

Improving Outcomes in Colorectal Cancer: Tips, Tools and Resources

Gregory A. Elkins, M.D.

Lincoln Primary Care Center/Southern WV
Health System

THE OFFICIAL SPONSOR OF BIRTHDAYS.®





ACS and Community Health Centers

- ACS has prioritized the need to effectively partner with CHCs
- Viewed as an ACS signature program
- More than **100 staff** across the country whose primary responsibility is establishing relationships and providing support to CHCs and state Primary Care Associations
- A multitude of tools and resources have been created, and more are in development
- Grant opportunities available



National Colorectal Cancer Roundtable

- National coalition of public, private, and voluntary organizations whose mission is to advance colorectal cancer control efforts by improving communication, coordination, and collaboration among health agencies, medical-professional organizations, and the public.
- Co-Founded by ACS and CDC in 1997
- Goal: increase the use of recommended colorectal cancer screening tests in at-risk populations
- Community Health Center taskgroup develops strategies and tools for CHCs

Collaboration with NACHC

CA CANCER J CLIN 2013;00:000-000

Strategies for Expanding Colorectal Cancer Screening at Community Health Centers

Mona Sarfaty, MD, MPH^{1*}; Mary Doroshenko, MA²; James Hotz, MD³; Durado Brooks, MD, MPH⁴; Seiji Hayashi, MD, MPH, FAAFP⁵; Terry C. Davis, PhD⁶; Djenaba Joseph, MD, MPH⁷; David Stevens, MD⁸; Donald L. Weaver, MD⁹; Michael Potter, MD¹⁰; Richard Wender, MD¹¹

Community health centers are uniquely positioned to address disparities in colorectal cancer (CRC) screening as they have addressed other disparities. In 2012, the federal Health Resources and Services Administration, which is the funding agency for the health center program, added a requirement that health centers report CRC screening rates as a standard performance measure. These annually reported, publically available data are a major strategic opportunity to improve screening rates for CRC. The Patient Protection and Affordable Care Act enacted provisions to expand the capacity of the federal health center program. The recent report of the Institute of Medicine on integrating public health and primary care included an entire section devoted to CRC screening as a target for joint work. These developments make this the ideal time to integrate lifesaving CRC screening into the preventive care already offered by health centers. This article offers 5 strategies that address the challenges health centers face in increasing CRC screening rates. The first 2 strategies focus on improving the processes of primary care. The third emphasizes working productively with other medical providers and institutions. The fourth strategy is about aligning leadership. The final strategy is focused on using tools that have been derived from models that work. *CA Cancer J Clin* 2013;000:000-000. ©2013 American Cancer Society, Inc.

Keywords: colorectal cancer screening, community health centers, strategies or strategic planning, public health, quality/quality improvement, Patient Centered Medical Home

Introduction

Reducing the incidence and mortality from colorectal cancer (CRC) is a high priority for addressing the toll that all cancers take on the US population.¹ Cancer is the leading cause of death for individuals aged younger than 80 years, and the leading cause of premature mortality.²⁻⁴ CRC is the nation's third leading cause of mortality from cancer, even though it has been shown to be preventable to a significant degree with timely screening. Screening for CRC reduces its incidence, mortality, and stage at presentation and improves survival. After a decade of progress, momentum in the direction of widespread CRC screening continued to build in 2011 and was further encouraged by the release of 2 national strategies developed as required by the Patient

Protection and Affordable Care Act with broad stakeholder input: the National Prevention Strategy and the National Quality Strategy. Both emphasized the importance of preventive services as essential components of a medical care system that will improve the health of the population as a whole.^{5,6}

However, the disparities in cancer incidence and mortality rates experienced by vulnerable populations are also evident in rates of screening for CRC.^{7,8} Community health centers (referred to hereafter as "health centers") are uniquely positioned to address disparities in CRC screening as they have addressed other disparities.⁹ To pursue this potential, the National Colorectal Cancer Roundtable (referred to hereafter as the "Roundtable"), a national leadership group

¹Associate Professor, Department of Family and Community Medicine, Thomas Jefferson University, Philadelphia, PA; ²Director, National Colorectal Cancer Roundtable, Washington, DC; ³Medical Director, Cancer Coalition of South Georgia, Albany, GA; ⁴Director, Colorectal and Prostate Cancers, American Cancer Society, Atlanta, GA; ⁵Chief Medical Officer, Bureau of Primary Health Care, Health Resources and Services Administration, Rockville, MD; ⁶Professor of Medicine and Pediatrics, Louisiana State University Health Science Center, New Orleans, LA; ⁷Medical Director, Colorectal Cancer Control Program, Centers for Disease Control and Prevention, Atlanta, GA; ⁸Associate Medical Officer and Director of Quality Center, National Association of Community Health Centers, Bethesda, MD; ⁹Chief Medical Officer, National Association of Community Health Centers, Bethesda, MD; ¹⁰Professor, Department of Family and Community Medicine, University of California at San Francisco School of Medicine, San Francisco, CA; ¹¹Alumni Professor and Chair, Department of Family and Community Medicine, Thomas Jefferson University, Philadelphia, PA

Corresponding author: Mona Sarfaty, MD, MPH, Department of Family and Community Medicine, Thomas Jefferson University, 833 Chestnut St, Suite 301, Philadelphia, PA 19107; mona.sarfaty@jefferson.edu

DISCLOSURES: Supported by the National Colorectal Cancer Roundtable. Dr. Hotz has received support for travel from the National Colorectal Cancer Roundtable for a one-day meeting in Washington, DC. The views expressed in this publication are solely the opinions of the authors and do not necessarily reflect the official policies of the US Department of Health and Human Services, the Health Resources and Services Administration, or the Centers for Disease Control and Prevention, nor does mention of the department or agency names imply endorsement by the US Government.

©2013 American Cancer Society, Inc. doi: 10.1002/caac.21191. Available online at cancerjournal.com

Strategy document outlining the challenges to screening, highlighting successful programs and processes, and recommending ways in which partner organizations can assist health centers in achieving their cancer-screening goals.

CA: A Cancer Journal for Clinicians, 2013

How to Increase Colorectal Cancer Screening Rates in Practice:

A Primary Care Clinician's* Evidence-Based
Toolbox and Guide
2008

**Including Family Physicians, General Internists, Obstetrician-Gynecologists,
Nurse Practitioners, Physician Assistants, and their Office Managers*

Mona Sarfaty, MD

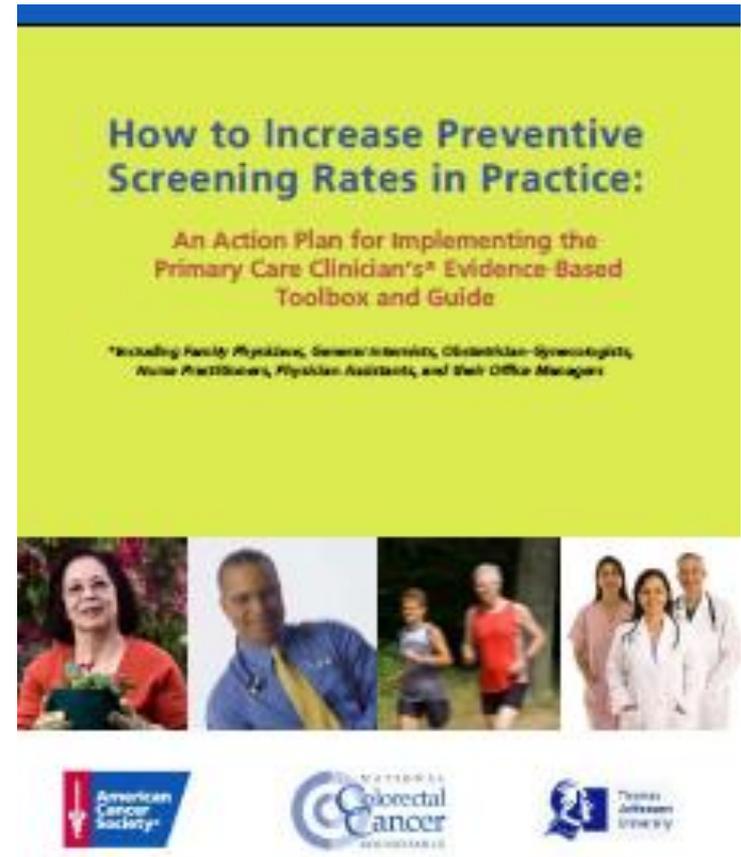
EDITORS

Karen Peterson, PhD
Richard Wender, MD



“Action Plan” Toolkit Version

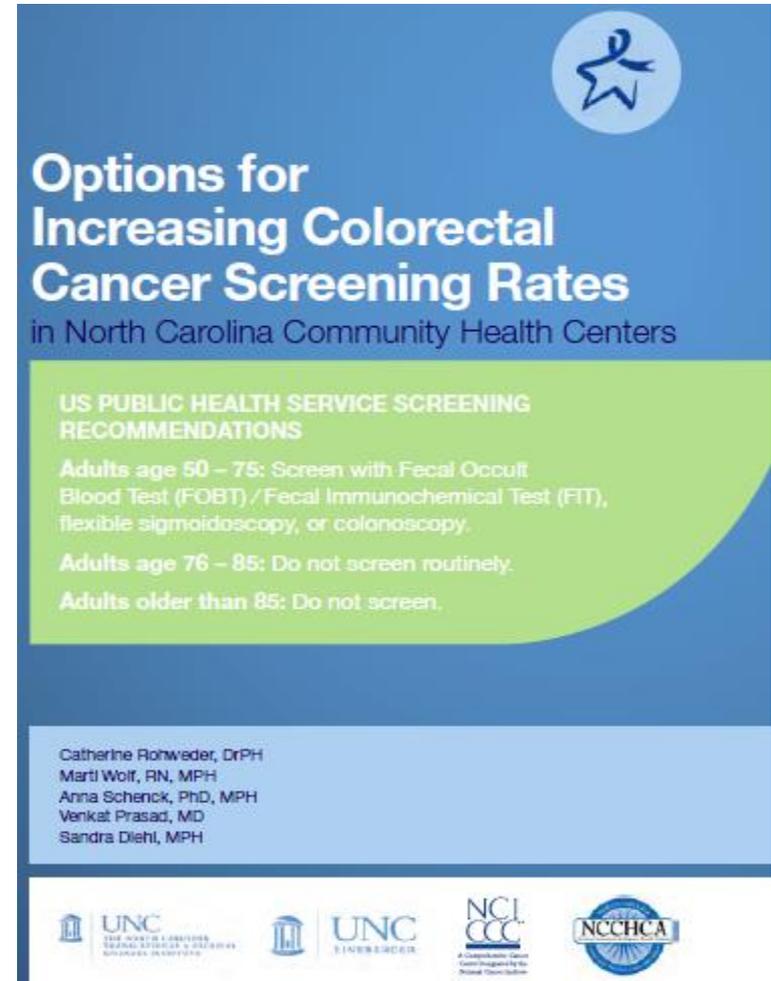
- Eight page guide introduces clinicians and staff to concepts and tools provided in the full Toolkit
- Contains links to the full Toolkit, tools and resources
- Not colorectal-specific; practical, action-oriented assistance that can be used in the office to improve screening rates for multiple cancer sites (colorectal, breast and cervical)



Available at
<http://nccrt.org/about/provider-education/crc-clinician-guide/>

Community Health Center Version

- Customized to meet unique needs of patients and providers in these settings
 - Step-by-step guidance on how to implement office systems change
- Developed by UNC researcher Dr. Catherine Rowheder (rohwerder@email.unc.edu, 919-966-6879)



The image shows the cover of a report titled "Options for Increasing Colorectal Cancer Screening Rates in North Carolina Community Health Centers". The cover has a blue background with a green curved section at the bottom. At the top right, there is a circular logo with a stylized figure. The title is in large white and yellow text. Below the title, it says "in North Carolina Community Health Centers". The green section contains text about US Public Health Service Screening Recommendations for different age groups. At the bottom, there is a list of authors: Catherine Rowheder, DrPH; Marti Wolf, RN, MPH; Anna Schenck, PhD, MPH; Venkat Prasad, MD; and Sandra Diehl, MPH. At the very bottom, there are logos for UNC, NCI/CCC, and NCCCHCA.

Options for Increasing Colorectal Cancer Screening Rates
in North Carolina Community Health Centers

US PUBLIC HEALTH SERVICE SCREENING RECOMMENDATIONS

Adults age 50 – 75: Screen with Fecal Occult Blood Test (FOBT) / Fecal Immunochemical Test (FIT), flexible sigmoidoscopy, or colonoscopy.

Adults age 76 – 85: Do not screen routinely.

Adults older than 85: Do not screen.

Catherine Rowheder, DrPH
Marti Wolf, RN, MPH
Anna Schenck, PhD, MPH
Venkat Prasad, MD
Sandra Diehl, MPH

UNC THE UNIVERSITY OF NORTH CAROLINA
NCL CCC A Comprehensive Cancer Center Inspired by the North Carolina Spirit
NCCCHCA

Funding for this project was provided by the University Cancer Research Fund of The UNC Lineberger Comprehensive Cancer Center

Staff Involvement

- Key Point.....the clinicians cannot do it all!
- Time that patients spend with non-clinician staff is underutilized
- Standing orders can empower nurses, intake staff, etc. to distribute educational materials, schedule appointments, etc.
- Involve staff in meetings to discuss progress in achieving office goals for improving the delivery of preventive services





Make a Recommendation

The primary reason patients say they are not screened is because a doctor did not advise it.
A recommendation from you is vital.

Develop a Screening Policy

Create a standardized course of action.
Engage your team in creating, supporting, and following the policy.

Communication

Measure Practice Progress

Establish a baseline screening rate, and set an ambitious practice goal.
Seeing screening rates improve can be rewarding for your team.

Be Persistent With Reminders

Track test results, and follow up with providers and patients.
You may need to remind patients several times before they follow through.



Why are 40% of at-risk individuals not screened?

Why patients aren't getting screened (according to Physicians)

Table 4 Perceived barriers by primary care physicians in Arizona to ordering CRC screening tests

Barriers	Ranked #1	Ranked #2	Ranked #3	Total votes (%)
Patient reluctance to undergo screening procedures	501	229	83	813 (83)
Patient fear of procedure or results	183	279	180	642 (65)
Patient lacks insurance coverage for screening procedure	188	147	173	508 (52)
Time constraints	42	55	107	204 (21)
Logistical problems for the patient	20	55	118	193 (20)
Lack of reimbursement for ordering or performing procedures	38	45	53	136 (14)
Decreased availability of screening tests	36	22	51	109 (11)
Other	27	7	17	51 (5)
Your familiarity with current guidelines	4	1	4	9 (1)



Why patients aren't getting screened *(according to Patients)*

“My doctor never talked to me about it!”



#1: Make a Recommendation

Essential #1:

Explore how your practice will assess a patient's risk status and receptivity to screening.

Essential #1:

Determine the screening tests and related messages you and your staff will share with patients.



Make a Recommendation

Goal = Recommendation to each eligible patient

- Requires an opportunistic/global approach*
 - Don't limit efforts to "check-ups"
- Requires a system that doesn't depend on the doctor alone
- Requires consistent messaging from clinicians and staff, taking into account patient knowledge and concerns



Recognize potential barriers to screening

Recommendation discussions must be sensitive to and address:

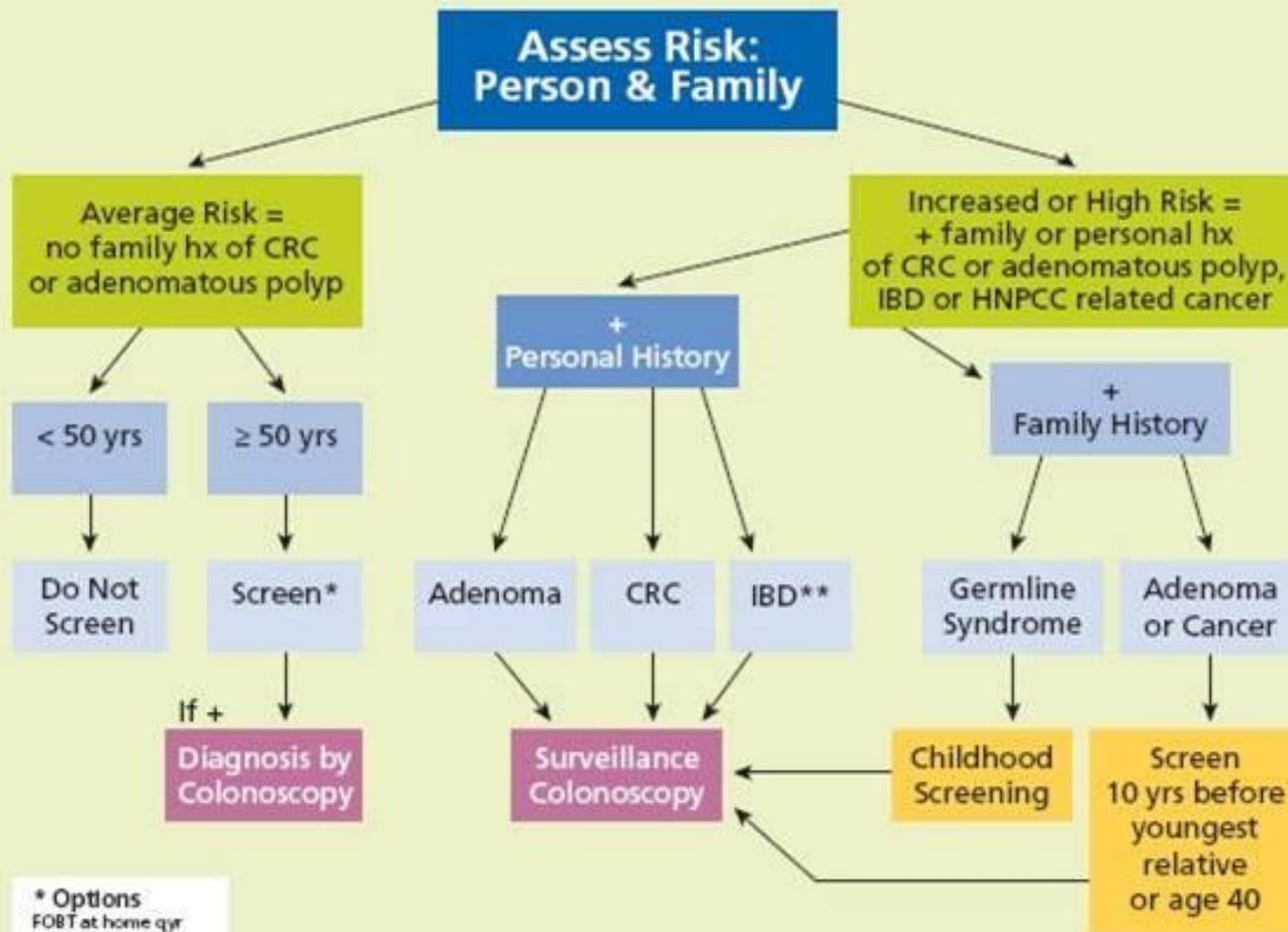
- Fear of cancer diagnosis
 - Perception that cancer is a “death sentence”
- Lack of understanding of need for asymptomatic screening
- Misconceptions about cancer causes and risks
- Embarrassment
- Concern over discomfort
- Cultural issues
- Patient preferences



Risk Assessment

- Making appropriate screening recommendation requires accurate assessment of each patient's risk status
- Individual Risk Levels
 - Average
 - Increased
 - High

Sample Screening Algorithm



* Options
 FOBT at home qyr
 Flex sig q5yr
 FOBT + flex sig
 DCBE q5-10 yrs
 Colonoscopy q10 yrs

** IBD refers to inflammatory bowel disease for eight years.



Risk Assessment

Q: How Many at Increased Risk?

A: Many more than we usually think.

- Emphasis on screening in the “average risk” population sometimes obscures the importance of risk assessment.
- In fact, 20-25% of the population is at increased risk of CRC.



#2 Develop a Screening Policy

Essential #2:

Create a standard course of action for screenings, document it, and share it.

Essential #2:

Compile a list of screening resources and determine the screening capacity available in your community.



Office Policy

An Office Policy states the intent of the practice

- Tangible, maintains consistency,
- Prerequisite for reliable, reproducible practice
- Algorithms can improve understanding and adherence to policy
- Beware: one size does not fit all practices!
- Beware: one size does not fit all patients!

Common Sense Colorectal Cancer Screening Recommendations¹ at a Glance

Risk Category	Age to Begin Screening	Recommendations
<p>Average risk No risk factors</p> <p>No symptoms²</p>	<p>< Age 50</p> <p>≥ Age 50</p>	<p>No screening needed</p> <p>Screen with any one of the following options:</p> <p><i>Tests That Find Polyps and Cancer</i></p> <p>FS q 5 yrs* CS q 10 yrs DCBE q 5 yrs* CTC q 5 yrs* OR</p> <p><i>Tests That Primarily Find Cancer</i></p> <p>gFOBT q 1 yr*,** FIT q 1 yr*,** sDNA***</p>
<p>Increased risk CRC or adenomatous polyp in a first-degree relative³</p>	<p>Age 40 or 10 years younger than the earliest diagnosis in the family, whichever comes first</p>	<p>Colonoscopy⁴</p>
<p>Highest risk Personal history for > 8 years of Crohn's disease or ulcerative colitis or a hereditary syndrome (HNPCC or, FAP, AFAP)</p>	<p>Any age</p>	<p>Needs specialty evaluation and colonoscopy</p>

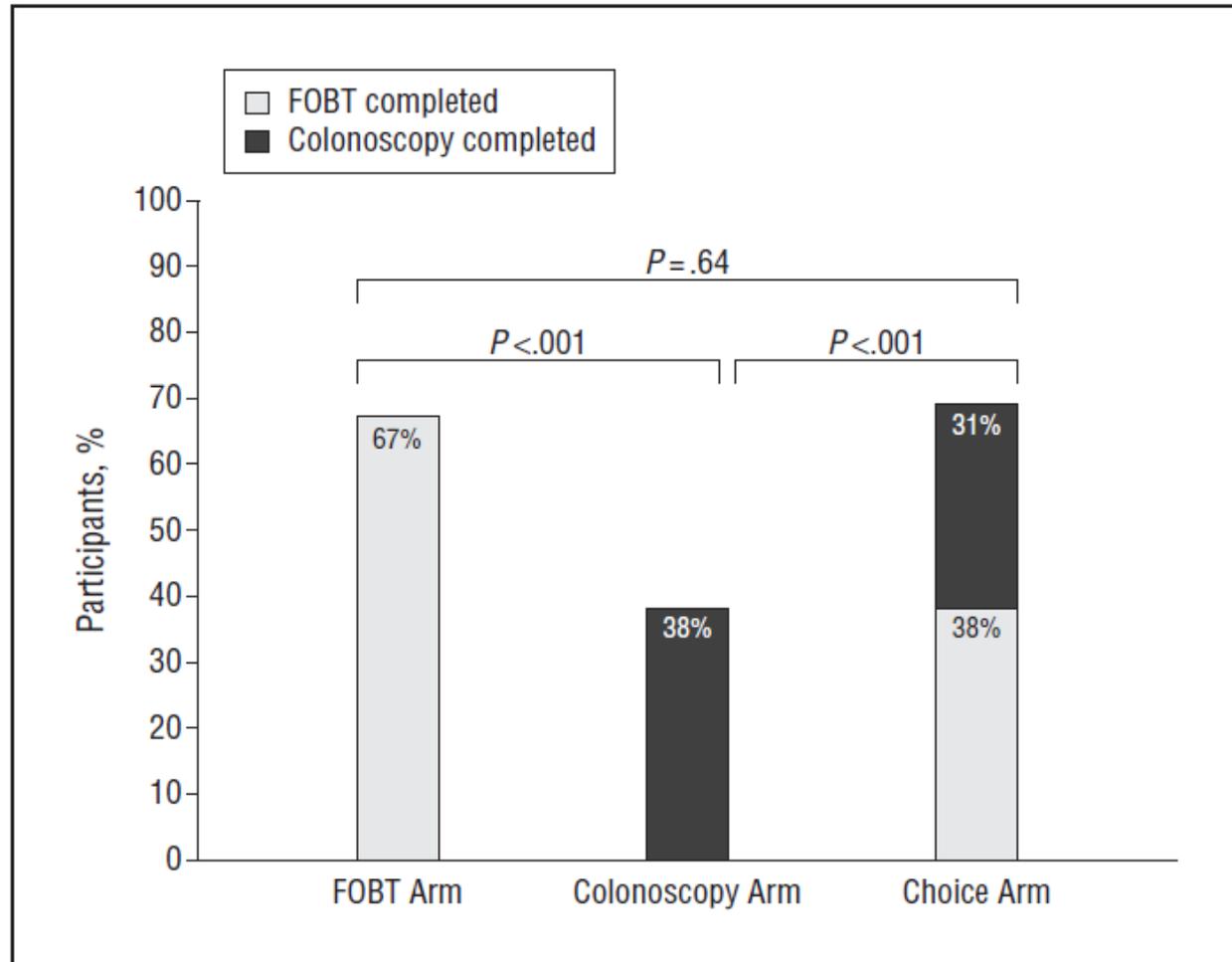


Office Screening Policy

Factors to Consider in Your Office Policy

1. Individual Risk Level (“risk stratification”)
2. Medical resources (e.g. location and accessibility of endoscopy facilities)
3. Insurance (deductible? copay? resources for uninsured?)
 - a. Impact of Affordable Care Act on preventive services
4. State and federal program policies and processes (CDC program,...)
5. Patient preferences/options

Patient Preferences



High Quality Stool Testing

CLINICIAN'S REFERENCE: FECAL OCCULT BLOOD TESTING (FOBT) FOR COLORECTAL CANCER SCREENING

Guidelines from the American Cancer Society, the US Preventive Services Taskforce, and others recommend high-sensitivity fecal occult blood tests (FOBT) as one option for colorectal cancer screening. This document provides state-of-the-science information about guaiac-based FOBT and fecal immunochemical tests (FIT).

- * Colorectal cancer screening with FOBT has been shown to decrease both incidence and mortality in randomized controlled trials.
- * High-sensitivity FOBT detects colorectal cancer at relatively high rates.
- * Modeling studies suggest that the years of life saved through a high-quality FOBT screening program are essentially the same as with a high-quality colonoscopy-based screening program.
- * Access to colonoscopy and other invasive tests may be limited or non-existent for many patients. In addition, some adults prefer less invasive tests.

All of these elements make FOBT a reasonable choice for patients.

Recent advances in stool blood screening include the emergence of new tests and improved understanding of the impact of quality factors on testing outcomes.

Two main types of FOBT are available – guaiac-based FOBT and FIT

Guaiac-based FOBTs have been the most common form of stool tests used in the US. Modern high-sensitivity forms of the guaiac test (such as Hemoccult Sensa) have much higher cancer and adenoma detection rates* than older tests (Hemoccult II and others).

Guaiac-based FOBT version	Sensitivity for cancer	Sensitivity for adenomas
Hemoccult Sensa (high-sensitivity)	50% – 79%	21% – 35%
Hemoccult II	13% – 50%	8% – 20%

These differences are so significant that screening guidelines now specify that only high-sensitivity forms of guaiac-based tests (like Hemoccult Sensa) should be used for colorectal cancer screening. Hemoccult II and similar older guaiac tests should no longer be used for colorectal cancer screening.

FITs also look for hidden blood in the stool, but these tests are specific for human blood and guaiac tests are not. There are many brands of FIT sold in the US, and there is no consensus that one brand is superior to another. There is evidence that patient adherence with FIT may be higher than with guaiac FOBT; this may be a result of preparation needed by patients (no dietary and medication restrictions, only 1 or 2 specimens required with some brands).

FIT and guaiac-based FOBT	Sensitivity for cancer	Sensitivity for adenomas
Immunochemical tests (FIT)	55% – 100%	15% – 44%
High-sensitivity guaiac-based FOBT (Hemoccult Sensa)	50% – 79%	21% – 35%

When done correctly FIT and high-sensitivity guaiac-based FOBT have similar performance*; both are significantly better than Hemoccult II and similar older tests.

*Sensitivities cited are based on review of studies that used colonoscopy as the reference standard to determine FOBT performance characteristics.



Clinicians Reference: FOBT
One page document designed to educate clinicians about important elements of colorectal cancer screening using fecal occult blood tests (FOBT).

Provides state-of-the-science information about guaiac and immunochemical FOBT, test performance and characteristics of high quality screening programs.

Available at
www.cancer.org/colonmd



Office Screening Policy

Standing orders

- Standing orders allow nursing staff or medical assistants to discuss CRC screening options, provide FOBT/FIT kits and instructions, and submit referrals for screening colonoscopy have been demonstrated to increase CRC screening rates
- Staff training on risk assessment, components of the screening discussion, ... is essential for a successful program.
- Check State practice regulations

Standing Orders

STANDING ORDER FOR COLORECTAL CANCER SCREENING

POLICY:

Under this standing order medical assistants and RNs with proper training may order a fecal occult blood test (FOBT), fecal immunochemical test (FIT), or hemoccult to screen for colorectal cancer for clients who meet these criteria.

PURPOSE:

Colorectal cancer (cancer of the colon or rectum) often begins as polyps, which are small growths inside the lining of the colon. While most polyps are harmless, some may turn into cancer. Colorectal cancer is the third most common cancer found in men and women in the United States. The lifetime risk for developing colorectal cancer is roughly 1 in 20.

The main purpose of colorectal cancer screening is to detect occult or hidden blood that may be present in the stool. The presence of blood may or may not be a sign of cancer. If blood is found, a colonoscopy is needed to detect the cause of bleeding. 9 out of 10 colorectal cancer deaths can be prevented through regular screening.

PROCEDURE:

1. Identify adults in need of regular colorectal cancer screening:
 - a. Average risk clients (medical assistant may perform screening): no family history of colorectal cancer or adenomatous polyps

Administer FOBT/FIT/ hemoccult

- a. Provide client with test kit
- b. Review instructions on how to use kit
- c. Explain diet or medication restrictions:
 - a. FIT test: no diet restrictions
 - b. FOBT test: avoid red meat, horseradish, vitamin supplements, aspirin, and ibuprofen (Advil)
- d. Explain procedure to return kit
- e. Close the loop: have client return kit

Document that kit was given to client in record.

Medical Director _____
Printed Name

Signature

Effective date _____

Date reviewed _____

Date revised _____



#3 Be Persistent with Reminders

Essential #3:

Determine how your practice will notify patient and physician when screening and follow up is due.

Essential #3:

Ensure that your system tracks test results and uses reminder prompts for patients and providers.



Clinician Reminder Types

- Chart Prompts
 - Problem lists
 - Screening schedules
 - Integrated summaries
- Alerts – “Flags” placed in chart
- Follow-Up Reminders
 - Tickler System
 - Logs and Tracking
- Electronic Reminder Systems



Patient Reminders

- Two types
 1. Education
 2. Cues to action

Office Wall Chart

American Cancer Society

Tests to Find Cancer Early

Ask your doctor or nurse about these tests.

Cancer Type	Who	When	What	How Often
Breast cancer	Women*	Starting at age 20	<ul style="list-style-type: none"> If you notice any change in your breasts such as a lump, tell your doctor or nurse right away. You may choose to do BSE (breast self-exam) to find breast changes. Have an exam of your breast by a doctor or nurse 	Every year Every 3 years
		Starting at age 40 and older	<ul style="list-style-type: none"> Have a mammogram (x-ray) of your breasts and An exam of your breast by a doctor or nurse 	Every year
Cervical cancer	Women**	Starting about 3 years after you start having sex but no later than age 21	Have ONE of the following: <ul style="list-style-type: none"> The regular Pap test OR The newer liquid Pap test 	Every year Every 2 years
		Starting at age 30	If you have had 3 normal Pap tests in a row, you may have: <ul style="list-style-type: none"> The regular or liquid Pap test OR Pap test with the new HPV test If you have NOT had 3 normal Pap tests in a row, then continue with your Pap tests every 1 or 2 years	Every 2 to 3 years Every 3 years
Prostate cancer	African American men OR men with a close family member with prostate cancer before age 65	Starting at age 45	<ul style="list-style-type: none"> Have a blood test to check your PSA (prostate-specific antigen) and a rectal exam to check your prostate gland 	Every year
	All other men	Starting at age 50	Your doctor should offer you a blood test to check the PSA in your blood and a rectal exam to check your prostate gland. Your doctor should talk to you about how you might or might not benefit from prostate cancer testing so you can decide if you want to be tested or not.	Every year
Colon cancer	Men and women*	Starting at age 50	Have ONE of these tests: <ul style="list-style-type: none"> Test to check for blood in your stool OR Test to look into the lower part of the colon (flexible sigmoidoscopy) OR Test to check for blood in your stool each year and a flexible sigmoidoscopy OR An x-ray of the colon (barium enema) OR A test to look into the entire colon (colonoscopy) Your doctor or nurse will help you decide which of these tests are best for you.	Every year Every 5 years Every 5 years Every 5 years Every 10 years
Other cancers	Women	Starting at age 20	Your doctor or nurse should check your thyroid gland, mouth, skin, lymph nodes, and ovaries.	Whenever you have your regular check-up
Other cancers	Men	Starting at age 20	Your doctor or nurse should check your thyroid gland, mouth, skin, lymph nodes, and testicles.	Whenever you have your regular check-up.

*You may need to begin testing for colon cancer or breast cancer earlier or be tested more often if you are more likely than other people to have these cancers. Talk to your doctor about this.

**If you have had a hysterectomy (your uterus and ovaries have been removed), you may choose to stop having the Pap test, unless the surgery was for cancer. If you are 35 or older and have had an inherited type of colon cancer called HNPCC, or someone in your family has had this type of cancer, then you may need to be tested each year for cancer of the endometrium (lining of the uterus). This testing is done with a biopsy.

Be sure to tell your doctor or nurse if you have had any type of cancer or if your mother, father, brother, sister, or children have had cancer.



Don't use tobacco. If you do, ask your doctor or nurse about quitting.



Get at least 30 minutes of physical activity on 5 or more days of the week.



Eat a healthy diet with plenty of fruits and vegetables.



Maintain a healthy weight.



Drink less alcohol, if you drink at all.



Protect yourself from the sun with an SPF (sun protection factor) of 15 or higher.

1.800.ACS.2345
www.cancer.org
Hope. Progress. Answers.™



- Screening guidelines for Breast, Cervical, Colon, Prostate and other cancers
- General lifestyle/prevention
 - Tobacco cessation
 - Healthy diet
 - Weight, etc
- English and Spanish

Patient Education



Get Tested For Colon Cancer: Here's How."

An 7-minute video reviewing options for colorectal cancer screening tests, including test preparation.

Available as DVD, or you can refer patients to the URL to view from their personal computer.

Telephone Reminder Scripts

gFOBT/FIT Follow-up Phone Script for Average-Risk Individuals

Introduction:

Good morning/afternoon. May I speak with _____?
(Note: Due to HIPAA regulations, the conversation should not proceed unless speaking directly with the patient.)

My name is _____ and I am calling from _____.

You recently received a stool test for colon cancer screening.

Did you have any questions about the test?

We are calling everyone who received one of these to see if there is any way we can help you complete the test.

1. “Have you had the chance to complete and mail your kit?”

If the answer is YES, get the approximate date to ensure that the test will be valid, and get the approximate date of receipt. Thank the participant and let him or her know that you will mail them the results.

If the answer is NO, ask the following question.

Patient Education



Get Tested For Colon Cancer: Here's How."

An 7-minute video reviewing options for colorectal cancer screening tests, including test preparation.

Available as DVD, or you can refer patients to the URL to view from their personal computer.



Follow up Reminders

- Track test completion, reports, appropriate follow up for positives
 - EMR
 - “Tickler” System
 - Logs and Tracking
- Requires staff time and commitment
- Ideal role for navigators/community health workers



#4 Measure Practice Progress

Essential #4:

Discuss how your screening system is working during regular staff meetings and make adjustments as needed.

Essential #4:

Have staff conduct a screening audit or contact a local company that can perform such a service.



Tracking Practice Progress

- Determine your baseline
- Set Realistic Goals
- Chart audits or other tracking measures (i.e. EHR reports)
- Provide staff-specific feedback on performance
- Seek patient feedback
- Identify strengths and weaknesses, barriers, opportunities to improve efficiency
- Track progress and periodically reassess goals



Flu + Stool testing

(A.K.A. “FluFIT”)



CRC Screening Outreach During Annual Flu Shot Activities (“FluFIT”)

- Combines CRC screening with annual flu shot campaigns
- Practice/ Clinic staff provide FOBT/FIT kits to eligible patients when they get their annual flu shot
 - Either a high sensitivity FOBT or a FIT kit can be used for the program
- Patient completes specimen collection **at home** and returns kit to doctor’s office or mails kit to the lab for processing



Potential Benefits of FluFIT

- Reaches patients at a time each year when they are already thinking about prevention
- Creates a seasonal focus on cancer screening that may add to other screening efforts
- Time-efficient way to expand team based care and involve non-physician staff in screening activities
- Educates patients that “just like a flu shot, you need FOBT/FIT every year”



FluFIT

- FLU-FOBT/FIT Interventions
 - Have been tailored and results replicated in:
 - (1) primary care underserved settings,
 - (2) high volume managed care flu shot clinics
 - (3) commercial pharmacies where flu shots are increasingly provided
 - Can be done with limited resources
 - Leads to higher screening rates

American Cancer Society FluFOBT Program Implementation Guide and Materials

The screenshot shows the American Cancer Society website. At the top, there are navigation links for 'Sign In', 'Register', 'Sign Up for Email', 'Español', and 'Asian & Pacific Languages'. Social media icons for Facebook, Google+, Twitter, and YouTube are also present. The American Cancer Society logo is on the left, with the tagline 'THE OFFICIAL SPONSOR OF BIRTHDAYS*'. To the right, it says 'JOIN THE FIGHT AGAINST CANCER' and has a 'DONATE' button with a downward arrow icon.

Below the header is a large image of a person's hands chopping vegetables like tomatoes and broccoli on a cutting board. Underneath the image is a search bar with the text 'How can we help you?' and 'search cancer.org'. To the right of the search bar are links for 'SEARCH', 'Live Chat', and '800-227-2345'.

A horizontal menu below the search bar includes: 'Home', 'Learn About Cancer', 'Stay Healthy' (which is highlighted), 'Find Support & Treatment', 'Explore Research', 'Get Involved', and 'Find Local ACS'.

The main content area shows the breadcrumb trail: 'Stay Healthy » Information for Health Care Professionals » ColonMD: Clinicians' Information Source » FluFOBT Program'. There are 'PRINT', 'SHARE', and 'SAVE' buttons. The main heading is 'American Cancer Society FluFOBT Program'. The text below reads: 'The American Cancer Society FluFOBT program is intended to assist medical practices in increasing colorectal cancer (CRC) screening. It has been demonstrated in the medical literature that offering and providing take-home fecal occult blood tests (FOBTs) or fecal immunochemical tests (FITs) to patients at the time of their annual flu shot increases CRC screening rates. Successful Flu-FIT and Flu-FOBT Programs have been implemented in community health centers, in a public hospital, and in a large health maintenance organization. They have also been pilot tested in commercial pharmacies.' Below this is a paragraph: 'In this section, you will find information to develop and deliver a successful FluFOBT Program. For additional information and resources visit flufobt.org.'

There is a section titled 'ACS FluFOBT Implementation Guide' with the text: 'This guide includes background information about the FluFOBT Program and its benefits, as well as patient eligibility criteria and education materials. It lists the steps required to set up a FluFOBT training program in your health center, including staff training and tracking tools.'

On the right side, there is a 'Stay Healthy Topics' section with a list of links: 'Stay Away from Tobacco', 'Eat Healthy and Get Active', 'Be Safe in the Sun', 'Other Ways to Protect Yourself', 'Find Cancer Early', 'ACS Programs to Help You Stay Well', 'Tools and Calculators', and 'Information for Health Care Professionals'.

www.cancer.org/flufobt



What's in the ACS FluFOBT Program Implementation Guide?

- Background information on colorectal cancer and FluFOBT
- Patient eligibility criteria
- Colorectal cancer screening recommendations
- Patient education
- Guidance on setting up your FluFOBT Program
- Implementation recommendations and resources
- Example advertising and tracking tools