Bree Collaborative Meeting

September 23, 2020 | Zoom Meeting

Agenda

- **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

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Determinants of Health

September 23, 2020| Bree Collaborative Meeting

I am STILL thinking about…

What makes us ill

AND

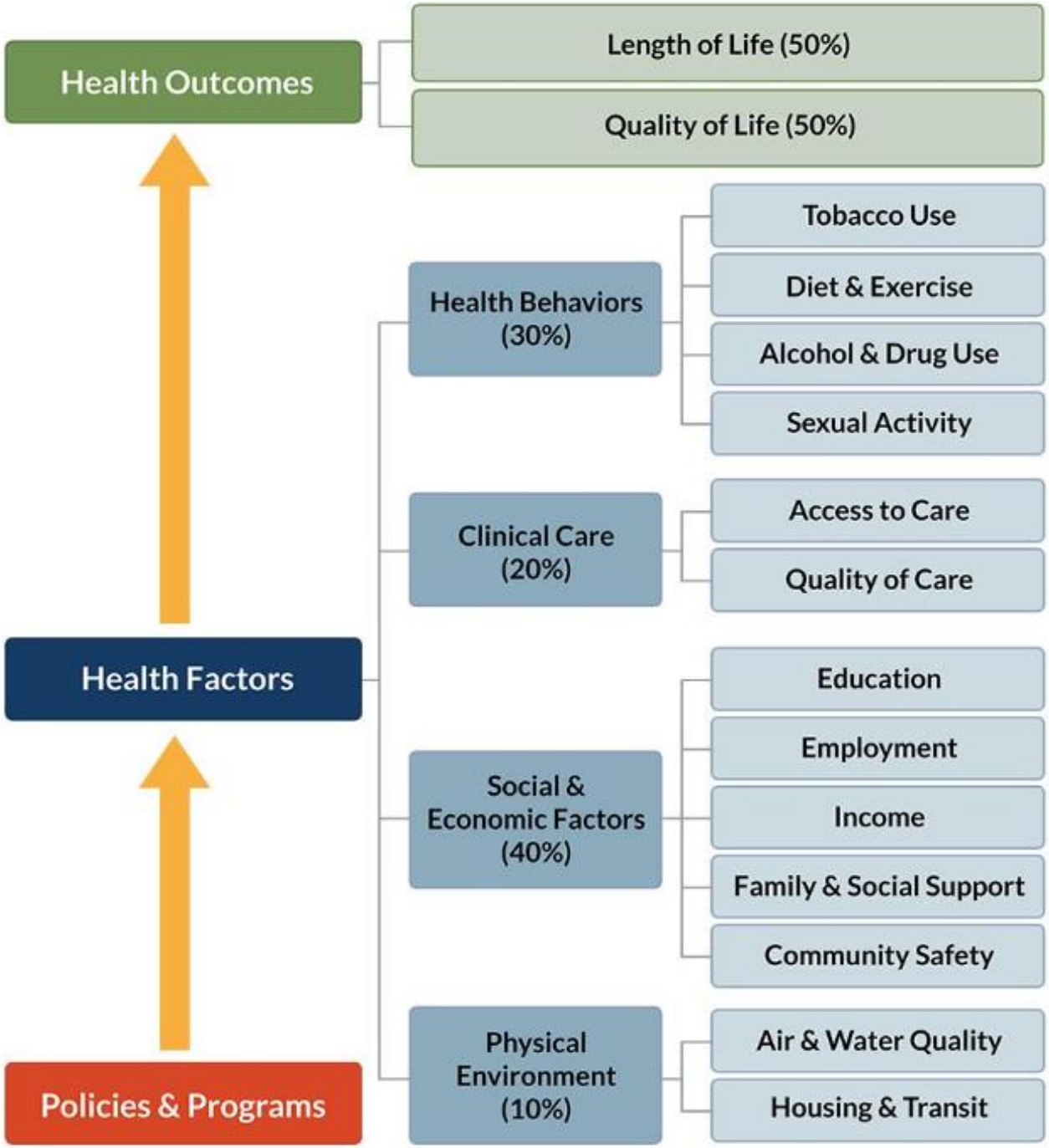
How and when we die

Or…

What is health?
What is it to be healthy?

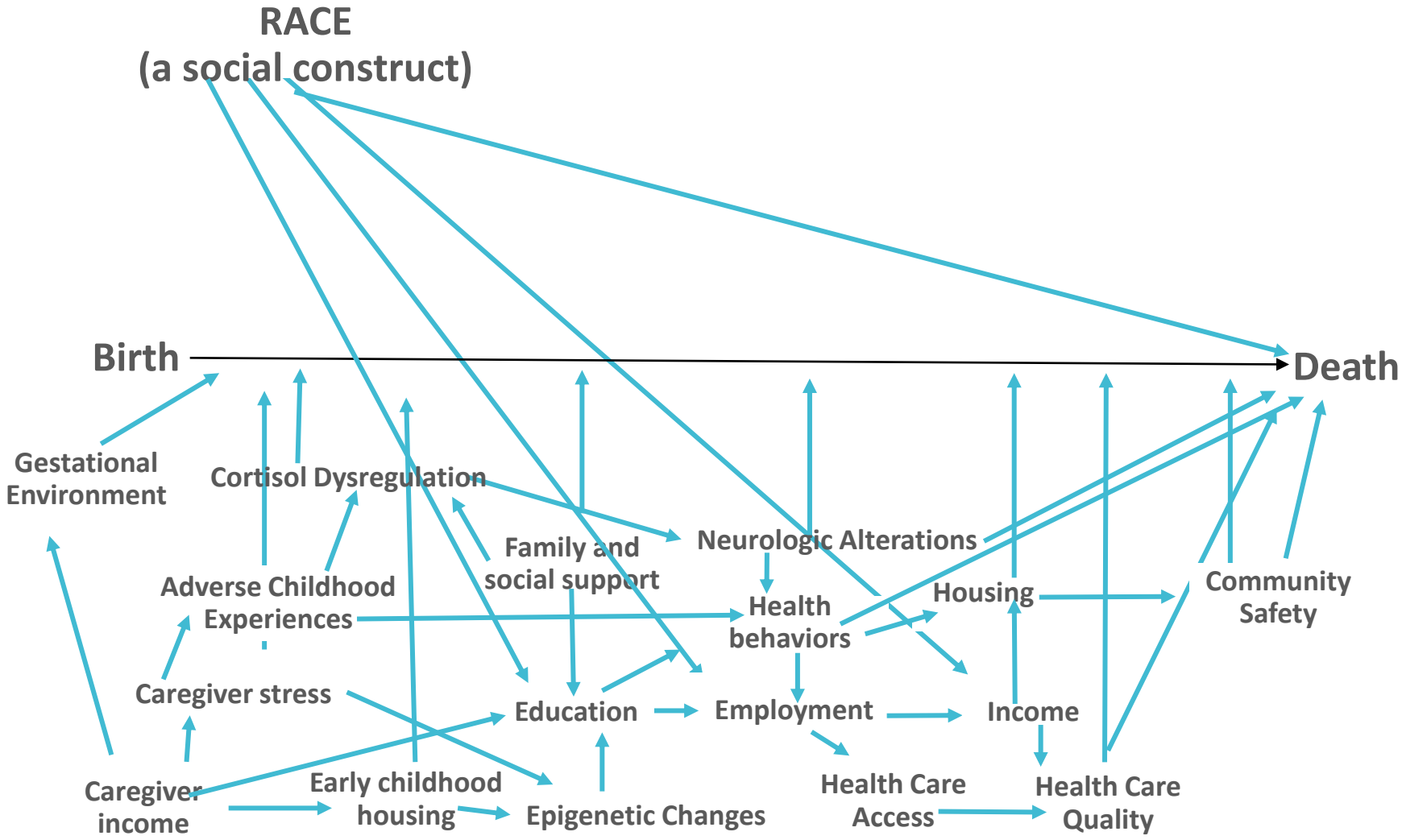
AND

How we can live longer?



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

Health is an Accumulation that takes place over time



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

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?

Nearly Dying In Childbirth: Why Preventable Complications Are Growing In U.S.

December 22, 2017 • 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,

CNN Health » Food | Fitness | Wellness | Parenting | Live Longer Live TV

After Serena Williams gave birth, 'Everything went bad'

LOST MOTHERS

Severe Complications for Women During Childbirth Are Skyrocketin — and Could Often Be Prevented

The rate of life-threatening

'If You Hemorrhage, Don't Clean Up': Advice From Mothers Who Almost Died

August 3, 2017 • We've heard from 3,100 women who survived life-threatening complications of pregnancy or childbirth. They told us what they wished they had known and what they would say to new and expectant mothers.

FEATURE

Why America's Black Mothers and Babies Are in a Life-or-Death Crisis

The answer to the disparity in death rates has everything to do with the lived experience of being a black woman in America.

U.S. Has The Worst Rate Of Maternal Deaths In The Developed World

May 12, 2017 • More American women are dying of pregnancy-related complications and that rate is rising.

SEARCH

CDC A-Z INDEX

About Us + Pregnancy-Related Deaths

Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why

December 7, 2017 · 7:51 PM ET

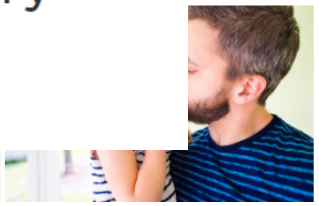
Heard on All Things Considered

Infertility +

Assisted Reproductive

defined as the death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of

Rounds

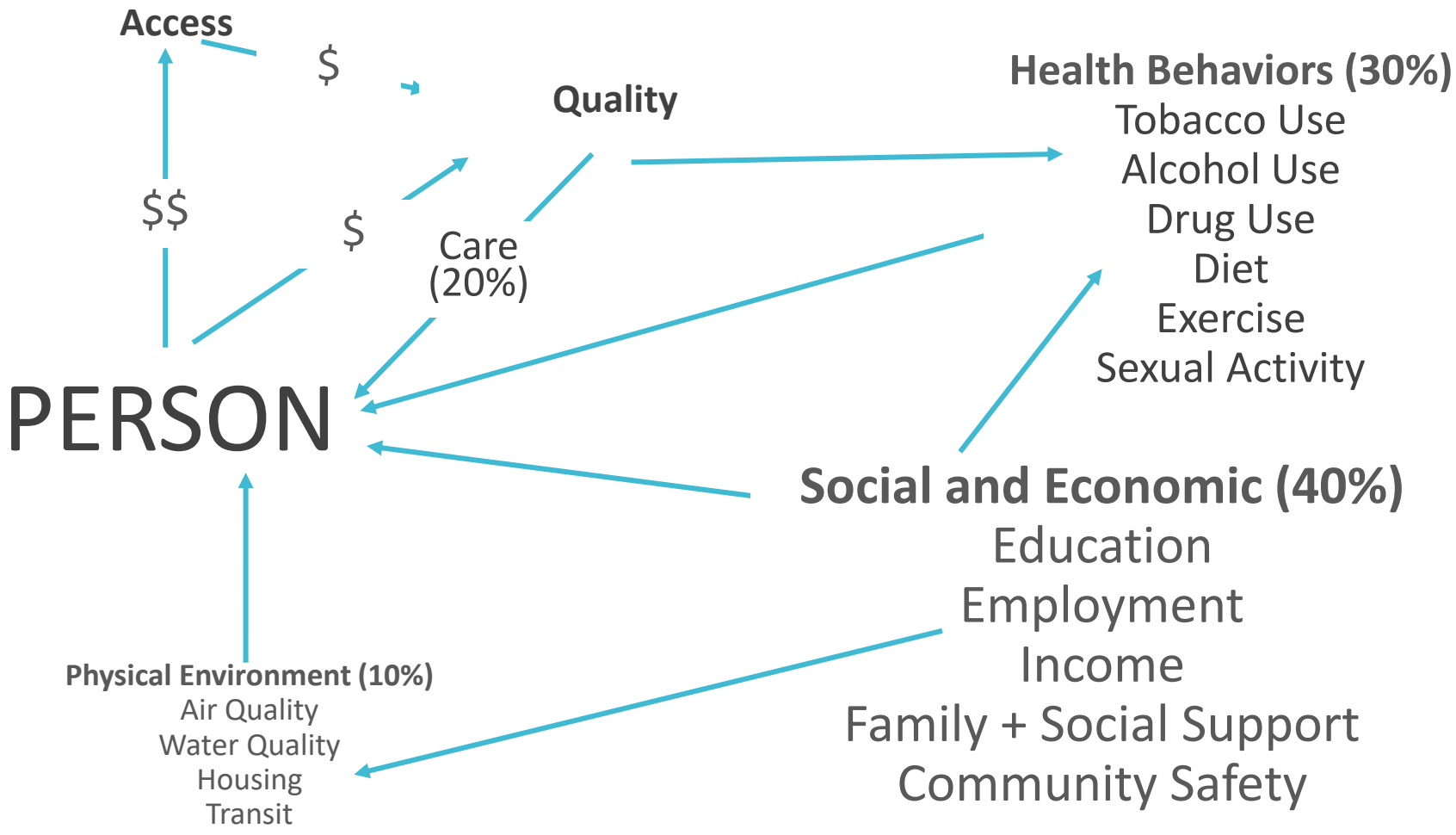


- Video: https://nowthisnews.com/videos/politics/black-women-die-from-childbirth-complications-at-alarming-rates

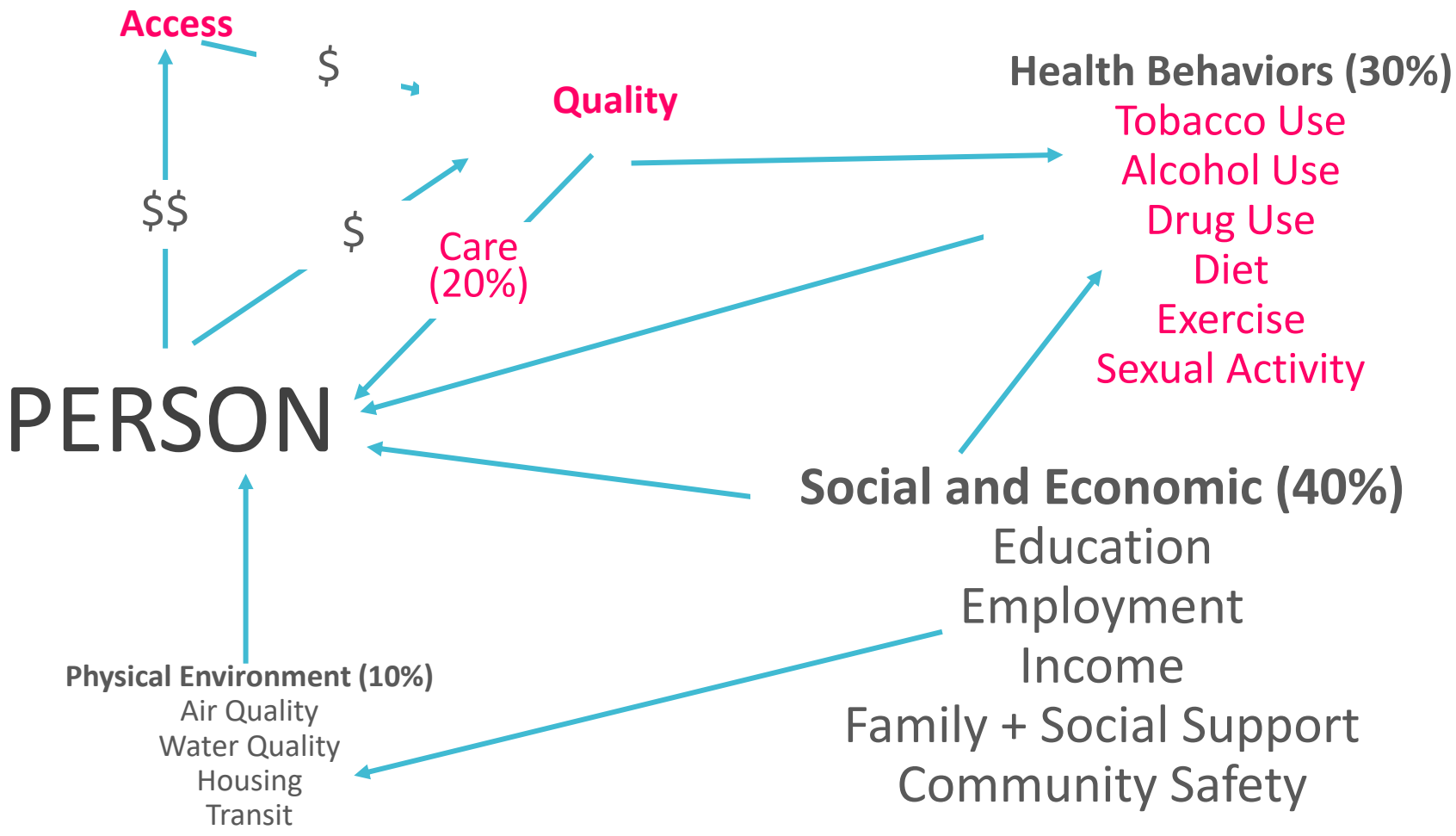
US Healthcare Vulnerabilites Revealed

- 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

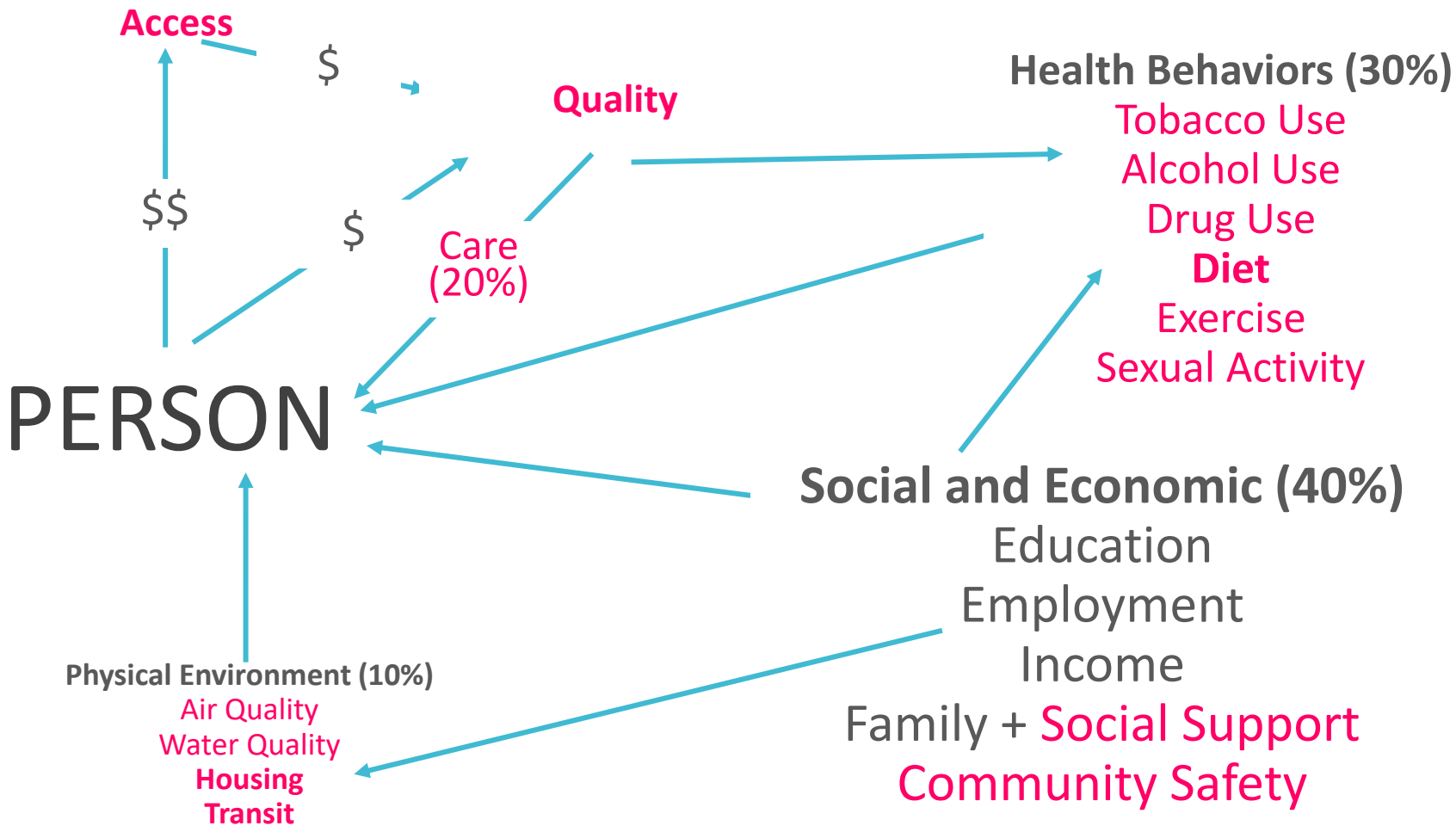
Health Ecosystem



Health care's swim lane



Health care's swim lane expanded



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

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

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

Unintended Consequences

- Harmful or helpful to screen?

NEJM Catalyst | Innovations in Care Delivery

COMMENTARY

Screening for Unmet Social Needs: Patient Engagement or Alienation?

Elena D. Butler, AB, Anna U. Morgan, MD, MSc, MSHP, Shreya Kangovi, MD, MS

Vol. No. | July 20, 2020
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.[1-3] 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.[4] Perhaps more importantly, "screen and refer" programs have had low uptake by patients and minimal effect on outcomes.[5-7] 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.[6] 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.[8] 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.[9,10] 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

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

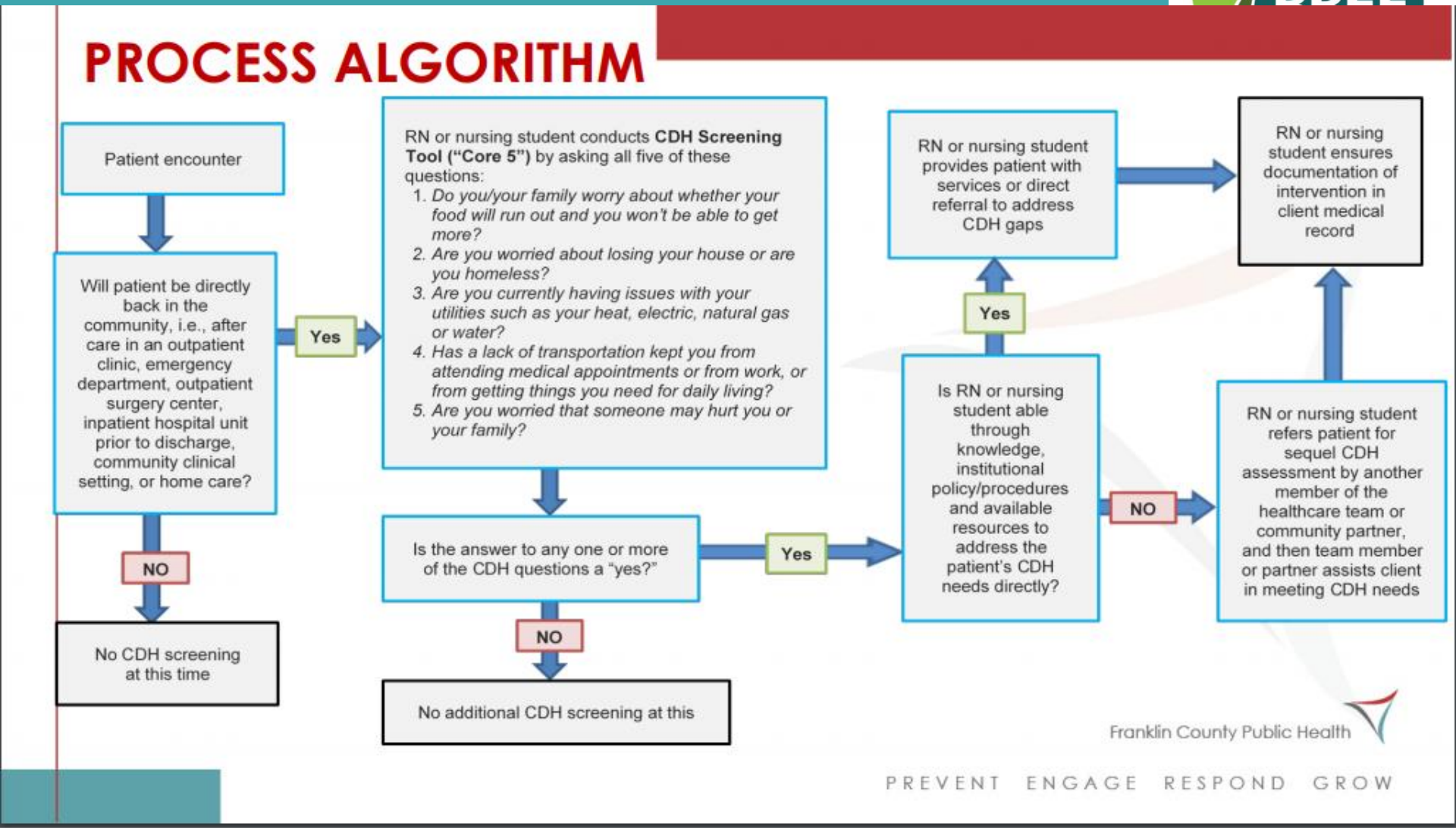
MQI Threshold: Data based on weighted screening for all three SDOH Housing, Food Insecurity and transportation needs for the 8 award points. Coding SDOH into EHR will receive 2 bonus points.

Washington State Hospital Association

New! Social Determinants of Health Screening

Washington State Health Care Authority

Core 5 Questions from Ohio



https://cdn.ymaws.com/www.ohiochc.org/resource/resmgr/opcwi/Core_5_Presentation_Final_4..pdf

Virginia Mason Expanded Core 5

*arrows represent added questions to Core 5 tool

	Yes	No
1. Has a lack of transportation kept you from work, attending medical appointments, or from getting things you need for your daily living?		
2. 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?		
3. Are you currently having concerns at home with your utilities such as your heat, electric, natural gas, or water?		
4. Have you ever skipped medications to save money?		
5. Are you worried about losing your housing or are you homeless?		
6. Do you or your family worry about whether your food will run out and you won't be able to get more?		
7. Are you worried that someone may hurt you or your family?		

Topic Update:
Primary Care

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

DR. ROBERT BREE COLLABORATIVE

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

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

Measurement

- 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

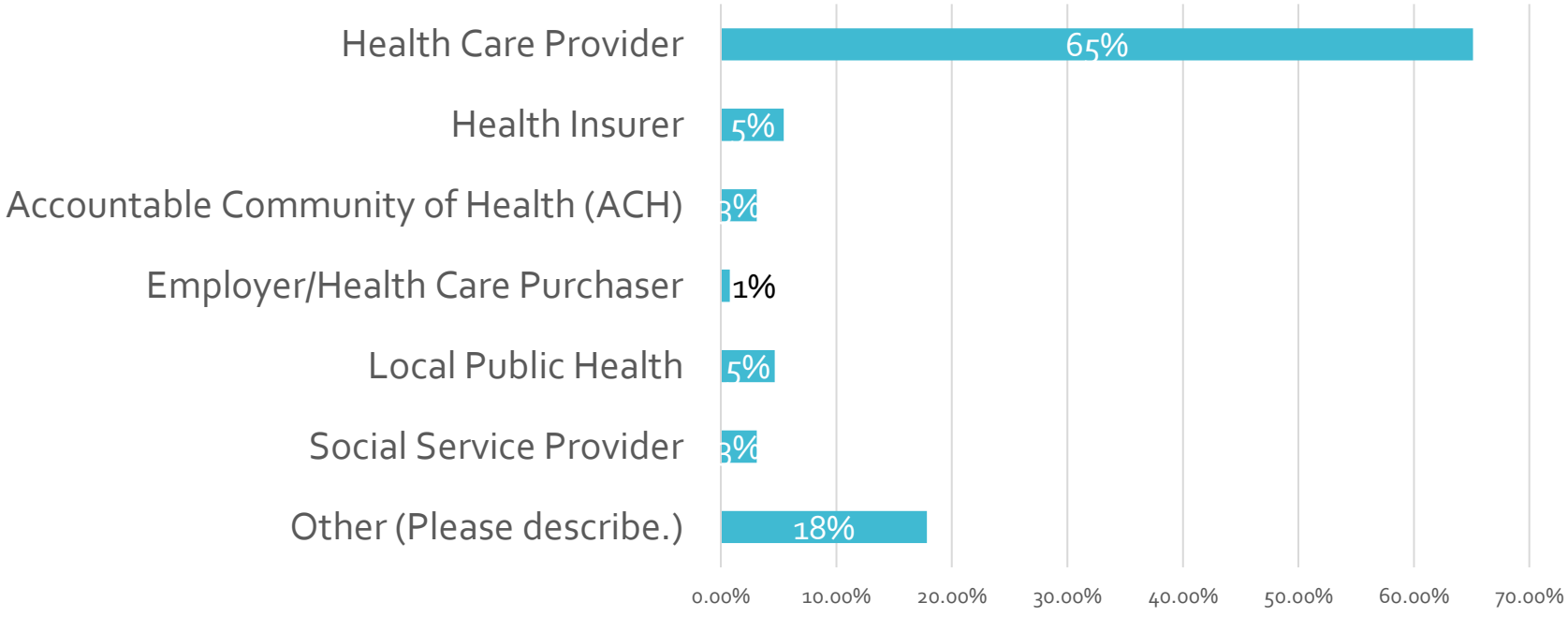
- Infrastructure
- Access
- Information
- Referrals
- Content of Care

Health Plan Checklist

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

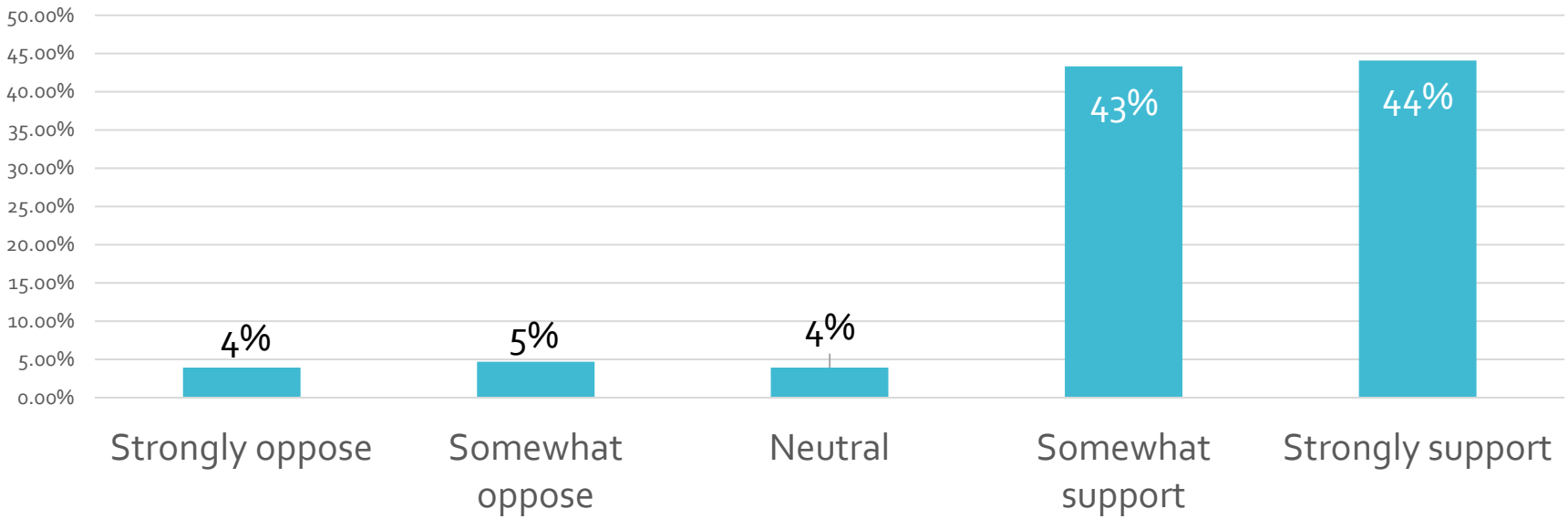
Survey Respondents

65% were health care providers (n=129)



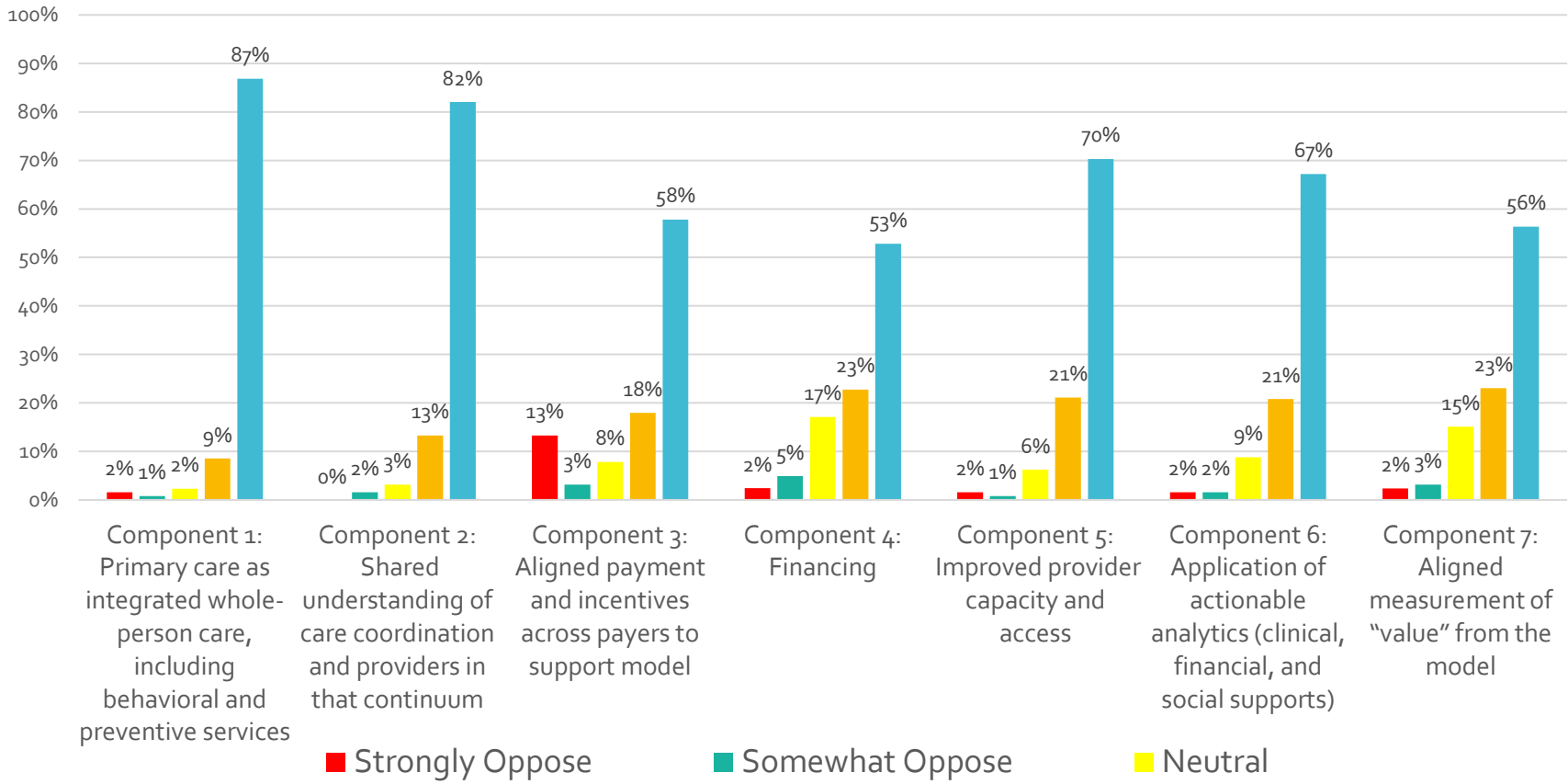
Overall Support for Proposed Model

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)



Disseminate for Public Comment: Colorectal Cancer Screening

Rick Ludwig, MD
Chief Executive Officer,
Pacific Medical Centers

DR. ROBERT BREE COLLABORATIVE

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*

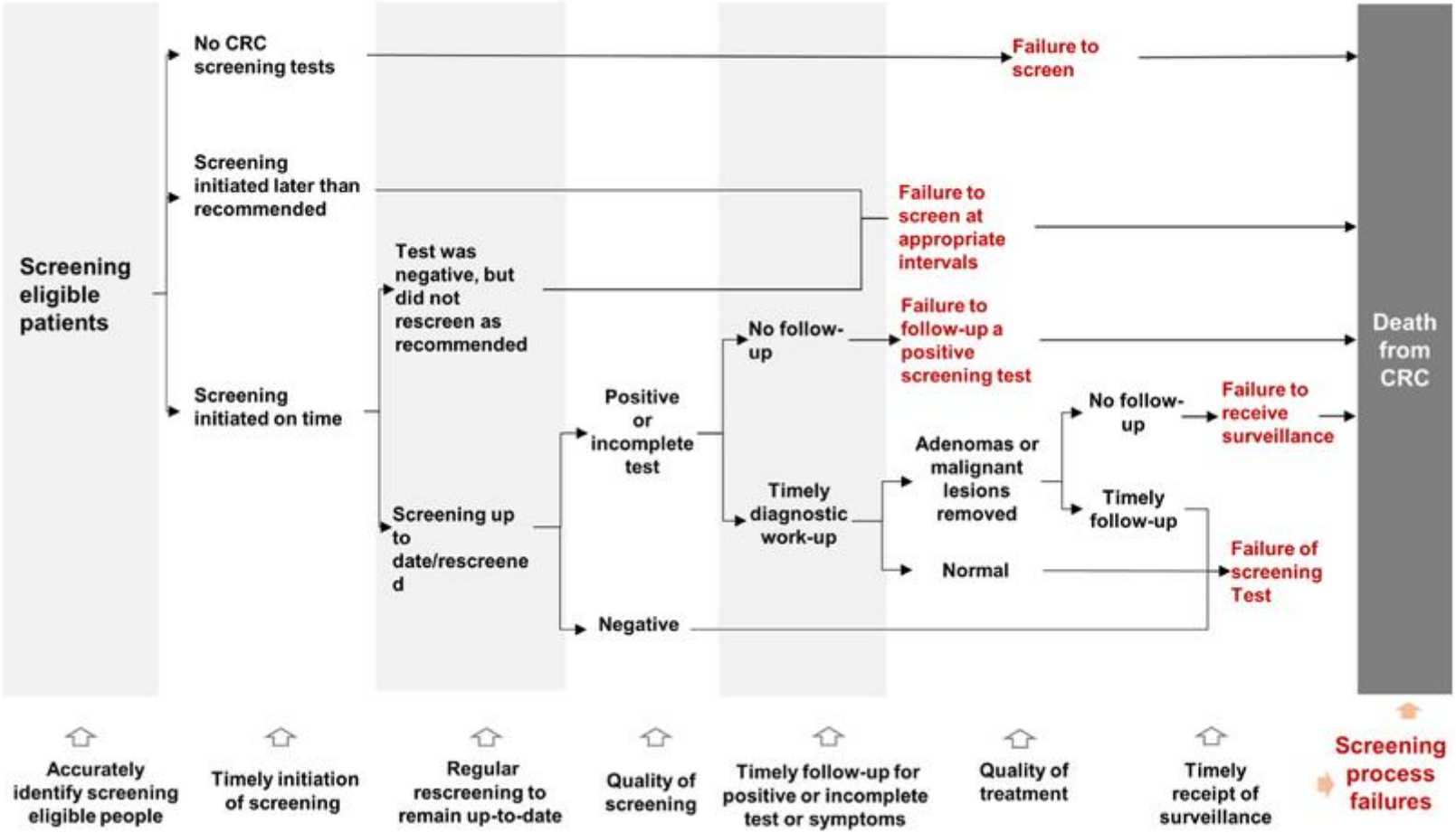
Meeting Schedule

- 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



- 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

Failure Points led to Focus Areas

- Tracking
- Measurement
- Person-centered care
- Payment

#1 Tracking

- 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.
  - Short term goal: Individual site-level registry
  - 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.
  - 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

DR. ROBERT 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 1: Factors Associated with Inpatient Care Utilization

	Population Studied	Predictors	Process	Outcome
Daly R. 2020	Antineoplastic therapy included receipt of any intravenous or oral cytotoxic, immunotherapeutic, or biologic agent	• Malignancy and treatment characteristics (77 features) • Medications (101 features) • Laboratory values (45 features	Machine learning from medical record data	Acute care visit for pre-defined list of preventable symptoms (e.g., nausea) within 6 months of start
Brooks GA. 2015	Patients with Advanced solid-tumor cancer Palliative-intent chemotherapy	• Age • Charlson comorbidity score • Creatinine clearance • Calcium level • Below-normal white blood cell and/or platelet count • Polychemotherapy (vs monotherapy) • Receipt of camptothecin chemotherapy	Medical record abstraction	Chemotherapy-related hospitalization adjudicated by the oncology clinical care team
Brooks GA. 2019	Patients with stage IV or recurrent solid tumor malignancy first chemotherapy treatment	• Albumin • Sodium	Abstracted administrative, EHR, and clinical data	All-cause hospitalization within 30 days of chemotherapy treatment
Grant RC. 2019	Adult patients with cancer commonly treated on outpatient basis	• Combination of cancer type and treatment regimen • Age • Emergency department visits in the prior year	Population-based administrative and clinical databases	Emergency department visit or hospitalization within 30 days after starting systemic therapy for cancer
Hong JC. 2018	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)	Factors with highest predictive gain: • Planned number of radiation fractions • Planned total radiation dose • Time since most recent ED visit • Weight loss • Age	Machine learning from pretreatment EHR data and treatment data	Any ED visit or hospitalization second day of treatment to completion of treatment

[i] Daly R, Gorenshteyn D, Nicholas KJ, et al. Building a Clinically Relevant Risk Model: Predicting Risk of a Potentially Preventable Acute Care Visit for Patients Starting Antineoplastic Treatment. *JCO Clinl Cancer Inform.* 2020;4:275-289. doi:10.1200/CCI.19.00104

[ii] Brooks GA, Kansagra AJ, Rao SR, et al. A Clinician Prediction Model to Assess Risk for Chemotherapy-Related Hospitalization in Patients Initiating Palliative Chemotherapy. *JAMA Oncol*. 2015; 1(4):441-447. doi:10.1001/jamaoncol.2015.0828

[iii] Brooks GA, Uno H, Aiello Bowles EJ, et al. Hospitalization Risk During Chemotherapy for Advanced Cancer: Development and Validation of Risk Stratification Models Using Real-World Data. *JCO Clin Cancer Informatics*. 2019. DOI: 10.1200/CCI.18.00147

[iv] Grant RC, Moineddin R, Yao Z, et al. Development and Validation of a Score to Predict Acute Care Use After Initiation of Systemic Therapy for Cancer. *JAMA Network Open.* 2019;2(10):e1912823. doi:10.1001/jamanetworkopen.2019.12823

[v] Hong JC, Niedzwiecki D, Palta M, et al. Predicting Emergency Visits and Hospital Admissions During Radiation and Chemoradiation: An Internally Validated Pretreatment Machine Learning Algorithm. *JCO Clin Cancer Informatics.* 2018;2:1-11. doi:10.1200/CCI.18.00037

#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

#3 Care Management

- 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)

#4 Availability of Integrated Palliative Care

- 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

DR. ROBERT 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, 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 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**

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

- 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

DR. ROBERT BREE COLLABORATIVE