

# Colorectal Cancer Screening Promotion Program

## Session 2 Training Agenda

Session 2: Increase Skills Needed to Impact Screening Rates

Duration: 1.25 hours

Slide #	Content	Time
1	Welcome and introductions Self-administered knowledge test about factors that influence colorectal cancer screening (confidential)	5 minutes
2	Program goals and overview, including objective: Increase the number of people in your practice who are screened for colorectal cancer	1 minute
3–8	Recap of information covered in Session 1	6 minutes
9–10	Oregon CRC screening rates and discussion	10 minutes
11–14	Your provider's screening rate Beginning of what works and doesn't to increase rates	5 minutes
15–17	Impact of provider recommendations and factors that affect the impact	2 minutes
18–19	Introduction of possible role of nonphysician clinical staff in CRC screening and what is needed to empower staff to promote CRC screening	5 minutes
20–22	Introduction to shared decision making and identifying the patient's decision stage	3 minutes
23–25	Matching the "pitch" to the decision stage	2 minutes
26–29	Introduction and discussion of the educational tools and patient handout. Participants spend 3 to 5 minutes looking at the tools.	5 minutes
30–31	Role play, followed by report-out	20 minutes
32	Summary of key points	1 minutes
	Complete the evaluation form. Complete and submit the knowledge test. "Round robin" about new information that attendees learned.	7 minutes

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# Colorectal Cancer Screening Promotion Program

## Session 2 Speaker Notes

Slide #	
2	<p><b>Program goals</b></p> <p>In the last session we talked about colorectal cancer and screening. In this session we're going to talk about clinic staff's role in promoting colorectal cancer screening and increasing the number of people in your practice who get screened. I'll begin with information about what works and how to do it. Then we'll do some role play using teaching tools developed for the training, patient handouts, and scripted key messages.</p> <p>Before we start we'll take a few minutes while you complete the pre-session test. After the session you'll repeat the test and get a copy of the answer key. (4 minutes)</p>
3	<p><b>Quick Recap of Session 1</b></p> <p>We'll start by quickly reviewing what you learned last time.</p>
4	<p><b>Remember this...</b></p> <p><i>[Click]</i> Ninety percent of colorectal cancers are diagnosed in people age 50 or older. So screening should begin at age 50 for people at "average risk." In general, this means having no history of close family members with cancer or precancerous polyp before age 60 and no personal history of colorectal cancer or precancerous polyps.</p>
5	<p><b>Screening: who and how</b></p> <p>All three methods save roughly the same number of lives and are recommended for screening people at average risk age 50 to 75 by the U.S. Preventive Health Services Task Force (USPSTF).</p> <p><i>[Click]</i> So, the best test is the one that gets done.</p>
6	<p><b>Screening older seniors</b></p> <p>Screening offers less benefit for people older than 75 because it takes roughly 7 to 12 years for a precancerous polyp to become a cancer and some risks are associated with screening tests (colon tears, bleeding, etc.). The USPSTF therefore recommends that screening be offered to people age 75 to 85 based on an individual assessment and that people age 85 and older should not be screened.</p>
7	<p><b>Polyps and colorectal cancer in African Americans</b></p> <p>African Americans are more likely than Whites to develop colorectal cancer in the right side of the colon and to develop it earlier. Many people recommend that screening should begin at age 45 or younger.</p>
8	<p><b>People who should begin screening at a younger age</b></p> <p>People with family history of early colorectal cancer or a hereditary high-risk condition should begin screening at age 40 or younger.</p>

<p>9</p>	<p><b>Oregon’s self-reported colorectal screening rate is ...</b></p> <p>Every state performs an annual Behavioral Risk Factor Surveillance System (BRFSS) survey. The 2006 survey included questions about colorectal cancer screening. Fifty-seven percent of Oregon respondents reported that they had had a sigmoidoscopy or colonoscopy in the past 10 years and 29% that they had completed a fecal occult blood test (FOBT) in the past year. It is likely that the report on the scoping tests is reasonably accurate, whereas the report on FOBT in the past year is probably higher than a record audit would show, because people lose track of exactly when they completed a test.</p>
<p>10</p>	<p><b>Are those rates accurate and good enough?</b></p> <p>It’s hard to know how many people have really been screened. Medicare data give a rate of about 41% for Oregon Medicare beneficiaries, but this number doesn’t include colonoscopies and sigmoidoscopies completed before people were enrolled in Medicare. It also includes people who didn’t start screening until well after age 50—well after the best time to screen.</p> <p><b>[Click] Are people beginning screening at 50 or later?</b>  Ask: What have you seen in your practice?  Speaker: Allow up to 3 minutes for responses.</p> <p><b>[Click] Who isn’t getting screened?</b>  Ask: Who in your practice puts off screening (race, gender)?  Speaker: Allow 2 to 4 brief responses.</p> <p>In general, screening rates are equal for men and women. However, people who are without insurance, who have a lower level of education, or who think that they are at low risk are less likely to be screened. African Americans are less likely than Whites to be screened for those reasons, as well as because they have less trust in the healthcare system.</p>
<p>11</p>	<p><b>Do you know what proportion of your PCP’s patients are up to date on colorectal cancer screening?</b></p> <p>Probably not... Few primary care practices know how well they are doing with screening. Use of electronic health records and their reports will begin to give practices more information about who needs screening and the opportunity to get them screened.</p>
<p>12</p>	<p><b>True or false?</b></p> <ul style="list-style-type: none"> <li>• Patients usually do what their primary care provider, medical assistant, or nurse tells them to do.</li> </ul> <p>Speaker: Allow participants to talk about their experiences and what they think about this statement.</p> <p>Then: Certainly lots of patients don’t follow instructions and we refer to them not very kindly as “noncompliant.” But most people do try to do what their PCP recommends. A lot of noncompliance—better called nonadherence—results from differences in patients’ and healthcare providers’ goals and values. An example is that the patient’s fear of being diagnosed with cancer is greater than the patient’s belief that the test will give peace of mind.</p> <p><b>[Click]</b> There are no proven methods of increasing patient compliance (follow-through) for colorectal cancer screening.</p>

	<p>Speaker: Allow participants to talk about their experiences and what they think about this statement.</p> <p>Then: A screening recommendation by a PCP is the strongest single factor in getting people to get screened for colorectal cancer. So, part of your job is to ensure that your practice is “compliant” with the recommendation by the USPSTF that all patients over the age of 50 are advised to get screened. Other proven methods are having reminder systems in place, empowering clinic staff to set up tests based on protocols and to reinforce recommendations, asking people to sign agreements that they will complete the test, and aligning the recommendations with the person’s values, such as being healthy to care for the family.</p>
13	<p><b>How valuable are public campaigns promoting colorectal screening?</b></p> <p>Benefits are overall relatively short-lived but important. Katie Couric’s ads produced a <u>temporary</u> increase in colonoscopy screening tests.</p>
14	<p><b>What you and your PCPs can do to increase colorectal cancer screening</b></p> <p>Did you know that 60% of Oregonians who responded to a telephone survey done by the Department of Human Services and reported never having had a sigmoidoscopy or colonoscopy in 2006 said that they were not at risk for colorectal cancer?</p>
15	<p><b>Recommendation by a PCP</b></p> <ul style="list-style-type: none"> <li>• Recommendation for CRC screening by a PCP is a very strong predictor of patient completion of screening.</li> <li>• Results vary, but screening was completed for* <ul style="list-style-type: none"> <li>– up to 90% with a recommendation</li> <li>– up to 25% without a recommendation</li> </ul> </li> </ul> <p><b>[Click]</b> You can remind people who are due or overdue for screening at any time...you don’t need to wait for the annual exam—particularly if they have been asked to complete a test or have been given a test kit and haven’t completed it.</p>
16	<p><b>But...</b></p> <p>Other factors also have an influence on whether people get screened, and the patient may not tell you if you don’t ask why they haven’t been screened or how they feel about screening.</p> <p>A good relationship with the provider <u>increases</u> the impact of the recommendation, whereas distrust in the healthcare system and unaddressed fears or concerns <u>decrease</u> the effect.</p>
17	<p><b>And...</b></p> <p>Other factors that decrease screening include lack of insurance and low literacy. People with low literacy have lower rates of screening, even if they have insurance.</p>
18	<p><b>Can clinic staff recommend screening?</b></p> <p>What do you think is required?</p> <p>Speaker: Allow participants to talk for 30 to 60 seconds.</p> <p><b>[Click]</b> The following are required to meet legal requirements and produce a consistent, reliable system in which all eligible patients are offered screening and get reminded.</p>

	<ul style="list-style-type: none"> <li>• <i>Agreement on “team” goals, expectations, and roles</i></li> <li>• <i>System to identify those due/overdue</i></li> <li>• <i>Consensus on preferred screening tests</i></li> <li>• <i>A standing order</i></li> <li>• <i>A standard process (written)</i></li> <li>• <i>Job descriptions that support roles</i></li> </ul>
<b>19</b>	<p><b>Recommendation from clinic staff</b></p> <p>An optimal system includes these components:</p> <ul style="list-style-type: none"> <li>• Practice team committed to improvement</li> <li>• Coordination with PCP</li> <li>• Use of the <i>decision stage model</i></li> <li>• Accountability and data shared among PCPs and clinic staff</li> <li>• Repeated reminders (phone, face-to-face, etc.)</li> </ul>
<b>20</b>	<p><b>Recommendations that get results</b></p> <p>The most effective approach involves knowing “where the patient is” regarding readiness for screening and then using a “pitch” that matches the stage.</p>
<b>21</b>	<p><b>A Decision Stage Model for CRC Screening</b></p> <p>This model divides people into 5 groups based on knowledge and readiness for getting screened. The next slide shows the 3 questions that are needed to sort out “where the patient is”.</p>
<b>22</b>	<p><b>Brief questionnaire to identify decision stage*</b></p> <p>The answers to this brief questionnaire will help you can provide the right information and “pitch.” Be aware that patients with low literacy may not be able to complete the questionnaire or read the instructions for their test.</p>
<b>23</b>	<p><b>What next? Making the “pitch” fit the stage.</b></p>
<b>24</b>	<p><b>“The pitch”</b></p> <p><b>Stage 1:</b> People who haven’t previously been asked to get screened and don’t know about the options need education.</p> <ul style="list-style-type: none"> <li>• Your packet includes a teaching tool that will help you make the pitch for screening and describe the different test options.</li> </ul> <p><b>Stage 2:</b> People who have heard about screening but aren’t considering getting screened or are considering getting screened need a slightly different approach.</p> <ul style="list-style-type: none"> <li>• Here it is important to find out about the barriers: why they aren’t considering getting screened; whether there is misinformation that you can correct about the benefits, risks, or tests themselves; whether there are financial or other barriers, etc. You</li> </ul>

	<p>must of course address the barriers and/or ensure that the PCP answers their questions and concerns.</p>
25	<p><b>“The pitch” (continued)</b></p> <p>For people who agree to be tested or were ready when you began the conversation, you probably won’t need to provide as much education. You will need to provide instructions and answer questions about the option that your provider recommends for the person, based on a protocol or documented recommendation.</p> <p>If the PCP recommends a scoping procedure, try to schedule the test for the patient before he or she leaves the office. For tests that the patient must schedule or complete on his or her own (FOBT kit), assess confidence. For example, ask: How confident are you that you will complete the stool test kit within the next two weeks, on a scale of 1 to 10? In general, when a person’s confidence level is less than 7, he or she is very likely not to follow through. This is a good time to ask about the reasons for the low confidence level.</p> <p>It may also be worthwhile to consider having the patient sign an agreement that he or she will do it. This technique has been shown to increase return rates for FOBT kits.</p>
26	<p><b>Teaching tool</b></p> <p>The teaching tool includes information and pictures that you have seen in the first presentation about colorectal cancer. You can use it to make your pitch for screening and educate people about the value of screening and the tests themselves.</p>
27	<p><b>Key messages for “the pitch”</b></p> <p>Many people avoid testing because they are afraid that it will be painful. Others avoid it because they are afraid that the doctor will find cancer. A really positive approach to screening, particularly to screening with colonoscopy, is that screening not only allows early diagnosis but actually can prevent colorectal cancer. So, there is “peace of mind” after a normal test. Regular testing with any method means that you are considerably less likely to die of colorectal cancer than if you have not been screened.</p> <p>The current estimates are that 1 in 17 men and 1 in 18 women in the U.S. will get colorectal cancer over their lifetime, and 1 in 44 men and 1 in 47 women will die from colorectal cancer. Incidence and death rates in the U.S. population are dropping, mostly because fewer people smoke; however, the rates for African Americans have not dropped. The continued high rate of colorectal cancer among African Americans is thought to result from lower screening rates and a mix of genetic and lifestyle differences. Lower screening rates and treatment differences increase deaths from colorectal cancer.</p>
28	<p><b>Key messages for “the pitch”</b></p> <p>Early diagnosis makes a big difference for colorectal cancer. Finding it at any early stage can give up to a 95% cure rate.</p> <p>Many studies have shown that convincing people who are reluctant to get tested works best when you align their positive values about family, life, and health with the benefits of screening, rather than telling them mostly about risks of dying.</p>
29	<p><b>Key messages for “the pitch”</b></p> <p>Many people worry that a sigmoidoscopy or colonoscopy will be painful. In general, colonoscopies are not painful, because people are given intravenous medicines for sedation</p>

	<p>and rarely remember having the procedure. Sigmoidoscopies may be uncomfortable, but are rarely very painful.</p> <p>The preparation is the least pleasant part of getting a sigmoidoscopy or colonoscopy, but it is necessary for a good-quality screening study. Although the preparation is unpleasant, it is “worth it” to get screened and have the opportunity to prevent cancer by finding precancerous polyps or diagnose cancer early, when it is very treatable. Most people who have had a colonoscopy or sigmoidoscopy report that even the preparation wasn’t as bad as they expected. People who have had a colonoscopy or sigmoidoscopy are the best advocates for screening.</p> <p>Be sure that your practice has reached consensus on preparations for colonoscopy and sigmoidoscopy that address active patients, patients who have physical limitations and may or may not have someone to assist them with the preparation, and those who have not tolerated prior preparation methods very well. Printed instructions in clear language for the preparation method selected by the provider simplify the task of explaining how to prepare for the study. The instructions should also include specific recommendations for what to do for vomiting or other problems. To minimize the risk of a poor preparation, it is worthwhile to have people describe their understanding of the directions.</p>
<p><b>30</b></p>	<p><b>Key messages</b></p> <p>Your key messages sheet includes several different ways to talk with people about screening to help you figure out what to say. Keep it handy until you’re really comfortable with talking to people about screening and addressing resistance.</p> <p>Spend about 5 minutes reviewing the patient handout and teaching tools—the <i>CRC Key Messages</i> and the <i>CRC Fact Sheet</i>. You will use those during the role-play exercise.</p>
<p><b>31</b></p>	<p><b>Role-play exercise</b></p> <p>Role play almost always feels a bit odd at first, but it’s a great way to “try out” a new kind of conversation, You have three minutes to plan.</p> <p><b>[Click]</b> Start your role play. You have five minutes to play your parts.</p>
<p><b>32</b></p>	<p><b>How did it go?</b></p> <p>You have two minutes to talk with your partner. Then I’m going to have each group briefly answer all of the questions on the slide. Then I’ll summarize your comments.</p> <p>When describing your role play, I want you to talk about the “behaviors” rather than whether you liked or disliked the approach. For example: “She used the tools to explain my choices and what would happen. The explanations were very clear.”</p> <p>Summarize:</p>
<p><b>33</b></p>	<p><b>Take-home messages</b></p> <p>Remember that clinic staff have a very important role to play in increasing the number of people who get screened for colorectal cancer and decreasing the number of people who die from colorectal cancer. An added attraction is that you know the people who will live healthier lives—they are your patients. Your recommendation, your reminder, your story about how doing the test really isn’t difficult, and your telling people that you and/or your family members have been screened all make a difference.</p>

	Now it is time for you to work with your providers to develop a plan for implementing a team-based colorectal cancer screening program in your practice.
<b>At the end of the session</b>	Thank you for participating in the training. Please fill out your evaluation and the post-training test and hand them to _____. When you've finished, we'll do a "round robin" report out on what you've learned. Each person will report on one new piece of information that he or she learned until everything has been reported.

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# Colorectal Cancer Screening Promotion Program

## Session 2 Pre/Post Test

1. The best way to get people who have not sent back their fecal occult blood test (FOBT) kits to do so is to tell them about their risk of dying from colorectal cancer.
  - a. True
  - b. False
  
2. A physician recommendation is one of the least important factors for patients completing colorectal cancer screening.
  - a. True
  - b. False
  
3. Other factors that increase patients' likelihood of completing recommended colorectal cancer screening include (select all that are correct)
  - a. Having a PCP
  - b. Assessment of personal risk as low
  - c. Family history of colorectal cancer
  - d. Low educational level
  - e. Distrust of the healthcare system
  - f. Insurance coverage
  
4. Clinic staff can initiate colorectal cancer screening in some situations. Which is not an acceptable situation for a recommendation?
  - a. Based on a written protocol and policy
  - b. Based on a standing order that identifies how to know who needs screening
  - c. Based on alerts without a written policy and standing order
  
5. One good, basic approach to colorectal cancer screening education and encouragement to get screened works for almost everyone.
  - a. True
  - b. False

6. In most practices, few people return FOBT kits. Asking people how confident they are that they will complete the test and requesting a signed agreement that they will return it can increase the return rate.
  - a. True
  - b. False
  
7. Which of the following provider office activities can increase colorectal cancer screening rates? (circle all that apply)
  - a. Scheduling screening appointments for patients
  - b. Providing clear information about the test and what to expect
  - c. Team approach to patient education and reminders using flow sheets or health maintenance face sheets (health maintenance views in EHR)
  
8. Asking a patient to commit to complete a screening test such as FOBT by signing an “agreement” increases follow-through.
  - a. True
  - b. False
  
9. Many people avoid getting screened for colorectal cancer because they are afraid that the test will show that they have cancer.
  - a. True
  - b. False
  
10. It’s a waste of time to ask patients about what might keep them from going for screening. Finding out won’t change the likelihood of screening.
  - a. True
  - b. False

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# Colorectal Cancer Screening Promotion Program

## Session 2 Answer Key for Pre/Post Test

1. The best way to get people who have not sent back their fecal occult blood test (FOBT) kits to do so is to tell them about their risk of dying from colorectal cancer.
  - a. True
  - b.  False

Most people respond better to messages that align with their personal values, such as staying healthy to be able to enjoy time with family or to be able to take care of their family. Most people are afraid that if they get tested they will be found to have cancer, which may result in screening avoidance.

2. A physician recommendation is one of the least important factors for patients completing colorectal cancer screening.
  - a. True
  - b.  False

A physician recommendation is the most important single factor associated with patients' getting screened. In state-sponsored telephone surveys (BRFSS), as many as 90% of people who reported getting screened said that they had gotten a recommendation by their physician. As few as 25% of people who did not report getting a recommendation completed screening.

3. Other factors that increase patients' likelihood of completing recommended colorectal cancer screening include (select all that are correct)
  - a.  Having a PCP
  - b. Assessment of personal risk as low
  - c.  Family history of colorectal cancer
  - d. Low educational level
  - e. Distrust of the healthcare system
  - f.  Insurance coverage

People with a low educational level are much less likely to get screened, even if they have insurance. African Americans have been found to be more distrustful of the healthcare system because of past and present unequal treatment.

4. Clinic staff can initiate colorectal cancer screening in some situations. Which is not an acceptable situation for a recommendation?
- a. Based on a written protocol and policy
  - b. Based on a standing order that identifies how to know who needs screening
  - c.  Based on alerts without a written policy and standing order

An alert is not sufficient; a physician order is required. A standing order signed by a physician, with a protocol for determining who should be screened and which tests should be ordered, allows the medical assistant to initiate getting the patient scheduled for tests or giving the patient a Hemoccult. The physician then “covers” the order in the medical record.

5. One good, basic approach to colorectal cancer screening education and encouragement to get screened works for almost everyone.
- a. True
  - b.  False

The most effective recommendations align with the individual patient’s “readiness stage” (whether he/she is ready to do it, ready to consider it, or knows nothing about it). See the readiness assessment tool. It is also important to align the recommendation with the patient’s own goals and values. Using the assessment tool and a “cheat sheet” can help you select effective messages.

6. In most practices, few people return FOBT kits. Asking people how confident they are that they will complete the test and requesting a signed agreement that they will return it can increase the return rate.
- a.  True
  - b. False

Several studies have found rates for return of the test kits at 35% to 50% of people. One study using the confidence question and agreement method increased the return to 75%.

7. Which of the following provider office activities can increase colorectal cancer screening rates? (circle all that apply)
- a.  Scheduling screening appointments for patients
  - b.  Providing clear information about the test and what to expect
  - c.  Team approach to patient education and reminders using flow sheets or health maintenance face sheets (health maintenance views in EHR)

8. Asking a patient to commit to complete a screening test such as FOBT by signing an “agreement” increases follow-through.

a.  True

b. False

In one study 75% of patients who were asked to sign an agreement completed FOBT as compared with usual return rates of 25% to 50%.

9. Many people avoid getting screened for colorectal cancer because they are afraid that the test will show that they have cancer.

a.  True

b. False

Regular screening can prevent most colorectal cancer. So it’s important to stress that screening is one of the few tests that really prevents cancer.

10. It’s a waste of time to ask patients about what might keep them from going for screening. Finding out won’t change the likelihood of their completing screening.

a. True

b.  False

Patients refuse or avoid screening for a variety of reasons including cost, fear of discomfort, fear that cancer will be found, and underassessment of risk. Discussing and addressing barriers, providing positive messages about screening, and aligning screening with personal values increases screening rates.

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# Colorectal Cancer Screening Promotion Program

## Session 2 Evaluation

### Learning Objectives

The presentation on colorectal cancer (CRC) screening prepared me to do the following:

1. Increase the number of patients in my practice who are screened for colorectal cancer

*Definitely*  
don't agree

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*Definitely*  
agree

1    2    3    4    5

### Process Change

I would like to see the following change implemented in my office:

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### Quality of Presentation

1. The presentation was clear and informative.
2. The slides were easy to read and understand.
3. The speaker presented the content effectively.
4. The role play helped me think about how I will motivate patients to get screened for colorectal cancer.
5. There was enough time for questions and discussion.
6. The presentation was free of commercial bias.

*Definitely*  
don't agree

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*Definitely*  
agree

1    2    3    4    5

1    2    3    4    5

1    2    3    4    5

1    2    3    4    5

1    2    3    4    5

1    2    3    4    5

### Toolkit

1. The two-sided *Colorectal Cancer Screening Guide* will help me discuss colorectal cancer screening options with patients.
2. The *Key Messages* tool will help me motivate patients to get screened for colorectal cancer.

1    2    3    4    5

1    2    3    4    5

**Suggestions for helping us better achieve the learning objectives:**

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