

# Colorectal Cancer Screening Practices: Survey of Primary Care Providers

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# SECTION A. COLORECTAL CANCER SCREENING KNOWLEDGE AND BELIEFS

**1. How effective do you believe the following screening procedures are in reducing colorectal cancer mortality in asymptomatic, average-risk patients aged 50 years and older?**

How effective is... (CHECK ONE BOX ON EACH LINE)	Very Effective	Somewhat Effective	Not Effective	Don't Know
a. Guaiac-based FOBT <sup>1</sup>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
b. Immunochemical FOBT or FIT <sup>2</sup>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
c. Flexible sigmoidoscopy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
d. Colonoscopy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
e. Double-contrast barium enema	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
f. Virtual colonoscopy (e.g., CT colonography)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
g. Fecal DNA testing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>

**2. Please indicate whether you agree or disagree with the following statements about colorectal cancer screening tests.**

(CHECK ONE BOX ON EACH LINE)	Agree	Neutral	Disagree	Don't Know
a. Guidelines recommend the digital rectal exam as a colorectal cancer screening test	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
b. If a stool blood test kit is returned and only one window is positive, the test should be repeated	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
c. A positive stool blood test should not be repeated with another stool blood test	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
d. Guidelines recommend that providers do a stool blood test in the office to make sure that at least one colorectal cancer screening test is completed	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
e. Patients referred for a screening colonoscopy who undergo a biopsy or polypectomy during the procedure may be required to pay a co-pay	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>

<sup>1</sup>FOBT: Fecal Occult Blood Test  
<sup>2</sup>FIT: Fecal Immunochemical Test

**3. Please indicate whether, in your opinion, the following barriers have affected your efforts to provide colorectal cancer screening for your patients.**

(CHECK ONE BOX ON EACH LINE)	Major Barrier	Minor Barrier	Not a Barrier	Don't Know
a. My patients do not follow through to complete colorectal cancer screening tests	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
b. My patients are reluctant or refuse to address colorectal cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
c. My patients are unaware of colorectal cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
d. My patients do not perceive colorectal cancer as a serious health threat	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
e. My patients have difficulty understanding the colorectal cancer screening information I give them	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
f. My patients' other health concerns have a higher priority than colorectal cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
g. I don't have enough time to discuss colorectal cancer screening with my patients	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
h. Resources for providing timely follow-up to positive FOBT/FIT screening tests are limited (e.g., lack of personnel, time)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
i. Resources for providing screening colonoscopy or flexible sigmoidoscopy are limited (e.g., lack of qualified personnel, equipment, facilities)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
j. My practice setting lacks an adequate reminder system for colorectal cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
k. My practice setting lacks an adequate tracking system for colorectal cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
l. Experts disagree about appropriate colorectal cancer screening and/or diagnostic modalities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
m. Provider reimbursement for conducting colorectal cancer screening is inadequate	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>
n. My patients cannot afford or lack adequate insurance coverage for colorectal cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	97 <input type="checkbox"/>

## SECTION B. COLORECTAL CANCER SCREENING RECOMMENDATIONS

**4. Which one of the following factors has the greatest influence on your recommendations for colorectal cancer screening? (CHECK ONE BOX)**

- 1  Guidelines or recommendations of any health plan with which you are affiliated
- 2  Clinical evidence in the published literature
- 3  Guidelines from national organizations (e.g., ACS/USMSTF, USPSTF, NCCN)\*
- 4  Day-to-day practice experiences
- 5  Other (specify): \_\_\_\_\_
- 6  None of these

\* ACS/USMSTF: Joint American Cancer Society/U.S. Multi-Society Task Force on Colorectal Cancer; USPSTF: Guidelines of the U.S. Preventive Services Task Force; NCCN: National Comprehensive Cancer Network Guidelines on Colon and Rectal Cancers

The questions in this section ask about your experiences with colorectal cancer screening. Please respond based on how you actually practice even if this differs from how you would like to practice under ideal circumstances.

5. Please complete the table below based on your colorectal cancer screening recommendations to asymptomatic, average-risk patients (in good health for their age). If you do not routinely recommend a particular test, check “no” and go to the next row.

Do you routinely recommend... (CHECK ONE BOX ON EACH LINE)	Your Recommended Starting Age	Your Recommended Frequency of Testing
a. Guaiac-based FOBT 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto; text-align: center;">-----</div> Years	Every <hr style="width: 50px; margin: 0 auto;"/> Years
b. Immunochemical FOBT or FIT 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto; text-align: center;">-----</div> Years	Every <hr style="width: 50px; margin: 0 auto;"/> Years
c. Colonoscopy 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto; text-align: center;">-----</div> Years	Every <hr style="width: 50px; margin: 0 auto;"/> Years
d. Flexible sigmoidoscopy 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto; text-align: center;">-----</div> Years	Every <hr style="width: 50px; margin: 0 auto;"/> Years
e. Double-contrast barium enema 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto; text-align: center;">-----</div> Years	Every <hr style="width: 50px; margin: 0 auto;"/> Years
f. Virtual colonoscopy (e.g., CT colonography) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto; text-align: center;">-----</div> Years	Every <hr style="width: 50px; margin: 0 auto;"/> Years
g. Fecal DNA testing 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto; text-align: center;">-----</div> Years	Every <hr style="width: 50px; margin: 0 auto;"/> Years
h. Digital rectal exam 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto; text-align: center;">-----</div> Years	Every <hr style="width: 50px; margin: 0 auto;"/> Years
i. Other (specify): _____	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto; text-align: center;">-----</div> Years	Every <hr style="width: 50px; margin: 0 auto;"/> Years

**If you routinely recommend guaiac-based FOBT (Yes to 5a), SKIP TO QUESTION 7.  
Otherwise, answer this question.**

**6. Why DON'T you routinely recommend guaiac-based FOBT? (CHECK ALL THAT APPLY)**

- |  |  |
|--|--|
| 1 <input type="checkbox"/> Preparation requirements for the patient        | 5 <input type="checkbox"/> Lack of or unknown test effectiveness                   |
| 2 <input type="checkbox"/> Lack of patient compliance                      | 6 <input type="checkbox"/> High cost or lack of insurance coverage for the patient |
| 3 <input type="checkbox"/> Patient fear or anxiety                         | 7 <input type="checkbox"/> Poor provider reimbursement                             |
| 4 <input type="checkbox"/> Unpleasantness of the procedure for the patient | 8 <input type="checkbox"/> Other (specify): _____                                  |

**If you routinely recommend immunochemical FOBT or FIT (Yes to 5b), SKIP TO QUESTION 8.  
Otherwise, answer this question.**

**7. Why DON'T you routinely recommend immunochemical FOBT or FIT? (CHECK ALL THAT APPLY)**

- |  |  |
|--|--|
| 1 <input type="checkbox"/> Preparation requirements for the patient        | 5 <input type="checkbox"/> Lack of or unknown test effectiveness                   |
| 2 <input type="checkbox"/> Lack of patient compliance                      | 6 <input type="checkbox"/> High cost or lack of insurance coverage for the patient |
| 3 <input type="checkbox"/> Patient fear or anxiety                         | 7 <input type="checkbox"/> Poor provider reimbursement                             |
| 4 <input type="checkbox"/> Unpleasantness of the procedure for the patient | 8 <input type="checkbox"/> Other (specify): _____                                  |

**If you routinely recommend colonoscopy (Yes to 5c), SKIP TO QUESTION 9.  
Otherwise, answer this question.**

**8. Why DON'T you routinely recommend colonoscopy? (CHECK ALL THAT APPLY)**

- |  |  |
|--|--|
| 1 <input type="checkbox"/> Preparation requirements for the patient                | 7 <input type="checkbox"/> Poor provider reimbursement             |
| 2 <input type="checkbox"/> Lack of patient compliance                              | 8 <input type="checkbox"/> Requirement of anesthesia               |
| 3 <input type="checkbox"/> Patient fear or anxiety                                 | 9 <input type="checkbox"/> Difficulties obtaining precertification |
| 4 <input type="checkbox"/> Unpleasantness of the procedure for the patient         | 10 <input type="checkbox"/> Poor endoscopic capacity in your area  |
| 5 <input type="checkbox"/> Lack of or unknown test effectiveness                   | 11 <input type="checkbox"/> Too many risks to the patient          |
| 6 <input type="checkbox"/> High cost or lack of insurance coverage for the patient | 12 <input type="checkbox"/> Other (specify): _____                 |

**Sections C and D ask about specific tests or modalities that are used to screen for colorectal cancer. Please respond based on how you actually practice even if this differs from how you would like to practice under ideal circumstances.**

## SECTION C. COLORECTAL CANCER SCREENING MODALITIES: FECAL OCCULT BLOOD TESTING OR FECAL IMMUNOCHEMICAL TESTING

If you do not order or perform FOBT/FIT in your practice, SKIP TO SECTION D on page 6.

**9. Please complete the table below based on your experiences in providing colorectal cancer screening with FOBT/FIT for your asymptomatic, average-risk patients.**

**During a typical month, how many times do you order or perform this screening test?**

(CHECK ONE BOX ON EACH LINE)	0	1–10	11–20	21–40	More Than 40	Don't Know
Office-based FOBT/FIT (e.g., via a digital rectal exam)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	97 <input type="checkbox"/>
FOBT/FIT with home test kits	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	97 <input type="checkbox"/>

**9A. Do you have a reminder system to ensure that patients who are given or mailed home FOBT/FIT kits complete and return the FOBT/FIT?**

- 1  Yes → GO TO QUESTION 9B
- 2  No → SKIP TO QUESTION 10
- 97  Don't know → SKIP TO QUESTION 10

**9B. What kinds of reminder systems do you use? (CHECK ALL THAT APPLY)**

- 1  Patient reminder telephone call
- 2  Mailed patient reminder
- 3  E-mailed patient reminder
- 4  Chart reminder to return kit at next visit
- 5  Other (specify): \_\_\_\_\_

**10. Which of the following do you usually recommend to a healthy, average-risk patient as an initial follow-up step to a positive FOBT/FIT? (CHECK ALL THAT APPLY)**

- 1  Repeat FOBT/FIT
- 2  Flexible sigmoidoscopy
- 3  Colonoscopy
- 4  Double-contrast barium enema
- 5  Virtual colonoscopy (e.g., CT colonography)
- 6  Other (specify): \_\_\_\_\_

**10A. Do you stop the workup if the second FOBT/FIT is negative?**

- 1  Yes
  - 2  No

**11. Do you have a mechanism (such as reminder calls or mailings, case management, or a tracking system) to ensure that patients with positive FOBT/FIT results complete follow-up testing?**

- 1  Yes → GO TO QUESTION 11A
- 2  No → SKIP TO QUESTION 12
- 97  Don't know → SKIP TO QUESTION 12

**11A. What is the mechanism? (CHECK ALL THAT APPLY)**

- 1  Patient reminder telephone call

- 2  Mailed patient reminder
- 3  E-mailed patient reminder
- 4  Case management or patient navigation
- 5  Tracking system or log
- 6  Scheduling system
- 7  Other (specify): \_\_\_\_\_

12. What percentage of FOBT/FIT with home test kits are completed by your patients?  
(Your best guess is fine.)

\_\_\_\_\_ %      97  Don't know

## SECTION D. SCREENING WITH ENDOSCOPY AND OTHER COLORECTAL CANCER SCREENING TESTS

13. Complete the table below based on your experiences in referring and/or providing colorectal cancer screening for your asymptomatic, average-risk patients.

During a <u>typical month</u> , how many times do you...	0	1–5	6–10	11–20	More Than 20	Don't Know
<b>(CHECK ONE BOX ON EACH LINE)</b>						
<b>Refer patients to another provider for screening:</b>						
a. Colonoscopy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	97 <input type="checkbox"/>
b. Sigmoidoscopy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	97 <input type="checkbox"/>
c. Double-contrast barium enema	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	97 <input type="checkbox"/>
d. Virtual colonoscopy (e.g., CT colonography)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	97 <input type="checkbox"/>
<b>Personally perform or supervise screening:</b>						
e. Colonoscopy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	97 <input type="checkbox"/>
f. Sigmoidoscopy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	97 <input type="checkbox"/>

14. Do you counsel patients about fees they may be required to pay if a biopsy or polypectomy is performed during a screening colonoscopy?

- 1  Yes
- 2  No
- 97  Don't know

15. Do you have a procedure or system that helps patients who have been referred for colorectal cancer screening complete the endoscopy (e.g., flexible sigmoidoscopy, colonoscopy)?

- 1  Yes → GO TO QUESTION 15A
- 2  No → SKIP TO QUESTION 16
- 97  Don't know → SKIP TO QUESTION 16

**15A. What is the procedure or system? (CHECK ALL THAT APPLY)**

- 1  Use a tracking system that reminds staff to follow up with patients
- 2  Get office staff to schedule screening appointment for patients
- 3  Send reminder letters to patients
- 4  Contact patients by phone to remind them
- 5  Contact patients by e-mail to remind them
- 6  Confirm completion through receipt of endoscopy report
- 7  Offer patients case managers or navigators
- 8  Other (specify): \_\_\_\_\_

**16. Over the past 2 years, has the volume of colorectal cancer screening tests you order, perform, or supervise:**

(CHECK ONE BOX ON EACH LINE)	Increased Substantially	Increased Somewhat	Stayed About the Same	Decreased Somewhat	Decreased Substantially	Don't Know	I Do Not Order or Perform This Test
a. Guaiac-based FOBT	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	97 <input type="checkbox"/>	6 <input type="checkbox"/>
b. Immunochemical FOBT or FIT	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	97 <input type="checkbox"/>	6 <input type="checkbox"/>
c. Screening sigmoidoscopy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	97 <input type="checkbox"/>	6 <input type="checkbox"/>
d. Screening colonoscopy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	97 <input type="checkbox"/>	6 <input type="checkbox"/>

**SECTION E. PRIMARY CARE PRACTICE SYSTEMS**

Some primary care physicians work in more than one location. Please answer the following questions as they relate to your main primary care practice location (i.e., the setting in which you spend the most hours per week).

**17. How many nurse practitioners, physician assistants, or other staff at your main primary care practice are involved in colorectal cancer screening activities (e.g., education, referral, tracking, patient navigation, and test distribution)?**

\_\_\_\_\_ 97  Don't know

**18. Has your main primary care practice implemented guidelines (e.g., practice protocols, policies, algorithms) for colorectal cancer screening?**

- 1  Yes
- 2  No
- 97  Don't know

**19. What type of medical record system does your main primary care practice use? (CHECK ALL THAT APPLY)**

- 1  Paper charts



- 2  Partial electronic medical records (e.g., lab results available electronically, but patient history on paper)
- 3  In transition from paper to full electronic medical records
- 4  Full electronic medical records

**20. Does your main primary care practice use a procedure or system to remind you or other members of the care team that a patient is due for colorectal cancer screening?**

- 1  Yes → GO TO QUESTION 20A
- 2  No → SKIP TO QUESTION 21
- 97  Don't know → SKIP TO QUESTION 21

**20A. What is the procedure or system? (CHECK ALL THAT APPLY)**

- 1  Special notation or flag in patient's chart
- 2  Computer prompt or computer-generated flow sheet
- 3  I routinely look it up in the medical record at the time of a visit
- 4  The practice regularly gives me a list of patients who are not up-to-date
- 5  Other (specify): \_\_\_\_\_

**21. Does your main primary care practice use a procedure or system to remind your patients that they are due for colorectal cancer screening?**

- 1  Yes → GO TO QUESTION 21A
- 2  No → SKIP TO QUESTION 22
- 97  Don't know → SKIP TO QUESTION 22

**21A. What is the procedure or system? (CHECK ALL THAT APPLY)**

- 1  Verbal prompt from you or a member of the care team during an office visit
- 2  Patient reminder telephone call
- 3  Mailed patient reminder
- 4  E-mailed patient reminder
- 5  Personalized Web page
- 6  Other (specify): \_\_\_\_\_

**22. During the past 12 months, did you receive feedback reports from any source regarding rates of colorectal cancer screening for your patients?**

- 1  Yes → GO TO QUESTION 22A
- 2  No → SKIP TO QUESTION 23
- 97  Don't know → SKIP TO QUESTION 23

**22A. Did these reports allow you to compare your own performance with your own patients to the performance of other practitioners and their patients?**

- 1  Yes
- 2  No
- 97  Don't know

**22B. During the past 12 months, were your payments adjusted based on your own performance, as reflected in these colorectal cancer screening reports?**

- 1  Yes
- 2  No

<sup>97</sup> Don't know

**23. Does your main primary care practice monitor the percentage of patients, aged 50 years and older, that are up-to-date with colorectal cancer screening?**

- 1  Yes → GO TO QUESTION 23A
- 2  No → SKIP TO QUESTION 24
- <sup>97</sup>  Don't know → SKIP TO QUESTION 24

**23A. What is the percentage of patients at your main primary care practice who are up-to-date with colorectal cancer screening? (Your best guess is fine.)**

\_\_\_\_\_ %                      <sup>97</sup> Don't know

**24. When it comes to educating patients about colorectal cancer screening, which of the following have been used by your main primary care practice in the past 6 months? (CHECK ALL THAT APPLY)**

- 1  Direct consultation during office visits
- 2  Nursing staff/PA/MA interactions
- 3  Office handouts (pamphlets, brochures, etc.)
- 4  Mailed information (pamphlets, brochures, etc.)
- 5  Referral to Web-based resources
- 6  DVDs
- 7  Other (specify): \_\_\_\_\_
- <sup>97</sup>  Don't know

**25. During the past 12 months, have you participated in any meetings, seminars, or Webinars that offer CMEs on colorectal cancer screening?**

- 1  Yes
- 2  No
- <sup>97</sup>  Don't know

26. During the past 12 months, have there been any activities in your community to encourage people to get screened for colorectal cancer?

- 1  Yes → GO TO QUESTION 26A
- 2  No → SKIP TO QUESTION 27
- 97  Don't know → SKIP TO QUESTION 27

26A. Please briefly describe these activities.

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## SECTION F. PRACTICE AND OTHER CHARACTERISTICS

27. How many hours per week do you spend in direct patient care?

\_\_\_\_\_ 97  Don't know

28. Including yourself, about how many physicians work in your main primary care practice location?

- 1  1
- 2  2–5
- 3  6–15
- 4  16–49
- 5  50–99
- 6  100+

29. During a typical week, approximately how many patients do you see in your main primary care practice location?

- 1  25 or fewer
- 2  26–50
- 3  51–75
- 4  76–100
- 5  101–125
- 6  126 or more

30. Approximately what percentage of your patients in your main primary care practice is aged 50 years and older? (Your best guess is fine.)

\_\_\_\_\_ % 97  Don't know

31. Approximately what percentage of your patients in your main primary care practice location is uninsured? (Your best guess is fine.)

\_\_\_\_\_ % 97  Don't know

32. Approximately what percentage of your patients in your main primary care practice location is insured by Medicaid? (Your best guess is fine.)

\_\_\_\_\_ % 97  Don't know

33. Approximately what percentage of your patients in your main primary care practice is of a racial or ethnic minority? (Your best guess is fine.)

\_\_\_\_\_ %                      97  Don't know

**SECTION G. PERSONAL CHARACTERISTICS**

34. What is your sex?

- 1  Male
- 2  Female

35. Are you Hispanic or Latino?

- 1  Yes
- 2  No

36. What is your race?

(CHECK ALL THAT APPLY)

- 1  White
- 2  Black or African American
- 3  Asian
- 4  Native Hawaiian or Other Pacific Islander
- 5  Native American or Alaska Native
- 6

37. What year did you graduate from medical school? \_\_\_\_\_

38. In which country did you complete your residency? \_\_\_\_\_

39. What is your primary clinical specialty?

- 1  Family practice
- 2  General practice
- 3  Internal medicine
- 4  Obstetrics/Gynecology
- 5  Other (specify): \_\_\_\_\_

40. The CDC is using data from this survey and other efforts to shape its colorectal cancer screening promotional efforts. Information from practicing doctors is especially important to CDC. We would like to contact you again in approximately 18 months. May we have your permission to contact you again?

- 1  Yes
- 2  No

41. Is there anything else you would like to tell us about colorectal cancer screening in your practice or in general?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you very much for completing this survey. Please return it in the envelope provided to:  
**ICF Macro**  
**Attn: Naomi Freedner**  
**126 College Street**  
**Burlington, VT 05401**

You can also fax your completed survey to the attention of Naomi Freedner at: 1-866-777-8356.