Colon Cancer – Motivating At Risk Kentuckians to Screening

Kentucky Public Health Leadership Institute Scholars:

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*Colon refers to colon and rectum cancer combined, also known as colorectal cancer

Executive Summary:

Colon Cancer* is the third most commonly occurring cancer and the second leading cause of death (from cancer) in Kentucky. Data from the Kentucky Cancer Registry show that there are an estimated 2,753 new colon cancer cases diagnosed and 930 deaths from colon cancer annually.

We are not helpless against this type of cancer. If detected early, through regular screenings, the cure rate is higher than 90 percent. There are also a number of lifestyle changes that can be made to lower the risk of developing the disease. Screenings and early detection are crucial in treating this disease. Both men and women are at risk of developing colon cancer. Screenings are encouraged because they can detect problems, such as polyps, which can develop into cancer, but can be easily removed when detected early. The goal is to not only raise awareness about colon cancer, but to drive patients toward their first screening and educate them about the warning signs which require immediate medical attention.

The Bottoms Up Team partnered with the Colon Cancer Prevention Project to produce a live television broadcast, collect caller demographics, conduct a post-broadcast survey, hold focus groups, and submit a request to the Behavioral Risk Factor Surveillance System for an additional question to the 2008 survey. The team reviewed the proposed script, designed caller demographic collection tool, designed post-broadcast survey, assisted with telephone bank logistics and collection, reviewed viewer demographics (provided by the television station), and reviewed consumer profiles for the viewing area.

Introduction/Background:

Because colon cancer is largely preventable through screenings, the Bottoms Up team chose to focus our project on a social marketing strategy to educate adults ages 50 and older (45 and older for African-Americans) about colon cancer screening in order to increase screening rates. Despite recent efforts to increase colon cancer screening and strong evidence that screening tests reduce colon cancer incidence and mortality, the prevalence of colon cancer screening in the United States is low. According to the 2004 Behavioral Risk Factor Surveillance System (BRFSS) only 26.5% of adults age 50 and older have had a fecal occult blood test (See Table 1.) The BRFSS also indicated that 53.0% of adults age 50 and older have ever had a sigmoidoscopy or colonoscopy (See Table 2.) In Kentucky, rates of screening are even lower than the national colon cancer screening rates. Only 24% of adults age 50 and older reported having had a fecal occult blood test and 47.2% report ever having a sigmoidoscopy or colonoscopy. This places Kentucky in the bottom 15% of the U.S. states for this type of screening.

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Age 50+ who have ever had a blood stool test

US	KY
26.5%	24.0%

Table 1.

Age 50+ who have ever had a sigmoidoscopy or colonoscopy

US	KY
53.0%	47.2%

- *Source*: BRFSS 2004

Table 2.

The age-adjusted incidence rate for colon cancer in Kentucky is 18.4% higher than the rest of the nation for 1999-2003 (See Table 3.). In Kentucky, gender differences in colon cancer incidence pattern the differences in the U.S., although the rates are significantly higher. The age-adjusted incidence rate for all men in Kentucky during 1999-2003 was 72.5 per 100,000 men which represents a 19.6% higher rate than the national estimate for men. The incidence of colon cancer in women in Kentucky is lower than that of men in Kentucky, but is 18.7% higher than the rate of women in the nation as a whole. Incidence rates in Kentucky by race also reveal racial differences in colon cancer. During 1999-2003, Blacks in Kentucky had an age-adjusted incidence rate of 73.7 per 100,000, which represented an 18.9% higher rate than Blacks in the nation in general. Likewise, White Kentuckians experienced an 18.2% higher age-adjusted incidence rate than Whites in the United States.

Age-adjusted Incidence Rates 1999-2003*

	US**	KY***
Overall	51.7	61.2
Males	60.6	72.5
Female	44.9	53.3
Blacks	62.0	73.7
Whites	51.2	60.5
Black Male	71.9	81.4
White Male	60.0	72.0
Black Female	55.5	68.9
White Female	44.2	52.4

Table 3.

- *Source*: Kentucky Cancer Registry

*Rates are expressed per 100,000 and are standardized to the 2000 Standard Million Population.

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**The US Age-Adjusted Incidence Rates were from Surveillance Epidemiology and End Results (SEER) data in year 1999-2003 and are per 100,000 population standardized to the 2000 Standard Population.
***The Kentucky Age-Adjusted Incidence Rates were from the Kentucky Cancer Registry and are per 100,000 population standardized to the 2000 Standard Population.

Our change master team studied social marketing campaigns in Kentucky as well as other states in order to narrow our focus. After completing a fishbone diagram to explore the possible reasons for low screening rates, we decided to look specifically at mass media campaigns. Utah recently conducted a statewide mass media social marketing campaign that was widely successful. In August, we held a conference call with the key players involved in the campaign and learned the following:

The Utah Cancer Action Network (UCAN – known as comprehensive cancer control in Utah) developed a colon cancer social marketing campaign. The key messages developed were:

- "The fact is, there are no early warning signs of colon cancer."
- "If you're 50 or older, call your doctor to find out which colon cancer screening option is right for you."
- "A simple test saves lives."

- Those messages were implemented as part of an integrated and comprehensive marketing strategy.
- The colon cancer campaign was supported by a grassroots effort that penetrated the community through parent-teacher associations, businesses, physicians, local health departments, and event sponsorships.
- Evaluation included phone surveys and focus groups for three subsequent phases of messaging, each assessing the effectiveness of the messages and media type used (TV, print or radio). Phases 2 & 3 of the campaigns were designed using this

In addition, as a result of the Colorectal Supplemental funding from CDC in 2004, KCC awarded fifteen community-based mini-grants to educate the general public and health care providers at the county/multi-county level in all regions of the state. One of those groups in central Kentucky produced a one-hour television show that has been produced for a second year in 2007. The first show aired on March 24, 2006, in 40 counties in Central and Eastern Kentucky and reached over 35,000 people. Last year's show aired March 30, 2007 covering the same geographic area. The one-hour call-in show, entitled "Catching a Killer," featured colon cancer survivors and local medical specialists, aiming to increase awareness about CRC screening guidelines.

CDC and ACS both launched nationwide public awareness campaigns in March 2007 targeting the general population 50+ to improve their

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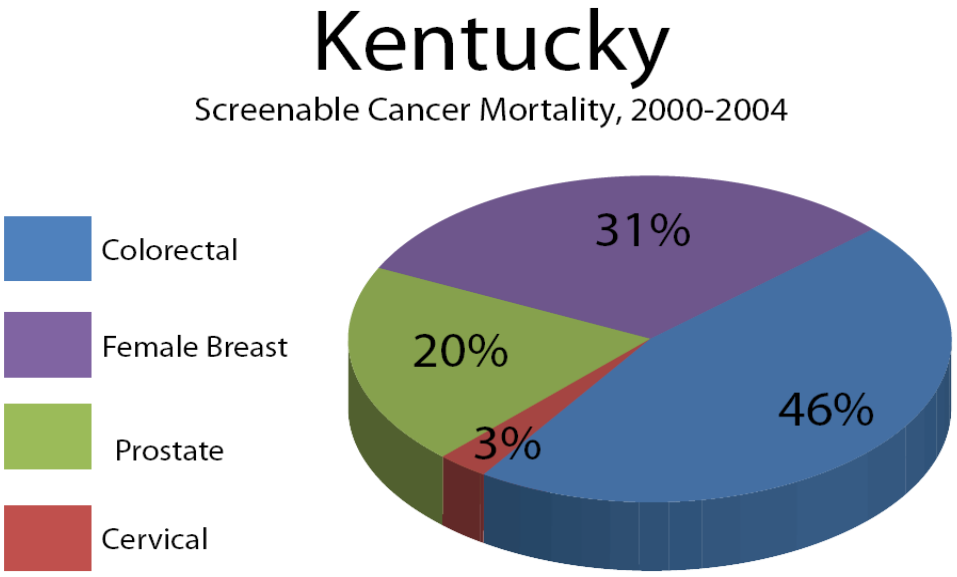
knowledge of the risk of not getting tested for colon cancer. CDC's is known as *Screen for Life* and the ACS campaign included TV advertisements (network and cable) complimented by print advertisements in national magazines, national healthcare provider publications and on-line advertising. In Kentucky, a colon cancer insert was produced in Northern Kentucky and was published in the Kentucky Inquirer. Additionally, ACS has aggressively promoted its Great American Health Check which allows patients to take a five minute survey and develop a personalized health plan to discuss with their personal physician. The Great American Health Check (www.cancer.org/healthcheck) addresses colon cancer screening. The ACS works in Kentucky with large employers to promote worksite wellness programming which includes the education about and promotion of colon cancer screening. Most recently ACS has become a partnering organization with Governor Fletcher's Get Healthy Kentucky effort.

After gathering this information, we chose to conduct and evaluate a live call-in television show in the greater Louisville area. Due to the success of similar shows the past two years in Lexington, we wanted to evaluate the success of a call-in show in another metropolitan area of Kentucky.

Problem Statement:

Colon cancer is one of the most preventable cancers, yet is the least prevented. (Figure 1.)



"Screenable" refers to those cancer sites that have early detection methods recommended by the American Cancer Society. Source: Kentucky Cancer Registry

Figure 1.

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Behavior Over Time Graph:

See Appendix 1

National Goals:

Our project addressed the following goals of the 10 Essential Public Health Services:

1) Monitor Health – The function of this service is not solely to identify health risks but also discover the health service needs that do not currently exist within the Public Health Infrastructure to address the aforementioned health risks. There are contributing factors keeping the screening rates to less that 40% for at risk populations. In reviewing results from the Colon Cancer Advertising Survey Report conducted for the Utah Cancer Action Network, a telephone survey consisting of 414 interviews with male and female Utah residents age 50 to 74, the majority perceived the following: that good diet was the number one thing they could do to reduce the risk of getting colon cancer; if they did get screened the majority of respondents did so because their Healthcare Provider motivated them to; and if they had not been screened the main reason was due to lack of symptoms. Based on Utah model we devised three series of questionnaire tools to help determine the status of Colon Cancer health services within Kentucky.

2) Inform, Educate, Empower – Based on the success of the Utah television advertisement campaign we assisted in the development caller log questionnaire used during "Catching a Killer," a live, one-hour television special that aired on WHAS-11 Tuesday, March, 11th, 2008 from 7 to 8 pm. The questionnaire was designed to capture baseline information on viewers that called into a phone bank during the show, staffed by physicians and nurses, for colon cancer information.

3) Evaluation – The caller log questionnaire data initially indicates that the callers were white females. We assembled the framework for a post-show telephone survey. Due to funding limitations the survey was not conducted. This opens the door for future data collection.

4) Research – Bottoms Up created and submitted a BRFSS question to determine why population is not getting screened.

National goals supported:

Healthy People 2010: Objectives to Improving Health

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1.3 Increase the proportion of persons appropriately counseled about health behaviors.
3.1 Reduce the overall cancer death rate
3.5 Reduce the colorectal cancer death rate
3.10 Increase the proportion of physicians and dentists who counsel their at-risk patients about tobacco use cessation, physical activity, and cancer screening

Target 13.9 deaths per 100,000 population
Baseline: 21.2 colorectal cancer deaths per 100,000 population occurred in 1998 (age adjusted to the year 2000 standard population)

Colon cancer is the second leading cause of cancer-related deaths in the United States. An estimated 130,200 cases of colon cancer and 56,300 deaths from colon cancer were expected to occur in 2000.

Under Healthy People 2010 Information Access Project Bringing Evidence to You:

- *Why hasn't this patient been screened for colon cancer?* An Iowa Research Network Study
  Conclusion: Reasons many patients remain unscreened for CRC include 1) factors related to health care system, patient, and physician that impede or prevent discussion; 2) patient refusal; and 3) the focus on diagnostic testing. Strategies to improve screening might include patient and physician education about the rationale for screening, university coverage for health maintenance exams, and development of effective tracking and reminder systems. The words physicians use to frame their recommendations are important and should be explored further.
- *Barriers of and facilitators to physician recommendation of colorectal cancer screening* Division of General Internal Medicine, University of Pennsylvania School of Medicine, Philadelphia, PA.
  Results: All the participating physicians were aware of and recommended colon cancer screening. The overwhelmingly preferred test was colonoscopy. Barriers of physician recommendation of colon cancer screening included patient co-morbidities, prior patient refusal of screening, physician forgetfulness, acute care visits, lack of time, and lack of reminder systems and test tracking systems
  Conclusion: there are multiple physician, patient, and system barriers to recommend CRCS. Thus, interventions may need to target barriers at multiple levels to successfully increase physician recommendation of CRCS.
- *Perceived ambiguity about cancer prevention recommendations: associations with cancer-related perceptions and behaviors in a US population survey* Division of Cancer Control and Population Sciences, National Cancer Institute
  Results: Perceived ambiguity was inversely associated with perceptions of the preventability of all three cancers, and with cancer specific risk-modifying behaviors including sigmoidoscopy-colonoscopy testing, sunscreen use, and

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smoking abstinence. Relationships with cancer risk perceptions and worry varied across different cancer types.
Conclusions: Perceived ambiguity about cancer prevention recommendations has significant and predictable associations with cancer prevention-related cognitions and behaviors, and some associations differ by cancer type. These finding have implications for future research and communication efforts.

The National Public Health Performance Standards Program

- Promote continuous quality improvement of public health systems; our proposed survey will identify the most likely step in the public health system that is the largest impediment to the screening process. Utilizing the tools that we have available to detect colon cancer at the earliest possible stage or eliminating it altogether by removing polyps effectively on the majority of the at risk population will enable funds to be redirected from costly treatment to cost effective prevention thus maximizing public health systems funding.

Project Objectives:

The following are the objectives of this project:

1. Identify barriers and perceptions regarding colon cancer screenings.
2. Recognize mass media tools and techniques to motivate at-risk populations.
3. Learn evaluation methods used in mass media campaigns.

Deliverables:

Our change master project will deliver the following:

1. A live television call-in show, “Catching Killer: Steps to Preventing Colon Cancer”, to be aired on March 11, 2008 on WHAS-11 Louisville. Our contribution included:
    a. Development of messages for the show
    b. Creation of caller profile forms (Appendix 2)
    c. Development of methodology for follow-up random telephone survey (Appendix 3)
2. A question added to the 2008 BRFSS regarding colon cancer screening (Appendix 4)
3. Evaluation of mass media campaign including:
    a. Random telephone survey (developed but not implemented due to funding constraints)
    b. Focus groups
    c. Results of call-in show via data collected
    d. Viewership of show

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Methodology:

Initially, we constructed a fishbone diagram (Appendix 5) to better understand the possible barriers to screening. This helped us develop the key messages for our campaign. We then reviewed similar campaigns in other regions and states, and attended a social marketing training to help us learn more about message development for our campaign. We learned that these campaigns typically reach the "low-hanging fruit", or the ones who would be the easiest to reach. When we decided to do a mass media campaign, we chose not narrow our target audience since the television viewing area would be so broad. Our target audience for the show was people over the age of 50, 45 for African-Americans, who have not been screened for colon cancer.

Working with the Colon Cancer Prevention Project of Kentucky, we contracted with the ABC affiliate in Louisville, WHAS-11, to produce a live television call-in show. WHAS-11 has approximately 390,000 weekly viewers over age 50. This station reaches 80% of this age group in a 29-county viewing area. The broadcast included several interviews with local celebrities including Diane Sawyer, Denny Crum, Joe B. Hall, Lancaster Gordon, and Crit Luallen. These segments were previously recorded and aired during the show. Rachel Platt, anchor for WHAS-11, was the live host of the show. The main feature of the show was a segment with Rachel Platt getting a colonoscopy. There were 10 phone lines open during the entire one-hour show to take calls from viewers. The lines were staffed with nurses and doctors trained in gastroenterology.

Upon completion of the show, our group evaluated the call records, and the viewership information. In addition, focus groups will be conducted concerning the focus of the messages and content of the show.

In addition, we submitted a question for the 2008 BRFSS regarding reasons for not getting screened for colon cancer.

Results:

"Catching a Killer: Steps to Prevent Colon Cancer" was aired on WHAS11 on March 11, 2008 at 7 pm to an audience of about 38,000 viewers, according to Nielson ratings meters in the station viewing area. Thirty second promotional commercials were aired 105 times from March 5th to 11th. Additional promotion was obtained through newspaper ads and articles including a donated ½ page ad in the March 7, 2008 edition of Business First, an article in Business First, mentions in Courier-Journal columns, and publicity through the following websites and email newsletters: Kentucky Medical Association, Peritus Public Relations, Patient Advocacy Foundation, C3: Colorectal Cancer Coalition and the Kentucky Cancer Consortium. Twelve nurses and physicians staffed the phone

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bank representing Norton Healthcare, Jewish Hospital & St. Mary's Healthcare and the Kentucky Cancer Program. They fielded 148 calls in the hour.

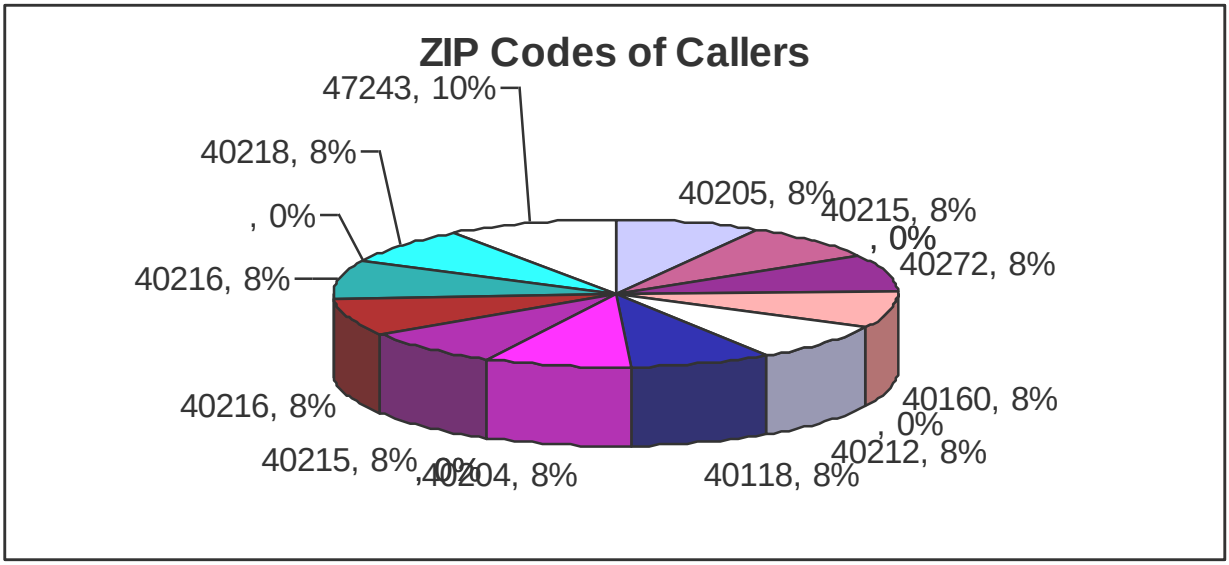

Figure 2.

The calls represented a range of the Louisville Metropolitan area including Southern Indiana. (Figure 2)

Calls were classified in terms of reasons categories including: Screening, Risk Factors, Colon Prep, Symptoms, Insurance/Ability to Pay and Other. Gender of callers was highly tilted in favor of Females and specifically White Females. (Figure 4.)

The callers were not random, so little can be drawn from these data except that white females were most likely to call in. (Figure3)

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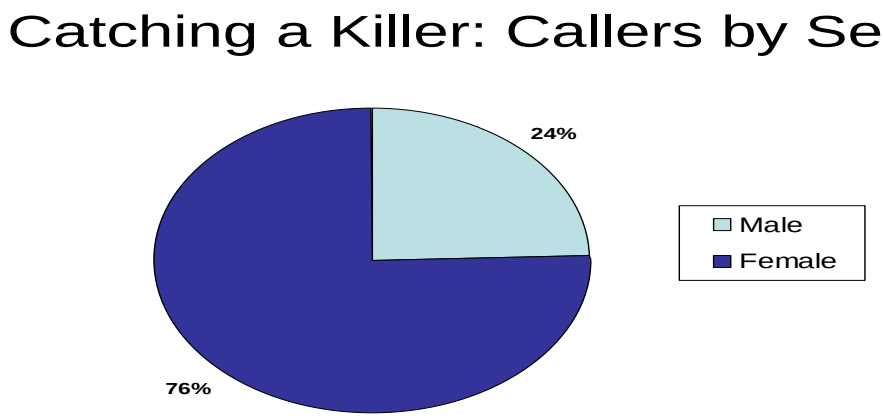

Figure 3.

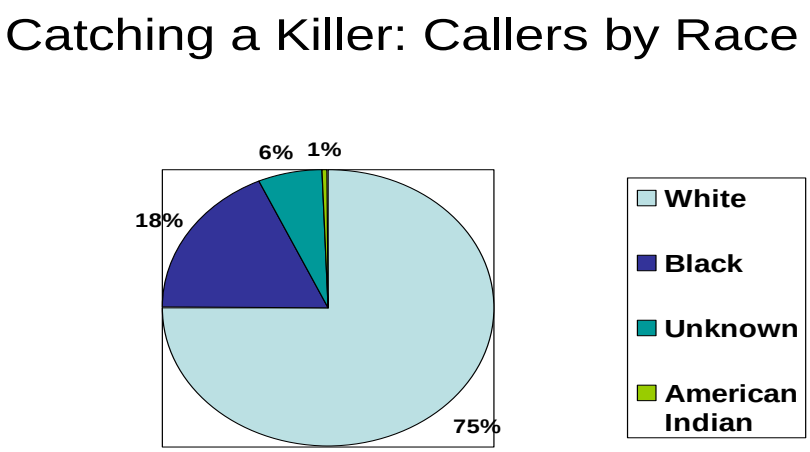

Figure 4.

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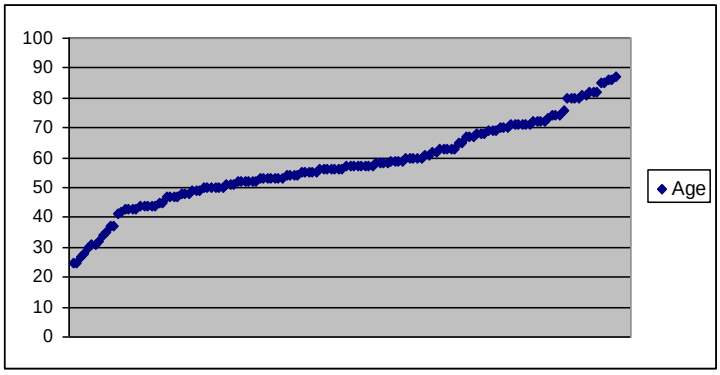
Catching a Killer: Callers by Age Distribution



Evaluation methods have been developed by the team, but were not able to be implemented. These included a randomized telephone survey to measure the reach and viewership of the show. However, the price for this greatly exceeded our resources. The survey itself, however, was developed.

In lieu of these quantitative results, it is the goal of the Colon Cancer Prevention Project to conduct a series of viewer survey and focus group sessions to collect qualitative information. The goal of these surveys will be to learn if the messages are well received by the intended audience of men and women aged 50 and older. We would like to learn specifically which of the survivor vignettes effectively compel the viewer to be screened and if the information was clear and understandable given the range of education levels that exist in the community. The surveys will be conducted in partnership with the Kentucky Cancer Program and the existing relationships with community groups.

An additional goal of the Colon Cancer Prevention Project is to create a 30 minute DVD of show segments and information (excluding the phone bank) to be re-aired on community and public access channels and distributed to hospitals, health departments and other places it could be played, perhaps in lobbies and waiting rooms. The segments will also be posted for viewing on the Project website and www.YouTube.com. The DVD will be offered to civic groups, churches and other organizations.

Conclusions:

Colon cancer involves two things that no one really wants to discuss: colon and cancer. While colon cancer is the most preventable yet least prevented of

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screenable cancer deaths, it may be one of the most difficult for people to discuss. However, the past has taught us that efforts by the public and private sector can change the impact of a disease. Given the success of the AIDS/HIV and breast cancer groups to increase awareness, we know that persistent messaging through media and public education can make a difference in awareness for prevention and early detection strategies.

There are also lots of myths to dispel about colon cancer. It is not a man's disease or a woman's disease. It is not a white disease or a black disease. Most colon cancers develop with little or no symptoms. You do not have to have a family history to be at risk for colon cancer. The test is not painful. Simply eating more fiber does not prevent or reverse colon cancer. Media can be a compelling way to dispel some of these myths. It is evident that with an issue that has so many educational, social and perception barriers, the message must be very simple: If you are 50 or older, get screened for colon cancer. In this case, we learned that the "low-hanging fruit" within the marketing strategy is probably white women. More work can be done to determine if this group is motivated by different factors than other demographic groups.

Evaluating media is expensive and any good campaign should be more long term. Without that kind of funding, this show was a successful way to engage the public and the phone bank component was very popular. In future shows, the phone bank should probably be much longer than just the one hour of the show's airing. In Utah, they are trying a new strategy to have a longer phone bank that will last perhaps five hours during prime-time. During that time, regular programming will air with the phone bank being plugged during commercials. Because some of the caller's concerns were complex and required multiple answers and explanations, the hour format is not as useful to viewers. Also, because many of the questions received that night and via the Colon Cancer Prevention Project's website following the show involved lack of insurance and the inability to pay, funding will need to be developed to meet these needs. As we are more successful in our efforts to educate the public and create a demand for screening, colon caner will need the kind of funding that the breast and cervical programs currently receive from federal and state sources.

It would also be interesting to be able to evaluate the relative effectiveness of the one hour show compared to the promotional commercials. The commercials have their own value which is why the American Cancer Society and Centers for Disease Control and Prevention have created such targeted commercials on colon cancer. However, these commercials were run only for a short time as well. The trend of having months dedicated to a disease is becoming less and less effective. With so many competing health messages, the public needs year-round information on what is important to them. Breast cancer is not contained during the month of October and colon cancer should not only be highlighted

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during March. The Partnership for Prevention's report titled "Preventive Care: A National Profile on Use, Disparities, and Health Benefits" states:

> 14,000 additional lives would be saved each year if we increased to 90 percent the portion of adults age 50 and older who are up to date with any recommended screening for colorectal cancer. Today, fewer than 50 percent of adults are up to date with screening. (http://www.prevent.org/images/stories/2007/ncpp/report%20highlights.pdf

This is their #3 (ranked) recommendation for opportunities to implement evidence based prevention strategies based on cost-effectiveness and return on investment. For reference, the other recommendations, in order, are about aspirin regimens, smoking cessation, flu vaccination, breast cancer screening and screening for chlamydial infection. It is shocking to most that colon cancer is on the "short list" of prevention opportunities.

It is the hope of the Change Master Team that public health will look for new and innovative strategies to increase screening for colon cancer. The Team hopes that there will be future opportunities for collaboration among public and private health partners on this issue.

Leadership Development Opportunities

Jessica DuMaurier, MPH, CHES

My change master team has been great to work with. Despite having a small group and losing our mentor early in the year, we maintained a strong work ethic and good communication to develop and complete our project. One of my goals for improvement this year was to become a better communicator especially as it relates to teamwork. Through KPHLI, I became much more aware of my communication skills and the importance in a leadership role. I was promoted to a supervisory position within my organization near the end of the KPHLI year and I feel I can use the knowledge and skills I learned to be a more effective leader.

Angela Champion, MPA

This past year as a KPHLI scholar has been very rewarding. Because I do not work in a traditional public health setting, the Change Master Project process has allowed me to partner with a wonderful group of professionals who work in state agencies and local health departments. I have found that the small group experience is especially rewarding and allowed for a great deal of creativity and energy. I am also glad to have been given the chance to work on aspects of my professional and personal development. I hope to have grown in both areas and to continue to do so.

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Irene Centers, BA

My participation in KPHLI has been challenging and rewarding. The Summit topics and speakers were excellent. I particularly liked (and will use) tools from systems thinking and mental models. I am already incorporating changes in my personal life and in my role as a supervisor that I learned from the Discovery 360 Series and the BarOn Emotional Quotient Inventory. It's been challenging at time to complete projects and make time to meet with our team, but it's definitely been worth it.

Amy L. Young

Initially I envisioned the KPHLI experience better equipping me to motive my current workforce to embrace the new improved direction that our agency was forging into while simultaneously thinking of the next potential staff member that would assist us in meeting the ongoing challenges in Public Health by similar management techniques that I have been exposed to over my management career. The KPHLI feedback tools indicated that my personality and some undetected natural tendencies however offered the greatest possibility for improvement rather than the mechanical tools that I perceived would benefit me the most in my Leadership skills. Others scored me lower on developing, mentoring and collaboration in the KPHLI feedback assessments. My style is analytical and my versatility to effectively interact with the other styles is low. I now regularly attend the Kentucky Health Department Association to interact with other Public Health Leaders and gain insight on how public health issues are being addressed across the state. I have also started having weekly team meetings with my staff to allow them to express what they are doing on an individual level and focus our efforts in the same direction. These meetings have also made me an effective liaison between upper management and my subordinates eliminating delays and confusion because communication is now uniform and timely. Finally I have also subscribed to on online Leadership Newsletter to stay abreast of developments in the constantly evolving realm of Leadership. There are still areas that I will continue to work on in my role as a Public Health leader. I appreciate the opportunity to identify these areas of potential improvement in addition to learning different leadership techniques through the course my KPHLI endeavor.

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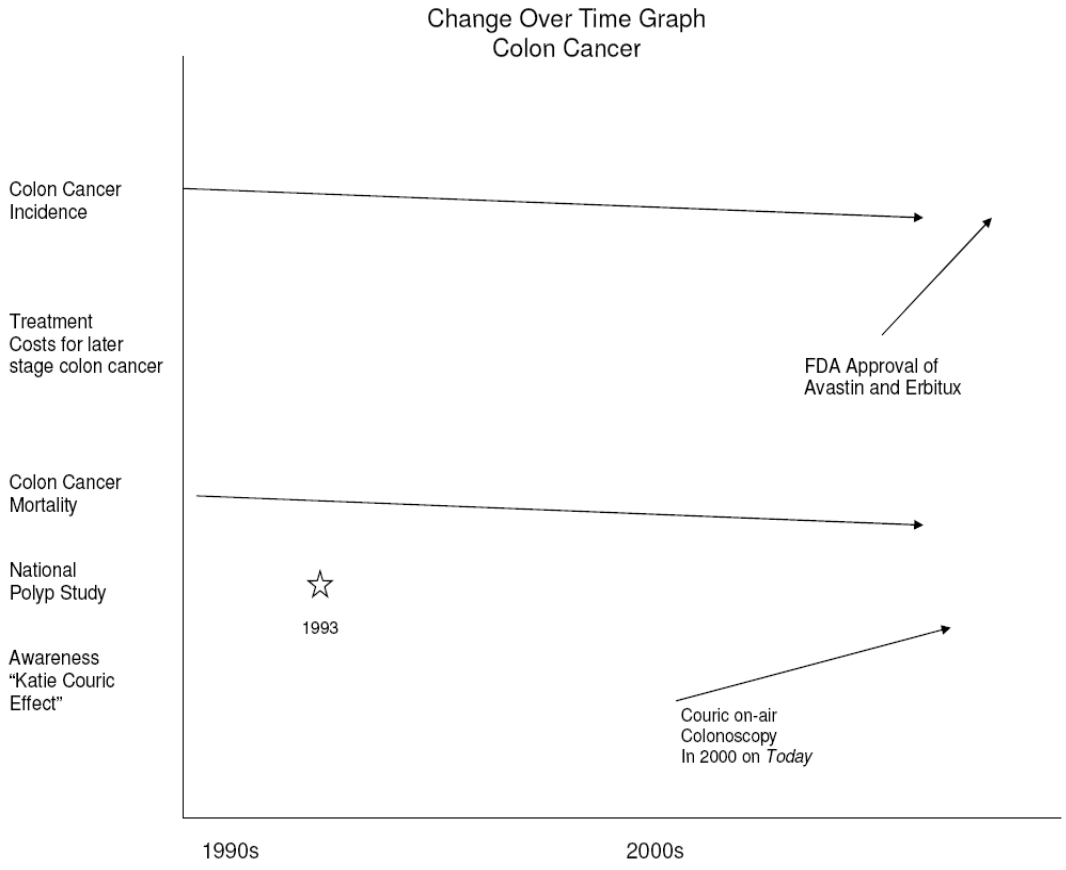
Appendix 1.



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Appendix 2.

Volunteer Initials _____

Colon Cancer Prevention Project
'Catching a Killer' Call Log – March 11, 2008

Might I ask you a few questions?

Gender (circle one): Female Male

What is your age _____

What is your zip code? _____

Which one or more of the following would you say is your race?
1 = White
2 = Black or African American
3 = Asian
4 = Native Hawaiian or Other Pacific Islander
5 = American Indian, Alaska Native
6 = Other Specify_____
8 = No additional choices
7 = Don't know /Not sure
9 = Refused.

Have you ever been screened for colon cancer? Yes No Not Applicable
If Yes, when? _____

Do you intend to be screened for colon cancer? Yes No Not Applicable

Nature of call (circle all that apply):

Screening _____

Risk Factors _____

Colon Prep _____

Symptoms _____

Insurance/Ability to Pay_____

Other (please explain) _____

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Appendix 3.

Random Telephone Follow-up Survey

Hello. I am calling as part of an evaluation study to measure the impact of a recent television broadcast on WHAS on an important health issue. I have just a few questions, and I'm looking for a member of this household who is 45 years old or over.

SCREENER

S1. How many people in this household are at least 45 years old?
- o One (GO TO S2)
- o Two or more (GO TO S4)

S2. Are you that person?
- o Yes (GO TO Q1)
- o No (GO TO S3)

S3. May I speak to that person?
- o Yes (GO TO S5)
- o No (SET UP CALLBACK)

S4. INSERT SELECTION PROCESS (LAST BIRTHDAY, ETC.)

S5. Hello. I am calling as part of an evaluation study to measure the impact of a recent television broadcast on WHAS on an important health issue. I have just a few questions, and I'm looking for a member of this household who is 45 years old or over. Would you be willing to participate? It will take just 2 or 3 minutes.
- o Yes
- o No (MARK REFUSE)

QUESTIONNAIRE

Q1. Have you seen any television programs lately focusing on a specific disease?
- o Yes
- o No (GO TO Q3)

Q2. What disease was it? (If "cancer" but not specifically "colon or colorectal cancer", ask what kind of cancer.)

- o Colorectal or Colon Cancer (GO TO Q4)
- o Something unrelated

Q3. On March 11, WHAS broadcast a show on colon cancer. Did you see that show?

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- Yes (GO TO Q4)
- No (GO TO Q5)

Q4. What was the main message of the show?

Q1. Get a test
Q2. Get a sigmoidoscopy or colonoscopy
Q3. See your doctor
Q4. Prevention
Q5. None of the above (GO TO Q6)

Q5. Having seen the program, are you now more likely to be tested for colon cancer?

- Yes
- No
- Have already been tested

Q6. What is your age?
Q7. What is your race?
Q8. What is your zip code?
Q9. Gender

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Appendix 4.

Request for an Added CDC Module to the 2008 Kentucky Behavioral Risk Factor Surveillance System (BRFSS)

Date September 28, 2007		
Name of Module Section 20, added question		
Name of Contact Person Irene Centers		
Branch/Division or Organization Governor's Office of Wellness & Physical Activity		
Mailing Address 275 E Main Street, 4W-E		
City Frankfort	**State** KY	**Zip** 40621
Telephone 502-564-9358 ext 3808	**Fax**	
E-mail irene.centers@ky.gov		

Importance of Module:

For which *Healthy Kentuckians 2010* goals will the module provide information? Please list number and description.

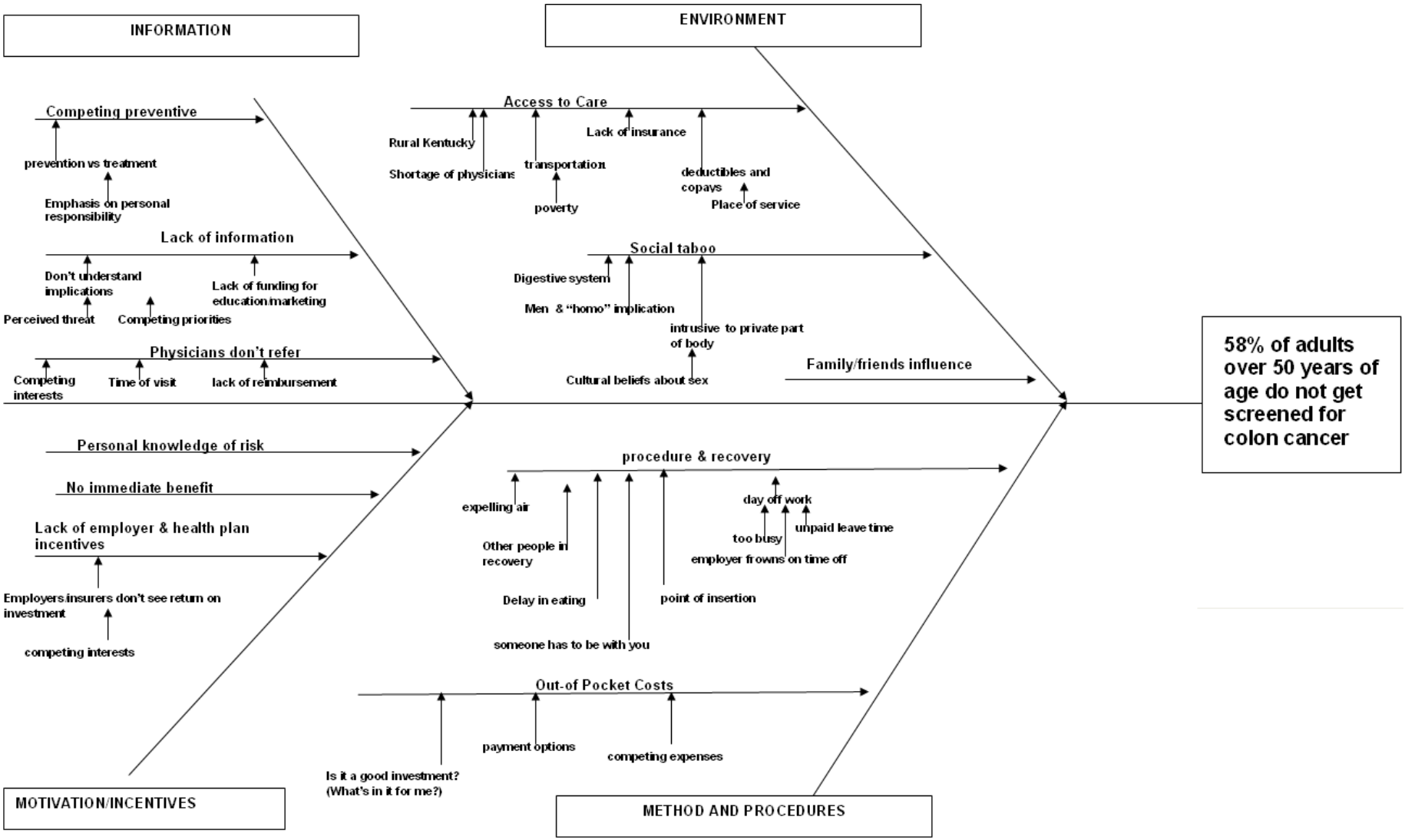
16.7 To reduce colorectal cancer deaths to no more then 15.2 per 100,000 people in Kentucky.
Colorectal cancer rates have not declined to the target level of 15.2 per 100,000, but this rate has declined from 21.2 in 1990 to 18.2 in 1997.
16.8 To increase to at least 50 percent the proportion of people ages 50 and older who have received fecal occult blood testing within the preceding one to two years and to at least 40 percent those who have ever received proctosigmoidoscopy.
In 1997, 26 percent of those ages 50 and older had received fecal occult blood testing within the preceding one to two years and 40% of people ages 50 and older had ever received a proctosigmoidoscopy.

☐ Is the topic a public health issue of high priority within the Department for Public Health? (Check for yes. Leave blank for no.) If yes, explain below.

Mid-Decade Status: In 2002, the death rate for colorectal cancer was 24.1 per 100,000 with a disparity in the death rates between males, 30 per 100,000, and females, 20.4 per 100,000.

*Colon refers to colon and rectum cancer combined, also known as colorectal cancer

Appendix 5.


INFORMATION
ENVIRONMENT
Competing preventive
prevention vs treatment
Emphasis on personal responsibility
Lack of information
Don't understand implications
Lack of funding for education/marketing
Perceived threat
Competing priorities
Physicians don't refer
Competing interests
Time of visit
lack of reimbursement
Access to Care
Rural Kentucky
Shortage of physicians
transportation
poverty
Lack of insurance
deductibles and copays
Place of service
Social taboo
Digestive system
Men & "homo" implication
intrusive to private part of body
Cultural beliefs about sex
Family/friends influence
58% of adults over 50 years of age do not get screened for colon cancer
Personal knowledge of risk
No immediate benefit
Lack of employer & health plan incentives
Employers insurers don't see return on investment
competing interests
procedure & recovery
expelling air
Other people in recovery
Delay in eating
someone has to be with you
point of insertion
day off work
too busy
unpaid leave time
employer frowns on time off
Out-of Pocket Costs
Is it a good investment? (What's in it for me?)
payment options
competing expenses
MOTIVATION/INCENTIVES
METHOD AND PROCEDURES