



# Colorectal Cancer Professional Development Webinar Series: Flu/FIT Programs: A Proven Approach to Increase Colorectal Cancer Screening

June 5, 2018  
1:00pm-2:00pm

This live activity, **“Flu/FIT Programs: A Proven Approach to Increase Colorectal Cancer Screening** has been reviewed and approved for 1.0 AAFP Prescribed by the American Academy of Family Physicians.”



# Flu/FIT Programs: A Proven Approach to Increase Colorectal Cancer Screening

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# FluFIT: An Evidence-Based Intervention to Improve CRC Screening

June 5, 2018

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# Colorectal Cancer

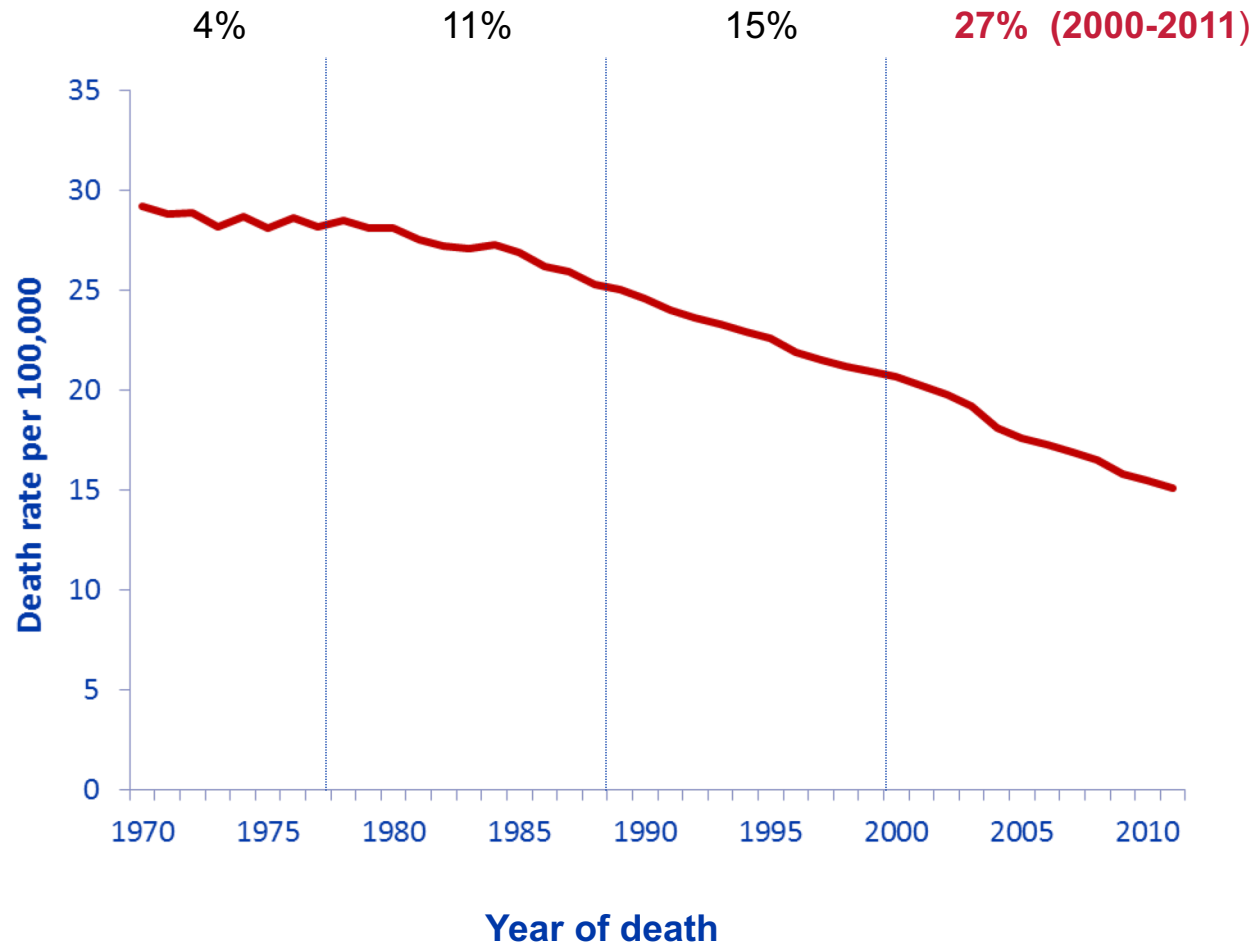


# Colorectal Cancer (CRC)

- Incidence and Mortality (US, 2018)
  - 140,250 new cases expected
  - 50,630 deaths
- 1.4 million Americans living with CRC
- Incidence and death rates have fallen steadily past 30 years

# Overall CRC death rate decline in the US

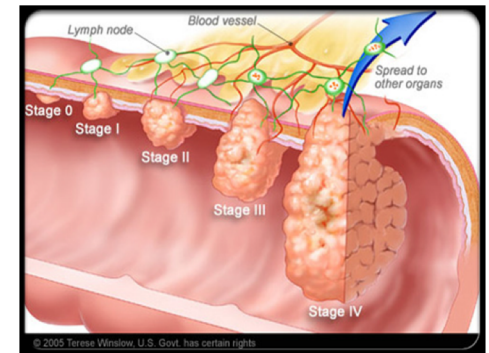
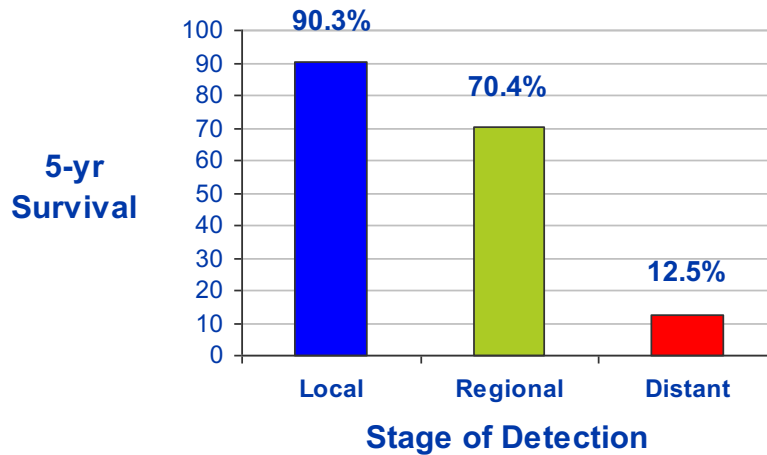
CRC mortality decline per decade:



# Decline in CRC Incidence and Mortality

- Decline due to:
  - Improvements in treatment
  - **Screening** → earlier cancer detection → improved survival

Survival Rates by Disease Stage\*





# Decline in CRC Incidence

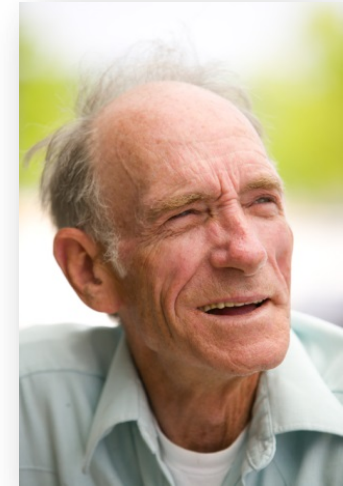
- Decline due to:
  - **Screening** → polyp removal → prevention
- Estimated that screening may have prevented **550,000** cases of colorectal cancer in the US over the past three decades



# CRC Screening Rates

In 2016, **67.3%** of US adults  $\geq 50$  yrs old were up to date with screening

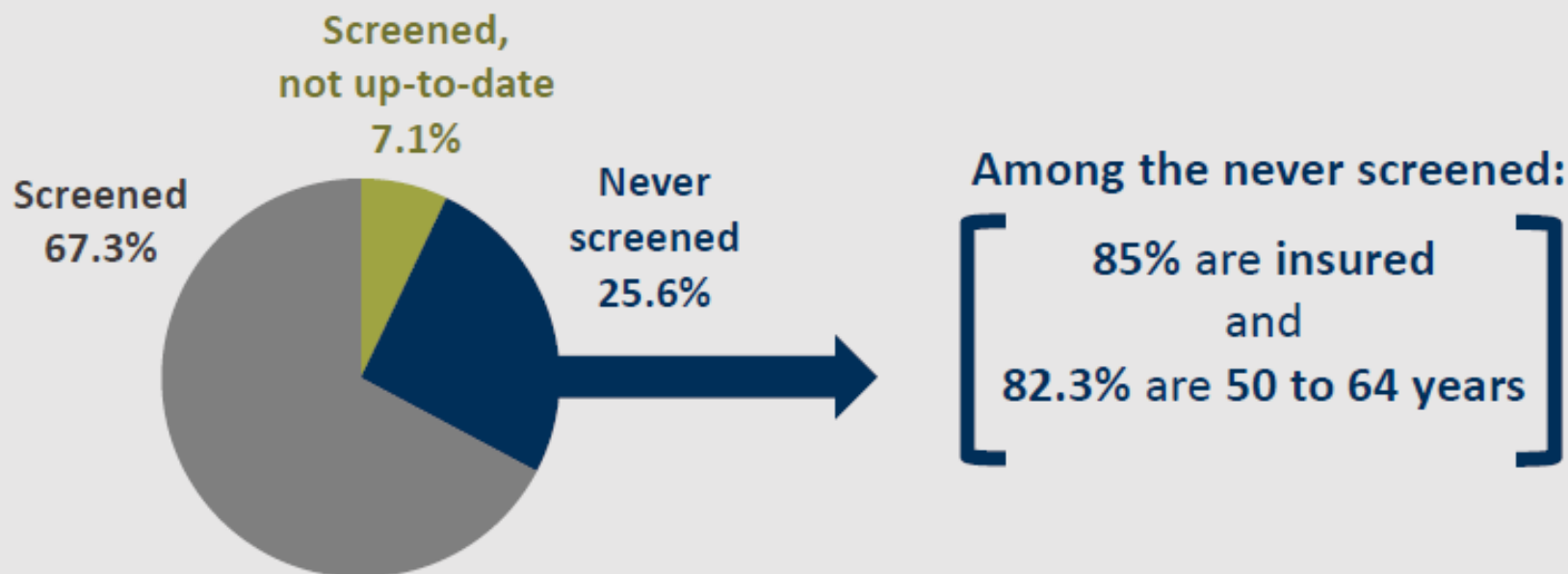
- More than 3 of 10 not up to date
- Lower rate in Hispanics, Native Americans and Asian Americans
- Lowest rates among low income, low education level and uninsured





# Who Else Is Not Screened?

Among adults aged 50 to 75 years, **one quarter** have never been screened.





# Screening Recommendations

# ACS 2018 Recommendations for CRC Screening

- The ACS recommends that adults aged **45 years and older** with an average risk of colorectal cancer undergo regular screening with either a high-sensitivity stool-based test or a structural (visual) exam, depending on patient preference and test availability.
- *As a part of the screening process, all positive results on non-colonoscopy screening tests should be followed up with timely colonoscopy.*

# ACS 2018 Recommendations for CRC Screening

- The ACS recommends that average-risk adults in good health with a life expectancy of greater than 10 years continue colorectal cancer screening **through the age of 75 years**. *(qualified recommendation)*
- The ACS recommends that clinicians individualize colorectal cancer screening decisions for individuals aged **76 through 85 years**, based on patient preferences, life expectancy, health status, and prior screening history. *(qualified recommendation)*
- The ACS recommends that clinicians discourage individuals **over age 85 years** from continuing colorectal cancer screening. *(qualified recommendation)*

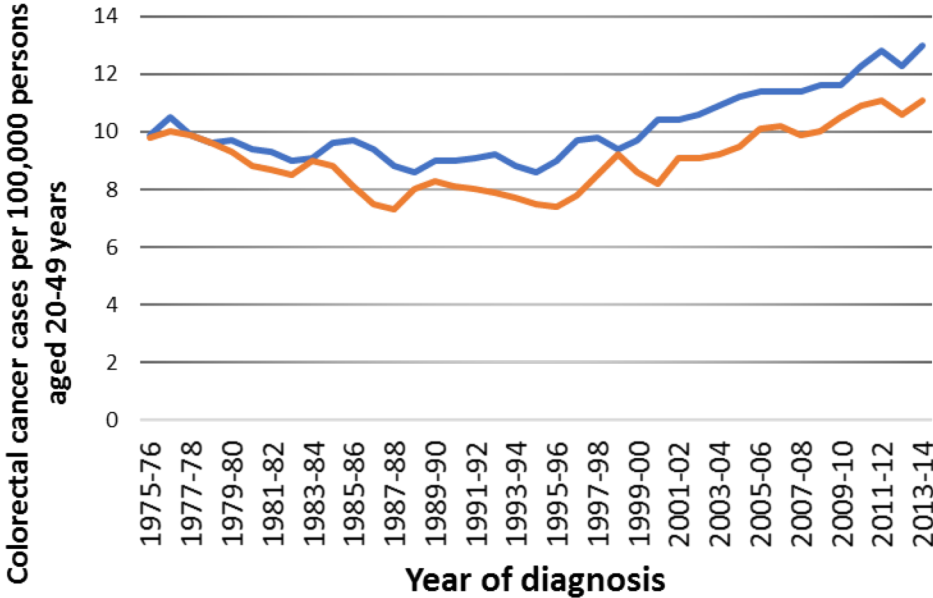
# ACS 2018 Recommendations for CRC Screening

- Options for CRC screening
  - Stool-based tests:
    - Fecal immunochemical test (FIT) every year
    - High sensitivity guaiac-based fecal occult blood test (HS-gFOBT) every year
    - Multi-target stool DNA test (mt-sDNA) every 3 years
  - Structural (visual) exams:
    - Colonoscopy (CSY) every 10 years
    - CT Colonography (CTC) every 5 years
    - Flexible sigmoidoscopy (FS) every 5 years
- As a part of the screening process, all positive results on non-colonoscopy screening tests should be followed up with timely colonoscopy.

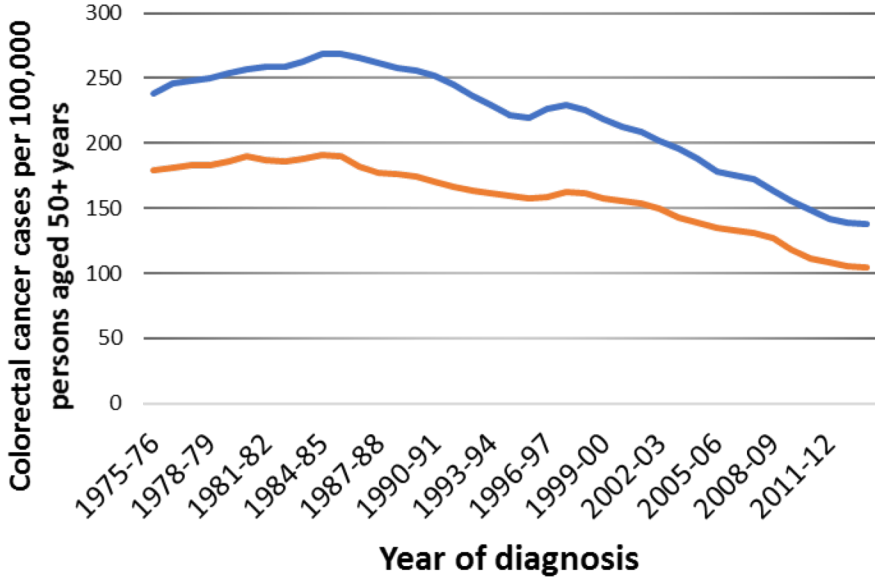
# Rationale – Disease Burden of CRC

Trends in Colorectal Cancer Incidence Rates by Age and Sex, 1975-2014

## Aged 20-49 years



## Aged 50+ years

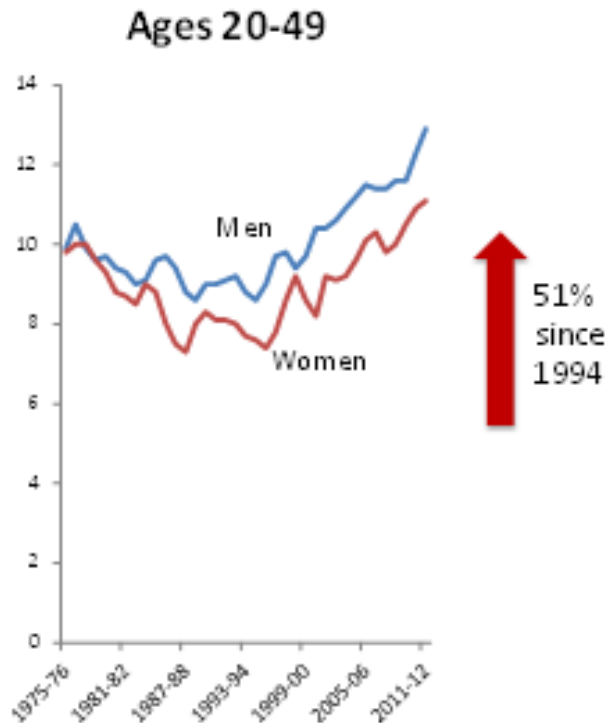


Source: Wolf A et al, Colorectal Cancer Screening for Average-Risk Adults: 2018 Guideline Update From the American Cancer Society CA Cancer J Clin 2018;





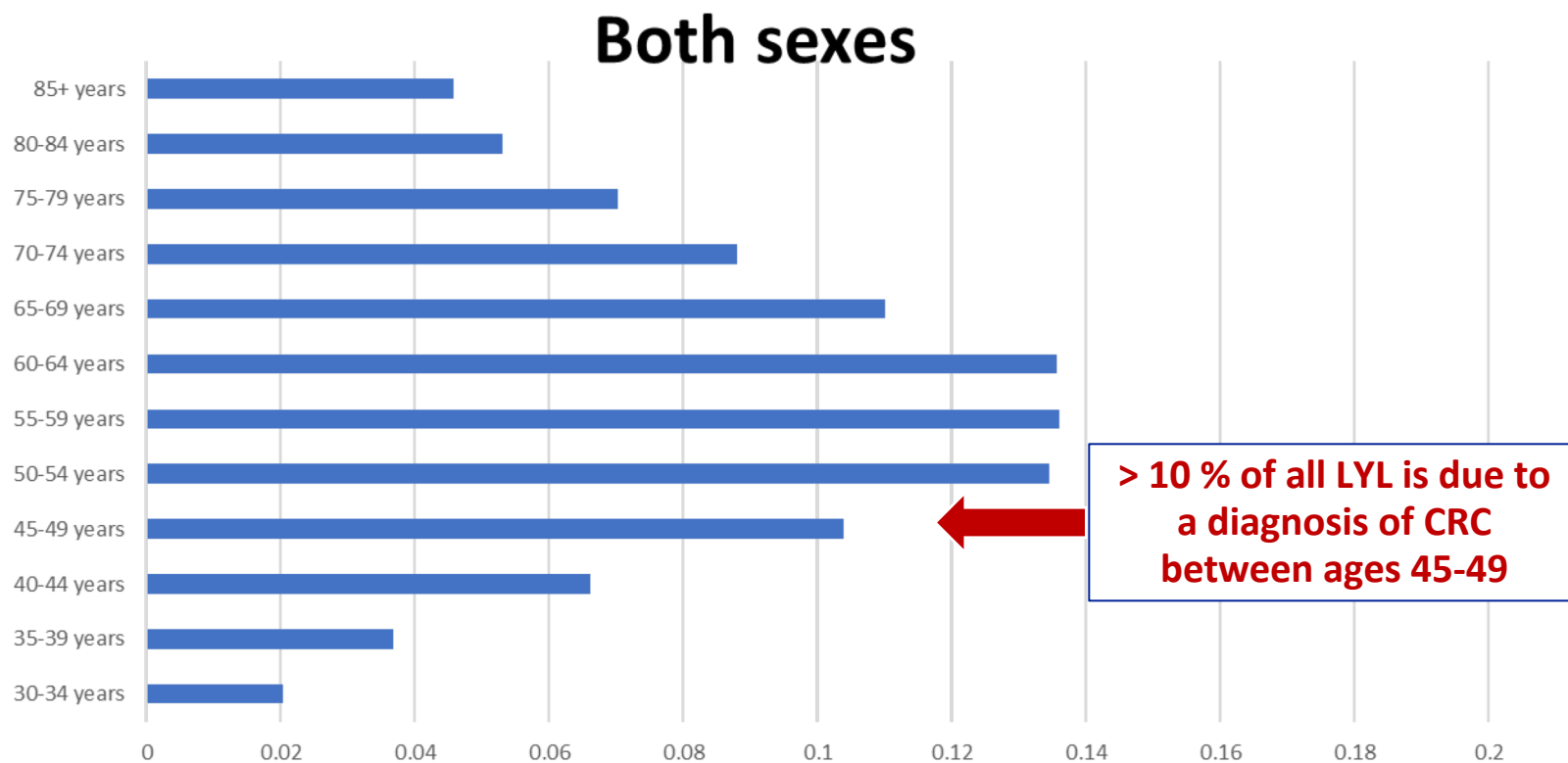
# CRC Incidence Increasing Under Age 50



Source: SEER 9 delay-adjusted rates, 1975-2012; 2-yr moving average

- While CRC rates are falling steadily in most over age 50, *diagnosis before age 50 is increasing*
  - Majority of the increase in age 40-49, but increases also seen in those in 30s and even 20s
- Rectal cancer increase > than colon cancer
- Numbers are small overall – but growing
  - Currently ~ one of every seven CRC diagnoses in US

# Percentage of Years of Potential Life Lost Due to Death from Colorectal Cancer by Age at Diagnosis *(incidence-based mortality 2010-14 with follow-up 20 years after diagnosis)*



# CRC Screening Guidelines for Average Risk Adults: ACS (2018); USPSTF (2016)

| Recommendations         | ACS, 2018   | USPSTF, 2016  |
|-------------------------|---|---|
| Age to start screening  | Age 45y<br>Starting at 45y (Q)  | Aged 50y (A)  |
| S-strong Q-Qualified    | Screening at aged 50y and older - (S)   |   |
| Choice of test          | High-sensitivity stool-based test or a structural exam.   | Different methods can accurately detect early stage CRC and adenomatous polyps.   |
| Acceptable Test options | <ul style="list-style-type: none"> <li>• FIT annually,</li> <li>• HSgFOBT annually</li> <li>• mt-sDNA every 3y</li> <li>• Colonoscopy every 10y</li> <li>• CTC every 5y</li> <li>• FS every 5y</li> </ul> <p>All positive non-colonoscopy tests should be followed up with colonoscopy.</p> | <ul style="list-style-type: none"> <li>• HSgFOBT annually</li> <li>• FIT annually</li> <li>• sDNA every 1 or 3 y</li> <li>• Colonoscopy every 10y</li> <li>• CTC every 5y</li> <li>• FS every 5y</li> <li>• FS every 10y plus FIT every year</li> </ul> |
| Age to stop screening   | Continue to 75y as long as health is good and life expectancy 10+y (Q)<br>76-85y individual decision making (Q)<br>>85y discouraged from screening (Q)  | 76-85 y individual decision making (C)  |



# 2018 UDS CRC Screening Measure

- Fecal occult blood test (FOBT) during the measurement period (MP) , or
- Flexible sigmoidoscopy during MP or the four years prior, or
- Colonoscopy during MP or the nine years prior, or
- **FIT-DNA** during MP or the two years prior, or
- **CT colonography** during MP or the four years prior

# Increased and High Risk

- Personal history of
  - Adenomatous Polyps
  - Colorectal cancer
  - Inflammatory bowel disease
    - Ulcerative colitis
    - Crohn's disease
- Family history
  - Colorectal cancer **or adenomas**
  - Hereditary syndrome (FAP, Lynch Syndrome,...)

## ***For people with these conditions***

- *Begin screening earlier (10 yr before age at dx of index case)*
  - *Colonoscopy is the **only** recommended screening test*



# Screening Tests



# Most Commonly Used Screening Tests

- Colonoscopy
- High Sensitivity Fecal Occult Blood Testing
  - High Sensitivity Guaiac Tests
  - **Fecal Immunochemical Tests (FIT)**



# PCP Beliefs and Preferences

- **Colonoscopy viewed as the best screening test, but:**
  - Many patients face barriers or not willing
  - Colonoscopy often recommended despite lack of adherence, access or other challenges
  - Patient preferences rarely solicited
  - Focus on colonoscopy is associated with low screening rates in a number of studies
- **Stool tests are widely used, but:**
  - Lack of knowledge re: performance of new vs. older forms of stool tests
  - Effectiveness questioned or underestimated

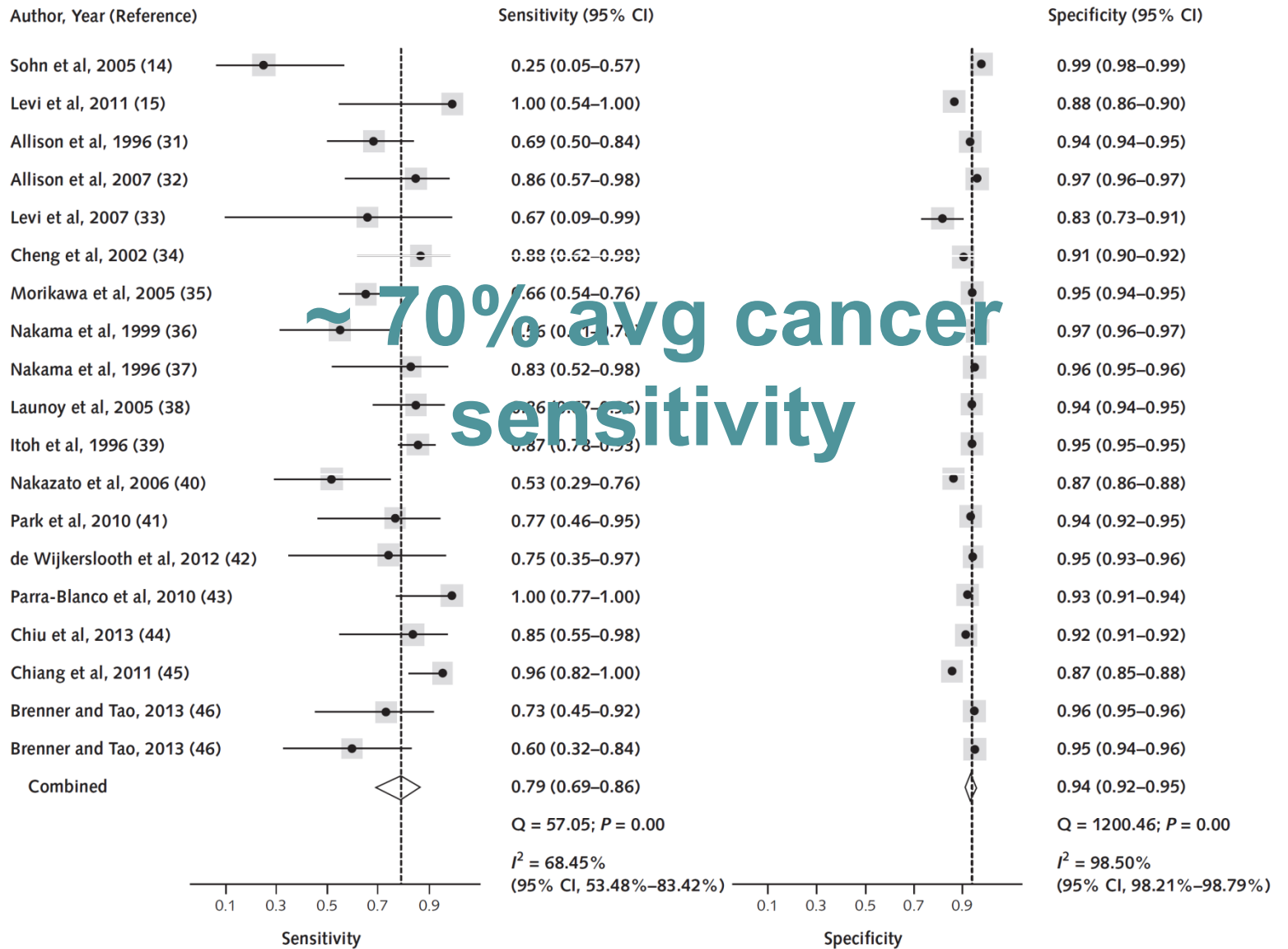


# Fecal Immunochemical Tests (FIT)

- Detect blood by immunoassay
- An antibody specifically recognizes the globin component of human hemoglobin
- Globin is prone to degradation from upper gastrointestinal tract proteases thus FIT are less likely to present false positive results from UGI bleeding
  - High specificity for human blood and for lower GI bleeding
- Some types require only 1 or 2 stool specimens
- Higher sensitivity than guaiac FOBT



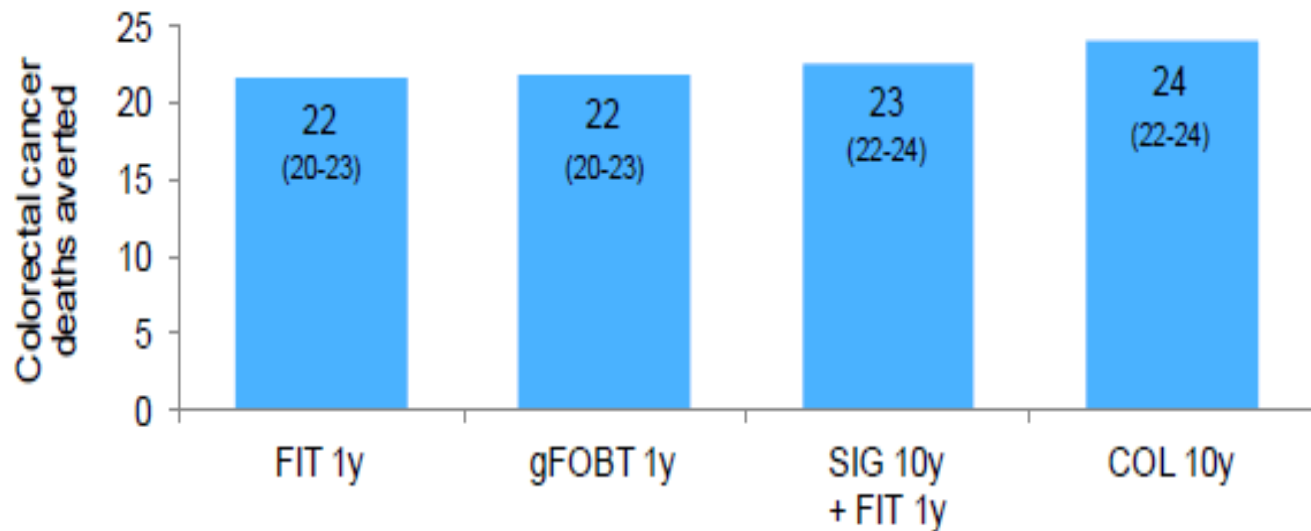
Figure 2. Pooled sensitivity and specificity for fecal immunochemical tests for the detection of colorectal cancer for all included studies.



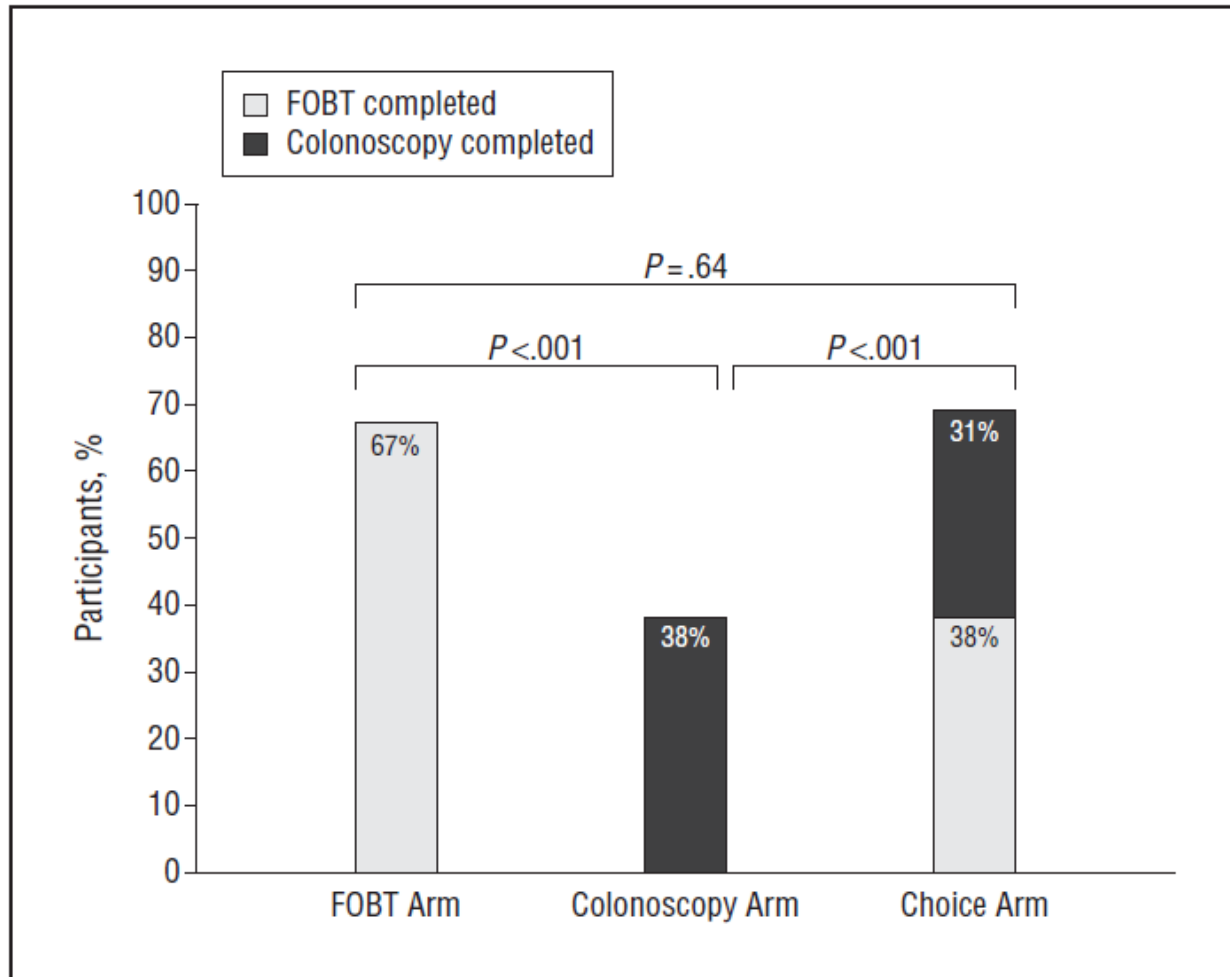
# Stool Test Efficacy (USPSTF 2015)

- Modeling studies suggest years of life saved through a high-quality stool-based screening program are similar to outcomes with a high-quality colonoscopy screening program

**B. Benefit: Colorectal Cancer Deaths Averted, per 1,000 Screened**



# Patient Preferences





# Stool Test Quality Issues

- Stool tests are appropriate only for *average risk* (no family history, no history of adenomas,...)
- Use only FIT or high sensitivity guaiac (Hemoccult Sensa)
  - Hemoccult II and other less sensitive guaiac tests should not be used for screening
- All positive tests must be followed up with colonoscopy
  - Follow up often lacking ( <75% adherence in many settings)
  - Patient should be aware of potential cost sharing if stool test is used for initial screen

# DRE collection is NOT Evidence-Based

## DRE Specimens

Essentially *worthless* as a screening tool for CRC and should NEVER be used.



**Missed 19 of 21 cancers**  
in largest study (gFOBT)

# High Quality Stool Testing



Guidelines from the American Cancer Society, the US Preventive Services Task Force, and others recommend Fecal Immunochemical Tests (FIT), High-Sensitivity Guaiac-Based Fecal Occult Blood Tests (HS-gFOBT) and FIT-DNA tests as options for colorectal cancer (CRC) screening in men and women at average risk for developing colorectal cancer.

This document provides state-of-the-science information about these tests.

 **Clinician's Reference**  
**STOOL-BASED TESTS FOR**  
**COLORECTAL CANCER**  
**SCREENING**

**80%**  
by **2018**

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

**Clinicians Reference: FOBT**  
Designed to educate clinicians about important elements of colorectal cancer screening using stool tests.

Provides state-of-the-science information about FIT, guaiac and stool DNA test performance, and characteristics of high quality screening programs.

Available at

[www.cancer.org/colonmd](http://www.cancer.org/colonmd)



# FluFIT





# What Do Flu Shots Have to do With CRC Screening?

- Many people who need flu shots are also at-risk for CRC
- Both are for asymptomatic individuals
- Both are preventative
- Both need to be repeated annually to be effective



# What is a FluFIT program?

- Staff educate patients about CRC and screening options, and provide FIT kits to average risk, eligible patients when they get their annual flu shot
- Patient collects FIT specimen and returns kit to office/pharmacy or mails kit to the lab for processing
- FluFIT programs are well accepted by patients
- Studies show FluFIT leads to higher CRC screening rates in a variety of clinical environments – including pharmacies

# FluFOBT – San Francisco General Hospital Trial

|   | Flu shot + FOBT kit<br>(268 patients) | Flu shot only<br>(246 patients) |
|---|---------------------------------------|---------------------------------|
| Up-to-date CRC screening<br><i>before</i> flu shot season | 54.5%                                 | 52.9%                           |
| Up-to-date CRC screening<br><i>after</i> flu shot season  | <b>84.3%</b>                          | 57.3%                           |
| Change: (p<0.001)   | +29.8 percentage points               | +4.4 percentage points          |

# FluFIT Implementation Guide and Materials



**fluFIT**

WHY DO IT   HOW TO DO IT   STAFF TRAINING   PROGRAM MATERIALS   FAQ   PUBLICATIONS   CONTACTS

## How To Do It:

*Setting up a FluFIT Program is not hard, but it does require some careful planning.*

### 1. PUT YOUR FLUFIT TEAM TOGETHER >

- **SELECT A FLUFIT CHAMPION TO COORDINATE YOUR EFFORTS**

This will usually be an enthusiastic physician, nurse, team leader, or quality improvement manager who has the time and skills to supervise the clinic staff who will carry out day to day FluFIT Program activities.

- **SELECT YOUR FLUFIT TEAM MEMBERS AND DETERMINE STAFFING REQUIREMENTS**

<https://www.cancer.org/content/dam/cancer-org/cancer-control/en/reports/american-cancer-society-flufobt-program-implementation-guide-for-primary-care-practices.pdf>



# How To Set Up Your FluFIT Program

- Put your team together
  - Select a champion to coordinate your efforts
  - Select team members across all segments of the organization
  - Coordination with local primary care and endoscopists



# Program Set Up

- Choose times and locations for your program and advertise the fact that CRC screening 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 patient eligibility
  - Provide patient education and offer screening tests BEFORE giving the flu shot



# Program Set Up

- Train your core team
  - Importance of flu shots and CRC screening
  - How to organize your workflow
  - Assessing patient eligibility
  - Patient education about FIT and how to complete the test
  - Protocols for test tracking and follow up
- Introduce program and plan to all staff

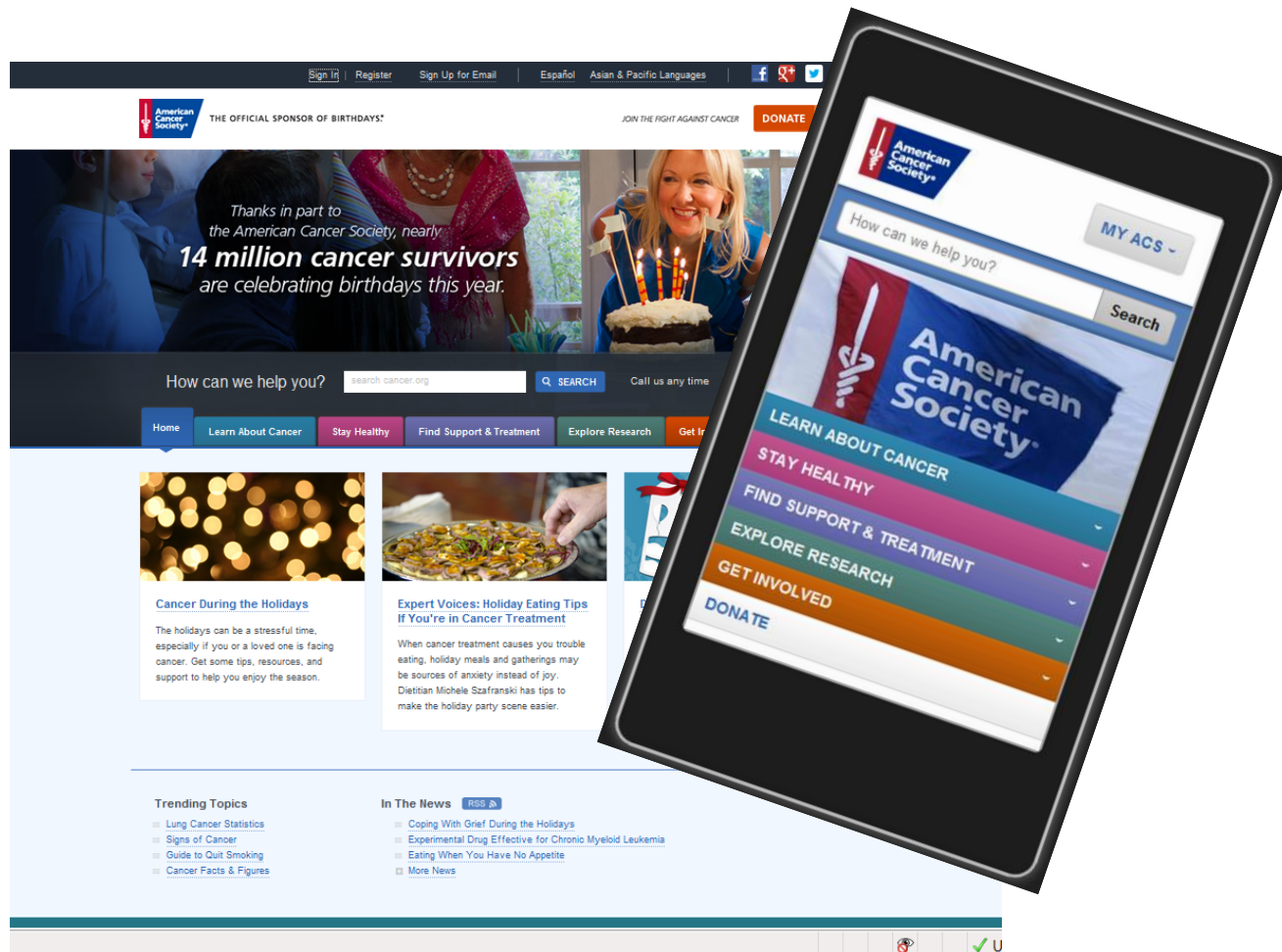


# Elements of Successful Program

- Strong leader(s)/champion(s)
- Organizational commitment
- Seamlessness of workflow/Ease of implementation
  - Can't interfere too much with ongoing care
- Clear goals and opportunities for communication
- Strong collaboration with primary care and endoscopy providers
- Ongoing monitoring, documentation and follow-up



[www.cancer.org/colonmd](http://www.cancer.org/colonmd)  
[www.cancer.org/professionals](http://www.cancer.org/professionals)



# Flu/FIT

Presenter: Rachel McLaughlin  
Sr. Dir. Population Health and Quality

6/5/2018



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# Outline

- Background
- Clinical Workflow
- In-house Tools
- Monitoring Results
- Outcomes
- Lessons Learned

# CRC is an Improvement Priority

- Overhaul of documentation and referral process, starting 8/2015
- Routine updates with the medical providers at 4-6 week intervals since 6/2017
- Concept introduced during routine update, by Dr. Sarah Henn (8/2017)
- To implement, needed a **process** and a way to **measure progress**

# Clinical Workflow

- MAs review lists of patients due for screening
  - Create FIT test orders
  - Generate patient labels
  - Prepare all the sample materials
- Medical providers meet with patients
  - Explain the test
  - Generate colonoscopy order, as needed
  - Document refusal and delete orders, as needed



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# Supporting Elements

- Standing order
- Templates
- Daily/Weekly patient lists
- Training



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# Daily/Weekly Reports

## Patients Scheduled 3/27/2018

| PCP Deidentified | Appt Time | Appt Prov Deidentified | Visit Type | PatName De-ID | PatientID DeID | CRC Screen |
|------------------|-----------|------------------------|------------|---------------|----------------|------------|
| Aben             | 9:00 am   | Aben                   | M-MEDICAL  | Rish          | ----           | Ordered    |
|                  | 11:00 am  | Aben                   | M-MEDICAL  | Bena          | ----           | Ordered    |
| Clry             | 1:00 pm   | Clry                   | M-MEDICAL  | Meon          | ----           | Needed     |
|                  | 1:40 pm   | Clry                   | M-MEDICAL  | Zajo          | ----           | Needed     |
|                  | 3:20 pm   | Clry                   | M-MEDICAL  | Roli          | ----           | Ordered    |
| Egce             | 1:00 pm   | Mean                   | M-MEDICAL  | Cala          | ----           | Needed     |
| Egth             | 9:20 am   | Egth                   | M-MEDICAL  | Brke          | ----           | Ordered    |
|                  | 2:40 pm   | Egth                   | M-MEDICAL  | Beye          | ----           | Ordered    |
| Feid             | 1:20 pm   | Feid                   | M-MEDICAL  | Wrjo          | ----           | Needed     |



## Schedule Details for FluFIT Campaign

Facility  
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Appt Prov De  
Ledo

## Patients Scheduled in the Next Week for Ledo

| Visit Date | Appt Time | Appt Prov Deidentified | PCP Deidentified | Visit Type | PatName D.. | PatientID D.. | HIV_Status | FluVaccine     |
|------------|-----------|------------------------|------------------|------------|-------------|---------------|------------|----------------|
| 3/27/2018  | 9:00 am   | Ledo                   | Ledo             | M-MEDICAL  | Dajo        | ----          | Positive   | Vaccinated     |
|            | 10:00 am  | Ledo                   | Ledo             | M-MEDICAL  | Gran        | ----          | Negative   | Vaccinated     |
|            | 11:40 am  | Ledo                   | Ledo             | M-MEDICAL  | Daer        | ----          | Positive   | Vaccinated     |
|            | 2:00 pm   | Ledo                   | Other            | M-MEDICAL  | Mica        | ----          | Negative   | Not Vaccinated |
|            | 4:00 pm   | Ledo                   | Ledo             | M-MEDICAL  | Grgr        | ----          | Negative   | Vaccinated     |
|            | 5:20 pm   | Ledo                   | Ledo             | M-MEDICAL  | Edad        | ----          | Positive   | Not Vaccinated |
| 3/29/2018  | 3:00 pm   | Ledo                   | Ledo             | M-MEDICAL  | Khah        | ----          | Negative   | Vaccinated     |
| 3/30/2018  | 5:00 pm   | Ledo                   | Ledo             | M-MEDICAL  | Ajak        | ----          | Positive   | Vaccinated     |
| 4/2/2018   | 8:20 am   | Ledo                   | Ledo             | M-MEDICAL  | Meso        | ----          | Negative   | Vaccinated     |
|            | 8:40 am   | Ledo                   | Ledo             | M-MEDICAL  | Siei        | ----          | Negative   | Not Vaccinated |
|            | 4:20 pm   | Ledo                   | Ledo             | M-MEDICAL  | Clwi        | ----          | Negative   | Not Vaccinated |



# Dashboards



## Colorectal Cancer Screening Dashboard

PCP Deidentified  
All

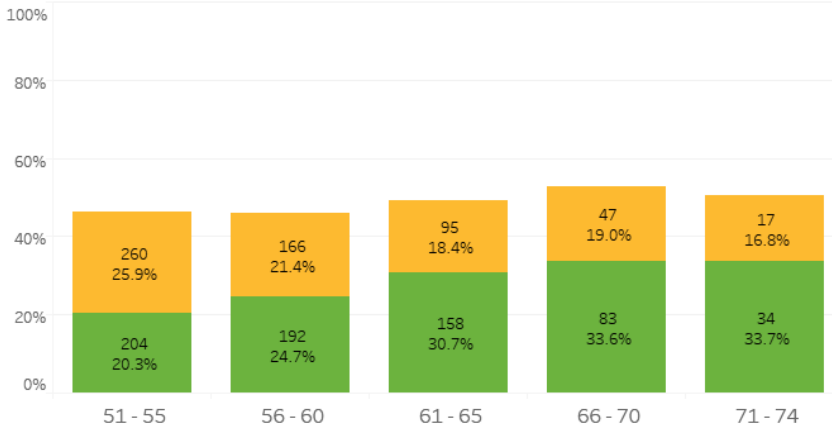
Total: 2,644

| Screened     | Ordered      | Needed       |
|--------------|--------------|--------------|
| <b>671</b>   | <b>585</b>   | <b>1,390</b> |
| <b>25.4%</b> | <b>22.1%</b> | <b>52.6%</b> |

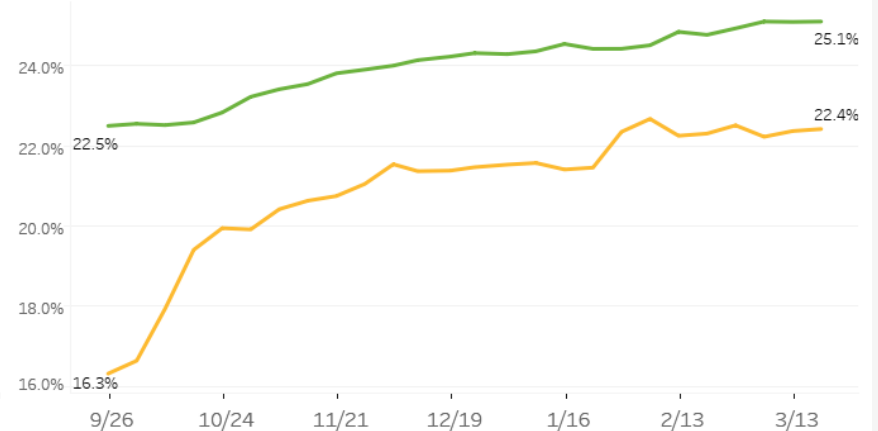
### Upcoming Appointments



### Screening Rates by Age Group

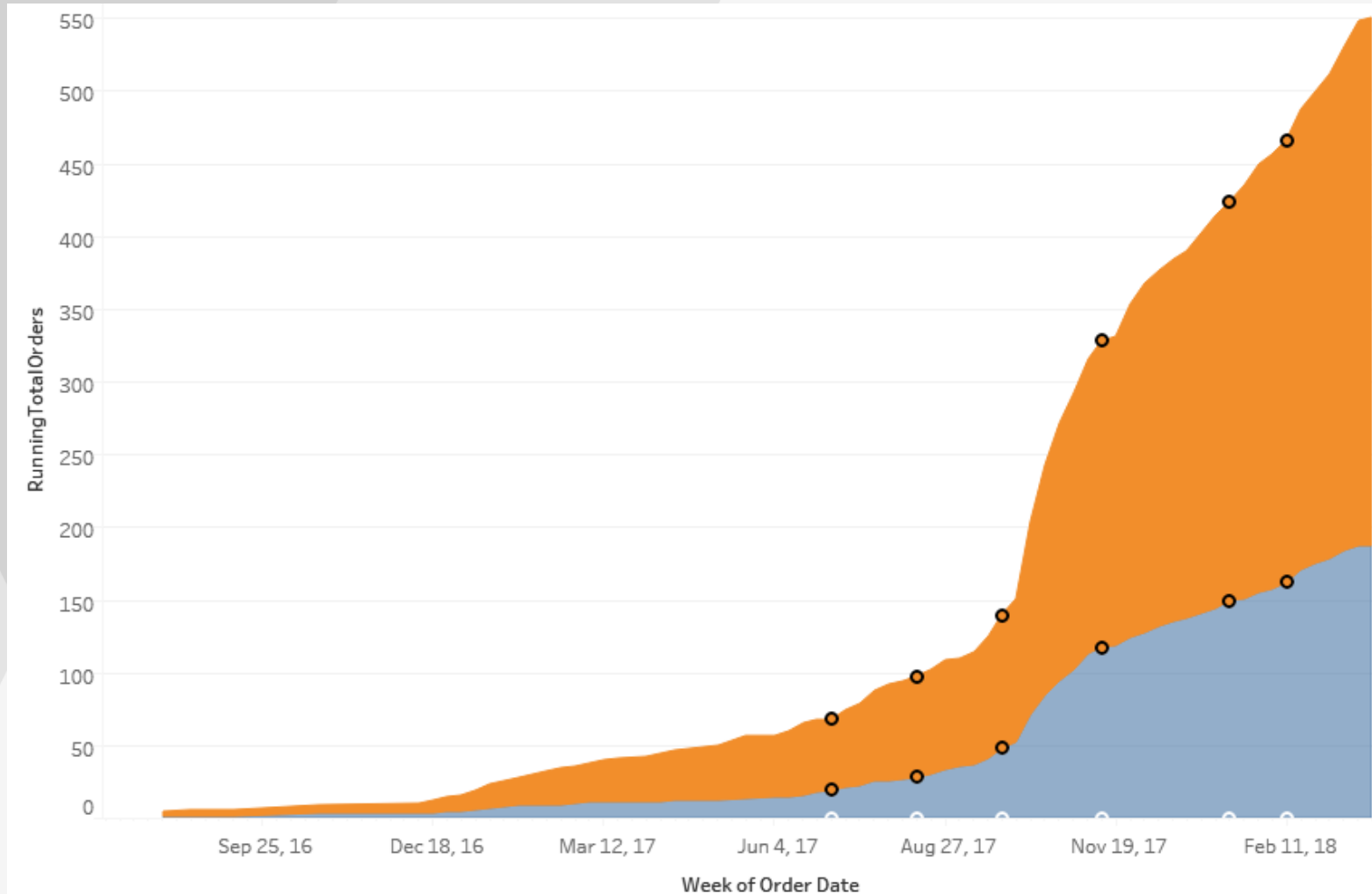


### Screening Rates over Time

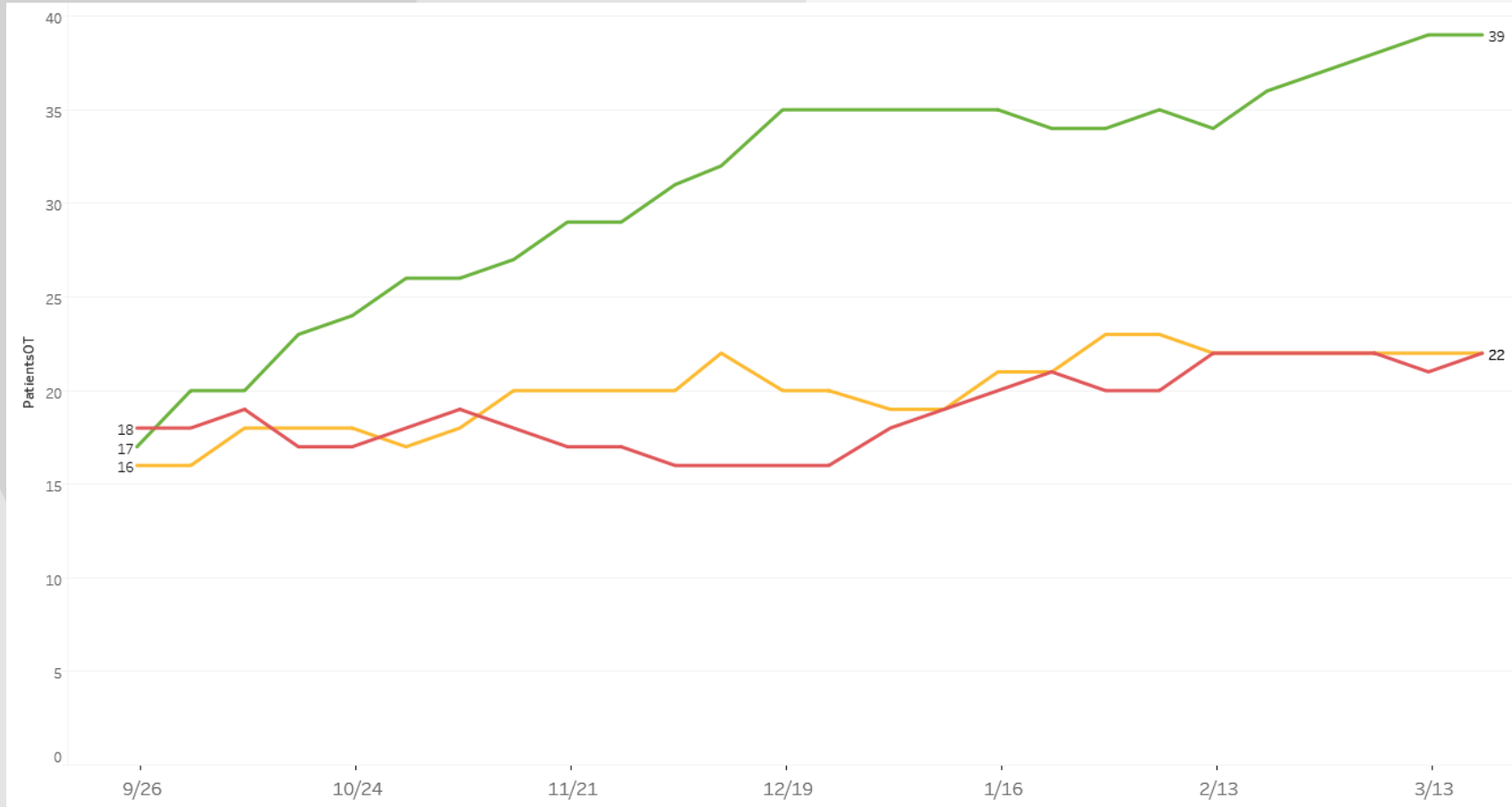




# FIT Test Orders over Time

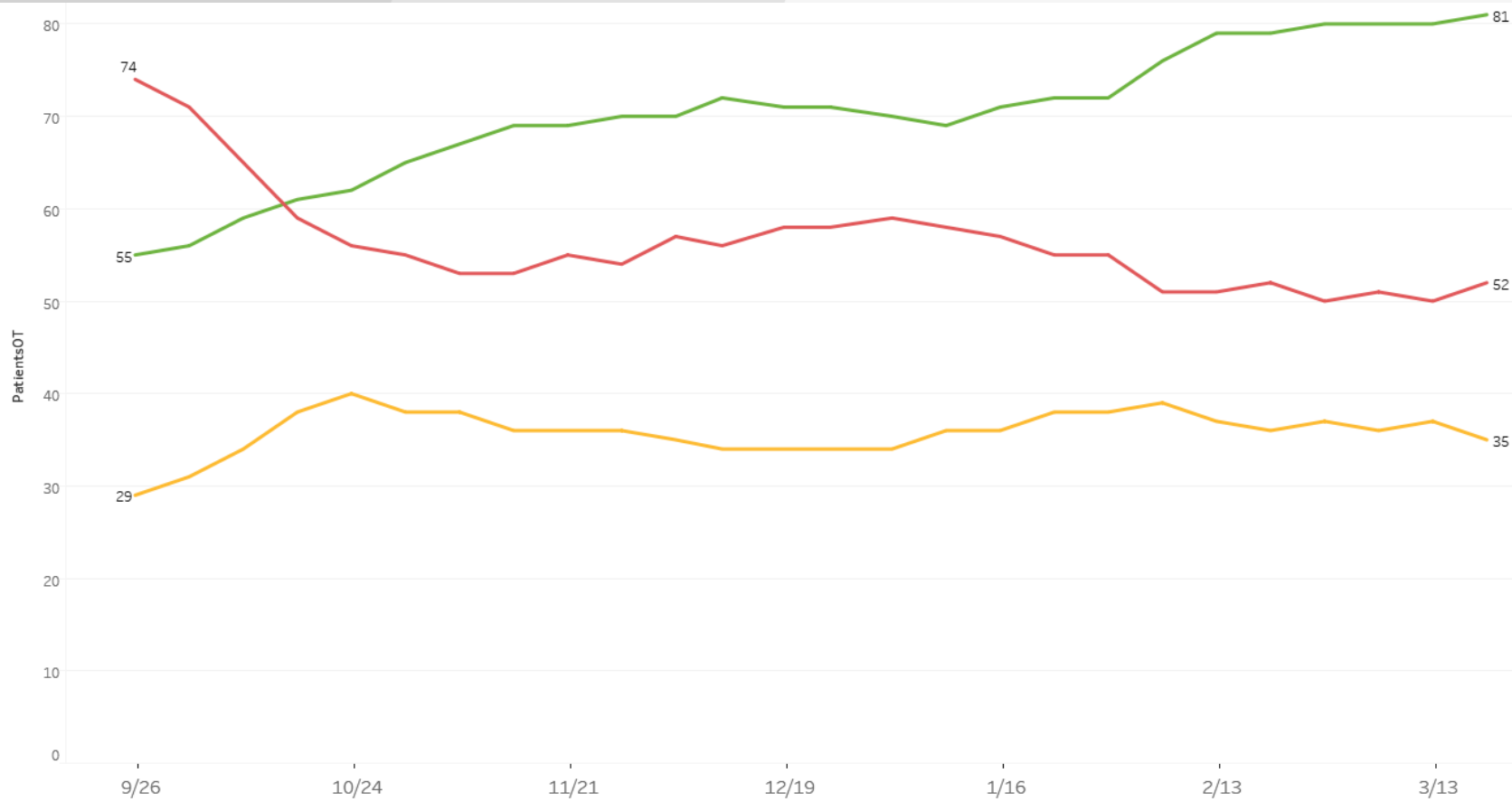


# Provider Achievement – Ex. 1



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# Provider Achievement, Ex. 2



# Outcomes Summary

- Introducing and updating dashboards has helped providers and their teams stay on top of screening
- FluFIT process and clinic templates dramatically increased both order rates and overall screening rates
- Providers who have greater buy-in have achieved better results
- Overall screening rate up 3% since introducing FluFIT, some providers up >20%

# Lessons Learned

- Insurance matters – Patients with Alliance have much better screening rates due to complete coverage of the FIT test
- Use of FluFIT improves screening rates
- Constant revision and reminders are essential
  - Biggest spurt in ordering was immediately after launch
- The process is still a challenge
  - Many patients still without orders
  - Many patients with incomplete orders – need reminders

# MA Feedback

- “All I do is print the label for the specimen on my admin day and ... when the patient checks in I print the requisition, and I give it to the patient ... and tell them that it’s a colorectal screening.”
- “[The provider] goes over the rest, sometimes I just give it to her before she goes in or [she] lets me know if I missed a patient 😊 **Team Work!**”
- “I haven’t had any push back from patients as of yet”

# Acknowledgements

- Sarah Henn, MD
  - Sr. Director of Healthcare Operations
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  - Manager of Population Health and Quality
- Lassine Cherif
  - HIT Data Analyst, DCPCA

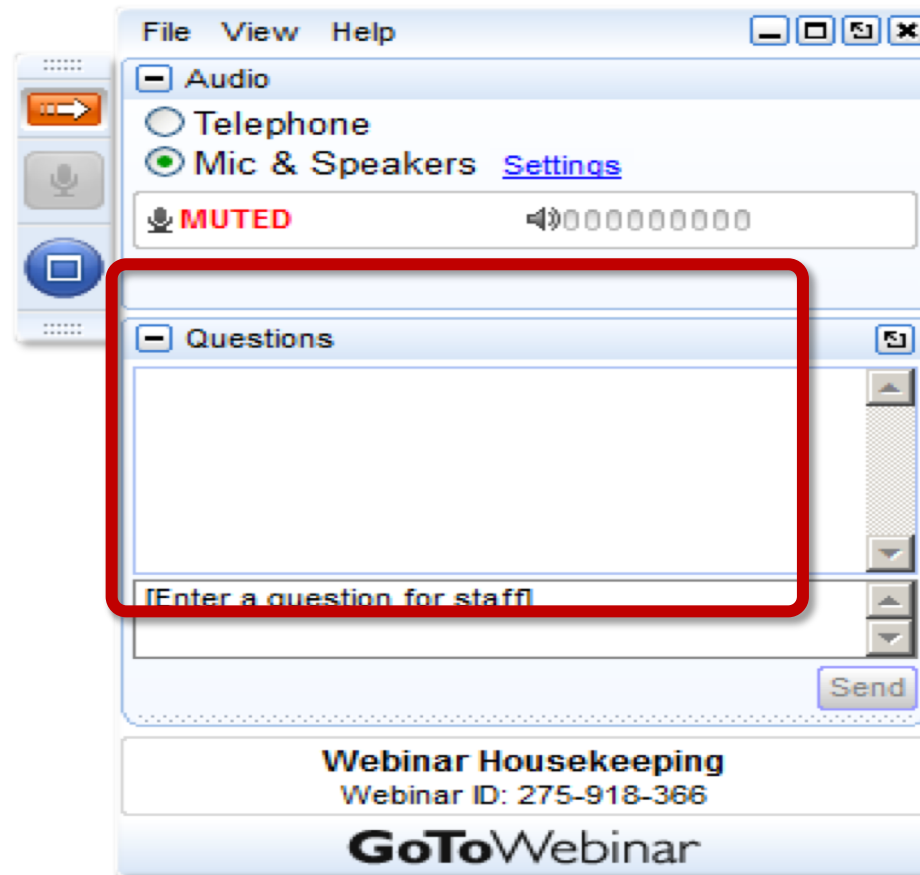
# Thank You!



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# Q&A



# **Webinar Satisfaction Poll Questions**

