

National Survey of Primary Care Physicians' Cancer Screening Recommendations and Practices

Colorectal and Lung Cancer Screening Questionnaire

Conducted by:



In collaboration with:



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The National Survey of Primary Care Physicians' Cancer Screening Recommendations and Practices, sponsored by the National Cancer Institute (NCI) in collaboration with the Agency for Healthcare Research and Quality and Centers for Disease Control and Prevention, is a nation-wide survey of family and general practitioners, general internists, and obstetrician/gynecologists.

In this survey, we request that you answer questions about your attitudes and practices related to colorectal and lung cancer screening procedures, **even if you are not currently performing these procedures yourself**. Because the survey is designed to accommodate a wide range of primary care physicians and practice settings, you may find that some questions do not apply to you. Most physicians will not need to answer every question in the survey.

Your name and contact number were provided to us by the American Medical Association. All information you provide in this survey will remain confidential. Your answers will be aggregated with those of other respondents in reports to NCI and any other parties.

Participation is voluntary, and there are no penalties to you for not responding. However, not responding could seriously affect the accuracy of final results, and your point of view may not be adequately represented in the survey findings.

Please fill out this survey within one week after you have received it. If you have any questions about the survey, please call us toll free at (800) 937- 8281 ext. 8343 or email at cathyanngrundmayer@westat.com.

Please return the completed survey in the enclosed postage-paid envelope. If another envelope is used, please send to:

Westat
Attn: Cathy Ann Grundmayer, TB-350
1650 Research Blvd.
Rockville, Maryland 20850

National Survey of Primary Care Physicians' Cancer Screening Recommendations and Practice

Survey Instructions:

- Cancer screening is defined in this survey as the periodic use of a testing procedure intended to find people at increased risk for cancer before its clinical detection or incidental discovery. Abnormal screening tests need to be evaluated to find those individuals with cancer. Cancer screening is used in patients who display no signs or symptoms of possible cancer (i.e., pain, bleeding, palpable masses, etc.).
- Many primary care physicians work in more than one setting. For the purpose of this survey, your main primary care practice is the one in which you spend the most hours per week.
- Most items are multiple choice. Please use an X or check mark to indicate your answers.
- For relevant items, if your answer is not adequately represented by available choices, please write it in after "Other (specify): _____".

Part A. Colorectal Cancer Screening Beliefs and Recommendations

***A1. How effective do you believe the following screening procedures are in reducing colorectal cancer mortality in 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 (e.g., Hemoccult II®, Hemoccult Sensa®, Coloscreen®)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>
b. Immunochemical FOBT (e.g., Instant-View®, InSure!™, immoCARE®, MonoHaem®)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>
c. Flexible sigmoidoscopy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>
d. Colonoscopy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>
e. Double-contrast barium enema	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>
f. Virtual colonoscopy (e.g., CT colonography)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>
g. Fecal DNA testing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>

The next several questions 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.

***A2. Please complete the table below based on your recommendations to asymptomatic, average-risk patients (in good health for their age) for colorectal cancer screening. If you do not routinely recommend a particular test, check “no” and go to the next row.**

Do you routinely recommend ...	Your Recommended Starting Age	Your Recommended Frequency of Testing	Is there an age at which you no longer recommend screening for healthy patients?
a. FOBT 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div> YEARS	EVERY <hr style="width: 50px; margin: 0 auto;"/> YEARS	1 <input type="checkbox"/> Yes, age ____ ____ 2 <input type="checkbox"/> No
b. 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;"></div> YEARS	EVERY <hr style="width: 50px; margin: 0 auto;"/> YEARS	1 <input type="checkbox"/> Yes, age ____ ____ 2 <input type="checkbox"/> No
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;"></div> YEARS	EVERY <hr style="width: 50px; margin: 0 auto;"/> YEARS	1 <input type="checkbox"/> Yes, age ____ ____ 2 <input type="checkbox"/> No
d. 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;"></div> YEARS	EVERY <hr style="width: 50px; margin: 0 auto;"/> YEARS	1 <input type="checkbox"/> Yes, age ____ ____ 2 <input type="checkbox"/> No
e. 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;"></div> YEARS	EVERY <hr style="width: 50px; margin: 0 auto;"/> YEARS	1 <input type="checkbox"/> Yes, age ____ ____ 2 <input type="checkbox"/> No
f. 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;"></div> YEARS	EVERY <hr style="width: 50px; margin: 0 auto;"/> YEARS	1 <input type="checkbox"/> Yes, age ____ ____ 2 <input type="checkbox"/> No

****A3. Which screening test or test combination would you be most likely to recommend for the following patients? Assume that these patients are:**

- asymptomatic and average-risk;
- treated in an ideal setting, without systemic or financial barriers to receiving care; and
- without previous screenings or expressed preferences for colorectal cancer screening.

Which screening test or test combination would you recommend for a... (CHECK ONE BOX ON EACH LINE)	Both FOBT and flexible sigmoidoscopy	FOBT only	Flexible sigmoidoscopy only	Both FOBT and colonoscopy	Colonoscopy only	Other (describe)	No screening
a. Healthy 50-year-old	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	<input style="width: 100%; height: 15px;" type="text"/>	06 <input type="checkbox"/>
b. Healthy 65-year-old	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	<input style="width: 100%; height: 15px;" type="text"/>	06 <input type="checkbox"/>
c. Healthy 80-year-old	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	<input style="width: 100%; height: 15px;" type="text"/>	06 <input type="checkbox"/>
d. 50-year-old with ischemic cardiomyopathy who experiences dyspnea with ordinary activity (NY Heart Association Class II) treated with appropriate medication	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	<input style="width: 100%; height: 40px;" type="text"/>	06 <input type="checkbox"/>
e. 65-year-old with ischemic cardiomyopathy who experiences dyspnea with ordinary activity (NY Heart Association Class II) treated with appropriate medication	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	<input style="width: 100%; height: 40px;" type="text"/>	06 <input type="checkbox"/>
f. 80-year-old with ischemic cardiomyopathy who experiences dyspnea with ordinary activity (NY Heart Association Class II) treated with appropriate medication	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	<input style="width: 100%; height: 40px;" type="text"/>	06 <input type="checkbox"/>
g. 50-year-old with unresectable non-small cell lung cancer	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	<input style="width: 100%; height: 15px;" type="text"/>	06 <input type="checkbox"/>
h. 65-year-old with unresectable non-small cell lung cancer	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	<input style="width: 100%; height: 15px;" type="text"/>	06 <input type="checkbox"/>
i. 80-year-old with unresectable non-small cell lung cancer	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	<input style="width: 100%; height: 15px;" type="text"/>	06 <input type="checkbox"/>

****A4. To what extent are the following factors influential in your recommendations for colorectal cancer screening?**

How influential is...

(CHECK ONE BOX ON EACH LINE)

	Very Influential	Somewhat Influential	Not Influential	Not Applicable or Not Familiar With
a. Clinical evidence in the published literature	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b. U.S. Preventive Services Task Force recommendations	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c. American Cancer Society guidelines	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d. Availability of reimbursement by third party payers, including Medicare and Medicaid	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e. Availability of providers to whom I can refer my patients for screening other than FOBT	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f. How colleagues in my practice or local community provide colorectal cancer screening for their patients	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g. My patients' preferences for colorectal cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h. Cost of screening tests for patients with no third party coverage	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i. Other (specify): <div style="border: 1px solid black; height: 30px; width: 300px; margin-top: 5px;"></div>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

A5. How often did you present more than one test option while discussing colorectal cancer screening with your asymptomatic, average-risk patients during the past 12 months?

(CHECK ONE BOX)

- 1 Never (SKIP TO A6)
- 2 Rarely
- 3 Sometimes
- 4 Usually

A5a. Which of the following screening tests did you discuss with your patients?
(CHECK ALL THAT APPLY)

- FOBT
- Sigmoidoscopy
- Colonoscopy
- Other (*specify*):

A6. How often did you recommend any one particular colorectal cancer screening test or test combination over others while discussing colorectal cancer screening with your asymptomatic, average-risk patients during the past 12 months?
(CHECK ONE BOX)

- 1 Never (SKIP TO A7 PAGE 7)
- 2 Rarely
- 3 Sometimes
- 4 Usually

A6a. Indicate the one screening test or test combination that you recommended over others to your patients.
(CHECK ONE BOX)

- 02 FOBT
- 03 Sigmoidoscopy
- 05 Colonoscopy
- 01 FOBT + Sigmoidoscopy
- 04 FOBT + Colonoscopy
- 95 Other (*specify*):

A7. How often did your asymptomatic, average-risk patients want you to decide which colorectal cancer screening test they should have during discussions of colorectal cancer screening in the past 12 months?

(CHECK ONE BOX)

- 1 Never
- 2 Rarely
- 3 Sometimes
- 4 Usually

****A8. When you talk to your asymptomatic, average-risk patients about colorectal cancer screening, how often do you encounter the following?**

(CHECK ONE BOX ON EACH LINE)

	Never	Rarely	Some-times	Usually
a. Not having enough time to discuss screening with my patients	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<u>My patients...</u>				
b. Do not want to discuss colorectal cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c. Have difficulty understanding the information I present about colorectal cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d. Are unaware of colorectal cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e. Do not perceive colorectal cancer as a serious health threat	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f. Cannot afford or lack adequate insurance coverage for colorectal cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g. Other (<i>specify</i>): _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

****A9. How often do you encounter the following barriers to colorectal cancer screening for asymptomatic, average risk patients in your practice?**

(CHECK ONE BOX ON EACH LINE)

	Never	Rarely	Sometimes	Usually
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"/>	4 <input type="checkbox"/>
<u>There is a shortage of trained providers in my geographic area of practice to conduct...</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b. Screening other than FOBT				
c. Follow-up of positive screening tests with invasive endoscopic procedures	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d. Other (specify): _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

***A10. Over the past 3 years, has the volume of colorectal cancer screening procedures that you order, perform, or supervise:**

(CHECK ONE BOX IN EACH ROW)	Increased Substantially (>20% per year)	Increased somewhat (<20% per year)	Stayed About the Same	Decreased Somewhat (<20% per year)	Decreased Substantially (>20% per year)	Don't Know
a. FOBT	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	8 <input type="checkbox"/>
b. Screening Sigmoidoscopy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	8 <input type="checkbox"/>
c. Screening Colonoscopy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	8 <input type="checkbox"/>

Colorectal Cancer Screening Modalities

These sections cover the specific 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.

Part B. Fecal Occult Blood Testing (FOBT)

***B1. For the majority of your patients, by what means do you conduct FOBT for screening purposes?**
(CHECK ONE BOX)

- 1 Complete a single FOBT card in the office during a digital rectal exam
(SKIP TO QUESTION B1b, NEXT PAGE)
- 2 Give or mail patients FOBT kits to complete at home
- 3 Both of the above
- 4 I do not use FOBT in my practice (SKIP TO C1, page 13)

***B1a. Do you have a mechanism to ensure that patients who are given or mailed home FOBT kits complete and return the FOBT?**

- 1 Yes
- 2 No (SKIP TO QUESTION B1b, next page)
- 8 Don't know (SKIP TO QUESTION B1b, next page)

***B1ai. What is the mechanism?**
(CHECK ALL THAT APPLY)

- Reminder telephone call
- Reminder by mail
- Chart reminder to return kit at next visit
- Other (specify):

****B1b. Please complete the table below based on your experiences in providing colorectal cancer screening with FOBT for your asymptomatic, average-risk patients.**

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

(CHECK ONE BOX IN EACH ROW)	0	1-10	11-20	21-40	More than 40
i. Office-based FOBT (e.g., via digital rectal exam)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
ii. FOBT with home test kits	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

****B2. Who orders or performs FOBT for your patients?**

(CHECK ALL THAT APPLY)

I order or perform

A nurse practitioner or physician's assistant orders or performs

Other (specify):

***B3. What brand of test do you use?**

(CHECK ALL THAT APPLY)

Hemoccult II®

Hemoccult Sensa®

Coloscreen®

Hemoccult® ICT

Insure!™

Instant-View®

immoCARE®

MonoHaem®

Other (specify):

Don't know

B4. Is laboratory analysis of FOBT conducted on site in your practice, or are FOBT cards sent to a central laboratory for processing?
(CHECK ONE BOX)

- 1 Conducted on site in practice
- 2 Sent to a central laboratory
- 8 Don't know

***B5. Which of the following do you usually recommend to a healthy, average-risk patient as an initial follow-up step to a positive FOBT?**
(CHECK ALL THAT APPLY)

Repeat FOBT →

Flexible sigmoidoscopy

Colonoscopy

Double contrast barium enema

Virtual colonoscopy (e.g., CT colonography)

Other (*specify*):

B5a. Do you stop the work-up if the second FOBT is negative?

Yes

No

B6. Do you have a mechanism (such as reminder calls or mailings, case management, or a tracking system) to ensure that patients with positive FOBT results complete initial follow-up testing?

- 1 Yes
- 2 No (SKIP TO QUESTION C1, page 13)
- 8 Don't Know (SKIP TO QUESTION C1, page 13)

B6a. What is the mechanism?
(CHECK ALL THAT APPLY)

Patient reminder telephone call

Mailed patient reminder

Case management

Tracking system or log

Scheduling system

Other (*specify*):

**Part C. Screening with Endoscopy and
Other Colorectal Cancer Tests**

****C1. Complete the table below based on your experiences in providing colorectal cancer screening with sigmoidoscopy for your asymptomatic, average-risk patients.**

During a typical month, how many times do you...
(CHECK ONE BOX IN EACH ROW)

	0	1-5	6-10	11-20	More than 20
a. <u>Refer</u> patients to another provider for screening <u>sigmoidoscopy</u> ?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b. <u>Personally perform or supervise</u> screening <u>sigmoidoscopy</u> ?	0 <input type="checkbox"/> (SKIP TO C2)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

***C1bi. Do you perform or supervise screening sigmoidoscopy?**
(CHECK ALL THAT APPLY)

- I perform
- I supervise a nurse practitioner or physician's assistant
- I supervise another clinician
- Other (*specify*):

****C2. During a typical month, how many times do you refer asymptomatic, average-risk patients for screening colonoscopy? (CHECK ONE BOX)**

- 0 (SKIP TO C3, PAGE 14)
- 1-5
- 6-10
- 11-20
- More than 20

***C2a. To whom do you usually refer your patients for screening colonoscopy?**
(CHECK ONE BOX)

01 Gastroenterologist

02 Surgeon

03 Family practitioner

04 Internist

95 Other (specify):

****C3. During a typical month, how many times do you personally perform or supervise screening colonoscopy for asymptomatic, average-risk patients?**
(CHECK ONE BOX)

0 (SKIP TO C4, PAGE 15)

1-5

6-10

11-20

More than 20

C3a. Do you perform or supervise screening colonoscopy?
(CHECK ALL THAT APPLY)

I perform

I supervise another clinician

Other (specify):

C4. Please indicate whether you agree or disagree with the following statements about colorectal cancer screening with colonoscopy for asymptomatic, average-risk patients.

(CHECK ONE BOX IN EACH ROW)	Strongly Agree	Some-what Agree	Some-what Disagree	Strongly Disagree	Not Applicable
a. It is the best of the available screening tests	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	0 <input type="checkbox"/>
b. It is readily available for my patients	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	0 <input type="checkbox"/>
c. I worry that I might be sued if I do not offer this test to my patients	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	0 <input type="checkbox"/>
d. Other (<i>specify</i>): <input style="width: 200px; height: 20px;" type="text"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	0 <input type="checkbox"/>

****C5. Complete the table below based on your experiences in providing colorectal cancer screening with double-contrast barium enema or virtual colonoscopy for your asymptomatic, average-risk patients.**

During a typical month, how many times do you refer your patients to another provider for this procedure?

(CHECK ONE BOX IN EACH ROW)	0	1-5	6-10	11-20	More than 20
a. Double-contrast barium enema	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b. 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"/>

C6. During the past 12 months, did you ever order colorectal cancer screening with fecal DNA testing (e.g., PreGen-Plus®) for your asymptomatic, average-risk patients?

(CHECK ONE BOX)

- 1 Yes
- 2 No
- 5 Not sure

Part D. Lung Cancer Screening

In this section, we are interested in your opinions about and experiences with lung cancer screening. This topic has relevance for primary care physicians and health care researchers because lung cancer is the most common cause of cancer-related death among both men and women in the U.S.

D1. How effective do you believe the screening procedures listed below are in reducing lung cancer mortality in the following asymptomatic patients aged 50 years and older?

(CHECK ONE BOX IN EACH ROW)

	Very Effective	Somewhat Effective	Not Effective	Don't Know
a. Never Smokers:				
i. Chest x-ray	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>
ii. Sputum cytology	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>
iii. Low radiation dose spiral CT	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>
b. Former Smokers:				
i. Chest x-ray	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>
ii. Sputum cytology	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>
iii. Low radiation dose spiral CT	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>
c. Current Smokers:				
i. Chest x-ray	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>
ii. Sputum cytology	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>
iii. Low radiation dose spiral CT	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	8 <input type="checkbox"/>

D2. Which, if any, screening test would you recommend for the following patients? Assume that these patients have:

- not been previously screened for lung cancer;
- no symptoms of lung cancer;
- expressed no preference for lung cancer screening in general or with a specific modality; and
- no occupational exposure to known or suspected lung carcinogens.

(CHECK ONE BOX IN EACH ROW)

	No screening	Chest x-ray only	Sputum cytology only	Both chest x-ray and sputum cytology	Low radiation dose spiral CT	Other (describe)
a. Healthy 50-year-old who: • has never smoked • has not had substantial exposure to second-hand smoke	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	<input type="text"/>
b. Healthy 50-year-old who: • has never smoked • has 20 years' exposure to second-hand smoke from a chain-smoking spouse	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	<input type="text"/>
c. Otherwise healthy 50-year-old former cigarette smoker with: • a 20-year pack history • patient quit smoking 1 year ago	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	<input type="text"/>
d. Otherwise healthy 50-year-old former cigarette smoker with: • a 20-year pack history • patient quit smoking 15 years ago	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	<input type="text"/>
e. Otherwise healthy 50-year-old current smoker who: • has smoked 1 pack of cigarettes per day for the past 20 years	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>	05 <input type="checkbox"/>	<input type="text"/>

D3. During the past 12 months, for an asymptomatic patient, did you ever...

(CHECK ONE BOX IN EACH ROW)

	Yes	No	Not sure
a. Order a chest x-ray for lung cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Order sputum cytology for lung cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	5 <input type="checkbox"/>
c. Order low radiation dose spiral CT for lung cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	5 <input type="checkbox"/>
d. <u>Initiate</u> a discussion about the risks and benefits of lung cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	5 <input type="checkbox"/>
e. Discuss, with a patient who had <u>self-referred</u> for the procedure, the results of a low radiation dose spiral CT exam	1 <input type="checkbox"/>	2 <input type="checkbox"/>	5 <input type="checkbox"/>
f. Refer a patient for enrollment in a clinical trial of lung cancer screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	5 <input type="checkbox"/>

D4. During the past 12 months, did any of your patients ask if they can or should be screened for lung cancer?

1 Yes → How many patients? (Please give your best estimate.)
 2 No

D5. With what proportion of your new patients do you ask about their cigarette smoking behavior?

- 1 None or a little (< 10%)
- 2 Some (11-25%)
- 3 Half (about 50%)
- 4 Most (about 75%)
- 5 Almost all (> 90%)

D6. Are you aware of, and have you ever referred a patient to, any of the following smoking cessation services?

(CHECK ONE BOX IN EACH ROW)

	Aware and Referred	Aware of It, Never Referred	Not Aware of It	Not sure
a. The 1-800-QUIT-NOW quitline	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b. The 1-877-44U-QUIT quitline	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4c. The www.smokefree.gov website	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d. Other (<i>specify</i>): _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

D7. To the best of your knowledge, do the following organizations recommend the use of lung cancer screening in asymptomatic patients?

(CHECK ONE BOX IN EACH ROW)

	Yes, recommend	No, don't recommend	Not sure
a. U.S. Preventive Services Task Force	1 <input type="checkbox"/>	2 <input type="checkbox"/>	5 <input type="checkbox"/>
b. American Cancer Society	1 <input type="checkbox"/>	2 <input type="checkbox"/>	5 <input type="checkbox"/>
c. American College of Radiology	1 <input type="checkbox"/>	2 <input type="checkbox"/>	5 <input type="checkbox"/>
d. American Thoracic Society	1 <input type="checkbox"/>	2 <input type="checkbox"/>	5 <input type="checkbox"/>
e. National Cancer Institute	1 <input type="checkbox"/>	2 <input type="checkbox"/>	5 <input type="checkbox"/>

D8. Is low radiation dose spiral CT available in the geographic area from which you draw your patients?

- 1 Yes
 2 No (SKIP TO E1 NEXT PAGE)
 5 Not sure (SKIP TO E1 NEXT PAGE)

D8a. Does the facility provide lung cancer screening?

- 1 Yes
 2 No
 5 Not sure

Part E. Practice and Other Characteristics

The questions in this final section will help us to better understand you and your medical practice.

E1. During a typical month, approximately what percent of your professional time do you spend in the following activities?

a.	Providing Primary Care	____ _ %
b.	Providing Subspecialty Care	____ _ %
c.	Research	____ _ %
d.	Teaching	____ _ %
e.	Administration	____ _ %
f.	Other (<i>specify</i>): _____	____ _ %
Total		1 0 0 %

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, that is, the setting where you spend the most hours per week.

***E2. Which of the following categories best describes your main primary care practice location (*i.e.*, the practice setting where you spend the most hours per week)? Are you a...**

(CHECK ONE BOX)

- 01 Full- or part-owner of a physician practice
- 02 Employee of a physician-owned practice
- 03 Employee of a large medical group or health care system
- 04 Employee of a staff or group model HMO
- 05 Employee of a university hospital or clinic
- 06 Employee of a hospital or clinic not associated with a university
(including community health clinics)
- 95 Other (*specify*):

***E3. Including yourself, about how many physicians work in your main primary care practice location?**
(CHECK ONE BOX)

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

***E3a. Is your main primary care practice in a single specialty or multi-specialty setting (where a multi-specialty practice includes specialists other than primary care physicians)?**
(CHECK ONE BOX)

- 1 Single specialty
- 2 Multi-specialty
- 95 Other (*specify*):

E4. How many nurse practitioners and/or physician assistants are in your main primary care practice location?
(CHECK ONE BOX)

- 0
- 1
- 2+

E5. Has your main primary care practice implemented guidelines for colorectal cancer screening?

- 1 Yes
- 2 No (SKIP TO QUESTION E6)

E5a. Do you have access to these practice guidelines in an electronic format (such as a Web site or computer information system)?

(CHECK ONE BOX ON EACH LINE)

	Yes	No
i. At the point of care (e.g., exam room)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
ii. At your desk or a work station, away from the point of care	1 <input type="checkbox"/>	2 <input type="checkbox"/>

E6. What type of medical record system does your main primary care practice use?

(CHECK ONE BOX)

- 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

E7. Does your main primary care practice have a mechanism to remind you or other members of the care team that a patient is due for colorectal cancer screening?

(CHECK ALL THAT APPLY)

- Yes, special notation or flag in patient's chart
- Yes, computer prompt or computer-generated flow sheet
- Yes, I routinely look it up in the medical record at the time of a visit
- Yes, other mechanism (*specify*):
- No

E8. Does your main primary care practice have a mechanism to remind your patients that they are due for colorectal cancer screening?
(CHECK ALL THAT APPLY)

- Yes, verbal prompt from you or a member of the care team during an office visit
- Yes, reminder by US mail
- Yes, reminder telephone call
- Yes, reminder by e-mail
- Yes, personalized Web page
- Yes, other mechanism (*specify*):
- No
- Not sure

E9. During the past 12 months, did you receive reports from any source regarding rates of colorectal cancer screening for your patients?

- 1 Yes
- 2 No (SKIP TO QUESTION E10)

E9a. 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
- 5 Not sure

E9b. 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
- 5 Not sure

***E10. During a typical week, approximately how many patients do you see in your main primary care practice location?**
 (CHECK ONE BOX)

- 25 or fewer
- 26-50
- 51-75
- 76-100
- 101-125
- 126 or more

E11. Approximately what percentage of your patients in your main primary care practice location is:
 (PLEASE GIVE YOUR BEST ESTIMATE)

(CHECK ONE BOX ON EACH LINE)

	0-5%	6-25%	26-50%	51-75%	76-100%	Don't Know
a. Uninsured	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	8 <input type="checkbox"/>
b. Insured by Medicaid	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	8 <input type="checkbox"/>

***E12. Approximately what percentage of your patients in your main primary care practice is female?**
 (PLEASE GIVE YOUR BEST ESTIMATE)

	Percentage of patients
a. Female	____ %

E13. Approximately what percentage of your patients in your main primary care practice is:
(PLEASE GIVE YOUR BEST ESTIMATE)

	Percentage of patients
a. less than 18 years	___ ___ ___ %
b. 18-39 years	___ ___ ___ %
c. 40-64 years	___ ___ ___ %
d. 65+ years	___ ___ ___ %
TOTAL	1 0 0 %

E14. Approximately what percentage of your patients in your main primary care practice is:
(PLEASE GIVE YOUR BEST ESTIMATE)

(CHECK ONE BOX ON EACH LINE)

	0-5%	6-25%	26-50%	51-75%	76-100%	Don't Know
a. White	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	8 <input type="checkbox"/>
b. Black or African-American	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	8 <input type="checkbox"/>
c. Asian	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	8 <input type="checkbox"/>
d. Native Hawaiian or Other Pacific Islander	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	8 <input type="checkbox"/>
e. American Indian or Alaska Native	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	8 <input type="checkbox"/>

E15. Approximately what percentage of patients in your main primary care practice is Hispanic or Latino? (YOUR BEST ESTIMATE IS FINE).
(CHECK ONE BOX)

- 0-5%
- 6-25%
- 26-50%
- 51-75%
- 76-100%
- Don't Know

***E16. Do you as an individual have an affiliation with a medical school, such as an adjunct, clinical, or other faculty appointment?**

1 Yes

2 No

****E17. Do you consider yourself to be Hispanic or Latino?**

1 Yes

2 No

****E18. What do you consider to be your race?**

(CHECK ALL THAT APPLY)

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

Other (*Specify*): _____

****E19. Is there anything else you would like to tell us about colorectal or lung cancer screening in your practice or in general?**

Thank you very much. We greatly appreciate your participation.