

Ideal Model for Colorectal Cancer Control: Groups Involved and Their Optimal Features

A. Policy Makers including Employers	B. Health Education (Health Educators, Community Health Workers, Outreach Workers, Media); Case Managers/Pt. Navigators	C. General Public	D. Target Population for CRC Screening*	E. Third Party Payers	F. Primary Care Providers (Internist, Family Physician, Gynecologist, Nurse Practitioner, Physician's Assistant, Allied Health staff)	G. Medical Specialists (Gastroenterologist, Surgeon, Radiologist, Pathologist)	H. Treatment Team (Surgeon, Oncologist, Radiation Oncologist, Case Manager; Patient Navigator, Social Workers, Home care, Hospice)	I. Researchers (Basic research, translational research, community-based participatory research, and provider surveys)
<p>1. Assure access to vegetables and fruits for low income populations through Women, Infant, and Children (WIC) and food stamp programs</p> <p>2. Assure coverage for CRC screening and treatment: by health insurance plans, and for the uninsured</p> <p>3. Reduce "structural" barriers to screening, e.g., allow workers time off for CRC screening</p> <p>4. Monitor HEDIS measures of insurers</p>	<p>5. Design new and implement through multiple channels new or existing health risk reduction and health promotion messages</p> <p>6. Design and implement CRC screening messages that are consistent, culturally sensitive, and appropriate to the literacy of the audience.</p> <p>7. Use strategies that are targeted to minorities and those with low CRC screening rates</p> <p>8. Utilize outreach and case management staff who are culturally</p>	<p>10. Receive primary prevention "Healthy Lifestyle" messages</p> <p>11. Heed recommendations to eat a healthy** diet; exercise; maintain a healthy weight; don't use tobacco products; limit alcohol</p> <p>12. Heed public information about diseases, risk factors, screening recommendations, and availability of programs targeted to those with low income, uninsured minorities</p> <p>13. Participate in community-based participatory research (surveys, focus groups)</p>	<p>14. Know about the need for CRC screening; know current recommendations</p> <p>15. Become motivated for screening having myths and fears dispelled</p> <p>16. Make an informed decision with health care provider about CRC screening</p> <p>17. Seek CRC screening, get screened, and keep up-to-date with recommended CRC screenings</p> <p>18. Select insurance that pays for screening, complications, and treatment</p> <p>19. Utilize insurance to pay for screening, if insured or seek no cost screening</p>	<p>20. Include CRC screening in benefit packages</p> <p>21. Work with providers to promote CRC screening</p> <p>22. Encourage members to utilize their CRC screening coverage</p> <p>23. Monitor HEDIS measures for CRC screening and seek improvement in rates</p>	<p>24. Exercise cultural sensitivity to patients of all races, ethnicities, national origins, cultures, genders, age, sexual preference, and socioeconomic status</p> <p>25. Make arrangements to see non-English-speaking patients</p> <p>26. Understand importance of CRC screening and follow current recommendations</p> <p>27. Institute a "screening scheme" or policy for the office practice</p> <p>28. List and utilize referral sources for CRC screening</p> <p>29. Take adequate family and personal history</p> <p>30. Recommend CRC screening based on best screening for the patient</p> <p>31. Clear patient for needed procedures</p> <p>32. Avoid use of single window FOBT in-office testing</p>	<p>39. Exercise cultural sensitivity to patients of all races, ethnicities, national origins, cultures, genders, age, sexual preference, and socioeconomic status</p> <p>40. Make arrangements to see non-English-speaking patients</p> <p>41. Maintain sufficient numbers of providers in each jurisdiction/region to perform needed procedures</p> <p>42. Perform colonoscopy, sigmoidoscopy, double contrast barium enema, etc.</p> <p>43. Perform polypectomy, biopsies, or additional procedures at time of colonoscopy to remove adenomatous polyps and/or cancers.</p> <p>44. Endoscopist: utilize colonoscopy software that captures CO-RADS elements</p> <p>45. Endoscopist: Report colonoscopy findings following the recommendations in CO-RADS</p>	<p>51. Exercise cultural sensitivity to patients of all races, ethnicities, national origins, cultures, genders, age, sexual preference, and socioeconomic status</p> <p>52. Make arrangements to see non-English-speaking patients</p> <p>53. "Navigate" patient through system, overcoming barriers of language, understanding, transportation, form completion, application for insurance, etc.</p> <p>54. Remove tumor; and stage cancer</p> <p>55. Be knowledgeable about current treatment recommendations</p> <p>56. Treat with most appropriate therapy</p> <p>57. Refer patients for clinical trials, as appropriate</p>	<p>60. Focus research on: descriptive epidemiology of CRC in Maryland; basic science of CRC; primary prevention; chemoprevention of CRC; patient and provider behavior change; new screening tests and their sensitivity, specificity, cost and acceptability; and new treatment of CRC</p>

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	<p>sensitive and of the same ethnicity/race /language as the target population.</p> <p>9. Reduce barriers to screening (transportation, language, comprehension, bowel preparation, etc.)</p>				<p>33. Send to specialist for screening (colonoscopy, DCBE, sig) or screen (FIT, FOBT, flex sig)</p> <p>34. Develop FOBT/FIT in office or in reference lab</p> <p>35. Expect that specialists will report colonoscopy results using CO-RADS</p> <p>36. Inform patient of results and provide appropriate recommendations</p> <p>37. Have reminder/recall/tickler system(s) for recalls including use of electronic health records that incorporate this feature</p> <p>38. Bill insurance or other funding source to pay for consult and screening</p>	<p>(Colonoscopy Reporting and Data System) in order to optimize communication with the patient and the referring physician</p> <p>46. Endoscopist: Send biopsies to pathologist</p> <p>47. Inform patient and referring provider/health department of results, recall interval, and recommendations</p> <p>48. Pathologist: Remain current on cancer reporting and staging guidelines</p> <p>49. Pathologist: Read specimens and report pathology findings to referring doctor(s) using standard categories/nomenclature that will facilitate communication with the endoscopist</p> <p>50. Receive payment from insurance or other funding source to pay for consult and testing</p>	<p>58. Provide follow-up care as needed</p> <p>59. Receive payment from insurance or other funding source to pay for consult and treatment services</p>	

- *Target population for CRC screening includes all people aged 50 years and older and people of any age with increased risk, i.e., genetic syndrome; family or personal history of adenomatous polyps or CRC; personal history of inflammatory bowel disease, ovarian or endometrial cancer.
- **"healthy diet": a mostly plant-based diet, high in vegetables and fruit.