

**Maryland Cancer Plan: Problems and Possible Solutions**  
**Colorectal Cancer Committee**

Letter	Problems	Possible Solutions	Responsible Parties
A	<ol style="list-style-type: none"> <li>1. Lack of knowledge by public about the disease (asymptomatic, etc.) and screening recommendations; ages for screening</li> <li>2. Inconsistent messages</li> </ol>	<ol style="list-style-type: none"> <li>1. Develop message</li> <li>2. Promote messages about CRC screening to people <math>\geq 50</math> and to those at increased risk to increase demand, such as:               <ol style="list-style-type: none"> <li>a. Support educational messages to reach every Maryland resident over the age of 50 years that strongly encourage discussion about colorectal cancer with private care provider. <u>Message:</u> Talk to your doctor about colorectal cancer screening (also a provider education issue)</li> <li>b. Educate each resident over the age of 50 years to be an advocate for himself/herself for colorectal cancer screening.</li> </ol> </li> <li>3. Support distribution of literature that conveys the above message. Literature must be available to reach all sexes, races, cultures and geographic differences that are present in Maryland.</li> <li>4. Take this message to the general public in every possible forum: mass media, printed materials, billboards, outreach workers, etc.</li> </ol>	
B	<ol style="list-style-type: none"> <li>1. Mistrust of healthcare system</li> </ol>	<ol style="list-style-type: none"> <li>1. Involve community groups to spread the message about early screening</li> <li>2. Use role models to target minority (or other) populations for screening (e.g., those successfully screened)</li> <li>3. Use members of the community in planning and implementing CRC Education and screening programs</li> <li>4. Hold a forum for health care providers, insurers, and the community</li> <li>5. Involve the clergy, Ministerial Alliance, and African American professional groups such as Monumental Medical Society</li> <li>6. Forum to address myths</li> </ol>	

C	<ol style="list-style-type: none"> <li>1. Confusion between colonic treatments (common in the community— which can be liquids sold on the street [laxative?], enemas, colonic irrigation by chiropractors or other lay providers) and colonoscopy/CRC screening</li> <li>2. Belief in myths about CRC testing</li> </ol>	<ol style="list-style-type: none"> <li>1. Examine the Knowledge, Attitudes, and Beliefs of public (focus groups)-survey through outreach workers and BRFS analysis</li> <li>2. Use role models to target minority (or other) populations for screening</li> <li>3. Support educational messages to reach every Maryland resident over the age of 50 years that strongly encourage discussion about colorectal cancer with private care provider. <u>Message:</u> Talk to your doctor about colorectal cancer screening (also a provider education issue)</li> <li>4. Support distribution of literature that conveys the above message. Literature must be available to reach all sexes, races, cultures and geographic differences that are present in Maryland.</li> <li>5. Take this message to the general public in every possible forum: mass media, printed materials, billboards, outreach workers, etc.</li> </ol>	
D	<ol style="list-style-type: none"> <li>1. Many patients have a “fear of knowing” which motivates them to avoid screening and going to the doctor altogether</li> <li>2. Belief in myths about CRC testing</li> <li>3. Fear of procedure and fear of knowing result</li> </ol>	<ol style="list-style-type: none"> <li>1. Involve community groups in every way possible to spread the message about early screening</li> <li>2. Use role models to target minority (or other) populations for screening</li> <li>3. Patient Navigators in community-based organizations</li> </ol>	
E	<ol style="list-style-type: none"> <li>1. Barriers to screening including preparation, transportation, having a person to pick the patient up after the procedure, taking a day off work, living alone</li> </ol>		

F	<ol style="list-style-type: none"> <li>1. Lack of PCPs to do initial exam before screening</li> <li>2. Lack of providers who accept low-income clients or medical assistance</li> </ol>	<ol style="list-style-type: none"> <li>1. Examine the Knowledge, Attitudes, and Beliefs of providers (focus groups or survey following focus groups); also examine availability for night and weekend hours</li> <li>2. Standards for sigmoidoscopy (#/year)</li> <li>3. Examine role of NP</li> </ol>	
G	<ol style="list-style-type: none"> <li>1. Lack of physicians to do colonoscopy and sigmoidoscopy</li> </ol>	<ol style="list-style-type: none"> <li>1. Identify the degree to which this is a problem</li> <li>2. Get providers out to the patients (i.e. Scope-mobile)</li> </ol>	
H	<ol style="list-style-type: none"> <li>1. Lack of consistent messaging of providers to clients regarding screening, and follow-up</li> <li>2. Doctor and Patient should get to choose most appropriate test for the patient, not the cheapest test</li> </ol>	<ol style="list-style-type: none"> <li>1. Examine the Knowledge, Attitudes, and Beliefs of providers (focus groups or survey following focus groups)</li> <li>2. Support collaboration among community organizations to have one consistent message regarding screening.</li> <li>3. Support a “Consensus Meeting” on CRC screening so all doctors will come on board with the same message</li> <li>4. Educate every health care provider regarding the importance of discussing colorectal cancer screening with every client over 50 years. <ol style="list-style-type: none"> <li>a. Educate every provider regarding available screening modalities. Support colonoscopy as the screening method of choice for all who have no identified contraindications.</li> <li>b. Place paramount importance on the discussion of informed consent when discussing screening.</li> </ol> </li> <li>5. Offer CME</li> <li>6. Include topic in MedChi meeting or other society meetings</li> </ol>	
I	<ol style="list-style-type: none"> <li>1. Language barriers in doctor’s offices</li> <li>2. Lack of provider time or reimbursement for certain cultural competencies</li> </ol>	<ol style="list-style-type: none"> <li>1. Cultural competency training and materials for providers; educate providers regarding cultural diversity and culture sensitivity as part of the knowledge base for informed consent.</li> <li>2. Patient Navigators in community-based organizations</li> <li>3. Have bi-lingual outreach workers (FTE in all medical facilities?)</li> </ol>	

J	1. Confusion by providers over which is the screening strategy to recommend— e.g., gynecologists and primary care providers doing single window FOBT testing		
K	1. Providers screening practices are not monitored	1. Add CRC screening as HEDIS measure (Health Plan Employer Data and Information Set sponsored, supported and maintained by the National Committee for Quality Assurance)	
L	1. Not all patients with insurance coverage are getting screened	1. Encourage companies/employers/large corporations to provide education for workers related to available colorectal screening. 2. Include messages to patients and providers that outline the importance of understanding available medical insurances coverage (also a patient education issue)	
M	1. Health insurance plans may not fully cover the CRC screening method recommended by the provider for the patient 2. Lack of health care coverage and reimbursement for CRC screening	1. Distribute information on cost-benefit of screening to CEO's, legislators, decision-makers on benefits packages for large groups 2. Encourage patients to advocate for screening payment when negotiating, for example, union contracts with companies. 3. Work to encourage and support top management that provides screening payment. 4. Advocate for payment of CRC screening by health insurers	
N	1. Too little funding for screening uninsured, especially in Baltimore City	1. Initiate a screening program in Baltimore City and secure more funding for screening uninsured population	
O	1. Funding is not available to pay for diagnosis and treatment for all who are screened	1. Initiate a statewide CRC program to pay for diagnosis and treatment, similar to BCCP	

P	1. People don't have a "healthy lifestyle"	1. Solutions and strategies—are they unique to colorectal cancer or should they be incorporated into the universal "healthy lifestyle" messages for all cancers and chronic disease prevention?	
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Strategies with no identified problem:

- Promote state/ongoing programs (also a patient education issue)
- Training in risk assessment and communication
- Educate regarding informed consent (also a provider education issue)
- Get info on clinical trials to patients (also a provider education issue)