**Bree Collaborative | Colorectal Cancer Guideline Implementation Workgroup**
May 8th, 2020 | 10:30 – 12:00
**Held Remotely Due to COVID-19**

## MEMBERS PRESENT

Rick Ludwig, MD, (Chair), Bree Collaborative, Providence Washington
Bev Green, MD, Kaiser Permanente Health Research Institute
Tracey Hugel, MSN, RN, Regence
Julie Stofel, Patient and Family Advocate
Patricia Auerbach, MD, UnitedHealthcare
Tammy Wild, MPH, RDN, LD, NSCA-CPT, American Cancer Society
Rachel Issaka, MD, MAS, Fred Hutch
Casey Eastman, MPH, Washington State Department of Health
Val Simianu, MD, MPH, Virginia Mason

## STAFF AND MEMBERS OF THE PUBLIC

Ginny Weir, MPH, Bree Collaborative
Alex Kushner, Bree Collaborative
Vickie A. Kolios-Morris, MSHSA, CPHQ, SCOAP and Spine COAP

## 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 April 10th Minutes.
*Outcome*: Passed with unanimous support.

## GENERAL DISCUSSION

- The group began by discussing the Washington Health Alliance 2019 Community Checkup, which touched on colorectal cancer (CRC) screening rates.
    - Overlake and East Providence Medical Group doing well. East Providence uses Epic and have a PCP group involved with GI. The PCPs own the screening process but are closely involved with GI docs.
    - Comment made that the report lacks racial information for screening numbers.
- Ms. Weir suggested that the group adopt and incorporate the 6 bullet points that Bev Green, MD, Family Physician, Senior Investigator at Kaiser Permanente Health Research Institute, put into the Community Checkup document. These are her suggestions for increasing screening in Washington State.
- Ms. Weir suggested using the day's meeting to reach a general consensus on recommendations and to discuss patient decision aids.
- Patricia Auerbach, MD, United Health Care, asked about point 4 of Dr. Green's list which asked for the elimination of patient financial obligations for colonoscopies that are part of preventative care. She was concerned that health plans would not agree to this because it might be seen as setting precedent for plans to fully cover all diagnostic procedures.
    - Dr. Green said that colonoscopies should be understood as the second step of screening, where the first step if FIT.
    - Dr. Green mentioned the legislation in Oregon that requires the follow up colonoscopy to be covered as part of screening. If a polyp is found during the colonoscopy and it gets removed, then it becomes diagnostic and there is a copay.

    - Tammy Wild, MPH, RDN, LD, NSCA-CPT, State Health Systems Manager, American Cancer Society, added that whether a polyp removal is covered is variable—it is very hard for patients to know what they will have to pay for a colonoscopy.
    - Dr. Ludwig said that this should be a significant piece of the group's recommendations, but there will be many details to work out.
- Dr. Ludwig also brought up surveillance copy after a positive colonoscopy. Does the group want to create recommendations around surveillance?
- The group agreed that covering follow up colonoscopy after positive FIT is important—especially because elective procedures have fallen behind due to COVID-19. There needs to be language that prevents screening colonoscopies from being billed as diagnostic colonoscopies, probably using similar language to what is in the Oregon legislation.
    - Another member also asked for language about transparency in pricing for patients.
- Ms. Weir asked about the kinds of outreach the group wanted to recommend for a person after they receive a positive colonoscopy.
    - Rachel Issaka, MD, MAS, Assistant member, Gastroenterology and Hepatology Clinical Research Division, Fred Hutch related the steps that Kaiser California has taken, some of which were: increasing endoscopy staff, creating registries, and tracking follow up at 3, 6, 9 months. These increased follow up rates from 74 percent to 81 percent. However, not all healthcare systems have the resources to do this.
    - Dr. Issaka looked at lower-resourced clinics in San Francisco and found that the highest performing ones had two people keeping track of a registry who were not doctors (they were nurses or some other role).
    - Dr. Green added that Kaiser does referrals that bypass PCP and go straight to GI (for colonoscopy). Really good nurse navigation works well, but it is hard to resource.
    - At UW nurse navigators call patients.
- Ms. Weir asked if nurse navigation programs work better if they are integrated with other cancer types, especially in small clinics.
    - A member voiced support for this idea. Dr. Issaka said that UW population health navigators do navigation for multiple types of cancer.
- The group also discussed the problem of a lack of data sharing between delivery systems and health plans.
- Multiple group members are working on a white paper on colonoscopy screening. It has been accepted and will be in production soon. Dr. Green has an editorial that will also be available soon.
- Ms. Weir asked about UK screening.
    - Screening there does not go through PCPs. It is done by the government with follow up done by the government, but they ration their care because they have fewer resources. Rates are fairly good.
- Ms. Weir asked about points 5 and 6 on Dr. Green's list in the Community Checkup. They pertain to increased funding to screen the uninsured.
    - Dr. Green said that this will not happen on a federal level.
    - Casey Eastman, MPH, Content Lead, Breast, Cervical, Colon Health Program, Washington State Department of Health said that if the state gets funding, they could cover uninsured who receive care from one of 6 qualified FQHCs in the state. That leaves 27 other FQHCs that are not part of this program, though.
    - COVID has impacted clinics' ability to keep up with screening. At the state level, cancer services are largely integrated. However, the state does not have funding secured for CRC screening after June for uninsured and under insured.
    - Dr. Green: we need to make CRC coverage more sustainable. The reason that CRC screening is not funded as well is that CRC legislation has not made it through congress.

- Dr. Green warned that there is potential for CRC progress to backslide in the wake of COVID. Dr. Issaka shared a piece she wrote about the collateral health impacts of COVID-19.
- Ms. Weir pivoted the discussion to patient decision aids and risk calculators. How can patients increase their own knowledge?
    - Julie Stofel, Patient and Family Advocate, said that the risk calculator she looked at had gaps. Tool asked for patient family history, but patients may not know their family history, especially if there was an adenomatous polyp that was removed.

**Action Item: Ms. Weir to send out Ms. Stofel's comments on the Healthwise tool.**

- Dr. Ludwig: there needs to be a decision aid tool for CRC. The FIT test is not well understood. More knowledge around FIT alone could increase screening rates.
- Ms. Weir would like the group to start commenting on and editing the recommendation document.

**Action Item: Ms. Weir to send out recommendation document and follow up with members individually to work on language to discuss at the next meeting.**

**GOOD OF THE ORDER**

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