

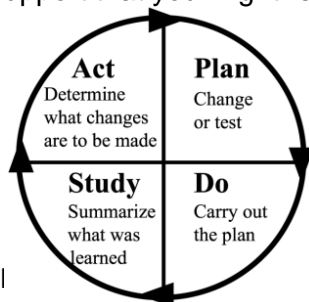
# Cancer Screening Quality Improvement Toolkit

## What is the Cancer Screening Quality Improvement Toolkit?

System-wide quality improvement is the vision that the Ministry of Health and Long-Term Care provides for all healthcare sectors, including primary care. Quality Improvement Plans (QIPs) are enablers to support this goal. “The QIP is about improving patient/client and provider experience, care effectiveness and value, through system improvement, continuously over time.”<sup>1</sup> Cancer Care Ontario has developed a Cancer Screening Quality Improvement Toolkit to support primary care providers in developing their QIPs related to cancer screening. The QIP guidance documents are available on the Health Quality Ontario (HQO) website at <http://www.hqontario.ca/Quality-Improvement/Quality-Improvement-Plans> . QIPs can now be submitted directly on the HQO website through the QIP navigator tool: [qipnavigator.hqontario.ca](http://qipnavigator.hqontario.ca).

## Why include cancer screening in your QIP?

For the 2016/2017 QIP cycle, colorectal cancer screening and cervical cancer screening are priority indicators. The Cancer Screening Quality Improvement Toolkit can support you in developing your cancer screening QIPs. This toolkit will assist practices in planning, implementing, monitoring and reporting on improvements in colorectal, cervical and breast cancer screening. It contains instructions (Section 1), examples on developing a QIP for cancer screening (Section 2) and an appendix with Cancer Care Ontario’s screening guidelines and recommendations. In addition, a supporting measurement, tracking and evaluation tool is available ([cancercare.on.ca/pcresources](http://cancercare.on.ca/pcresources)). If you choose to use the toolkit, please let us know by emailing [screenforlife@cancercare.on.ca](mailto:screenforlife@cancercare.on.ca) with “Cancer Screening Quality Improvement Toolkit” in the subject line. Informing us of your decision to participate will allow us to provide you with any support that you might require through our Regional Cancer Programs.



Revised Fel

Cancer Care Ontario recommends applying the Plan, Do, Study, Act (PDSA)<sup>2</sup> cycle of continuous improvement for QIP development.

	What happens in this part of the cycle? <sup>3</sup>	Tips
Plan	<ul style="list-style-type: none"> <li>• Create a baseline: know current screening rates</li> <li>• Define an achievable screening rate goal</li> <li>• Define data required to track and measure your goal</li> </ul>	<ul style="list-style-type: none"> <li>• Keep things simple and manageable, and set small and achievable goals (e.g., focus on only one type of screening for the first year)</li> </ul>
Do	<ul style="list-style-type: none"> <li>• Put the plan into practice</li> <li>• Collect data</li> <li>• Record useful observations</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure that data are collected and recorded consistently</li> </ul>
Study	<ul style="list-style-type: none"> <li>• Analyze the data collected to track progress</li> <li>• Determine the next step needed to help meet the screening rate goal</li> </ul>	<ul style="list-style-type: none"> <li>• Set a timeline for progress checkpoints that are achievable and make sense for your practice</li> </ul>
Act	<ul style="list-style-type: none"> <li>• Make changes</li> </ul>	<ul style="list-style-type: none"> <li>• Make simple changes to help achieve goals (e.g., take opportunities to discuss screening with patients in the office for other reasons)</li> </ul>

<sup>1</sup> 2013/14 Quality Improvement Plan Guidance for primary care organizations in Ontario. Available from: [http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/qi\\_primary.aspx](http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/qi_primary.aspx).

<sup>2</sup> Langley et al. 1996. Link available upon request.

<sup>3</sup> National Academy for State Health Policy. PDSA Cycles. Available from: <http://www.nashp.org/sites/default/files/abcd/abcd.ut.pdsa.cycles.definedsimple.pdf>.

# Section 1: Instructions

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## 1.1 Plan

Your practice should begin by creating a cancer screening improvement plan. There are four simple steps involved in this process.

### **Four-Step Plan Checklist:**

- 1. Identify quality improvement team members;
- 2. Develop Quality Improvement Plan (QIP);
- 3. Develop methodology for tracking and measuring change, and evaluation; and
- 4. Raise awareness and orient staff who are directly involved or who may be indirectly impacted by the initiative.

### **1. Identify quality improvement team members**

Identifying who will be involved and ensuring that they are properly oriented is a key to successful implementation. The practice will need to:

- Select a lead coordinator to act as main point of contact;
- Clearly define roles and responsibilities;
- Ensure that there is enough staff support to carry out the initiative; and
- Identify who will be administering cancer screening (e.g., primary care providers, nurses, other healthcare professionals).

### **2. Develop Quality Improvement Plan (QIP)**

Refer to the example measurement and change ideas in Section 2 of this toolkit and fill out the QIP navigator tool.

### **3. Develop methodology for tracking and measuring change, and evaluation**

Start by establishing your targets and process measures. There are a number of data sources that can be used to establish the baseline and set targets, including your electronic medical record (EMR), the Target Population/Service Report (TPSR) and the primary care

Screening Activity Report (SAR) ([cancercare.on.ca/sar](http://cancercare.on.ca/sar)) for cervical, colorectal and breast cancer screening. Primary care providers wishing to register to access their SAR can do so by contacting eHealth Ontario at [ONEIDBusinessSupport@ehealthontario.on.ca](mailto:ONEIDBusinessSupport@ehealthontario.on.ca).

Record the baseline and target for the initiative. A sample Measurement, Tracking and Evaluation Tool is available as a supporting document at [cancercare.on.ca/pcresources](http://cancercare.on.ca/pcresources). Review your target and measure progress towards achieving it to help you to identify any variance along the way and mitigate any issues. Please refer to the Health Quality Ontario Primary Care Sector Resources page to access the Indicator Technical Specifications document and other helpful resources: [qipnavigator.hqontario.ca/Resources/PrimaryCareSector.aspx](http://qipnavigator.hqontario.ca/Resources/PrimaryCareSector.aspx).

#### 4. Raise awareness and orient staff who are directly involved or who may be indirectly impacted by the initiative

It is important to hold an orientation session for primary care providers, healthcare professionals and other staff members directly involved in the initiative. Provide participants with this toolkit and build or formalize changes to current practice workflows to accommodate it. You will also want to raise awareness around your quality improvement initiatives with other providers and staff who may not be directly involved so that the quality improvement process runs smoothly. This can be done in many ways, such as via email and announcements at staff meetings.

### 1.2 Do

There are two steps in the **Do** phase of the cancer screening quality improvement plan.

#### Two-Step Do Checklist:

- 1. Develop list of patients to be screened; and
- 2. Execute plan.

#### 1. Develop list of patients to be screened

To support your activities, your practice will need to generate a list of patients who are due for screening. Potential sources of information include your practice's electronic medical record (EMR) and Cancer Care Ontario's Screening Activity Report (SAR) ([cancercare.on.ca/sar](http://cancercare.on.ca/sar)).

If your practice uses PS Suite EMR or Accuro EMR and you require assistance in learning how to use your EMR to support your cancer screening quality improvement activities, please contact Cancer Care Ontario at [screenforlife@cancercare.on.ca](mailto:screenforlife@cancercare.on.ca) to request access to training resources.

Once you have created a list, you may choose to develop a tracking template in Excel. Please refer to the example Patient Tracking tool below, which demonstrates how to track patients. This fillable template is also available as a supporting document at [cancercare.on.ca/pcresources](http://cancercare.on.ca/pcresources):

Current Status (blank = Not Called)	First Name	Last Name	Telephone # (preferred)	Telephone # (alternate)	Age	Date of First Call	Date of Last Call	Total # of Calls	Date of Booked Appointment	Reason for Refusing Screening	Notes

## 2. Execute plan

Execute your planned activities. Throughout the process, your lead coordinator should supervise the initiative and provide timely responses to staff questions. Holding regular team meetings to track progress, troubleshoot challenges and celebrate successes is key to ensuring that the team stays engaged and motivated, and that issues are addressed.



### 1.3 Study

There are three steps in the **Study** phase of the cancer screening quality improvement plan

#### **Three-Step Study Checklist:**

- 1. Keep track of your progress towards achieving your targets by filling out the Measurement, Tracking and Evaluation Tool on an ongoing basis (an example is provided in the supporting documents at [cancercare.on.ca/pcresources](http://cancercare.on.ca/pcresources));
- 2. Hold regular quality improvement team checkpoint meetings and review results; and
- 3. Share results with all other healthcare professionals and staff members within the practice.

### 1.4 Act

#### **Three-Step Act Checklist:**

1. Keep track of your progress;
2. Modify the plan, as appropriate; and
3. Evaluate the quality improvement initiative.

#### **1. Keep track of your progress**

Keep track of your progress towards achieving your targets by filling out the Measurement, Tracking and Evaluation Tool on an on-going basis (an example is provided in the supporting documents at [cancercare.on.ca/pcresources](http://cancercare.on.ca/pcresources)).

#### **2. Modify the plan, as appropriate**

Make any necessary adjustments to the process and ensure that all involved primary care providers, healthcare professionals and other staff members are kept abreast of these changes.



### 3. Evaluate the quality improvement initiative.

- At the end of the fiscal year, take your final measures and complete the Measurement, Tracking and Evaluation Tool (such as the example provided in the supporting documents at [cancercare.on.ca/pcresources](http://cancercare.on.ca/pcresources)) to determine whether your practice achieved its target.
- Get feedback from primary care providers, healthcare professionals and other staff who were involved in the initiative regarding:
  - What went well?
  - What challenges/difficulties were encountered?
  - What could be done differently?

## Section 2: Develop Quality Improvement Plan (QIP)

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This section is intended to support the development of your practice's Cancer Screening QIP and is to be used in conjunction with the QIP navigator tool found on the Health Quality Ontario website: [qipnavigator.hqontario.ca](http://qipnavigator.hqontario.ca).

You may choose to follow the examples provided below or use them to develop your own targets and change ideas. The examples include indicators, methodologies and process measures that you may consider including in your QIP.



## 2.1 Colorectal Cancer Screening

Sample target:

**Measure**

Objective, Measure / Indicator ? > GOTO CHANGE IDEA

Quality Dimension ? Effective

Sector \* ?

Objective \* ?

Measure / Indicator

Priority \* ?

Unit of Measure \* ?  If other, specify

Population \* ?  If other, specify

Data Source \* ?  If other, specify

Period \* ?  Please specify \*

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Organization

Direction of Improvement ?  Higher is better

Current Performance ?   *between 0.00 and 100.00*  
 Collecting Baseline ?  
 Suppressed ?

Absolute Target ?   *between 0.00 and 100.00* Relative Target ?  %  
 Collecting Baseline ?

Target Justification ?

Sample change ideas:

**Change Idea**
> GOTO MEASURE

Change Idea ? Effective

Quality Dimension ? Effective

Objective ? Improve rate of cancer screening.

Measure / Indicator ? Percentage of patients aged 50-74 who had a fecal occult blood test within past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within the past 10 years

Organization PC xyz

Change Number # 1

Planned Improvement Initiatives (Change Ideas) ? Train staff on how to use EMR to develop search to identify screening eligible patients. To gain access to CCO EMR Optimization tools for TELUS PS Suite and Accuro EMRs, please contact the CCO Contact Centre at screenforlife@cancercare.on.ca )

Methods ? Develop staff training, set up training, and train staff

Process Measures ? % of staff trained on EMR template

Goal For Change Ideas ? 80% of staff will be trained by October 2016

Comments ? Many staff work part-time so scheduling difficult

> GO TO CHANGE #
# 1 v
✕ DELETE THIS CHANGE IDEA
CANCEL
SAVE
SAVE & CLOSE
+ ADD NEW CHANGE IDEA



**Change Idea**

Change Idea ? **> GOTO MEASURE**

Quality Dimension ? Effective

Objective ? Improve rate of cancer screening.

Measure / Indicator ? **Percentage of patients aged 50-74 who had a fecal occult blood test within past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within the past 10 years**

Organization PC xyz

Change Number # 2

Planned Improvement Initiatives (Change Ideas) ?  
 Register for CCO Screening Activity Report (SAR) in order to cross reference screening information in EMR for accuracy and completeness. For more information on the SAR and how to register, please go to <https://www.cancercare.on.ca/sar/>

Methods ?  
 Contact Local Registration Agent to schedule time for on-site registration for ONE ID. All physicians to be registered for access to the SAR and identified staff to be registered as delegates.

Process Measures ?  
 % of physicians registered to access the SAR  
 % of staff registered as delegates to access the SAR on behalf of the physician

Goal For Change Ideas ?  
 100% of physicians registered  
 100% of delegates registered

Comments ?

**> GO TO CHANGE #** #2 **✗ DELETE THIS CHANGE IDEA** **CANCEL** **SAVE** **SAVE & CLOSE** **+ ADD NEW CHANGE IDEA**



**Change Idea**

Change Idea ? **> GOTO MEASURE**

Quality Dimension ? Effective

Objective ? Improve rate of cancer screening.

Measure / Indicator ? Percentage of patients aged 50-74 who had a fecal occult blood test within past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within the past 10 years

Organization PC xyz

Change Number # 3

Planned Improvement Initiatives (Change Ideas) ? Set up monthly team meetings to review SAR and EMR generated report on patients due for colorectal screening. Develop list of patients to call to pick up FOBT kit or for referral for sigmoidoscopy or colonoscopy.

Methods ? Schedule monthly meeting that coincides with monthly release of the SAR report.

Process Measures ? Completion of team review meetings every month.  
% of eligible patients identified

Goal For Change Ideas ? All scheduled team meetings are held  
100% of patients that require screening are identified each month to be called.

Comments ?

**> GO TO CHANGE #** #3 **✗ DELETE THIS CHANGE IDEA** **CANCEL** **SAVE** **SAVE & CLOSE** **+ ADD NEW CHANGE IDEA**



**Change Idea**

Change Idea ? **> GOTO MEASURE**

Quality Dimension ? Effective

Objective ? Improve rate of cancer screening.

Measure / Indicator ? Percentage of patients aged 50-74 who had a fecal occult blood test within past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within the past 10 years

Organization PC xyz

Change Number # 4

Planned Improvement Initiatives (Change Ideas) ?  
 Call all patients who are due for colorectal screening to advise them that they are due for screening. Provide them with instructions on how to obtain an FOBT kit or provide referral for sigmoidoscopy or colonoscopy as appropriate. ^  
v

Methods ?  
 Make phone calls to patients who are due for colorectal screening ^  
v

Process Measures ?  
 % of patients called who are reached ^  
v

Goal For Change Ideas ?  
 80% of all patients called are reached ^  
v

Comments ?  
 Not all patients may be reached for various reasons (left voicemail message, wrong number, out of town etc.). Consider allocating time to make phone calls outside of daytime business hours. ^  
v

**> GO TO CHANGE #** #4 v **✗ DELETE THIS CHANGE IDEA** **CANCEL** **SAVE** **SAVE & CLOSE** **+ ADD NEW CHANGE IDEA**



**Change Idea**

Change Idea ? **> GOTO MEASURE**

Quality Dimension ? Effective

Objective ? Improve rate of cancer screening.

Measure / Indicator ? **Percentage of patients aged 50-74 who had a fecal occult blood test within past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within the past 10 years**

Organization PC xyz

Change Number # 5

Planned Improvement Initiatives (Change Ideas) ?  
Provide all average risk patients with FOBT kits and information on colorectal screening.

Methods ?  
Mail FOBT kits to patients and have them available at the practice for patients who have an appointment at the practice.  
Schedule FOBT kit distribution and education days.

Process Measures ?  
% of average risk patients who receive an FOBT kit  
# of FOBT kit distribution days scheduled

Goal For Change Ideas ?  
80% of eligible patients receive an FOBT kit  
2 FOBT distribution days scheduled

Comments ?  
Not all eligible patients may choose to get screened or receive a kit if they are not reached during phone call outreach.

**> GO TO CHANGE #** # 5 **✗ DELETE THIS CHANGE IDEA** **CANCEL** **SAVE** **SAVE & CLOSE** **+ ADD NEW CHANGE IDEA**

**Change Idea**
➔ GOTO MEASURE

Change Idea ?

Quality Dimension ? Effective

Objective ? Improve rate of cancer screening.

Measure / Indicator ? Percentage of patients aged 50-74 who had a fecal occult blood test within past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within the past 10 years

Organization PC xyz

Change Number # 6

Planned Improvement Initiatives (Change Ideas) ?

Methods ?

Process Measures ?

Goal For Change Ideas ? 100% of physicians signed up for Physician Linked Correspondence

Comments ?

➔ GO TO CHANGE #
# 6 ▼
✕ DELETE THIS CHANGE IDEA
CANCEL
SAVE
SAVE & CLOSE
+ ADD NEW CHANGE IDEA



Once completed, your QIP will look similar to the example below (please note that additional change ideas are included in this work plan). You will be able to export this work plan into Excel.

ID	AIM	MEASURE						CHANGE					
	OBJECTIVE	MEASURE / INDICATOR	UNIT / POPULATION	SOURCE / PERIOD	ORG ID	CURRENT PERFORMANCE	TARGET PERFORMANCE	TARGET JUSTIFICATION	PLANNED IMPROVEMENT INITIATIVES (CHANGE IDEAS)	METHODS	PROCESS MEASURES	GOAL FOR CHANGE IDEAS	COMMENTS
<b>EFFECTIVE</b>													
1	Improve rate of cancer screening.	Percentage of patients aged 50-74 who had a fecal occult blood test within past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within the past 10 years	% / PC organization population eligible for screening	See Tech Specs / Annually	9999993	40.00	60.00	This target represents the current provincial average of patients up-to-date for colorectal screening.	#1) Train staff on how to use EMR to develop search to identify screening eligible patients. To gain access to CCO EMR Optimization tools for TELUS PS Suite and Accuro EMRs, please contact the CCO Contact Centre at <a href="mailto:screenforlife@cancercare.on.ca">screenforlife@cancercare.on.ca</a> )  #2) Register for CCO Screening Activity Report (SAR) in order to cross reference screening information in EMR for accuracy and completeness. For more information on the SAR and how to register, please go to <a href="https://www.cancercare.on.ca/sar/">https://www.cancercare.on.ca/sar/</a>  #3) Set up monthly team meetings to review SAR and EMR generated report on patients due for colorectal screening. Develop list of patients to call to pick up FOBT kit or for referral for sigmoidoscopy or colonoscopy.	Develop staff training, set up training, and train staff   Contact Local Registration Agent to schedule time for on-site registration for ONE ID. All physicians to be registered for access to the SAR and identified staff to be registered as delegates.  Schedule monthly meeting that coincides with monthly release of the SAR report.	% of staff trained on EMR template  % of physicians registered to access the SAR % of staff registered as delegates to access the SAR on behalf of the physician  Completion of team review meetings every month. % of eligible patients identified	80% of staff will be trained by October 2016  100% of physicians registered 100% of delegates registered  All scheduled team meetings are held 100% of patients that require screening are identified each month to be called.	Many staff work part-time so scheduling difficult    



## 2.2 Cervical Cancer Screening

Sample target:

**Measure**

Objective, Measure / Indicator ? GOTO CHANGE IDEA

Quality Dimension ? Effective

Sector \* ? PC

Objective \* ? Improve rate of cancer screening.

Measure / Indicator Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years

Priority \* ?

Unit of Measure \* ? % If other, specify

Population \* ? PC organization population eligible for screening If other, specify

Data Source \* ? See Tech Specs If other, specify

Period \* ? Other Please specify

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Organization PC xyz

Direction of Improvement ? ↑ Higher is better

Current Performance ?  70.00 *between 0.00 and 100.00*  
 Collecting Baseline ?  
 Suppressed ?

Absolute Target ?  85.00 *between 0.00 and 100.00* Relative Target ?  %  
 Collecting Baseline ?

Target Justification ? Aligned with provincial target screening participation rate.

Sample change ideas:

**Change Idea**
➤ GOTO MEASURE

Change Idea ?

Quality Dimension ?      Effective

Objective ?              Improve rate of cancer screening.

Measure / Indicator ?      Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years

Organization                  PC xyz

Change Number                # 1

Planned Improvement Initiatives (Change Ideas) ?      Set up monthly team meetings to review Screening Activity Report (SAR) and EMR generated report on patients due for cervical screening and develop a list of patients to be called to schedule a Pap test.

Methods ?                      Schedule monthly meeting that coincides with monthly release of the SAR report.

Process Measures ?            Completion of team meetings every month.

Goal For Change Ideas ?      100% of all patients that require screening are identified each month to be called.

Comments ?

➤ GO TO CHANGE #
# 1 ▼
✕ DELETE THIS CHANGE IDEA
CANCEL
💾 SAVE
💾 SAVE & CLOSE
+ ADD NEW CHANGE IDEA



**Change Idea**

Change Idea [?](#) **> GOTO MEASURE**

Quality Dimension [?](#) Effective

Objective [?](#) Improve rate of cancer screening.

Measure / Indicator [?](#) **Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years**

Organization PC xyz

Change Number # 2

Planned Improvement Initiatives (Change Ideas) [?](#) Call patients due for cervical screening to invite them to get screened based on results of EMR search and validation by physicians.

Methods [?](#) Invitation phone calls are made to screening eligible patients by administrative staff.

Process Measures [?](#) % of patients called  
% of patients reached who schedule a Pap test

Goal For Change Ideas [?](#) Call 100% of patients on screening eligible list  
70% of patients reached schedule a test

Comments [?](#) Not all patients may be reached due to a variety of reasons (e.g. wrong telephone number, out of town etc.).  
Not all patients reached may choose to schedule a test.

**> GO TO CHANGE #** #2 **✖ DELETE THIS CHANGE IDEA** **CANCEL** **SAVE** **SAVE & CLOSE** **+ ADD NEW CHANGE IDEA**



**Change Idea**

Change Idea [?](#) **> GOTO MEASURE**

Quality Dimension [?](#) Effective

Objective [?](#) Improve rate of cancer screening.

Measure / Indicator [?](#) Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years

Organization PC xyz

Change Number # 3

Planned Improvement Initiatives (Change Ideas) [?](#)  
 Conduct Pap tests on all eligible patients

Methods [?](#)  
 Conduct Pap test

Process Measures [?](#)  
 % of Pap tests conducted out of those scheduled

Goal For Change Ideas [?](#)  
 85% of patients who scheduled a Pap test, are screened

Comments [?](#)  
 Some patients who schedule a test may end up cancelling it.  
 Consider making reminder calls for tests booked far in advance to minimize no-shows.

**> GO TO CHANGE #** # 3 **✗ DELETE THIS CHANGE IDEA** **CANCEL** **SAVE** **SAVE & CLOSE** **+ ADD NEW CHANGE IDEA**

Once completed, your QIP will look similar to the example below (please note that additional changes ideas are included in this work plan). You will be able to export this work plan into Excel.

D	AIM	MEASURE						CHANGE					
	OBJECTIVE	MEASURE / INDICATOR	UNIT / POPULATION	SOURCE / PERIOD	ORG ID	CURRENT PERFORMANCE	TARGET PERFORMANCE	TARGET JUSTIFICATION	PLANNED IMPROVEMENT INITIATIVES (CHANGE IDEAS)	METHODS	PROCESS MEASURES	GOAL FOR CHANGE IDEAS	COMMENTS
2	Improve rate of cancer screening.	Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years	% / PC organization population eligible for screening	See Tech Specs / Annually	9999993	70.00	85.00	Aligned with provincial target screening participation rate.	<p>#1) Set up monthly team meetings to review Screening Activity Report (SAR) and EMR generated report on patients due for cervical screening and develop a list of patients to be called to schedule a Pap test.</p> <p>#2) Call patients due for cervical screening to invite them to get screened based on results of EMR search and validation by physicians.</p> <p>#3) Conduct Pap tests on all eligible patients</p>	<p>Schedule monthly meeting that coincides with monthly release of the SAR report.</p> <p>Invitation phone calls are made to screening eligible patients by administrative staff.</p> <p>Conduct Pap test</p>	<p>Completion of team meetings every month.</p> <p>% of patients called reached who schedule a Pap test</p> <p>% of Pap tests conducted out of those scheduled</p>	<p>100% of all patients that require screening are identified each month to be called.</p> <p>Call 100% of patients on screening eligible list 70% of patients reached schedule a test</p> <p>85% of patients who scheduled a Pap test, are screened</p>	<p>Not all patients may be reached due to a variety of reasons (e.g. wrong telephone number, out of town etc.). Not all patients reached may choose to schedule a test. Consider allocating time to make calls outside of daytime business hours.</p> <p>Some patients who schedule a test may end up cancelling it. Consider making reminder calls for tests booked far in advance to minimize no-shows.</p>

## Acknowledgement:

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# Cancer Care Ontario Guidelines for Breast, Cervical and Colorectal Cancer Screening



Ontario Breast Screening Program (OBSP)		
	Average Risk	High Risk
Screening Recommendation	Mammogram every two years for most women	Mammogram and screening breast MRI every year
Screening Population	Women 50 to 74 years of age	Women 30 to 69 years of age identified as high risk (see eligibility for criteria)
Outside the Screening Population	<ul style="list-style-type: none"> <li>Screening starts at age 50 for women at average risk.</li> <li>Women over age 74 can be screened within the OBSP; however, they are encouraged to make a personal decision about breast screening in consultation with their healthcare provider. The OBSP will not recall women over age 74 to participate in the program. To continue screening through the OBSP, a healthcare provider will need to provide a referral.</li> </ul>	<ul style="list-style-type: none"> <li>Screening starts at age 30 for women at high risk.</li> <li>Women 70 to 74 years of age identified as high risk should be screened with mammography only.</li> <li>Women over age 74 can be screened within the OBSP; however, they are encouraged to make a personal decision about breast screening in consultation with their healthcare provider. The OBSP will not recall women over age 74 to participate in the program. To continue screening through the OBSP, a healthcare provider will need to provide a referral.</li> </ul>
Eligibility	<ul style="list-style-type: none"> <li>Physician referral or self-referral to the OBSP</li> <li>No acute breast symptoms</li> <li>No personal history of breast cancer</li> <li>No current breast implants</li> <li>No screening mammogram within the last 11 months</li> </ul>	<ul style="list-style-type: none"> <li>Physician referral</li> <li>No acute breast symptoms</li> <li>Meet one of the following risk criteria:                             <ul style="list-style-type: none"> <li>Are known to be carriers of a deleterious gene mutation</li> <li>Are the first-degree relative of a mutation carrier and have declined genetic testing</li> <li>Have a family history that indicates a lifetime risk of breast cancer that is <math>\geq 25\%</math> confirmed through genetic assessment</li> <li>Have received radiation therapy to the chest before age 30 and at least eight years previously</li> </ul> </li> </ul>

Ontario Cervical Screening Program (OCSP)	
Screening Recommendation	Cervical cytology (Pap test) every three years
Screening Population	<ul style="list-style-type: none"> <li>Screening initiation: women 21 years of age who are or have ever been sexually active</li> <li>Screening cessation: women 70 years of age if <math>\geq</math> three negative/normal cytology tests in the previous 10 years</li> </ul>

For information on follow-up and special circumstances see: "Ontario Cervical Screening Cytology Guidelines Summary" available at [www.cancercare.on.ca/presources](http://www.cancercare.on.ca/presources)

ColonCancerCheck (CCC)		
	Average Risk	Increased Risk
Screening Recommendation	Fecal occult blood test (FOBT) every two years	Colonoscopy
Screening Population	Asymptomatic men and women 50 to 74 years of age without a family history of colorectal cancer	<ul style="list-style-type: none"> <li>Increased risk is defined as a family history of colorectal cancer in one or more first-degree relatives (parent, sibling or child)</li> <li>Begin at 50 years of age, or 10 years earlier than the age the relative was diagnosed, whichever occurs first</li> </ul>

An abnormal FOBT should be followed up with colonoscopy.

For additional resources visit: [www.cancercare.on.ca/presources](http://www.cancercare.on.ca/presources)  
**Questions? Contact us at:** [screenforlife@cancercare.on.ca](mailto:screenforlife@cancercare.on.ca) | 1.866.662.9233  
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# Lignes directrices pour le dépistage cancer du sein, du col de l'utérus et du cancer colorectal

**Dépistage pour la vie**  
 Le dépistage du cancer détecte ce qui est invisible.  
 ☑ Sein ☑ Col de l'utérus ☑ Colorectal

Programme ontarien de dépistage du cancer du sein (PODCS)		
	Risque moyen	Risque élevé
Recommandations pour le dépistage	Mammographie tous les 2 ans pour la majorité des femmes	Mammographie et RMN de dépistage tous les ans
Population visée	Femmes de 50 à 74 ans	Femmes de 30 à 69 ans considérées à risque élevé (voir les critères d'admissibilité)
Population non visée	<ul style="list-style-type: none"> <li>Le dépistage commence à 50 ans</li> <li>Les femmes de plus de 74 ans peuvent passer des examens de dépistage dans le cadre du PODCS, mais elles sont invitées à prendre une décision personnelle à propos du dépistage du cancer du sein en consultation avec leur fournisseur de soins de santé. Le PODCS n'envoie pas de lettre de rappel aux femmes de plus de 74 ans pour qu'elles participent au programme. Pour continuer le dépistage par l'entremise du PODCS, vous devez être référée par un fournisseur de soins de santé</li> </ul>	<ul style="list-style-type: none"> <li>Le dépistage commence à 30 ans</li> <li>Les femmes de 70 à 74 ans reconnues à risque élevé devraient passer un examen ne comportant qu'une mammographie</li> <li>Les femmes de plus de 74 ans peuvent passer des examens de dépistage dans le cadre du PODCS, mais elles sont invitées à prendre une décision personnelle à propos du dépistage du cancer du sein en consultation avec leur fournisseur de soins de santé. Le PODCS n'envoie pas de lettre de rappel aux femmes de plus de 74 ans pour qu'elles participent au programme. Pour continuer le dépistage par l'entremise du PODCS, vous devez être référée par un fournisseur de soins de santé</li> </ul>
Admissibilité	<ul style="list-style-type: none"> <li>Aucun symptôme mammaire aigu</li> <li>Aucun antécédent personnel de cancer du sein</li> <li>Pas d'implants mammaires</li> <li>Pas de mammographie de dépistage depuis 11 mois</li> </ul>	<ul style="list-style-type: none"> <li>Aucun symptôme mammaire aigu</li> <li>Répondre à l'un des critères de risque suivants :                             <ul style="list-style-type: none"> <li>✓ Être porteuse d'une mutation génétique délétère</li> <li>✓ Être parente au premier degré d'un porteur de mutation et avoir refusé une évaluation génétique</li> <li>✓ Avoir des antécédents familiaux indiquant un risque à vie de cancer du sein ≥ 25% confirmé une évaluation génétique</li> <li>✓ Avoir reçu une radiothérapie de la poitrine avant 30 ans, il y a au moins 8 ans</li> </ul> </li> </ul>

Programme ontarien de dépistage du cancer du col de l'utérus (PODCCU)	
Recommandations pour le dépistage	Cytologie cervicale (test Pap) tous les 3 ans
Population visée	<ul style="list-style-type: none"> <li>Début: femmes de 21 ans qui ont ou ont déjà eu des activités sexuelles</li> <li>Fin: 70 ans si ≥ 3 cytologies négatives/normales au cours des 10 dernières années</li> </ul>

Pour plus d'informations sur le suivi et les circonstances spéciales, voir le document : Ontario Cervical Screening Cytology Guidelines Summary, à l'adresse : [www.cancercare.on.ca/presources](http://www.cancercare.on.ca/presources).

ColonCancerCheck (CCC)		
	Risque moyen	Risque accru
Recommandations pour le dépistage	Test du sang occulte fécal (TSOF) tous les 2 ans	Coloscopie
Population visée	Hommes et femmes asymptomatiques âgés de 50 à 74 ans, sans antécédents familiaux de cancer colorectal	<ul style="list-style-type: none"> <li>Défini comme des antécédents familiaux de cancer colorectal chez au moins 1 parent au premier degré (père ou mère, frère ou sœur ou enfant)</li> <li>Début à 50 ans ou 10 ans avant l'âge à laquelle le parent fut diagnostiqué, selon la première éventualité</li> </ul>

Les TSOF anormaux devraient être suivis d'une coloscopie.

Pour d'autres ressources, consultez le site : [www.cancercare.on.ca/presources](http://www.cancercare.on.ca/presources)  
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