
# GUAM CANCER TOOLKIT:
# COLORECTAL CANCER

## OCTOBER 2018

Presented by:
The Guam Comprehensive Cancer Control Coalition in partnership with the American Cancer Society, Department of Public Health and Social Services (Guam Breast and Cervical Cancer Early Detection Program, Guam Comprehensive Cancer Control Program), Guam Regional Medical City, Guam Cancer Care, and University of Guam Cancer Research Center

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#ConquerCancer
Guam Cancer Coalition

## Introduction

Non-communicable diseases such as heart disease, cancer, diabetes and stroke have been the top leading killers in Guam for many decades. In 2014, it accounted for more than 56% of all deaths in Guam.

Accordingly, cancer continues to be the second leading cause of death in Guam in 2014 making it one of the most formidable health burdens in our community. On average, 1 Guamanian is diagnosed with cancer each day, while 1 Guamanian dies of cancer every 2.5 days.

According to the Guam Cancer Facts and Figures 2008 to 2012, 10.6% of all cancer deaths in Guam were due to cancer of the colon and rectum thus ranking colorectal cancer as the third leading cause among all cancer deaths. Moreover, between 2008 to 2012, colorectal cancer incidence has remained high at 10.0%, ranking fourth among all new cancer cases being diagnosed on island.

Furthermore, the Guam Cancer Facts and Figures 2008- 2012 states that unlike incidence rates of other cancer types, it appears that colorectal cancer is uniformly distributed across ethnic groups. However, the death rate of colorectal cancer is twice as high in Chamorros as compared to Filipinos.

It is also important to note that although Guam has the infrastructure to provide cancer screening services, colorectal cancer screening rates reflect poor utilization of these services. In 2012, only 42.6% of adults 50 and over ever had a sigmoidoscopy or colonoscopy in Guam compared to the nationwide rate of 67.3%. In an initial BRFSS analysis it appears that there is a high rate of Guamanians across all ethnicities who are 50 years and over who never had a sigmodioscopy or colonoscopy. This is also similar to fecal occult blood test rates where only 7.7% of adults aged 50 and over have had a blood stool test within the past two years compared to the nationwide rate of 14.2%.

Realizing the need to re-focus its priorities on colorectal cancer prevention and control, the Guam Comprehensive Cancer Control Coalition joined hundreds of organization that signed the nationwide 80% by 2018 pledge in January 2015. The pledge calls for the increase of colorectal cancer screening rates to 80% by 2018. The movement is supported by the National Colorectal Cancer Roundtable, American Cancer Society, and the Centers for Disease Control and Prevention.

In September 2015, the American Cancer Society in Guam convened a stakeholder's meeting where a draft strategic plan was developed. Stakeholders and partners identified the following 5 priority areas:

**CRC Stakeholder Meeting 5 Priority Areas:**

**Patient:**

1. Address the "butt" issue; increase community education.

**Provider:**

2. Education: Get all providers and nurses on the same page about screening tests and intervals.
3. Screenings: Have providers start with less invasive tests.

**Systems:**

4. Identify systems and protocol changes needed to improve workflow and quality improvement.
5. Provide incentives at all levels.

As the draft Colorectal Cancer Strategic Plan 2015 - 2017 was put in place, the Guam Comprehensive Cancer Control Coalition (Guam Cancer Coalition) prioritized the implementation of activities and tasks identified in the plan.

The Colorectal Cancer Prevention and Control Toolkit was developed by the Guam Cancer Coalition as a means to support community partners and stakeholders in providing evidence-based strategies to improve colorectal cancer screening rates by enhancing and strengthening health care organizations' systems and clinical practices. This is a priority task identified in the plan.

Through these efforts, the Guam Cancer Coalition aims to work with providers to strengthen their particular systems by reducing duplication of efforts, synergizing strategies, and maximizing the use of limited funding with the objective of increasing Guam's colorectal cancer screening rates, and meeting the 80% by 2018 challenge.

## Objectives

- Understand the impact of colorectal cancer in Guam thru current data of incidence and mortality
- Increase the percentage of adults aged 50 and over who have ever had a sigmoidoscopy or colonoscopy
- Know the importance of early detection and recommendations for colorectal cancer screening
- Learn and understand the U.S. Preventive Services Task Force screening guidelines and American Cancer Society's colorectal cancer screening strategies and toolkit

Hospitals and clinics use standardized minimum screening guidelines:

- Strengthen Health Systems
- Improve Standards of Care
- Strengthen Health Systems

This publication was supported by the Cooperative Agreement Number 6 NU58DP006269-01-02 from the U.S. Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Centers for Disease Control and Prevention.


## Shared Goal: Reaching 80% for Colorectal Cancer By 2018

**Background**

Colorectal cancer is a major public health problem. It is the second leading cause of cancer death, and a cause of considerable suffering among more than 140,000 adults diagnosed with colorectal cancer each year. However, colorectal cancer can be detected early at a curable stage, and it can be prevented through the detection and removal of precancerous polyps.

**Commitment**

Our organizations stand united in the belief that we can eliminate colorectal cancer as a major public health problem. We have screening technologies that work, the national capacity to apply these technologies, and effective local models for delivering the continuum of care in a more organized fashion. Equal access to care is everyone's responsibility. We share a commitment to eliminating disparities in access to care. As such, our organizations will work to empower communities, patients, providers, community health centers and health systems to embrace these models and develop the partnerships needed to deliver coordinated, quality colorectal cancer screening and follow up care that engages the patient and empowers them to complete needed care from screening through treatment and long-term follow-up.

**Pledge**

The **Guam Comprehensive Cancer Control Coalition** is embracing the shared goal of reaching 80% screened for colorectal cancer by 2018.

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# Guam Comprehensive Cancer Control Coalition

## (Guam Cancer Coalition)

#CONQUER CANCER
GUAM CANCER COALITION

## Vision

The vision of the Guam Comprehensive Cancer Control Coalition (Guam Cancer Coalition) is that the people of Guam will be cancer-free, embracing a healthy lifestyle and living in a healthy environment.

## Mission

The Guam Cancer Coalition has identified it as their mission to reduce cancer incidence and mortality on Guam through collaboration of public and private stakeholders.

## Goals

In the Guam Comprehensive Cancer Control Plan for 2018-2022, the Guam Cancer Coalition identified the following major goals:

- Prevent and reduce exposure to cancer risk factors.
- Detect all cancers at the earliest stage.
- Enhance the quality of life for cancer survivors.
- Improve the collec on and dissemina on of quality, cancer- related data for Guam.
- Promote a social and policy environment that is conducive to healthy lifestyles.

## Values

The Guam Cancer Coalition's work is guided by the following Core Values:

- Respect: We respect opinions, each other and value the unique perspective that each individual brings.
- Collaboration: We will work together, not against each other, for solutions.
- Innovation: We keep an open-mind for creative ways to solve problems.
- Impact: Our work will have positive impact on the community.
- Commitment: We are commited to evidenced-based Comprehensive Cancer Control that continually engages the community.
- Trust: We trust one another to act with integrity and in good faith.

# About Comprehensive Cancer Control

## What is Comprehensive Cancer Control (CCC)?

CCC is a collaborative process through which a community pools resources to reduce the burden of cancer that results in risk reduction, early detection, better treatment, and enhanced survivorship.

## CCC is based on the following principles:

- Scientific research guides decisions on which steps to take first.
- The full scope of cancer care is addressed, from prevention to early detection and treatment to end-of-life issues.
- Many people are involved, including doctors, public health personnel, non-profit organizations, insurance companies, businesses, cancer survivors, government agencies, colleges and universities, and advocates.
- Experts in many areas work together, including specialists in administration, basic and applied research, evaluation, health education, program development, public policy, public health surveillance, clinical services, and health communication.

The Guam CCC Program was funded through a grant from the U.S. Centers for Disease Control and Prevention from 2007– 2012. In 2012 and 2017, the program received a new five-year agreement to continue supporting the Guam Cancer Coalition. The Guam CCC Program is operated by the Department of Public Health and Social Services, and uses an "integrated and coordinated approach to reduce cancer incidence, morbidity, and mortality through prevention, early detection, treatment, rehabilitation, and palliation."

## Why is CCC planning important?

For more than a decade, cancer has been the second leading cause of death on Guam. The Guam Cancer Facts and Figures 2008-2012 reports that 1,904 people on Guam were diagnosed with cancer from 2008-2012, and 736 of Guam's people died of cancer within the same period. The burden of cancer on Guam is great, evidenced by the fact that Guam's people have some of the highest rates of particular cancers when compared to the U.S. and its Territories.

*Coalitions can tackle cross-cutting issues.*

A united front against cancer can tackle major issues—like better access to quality care, survivorship, health disparities, and quality of life— that are too broad and cross-cutting for any one organization to confront alone.

# About Comprehensive Cancer Control

### History of CCC in Guam and the Pacific:

- Mid-1990: The Pacific Basin Medical Association (PBMA) began to raise concerns for the increasing number of patients dying from cancer. At the same time, the Pacific Islands Health Officers Association (PIHOA), the regional health policy body for the United States Associated Pacific Island (USAPI) Jurisdictions, was developing a strategic plan which focused on chronic diseases.

- 1999: The U.S. President's Cancer Council was presented with testimony regarding cancer health disparities in the USAPI Jurisdictions, and in February 2001, both PBMA and PIHOA identified cancer as a priority and these issues were discussed numerous times at the Federal level.

- 2002: The National Cancer Institute's Center to Reduce Cancer Health Disparities and the National Institutes of Health's National Center on Minority Health Disparities provided financial resources in response to Pacific advocates' requests.

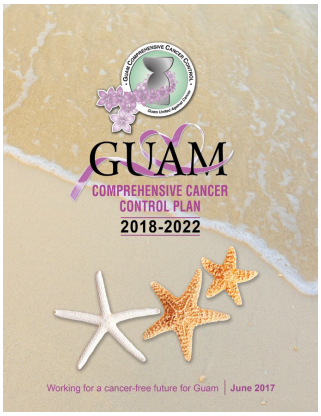
- 2003: A cancer needs assessment was conducted in Guam by the University of Hawaii Department of Family Medicine and Community Health, identifying cancer as the second leading cause of death in Guam.

- 2004: The University of Hawaii received a National Comprehensive Cancer Control planning grant on behalf of five of the six USAPI Jurisdictions, including Guam, funded by the U.S. Centers for Disease Control and Prevention, Division of Cancer Prevention and Control.

- 2005: The American Cancer Society-Guam Field Office led the CCC planning efforts on Guam, with its primary purpose of developing a CCC Plan.

- 2007-2012: The Department of Public Health & Social Services (DPHSS) received funding from the Centers for Disease Control and Prevention (CDC) to implement the Guam Cancer Plan, led by the Guam Cancer Coalition. This grant provided funding to carry out activities identified in the Cancer Plan over a five-year period. Accomplishments in the past five years include, but are not limited to: Guam Cancer Facts and Figures, 2003-2017; Guam Cancer Passport: A Guide to Survivorship and Care; brochures on Colon Cancer, Nasopharyngeal Cancer and Guam Cancer Registry; advocated for policy change such as the tobacco tax increase; and finalized the Guam Comprehensive Cancer Control Plan 2013-2017.

- 2013-2017: DPHSS received another five-year funding from CDC to implement the Guam Cancer Plan. Accomplishments in the past five years include, but are not limited to: Guam Cancer Facts and Figures booklet and infographic brochure, 2008-2012; Hope Project video; advocated for policy change such as the smokeless tobacco tax increase and raising the minimum age for purchasing tobacco products and e-cigarettes from 18 to 21 years old.




- 2018-present: The Guam Cancer Coalition finalized the Guam Comprehensive Cancer Control Plan 2018-2022. Each of the Coalition's Action Teams are currently implementing priority strategies and activities to meet the objectives identified in the plan.

# About Comprehensive Cancer Control

## Who developed Guam's CCC Plan?

The Guam Cancer Coalition members, comprised of representatives from key public, private, and non-profit stakeholders in the cancer network on Guam, such as the American Cancer Society, Guam Cancer Care, Guam Cancer Registry, Department of Public Health & Social Services, the University of Guam, cancer survivors and caregivers, and various medical organizations developed the Guam CCC Plan.

The 2018-2022 Guam Comprehensive Cancer Control Plan addresses the cancer continuum, inclusive of Prevention; Screening, Early Detection & Treatment; Survivorship & Quality of Life; Data & Research; and Policy & Advocacy.

## The Guam Cancer Coalition is structured to support the implementation of the Cancer Plan. Committees and Action Teams include:

- **Steering Committee** — the governing (advisory and decision-making) body of the Guam Cancer Coalition which approves the Guiding Principles under which the Guam Cancer Coalition operates to accomplish its mission.

- **Action Teams:**
  - **Prevention** — Prevent and reduce exposure to cancer risk factors.
  - **Screening, Early Detection & Treatment** — Detect all cancers at the earliest stage.
  - **Survivorship & Quality of Life** — Enhance quality of life for cancer survivors.
  - **Data & Research** — Improve the collection and dissemination of quality, cancer-related data for Guam.
  - **Policy & Advocacy** — Promote social and policy environment conducive to living healthy lifestyles.

## How can I get involved?

The success of the Guam Cancer Coalition and the implementation of the Cancer Plan depend on the commitment and involvement of a broad spectrum of organizations and partners who are willing to share their expertise, resources and experiences with one another.

Whether you are interested in serving on a committee, action team, or just want to participate in CCC activities on occasion, we welcome your participation.

## Is the Guam Cancer Coalition different from the Non-Communicable Disease (NCD) Consortium?

The Guam Cancer Coalition and the NCD Consortium are different organizations.

The Guam Cancer Coalition implements the Guam Comprehensive Cancer Control Plan and works to respond to cancer-specific issues in the island. The NCD Consortium implements the Guam Non Communicable Disease Strategic Plan.

## Guam Cancer Coalition Membership Guidelines

The Guam Cancer Coalition is broad-based, inclusive and open to all individuals, Community Based Organizations (CBOs), Departments and Agencies that are committed to reducing the burden of cancer in Guam and whose mission(s) are not in conflict with the Guam Cancer Coalition priorities. Applicants who are less than eighteen (18) years of age should have the consent of their parent or legal guardian. Membership is based on the following membership guidelines:

1. The completion and submission of the Guam Cancer Coalition Membership Application to the Department of Public Health and Social Services, Guam Comprehensive Cancer Control Program.
2. Willingness to endorse and support the implementation of Guam Cancer Coalition guiding principles.
3. Make an effort to recruit new member(s) to participate in the Guam Cancer Coalition.
4. Coordinate and collaborate within their organizations or within multiple organizations to implement strategies that address Guam Cancer Coalition guiding principles.
5. Share information (to include data) during meeting(s) about members' progress and accomplishments.
6. Each member (individuals, CBO, Department and Agencies) shall designate a representative and an alternate, both of whom are encouraged to attend coalition meetings.
7. Share ideas, information, recommendations, and engage in active discussion of issues.
8. Share ideas, information, recommendations for reviewing and revising the Cancer Plan.
9. Coalition members maintain the right to resign their membership at any time.
10. Members who cannot be physically present at the meetings may still participate via teleconferencing and be counted as present if and when teleconferencing services are made available.
11. Steering committee members are required to be present at least twice a year during the general Guam Cancer Coalition meetings.

Upon receipt, review, and approval of the application, you will receive a copy of the Guam Comprehensive Cancer Control Plan, information on the next scheduled Committee or Action Team meeting relevant to your membership request. You will also be added to the coalition email list where you will be sent updates, reminders and information regarding the coalition.

# Guam Comprehensive Cancer Control Coalition
# MEMBERSHIP APPLICATION

The Guam Comprehensive Cancer Control Coalition (Cancer Coalition) is a diverse group of public and private sector stakeholders and individuals whose collaborative work identifies methods to reduce the burden of cancer and eliminate gaps in cancer services in Guam. The success of the Cancer Coalition and the implementation of the Guam Comprehensive Cancer Control Plan depend on the commitment and involvement of a broad spectrum of organizations and partners who are willing to share their expertise, resources and experiences with one another. As a member of the Cancer Coalition, you will:

- be involved with developing, enhancing, and supporting cancer programs and services;
- be able to advocate for and support cancer survivors and their families; and
- be able to network with others in the community that shares a strong interest in cancer and access cancer-related resources and information.

**WE INVITE YOU TO JOIN US AS WE WORK TO REDUCE THE BURDEN OF CANCER IN GUAM.**

First Name Middle Initial Last Name

Mr. / Ms. / Dr. _____

_____

Mailing Address

_____

Phone Number (1) Phone Number (2) Fax Number

_____

Email Address

_____

I represent: (Please check all that apply)

☐ Individual (I am not part of an organization. I am interested in joining as an individual/citizen.)

☐ Government ☐ National ☐ Territory / State / Local

☐ Non-Government ☐ For Profit ☐ Non-Profit

☐ Other ☐ Describe

If Government / Non-Government / Other:

Name of Organization:_____

Name:_____

Your Position Title:_____

☐ I am a cancer survivor. ☐ I am a caregiver. (Optional)

Yes, my organization / I would:

☐ like to participate in Guam's cancer control efforts

☐ like to participate in Guam's cancer control efforts on an as needed basis

☐ like to be informed of Guam's cancer control efforts via email or mail

My / my organization's area of interest(s) is:

☐ Prevention

☐ Screening, Early Detection, & Treatment

☐ Policy & Advocacy

☐ Survivorship & Quality of Life

☐ Data & Research

How did you learn about the Coalition:

☐ Colleagues

☐ Friends

☐ Cancer Survivor

☐ Media

☐ Others (Specify)_____

If you belong to an organization/program, please tell us about it. What are its goals and who is the audience?

_____

_____


# Colorectal Cancer Data

#CONQUER CANCER
Guam Cancer Coalition

## Top 5 Cancer Incidence and Mortality, Guam 2008-2012

| Cancer site | Incidence | % of total cancer incidence |
|---|---|---|
| 1. Breast (female) | 292 | 15.3% |
| 2. Lung & bronchus | 281 | 14.8% |
| 3. Prostate | 201 | 10.6% |
| 4. Colon, rectum & anus | 190 | 10.0% |
| 5. Cervix | 130 | 6.8% |

| Cancer site | Mortality | % of total cancer mortality |
|---|---|---|
| 1. Lung & bronchus | 213 | 28.9% |
| 2. Liver | 81 | 11.0% |
| 3. Colon & rectum | 78 | 10.6% |
| 4. Prostate | 40 | 5.4% |
| 5. Breast (female) | 37 | 5.0% |

*Source: David et al., Guam Cancer Facts & Figures 2008-2012, 2015.*

## Overall Colorectal Cancer Rates, Guam 2008-2012

| | Incidence Rate | Mortality Rate |
|---|---|---|
| Crude | 23.8 | 9.8 |
| Age-adjusted* | 33.7 | 14.4 |
| Total U.S. | 42.8 | 15.7 |

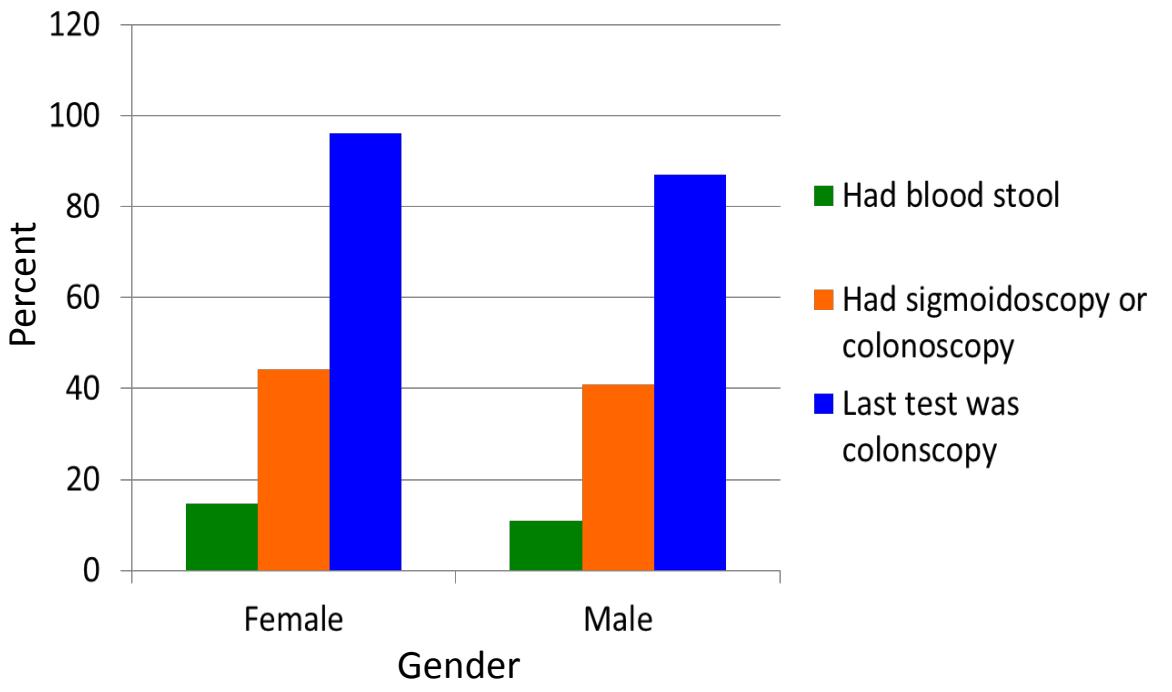
| Gender-Specific Colorectal Cancer | | |
|---|---|---|
| | Incidence Rate* | Mortality Rate* |
| Female | 24.1 | 8.4 |
| Male | 41.8 | 19.4 |
| Overall | 33.7 | 14.4 |

| Race/Ethnic-Specific Colorectal Cancer | |
|---|---|
| | Mortality Rate* |
| Chamorro | 20.8 |
| Filipino | 10.8 |
| Micronesian | --- |
| Asian | --- |
| Caucasian | --- |
| U.S. Total | 15.7 |

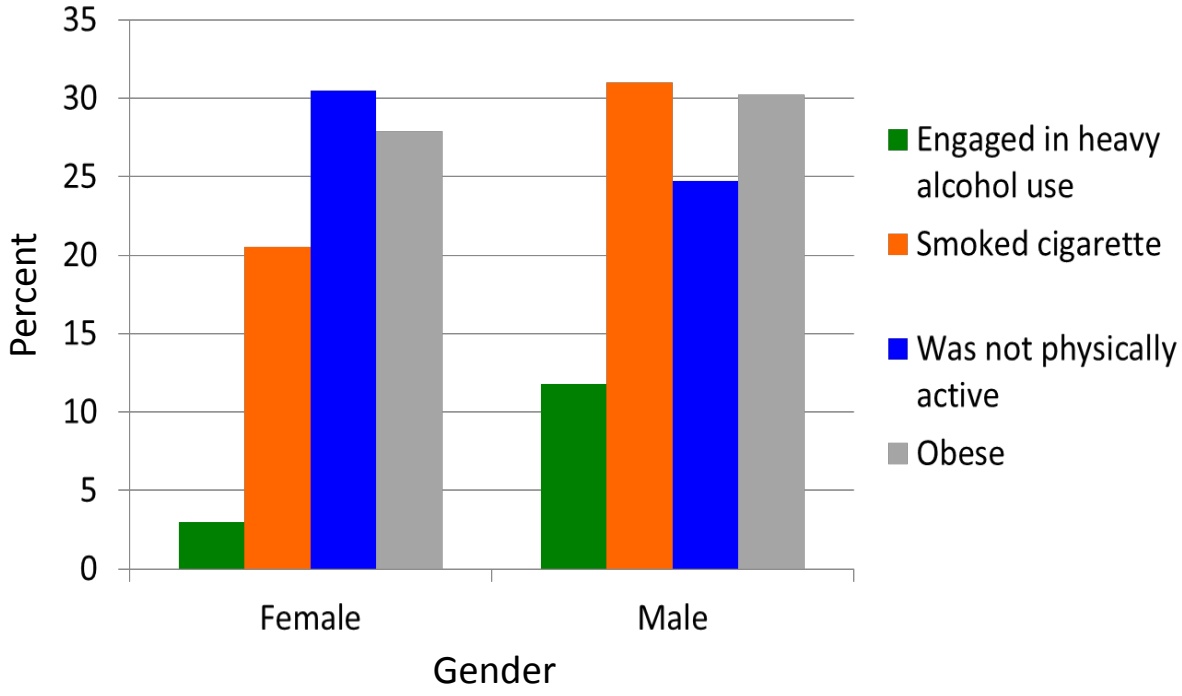
*Age-adjusted to the 2000 U.S. Standard Population. Per 100,000 people.
--- Rate suppressed, <5 cases

*Source: David et al., Guam Cancer Facts & Figures 2008-2012, 2015.*

## Gender-Specific Colorectal Cancer Screening, Guam 2012

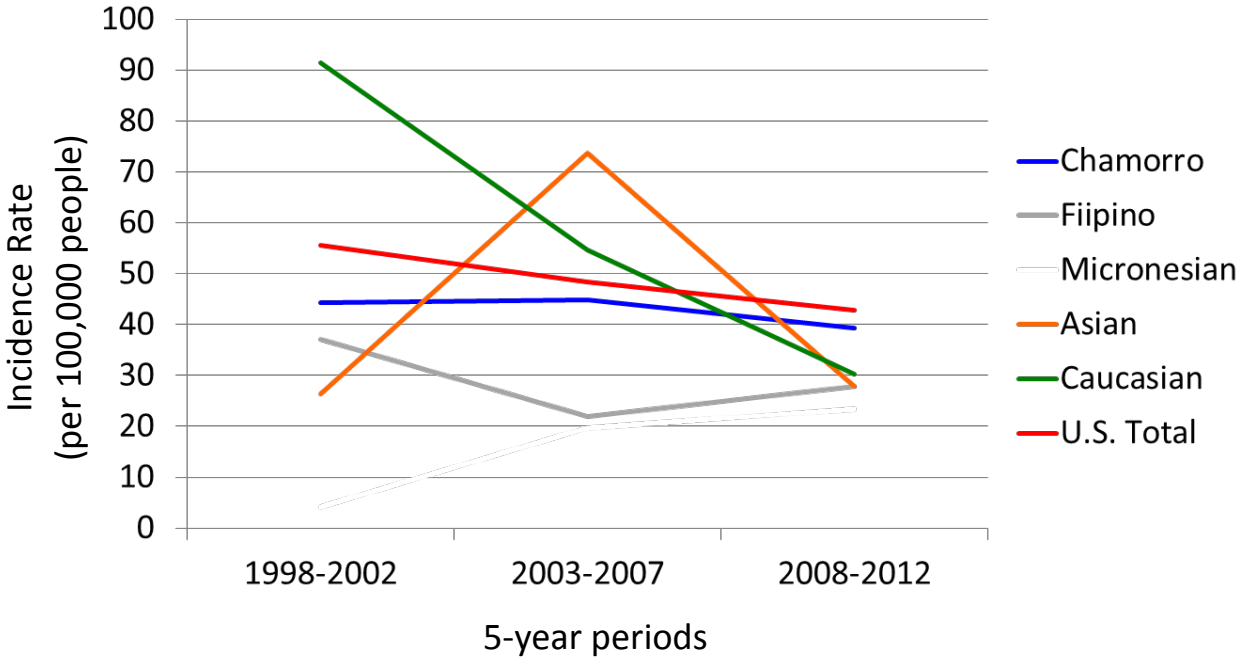



## Gender-Specific Colorectal Cancer Risk Factors, Guam 2012




*Source: Guam Behavioral Risk Factor Surveillance System, 2016.*

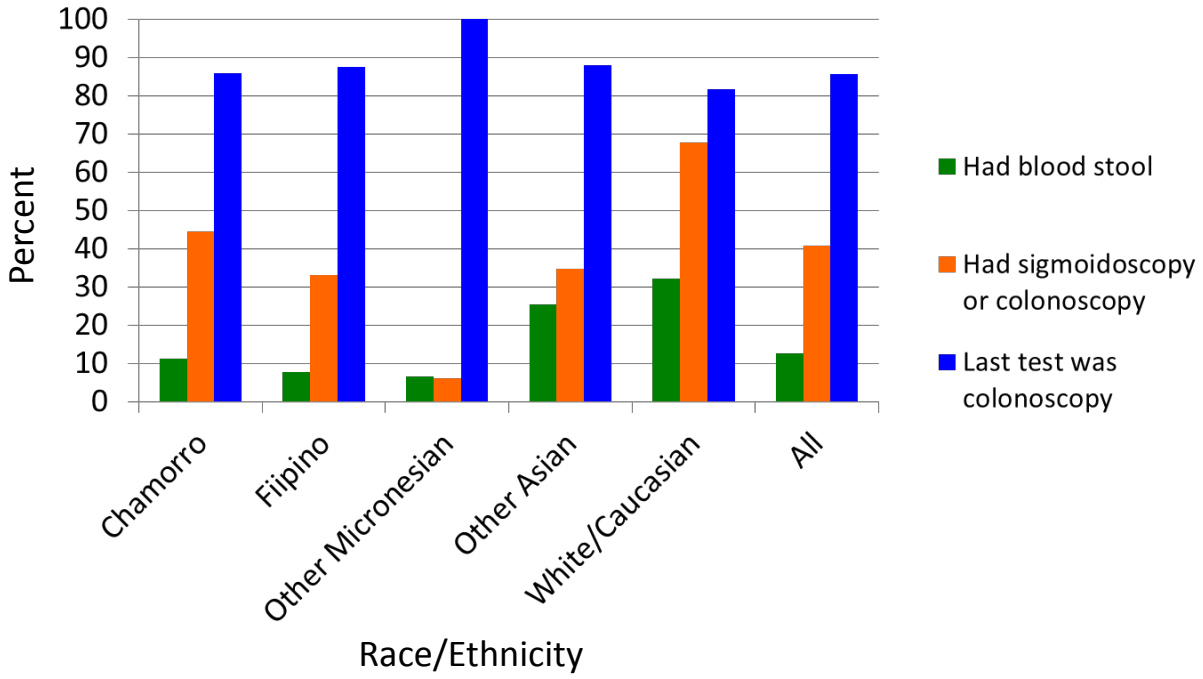
## Race/Ethnic-Specific Colorectal Cancer Average Incidence Rates*, By 5-Year Periods, Guam




*Age-adjusted to the 2000 U.S. Standard Population.

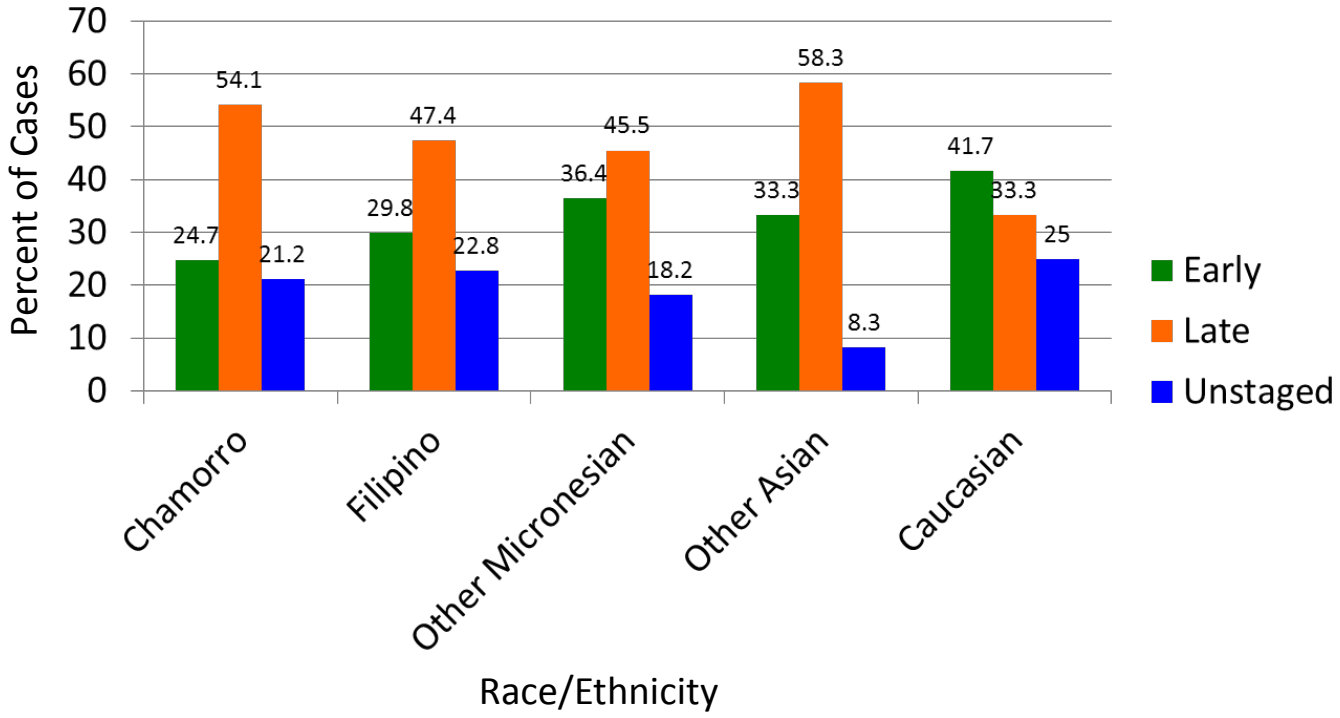
*Source: David et al., 2015 Guam Cancer Facts & Figures 2008-2012.*

## Race/Ethnic-Specific Colorectal Cancer Screening, Guam 2012




*Source: Guam Behavioral Risk Factor Surveillance System, 2016.*

## Stage of Colorectal Cancer Diagnosis, By Rate/Ethnicity, Guam 2008-2012




Early = localized. Late = regional and distant.

*Source: Guam Cancer Registry, 2016.*

### Key Points

- Colorectal cancer incidence – Guam (33.7) lower than U.S. (42.8)
  - Males almost 2x females
  - Lower than U.S. in all race/ethnicities
  - Highest in Chamorro, lowest in Micronesian Groups

- Colorectal cancer mortality – Guam (14.4) lower than U.S. (15.7)
  - Males almost 2x females
  - Chamorros (20.8) almost 2x Filipinos (10.8)
  - Chamorros higher than U.S.

- Colorectal cancer screening
  - Highest in White/Caucasian (67.9%); <50% in remaining race/ethnicities
  - Colonoscopy most common

- Colorectal cancer risk factors
  - Gender disparity for alcohol and smoking – higher in males
  - Smoking in Chamorros at least 2x other race/ethnicities

- Colorectal cancer staging
  - More late stage than early stage for all race/ethnicities, except Caucasian

## Colorectal Cancer Screening (%), Adults 50 Years and Older, US, 2013

| | FOBT* | Endoscopy† | Combined FOBT/ Endoscopy‡ |
|---|---|---|---|
| **Overall** | **7.8** | **55.9** | **58.6** |
| **Gender** | | | |
| Males | 7.8 | 56.1 | 58.8 |
| Females | 7.7 | 55.8 | 58.6 |
| **Age (years)** | | | |
| 50-64 | 6.8 | 50.4 | 53.1 |
| 65+ | 8.8 | 62.3 | 65.1 |
| **Race/Ethnicity§** | | | |
| White | 7.4 | 58.0 | 60.5 |
| Black | 8.5 | 56.5 | 59.4 |
| Hispanic | 8.4 | 41.5 | 44.9 |
| American Indian / Alaska Native | ** | 47.9 | 49.3 |
| Asian | 10.9 | 48.6 | 53.2 |
| **Education** | | | |
| Some high school or less | 6.8 | 40.0 | 43.1 |
| High school diploma or GED | 7.3 | 52.6 | 55.2 |
| Some college/Assoc. degree | 8.6 | 58.0 | 60.7 |
| College graduate | 7.9 | 65.4 | 68.0 |
| **Sexual Orientation** | | | |
| Gay/Lesbian | 10.7 | 69.4 | 73.8 |
| Straight | 7.8 | 55.8 | 58.5 |
| Bisexual | ** | ** | ** |
| **Insurance Status¶** | | | |
| Uninsured | 3.9 | 20.6 | 23.3 |
| Insured | 7.1 | 54.5 | 57.2 |
| **Immigration Status** | | | |
| Born in US | 7.8 | 57.7 | 60.4 |
| Born in US territory# | 11.1 | 49.4 | 55.0 |
| In US fewer than 10 years | ** | 17.3 | 20.2 |
| In US 10+ years | 7.7 | 47.2 | 50.4 |

FOBT-fecal occult blood test. GED-General Educational Development high school equivalency. *Within the past year. †A sigmoidoscopy within the past five years OR a colonoscopy within the past 10 years. ‡Either a FOBT within the past year, sigmoidoscopy within the past five years, or a colonoscopy within the past 10 years. §Estimates for white, black, American Indian/Alaska Native, and Asian are among non-Hispanics. Estimate for Asians does not include Native Hawaiians or other Pacific Islanders. ¶Among persons 50-64 years of age. #Have been in the US for any length of time. **Estimate not provided due to instability. Note: The colorectal cancer screening prevalence estimates do not distinguish between examinations for screening and diagnosis. The 2013 estimates for endoscopy and combined FOBT/endoscopy are not comparable to estimates from 2008 and prior because of changes in questions assessing endoscopy use. Estimates are age adjusted to the 2000 US standard population, see Statistical Notes (p. 36) for further information.

Source: Centers for Disease Control and Prevention. National Health Interview Survey, 2013. Public use data file. See Survey Sources (p. 38) for complete citation and more information.

American Cancer Society, Surveillance Research, 2016

## Colorectal Cancer Screening (%), Adults 50 Years and Older, US, 2014

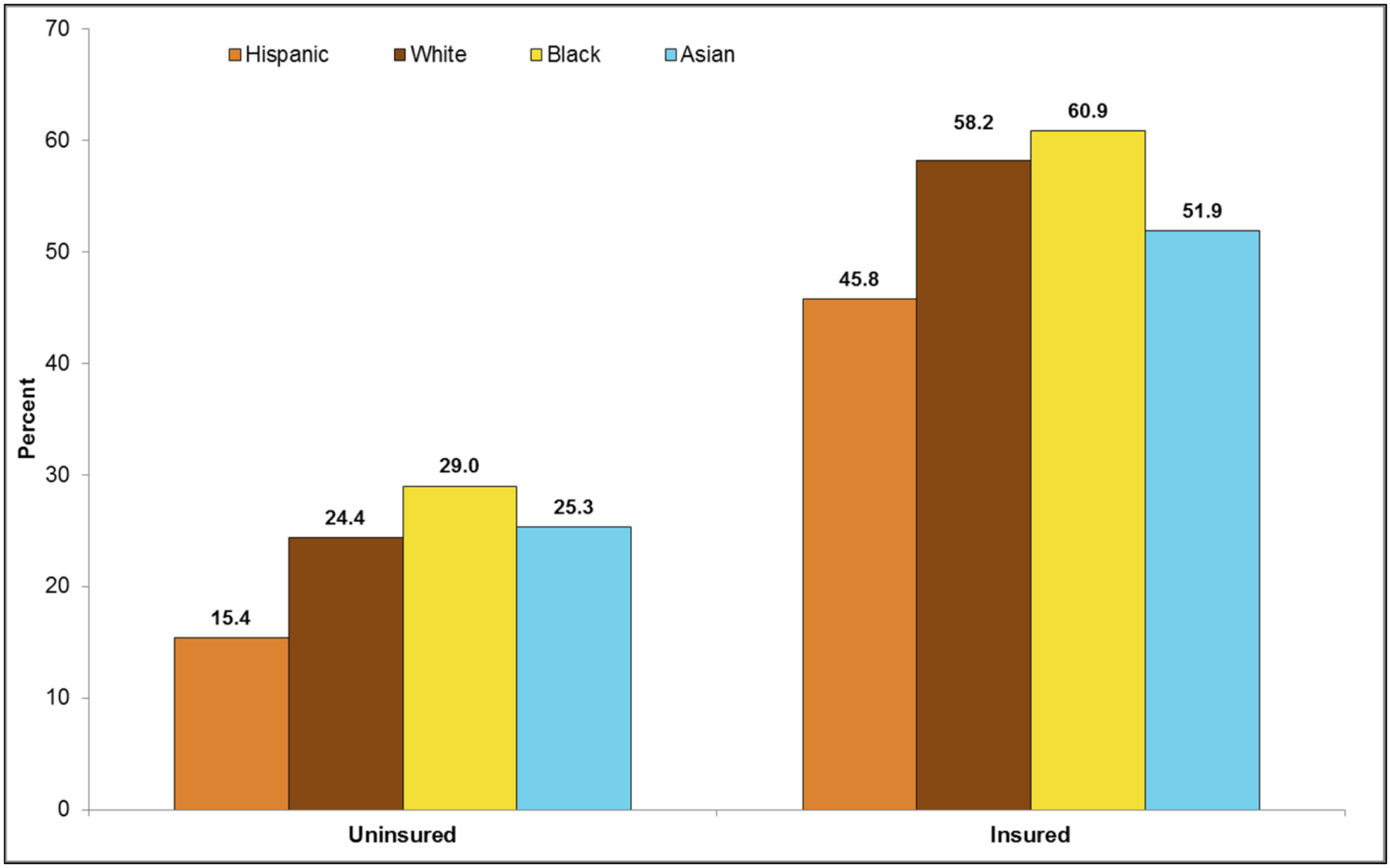
| | FOBT* | Endoscopy† | Combined FOBT/Endoscopy‡ | | | | |
|---|---|---|---|---|---|---|---|
| | 50 years and older | 50 years and older | 50 years and older | 50 to 64 years | 65 years and older | No usual source of medical care§ | No health insurance¶ |
| **United States (median)** | **8.2** | **63.9** | **67.6** | **60.8** | **76.1** | **34.6** | **28.7** |
| *Range* | *3.0-20.4* | *56.1-73.4* | *58.0-76.0* | *51.3-73.4* | *68.5-81.8* | *25.2-49.2* | *19.6-52.7* |
| Alabama | 7.7 | 63.6 | 65.9 | 58.0 | 76.9 | 28.4 | 19.7 |
| Alaska | 4.6 | 59.1 | 61.2 | 56.6 | 71.6 | 38.8 | 28.4 |
| Arizona | 10.7 | 61.9 | 65.6 | 57.1 | 75.9 | 36.9 | 27.1 |
| Arkansas | 7.2 | 59.5 | 62.1 | 55.3 | 70.5 | 25.3 | 23.4 |
| California | 20.4 | 61.0 | 68.6 | 60.7 | 80.1 | 31.6 | 26.7 |
| Colorado | 8.8 | 64.0 | 67.7 | 61.4 | 78.0 | 31.0 | 26.2 |
| Connecticut | 9.4 | 71.5 | 73.8 | 70.0 | 79.1 | 35.5 | 37.2 |
| Delaware | 5.9 | 71.9 | 73.2 | 67.0 | 81.7 | 43.7 | 49.0 |
| District of Columbia | 10.1 | 65.7 | 69.5 | 63.6 | 78.2 | 31.9 | # |
| Florida | 13.9 | 65.6 | 69.2 | 57.9 | 81.8 | 31.0 | 25.6 |
| Georgia | 10.7 | 65.1 | 67.6 | 60.8 | 78.2 | 36.9 | 26.8 |
| Hawaii | 17.4 | 60.2 | 69.3 | 65.5 | 74.1 | 37.3 | 37.9 |
| Idaho | 5.9 | 60.6 | 62.5 | 53.9 | 74.0 | 26.7 | 19.6 |
| Illinois | 6.7 | 60.3 | 62.5 | 57.2 | 70.3 | 29.8 | 27.9 |
| Indiana | 8.2 | 60.0 | 62.5 | 56.5 | 71.2 | 30.8 | 29.4 |
| Iowa | 7.0 | 66.0 | 68.2 | 63.2 | 74.8 | 35.9 | 26.9 |
| Kansas | 8.2 | 62.9 | 65.9 | 59.9 | 74.1 | 29.1 | 29.0 |
| Kentucky | 10.0 | 65.6 | 68.1 | 62.7 | 75.6 | 36.2 | 33.0 |
| Louisiana | 10.0 | 62.1 | 65.8 | 58.2 | 76.8 | 32.0 | 32.5 |
| Maine | 6.8 | 73.1 | 75.2 | 71.0 | 80.8 | 34.0 | 44.9 |
| Maryland | 11.5 | 69.3 | 72.1 | 65.9 | 81.5 | 49.2 | 44.1 |
| Massachusetts | 9.5 | 72.7 | 76.0 | 73.4 | 79.9 | 41.0 | 52.7 |
| Michigan | 9.0 | 69.9 | 72.1 | 66.0 | 80.8 | 38.2 | 35.1 |
| Minnesota | 5.8 | 69.4 | 71.7 | 67.6 | 78.0 | 46.3 | 41.6 |
| Mississippi | 11.5 | 58.8 | 62.0 | 54.6 | 72.4 | 34.0 | 28.5 |
| Missouri | 6.8 | 61.1 | 63.5 | 56.8 | 72.7 | 31.2 | 23.1 |
| Montana | 6.6 | 60.3 | 63.4 | 56.4 | 72.8 | 32.7 | 27.9 |
| Nebraska | 7.6 | 62.3 | 65.0 | 60.1 | 71.8 | 32.7 | 24.5 |
| Nevada | 12.1 | 56.4 | 61.6 | 51.6 | 75.6 | 29.2 | 22.5 |
| New Hampshire | 6.0 | 72.6 | 74.2 | 69.4 | 81.7 | 38.9 | 38.7 |
| New Jersey | 7.9 | 63.9 | 66.4 | 59.9 | 76.0 | 35.4 | 35.5 |
| New Mexico | 8.5 | 58.6 | 62.5 | 57.0 | 69.9 | 36.4 | 33.0 |
| New York | 8.8 | 66.7 | 69.4 | 64.0 | 77.0 | 28.8 | 36.8 |
| North Carolina | 11.4 | 68.5 | 71.8 | 66.6 | 78.8 | 30.0 | 33.4 |
| North Dakota | 6.9 | 60.7 | 63.6 | 56.8 | 73.1 | 35.5 | 20.9 |
| Ohio | 8.2 | 62.8 | 66.2 | 59.8 | 75.0 | 34.6 | 26.3 |
| Oklahoma | 8.6 | 56.3 | 59.4 | 51.5 | 70.3 | 25.2 | 20.0 |
| Oregon | 10.9 | 63.9 | 68.3 | 60.8 | 78.4 | 31.0 | 38.3 |
| Pennsylvania | 7.6 | 64.9 | 67.4 | 62.8 | 73.6 | 32.9 | 32.4 |
| Rhode Island | 8.7 | 73.4 | 75.5 | 71.6 | 80.9 | 32.6 | 47.9 |
| South Carolina | 7.9 | 66.5 | 69.0 | 61.4 | 78.8 | 36.0 | 25.4 |
| South Dakota | 7.7 | 64.6 | 67.5 | 62.2 | 74.7 | 44.4 | 33.5 |
| Tennessee | 9.2 | 63.5 | 66.6 | 59.1 | 76.6 | 34.6 | 20.6 |
| Texas | 8.5 | 59.3 | 62.7 | 55.8 | 73.4 | 29.2 | 23.0 |
| Utah | 3.0 | 70.0 | 70.7 | 65.5 | 78.5 | 42.3 | 24.6 |
| Vermont | 6.6 | 68.5 | 71.0 | 67.2 | 76.5 | 35.6 | 32.8 |
| Virginia | 7.7 | 67.8 | 70.0 | 65.9 | 76.1 | 37.9 | 38.0 |
| Washington | 10.9 | 65.8 | 70.1 | 65.5 | 76.9 | 38.6 | 24.7 |
| West Virginia | 10.7 | 61.7 | 65.4 | 59.3 | 73.1 | 38.4 | 34.2 |
| Wisconsin | 6.8 | 71.9 | 73.8 | 68.9 | 80.6 | 37.8 | 41.2 |
| Wyoming | 4.8 | 56.1 | 58.0 | 51.3 | 68.5 | 31.0 | 20.1 |

FOBT-fecal occult blood test. *Within the past year. †Sigmoidoscopy within the past five years or colonoscopy within the past 10 years. ‡A fecal occult blood test within the past year or sigmoidoscopy within the past five years or colonoscopy within the past 10 years. §Among persons ages 50 years and older with no personal doctor or health care provider. ¶Among persons 50-64 years of age. #Estimate not provided due to instability. Note: The colorectal cancer screening prevalence estimates do not distinguish between examinations for screening and diagnosis.

Source: Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System, 2014. Public use data file. See Survey Sources (p. 38) for complete citation and more information.

American Cancer Society, Surveillance Research, 2016

## Colorectal Cancer Screening*, Adults 50 to 64 by Race/Ethnicity† and Insurance Status, US, 2013




*Either a fecal occult blood test within the past year or sigmoidoscopy within the past 5 years or colonoscopy within the past 10 years. †Estimates for white, black, and Asian are among non-Hispanics. Note: The 2013 estimates for combined FOBT/endoscopy are not comparable to estimates from 2008 and prior because of changes in questions assessing endoscopy use. Percentages are age adjusted to the 2000 US standard population; see Statistical Notes (p. 36) for further information.

Source: Centers for Disease Control and Prevention. National Health Interview Survey, 2013. Public use data file. See Survey Sources (p. 38) for complete citation and more information.

American Cancer Society, Surveillance Research, 2016


# Colorectal Cancer 101

#CONQUER CANCER
Guam Cancer Coalition

# Colorectal Cancer

## Basic description

Colorectal cancer is the third most common cancer in both men and women and, when men and women are combined, the second most common cause of US cancer deaths. Early colorectal cancer usually has no symptoms. Warning signs typically occur with more advanced disease and may include rectal bleeding, blood in the stool, a change in bowel habits, or cramping pain in the lower abdomen.

## Opportunities

**Prevention** Even though the exact cause of most colorectal cancers isn't known, prevention and early detection are possible because most colon cancers develop from polyps. Early detection tests for colorectal cancer can help find polyps, which can be easily removed, thereby lowering a person's cancer risk. Risk may be further reduced by regular physical activity; getting to and staying at a healthy body weight; limiting intake of high saturated-fat foods – especially red meat and processed meats; not smoking; limiting alcohol intake; and eating plenty of fruits, vegetables, and whole-grain foods.

**Detection** Colorectal cancers are more successfully treated when detected early. Beginning at age 50, people at average risk with no symptoms should follow one of the testing options below:

### 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 guaiac-based fecal occult blood test (gFOBT)** or
- Yearly fecal immunochemical test (FIT)** or
- Stool DNA test (sDNA), every 3 years*

** If the test is positive, a colonoscopy should be done.*
*** Highly sensitive versions of these tests should be used with the take-home multiple sample method. A gFOBT or FIT done during a digital rectal exam in the provider's office is not adequate for screening.*

Visit www.cancer.org for details about our guidelines specifically for people at increased or high risk.

**Treatment** Surgery is the most common treatment for colorectal cancer, usually for cancer that has not spread. Chemotherapy or chemotherapy plus radiation is given before or after surgery for patients whose cancer has spread beyond the colon. Regular follow-up exams and blood tests may be recommended for patients who have been treated for colorectal cancer because if the cancer is going to recur, it tends to happen in the first 2 to 3 years after treatment.

## Who is at risk?

**Gender** Men and women are similarly affected.

**Age** More than 90% of colorectal cancers are diagnosed in people 50 and older.

American Cancer Society®

# Colorectal Cancer

**Racial/Ethnic background** African Americans have the highest rates of colorectal cancer of all racial and ethnic groups in the United States. Jews of Eastern European descent (Ashkenazi Jews) also have a higher rate of colon cancer.

**Other risk factors**

- Heredity – Fewer than 10% of colorectal cancers are caused by inherited gene mutations.
- Personal history of colorectal polyps, previously treated colorectal cancer, or inflammatory bowel disease
- Obesity
- Physical inactivity
- High-fat diets
- Smoking
- Alcohol use

### Colorectal cancer in the United States: 2016 estimates

- New cases: 134,490
  Colon: 95,270
  Rectum: 39,220
- Deaths per year: 49,190
- 5-year localized survival rate: 90%
- 5-year overall survival rate: 65%

## Quality-of-life issues

From the time of diagnosis, the quality of life for every person with cancer is affected in some way. They may be affected socially, psychologically, physically, and spiritually.

Concerns that patients most often express are fear of recurrence; chronic and/or acute pain; sexual problems; fatigue; guilt for delaying testing or treatment, or for doing things that may have caused the cancer; changes in physical appearance; depression; sleep difficulties; changes in what they are able to do after treatment; and the impact of cancer on finances and loved ones. People with colorectal cancer are often concerned about bowel dysfunction and the associated social stigma, as well as the effects of chemotherapy and radiation.

## Bottom line

Screening tests offer the most powerful opportunity to prevent colorectal cancer or detect the disease early. Although people cannot change their genetic makeup or family health history, most people can reduce their risk of colorectal cancer by following the American Cancer Society's testing guidelines; eating a healthy diet with an emphasis on plant-based foods; staying at a healthy weight; avoiding tobacco; limiting alcohol intake; and increasing their level of physical activity.

American Cancer Society®

cancer.org | 1.800.227.2345
1.866.228.4327 TTY

BBB ACCREDITED CHARITY
bbb.org/charity

Written January 2016

# 7 THINGS to KNOW ABOUT GETTING a COLONOSCOPY

**Colon cancer screening is important because it can prevent cancer or find it early when it is easier to treat. The American Cancer Society recommends colon cancer testing (there are several acceptable methods) for everyone starting at age 50, though some people with certain risk factors may need to start at a younger age. Colonoscopy is one of the most widely used tests because not only can it find colon cancers, it can also find polyps that can be removed before they turn into cancer. Knowing what to expect can take away some of the fear and anxiety of a colonoscopy and the preparation required for it, often called bowel prep. Here are 7 things to know before you go:**

## 1 WHAT IS A COLONOSCOPY?

A colonoscopy is an exam that lets a doctor closely look at the inside of the entire colon and rectum to find polyps or signs of cancer. Polyps are small growths that over time can become cancer. The doctor uses a flexible, hollow, lighted tube about the thickness of a finger that has a tiny video camera on the end. This tube, called a colonoscope, is gently eased inside the colon and sends pictures to a TV screen. Special instruments can be passed through the colonoscope to remove small polyps or take tissue samples if needed.

## 2 WHAT IS A BOWEL PREP?

Bowel prep is a process to clean out the colon as much as possible so the doctor can see the inside clearly and get good pictures. The prep may include eating a special diet, drinking up to a gallon of a liquid laxative, medicines, and sometimes enemas that make you go to the bathroom a lot. You may also be instructed to stop taking certain over-the-counter or prescription medications as long as a week before the test.

## 3 WHERE ARE COLONOSCOPIES DONE?

Colonoscopies may be done in a doctor's office, a hospital, a clinic, or a surgery center. The tests are typically done in a private room.

## 4 WHAT TO EXPECT

The colonoscopy itself takes about 30 minutes. Patients are usually given medicine to help them relax and sleep while it's done. If so, you will not be allowed to drive afterward, so someone you know must come with you and drive you home. You'll also have to plan to stay home the day of the test until the drugs wear off.

## 5 DOES IT HURT?

Most people don't feel pain during any of the tests, but may feel cramping or discomfort afterward because of air that was puffed into the colon during the test, to keep it open for the doctor to examine.

## 6 WHAT IF THEY FIND SOMETHING?

If a small polyp is found during a colonoscopy, your doctor will probably remove it during the test. If a polyp is too large to be removed, or if you have an abnormality that looks like cancer, the doctor will take a small piece of it out to check it for cancer or pre-cancer cells (a biopsy). The results of this tissue analysis will determine whether you need additional procedures or treatment.

## 7 HOW OFTEN IS A COLONOSCOPY NEEDED?

If nothing is found, you can go up to 10 years without another one. If something is found, you may need more frequent tests or treatment.

## COLORECTAL CANCER: CATCHING IT EARLY

American Cancer Society // Infographics // 2017

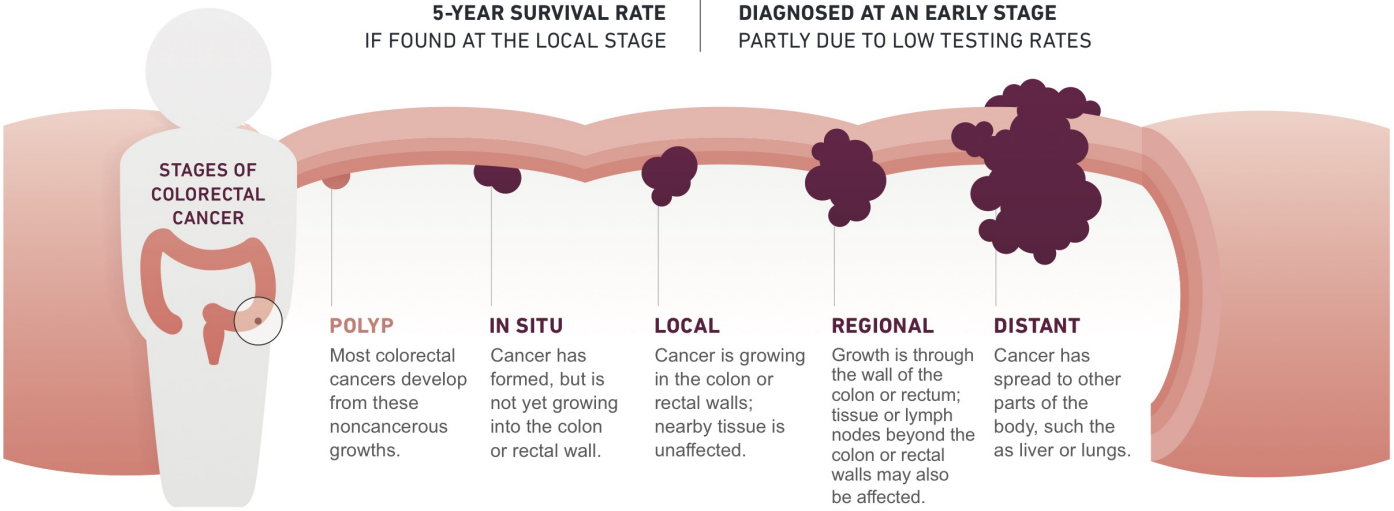
Colorectal cancer is the third most commonly diagnosed cancer in both men and women in the US. Routine testing can help prevent colorectal cancer or find it at an early stage, when it's smaller and easier to treat. If it's found early, the 5-year survival rate is 90%. Many more lives could be saved by understanding colorectal cancer risks, increasing screening rates, and making lifestyle changes.

**90%**

**5-YEAR SURVIVAL RATE**
IF FOUND AT THE LOCAL STAGE

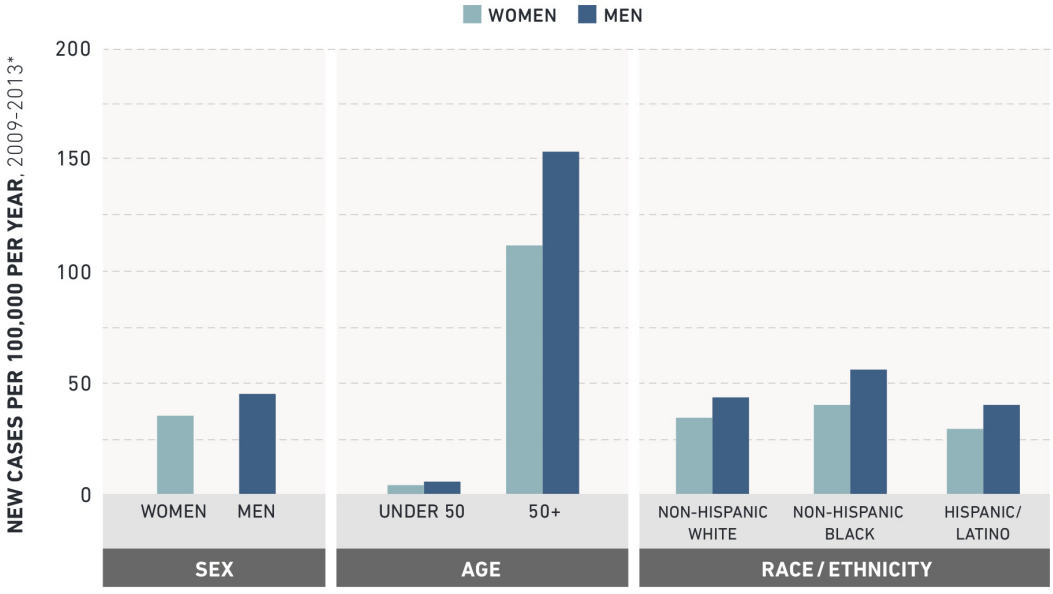
**39%**

**DIAGNOSED AT AN EARLY STAGE**
PARTLY DUE TO LOW TESTING RATES




## WHO GETS COLORECTAL CANCER?

ANYONE CAN GET COLORECTAL CANCER, BUT SOME PEOPLE ARE AT AN INCREASED RISK.




*Age adjusted to the 2000 US standard population
Data source: *Colorectal Cancer Facts & Figures 2017-2019*

## WHAT CAN YOU DO ABOUT IT?

REDUCE YOUR RISK BY MANAGING YOUR DIET, WEIGHT, AND PHYSICAL ACTIVITY, AND BY AVOIDING TOBACCO.

| | DIET | BODY MASS INDEX | ACTIVITY | LIFESTYLE |
|---|---|---|---|---|
| DO |   |  18–25 |  |  |
| LIMIT |  |  25+ A BMI of 25 or higher is considered overweight or obese. |  |  |

## IF YOU'RE 50 OR OLDER,* TALK TO YOUR DOCTOR ABOUT GETTING TESTED.

| TYPE OF SCREENING TEST | PROS | CONS |
|---|---|---|
| **VISUAL EXAMINATION TESTS** | | |
| **Flexible Sigmoidoscopy**<br>Slender tube inserted through the rectum into the colon. Provides visual exam of rectum and lower part of colon. | • Fairly quick<br>• Sedation usually not used<br>• Does not require a specialist<br>• Should be done every 5 years | • Doesn't view upper part of colon<br>• Can't see or remove all polyps<br>• Colonoscopy needed if abnormal |
| **Colonoscopy**<br>Direct exam of colon and rectum. Polyps removed if present. Required for abnormal results from other tests. | • Can usually view entire colorectum<br>• Can biopsy and remove polyps<br>• Done every 10 years | • Can be expensive<br>• Higher risk than other tests<br>• Full bowel preparation needed |
| **Double-contrast Barium Enema**<br>X-ray exam of colon. Barium sulfate is put in through the rectum and spreads throughout the colon. | • Can usually view entire colorectum<br>• Relatively safe<br>• No sedation needed<br>• Should be done every 5 years | • Can miss small polyps<br>• Can't remove polyps during test<br>• Full bowel preparation needed<br>• Colonoscopy needed if abnormal |
| **CT Colonography**<br>Detailed, cross-sectional, 2-D or 3-D views of the colon and rectum with an x-ray machine linked to a computer | • Fairly quick and safe<br>• Can usually view entire colorectum<br>• No sedation needed<br>• Should be done every 5 years | • Still fairly new test<br>• Can't remove polyps during test<br>• Full bowel preparation needed<br>• Colonoscopy needed if abnormal |
| **STOOL TESTS** | | |
| **Guaiac-based Fecal Occult Blood Test/ Fecal Immunochemical Test**<br>Can detect blood in stool caused by tumors or polyps. Health care provider gives patient at-home kit. | • No direct risk to the colorectum<br>• No bowel preparation<br>• Sampling done at home | • May miss some polyps/cancers<br>• Done every year<br>• Colonoscopy needed if abnormal |
| **Stool DNA Test**<br>Looks for certain DNA changes from cancer or polyps cells. Health care provider has kit sent to patient. | • No direct risk to the colorectum<br>• No bowel preparation<br>• Sampling done at home | • May miss some polyps/cancers<br>• Colonoscopy needed if abnormal |

*For average-risk individuals with no symptoms, testing should begin at age 50. If you are at increased risk or are experiencing symptoms, speak to your health care provider right away.
**Symptoms include:** Rectal bleeding, blood in the stool, dark- or black-colored stools, change in shape of stool, lower stomach cramping, unnecessary urge to have a bowel movement, prolonged constipation or diarrhea, and unintentional weight loss.

## A UNITED FORCE AGAINST CANCER

The American Cancer Society is global grassroots force of two million strong.
Our mission is to save lives, celebrate lives, and lead the fight for a world without cancer.

**Learn More** // cancer.org/colon
**Detect It Early** // cancer.org/colontesting
**Live Healthy** // cancer.org/nupa


# Colorectal Cancer Screening

## U.S. Preventive Services Task Force
## American Cancer Society

#CONQUER CANCER
Guam Cancer Coalition

## U.S. Preventive Services Task Force (USPSTF)

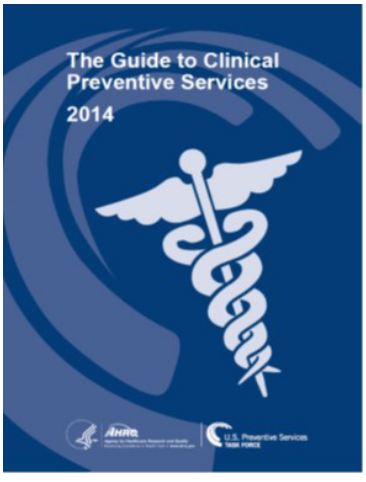
- The USPSTF is an independent panel of non-Federal experts in prevention and evidence-based medicine and is composed of primary care providers (such as internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and health behavior specialists).

- The USPSTF conducts scientific evidence reviews of a broad range of clinical preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health systems. These recommendations are published in the form of "Recommendation Statements."

### Tools for Using Recommendations in Primary Care Practice

- The work of the USPSTF has helped establish the importance of prevention in primary care. There are many tools and resources available to help you implement USPSTF recommendations into practice.

- To learn more detailed information about these tools and resources, visit http://www.uspreventiveservicestaskforce.org/tools.htm.



## Grade Definitions

The USPSTF updated its definitions of the grades it assigns to recommendations and not includes "suggestions for practice" associated with each grade. The USPSTF has also defined levels of certainty regarding net benefit.

| 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 selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small. | Offer or provide this service for selected patients depending on individual circumstances. |
| **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. |

## Levels of Certainty Regarding Net Benefit

| Level of Certainty | Description |
|---|---|
| **High** | The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies. |
| **Moderate** | The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as:<br><br>· The number, size, or quality of individual studies.<br>· Inconsistency of findings across individual studies.<br>· Limited generalizability of findings to routine primary care practice.<br>· Lack of coherence in the chain of evidence.<br><br>As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion. |
| **Low** | The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:<br><br>· The limited number or size of studies.<br>· Important flaws in study design or methods.<br>· Inconsistency of findings across individual studies.<br>· Gaps in the chain of evidence.<br>· Findings not generalizable to routine primary care practice.<br>· Lack of information on important health outcomes.<br><br>More information may allow estimation of effects on health outcomes. |

*The USPSTF defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

## Quality of Evidence

The USPSTF grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

- **Good:** Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

- **Fair:** Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

- **Poor:** Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

## Screening for Colorectal Cancer
## Clinical Summary of U.S. Preventive Services Task Force Recommendation

| Population | Adults age 50 to 75 years | Adults age 76 to 85 years | Adults older than 85 years |
|---|---|---|---|
| **Recommendation** | Screen with high sensitivity fecal occult blood testing (FOBT), sigmoidoscopy, or colonoscopy.<br>Grade: A | Do not automatically screen.<br>Grade: C | Do not screen.<br>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.<br>Grade: I (Insufficient Evidence) | | |

| | | |
|---|---|---|
| **Screening Tests** | High sensitivity FOBT, sigmoidoscopy with FOBT, and colonoscopy are effective in decreasing colorectal cancer mortality.<br>The risks and benefits of these screening methods vary.<br>Colonoscopy and flexible sigmoidoscopy (to a lesser degree) entail possible serious complications. | |
| **Screening Test Intervals** | Intervals for recommended screening strategies:<br>1. Annual screening with high-sensitivity fecal occult blood testing<br>2. Sigmoidoscopy every 5 years, with high-sensitivity fecal occult blood testing every 3 years<br>3. Screening colonoscopy every 10 years | |
| **Balance of Benefits and Harms** | The benefits of screening outweigh the potential harms for 50- to 75-year-olds. | 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. |
| **Implementation** | Focus on strategies that maximize the number of individuals who get screened.<br>Practice shared decision making; discussions with patients should incorporate information on test quality and availability.<br>Individuals with a personal history of cancer or adenomatous polyps are followed by a surveillance regimen, and screening guidelines are not applicable | |
| **Other Relevant USPSTF Recommendations** | 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.uspreventiveservicestaskforce.org. | |

## Health Care Solutions From the American Cancer Society

### How to increase Colon Cancer Screening Rates in Practice
### An Action Plan to Implement Four Essential Strategies for Clinicians*

*Includes family physicians, general internists, obstetrician-gynecologists, nurse practitioners, physician assistants, and their office managers

## Saving Lives through Cancer Screenings

As a clinicians, you know the importance of screenings in both preventing cancer and finding it early. However, it can be a challenge to encourage patients to get screened and to engage staff in the process. That's why it's so important to have a plan that implements practice changes to increase cancer screening rates.

On the pages that follow are a sustainable plan for your practice that is evidence-based and tools specific to colorectal cancer (CRC)

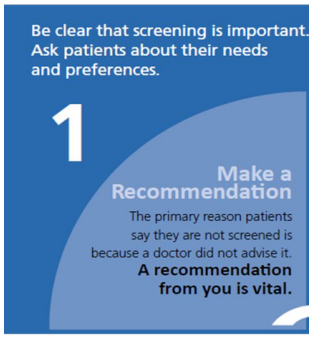
Benefits to your health system include:

- Patients are more motivated to get screened for cancer.
- Having free, easy-to-use tools saves staff time and reduce costs.
- Interventions are evidence-based and, when used consistently, can improve overall cancer screening rates.

For more information on the topics in this booklet, visit **cancer.org/colonmd or** call **1-800-227-2345**.

# Improve Cancer Screening Rates

## Using the Four Essential Strategies




## Essential #1
## Make a Recommendation

Evidence accumulated over two decades shows that a recommendation from a doctor is the most powerful factor in a patient's decision to get screened for cancer. Determine the screening messages you and your staff will share with patients. Explore how your practice will assess a patient's risk status and openness to screening, taking into consideration insurance coverage and individual preferences.

Assess the patient's risk status, discuss needs, and offer several test options to increase the likelihood that a patient will get screened. At a minimum, offer a choice between a high-sensitivity, multiple-sample stool blood test (FOBT or FIT) and a colonoscopy.

Take steps to identify and screen every age-appropriate patient. As shown below, start with patients who are easiest to reach and gradually incorporate groups that are less accessible:

- Patients who appear to regular checkups
- Patients who receive regular care for chronic conditions
- Patients who come in only when they have a problem
- 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 openness to screening.

**Tools for Your Practice**
To assess these tools, go to **cancer.org/screeningactionplan**.

**Screening Options and Patient Readiness**
- Understand CRC screening options: *Common Sense Cancer Screening, CRC Screening Guideline Tables*, and *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*

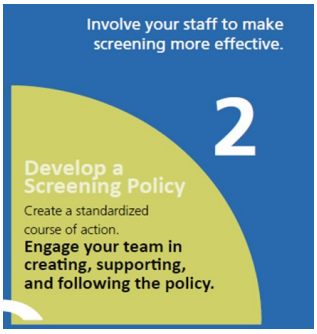
**Outreach to Underserved Populations**
- Use culturally and linguistically appropriate educational materials.

| Common Sense Colorectal Cancer Screening Recommendations at a Glance | | | |
|---|---|---|---|
| **Risk Category** | **Age at Begin Screening** | **Recommendations** | **Notes** |
| **Average Risk**[1]<br>No risk factors<br><br>No symptoms[2] | **≥ Age 50** | **Screen with any one of the following options:**<br>Tests That Find Polyps and Cancer[3]<br><br>✓ Flexible sigmoidoscopy q 5<br>✓ Colonoscopy q 10 yrs<br>✓ Double contrast barium enema q 5 yrs*<br>✓ Computed tomography colonography q 5 yrs*<br>OR<br>Tests That Primarily Find Cancer<br>✓ Guaiac-based fecal occult<br>✓ Blood test q 1 yr*,**<br>✓ Fecal immunochemical test q 1 yr*,**<br>✓ 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.<br>[2] Patients with symptoms merit an evaluation of their condition to precede screening.<br>[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.<br><br>*If the test is positive, a colonoscopy should be done.<br>**The multiple stool take-home test should be used. One test done by the doctor in the office is not adequate for testing.<br>***Interval uncertain. |

| Common Sense Colorectal Cancer Screening Recommendations at a Glance | | | |
|---|---|---|---|
| **Risk Category** | **Age at 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** | **Colonoscoply[5]** | [4]Patients with a personal history of CRC or adenomatous polyp require a surveillance plan not screening.<br>[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:<br>1) One should be a FDR of the other two.<br>2) At least two successive generations should be affected.<br>3) At least one cancer should be diagnosed before age 50.<br>4) Familial adenomatous polyposis should be excluded in the CRC case.<br>5) Tumors should be verified by pathological examination. |

| 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 adenomatous polyp | 2-to-3 fold increase |
| Two second-degree relatives with colon cancer | About a 2-to-3 fold increase |
| To first-degree relatives with colon cancer | 3-to-4 fold increase |
| First-degree relative with colorectal cancer diagnosed at < 50 years | 3-to-a 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.




## Essential #2
## Develop a Screening Policy

Create a standard course of action for screenings. Document it, and then 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
- 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). Academic evidence has shown that performing a single-sample stool blood test in the office is not best application of the test as it often fails to detect abnormalities.

Take steps to identify and screen every age-appropriate patient. 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 the necessary next steps before and after they leave your office to increase the likelihood that they will get screened.

**Tools for Your Practice**
To access these tools, go to **cancer.org/screeningactionplan**.

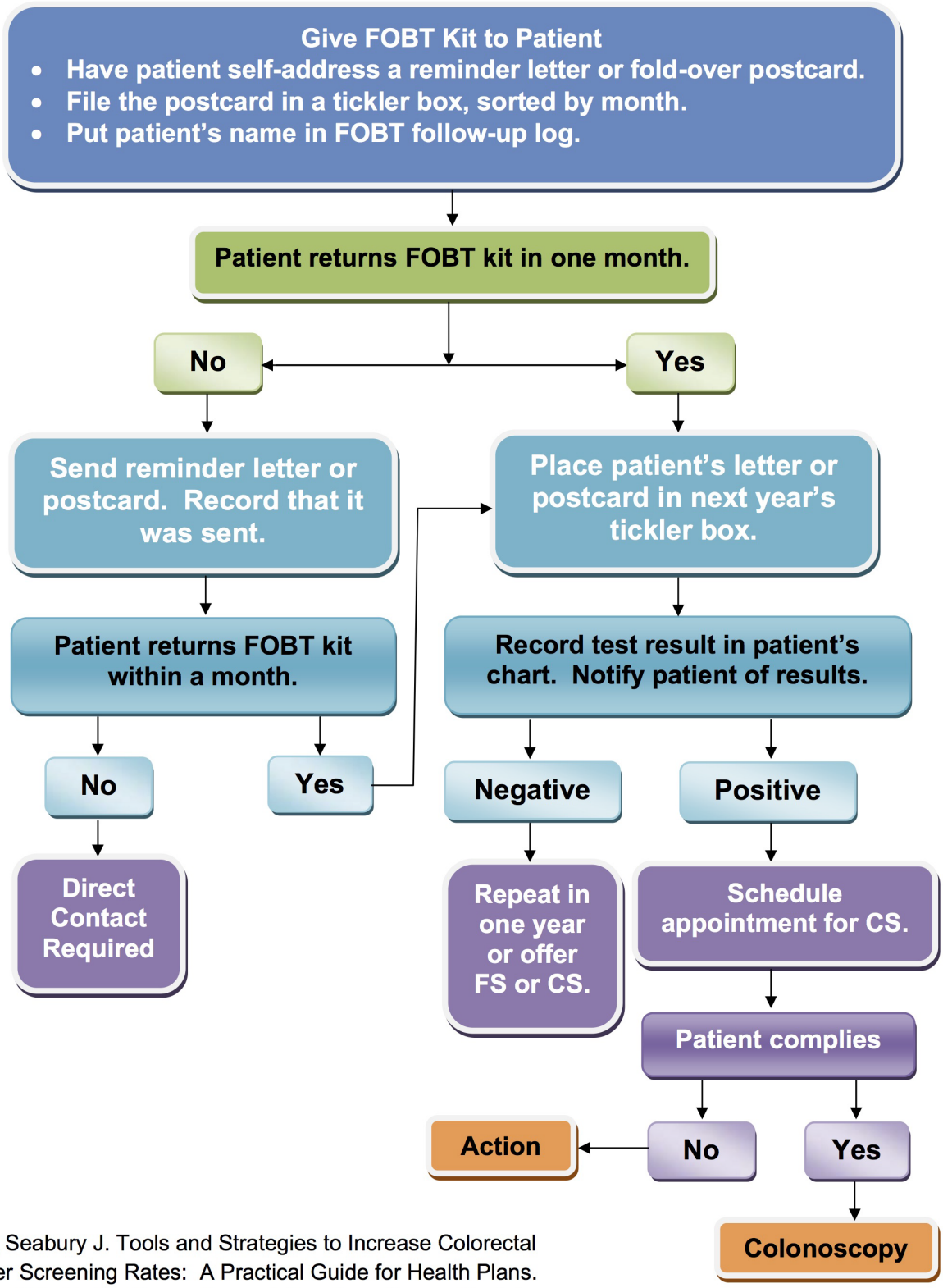
**Screening Policy and Office Visits**

- Use these sample CRC screening policies as a starting point: *Sample CRC Screening Algorithm 1, Sample CRC Screening Algorithm 2,* and *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**

- Use these brochures, sample letters, pamphlets, and videos for patients. View the *Educate Your Patients* section of **cancer.org/colonmd**.

# Sample FOBT Policy in Flow Chart Form*

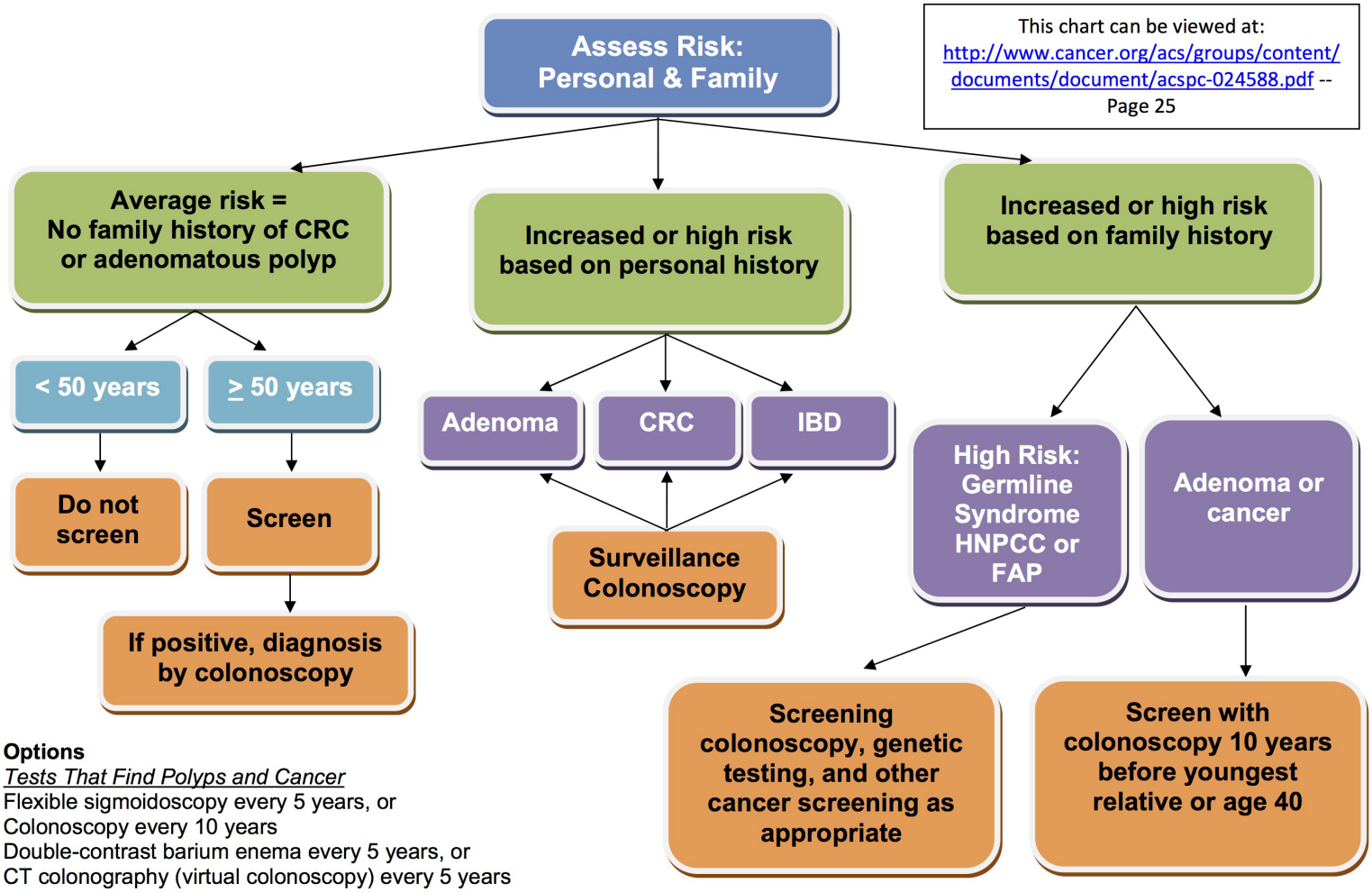



*From Seabury J. Tools and Strategies to Increase Colorectal Cancer Screening Rates: A Practical Guide for Health Plans. Harvard Center for Prevention and American Cancer Society, 2004. Approach reprinted from procedures of Dartmouth Medical School, 2003.

This chart can be viewed at: http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf -- Page 30

# Sample Screening Algorithm

This chart can be viewed at: http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf -- Page 25




**Options**

*Tests That Find Polyps and Cancer*

Flexible sigmoidoscopy every 5 years, or
Colonoscopy every 10 years
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)*, or
Stool DNA test (SDNA), interval uncertain

*The multiple stool take-home test should be used. One test done by the doctor in the office is not adequate for testing.

The tests that are designed to find both early cancer and polyps are preferred if these tests are available and the patient is willing to have one of these more invasive tests.

# Sample Office Policy Worksheet: What is Everyone's Role?

## 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: _____

This chart can be viewed at: http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf -- Page 47

# Sample Office Policy Worksheet

## 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: _____**

This chart can be viewed at: http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf -- Page 47

## 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 tests – 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 1)

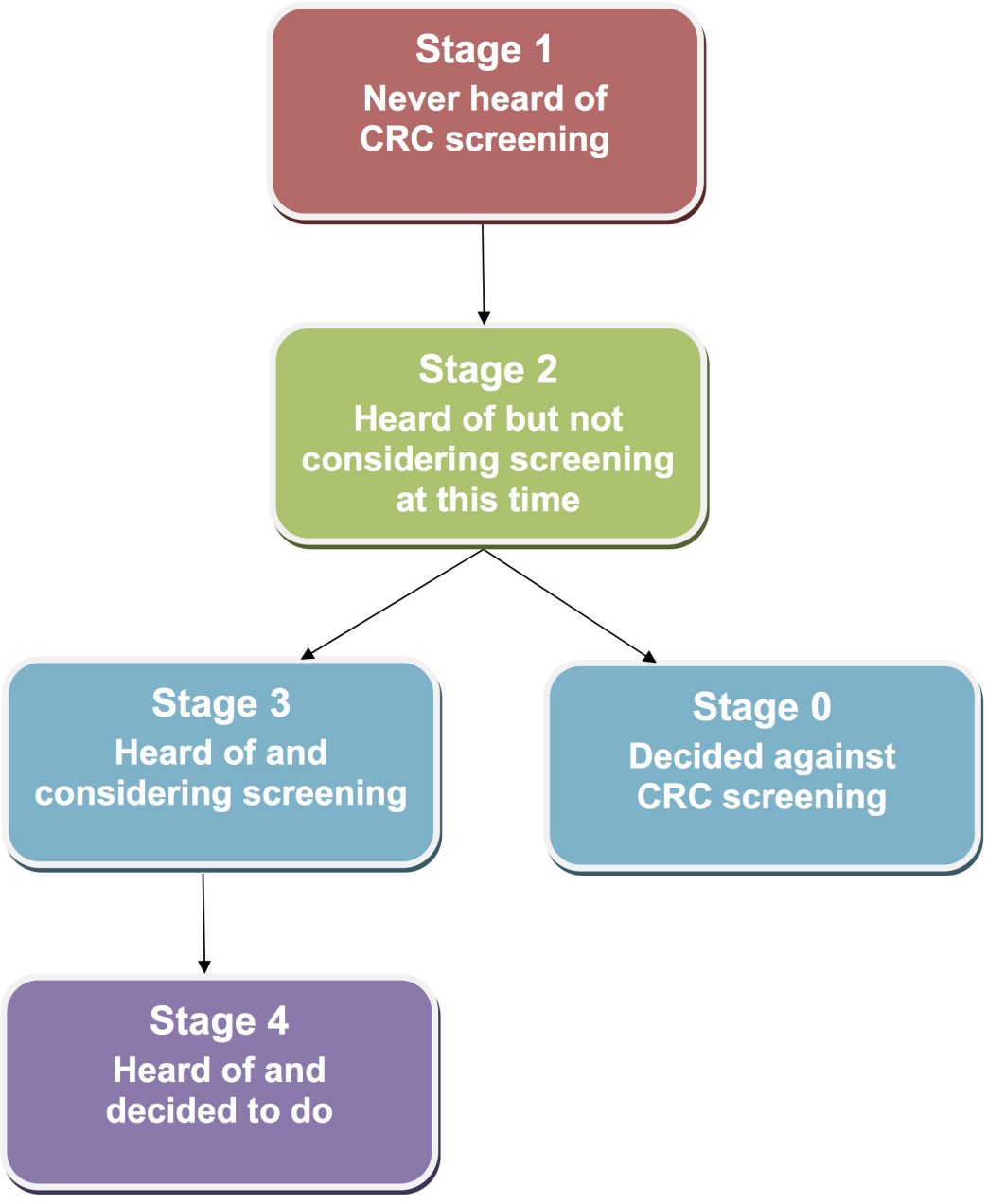
3. Which of the following statements best describes your thoughts about doing a (stool blood test, CTC, CS) in the future?

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 places 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

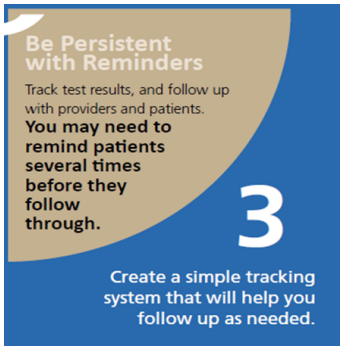
*Source: Adapted from RE Myers, 2003*

# Decision Stage Model for CRC Screening*




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

This model can be viewed at:
http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf -- Page 51




## Essential #3
## Be Persistent with Reminders

Physician and patient reminders contribute to increased screening rate. Determine how your practice will notify patients and physicians when screening or follow up is due. Put office systems in place that track test results and that use reminder prompts for patients and providers, and follow up on all positives.

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. Postcards, letters, prescriptions, in-person conversations, and phone calls can encourage patients to follow through with screening. To achieve high screening rates with take-home stool blood tests, reminders and tracking systems are essential.

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. Actively monitor whether screening and all necessary follow-up tests are completed in a timely manner. In the case of a positive stool blood test, do not repeat the test, but always refer a patient for colonoscopy.

**Tools for Your Practice**
To access these tools, go to **cancer.org/screeningactionplan**.

**Reminder Systems**
- 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*

**Tracking Information**
- View the sample reminders in the Your Practice section of cancer.org/colonmd.
- View a sample CRC tracking log: *CRC Tracking Template*

# Purchasing an Electronic Health Record System

## Optimizing CRC Screening Performance Using the EHR

- ✓ EHR 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.

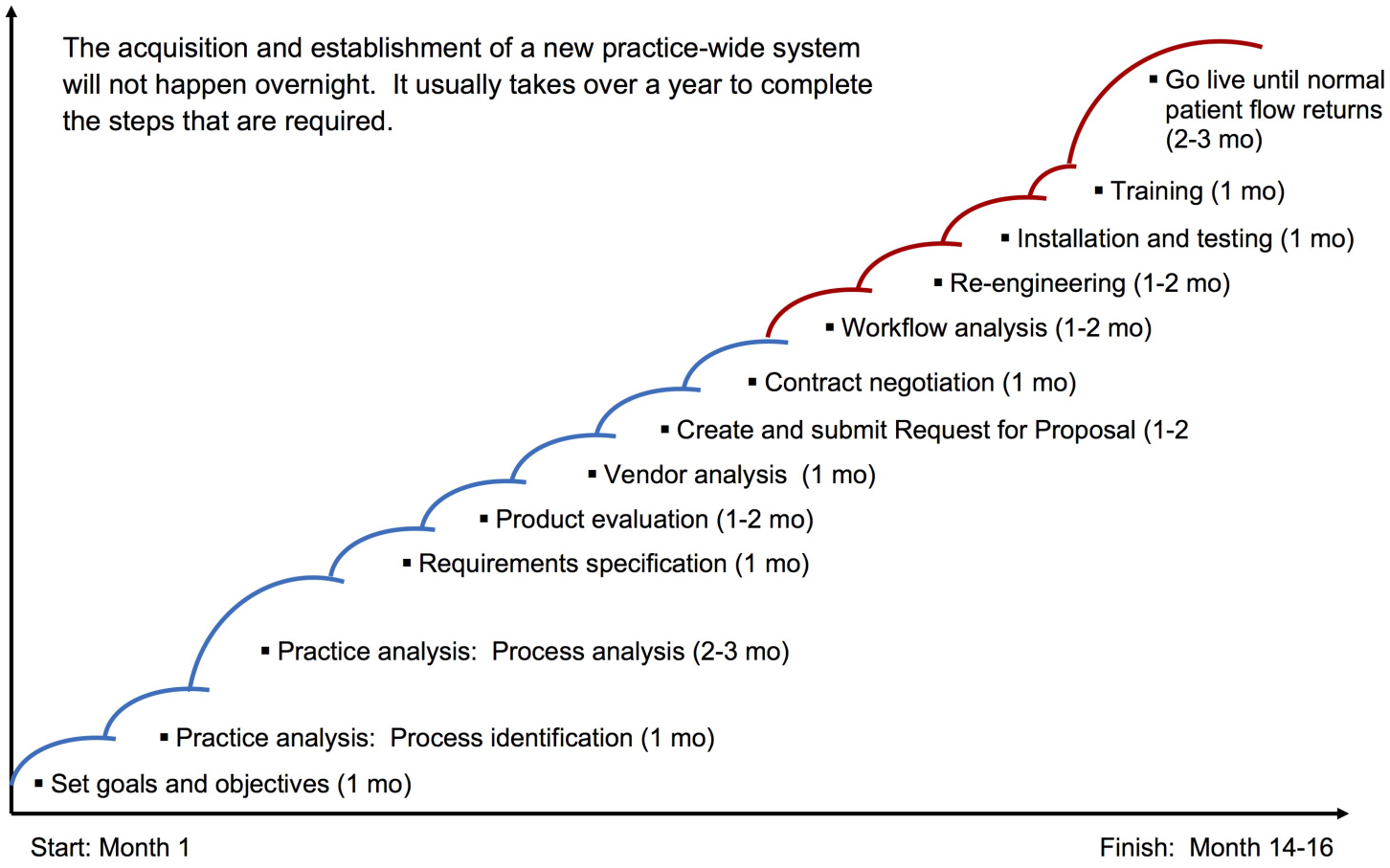
- ✓ When trying to optimize colorectal cancer screening performance, certain functional criteria should be included in the RFP. All of the criteria listed are also included in the CCHIT 2009 Ambulatory criteria, so any system with CCHIT certification should have the functionality to maximize CRC screening.

- ✓ 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 records systems. Vendors should be asked about the potential to interface with this tool.

| Reliable Sources of EHR Ratings | | |
|---|---|---|
| **Sources of EHR 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 |

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

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



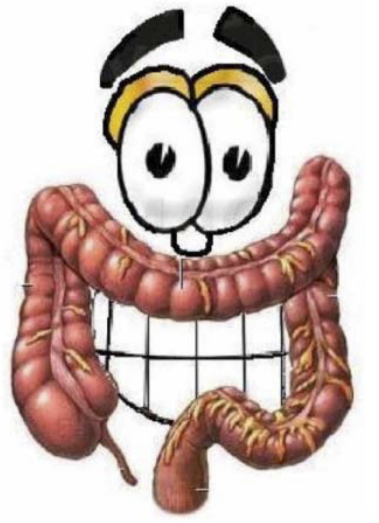

Adapted from *The Use of Electronic Health Records in Optimizing the Delivery of Colorectal Cancer Screening in Primary Care* by Randa Sifir, MD; Mona Sarfaty, MD; Smiriti Sharma

# 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.

## 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 completed | 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._____ |
| | h. Scheduled for CS if positive | h._____ |


## Essential #4
## Measure Practice Progress

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

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.

**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 how to include harder-to-reach patient groups.

**Tools for Your Practice**

To access these tools, go to **cancer.org/screeningactionplan**.

**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:* This activity has been reviewed and is valid for up to 20 Prescribed continuing medical education (CME) credits by the American Academy of Family Physicians (AAFP). AAFP Prescribed credit is accepted by the American Medical Association (AMA) as applicable toward the Physician's Recognition Award (PRA) and equivalent to AMA PRA Category 1 Credit. When applying for the PRA, Prescribed credit must be reported as Prescribed credit, not as Category 1.

## Internal Practice Questionnaire

1. **Goals**

   Are we functioning in accordance with our stated purpose or vision?
   Are we providing the services we say we want to provide?
   What is working well? Why?
   What is not working well? Why?
   What could be done differently?
   Do we need to re-evaluate our goals?
   Do we need to re-evaluate the services we offer?

2. **Materials**

   How do the cancer prevention materials fit our needs?
   Should we modify any of the cancer prevention materials?

3. **Documentation**

   Are we documenting the services we provide?

4. **Staff Performance and Satisfaction**

   Are all staff contributing suggestions?
   Is everyone working together as a team?
   Are all the functions being covered?
   How do staff members feel about their work?

*Source: Agency for Healthcare Research and Quality*

# 8 Steps to Chart Audit for Quality

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

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

For many family physicians, the idea of a chart audit conjures up images of federal investigations or insurance company representatives descending on their offices to look for evidence of wrongdoing. For the most part, however, a chart audit is not so scary. A chart audit is simply a tool physicians can use to check their own performance, determine how they're doing and identify areas where they might improve. The purpose of this article is to describe some scenarios in which a chart audit might be helpful and to offer step-by-step instructions for doing one.

**Why a chart audit?**

Chart audits can serve many purposes, from compliance to research to administrative to clinical. You can conduct a chart audit on virtually any aspect of care that is ordinarily documented in the medical record. Practices frustrated with clinical processes that don't work well can use chart audits to document that something is wrong, find the defect in the process and fix it. Perhaps the most beneficial use for 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 the vaccine is not being offered or given as recommended, then there is room for improvement. The same practice should review the panels of individual physicians within the group to see if they differ in performance on this measure and to give focus to their improvement efforts. A chart audit is one of numerous data sources available for quality improvement efforts (for additional chart audit ideas, see below). Others include patient surveys, discharge summary reviews, billing/claims data and employee feedback.

**POTENTIAL TOPICS FOR QUALITY AUDITS**

**Preventive care**

Percentage of women ages 21-64 who have had a Pap smear within the past three years
Percentage of adults ages 51-80 who have had colon cancer screening
Percentage of children age 2 who have completed all recommended immunizations
Percentage of elderly adults with documented fall risk assessment within the past year

**Chronic disease management**

Percentage of patients with hypertension whose last blood pressure reading was < 140/90
Percentage of patients with diabetes with A1C level recorded in the last year
Percentage of patients with diabetes whose A1C is < 7.0
Percentage of patients with diabetes with a documented eye exam within the last year
Percentage of patients with persistent asthma who are on an anti-inflammatory agent

Note: Any of these metrics would have to be defined with greater specificity before use.

**How to do it**

Below we describe eight steps to a formal chart audit. Although the process is not necessarily linear, we will discuss each step in the order it might typically occur, using the example of a breast cancer screening audit to illustrate each step. Because the audit will involve reviewing confidential data, it is important to check your institutional guidelines regarding patient confidentiality before you get too far into the planning process.

**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. If possible, choose an area that interests you. You will find that you are more able to recognize nuances in your study when you have personal interest in the topic. Of course, 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.

You should also consider early in the process how important external comparison is to your purpose. If it is quite important, then choose a topic that has an existing, well-defined measure and available benchmark data – even one you might not choose otherwise – because this will be more practical than developing your own standard for comparison. Chart auditing is an iterative process – don't be discouraged if you change directions several times before settling on a topic. *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 decides to focus its 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).

For example, if you decided to review the rate at which foot exams were performed on patients with diabetes in the last year, you would need to decide what qualifies as an adequate foot exam. Is it monofilament testing for sensation? Visual inspection? Palpation of pulses? Many would say all three are necessary for a complete foot exam. If only two of the three are documented, how will you count that?

It may be worthwhile to do a literature review to help you define your measures or consult measures used by insurers or accrediting bodies; adopting measure that have been used successfully in the past will make your work easier. A literature review may also help you identify benchmarks for comparison.

Once you've chose measure that seem workable, it can be helpful to conduct a pilot audit. Just going through a few charts will help to identify issues that need to be clarified before starting a full audit.

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

- Times since last mammogram. This provides the most specific information but would require more analysis.
- Mammogram completed within last year. This measure attempts to assess compliance with clinical guidelines. The U.S. Preventive Services Task Force recommends screening mammography every one to two years for women age 40 and older. However, the Healthcare Effectiveness Data and Information Set (HEDIS) measure, which most health plans use for National Committee for Quality Assurance (NCQA)

- accreditation purposes, require at least one mammogram completed within the past 24 months.
- Mammogram ordered within last year. Do you want to measure only whether the study was done, or whether it was recommended or ordered by the provider? Should providers be held accountable when patients decline to have the test?

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.

If you want to track a measure over time, or if you want your results to be statistically valid, your sample size is critical. If the sample is too small, the random variability will be too large, and the results will be limited in their applicability.

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

**DETERMINING SAMPLE SIZE**

Calculating a statistically valid sample size for a chart review follows steps adapted from statistical techniques used for descriptive studies. The process uses a nomogram, or table, to identify the desired number:

**1. Estimate the expected proportion within the population that will have the measure of interest.**

If you have a benchmark from literature or prior studies, use it. Otherwise, consult with colleagues or experts in the field to determine an estimate. The tables generally require this proportion to be 50 percent or less. If more than 50 of the population is expected to have the characteristic, then base your sample size calculation on the proportion without the characteristic.

**2. Specify the width of the confidence interval you wish to use.**

All empirical estimates based on a sample have a certain degree of uncertainty associated with them. It is necessary, therefore, to specify the desired width of the confidence interval (W). This gives a range of values that you can be confident contain the true value. In most cases, an appropriate width is 0.20 (that is, plus or minus 10 percent).

**3. Set the confidence level.**

This is a measure of the precision or level of uncertainty. Typically 95 percent is used, meaning that we are 95 percent certain that the interval includes the true value. This arbitrary, however, and other levels of confidence can be used. The table shown is for a 95-percent confidence level. The narrower the width of the confidence interval and the higher the confidence level, the larger the sample size.

**4. Use the nomogram (below) to estimate sample size.**

**Sample size for a descriptive study of a dichotomous variable 95-percent confidence interval**

| Width of the confidence interval (W) | 0.10 | 0.15 | 0.20 | 0.25 | 0.30 |
|---|---|---|---|---|---|
| Expected proportion (P) | | | | | |
| 0.10 | 138 | 61 | | | |
| 0.15 | 196 | 87 | 49 | 31 | |
| 0.20 | 246 | 109 | 61 | 39 | 27 |
| 0.25 | 288 | 128 | 72 | 46 | 32 |
| 0.30 | 323 | 143 | 81 | 52 | 36 |
| 0.40 | 369 | 164 | 92 | 59 | 41 |
| 0.50 | 384 | 171 | 96 | 61 | 43 |

Adapted with permission from Hulley SB, et al. *Designing Clinical Research*, 3rd ed. Philadelphia: Wolters Kluwer Health; 2006:91.

**AN EXAMPLE**

According to HEDIS 2007 Audit Means, Percentiles and Rations, the NCQA's annual report of health plan performance data, 68.9 percent of women age 40 to 69 had a mammogram during 2006. This makes the expected proportion of those without screening 31.1 percent. We choose a width of the confidence interval of 0.20 (plus or minus 10 percent) and a confidence level of 95 percent. This means that we want to be 95 percent confident that the result fails between 58.9 percent and 78.9 percent. Using the nomogram to determine the sample size, we read down the left column of figures for the expected proportion without the characteristics (0.30 is the closest value to 31.1 percent) and then across to the chosen width of the confidence interval (0.20), When we follow the column down, we find the required sample size (81). If the number required is too large to be completed, we can recalculate with a lower confidence level or wider interval; this will produce a 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.

Many chart audits involve the calculation of a rate, percentage, mean or other statistical measurement. An electronic spreadsheet format can be customized to do these calculations for you. For those more comfortable with paper-based systems, a preprinted form that lists the specific items to check in each chart serves well as an audit tool. One form is completed for each chart, and the forms can then be sorted and counted as desired. A separate form can be used to tabulate results.

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 (see the completed forms below)

**CHART AUDIT FOR BREAST CANCER SCREENING**

| Patient Identification | | Inclusion Criteria | | | Exclusion Criteria | | Mammogram in past 24 months | | No Mammogram in past 24 months | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient Name | MRN | Age 42-69 as of 12/31/07 | 3 visits in past 3 years | 1 visit in past 13 months | Bilateral mastectomy | Left practice, terminally ill, expired | Locally | Elsewhere | No discussion documented | Discussed, patient declined | Mammo-gram ordered, not completed |
| Jane D | A2345 | 53 | yes | yes | no | no | yes | no | | | |
| Sue S | B2345 | 62 | yes | yes | no | no | yes | no | | | |
| Ann J | C2345 | 59 | yes | yes | no | no | no | no | yes | no | no |
| Betty M | D2345 | 65 | yes | yes | yes | no | | | | | |
| Julie J | E2345 | 57 | yes | yes | no | yes | | | | | |
| Bonnie B | F2345 | 52 | no | | | | | | | | |
| Allice G | G2345 | 52 | yes | yes | no | no | yes | no | | | |
| Kate H | H2345 | 61 | yes | no | | | | | | | |
| Dana T | I2345 | 63 | yes | yes | right side only | no | no | yes | | | |
| Doris B | J2345 | 40 | | | | | | | | | |
| Helen P | K2345 | 64 | yes | yes | no | no | yes | no | | | |
| Evelyn P | L2345 | 51 | yes | yes | no | no | yes | no | | | |
| Paula T | M2345 | 49 | yes | yes | no | no | yes | no | | | |
| Mary S | N2345 | 69 | yes | yes | no | no | yes | no | | | |

Note: Shading indicates that the patient has not met the exclusion or inclusion criteria.

**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 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 (see the results table below).

**BREAST CANCER SCREENING RESULTS**

| | # | % |
|---|---|---|
| Total charts reviewed | 100 | |
| Patients included in audit | 81 | |
| Patients who received mammogram | 46 | 57 |
| Received mammogram locally | 25 | 31 |
| Received mammogram elsewhere | 10 | 12 |
| Patients with no documentation of completed mammogram | 35 | 43 |
| Documented declined mammography | 6 | 17 |
| Documented mammogram ordered, not completed | 4 | 13 |
| No documentation of discussion of mammography | 25 | 71 |

**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 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.

**Make it count**

Chart audits can be useful tools in improvement and safety efforts. It is essential to define precisely what you want to measure and the criteria by which you will measure it. (If you're floundering, you probably haven't defined this well enough.) Sample sizes can be chosen informally or determined in a statistically valid fashion. Summarize your data in a way that makes sense for the problem you're addressing. Make sure to act on problems you find, and remeasure later to see that your changes made a difference. You and your patients will be glad you did.

## Saving Lives through Preventive Screening

- Implement practice changes to achieve the Four Essentials and increase cancer screening rates
- Take steps to identify and screen every age-appropriate patient
- Involve your staff, and put office system in place
- Follow a continuous improvement model to develop and test changes

1. Develop Your Plan
2. Act on Your Plan
3. Study Your Results
4. Adjust Your Results

Source: Adapted from materials of the Maryland State Cancer Program, and the Montgomery County Cancer Crusade, 2001.

# FOBT/FIT Follow-up Phone Script for Average-Risk Individuals

**Introduction:**

Good Morning/Afternoon. May I speak with _____?
(Note: Due to HIPAA regulations, the conversation should not proceed unless speaking directly with the patient.)
My name is _____ and I am calling from_____.
You recently received a stool blood test for colon cancer screening.
Did you have any questions about the test?
We are calling everyone who received one of these to see if there is any way we can help you complete the test.

**1. "Have you had the chance to complete and mail your kit?"**
**If the answer is YES,** get the approximate date to ensure that the test will be valid, and get the approximate date of receipt. Thank the participant and let them know that you will mail them their results.

**If the answer is NO,** ask the following question.
Mr./Ms. _____, is there any reason why you have not completed your kit?
(Document reason; possible reasons are listed below.)
– Diet and Drug Restrictions
– Test is difficult and disgusting
– Haven't had the time
– Changed my mind
– Received other colorectal cancer testing
– Believe it is not effective way of screening
– Health Insurance/Doctor

**2. Emphasize the benefits of screening and program services.**
"Colorectal Cancer can affect anyone – men and women alike – and your increases with age. Colorectal Cancer is highly preventable, treatable and often curable. There are several screening tests for colorectal cancer. These tests not only detect colorectal cancer early but can prevent colorectal cancer.
Beginning at age 50, men and women should be screened regularly for colorectal cancer. If you have a personal or family history of colorectal cancer or colorectal polyps, or personal history of another cancer or inflammatory bowel disease, you should begin screening earlier.

**3. If patient indicates that they prefer a colonoscopy, ask "Do you have health insurance?"**
If they are insured, suggest a visit to an endoscopist (gastroenterologist or general surgeon) for a colonoscopy. If they do not know a gastroenterologist, give physician referral phone number and appropriate form.

**If they are uninsured,** encourage them to follow through with FOBT.

**Mr./Ms._____ Thank you for your time today.**
**Do you have any questions? If you need further assistance with completing your kit or have any questions, please give us a call at_____.**

**Note: Please document and track these conversations.**

Source: Maryland State Cancer Program, Montgomery County Cancer Crusade, 2001.

# Follow-up Phone Script for Individuals at Increased Risk

## Introduction:

Good Morning/Afternoon. May I speak with_____ DOB:_____
**(Full Name)**
(Note: Due to HIPAA regulations, the conversation should not proceed unless speaking directly with the patient.)
My name is _____ and I am calling from_____.
You recently received a referral for a colonoscopy screening test for colon cancer.
Did you have any questions about the test?
We are calling to see if there is any way we can help you get screening for colorectal cancer.

**1. "I see that on the form you filled out, you checked off:" (Confirm their response.)**
– Family History of Colorectal Cancer or Polyps – Specify: _____
– Personal History of Colorectal Cancer or Polyps – Specify: _____
or *Inflammatory Bowel Disease – Specify: _____

**2. "Can you tell me more about your history (family history) or symptoms?"**
Assess the history or symptoms for significance. (Significant personal or family history is an adenomatous polyp or colorectal cancer in one first-order relative under age 60 ormore than one first or second degree relative over age 60, or a personal history of inflammatory bowel disease such as Crohn's Disease or Ulcerative Colitis* for over 8 years.)

**3. "Because of your history/family history/symptoms, we recommend that you have a colonoscopy for proper screening."**

**4. If the person needs more motivation, emphasize the benefits of screening.**
"Colorectal Cancer can affect anyone – men and women alike – and risk increases with age. Colorectal Cancer is highly preventable, treatable, and often curable. Most colorectal cancers cause no symptoms in the early stages, which is why screening is so important. There are several screening tests for colorectal cancer. These tests not only detect colorectal cancer early but can also prevent colorectal cancer. Beginning at age 50, men and women should be screened regularly for colorectal cancer. If you have a personal or family history of colorectal cancer or colorectal polyps, or a personal history of an inflammatory bowel disease, you should begin screening earlier."
* Inflammatory Bowel Disease – Ulcerative Colitis, Crohn's Disease.

**5. "Have you heard about the colonoscopy (or other procedures)?"**
**Discuss as appropriate.**
If further assessment indicates that the individual is at increased risk or has significant symptoms, continue to encourage a colonoscopy:

**6. "Do you have health insurance? Do you have a gastroenterologist or surgeon who does colonoscopy?"**
Respond as appropriate with suggestions and problem solving.

**If they are uninsured,** explore alternative options that are available. The office should determine in advance what these options might be.

**Mr./Ms._____ Thank you for your time today.**

**Do you have any questions? If you need further assistance or have any questions, please give us a call at _____.**

# Letter to Patient at Increased or High Risk

Date

Dear_____

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

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

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

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

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

Sincerely,

Medical Director

# Letter to Patient at Average Risk

Date

Name
Street
City

Dear (Name):

Our office has made a commitment to promote the health of its members, and to provide education regarding preventive health measures that you can take to maintain a healthy lifestyle. Our records indicate that you are either overdue for colorectal cancer screening tests, or that you have never had a colorectal cancer screening test.

I am writing to ask you to call our office today to schedule a colorectal cancer screening appointment. By getting colorectal cancer screening tests regularly, colorectal cancer can be found and treated early when the chances for cure are best. Many of these tests can also help prevent the development of colorectal cancer.

The American Cancer Society recommends that average-risk individuals choose one of the following options for colorectal cancer screening. Screening should begin at age 50.

*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)*,**, 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.**

We have also included for your reference an informational pamphlet on colorectal cancer. Should you have any questions about this pamphlet or colorectal cancer screening tests, please contact us. Thank you for taking time to take care of your health.

Sincerely,

Enclosure: *Colorectal Cancer Screening Brochure*

## Result letter: Patient Who Has a Positive Screening Result

**Note that this letter is for stool blood test, but a similar letter should be sent for patients with positive Stool DNA, CT Colonography, Double Contract Barium Enema or Flexible Sigmoidoscopy.**

### Main Street Medical

Date

Name
Street
City

Dear _____,

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

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

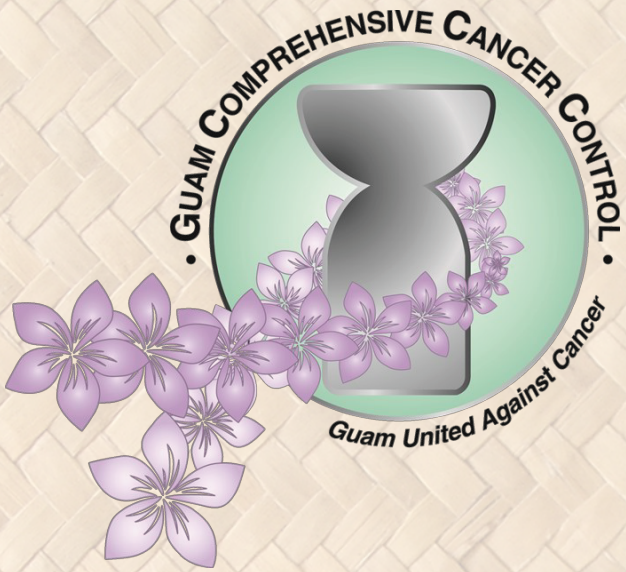
We can assist you with scheduling a colonoscopy. Please call or visit our office at _____ to obtain a referral or set up an appointment. Also, please take this letter with you to your next doctor's appointment.

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

Sincerely,

Medical Director

Enclosure




# Diet/Nutrition Guidelines

#CONQUER CANCER
Guam Cancer Coalition

USDA
United States Department of Agriculture

# MyPlate Daily Checklist

## Find your Healthy Eating Style

Everything you eat and drink matters. Find your healthy eating style that reflects your preferences, culture, traditions, and budget—and maintain it for a lifetime! The right mix can help you be healthier now and into the future. The key is choosing a variety of foods and beverages from each food group—*and making sure that each choice is limited in saturated fat, sodium, and added sugars*. Start with small changes—**"MyWins"**—to make healthier choices you can enjoy.

**Food Group Amounts for 2,000 Calories a Day**

| Fruits | Vegetables | Grains | Protein | Dairy |
|---|---|---|---|---|
| **2 cups** | **2 1/2 cups** | **6 ounces** | **5 1/2 ounces** | **3 cups** |
| Focus on whole fruits | Vary your veggies | Make half your grains whole grains | Vary your protein routine | Move to low-fat or fat-free milk or yogurt |
| Focus on whole fruits that are fresh, frozen, canned, or dried. | Choose a variety of colorful fresh, frozen, and canned vegetables—make sure to include dark green, red, and orange choices. | Find whole-grain foods by reading the Nutrition Facts label and ingredients list. | Mix up your protein foods to include seafood, beans and peas, unsalted nuts and seeds, soy products, eggs, and lean meats and poultry. | Choose fat-free milk, yogurt, and soy beverages (soy milk) to cut back on your saturated fat. |

**Limit**

Drink and eat less sodium, saturated fat, and added sugars. Limit:

- Sodium to **2,300 milligrams** a day.
- Saturated fat to **22 grams** a day.
- Added sugars to **50 grams** a day.

Be active your way: Children 6 to 17 years old should move **60 minutes** every day. Adults should be physically active at least **2 1/2 hours** per week.

**Use SuperTracker to create a personal plan based on your age, sex, height, weight, and physical activity level.**

SuperTracker.usda.gov

# **MyPlate** Daily Checklist

Write down the foods you ate today and track your daily MyPlate, MyWins!

| Food group targets for a 2,000 calorie* pattern are: | | Write your food choices for each food group | Did you reach your target? |
|---|---|---|---|
| Fruits | **2 cups**<br>1 cup of fruits counts as<br>• 1 cup raw or cooked fruit; or<br>• 1/2 cup dried fruit; or<br>• 1 cup 100% fruit juice. | | Y<br>N |
| Vegetables | **2 1/2 cups**<br>1 cup vegetables counts as<br>• 1 cup raw or cooked vegetables; or<br>• 2 cups leafy salad greens; or<br>• 1 cup 100% vegetable juice. | | Y<br>N |
| Grains | **6 ounce equivalents**<br>1 ounce of grains counts as<br>• 1 slice bread; or<br>• 1 ounce ready-to-eat cereal; or<br>• 1/2 cup cooked rice, pasta, or cereal. | | Y<br>N |
| Protein | **5 1/2 ounce equivalents**<br>1 ounce of protein counts as<br>• 1 ounce lean meat, poultry, or seafood; or<br>• 1 egg; or<br>• 1 Tbsp peanut butter; or<br>• 1/4 cup cooked beans or peas; or<br>• 1/2 ounce nuts or seeds. | | Y<br>N |
| Dairy | **3 cups**<br>1 cup of dairy counts as<br>• 1 cup milk; or<br>• 1 cup yogurt; or<br>• 1 cup fortified soy beverage; or<br>• 1 1/2 ounces natural cheese or 2 ounces processed cheese. | | Y<br>N |

Limit

Limit:

- Sodium to **2,300 milligrams** a day.
- Saturated fat to **22 grams** a day.
- Added sugars to **50 grams** a day.

Y N

Activity

Be active your way:

**Adults:**

- Be physically active at least **2 1/2 hours** per week.

**Children 6 to 17 years old:**

- Move at least **60 minutes** every day.

Y N

* This 2,000 calorie pattern is only an estimate of your needs. Monitor your body weight and adjust your calories if needed.

MyWins

ChooseMyPlate.gov

**Track your MyPlate, MyWins**

_____

_____

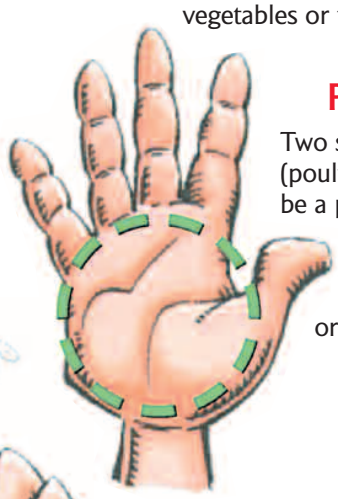
_____

Center for Nutrition Policy and Promotion
January 2016

# THE SECRET TO SERVING SIZE IS IN YOUR HAND


## A fist or cupped hand = 1 cup

1 serving = 1/2 cup cereal, cooked pasta or rice
**or** 1 cup of raw, leafy green vegetables
**or** 1/2 cup of cooked or raw, chopped vegetables or fruit

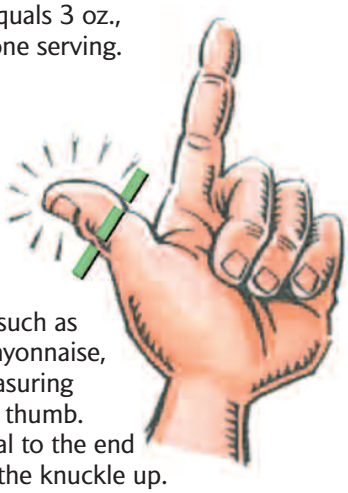


## Palm = 3 oz.of meat

Two servings, or 6 oz., of lean meat (poultry, fish, shellfish, beef) should be a part of a daily diet. Measure the right amount with your palm. One palm size portion equals 3 oz., or one serving.

## A thumb = 1 oz. of cheese

Consuming low-fat cheese is a good way to help you meet the required servings from the milk, yogurt and cheese group. 1 1/2 - 2 oz. of low-fat cheese counts as 1 of the 2-3 daily recommended servings.



## Thumb tip = 1 teaspoon

Keep high-fat foods, such as peanut butter and mayonnaise, at a minimum by measuring the serving with your thumb. One teaspoon is equal to the end of your thumb, from the knuckle up. Three teaspoons equals 1 tablespoon.

## Handful = 1-2 oz.of snack food

Snacking can add up. Remember, 1 handful equals 1 oz. of nuts and small candies. For chips and pretzels, 2 handfuls equals 1 oz.

## 1 tennis ball = 1 serving of fruit

Healthy diets include 2-4 servings of fruit a day.

*Because hand sizes vary, compare your fist size to an actual measuring cup.*

Color Me Healthy...*preschoolers moving and eating healthy*

eat right. Academy of Nutrition and Dietetics

# Eat Right

Food, Nutrition and Health Tips from the Academy of Nutrition and Dietetics

## Shop Smart — Get the Facts on Food Labels

Become a smart shopper by reading food labels to find out more about the foods you eat. The Nutrition Facts panel found on most food labels will help you:

- Find out which foods are good sources of fiber, calcium, iron, and vitamin C
- Compare similar foods to find out which one is lower in fat and calories
- Search for low-sodium foods
- Look for foods that are low in saturated fat and trans fats

### A Quick Guide to Reading the Nutrition Facts Label

*Start with the Serving Size*

- Look here for both the serving size (the amount for one serving), and the number of servings in the package.
- Remember to check your portion size to the serving size listed on the label. If the label serving size is one cup, and you eat two cups, you are getting twice the calories, fat and other nutrients listed on the label.

*Check Out the Total Calories and Fat*

Find out how many calories are in a single serving and the number of calories from fat. It's smart to cut back on calories and fat if you are watching your weight!

*Let the Percent Daily Values Be Your Guide*

Use percent Daily Values (DV) to help you evaluate how a particular food fits into your daily meal plan:

- Daily Values are average levels of nutrients for a person eating 2,000 calories a day. A food item with a 5% DV means 5% of the amount of fat that a person consuming 2,000 calories a day would eat.
- Remember: percent DV are for the entire day — not just for one meal or snack.
- You may need more or less than 2,000 calories per day. For some nutrients you may need more or less than 100% DV.

*The High and Low of Daily Values*

- 5 percent or less is low — try to aim low in total fat, saturated fat, cholesterol, and sodium
- 20 percent or more is high — try to aim high in vitamins, minerals and fiber

**Nutrition Facts**

Serving Size 1 cup (228g)
Servings Per Container 2

| Amount Per Serving | |
|---|---|
| Calories 250 | Calories from Fat 110 |
| | % Daily Value* |
| Total Fat 12g | 18% |
| Saturated Fat 3g | 15% |
| *Trans* Fat 1.5g | |
| Cholesterol 30mg | 10% |
| Sodium 470mg | 20% |
| Total Carbohydrate 31g | 10% |
| Dietary Fiber 0g | 0% |
| Sugars 5g | |
| Protein 5g | |
| Vitamin A | 4% |
| Vitamin C | 2% |
| Calcium | 20% |
| Iron | 4% |

* Percent Daily Values are based on a 2,000 calorie diet. Your Daily Values may be higher or lower depending on your calorie needs:

| | Calories: | 2,000 | 2,500 |
|---|---|---|---|
| Total Fat | Less than | 65g | 80g |
| Sat Fat | Less than | 20g | 25g |
| Cholesterol | Less than | 300mg | 300mg |
| Sodium | Less than | 2,400mg | 2,400mg |
| Total Carbohydrate | | 300g | 375g |
| Dietary Fiber | | 25g | 30g |

For more food label information, visit the Food and Drug Administration at **www.fda.gov/Food/ResourcesForYou/Consumers**

### *Limit Fat, Cholesterol and Sodium*

Eating less of these nutrients may help reduce your risk for heart disease, high blood pressure and cancer:

- Total fat includes saturated, polyunsaturated and monounsaturated fat. Limit to 100% DV or less per day.
- Saturated fat and trans fat are linked to an increased risk of heart disease.
- Sodium — high levels can add up to high blood pressure.
- Remember to aim low for % DV of these nutrients.

### *Get Enough Vitamins, Minerals and Fiber*

- Eat more fiber, vitamins A and C, calcium, and iron to maintain good health and help reduce your risk of certain health problems such as osteoporosis and anemia.
- Choose more fruits and vegetables to get more of these nutrients.
- Remember to aim high for % DV of these nutrients.

### *Additional Nutrients*

- Carbohydrates — There are three types of carbohydrates: sugars, starches and fiber. Select whole-grain breads, cereals, rice and pasta plus fruits and vegetables.
- Sugars — simple carbohydrates or sugars occur naturally in foods such as fruit juice (fructose), or come from refined sources such as table sugar (sucrose) or corn syrup.

### *Check the Ingredient List*

Foods with more than one ingredient must have an ingredient list on the label. Ingredients are listed in descending order by weight. Those in the largest amounts are listed first. Effective January 2006, manufacturers are required to clearly state if food products contain any ingredients that contain protein derived from the eight major allergenic foods. These foods are milk, eggs, fish, crustacean shellfish, tree nuts, peanuts, wheat and soybeans.

### *What Health Claims on Food Labels Really Mean*

FDA has strict guidelines on how certain food label terms can be used. Some of the most common claims seen on food packages:

- **Low calorie** — Less than 40 calories per serving.
- **Low cholesterol** — Less than 20 mg of cholesterol and 2 gm or less of saturated fat per serving.
- **Reduced** — 25% less of the specified nutrient or calories than the usual product.
- **Good source of** — Provides at least 10% of the DV of a particular vitamin or nutrient per serving.
- **Calorie free** — Less than 5 calories per serving.
- **Fat free / sugar free** — Less than ½ gram of fat or sugar per serving.
- **Low sodium** — Less than 140 mg of sodium per serving.
- **High in** — Provides 20% or more of the Daily Value of a specified nutrient per serving.
- **High fiber** — 5 or more grams of fiber per serving.

FDA also sets standards for health-related claims on food labels to help consumers identify foods that are rich in nutrients and may help to reduce their risk for certain diseases. For example, health claims may highlight the link between calcium and osteoporosis, fiber and calcium, heart disease and fat or high blood pressure and sodium.

**For a referral to a registered dietitian nutritionist and for additional food and nutrition information visit www.eatright.org.**

eat right®

The Academy of Nutrition and Dietetics is the largest organization of food and nutrition professionals. The Academy is committed to improving the public's health and advancing the profession of dietetics through research, education and advocacy.

Authored by registered dietitian nutritionists on staff with the Academy of Nutrition and Dietetics

*Sources: US Food and Drug Administration, ADA Complete Food & Nutrition Guide*


# Communications Guidelines

#CONQUER CANCER
GUAM CANCER COALITION

# 80% by 2018

## *Recommended Messaging*
*to Reach the Unscreened*

# 2017 COMMUNICATIONS GUIDEBOOK

See Communications Companion Guides for Messaging to Hispanics/Latinos and Asian Americans about Colorectal Cancer Screening

National Colorectal Cancer Roundtable

80% by 2018 — Screening Saves Lives — Reaching 80% screened for colorectal cancer by 2018

American Cancer Society®

COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

# Contents

COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

## Dear 80% by 2018 Colleagues:

In 2014 we launched our challenge to achieve a nationwide 80% colorectal cancer screening rate by 2018. I am in awe of how far we have come in the past three years. When we began, we knew we would be excited if 50 organizations signed our 80% by 2018 pledge. As I write, we are at 1,400 and counting! And it is because of you – your passion, your work, and your knowhow – that what we do makes a real difference and saves lives.

We are now seeing some great signs of progress. For instance, data from Health Resources and Services Administration (HRSA) about screening rates at federally qualified health centers (FQHCs) show significant gains in colorectal cancer screening rates for these centers. The rates have climbed two percentage points each year for the past three years and in 2015, jumped by nearly four points to 38.3 percent. The 2015 HEDIS rates have gone up notably for Medicare plans to 67.2%, and the 2015 rates from the National Health Interview Survey got off a plateau and jumped from 59% in 2013 to 63% in 2015, meaning nearly 4 million more people were screened.

But our work is not nearly done. Colorectal cancer remains the second-leading cause of cancer death in the United States, when men and women are combined, and too many Americans are not being regularly screened. And we know that those who are still unscreened are those who are the most difficult to reach. As we draw another year closer to 2018, we need to redouble our efforts to change this reality. I am glad to take on this challenge, and if you've signed the 80% by 2018 pledge, I know you are too!

I am excited to present to you the 2017 Edition of the Communications Guidebook, which focuses on three key unscreened audiences, featuring tools and information that will help you reach out to them. Additionally, there are new sections, such as sections to provide advice on earning earned media and engaging celebrities.

As a reminder, a companion guide for Hispanics/Latinos is also available, and this year we are launching a new Asian American Companion Guide for Messaging about Colorectal Cancer Screening. As always, the resources in these guidebooks are not intended to replace any partner's outreach effort, campaign or media blitz around colorectal cancer screening. Rather, we hope the information will supplement your current efforts and magnify our collective voice with these critical audiences.

I thank you all for your continued efforts and partnership in the 80% by 2018 initiative. If we can achieve 80% by 2018, 277,000 cases and 203,000 colorectal cancer deaths would be prevented by 2030. We have a moral obligation to do everything possible to achieve that goal.

Finally, I would like to thank the American Cancer Society, the Centers for Disease Control, and the members of the NCCRT Public Awareness Task Force who work diligently on these resources each year.

With your help, we can make 80% by 2018 a reality!

Richard C. Wender, MD
Chair, National Colorectal Cancer Roundtable
Chief Cancer Control Officer
American Cancer Society, Inc.

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# Overview



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# Expanding Success: Doubling Down our Efforts to Reach the Unscreened

## Introduction

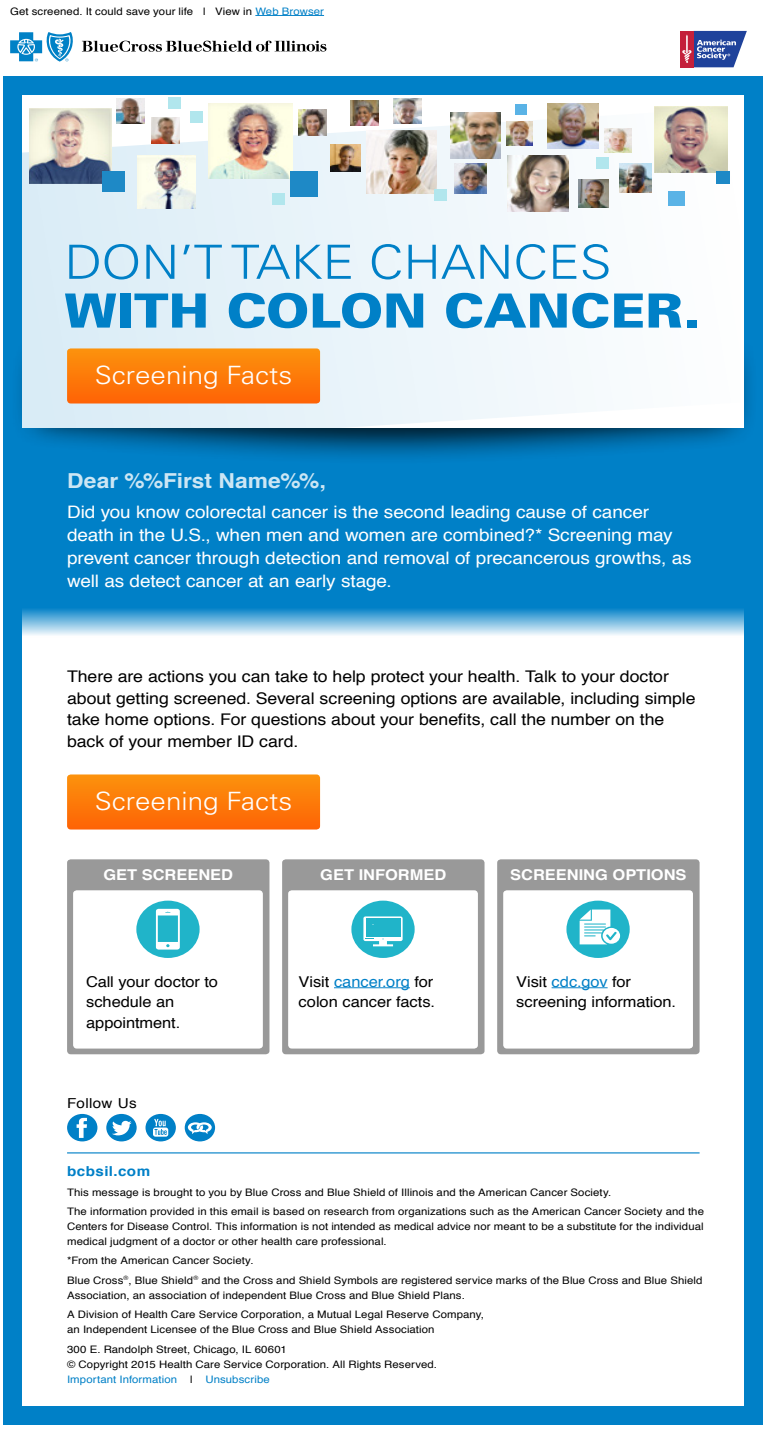
**Colorectal cancer incidence rates have dropped 30% in the U.S. over the last decade among adults 50 and older.** The percentage of the population up to date with recommended colorectal cancer screening increased from 54% in 2002 to 65.7% in 2014.[1] More people now have insurance coverage for colorectal cancer screening. Top health systems are already achieving 80% screening rates, and Massachusetts is already screening over 76% of their eligible population, the highest state screening rate in the nation.

These factors help to validate that an average national screening rate of 80% is indeed achievable. More importantly, we know that 203,000 lives can be saved by 2030 if we can achieve 80% by 2018, a truly astounding number.[2] However, to ensure that we can achieve this goal as a nation, it is critical to reach the unscreened.

The members of the National Colorectal Cancer Roundtable (NCCRT) conducted extensive strategic planning to determine how to get to an 80% screening rate. The NCCRT's Public Awareness Task Group worked with the American Cancer Society to conduct market research, determine priority populations who are not receiving screening and test key messages. The target audiences included:

- Newly Insured,
- Financially Challenged,
- Insured Procrastinators/Rationalizers,
- African Americans, and
- Hispanics.

## Sample Uses of Tested Messages



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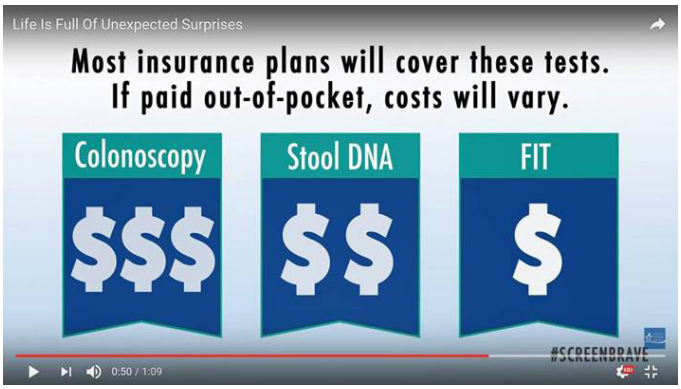
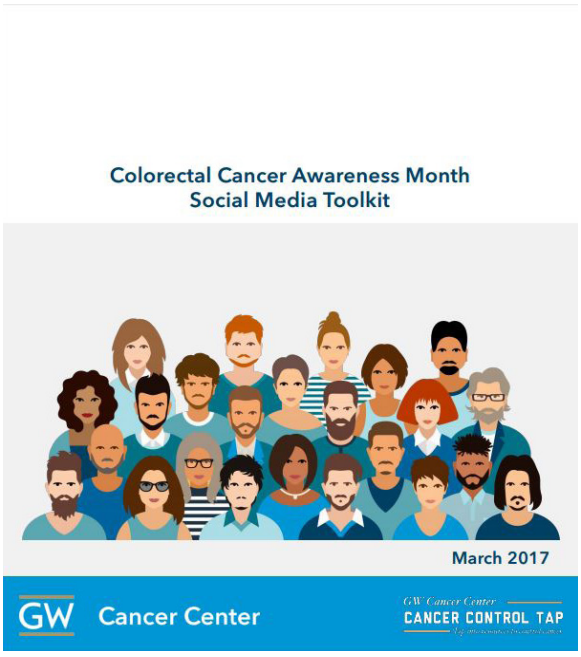
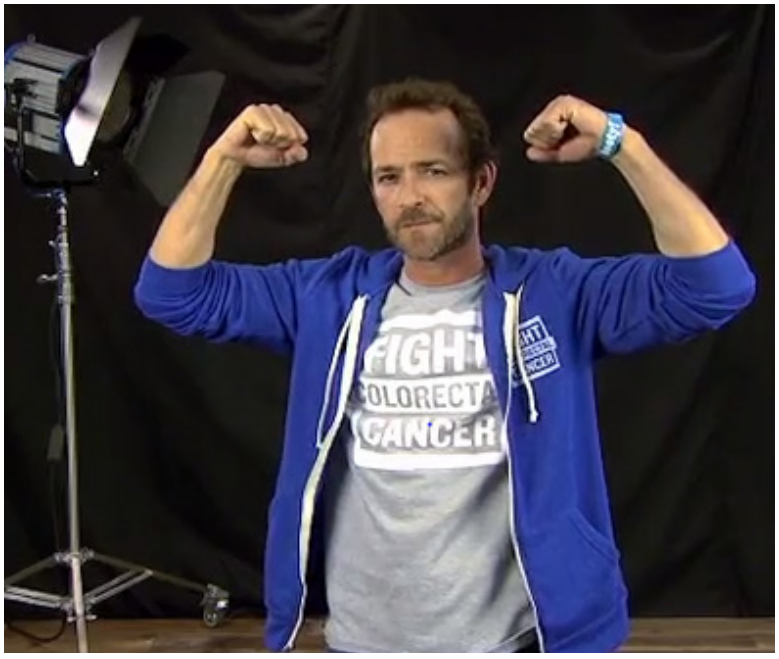
## Sample Uses of Tested Messages

In 2015, the messages for our target audiences presented in this guide were shared with NCCRT members, 80% by 2018 partners and others for their own use. We were excited to see these messages appear in a wide variety of formats from health plan reminder postcards to PSAs featuring celebrities to social media toolkits, making the 2015 Communications Guidebook one of our mostly widely used tools.

Our hope is that our partners continue to use these messages in 2017 with their continued creativity and cleverness in order to get through to the unscreened and move them to action.

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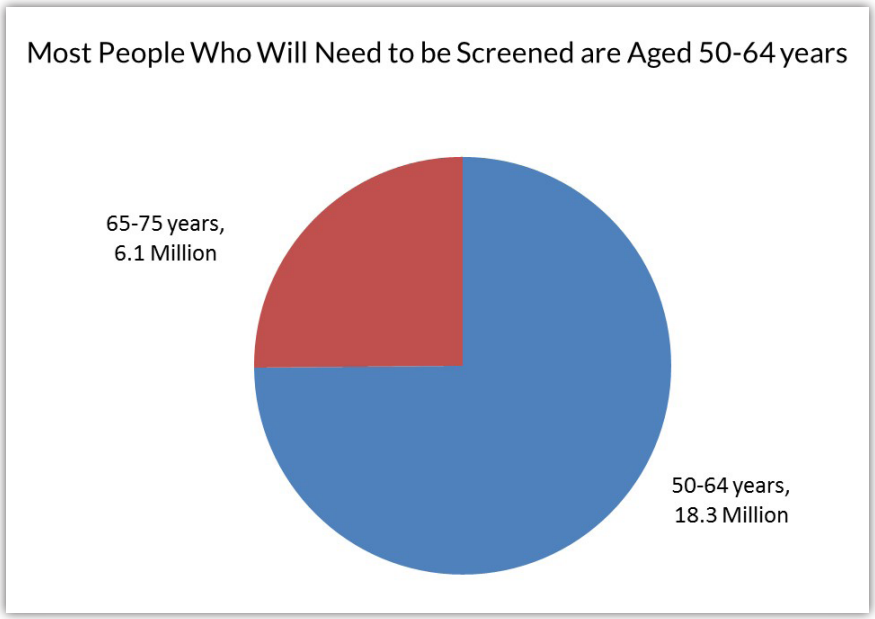
# Learning About the Unscreened

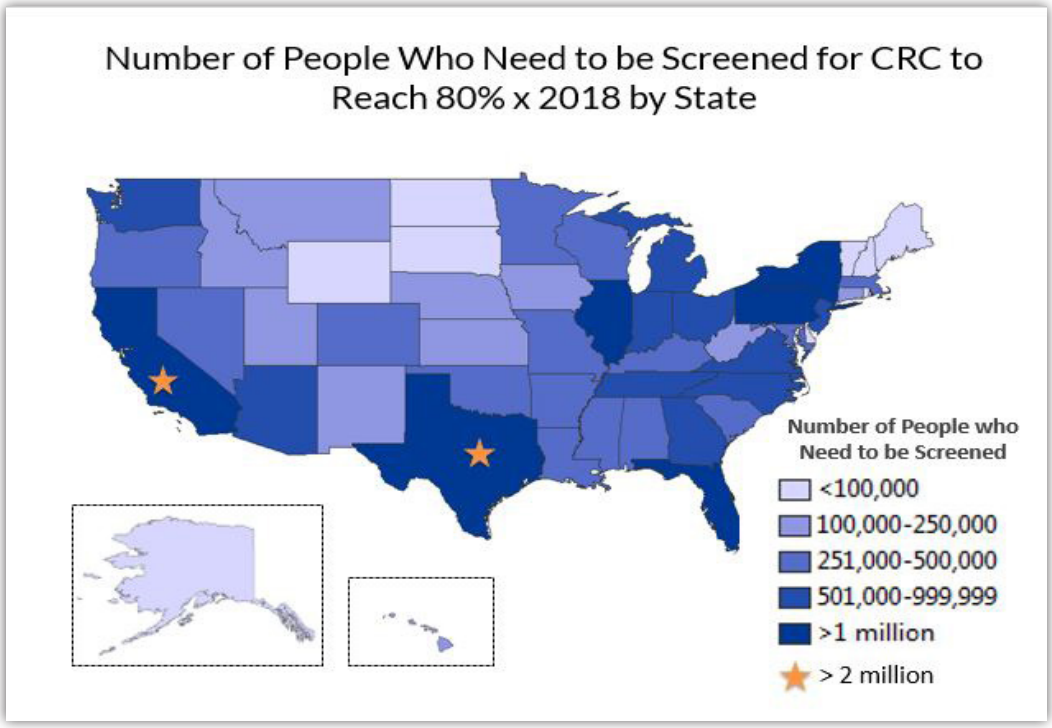
## Characteristics of the Unscreened

### *Screening Demographics*

It's important to know more about the populations we are targeting. Screening rates are particularly low in certain subgroups (Hispanics, Medicaid, Uninsured). There is an equal need between men and women. The chart to the right shows the importance of targeting efforts to reach the unscreened toward a slightly younger audience, as most people who need to be screened are 50-64 years old.




It's also worth noting that the number needing screening varies widely by state. The map below shows where those who need to be screened are most likely to reside, purely in terms of population. The number of people who need to be screened by state is a function of their population of 50- to 75-year-olds and to a lesser extent, colorectal cancer (CRC) screening prevalence. For example, California's CRC screening prevalence is about the national average, but because of their large population, they have the greatest number of people in need of CRC screening.



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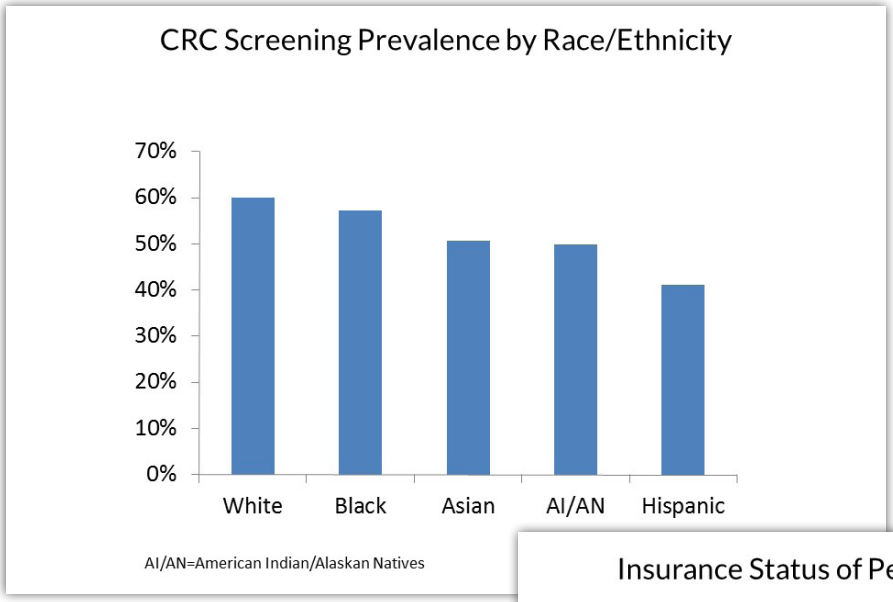
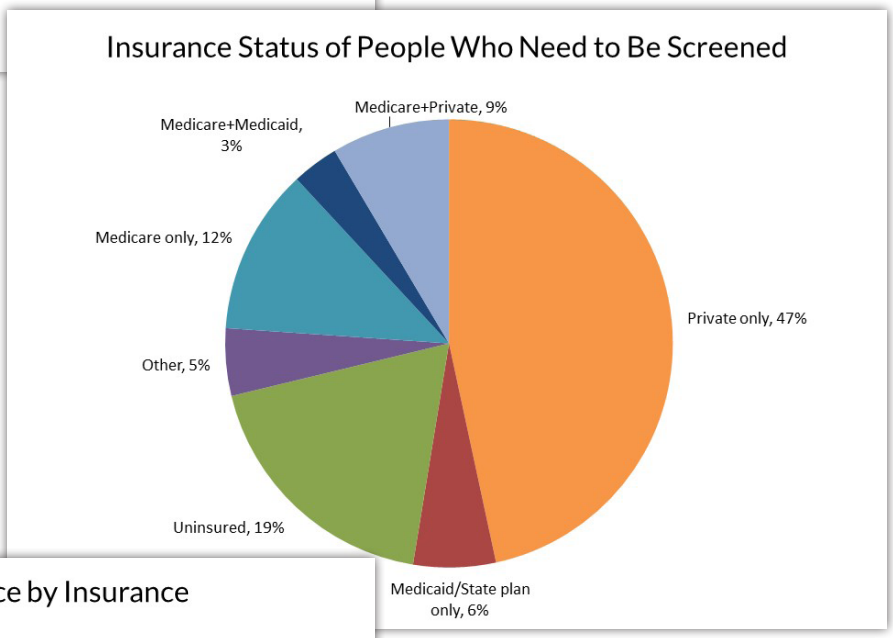
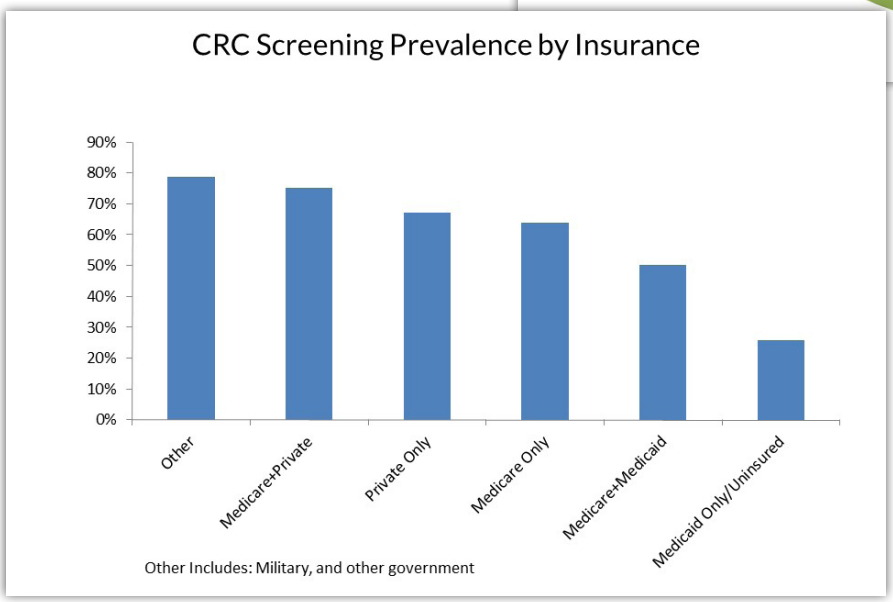
## *Screening Demographics*




The chart above shows the colorectal cancer screening rates by ethnicity. The chart to the right shows the insurance status for people who have not been screened for colorectal cancer: 47% percent of those who need screening have private insurance; 18% have Medicaid plus another type of coverage; and 12% have Medicaid only. The chart below shows the insurance coverage for those who have been screened.



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## *Demographic and Emotional Profile*

In 2014, the American Cancer Society (ACS), with guidance from the Centers for Disease Control and Prevention (CDC), conducted market research with a representative sample of 1,023 U.S. adults 50 years of age or older, followed by qualitative interviews with select audiences. The purpose of each assessment was to understand the rationale of those being screened compared with the unscreened.[4]

Demographic and psychographic data were assessed to determine which audiences were best to microtarget. Microtargeting specific audiences will inform strategy, ensuring appropriate messages are communicated through the best channels to make the most impact.

| | Demographic Profile | Emotional Profile |
|---|---|---|
| AGE | More likely to be younger than those screened; nearly two-thirds are 50–59 years of age | Think they already are taking care of their health<br>Fearful of the unknown<br>Fearful of preparation/procedure<br>Focused on more immediate health concerns<br>Procrastinators<br>Rationalize reasons for not being screened<br>Lack sense of urgency around the issue<br>Have an "I know best" attitude |
| INSURANCE STATUS | More likely to be uninsured (nearly one-quarter) than those screened | |
| INCOME | Slightly lower income than those screened, with over one-half earning under $40K per year | |
| RACE/ETHNICITY | More likely to be Hispanic than those screened (nearly 5 in 10 eligible Hispanics are not being screened) | |
| EDUCATION | Slightly more likely (around 7 in 10) to have less than a 4-year college degree than those who have been screened | |
| CANCER CONNECTION | Less likely to be a cancer survivor (<7%) and less likely to have a close friend/family member with cancer than those screened (just over half) | |

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## Top Barriers To Screening

It's important to know more about the populations we are targeting. Overall, unscreened audiences have some similarities in attitudes, aspirations, values, fears and other psychological criteria (psychographics) as the unscreened, but they all have unique barriers and will respond best to personalized messages. When we look at the barriers to screening, we are able to see these main barriers emerging within the target populations.

### 1 RATIONALIZED AVOIDANCE

While the unscreened base is knowledgeable about screening, they fail to recognize its importance and have typically rationalized avoidance.

### 2 LACK OF AFFORDABILITY

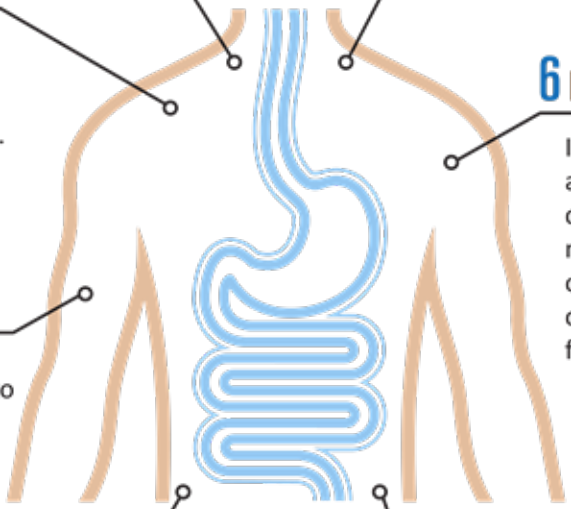
Socioeconomic gaps are evident in the unscreened population. Affordability is the number one issue given for not being screened.

### 3 NO SYMPTOMS OR FAMILY HISTORY

The unscreened often feel that screening messages do not apply to them, either because they do not have symptoms or do not have a family history of the disease.

### 4 NEGATIVE CONNOTATION

The unscreened population typically has some baseline familiarity with the tests, particularly colonoscopies. However, there is a negative connotation with the test, as many of the unscreened describe it as invasive, unpleasant, or embarrassing.



### 5 NO DOCTOR RECOMMENDATION

Many cite that their doctor has not recommended screening to them. This is the number one reason among the Black/African Americans, and the number three reason among the Hispanics.

### 6 NO PERSONAL CONNECTION

Interestingly, the unscreened are less likely to have a personal connection to cancer. They tend not to have had a close friend or family member with cancer, or are unaware of their family history.

### 7 LOW LEVELS OF HEALTHY BEHAVIOR

Despite self-identifying as "healthy" at similar levels as the screened, the unscreened population underindexes on numerous metrics of healthy behavior, such as caring about their health, visiting the doctor, or talking to their doctor about screening.

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## 5 Priority Populations

The following five priority populations were identified, based on the research conducted by the American Cancer Society and with input from the NCCRT Public Awareness Task Group. This research will be discussed in more detail throughout this guidebook:

| NEWLY INSURED | FINANCIALLY CHALLENGED | INSURED, PROCRASTINATORS/ RATIONALIZERS | AFRICAN AMERICANS | HISPANICS |
|---|---|---|---|---|

Messages have been tested with each of these groups, though there is overlap between audiences. African Americans and Hispanics cut across all target groups but will need special focus if we are to get to 80% by 2018. Hispanics are a priority audience due to their low screening rate (52%).[5] African Americans are a priority audience due to their high colorectal cancer incidence rate.[6]

The outreach gaps include low socio-economic groups and the newly insured, but also include some surprises, such as individuals with insurance who are just not responding to our traditional, rational messages about screening.

Several of our 80% by 2018 partners are successfully reaching the financially challenged audience, offering information and low-cost screening. Though a few NCCRT members are extremely strategic in their use of data to drive outreach to subpopulations, most partner campaigns focus on overall awareness and do not have campaign messages that have been tailored for niche audiences.

Additionally, the growing availability of health insurance creates a strong opportunity for action, given that affordability is the number two barrier to screening and that with insurance comes improved screening access.

On the whole, these subpopulations could benefit from amplified efforts backed by tested messages about the importance of screening.

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# How to Reach the Unscreened

## Effective Pathways To Screening

It's important to communicate messaging through the proper channels in order to reach our goal to get adults over 50 screened for colorectal cancer. Below depicts the pathway to screening, which will play a critical role in outreach efforts.

**Unscreened may be knowledgeable about screening tests but have rationalized avoidance. To change behavior and overcome the barriers limiting screening, personalized messages must:**

- Make the case for early detection
- Eliminate real and perceived barriers
- Align systems to reinforce messages
- Engage family and community networks

**In order to do this, the messages must:**

- Elicit support and testimony from peers and survivors to localize and connect the unscreened with those affected by colorectal cancer
- Engage family and community networks to articulate the need for screening and make it relevant to each person
- Align systems to reinforce messages and equalize the importance of screening among consumers and physicians
- Destigmatize the test and perceived barriers to conquer fear and provide information on screening options

**We will motivate the desired action by:**

- **Identifying influencers and using the right messengers to dispatch the messages**
- **Using tested messaging**
- **Executing campaign assets**
- **Using effective communication channels**
- **Measuring and improving upon our successes**

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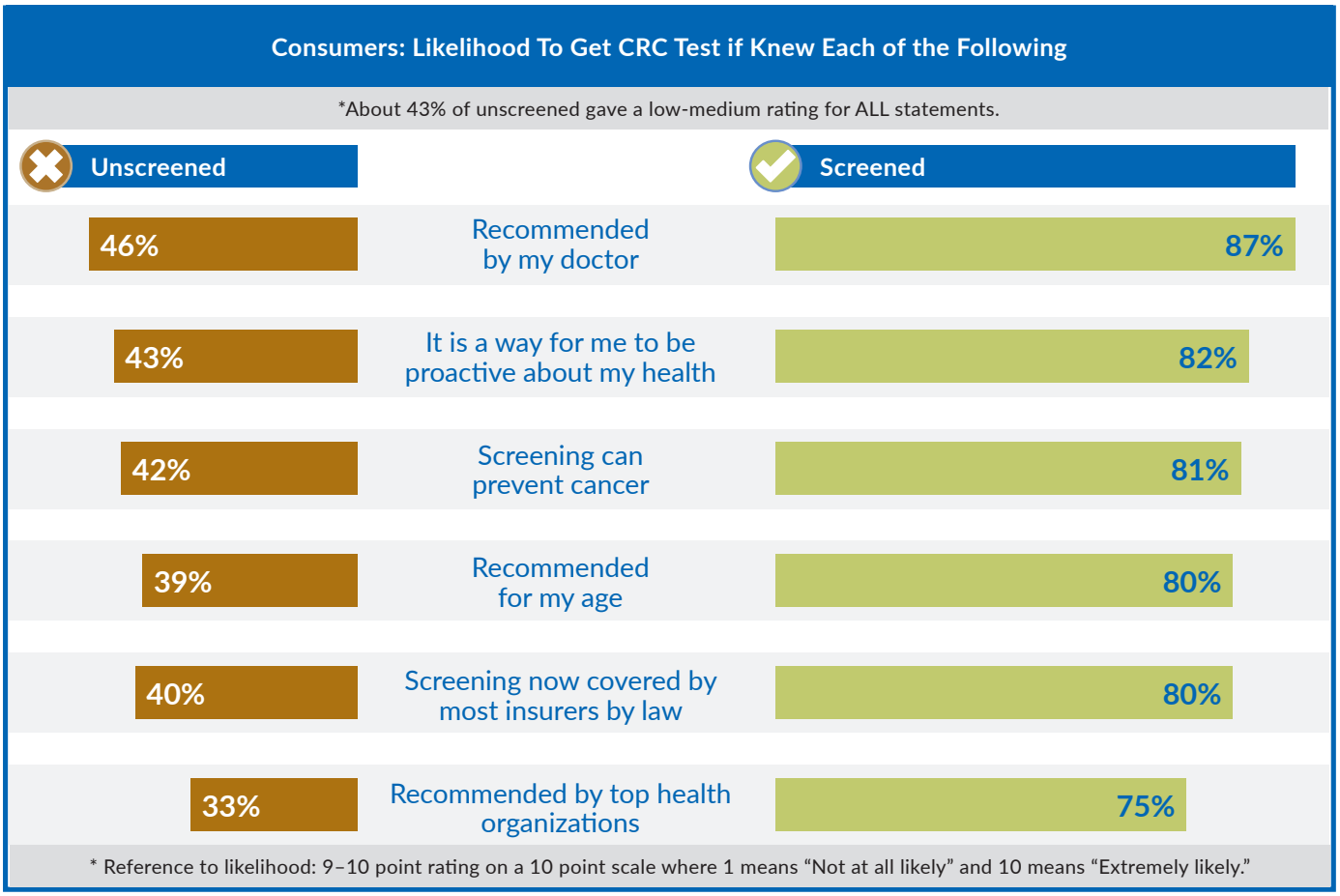
## Motivation

The most effective messages will resonate with the priority audience, both rationally and emotionally, and include a call-to-action that motivates. The American Cancer Society and the NCCRT Public Awareness Task Group developed twelve messages to test with our priority unscreened audiences, taking the following six core motivators into consideration.

| | |
|---|---|
| **Support and Testimony** | Hearing about someone else's screening experience relieves concerns and provides reassurance that the procedure is not as bad as perceived. It can also help make the connection about why screening is important. |
| **Empowerment and Control** | Feeling accomplished and proud comes with making a positive impact on health, allowing them to fix and prevent issues. |
| **Physical Survivor/ Expectation** | They want to stay in good health for as long as possible and may need to better understand the impact that the role of screening plays in that decision, as well as the toll that colorectal cancer can take on people like them. |
| **Trust** | Trust in a healthcare provider or other messenger can motivate to action. |
| **Options** | Some consumers need a different pathway to screening and want to be informed, knowledgeable, prepared and responsible about their health. |
| **Affordability** | Becoming more knowledgeable about screening coverage and options is important to these audiences. |

## *Logical/Rational Messages are Less Effective with the Unscreened*

Additionally, logical and rational messages about the benefits of screening will likely be insufficient to move the unscreened base. The data below show the likelihood that individuals would be screened if they were aware of specific information.




**To break down screening inertia and overcome barriers, we designed messaging that is tailored to address specific concerns, that resonates with consumers, and that is delivered through effective and trusted channels.**

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## *The Importance of the Right Messenger*

The right messengers are critical to reaching the unscreened. Important messengers to reach all of our priority audiences are:

**Physicians are viewed as a trusted source for health information.**

It's been well documented that physicians play a critical role in encouraging patients to get screened and providing information on the importance of colorectal cancer screening. Physicians need to understand some of the very real barriers that stop the unscreened from following through. **It's also important to note that our priority audiences are not regularly visiting their physician so we must look beyond physicians to reach these audiences.**

**Survivors make it personal.**

Less than half of the unscreened have a family history or personal connection to colorectal cancer. By sharing personal stories through survivors, it helps put a face on colorectal cancer and create urgency for testing, particularly if the survivor comes from the prioritized community.

**Community organizations and nonprofit organizations must be mobilized.**

Again, many of the unscreened do not regularly go to the doctor. Community organizations can play a key role in directing audiences to screening resources and informing them of their testing options.

**Insurance carriers clear up confusion.**

Insurance carriers are able to educate their constituents on coverage and screening options, and address concerns about affordability.

**Celebrities can help break through the clutter.**

One of the challenges to the public health community is to engage the unscreened at a more emotional level and break through the clutter of competing priorities and/or procrastination/rationalization. Finding someone who is well-known — a "celebrity" — to deliver the screening message is one way to do that. See our new resource on Engaging Celebrities for more advice at http://nccrt.org/tools/80-percent-by-2018/80-by-2018-communications-guidebook/#new

**While all of these messengers are key, each audience has individual needs. Of added importance is knowing your audience and reaching them through the proper channels, with the best messages.**

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## *Keys to Successful Messaging*

These messages are NOT meant to replace any organization's signature campaign on colorectal cancer screening. General awareness of screening is high, and it needs to stay that way. Rather, the NCCRT is challenging groups to think more strategically about reaching the unscreened and incorporating these tested messages into those efforts.

Messaging should NOT be focused on broad awareness but instead needs to be aligned with the six core emotional motivations that might compel unscreened individuals to get screened in the future.

Messages that will resonate the best with unscreened individuals should specifically:


Address misperceptions and fears around the test;

Feature testimonies from those who have been screened; and

Provide patients with the information and knowledge they need, including potential alternative screening solutions, to feel prepared and responsible about the process and results.

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# Motivating the Unscreened

As partners in the 80% by 2018 effort, we encourage you to consider various ways to incorporate and adapt these tested messages in your communications to your unscreened constituents. These messages can be made even more powerful with creativity and/or delivery by the right messenger.

## Top-rated Messages: Market Research Results

| Message #1 | *There are several screening options available, including simple take-home options. Talk to your doctor about getting screened.* |
|---|---|

**Why does this message work?**

**Ties to emotional driver of empowerment**

- Consumers have a need to be informed, knowledgeable, prepared and responsible about their health.
- This message allows consumers to feel control regardless of barriers they may face (e.g. affordability, fear, etc.).

**Alleviates a diverse set of barriers**

- Diminishes fear associated with standard procedures and prep.
- Too easy for even procrastinators to put off.
- Suggests a more affordable option.

**Appeals more than other "options" messages**

- The phrase "at home" was very important to the success of this message. Other "options" messages that did not specify the test could be done at home did not resonate as well with consumers.

| Message #2 | *Colorectal cancer is the second-leading cause of cancer death in the U.S. when men and women are combined, yet it can be prevented or detected at an early stage.* |
|---|---|

**Why does this message work?**

**Ties to emotional driver of empowerment**

- Educates people about their ability to take control of their own health through prevention and early detection.
- Detecting issues early means that there is an opportunity to fix problems and prevent future issues.
- Appeals to the desire to stay in good health as long as possible.

**Challenges assumptions**

- Challenges the assumption that colorectal cancer "can't happen to them," particularly for those who don't believe they are at risk unless they have symptoms or a family history.

**Appeals more than other "empowerment" messages**

- Describes the problem while simultaneously giving the consumer a way to address it.

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## Message #3

***Preventing colon cancer or finding it early doesn't have to be expensive. There are simple, affordable tests available. Get screened! Call your doctor today.***

**Why does this message work?**

**Ties to emotional driver of empowerment**

- Consumers have a need to be informed, knowledgeable, prepared and responsible about their health.
- Encourages consumers to take control of their health, while addressing concerns about affordability.

**Alleviates major barrier**

- Hits the affordability issue head on.
- Alleviates the stress of financial hardships that often comes with health care.

**Appeal of "options" message continues**

- Couples "options" messages with key information about why those options might work for them.

*Uniquely appealing message for the Newly Insured.*

## Message #4

***Most health insurance plans cover lifesaving preventive tests. Use the health benefits you are paying for to get screened for colon cancer. Call your doctor today.***

**Why does this message work?**

**Ties to emotional driver of empowerment**

- This message empowers people who are newly insured to use their newly acquired health insurance to have a positive impact on their health.
- This group feels optimistic about their health after receiving coverage. At a time when they are feeling newly empowered and optimistic, now is the time to motivate them to get screened.

**Alleviates major barrier**

- This messages also addresses affordability issues by educating the audience about access to services they may not have enjoyed before.

**Uniquely appealing for Newly Insured audiences**

- While the other top three messages resonated with all groups, this message was unique, in that it only resonated with the newly insured.
- This message taps into the interest of the newly insured to use benefits they may not have enjoyed previously.

The most effective messages will resonate with the priority audience, both rationally and emotionally, and include a call-to-action that motivates.

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# Priority Population Profiles

## *Insured, Procrastinators/Rationalizers*

The Insured, Procrastinators/Rationalizers are the closest to our general market consumer. They represent men and women over the age of 50 that either have other health issues on their mind or fear the procedure. In addition, many self-identify as "healthy" at similar levels as those screened, but are less likely to actually conduct healthy behaviors.

Despite self-identifying as "healthy" at similar levels as those screened, the unscreened population are under indexes on numerous metrics of healthy behavior.

| Consumers: Healthy Behaviors among Those Screened vs. Not Screened | | Unscreened | Screened | | Unscreened | Screened |
|---|---|---|---|---|---|---|
| PERCEPTIONS OF HEALTH | Consider myself to be "healthy"* | 48% | 47% | Care a great deal about maintaining my health* | 61% | 80% |
| VISITS TO DOCTORS | Have gone to the doctor in past year | 63% | 94% | Avoid going to the doctor as much as possible* | 44% | 20% |
| DISCUSSIONS ABOUT SCREENING | Have talked to doctor about screening | 44% | 88% | Have talked to family/ close friends about screening | 44% | 68% |
| ACTIVITY LEVEL | Exercise on a regular basis | 50% | 55% | Participate in sports/ fitness activities on regular basis | 14% | 21% |

*Data given = 8-10 rating on a 10 point scale where 1 means "Strongly disagree" and 10 means "Strongly agree."

### Motivating the Insured, Procrastinators/ Rationalizers

The insured, procrastinators/rationalizers are driven by control. While this audience cares a great deal about maintaining their health and exercise regularly, nearly half are doctor adverse and less than half speak with their doctor about colorectal cancer screening. They may not understand that colon cancer screening is something you do when you do not have symptoms. They do not consider it enough of a top priority to get screened.

This audience also reports not being screened because they've heard negative testimonials related to the test and its preparation. Fear of the unknown serves as a major barrier as well. Providing information on options that are more comfortable and private will help motivate them.

### Channels and Messengers To Reach Insured, Procrastinators/Rationalizers

- **Physicians:** This audience prefers receiving health care information from their physician.
- **Family and Friends:** Utilizing testimonials will help to relieve fear of the test, while instilling the urgency to get tested.
- **Online Media and Website:** This audience often turns to online media for information about health concerns.
- **Celebrities:** Celebrities, particularly those who resonate with the priority audience, can help break through clutter and garner attention to the cause.
- **Community Organizations:** Provide a good avenue to reach this audience, particularly those that are not regularly seeing a physician.

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# PROFILE OF AWARE AND ABLE

*Annual salary of $50k – AND – insured*

*Baseline Screening Likelihood: 15.4%*

## MESSAGES & CHANNELS THAT RESONATE THE BEST

1. *There are several screening options available, including simple take-home options. Talk to your doctor about getting screened.*

   **"I think more people would feel comfortable doing it at home than doing an outpatient procedure."**

   Emotional Driver: Control — Adjusted Screening Likelihood: 20.2%

2. *Colorectal cancer is the second-leading cause of cancer deaths in the U.S. when men and women are combined, yet it can often be prevented or detected at an early stage.*

   **"Using the phrase 'second-leading cause of cancer deaths' scares me. It would make me look into screening more so than the other ads."**

   Emotional Driver: Control — Adjusted Screening Likelihood: 19.7%

**NOTE: In all of the following charts, the term "over index" means the population is more inclined toward a trait or characteristic than average; and the term "under index" means the group is less inclined to have a trait or characteristic than average.*

**Discussions with doctor or health care provider are the most preferred way of getting health info, followed by a website.**

## HEALTHY LIFESTYLE BEHAVIORS

- **48%** are doctor adverse
- **39%** talk to doctor about screening
- **39%** talk to family/ friends about screening
- **52%** consider themselves healthy
- **62%** care a great deal about maintaining health
- **56%** exercise on a regular basis

## TOP BARRIERS TO SCREENING

- Been procrastinating
- No family history
- No symptoms

## DEMOGRAPHIC PROFILE

- **Employment** Over index* total for full-time employment
- **Education** Over index total for 4-year degree or higher
- **Income** Over index total for $50k+ income
- **Marital Status/Children** Over index total for married/living with partner and for having children
- **Insurance Status** Over index total for insured

**While this group is financially able to pay for CRC screening solutions, there is still an interest for alternative options that may be simpler compared to traditional screening tests, like the colonoscopy. Physicians may be a good source for getting the information out to this group, but testimonies from friends and family may be useful as well.**

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# PROFILE OF FEARFUL PROCRASTINATORS

*Have not been screened because they heard test or prep was unpleasant or embarrassing, of fear/afraid, or have been procrastinating*

*Baseline Screening Likelihood: 11.7%*

## MESSAGES & CHANNELS THAT RESONATE THE BEST

1. *There are several screening options available, including simple take-home options. Talk to your doctor about getting screened.*
   **"Privacy, less embarrassment, and no need to pay for a taxi to and from the appointment."**
   Emotional Driver: Control — Adjusted Screening Likelihood: 21.4%

2. *Colorectal cancer is the second-leading cause of cancer deaths in the U.S. when men and women are combined, yet it can often be prevented or detected at an early stage.*
   **"It is a scary statement, but it makes you really think; it's a wakeup call."**
   Emotional Driver: Control — Adjusted Screening Likelihood: 19.7%

3. *Preventing colon cancer, or finding it early, doesn't have to be expensive. There are simple, affordable tests available. Get screened! Call your doctor today.*
   **"Cost is a high priority for me."**
   Emotional Driver: Expectations — Adjusted Screening Likelihood: 19.1%

**Discussions with doctor or health care provider are the most preferred way of getting health info, followed by a website.**

## TOP BARRIERS TO SCREENING

- Been procrastinating
- Heard test was unpleasant
- Heard prep was unpleasant
- Fear/afraid

## DEMOGRAPHIC PROFILE

- **Insurance Status** — Over index total for insured
- **Children** — Over index total for having children

## HEALTHY LIFESTYLE BEHAVIORS

- **53%** are doctor adverse
- **44%** talk to doctor about screening
- **41%** talk to family/ friends about screening
- **42%** consider themselves healthy
- **57%** care a great deal about maintaining health
- **45%** exercise on a regular basis

**Despite the fact that nearly one-quarter of this group has served as a caregiver to someone with cancer, they are pushing off being screened. Their procrastination seems to be driven by fear of the test or prep, so alternative solutions outside of colonoscopies will appeal to this group. Physicians, family and community organizations may be good channels to reach these individuals.**

## *Financially Challenged*

The Financially Challenged audience represents the low socioeconomic population that typically experiences a disproportionate share of health disparities. They are often restricted by high deductibles or do not have access to health insurance, or are underinsured.

While more consumers are accessing insurance, there are still approximately 32.3 million people who were uninsured, in part to states that have not expanded Medicaid eligibility, at the beginning of 2015.[7]

- The uninsured are less likely to have received cancer screenings and are even less likely to receive follow-up care after a diagnosis.
- Family/friends are not top sources of screening information.

### Motivating the Financially Challenged

Like the insured procrastinators, the financially challenged are driven by control. This message about affordability tested high with this audience: **Preventing colon cancer, or finding it early, doesn't have to be expensive. There are simple, affordable tests available. Get Screened! Call your doctor today.** Because this audience is either not insured or has an income of under $30,000, messages around affordability will drive action, as healthcare costs are a major concern for them. They respond to messages that promote alternative, less expensive options for screening.

### Channels and Messengers To Reach Financially Challenged

- **Community Clinics/Nonprofit Organizations:** The majority of the financially challenged population receives health care from community clinics since they do not visit a primary care physician regularly.
- **Primary Care Physicians:** It is estimated that in 2012, 43% of America's working-age adults didn't go to the doctor or access other medical services because of the cost,[8] but doctors are a very trusted source of information for this audience. Whenever possible systems should be in place to flag patients in need of screening when they do go to the doctor for sick visits, so doctors can use the opportunity to educate patients about colorectal cancer and testing options. The following resources can help with systematic change:
  - Primary Care Clinicians - http://nccrt.org/about/provider-education/crc-clinician-guide/
  - Community Health Centers - http://nccrt.org/about/provider-education/manual-for-community-health-centers-2/
- **Online Media and Website:** This audience often turns to online media for information about health concerns.
- **Community Health Centers (CHC):** CHCs are a major primary care provider for the underserved.

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## PROFILE OF THE FINANCIALLY CHALLENGED

*Annual salary of <$30k – OR – not insured*

*Baseline Screening Likelihood: 8.6%*

### MESSAGES & CHANNELS THAT RESONATE THE BEST

1. *There are several screening options available, including simple take-home options. Talk to your doctor about getting screened.*
   **"Simple and I can do it in the privacy of my home."**
   Emotional Driver: Control — Adjusted Screening Likelihood: 18.6%

2. *Preventing colon cancer, or finding it early, doesn't have to be expensive. There are simple, affordable tests available. Get screened! Call your doctor today.*
   **"Cost is a great concern as I have no insurance and little income."**
   Emotional Driver: Control — Adjusted Screening Likelihood: 17.5%

3. *Colorectal cancer is the second-leading cause of cancer deaths in the U.S. when men and women are combined, yet it can often be prevented or detected at an early stage.*
   **"Brings to mind how important it is to get checked so that a person can prevent death from colon cancer."**
   Emotional Driver: Expectations — Adjusted Screening Likelihood: 16.7%

**Discussions with doctor or health care provider are the most preferred way of getting health info, followed by a website.**

### TOP BARRIERS TO SCREENING

- Affordability
- No symptoms
- No family history

### DEMOGRAPHIC PROFILE

- **Employment** — Over index total for not employed and disabled
- **Education** — Over index total for high school degree or less
- **Income** — Over index total for less than $30k income
- **Marital Status/Children** — Over index total for married/living with partner and for having children
- **Insurance Status** — Under index total for insured

**This group clearly needs alternative, less expensive solutions for screening. Community health organizations or other nonprofits may be good channels to get these individuals engaged given that over half are doctor adverse and only a small proportion are actually talking to family and friends about screening.**

### HEALTHY LIFESTYLE BEHAVIORS

- **56%** are doctor adverse
- **27%** talk to doctor about screening
- **28%** talk to family/ friends about screening
- **41%** consider themselves healthy
- **55%** care a great deal about maintaining health
- **42%** exercise on a regular basis

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## *Newly Insured*

The Insured, Newly Empowered audience now has access to insurance through the Affordable Care Act (ACA) Health Insurance Marketplace or expanded Medicaid eligibility, offering them cost-effective access to medical test procedures that they may not have had previously.

Approximately 81% of the Newly Insured feel optimistic about their health after receiving coverage and 60% have already used their insurance to receive medical care or get a prescription filled. At a time when they are feeling newly empowered and optimistic, now is the time to motivate them to get screened.

### Motivating the Newly Insured

Many may be disenfranchised workers, non-working or self-employed. They may not have carried health coverage in the past but are benefiting from new access to coverage, or may be compelled by the ACA's tax penalties on uninsured persons.

Motivating this audience should focus on educating them on screening options through the best channels, while encouraging them to take full advantage of new insurance plans to detect or prevent colorectal cancer. Because they may have not had insurance coverage in the past, they may require additional education on what insurance offers, and how prevention is covered.

While the "options" message was the highest message within this group, as with the other priority audiences, it is worth noting that the message below tested second highest.

**Message #2 for newly insured: Most health insurance plans cover lifesaving preventive tests. Use the health benefits you are paying for to get screened for colon cancer. Call your doctor today.**

### Channels and Messengers To Reach Newly Insured

- **Primary Care Physicians, Pharmacies:** 60% have already used their insurance to receive medical care or get a prescription filled.
- **Medicaid Providers/Offices:** Studies have found that the biggest factor in reducing the uninsured rate was the expansion of Medicaid eligibility.
- **Insurance Providers:** Educate newly insured about their new coverage, and what is covered.
- **Community Health Centers:** As a portion of their patients move to either Medicaid coverage or coverage from the exchanges, health centers play a critical role in reaching the newly insured.
- **Community Organizations and Nonprofits:** Although a large number of newly insured are using their new benefits, many are still physician adverse so it's important to relay information through additional channels.

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# PROFILE OF THE NEWLY INSURED

*Insured for less than 1 year*

## MESSAGES & CHANNELS THAT RESONATE THE BEST

| | | |
|---|---|---|
| 1 | *There are several screening options available, including simple take-home options. Talk to your doctor about getting screened.* | **"It can be done at home and I don't have to go to a hospital to get screened."** |
| | Emotional Driver: Control | |
| 2 | *Most health insurance plans cover lifesaving preventive tests. Use the health benefits you are paying for to get screened for colon cancer. Call your doctor today.* | **"If the insurance company is willing to pay for it, it must be a good idea."** |
| | Emotional Driver: Control | |
| 3 | *Preventing colon cancer, or finding it early, doesn't have to be expensive. There are simple, affordable tests available. Get screened! Call your doctor today.* | **"Knowing that there are simple and affordable tests available."** |
| | Emotional Driver: Control | |
| 4 | *Colorectal cancer is the second-leading cause of cancer deaths in the U.S. when men and women are combined, yet it can often be prevented or detected at an early stage.* | **"It is informative, telling me something that I did not know. After hearing this message my likely course of action would be to ask my doctor at my next annual physical to include colon cancer screening as part of my exam if she is not already doing so."** |
| | Emotional Driver: Expectations | |

**Discussions with doctor or health care provider are the most preferred way of getting health info, followed by a website.**

## HEALTHY LIFESTYLE BEHAVIORS

- **59%** are doctor adverse
- **29%** talk to doctor about screening
- **32%** talk to family/ friends about screening
- **45%** consider themselves healthy
- **55%** care a great deal about maintaining health
- **48%** exercise on a regular basis

## TOP BARRIERS TO SCREENING

- No symptoms
- Heard the test was unpleasant
- No family history

## DEMOGRAPHIC PROFILE

- **Income**
  Over index total for less than $30k income
- **Marital Status/Children**
  Over index total for NOT having children
- **Race/Ethnicity**
  Over index total for Hispanic

**This group is clearly looking for alternative, less expensive options for screening. Very few newly insured individuals talk with their doctor about screening and a large proportion are doctor adverse. This makes it really important to rely on other sources of getting the word out about screening, such as community health organizations or nonprofits.**

## *African Americans*

African Americans are the second-most uninsured population in the U.S.[9] and have one of the highest colorectal cancer incidence and mortality rates of all the racial groups in the U.S.[10] The American Cancer Society estimated that approximately 18,000 African American men and women would be diagnosed with colorectal cancer during the year 2013 and in that same year approximately 6,850 would die.[11]

### Reaching African American Men and Women

Reaching African American men and women requires respect for cultural norms and barriers.

**Male Priority Audience:** Trust is an important prerequisite that needs to be at the core of health promotional efforts within the African American community.

**Female Priority Audience:** Women are one of the main influencers of health behaviors in the African American community and are often the disseminator of health information to their families and communities.

### Motivating the African American Population

Messages should focus on taking steps to have a positive impact on one's health, while stressing the fact that regardless of a lack of symptoms, screening is important now. The concept that screening is something that happens when you are well (no symptoms) seems not to be well appreciated by this audience. Additionally, messages for the males in this population should be sensitive to cultural perceptions regarding various screening methods. This can be achieved through education on screening options and utilizing testimonials from the African American community.

### Channels and Messengers To Reach African Americans

- **Primary Care Physicians:** Unscreened African Americans cite no doctor recommendation as being their number one reason for not being screened. Whenever possible systems should be in place to flag patients in need of screening when they do go to the doctor for sick visits, so doctors can use the opportunity to educate patients about colorectal cancer and testing options. The following resources can help with systematic change:
  - Clinician's Guide - http://nccrt.org/about/provider-education/crc-clinician-guide/
  - Community Health Centers - http://nccrt.org/about/provider-education/manual-for-community-health-centers-2/
- **Television:** Serves as a top source for receiving health information and a preferred channel for receiving information specific to health.
- **Online Media and Website:** This audience often turns to online media for information about health concerns.
- **Faith and Community Organizations**: Faith centers and community organizations are trusted partners where important information is often passed along to constituents.

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# PROFILE OF UNSCREENED BLACK/AFRICAN AMERICANS

*Baseline Screening Likelihood: 22.1%*

## MESSAGES & CHANNELS THAT RESONATE THE BEST

1. *There are several screening options available, including simple take-home options. Talk to your doctor about getting screened.*
   **"I have heard that this test is uncomfortable but if there are several options, I would be more likely to see which option would be good for me."**
   Emotional Driver: Control — Adjusted Screening Likelihood: 28.2%

2. *Colorectal cancer is the second-leading cause of cancer deaths in the U.S. when men and women are combined, yet it can often be prevented or detected at an early stage.*
   **"I did not know that it was second in cancer deaths, and since colon cancer is in the family, screening becomes a priority."**
   Emotional Driver: Expectations — Adjusted Screening Likelihood: 28.7%

3. *Preventing colon cancer, or finding it early, doesn't have to be expensive. There are simple, affordable tests available. Get screened! Call your doctor today.*
   **"It lets you know you can get a test at an affordable price to ensure your health."**
   Emotional Driver: Control — Adjusted Screening Likelihood: 27.9%

**Discussions with doctor or health care provider are the most preferred way of getting health info, followed by a website.**

## TOP BARRIERS TO SCREENING

- No symptoms
- Been procrastinating
- Affordability

## DEMOGRAPHIC PROFILE

**Marital Status**
Over index total for single/never married

**Insurance Status**
Under index total for private insurance

## HEALTHY LIFESTYLE BEHAVIORS

- **37%** are doctor adverse
- **37%** talk to doctor about screening
- **34%** talk to family/ friends about screening
- **37%** consider themselves healthy
- **74%** care a great deal about maintaining health
- **43%** exercise on a regular basis

**Similar to fearful procrastinators, despite the fact that one-quarter of this group has served as a caregiver to someone with cancer, they are delaying being screened or have not been screened because they have not experienced any symptoms. Physicians and community organizations would be useful channels to reach this group.**

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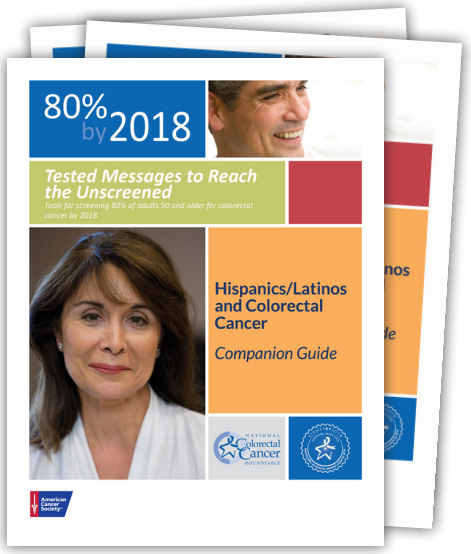
## *Hispanics/Latinos**

Hispanics/Latinos are the most uninsured population in the U.S.[12] and are more likely than others to not be screened.[13] In fact, our 2014 research with English-speaking Hispanics shows that 70% do not talk to their doctor about screening. It is important that we focus on efforts to improve screening rates among this population to positively impact the national average.

### Motivating the Hispanic/Latino Population

Successful messaging to Hispanic/Latino audiences should be intentionally bold and direct because the most effective campaigns convey risk and urgency clearly and directly. There are also cultural nuances in language that makes subtle messaging less effective.

While the following messages were tested only with English-speaking Hispanics, message testing for Spanish-speaking and bilingual Hispanics was completed in 2015. See the *Hispanics/Latinos and Colorectal Cancer Companion Guide* for an in-depth look at effective messages to reach Hispanics/Latinos, including audience-tested Spanish messages.




To motivate Hispanics/Latinos, it is important to understand how to effectively conduct education about screening options, particularly affordable options. Family relationships are strong; however, this research showed that friends and family may be reluctant to discuss sensitive health matters with each other. As such, it's important to engage this audience through alternative channels.

### Channels and Messengers To Reach Hispanics/Latinos

- **Physicians:** The Hispanic/Latino population has a high trust in their physicians and views them as a top source for information. Unscreened Hispanics/Latinos saying that "My doctor did not recommend it" is the number three reason they give for not being screened. Unfortunately, only a small percent visits their physicians regularly so additional messaging channels are needed. Whenever possible systems should be in place to flag patients in need of screening when they do go to the doctor for sick visits, so doctors can use the opportunity to educate patients about colorectal cancer and testing options. The following resources can help with systematic change:
  - Clinician's Guide - http://nccrt.org/about/provider-education/crc-clinician-guide/
  - Community Health Centers - http://nccrt.org/about/provider-education/manual-for-community-health-centers-2/
- **National Health Organizations, News Reports and Advertisements:** This audience is much more open to advertising messages than other populations and would like to receive information through these sources.
- **Text Messages:** This audience is much more receptive to text message campaigns from avenues they are comfortable with, such as their mobile device.
- **Television:** Top source for receiving health information, and a preferred channel for receiving information specific to health. Respectable television sources include *Telemundo* and *Univision*.

*The 2014 market research was conducted with an English-speaking audience. Please see our 2016 Companion Guide with Spanish messages for a summary of recent market research conducted with bicultural, unacculturated Hispanics.

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# PROFILE OF UNSCREENED HISPANICS (English-Speaking Only)

*Baseline Screening Likelihood: 21.2%*

## MESSAGES & CHANNELS THAT RESONATE THE BEST

1. *There are several screening options available, including simple take-home options. Talk to your doctor about getting screened.*
   - **"I can test on my own, at home and at my leisure so I won't be embarrassed."**
   - Emotional Driver: Control
   - Adjusted Screening Likelihood: 28.5%

2. *Colorectal cancer is the second-leading cause of cancer deaths in the U.S. when men and women are combined, yet it can often be prevented or detected at an early stage.*
   - **"The fact that it is the second-leading cause of deaths related to cancer would scare me enough to get tested. I did not realize that it was the second-leading cause of death. Knowing this would change my mind about cancer testing."**
   - Emotional Driver: Expectations
   - Adjusted Screening Likelihood: 29.3%

3. *Preventing colon cancer, or finding it early, doesn't have to be expensive. There are simple, affordable tests available. Get screened! Call your doctor today.*
   - **"The affordable line is all."**
   - Emotional Driver: Control
   - Adjusted Screening Likelihood: 27.9%

**Discussions with doctor or health care provider are the most preferred way of getting health info, followed by a website.**

## TOP BARRIERS TO SCREENING

- No family history
- No symptoms
- Affordability

## DEMOGRAPHIC PROFILE

- **Age**
  Over index total for 50-64 years old
- **Insurance Tenure**
  Over index total for insured less than 1 year
- **Cancer Connection**
  Directionally under index total for survivors

**This group is looking for alternative, less expensive options for screening. Few talk with their doctor about screening. In addition, friends and family are not a top source of screening info either. This group needs to be engaged through other channels. Qualitatively, this group mentioned TV as a source for health info and a preferred channel for receiving info about screening.**

## HEALTHY LIFESTYLE BEHAVIORS

- **48%** are doctor adverse
- **30%** talk to doctor about screening
- **37%** talk to family/ friends about screening
- **48%** consider themselves healthy
- **67%** care a great deal about maintaining health
- **50%** exercise on a regular basis

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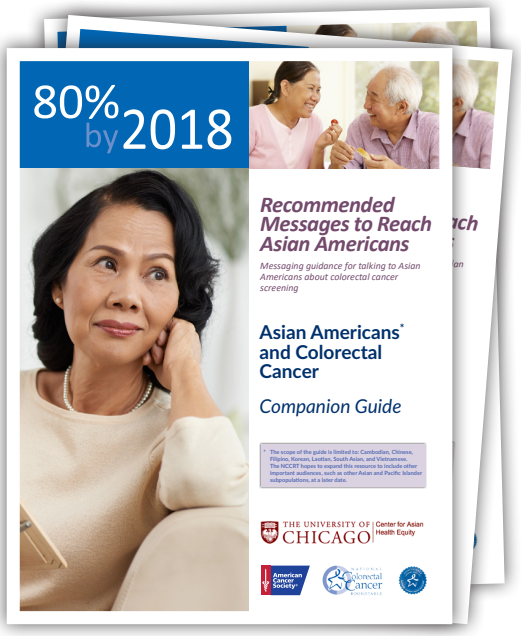
## *Asian Americans*

Please see our new *2017 Asian Americans Companion Guide* at http://nccrt.org/tools/80-percent-by-2018/asian-american-companion-guide/ for a summary of consumer research conducted with seven Asian American subpopulations about screening, including recommended messages.




# Tools To Reach the Priority Populations

## Collateral Featuring Tested Messages

Your participation is critical to reaching an 80% colorectal cancer screening rate by 2018. Partners are encouraged to leverage the resources provided within this guidebook to support outreach efforts, using both the tools provided below and the research to develop more creative, emotional ways to convey key messages:

| | |
|---|---|
| **Banner Ads** | http://nccrt.org/tools/80-percent-by-2018/80-by-2018-communications-guidebook/80-by-2018-communications-guidebook-banner-ads/ |
| **Social Media Toolkit (provided by George Washington Cancer Center)** | http://bit.ly/Colorectal2017Toolkit |
| **In-Office Screen Slides** | http://nccrt.org/tools/80-percent-by-2018/80-by-2018-communications-guidebook/80-by-2018-communications-guidebook-medical-office-screen-slides/ |
| **Sample Radio/TV PSA Scripts** | http://nccrt.org/wp-content/uploads/Radio-and-TV-PSA-Scripts.pdf |
| **Infographics** | http://nccrt.org/wp-content/plugins/download-monitor/download.php?id=145 |
| **Sample CEO Champion Letter** | http://nccrt.org/wp-content/plugins/download-monitor/download.php?id=164 |
| **Sample Email from a CEO to Employees** | http://nccrt.org/wp-content/plugins/download-monitor/download.php?id=166 |
| **Sample Email from a Hospital to Staff** | http://nccrt.org/wp-content/plugins/download-monitor/download.php?id=165 |

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## MIYO

MIYO (Make it Your Own) is a free web-based platform for creating your own custom educational materials in English and Spanish. These include posters, flyers, inserts and more tools to promote colorectal cancer screening and other topics.


MIYO
make it your own


MIYO offers hundreds of messages to choose from, including the messages tested by the NCCRT and American Cancer Society. MIYO was created through the generous support of National Cancer Institute (NCI) and the CDC.

www.miyoworks.org

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# Templates

## *Talking Points for Media*

Colorectal cancer is the second-leading cause of cancer deaths in the United States, yet it is highly ***preventable, detectable and treatable***. Screening saves lives. Get screened.

| IMPORTANCE OF SCREENING | PAYMENT & INSURANCE INFORMATION | TESTING OPTIONS |
|---|---|---|
| ▸ It is estimated that in 2017, over 135,000 cases of colorectal cancer will be diagnosed in the U.S.<br>▸ In 2017, over 50,000 people are expected to die from colorectal cancer.<br>▪ Most people with early stage colorectal cancer (commonly referred to as colon cancer) have it and don't know it.<br>▸ Colon cancer can often be prevented through screening.<br>▸ Screening tests can find pre-cancerous polyps; removing polyps prevents colon cancer.<br>▪ If the tests find cancer early, colon cancer is very treatable.<br>▸ Men and women 50 or older should get screened, regardless of family history because:<br>▪ in its earliest, most treatable stage, colon polyps and early colon cancers often do not cause symptoms; and<br>▪ most colon cancers occur in those without a family history.<br>▸ Those with a family history of colon cancer should let their doctor know; they may have to begin screening at an earlier age.<br>▸ People of all ages should talk to their doctor about colon cancer to rule out a family history of the disease or to discuss any symptoms, such as blood in the stool or a persistent change in bowel habits.<br>▸ It's important to take control and talk to your doctor. Get screened to prevent colon cancer. | Medicare pays for colon cancer screening. To find out about Medicare coverage, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov<br><br>Most private insurance plans are required to pay for colon cancer screening, often with limited, if any, out-of-pocket costs. Check your health plan for details on your specific coverage.<br><br>Those who signed up for insurance through the Affordable Care Act are covered for preventive services, such as colon cancer screening. They should check with their plan for details.<br><br>▸ There may be resources available in local communities to help pay for colon cancer screenings for the uninsured.<br>▸ Community organizations and advocacy groups are great resources to learn more. | ▸ Men and women aged 50 and older (at average risk) should be screened for colon cancer.<br>▸ Fortunately, there are multiple screening tests for colon cancer; a doctor can advise as to which test is best for individual needs.<br>▸ The most commonly used screening tests are:<br>▪ Fecal Occult Blood Testing (FOBT) or Fecal Immunochemical Test (FIT) every year.<br>▪ Colonoscopy every 10 years.<br>▸ Newer tests such as Stool DNA and CT Colonography are now among recommended options.<br>▸ Many people think colonoscopy is the only option—it's not! Consult a doctor about other options, such as take-home tests.<br>▸ Men and women 50 and over who haven't been screened should remind their doctor that they're overdue.<br>▸ Colon polyps and early colon cancers often cause no symptoms. Blood in stool; rectal bleeding; a change in bowel habits; narrowing of stool; unexplained weight loss; fatigue; anemia or constipation that lasts for more than a few days can be symptoms of colon cancer. It's critical to consult a doctor, regardless of age, if these symptoms are present. |
| **FINANCIALLY CHALLENGED** | **INSURED \| HEALTH CONFIDENT** | **INSURED \| EMPOWERED** |

Include stories from survivors, caregivers, families, celebrities and doctors—particularly those who are known by or look like the priority audience to relay these messages:

**- Personal experience with screening, early detection, and prevention -**

**- Decision pathways, and what obstacles they overcame to get screened -**

**- What they would tell others who are reluctant to get screened -**

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## *Sample Pledge Press Release*

### (Insert Organization) Commits to Life-Saving Role

### (Insert Organization) Joins Forces with More Than a Thousand Local and National Organizations to Increase Colorectal Cancer Screening Rates Across the Country

### "80% by 2018" is a shared goal to have 80% of adults aged 50 and older regularly screened for colorectal cancer by 2018.

Insert City (and date) – Colorectal cancer screening has been proven to save lives. (Insert Organization) today announced that it has made the pledge to help increase colorectal cancer screening rates by supporting the 80% by 2018 initiative, led by the American Cancer Society (ACS), the Centers for Disease Control and Prevention (CDC) and the National Colorectal Cancer Roundtable (a coalition co-founded by ACS and CDC).

Colorectal cancer is the nation's second-leading cause of cancer-related deaths in the U.S. when men and women are combined; however, it is one of only a few cancers that can be prevented. Through colorectal cancer screening, doctors can find and remove hidden growths (called "polyps") in the colon, before they become cancerous. Removing polyps can prevent cancer.

"80% by 2018" is a National Colorectal Cancer Roundtable (NCCRT) initiative in which more than a thousand organizations have committed to substantially reducing colorectal cancer as a major public health problem and are working toward the shared goal of 80% of adults aged 50 and older being regularly screened for colorectal cancer by 2018. Leading public health organizations, such as NCCRT, CDC and the ACS are rallying organizations to embrace this shared goal. If we can achieve 80% by 2018, 277,000 cases and 203,000 colorectal cancer deaths would be prevented by 2030.

"Colon cancer is a major public health problem, and adults age 50 and older should be regularly screened for it, but we have found that many people aren't getting screened because they don't believe they are at risk, don't understand that there are test options or don't think they can afford it," said (insert name). "The truth is that simply aging puts you at greater risk for colon cancer. Colorectal cancer in its early stages usually has no symptoms, so most everyone 50 and older should get screened. There are several screening options – even take-home options – available. Plus, many public and private insurance plans cover colorectal cancer screening and there may be local resources available to help those that are uninsured." [personalize quote before use]

While colorectal cancer incidence rates have dropped in the U.S. among adults 50 and older, it is still is the 2nd leading cause of cancer death in the United States, despite being highly preventable, detectable and treatable. In fact, it is estimated that in 2017, over 135,000 cases of colorectal cancer will be diagnosed.

Part of the 80% by 2018 goal is to leverage the energy of multiple and diverse partners to empower communities, patients and providers to increase screening rates. The 80% by 2018 initiative consists of health care providers, health systems, communities, businesses, community health centers, government, non-profit organizations and patient advocacy groups, among others, who are committed to getting more people screened for colorectal cancer to prevent more cancers and save lives.

"We are thrilled to join the cause to improve colon cancer screening rates," said (insert name). "We are asking all members of our community to come together and help us by getting screened and talking to your friends and family who are over 50 years of age about getting screened. Together, we can help make colon cancer a major public health success story." [personalize quote before use]

For more information or to learn about resources in your area, visit: xxxxxxxx.

[Insert Organization's Boiler Plate Language – include organization description, mission and contract information including website]

[INSERT APPROPRIATE LINK FOR MORE INFORMATION (e.g. For more information about colorectal cancer screening, visit www.cancer.org/colon or contact the American Cancer Society at 1-800-227-2345. For more information about the 80% by 2018 initiative, visit www.nccrt.org.)]

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## *Sample New Initiative Press Release*

### (Insert Organization) Announces [insert new initiative] (e.g. Screening Program for the Uninsured]

### (Insert Organization) Joins Major National Effort to Save Lives from Colorectal Cancer by 2018 Through Increased Screening

[Insert city, state] – [insert date] – (Insert organization) today announced [insert one or two sentences describing the new initiative (e.g. that they launched a new screening program for the uninsured, that they have a new patient or physician reminder system, that there is a targeted community outreach program, etc.)]

This promising program is a key part of [insert organization]'s commitment to the 80% by 2018 initiative, a shared goal led by the National Colorectal Cancer Roundtable (NCCRT) to have 80% of adults regularly screening for colorectal cancer by 2018. [insert organization] signed the 80% by 2018 pledge at an event on [insert date].

[Insert details about the new initiative.]

[Insert quote from org spokesperson about why they began this initiative, steps they've taken and/or how it is important to the community. Include recognition of key partners for supporting the initiative if applicable.]

[Insert quote from American Cancer Society health systems staff praising partner org efforts and commenting on its importance. Contact your local ACS health systems staff to request a quote.]

"80% by 2018" is an NCCRT initiative in which more than a thousand organizations have committed to substantially reducing colorectal cancer as a major public health problem and are working toward the shared goal of 80% of adults aged 50 and older being regularly screened for colorectal cancer by 2018. Colorectal cancer is the second-leading cause of cancer deaths in the U.S. when men and women are combined, and a cause of considerable suffering among more than 135,000 adults diagnosed with colorectal cancer each year in the U.S. When adults get screened for colorectal cancer, it can be detected early at a stage when treatment is most likely to be successful, and in some cases, it can be prevented through the detection and removal of precancerous polyps. According to a 2015 study, if we can achieve 80% by 2018, 277,000 cases and 203,000 colorectal cancer deaths would be prevented by 2030.

For more information or to learn about resources in your area, visit: xxxxxxxx.

[Insert Organization's Boiler Plate Language – include organization description, mission and contract information including website]

[INSERT APPROPRIATE LINK FOR MORE INFORMATION (e.g. For more information about colorectal cancer screening, visit www.cancer.org/colon or contact the American Cancer Society at 1-800-227-2345. For more information about the 80% by 2018 initiative, visit www.nccrt.org.)]

COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

## *Sample Success Announcement*

### (Insert Organization) Announces [insert key success reported] (e.g. #% Colorectal Cancer Screening Increase since 20XX)]

### (Insert Organization) is Part of a Major National Effort to Save Lives from Colorectal Cancer by 2018 Through Increased Screening

[Insert city, state] – [insert date] – (Insert organization) today announced [insert one or two sentences describing the success (e.g. that they have increased colorectal cancer screening interventions by #% among their eligible patient population since 20XX. OR In 20XX, just #% of patients age 50 and over were being screened for colorectal cancer; today, over #% are being screened, etc.)]

This incredible success is a key part of [insert organization]'s commitment to the 80% by 2018 initiative, a shared goal led by the National Colorectal Cancer Roundtable (NCCRT) to have 80% of adults regularly screening for colorectal cancer by 2018. [insert organization] signed the 80% by 2018 pledge at an event on [insert date].

[Insert details about the effort/success and how it was achieved.]

[Insert quote from org spokesperson about why they are making this effort, steps they've taken and/or how this effort is important to the community. Include recognition of key partners for supporting this effort if applicable.]

[Insert quote from American Cancer Society health systems staff praising partner org efforts and citing the importance of screening. Contact your local ACS health systems staff to request a quote.]

"80% by 2018" is an NCCRT initiative in which more than a thousand organizations have committed to substantially reducing colorectal cancer as a major public health problem and are working toward the shared goal of 80% of adults aged 50 and older being regularly screened for colorectal cancer by 2018. Colorectal cancer is the second-leading cause of cancer deaths in the U.S. when men and women are combined, and a cause of considerable suffering among more than 135,000 adults diagnosed with colorectal cancer each year in the U.S. When adults get screened for colorectal cancer, it can be detected early at a stage when treatment is most likely to be successful, and in some cases, it can be prevented through the detection and removal of precancerous polyps. According to a 2015 study, if we can achieve 80% by 2018, 277,000 cases and 203,000 colorectal cancer deaths would be prevented by 2030.

For more information or to learn about resources in your area, visit: xxxxxxxx.

[Insert Organization's Boiler Plate Language – include organization description, mission and contract information including website]

[INSERT APPROPRIATE LINK FOR MORE INFORMATION (e.g. For more information about colorectal cancer screening, visit www.cancer.org/colon or contact the American Cancer Society at 1-800-227-2345. For more information about the 80% by 2018 initiative, visit www.nccrt.org.)]

COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

Check out our new resource on Earning Earned Media at http://nccrt.org/tools/80-percent-by-2018/80-by-2018-communications-guidebook/#new for more advice about media engagement.

## Sample Media Pitch

Dear (insert editor),

(Insert organization) is proud to announce that we have joined forces with more than a thousand local and national organizations to increase colorectal cancer screening rates throughout the country, as part of the 80% by 2018 initiative.

Colorectal cancer is a major public health problem as the second-leading cause of cancer death in the United States, despite being highly preventable, detectable and treatable. We ask you, in recognition of National Colorectal Cancer Awareness Month (insert other observances), to help us encourage more people to get screened for colorectal cancer to prevent more cancers and save lives. It's particularly important that your readers know that:

- The risk of colorectal cancer begins to rise significantly around age 50, so every man and woman should begin regular screening by age 50.
- There are several screening options – even take-home options – available.
- Most public and private insurance plans cover colorectal cancer screening.
- There may be local resources available to help those that are uninsured.

We would love to further discuss with you.

## Sample Email from a CEO to Employees

### Subject: Colorectal Cancer Awareness Month

March is National Colorectal Cancer Awareness Month, a great time to make sure you and your family take advantage of life-saving colon cancer screening. Colorectal cancer is the second-leading cause of cancer deaths in the U.S. when men and women are combined, yet it can often be prevented or detected at an early stage.

You are more likely to get colon cancer as you age. If you're over 50, you should get screened for colon cancer. Similarly, talk to your doctor about screening if you have a family history of the disease, even if you are under 50. If you have coverage through [enter name of employee plan], your health plan provides full coverage for recommended colon cancer screening tests. There are several screening options available, including simple take-home options. Talk to your doctor about getting screened.

Now is also a great time to remind your family and friends who are over 50 to get screened. Most health plans now provide coverage for colon cancer screening, and many people now qualify for health care coverage with [Name of State Health Exchange and/or Expanded Medicaid Plan if Available]. [Add information how to access charitable screening services for the uninsured if available].

Learn more about colon cancer and recommended screening tests at www.cancer.org/colon. If you or your family members have additional questions about colon cancer screening, contact the American Cancer Society at 1-800-227-2345 or [insert other partner if desired].

## Don't Forget the Blue Star!

The Blue Star is a symbol that represents all individuals engaged in the fight against colorectal cancer.

For additional information on the Blue Star and how to utilize it, please refer to the Blue Star/March Marketing Kit located at: http://nccrt.org/about/public-education/blue-star-marketing-kit/

Download Blue Star graphics at: http://nccrt.org/about/bluestar/

COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

# Being a Part of the 80% by 2018 Effort

## All About 80% by 2018

As we are all playing a role in the 80% by 2018 initiative, when speaking to media or potential partners about the campaign there are a number of assets available on the National Colorectal Cancer Roundtable website (http://nccrt.org), or you can link to materials below:


80% by 2018 Talking Points

80% by 80% by 2018 Online Pledge

80% by 2018 Graphics

80% by 2018 Blog

80% by 2018 Organizations

80% by 2018 Press Backgrounder

80% by 2018 Promo Reel (40 seconds)

Watch Katie Couric voice her support for 80% by 2018

Watch Dr. Richard Wender, NCCRT Chair, review the 10 steps it will take to get to 80% by 2018

Watch 80% by 2018 webinar archives and check nccrt.org for upcoming events

## How to Work With Partners

80% by 2018 Briefs explain the roles various partners can play in 80% by 2018.
Visit nccrt.org/tools/80by2018 to access the following materials:

- 80% by 2018 Welcome Packet
- What can primary care doctors do to advance 80% by 2018?
- What can hospitals do to advance 80% by 2018?
- What can insurers do to advance 80% by 2018?
- What can employers do to advance 80% by 2018?
- What can community organizations do to advance 80% by 2018?
- What can endoscopists do to advance 80% by 2018?
- What can women's health providers do to advance 80% by 2018?
- What can survivors and families do to advance 80% by 2018?
- What can Comprehensive Cancer Control coalitions do to advance 80% by 2018?
- What can radiologists do to advance 80% by 2018?

**Our list of 80% by 2018 resources is growing. Bookmark nccrt.org and check our website often!**

Interested in how your mayor, governor or state legislators can support colorectal cancer screening or 80% by 2018? Email Citseko.staples@cancer.org for a copy of ACS CAN's 80% by 2018 documents for state or local policy makers.

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## Engaging Celebrities

Identifying celebrity ambassadors with a personal connection to the cause and mission of the campaign can also help your message resonate. Visit our new resource on Engaging Celebrities for advice on how to successfully work with celebrities to promote CRC screening at http://nccrt.org/tools/80-percent-by-2018/80-by-2018-communications-guidebook/#new.


COLON CANCER SCREENING MESSAGING AND OUTREACH

Working with Celebrity Ambassadors

Identify Campaign Goals | Determine Your Audience | Identify Possible Ambassadors | Map Out Commitment | Make the "Ask" | Be a Good Partner | Define the Action Step | CELEBRITY ENGAGEMENT

Why use celebrity ambassadors?

We have heard again and again about the need for messaging to break through marketing "clutter" to reach the unscreened, particularly those who are not getting screened because of competing priorities or procrastination. In many instances, the unscreened generally know they need to be screened for colorectal cancer, but for whatever reason, the messages they have received about screening have not been enough to move them to action. In these instances, the challenge for the public health community is going beyond providing a rational message about the need for screening and to instead, engage the unscreened at a more emotional level. Finding someone who is well-known — a "celebrity" — to deliver the message is one way to do that.



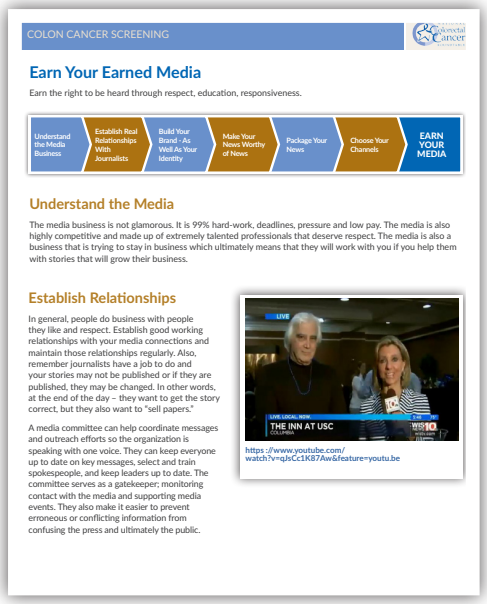
What qualifications are needed from a celebrity ambassador?

Thinking broadly about who is a celebrity is an important first step. Beyond film and TV stars and professional athletes, more and more self-made "talent" is emerging from the digital space. There are influencers — whether they are fashion, food, fitness or animal bloggers — who have a huge captive audience they reach daily with tailored content. The growing number of digital influencers have very strong connections with their audiences, who tend to be very engaged.

Additionally, many approachable and recognizable local celebrities should not be overlooked: community officials, regional news anchors, weather people, radio hosts, members of local sports teams and coaches, university and even high school mascots; we've seen animal ambassadors with truly impressive social media followings!

The Greater Chattanooga Colon Cancer Foundation (GCCCF), for example, had success asking recognizable leaders from the community to appear on billboards about screening, such as the county sheriff, the monsignor from a Catholic church, a Baptist church pastor and various political leaders, such as the mayor, a state representative and a US Senator. These familiar local leaders grabbed the attention of those driving by, creating visibility for the campaign that was not present when a previous campaign used unknown individuals.




COLON CANCER SCREENING

Earn Your Earned Media

Earn the right to be heard through respect, education, responsiveness.

Understand the Media Business | Establish Real Relationships With Journalists | Build Your Brand - As Well As Your Identity | Make Your News Worthy of News | Package Your News | Choose Your Channels | EARN YOUR MEDIA

Understand the Media

The media business is not glamorous. It is 99% hard-work, deadlines, pressure and low pay. The media is also highly competitive and made up of extremely talented professionals that deserve respect. The media is also a business that is trying to stay in business which ultimately means that they will work with you if you help them with stories that will grow their business.

Establish Relationships

In general, people do business with people they like and respect. Establish good working relationships with your media connections and maintain those relationships regularly. Also, remember journalists have a job to do and your stories may not be published or if they are published, they may be changed. In other words, at the end of the day -- they want to get the story correct, but they also want to "sell papers."

A media committee can help coordinate messages and outreach efforts so the organization is speaking with one voice. They can keep everyone up to date on key messages, select and train spokespeople, and keep leaders up to date. The committee serves as a gatekeeper; monitoring contact with the media and supporting media events. They also make it easier to prevent erroneous or conflicting information from confusing the press and ultimately the public.



https://www.youtube.com/watch?v=qJsCc1K87Aw&feature=youtu.be

## Earning Your Earned Media

While funding to purchase ad placement about CRC screening may be limited, you may be able to secure media coverage by building strong relationships with the media, tapping into social media and being ready to promote your key messages. Visit our new resource on Earning Your Earned Media at http://nccrt.org/tools/80-percent-by-2018/80-by-2018-communications-guidebook/#new

## Colorectal Cancer Speakers Bureau

The Colorectal Cancer (CRC) Speakers Bureau is a joint project of the ACS, NCCRT and the National Association of Community Health Centers. The Bureau is composed of trained clinicians across the U.S. who are available to speak on colorectal cancer risk factors, and prevention and early detection to medical and lay audiences. To request a speaker from the CRC Speakers Bureau contact us at http://nccrt.org/about/provider-education/crc-speakers-bureau/.

COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

## Celebrating Success

We are encouraging NCCRT members to share stories of their successes around the 80% by 2018 efforts. We love to celebrate when organizations embrace 80% by 2018, set organizational goals, implement change or make progress. We invite you to post these stories and share success on:

- 80% by 2018 Hall of Fame (http://nccrt.org/tools/80-percent-by-2018/hall-of-fame/) to submit your screening success if your organization has hit 80%!
- NCCRT Facebook page (https://www.facebook.com/coloncancerroundtable).
- Blue Star Facebook page (https://www.facebook.com/BlueStarColonCancer).
- Follow @NCCRTnews (twitter.com/NCCRTnews) and tweet using #NCCRT and #80by18.
- Use the press release templates from pages 34 and 35 to share successes nationally or locally.
- Submit a nomination for a 80% by 2018 National Achievement Award (nominations accepted each fall) at http://nccrt.org/tools/2017-80-by-2018-national-achievement-awards/.


Showcase successes to your audiences. In 2017 a concerted effort is being made to build excitement about the 80% by 2018 initiative. Post about milestones in screening efforts, successful collaborations and your colon cancer screening champions.

***EXAMPLE: XXX Health Center is a proud participant in the 2017 Colon Cancer (INSERT STATE) Roundtable taking place on (INSERT DATE). We are at (XX) percent screened for colon cancer and hope to reach 80% by 2018.***

Please visit the previous Blue Star/March Marketing Kit located at http://nccrt.org/about/public-education/blue-star-marketing-kit/ and our new resource on Earning Your Earned Media at http://nccrt.org/tools/80-percent-by-2018/80-by-2018-communications-guidebook/#new for additional information on working with social and traditional media.

## Evaluating Your 80% by 2018 Messaging Efforts

While the resources and recommendations from this guide are based on market research, partners will still want to establish if they are using these recommendations in a way that is moving the unscreened to action. As such, we encourage all our partners to continue to evaluate their efforts and make continuous improvements, as needed. For more advice on evaluating 80% by 2018 messaging efforts, visit our new resource on Evaluating Colorectal Cancer Communications Campaigns, *Guidance for Evaluating the Effectiveness and Impact of 80% by 2018 Communications Efforts* at http://nccrt.org/tools/80-percent-by-2018/80-by-2018-communications-guidebook/#new.

Additionally, we encourage all partners in the 80% by 2018 effort to assess where they are, set clear and achievable goals, evaluate their efforts, and understand and share their successes! The NCCRT Evaluation 101 toolkit can help: http://nccrt.org/about/public-education/evaluation-toolkit/.

COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

## Acknowledgments

Thank you to those who contributed to the development of this tool!

- *Marc Harwitz*
- *Linda Lutz*
- *Anjee Davis, MPPA*
- *David Greenwald, MD*
- *Cindy Gelb*
- *Robert Smith, PhD*
- *Durado Brooks, MD, MPH*
- *Faye Wong*
- *Melonie Thomas*
- *Djenaba Joseph, MD*
- *Tamar Wallace*
- *Andrea Dwyer*
- *Katie Bathje, MA, LPCC*
- *Frank Berger, PhD*
- *Jen Brady*
- *Grace Butler, PhD*
- *Mari Carlesimo, JD*
- *Anne Carlson*
- *Teresa Chapa, PhD, MPA*
- *Gregory Davault*
- *Jo-Ellen DeLuca*
- *Aimee Frank*
- *Stephanie Guiffre, MPA*
- *Rosie Henson, MSSW, MPH*
- *Richard Wender, MD*
- *Debbie Kirkland*
- *Anne Major*
- *Jennifer Michalek*
- *Anita Mitchell*
- *Kerstin Ohlander*
- *Anne-Louise B. Oliphant*
- *Karen J. Peterson, PhD*
- *Jane E. Rubinstein*
- *Michael Sapienza*
- *Randy Schwartz, MSPH*
- *Andrea Shepherd*
- *Priyanka Surio*
- *Charlie Weatherspoon*
- *Thomas Weber, MD*
- *Steve Weiss*
- *Lauren Whalens*
- *David Simpkins*
- *Dionne Christopher*
- *Angela Hayes*
- *Mary Doroshenk, MA*
- *Colleen Fitzwater*
- *H & K Strategies*
- *Emily Butler Bell, MPH*
- *Theresa Maschke*
- *Nikki Spencer*
- *Rebecca Siegel, MPH*
- *Mario Alvarez*
- *Kathleen Lobb*
- *Jane Rubinstein*
- *Lori Chertoff*
- *Marshall Horton*
- *John Patton*
- *Kanako Kashima*
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COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

# Appendix A

## Social Media Editorial Calendar

This year's calendar focuses on themes and messages for our Priority Consumers.

- "Theme titles" are used for internal copywriting and explanation only, and will not be published externally.
- Quotes are representative and serve as examples.
- Posts can be enhanced by using video vs. static images. Facebook, Instagram and Twitter all allow for video uploads, just remember that some have size and length limits.
- Don't miss the sample posts listed at the end to help celebrate successes (screening rate improvements, new collaborations, etc.)

| JANUARY | |
|---|---|
| Theme* | **A Healthier You in the New Year**<br>The New Year is a time when many focus on getting healthier. Encourage everyone to take action now to become healthier, and include a preventative colon cancer screening as one of the ways to get there. |
| Sample Facebook | It's the New Year and that means an opportunity for a fresh start when it comes to your health. Wellness checks should be at the top of your list. If you're 50 or older, add getting screened for colon cancer to the list. There are several screening options available, including affordable, take home options. Talk to your doctor today. (link to website)<br><br>- Attach shareable graphic<br><br>Trying to be a healthier you this year? If you're 50 or older, be sure that includes a colon cancer screening. Ask your doctor about which option for screening is best for you. (link to website) |
| Sample Twitter | Happy #NewYear! Happy Healthier You! Be proactive and schedule a #coloncancer screening this month. (link to website)<br><br>50 or older? Start the #NewYear right, talk to your doctor about #coloncancer. Getting screened could save your life. (attach shareable graphic)<br><br>Setting #NewYearsResolutions? Add #coloncancer screenings—ask your doctor about your options, including simple take-home tests. |
| Sample Instagram/ Pinterest | **Instagram**<br>This is the year to get healthier. This includes calling your doctor and getting screened for #coloncancer #getscreened - Upload photo of to do list or resolution-related image<br><br>**Pinterest**<br>Board idea – New Year, New You: photos or graphics of health-focused resolutions, including exercise, eating healthy and preventative screenings such as colon cancer. |
| Sample Internal Communications | This year take your health into your own hands. We're committed to improving colon cancer screening rates! If you're 50 or older, talk to your doctor about getting screened – sooner if you have a family history of the disease. If you're younger, encourage your family and friends to get screened. Together, let's save lives and reduce colon cancer throughout the nation. |

## COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

| FEBRUARY | |
|---|---|
| **Theme*** | **Be Proactive in Cancer Prevention**<br>February is National Cancer Prevention Month. Many cancer deaths could be prevented by making healthier choices, including not smoking, eating healthy, getting enough exercise and getting recommended screening tests, including screening for colon cancer if you are 50 or over. |
| **Sample Facebook** | February is National Cancer Prevention Month! Help prevent cancer by not smoking, eating right and being physically active. Part of your prevention plan should include getting recommended screenings for cancer. Haven't been screened for colon cancer and you're 50 or older? Talk to your doctor about what screening option is best for you. (insert website link)<br><br>Preventing colon cancer, or finding it early, doesn't have to be expensive. There are simple, affordable tests available. Talk to you doctor! (insert website link) |
| **Sample Twitter** | Turning 50 this year? Be sure to put #coloncancer on your list of #cancer screenings, even if you're healthy. (insert link to website)<br><br>Eating healthy, being active, not smoking can help prevent #cancer. So can screenings, including for #coloncancer. (insert link to website) |
| **Sample Instagram/ Pinterest** | **Instagram**<br>Many cancer deaths could be prevented through better choices, like not smoking, eating healthy, being more physically active and getting recommended cancer screenings. If you're 50 or older, add #coloncancer screening to your list and #getscreened today. - Upload image of an appointment card for doctor's appointment<br><br>**Pinterest**<br>Board idea – Photos or links to blogs of survivors or those who had a pre-cancerous polyp removed. |
| **Sample Internal Communications** | One in three adults over the age of 50 is still not getting screened for colon cancer as recommended. If you are 50 or older, start the conversation with your doctor about screening today. There are several screening options available, including simple take home tests. |

# COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

| MARCH | |
|---|---|
| **Theme*** | **National Colorectal Cancer Awareness Month**<br>Raising awareness of colon cancer screening and a call to action for those aged 50 or older to get screened.<br><br>***Note – this year we will be doing a Thunderclap during March.***<br>***For more information, contact nccrt@cancer.org*** |
| **Sample Facebook** | March is National Colorectal Cancer Awareness Month. Colorectal cancer is the 2nd leading cancer killer in the US among men and women combined, but colon cancer can often be prevented or found at an earlier stage with regular screening. We need your help in encouraging friends and family 50 and older to get screened. Get tips here: (insert website link)<br><br>It's National Colorectal Cancer Awareness Month! Are you 50 or older? Then you need to be screened as your risk of developing this cancer increases with age. Even if you feel healthy, you should be regularly screened. Learn more about screening options available to you, including simple take home options: (insert website link)<br><br>This month, show your support for colon cancer research and screenings by using #CRCAwareness on Twitter and Facebook and tagging those who need to get screened. Colon cancer is highly treatable if caught at an early stage and is one of the few cancers that can often be prevented through screening.<br>- Attach shareable graphic of campaign |
| **Sample Twitter** | Show support for #colon cancer research & screenings by using #CRCAwareness this month and tag those who need to #getscreened. (insert link to website)<br><br>In honor of National #CRCAwareness Month, ask friends 50 and older to #getscreened #coloncancer. (insert link to website)<br><br>#Colon cancer is preventable, treatable and beatable. Call your doctor today about screening. #Getscreened #CRCAwareness. (insert link to website)<br><br>Help us ensure all adults 50 & older #getscreened regularly for colon cancer. (insert link to website) |
| **Sample Instagram/ Pinterest** | **Instagram**<br>Colorectal cancer is the 2nd leading cause of cancer deaths in the US when men and women are combined, but it can often be prevented through screening or found at an early stage. Remind those who are over 50 to #getscreened regularly.<br><br>- Upload images of texts, phones, two people talking to emphasize the need to communicate about colon cancer with others<br><br>It's National Colorectal Cancer Awareness Month. There are various options available for testing, including simple take home options. Talk to your doctor about getting screened for #coloncancer.<br>- Upload shareable graphic about National Colorectal Cancer Awareness Month<br><br>**Pinterest**<br>Board idea – National Colorectal Cancer Awareness Month: images of how a polyp can be removed during a colonoscopy; listing of tests available. |
| **Sample Internal Communications** | It's National Colorectal Cancer Awareness Month. What steps are you taking this month to ensure that more people take advantage of potentially life-saving colon cancer screening? Encourage your friends and family ages 50 and older to talk to their doctor about getting screened. |

# COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

| APRIL | |
|---|---|
| **Theme*** | **Accelerating Health Equity for the Nation**<br>April is National Minority Health Month and this year's theme is "Accelerating Health Equity for the Nation." Let's work together to raise awareness about the need for health equity, including health equity around colon cancer screening. |
| **Sample Facebook** | Colorectal cancer is the 2nd leading cause of cancer death for Hispanics when men and women are combined. Spread the word that if you are over 50, you're at a higher risk for colon cancer—even if you are healthy. There are simple, take-home, affordable screening options. Talk to your doctor today. (insert website link)<br><br>African-Americans have the highest colon cancer incidence and mortality rates in the US. Colon cancer screenings can prevent cancer or find it early when it is more treatable. If you are 50 or older, don't put off your colon cancer screening any longer. Call your doctor today. (insert link to website) |
| **Sample Twitter** | Afraid of #coloncancer screening? Talk to someone who's been through it & hear why it's worth it to #getscreened. (insert link to website)<br><br>Stop making excuses. We recommend adults 50 & over #getscreened for #coloncancer on a regular basis. Here's why: (insert link to website) |
| **Sample Instagram/ Pinterest** | **Instagram**<br>National Minority Health Month is a time to raise awareness of the need for heath equity among racial and ethnic minorities, including for #coloncancer screening. Tag us and share your story about what you are doing to raise awareness.<br><br>- Upload shareable graphic about disparities in colon cancer screening<br><br>**Pinterest**<br>Board idea – Images showing how partners organizations, individuals or groups that are raising awareness in their communities either through in-person clinics, community boards, PSAs, etc. |
| **Sample Internal Communications** | This is National Minority Health Month, a time to double down on our commitment and efforts to ensure better health equity for all, including in the area of colon cancer screening. Together, our efforts can save lives and reduce colon cancer in all communities. |

## COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

| MAY | |
|---|---|
| **Theme*** | **National Women's Health Week and Mother's Day**<br>May is a time to pay special attention to the women in our lives and what they do for us. It's also important that they focus on themselves and make their health a priority, including getting screened for colon cancer. |
| **Sample Facebook** | An estimated 63,670 new cases of colon cancer will be diagnosed in women this year, but colon cancer can be prevented or caught early when it is more treatable. Take time for your own health, and talk to your doctor about getting screened. Learn more about the options available, including the simple take home tests. - Upload image of woman talking to her doctor<br><br>Do you think your busy schedule means you don't have time for a colon cancer screening? If you're 50 or older, you need to get screened. Screening is something you do when you are healthy to stay healthy! Tell the women in your life to take time out for them, and get screened for colon cancer. (insert website link) |
| **Sample Twitter** | Moms, do something important for YOU. 50 or older? #getscreened for #coloncancer. (insert link to website)<br><br>Make your #health the priority this month. Improve your health and #getscreened for #coloncancer. Here's why: (insert link to website) |
| **Sample Instagram/ Pinterest** | **Instagram**<br>Moms, this year we want you to have the gift of better health. If you're 50 or older, you need to #getscreened for #colon cancer. There are several screening options available including simple, take-home tests. Talk to your doctor today.<br><br>- Upload image related to Mother's Day, presents<br><br>Female Patient Story: "I thought I was healthy, and I don't have a family history of colon cancer. When my doctor suggested I get screened when I turned 50, I'm glad I followed her advice. They found a polyp and removed it." #getscreened #trustus.<br><br>- Upload image of female who had a pre-cancerous polyp removed<br><br>**Pinterest**<br>Board idea – Infographics focusing on women and colon cancer or other shareable graphics asking the women in their lives to get screened for colon cancer. |
| **Sample Internal Communications** | Contrary to popular belief, the number of women who get colon cancer is nearly equal to men. Be sure to encourage everyone to be screened for colon cancer. |

## COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

| JUNE | |
|---|---|
| **Theme*** | **Men's Health Week and Father's Day**<br>Men's Health Week is an annual occurrence leading up to Father's Day. Use this week to create awareness for preventable health problems and promote healthy behaviors such as getting screened for colon cancer. |
| **Sample Facebook** | Colon cancer can be prevented or treated at an earlier stage, but an estimated 27,150 men will succumb to the disease in 2017. Don't procrastinate any longer! Take your health into your own hands and talk to your doctor about colon cancer screening. - Upload shareable statistics graphic.<br><br>Men, you take charge of other things in your life, and it's just as important to take charge of your health. Get screened for colon cancer. There are several screening options available, including simple tests you can do at home. Talk to your doctor today! (insert website link) |
| **Sample Twitter** | Men, there are several ways to #getscreened for #coloncancer. Ask your doctor about your options. (insert link to website)<br><br>Dads, are you daunted by a #coloncancer screening? Talk to someone who's been through it and hear why you should #getscreened. (insert website link) |
| **Sample Instagram/ Pinterest** | **Instagram**<br>Dads, there are a lot of people relying on you to take control of your health and that includes getting a #coloncancer screening. Think of all the reasons you have in your life to call your doctor and #getscreened.<br><br>- Upload image of dad(s) celebrating a special moment in their child's life (graduation, walking daughter down the aisle, etc.)<br><br>Fear can be a factor keeping the man you care about from getting a #coloncancer screening. Here's some information that can help put him in charge of his health. #getscreened<br><br>- Upload image related to testing and myth busting, and/or include infographics such as 7 Things to Know About Colonoscopies<br><br>**Pinterest**<br>Board idea – Male Survivor Stories: images and quotes from colon cancer survivors on why they got screened and how their life has changed since beating the disease. |
| **Sample Internal Communications** | Colon cancer symptoms don't always appear until the cancer has advanced to a later stage. Men and women aged 50 and older need to get screened for colon cancer – even if they feel healthy. Regular screening is the key to early detection! |

# COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

| JULY | |
|---|---|
| **Theme*** | **Family Reunion Time**<br>When families are gathered together, it's is a great time to discuss family history, including their health history. Families can remind each other to stay healthy for each other by getting colon cancer screening, including if there is a family history of the disease for which they need to be screened early. |
| **Sample Facebook** | Colorectal cancer is the 2nd leading cause of cancer deaths in the US when men and women are combined, yet it can be prevented or found at an early stage. Remind the people you love who are 50 and older to get screened! (insert website link)<br><br>Do you know if you have a family history of colon cancer? If not, it's time to get the conversation started. Regular screening is the best way to prevent colon cancer, starting at 50, but if you have a parent or sibling who had colon cancer, you may need to be screened earlier.<br><br>- Attach image related to doctor-patient relationship |
| **Sample Twitter** | We want you to #getscreened for #coloncancer!<br><br>- Attach image of family gathering<br><br>Gain your freedom from fear of #coloncancer screenings. Talk to your doctor and #getscreened. (insert link to website) |
| **Sample Instagram/ Pinterest** | **Instagram**<br>Be there for your family. Colorectal cancer is the 2nd leading cause of death in the United States when men and women are combined, but it can be prevented or found at an early stage. Call your doctor and #getscreened.<br><br>- Upload image of family reunion (large group shot of a family<br><br>**Pinterest**<br>Board idea – shareable graphics of families with quotes saying to get screened for colon cancer. |
| **Sample Internal Communications** | We all want to be there for our families. Colorectal cancer is the 2nd leading cause of cancer death among men and women combined, but it almost always starts with a polyp. Screening can help save lives by finding polyps before they become cancer. If these polyps are removed, colon cancer can often be prevented. |

## COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

| AUGUST | |
|---|---|
| **Theme*** | **The Faces of Colon Cancer**<br>Sharing survivor stories and stories of those who prevented cancer through screening adds an emotional component to the logical arguments for colon cancer screening. |
| **Sample Facebook** | This month, we're drawing much needed attention to stories of those who have survived colon cancer. Hear from [insert name] about [his/her] colon cancer screening, how doctors detected the disease early: "I wasn't going to get screened but [clinic name] encouraged me to follow through with screening. My screening exam may have saved my life." (insert website link)<br><br>Colon cancer can be prevented or detected early through screening. Doctors found and removed polyps from [Insert name]'s colon during a routine colonoscopy. (insert website link) |
| **Sample Twitter** | "I'm thankful that I've beaten #coloncancer & can be here to see my grandkids grow up."[Insert name] #getscreened. (insert website link)<br><br>Thank you to all of the #coloncancer survivors who shared their stories & encouraged others to #getscreened. (insert website link) |
| **Sample Instagram/ Pinterest** | **Instagram**<br>This month, we'd like to support colon cancer survivors who'd like to share their story. Tag us, share your stories and tell us why you want to share the message to #getscreened. We'll feature as many of your stories as possible!<br><br>- Upload image of colon cancer survivor<br><br>Survivor Story: "I had a family history of colon cancer, so when my doctor suggested I get screened earlier than 50, I took her advice. They found a polyp and were able to treat it and remove it completely." #getscreened #trustus.<br><br>- Upload image of colon cancer survivor<br><br>**Pinterest**<br>Board idea – Survivor Stories: images and quotes from colon cancer survivors, how their life has changed since beating the disease and why they think screening is important. |
| **Sample Internal Communications** | There are currently more than one million colon cancer survivors in the United States. Share your story and encourage others to get regular screenings. |

# COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

| SEPTEMBER | |
|---|---|
| **Theme*** | **Take Responsibility for your Health during Healthy Aging Month**<br>National Healthy Aging Month allows us to showcase colon cancer screening as one of the ways the older population can take charge of their health so they can enjoy this time in their life. |
| **Sample Facebook** | As you get older your risk for colon cancer increases. If you are over 50, talk to your doctor about getting screened for colon cancer. There are several screening options available, including simple take home tests. Talk to your doctor about getting screened. (insert website link)<br><br>It's National Health Aging Month, and it's time to take charge of your health! Colon cancer can often be prevented or detected at an early stage, but you need to get screened. Call your doctor today so you can enjoy all that life has to offer.<br><br>- Attach image of shareable graphic on prevention |
| **Sample Twitter** | #Coloncancer risk increases as you age, but it can often be prevented through screening. #getscreened. (insert website link)<br><br>Retirement calling you? So is your doctor. It's time to #getscreened for #coloncancer.<br><br>- Attach image of older couple enjoying travel, a walk, etc. |
| **Sample Instagram/ Pinterest** | **Instagram**<br>Most colon cancer cases are found in people age 50 and older, but colon cancer can often be prevented through screening. Take charge of your health. Have a conversation with your doctor about what #coloncancer screening option is best for you.<br><br>- Upload image related to doctor's office<br><br>This month, we want you to stay smart about colon cancer. Did you know colon cancer is the second most common cancer in the US when men and women are combined? But if detected and treated early, the 5-year survival rate is about 90%. #staysmart #stayhealthy.<br><br>**Pinterest**<br>Board idea – Age Healthily - infographics or statistics about colon cancer rates rising as people age; tips for early detection. |
| **Sample Internal Communications** | The lifetime risk of developing colon cancer is about 1 in 20, and risk increases as we get older. Encourage your loved ones 50 and older to get regular screenings. |

# COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

| OCTOBER | |
|---|---|
| **Theme*** | **Make an Important Call this Fall**<br>Don't put colon cancer screening off for yet another season. Encourage people to stop making excuses, and just make that important call to their doctor this Fall. |
| **Sample Facebook** | Has time or money been your go-to excuse for not getting screened for colon cancer? There are simple, affordable take home options for screening available. View our list of nearby clinics and hospitals that provide us colon cancer screening options. Make the call this fall! Talk to your doctor about colon cancer screening. (insert website link)<br><br>- Attach map of screening locations specific to your area<br><br>Pumpkin patches, hay rides and leaf peeping are what autumn is all about. This year, it's also your Fall to Call. If you're 50 or older, call your doctor about colon cancer screening. Don't let another season go by without getting screened.<br><br>- Attach shareable graphic |
| **Sample Twitter** | Don't put off #coloncancer screenings for yet another season. It's the Fall to Call! Call your doctor today. (insert website link)<br><br>50 or older? #Getscreened for #coloncancer before another leaf falls. (insert website link)<br><br>-Attach image of fall foliage |
| **Sample Instagram/ Pinterest** | **Instagram**<br>Everyone should enjoy what autumn has to offer, but don't put off your #coloncancer screening for another season. If you're 50 or older, call your doctor and #getscreened.<br><br>- Upload an autumn image<br><br>**Pinterest**<br>Board idea – Images of clinics and hospitals in the area (autumn outside shots where possible) that offer colon cancer screenings as well as a map of locations in fall colors. |
| **Sample Internal Communications** | Colorectal cancer is the 2nd leading cause of cancer-related deaths in the country when men and women are combined, but it can be prevented through screening. Encourage those 50 and older not to wait another day before calling their doctor about getting screened. |

# COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

| NOVEMBER | |
|---|---|
| **Theme*** | **Taking Care of our Caregivers**<br>Family Caregivers often ignore their own health for the sake of another. We need to persuade them to put themselves first for once, and get screened for colon cancer. |
| **Sample Facebook** | We're thankful for you, the family caregiver. Remember to take time out for yourself, and don't forget about your health. If you're 50 or older, you need to call your doctor and get screened for colon cancer. Don't think you have the time? There are simple take home options available for screening. Thanks for all that you do!<br><br>Attach thank you image<br><br>Do you know a family caregiver over the age of 50? Remind them that it's time to get screened for colon cancer. Colorectal cancer is the 2nd leading cause of cancer-related deaths when men and women are combined, yet it can often be prevented or found at an early stage. Remind your loved one how important it is to take care of their own health, too. (insert website link) |
| **Sample Twitter** | Caregivers, take care of yourself, too. #Getscreened for #coloncancer. Call your doctor today. (insert website link)<br><br>Thank you, family caregivers! Keep yourself healthy by calling your doctor about your #coloncancer screening today. (insert website link) |
| **Sample Instagram/ Pinterest** | **Instagram**<br>It's National Family Caregiver Month. If you are a caregiver who has gotten screened for colon cancer, tag us and share your story. Tell us why you decided to #getscreened. We'll feature as many of your stories as possible!<br><br>- Upload image of family caregiver who took time to get screened<br><br>**Pinterest**<br>Board idea – Images and quotes of family caregivers who got screened. |
| **Sample Internal Communications** | Caregivers have such an important role, and it can be hard for them to find the time to take care of their own health, too. Remind your family and friends who are caregivers 50 or older to get screened! |

## COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

| DECEMBER | |
|---|---|
| **Theme*** | **Give the gift of colon cancer screening to your family**<br>One of the best gifts we can give ourselves, family and friends this season is to raise awareness of the benefits of colon cancer screening. |
| **Sample Facebook** | Will you see your parents or grandparents this holiday season? If they are 50 or older, remind them to talk to their doctor about colon cancer screening. They need to know this is important you.<br><br>- Attach image of holiday gathering<br><br>Give yourself and your family the gift of a healthy you this year. If you are 50 or older, you need to be screened for colon cancer. Call your doctor today. (insert website link) |
| **Sample Twitter** | Seeing the family during the holidays? Remind those over 50 to #getscreened for #coloncancer.<br><br>- Attach image of family holiday photo<br><br>Don't forget your own health over the holidays! Talk to your doctor and make an appointment for #coloncancer screening. (insert website link) |
| **Sample Instagram/ Pinterest** | **Instagram**<br>#Coloncancer screenings may not make it to someone's gift list, but the holidays are the perfect time to talk about screenings with your friends and loved ones. Remind them about the gift of a healthy life. #getscreened.<br><br>- Upload image of gift list<br><br>**Pinterest**<br>Board idea – images of holiday scenes and winder landscapes with inspirational messages about taking health into your own hands. |
| **Sample Internal Communications** | Fighting colon cancer starts with a conversation. Remind your family and friends over the age of 50 to get screened! |

# COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

| ACHIEVEMENT POSTS | |
|---|---|
| **Theme*** | **Celebrate your 80% by 2018 Successes!**<br>Staying motivated is important to the 80% by 2018 effort. One way to do that is to share – and celebrate – your achievements throughout the year. |
| **Sample Facebook** | [INSERT ORGANIZATION NAME] hit a major milestone in our efforts to increase colon cancer screening rates. [INSERT ACHIEVEMENT]<br><br>- Attach shareable graphic of 2015 highlights<br><br>Join us in congratulating [INSERT ORGANIZATION] in achieving [XX]% colon cancer screening rate. This success takes us one step closer to achieving our goal of 80% of eligible adults screened by the year 2018. (insert website link)<br><br>What an event! On [INSERT DATE], [INSERT ORGANIZATION] joined with [#] other organizations for the [NAME OF SUMMIT OR FORUM]. Working together we can get more people screened and save more lives from colon cancer.<br><br>-Attach photo or video from event<br><br>[INSERT NAME] had his/her first colon cancer screening thanks to our efforts to get more people screened. Hear his/her story. (insert website link)<br><br>-Attach photo of survivor |
| **Sample Twitter** | Great work in [INSERT GEOGRAPHY] to stop #coloncancer. [INSERT SUCCESS] (insert link to story)<br><br>Look at the success of [INSERT COLLABORATOR OR COLLEAGUE] who raised #coloncancer screening rates by XX%.<br><br>- Attach image of screening rates chart<br><br>What a great 2017! Look at our increase in #coloncancer screenings this year. #savinglives (insert website link)<br><br>Kudos to the researchers at [INSERT ORGANIZATION] who have [INSERT SUCCESS] (insert website link)<br><br>Thanks to our [ORGANIZATION'S] volunteers/collaborators supporting our goal of getting people screened for #coloncancer<br><br>- Attach group photo of volunteers or collaborators |
| **Sample Instagram/ Pinterest** | **Instagram**<br>We're highlighting our staff and the important role they play in helping people #getscreened for #coloncancer. [INSERT INFO ON SUCCES OF STAFF]<br><br>- Upload photos of staff<br><br>**Pinterest**<br>Board idea – Infographic or shareable images of major milestones throughout the year (e.g. new research studies, survivor stories, community engagement, etc.) |
| **Sample Internal Communications** | Let's keep the momentum around 80% by 2018 high by putting the spotlight on leaders and successes in this effort. There is a role for all of us to play! |

COLON CANCER SCREENING COMMUNICATIONS GUIDEBOOK 2017

# Appendix B

## Market Research Results

See how each message tested and in what way it resonated with the priority audience.

| | | |
|---|---|---|
| ★ **There are several screening options available, including simple take-home options. Talk to your doctor about getting screened.** | 27% | OPTIONS |
| ★ **Colorectal cancer is the second-leading cause of cancer deaths in the U.S. when men and women are combined, yet it can often be prevented or detected at an early stage.** | 13% | EARLY DETECTION |
| ★ **Preventing colon cancer, or finding it early, doesn't have to be expensive. There are simple, affordable tests available. Get screened! Call your doctor today.** | 12% | AFFORDABILITY |
| ★ **Most health insurance plans cover lifesaving preventive tests. Use the health benefits you are paying for to get screened for colon cancer. Call your doctor today.** | 10% | AFFORDABILITY |
| Many people with colon cancer do not have any symptoms or family history, which is why screening is so important even when you feel healthy. Get screened! Call your doctor today. | 9% | NO SYMPTOMS |
| Feel healthy? This is a great time to get screened for colon cancer. It often starts without symptoms. Call your doctor. Get screened! | 6% | NO SYMPTOMS |
| If you are 50 or older, get screened for yourself and the ones you love. Don't take unnecessary risks and miss the moments in life that matter. | 6% | FAMILY |
| Make sure you and your family are up-to-date on colon cancer screening. If you are 50 or older, get screened for yourself and the ones you love. This matters. | 4% | FAMILY |
| Nearly two-thirds of adults 50 and older are getting tested for colon cancer. Join the national movement to increase colon cancer screening rates to 80% by 2018. | 4% | JOIN THE CROWD |
| Nearly two-thirds of adults 50 and older are regularly screened for colon cancer. You should be one of them. Get screened! Call your doctor today. | 3% | JOIN THE CROWD |
| Don't take chances with colon cancer; take charge! Ask your doctor about testing options available for you and your family. | 3% | OPTIONS |
| Lead your family in the fight against colon cancer. Make sure you and your family are up to date on screening. Get screened for yourself and the ones you love. | 3% | FAMILY |

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# Guam Community Partners and Resources

#CONQUER CANCER
Guam Cancer Coalition

**American Cancer Society (Guam office)**

The American Cancer Society is here to help you in your fight with cancer. We offer programs and services for those who have been diagnosed with cancer, free of charge. The Guam Field Office can be reached at 477-9451 Monday – Friday from 8:30 AM – 4:00 PM. Trained cancer information specialists are available 24 hours a day, seven days a week to answer questions about cancer, link callers with resources in the community, and give information on local events: Call 1-800-227-2345.

- **Location:** 250 Route 4, Suite 204, Nanbo Guahan Building, Hagatna, Guam 96910, (across Guam Public Library)
- **Phone:** (671) 477-9451/ 1-800-227-2345
- **Fax:** (671) 477-9450
- **Website:** www.cancer.org

**Guam Breast and Cervical Cancer Early Detection and Screening Program, Department of Public Health and Social Services**

The Guam Breast and Cervical Cancer Early Detection Program (GBCCEDP) offers FREE Mammogram and Pap test to eligible women ages 21 - 64 years old. It's located at the Mangilao Central Public Health, 1st floor, Room 160 near the Dental Clinic and opens from 8:00am to 5:00pm except on weekends, and GovGuam holidays. To contact, please call 735-0671/2/5 to learn if you are eligible. GBCCEDP is a 100% Federally Funded Program. Early detection is your best protection, because no woman deserves to have cancer.

- **Location:** Central Public Health, 123 Chalan Kareta, Mangilao, Guam
- **Phone:** (671) 735-0671/72/75
- **Website:** www.dphss.guam.gov/content/breast-and-cervical-cancer-early-detection-program

**Guam Cancer Care, Cancer Screening Program**

Guam Cancer Care takes a stand against cancer and encourages a proactive approach to health through screening. By implementing the Cancer Screening Program, Guam Cancer Care works collaboratively with the Guam Comprehensive Cancer Control Coalition (GCCC), Guam Breast and Cervical Cancer Early Detection Program (GBCCEDP), the Non-Communicable Disease Consortium (NCD), and local primary clinics and physicians to conduct an all year round screening program for the residents of Guam. The program also collaborates with local health insurance companies, businesses, and schools to conduct Health Fairs for their employees and family members to encourage the importance of screening and to live a healthy lifestyle.

**Location:** 341 S. Marine Corps Drive, RK Plaza Suite 102, Tamuning, Guam 96913
**Phone:** (671) 969-2223 Office
**Fax:** (671) 969-3222
**Website**: www.guamcancercare.org

**Guam Community Health Centers**

The Guam Community Health Centers, Federally Qualified Centers, are multi-specialty primary care clinics. The Southern Region Community Health Center (SRCHC) has been in existence for 27 years, first opening its doors in 1984, and the Northern Region Community Health Center (NRCHC) was established in 1998. The Southern and Northern Region Community Health Centers of the Department of Public Health and Social Services provide primary healthcare, acute outpatient care, and preventive services to the community. Family practitioners, pediatricians, internists, nurse practitioners, and other health professionals provide a full range of essential primary care services.

- **Location:** Northern Region CHC: 520 West Santa Monica Avenue, Dededo, Guam
- **Phone:** (671) 635-7400/4410; **Fax:** (671) 635-4416
- **Location:** Southern Region CHC: 162 Apman Drive, Inarajan, Guam
- **Phone:** (671) 828-7517/7518; **Fax:** (671) 828-7533
- **Website:** www.dphss.guam.gov

**Guam Comprehensive Cancer Control Coalition**

The Guam Comprehensive Cancer Control Coalition (GCCCC) is a collaborative process through which a community pools resources to reduce the burden of cancer that results in risk reduction, early detection, better treatment and enhanced survivorship. This program focuses on bringing representatives from the cancer network on Guam (public, private and non-profit organizations as well as individuals) together to address prevention, early detection and treatment, survivorship, data and research, and policy and advocacy issues faced by cancer patients, survivors, caregivers, and families on Guam.

- **Location:** DPHSS, 123 Chalan Kareta, Mangilao 96913-6304
- **Phone**: (671) 735-7335
- **Social Media**: Facebook/Instagram @ GUAMCCC; Twitter @ GCCCP

**Guam Regional Medical City Patient Education Department**

Guam Regional Medical City's Patient and Family Education program is here to help improve your experience of care. Through a team-based approach, we ensure that most of your health questions are answered and your learning needs met—whether you are an inpatient, outpatient, family member, friend, or visitor. When providing educational services, the Patient and Family Education provide the right health information that will help you understand more about your health and illness, understand your treatment choices, help you make better decisions about your health and those close to you, and communicate better with your healthcare providers.

- Location: 133 Route 3, Dededo, Guam 96929
- Phone: (671) 645-5500 x 3685, 3687, 5688
- Website: www.grmc.gu

The **University of Guam Cancer Research Center (UOG CRC)** was established in 2003 to lay the foundation for promoting and sustaining cancer research in our region. The University of Hawaii Cancer Center and the UOG CRC formed a partnership with funding from the National Cancer Institute to advance cancer health equity in Pacific Islanders. The Community Outreach Core (COC) of the UOG CRC was organized as a community based approach to raise awareness of cancer, promote cancer prevention and screening in our communities. One of COC's aims is to provide targeted cancer prevention outreach to primary care physicians who serve Micronesian populations. To accomplish this aim, the COC has partnered with local stakeholder organizations to fill a need for health provider education on cervical cancer screening and HPV vaccine.

- **Location:** University of Guam #27 Dean's Circle, Mangilao 96923
- **Phone**: (671)735-3036
- **Website**: www.guamcrc.org
- **Social Media:** Facebook @ UOGCANCERRESEARCH

# Services Available on Guam

It is important to get information about cancer so you are well informed and best able to make decisions.

**Hospitals:**
Guam Memorial Hospital – 647-2330/2552/2939
Guam Regional Medical City – 649-4764
U.S. Naval Hospital Guam – 344-9340/9202/9586 (for active duty and retired military and dependents only)

**Who do I call for insurance questions?**
AFLAC – 989-7810
Medicaid Assistance Program, Department of Public Health and Social Services (DPHSS) – 735 7245/7241/7239/7328
Medically Indigent Program (MIP), Department of Public Health and Social Services (DPHSS):
- Dededo – 635-7466/7485/7487
- Inarajan – 828-7524
- Mangilao – 735-7245/7241/7239/7328

Medicare Assistance Program – 735-7421
NetCare – 472-3610
SelectCare – 477-9808
StayWell – 477-5091
TakeCare – 647-3526
TRICARE Area Office-Pacific - 1-888-777-8343

**Who provides cancer information and resources?**
American Cancer Society Guam Field Office – 477-9451/1-800-227-2345
- Website: www.cancer.org

Edward M. Calvo Cancer Foundation – 472-6854
- Website: www.guamisgood.org

Guam Breast and Cervical Cancer Early Detection Program, DPHSS – 735-0671/72
Guam Cancer Care – 969-2223
- Website: www.guamcancercare.org

Guam Comprehensive Cancer Control Program, DPHSS – 735-7335/0670/0673
- Website: www.facebook.com/guamccc

National Cancer Institute Cancer Information Service – 1-800-422-6237
- Website: www.cancer.gov

Patient and Family Education Resource Center, Guam Regional Medical City – 645-5500 ext. 3687/3685/5688

**Where can I go for cancer treatment?**
Cancer Center of Guam – 647-4656
FHP Cancer Center – 646-5825 ext. 8220
Guam Regional Medical City – 649-4764
Island Cancer Center – 646-3363
Latte Stone Cancer Care Clinic – 777-3305

**What government assistance programs are available?**
Catastrophic Illness Assistance Program – 735-7293
Department of Integrated Services for Individuals with Disabilities – 475-4624
Department of Public Health and Social Services:
- Guam Breast and Cervical Cancer Early Detection Program, DPHSS – 735-0671/72
- Supplemental Nutrition Assistance Program (SNAP):
  - Dededo – 635-7466/7485/7487
  - Inarajan – 828-7524
  - Mangilao – 735-7245/7241/7239/7328
  - Medical Social Services – 735-7168/7351/7356/7174

Guam Behavioral Health and Wellness Center (24-Hour Crisis Hotline) – 647-8833
Guam Medical Referral Office:
- Guam office – 475-9350/53
- Hawaii office – 1-808-228-0242
- Los Angeles office – 1-323-770-6177
- Philippines office – 011-632-579-5002/3

Guam Memorial Hospital, Medical Social Services – 647-2451
Skilled Nursing Unit, Medical Social Services – 633-1805
Suicide Prevention Lifeline – 1-800-273-8255

**Who can help me with In-home services?**
Blessed Intermediate Home Care Services – 647-5121/653-1900
Caring Angels – 989-HALO/4256
Catholic Social Services – 635-1422
Divine Glory Home Care Services – 486-3410/488-8108
FHP Home Health (Hospice provider) – 646-5825 ext. 8473
Guahan Caregivers – 788-8825
Guam Nursing Services – 649-2815 or 649-4000
Guam Visiting Nurses – 646-6877
Health Services of the Pacific (Homecare and Hospice provider) – 647-5355
National Family Caregiver Support Program (NFCSP) – 735-3277
Paradise Home Care – 475-4005 or 988-4005

**Who provides social services and/or caregiver respite services?**
Ayuda Foundation – 473-3003
Catholic Social Service – 635-1422
Guam Behavioral Health and Wellness Center (24-Hour Crisis Hotline) – 647-8833
Health Services of the Pacific – 647-5355
National Family Caregiver Support Program (NFCSP) – 735-3277
Salvation Army's Family Services Center – 477-3528

**Who can provide transportation services?**
Division of Senior Citizens – 735-7382/7011
Guam Cancer Care – 969-2223
Guam Regional Transit Authority – 475-4686 / 16
St. Joseph's Medical Transport – 648-7568

**Who do I contact for legal assistance?**
Fisher and Associates (Legal Aid Services) – 472-1131
Guam Legal Services Corporation – Disability Law Center – 477-9811
Office of the Public Guardian – 475-3173

**Cancer Data and Research Partners**
Guam Cancer Registry – 735-2988/2989
Guam Cancer Research Center – 735-3036
Guam Cancer Trust Fund – 735-2672
Guam Comprehensive Cancer Control Coalition/Program – 735-7335/0670/0673
Pacific Regional Central Cancer Registry – 1-808-692-0854
Guam Office – 735-2988
Hawaii Office – 1-808-692-0854
Website: www.pacificcancer.org

**Online Resources:**
National Cancer Institute – 1-800-4-CANCER (1-800-422-6237)
Website: www.cancer.gov

www.medlineplus.gov is a great resource for anything medical. It has a drug dictionary, medical terminology dictionary, and everything about difference cancers and their treatments written in understandable language.

Prevent Cancer Foundation – (703) 836-4412
Website: www.preventcancer.org


This publication was supported by the Cooperative Agreement Number 6 NU58DP006269-01-02 from the U.S. Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Centers for Disease Control and Prevention.