# Bree Collaborative Meeting

July 28, 2021| Zoom Meeting

# Agenda

- **Welcome and Introductions**
  - Meeting Minutes
- **Presentation:** Implementation
- **Presentation:** AMDG New Topics
- **Final Adoption:** Cervical Cancer Screening
- **Topic Update:** Telehealth
- **Topic Update:** Total Knee and Total Hip Replacement
- **Topic Update:** Opioid Use and Older Adults
- **Next Steps and Close**

# May 26th Meeting Minutes

**Dr. Robert Bree Collaborative Meeting Minutes**
**May 26th, 2021 | 12:30-2:30**
**Held Virtually**

**Members Present**

Hugh Straley, MD, Bree Collaborative (Chair)
Susie Dade, MS, Patient Representative
DC Dugdale, MD, MS, University of Washington Medical Center
Gary Franklin, MD, Washington State Department of Labor and Industries
Stuart Freed, MD, Confluence Health
Richard Goss, MD, Harborview Medical Center
Norifumi Kamo, MD, MPP, Virginia Mason Franciscan Medical Center
Darcy Jaffe, MN, ARNP, NE-BC, FACHE, Washington State Hospital Association
Rick Ludwig, MD, Providence Health Accountable Care
Greg Marchand, The Boeing Company
Kimberly Moore, MD, Franciscan Health System
Drew Oliveira, MD, Regence
Mark Haugen, MD, Physician, Walla Walla Clinic
Susane Quistgaard, MD, Premera Blue Cross
Kevin Pieper, MD, MHA, Kadlec Regional Medical Center
Karen Johnson, PhD, Washington Health Alliance.
Carl Olden, MD, Pacific Crest Family Medicine
John Robinson, MD, SM, First Choice Health
Jeanne Rupert, DO, PhD, The Everett Clinic
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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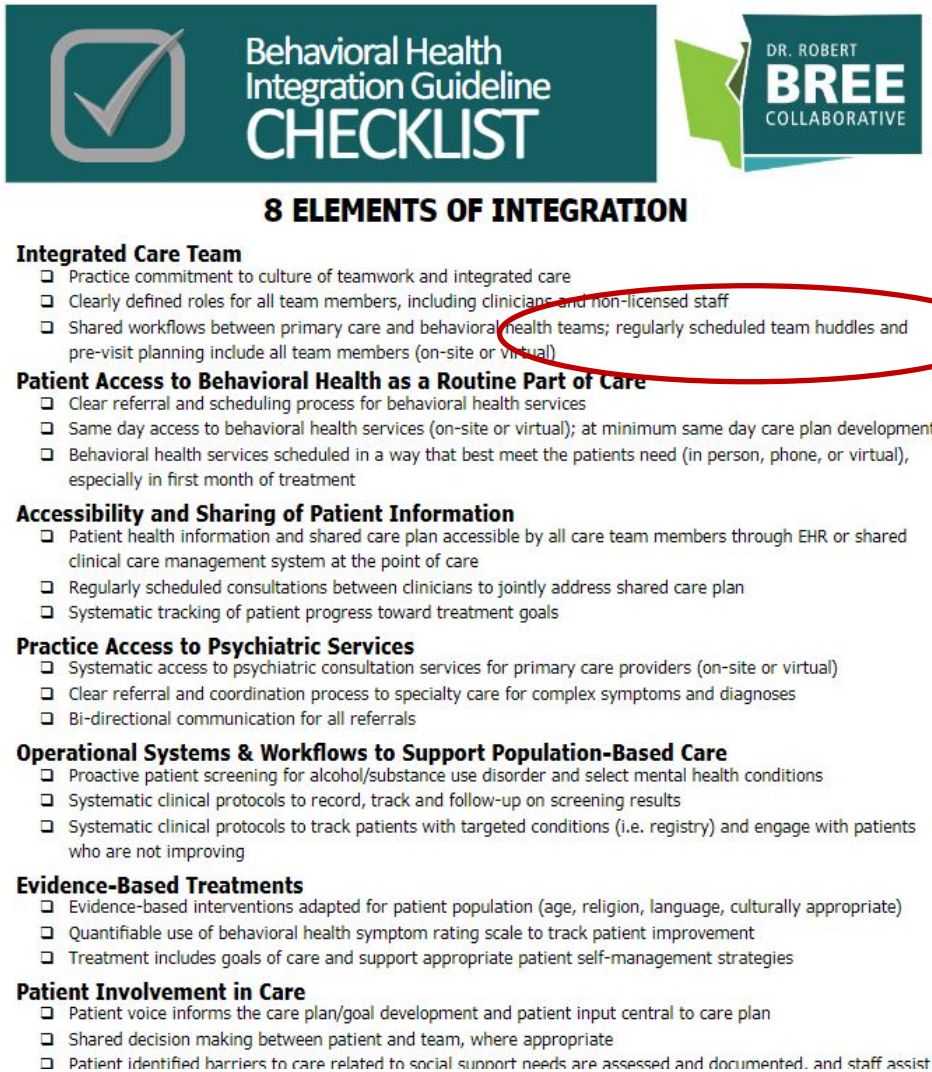
# Implementation Webinars

| Topic | Attendees |
|---|---|
| Interoperability: Removing Barriers to Value-Based Success *(April)* | 263 |
| Colorectal Cancer *(May)* | 15 |
| The Role of Policy and Practice in Supporting Health and Housing Partnerships *(June)* | 15 |
| Aligning Quality Measures: Can We Measure What matters more Efficiently? *(July)* | 472 |
| Medical Respite for People Experiencing Homelessness *(July)* | 58 |
| Supportive Housing for SUD Populations *(August)* | Registration opening Monday |
| Clinician Wellness and Suicide Prevention *(September)* | Registration opening in August |
| Implementing Aligned Payment Model *(October)* | Registration opening in August |

# 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 Care of Kent

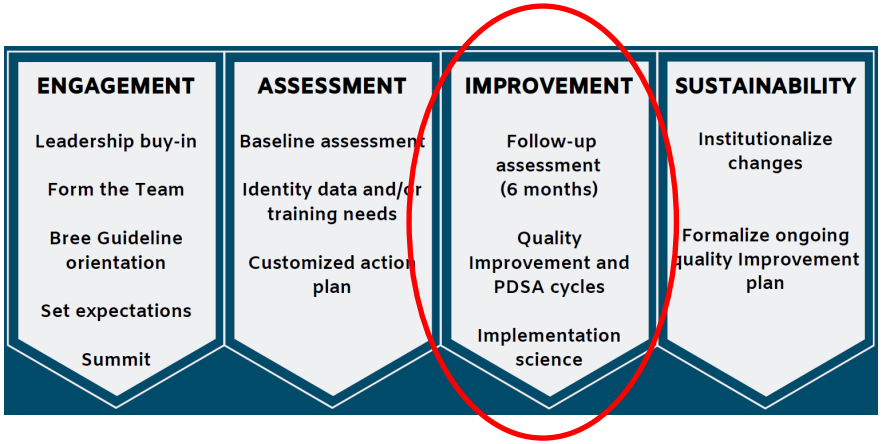
**Action Item:**
Increase frequency of team huddles to facilitate integrated care, internal behavioral health referrals and warm hand-offs.

- ✓ Increased frequency of on-site BH provider from 1 to 2x a week
- ✓ Invited BH Provider to weekly Provider meeting to increase face time, relationships, pre-visit planning
- ✓ Created small informational flyer with picture about BH provider, made available in all Provider rooms. Included in pre visit paperwork

**Result = 300% increase in referrals from Feb 2021 to June 2021**

# Pilot Group Action Plan Work

- Workflow mapping to track & improve outside referrals – PDSA starting in August
- Tracking mechanism and increased team huddles to improve internal BH referrals
- Implement depression screening (PHQ-9 and GAD-7) for all patients > 12
- Population health registries for OUD
- Collaborative Safety Planning
- Write and implement policy for provider support after patient death by suicide
- Virtual telehealth warm handoff for behavioral health process



# Ongoing and Future Implementation Efforts

- Implementation Page and Web Based Resource Library
- Online Assessments for broader community
- Presentation to WA Association for Community Health Quarterly Learning Collaborative on Behavioral Health Integration (June)
- Closing plenary presentation at NW Primary Care Association *Partners in Care Conference: Integration in Action* (August)
- Health Plan Implementation Resources
  - Denial data
- Funding

# Questions & Discussion

# AMDG New Topic Suggestions

- Healthy Weight Management Programs & Strategies
- Hep C screening and treatment
- Implementation project on low back pain
- Maybe-s:
  - Asthma
  - Co-occurring substance abuse and mental health
  - Health Equity/Breast Cancer screening
- No-s
  - Annual cardiac screening
  - Adverse Childhood Experiences (ACEs)

# Other Suggestions

- Infection Control Measures post pandemic in clinical outpatient settings. I think this would be evolving during project as I think we struggle at my clinic to decide what requirements will need to be in place as life moves forward with COVID and lack of other disease like respiratory disease. Do people always mask in office with cold symptoms? I think historically more curtesy. Do we room patients that are ill immediately? What did we learn from COVID to help us address infectious control in our offices? What more should we be doing to protect healthy patients and staff? I think we have universal measures but not even close to universal application. Hospitals and nursing homes may have better protocols than many offices but I would say the variance of this is very high depending on regulatory measures differing on level of oversight. A private clinic like mine doesn't have JACHO. OSHA yes. Just a thought.

# **Final Adoption:**
# Cervical Cancer Screening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# Thank You
## Members

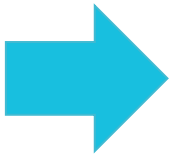
- **Chair:** Laura Kate Zaichkin, MPH, SEIU 775 Benefits Group
- Virginia Arnold, DNP ARNP, Neighborcare Health at Pike Place Market
- Diana Buist, PhD, MPH, Kaiser Permanente Washington Health Research Institute
- LuAnn Chen, MD, MHA, FAAFP, Community Health Plan of Washington
- Leslie Edwards, CNM, Nurse Midwife
- Colleen Haller, MPH, Community Health Plan of Washington
- Beth Kruse, CNM, Public Health Seattle King County
- Jordann Loehr, MD, Toppenish Medical-Dental Clinic
- Constance Mao, MD, University of Washington School of Medicine
- Michelle Sullivan, Yakima Neighborhood Health
- Sandra White, MD, Cellnetix
- Rachel Winer, PhD, University of Washington

# Review: Mapping Population Need(s)
## What problem are we trying to solve?

- Goal: Reduce mortality from cancer
  WA in top 1/3 for screening
- Population who does not come in for screening
  - Talking to people about cancer (fear of a positive, sexual trauma, obesity)
  - More at risk for death
  - Do not think they need to come in (bimodal communication based on age)
- Population who needs follow-up from screening
  - Interpretation may be difficult for PCPs
  - Lack of colposcopists
  - System-level follow-up often lacking
- Primary prevention – HPV vaccine

# Review: Building from Previous Frameworks

- Colorectal Cancer Screening
  - Tracking
  - Measurement
  - Person-centered care
  - Payment
- Reproductive and Sexual Health
  - Cultural humility
  - Access
  - Person-centered care
  - Appropriate care



- Cervical Cancer Screening
  - Tracking + measurement relevant – race and prioritized populations
  - Trauma-informed pelvic exam
  - Include HPV vaccine focus
  - Communication addressing fear + stigma

# **Public Comment**
## Through June

- Two comments:
  - Washington state should advocate to the FDA for approval of self-swab
    - No real mechanism to do this – no change made
  - More specificity around waiving cost share for screening
    - Changes made to health plans – purchasers - Legislature

# Change made

- Specify the removal of member cost sharing (note this does not apply to monitoring after a diagnosis has been made or to treatment) for:
  - All steps of cervical cancer screening including colposcopy and biopsy after an abnormal pap.
  - All steps of colorectal cancer screening including colonoscopy to evaluate an abnormal colorectal cancer screening test (i.e., sigmoidoscopy, stool, blood, imaging screening test), whether or not polypectomy or biopsy is performed; and screening colonoscopy if a polyp is identified and removed in the procedure.
  - All steps of breast cancer screening to evaluate an abnormal screening mammogram including diagnostic mammography and/or ultrasound, whether or not a breast biopsy is performed.

# Recommendation

- Vote for final adoption

# Dissemination for Public Comment: Telehealth

Shawn West, MD

# Members

- Shawn West, MD (Chair), Embright
- Christopher Cable, MD, Kaiser Permanente Washington
- Christopher Chen, MD, Health Care Authority
- Crystal Wong, MD, University of Washington Medicine
- Cara Towle, RN, MSN, University of Washington Psychiatry & Behavioral Sciences
- Darcie Johnson, MSW, CPHQ, Premera Blue Cross
- David Tauben, MD, FACP, University of Washington Medicine
- Janna Wilson, King County Public Health
- Jeb Shepard, Washington State Medical Association
- Jennifer Polello MHPA, MCHES, PCMH-CCE, Community Health Plan of Washington
- Laura Groshong, LICSW, Private Practice Psychotherapist
- Lindsay Mas, SEIU 775 Benefits Group
- Lydia Bartholomew, MD, Aetna
- Mandy Weeks-Green, Washington Office of the Insurance Commissioner
- Omar Daoud, PharmD, Community Health Plan of Washington
- Stephanie Shushan, MPH, Community Health Plan of Washington
- Sarah Levy, MD, Kaiser Permanente Washington
- Todd Wise, MD, MBA, Providence
- Wendy Brzezny, North Central Accountable Community of Health

# Summary: HB 1196

- Audio-only telehealth
- Services must be provided by a provider with whom the patient has an established relationship
- Services must be covered, medically necessary, and/or essential health benefits under the ACA
- *Services must be determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards*

# Appropriateness

- Exercise clinical judgment in determining whether telehealth services are appropriate for a given service, a given person, and a given situation.
- Adopt criteria below to determine appropriateness of telehealth service(s):
  - Visit does not detract from longitudinal relationship.
  - No need for a physical examination or assessment can be made virtually and/or information to be gathered is anticipated to be patient-reported.
  - No anticipation for aggressive intervention(s).
  - Condition(s) not at risk for acute complication(s).
  - Patient has consented to receive telehealth.
  - Patient has audio-only or audiovisual capabilities.
  - Privacy can be ensured during visit.

# Appropriateness

- For new patients, comprehensively triage/screen to ensure patient should not be offered in-person prior to telehealth.
- Episodic, direct-to-patient telemedicine services used only as an intermittent alternative to usual source of care to meet immediate acute care needs.

Ensure equitable access to telehealth services such as not restricting telehealth to those who have home-based video capabilities, or if labs are required.

# Person-Centered Interaction(s)

- Prior to the telehealth visit, ensure the provider and/or care team understands the patient's expectations and the person understands the capabilities of the system.
- Ensure patient consents to having a virtual visit and the protocol if the visual component of audio-visual fails.
- If during the course of a telehealth visit, the provider determines that an in-person visit is needed, clearly document steps taken to provide in-person visit.
- All staff who interact with the person are clearly identified.
- Staff are professional, interacting with the person in private areas and in professional dress.
- Information is integrated into the health record.
- Person's usual source of care is identified and information is sent and/or care is coordinated

# Measurement and Follow-up

- Modernize data infrastructure to differentiate in-person, audio-visual, and audio-only services
- Report on standardized quality and safety measures including:
  - Downstream healthcare utilization.
  - Patient-reported outcome(s).
  - Patient satisfaction.
- Stratify metrics by race/ethnicity, sex, age categories (i.e., <18, 19-45, 45-64, 65-74, >75) to identify disparities in outcomes and utilization

# How to define appropriateness

- Services that are appropriate
  - Define clearly inappropriate
  - Define clearly appropriate
  - Move to middle
- For which patients is this appropriate?
  - Align with patient preference
  - Broadband
  - Attention to equity and quality

# Recommendation

Approve for Dissemination for Public Comment

# **Topic Update:** Total Joint Replacement Bundle

Revised July 23, 2021

DR. ROBERT BREE COLLABORATIVE

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# Workgroup Members

| Name | Title | Organization |
|---|---|---|
| Bob Mecklenburg, MD (Chair) | Retired | Virginia Mason Medical Center |
| Matt Albright | Regional Director of Orthopedics & Sports Medicine | Providence St. Joseph Health |
| Kevin Fleming, MBA | Chief Operating Officer | |
| Michael Griffin | Associate Vice President | |
| Lydia Bartholomew, MD, MHA, FAAPL, FAAFP, CHIE | CMO Clinical Health Services West and Southcentral | Aetna |
| LuAnn Chen, MD, MHA | Senior Medical Director | Community Health Plan of Washington |
| Michael Chen | Senior Program Consultant | Premera Blue Cross |
| Andrew Friedman, MD | Physical Medicine & Rehabilitation Specialist | Virginia Mason Medical Center |
| Kevin Macdonald, MD | Orthopedic surgeon | |
| Paul Manner, MD | Orthopedic surgeon | University of Washington |
| Cat Mazzawy, RN | Senior Director, Safety and Quality | Washington State Hospital Association |
| Linda Radach | Patient Advocate | |
| Tom Stoll, MD | Chief, Orthopedic Surgery | Kaiser Permanente Washington |
| Emily Transue, MD, MHA | Associate Medical Director | Health Care Authority |

# Process

- ✓Members recruited
- ✓Charter Approved
- ✓Review Cycle I: February and March
- ✓Review Cycle II: March
- ✓Review Cycle III – April
- ✓Review Cycle IV – May
- ✓Review Metrics, Quality Standards, and Warranty – June/July
- ✓Other changes – August/September

- **Present draft – September**
- Public Comment
- Final Adoption – November

# Bundle Overview

- Specifies a quality standard for production, purchasing and payment
- Facilitates direct contracting between employer and provider
- Current implementation by employers, providers, and health plans
- Published outcomes: high quality and satisfaction with lower cost

# Bundle Architecture

**Clinical standards**

- Appropriateness
- Fitness for surgery
- Best practice surgery
- Return to function

**Administrative standards**

- Reporting standards for quality as specified by employers
- Warranty against avoidable readmissions

# Changes to date to 2017 edition of bundle

**Current edition supported by 192 appraised citations of which 67 are new**

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Clinical Standards

1. Appropriateness: no substantive change
2. Fitness for surgery
   - Increased evidence-based specificity of pre-op testing per National Institute for Clinical Excellence
   - Screening for propensity for nausea/vomiting and constipation
   - Consider testing for serum albumin and/or CPK

# Changes to date to 2017 edition of bundle

**Current edition supported by 192 appraised citations of which 67 are new**

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Clinical Standards

3. Safe surgery
   - COVID-19: All medical, administrative, support staff, volunteers, and patients should be vaccinated for circulating illness or wear a mask on campus per CDC guidelines.
   - IMPLANTS: On a semiannual basis, provider groups will require contracted implant manufacturers to provide data from a national registry and their internal records concerning device failure and complications reported for patients receiving implants sold to the provider group.
   - On a semiannual basis, the provider/hospital/facility will evaluate component retention/failure and compare them to the national industry retention/failure rates. Any components that have a greater than 3% deviation from national average must be investigated prior to any further usage.
   - Facilities must report level I data to the American Joint Replacement Registry.
4. Return to Function: No substantive change

# Changes to date to 2017 edition of bundle

**Current edition supported by 192 appraised citations of which 67 are new**


Metrics and Warranty

- Reporting Standards for Quality: No substantive changes
- Warranty
  - Citations reconciled to updated CMS standards. Warranty for wound infection moved from 30 days to 90 days per CMS guidelines.

Next Session: Same Day Surgery

# Action Steps

Comments, critique, counterpoint

# **Topic Update:** Opioid Prescribing for Older Adults

DR. ROBERT BREE COLLABORATIVE

July 28, 2021|Zoom Meeting

# Workgroup Members

- Gary Franklin, MD, MPH (Co-chair), Washington State Department of Labor and Industries
- Darcy Jaffe, MN, ARNP, NE-BC, FACHE (Co-chair), Washington State Hospital Association
- Mark Sullivan, MD, PhD (Co-chair), University of Washington
- Judy Zerzan-Thul, MD, MPH (Co-chair), Washington State Health Care Authority
- Carla Ainsworth, MD, MPH, Iora Primary Care - Central District
- Denise Boudreau, PhD, RPh, MS, Kaiser Permanente Washington Health Research Institute
- Siobhan Brown, MPH, CPH, CHES, Community Health Plan of Washington
- Rose Bingham, Patient Advocate
- Pam Davies, MS, ARNP, FAANP, University of Washington / Seattle Pacific University
- Elizabeth Eckstrom, MD, Oregon Health Sciences University
- James Floyd, MD, University of Washington School of Medicine
- Nancy Fisher, MD, Ex Officio
- Jason Fodeman, MD, Washington State Department of Labor and Industries
- Debra Gordon, RN, DNP, FAAN, University of Washington School of Medicine
- Shelly Gray, PharmD, University of Washington
- Clarissa Hsu, PhD, Kaiser Permanente Washington Research Institute
- Michael Parchman, MD, Kaiser Permanente Washington Research Institute
- Jaymie Mai, PharmD, Washington State Department of Labor and Industries
- Wayne McCormick, MD, University of Washington
- Kushang Patel, MD, University of Washington
- Elizabeth Phelan, MD, University of Washington
- Yusuf Rashid, RPh, Community Health Plan of Washington
- Dawn Shuford-Pavlich, Department of Social and Health Services
- Steven Stanos, DO, Swedish
- Angela Sparks, MD, Kaiser Permanente Washington
- Gina Wolf, DC , Wolf Chiropractic Clinic

# Timeline

- ✓ January: Charter and scope defined
- ✓ March: Acute prescribing I
- ✓ April: Acute prescribing II
- ✓ May: Co-prescribing with opioids
- ✓ June: Non-pharmacologic pain management I
- ✓ July: Non-pharmacologic pain management II & Co-prescribing with opioids review
- August: Non-pharmacologic pain management & Patient-centered comments
- Sep: Tapering and de-prescribing

# Mapping Focus Areas to Objectives

- ✓ **Acute prescribing**
- ✓ **Co-prescribing with opioids**
- ✓ **Non-opioid pharmacologic pain management**
- ✓ **Non-pharmacologic pain management**

- **Types of opioid therapy**
- **Tapering and de-prescribing**

- ✓ Prevent transition to chronic prescribing
- ✓ Reduce impact on cognition, falls, delirium
- ✓ Outline/compare risks and benefits
- ✓ Outline/compare risks and benefits

- Reduce use of long-acting opioids and chronic opioid therapy
- Differentiators with recent Bree recommendations for legacy patients

# Brief Evidence Summary

- Little high-grade evidence on transition to chronic opioid use specific to advancing age by decade of life.
- Approaches to reduce transition include mobile phone therapies, motivational interviewing, transitional pain service, de-prescribing algorithms, education, state rules & reimbursement policies

# Draft Recommendations

- Perform a risk assessment for severe acute pain and adverse effects of opioids prior to prescribing as outlined in 2018 BREE guidelines and 2015 AMDG perioperative supplement.
- Establish realistic goals and expectations including plans to reduce and discontinue opioid therapy. Use shared decision-making to set goals to maximize quality of life, minimize risk of adverse events, side effects and persistent opioid use.
- Optimize pain care by involving the patient and family or caregiver in discussing and agreeing on a pain management plan BEFORE any elective procedures
- Discharge planning and transition coordination – provider who "owns" care trajectory (list of who can do this e.g., PCMH, clinical pharmacist)
  All care transitions for older adults who are on opioids should include a clear plan for insuring that patient benefit is greater than harm and specifically name who is responsible for that activity."
- While multi-modal approaches are important, avoid complicated regimens. Take into consideration other medications the patient is taking such as sedatives, muscle relaxers, antihistamines, anticholinergics.
- When used, opioid should be used at the lowest dose and for the briefest duration.

# Draft Recommendations

- Start at 25%-50% of what would be initiated in a younger adult and extend the dosing intervals.
- Avoid using long-acting opioids for acute pain (methadone, levorphanol, fentanyl patch or opioid delivered by extended-release forms).
- Maintain a high vigilance for exaggerated side effects including respiratory depression, constipation with need for bowel prophylaxis, delirium and psychomotor effects leading to falls
- Track opioid use and signs of potential misuse including the development of opioid use disorder during acute recovery and related functional status with outcome measures such as mood, mobility, ADLs, sleep, appetite, cognitive impairment, weight changes.
- Optimize pain care by involving the patient and family or caregiver in the discharge and provide clear oral and readable written instructions on:
  - The risks, safe use, and storage of opioids and proper disposal of controlled substances through Safe Medication Return Program.
  - Which provider will be responsible for managing acute and/or postoperative pain, including who will be prescribing any opioids.
  - Planned taper of postoperative opioids, including a timeline for return to preoperative or lower opioid dosing for those on chronic opioids.
- Perform medication review and reconciliation at follow up visits to ensure the patient is not continuing medication that s/he no longer needs.

# Non-Pharmacologic Discussion

- Reviewed evidence on opioid prescribing for tai chi, mindfulness, yoga, aerobic exercise, and strength training,
- Common limitations: limited evidence specific to older adults, difficult to maintain non-pharmacologic interventions, access issues
- Older adults require multiple modalities to manage chro

# Bree Collaborative Meeting

September 22, 2021

12:30 – 2:30pm

DR. ROBERT BREE COLLABORATIVE