



# NEVADA HOME-BASED COLORECTAL CANCER (CRC) SCREENING TOOLKIT

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Nevada Colorectal Cancer Collaborative, July 2024

## Introduction

This toolkit is designed to serve as a guide for Nevada healthcare providers and organizations seeking to increase colorectal cancer (CRC) screening in their community through the provision of at-home CRC screening kits to increase access to and completion of recommended CRC screening.

### Toolkit Development

The contents of this toolkit were developed and sourced by the Nevada Cancer Coalition and Tayler Gerhard, MPHc, a graduate student at the University of Nevada, Reno.

The content contained within and presented by this toolkit is the culmination of published research and publicly available information on CRC and CRC screening procedures. CRC screening is an increasingly important process in cancer early detection and treatment. Strategies to promote CRC screening require nuanced approaches to ensure patient access and completion.

### Toolkit Objective

Users of this toolkit will improve their understanding of the need for increased access and availability of CRC screening in the state of Nevada, and find direction toward the appropriate tools and resources for healthcare systems to distribute at-home CRC screening kits in communities they serve successfully.

### Audience

This toolkit is designed to assist various healthcare organizations and providers interested in delivering at-home CRC screening in their communities.

### Contact

For questions or concerns related to the content of this toolkit, or if you are interested in locating additional provider resources, the Nevada Cancer Coalition is available.

### **Nevada Cancer Coalition**

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# The Importance of Colorectal Cancer Screening

## Colorectal Cancer Overview

Colorectal cancer (CRC) is a growing concern in Nevada and across the United States (U.S.). It has the third highest cancer incidence in the U.S. for men and women combined, not including skin cancers,<sup>1</sup> and the fourth highest cancer incidence in Nevada. However, when compared to all other cancers, CRC has the second highest mortality rate for men and women combined in both Nevada and the U.S., following only lung cancer.<sup>2</sup>

Across the U.S., CRC incidence has experienced an unusual fluctuation over the past 40 years. Although the overall rate of CRC diagnoses has gradually decreased following increased screening efforts and a greater focus on lifestyle-based risk factor reduction, this pattern primarily applies to older adults. Recently, statistics indicate an increase in diagnoses in people below 55 years old, with incidence tending to increase in this age group by around 1-2% per year for about the past 30 years. Current data estimates the lifetime risk for a person developing CRC is approximately 4.3% or 1 in 23 for men and 4% or 1 in 25 for women.<sup>3</sup>

Similar to trends seen with CRC incidence, CRC mortality in the U.S. has gradually declined in older adults over the past few decades, whereas mortality rates for people under 55 years old have increased by about 1% annually since the mid-2000s.<sup>4</sup> These changes in CRC incidence and mortality trends indicate the need for more comprehensive screening efforts that address a greater proportion of the population.

The CRC incidence and mortality trends in Nevada are no exception to many patterns documented across the U.S. As shown in **Figure 1**, incidence rates over the most recent 10 years of available data have ranged from 33.8 to 42.1 per 100,000 population in Nevada. Although the incidence rates do show a tendency toward a slight decline in these 10 years, the year-to-year fluctuation in rates demonstrates the need for increased screening efforts to establish greater control and surveillance of CRC in Nevada. Mortality trend data in Nevada highlights an even more pressing concern. The same timeframe features mortality rates between 13.8 and 17.9 per 100,000 population. However, there is less indication that mortality rates appear to be decreasing over time, and large surges of CRC-related mortality, such as that seen in 2017, necessitate greater efforts toward CRC prevention and screening if we wish to see an improved mortality trend in Nevada.

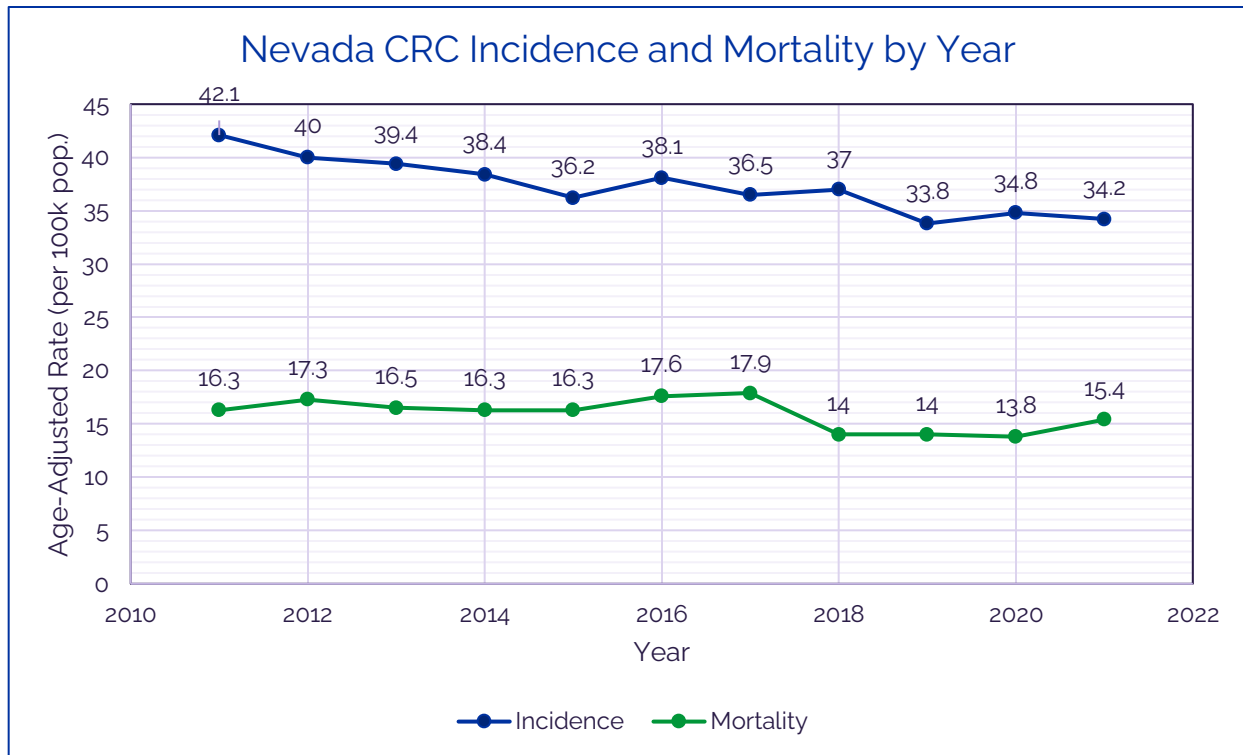
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<sup>1</sup> The American Cancer Society. (2024). [Colorectal Cancer Key Statistics](#)

<sup>2</sup> Nevada Central Cancer Registry. (2024). [Cancer Incidence and Mortality in Nevada](#)

<sup>3</sup> The American Cancer Society. (2024). [Colorectal Cancer Key Statistics](#)

<sup>4</sup> The American Cancer Society. (2024). [Colorectal Cancer Key Statistics](#)



**Figure 1. Nevada CRC Incidence and Mortality by Year.<sup>5</sup>**

### Evidence for Colorectal Cancer Screening

As of 2021, the U.S. Preventive Services Task Force (USPSTF) recommends adults 45 years or older complete CRC screening. The organization further advises the greatest benefit from screening impacts those between 50 and 75 years old.<sup>6</sup> With recent trends indicating an increase in CRC incidence in adults below 55 years old, changing these recommendations is an evidence-based action that provides key guidelines for healthcare practitioners who seek to connect their communities with appropriate care and reduce the impact of CRC in Nevada.

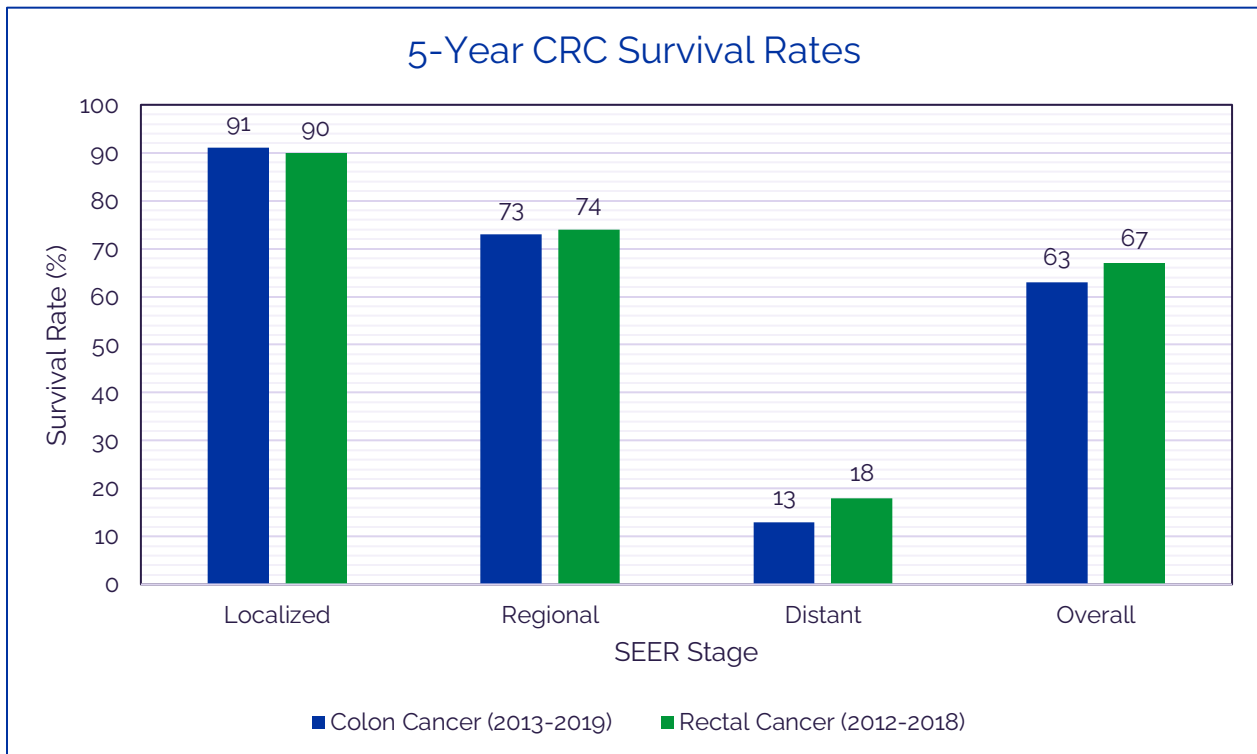
Multiple CRC screening tests are available for patients, with varying degrees of accessibility, ease, and accuracy. Stool-based tests include high-sensitivity guaiac-based fecal occult blood testing (HSgFOBT), fecal immunochemical test (FIT), and stool DNA with fecal immunochemical test (sDNA-FIT). Each of these screening tests is less likely to provide a complete picture of colorectal health and generally requires more frequent follow-up, but are often more accessible to patients and less disruptive to one's day-to-day life. Direct visualization tests include colonoscopy, CT colonography, flexible sigmoidoscopy, and flexible sigmoidoscopy with FIT. While these options provide a more complete picture of colorectal health and generally require less frequent follow-up, they may be less accessible and more disruptive to

<sup>5</sup> Nevada Central Cancer Registry. (2024). [Cancer Incidence and Mortality in Nevada](#)

<sup>6</sup> U.S. Preventive Services Task Force. (2021). [Colorectal Cancer: Screening](#)

one's day-to-day life.<sup>7</sup> Regardless of the test used, it is imperative healthcare providers work to connect their communities with a suitable test option for each individual.

The 5-year survival rates for CRC highlight the need to connect unscreened individuals with screening resources in a timely manner. The data presented in **Figure 2** highlights the 5-year survival rates for patients diagnosed with colon or rectal cancer between the years 2013-2019 and 2012-2018, respectively. The SEER stages are used to describe the cancer's degree of spread throughout the body, in which 'localized' describes no cancerous spread, 'regional' describes nearby cancerous spread, and 'distant' describes metastasis to farther organs or bodily structures. Patients who utilize screening resources and detect CRC in an early, localized stage are shown to have significantly higher survivorship throughout five years compared to patients who are diagnosed at a highly metastatic, distant stage.<sup>8</sup> Prevention and early diagnosis with regard to CRC are key components to providing patients both quality and quantity of life.



**Figure 2. 5-Year CRC Survival Rates.**

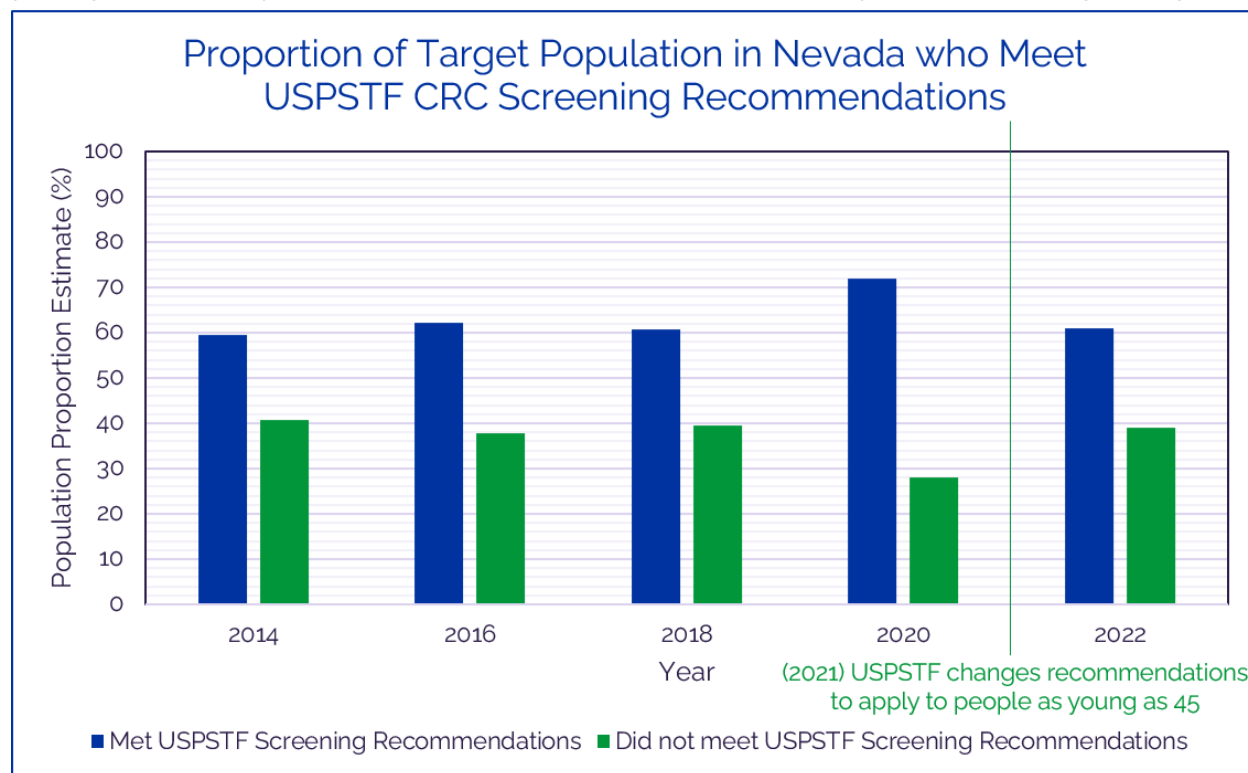
<sup>7</sup> U.S. Preventive Services Task Force. (2021). [Colorectal Cancer: Screening](#)

<sup>8</sup> The American Cancer Society. (2024). [CRC 5-Year Survival Rates](#)

## Current Colorectal Cancer Screening Rates in Nevada

Based on data provided by the Behavioral Risk Factor Surveillance System (BRFSS), which is presented in

**Figure 3**, the proportion of adults following the USPSTF recommendations for CRC screening seems to have gradually increased over the past decade. However, a sudden drop-off is noticeable in 2022 following the 2021 change to the organization's recommended target population to include adults as young as 45 years old.<sup>9</sup> As knowledge of CRC continues to evolve, there is always the potential for changes in screening recommendations. If we wish to increase screening compliance amidst an ever-evolving health issue, it will be important for providers, health organizations, and other community partners to improve CRC-related engagement with individuals younger than 50 years old and increase overall community awareness regarding the



new recommendations.

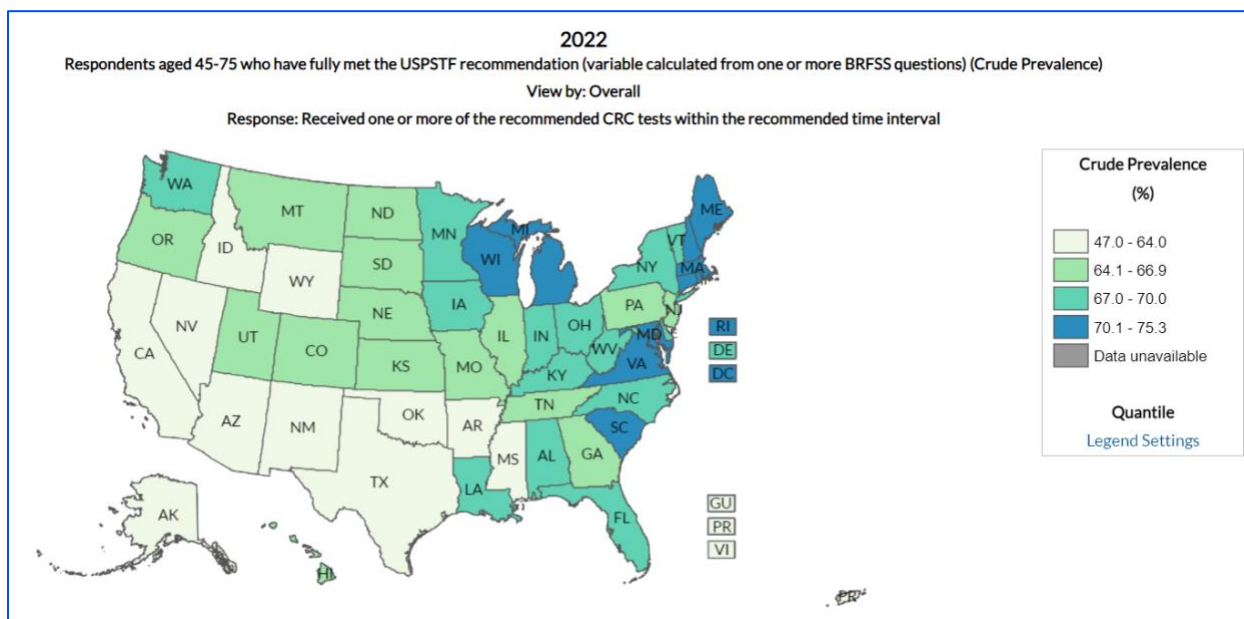
**Figure 3. Proportion of Target Population in Nevada who Meet USPSTF CRC Screening Recommendations.**

**Figure 4** presents a heat map taken from the BRFSS, which also provides a helpful visual representation of the comparative CRC screening rates in states across the U.S.<sup>10</sup> The map synthesizes screening data from 2022 to provide context on relative screening completion in terms of population proportion. As evidenced by the map, Nevada is grouped with states exhibiting the lowest proportion of the target population who completed USPSTF-recommended screening, at only 60.9%. With

<sup>9</sup> Centers for Disease Control and Prevention (2023). [BRFSS Prevalence and Trend Data](#)

<sup>10</sup> Centers for Disease Control and Prevention. (2023). [BRFSS CRC Screening Map](#)

some states having a screening rate as high as 75.3%, the need for comprehensive, reliable, and available CRC screening resources in Nevada is clear.



**Figure 4. 2022 CRC Screening U.S. Heat Map.** Image taken from the [2022 BRFSS](#).

## Factors Impacting Colorectal Cancer Incidence, Mortality, and Screening

### Accessibility and Barriers

Accessibility issues and structural barriers are important factors to consider when seeking to increase CRC screening. Not every screening test is going to be the best fit for meeting the needs of each unique individual or community. Although colonoscopies and flexible sigmoidoscopies may provide a more complete picture of colorectal health, it is important to remember that stool-based screening tests offer people a reliable screening option that can help reduce accessibility issues and barriers to screening. However, ensuring the use of stool-based screening tests still involves some important barriers providers may need to address. The Community Preventive Services Task Force (CPSTF) outlines several evidence-based recommendations healthcare practitioners and health organizations can follow when attempting to connect communities with these resources. These recommendations are succinctly expressed in the following list:<sup>11</sup>

- Reducing time or distance between service delivery settings and target populations.
- Modifying hours of service to meet client needs.
- Offering services in alternative or non-clinical settings (e.g. mobile mammography vans, at worksites, or in residential communities).

<sup>11</sup> The Community Guide. (2010). [Reducing Structural Barriers for Clients - Colorectal Cancer](#)

- Eliminating or simplifying administrative procedures and other obstacles (e.g. scheduling assistance, patient navigators, transportation, dependent care, translation services, limiting the number of clinic visits).

While these recommendations are useful, organizations should understand the requirements that must be fulfilled to meaningfully implement them. The CPSTF provides useful tips for implementing their recommendations for reducing structural barriers to stool-based CRC screening options. These considerations are succinctly expressed in the following list:<sup>12</sup>

- Alternative screening sites need to be identified.
- Adequate staffing is required for alternate sites or extended hours.
- When test results are abnormal, follow-up must be provided to clients lacking access to regular care.

Each of these tips requires healthcare practitioners and health organizations to carefully examine their workflow and capacity for procedural change. Although implementing these recommended strategies may come with some initial barriers, all efforts made encourage a healthier community and population overall. It is important to note that while these recommendations may be useful and evidence-based, the CPSTF has only defined these recommendations for stool-based screening through FOBT. Not enough literature yet exists for definitive statements to be made regarding CRC screening through FIT or sDNA-FIT. However, given the similar nature of the sample collection methods and at-home screening delivery, these recommendations may still be applicable to providers and organizations who seek to connect their communities with these resources.

### Colorectal Cancer Disparities

CRC is not an issue that uniformly impacts all people across different demographic characteristics. It is important to understand disparities seen within CRC trends across various demographics to effectively address the specific needs of each unique community. Not all CRC screening efforts are appropriate or applicable to the unique challenges faced by different groups who are disproportionately affected by this health issue, so it is important to adapt and modify approaches to meet individual needs and ensure a healthier outcome for all. The following disparities highlighted within Nevada are merely meant to provide an overview of how CRC differentially impacts certain populations. More disparities across a range of demographics and social factors likely exist, and should always be taken into consideration when developing initiatives and approaches to connect different communities with at-home CRC screening kits.

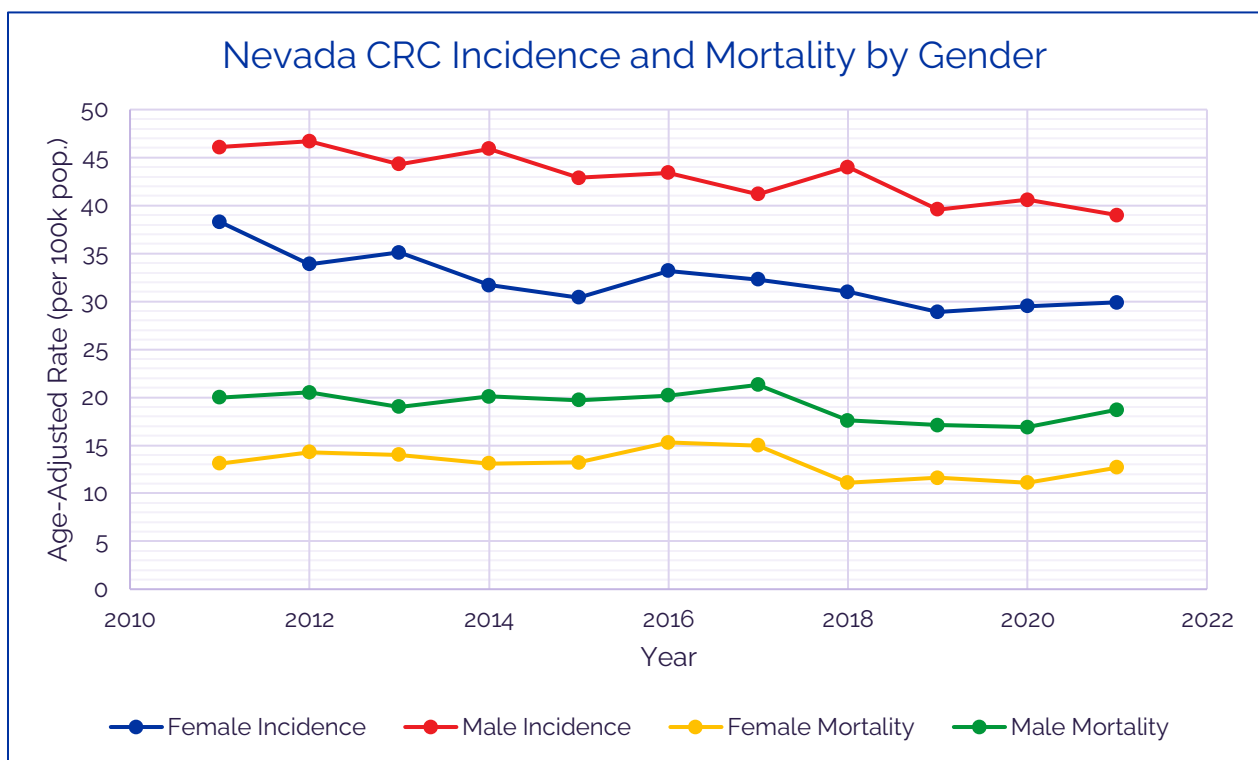
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<sup>12</sup> The Community Guide. (2020). [Reducing Structural Barriers for Clients - Colorectal Cancer](#)



## Gender

An important disparity seen in Nevada CRC trends involves the incidence and mortality rates according to gender. **Figure 5** presents these trends from 2011 to 2021.<sup>13</sup> The results indicate within these 10 years, males' CRC incidence was consistently higher than females', ranging from 7.8 to 14.2 more cases per 100,000 population. This same trend is seen with CRC-related mortality, with male mortality consistently higher than female mortality by 4.9 to 7 deaths per 100,000 population each year. Given these trends in Nevada and the fact that men are already at a higher lifetime risk of developing CRC, screening efforts need to be adapted to focus on reducing this disparity and ensuring more males receive the necessary resources for prevention and early detection. It is important to note these disparities do not necessarily exist due to a disparity in screening rates. Both genders have been shown to have relatively similar CRC screening rates since the year 2000.<sup>14</sup> However, it is apparent that males can gain the most benefit from more intensely focused screening efforts that aim to improve awareness about their increased risk for CRC incidence and mortality and, consequently, reduce the impact of the existing disparity over time.



**Figure 5. Nevada CRC Incidence and Mortality Trends by Gender.**

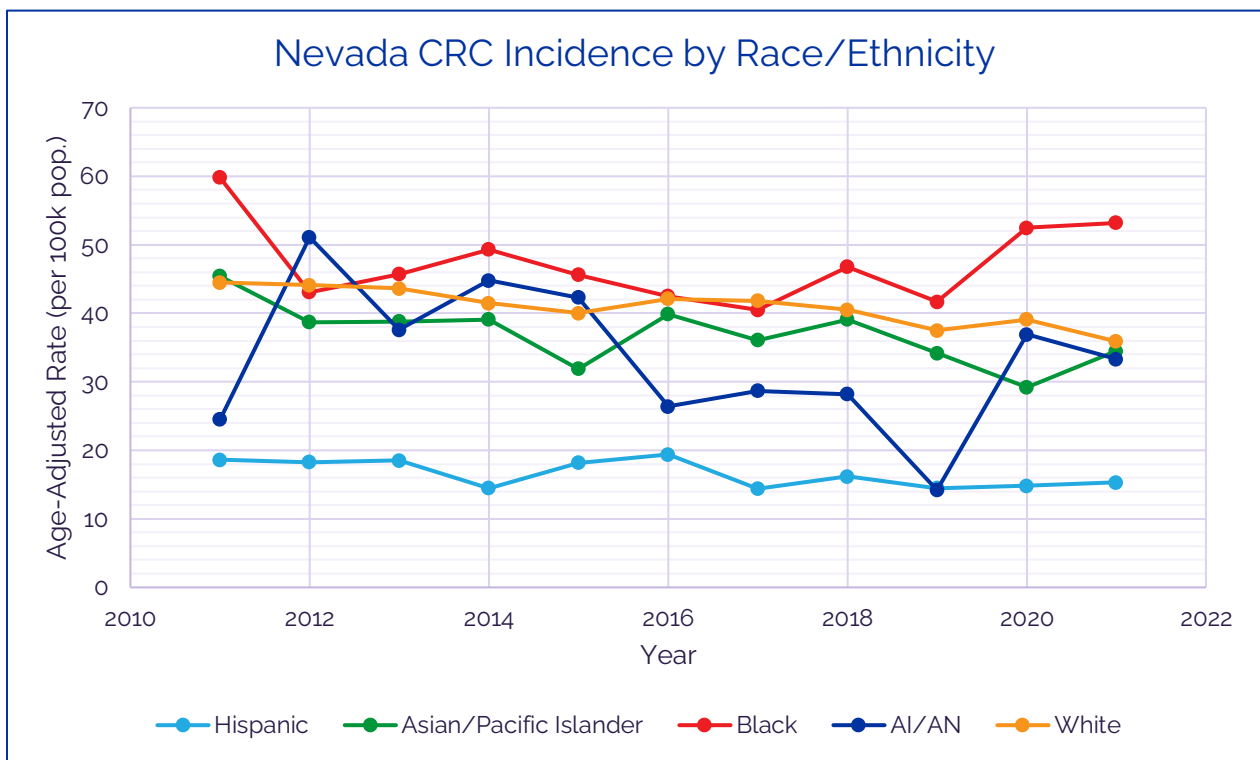
## Race/Ethnicity

CRC incidence and mortality rates also vary dramatically by race and ethnicity. These disparities, like those seen in other health outcomes, are considered to be

<sup>13</sup> Nevada Central Cancer Registry. (2024). [Cancer Incidence and Mortality in Nevada](#)

<sup>14</sup> National Center for Health Statistics. Health, United States. (2019). [Table 035](#).

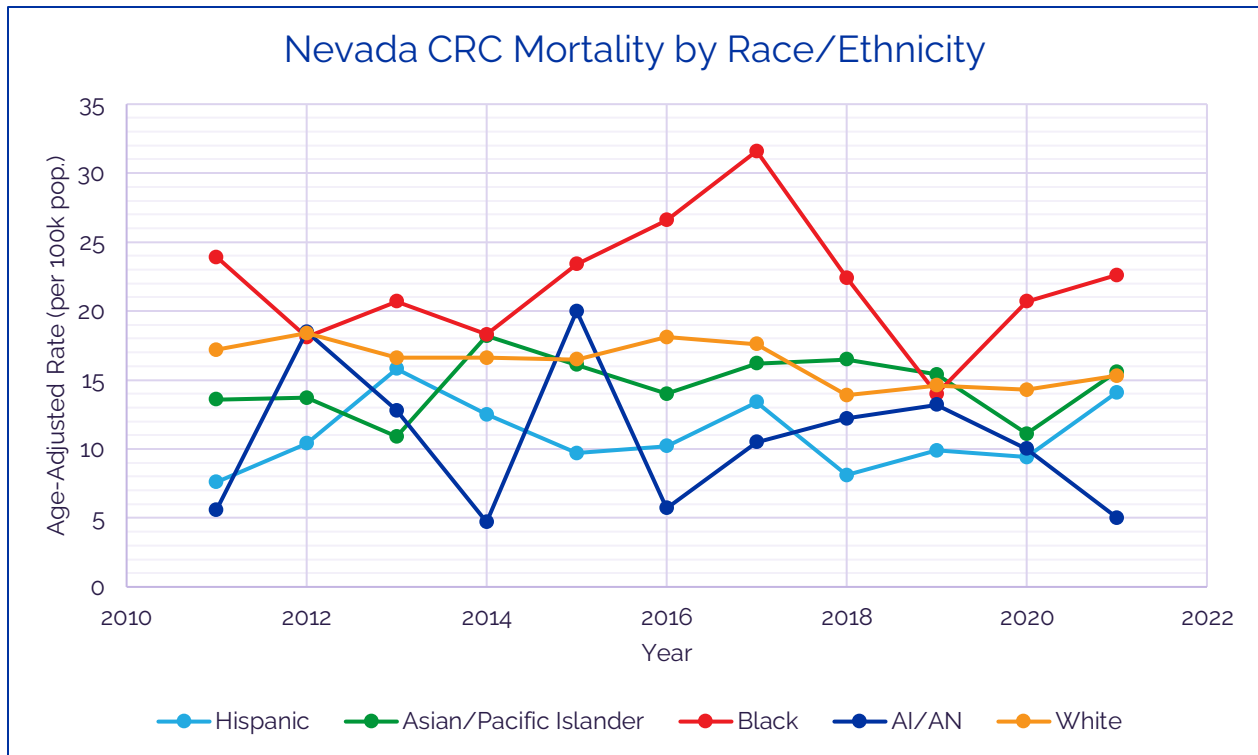
influenced by a multitude of factors, including, but not limited to, differential access to and quality of healthcare, differential economic stability, and other adverse social determinants of health that measurably persist even today.<sup>15</sup> **Figure 6** and **Figure 7** present the CRC trends by race/ethnicity seen across the 10-year span from 2011 to 2021 in Nevada.<sup>16</sup> One of the most evident trends is that CRC incidence and mortality are consistently highest in Nevada's Black populations, often followed by white and Asian/Pacific Islander populations. Additionally, although not consistently highest in terms of incidence and mortality rates, it remains important to address the high degree of fluctuation present in CRC incidence and mortality for American Indian/Alaskan Native (AI/AN) populations. The lack of stability in these trends indicates the necessity for increased screening efforts that address the specific needs of this population and promote more effective CRC early detection. From 2011 to 2021, Hispanic populations in Nevada consistently experienced a relatively stable trend of some of the lowest rates of CRC incidence and slightly lower mortality than other racial/ethnic groups. However, it will still be necessary to ensure this trend continues through outreach and by connecting patients to appropriate screening resources.



**Figure 6. Nevada CRC Incidence Trends by Race/Ethnicity.**

<sup>15</sup> Town M, Eke P, Zhao G, et al. (2024). *Racial and Ethnic Differences in Social Determinants of Health and Health-Related Social Needs Among Adults – Behavioral Risk Factor Surveillance System, United States, 2022*. Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report (MMWR). <http://dx.doi.org/10.15585/mmwr.mm7309a3>

<sup>16</sup> Nevada Central Cancer Registry. (2024). [Cancer Incidence and Mortality in Nevada](#)



**Figure 7. Nevada CRC Mortality Trends by Race/Ethnicity.**

### Rurality

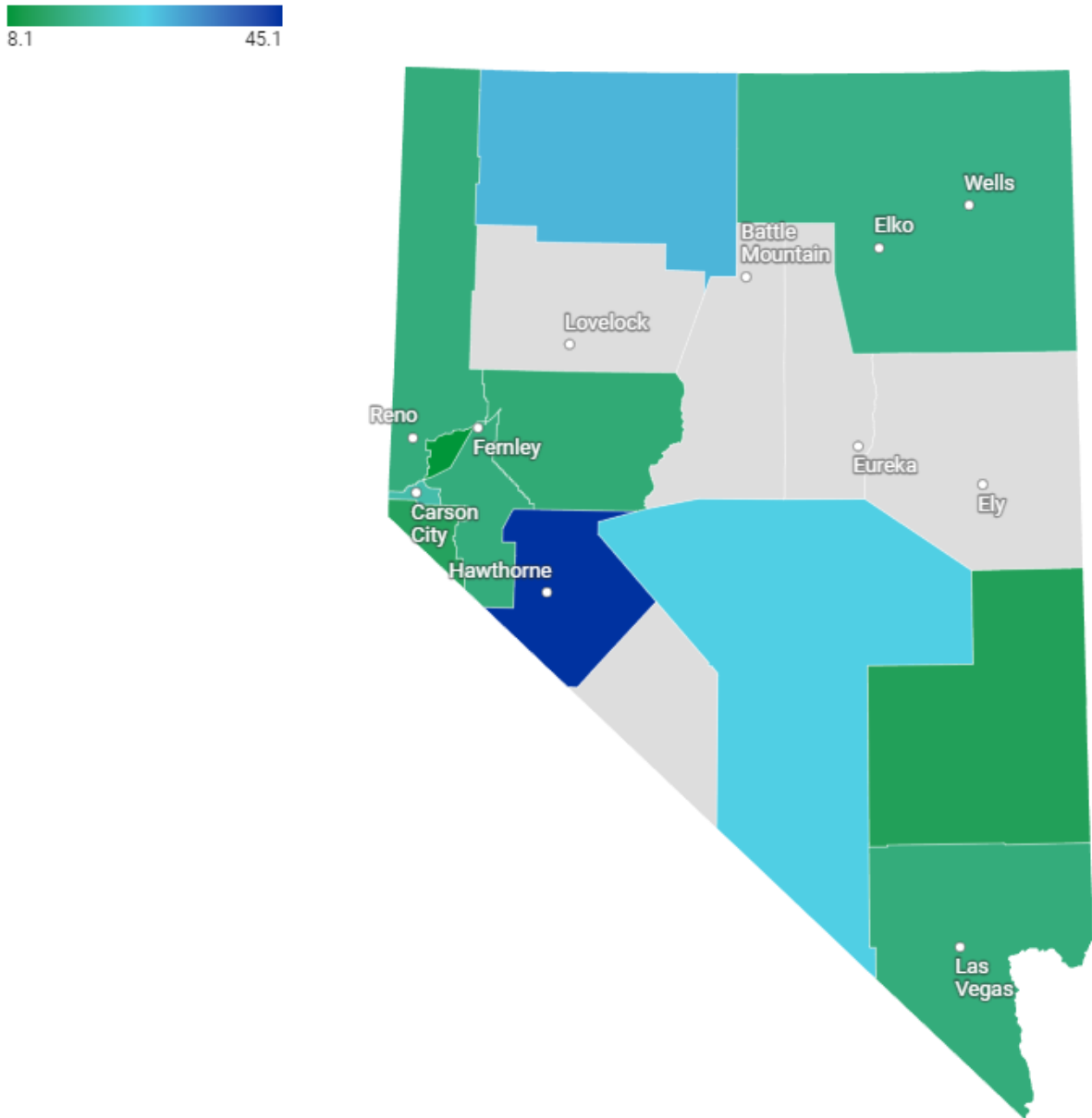
Another disparity that is especially important to acknowledge within Nevada involves CRC incidence and mortality differences between urban and rural residents. As recognized by the Nevada State Office of Rural Health, there are three urban counties, three rural counties, and 11 frontier counties in Nevada.<sup>17</sup> With such a large proportion of Nevada's counties rural or frontier, reliable access to primary care physicians and facilities with colonoscopy services is limited to the residents within a small proportion of Nevada's overall landmass. This impact is especially apparent when considering CRC mortality distribution by county, as shown in **Figure 8**. In 2021, Mineral, Humboldt, and Nye counties had the highest age-adjusted CRC mortality rates, at 45.1, 29.6, and 26.7 per 100,000 population, respectively.<sup>18</sup> This data is also consistent with rural-urban trends seen at the national level. The National Cancer Institute reports both incidence and mortality for CRC are higher across the rural U.S. compared to the urban U.S., which is often attributed to rural residents having reduced healthcare access, a greater burden of poverty and low income, reduced engagement in screening behaviors, and greater engagement in risky health behaviors that increase risk for CRC, such as tobacco use and poor dietary choices.<sup>19</sup>

<sup>17</sup> University of Nevada, Reno, School of Medicine, Office of Statewide Initiatives. (2023). [Nevada Rural and Frontier Health Data Book](#)

<sup>18</sup> Nevada Central Cancer Registry. (2024). [Cancer Incidence and Mortality in Nevada](#)

<sup>19</sup> National Cancer Institute. (2022). [Rural-Urban Disparities in Cancer](#)

## Nevada Colorectal Cancer Mortality by County, 2021



**Figure 8. 2021 Nevada CRC Mortality by County Heat Map.** Image taken from the Nevada Cancer Coalition's [2024 Colorectal Cancer Data & Resources Website](#).

### Screening Rates

Understanding trends in screening rates stratified by the demographics impacted by CRC disparities also provides some insight into the gaps that need to be addressed in improved screening efforts. A recent publication of *Health, United States* from 2019 provides a useful view into CRC screening rates across the U.S., stratified by multiple demographic characteristics, including race and ethnicity. **Figure 9** presents the most recent screening data for a visual comparison of the screening rates seen

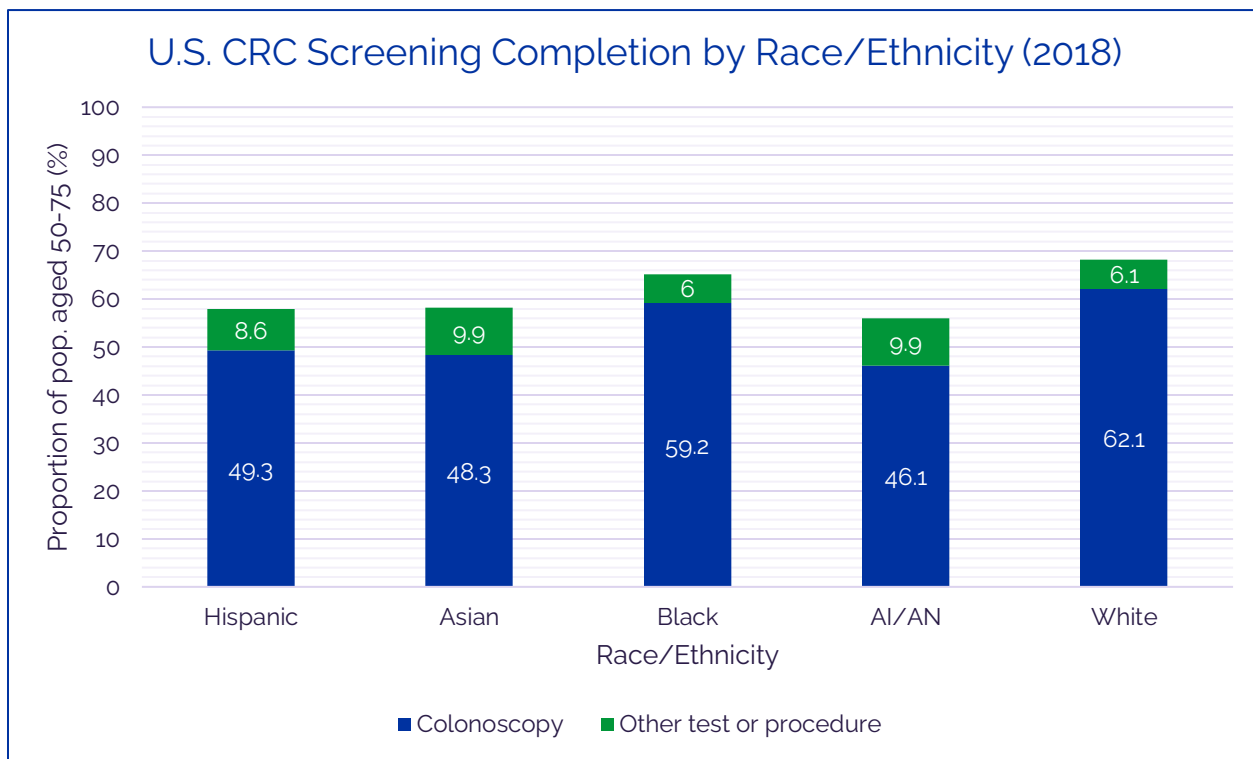
across different racial and ethnic populations. **Figure 10** also presents synthesized trend data in screening rates stratified by racial/ethnic group from 2000 to 2018 in a cropped image taken directly from the publication's table.<sup>20</sup>

The published data indicates that from 2000 to 2018, screening rates for CRC have generally increased for each racial/ethnic group. During this timeframe, white populations consistently had the highest rates of screening completion, while Hispanic populations typically had the lowest. It is important to note that while Black populations experience the most disproportionate rates of CRC incidence and mortality, the trend data shows that Black Americans are beginning to complete CRC screening at a similar rate to white Americans, with 68.2% of white Americans and 65.2% of Black Americans completing CRC screening in 2018. While this progress is positive, it remains necessary to continue engaging disproportionately affected populations to increase screening and ensure prevention and early detection are possible for those most at risk. This is also still the case for populations with more modest rates of CRC incidence and mortality. Despite white, Asian/Pacific Islander, and AI/AN populations being less impacted by CRC than Black populations, data from 2018 still shows that 31.8% of white Americans, 41.8% of Asian Americans, and 44% of American Indians/Alaskan Natives did not complete their recommended CRC screening. This creates a large gap that needs to be addressed on multiple levels if we hope to improve screening rates and outcomes for CRC. Additionally, although Hispanic populations are noted to have lower rates of CRC incidence and mortality, their screening rates are also consistently lowest, with 42.1% of the population failing to complete their recommended screening test in 2018, and even more in years prior. With this in mind, we must consider the possibility that the lower rates of CRC incidence could be due to a low proportion of the population completing screening even when it would be necessary. Improving screening rates in this group could reveal a health disparity that exists but is not able to be captured by current data.

Another important distinction is that for all racial/ethnic groups, colonoscopy is the most common screening test used to meet CRC screening recommendations. However, the goal of this toolkit is to increase the baseline proportion of patients within the recommended age range who get screened for CRC, regardless of the test used. In 2018, only 6% to 9.9% of each racial/ethnic group relied on alternate screening methods to meet USPSTF recommendations. Thus, at-home stool-based CRC screening kits still offer an effective and reliable way to ensure patients who are not currently completing any form of screening can still receive a useful CRC screening option. This can help close the gap between those not screening at all and those receiving some form of screening in each group.

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<sup>20</sup> National Center for Health Statistics. Health, United States. (2019). [Table 035](#)



**Figure 9. U.S. CRC Screening Completion by Race/Ethnicity (2018).**

Characteristic	Any colorectal test or procedure <sup>1</sup>					Colonoscopy <sup>2</sup>				
	2000	2005	2010	2015	2018	2000	2005	2010	2015	2018
<b>Race<sup>4</sup></b>										
White only.....	34.9	45.6	59.8	63.7	68.2	19.7	38.9	56.0	60.7	62.1
Black or African American only.....	29.6	38.1	55.2	59.6	65.2	17.4	32.2	51.8	56.3	59.2
American Indian or Alaska Native only .....	*35.2	*33.9	48.9	48.9	56.0	*	*	46.7	45.3	46.1
Asian only .....	20.4	30.8	47.1	52.3	58.2	*8.6	24.4	43.6	45.8	48.3
Native Hawaiian or Other Pacific Islander only .....	*	*	*	*	*	*	*	*	*	*
2 or more races .....	37.5	33.8	51.9	52.7	67.7	*25.1	29.6	48.4	49.8	58.6
<b>Hispanic origin and race<sup>4</sup></b>										
Hispanic or Latino .....	21.7	28.5	46.5	47.4	57.9	13.3	23.1	43.9	44.0	49.3

**Figure 10. U.S. CRC Screening Completion Trend Data by Race/Ethnicity (2000 – 2018).**

## Education, Marketing, Messaging, and Promotion for Colorectal Cancer Screening

Ensuring CRC screening efforts are well-received and understandable by the communities that healthcare providers and health organizations aim to engage in requires several evidence-based considerations. The CPSTF and the American Cancer Society provide several recommendations based on strategies that have demonstrated promise for increasing stool-based screening completion.

**Small media** with targeted or tailored messaging is a recommended communication strategy to increase awareness, education, and motivation in clients who need to meet recommended screening requirements through stool-based testing. This form of media communication may include videos, letters, brochures, newsletters, and other printed forms of messaging.<sup>21</sup>

**One-on-one education** is another recommended communication strategy to increase knowledge and motivation in clients who may not fully understand screening benefits and strategies for overcoming perceived barriers to screening.<sup>22</sup> This recommendation also applies to stool-based testing and has been recognized by the CPSTF as an evidence-based practice. Education could be provided to clients by a variety of personnel, including healthcare workers, lay health advisors, or volunteers. Furthermore, education may be provided to clients by telephone or in-person in a variety of settings, including clinical, community, workplace, or household environments. One of the benefits of using one-on-one education with stool-based CRC screening is that educational material may be tailored to the individual or remain untailored to provide a broader context.

For now, group education is not a recommended practice for increasing awareness and knowledge of CRC screening. The CPSTF recognizes that insufficient evidence exists to confirm the effectiveness of group education, or lack thereof.<sup>23</sup> However, it is important to understand that discussing CRC screening and prevention may involve sensitive topics that can cause embarrassment or awkwardness for some. This can hinder group-based education efforts, making one-on-one education for CRC screening the preferred communication strategy

In 2019, the American Cancer Society and the National Colorectal Cancer Roundtable produced a CRC screening messaging guidebook, shown in **Figure 11**, as a tool for developing effective messaging geared toward people who are unscreened. The content contained in the guidebook was based on market research that concluded in 2018. Recommendations from the guidebook include having messages delivered by personal doctors, healthcare professionals, or friends and family. It also mentions the importance of highlighting specific themes within CRC

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<sup>21</sup> The Community Guide. (2020). [Small Media Targeting Clients](#)

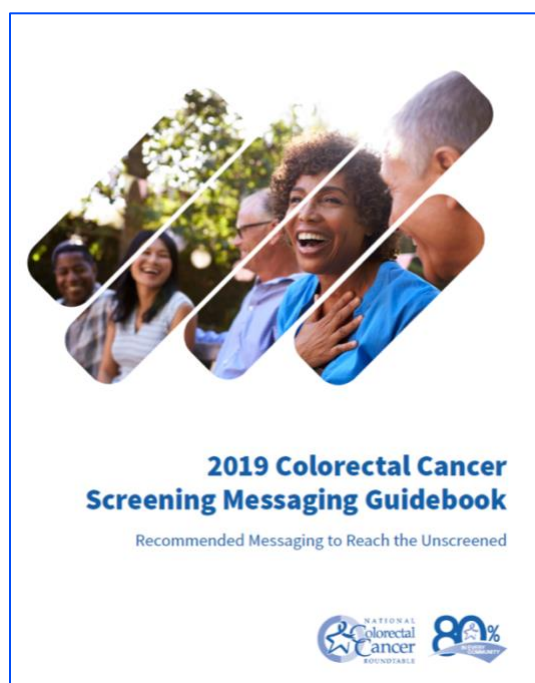
<sup>22</sup> The Community Guide. (2020). [One-on-One Education for Clients](#)

<sup>23</sup> The Community Guide. (2021). [Group Education for Clients](#)

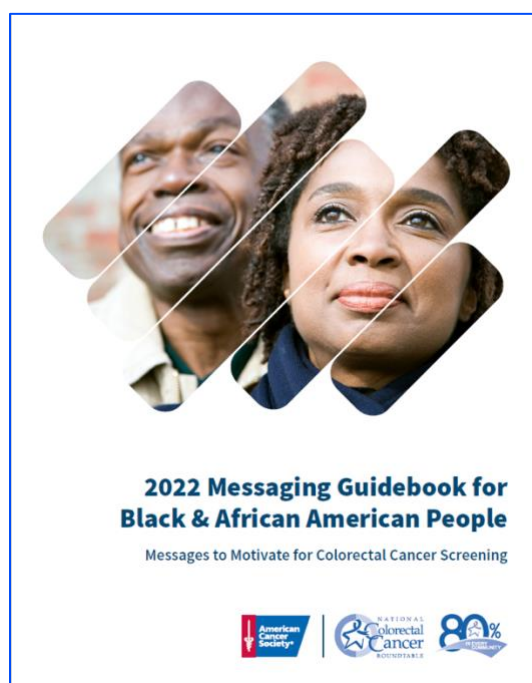


messaging, such as screening being a preventive measure, the availability of at-home screening, and the fact that people similar to the intended audience can find ways to get screened. Ideas for tailoring messages based on different priority population characteristics are also included in the guidebook. This is by no means an exhaustive list of the guidebook's provisions on messaging and marketing for CRC screening. This tool is an important resource for those aiming to increase at-home CRC screening, and it should be referenced for a more comprehensive understanding of how to develop effective, engaging, and motivating messages.<sup>24</sup>

In 2022, the American Cancer Society and the National Colorectal Cancer Roundtable produced a companion guidebook to the 2018 CRC screening messaging guidebook. The 2022 guidebook, shown in **Figure 12**, focused specifically on developing effective messaging for Black Americans who remain unscreened for CRC.<sup>25</sup> As mentioned previously, Black Americans experience the highest rates of CRC incidence and mortality. Developing messaging geared toward reducing this disparity is important and requires the right tools to be done effectively.



**Figure 11. CRC Screening Messaging Guidebook from The American Cancer Society.**



**Figure 12. CRC Screening Messaging Guidebook for Black & African American People from The American Cancer Society.**

<sup>24</sup> The American Cancer Society. (2019). [CRC Screening Messaging Guidebook](#)

<sup>25</sup> The American Cancer Society. (2022). [Black & African American CRC Screening Messaging Guidebook](#)



For additional resources that may be helpful when conducting education, marketing, messaging, and/or promotion for CRC screening, see **Appendix A: Resources for Education, Marketing, Messaging, and Promotion**

## **Workflow Process Map: Distributing At-Home Colorectal Cancer Screening Kits**

The workflow process map, shown in **Figure 13**, outlines overarching steps with more detailed directions that healthcare providers and health organizations can follow while conducting community outreach and distributing at-home CRC screening kits. The steps provided are designed to ensure adequate patient understanding of the screening process, successful follow-up, and accurate measurement associated with screening kit distribution.

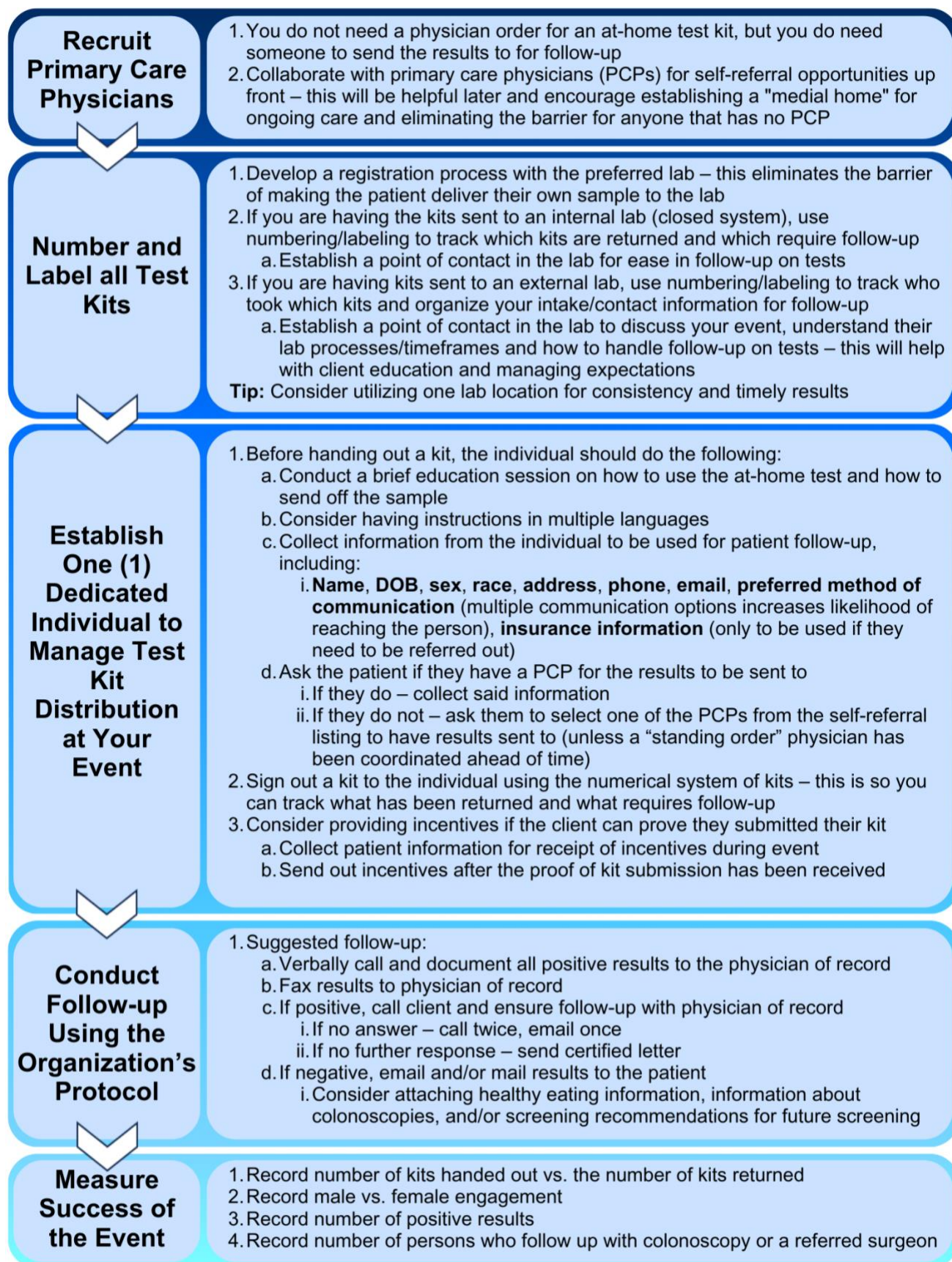


Figure 13. Workflow Process Map for At-Home CRC Screening Kit Distribution. 18

## Appendix A: Resources for Education, Marketing, Messaging, and Promotion

The following is a compilation of resources that providers and health organizations may find useful when conducting education, marketing, messaging, and/or promotion for CRC screening.

**Videos 1-4** provide simple and helpful explanations about the need to get screened for CRC. Some also provide a general overview of different screening options and what may be experienced during CRC screening. All of the videos below, as well as additional ones that may be helpful, can be found under the Colorectal Cancer playlist on the Nevada Cancer Coalition's YouTube page.

<https://www.youtube.com/playlist?list=PL73bytSFIE1iRexyeUBEKNp8BtMEbSDe1>



**Video 1. The American Cancer Society. (2023).** [Colorectal Cancer Screening](#)



**Video 2. UCLA Health. (2022).** [Colorectal Cancer Screening Options](#)



**Video 3. Cologuard. (2022).** [How to Use Cologuard \(English\)](#)



**Video 4. Cleveland Clinic. (2022).** [6 Warning Signs of Colon Cancer](#)

For providers and health organizations who seek to connect communities with Cologuard, **Video 3** is offered in a variety of different languages to meet the different needs of individuals. These videos, as well as other helpful videos about Cologuard, can be found on the company's YouTube page.

<https://www.youtube.com/@Cologuard/videos>

The American College of Gastroenterology produced a CRC Community Education Toolkit. The toolkit contains a variety of infographics, social media templates, and additional resources for increasing education and awareness of CRC screening. Many of the materials are available in multiple languages.

<https://gi.org/education/educating-you-your-colleagues/colorectal-cancer-awareness-education-resources/crc-community-education-toolkit/>

The American Cancer Society produced a simple two-page infographic about the importance of early detection for CRC. The infographic provides a concise comparison between stool-based and direct visualization methods of CRC screening.

<https://www.cancer.org/content/dam/cancer-org/online-documents/en/pdf/infographics/colorectal-cancer-catching-it-early-infographic-print.pdf>

The Centers for Disease Control and Prevention (CDC) emphasizes the importance of creating and using effective visuals for health communication and education. They reference a collection of resources and guides that can help providers and health organizations develop appropriate visual materials for promoting at-home CRC screening kits.

<https://www.cdc.gov/healthliteracy/developmaterials/visual-communication.html#:~:text=Visuals%2C%20such%20as%20pictures%2C%20drawings,written%20or%20spoken%20health%20messages.>



## Appendix B: Clinical Materials

The following materials are meant to provide useful information and resources to healthcare providers and health organizations who seek to understand more about and/or increase at-home CRC screening.

This article provides a succinct overview on the comparison between FIT and FOBT. Both are viable options for communities with low CRC screening rates and lack of access to colonoscopies, but it is important to understand the individual differences between implementing one test versus the other.

<https://www.ficomputing.net/pdf/June04/YoungArticle.pdf>

The CPSTF recommends implementing patient navigation services to increase CRC screening for those impacted by CRC disparities related to race/ethnicity and/or low income. More information on how these services may increase health equity with regard to CRC screening can be found on the Community Guide's web page.

<https://www.thecommunityguide.org/findings/cancer-screening-patient-navigation-services-to-increase-colorectal-cancer-screening.html>

The American Cancer Society, as part of the National Colorectal Cancer Roundtable, released a guide for clinicians which outlines the dos and don'ts for CRC screening.

<https://nccrt.org/wp-content/uploads/2024/08/Dos-and-Donts-Colorectal-Screening-NCCRT-Locked.pdf>

The American Cancer Society and the National Colorectal Cancer Roundtable provide updated resources for colorectal cancer screening in their resource center.

<https://nccrt.org/resources/>

The following information on the next two pages provides an example of a registration form that can be used to collect patient information when distributing at-home CRC screening kits. The form is provided as a sample, in both English and Spanish, and can be used as a guide for developing a tailored form based on the needs of providers or organizations.

# REGISTRATION FORM

Kit # \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Phone / Cell number \_\_\_\_\_

Age: \_\_\_\_\_

Gender: M / F

Prior Colonoscopy: YES NO

Results \_\_\_\_\_

Any Family History of Colon Cancer? \_\_\_\_\_

Any Current Concerns \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

## Formulario de Inscripción

Botiquín #

Apellido \_\_\_\_\_ Nombre \_\_\_\_\_

Teléfono / Número de celular \_\_\_\_\_

Edad: \_\_\_\_\_

Género: M / F

Colonoscopia previa Si / NO

Resultados \_\_\_\_\_

cualquier antecedente familiar de cáncer de colon? \_\_\_\_\_

Cualquier preocupación actual: \_\_\_\_\_

Médico de atención primaria \_\_\_\_\_

## Appendix C: Research

The following section highlights research that discusses helpful findings for increasing CRC screening. While not all research may be applicable to every community, these articles may contain important findings that healthcare providers and health organizations can tailor to their own needs as they implement strategies for connecting communities with at-home CRC screening kits.

A randomized trial finds that patients who are offered multiple screening options have an increased likelihood of completing screening, compared to patients who are only offered colonoscopies.

<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1134849>

A randomized trial finds that a risk-adapted approach for recommending different CRC screening strategies may not result in significant differences in advanced neoplasm detection rates while still reducing screening costs per neoplasm detected.

<https://doi.org/10.1016/j.cgh.2022.08.003>

A randomized trial finds that patients who receive outreach for FIT screening when they are due for repeat screening tend to sustain screening completion at a higher rate than those that do not receive outreach when they are due for repeat screening.

<https://doi.org/10.1016/j.cgh.2021.07.022>