Implementing "Flu-Fit":
An Innovative Way To Incorporate Influenza Vaccination and Colorectal Cancer Screening

HSAG Webinar
August 4, 2015
Durado Brooks, MD, MPH
American Cancer Society
ACS FluFOBT Program Training

Learning Objectives

By the end of this training, you will:

- Understand the impact of colorectal cancer (CRC) and the opportunities around screening for colorectal cancer
- Know the importance of early detection and evidence supporting current recommendations for CRC screening
- Understand how the ACS FluFOBT Program can reduce the risk of colorectal cancer
- Be aware of resources to assist with implementation of the ACS FluFOBT Program
Colorectal Cancer
Colorectal Cancer (CRC)

- 3rd most common cancer and the 2nd deadliest in the U.S.
  - 132,800 new cases
  - More than 49,000 deaths
  - Incidence and mortality higher in African Americans, Native Americans

- Incidence and death rates falling steadily over the past 20 years
  - Treatment advances
  - Screening --> early detection
Benefits of Screening

Survival Rates by Disease Stage*

- Local: 90.3%
- Regional: 70.4%
- Distant: 12.5%

5-yr Survival

*1996 - 2003
Decline in CRC Incidence and Mortality

- Decline due to:
  - Improvements in treatment
  - Screening → earlier cancer detection
  - **Screening** → polyp removal → prevention

- Recent study estimates that screening has prevented more than **500,000** colorectal cancers in the US over the past three decades
80% Colon Cancer Screening Rate By 2018
CRC mortality under 2 screening scenarios

80% screening rate by 2018 yields:
- **43,000** averted cases and **21,000** averted cancer deaths/yr
- **277,000** cases averted and **203,000 total averted deaths** from 2013 through 2030
80% by 2018

Primary Care Physicians
working together to save lives

Colorectal cancer is the second leading cause of cancer death in the United States among men and women combined, yet it's one of the most preventable.

The number of colorectal cancer cases is dropping thanks to screening. We are helping save lives. We can save more.

http://nccrt.org/tools/80-percent-by-2018
80% by 2018

Employers
working together to save lives

80% by 2018

Insurers
working together to save lives

80% by 2018

Hospitals
working together to save lives

80% by 2018

Communities
working together to save lives

Screening Rates
Age: the most impactful risk factor

CRC usually develops after age 50.

The chances of getting it increases as you get older.

CRC screening should begin at age 50 for most people, earlier for those with a family history.

http://science.education.nih.gov/supplements/nih1/cancer/guide/pdfs/ACT3M.PDF.
Who’s at **High** Risk of Colon Cancer?

- **Personal history of**
  - Polyps
  - Colorectal cancer
  - Inflammatory bowel disease
    - Ulcerative colitis
    - Crohn’s disease

- **Family history of**
  - Colorectal cancer or polyps
  - Hereditary syndrome (FAP, Lynch Syndrome,...)

*People with these conditions are not candidates for stool tests; must be screened with colonoscopy.*
CRC Screening: National Rates

In 2012, 65.1% of US adults were up to date with screening.*

- Rate higher in those age 65-75 (76.8%)
- Rates of up-to-date Blacks and Whites were equivalent.
- Lower rates for Hispanics and Native Americans
- Lowest rates among the uninsured

CRC Screening: HSAG states

2012 screening rates* by state/territory:

- Arizona 58.7%
- California 67.2%
- Florida 66.1%
- Ohio 63.5%

- Differences by race/ethnicity, education, income and insurance status in all states

Many “At-Risk” Remain Unscreened

Testing status of adults aged 50–75 years

- 65% Up-to-date CRC testing
- 28% Tested but not up-to-date
- 7% Never tested

Insurance status of never tested adults aged 50–75 years

- 76% Insured
- 24% Uninsured

What’s the Problem?

- Medical practice is demand (patient) driven
- Practice demands are numerous/diverse
- Few practices currently have mechanisms to assure that every eligible patient gets an appropriate recommendation for screening.
- Opportunistic vs organized screening
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

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“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/
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.
Screening Tests
Recommended Screening Tests
ACS and USPSTF

- Colonoscopy every 10 years
- High Sensitivity Fecal Occult Blood Testing every year (annually)
  - Guaiac
  - Immunochemical
- Flexible Sigmoidoscopy (FSIG) every 5 years
  - Rarely used in U.S.
Colonoscopy
Colonoscopy Limitations

- Evidence does not support “best test” or “gold standard”
  - Colonoscopy misses ~ 10% of significant lesions in expert settings
  - Higher potential for patient injury than other tests
  - More costly on a one-time basis
  - Test performance is highly operator dependent

- Greater patient requirements for successful completion
  - Requires a bowel prep and facility visit, and often a pre-procedure specialty office visit

- Access
  - Limited by insurance status, local resources

- Patient preference
  - Many individuals don’t want an invasive test or a test that requires a bowel prep
Patient Preferences

Inadomi, Arch Intern Med 2012
Stool Tests

- Look for hidden blood in stool.
- Two major types
Stool Tests: Guaiac

- Most common type in U.S.
- Solid evidence (3 RCT’s)
- 30 year f/u (NEJM Oct 2011)
- Need specimens from 3 bowel movements
- Non-specific
- Results influenced by food and medications
- Better sensitivity with newer versions (Hemoccult Sensa)
- Older forms (Hemoccult II) **not recommended**!
Stool Tests: Immunochemical (FIT)

- Specific for human blood and for lower GI bleeding
- Results not influenced by foods or medications
- Some types require only 1 or 2 stool specimens
- Higher sensitivity than older forms of guaiac-based FOBT
- Somewhat more costly than guaiac tests – but higher reimbursement may offset
Stool Testing Quality Issues

- In-office FOBT is essentially worthless as a screening tool for CRC and should never be used.
- CRC screening by FOBT should be performed with high-sensitivity FOBT - either FIT or a highly sensitive gFOBT (such as Hemoccult SENSA).
  - Older, less sensitive guiaic tests (such as Hemoccult II) should not be used for CRC screening.
- Annual testing
- All positive screening tests should be evaluated by colonoscopy

*Stool tests are appropriate only for average risk patients*
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
FluFIT/FluFOBT
(“FluFIT”)
What is a FluFIT program?

- Annual flu shot visits are an opportunity to reach many people who also need CRC screening
- Health center staff recommend CRC screening and provide FIT/FOBT kits to average risk, eligible patients when they get their annual flu shot
  - Either a high sensitivity FOBT or a FIT can be used for the program
- Patient completes FIT/FOBT at home and returns kit to doctor’s office or mails kit to the lab for processing
- FluFIT programs are well accepted by patients
- Studies show FluFIT lead to higher CRC screening rates in a variety of clinical environments
## San Francisco General Hospital Randomized Trial
(Flu shot clinic attendees randomized to Flu Only vs. Flu + FOBT on different dates – included telephone follow-up for FOBT recipients)

<table>
<thead>
<tr>
<th></th>
<th>FLU+FOBT days</th>
<th>FLU Only days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(268 patients)</td>
<td>(246 patients)</td>
</tr>
<tr>
<td>Up-to-Date Before Flu Season</td>
<td>52.9%</td>
<td>54.5%</td>
</tr>
<tr>
<td>Up-to-Date After Flu Season</td>
<td>57.3%</td>
<td>84.3%</td>
</tr>
<tr>
<td>Change: (p&lt;0.001) points</td>
<td>+4.4 points</td>
<td>+29.8 points</td>
</tr>
</tbody>
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Ann Fam Med, 2009
TABLE 2—Proportion of Participants Completing Colorectal Cancer Screening Within 90 Days of Receiving Influenza Vaccination: FLU-FIT Program, Kaiser Permanente Northern California, 2009–2010

<table>
<thead>
<tr>
<th>Test</th>
<th>Intervention (n = 3351), No. (%)</th>
<th>Control (n = 2884), No. (%)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIT</td>
<td>900 (26.9)</td>
<td>336 (11.7)</td>
<td>≤ .001</td>
</tr>
<tr>
<td>Sigmoidoscopy</td>
<td>62 (1.9)</td>
<td>68 (2.4)</td>
<td>.16</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>86 (2.6)</td>
<td>61 (2.1)</td>
<td>.24</td>
</tr>
<tr>
<td>FIT, sigmoidoscopy, or colonoscopy</td>
<td>996 (29.7)</td>
<td>438 (15.2)</td>
<td>≤ .001</td>
</tr>
</tbody>
</table>

*Note.* FIT = fecal immunochemical test.
Why try FluFIT?

- Many sites use FluFIT to begin the process of incorporating CRC screening into routine practice outside of Flu season

- Same Guidelines Apply
  - Like flu shots, CRC screening with stool tests are repeated every year
  - Annual testing is needed to be effective and evidence-based
How To Set Up Your FluFIT Program

- Put your team together
  - Select a champion to coordinate your efforts
  - Select team members and staffing levels
- Train your team (see ACS FluFOBT Program Implementation Guide)
  - Information about the importance of flu shots and CRC screening
  - Information about how to organize your workflow
  - Assessing eligibility
  - Talking points with patients about FIT/FOBT and completing the test
  - Record keeping and follow up with patients provided FIT/FOBT kits
Program Set Up (continued)

- Choose times and locations for your program and advertise the fact that FIT/FOBT will be offered with flu shots this year. Decide:
  - When to start
  - Where to hold the program
  - How to advertise

- Design a patient flow and management plan
  - Assess eligibility
  - Offer FIT/FOBT **BEFORE** giving the flu shot
CRC Screening Eligibility & FluFIT

- When should a patient be offered a FIT/FOBT kit during the program?
- Patient –
  - Is 50 years or older...
  - Has not had a colonoscopy in the last 10 years...
  - Has not had an FIT/FOBT test in the past year...
CRC Screening Eligibility & FluFIT

- When should a patient **NOT** be offered an FIT/FOBT kit?
  - Less than age 50
  - Had a colonoscopy in the last 10 years
  - Had an FIT/FOBT test in the past year
  - Has a personal history of Crohn’s Disease or Ulcerative Colitis*
  - Has a personal history of polyps or cancer*
  - Has a family history of polyps or cancer in a family member younger than age 60*
  - Rectal bleeding, blood in stool or other symptoms

*Patients with these risk factors should be directed to a clinician for appropriate screening recommendations*
Program Set Up (continued)

- Develop systems to support follow up for those patients who received FIT/FOBT kits
  - Provide patients with clear instructions
  - Provide a return envelope for kits
  - Reminder phone calls and/or postcards
  - Follow up care (remember: all patients with a positive stool test must have colonoscopy follow up!)

- Get started, implement your FluFIT program
Talking with Patients about CRC

- It is important to educate your patients about the importance of colorectal cancer screening and the FIT/FOBT.
- It is very important to remind patients to complete and return the FIT/FOBT kit (with instructions for doing so) at the time the kits are distributed.
- Telephone or post card reminders are imperative if the patient has not returned the kit within 14 days.

Studies show that reminders can double return rates!
American Cancer Society FluFOBT Program
Implementation Guide and Materials

American Cancer Society FluFOBT Program
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.

In this section, you will find information to develop and deliver a successful FluFOBT Program. For additional information and resources visit flufobt.org.

ACS FluFOBT Implementation Guide
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.

www.cancer.org/flufobt
What’s in the ACS FluFOBT Program Implementation Guide?

- Background information on Colorectal Cancer and FluFIT/FluFOBT
- Patient eligibility criteria
- Colorectal cancer screening recommendations
- Patient education
- Guidance on setting up your program
- Implementation recommendations and resources
- Example advertising and tracking tools
Innovative Programs to Provide Colorectal Cancer Screening during Annual Influenza Vaccination Campaigns

HOW TO DO IT?

Setting up a FLU-FIT or FLU-FOBT Program is not hard, but it does require some careful planning and staff training before you start.

5 Simple Steps!

1. Put Together Your FLU-FIT or FLU-FOBT Team
2. Choose Times and Places for FLU-FIT or FLU-FOBT and Advertise Them
3. Patient Flow and Line Management Plan
4. Develop systems to support follow-up of FIT/FOBT kits dispensed
5. Final Preparations

FAQ

Downloadable FLU-FIT and FLU-FOBT Program Materials

Answers to frequently asked questions

http://flufobt.org
Questions