Bree Collaborative Meeting

May 20, 2020 | Zoom Meeting

Agenda

- **Welcome and Introductions**
- **Meeting Minutes and Retreat Summary**
  - Action Item: Approve minutes
- **Discussion:** Impact of COVID-19 on WA Health Care System
- **Presentation:** The Role of the Delivery System in Addressing the Social Determinants of Health
- **Presentation:** Implementation Update
- **Discussion:** Topics for 2021
  - Action Item: Select 6-7 potential topics
- **Final Adoption:** Opioid Prescribing – Long-Term Opioid Therapy
  - Action Item: Final Adoption
- **Topic Update:** Oncology Care
- **Topic Update:** Colorectal Cancer Screening
- **Topic Update:** Primary Care
- **Topic Update:** Reproductive and Sexual Health
- **Next Steps and Close**

March 18th Meeting Minutes

Dr. Robert Bree Collaborative Meeting Minutes
March 18th, 2020 | 12:30-2:30
Held Remotely Due to COVID-19

Members Present

Hugh Straley, MD, (Chair)
Susie Dade, MS, Washington Health Alliance
Gary Franklin, MD, Washington State Department of Labor and Industries
Rick Ludwig, MD, Providence Health Accountable Care
Robert Mecklenburg, MD, Virginia Mason Medical Center
Laura Kate Zaichkin, MPH, SEIU 775 Benefits Group
Angie Sparks, MD, Kaiser Permanente
Judy Zerzan, MD, MPH, Washington State Health Care Authority
Shawn West, MD, Embright
Drew Oliveira, MD, Regence
Mary Kay O'Neill, MD, MBA, Mercer
Stuart Freed, MD, Confluence Health

Discussion: Impact of COVID-19 on WA Health Care System

DR. ROBERT BREE COLLABORATIVE

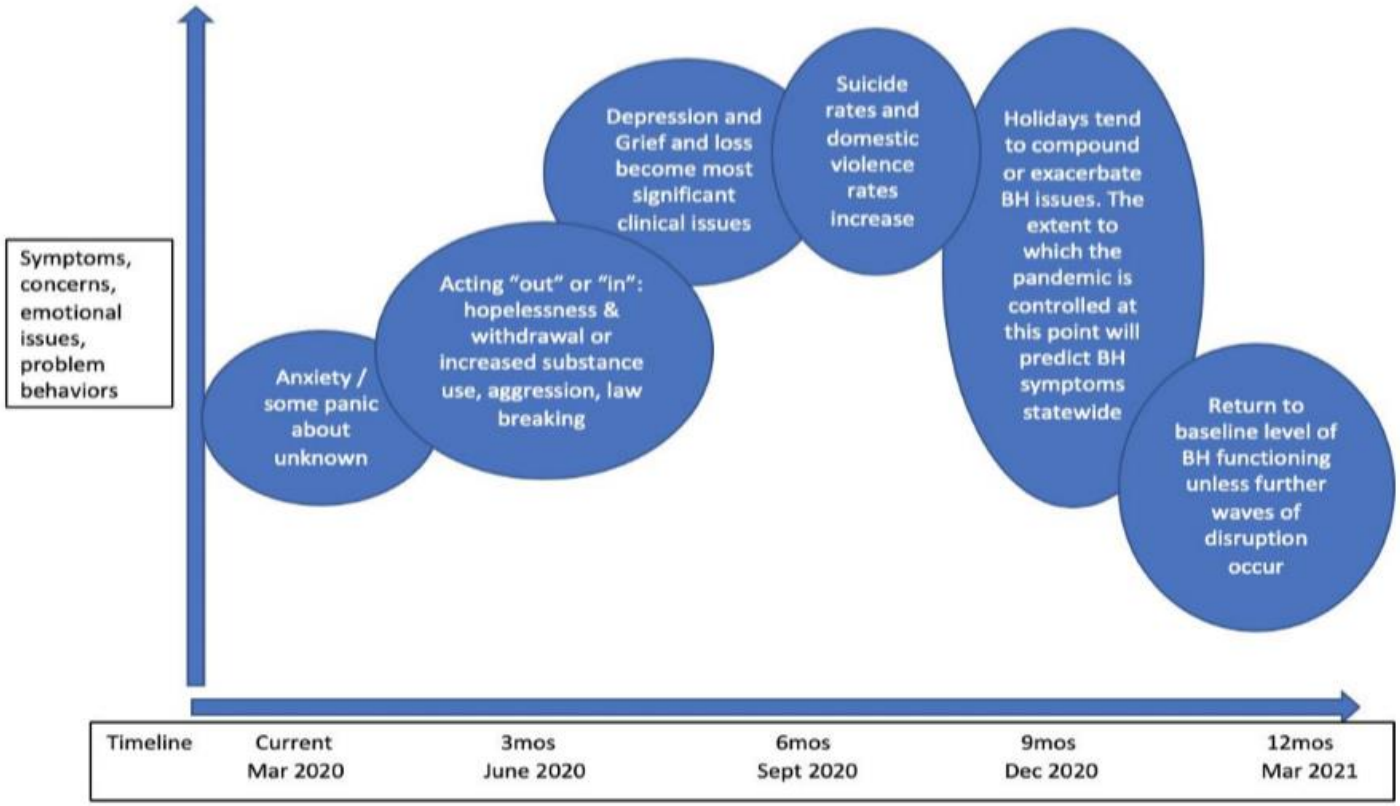
May 20th, 2020 | Zoom Meeting

Our Current Workgroups
What We're Reading

- Colorectal Cancer Screening and Prevention in the COVID-19 Era
  - Authors: Rachel B. Issaka, MD, MAS (Workgroup Member); Ma Somsouk, MD, MAS
  - "nearly 23 million adults aged 50 to 75 are past due for screening, and an estimated 53 000 Americans will die from colorectal cancer this year…adult primary care and gastroenterology visits have declined by 49% and 61%, respectively…To address this problem, health care organizations can leverage mailed fecal immunochemical tests (FIT) outreach programs. In the midst of a pandemic, we cannot and should not abandon disease prevention."
- 10 communication tips for physician phone visits during COVID-19
  - Authors: Eli Martinez, PhD; Adam Sattler, PhD; Michelle Sherman, PhD; Michael Wootten, MD; University of Minnesota, Department of Family Medicine and Community Health.
  - "Elicit reactions to recommendations overtly. Because you cannot see the patient's nonverbal reactions, regularly ask, "What do you think about that?"

Anticipating Behavioral Health Need

Forecasted Behavioral Health Symptoms from COVID-19 Over Time



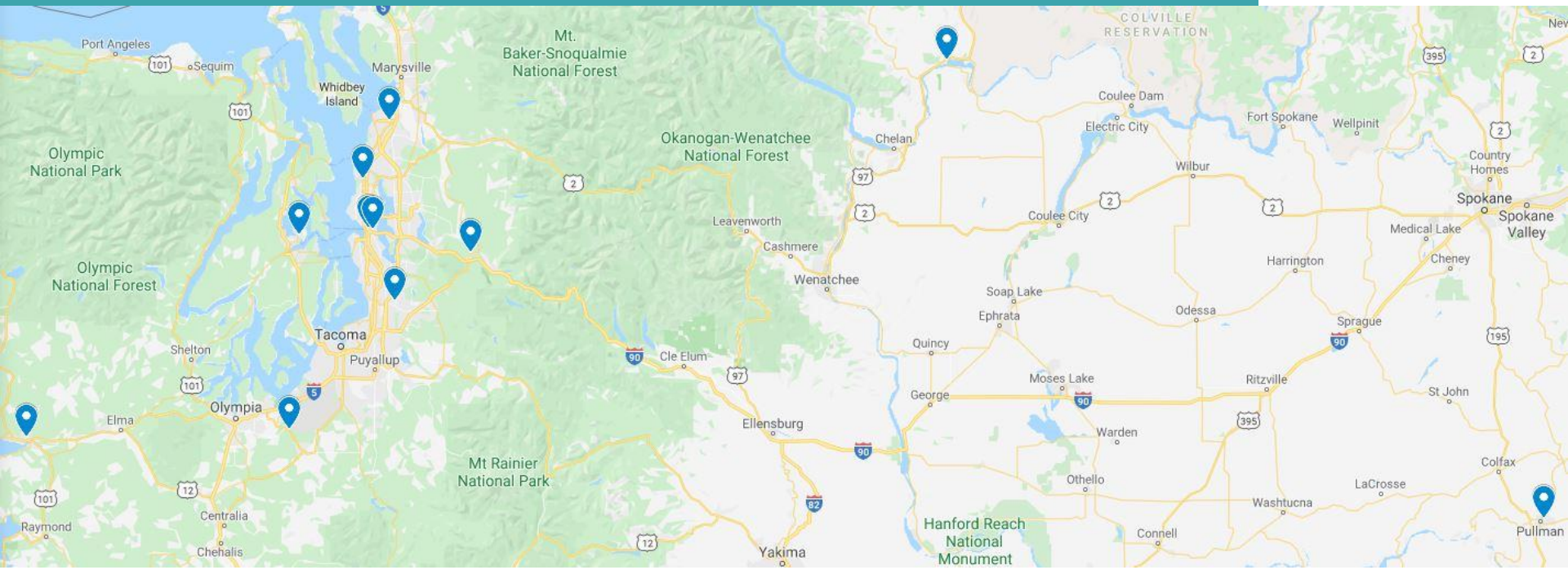
NOTE: Where people start on this chart is strongly predicted by their baseline level of functioning BEFORE the outbreak / pandemic, and the degree to which they have SOCIAL SUPPORT and use ACTIVE COPING SKILLS.
If the situation comes to a resolvable level after 12 months, the VAST majority of people will return to their baseline level of functioning. If the situation cascades, then the emotional and behavioral responses become compounded over time.

Implementation Update

Amy Etzel
Implementation Manager, Bree Collaborative

May 20th, 2020 | Zoom Meeting

Behavioral Health Integration Initiative (BHII)



Aberdeen Family Medical Clinic – Harbor Medical Group
Bremerton – Kitsap Medical Group
Brewster – Family Health Centers
Community Health Centers of Snohomish County
Family Care of Kent
Nisqually Tribal Health Clinic
Pullman Family Medicine
Seattle Children's Clinic at Harborview
Seattle Children's Hospital Odessa Brown Children's Clinic
Shoreline – International Community Health Services
Snoqualmie Ridge Medical Clinic

How COVID-19 has affected BHII Work

- Action Plan goals remain the same, **how** we achieve the goals has changed
- Delayed timelines for Action Plan items
- Will not complete a June 2020 Assessment; next Assessment January 2021

BHII Action Plans - Success Stories

Core Process Measures: Opioid Use Disorder Treatment
Primary Care Setting

Measure	Description
Reduce Stigma	Percentage of providers and support staff that receive training on sensitivity toward addiction, dependence and non-stigmatizing language.
Buprenorphine	Percentage of primary care providers, including ARNPSs and PAs, that are waivered to prescribe buprenorphine.
Naloxone	Percentage of patients with an opioid use disorder diagnosis that have a Naloxone prescription.
Prescribing	Percentage of patients with an opioid use disorder diagnosis receiving MAT (buprenorphine, naloxone, methadone).
Access to Behavioral Health	Percentage of patients with identified behavioral health needs that received warm hand-off or same day referral to behavioral health services (if warm hand-off not available).

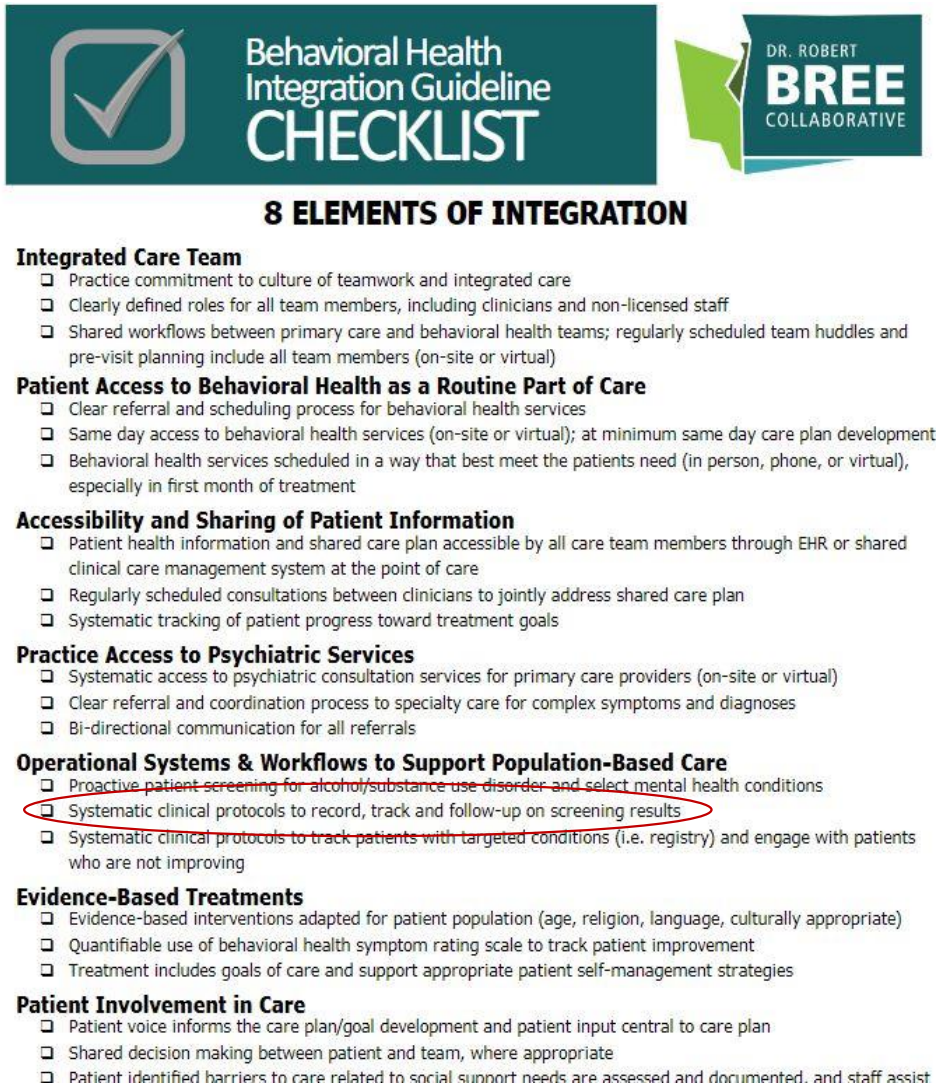
Snoqualmie Ridge Medical Clinic

Action Item:
Increase by 20% the number of patients with an opioid use disorder diagnosis that have a Naloxone prescription.

Baseline: 10 Naloxone prescriptions written in 2019.

- ✓ Conducted Naloxone prescribing training for all Provider teams in February and posted patient education materials in all exam rooms. Within 2 weeks of training, exceeded 2019 baseline with 12 prescriptions. Will continue monthly tracking to ensure not just a one-time bump.

BHII Action Plans – Success Stories



Behavioral Health Integration Guideline CHECKLIST

DR. ROBERT BREE COLLABORATIVE

8 ELEMENTS OF INTEGRATION

Integrated Care Team
- ❑ Practice commitment to culture of teamwork and integrated care
- ❑ Clearly defined roles for all team members, including clinicians and non-licensed staff
- ❑ Shared workflows between primary care and behavioral health teams; regularly scheduled team huddles and pre-visit planning include all team members (on-site or virtual)

Patient Access to Behavioral Health as a Routine Part of Care
- ❑ Clear referral and scheduling process for behavioral health services
- ❑ Same day access to behavioral health services (on-site or virtual); at minimum same day care plan development
- ❑ Behavioral health services scheduled in a way that best meet the patients need (in person, phone, or virtual), especially in first month of treatment

Accessibility and Sharing of Patient Information
- ❑ Patient health information and shared care plan accessible by all care team members through EHR or shared clinical care management system at the point of care
- ❑ Regularly scheduled consultations between clinicians to jointly address shared care plan
- ❑ Systematic tracking of patient progress toward treatment goals

Practice Access to Psychiatric Services
- ❑ Systematic access to psychiatric consultation services for primary care providers (on-site or virtual)
- ❑ Clear referral and coordination process to specialty care for complex symptoms and diagnoses
- ❑ Bi-directional communication for all referrals

Operational Systems & Workflows to Support Population-Based Care
- ❑ Proactive patient screening for alcohol/substance use disorder and select mental health conditions
- ❑ Systematic clinical protocols to record, track and follow-up on screening results
- ❑ Systematic clinical protocols to track patients with targeted conditions (i.e. registry) and engage with patients who are not improving

Evidence-Based Treatments
- ❑ Evidence-based interventions adapted for patient population (age, religion, language, culturally appropriate)
- ❑ Quantifiable use of behavioral health symptom rating scale to track patient improvement
- ❑ Treatment includes goals of care and support appropriate patient self-management strategies

Patient Involvement in Care
- ❑ Patient voice informs the care plan/goal development and patient input central to care plan
- ❑ Shared decision making between patient and team, where appropriate
- ❑ Patient identified barriers to care related to social support needs are assessed and documented, and staff assist

Community Health Centers of Snohomish County

Action Item:
Improve tracking of screening tools

- ✓ Built a registry of Behavioral Health patients, including capability to show run chart of last 5 PHQ-9 scores for each patient.
- ✓ Building in capability to flag anyone with moderate to severe PHQ-9 score and has not been seen in 60 days. This will be added to medical panel report that MAs regularly receive for outreach. PDSA to start in July.

Reflections from the BHII Pilot Group
Canary in the coal mine

- Concerns of current and future increased Behavioral Health needs for staff and patient population
- Fear about telehealth billing regulations going back to 'normal', while telehealth services continue
- Want guidance on what services are best offered via telehealth vs. in-person
- Want improved communication to share with patients around when to seek primary care services, and related safety concerns
- Biggest telehealth hurdles around workflows, not technology

Implementation Webinars

Topic	Attendees
Behavioral Health Integration *(Jan)*	100 +
Suicide Care *(Feb)*	93
Addiction & Dependence Treatment *(April)*	73
Opioid Use Disorder Treatment *(May)*	60 registered attendees
Motivational Interviewing in SBIRT *(June)*	Registration opens end of May
Provider Wellness & Burnout *(July)*	Registration opens end of June

Send me your suggestions for webinar topics!

Virtual Behavioral Health Integration Summit

Day 1: June 16th

1:00 – 4:30 pm
152 registered attendees

- Bree Collaborative origins
- Telehealth and Behavioral Health Integration
- HCA Perspective
- Trauma Informed Care

Day 2: June 23rd

8:30 am – 12:00 pm
139 registered attendees

- Clinician Wellness
- Panel discussion on SBIRT, Opioid Use Disorder, and Suicide Care
- Panel discussion and Q & A on Billing for Behavioral Health Services in Primary Care

Topics for 2021

Ginny Weir, MPH
Director, Bree Collaborative

May 20th, 2020 | Bree Collaborative Meeting

Topic Selection Worksheet

Bree Collaborative | 2021 Topic Selection Worksheet

	Must have one of these four				Must have	Must have	Must have	Nice to have	Nice to have
Potential Topic for 2021	*Variation*	*Patient Safety Issue*	*Cost*	*Equity Issue*	*Proven Impact Strategy Within Health Care*	*Unique Bree Role*	*Data Available*	*Shared-decision making*	*Other Notes (e.g., community support, Choosing Wisely)*

Our Purpose

- *"…to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State."*

- *"…identify **health care services** for which there are substantial variation in practice patterns or high utilization trends in Washington state, without producing better care outcomes for patients, that are indicators of poor quality and potential waste in the health care system. On an annual basis, the collaborative shall identify up to three health care services it will address."*

30 sets of recommendations
+ 4 for 2020

Pain (chronic and acute)
- *Collaborative care for chronic pain (2018)*
- *Low back pain management (2013)*
- *Opioid prescribing metrics (2017)*
- *Opioid prescribing for postoperative pain (2018)*
- *Opioid prescribing in dentistry (2017)*
- *Long-term opioid prescribing management (2019)*

Behavioral Health
- *Integrating behavioral health into primary care (2016)*
- *Addiction and substance use disorder screening and intervention (2014)*
- *Suicide care (2018)*
- *Treatment for opioid use disorder (2016)*
- *Prescribing antipsychotics to children and adolescents (2016)*
- *Risk of Violence to Others (2019)*

Oncology
- *Oncology care: breast and prostate (2015)*
- *Prostate cancer screening (2015)*
- *Oncology care: inpatient service use (2020)*
- *Colorectal cancer screening (2020)*

Procedural (surgical)
- *Bundled payment models and warranties: Total knee and total hip replacement (2013, re-review 2017)*
- *Lumbar fusion (2014, re-review 2018)*
- *Coronary artery bypass surgery (2015)*
- *Bariatric surgery (2016)*
- *Hysterectomy (2017)*
- *Data collection on appropriate cardiac surgery (2013)*
- *Spine SCOAP (2013)*

Reproductive Health
- *Obstetric care (2012)*
- *Maternity bundle (2019)*
- *Reproductive and sexual health (2020)*

Aging
- *Advance care planning for the end-of-life (2014)*
- *Alzheimer's disease and other dementias (2017)*

Palliative care (2019)
Hospital readmissions (2014)
LGBTQ health care (2018)
Shared decision making (2019)
Primary care (2020)

Topic Re-Review
Bylaws

Final products may be selected for re-review annually or if "new evidence suggests the need for modification of clinically important recommendations (e.g., if new evidence shows that a recommended intervention causes previously unknown substantial harm, that a new intervention is significantly superior to a previously recommended intervention from an efficacy or harms perspective, or that a recommendation can be applied to new populations)" one year after adoption.

Evidence Review (1/2)
May 2019-Present

- AHRQ Evidence-Based Practice Reports (excluding those in process)
  - April 2020 Noninvasive Nonpharmacological Treatment for Chronic Pain
  - April 2020 Opioid Treatments for Chronic Pain
  - April 2020 Nonopioid Pharmacologic Treatments for Chronic Pain
  - April 2020 Diagnosis and Treatment of Clinical Alzheimer's-Type Dementia
  - September 2019 Antipsychotics for the Prevention and Treatment of Delirium
  - September 2019 Comparative Effectiveness of Analgesics To Reduce Acute Pain in the Prehospital Setting
- Center for Disease Control and Prevention
- Institute for Clinical and Economic Review = N/A
- Veterans Administration Evidence-based Synthesis Program
  - August 2019 Evidence Brief: Barriers and Facilitators to Use of Medications for Opioid Use Disorder
  - August 019 Evidence Brief: Managing Acute Pain in Patients with Opioid Use Disorder on Medication-assisted Treatment
  - May 2019 Systematic Review: Risk Factors and Interventions to Prevent or Delay Long-term Nursing Home Placement for Adults with Impairments
- USPSTF
  - February 2020 Cognitive Impairment in Older Adults: Screening = I
- National Guideline Clearinghouse (funding ended)

Evidence Review (2/2)
May 2019-Present – Cochrane

- Dementia/Delirium
  - April 2020 Aspirin and other non-steroidal anti-inflammatory drugs for the prevention of dementia
  - April 2020 Simulated presence therapy for dementia
  - February 2020 Benzodiazepines for treatment of patients with delirium excluding those who are cared for in an intensive care unit
  - January 2020 Drug therapy for delirium in terminally ill adults
  - December 2019 Addenbrooke's Cognitive Examination III (ACE-III) and mini-ACE for the detection of dementia and mild cognitive impairment
  - November 2019 Animal-assisted therapy for dementia
  - September 2019 Mini-Cog for the diagnosis of Alzheimer's disease dementia and other dementias within a secondary care setting
  - September 2019 Pharmacological interventions for the treatment of delirium in critically ill adults
- Pain
  - April 2020 Non-steroidal anti-inflammatory drugs for acute low back pain
  - April 2020 Epidural corticosteroid injections for lumbosacral radicular pain
  - February 2020 Means restriction for the prevention of suicide by jumping
  - November 2019 Individual recovery expectations and prognosis of outcomes in non-specific low back pain: prognostic factor review
  - November 2019 Workplace interventions for increasing standing or walking for decreasing musculoskeletal symptoms in sedentary workers
- Behavioral Health
  - March 2020 Alcoholics Anonymous and other 12-step programs for alcohol use disorder
  - February 2020 Dihydrocodeine for detoxification and maintenance treatment in individuals with opiate use disorders
  - December 2019 Pharmacy-based management for depression in adults
  - December 2019 Pharmacological interventions for treatment-resistant depression in adults
  - December 2019 Psychosocial interventions for people with both severe mental illness and substance misuse
  - November 2019 Psychological interventions for co-occurring depression and substance use disorders
  - June 2019 Antidepressants plus benzodiazepines for adults with major depression
- Advance Care Planning: February 2020 Advance care planning for adults with heart failure
- ADHD: June 2019 Social skills training for attention deficit hyperactivity disorder (ADHD) in children aged 5 to 18 years

Previously considered, not selected

- *Emergency room use (2012, 2013, 2015)*
- *Chemotherapy*
- *Obesity/ Youth Obesity* (2013, 2015)
- *Sleep Therapy*
- *Hepatitis C Management*
- *Antibiotic Stewardship*
- *Diabetes Care Bundled Payment Model*
- *Falls Prevention*
- *Genetic Testing*
- *Post-Acute Brain Injury Treatment*
- *Clinician Wellness*
- *Prior Authorization*
- *Re-Review of Potentially Avoidable Hospital Readmissions*
- *Retinal imaging*
- *Vitamin D Screening*
- *Opioids in the elderly*

Topics Selected v Topics Considered

	Topics Proposed	Topics Completed
2012	• *Emergency room use* • Preventable hospital readmissions • Back surgery • Chronic pain • Cardiology procedures • C-sections and "convenience inductions" • *Chemotherapy* • Early-stage prostate cancer	• Obstetrics (August 2012) • Cardiology (January 2013)*
2013	• Addiction/Dependence Treatment • End-of-Life Care • Elective Surgeries • *Inappropriate ER Use* • Oncology Care • *Colonoscopy* • *Obesity*	• Endorsing Spine SCOAP (April 2013) • Low Back Pain (November 2013) • Total Knee and Total Hip Replacement Bundle and Warranty (November 2013)
2014	• Mental Health Integration • *Sleep Therapy* • AMDG Opioid Prescribing Guidelines • Prostate Specific Antigen Testing • Oncology Care • Coronary Artery Disease Bundled Payment Model • *Hepatitis C Management*	• Potentially Avoidable Hospital Readmissions (July 2014) • Lumbar Fusion Bundle and Warranty (September 2014) • End-of-Life Care (November 2014) • Addition and Dependence Treatment (January 2015)*
2015	• Alzheimer's Care • *Antibiotic Stewardship* • Bariatric Surgery Bundled Payment Model • Depression Screening • *Diabetes Care Bundled Payment Model* • *Emergency Room Use* • *Falls Prevention* • *Genetic Testing* • Health Services Coordination • Hysterectomy • Mental Health Integration • *Post-Acute Brain Injury Treatment* • Psychotropic Drug Use in Pediatric Populations • Suicide Prevention • *Youth Obesity*	• AMDG Opioid Prescribing Guideline (ongoing) • Coronary Artery Bypass Surgery Bundled Payment Model (September 2015) • Prostate Cancer Screening (November 2015) • Oncology Care (March 2016)*
2016	• Addiction Treatment (became Opioid Use Disorder) • Alzheimer's Disease and Other Dementias • Blood Transfusions • Care Coordination • *Clinician Wellness* • Hysterectomy • *Prior Authorization*	• AMDG Opioid Prescribing Guideline (ongoing) • Prior Authorization Summit • Bariatric Surgery Bundled Payment Model and Warranty (November 2016) • Pediatric Psychotropic Drug Use (November 2016) • Behavioral Health Integration (March 2017)*
2017	• LGBT Health Care • Suicide Prevention • Blood Product Use • *Re-Review of Potentially Avoidable Hospital Readmissions* • Re-Review of Lumbar Fusion • Collaborative Care for Chronic Pain	• Opioid Prescribing (ongoing) • Alzheimer's Disease and Other Dementias (November 2017) • Re-Review Total Knee and Total Hip Replacement (November 2017) • Opioid Use Disorder Treatment (November 2017) • Hysterectomy (January 2018)*
2018	• Shared decision making • Maternity bundle (including long-acting reversible contraceptive) • Adapting the total joint replacement bundle to outpatient care • *Retinal imaging* • Expanding end-of-life care recommendations/palliative care	• Opioid Prescribing (ongoing) • Collaborative Care for Chronic Pain (January 2019)* • Endorsing Blood Product Use • LGBTQ Health Care (September 2018) • Re-Review Lumbar Fusion (January 2019)* • Suicide Prevention (September 2018)
2019	• Reproductive Health (Senate Bill 5602) • Chemotherapy and Inpatient Care • Primary Care • *Opioid Prescribing/Chronic Pain* • *Vitamin D Screening* • *Institutional Racism and Unconscious Bias* • Colorectal Cancer Screening • *Updating Avoidable Hospital Readmissions*	• Opioid Prescribing (ongoing) • Maternity Bundle (January 2020) • Palliative Care (November 2019) • Shared Decision Making (November 2019) • Risk to Self and Others (January 2020)
2020		• Colorectal Cancer Screening • Primary Care • Oncology and Inpatient Care • Reproductive and Sexual Health

Topic Suggestions

AMDG Group

- Opioids in the elderly
- Telehealth

From Community

- Pediatric Asthma – potentially a bundle
- Survey = review LGBTQ recommendations
- Genetic testing
- Prior authorization

No recommendation for re-review from prior workgroup members other than Total Joint Bundle

Telehealth

Telemedicine in Colorado Report

- Does telemedicine replace in-person use of health care or add to it?
- Could increasing telehealth investment in FQHCs, RHCs, and IHS decrease the use of other types of services, such as emergency rooms?
- Will the increased use of telemedicine increase spending on health care
- Is the telemedicine business case sound for providers? Does it create administrative headaches — like trying to collect co-pays from patients or navigating different billing rules between payers? How has it affected clinical scheduling and workflow?
- To what extent would increasing access to telemedicine meet the health care needs of new Medicaid members in the expected enrollment surge?
- Did expanding telemedicine improve access to needed care in rural sectors, older adults, people with disabilities, or others who are underserved?

2021 Bree topic selection work sheet
Update 2017 bundle for total joint replacement

Why bother?

1. Bundle has been widely implemented: WA and beyond
2. Bundle has benefit to providers, employers, and plans in terms of affordability, safety, outcomes, patient satisfaction
3. Bundle provides a template for approaching three fundamentals of health care reform
    a. Production of health care : appropriateness, safety, best practice surgery, and return to function (includes SDM)
    b. Purchasing: direct contracting based on RFP and direct reporting of market-relevant quality to employer
    c. Payment: prospective fixed payment with warranty against avoidable complications

2021 Bree topic selection work sheet

Must have one of four: variation, cost, equity, safety

1. Variation

Knee replacement surgery for women ages 45–64

OLYMPIA		BELLINGHAM	
Women, 45–64 years	60% *More* Likely	Women, 45–64 years	30% *Less* Likely

http://wahealthalliance.org/wp-content/uploads/2016-different-regions-different-care.pdf

2. Cost

"The Alliance estimates that current prices for a knee replacement in our region range from $11,000 to $39,000, with more extreme prices possible."

http://wahealthalliance.org/wp-content/uploads/2016-different-regions-different-care.pdf

3. Equity

In 2005-06, the rates of knee replacement for Medicare recipients was 5.6 per 1,000 for black enrollees and 9.1 per 1,000 for all others.

https://www.dartmouthatlas.org/downloads/reports/Joint_Replacement_0410.pdf

2021 Bree topic selection work sheet

Must have one of four: variation, cost, equity, safety

4. Safety

		2017 Non-COE joint replacement		2017 COE joint replacement	
Post-Operative Events	**Description**	**Count**	**Cost**	**Count**	**Cost**
7-day complications	Infection	1	$9,619.22	0	$0.00
30-day complications	Pulmonary embolism	2	$76,800.94	0	$0.00
90-day complications		0	$0.00	0	$0.00
30-day readmissions	All causes	12	N/A	0	$0.00
182-day TJR revisions		5	$220,968.43	0	$0.00

2021 Bree topic selection work sheet

Must have all three: impact, unique Bree role, data

Must have all of following three:

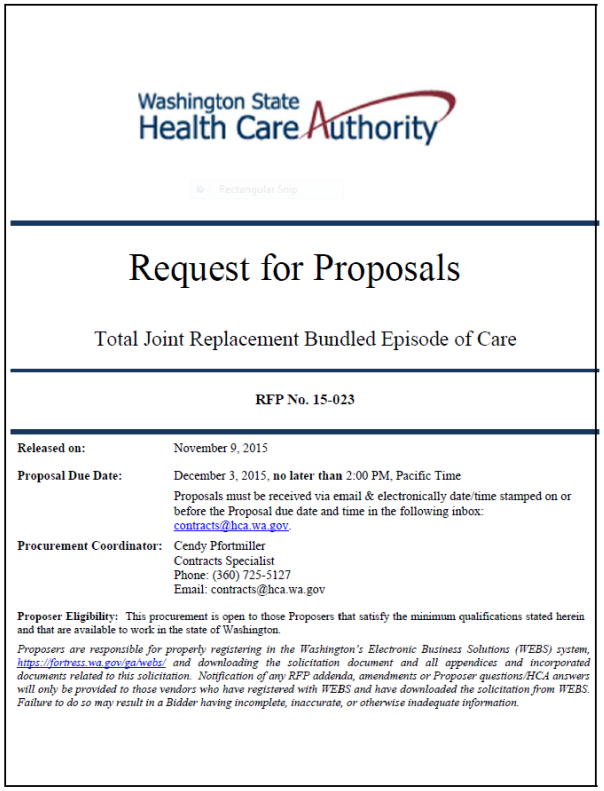
1. Proven impact
   a. 15% cost savings for employer; $1000 savings per patient
   b. Nearly 90% rated patient experience at 9 out of 10
   c. KOOS: 50 → 74
   d. Employer controls clinical and business process
      1) Direct contracting locks in Bree quality and price without preauth
      2) Choice of network of providers based on Bree-informed RFP
      3) Market-relevant quality reported directly to employer

2021 Bree topic selection work sheet

Must have all three: impact, unique Bree role, data

Must have all of following three:

2. Unique Bree role
   a. State standard for WA
   b. Non-proprietary standards and evidence table in public domain
   c. Four cycle model broadly applicable
   d. Adopted by providers, employers, and plans as guide to contracting
   e. Used in HCA's two ACOs



Washington State Health Care Authority

Request for Proposals

Total Joint Replacement Bundled Episode of Care

RFP No. 15-023

Released on:	November 9, 2015
Proposal Due Date:	December 3, 2015, **no later than** 2:00 PM, Pacific Time Proposals must be received via email & electronically date/time stamped on or before the Proposal due date and time in the following inbox: contracts@hca.wa.gov.
Procurement Coordinator:	Cendy Pfortmiller Contracts Specialist Phone: (360) 725-5127 Email: contracts@hca.wa.gov

Proposer Eligibility: This procurement is open to those Proposers that satisfy the minimum qualifications stated herein and that are available to work in the state of Washington.

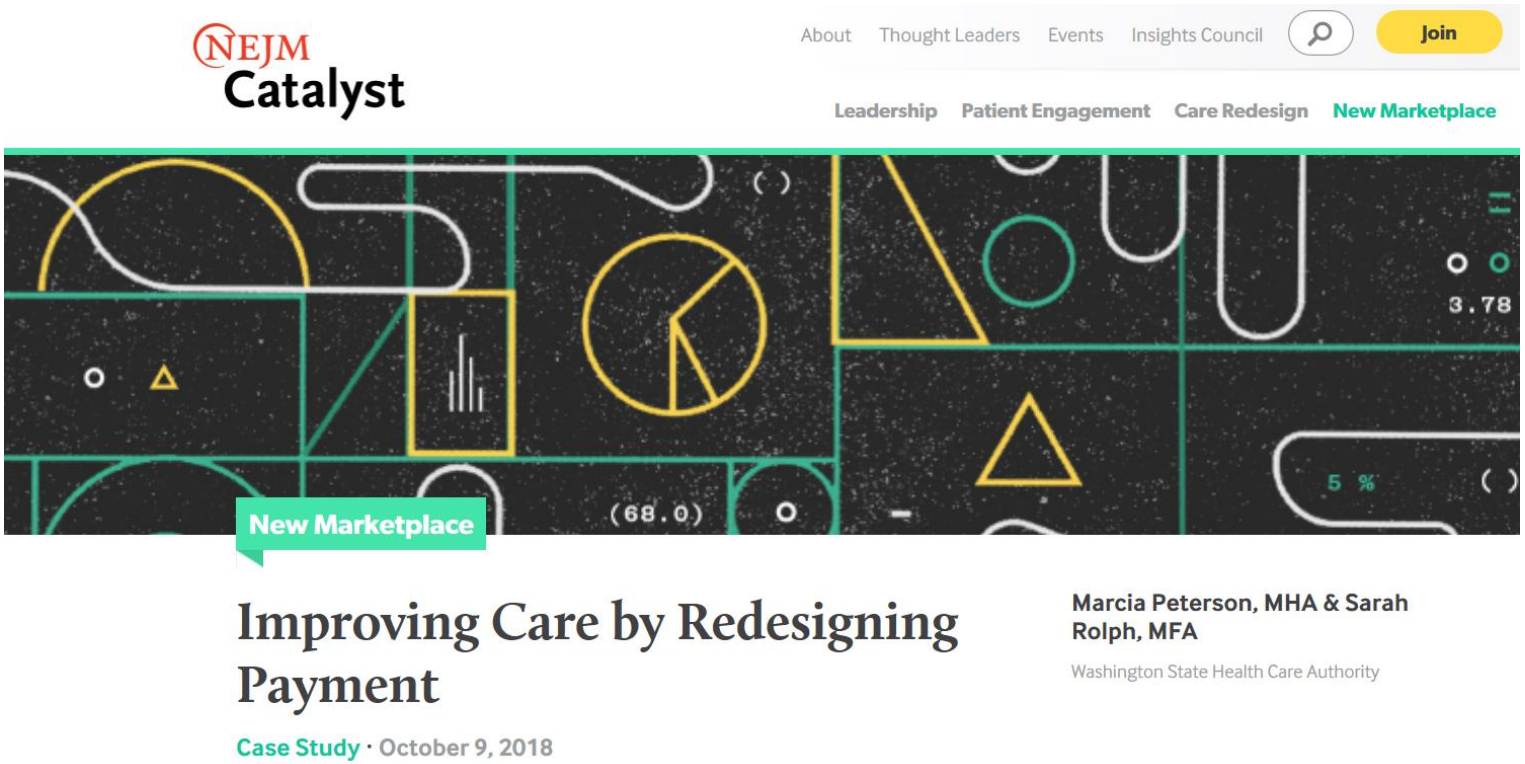
Proposers are responsible for properly registering in the Washington's Electronic Business Solutions (WEBS) system, https://fortress.wa.gov/ga/webs/ and downloading the solicitation document and all appendices and incorporated documents related to this solicitation. Notification of any RFP addenda, amendments or Proposer questions/HCA answers will only be provided to those vendors who have registered with WEBS and have downloaded the solicitation from WEBS. Failure to do so may result in a Bidder having incomplete, inaccurate, or otherwise inadequate information.

2021 Bree topic selection work sheet

Must have all three: impact, unique Bree role, data

Must have all of following three:

3. Data available



2021 Bree topic selection work sheet

Must have all three: impact, unique Bree role, data

Nice to have:

1. Shared decision-making

Language in 2017 version:

"C) Shared decision-making. Patient must participate in shared decision-making.

- A Washington State- approved patient decision aid should be used when available.
- As part of the shared decision-making process, the surgeon should discuss the type of implant under consideration including year the implant was introduced, the reported failure rate at 1, 5 and 10 years (if known) from available registries, and the surgeon's level of experience with the device. "

Final Adoption:
Opioid Prescribing: Long-Term Opioid Therapy

Gary Franklin, MD, MPH
Medical Director, Washington State Department of Labor and Industries

Charissa Fotinos, MD
Deputy Chief Medical Officer, Washington State Health Care Authority

Andrew Saxon, MD
Director, Center of Excellence in Substance Abuse Treatment and Education (CESATE), VA Puget Sound Health Care System

May 20th, 2020 | Bree Collaborative Meeting

Workgroup Members

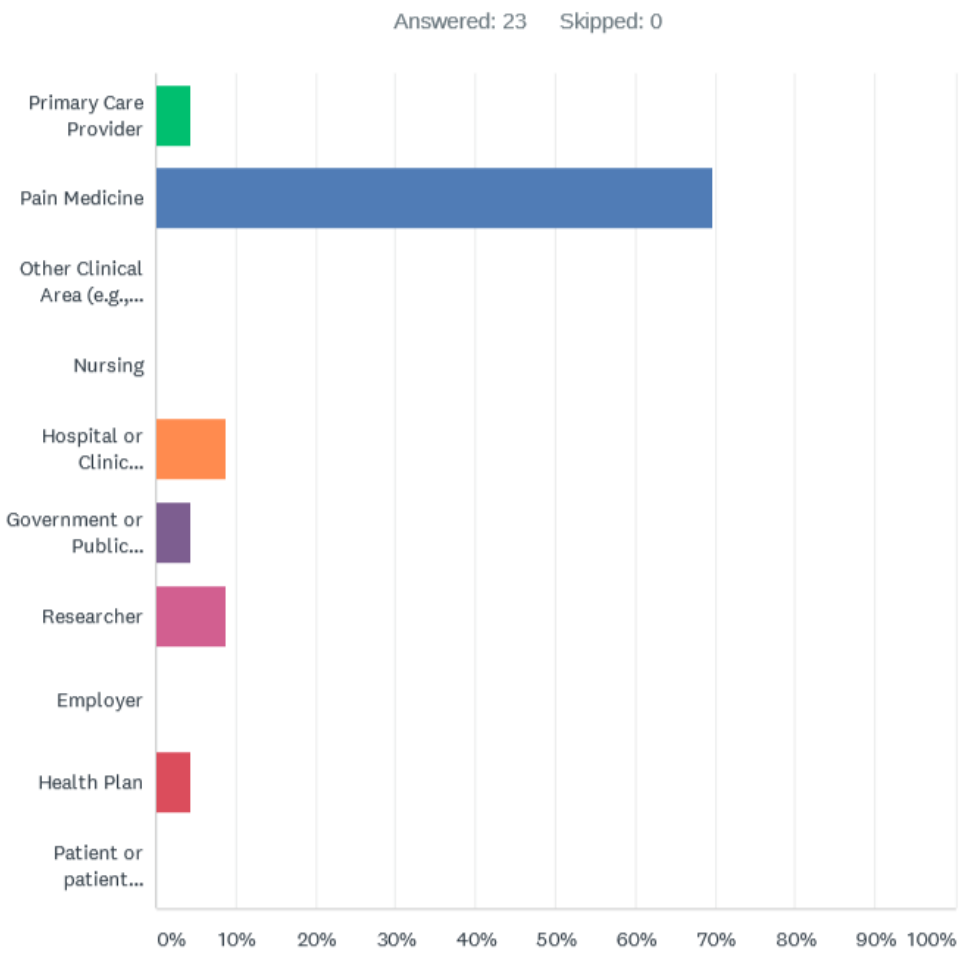
- **Co-Chairs:** Gary Franklin, MD, MPH, Medical Director, Washington State Department of Labor and Industries, Charissa Fotinos, MD, Deputy Chief Medical Officer, Washington State Health Care Authority, Andrew Saxon, MD, Director, Center of Excellence in Substance Abuse Treatment and Education (CESATE), VA Puget Sound Health Care System
- **Members:**
- Rose Bigham and Cyndi Hoenhous, Co-chairs, Patient Advocates Washington Patients in Intractable Pain
- Malcolm Butler, MD Chief Medical Officer Columbia Valley Community Health
- Pamela Stitzlein Davies, MS, ARNP, FAANP Nurse Practitioner Departments of Neurology & Nursing, University of Washington
- Jason Fodeman, MD, Washington State Department of Labor and Industries
- Andrew Friedman, MD Physical Medicine and Rehabilitation Virginia Mason Medical Center
- Kelly Golob, DC Chiropractor Tumwater Chiropractic Center
- Dan Kent, MD Chief Medical Officer UnitedHealthcare
- Kathy Lofy, MD Chief Science Officer Washington State Department of Health
- Jaymie Mai, PharmD Pharmacy Manager Washington State Department of Labor and Industries
- Gregory Rudolph, MD Addiction Medicine Swedish Pain Services
- Jennifer Davies-Sandler Patient Advocate
- Mark Stephens President Change Management Consulting
- Mark Sullivan, MD, PhD Psychiatrist University of Washington
- David Tauben, MD Chief of Pain Medicine University of Washington Medical Center
- Gregory Terman MD, PhD Professor Department of Anesthesiology and Pain Medicine and the Graduate Program in Neurobiology and Behavior, University of Washington

Guidelines
Focus Areas

- Establishing a relationship: patient engagement
- Assessment
- Treatment including selecting a treatment pathway
  - Maintain and monitor
  - Tapering or discontinuation
  - Transition to medications for opioid use disorder (MOUD)
- Recommendations for Health Plans and Health Delivery Systems

Public Comment Period
March 23 – April 17

- Charis Wolf LAc, AEMP, MSTCM PhD-s President, WAEMA Board
- Nate Myszka Senior Manager, State Government Affairs Medtronic
- Greg Rudolf MD, Swedish Pain Services
- Steven Stanos, DO Medical Director, Swedish Health System Pain Medicine and Services Medical Director, Swedish Pain Services Swedish Health System



Public Comments Summary

- Time-consuming/PCPs not able to perform assessment/not reimbursed
- 2019 HHS Interagency Task Force Recommendations
- Engagement
  - More education + trauma-informed care
- Assessment
  - Sleep hygiene
  - Additional diagnostic testing
  - Consultation with pain medicine subspecialist
  - EDIE query
  - Hepatitis C
- Treatment
  - Interventional pain procedures
  - Involve surgeons
  - Naloxone
  - Specific prescriptions (e.g., gabapentin)
  - Use OUD not addiction

Patient Engagement

- Respect
- Discuss goals of care
- Set expectations – safety while maximizing function
- Assess knowledge about pain and medication(s), educate on knowledge gaps + psychological factors
- Engage and educate others, where appropriate
- Consistent messaging
- Cultural competency

Source: Wyse JJ, Ganzini L, Dobscha SK, Krebs EE, Morasco BJ. Setting Expectations, Following Orders, Safety, and Standardization: Clinicians' Strategies to Guide Difficult Conversations About Opioid Prescribing. J Gen Intern Med. 2019 Jul;34(7):1200-1206.
Kennedy LC, Binswanger IA, Mueller SR, Levy C, Matlock DD, Calcaterra SL, Koester S, Frank JW. "Those Conversations in My Experience Don't Go Well": A Qualitative Study of Primary Care Provider Experiences Tapering Long-term Opioid Medications. Pain Med. 2018 Nov 1;19(11):2201-2211.
Sullivan MD, Turner JA, DiLodovico C, D'Appollonio A, Stephens K, Chan YF. Prescription Opioid Taper Support for Outpatients With Chronic Pain: A Randomized Controlled Trial. J Pain. 2017 Mar;18(3):308-318.

Assessment

Involve specialists, multidisciplinary team if available. Diagnostic assessment.

- Patient history
- Observation of affect and behavior
- Health record
- Physical exam
- Sleep hygiene
- Pain and functional status
- Prescription Monitoring Program
- Urine drug test
- Review comorbidities with particular attention to psychiatric and substance use disorders (i.e., depression, anxiety, suicidality, post-traumatic stress disorder, adverse childhood experiences, alcohol misuse, substance use)
- Validated tool to determine level of risk
- Evaluate for opioid use disorder

Treatment

- Naloxone
- Referencing WAC (e.g., documentation)
- Involve behavioral health providers, where possible
- Use non-opioid pharmacological pain management
- Use non-pharmacological pain management
- Risks/benefits
  - Maintain and Monitor
    - Periodic review + written agreement as stated in WAC
  - Tapering or Discontinuation **->** HHS Guidelines
  - Medications for opioid use disorder
    - Remove dosing guidance

HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

This *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics* provides advice to clinicians who are contemplating or initiating a reduction in opioid dosage or discontinuation of long-term opioid therapy for chronic pain. In each case the clinician should review the risks and benefits of the current therapy with the patient, and decide if tapering is appropriate based on individual circumstances.

After increasing every year for more than a decade, annual opioid prescriptions in the United States peaked at 255 million in 2012 and then decreased to 191 million in 2017.[i] More judicious opioid analgesic prescribing can benefit individual patients as well as public health when opioid analgesic use is limited to situations where benefits of opioids are likely to outweigh risks. At the same time opioid analgesic prescribing changes, such as dose escalation, dose reduction or discontinuation of long-term opioid analgesics, have potential to harm or put patients at risk if not made in a thoughtful, deliberative, collaborative, and measured manner.

Risks of rapid opioid taper

- Opioids should not be tapered rapidly or discontinued suddenly due to the risks of significant opioid withdrawal.
- Risks of rapid tapering or sudden discontinuation of opioids in physically dependent[ii] patients include acute withdrawal symptoms, exacerbation of pain, serious psychological distress, and thoughts of suicide.[1] Patients may seek other sources of opioids, potentially including illicit opioids, as a way to treat their pain or withdrawal symptoms.[1]
- Unless there are indications of a life-threatening issue, such as warning signs of impending overdose, HHS does not recommend abrupt opioid dose reduction or discontinuation.

Whether or not opioids are tapered, safe and effective nonopioid treatments should be integrated into patients' pain management plans based on an individualized assessment of benefits and risks considering the patient's diagnosis, circumstances, and unique

needs.[2,3,5] Coordin
Clinicians have a
coordinated ma
problems, and
specific guidan
(the *CDC Guid*
and the *VA/D*
for Chronic P
reviewed lit

Consider[iii] tapering to a reduced opioid dosage, or tapering and discontinuing opioid therapy, when

- Pain im
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- The pat
period

- Pain improves[3]
- The patient requests dosage reduction or discontinuation[2,3,5]
- Pain and function are not meaningfully improved[2,3,5]
- The patient is receiving higher opioid doses without evidence of benefit from the higher dose[2,3]
- The patient has current evidence of opioid misuse[3,5]
- The patient experiences side effects[iv] that diminish quality of life or impair function[3]
- The patient experiences an overdose or other serious event (e.g., hospitalization, injury),[2,5] or has warning signs for an impending event such as confusion, sedation, or slurred speech[2,6]
- The patient is receiving medications (e.g., benzodiazepines) or has medical conditions (e.g., lung disease, sleep apnea, liver disease, kidney disease, fall risk, advanced age) that increase risk for adverse outcomes[3,5]
- The patient has been treated with opioids for a prolonged period (e.g., years), and current benefit-harm balance is unclear

[i] https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html

[ii] Physical dependence occurs with daily, around-the-clock use of opioids for more than a few d
requiring more of it to achieve a certain effect (tolerance). Patients with physical dependence
if drug use is abruptly ceased (withdrawal).

[iii] Additional tools to help weigh decisions about continuing opioid therapy are available: Assessin
Management Opioid Taper Decision Tool, and Tapering Opioids for Chronic Pain.

[iv] e.g., drowsiness, constipation, depressed cognition

Pain Rules (WAC)

PDF **WAC 246-919-905**

Patient evaluation and patient record—Chronic pain.

When the patient enters the chronic pain phase, the patient shall be reevaluated as if presenting with a new disease. The physician shall include in the patient's record:

(1) An appropriate history including:

(a) The nature and intensity of the pain;

(b) The effect of pain on physical and psychosocial function;

(c) Current and relevant past treatments for pain, including opioids and other medications and their efficacy; and

(d) Review of comorbidities with particular attention to psychiatric and substance use.

(2) Appropriate physical examination.

(3) Ancillary information and tools to include:

(a) Review of the PMP to identify any medications received by the patient in accordance with the provisions of WAC 246-919-985;

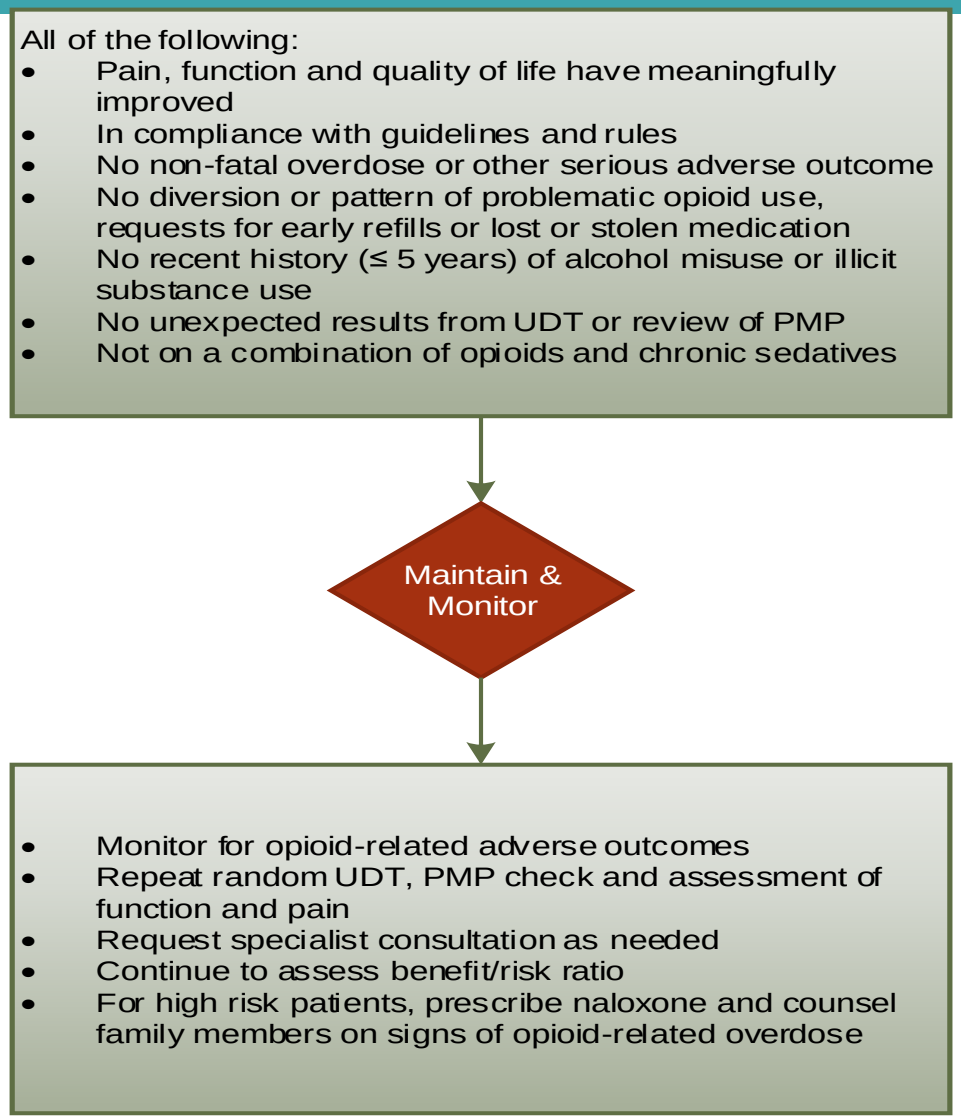
(b) Any pertinent diagnostic, therapeutic, and laboratory results;

(c) Pertinent consultations; and

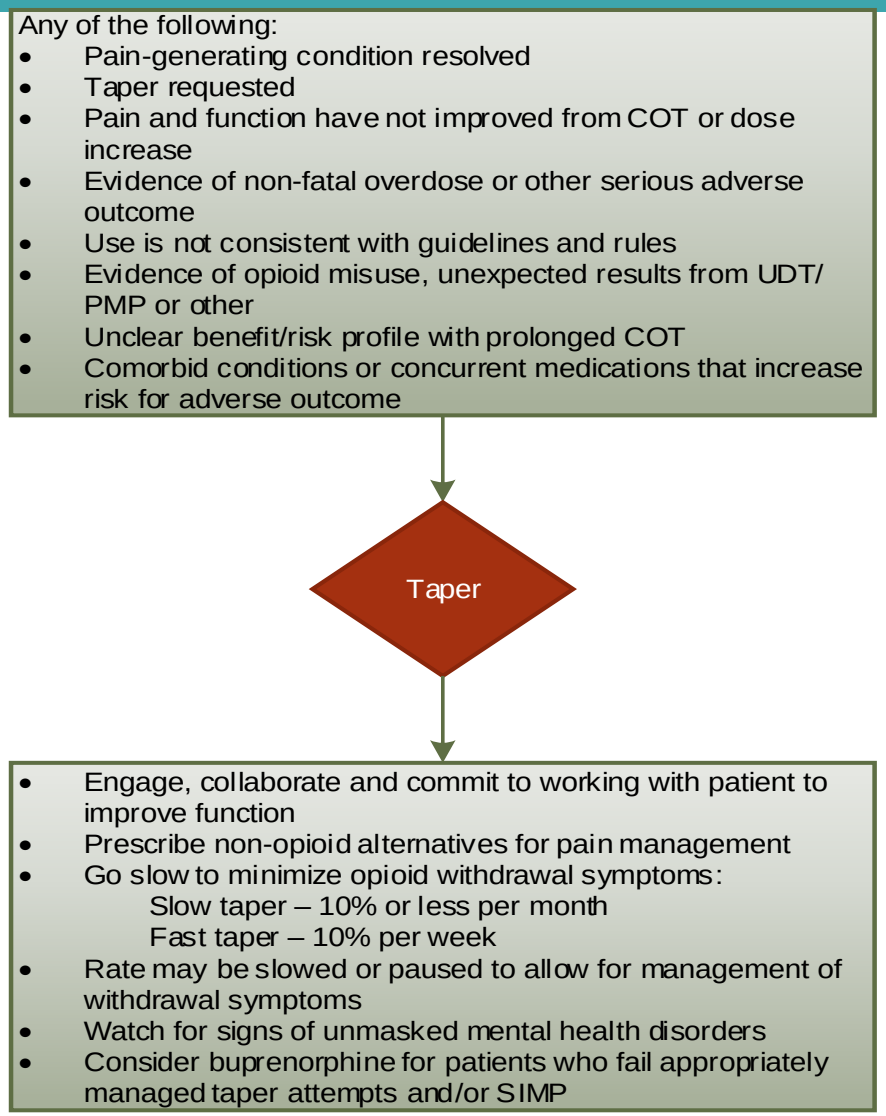
(d) Use of a risk assessment tool that is a professionally developed, clinically recommended questionnaire appropriate for characterizing a patient's level of risk for opioid or other substance use disorders to assign the patient to a high-, moderate-, or low-risk category.

(4) Assessment. The physician must document medical decision making to include:

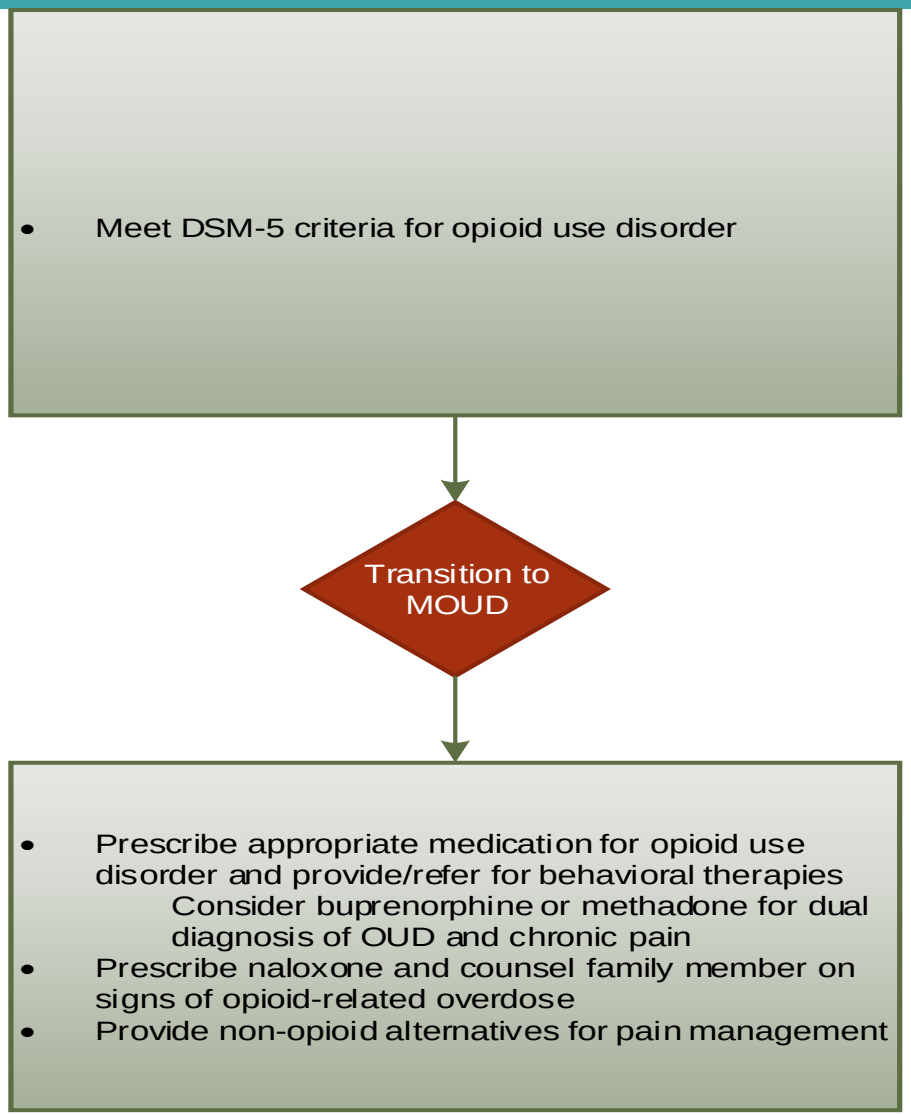
Maintain and Monitor Pathway



Taper Pathway



Transition to MOUD Pathway



Health System Recommendations

- Health Plans
  - More explanation of SIMPs
  - E.g., Expand reimbursement for Structured Intensive Multidisciplinary Programs (SIMP) to increase access and availability when medically necessary
- Health Care Systems
  - Telepain
  - e.g., Train staff on motivational interviewing

Recommendation

Adopt Long-Term Opioid Therapy Recommendations

Topic Update: Reproductive and Sexual Health

Charissa Fotinos, MD
Deputy Chief Medical Officer, Washington State Health Care Authority

DR. ROBERT BREE COLLABORATIVE

May 20, 2020 | Zoom Meeting

Review: Senate Bill 5602

Eliminating barriers to reproductive health care for all

Sponsors: Randall, Wilson, C., Nguyen, Das, Saldaña, Cleveland, Takko, Kuderer, Hasegawa, Rolfes, Van De Wege, Keiser, Hunt, Wellman, Billig, Dhingra, Conway, Pedersen, Frockt, Salomon, Palumbo, Darneille, McCoy, Liias, Mullet, Carlyle

More information:
https://app.leg.wa.gov/billsummary?BillNumber=5602&Initiative=false&Year=2019

NEW SECTION. Sec. 6. A new section is added to chapter 70.250 RCW to read as follows:

(1) No later than January 1, 2020, the collaborative shall begin a review to identify, define, and endorse guidelines for the provision of high quality sexual and reproductive health services in clinical settings throughout Washington. This shall include the development of specific clinical recommendations to improve sexual and reproductive health care for:

(a) People of color;

(b) Immigrants and refugees;

(c) Victims and survivors of violence; and

(d) People with disabilities.

(2) The collaborative shall conduct its review consistent with the activities, processes, and reporting standards specified in RCW 70.250.050. In conducting its review, the collaborative shall apply a whole-person framework to develop evidence-based, culturally sensitive recommendations to improve standards of care and health equity.

(3) By December 15, 2020, the collaborative, through the authority, shall provide a status report to the committees of the legislature with jurisdiction over matters related to health care and to the governor.

Review
Workgroup Members

- **Chair:** Charissa Fotinos, MD, Deputy Chief Medical Officer, Washington State Health Care Authority
- Paul Dillon/Lili Navarrete, Latinx Outreach & Organizing Program, Planned Parenthood of Greater Washington and North Idaho
- Janet Cady, ARNP, Medical Director, School Based Program, Neighborcare
- Angela Chien, MD, Obstetrics and Gynecology, EvergreenHealth
- Colin Fields, MD, Chief, Gender Health program, Kaiser Permanente Washington
- Leo Gaeta, Vice President of Programs, Columbia Basin Health Association, Othello Clinic
- Cynthia Harris, PhD, Family Planning Program Manager, Department of Health
- Rita Hsu, MD, FACOG, Obstetrics and Gynecology, Confluence Health
- Heather Maisen, MPH, MSW, Family Planning Program Manager, Seattle King County Public Health
- Adrianne Moore, Deputy Director of Quality Improvement, Upstream
- Claire Tierney, Healthy Relationships Program Manager, ARC of King County
- Ivanova Smith, Patient Advocate
- Mandy Weeks-Green, Senior Health Policy Analyst, Officer of the Insurance Commissioner
- Catherine West, JD, Staff Attorney, Legal Voice (was northwest women's law center)
- Giselle Zapata-García, Co-Director, Latinos Promoting Good Health (also Latinx Health Board, Executive Committee Co-Chair)

Meeting Schedule

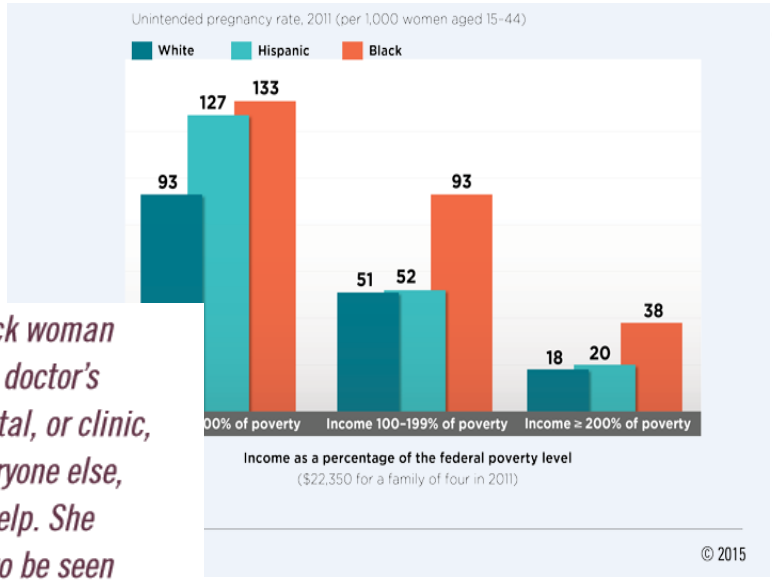
- January + February – scoping work and agenda setting
- March – Immigrants and Refugees
- April – People of Color
- May – People with Disabilities
- June – Impact of Violence (including human trafficking)
- July – AI/AN
- August – Intersecting Identities and Holistic Change
- September – Finalize language + present for dissemination for public comment
- October – Public Comment
- November – Final Vote

Immigrants and Refugees

- Presentation from Leo Gaeta, Vice President of Programs and Karina Silva, Family Planning Coordinator, The Columbia Basin Health Association (CBHA) Experience
  - Patient knowledge and comfort level regarding contraception use
  - Cultural beliefs and myths
  - Access and affordability
  - Public Charge
  - Community
  - Medical care team workflows
  - Staff knowledge and comfort level regarding contraception counseling

People of Color

- Heather Maisen, MSW, MPH, Family Planning Program Manager, Public Health – Seattle & King County



"When a Black woman walks into a doctor's office, hospital, or clinic, just like everyone else, she wants help. She also wants to be seen as fully human and autonomous, capable of making good decisions for herself."

—**ALICIA WALTERS,**
FOUNDER OF ECHOING IDA

People with Disabilities

- True Inclusion in Parenting: Ivanova Smith, UW LEND Faculty
- https://youtu.be/XO1e62LX3Rg

The needs of persons with disabilities are often overlooked or neglected.

Disability is everyone's business.

Focus Areas

- Access
  - Physical, Language, Cognitive
  - Insurance
- Patient-centeredness
  - Trust
  - Understanding individual need
- Appropriate care
  - Prevention, screening treatment (e.g., cancer screening, STIs)
  - Family planning
  - Pre-conception, prenatal, labor and delivery, postpartum
- Cultural sensitivity and being humble
  - Understanding background
  - Bias free

Topic Update: Colorectal Cancer Screening

Rick Ludwig, MD
Chief Executive Officer,
Pacific Medical Centers

DR. ROBERT BREE COLLABORATIVE

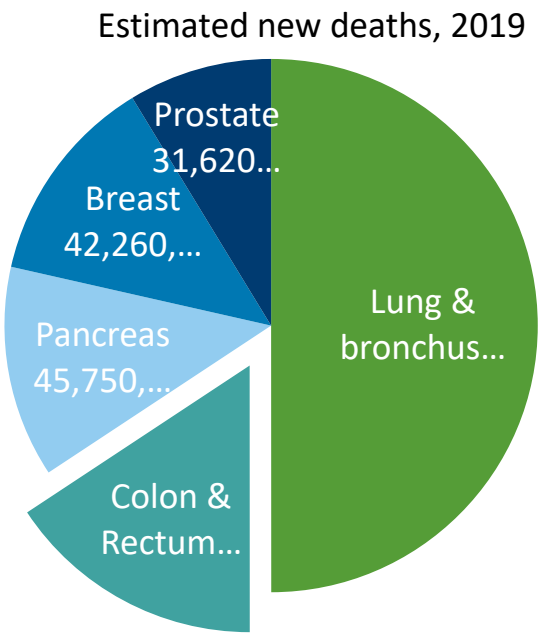
May 20, 2020 | Zoom Meeting

Review: Workgroup Members

- **Chair:** Rick Ludwig, MD, Chief Executive Officer, Pacific Medical Centers
- Patricia Auerbach, MD, MBA, FACP, Chief Medical Officer, Washington, Oregon, and Idaho, Employer & Individual, Medicare & Retirement, UnitedHealthcare
- Elizabeth Broussard, MD, Gastroenterology, Pacific Medical Centers First Hill
- Jason Dominitz, MD, MHS, National Program Director, Gastroenterology, Veterans Health Administration
- John Dunn, MD, Medical Director of Prevention, Kaiser Permanente Washington
- Casey Eastman, MPH, Content Lead, Breast, Cervical, Colon Health Program, Washington State Department of Health
- Bev Green, MD, MPH, Senior Investigator, Family Physician, Kaiser Permanente Washington
- John Inadomi, MD, Gastroenterology, University of Washington Medicine
- Rachel Issaka, MD, MAS, Assistant Member, Clinical Research Division, Gastroenterology & Hepatology, Fred Hutchinson Cancer Research Center
- Joanna Law, MD, Gastroenterology, Virginia Mason Medical Center
- Vlad Simianu, MD, MPH, Colon and Rectal Surgery, Virginia Mason Medical Center
- Julie Stofel, Patient and Family Advocate
- Tammy Wild, MPH, RDN, LD, State Health Systems Manager, American Cancer Society

Slides borrowed from Beverly Green, MD, MPH
Senior Investigator and Family Physician, Kaiser Permanente Washington Health Research Institute and Kaiser Permanente Washington

Decreasing the Burden of Colorectal Cancer



Colorectal Cancer (CRC) second leading cause of cancer death

CRC screening decreases incidence and mortality:

- Find and remove pre-cancerous lesions
- Find cancers early

KAISER PERMANENTE®

Screening Decreases Colorectal Cancer (CRC) Incidence and Mortality

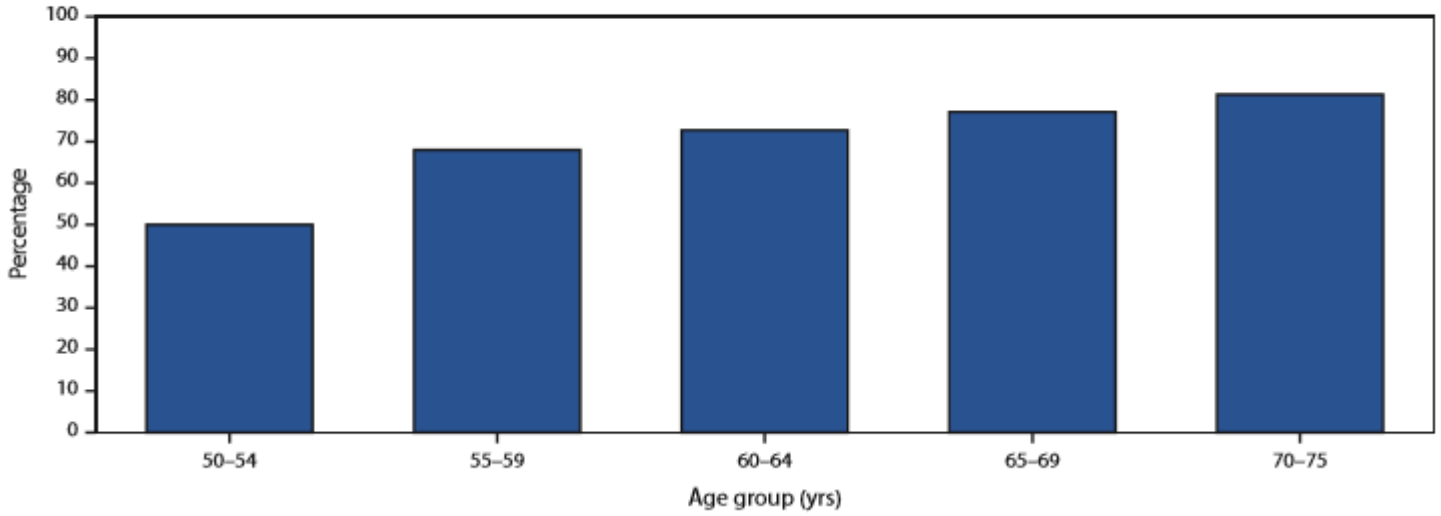
The US Preventive Services Task Force strongly recommends CRC screening (Grade A).

Modeling has found that these several screening modalities were equally effective, and cost-effective **if adhered** to as recommended.

- Colonoscopy every 10 years
- Fecal Immunochemical testing every year
- Flexible sigmoidoscopy every 5 years (with or without FIT)
- Stool DNA/FIT every 3 years
- CT colonoscopy every 5 years

We still have work to do

FIGURE. Percentage of respondents aged 50–75 years who reported being up to date* with colorectal cancer screening, by age — Behavioral Risk Factor Surveillance System (BRFSS), United States, 2018†,§



- Source: Joseph DA, King JB, Dowling NF, Thomas CC, Richardson LC. Vital Signs: Colorectal Cancer Screening Test Use — United States, 2018. MMWR Morb Mortal Wkly Rep 2020;69:253–259. DOI: http://dx.doi.org/10.15585/mmwr.mm6910a1

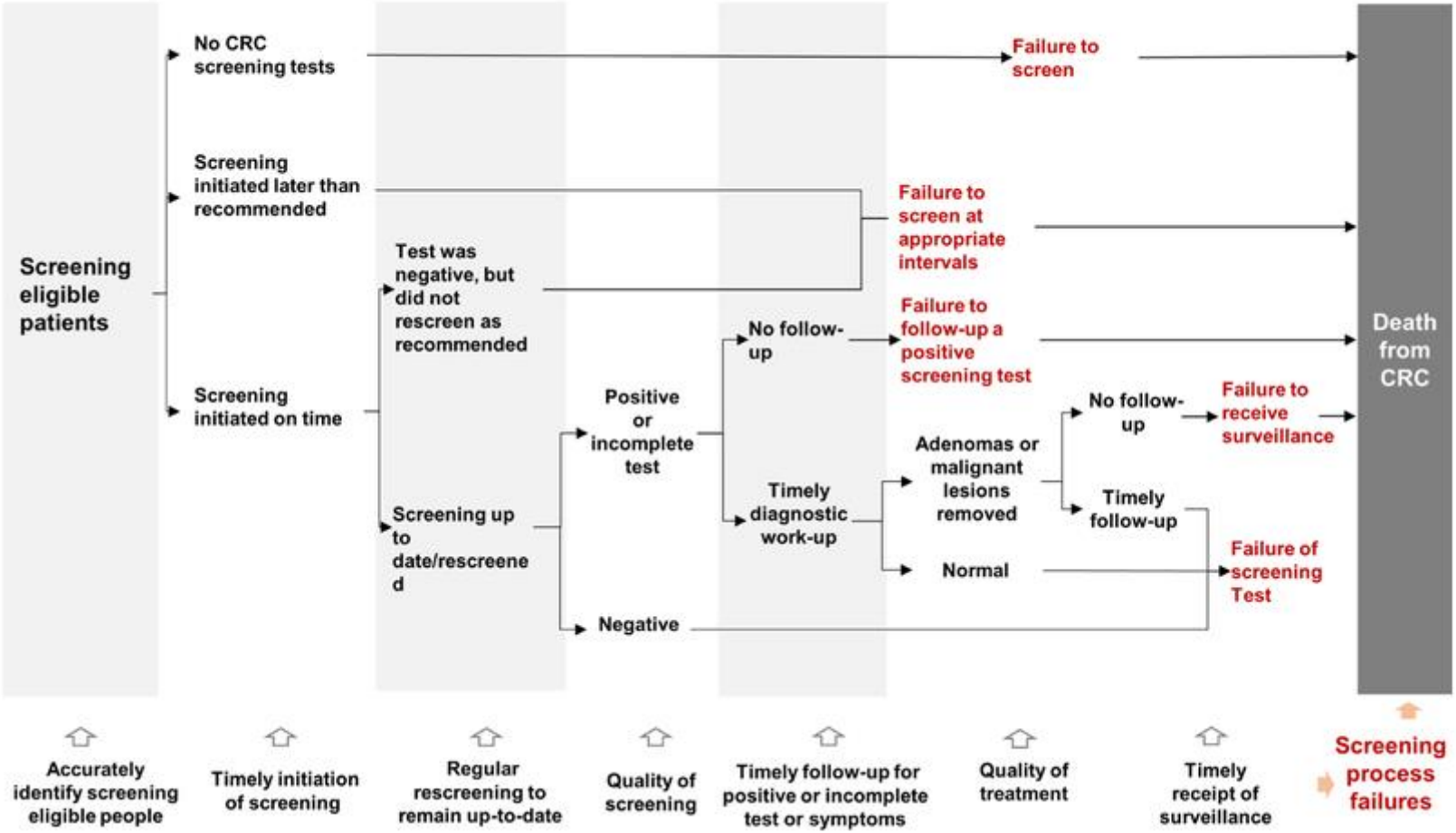
WHA Community Checkup
Barriers

- Stigma
- Colonoscopy Preparation
- Financial Uncertainties
- System Inconsistencies
- Disparities in Screening and Treatment

"There should not be anyone who dies of colorectal cancer in this country. If everyone was screened at appropriate intervals and in a timely way, we could eliminate or, at a minimum, significantly reduce the number of deaths. Too many times people show up in the Emergency Room because of a bowel obstruction, but by then, it's too late."

– **Dr. Rick Ludwig**, interim Chief Executive Officer at Pacific Medical Centers and Medical Director of the U.S. Family Health Plan at Pacific Medical Centers

Where to Intervene



- Source: Doubeni CA, Fedewa SA, Levin TR, et al. Modifiable Failures in the Colorectal Cancer Screening Process and Their Association With Risk of Death. Gastroenterology. 2019;156(1):63-74.e6. doi:10.1053/j.gastro.2018.09.040

What is the best way to increase screening rates? (Average Risk People age 50-75)

- >100 trials have studied this
- We now know what increases screening uptake
  - Direct mailing of fecal kits increases screening rates by about 22% (with little difference by race/ethnicity, education, income)
  - Flu-FIT programs are moderately effective
  - Navigation is also very effective
  - Screening rates go up if FIT is offered as an option
  - Patient incentives mixed
  - Interventions targeting physicians/teams are not very effective and can be expensive

WHA Community Checkup
Solutions

Dr. Beverly Green, Family Physician and Senior Investigator at Kaiser Permanente Washington Health Research Institute has been studying colorectal cancer screening rates for more than 20 years. She says colorectal cancer screening rates can be dramatically increased and one mechanism to do that is mailing home-testing FIT kits to patients. A study of 21 primary care clinics and almost 5,000 patients saw a 30% increase in screening by mailing kits to patients at home.[xiv] She has also watched as mailing FIT kits enabled Kaiser Permanente in California to reach screening rates over 80% with colorectal cancer deaths

Based on Dr. Green's research, there are several other policy and practice changes that would increase colorectal cancer screening rates in Washington state:

1. require measurement of colorectal cancer screening rates for the Medicaid population by the state and/or federal government;
2. tie provider payments to showing improvement in colorectal cancer screening rates in state health care purchasing contracts (along with other quality measures);
3. improve outreach to ensure that each positive FIT result leads to a colonoscopy;
4. eliminate patient financial obligations for colonoscopies that are part of preventive care—including if they become diagnostic when a polyp is removed or if they are after a positive FIT;
5. increase funding to provide colorectal cancer screenings to the uninsured; and
6. allow patients who are income-eligible to have the same access to free screening and treatment as those with breast and cervical cancer.

Shared Decision Making

healthwise
for every health decision

Colorectal Cancer: Which Screening Test Should I Have?

Here's a record of your answers. You can use it to talk with your doctor or loved ones about your decision.

1. Get the facts
2. Compare your options
3. What matters most to you?
4. Where are you leaning now?
5. What else do you need to make your decision?

1. Get the facts

Your options

- Get a stool test that you can do at home.
- Get a colonoscopy, sigmoidoscopy, or CT colonography at a doctor's office, clinic, or hospital.

This information is for people who are at average risk for colorectal cancer. Your doctor may recommend getting tested earlier or more often if you have a higher risk.

Key points to remember

- All of the screening tests work well to lower your risk of getting and dying from colorect cancer. No matter what test you choose, regular testing can find signs of cancer early, the cancer may be easier to treat.
- The tests differ in how they are done, how often they are done, and how you prepar them. Your preferences are important in choosing what test to have. Think about w most to you as you look at what each test involves.
- No matter which test you choose, it's important that you have the test on the reco schedule and have any follow-up visits or tests as needed. That gives you the b reducing the risk of dying from colorectal cancer.
- Your risk for colorectal cancer gets higher as you get older. Talk with your doct risk and when to start and stop screening.

FAQs

What is colorectal cancer?

Colorectal cancer happens when cells that are not normal grow in your color 1 in appendix) . Most people just call it "colon cancer."

These cancers usually begin as polyps. Polyps are growths attached to the inside rectum. Colon polyps are common. Most of them don't turn into cancer. Polyps are found some screening tests. And polyps found during a colonoscopy usually can be removed at the same time.

COMMENTARY

CA CANCER J CLIN 2018;68:2

From Guideline to Practice: New Shared Decision-Making Tools for Colorectal Cancer Screening From the American Cancer Society

Robert J. Volk, PhD [1]; Viola B. Leal, MPH [2]; Lianne E. Jacobs, MPH [3]; Andrew M.D. Wolf, MD [4]; Durado D. Brooks, MD, MPH [5]; Richard C. Wender, MD [6,7]; Robert A. Smith, PhD [8]

[1]Professor, Department of Health Services Research, The University of Texas MD Anderson Cancer Center, Houston, TX; [2]Program Manager, Department of Health Services Research, The University of Texas MD Anderson Cancer Center, Houston, TX; [3]Project Manager, Department of Health Services Research, The University of Texas MD Anderson Cancer Center, Houston, TX; [4]Associate Professor of Medicine, Department of Medicine, University of Virginia School of Medicine, Charlottesville, VA; [5]Vice President, Cancer Control Interventions, Prevention, and Early Detection, American Cancer Society, Atlanta, GA; [6]Chief Cancer Control Officer, American Cancer Society, Atlanta, GA; [7]Professor, Department of Family and Community Medicine, Thomas Jefferson University, Philadelphia, PA; [8]Vice President, Cancer Screening, Cancer Control Department, American Cancer Society, Atlanta, GA.

Corresponding author: Robert J. Volk, PhD, Department of Health Services Research, Unit 1444, The University of Texas MD Anderson Cancer Center, PO Box 301402, Houston, TX 77230-1402; bwolk@mdanderson.org

Disclosures: The American Cancer Society (ACS) receives partial funding from the Centers for Disease Control and Prevention to support the National Colorectal Cancer Roundtable, of which Richard C. Wender is the Chair, Robert A. Smith is the Co-Chair, and Durado D. Brooks is a Steering Committee member, to support initiatives related to colorectal cancer screening. The ACS also received contributions from Ibrocon Diagnostics Inc, Polymedco Inc, Exact Sciences, Epigenomics Inc, Clinical Genomics, Medtronic GI Solutions Inc, Quest Diagnostics, Earlydign, the American Society for Gastrointestinal Endoscopy, Medtel Gastrointestinal Endoscopy, the American College of Gastroenterology, the American College of Radiology, and the American Gastroenterological Association to support the annual meeting of the National Colorectal Cancer Roundtable. ACS cancer screening guideline development is supported by ACS operational funds; neither the Roundtables nor sources of funding described in this disclosure have had any role, involvement, or influence made any financial contributions to ACS screening guideline development or approval. This work was also supported in part by a grant to Robert J. Volk from The University of Texas MD Anderson Cancer Center Duncan Family Institute for Cancer Prevention and Risk Assessment. The decision support tools described in this commentary were developed under a contract between The University of Texas MD Anderson Cancer Center and the ACS.

doi: 10.3322/caac.21459. Available online at cacancerjournal.com

The goal of the American Cancer Society (ACS) 2018 guideline update for colorectal cancer (CRC) screening is to reduce the incidence of and deaths from CRC for average-risk adults aged 45 years and older through the use of screening tests that are selected to align with a patient's preferences and test availability.[1] Beginning screening at age 45 years is a qualified recommendation, and regular screening of adults aged 50 years and older is a strong recommendation. The basis for the grading of these recommendations is described in the guideline update.[1] For adults in good health with at least a 10-year life expectancy, screening should continue to age 75 years, whereas the decision to screen individuals ages 76 through 85 years should be individualized based on patient preferences, life expectancy, health status, and prior screening history (qualified recommendation). Clinicians should discourage individuals older than 85 years from continuing screening (qualified recommendation). The updated guideline includes details about the process for developing and rating the recommendations.[1]

In the updated guideline, the ACS Guideline Development Group placed greater emphasis on the importance of patient preferences and choice in selecting a screening test, with the goal of increasing CRC screening uptake and adherence. Six screening options are included in the new guideline, including 3 stool-based tests (fecal immunochemical test [FIT]; high-sensitivity guaiac-based fecal occult blood test [HSgFOBT]; and multitarget stool DNA test [mt-sDNA]) and 3 structural (visual) examinations (colonoscopy, computed tomography colonography [CTC], and flexible sigmoidoscopy [FS]). Each option is associated with unique operational and performance attributes as well as demands on patients, and there is an extensive literature demonstrating variability in how patients value the attributes of CRC screening options.[2-5] These attributes, which include the frequency of testing, test procedures, and required preparation, alone or in combination, can impact a patient's preference for CRC screening tests.[3] Provider recommendations also strongly influence the uptake of screening and choice of test.[6] Decision making about CRC screening therefore involves the patient weighing the importance of the test attributes when making a decision with a health care provider about which test is right for them. In the absence of the provider's assessment of patient preferences, screening may not take place if the test offered is judged by the patient to be undesirable. There is evidence that screening intentions are higher among patients who are offered an option that is consonant with their preferences.[5,7]

The updated guideline emphasizes the importance of communication about CRC screening between health care providers and patients to improve CRC screening utilization.[8] Shared decision making is a collaborative process that allows patients and their health care providers to make decisions together, accounting for the best scientific evidence available as well as the values and preferences of the patient.[9] With the release of its updated CRC screening guideline, the ACS has developed decision support tools to engage patients and health care providers in making shared decisions about screening (cancer.org/health-care-professionals/colon-md.html). Here, we introduce these new tools for supporting shared decision

Meeting Schedule

- January + February – scoping work, agenda setting, understanding colorectal cancer
- March – Understanding where to intervene
- April – Report out of members ideal state
- May – Drafting short and long-term recommendations
- June – Stakeholder language
- July – Finalizing stakeholder language, recommendations potentially out for public comment

Topic Update:
Oncology Care

Hugh Straley, MD
Chair, Bree Collaborative

DR. ROBERT BREE COLLABORATIVE

May 20, 2020 | Zoom Meeting

Review: Workgroup Members

- **Chair:** Hugh Straley, MD, Chair, Bree Collaborative
- Sibel Blau, MD, Oncologist, Northwest Medical Specialties
- Andra Davis, PhD, MN, BSN, Assistant Professor, Vancouver, Washington State University
- Gurpreet Dhillon, MBA, Director, Hospice, Palliative Care and PeaceHealth St. Joseph Cancer Center Service Lines, PeaceHealth
- Stefanie Hafermann, RN, Lead, Program Design, Clinical Services, Cambia Health Plans
- Blair Irwin, MD, MBA, Oncologist, Multicare Regional Cancer Center
- Barb Jensen, RN, BSN, MBA, Director of Oncology and Palliative Care, Skagit Regional Health
- Nancy Thompson, RN, MS, AOCNS, Director, Quality & Clinical Practice, Swedish Cancer Institute
- Laura Panattoni, PhD, Staff Scientist, Hutchinson Institute for Cancer Outcomes Research
- Camille Puronen, MD, Oncologist, Kaiser Permanente Washington

The Problem

- ~39.3% of people diagnosed with cancer in lifetime, median age=66 years
  - Disparities in incidence and mortality rates based on race, ethnicity, socioeconomic status
- Wide variety of side effects from chemotherapy and radiation
- Patients frequently seek treatment through EDs + other inpatient care = poor symptom management, stress, risk of infections

- https://www.cancer.gov/about-cancer/understanding/statistics
- Centers for Disease Control and Prevention. Side Effects of Cancer Treatment. Available: www.cdc.gov/cancer/survivors/patients/side-effects-of-treatment.htm
- Panattoni L, Fedorenko C, Greenwood-Hickman MA, Kreizenbeck K, Walker JR, Martins R, Eaton KD, Rieke JW, Conklin T, Smith B, Lyman G, Ramsey SD. Characterizing Potentially Preventable Cancer- and Chronic Disease–Related Emergency Department Use in the Year After Treatment Initiation: A Regional Study. J Oncol Pract. 2018 Mar;14(3):e176-e185.
- Singh GK, Jemal A. Socioeconomic and Racial/Ethnic Disparities in Cancer Mortality, Incidence, and Survival in the United States, 1950-2014: Over Six Decades of Changing Patterns and Widening Inequalities. J Environ Public Health. 2017;2017:2819372. doi:10.1155/2017/2819372

Work Thus Far
Reviewing Literature

JAMA Network Open.

Original Investigation | Emergency Medicine

Analysis of Diagnoses, Symptoms, Medications, and Admis
Among Patients With Cancer Presenting to Emergency Dep

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Arvind Venkat, MD; Jason Wilson, MD, MA; Charles R. Thomas Jr, MD; Jason J. Bischof, MD; Gary H. Lyman, MD, MPH

Systematic Review of Hospital Readmissions Among Patients With Cancer in the United States

Janice F. Bell, PhD, MN, MPH, Robin L. Whitney, RN, PhD, Sarah C. Reed, MSW, MPH, Hermine Poghosyan, PhD, MPH, Rebecca S. Lash, PhD, MPP, RN, Katherine K. Kim, PhD, MPH, MBA, Andra Davis, RN, MN, PhD, Richard J. Bold, MD, and Jill G. Joseph, MD, PhD

ONS Abstract (ID: 3673)
Title: Nurse Telephone Triage to Improve Patient Outcomes and Emergency Room Utilization for Patients Receiving Chemotherapy

Andra Davis, PhD, MN, RN

Best Practices for Reducing Unplanned Acute Care for Patients With Cancer

Nathan R. Handley, Lynn M. Schuchter, and Justin E. Bekelman

Abstract

Variation and cost in oncology care represent a large and growing burden for the US health care system, and acute hospital care is one of the single largest drivers. Reduction of unplanned acute care is a major priority for clinical transformation in oncology; proposed changes to Medicare reimbursement for patients with cancer who suffer unplanned admissions while receiving chemotherapy heighten the need. We conducted a review of best practices to reduce unplanned acute care for patients with cancer. We searched PubMed for articles published between 2000 and 2017 and reviewed guidelines published by professional organizations. We identified five strategies to reduce unplanned acute care for patients with cancer: (1) identify patients at high risk for unplanned acute care; (2) enhance access and care coordination; (3) standardize clinical pathways for symptom management; (4) develop new loci for urgent cancer care; and (5) use early palliative care. We assessed each strategy on the basis of specific outcomes: reduction in emergency department visits, reduction in hospitalizations, and reduction in rehospitalizations within 30 days. For each, we define gaps in knowledge and identify areas for future effort. These ed separately or, with possibly more success, as an planned acute care for patients with cancer. Because of d the limited data on effectiveness, there should be o identify the optimal strategies to reduce emergency department visits, hospitalizations, and rehospitalizations. Proposed reimbursement changes amplify the need for cancer programs to focus on this issue.

Best Practices for Reducing Unplanned Acute Care for Patients With Cancer

- **Identify patients at high risk for unplanned acute care**
- **Enhance access and care coordination**
- **Standardize clinical pathways for symptom management**
- Develop new loci for urgent cancer care
- Use early palliative care – see palliative care recommendations

- Source: Handley NR, Schuchter LM, Bekelman JE. Best Practices for Reducing Unplanned Acute Care for Patients With Cancer. Journal of Oncology Practice 14, 5, May 2018. 306-314.

Hospitalization Risk During Chemotherapy for Advanced Cancer: Development and Validation of Risk Stratification Models Using Real-World Data

- Patients with advanced nonhematologic cancer, median age = 63 years
- Developed models to predict risk of hospitalization within 30 days after start of chemotherapy
- Two variables, pretreatment sodium and albumin levels, stratified patents into high-risk and standard risk groups with hospitalization risks of 24.2% v 8.7%

- Source: Brooks GA, Uno H, Bowles EJA, Menter AR, O'Keeffee-Rosetti M, Tosteson ANA, et al. Hospitalization Risk During Chemotherapy for Advanced Cancer: Development and Validation of Risk Stratification Models Using Real-World Data. ASCO. April 2019. 1-10.

Meeting Schedule

- January – scoping work and agenda setting
- February – Continuing to agenda-set and hearing from Camille E Puronen, MD, Oncologist, Kaiser Permanente Washington on the Presentation: Nurse Navigator Program at Kaiser
- March - Andra Davis, PhD, MN, RN Assistant Professor, Washington State University College of Nursing – Vancouver, on Nurse-Led Symptom Support AND Laura Panattoni, PhD Senior Staff Scientist, Hutchinson Center for Cancer Outcomes Research on Risk Stratification
- April - Sibel Blau, MD, President/CEO, Quality Cancer Care Alliance Network, Medical Director, Oncology Division-NWMS on Risk Stratification and Patient Outreach
- May – Report out on members risk stratification standard
- June – Finalize risk stratification standard and outline nurse-led management and symptom management pathways

Focus Areas

- Assessment including of patient satisfaction with oncology care
  - Symptom inventory, anxiety, depression, fatigue, pain, sleep quality
- Risk stratification mechanisms to better meet patient need(s)
- Wrap-around supportive services through interdisciplinary team-based care
  - Post-discharge nursing phone calls
  - Post-discharge provider follow-up appointments
  - Symptom management/triage/pathways
  - Telehealth
- Assessing and addressing caregiver need(s)
- Integrating palliative care alongside life-prolonging and/or curative care

Topic Update:
Primary Care

Judy Zerzan, MD, MPH
Chief Medical Officer,
Washington State Health Care Authority

DR. ROBERT BREE COLLABORATIVE

May 20, 2020 | Zoom Meeting

Review: Workgroup Members

- Chair: Judy Zerzan, MD, MPH, Chief Medical Officer, Washington State Health Care Authority
- Patricia Auerbach, MD, MBA, Senior Medical Director, United Health Care
- Cynthia Burdick, MD, Medical Director, Medicare and Medicaid , Kaiser Permanente Washington
- Tony Butruille, MD, Family Physician, Cascade Medical
- Susie Dade, MS, Deputy Director, Washington Health Alliance
- Jason Fodeman, MD, Associate Medical Director, Washington State Department of Labor and Industries
- Bianca Frogner, PhD, Associate Professor, Family Medicine; Director of Center for Health Workforce Studies, University of Washington School of Medicine
- Ingrid Gerbino, MD, FACP, Chief, Department of Primary Care, Virginia Mason
- Louise Kaplan, PhD, ARNP, FNP-BC, FAANP, FAAN, Associate Professor, Associate Academic Director, Washington State University Vancouver College of Nursing
- Cat Mazzawy, RN, MSN, CPPS, Sr. Director for Safety & Quality, Washington State Hospital Association
- Carl Olden, MD, Family Physician, Virginia Mason Memorial
- Julie Osgood, DrPH, VP Clinic Operations, Valley Medical Center
- Mary Kay O'Neill, MS, MBA, Partner, Mercer
- Ashok Reddy, MD, MS, Assistant Professor, Medicine, University of Washington School of Medicine, Veterans Administration
- Keri Waterland, PhD, MAOB, Division Director, Division of Behavioral Health and Recovery, Health Care Authority
- Laura Kate Zaichkin, MPH, Director, Health Plan Performance and Strategy, SEIU 775 Benefits Group

Meeting Schedule

- January + February – scoping work and agenda setting
- March – Review WA OFM Report, complementary work
- April – Primary care and telehealth, continuing to build definition
- May – Survey results
- June – Draft conceptual model

Stepping Back
Why does it matter to define primary care?

- What we're reading:
  - Washington hospitals, community health centers face a new crisis: red ink
  - State of Reform's A Marshall Plan for primary care, public health
    …The first and most critical step in our Marshall Plan is to immediately change the way we pay for primary care, from transactional fee-for-service to prospective payment. This means health insurance companies, Medicare, Medicaid and all other payers would pay primary care providers a fixed monthly fee for a broad range of services rather than paying a claim for each service.

- Who are we paying? What are we paying for?

- What about attribution? Many mechanisms – HCPLAN Accelerating and Aligning Population-Based Payment Models: Patient Attribution

Defining Primary Care

- Described by the Institute of Medicine in 1978 as *accessible, comprehensive, coordinated, continuous, and accountable*
- Barbara Starfield = *first-contact care, longitudinal, comprehensive*
- Also: *advocacy, community context, family context, goal-oriented care, health promotion, integration, based on a relationship*

- **Four Cs = first contact, comprehensive, continuous, and coordinated**

Sources: Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502. Primary Care Collaborative. Investing in Primary Care: A State-Level Analysis. https://www.pcpcc.org/resource/evidence2019

Primary Care: A Critical Review Of The Evidence On Quality And Costs Of Health Care

Policy discussions imply three general definitions of primary care:

- A specialty of medical **providers**,
- A set of functions or **services** in a usual source of care, and
- An orientation of **health systems**

- Source: Friedberg MW, Hussey PS, Schneider EC. Primary Care: A Critical Review Of The Evidence On Quality And Costs Of Health Care. Health Affairs. 29:5. May 2010. 766-772.

Milbank
Standardizing the Measurement of Commercial Health Plan Primary Care Spending

- **Provider**: All the services delivered by pre-defined primary care providers in an ambulatory setting
- **Favorite: Service**: Services that meet particular definitions including being: comprehensive, first-contact for wide variety (not limited) conditions, coordinated, and take place over time (longitudinal)
- **Service**: All office visits and preventative services independent of the provider type
- **Service and Provider**: Based in claims, all services delivered by pre-defined primary care providers not limited to ambulatory setting
- **Health systems**: Primary care delivered at a system level, useful for capitated systems but most difficult to measure.
- Source: Bailit MH, Friedberg MW, Houy ML. Standardizing the Measurement of Commercial Health Plan Primary Care Spending. Ilbank Memorial Fund. July 2017.

Washington State Office of Financial Management

- Separate definitions of primary care provider and primary care services were determined and then claims meeting both definitions were included as primary care expenditures
- Data from All-Payer Claims Database
  - Does not include non-claims based
  - Dental excluded, vision included
  - Claims data do not capture whether care delivered in primary care clinic or office. Some nurse practitioner and physician assistant may practice in surgical or other setting, adjustments 41% and 34% were made to account for this.
- No roster of PCPs
- Narrow: 4.4% of total expenditures
  - representing providers who traditionally perform roles contained within strict definitions of primary care
- Broad: 5.6% of total expenditures
  - representing providers who perform roles not traditionally contained within a strict definition of primary care (e.g., obstetricians)

- Source: Office of Financial Management. Primary Care Expenditures: Summary of current primary are expenditures and investment in Washington. December 2019.

Who Provides Primary Care?
From OFM Report

Appendix C: List of providers

Narrow definition of primary care provider

Taxonomy Code	Description
207Q00000X	Family Medicine
207QA0000X	Family Medicine, Adolescent Medicine
207QA0505X	Family Medicine, Adult Medicine
207QG0300X	Family Medicine, Geriatric Medicine
261QF0400X	Federally Qualified Health Center
208D00000X	General Practice
207R00000X	Internal Medicine
207RG0300X	Internal Medicine, Geriatric Medicine
175F00000X	Naturopath
208000000X	Pediatrics
2080A0000X	Pediatrics, Adolescent Medicine
2083P0500X	Preventive Medicine, Preventive Medicine/Occupational Environmental Medicine
261QP2300X	Primary care clinic
261QR1300X	Rural health clinic

Nurse practitioner and physician assistant definitions

Taxonomy Code	Description
363L00000X	Nurse Practitioner
363LA2100X	Nurse Practitioner, Acute Care
363LA2200X	Nurse Practitioner, Adult Health
363LC1500X	Nurse Practitioner, Community Health
363LC0200X	Nurse Practitioner, Critical Care Medicine
363LF0000X	Nurse Practitioner, Family
363LG0600X	Nurse Practitioner, Gerontology
363LN0000X	Nurse Practitioner, Neonatal
363LN0005X	Nurse Practitioner, Neonatal, Critical Care
363LX0001X	Nurse Practitioner, Obstetrics & Gynecology
363LX0106X	Nurse Practitioner, Occupational Health
363LP0200X	Nurse Practitioner, Pediatrics
363LP0222X	Nurse Practitioner, Pediatrics, Critical Care
363LP1700X	Nurse Practitioner, Perinatal
363LP2300X	Nurse Practitioner, Primary Care
363LP0808X	Nurse Practitioner, Psychiatric/Mental Health
363LS0200X	Nurse Practitioner, School
363LW0102X	Nurse Practitioner, Women's Health
363A00000X	Physician Assistant
363AM0700X	Physician Assistant, Medical
363AS0400X	Physician Assistant, Surgical

Workgroup Direction

- **What:** Primary care is based in Four Cs = first contact, comprehensive, continuous, and coordinated
  - Want to offer aspirational vision for primary care and workable means of measurement with claims (knowing these limitations)
- **Who:** Provider is the **quarterback**
  - Provider needs to be addressing multiple organ systems
    - Psychologist = NO
    - OB GYN = NO
    - Chiropractor = NO
    - Midwives = some perform more primary type care outside of maternity services
    - Naturopath = ???
- Back to original questions
  Who are we paying?
  What are we paying for?

Behavioral Health Integration Virtual Summit
Day 1: June 16th 1:00 – 4:30pm
Day 2: June 23rd 8:30 – 12:00pm

Bree Collaborative Meeting
July 15th, 2020 | 12:30 – 4:30pm

DR. ROBERT BREE COLLABORATIVE