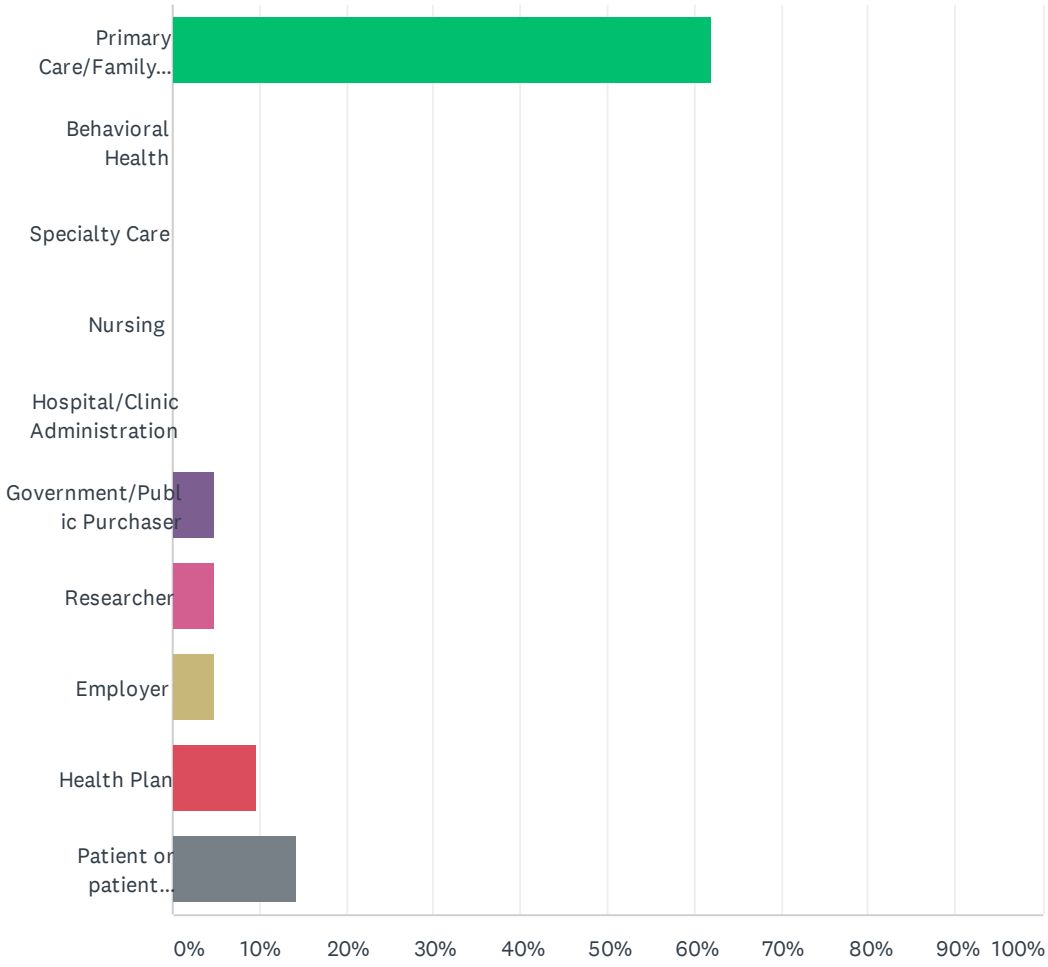
Q1 What sector do you represent? (Choose the option that is the best fit.)

Answered: 21 Skipped: 0



ANSWER CHOICES	RESPONSES	
Primary Care/Family Medicine Provider	61.90%	13
Behavioral Health	0.00%	0
Specialty Care	0.00%	0
Nursing	0.00%	0
Hospital/Clinic Administration	0.00%	0
Government/Public Purchaser	4.76%	1
Researcher	4.76%	1
Employer	4.76%	1
Health Plan	9.52%	2
Patient or patient advocate	14.29%	3
TOTAL		21

#	OTHER (PLEASE SPECIFY)	DATE
1	Washington Academy of Family Physicians	12/28/2020 9:42 AM
2	But have been a practicing FP for 29 years in a large system	12/7/2020 4:19 PM

Q2 Do you have comments on how we have defined primary care?

Answered: 21 Skipped: 0

#	RESPONSES	DATE
1	In our experience, and in the experiences of fellow constituent chapters of the American Academy of Family Physicians, defining primary care has been among the most difficult challenges in measuring primary care. WAFP appreciates the foundational research of Dr. Starfield and the expertise of the Milbank Memorial Fund. With all due respect to the regulatory definition of what constitutes a primary care provider, we have concerns with the Workgroup's definition. First, pediatricians and internists should be labeled as general pediatricians and general internists. Given the wealth of subspecialties of each, we believe this wording change would more accurately capture the universe of primary care. Second, while we acknowledge the important contributions of our naturopathic colleagues, we believe they would not qualify as primary care providers under the stated definition. Generally speaking, we believe the Collaborative should define "primary care providers" as it sees fit, regardless of any statutory definitions. Dr. Starfield's guide provides a time-tested example; within that are guideposts to aid in this exercise. While primary care is unique in its substantial commitment to coordination, comprehensiveness and continuity, numerous specialties offer a combination of these tenets to a greater or lesser degree. One differentiating aspect of primary care apart is first contact: If a patient wouldn't discuss abdominal pains, ankle sprains, anxiety and asthma in the same appointment, it's not primary care.	12/28/2020 9:42 AM
2	it is a mistake to try to measure and define primary care as a list of functions- as you see, it is all of these things and more. there is no mention of the depth and importnace of personal relationship between patients and primary care providers/teams	12/27/2020 10:50 PM
3	Overall it felt workable as a definition with a lot of variables	12/20/2020 2:41 PM
4	Although certainly some would define even more broadly, I felt like it accurately reflected my ideal scope of practice. Howrver, without some dramatic shift in how we do our work and supply we receive, the ability to accomplish this for the average patient feels near impossible.	12/15/2020 9:41 PM
5	Before including ND as primary care - would like to see evidence that outcomes are equivalent with 'standard' MD/NP/PA care.	12/15/2020 7:27 PM
6	The definition is excellent and comprehensive.	12/15/2020 5:27 PM
7	Yes. Title 18RCW is at odds with various other states and in particular insurance/Medicare in this definition. Naturopaths are not generally recognized by insurance/Medicare and multiple other states as primary care providers. For that reason, many tests and treatments are not able to be ordered by them and reimbursed by payors.. As such, they cannot be said to be independent practitioners in practice.	12/14/2020 5:20 PM
8	This: Team-based care led by an accountable provider that serves as a person's source of first contact with the larger healthcare system and coordinator of the health care services that the person receives. Primary care includes a comprehensive array of appropriate, evidence-informed services to foster a continuous relationship over time. That's straightforward enough. This captures the essential value we offer our patients	12/14/2020 4:33 PM
9	in my opinion, naturopaths do not provide comprehensive primary care. They are usually not available after hours, provide opinions and services that are not consistent with evidence based guidelines.	12/14/2020 3:44 PM
10	At age 87 and long retired I do not recognize what is described here as what I knew as primary care in relatively isolated small communities of 2500 to 6000.	12/14/2020 2:36 PM
11	The definition is good and includes of a good wholistic view of the patient -clinician relationship that is so important. The professionals who deliver primary medical care and serve as the point of first contact and long term relationship management need to have the proper background and training. For this reason, naturopaths have no place in this role.	12/14/2020 1:57 PM
12	see below	12/14/2020 11:32 AM
13	No	12/14/2020 10:14 AM
14	Naturopaths are not primary care providers	12/12/2020 6:17 PM
15	no thanks for including integrated BH	12/10/2020 9:51 AM
16	no	12/7/2020 4:19 PM

17	No	12/3/2020 8:01 PM
18	No	12/3/2020 5:33 PM
19	No. Very well represented of previous definitions	12/3/2020 11:53 AM
20	seems appropriate	12/1/2020 8:35 AM
21	It's helpful to see a definition that goes beyond the theoretical to spell out what primary care looks like in practice.	11/30/2020 12:57 PM

Q3 Do you have comments on our must have or recommended elements for primary care sites?

Answered: 21 Skipped: 0

#	RESPONSES	DATE
1	The Bree Collaborative's must-have and recommended checklists are excellent guides that, if followed, would provide a community with exemplary primary care. We note, however, that team-based care encompasses more than traditional medical care; community connectors, social workers, pharmacists and other adjacent professionals serve as critical team members but are unlisted in the report. And while we agree wholeheartedly on the importance of integrated behavioral health, we acknowledge the dearth of behavioral health providers in state's rural areas. We also appreciate that such a discussion is far beyond the scope of the report but nonetheless wish to call attention to this deficit between provider and need.	12/28/2020 9:42 AM
2	laundry list/checklist. will lead to yet another set of meaningless measures.	12/27/2020 10:50 PM
3	Yes - looks like definitions for annual screenings could include some element of sexual and relationship health/safety (thinking not just about STI screening but about risk of sexual/physical/verbal abuse and mistreatment).	12/20/2020 2:41 PM
4	Comprehensive and feel inclusive.	12/15/2020 9:41 PM
5	There should also be requirement that practices state up front what legal services that they do NOT provide (e.g., reproductive health services like abortion, end of life services such as Medical Aid in Dying)	12/15/2020 7:27 PM
6	Figure 1 should include preventive services, cancer screenings, immunizations, family planning, counseling and education, in addition to care of chronic medical conditions like asthma and hypertension.	12/15/2020 5:27 PM
7	No	12/14/2020 5:20 PM
8	The checklist? Do you feel you are expanding the requirements on primary care providers while we continue to struggle in the FFS payment structure? That's been our history the twenty years I've been in practice... The strongly recommended elements for high quality care leave me disheartened. Many good ideas but there's a point where the practicing physician (or any provider) feels fractured trying to track it all.	12/14/2020 4:33 PM
9	This info is most suitable for urban settings with a minimum limitation of supply of providers. This is not the situation in rural settings where physician practices or local hospitals cannot afford to financially subsidize providers such as behavioral health providers, etc	12/14/2020 3:44 PM
10	No	12/14/2020 2:36 PM
11	When possible, the primary care site should promote having a continuous relationship over time with the same clinicians, in order to build trust and familiarity.	12/14/2020 1:57 PM
12	see below	12/14/2020 11:32 AM
13	No	12/14/2020 10:14 AM
14	No	12/12/2020 6:17 PM
15	I notice you mention as a must have co-located or integrated models. I think WA State has gone beyond just co-location and should strive for integrated models. I would take out co-location. Bree recommendations for BH integration have been out several years so let's challenge ourselves to stick to best practice	12/10/2020 9:51 AM
16	Agreements or contracts among providers, plans, and other organizations to coordinate transitions are in place including ---with the very wide variety of providers adn services that patients access and require this is almost impossible for a PCP office--how many of these agreemnts would i need to put i nplace--choiro, behavioral health, PT, Massage. Ed adn Hospital is one thing, but in the industry where there are still many solo practitioners such as those listed this would be come all too cumbersome and costly for a practice to do or even begin to monitor. while it is aloft goal, it is not realistic. par your request down to the really important agreements--Ed Hospitals, SNF, etc and you will get more buy in. Item 2 uring a clinical visit, patients and providers engage in: Self-management support Shared decision making Motivational interviewing for behavior change Again, wile it is a good goal, to expect each visit for a busy, overworked pcp to partake in motivational interviewing at each visit is not realistic, perhaps requesting that the office providers have had training on motivational interviewing would be a better start	12/7/2020 4:19 PM

17	No	12/3/2020 8:01 PM
18	No	12/3/2020 5:33 PM
19	Behavioral Health as stronger priority	12/3/2020 11:53 AM
20	Preventive services including USPSTF recommended cancer screenings ** Include under Preventative Services: Active Immunization Plan (ACIP recommended immunizations)	12/1/2020 8:35 AM
21	(1) Oral health is not mentioned at all in the report. This is part of "whole person" care as described in the checklist on p. 6. This is surprising, given that Washington state, with the support of the Arcora Foundation, has been a leader in oral health integration with primary care. Oral health is connected to overall health outcomes - it is primary care as much as behavioral health or other traditionally neglected areas. (2) "Non-discrimination in hiring practices" is mentioned without definition. To advance health equity, we need to go beyond non-discrimination to describe what inclusive and equitable hiring means and which groups are included in these considerations. A much bolder statement is needed.	11/30/2020 12:57 PM

Q4 Do you have comments on our checklists for other stakeholders?

Answered: 21 Skipped: 0

#	RESPONSES	DATE
1	WAFP and our national affiliate, the American Academy of Family Physicians, hear from our membership that, by far, their most pressing concern is administrative burden. WAFP understands the need for reporting requirements but asks that any documentation not add to the burden that primary care physicians already face. Improving the primary care system only to further burn out clinicians is counterproductive.	12/28/2020 9:42 AM
2	just pay primary care more and see what happens. pay specialty care less.	12/27/2020 10:50 PM
3	Thorough	12/20/2020 2:41 PM
4	No	12/15/2020 9:41 PM
5	Clarity and informed consent on areas of care that are NOT covered by the practice (reproductive health, gender care, end-of-life care (such as Medical Aid in Dying).	12/15/2020 7:27 PM
6	Must have elements should include high quality translation services. Primary Care Site Information should also include Family History	12/15/2020 5:27 PM
7	Yes. Recommendations for periodic screening (Content of Care pg 8) need to be evidence based. There are far more behavioral health issues encountered in primary care than those listed.	12/14/2020 5:20 PM
8	For those of us who feel we are providing high value care, we regularly get feedback on quality measures (usually from our own record system), but we don't get useful information on cost of care. The cost and quality data shared by payers are not timely. If I was responsible for using the best cost information I've seen from payers, it would be like driving backward on the freeway with my eyes closed while someone sitting next to me gives me directions as they scroll through their social feeds. We can't manage costs that we are blind to. Payers need to be responsible to share attribution information with providers, not just members. In value based arrangements, accurate member rosters are critical	12/14/2020 4:33 PM
9	no	12/14/2020 3:44 PM
10	No	12/14/2020 2:36 PM
11	Quality of care measurement should start with just a few items and then adjust over time, so as not to overwhelm the new practices. When everything is a priority, nothing is a priority.	12/14/2020 1:57 PM
12	see below	12/14/2020 11:32 AM
13	No	12/14/2020 10:14 AM
14	no	12/12/2020 6:17 PM
15	no	12/10/2020 9:51 AM
16	no	12/7/2020 4:19 PM
17	No	12/3/2020 8:01 PM
18	No	12/3/2020 5:33 PM
19	NO	12/3/2020 11:53 AM
20	-Active immunization Plan defined as: either offer appropriate (ACIP) recommended immunizations, or refer WITH Rx to an active immunization pharmacy or Immunization site	12/1/2020 8:35 AM
21	The health plan checklist does not address geographic (e.g., rural/urban) disparities: "Data from care delivery sites is collected and aggregated to understand variation in care and look for underlying issues such as disparities in access or services provided within and across..." These analyses are critical to evaluate access and equity.	11/30/2020 12:57 PM

Q5 Do you have comments on the components of primary care that have a large impact/content of care?

Answered: 16 Skipped: 5

#	RESPONSES	DATE
1	WAFP agrees with the report's identified tenets of primary care, though with two caveats. First, the report alludes to this, and we wish to make it explicit: While other specialties may employ screening as needed, screening is a central, everyday function of primary care. Advanced primary care is poised to actively manage behavioral health, social determinants of health and other issues that are being screened for. While some specialist offices may have a screening questionnaire, they're not poised to take care of the issues that screen positive. Second, the section on integrated behavioral health notes the pervasiveness of mental illnesses and substance use disorders. Additional elaboration sees only the mention of depression and anxiety. Yet the potential range of behavioral health disorders that may present at a primary care clinic is vast:managing bipolar disorder, ADHD, PTSD, addiction, insomnia, dementia, and lifestyle and behavioral change are just some of the potential concerns that a primary care physician may encounter. Integrated behavioral health cannot solely, or even mostly, serve a mission of helping patients overcome depression and anxiety. To do so would be to artificially narrow the scope and potential of integrated behavioral health.	12/28/2020 9:42 AM
2	Given that telehealth parity is moving forward, would perhaps dig in a bit to how primary care providing expanded access may be limited/need to be supplemented based on the communities they serve (not all will have regular cell phone access or access to video/internet). Similarly would have a call out for ability to serve those with various language literacy and health literacy needs?	12/20/2020 2:41 PM
3	Need far more support and decreased administrative burden (from extra EMR clicks to decreased paperwork that doesn't improve outcomes) in order to conceive of achieving this very appropriate goals.	12/15/2020 9:41 PM
4	Again - practices that limit their primary care (do not include reproductive health across the spectrum, gender care or Medical Aid in Dying).	12/15/2020 7:27 PM
5	Another component is Trusted Relationship	12/15/2020 5:27 PM
6	No	12/14/2020 5:20 PM
7	My greatest concern with moving to value is lack of cost info. We've built moderately useful quality infrastructure in this state but we don't get to see cost.	12/14/2020 4:33 PM
8	The experience of my family members show that providers spend more time focusing on the providers agenda in order to check off the boxes and insurance expectations rather than attending to the agenda of the patient.	12/14/2020 3:44 PM
9	The relationship over time and familiarity of doctor with the person being served in the "secret sauce" of family medicine and other primary care. It facilitates care in a variety of ways, and allows phone care, web messaging and virtual care when needed.	12/14/2020 1:57 PM
10	see below	12/14/2020 11:32 AM
11	no	12/12/2020 6:17 PM
12	no	12/7/2020 4:19 PM
13	No	12/3/2020 8:01 PM
14	Allowing all employees have access to every patient's medical records makes patients like myself not want to see a doctor unless I'm dying.	12/3/2020 5:33 PM
15	No	12/3/2020 11:53 AM
16	immunizations are mentioned as recommended, however there should be language beyond recommendation and updating the immunization record. Should include: assessment for risk factors and recommended (ACIP) immunizations AND active immunization in clinic OR Rx Referral, Also, HIT outreach for appropriate immunizations and series completions	12/1/2020 8:35 AM

Q6 Do you have comments on measuring or paying for primary care?

Answered: 16 Skipped: 5

#	RESPONSES	DATE
1	WAFP fully supports the Workgroup's recommendation of shifting away from fee-for-service payments and is in agreement with the other information and conclusions laid out in this section.	12/28/2020 9:42 AM
2	depressing and uninspring list of even more measures of primary care; all losing track of the fact that primary care is so much more than the sum of its parts. please use Rebecca Etz' measures of relationsihp and value of primary care	12/27/2020 10:50 PM
3	None	12/20/2020 2:41 PM
4	Agree fee for service doesn't improve care. Needs acknowledgement of payment parity for non traditional models -- emails, phone and video.	12/15/2020 9:41 PM
5	No	12/15/2020 7:27 PM
6	I agree with the recommendations.	12/15/2020 5:27 PM
7	I am curious why this is coming up now? These issues have been published for some 40 years with little movement nationally.	12/14/2020 5:20 PM
8	For those of us in private practice, it's felt like payment is broken for quite some time. For the past fifteen years, a decision to hire a new doctor required a guess about how long it would take for them to start covering their costs. The good news is starting salaries in the area have jumped in the past ten years, but the bad news is they've exceeded pay of a 90th percentile productive veteran doc, so private practice docs face a daunting investment to bring in new providers. If we hire someone new now, it's more than five years to just start covering their costs, and breakeven is years past that. Will they stay long enough to not lose money? I feel we're paid well enough to stay doing what we are doing, but not well enough to cover new hires. This needs a reset.	12/14/2020 4:33 PM
9	I have been in practice for over 35 years, and my observation is that the expectations of PCPs continue to increase--ie, population health, determining social determinants of health (most of which we have no influence over), mental health care, all of which are not usually either separately billable, or do not contribute to the billing equation. This kind of thing is driving docs out of practice.	12/14/2020 3:44 PM
10	Payment reform is fundamental and absolutely required to achieve the goals of this report.	12/14/2020 1:57 PM
11	no	12/12/2020 6:17 PM
12	When it comes to VBP the more a patient is aligned with a specific provider or group the better the data and outcomes. There needs to be part of this plan that more directly aligns Pt/provider.	12/7/2020 4:19 PM
13	No	12/3/2020 8:01 PM
14	Stop making insurance so complicated	12/3/2020 5:33 PM
15	Yes, parity is crucial to maintain and recruit primary medical providers	12/3/2020 11:53 AM
16	Immunization should have a positive impact on the payment model. Perhaps excluding the vaccination costs from the total cost of care may incentivize the HCP to vaccinate in office	12/1/2020 8:35 AM

Q7 Are there any errors in the report or anything our report is missing?

Answered: 12 Skipped: 9

#	RESPONSES	DATE
1	The American Board of Medical Specialties refers to our specialty as family medicine, and we feel this term is preferred instead of “family practice.” We would request the report’s language be modified, given the enduring confusion in some corners between family medicine and general practitioners.	12/28/2020 9:42 AM
2	the problem is that we have overvalued specialty care, especially procedures and hospitals. rather than focusing on the quantifying the value of primary care, work on reducing the price of specialty care	12/27/2020 10:50 PM
3	Not noticed	12/20/2020 2:41 PM
4	Could use an update about virtual care.	12/15/2020 9:41 PM
5	See above - it needs to be transparent to our patients what we do NOT do.	12/15/2020 7:27 PM
6	only as noted in question 3, 4, 5.	12/15/2020 5:27 PM
7	I am unclear what is the problem you are trying to address. Is it definition? Scope of practice? Payment? And you have failed to sufficiently emphasize the severe decline in primary care providers matched against increasing demand for services by an aging population.	12/14/2020 5:20 PM
8	I see no errors	12/14/2020 4:33 PM
9	no	12/12/2020 6:17 PM
10	No	12/3/2020 5:33 PM
11	Not that I observed	12/3/2020 11:53 AM
12	There remains a note in the payment discussion to insert information on quality/cost of care.	11/30/2020 12:57 PM

Q8 How can our report better address health disparities?

Answered: 15 Skipped: 6

#	RESPONSES	DATE
1	A 2019 study published in JAMA Internal Medicine (https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2724393) found that for every 10 additional primary care physicians per 100,000 population, an increase of 51.5 days of life expectancy could be expected. This data demonstrates a profound need for growth within the pipeline and population of primary care physicians: Imagine if PCPs were plentiful away from Washington's cities, and rural care was not in a perennial state of crisis. Imagine the potential impact on vaccine hesitancy among Black Washingtonians if more were able to access PCPs who looked like them. Imagine the potential impact on health equities if Latinx patients had ample choices among PCPs who speak their language and understand their culture.	12/28/2020 9:42 AM
2	primary care is best distributed in our state compared to any other specialties - you should acknowledge the important role of primary care in improving disparities	12/27/2020 10:50 PM
3	Along the way there were call outs for needs on reporting of data relevant around race, outcomes for sexual and gender identity. Perhaps just a broader statement about how defining/structuring primary care will need anti-racist / EDI lens?	12/20/2020 2:41 PM
4	Time and patience is how to foster trust among traditionally underserved populations. 15-20 min visits work to get at the crux of health disparities, they work for the idealized healthy young tech worker perhaps.	12/15/2020 9:41 PM
5	see above	12/15/2020 7:27 PM
6	attention to cultural humility and shared decision making	12/15/2020 5:27 PM
7	Whatever can be said about declines in primary care access, payment, etc. are magnified in communities of color and rural areas. This should be stated directly. Payment incentives and site specific training in those locations might be promoted.	12/14/2020 5:20 PM
8	we should be responsible for evaluating our performance on screenings and basic chronic disease care (such as hypertension) within a health disparities mindset	12/14/2020 4:33 PM
9	FQHCs have been at the forefront of improving primary care, in large part because of the innovative ways they are supported financially. Our goal should be for all primary care to have such good support and be free of FFS systems.	12/14/2020 1:57 PM
10	My feelings is that health disparities are primarily a reflection of social problems. If you have an uneducated inner city person who cannot read, how can you expect them to have the same level of health. If we really want to treat health disparities, you need to start with calling for a dramatic overhaul of our educational system. The problem is more social than related to the medical system.	12/14/2020 11:32 AM
11	?	12/12/2020 6:17 PM
12	Stop allowing every employee have unlimited access to everyone's medical records. I have be treated differently based on this.	12/3/2020 5:33 PM
13	Patient flow volumes would be helpful in getting legislators to understand the challenges of patients seen in one day by a primary care provider	12/3/2020 11:53 AM
14	Immunizations are one of the core tools for population health.	12/1/2020 8:35 AM
15	As noted above, define the disparities to be addressed (who are the disparate groups that need to be considered), including geographic disparities, and find a way to include oral health integration with primary care.	11/30/2020 12:57 PM

Q9 Do you have any general comments?

Answered: 13 Skipped: 8

#	RESPONSES	DATE
1	WAFP thanks the Bree Collaborative for its thoughtful work and leadership on this critical issue. We stand ready to help support this and other efforts toward health care reform which advance primary care investment as a mechanism to improve patient care, population health, and provider satisfaction, while simultaneously reducing total health care expenditures.	12/28/2020 9:42 AM
2	Great job on first go round	12/20/2020 2:41 PM
3	Overall seems spot on and fairly self evident from my perspective.	12/15/2020 9:41 PM
4	See above	12/15/2020 7:27 PM
5	no	12/14/2020 4:33 PM
6	This does not completely address the situation where a specialty physician needs to be the one to see the patient and order tests as appropriate--ie, an RA patient and their rheumatologist. The system needs to be flexible with these situations rather than trying to make them conform to a PCP first type model	12/14/2020 3:44 PM
7	Barriers between primary care and other services need to be removed to facilitate good care, for example, with mental health care.	12/14/2020 1:57 PM
8	My favorite definition of leadership is a good leader "leaves consensus in his wake". There can be many different leadership styles all of which can be successful and will vary based on personality types. By your codifying the process you are basically condemning various styles which may be very successful. For instance I find daily team meetings a colossal waste of time but work extremely closely with my team in a collaborative manner. My meetings are much more focused. Any general position paper should not get so specific, especially in relationship to screening. These recommendations change all the time and you do a disservice when you codify something that may be dated tomorrow. In trying to be comprehensive you are too detailed and this should be much more general (ie follow the current immunization guidelines or breast cancer guidelines etc, do not state the guidelines). this paper is too process oriented rather than outcome oriented. Always a mistake. All in all sounds far too much like a politically correct paper.	12/14/2020 11:32 AM
9	Please advocate for expanding GME as opposed to expanding the scope of practice of PAs and NPs.	12/14/2020 10:14 AM
10	Naturopaths are not primary care providers	12/12/2020 6:17 PM
11	See the comments above	12/3/2020 5:33 PM
12	Reimbursement is key to patient safety. Working in an environment that promotes 10 minutes for a patient visit increases risk of omissions resulting in complicated care needs in the future. Such omission will create greater expense to the system if appropriate time is not reimbursed for patient care needs.	12/3/2020 11:53 AM
13	Immunizations are one of the core tools for population health. There could be standard language for every Bree initiative that includes immunization. Not every patient has a primary care provider and may have insurances don't require it for specialty care. Also, with telehealth becoming more accessible, there should be guidance on how to capture immunizations in this new evolution for primary care visits.	12/1/2020 8:35 AM

Q10 Name:

Answered: 15 Skipped: 6

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest
Kaiser Foundation Health Plan of Washington
Kaiser Foundation Health Plan of Washington Options, Inc.

December 28, 2020

Ginny Weir, MPH
Director, The Bree Collaborative
Foundation for Health Care Quality
705 Second Ave, Suite 410
Seattle, WA 98104
Submitted via email to: bree@qualityhealth.org

Re: Primary Care Report & Recommendations and Perinatal Bundled Payment Model Revision

Dear Ms. Weir:

Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, and Kaiser Foundation Health Plan of Washington Options, Inc. in concert with our Permanente Medical Groups (collectively "Kaiser Permanente"), appreciate the opportunity to provide comments to the Bree Collaborative (the "Collaborative") on the draft Primary Care Report and Recommendations ("Primary Care Report") and Perinatal Bundled Payment Model Revision ("Perinatal Payment Model"). Kaiser Permanente is an integrated health care system that covers and cares for nearly 800,000 members in Washington State. We are committed to delivering affordable, coordinated, and high-quality care and coverage that supports not only our members but also the communities we serve.

Both the Primary Care Report and Perinatal Payment Model provide important frameworks centered on improving the health of Washingtonians, including an emphasis on tying health care spending to quality. Kaiser Permanente operates as a fully capitated integrated delivery system with a strong focus on primary care. Our model avoids the pitfalls and perverse incentives associated with traditional fee-for-service medicine, ensuring our members get the right care at the right time. We offer support for many of the components included in these reports and outline some feedback for your consideration.

Primary Care Report and Recommendations.

Kaiser Permanente supports the elements included in the Primary Care Site Checklist and we incorporate these items into our care delivery infrastructure. We would like to highlight the importance of utilizing care management programs in a primary care practice, in particular the ways in which nursing and pharmacy staff can lead chronic disease management. Kaiser Permanente clinicians are supported by our Care Management Institute, which researches, develops and shares the latest evidence-based knowledge across our organization. We recognize that a team-based approach to chronic disease management can improve patient outcomes and avoid the costs and problems that occur when chronic conditions are left unchecked.

In addition to our role as a care delivery organization, Kaiser Permanente provides health coverage, giving us a unique perspective on the role of health plans in financing and supporting primary care. Kaiser Permanente supports moving away from a fee-for-service health care system that rewards quantity over quality. We are in favor of investing in primary care through evolving payment models that support better care, access, and a lower total cost of care. We agree with the Collaborative's

assessment that "traditional fee-for-service payment approaches do not reimburse many of the activities to support high-performing primary care practices (i.e. care coordination, population health)." Kaiser Permanente's integrated system is built upon a capitated payment model, where we perform numerous care management services that are not captured in a traditional fee-for-service setting. These functions are delivered not only through our clinicians but also our health plans. Some examples include additional evaluation during a primary care visit to prevent acute health problems and over-utilization of unnecessary health care services; expanding urgent care facilities as an alternative to expensive emergency departments; care coordination to prevent hospital readmissions; and virtual care chat between members and providers to avoid expensive in-person office visits. Payment models should support team-based care that allows clinicians to interact with their patients for longitudinal care over time, not simply paying for "visits" but for all the care coordination that goes on in between those visits.

Kaiser Permanente supports value-based payment models and the Collaborative's recommendation to adopt "non-fee-for-service payment mechanisms in a manner that aligns key healthcare stakeholders." We have a long history of value-based reimbursement with externally contracted providers. Our practices have historically focused on tying reimbursement to population-based HEDIS and Medicare 5 Star metrics that reward and incent primary care practices to deliver on quality outcomes. We are continuing to develop our capabilities to reimburse and reward primary care groups on other attributes of value such as affordability and patient experience.

Additionally, we acknowledge that employers and purchasers of health care play an important role in transforming health care financing. It will be important to engage these groups throughout the shift to value-based payment methodologies. Ultimately, in order to garner widespread support for these new payment mechanisms, it will be necessary to demonstrate through analytics and metrics how their dollars are achieving value in improved health outcomes and savings.

Perinatal Bundled Payment Model Revision

Kaiser Permanente appreciates the work by the Collaborative to revise their Perinatal Payment Model, including the Collaborative's focus on payment strategies incentivizing care coordination in support of the gestational parent and child. We agree with the quality metrics outlined in this report but suggest the Collaborative consider adding preterm birth rate or newborn birthweight as additional metrics.

The model excludes gestational parents over age 40, which would exclude a significant number of our patient population. Our assumption is that this exclusion is a result of the risk profile associated with older gestational parents, however, it would be valuable to consider how payment models could be constructed for this sizeable patient population. The Perinatal Payment Model also excludes contraception and genetic testing. We are not certain why these services were excluded from the model.

We understand the Collaborative's recommendation to implement retrospective reimbursement with reconciliation as a first step for the Perinatal Payment Model. We would, however, appreciate further discussion on the details of ultimately transitioning to a prospective payment model and why the Collaborative ultimately believes that a prospective payment model is preferred.

We appreciate the Collaborative's thoughtful and transparent approach to the Primary Care Report and Perinatal Payment Model. As a participant on the Collaborative, we look forward to continuing these discussions and the important work to improve the health and well-being of Washingtonians.

Sincerely,

Simon Vismantas
Senior Regulatory Affairs Consultant
Government Relations

Kaiser Permanente Washington
1300 SW 27th St.
Renton, WA 98057-2435
Office: 206-630-4042
Cell: 847-894-5310
E-mail: simon.p.vismantas@kp.org

Merlene Converse
Senior Regulatory Consultant
Government Relations

Kaiser Permanente Northwest
500 NE Multnomah St., Suite 100 -- Floor 8
Portland, Oregon 97232
Cell: 503-936-3580
E-mail: Merlene.S.Converse@kp.org

From: carrieho@comcast.net
To: Bree Collaborative
Subject: re; primary care feedback
Date: Friday, December 4, 2020 12:14:28 PM

To Whom It May Concern,

I appreciate Bree organization discussing the importance of primary care and how it helps our patients and community
I have read over the draft of the primary care draft documents

I am in agreement with most of what is written except for a couple of areas of concern

1. listed under primary care practices - the document lists naturopaths. While many patients may use naturopaths in addition to traditional clinicians. Naturopaths by the nature of their training and expertise are NOT primary care clinicians.
they would be adjunct (possibly) to an integrated healt care approach to patient care.

Many of the recommendations from naturopathy are not based in good scientific evidence. There is also significant cost associated with unnecessary testing and unproven therapies that are sometimes used. They do not have the same CME requirements, training or even focus on prevention and preventive services (such as cancer screening, diabetes, htn and other chronic medical condition management.

I would recommend that the Bree collaborative REMOVE naturopath from this primary care document.

2. there are many items listed that make for a quality experience in primary care and while I agree those elements are important- several smaller practices (especially now with covid and cutbacks) may find it difficult to have all of these services and resources in a practice.
I hope the Bree collaborative can nuance the language- to point out an ideal (if able) but not take away from smaller practices that also provide primary care

thank you

Carrie Horwitch MD, MPH