- Guidelines, Scientific Articles, Presentations
- Sample Reminders, Toolbox, CME Course, Medicare Coverage, Facts and Figures, Journals
- Interactive Web-based Toolkit: "How to Increase Colorectal Cancer Screening Rates in Practice" <http://www5.cancer.org/asp/pcmanual/default.aspx>

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

<http://www.ahrq.gov/ppip/healthymen.htm> and <http://www.ahrq.gov/ppip/healthywom.htm>

(Materials available in Spanish)

- Health Checklists for Men and Women

OFFICE FOR DISEASE PREVENTION AND HEALTH PROMOTION

<http://www.healthfinder.gov/prevention/ViewTopic.aspx?topicID=15&cnt=1&areaID=5>

- Quick Guide to Healthy Living: Get Tested for Colorectal Cancer

APPENDIX D:

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