Enhancing Diagnostic Evaluation In Colorectal Cancer Screening

A National Cancer Institute-funded study

Thomas Jefferson University and Aetna U.S. Healthcare™
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. Assess the impact of fecal occult-blood test (FOBT) screening with CDE on disease stage.

4. Describe clinical findings for FOBT+ patients who have CDE.


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

Colorectal Cancer Mortality, New Jersey

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

Colorectal Cancer 5-year Survival by Disease Stage

Early Stage
(dukes A,B) 91%

Late Stage
(Dukes C) 63%

Late Stage
(Dukes D) 7%

Primary Prevention:

1. Dietary

   Increase dietary fiber and decrease fat

Secondary Prevention Strategies:

2. Screening

   Age 50:

   - Annual fecal occult blood test plus
   - Flexible sigmoidoscopy every 5 years*
   - Colonoscopy every 10 years*
   - Double contrast barium enema every 5-10 years*

* Digital rectal exam is also recommended.
Early Colorectal Cancer Found in Randomized FOBT Screening with CDE

<table>
<thead>
<tr>
<th>Participants</th>
<th>Control Group Early Stage Cancer</th>
<th>Intervention Group Early Stage Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>41.0%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Sweden</td>
<td>45.0%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Denmark</td>
<td>46.0%</td>
<td>81.0%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>58.0%</td>
<td>61.0%</td>
</tr>
<tr>
<td>New York</td>
<td>33.0%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

Toribara and Sleisenger, 1995
Colorectal Cancer Screening Program

- FOBT materials mailed to HMO member
- Member returns completed FOBT
- Test results mailed to physician and prompt mailed to patient

Abnormal FOBT: physician follow-up with CDE

Normal FOBT: materials mailed next year
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

No slides positive = normal; yearly FOBT recommended
Colorectal Cancer and Adenomas (>1 cm) Cases Found When CDE is Used in FOBT Follow-up

<table>
<thead>
<tr>
<th>Study</th>
<th>% cases found</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myers et al. (1993)*</td>
<td>26%</td>
</tr>
<tr>
<td>Allison et al. (1996)**</td>
<td>23%</td>
</tr>
<tr>
<td>Rockey et al. (1988)**</td>
<td>17%</td>
</tr>
</tbody>
</table>


In 1991, the Physician Insurers Association of America (PIAA) reported on insurance claims paid because of a delay in the diagnosis of colorectal cancer. The average indemnity payment was $234,373 with payments ranging from $1,500 to $1,650,000. In 52% of the cases, failure to perform an endoscopic examination was cited as the reason for delay.

*Connecticut Medicine 1992; 56: 207-209*
Data on CDE in Primary Care Practices: 1993-1994
Follow-up Status for FOBT(+) Patients*

- 7% never seen in office
- 11% lost to follow-up
- 82% contacted their physician

*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*

- 55% repeat FOBT
- 24% digital rectal exam
- 19% barium enema x-ray (no flexible sigmoidoscopy)
- 11% flexible sigmoidoscopy (no barium enema)
- 9% upper GI series
- 8% bad no follow-up
- 4% rigid sigmoidoscopy
- 3% other

*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*

2.4% cancer

23.8% polyps

23.8% normal

50.0% other**

*N = 6052 ** hemorrhoids, diverticulitis, stomach ulcer

CDE Completion Rates

FOBT+ Patients
(N=2330)

CDE Completed (40%)

CDE Not Completed (60%)

Myers et al., 1998. Unpublished
Data on CDE in Primary Care Practices: 1997-1998
# COMPLETE DIAGNOSTIC EVALUATION PRESENTATION

## ATTENDANCE SHEET

<table>
<thead>
<tr>
<th>Attendee Name</th>
<th>Participation Status</th>
<th>Attendee Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>«Dr. Name»</td>
<td>Yes  ☐</td>
<td></td>
</tr>
<tr>
<td>«Dr. Name»</td>
<td>No   ☐</td>
<td></td>
</tr>
<tr>
<td>«Dr. Name»</td>
<td>Yes  ☐</td>
<td></td>
</tr>
<tr>
<td>«Dr. Name»</td>
<td>No   ☐</td>
<td></td>
</tr>
<tr>
<td>«Dr. Name»</td>
<td>Yes  ☐</td>
<td></td>
</tr>
<tr>
<td>«Dr. Name»</td>
<td>No   ☐</td>
<td></td>
</tr>
<tr>
<td>«Dr. Name»</td>
<td>Yes  ☐</td>
<td></td>
</tr>
<tr>
<td>«Dr. Name»</td>
<td>No   ☐</td>
<td></td>
</tr>
<tr>
<td>«Other Participant»</td>
<td>Yes  ☐</td>
<td></td>
</tr>
<tr>
<td>«Other Participant»</td>
<td>No   ☐</td>
<td></td>
</tr>
<tr>
<td>«Other Participant»</td>
<td>Yes  ☐</td>
<td></td>
</tr>
<tr>
<td>«Other Participant»</td>
<td>No   ☐</td>
<td></td>
</tr>
</tbody>
</table>
Suggested Strategies for Enhancing Current U.S. Healthcare Check® Screening Program

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

1. Provide patient prompt to encourage screening

2. Provide general patient prompt that encourages follow-up of test results

3. Provide patient prompt to encourage CDE after physician recommendation

4. Provide physician CDE reminder/feedback

5. Remove patients with CDE from screening program
HAVING A FOLLOW-UP EXAM MAKES SENSE

YOU HAVE MANY IMPORTANT THINGS TO DO...
Finding out the reason for your abnormal stool blood test result is one of them.

COLORECTAL CANCER IS NOT UNCOMMON
The chance of having colorectal cancer is increased if you have an abnormal stool blood test result.

COLORECTAL CANCER CAN BE PRESENT WITHOUT PHYSICAL SYMPTOMS
By the time symptom occur, the disease is often too hard to cure.

EARLY DETECTION IS EFFECTIVE
Having a follow-up exam is the best way to find colorectal cancer early.

YOUR BEST PROTECTION IS EARLY DETECTION
When colorectal cancer is found early, it is easier to cure.

STOP WORRYING ABOUT YOUR ABNORMAL STOOL BLOOD TEST RESULT
You can protect your health by having a follow-up exam.

FOLLOW-UP FOR AN ABNORMAL STOOL BLOOD TEST
Physicians recommend either colonoscopy or flexible sigmoidoscopy and barium enema x-ray.

TALK TO FAMILY AND FRIENDS
Your health is important to them.

ITS EASY TO SET UP A CONVENIENT OFFICE VISIT FOR FOLLOW-UP
A follow-up exam can be arranged to fit your schedule.

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

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.

450 Practices
Practice Name

Number of patients = 2,330
Number of patients = 9

☐ Completed CDE  ■ Did Not Complete CDE

Over for more information

Factors That Influence Practice CDE Rates*

CDE rates are low in practices where physicians:

- Think that CDE is not likely to reveal clinically significant disease.
- Believe that procedures other than CDE are adequate for follow-up.
- Worry about CDE-related costs.
- Have difficulty persuading patients to undergo CDE.
- Have questions about the number of FOBT slides that are positive, patient characteristics, medication use and diet.

CDE rates are high in practices where physicians know:

- CDE can detect important benign conditions and significant colorectal neoplasms.
- CDE allows for thorough visualization of the colon and rectum.
- Incomplete diagnostic evaluation is a major source of medical malpractice litigation. (In 1991, the average indemnity payment was $234,373.)
- Patient education can increase adherence.
- 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

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

Diagnoses for FOBT+ Patients in 286 Primary Care Practices*

- Colorectal Cancer
- Colorectal Polyps
- Diverticula
- Ulcer
- Other
- Normal Findings

Percent of Patients

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

*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*

*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.

Physicians in primary care practices routinely see patients with FOBT+ results 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 POBT+ patients.

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)

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

<table>
<thead>
<tr>
<th>Physician</th>
<th>Yes</th>
<th>No</th>
<th>If No, Please explain:</th>
</tr>
</thead>
<tbody>
<tr>
<td>«docname1»</td>
<td>☐</td>
<td>☐</td>
<td>______________________</td>
</tr>
<tr>
<td>«docname2»</td>
<td>☐</td>
<td>☐</td>
<td>______________________</td>
</tr>
<tr>
<td>«docname3»</td>
<td>☐</td>
<td>☐</td>
<td>______________________</td>
</tr>
<tr>
<td>«docname4»</td>
<td>☐</td>
<td>☐</td>
<td>______________________</td>
</tr>
<tr>
<td>«docname5»</td>
<td>☐</td>
<td>☐</td>
<td>______________________</td>
</tr>
<tr>
<td>«docname6»</td>
<td>☐</td>
<td>☐</td>
<td>______________________</td>
</tr>
<tr>
<td>«docname7»</td>
<td>☐</td>
<td>☐</td>
<td>______________________</td>
</tr>
<tr>
<td>«docname8»</td>
<td>☐</td>
<td>☐</td>
<td>______________________</td>
</tr>
<tr>
<td>«docname9»</td>
<td>☐</td>
<td>☐</td>
<td>______________________</td>
</tr>
<tr>
<td>Other Physician</td>
<td>☐</td>
<td>☐</td>
<td>______________________</td>
</tr>
</tbody>
</table>

«pacname»
September 29, 2000

Dear 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

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

Diagnosis:

- Colon Cancer
- Rectal Cancer
- Polyp
- Diverticulosis
- Diverticulitis
- Peptic ulcer disease
- AVM
- Hemorrhoids
- Other:

- No pathology found

________/_______/_______
Physician Signature

________/_______/_______
Date
Office ID «HMOM»
FOBT+ Patient
Complete Diagnostic Evaluation Feedback Form

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>

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>ID Number</th>
<th>FOBT+ Result Date</th>
<th>CDE Status</th>
</tr>
</thead>
</table>
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 FOBT+ 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 to date 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 anticipated 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
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.
Enhancing Diagnostic Evaluation in Colorectal Screening
Part 1
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.
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 your 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 primary 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?

☐ Yes → GO TO A1b
☐ 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?

☐ Yes → GO TO A2b
☐ 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 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

☐ schedule an office visit when the patient contacts the office?
☐ contact the patient and schedule an office visit?
☐ 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.

<table>
<thead>
<tr>
<th>FOR-KEY TO HEADINGS SEE BELOW¹</th>
<th>Repeat FOBT</th>
<th>BE Alone</th>
<th>FS Alone</th>
<th>Upper G.I. Eval.</th>
<th>BE&amp;FS Combined</th>
<th>CX</th>
<th>OTHER (SPECIFY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B2a. Patient appears to be in good health.................................</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>B2b. Patient did not follow the dietary instructions while doing the FOBTs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>B2c. Patient is between 50 and 59 years of age............................</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>B2d. Patient has a personal history of hemorrhoids........................</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>B2e. Patient has no family history of colorectal cancer or polyps........</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>B2f. Patient is between 60 and 69 years of age.............................</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>B2g. Patient has fewer than three FOBT cards that are positive............</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>B2h. Patient has a normal hemoglobin level..................................</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>B2i. Patient was taking aspirin while doing the FOBTs ....................</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>B2j. Patient is 70 or more years of age....................................</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>

¹KEY 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
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.

<table>
<thead>
<tr>
<th>CIRCLE ONE</th>
<th>STRONGLY AGREE</th>
<th>MODERATELY AGREE</th>
<th>SLIGHTLY AGREED</th>
<th>SLIGHTLY DISAGREE</th>
<th>MODERATELY DISAGREE</th>
<th>STRONGLY DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. In recommending diagnostic follow up for patients with an FOBT-positive result, I think I am consistent with standard practice in the community.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>b. I believe that evaluation of the colon and rectum for an FOBT-positive result is costly for my practice.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>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.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>d. The cost of diagnostic follow-up to my practice influences what I recommend for a patient with an FOBT-positive result.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>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.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>f. I believe that patients with an FOBT-positive result often do not comply with a recommendation for evaluation of the colon and rectum.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>g. I believe that evaluation of the colon and rectum causes a lot of physical discomfort for patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>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.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>i. I think that having an evaluation of the colon and rectum for an FOBT-positive result takes a lot of patient time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>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.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th></th>
<th>CIRCLE ONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>STRONGLY AGREE</td>
</tr>
<tr>
<td>a. For me, not being sure of the appropriate diagnostic follow up for FOBT-positive patients is stressful</td>
<td>1</td>
</tr>
<tr>
<td>b. I am concerned that I might be held accountable for the consequences of diagnostic follow-up for FOBT-positive patients</td>
<td>1</td>
</tr>
<tr>
<td>c. I feel anxious because I am not sure what diagnostic follow-up to recommend for FOBT positive patients</td>
<td>1</td>
</tr>
<tr>
<td>d. I feel uncomfortable about making a strong recommendation for evaluation of the colon and rectum for FOBT-positive patients</td>
<td>1</td>
</tr>
<tr>
<td>e. I worry about malpractice in the diagnostic follow up of FOBT-positive patients</td>
<td>1</td>
</tr>
<tr>
<td>f. I do not like to push FOBT-positive patients to have an evaluation of the colon and rectum</td>
<td>1</td>
</tr>
</tbody>
</table>
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)

________________________________________________________

________________________________________________________

F1. During the past 12 months, how many newly-diagnosed colorectal cancer patients have you personally seen in your practice? NEWLY-DIAGNOSED COLORECTAL CANCER PATIENTS

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

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?

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**

- [ ] Allegheny University Health System
- [ ] Albert Einstein Healthcare Network
- [ ] Crozier-Keystone Health System
- [ ] Jefferson Health System
- [ ] Mainline Health System
- [ ] Mercy Health System
- [ ] Temple University
- [ ] University of Pennsylvania
- [ ] 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**

- [ ] Family practice medicine
- [ ] General practice
- [ ] General internal medicine
- [ ] Obstetrics/Gynecology
- [ ] Other (SPECIFY)

---

F5. Are you board-certified in that specialty?

- [ ] Yes
- [ ] 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?

- [ ] Male
- [ ] Female

---

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

**PLEASE CHECK ONLY ONE**

- [ ] White
- [ ] African American
- [ ] Hispanic
- [ ] Asian/Pacific Islander
- [ ] Native American
- [ ] OTHER (SPECIFY)

---

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

- [ ] Yes
- [ ] 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.
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

<table>
<thead>
<tr>
<th>Procedure</th>
<th>VERY EFFECTIVE</th>
<th>SOMEWHAT EFFECTIVE</th>
<th>NOT EFFECTIVE</th>
<th>DON'T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Fecal occult blood test</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b. Flexible sigmoidoscopy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c. Colonoscopy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d. Double contrast barium enema</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

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.

B 1. 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

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.

<table>
<thead>
<tr>
<th>FOR KEY TO HEADINGS SEE BELOW¹</th>
<th>Repeat FOBT</th>
<th>BE Alone</th>
<th>FS Alone</th>
<th>Upper G.I. Eval.</th>
<th>BE&amp;FS Combined</th>
<th>CX</th>
<th>OTHER (SPECIFY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Patient appears to be in good health</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
<td>6 □</td>
<td>9 □</td>
</tr>
<tr>
<td>b. Patient did not follow the dietary instructions while doing the FOBTs</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
<td>6 □</td>
<td>9 □</td>
</tr>
<tr>
<td>c. Patient is between 50 and 59 years of age</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
<td>6 □</td>
<td>9 □</td>
</tr>
<tr>
<td>d. Patient has a personal history of hemorrhoids</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
<td>6 □</td>
<td>9 □</td>
</tr>
<tr>
<td>e. Patient has no family history of colorectal cancer or polyps</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
<td>6 □</td>
<td>9 □</td>
</tr>
<tr>
<td>f. Patient is between 60 and 69 years of age</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
<td>6 □</td>
<td>9 □</td>
</tr>
<tr>
<td>g. Patient has fewer than three FOBT cards that are positive</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
<td>6 □</td>
<td>9 □</td>
</tr>
<tr>
<td>h. Patient has a normal hemoglobin</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
<td>6 □</td>
<td>9 □</td>
</tr>
<tr>
<td>i. Patient was taking aspirin while doing the FOBTs</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
<td>6 □</td>
<td>9 □</td>
</tr>
<tr>
<td>j. Patient is 70 or more years of age</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
<td>6 □</td>
<td>9 □</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Moderately Agree</th>
<th>Slightly Agree</th>
<th>Slightly Disagree</th>
<th>Moderately Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. For me, not being sure of the appropriate diagnostic follow-up for FOBT-positive patients is stressful.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>b. I am concerned that I might be held accountable for the consequences of diagnostic follow-up for FOBT-positive patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>c. I feel anxious because I am not sure what diagnostic follow-up to recommend for FOBT-positive patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>d. I feel uncomfortable about making a strong recommendation for evaluation of the colon and rectum for FOBT-positive patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>e. I worry about malpractice in the diagnostic follow-up of FOBT-positive patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>f. I do not like to push FOBT-positive patients to have an evaluation of the colon and rectum.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Moderately Agree</th>
<th>Slightly Agree</th>
<th>Slightly Disagree</th>
<th>Moderately Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. In recommending diagnostic follow up for patients with an FOBT-positive result, I think I am consistent with standard practice in the community.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>b. I believe that evaluation of the colon and rectum for an FOBT-positive result is costly for my practice.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>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.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>d. The cost of diagnostic follow-up to my practice influences what-I recommend for a patient with an FOBT-positive result.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>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.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>f. I believe that patients with an FOBT-positive result often do not comply with a recommendation for evaluation of the colon and rectum.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>g. I believe that evaluation of the colon and rectum causes a lot of physical discomfort for patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>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.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I think that having an evaluation of the colon and rectum for an FOBT-positive result takes a lot of patient time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>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.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
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:

A medical history? ..................
A family history of cancer among first-degree relatives, such as parents, siblings, and children? ............
A family history of cancer among second-degree relatives, such as grandparents, aunts, and uncles? ..........,
Age of diagnosis of relatives with cancer? ................
Information about diet? ................
Information about exercise? ...........
Information about tobacco use? ........

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 patients?**
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 patients?**
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.)

☐ Yes
☐ 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?

☐ Less than 10%
☐ 10 to 19%
☐ 20 to 49%
☐ 50 to 100%
☐ 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

☐ Very interested
☐ Somewhat interested?
☐ Not very interested
☐ Not interested at all
☐ 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

Dear Doctors:

Aetna U.S. Healthcare™ screening program records indicate that, a patient in your office, had a positive fecal occult blood test (FOBT) result on . 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**

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

**Diagnosis:**

- Colon Cancer
- Rectal Cancer
- Poly
- Diverticulosis
- Diverticulitis
- Peptic ulcer disease
- AVM
- Hemorrhoids
- No pathology found
- Other:

---

Physician Signature: ___________________________  Date: ___________________________  Office ID: «HMOID»