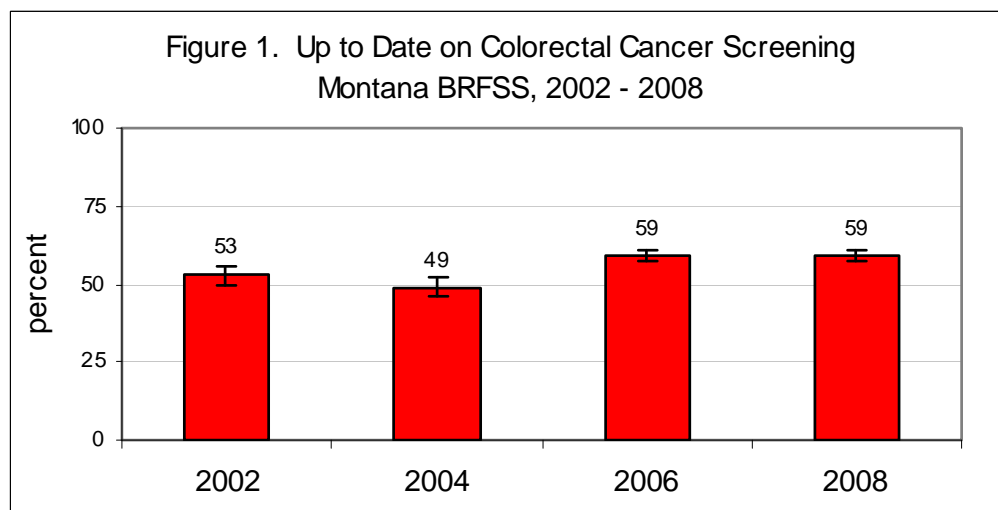


Barriers to Colorectal Cancer Screening in Montana, BRFSS 2008

The Behavioral Risk Factor Surveillance System (BRFSS) provides population-based estimates of health care access and behavior, including cancer screening participation.¹ It is a randomly dialed, anonymous telephone survey conducted throughout each year. The cancer screening module is included in even years. Participants 50 years and older are asked if they have ever had a take-home fecal occult blood test (FOBT) or an endoscopy. If they report having had the tests, they are asked how long ago they had their last test.

Participants were classified as up-to-date on colorectal cancer screening if they reported a colonoscopy or sigmoidoscopy within 10 years or a Fecal Occult Blood Test (FOBT) within one year for the 2002, 2004, and 2006 surveys. The 2008 survey was the first time participants were asked to distinguish between colonoscopy and flexible sigmoidoscopy. For the 2008 survey, participants were classified as up-to-date if they reported having a colonoscopy within 10 years, a flexible sigmoidoscopy within five years, or an FOBT within one year.² In most survey years, slightly more than half of the participants reported being up to date on colorectal cancer screening (Figure 1).

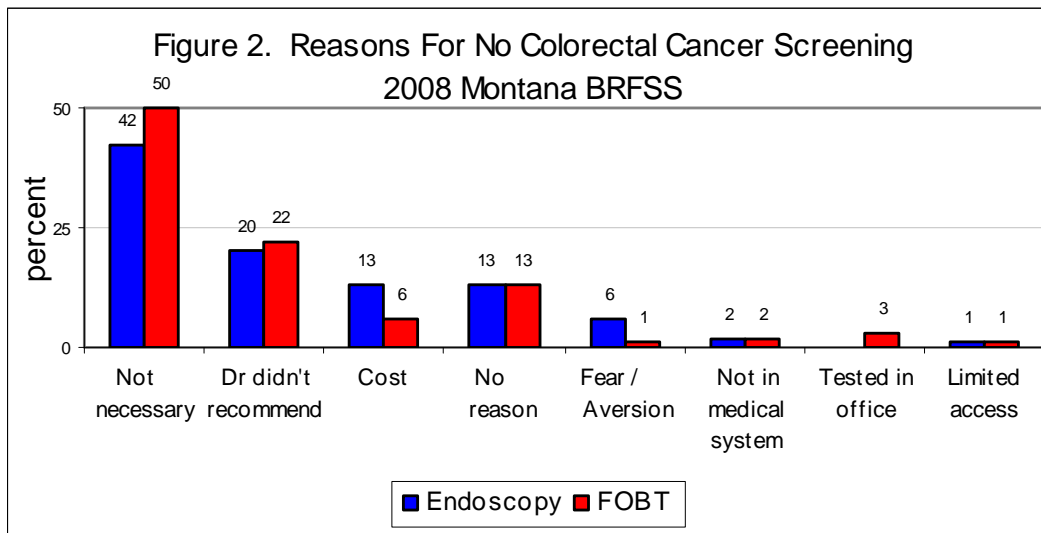


In 2008, participants who were not up-to-date on colorectal cancer screening were asked why they had not been screened. These were open-ended questions. The interviewer did not read possible responses and coded the first reason volunteered by the participant. There were eight coded checkboxes or the option of "Other(specify)." If interviewers could not readily code a response, they transcribed the response given for later review and coding. Fewer than 1% of "Other" responses were not coded after review.

The most common reason for not having either test was the belief that screening was not necessary, followed by lack of provider recommendation (Figure 2). Cost was a greater barrier to endoscopy than to FOBT.

¹ Montana Behavioral Risk Factor Surveillance System, <http://74.205.72.25/html/brfss-index.shtml>

² US Preventive Services Task Force. Screening for colorectal cancer: US Preventive Services Task Force recommendation statement. AHRQ publication 08-05124-EF-3. Rockville, MD: Agency for Healthcare Research and Quality. 2008. www.ahrq.gov



The next most common response was "No specific reason" for both kinds of tests, followed by fear of or aversion to endoscopy or the preparation for endoscopy. A small number of participants were not engaged in the medical system, either because they did not have a health care provider, did not believe in doctors, or did not seek preventive health care.

Due to small numbers of responses to some items (distance to a medical center, lack of transportation, difficulty in getting an appointment, inadequate access for people with disabilities), we grouped them into a category of "Limited Access" to health care or to the screening procedures. In the aggregate, fewer than 1% of participants for each kind of test reported Limited Access as reasons for not being screened.

Fewer than 1% of participants said they had not been screened by endoscopy because they preferred FOBT and fewer than 1% said they had not had an FOBT because they preferred endoscopy. Three percent of participants who had not had a home FOBT test said they had a fecal test in the physician's office.

In summary, 62% of participants who had not been screened by endoscopy and 72% who had not been screened by FOBT said they did not believe they needed to be screened or their health care provider had not recommended screening. Relatively few cited cost as the primary barrier, even for endoscopy, and fewer than 1% reported barriers of access to health care or the screening procedures.

These results for Montana are similar to those from studies elsewhere in the US which report that lack of patient awareness and lack of provider recommendation are the main reasons for low participation in cancer screening in general and colorectal cancer screening in particular.³

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Montana Department of Health and Human Services
1400 Broadway C-317, PO Box 202951
Helena, MT 59620-2951

³ Messina et al. 2005. *Am J Prev Med* 28:439-446; Subramanian et al. 2004. *Prev Med* 38:536-550; Cibula and Morrow. 2003. *J Public Health Manag Pract* 9:315-321; Tabbarah et al. 2005. *J Community Health* 30:55-74; Zapka et al. 2002. *Am J Prev Med* 23:28-35; Klabunde et al. 2006. *Am J Prev Med* 30:313-319; Wee et al. 2005. *Prev Med* 41:23-29; Klabunde et al. 2005 *Med Care* 43:939-944.