Bree Collaborative | Primary Care Workgroup
August 12th, 2020 | 11:30 a.m. – 1:00 p.m.
Held Remotely

MEMBERS PRESENT

Judy Zerzan, MD, MPH (Chair), Chief Medical Officer, Washington State Health Care Authority
Louise Kaplan, PhD, ARNP, FNP-BC, FAANP, FAAN, Associate Professor, Associate Academic Director, Washington State University Vancouver College of Nursing
Laura Kate Zaichkin, MPH, Director of Health Plan Performance and Strategy, SEIU 775 Benefits Group
Tony Butruille, MD, Chair, Primary Care Investment Task Force, Washington Academy of Family Physicians
Karen Johnson, PhD, MHSA, Director of Performance Improvement and Innovation, Washington Health Alliance
Cynthia Burdick, MD, Medical Director of Medicare and Medicaid, Kaiser Permanente Washington
Jason Fodeman, MD, Associate Medical Director, Washington State Department of Labor and Industries
Bianca Frogner, PhD, Associate Professor of Family Medicine, Director of Center for Health Workforce Studies, University of Washington School of Medicine
Patricia Auerbach, MD, MBA, Chief Medical Officer, United Health Care
Catherine Mazzawy, Senior Director, Safety and Quality, Washington State Hospital Association
Ashok Reddy, MD, MS, Assistant Professor of Medicine, University of Washington School of Medicine, Veterans Administration
Ingrid Gerbino, MD, FACP, Chief, Department of Primary Care, Virginia Mason
Bob Marsalli, Chief Executive Officer, Washington Association for Community Health

STAFF AND MEMBERS OF THE PUBLIC

Pam Crone, Legislative Consulting, American Congress of Obstetricians and Gynecologist
Sarah W. Prager, MD, MAS, Professor, Obstetrics and Gynecology Division Chief, University of Washington
Ginny Weir, MPH, Bree Collaborative
Alex Kushner, Bree Collaborative
Amy Etzel, Bree Collaborative
Jeb Shepard, Director, Policy, Washington State Medical Association
Charleen Johnson
John C. Olson, MD
Bob Crittenden, MD, Cambia Grove

BREE COLLABORATIVE OVERVIEW

Judy Zerzan, MD, MPH, Washington State Health Care Authority and Ginny Weir, MPH, Bree Collaborative welcomed members to the workgroup and those present introduced themselves.

Motion: Approval of July 8th Minutes
Outcome: Passed with unanimous support

GENERAL DISCUSSION—HCA PRIMARY CARE PLAN

Dr. Zerzan began with an update on the HCA primary care workgroups. There has been broad agreement on a plan for primary care from these two groups, and a plan was released for public comment.

- The plan outlines what primary care should do, a payment model (transformation of care fee, comprehensive primary care payment, performance incentive payment), and metrics (including transformation measures).
- The plan received many public comments. Most of the comments were about implementation.
    - Implementation details have yet to be determined—the HCA groups are aiming for agreement on a high-level model right now.
- Laura Kate Zaichkin, MPH, Director of Health Plan Performance and Strategy, SEIU 775 Benefits Group, asked how aligned the commercial payers and purchasers are with the proposed model. Dr. Zerzan answered that commercial groups were involved and around the table, although there was some question as to how important primary care is.
- There were several comments about attribution—the model says they want 90% attributed to primary care. This workgroup can help flesh out that discussion.
- Jeb Shepard, Director, Policy, Washington State Medical Association, asked for an explicit mention of the quadruple aim, including reducing administrative burden.
- John C. Olson, MD, asked what the opposition has been to having a high percentage of primary care.
    - The payers are enthusiastic, but sometimes patients do not want to utilize primary care.
    - Even among enthusiastic purchasers, there is reluctance to ask employees to name primary care doctors.
- Ms. Weir asked how other states with similar models handle attribution.
    - The group agreed that it would be worth looking at how Oregon manages this.
    - CPC+ is leaving attribution to each payer, but the learning from that seems to be that it does not work well.
        - A member added that this is an opportunity for Washington to lead the way on attribution.
- Ms. Weir asked for comments on the quality measures found in the HCA plan.
    - Concern was expressed over whether emergency room utilization is under the PCP's control.
        - Multiple members argued that good primary care does directly result in fewer emergency room visits.
    - Mr. Shepard gave feedback that WSMA has heard from physicians: it is important that PCPs be measured on things that they can control. For example, it is hard to guarantee compliance with adolescent well childhood visits.
    - Ms. Zaichkin: there is a missing experience measure relating to coordinated care or care communication.
    - Sarah W. Prager, MD, MAS, Professor, Obstetrics and Gynecology Division Chief, University of Washington expressed concern that non-OB/GYNs would not know how to adequately council patients on contraceptive care.
        - Dr. Zerzan answered that this measure does not require contraceptive care for all patients and only measures that, when contraceptives are used, they are the more effective methods.
- Dr. Zerzan spoke about next steps for the HCA plan. The groups will continue meeting every other month. There is also a memorandum of understanding that is a commitment to continued work on primary care—hoping to have a public signing at the end of September.

GENERAL DISCUSSION—ATTRIBUTION

Ms. Weir pivoted to discussion of the group's recommendations on attribution. Dr. Zerzan said that the HCP-LAN and other docs sent out were on the right track.

- Ashok Reddy, MD, MS, Assistant Professor of Medicine, University of Washington School of Medicine, Veterans Administration, reiterated that CPC+ was one of the first models to do voluntary attribution and it was very difficult for them.
- Karen Johnson, PhD, MHSA, Director of Performance Improvement and Innovation, Washington Health Alliance, elaborated on some of the difficulties of attribution:
    - Linked to both definition of primary care and implementation.
    - It is very difficult to understand how people are using different providers for different purposes using solely claims data.
    - We also never ask the patient which doctor they want, instead we try to assign based on claims data.
- Multiple members concurred that no one has yet come up with a satisfactory and tested alternative to doing attribution via claims data.
- One member offered the idea of including the patient in their PMPM payment to incent them to have a PCP.
- Ms. Zaichkin added that her group puts the PCP's name on the member's card and makes PCP visits free, as an incentive.
- Louise Kaplan, PhD, ARNP, FNP-BC, FAANP, FAAN, Associate Professor, Associate Academic Director, Washington State University Vancouver College of Nursing, said that patients who are accessing care through these plans often have instability in their lives; if a patient moves it may become impossible for them to get to their PCP.
    - If we let patients decide, patients may not have any idea how to make a good decision (or they may not have a choice depending on their community).
- Some patients also prefer utilizing emergency room care because it is easier to access—no appointment is needed.
- Dr. Prager asked about distribution of funds in the HCA's plan. Dr. Zerzan: discussion has been that PCP would oversee money distribution in conversation with specialists.
- Telehealth may change the need for urgent care by making it easier for patients to access their PCP.
- Dr. Prager voiced a concern about potential capitated care models: they can disincentivize appropriate referrals and taking care of sicker people and can lead to unpaid time on emails.
    - Dr. Zerzan clarified that the HCA model for PMPM would be risk adjusted, does not put the burden of paying for referrals onto the PCP, and does not require unpaid email time.

GENERAL DISCUSSION—OB/GYN INCLUSION

The group turned to hearing from Dr. Prager and Pam Crone, Legislative Consulting, American Congress of Obstetricians and Gynecologist.

- Dr. Prager made the case for including OBs in the group's definition of primary care: some patients do not have a primary care doctor other than their OB/GYN and OBs end up managing referrals in some way. OBs become de facto PCPs when they discover non-gynecological issues in patients.
    - However, she does not think that OBs should be routinely taking care of general issues for people who do not have a specific gynecological need on that day. She also does not want to incentivize people to go to OBs for issues in other parts of the body.
    - Dr. Kaplan added that patients come into their OB for chest pain because the OB is the only doctor that they have an ongoing relationship with at the time.
- Another member advocated for returning to the four Cs of the group's definition—OBs do not fall into these categories.

- Another important facet of primary care is population management; a lot of the work of primary care is proactive and utilizes outreach to a population that is being managed. This is not the type of care being done by OBs.

Action Item: Ms. Weir to send out recommendations as they stand to the group for feedback and edits.

GOOD OF THE ORDER

Dr. Zerzan and Ms. Weir thanked all for attending and adjourned the meeting.