Agenda

• Chair Report March 20 Meeting Minutes
  • Action Item: Approve minutes
• Wisconsin Collaborative for Healthcare Quality
• Agency Medical Directors Group: Input on New Topics
• Looking Back, Looking Forward
  • Action Item: Select 7-8 Preliminary Topics
• BREAK
• Workgroup Update: Opioid Prescribing
• Workgroup Update: Risk of Violence to Others
• Workgroup Update: Maternity Bundle
• Workgroup Update: Shared Decision Making
• Workgroup Update: Palliative Care
• Next Steps and Close
Welcome

Laura Kate Zaichkin, MPH
Director of Health Plan Performance and Strategy
SEIU 775 Benefits Group
New Funding
ESHB 1109

(31) $300,000 of the general fund—state appropriation for fiscal year 2020 and $300,000 of the general fund—state appropriation for fiscal year 2021 are provided solely for the Bree collaborative to support collaborative learning and targeted technical assistance for quality improvement initiatives. The collaborative must use these amounts to hire one full-time staff person to promote the adoption of Bree collaborative recommendations and to hold two conferences focused on the sharing of best implementation practices.
# March 20th Meeting Minutes

**Dr. Robert Bree Collaborative Meeting Minutes**  
March 20th, 2019 | 12:30-4:30  
Puget Sound Regional Council  
1101 Western Ave | Seattle, WA 98104

## Members Present

<table>
<thead>
<tr>
<th>Hugh Straley, MD, (Chair)</th>
<th>Kimberly Moore, MD, Franciscan Health System</th>
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<tbody>
<tr>
<td>Susie Dade, MS, Washington Health Alliance</td>
<td>Carl Olden, MD, Pacific Crest Family Medicine</td>
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<td>Peter Dunbar, MB, ChB, MBA, Foundation for Health Care Quality</td>
<td>Drew Oliveira,* MD, Regence</td>
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<td>Gary Franklin, MD, Labor and Industries</td>
<td>Mary Kay O’Neill MD, MBA, Mercer</td>
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<td>Stuart Freed, MD, Confluence Health</td>
<td>John Robinson, MD, SM, First Choice Health</td>
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<tr>
<td>Richard Goss,* MD, Harborview Medical Center</td>
<td>Jeanne Rupert, DO, PhD, One Medical</td>
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<tr>
<td>Rick Ludwig, MD, Providence Health Accountable Care</td>
<td>Kerry Schaefer, MS, King County</td>
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<tr>
<td>Greg Marchand, Director, The Boeing Company</td>
<td>Angie Sparks, MD, Kaiser Permanente</td>
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<tr>
<td>Robert Mecklenburg, MD, Virginia Mason Medical Center</td>
<td>Shawn West, MD, Provider</td>
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<td>Judy Zerzan, MD, MPH, Health Care Authority</td>
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Value Acceleration Strategic Initiative

Imran Andrabi, MD
President and CEO of ThedaCare
Chair of WCHQ Value Acceleration Advisory Group

Gabrielle Rude, PhD
WCHQ Director of Practice Transformation

Bree Collaborative
May 15, 2019
The WCHQ Mission

Founded by Wisconsin health care leaders in 2003, WCHQ is one of the first organizations of its kind in the country. It is dedicated to helping health care professionals improve the quality and affordability of health care through collaboration and public reporting.
WCHQ Participants

Members
Wisconsin Healthcare Provider Organizations
- Health Systems
- Medical Groups
- Hospitals
- Dental Practices

Board of Directors
- Providers
- Purchasers
- Payers

Stakeholders
Local, Regional & National Collaborators
- Purchasers / Payers
- Consumers
- Advocacy Organizations
- Government Agencies
- Research Institutions
- Foundations
## WCHQ Member Organizations

Wisconsin health systems, physician groups, and hospitals

<table>
<thead>
<tr>
<th>Access Community Health Centers</th>
<th>Froedtert Health</th>
<th>ProHealth Care</th>
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<tr>
<td>Ascension Wisconsin</td>
<td>Gundersen Health System</td>
<td>Richland Medical Center</td>
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<tr>
<td>Aspirus</td>
<td>HealthPartners</td>
<td>Sauk Prairie Memorial Hospital &amp; Clinics</td>
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<tr>
<td>Associated Physicians</td>
<td>Holy Family Memorial</td>
<td>Sixteenth Street Community Health Centers</td>
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<td>Aurora Health Care</td>
<td>Marshfield Clinic Health System</td>
<td>SSM Health</td>
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<tr>
<td>Bellin Health</td>
<td>Mayo Clinic Health System</td>
<td>ThedaCare</td>
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<tr>
<td>Beloit Health System</td>
<td>Medical College of Wisconsin</td>
<td>UnityPoint Health</td>
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<tr>
<td>Children’s Medical Group</td>
<td>Mercy Health System</td>
<td>UW Health</td>
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<tr>
<td>Divine Savior Healthcare</td>
<td>Oak Leaf Network</td>
<td>Vibrant Family Health Center</td>
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<tr>
<td>ForwardDental</td>
<td>Prairie Clinic</td>
<td>Wildwood Family Clinic</td>
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<td>Fort HealthCare</td>
<td>Prevea Health</td>
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<td>Primary Care Associates of Appleton</td>
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Wisconsin Collaborative for Healthcare Quality
WCHQ Core Competencies

• Development, collection and public reporting of performance measures
• Creation and dissemination of quality improvement strategies
• Facilitation of collaboration and sharing of best practices across the WCHQ membership
Performance Measurement & Public Reporting

• WCHQ data is submitted from member organizations’ EHRs and includes all patients, all payers
• Statewide benchmarking
• Customized facility-specific score cards are sent to members
• Analysts are on staff to assist members in running reports
• WCHQ collects disparity data that will soon be released in a public report
2019 WCHQ Measures*

44 Total Measures

- Behavioral Health
- Cancer Prevention
- Cardiac Specialty
- Diabetes
- Hypertension
- Immunizations
- IVD
- Obesity
- Osteoporosis
- Patient Experience
- Pediatric Prevention
- Tobacco Use and Cessation

Number of Measures

- Process
- Outcome
- Composite

* Publicly reported on WCHQ.org
WCHQ Public Reporting of Performance at the Clinic Level

Measure results

Measure:
Diabetes: Blood Sugar (A1c) Control

Reporting period:
Q1 2018 - Q4 2018

<table>
<thead>
<tr>
<th>Name</th>
<th>Result</th>
<th>Patients</th>
<th>Historical</th>
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<tr>
<td>ABHC-GREEN BAY, MASON ST</td>
<td></td>
<td>894</td>
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<td>ACHC ERDMAN FAM MED</td>
<td></td>
<td>368</td>
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<tr>
<td>ACHC WINGRA PARK FISH FAM MED CENTER</td>
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<tr>
<td>AMC-ABMC, STE 120</td>
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<td>832</td>
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<tr>
<td>AHC-AWAMC POT 2ND FLR</td>
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<tr>
<td>AHC-BROOKFIELD</td>
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The WCHQ Mission

For more than 15 years WCHQ has been dedicated to helping health care professionals improve the quality and affordability of health care through collaboration and public reporting.
Healthcare in Wisconsin is Exceptional

And now....

• Wisconsin has the opportunity to improve performance related to the per capita cost of health care.

• WCHQ’s members have asked for bold initiatives that transcend boundaries
  ▪ New partners
  ▪ New focus on affordability
  ▪ New speed of improvement
The Value Acceleration Initiative

• Narrow the focus
• Engage payers and purchasers in improvement alongside providers
• Use claims and clinical data
• Identify improvement strategies spanning clinical practice, benefit design, and contracting
Priority Selection Criteria

• High cost area of care and/or procedures;
• Low performance compared to available benchmark data;
• Significant variation in practice;
• High utilization without demonstrating better patient outcomes;
• Alignment with national, regional and state pay-for-performance programs;
• Patient safety concerns, and
• In 2019: feasible for first year of the initiative
2019 Value Acceleration Focus Area

• Patients with Multiple Morbidities

Steering Team Responsibilities

• Review available literature and data
• Consult with specialists and specialty organizations
• Identify improvement strategies
• Develop report of recommendations across the healthcare continuum -- clinical, contracting, and benefit design
WCHQ: 2019 and Beyond

• Oral Health Collaborative
• Disparities
• Clinical Claims Data Integration
• Measure Harmonization
• Individual Provider Reporting
• Continue Value Acceleration Work
Thank You

Questions

Gabrielle Rude, PhD, grude@wchq.org

Imran Andrabi, MD, imran.andrabi@thedacare.org
Agency Medical Directors Group: Input on New Topics

Judy Zerzan, MD, MPH
Chief Medical Officer, Washington State Health Care Authority
Looking Back, Looking Forward

Discussing Topics for 2020
Reviewing Status of Previous Recommendations

Ginny Weir, MPH
Director

May 15, 2019 | Puget Sound Regional Council
Our Purpose

• “...to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.”

• “…identify **health care services** for which there are substantial variation in practice patterns or high utilization trends in Washington state, without producing better care outcomes for patients, that are indicators of poor quality and potential waste in the health care system. On an annual basis, the collaborative shall identify up to three health care services it will address.”
Final products may be selected for re-review annually or if “new evidence suggests the need for modification of clinically important recommendations (e.g., if new evidence shows that a recommended intervention causes previously unknown substantial harm, that a new intervention is significantly superior to a previously recommended intervention from an efficacy or harms perspective, or that a recommendation can be applied to new populations)” one year after adoption.
NEW SECTION. Sec. 6. A new section is added to chapter 70.250 RCW to read as follows:

1. No later than January 1, 2020, the collaborative shall begin a review to identify, define, and endorse guidelines for the provision of high quality sexual and reproductive health services in clinical settings throughout Washington. This shall include the development of specific clinical recommendations to improve sexual and reproductive health care for:
   a. People of color;
   b. Immigrants and refugees;
   c. Victims and survivors of violence; and
   d. People with disabilities.

2. The collaborative shall conduct its review consistent with the activities, processes, and reporting standards specified in RCW 70.250.050. In conducting its review, the collaborative shall apply a whole-person framework to develop evidence-based, culturally sensitive recommendations to improve standards of care and health equity.

3. By December 15, 2020, the collaborative, through the authority, shall provide a status report to the committees of the legislature with jurisdiction over matters related to health care and to the governor.

Suggestions from the Community

- Endoscopic procedures
- Chronic Heart Failure (e.g., optimal care for CHF patients after discharge from the hospital)
- Prior authorization/health plan variation
- Prior authorizations (esp for medication)
- Avoiding emergency department utilization (e.g., CARES model in Spokane)
- PTSD/Trauma Treatment, and Mental Health (see attached) Medications (e.g. "Seattle is Dying")
- Statewide Healthcare Insulin-Drug Pricing for Diabetics
- Primary care bundle
- Chronic pain (e.g., non-pharmacological treatments coverage, evidence, education of providers and public)
Suggestions from the Community

• Real EHR Interoperability leading to better continuity of care
• Enhanced patient safety as a result of much better enterprise (s) Clinical Reconciliation. (Medication, Allergy and Problem lists)
• Gender inequality in ST-Elevation Myocardial Infarction (STEMI) care
• Behavioral Health Homes (integration of medical services into behavioral health clinics). I know that our primary focus 2 years prior was on primary care integration.
• Racial disparity (e.g., African American rates of high blood pressure, stress, and maternal mortality)
• Healthy eating in disease prevention
• Autoimmune disorders
• Oncology centers of excellence
• Sepsis protocols
THE SEPSIS EPIDEMIC: 
COSTS, CAUSES, MORTALITY RATES, 
AND SOLUTIONS

Costs: Thousands of Lives Lost Annually, Billions of Dollars Drained

Sepsis is a national public health crisis affecting more than 1.7 million Americans annually. Approximately 270,000 Americans die from sepsis each year, more than breast cancer, prostate cancer, HIV/AIDS, and opioid overdoses combined.¹

This crisis is further exacerbated by the economic burden of sepsis management. Sepsis is the most common and expensive clinical condition treated in hospitals, costing $23.7 billion annually. Sepsis is the second-highest hospital condition billed to Medicaid, behind childbirth costs.²

Causes: What is Sepsis?

Sepsis is the body’s overwhelming and life-threatening response to an infection, such as pneumonia, influenza, or urinary tract infections. Without timely treatment, sepsis can rapidly lead to tissue damage, organ failure, and death. Many of those who survive sepsis are left with life-changing effects, which may include, post-traumatic stress disorder, chronic pain, organ dysfunction, or amputations.

Mortality Rates: Disparities Reported Among States, Diverse Communities

According to the CDC, states with the highest age-adjusted sepsis death rate per 100,000 total population include: Louisiana, Kentucky, Alabama, Mississippi, New Jersey, Indiana, Texas, Georgia, West Virginia, and South Carolina.³

Hospital characteristics contribute to higher sepsis mortality rates in African American and Latino populations. This health disparity underscores the importance of improving sepsis identification and management in hospitals serving diverse communities.
1. Too frequent cervical cancer screening in women
2. Preoperative baseline laboratory studies prior to low-risk surgery
3. Unnecessary imaging for eye disease
4. Annual EKGs or cardiac screening in low risk, asymptomatic individuals
5. Prescribing antibiotics for acute upper respiratory and ear infections
6. PSA screening
7. Population-based screening for OH-Vitamin D deficiency
8. Imaging for uncomplicated low back pain in the first six weeks
9. Preoperative EKG, chest x-ray and pulmonary function testing prior to low risk surgery
10. Cardiac stress testing
11. Imaging for uncomplicated headache
Re-Review Protocol

I. Expert Comments

1. Email workgroup chair and members key questions and the focus areas for feedback on whether new evidence or guidelines exist
   • Are you aware of new evidence (published after the recommendation) that contradict the focus areas?
   • Are you aware of any changes to the community standard of care around our focus areas?
   • Are you aware of new guidelines that might contradict the focus areas?
   • Are you aware of new work within Washington State that aligns with the focus areas?
   • Do you have suggestions for ways in which the recommendations should be expanded?

2. Email other interested stakeholders and topic-specific regional organizations the key questions and a request for input on new protocols or known evidence
Re-Review Protocol

II. Evidence and Guideline Review

3. AHRQ Evidence-Based Practice Reports
   • Includes USPSTF reviews

4. Cochrane Collection

5. Health Technology Assessment Program

6. Center for Disease Control and Prevention

7. Institute for Clinical and Economic Review

8. Veterans Administration Evidence-based Synthesis Program

9. Others, as applicable (e.g., American Heart Association)
• Eliminate all elective deliveries before the 39th week (those deliveries for which there is no appropriate documentation of medical necessity).

• Decrease elective inductions of labor between 39 and up to 41 weeks.

• Decrease unsupported variation among Washington hospitals in the primary cesarean-section rate.

Currently developing maternity care bundle
AHRQ Evidence-Based Practice Reports
- Strategies To Reduce Cesarean Birth in Low-Risk Women (October 2012)

American College of Obstetricians and Gynecologists
- Elimination of Non-Medically Indicated (Elective) Deliveries before 39 Weeks Gestational Age (February 2012)
- Patient information on cesarean birth (May 2015)
- Cesarean Delivery on Maternal Request (April 2013, reaffirmed 2017)
- Safe Prevention of the Primary Cesarean Delivery (March 2014, reaffirmed 2016)
- Nonmedically Indicated Early-Term Deliveries (April 2013, reaffirmed 2017)

Cochrane Collection
- Non-clinical interventions for reducing unnecessary caesarean section (2018)
- Planned caesarean section versus planned vaginal birth for severe pre-eclampsia (2017)
- Impact of offering incentives in exchange for attending prenatal care visits on maternal and neonatal health outcomes (2015)
- Routine antibiotics at cesarean section to reduce infection (2014)
- Planned elective repeat caesarean section versus planned vaginal birth for women with a previous caesarean birth (2013)
- Cephalic version by postural management for breech presentation (2012)
- Relaxation therapy for preventing and treating preterm labour (2012)

BMJ Clinical Evidence - Preterm or premature birth review conducted June 2010.
March of Dimes (having a c-section, less than 39 weeks toolkit)
• Clinical Outcomes Assessment Program (COAP)
• Publicly disclose hospitals’ insufficient information reports and the appropriateness of PCI procedures
• Realistic and aggressive timeline
• Average rate of insufficient information to determine appropriate use of non-acute PCI has reduced steadily from 29% in 2011 to 22% in 2014.

COAP recommendation:
• All hospitals participate in Spine COAP
  • 18 Hospitals participating
• Results unblinded
  • Length of stay, radiologic verification of surgical level, and smoking use have been transparently available on the website.
• Increase appropriate evaluation and management of patients with new onset and persistent acute low back pain and/or nonspecific LBP not associated with major trauma (no red flags) in primary care

• Increase early identification and management of patients that present with LBP not associated with major trauma (no red flags) but have psychosocial factors (yellow flags) that place them at a high risk for developing chronic low back pain

• Increase awareness of low back pain management among individual patients and the general public
Low Back Pain
Evidence and Guideline Review

• AHRQ Evidence-Based Practice Reports
  • Treatment for Acute Pain: An Evidence Map (2019)
  • Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review (2018)
  • Noninvasive Treatments for Low Back Pain (2016)
  • Pain Management Injection Therapies for Low Back Pain (2015)
  • Complementary and Alternative Medicine in Back Pain Utilization (2014)

• Guidelines
  • Department of Defense, Department of Veterans Affairs, Veterans Health Administration clinical practice guideline for diagnosis and treatment of low back pain (September 2017)
  • American College of Physicians Noninvasive treatments for acute, subacute, and chronic low back pain: a clinical practice guideline (April 2017)
  • American Academy of Physical Medicine and Rehabilitation - See AHRQ's Noninvasive treatments for low back pain and Choosing Wisely (September 2014)
  • American College of Occupational and Environmental Medicine - can't access without membership
  • North American Spine Society Diagnosis and Treatment of Low-Back Pain Evidence-Based Guideline (under development)

• Cochrane Collection
  • Multidisciplinary treatment at the early stages of low back pain (2017)
  • Yoga treatment for chronic non-specific low back pain (2017)
  • Non-steroidal anti-inflammatory drugs for low back pain with sciatica (2016)
  • Surgical versus non-surgical treatment for lumbar spinal stenosis (2016)
  • Massage for low-back pain (2015)
  • Pilates for low back pain (2015)
  • Cognitive-behavioural treatment for neck pain (2015)
Low Back Pain Evidence and Guideline Review

- Center for Disease Control and Prevention – (out of scope) Use of Complementary Health Approaches for Musculoskeletal Pain Disorders Among Adults: United States, 2012
- Institute for Clinical and Economic Review
  - Low Back Pain (October 2017)
  - Management Options for Patients with Low Back Pain Disorders (June 2011)
- BMJ Clinical Evidence
  - Low back pain (chronic) (Published October 2010, April 2009 search)
  - Low back pain (acute) non-drug treatments (Published, August 2015, October 2013 search)
  - Neck pain with radiculopathy (Published December 2015, September 2014 search)
- Veterans Administration Evidence-based Synthesis Program
  - Option to expand recommendations: Evidence Map of Acupuncture (January 2014); Evidence Map of Yoga for High-Impact Conditions Affecting Veterans (August 2014); Evidence Map of Tai Chi (September 2014); Evidence Map of Mindfulness (October 2014)
  - Electronic Health Record-based Interventions for Reducing Inappropriate Imaging in the Clinical Setting: A Systematic Review of the Evidence (January 2015)
- National Guideline Clearinghouse
  - ACR Appropriateness Criteria® low back pain (2015)
  - Washington State L&I Options for documenting functional improvement in conservative care (April 2014)
  - Colorado Workers Comp Low back pain medical treatment guidelines (February 2014)
Accountable Payment Models: Total Knee and Total Hip Replacement

Avoidable Hospital Readmissions
July 2014

• Build community-collaboratives
• Adopt the Washington State Hospital Association's Care Transitions Toolkit
• Measure and report
Avoidable Hospital Readmissions
Evidence and Guideline Review

- AHRQ Evidence-Based Practice Reports
  - Transitional Care Interventions To Prevent Readmissions for People With Heart Failure (May 2014)
  - Management Strategies to Reduce Psychiatric Readmissions (May 2015)
  - Re-Engineered Discharge (RED) Toolkit
- National Guideline Clearinghouse - Many guidelines on care transitions and on management of particular conditions that include preventing readmissions
  - American College of Emergency Physicians (February 2017) Exclusively Endorses Edie™ (A.K.A. Premanage ED) Solution From Collective Medical Technologies
- Cochrane Collection
  - (2017) Services for patients discharged home early
  - (2016) Discharge planning from hospital
- BMJ Clinical Evidence (not specifically)
- Veterans Administration Evidence-based Synthesis Program
  - Risk Prediction Models for Hospital Readmission: A Systematic Review (October 2011)
  - Transitions of Care from Hospital to Home: An Overview of Systematic Reviews and Recommendations for Improving Transitional Care in the Veterans Health Administration (January 2015)
• WSHA still recommends all hospitals implement the elements of WSHA’s Care Transitions Toolkit.
  • Toolkit outlines baseline readmission interventions that all hospitals should have well implemented and embedded into culture. WSHA now focusing on expanding to incorporate more elements of person and family engagement and health equity.

• For the past two years, WSHA has been promoting and coaching hospitals on implementation of The Agency for Healthcare Research and Quality’s ASPIRE guide.
  • Focuses on whole-person transitional care for all patients rather than solely focusing on medical readmission interventions.

• This year, WSHA narrowed readmissions focus to high utilizers or Multi Visit Patients (MVP) (4+ visits in 12 months) – spreading to all hospitals
  • Term developed by Dr. Amy Boutwell, lead author of ASPIRE who has coached WA hospitals to implement MVP Method.
  • MVP’s in WA are 7% of hospitalized patients, 55% of 30-day all-cause all-payer readmissions (CHARS)
· Accountable Communities of Health highly focused on supporting hospitals with implementing the elements of WSHA’s Care Transitions Toolkit.
  · We have begun to engage the ACH’s on supporting the MVP work.
· Readmission recommendations should be expanded to include more focus on person and family engagement and improving health equity.
• Awareness of advance care planning, advance directives, and POLST in Washington State

• The number of people who participate in advance care planning in the clinical and community settings

• The number of people who record their wishes and goals for end-of-life care using documents that: accurately represent their values; are easily understandable by all readers including family members, friends, and health care providers; and can be acted upon in the health care setting

• The accessibility of completed advance directives and POLST for health systems and providers

• The likelihood that a patient’s end-of-life care choices are honored

Palliative Care recommendations currently being developed.
End-of-Life Care
Evidence and Guideline Review

- AHRQ Evidence-Based Practice Reports: Assessment Tools for Palliative Care (May 2017)


- Cochrane Collection
  - Advance care planning for haemodialysis patients (2016)
  - End-of-life care pathways for the dying (2016)

- Center for Disease Control and Prevention
  - Some data briefs on use of advance directives in specific populations

- Institute for Clinical and Economic Review
  - Palliative Care in the Outpatient Setting (April 2016)

- Veterans Administration Evidence-based Synthesis Program
  - Effectiveness of Family and Caregiver Interventions on Patient Outcomes among Adults with Cancer or Memory-Related Disorders: A Systematic Review (April 2013)
  - Racial and ethnic disparities in the VA healthcare System: A systematic review (June 2007)
• Reduce stigma
• Increase screening
• Provide brief intervention and brief treatment
• Facilitate referrals
• Address the opioid epidemic
Addiction and Dependence Treatment Evidence and Guideline Review

- AHRQ Evidence-Based Practice Reports
  - **Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions** (November 2018) B The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.
  - Currently being updated: "Drug Use in Adolescents and Adults, Including Pregnant Women: Screening"
  - (2016) Pharmacotherapy for Adults With Alcohol Use Disorder in Outpatient Settings
- Cochrane Collection
  - Psychosocial interventions to reduce alcohol consumption in concurrent problem alcohol and illicit drug users (2018)
  - Motivational interviewing (MI) for preventing alcohol misuse in young adults is not effective enough (2016)
  - Can brief interventions delivered in schools reduce substance use among adolescents? (2016)
  - Interventions for drug-using offenders with co-occurring mental illness (2015)
  - Interventions for female drug-using offenders (2015)
  - Psychosocial interventions to reduce sedative use, abuse and dependence
- Center for Disease Control and Prevention
  - MMWR March 2017 "Screening for Excessive Alcohol Use and Brief Counseling of Adults — 17 States and the District of Columbia, 2014"
- Institute for Clinical and Economic Review: Opioid Dependence (July 2014)
- Veterans Administration Evidence-based Synthesis Program
  - e-Interventions for Alcohol Misuse (September 2014)
- Other studies: Ten Years of Implementing SBIRT: Lessons Learned. Subst Abus. 2017 Aug 1:0.
Psychosocial interventions to reduce alcohol consumption in concurrent problem alcohol and illicit drug users (2018)

Comparison 2: brief intervention versus treatment as usual (three studies, 197 participants)

There was no significant difference between groups for either of the primary outcomes (alcohol use, measured as scores on the Alcohol Use Disorders Identification Test (AUDIT) or Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) at three months: standardised mean difference (SMD) 0.07 (95% CI -0.24 to 0.37); and retention in treatment, measured at three months: RR 0.94 (95% CI 0.78 to 1.13), or for any of the secondary outcomes reported. The quality of evidence for the primary outcomes was low.
Addiction and Dependence Treatment
Expert Comments

Rick Ries, MD, University of Washington Medical Center (2018)

- The UW ACO has made good progress with the first three items by integration of screening and to some degree behavioral health integration in many primary care sites by including this and with EPIC “builds” right into the EPIC yearly health maintenance evaluation.
• Disability Despite Non-Surgical Therapy
• Fitness for Surgery
• CABG Procedure
• Post Operative Care and Return to Function
• Quality Metrics
• Warranty
Coronary Artery Bypass Graft Surgical Bundle and Warranty
Evidence and Guideline Review

- AHRQ Evidence-Based Practice Reports
  - Noninvasive Testing for Coronary Artery Disease (March 2016)
  - Diagnostic Accuracy of Screening Tests and Treatment of Post-Acute Coronary Syndrome (ACS) Depression: A Systematic Review (April 2017)

- Guidelines
  - Clinical guidelines on myocardial revascularization (April 2016) have been issued by the following organizations: American College of Cardiology (ACC)/American Heart Association (AHA); European Society of Cardiology (ESC)/European Association for Cardio-Thoracic Surgery (EACTS); Society of Thoracic Surgeons
  - STS (December 2015) New Clinical Practice Guidelines Recommend Use of Arteries Rather than Veins in Heart Bypass Surgery
  - The Society of Thoracic Surgeons Clinical Practice Guidelines on Arterial Conduits for Coronary Artery Bypass Grafting

- Cochrane Collection
  - Interventions to promote patient utilisation of cardiac rehabilitation (2018)
  - Effects of remote ischaemic preconditioning in patients undergoing coronary artery bypass graft surgery (with or without valve surgery) (2017)
  - Psychological treatments for coronary heart disease (2017)
  - Education for people with coronary heart disease (2017)
Coronary Artery Bypass Graft Surgical Bundle and Warranty
Evidence and Guideline Review

- Exercise-based rehabilitation for coronary heart disease (2016)
- Antiplatelet agents for preventing failure of peripheral arterial grafts (2015)
- Internet-based programmes for people with heart disease (2015)
- Do statins prevent kidney failure in adults after surgery where cardiac bypass is used? (2015)

- Health Technology Assessment Program
  - Cardiac stents (March 2016) - Either drug eluting or bare metal cardiac stents are a covered benefit when cardiac stents are indicated
  - Prior: Carotid artery stenting (November 2013) - Carotid Artery Stenting is a covered benefit with conditions consistent with the criteria identified in the reimbursement determination.

- Veterans Administration Evidence-based Synthesis Program - No specific reviews - certain elements (e.g., management of hypoglycemia)
• I don’t think it would be very important to do this. I’ve found that often CABG patients are too complex, and often the operation is fairly urgent. Not a lot of patient are appropriate for the bundle. – Drew Baldwin, MD, Virginia Mason

• Unencumbered with data, my bias would be to re-review the bundle to keep it market-relevant. – Bob Mecklenburg, MD, Virginia Mason
Prostate Cancer Screening
November 2015

- No routine screening with PSA testing for men:
  - At average risk 70 years and older,
  - At average risk under 55 years old,
  - Who have significant co-morbid conditions, or with a life expectancy less than 10 years.

- Shared decision making process formalized and documented in the patient’s medical record.
  - Should be certified by State when available
  - Should not be used alone without a comprehensive, patient-centered discussion.

- Two possible pathways depending on the physician’s interpretation of the evidence
Prostate Cancer Screening
Evidence and Guideline Review

• AHRQ Evidence-Based Practice Reports
  • **New USPSTF recommendation Screening for Prostate Cancer** (May 2018)
    • Moved recommendation from grade D (Discourage the use of this service) to C (Offer or provide this service for selected patients depending on individual circumstances).
    • More closely aligned with Bree 2015 language
    • New language: For men aged 55 to 69 years, the decision to undergo periodic PSA-based screening for prostate cancer should be an individual one and should include discussion of the potential benefits and harms of screening with their clinician. (C)
    • Men age 70 and older: The USPSTF recommends against PSA-based screening for prostate cancer in men age 70 years and older. (D)

• American Urological Association Early Detection of Prostate Cancer (Published 2013; Reviewed and Validity Confirmed 2015) same as included in recommendations

• Veterans Administration Evidence-based Synthesis Program

• The Effects of Shared Decision Making on Cancer Screening – A Systematic Review (September 2014)
I am unaware of significant changes in any of these areas. – Matt Handley, MD, Kaiser Permanente of Washington

From the patient & family perspective, I feel the recommendations from the workgroup are still relevant. My only suggestion (if a re-review is set up) is for the recommendations to see wider distribution and to be more visible in the community. - Steve Lovell, patient advocate
Reducing unnecessary advanced imaging for early prostate and breast cancer
Integration of palliative care alongside active anti-cancer therapy

Palliative Care recommendations currently being developed.
AHRQ Evidence-Based Practice Reports
- Assessment Tools for Palliative Care (May 2017)

Guidelines: American Society of Clinical Oncology Integration of Palliative Care Into Standard Oncology Care (October 2016)
- The April 2012 and October 2013 Choosing Wisely guidelines on early prostate and breast cancer are still in effect.

Cochrane Collection: Early palliative care for adults with advanced cancer (2017)

Institute for Clinical and Economic Review Palliative Care in the Outpatient Setting (April 2016)

BMJ Clinical Evidence Benign prostatic hyperplasia and male lower urinary tract symptoms (LUTS) (search July 2009); Breast cancer (non-metastatic) (April 2009 search)

Veterans Administration Evidence-based Synthesis Program
- Integrated Outpatient Palliative Care in Oncology (October 2017)
I do not have any evidence to suggest that this work need to be re-addressed. – Keith Eaton, MD, Seattle Cancer Care Alliance
• Eligibility Due to Obesity Despite Non-Surgical Therapy
• Fitness for Surgery
• Bariatric Surgery
• Post-Operative Care and Return to Function
• Quality Metrics
• Warranty
• I think there isn’t any new evidence that would substantially change this. – David Arterburn, MD, Kaiser Permanente
• Initial medical and psychological evaluation using appropriate assessment
• Access to comprehensive, family-centered psychosocial care whether within the primary care setting through integrated behavioral health care or through a supported referral
• Evidence-based, best practice antipsychotic prescribing recommendations such as from the American Academy of Child and Adolescent Psychiatry
• If antipsychotics are prescribed, manage side effects including monitoring for changes in weight blood glucose (HgA1C), cholesterol, and other metabolic changes (baseline and at regular intervals).
Pediatric Psychotropic Use
Evidence and Guideline Review

- AHRQ
  - (2017) First- and Second-Generation Antipsychotics in Children and Young Adults: Systematic Review Update
  - There was little information directly comparing different antipsychotics, on patient-important outcomes including quality of life, and on outcomes for young children. First generation antipsychotics (FGA) probably cause less weight gain than second generation antipsychotics (SGA) and (for schizophrenia) there may be little or no difference between the classes for reducing symptoms and illness severity. SGAs probably improve to some extent symptoms for which they are usually prescribed, but also cause adverse effects including weight gain, high triglyceride levels, extrapyramidal symptoms, sedation, and somnolence. More research is needed comparing the effects of different antipsychotics over the long-term and developing monitoring systems.

- ICER
  - Tardive Dyskinesia (December 2017)
Some of us sat on a SAMHSA panel last May about antipsychotic prescribing. That report just got published: https://store.samhsa.gov/treatment-prevention-recovery/antipsychotics - Rob Penfold, PhD, Kaiser Permanente Washington Health Research Institute
Integrated Care Team

Patient Access to Behavioral Health as a Routine Part of Care

Accessibility and Sharing of Patient Information

Practice Access to Psychiatric Services

Operational Systems and Workflows to Support Population-Based Care

Evidence-Based Treatments

Patient Involvement in Care

Data for Quality Improvement
Opioid Use Disorder
November 2017

- Access to evidence-based treatment
  - Medication treatment: buprenorphine, methadone, naltrexone (e.g., increase geographic reach, increase number of providers)
  - Reduction in stigma associated with treatment

- Referral information
  - Providers and patients know where to access care
  - Accessible inventory of buprenorphine and methadone prescribers
  - Referral infrastructure that supports patients and providers

- Integrated behavioral and physical health to support whole-person care
  - Treatment of comorbid conditions including multiple substance use, mental illness, and physical health in line with Behavioral Health Integration Report and Recommendations
Opioid Use Disorder
Evidence and Guideline Review

- ICER
  - (2018) Opioid Use Disorder Extended-Release Opioid Agonists and Antagonist Medications for Addiction Treatment (MAT) in Patients with Opioid Use Disorder: Effectiveness and Value
Opioid Use Disorder
Expert Opinion

- I don’t know of major new findings. Nothing that contradicts our findings per se. – Caleb Banta Green, PhD, University of Washington

- In general, I am also not aware of any new data that would change our recommendations. A randomized trial that compared oral to injectable naltrexone was completed which showed superiority of the injectable, and that is in line with our recommendations. – Andrew Saxon, MD, University of Washington School of Medicine, VA Puget Sound Health Care System

- One area where the guideline could use updating in my opinion is the area of measurement. The current section focuses on OUD related outcomes and penetration of services. Our recommendations are to support the evidence-based use of medications for opioid use disorder. The consensus for use of these is persisting treatment, but our measurement section does not emphasize the importance of this or set standards that I think we would want to. Several other organizations have been working on measurement development and I think we could endorse one of these as appropriate to adopt for use in some way. I would suggest the National Quality Forums measure for MOUD persistence - Ryan Caldeiro, MD, Kaiser Permanente
Alzheimer’s Disease and Other Dementias
November 2017

• Early detection and appropriate diagnosis
• Ongoing care and support or management including for family members and caregivers
• Advance care planning and palliative care
• Assessment and planning for need for increased support and/or higher levels of care
• Preparing for potential hospitalization
• Screening for delirium risk during hospitalization for all patients over 65
Alzheimer’s Disease and Other Dementias Evidence and Guideline Review

- AHRQ
  - To be completed (2018) Care Interventions for People With Dementia (PWD) and Their Caregivers
I am currently working on a revision of the LANCET Commission. It contains a lot of new information – most of it does not reference the questions or focus areas below but there will be some. In addition the National Academy of Medicine has a major report in progress that focus on ongoing care of persons with AD. To me the question for Bree is, do we wait and harvest the work of these two national/international type evidence collection exercises – or try to run in parallel. There’s a lot in this area and some aspects (like medication treatments, advance care planning) are indeed changing – Eric Larson, MD, Kaiser Permanente Washington
• Assessment and medical management, by indication
• Uterine sparing procedures, by indication
• Surgical procedure including follow-up care, emphasizing the enhanced recovery after surgery protocol and use of a minimally invasive approach
Conclusion. A range of interventions are effective for reducing fibroid size and improving symptoms. Some medications and procedures also improve quality of life. Few studies directly compare interventions. The risk of encountering a leiomyosarcoma at the time of fibroid surgery is low, and the method of fibroid removal may influence survival. Evidence to guide choice of intervention is likely best when applied in the context of individual patient needs and preferences.

Cochrane

Approaches to endometrial ablation have evolved from first-generation techniques to newer second- and third-generation approaches. Current evidence suggests that compared to first-generation techniques (endometrial laser ablation, transcervical resection of the endometrium, rollerball endometrial ablation), second-generation approaches (thermal balloon endometrial ablation, microwave endometrial ablation, hydrothermal ablation, bipolar radiofrequency endometrial ablation, endometrial cryotherapy) are of equivalent efficacy for heavy menstrual bleeding, with comparable rates of amenorrhoea and improvement on the PBAC. Second-generation techniques are associated with shorter operating times and are performed more often under local rather than general anaesthesia. It is uncertain whether perforation rates differed between second- and first-generation techniques. Evidence was insufficient to show which second-generation approaches were superior to others and to reveal the efficacy and safety of third-generation approaches versus first- and second-generation techniques.
Previously considered, not selected

- Chemotherapy
- Colonoscopy
- Obesity/ Youth Obesity (2013, 2015)
- Sleep Therapy
- Hepatitis C Management
- Antibiotic Stewardship
- Diabetes Care Bundled Payment Model
- Falls Prevention
- Genetic Testing
- Post-Acute Brain Injury Treatment
- Clinician Wellness
- Prior Authorization
- Re-Review of Potentially Avoidable Hospital Readmissions
- Retinal imaging
Break
Workgroup Members

- **Co-Chair**: Gary Franklin, MD, MPH, Medical Director, Washington State Department of Labor and Industries
- **Co-Chair**: Charissa Fotinos, MD, Deputy Medical Officer, Health Care Authority
- **Co-Chair**: Andrew Saxon, MD, Director, Center of Excellence in Substance Abuse Treatment and Education (CESATE), VA Puget Sound Health Care System
- Jane C. Ballantyne MD, FRCA, Professor (retired) of Anesthesiology and Pain Medicine, Director, University of Washington Pain Fellowship
- Chris Baumgartner, Director Prescription Monitoring Program, Washington State Department of Health
- David Buchholz, MD, Medical Director of Provider Engagement, Premera Blue Cross
- Pamela J. Davies MS, ARNP, ACHPN, BC, Teaching Associate, University of Washington Medical Center
- Deborah Fulton-Kehoe, PhD, MPH, Senior Research Scientist, University of Washington
- Frances Gough, MD, Chief Medical Officer, Molina
- Dan Kent, MD, Chief Medical Officer, United Healthcare
- Kathy Lofy, MD, Chief Science Officer, Washington State Department of Health
- Jaymie Mai, PharmD, Pharmacy Manager, Washington State Department of Labor and Industries
- Joseph O. Merrill, MD, MPH, Acting Assistant Professor, Internal Medicine
- Attending Physician, Adult Medicine Clinic, Harborview
- Mark Murphy, MD, Addiction Medicine, Multicare Health
- Yusuf Rashid, PharmD, Vice President, Community Health Plan of Washington
- Shirley Reitz, PharmD, Pharmacist, OmedaRx, Cambia Health
- Greg Rudolf, MD, Pain Services, Swedish
- Mark Stephens, Principal, CareSync Consulting, LLC
- Mark Sullivan
- David Tauben, MD, Chief of Pain Medicine, University of Washington Medical Center
- Gregory Terman MD, PhD, Professor, Department of Anesthesiology and Pain Medicine and the Graduate Program in Neurobiology and Behavior-Co-Chair Peri-op Workgroup
- John Vassall, MD, FACP, Physician Executive, Qualis Health
- Michael Von Korff, ScD, Senior Investigator, Group Health Research Institute
Learnings and Discussions

- Data from Labor and Industries and Health Care Authority
- Literature on Assessment Tools
- Literature on Tapering
- BRAVO protocol
- Oregon Health Authority’s policies
- Learning from Polyclinic
- Learning from Columbia Valley Community Health
## Vancouver, WA Conference August 9th

**Patient-Centered Approach to Chronic Opioid Management**

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<tr>
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<tr>
<td>8:00-8:15</td>
<td>Drs. Franklin, Fotinos, and Saxon – Conference Co-chairs</td>
<td>Welcome and Objectives</td>
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<tr>
<td>8:15-8:30</td>
<td><strong>Michelle Marikos</strong></td>
<td>Peer support, and my own experience</td>
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<tr>
<td>8:30-8:50</td>
<td>Debbie Dowell, MD, MPH</td>
<td>The role of the CDC guideline in addressing patients on chronic opioid therapy</td>
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<td>9:50-9:10</td>
<td>Amy Bohnert, PhD</td>
<td>The changing epidemiology of the opioid epidemic and prevalence of patients on chronic opioid therapy</td>
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<td>9:10-9:30</td>
<td>Roger Chou, MD</td>
<td>Reviewing the evidence on outcomes of opioid tapers</td>
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<td>9:30-10:00</td>
<td>Q &amp; A</td>
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<td>Break</td>
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<tr>
<td>10:15-10:35</td>
<td>Erin Krebs, MD, MPH</td>
<td>Advancing the research agenda on providing a systematic, patient centered approach to tapering patients on chronic opioid therapy</td>
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<td>10:35-10:55</td>
<td>Michael Von Korff, ScD</td>
<td>Using validated instruments to assess effectiveness, risk of harm, and dependence/OUD of patients on chronic opioid therapy</td>
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<td>10:55-11:15</td>
<td>Jane Ballantyne, MD</td>
<td>Differentiating dependence and opioid use disorder</td>
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<td>11:15-11:35</td>
<td>Sean Mackey, MD (?)</td>
<td>Identifying patients who benefit from chronic opioid therapy</td>
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<td>11:35-12:05</td>
<td>Q &amp; A</td>
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<td>12:05-12:50</td>
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<td>12:50-1:50</td>
<td>Mark Sullivan, MD, PhD – Moderator</td>
<td>Panel: Engaging providers and patients</td>
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<td>Andrew Suchocki, MD, MPH</td>
<td>Engaging primary care</td>
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<td>Stephen Thielke, MD</td>
<td>Addressing the geriatric patient on chronic opioids</td>
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<td>1:50-2:10</td>
<td>Joe Merrill, MD</td>
<td>Opioid Agonist/Antagonist Therapy</td>
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<td>2:10-2:25</td>
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<td>2:25-3:25</td>
<td>Stuart Freed, MD – Moderator</td>
<td>Panel: Pain care innovations in health care systems</td>
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<td>Laura Mae Baldwin, MD, MPH</td>
<td>• University of Washington - Six Building Blocks</td>
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<td>Malcolm Butler, MD</td>
<td>• North Central Accountable Community of Health</td>
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<td>Ariel Smits MD</td>
<td>• Oregon Health Authority</td>
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<td>Jim Shames, MD, MPH</td>
<td>• Oregon Pain Guidance</td>
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<tr>
<td>3:25-4:00</td>
<td>Drs. Franklin, Fotinos, and Saxon</td>
<td>Summary and Closing Remarks</td>
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FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering

Safety Announcement

[4-9-2019] The U.S. Food and Drug Administration (FDA) has received reports of serious harm in patients who are having these medicines discontinue serious withdrawal symptoms.

Perspective
No Shortcuts to Safer Opioid Prescribing
Deborah Dowell, M.D., M.P.H., Tamara Haegerich, Ph.D., and Roger Chou, M.D.

Since the Centers for Disease Control and Prevention (CDC) released its Guideline for Prescribing Opioids for Chronic Pain in 2016, the medical and health policy communities have largely embraced its recommendations. A majority of state Medicaid agencies reported having implemented the guideline in fee-for-service programs by 2018, and several states passed legislation to increase access to nonopioid pain treatments. Although outpatient opioid prescribing had been declining since 2012, accelerated decreases — including in high-risk prescribing — followed the guideline’s release. Indeed, guideline uptake has been rapid. Difficulties faced by clinicians in prescribing opioids safely and effectively, growing awareness of opioid-associated risks, and a public health imperative to address opioid overdose underscored the need for guidance and probably facilitated uptake. Furthermore, the guideline was rated as high quality by the ECRI
For example, Oregon’s Medicaid and Washington’s Bree Collaborative are two current statewide policy recommendation groups that misapply the 2016 CDC Guideline and cite it as a basis for mandated opioid tapering in patients taking long-term opioid prescriptions, despite the CDC authors noting that (1) the creation of “hard limits or ‘cutting off’ opioids” is not supported by the CDC, and (2) that it “does not suggest discontinuation of opioids” for patients taking high-dose opioids, and supports reduction in cases of patient consent to do so. As such, proposals to force taper select patient groups to a pre-specified dose limit, or completely off their pain medication(s) stand in direct opposition with the CDC recommendations.
Chronic opioid therapy needs to be individualized, but most people aren't getting that

In response to the opinion piece Applause for the CDC opioid guideline authors we would like to correct the record. We were surprised to see a reference to work done by the Bree Collaborative as an example of a public program advocating involuntary tapers among patients on chronic opioid therapy for pain; this is incorrect.

The Collaborative has convened a workgroup to develop best practices for opioid prescribing for Washington state since late 2015 and is now focused on developing guidance on a patient-centered approach for people who have been prescribed chronic opioids for pain. We are a public-private partnership that makes recommendations to our state including to state agencies.
Example: Tapering Flowchart

Opioid Tapering Flowchart

- Systematically Assess Risks & Benefits (see document)
  - Risks > Benefits
    - Initiate BRAVO* protocol
      - Able to taper down until Benefits > Risks
        - On a quarterly basis, re-assess and document the risks & benefits
          - Dx = Opioid Use Disorder
            - Transition to MAT with buprenorphine (X-Waiver required) or other OUD Tx
    - Not able to taper down until Benefits > Risks
      - Dx = Complex Persistent Opioid Dependence (see document for definition)
        - Transition to buprenorphine off-label for pain (X-Waiver not required but recommended)
          - Slow down taper
            - On a quarterly basis, re-assess and document the risks & benefits
  - Benefits > Risks
    - Document Risk Benefit Assessment (RBA)
      - Monitor RBA Quarterly

Source: Mark Stephens, Change Management Consulting. www.oregonpainguidance.org
Malcolm Butler MD – 25 years as PCP and CMO of safety net clinic

• Care should be individualized and thoughtful.

• Patient engagement
  • Start the first session with “we won’t change very much today”

• Assure that goal is to keep the patient safe

• Review your credentials and your care team’s capabilities

• Let them know that you need to:
  • Review all of their prior care
  • Re-evaluate them
  • Practice within the standards of care, “my first job is to keep you safe.”
Workgroup Update:
Risk of Violence to Others

Kim Moore, MD
Associate Chief Medical Director,
CHI Franciscan
Workgroup Members

- **Chair:** Kim Moore, MD, Associate Chief Medical Director, CHI Franciscan
- G. Andrew Benjamin, JD, PhD, ABPP, Clinical Psychologist, Affiliate Professor of Law, University of Washington
- Kate Comtois, PhD, MPH, Professor, Department of Psychiatry and Behavioral Sciences, Harborview Medical Center
- Jaclyn Greenberg, JD, LLM, Policy Director, Legal Affairs, Washington State Hospital Association
- Laura Groshong, LICSW, Clinical Social Work, Private Practice
- Ian Harrel, MSW, Chief Operating Officer, Behavioral Health Resources
- Neetha Mony, State Suicide Prevention Plan Program Manager, Injury & Violence Prevention, Prevention and Community Health, Washington State Department of Health
- Kelli Nomura, MBA, Behavioral Health Administrator, King County
- Mary Ellen O'Keefe, ARNP, MN, MBA, Clinical Nurse Specialist - Adult Psychiatric/Mental Health Nursing; President Elect, Association of Advanced Psychiatric Nurse Practitioners
- Jennifer Piel, MD, JD, Psychiatrist, Department of Psychiatry, University of Washington
- Julie Rickard, PhD, Program Director, American Behavioral Health Systems – Parkside
- Samantha Slaughter, PsyD, Member, WA State Psychological Association
- Jeffery Sung, MD, Member, Washington State Psychiatric Association
- Amira Whitehill, MFT, Member, Washington Association for Marriage and Family Therapists
- **NEW:** Marianne Marlow, MA, LMHC, Member, Washington Mental Health Counseling Association
- **NEW:** Adrianne Tillery, Harborview Mental Health and Addiction Services (Certified Counselor)
• 2016 Washington State Supreme Court decision
• “Alters the scope of the ‘duty to warn or protect’ in at least three critical ways:
  1. It brings into question the groups of health care professionals who are subject to the duty to warn or protect in the voluntary inpatient and outpatient setting.
  2. The duty now clearly applies in the voluntary inpatient and outpatient setting.
  3. Most importantly, outside of the context of an involuntary commitment proceeding, the scope of persons to warn or protect now includes those that are ‘foreseeable’ victims, not reasonably identifiable victims subject to an actual threat.” Source: www.phyins.com/uploads/file/Volk%20recs-FINAL.PDF
Literature Review
Assessment

Search Terms: (violence* OR homicide*) AND (assess* OR risk* OR predict*) AND patient AND 'last 10 years'[PDat] AND (systematic review OR meta analysis)

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| Aho A, Remahl E, Paavilainen E. Homicide in the western family and background factors of perpetrator. Scand J Public Health. 2017 Jul;45(5):555-563. | AIM: Familicide is a multiple-victim homicide incident in which the killer's spouse and one or more children are slain. A systematic review was conducted to reveal the background factors of western homicide perpetrators.

METHODS: The systematic search was performed in the Arno, Medline, Cinahl, Madline, EBSCOhost Academic Search Premier and Social Services abstracts databases. The keywords were familialicide, family homicide, familialicide-suicide, familialicide-suicide, extended suicide, child, murder, family, familialicide and infanticide. The searches revealed 4199 references from the databases. The references were filtered and 32 peer-reviewed research articles revealed in years 2004-2014 were selected as data. The articles were analysed using inductive content analysis, by finding all possible background factors related to homicide.

RESULTS: The factors were described as percentages of the range. The background factors of familialicide perpetrators were categorised as follows: perpetrator who had committed homicide of a child and intimate partner and possibly committed suicide; a father who killed his children; a mother who had killed a child; a father who had committed a familialicide; and a mother who had committed a familialicide.

CONCLUSIONS: Psychological instability, violence and crime were found in all these categories of familialicides. Perpetrators who had committed a familialicide in addition to the familialicide had more often been diagnosed with depression, but they sought treatment for mental health problems less often and had violence and self-destructiveness less often in their background than in other familialicide categories. Social and healthcare professionals should be more sensitive to emerging family problems and be prepared for intervention. | https://journals.sagepub.com/doi/abs/10.1177/1403494617735877 | |

DESIGN: Systematic review and meta-analysis.

MAIN OUTCOME MEASURE: Harms related to suicidality, hostility, activation events, psychotic events and mood disturbances.

SETTING: Published trials identified by searching PubMed and Embase and clinical study reports obtained from the European and UK drug regulators.

PARTICIPANTS: Double-blind, placebo-controlled trials in adult healthy volunteers that reported on suicidality or violence or precursor events to suicidality or violence.

RESULTS: A total of 5787 publications were screened and 130 trials fulfilled our inclusion criteria. The trials were generally uninformative; 97 trials did not report the randomisation method, 75 trials did not report any discontinuations and 63 trials did not report any adverse events or lack thereof. Eleven of the 130 published trials and two of 29 clinical study reports we received from the regulatory agencies presented data for our meta-analysis. Treatment of adult healthy volunteers with antidepressants doubled their risk of harms related to suicidality and violence, odds ratio 1.85 (95% confidence interval 1.11 to 3.05, p = 0.02, I2 = 15%). The number needed to treat to harm one healthy person was 16 (95% confidence interval 8 to 100; Mantel-Haenszel risk difference 0.06). There can be little doubt that we underestimate the harms of antidepressants, as we only had access to the published articles for 11 of our 13 trials.

CONCLUSIONS: Antidepressants double the occurrence of events in adult healthy volunteers that can lead to suicide and violence. |
| https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5086537/ |
ITA INVESTIGATIONS: CAN STANDARDIZED ASSESSMENT INSTRUMENTS ASSIST IN DECISION MAKING?

In 1973, the Involuntary Treatment Act (ITA) was passed in Washington State to:

- Provide prompt evaluation and timely and appropriate treatment of persons with serious mental disorders,
- Safeguard individual rights, and
- Protect public safety.¹

Involuntary civil commitments permit the state to commit a person to a mental hospital or institution against the individual's will when meeting certain legal criteria. To determine whether an individual meets the law's requirements, an Investigator, or Designated Mental Health Professional (DMHP) must conduct a face-to-face interview. Individuals can be involuntarily committed to an inpatient psychiatric facility if they (1) present a likelihood of serious harm to themselves or others, or (2) are gravely disabled² and the DMHP believes this is due to a mental disorder.³

The ITA statute (RCW 71.05.020(25)) clarifies that serious harm exists when there is any substantial risk that physical injury will be inflicted. This risk may be established by recent overt acts, threats, or attempts to inflict physical harm, or behavior which places another individual in reasonable fear of sustaining harm.

Summary

In Washington State, specialized investigators, called Designated Mental Health Professionals (DMHPs), are responsible for determining if individuals can be committed for 72 hours under the state's Involuntary Treatment Act (ITA). The criteria established under the ITA statute (RCW 71.05.020(25)) allow individuals to be involuntarily detained to a psychiatric facility if, as a result of a mental disorder, the individual is gravely disabled or presents a substantial risk of serious harm to him or herself or others.

A DMHP relies on both professional judgment and historical case records to determine the extent to which an individual may pose a risk. While protocols have been adopted for ITA investigations, at present, DMHPs do not use a standardized risk assessment instrument to determine the level of danger an individual may pose.

This report reviews both mental health and risk assessment instruments that potentially could be utilized in an ITA investigation. None of the risk instruments discussed here, however, have been validated for use within the general population. While we could not identify suitable instruments for ITA investigations within the research literature, other measures are discussed which may assist a DMHP in the investigation process. These options include expanded access to criminal records and centralized access to previous mental health investigation and commitment data.

¹ RCW 71.05.010
² In statute, "gravely disabled" refers to a condition "in which a person, as a result of a mental disorder: (a) is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety." RCW 71.05.020 (17).
³ RCW 71.05.150
**Fordham Risk Screening Tool**

1) **Violent Behavior** "If both recent and severe are selected, please proceed to Section 3.
   a. Is there any information suggestive of violent behavior?
   b. "Have you ever physically hurt someone? When was the last time? What happened?"
   c. "Ever tried to hurt someone? Ever come close? Anybody injured?"
   d. "How many times have you hurt someone in the last 6 months?"

- Recent (past 6 months): Yes No
- Severe (requiring medical attention or acts that could have resulted in serious harm): Yes No

2) **Violent Threats** "If both recent and severe are selected in any combination between Section 1 and Section 2, please proceed to Section 5.
   a. Is there any information suggestive of violent threats?
   b. "Have you ever threatened someone? When was the last time? What happened?"
   c. "How many times did you threaten to harm someone in the last 6 months?"
   d. "Ever made threats with a knife or a gun? When? What happened?"

- Recent (past 6 months): Yes No
- Severe (threats of injury that could potentially require medical attention if carried out): Yes No

3) **Violent thoughts** "If both recent and severe are selected in any combination between Section 1, Section 2, and Section 3, please proceed to Section 5.
   a. Any information suggestive of violent thoughts?
   b. "Ever had thoughts about hurting someone? When was the last time?"
   c. "What happened? Why didn’t you act on those thoughts?"
   d. "How often did you think about hurting someone in the last 6 months?"

- Recent (past 6 months): Yes No
- Severe: Yes No

4) **Supplemental questions** "If yes was selected for any question in Section 4, return to Section 1 and asks questions again focusing on new information.
   a. Have you ever?
      i. Gotten into fights? Yes No
      ii. Had an order of protection taken out against you? Yes No
      iii. Been arrested on a violent charge? Yes No

5) **Additional risk factors**
   Current evidence of:
   a. Agitation or hostility: Yes No
   b. Paranoid ideation or delusions related to control: Yes No
   c. Treatment resistances (e.g., refusal to take medications): Yes No

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<td>PubMed</td>
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<td>Interpersonal hurts and violence against the individual have a high prevalence and are associated with a range of long-term problems in terms of psychological functioning. There is a growing body of research highlighting the role of forgiveness therapy in improving different aspects of psychological health in populations who have experienced diverse types of hurt, violence, or trauma. This article reports the findings of a systematic review and meta-analysis of the efficacy of process-based forgiveness interventions among samples of adolescents and adults who had experienced a range of sources of hurt or violence against them. Randomized controlled trials were retrieved using electronic databases and an examination of reference sections of previous reviews, each study was assessed for risk of bias. Standardized mean differences (SMDs) and confidence intervals (CIs) were used to assess treatment effects. The results suggest that forgiveness interventions are effective in reducing depression (SMD = -0.37, 95% CI [-0.68, -0.07]), anger and hostility (SMD = -0.49, 95% CI [-0.77, -0.22]), and stress and distress (SMD = -0.66, 95% CI [-0.91, -0.41]) and in promoting positive effect (SMD = -0.28, 95% CI [-0.52, 0.06]). There was also evidence of improvements in state (SMD = -0.56, 95% CI [-0.85, -0.21]) and trait (SMD = -0.43, 95% CI [-0.67, -0.20]) forgiveness. The findings provide moderate strong evidence to suggest that forgiving a variety of real-life interpersonal offenses can be effective in promoting different dimensions of mental well-being. Further research is, however, needed.</td>
<td><a href="https://journals.sagepub.com/doi/abs/10.1177/0261830016647079?list=cr_pub%3Cpubmed&amp;url=vert%3A%38&amp;v=39.88-203887%3Aid%3Ar%3Ald%3Acrossref.org%3AJourn">https://journals.sagepub.com/doi/abs/10.1177/0261830016647079?list=cr_pub%3Cpubmed&amp;url=vert%3A%38&amp;v=39.88-203887%3Aid%3Ar%3Ald%3Acrossref.org%3AJourn</a> alContentDPP</td>
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Next Steps: Build the Care Pathway

• Identification of Violence Risk
• Assessment of Violence Risk
  • Screen all patients who may be at risk for violence for behavioral health conditions (i.e., mental health, substance use), associated with increased risk using a validated instrument(s)
  • Further identify risk of violence with a validated instrument and identify additional risk factors
• Violence Risk Treatment
• Discharging patients (by treatment setting)
Workgroup Update: Maternity Bundled Payment Model

Carl Olden, MD
Family Physician,
Pacific Crest Family Medicine
Workgroup Members

- **Chair:** Carl Olden, MD, Family Physician, Pacific Crest Family Medicine
- Anaya Balter, RN, CNM, MSN, MBA, Clinical Director for Women's Health, Washington State Health Care Authority
- David Buchholz, MD, Medical Director, Collaborative Health Care Solutions, Premera
- Andrew Castrodale, MD, Family Physician, Coulee Medical Center
- Francie Chalmers, MD, Pediatrician, Member, Washington Chapter of the American Academy of Pediatrics
- Angela Chien, MD, Obstetrics and Gynecology, EvergreenHealth
- Neva Gerke, LM, President, Midwives Association of Washington
- Molly Firth, MPH, Patient Advocate
- Lisa Humes-Schulz, MPA/Lisa Pepperdine, MD, Director of Strategic Initiatives/ Director of Clinical Services, Planned Parenthood of the Great Northwest and Hawaiian Islands
- Rita Hsu, MD, FACOG, Obstetrics and Gynecology, Confluence Health
- Caroline Kline, MD, Obstetrics and Gynecology, Overlake Medical Center
- Dale Reisner, MD, Obstetrics and Gynecology, Swedish Medical Center
- Janine Reisinger, MPH, Director, Maternal-Infant Health Initiatives, Washington State Hospital Association
- Mark Schemmel, MD, Obstetrics and Gynecology, Spokane Obstetrics and Gynecology, Providence Health and Services
- Vivienne Souter, MD, Research Director, Obstetrics Clinical Outcomes Assessment Program
Care Pathway

• Prenatal Care
  • Monthly visits up to 28 weeks gestation
  • Biweekly visits up to 36 weeks gestation
  • Allowing for group visits

• Labor Management and Delivery

• Postpartum Care

• Prenatal Care
• Aligning with the Washington State Hospital Association’s labor management guidelines (to be published shortly)
• Emphasizing a physiologic birth (e.g., spontaneous onset and progression of labor, vaginal birth of the infant and placenta)
  • Addressing the ARRIVE trial on inductions of labor at 39 weeks
• Shared decision making, where appropriate
• Immediate postpartum LARC is accessible if desired by a patient
• 2012 Bree Collaborative Obstetric guidelines
Postpartum Care

- Where we can have a big impact
- At least two visits with additional visits as needed
  - By three weeks
  - Before 12 weeks – assessment of mood (e.g., depression, anxiety), infant care, sleep, physical recovery, vaccines etc.

Figure 1. Proposed paradigm shift for postpartum visits. The American College of Obstetricians and Gynecologists’ Presidential Task Force on Redefining the Postpartum Visit and the Committee on Obstetric Practice propose shifting the paradigm for postpartum care from a single 6-week visit (bottom) to a postpartum process (top). Abbreviations: BP, blood pressure; f/u, follow-up.
Patient Population

- Low risk bundle based on patient characteristics may exclude most vulnerable families
  - Spent much discussion parsing out what this could/should look like
- Option to remove highest 1% and lowest 1% of costs from bundle (New York Medicaid did this)
- Mix of these two

- Extending bundle to 12 months postpartum
Example from HPC-LAN

- When does bundle start? (e.g., conception, 270 days before delivery) **270 days**
- When does bundle end? (neonatal care, 30-days post delivery) **12 weeks – 12 months**

**Figure 1: Maternity Episode Definition and Timeline**

- **Starting Point**: ~40 weeks prior or pregnancy
- **Birth**: Post 37 weeks for low-risk pregnancies
- **Stopping Point**: ~60 days post birth

**Goals**
- Use of evidence-based care to achieve woman- and family-centered care
- Improving coordination across providers, settings, and maternity care

**Reimbursable Services Directly Related**
- Monthly prenatal visits
- Routine ultrasound
- Blood testing
- Diabetes testing
- Generic testing

**Not Typically Reimbursed**
- Doula
- Care coordinators
- Group education meetings
- Childbirth education classes

**NOT Directly Related**
- Preventive screenings (chlamydia, cervical cancer)

**Services (Examples)**
- Labor and Birth
- Breastfeeding support
- Depression screening
- Contraception planning
- Ensuring link from birth to pediatric care provider occurs

**Track Quality Measures**

Workgroup Update:
Shared Decision Making

Emily Transue, MD, MHA
Associate Medical Director,
Washington State Health Care Authority
Workgroup Members

- **Chair:** Emily Transue, MD, MHA, Associate Medical Director, Washington State Health Care Authority
- David Buchholz, MD, Medical Director, Premera
- Sharon Gilmore, RN, Risk Consultant, Coverys
- Leah Hole-Marshall, JD, General Counsel and Chief Strategist, Washington Health Benefit Exchange
- Steve Jacobson MD, MHA, CPC, Associate Medical Director, Care Coordination, The Everett Clinic, a DaVita Medical Group
- Dan Kent, MD, Medical Director, United Health Care
- Andrew Kartunen, Program Director, Growth and Strategy, Virginia Mason Medical System
- Dan Lessler, MD, Physician Executive for Community Engagement and Leadership, Comagine Health
- Jessica Martinson, MA, Director of Clinical Education and Professional Development, Washington State Medical Association
- Karen Merrikin, JD, Consultant, Washington State Health Care Authority
- Randy Moseley, MD, Medical Director, Quality, Confluence Health
- Michael Myint, MD, Medical Director, Population Health, Swedish Hospital
- Martine Pierre Louis, MPH, Director, Interpreter Services, Harborview Medical Center
- Karen Posner, PhD, Research Professor, Laura Cheney Professor in Anesthesia Patient Safety, Department of Anesthesiology & Pain Medicine, University of Washington
- Angie Sparks, MD, Family Physician and Medical Director, Clinical Knowledge Development, Kaiser Permanente of Washington
- Anita Sulaiman, Patient Advocate

Slide 2
Selected Health Care Services

- Procedural:
  - Knee and Hip Osteoarthritis (HCA certified)
  - Spine Surgery (HCA certified)
  - Abnormal Uterine Bleeding
  - Trial of Labor After Cesarean Section (HCA certified)

- Advanced Care Planning (HCA certified)

- Screening:
  - Prostate Specific Antigen Testing
  - Breast Cancer Screening

- Behavioral health:
  - Depression Treatment
  - Attention Deficit Hyperactivity Disorder Treatment
  - Opioid Use Disorder Treatment
Staging

I. Existing pilots to widely used
II. Certified, not widely used
III. Aids available, not certified, not widely used
IV. No aids available or few aids (want to incentivize creation of aids)
By Stage

I
- Knee and Hip Osteoarthritis
- Advanced Care Planning
- Spine Surgery
- Trial of Labor After Cesarean Section

II (none)

III
- Abnormal Uterine Bleeding
- PSA Testing
- Depression Treatment
- ADHD Treatment
- Breast Cancer Screening

IV
- Opioid Use Disorder Treatment
• Leadership and culture
• Patient education and engagement
• Healthcare team knowledge and training
• Action and Implementation
• Tracking, monitoring, and reporting
• Accountability
Playbook
Drivers of change

- Incentivize through payment
- High-quality aids
- Policy approaches to make standard for informed consent
- Accreditation and certification
Workgroup Update: Palliative Care

Ginny Weir

May 15th, 2019 | Puget Sound Regional Council
Workgroup Members

- **Chair:** John Robinson, MD, SM, Chief Medical Officer, First Choice Health
- Lydia Bartholomew, MD, Senior Medical Director, Pacific Northwest, Aetna
- George Birchfield, MD, Inpatient Hospice, EvergreenHealth
- Raleigh Bowden, MD, Director, Okanogan Palliative Care Team
- Mary Catlin, MPH, Senior Director, Honoring Choices, Washington State Hospital Association
- Randy Curtis, MD, MPH, Director, Cambia Palliative Care Center of Excellence, University of Washington Medicine
- Leslie Emerick, Legislative Consultant, Home Care Association of Washington
- Ross Hayes, MD, Palliative Care Program, Bioethics, Rehabilitation, Pediatrician, Seattle Childrens
- Greg Malone, MA, MDiv, BCC, Palliative Care Services Manager, Swedish Medical Group
- Kerry Schaefer, MS, Strategic Planner for Employee Health, King County
- Bruce Smith, MD, Medical Director of Providence Hospice of Seattle, Providence Health and Services
- Richard Stuart, DSW, Psychologist, Swedish Medical Center - Edmonds Campus
- Stephen Thielke, MD, Geriatric Psychiatry, University of Washington
- Cynthia Tomik, LICSW, Manager, Palliative Care, Evergreen Health
- Gregg Vandekieft, MD, MA, Medical Director for Palliative Care, Providence St. Peter Hospital
- Hope Wechkin, MD, Medical Director, Hospice and Palliative Care, EvergreenHealth
Answering Key Questions

- How do we define palliative care?
- How can we pay for the set of diffuse services that we agree should be part of palliative care?
- Who should get these services?
How we Define Palliative Care

“Palliative care focuses on expert assessment and management of [symptoms including] pain...assessment and support of caregiver needs, and coordination of care. Palliative care attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person- and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness.”

Palliative Care Enhanced Model

Justis, Pat. Presentation to Palliative Care workgroup. April 12, 2019.
Focus Areas

- Outreach and increased awareness of palliative care including cultural competency and knowledge of cultural needs in the local community.
- Increased consistency in how palliative care is implemented through endorsing the National Consensus Project Guidelines.
- Financial support for the sometimes diffuse services that support members within palliative care through a per member per month palliative care benefit.
- Defining a patient population for whom palliative care will offer benefit by adapting the criteria of the American Academy of Hospice and Palliative Medicine: Payment Reforms to Improve Care for Patients with Serious Illness Patient and Caregiver Support for Serious Illness (PACSSI) criteria.
1. **Structure and Processes of Care:** The composition of an interdisciplinary team is outlined, including the professional qualifications, education, training, and support needed to deliver optimal patient- and family-centered care. Domain 1 also defines the elements of the palliative care assessment and care plan, as well as systems and processes specific to palliative care.

2. **Physical Aspects of Care:** The palliative care assessment, care planning, and treatment of physical symptoms are described, emphasizing patient- and family-directed holistic care.

3. **Psychological and Psychiatric Aspects:** The domain focuses on the processes for systematically assessing and addressing the psychological and psychiatric aspects of care in the context of serious illness.
4. **Social Aspects of Care:** Domain 4 outlines the palliative care approach to assessing and addressing patient and family social support needs.

5. **Spiritual, Religious, and Existential Aspects of Care:** The spiritual, religious, and existential aspects of care are described, including the importance of screening for unmet needs.

6. **Cultural Aspects of Care:** The domain outlines the ways in which culture influences both palliative care delivery and the experience of that care by the patient and family, from the time of diagnosis through death and bereavement.

7. **Care of the Patient Nearing the End of Life:** This domain focuses on the symptoms and situations that are common in the final days and weeks of life.

8. **Ethical and Legal Aspects of Care:** Content includes advance care planning, surrogate decision-making, regulatory and legal considerations, and related palliative care issues, focusing on ethical imperatives and processes to support patient autonomy.
### American Academy of Hospice and Palliative Medicine: Payment Reforms to Improve Care for Patients with Serious Illness Patient and Caregiver Support for Serious Illness (PACSSI) criteria

<table>
<thead>
<tr>
<th>Tier</th>
<th>Diagnosis of Serious Illness (one of the below)</th>
<th>Function (one of the below)</th>
<th>Health Care Utilization</th>
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<tr>
<td><strong>Tier 1: Moderate Complexity</strong></td>
<td>One of the specified diseases, disorders, or health conditions in Table 2 below&lt;br&gt;Three or more serious chronic conditions*</td>
<td>Non-Cancer: PPS of ≤60% or ≥ 1 ADLs or DME order (oxygen, wheelchair, hospital bed)&lt;br&gt;Cancer: PPS of ≤70% or ECOG ≥2 or ≥ 1 ADL or DME order (oxygen, wheelchair, hospital bed)</td>
<td>One significant health care utilization in the past 12 months, which may include:&lt;br&gt;- ED visit&lt;br&gt;- Observation stay&lt;br&gt;- Inpatient hospitalization&lt;br&gt;Note: This criterion may be waived under certain circumstances specified below.</td>
</tr>
<tr>
<td><strong>Tier 2: High Complexity</strong></td>
<td>Same as above, Excluding dementia as the primary illness</td>
<td>Non-Cancer: PPS of ≤50% or ≥ 2 ADLs&lt;br&gt;Cancer: PPS of ≤60% or ECOG ≥3 or ≥ 2 ADLs</td>
<td>Inpatient hospitalization in the past 12 months AND one of the following&lt;br&gt;- ED visit&lt;br&gt;- Observation stay&lt;br&gt;- Second Hospitalization&lt;br&gt;Note: This criterion may be waived under certain circumstances specified below.</td>
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Diagnoses

• Option 1: A diagnosis of one of the following would meet the serious illness criterion:
  • Metastatic Cancer
  • Pancreatic, Gastrointestinal, Lung, Brain, Hematologic, or Ovarian cancers
  • Heart Failure with Class III or IV level function under the New York Heart Association (NYHA) Functional Classification
  • Heart Failure with a Left Ventricular Assist Device (LVAD)
  • Advanced Pulmonary Disease (Pulmonary Hypertension, Chronic Obstructive Pulmonary Disease, Pulmonary Fibrosis)
  • Advanced Dementia with stage 6 or 7 using the Functional Assessment Staging Tool (FAST) or ≥ 2 ADLs*
  • Progressive Neurologic Disorder (e.g. Cerebrovascular Accident (CVA), Parkinson’s Disease, Amyotrophic Lateral Sclerosis, Progressive Supranuclear Palsy)
  • Hepatic Failure (Cirrhosis)
  • Stage IV or V Renal Disease
  • Protein-Calorie Malnutrition
  • Cachexia
  • Hip Fracture (with functional decline)

• Option 2 Diagnoses of three or more serious chronic conditions would also allow a patient to meet the serious illness criterion. Dementia as the primary illness would be confined to the moderate complexity group, as the rate of decline is often slow, and functional limitations occur significantly earlier in the course of an illness.
Answering our Charter’s Aim

To develop best practice recommendations for palliative care regarding:

• Assessment of patients with serious illness for primary and/or specialty palliative care need,
• Care delivery frameworks, and
• Payment models to support delivery of care.
Next Meeting:

Wednesday, July 24th, 2019
12:30 – 4:30

Puget Sound Regional Council
5th Floor Board Room
1011 Western Avenue, Seattle WA