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

DR. ROBERT BREE COLLABORATIVE

July 22, 2020 | Zoom Meeting

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

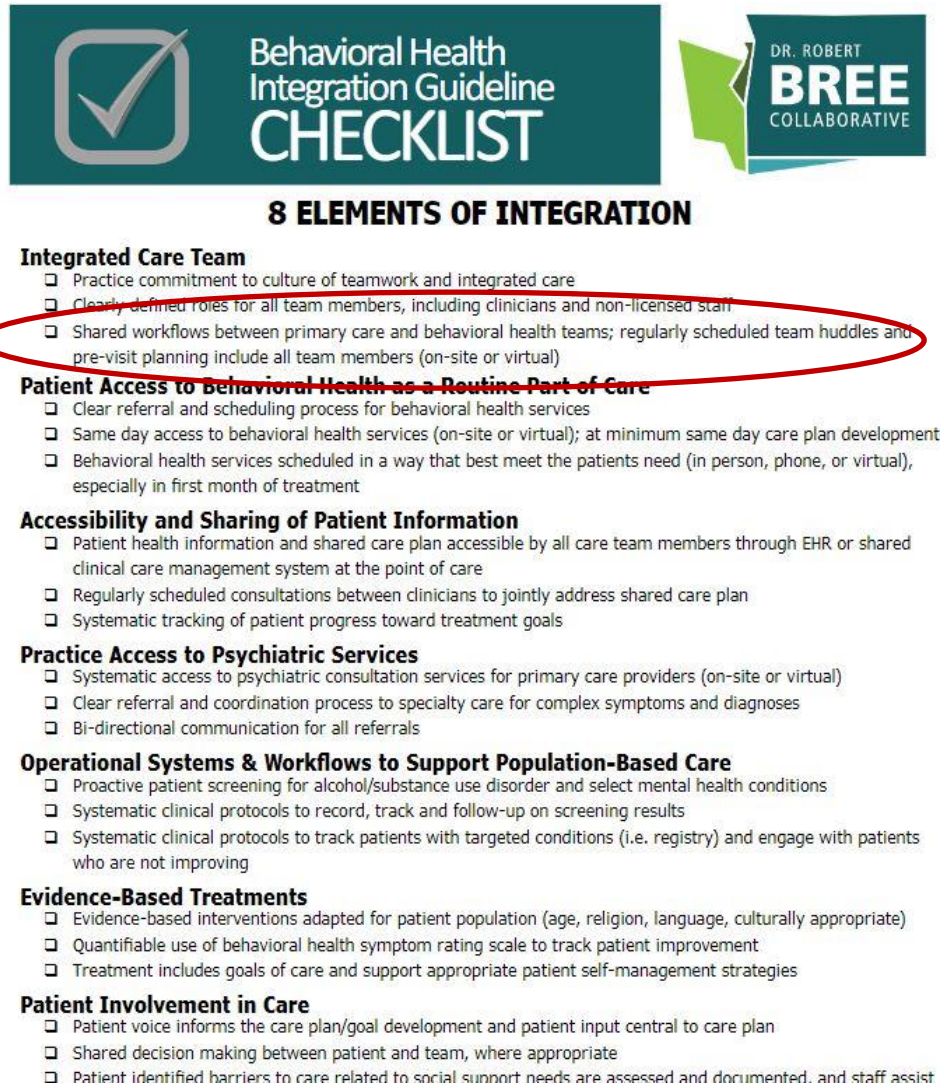
- "Quality of speakers was outstanding"
- "…content specific to implementation, what worked and what didn't"
- "Good variety of speakers"

Implementation Webinars

Topic	Attendees
Opioid Use Disorder Treatment (May)	88
Motivational Interviewing in SBIRT *(June)*	82
Clinician Wellness & Endurance in the COVID-19 Era *(August 19)*	78 currently registered
Addressing Alzheimer's Disease & Other Dementias in Washington State *(August 26)*	29 currently registered
Race, Stigma and Bias *(September 23)*	Registration to open end of August
Patient Advocacy and Mental Health *(October 21)*	Registration to open end of September

Send me your suggestions for webinar topics!

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

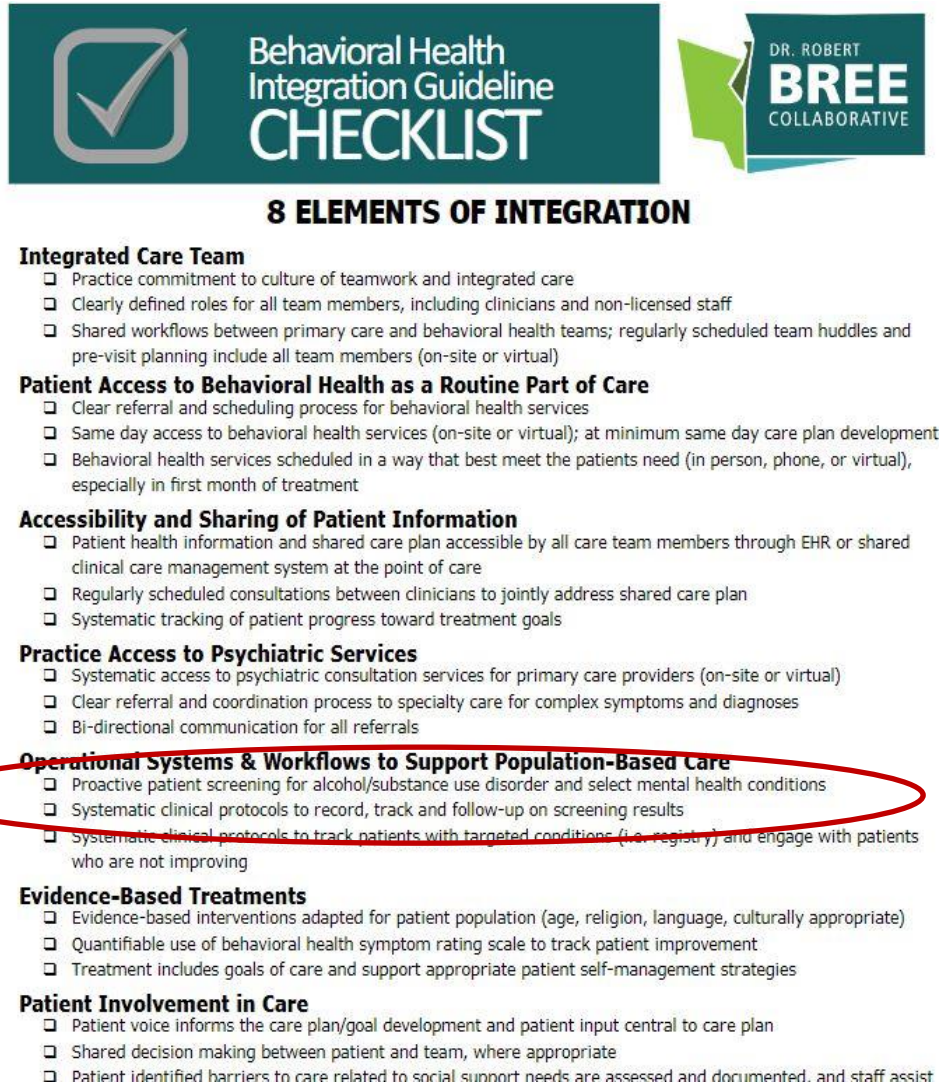
Patient Involvement in Care
- ❑ Patient voice informs the care plan/goal development and patient input central to care plan
- ❑ Shared decision making between patient and team, where appropriate
- ❑ Patient identified barriers to care related to social support needs are assessed and documented, and staff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

Family Health Centers – Brewster Jay Avenue Clinic

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



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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

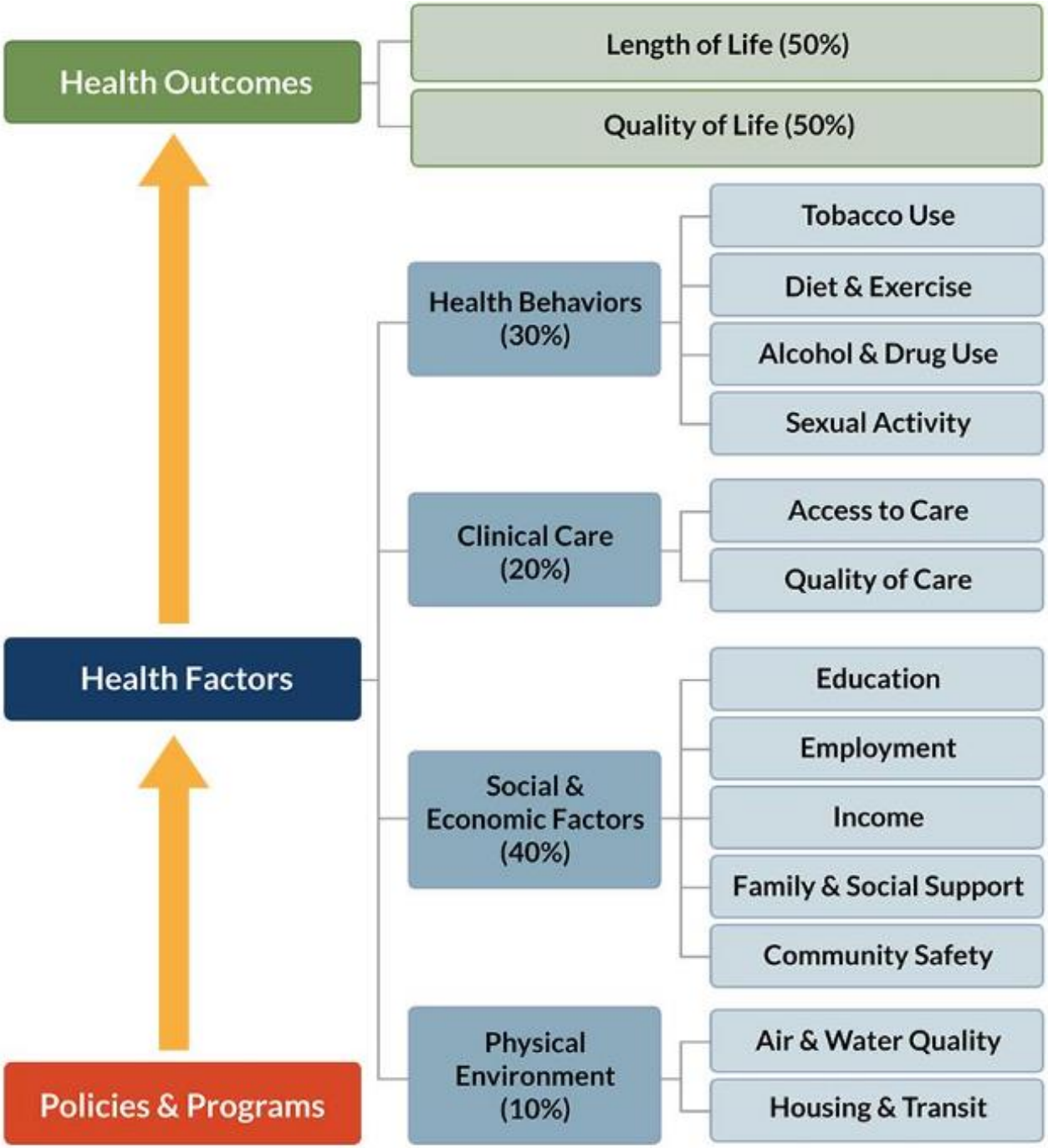
Topics for 2021

Ginny Weir, MPH
Director, Bree Collaborative

July 22nd, 2020 | Bree Collaborative Meeting

Big Picture

What makes us ill?
What impacts quality of life?
How do we die?



Source: https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five

10 Leading Causes of Death by Age Group, United States – 2018

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Congenital Anomalies 4,473	Unintentional Injury 1,226	Unintentional Injury 734	Unintentional Injury 692	Unintentional Injury 12,044	Unintentional Injury 24,614	Unintentional Injury 22,667	Malignant Neoplasms 37,301	Malignant Neoplasms 113,947	Heart Disease 526,509	Heart Disease 655,381
2	Short Gestation 3,679	Congenital Anomalies 384	Malignant Neoplasms 393	Suicide 596	Suicide 6,211	Suicide 8,020	Malignant Neoplasms 10,640	Heart Disease 32,220	Heart Disease 81,042	Malignant Neoplasms 431,102	Malignant Neoplasms 599,274
3	Maternal Pregnancy Comp. 1,358	Homicide 353	Congenital Anomalies 201	Malignant Neoplasms 450	Homicide 4,607	Homicide 5,234	Heart Disease 10,532	Unintentional Injury 23,056	Unintentional Injury 23,693	Chronic Low. Respiratory Disease 135,560	Unintentional Injury 167,127
4	SIDS 1,334	Malignant Neoplasms 326	Homicide 121	Congenital Anomalies 172	Malignant Neoplasms 1,371	Malignant Neoplasms 3,684	Suicide 7,521	Suicide 8,345	Chronic Low. Respiratory Disease 18,804	Cerebro-vascular 127,244	Chronic Low. Respiratory Disease 159,486
5	Unintentional Injury 1,168	Influenza & Pneumonia 122	Influenza & Pneumonia 71	Homicide 168	Heart Disease 905	Heart Disease 3,561	Homicide 3,304	Liver Disease 8,157	Diabetes Mellitus 14,941	Alzheimer's Disease 120,658	Cerebro-vascular 147,810
6	Placenta Cord. Membranes 724	Heart Disease 115	Chronic Low. Respiratory Disease 68	Heart Disease 101	Congenital Anomalies 354	Liver Disease 1,008	Liver Disease 3,108	Diabetes Mellitus 6,414	Liver Disease 13,945	Diabetes Mellitus 60,182	Alzheimer's Disease 122,019
7	Bacterial Sepsis 579	Perinatal Period 62	Heart Disease 68	Chronic Low Respiratory Disease 64	Diabetes Mellitus 246	Diabetes Mellitus 837	Diabetes Mellitus 2,282	Cerebro-vascular 5,128	Cerebro-vascular 12,789	Unintentional Injury 57,213	Diabetes Mellitus 84,946
8	Circulatory System Disease 428	Septicemia 54	Cerebro-vascular 34	Cerebro-vascular 54	Influenza & Pneumonia 200	Cerebro-vascular 567	Cerebro-vascular 1,704	Chronic Low. Respiratory Disease 3,807	Suicide 8,540	Influenza & Pneumonia 48,888	Influenza & Pneumonia 59,120
9	Respiratory Distress 390	Chronic Low. Respiratory Disease 50	Septicemia 34	Influenza & Pneumonia 51	Chronic Low. Respiratory Disease 165	HIV 482	Influenza & Pneumonia 956	Septicemia 2,380	Septicemia 5,956	Nephritis 42,232	Nephritis 51,386
10	Neonatal Hemorrhage 375	Cerebro-vascular 43	Benign Neoplasms 19	Benign Neoplasms 30	Complicated Pregnancy 151	Influenza & Pneumonia 457	Septicemia 829	Influenza & Pneumonia 2,339	Influenza & Pneumonia 5,858	Parkinson's Disease 32,988	Suicide 48,344

Data Source: National Vital Statistics System, National Center for Health Statistics, CDC.
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.

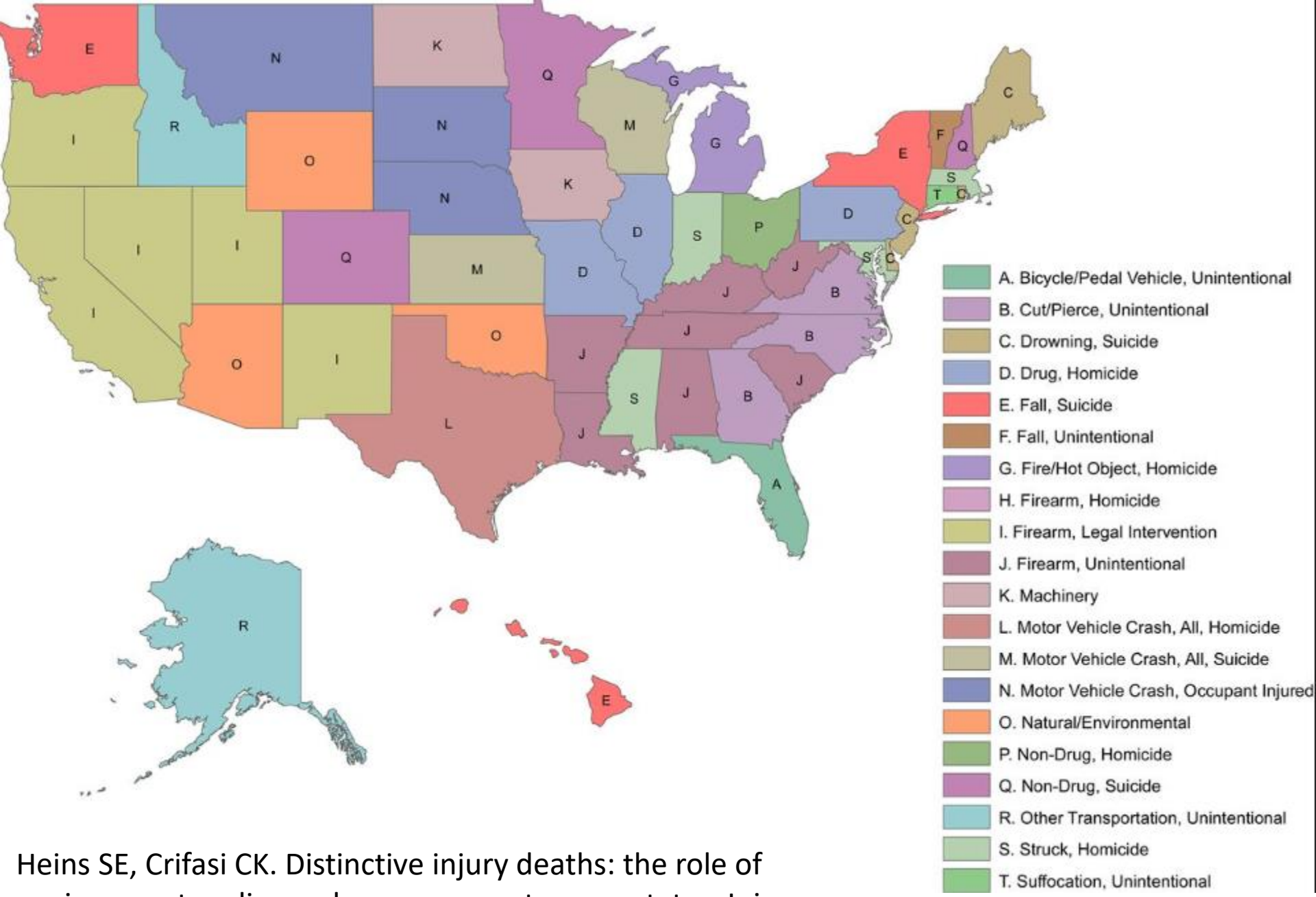
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

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?

	2018	2017	2016
	%	%	%
Cost	25	16	27
Access	22	24	20
Drug/Alcohol abuse	10	14	3
Cancer	10	11	12
Obesity	7	7	8
Diabetes	2	2	3
Mental Illness	2	3	3
Heart disease	1	1	2
Finding cures for diseases	1	<1	1
Government Interference	1	1	<1
AIDS	1	<1	<1

Source: https://news.gallup.com/poll/245054/americans-remain-dissatisfied-healthcare-costs.aspx



Heins SE, Crifasi CK. Distinctive injury deaths: the role of environment, policy and measurement across states. Inj Prev. 2016;22(4):247-252.

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

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."*

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.

Annual cardiac screening

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

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

Source: Washington Health Alliance. Right Care : First, Do No Harm: Calculating Health Care Waste in Washington State. 2019. https://www.wacommunitycheckup.org/reports/first-do-no-harm-calculating-health-care-waste-in-washington-state-oct-2019/#Statewide%20Results

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

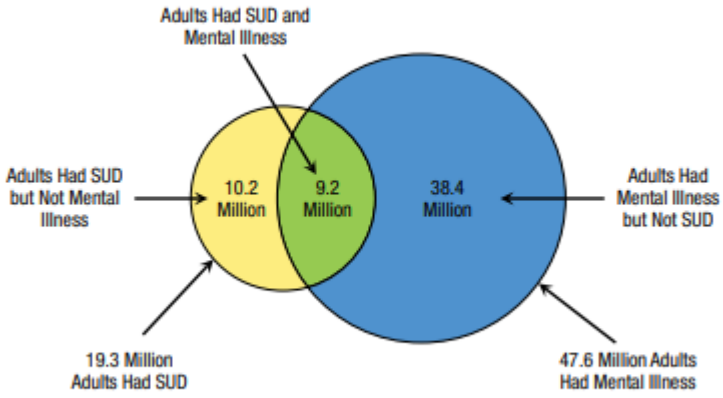
Challenges:
- No fee-for-service billing option
- May require contracting with community organizations
- Requires alternative payment options

Co-occurring substance abuse and mental health

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

Figure 53. Past Year Substance Use Disorder (SUD) and Mental Illness among Adults Aged 18 or Older: 2018



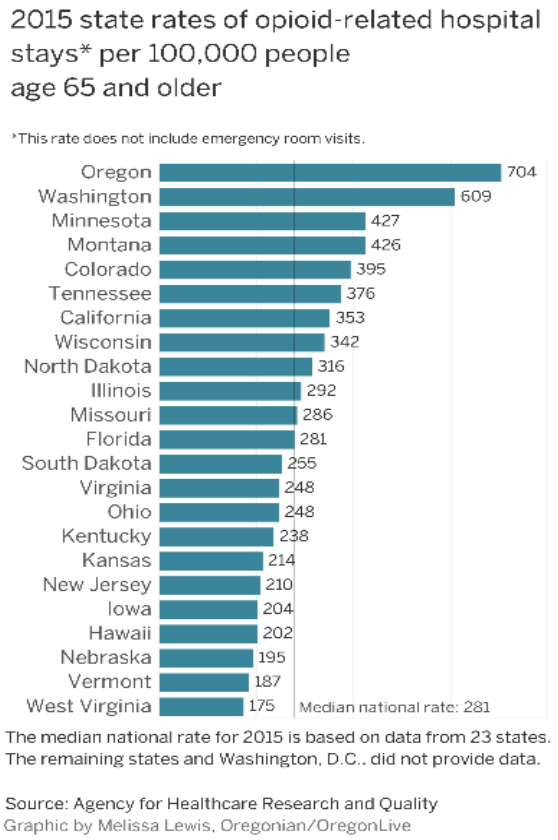
AMDG
agency medical directors' group

A collaboration of state agencies, working together to improve health care quality for Washington State citizens

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



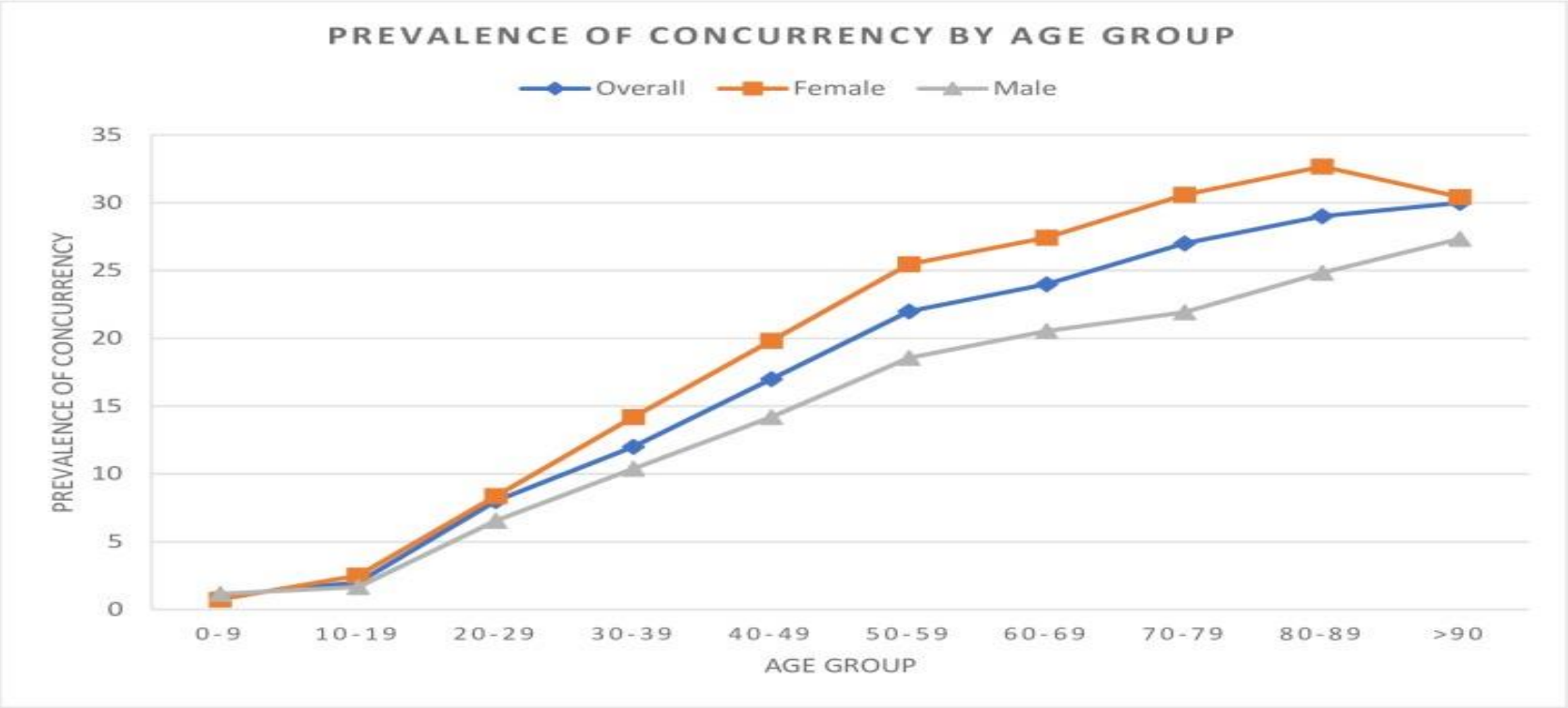
Opioid and Drug-involved overdose deaths-United States, 2017-2018
MMWR 2020 (March); 69: 290-97

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

BMJ Open. 2019 Sep 6;9(9):e030858. doi: 10.1136/bmjopen-2019-030858.

Characterisation of concurrent use of prescription opioids and benzodiazepine/Z-drugs in Alberta, Canada: a population-based study.

Sharma V[1], Weir D[2], Samanani S[3], Simpson SH[4], Gilani F[5], Jess E[5], Eurich DT[6].



Two examples of where New Bree Guidance could help

- BMJ Open Respir Res. 2020 Mar;7(1):e000483. doi: 10.1136/bmjresp-2019-000483
  - 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)

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

Source: Washington Health Alliance. Right Care : First, Do No Harm: Calculating Health Care Waste in Washington State. 2019. https://www.wacommunitycheckup.org/reports/first-do-no-harm-calculating-health-care-waste-in-washington-state-oct-2019/#Statewide%20Results

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?

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

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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

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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

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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

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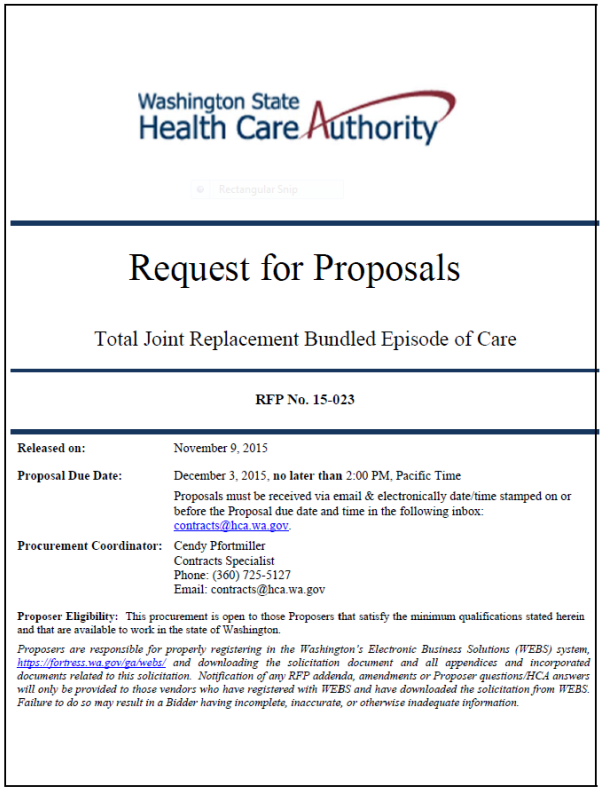
2021 Bree topic selection work sheet

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.

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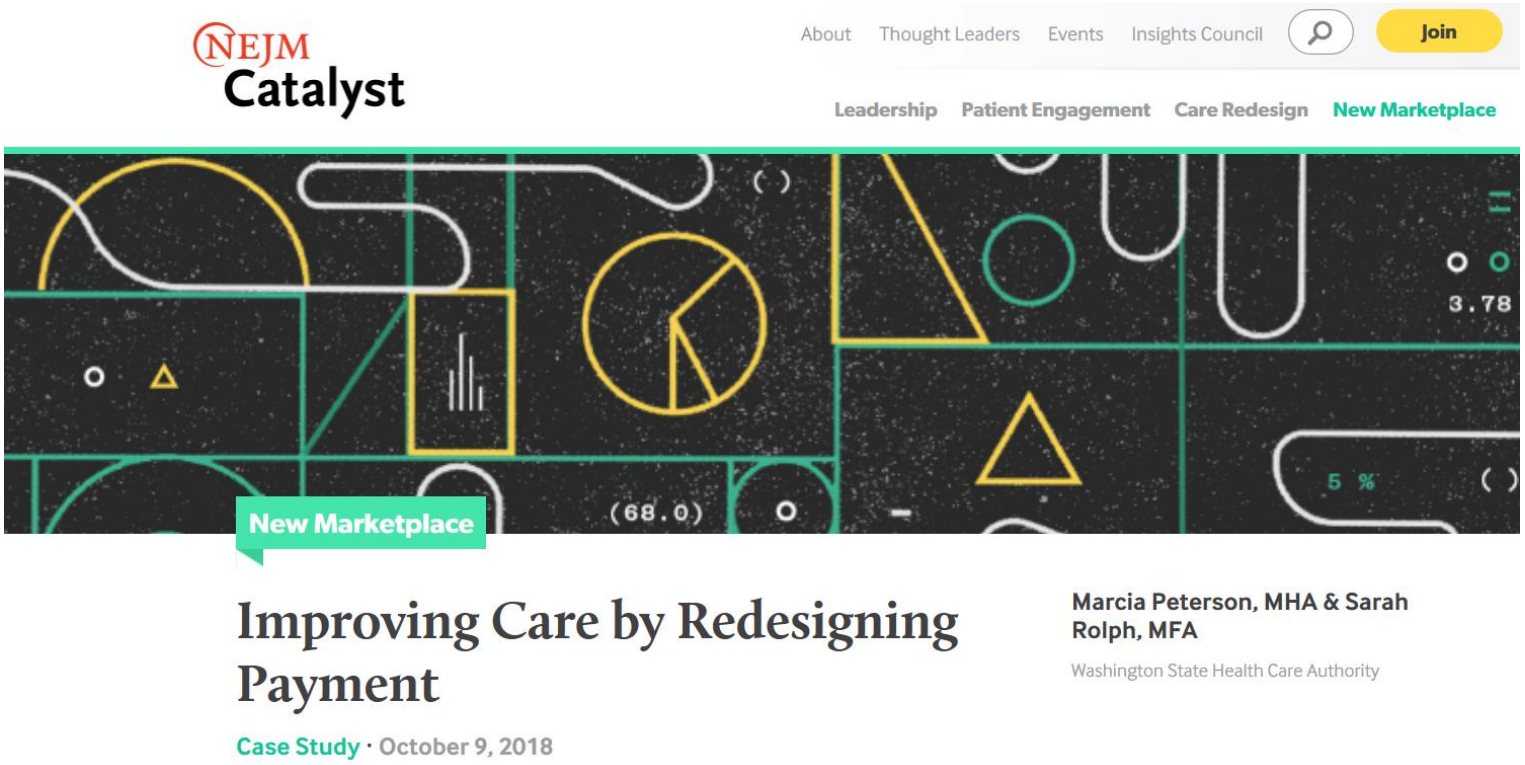
2021 Bree topic selection work sheet

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

Must have all of following three:

3. Data available



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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. "

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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**

Topic Update: Reproductive and Sexual Health

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

DR. ROBERT BREE COLLABORATIVE

July 22, 2020| Zoom Meeting

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, infantizing, 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**

Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J Health Care Poor Underserved. 1998;9(2):117-125. Shepherd SM. Cultural awareness workshops: limitations and practical consequences. BMC Med Educ. 2019;19(1):14. Published 2019 Jan 8. Horvat L, Horey D, Romios P, Kis-Rigo J. Cultural competence education for health professionals. Cochrane Database Syst Rev. 2014;(5):CD009405. Published 2014 May 5. doi:10.1002/14651858.CD009405.pub2Truong M, Paradies Y, Priest N. Interventions to improve cultural competency in healthcare: a systematic review of reviews. BMC Health Serv Res. 2014;14:99. Published 2014 Mar 3. Chang ES, Simon M, Dong X. Integrating cultural humility into health care professional education and training. Adv Health Sci Educ Theory Pract. 2012;17(2):269-278. doi:10.1007/s10459-010-9264-1

#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

#4 Appropriate care

- 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

DR. ROBERT BREE COLLABORATIVE

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*

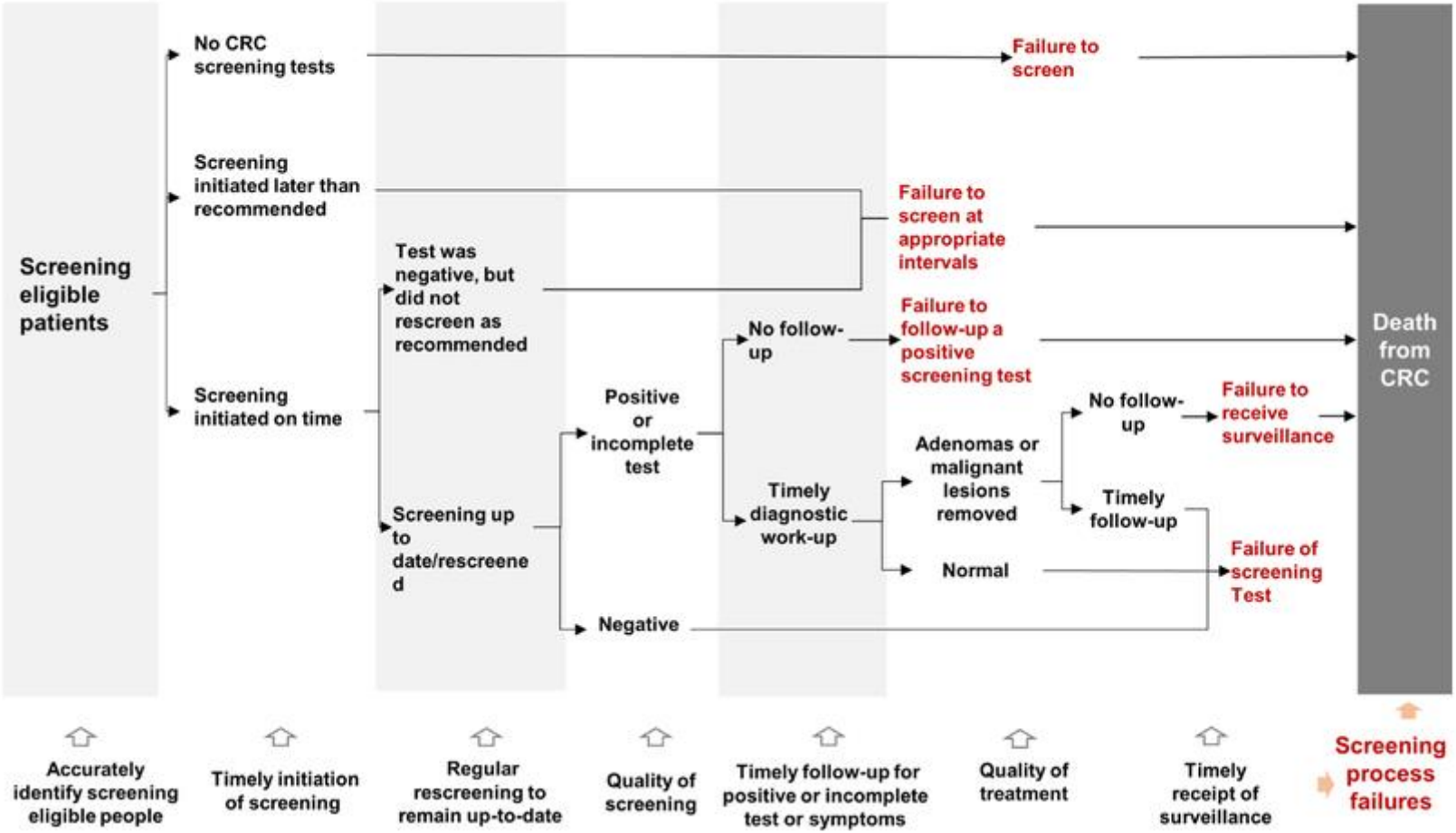
Why Colorectal Cancer Screening

- 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



- 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

#1 Tracking

- 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

#3 Patient-Centered Care

- 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.

#4 Payment

- (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

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, 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

Questions? Comments?

Topic Update:
Oncology Care

Hugh Straley, MD
Chair, Bree Collaborative

DR. ROBERT BREE COLLABORATIVE

July 22, 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

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

- 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

#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

#4 Integrating palliative care alongside life-prolonging and/or curative care

- 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

DR. ROBERT BREE COLLABORATIVE

July 22, 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
- 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

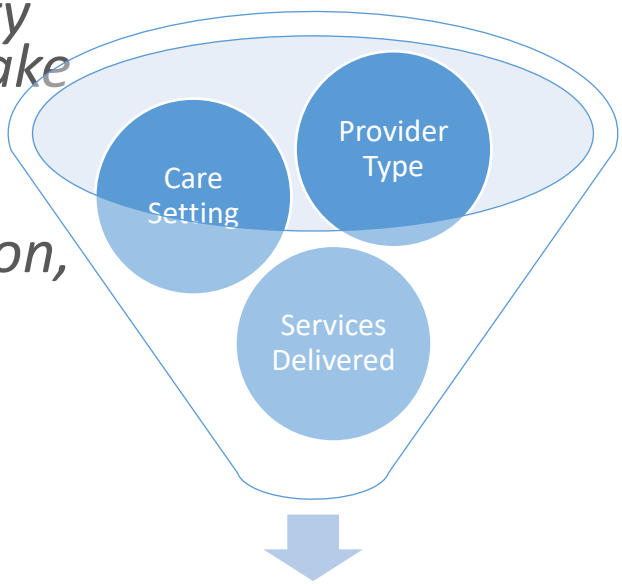
HCA announces public comment period for proposed Multi-payer Primary Care Transformation Model

- 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**

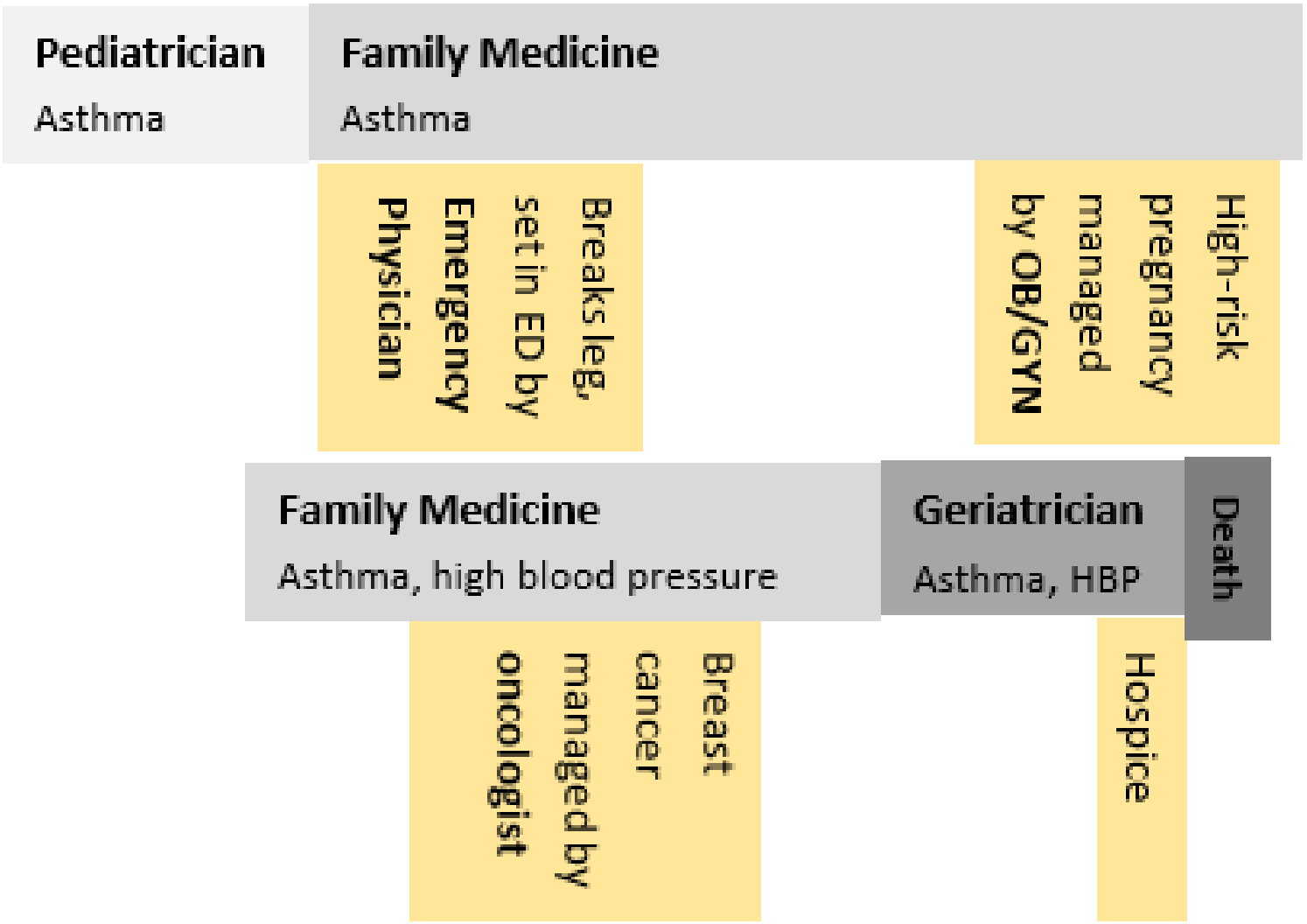


Sources: Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502. Primary Care Collaborative. Investing in Primary Care: A State-Level Analysis. https://www.pcpcc.org/resource/evidence2019

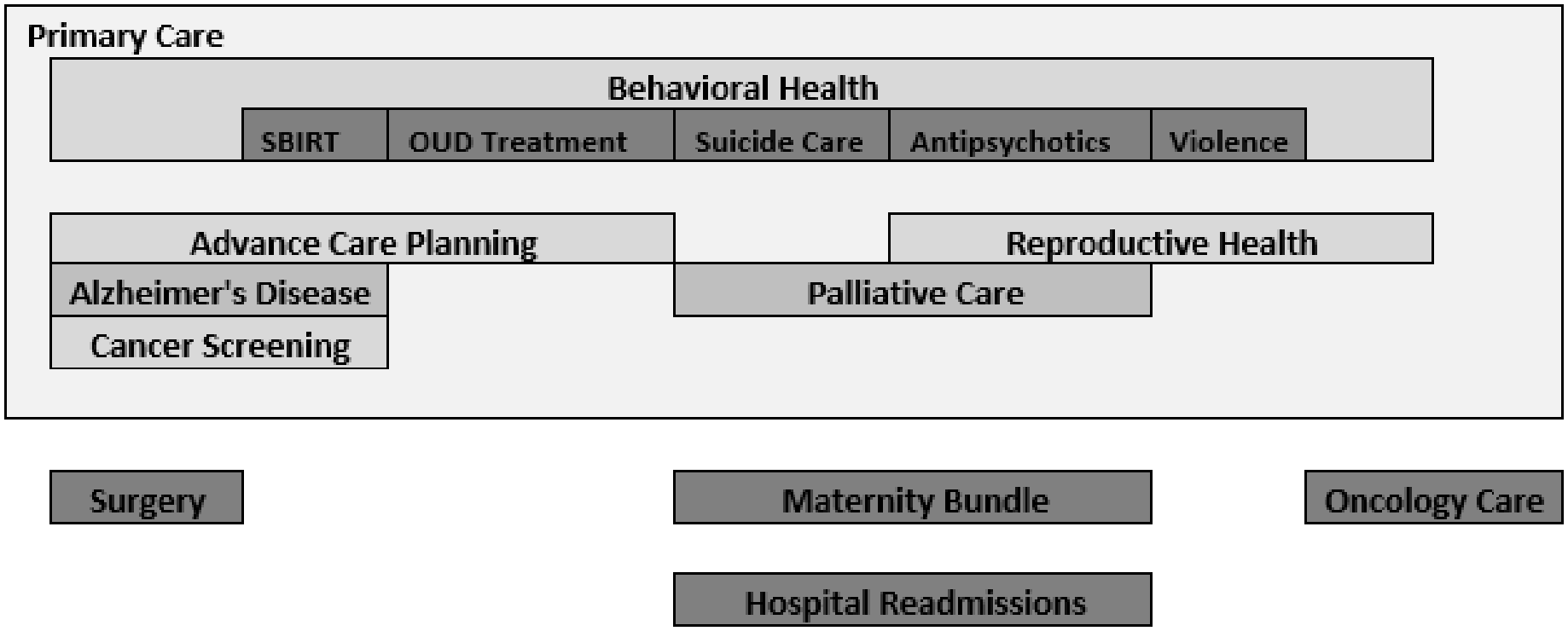
Our Definition
If primary care, must meet all:

- 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
Breaks leg, set in ED by Emergency Physician
High-risk pregnancy managed by OB/GYN
Family Medicine
Asthma, high blood pressure
Geriatrician
Asthma, HBP
Death
Breast cancer managed by oncologist
Hospice

Aligning with Previous Recommendations



Pacific Business Group on Health
Advanced Primary Care

- "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."

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.

Questions? Comments?

Bree Collaborative Meeting

September 16th, 2020

12:30 – 4:30pm

DR. ROBERT BREE COLLABORATIVE