Colorectal Cancer Navigation

Increasing Colorectal Cancer Screening Rates in Michigan

Michigan Department of Community Health

MDCH

Rick Snyder, Governor
James K. Haveman, Director

Contents

Statement of Purpose

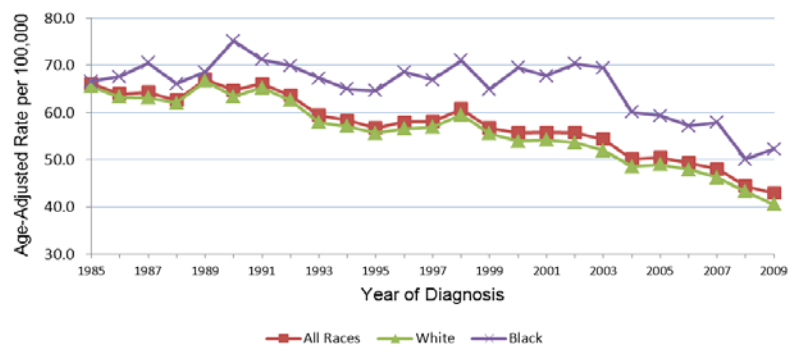
Reducing the burden of colorectal cancer on the state's residents has been a focus of the Michigan Department of Community Health since 1997. In 2006, the Department began a small colorectal cancer screening program for low-income men and women. Building on the success of that program, Michigan received funding in 2010 from the Centers for Disease Control and Prevention to expand colorectal cancer screening services through a multi-year grant.

The purpose of this document is to share lessons learned through the work in Michigan, with a special focus on patient navigation. The intended outcome is to disseminate evidence-based strategies and interventions to help providers increase their colorectal cancer screening rates.

Introduction to Colorectal Cancer & Screening

Colorectal cancer is the third most common cancer in both men and women. Nationally, it is expected that 103,170 cases of invasive colon cancer and 40,290 cases of rectal cancer will diagnosed in 2012. It also is expected that 51,690 colorectal cancer-related deaths will occur in 2012, representing 9 percent of all cancer deaths for the year. The incidence of colorectal cancer has been diminishing over time, a fact that is largely attributed to improved early detection and screening tests. However, as noted in Figure 1, differences still remain in the incidence rates of Caucasians and African Americans.[1]

Figure 1: Incidence Rates of Invasive Cancers of the Colon and Rectum
Michigan Residents



Colorectal Cancer Screening Disparities

Within the state of Michigan, health disparities exist in colorectal cancer screening rates in the areas of race/ethnicity, educational level, and annual household income.[3]

Race/ethnicity:

- White non-Hispanic – 70.4%
- Black non-Hispanic – 67.8 %
- Hispanic – 59%
- Other non-Hispanic – 56.4%

Educational level:

- College graduate – 75.1%
- High school graduate – 63%
- Some college – 71.8%
- Less than high school – 59.2%

Annual household income:

- < $20,000 – 57%
- $20,000 to $34,999 – 67.3%
- $35,000 to $49,999 – 73%
- $50,000 to $74,999 – 73.6%
- > $75,000 – 73.5%

Men and women over the age of 50 have the highest risk of being diagnosed with colorectal cancer; 91 percent of all cases occur in this age group. Therefore, beginning at age 50, men and women of average risk for developing colorectal cancer should begin screening.[1] Screening may start earlier for those who are at an increased or high risk of colorectal cancer due to a personal or family medical history. The appropriate time to begin testing should be established for each patient through consultation with their medical provider. With regular screening, colorectal polyps can be detected and removed prior to becoming cancerous.[2]

Early detection of colorectal cancer is important, because it allows for treatment in early stages, when survival rates are higher. The five-year survival rate for a localized colorectal cancer is 90 percent; unfortunately, only 39 percent of cancers are detected at this stage, partly due to low screening rates. At a distant stage, the colorectal cancer five-year survival rate plummets to 12 percent.[1]

The Benefits of Patient Navigation

Medical treatment for cancer patients has become increasingly complex. The process of diagnosis and treatment planning often requires assessment and recommendations across clinical specialties. Health care systems frequently fail to address patients' psychosocial, informational and care coordination needs, leaving patients and their families to coordinate their own healthcare. This fragmentation has led to the development of the patient navigation specialty to guide patients through the cancer care continuum, from screening through survivorship.[4] Patient navigation is a system intervention aimed at eliminating barriers to care by simplifying access. The concept of patient navigation was developed by Harold P. Freeman, MD, who believed that cancer survival in underserved populations would be impacted if barriers to the diagnosis and treatment of cancer were addressed. Dr. Freeman demonstrated a significant increase in the five-year breast cancer survival rate of African American women by decreasing the incidence of late-stage diagnosis.[5]

Anything that interferes with the completion of a screening test is a barrier. Barriers include fear (a fear of cancer or of the test itself) and financial issues (lack of insurance, high co-pays, transportation issues, and lack of paid sick time). Knowledge, modesty, cultural conflicts, language issues, and competing health, family or work responsibilities also can be barriers.[4,6] Patient navigation identifies these barriers and focuses on their resolution. Navigation services can be handled by one person or shared by several individuals. Research demonstrates many different types of interventions increase screening rates over usual care.[2,7,8] In a study by Lasser, 59 percent of the patients contacted by navigators were screened at six months, compared with 8.9 percent in the control group.[7] Providers and hospitals also benefit from navigation. From increased screening rates to decreased no-show rates along with better colonoscopy preparation, there are clear economic benefits in instituting a navigation program.[9]

Reducing Patient Barriers Saves Money

Grand River Gastroenterology (GRG) identified transportation as the main barrier to colonoscopy completion, accounting for 30 percent of cancellations. To address this barrier, it contracted with an ambulance company to provide transportation. (The medically trained drivers met the "responsible adult" requirement for release of colonoscopy patients.) By addressing this barrier, GRG's cancellation rate due to transportation issues decreased 54 percent between 2010 and 2011. Once the cost of the transportation services was deducted, the estimated cost savings was $168,152.[10]

	Cost	Patients	Total	Percent
Colonoscopy	$1600.00	110	$176,000.00	100%
Transportation	$71.16	110	$7828.00	4%
Potential Cancellation Avoidance Savings by Providing Free Transportation			$168,152.00	96%

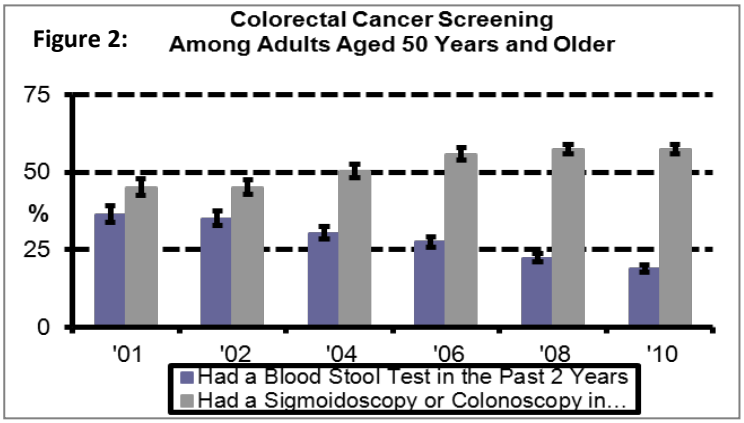
Choosing the Best Screening Method

The U.S. Preventive Services Task Force recommends the following colorectal cancer screening options: fecal occult blood testing (FOBT); fecal immunochemical test (FIT); sigmoidoscopy; and colonoscopy.[11]

Colorectal cancer screening tests have been divided into two different categories: those that find polyps and cancer, and those that primarily find cancer. The tests focusing primarily on cancer detection include stool-based tests, high-sensitivity guaiac FOBT, and FIT, while the tests that find polyps and cancer include sigmoidoscopy and colonoscopy.[12] FOBT, FIT and sigmoidoscopy are only recommended for those with an average risk of colon cancer. Colonoscopy is the only screening method recommended for those at an increased or high risk of colorectal cancer due to personal or family medical history.[13]

Medical providers should discuss risk-appropriate screening options (FOBT, FIT, colonoscopy, or sigmoidoscopy) and intervals based upon the individual's risk factors. Figure 2 shows overall screening rates for Michigan adults 50 years and older using either a blood stool test (FOBT, FIT) in the past two years or sigmoidoscopy or colonoscopy in the past five years. The use of the blood stool kit has decreased since 2001, while the use of the colonoscopy or sigmoidoscopy has increased. However, the overall rate has leveled off in recent years.[14]

Figure 2: Colorectal Cancer Screening Among Adults Aged 50 Years and Older



The National Colorectal Cancer Roundtable recommends that patients be given options in colorectal cancer screening as it increases the likelihood of screening completion. At a minimum, an average-risk patient should be given the choice between FOBT/FIT and colonoscopy.[15] Some organizations, including the American College of Gastroenterology (ACG), have recommended colonoscopy as their preferred strategy for colorectal cancer screening, since it prevents cancer through polyp removal. However, they acknowledge that patient preference, economic limitations, and other barriers will limit this as a screening test for some patients. In this situation, the ACG recommends patients be offered an alternative screening method.[16]

Ultimately, the best screening method for average-risk clients is the test that the patient is willing and able to complete. According to research, patient and provider differences in testing preferences impact screening rates. While colonoscopy is often preferred because it can prevent cancer, providers should assess patient resources and willingness to undergo an invasive test, offering screening alternatives as appropriate to average-risk patients.[2]

Patient Education

Education is Key

St. Joseph Mercy Ann Arbor a 537-bed teaching hospital near Ann Arbor utilizes navigation in its comprehensive cancer care.

The hospital already had a Nurse Navigation program for cancer treatment. In 2012, it added colorectal cancer screening navigation with the institution of the Life Colon Cancer Screening Program, which offers free colonoscopies to low-income, uninsured area residents.

The navigator identified the importance of increasing the knowledge and comfort level of providers and staff as the key to reducing barriers in educating patients about colon cancer screening and risk reduction: "As with any risk reduction initiative, the more comfortable the staff person is with discussing the issues, the more informed the patient will be."

By educating medical assistants and other staff, the hospital has created a setting in which screening interventions are not limited to the physician.[19]

Research has shown that patients attribute a lack of screening to inadequate education about colorectal cancer and its screening.[2] Limited time may cause providers to accept patients' refusal without exploring barriers.[7] Therefore, one of the most important interventions to increase colorectal cancer screening rates is expanded patient education.

Health literacy, defined as "the ability to understand health information and to use that information to make good decisions about your health and medical care,"[17] varies greatly between patients. A team approach typically is the best way to address patients' need for education. By enlisting the help of other staff, providers can increase screening rates without the entire responsibility of conducting preventive services education.[6]

Asking questions of patients can provide a quick assessment of patient knowledge, fears, and barriers to colorectal cancer screening and also provide an assessment of what stage of change they are in. Different interventions are required for patients who are in pre-contemplative and contemplative stages, than for patients who are in the preparation or action stages. By taking time to listen to — and respect — a person's concerns, a provider can help decrease fear and ultimately reduce barriers to screening. In a survey conducted by the Colon Cancer Alliance, 70 percent of respondents admitted they had not been screened for colorectal cancer, primarily due to their fear of the colonoscopy procedure itself.[18] Knowledge can address fears, superstitions and myths.

Providers and staff should approach patient education as a conversation, rather than a lecture, taking care to use simple non-medical terms. The focus should be on building trust to help patients verbalize concerns and ask questions. The goal of this conversation is to help patients understand colorectal cancer is preventable and curable when caught early and to educate them about the fact that symptoms only happen in the later stages of the disease, making screening important for early detection and survival.

FOBT/ FIT Navigation

Many physicians do not utilize FOBT/FIT in colorectal cancer screening due to low return rates. National studies have demonstrated an FOBT kit return rate of 10 percent to 50 percent.[8] The Michigan Colorectal Cancer Early Detection Program (MCRCEDP), however, has demonstrated kit return rate as high as 88.2 percent.[20] The difference between the national and Michigan rates is the addition of patient navigation which, in the MCRCEDP, consists of both patient education and barrier reduction.

Patient Education Important in FOBT Return

Muskegon County Health Department provides navigation for FOBT use as a part of MCRCEDP. The department's navigator provides patient education on colorectal cancer and kit completion, with the level of patient education based on the navigator's assessment of the patient's needs. Allowing for patient questions is an important part of patient education. The first aspect of this education is assessment of the patient's knowledge of colorectal cancer. "Many patients do not understand that this cancer, which is so deadly in its later stages, may be detected early," Navigator Michelle Olmstead says. "Some patients will need step-by-step instruction on kit completion. At times, this may include showing the patients a sample kit and verbally walking them through the collection processes step by step. But, while good patient education may take several minutes, its outcome is an increase in FOBT return rates."[21]

The Community Preventive Services Task Force recommends the use of one-on-one education in FOBT screening because it helps the patient understand the reason for, and benefits of, cancer screening, as well as the existence of barriers and ways to overcome them. This knowledge helps patients follow through with screening. The education can be delivered by different members of the health care team, either in person and by telephone.[22] It is important that anyone providing FOBT/ FIT education be familiar with the kit and the stool collection process. Patient education has not only been shown to increase the kit return rate, but it also has been shown to improve the timeliness of the return.[23]

While lack of knowledge is a major barrier in FOBT/FIT screening, there are other barriers that can be addressed by navigation. Through patient assessment, the navigator can determine those issues that might interfere with kit completion. Often, something as simple as providing a self-addressed stamped envelope may increase returns. Navigators can develop a tracking system for kit return and, when patients do not return kits in the anticipated one- to two-week time period, staff can make follow-up phone calls to them, addressing barriers and answering questions, resulting in increased kit return rates.

FOBT/ FIT Navigation *(continued)*

Steps in FOBT education/navigation:

1. **Assessment of readiness for screening:** After educating patients about colorectal cancer, ask if they are interested in screening, and allow their answer to be "no." A "no" answer is indication that further patient education is needed prior to screening; that education can be addressed in future visits.
2. **Determine screening type:** Average-risk clients should be told the pros and cons and given a choice of screening type.
3. **The FOBT kit education:** Tell patients what an FOBT kit does (i.e., finds blood in stool that cannot be seen with the eye).
4. **Positive and negative results:** Explain that the presence of blood is called a positive test. A positive test does not mean they have cancer, but it will require a follow-up colonoscopy to determine the source of the blood. A negative result means no blood was found. If results are negative, they will need to return in one year for another FOBT screening. To be effective, FOBT must be completed annually.[24]
5. **Kit completion:** Before meeting with a patient, open a kit and read the instructions. Determine if there are any cases in which the instructions are confusing and whether patients are given suggestions for stool collection. If patients don't know what to do, they are less likely to complete the test.
6. **FOBT (as opposed to FIT):** If your office uses the high-sensitivity guaiac test instead of the FIT, patients will need to have multiple samples. Instruct patients that this should be from consecutive bowel movements, since this will increase the effectiveness of the test.
7. **Follow-up phone calls:** Develop a tracking system for kits given to patients. Follow up on unreturned tests with a phone call. This allows patients to ask questions and express concerns and will typically motivate them to finish the test.

100% FOBT Return Rate

Part of the mission of the Dearborn-based **Arab Community Center for Economic and Social Services** (ACCESS) is a public health initiative supporting Arab populations. ACCESS instituted FOBT screenings as part of its colorectal cancer campaign.

Navigator Hiam Hamade reports that ACCESS has a 100-percent return rate for this program and says patient education was an important part of achieving that rate, as was assessment of patients' readiness to test.

After providing patient education, Hamade only gives kits to those patients who are invested in completing the testing. When patients do not return their tests in a timely manner, she contacts them to determine if there is a need for follow-up education. To date, every kit she has handed out has been returned.[25]

DRE is not approved for Colorectal Cancer Screening

Studies show that stool samples obtained as a part of a digital rectal exam can miss up to 95 percent of adenomas and cancers. An in-office FOBT is not an appropriate screening test for colorectal cancer.[2]

Navigation for Colonoscopies

Decreased No-Shows

The Calhoun County Cancer Control Coalition (5Cs) is a collaborative organization based in Battle Creek. In 2009, it instituted a free colonoscopy program to provide screening opportunities to the under-insured and uninsured in Calhoun County.

The key to the success of the 2012 Free Colonoscopy program was the addition of patient navigation. The patient navigator performed patient education, assessed readiness for screening, worked with the physician office to share necessary information, taught appropriate preparation, called the patient one week before the procedure, and worked to confirm patient transportation.

In 2010, only 85 percent of the scheduled colonoscopies were completed; in 2011, only 80 percent were completed. In 2012, patient navigation brought the colonoscopy completion rate up to 98 percent.

"Practices need to understand that if they free up the money for a navigator position, it will pay for itself in higher colonoscopy completion rates," 5Cs coordinator Jenny Rogers says.[27]

Colonoscopy presents some unique barriers for patients, including an uncomfortable preparation process, time off work, and the need for an escort, who may also have to take time off work. The nature of the test itself can create feelings of embarrassment or fear.[6] Navigators can supplement provider education and can help calm fears and reduce anxiety.[26] With colonoscopy, patient navigation includes education on the colonoscopy procedure and preparation for the procedure, as well as reviewing insurance and transportation issues.

Navigation can reduce no-show rates and improve colonoscopy quality via improved bowel preparation.[26] The combination of patient education and patient navigation has been demonstrated to increase patient knowledge of colonoscopy, decrease patient fear, and ultimately increase the number of patients who complete screening colonoscopies.[13]

Steps in Colonoscopy Education/Navigation

1. **Assess readiness for screening:** After providing education about colorectal cancer, ask patients if they are interested in screening. Allow the answer to be "no." A "no" indicates that further education is needed prior to screening — a need that can be met in future visits.
2. **Determine screening type:** Average-risk clients should be informed of the pros and cons of each test and given the choice of screening type. Colonoscopy is the only screening recommended for those who are at an increased or high risk for colorectal cancer.
3. **Educate about colonoscopy procedure:** Prepare patients for what will happen. For example: "You will be given medication that will relax you and make you sleepy. The procedure will last 30 to 60 minutes, and you will sleep through it. The medications will leave you sleepy, which is why you will need someone to drive you home. During the colonoscopy, a small flexible tube will be inserted into the rectum and up through the colon. The tube has a tiny camera that allows the physician to see the colon. If a growth is found, it usually is removed at that time."

Navigation for Colonoscopies *(continued)*

Knowing what to expect decreases anxiety, so ask patients if they have any questions. Unasked questions may lead to fear or failure to show for the procedure.

4. **Barrier reduction:** In colonoscopy, financial barriers can be an issue, whether or not patients have insurance. Underinsured patients often see the cost of colonoscopy as cost prohibitive, and even the cost of preparation medications can be a barrier for some patients. Transportation may be an issue, as patients are not able to drive themselves home after a procedure, and most facilities require they be discharged to a responsible adult. By talking to patients about the barriers they face, problems can be identified and, where possible, resolved.
5. **Bowel preparation instructions:** Since bowel preparation is the key to a successful colonoscopy, patients need specific education about this. Navigators can help patients understand that all stool must be removed from the colon in order for the doctor to see any polyps that might be present; this education should be done both in writing and verbally. Tell patients that on the day before the test, they should not eat solid food or milk products. They need to understand that hydration is important, since fluids work with the medications in cleaning out the colon. Patients can be given ideas for approved fluids, but should be cautioned about items with red or purple dye. Patients should be forewarned that they will need to use the bathroom frequently. A review of these instructions should be done at least twice: once when the appointment is set and again just prior to the procedure.
6. **Reminder calls:** Reminder calls can serve multiple purposes. While reviewing preparation instructions and discussing barriers, navigators can assess the patient's intent to follow through on the procedure by asking:
    - Does the patient know where to go?
    - Does the patient have a transportation plan?
    - Do they have preparation and hydration supplies?
    - Are there any other concerns that might prevent them from completing the procedure?

Being the Patient can be Difficult

District Health Department #4 provides navigation for colonoscopies as a part of the MCRCEDP.

Navigator Karol Kain says it's important to remember that being a patient can be difficult: Patients may not know what door of the hospital to use, or they may not be able to afford the expensive preparation, but they might feel it is inappropriate to tell the physician. She has found that patients appreciate knowing that there is someone to call when they have a little bit of fear or have a question. As navigator, she can call the physician and ask for a less expensive preparation option or for a free sample, enabling low-income patients to follow through on colonoscopies without having to choose between medication, food or gas.

Kain has developed a tracking sheet for each of her patients. She calls them two weeks before their procedures to ensure that they have their prep kit and understand what to do. She also calls them two days before the procedure to make sure they are on track and to answer any final questions they might have.

Reminder Systems

Client Reminder Cards

HealthPlus of Michigan is a health and wellness organization providing customized, nationally recognized health plans. It employs more than 400 full- and part-time staff.

In 2012, HealthPlus sent client reminder cards to employees eligible for colorectal cancer screening. Eligibility was determined by those who did not meet 2012 HEDIS measures. This included men and women ages 50-75 who had not received one or more of the following screenings: FOBT or FIT (yearly); flexible sigmoidoscopy (every five years); colonoscopy (every 10 years). Those who had colorectal cancer or a total colectomy were excluded.

In total, 94 people were identified and sent the intervention. Within six months, employee screening rates improved 15 percent.[32]

Reminder systems are an evidence-based intervention shown to improve colorectal cancer screening rates for eligible patients. They can be implemented in a variety of ways, do not need to be complex to be effective, and can be used directly with patients, as well as in medical offices to prompt physicians to refer patients for screening.[29]

Patient Reminders

There is strong evidence to support the effectiveness of patient reminder systems in increasing colorectal cancer screening rates. Patient reminders can come in many forms: letters, postcards, e-mails, and phone calls,[30] all of which can be used to inform patients that they are due (or overdue) for a colorectal cancer screening.

Patient reminders can be general for mass appeal or customized to appeal to a specific patient population. Culturally appropriate, customized reminders are most effective in increasing colorectal cancer screening by FOBT. Patient reminders for increasing other methods of colorectal cancer screening, such as colonoscopies and sigmoidoscopy, also have been found to be effective.[30]

According to the Community Preventive Services Task Force, reminders can be most effective when they are paired with another intervention, such as: printed or telephoned reminders; additional text or discussions about why screening is important and how barriers can be overcome; and assistance in scheduling appointments.

Provider Reminders

Providers play an important role in ensuring that patients are screened for cancer. The Community Preventive Services Task Force recommends provider reminder systems, based upon strong evidence of their effectiveness in increasing colorectal cancer screening by FOBT. There are many types of provider reminder and recall systems. A reminder system signals the provider and his or her staff that the patient is due for a colon cancer screening, and a recall informs the physician that the screening is overdue.[31]

Reminder Systems *(continued)*

Reminders and recalls can be implemented in several different ways. The following techniques are from *A Primary Care Clinician's Evidence-Based Toolbox and Guide*.[29]

Chart prompts: Problem lists, screening schedules, summaries, and electronic reminders serve as visual reminders for the physician and medical staff. Office charts can be prepared with these types of prompts included. Electronic medical records can more easily incorporate chart prompts and track a patient's medical record.

Audits and feedback: Chart reviews can be time consuming. However, collecting colorectal cancer screening information is not difficult and can be used to increase the quality of care in the practice. Measuring the rate of colorectal cancer screenings successfully completed within the office's relevant patient population through chart audits is an effective way of viewing how well the office refers patients for colorectal cancer screenings. By reviewing these audits regularly and giving feedback to staff, the office can implement quality improvement measures to reach its screening target.

Ticklers and logs: A tickler file is a series of file folders, usually one for each month of the year, but sometimes, one for days of the month, as well. Copies of referrals for services and labs are placed in the folders. When results or reports arrive, the copy is pulled from the tickler file, the patient is notified of the results by phone or mail, and a follow-up appointment is scheduled, if necessary. The results are then placed in the patient's chart. Tickler files also provide a way to track patients who are not following up in the way recommended by the provider.

Staff assignments: Reminder systems also can include changes in staff assignments so staff can encourage screening and/or initiate the screening process. This multidisciplinary approach can help to increase screening rates by utilizing staff in different ways. Staff can be encouraged to speak to the patient regarding screening and send information to the patient prior to the office visit so patients already are informed about screening when they arrive to talk with the provider.[29]

Celebrate Your 50th with a Colonoscopy

The Inter-Tribal Council of Michigan, Office of Health Education and Chronic Disease, has instituted a colorectal cancer prevention and control program aimed at increasing colon cancer screening rates among tribal communities in Michigan.

A unique aspect of this program is the fact that providers send birthday cards to patients celebrating their 50th birthdays. The cards acknowledge not only the birthday, but the patient's good health, and it encourages him or her to seek colorectal cancer screening.

The Inter-Tribal Council also has facilitated implementation of provider reminder systems, including electronic medical record systems. The provider reminder systems are tailored to each office, based upon the resources of that office.[33]

Reminder systems can significantly increase colorectal cancer screening within a health practice. Consider the many evidenced-based interventions available for implementation in your practice.

Conclusion

Navigation works because it puts the focus on the patient and facilitates resolution of the issues experienced by patients. To be effective, navigators need to have time to identify and solve barriers. A navigation intervention can be big or small. Provider's offices can begin with increased patient education or the institution of client reminders.

Customize Your Own Educational Materials

MIYO (Make It Your Own) is a Web-based system providing tools for the creation of customized, culturally appropriate colorectal education materials that can be targeted to a specific population without having to develop them from scratch.

This free resource has evidence-based messages and hundreds of photos that can be used to create posters, client reminder cards, and other forms of small media.

Images and messages represent different racial and ethnic groups and can be created in English or Spanish. The products can be personalized with your logo, and creations can be saved for future revisions. With product creation free, printing is the only cost of these materials.

More information about MIYO is available on page 13.

Steps in starting a navigation program

- **Establish a champion:** Identify the person who will do the research and determine the possibilities and the resources available in your system.
- **Complete a needs assessment:** The goal of the needs assessment is to identify strengths and weaknesses in directing clients toward colorectal cancer screening. Take an honest look at patient education, barrier reduction, and screening reminders. Where do you excel? Where could you make some changes? Where are you missing patients? What are the reasons given for "no-shows?" How are patients doing with their colonoscopy preparation? What are your current client screening rates? Are you offering screening options?
- **Analyze navigation tasks:** Given your patient population, what changes can you make to your practice to address the needs you have identified? For example, when Grand River Gastroenterology identified that transportation issues contributed to a large number of no-shows each year, the practice found a way to address the barrier, and thus, save money. What resources are available in your office or your community to address identified needs? Can your staff be trained to address patient education on screening?
- **Develop intervention(s):** Choose your intervention(s), and develop a plan for implementation. Are you implementing this with existing staff? How are work responsibilities being adjusted? What steps need to be put into place for implementation?
- **Initiate your program.**
- **Evaluate your program's effectiveness:** Use the data gathered in your needs assessment to determine the effectiveness of your program. Has there been an increase in screening rates? Has your no-show rate dropped? Are colon preparations better overall? Have you improved communication with other providers?

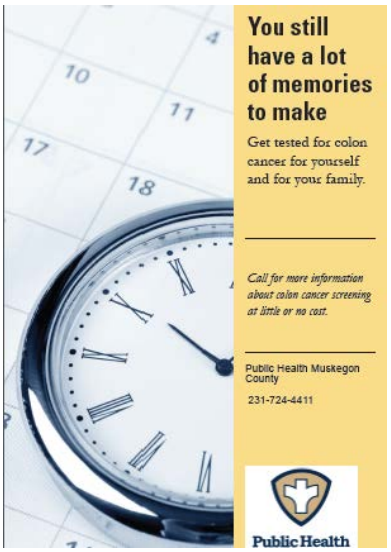
For assistance starting a navigation program, contact the Michigan Cancer Consortium at 877-588-6224 (toll-free).

More Information

The following online resources provide additional details about developing your own navigation system to increase your colorectal cancer screening rates.

1. **How to Increase Preventive Screening Rates in Practice: An Action Plan for Implementing a Primary Care Clinician's Evidence-Based Toolbox and Guide**
   www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-029276.pdf
   - ► Condensed guide with action-oriented assistance to help providers improve their practice's colorectal cancer screening rates
2. **How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's Evidence-Based Toolbox and Guide, 2008**
   www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf
   - ► More detailed version of the previous resource
3. **Clinician's Reference: Fecal Occult Blood Testing (FOBT) for Colorectal Cancer Screening**
   www.nccrt.org/wp-content/uploads/FOBTCliniciansReferenceFinal.pdf
   - ► Information about guaiac-based FOBT and FIT
4. **Colonoscopy Patient Navigation: A Resource Kit to Help You Get Started**
   www.nyc.gov/html/doh/downloads/pdf/cancer/colon-patient-toolkit.pdf
   - ► Toolkit designed to assist in the development of a colonoscopy patient navigation program
5. **A Practical Guide to Increasing Screening Colonoscopy**
   www.nyc.gov/html/doh/downloads/pdf/cancer/cancer-colonoscopy-guide.pdf
6. **The Community Guide — Cancer Prevention & Control**
   www.thecommunityguide.org/cancer/index.html
   - ► Summary of evidence related to interventions for increasing cancer screening, as well as links to research-tested programs
7. **Colorectal Cancer Facts and Figures, 2011-2013**
   www.cancer.org/acs/groups/content/@epidemiologysurveillance/documents/document/acspc-028323.pdf
   - ► Information about colorectal cancer risk factors and table designed for doctor/patient conversations regarding screening test type

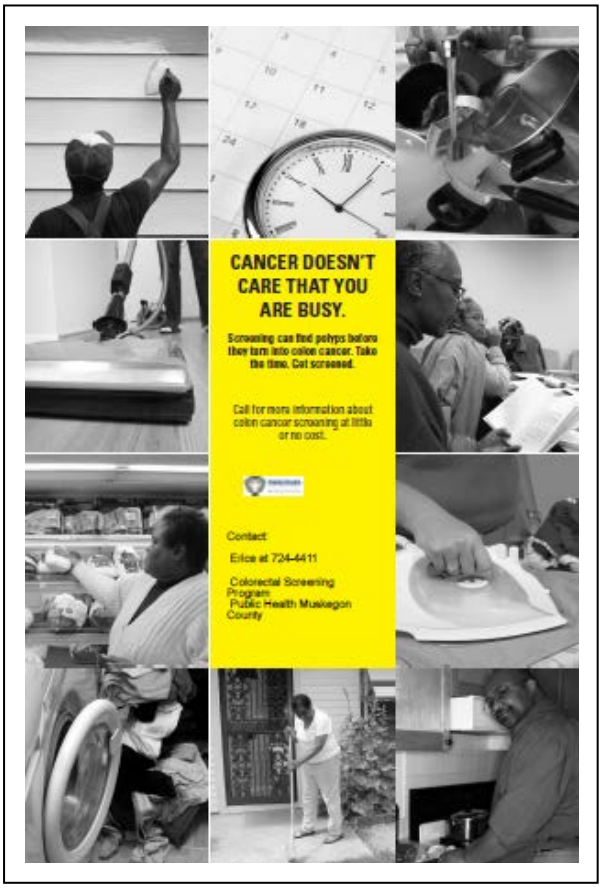
Using MIYO to Create Your Materials



1. Create an account by visiting http://miyo.gwb.wustl.edu/newuser.php?project=103. (You will use www.miyoworks.org for future visits to MIYO.)
2. Review the document choices and the changeable aspects of each.
3. Select the document that most closely matches your needs and add it to your personal collection.
4. Open your copy and make it your own. Although each document is different, with most, you can:
   - select pictures to match your audience;
   - select stories to match your intended message;
   - add slogans and program-specific messages; and
   - attach a logo or unique image to brand the document.
5. Once you've made all of your selections, click to create your document, and then download a PDF to review and print.

References

1. American Cancer Society. (2012) Cancer Facts & Figures, 2012. (Atlanta: American Cancer Society.)
2. American Cancer Society. (2011) Colorectal Cancer Facts & Figures, 2011-2013. (Atlanta: American Cancer Society.)
3. Fussman C. (2011) 2010 Michigan BRFSS Cancer Tables. (Lansing, MI: Michigan Department of Community Health Division of Genomics, Perinatal Health, and Chronic Disease Epidemiology, Surveillance and Program Evaluation Section, Chronic Disease Epidemiology Unit.)
4. Wells K, Battaglia T, Dudley D, et al. (2008) Patient Navigation: State of the Art or Is it Science? *Cancer;* 113(8): 1999-2010.
5. Freeman H. (2006) Patient Navigation: A Community-Centered Approach to Reducing Cancer Mortality. *J Cancer Educ;* 121(Supplement): S11-14.
6. Lasser K, Avanian J, Fletcher R, & Good M. (2008) Barriers to Colorectal Cancer Screening in Community Health Centers: A Qualitative Study. *BMC Fam Pract;* 9:15.
7. Lasser K, Murillo J, Medlin E, et al. (2009) A Multilevel Intervention to Promote Colorectal Cancer Screening Among Community Health Center Patients: Results of a Pilot Study. *BMC Fam Pract;* 10:37.
8. Lee JK, Reis V, Liu S, et al. (2009) Improving Fecal Occult Blood Testing Compliance Using a Mailed Education Reminder. *J Gen Intern Med;* 24(11): 1192-1197.
9. New York City Health. Colonoscopy Patient Navigation: A Resource Kit to Help You Get Started. Available at www.nyc.gov/html/doh/downloads/pdf/cancer/colon-patient-toolkit.pdf. Accessed November 14, 2012.
10. Nestell C, Carlton L, Kortz L, & Gribbon T. (2012) Transportation Navigation: Improving Colonoscopy Completion Rates. Poster presented at 2012 Dialogue for Action on Colorectal Cancer Screening.
11. US Preventative Services Task Force. (2009) Screening for Colorectal Cancer. Available at www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm. Accessed January 30, 2013.
12. American Cancer Society. (2012) American Cancer Society Guidelines for the Early Detection of Cancer. Available at www.cancer.org/healthy/findcancerearly/cancerscreeningguidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer. Accessed January 30, 2013.
13. National Comprehensive Cancer Network. (2012) NCCN Clinical Practice Guidelines in Oncology: Colorectal Cancer Screening (Version 2.2012). Available at www.NCCN.org. Accessed January 30, 2012.
14. Fussman C. (2011) Health Risk Behaviors in the State of Michigan: 2010 Behavioral Risk Factor Survey. 24th Annual Report. (Lansing, MI: Michigan Department of Community Health, Division of Genomics, Perinatal



Health, and Chronic Disease Epidemiology, Surveillance and Program Evaluation Section, Chronic Disease Epidemiology Unit.)
15. National Colorectal Cancer Roundtable. (2011) How to Increase Preventive Screening Rates in Practice: An Action Plan for Implementing a Primary Care Clinician's Evidence-Based Toolbox and Guide. Available at www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-029276.pdf. Accessed January 10, 2013.
16. Rex D, Johnson D, Anderson J, et al. (2009) American College of Gastroenterology Guidelines for Colorectal Cancer Screening, 2008. *Am f Gastroenterol;* 104: 739-750.
17. Medline Plus. (2012) Health Literacy. Available at www.nlm.nih.gov/medlineplus/healthliteracy.html. Accessed February 8, 2013.
18. Colon Cancer Alliance. (2011) Colonoscopy Perceptions Survey Summary. Available at www.ccalliance.org/pdf/ColonoscopyPerceptionsSurvey-ReportSummary.pdf. Accessed February 8, 2013.
19. Schmidt J. (2013) Saint Joseph Mercy Health System, Ann Arbor, MI.
20. Michigan Department of Community Health, 2011.
21. Olmstead M. (2013) Muskegon County Health Department, Muskegon, MI.
22. Guide to Community Preventive Services. Increasing Cancer Screening: One-on-One Education. Available at www.thecommunityguide.org/cancer/screening/client-oriented/OneOnOneEducation.html. Accessed February 15, 2013.
23. Stokamer C, Tenner C, Chaudhuri J, et al. (2005) Randomized Controlled Trial of the Impact of Intensive Patient Education on Compliance with Fecal Occult Blood Testing. *J Gen Intern Med;* 20: 278-282.
24. Nash D, Azeez S, Wlahov D, & Schori M. (2006) Evaluation of an Intervention to Increase Screening Colonoscopy in an Urban Public Hospital Setting. *J Urban Health;* 83(2): 231-243.
25. Hamade H. (2013) Arab Community Center for Economic and Social Services, Dearborn, MI.
26. Chen L, Santos S, Jandorf L, et al. (2008) A Program to Enhance Completion of Screening Colonoscopy Among Urban Minorities. *Clin Gastroenterol Hepatol;* 6(4): 443-450.
27. Rogers J. Calhoun County Cancer Control Coalition, Battle Creek, MI.
28. Kain K. District Health Department #4, Alpena, MI.
29. Sarfaty M. (2008) How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's Evidence-Based Toolbox and Guide, 2008. (Atlanta, GA: American Cancer Society.)
30. Guide to Community Preventive Services. Increasing Cancer Screening: Client Reminders. Available at www.thecommunityguide.org/cancer/screening/client-oriented/reminders.html. Accessed February 15, 2013.
31. Guide to Community Preventive Services. Increasing Cancer Screening: Provider Reminder and Recall Systems. www.thecommunityguide.org/cancer/screening/provider-oriented/reminders.html. Accessed February 15, 2013.
32. McFall A. Michigan Department of Community Health, Lansing, MI.
33. Pingatore N. Intertribal Council of Michigan, Sault Saint Marie, MI.

Suggested citation: Webster D, Notier A. Colorectal Cancer Navigation: Increasing Colorectal Cancer Screening Rates in Michigan, Lansing, MI: Michigan Department of Community Health, Chronic Disease Division, Cancer Prevention and Control Section, March 2013.

Michigan Department of Community Health
Cancer Prevention and Control Section
Washington Square Building, 5th Floor
109 Michigan Ave.
Lansing, MI 48913

March 2013

This publication was supported in part by funding from the Centers for Disease Control and Prevention (CDC) Cooperative Agreement # 5U58DP002022. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.