Colorectal Cancer Screening Rates in Health Centers

Data Source: UDS data 2012.
Adults 50-75 years of age who have received any of the following: colonoscopy during reporting year or previous 9 years, flexible sigmoidoscopy conducted during reporting year or previous 4 years, or FOBT or FIT during reporting year.
Sub-Optimal Screening Rates

*Reasons (according to Patients)*

- Low awareness of CRC as a *personal* health threat
- Lack of knowledge of screening benefits
- Fear, embarrassment, discomfort
- Time
- Cost
- Access
- Structural issues (lack of systems in most settings)
- “My doctor never talked to me about it!”

*But 98% of physicians say they are screening*
What’s the Problem?

The vast majority of PCPs recommend screening, *but not to all at-risk patients*, because:

- 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
National Colorectal Cancer Roundtable

• Co-Founded by ACS and CDC in 1997
• Mission – increase colorectal cancer screening throughout the U.S.
• Collaborative partnership of over 70 member organizations
• Includes many nationally known experts, thought leaders, and decision makers on colorectal cancer
• A wide range of projects, tools and publications have been produced and disseminated
• Learn more at www.nccrt.org
The Quality of Colonoscopy Services—Responsibilities of Referring Clinicians

A Consensus Statement of the Quality Assurance Task Group, National Colorectal Cancer Roundtable

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Primary care clinicians initiate and oversee colorectal screening for their patients, but colonoscopy, a central component of serenocarcass examination, is usually performed by other physicians. This consensus statement reflects the joint efforts of experts who have reviewed the literature and developed a consensus on the responsibilities of referring clinicians in the context of colorectal cancer screening.

Guideline from the American Cancer Society, the US Preventive Services Task Force, and other recommend high-sensitivity fecal occult blood tests (FOBT) as one option for colorectal cancer screening. This document provides state-of-the-art information about genetic-based FIT and fecal immunologic tests (FIT) for colorectal cancer screening.

Two main types of FOBT are available—genetic-based FIT and HCT

Guidelines for FOBT have been the most common form of stool tests used in the US. Modern high-sensitivity FOBTs have been found to be as effective as genetic-based FOBTs in detecting colorectal cancer and adenomas. FIT is more sensitive than genetic-based FOBTs in detecting colorectal cancer and adenomas.

Abstract

While colorectal cancer is the most common cancer in men and women, early detection and prevention can significantly reduce the risk of developing and dying from this disease. The Patient Centered Medical Home Model (PCMH) aims to improve primary care by providing comprehensive, coordinated care to patients. PCMH is a model that focuses on providing high-quality, patient-centered care and improving access to care by reducing wait times for appointments.

Sanctions enforced: As part of the patient-centered medical home model, increasing communication between different healthcare providers and patients can improve outcomes. This collaborative approach can lead to better management of chronic conditions and overall health.

Tools, Resources and Publications

Tools, Resources and Publications
Improving Screening Rates
# Characteristics of High Performing Practices

## Table 2. Strategies to Achieve High Performance in Colorectal Cancer Screening

<table>
<thead>
<tr>
<th>Improvement Model</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritize performance</td>
<td>Commit to practice changes needed to improve.</td>
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<tr>
<td></td>
<td>Have regular practice meetings to review improvement approaches and their impact.</td>
</tr>
<tr>
<td></td>
<td>Offer patients choice of recommended CRC screening options.</td>
</tr>
<tr>
<td>Delivery system design</td>
<td>Adopt and publicize recommendation for regular health maintenance visits.</td>
</tr>
<tr>
<td></td>
<td>Remind patients of needed health maintenance visits.</td>
</tr>
<tr>
<td></td>
<td>Standing orders for CRC screening.</td>
</tr>
<tr>
<td></td>
<td>Review CRC screening status at all patient visits.</td>
</tr>
<tr>
<td>Electronic medical record tools</td>
<td>Maintain accurate information in the health maintenance tables.</td>
</tr>
<tr>
<td></td>
<td>Empower all staff to review health maintenance table at all patient contacts.</td>
</tr>
<tr>
<td></td>
<td>Use reports to identify and contact patients not current with CRC screening.</td>
</tr>
<tr>
<td>Patient activation</td>
<td>Repeat messages to patients who do not initially agree to screening.</td>
</tr>
<tr>
<td></td>
<td>Provide patient education materials about CRC screening.</td>
</tr>
<tr>
<td></td>
<td>Contact patients that have not completed ordered screening.</td>
</tr>
</tbody>
</table>
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

American Cancer Society*  National Colorectal Cancer Roundtable  Thomas Jefferson University
Toolkit - Multiple Versions

- Original, full-length*
- Action Plan*
  - Pennsylvania Academy of Family Physicians
    http://www.nxtbook.com/nxtbooks/pafp/crc-screening_quickguide/index.php#/0
- Community Health Center version

* Available at www.nccrt.org and www.cancer.org/colonmd
Staff Involvement

- Key Point.....the clinicians can’t 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 for mammography, etc.
- Involve staff in meetings to discuss progress in achieving office goals for improving the delivery of preventive services
Develop a Screening Policy
Create a standardized course of action.
Engage your team in creating, supporting, and following the policy.

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.
The Four Essentials to Cancer Screening

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.

Communication
#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.
Sample Screening Algorithm

Assess Risk: Personal & Family History

Average risk = No family history of CRC or adenomatous polyp

< 50 years

Do not screen

≥ 50 years

Screen

If positive, diagnosis by colonoscopy

Increased or high risk based on personal history

Adenoma

CRC

IBD

Surveillance Colonoscopy

Screening colonoscopy, genetic testing, and other cancer screening as appropriate

High Risk: Germline Syndrome

HNPCC or FAP

Adenoma or cancer

Screen with colonoscopy 10 years before youngest relative or age 40

Sample Tools for Your Practice

This version of stage theory was adapted from the work of RE Myers.

Assess Risk: Personal & Family History

Increased or high risk based on family history

No family history of CRC or adenomatous polyp

Increased or high risk based on personal history

< 50 years

Increased or high risk based on family history

≥ 50 years

Increased or high risk based on family history

Options

Tests That Find Polyps and Cancer
Flexible sigmoidoscopy every 5 years, or
Colonoscopy every 10 years
Double-contrast barium enema every 5 years, or
CT colonography (virtual colonoscopy) every 5 years

Tests That Primarily Find Cancer
Yearly fecal occult blood test (gFOBT)*, or
Yearly fecal immunochemical test (FIT)*, or
Stool DNA test (SDNA), interval uncertain

*The multiple stool take-home test should be used. One test done by the doctor in the office is not adequate for testing.
The tests that are designed to find both early cancer and polyps are preferred if these tests are available and the patient is willing to have one of these more invasive tests.
Recognize potential barriers to screening

Recommendation 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
- Cost concerns
Affordable Care Act

Cancer Screening:

- No co-pays and coverage for cancer screening with an “A” or “B” recommendation from USPSTF.
- Waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue.
- “Loophole” led to co-pays for some when polyp found during screening exam. This has been addressed for private plans, but remains an issue for Medicare.
#2 Develop a Screening Policy

**Essential #2:**

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

- Choose your guideline
- Choose your test(s)

**Essential #2:**

Compile a list of screening resources and determine the screening capacity available in your community.
<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Age to Begin Screening</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average risk</strong>&lt;br&gt;No risk factors&lt;br&gt;No symptoms²</td>
<td>&lt; Age 50</td>
<td>No screening needed&lt;br&gt;Screen with any one of the following options:&lt;br&gt;Tests That Find Polyps and Cancer&lt;br&gt;FS q 5 yrs*&lt;br&gt;CS q 10 yrs&lt;br&gt;DCBE q 5 yrs*&lt;br&gt;CTC q 5 yrs*&lt;br&gt;OR&lt;br&gt;Tests That Primarily Find Cancer&lt;br&gt;gFOBT q 1 yr**, sDNA***</td>
</tr>
<tr>
<td><strong>Increased risk</strong>&lt;br&gt;CRC or adenomatous polyp in a first-degree relative³</td>
<td>Age 40 or 10 years younger than the earliest diagnosis in the family, whichever comes first</td>
<td>Colonoscopy⁴</td>
</tr>
<tr>
<td><strong>Highest risk</strong>&lt;br&gt;Personal history for &gt; 8 years of Crohn’s disease or ulcerative colitis or a hereditary syndrome (HNPCC or, FAP, AFAP)</td>
<td>Any age</td>
<td>Needs specialty evaluation and colonoscopy</td>
</tr>
</tbody>
</table>
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
  - Measurable outcomes vary widely (i.e. 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
Fecal Occult Blood Tests

- Look for hidden blood in stool
- Two major types (but multiple brands)
Guaiac Tests

- Most common type in U.S.
- Best evidence (3 RCT’s)
- 30 year f/u (NEJM Oct 2013)
- Need specimens from 3 bowel movements
- Non-specific
- Results influenced by foods and medications
- Older forms (Hemoccult II) have unacceptably low sensitivity
- Better sensitivity with newer versions (Hemoccult Sensa)
Fecal Immunochemical Tests (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
- Slightly more costly than guaiac tests
FOBT Quality Issues

Sensitivity of Take Home vs. In-Office FOBT

<table>
<thead>
<tr>
<th>FOBT method (Hemoccult II)</th>
<th>Sensitivity</th>
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<tr>
<td></td>
<td><strong>All Advanced Lesions</strong></td>
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<tr>
<td>3 card, take-home</td>
<td>23.9 %</td>
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<tr>
<td>Single sample, in-office</td>
<td>4.9 %</td>
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Collins et al, Annals of Int Med Jan 2005
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 guaiac tests (such as Hemoccult II) should not be used for CRC screening.
- Annual testing
- All positive screening tests should be evaluated by colonoscopy
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
#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.
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.
Dear (Name):

Colon cancer is the second leading cause of cancer-related deaths in the United States, and men and women are equally at risk. The good news is that colon cancer can be prevented or detected early and death from colon cancer can be prevented if screening is done on a regular basis.

Our records indicate that it is time for your annual physical and cancer screening. Please call your primary care physician, at XXX-XXX-XXXX so that you can schedule an appointment at your earliest convenience.

Sincerely,
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
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.
# Chart Audit Tool

## Chart Audit Template

<table>
<thead>
<tr>
<th>Name</th>
<th>ID</th>
<th>Date</th>
<th>Gender</th>
<th>Race</th>
<th>Ethnicity</th>
<th>Screen Choice</th>
<th>FOBT</th>
<th>Return</th>
<th>Result</th>
<th>Result Date</th>
<th>Flexible Sigmoidoscopy</th>
<th>CS</th>
<th>Result</th>
<th>Result Date</th>
<th>Diagnosis</th>
<th>Colonoscopy</th>
<th>CS</th>
<th>Result</th>
<th>Result Date</th>
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<td>FOBT/FS or CS DCBD</td>
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<td>FOBT</td>
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Diagnosis column is left blank as it can vary based on the results of the medical procedures.
Case Study:
Collaborative CRC Screening Improvement Project in the CHC Setting

Collaborators:
Lone Star Family Health Center (LSFHC), Texas Association of Community Health Centers (TACHC), Texas Medical Association (TMA) and American Cancer Society (ACS)
Case Study

Project Overview:

- System-based policy/practice change initiative aimed to increase CRC screening rates among the patient population of a federally-qualified health center, Lone Star Family Health Center (LSFHC)
- Training and operational support from ACS, TACHC and TMA’s Physician Oncology Education Program
- Funded through Walmart Foundation
Case Study

Project Description:

- Clinician and staff education
- CRC policies and procedures developed and implemented based on the “4 Essentials” of the NCCRT/ACS Clinician’s Toolbox
- Referral network strengthened
- CRC screening promoted in LSFHC community outreach efforts
- Technical support and evaluation through TACHC
Case Study

Project Implementation:
- Clinician and staff education
- CRC screening question added to patient history
- Provider prompt created in EHR
- Patient reminder calls initiated
- Screening completion tracking initiated
- CRC screening message added to telephone on-hold system
Case Study

Outcomes:

- Screening rate nearly doubled (174 patients screened vs 93 in preceding year)
- Increased patient compliance with screening recommendation
Case Study

Lessons Learned:
- Support staff is key (drove the process, facilitated provider and patient uptake)
- Establishing policy ensures a consistent standard of care and provides sustainability
- Use of EHR facilitates patient identification and tracking
- Potential for use as a quality-improvement initiative for PCMH certification
Case Study

Challenges:

- Patient limitations (transportation, out-of-pocket costs)
- Difficulty arranging diagnostic colonoscopy for uninsured patient
- Referral reminders and support system needed
CRC screening and the Patient Centered Medical Home
Promoting Cancer Screening Within the Patient Centered Medical Home

Mona Sarfaty, MD, MPH; Richard Wender, MD; Robert Smith, PhD

Abstract

While consensus has grown that primary care is the essential access point in a high-performing health care system, the current model of primary care underperforms in both chronic disease management and prevention. The Patient Centered Medical Home model (PCMH) is at the center of efforts to reinvent primary care practice, and is regarded as the most promising approach to addressing the burden of chronic disease, improving health outcomes, and reducing health spending. However, the potential for the medical home to improve the delivery of cancer screening (and preventive services in general) has received limited attention in both conceptualization and practice. Medical home demonstrations to date have included few evidence-based preventive services in their outcome measures, and few have evaluated the effect of different payment models. Decreasing use of hospitals and emergency rooms and an emphasis on improving chronic care represent improvements in effective delivery of healthcare, but leave opportunities for reducing the burden of cancer untouched. Data confirm that what does or does not happen in the primary care setting has a substantial impact on cancer outcomes. Insofar as cancer is the leading cause of death before age 80, the PCMH model must prioritize adherence to cancer screening according to recommended guidelines, and systems, financial incentives, and reimbursements must be aligned to achieve that goal. This article explores capacities that are needed in the medical home model to facilitate the integration of cancer screening and other preventive services. These capacities include improved patient access and communication, health risk assessments, periodic preventive health exams, use of registries that store cancer risk information and screening history, ability to track and follow up on tests and referrals, feedback on performance, and payment models that reward cancer screening. CA Cancer J Clin 2011;000:000–000. ©2011 American Cancer Society.
NCQA Standards & Guidelines of the PCMH

1. Enhance Access and Continuity
2. Identify and Manage Patient Populations
3. Plan and Manage Care
4. Provide Self-Care Support & Community Resources
5. Track and Coordinate Care
6. Measure & Improve Performance

* Standards for Patient-Centered Medical Home (PCMH) 2011. Published by the National Committee for Quality Assurance: Washington, DC; Appendix 3-2.
Support of PCMH

Clinician’s Toolbox supports CHC efforts to meet PCMH Standards:

- Standard 2: Identify and Manage Patient Population
- Standard 3: Plan and Manage Care
- Standard 5: Track and Coordinate Care
- Standard 6: Measure and Improve Performance
ACS Support of PCMH

- **PCMH Standard 4: Provide Self-Care and Community Support**
  - ACS **1-800-227-2345** 24hr/7days a week. Provides support for full cancer continuum from prevention through survivorship.
  - 1-800# also supports over 170 languages and provides access to community resources. For example, support for newly diagnosed patients and their families.
  - [www.cancer.org](http://www.cancer.org) provides comprehensive information, video, podcasts, etc.
  - Patient Brochures, posters, videos, etc. to support preventive care delivery (*also relevant for EHR meaningful use*)
Screening Navigation
Figure 1. Flow diagram is shown for Community Cancer Screening Program patient navigator activities at community health center clinics.
Patient Navigation

Most CRC screening navigator models include:
• Repeat phone calls to patients to aid with scheduling,
• Bowel preparation instructions
• Appointment reminders.

Some include more expansive services such as:
• Translation services
• Assistance with transportation
• Referral to other social services if needed
• Face-to-face meetings with participants/clients
• Accompanying to endoscopy visits if needed.
Figure 2. Type of colorectal testing completed for those current for testing, both years 1 and 2.
FluFOBT / FluFIT
CRC Screening Outreach During Annual Flu Shot Activities

- Potential Benefits of “Flu-FOBT” or “Flu-FIT” Programs:
  - 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 involve non-physician staff in screening activities
  - Educates patients that “just like a flu shot, you need FOBT/FIT every year”

*Slide courtesy of Dr. Michael Potter*
Results – SFGH 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 Only days</th>
<th>FLU+FOBT days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(246 patients)</td>
<td>(268 patients)</td>
</tr>
<tr>
<td>Up-to-Date Before Flu Season</td>
<td>52.9%</td>
<td>54.5%</td>
</tr>
<tr>
<td>(Oct 16, 2006)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up-to-Date After Flu Season</td>
<td>57.3%</td>
<td>84.3%</td>
</tr>
<tr>
<td>(Mar 31, 2007)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change: (p&lt;0.001)</td>
<td>+4.4 points</td>
<td>+29.8 points</td>
</tr>
</tbody>
</table>

*Ann Fam Med, 2009*
FLU-FOBT/FIT

FLU-FOBT/FIT Interventions

- Has 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
Flu/FIT Implementation Guide and Materials

http://flufobt.org
ACS Resources

- Information and materials on colorectal cancer for clinicians and patients are available at: [www.cancer.org/colonmd](http://www.cancer.org/colonmd)

- Updated materials for other cancers are available at: [www.cancer.org/professionals](http://www.cancer.org/professionals)