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PERCEPTIONS OF ORAL CANCER SCREENINGS COMPARED TO OTHER
CANCER SCREENINGS: A PILOT STUDY

by

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A thesis submitted in partial

fulfillment

of the requirements for the degree of

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Committee Approval

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RE: regarding study number IRB-FY2015-86 : Public Perceptions of Oral Cancer Screenings

Dear Ms. Stephenson:

I have reviewed your request for expedited approval of the new study listed above. This is to confirm that I have approved your application.

Notify the HSC of any adverse events. Serious, unexpected adverse events must be reported in writing within 10 business days.

Submit progress reports on your project in six months. You should report how many subjects have participated in the project and verify that you are following the methods and procedures outlined in your approved protocol. Then, report to the Human Subjects Committee when your project has been completed. Reporting forms are available on-line.

You may conduct your study as described in your application effective immediately. The study is subject to renewal on or before Jul 27, 2016, unless closed before that date.

Please note that any changes to the study as approved must be promptly reported and approved. Some changes may be approved by expedited review; others require full board review. Contact Tom Bailey ([208-282-2179](tel:208-282-2179); email humsbj@isu.edu) if you have any questions or require further information.

Sincerely,

Ralph Baergen, PhD, MPH, CIP
Human Subjects Chair

Dedication

This thesis is dedicated to my family:

My manchild, Connor Hollenbeck, for his perpetually positive outlook on life and the joy he brings me on a daily basis;

My husband, Ryan Hollenbeck, for loving me even at my most unlovable, stress-fueled moments, and for stepping up as my partner when grad school and household chores just didn't quite mesh;

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List of Abbreviations

AAOMP	American Academy of Oral and Maxillofacial Pathology
ACS	American Cancer Society
ADA	American Dental Association
ADHA	American Dental Hygienists' Association
BC	Breast Cancer
CATI	Computer-Assisted Telephone Interview
CC	Colon Cancer
CDC	Centers for Disease Control and Prevention
CE	Continuing Education
CVI	Content Validity Index
FDA	Food and Drug Administration
FOBT	Fecal Occult Blood Testing
FWE	Family Wise Error
HPV	Human Papilloma Virus
HSC	Human Subjects Committee
LBC	Liquid-Based Cytology
LDCT	Low-Dose Computed Tomography
NCI	National Cancer Institute
NDHRA	National Dental Hygiene Research Agenda
NIDCR	National Institute of Dental and Craniofacial Research
NIH	National Institutes of Health
OC	Oral Cancer
OCS	Oral Cancer Screening
OSCC	Oropharyngeal Squamous Cell Carcinoma
PC	Prostate Cancer
PSA	Prostate-Specific Antigen
SES	Socioeconomic Status

STS	Scientific Telephone Samples
US	United States
USCB	United States Census Bureau
USDHHS	United States Department of Health and Human Services
USPSTF	United States Preventive Services Task Force
WHO	World Health Organization

Abstract

This pilot study utilized a purposive sample (N=100) of adults residing in Idaho. A self-designed, validated interview-administered questionnaire was administered by a data collection service using computer-assisted telephone interview software to assess consumer perceptions about oral, breast, prostate, and colon cancer screenings. Data were analyzed using descriptive statistics, frequencies, and Pearson's Chi-Square tests. Participants were predominantly white (90%) with a mean age of 52.7 years and some post-high school education (80%). The majority perceived each cancer screening as very helpful, and reported perceiving no associated risks. Findings supported a significant association ($p < 0.05$) between consumer perceptions of benefits, risks, and barriers between oral cancer screening and each of the selected cancer screenings. This study identified associations between consumer perceptions of oral cancer screenings when compared with breast, prostate and colon screenings. Concerns about cost and time for screenings seem to reflect low awareness regarding differences between oral and other screenings.

Chapter I

Introduction

Oral cancer (OC) is often regarded as a rarely occurring disease; however, in the United States (US), over 300,000 men and women are living with a prior diagnosis of cancer of the oral cavity and pharynx (United States Department of Health and Human Services [USDHHS], National Institutes of Health [NIH], National Cancer Institute [NCI], 2016a). Additionally, the American Cancer Society (ACS) estimated that over 48,000 new cases would be diagnosed in 2016 alone (American Cancer Society [ACS], 2016a). Approximately one in every one hundred men and women will be diagnosed with oral and pharyngeal cancer at some point in their lifetimes (USDHHS, NIH, NCI, 2016a). When detected early, while still in a localized stage, OC has an 83.3% five-year survival rate. However, the survival rate falls to 63.3% once the cancer has spread to regional lymph nodes, and drops further to 38% with metastasis. Projections for the number of individuals expected to die of oral and pharyngeal cancer in 2016 was estimated at approximately 9,570 (USDHHS, NIH, NCI, 2016a).

Evidence-based clinical guidelines developed by an expert panel convened by the American Dental Association (ADA) identified potential risks and benefits of OC screenings, including the psychological risk of false positives creating fear among patients. Despite the risks, Rethman et al. (2010) recommended the use of routine visual and tactile examinations by dental professionals to aid in detection of OC as follows.

Despite the limitations of clinical oral cancer examinations, the majority of the panel members concurred that the potential life-saving benefits for the smaller percentage of patients with treatable malignant lesions was

more important than the potential physical and psychological harms incurred by the higher percentage of patients with benign or non-progressive lesions (p. 516).

Rethman et al. (2010) also concluded there was insufficient evidence to support the use of adjunctive detection aids at that time. However, OC continues to be diagnosed at advanced stages of disease. There is a general consensus in the literature that this late diagnosis indicates the need for improved clinical oral examinations and the development of adjunctive devices to help detect and diagnose lesions (Epstein, Guneri, Boyacioglu, & Abt, 2012).

The ADA clinical guidelines contrast sharply with recommendations made in an April 2013 article in *Consumer Reports*, which listed OC screening as one of eight screenings to *avoid* for everyone but high risk patients, primarily because the cancer is relatively uncommon. This recommendation from *Consumer Reports* was based on a Recommendation Statement from the United States Preventive Services Task Force (USPSTF) indicating insufficient evidence exists to recommend for or against OC screening in asymptomatic adults in the primary care setting (USPSTF, 2004). An updated version of the USPSTF recommendation was released in 2011, although the conclusions were the same, citing a lack of evidence regarding improved health outcomes or harms of screening. However, the latest USPSTF recommendation statement indicated that the recommendation “focuses on oral cancer screenings...performed by primary care providers” and not screenings by oral health care providers or otolaryngologists (USPSTF, 2013, para. 10).

In response to the 2013 *Consumer Reports* article, a letter from leaders of the ADA and the American Academy of Oral and Maxillofacial Pathology (AAOMP) was released, which stated:

We are disappointed that the March 2013 issue of *Consumer Reports* dissuades most people from routine oral cancer screenings...These non-invasive visual and tactile examinations (which are generally included with no additional fee for the cancer screening component) can result in earlier diagnosis of oral cancer specifically but also a multitude of other oral diseases in general. The ADA and AAOMP will continue to support and encourage scientific investigations regarding detection of oral cancer with the firm belief that one missed oral cancer is one too many (Williams, 2013, para. 3).

Reportedly, in response to the controversy regarding OC screening, Dr. John Santa, the director of the *Consumer Reports* Ratings Center, has stood by the recommendation of the original article, citing a lack of evidence that shows OC screening saves lives. Dr. Santa also noted that OC screenings can result in false positives and unnecessary biopsies for patients (Domino, 2013). While it is clear the ADA and AAOMP assert the benefits of screening outweigh the risks of false positives and unnecessary biopsies, the USPSTF and *Consumer Reports* do not. Little is known about consumers' perceptions of the benefits and risks of OC screening, especially in relation to their perceptions of screenings for early detection of other common forms of cancer. Recently publicized recommendations to avoid OC screenings are not intended to apply to the dental setting; however, the public may not recognize the distinction and receive routine screenings essential for early detection. Previous studies also indicated

consumers were largely unaware of the benefits of OC screenings and often reported never having received one (Awojobi et al., 2012; Tomar & Logan, 2005; Patton et al., 2004; Horowitz, Canto, & Child, 2002; Paudyal, Flohr, & Llewellyn, 2014).

Statement of the Problem

Information regarding the public's perception of the benefits of OC screenings and the various techniques used to conduct them was limited at the time of the study; fear of false positives and unnecessary biopsies was conjecture.

Purpose of the Study

The intent of this study was to determine perceptions of Idaho adults regarding OC screenings as compared to other common cancer screenings such as breast cancer screenings, prostate cancer screenings, and colon cancer screenings.

Professional Significance of the Study

This study addressed the following objective from the American Dental Hygienists' Association (ADHA) National Dental Hygiene Research Agenda (NDHRA):

Category A. Health Promotion and Disease Prevention

Objective 5. Investigate the effectiveness of oral self-care behaviors that prevent or reduce oral diseases among all age, social and cultural groups.

(ADHA, 2007, p. 1).

Additionally, this study addressed the following Healthy People 2020 objectives:

OH-6: Increase the proportion of oral and pharyngeal cancers detected at the earliest stage.

OH-14.2: Increase the proportion of adults who received an oral and pharyngeal cancer screening from a dentist or dental hygienist in the past year (U. S.

Department of Health and Human Services, 2016).

This study identified public perceptions of Idaho adults regarding OC screening through telephone interviews. The study also might serve as a pilot for a national survey of public perceptions. Additionally, findings from this study may be considered when developing future practice recommendations for both primary care and dental care providers.

Research Questions and Hypotheses

- 1) What are Idaho adults' perceptions of the benefits, risks, and barriers of OC screening?
- 2) How do Idaho adults' perceptions of OC screenings compare to perceptions of other cancer screenings, specifically those for breast cancer, prostate cancer, and colon cancer?

These research questions led to the development of the following null hypotheses:

- 1) There is no association between Idaho adults' perceptions of oral cancer screening and breast cancer screening.
- 2) There is no association between Idaho adults' perceptions of oral cancer screening and prostate cancer screening.
- 3) There is no association between Idaho adults' perceptions of oral cancer screening and colon cancer screening.

Definitions

Public. Of or relating to people in general (Public, 2016). In this study, a sample of the public were English-speaking adult residents of Idaho who were identified from a sample purchased through Scientific Telephone Samples (STS).

Oral cancer. Cancer that forms in tissues of the oral cavity (the mouth) or the oropharynx (the part of the throat at the back of the mouth) (USDHHS, NIH, NCI, 2016b).

Oral cancer screening. Includes a thorough history and physical examination. The clinician reviews the social, familial, and medical history and should document risk behaviors (tobacco and alcohol usage), a history of head and neck radiotherapy, familial history of head and neck cancer, and a personal history of cancer. The clinician then visually inspects the head, neck, oral, and pharyngeal regions. This procedure involves digital palpation of neck node regions, bimanual palpation of the floor of mouth and tongue, and inspection with palpation and/or observation of the oral and pharyngeal mucosa with an adequate light source; mouth mirrors are essential to the examination. Forceful protraction of the tongue with gauze is necessary to visualize fully the posterior lateral tongue and tongue base (Oral Cancer Foundation, 2016).

Other oral cancer screening adjuncts. Includes technologies such as toluidine blue, brush cytology (OralCDx), tissue chemiluminescence (ViziLite, MicroLux), and autofluorescence (VELscope, Identafi, OralID).

Other cancer screenings. Includes screenings for breast cancer, prostate cancer, and colon cancer.

Sensitivity. Measures the proportion of true positives. In this study, sensitivity refers to the probability that a test will identify disease in a person who has the disease.

Specificity. Measures the proportion of true negatives. In this study, specificity refers to the probability that a test will identify a person as disease-free when the person does not have the disease.

Benefits. Advantages of a cancer screening.

Risks. Chances of harm or loss. In this study, risks also include the chance of any negative outcome as a result of receiving a cancer screening.

Barriers. Obstacles; in this study, barriers may include access to health care providers, cost, etc.

Perception. Understanding or comprehension. In this study, perception refers to the respondents' thoughts regarding benefits, risks, and barriers of cancer screenings as measured through a telephone-administered questionnaire.

Conclusion

The increasing prevalence of OC and the significant escalation in mortality rates resulting from later detection of OC emphasizes the importance of early detection. Due to the benefits of early detection, clinical guidelines recommend routine visual and tactile examinations by oral health professionals despite documented limitations. Conversely, guidelines from the USPSTF cite insufficient evidence to recommend for or against screening in a primary care setting. USPSTF guidelines are not intended to apply to the dental setting; however, the public may not recognize the distinction and may not have routine oral examinations, potentially resulting in fewer people receiving screenings essential to early detection. The fear of false positives and unnecessary biopsies is conjecture as the public's perception of the benefits of OC screenings was limited at the time of the study. The purpose of this study was to determine perceptions of Idaho adults regarding OC screenings as compared to other common cancer screenings such as breast cancer screenings, prostate cancer screenings, and colon cancer screenings.

CHAPTER II

Literature Review

OC has a high five-year survival rate (83.3%) when detected early in a localized stage. Unfortunately, most cases are detected after regional or distant metastasis has occurred, when the survival rate can drop to less than half (USDHHS, NIH, NCI, 2016a). Seemingly conflicting recommendations for screening from the ADA and the USPSTF may be confusing for the general public, and result in fewer people being screened. Public perceptions of the risks, benefits, and barriers to OC screening and in relation to other cancer screenings is limited. Therefore, the purpose of this study was to determine perceptions of Idaho adults regarding OC screenings as compared to other common cancer screenings such as breast cancer screenings, prostate cancer screenings, and colon cancer screenings.

This literature review consists of the following topic areas: (a) overview of OC and epidemiology; (b) efficacy of OC screenings including OC screening devices and a related discussion regarding efficacy of other cancer screenings (such as mammography and colonoscopy); (c) knowledge, practices, and attitudes of oral health professionals regarding OC screenings; and, (d) consumer awareness and perceptions of OC screenings. The databases PubMed, EBSCOhost, and the Cochrane Library were searched using combinations of the MeSH terms oral cancer, dental hygienists, early detection of cancer, and treatment outcome.

Overview of Oral Cancer and Epidemiology

Oral cancers are named based on their location in the head or neck and include cancers of the lip, oral cavity, and oropharynx. While OCs may be lymphomas,

melanomas, salivary gland tumors, sarcomas of the soft tissue or jaw bone, or metastases from other parts of the body, 90% of OCs are squamous cell carcinomas developing in the mucosal lining of the mouth, nose, and throat (USPSTF, 2013, p. 1).

Oropharyngeal squamous cell carcinoma (OSCC) is a growing epidemic, particularly among younger populations (<60 years old), due to an increased incidence of human papilloma virus (HPV) infection. HPV causes a form of OSCC that is epidemiologically and clinically distinct from the HPV-negative form of OSCC, typically associated with alcohol and tobacco use (Chaturvedi et al., 2011). The Centers for Disease Control and Prevention (CDC) estimates 70% of cancers of the oropharynx are caused by HPV (USDHHS, Centers for Disease Control (CDC), 2016). However, alcohol and tobacco use remain the leading causes of all other types of OCs. OC risk is highest among individuals who use both alcohol and tobacco versus those who use one or the other. While HPV-positive forms of OSCC show improved long- and short-term survival in comparison to HPV-negative forms of OSCC, approximately 65% of OC cases are diagnosed in the later stages of the disease when regional or distant metastasis has occurred (USDHHS, NIH, NCI, 2013).

Detection of OC lesions when localized results in a five-year survival rate of 83.3%. The relative five-year survival rate of all oral and oropharyngeal cancers decreases to 63.3% with regional metastasis, and to 38% once distant metastasis has occurred (USDHHS, NIH, NCI, 2016a). The increase in mortality as a result of metastasis underscores the importance of early detection.

Efficacy of Oral Cancer Screenings

The World Health Organization (WHO), CDC, and the NIH recommend an OC screening examination consists of a visual and tactile inspection of the face, neck, lips, labial mucosa, buccal mucosa, gingiva, floor of the mouth, tongue, and palate, using a mouth mirror to aid in visualizing all surfaces. Any abnormality detected during the screening should be re-evaluated in two weeks; if the abnormality remains, a biopsy may be considered to obtain a definitive diagnosis, as an excisional biopsy remains the gold standard for histologic diagnosis of OC (USDHHS, NIH, National Institute of Dental and Craniofacial Research [NIDCR], 2013; Rethman et al., 2010; Carreras-Torras & Gay-Escoda, 2015).

Although some evidence regarding the efficacy of the OC screening in reducing mortality exists, it is inadequate at this time (USDHHS, NIH, NIDCR, 2013). Brocklehurst et al. (2013) performed a systematic review to assess the effectiveness of current screening methods in decreasing OC mortality. Of 3,239 citations, only one randomized controlled trial met the inclusion criteria: a study conducted in India that consisted of thirteen clusters ($N=191,873$) of medically healthy adults ages 35 and older with no history of OC (p. 9). Six of the clusters ($n=95,356$) served as the control group; the remaining seven clusters ($n=96,617$) received visual oral screenings every three years by trained healthcare workers. During a 15-year follow-up, no statistically significant difference was found in incidence between the screened group and the control group, but there was an 81% reduction in OC mortality in high risk individuals who complied with all four rounds of screenings, and a 47% reduction in mortality for those who complied with three screening rounds (Sankaranarayanan et al., 2012, p. 317). While these results suggest visual OC screenings reduce the mortality rate in high risk individuals, the study

does have a high risk of bias due to methodological limitations. These limitations included:

...lack of detail regarding random assignment of clusters, the small number of clusters, no analysis of the effect of clustering on the results, no blinding of the outcome assessment, and lack of information about withdrawals and drop-outs. Additionally, only 63% of participants with positive screening results complied with referrals and only a small proportion of lesions were biopsied for histological confirmation of diagnosis (Ford & Farah, 2013, p. e2).

More studies are needed to assess efficacy of visual oral screenings (Brocklehurst et al., 2013).

A meta-analysis by Epstein et al. (2012) of observational studies ($N=24$) sought to evaluate the effectiveness of the clinical OC screening in predicting dysplasia or OC. The 24 studies meeting the inclusion criteria included a total of 7,079 patients and 1,956 biopsies. The study found, while the clinical OC exam had good sensitivity (ranging from 84-100%), the results may have been skewed as all of the patients diagnosed with dysplasia or OSCC underwent a biopsy for a definitive diagnosis, and histological diagnosis as a part of the study design was part of the inclusion criteria. However, the specificity of the clinical oral exam was poor (ranging from 1%-51%), as the exam itself may not accurately determine the nature of a lesion. Overall, the study found that the clinical OC examination is not a sufficient diagnostic method for predicting dysplasia and OSCC. The study results highlight the need for improving the predictive validity of the clinical oral exam, with the authors also emphasizing a need for development of effective adjuncts for detection and diagnosis of OC.

Evidence-based clinical recommendations regarding screening for oral squamous cell carcinomas (OSCC) from the American Dental Association Council on Scientific Affairs have been developed for dental professionals with the support of the CDC (Rethman et al., 2010). A search of Medline resulted in the selection of five systematic reviews and four clinical studies as the basis for these recommendations. The ADA panel found, while community-based screenings may not reduce the mortality rate of OC in the general population, such screenings may reduce the mortality rate in high risk individuals. Further, the ADA Council concluded community-based screenings may result in the detection of OCs in the earlier stages of the disease. Therefore, the panel supported OC screening as part of the visual and tactile oral examination for both community-based screening settings and dental office settings, noting clinicians should also consider the patient history and assess OC risk (Rethman et al., 2010).

Oral cancer screening devices. While the excisional biopsy remains the gold standard for definitive diagnosis of OC, non-invasive adjunctive techniques have been developed to aid in early detection. Adjunctive techniques and technologies currently include the use of toluidine blue, light-based visualization, transepithelial cytology of disaggregated cells, and salivary diagnostics. New technologies continue to emerge.

Toluidine blue, also known as tolonium chloride, has been utilized for more than 40 years for vital staining as a tissue marker. Due to its attraction to nuclear material with a high DNA or RNA content, the dye concentrates in dysplastic or malignant cells in the epithelium (Jones, 2013). Reported sensitivity and specificity for toluidine blue varies based on recent studies, ranging from 56-67% for sensitivity and 57-81% for specificity (Kerr & Shah, 2013, p. 338). Toluidine blue can be a valuable adjunct in detecting

potentially dysplastic or malignant lesions in high risk individuals, but insufficient evidence exists to recommend for or against its use in the general population (Rethman et al., 2010).

Devices utilizing light-based visualization include chemiluminescence, or tissue reflectance (ViziLite® and ViziLite Plus®), blue light LED (Orascoptic DK® and Microlux/DL®), or autofluorescence (VELscope®, Identafi®, and OralID®). Essentially, each of these light-based technologies seek to improve visualization of potentially malignant lesions that may not be clearly visible under regular white light. Devices that rely on autofluorescence work based on fluorospheres, which are naturally occurring in human tissue. Changes in the epithelium, specifically the subepithelial stroma, and a reduction in fluorospheres occur when dysplasia begins to develop. This change reduces the ability of the tissue to fluoresce; dysplastic and malignant lesions will, therefore, appear darker than the surrounding healthy tissues (Jones, 2013; Messadi, 2013). Studies show sensitivity for autofluorescence ranging from 50-86%, with 15-30% specificity (Kerr & Shah, 2013, p. 337). However, none of the devices using light-based technology have been shown to enhance the visualization of lesions not visible under normal lighting, nor are they able to discern between high-risk and low-risk lesions. Some promise is shown with autofluorescence devices as an aid in determining surgical margins; however, thus far, evidence is weak to support use in early detection of malignant lesions (Messadi, 2013; Rethman et al., 2010; Ayoub et al., 2015).

Unlike the other adjunctive techniques listed previously, transepithelial cytology of disaggregated cells, formerly known as the “brush biopsy,” and available commercially as the OralCDx Brush Test®, is primarily used to aid in diagnosis of lesions

rather than detection. Studies report sensitivity and specificity ranging from 71-100% and 27-94%, respectively (Kerr & Shah, 2013, p. 339). The brush test uses exfoliative cytology to obtain a transepithelial sample of the lesion which is then affixed to a slide, stained, and evaluated microscopically (Jones, 2013; Messadi, 2013, p. 62). The test should be limited to “small, relatively flat epithelial lesions in which a representative sample of the lesion can be procured by the brush” (Kerr & Shah, 2013, p. 340).

Although the brush test is able to identify disaggregated dysplastic cells, a scalpel biopsy must follow any positive result for definitive diagnosis. The use of this test on inappropriate lesions frequently results in atypical test results, essentially false positives, requiring unnecessary scalpel biopsies. However, specific clinical situations may warrant its use; for example, as an alternative to multiple scalpel biopsies, in patients who may be non-compliant in referrals, for those who cannot safely tolerate a surgical procedure, and in those with access to care restraints (Rethman et al., 2010).

Saliva has also been used as a diagnostic tool for many oral and systemic diseases including dental caries, periodontitis, HIV, hepatitis C, and various cancers through the analysis of molecular biomarkers. While the overall concentration of biomarkers in saliva is low compared to serum, the ability to analyze biomarkers in saliva continues to improve with modern scientific advances (Messadi, 2013). Salivary diagnostics could be used as a modality for diagnosis, prognosis, and monitoring post-therapy status (Omar, 2015). In one study, Li et al. (2004) collected saliva from subjects with OSCC ($n=32$) and a control group ($n=32$) of the same age, gender, and history of smoking. The saliva was analyzed, resulting in the detection of seven mRNA biomarkers indicative of cancer. The combination of these biomarkers yielded 91% sensitivity and 91% specificity in

distinguishing OSCC from the controls. While this study was limited by the relatively small sample size, it did conclude saliva shows promise as a means of screening that is non-invasive, relatively inexpensive, and accessible.

One promising advancement in salivary diagnostics, the Vigilant Biosciences' OncAlert™ Oral Cancer Rapid Point-of-Care Risk Assessment System, is designed to detect specific protein markers for squamous cell carcinoma. The patient uses a special oral rinse designed to capture the protein markers then expectorates into a cup, where a testing strip is then inserted. Results are received in minutes. This new technology may lead to the earlier detection of OSCC, even before any clinical signs and symptoms are detected. The rapid point-of-care test and the lab assay are not currently on the market, but availability is anticipated as early as this year (Vigilant Biosciences, 2015).

Summary of efficacy of oral cancer screenings. OC screenings by oral health care providers including visual and tactile examination are recommended by the NIH, CDC and USPSTF for the general public in the dental office setting. Community-based screening is recommended for high risk individuals. Data regarding a reduction in mortality is not strong, although the five-year survival rate is improved with early detection. Patient history and risk factors are important considerations. Adjunctive techniques currently are not recommended as more research is indicated to document added value in detecting OC. Autofluorescence and salivary diagnostics show promise for the future, pending the publication of strong evidence documenting efficacy. Transepithelial cytology of disaggregated cells, or exfoliative cytology, has value in identifying dysplastic cells, but is not a definitive diagnostic device, and requires surgical biopsy to diagnose OC following positive results. Adjunctive techniques may have value

in some patient populations such as those who are noncompliant with referrals, those with access to care restraints, and those unable to tolerate surgical procedures.

Efficacy of Other Cancer Screenings

The USPSTF regularly conducts systematic reviews to update its recommendations for cancer screenings for the most common types of cancer. Those recommendations and the 2016 guidelines for cancer screenings published by the ACS are summarized in this subsection of the literature review for potential comparison with recommendations for OC (ACS, 2015).

Breast cancer. Breast cancer is the second most commonly diagnosed cancer in women in the United States and the second leading cause of cancer-related death (Nelson et al., 2016). Stage of the cancer at diagnosis determines treatment options and influences survival rates. The five-year survival rate for localized breast cancer is 98.8%; it declines to 85.2% with regional lymph node involvement and 26.3% if diagnosed after distant metastasis (USDHHS, NIH, NCI, 2016c). The latest USPSTF breast cancer screening systematic review and related recommendations were published in 2016 (Nelson et al., 2016). The report found sufficient evidence that mammography reduces mortality in women age 40 to 74. However, data are insufficient for women 75 years of age and above. The latest guidelines recommend biennial screening for women at average risk for breast cancer from age 50-74. The report also found evidence of harms related to mammography, most notably related to over diagnosis and overtreatment. False positives and their resulting harms are common, and are higher among women age 40-49. As a result, the USPSTF recommends the decision to start biennial screening at age 40 be an individual one. Women at a higher risk for breast cancer may benefit more than women

at average risk from beginning breast cancer screening in their 40's. Potential harms listed in the review included radiation exposure, pain during the procedure, and psychological harms. The USPSTF review reported patients frequently report adverse experiences, including pain during screening tests, anxiety about the procedure, and apprehension about results, yet the recommendation is to continue using mammography for breast cancer screening due to its benefits. There was no difference in the number of breast cancer deaths between women screened annually versus biannually for women age 50 and older (Nelson et al., 2016).

Debate persists regarding false positives and possible risks associated with breast cancer screenings (Nelson et al., 2016). A 2014 systematic review by a group of researchers at Harvard Medical School's Department of Health Care and Policy and Brigham and Women's Hospital evaluated 50 years of studies regarding the benefits and risks of screening mammography. Findings indicated benefits may not be as great as estimated, and risks might be greater than estimated. Decisions regarding mammography screening should be related to assessment of individual patient history and needs, medical factors, and personal preferences (Pace & Keating, 2014). Another 2014 systematic review by researchers from the University of California at San Francisco assessed the value of screening in older women and concluded mammography screening for women over 70 years of age should be related to life expectancy (Walter & Schonberg, 2014). Recommendations to stop or continue screenings were based on less than or greater than 10 years life expectancy, complete disclosure of risks and benefits, and a personal decision made by women and their primary health care provider.

The 2016 ACS recommendations for breast cancer screenings include the option to begin yearly mammograms for women 40-44 years of age if a woman so chooses, yearly mammograms for women 45-54 years of age, and mammograms every 2 years for women aged 55 and older, with the option of yearly mammograms to continue if the woman prefers (ACS, 2015). Like recommendations for OC screenings, the ACS recommendations exceed the evidence-based recommendations, although a benefit of decreased mortality has been documented for mammography in certain age groups of women.

Colorectal cancer. Colorectal cancer is the fourth most common cancer in the U.S., occurring more frequently in men than in women (USDHHS, NIH, NCI, 2016e). Colorectal cancer develops from previously benign lesions over an approximate 10-year time span; like most cancers, stage at time of diagnosis impacts treatment options and earlier detection results in a better prognosis (Holme et al., 2013). The five-year survival rate for localized colorectal cancer is 90.1%; it declines to 71.2% with regional metastasis and 13.5% with distant metastasis (USDHHS, NIH, NCI, 2016e).

A final recommendation and report from the USPSTF on colorectal cancer screening is in the process of being updated; however, a systematic review from 2002 was used as the basis for its most current recommendation. The 2002 review concluded the only screening method showing evidence of a reduction in mortality is fecal occult blood testing (FOBT), which tests for blood in the stool from cancerous lesions and benign precursors in the colon and rectum. Once blood is detected in the stool, a colonoscopy is recommended to find the source of the bleeding. A longer-term follow up

to the 2002 review showed maintained mortality reduction in participants who received treatment for colorectal cancer that was first detected with FOBT (Hewitson et al., 2007). In 2008, with no new trials regarding other screening methods for colorectal cancer, the USPSFT performed a decision analytic modeling analysis to project a benefit from screening with colonoscopy, sigmoidoscopy, or FOBT every five years combined with some other type of fecal testing every two to three years. Despite a lack of evidence showing any of the methods to be particularly effective versus the others, the USPSTF determined any of the screening methods is effective in comparison to no screening (USPSTF, 2008). In March 2008, a joint recommendation from the American Cancer Society, the U.S. Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology recommended screenings for colorectal cancer beginning at age 50 with yearly FOBT; a flexible sigmoidoscopy, a double-contrast barium enema, or a CT colonography every five years; and a colonoscopy every ten years, with methods utilizing direct visualization of the colon preferred over indirect methods (Levin et al., 2008).

A meta-analysis to compare FOBT and flexible sigmoidoscopy in their ability to reduce colorectal cancer mortality was published in 2013. Nine studies were identified; four comparing FOBT to no screening and five comparing flexible sigmoidoscopy to no screening; no studies were identified that compared the two screenings directly. The authors concluded high quality evidence existed to demonstrate a reduction in mortality from colorectal cancer when FOBT or flexible sigmoidoscopy were used for screening, although they could not conclude the superiority of one over the other (Holme et al., 2013). Incomplete reporting of adverse events associated with the screenings resulted in

limitation of interpretation. More validation is needed from studies with more complete reporting of harms to determine major complications associated with screenings.

Supporting the findings of Holme et al. (2013), a meta-analysis comparing FOBT, flexible sigmoidoscopy, and colonoscopy found all three methods of screening were effective in reducing mortality from colorectal cancer (Elmunzer et al., 2015). Despite the limitations of observational data for colonoscopy versus higher-quality evidence to support FOBT and flexible sigmoidoscopy, this study concluded colonoscopy was the most effective test for reducing mortality at 57%, compared to 40% for flexible sigmoidoscopy and 18% for FOBT (Elmunzer et al., 2015, p. 704).

Lung cancer. Lung cancer is the second most common type of cancer in the United States and is the leading cause of all cancer-related deaths (USDHHS, NIH, NCI, 2016f). Smoking is the leading cause of lung cancer for both current smokers and former smokers, as risk continues even after smoking stops. Occupational and environmental exposures can also put a person at risk for lung cancer. Others at an increased risk include older adults and those with a family history of lung cancer, pulmonary fibrosis, or chronic obstructive pulmonary disorder (Humphrey et al., 2013). As with most cancers, mortality is improved with an earlier stage at diagnosis; however, lung cancer has only a 55.2% mortality rate even with early diagnosis, which decreases to 4.3% with distant metastasis, resulting in a relative five-year survival rate of only 17.7% (USDHHS, NIH, NCI, 2016f).

In 2004, the USPSTF determined insufficient evidence existed to recommend screening for lung cancer with chest radiography or low-dose computed tomography (LDCT). A systematic review to update the 2004 recommendation was published in

2013, and focused on LDCT (Humphrey et al., 2013). This systematic review identified four trials reporting results of LDCT screening; the largest of the four trials reported a significant 20% reduction in lung cancer mortality; the other three smaller trials showed no benefit to screening (Humphrey et al., 2013). Harms identified were radiation exposure, over-diagnosis, and a high rate of false positives which then resulted in additional imaging and, thus, additional radiation exposure. The authors concluded LDCT screening can reduce mortality and suggested the benefits and harms must be weighed against one another (Humphrey et al., 2013).

The ACS does not recommend lung cancer screening for anyone other than those considered high risk individuals between 55- and 74-years old, in fairly good health, with a 30 pack-year history of smoking (found by multiplying the number of packs a person smokes per day multiplied by the number of years a person has smoked), *and* currently smoking or having quit within the last fifteen years (ACS, 2015). The ACS only recommends LDCT screening at a facility with a significant amount of experience in using LDCT for lung cancer screening as well as the resources for follow up care if such care is needed, as approximately one in four screenings will have abnormal findings requiring follow up. Follow up may include additional imaging, resulting in increased radiation exposure, or more invasive tests such as needle biopsies or surgery to remove a portion of the lung. Complications from invasive tests may include a collapsed lung or (rarely) death in people who either do not have cancer or who have very early stage cancer (ACS, 2015). LDCT is the only lung cancer screening recommended by the ACS, and it is only recommended for the high risk individuals with specific characteristics identified above.

Cervical cancer. When compared to other cancers, the occurrence of cervical cancer is rare, representing only about 0.8% of all cancers in the U.S. (USDHHS, NIH, NCI, 2016d). An estimated 12,990 new cases will be diagnosed in 2016 (ACS, 2016a). In contrast, OC represents 2.9% of all cancers, with approximately 48,330 people diagnosed in 2016 (USDHHS, NIH, NCI, 2016a). The five-year relative survival rate for cervical cancer is 91.3% in the localized stage, but with regional and distant metastasis drops to 57.4% and 16.8%, respectively (USDHHS, NIH, NCI, 2016d). Cervical cancer screening programs using conventional cytology have reduced cervical cancer incidence and mortality by approximately 1.0% each year for the past ten years. However, there has been significant interest in developing new technologies as alternatives and adjuncts to conventional cytology.

HPV is the most common cause of cervical cancer, although not all women with HPV will develop cervical cancer (USDHHS, NIH, NCI, 2016d). Liquid-based cytology (LBC) improves specimen collection by allowing for co-testing for HPV. Other technologies are also being developed to aid in detection of the high-risk types of HPV specifically linked to cervical cancer. There are currently three tests for high-risk HPV approved by the U.S. Food and Drug Administration (FDA); a fourth test is awaiting FDA approval.

Primarily, screening benefits depend upon the detection and treatment of cervical intraepithelial neoplasia in the preclinical phase. In the United States, cytologic detection of a squamous intraepithelial lesion results in an immediate referral for biopsy; other abnormal screening results indicate a need for more frequent retesting, with a referral for biopsy with persistent abnormal cytologic findings (Vesco et al., 2011).

In 2003, the USPSTF recommended conventional cytology for cervical cancer screening but determined evidence was insufficient to support LBC or HPV testing. A systematic review found that LBC and conventional cytology had equal sensitivity and specificity; six studies in the review showed higher sensitivity with HPV screening but less specificity than cytology. Eight studies showed no clear advantage to co-testing with HPV and cytology over primary HPV testing alone; mixed results regarding the efficacy of HPV co-testing resulted from incomplete reporting of results for all types of screening. As a result of this systematic review, updated USPSTF recommendations included the use of LBC or conventional cytology for cervical cancer screening, but suggested more evidence is needed before adopting HPV-enhanced screening for women over age 30 (Vesco et al., 2011).

Similarly to ACS screening guidelines for breast cancer and OC, the ACS screening guidelines for cervical cancer exceed those of the USPSTF. The ACS recommends Pap tests (cytology) every three years beginning at age 21, with no HPV testing unless an abnormal Pap is found; women ages 30-65 should have co-testing (cytology with HPV testing) every five years; women over 65 should only continue to have a Pap test if serious pre-cancerous lesions have been found in the last 20 years or less. Women who have had their cervix removed with no history of cervical cancer or pre-cancer do not need testing, nor do women under age 21, although it is recommended women who have received the HPV vaccination continue to follow the screening guidelines for their respective age group (ACS, 2015).

Prostate cancer. Prostate cancer is the third most common type of cancer in the U.S., but only the sixth leading cause of cancer death, primarily due to its 100% five-year

relative survival rate when detected early (USDHHS, NIH, NCI, 2016g). Prostate specific antigen (PSA)-based screening is used to detect prostate cancer in earlier, asymptomatic stages; treatment in earlier stages may be more effective and result in improved outcomes.

A 2011 review of the evidence initiated by the USPSTF to update 2002 and 2008 recommendations regarding screenings and treatments for prostate cancers included five screening trials. One of the largest and highest quality studies reported a reduction in mortality with screening when compared to no screening; however, a second study of similar size and quality found no statistically significant reduction in mortality (Chou et al., 2011). In addition to these conflicting results with screening, one study also found that receiving a prostatectomy after prostate cancer was detected decreased mortality when compared to a “watch and wait” protocol over a 13-year time period, although benefits appeared to be limited to men younger than age 65 (Chou et al., 2011).

Treatment for prostate cancer may include removal of the prostate (prostatectomy) and/or radiation, both of which can have significant unintended side effects, including erectile dysfunction, urinary incontinence, and bowel dysfunction. False positives can result in infections and urine retention for men who undergo an unnecessary biopsy. Chou et al. (2011) found, while PSA-based screening is associated with increased prostate cancer detection, it has little to no effect on disease specific mortality after a ten year period, and harms associated with diagnosis may be significant. Determining which patients may benefit from screening and treatment presents a challenge; therefore, optimal screening intervals and PSA thresholds have yet to be definitively determined by the USPSTF (Chou, 2011).

The ACS agreed with the USPSTF that research does not yet show the benefits of screening outweigh the potential harms and, therefore, suggests that men over age 50 speak to their physician to discuss the potential risks and benefits to make an informed decision about whether or not testing would be in their best interest. Those individuals who agree to testing should receive the PSA blood test; a clinical rectal exam is optional (ACS, 2015). Interestingly, although the ACS and USPSTF both state that research does not currently support the benefits of screening over potential harms, the National Cancer Institute attributes the high five-year relative survival rate of prostate cancer to its early detection as a result of screening (USDHHS, NIH, NCI, 2016g).

Ovarian cancer. Ovarian cancer has the highest mortality rate among all gynecologic cancers, although it only accounts for 1.3% of all new cancer diagnoses in the U.S. (USDHHS, NIH, NCI, 2016h). The USPSTF released a recommendation against screening for ovarian cancer in 2004 due to evidence that the impact of screening on mortality was minimal; a 2012 literature review reaffirmed the 2004 recommendation as no new evidence was found regarding benefits of screening for ovarian cancer (Barton and Lin., 2012).

Screening for ovarian cancer typically includes either a transvaginal ultrasound or a blood test for cancer antigen CA – 125 (Barton and Lin., 2012; ACS, 2015). Unfortunately, for women who are at average risk for developing ovarian cancer, these screenings typically result in unnecessary testing and surgeries but do not decrease mortality; therefore, “no major medical or professional organization recommends [their] routine use” for screening (ACS, 2015, para. 9).

Summary of efficacy of other cancer screenings. Screening recommendations from the USPSTF for various cancers differ based on the research available at the time of the recommendation. For many cancers, the current ACS screening guidelines meet or exceed those of the USPSTF even for average-risk individuals, particularly regarding screenings for breast cancer, cervical cancer, and colorectal cancer; for high risk individuals, screenings for lung cancer are also included. The ACS also recommends that, in addition to the regular exam by a dental professional, physicians also examine the mouth and throat as part of a routine checkup, contrary to recommendations from the USPSTF recommending against routine OC screening by primary care providers.

Knowledge, Practices, and Attitudes of Oral Health Professionals

Although OC screening/examination in the dental setting is widely recognized by oral health care professionals as the standard of care, the provision of tobacco cessation information, counseling, and/or referrals for high risk behaviors such as alcohol abuse and tobacco use are lacking (Cruz et al., 2005). Cruz et al. (2005) conducted a survey to identify practice patterns for early OC detection and prevention. A mailed questionnaire was sent to a random sample of 1,025 dentists and 1,025 dental hygienists ($N=2,050$) in New York state; 499 dentists and 630 dental hygienists ($n= 1,129$) responded. The survey found that most dentists and dental hygienists provide regular OC screenings (OCS) to their patients aged 40 and older; however, tobacco cessation counseling was not implemented for the majority of respondents nor was alcohol counseling. Approximately half of the oral health care providers said that they ask their patients about it, but most do not assist the patient with formulating a plan to quit (Cruz et al., 2005).

Another study by Maybury et al. (2012) may help to provide insight as to why providers do not typically assist patients with formulating a plan for alcohol and/or tobacco cessation. The purpose of the study was to assess dentists' knowledge and skills for early detection and diagnosis of OC. A mailed questionnaire was sent to randomly selected general practice dentists ($N=1,169$) in Maryland. Responses ($n=463$) were used to measure providers' knowledge of OC risk factors, knowledge of OC diagnostic procedures, combined knowledge index of risk factors and diagnostics, and dentists' opinions of their OC education, training, and current knowledge. The majority (83%) of respondents felt inadequately trained to provide alcohol cessation information, and 65% felt inadequately trained to provide tobacco cessation information. The study also found that 98% of responding dentists could identify true risk factors such as tobacco and alcohol use, but 61% also incorrectly identified other oral conditions such as poor oral hygiene and ill-fitting dentures as risk factors. Gaps in knowledge of risk factors and diagnostic procedures were identified, as less than half of the respondents recognized the two most common lesions associated with OC, leukoplakia and erythroplakia, leading to the conclusion that if dentists do not know what to look for, OC lesions may be missed. Most respondents (83%) admitted that they were not as knowledgeable about signs, symptoms, and risk factors as they believed they should be, and only 7% strongly agreed that their OC knowledge was current.

A study by Awojobi, Newton, & Scott (2015) utilized semi-structured interviews of general dentists in the United Kingdom ($N=16$) to assess dentists' opinions and practices regarding OC. While all of the dentists reported regularly performing visual soft tissue examinations, only half of those reported discussing OC screening with the

patient. Identified barriers included lack of time for the discussion to take place, lack of financial incentive, and the potential for fear or anxiety among patients by using the word ‘cancer’. Those dentists who believed they had adequate knowledge, training, and experience with OC and tobacco cessation were more likely to discuss OC screening with their patients than those who felt less confident.

Current literature regarding dental hygienists’ knowledge, opinions, and practices regarding OC detection is limited; however, a study by Forrest, Horowitz, & Shmuelly (2001) had similar findings regarding dental hygienists’ knowledge of OC risk factors to those of Maybury et al. (2012) for dentists. A random sample of licensed dental hygienists in the U.S. ($N=960$) were mailed a questionnaire focusing on OC risk assessment and continuing education needs. Responses ($n=464$) revealed that 99.8% of respondents correctly identified tobacco use, and 89.8% correctly identified alcohol use as risk factors, but 27% and 64.6% incorrectly identified ill-fitting dentures and poor oral hygiene, respectively. Only 2% of respondents strongly agreed that their knowledge of OC was current.

Conclusions of previous studies of knowledge and practices regarding OCS have emphasized a need for additional education and training in OC detection and training in tobacco and/or alcohol cessation counseling for oral health care providers (Cruz et al., 2005; Maybury et al., 2012; Awojobi et al., 2015; Forrest et al., 2001). A subsequent study by Walsh et al. (2013) confirmed the positive effects of continuing education (CE) courses on dental hygienists’ knowledge, attitudes, and behaviors regarding OCS using a pretest/post-test design. Sixty-four standardized CE courses on OCS and tobacco cessation were given among ten public health districts throughout the

United States. The convenience sample of clinical dental hygienists ($N = 1,463$) completed a baseline survey at the beginning of each course. A follow-up questionnaire ($n = 543$) was mailed six months after the CE course to determine if oropharyngeal cancer screenings and tobacco cessation counseling behaviors changed following course attendance. At baseline, the survey administered by Walsh, et al. revealed that, while nearly all respondents recognized the importance of early detection of OC, approximately 50% of the hygienists who reported regularly performing OCS were not including neck palpations and, therefore, not performing a comprehensive evaluation. Comparison of baseline data and the follow-up data revealed that CE courses improved hygienists' knowledge and behavior regarding OCS and tobacco cessation counseling, which could ultimately make a difference in OC prevention and detection (Walsh et al., 2013).

Consumer Awareness and Perceptions of Oral Cancer Screenings

Current literature regarding consumer awareness and perceptions of OC screenings from a national perspective in the United States is limited; however, some studies have examined adults' perspectives in specific states and in other countries. A cross-sectional survey by Awojobi et al. (2012) was performed in the United Kingdom to assess dental patients' experiences with and awareness of OC and OCS. Eligible participants ($N = 362$) were English-speaking adults who had no previous history of OC. Completed questionnaires ($n = 184$) from eligible participants revealed that 20% of respondents had *never* heard of OC, 77% knew little or nothing about OC, and 72% did not realize that their oral health care provider routinely screens for OC. Only 1% of respondents reported extreme levels of concern or anxiety regarding OCS, as the majority (64%) indicated little to no anxiety or concern about OCS. Although most respondents

were unaware of OC and OCS in general, 92% indicated that they would like their oral health care provider to tell them that they are being screened, and 97% reported that they would like to receive more information from their oral healthcare provider about how to reduce their risk of developing OC.

Similar findings in the United States include those of Tomar and Logan (2005), who performed a telephone survey of Florida adults ages 40 years and above using random digit dialing ($N=1,780$). The survey found that 15.5% of respondents reported having never heard of OC, and an additional 40.3% reported knowing little or nothing about OC. Respondents with a low socioeconomic status and blacks and Hispanics were less likely to have received an OCS than whites, highlighting racial/ethnicity and socioeconomic disparities. These findings supported those of another telephone survey performed by Patton et al. (2004) of North Carolina adults ($n=1,096$) indicating that 14% of respondents had never heard of OC, and only 29% reported ever receiving an OCS. A written survey performed by Posorski et al. (2014) of Illinois adults ($N=66$) aged 55 years and older had similar findings, with 27.9% of respondents having ever received an OCS, although 82% stated that they knew little or nothing about OC- twice that of Tomar and Logan (2005). These reports are also consistent with the findings from a focus group of Maryland adults ($N=26$) aged 40 years and older, which found that many of the focus group participants had never had an OCS or were even aware that such a screening existed (Horowitz, Canto, & Child, 2002).

Studies have documented low consumer knowledge and awareness of OC, related risk factors, and clinical signs. Most participants of the studies cited reported never having received an OC screening or were unaware that their health care provider screens

for OC at all. Race/ethnicity and socioeconomic status appear to indicate individuals with a lower socioeconomic status, blacks, and Hispanics are less likely to have received an OCS.

Summary of Findings

The majority of OC cases are typically detected in the later stages of the disease when regional or distant metastasis has occurred, resulting in a significant increase in mortality. Relative five-year survival rates are decreased by more than half once metastasis has occurred, highlighting the importance of early detection and intervention. Patient history and risk factors are important considerations for determining the need for screening, although identifying those individuals at risk is more difficult with HPV being a major risk factor. Alcohol and tobacco use remain the major risk factors for OC, although HPV-related OPSCC is on the rise.

Visual and tactile examination for OC by a trained oral health care professional is recommended by most major health organizations, despite a lack of strong evidence regarding a reduction in mortality. However, adjunctive techniques for OC detection are not currently recommended due to insufficient research documenting added value in OC detection. Adjunctive techniques may have value in certain patient populations such as those who are noncompliant with referrals, those with access to care restraints, and those unable to tolerate surgical procedures. New tests, specifically involving salivary testing for OSCC biomarkers for early detection of OC, are being developed but are not currently on the market.

Comparison of screening recommendations for OC versus other common cancer screenings indicates that ACS screening guidelines meet or exceed those of the USPSTF

for average-risk individuals, particularly regarding screenings for breast cancer, cervical cancer, and colorectal cancer; for high risk individuals, screenings for lung cancer are also recommended by the ACS but not the USPSTF. The ACS recommendations for OC screening also exceed those of the USPSTF, recommending that in addition to the routine OCS by a dental professional, physicians also examine the mouth and throat as part of a routine checkup. Although OCS is widely viewed as the standard of care among oral healthcare providers, many providers report that they may not be as knowledgeable about signs, symptoms, and risk factors for OC as they should be. Studies have identified gaps in knowledge regarding risk factors and diagnostic procedures, as well as in identification of lesions commonly associated with OC. If providers are not competent in detection of these abnormalities, lesions may remain unnoticed. Additionally, providers do not feel adequately prepared to implement tobacco and/or alcohol cessation counseling or referrals for their patients. Therefore, additional training, experience, and emphasis in professional education curricula as well as in the form of CE courses post-licensure would be beneficial to all oral healthcare professionals to increase knowledge and awareness.

OC awareness is also lacking among consumers, as multiple studies show low overall knowledge of OC, OC risk factors, and clinical signs in scattered populations throughout the United States and in other countries. Most consumers report having never received an OCS, and many are unaware that their oral healthcare providers even screen for OC. Individuals with lower SES and blacks or Hispanics appear to be less likely to have received an OCS than white individuals.

The purpose of this study was to determine perceptions of Idaho adults regarding OC screenings as compared to other common cancer screenings such as breast cancer screenings, prostate cancer screenings, and colon cancer screenings.

CHAPTER III

Methodology

The purpose of this study was to determine perceptions of Idaho adults regarding OC screenings as compared to other common cancer screenings such as breast cancer screenings, prostate cancer screenings, and colon cancer screenings. The study was designed to test the following null hypotheses:

- 1) There is no association between Idaho adults' perceptions of oral cancer screening and breast cancer screening.
- 2) There is no association between Idaho adults' perceptions of oral cancer screening and prostate cancer screening.
- 3) There is no association between Idaho adults' perceptions of oral cancer screening and colon cancer screening.

Design

This quantitative pilot study utilized an interview-administered questionnaire using computer-assisted telephone interview software (CATI) to assess consumer perceptions about cancer screenings. A study of a sample of Idaho adults with no known history of OC may serve as a pilot for a larger national study in the future. The key variables considered for this study were participants' recollection of having received an oral, breast, prostate, and colon cancer screenings, perceived benefits and risks of those cancer screenings and perceived barriers to receiving them. These variables were compared to examine associations between consumer perceptions of OC screenings and other cancer screenings.

Research Context

This survey of Idahoans and their perspectives on OC and other cancer screenings was conducted using an interview-administered questionnaire via telephone due to a higher likelihood of an adequate response rate versus questionnaires distributed through an online format (Dillman, Smyth, and Christian, 2009). An experienced survey firm, Bennett Research, was employed to conduct the telephone survey.

Research Participants

Sample description. A non-probability, purposive sample of Idaho adults (N=100) was utilized. The sample size for this pilot study was determined based on feasibility and cost. The sample was purchased from Scientific Telephone Samples. Inclusion criteria established for the sample were adults aged 18 years and older residing in Idaho. The increased portability of cellular telephones had the potential to result in respondents who had a telephone number originating in Idaho, but who had since moved out of state while maintaining the Idaho-originated number. These participants were excluded from the study. Participants were also excluded if they were non-English-speaking or had a history of OC.

Human subjects' protection. The study protocol was submitted to the Idaho State University Human Subjects Committee for expedited review and approval was obtained. An introduction stating the purpose of the study and participants' rights was provided at the onset of the telephone call to each participant, and verbal informed consent was obtained prior to administering the survey (Appendix A). Anonymity was maintained as no personally identifiable information was gathered in the interview or stored with the responses to the interview questions. Additionally, all data collected have been stored in a password-protected file. Upon completion of the thesis, all survey-related

information will be stored in a locked file cabinet by the major thesis advisor for a period of seven years.

Data Collection

Data collection instrument. The instrument for this study was a self-designed, semi-structured interview-administered questionnaire comprised of closed-ended and open-ended items (Appendix B). Information gathered from the literature review was used to guide the development of the instrument. The interview-administered questionnaire questions about experiences and perceptions of OC screenings and perceptions of other health screenings followed by demographic questions. Items included categorical items, questions with Likert-scale response options, and open-ended questions to allow for comments.

Content validity of the instrument was established to ensure that the questions were relevant to the subject(s) of interest, in this case, OC screenings and other health screenings. To determine content validity, the research instrument was reviewed for relevance, content, and validity by five experts in the subjects of OC and/or health screenings. The letter requesting the experts' assistance to establish content validity is found in Appendix C. The experts used a content validity assessment form (Appendix D) containing a content validity index (CVI) to determine validity of each item using a Likert-type scale where 1= not relevant, 2= somewhat relevant, 3= relevant, and 4= very relevant. Once the raters evaluated the instrument using the Likert-type scale, the responses were coded into two categories in the CVI to determine if the content was valid (Wynd et al., 2003). Feedback from the experts, found in Appendix E, was incorporated into the research instrument before pilot testing was conducted. Pilot testing was

conducted with a convenience sample of five individuals who met the inclusion criteria of being adults aged 18 years or older residing in Idaho who also had no previous diagnosis of OC. The survey was administered to the same subjects one week apart to establish test-retest reliability. Pilot testing results are found in Appendix F.

Procedures and protocols. Burnett Research, a market research company, conducted the survey via telephone. Burnett Research, established in 1972, has been operating call centers since 1986. Call centers are equipped with 250 CATI stations, where trained telephone interviewers conducted the interviews and recorded responses in the system. Interviewers are trained in a two-day process consisting of a combination of classroom training, role-play, and live on-the-telephone experience with feedback from supervisors monitoring the calls. The Burnett Research training manual for interviewers, which describes common terminology, practices, and coding procedures, is attached in Appendix G.

The interview-administered questionnaire was programmed into the CATI software and tested by the interviewers prior to implementation to ensure that the correct data were collected and to assess whether the survey was user-friendly for interviewers. Suggestions from Burnett Research to improve ease of administration and improve clarity were incorporated into the questionnaire, which was then re-submitted to HSC for additional approval. Following the HSC approval of the modified instrument, landline numbers were programmed through a predictive dialer, which filtered the sample purchased from STS and pre-coded numbers associated with faxes, computer phones, no-answers, etc. (any calls that were not “live”) before sending the live calls to the interviewers to administer the survey. Cellular telephone numbers from the sample did

not use the predictive dialer, and were dialed by each interviewer on a one-to-one basis per federal regulations. Calls were made on weekdays between 5:00-9:00 pm respondent-time. Participants' responses to the survey required approximately five to ten minutes.

Limitations

Limitations of this study include the non-probability sample, which precludes generalizability of the results beyond the group of respondents. As a pilot study with a small sample size, results cannot be generalized to all Idahoans; however, the purpose of the study was to explore potential associations between consumers' perceptions of OC with other exams so a broader study can be designed for a larger population. The exclusion of non-English speaking respondents is a limitation. The volunteer nature of the sample and the higher level of education of respondents also potentially influenced the findings of the study as participants may have been more interested, knowledgeable, or motivated than the general population. Age may also be a limitation, as 23% of respondents were under 40, the minimum age at which some screenings (with the exception of oral cancer screening) are recommended to begin. An older population could influence the number of respondents with screening experiences. An additional limitation was the self-generated questionnaire, although the instrument was developed from the literature review and efforts were made to validate the instrument.

Limitations also included the use of the telephone to administer the instrument. Telephone survey respondents feel less of an obligation to participate in telephone surveys, leading to an increased likelihood of refusal (Dillman et al., 2009). Telephone surveys are also becoming less representative of the general population due to a decrease in landlines and the increased use of cellular telephones as the primary method of

telephone communication. An attempt to compensate for this decrease in landline use was to purchase a sample consisting of a fifty-fifty combination of landline numbers and cellular telephone numbers originating from Idaho, which is representative of the estimated 56.1% of Idaho homes with only wireless telephone service as reported by the CDC (USDHHS, CDC, National Center for Health Statistics (NCHS), 2016).

Statistical Analysis

Demographic data were analyzed using descriptive statistics and frequencies. The categorical data from closed-ended questions were analyzed using Pearson's Chi-Square test for association to examine distribution differences and relationships between variables. To minimize the likelihood of a Type I error due to multiple comparisons analyzed in each set of tests (i.e., OC compared to BC, CC, and PC), a Bonferroni strategy was used to maintain the family-wise error (FWE) rate of 0.05, which was calculated by dividing the 0.05 FWE rate by the number of tests, in this case four. This calculation indicated that an alpha level of 0.0125 should be used for statistical significance for each chi-square test within the sets. A phi coefficient was used to determine the magnitude of effect size, or strength of significant associations, identified in the crosstabs according to the following scale: .1 weak, .3 moderate, .5 strong (U.S. Department of the Interior, U.S. Geological Survey, Fort Collins Science Center, 2016).

Conclusion

This descriptive study of Idaho adults was conducted to identify perceptions of cancer screenings, including OC screenings, using a self-designed interview-administered questionnaire. The research instrument, consisting of both closed- and open-ended questions, was tested for content validity using a CVI from five subject matter experts.

After feedback from the subject matter experts was incorporated into the instrument, reliability was established by using a test-retest method with a convenience sample of five Idaho adults who met the inclusion criteria of the study.

Participants of this study consisted of a random sample of Idaho adults aged 18 years and older with no history of OC. The telephone survey was conducted by Burnett Research in December 2015 following Human Subjects Committee approval. The limitations of the study are the non-probability sample, the use of a self-generated questionnaire, use of the telephone to conduct the survey, and unique characteristics of the population such as age, education level, race, and language spoken.

Demographic data were analyzed using descriptive statistics and frequencies. The categorical data from closed-ended questions were analyzed using Pearson's Chi-Square test for association to look at distribution differences and relationships between variables. A FWE rate of 0.05 was established to minimize the likelihood of a Type I error. The FWE indicated that an alpha level of less than 0.0125 should be used for statistical significance.

A manuscript entitled, *Perceptions of Oral Cancer Screenings Compared to Other Cancer Screenings: A Pilot Study*, will be submitted for publication in the Journal of Dental Hygiene to report results, discussion and conclusions in lieu of the traditional thesis Chapters IV and V. The publishable manuscript section of the thesis reflects the manuscript specifications outlined in the author guidelines. Guidelines for manuscript submission are found in Appendix H.

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Appendix A
Idaho State University
Script for Verbal Consent

Perceptions of Oral Cancer Screenings Compared to Other Cancer Screenings: A Pilot Study

GREETING/INTRO. Hello, my name is _____, calling from Bernett Research on behalf of Colleen Stephenson, a graduate student from the Idaho State University Department of Dental Hygiene, who is conducting research about cancer screenings. Screenings are tests that look for diseases before you have symptoms. Screening tests can often find diseases early, when they're easier to treat. (U. S. National Library of Medicine, National Institutes of Health, Medline Plus, 2014).

The purpose of this study is to determine perceptions of Idaho adults regarding oral cancer screenings as compared to other common cancer screenings, such as breast cancer screenings, prostate cancer screenings, and colon cancer screenings.

Oral cancer screening consists of an examination of the mouth, head, and neck that is performed by visual examination, looking and palpation, feeling.

We estimate that approximately 100 people will participate in this study. You will be asked to complete a short interview about health screenings. This should take about 10 minutes.

There is a small chance that some of the questions might make you feel uncomfortable, although we do not anticipate that they will. You don't have to answer those questions if you don't want to. We will just skip that question and go on to the next one.

All the information we receive from you by telephone will be anonymous. We will not identify you or use any information that would make it possible for anyone to identify you in any presentation or written reports about this study. If it is okay with you, we

might want to use direct quotes from you, but these would only be quoted as coming from “a person” or a person of a certain label or title, like “one woman said.” When we finish with all the telephone surveys from everyone who has agreed to participate, the primary investigator will group all the answers together in any report or presentation.

There will be no way to identify individual participants.

No personal information will be gathered in the interviews or stored with the responses to the interview questions.

This research is not being conducted to benefit you directly, but your answers might help health care professionals to better understand consumer opinions about cancer screenings and address barriers to people receiving recommended screenings.

You do have the right to refuse participation in this research study.

You can also call Colleen Stephenson, the primary investigator, at (208)406-6645 with questions about this research study. All research involving human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have any questions regarding your rights as a research subject, you may contact the ISU Human Subjects Committee office at (208) 282-2179.

Your participation in this survey is completely voluntary, so you do not have to participate in this survey unless you want to.

Would you be willing to answer some questions to help me determine if you are eligible for this study?

- 1 Yes **[CONTINUE]**
- 2 No **[THANK AND TERMINATE]**

Appendix B
Perceptions of Cancer Screenings Questionnaire

(Interview-Administered Questionnaire)

Introduction to the study

- Script [In Appendix B]

Eligibility

- S3. Do you speak and understand English?
(IF NO) Is there anyone else in the home who does speak English that would be willing to participate?
1. Yes [**CONTINUE**]
 2. No – someone else coming to the telephone [**GO BACK TO INTRO AND CONTINUE**]
 3. No [**THANK AND TERMINATE**]
- S4. Are you 18 years old or older?
1. Yes [**CONTINUE**]
 2. No - someone else coming to the telephone [**GO BACK TO INTRO AND CONTINUE**]
 3. No – no one over 18 yrs old ever [**THANK AND TERMINATE**]
- S5. Do you currently live in Idaho?
1. Yes [**CONTINUE**]
 2. No [**THANK AND TERMINATE**]
- S6. Have you ever been diagnosed with oral cancer, sometimes referred to as mouth or throat cancer?
1. Yes [**THANK AND TERMINATE**]
 2. No [**CONTINUE**]
- S7. Good, it looks like you meet the criteria to be eligible for this study. Do I have your permission to begin asking you questions?
1. Yes [**CONTINUE**]
 2. No [**THANK AND TERMINATE**]
- S8. Are you...?
1. Male
 2. Female
 3. Transgender/Gender Neutral
 4. **(DO NOT READ)** Prefer not to answer/Refused

[EVERYONE] Oral Cancer

1. Have you ever had an oral cancer screening? An oral cancer screening includes an examination of the mouth, head, and neck that is often performed by having you stick out your tongue, looking inside your mouth, and feeling around the tongue, mouth, head, and neck.
 1. Yes- [CONTINUE]
 2. No [SKIP TO Q4]

2. Did the person who performed the exam tell you what they were doing, and why?
 1. Yes
 2. No
 3. **(DO NOT READ)** Unsure/Don't know

3. Who performed the oral cancer screening(s)? **(READ LIST, SELECT ALL THAT APPLY)**
 1. Dentist
 2. Dental Hygienist, person who "cleans" the teeth
 3. Primary health care provider a doctor, physician's assistant, nurse practitioner
 4. **(DO NOT READ)** Other (**SPECIFY**_____)
 5. **(DO NOT READ)** Unsure/Don't Know

4. Do any of the following concerns that people might have about getting an oral cancer screening apply to you? **(READ LIST, SELECT ALL THAT APPLY)**
 1. Fear of finding cancer
 2. Fear of having a mouth and throat exam
 3. Fear of pain during the exam
 4. Any others (**SPECIFY**_____)
 5. **(DO NOT READ)** None of these concern me

5. How helpful do you perceive oral cancer screening to be? **(READ LIST)**
 1. Very helpful
 2. Helpful
 3. **(DO NOT READ)** No opinion
 4. Not very helpful
 5. Not helpful at all

6. Which of the following do you think are barriers to getting an oral cancer screening?
 1. Cost
 2. Time
 3. Any others? (**SPECIFY**_____)
 4. **(DO NOT READ)** None of these

**[IF S8=2 (FEMALE), CONTINUE, IF NOT SKIP TO LOGIC BEFORE Q11]
Breast Cancer Screening**

7. Have you ever had a screening for breast cancer? This might have included a mammogram or a clinical breast exam.
 1. Yes
 2. No
 3. **(DO NOT READ)** Unsure/Don't Know

8. Do any of the following concerns that people might have about getting a breast cancer screening apply to you? **(READ LIST; SELECT ALL THAT APPLY)**
 1. Fear of finding cancer
 2. The exam is embarrassing
 3. Fear of pain during the exam
 4. Any others **(SPECIFY _____)**
 5. **(DO NOT READ)** None of these concern me

9. How helpful do you perceive breast cancer screening to be? **(READ LIST)**
 1. Very helpful
 2. Helpful
 3. **(DO NOT READ)** No opinion
 4. Not very helpful
 5. Not helpful at all

10. Which of the following do you think are barriers to getting a breast cancer screening? **(READ LIST)**
 1. Cost
 2. Time
 3. Any others **(SPECIFY _____)**
 4. **(DO NOT READ)** None of these

[IF S8=1 (MALE), CONTINUE. IF NOT SKIP TO Q15] Prostate Cancer Screening

11. Have you ever had a screening for prostate cancer? This might have included a blood test or a rectal exam.
 1. Yes
 2. No
 3. **(DO NOT READ)** Unsure/Don't Know

12. Do any of the following concerns that people might have about getting a prostate cancer screening apply to you? **(READ LIST, SELECT ALL THAT APPLY)**
 1. Fear of finding cancer
 2. The exam is embarrassing
 3. Fear of pain during the exam
 4. Any others **(SPECIFY _____)**
 5. **(DO NOT READ)** None of these concern me

13. How helpful do you perceive prostate cancer screening to be? **(READ LIST)**
 1. Very helpful
 2. Helpful

3. **(DO NOT READ)** No opinion
 4. Not very helpful
 5. Not helpful at all
14. Which of the following do you think are barriers to prostate cancer screening?
(READ LIST)
1. Cost
 2. Time
 3. Any others? (**SPECIFY**_____)
 4. **(DO NOT READ)** None of these

[ASK OF EVERYONE] Colon Cancer Screening

15. Have you ever had a screening for colon cancer? This might have included an at-home stool test or a colonoscopy.
1. Yes
 2. No
 3. **(DO NOT READ)** Unsure/Don't Know
16. Do any of the following concerns that people might have about getting a colon cancer screening apply to you? **(READ LIST, SELECT ALL THAT APPLY)**
1. Fear of finding cancer
 2. The exam is embarrassing
 3. Fear of pain during the exam
 4. The prep for the exam is unpleasant
 5. Any others (**SPECIFY**_____)
 6. **(DO NOT READ)** None of these concern me
17. How helpful do you perceive colon cancer screening to be? **(READ LIST)**
1. Very helpful
 2. Helpful
 3. **(DO NOT READ)** No opinion
 4. Not very helpful
 5. Not helpful at all
18. Which of the following do you think are barriers to colon cancer screening?
(READ LIST)
1. Cost
 2. Time
 3. Any others? (**SPECIFY**)
 4. **(DO NOT READ)** None of these
19. Do you have any other comments to add about any of the screenings we have discussed?
1. Enter response [**GO TO 19OE**]

2. No other comments/Don't know/Refused [**GO TO DEMO**]

19OE. **(IF NEEDED)** What other comments do you have about any of the screenings we have discussed? [**OPEN END**] (**PROBE TWICE AND CLARIFY AS NEEDED**)

Demographics

DEMO. Now I would like to ask you a few final questions for statistical purposes only.

20. What is your age? (**RECORD TWO DIGIT AGE, IF DK/REFUSED ENTER 9999**)
21. What is your race or ethnicity? (**READ LIST, SELECT ALL THAT APPLY**)
1. White
 2. Hispanic or Latino
 3. Black or African American
 4. Native American or American Indian
 5. Asian / Pacific Islander
 6. (**DO NOT READ**) Other (**SPECIFY**_____)
 7. (**DO NOT READ**) Prefer not to answer/Refused
22. What is the highest level of education you have completed? (**DO NOT READ LIST, CLARIFY FROM IT AS NEEDED**)
1. Some high school, no diploma
 2. High school graduate, diploma or the equivalent, for example: GED
 3. Some college, no degree
 4. Trade/technical/vocational training
 5. Associate degree
 6. Bachelor's degree
 7. Master's degree
 8. Doctoral degree
 9. (**DO NOT READ**) Prefer not to answer/Refused

FINISH. Those are all of my questions. Thank you very much for completing this survey. Again, this survey was for informational purposes only. Thank you and have a good day.

Appendix C**Letter to Experts- Content Validity**

July 13, 2015

Dear _____,

As a candidate for the Master of Science in Dental Hygiene degree at Idaho State University, I am in the process of completing my thesis, entitled Public Perceptions of Oral Cancer Screenings. The purpose of this study is to determine Idaho adults' perceptions of oral cancer screenings and how those perceptions compare to other health screenings, specifically those for breast cancer, prostate cancer, and colon cancer. Perceived barriers to screening will also be explored as part of this study.

I am contacting you to request your assistance as a content expert in the area of oral cancer and/or other health screenings. I need to establish content validity for the survey instrument prior to establishing reliability. Would you please review the survey instrument to determine whether each item is relevant to the stated purpose of the study? The instrument consists of 33 questions and should take 10-15 minutes of your time to review.

My major co-advisors, JoAnn Gurenlian and Denise Bowen, and I would very much appreciate your time and expertise in reviewing this instrument for content validity. You may indicate whether you would be willing to do so by replying to this e-mail. I look forward to hearing from you soon!

Sincerely,

Colleen Stephenson, RDH-ER, BS

Appendix D

Content Validity Instrument

As a subject expert in oral cancer screenings or other cancer screenings, please review the following items for content validity.

Check one of the following:

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant**
- 4- Very relevant**

to represent your assessment of the question validity. In addition, please feel free to make comments or recommendations in the space provided. Thank you for your time and contribution!

Introduction to the study

- Script [In Appendix B]

Eligibility

- 1) Do you speak English?
 - a. Yes- *proceed*
 - b. No- *ineligible; ask if there is anyone in the home who does. If yes, proceed. If no, end survey*

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant**
- 4- Very relevant**

Comments:

- 2) Are you 18 years of age or older?
 - a. Yes- *proceed*
 - b. No- *ineligible; end survey*

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant**
- 4- Very relevant**

Comments:

3) Are you currently residing in Idaho?

- a. Yes- *proceed*
- b. No- *ineligible; end survey*

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant**
- 4- Very relevant**

Comments:

21) Have you even been diagnosed with oral cancer?

- a. Yes- *ineligible; end survey*
- b. No- *proceed*

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant**
- 4- Very relevant**

Comments:

Demographics

22) What is your date of birth? *Month/Year*

a. _____

- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant
- 4- Very relevant

Comments:

23) What is your sex?

- a. Male
- b. Female

- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant
- 4- Very relevant

Comments:

26) What is your race or ethnicity? *Indicate all that apply*

- a. White
- b. Hispanic or Latino
- c. Black or African American
- d. Native American or American Indian
- e. Asian / Pacific Islander
- f. Other-*specify*_____

g. Prefer not to answer

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

27) What is the highest level of education you have completed?

a. Some high school, no diploma

b. High school graduate, diploma or the equivalent (*for example: GED*)

c. Some college, no degree

d. Trade/technical/vocational training

e. Associate degree

f. Bachelor's degree

g. Master's degree

h. Doctoral degree

i. Prefer not to answer

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

Oral Cancer

9) Have you ever had an oral (mouth) cancer screening?

- a. Yes
- b. No
- c. Unsure/Don't Know

- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant
- 4- Very relevant

Comments:

10) If so, who performed the oral cancer screening(s)? *Indicate all that apply*

- a. Dentist
- b. Dental Hygienist
- c. Primary care provider (physician, PA, nurse practitioner)
- d. Other- *specify* _____
- e. Unsure/Don't Know

- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant
- 4- Very relevant

Comments:

12) Do you perceive any risks to having an oral cancer screening?

- a. Yes
 - i. If you answered yes, what risks do you perceive?
 - ii. _____

- b. No
- c. Unsure/Don't Know

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant**
- 4- Very relevant**

Comments:

14) How beneficial do you perceive oral cancer screening to be?

- a. Very beneficial
- b. Beneficial
- c. Neutral
- d. Not very beneficial
- e. Not beneficial at all

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant**
- 4- Very relevant**

Comments:

17) Do you think that the benefits of screening outweigh the risks?

- a. Yes
- b. No
- c. Unsure/Don't know

- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant
- 4- Very relevant

Comments:

17) Do you perceive any barriers to oral cancer screening?

a. Yes

i. If you answered yes, what barriers do you perceive?

ii. _____

b. No

c. Unsure/Don't Know

- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant
- 4- Very relevant

Comments:

18) Any comments?

a. _____

- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant
- 4- Very relevant

Comments:

Breast Cancer Screening *Females Only*

16) Have you ever had a screening for breast cancer?

a. Yes

i. If so, what type of screening did you have? (Indicate all that apply)

1. Mammogram

2. Clinical breast exam

3. Unsure/Don't know

b. No

c. Unsure/Don't Know

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

17) Do you perceive any risks to having a breast cancer screening?

a. Yes

i. If you answered yes, what risks do you perceive?

ii. _____

b. No

c. Unsure/Don't Know

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

18) How beneficial do you perceive breast cancer screening to be?

a. Very beneficial

b. Beneficial

c. Neutral

d. Not very beneficial

e. Not beneficial at all

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

19) Do you think that the benefits of screening outweigh the risks?

a. Yes

b. No

c. Unsure/Don't know

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

20) Do you perceive any barriers to breast cancer screening?

a. Yes

i. If you answered yes, what barriers do you perceive?

ii. _____

b. No

c. Unsure/Don't Know

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

21) Any comments?

a. _____

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

Prostate Cancer Screening *Males Only*

22) Have you ever had a screening for prostate cancer?

a. Yes

i. If so, what type of screening did you have? (Indicate all that apply)

1. PSA blood test
2. Rectal exam
3. Unsure/Don't know

b. No

c. Unsure/Don't Know

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

23) Do you perceive any risks to having a prostate cancer screening?

a. Yes

i. If you answered yes, what risks do you perceive?

ii. _____

b. No

c. Unsure/Don't Know

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

24) How beneficial do you perceive prostate cancer screening to be?

- a. Very beneficial
- b. Beneficial
- c. Neutral
- d. Not very beneficial
- e. Not beneficial at all

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant**
- 4- Very relevant**

Comments:

25) Do you think that the benefits of screening outweigh the risks?

- a. Yes
- b. No
- c. Unsure/Don't know

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant**
- 4- Very relevant**

Comments:

26) Do you perceive any barriers to prostate cancer screening?

- a. Yes
 - i. If you answered yes, what barriers do you perceive?
 - ii. _____

- b. No
- c. Unsure/Don't Know

- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant
- 4- Very relevant

Comments:

27) Any comments?

a. _____

- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant
- 4- Very relevant

Comments:

Colon Cancer Screening *Males and Females*

28) Have you ever had a screening for colon cancer?

- a. Yes
 - i. If so, what type of screening did you have? (Indicate all that apply)
 1. Fecal occult blood testing (FOBT)
 2. Flexible sigmoidoscopy
 3. CT colonography or double-contrast barium enema
 4. Colonoscopy
 5. Unsure/Don't Know

- b. No
- c. Unsure/Don't Know

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant**
- 4- Very relevant**

Comments:

29) Do you perceive any risks to having a colon cancer screening?

- a. Yes
 - i. If you answered yes, what risks do you perceive?
 - ii. _____

- b. No
- c. Unsure/Don't Know

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant**
- 4- Very relevant**

Comments:

30) How beneficial do you perceive colon cancer screening to be?

- a. Very beneficial
- b. Beneficial
- c. Neutral
- d. Not very beneficial

e. Not beneficial at all

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

31) Do you think that the benefits of screening outweigh the risks?

a. Yes

b. No

c. Unsure/Don't know

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

32) Do you perceive any barriers to colon cancer screening?

a. Yes

i. If you answered yes, what barriers do you perceive?

ii. _____

b. No

c. Unsure/Don't Know

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

33) Any comments?

a. _____

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

Thank you for taking the time to complete this survey! *End*

Appendix E

Content Validity Instrument Experts' Feedback Summary

Experts' comments are bolded and italicized

The eligibility should be spelled out up front so that you can eliminate questions 1, 2 and 4. You need to determine the criteria. Demographics typically are at the end of the survey instead of in the beginning.

Questions need to stand out for those conducting the survey, so the question numbers should not be indented. See Qs 1-3 as an example.

For the other cancer screening questions, it appears that if they have had one of those cancers, the interviewers continue the interview, whereas with oral cancer, they end the survey, why? Why not get the perceptions of those who have had oral cancer and how they value, or not, having a screening, etc.?

Have you reviewed the survey's / focus group interviews conducted by Dr. Alice M. Horowitz? She is the leading expert and it would be good to have her review your instrument.

As a subject expert in oral cancer screenings or other cancer screenings, please review the following items for content validity.

Check one of the following:

5- Not relevant

6- Somewhat relevant

7- Relevant

8- Very relevant

to represent your assessment of the question validity. In addition, please feel free to make comments or recommendations in the space provided. Thank you for your time and contribution!

Introduction to the study

- Script [In Appendix B]

Eligibility

- 4) Do you speak English?
- a. Yes- *proceed*
 - b. No- *ineligible; ask if there is anyone in the home who does. If yes, proceed. If no, end survey*

- 1- Not relevant**
- 2- Somewhat relevant (1 out of 5)**
- 3- Relevant (4 out of 5)**
- 4- Very relevant**

Comments:

Are those conducting the telephone interview not fluent in another language, e.g., Spanish? It would be good to have someone fluent in another language so that you're not limiting the survey to only English speakers.

Should they also understand English?

- 5) Are you 18 years of age or older?
- a. Yes- *proceed*
 - b. No- *ineligible; end survey*

- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant (5 out of 5)
- 4- Very relevant

Comments:

If the person responds they are not 18 years of age, should you inquire if there is someone 18 years old or older living at that address?

- 6) Are you currently residing in Idaho?
 - a. Yes- *proceed*
 - b. No- *ineligible; end survey*

- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant
- 4- Very relevant (5 out of 5)

Comments:

- 27) Have you even been diagnosed with oral cancer?
 - a. Yes- *ineligible; end survey*
 - b. No- *proceed*

- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant

4- Very relevant (5 out of 5)

Comments:

Check typo “ever” been diagnosed.... I wonder if people will identify with the term “oral” cancer – you might want to use lay terminology “mouth” or “mouth or throat” cancer, depending upon whether or not you are planning to include all oropharyngeal cancers or just oral cancers

Demographics

– why is this important to have in the beginning of the survey? Typically, demographics are at the end.

28) What is your date of birth? *Month/Year*

Why not ask how old they are or give an age range

Is there a reason you are asking for the month and not just the year?

Why do you need the month? Should you just ask either the birth year or just ask what is their current age

a. _____

1- Not relevant

2- Somewhat relevant

3- Relevant (5 out of 5)

4- Very relevant

Comments:

I’m sure there is a reason that was discussed with the statistician regarding asking date of birth rather than age, but if this wasn’t discussed, make sure you identify which will give you the most significant information

Not sure why the month is important – I would just ask for the year of birth. Or you could ask “how old are you?”

29) What is your sex?

- a. Male
- b. Female

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant (5 out of 5)**
- 4- Very relevant**

Comments:

Not a specific inclusion or exclusion criteria

34) What is your race or ethnicity? *Indicate all that apply*

- a. White
- b. Hispanic or Latino
- c. Black or African American
- d. Native American or American Indian
- e. Asian / Pacific Islander
- f. Other-*specify*_____
- g. Prefer not to answer

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant (5 out of 5)**

4- Very relevant

Comments:

35) What is the highest level of education you have completed?

- a. Some high school, no diploma
- b. High school graduate, diploma or the equivalent (*for example: GED*)
- c. Some college, no degree
- d. Trade/technical/vocational training
- e. Associate degree
- f. Bachelor's degree
- g. Master's degree
- h. Doctoral degree
- i. Prefer not to answer

1- Not relevant

2- Somewhat relevant

3- Relevant (5 out of 5)

4- Very relevant

Comments:

Oral Cancer

18) Have you ever had an oral (mouth) cancer screening?

- a. Yes
- b. No

c. Unsure/Don't Know

- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant
- 4- Very relevant (5 out of 5)

Comments:

If someone checks "unsure" – will the person conducting the interview describe what this experience is like? Some may not identify the exam as an oral cancer screening when they have actually had one

If the response is NO, or Unsure, have the interviewer describe the OC screening: having you stick out your tongue, wrapping gauze around it, etc.

Did the person doing this, tell you what they were doing and why? Often an OC screening has been performed but the provider hasn't told the patient what he/she is doing or why

11) If so, who performed the oral cancer screening(s)? *Indicate all that apply*

- a. Dentist
- b. Dental Hygienist
- c. Primary care provider (physician, PA, nurse practitioner)
- d. Other- *specify* _____
- e. Unsure/Don't Know

- 1- Not relevant
- 2- Somewhat relevant

3- Relevant (1 out of 5)

4- Very relevant (4 out of 5)

Comments:

Doctor, physician assistant ... depending on their education level, the term doctor might be more familiar.

Of course, many people do not differentiate the dental hygienist from a dental assistant. If someone says, "One of the girls in the dental office" – will your interviewer mark "unsure" – something to think about in terms of how you will train your interviewer

You might want to add a question about where (what environment) they had the oral cancer screening

23) **Do you perceive any risks to having an oral cancer screening?**

a. Yes

i. If you answered yes, what risks do you perceive?

b. No

c. Unsure/Don't Know

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant (5 out of 5)

Comments:

Provide a list of reasons so that the tabulation is more objective. This will allow the interviewer to check off the participant's response. You can always have other and if you see a pattern of common responses, then add them to the list.

Might be challenging for them to come up with "risks". You might want to consider, asking, "do you have any questions about an oral cancer screening?", do you know what an oral cancer screening is? What concerns you about having an oral cancer screening?

26) How beneficial do you perceive oral cancer screening to be?

- a. Very beneficial
- b. Beneficial
- c. Neutral
- d. Not very beneficial
- e. Not beneficial at all

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant (5 out of 5)

Comments:

I am trying to imagine what someone might say to this question. I might rephrase this to use lay language "Is there anything about having an oral cancer screening that bothers (concerns) you?" I assume that you will pilot-test this instrument with some consumers who are representative of your study population after you get this feedback

on validating the instrument. It will likely prove very enlightening in terms of how well they understand the questions.

Might want to reword to, “what are the benefits of having an oral cancer screening?”

30) Do you think that the benefits of screening outweigh the risks?

- a. Yes
- b. No
- c. Unsure/Don't know

1- Not relevant (3 out of 5)

2- Somewhat relevant (1 out of 5)

3- Relevant (1 out of 5)

4- Very relevant

Comments:

This question seems somewhat biased, because OC screenings are such a different procedure than breast, prostate and colon screenings. I don't think benefits outweighing risks of any of these types of cancer will give you additional significant data

I might suggest “helpful” instead of “beneficial”

Similar to question #12. Not sure how much this question adds to data collection. The assumption would be that people will say, yes the benefits outweigh the risks.

32) Do you perceive any barriers to oral cancer screening?

- a. Yes
 - i. If you answered yes, what barriers do you perceive?

- i. _____
- b. No
- c. Unsure/Don't Know

- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant (5 out of 5)
- 4- Very relevant

Comments:

Again, provide a list of reasons so that the tabulation is more objective. This will allow the interviewer to check off the participant's response. You can always have other and if you see a pattern of common responses, then add them to the list.

What types of barriers do you expect they will have? Some participants may need some prompting with an example??

Consider rewording to, "what concerns you about having an oral cancer screening"? or what bothers you about having an oral cancer screening?

I might suggest rephrasing "Do you think that there are any barriers to getting an oral cancer screening?"

33) Any comments?

- a. _____
- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant

4- Very relevant

Comments:

Comments in reference to what???

I would suggest asking for comments at end of survey rather than end of each section to help prevent participant fatigue/disinterest

Breast Cancer Screening Females Only

17) Have you ever had a screening for breast cancer?

a. Yes

i. If so, what type of screening did you have? (Indicate all that apply)

1. Mammogram

2. Clinical breast exam

3. Unsure/Don't know

d. No

e. Unsure/Don't Know

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant (5 out of 5)

Comments:

Does the clinical exam include a self breast exam? You may need to specify.

18) Do you perceive any risks to having a breast cancer screening?

- a. Yes
 - i. If you answered yes, what risks do you perceive?
 - ii. _____
- b. No
- c. Unsure/Don't Know

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant (5 out of 5)**
- 4- Very relevant**

Comments:

19) How beneficial do you perceive breast cancer screening to be?

- a. Very beneficial
- b. Beneficial
- c. Neutral
- d. Not very beneficial
- e. Not beneficial at all

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant (5 out of 5)**
- 4- Very relevant**

Comments:

Could reword: What are the benefits of breast cancer screenings? Question 18 & 19 are very similar and may confuse the respondent.

34) Do you think that the benefits of screening outweigh the risks?

- a. Yes
- b. No
- c. Unsure/Don't know

- 1- Not relevant (3 out of 5)**
- 2- Somewhat relevant (1 out of 5)**
- 3- Relevant (1 out of 5)**
- 4- Very relevant**

Comments:

Same comment as for oral cancer

35) Do you perceive any barriers to breast cancer screening?

- a. Yes
 - i. If you answered yes, what barriers do you perceive?
 - ii. _____
- b. No
- c. Unsure/Don't Know

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant (5 out of 5)**

4- Very relevant

Comments:

Again, what are you looking for here. Financial, psychological, social, maybe provide some examples.

Consider comments from oral cancer

36) Any comments?

a. _____

1- Not relevant (3 out of 5)

2- Somewhat relevant (2 out of 5)

3- Relevant

4- Very relevant

Comments:

Better for all of them at the end

Prostate Cancer Screening Males Only

37) Have you ever had a screening for prostate cancer?

a. Yes

i. If so, what type of screening did you have? (Indicate all that apply)

1. PSA blood test

2. Rectal exam

3. Unsure/Don't know

d. No

e. Unsure/Don't Know

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant (5 out of 5)**
- 4- Very relevant**

Comments:

38) Do you perceive any risks to having a prostate cancer screening?

- a. Yes
 - i. If you answered yes, what risks do you perceive?
 - ii. _____
- b. No
- c. Unsure/Don't Know

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant (5 out of 5)**
- 4- Very relevant**

Comments:

39) How beneficial do you perceive prostate cancer screening to be?

- a. Very beneficial
- b. Beneficial
- c. Neutral
- d. Not very beneficial

e. Not beneficial at all

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant (5 out of 5)**
- 4- Very relevant**

Comments:

40) Do you think that the benefits of prostate cancer screening outweigh the risks?

- a. Yes
- b. No
- c. Unsure/Don't know

- 1- Not relevant (3 out of 5)**
- 2- Somewhat relevant (1 out of 5)**
- 3- Relevant (1 out of 5)**
- 4- Very relevant**

Comments:

41) Do you perceive any barriers to prostate cancer screening?

- a. Yes
 - i. If you answered yes, what barriers do you perceive?
 - ii. _____
- b. No

c. Unsure/Don't Know

- 1- Not relevant
- 2- Somewhat relevant
- 3- Relevant (*5 out of 5*)
- 4- Very relevant

Comments:

42) Any comments?

a. _____

- 1- Not relevant (*1 out of 5*)
- 2- Somewhat relevant
- 3- Relevant
- 4- Very relevant

Comments:

Ask at the end

Colon Cancer Screening *Males and Females*

43) Have you ever had a screening for colon cancer?

a. Yes

i. If so, what type of screening did you have? (Indicate all that apply)

1. Fecal occult blood testing (FOBT)
2. Flexible sigmoidoscopy

3. CT colonography or double-contrast barium enema
4. Colonoscopy
5. Unsure/Don't Know

- d. No
- e. Unsure/Don't Know

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant (5 out of 5)**
- 4- Very relevant**

Comments:

Your interviewer will definitely need training on the above tests to be able to describe them to participants – many people will not know the difference between choices 2,3,4 since most are asleep for #2 and 4

Do you think people will know which specific test or test name that they had?

44) Do you perceive any risks to having a colon cancer screening?

- a. Yes
 - i. If you answered yes, what risks do you perceive?
 - ii. _____

- b. No
- c. Unsure/Don't Know

- 1- Not relevant**

- 2- Somewhat relevant**
- 3- Relevant (5 out of 5)**
- 4- Very relevant**

Comments:

45) How beneficial do you perceive colon cancer screening to be?

- a. Very beneficial
- b. Beneficial
- c. Neutral
- d. Not very beneficial
- e. Not beneficial at all

- 1- Not relevant**
- 2- Somewhat relevant**
- 3- Relevant (5 out of 5)**
- 4- Very relevant**

Comments:

46) Do you think that the benefits of screening outweigh the risks?

- a. Yes
- b. No
- c. Unsure/Don't know

- 1- Not relevant (3 out of 5)**

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

47) Do you perceive any barriers to colon cancer screening?

a. Yes

i. If you answered yes, what barriers do you perceive?

ii. _____

b. No

c. Unsure/Don't Know

1- Not relevant

2- Somewhat relevant

3- Relevant (5 out of 5)

4- Very relevant

Comments:

48) Any comments?

a. _____

1- Not relevant

2- Somewhat relevant

3- Relevant

4- Very relevant

Comments:

There are a lot of questions, which might cause a person to rush answers or just hang up. Is there a way that you could minimize the number of questions by grouping the various cancer screenings under the 6-7 basic questions you are asking for each cancer? Just a thought.

Thank you for taking the time to complete this survey! *End*

Appendix F

Instrument- Interview-Administered Questionnaire- Pilot Test Summary

Introduction to the study

- Script [In Appendix B]

Oral Cancer

1) Have you ever had an oral cancer screening? *Describe- “an oral cancer screening includes an examination of the mouth, head, and neck that is often performed by having you stick out your tongue, looking inside your mouth, and feeling around the tongue, mouth, head, and neck.”*

a. *Yes- Proceed with the following questions*

i. Did the person who performed the exam tell you what they were doing, and why?

1. Yes
2. No
3. Unsure/Don't know

ii. Who performed the oral cancer screening(s)? *Indicate all that apply*

1. Dentist
2. Dental Hygienist (*person who “cleans” the teeth*)
3. Primary health care provider (*doctor, physician's assistant, nurse practitioner*)

4. Other-

*Specify*_____

5. Unsure/Don't Know

- b. No- *Skip to next question*
- c. Unsure/Don't Know

Participant	Test Answer	Retest Answer
C.N.	A, i-3, ii-1, 2	A, i-3, ii-1, 2
A.S.	C	C
S.M.	B	B
T.F.	A, i-1, ii-2	A, i-1, ii-2
J.D.	C	C

- 2) Do any of the following concerns that people might have about getting an oral cancer screening apply to you?
- Fear of finding cancer
 - Fear of having a mouth and throat exam
 - Fear of pain during the exam
 - Other- *Specify* _____
 - None of these concern me

Participant	Test Answer	Retest Answer
C.N.	A	A
A.S.	A	A
S.M.	A, C	A, C
T.F.	A	A
J.D.	A	A

29) How helpful do you perceive oral cancer screening to be?

- a. Very helpful
- b. Helpful
- c. No opinion
- d. Not very helpful
- e. Not helpful at all

Participant	Test Answer	Retest Answer
C.N.	A	A
A.S.	B	B
S.M.	B	B
T.F.	A	A
J.D.	A	A

37) Which of the following do you think are barriers to getting an oral cancer screening?

- a. Cost
- b. Time
- c. Other- *Specify* _____
- d. None of these

Participant	Test Answer	Retest Answer
C.N.	D	D
A.S.	B	B

S.M.	A, C- "Having to go to the dentist"	A, C- "Having to go to the dentist"
T.F.	D	D
J.D.	A, B	A.B

Breast Cancer Screening *Females Only*

38) Have you ever had a screening for breast cancer? *Describe- "this might have included a mammogram or a clinical breast exam."*

- b. Yes
- c. No
- d. Unsure/Don't Know

Participant	Test Answer	Retest Answer
C.N.	B	B
A.S.		
S.M.	C	B
T.F.		
J.D.		

6) Do any of the following concerns that people might have about getting a breast cancer screening apply to you?

- a. Fear of finding cancer
- b. The exam is embarrassing
- c. Fear of pain during the exam
- d. Other- *Specify* _____

- e. None of these concern me

Participant	Test Answer	Retest Answer
C.N.	A, C	A, C
A.S.		
S.M.	A, B, C	A, B, C
T.F.		
J.D.		

- 7) How helpful do you perceive breast cancer screening to be?

- f. Very helpful
g. Helpful
h. No opinion
i. Not very helpful
j. Not helpful at all

Participant	Test Answer	Retest Answer
C.N.	A	A
A.S.		
S.M.	A	A
T.F.		
J.D.		

- 8) Which of the following do you think are barriers to getting a breast cancer screening?

- a. Cost
- b. Time
- c. Other- *Specify* _____
- d. None of these

Participant	Test Answer	Retest Answer
C.N.	C- "I'm afraid it will hurt"	C- "I heard mammograms hurt"
A.S.		
S.M.	A, C- "It's kind of intimidating"	A, C- "It makes me nervous"
T.F.		
J.D.		

Prostate Cancer Screening *Males Only*

15) Have you ever had a screening for prostate cancer? *Describe- "this might have included a blood test or a rectal exam."*

- a. Yes
- f. No
- g. Unsure/Don't Know

Participant	Test Answer	Retest Answer
C.N.		
A.S.	B	B
S.M.		
T.F.	B	B

J.D.	B	B
------	---	---

11) Do any of the following concerns that people might have about getting a prostate cancer screening apply to you?

- a. Fear of finding cancer
- b. The exam is embarrassing
- c. Fear of pain during the exam
- d. Other- *Specify* _____
- e. None of these concern me

Participant	Test Answer	Retest Answer
C.N.		
A.S.	A	A
S.M.		
T.F.	A	A, C
J.D.	A, B	A, B

12) How helpful do you perceive prostate cancer screening to be?

- a. Very helpful
- b. Helpful
- c. No opinion
- d. Not very helpful
- e. Not helpful at all

Participant	Test Answer	Retest Answer

C.N.		
A.S.	A	A
S.M.		
T.F.	A	A
J.D.	B	B

13) Which of the following do you think are barriers to prostate cancer screening?

- a. Cost
- b. Time
- c. Other- *Specify* _____
- d. None of these

Participant	Test Answer	Retest Answer
C.N.		
A.S.	A	A
S.M.		
T.F.	A, C- "I don't want the doctor sticking anything up my you-know-what"	A, C- "I don't want the doctor sticking anything up my butthole"
J.D.	A	A

Colon Cancer Screening *Males and Females*

14) Have you ever had a screening for colon cancer? *Describe- "this might have included an at-home stool test or a colonoscopy."*

- a. Yes

- f. No
- g. Unsure/Don't Know

Participant	Test Answer	Retest Answer
C.N.	B	B
A.S.	B	B
S.M.	B	B
T.F.	B	B
J.D.	B	B

15) Do any of the following concerns that people might have about getting a colon cancer screening apply to you?

- a. Fear of finding cancer
- b. The exam is embarrassing
- c. Fear of pain during the exam
- d. The prep for the exam is unpleasant
- e. Other- *Specify* _____
- f. None of these concern me

Participant	Test Answer	Retest Answer
C.N.	A, D	A, D
A.S.	A, D	A, D
S.M.	A	A
T.F.	A, B, D	A, B, D
J.D.	A	A

16) How helpful do you perceive colon cancer screening to be?

- a. Very helpful
- b. Helpful
- c. No opinion
- d. Not very helpful
- e. Not helpful at all

Participant	Test Answer	Retest Answer
C.N.	B	A
A.S.	A	A
S.M.	A	A
T.F.	B	B
J.D.	B	B

17) Which of the following do you think are barriers to colon cancer screening?

- a. Cost
- b. Time
- c. Other- *Specify*_____
- d. None of these

Participant	Test Answer	Retest Answer
C.N.	A	A
A.S.	A, B	A, B
S.M.	A	A

T.F.	A, C- "Having to do the cleanse before"	A, C- "The cleanse"
J.D.	A	A

18) Do you have any other comments to add about any of the screenings we have discussed?

- a. A.S.- "My dad's life was saved by a screening for prostate cancer so I know I should get one, too" _____

Demographics

47) What is your age?

- a. _____

Participant	Test Answer	Retest Answer
C.N.	46	
A.S.	38	
S.M.	27	
T.F.	43	
J.D.	25	

48) What is your sex?

- a. Male
- b. Female
- c. Transgender
- d. Prefer not to answer

Participant	Test Answer	Retest Answer
C.N.	B	
A.S.	A	
S.M.	B	
T.F.	A	
J.D.	A	

55) What is your race or ethnicity? *Indicate all that apply*

- a. White
- b. Hispanic or Latino
- c. Black or African American
- d. Native American or American Indian
- e. Asian / Pacific Islander
- f. Other-*specify*_____
- g. Prefer not to answer

Participant	Test Answer	Retest Answer
C.N.	A	
A.S.	A	
S.M.	A	
T.F.	A	
J.D.	A	

56) What is the highest level of education you have completed?

- a. Some high school, no diploma
- b. High school graduate, diploma or the equivalent (*for example: GED*)
- c. Some college, no degree
- d. Trade/technical/vocational training
- e. Associate degree
- f. Bachelor's degree
- g. Master's degree
- h. Doctoral degree
- i. Prefer not to answer

Participant	Test Answer	Retest Answer
C.N.	F	
A.S.	F	
S.M.	B	
T.F.	D	
J.D.	A	

Thank you for taking the time to complete this survey! *End*

Appendix G
Bernett Training Manual

See next page



Interviewer Training Manual

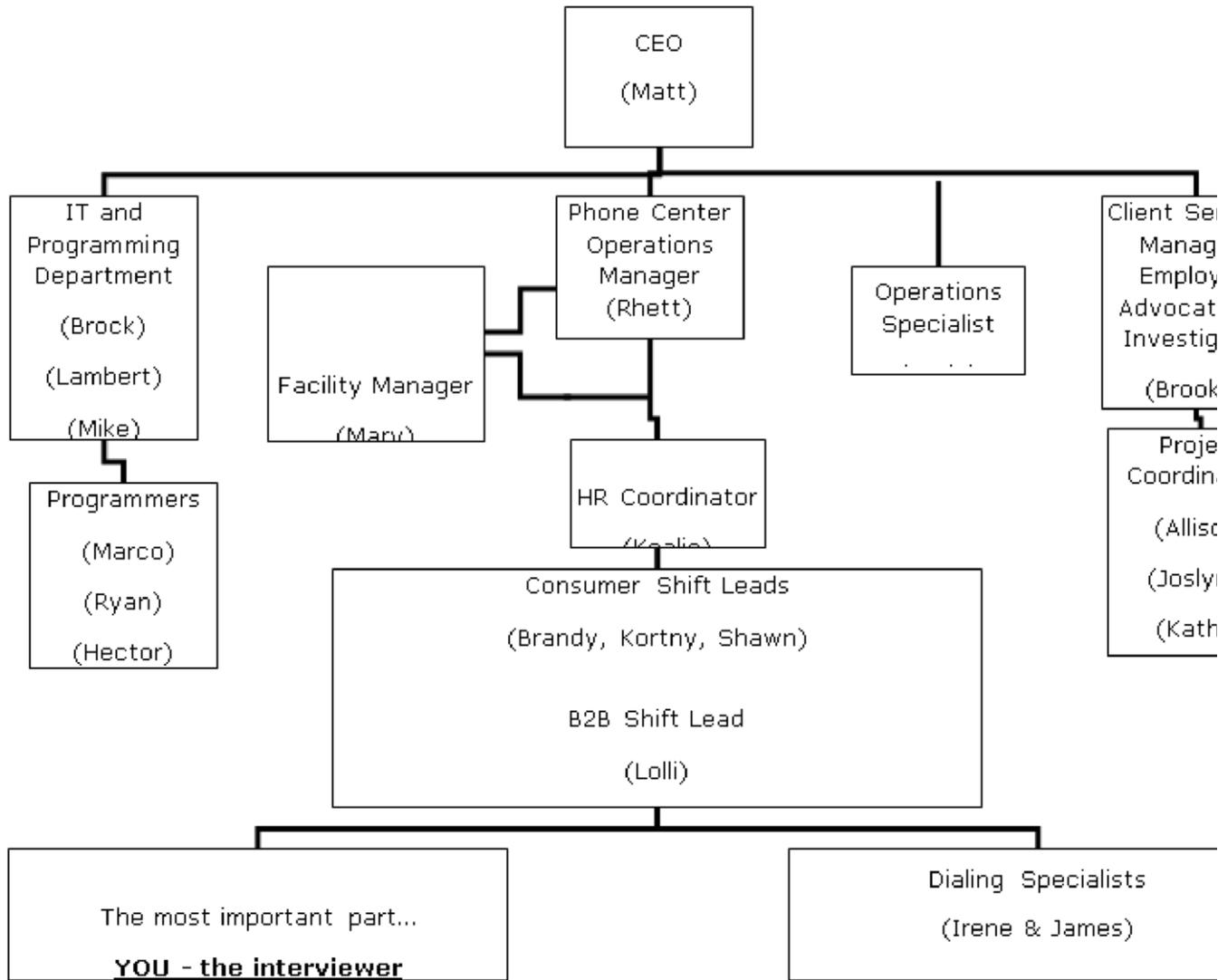


 **Bernett**

Bernett Research

Bernett Research was started in 1972 by Bernyce Hayes. Bernyce worked as an interviewer for Survey & Research before she decided to start her own business with her friend Netta Grollman. Bernyce & Netta combined their names, and came up with a name for their new business - Bernett Research. Bernett's headquarters were located in the basement of the Hayes' family home until the day came when an 18 wheeler showed up to unload test products. At that point, Bernett relocated to more corporate surroundings. Today, Bernyce's son Matt is CEO and works from the Boston office. There are currently two field offices in Idaho, one in Oregon, and one in Utah, in addition to the office in Boston. The Idaho field offices are located in Pocatello and Rexburg, the Oregon office is located in Albany, and the Utah office is located in Orem. In our call centers, we mainly conduct surveys over the telephone. Our most important goal is to collect completely accurate data.

Our office contains the following personnel and areas of responsibility:



Shift Line and Attendance Line!

Shift Line - (208) 232-8925 (listen to message)
Attendance Line - (208) 232-8890 (follow prompts)

The shift line is usually updated Monday–Friday between 2:00pm and 2:30pm for Nightshift employees. Please note when calling the shift line during the week that this line is used for both the dayshift and nightshift employees. Please make sure that the message you are listening to is for the correct shift! For weekend shifts, the shift line is updated on Friday night for Saturday’s shift and on Saturday night for Sunday’s shift. This is typically done by 9:00pm both days. The shift line for Dayshift is usually updated between 6pm and 9pm Sunday through Thursday for the next day’s shift.

The shift line provides information on the day’s shifts. All employees are expected to call the shift line on the days that they work and if they want to come in for extra hours. If you have an attendance related problem, it is not acceptable to leave a message on the shift line.

If you need to contact us regarding your attendance, you should call and leave a message on the attendance line. Be sure to follow the menus (“You are currently an interviewer”; “You need to report an absence” are the prompts you would follow) to report an absence and be sure to **state your name** and **explain the nature** of you attendance issue – we must have a reason to mark why you were absent.

We are also on Facebook! Look for Bennett Research - Pocatello. Our FB page is created to update and inform employees on shift information/changes, hiring, events, and announcements. We encourage our current staff members check it often for info!

Scheduling and Pay Periods

Pay periods start on Saturday and end on Friday, as does scheduling. Schedule requests must be submitted by end of shift Wednesday of the week prior to the schedule being posted. All hours that are accumulated starting on Saturday morning up until the following Friday evening will be paid on the following Friday’s paycheck. Bennett employees are paid every week. Paychecks may be picked up in the office on Fridays after 9am. Any paychecks that are not picked up will be kept in our office for 6 months, and if we still have it at that time, it will be submitted to the state as unclaimed property. **As a reminder, Saturday and Sunday shifts generally start at 10am. Payscale**

New employees are paid \$7.25 per hour (min. wage) for the entire two day training period. After training is complete, interviewers are placed on a variable rate of \$8.00 - \$10.00 per hour based on their individual production compared to the overall average for each project. Pay is based on weekly production since we get paid weekly.

<u>Formula Example</u>	<u>Actual Example</u>
Interviewer’s Completes per Hour	1.50 Comps/Hr
----- x 100%	-----
- x 100%	
= 150%	

Project Completes per Hour

1.0 Comps/Hr

Interviewer %	Hourly Rate
Less than 95%	8.00
95 - 110%	8.25
111 - 120%	8.50
121 - 125%	8.75
126 - 130%	9.00
131 - 135%	9.25
136 - 140%	9.50
141 - 150%	9.75
151% and above	10.00

Productivity Probation

Any interviewer with three consecutive months of overall negative productivity will be placed on productivity probation. During this period, the interviewer must increase his/her overall productivity to an acceptable level or face the possibility of termination of their employment. The two day training period does not count toward productivity.

Breaks and Lunches

Breaks are determined based on how long you have worked during the shift. For every hour you work, you earn 3 ½ minutes of break time. You will also be provided with up to 30 minutes of an unpaid lunch for any shift that you will be **working** 6 hours or more.

The amount of break and lunch time that you have used and other related information is displayed on your computer monitor before you log into a project.

Breaks and lunches may be taken **after working for at least 1 hour**, and no breaks or lunches are allowed for the last 30 minutes of the shift. You are not required to take breaks or lunches, but you cannot go home early if you choose not to take any breaks or have a lunch. You also don't have to take the full time allowed for lunches (30 minutes), but you cannot split it up throughout the day – you can only have 1 lunch punch.

Dress Code

The dress of a person has a direct effect on the professionalism they exhibit when conducting an interview. The following dress code is enforced:

- Good personal hygiene must be maintained at all times.
- Dress appropriately so as not to distract from the professionalism of the office or the concentration of your co-workers.
- No see-through or revealing clothing.
- No clothing, hats or pins with any kind of drug and/or alcohol reference or profanity. If it will offend someone else, please do not wear it to work.
- Shoes must be worn at all times.

Personal Calls

As an interviewer, you are unable to receive personal calls while at work. Supervisors will not relay messages for you. This excludes any emergency situations.

Cell Phones & Electronic Devices

If you bring your cell phone or electronic device to work, turn it off or turn it on silent before you walk in the door. **These should not be visible while dialing.** You are not allowed to use/check your phone or device while on the dialing floor. If your cell phone or device goes off while you are at work, or if you are using/checking it while on the dialing floor, it can be met with disciplinary action up to and including termination.

Smoking

Smoking is allowed outside in smoke shack/carport area in the parking lot. Please use the ashtray that is provided to discard your cigarette butts.

Other Rules

While you are at your station:

- It is not allowable to:

- Eat anything or chew gum (even if a supervisor gives it to you)
 - Remove your shoes and/or put soles of shoes on a chair, your cubicle, etc.
 - Play with cards or do any other game/activity not approved by a manager
 - Read or do homework - this includes magazines and newspapers
 - Talk to anyone behind or across the aisle from you (anyone but your immediate neighbor)
 - Use computers for anything but work (no Internet/games)
- It is allowable to:
 - Talk quietly to your neighbors on either side of you
 - Have a beverage at your desk
 - Doodle/draw, color, do word searches or crossword puzzles
 - Read materials passed out by supervisors or approved by a manager

Office Property

Destruction of office property is absolutely unacceptable. All the materials that we provide you with are designed to make your job easier, and by destroying them, you are eliminating their usefulness not only for yourself but for your co-workers as well. Destruction of office property will be met with disciplinary action. This includes writing on folders, desks, etc.

Vocabulary

SURVEY RESEARCH: The process of linking the consumer, customer, and public to a client or marketer, through gathered marketing opportunities and problems, as well as to generate, refine, and evaluate marketing actions, monitor marketing performance, and improve the understanding of the marketing process.

CLIENT: The company, organization, or person who hires Burnett Research to conduct a research project.

RESPONDENT: Any individual who answers the phone, whether or not they are willing to complete the survey with you, the interviewer.

QUESTIONNAIRE: The series of questions asked of the respondent. These questions may include instructions to the interviewer to inform him or her how to conduct the study.

CONFIDENTIALITY: The ethical and/or legal principal that all information will be kept private, unless otherwise instructed. This refers to both respondent and client confidentiality.

BRIEFING: Project briefing takes place before dialing on a specific project. During a briefing, a supervisor walks you through the survey and gives you any additional information that you will need to know for the specific project. You will ALWAYS be briefed on a project before dialing on it. It is encouraged that you take notes to help you remember important project information.

VERBATIM: Verbatim means asking the questions in the survey exactly as written, or word-for word without dropping off or adding words.

BIAS: Anything that may influence the respondent's opinion, whether it is the way a question is worded, the way an interviewer asks the question, etc.

RAPPORT: A relationship that makes communication easy. In survey research it would refer to making the respondent feel at ease and comfortable without biasing their opinions.

SCREENING QUESTIONS: The questions that determine which respondents are eligible for a particular study, based upon criteria set by the client. Screening questions are usually at the beginning of the questionnaire and are also called qualifying questions.

QUALIFIED RESPONDENT: A consumer who has qualified for the survey, based upon their responses to the screening questions.

QUOTA: The number of qualified interviews to be completed.

SKIP PATTERN: Skip patterns involve the process of skipping particular questions depending upon how the respondent answers previous questions.

NOTATIONS: Notations are instructions for the interviewer on how to conduct the interview. These include, but are not limited to, when to probe, when and/or how to clarify, when to read lists etc.

CLOSE-ENDED QUESTION: A question where the respondent must pick a response from a list of acceptable responses, such as excellent, very good, good, fair, poor or a yes or no.

OPEN-ENDED QUESTION: A question that allows respondents to express opinions in their own words. It is an opportunity for the respondent to give a fuller, detailed response rather than choosing an option from a predetermined list.

OTHER SPECIFY: An option on the list that allows us to specify the answer given, if it does NOT already fit on the list, rather than forcing a response from the list.

PROBING: Asking for additional answers or information by using such questions as "What else?" or "What others?" until the respondent can give no more new information.

CLARIFYING: The technique of asking a respondent to explain in more detail an answer he or she has just given by asking questions like, "In what way?" "How do they do that?", "Why do you feel that way?", "Tell me more about...", and "What do you mean by..."

DEMOGRAPHICS/STATISTICAL: Demographic and statistical questions pertain to vital statistics such as age, income, gender, education, and personal characteristics of the respondent. Demographics refer to the basic characteristics of a group of respondents. These questions are usually at the very end of the survey.

PRESCREENING: Often, there are quotas that fill much slower than other quotas. As a result, these hard-to-fill quotas are often the last quotas open, and the production rate is negatively affected. To counteract this, interviewers are instructed to request to speak with a person who falls into a specific demographic.

SAMPLE: In the telephone center the phone numbers that you dial are referred to as the sample.

Types of Sample:

- **RDD** – RDD stands for Random Digit Dialing. This type of sample is randomly generated. Usually there is a known or set prefix and/or area code, and the last four digits are randomly generated. This type of sample is the most commonly used type of sample because it is the least expensive.

However, because the sample is randomly generated, there will be many businesses and disconnected numbers.

- **Targeted** – Targeted sample is sample that is geared towards specific criteria. Sample can be targeted for just about any demographic. For example – income, ethnicity, age, county, etc.
- **Customer List** – A customer list is exactly what it sounds like. This type of sample will include a name of someone to ask for and speak with. Customer lists are usually provided by the client.

DISPOSITION: The outcome of each telephone call. (No answer, answering machine, disconnected number, busy, initial refusal, etc.)

MONITOR: Monitoring is when a Supervisor taps into an Interviewer's telephone line in order to listen to the survey being conducted and is able to view the Interviewer's computer screen. Monitoring is done for quality control purposes. Monitoring is one means of validating or giving assurance that the data is collected from qualified respondents who are interviewed under prescribed conditions. We also use monitoring to extend an interviewer's training by giving feedback on the interviewer's performance.

VALIDATION: Validating is when a supervisor calls back a respondent who has completed a survey to ensure the accuracy of the survey by verifying a few of their responses from the survey.

QUALITIES NEEDED BY ALL BERNETT INTERVIEWERS

1. INTEGRITY

Integrity is defined as a steadfast adherence to a code, be it moral or ethical. As an interviewer, there are detailed rules that need to be followed all of the time. Supervisors monitor and validate to ensure that surveys are being conducted properly, but it is not possible to have a supervisor listen to every call, or call every respondent back. For this reason it is extremely important that each interviewer has the integrity to work independently.

2. ORGANIZED WORK HABITS

An interviewer must be able to pay strong attention to detail and follow a prepared set of instructions. Before ever working on a project you will be briefed on that questionnaire. Your supervisor will explain how the survey is to be conducted. The instructions

they give are important in ensuring that quality is used in conducting each survey and need to be followed.

Completing work accurately the first time will save you from having to call a respondent back a second time to fix a mistake. Being able to adhere to guidelines, directions, and being able to pay strong attention to detail are very important to the quality of the data we collect.

3. POSITIVE ATTITUDE

Due to the nature of this job it is very important to maintain a positive attitude. The success of each interview depends considerably on your ability to create a friendly, non-threatening, positive and neutral atmosphere. A bad attitude can be picked up on by respondents. This may make them feel that you don't see your job as important - so they do not see it as important. This will eventually show in the amount of surveys you conduct. There are often times when you may need to work on a project you don't like, or it may be difficult to find a qualified respondent. This must be taken in stride and with a good attitude. Remember that you will be spending extended periods of time on the telephone gathering very important information. Not every study will be easy or fun to work on. Sometimes it is difficult to get someone to speak with you. Always keep in mind that the job we do is an important one, and the opinions we gather are vital.

4. FLEXIBLE AND ADAPTABLE

We have a number of clients that ask us to collect various kinds of data, which means we conduct a lot of surveys. Some surveys we conduct will be short and others will be long. Some will require a lot of reading and we may have to ask some uncomfortable personal questions. We also speak with a variety of respondents, some are polite, some are rude, and some like to talk a lot. Each one has an important opinion that we need to gather. We must adapt to whatever questionnaire we work on and we must be able to adapt to the respondents that we talk with. Every survey that we conduct will be different, and every respondent will put different demands on our skills as interviewers. We must be able to adapt to these demands.

5. COMMUNICATIONS SKILLS

The job we do relies heavily on our communication skills. We need to be able to listen to a respondent and be able to gather their opinion and convey the importance of that opinion. By listening to the respondent we can make sure that they understand the questions that we are asking and that they are answering them

thoughtfully and honestly. Building rapport with a respondent early in the questionnaire is very important. This can be done simply by the way you read the questionnaire. We don't need to become overly friendly since this may allow the respondent to take charge. Personal conversation is not needed to establish rapport; it only adds time to the survey and may bias opinions. A tone that is conversational and set at an understanding pace is all that is needed. This requires an understanding of the questionnaire and the respondent so that you can adapt to whatever needs this respondent requires. Some respondents are in a hurry and are comfortable with a quicker reading pace. If you read too slowly to these respondents they may get bored or grow impatient and hang up on you. Yet other respondents have the time and may need some extra attention to get through the questionnaire. Good communication skills are needed to assess each respondent's needs and then adapt to them. We must also be able to listen and record each important opinion.

6. ACCEPTING REJECTION

No matter how important the questions are, or how polite and professional you are, not every person you speak to is going to want to participate in a survey. This is to be expected and taken in stride. Some respondents may even refuse to finish a questionnaire with you once you have started. A reasonable amount of refusals and terminations are to be expected. Sometimes simply explaining that we aren't selling anything, or that the questions will only take a few minutes is all that is needed to secure a respondent. If that doesn't work, simply accept their choice gracefully and thank them for their time and proceed to the next call. If you are getting an unusually high number of these kinds of calls, there may be a problem with the communication skills you just read about and extra training may be required. It is important to remember at all times that you represent Bennett Research and the survey research industry and no matter how rude a respondent may be, we must always remain professional and polite.

7. CONFIDENCE AND ASSERTIVENESS

If you sound confident over the telephone, it adds credibility to what you are doing and more people feel comfortable completing a survey with you. If you are unsure of yourself, the respondent may also be unsure about giving their personal information. If a respondent wanders, keeping them on the right track and controlling their responses will require some amount of assertiveness. Always be polite, but as soon as possible get back to the questionnaire. Since not everyone you talk to is going to want to give their opinion, some degree of assertiveness will also

be needed to convince a respondent that we need their opinion and value their time. Being confident and assertive in the work we do can only help us in this job. Respondents can sense how we feel about our work and if we are unsure, they may also be unsure about giving their opinions.

8. CLIENT CONFIDENTIALITY

Due to the nature of our work, we are not allowed to discuss a project's subject matter with anyone not directly involved in the study. This means that family and friends should not be told specifically about surveys you work on. Questionnaires and fly sheets cannot be removed from the premises. In the event that you are told who the client is you are not allowed to disclose this information to anyone, including a respondent, unless a supervisor in the project briefing tells you.

9. PROFESSIONAL BEHAVIOR

It is very important that we leave respondents knowing that their opinions are very important. We can do this by conducting ourselves like professionals concerned about the job we are doing. Many people who refuse to participate in survey research studies do so because of a previous bad experience with this type of phone call. Survey research is a rare moment where a respondent can give his or her honest opinion and know that someone will hear that opinion. It is very important for us to convey that to each respondent, by the way we speak and respond to their answers. The way that we conduct ourselves affects every aspect of the work we do. People are more willing to speak to someone who has approached them in the most professional and polite manner and sound genuinely concerned about their opinion.

5 PARTS OF A SURVEY

1. **Introduction** – contains 3 parts; who you are, where you are calling from and what you are calling about. (Does not always have to be read verbatim.)
2. **Screening/Qualification Questions** – these questions are asked to find respondents that are qualified to take the survey. (i.e. age, product or service used, etc.)
3. **Body** – the actual questions in the survey.

4. **Demographics/Classification Questions** – questions asked to determine which category will include their answers.
5. **Closing** – ending of the survey, includes a brief but sincere thanks of appreciation. (Does not always have to be read verbatim.)

Not every person you speak with is knowledgeable enough about the topic of the questionnaire to give a valid opinion. Some people may already be biased by reason of special interest or experience. Qualifications may vary depending on the nature of the study, but they may include a specific gender, only registered voters, or certain purchasing habits. If we are going to the expense to gather opinions, then we want to gather them from the people who are most knowledgeable about the issue or product that we are researching, and are most qualified to speak for the target population.

Introductions

The most important thing to remember about introductions is that you have about 30 seconds (and sometimes less time than that) to convince a respondent to go through a survey with you. There are certain things that you can do to increase your chances in this area that will in turn increase your productivity and your pay.

Helpful Info:

1. Use your first and last name. It sounds professional, our clients require it, and it reassures the respondent that what you are doing is legitimate.
2. Speak at an appropriate pace and clearly. The tone and speed of your voice seriously contribute to your credibility. Respondents need to be able to understand you to participate.
3. Do not anticipate rejection. Treat everyone that you speak to as a potential complete and you will find that you will get completes.
4. If someone asks you about the length of the interview, let the respondent know that it does vary based upon his or her responses, but that you will go as quickly as possible. You can give them a realistic estimate if needed, but avoid doing so unless they persist (especially with lengthy surveys).
5. After reading your introduction, jump right into the first question rather than asking the respondent if they would like to participate. You do not want to give the respondent a point

where they can very easily refuse, don't give them the option to say no.

6. **You can only give the respondent information that is in the introduction unless otherwise instructed in briefing.** A typical question that may surface if the intro is vague is "What is the survey about?" If this should happen, repeat the information in your introduction. If the intro is too vague and doesn't give anything specific, you can say something such as "I am not allowed to elaborate any further, as that may bias your response, but the topic of the survey will become apparent in the first few questions." NEVER give out client info (like who we're doing the survey for, etc.) unless told in briefing that you can.

Some Examples of Introductions:

1. Hello. My name is _____, from Bennett Research. We are talking to people today about their preferences and attitudes and your household has been randomly selected to be in this study. This is not a sales call, and your answers will be kept in strict confidence.
2. Hello. This is _____, from Hillside Research, a public opinion polling firm in Austin, Texas. We are calling people in your part of Texas tonight seeking the opinions of registered voters about important issues facing the nation, the state and its communities... (Do Not Pause)
 - a. Are you registered to vote at the address where I've reached you?
3. Hello. I'm _____, from Goldberger Consultants, a national research firm. We're talking with people in your area today and would like to ask you a few questions on a confidential basis...
4. Hello. My name is _____ with Copernicus Research, a national research firm. We are conducting a brief study on the schools in your area. Your household has been randomly selected to be in our study.
5. Hello. I'm _____ of Decima Research, a national research firm. We are talking with people all around that nation today, and would like to ask you a few questions on

a confidential basis. I am not selling anything, nor will I ask you for a donation...

6. Hello. My name is _____. I'm working for radio stations in the South Carolina area. These radio stations would like the opinions of people in your area about their programming so they can better serve their listeners. By taking part in our survey, your opinions will have a direct impact on what you hear on the radio...

7. Hello. I'm _____ from Walker Research. We are conducting a survey about beverages, and I would like to include your opinion or those of someone in your household...

Dispositions

Dispositions are codes we assign to each phone number after finishing a call. The code tells the computer if the number should be called back or not and when we should call it again. It is imperative that we disposition numbers in an accurate and timely manner. If we disposition inaccurately, it could cause us to call back people who said they did not want to do the survey or it could cause us to "lose" the number of a respondent who said that they wanted to do the survey. The following is a brief listing of the dispositions.

No answer - We only let the phone ring 4 times. If no one answers, we then hang up and mark No Answer. Calls dispositioned as No Answer generally will be called back in about 2 hours.

Answering machine - We immediately use this punch when we have determined that our call has been picked up by a residential answering machine. When a number is dispositioned as "Answering Machine" it will generally be dialed again in about 2 hours.

- We generally do not listen to and/or leave messages unless instructed to do so in the project briefing.
- When dialing on a consumer job, if the answering machine is clearly for a commercial business, (e.g. it is for a nationally known chain, you get a phone tree, etc.) we

would then code this as a business. If the answering machine is possibly for a residential business, we would code this as answering machine with the intention of reaching a household resident later.

- On business jobs, it is okay to listen to part of a person's voicemail in order to try and get the name of the person we need to speak with. We should include the person's name in the callback notes so the next interviewer will know who to ask for.

Busy – We generally do not get busy signals because the dialer will automatically disposition this type of call. However, on the rare occasion that we do encounter a busy signal, we should code it as such. Numbers that have been dispositioned as Busy will generally be dialed again in about 20 minutes.

Disconnected Phone – When we hear a message that says “The number you have dialed has been disconnected,” “is no longer in service,” “is not a working number,” etc. we disposition as Disconnected Phone. Numbers dispositioned as Disconnected Phone will usually not be dialed again.

Business/Government Phone (exclusive to consumer jobs) – If we dial a number and it sounds like we have reached a business, then we should ask the respondent “Is this a business or a residence?” If they say it is a business, we should tell them, “I am sorry, I have the wrong number,” hang up the phone, and disposition Business/Government Phone. Calls that have been marked as Business/Government Phone will not be dialed again.

- If the number is ‘both’ a business and a residence we can conduct the survey if the respondent is willing.

Residential Phone (exclusive to B2B jobs) – We use this disposition on B2B jobs if we dial a residence that is not also a business. Calls that are dispositioned as Residential will not be dialed again.

- If the number is ‘both’ a business and a residence we can conduct the survey if the respondent is willing.

Respondent Not Available – If a respondent is not currently available to do a survey (e.g. respondent is not home, respondent says “I am busy right now” or “I am on my way out the door,” etc.) and you are not able to get a specific day and/or

time to call back or the respondent hangs up during or immediately after the intro without saying anything, we would code this as Respondent Not Available. The key here is that the respondent has made no indication that they are not willing to do the survey either now or later. We will be able to dial this number again in about 2 hours.

- If we are not offered a time to call back, we should ask for one so that we do not continue to call a number when it is inconvenient for the respondent. This also gives a respondent who may not be willing to participate now or in the future an opportunity to refuse so that we do not waste time calling them again. If we are successful in obtaining a call back time we should disposition the number as either a soft or hard appointment.

Soft Initial Refusal – If at any point while we are reading our introduction the respondent indicates they are unwilling to participate in the survey, we code this as Soft Initial Refusal. Before coding a Soft Initial Refusal, we must use a refusal rebuttal as a second attempt to try and get them to participate. Examples of a refusal rebuttal would be “We really value your opinions” or “We would really appreciate your time.” If the respondent has refused, but we are unable to use a refusal rebuttal because the respondent hangs up too quickly, they hang up after the refusal rebuttal, or they are still not interested, we should still code this as Soft Initial Refusal. Calls dispositioned as Soft Initial Refusal are generally not called back.

- If a respondent claims that they have already taken part in the survey and we verify with the respondent that they were recently asked the *same* questions to what is asked in the survey, we also code this as Soft Initial Refusal. Usually though they have completed a *similar* survey with another company, and it wasn't us. In most cases we should try to get them to participate even if they think it's similar to one they've recently done. You can also give these records to a sup to check for duplicate #s.
- If we call someone on his or her cell phone and they indicate that this is an unacceptable line for them to complete a survey on, we should code Soft Initial Refusal.
- If we receive a message that indicates that this household does not accept calls from telephone surveyors or solicitors (or otherwise indicates that the household does

not do surveys) and there is not a disposition for Privacy Manager, we should code this as Soft Initial Refusal. If the privacy manager only says that they do not accept calls from telemarketers, we should try to get through by following the instructions on the message.

- If a respondent says that they are on a Do Not Call List (but they do not request to be added to our Do Not Call List) and they hang up before we have a chance to explain that the Do Not Call List does not apply to us - and they are upset, then we would code this as Soft Initial Refusal. Otherwise we should try to call them back to do the survey.

Hard Initial Refusal – We use Hard Initial Refusal when a respondent refuses to participate at any point in the introduction (like with Soft Initial Refusal), but the person is upset or threatening recourse (e.g. respondent is yelling, respondent threatens to sue, etc). Calls that are dispositioned as Hard Initial Refusal are never called back.

- If we call a number and the qualified respondent is deceased, and there is neither a Deceased nor a Wrong Number option, we should code this as a Hard Initial Refusal.

Computer Tone – When the dialer connects us to a number, and we hear a high pitched tone (it sounds kind of like the beep at the end of an answering machine) we should disposition this type of call as a Computer Tone. Often, our screen will also indicate that the number is a fax or modem. Calls dispositioned as Computer Tone will not be called again. **Language Problems**

– If a respondent answers the phone in a foreign language we should ask them “Do you speak English?” If they say “no” ask if there is anyone in their household that does speak English. If they say “no” then we should politely thank them for their time and hang up, marking the call as Language Problems. If they say “yes” ask if that person is available, and if they are not, we should schedule a callback for a time when they will be available. Calls dispositioned as Language Problems are not usually called back.

- We cannot do surveys with someone who is hearing impaired and using a TTY phone that is translated through a third party (operator).

- We cannot conduct the survey with a person in a language other than English, even if we know the language (unless specifically briefed to do so).
- If we cannot hear a respondent after we have asked them to speak up or if they are hard of hearing, then we can disposition the call as Language Problems if it's not a problem with the phone on either end (or Communication Difficulty if it is available).

Hard Appointment – We should set a Hard Appointment any time that we are given a specific day and time to call the Name On List or qualified respondent. We do not have to get the day and time to call back from the Name On List or qualified respondent. We can accept a specific day and time from any person at the number dialed. When setting a Hard Appointment, we should ask for the respondent's name (if we do not already have it) and type it in the callback notes. Hard Appointments are called back at the specified time requested.

- We would also set a Hard Appointment if we were given a specific day and a time range to call the Name On List or qualified respondent. If we are given a time range, we should set the appointment for the first time in the time range. For example, if we are given the time range of 5:00pm to 7:00pm, then we would set the appointment for 5:00pm.
- We would also set a Hard Appointment if we are told to call back after a certain time. For example, if we are told to call after 5:00pm, then we would set the appointment for 5:00pm.
- If we are told to call back in 2 hours, we would set a Hard Appointment for 2 hours.
- We can also use Hard Appointment after a respondent has already started answering questions. While in the survey, we would type "stop" to get to the appointment screen. If open ends have been asked, we need to record the respondent's name and phone number before typing stop, fill out the answers on the open end sheet and fill out the callback date and time, then give this to a supervisor so that it is available for when we call back.

Soft Appointment – We use Soft Appointment when we are given a specific day to call back but not a specific time. Soft Appointments are called back as scheduled.

- If the Name On List or qualified respondent is out of town or otherwise unavailable for a certain period of time we should attempt to schedule a Soft Appointment for when he/she will be available regardless of whether or not the survey will still be in the field at that time. If the qualified respondent is not going to be available for a couple of months, etc. we still must schedule a Soft Appointment.
- We should schedule a Soft Appointment when we are given a nonspecific time range to call back (e.g. "try back in a couple hours", "give me a call in a few days", etc.)
- We should schedule a Soft Appointment if we are not given a specific day to call back, but we are told that the Name On List or qualified respondent will not be available on a certain day.
- Phone messages like "The following number is *temporarily* disconnected," "is being checked for trouble," etc. we code as a soft appointment for two days, as those numbers may be back in service shortly.

Change Name (usually only on NOL jobs) - We use the disposition Change Name if the person we need to speak with is not the Name On List (and the survey is not Name On List Only).

Change Number (usually only on NOL jobs) - We disposition a number as Change Number if it is necessary to reach the Name On List at a different number than what we have in our records. This disposition will require us to enter a new 10 digit phone number and a soft appointment time. Sample coded as Change Number will be called back at the set appointment time.

Wrong Number (usually only on NOL jobs) - We disposition a number as Wrong Number on Name On List surveys when the person who answers tells us we have a wrong number or indicates that the Name On List cannot be reached at the number we have dialed, but does not offer an alternate phone number. Sample coded as Wrong Number will not be dialed again.

- If we call a number and the qualified respondent is deceased, and there is not a Deceased option we should code this as Wrong Number.

IR Gate Keeper (exclusive to B2B jobs) - We disposition a number as IR Gate Keeper on business jobs when a gate keeper (i.e. secretary) refuses for someone else. The refusal may occur

at any time in the introduction (similar to Soft/Hard Initial Refusal). Numbers that are dispositioned as IR Gate Keeper are usually not dialed again.

- We would never use the dispositions Soft Initial Refusal or Hard Initial Refusal if we are speaking with a gate keeper, even if they are very upset. Anytime that we have a gate keeper refuse for someone else, we should code IR Gate Keeper.

IR Company Policy (exclusive to B2B jobs) – We disposition a number as IR Company Policy when a respondent refuses to do a survey because their company does not allow them to participate in our surveys. The refusal may occur at anytime in the intro (similar to Soft/Hard Initial Refusal). Numbers dispositioned as IR Company Policy are usually not dialed again.

Out of Business (exclusive to B2B jobs) – We disposition a number as Out of Business if the business that we are calling is no longer operating or has been shut down. Numbers that are dispositioned as Out of Business are not dialed again.

No Longer Employed (exclusive to NOL B2B jobs) – We disposition a number as No Longer Employed when a Name On List no longer works for the company we are calling. Numbers that are dispositioned as No Longer Employed will not be called again.

- We cannot take an alternate number for a NOL that is no longer employed. We should just disposition this as No Longer Employed.

Referred to Another Location (exclusive to B2B jobs) – We disposition a number as Referred to Another Location when a respondent from a business indicates that we need to speak to someone in a different office than the one we are calling. Numbers that are dispositioned as Referred to Another Location are generally not dialed again.

Add to Do Not Call List – This option is used if a respondent requests to be added to our Do Not Call list. The key to this disposition is that they mention something on which we would store numbers (e.g. list, computer, database, etc.) and that they

give a command or make a request (i.e., “Please remove me from your database” or “Put me on your do not call list”). We must never offer to put someone on our do not call list nor use this option unless specifically requested. A person can request to be put on the list at any time. It is also not necessary for the person requesting to be put on the list to be a qualified respondent for the survey – anyone we speak with can make the request. Calls that are dispositioned as Add to Do Not Call List are not dialed again.

- If someone only states that they are on a Do Not Call List but doesn’t make a request or command to be added/removed from ours, we should politely let them know that those lists do not apply to Market Research companies like us and try to get them to participate in the survey. If they do not want to participate then this would be coded as a Soft Initial Refusal.
- If a person completes a survey, then asks to be added to our Do Not Call List, write down the phone number and give it to a supervisor.

Any of the above outlined dispositions may be altered as exceptions on a per project basis. These situations will be explained by a supervisor in the project briefing.



Tips for Increasing Productivity

- ❖ Get through surveys as quickly as possible. Your speed will vary depending on the respondent, but go as quickly as they can handle.
- ❖ Shorten your introductions if they don’t have to be read verbatim. Get out your main points, but don’t read any unnecessary information.
- ❖ DIAL CONSISTENTLY. You should never even be able to see your y/n screen and should disposition calls and set appointments quickly.

- ❖ Ask a supervisor for your rate compared to the overall rate on the project – you always want your rate to be ABOVE the overall rate.
- ❖ Be able to answer respondents' questions accurately so that they take you seriously. They will be more likely to take the survey. Confidence, assertiveness, and tone are also very important, and respondents will be more likely to do the survey if you know what you're doing and if you sound cheerful about it.
- ❖ It is a good idea if a respondent seems irritated or upset to tell them that you appreciate their time, and that they're almost done with the survey (when you're getting near the end). This can help avoid a break off if the respondent seems like they want to go.
- ❖ Don't ask the respondent if they're willing to participate or if now's a good time to do the survey – just jump right into it.
- ❖ Smile and Dial! If you have a positive attitude overall and don't complain about the projects that you are on, etc. you will be more likely to get more completes.

Collecting Accurate Information

At Bennett Research, our number one goal is to collect 100% accurate data. To ensure that accurate data is being collected, there are a few different things that Supervisors do to check an interviewer's work.

- ❖ Validating – validating involves calling back respondents who have completed a survey to verify

their responses and to verify that the interviewer that they spoke with was polite and courteous.

- ❖ Monitoring – One of the best ways that a supervisor can give an interviewer feedback is by monitoring them. When a supervisor is monitoring an interviewer, the supervisor is not only listening to the conversation, but also viewing the interviewer's screen. Supervisors monitor 10% - 15% of the surveys that are completed, depending on the project. Keep in mind that monitor evaluations are designed to help you improve, so don't be afraid to ask questions. While a supervisor is monitoring an interviewer, the supervisor fills out a Monitor Evaluation Form.
 - The Monitor Evaluation form is broken down into the following main categories:
 - Introduction and Work Habits
 - Verbatim and Accuracy
 - Control and Rapport
 - Objectivity

Falsification and Skipping Questions

Falsification and skipping questions are very serious offenses that will result in severe disciplinary consequences, up to and including immediate termination. Remember that **every** question in a survey has to be asked and answered. When you ask a question you must get a valid response before moving onto the next question. It is never acceptable to skip a question or a series of questions, even if the respondent tells you to do so, put in a random response that the respondent did not give you, etc. in order to move forward with the survey and/or get a complete.

Disciplines on Monitor Evaluations

If you receive a discipline on a monitor evaluation, it will result in 50 points being taken off of your total score.

Monitor Evaluation Form

Total Score

- Intros Only
- Not Qualified/Break Off
- Completed Survey
- Warning

Interviewer: _____

Interviewer ID#: _____

Date: _____

Project: _____

Introductions and Work Habits

Scale: 4 - Outstanding 3 - Doing Well 2 - Needs Improvement 1 - Unacceptable

- Conversational/Enthusiastic Tone
- Dispositions Accurately/Quickly
- Answers Questions Appropriately
- Dials Consistently/Stays
- Uses Refusal Rebuttals
- Exhausts HH/Follows I

Engaged/Attentive

Verbatim and Accuracy

- Reads Verbatim/Does Not
 - Enters Answers/Notes
 - Follows
 - Pre-Code Uses Correct
 - Correctly Only Accepts Listed
 - Notations/Instruction
 - Pronunciation
 - Answers/
 - Probes/Clarifies as Needed/ Answers
- Questions Appropriately

Control and Rapport

- Reads w/o Stumbling and Fillers
- Repeats Text as Necessary
- Keeps the Focus
- on the Sur Stays Engaged/Attentive
- Uses Clear/Appropriate Pace, Tone, Avoids Break-Offs
- and Language

Objectivity

- Does Not Comment on Survey
- Does Not Suggest Responses
- Does Not Interpret

Goals for Next Monitor:

Comments/Suggestions:

98

Interviewer Signature: Supervisor Signature:

Introduction and Work Habits

Conversational/Enthusiastic Tone – We want to sound warm, conversational, and enthusiastic when speaking to a respondent, as it will help establish rapport. We should avoid sounding short, tired, bored, etc., even if a respondent is wearing on our patience or if we're having a bad day.

Dials Consistently/Stays Engaged/Attentive – Increasing our call volume is what makes us take more calls, and it allows us to talk to more people and be more productive. We should always move on to the next interview swiftly (within 3 seconds) to reduce lag time between calls. We must actively try to engage respondents. Because of the nature of the automatic dialer, it is possible that when we are waiting for a call we will be connected to a respondent at any time. For this reason, it is essential that we stay focused and prepare ourselves for all calls and always remain engaged and attentive.

Dispositions Accurately/Quickly – It is imperative that we disposition calls in an accurate manner. This will ensure that we call back sample that can be called back and also ensure that we will not call back numbers that do not need to be called back. Calls should be dispositioned in a timely manner and appointments should be set as quickly as possible. After having our open ends checked, we should type them in quickly so that we can move on to the next interview.

Uses Refusal Rebuttals – A refusal rebuttal is a second attempt to complete a survey when the respondent has refused to participate. Any time a respondent initially refuses to participate in a survey, we should make a second attempt to get them to do the survey, and should also alleviate any doubts the respondent may have about the surveying process. For example, we can reassure the respondent that we are not selling anything, that their opinions are important, that the survey is completely confidential, or that we will complete the survey as quickly as possible. If we are unable to make a rebuttal attempt, however, it is okay to code the number as an initial refusal since they have already refused to participate. If the respondent refuses a second time after we give a rebuttal, we should try to exhaust the household to see if someone else would be willing to participate, but should code the call as an initial refusal if no one else is willing.

Answers Questions Appropriately – We must field any questions that a respondent may have and answer them appropriately. When we are unsure of an answer, a supervisor can assist us.

Exhausts HH/Follows Instructions – When a respondent disqualifies it is possible that someone else in the household may qualify for the survey. In that case we always want to make an effort to ask for another individual that may be willing to participate in our survey. Remember to go back to the intro screen when speaking with a new respondent so that they know who we are and why we are calling. If the respondent refuses after we give a refusal rebuttal, we should try to exhaust the household to see if someone else would be willing to participate. This will help ensure that sample is being used to its fullest extent. This will not apply to some surveys (e.g. name-on-list only surveys). Following instructions is imperative and can range from pre-screening correctly, to using your full name, to reading the intro verbatim. Pre-Screening: some demographic groups are harder to reach than others. Because of this we are often required to ask for them before we talk to anyone else in the household. Pre-screens can be announced in briefings, by supervisors, and/or put up on boards around the room. Using Full Name: we must always use our full name when introducing ourselves to respondents. It sounds more professional and our clients require it. Reading Intro Verbatim: some clients require us to read the introduction screen verbatim. In those cases, it is required that we read the introduction word for word as it appears on the screen. When it is required, it will be mentioned in the project briefing – otherwise we never require it to be read verbatim.

Verbatim and Accuracy

Reads Verbatim/Does Not Pre-Code – We must read every question word for word as it appears in the survey. Slight changes in wording can change the meaning of a question, detract from our accuracy, and/or adversely affect productivity. We should read every question to the respondent and get their answer after we read the question. If a respondent gives a valid answer to a question before we have asked it, we must still read the question to them when it appears in the survey.

Uses Correct Pronunciation – To appropriately convey surveys to respondents, we must pronounce each word in the survey correctly. Words or phrases that are difficult to pronounce will be covered in briefings, and sometimes a phonetic spelling is provided in the survey as well. A supervisor can also assist us when we are unsure of how to pronounce something.

Enters Answers/Notes Correctly – We must code all responses accurately. In some instances lists are not in numerical order. We should pay close attention to avoid coding answers incorrectly. Answers for other specifics should answer the question and appear in the same format as the other answers on the list. We should avoid entering “all of them,” “none,” and “don’t know” into other specifics. Open ends should appropriately answer the question. Open ends need to be recorded word for word as the respondent is

giving the answer, other than filler words or ending phrases like 'that's it' or 'that's all.' Proper spelling, capitalization, and punctuation must be used for all open ends and other specifics. All types of notes should be entered in correctly.

Only Accepts Listed Answers/Answers Questions Appropriately – When a question gives a list of acceptable options, a respondent's answer must exactly match an answer from the list (e.g. "yeah" is not the same as "yes"). When this is not the case we must probe as necessary until the respondent gives an answer that accurately corresponds to an answer on the list. We must field any questions that a respondent may have and answer them appropriately. When we are unsure of an answer, a supervisor can assist us.

Follows Notations/Instructions – Notations are on screen directionals that are designed to assist us in accurate data collection. We should follow these at all times. Many surveys have specific instructions covered during the project briefing. It is vital to the accuracy of the survey that we follow these instructions as intended. We must never offer the responses "don't know" or "refused" as options in a survey. Offering these responses to the respondent indicates that they are acceptable, though often they are not. All other specifics need to be checked by a supervisor before we continue on to the next question. Written open ends must be checked by a supervisor before we can type them in at the end of the survey. We should use the rule of three where applicable to help cut down on our average survey time. The rule of three can also be called training the respondent. For example, if the respondent were asked to rate their bank on 10 attributes, using the same scale for each attribute, we would only need to read the scale to the respondent for the first three attributes. As long as the respondent is trained, and is able to answer the question without hearing it, we may drop the scale if there are no other questions in between.

Probes/Clarifies as Needed/Correctly – When a respondent answers "I don't know" to a question, we need to probe for an appropriate response. Opinion surveys have no right or wrong answers, so we should encourage a respondent to give their opinion. Often times an estimate or guess is fine in lieu of an exact answer. For open ends: words or terms that are unclear or could have multiple meanings should be clarified so that we more clearly capture what a respondent is trying to convey. We want to give our clients the most complete and meaningful data possible, so when in doubt clarify. It is better to have too much information rather than too little. We should always probe as much as necessary before we start to clarify any subjective terms. This allows the respondent to give a complete answer. The amount of probing required for each question will be listed in the notations or announced in the project briefing. We want to probe with open ended questions (e.g. what others? or why else?), because then a respondent would be more apt to give a full answer. Probing with a closed ended question like "any others?" gives the respondent the opportunity to cut an answer short even though he/she

might have more to share. When a question allows for more than one answer, we should probe until the respondent has no more responses to give.

Control and Rapport

Reads w/o Stumbling and Fillers – We need to read clearly to properly communicate what a question is asking. If we do stumble over the text, we should re-read it correctly for the benefit of the respondent. We should try to avoid filling gaps in speech with unnecessary utterances like “um,” “uh,” or “and.” When used, filler words may become distracting to a respondent and may decrease their interest in completing the survey. We should avoid using biasing filler words because in addition to potentially being distracting, these words (e.g. good, great, thanks, super), give the respondent either positive or negative feedback on their answers and may influence their answers.

Stays Engaged/Attentive – We must actively try to engage respondents. Because of the nature of the automatic dialer, it is possible that when we are waiting for a call we will be connected to a respondent at any time. For this reason, it is essential that we stay focused and prepare ourselves for all calls. Thereafter while in the survey, we must stay focused on communicating with the respondent to complete the survey. This includes when we are put on hold or during music montages.

Repeats Text as Necessary – When a respondent requires a question or scale be repeated, we should do so as necessary. We must pay attention to a respondent’s verbal cues, as sometimes they may have misheard or misunderstood what we are reading to them.

Uses Clear/Appropriate Pace, Tone, and Language – When conducting a survey we want to maintain a pace that is comfortable for both the respondent and us, while allowing us to complete the survey in a timely manner. We want to sound warm and conversational when speaking to a respondent, as it will help establish rapport. We should avoid sounding short, tired, bored, etc., even if a respondent is wearing on our patience or if we’re having a bad day. We should conduct ourselves in a professional manner at all times. Inappropriate language can offend other employees, respondents, clients, and visitors to our office. It is imperative that we refrain from cursing, making derogatory remarks, gossip, etc.

Keeps the Focus on the Survey/Avoids Break-Offs – While it is important to build rapport with a respondent, we must keep the respondent and ourselves focused on the survey we are conducting. We should avoid any conversations unrelated to completing the survey. Likewise, if the respondent loses focus, we should redirect their attention to finishing the survey. When a respondent attempts to end an interview before we have completed the survey, we need to make an effort to keep the respondent on the line so that their opinions may be included with our data. If a respondent cannot

immediately continue, we should then ask for a more convenient time to call back and finish the survey.

Objectivity

Does Not Comment on Survey – We should refrain from making any comments about a survey or question to a respondent. This will allow us to remain neutral and keep the respondent focused on his/her own opinions.

Does Not Suggest Responses – We should always remain unbiased throughout a survey. We should avoid intentionally and unintentionally influencing the way a respondent answers a question. This includes reading an option in a different tone of voice than when reading other options and offering a respondent only one option when clarifying a response. We should keep an unbiased tone throughout the survey and always offer the respondent more than one option either by re-reading the question or list of answers, or by politely asking the respondent to repeat the missed response.

Does Not Interpret – We should avoid re-phrasing or explaining any of the questions or words in a survey. Generally, when a respondent is unsure of what a question is asking, we should repeat the question verbatim. It is acceptable to let the respondent know that we cannot interpret the questions/wording so that we do not bias their opinions.



Conducting an Interview

This portion of the training is designed to illustrate what conducting an interview with an actual respondent will be like. These are the types of questions you will see on your screen...

-

TELNUMB=2082328890. TZ: p TIMESTRIED: 0

Hello, this is _____ calling from Bernett Research.

This is called the SMS screen. The SMS screen is the first screen that will appear when a record is sent to your station. Typically, it will have a small part of the introduction and a list of dispositions.

- 1 Proceed with interview
 - 2 No answer
 - 3 Answering machine
 - 4 Busy
 - 5 Disconnected Phone
 - 6 Business/Government Phone
 - 7 Respondent not available
 - 8 Soft Initial Refusal
 - 9 Hard Initial Refusal
 - 10 Computer Tone
 - 11 Language Problems
 - 12 Hard Appointment
 - 13 Soft Appointment
 - 14 Change number
 - 15 Add To Do Not Call List
- Please enter choice, or r to redial:

-

If a number has been dialed before, this screen may be the first screen you see when a number comes up. This screen shows you callback notes that interviewers have left. You should quickly look it over for any helpful notes. In this example, an interviewer has a

left a note directing you to talk to Jim Thorpe. After reading the notes, hit any key to continue and see the dispositions. Only leave notes that are helpful for the next interviewer!

Hello, this is _____ calling from Bernett Research.

TELNUMB=7042630322. TZ: e

Comments from previous interviews:
 ***Thu Jan 25 17:57 2007:PBM098220
 Result(13)Appointment
 Appointment made for Fri Jan 26 20:00 2007

***Fri Jan 26 20:00 2007:PNB096293 Result(13)Appointment
 Appointment made for Sat Jan 27 18:00 2007
 Ask for Jim Thorpe

Hit any key to continue

-

TZ = p TELNUMB=2082328890 MARKET=1

1/INTRO

This is _____ calling on behalf of Bernett research. We are calling people in your area to do a survey about recent events in your city.

- 1 Continue
- 2 Respondent Not Available
- 3 Schedule Callback
- 4 Soft Initial Refusal
- 5 Hard Initial Refusal
- 6 Call Substitute Number
- 7 Wrong Number
- 8 RETURN TO SMS SCREEN

Reply may not be NULL or DK or REF
 .. Reply may be one of the above

Response:

This is the Intro screen. Here you can see the three parts of the introduction: who you are, where you are calling from, and why you are calling.

- ❖ Remember to use your first and last name here.
- ❖ Type in "1" and hit enter to jump right into the first question in the survey.
- ❖ Dispositions appear again.
- ❖ Use option 8 for a more comprehensive list, but you can't get back into the survey if you use this punch!
- ❖ Call Substitute Number – for numbers that have changed or if NOL moved, etc.
- ❖ Pre-Screening should be done here. Listen for announcements from Sups for info on who to pre-screen for. If the 'target' person is not available, continue with whomever you have on the phone.

TZ = p TELNUMB=2082328890 MARKET=1

2/Q1

The following questions will help ensure that we represent as many people as possible.

1 Continue

Reply may not be NULL or DK or REF
.. Reply may be one of the above

This is a fairly common introduction into the screening or qualification questions. These questions often determine which quota a respondent will fit into.

Response:

TZ = p TELNUMB=2082328890 MARKET=1

3/QA

I will read you a number of age categories. Please tell me which category your age falls into.

- 1 Under 18
- 2 18-20
- 3 21-25
- 4 26-40
- 5 41-60
- 6 Over 60
- 7 DK/REF

Reply may not be NULL or DK or REF
.. Reply may be one of the above

On age group questions it is all right to read the list until a valid response is given, because the respondent's answer will not change if they hear the rest of the list.
❖ Pay attention to on screen notations! They convey very important information.

Response:

TZ = p TELNUMB=2082328890 MARKET=1

Reply may not be NULL or DK or REF
.. Reply may be one of the above

4/NQQA

Resp
onse:

Respondent Does Not Qualify NQ:AGE

This is the screen that will appear if a respondent disqualifies. Notice that this not only shows you that they disqualified, but also why they disqualified.

Thank you - That is all the questions I have at this time

1 Terminate

TZ = p TELNUMB=2082328890 MARKET=1

4/NQQA

Respondent Does Not Qualify NQ:AGE

Thank you - That is all the questions I have at this time

1 Terminate

Reply may not be NULL or DK or REF
.. Reply may be one of the above

The character to the left (often referred to as a carrot or a 'less than' symbol, is used to back up in quancept. Backing up will take you to the previous screen and "<<" will take you to your introduction, but this command should be used with caution.

Response: <

TZ = p TELNUMB=2082328890 MARKET=1

5/QA

I will read you a number of age categories. Please tell me which category your age falls into.

This is how the screen will appear when backing up. Selecting 'n' will allow you to change the previous response.

- 1 Under 18
- 2 18-20
- 3 21-25
- 4 26-40
- 5 41-60
- 6 Over 60
- 7 DK/REF

Reply may not be NULL or DK or REF
Previous Response - Under 18

Answer was Under 18

Is this correct (y/n) ?

TZ = p TELNUMB=2082328890 MARKET=1

6/QB

Gender by observation

- 1 Male
- 2 Female

Never ask this question of a respondent unless absolutely necessary. If you have to ask, do so tactfully!

Reply may not be NULL or DK or REF
.. Reply may be one of the above

Response:

TZ = p TELNUMB=2082328890 MARKET=1

7/Q1B

Now, on a different topic...

1 Continue

Reply may not be NULL or DK or REF
.. Reply may be one of the above

This is an example of a transition screen. Even though this is not a question, it must be read exactly verbatim. This often informs the respondent of an upcoming subject change or gives them other important information about what is going to follow. They have to be read, you cannot skip them!!

Response:

TZ = p TELNUMB=2082328890 MARKET=1

8/Q2B

Which of the following do you use in your home?

- 1 Cell phone
- 2 DVD player
- 3 Home Theater system
- 4 Computer
- 5 None

This is an example of a multi-punch question, as indicated by the on screen notation. To select more than one response, select the space bar between responses. On questions of this type, get a "yes" or "no" after each response. If the respondent were to answer "no" to all 4 of these options, the answer of "none" is implied, and is not read aloud, as it is the only possible acceptable response at that point.

Reply may not be NULL or DK or REF
.. Reply may be a combination of the above

Response:

TZ = p TELNUMB=2082328890 MARKET=1

9/Q2A

Is that a laptop, a desktop or both?

- 1 Laptop
- 2 Desktop

Reply may not be NULL or DK or REF
 .. Reply may be a combination of the above

Response:

In this example of a multi-punch question, it is not necessary to read the list, as it is part of the question. If a respondent replied "both" on this question, both options would need to be entered, as both is not an option on the list.

TZ = p TELNUMB=2082328890 MARKET=1

10/QE5INT

Do you do business with any of the following firms?

- 1 Continue

Reply may not be NULL or DK or REF
 .. Reply may be one of the above

Response:

Another example of a transition screen.

TZ = p TELNUMB=2082328890 MARKET=1

11/QE5

Be sure to get a firm "yes" or "no" response. On close-ended questions, if it isn't on your list, it isn't an option! That means "well... maybe", "yeah", or "I did 15 years ago" would not be a viable response here. It is perfectly acceptable to respond with something like "I just have a yes or no, how would you like me to record your answer?". Also, notice option 8. "Don't Know" is

an acceptable answer, but 'don't know' must always be probed. There are different ways to do this, and it will vary with different types of questions, but generally "You

may base this on anything you may have seen, read or heard," or "There are no right or wrong answers, your best guess is fine," or "To the best of your knowledge, what would you say?" are broad statements that will work on just about any question.

Fidelity

- 1 Yes
- 2 No
- 8 DK/REF

Reply may not be NULL or DK or REF

.. Reply may be one of the above

Response:

TZ = p TELNUMB=2082328890 MARKET=1

16/QE5C

Prudential, This is the company that sells insurance and annuity products and is not part of Wachovia Securities.

- 1 Yes
- 2 No
- 8 DK/REF

This is an example of a very important on screen notation. This prompts the interviewer to read additional information based upon the respondent's answer to the initial question. Also, note the highlighted text. Highlighted text should be emphasized using voice tone.

Reply may not be NULL or DK or REF
.. Reply may be one of the above

Response:

TZ = p TELNUMB=2082328890 MARKET=1

21/QF

Of all the firms you _____ for investments, financial advice, insurance or deposits, which _____ company do you consider your most important provider of financial services; that is the company where you have _____ of your assets _____ stocks, bonds, mutual funds, bank accounts, certificates of deposit, personal retirement accounts such as IRAs, but _____ real estate, business assets or assets you have through your work?

- 1 AG Edwards
- 2 Ameriprise Financial, formerly known as American Express Financial Advisors
- 3 AXA Advisors (Formerly Equitable, Alliance Capital)
- 4 Charles Schwab
- 5 Fidelity
- 6 Hartford Financial

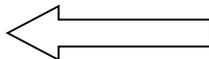
Reply may not be NULL or DK or REF
.. Reply may be one of the above

Response:

Enter '+' to scroll forward

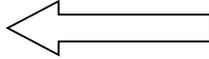
Again in the text of this question there are several highlighted words that need to be emphasized. Notice that the list of answers for this particular question is listed alphabetically, but the list appears to only go through the letter 'h'. This as well as the notation "Enter '+' to scroll forward" that is bolded just to the left indicates that the list is probably too large to fit on one screen. Use the '+' and '-' keys to see more of the list. If you were to scroll forward, you would see two subsequent screens, as indicated by the arrows to the left. Notations are very important here as well, as they indicate that this is a 'Do Not Read List', and that it will only accept a single response.

- 7 Merrill Lynch
- 8 MetLife
- 9 Prudential Financial
- 14 Smith Barney
- 10 Wells Fargo



12 Edward Jones

13 Wachovia Securities
 11 Other (Specify)



TZ = p TELNUMB=2082328890 MARKET=1

21/QF

Of all the firms you for investments, financial advice, insurance or deposits, which company do you consider your important provider of financial services; that is the company where you have most of your assets stocks, bonds, mutual funds, bank accounts, certificates of deposit, personal retirement accounts such as IRAs, but real estate, business assets or assets you have through your work?

- 1 AG Edwards
- 2 Ameriprise Financial, formerly known as American Express Financial Advisors
- 3 AXA Advisors (Formerly Equitable, Alliance Capital)
- 4 Charles Schwab
- 5 Fidelity
- 6 Hartford Financial

Here we are looking at the same screen in order to illustrate the "stop" command. This command is used when a respondent cannot complete the interview, but is willing to be called back to complete the interview at a later time. The "stop" command will save the responses that have already been given so that the respondent does not have to start over again. This command will eventually prompt the interviewer to schedule a callback.

Reply may not be NULL or DK or REF
 .. Reply may be one of the above

Response: **stop**

Enter '+' to scroll forward

Inspect or change anything before stopping (y/n) ?

Do you wish to write data now (y/n) ?

After typing in "stop", the following questions will be asked. If you do not wish to change anything, type "n". Remember, once you reach the callback screen, you cannot return to the survey. Always say "y" to writing data. This is what saves the respondent's answers, so that they do not have to start over when we call them back.

Enter appointment time (local to respondent), if any (or ? for help)
Time:

SETTING APPOINTMENTS

Full date/time specification 02/08/31-15:20 or 02/08/31-3:20pm or
08/31-10:35am (10:35am on 31 August) If your
supervisor sets the environment variable
QCEUROPEAN to 1, you must enter dates in the format
dd/mm; for example: 31/08-10:35am (10:35am on 31
August)

Appointments for later today 10:00am or 10:00 or 10pm or 22:00

Appointments for tomorrow tomorrow or tomorrow 11:15am

Appointments for specific days mo 10:00am (10am on Monday)
th 21:30 (9:30pm on Thursday)

Appointments relative to the now + 10 (in 10 minutes' time)
current time/date now + 10m (in 10 minutes' time)
now + 1h + 30 (in 1.5 hour's time) now + 2d (same time
2 days from now) now + 1w (same time 1 week from
now)

After typing "stop" you will be directed to the appointment screen. If you type in "??" at the appointment screen, a tutorial on how to set up an appointment will appear, similar to the one on the left. This displays information on different ways to set up and schedule callbacks. After setting the appointment time, you will be offered a place to enter in any comments. If you stop an interview, always get the respondent's name, so that the person completing the survey knows exactly who to ask for. When entering in callback notes, only enter in notes that are vital to the next interviewer who will be calling.

Hit any key to continue to calendar, appointments outside the times and dates shown in the calendar may not be accepted.

TZ = p TELNUMB=2082328890 MARKET=1

19/QF

Of all the firms you for investments, financial advice,
insurance or
deposits, which company do you consider your important
provider of
financial services; that is the company where you have most of your
assets
stocks, bonds, mutual funds, bank accounts, certificates of
deposit,
personal retirement accounts such as IRAs, but real estate,
business assets or assets you have through your work?

There are times that you will need to break a survey off. For example, if the respondent were to refuse this question, you will notice that there is no way to enter in that response, as it is not an acceptable answer. In this case, the survey will have to be broken off. The command for this is "quit". This is also used when a respondent does not wish to answer any more questions, and does not wish to be called back at a later date. This command will terminate the number, and it will not get called back.

- 1 AG Edwards
- 2 Ameriprise Financial, formerly known as American Express
Financial Advisors
- 3 AXA Advisors (Formerly Equitable, Alliance Capital)
- 4 Charles Schwab

- 5 Fidelity
- 6 Hartford Financial

Reply may not be NULL or DK or REF
 .. Reply may be one of the above

Response: quit

Enter '+' to scroll forward

TZ = p TELNUMB=2082328890 MARKET=1

20/QBO

**** BREAK OFF TERMINATION ****

- 1 Survey is too long
- 2 Questions are repetitive
- 3 Questions weren't applicable to respondent, talking to wrong person
- 4 Question didn't allow Don't Know as answer
- 5 Question didn't allow Refused as answer
- 6 Respondent just hung up (DID YOU TRY TO RE-CONNECT CALL?)
- 7 Respondent had to go- refused scheduled callback
- 8 OTHER

Once you have typed in "quit" the following screen will appear. Select the option from the list that fits the individual situation. If this were for the previous example, you would select option 5. Also notice option 6 on this list. If you are suddenly disconnected from a respondent, you always want to try and call them back. You need to try and do this before typing "quit". The command for this is "*redial". This should be typed in if you can hear a pulsing tone. If you heard the "click" from someone hanging up, but for some reason, you do not have a pulsing tone, type "*hangup" before typing "*redial" to insure that your phone has indeed disconnected.

Reply may not be NULL or DK or REF
 .. Reply may be one of the above

Response:

Z = p TELNUMB=2082328890 MARKET=1

20/Q33INT

Now I would like to read you a list of statements that may or may not describe your Ameriprise financial advisor.

On a scale of 10 to 1, where 10 is "Describes Perfectly" and 1 is "Does Not Describe at All", please tell me how well the following statements describe your financial advisor.

- 1 Continue

So far, all the questions that we have seen have been close-ended questions. There are several types of close-ended questions. Another type of close-ended question is where you must get a numerical response. With any type of close-ended question, you must get EXACT answers. This transition screen is setting the respondent up for the next set of questions. This information is essential to the respondent's understanding of the following questions.

Reply may not be NULL or DK or REF
.. Reply may be one of the above

Response:

TZ = p TELNUMB=2082328890 MARKET=1
21/Q33

Your advisor...

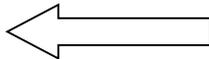
Notice that the statement that the respondent is supposed to be rating their advisor on is highlighted. This does not indicate that it should be emphasized, it is simply highlighted so that it is easily distinguished from all the other information on the screen.

DESCRIBES AT ALL DOES NOT DESCRIBE PERFECTLY

10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1

98 > DK/REF

1 to 10 98



Acceptable responses are listed to the left, as indicated by the arrow. Anything not listed or not within the range listed will not be accepted.

Reply may not be NULL or DK or REF
.. Reply may be a numeric value

Response:

TZ = p TELNUMB=2082328890 MARKET=1

32/Q8

Now, on a different topic...

1 Continue

Transition screens are your friends!!! Learn to love them, and read them every time!

Reply may not be NULL or DK or REF
.. Reply may be one of the above

Response:

TZ = p TELNUMB=2082328890 MARKET=1

33/Q7

Which radio stations, if any, have you listened to in the past 24 hours?

Which others?

- 1 WUSF-FM 89.7 NPR
- 2 WLPJ-FM 91.5 The Joy FM Network
- 3 WYUU-FM 92.5 La Nueva 92.5
- 4 WFLZ-FM 93.3 93.3 FLZ
- 5 WSJT-FM 94.1 Smooth Jazz
- 6 WWRM-FM 94.9 Magic 94-9
- 7 WBTP-FM 95.7 The Beat
- 8 WSUN-FM 97.1 97X
- 9 WXTB-FM 97.9 98 Rock
- 10 WLLD-FM 98.7 Wild
- 11 WQYK-FM 99.5 Tampa Bay's Country S
- 12 WMTX-FM 100.7 Mix 100.7
- 13 WPOI-FM 101.5 101-5 The Point
- 14 WHPT-FM 102.5 102-5 The Bone
- 15 WFUS-FM 103.5 US 103.5
- 16 WRBQ-FM 104.7 Q105
- 17 WDUV-FM 105.5 The Dove
- 18 WJQB-FM 106.3 True Oldies 106.3
- 19 WXGL-FM 107.3 107-3 The Eagle
- 20 WDAE-AM 620 Sports Animal
- 21 WFLA-AM 970 News Radio
- 22 WWBA-AM 1040 News Talk AM 1040
- 23 WTMP-AM 1150 Tampa's True Adult Ur
- 24 WHNZ-AM 1250 Impact Radio
- 25 WRXB-AM 1590
- 26 Other
- 27 DK
- 28 NONE

This question has a very long list of answers, and will be a list that will need to be scrolled through using the "+" and "-" keys. To make it a bit easier on the eyes, it has been compiled into one list/one screen for this example.

Even though this list is very lengthy, it is possible that it does not include every station. For this reason, option 26 "Other (Specify)" is available. Other specifies have to be checked by a Supervisor. This needs to happen for every single other specify. Once you have entered in all the information necessary, raise your hand and *snap* your fingers. A sup will come running to double check your response. There are some responses that should never be typed into an other specify. This would include "none", "all of them" or "both of them". If these were acceptable responses, they would be options on the list. When entering information into an other specify, make sure that it 'matches' the other responses on the list as closely as possible.

As with all close-ended questions it is very important to get exact answers. Even though this list is a Do Not Read list, it is still possible to use this list when *Clarifying for fact*. For example, if a respondent said "I've listened to 94.9, WSJT, Smooth Jazz". In this situation, the respondent has "created" a station from two existing stations. To clarify in this instance, you would say, "I have WWRM-FM 94.9 Magic 94-9 or WSJT 94.1 Smooth Jazz WSJT. Did you mean one of those stations, or something else?" In this type of situation it is very important that you offer "or something else" to insure that the respondent can give an answer that was not offered by the interviewer, which ensures accuracy.

35/Q5

San Bernardino County Board of Supervisors

- 1 Strongly Favorable
- 2 Somewhat Favorable
- 3 Somewhat Unfavorable
- 4 Strongly Unfavorable
- 5 Can't Rate
- 6 Never Heard

Reply may not be NULL or DK or REF
 .. Reply may be one of the above

Response:

p TELNUMB=2082328890 MARKET=1

TZ =

36/Q14A

Jeff Burum

- 1 Strongly Favorable
- 2 Somewhat Favorable
- 3 Somewhat Unfavorable
- 4 Strongly Unfavorable
- 5 Can't Rate
- 6 Never Heard

Reply may not be NULL or DK or REF
 .. Reply may be one of the above

Response:

TZ = p TELNUMB=2082328890 MARKET=1

37/Q6

County Board of Supervisors Chairman Bill Postmus

- 1 Strongly Favorable
- 2 Somewhat Favorable
- 3 Somewhat Unfavorable
- 4 Strongly Unfavorable
- 5 Can't Rate
- 6 Never Heard

Reply may not be NULL or DK or REF
 .. Reply may be one of the above

Response:

The following Public Figures & Organizations are being rated using the same scale. When using the same scale for a series of questions, it is possible to train the respondent using the "3x Rule". This means that after reading the scale for the first three Public Figures or Organizations, you may drop the scale, and just read the new Public Figure or Organization. Of course, if the respondent is unsure or needs to hear the scale, you should re-read it for them. After hearing the scale three times, most respondents are able to remember it and answer without prompting. However, it is required to read the scales at least the first three times. This is a great way to lower survey time, which can increase the amount of surveys that you can complete in an hour, and therefore raise your hourly rate!

All the questions that we have discussed so far have been close-ended questions. The next series of questions are open-ended questions. Remember that open-ended questions are questions that allow the respondent to answer however they would like, meaning they do not have to give a response from a list. Some open-ended responses are typed in at the end of the survey and others are recorded at the time they are asked. Here are some tips on Openends.

1. Make sure that the respondent actually answers the question. If the respondent gives you an answer that does not answer the question, reask the question until the respondent *does* answer the question. It is unacceptable to accept a response that does not answer the question, but we still want to record everything verbatim, not including filler words or ending phrases like 'that's it' or 'that's all' while trying to get a valid answer.
2. Probe and clarify!!!! It is important that the respondent not only answers the question, but that their answer is specific and complete. If a verbatim question is not probed or clarified properly, you may be required to call the respondent back to get the information that is lacking. Save everyone some time and do it right the first time. Make sure that you are probing with an open-ended question such as "What else?" or "Why Else?" Do not probe with "Anything Else?" as you are giving the respondent the opportunity to say "No." Here are some tips on clarifying:

If they say:

GOOD

CONVENIENT

BAD

CUTE

BETTER

FAIR

OKAY

I DID NOT LIKE IT

I JUST NEED ONE

I DONT KNOW

IT IS THE SAME WILL you tell me again so that I have it down correctly?

LOW PRICE

HIGH PRICE

Clarify with:

WHY is it GOOD?

WHY is it CONVENIENT?

WHY is it BAD?

WHY is it CUTE?

WHY is it BETTER?

WHY is it FAIR?

WHY is it OKAY?

WHY did you not like it?

WHY did you need it?

WHAT is your best guess?

WHAT do you consider to be a LOW PRICE?

WHAT do you consider to be a HIGH PRICE?

3. Answers should always be recorded verbatim as the respondent says it. For example, if the respondent said, "I like Safeway because it is close

- to my house," then you would write down or type in "I like Safeway because it is close to my house." Recording an answer such as "He said that he likes Safeway because it's close to his house" is not acceptable.
4. Never record a response that cannot stand on its own. For example, "see previous response," "same as before," etc. are not valid responses. Each response is looked at separately, and a respondent's answers are never tied together, but rather looked at in an aggregate form. For this reason, each answer must be complete on its own, and cannot rely upon past answers to be considered complete. No shortcuts can be taken.
 5. Do not leave your keyboard on caps lock or type all in lower case letters; please use proper capitalization and also spell everything correctly.
 6. **All open-ends must be checked by a supervisor** before they are typed in for written OEs, and at the end of the call for typed OEs.
 7. If you have to schedule a callback with a respondent who has started the survey, and has been asked an open-ended question, you need to record their response just as you would a complete response. Please be sure to record all respondent information, including the respondent's telephone number, name, and respondent number on the paper if it's a written OE. Please give the completed written OE form to a supervisor. Because you are setting a callback, the callback will most likely not be completed by you. Whoever does complete the call will need all of this information. For typed OEs get them checked at the end of the call like normal. **Be sure to leave callback notes with pertinent information for all mid interview callbacks.**
 8. When you are recording a respondent's answer, avoid dead air. Let the respondent know that you are recording their response.
 9. For all open ends do not include filler words, or ending phrases like 'that's it' or 'that's all.'

There are two types of open-ended questions. REMEMBER to get them ALL checked by a supervisor! The first type of open-ended question that we will discuss are open-ends that are written out and typed into the computer at the end of the survey, after the respondent is off the phone. Here is what this type will look like in quancept:

TZ = p TELNUMB=2082328890 MARKET=1

46/R1X2A

Please tell me what there is about the product, if anything, that you like about it? What else do you like about it?

(PROBE AND CLARIFY UNTIL UNPRODUCTIVE)

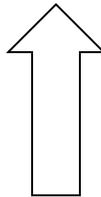
- ❖ Pay attention to on-screen notations. They tell you:
 - to probe and clarify until unproductive
 - what statements to probe with
- ❖ Also note the on-screen notation that is highlighted (meaning it is extra important). "Make sure the response answers the question". This cannot be stressed enough.
- ❖ The question number is highlighted, as indicated by the arrow to the left. This is the question number you should write down on your open-end sheet.
- ❖ Once you have recorded all this information, you will select "1" to continue with the interview.

 * PROBE WITH: WHAT ELSE DO YOU LIKE ABOUT IT? *
 * CLARIFY WITH: WHAT DO YOU MEAN BY _____? *

THIS IS THE VERBATIM FOR QUESTION

1 Continue

Reply may not be NULL or DK or REF
.. Reply may be one of the above



Response:

Below is an example of an open-end sheet where you will record the previous answer. Take a look.

Today's

Date _____ Your Name _____

Your Employee Id

Respondent number is found at the very end of the survey on the screen. y/n

Respondent name and phone are both collected at the end of the survey.

Date: ____/____/____ Interviewer Name: _____ Number: _____

Respondent NUMBER: _____
Respondent NAME: _____
Respondent PHONE: _____

CB Date/Time: _____ Sup: _____
Project Name: _____
Project Number: _____
*Ask a supervisor if you are unsure of the Project Name or Number

OPEN END 1 QUESTION #

This is the box where you will write in the project number the question and project name for each open-end number this at you fill out. Ask a supervisor if entered in. you are unsure of what these should be.

If you get a supervisor interview 'stop' with initial have already asked they 1+ open ended questions, approved the must put what you end. set for the callback date and time so that we can be prepared for the callback.

The second type of open-ended question is the type that gets typed in as the respondent is answering. This is what it will look like in quancept.

TZ = p TELNUMB=2082328890 MARKET=1

47/NSILIK
 What, if anything, did you particularly LIKE
 about the commercial?
 (PROBE WITH "WHAT ELSE?" UNTIL
 UNPRODUCTIVE. PROBE FOR
 CLARITY IF NECESSARY.)

Reply may not be NULL or DK or REF
 .. Reply may be open ended
 type return twice to finish response

- ❖ Watch Notations
 - Probe until unproductive
 - Probe for clarity (clarify) if necessary
- ❖ Ask the respondent to slow down if necessary. More than 5 words ahead of you is too much!!

Response:

TZ = p TELNUMB=2082328890 MARKET=1

48/DEMOS

The following questions are for classification purposes only.

1 Continue

Reply may not be NULL or DK or REF
 .. Reply may be one of the above

Response:

The last section of the questionnaire is the classification questions. Classification questions may seem similar to the screening or qualification questions, but they are used for a different purpose. A respondent's answers to the classification questions will determine how their responses are grouped with other respondents.

If a respondent breaks off the survey during the classification questions, raise your hand and let a sup know. You can still get credit for the complete, as the responses to classification questions are desired, but not essential to the survey.

TZ = p TELNUMB=2082328890 MARKET=1

49/Q27

Do you generally think of yourself as a Democrat, an Independent, a Republican or something else?

Would you call yourself a strong
 or a not very strong ?

Do you think of yourself as closer to the Democratic
 or Republican party?

- 1 Strong Democrat
- 2 Not Strong Democrat
- 3 Independent Democrat
- 4 Independent
- 5 Independent Republican
- 6 Not Strong Republican
- 7 Strong Republican
- 8 Don't Know

Again in this question, notations are extremely important. In this example, you will need to ask an additional question based on the respondent's answer before you can code their response.

Reply may not be NULL or DK or REF
 .. Reply may be one of the above

Response:

TZ = p TELNUMB=2082328890 MARKET=1

50/Q14

Do you own, rent or lease your home?

- 1 Own
- 2 Rent
- 3 Lease
- 4 Refused

This question is very straightforward, but it is still important to watch notations regarding whether to "read" or "do not read" options.

Reply may not be NULL or DK or REF
 .. Reply may be one of the above

Response:

TZ = p TELNUMB=2082328890 MARKET=1

51/Q15

On questions such as income, where you are asking the respondent for factual information, it is acceptable to read the list until a valid response is given. If you are not sure whether or not this would be acceptable, ask yourself the following question: "Does the respondent's answer have the potential to change if they heard the rest of this list?". It is always best to be

Which of the following includes your total household income:

- 1 Under 25,000
- 2 25,000 to under 50,000
- 3 50,000 to under 75,000
- 4 75,000 to under 100,000
- 5 or above 100,000
- 6 DK/REF

safe, so if you are still unsure, it would be best to simply read the entire list.

Reply may not be NULL or DK or REF
 .. Reply may be one of the above

Response:

TZ = p TELNUMB=2082328890 MARKET=1

52/VNAME

So that my supervisor may verify that I spoke with you, may I have your name?

Reply may not be NULL or DK or REF
 .. Reply may be open ended
 type return twice to finish response

Response:

We collect respondents' names for validation purposes only, should a supervisor need to contact the respondent to verify that the survey actually took place. If a respondent is concerned about giving their name, assure them that their name will never be tied to their answers and their answers will never be looked at individually.

If a respondent refuses to give their name, that is completely acceptable. Simply enter in "Mr. Refused" or "Mrs. Refused" so that their gender is evident.

TZ = p TELNUMB=2082328890 MARKET=1

53/VPHONE

May I verify that I reached you at
 ?

Is this correct?

- 1 Yes
- 2 No

This is used simply to verify that we have indeed reached the correct number. If the respondent voices a concern about being called again or solicited because they completed a survey, assure the respondent that we do not sell their information, and this is used simply to verify that we have reached them at the listed number.

Reply may not be NULL or DK or REF
 .. Reply may be one of the above

Response:

TZ = p TELNUMB=2082328890 MARKET=1

53/NEWPHONE If the respondent indicates that the number on your screen is not the correct

What is the correct phone number?

(RECORD WITHOUT PUNCTUATION, e.g. 5555551234) without punctuation. There is an example to the left, as indicated by the

Reply may not be NULL or DK or REF
.. Reply may be open ended
type return twice to finish response

number, you will need to enter in the correct number. Record the number as an example to the left, as indicated by the arrow.



Response:

TZ = p TELNUMB=2082328890 MARKET=1

54/FINISH

Those are all of my questions. Thank you very much for completing this survey. Again, this survey was for informational purposes only. Thank you and have a good day.

1 Continue

Reply may not be NULL or DK or REF
.. Reply may be one of the above

Response:

The closing statements generally thank the respondent for their participation and do not necessarily need to be read exact verbatim. Be sure to hit "1" to continue once you are off the phone with the respondent, as this will stop your survey timer.

TZ = p TELNUMB=2082328890 MARKET=1

55/VVERB

Please have a your verbatims.
These were the verbs asked during the interview...

R1x2A - Please tell me what there is about the 7UP product, if anything, that you ?

1 Continue

Reply may not be NULL or DK or REF
.. Reply may be one of the above

Response:

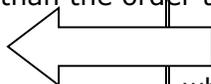
This is the screen you will sit on while you fill out your verbatim sheet and get it checked by a supervisor. This screen will list all the open-ended questions that were asked during the survey. Hit "1" to continue on to the screen where you can type in the response.

-

TZ = p TELNUMB=2082328890 MARKET=1

56/QVERB2 This is where the answers to open-ended questions get typed R1x2A -
Please tell me what there is about the 7UP product, if in. Pay very close attention to the anything,
that question number to the left. you ? Occasionally, questions will come up in
a different order at the end
TYPE IN VERB HERE FOR QUESTION than the order they were asked in the
survey. Type <enter> twice
Reply may not be NULL or DK or REF
.. Reply may be open ended
type return twice to finish response

when you are finished.



Response:

-

Another interview (y/n) ?

Data written for respondent 6

After you have entered in all information, you will be prompted for "Another interview (y/n)?" Just below this is the respondent number, which has been bolded to the left. This should be written down on the open-end sheet.

Common Questions

- ❖ **Where are you calling from?**
 - Sometimes we will be calling "on behalf of" another company from Bernett Research. It is acceptable to let the respondent know that you are calling from Bernett Research unless specifically instructed otherwise in a project briefing.
- ❖ **What is this survey about?**
 - The best way to deal with this is to read or re-read the introduction to the respondent. If the introduction is vague or the respondent asks for more information than what is provided in the intro, let them know that you are not allowed to give any more information than that, as it may bias their opinions, but the topic of the survey will become apparent after a few questions.
- ❖ **Who is sponsoring this? / Who is this survey for?**
 - Whether or not you can divulge this information to the respondent will be covered in the project briefing. In some cases, you may not know this information or you may not be able to tell the respondent this information. In these situations, the best response is "I'm not told that information, so that I do not bias people's responses."
- ❖ **Where did you get my number?**
 - This will depend on the study. Most of the time, the numbers are randomly generated by a computer, but occasionally they are provided by the client.
- ❖ **How long is this going to take?**
 - Again, this will depend on the study. It is always best to give the respondent a realistic estimate. This will be supplied in the introductions on occasion, and should be covered in the project briefing. If it is not possible to give an estimate, or if the survey length could vary greatly, let the respondent know that. "The length of the survey varies, depending upon your answers" is a good way to deal with this situation.
- ❖ **What's in this for me?**

- On occasion, we conduct studies that offer an incentive for people that qualify and complete the survey. For studies where there is no incentive, a response such as “You have the opportunity to share your opinion” will usually work.
- ❖ **I’ve already done this survey.**
 - In this situation, always ask the respondent to describe the survey that they completed, and ask them to give examples of a few of the questions that they were asked. It is possible that another survey research firm is conducting a survey in the same area or that we are conducting an ongoing project that is completed in waves. If the respondent describes the survey that you are calling to complete, thank them for the time that they spent completing the survey before ending the call. If there is no punch for duplicate record, code this as a soft initial refusal. If the respondent describes a different survey, let them know that we are actually conducting a different study, and we would very much like to include their opinions.
- ❖ **I’m on the National Do Not Call List.**
 - The National Do Not Call List applies to telemarketers, not survey researchers, but many respondents believe that it does apply to the Market Research industry. The most important things to remember when speaking with a respondent in this situation are tact, patience and professionalism. Inform the respondent in a non-confrontational way that the law does not apply to survey researchers, because we do not sell anything. Remember that you are not only representing Burnett Research, but the entire Market Research industry, and you do not want to leave a respondent with a poor impression that would affect their willingness to participate in future studies.
- ❖ **Where can I get the results of the survey? / What will be done with my answers?**
 - Because our clients pay to have research studies conducted, the results of the survey belong solely to the client. What the client wishes to do with the results is entirely up to them. You may always assure the respondent that their responses are never looked at individually, and their name is never tied to their answers.
- ❖ **I don’t understand the question; can you explain it for me?/What does that mean?**
 - Should this ever happen, the best response is the truth! Tell the respondent something like “So that I do not bias your responses, I am not allowed to interpret the questions for you.” Or “Whatever that means to you. I am not allowed to interpret the questions, so that I do not bias your responses.”
 - ❖ **Didn’t you just ask me that question?**

- Don't be afraid to re-read questions to the respondent. Some questions may sound similar, but they are asking something slightly different. You can always say "The previous question was asking (insert previous question) and this question is asking (insert current question)"

Bernett Rules

- ❖ **The Rule of Three** – The Rule of Three can also be called training the respondent. For example, if the respondent were asked to rate their bank on 10 attributes, using the same scale for each attribute, the interviewer only needs to read the scale to the respondent for the first three attributes. As long as the respondent is trained, and is able to answer the question without hearing the scale, it may be dropped.
- ❖ **Probing Initial Don't Knows** – Any time a respondent answers, "I don't know" to a question, it should be probed. This encourages the respondent to really think about their answer, and also lets them know that "don't know" isn't an answer that is easily accepted. If the question is looking for a numerical answer, such as "How much do you spend on groceries in a two week period?", an appropriate probe to an answer of "don't know" would be something like "What would be your best guess?" or "Your best estimate/guess is fine". Probing "don't know" on a question that is not asking for a numerical response can be a bit tricky. Phrases such as "You may base this on anything that you may have seen, read or heard" or "To the best of your knowledge..." seem to work the best.
- ❖ **Reading Verbatim** – It is our number one goal to collect accurate information. Reading everything exact verbatim ensures that every respondent hears the same version of the survey. This is essential to the accuracy of our results. Always, Always, Always read exactly verbatim!
- ❖ **Breaking Off Surveys** – On occasion, respondents will qualify for a study, but may not know enough about the subject of the survey to give an informed opinion. As a result, a respondent may answer "don't know" to a large portion of the questions. If the respondent answers "don't know" to 1/3 or more of the questions in the survey, the survey should be broken off. In this situation, thank the respondent for their time, and let them know that is all the questions you have for them. To break a survey off type "quit". Usually it is best to ask a supervisor before doing this
- ❖ **Break-Offs in Classification** – If a respondent breaks off during the classification questions at the end of the survey, in most cases, the survey can still be kept. If this happens, call a supervisor over by raising your hand, and explain what happened. In most cases, a

supervisor, AND ONLY A SUPERVISOR, may refuse the rest of the survey out.

- ❖ **Other Specifies** – Other specifies must **always** be checked by a supervisor. Answers such as “all of them”, “none”, “don’t know”, etc. are not acceptable answers for an other specify. Answers in other specifies should match the list. For example, if the question were “What is your favorite fast food restaurant?” and the list looked like this:

1. McDonald’s
2. Wendy’s
3. Arby’s
4. Other (specify)

An acceptable other specify would be “Jack in the Box”. “I like to eat at Jack in the Box” would not be acceptable.

- ❖ **Knowing When to Snap** – You should snap for a supervisor if you have a respondent on the phone and you need a supervisor’s assistance. Please remember to put the respondent on hold before speaking to the supervisor. Always let a respondent know that you are going to put them on hold so that they do not think they have been disconnected and hang up. If you have a question, or need help and do not have a respondent on the phone, raise your hand and a sup will get to you ASAP.
- ❖ **Who to Complete Surveys with** – The respondent that completes the survey should always be a resident of the household that you have called. If the respondent is not a resident, ask to speak with someone who is. Also, be sure that you complete the survey with the respondent who qualified for the survey. You cannot switch respondents midsurvey.

Helpful Information

- If you need to ask a supervisor a question, be sure to mute your phone – before you mute your phone, let the respondent know that you are going to put them on hold so that they don’t think that you hung up on them.
- Don’t mute your phone at all unless you’re asking a supervisor a question.

- The shift may run later than usual depending on the day – we will try to give everyone as much advance notice as possible about what time it will end, but keep in mind you are scheduled until the end of shift, whatever that time may be.
- The shift may start later than your scheduled time depending on the day, but we won't call you in *before* your scheduled time (example: you are scheduled for 4:00pm M-F on Nightshift, but on one of those days we might call you in at 5:00pm instead of 4:00pm).
- Flexibility and adaptability are a crucial part of this job – things will change at the drop of a hat and our staffing needs for the day can change at any time – it might seem a bit hectic at times, but please keep in mind that we get new projects/instructions/changes lastminute and we will try and do whatever we can to please our clients and accommodate them, even if it means adjusting things without much notice, if any.
- If a supervisor tells you to switch to a job you haven't been briefed on, don't switch. Let them know you haven't been briefed and **DO NOT** dial on it.
- If you've already been briefed on a project, don't go into briefing again on it unless specially instructed to.
- Make sure your phone is turned on; it won't let you dial unless it is and it will say 'check hook status.'
- Make sure your other specifics are in the **SAME** format as the list.
- If you have a respondent on the line that is being inappropriate or razzing you, it is ok to let them know that you are going to disconnect the call and then disconnect the call. Be sure to alert a supervisor right away if you are going to do this/have done this so that they are aware of the situation.
- Control your respondents. When they ask you questions you should politely answer them, but jump right back into the survey and don't let them get off track. Always bring it back to the survey.
- You cannot give out personal information to respondents or take down respondent information for any personal reasons.

- If you come into a briefing that has already started, please sit down quietly – the briefer will wrap around for you later on to cover what you missed.
- Always let the survey kick someone out, even if you don't think that they will qualify. For example, if a respondent says something like 'I wouldn't qualify because I don't own a TV,' and the survey is about TV viewing, have them go through the first few questions and let the survey kick them out. You can say something like 'that's fine, we'd still like to go through a few quick questions with you anyway' and jump right into the survey.
- You are eligible for direct deposit if you're a Supervisor, Dialing Specialist, or have worked here for one year or more.
- If you ever hang up on someone, be sure to write down the respondent information and alert a supervisor **RIGHT AWAY**. We will call the respondent back to apologize.
- The computers in the break room are available for Internet use only.
See the Computer Policy for more information.
- Any special arrangements with scheduling, attendance, etc. **MUST** be approved through HR [or the shift manager if HR isn't available].
- If there is an issue on a job or something weird happening in the survey/on your calls, write down the respondent information (phone #, record #, or respondent number) and alert a supervisor.
- On gender questions you can say 'I am required to ask, are you male or female?' if you absolutely cannot determine gender by observation.
- If a message comes up saying something like 'Interview now over quota, accept anyway?' **ALWAYS** say **NO!**
- When dialing, you know to raise your hand or snap if you need someone. Some additional things we do include: peace sign=game related stuff, thumbs up=rate if we're announcing it.
- **NEVER OFFER** a supervisor. We don't want calls to escalate unless the respondent requests it.

- Don't get discouraged if you're on a job that is difficult to get completes on! Everyone else on the job is most likely struggling, and there will be easier surveys that you will dial on.
- When setting callbacks/appointments, you can use different criteria.
d=day, tom=tomorrow, m=minutes, h=hours, w=weeks, n=now
Here are some examples: +1d, tom -30m, +45m, +4w, fri 5:15pm, mon 8am, n, wed -1h
- Everyone has to work their full scheduled shifts if OT is approved, even if it puts you over 40 hours.
- You cannot leave the premises unless you're clocked out on lunch or completely logged out. The premises include the whole mall and the entire parking lot.
- If you come in for extra hours, please stay for 2+ hours. We will also only do briefings at the top of the hour at the shift start times (3pm/4pm m-f, 10am sat-sun) unless otherwise specified.
- If you are dialing and the call connects but it is just dead air, code RNA.
- Some common refusal rebuttals: We would really value your opinions, we're only interested in your opinions, we would really like to include your opinions in our study, this is a unique opportunity for your opinions to be represented, your opinions will help us in collecting valuable information.
- If you are reading a scale that has \$ in it, you must say the full amount in dollars at least once. Example:
 - 1 Under \$25,000
 - 2 \$25 to less than \$35,000
 - 3 \$35 to less than \$50,000
 - 4 \$50 to less than \$75,000
 - 5 Over \$75,000
 You must say 'thousand dollars' at least once - so you could say "under 25 thousand dollars, 25 to less than 35, 35 to less than 50" etc.)
- Pay close attention to the callback notes at the beginning of the call. If someone else had to type 'stop' and schedule a callback to complete the survey, it may start in the middle or wherever the previous interviewer left off. You must continue the survey

with same person who started it. The name will be in the callback notes.

- Don't log in prior to your start time unless you've been given permission.
- You may get monitored more than once per day, and it doesn't mean you're in trouble. It's a good thing! We like to give focused feedback and make sure that you're improving.
- When in doubt, ask a sup.

The Proper Way to Clean Up Your Station:

- Leave the computer on
- Turn off the headset and place the earphones on the hook (if there is a hook) - Put the keyboard on top of the tower
- Place the black folder upright, spine out between the computer tower and the station divider
- Clean up any garbage, stickies, pencils/pens, papers, etc. and make it look neat

Here is what your computer screen will look like when you log in and out - remember to only take break time if you've earned it:

Pocatello Station 25	Time worked today:
00:00	
Katie Chikonde started	Break Time Earned:
00:00 today at 3:00pm	Break
Time Used:	
00:00	
Last project worked:	Break Time Remaining:
00:00	
Louisville Combined Market Callback	Lunch Time Used:
00:00	

Select (P)roject, (B)reak, (L)unch or (Q)uit for the day:

HELPFUL THINGS YOU CAN USE WHILE YOU'RE IN A SURVEY:

Command	Result
Stop	Will schedule a callback for a later time
Quit	Will break off or end a call, a list of reasons for the break off will be displayed
Off	Will break off or end a call, a list of reasons for the break off will be displayed
?	Brings up a list of all questions that have been answered
??	Brings up a list of all questions that have been answered and their answer
<	Will allow you to back up one question
<<	Will take you back to the introduction
<#	Inserting the question number after the < will take you back to a specific question (e.g. <q1)
>	Will allow you to skip forward one question
>>	After backing up, this will allow you to return to the last question that was answered
>#	Inserting the question number after the > will take you forward to a specific question, after backing up, if it has already been answered (e.g. >q5)
+	Will allow you to scroll forward on lists that are too long to fit on one screen
-	Will allow you to scroll back on lists that are too long to fit on one screen
!#	On a multi-punch list if you have a miss-punch and want to remove a selection type ! followed by the number you want removed (e.g. 1 2 3 4 !1 will remove 1 from the selection)
??*	Will allow you to view what the program is showing for all loops
*redial	Will allow you to reconnect the call
*comment	Will show you all callback notes/comments and let you add more

Extra Information:

- Please avoid spraying perfume in the building. It can aggravate allergies, and we want to keep everyone safe and happy.
- When verifying information and phonetics need to be used, you must use the International Phonetic Alphabet that is in the black folders

- For race/ethnicity other specifies:

List responses are ideal, but if someone gives an answer that is not on the list (e.g. Hispanic, Mixed Race, Human, Cat People, whatever..) this should be typed into the other specify as long as there is an other specify available for use.

We need to clarify for a listed response if a flippant answer like "human" is given, or if it seems like a respondent may have mistaken nationality for ethnicity and replied with "Irish" or "American" or something along those lines. If the respondent persists with the same flippant response after we clarify though, we would like to see that response typed into the other specify.

If the respondent has heard the list, and answers with an unlisted race or ethnicity that is clearly something that a reasonable person might self-identify as (like Hispanic or Mixed), do not try to clarify for a listed response. In those cases, we would like to see the response given entered into the other specify without clarifying.

The race vs. ethnicity debate can be very subjective, so everyone should use common sense and do the best they can to accurately record a response here.

HOW TO RESPOND TO QUESTIONS ABOUT THE DO NOT CALL LIST

The National Do Not Call List applies to telemarketers, not survey researchers, but many respondents believe that it does apply to the Market Research industry. The most important things to remember when speaking with a respondent in this situation are tact, patience and professionalism. Inform the respondent in a nonconfrontational way that the law does not apply to survey researchers because we do not sell anything. Remember that you are not only representing Bennett Research, but also our clients and the Market Research industry as a whole. You do not want to leave a respondent with a poor impression that would affect their willingness to participate in future studies.

- ✓ **“There’s a law that says you can’t call me.”** ○ MRA (Marketing Research Association) Response = Most types of opinion and marketing research studies are exempt under the law that congress recently

passed. That law was passed to regulate the activities of the telemarketing industry. This is a legitimate research call. Your opinions count!

- The calls made by marketing research firms are not regulated or prohibited by the Federal Trade Commission (FTC).
 - As an exempt organization, we are not required to scrub our call lists against the National Do Not Call Registry.
- ✓ **“I’m on a do-not-call list. I’m going to report you.”** ○ MRA Response = Congress has exempted marketing research studies from the laws that regulate telemarketers because they recognize the value of your opinions. Your opinions are important to us.
- My call is PURE RESEARCH. Only telemarketing companies are required by law to create a “do not call” list and to enforce a “do not call” policy. We are a marketing research firm, not a telemarketing company.
- ✓ **“What’s the difference between you and a telemarketer?”** ○ MRA Response = As researchers, we simply want to ask your opinions about products and services you use. Telemarketers attempt to sell you something.
- ✓ **“Are you going to sell me something?”** ○ MRA Response = No. I am simply interested in your opinions. Legitimate opinion and marketing researchers will never try to sell you anything.
- We are not selling anything.
- ✓ **“Take my name off of your call list.”** ○ MRA Response = I understand how the law might be confusing, but research calls are not included in the regulations that apply to telemarketing calls. However, if you do not wish to participate in our legitimate research project, we respect your right to do that.
- Bennett Response = I can take care of that for you, but we would still really value your opinions if you would be willing to participate in our research study.

Probation Policy

Bennett Research hires all interviewers on a probationary status. The probationary period will consist of a two day initial training period, along with thirty days with a minimum of forty hours training period. **During the**

probationary period, the employee's productivity, attendance and skill development will be monitored. The two day initial training period is paid for at minimum wage, and the remaining portion of the probationary period, on-the-phone time is paid based on productivity.

Employment may be terminated by Bennett Research at any time during the probationary period if the company does not feel that the employee is making satisfactory progress toward the development of the skills required to perform the job at a satisfactory level.

At the end of the thirty-day probationary period and after forty hours of work, the employee will be placed on a regular, part-time status to work as scheduled.

If the employee's performance drops below acceptable levels, at any point in the future, the employee may either be placed on probation again or their employment may be terminated.

Monitoring

Bennett Research frequently monitors the conversations between interviewers and respondents. This monitoring is done for training and quality control purposes.

Quitting or Termination of Employment

Bennett Research expects the courtesy of at least one full week notice when an interviewer intends to quit. If an interviewer fails to extend this courtesy, there will be two consequences:

- 1) They will be paid \$8.00/hour for any unpaid services.
- 2) They may not be eligible to be hired to work for Bennett Research in the future.

If it is determined that a Bennett Research interviewer's employment should be terminated for less than satisfactory performance, they will be dismissed and receive \$8.00/hour for any unpaid services on their final paycheck.

Scheduling & Attendance Policy

We make commitments to our clients based on the commitments our staff makes to us. When any staff member does not show up for a scheduled shift, we stand the risk of not completing our work on time. We take our commitments seriously, and we expect the same of our staff members. Those who cannot make and keep commitments will not be eligible to work

with us. The scheduling week starts on Saturday and ends on Friday. Weekly scheduling is the sole responsibility of each interviewer. The interviewer is expected to make a permanent schedule when they are hired. Each interviewer is expected to work one of the following scheduling options:

- ☎ Work three shifts during the week (Monday through Friday) and one weekend shift.
- ☎ Work weekends only. You may come in for extra hours during the week if there is availability.
- ☎ Work Monday through Friday (made available on a case-by-case basis).

The schedule gets posted on Thursday afternoon, so if a staff member needs to take time off or change their schedule the form must be signed and turned in by Wednesday. If there are any conflicts in the assigned schedule, those conflicts must be resolved on Friday. We make our commitments to our clients based on the posted schedule and changes are difficult for everyone.

Your Responsibility as an Employee: Once the schedule is posted, you are required to work the shifts you are scheduled. When each employee signs for their check, they are also responsible for checking their schedule.

Daily Shift Update Line: The Shift Update Line is 232-8925. Employees are expected to call this number on the days they are scheduled to find out the specific times they are scheduled. It is possible that some or no employees will be asked to come in on certain days, depending on the needs of our clients and our project load. For these reasons, please note the number of hours you work from week to week may vary.

Absence with a phone call: Staff members who are going to be late, or for some reason are going to miss a shift need to call 232-8890. Be sure to follow the menus (“You are currently an interviewer”; “You need to report an absence” are the prompts you would follow) to report an absence and be sure to *state your name* and *explain the nature* of your attendance issue. If the absence is due to illness, the illness lasts more than one day, and the employee provides medical documentation with the necessity to miss work, the entire block of days missed due to illness will be counted as one absence. The interviewer is required to call in each day during a sick period. If the absence is due to some other reason (car trouble, etc.) the employee is expected to make arrangements to be at work on the next scheduled day. **During the probationary period employees should not have any absences.** Once the probationary period is over, no more than three absences will be allowed in a 90-day period. If a fourth absence

occurs, the person's employment may be terminated. If an employee has attendance problems, the employee is strongly encouraged to work entire shifts they are not scheduled for, as this will be taken into consideration when determining whether or not to terminate their employment.

Other Attendance Issues: Late for Shift/Leaves Early: If an employee is more than fifteen (15) minutes late for their shift or leaves early, this attendance problem will automatically be considered an absence. Any staff member who is late for their shift, but is less than fifteen (15) minutes late for their shift, will incur warnings for each infraction, until their employment is either suspended or terminated.

Late from Break: Any employee who has used more break time than allotted, but is less than ten (10) minutes late from break, will incur warnings for each infraction, until their employment is either suspended or terminated. If, at any time, an employee has gone ten (10) minutes or more over their allotted break time, this attendance problem will automatically cause the employee's employment to be suspended or terminated.

Late from Lunch: Any employee who has used more lunch time than allotted will incur warnings for each infraction, until their employment is either suspended or terminated.

No Call / No Show: The employment of any staff member who misses a scheduled shift and fails to contact a supervisor before the shift will be considered as quit without notice. Further, all unpaid hours will be paid at \$8.00/hour and the person may not be eligible for rehire.

Appendix H

Journal of Dental Hygiene Author Guidelines

See next page

Author Guidelines

Editorial Staff

Editor-in-Chief Rebecca Wilder, RDH, MS	Administrative Editor John Iwanski	Staff Editor Josh Snyder	Editor Emeritus Mary Alice Gaston, RDH, MS
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Statement of Purpose

The Journal of Dental Hygiene (JDH) is the refereed, scientific publication of the American Dental Hygienists' Association (ADHA). It promotes the publication of original creative work related to dental hygiene research, education and evidencebased practice. The JDH supports the development and dissemination of a unique dental hygiene body of knowledge through scientific inquiry in basic, behavioral, clinical and translational research.

Author Guidelines

Starting with the Summer 2004 issue, the JDH has been published online. The online format provides searching capabilities to JDH readers by establishing a link to dental hygiene research indexed through the National Library of Medicine and PubMed.

Manuscript Requirements

Manuscripts are evaluated for quality, depth and significance of research, comprehensive evaluation of the available literature, and the expertise of the author(s) in the given subject. Content must provide new information and be of general importance to dental hygiene. The JDH discourages submitting more than one article on related aspects of the same research. If multiple papers are submitted from the same project, significant differences in the papers must be evident.

Originality

Manuscripts must be original, unpublished, owned by the author and not submitted elsewhere. Authors are responsible for obtaining permission to use any materials (tables, charts, photographs, etc.) that are owned by others. Written permission to reprint material must be secured from the copyright owner and sent to ADHA when the manuscript is accepted for publication. The letter requesting permission must specifically state the original source, using wording stipulated by the grantor.

Manuscript Categories

The JDH publishes original scientific investigations, literature reviews, theoretical articles, brief reports and special feature articles related to dental hygiene. Specific categories of articles are as follows: Original Research Reports, Literature Reviews, Short Reports, Critical Issues in Dental Hygiene, and Innovations in Education and Technology. All submissions are reviewed by the editor and by members of the Editorial Review Board.

Original Research Reports – Limited to 4,000 words (excluding cover page, abstract, references and tables/figures).

Include reports of basic, behavioral, clinical and translational studies that provide new information, applications or theoretical developments. Original Research Reports include an Abstract, Introduction (including the review of the literature and ending

with a statement of the study purpose), Methods and Materials, Results, Discussion, and Conclusion.

Abstract: Approximately 250 words. Use the headings "Purpose" (purpose), "Methods" (design, subjects, procedures, measurements), "Results" (principal findings) and "Conclusion (i.e. Major conclusions)." The abstract must be able to stand alone. References should therefore be avoided.

Text: The body of the manuscript should be divided into sections preceded by the appropriate subheading. Major subheadings should be in capital letters at the left-hand margin. Secondary subheads should appear at the left-hand margin and be typed in upper and lower case and in bold face.

Introduction (including the literature review): Cite a variety of relevant studies that relate to the need for the current study and its significance. References should be as current as possible, unless a hallmark study is included. Compare findings of previous studies, clearly indicating all sources of concepts and data. When a source is directly quoted, use quotation marks. However, use of quotation marks should be limited. End this section with a clear statement of the purpose of the study, hypothesis or research objectives.

Methods and Materials: Describe the research design (e.g. randomized controlled trial) and procedures (e.g. IRB approval, target population, inclusion/exclusion criteria, recruitment, informed consent, variables to be tested, instruments, equipment, procedures and method of data analysis). Specify the measurements and statistical tests used as well as related levels of significance. Furthermore, assure an adherence to all pertinent federal and state regulations concerning the protection of the rights and welfare of all human and animal subjects.

Results: Summarize all relevant data and study findings. Do not repeat in the text the data reported in tables and figures verbatim, but do refer to the data and emphasize important findings (e.g. Table 1 shows that most of the subjects were African American and between the ages of 12 and 16).

Discussion: Evaluate and interpret the findings. Compare them with those of other related studies.

Discuss how they relate to dental hygiene practice, profession, education or research. Include overall health promotion and disease prevention, clinical and primary care for individuals and groups and basic and applied science. Discuss study limitations; implications for dental hygiene practice, education, and research; and recommendations or plans for further study.

Conclusion: State the conclusions, theories, or implications that may be drawn from the study. This section should be one to two paragraphs or can be listed as bulleted points.

Literature Reviews – Limited to 3,000 words (excluding cover page, abstract, references and tables/figures).

A presentation of relevant and primary published material on a specific topic constitutes a comprehensive literature review. Such a review includes a summary and critique of the current status of the topic, and the aspects requiring further study.

Abstract: Literature reviews begin with a nonstructured abstract — a brief statement of purpose, content summary, conclusions and recommendations.

Short Reports – Limited to no more than 2,000 words (excluding cover page, abstract, references and tables/figures). Illustrations should be limited to a total of no more than two (e.g. two figures, two tables, or one figure and one table).

The JDH publishes short reports related to dental hygiene. Short reports are limited in scope and should begin with a brief, non-structured abstract that describes the topic.

Text: A concise introduction (which includes a literature review), detailed description of the topic or activity, and discussion, conclusion and recommendations must also be included. References are necessary to support the rationale and methods presented.

A short report may describe a clinical case study, an educational innovation, a research method, a concept or theory, or other current topics.

Clinical Case Study: A report that describes a unique aspect of patient care not previously documented in the literature. Such reports usually focus on a single patient or groups of patients with similar conditions. Suitable topics include, but are not limited to, innovative preventive methods or programs, educational methods or approaches, health promotion interventions, unique clinical conditions, or pathologies and ethical issues.

Theoretical Manuscript: A report that provides a well-supported explanation for natural phenomena that clarify a set of interrelated concepts, definitions, or propositions about dental hygiene care or processes. Such reports provide new knowledge, insight, or interpretation; and discussion, conclusions, and recommendations. These reports begin with a non-structured abstract. At least four keywords are listed at the end of the abstract.

Critical Issues in Dental Hygiene – Limited to 4,000 words (excluding cover page, abstract, references and tables/figures).

The purpose of this category is to highlight challenges and opportunities pertinent to the future directions of the profession of dental hygiene.

Text: Articles in this category should follow the basic structure for text outlined for Original Research Reports.

Innovations in Education and Technology – Limited to 4,000 words (excluding cover page, abstract, references and tables/figures).

The purpose of this category is to feature short reports of innovative teaching applications and techniques as well as new technologies available for increased communication and learning in dental hygiene education.

Text: Articles in this category should follow the basic structure for text outlined for Original Research Reports.

Manuscript Submission

Authors submitting a manuscript to the JDH should utilize the BenchPress system, located at <http://submit-jdh.adha.org/>. Specific instructions

for submission will be outlined on the BenchPress website. There is no charge for submission. Receipt of submission will be acknowledged by email.

All papers are reviewed by the editor and assigned to three reviewers. The editor reserves the right to return, without review, any manuscript that does not meet JDH criteria for formal review.

The review process takes approximately ten to twelve weeks, depending on the need for authors to make revisions. All reviewer comments, as well as notification of acceptance or rejection, are submitted to the corresponding author. For any questions about the manuscript submission process, contact Staff Editor Josh Snyder at josh@sadha.net.

Manuscript Preparation and Style

Standard usage of the English language is expected. Manuscripts should contain one-inch margins, double spacing and Verdana 10 pt. font. All pages should be numbered, beginning with title page and ending with references.

Title Page: A title page must include: 1) title of article, which should be concise yet informative, 2) first name, middle initial and last name of each author, with academic credentials, 3) each author or coauthor's job title, department and institution or place of employment (if other than academic), 4) disclaimers/disclosures, if any, 5) name, address, all contact information of author responsible for correspondence about the manuscript, and 6) funding sources for the project, equipment, drugs, etc.

Blinding Manuscripts: All information that can identify the author(s) (such as author name, institutional affiliation, IRB approval, acknowledgements, etc.) should be included in the title page. Manuscripts must be blinded and any of the above identifying information should be removed from the text for the review process. If a manuscript is accepted for publication, this information can be added back into the manuscript for publication.

Keywords: When submitting a manuscript, please choose four to six keywords from the list provided by BenchPress. These key words will be

used for indexing purposes during the review process. If a manuscript is accepted for publication, a more detailed list of key words can be provided.

National Dental Hygiene Research Agenda: Identify how the study supports a specific topic area and related objective from the National Dental Hygiene Research Agenda (NDHRA). For example: This study supports the objective: Assess strategies for effective communication between the dental hygienist and the client, under Health Promotion/Disease Prevention. NDHRA statements can be found at: http://www.adha.org/downloads/Research_agenda%20-ADHA_Final_Report.pdf

Author Biography: Please include a brief biographical sketch of each author at the end of the cover letter. List names, credentials, titles, affiliations and locations. Example: "Mary B. Jones, RDH, MA, is assistant professor and clinic director, Department of Dental Hygiene; Bill R. Smith, DDS, MEd, is associate professor, Department of Pediatric Dentistry. Both are at the University of Minnesota in Minneapolis."

Disclosure: Authors are obligated to identify any actual or potential conflict of interest in publishing the manuscript. This includes association with a company that produces, distributes or markets any products mentioned, or with funding provided to help prepare the manuscript. Disclosures should appear at the beginning of the manuscript.

Acknowledgments: Be brief and straightforward. Example: "The authors thank Jane Smith, RDH, for her assistance in developing the survey instrument." Anyone making a substantial contribution to the conduct of the research or the resulting report should be appropriately credited as an author.

Acronyms: Spell out abbreviations and acronyms on first mention followed by the abbreviation in parentheses. Limit the overall use of abbreviations in the text.

Medication, Product or Device Names: Throughout the text, use generic, nonproprietary names for medications, products and devices. At the first mention, state the generic name followed in parentheses by the trade name with the

register® or trademark™ symbol and the manufacturer's name and city/state.

Example: Chlorhexidine (Peridex®; 3M ESPE, Minneapolis, MN) coded or abbreviated as CHX

Visual Aids

Do not embed tables and figures in the body of the text. These should be provided as separate files, per BenchPress instruction. All tables and figures must be blinded for the review process.

Tables: All tables must have a title that is brief but self-explanatory. Readers should not have to refer to the text to understand a table. The main body of text should not overly depend on the tables. Indicate explanatory notes to items in the table with reference marks (*, #). Cite each table in the text in the order in which it is to appear. Identify tables with Roman Numerals (example: Table I).

Figures: Includes charts, graphs, photographs and artwork. All should include a brief caption and use Arabic numerals (example: Figure 1). Cite each figure in the text in the order in which it will appear.

Photographs: High-resolution digital photos are preferred, with a resolution of at least 300 pixels per inch.

References

The JDH follows National Library of Medicine (NLM) citation style. Please refer to <http://www.wsulibs.wsu.edu/quickguides/nlm> for specifics.

Each reference should be numbered in the order it first appears in the text. If a source is cited more than once, the first reference number it is given is used throughout. Each reference in the text should be in superscript format. Continuous references should be connected with a dash (example: 7,8-10). ADHA editorial staff does not assume responsibility for verifying references. For more information and detailed examples, please visit the International Committee of Medical Journal Editors at www.icmje.org. Please ensure that every reference cited in the text is also present in the reference list and vice versa. Citation of a reference as "in press" implies that the item has been accepted for publication.

Please list all authors. Capitalize only the first word of the journal article title, and use the NLM journal abbreviations found at www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=journals. If more than six authors are listed, list the first three followed by et al.

Examples of reference citations:

Example Article in a Journal: Michalowicz BS, Hodges JS, DiAngelis AJ, et al. Treatment of periodontal disease and the risk of preterm birth. *N Engl J Med*. 2006;355(18):1885-1894.

Smith MA, Jones BB. Curette sharpness: a literature review. *J Dent Hyg*. 1996;77:382-390.

Book citations: Spolarich AE, Gurenlian JR. Druginduced adverse oral events. In: Daniel SJ, Harfst SA, Wilder RS, ed. *Mosby's Dental Hygiene: Concepts, Cases and Competencies*. 2nd ed. St. Louis, MO. Mosby/Elsevier Publishing. 2008. p. 259-276.

Internet citations: NLM requires the standard elements of a citation for an Internet resource, with a few modifications. The main elements required:

Polgreen PM, Diekema DJ, Vandenberg J, et al. Risk factors for groin wound infection after femoral artery catheterization: a case-control study. *Infect Control Hosp Epidemiol* [Internet]. 2006 Jan [cited 2007 Jan 5];27(1):34-7. Available from: <http://www.journals.uchicago.edu/ICHE/journal/issues/v27n1/2004069/2004069.web.pdf>

Poole KE, Compston JE. Osteoporosis and its management. *BMJ* [Internet]. 2006 Dec 16 [cited 2007 Jan 4];333(7581):1251-6. Available from: <http://www.bmj.com/cgi/reprint/333/7581/1251?maxtoshow=&HITS=10&hits=10&RESULTFORM AT=&andorexactfulltext=and&searchid=1&FIRST INDEX=0&sortspec=relevance&volume=333&firstpage=1251&resourcetype=HWCIT>

Publication

Accepted manuscripts are edited and sent to the principal author for approval of technical accuracy. Editors reserve the right to edit or rewrite copy to fit the style requirements of the JDH. All authors

must sign agreements that permit the article to be published and to transfer copyright.

For further information, please contact the JDH by phone at 312-440-8900 or by e-mail at JoshS@adha.net.

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Example: Additionally, the efforts of the office administrator, with regard to accommodating schedules and financing, could have been a factor (Vaccari, personal communication, April 2008).

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The ADHA owns the copyright for all editorial content published in the JDH. An author agreement form, requiring copyright transfer from authors, signed by each author, must be signed before the manuscript is published in the JDH. Manuscripts without a signed author agreement form will not be published until the JDH's Editorial office receives a valid, executed author agreement form from each author. If the manuscript is rejected by the JDH, all copyrights in the manuscript will be retained by the author(s). All accepted manuscripts and their accompanying illustrations become the permanent property of the ADHA and may not be published elsewhere in full or in part, in print or electronically, without written permission from the ADHA's Communications Division.

NIH Open Access Policy

National Institutes of Health Public Access Policy: Authors' Responsibilities – The National Institutes of Health (NIH) Public Access Policy implemented a law passed in December 2007 that affects authors who receive funding from the NIH. As of April 7, 2008, all peer-reviewed articles that arise, in whole or in part, from direct costs funded by NIH, or from NIH staff, that are accepted for publication by a peer-reviewed journal—including JDH—must be deposited with the National Library of Medicine's PubMed Central, in the form of a copy of the manuscript's final version on its acceptance. Please see the following NIH site regarding questions that authors may have about the policy: <http://publicaccess.nih.gov>.

For JDH papers, when the author deposits the accepted manuscript with PubMed Central, he or she should specify that the manuscript is not to be made available until 12 months after publication (not acceptance). Thereby, the manuscripts will be made publicly available by PubMed Central at the same time that the JDH makes its full text available to the public free of charge.

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**PERCEPTIONS OF ORAL CANCER SCREENING COMPARED TO OTHER
CANCER SCREENINGS: A PILOT STUDY**

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Abstract

Purpose: The purpose of this pilot study was to compare public perceptions of Idaho adults regarding oral cancer (OC) screening with other common cancer screenings including breast cancer (BC), prostate cancer (PC), and colon cancer (CC) screenings.

Methods: This study utilized a non-probability, purposive sample (N=100) of adults residing in Idaho. A self-designed, validated interview-administered questionnaire was administered by an experienced data collection service using computer-assisted telephone interview (CATI) software to assess consumer perceptions about cancer screenings. Data were analyzed using descriptive statistics, frequencies, and Pearson's Chi-Square tests.

Results: Participants were predominantly white (90%) with a mean age of 52.7 years and some post-high school education (80%). The majority perceived benefits of each cancer screening as very helpful: OC screening (60%), (b) BC screening (79.2% females), (c) PC screening (63.8% males), and (d) CC screening and reported perceiving no risks regarding OC (80%), BC (60.4%), PC (66%) screening. Only 11% reported fear of finding cancer with OC screening. The findings supported significant associations ($p < 0.05$) between consumer perceptions of cost and time as barriers to all of the selected cancer screenings.

Conclusion: This pilot study identified associations between consumer perceptions of OC screening when compared with BC, PC, and CC. Concerns about cost and time for cancer screenings may reflect low consumer awareness regarding differences between OC and other cancer screenings. Future studies including larger samples representing a more diverse population are recommended to further explore the basis of participants' perceptions and to identify ways to minimize barriers to cancer screening.

Keywords: oral cancers; cancer screening; mouth neoplasms, prevention and control; attitudes to health

This study supports the ADHA National Dental Hygiene Research Agenda area, Health Promotion and Disease Prevention: Investigate the effectiveness of oral self-care behaviors that prevent or reduce oral diseases among all age, social and cultural groups.

Introduction

Oral cancer (OC) is regarded as a rarely occurring disease; however, according to the National Cancer Institute (NCI), over 300,000 men and women are living with a prior diagnosis of cancer of the oral cavity and pharynx in the United States (US).¹

Additionally, the American Cancer Society (ACS) estimated over 48,000 new cases would be diagnosed in 2016 alone.² Approximately one in 100 men and women will be diagnosed with oral and pharyngeal cancer at some point in their lifetimes.¹ OC has a high five-year survival rate (83.3%) when detected early in a localized stage.

Unfortunately, most cases are detected after regional or distant metastasis has occurred, when the survival rate can drop by more than half.¹

Although some evidence regarding the efficacy of the OC screening in reducing mortality exists, it is inadequate.³⁻⁴ An expert panel convened by the American Dental Association (ADA) to develop evidence-based clinical recommendations for OC screening concluded, while community-based screenings may not reduce the mortality rate of OC in the general population, such screenings may reduce the mortality rate in high risk individuals. Further, the ADA panel concluded that community-based screenings may result in the detection of OC in the earlier stages of the disease.⁵ NCI data indicate, when detected early while still in a localized stage, OC has an 83.3% five-year survival rate. However, the survival rate falls to 63.3% once the cancer has spread to regional lymph nodes, and drops further to 38% with metastasis.¹ Accordingly, the ADA guidelines supported OC screening as part of the visual and tactile oral examination for both community-based and dental office settings, noting that clinicians should also consider patient history and assess OC risk.⁵ These evidence-based clinical guidelines

identified potential risks and benefits of OC screenings, including the psychological risk of false positives creating fear among patients, yet concluded that the benefit of early detection of treatable malignant lesions outweighed the risk of potential harms. In contrast, recommendations from the United States Preventive Services Task Force (USPSTF) indicate insufficient evidence exists to recommend for or against OC screening in asymptomatic adults in the primary care setting, despite the benefits of early detection.⁶

Similarly to OC, the risk of psychological harms was identified by the USPSTF (2016) as a risk of breast cancer (BC) screening.⁷ This review noted patients frequently report adverse experiences, including pain during screening tests, anxiety about the procedure, and apprehension about results. Psychosocial barriers identified regarding colon cancer (CC) screening also have included fear of the procedure, concern regarding preparation for the exam, and fear and apprehension of results.⁸⁻⁹ Despite the risk for these fears and concerns, screenings for breast and colon cancer continue to be recommended by the USPSTF.^{7,10} None of the studies included in the latest review of evidence from the USPSTF for prostate cancer (PC) screening provided information on potential psychological harms.¹¹ The USPSTF recommendation for PC screening states that research does not currently support the benefits of PC screening over potential harms; however, the NCI attributes the high five-year relative survival rate for PC to its early detection as a result of screening.¹²

In addition to psychosocial risks, cost has been consistently identified as a barrier to screening utilization among consumers.^{8,13} Other attributes of the screenings, including time to perform the screening, efficacy, and the screening process itself, also have been

identified. Factors such as preparation prior to screening, discomfort and pain, and the risk of complications have been cited as significant determinants of choice when deciding whether or not to have a screening performed.⁸⁻⁹

USPSTF screening recommendations for various cancers differ based on research available at the time of the recommendation. For many cancers, the current ACS screening guidelines meet or exceed those of the USPSTF for average-risk individuals, particularly regarding screenings for BC and CC.^{7,10,14} The ACS recommendations for OC screening also exceed those of the USPSTF. The ACS recommends, in addition to the regular exam by a dental professional, physicians also examine the mouth and throat as part of a routine checkup, contrary to USPSTF recommendations against routine OC screening by primary care providers.^{6,15} While the USPSTF recommendations regarding OC screenings in the primary care setting do not apply to the dental setting, seemingly conflicting recommendations for screening from the ADA, the ACS, and the USPSTF may be confusing for the general public and oral health professionals, and result in fewer people being screened. Although most oral healthcare providers report regularly performing OC screenings, approximately half do not perform head and neck palpations and, therefore, are not performing a comprehensive exam.¹⁶⁻¹⁸

Some evidence indicates OC awareness is lacking among consumers, as multiple studies show low overall knowledge of OC, OC risk factors, and clinical signs in populations throughout the US and other countries. Previous studies have indicated consumers were largely unaware of the benefits of OC screenings, many were unaware that their oral healthcare providers screen for OC, and most reported never having received an OC screening.¹⁹⁻²⁴ This low awareness may result from lack of

communication from oral healthcare providers, as only half of those who report performing regular OC screenings report discussing the screening with their patients.¹⁷

Public perceptions of the risks, benefits, and barriers to OC screening in relation to other cancer screenings is limited. Therefore, the purpose of this pilot study was to explore perceptions of Idaho adults regarding OC screenings as compared to other common cancer screenings including BC screenings, PC screenings, and CC screenings. The study was designed to test the following null hypotheses: 1) There is no association between Idaho adults' perceptions of OC screening and BC screening; 2) there is no association between Idaho adults' perceptions of OC screening and PC screening; and, 3) there is no association between Idaho adults' perceptions of OC screening and CC screening.

Methods and Materials

This quantitative pilot study was conducted using computer-assisted telephone interview software (CATI) due to a higher likelihood of an adequate response rate versus questionnaires distributed through an online format.²⁵ An experienced survey firm was employed to conduct the telephone survey.

A non-probability, purposive sample of Idaho adults (N=100) was utilized. The sample size for this pilot study was determined based on feasibility and cost. The random sample was purchased from a large sampling supplier. Inclusion criteria consisted of adults aged 18 years and older residing in Idaho. Exclusion criteria were non-English speaking individuals, those with a history of OC, and those respondents with cellular telephone numbers originating in Idaho but living out-of-state.

The study protocol was approved by the sponsoring institution's Human Subjects Committee based on expedited review (IRB-FY2015-86). At the onset of the telephone call to each participant, an introduction stating the purpose of the study and participants' rights was provided, and verbal informed consent was obtained prior to administering the survey. Anonymity was maintained as no personally identifiable information was gathered in the interview or stored with the responses to the interview questions.

The instrument was a self-designed, interview-administered questionnaire. A Content Validity Index was used to establish validity of the questionnaire using five experts in the subject of OC and/or health screenings. Questions that were deemed not relevant or only somewhat relevant by a majority of the experts were eliminated or revised. Each of the questions in the final instrument were deemed relevant or very relevant by the experts. Pilot testing then was conducted on the final instrument with a convenience sample (N=5) that met the inclusion and exclusion criteria. The survey was administered twice to these subjects, one week apart, to establish test-retest reliability, yielding agreement of 95%.

Trained, experienced interviewers were briefed by a supervisor regarding the project content prior to implementation using information supplied by the primary investigator. The interview-administered questionnaire was programmed into the CATI software and tested by the interviewers prior to implementation to ensure that correct data were collected and assess whether the instrument was user-friendly for interviewers, and minor modifications were made and approved by the IRB. Landline numbers were programmed through a predictive dialer, which filtered the purchased sample and pre-coded numbers associated with faxes, computer phones, no-answers, etc. (any calls that

were not “live”) before sending the live calls to the interviewers to administer the survey. Cellular telephone numbers from the sample do not use the predictive dialer, and were dialed by each interviewer on a one-to-one basis per federal regulations. Participants’ responses to the survey required approximately five to ten minutes.

Demographic data were analyzed using descriptive statistics and frequencies. The categorical data from closed-ended questions were analyzed using Pearson’s Chi-Square test for association to examine distribution differences and relationships between variables. To minimize the likelihood of a Type I error due to multiple comparisons analyzed in each set of tests (i.e., OC compared to BC, CC, and PC), a Bonferroni strategy was used to maintain the family-wise error rate of 0.05, calculated by dividing the 0.05 error rate by the number of tests, in this case four, which indicated that an alpha level of .0125 should be used for statistical significance for each chi-square test within the sets. A phi coefficient was used to determine the magnitude of effect size, or strength of significant associations, identified in the crosstabs according to the following scale: .1 weak, .3 moderate, .5 strong.²⁶

Results

The pilot study sample included a total of 100 subjects, 47 males and 53 females. Participants were predominantly white (90%) and had a mean age of 52.7 years with a median age of 58 years. The majority of participants had some post-high school education (n=80) with most having completed a certificate (n=7) or degree (n=48) (Table I).

Table II summarizes participants’ responses regarding OC and other cancer screenings is found in Table II. Over half of the respondents reported ever having each of

the following cancer screenings: (a) an OC screening (54% of all participants), (b) BC screening (94.3% of females), (c) PC screening (56% of males), and (d) CC screening (59.6% of all participants). The majority of respondents reported believing screenings were very helpful: (a) OC screening (60% of all participants), (b) BC screening (79.2% of females), (c) PC screening (63.8% of males), and (d) CC screening (84% of all participants). The majority of participants reported having no fears or concerns regarding screenings for OC (79% of all participants), BC (60.4% of females), or PC (66% of males); however, only 35% of all participants reported no fears or concerns regarding CC screenings. The most frequently reported barrier to any screening was cost: (a) OC screening (57% of all participants), (b) BC screening (51% of females), (c) PC screening (40.4%), and CC screening (61% of all participants).

Data regarding associations between participants' responses regarding OC screenings and other cancer screenings are found in Table III. Crosstabs were calculated by gender of respondents because some of the cancer screenings included in the chi-square analyses only applied to one gender, BC for females and PC for males. Although CC screenings are indicated for both groups, analyses were conducted by gender to maintain equality in sample size and statistical power. Crosstabs regarding ever having OC or other cancer screenings indicated the only statistically significant association was between OC and PC screenings ($p=.007$) with the phi coefficient indicating a moderate to large effect size ($\phi=.391$). A statistically significant association regarding participants' opinions on whether or not screenings were helpful was found between OC and BC screenings ($p=.006$, $\phi=.484$) and between OC and CC screenings for both females ($p=0.010$, $\phi=.563$) and males ($p=.000$, $\phi=.725$) with a large effect size.

Further analysis examined associations between OC and other cancer screenings regarding participants' fears and concerns (Table III). Fear of finding cancer was significantly associated with a large effect size when comparing OC and BC ($p=.000$, $\phi=.564$), OC and PC ($p=.001$, $\phi=.474$), and OC and CC for females ($p=.000$, $\phi=.605$); for males, OC and CC were significantly associated ($p=.004$) with a moderate to large effect size ($\phi=.422$). Fear of pain was significant only when comparing OC and CC screenings for females ($p=.001$, $\phi=.438$). Responses indicating no fears or concerns were only significant when comparing OC and BC ($p=.003$) with a moderate to large effect size ($\phi=.413$).

Crosstabs between OC and other cancer screenings were also examined in relation to participants' responses regarding barriers to screenings (Table III). Cost of cancer screenings was significantly associated with a large effect size when comparing OC and BC ($p=.000$, $\phi=.492$), OC and PC ($p=.000$, $\phi=.531$), and OC and CC for females ($p=.000$, $\phi=.579$) and males ($p=.001$, $\phi=.500$). When comparing time as a barrier to cancer screenings, significant associations with a large effect size were found between OC and PC ($p=.000$, $\phi=.674$) and OC and CC for males only ($p=.000$, $\phi=.528$); a significant association also was found when comparing OC and CC for females ($p=.006$) with a moderate effect size ($\phi=.377$). Other barriers reported by respondents were statistically significant with a large effect size for OC and CC for females ($p=.001$, $\phi=.473$) and males ($p=.000$, $\phi=.515$). Additional barriers specified by participants included lack of awareness regarding need for OCS screening and lack of opportunities for OCS outside of the dental setting, concerns regarding radiation for BC screening, accuracy and the risk of false positives for PC screening, and embarrassment, fear, and the preparation process for CC

screening. Associations between responses of participants reporting no barriers to OC and no barriers to other cancer screenings were statistically significant with a moderate to large effect size when comparing OC and BC ($p=.002$, $\phi=.424$) and OC and PC ($p=.007$, $\phi=.392$).

When comparing perceptions of OC screening and BC screening, a significant association was found between participants' opinions on whether screenings were helpful ($p=.006$), fear of finding cancer as a concern ($p=.000$), and cost as a barrier ($p=.000$); therefore, the null hypothesis predicting no association between Idaho adults' perceptions of OC screening and BC screening was rejected. When comparing perceptions of OC screening and PC screening, a significant association was found between participants' fear of finding cancer as a concern ($p=.001$), and cost ($p=.000$) and time ($p=.000$) as barriers; therefore, the null hypothesis predicting no association between Idaho adults' perceptions of OC screening and PC screening was rejected. When comparing perceptions of OC screening and CC screening, a significant association was found between male participants' opinions on whether or not screenings were helpful ($p=.000$), both male and female participants' fear of finding cancer as a concern ($p=.004$ and $p=.000$), female participants' fear of pain ($p=.001$), and male and female participants' perception of cost ($p=.001$ and $p=.000$) and time ($p=.000$ and $p=.006$) as barriers; therefore, the null hypothesis predicting no association between Idaho adults' perceptions of OC screening and CC screening was rejected.

Discussion

Ninety percent of the respondents for the sample included in this pilot study were white; however, this proportion is reflective of the 93.5% white racial majority in the

population of Idaho.²⁷ In addition, over half of the respondents in the sample reported having completed a trade/vocational certificate or degree, with four out of ten earning a bachelor's degree or higher, whereas 24.4% of the population of Idaho reportedly has earned a bachelor's degree or higher.²⁷ These respondents' perspectives may have been influenced by being more highly educated than the general population. These sample characteristics are important considerations for this discussion of the findings. More diverse population need to be included in larger or national studies.

Slightly over half of these respondents self-reported ever having received an OC screening. This screening rate was high when compared to previous studies which indicated a rate of less than 30%.^{21,24} This higher screening rate may be due to the predominantly white, more highly educated, English-speaking population. Previous studies appear to indicate individuals with a lower socioeconomic status, blacks, and Hispanics are less likely to have received an OC screening.^{21,24}

Data also indicated that the vast majority of respondents reported perceiving no risks related to OC screenings. The most recent USPSTF report regarding screening of OC indicated that no studies have reported harms from OC screenings; thus, it appears that these consumers had accurate perceptions regarding the low potential for risk of harms due to OC screenings. Self-reported rates for PC and CC screenings were comparable to those for OC at just over half; however, more than nine out of every ten females reported having had BC screening.

Similar to perceptions of OC screenings, the majority of the respondents reported believing that all of the other cancer screenings were helpful and perceiving no risks regarding screenings for BC and PC. One of three participants, however, reported

perceiving risks regarding CC screening, specifically mentioning in open-ended, follow-up questions preparation for the exam, embarrassment, pain, and fear of the unpleasant experience of the exam itself. These findings support those of Young and Womeldorph (2013), which identified embarrassment, pain, and fear of invasive procedures, and Mansfield et al. (2016), which identified preparation and discomfort as barriers to CC screening.⁸⁻⁹

The most frequently reported barrier to all of the selected cancer screenings was cost, despite large differences in cost among the various screenings. Cost has been reported in the literature as a significant determinant in screening preferences.^{8,13}

Findings supported an association between consumer perceptions of benefits, risks, and barriers between OC and each of the selected cancer screenings. Respondents' perceptions of the helpfulness of OC compared to BC and OC and CC for both males and females were significantly associated; however, perceptions of the benefits of OC compared to PC were not significantly associated. This finding is interesting because the majority of these respondents perceived all of the screenings as very helpful. There were statistically significant associations between respondents' fear of finding cancer when comparing OC with BC, PC, and CC screenings, with the majority not experiencing fear of finding cancer as a concern for any of these cancer screenings. This finding appears to indicate oral healthcare providers' reported concern regarding the potential for fear or anxiety among patients by using the word 'cancer' when discussing OC screening may be unfounded.¹⁷ In fact, despite low consumer awareness regarding OC overall, consumers have indicated they would like their oral health care provider to tell them they are being

screened and would like to receive more information from their oral healthcare provider about how to reduce their risk of developing OC.¹⁹⁻²⁴

Significant associations were identified in participants' responses regarding barriers to OC screenings and other cancer screenings. When comparing time as a barrier to cancer screenings, significant associations were found between OC and PC and OC and CC for both males and females, but not when comparing OC and BC. These associations may be related to a comparable amount of time for receiving OC and PC screenings; however, it appears that consumers were not aware of the significant difference in time required for OC screenings in comparison to CC screenings. OC screening takes only minutes to perform as part of a routine dental examination appointment, which typically requires one hour, whereas the colonoscopy involves preparation the day before the procedure and sedation the day of the procedure, in addition to the actual procedure time of approximately 30 minutes.

Cost as a barrier was significantly associated when comparing OC and BC, OC and PC, and OC and CC for both males and females. This finding implies a potential lack of consumer awareness regarding the cost of OC screening in comparison to other cancer screenings. The OC screening is commonly included with no additional cost in the comprehensive dental examination at \$35-65, and the cost of a dental examination is low in comparison to costs of other cancer screenings.²⁸ Cost Helper Health (2016) estimates the average cost of the other cancer screenings for uninsured and insured individuals. BC screenings average \$102 for the uninsured, with an out of pocket cost of \$10-35 for insured individuals. Estimates for PC screenings were \$20-50 for a home PSA screening, increasing to as much as \$120 in a hospital setting; a digital rectal exam ranges from \$15-

215, with co-pays of \$0-30. The cost of CC screening, specifically colonoscopy, varies widely from \$2010 to over \$3000 with an average cost of \$3081 for the uninsured. Out of pocket costs for insured individuals ranges from \$0-1000 on average.²⁹ The association between consumers' concerns regarding the cost of OC and other cancer screenings may be related to insurance and reimbursement, as only 50% of the U.S. population was reported as having private dental insurance in 2010.³⁰ In comparison, the CDC reported that 95% of U.S. adults had medical insurance including 67.3% with private insurance and another 17.7% with public health plan coverage in 2014.³¹ Clearly, there is a need for consumer education regarding the fact that OC screenings are low cost in comparison with other cancer screenings.

Opportunities for increasing OC screening rates will require consumer education regarding the need for regular screenings, increasing access, and addressing concerns about cost and time. Education is necessary, and begins with oral healthcare professionals informing patients about the procedure while it is being performed. The provision of OC screenings by advanced practitioners or dental hygienists in alternative settings may provide less expensive options for receiving OC screenings.³² Seeking broader health care coverage for preventive screenings, creating lower cost options, and better reimbursement options may also improve accessibility. Improving OC screening accessibility could lead to earlier detection, and earlier detection prior to metastasis has been shown to result in decreased mortality.¹

Limitations of this study include the non-probability sample, which precludes generalizability of the results beyond the sample of Idaho adults. As a pilot study with a small sample size, results cannot be generalized to all Idahoans; however, the purpose of

the study was to explore potential associations between consumers' perceptions of OC with other exams so a broader study could be designed for a larger population. The primarily white, English-speaking sample may have had different perceptions than more diverse populations or underserved populations. The volunteer nature of the sample and the higher level of education of respondents also potentially influences the findings of the study as participants may have been more interested, knowledgeable, or motivated than the general population. Age may also be a limitation, as 23% of respondents were under 40, the minimum age at which some screenings (with the exception of oral cancer screening) are recommended. An older population could influence the number of respondents with screening experiences. Nonetheless, the protocol and validated instrument and the insights gained regarding consumer perceptions of OC screenings in comparison to other cancer screenings can be used to inform subsequent studies.

Telephone surveys are becoming less representative of the general population due to a decrease in landlines and the increased use of cellular telephones as the primary method of telephone communication. An attempt to compensate for this decrease in landline use was to purchase a sample consisting of a fifty-fifty combination of landline numbers and cellular telephone numbers originating from Idaho, which is representative of the estimated 56.1% of Idaho homes with only wireless telephone service as reported by the CDC.³³

Recommendations for future studies include a larger randomized sample representing a more diverse population, as well as the addition of a qualitative aspect to investigate reasons for selecting various options or why they were associated. The

telephone would be the best method for survey administration, however, focusing on qualitative exploration of the basis of participants' perceptions.

Conclusion

This study of Idaho adults was conducted to compare perceptions of OC screenings to other cancer screenings using a self-designed interview-administered questionnaire. Results indicated that the vast majority of participants perceived each of the cancer screenings as very helpful, and reported having no fears or concerns regarding screening. A lack of consumer awareness regarding differences between the selected cancer screenings was apparent based on perceptions of cost and time, the most commonly reported barriers identified for each of the screenings. This pilot study highlights the need to educate the public regarding the OC screening as it is embedded in the relatively inexpensive cost of the dental examination, takes minutes to perform, and is noninvasive and not painful. Future studies including a larger nonprobability sample representing a more diverse population are recommended to further explore the basis of participants' perceptions and to identify ways to minimize barriers to cancer screening. Improving OC screening accessibility could lead to earlier detection, and earlier detection prior to metastasis has been shown to result in decreased mortality.

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Table I. Demographic Characteristics of Sample of Idaho Adults (N=100)

Variable	Characteristic	N
Gender	Male	47
	Female	53
Age	Mean	52.7
	Median	58
	Range	18-93
	Under 40	23
	Over 40	74
	No Answer	3
Race	White	90
	Hispanic	5
	Native American	1
	Asian/Pacific Islander	1
	Other	2
	No Answer	1
Highest Level of Education	Some High School	2
	High School Diploma/GED	14
	Some College/No Degree	25
	Technical/Trade Certificate	7
	Associate Degree	9
	Bachelor's Degree	25
	Master's Degree	14
	No Answer	4

Table II. Summary of Responses Regarding Oral Cancer and Other Cancer Screenings

Screening	Responses	Oral Cancer (OC) (N=100)	Breast Cancer (BC) (N=53)	Prostate Cancer (PC) (N=47)	Colon Cancer (CC) (N=100)
Ever Had	Yes	54 (54%)	50 (94.3%)	28 (59.6%)	56 (56%)
	No	46 (46%)	3 (5.7%)	19 (40.4%)	44 (44%)
Helpful	Very	60 (60%)	42 (79.2%)	30 (63.8%)	84 (84%)
	Somewhat	21 (21%)	11 (20.8%)	12 (25.5%)	12 (12%)
	No Opinion	17 (17%)	0	4 (8.5%)	4 (4%)
	Not Very	1 (1%)	0	1 (2.1%)	0
	Not	1 (1%)	0	0	0
*Fears/Concerns	Finding Cancer	11 (11%)	11 (20.8%)	5 (10.6%)	16 (16%)
	Embarrassing	2 (2%)	7 (13.2%)	13 (27.7%)	25 (25%)
	Pain	2 (2%)	11 (20.8%)	5 (10.6%)	15 (15%)
	Prep for Exam	NA	NA	NA	54 (54%)
	Other	2 (2%)	1 (11.9%)	0	2 (2%)
	None	86 (86%)	32 (60.4%)	31 (66%)	35 (35%)
*Barriers	Cost	57 (57%)	27 (51%)	19 (40.4%)	61 (61%)
	Time	33 (33%)	18 (34%)	17 (36.2%)	47 (47%)
	Other	13 (13%)	9 (17%)	5 (10.6%)	13 (13%)
	None	20 (20%)	10 (19%)	18 (34%)	18 (18%)

*Total may be greater than 100% of population due to “select all that apply” option

Table III. Chi Square Analysis for Comparison of Respondents' Perspectives of Oral Cancer Screenings and Other Cancer Screenings

Crosstabs (N)	OC/BC Female (53)	OC/PC Male (47)	OC/CC Female (53)	OC/CC Male (47)	
Ever Had	$\chi^2 = .026$	$\chi^2 = 7.204$	$\chi^2 = .561$	$\chi^2 = 5.071$	
	$\phi = -.022$	$\phi = .391$	$\phi = -.103$	$\phi = .328$	
	$p = .871$	$p = .007^{**}$	$p = .454$	$p = .024$	
Helpful	$\chi^2 = 12.402$	$\chi^2 = 17.684$	$\chi^2 = 16.777$	$\chi^2 = 24.692$	
	$\phi = .484$	$\phi = .613$	$\phi = .563$	$\phi = .725$	
	$p = .006^{**}$	$p = .039$	$p = .010$	$p = .000^{**}$	
Fears/ Concerns*	Finding Cancer				
	$\chi^2 = 16.857$ $\phi = .564$ $p = .000^{**}$	$\chi^2 = 10.582$ $\phi = .474$ $p = .001^{**}$	$\chi^2 = 19.394$ $\phi = .605$ $p = .000^{**}$	$\chi^2 = 8.360$ $\phi = .422$ $p = .004^{**}$	
	Pain				
	$\chi^2 = 1.081$ $\phi = .143$ $p = .299$	$\chi^2 = n/a$ $\phi = n/a$ $p = n/a$	$\chi^2 = 10.161$ $\phi = .438$ $p = .001^{**}$	$\chi^2 = n/a$ $\phi = n/a$ $p = n/a$	
	Other				
	$\chi^2 = n/a$ $\phi = n/a$ $p = n/a$				
	None				
	$\chi^2 = 9.028$ $\phi = .413$ $p = .003^{**}$	$\chi^2 = 3.260$ $\phi = .263$ $p = .071$	$\chi^2 = 2.758$ $\phi = .228$ $p = .097$	$\chi^2 = 2.866$ $\phi = .247$ $p = .090$	
	Barriers*	Cost			
		$\chi^2 = 12.814$ $\phi = .492$ $p = .000^{**}$	$\chi^2 = 13.231$ $\phi = .531$ $p = .000^{**}$	$\chi^2 = 17.790$ $\phi = .579$ $p = .000^{**}$	$\chi^2 = 11.750$ $\phi = .500$ $p = .001^{**}$
Time					
$\chi^2 = 4.020$ $\phi = .275$ $p = .045$		$\chi^2 = 21.352$ $\phi = .674$ $p = .000^{**}$	$\chi^2 = 7.526$ $\phi = .377$ $p = .006^{**}$	$\chi^2 = 13.125$ $\phi = .528$ $p = .000^{**}$	
Other					
$\chi^2 = 5.233$ $\phi = .314$ $p = .022$		$\chi^2 = 2.782$ $\phi = .243$ $p = .095$	$\chi^2 = 11.848$ $\phi = .473$ $p = .001^{**}$	$\chi^2 = 12.461$ $\phi = .515$ $p = .000^{**}$	
None					

	$\chi^2=9.532$ $\phi =.424$ $p =.002^{**}$	$\chi^2=7.204$ $\phi =.392$ $p =.007^{**}$	$\chi^2=2.814$ $\phi =.230$ $p = .093$	$\chi^2=5.012$ $\phi =.327$ $p =.025$
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* Chi-Square (χ^2) Tests df = 1; Phi Coefficient (ϕ); Magnitude of effect size: Small (.1-.299), Medium (.3-.499), Large ($\geq .5$)

** $p < 0.0125$ (based on < 0.05 FWE)