
Bree Collaborative | Colorectal Cancer Guideline Implementation Workgroup

July 10, 2020 | 10:30 – 12:00

Held Remotely

MEMBERS PRESENT

Rick Ludwig, MD, (Chair), Bree Collaborative,
Providence Washington

Bev Green, MD, Kaiser Permanente Health
Research Institute

Julie Stofel, Patient and Family Advocate

Patricia Auerbach, MD, UnitedHealthcare

Casey Eastman, MPH, Washington
State Department of Health

Val Simianu, MD, MPH, Virginia Mason

Jason Dominiz, MD, Veterans Administration

Rachel Issaka, MD, MAS, Fred Hutch

STAFF AND MEMBERS OF THE PUBLIC

Ginny Weir, MPH, Bree Collaborative

David Stenstrom, Pacific Choice Health Plans

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 May 8th Minutes with one change suggested by a member.

Outcome: Passed with unanimous support.

GENERAL DISCUSSION

- Washington State does not have good data on race. Health plans are not required to collect race data. Health systems are not mandated to collect data. Washington state does not have a comprehensive way to address screening by race and ethnicity.
 - Unsure of legal and regulatory landscape for collection of data on race. Could not be mandatory for the person to respond.
 - Optum and Pacific Choice Health Plans do collect race data.
 - Unsure if this is available for every patient.
 - FQHCs are required to report race for patients as part of grants.
 - The workgroup agrees that race data should be part of recommendations.
 - Part of Providence through EPIC. Unknown category is 5%.
 - The WA Health Alliance has data on colorectal cancer screening for Medicaid and commercial plans but does not have commercial plans on race.
- Delaware model
 - Good proof of concept that a state can manage an initiative to incentivize and follow through with colonoscopy.
 - Small state that is really a big city. Harder to do a colonoscopy-focused initiative within a larger state.
 - Bev will look into whether Delaware is still paying for this program.
 - Kentucky is having similar successes through an organization called Kick the Butt. The organization is working on legislation and money toward colon cancer screening.
 - New Hampshire has a colonoscopy program and a registry.
- Legislation
 - Federal work to not charge for conversion of colonoscopy from diagnostic and colonoscopy following a positive FIT. The workgroup will copy Oregon's Legislation as

that passed and is comprehensive without setting forth implication for other diseases such as breast cancer.

- How to pay for a navigator
 - Some kind of capitated payment for primary care coupled with a quality metric and the sites have to decide for themselves
 - The issue with ACOs from Providence's perspective is there are too many different payment models from different payers. Those contracts do not get as much attention as they should.
 - Cannot just pay for numbers and build the staff around that.
 - Forward thinking countries think of the whole model.
 - NHS has massive issues with colonoscopy. The NHS has taken on a national approach to assuring colonoscopy quality because the system has a lot of cases of post-colonoscopy cancer, cancer that was not caught. Quality control issues with colonoscopy.
 - Alliance has created a slight incentive for groups to pay attention to colorectal screening rates. Can we build on that? The people that lead are the group practices that agree to have their numbers presented.
 - Recognize the programs that get on that list. Can we help market them? That will incentivize them to go better. They typically have electronic records.
- What to say about type of FIT test. Workgroup decided on "use a high-quality one-sample FIT test."
- How to present the payment recommendations. These are best addressed when grouped together
- Sedation
 - Workgroup members related their personal experience with having no sedation with a colonoscopy.
 - Shared decision – not great literature to help guide the conversations around sedation. Harder to say use shared decision making. Educational materials might be the best we can get.
 - For lung cancer, people have more decisional conflict after using shared decision making.
 - Should say sedation not anesthesia.
 - Sedation on demand as an option.
 - Deep sedation does require certain criteria from the health plans. When deep sedation is needed and when not needed.

GOOD OF THE ORDER

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