Bree Collaborative | Colorectal Cancer Guideline Implementation Workgroup
April 10th, 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
Val Simianu, MD, MPH, Colon and Rectal Surgeon, Virginia Mason, and Associate Medical Director at SCOAP
Elizabeth Broussard, MD, Gastroenterology, Pacific Medical Centers First Hill

STAFF AND MEMBERS OF THE PUBLIC

Ginny Weir, MPH, 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
Ramya Raman, Exact Sciences

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.

Motion: Approval of March 20th Minutes.
Outcome: Passed with unanimous support.

GENERAL DISCUSSION

- Rachel Issaka, MD, MAS, Assistant member, Gastroenterology and Hepatology Clinical Research Division, Fred Hutch, reviewed the outline that she wrote for the ideal state of colorectal cancer care.
    - Mail FIT program that is owned by health care systems with mandated reporting to the state. Health systems would need to report on an annual or semiannual basis.
- Julie Stofel, Patient and Family Advocate, reviewed her outline for the ideal state of CRC care.
    - More patient education and doctor training on risk and early detection.
    - More transparency for the patient in how their risk is being calculated.
    - Increased screening (Medicaid incentives to match Medicare screening incentives, and system/vendor mailing reminders and test kits with results returned to provider and state registry).
    - Washington State CRC Screening Registry.
    - She also reviewed a pathway for early detection that includes signs and symptoms as well as screening, to reduce death from CRC. She also emphasized the importance of signs and symptoms even after a negative test—would like to see providers following up on these.

        - Dr. Green mentioned that properly classifying patients' needed follow up can be difficult.
- Jason Dominitz, MD, MHS, National Director of Gastroenterology, VA Puget Sound, discussed the GIQuIC registry: he sends data from his endoscopy reporting system to this registry for benchmarking his clinic. The state could potentially use GIQuIC, but providers would need to all be using one of the approved technologies that work with GIQuIC.
    - There is a business case for tracking endoscopy—there is a lot of overuse of colonoscopy in addition to underuse. Catching CRC early leads to lower treatment costs.
- Dr. Ludwig: another asset that is currently underutilized is the patient themselves. Could be providing better education to patients about their testing needs.
- The group discussed the New Hampshire screening rates—they could look at that registry to see if it improved screening rates. Dr. Green suggested contacting Lynn Butterly, MD.
- Tammy Wild, MPH, RDN, LD, NSCA-CPT, State Health Systems Manager, American Cancer Society, reviewed strategies for success for mail FIT, based on her experience with mail FIT done at the clinic level by FQHCs with results going back to the PCP. Strategies for success include:
    - Sending simple, easy to follow instructions to complete the kit.
    - A streamlined process for patients to return the kit through a drop box at the clinic and/or providing return postage.
    - A short window for completing and returning the test.
        - Dr. Green mentioned that it is very difficult for clinics to implement mail FIT on their own, in her experience.
- Dr. Ludwig asked the group who should ultimately be accountable for the results of a test—both in terms of informing the patient and coordinating next steps.
    - Dr. Green explained that, at Kaiser, tests go back to the GI and sometimes the PCP if the GI cannot handle it.
    - Dr. Green also mentioned that there are many steps to getting a colonoscopy scheduled, and it is not always in the doctors' wheelhouse to be administrators.
- The group discussed Cologuard, a vendor, who follows up with patients after negative mail tests and reminds patients when they need another test. However, they do not follow up on positive tests to make sure that the patient gets a colonoscopy.
    - Dr. Green emphasized the importance of follow up after a positive FIT. When patients are not part of an integrated health system, it can difficult to track whether this happens.
    - One possible fix would be requiring the community clinic to receive a record of the colonoscopy if they referred for it.
- Patricia Auerbach, MD, United Health Care said that her ideal state for CRC screening would be to have the healthcare system in charge of FIT mailing.
- Dr. Issaka mentioned the importance of a state registry that records basic metrics; this would allow different health care systems to compare their results and possibly incent better care.
- Dr. Ludwig: PCPs have a duty to let patients know what they need and to keep records of screening that has been done. The accountability question is important, and the group will need to tie it to some entity.
- Overall, the group has a desire for a state registry that owns screening information.
    - Dr. Green emphasized that it is very important to have everyone start measuring their screening rates— Medicaid should match Medicare on measurement of screening rates.
    - As a state, Washington also lacks data on race, homelessness, and other factors that could affect CRC risk.
- Group has consensus around health care systems owning the process of mail FIT.
    - Vendors can be contracted to help with this process.
- The group discussed who pays for mail FIT.

    - A Washington state incentive for higher screening rates would greatly help in this regard. Incentives can increase rates of screening.
    - Oregon recently stopped incentivizing their Medicaid FIT—it will be interesting to see if the numbers drop as a result.
- Group agreed that final recommendations should talk about measurement and especially get Medicaid to measure like Medicare.
- Julie Stofel asked for better decision aids for those seeking CRC screening. She also asked the group if there is any definitive data about the rate of false negatives for FIT testing.

Action Item: Dr. Green to send out an editorial she wrote about payment for cancer care.

GOOD OF THE ORDER

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