**Bree Collaborative | Colorectal Cancer Guideline Implementation Workgroup**
March 20th, 2020 | 10:30 – 12:00
**Held Remotely Due to COVID-19**

## MEMBERS PRESENT

Rick Ludwig, MD, (Chair), Bree Collaborative, Providence Washington
Jason Dominitz, MD, MHS, National Director of Gastroenterology, VA Puget Sound
Bev Green, MD, Family Physician, Senior Investigator at Kaiser Permanente Health Research Institute
Julie Stofel, Patient and Family Advocate
Patricia Auerbach, MD, United Health Care
Tammy Wild, MPH, RDN, LD, NSCA-CPT, State Health Systems Manager, American Cancer Society
Rachel Issaka, MD, MAS, Assistant member, Gastroenterology and Hepatology Clinical Research Division, Fred Hutch
Casey Eastman, MPH, Content Lead, Breast, Cervical, Colon Health Program, Washington State Department of Health

## 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 COAP
Ari Bell-Brown, MPH, Fred Hutch

## 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. Bev Green, MD, Family Physician, Senior Investigator at Kaiser Permanente Health Research Institute, noted a change to last session's minutes.

*Motion*: Approval of February 14th Minutes, with changes noted by Dr. Green.
*Outcome*: Passed with unanimous support.

## GENERAL DISCUSSION

- Dr. Green reviewed her notes: rates of testing are going up but disparities are going up as well. The elderly (65+) seem to do better with all screenings. Possible that this has to do with better insurance for this age band.
- Ms. Weir reviewed what took place at the last Bree Collaborative board meeting: this workgroup's charter was adopted and approved by the collaborative.
    - Ms. Weir also added example text from an old Bree recommendation to this group's draft recommendation document. Members can look to this text as an example of what the group will eventually be producing.
- Ms. Weir brought up the Oregon legislation that would require follow up colonoscopies after a positive FIT test to have a $0 copay. Ms. Weir is going to contact our Governor's policy adviser about this.
- Ms. Weir moved the group to a discussion of Appendix C of the draft recommendations: Guideline and Systematic Review Search Results. The Bree looks at bodies that do systematic reviews of the topics that are relevant to the workgroup.
    - Dr. Ludwig asked if the group should read some of these studies or if they will be summarized for the group. Ms. Weir: some of the studies are just confirming that

screening saves lives. However, the articles relating to interventions to increase screening could be the most useful to read.
    - Rachel Issaka, M.D., M.A.S., Assistant member, Gastroenterology and Hepatology Clinical Research Division, Fred Hutch, added that the best evidence for intervention right now is for mailed FIT. Everything else has mixed data. Even though mail FIT works well across the board, how well it works depends a lot on the healthcare system's ability to support the program. Those details are very important.
- Dr. Green reiterated that the ideal is to have an organized system that sends out FITs; the doctor only follows up when a FIT has been missed. Positive FITs go straight to the GI and bypass PCP (so that PCP is not overtaxed).
    - Dr. Ludwig: without a very crisp and defined process, it is easy to have failure points. Perhaps the group should push mailed FIT in the recommendations if it is the most effective.
    - Nurse navigation is quite expensive and under resourced, so mailed FIT might be a more realistic recommendation. Navigation is also needed for so many things besides CRC screening that are also important.
    - Might be able to incorporate nurse navigators provided by the health plans since plans usually have navigators for their sickest patient.
- Dr. Issaka added that if the recommendations emphasize mail FIT, they need to clear that positive FIT patients must be able to get a follow up colonoscopy and that clinics have a clear plan for how this will happen.
    - This could be a performance measure for positive FITs that goes with such programs. Mailed FIT does not matter if there is no follow up.
- Ms. Weir suggested that the group could point out aspects of programs that have worked in the past to increase screening.
    - Dr. Green: recommendations should note that there needs to be a shift from thinking of mailing as a one-and-done problem versus something that is ongoing. Just showing what works is not sufficient—the group has to talk about how to maintain programs in the long term.
    - Dr. Issaka added that the Canadian screening program has been successful in part because of the amount of money the government has invested in the program's infrastructure.
    - Dr. Green believes that a state-level investment would be sufficient to improve screening and that the state has an incentive since screening saves money in the long run.
    - The group discussed which state agency would take charge of a screening initiative, but no conclusion was reached.
    - No other state in the US—that the group knows of—takes ownership of the screening process at a state level. This would be an innovative approach for Washington.
- Ms. Weir asked what the group would recommend for health plans if state-ownership is not a possibility.
    - Plans with Medicare (and metrics) are doing well—so metrics help. Medicaid plans want to improve screening, but they have to put QI resources on issues that they are required to measure.
    - A member suggested looking for more research on the cost benefits or cost neutrality of a FIT program to help incentivize plans to invest.
- The group had a discussion about offering incentives to providers; Medicare advantage plans incentivize providers and see results from this. Metrics and incentives are both helpful. Possibility to recommend metrics for Medicaid.

- Dr. Green brought up the importance of having a program in place for the uninsured since they currently have the worst screening rates.
- Ms. Weir proposed a plan for the group to think about what an ideal system would look like and then which pieces of that system would be realistic to recommend.

**Action Item:** All to prepare a written example of an ideal system for the group to build off in future meetings.

- Who, in a perfect world, would own the mail FIT process?
    - Dr. Green suggested an agnostic system where vendors work with providers and charge based on insurance type.
    - Jason Dominitz, M.D., M.H.S., National Director of Gastroenterology, VA Puget Sound, emphasized the importance of infrastructure, financial support, and accountability from the state.
    - Julie Stofel, Patient and Family Advocate added the idea of having a centralized repository through the state that tracks whether a FIT test was sent and what the results were. Dr Green added to this that we would also want to have and use a colonoscopy registry.
- Vickie A. Kolios-Morris, MSHSA, CPHQ, Senior Program Director, SCOAP and Spine COAP, mentioned the possibility of marrying a larger state registry (of screening info) to the SCOAP colorectal registry for comparison of process and outcomes measures for those patient that do proceed down the surgical route.
- Ms. Weir said that it might not be realistic for this group's big ask be for a state-led effort. It might be better to give individual plans/providers/etc. steps they can take to improve screening.
- Dr. Ludwig brought up the potential problem that many private clinics have GIs who want to do colonoscopies; having more FITs could reduce the number of procedures they are doing. Private entities might be reluctant to do this. GI doctors are already upset about the Cologuard test.
- The group discussed the importance of education for doctors on proper CRC screening.

**GOOD OF THE ORDER**

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