Bree Collaborative Meeting

September 23, 2020 | Zoom Meeting
Welcome and Introductions
Meeting Minutes
  • Action Item: Approve minutes
Presentation: Implementation Update
Discussion: Determinants of Health
Topic Update: Primary Care
Vote to Disseminate for Public Comment: Oncology Care
Vote to Disseminate for Public Comment: Colorectal Cancer Screening
Vote to Disseminate for Public Comment: Reproductive and Sexual Health
Next Steps and Close
July 22 Meeting Minutes

Dr. Robert Bree Collaborative Meeting Minutes
July 22nd, 2020 | 12:30-3:30
Held Virtually

Members Present
Hugh Straley, MD, (Chair)
Susie Dade, MS
Gary Franklin, MD, Washington State Department of Labor and Industries
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
Kimberly Moore, MD, Franciscan Health System
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
Implementation Update

Amy Etzel
Implementation Manager, Bree Collaborative

September 23, 2020 | Zoom Meeting
Determinants of Health
I am STILL thinking about...

What makes us ill

AND

How and when we die
What is health?
What is it to be healthy?
AND
How we can live longer?
Health is an Accumulation that takes place over time

RACE (a social construct)

Birth

Gestational Environment
Cortisol Dysregulation
Adverse Childhood Experiences
Caregiver stress
Caregiver income
Early childhood housing

Family and social support
Education
Epigenetic Changes
Health behaviors
Neurologic Alterations

Employment

Housing

Income

Health Care Access
Health Care Quality

Community Safety

Death
## 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>
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<tbody>
<tr>
<td>1</td>
<td>Congenital Anomalies 4,473</td>
<td>Unintentional Injury 1,226</td>
<td>Unintentional Injury 734</td>
<td>Unintentional Injury 692</td>
<td>Unintentional Injury 12,044</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>Malignant Neoplasms 655,381</td>
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<tr>
<td>2</td>
<td>Short Gestation 3,679</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>Malignant Neoplasms 431,102</td>
<td>Malignant Neoplasms 599,274</td>
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<tr>
<td>4</td>
<td>SIDS 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>Chronic Low Respiratory Disease 135,500</td>
<td>Chronic Low Respiratory Disease 159,486</td>
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<tr>
<td>5</td>
<td>Unintentional Injury 1,168</td>
<td>Influenza &amp; Pneumonia 71</td>
<td>Influenza &amp; Pneumonia 122</td>
<td>Homicide 168</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>
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<tr>
<td>6</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>
<td>Cerebrovascular 122,019</td>
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<td>7</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 2,828</td>
<td>Cerebrovascular 5,128</td>
<td>Cerebrovascular 12,789</td>
<td>Unintentional Injury 157,213</td>
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<tr>
<td>8</td>
<td>Circulatory System Disease 428</td>
<td>Septicemia 54</td>
<td>Cerebrovascular 34</td>
<td>Cerebrovascular 54</td>
<td>Influenza &amp; Pneumonia 200</td>
<td>Cerebrovascular 567</td>
<td>Cerebrovascular 1,704</td>
<td>Chronic Low Respiratory Disease 3,807</td>
<td>Chronic Low Respiratory Disease 8,540</td>
<td>Influenza &amp; Pneumonia 48,888</td>
<td>Influenza &amp; Pneumonia 59,120</td>
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<td>9</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>
<td>Nephritis 51,386</td>
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<tr>
<td>10</td>
<td>Neonatal Hemorrhage 375</td>
<td>Cerebrovascular 43</td>
<td>Benign Neoplasms 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>
<td>Suicide 48,344</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™.
Health equity

Attainment of the highest level of health for all people...efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

– Healthy People 2020 (www.healthypeople.gov)

Can we get here with variable health care access?
Can we get here with variable health care quality?
Can we get here with variation in health from social determinants?
Is clinical care the BEST place for SDoH?
Severe Complications for Women During Childbirth Are Skyrocketing — and Could Often Be Prevented

The rate of life-threatening complications for new mothers in the U.S. has more than doubled in two decades as a result of pre-existing conditions.
US Healthcare Vulnerabilities Revealed

- Lack of Leadership for Transformation
- Unprepared, Underfunded Public Health Care System
- Pervasive Health Inequities
- Broken Financing
- Lack of Data and Information
- Fragmented, Inefficient, and Unprepared Delivery Systems
Health Ecosystem

Access

Quality

Health Behaviors (30%)
- Tobacco Use
- Alcohol Use
- Drug Use
- Diet
- Exercise
- Sexual Activity

Social and Economic (40%)
- Education
- Employment
- Income
- Family + Social Support
- Community Safety

Physical Environment (10%)
- Air Quality
- Water Quality
- Housing
- Transit
Health care’s swim lane

Access

$ $

Quality

Care (20%)

Health Behaviors (30%)
- Tobacco Use
- Alcohol Use
- Drug Use
- Diet
- Exercise
- Sexual Activity

Social and Economic (40%)
- Education
- Employment
- Income
- Family + Social Support
- Community Safety

Physical Environment (10%)
- Air Quality
- Water Quality
- Housing
- Transit
Health care’s swim lane expanded

PERSON

Access

$ $ $

Quality

Care (20%)

$ $ $

Health Behaviors (30%)
- Tobacco Use
- Alcohol Use
- Drug Use
- Diet
- Exercise
- Sexual Activity

Social and Economic (40%)
- Education
- Employment
- Income
- Family + Social Support
- Community Safety

Physical Environment (10%)
- Air Quality
- Water Quality
- Housing
- Transit
U.S. Preventive Services Task Force (USPSTF) is assessing the role of SDoHs in primary care prevention.

Table 1. Social Determinants of Health, by Domain and Organization

<table>
<thead>
<tr>
<th>Social Determinant</th>
<th>Healthy People 2020 (DHHS) (7)</th>
<th>Accountable Health Communities Model (CMS) (10)</th>
<th>Community Preventive Services Task Force (CDC) (8)</th>
<th>Campbell and Cochrane Equity Methods Group (9)</th>
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<tbody>
<tr>
<td>Housing</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Food security</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>Transportation</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socioeconomic status and financial strain</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Violence and interpersonal safety*</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Employment</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Community and social connections</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Education</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Health behaviors†</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Mental health</td>
<td>X</td>
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<tr>
<td>Disabilities</td>
<td>X</td>
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<td></td>
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<tr>
<td>Neighborhood and built environment</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Race/ethnicity, culture, religion, and language</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Health care access and health literacy</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Law and justice system</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Gender and sexual orientation</td>
<td>X</td>
<td></td>
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<td>X</td>
</tr>
</tbody>
</table>

CDC = Centers for Disease Control and Prevention; CMS = Centers for Medicare & Medicaid Services; DHHS = Department of Health and Human Services.
* Includes domestic abuse, elder abuse, and child maltreatment.
† Includes substance use/abuse, physical activity, and healthy diet.

https://www.acpjournals.org/doi/10.7326/M20-0730
Screening for Unmet Social Needs: Patient Engagement or Alienation?
Elena D. Butler, AB, Anna U. Morgan, MD, MSc, MSHP, Shreya Kangovi, MD, MS
DOI: 10.1056/CAT.19.1037

The importance of addressing unmet social needs has been recently underscored by Covid-19 racial disparities and a massive economic recession. However, as the rush to implementation outpaces research and rigorous evaluation, we are seeing the potential for unintended consequences. Here we offer guidance that will enable health care leaders to ensure that their organizations’ social needs screening programs engage patients rather than alienate them.

The momentum behind social needs screening is mounting, spurred by National Academy of Medicine guidelines, risk-based managed-care contracts, and electronic health record (EHR) vendors. Even with external incentives, social needs screening has not exactly been embraced by providers: only 16% of physician practices and 24% of hospitals currently screen for key social risk domains. Perhaps more importantly, “screen and refer” programs have had low uptake by patients and minimal effect on outcomes. The recent CONNECT trial evaluated a program in which the Johns Hopkins Health System used the Healthify platform to screen and refer high-risk patients to community-based organizations addressing the social determinants of health. This program did not affect emergency room visits or hospitalizations, the rates of referral to services, or the resolution of social needs. These results may be explained by staff-reported barriers, including uncertainty about the quality of services being offered and the inability to follow up with patients after referral.

Beyond these disappointing early data on the benefits of social needs screening, patient advocates are increasingly concerned about the potential for harm. Social needs screening probes the most private and potentially stigmatized areas of patients’ lives, including poverty, racism, and intimate-partner violence. Screening without careful deliberation can harm patients through trauma, discrimination, or legal consequences such as loss of child custody or deportation. Early social needs screening in many health care settings can be insensitive to these risks, with untrained clinical staff speeding through a rote checklist, often without explicit consent. Moreover, when

- Harmful or helpful to screen?
HCA MCO Questions (asked by plan)
Medicaid clients with special needs

- **Food insecurity**
The Hunger Vital Sign ([LOINC® 88121-9](#)) is a validated 2-question food insecurity tool from a peer-reviewed journal article that identifies households as being at risk for food insecurity ([LOINC® 88124-3](#)) if they answer that either or both of the following statements is “often true” or “sometimes true” (vs. “never true”):
  - **LOINC® 88122-7** Within the past 12 months we worried whether our food would run out before we got money to buy more
  - **LOINC® 88123-5** Within the past 12 months the food we bought just didn't last and we didn't have money to get more

- **Housing instability** ([PRAPARE assessment tool](#))
  What is your current housing situation? ([LOINC® code 71802-3](#)).
  - I have housing
  - I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
  - I choose not to answer that question

- **Transportation access** ([PRAPARE assessment tool](#))
  Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? ([LOINC® code 93030-5](#))
  - Yes, it has kept me from medical appointments or from getting my medications
  - Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
  - No
NEW! Social Determinants of Health (SDO) Screening

Inpatient Screening for Social Determinants of Health (SDOH)
Screening for housing stability, food insecurity, and transportation needs SDOH. Must be screening for all three.

Upload a copy of screening tool or screening question in use
Examples: CMS Tool, PRAPARE, Core5

Upload of codes used to document SDOH in EHR Examples: (LOINC, SNOMED, Z-Codes, Other) in QBS

Data Collection System: WSHA Quality Benchmarking System

Submission Frequency: Once during the incentive period

MQI Threshold: Data based on weighted screening for all three SDOH
Housing, Food Insecurity and transportation needs for the 8 award points. Coding SDOH into EHR will receive 2 bonus points.
Core 5 Questions from Ohio

PROCESS ALGORITHM

RN or nursing student conducts CDH Screening Tool ("Core 5") by asking all five of these questions:
1. Do you or your family worry about whether your food will run out and you won’t be able to get more?
2. Are you worried about losing your house or are you homeless?
3. Are you currently having issues with your utilities such as your heat, electric, natural gas or water?
4. Has a lack of transportation kept you from attending medical appointments or from work, or from getting things you need for daily living?
5. Are you worried that someone may hurt you or your family?

RN or nursing student provides patient with services or direct referral to address CDH gaps

Is RN or nursing student able through knowledge, institutional policy/procedures and available resources to address the patient’s CDH needs directly?

RN or nursing student ensures documentation of intervention in client medical record

https://cdn.ymaws.com/www.ohiochc.org/resource/resmgr/opcwi/Core_5_Presentation_Final_4..pdf
*arrows represent added questions to Core 5 tool*

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<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Has a lack of transportation kept you from work, attending medical appointments, or from getting things you need for your daily living?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2.</td>
<td>Do you have concerns about your ability to care for yourself after surgery or are worried you won’t have anyone to help you when you get home?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>3.</td>
<td>Are you currently having concerns at home with your utilities such as your heat, electric, natural gas, or water?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4.</td>
<td>Have you ever skipped medications to save money?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>5.</td>
<td>Are you worried about losing your housing or are you homeless?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6.</td>
<td>Do you or your family worry about whether your food will run out and you won’t be able to get more?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7.</td>
<td>Are you worried that someone may hurt you or your family?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
Topic Update: Primary Care

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

September 23, 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
- 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
- Karen Johnson, PhD, Director, Performance Improvement & Innovation, Washington Health Alliance
- 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
We know WHY, need to determine WHAT

And what do you burn, apart from witches?
Definition
If primary care, must meet all:

• **Accountable** through a team and/or provider that includes physical and behavioral health (MD, DO, ARNP, PA, OPA, ND)
• **First Contact** assess, triage, direct
• **Comprehensive** whole person
• **Continuous** long-term relationship
• **Coordinated** care plan and referrals
• **Appropriate** evidence-based
• Current State: Based in claims, care delivered in an ambulatory setting by a predefined group of providers and team members including lab and drug costs
Components of Primary Care with Large Impact

- Care coordination
- Integrated behavioral health
- Disease prevention and screening
- Chronic condition management
- Medication management
- Health promotion
- Person-centered care that considers physical, emotional, and social needs
Delivery Site Checklist

- Infrastructure
- Access
- Information
- Referrals
- Content of Care
A payment mechanism supports primary care features that are not reimbursed through traditional fee-for-service payments. These mechanisms include value-based reimbursement such as fee-for-service enhancements or prospective payments made in the form of per member per month (PMPM) payments that could include incentives for transformation, performance-based incentives, or more expansive forms of capitation.
Survey Respondents

65% were health care providers (n=129)

- Health Care Provider: 65%
- Health Insurer: 5%
- Accountable Community of Health (ACH): 3%
- Employer/Health Care Purchaser: 1%
- Local Public Health: 5%
- Social Service Provider: 3%
- Other (Please describe.): 18%
Overall Support for Proposed Model

87% somewhat or strongly support the model (n=129)
Level of Support by Proposed Component

75%+ somewhat or strongly support each of the components (n=129)

- **Component 1:** Primary care as integrated whole-person care, including behavioral and preventive services
- **Component 2:** Shared understanding of care coordination and providers in that continuum
- **Component 3:** Aligned payment and incentives across payers to support model
- **Component 4:** Financing
- **Component 5:** Improved provider capacity and access
- **Component 6:** Application of actionable analytics (clinical, financial, and social supports)
- **Component 7:** Aligned measurement of “value” from the model

<table>
<thead>
<tr>
<th>Component</th>
<th>Strongly Oppose</th>
<th>Somewhat Oppose</th>
<th>Neutral</th>
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<tbody>
<tr>
<td>Component 1</td>
<td>2% 1% 2%</td>
<td>9% 13% 2%</td>
<td>87% 82%</td>
</tr>
<tr>
<td>Component 2</td>
<td>0% 2% 3%</td>
<td>13% 18%</td>
<td>3% 58%</td>
</tr>
<tr>
<td>Component 3</td>
<td>13% 3% 8%</td>
<td>2% 17%</td>
<td>23% 53%</td>
</tr>
<tr>
<td>Component 4</td>
<td>2% 9% 6%</td>
<td>2% 1%</td>
<td>21% 70%</td>
</tr>
<tr>
<td>Component 5</td>
<td>2% 2% 9%</td>
<td>2% 1%</td>
<td>21% 67%</td>
</tr>
<tr>
<td>Component 6</td>
<td>2% 3% 15%</td>
<td>2% 1%</td>
<td>23% 56%</td>
</tr>
<tr>
<td>Component 7</td>
<td>2% 3%</td>
<td>10% 20%</td>
<td>30% 40% 50% 60% 70% 80% 90% 100%</td>
</tr>
</tbody>
</table>
Disseminate for Public Comment:
Colorectal Cancer Screening

Rick Ludwig, MD
Chief Executive Officer,
Pacific Medical Centers

September 23, 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
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
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
Focus Areas Address Failures in Pathway

Failure Points led to Focus Areas

- Tracking
- Measurement
- Person-centered care
- Payment
• Track outcomes and identify disparities in cancer screening and mortality through comprehensive cancer screening registry (colon, breast, cervical) including screening, screening outcome, and factors known to affect screening and outcome including race, ethnicity, and insurance status.
  o Short term goal: Individual site-level registry
  o Long-term goal: Centralized registry managed by state agency
• Conduct outreach on need for cancer screening at appropriate intervals depending on the colorectal cancer screening modality they have selected or that is most appropriate for them including follow-up on abnormal non-colonoscopic screening tests.
  o Manage outreach and registry through dedicated role at site level
• Targeted outreach to populations with historical or demonstrated lower colorectal cancer screening rates including Black Americans
#2 Measurement

- Request self-reported race and ethnicity at a site level and report at a health plan level to identify disparities
- Report screening completion by race and ethnicity by site and health plan
- Include measurement of the colorectal cancer screening rate (NQF #0034) for all appropriate populations including for Medicaid
- Track positive fecal tests with follow-up colonoscopy
#3 Person-Centered Care

- For patients 50-75, individualize screening modality choice considering overall health, history of prior screening, and risk factors, using shared decision making.
- For patients electing or who are recommended to have a colonoscopy, offer education around sedation options, including no sedation or sedation on demand.
#4 Payment

- Develop a cost calculation worksheet to show the return on investment for colorectal cancer screening
- Tie provider payments to showing improvement in colorectal cancer screening rates in state health care purchasing contracts
- Waive member cost share for colonoscopy to evaluate an abnormal colorectal cancer screening test (i.e., sigmoidoscopy, stool, blood, imaging screening test), whether polypectomy or biopsy is performed
- Waive the member cost share for screening colonoscopy if a polyp is identified and removed in the procedure
- Allow patients who are income-eligible to have the same access to free screening and treatment as those with breast and cervical cancer
Recommendation

Vote to disseminate for public comment
Disseminate for Public Comment:
Oncology Care

Hugh Straley, MD
Chair, Bree Collaborative

September 23, 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 – Holistic review
- September – Present for public comment disseminate
- October – Public Comment
- November – Final approval
#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 a registry of patients based on risk including age, comorbidities, type and stage of cancer, treatment intensity, depression, distress.
- Assess for social determinants of health including housing, food security, patient ability to care for self or presence of a caregiver.
<table>
<thead>
<tr>
<th>Population Studied</th>
<th>Predictors</th>
<th>Process</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daly R. 2020</td>
<td>Antineoplastic therapy included receipt of any intravenous or oral cytotoxic, immunotherapeutic, or biologic agent</td>
<td>• Malignancy and treatment characteristics (77 features) • Medications (101 features) • Laboratory values (45 features)</td>
<td>Machine learning from medical record data</td>
</tr>
<tr>
<td>Brooks GA. 2015</td>
<td>Patients with Advanced solid-tumor cancer Palliative-intent chemotherapy</td>
<td>• Age • Charlson comorbidity score • Creatinine clearance • Calcium level • Below-normal white blood cell and/or platelet count • Polychemotherapy (vs monotherapy) • Receipt of camptothecin chemotherapy</td>
<td>Medical record abstraction</td>
</tr>
<tr>
<td>Brooks GA. 2019</td>
<td>Patients with stage IV or recurrent solid tumor malignancy first chemotherapy treatment</td>
<td>• Albumin • Sodium</td>
<td>Abstracted administrative, EHR, and clinical data</td>
</tr>
<tr>
<td>Grant RC. 2019</td>
<td>Adult patients with cancer commonly treated on outpatient basis</td>
<td>• Combination of cancer type and treatment regimen • Age • Emergency department visits in the prior year</td>
<td>Population-based administrative and clinical databases</td>
</tr>
<tr>
<td>Hong JC. 2018</td>
<td>Patients undergoing chemotherapy or radiation therapy All adult patients who underwent outpatient external-beam RT with or without concurrent systemic therapy (chemotherapy, immunotherapy, or hormonal therapy)</td>
<td>Factors with highest predictive gain: • Planned number of radiation fractions • Planned total radiation dose • Time since most recent ED visit • Weight loss • Age</td>
<td>Machine learning from pretreatment EHR data and treatment data</td>
</tr>
</tbody>
</table>


#2 Person-Centered Care

- Early conversations on patient goals of care including around inpatient care use and medical interventions
- Education on symptom management and how to access care team
- Person and caregivers understand signs, symptoms, and complications that may necessitate urgent or emergency care
- Access care (e.g., care team, nurse triage) is available 24/7 who has access to the patient’s medical record
- Telehealth standards built into care pathways
• Standard protocol for management based on risk based on internal clinic resources including at a minimum:
  • Post-treatment outreach to those identified as higher risk
  • Post-treatment provider follow-up appointments
  • Post-discharge outreach to those who have accessed inpatient care

• Standard symptom management and triage pathways for common side effects (e.g., Canadian developed triage management system COSTaRS)
For patients who are higher-risk and/or higher-need with need for symptom management, consider referral to interdisciplinary specialty palliative care as outlined in the 2019 Bree Collaborative Palliative Care recommendations.
Recommendation

Vote to disseminate for public comment
Disseminate for Public Comment: Reproductive and Sexual Health

Ginny Weir, MPH
Director, Bree Collaborative

September 23, 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)
Context

- Historical coercion and violation of human rights
- Intersectionality informs identity, past experiences, access to resources, impact of both positive and negative historical events, and care needs
- Reproductive and Sexual health services are BROAD
  - Screening and treatment for sexually transmitted infections
  - Screening and treatment for conditions of the genital organs including cancer as well as conditions that can impact quality of life such as fibroids and endometriosis
  - Family planning including contraception, infertility treatment, pre-conception care, prenatal care, labor and delivery, and postpartum care
What needs to change?

• We don’t know everything that needs to change
• Lack of understanding of how individual and group identity informs risk, resilience, choices, exposures
• Many barriers to care (language/physical/hours/insurance)
• Clinical encounters can be traumatic or harmful due to implicit bias, tone, etc
• People do not get what they want or need out of a clinical encounter – birth control, education
#1 Cultural Humility

- 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 historical and cultural background of your patient population including the role of the state or the medical establishment in causing harm or oppression and self-awareness of implicit bias
- Engage with the community
- Provide culturally humble care

#2 Access

- Enhanced access to care (e.g., same-day access, after hours, telehealth)
- Physical accessibility including transportation
- Understand financial barriers (including insurance) for patient population including from immigration or residency status
- Materials and services in languages appropriate to your population
- Accessible materials that are easy to understand and available in a variety of accessible formats including braille, large print, audio
- Assess the person’s understanding of topics discussed using the teach back or show me method (demonstrate what they have been told)
#3 Person-centered care

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

- Understand individual needs
- Build interpersonal trust within the clinical visit
- Build a trauma-aware workforce of clinical and non-clinical staff
- Examine and mitigate coercion or provider bias including implicit bias based on race, ethnicity, being indigenous, gender, sex, LGBTQ+, age, disability, immigration status, weight, or other patient-specific factors
- Reaffirm the confidentiality of care including test results, medications, appointments, and communications
- Involve family or friends if desired by the person
#4 Appropriate care

- Educate on healthy relationships and intimate partner violence
- Prevention, screening, and onsite treatment or referral for reproductive health conditions including cancer screenings as outlined in the USPSTF, STI screening and treatment, and behavioral health SBIRT
- Parenting intention in the next year annually
- Contraceptive counseling including a full range of contraceptive choices during same-day appointments and infertility treatment (or referral – shared-decision making approach for all people)
- Accessible pre-conception care, prenatal care, labor and delivery, postpartum care, and abortion services
Recommendation

Vote to disseminate for public comment
Bree Collaborative Meeting
November 18th, 2020
12:30 – 3:30pm