Action Plan on Colorectal Cancer for the State of Texas

August 2000

Administered by:
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In 1999 the Texas Cancer Council allocated funding for the formulation of an Action Plan on Colorectal Cancer for the State of Texas. The goal of the project was to identify the education, prevention and support resources currently available in the state and to recommend and prioritize those needing development, to reduce the impact of colorectal cancer in Texas.

Colorectal cancer is the third most common form of cancer in the United States and the second leading cause of cancer deaths. In Texas in 1998, more than 3,200 individuals lost their lives to colorectal cancer, and it is estimated that 8,300 new cases will be diagnosed by the end of 2000. Yet, colorectal cancer is preventable and, when detected early, eminently curable. The five-year relative survival rate is 90% when it is discovered and treated early.

In Texas, all ethnic groups have had increases in the number of new cases diagnosed at percentages higher than the increases in the general population during the same time period (1992-1996). African Americans consistently have higher incidence rates and higher overall death rates than do other racial/ethnic groups. For all races combined, the incidence rate is over 40% higher in men than in women and increases steadily as individuals age. In addition, the total number of deaths from colorectal cancer increased by more than 20% in the ten years from 1989 through 1998. Existing screening procedures have been demonstrated to reduce mortality from colorectal cancer, but fewer than 35% of Texans report ever having had colorectal cancer screening beyond a digital rectal examination.

This Action Plan identifies and discusses the many factors that influence the current levels of colorectal cancer incidence and death, including current knowledge, attitudes and practices among the public and healthcare providers, access to and availability of services and financial and policy issues. It provides a list of specific recommendations to achieve the following goals:

1. Increase public awareness of, and demand for, colorectal cancer screening services.

2. Increase availability of colorectal cancer prevention, screening and detection information and services.
3. Increase access to and use of diagnostic services, appropriate treatment and follow-up.

4. Enhance healthcare professionals’ knowledge, skills and practices in colorectal cancer prevention, diagnosis, treatment, rehabilitation and support.

5. Conduct research and collect relevant data to facilitate the achievement of these goals.

The contributors to this document are pleased to join the Texas Cancer Council in the realization of its mission: “... reducing the human and economic impact of cancer on Texans through the promotion and support of collaborative, innovative, and effective programs and policies for cancer prevention and control.”
Introduction
Introduction

Project Charge

In 1999 the Texas Cancer Council allocated funding for the formulation of an Action Plan on Colorectal Cancer for the State of Texas. The goal of the project was to identify the education, prevention and support resources currently available in the state and to recommend and prioritize those needing development, to reduce the impact of colorectal cancer in Texas.

Steering Committee

A dynamic committee was assembled that included physicians from private and public healthcare sectors, epidemiologists and behavioral science experts, representatives from the Texas Department of Health and the American Cancer Society, Texas Division, various non-physician healthcare professionals, public affairs and media specialists, survivors and family members and featured geographical representation from El Paso, Dallas, San Antonio, Lubbock, Rio Grande Valley and West Texas. The committee was chaired by Bernard Levin, M.D., Vice President for Cancer Prevention at The University of Texas M. D. Anderson Cancer Center in Houston. Members included:

Frank Ambriz, P.A.-C.,
The University of Texas — Pan American, Edinburg

Grace Butler, Ph.D., survivor,
The University of Houston, Houston

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Susan Cooley, Ph.D., R.N., survivor, Houston

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Plan Development Process and Timeline

The initial planning meeting for the project was held August 24, 1999. The full committee was recruited by mid-October, and a project timeline was constructed to convene three in-depth discussion sessions to address the many facets of colorectal cancer in Texas, including prevention, screening and detection; diagnosis and treatment; and rehabilitation, symptom control and palliative care. Guest presenters contributed their expert perspectives to the meetings. The Steering Committee identified a number of major issues and proposed a range and variety of strategies.

In April and May 2000, the committee was reorganized into a number of smaller “working groups,” to discuss in more depth the recommended goals and strategies from specific points of view. They defined a number of needs more precisely and designated priorities. In its fourth meeting the full committee confirmed its recommendations formatted in alignment with the 1998 Texas Cancer Plan.

The draft Action Plan document was reviewed and revised by members of the Steering Committee and Texas Cancer Council staff. The final printed document is scheduled for distribution to healthcare professionals, educators, policy-makers and opinion leaders, and for public posting on the World Wide Web, by the end of summer. The committee will convene one more time in August 2000 to discuss implementation of its recommendations.

Schedule of Activities

November 30, 1999  Meeting #1: Prevention & Early Detection
January 18, 2000  Meeting #2: Diagnosis & Treatment
March 27  Meeting #3: Rehabilitation, Symptom Control & Palliative Care
April to May  Working Group Discussions:
Service Availability: Prevention, Screening & Diagnosis
Professional Education
Patient & Family Education
Public Information
Policy Development & Enactment
Research
June 9  Meeting #4: Review of Action Plan Recommendations
June 15  Final Plan to Texas Cancer Council for review
July 31  Plan completed
August 15  Plan distributed in hard copy and via Internet
August 15  Meeting #5: Implementation in FY2001
**Acknowledgments**

In addition to the project Steering Committee, appreciation goes to the Texas Cancer Council staff and the following people, all of whom contributed to the successful completion of the Action Plan:

Carolyn G. Bernard, Texas Cancer Data Center
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Lynn S. Couey, New York State Department of Health
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Lyone Hochman, M.D., St. Luke's Episcopal Hospital
Nancy C. Lee, M.D., National Centers for Disease Control
Andrea Littlefield, Breast and Cervical Cancer Control Program, Texas Department of Health
Susan Loehner, Nurse Oncology Education Program
Susan Madigan, R.N., U.T. M. D. Anderson Cancer Center
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Porter Storey, M.D., The Hospice at the Texas Medical Center
Claire Turney, U.T. M. D. Anderson Cancer Center
Sadai Varghese, U.T. M. D. Anderson Cancer Center
Jo Ann Ward, M.P.H., Cancer Information Service
Martha Crosier Wood, Massachusetts Department of Public Health
Jenny E. Young, M.A., Texas Medical Association
The Challenge: Colorectal Cancer in Texas
Cancers of the colon, rectum and anus constitute the third most common form of internal malignant cancer in the United States, and when statistics for men and women are combined, colorectal cancer is second only to lung cancer as the leading cause of cancer deaths. In 2000 it is estimated that nationwide there will be 130,200 new cases of colorectal cancer and 56,300 deaths.¹ In Texas in 1998 (the most recent year for which data are available), 3,276 persons died from colorectal cancer²; approximately 8,300 new cases are expected to be diagnosed in 2000.³

What is Colorectal Cancer?

Colon and rectal cancers develop in the lower gastrointestinal (GI) tract, the system that processes food for energy and rids the body of solid waste matter (fecal matter or stool). Cancer can develop in any part of the colon or rectum and is thought to develop slowly over a period of several years. Before a cancer develops, there usually are precancerous changes in the lining of the colon or rectum, including dysplasia or adenomatous polyps. A polyp is a growth of tissue into the lumen of the colon or rectum. Some types of polyps (hyperplastic polyps and inflammatory polyps) are not precancerous, but having adenomatous polyps (also called adenomas) does increase one’s risk of developing cancer, especially if there are multiple adenomas, if they are over one centimeter in size or if they display abnormal cellular patterns (dysplasia).

In contrast to the growth of an adenoma into the hollow lining of the colon, a cancer can grow inward through the wall of the large bowel. If not treated, cells from the tumor may break away and spread through the bloodstream or lymph system to other parts of the body, where they can form secondary tumors (a process called metastasis).
Over 95% of colorectal cancers are adenocarcinomas — derived from the glandular cells lining the inside of the colon and rectum. Other, rarer types of tumors may also develop in the colon and rectum, including carcinoid tumors (from hormone-producing cells of the intestine), gastrointestinal stromal tumors (from the connective tissue and muscle layers in the colon or rectal wall) and lymphomas (cancers of the immune system and its component cells).

Cancers beginning in different areas of the large bowel may cause different symptoms. Signs and symptoms of colorectal cancer include rectal bleeding, blood in the stool and a change in bowel habits. The cancer can exist for an extended time without symptoms; those detected because of symptoms have usually progressed beyond a localized stage.

Several effective screening tools exist for the early detection of adenomatous polyps and colorectal cancer. Screening with fecal occult blood testing and flexible sigmoidoscopy has been shown to reduce death rates either by detecting and removing polyps before they become malignant, or by detecting and removing early-stage colorectal cancers when still highly curable. The following procedures are currently available for use in colorectal cancer screening:

**Digital Rectal Examination (DRE):** A simple, painless test during which a physician inserts a lubricated, gloved finger into the rectum to feel for irregular or abnormal areas. Although useful in detecting some polyps and cancers, the DRE is limited to only the rectum area, and should be performed prior to sigmoidoscopy, colonoscopy or double-contrast barium enema.

**Fecal Occult Blood Test (FOBT):** Examines samples of stool for the presence of hidden, or “occult,” blood that can be a sign of tumor or polyps in the intestine. Patients receive a test kit to take home along with dietary instructions to follow for several days before beginning the test. The test consists of taking a small stool sample from three consecutive bowel movements and then returning the kit to the doctor’s office or laboratory for evaluation. Randomized controlled studies have demonstrated the effectiveness of annual or biennial FOBTs in reducing cancer mortality.

**Flexible Sigmoidoscopy:** Insertion of a slender, flexible, hollow, lighted tube (sigmoidoscope) into the rectum to view the inside of the rectum and the lower part of the colon (sigmoid) for cancer or polyps. This test may be somewhat uncomfortable, but it is generally not painful. If a polyp or other mass is observed, the patient is referred for colonoscopy to obtain a biopsy, and to observe the remainder of the colon that is not reachable by sigmoidoscope. Case-control studies have demonstrated a reduction in colon cancers within the distal colon (within reach of the instrument).

**Colonoscopy:** Insertion of a long, flexible, hollow, lighted tube, similar to a sigmoidoscope, through the rectum, to examine the entire colon. The colonoscope is connected to a video camera that allows the physician to view closely the inside of the colon. If a polyp is found, it can be removed immediately by passing a wire loop through the colonoscope and cutting the polyp from the wall of the colon with an electrical current. Colonoscopy requires more extensive preparation than does sigmoidoscopy, usually including sedation during the examination. While comparative studies suggest a reduction in colorectal cancer incidence after colonoscopy, a randomized controlled trial has just begun.
**Barium Enema with Air Contrast (also called Double-Contrast Barium Enema):** An enema of barium sulfate is given through the rectum to partially fill and open the colon. The barium sulfate spreads throughout the colon and then most of it is removed. The colon is partially inflated with air, expanding it and increasing the contrast and quality of x-rays.

New technologies hold promise for the design of colorectal cancer screening tests with acceptable sensitivity and specificity that are minimally invasive and relatively safe. Virtual colonoscopy, a method of imaging the colon in which thin-section, helical computed tomography (CT) is used to generate high-resolution, two-dimensional axial images from which three-dimensional images are then reconstructed offline, is currently being studied to compare its diagnostic performance with that of conventional colonoscopy, with initial positive results. Although virtual colonoscopy requires full bowel preparation, it takes less time and does not require sedation. In addition, molecular genetic approaches for colorectal cancer screening that detect DNA mutations in stool have the potential to be very specific and sensitive as well as cost-effective. Such alternatives to current screening techniques may be more tolerable to patients, thereby increasing their compliance.

Colorectal cancer is highly preventable and, when detected early, eminently curable. The five-year relative survival rate is 90% when it is discovered and treated early. Unfortunately, only 37% of colorectal cancers are found at this early stage. The five-year relative survival rate decreases to 65% after the cancer has spread to nearby organs or lymph nodes, and to only 8% if it has spread to distant parts of the body.

Surgery is the most common form of therapy for colorectal cancer, and for cancers that have not metastasized, it is frequently curative. Chemotherapy, or chemotherapy plus radiation, is given before or after surgery to most patients whose cancer has deeply perforated the bowel wall or has spread to the lymph nodes. A permanent colostomy — creation of an abdominal opening for elimination of body wastes — is rarely needed for colon cancer and only infrequently for rectal cancer.

When the cancer cannot be cured, effective symptom control and, if needed, palliative care are appropriate parts of a comprehensive care plan that optimally involves the hospital, the patient’s own physician and inpatient or outpatient hospice.

**Risk Factors**

Individuals at higher than average risk for colorectal cancer have one or more of the following characteristics or behaviors:

**Age:** The risk of developing colorectal cancer (incidence) increases with age in men and women; incidence (expressed as per 100,000 people per year) is six times higher among persons aged 65 years and older than among persons aged 40 to 64 years. More than 70% of newly diagnosed colorectal cancers occur in persons aged 65 years and older.
Gender and Race: At all ages, men are more likely to develop colorectal cancer than women. Between 1991-95, the incidence rate of colorectal cancer was 54.4 per 100,000 among men and 38.2 per 100,000 among women. In this same time period, men were more likely to die from colorectal cancer (21.9 per 100,000) than women (14.9 per 100,000). African Americans have higher colorectal cancer incidence and mortality rates overall than men and women of other racial and ethnic groups (Tables 1 and 3).

Familial Factors: An individual who has an inherited susceptibility syndrome, such as familial adenomatous polyposis or hereditary nonpolyposis colon cancer, with known alterations of cancer susceptibility genes, has a significantly increased risk of developing colorectal cancer.

Personal Factors: A personal history of colon cancer, colorectal adenomatous polyps or long-standing inflammatory bowel disease also increases the likelihood of developing colorectal cancer.

Behavioral Factors: A diet high in animal fats (particularly associated with red meat) is thought to increase the risk for developing colorectal cancer, while a diet high in vegetables, fruits and fiber is considered protective. Obesity has been shown to increase the risk for colon cancer in men.

Participation in regular physical activity may reduce a person’s risk for developing colon cancer. Postmenopausal women who use hormone replacement therapy and men and women who use non-steroidal anti-inflammatory drugs regularly over two decades may have decreased risk for colon cancer and other cancers of the digestive tract. Both high intake of alcohol and use of tobacco products are associated with increased risk of colorectal cancer.

Incidence and Mortality

Nationally, colorectal cancer incidence rates — the number of newly diagnosed cases among both genders and all ethnic groups per 100,000 persons (age-adjusted to the 1970 standard) — have declined in the last 15 years, but trends vary significantly within the various demographic groups. The incidence of colorectal cancer remains among the highest of all cancer incidences. Blacks have higher incidence
rates and higher overall death rates than do the other racial/ethnic groups. For all races combined, the colorectal cancer incidence rate is over 40% higher in men than in women, and increases steadily as individuals age.11

Colorectal cancer incidence data for Texas are only available for 1992, 1995 and 1996. While not sufficient to allow reliable trend analysis, these data show that from 1992 to 1996 the number of new cases diagnosed in one year increased by over 10%. All ethnic groups showed increases in incidence, with new cases among Hispanics up by more than 41% in a period when that population group increased by 16.4% in Texas (Table 1).

Mortality from colorectal cancer in Texas is documented each year and, as shown in Table 2, steadily increased through 1998, the most recent year for which data are available. The number of deaths due to

### Table 2

Deaths Due to Colorectal Cancer in Texas 1989-1998

The number of deaths in Texas due to colon and rectal cancer has increased over 20%, from 2,725 in 1989 to 3,276 in 1998.

<table>
<thead>
<tr>
<th>Year</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>2,725</td>
</tr>
<tr>
<td>1990</td>
<td>2,815</td>
</tr>
<tr>
<td>1991</td>
<td>2,920</td>
</tr>
<tr>
<td>1992</td>
<td>3,012</td>
</tr>
<tr>
<td>1993</td>
<td>3,081</td>
</tr>
<tr>
<td>1994</td>
<td>3,096</td>
</tr>
<tr>
<td>1995</td>
<td>3,134</td>
</tr>
<tr>
<td>1996</td>
<td>3,218</td>
</tr>
<tr>
<td>1997</td>
<td>3,235</td>
</tr>
<tr>
<td>1998</td>
<td>3,276</td>
</tr>
</tbody>
</table>

SOURCE: Texas Cancer Data Center, 2000
colon and rectal cancers increased by over 20% in the ten years from 1989 through 1998. Both male and female African Americans had significantly higher mortality compared with Caucasians or Hispanics (Table 3).

By and large, Texas counties with the highest mortality rates for colorectal cancers for all ethnic groups contain, or are adjacent to, major metropolitan areas (Appendix A). Data reviewed were aggregated for 1990 through 1997. This “urban effect” has also been previously documented.12

Prevention and Screening Guidelines

Changes in diet (increased intake of vegetables and other sources of fiber and decreased intake of red meat and alcohol), increased physical activity and screening for colorectal cancer or adenomatous polyps may have played a role in more recently observed declines in incidence and death rates, suggesting the potential for increased benefits in the future.13 The U.S. Preventive Services Task Force, the American Cancer Society and the Interdisciplinary Task Force established new screening guidelines for colorectal cancer that were published in the mid-1990s. The American Cancer Society guidelines currently recommend that individuals age 50 and older at average risk have:

- Annual fecal occult blood test and flexible sigmoidoscopy every five years; OR
- Colonoscopy every ten years; OR
- Double-contrast barium enema every five to ten years. (More recent data suggest that the double-contrast barium enema may not have the necessary sensitivity to be used in the routine screening of average-risk individuals.)14

Individuals at moderate or high risk should consult with their physicians to have earlier or more frequent screenings as part of an approved management plan. Table 4 outlines the ACS guidelines in more detail.

Current Knowledge, Attitudes and Practices

Accurate assessment of the current level of understanding of colorectal cancer risk, individuals’ willingness to obtain screening and how physicians offer and promote screening to their patients is crucial to determining effective ways to reduce incidence and mortality in Texas. While more comprehensive research is needed to establish these baselines, some data are available and of interest.

Public

Although as many as 80% of colorectal cancers are diagnosed in individuals whose risk for the disease was deemed average, fewer than 35% of the Texas population surveyed by the Texas Department of Health reported ever having had a colorectal cancer screening test beyond the simple digital rectal exam (Table 5). Vernon’s comprehensive review15 of published literature on adherence to colorectal cancer screening by fecal occult blood test and flexible sigmoidoscopy documents the reasons given most fre-
quently for nonparticipation, including practicality (scheduling conflicts, inconvenience, lack of interest, cost), not having signs or symptoms of colorectal cancer, embarrassment or concerns about discomfort and not wanting to know the results. Committee discussions identified barriers to screening as lack of understanding both of the procedures used and of quality standards for them, low interest and perception of risk, lack of awareness of family incidence and inadequate promotion by physicians. Perceived barriers to diagnosis and treatment were believed to include economic limitations, cultural aversion to showing one’s body, lack of knowledge about colorectal cancer, fear, denial, fatalism, bureaucracy and hardship on the family.

**Department of Health**

In 1999 the Texas Department of Health surveyed the healthcare providers under contract for breast and cervical cancer screening — usually community or county clinics within the 11 public health regions in the state — about their provision of colorectal cancer screening services. While clinic medical directors have latitude to implement new programs, the determining factor is almost entirely the availability of funding. Of 27 respondents to the survey, 11 reported that they do provide screening for colorectal cancer and eight more plan to initiate such a program. Six indicated that their client populations have expressed interest in this service.

**Primary Care Physicians**

A statewide survey of primary care physicians sponsored jointly by the Texas Medical Association, the American Cancer Society, Texas Division, and the Texas Cancer Council has yielded preliminary findings about their knowledge and perceptions regarding colorectal cancer screening. Most respondents reported that they believe this cancer is largely preventable and that available screening procedures are at least somewhat effective in reducing mortality among average-risk, asymptomatic individuals age 50 or over (except colonoscopy, which the great majority agree is “very effective”). Most of the first-wave respondents say they either recommend, perform themselves or order either FOBTs or flexible sigmoidoscopies for such individuals. Physicians perceived the most serious patient barriers to FOBT to be the time and trouble the test takes, embarrassment or that it was not recommended by a physician; top barriers to sigmoidoscopy were believed to be embarrassment, the time and trouble and the cost. The most serious physician barriers to recommending FOBTs to their patients were reported as poor patient compliance and the questionable efficacy of the test, while for sigmoidoscopy they were lack of training or equipment, expense and poor patient compliance. (Appendix B includes the survey instrument and an analysis of preliminary results. Final results are expected by the end of August 2000.)

### Table 3

<table>
<thead>
<tr>
<th>Colon and Rectal Cancer Death Rates* in Texas, 1998</th>
<th>Caucasians</th>
<th>African Americans</th>
<th>Hispanics</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>16.00</td>
<td>28.44</td>
<td>13.97</td>
<td>16.70</td>
</tr>
<tr>
<td>Female</td>
<td>11.52</td>
<td>18.01</td>
<td>7.03</td>
<td>11.37</td>
</tr>
<tr>
<td>Rectal Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2.86</td>
<td>5.27</td>
<td>3.27</td>
<td>3.14</td>
</tr>
<tr>
<td>Female</td>
<td>2.13</td>
<td>3.55</td>
<td>1.30</td>
<td>2.10</td>
</tr>
</tbody>
</table>

* per 100,000 population

SOURCE: Texas Cancer Registry
Table 4

ACS Guidelines for Screening and Surveillance for Early Detection of Colorectal Polyps and Cancer*

<table>
<thead>
<tr>
<th>Average Risk</th>
<th>Recommendation</th>
<th>Age to Begin</th>
<th>Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>All people 50 years or older who are not in the categories below</td>
<td>One of the following: FOBT plus flexible sigmoidoscopy or TCE</td>
<td>Age 50</td>
<td>FOBT every year and flexible sigmoidoscopy every 5 years; colonoscopy every 5 years or DCBE every 5-10 years</td>
</tr>
<tr>
<td>Moderate Risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People with single, small (&lt;1 cm) adenomatous polyps</td>
<td>Colonoscopy</td>
<td>At time of initial polyp diagnosis</td>
<td>TCE within 3 years after initial polyp removal; if normal, as per average risk recommendations (above)</td>
</tr>
<tr>
<td>People with large (≥ 1 cm) or multiple adenomatous polyps of any size</td>
<td>Colonoscopy</td>
<td>At time of initial polyp diagnosis</td>
<td>TCE within 3 years after initial polyp removal; if normal, TCE every 5 years</td>
</tr>
<tr>
<td>Personal history of curative-intent resection of colorectal cancer</td>
<td>TCE</td>
<td>Within 1 year after resection</td>
<td>If normal, TCE in 3 years; if still normal, TCE every 5 years</td>
</tr>
<tr>
<td>Colorectal cancer or adenomatous polyps in 1° degree relative younger than age 60, or in 2° or more 1° degree relatives of any age</td>
<td>TCE</td>
<td>Age 40 or 10 years before the youngest case in the family, whichever is earlier</td>
<td>Every 5 years</td>
</tr>
<tr>
<td>Colorectal cancer in other relatives (not included above)</td>
<td>As per average risk recommendations (above); may consider beginning screening before age 50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family history of familial adenomatous polyposis</td>
<td>Early surveillance with endoscopy, counseling to consider genetic testing and referral to a specialty center</td>
<td>Puberty</td>
<td>If genetic test positive, or polyposis confirmed, consider colectomy; otherwise, endoscopy every 1-2 years</td>
</tr>
<tr>
<td>Family history of hereditary non-polyposis colon cancer</td>
<td>Colonoscopy and counseling to consider genetic testing</td>
<td>Age 21</td>
<td>If genetic test positive, or if patient has not had genetic testing, colonoscopy every 2 years until age 40, then every year.</td>
</tr>
<tr>
<td>Inflammatory bowel disease</td>
<td>Colonoscopies with biopsies for dysplasia</td>
<td>8 years after the start of pancolitis; 12-15 years after the start of left-sided colitis</td>
<td>Every 1-2 years</td>
</tr>
</tbody>
</table>

* Approximately 70-80% of cases are from average-risk individuals; approximately 15-20% are from moderate-risk individuals; and 5-10% are from high-risk individuals.
1 Digital rectal examination should be done at the time of each sigmoidoscopy, colonoscopy or double-contrast barium enema.
2 Annual FOBT has been shown to reduce mortality from colorectal cancer, so this is preferable to no screening. However, the ACS recommends that annual FOBT be accompanied by flexible sigmoidoscopy to further reduce the risk of colorectal cancer mortality.
3 TCE includes either colonoscopy or DCBE. The choice of procedure should depend on the medical status of the patient and the relative quality of the medical examinations available in a specific community. Flexible sigmoidoscopy should be performed in those instances in which the rectosigmoid colon is not well visualized by DCBE. DCBE would be performed when the entire colon has not been adequately evaluated by colonoscopy.
4 This assumes that a perioperative TCE was done.
SOURCE: The American Cancer Society 15
Access to and Availability of Services

While major urban areas in Texas are not lacking in treatment facilities, patients in outlying areas must travel, sometimes extensively, to access them. Quality of technology can be variable, and support services, such as ostomy management, nutritional counseling and skin care, are at times unavailable in more rural parts of the state, not only due to fewer resources but also because they are not recognized as a defined need.

Patients who are uninsured or, for other reasons, seek care through county hospital systems can face long waits, and often they are then referred to university medical centers. County hospitals can be inflexible in restricting access based on residency, and access can be more difficult if a clear diagnosis has not been made.

Fragmentation of care can result when clinic providers treat health complaints only on an as-needed basis, and the number of people who receive their medical care this way is increasing. Statewide, access for uninsured individuals to screening services is especially limited, and there is often a lack of follow-up of positive FOBTs by colonoscopy. Patients with fewer financial resources often have a variety of logistical issues that can also reduce their access to treatment.

Advanced colorectal cancer patients often need a whole spectrum of services as their cancer progresses, including more active and urgent palliative care. There are approximately 230 hospices in Texas, and while most of them can provide a nurse or social worker, they may not be able to deliver injectable medications to a patient who, for example, is unable to swallow, especially in areas remote from major cancer centers.

Financial and Policy Issues

Costs and Cost-Effectiveness: At less than $10, FOBT is the least expensive colorectal cancer screening method; however, although it is the only intervention that has been proven by randomized controlled trials to reduce mortality, it is less sensitive and specific in detecting adenomas than methods that visualize the mucosa directly. Flexible sigmoidoscopy costs about $200, while colonoscopy, the most comprehensive and accurate test now available, can range from $900 (reported in Dallas and Houston)
to as much as $1,500.\textsuperscript{17} Although two recently published studies strengthen the evidence that colonoscopy can detect cancer and precancerous lesions that cannot be found with sigmoidoscopy,\textsuperscript{18, 19} and the National Cancer Institute is piloting randomized trials in four centers in the United States,\textsuperscript{20} significant questions remain about the feasibility of implementing widespread colonoscopy for screening purposes.

Cost-effectiveness is a multi-faceted indicator that requires assessment of diverse factors over several years — a fact that places it outside the usual time frame of annual budgeting. Brown and Knopf reviewed a number of cost-effectiveness analysis models, developed to evaluate colorectal cancer screening, that incorporated information or estimates about the following five types of model parameters:

1. the epidemiology of population screening, including cancer-specific epidemiology;
2. the natural history of the disease process;
3. performance characteristics, e.g., sensitivity and specificity of tests used for screening;
4. characteristics of the screening program; and
5. the economic cost of services and procedures associated with the screening program, as well as services and procedures associated with disease detection and treatment in the absence of screening.

They concluded that “in general, screening for colorectal cancer appears to be favorably cost effective … estimates also compare favorably to those for mammography screening.”\textsuperscript{21}

Vernon pointed out that existing analyses of the cost-effectiveness of different colorectal cancer screening procedures identify compliance as a determining factor in the equation. For FOBT alone to be the most cost-effective method, compliance must be 80% to equal the mortality reduction achieved with one-time colonoscopy at 50% compliance or with annual FOBT plus periodic sigmoidoscopy at 60% compliance. If compliance with annual FOBT is less than 50%, it is no longer cost-effective compared with annual FOBT plus periodic sigmoidoscopy or even with one-time colonoscopy.\textsuperscript{22}

**Reimbursement:** Medicare only began covering colorectal cancer screening for average-risk individuals in 1998. By congressional law, Medicare is directed to pay for FOBT annually and flexible sigmoidoscopy every four years for those at average risk, when ordered by the attending physician. Medicare covers screening colonoscopy once every two years for high-risk patients only. Barium enema may be covered as an alternative to colonoscopy under special circumstances, as determined by the physician.

Reimbursement rates under Medicare and private insurance plans (HMOs and traditional indemnity) vary by type of provider and location within the state, but are almost universally less than the actual charges for colorectal screening tests. While statewide comparison data are not available, Medicare’s reimbursement rates can be less than 30% of the usual fees charged; in no case were reimbursements found to be as high as 50%.

Medicaid legislation authorizes, but does not require, the states to cover colorectal cancer screening under their
respective programs. Some states cover the procedures in the context of diagnosis but not as screening. Texas’ Medicaid plan reimburses FOBT, flexible sigmoidoscopy and colonoscopy in varying amounts, depending on the context of each medical case, but at rates that are well below half the usual charges for these procedures.

Commercial health plan providers express interest in positive outcomes as well as concern for financial impacts, but they often see long-term prevention programs as a cost that may not “pay off” until far into the future, if at all — a perspective that influences their willingness to cover screening procedures. Physicians and facilities providing these services when they are not fully reimbursed must either absorb the uncovered costs or pass them back to their patients. These facts may diminish the frequency and enthusiasm with which colorectal cancer screening is recommended to constituents.

The presence and type of health insurance has been statistically associated with stage at diagnosis, significantly increasing the odds that patients who are uninsured or insured by Medicaid will not have a diagnosis of their colorectal cancer until it is in a late stage. In addition to screening, the reimbursement structure defines how treatment and supportive services for cancer patients are delivered, both by government programs and by negotiated health plans. Coverage is often limited or not provided at all for symptom control, pain management, treatment for depression and other related needs, as well as for hospice services. Patients who have advanced disease and are near the end of life sometimes must go to acute care facilities or nursing homes when a hospice would be more appropriate to their needs, and more cost-effective.

Policy Issues: The impact of the change in Medicare policy to reimburse for colorectal cancer screening is being tracked by the American College of Gastroenterology Colorectal Cancer Screening Registry, which has documented an increase in colorectal cancer screening and subsequent cancer detection among asymptomatic patients with no prior history of colorectal neoplasia. It would be highly desirable if a legislative mandate for colorectal cancer screening, similar to the one now in place for mammography, received broad support in Texas. Such a requirement has been enacted by the Commonwealth of Virginia, effective July 1, 2000, and stipulates that health insurers, HMOs, corporations providing health-care coverage subscription contracts, their state employees’ health insurance program and the Virginia Medicaid program provide coverage for colorectal cancer screening in accordance with the most recently published recommendations established by the American College of Gastroenterology in consultation with the American Cancer Society. Further, it explicitly states that the coverage cannot be more restrictive than, or separate from, coverage provided for any other illness, condition or disorder. Over the long term, colorectal cancer screening may reduce costs attributable to the care of patients with advanced colorectal cancer, but at present the full financial impact of such a mandate is not known.

Managed care plan providers also amass great amounts of data about utilization patterns and outcomes that would be valuable in improving care and prevention. Incorporating colorectal cancer screening into the Health Plan Employer Data and Information Set List of Measures as an assessment criterion for managed care organizations could serve as a powerful implementation incentive. HEDIS, utilized by the National Committee for Quality Assurance in its accreditation process, provides assessment criteria for Medicaid, Medicare and commercial health plans in effectiveness of care, access/availability of care, use of services, satisfaction with the experience of care and cost. Although voluntary, the program is widely
regarded as an objective measure of health plan quality. Screening for breast and cervical cancers is among the measures now in place, and inclusion of colorectal cancer screening has been suggested as a way to influence health plans to begin or increase such coverage.

Cancer patients in the current healthcare reality are sent home from the hospital earlier and sicker, and family members are not as available as in the past to assume caregiving responsibilities at home. Moreover, Medicare has cut back dramatically on reimbursements for home care services, and in recent years a large percentage of home health agencies have gone out of business. Medicaid is only available to the extremely poor, with communities left to find the resources to care for those who are not eligible and have no insurance. Texas is among the twelve states whose combined federal and state Medicaid funding is lowest — in 1996 (when the most recent analysis was done), Texas Medicaid recipients overall received only 80% of the amount spent on average nationally; Texas beneficiaries aged 65 or older received only 72% of the national average.26

Health policy at the state level is thought by many to be the arena where the most knowledgeable, insightful and, in the end, visionary progress can be made to reduce colorectal cancer incidence and deaths.
Current Resources
Current Resources

A number of resources are in place and available to Texans for colorectal cancer information, prevention and treatment services and support. The following organizations and activities either were established for the express purpose of serving Texans or sponsor special initiatives within the state.

The Texas Cancer Council

Created by the Texas Legislature in 1985, the Texas Cancer Council is the state agency dedicated to reducing the human and economic impact of cancer on Texans through the promotion and support of collaborative, innovative and effective programs and policies for cancer prevention and control. Its Texas Cancer Plan serves as a comprehensive, statewide blueprint for meeting the growing challenge of cancer control among all sectors of the state — public, private and volunteer — and represents a broad consensus about ways to address the priority issues of prevention, early detection and treatment. The Council promotes implementation of the Plan both by direct intervention and by funding cancer control projects.

The Council is an “initiatives agency” that provides state funds as “seed” money to stimulate critically needed cancer services around the state. Council projects focus on public and professional education, early detection, information and referral and access to care and quality of life.

In addition to funding the formulation of this Action Plan on Colorectal Cancer for the State of Texas, the Council funds the Texas Cancer Data Center, the Physician Oncology Education Program (POEP) and the Nurse Oncology Education Program (NOEP) on an ongoing basis, as well as special projects in West Texas and El Paso that promote awareness and early detection of colon cancer for selected underserved populations.

Contact: Texas Cancer Council
P.O. Box 12097, Austin, TX 78711-2097
(512) 463-3190  (512) 475-2563 (fax)
www.texascancercouncil.org
The American Cancer Society, Texas Division

The American Cancer Society is the nationwide community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives and diminishing suffering from cancer through research, education, advocacy and service. ACS consists of a National Society, chartered divisions throughout the country and over 3,400 local units, governed by volunteer members from both the medical and lay sectors. The Texas Division office is located in Austin and local units in more than 20 communities serve the state’s population.

Recognizing colorectal cancer as a priority in ACS goal-setting for 2015, the Texas Division established a special Colorectal Cancer Committee in 1999 under the leadership of Andre E. Avots-Avotins, M.D., Ph.D. Several members of this group also participated in the formulation of the Texas Cancer Council Action Plan on Colorectal Cancer for Texas, and the recommendations resulting from both these strategic initiatives coincide notably (Appendix C). The division also serves as a distribution point for elements of the ACS’s national colorectal cancer awareness campaign that was launched in June 2000.

Contact: The American Cancer Society, Texas Division, Inc.
1-800-ACS-2345
www.acs-tx.org

The Cancer Information Service

The Cancer Information Service was established in 1975 by the National Cancer Institute to meet the information needs of cancer patients, their families, health professionals and the public. CIS’s main program components include a toll-free telephone service (1-800-4-CANCER) and an outreach program that focuses on providing technical assistance to partners reaching minority and underserved audiences. Calls from residents of Texas are switched to the CIS regional office located at the University of Texas M. D. Anderson Cancer Center in Houston, where they are answered rapidly, responsively and confidentially. CIS answers calls in English and Spanish and for the deaf with TTY capability.

Through CIS, the National Cancer Institute provides comprehensive information both to the lay public and to health professionals about colorectal cancer prevention and detection. In 1999 the Houston regional office documented that only 7% of all calls received from individuals over age 50 were about colorectal cancer; of those, 90% were from diagnosed cancer patients or their spouses, relatives or friends.

Contact: The Cancer Information Service
1-800-4-CANCER
cis.nci.nih.gov
The Texas Cancer Data Center

The Texas Cancer Data Center provides information on health professionals, health facilities, demographics and statistics and community resources in the state via the Internet at no charge. Funded by the Texas Cancer Council, TCDC databases can be used by Texans to find resources related to different phases of cancer care and to answer questions they may have about cancer.

Contact: The Texas Cancer Data Center
(713) 792-2277
www.txcancer.org

The Cancer Gateway of Texas

The Cancer Gateway of Texas provides state residents convenient and organized access to cancer-related resources, publications and information available on the Internet that meet the criteria developed by the Texas Cancer Data Center staff and Advisory Committee. Internet websites that are selected are organized into categories by cancer type, including colon and rectum, and by topic area, such as prevention, treatment and support.

Links accessible through the Gateway include but are not limited to Texas-based sites; they include national organizations and unique agencies and groups that feature credible information on rare cancers or general cancer-related issues that may be beneficial to Texans.

Contact: The Cancer Gateway of Texas
www.cancergateway.org

The Texas Department of Health

In 1994 the Texas Department of Health became the first state agency in the nation to pilot Put Prevention Into Practice, a national, research-based public-private program to increase the appropriate use of clinical preventive services (e.g., screening, immunizations and counseling). TDH is currently the only state agency with hands-on experience in the actual implementation of the PPIP strategy. PPIP supports cancer risk assessment and screening for major cancers, including colorectal, and offers education about them. Services are offered through TDH’s regional clinics, local health departments, community health centers and family practice residency training programs.

The passage of the Texas Cancer Control Act in 1979 established cancer as a reportable disease in Texas. Amended in 1989, the law requires cancer incidence reporting by all hospitals, clinical laboratories and cancer treatment centers in Texas. The Texas Cancer Registry collects, analyzes and disseminates these data. TCR data are used by health researchers, policy planners and private citizens interested in cancer control issues, including the evaluation of cancer prevention and control activities.
Current Resources

and assessment of need and location of healthcare delivery systems. TCR data lead to improved care for cancer patients by providing hospitals with statistical information that may be used in case management, treatment evaluation and resource planning.

The Texas Behavioral Risk Factor Surveillance System, initiated in 1987, is a federally funded ongoing telephone survey of randomly selected adult Texans designed to collect data on lifestyle risk factors contributing to the leading causes of death and chronic diseases. Sample sizes for Texas were increased in the 1999 survey from 1,500 to 5,000. Rotating core questions relating to colorectal cancer screening were included in 1995, 1997 and 1999, and the 2001 survey will be redesigned to expand on the data collected in this area. Because the BRFSS is nationwide, comparisons can be made between Texas and other states and between Texas and the national average.

The Comprehensive Cancer Control Program is funded by the national Centers for Disease Prevention and Control and is collaboratively administered with the Texas Cancer Council. The goals of the program are to 1) improve and expand collaborative efforts already in place among the different groups working in cancer control in Texas; 2) increase the use of the Texas Cancer Plan as the statewide document directing cancer control efforts; 3) develop a process for prioritizing the Texas Cancer Plan; and 4) disseminate information available to local communities and provide technical assistance to communities working on local cancer control efforts.

Contact: Texas Department of Health
1100 West 49th St., Austin, TX 78756-3199
(512) 458-7111
www.tdh.texas.gov

The University of Texas M. D. Anderson Cancer Center

One of two NCI-designated comprehensive cancer centers in the state, U. T. M. D. Anderson Cancer Center focuses exclusively on patient care, research, education and prevention of cancer. Services for outpatients include the innovative multidisciplinary care centers that first opened in 1996. The Gastrointestinal Center provides specialized care for (among others) bowel, colon, rectal and anal cancers by a team of experts who collaborate to provide a tailored treatment plan to each individual patient.

Contact: U.T. M. D. Anderson Cancer Center
1515 Holcombe Boulevard, Houston, Texas 77030
Information Line: 1-800-392-1611
www.mdanderson.org
Cancer Care Facilities

The Texas Cancer Data Center offers information on 71 hospitals in the state that have cancer programs approved by the American College of Surgeons. In addition, they list 36 free-standing cancer centers. The two Texas institutions designated by the National Cancer Institute as comprehensive cancer centers are The University of Texas M. D. Anderson Cancer Center in Houston and the San Antonio Cancer Institute.

Physician Specialists

Table 6 shows the number of physicians practicing in each of Texas’ 11 public health regions who specialize in the diagnosis and/or treatment of colorectal cancer, according to the State Board of Medical Examiners (January 2000). The relevant specialties include gastroenterology, colon and rectal surgery, oncology and therapeutic radiology.

Table 6

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<tr>
<th>Public Health Region</th>
<th>Gastroenterologists</th>
<th>Colon &amp; Rectal Surgeons</th>
<th>Oncologists</th>
<th>Therapeutic Radiologists</th>
<th>Total # Specialists</th>
<th>Ratio to PHR Population 50+</th>
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</table>

SOURCE: Texas Cancer Data Center, 2000
SOURCE OF MAP: Texas Department of Health, 1995
Non-Physician Healthcare Professionals

Nurses, nurse practitioners, physician assistants and other “physician extenders” are professionally qualified, with appropriate education and training, to provide cancer prevention counseling and instruction on proper use of FOBT, as well as to perform flexible sigmoidoscopy.

Physician Oncology Education Program

The POEP was established by the Texas Medical Association in 1987 and is funded by the Texas Cancer Council to provide Texas physicians and those in training to become physicians with the knowledge and skills necessary to reduce cancer morbidity and mortality through collaboration among the public, private and volunteer sectors of the state. Among the educational materials offered for purchase are a colorectal cancer module featuring 35mm slides and a book and a colorectal cancer section in the Cancer in Special Populations module. Colorectal cancer is also covered in several books published under the auspices of POEP that address recommended core curriculum objectives and the health professional's role in cancer screening. The POEP Speakers' Bureau topic list includes colorectal cancer and provides experts to speak at no charge to requesting institutions.

Contact: Physician Oncology Education Program
401 West 15th Street, Austin, TX 78701-1680
(512) 370-1672 (in Austin) 1-800-880-1300, Ext. 1672
www.poep.org

Nurse Oncology Education Program

The NOEP is a statewide cancer education project of the Texas Nurses Foundation, with funding provided by the Texas Cancer Council. In its efforts to educate all nurses in all practice settings about cancer, early detection and treatment, NOEP presents continuing nursing education workshops throughout the state on a variety of cancer-related topics, including colorectal cancer. Opportunities are also available to earn Continuing Nursing Education credit through online self-study, and NOEP offers books, videos and presentations on a variety of topics in cancer prevention, detection, treatment and rehabilitation.

Contact: Nurse Oncology Education Program
7600 Burnet Rd., Suite 440, Austin, TX 78757
(512) 467-2803 (in Austin) 1-800-515-6770
www.texasnurses.org/foundation/noep
National Colorectal Cancer Awareness Month

In 1999, Congress designated March to be National Colorectal Cancer Awareness Month. The Center for Disease Control and Prevention, the American Cancer Society, the American Gastroenterological Association, National Colorectal Cancer Roundtable (NCCRT) and others produced broadcast messages and print materials, special events and promotional efforts to raise public awareness about risk factors and prevention strategies. NBC Today Show co-anchor Katie Couric collaborated with cancer fundraiser Lilly Tartikoff and the Entertainment Industry Foundation to establish the National Colorectal Cancer Research Alliance, not only to advance research but also to increase public knowledge and action on preventive testing. Dr. Levin serves as a member of the Medical Advisory Board for the NCCRA and as chair of the National Colorectal Cancer Roundtable (NCCRT).

The University of Texas M. D. Anderson Cancer Center took a leadership role through national, regional and local media events and the creation of special broadcast and print messages to encourage colorectal cancer awareness and prevention.

Contact: 1-877-35-COLON
www.preventcancer.org/colorectal.htm
Recommendations
Goal 1: **Increase public awareness of, and demand for, colorectal cancer screening services.**

- Increase to 80% the proportion of the Texas population who are aware that colorectal cancer screening can detect polyps, that removal of polyps can prevent colorectal cancer and that colorectal cancer is curable if detected early.

- Design and launch public awareness initiatives emphasizing risk factors and the importance of screening even in the absence of symptoms, what screening entails and why compliance over the long term is recommended.

- Tailor messages to appeal to the interests and values of specific audiences and utilize a variety of communication methods and venues with demonstrated success in reaching those audiences.

- Feature open discussion by public figures, optimally associated with Texas, to increase the comfort level of those who might be embarrassed or fearful.

- Forge working relationships with existing, highly credible community-based organizations, including churches, neighborhood centers and social clubs, to provide cancer information and support to their members and participants through educational forums, health fairs and “cancer ministries” (example, Appendix D).

- Schedule special concentration of the above-mentioned activities each March, during National Colorectal Awareness Month, and April, during National Minority Cancer Awareness Month.
Goal 2:  
**Increase availability of colorectal cancer prevention, screening and detection information and services.**

- Collaborate with cancer information and education groups to examine existing materials for cultural sensitivity and relevance, identify gaps, develop new materials if needed, disseminate information and evaluate effectiveness.

- Convene key policy-makers in the public and private sectors, decision-makers in the insurance and healthcare industries and corporate executives to increase their knowledge about the benefits of colorectal cancer screening and secure their commitment to include coverage for it in employee health plans.

- Incorporate colorectal cancer screening into regular annual physical examinations for individuals age 50 or older, or earlier for those at greater than average risk, as a covered insurance benefit.

- Advocate increasing reimbursement for colorectal cancer screening services from Medicare, Medicaid and insurance plans to adequate levels to eliminate the current disincentive for healthcare providers to recommend them to their patients.

- Institute colorectal cancer screening criteria into the Health Plan Employer Data and Information Set (HEDIS) List of Measures, established by the National Committee for Quality Assurance.

- Distribute services on a regional basis within the state to increase their accessibility and coordination beyond what has been possible through the municipal or county framework.

Goal 3:  
**Increase access to and use of diagnostic services and appropriate treatment and follow-up.**

- Increase the number of Texas practitioners utilizing state-of-the-science treatments for colorectal cancer, including endoscopy, surgery and adjuvant treatments, as measured by baseline and post-intervention treatment procedure reports from institutions and private practice sites across the state.

- Establish a comprehensive and quickly accessible information source, such as an interactive website or telephone “hotline,” for healthcare providers relating to colorectal diagnosis, treatment, rehabilitation and after-treatment follow-up.

- Identify educational messages and methods for educating the public, colorectal cancer patients and their families about the concept of “continuum of care,” including appropriate diagnostic services, treatment and rehabilitation, nutrition counseling and other supportive services, effective symptom control, palliative care when needed and relevant survivorship issues.

- Assist health plans in implementing guidelines for positive survivorship.
Goal 4: Enhance healthcare professionals’ knowledge, skills and practices in colorectal cancer prevention, diagnosis, treatment, rehabilitation and support.

- Add colorectal cancer screening to medical, nursing, residency and applied health curricula.

- Increase the number and scope of colorectal cancer educational programs offered by the POEP, NOEP, Oncology Nursing Society and other organizations that are targeted to family practice, internal medicine and ob-gyn physicians, residents and nurse practitioners.

- Redesign educational program content to make it more relevant to today’s healthcare environment, including current information on obtaining the maximum legitimate reimbursement for colorectal cancer screening services and the benefits of screening as sound medical practice management and possible litigation avoidance.

- Develop and disseminate “state-of-the-science” communiqués to keep physicians and other healthcare providers up to date on the prevention or early detection of colorectal cancer.

- Train nurses in ostomy and bowel management skills and collaborate with the Nurse Oncology Education Program, the Oncology Nursing Society and other professional nursing organizations to promote them.

- Train pharmacists and pharmacy students in bowel control and pain management pharmacology.

- Review current professional education materials regarding treatment options, including efficacy, side effects and quality-of-life post-treatment, for colorectal cancer and its precursors. Collaborate with the American Cancer Society and other professional organizations to identify informational gaps, develop new materials if needed, disseminate information and evaluate effectiveness.

- Provide valued recognition for training in colorectal cancer services, such as certification and continuing medical education credit.

- Assess primary providers’ knowledge and practices regarding patient referral to, and appropriate use of, treatment, supportive services and follow-up care of colorectal cancer survivors, including appropriate use of hospice, and design educational interventions accordingly using a variety of modalities.
Goal 5:  
**Conduct research and collect relevant data to facilitate the achievement of these goals.**

- Utilize the findings of the Texas Medical Association survey on primary care physician knowledge, attitudes and practices regarding colorectal cancer screening to increase the number of physicians that promote screening to their patients. Identify current baselines for desired behaviors and set quantified goals for improvement within specific timeframes.

- Collaborate with the Department of Health to improve the usefulness of data obtained through the Behavioral Risk Factor Surveillance System, through contracted special surveys, expansion of the sample size and enhancement of questions asked about colorectal cancer screening.

- Survey members of the public, with special focus on those at increased risk for colorectal cancer, on their awareness, attitudes and practices relating to colorectal cancer prevention and screening. Collect and analyze data to determine the influence of race/ethnicity, location (notably, urban vs. rural areas), socioeconomics, gender and previous cancer diagnosis. Identify current baselines for desired behaviors and set quantified goals for improvement within specific timeframes.

- Pilot-test public awareness strategies and a screening intervention in a representative community to confirm what works most successfully and extend the results throughout the state.

- Assess Texas’ present capacity for and distribution of screening and treatment services, especially to the uninsured and underserved.

- Define and analyze the cost-effectiveness of colorectal cancer screening in Texas.
Conclusion
The Steering Committee took a long-range approach in identifying the pivotal issues relating to the impact that colorectal cancer has on the State of Texas and in forming its recommendations on how to reduce that impact. It is understood that the initiatives put forward in this document often call for fundamental system changes in the areas of professional education, health policy and services distribution that will require an inspired collaborative effort to achieve, and are not likely to produce measurable results in the immediate term. But the need for action has been felt not only in Texas, but in many other states and also at the national level, and the potential is strong for productive synergy. Implementation of even some of the recommendations herein on a pilot basis will lay the foundation for significant progress in the future.

We thank the Texas Cancer Council for giving us the opportunity to participate.
References
References


2. Texas Cancer Data Center.


20 Winawer.


22 Vernon.


25 Reuters Health Information. “Medicare Funding Increases Colorectal Cancer Screening and Detection.” Reuters Medical News (October 19, 1999).

Appendices
Appendix A

Top Counties for Colorectal Cancer Mortality by Race/Ethnicity 1990-1997

Average annual rates are per 100,000, age-adjusted to the 1970 U.S. standard. Counties with fewer than 25 deaths were excluded.
Source: Texas Cancer Registry
## Top Counties for Colorectal Cancer Mortality Rates*
### 1990-1997, for Each Race and Gender

<table>
<thead>
<tr>
<th>All Races</th>
<th>Anglos</th>
<th>African Americans</th>
<th>Hispanics</th>
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<td>Male</td>
<td>Female</td>
<td>Male</td>
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<td>Bastrop*</td>
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</table>

* Designated urban counties
★ Average annual rates per 100,000, age-adjusted to the 1970 U.S. standard. Counties with fewer than 25 deaths were excluded.

SOURCE: Texas Cancer Registry
### Colorectal Cancer Mortality Rates, 1990-1997

#### Urban/Rural Counties

<table>
<thead>
<tr>
<th>Rural Counties</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
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<td># Deaths</td>
<td>Rate(^2)</td>
<td># Deaths</td>
<td>Rate(^2)</td>
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<td>Other</td>
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### Metropolitan Counties of Texas
58 of Total 254 Counties

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</table>

\(^1\) See list below of designated urban counties
\(^2\) Rates are per 100,000 and age-adjusted to the 1970 U.S. standard.

SOURCE: Texas Cancer Registry
Appendix B

Texas Medical Association Cancer Screening Survey

Practice Characteristics
1. Approximately how many patients do you see in a typical day?
   - 5-10
   - 11-15
   - 16-20
   - 21-25
   - 26-30
   - ≥31

2. Approximately how many minutes do you spend with each patient?
   - 1-5
   - 6-10
   - 11-15
   - 16-20
   - 21-25
   - ≥26

3. Are you currently affiliated with a medical school, residency training or fellowship program?  YES  NO

4. Did you receive training in flexible sigmoidoscopy:
   a. During residency?  YES  NO
   b. Post-residency?  YES  NO

Cancer Screening Practices
5. Do you believe that colorectal cancer is a preventable disease?  YES  NO

6. Please indicate whether or not you think the following tests are effective in reducing cancer mortality for average risk, asymptomatic individuals over the age of 50.

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<th>Test</th>
<th>Very Effective</th>
<th>Somewhat Effective</th>
<th>Not Effective</th>
<th>Not Sure</th>
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<tr>
<td>Digital Rectal Exam for prostate cancer</td>
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<tr>
<td>Fecal Occult Blood Test – 3-card home test</td>
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<tr>
<td>FOBT—in-office digital rectal exam</td>
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<td>Sigmoidoscopy</td>
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<tr>
<td>Prostate Specific Antigen Test</td>
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7. Do you recommend and/or perform the following cancer screening procedures in your practice?

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<th>Perform/Order</th>
<th>Average Starting Age (yrs)</th>
<th>Interval</th>
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<td>Digital Rectal Exam for colorectal cancer</td>
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<td>Every___yr(s)</td>
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<tr>
<td>Digital Rectal Exam for prostate cancer</td>
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<td>Every___yr(s)</td>
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<td>Mammography</td>
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<td>Every___yr(s)</td>
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<tr>
<td>Prostate Specific Antigen Test</td>
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<td></td>
<td></td>
<td>Every___yr(s)</td>
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</table>

Cancer Screening Guidelines
8. The American Cancer Society (ACS) provides the following recommendation for colorectal cancer screening for average risk individuals:

   “For average risk individuals age 50 and older: (1) an annual fecal occult blood test together with a flexible sigmoidoscopy every 5 years, or (2) a total colon exam, by colonoscopy every 10 years, or by double contrast barium enema every 5-10 years.”

Please indicate your degree of agreement with these recommendations (circle one):

Agree Completely  Neutral  Disagree Completely  Not Familiar
1                  2               3                 4                 5                 6
9. For those screening procedures that you do recommend or perform in your practice, what information are your recommendations based on?

<table>
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<tr>
<th>YES</th>
<th>NO</th>
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<tr>
<td>Your assessment of clinical evidence published in the medical literature.</td>
<td></td>
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<tr>
<td>Your assessment of national screening recommendations and/or guidelines.</td>
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</tr>
<tr>
<td>Your assessment of your own institution’s recommendations and/or guidelines.</td>
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<tr>
<td>Availability of reimbursement by third party payors, including Medicare</td>
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<td>Training in medical school or residency</td>
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<td>Continuing medical education</td>
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<td>Customary practice in community</td>
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<td>Discussions with colleagues</td>
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<td>Advertisements/promotions/media announcements</td>
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**Screening with Fecal Occult Blood Testing (FOBT)**

10. Do you recommend or perform colorectal cancer screening with a 3-day fecal occult blood testing (FOBT) kit to your asymptomatic, average-risk patients?

- [ ] Recommend
- [ ] Perform/Order
- [ ] NO (skip to question #18)

11. Which FOBT method(s) do you recommend and/or order (check all that apply)?

- [ ] At-home card tests
- [ ] In-office digital rectal exams

12. At what age do you recommend patients begin FOBT screening? _______ years

13. At what interval do you recommend FOBT screening? Every _______ yr(s)

14. Is there an average age threshold at which you no longer recommend FOBT screening?

- [ ] YES
- [ ] NO

What is the average termination age? _______ years

15. What do you recommend to your patients as an initial follow-up step to a positive FOBT? (check all that apply)

- [ ] Repeat FOBT
- [ ] Sigmoidoscopy
- [ ] Colonoscopy
- [ ] Double contrast barium enema
- [ ] Other _______

16. Do you conduct the initial follow-up testing to a positive FOBT, or refer the patient to another provider?

- [ ] I conduct
- [ ] Refer to another provider in my practice
- [ ] Refer to another provider outside my practice

17. Of the asymptomatic, average-risk patients to whom you recommend FOBT, please estimate the percentage who actually complete the test: _______ %

18. Do you think any of the following reasons might cause patients to refuse or not comply with a physician’s FOBT recommendation? Please rate each possible reason from 1 (no influence on patient refusal) to 5 (a strong influence on patient refusal).

<table>
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<th>No Influence</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>Strong Influence</th>
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<tr>
<td>a. Cost and/or lack of insurance coverage for test</td>
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<tr>
<td>b. Time and trouble</td>
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<tr>
<td>c. Embarrassment and/or discomfort</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Worried about result</td>
<td></td>
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</tr>
<tr>
<td>e. Patient does not perceive colorectal cancer as a serious health threat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Procedure was not recommended by patient’s physician</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
19. Do you think any of the following reasons keep you or other physicians from recommending, ordering or performing colorectal cancer screening with FOBT? Please rank each possible reason from 1 (no influence on a physician’s decision) to 5 (a strong influence on a physician’s decision).

<table>
<thead>
<tr>
<th>Reason</th>
<th>No Influence</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Strong Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Test is too expensive/ inadequate reimbursement</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>b. Too many false positives</td>
<td></td>
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<td></td>
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<tr>
<td>c. Too many false negatives</td>
<td></td>
<td></td>
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<tr>
<td>d. Too inconvenient for patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Poor patient compliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. The belief that colorectal cancer is not a preventable disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Screening with Sigmoidoscopy

20. Do you personally recommend or perform colorectal cancer screening with flexible sigmoidoscopy (FS) in your practice?
   - Recommend
   - Perform/Order
   - NO (skip to question #29)

21. For asymptomatic, average-risk patients, at what age do you begin recommending or performing FS screening? ________ years

22. At what interval do you recommend/perform FS screening? Every ________ yr(s)

23. Is there an average age threshold at which you no longer recommend/perform FS screening?
   - YES
   - NO
   What is the average termination age? ________ years

24. Do you personally perform flexible sigmoidoscopy, or supervise someone else who performs the procedure?
   - I personally perform
   - I supervise others
   - I recommend the procedure
   - Other

25. What do you recommend to your patients as an initial follow-up step to an abnormal flexible sigmoidoscopy (check all that apply)?
   - Repeat Sigmoidoscopy
   - FOBT
   - Colonoscopy
   - Double contrast barium enema
   - Other

26. Do you conduct the initial follow-up testing to an abnormal sigmoidoscopy exam, or refer the patient to another provider?
   - I conduct
   - I refer to another provider in my practice
   - I refer to another provider outside my practice

27. Approximately how many flexible sigmoidoscopy exams do you recommend/perform each month? ________ exams

28. Of the asymptomatic, average-risk patients to whom you recommend/perform flexible sigmoidoscopy, please estimate the percentage who agree to undergo the procedure: ________ %

29. Do you think any of the following reasons might cause patients to refuse or not comply with a physician’s flexible sigmoidoscopy recommendation? Please rate each possible reason from 1 (no influence on patient refusal) to 5 (a strong influence on patient refusal).

<table>
<thead>
<tr>
<th>Reason</th>
<th>No Influence</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Strong Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Cost/lack of insurance coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Time and trouble</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>c. Embarrassment and/or discomfort</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Worried about result</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Concerns over risks of procedure (Such as perforations)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Patient does not perceive colorectal cancer as a serious threat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Procedure not recommended by patient’s physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
30. Do you think any of the following reasons keep you or other physicians from recommending, ordering or performing colorectal cancer screening with flexible sigmoidoscopy? Please rank each possible reason from 1 (no influence on a physician’s decision) to 5 (a strong influence on a physician’s decision).

<table>
<thead>
<tr>
<th>Reason</th>
<th>No Influence</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Strong Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Too expensive/inadequate reimbursement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Test is not efficacious</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>c. Lack of equipment/facilities for procedure</td>
<td></td>
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<tr>
<td>d. Lack of training in the procedure</td>
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</tr>
<tr>
<td>e. Concerns over risks to the patient (such as perforations)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Poor patient compliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. The belief that colorectal cancer is not a preventable disease</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Other Colorectal Cancer Screening

31. Do you recommend either of the following colorectal cancer screening procedures to your asymptomatic, average-risk patients over the age of 50?

<table>
<thead>
<tr>
<th>Procedure</th>
<th>No Recommend</th>
<th>Perform/Order</th>
<th>Average Starting Age (yrs)</th>
<th>Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td></td>
<td></td>
<td></td>
<td>Every___yr(s)</td>
</tr>
<tr>
<td>Double Contrast Barium Enema</td>
<td></td>
<td></td>
<td></td>
<td>Every___yr(s)</td>
</tr>
</tbody>
</table>

Demographic Information

32. What is your age? _____ years

33. What year did you graduate from medical school? 19______

34. What year did you complete your residency? 19______

35. What is your gender?  □ MALE  □ FEMALE

36. What is your primary specialty? ________________________

37. What is your secondary specialty (if applicable)? __________

38. Do you have a personal or family history of any of the following (check all that apply)?
   □ Colorectal cancer  □ Breast cancer  □ Prostate cancer

Comments

39. What do you feel would be the most worthwhile way to increase physicians’ awareness of colorectal cancer screening?

40. What do you feel would be the most worthwhile way to increase the public’s awareness of colorectal cancer screening?

41. Do you have any final comments? __________________________

A joint project of the TMA Medical Director’s Forum Workgroup on Prevention, The U.T. M.D. Anderson Cancer Center, and the American Cancer Society.

Thank you for your participation!
Texas Medical Association Colorectal Cancer Screening Survey
Summary of Preliminary Results as of 7/15/00

**Overall Sample Size:** 3,014 (2,984 with deliverable addresses)

**Total returned:** 826 (748 data entered to date; approximate 28% initial response rate)

**Number used for preliminary analysis:** 711 (due to missing variables for some questions)

**Mean Age:** 48 (range: 25-85)

**Gender:** 27% Female, 73% Male

**Specialties:**
- Family Practice (FP) 46%
- Internal Medicine (IM) 25%
- Gynecology (OB/GYN) 14%
- Other 15%

Colorectal Cancer Screening Practices by Primary Care Providers in Texas
Self-Reported Practice of CRC Screening

<table>
<thead>
<tr>
<th>Self-Reported Practice of CRC Screening</th>
<th>% (N), mean</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fecal Occult Blood Test (FOBT)</strong></td>
<td></td>
</tr>
<tr>
<td>Recommend</td>
<td>31 (189)</td>
</tr>
<tr>
<td>Perform/Order</td>
<td>51 (305)</td>
</tr>
<tr>
<td>None</td>
<td>18 (108)</td>
</tr>
<tr>
<td>Mean Starting Age¹</td>
<td>45 (range: 16-60)</td>
</tr>
<tr>
<td>Mean Interval¹</td>
<td>Every 1.1 years (range: 6 months-5 years)</td>
</tr>
<tr>
<td>Mean Perceived Compliance Rate¹</td>
<td>67%</td>
</tr>
</tbody>
</table>

| **Flexible Sigmoidoscopy**             |             |
| Recommend                              | 47 (287)    |
| Perform/Order                          | 24 (147)    |
| Neither                                | 29 (173)    |
| Mean Number Exams/Month¹               | 11 (range: 0-200) |
| Mean Starting Age¹                     | 49 (range: 20-65) |
| Mean Interval¹                         | Every 4.5 years (range: 1-10 years) |
| Mean Perceived Compliance Rate¹        | 56%         |

¹ As a proportion of those who responded that they either recommended or performed/ordered screening.
Texas Medical Association CRC Screening Survey Results continued

Do You Believe Colorectal Cancer is a Preventable Disease?

- 91% Yes
- 9% No

How Effective are the Following Tests for Reducing Cancer Mortality Among Average Risk, Asymptomatic Individuals ≥50?

- FOBT
- 3 card Test
- FOBT
- DRE
- Flex Sig
- DCBE
- Colonoscopy

Do You Recommend and/or Perform/Order the Following Tests Among Average Risk, Asymptomatic Individuals ≥50?

- Recommend
- Perform/Order
- No

Perceived MD Barriers to Recommending CRC Screening

- Too expensive
- Not efficacious
- Poor patient compliance
- CRC not preventable
- Risks
- Lack of training/equipment

Perceived Patient Barriers to CRC Screening

- Cost
- Time/trouble
- Embarrassment
- Worry about result
- CRC not serious
- Not recommended
## Appendix C

### American Cancer Society/Texas Division Inc. 2000-2005 Outcomes  
Colorectal Cancer

<table>
<thead>
<tr>
<th>Nationwide Objectives</th>
<th>Division Outcomes by the year 2005 unless otherwise indicated</th>
<th>Priority Ranking</th>
<th>Outcome Indicator Data</th>
<th>Area of Focus</th>
<th>Program of Work/Activity</th>
<th>Activity Tracking Outputs</th>
<th>Year to Initiate</th>
</tr>
</thead>
</table>
| Early Detection: Increase to 75% the proportion of people aged 50 and older who have colorectal screening consistent with American Cancer Society guidelines by 2015. | Primary care providers in Texas promote regular colorectal screenings in accordance with ACS guidelines. | 1 | Texas Medical Association (TMA) survey; outpatient units endoscopy data; hospital data on number of flex sigmoidoscopies, number of fecal occult blood tests (FOBT), number of barium enemas and number of colonoscopies done; Texas Cancer Registry (staging data); Medicare/Medicaid data | Systems Change | • Educational model that provides information to physicians on screening  
• Review Put Prevention Into Practice (PPIP) if appropriate  
• Work with Physician & Nurse Oncology Education Program  
• Conduct awareness campaign  
• Conduct data gathering  
• Collaborate to enhance residency education curriculum standards  
• Initiate physician recognition award/recognition program for colorectal cancer awareness/screening  
• Collaborate with Cancer Teaching and Curriculum Enhancement in Undergraduate Medicine programs (CATCUM)  
• Specialist/On-site educators to explain & deal with screening issues and answer questions  
• Available materials that are culturally appropriate | • Number of health professional programs delivered  
• Number of health professionals attending the programs (Texas Cancer Council)  
• Number of residency programs contacted by ACS to promote regular screening in accordance with ACS guidelines  
• Number of county medical societies contacted about ACS screening guidelines.  
• Number of culturally relevant materials available | 2000 |

1. Division Outcomes are the desired end results.
2. Outcome indicator data looks at health-related, behavioral, and other data to measure progress toward achieving our desired results (such as improvements in screening behaviors, reductions in incidence, mortality and late-stage diagnosis, changes in laws to support access and coverage of care, changes in school health policies, etc). Outcome indicator data answers the questions: “Are we making a difference? Are we achieving the desired results? Are we making progress toward our overall goals?”
3. Five areas of focus include: knowledge/awareness, behavior, systems change, policy, and improvement in outcome indicator data.
4. Activity tracking looks at what strategies and programs are being implemented to reach desired outcomes (such as how many people were reached with what programs.) Activity tracking answers the questions: “What are we doing? Who are we reaching?”
## 2000-2005 Outcomes

<table>
<thead>
<tr>
<th>Nationwide Objectives</th>
<th>Division Assessments by the year 2005 unless otherwise indicated</th>
<th>Priority Ranking</th>
<th>Outcome Indicator Data</th>
<th>Area of Focus</th>
<th>Program of Work/Activity</th>
<th>Activity Tracking Outputs</th>
<th>Year to Initiate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality:</strong> Reduce the mortality rate of colorectal cancer by 50% by 2015.</td>
<td>Financial barriers that impact coverage for detection and treatment of colorectal adenomas and carcinomas according to ACS guidelines are removed.</td>
<td>2</td>
<td>Survey health insurance carriers/HMO’s; policies address frequency and level of reimbursement; legislation is introduced; county hospital survey to determine uninsured treated there</td>
<td>Policy Change/System Change</td>
<td>• Advocate for adequate reimbursement through Govt. Relations • Advocate for insurance coverage for colorectal cancer screening • ACS interacts with worksites with employers/purchasers of insurance to survey and determine what screening mechanisms are offered/covered by their insurance • HEDIS Indicators</td>
<td>• Number of government officials contacted • Number of employers contacted • Number of bills introduced into legislature • Number of 3rd party payers contacted • Number of county judges or commissioners contacted</td>
<td>2000</td>
</tr>
<tr>
<td><strong>Early Detection:</strong> Increase to 75% the proportion of people aged 50 and older who have colorectal cancer screening consistent with American Cancer Society guidelines by 2015.</td>
<td>ACS has human and financial resources within Texas Division to implement colorectal cancer programs to meet 2015 goals.</td>
<td>3</td>
<td>ACS has the resources including human and financial within the Texas Division to implement colorectal cancer programs to meet 2015 goals.</td>
<td>System Change</td>
<td>• Data collection strategy with manpower and funds to do • Funding strategy for employees for data collection, program management • Recruitment strategy for volunteers (crosscutting volunteers) • Work with other divisions to provide culturally relevant materials from National through appropriate lines of communication • Work with Centers for Disease Control/ Texas Dept. of Health for funds available</td>
<td>• Amount of (budget) allocated to colorectal cancer • Number of full time employee staff devoted to colorectal cancer • Number of volunteers (Division/unit) • Number of partners</td>
<td>2000</td>
</tr>
<tr>
<td><strong>Early Detection:</strong> Increase to 75% the proportion of people aged 50 and older who have colorectal screening consistent with American Cancer Society guidelines by 2015.</td>
<td>Baseline data to assess knowledge, attitudes and practices of physician and consumer regarding colorectal cancer screening and treatment, is obtained.</td>
<td>4</td>
<td>TMA survey; survey of advanced practice nurses and physician assistants; BRFSS with questions added on colorectal cancer; consumer survey of knowledge-attitudes-practices.</td>
<td>Improve Data</td>
<td>• Funding strategy for BRFSS questions to address colorectal cancer • Data gathering strategy (managers to collect) • Consumer survey strategy (identify appropriate tools)</td>
<td>• Number of appropriate questions added to BRFSS • Consumer survey results • Analysis of data from surveys • Review of content and results from TMA survey</td>
<td>2000</td>
</tr>
</tbody>
</table>
### 2000-2005 Outcomes

#### Early Detection:
- **Increase to 75% the proportion of people aged 50 and older who have colorectal screening consistent with American Cancer Society guidelines by 2015.**

<table>
<thead>
<tr>
<th>Nationwide Objectives</th>
<th>Division Outcomes by the year 2005 unless otherwise indicated</th>
<th>Priority Ranking</th>
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<th>Activity Tracking Outputs</th>
<th>Year to Initiate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Early Detection:</strong></td>
<td>Increase to 75% the proportion of people aged 50 and older who have colorectal screening consistent with American Cancer Society guidelines by 2015.</td>
<td>5</td>
<td>Model exists</td>
<td>Knowledge/Awareness</td>
<td>• Establish a committee to review current models that exist and develop a model in accordance with ACS guidelines</td>
<td>2000</td>
<td></td>
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</tr>
<tr>
<td><strong>Early Detection:</strong></td>
<td>Increase to 75% the proportion of people aged 50 and older who have colorectal screening consistent with American Cancer Society guidelines by 2015.</td>
<td>6</td>
<td>TMA survey of primary care providers; marketing survey pre/post campaign to determine effectiveness; awareness campaign exists</td>
<td>System Change</td>
<td>• Awareness campaign</td>
<td>• Number of articles submitted to county medical society newsletters</td>
<td>2000</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Early Detection:</strong></td>
<td>Increase to 75% the proportion of people aged 50 and older who have colorectal screening consistent with American Cancer Society guidelines by 2015.</td>
<td>7</td>
<td>Community assessments contain information on screening locations; credentialing data (health care providers able to provide screening); number of endoscopy centers; TMA survey; number of training programs for primary care providers including nurses, physician assistants, primary care physicians and nurse practitioners; American Gastroenterology Association data</td>
<td>Improve Data</td>
<td>• Data gathering strategy</td>
<td>• Number of data gatherers</td>
<td>2000</td>
</tr>
</tbody>
</table>

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*Division Colorectal Cancer Outcomes, approved by the board on 5-5-00*
Appendix D

Windsor Village United Methodist Church LIFE Ministry Strategic Plan

Introduction
Oh God, it's cancer! A diagnosis of cancer conjures up a multitude of emotions - fear, despair, depression, uncertainty, fatalism - all have a profound impact on the individual and on the individual's family and loved ones. What does one do when told cancer is present? Where does one go for medical advice, emotional sustenance and spiritual support? Often the most probing questions asked are "Am I going to die? How long do I have to live?" Most people are ill prepared to accept the diagnosis, consider implications or contemplate a future as a consequence of this momentary confusion over what should be done.

It is said that cancer has reached epidemic proportions, especially among people over 50. Every 45 seconds, someone dies of cancer in this country. This amounts to over 500,000 deaths per year. The medical profession and research scientists have endeavored to give us hope, based on current findings and new protocols for detecting and treating this disease. It is encouraging to note that "as detection and treatments have improved, many types of cancers have shifted from acute to chronic diseases, and some cancers are now highly curable. The statistics are positive, but numbers do not really tell very much about how persons with cancer survive - physically, psychologically, socially, economically, or spiritually. They do not tell us how people with a cancer diagnosis learn to live with fear and uncertainty or how they manage to be hopeful."

To be sure, hope may be abandoned because, according to recent data, we are losing ground in our efforts to eradicate cancer. Over the recent decades, breast and colon cancer have shot up 60%, prostate up 100%, testicular up 300%. Lung cancer has risen 262% at the very time when the number of smokers has been dropping from 50% to 25% of the population.

The incidence of cancer among African Americans is indeed troublesome. "Overall, blacks are more likely to develop cancer than persons of any other racial and ethnic group. Black women have the highest incidence rates of colon and rectum (44.9 per 100,000) and lung and bronchus (46.2 per 100,000). Black men have the highest incidence rates of prostate (222.9 per 100,000), colon and rectum (58.1 per 100,000). Black men are at least 50% more likely to develop prostate cancer than men of any other racial and ethnic group. . . . Blacks are about 33% more likely to die of cancer than whites, and are 2 times more likely to die of cancer than Asian/Pacific Islanders, American Indians, and Hispanics. During 1990-1996, cancer mortality rates were 223.4 per 100,000 among blacks, 167.5 per 100,000 among whites, 104.9 per 100,000 among Hispanics. . . . Black women are more likely to die of breast and colon and rectum cancer than are women of any other racial and ethnic group. Black men have the highest mortality rates of colon and rectum, lung and bronchus, and prostate cancer. Black men are more than twice as likely to die of prostate cancer than men of other racial and ethnic groups." (American Cancer Society Cancer Facts & Figures 2000, pages 28 and 29.)

Clearly, something is wrong with this equation. The need for education, prevention, and treatment initiatives among Blacks is imperative. These and other data suggest there is critical need to provide assistance to those who have been diagnosed with cancer and to their significant others as well.

Overview
This is a ministry about life. It is a ministry about health, caring, love, and compassion. Life is what Jesus came to give. Our Lord Jesus Christ came to this world to take on our infirmities. Jesus said, "I am come that they might have life, and that they might have it more abundantly." (John 10:10) It was His mission to bring complete restoration of our bodies, our minds and our hearts. He came to give health. Jesus was not, is not, and will not ever be restricted in carrying out His mission. When we reflect on the life of Jesus, everything He did was centered around life - our earthly life and our eternal life.

Life is at the heart of this ministry for it is the heart of our belief system. We believe the Word of God; we believe cancer stricken Christians can stand on His Word which tells us we can have life and we can have it more abundantly. Our life work on earth is a preparation for our life eternal. Thus, we have chosen LIFE - as the title of the Windsor Village United Methodist Church Cancer Ministry.

Our Vision
The LIFE Ministry provides insight, education and a spiritual comfort zone for those who have been touched by and living with cancer.

Our Mission
Our mission is to glorify God in all that we think, say, and do. Our mission is to inspire and to assist cancer survivors who are hurting, to have a bountiful life in Christ.

Our Goal
Our goal is to address the needs of the congregation by providing spiritual guidance and support, and by planning and conducting programs and activities that will be effective in promoting spiritual, emotional and physical empowerment while living with cancer. The LIFE Ministry will offer survivors, their loved ones, professional health providers and others, support for living their lives - though touched by cancer - in abundance. It is our desire to provide caring and loving support to persons living with, coping with, and surviving cancer.

Our Values and Belief System
"And truly Jesus did many other signs in the presence of His disciples, which are not written in this book; but these are written that you may believe that Jesus is the Christ, the Son of God, and that believing you may have life in His name." (John 30-31).

LIFE Ministry participants will:
• Accept as truth that God has endowed us with everything we need to become the person He wants us to be.
• Place our perfect trust in the Lord. God has promised to make a way out of no way.
• Make every effort to read the Bible daily. Read with a red pencil and shade those verses that have special meaning to us.
• Pray those scriptural promises back to God.
• Visualize and assert our assets. Affirm “God is with me in this!”

Objectives

The Cancer Ministry recently conducted a survey of the Windsor Village congregation. This survey was designed to elicit respondents’ most pressing needs regarding cancer and to ascertain the level of interest they might have in becoming active members of the Cancer Ministry. The pressing needs expressed by our congregation during this church-wide survey, are the building blocks upon which the following objectives are based.

1. To Address the Need for Prayer and Spiritual Guidance LIFE Ministry Participants will:
   A. Encourage LIFE Ministry participants to become conversant with healing scriptures. We will focus our thoughts on giving love while expecting nothing in return (1 Corinthians 13: 4-8); we will saturate our minds with that which is good and pure – God’s word (Phil. 4:8); and we will develop feisty attitudes toward eliminating disease in one’s body. (Matthew 11:12).
   B. Partner with the Prayer Ministry in praying for and with those seeking spiritual guidance and support. Through prayer, we will petition Our Lord and Savior to address the concerns of participants.
   C. Forward pertinent information to the Prayer Ministry so that cancer survivors may be blessed by their prayers, outreach, and support.

2. To Address the Need for Support Group Assistance LIFE Ministry Participants Will:
   A. Hold regularly scheduled support group sessions for sharing information, concerns and the like.
   B. Seek assistance of professional health care providers who will, from time to time, address the support group participants on topics of greatest interest and need.
   C. Inform participants of resources and services available to survivors and their loved ones.

3. To Address the Need for Education and Information, LIFE Ministry Participants will:
   A. Plan and conduct educational forums that address topics that are of interest and concern to participants. Topics may include (but are not limited to) cancer prevention, cancer treatment, survivorship, caregiving, nutrition, and the like.
   B. Develop programs and activities that address the pressing needs identified by the congregation in the Cancer Survey.
   C. Gather and distribute literature that addresses issues related to cancer.

4. To Address Family Life Issues LIFE Ministry Participants Will:
   A. Conduct workshops that focus on family matters which may include topics on intimacy, respite care, children and their coping strategies.
   B. Assist families, children and significant others in understanding adjustments that often are needed for coping with cancer.
   C. Offer supportive environment for discussing family life issues and suggest resources appropriate to addressing those issues.

NOTE: Discussions, workshops, and all other assistance are not considered to be therapeutic in nature. When professional assistance is needed, participants will be so advised.

5. To Address the Need for Personal Care Assistance, LIFE Ministry Participants Will:
   A. Offer support to families in the area, caregiving to the extent that is appropriate for Ministry members and of value to the family. For example, we may be in a position to sit with a patient to give respite care to the family, run short errands for a patient who lives alone, or perhaps do light work.
   B. Assist in scheduling hospital, home, nursing home, and hospice visitation as the need arises and as ministry members are available to provide.
   C. Call and/or visit cancer patients to offer encouragement, support, comfort, and prayers.

6. To Address Insurance, Social Security and other Financial Issues, LIFE Ministry Participants Will:
   A. Invite experts in the field to conduct workshops on topics of interest and need such as benefit plans, choosing a provider, planning for non-covered costs.
   B. Make available references and resources regarding types of insurance, government programs and the like.
   C. Inform survivors of programs such as Medicare and Medicaid, long-term care insurance and HMOs.

7. To Address the Need for Learning about Good Nutrition LIFE Ministry Participants Will:
   A. Inform patients and their families in need of balanced nutritional diets and diet supplements.
   B. Engage the services of nutritionists. Conduct cooking and food selection, storage, and preparation courses (taught by certified dietitians and nutritionists).
   C. Disseminate information and conduct workshops on nutrition and cancer. Attention will also be given, as the need dictates, to the older members and their nutritional needs. It is widely accepted that with advancing age the propensity toward malnutrition increases. Special attention will be given to this population of the congregation.

8. Transportation:
   A. Establish communication with the American Cancer Society (and other appropriate agencies) to arrange transportation for treatments of cancer patients.
   B. Assist patients/survivors in utilizing transportation services that are available.

9. Celebrations and Recognition:
   A. Develop programs to recognize survivors (patients and/or caregivers) to recognize their contributions to others – in spite of challenges they themselves have faced and overcome. Details to be developed by the Ministry.
   B. Establish a “Survivors Award.” (Additional thought will be given to this as we develop it).
   C. Annual Candle Light Service in honor of those who have survived cancer patients and caregivers.
Strategies
LIFE Ministers will prayerfully:

1. Communicate the vision and mission throughout the Windsor Village Church family. Potential members and others will become fully aware and understanding of the LIFE Ministry and its purposes.

2. Enlist the participation of those who have expressed interest in becoming a member of LIFE Ministry.

3. Organize a team of Ministry leaders who can take the Cancer Survey results and develop them into programs and activities to accomplish the mission, goals and purposes of LIFE Ministry.

4. Produce a strategic plan for maximizing the great potential that awaits this Ministry.

5. Communicate with pastors and enlist their unwavering support from the pulpit and in other formats.

6. Communicate and form partnerships with related ministries including: Prayer Ministry, Hospital Ministry, Transition Ministry, Grief Ministry, Health & Welfare Ministry and others.

7. Develop and/or strengthen relationships with medical institutions in the community including The University of Texas M. D. Anderson Cancer Center, Baylor College of Medicine, Texas Children’s Hospital Cancer Center, Methodist Hospital, St. Luke’s Hospital and others in partnerships and collaboration to educate the community.

8. Develop and/or strengthen relationships with religious institutions in the community including churches that have cancer ministries, CanCare and chaplains of medical institutions to promote spiritual support for survivors.

9. Pursue ministry opportunities in the larger community that will produce financial support. Ultimately the LIFE Ministry will become a 501(c) 3 organization. As such, it will collaborate with community health initiatives that would also become 501(c) 3 in scope.

10. Remain vigilant in our quest to offer education and spiritual support to the community with the hope that cancer no longer will ravage the African American community.

Summary
The LIFE Ministry is committed to raising awareness, providing support, and promoting spiritual empowerment to those in our midst who have been touched by cancer. Data presented in this plan, regarding the incidence of cancer among African Americans, are simply unacceptable. We can ill-afford to proceed with business as usual. There is a need for an all-out affront against this disease. The LIFE Ministry intends to do all within its power to address this serious problem that exists within our community.

Although this is an ambitious program in scope and depth, we believe that the Holy Spirit will lead us and light our path: and that our Father God, through Jesus Christ Our Lord and Savior, will provide the way.