Enhancing Diagnostic Evaluation In Colorectal Cancer Screening

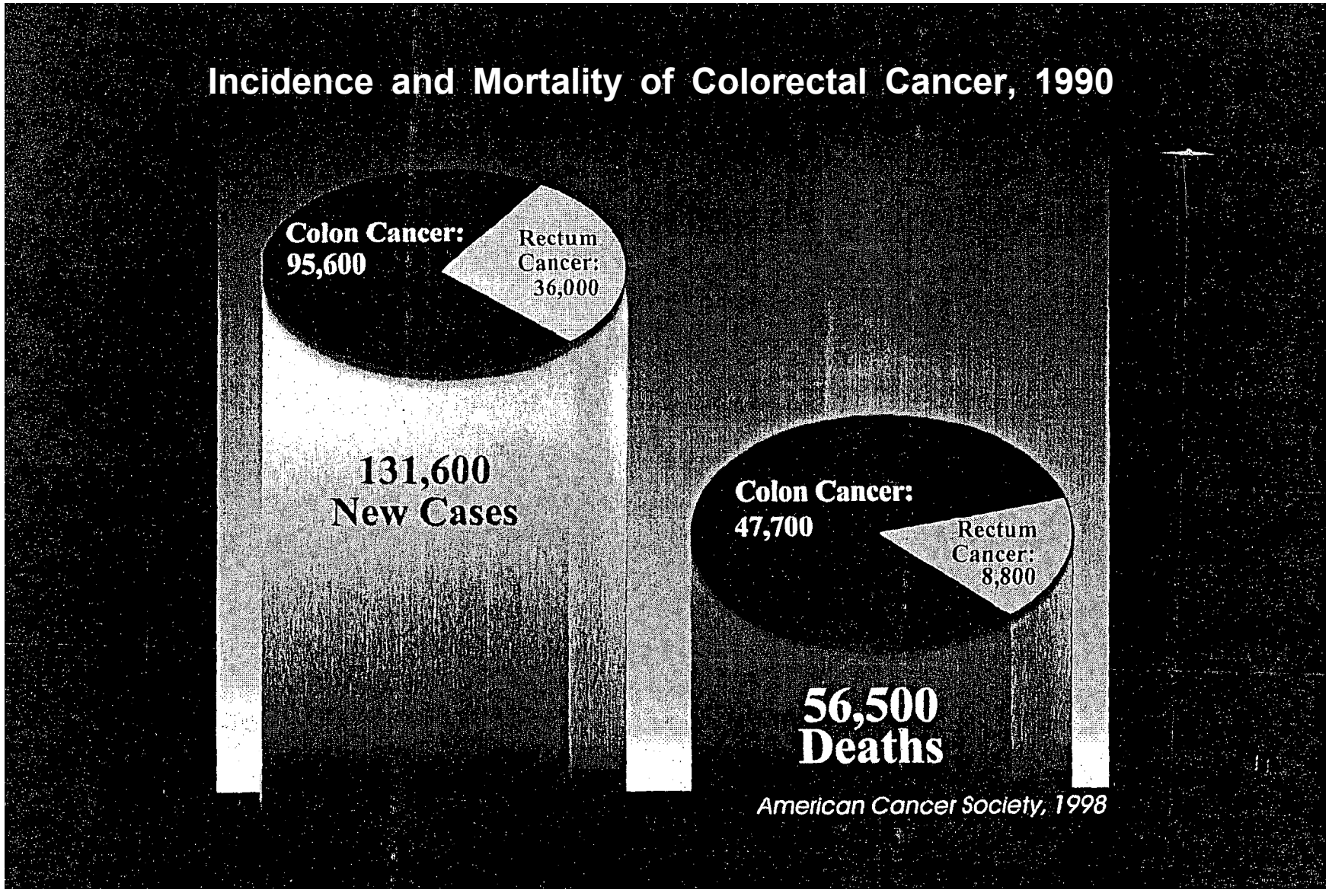
A National Cancer Institute-funded study

Thomas Jefferson University and AEtna U.S. Healthcare™

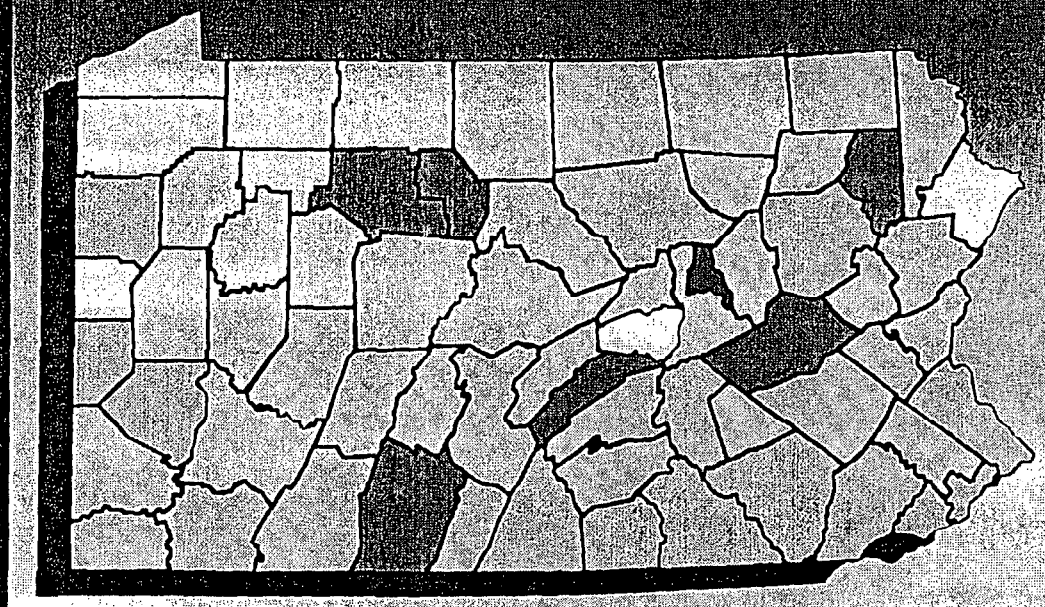
Presentation Objectives

At the conclusion of this presentation participants will be able to:

1. Know the incidence, mortality, and five-year survival rates. for colorectal cancer.
2. Define Complete Diagnostic Evaluation (CDE).
3. Asses the impact of fecal occult-blood test (FOBT) screening with CDE on disease stage.
4. Describe clinical findings for FOBT+ patients who have CDE.
5. Report CDE rates for primary care practices.
6. Review information regarding CDE rates for primary care practices.


Incidence and Mortality of Colorectal Cancer, 1990
Colon Cancer: 95,600
Rectum Cancer: 36,000
131,600 New Cases
Colon Cancer: 47,700
Rectum Cancer: 8,800
56,500 Deaths
American Cancer Society, 1998

Colorectal Cancer Mortality, Pennsylvania



Age adjusted rate:

- *Higher than expected & rate ≥ U.S. + 33%*
- *Higher than expected*
- *Similar to expected*
- *Lower than expected*

Cancer mortality for all races, sexes, and ages, 1983-87, US 1970 Standard NTIS State Cancer Central Map and Date Program, 1994.

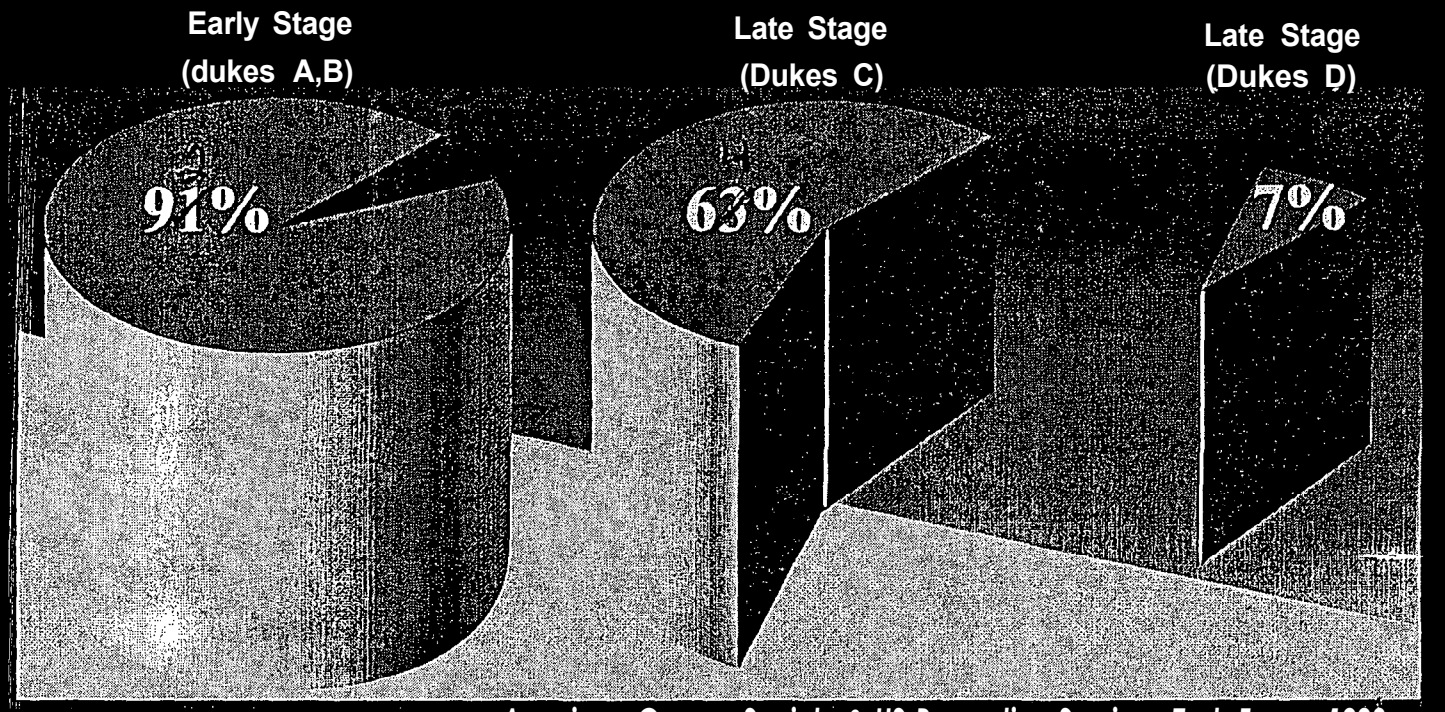
Colorectal Cancer Mortality, New Jersey

Age adjusted rate:

- *Higher than expected & rate ≥ U.S. + 33%*
- *Higher than expected*
- *Similar to expected*
- *Lower than expected*

Cancer mortality for all races, sexes, and ages 1983-87, US 1970 Standard. NTIS State Cancer Central Map and Data Program, 1994.

Colorectal Cancer 5-year Survival by Disease Stage



American Cancer Society & US Preventive Services Task Force, 1998

1. Primary Prevention: *Dietary*

Increase dietary fiber and

decrease fat

2. Secondary Prevention Strategies: *Screening*

Age 50:

- **Annual fecal occult blood test** plus
  Flexible sigmoidoscopy every 5 years*

  or

- Colonoscopy every 10 years*

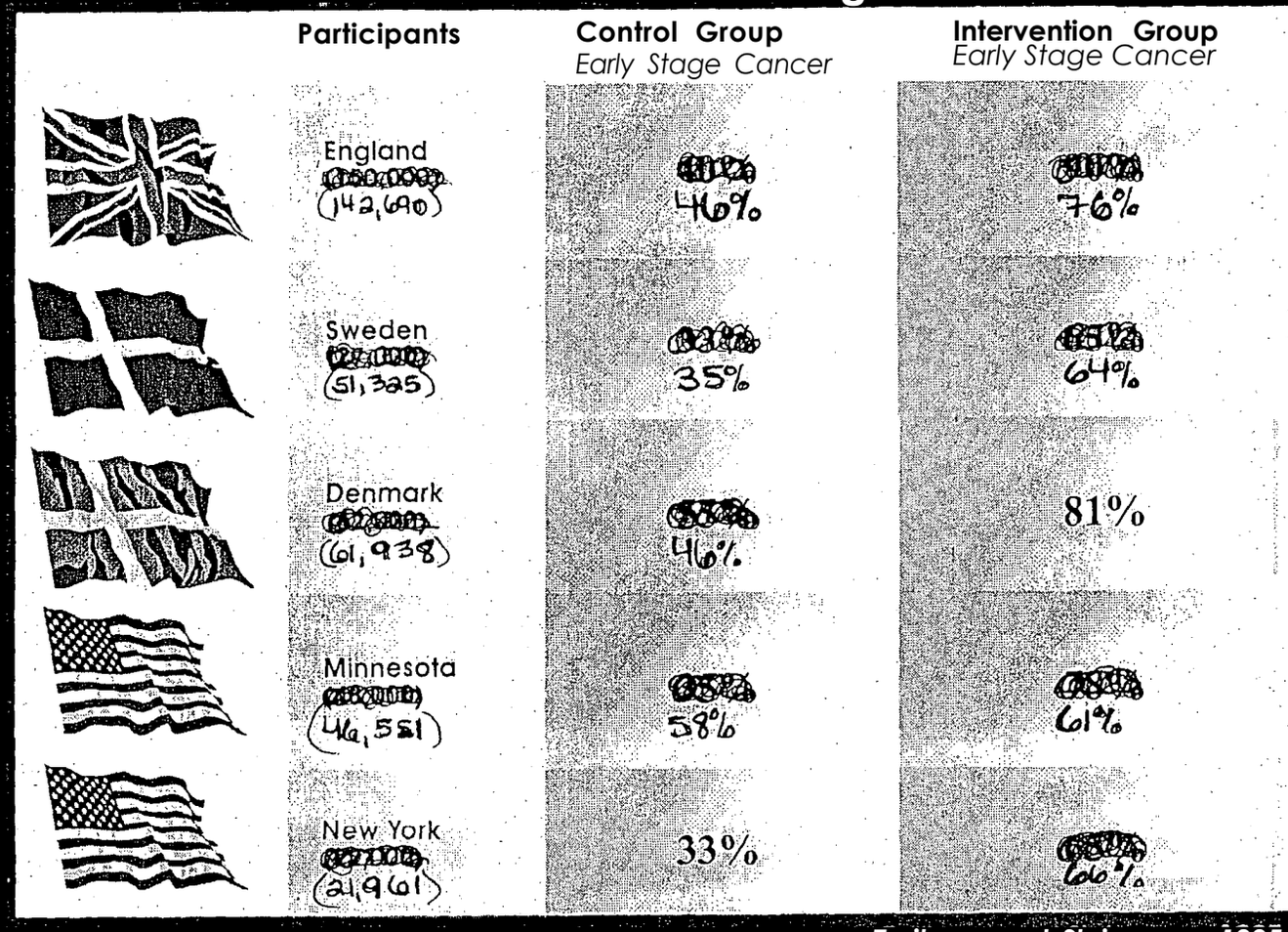
  or

- Double contrast barium enema every 5-10 years*

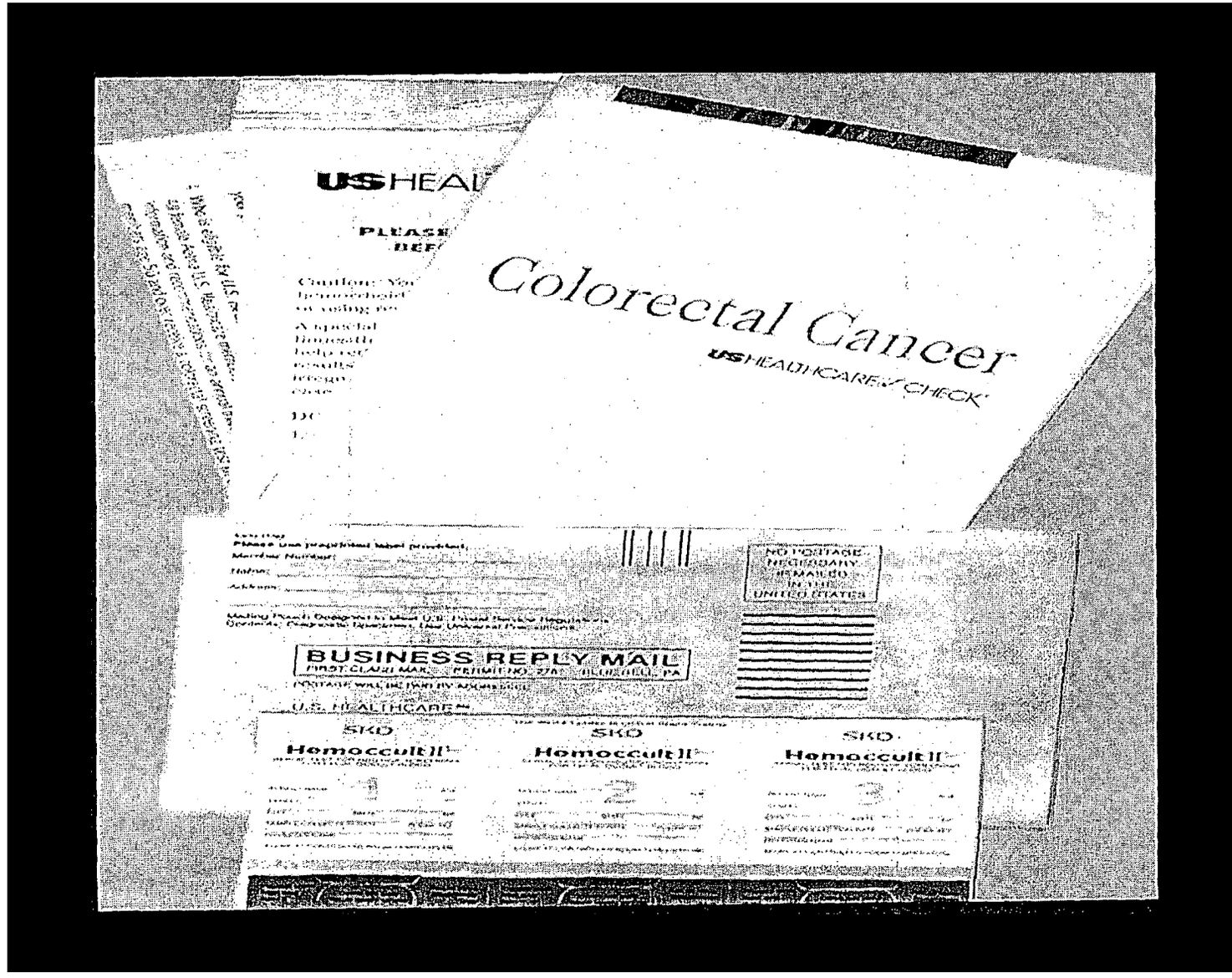
*Digital rectal exam is also recommended

American Cancer Society & U.S. Preventive Services Task Force 1996

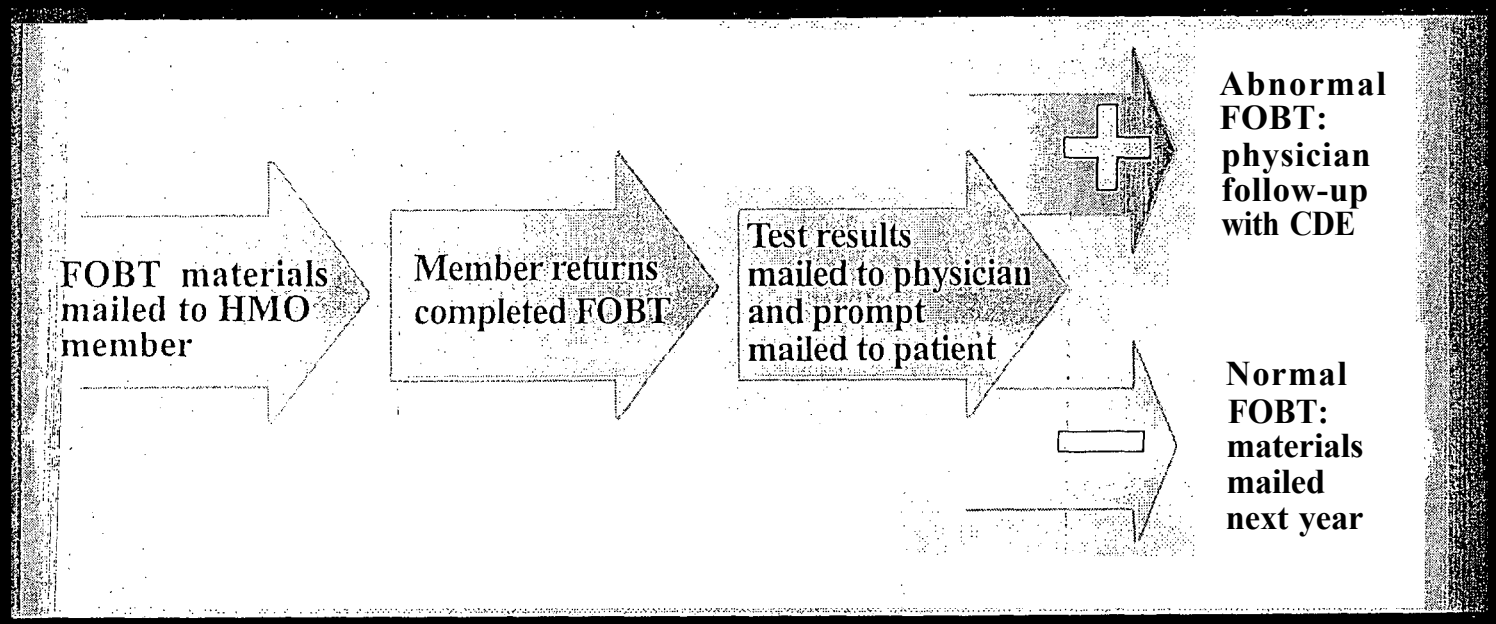
Early Colorectal Cancer Found in Randomized FOBT Screening with CDE



Toribara and Sleisenger, 1995


Colorectal Cancer
USHEALTHCARE's CHECK
NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES
BUSINESS REPLY MAIL
U.S. HEALTHCARE
SKD
Hemoccult II
SKD
Hemoccult II
SKD
Hemoccult II

Colorectal Cancer Screening Program



Complete Diagnostic Evaluation

CDE =

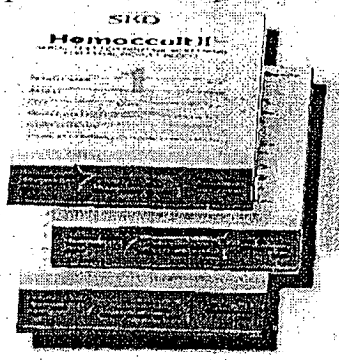
Colonoscopy

or

Barium Enema X-ray
and
Flexible Sigmoidoscopy

Normal and Abnormal FOBT Results

Fecal Occult Blood Testing (FOBT) comprises three separate test slides.

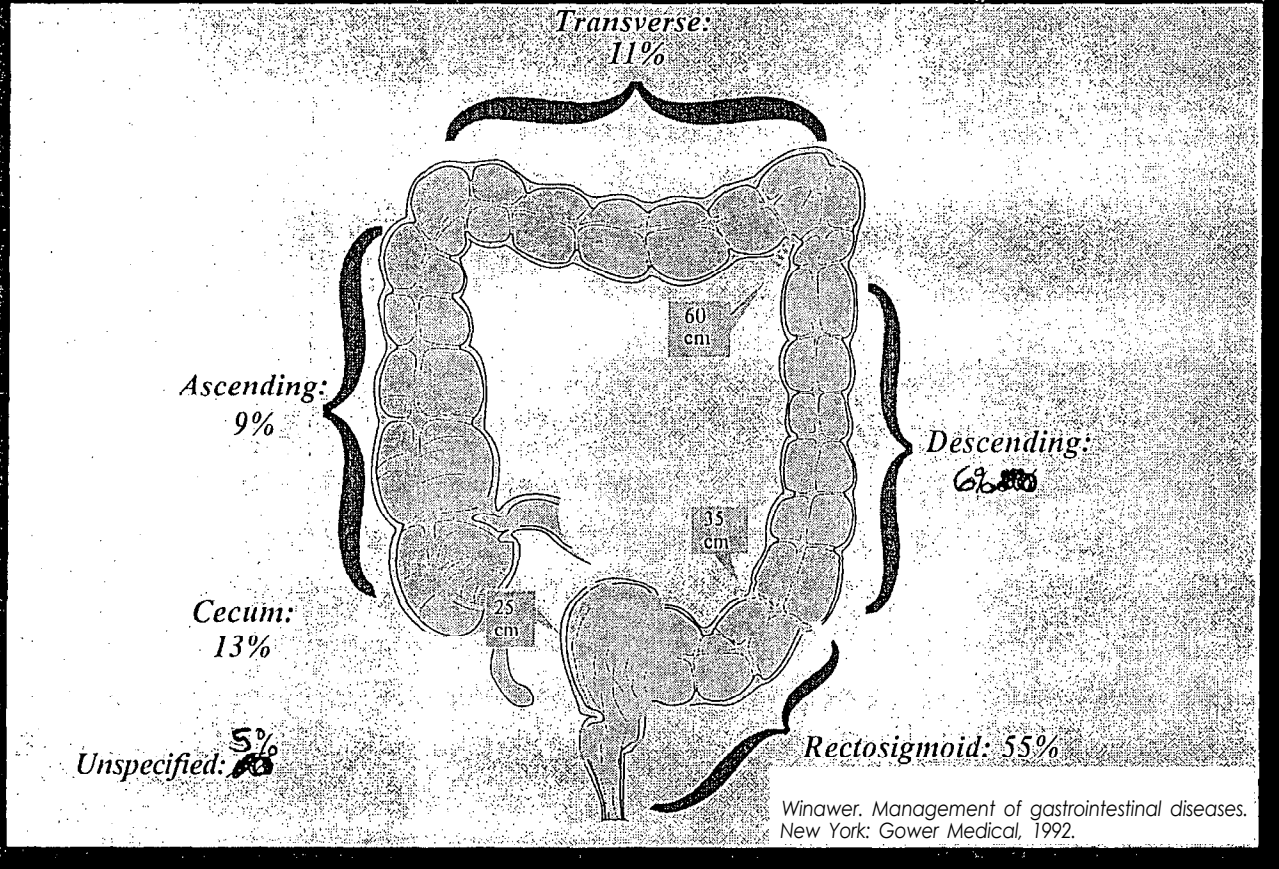


1, 2, or 3 slides positive = abnormal

Complete Diagnostic Evaluation (CDE)

No slides positive = normal; yearly FOBT recommended

Where Colorectal Cancers are Found



Winawer. Management of gastrointestinal diseases. New York: Gower Medical, 1992.

The World Leader in Occult Blood Testing

SKD

Hemoccult

SENSA

Colorectal Cancer and Adenomas (>1 cm) Cases Found When CDE is Used in FOBT Follow-up

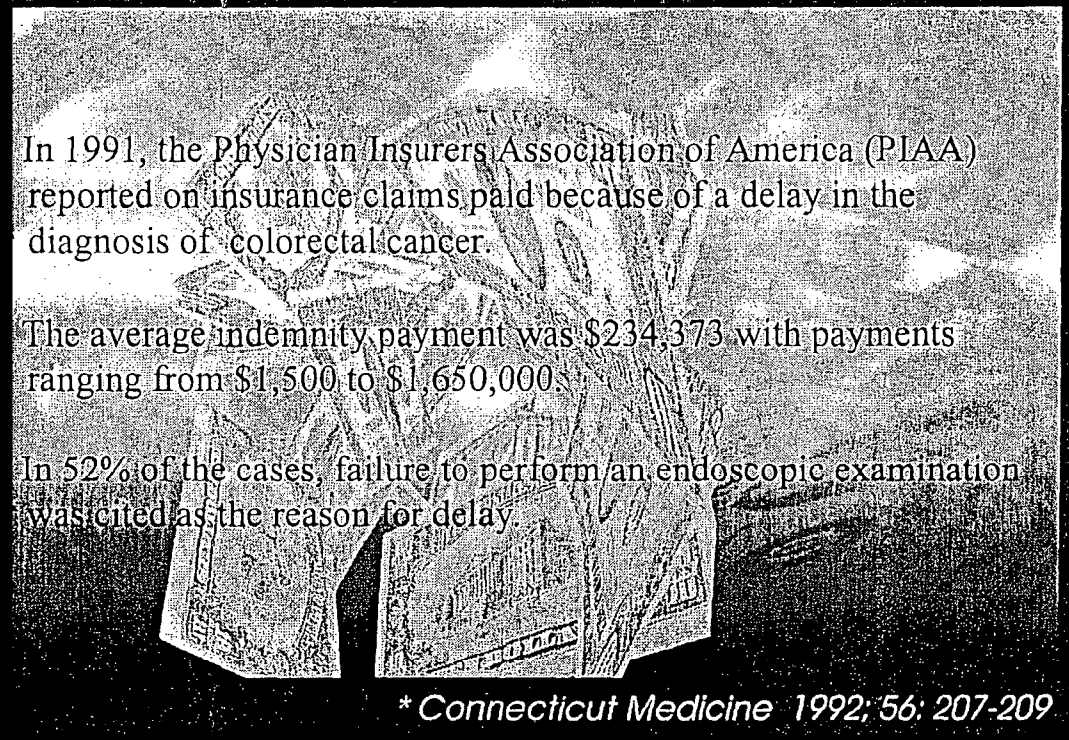
Study	*% cases found*
Myers et al. (1993)*	26%
Allison et al. (1996)**	23%
Rockey et al. (1988)***	17%

* Meyers et al. Screening for colorectal neoplasia: physician's adherence to complete diagnostic evaluation. American Journal of Public Health, 1993; 83(11): 1620-1622.

** Allison et al. A comparison of fecal occult-blood tests for colorectal cancer screening. New England Journal of Medicine, 1996; 334(3): 155-159

*** Rockey et al. Relative frequency of upper gastrointestinal and colonic lesions in patients with positive fecal occult-blood tests. New England Journal of Medicine, 1998; 339(3): 153-159.

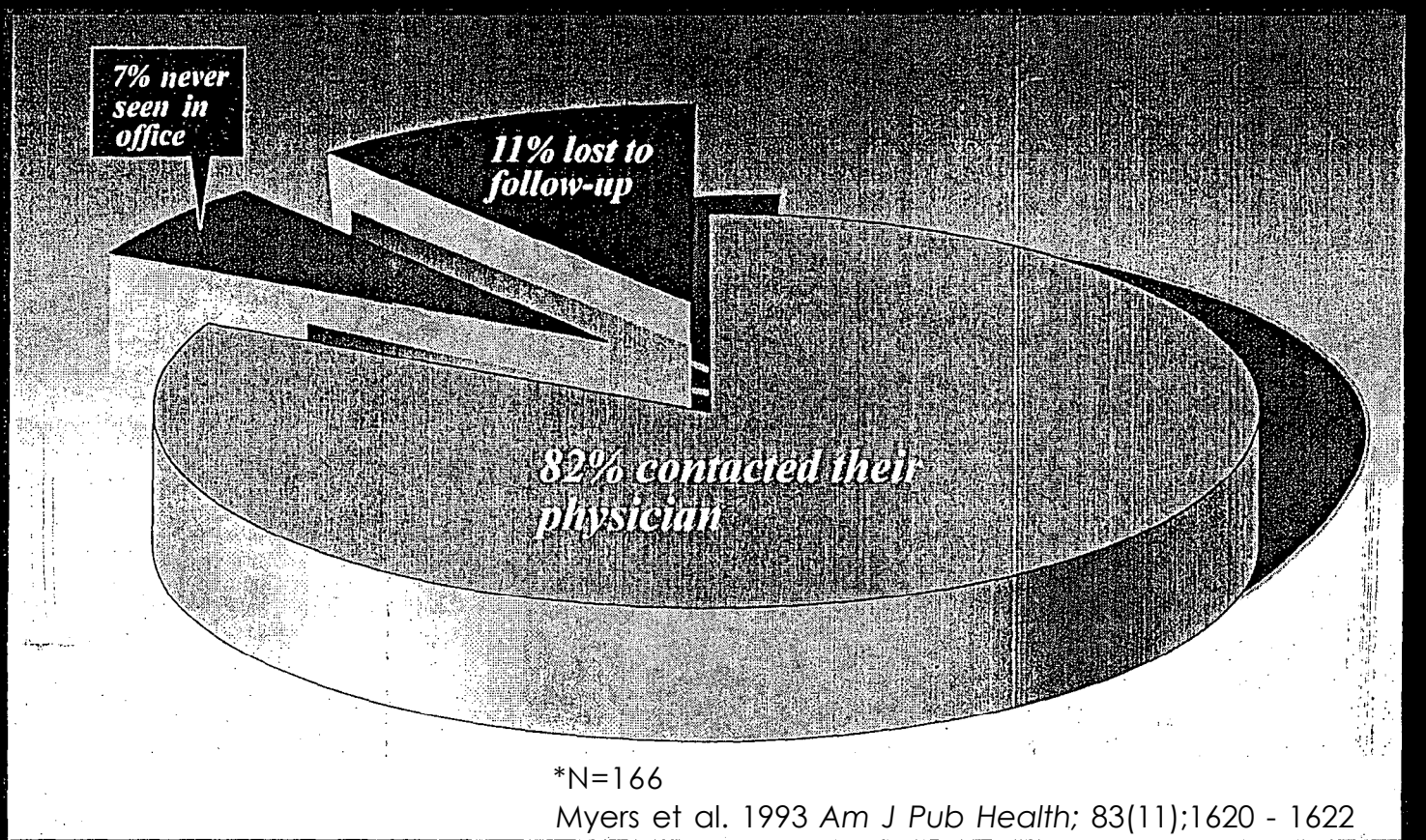
The Physician Insurer's Association Of America (PIAA) Closed Claim Studies*



** Connecticut Medicine 1992; 56: 207-209*

Data on CDE in Primary Care Practices: 1993-1994

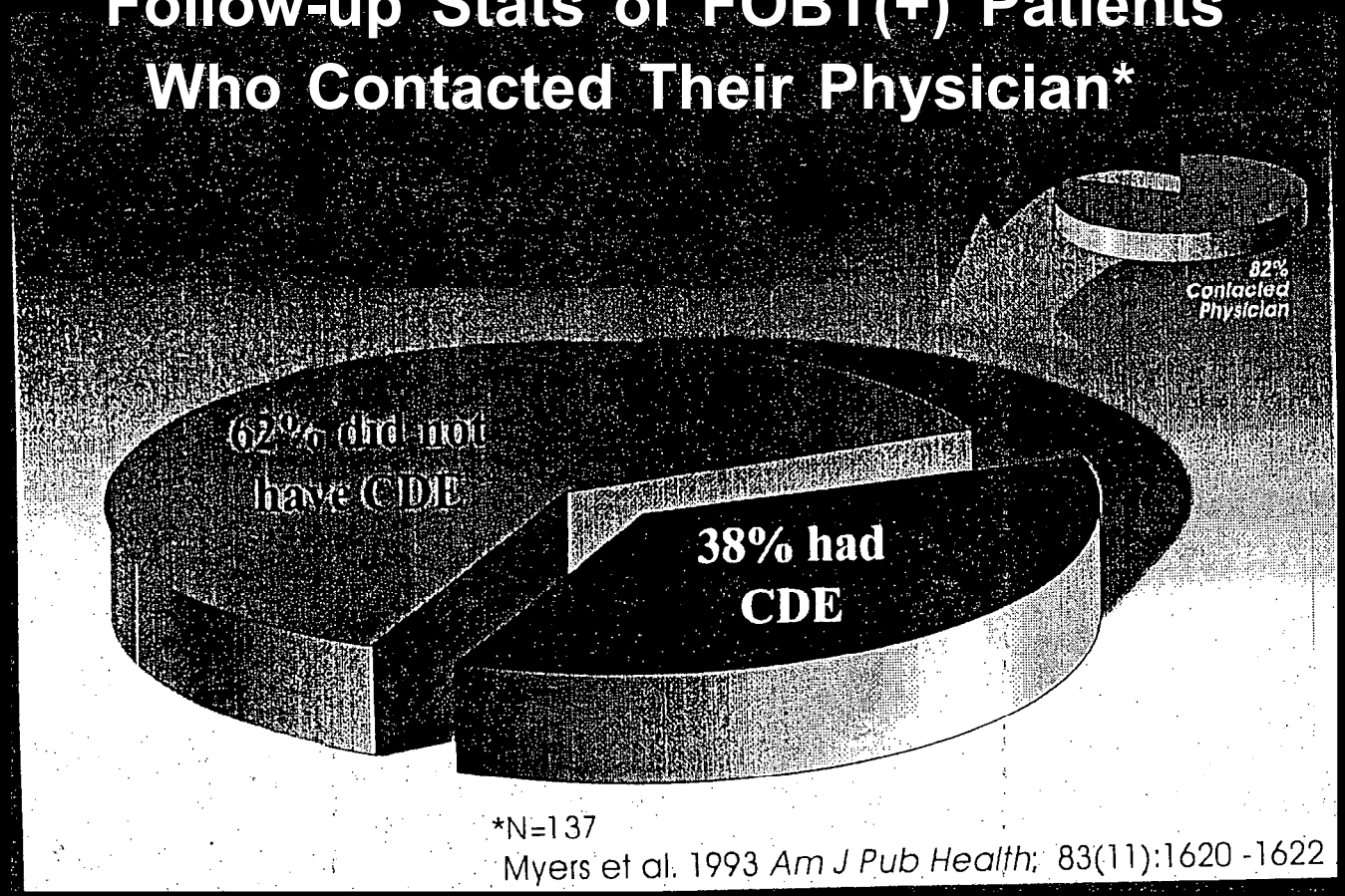
Follow-up Status for FOBT(+) Patients*



*N=166

Myers et al. 1993 *Am J Pub Health;* 83(11);1620 - 1622

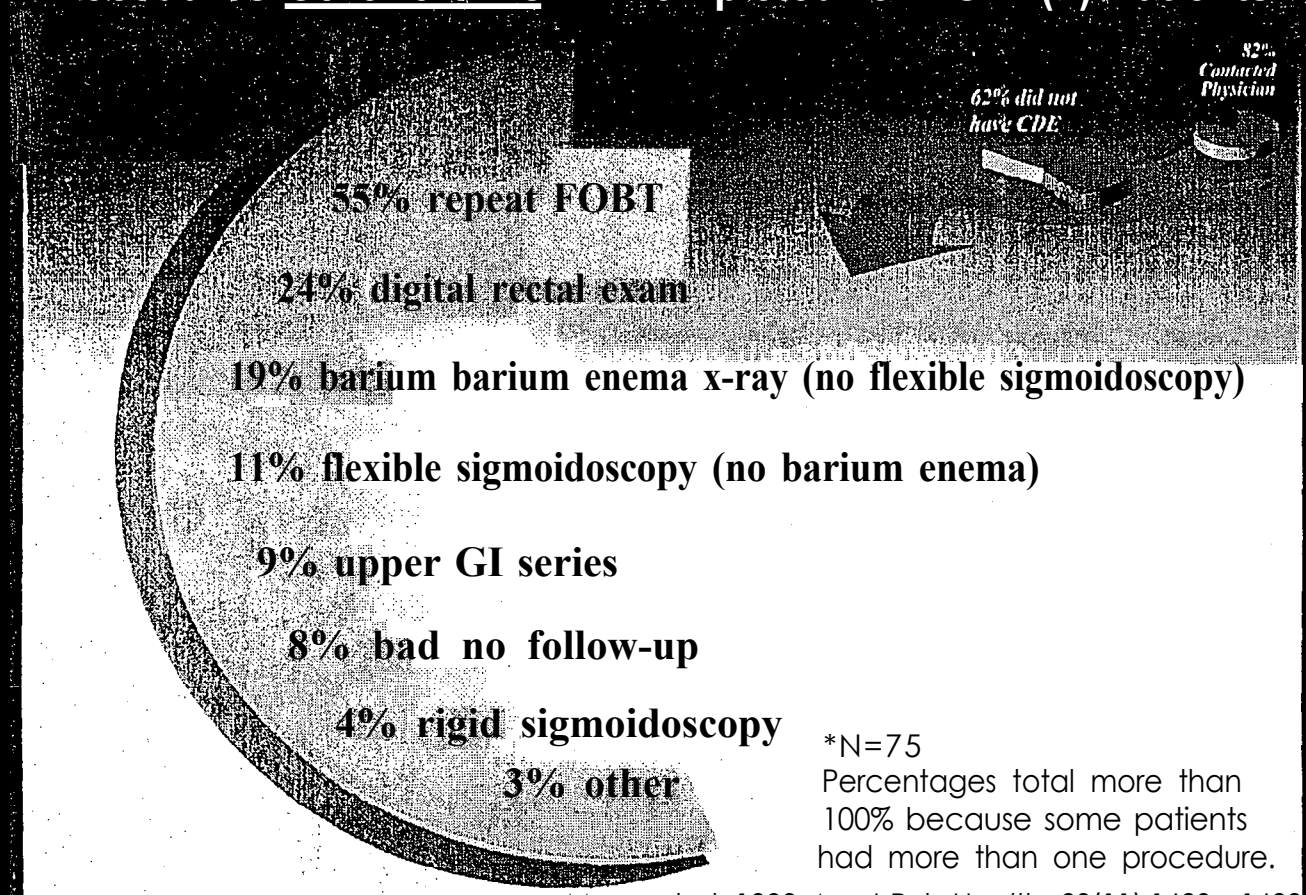
Follow-up Stats of FOBT(+) Patients Who Contacted Their Physician*



*N=137

Myers et al. 1993 *Am J Pub Health*; 83(11):1620 -1622

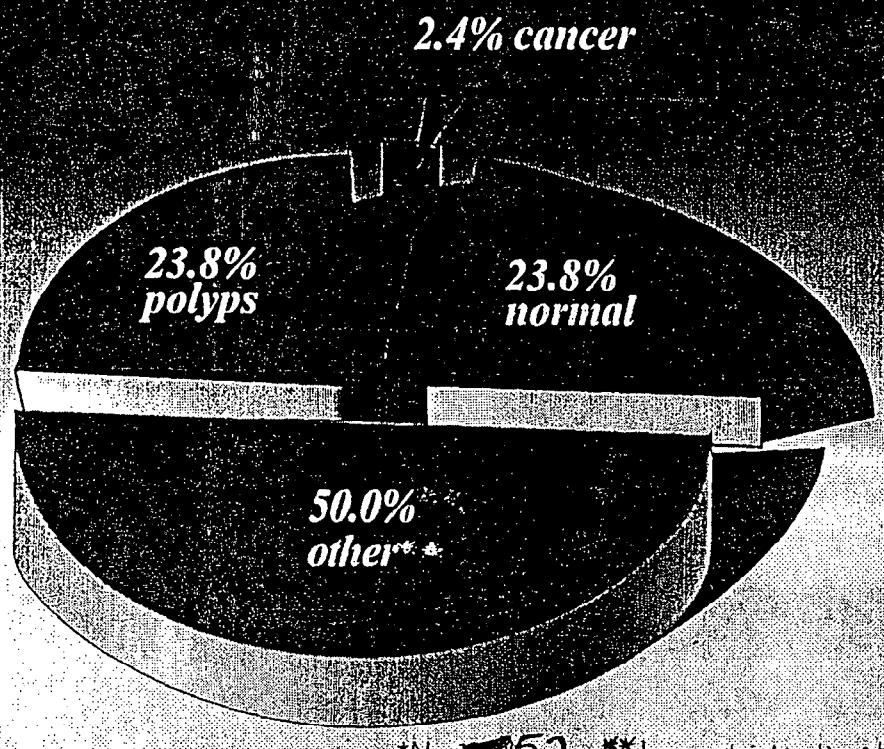
Procedures *Other than CDE* Completed for FOBT(+) Patients*



*N=75
Percentages total more than 100% because some patients had more than one procedure.

Myers at al. 1993 *Am J Pub Health;* 83(11):1620 - 1622

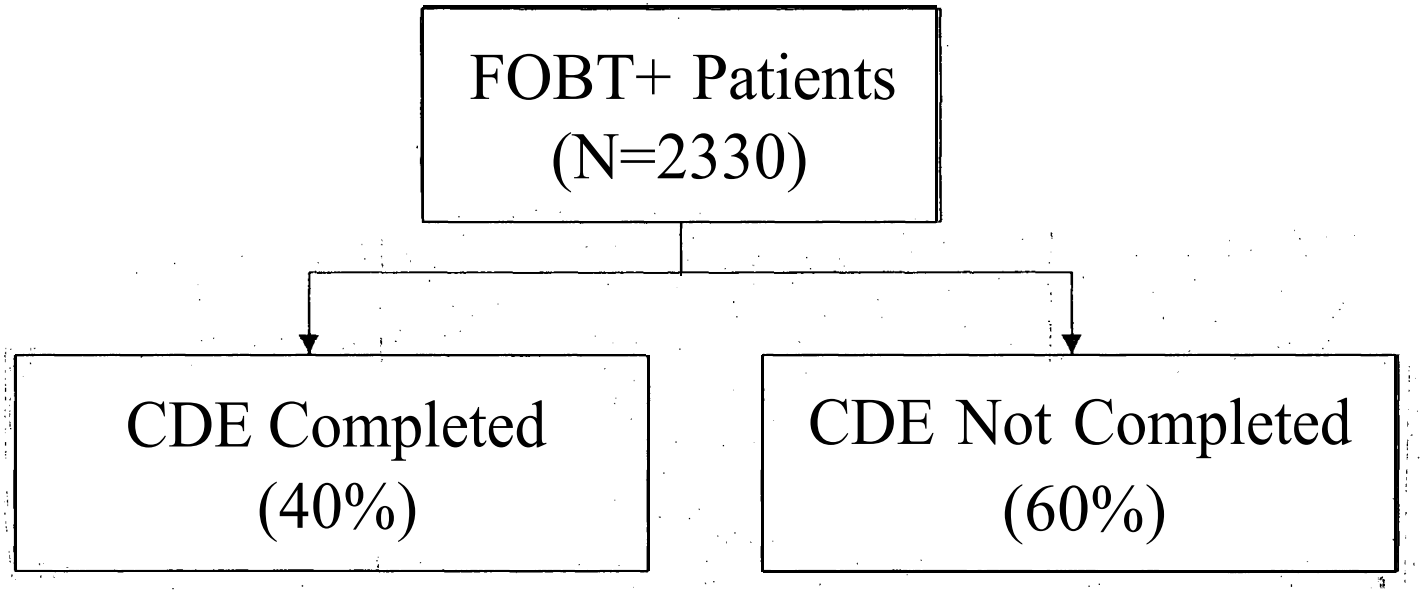
Clinical Findings for FOBT(+) Patients With CDE*



*N=52 **hemorrhoids, diverticulitis, stomach ulcer

Myers et al. 1993 *Am J Pub Health*: 83(11): 1620-1622

CDE Completion Rates



Myers et al., 1998. Unpublished

Data on CDE in Primary Care Practices: 1997-1998

THOMAS JEFFERSON UNIVERSITY

COMPLETE DIAGNOSTIC EVALUATION PRESENTATION

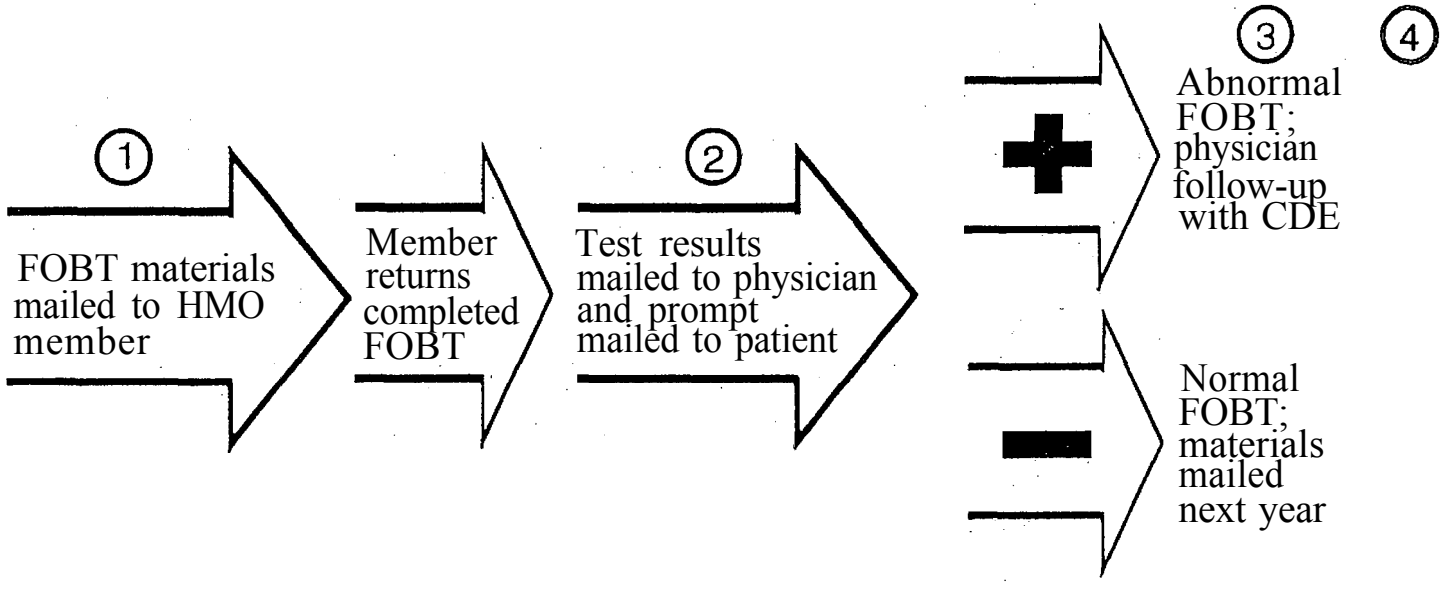
ATTENDANCE SHEET

Practice Name: _____ **Date of Visit:** _____

Attendee Name	**Participation Status**		**Attendee Signature**
	Yes	**No**	
«Dr. Name»	❑	❑	_____
«Dr. Name»	❑	❑	_____
«Dr. Name»	❑	❑	_____
«Dr. Name»	❑	❑	_____
«Dr. Name»	❑	❑	_____
«Dr. Name»	❑	❑	_____
«Other Participant»	❑	❑	_____
_____			
«Other Participant»	❑	❑	_____
_____			
«Other Participant»	❑	❑	_____
_____			

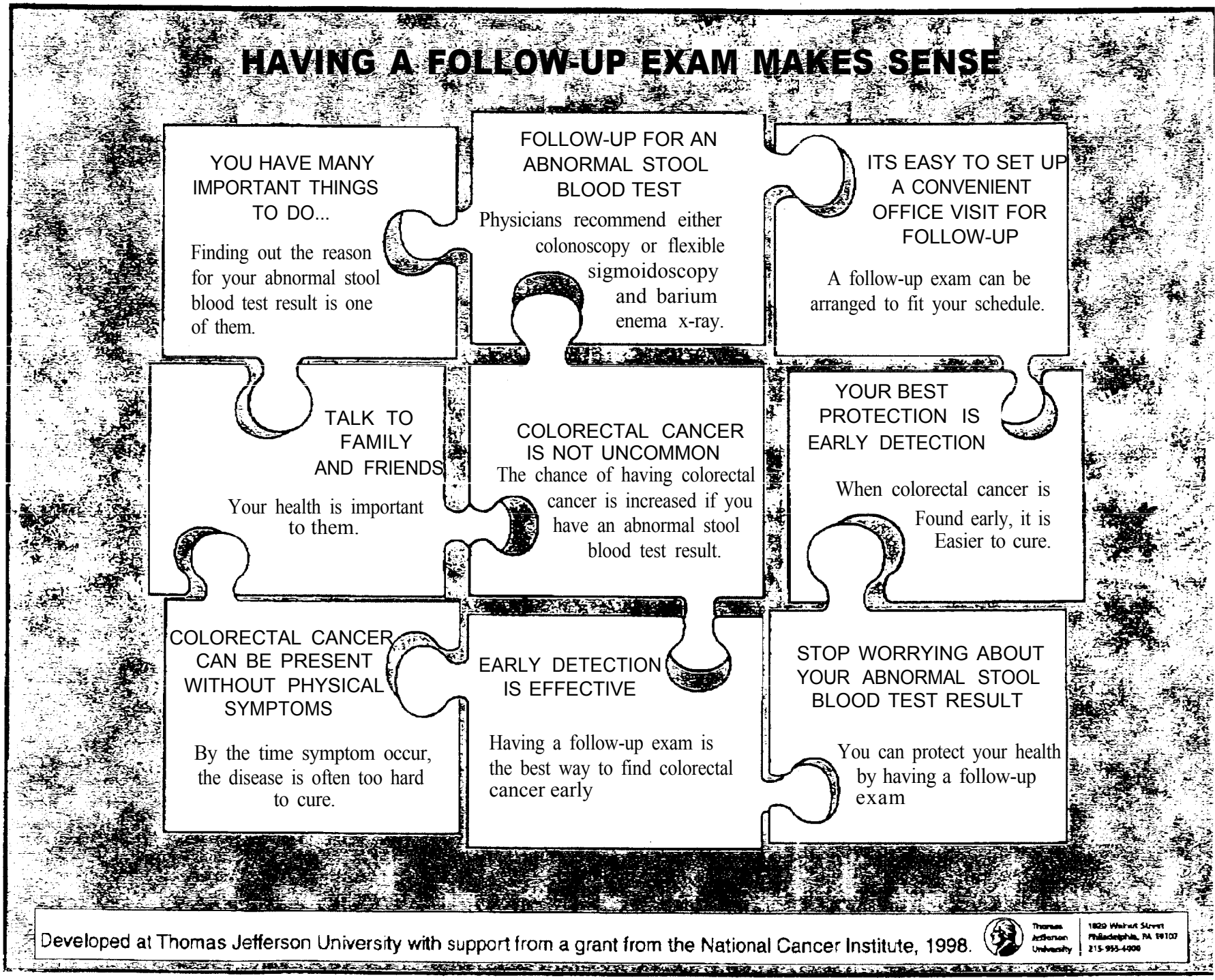
Suggested Strategies for Enhancing Current U.S. Healthcare Check® Screening Program

Current Screening Program and, Suggested Strategies (1-5)



1	2	3	4	5
Provide patient prompt to encourage screening	Provide general patient prompt that encourages follow-up of ? results	Provide patient prompt to encourage CDE after physician recommendat ion	Provide physician CDE reminder/ feedback	Remove patients with CDE from screening program

HAVING A FOLLOW-UP EXAM MAKES SENSE



Developed at Thomas Jefferson University with support from a grant from the National Cancer Institute, 1998.

Thomas Jefferson University
1825 Walnut Street
Philadelphia, PA 19107
215-955-6000

Practice Name

CDE Review

A report for primary care practices involved in "The CDE Study";
a National Cancer Institute-funded study of diagnostic evaluation
among patients with a positive fecal occult-blood test (FOBT+) result.

"By performing CDE, you can provide the best possible care to patients who have a positive FOBT result."

David Badolato, MD
Upper Dublin Professional Center

CDE is State of the Art
Follow-up Care for FOBT+ Patients

CDE
Complete
Diagnostic
Evaluation

=

Colonoscopy

or

Barium enema x-ray
AND
Flexible sigmoidoscopy

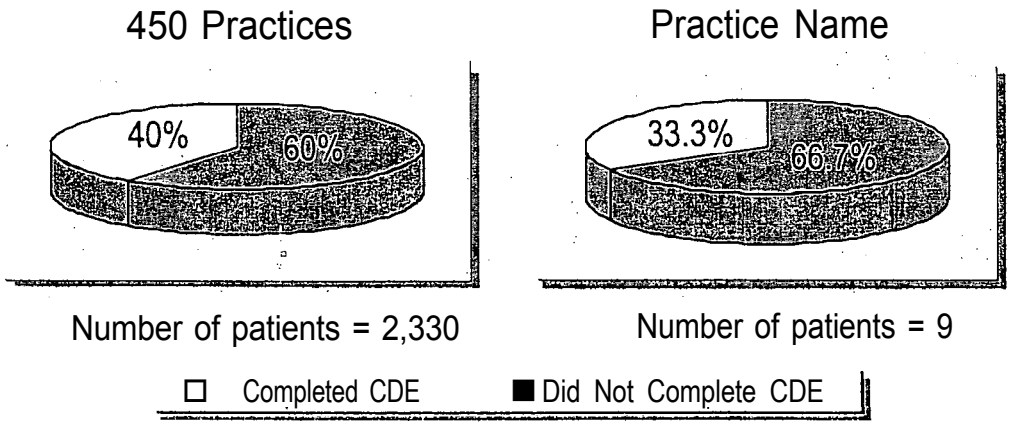
Physicians in primary care practices routinely see patients with a FOBT+ result from the U.S. Healthcare Check Program.®

Thomas Jefferson University and AEtna U.S. Healthcare™ encourage primary care physicians to consider CDE for patients with FOBT+ results obtained through the U.S. Healthcare Check Program.®

The American Cancer Society, The American College of Physicians, and numerous professional organizations support CDE for FOBT+ patients[1,2,3]

Feedback for Practices in the CDE Study

CDE completion rates shown below are based on information provided by primary care practices for patients who had a FOBT+ result in 1994-1995. Rates are adjusted to account for patients who were not eligible for CDE. Information for your practice is based on a random sample of patients.



Over for more information

1. Amencan Cancer Society, Facts and Figures - 1998. Atlanta, GA: American Cancer Society, Inc. 1998.
2. Annals of Internal Medicine. 1997;126:808-810.
3. Gastroenterology. 1997;112:594-642

Factors That Influence Practice CDE Rates*

CDE rates are low in practices where physicians:	CDE rates are high in practices where physicians know:
❑ Think that CDE is not likely to reveal clinically significant disease.	❑ CDE can detect important benign conditions and significant colorectal neoplasms.
❑ Believe that procedures other than CDE are adequate for follow-up.	❑ CDE allows for thorough visualization of the colon and rectum.
❑ Worry about CDE-related costs.	❑ Incomplete diagnostic evaluation is a major source of medical malpractice litigation. (In 1991, the average indemnity payment was $234,373.)[4]
❑ Have difficulty persuading patients to undergo CDE.	❑ Patient education can increase adherence.
❑ Have questions about the number of FOBT slides that are positive, patient characteristics, medication use and diet.	❑ The number of FOBT slides that are positive is not associated with disease status. ❑ Family history does not predict who will have an FOBT+ result. ❑ Colorectal cancer is positively associated with age, and most older patients tolerate CDE well. ❑ Hemoglobin levels do not predict who will have an FOBT+ result. ❑ NSAIDs or anticoagulants may cause a "false-positive", but they may also cause an existing colorectal cancer or polyp to bleed. ❑ The effect of diet on FOBT results is minimal.

* Based on information provided by all practices.
Highlighted area in the left column indicates factors specified by one or more physicians in your practice.

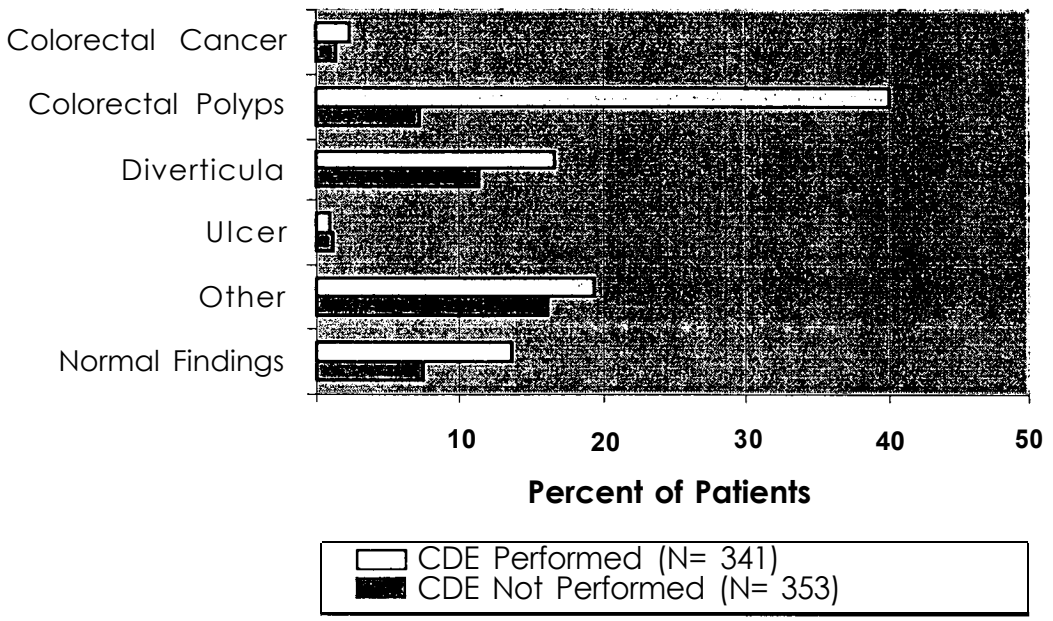
Factors Other Than Those Shown Above For Your Practice	Recommendations
❑ _____	❑ _____
❑ _____	❑ _____
❑ _____	❑ _____
❑ _____	❑ _____
❑ _____	❑ _____

4. Connecticut Medical Insurance Company. PIAA closed claim studies: Breast cancer and colon cancer results Connecticut Medicine. 1992;56(4):207-209.

Physician-Reported Data On FOBT+ Patient Care (continued)

Diagnoses for FOBT+ Patients

in 286 Primary Care Practices*



*Number represents practices that reported information on FOBT+ patients.
No diagnostic information was provided for 4(70%) patients who had CDE and 194(55.3%) patients who did not have CDE.

Reasons Why CDE Was Not Performed For FOBT+ Patients

In 192 Primary Care Practices*

Reason Reported By Primary Care Physician	N	%
Procedures other than CDE were performed follow-up	102	28.9
Patient was referred for CDE, but not performed	60	17.0
Patient refused CDE	37	10.5
Procedures other than CDE completed prior to FOBT+ result	13	3.7
Patient medical history / condition**	10	2.8
No record of FOBT+ result / patient not known to practice	10	2.8
Use of medications (NSAIDs) during testing period	4	1.1
Patient nonadherence to dietary restrictions	3	0.8
No reason provided	114	32.3
	353	100%

*Number represents practices that reported information on FOBT+ patients.
**Patient's medical history suggested reason for FOBT+ result/or patient's medical condition contradicted CDE.

CDE Review - Progress Report

An update on FOBT+ patient care in primary care practices participating in "The CDE Study; a National Cancer Institute-funded study of diagnostic evaluation among patients with a positive fecal occult-blood test (FOBT+) result.

Vol.2

"By performing CDE, you can provide the best possible care to patients who have a positive FOBT result."

David J. Badolato, MD
Family Practice Associates of Upper Dublin

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The American Cancer Society, The American College of Physicians, and numerous professional organizations support CDE for POBT+ patients.

CDE
Complete
Diagnostic
Evaluation

=

Colonoscopy

or

Barium enema x-ray
A N D
Flexible sigmoidoscopy

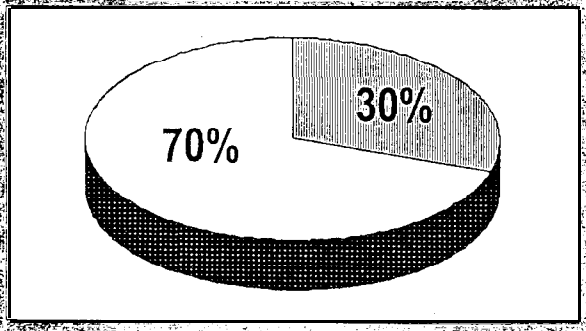
Physician-Reported Data On FOBT+ Patient Care

CDE completion rates shown below are based on information provided by **all primary care practices in the CDE Study** (aggregate data) for patients who had a positive FOBT result **from August 1998 to March 1999.** Rates are adjusted to account for patients who were not eligible for CDE.

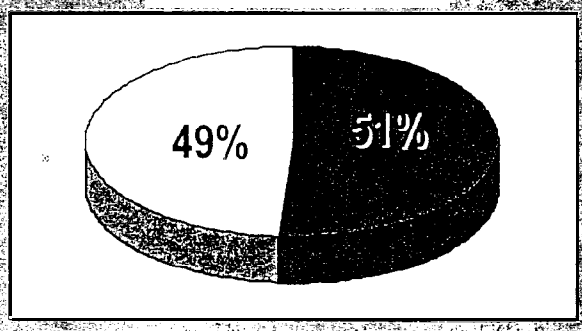
CDE Recommendation and Performance Rates

For FOBT+ Patients in 453 Primary Care Practices

CDE Recommended
(N = 694 Patients)



CDE Performed
(N = 694 Patients)



Thomas Jefferson University | Jefferson Medical College

Behavioral Epidemiology Section
Department of Medicine
Division of Medical Oncology

125 South 9th Street
Suite 403 Sheridan Building
Philadelphia, PA 19107
215-503-7801
Fax: 215-923-9506

January 6, 1999

Dear Dr.

Recently, you participated in a telephone survey on colorectal cancer screening. That survey is part of "The Complete Diagnostic Evaluation (CDE) Study," a National Cancer Institute-funded research project. The CDE Study focuses on primary care physician follow up of patients who have a positive screening fecal occult blood test (FOBT+) result More than 480 primary care physicians completed the survey.

The research team at Thomas Jefferson University has analyzed responses to survey items in order to learn why physicians may choose not to use CDE. Analysis of responses by all physicians identified perceptions that may impact CDE performance. I have summarized, these perceptions below and have checked areas of concern, if any, that were indicated by your responses. These results are confidential.

- ☐ Uncertainty related to CDE
- ☐ Awareness of time required for CDE
- ☐ Perception of costs related to CDE
- ☐ Belief that CDE is standard practice
- ☐ Intention to. recommend CDE to FOBT+ patients

My colleagues (Drs. Edith Mitchell, Barbara Turner, David Weinberg) and I would like to speak with you about any CDE-related concerns you may have, so that we may better understand your views. One of us will call you in the coming days to have this conversation. If you have any questions about The CDE Study, please call me at (215)503-4056. Thank you for your ongoing participation in this important project.

Best regards,

Ronald E. Myers, Ph.D.

DATE

«docfnamel» «doclnamel», «degree»
«pracname»
«address1»
«address2»
«city», «state» «zip»

Dear Dr. «doclnamel»:

U.S. Healthcare and Thomas Jefferson University are working together on a National Cancer Institute-supported study of colorectal cancer screening. The study is based on needs identified by primary care physicians who have provided information in the past on patients served by the U.S. Healthcare Check™ Program. Through this study, we will generate information you can use in following patients who have a screening positive fecal occult blood test (FOBT+) result.

Practices that participate in the study will be asked to provide follow-up information on U.S. Healthcare members who have had a FOBT+ result in the U.S. Healthcare Check™ program and respond to a brief telephone survey at the beginning and end of the study. Physicians in participating practices will receive CME credits, educational materials, and a summary of results. Participation will also be valued in our Quality Care Compensation model by satisfying a CME criterion for additional compensation.

- To award CME credit, it is necessary that we know which practice physicians will participate in the study. On the attached form, please check "Yes" for each physician who will participate and check "No" for each physician who will not participate.

- We have also attached a FOBT+ Follow up Form that lists up to nine U.S. Healthcare members in your practice who had a screening FOBT+ result in the U.S. Healthcare Check™ Program during 1994-1995. For each member, there is name, HMO ID, an FOBT+ result date, and areas to record information about follow-up flexible sigmoidoscopy (FS), barium enema x-ray (BE), and colonoscopy (CX). The information can be provided via one of the following options:

  Option 1: Fit; information and return the form using the enclosed postage-paid return envelope by **December 24, 1997.**
  Option 2: Copy pertinent pages (with dates of defined procedures) from the patient's chart and mail them in using the enclosed envelope by **December 24, 1997.**
  Option 3: Contact Dr. Ronald E. Myers, Department of Medicine, Thomas Jefferson University. Call (215)503-4086 by **December 24, 1997** and ask for a chart audit team to visit your office and collect the requested information.

Please return all completed forms by **December 24, 1997.** If you have any questions, feel free to contact me at (215) 283-6883 or Dr. Myers at the number shown above: We look forward to working with you on this important project.

Best regards,

Neil Schlackman, MD
Senior Medical Director
AEtna US Healthcare

Ronald E. Myers, PhD
Associate Professor
Thomas Jefferson University

«pacnname»

Please check “Yes” for each physician who will participate and check “No” for each physician who will not participate.

Physician	Yes	No	If No, Please explain:
«docname1»	❑	❑	_____
«docname2»	❑	❑	_____
«docname3»	❑	❑	_____
«docname4»	❑	❑	_____
«docname5»	❑	❑	_____
«docname6»	❑	❑	_____
«docname7»	❑	❑	_____
«docname8»	❑	❑	_____
«docname9»	❑	❑	_____
_____ Other Physician	❑	❑	_____

September 29, 2000

«Office»
«ADDRESS1»
«ADDRESS2»
«City», «State» «zip»

Dear Doctors «Doctors»:

AEtna U.S. Healthcare™ screening program records indicate that «FNAME» «NAME» («MEMBRID»), a patient in your office, had a positive fecal occult blood test (FORT) result on *FORTDT*. As a participant in "The CDE Study." an NCI-funded study on colorectal cancer screening and follow-up, your office is asked to record the information requested below for the patient.

Please fax the completed form to (215) 923-9506. A secure fax line, within two weeks of receipt. Alternatively, send a copy of the completed form by mail using the enclosed addressed. postage-paid envelope.

Thank you for your prompt. response. If you have any questions, please call Dr. Myers at (215)503-4086.

Best regards,

Neil Schlackman, MD
Senior Medical Director
AEtna US healthcare

Ronald E, Myers, PhD
Associate Professor
Thomas Jefferson University

FORT+ FOLLOW-UP FORM

Flexible Sigmoidoscopy (FS)	**Barium Enema X-Ray (BE)**	**Colonoscopy (Cx)**	**Reason(s) why both FS and BE or CX not advised or not done**
Not advised ❑	Not advised ❑	Not advised ❑	❑ Procedure(s) completed just prior to FOBT+ result date. ❑ Patient not known to practice at time of FOBT+ result. ❑ Patient Ieft practice before procedure could be done. ❑ Patient medical condition contradicted use of procedure(s). ❑ Patient referred to specialist, but procedure(s) not done. ❑ Patient deceased ❑ Other
Advised, but not done ❑	Advised, but not done ❑	Advise, but not done ❑	
FS Done ❑	BE Done ❑	Cx Done ❑	
Date: / /	Date: / /	Date: / /	

Diagnosis:					
	❑ Colon Cancer	❑ Diverticolitis	❑ No pathology found		
	❑ Rectal Cancer	❑ Peptic ulcer disease	❑ Other:		
	❑ Polyp	❑ AVM			
	❑ Diverticulosis	❑ Hemorrhoids			

Physician Signature

Date

Office ID «HMOM»

FOBT+ Patient
Complete Diagnostic Evaluation Feedback Form
<DATE>

Please find below a list of patients in your practice with a positive fecal occult blood test (FOBT+) result in the US Healthcare Colorectal Cancer Screening Program. Information is provided on the date of the FOBT+ result and on the complete diagnostic evaluation (CDE) status of each patient.

Patient CDE status was determined on the basis of information provided by your practice on an FOBT+ Patient Follow-up form and inspection of US Healthcare administrative data.

If you have any questions related to the information provided here, please call our office at <TELEPHONE NUMBER>.

Sincerely,

<NAME>

Patient Name	ID Number	FOBT+ Result Date	CDE Status

Thomas Jefferson University | Jefferson Medical College

Office of Continuing Medical Education 1020 Locust Street
Suite M32
Philadelphia, PA 19107-6799

215-955-6992
Fax: 215-923-3212

Dear Doctor:

Thank you for participating in The CDE Study, a National Cancer Institute-funded study that is being conducted by Thomas Jefferson University and Aetna U.S. Healthcare™ on the complete diagnostic evaluation (CDE) of patients with positive fecal occult blood test (FOBT+) result. Objectives of the study are to:

- Identify FOBT+ patients who are eligible for complete diagnostic evaluation (CDE)
- Develop methods to encourage the performance of CDE for FORT+ patients
- Facilitate the appropriate use of CDE colorectal cancer screening

Jefferson Medical College of Thomas Jefferson University, as a member of the Consortium for Continuing Medical Education is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. This letter is being sent to give you information about the CME aspects of the study.

Jefferson Medical College designates the educational activities completed lo dale for up to 3 credits in Category 1 toward the AMA Physician's recognition award. This award of credit will vary between 2 and 3 hours, depending on the amount of time each physician has spent in study-related activities. Up to 9 additional CME credits will be provided to physicians who complete this study. Physicians should only claim the hours of credit that they actually spent in the study activities. The anticpated mail dates for the provision of CME certificates are as follows:

- November 30, 1998: After the initial phase is complete (up to 3 credits).
- January 15, 2000: After the full study is completed (up to 9 credits).

The Office of CME at Jefferson is proud to be part of this important study. If you have any questions regarding the CME aspects of this activity, or your certificate, please don't hesitate to call us at 215-955-6992.

Yours truly,

Timothy P. Brigham, PhD
Assistant Dean
Graduate and Continuing Medical Education

Thomas Jefferson University | Jefferson Medical College

Office of Continuing Medical Education 1020 Locust Street
Suite M32
Philadelphia, PA 19107-6799

215-955-6992
Fax: 215-923-3212

Dr. Name and Address

Enhancing Diagnostic Evaluation in Colorectal Screening

Part 1

09/02/1998 - 11/30/1998

Initial Activity

CME Certificate

Jefferson Medical College designates this educational activity for a maximum of 2.00 hours in Category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Dr. Name claimed 2.00 hours of credit for this activity.

Jefferson Medical College of Thomas Jefferson University, as a member of the Consortium for Academic Continuing Medical Education, is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

Thomas Jefferson University | Jefferson Medical College

Office of Continuing Medical Education 1020 Locust Street
Suite M32
Philadelphia, PA 19107-6799
215-955-6992
Fax: 245-923-3212

Dr. Name and Address

Enhancing Diagnostic Evaluation in Colorectal Screening
Part 1
09/01/1998 - 11/29/1998
Survey

CME Certificate

Jefferson Medical College designates this educational activity for a maximum of 1.00 how in Category; 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Dr. Name claimed 1.00 hours of credit for this activity.

Jefferson Medical College of Thomas Jefferson University as a member of the Consortium for Academic Continuing Medical Education, is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

Thomas Jefferson University | Jefferson Medical College

Behavioral Epidemiology Section
Department of Medicine
Division of Medical Oncology

125 South 9th Street
Suite 403 Sheridan Building
Philadelphia, PA 19107
215-503-7801
Fax: 215-923-9506

National Cancer Institute-Sponsored Study on the Follow-up of Patients with Positive Fecal Occult Blood Tests

Letter of Introduction and Confidentiality Statement

Dear Dr. «DRLNAME»:

Thank you for participating in "The CDE Study", funded by the National Cancer Institute. Thomas Jefferson University and AEtna U.S. Healthcare™ are conducting this study on the complete diagnostic evaluation (CDE) of patients with a positive fecal occult blood test (FOBT+). A Nurse Educator from "The CDE Study" research team will deliver an educational program on CDE to your practice.

Please be assured that all responses to questions and all information collected as part of this visit Are kept *strictly confidential* and will not be shared with anyone outside of the immediate research team. Any publications or professional talks. that result from this work will present the data in aggregate form. None of the information will allow for the identification of specific physicians or primary care practices.

At the conclusion of the educational program, please *complete and return the evaluation form* enclosed in your packet. Please feel free to contact me should you have any questions. I can be reached at 215-503-4086.

Again, thank you for you time and participation in this important study.

Sincerely,

Ron Myers, Ph.D.
Principal Investigator

Baseline Survey - Mailed

PHYSICIAN COLORECTAL CANCER SCREENING AND FOLLOW-UP SURVEY

Conducted by Mathematica Policy Research, Inc.

for

Thomas Jefferson University

REVISION May 1998

SELF-ADMINISTERED VERSION (5/6/98)

A. **OPINION ABOUT A MAILED FOBT PROGRAM AND APPROPRIATE DIAGNOSTIC WORKUP**

Aetna/U.S. Healthcare has a colorectal cancer screening program that mails fecal occult blood test (FOBT) cards (stool hemoccult cards) directly to patients with a mailer to return the samples to the program. The program informs the primal care provider of these results. We would like to begin by asking you a few questions about this program.

A1a. Does the mailed FOBT program help you practice medicine?

01 ☐ Yes → GO TO A1b
00 ☐ No → GO TO A2a

A1b. What is the major way the program helps you?

PLEASE PRINT ONE RESPONSE

_____

_____

_____

A2a. Does the mailed FOBT program create any problems for you?

01 ☐ Yes → GO TO A2b
02 ☐ No → GO TO A3a

A2b. What is the major problem?

PLEASE PRINT ONE RESPONSE

_____

_____

_____

A3a. In your experience, how often does diagnostic follow-up of FOBT positive patients in the (mailed FOBT) program result in a finding of a colorectal cancer? Thinking of 100 FOBT-positive patients, how many do you think would be diagnosed with colorectal cancer? An estimate is fine.

|___|___|___| OUT OF 100 CASES

A3b. In your experience, how often does diagnostic follow-up of FOBT positive patients in the (mailed FOBT) program result in a finding of colorectal polyps? Thinking of 100-FOBT-positive patients, how many do you think would be diagnosed with colorectal polyps? An estimate is fine. Please do not include cases where colorectal cancer is also present.

|___|___|___| OUT OF 100 CASES

B . CASE SCENARIO ABOUT DIAGNOSTIC FOLLOW-UP OF AN FOBT POSITIVE PATIENT

Next, we would like to ask your opinions about the diagnostic follow-up of a hypothetical patient who has a positive FOBT result in an HMO colorectal cancer screening program. The scenario is as follows:

Assume that an adult patient over 50 years of age has completed a set of fecal occult blood test cards (FOBTs) that he or she received through the screening program and has a positive FOBT result. Your office is informed about the test result by mail. The patient also receives a letter from the HMO which advises him or her to call your office to find out what to do next.

B1. What do you routinely do when you are informed by the program that a patient has a positive FOBT result? Do you...

PLEASE CHECK ONE ONLY

01 ☐ schedule an office visit when the patient contacts the office?
02 ☐ contact the patient and schedule an office visit?
03 ☐ or, do something else? What else?
(PLEASE PRINT YOUR RESPONSE)

_____

_____

_____

B2. Physicians may recommend different approaches for diagnostic follow-up when they talk to an FOBT-positive patient who is 50 or older about a positive screening FOBT result, Following is a series of sentences that describe different patient characteristics, Please indicate which approach to follow-up you would be most likely to recommend in each situation.

FOR-KEY TO HEADINGS SEE BELOW[1]	Repeat FOBT	BE Alone	FS Alone	Upper G.I. Eval.	BE&FS Combined	CX	OTHER (SPECIFY)
B2a. Patient appears to be in good health.....	1	2	3	4	5	6	9 _____
B2b. Patient did not follow the dietary instructions while doing the FOBTs	1	2	3	4	5	6	9 _____
B2c. Patient is between 50 and 59 years of age.....	1	2	3	4	5	6	9 _____
B2d. Patient has a personal history of hemorrhoids.....	1	2	3	4	5	6	9 _____
B2e. Patient has no family history of colorectal cancer or polyps.....	1	2	3	4	5	6	9 _____
B2f. Patient is between 60 and 69 years of age.....	1	2	3	4	5	6	9 _____
B2g. Patient has fewer than three FOBT cards that are positive.....	1	2	3	4	5	6	9 _____
B2h. Patient has a normal hemoglobin level.....	1	2	3	4	5	6	9 _____
B2i. Patient was taking aspirin while doing the FOBTs	1	2	3	4	5	6	9 _____
B2j. Patient is 70 or more years of age.....	1	2	3	4	5	6	9 _____

[1]KEY TO HEADINGS:

FOBT - Fecal Occult Blood Test
BE - Barium Enema
FS - Flexible Sigmoidoscopy
BE & FS Combined - Combined double contrast barium enema x-ray and flexible sigmoidoscopy
CX - Colonoscopy

PHYSICIAN PERCEPTIONS ABOUT FOBT SCREENING EVALUATION OF THE COLON AND RECTUM

C1. The following statements relate to your perceptions about FOBT screening and diagnostic follow-up of patients with an FOBT-positive result. When the phrase *"evaluation of the colon and rectum"* is used in the following statements, it refers to either colonoscopy OR the combination of double contrast barium enema x-ray AND a flexible sigmoidoscopy. For each statement, please indicate whether you agree or disagree.

	CIRCLE ONE					
	STRONGLY AGREE	MODERATELY AGREE	SLIGHTLY AGREE	SLIGHTLY DISAGREE	MODERATELY DISAGREE	STRONGLY DISAGREE
a. In recommending diagnostic follow up for patients with an FOBT-positive result, I think I am consistent with standard practice in the community.....	1	2	3	4	5	6
b. I believe that evaluation of the colon and-rectum for an FOBT-positive result is costly for my practice.....	1	2	3	4	5	6
c. I think that preparing patients to have an evaluation of the colon and rectum for an FOBT-positive result takes a lot of physician time	1	2	3	4	5	6
d. The cost of diagnostic follow-up to my practice influences what I recommend for a patient with an FOBT-positive result	1	2	3	4	5	6
e. I believe it is standard practice for primary care physicians in the community to recommend evaluation of the colon and rectum for an FOBT-positive result	1	2	3	4	5	6
f. I believe that patients with an FOBT-positive result often do not comply with a recommendation for evaluation of the colon and rectum.....	1	2	3	4	5	6
g. I believe that evaluation of the colon and rectum causes a lot of physical discomfort for patients.....	1	2	3	4	5	6
h. I think that for patients with an FOBT-positive result, the benefits of evaluation of the colon and rectum outweigh the risks of having these procedures	1	2	3	4	5	6
i. I think that having an evaluation of the colon and rectum for an FOBT-positive result takes a lot of patient time.....	1	2	3	4	5	6
j. I believe that FOBT-positive patients who have normal findings based on an evaluation of the colon and rectum should still have an annual FOBT screening.....	1	2	3	4	5	6

D. **PERCEPTIONS ABOUT UNCERTAINTY**

D1. The following statements reflect what physicians may feel when they recommend diagnostic follow-up for an FOBT-positive patient. For each statement, please indicate whether you agree or disagree.

	CIRCLE ONE					
	STRONGLY AGREE	MODERATELY AGREE	SLIGHTLY AGREE	SLIGHTLY DISAGREE	MODERATELY DISAGREE	STRONGLY DISAGREE
a. For me, not being sure of the appropriate diagnostic follow up for FOBT-positive patients is stressful	1	2	3	4	5	6
b. I am concerned that I might be held accountable for the consequences of diagnostic follow-up for FOBT- positive patients	1	2	3	4	5	6
c. I feel anxious because I am not sure what diagnostic follow-up to recommend for FOBT positive patients	1	2	3	4	5	6
d. I feel uncomfortable about making a strong recommendation for evaluation of the colon and rectum for FOBT-positive patients	1	2	3	4	5	6
e. I worry about malpractice in the diagnostic follow up of FOBT-positive patients	1	2	3	4	5	6
f. I do not like to push FOBT-positive patients to have an evaluation of the colon and rectum	1	2	3	4	5	6

E. **APPROACH TO DIAGNOSTIC FOLLOWUP**

E1. The following statements reflect what physicians plan to do about the way they currently approach the diagnostic evaluation of FOBT-positive patients. Please indicate which statement best describes you.

PLEASE CHECK ONE ONLY

01 ☐ I don't see a need to change the way I handle the diagnostic followup of FOBT-positive patients → **GO TO F1**

02 ☐ I am seriously thinking about changing the way I handle the diagnostic followup of FOBT-positive patients → **GO TO F1**

03 ☐ I am currently planning to change the way I handle the diagnostic followup of FOBT-positive patients → **GO TO E1a**

E1a. What do you plan to do? (PLEASE PRINT YOUR **RESPONSE)**

_____

_____

_____

6. FINALLY, WE WOULD LIKE TO ASK YOU A FEW BACKGROUND QUESTIONS ABOUT YOUR PATIENTS, YOUR PRACTICE, AND YOU.

F1. During the past 12 months, how **many** newly-diagnosed colorectal cancer patients have you **personally** seen in your practice? An estimate is fine.

|__|__|__| NEWLY-DIAGNOSED COLORECTAL CANCER PATIENTS

F1a. During the past 12 months, approximately what **percentage** of your newly-diagnosed colorectal cancer patients were diagnosed because they had an FOBT-positive result? An estimate is fine.

|__|__|__| OF NEWLY-DIAGNOSED COLORECTAL CANCER PATIENTS

F1b. During the past 12 months, how **many** newly-diagnosed colorectal polyp patients have you **personally** seen in your practice?

|__|__|__| NEWLY-DIAGNOSED COLORECTAL POLYP PATIENTS

F1c. During the past 12 months, approximately what **percentage** of your newly-diagnosed polyp patients were diagnosed because they had an FOBT-positive result?

|__|__|__| % OF NEWLY-DIAGNOSED COLORECTAL POLYP PATIENTS

F-2a. How would you characterize your practice? Would you say it's .

PLEASE CHECK ONLY ONE.

01 ☐ a solo practice,
02 ☐ a practice with one other physician,
03 ☐ a single-specialty group practice, or
04 ☐ a multi-specialty group practice?

F2b. How would you describe your practice setting? Would you say its...

PLEASE CHECK ONLY ONE

01 ☐ a community-based practice,
02 ☐ a hospital-based practice, or
03 ☐ another type of practice? (SPECIFY)

_____

F3a. Is your practice part of an Integrated Delivery System (e.g., Allegheny, Crozier-Keystone, Einstein, Jefferson, Mainline, Mercy, Temple, University of Pennsylvania, etc.)?

01 ☐ YES → **GO TO F3b**
00 ☐ NO → **GO TO F4**

F3b. Which one?

PLEASE CHECK ONLY ONE

01 ☐ Allegheny University Health System
02 ☐ Albert Einstein Healthcare Network
03 ☐ Crozier-Keystone Health System
04 ☐ Jefferson Health System
05 ☐ Mainline Health System
06 ☐ Mercy Health System
07 ☐ Temple University
08 ☐ University of Pennsylvania
09 ☐ Other (SPECIFY)

_____

F3c. In what year did the practice become part of the system?

19|__|__| YEAR

F4. What is your **primary** medical specialty?

PLEASE CHECK ONLY ONE

01 ☐ Family practice medicine
02 ☐ General practice
03 ☐ General internal medicine
04 ☐ Obstetrics/Gynecology
05 ☐ Other (SPECIFY)

_____

F5. Are you board-certified in that specialty?

01 ☐ Yes
00 ☐ No

F6. In what year did you graduate from medical school?

19|__|__| YEAR

F7. How old were you on your last birthday?

|__|__|YEARS

F8. What is your gender?

01 ☐ Male
02 ☐ Female

F9. With which ethnic or racial group do you most closely identify?

PLEASE CHECK ONLY ONE

01 ☐ White
02 ☐ African American
03 ☐ Hispanic
04 ☐ Asian/Pacific Islander
05 ☐ Native American
06 ☐ OTHER (SPECIFY)

_____

F10. Are you interested in receiving a summary of findings from this survey?

01 ☐ Yes
00 ☐ No

F11. To what address should we mail it?

NAME:

_____

STREET AND/OR P.O. BOX:

_____

CITY:

_____

STATE:

_____

ZIP CODE:

_____

Thank you very much for your assistance. We appreciate your taking the time to share your opinions with us.

Endpoint Survey - Mailed

PHYSICIAN COLORECTAL CANCER SCREENING AND FOLLOW-UP SURVEY

Conducted by Mathematics Policy Research, Inc.

for

Thomas Jefferson University

REVISION June 2000

SELF-ADMINISTERED VERSION

I. SUMMARY OF FINDINGS WILL BE PROVIDED

After survey data collection and analysis is completed, we will send you a summary of findings. The summary will be sent to your practice address. If you prefer, we can send the results to an alternate mailing address, or by E-mail. If you would like us to mail the results to an alternate mailing address, please provide the address below. If you would like us to send you the results by E-mail, please provide that address below.

I.1

ALTERNATE MAILING ADDRESS:		
NAME:		
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP:**

I.2

E-MAIL ADDRESS:

A. CANCER SCREENING BELIEFS AND PRACTICES

This section includes questions about different approaches to colorectal cancer screening. Please respond based on how you actually practice even if this differs from how you would like to practice under ideal circumstances.

A1. How effective or ineffective do you believe the following **screening procedures** are in reducing colorectal cancer mortality in average-risk patients aged 50 years and older?

CHECK ONE BOX ON EACH LINE

	VERY EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE	DON'T KNOW
a. Fecal occult blood test	1 ☐	2 ☐	3 ☐	4 ☐
b. Flexible sigmoidoscopy	1 ☐	2 ☐	3 ☐	4 ☐
c. Colonoscopy	1 ☐	2 ☐	3 ☐	4 ☐
d. Double contrast barium enema	1 ☐	2 ☐	3 ☐	4 ☐

A2. Which screening test or test combination do you **most often** recommend to your asymptomatic, average-risk patients as a colorectal cancer screening strategy?

CHECK ONE BOX

1 ☐ Fecal occult blood test alone

2 ☐ Flexible sigmoidoscopy alone

3 ☐ Either fecal occult blood test **or** flexible sigmoidoscopy

4 ☐ Both fecal occult blood test **and** flexible sigmoidoscopy

5 ☐ Colonoscopy

6 ☐ Double contrast barium enema

7 ☐ Both double contrast barium enema **and** flexible sigmoidoscopy

8 ☐ Other (Describe):_____

9 ☐ I do not recommend colorectal cancer screening at this time

B. CASE SCENARIO ABOUT DIAGNOSTIC FOLLOW-UP OF AN FOBT POSITIVE (FOBT+) PATIENT

Aetna U.S. Healthcare has a colorectal cancer screening program that mails fecal occult blood test (FOBT) cards (stool hemoccult cards) directly to patients with a mailer to return the samples to the program. The program informs the primary care provider of these results. We would like your opinions about the diagnostic evaluation of a hypothetical patient who has a positive FOBT result in an HMO colorectal cancer screening program. The scenario is as follows:

Assume that an adult patient 50 or more years of age has completed a set of fecal occult blood test cards (FOBTs) that he or she received through the screening program and has a positive FOBT result. Your office is informed about the test result by mail. The patient also receives a letter from the HMO which advises him or her to call your office to find out what to do next.

B1. What do you routinely do when you are informed by the program that a patient has a positive FOBT result? Do you

CHECK ONE BOX

1 ☐ schedule an office visit when the patient contacts the office?

2 ☐ contact the patient and schedule an office visit?

3 ☐ or, do something else? What else?

(PLEASE INDICATE YOUR RESPONSE)

_____

_____

_____

C. PHYSICIAN PERCEPTIONS ABOUT FOBT SCREENING AND FOBT+ PATIENT DIAGNOSTIC FOLLOW-UP

C1. Physicians may recommend different approaches for diagnostic follow-up when they talk to an FOBT-positive patient who is 50 or older about a positive screening FOBT result. Following is a series of sentences that describe different patient characteristics. Please indicate which approach to follow-up you would be most likely to recommend in each situation.

	FOR KEY TO HEADINGS SEE BELOW[1]	Repeat FOBT	BE Alone	FS Alone	Upper G.I. Eval.	BE&FS Combined	CX	OTHER (SPECIFY)
a.	Patient appears to be in good health	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	9 ☐ _____
b.	Patient did not follow the dietary instructions while doing the FOBTs	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	9 ☐ _____
c.	Patient is between 50 and 59 years of age	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	9 ☐ _____
d.	Patient has a personal history of hemorrhoids	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	9 ☐ _____
e.	Patient has no family history of colorectal cancer or polyps	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	9 ☐ _____
f.	Patient is between 60 and 69 years of age	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	9 ☐ _____
g.	Patient. has fewer than three FOBT cards that are positive	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	9 ☐ _____
h.	Patient has a normal hemoglobin	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	9 ☐ _____
i.	Patient was taking aspirin while doing the FOBTs	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	9 ☐ _____
j.	Patient is 70 or more years of age	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	9 ☐ _____

[1] **KEY TO HEADINGS:**

FOBT - Fecal Occult Blood Test
BE - Barium Enema
FS - Flexible Sigmoidoscopy
BE & FS Combined - Combined double contrast barium enema x-ray and flexible sigmoidoscopy
CX - Colonoscopy

C2. The following statements reflect what physicians may feel when they recommend diagnostic follow-up for an FOBT-positive patient. For each statement, please indicate whether you agree or disagree.

CHECK ONLY ONE BOX ON EACH LINE

	STRONGLY AGREE	MODERATELY AGREE	SLIGHTLY AGREE	SLIGHTLY DISAGREE	MODERATELY DISAGREE	STRONGLY DISAGREE
a. For me, not being sure of the appropriate diagnostic follow-up for FOBT-positive patients is stressful	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
b. I am concerned that I might be held accountable for the consequences of diagnostic follow-up for FOBT- positive patients	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
c. I feel anxious because I am not sure what diagnostic follow-up to recommend for FOBT positive patients	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
d. I feel uncomfortable about making a strong recommendation for evaluation of the colon and rectum for FOBT-positive patients	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
e. I worry about malpractice in the diagnostic follow-up of FOBT-positive patients	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
f. I do not like to push FOBT-positive patients to have an evaluation of the colon -and rectum	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐

C3. The following statements relate to your perceptions about FOBT screening and diagnostic follow-up of patients with an FOBT-positive result. When the phrase *"evaluation of the colon and rectum"* is used in the following statements, it refers to either colonoscopy OR the combination of double contrast barium enema x-ray AND a flexible sigmoidoscopy. For each statement, please indicate whether you agree or disagree.

CHECK ONLY ONE BOX ON EACH LINE

	STRONGLY AGREE	MODERATELY AGREE	SLIGHTLY AGREE	SLIGHTLY DISAGREE	MODERATELY DISAGREE	STRONGLY DISAGREE
a. In recommending diagnostic follow up for patients with an FOBT-positive result, I think I am consistent with standard practice in the community.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
b. I believe that evaluation of the colon and rectum for an FOBT-positive result is costly for my practice.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
c. I think that preparing patients to have an evaluation of the colon and rectum for an FOBT-positive result takes a lot of physician time.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
d. The cost of diagnostic follow-up to my practice influences what-I recommend for a patient with an FOBT-positive result.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
e. I believe it is standard practice for primary care physicians in the community to recommend evaluation of the colon and rectum for an FOBT-positive result.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
f. I believe that patients with an FOBT-positive result often do not comply with a recommendation for evaluation of the colon and rectum.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
g. I believe that evaluation of the colon and rectum causes a lot of physical discomfort for patients.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
h. I think-that for patients with an FOBT-positive result, the benefits of evaluation of the colon and rectum outweigh the risks of having these procedures.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
I think that having an evaluation of the colon and rectum for an FOBT-pos.itive result takes a lot of patient time.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
j. I believe that FOBT-positive patients who have normal findings based on an evaluation of the colon and rectum should still have an annual FOBT screening.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐

D. CANCER SUSCEPTIBILITY TESTING

Cancer susceptibility testing is emerging as an area of interest for primary care physicians. It is important to understand physician needs in this area. This section includes questions about cancer susceptibility testing.

D1. What do you believe is the best predictor of risk for cancer among asymptomatic patients?

CHECK ONE

1 ☐ Personal history

2 ☐ Family history

3 ☐ Age

4 ☐ Environment (lifestyle)

5 ☐ Other (PLEASE SPECIFY)

_____

D2. How frequently do you ask new patients to provide:

CHECK ONE BOX ON EACH LINE

	VERY FREQUENTLY	SOMEWHAT FREQUENTLY	INFREQUENTLY	NEVER	NOT APPLICABLE
a. A medical history?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. A family history of cancer among first-degree relatives, such as parents, siblings, and children?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. A family history of cancer among second-degree relatives, such as grandparents, aunts, and uncles?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
d. Age of diagnosis of relatives with cancer?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
e. Information about diet?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
f. Information about exercise?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
g. Information about tobacco use?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

D3. During the past 12 months; have any of your patients asked you if they can or should get tested for an inherited cancer susceptibility gene?

1 ☐ Yes → **If YES, how many <u>patients?</u>**

0 ☐ No

D4. During the past 12 months, have you referred any of your patients to another health care provider for a genetic test for inherited cancer susceptibility, or for an assessment of whether or not they are candidates for genetic testing?

1 ☐ Yes → **If YES, how many <u>patients?</u>**

0 ☐ No

D5. During the past 12 months, have you ordered a genetic test for inherited cancer susceptibility? (**Do not** include patients whom you referred to another health care provider for testing.)

1 ☐ Yes

0 ☐ No → **IF NO, SKIP TO Q.D7**

D6. During the past 12 months, for approximately how many patients did you directly order a laboratory genetic test for inherited susceptibility to the following cancers? ENTER "0" FOR NONE

a. Hereditary colon cancer..... How many? _____

b. Breast or ovarian cancer..... How many? _____

c. Other (SPECIFY) ..... How many? _____

_____

D7. In your opinion, what percentage of patients who carry a gene for hereditary non-polyposis colorectal cancer (HNPCC) will actually go on to develop colorectal cancer?

1 ☐ Less than 10%

2 ☐ 10 to 19%

3 ☐ 20 to 49%

4 ☐ 50 to 100%

5 ☐ Not sure.

D8: How interested would you be in receiving continuing medical education credits for training in genetic risk assessment and testing for inherited cancer susceptibility?

CHECK ONE

1 ☐ Very interested

2 ☐ Somewhat interested?

3 ☐ Not very interested

4 ☐ Not interested at all

5 ☐ Not sure

E. FINALLY, WE WOULD LIKE TO ASK YOU A FEW BACKGROUND QUESTIONS ABOUT YOUR PATIENTS AND YOUR PRACTICE

E1. During the past 12 months, how **many** newly-diagnosed colorectal cancer patients have you **personally** seen in your practice? An estimate is fine.

|___|___|___| NEWLY-DIAGNOSED COLORECTAL CANCER PATIENTS

E1a. During the past 12 months, approximately what **percentage** of your newly-diagnosed colorectal cancer patients were diagnosed because they had an FOBT-positive result? An estimate is fine.

|___|___|___| OF NEWLY-DIAGNOSED COLORECTAL CANCER PATIENTS

E1b. During the past 12 months, how **many** newly-diagnosed colorectal polyp patients have you **personally** seen in your practice?

|___|___|___| NEWLY-DIAGNOSED COLORECTAL POLYP PATIENTS

E1c. During the past 12 months, approximately what **percentage** of your newly-diagnosed polyp patients were diagnosed because they had an FOBT-positive result?

|___|___|___| % OF NEWLY-DIAGNOSED COLORECTAL POLYP PATIENTS

E1d. On average, how many patients do you see each week?

1 ☐ Less than 75

2 ☐ 75-99

3 ☐ 100-139

4 ☐ 140 or more

E2a. How would you characterize your practice? Would you say it's...

CHECK ONE BOX

1 ☐ a solo practice,

2 ☐ a practice with one other physician,

3 ☐ a single-specialty group practice, or

4 ☐ a multi-specialty group practice?

E2b. How would you describe your practice setting? Would you say its.

CHECK ONE BOX

1 ☐ a community-based practice,

2 ☐ a hospital-based practice, or

3 ☐ another type of practice? (SPECIFY)

_____

E3a. Is the practice where you spend the most hours per week part of an Integrated Delivery System (e.g., Crozier-Keystone, Einstein, Jefferson, Mainline, Mercy, Temple, Tenet, University of Pennsylvania, etc.)?

1 ☐ Yes → **GO TO Q.F3b**

0 ☐ No → **GO TO END**

E3b. Which one?

CHECK ONE BOX

1 ☐ Albert Einstein Healthcare Network

2 ☐ Crozier-Keystone Health System

3 ☐ Jefferson Health System

4 ☐ Mainline Health System

5 ☐ Mercy Health System

6 ☐ Temple University

7 ☐ Tenet Health System

8 ☐ University of Pennsylvania

9 ☐ Other (SPECIFY)

_____

Thank you very much for your assistance. We appreciate your taking the time to share your opinions with us.

PLEASE MAIL YOUR COMPLETED SURVEYS TO:

Dr. Ronald E. Myers
Director, The CDE Study
Thomas Jefferson University
125 South Ninth Street, Suite 403
Philadelphia, PA 19107

September 29, 2000

«Office»
«ADDRESS1»
«ADDRESS2»
«City», «State» «Zip»

Dear Doctors «Doctors»:

AEtna U.S. Healthcare™ screening program records indicate that **«FNAM» «LNAME»** «MEMBRID», a patient in your office, had a positive fecal occult blood test (FOBT) result on **«FOBTDT».** As a participant in "The CDE Study," an NCI-funded study on colorectal cancer screening and follow-up, your office is asked to record the information requested below for the patient.

Please fax the completed form to (215)923-9506, a secure fax line, within two weeks of receipt. Alternatively, send a copy of the completed form by mail using the enclosed addressed, postage-paid envelope.

Thank you for your prompt response. If you have any questions, please call Dr. Myers at (215)503-4086.

Best regards,

Neil Schlackman, MD
Senior Medical Director
AEtna US Healthcare

Ronald E. Myers, PhD
Associate Professor
Thomas Jefferson University

FOBT+ FOLLOW-UP FORM

Flexible Sigmoidoscopy (FS)	**Barium Enema X-Ray (BE)**	**Colonoscopy (Cx)**	**Reason(s) why both FS and BE or CX not advised or not done**
Not advised ☐	Not advised ☐	Not advised ☐	☐ Procedure(s) completed just prior to FOBT+ result date.
Advised, but not done ☐	Advised, but not done ☐	Advised, but not done ☐	☐ Patient not known to practice at time of FOBT+ result. ☐ Patient left practice before procedure(s) could be done. ☐ Patient medical condition contraindicated use of procedure(s). ☐ Patient referred to specialist, but procedure(s) not done. ☐ Patient deceased.
FS Done ☐	BE Done. ☐	Cx Done ☐	☐ Other:
Date: ___/___/___	Date: ___/___/___	Date: ___/___/___	_____ _____

Diagnosis:

☐ Colon Cancer	☐ Diverticulitis	☐ No pathology found
☐ Rectal Cancer	☐ Peptic ulcer disease	☐ Other:
☐ Polyp	☐ AVM	
☐ Diverticulosis	☐ Hemorrhoids	

_____
Physician Signature

___/___/___
Date

Office ID «HMOID»