Attachment 7

Clinic-Focused Intervention Training Curriculum Summary and Objectives and Presentations

Implementation and Evaluation of an Intervention to Increase Colorectal Cancer Screening in Primary Care Clinics

Funded by Division of Cancer Prevention and Control at
Centers for Disease Control and Prevention (CDC)

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MODULE I
PROJECT OVERVIEW: IMPLEMENTATION AND EVALUATION

Goals of Intervention Program

- Increase colorectal cancer (CRC) screening among *average-risk men* and *women* in primary care clinics
- Increase motivation/intention of patients, clinicians, and clinical staff to complete CRC screening by:
  - improving beliefs and attitudes toward CRC screening
  - strengthening facilitators (office systems)
  - decreasing or eliminating barriers
  - increasing social support

Intervention

- There are two parts to this intervention:
  - Patient-focused
  - Clinic-focused
    - At the clinic, all staff will be involved
      - Clinicians
      - Clinical staff
        - Front desk staff
        - Medical assistants
        - Nurses

Patient-focused Intervention

- CRC screening education packets with letter signed by physicians sent to patients about 1–2 weeks before HME appointment
- Patients read CRC screening facts
- Patients review CRC screening options

Patient-focused Intervention

- Patients are primed for a conversation with their clinician about CRC screening options
- Conversation with clinician about CRC screening options leads to a CRC screening decision about modality
- Patients then
  - receive FOBT kits and instructions, OR
  - recommendation to schedule FS or colonoscopy appointment

Clinic-focused Intervention

- CRC training/skills building workshop with primary care clinicians and clinical staff
  - Clinicians enhance skills regarding motivating patients to get screened
  - Clinical staff enhance skills for patient interactions and for office reminder systems

Clinic-focused Intervention

- Clinicians:
  - Have conversation about CRC screening with patients
  - Make mutual decision regarding screening modality
  - Implement screening:
    - FOBT cards
    - FS appointment
    - Colonoscopy appointment
- All Clinical Staff and Clinicians:
  - Formulate reminder system plan
    - To prompt discussion of CRC screening
    - For return of FOBT cards
    - Appointment follow-up

Clinic-focused Intervention

- Nurses or MAs:
  - Use opportunities for patient education about CRC screening
  - Place CRC screening reminders in patient charts for clinicians
- If FOBT chosen:
  - Give FOBT kits to patients with standardized instructions
  - Trained to tailor FOBT instructions for patients who call in with questions
- If Flexible Sigmoidoscopy (FS) or Colonoscopy chosen:
  - Give patient information regarding appointment set up

Clinic-focused Intervention

Using reminder system implemented, Nurses/MAs:

- Follow-up with patients if FOBT results do not come in from lab
- Follow-up with patients regarding FS or colonoscopy appointments
- Take incoming calls from patients to help with questions about FS or colonoscopy
- Follow-up with patients if FS or colonoscopy appointments not made/kept

Intervention/Evaluation Design

Four Arms

Clinics Randomized

1. Patient-focused intervention
2. Clinic-focused intervention
3. Combined patient-clinic intervention
4. Usual care control group

Evaluation Study Design

- Pre- and post-test design
- Baseline, 12 month follow-up assessments
  - Patients
  - Clinic staff
  - Clinicians

Pre-Intervention	Post-Intervention
Clinic staff/clinicians	Clinic staff/clinicians
Patients	Patients

OUTCOMES

- Behavioral
  - Primary – CRC screening tests done
  - Secondary – CRC screening conversations; kits distributed; appointments made
- Intermediate
  - Changes in attitude, beliefs, social influence
- Outcomes will be assessed via:
  - Clinician, clinical staff, patient surveys
  - FOBT laboratory test records
  - FS and Colonoscopy procedure records

Survey Instruments

- Clinician/Clinical Staff/Patient Surveys
  - Patient education about CRC screening
  - Conversations about CRC screening
  - Intentions, motivations, attitudes, norms, facilitators, barriers related to CRC screening modalities
- CRC screening
  - FOBT card distribution
  - FS recommendation/intention
  - Colonoscopy recommendation/intention

What We Need from You

- Commitment to study and adherence to protocol
- Permission to contact about 225 of your patients
- Your participation in 3 hours of CE training for CRC screening
- Survey completion pre- and post- intervention (12 month follow-up)

Provider Training Objectives

- Review current information about colorectal cancer (CRC) and CRC screening
- Motivate clinicians and clinical staff to engage in CRC screening conversations with patients and to actively encourage and endorse CRC screening
- Provide tools for targeted and effective CRC screening conversations with patients so that a shared screening decision may be made
- Disseminate tools to effectively manage CRC screening office systems
- Generate discussion about and find solutions to barriers to CRC screening that work for individuals and for specific clinic settings

MODULE II
CRC and CRC SCREENING
STATISTICS, EVIDENCE and GUIDELINES

Module II Objectives

- Review CRC and CRC screening statistics
- Briefly review CRC screening modalities, with some evidence of efficacy and pros/cons of each
- Review USPSTF CRC screening recommendations, and ACS and ACG guidelines for average-risk patients

Colorectal Cancer Screening
BUILDING THE CASE

Colorectal Cancer (CRC)

- CRC is third most common cancer diagnosed in the US
- Second leading cause of cancer death
- Lifetime probability of developing CRC is about 1 in 17 (1 in 17 men; 1 in 18 women)
- Lifetime probability of dying from CRC is about 1 in 43
- Average person dying of CRC loses about 13 years of life

Colorectal Cancer Burden

- American Cancer Society estimates:
  - 145,000 new cases of CRC will be diagnosed in 2005
    - Males 72,648
    - Females 72,352
  - 56,000 individuals will die from CRC in 2005
    - Males 27,956
    - Females 28,044
- Treatment cost of CRC in the U.S. is over $6.5 billion per year

CRC Incidence and Mortality Rates

Average Annual Age-Specific SEER Incidence per 100,000 Persons and U.S. Mortality Rates By Gender, 1998-2002

(Graph)

Adenoma-Carcinoma Sequence

-Most CRC begins as polyps-over 95% of CRC arises in adenomatous polyps
-Twenty-five percent of adults have adenomatous polpsa at age 50-about 5% would progress to cancer if left in the colon
-Transformation occurs to change polyps to carcinoma: process takes about 10-15 years

Colorectal Cancer Detection

- Today CRC is the most preventable cancer
- When CRC is detected at an early, localized stage, 5-year survival is 90%
- Survival drops to:
  - 67% if detected at regional stage
  - 10% if detected at distant stage
- Only 38% of CRC is discovered at the localized stage

Objectives of CRC Screening

Detect surgically curable CRC (Dukes' A or B)

Prevent cancers by detecting and resecting pre-malignant benign polyps

Accepted CRC Screening Modalities

- Fecal Occult Blood Test (FOBT)
- Flexible Sigmoidoscopy (FS)
- FOBT plus FS
- Colonoscopy
- Double Contrast Barium Enema (DCBE)

Colorectal Cancer Screening

- U.S. Preventive Services Task Force (USPSTF) strongly recommends screening
- National Committee for Quality Assurance (NCQA) added CRC measure to the Health Plan Employer Data and Information Set (HEDIS®) in 2004
- American Cancer Society has developed CRC Screening Guidelines

Average Risk for CRC

- Asymptomatic
- No family or personal history of colorectal neoplasia
- No chronic ulcerative colitis or Crohn's colitis
- Begin screening at age 50

  (*MOST* CRC occurs in those of average risk; only 20% of CRC cases in those with family history – first-degree relative - USPSTF)

American Cancer Society 2005 CRC Screening Guidelines

Beginning at age 50, average risk men and women should follow one of the following examination schedules:

- Fecal Occult Blood Test (FOBT) every year (not in-office FOBT)
- Flexible Sigmoidoscopy (FS) every 5 years
- Annual FOBT and FS every 5 years (preferred over FOBT or FS alone)
- Double-Contrast Barium Enema (DCBE) every 5 years
- Colonoscopy every 10 years

American College of Gastroenterology CRC Screening Guidelines

Beginning at age 50, average risk men and women should follow one of the following examination schedules:

- Preferred screening strategy:
  - Colonoscopy every 10 years
- Alternative screening strategy:
  - FS every 5 years plus annual FOBT

US Preventive Services Task Force

- Screening strategy choice should be based on:
  - Patient preferences
  - Medical contraindications
  - Patient adherence
  - Available resources for testing and follow-up
- USPSTF: "Clinicians should talk to patients about the benefits and potential harms associated with each option before selecting a screening strategy."
- Cost-effective – less than $30,000 per additional year of life gained, regardless of screening strategy

CRC Screening Efficacy Evidence Summary

- Randomized controlled trials:

  Annual and biennial FOBT screening reduces CRC mortality by 15-33% and incidence by 17-20%
- Case-control studies:

  Sigmoidoscopic screening could reduce CRC mortality by 59-75%

Fecal Occult Blood Test
Efficacy

Three randomized controlled trials, all using Hemoccult ® test kit, show reductions in risk of death from 15-33%.

Annual FOBT v. Usual care – 33% lower CRC mortality (U.S. study, randomized volunteers and rehydrated test cards)*

1. 9.46 deaths per 1,000 (annual FOBT)
2. 14.09 deaths per 1,000 (usual care)
3. Biennial screening reduced mortality by 21%

Two European trials found 15-18% lower CRC mortality (unrehydrated test cards, biennial screening)**

*N Eng J Med 1993; 328:1365 and J Natl Cancer Inst 1999; 91: 434
** Lancet 1996; 348:1472 and Lancet 1996; 348:1467

Fecal Occult Blood Test
Sensitivity/Specificity

Single test

1. Sensitivity – 40%
2. Specificity – 96-98%

Hydration of specimen increases sensitivity (60%) but reduces specificity (90%)*

Of patients who have a +FOBT using rehydrated slides:

2% will have cancer
6-8% will have cancer or a large polyp

Annual screening with hydrated specimens detected 49% of all incident cancers**, but 38% has at least one colonoscopy due to + result

*Ann Intern Med 1997; 126(10): 811
** N Engl J Med 1993; 328: 1365

Fecal Occult Blood Test
Sensitivity/Specificity

- Single in office Digital Rectal Exam (DRE) and FOBT card test
  - Sensitivity for detecting advanced neoplasia 4.6%*
  - Specificity 97.5%*
- Of 284 individuals with advanced neoplasia, only 14 were found using DRE and in-office FOBT* (Note: This method is NOT recommended)
- Common practice among primary care physicians**:
  - 32% overall do it
  - Variation by specialty (24% to 64%)
  - ObGyns proportionately more often (xx%)
  - Xx specialty least often (xx%)

Fecal Occult Blood Test
Advantages

Non-invasive
No complications
At-home test
Detects most CRCs and many advanced adenomas
Reduces CRC mortality and incidence
Feasible, widely available, and acceptable
Low up-front cost, highly cost effective

Fecal Occult Blood Test
Disadvantages

- Physician and patient compliance
- Tracking of returns
- Patient reluctance
- Patient dietary restriction
- Low sensitivity and specificity with one test
- Has to be repeated annually to be effective

Flexible Sigmoidoscopy
Efficacy

Case-control studies –

Mortality reduction

59%* (Flexible sigmoidoscope) (from cancers within reach of the sigmoidoscope)

60%** (Rigid sigmoidoscope)

Adjusted odds ratio .41 (on distal CRC)

*J Natl Cancer Inst 1992; 84: 1572
** N Engl J Med 1992; 326: 653

Randomized controlled trials are underway

Flexible Sigmoidoscopy
Sensitivity/Specificity

Identify 70-80% of patients with advanced adenomas or cancer* (using colonoscopy as the criterion standard—FS results trigger examination of the entire colon)

First-time sigmoidoscopic screening detects about 7 cancers and about 60 large polpys per 1,000 examinations

Specificity difficult to define (but some polyps of low malignant potential may be removed)

*N Engl J Med 2000; 343:162 and N Engl J Med 2000; 343:169

Flexible Sigmoidoscopy
Advantages

Feasible, safe, acceptable
Simple bowel preparation
No sedation
Clinician can see rectum and distal half of colon—where half of CRC occurs
Sometimes polyps can be removed during the screening test-diagnostic and therapeutic

FOBT plus Flexible Sigmoidoscopy

- Why both? Combination corrects limitations of either test alone
  - FOBT insensitive for smaller polyps and distal cancers
  - Flexible sigmoidoscopy misses 30-40% of all polyps and cancers

FOBT plus Flexible Sigmoidoscopy
Efficacy and Sensitivity/Specificity

- Currently no randomized trials to compare tests alone vs. combined with mortality as endpoint
- European randomized trials
  - Adding sigmoidoscopy to FOBT increased the identification of adenomas or cancer by a factor of 2 or more

Colonoscopy
Efficacy

- Scientific evidence of efficacy - still being evaluated - National Polyp Study (1993)*
  - CRC incidence reduced by more than 75% (76-90%) with colonoscopy (compared to expected rate)
  - However, based on historical controls and trial participants had more complete polyp removal than may occur in screening setting
- 1 case-control study**
  - Lower incidence (OR=.47) and lower mortality (OR=.43)

*N Engl J Med 1993;329:1977
**Arch Intern Med 1995;155:1741

Colonoscopy
Sensitivity/Specificity

- Estimated sensitivity of a single exam is 90% for large polyps and 75% for small polyps (< 1 cm)*
- Specificity difficult to define (as with sigmoidoscopy)

*Gastroenterology 1997;112:24

Colonoscopy
Advantages

- Gold standard - some clinicians believe it is the most accurate test for finding polyps and cancers
- Clinicians see lining of entire colon and rectum
- Most polyps and lesions can be removed during test – diagnostic & therapeutic
- One test for 10 years – efficient – infrequent screening possible

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Double Contrast Barium Enema

- Alternative method for visualizing the rectum and entire colon
- No randomized trials examining reduction in incidence or mortality using DCBE – still being evaluated
- Substantially less sensitive and specific than colonoscopy for detecting neoplasia
- National Polyp Study – DCBE not as sensitive as colonoscopy

SUMMARY

- Only annual and biennial FOBT have been shown in RCTs to reduce CRC incidence and mortality
- Observational studies suggest that other screening modalities may reduce these outcomes, as well
- One-time FOBT, sigmoidoscopy, or FOBT + sigmoidoscopy may miss a large proportion of advanced neoplasia when compared to colonoscopy
- Similarly, BE misses many polyps when compared to colonoscopy
- Screening for colorectal cancer appears cost-effective compared with no screening, but a single optimal strategy cannot be determined from the currently available data

Colorectal Cancer Screening
UTILIZATION

CRC Screening:
Population-based Survey (BRFSS)

National Data

- FOBT within 12 mos 21.5%
- Lower endoscopy within 10 yrs 45.0%
- Either FOBT within 12 mos or lower endoscopy within 10 yrs 54.0%

New Mexico Data

- "Have you ever used a home blood stool test kit to determine whether your stool contained blood?" (population 50+ yrs)
  - 40.2% yes

- "Have you ever had a sigmoidoscopy or colonoscopy exam?" (population 50+ yrs)
  - 44.2% yes

*Behavioral Risk Factor Surveillance System 2002

Lovelace 1998 3-yr CRC Screening Rates (Patients 50-80 yrs)

Colonoscopy -18%
Flexible Sigmoidoscopy -18%

FOBT - 30%
No CRC Screening - 48%

HANDOUTS MODULE II

- USPSTF: Screening for Colorectal Cancer - Recommendations and Rationale (with reference list)
- USPSTF: Screening for Colorectal Cancer in Adults at Average Risk – A Summary of the Evidence (with reference list)
- American College of Gastroenterology: Recommendations on Colorectal Cancer Screening
- List of websites relevant for CRC screening

MODULE III
ENHANCING SKILLS for CRC SCREENING CONVERSATIONS with PATIENTS

Module III Objectives

- To provide tools for effective patient-clinician and patient-clinical staff CRC screening conversations that result in a shared screening decision;
- To provide key messages, based upon common barriers/facilitators, to motivate clinicians and clinical staff to actively encourage and endorse CRC screening among their patients

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Colorectal Cancer Screening
WHAT'S IMPEDING SCREENING?
QUESTIONS:

- Are patients being seen?
- Are patients informed re screening? "Screen for Life" CDC multimedia campaign – is this enough?
- How are patients due for screening detected and how is screening tracked?
- How do clinicians and patients make decisions about screening?

Colorectal Cancer Screening

- Do patients keep their CRC screening test appointments?
  - 38% of patients did not keep their first scheduled appointment for a colonoscopy or flexible sigmoidoscopy^
- Do clinicians have CRC screening conversations with their patients?
  - Clinicians rarely discuss CRC screening with their patients
    - CRC was discussed with only 14% of patients 50+ yrs in a rural primary care setting*
- Do clinicians capitalize on well visits to discuss CRC screening?
  - Only 24% of well visits included delivery of FOBT screening and only 8% included referrals for sigmoidoscopy**

^ Turner et al., Ann Intern Med 2004;140
* Ellerbeck et al., J Gen Intern Med 2001; 16(10)
** Stange et al., Prev Med 2000; 31(2 Pt 1)

Colorectal Cancer Screening

- Public awareness campaigns (e.g., CDC "Screen for Life") targeting the public are great, BUT CRC messages need to be reiterated in a health care setting!!
- One key to increasing CRC screening is capitalizing on existing patient-clinician and

patient-clinical staff interactions!!

Colorectal Cancer Screening

- How do clinicians and patients make decisions about CRC screening?
  - Clinician Factors
  - Patient Factors
- Goal: Shared Decision-Making

What Motivates Behavior?

- We all know that certain factors motivate behavior
- Focusing on these factors in interpersonal interactions can help patients get motivated to engage in a behavior one is trying to encourage

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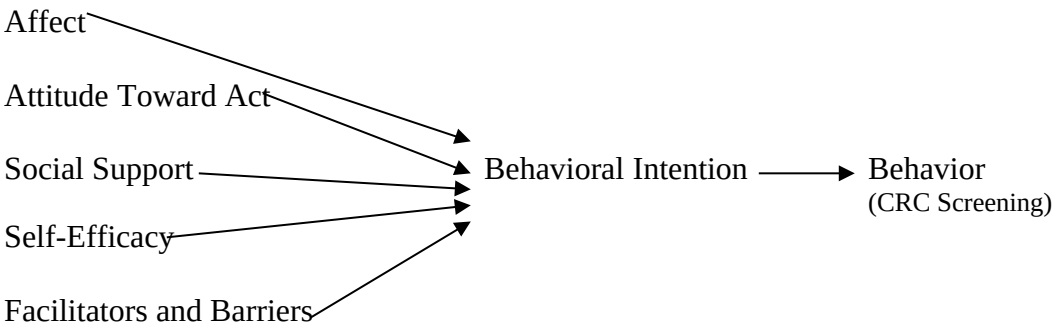
Integrated Behavioral Model*



* J Appl Soc Psychol 1998; 28(17): 1559

Clinician Factors*

- Positive Beliefs/Attitudes
  - Patients benefit from early detection of CRC
  - Patients feel good having negative screening result
  - Makes clinician feel good about detecting cancer and saving patient
  - What else? How can these be reinforced?

*Cancer Epi Biom Prev 2000; 9:665, Cancer Det Prev 2004, and Report to ACS, CDC 1998 (Battelle)

Clinician Factors

- Negative Beliefs/Attitudes
  - Time-consuming and expensive
  - Not as cost-effective as other preventive actions
  - Difficult to convince patients
  - Patients won't follow recommendations

Clinician Factors

- Time-consuming and expensive
  - Screening tests covered by most health plans with small co-pay
  - Impact upon practice is positive
- Not as cost-effective as other preventive actions
  - CRC is the most preventable cancer today
  - Several randomized controlled trials are underway
  - One smaller randomized controlled trial demonstrated an 80% reduction in CRC incidence among individuals receiving endoscopic screening*
- Difficult to convince patients
  - Patients need encouragement and endorsement in the health care setting

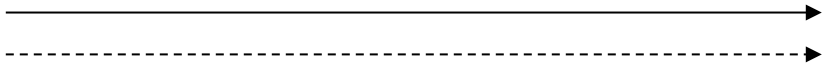
*Thiis-Evensen et al. Scand J Gastroenterol 1999;34(4)

Integrated Behavioral Model

- Intention
- Affect
- Beliefs and Attitudes
- Social Influence/support
- Self-efficacy
- Facilitators/Barriers

Intention-Behavior Continuum

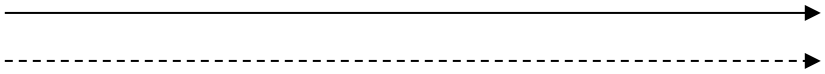
Intention — Behavior
Motivation — CRC Screening



Our goal is to move the patient along the Intention–Behavior Continuum - from just thinking about CRC screening to doing it!

Intention-Behavior Continuum

Intention — Behavior
Motivation — CRC Screening



The first step in moving the patient along this continuum is assessing where the individual is currently in terms of intention (and what affect, beliefs, attitudes, and social support factors are driving this).

What Factors are Important to this Individual?

- Intention/Motivation “How likely is this patient to get CRC screening if you recommend it?
- Affect “How do you feel about having a CRC test?”
- Attitudes/Beliefs “What is bad about getting a CRC test, and what is good about getting it?”
- Social Support “What does your spouse/partner think you should do?”
- Self-efficacy “If you wanted to have a CRC test, could you? If not, why not?”

What Factors are Important to this Individual?

Patient Conversation Guide

- React differently to negative responses than to positive responses
- Ask targeted questions to get as much individual information as possible
- Don’t overwhelm someone who isn’t ready with too much information
- Don’t expect rational arguments to work for affective factors
- Remember social support factors
- Work toward a plan!!

Patient Factors*

- Affect
  - Stressful
  - Uncomfortable
- Positive Beliefs/Attitudes
  - Prevents CRC via polyp removal (FS)
  - Helps protect your health so you can take care of your family
  - Gives feeling of control over health

*Cancer Epi Biom Prev 2000; 9: 685, Cancer Det Prev 2004, Report to ACS, CDC 1998 (Battelle)

Patient Factors

- Negative Beliefs/Attitudes
  - Needed only if have symptoms
  - Needed only if family history of CRC
  - Unnecessary if follow a healthy diet
- Social Influence/Support
  - Spouse/partner encourages or discourages
  - Physician encourages

Patient Factors

- Reinforce positive beliefs/attitudes (“When you have the screening test done, you’re taking good care of yourself.”
- Counter/negate negative beliefs/attitudes (“It doesn’t hurt very much. Even if you don’t have symptoms, it’s necessary.”)
- Reinforce social influence (“Talk this over with your spouse/partner and we’ll talk again.”; “As your physician, I strongly recommend that you do a (FOBT)/(FS))”

Increasing Patient Interest

- Only 30-50% of patients who were given information about CRC screening indicate interest in having flexible sigmoidoscopy*
- Providing print education materials isn’t enough!
- Primary care clinicians can increase patient interest/willingness through discussion and endorsement/encouragement

*J Gen Intern Med 1999;14

Increasing Patient Interest

- Use patient education print materials as a cue – have them available in the office!
- Initiate conversation
- Respond to questions (more about this in Module IV)
- Remain open to patient ambivalence and use reflective listening – talk it through (more about this in Module IV)

Increasing Patient Interest

- Keep screening guidelines in the office – show to patients
- Tell patients about their options
- Review procedures – preparation before test, what to expect in the office for sigmoidoscopy, any side-effects
- How much detail does an individual patient need to make a decision? Respond to cues from patient! (more in Module IV)
- Address concerns/barriers!

Increasing Patient Interest

- Give patients information about risk ("second leading cause of cancer death" and "average person dying of CRC loses about 13 years of life" – see Module II)
- Give options for testing
- But give your opinion too – patients want advice from their doctor
- Discuss pros/cons of tests

Fecal Occult Blood Test
PROS

Non-invasive and no complications
At-home test –private
"You won't need to miss work"
Evidence shows it saves lives
Clear instructions – but stress that patients can ask questions!

Fecal Occult Blood Test
CONS

May miss some polyps and cancers
"You need to avoid some foods and medicines before and until stool samples are collected"
"You may find it unpleasant"

Flexible Sigmoidoscopy
PROS

Clinician can see rectum and distal half of colon-where half of CRC occurs

Sometimes polyps can be removed during the screening test—diagnostic and therapeutic

Some evidence suggests it saves lives

Flexible Sigmoidoscopy
CONS

Clinician can only see part of the colon

"You may need to avoid some foods and use strong laxatives and/or enemas before test"

"You will miss half a day of work"

"You may feel discomfort during and after the exam"

Very slight risk of perforation of the colon, reaction to medication, bleeding

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Colonoscopy
PROS

- Some evidence suggests it saves lives
- Some clinicians believe it is the best test for finding polyps and cancers
- Clinicians see lining of entire colon and rectum
- Most polyps and lesions can be removed during test

Colonoscopy

CONS

- Scientific evidence of efficacy is still being evaluated
- More extensive bowel preparation than other tests – restricted diet and strong laxatives and/or enemas
- "Must be done in office and you must miss a day of work"
- "You will need to take medication to relax and someone will have to drive you home"
- Slight risk of perforation of the colon, reaction to medication, bleeding
- Capacity issues – long waiting time for appt

Barium Enema

PROS/CONS

- Alternative method for visualizing the rectum and entire colon
- No studies examining reduction in incidence or mortality using double contrast barium enema (DCBE) – still being evaluated
- National Polyp Study – DCBE not as sensitive as colonoscopy

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Motivating Patients – Clinical Staff

- Encourage patients to ask questions of clinical staff about CRC screening
- Encourage patients to explore CRC screening options with clinician
- Opportunities for patient-clinical staff interaction
  - ***"front-end" – during check-in, "rooming"***
  - ***"back-end" – after appointments***

Motivating Patients – Clinical Staff

Perceived Risk - give patients information about risk AS A FIRST STEP

- CRC is second leading cause of cancer death, and the third most diagnosed cancer
- Risk of CRC in your lifetime is 1 in 17
- When CRC is found at an early stage, survival is 90% (most cancers detected early are curable!)
- Average person dying of CRC loses 13 years of life

Motivating Patients – Clinical Staff

Conversation during "rooming"

- Hand out materials during "rooming"
- Materials in waiting room (patient-initiated)
  - Poster / Pamphlet / Flip-chart
- Materials in exam room (patient-initiated)
  - Poster / Pamphlet / Flip-chart
- Materials in exam room (clinician-initiated)
  - Poster / Pamphlet / Flip-chart

Summary Tool (handout)

- Use this as a prompt for conversations with your patients
- Includes patient risk, screening guidelines and some pros/cons for each test
- Emphasize importance and potential benefits of screening – clarify cons for each test
- Explore options with patients
- Give your opinion/advice!

HANDOUTS MODULE III

- Summary tool to use with patients
- Integrated Behavioral Model
- Patient Conversation Guide
- Screen for Life Health Professional Facts on Screening
- References

MODULE IV
MOTIVATIONAL INTERVIEWING
for CRC Screening

Module IV Objectives

- Review principles and framing of the interpersonal style of motivational interviewing
- Discuss motivational interviewing as it applies to increasing patient motivation for preventive care, specifically CRC screening
- Provide mental maps and mental reminder systems for targeted and effective conversations with patients about CRC screening

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MOTIVATIONAL INTERVIEWING

- This module will review/enhance your ability to motivate your patients to have CRC screening tests
- This module isn't about teaching you how to interact with your patients!
- This is a tool for you to use
- The goal is to LISTEN to the patient carefully and LATER to react to the patient's ambivalence with:
  - reinforcement (for +)
  - counter arguments/evidence (for -)

MOTIVATIONAL INTERVIEWING

- Interpersonal style
  - Become more effective in developing individualized approaches to encourage preventive care (e.g. CRC screening)
- Mental reminder systems
  - OARS
  - FRAMES
- Provides structure for what you already do
  - "Mental Map"

Definition of Motivational Interviewing

A directive, patient-centered counseling style for eliciting behavior change by helping patients to explore and resolve ambivalence

How to get people to make decisions!

Fix-it v. Motivational Approach

Fix-it Approach

-Patients need to act now
-Patients lack knowledge
-Education will convince patients
-Patients just need advice

Motivational Approach

-Patients might not be ready for action yet
-Patients have intrinsic motivation but need encouragement
-Patients have education/knowledge
-Patients are willing to explore options

Fix-it v. Motivational Approach

Fix-it Role

-More appropriate for diseases caused by risk behaviors
-Not as appropriate for helping patients change risk behaviors or adopt preventive care

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Motivational Interviewing Framing

- Seeking to understand the patient's frame of reference, particularly via *REFLECTIVE LISTENING*
- Expressing acceptance and affirmation
- Eliciting and selectively reinforcing the patient's own self-motivational statements
- Assessing/Monitoring the patient's degree of readiness to change
- Affirming the patient's freedom of choice and self-direction

General Principles of Motivational Interviewing

- Express empathy
- Develop discrepancy
- Roll with resistance
- Support

General Principles of Motivational Interviewing

- Express empathy
  - Acceptance facilitates change
  - Skillful reflective listening is fundamental
  - Ambivalence is normal

General Principles of Motivational Interviewing

- Develop discrepancy
  - Patient should come up with + arguments with clinician facilitation
  - Patient needs to perceive a discrepancy between present behavior and personal goals or values

General Principles of Motivational Interviewing

- Roll with resistance
  - Avoid arguing
  - Don’t oppose resistance directly or immediately
  - Patient is the primary resource for answers about his/her behavior
  - Use resistance as signal to respond differently

General Principles of Motivational Interviewing

- Support self-efficacy
  - Patient, not clinician, is responsible for choosing and carrying out behavior
  - Clinician’s support is key and should be based on patient’s perception of barriers
  - Reinforce patient’s own motivation and capacity to carry out behavior

Motivational Interviewing Patient Decision Balance

+	-
Reasons to have CRC test (Motivation)	Reasons not to have CRC test (Resistance)
Benefits of having CRC test	Concerns about having CRC test
Willingness	**Reluctance**

Motivational Interviewing Framing

OARS

- Open-ended questions
- Affirmation or reinforcement
- Reflective listening
  - Simple reflection
  - Amplified reflection
- Summaries

Motivational Interviewing Framing: OARS

Open-ended questions

- "Do you know what an FOBT is?" yes/no
- How much information does the patient have, how accurate is that information, and what about the person's intention or motivation to get one?
- "What do you know about the FOBT?"
- "Tell me what your experience has been with the FOBT."
- "How do you feel about doing an FOBT?"
- Try to get the patient to give you MORE rather than LESS information
- Use prompts like "Describe…." and "Tell me about…" - conversational shortcuts to get more information and ask fewer questions to get it!

Reflective Listening

Patient: *I don't want to have a test for colon cancer because I think it will hurt and anyway, I have my diabetes to worry about.*

Clinician: You're worried about getting your diabetes under control, and you don't want to worry about another disease at the same time, especially if the test might be uncomfortable.
(using reflective listening)

Reflective Listening

Patient: *I don't want to have a test for colon cancer because I think it will hurt and anyway, I have my diabetes to worry about.*

Clinician: You're worried about getting your diabetes under control, and you don't want to worry about another disease at the same time, especially if the test might be uncomfortable. I know, I don't like to have tests that might hurt or be embarrassing, either!
(using reflective listening and affirmation)

Summaries

- Collecting summaries
  - Short – just a few sentences
  - Continue, rather than interrupt, patient's conversational momentum
  - End with "what else?" (NOT "is there anything else?" a closed question that invites "no" as the answer)
  - Gives patient opportunity to correct you
- Linking summaries
  - Encourages patient to reflect
- Transitional summaries
  - Shift from one focus to another

Assessing Patient's Readiness to Change

Patient: *I heard about Katie Couric getting that colon cancer test done. I don't know much about that, but I guess it might have saved her life. Too bad about her husband not doing it, maybe he wouldn't have died.*

Where is this patient in the intention-behavior continuum for CRC screening? Not on the radar screen at all? Thinking about it? Ready to do it? Making plans to have it done? Having it done regularly?

Assessing Patient's Readiness to Change

- Precontemplation – not on the radar screen
- Contemplation – thinking about it
- Preparation – still thinking, but starting to plan
- Action – has had 1 or more CRC screening tests
- Maintenance – having screening done regularly

Patient Decision Balance and Flowchart

Why do any of this?

- To determine where they are in the intention-behavior continuum
- To then explore what factors are important to this INDIVIDUAL – what impacts the intention for CRC screening
- To tailor your messages to "fit" the individual's current frame of mind about CRC screening
  - How much information to give (e.g. how much detail)
  - What attitudes, beliefs, social support factors to reinforce or to counter

Patient Decision Balance and Flowchart

- Motivational interviewing is the "how" in the conversation guide – "intervene" to reinforce positive factors and counter negative factors
  - using the principles and framing of motivational interviewing
- Motivational interviewing is the piece between education and getting the patient into 'action'

FRAMES

- Feedback
- Responsibility
- Advice-giving
- Menu of Change Options
- Empathic counseling
- Self-efficacy

Frames Examples

Clinician: So, Chris, you've read the information about CRC screening and you have some questions about the different tests. Your questions were really on target (feedback).

fRames Examples

Clinician: It's up to you what to do now. CRC screening is a way to take care of yourself (responsibility).

frAmes Examples

Clinician: I would recommend that you have an FOBT now and every year, as well as a flexible sigmoidoscopy now and again in five years if those FOBTs are negative. (advice).

fraMeS Examples

Clinician: I think that you have all of the information you need to make a good decision (self-efficacy) and I'm available if you want to talk about it some more (menu of options).

fraMes Examples

*Clinician: If you decide not to have a flexible sigmoidoscopy in 5 years, you should still continue to have the FOBTs every year (*menu of options*).*

framEs Examples

*Clinician: I know this was a lot of information and that it's a hard choice to make (*empathy*).*

Summary: Strategies for Motivation Enhancement

Build Motivation

- Ask open-ended questions
- Listen reflectively
- Affirm the patient
- Summarize
- Present personal feedback
- Handle resistance
- Reframe statement
- Elicit self-motivational statements

Summary: Strategies for Motivation Enhancement

Strengthen/Reinforce Commitment

- Recognize readiness for change
- Discuss a plan
- Communicate free choice
- Discuss consequences of action/inaction
- Give information and advice
- Deal with resistance
- Make a plan

HANDOUTS MODULE IV

- Motivational Interviewing
- Patient Conversation Guide with motivational interviewing framing
- References

MODULE Va
OFFICE SYSTEMS FOR CRC SCREENING

Module Va Objectives

- To engage clinicians and clinical staff in a discussion to:
  - review existing office-based CRC tracking system
  - generate potential improvements or alternate solutions
- To provide clinicians and clinical staff with some options for office-based tracking of CRC screening, including identification of patients due for screening and follow-up
- To reach group consensus about office system changes that would fit best within the specific clinic structure

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Clinic-focused Intervention

- Clinicians: have conversation about CRC screening with patients
- All Clinical Staff:
  - Formulate reminder system (office) plan
- Nurses or MAs:
  - Use opportunities for patient education about CRC screening
  - Place CRC screening reminders in patient charts for clinicians
  - Give FOBT kits, with standardized instructions, to patients
  - Apply training to tailor FOBT instructions for patients who call in with questions

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Clinic-focused Intervention

- Nurses or MAs:
  - Follow-up with patients if FOBT results do not come in from lab
  - Give patients information or assist with appointments for FS or colonoscopy appointments
  - Take incoming calls from patients to help with questions about FS or colonoscopy
  - Follow-up with patients if FS appointment not made/kept

Office Systems for CRC Screening

- Identifying eligible patients
- Tracking kits/appointments
- Patient follow-up

Identifying Eligible Patients

- Enter CRC screening information with vitals, e.g. on health maintenance form
  - Create preventive checklist
  - "Do you smoke?" "Have you had CRC screening?" yes/no

Identifying Eligible Patients

- Staff review of patient records/visits
  - Before each visit?
  - Weekly/monthly review – create slip and insert in patient file?
- Data collected during "rooming"
- Data collected on health maintenance form
- How is this noted?
- Prompting clinicians to discuss CRC screening with patients

Identifying Eligible Patients and Tracking

- Computerized "Prevention trap door"
  - System generates letters to patients who are due for screening
  - Bar codes for kits
- Paper tracking
  - "Stamp" on a piece of paper already in system
  - Patient list for each type of test (with date and compliance columns)
  - Tickler Files

Tracking: Tickler File (paper based)

- Clinician recommends test
- Staff gives kit or contact information to patient (gastroenterology telephone/location)
- Staff completes slip for test
- Slip goes into tickler file
- Staff (usually MA) checks file weekly (and checks for appointments, labs)
- MA notifies clinician when test hasn't been completed (e.g. patient doesn't make appointment or no-show)

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Tracking: Tickler File (paper based)

- Clinician asks MA to
  - Send a reminder letter to the patient
  - Telephone the patient
  - Wait until patient's next visit (clinician will discuss)
- Need for MA report to clinician?
  - Instead, MA directly contacts patient when finds information in tickler file that appointment hasn't been made or kept

Tracking: Color-coded Tickler File (paper-based)

- Every month is a different color
- Clinician has a single sheet – checks for test (e.g. FOBT, FS) needed, includes date
- Sheet is put into tickler file
- Each MA has a file for each month

Tracking: Color-coded Tickler File (paper-based)

- Sheet is kept in the file until it's been resolved – file is kept in drawer until all has been resolved
- MA can easily look in the drawer and spot those that aren't the current month's color – cue to check
- MA makes progress notes at each check

Tracking Kits/Appointments

- How is FOBT kit distribution recorded?
  - Patient file
  - Tickler file
- Who makes FS or Colonoscopy appointments?
  - Staff
  - Patient
    - Who follows up - and when - if patient makes appt?

Patient Follow-up

- Reminder Letters

- Frequency and how long before sent?
- Very important for colonoscopy (long wait)

◆ Telephone calls
- Who makes? MAs?
- Does clinician have to recommend?

◆ What prompts patient follow-up?
- Lab notifies no appointment/no-show
- Tickler files

Office Systems

What will work in this clinic?

◆ Next steps:
- Formulate a specific plan
- Set up a time schedule
  - For plan
  - For implementation

MODULE Vb
PROJECT
IMPLEMENTATION

Clinicians

◆ What is your implementation plan?

- How do you plan to increase CRC screening in your clinic?
- How will you increase conversations with patients about CRC screening?
- How will you modify your conversations with patients about CRC screening?

Clinical Staff

◆ What is your implementation plan?

- How will you modify the protocol for identifying patients due for CRC screening?
- How will you modify your conversations with patients about CRC screening?
- How will you modify the protocol for answering questions when patients call in?
- How will you modify the protocol for handing out FOBT kits?
- How will you modify the protocol for patient appointment setting and follow-up?

WHO IS IN CHARGE OF:

IMPLEMENTATION

PLAN?