Improving Outcomes in Colorectal Cancer:
Tips, Tools and Resources

Gregory A. Elkins, M.D.
Lincoln Primary Care Center/Southern WV Health System
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

www.nccrt.org
Collaboration with NACHC

Strategies for Expanding Colorectal Cancer Screening at Community Health Centers

Collaboration with NACHC

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.

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
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 (rohweder@email.unc.edu, 919-966-6879)

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

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

Cancer Causes Control., 2011
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.
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
Making appropriate screening recommendation requires accurate assessment of each patient’s risk status.

Individual Risk Levels

- Average
- Increased
- High
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.
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!
<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Age to Begin Screening</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| **Average risk**  
No risk factors  
No symptoms<sup>2</sup> | < Age 50  
≥ Age 50 | No screening needed  
Screen with any one of the following options:  
*Tests That Find Polyps and Cancer*  
FS q 5 yrs*  
CS q 10 yrs  
DCBE q 5 yrs*  
CTC q 5 yrs*  
OR  
*Tests That Primarily Find Cancer*  
gFOBT q 1 yr,**  
FIT q 1 yr,**  
sDNA*** |
| **Increased risk**  
CRC or adenomatous polyp in a first-degree relative<sup>3</sup> | Age 40 or 10 years younger than the earliest diagnosis in the family, whichever comes first | Colonoscopy<sup>4</sup> |
| **Highest risk**  
Personal history for > 8 years of Crohn’s disease or ulcerative colitis or a hereditary syndrome (HNPCC or, FAP, AFAP) | Any age | Needs specialty evaluation and colonoscopy |
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

![Diagram showing patient preferences between FOBT and Colonoscopy completed.]

- FOBT completed: 67%
- Colonoscopy completed: 38%

For FOBT Arm, Colonoscopy Arm, and Choice Arm, p-values are given:
- FOBT Arm vs Colonoscopy Arm: p = 0.64
- Colonoscopy Arm vs Choice Arm: p < 0.01
- FOBT Arm vs Choice Arm: p < 0.01

Inadomi, Arch Intern Med 2012
High Quality Stool Testing

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.

J Am Board Fam Med 2009
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

Medical Director __________________________ Printed Name __________________________ Signature __________________________

Effective date __________________________ Date reviewed __________________________

Date revised __________________________

San Francisco Health Plan
# 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
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.
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
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

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 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 learning tools.

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