Bree Collaborative | Colorectal Cancer Guideline Implementation Workgroup
January 10th, 2020 | 10:30 – 12:00
Foundation for Health Care Quality
705 2nd Avenue, Suite 410 | Seattle, WA 98104

MEMBERS PRESENT

Rick Ludwig, MD, Bree Collaborative, Providence Washington
John Dunn, MD, Pediatrician, Kaiser Permanente
Bev Green, MD, Family Physician, Senior Investigator at Kaiser Permanente Health Research Institute
Julie Stofell, Manager, Clinical Programming
Hagen Kennecke,* MD, Medical Oncology, Virginia Mason
Patricia Auerbach,* MD, United Health Care

STAFF AND MEMBERS OF THE PUBLIC

Ginny Weir, MPH, Bree Collaborative
Amy Etzel, Bree Collaborative
Alex Kushner, Bree Collaborative

* By phone/web conference

BREE COLLABORATIVE OVERVIEW

Rick Ludwig, MD, Bree Collaborative, Providence Washington, and Ginny Weir, MPH, Bree Collaborative welcomed members to the workgroup and those present introduced themselves and gave a short summary of their background.

Ms. Weir gave a short overview of the Bree Collaborative, covering:

- Roberts Rules of Order
- Why the Bree Collaborative was formed and how it chooses its members and workgroup topics
- How recommendations are developed
- The proposed plan and timeline for this workgroup

CHARTER DISCUSSION

Ms. Weir opened up the floor to discussion by prompting the group with a question: what changes would the group like to see in colorectal care in 10 years as the result of their work?

- Heightened public awareness around colorectal cancer screening.
    - Better public information regarding the different types of colorectal cancer screening and the pros and cons of each test.
        - The group discussed briefly the pros and cons of a fecal test versus a colonoscopy. While colonoscopy can remove cancer in some cases, it has a 10 percent miss rate and is dependent on human skill. Fecal test is more frequent (1 year for fecal versus 10 years for colonoscopy).
    - Practitioners may have a knowledge gap regarding which type of screening to use that the group would like to address.
    - Follow up colonoscopy rates are quite low after a positive fecal test—practitioners need to make this recommendation more strongly.
- Any test is better than no test. Kaiser Permanente WA conducted a trial where that saw screening double screening over 10 years. People who are not screened over time tend to get

harder to screen. Kaiser saw results from mailing fecal tests out, especially to non-white populations which prefer fecal tests over a colonoscopy.
    - Kaiser also found that providing navigation with a nurse led to a 10% increase in screening.
    - Kaiser also did a cluster trial using a registry built into Epic that could alert doctors when patients were due for screening and print mailing labels for fecal kits. When clinics implemented this system, they got a 17-18% increase in testing. However, clinics had issues implementing the system.
- Emphasize to practitioners and health plans that colorectal screening is one of the most cost effective cancer measures.
- The group discussed which methods are most effective for increasing screening rates.
    - One member argued that embedding screening reminders into primary care virtual records (so that patients going to primary care are automatically flagged) produced better results than mail reminders.
    - Kaiser compared their fecal kit mailing test to good Epic health integration and found that the kits were more effective. Providing navigation was also more effective.
    - Providence saw strong results from Epic integration with primary care and outreach.
    - Group agreed that best practices for increasing screening rates and outreach is fertile ground for the group.
- Rural areas and the uninsured are the two populations with the lowest screening rates.
- The group agreed that the problem statement that they are trying to address is how to close screening rate disparities, especially given the relative simplicity of screening.
- Ms. Weir asked whether or not to address the starting age of screening in the recommendations.
    - The group also brings up addressing data around genetic testing for risk and data based on race.
- The low rate of follow up colonoscopy after positive fit was reemphasized. Health plans should be responsible for this in addition to providers.
- The group agreed that best practices for surveillance after a polyp is identified should be in scope.

Action Items: Group to look at AGA collaborative review of surveillance recommendations.

- The group discussed whether or not anesthesia should be covered during a colonoscopy.
    - There is large variability on coverage of anesthesia depending on the quality of the health plan.
- Behavioral work is also an important factor in encouraging screening—this might be a realm for the workgroup to consider.
- The group discussed that, in an ideal world, there would be a state registry that tracks colon cancer screening so that patients who are changing providers or health plans (or who have no insurance or health care) have a record of when they need to be screened.
- The group can help the patient, providers, and health plans have a common vision in terms of screening.
- Ms. Weir summed up key scoping focuses for the charter:
    - Which screening modalities are appropriate in different situations
    - Increasing accessibility to screening and screening rates in general
    - Billing for anesthesia
    - Beginning and ending age for screening, especially for high risk populations

    - Shared decisions making for screening
- Dr. Green suggested coming up with metrics for measuring the success of the group's work. She suggested having someone from the Health Alliance come to talk about measuring screening data—they can pull Medicare data and health plan data.
    - Possibility of recommending that health plans be accountable to Medicaid metrics in the same way that they are to Medicare.
- The group discussed other members who need to be at the table:
    - Someone from UW—Dr. Green will contact Dr. John Inodomi
    - Dr. Jason Dominitz was recommended (Dr. Green to reach out to him)
    - More gastroenterologists
    - Advocacy groups (American Cancer Society—Dr. Green recommended Tammy Wild; Casey Eastman at the colon health program for the state)

GOOD OF THE ORDER

Dr. Ludwig thanked all for attending and adjourned the meeting.