Bree Collaborative Meeting

July 22, 2020 | Zoom Meeting
Agenda

• Welcome and Introductions
• Meeting Minutes
  • Action Item: Approve minutes
• Presentation: Implementation Update
• Discussion: Topics for 2021
  • Action Item: Select 4 topics
• Topic Update: Reproductive and Sexual Health
• Topic Update: Oncology Care
• Topic Update: Colorectal Cancer Screening
• Topic Update: Primary Care
• Next Steps and Close
May 20th Meeting Minutes

Dr. Robert Bree Collaborative Meeting Minutes
May 20th, 2020 | 12:30-4:30
Held Virtually

Members Present

Hugh Straley, MD, (Chair)
Susie Dade, MS
Gary Franklin, MD, Washington State Department of Labor and Industries
Stuart Freed, MD, Confluence Health
Richard Goss, MD, Harborview Medical Center
Sonja Kellen, Global Health & Wellness
Benefits, Microsoft
Dan Kent, MD, United Health Care
Darcy Jaffe, MN, ARNP, NE-BC, FACHE, Washington State Hospital Association
Rick Ludwig, MD, Providence Health Accountable Care
Greg Marchand, Benefits & Policy, The Boeing

Company
Robert Mecklenburg, MD, Virginia Mason Medical Center
Drew Oliveira, MD, Regence
Carl Olden, MD, Pacific Crest Family Medicine
Mary Kay O’Neill, MD, MBA, Mercer
John Robinson, MD, SM, First Choice Health
Jeanne Rupert, DO, PhD, Provider, One Medical
Angie Sparks, MD, Kaiser Permanente
Shawn West, MD, Embright
Laura Kate Zaichkin, MPH, SEIU 775 Benefits Group
Judy Zerzan, MD, MPH, Washington State Health Care Authority
Thoughts

- Anticipating increased behavioral health need
- Re-convening maternity bundled payment model group July 28th
- Social determinants of health
- Implicit bias
Implementation Update

Amy Etzel
Implementation Manager, Bree Collaborative
Virtual Behavioral Health Integration Summit

Day 1: June 16th
1:00 – 4:00 pm
234 registered attendees

❖ “Best trauma informed care presentation I have ever seen”
❖ “...hearing from folks actually doing the work”
❖ “Very interactive”

Day 2: June 23rd
8:30 am – 12:00 pm
212 registered attendees

❖ “Quality of speakers was outstanding”
❖ “…content specific to implementation, what worked and what didn’t”
❖ “Good variety of speakers”
## Implementation Webinars

<table>
<thead>
<tr>
<th>Topic</th>
<th>Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid Use Disorder Treatment (May)</td>
<td>88</td>
</tr>
<tr>
<td>Motivational Interviewing in SBIRT (<em>June</em>)</td>
<td>82</td>
</tr>
<tr>
<td>Clinician Wellness &amp; Endurance in the COVID-19 Era (<em>August 19</em>)</td>
<td>78 currently registered</td>
</tr>
<tr>
<td>Addressing Alzheimer’s Disease &amp; Other Dementias in Washington State (<em>August 26</em>)</td>
<td>29 currently registered</td>
</tr>
<tr>
<td>Race, Stigma and Bias (<em>September 23</em>)</td>
<td>Registration to open end of August</td>
</tr>
<tr>
<td>Patient Advocacy and Mental Health (<em>October 21</em>)</td>
<td>Registration to open end of September</td>
</tr>
</tbody>
</table>

Send me your suggestions for webinar topics!
Action Item:
Increase frequency of team huddles to facilitate integrated care and warm hand-offs

✓ Completed workflow mapping in early February to identify current process and potential improvement areas

✓ Implemented daily morning huddles late February that now include community health worker and behavioral health staff (via phone if needed)

✓ Built report to track warm handoffs
BHII Action Plans - Success Stories

Nisqually Indian Health Care

**Action Item:**
Implement screening tools into patient flow and document/track in EHR

- Developed tribal specific ‘holistic health survey’ that assesses depression and alcohol/drug use
- Integrated survey into EHR, with ability to show graph of results over time
- PDSA of administering survey in telehealth appointments to begin late July
Topics for 2021

Ginny Weir, MPH
Director, Bree Collaborative

July 22nd, 2020 | Bree Collaborative Meeting
What makes us ill?
What impacts quality of life?
How do we die?
## 10 Leading Causes of Death by Age Group, United States - 2018

<table>
<thead>
<tr>
<th>Rank</th>
<th>&lt;1</th>
<th>1-4</th>
<th>5-9</th>
<th>10-14</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4,473</td>
<td>Unintentional Injury 1,226</td>
<td>Unintentional Injury 734</td>
<td>Unintentional Injury 922</td>
<td>Unintentional Injury 24,614</td>
<td>Unintentional Injury 22,667</td>
<td>Malignant Neoplasms 37,301</td>
<td>Malignant Neoplasms 113,947</td>
<td>Heart Disease 526,509</td>
<td>Heart Disease</td>
<td>655,381</td>
</tr>
<tr>
<td>2</td>
<td>3,679</td>
<td>Short Gestation 384</td>
<td>Congenital Anomalies 384</td>
<td>Malignant Neoplasms 393</td>
<td>Suicide 596</td>
<td>Suicide 6,211</td>
<td>Suicide 8,020</td>
<td>Malignant Neoplasms 10,640</td>
<td>Heart Disease 32,220</td>
<td>Heart Disease 81,042</td>
<td>431,102</td>
</tr>
<tr>
<td>3</td>
<td>1,358</td>
<td>Congenital Anomalies 201</td>
<td>Maternal Pregnancy Comp. 353</td>
<td>Malignant Neoplasms 450</td>
<td>Homicide 4,607</td>
<td>Homicide 5,234</td>
<td>Heart Disease 10,532</td>
<td>Unintentional Injury 23,056</td>
<td>Unintentional Injury 23,693</td>
<td>Chronic Low. Respiratory Disease 135,500</td>
<td>Unintentional Injury 167,127</td>
</tr>
<tr>
<td>4</td>
<td>1,334</td>
<td>Malignant Neoplasms 326</td>
<td>Homicide 121</td>
<td>Congenital Anomalies 172</td>
<td>Malignant Neoplasms 3,684</td>
<td>Suicide 7,521</td>
<td>Suicide 8,345</td>
<td>Chronic Low. Respiratory Disease 18,804</td>
<td>Cerebrovascular 127,244</td>
<td>Chronic Low. Respiratory Disease 159,486</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>1,168</td>
<td>Unintentional Injury 71</td>
<td>Influenza &amp; Pneumonia 122</td>
<td>Heart Disease 905</td>
<td>Heart Disease 3,561</td>
<td>Homicide 3,304</td>
<td>Liver Disease 8,157</td>
<td>Diabetes Mellitus 14,941</td>
<td>Alzheimer's Disease 120,658</td>
<td>Cerebrovascular 147,810</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>1,324</td>
<td>Placenta Cord. Membranes 724</td>
<td>Heart Disease 115</td>
<td>Chronic Low. Respiratory Disease 68</td>
<td>Heart Disease 101</td>
<td>Congenital Anomalies 354</td>
<td>Liver Disease 1,008</td>
<td>Liver Disease 3,108</td>
<td>Diabetes Mellitus 6,414</td>
<td>Diabetes Mellitus 60,182</td>
<td>Alzheimer's Disease 122,019</td>
</tr>
<tr>
<td>7</td>
<td>579</td>
<td>Bacterial Sepsis 579</td>
<td>Perinatal Period 62</td>
<td>Heart Disease 68</td>
<td>Chronic Low. Respiratory Disease 64</td>
<td>Congenital Anomalies 246</td>
<td>Diabetes Mellitus 837</td>
<td>Diabetes Mellitus 2,282</td>
<td>Cerebrovascular 12,789</td>
<td>Unintentional Injury 57,213</td>
<td>Diabetes Mellitus 84,946</td>
</tr>
<tr>
<td>8</td>
<td>428</td>
<td>Circulatory System Disease 54</td>
<td>Septicemia 34</td>
<td>Chronic Low. Respiratory Disease 200</td>
<td>Cerebrovascular 567</td>
<td>Cerebrovascular 1,704</td>
<td>Chronic Low. Respiratory Disease 3,807</td>
<td>Suicide 8,540</td>
<td>Influenza &amp; Pneumonia 48,888</td>
<td>Influenza &amp; Pneumonia 59,120</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>390</td>
<td>Respiratory Distress 390</td>
<td>Chronic Low. Respiratory Disease 50</td>
<td>Septicemia 34</td>
<td>Influenza &amp; Pneumonia 51</td>
<td>Chronic Low. Respiratory Disease 165</td>
<td>HIV 482</td>
<td>Influenza &amp; Pneumonia 956</td>
<td>Septicemia 2,380</td>
<td>Septicemia 5,956</td>
<td>Nephritis 42,232</td>
</tr>
<tr>
<td>10</td>
<td>375</td>
<td>Neonatal Hemorrhage 43</td>
<td>Cerebrovascular 43</td>
<td>Congenital Anomalies 19</td>
<td>Benign Neoplasms 30</td>
<td>Complicated Pregnancy 151</td>
<td>Influenza &amp; Pneumonia 457</td>
<td>Septicemia 829</td>
<td>Influenza &amp; Pneumonia 2,339</td>
<td>Influenza &amp; Pneumonia 5,858</td>
<td>Parkinson's Disease 32,988</td>
</tr>
</tbody>
</table>

**Data Source:** National Vital Statistics System, National Center for Health Statistics, CDC. 
**Produced by:** National Center for Injury Prevention and Control, CDC using WISQARS™.
### Americans' Perceptions of the Most Urgent Health Problems Facing the U.S.

What would you say is the most urgent health problem facing this country at the present time?

<table>
<thead>
<tr>
<th>Health Issue</th>
<th>2018</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>25</td>
<td>16</td>
<td>27</td>
</tr>
<tr>
<td>Access</td>
<td>22</td>
<td>24</td>
<td>20</td>
</tr>
<tr>
<td>Drug/Alcohol abuse</td>
<td>10</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Cancer</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Obesity</td>
<td>7</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Heart disease</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Finding cures for diseases</td>
<td>1</td>
<td>&lt;1</td>
<td>1</td>
</tr>
<tr>
<td>Government Interference</td>
<td>1</td>
<td>1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>AIDS</td>
<td>1</td>
<td>&lt;1</td>
<td>&lt;1</td>
</tr>
</tbody>
</table>

Source: https://news.gallup.com/poll/245054/americans-remain-dissatisfied-healthcare-costs.aspx
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)
Topics from May Meeting

- Annual cardiac screening
- Asthma
- Co-occurring substance abuse and mental health
- Cervical cancer screening
- Opioids in the elderly
- Telehealth
- Total Joint Bundle Re-review
### Bree Collaborative | 2021 Topic Selection Worksheet

<table>
<thead>
<tr>
<th>Potential Topic for 2021</th>
<th>Must have one of these four</th>
<th>Must have</th>
<th>Must have</th>
<th>Must have</th>
<th>Nice to have</th>
<th>Nice to have</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Variation</td>
<td>Patient Safety Issue</td>
<td>Cost</td>
<td>Equity Issue</td>
<td>Proven Impact Strategy Within Health Care</td>
<td>Unique Bree Role</td>
</tr>
</tbody>
</table>
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.”
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.
Annual cardiac screening

• From: Washington Health Alliance data (1=commercial, 3=Medicaid)

<table>
<thead>
<tr>
<th>Low-Value Services</th>
<th># of Services Examined</th>
<th># of Low-Value Services</th>
<th>Waste Index</th>
<th># of People Impacted</th>
<th>Estimated Spend on Low-Value (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Annual cardiac screening (EKG or other testing including lab) in low risk individuals without symptoms</td>
<td>1,761,473</td>
<td>610,150</td>
<td>35%</td>
<td>566,428</td>
<td>$76.3</td>
</tr>
<tr>
<td>3. Annual cardiac screening (EKG or other testing including lab) in low risk individuals without symptoms</td>
<td>832,049</td>
<td>208,425</td>
<td>25%</td>
<td>190,711</td>
<td>$4.9</td>
</tr>
</tbody>
</table>

Asthma

- From: Community (Seattle King County Public Health)

Preventive Primary Care – Planned Asthma Visits

**Quality Opportunities:**
- Prompt follow-up after urgent care visits
- Routine asthma control monitoring, medication adjustment, and self-management support
- Provision and review of written Asthma Action Plan

**Challenges, low uptake of guideline care:**
- Infrequent asthma-specific preventive visits
- Inconsistent use of spirometry, control assessment, and monitoring of controller medication adherence
- Low distribution of Asthma Action Plan

Asthma CHW home-visits for education and disease self-management:

**Opportunities, pay for visits and supplies:**
- Home visits with culturally competent CHW
- Provide supplies to reduce triggers (HEPA vacuum, mattress covers, safe cleaning kits)
- Increase disease control and improve quality of life

**Challenges:**
- No fee-for-service billing option
- May require contracting with community organizations
- Requires alternative payment options
Suggested by community (Behavioral Health Institute at Harborview)

- “...often occur simultaneously in individuals with mental illness, usually to cope with overwhelming symptoms. The combination of these two illnesses has its own term: dual diagnosis, or co-occurring disorders. Either disorder (substance use or mental illness) can develop first.”

National Alliance on Mental Health

- ~1/12 Americans have a substance use disorder, 1/5 have mental illness, ~40-50% have dual diagnosis

National Council for Behavioral Health
Prescribing Opioids in Older Adults

- Goal – Reduce risk of falls
  - Follow same best practices for prescribing opioids (AMDG)
  - Prescribe immediate-release opioids at the lowest effective dose (AMDG)
    - Initiate opioid therapy at a 25% to 50% lower dose than that recommended for younger adults

Source: AHRQ
Opioid and Drug-involved overdose deaths-United States, 2017-2018
MMWR 2020 (March); 69: 290-97

Death rates declined for prescription opioids between 2017-2018 for all age groups except those >= 65 yrs, where rates increased 4.8 %; for all opioids including heroin the rate increased 11.8% in this age group
Characterisation of concurrent use of prescription opioids and benzodiazepine/Z-drugs in Alberta, Canada: a population-based study.
Sharma V¹, Weir D², Samanani S³, Simpson SH⁴, Gilani F⁵, Jess E⁵, Eurich DT⁶.
Two examples of where New Bree Guidance could help

  • Increased respiratory events (hosp/ED with COPD exacerbation or respiratory depression) among COPD patients on concomitant opioid and sedative use

• J Arthroplasty. 2020 Apr 14;S0883-5403(20)30349-1. doi: 10.1016/j.arth.2020.04.019
  • Almost 10% rate of persistent opioid use among THA patients receiving the highest post-op prescribing
Cervical cancer screening

- From: Washington Health Alliance (7=commercial, 9=Medicaid)

<table>
<thead>
<tr>
<th>Low-Value Services</th>
<th># of Services Examined</th>
<th># of Low-Value Services</th>
<th>Waste Index</th>
<th># of People Impacted</th>
<th>Estimated Spend on Low-Value (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Too frequent cervical cancer screening for women who have had adequate prior</td>
<td>715,669</td>
<td>173,607</td>
<td>24%</td>
<td>171,797</td>
<td>$28.0</td>
</tr>
<tr>
<td>screening and are not otherwise at high risk for cervical cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Too frequent cervical cancer screening for women who have had adequate prior</td>
<td>307,513</td>
<td>51,758</td>
<td>17%</td>
<td>51,029</td>
<td>$2.8</td>
</tr>
<tr>
<td>screening and are not otherwise at high risk for cervical cancer</td>
<td></td>
<td></td>
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</tbody>
</table>

Telehealth – Many questions

Resource: 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?
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
1. **Variation**

   **Knee replacement surgery for women ages 45–64**

<table>
<thead>
<tr>
<th>OLYMPIA</th>
<th>BELLINGHAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women, 45–64 years</td>
<td>Women, 45–64 years</td>
</tr>
<tr>
<td>60% More Likely</td>
<td>30% Less Likely</td>
</tr>
</tbody>
</table>


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.”


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](https://www.dartmouthatlas.org/downloads/reports/Joint_Replacement_0410.pdf)
4. Safety

<table>
<thead>
<tr>
<th>Post-Operative Events</th>
<th>Description</th>
<th>2017 Non-COE joint replacement</th>
<th>2017 COE joint replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Count</td>
<td>Cost</td>
</tr>
<tr>
<td>7-day complications</td>
<td>Infection</td>
<td>1</td>
<td>$9,619.22</td>
</tr>
<tr>
<td>30-day complications</td>
<td>Pulmonary embolism</td>
<td>2</td>
<td>$76,800.94</td>
</tr>
<tr>
<td>90-day complications</td>
<td></td>
<td>0</td>
<td>$0.00</td>
</tr>
<tr>
<td>30-day readmissions</td>
<td>All causes</td>
<td>12</td>
<td>N/A</td>
</tr>
<tr>
<td>182-day TJR revisions</td>
<td></td>
<td>5</td>
<td>$220,968.43</td>
</tr>
</tbody>
</table>
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
2021 Bree topic selection work sheet
Must have all three: impact, unique Bree role, data

Must have all of following three:
3. Data available

Improving Care by Redesigning Payment
Case Study · October 9, 2018
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. “
VOTE for 4

- Annual cardiac screening
- Asthma
- Co-occurring substance abuse and mental health
- Cervical cancer screening
- Opioids in the elderly
- Telehealth
- Total Joint Bundle Re-review

• Here: [https://pollev.com/breecollabor088](https://pollev.com/breecollabor088)
Topic Update: Reproductive and Sexual Health

Charissa Fotinos, MD
Deputy Chief Medical Officer, Washington State Health Care Authority
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 – Intersecting Identities and Holistic Change
- August – AI/AN
- September – Finalize language + present for dissemination for public comment
- October – Public Comment
- November – Final Vote
#1 Cultural Humility

- Competence = “detached mastery of theoretically finite body of knowledge,” = problematic false sense of security [from] stereotyping” where behaviors/symptoms are ascribed to person’s cultural background rather than disease

- Cultural awareness trainings do not show meaningful change (short, infantilizing, unable to make up for empathy-burnout from time-scare providers,

- Cultural humility = life-long learning process, flexibility, assess anew cultural dimensions of person’s experience

- No static endpoint instead self-questioning and self-critique, and active listening

- Understand the cultural background of your patient population

- Provide culturally humble care, free of coercion or provider bias

#2 Access

• Assess and address physical accessibility
• Understand insurance barriers (i.e., from immigration status) – offer resources
• Offer materials and services in languages appropriate to your population
• Use easy to understand language and materials (8th grade)
• Assess the person’s understanding of topics discussed using the teach back or show me method (demonstrate what they have been told)
#3 Patient-centeredness

Trauma-informed care = understanding individual life experiences (e.g., asking what has happened to you) Clinical encounter empower not re-traumatize

- Offer trauma-informed care and work to build trust
- Reaffirm the confidentiality of conversations and any test results
- Support
- Involve family or friends if desired by the person
- Understand needs of the patient
Educate and empower rather than screen for violence/abuse

Offer prevention, screening, treatment or referral for reproductive health conditions (e.g., USPSTF cancer screening, STIs)

Ask about **parenting intention** and offer family planning including contraception and infertility

Pre-conception care, prenatal care, labor and delivery, and postpartum care
Questions? Comments?
Topic Update: Colorectal Cancer Screening

Rick Ludwig, MD
Chief Executive Officer,
Pacific Medical Centers

July 22, 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
Why Colorectal Cancer Screening

• Colon cancer is the second leading cause of cancer death in the United States
• Black Americans have a 10% higher mortality rate from mainly from later diagnoses
• Historically less attention than breast, cervical, prostate cancers
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 – Draft stakeholder language
• August – Revise stakeholder language
• September – Presentation for public comment
• October – Address public comment
• November – Final adoption
Focus Areas Address Failures in Pathway

Address disparities in cancer mortality through a comprehensive cancer screening registry including colon, breast, and cervical. Eventually this registry will be centralized and managed by a Washington state agency. Until that point, each delivery organization should keep a site-level registry of screening for the above cancers for people attributed to the practice.

The registry should be managed by a dedicated person or persons at the site level to follow-up with people at appropriate intervals depending on the screening modality they have selected or that is most appropriate for them and include outreach for initial screening and follow-up on positive FITs.

Conduct targeted outreach to sub-populations within your attributed population with known historical or demonstrated lower colorectal cancer screening rates including Black Americans.
#2 Measurement

- Measure patient race at a site and health plan level
- Include measurement of the colorectal cancer screening rate NQF #0034 for all populations including Medicaid in appropriate populations
- Tie provider payments to showing improvement in colorectal cancer screening rates in state health care purchasing contracts and private purchasing contracts
For patients 50-75 for whom a specific screening modality is not otherwise indicated, offer shared decision making around type of screening.

For patients electing or who are recommended to have a colonoscopy, offer education around no sedation as an option.
(from OR legislation) A health benefit plan shall provide coverage for all colorectal cancer screening examinations and laboratory tests assigned either a grade of A or a grade of B by the United States Preventive Services Task Force. If an insured person is 50 years of age or older, an insurer may not impose cost sharing on the coverage including at a minimum:

- Fecal occult blood tests
- Colonoscopies, including the removal of polyps during a screening procedure
- Double contrast barium enemas
- A colonoscopy, including the removal of polyps during the procedure, if the insured has a positive result on any fecal test assigned either a grade of A or a grade of B by the United States Preventive Services Task Force.

If an insured is at high risk for colorectal cancer, coverage shall include colorectal cancer screening examinations and laboratory tests as recommended by the treating physician.

Develop a cost calculation worksheet to show a return on investment to the community for colorectal cancer screening.

Allow patients who are income-eligible to have the same access to free screening and treatment as those with breast and cervical cancer.
Colorectal Cancer: Which Screening Test Should I Have?

Here is 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 must you know?
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 colorectal cancer. No matter what test you choose, regular testing can find signs of cancer early.
- The tests differ in how they are done, how often they are done, and how you prepare for them. Your preferences are important in choosing which test is best for you. Think about what you would like to keep in mind when you look at each test method.
- No matter what test you choose, it’s important that you have the test done in the recommended schedule and have any follow-up visits or tests as needed. That gives you the best chance of finding colorectal cancer early.
- Your risk for colorectal cancer gets higher as you get older. Talk with your doctor and when to start and stop screening.

FAQs

What is colorectal cancer?

Colorectal cancer happens when cells that are not normal grow in your colon or rectum. Most people call it “colon cancer.”

These cancers usually begin as polyps. Polyps are growths attached to the inside lining of the colon and rectum. Colon polyps are common. Most of them don’t turn into cancer. Polyps that become cancerous are called adenomatous polyps. They can develop into colorectal cancer.

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

slide 55

Shared Decision Making

Slide 54

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

Susan D. Sisko, MD, PhD, MS; Kate R. Koo, MD, MSc; Lauren J. Jones, MD, MPH; shawn S. Kim, MD, MPH; Michael G. Greenlee, PhD, MPP; Amanda E. Little, MD, MSc; Rachel M. White, MD, PhD; and Lucinda M. Goodrich, MD, MA

The goal of the American Cancer Society (ACS) and guideline update for colorectal cancer screening is to reduce the incidence of and deaths from CRC for average-risk adults aged 50 years and older through the use of screening that is recommended at age 50 years or a qualified recommendation and is available at age 50 years or older. This is a summary recommendation. The burden for the period of average-risk CRC is 45 years, wherein the guideline summary emphasizes use through age 75 years. The recommended testing methods used for CRC screening include colorectal cancer screening, including use of flexible sigmoidoscopy every 10 years, or colonoscopy every 10 years, or every 5 years with a validated screening test, or every 3 years with a validated screening test.

The updated guidelines provide guidance for patients on developing and using the tools.

In the updated guidelines, the ACS Colorectal Development Group provided guidance on the recommendations of previous colorectal cancer screening and associated screening tests. The screening options are defined in the new guidelines, including colonoscopy, computed tomography colonography, and fecal immunochemical testing (FIT).

In the new guidelines, average-risk CRC screening is defined as the use of a colorectal cancer screening test, either colonoscopy, or flexible sigmoidoscopy, or FIT every 10 years. The guidelines also define colorectal cancer screening as the use of one or more colorectal cancer screening tests, either colonoscopy, or flexible sigmoidoscopy, or FIT every 10 years.

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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
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

• July – Symptom management

• August – Review for presentation
Why?

• ~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

#1 Assessment and Risk Stratification

- Develop a standard process to assess a patient’s risk of inpatient care use – low/high that determines intensity of care management.
- Dedicated function of maintaining an on-site registry of patients based on risk
- Assess comorbidities
- Assess social determinants of health including housing, food security, ability to care for yourself or presence of a caregiver
#2 Patient-Centered Care

- Early conversations on patient goals of care including around inpatient care use and medical interventions
- Understand signs, symptoms, and other red flags that may necessitate entry into a hospital setting
- How to contact the care team during work and after hours
#3 Case Management

- Standard protocol for care management based on risk based on internal clinic resources including at a minimum:
  - Post-discharge outreach to those identified as higher-risk
  - Post-discharge provider follow-up appointments
- Standard symptom management and triage pathways
- Telehealth protocols
For patients who are higher-risk and/or higher-need, consider referral to interdisciplinary specialty palliative care as outlined in the 2019 Bree Collaborative Palliative Care recommendations.
Questions? Comments?
Topic Update: Primary Care

Judy Zerzan, MD, MPH
Chief Medical Officer,
Washington State Health Care Authority
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
• July – Refine seven elements
• August – Finalize definition
Why

• More primary care = better health outcomes and we want better health outcomes BUT
• Need to define who we are paying, what we are paying for
Health Care Authority (HCA) invites you to provide public comment on the proposed Multi-payer Primary Care Transformation Model. The model was developed in collaboration with Washington State payers (health care plans) and primary care providers during the last year.

The public comment period ends on Friday, July 31, 2020.

To learn more about this model, visit Multi-payer Primary Care Transformation Model page.
Defining Primary Care

- IOM 1978 as accessible, comprehensive, coordinated, continuous, and accountable
- Barbara Starfield = Service definition: Services that meet particular definitions including being: comprehensive, first-contact for wide variety (not limited) conditions, coordinated, and take place over time (longitudinal)
- Also: advocacy, community context, family context, goal-oriented care, health promotion, integration, based on a relationship

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

Our Definition
If primary care, must meet all:

- **Accountable** (MD, DO, ARNP, PA, OPA, ND)
- **Team-Based** (Behavioral health + care coordination function)
- **First Contact**
- **Comprehensive**
- **Continuous**
- **Coordinated**
- **Appropriate**
Example

Pediatrician
Asthma

Family Medicine
Asthma

Emergency physician
Breaksleg, set in ED by by OB/GYN

High-risk pregnancy

Geriatrician
Asthma, HBP

Death

Family Medicine
Asthma, high blood pressure

Breast cancer

managed by oncologist

Hospice
Aligning with Previous Recommendations

Primary Care

Behavioral Health
- SBIRT
- OUD Treatment
- Suicide Care
- Antipsychotics
- Violence

Advance Care Planning
- Alzheimer's Disease
- Cancer Screening

Reproductive Health
- Palliative Care

Surgery

Maternity Bundle

Oncology Care

Hospital Readmissions
“I can get care and information from my primary care team when I need it and in the way that best meets my needs.”

“My primary care team knows me and keeps me well; when I need planned surgery or emergency care, they know what happened and support me in becoming well again.”

“My primary care team can meet most of my healthcare needs; when I do need to see a specialist, they help me find the right one and communicate with them about me.”

“My primary care team knows and supports the whole me - not just my body.”
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)

Questions? Comments?
Bree Collaborative Meeting
September 16th, 2020
12:30 – 4:30pm