Bree Collaborative Meeting

September 22nd, 2021| Zoom Meeting

Agenda

- **Welcome and Introductions**
  - Adopt Meeting Minutes
- **Final Adoption:** Telehealth
  - Adopt Recommendations
- **Dissemination for Public Comment:** Total Joint Replacement Bundle
  - Approve for Public Comment
- **Discussion:** New topics for 2022
  - Select 4 Topics
- **Next Steps and Close**

July 28th Meeting Minutes

Dr. Robert Bree Collaborative Meeting Minutes
July 28th, 2021 | 12:30-2:30
Held Virtually

Members Present

Gary Franklin, MD, Washington State Department of Labor and Industries
Norifumi Kamo, MD, MPP, Virginia Mason Franciscan Medical Center
Darcy Jaffe, MN, ARNP, NE-BC, FACHE, Washington State Hospital Association
Drew Oliveira, MD, Regence
Mary Kay O'Neill, MD, MBA, Mercer
Susane Quistgaard, MD, Premera Blue Cross
John Robinson, MD, SM, First Choice Health
Jeanne Rupert, DO, PhD, The Everett Clinic
Shawn West, MD, Embright
Laura Kate Zaichkin, MPH, SEIU 775 Benefits Group
Judy Zerzan, MD, MPH, Washington State Health Care Authority
DC Dugdale, MD, MS, University of Washington Care Medical Center
Rick Ludwig, MD, Providence Health

Final Adoption: Telehealth

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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
- 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

Public Comments and Changes

- Language on why no specific yes/no list of telehealth services
  - Included Oregon Leadership Council's Telehealth Service Recommendations as supplemental resource
  - Added language for patients on expectations of appropriate telehealth services
- Scope
  - Did not include behavioral health recommendations
- Cultural awareness
  - Added language around cultural awareness lens
- Patient – centered interactions
  - Added language so as not to persuade patient toward telehealth
  - Reinforcing language around mutual consent
  - Reinforcing language in the case of no PCP
- Legal barriers
  - Additional issues beyond confidentially to include considerations for subscribing and licensure across states; added Center for Connected Health Policies resource for tracking WA specific regulatory changes

Appropriateness

- Exercise clinical judgment in determining whether telehealth services are appropriate for a given service, a given person, and a given situation.
- Clear criteria below to determine appropriateness of telehealth service(s):
  - Visit does not detract from longitudinal relationship patient has with usual source of care.
  - No need for a hands-on physical examination (i.e., assessment can be made visually or auditorily, information gathered is anticipated to be largely verbally reported but may include information gathered through physical observation of the patient). Outcome or evaluation would not be changed by physical exam or other information collected in person.
  - No anticipation of a needed procedure or urgent intervention(s).
  - Condition(s) not at risk for acute complication(s).
  - Patient fully understands risks, benefits, and safety of telehealth visit.
  - Patient wants telehealth visit.
  - Patient has audiovisual or at least audio-only capabilities.
  - Privacy can be ensured during visit to the patient's satisfaction.
  - Anticipated interventions can be addressed within the visit, at the discretion of the provider.

Appropriateness

- For new patients, follow the same procedures for gathering patient chief complaints as for in-person visits. Emergency medical conditions or chief complaints representing the risk of an emergency medical situation, should not be scheduled into visits either in person or virtually.

- Episodic, direct-to-patient telemedicine services used only as an intermittent alternative to usual source of care to meet immediate acute care needs and is evidence-informed (e.g., not overprescribing).

- Equitable access such as not restricting a telehealth appointment based on the person having video capabilities, their age, language proficiency, or if a component of information to be gathered (e.g., labs) are required to be done outside of the person's home.

- For patients with limited English proficiency, utilize interpreter services.

- Plan in place in case patient needs in person care through a warm handoff.

Person-Centered Interaction(s)

- Provider/care team understands patient's expectations; patient understands capabilities of care provided via telehealth.
- Provider/care team uses a cultural awareness lens when discussing options with patient.
- Clearly communicated contingency plan in the case of technology failure or urgent need.
- Patient can opt-into a face-to-face visit.
- All staff who interact with the person and their credentials are clearly identified.
- Staff are professional, interacting with the person in private areas and in professional dress.
- Patient's usual source of in-person care is identified or noted if no usual source of care exists.
- Information from telehealth visit is integrated into medical record immediately following the telemedicine encounter; or provided to patient if not an established patient.
- Provider/care team have defined process to coordinate transfer to appropriate level of care if medical needs cannot be fulfilled via telemedicine visit.

Measurement and Follow-up

- Data infrastructure differentiates in-person, audio-visual, and audio-only.
- Standardized quality and safety measures are routinely monitored through:
  - Downstream healthcare utilization.
  - Evidence based care.
  - Patient-reported outcome(s).
  - Patient satisfaction.
- Metrics are stratified to identify disparities in outcomes and utilization by:
  - Race/ethnicity
  - Language
  - Sex
  - Age categories (i.e., <18, 18-44, 45-64, 65-74, >74 [or 75 or older])
  - Insurance status

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

Action Step

Vote on Final Adoption

Dissemination for Public Comment: Total Joint Replacement Bundle

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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
- ✓Same-Day Surgery – 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
  - For employer: a procurement model
    - Use of an RFP selects best providers and eliminates variability of “networks”
    - Standard product with fixed pricing and warranty controls cost
  - For provider: explicit clinical content precludes need for preauthorization
  - For patient: quality standards mean reliable outcomes at lower cost
- 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

Five Substantive Changes to 2017 edition

1. Personal Care Partner

If infectious disease precautions prevent direct participation of care partner, include them in an alternative such as a telemedicine visit.

2. Social determinants of health

Screen for housing instability, food insecurity, and transportation needs.

3. 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.

4. Surgical 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 the implants sold to the provider group. Any components that have a greater than 3% deviation from national average must be investigated prior to any further usage.

Five Substantive Changes to 2017 edition

5. Same-day discharge

Same-day discharge is discharge within 24 hours of surgery.

With proper patient selection and support, same-day discharge following joint replacement has become an option. When appropriate, providers should allow and facilitate same-day discharge. Specific standards for planning same-day discharge include:

a. Providers have managed risk factors listed in section on Fitness for Surgery,

b. Patient has agreed to same-day discharge through the Shared Decision-Making Process,

c. Patient has engaged a capable personal care partner who has met Bree requirements and who will be on-site with the patient the night following discharge, and

d. Patient will be discharged to a home environment that is both safe and provides adequate support including assistive devices.

Five Substantive Changes to 2017 edition

5. Same-day discharge, continued

The decision regarding timing of discharge resides with the clinical team and the patient.
The patient and care team have the option of modifying the timing of discharge based on the patient's clinical course and preferences.

Reimbursement for same-day surgery may be subject to contracted terms which acknowledge the lower costs of medical resources associated with a reduced length of stay.

Action Step

Approve for dissemination for public comment

Discussion:
Topics for 2022

Source: @petesouza, the Obama White House, https://www.instagram.com/p/BRCdveTlWQ3/?hl=en

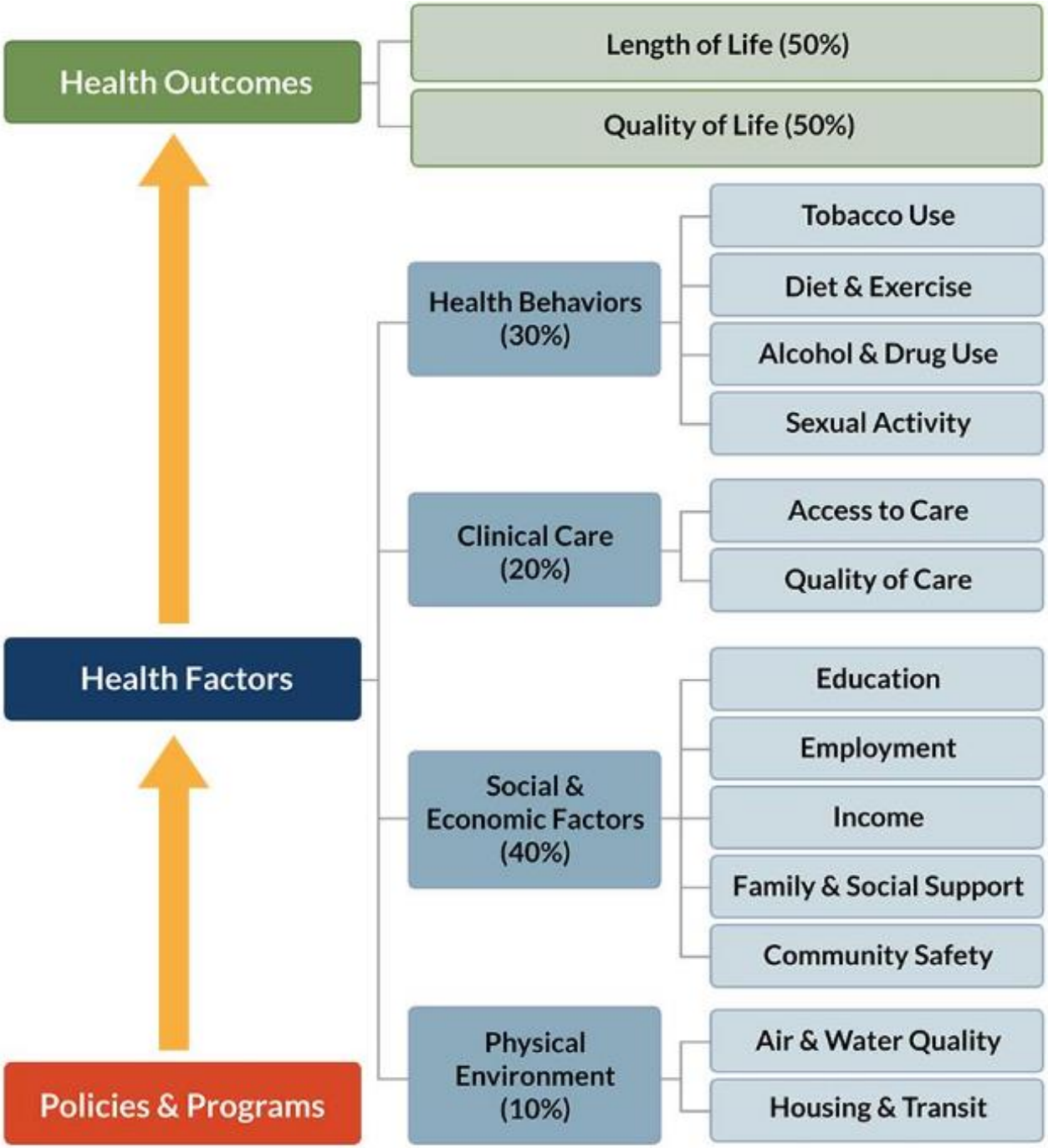
Table. Number of Deaths for Leading Causes of Death, US, 2015-2020[a]

Cause of death	No. of deaths by year					
	2015	2016	2017	2018	2019	2020
Total deaths	2 712 630	2 744 248	2 813 503	2 839 205	2 854 838	3 358 814
Heart disease	633 842	635 260	647 457	655 381	659 041	690 882
Cancer	595 930	598 038	599 108	599 274	599 601	598 932
COVID-19[b]						345 323
Unintentional injuries	146 571	161 374	169 936	167 127	173 040	192 176
Stroke	140 323	142 142	146 383	147 810	150 005	159 050
Chronic lower respiratory diseases	155 041	154 596	160 201	159 486	156 979	151 637
Alzheimer disease	110 561	116 103	121 404	122 019	121 499	133 382
Diabetes	79 535	80 058	83 564	84 946	87 647	101 106
Influenza and pneumonia	57 062	51 537	55 672	59 120	49 783	53 495
Kidney disease	49 959	50 046	50 633	51 386	51 565	52 260
Suicide	44 193	44 965	47 173	48 344	47 511	44 834

[a] Leading causes are classified according to underlying cause and presented according to the number of deaths among US residents. For more information, see the article by Heron.[4] Source: National Center for Health Statistics. National Vital Statistics System: mortality statistics (http://www.cdc.gov/nchs/deaths.htm). Data for 2015-2019 are final; data for 2020 are provisional.

[b] Deaths with confirmed or presumed COVID-19, coded to *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* code U07.1 as the underlying cause of death.

Ahmad FB, Anderson RN. The Leading Causes of Death in the US for 2020. JAMA. 2021 May 11;325(18):1829-1830.



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


We Can Do Better!

Our Framework

- Must have AT LEAST one of:
  - Population Impacted
  - Variation
  - Patient Safety
  - Cost
  - Equity
- Must have: Proven Impact Strategy
- Must have: Data Available

Our Past Guidelines

- **Pain (chronic and acute)**
  - *Collaborative care for chronic pain (2018)*
  - *Low back pain management (2013)*
  - *Opioid prescribing metrics (2017)*
  - *Opioid prescribing for postoperative pain (2018)*
  - *Opioid prescribing in dentistry (2017)*
  - *Long-term opioid prescribing management (2019)*
  - *Opioid Prescribing in older adults (2021)*
- **Behavioral Health**
  - *Integrating behavioral health into primary care (2016)*
  - *Addiction and substance use disorder screening and intervention (2014)*
  - *Suicide care (2018)*
  - *Treatment for opioid use disorder (2016)*
  - *Prescribing antipsychotics to children and adolescents (2016)*
  - *Risk of Violence to Others (2019)*
- **Oncology**
  - *Oncology care: breast and prostate (2015)*
  - *Prostate cancer screening (2015)*
  - *Oncology care: inpatient service use (2020)*
  - *Colorectal cancer screening (2020)*
  - *Cervical cancer screening (2021)*
- **Procedural (surgical)**
  - *Bundled payment models and warranties:*
  - *Total knee and total hip replacement (2013, re-review 2017, rereview 2021)*
  - *Lumbar fusion (2014, re-review 2018)*
  - *Coronary artery bypass surgery (2015)*
  - *Bariatric surgery (2016)*
  - *Hysterectomy (2017)*
  - *Data collection on appropriate cardiac surgery (2013)*
  - *Spine SCOAP (2013)*
- **Reproductive Health**
  - *Obstetric care (2012)*
  - *Maternity bundle (2019)*
  - *Reproductive and sexual health (2020)*
- **Aging**
  - *Advance care planning for the end-of-life (2014)*
  - *Alzheimer's disease and other dementias (2017)*
- **Palliative care (2019)**
- **Hospital readmissions (2014)**
- **LGBTQ health care (2018)**
- **Shared decision making (2019)**
- **Primary care (2020)**
- **Telehealth (2021)**


BREAK

Suggestions from May and July Meetings

- Healthy weight management programs and strategies
- Hepatitis C screening and treatment
- Implementation project on low back pain
- Pediatric asthma
- Co-occurring substance abuse and mental health
- Breast cancer screening equity
- Annual cardiac screening
- Health equity -institutional and individual bias (racism) (im/explicit)
- Conditions whose management would be aided by screening for Adverse Childhood Experiences (ACEs)
- Mark Haugen: Infection control measures
- Angie Sparks: Injectables to treat overuse injuries + osteoarthritis (e.g., platelet-rich-plasma, Synvisc, stem cell injections)


Activities
Visual settings
Edit
When poll is active, respond at PollEv.com/fhcq900
Text FHCQ900 to 22333 once to join
Preliminary vote: Topics for 2021 (Vote for 4)
ACEs
Annual Cardiac Screening
Asthma
Breast Cancer Screening
Co-Occurring Mental Health and Substance Use Disorder
Equity + Bias
Hep C
Infection Control
Injectables
Low Back Pain
Weight Management

AMDG New Topic Ranking

- Yes-es
  - 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)

Health Technology Clinical Committee
Findings and Decision

Injectables to treat overuse injuries + osteoarthritis

Topic: Stem cell therapy for musculoskeletal conditions
Meeting Date: June 12, 2020
Final Adoption: July 10, 2020

Meeting materials and transcript are available on the HTA website.

Number and coverage topic:

20200612A – Stem cell therapy for musculoskeletal conditions

HTCC coverage determination:

Stem cell therapy for musculoskeletal conditions is **not a covered benefit**.

Annual cardiac screening

Currently under review

Title	Phase	HTCC review
Noninvasive cardiac imaging	Draft report	November 5, 2021
Use of cardiac magnetic resonance angiography in adults and children	Draft report	November 19, 2021
Acupuncture for chronic migraine and chronic tension-type headaches	Draft key questions	March 18, 2022

Outpatient Infectious Control Measures

- Covid-19 highlighted importance of infectious control measures (masking, eye protection, hand sanitizer, separation of sick from well, rapid testing of staff, require more vaccinations to work in healthcare, etc.) to reduce viral + bacterial exposure
  - Outpatient clinics have varying approaches with varying regulation
  - Measures appear to have reduced RSV, acute bronchitis, common cold, flu cases in 2020 (coupled with school closing and viral competition)
  - Complacency will likely lead to spread, unwanted hospitalization, death in vulnerable populations
  - Concern for when indoor masking mandates and less consciousness arrives old habits will prevail and unwarranted illness will come back
- Proposal: Bree develop standardized Infectious Control Measures that can be followed in the outpatient setting. For example, if a
  - Ex: patient presents with a cough or runny nose our office setting required to mask, roomed immediately, have rapid tests available (viral panel, Covid, flu, etc.), in order to limit exposure to our patients
  - Larger systems (esp. on west side of WA) easier to place into policy
  - Smaller practices in rural areas with less patient compliance to these measures a consensus or standard could be helpful.

Our Framework

- Must have AT LEAST one of:
  - Population Impacted
  - Variation
  - Patient Safety
  - Cost
  - Equity
- Must have: Proven Impact Strategy
- Must have: Data Available


Break Time

Activities

Visual settings

Edit

When poll is active, respond at **PollEv.com/fhcq900**

Text **FHCQ900** to **22333** once to join

Final Vote

A

B

C

D

None of the above

Bree Collaborative Meeting

November 17th, 2021

12:30 – 2:30pm

DR. ROBERT BREE COLLABORATIVE