
Bree Collaborative | Colorectal Cancer Guideline Implementation WorkgroupFebruary 14th, 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 WashingtonBev Green, MD, Family Physician, Senior
Investigator at Kaiser Permanente Health
Research Institute

Julie Stofel, Patient and Family Advocate

Hagen Kennecke,* MD, Medical Oncology,
Virginia Mason

Patricia Auerbach, MD, United Health Care

Elizabeth Broussard,* MD, Gastroenterology,
Pacific Medical Centers First HillTammy Wild, MPH, RDN, LD, NSCA-CPT, State
Health Systems Manager, American Cancer
SocietyVal Simianu,* MD, MPH, Colon and Rectal
Surgeon, Virginia Mason, and Associate
Medical Director at SCOAPRachel Issaka,* M.D., M.A.S., Assistant member,
Gastroenterology and Hepatology Clinical
Research Division, Fred Hutch**STAFF AND MEMBERS OF THE PUBLIC**

Ginny Weir, MPH, Bree Collaborative

Amy Etzel,* Bree Collaborative

Alex Kushner, Bree Collaborative

Vickie A. Kolios-Morris,* MSHSA, CPHQ,
Senior Program Director, SCOAP and Spine
COAPAri Bell-Brown,* MPH, Fred Hutch (working with
Rachel Issaka)Joanna Law,* MD, FRCPC, FASGE,
Gastroenterology, Virginia Mason

* 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. Dr. Ludwig noted a typo in the minutes and asked for the removal of an incorrect statement about the need for anesthesia during a colonoscopy.

Motion: Approval of January 10th Minutes, with two changes noted by Dr. Ludwig.

Outcome: Passed with unanimous support.

PRESENTATION BY BEV GREEN: COLORECTAL CANCER CONTROL LITERATURE REVIEW

Bev Green, MD, Family physician, Senior Investigator at Kaiser Permanente Health Research Institute, gave a presentation to the workgroup about the current literature for colorectal cancer.

- Colorectal Cancer (CRC) is the second leading cause of cancer death. CRC screening decreases incidence and mortality by finding and removing pre-cancerous lesions and by finding the cancer early.
- Rates of cancer and mortality in 45-50 age range is going up; however, in general it is more prevalent in older populations. Those over 80 are often not screened anymore even though they have highest risk.
- Dr. Green reviewed the causes of CRC death: never screened is the largest cause of failure. Failure of follow-up after has the highest risk of CRC death.

- Dr. Green reviewed the Washington State CRC screening rate. Medicare rates nationally are higher than state rates.
 - Large screening disparities between urban and rural areas, especially for Medicaid population.
- Best ways to increase screening rates: Direct mailing of fecal kits; Flu-FIT programs are moderately effective; education and telephone reminders; navigation is very effective; rates increase if FIT is offered; interventions targeting physicians/teams; patient incentives are mixed.
- Dr. Green then reviewed Kaiser’s Systems of Support study to increase CRC screening.
 - 5000 patients randomized to either usual care or mailed, those plus telephone reminders, or all of those interventions plus nurse navigation, with interventions repeated in year 2 for those still eligible for screening.
 - At 12 months, CRC screening rates in the usual care, mail only, mail plus phone reminder, and mail plus navigation were 39%, 62%, 68%, and 75% respectively.
- Less is known about how to spread, scale-up, and sustain research tested programs for increasing screening uptake.
- Kaiser found it was harder to increase rates at FQHCs. Only 4% increase with mailed FITs because implementation is difficult. When clinics had dedicated implementation teams, rates went up. Without implementation teams, FIT mailing was always unsuccessful.
- University of Washington and Kaiser investigators did another study with 2 Medicaid health plans and used vendors to support the clinics in mailing FIT tests. Rates increased by 18%.
- Washington’s Medicaid CRC screening rates from 2015-2018 have been mostly flat; Oregon’s have increased.
- Last slide is of Northern California care—moved to a FIT program and are tracking all results—over 80 percent for the whole population screened—mortality rates cut by over half.
- Julie Stofel, Manager, Clinical Programming, mentioned the importance of asking about family history of polyps and inflammatory bowel disease.
 - Dr. Green emphasized the importance of putting systems in place to ask those questions.

Action Item: Ms. Weir to email Dr. Green’s slideshow out to the workgroup members.

CHARTER DISCUSSION

Ms. Weir directed the group back to discussing the scope of its work going forward, and any changes that the group would like to make to the Charter:

- In the Purpose section, the follow changes were made:
 - Changing “endorsement of” in the second bullet to “reviewing existing” since the goal is to review existing guidelines before endorsing them.
 - Changing the anesthesia bullet to “informed decision making around anesthesia during screening, including no anesthesia”.
 - A member asked about racial and ethnic data on disparities in care. Dr. Ludwig said that the WHA has helpful data, **Ms. Weir and Dr. Ludwig will look this up.**
 - Rachel Issaka, M.D., M.A.S., Fred Hutch, noted that the current data does not note any racial disparities in screening, but that seems hard to believe.
 - One member made a comment about the need for more education around the signs and symptoms of colorectal cancer. Dr. Green talked about rectal bleeding education.
 - Dr. Ludwig asked the group about best practices for surveillance after identification of a polyp—he thought it might be too large of an ask for the group. Two other members agreed and encouraged focusing on improving screening since surveillance is a large topic. That bullet point was removed from the charter.
- Dr. Issaka said that payers need incentives to follow up with a colonoscopy after a positive fit.

- Needs to be a package for both FIT and colonoscopy, but Dr. Green said she doesn't know how to do it practically. Part of the issue is that after the positive FIT it is no longer an asymptomatic test, it becomes diagnostic—this changes co-pay and other payment. Also, whether or not the follow up is considered asymptomatic or diagnostic is inconsistent.
- Oregon has passed legislation that does not allow out of pocket payment for patients after positive FIT for a colonoscopy.
- Ms. Weir summarized that there are two issues: what is the copay after a positive FIT, and how does a plan know that a positive FIT has happened?
- Ms. Weir asked the group, in an ideal world, who sends out the FITs?
 - Dr. Ludwig said that the PCP owns the FIT process.
 - Dr. Auerbach agreed, but the PCP needs to have a resource to do this—someone who handles FIT. Dr. Green said that Kaiser would not do this and Europe does not either—this would overload PCP. PCPs need to have a centralized system and staff for managing FITs.
- Ms. Weir asked how we can systematize screening. Dr. Issaka discussed a study that found higher performing clinics all had a registry for FITs.
- Ms. Weir asked what the department of health could do to help fill the tracking gap.
- Dr. Issaka said that a low hanging fruit for the DOH could be that in WA our goal should be that 75% of eligible patients are screened regardless of payer.
- In the Purpose section of the charter, Dr. Auerbach asked about the bullet addressing “metrics to incentivize screening”. She pointed out that metrics are a baseline and the group removed “to incentivize” from that bullet.
- Dr. Ludwig discussed the need for a place where racial/ethnic data gets reported. The group may want to develop best practice recommendations about the collection of such data.
- The group discussed how to protect patients who have a false negative FIT test. What is the follow up after screening?
 - If there are symptoms of colon cancer, there should be follow up past the FIT test.
- Ms. Stofel commented that the aim of the workgroup should be more than increasing screening—it has to address the desired outcome of such an effort—to reduce deaths.
 - Language was added to the end of the Aim statement: “to decrease incidence of and mortality from colorectal cancer.”
- Dr. Issaka commented on adding language to the first bullet in the Purpose section to address follow up after a positive FIT.
 - The group added “including follow-up after a positive stool test” to the end of the first bullet.
- Ms. Stofel asked the group how it would address patients who have symptoms. Dr. Green replied that those patients would no longer fall under the umbrella of screening and the issue becomes one of public education and provider education on the symptoms of colon cancer.
- Dr. Ludwig mentioned the possibility of addressing colonoscopy quality.
- Dr. Green said that there are many bad FIT tests available in the community. The group agreed that a recommendation around FIT tests would be useful—Dr. Ludwig suggested a footnote.
- Dr. Stofel returned to the importance of making recommendations about education for providers and the public. Ms. Weir said that the group could include such recommendations in the final report's “Appropriate Screening” section.

GOOD OF THE ORDER

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