CRC Screening Improvement Action Plan

Please complete the Action Plan, including the following interventions:

SCREEND
Improving Colorectal Cancer Screening Rates in North Dakota

Choose at least 2 Primary EBIs	Provider Assessment/Feedback	Evaluate provider performance in delivering or offering screening to clients (assessment) and present providers with information about their performance in providing screening (feedback).
	Provider Reminders/Recall Systems	Inform healthcare providers that it is time for a client's cancer screening test (reminder) or that the client is overdue for screening (recall).
	Client Reminders	Written (letter, postcard, or email) or telephone messages (including automated messages) advising people that they are due for screening.
	Reducing Structural Barriers	Non-economic burdens or obstacles that make it difficult for people to access cancer screening. Examples include: modifying hours of service to meet client needs; offering services in alternative settings; eliminating or simplifying administrative procedures or other obstacles such as transportation, dependent care, translation services, etc.
Choose at least 1 Supportive EBI	Small Media	Videos and printed materials that can be used to inform and motivate people to be screened for cancer.
	Patient Navigation	Used by partnering clinics as an approach to reduce barriers to access and use of cancer screening services, and to support implementation of EBIs. It may also be used to facilitate completion of follow-up colonoscopies performed after a positive or abnormal CRC screening test.
Choose at least 1 Tool	Provider recommendation to patient	The positive impact of advice from a doctor is well documented. This assures all patients receive this important message.
	Policy Development	The foundation of a systematic approach. This is the precondition for a reliable and predictable office practice.
	Tracking and Follow-up of screening tests	Use of reminder system for office staff to check back with the patient who is screening such as with a take home FIT test to encourage them to complete it.
	Measuring Practice Progress	Using data, staff and patient feedback, and/or meetings to evaluate and share progress of new procedures. This allows the opportunity to rehearse new skills, identify need for continuing education and explore ways to support one another, positively reinforce areas of excellence and develop solutions for deficiencies.

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Template

Overall SMART Goal: (Example: Quality Health Clinic will improve CRC Screening rates by 25% by 12/30/2021.)

Interventions	Smart Goal Specific, Meaningful, Action oriented, Realistic, Timeline	Team Members (specific)	Community Partners	Resources
1.				
2.				
3.				
4.				
5.				

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