

Bree Collaborative

New Topics Discussion 2014

Contents

1. Coronary Artery Disease Bundle..... 1

2. Prostate Specific Antigen Screening Testing..... 4

3. Opioids 6

4. Oncology 7

1. Coronary Artery Disease Bundle

Champion: Bob Mecklenburg

“Coronary artery disease (CAD) is the most common type of heart disease. CAD happens when the arteries that supply blood to heart muscle become hardened and narrowed... due to the buildup of cholesterol and other material, called plaque, on their inner walls.¹ In 2010, the prevalence of CHD was greatest among persons aged ≥65 years (19.8%) and among men (7.8%).”²

A high-prevalence, high cost treatment of coronary artery disease is coronary artery bypass surgery (CABG). CABG is characterized by: 1) variation in utilization not clearly related to need, 2) variation in price, and 3) variation in complication rates among health care providers.

In summary, the prevalence of CABG, its aggregate cost and its avoidable complication rates have made this surgical procedure a priority for public and private sectors as well as the broader community. Bree knows how to use warranties and bundled payments to improve appropriateness, safety and affordability by facilitating market based health care reform. We now have the opportunity to apply our model to CABG surgery.

Category	Description	Rating 1=low; 5=high
Variation in practice patterns/ High utilization - Waste and inefficiency	<ul style="list-style-type: none"> • Data from the Dartmouth Atlas shows variation in geographic frequency of CABG unexplained by need. A report from the Washington State Hospital Association indicates the price of CABG varies nearly three-fold among Seattle hospitals and exceeds \$250,000 for one prominent institution. • Most important, complication rates vary widely. A study published by the University of Michigan in 2014 demonstrated an 18.2 % variation in healthcare acquired infections across 33 medical centers in that state. These infections included sepsis, pneumonia and wound infection. • In addition, the 2013 report of the California Coronary Artery Bypass Graft Outcomes Reporting Program showed a variation of in hospital mortality ranging from 0% to 33% after adjusting for preoperative health, a 30-day readmission rate ranging from 0% to 30%, a postoperative stroke rate ranging from 0% to 6.29% across hospitals, and a surgeon-associated operative mortality ranging from 0% to 17%. 	

¹ US National Library of Medicine. Coronary Artery Disease. Available: <http://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html>

² Centers for Disease Control and Prevention. Prevalence of Coronary Heart Disease. October 14, 2011. Available: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6040a1.htm>

Bree Collaborative New Topic Selection

Patient Safety/Poor Health Outcomes	CAD is the leading cause of death in the United States in both men and women and claims more lives each year than the next four leading causes of death combined—cancer, chronic lower respiratory diseases, accidents, and diabetes mellitus. ^{17,3}	
Cost (Direct & Indirect)	The direct and indirect cost of coronary artery disease exceeds \$108B per year and claims more lives each year than cancer, chronic lung disease, accidents and diabetes combined. ²⁰	
Proven means/strategies to address topic*	Bundled payment models offer a path toward improvement in quality and affordability. Such models, pioneered by Geisinger Health Systems, achieved a 10% reduction in hospital readmissions, shorter length of stay and reduced hospital charges. The experience of CMS with a bundled payment model for CABG, initiated in 2013, saved \$42.3B in demonstration hospitals. ⁴	
Data is Available	Data on utilization available through COAP.	
Bree Uniquely Positioned for Impact	No other groups developing publically-accessible bundled payment models.	
Shared-Decision Making Available	The Washington Health Care Authority identifies CABG as a priority for Shared Decision Making. Yes, many are available: Mayo Clinic: http://www.mayoclinic.org/diseases-conditions/coronary-artery-disease/expert-answers/coronary-artery-disease/FAQ-20058302?p=1	
Health Technology Assessment Topic	Cardiac Nuclear Imaging: http://www.hca.wa.gov/hta/Pages/nuclear.aspx Carotid Artery Stenting: http://www.hca.wa.gov/hta/Pages/cas.aspx Cardiac Stent: http://www.hca.wa.gov/hta/Pages/stent.aspx	
Choosing Wisely Available	CABG is a focus of several recommendations by Choosing Wisely. Society of Cardiovascular Computed Tomography. Available: http://www.choosingwisely.org/doctor-patient-lists/society-of-cardiovascular-computed-tomography/ . Society for Cardiovascular Magnetic Resonance. Available: http://www.choosingwisely.org/doctor-patient-lists/society-for-cardiovascular-magnetic-resonance/ . Heart imaging tests before surgery: When you need them—and when you don't.	

³ Cleveland Clinic Center for Continuing Education. Coronary Artery Disease. Available: www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/cardiology/coronary-artery-disease/.

⁴ Delbanco S. The Payment Reform Landscape: Bundled Payment. Health Affairs Blog. July 2, 2014. Available: <http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment/>

⁴ US National Library of Medicine. Coronary Artery Disease. Available: <http://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html>

⁴ Centers for Disease Control and Prevention. Prevalence of Coronary Heart Disease. October 14, 2011. Available: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6040a1.htm>

⁴ Maddox TM, Chan PS, Spertus JA, Tang F, Jones P, Ho PM, Bradley SM, Tsai TT, Bhatt DL, Peterson PN. Variations in coronary artery disease secondary prevention prescriptions among outpatient cardiology practices: insights from the NCDR (National Cardiovascular Data Registry). J Am Coll Cardiol. 2014 Feb 18;63(6):539-46.

⁴ Cleveland Clinic Center for Continuing Education. Coronary Artery Disease. Available: www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/cardiology/coronary-artery-disease/.

⁴ Delbanco S. The Payment Reform Landscape: Bundled Payment. Health Affairs Blog. July 2, 2014. Available: <http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment/>

Bree Collaborative New Topic Selection

	Available: http://consumerhealthchoices.org/wp-content/uploads/2013/02/ChoosingWiselyImagingBeforeSurgeryACC.pdf	
Implement-ability	The warranty and four cycle bundled payment model, previously endorsed by the Bree Collaborative for total joint replacement, has won active support by providers, purchasers, health plans and quality organizations in addition to non-profit organizations and patient activists. This model has recently been brought to market.	

2. Prostate Specific Antigen Screening Testing

Champion: Leah Hole-Marshall

The USPSTF recommends against PSA-based screening for prostate cancer. Grade: D Recommendation.

- Based on this work, the Task Force concludes that many men are harmed as a result of prostate cancer screening and few, if any, benefit. A better test and better treatment options are needed. Until these are available, the USPSTF has recommended against screening for prostate cancer.

The American Academy of Family Practice (AAFP), American Urological Association (AUA), and American Society of Clinical Oncology (ASCO) as well as other organizations, also have recommendations about PSA screening that largely line up with USPSTF or recommend caution.

To date, **at least 29 states, including Washington State**, have enacted laws requiring insurers to include coverage for PSA testing. Washington State:

- Requires State employees to have coverage.
- Requires state's basic health plan to include coverage.
- Requires disability insurance to include coverage.
- Requires health service contracts to include coverage.

Category	Description
Variation in practice patterns/ High utilization -Waste and inefficiency	A 2010 study of 11,892 men with localized prostate cancer treated at 36 different clinical sites concluded that “Substantial variation exists in management of localized prostate cancer that is not explained by measurable factors... data suggest both overtreatment of low-risk disease and under-treatment of high-risk disease” ⁵ State agencies recommend PSA testing topic for Bree review and recommendation.
Patient Safety/Poor Health Outcomes	For every 1,000 men who are screened with the PSA test: ⁶ <ul style="list-style-type: none"> • 30 to 40 men will develop erectile dysfunction or urinary incontinence due to treatment • 2 men will experience a serious cardiovascular event, such as a heart attack, due to treatment • 1 man will develop a serious blood clot in his leg or lungs due to treatment • For every 3,000 men who are screened with the PSA test: • 1 man will die due to complications from surgical treatment
Cost (Direct & Indirect)	Prostate cancer treatment accounted for \$9.9 billion in health care costs in the United States in 2006. Costs of care vary markedly with choice of initial treatment option. ⁷ In one study following a cohort of over

⁵ Cooperberg MR, Broering JM, Carroll PR. Time trends and local variation in primary treatment of localized prostate cancer. J Clin. Oncol. 2010; 28(7): 1117-23

⁶ US Preventive Services Task Force. USPDTF Prostate Cancer Screening Recommendation What are the benefits and harms of prostate cancer screening? Available: <http://www.uspreventiveservicestaskforce.org/prostatecancerscreening/prostatecancerinfo.pdf>

⁷ National Cancer Institute. Cancer Trends Progress Report – 2009/2010 Update. <http://progressreport.cancer.gov/>, retrieved September 11, 2011.

Bree Collaborative New Topic Selection

	13,000 men over age 66 for five years, 5-year incremental costs of care ranged from \$9,130 for patients whose initial management approach was watchful waiting, to \$26,896 for those whose initial management was hormonal therapy. ⁸
Proven means/strategies to address topic*	Yes, Adopt community standard based on evidence, ideally aligned with other trusted recommendations (e.g. USPSTF, AAFP). Encourage shared decision making.
Data is Available	State agencies can provide data on PSA testing costs and treatment costs. Significant clinical literature is available on PSA testing and treatment harms, benefits, and costs.
Bree Uniquely Positioned for Impact	Can bring community together to endorse community standard and recommend to the legislature
Shared-Decision Making Available	Han PK, Kobrin S, Breen N, Joseph DA, Li J, Frosch DL, Klabunde CN. National evidence on the use of shared decision making in prostate-specific antigen screening. <i>Ann Fam Med</i> . 2013 Jul-Aug;11(4):306-14. Li J, Berkowitz Z, Richards TB, Richardson LC. Shared decision making in prostate-specific antigen testing with men older than 70 years. <i>J Am Board Fam Med</i> . 2013 Jul-Aug;26(4):401-8.
Health Technology Assessment Topic	Was chosen as an HTA topic, but decision was made to not move forward due to likely conflict with current mandated state coverage.
Choosing Wisely Available	Yes “Do not routinely screen for prostate cancer using a prostate-specific antigen (PSA) test or digital rectal exam.” ⁹ <ul style="list-style-type: none"> • There is convincing evidence that PSA-based screening leads to substantial over-diagnosis of prostate tumors. • Many tumors will not harm patients, while the risks of treatment are significant. • Physicians should not offer or order PSA screening unless they are prepared to engage in shared decision making that enables an informed choice by patients.
Implement-ability	<ul style="list-style-type: none"> • Propose to adopt evidence based recommendation and propose new legislation. • Propose community standard of widespread use of evidence-based shared decision making prior to testing.

⁸ Claire F. Snyder, Kevin D. Frick, Amanda L. Blackford, Robert J. Herbert, Bridget A. Neville, Michael A. Carducci, and Craig C. Earle. How does initial treatment choice affect short-term and long-term costs for clinically localized prostate cancer? *Cancer*, 2010; DOI: 10.1002/cncr.25517

⁹ American Academy of Family Physicians. Prostate Cancer Screening Using a Prostate-specific Antigen (PSA) Test or Digital Rectal Exam Choosing Wisely Recommendation. Available: <http://www.aafp.org/patient-care/clinical-recommendations/all/cw-prostate-cancer.html>.

Bree Collaborative New Topic Selection

3. Opioids

Champion: Gary Franklin

Category	Description
Variation in practice patterns/ High utilization -Waste and inefficiency	Extremely high utilization and variation in prescribing practice. “Geographic variation in prevalence of prescribed opioids is large, greater than variation observed for other healthcare services...Wide variation in prescribing opioids reflects weak consensus regarding the appropriate use of opioids for treating pain, especially chronic non-cancer pain. Patients’ demands for treatment have increased, more potent opioids have become available, an epidemic of abuse has emerged, and calls for increased government regulation are growing.” ¹⁰
Patient Safety/Poor Health Outcomes	Epidemic of mortality, overdose morbidity and a host of serious adverse events, dependence, addiction
Cost (Direct & Indirect)	Medium for drugs per se, extremely high for adverse outcomes
Proven means/strategies to address topic*	Labor and Industries has successfully implemented guidelines similar to those being developed by the AMDG group
Bree Uniquely Positioned for Impact	The Bree would have a unique ability to widely disseminate the AMDG guidelines, and the payers would be able to implement the recommendations
Shared-Decision Making Available	The opportunity to implement shared decision making tools, such as the patient treatment agreement, is modest
Health Technology Assessment Topic	No
Choosing Wisely Available	American Academy of Neurology - Don’t use opioid or Butalbital treatment for migraine except as a last resort. ¹¹ American Society of Anesthesiologists - Don’t prescribe opioid analgesics as first-line therapy to treat chronic non-cancer pain; Don’t prescribe opioid analgesics as long-term therapy to treat chronic non-cancer pain until the risks are considered and discussed with the patient. ¹²
Implement-ability	Medium-high capacity to implement recommendations

¹⁰ McDonald DC, Carlson K, Izrael D. Geographic variation in opioid prescribing in the U.S. J Pain. 2012 Oct;13(10):988-96.

¹¹ American Academy of Neurology. American Academy of Neurology: Five Things Physicians and Patients Should Question. Available: <http://www.choosingwisely.org/doctor-patient-lists/american-academy-of-neurology/>

¹² American Society of Anesthesiologists. American Society of Anesthesiologists (ASA) releases Choosing Wisely® list for pain medicine. Available: <http://www.choosingwisely.org/american-society-of-anesthesiologists-asa-releases-choosing-wisely-list-for-pain-medicine/>.

4. Oncology

Champion: Jeffery Thompson

Cancer is typically in the top 1-3 health care expenditures for an employer, both public and private. Small and medium size employers, covering the majority of the insured, often see one to two cases per year that fall under the category of a high cost claimants costs exceeding (\$100,000 dollars). High costs claimants can have a significant impact on the employer as well as the member. One employer strategy to lessen the overall impact of a high cost is to purchase “stop loss” insurance (insurance to protect against shock claims). Stop loss insurance as well as group insurance, related to cancer care and costs, continues to add to the unaffordability of health care benefit for employees and members. Turning our attention to the cancer care and applying the Triple Aim (better health, better care and lower cost) should be a priority for the Bree. The section below offer a snap shoot on the current numbers and programs related to cancer.

Category	Description	Rating
<p>Prevalence and Insurer Costs</p>	<p>Cancer is the leading cause of death among men and women under age 85.¹⁻² An encouraging statistic shows cancer death rates have decreased by 22.2 percent in men and 13.9 percent in women between 1990-1991 and 2007. This is largely due to decreases in death rates for lung and prostate cancers among men, breast cancers among women, and colorectal cancers among both men and women. Decreased death rates for breast, colorectal, and prostate cancers during this time are attributable to improvements in early detection and treatment.³</p> <ul style="list-style-type: none"> ▪ The most commonly diagnosed types of cancer for adult men are prostate, lung, and colorectal; for adult women, breast, lung and colorectal. For pediatrics, the most commonly diagnosed types of cancer are leukemia, brain and nervous system, and bone and connective tissue cancer. ▪ About 56 percent of adult hospitalizations primarily for cancer were covered by government payers (47.8 percent by Medicare and 8.6 percent by Medicaid) and 37.2 percent were paid for by private insurance. <ul style="list-style-type: none"> ▪ Adults: The most expensive cancer hospital stays were for leukemia (\$40,200 per stay), multiple myeloma (\$28,700 per stay), and non-Hodgkin's lymphoma (\$24,900 per stay). Costs per hospital day were highest for prostate cancer (\$4,600 per day), breast cancer (\$4,100 per day), and thyroid cancer (\$3,500 per day). ▪ Pediatrics: The most expensive pediatric cancer hospitalizations in 2009 were for leukemia (\$55,700 per stay) and non-Hodgkin's lymphoma (\$46,900 per stay). The most common diagnoses for hospital stays with a secondary diagnosis of cancer, were complications of surgical procedures/medical care or complications of devices, implants or grafts (5.5 percent), pneumonia (5.2 percent), and septicemia (4.4 percent). 	

Bree Collaborative New Topic Selection

Variation in practice patterns	<p>There is well documented provider (primary care and oncology) variation in cancer prevention, screening, and treatment as well as end of life care. Washington State has been fortunate in having several studies using national Surveillance, Epidemiology, and End Results (SEER) data matched with payer sponsored claims.⁴ For example, in WA State both under and over use of expensive agents are common without returning value (e.g. colony-stimulating factor use).^{6,7}</p>	
Cost (Direct & Indirect)	<p>Direct costs related to cancer present unique issues in characterizing cancer type, site, stage, treatment, and reoccurrence. Claims based data cannot distinguish these clinical issues; however, Washington is one of several states with access to the SEER data, which assists in defining, mortality and morbidity trends and can be linked to claims data to track costs.</p> <p>The use of specialty drugs is a leading driver in the increased cost of cancer care. Cost in some cases can exceed \$80,000 to \$90,000 per treatment per year.¹⁹ While there have been remarkable results with some specialty drugs the “off label” and “off protocol” use lessen their value with unproven outcomes.</p> <p>Indirect costs related to cancers and disability claims as well as extended periods of absence from work, impact on the patient, family, and employer. Cancers with the highest loss of quality life and the most disease burden are lung cancer followed by breast, colon and prostate.²⁰</p>	
Proven means/strategies	<ul style="list-style-type: none"> • <u>Oncology Benefit Managers (OBM)</u> are contracted vendors that employers use to control the increasing costs in cancer treatments and over utilization based on guidelines, utilization management, and prior authorization. • <u>Centers of Experience/Excellence (COE)</u> are typically large hospitals/systems used by employers in direct contracting relationships. These centers demonstrate best practices by working collaboratively around a specific clinical service (e.g. tumor issues and transplants) . • <u>Second Opinion Services (Medical Expert Opinion)</u> are vendors who employ/contract with groups of professionals to render advice on treatment, diagnoses, and surgeries. These services can include a full record, tissue/pathology, and radiology film reviews to render an opinion on the correctness of a diagnosis or treatment. • <u>Shared Decision Making</u> – see below 	
Leadership	<p>Several new initiatives are underway in Washington State. Dr. Scott Ramsey is spearheading the use of SEER and employer claims (with Regence) data to report out on practice variation in prostate and breast cancer. Premera is piloting the monitoring and reporting of practices that adhere to the Choosing Wisely cancer decisions in treatment and diagnosis.</p>	
Data Availability	<p>There are several accessible data bases in WA State (SEERs, Claims, and CHARs) that can be used to measure and monitor cancer care.</p>	

Bree Collaborative New Topic Selection

<p>Shared-Decision Making</p>	<p>Several Shared Decision tools have been shown to improve patient satisfaction and overall understanding of member health care needs.¹³⁻¹⁴ Certification of decision tools are now available through the Health Care Authority (HCA), which can offer standards to review the evidence of decision support effectiveness and liability protections.¹⁵</p> <p>There are many toolkits for providers for cancer.</p> <ul style="list-style-type: none"> • Dartmouth Toolkit: http://med.dartmouth-hitchcock.org/csdm_toolkits/specialty_care_toolkit.html http://www.innovations.ahrq.gov/content.aspx?id=2811 • The Ottawa Personal Decision Guide: http://decisionaid.ohri.ca/decguide.html • The Foundation for Informed Medical Decision Making: http://www.informedmedicaldecisions.org/ • Health Wise: http://www.healthwise.org/products/shareddecisionmaking.aspx 	
<p>Health Technology Assessment (HTA)</p>	<p>There are several HTA topics germane to cancer including, 1) PET scans in lymphoma to diagnose, 2) use of MRI in breast cancer screening, 3) Use of Proton Beam therapy.¹⁸</p>	
<p>Choosing Wisely</p>	<p>Choosing Wisely tools can help to drive the right conversations between providers and patients, ensuring right care is delivered at the right time. Cancer related topics include; 1) do not use cancer therapies with low evidence on stage 3 and 4 solid tumors (oncology), 2) limit PET scans in prostate and breast cancers (oncology), 3) limit colony stimulating factor use (oncology), 4) do not repeat colonoscopy – if high quality – sooner than every 10 years (GI), 5) limit bone scans in prostate cancer (urology), 6) do not use PET scanning in a health population (nuclear medicine) and 7) do not screen for ovarian cancer in low risk women (GYN)</p>	
<p>Patient Safety</p>	<p>It has been documented in Washington State variation exists in initial staging, continuing treatment, and terminal phases of cancer care.^{8,9} In a survey cancer patients mentioned having both safety and service concerns.¹⁶</p>	

References

1 Heron M. Deaths: Leading causes for 2007. National vital statistics reports; vol 59, no 8. Hyattsville, MD: National Center for Health Statistics. 2011.

2 Altekruze S.F., Kosary C.L., Krapcho M., (editors) ea. Surveillance, Epidemiology, and End Results Cancer Statistics Review, 1975-2007. Bethesda, MD: National Cancer Institute; 2010.

3 Siegel R., Ward E., Brawley O., Jemal A. Cancer statistics, 2011: The impact of eliminating socioeconomic and racial disparities on premature cancer deaths. CA Cancer J Clin. Jul-Aug 2011;61(4):212-236.

Bree Collaborative New Topic Selection

4. [Etzioni R](#), Measuring costs: administrative claims data, clinical trials, and beyond, *Med Care*. 2002 Jun;40(6 Suppl):III63-72
5. Yabroff KR, Specialty differences in primary care physician reports of papanicolaou test screening practices: a national survey, 2006 to 2007, *Ann Intern Med*. 2009 Nov 3;151(9):602-11
6. McCune JS; Colony-stimulating factor use and impact on febrile neutropenia among patients with newly diagnosed breast, colorectal, or non-small cell lung cancer who were receiving chemotherapy; *Pharmacotherapy*. 2012 Jan;32(1):7-19
7. Ramsey SD, Colony-stimulating factor prescribing patterns in patients receiving chemotherapy for cancer; *Am J Manag Care*. 2010 Sep;16(9):678-86.
8. Taplin SH, Stage, age, comorbidity, and direct costs of colon, prostate, and breast cancer care *Natl Cancer Inst*. 1995 Mar 15;87(6):417-26
9. Smith AA Advanced practice registered nurses, physician assistants and cancer prevention and screening: a systematic review; *BMC Health Serv Res*. 2014 Feb 12;14:68
10. Gore JL; Hospital-level variation in the quality of urologic cancer surgery; *Cancer*. 2012 Feb 15;118(4):987-96
11. Gold LS, Advanced diagnostic breast cancer imaging: variation and patterns of care in Washington state, *Oncol Pract*. 2013 Sep;9(5):e194-202
12. Choosing Wisely <http://www.choosingwisely.org/doctor-patient-lists/> visited 9/5/2014
13. Légaré F, A review of the ways in which healthcare professionals can be helped to adopt practices to involve their patients in the healthcare decision making process, Date verified by innovator: June 09, 2014 http://summaries.cochrane.org/CD006732/EPOC_a-review-of-the-ways-in-which-healthcare-professionals-can-be-helped-to-adopt-practices-to-involve-their-patients-in-the-healthcare-decision-making-process
14. O'Connor AM, Rostom A, Fiset V, et al. Decision aids for patients facing health treatment or screening decisions: systematic review. *BMJ*. 1999;319(7212):731-4
15. WAC 182-60-005 Authority and purpose. Under RCW 7.70.060(4), the agency's medical director is authorized to independently assess and certify patient decision aids.
16. Weingart, Saul N, Patient-Reported Safety and Quality of Care in Outpatient Oncology, *Joint Commission Journal on Quality and Patient Safety*, Volume 33, Number 2, February 2007, pp. 83-94
17. Koopmanschap, M, The impact of indirect costs on outcomes of health care programs, *Health Economics*, Volume 3, Issue 6, pages 385–393, November/December 1994
18. Health Care Authority Health Technology Assessments, http://www.hca.wa.gov/hta/Pages/Forms/HTA_Findings.aspx, visited 9/5/2014
19. Editorial Board, Extremely Expensive Cancer Drugs, *NYT*, Published: July 6, 2011
20. Brown ML, The burden of illness of cancer: economic cost and quality of life, *Annu Rev Public Health*. 2001;22:91-113.