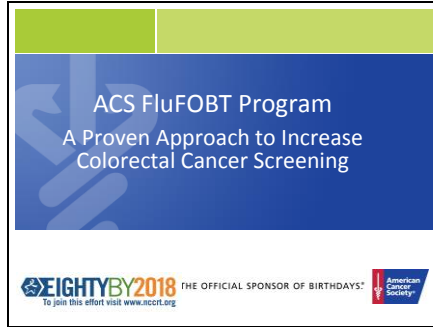


Slide 1

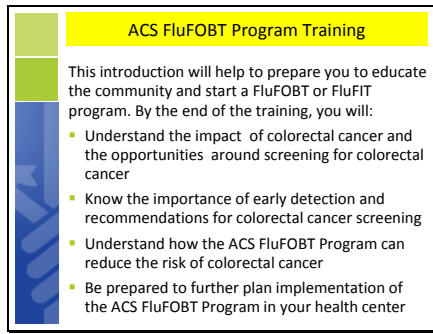


ACS FluFOBT Program
A Proven Approach to Increase
Colorectal Cancer Screening

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American Cancer Society

Slide 2

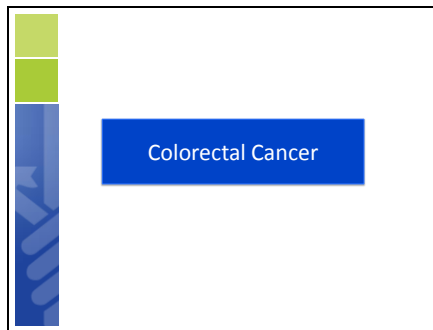


ACS FluFOBT Program Training

This introduction will help to prepare you to educate the community and start a FluFOBT or FluFIT program. By the end of the training, you will:

- Understand the impact of colorectal cancer and the opportunities around screening for colorectal cancer
- Know the importance of early detection and recommendations for colorectal cancer screening
- Understand how the ACS FluFOBT Program can reduce the risk of colorectal cancer
- Be prepared to further plan implementation of the ACS FluFOBT Program in your health center

Slide 3



Colorectal Cancer

Slide 4

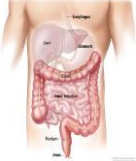
Colorectal Cancer

- The 3rd most common cancer in the U.S.
 - 132,700 new cases expected in 2015
- The 2nd deadliest cancer
 - 49,700 deaths this year
- Highly preventable and treatable
 - More than 1 million U.S. colorectal cancer survivors

Slide 5

Colon and Rectum

- The colon (large bowel or large intestine)
 - is a muscular tube about 5 feet long
 - absorbs water and salt from food
 - stores waste matter
- The rectum is the last 6 inches of the digestive system.




Slide 6

Colorectal Cancer

- Cancer that begins in either the colon or rectum
- Often called simply "colon cancer", or "CRC"
- Usually develops from pre-cancerous growth called a "polyp" in the lining of the colon or rectum.
- Finding and removing polyps can prevent CRC from occurring.

Slide 7

Who Can Get Colorectal Cancer?



Anyone.

Men and women of all ages and races get CRC.

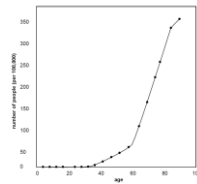
The good news is that screening can prevent getting the disease and dying from it.

Slide 8

Age: the most impactful risk factor

CRC usually develops after age 50.

The chances of getting it increases as you get older.



Age	Number of cases per 100,000
0	0
20	0
40	~10
60	~50
80	~150
100	~350

<http://science.education.nih.gov/supplements/nih1/cancer/guide/pdfs/ACT3M.PDF>

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

Graph obtained from <http://science.education.nih.gov/supplements/nih1/cancer/guide/pdfs/ACT3M.PDF>
Accessed 07/08/2013

Slide 9

Who's at **High** Risk of Colon Cancer?

- A personal history of
 - Polyps
 - Colorectal cancer
 - Inflammatory bowel disease
 - Ulcerative colitis
 - Crohn's disease
- A family history of
 - Colorectal cancer or polyps
 - Hereditary colorectal cancer syndrome

People with these conditions may need different screening. Check with a provider before giving an FOBT kit.

Slide 10

Screening


- **Screening** tests are done for people who don't have symptoms ("asymptomatic"). They are part of routine health care – like checking your blood pressure. They should be done at regular intervals.
- **CRC Screening** tests look for early cancer or pre-cancer (polyps) of the colon and/or rectum.

Slide 11

Why Test?

There are two aims of testing:


- 1. Prevention**
Find and remove polyps to prevent cancer
- 2. Early Detection**
Find cancer in the early stages, when best chance for a cure



Slide 12

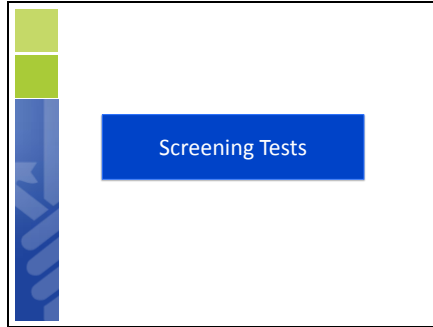
Why Testing is Important

People can't feel abnormal growths (polyps or early cancer) growing inside of them.

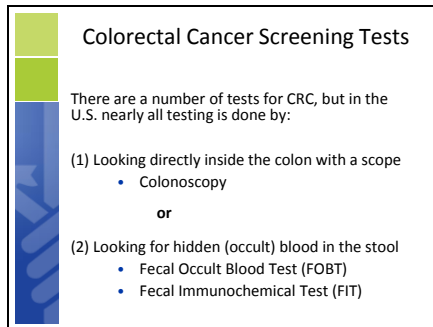


The only way to find them is by getting tested.

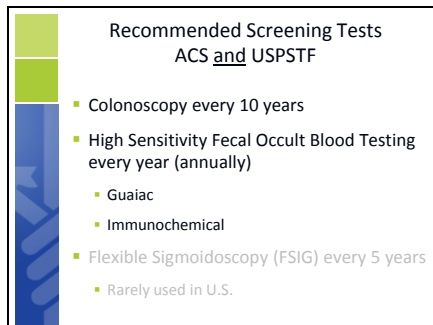
Slide 13



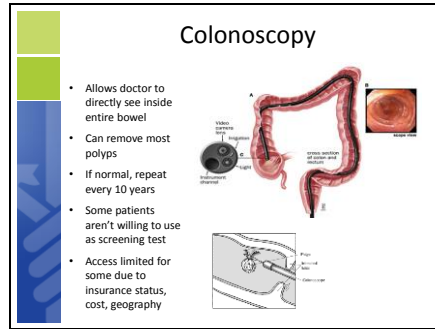
Slide 14



Slide 15



Flexible sigmoidoscopy is included on this slide because it is recommended by both ACS and USPSTF, but the pale grey text reflects its' low level of usage. It is available in only a few places in the US and accounts for only a tiny proportion of screening.



Colonoscopy: A **colonoscope** is a long, lighted flexible scope that is inserted through the rectum. Allows the doctor to see the lining of the entire colon. The colonoscope is also connected to a video camera and display monitor so the doctor can closely examine the inside of the colon.

If a small polyp is found, the doctor may remove it. Polyps, even those that are not cancerous, can eventually become cancerous. For this reason, they are usually removed. This is done by passing a wire loop through the colonoscope to cut the polyp from the wall of the colon with an electrical current. The polyp can then be sent to a lab to be checked under a microscope to see if it has any areas that have changed into cancer.

If the doctor sees a large polyp or tumor or anything else abnormal, a **biopsy** will be done. In this procedure, a small piece of tissue is taken out through the colonoscope. Examination of the tissue can help determine if it is a cancer, a noncancerous (benign) growth, or a result of inflammation.

Slide 17

Stool Testing (FOBT and FIT)

Polyps and cancer often leak only small amounts of blood which can't be seen (hidden or "occult" blood).

Fecal Occult Blood Tests (FOBT) and Fecal Immunochemical Tests (FIT) can find this small amount of blood in the stool.

If blood is found in the stool the patient needs a colonoscopy.

Slide 18

FOBT and FIT

Variety of brands and collection methods.


Some require patients to collect stool samples on cards.



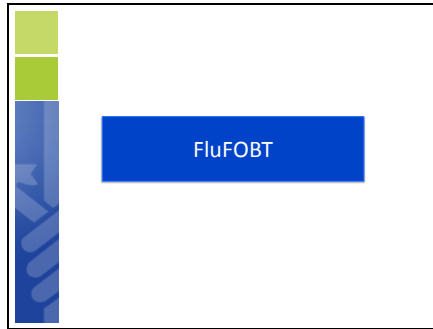
Slide 19

FOBT and FIT

Others require stool samples be placed in a tube.



Slide 20



Slide 21

What is a FluFOBT 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 FOBT kits to eligible patients when they get their annual flu shot
 - Either a high sensitivity FOBT or a FIT can be used for the FluFOBT Program
- Patient completes FOBT **at home** and returns kit to doctor's office or mails kit to the lab for processing
- FluFOBT programs are well accepted by patients
- Studies show FluFOBT leads to higher CRC screening rates (including studies in community health centers)


Discuss the pairing of flu and FOBT. Clinic staff need to understand the connection (both flu vaccination and FOBT/FIT testing must be done annually to be effective) and it is also important for them to share this with patients.

Slide 22

Why try FluFOBT?

- Many sites use FluFOBT 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

Slide 23




How To Set Up Your Flu-FOBT 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 FOBT and completing the test
 - Record keeping and follow up with patients provided FOBT kits

Detail each component of the set up


Slide 24



Program Set Up (continued)

- Choose times and locations for your program and advertise the fact that 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 FOBT/FIT BEFORE giving the flu shot

Slide 25



CRC Screening Eligibility & FluFOBT

- When should a patient be offered a FOBT kit during the ACS FluFOBT Program?
- Patient –
 - Is 50 years or older...
 - Has not had a colonoscopy in the last 10 years...
 - Has not had an FOBT test in the past year...

Slide 26

CRC Screening Eligibility & Flu-FOBT

- When should a patient **NOT** be offered a FOBT kit during the Flu-FOBT clinic?
 - Less than age 50
 - Had a colonoscopy in the last 10 years
 - Had a 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 correct screening recommendations

Slide 27

Program Set Up (continued)

- Develop systems to support follow up for those patients who received 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 FluFOBT program

Slide 28

Talking with Patients about CRC

- It is important to educate your patients about the importance of colorectal cancer screening and the FOBT
- It is very important to remind patients to complete and return the 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!

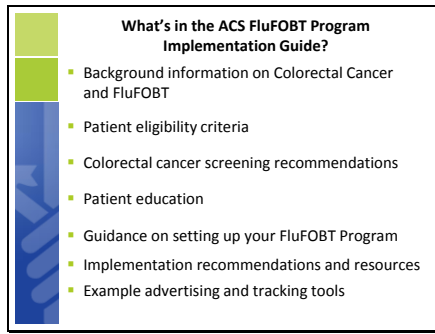
Discuss useful points to share with patients regarding facts about CRC and screening as well as FOBT kits. It is important for the patient to understand the instructions on how to do the test they are given. Patients should be asked to return it within 2 weeks.

Telephone calls may have even more of an impact than mailed reminders but both types of reminders work to increase return rates. 2 weeks is the optimal time to call/or send a reminder to patients who have not returned a kit.

Slide 29



Slide 30



Discuss why the Implementation Guide was developed; what is included and the goals/purpose/use of the Guide

Slide 31



University of California, San Francisco put together by Dr. Michael Potter and colleagues
Flufobt.org or flufit.org

Includes: CDC flu Vaccine Guidelines; Info on commonly used FOBT and FIT brands; patient instructions on commonly used brands (in a few languages and visual to address lower literacy levels; Talking points for clinic staff to use with patients about crc screening and fit/fobt; Sample fit/fobt results tracking sheet; sample postcard reminder; sample telephone reminder script;

Sample posters to advertise the flu/fobt program.

Slide 32

Acknowledgments

The American Cancer Society would like to thank Michael Potter, MD, former National Colorectal Cancer Roundtable (NCCRT) Steering Committee member and current chair of the NCCRT Professional Education and Practice Task Group, and his colleagues (at UCSF, the San Francisco Department of Public Health, and Kariser Permanente) and funders (ACS, CDC, and NCI), for developing and demonstrating the effectiveness of FLuFOBT interventions.

We thank FLuFOBT project coordinators La Phengrasamy, MPH, Vicky Gomez MPH, and Tina Yu for developing and field-testing many of the program materials and procedures included in this Implementation Guide.

We would also like to thank Holly Wolf, PhD, MSPH, NCCRT Steering Committee member and chair of the NCCRT Policy Action Task Group, and her colleagues at the Colorado Colorectal Screening Program for organizing FLuFOBT.org Web site materials into a model implementation guide.

<http://www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-033144.pdf>

[Share and leave behind the Clinician's Reference: FOBT](#) document (link above)

This document is designed to educate clinicians about important elements of colorectal cancer screening using fecal occult blood tests (FOBT). It provides state-of-the-science information about the major types of fecal tests (guaiac and immunochemical), test performance, and characteristics of high quality screening programs.

Questions



The slide features a vertical decorative bar on the left side, composed of two light green rectangular segments at the top and a larger blue segment below. The blue segment contains a white upward-pointing arrow and a white question mark. The main content area is white and contains the word "Questions" at the top center. Below the text is a 3D illustration of a white, stylized human figure standing on a white surface, looking up at a large, blue, 3D question mark.