Agenda

• Chair Report, May 15 Meeting Minutes
  • Action Item: Approve minutes
• Selecting New Topics
  • Action Item: Select 3 health care service topics for 2020

• 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
(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.
May 15th Meeting Minutes

Dr. Robert Bree Collaborative Meeting Minutes - DRAFT  
May 15th, 2019 | 12:30-4:30  
Puget Sound Regional Council  
1101 Western Ave | Seattle, WA 98104

<table>
<thead>
<tr>
<th>Members Present</th>
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<tr>
<td>Hugh Straley, MD, (Chair)</td>
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<td>Susie Dade, MS, Washington Health Alliance</td>
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<td>Gary Franklin, MD, Labor and Industries</td>
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<td>Stuart Freed, MD, Confluence Health</td>
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<td>Richard Goss, MD, Harborview Medical Center</td>
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<td>Ian Corbridge (for Darcy Jaffe), Washington State Hospital Association</td>
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<tr>
<td>Rick Ludwig,* MD, Providence Health Accountable Care</td>
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<td>Greg Marchand, Director, Benefits &amp; Policy, The Boeing Company</td>
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<tr>
<td>Robert Mecklenburg, MD, Virginia Mason Medical Center</td>
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<tr>
<td>Kimberly Moore, MD, Franciscan Health System</td>
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<tr>
<td>Carl Olden, MD, Pacific Crest Family Medicine</td>
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<td>Drew Oliveira, MD, Regence</td>
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<td>Mary Kay O’Neill MD, MBA, Mercer</td>
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<tr>
<td>Jeanne Rupert,* DO, PhD, One Medical</td>
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<td>Angie Sparks, MD, Kaiser Permanente</td>
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<tr>
<td>Shawn West, MD, Provider</td>
</tr>
<tr>
<td>Laura Kate Zaichkin, MPH, SEIU 775 Benefits Group</td>
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<tr>
<td>Judy Zerzan, MD, Health Care Authority</td>
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</tbody>
</table>
Selecting Final Topics for 2020

Ginny Weir, MPH
Director

July 24th, 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.”
From May Meeting

• Reproductive Health (Senate Bill 5602)

1. Chemotherapy and Emergency Department/Hospital Use
2. Primary Care
3. Opioid Prescribing/Chronic Pain
4. Vitamin D Screening
5. Institutional Racism and Unconscious Bias
6. Colorectal Cancer Screening
7. Updating Avoidable Hospital Readmissions
Process

- Quantify the issue
- Hear from experts
- Understand possible solutions
- Compare topics as good fit for Bree
  - Manageable scope
- Discuss
- Vote (for three)
Reproductive Health
Senate Bill 5602

(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.

Chemotherapy and Emergency Department/Hospital Use
Chemotherapy and Emergency Department/Hospital Use

- 27% oncology pts had at least one ED visit – of those, 49.8% had a potentially preventable cancer-related diagnosis, whereas 3.2% had a potentially preventable chronic disease–related diagnosis. Considering all diagnosis fields, 45.0%, 9.4%, and 18.5% included a potentially preventable cancer-related diagnosis only, a potentially preventable chronic disease–related diagnosis only, and both types of diagnoses, respectively.

## Chemotherapy and Emergency Department/Hospital Use

<table>
<thead>
<tr>
<th>EoL Metric</th>
<th>Last Year (2014-2016)</th>
<th>This Year (2015-2017)</th>
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<tbody>
<tr>
<td>Chemo last 14 days</td>
<td>5.6%</td>
<td>5.7%</td>
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<tr>
<td>2+ ED visits last 30 days</td>
<td>15.4%</td>
<td>16.4%</td>
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<tr>
<td>ICU stay last 30 days</td>
<td>24.1%</td>
<td>24.5%</td>
</tr>
<tr>
<td>Hospice at least 3 days prior to death</td>
<td>61.6%</td>
<td>61.7%</td>
</tr>
</tbody>
</table>

Source: The Hutchinson Center for Cancer Outcomes Research data of the state's largest public and commercial insurance providers on end-of-life issues in oncology
Primary Care
8c
Amount of the American health care dollar spent on primary care

$15.8M
Savings to payers in 26 months after the implementation of a primary care-focused program at Denver Health

49,000
Projected nationwide shortfall of primary care physicians by 2030

11 of 11
Rank of the U.S. health care system, among 11 high-income countries, in overall ranking, access, equity and health care outcomes

HEALTH CARE IS INCREASINGLY EXPENSIVE
In 2014, the U.S. spent 16.6% of its GDP on health care, by far more than another nation. Washington is not immune: Premiums for the state’s health insurance exchange rose for the fourth straight year in 2015. “Our biggest challenge continues to be addressing the rising costs of health care,” said Mike Kreidler, state insurance commissioner.

PRIMARY CARE DECREASES COSTS
Investing in primary care leads to downstream cost savings. A study by the Commonwealth Fund found that increased primary care fees and usage would yield a sixfold decrease in Medicare services and an overall 2% drop in total Medicare costs. In Oregon’s Patient-Centered Primary Care Home Program, every $1 increase in primary care-related expenditures resulted in $1.3 saved in other areas, including department and inpatient care costs.

PRIMARY CARE IMPROVES HEALTH
Research has been clear: Primary care prevents illness and death and is associated with greater health equity. And countries with greater orientation to primary care experience better health outcomes than unoriented countries. But research has also shown that, in Washington, a 2% reduction in rural primary care physicians is possible by 2025.

PATIENT HAPPINESS IS GREATER
Research has shown that patients are more satisfied in primary-care intensive settings. One study of an urban safety net delivery system found an increase in five of six patient experience-related metrics in a span of little more than two years after expanding and improving the primary care delivery system.

1. Patient-Centered Primary Care Collaborative
2. “Population Health in Primary Care: Cost, Quality, and Experience Impact,” American Journal of Accountable Care
5. “Get ready for higher premiums on Washington state’s health-care exchange,” The Seattle Times, Sept. 12, 2013
6. “Paying More for Primary Care Can It Help Bend the Medicare Cost Curve?” The Commonwealth Fund
8. "Construction of Primary Care to Health Systems and Health," Hilliard Quarterly
10. "Evaluation of Policy Options for Increasing the Availability of Primary Care Services in Rural Washington State," RAND Health

Washington Academy of Family Physicians
1239 120th Ave. NE, Suite G
Bellevue, WA 98005
www.wafp.net
Summit Goal: Convene clinicians, health systems, and others to discuss innovative ways to strengthen primary care and identify opportunities to collaborative and/or advance new strategies

Bree role
• Defining primary care
• Innovative reimbursement (e.g., multi-payer, risk adjusted comprehensive prospective payment based on patients empaneled to practice, support new infrastructure)
Opioid Prescribing
Chronic Pain
• Continue Opioid Prescribing Workgroup – Focus on older adults
  • 80% of those >65 have multiple chronic conditions, chronic pain common
  • Higher risk of adverse events
  • ~19% elderly adults at least one opioid prescription

• Chronic pain
  • Align with Collaborative Care for Chronic Pain Report (2018)
  • Community concern


Goal – Reduce risk of falls

- Follow same best practices for prescribing opioids (AMDG)
- Prescribe immediate-release opioids at the lowest effective dose (AMDG)
  - Initiate opioid therapy at a 25% to 50% lower dose than that recommended for younger adults

Source: AHRC

2015 state rates of opioid-related hospital stays* per 100,000 people age 65 and older

*This rate does not include emergency room visits.

- Oregon: 704
- Washington: 609
- Minnesota: 427
- Montana: 426
- Colorado: 395
- Tennessee: 376
- California: 353
- Wisconsin: 342
- North Dakota: 316
- Illinois: 292
- Missouri: 286
- Florida: 281
- South Dakota: 255
- Virginia: 248
- Ohio: 248
- Kentucky: 238
- Kansas: 214
- New Jersey: 210
- Iowa: 204
- Hawaii: 202
- Nebraska: 195
- Vermont: 187
- West Virginia: 175

The median national rate for 2015 is based on data from 23 states. The remaining states and Washington, D.C., did not provide data.

Source: Agency for Healthcare Research and Quality

Graphic by Melissa Lewis, Oregonian/OregonLive
Figure 1. Number of opioid-related inpatient stays and ED visits among patients aged 65 years and older, by age group, 2010 versus 2015

Opioids’ Impact on Seniors

New AHRQ data provide important insights into opioid use among seniors, including the average annual number of seniors who filled opioid prescriptions in 2015 and 2016 and the increase in opioid-related hospitalizations among seniors between 2010 and 2015.

Average Annual Opioid Prescription Use Among Seniors, 2015-2016

- 10 million (19%) filled at least 1 opioid prescription
- 4 million (7%) filled 4 or more opioid prescriptions

Increase in Opioid-Related Hospitalizations Among Seniors, 2010-2015

- 34% increase in the rate of opioid-related hospitalizations
- Hospitalizations Per 100,000 Population:
  - 2010: 199
  - 2015: 268

Vitamin D Screening
Vitamin D Deficiency Screening

Choosing Wisely Recommendations:
Don’t perform population-based screening for vitamin D deficiency.
- American Society of Clinical Pathology
Don’t routinely measure 1, 25-dihydroxyvitamin D unless the patient has hypercalcemia or decreased kidney function.
- Endocrine Society

U.S. Preventive Services Task Force
The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for vitamin D deficiency in asymptomatic adults.

John Dunn, MD, Medical Director of Preventive Care, KP-WA
Vitamin D is important for body function, and targeted testing in individuals with certain medical history or risk factors may be appropriate. However, there isn’t even agreement on precisely what level of vitamin D should be considered as “deficiency,” or on what the actual clinical impact of low vitamin D levels may be (despite the press this gets, most studies on this are not well done, and the actual relationship between vitamin D levels and many clinical conditions is tenuous at best). Ultimately, there isn’t any good evidence that screening asymptomatic adults with no risk factors has any impact on clinical outcomes.
Measure on Vitamin D Deficiency Screening in the MedInsight Health Waste Calculator

Any population-based screening for vitamin D in the absence of risk factors is identified as “Wasteful.”

Vitamin D screening is considered “Not Wasteful” when certain clinical conditions are present:

• Chronic conditions (rickets, osteomalacia, osteoporosis, chronic kidney disease, hepatic failure, malabsorption syndromes like cystic fibrosis or IBD, etc.)
• Risk factors for vitamin D deficiency (e.g., sarcoidosis, tuberculosis, etc.)
• High risk medications (e.g., anticonvulsant medications or glucocorticoids)
• Pregnancy
• Obesity (BMI >30 kg/m2)
• History of falls and traumatic fractures in older adults
Health Waste Calculator Results: Vitamin D Deficiency Screening

The overall Waste Index is 29% for both the commercially insured and Medicaid insured populations. **A total of 40,049 wasteful services were delivered, impacting 38,998 individuals at an estimated cost of $7.7 million.**
Vitamin D Deficiency Screening: Degree of Low Value Screening Varies by County

Results for Commercial and Medicaid combined

Results by county range: 12% - 41% (low value screening as a percent of total)

Source: Washington Health Alliance, “First, Do No Harm,” December 2018
Measurement Period: July 2016 – June 2017
Institutional Racism and Unconscious Bias
Institutional Racism and Unconscious Bias

- Institutional racism v overt racism
- Racial disparities in maternal mortality, chronic illness, premature death, failure to receive appropriate care for pneumonia, heart attacks, pain, post-operative complication prevention
- White laypeople and white medical students and residents reported believing that black patients feel less pain. (Hoffman, 2016)

Solutions:
- Current CA legislation to require training for nurses, doctors and other medical professionals on how to spot implicit bias on the job
- King County training Addressing Implicit Bias, Racial Anxiety, and Stereotype Threat
- Harvard Implicit Association Test
- John Powell framework Haas Institute for a Fair and Inclusive Society used by some Accountable Communities of Health

Colorectal Cancer Screening
<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults, beginning at age 50 years and continuing until age 75 years</td>
<td>The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.</td>
<td>A</td>
</tr>
<tr>
<td>Adults age 76 to 85 years</td>
<td>The USPSTF recommends against routine screening for colorectal cancer in adults 76 to 85 years of age. There may be considerations that support colorectal cancer screening in an individual patient.</td>
<td>C</td>
</tr>
<tr>
<td>Adults older than age 85 years</td>
<td>The USPSTF recommends against screening for colorectal cancer in adults older than age 85 years.</td>
<td>D</td>
</tr>
</tbody>
</table>
The ACS recommends that people at average risk* of colorectal cancer **start regular screening at age 45.** This can be done either with a sensitive test that looks for signs of cancer in a person’s stool (a stool-based test), or with an exam that looks at the colon and rectum (a visual exam). These options are listed below.

**Stool-based tests**
- Highly sensitive fecal immunochemical test (FIT) every year
- Highly sensitive guaiac-based fecal occult blood test (gFOBT) every year
- Multi-targeted stool DNA test (MT-sDNA) every 3 years

**Visual (structural) exams of the colon and rectum**
- Colonoscopy every 10 years
- CT colonography (virtual colonoscopy) every 5 years
- Flexible sigmoidoscopy (FSIG) every 5 years

*Source: https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html*
### Colorectal Cancer Screening

**Figure 14. Health screenings among Medicaid and Medicare enrollees, by racial/ethnic group, July 2014-June 2015.** Green rate is significantly better than Medicaid statewide rate; Gray- not significantly different; Red- significantly worse; Yellow- too few cases to report. Color rankings based on Wilson Score Interval statistical test.

<table>
<thead>
<tr>
<th>RACIAL/ETHNIC GROUP</th>
<th>Health Screenings</th>
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<tbody>
<tr>
<td></td>
<td>Adolescent well-care visits</td>
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<td>---------------------------</td>
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<tr>
<td>Statewide commercial (all races)</td>
<td>44%</td>
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<tr>
<td>Statewide (all races)</td>
<td>41%</td>
</tr>
<tr>
<td>American Indian and Alaska Native</td>
<td>41%</td>
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<tr>
<td>Asian</td>
<td>43%</td>
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<tr>
<td>Black or African American</td>
<td>45%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>42%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander</td>
<td>44%</td>
</tr>
<tr>
<td>White</td>
<td>40%</td>
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*Did not meet public reporting denominator minimum (<160) threshold requirement.*

Source: https://www.wacommunitycheckup.org/reports/2016-community-checkup-report-hq/#Cancer%20Screening%20Rates%20Show%20Room%20for%20Improvemen
Figure 1.
Proportional rates of individual sedative usage between 2000 and 2013.

Avoidable Hospital Readmissions
Avoidable Hospital Readmissions

Unplanned hospital readmissions are often due to the lack of a comprehensive and patient-centered discharge plan or care coordination. These potentially avoidable hospital readmissions are a sign of low quality care, lead to poor patient health, and are expensive. This workgroup met from May 2012 to March 2013 and reconvened with new membership to meet from April to June 2014 and developed the following strategies:

- Alignment with local activities to reduce hospital readmissions
- Increasing measurement, transparency, and reporting
- Tying physician and hospital payment to the reduction of avoidable hospital readmissions

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<tr>
<th></th>
<th>Heart Attack Readmit</th>
<th>Heart Failure Readmit</th>
<th>Pneumonia Readmit</th>
<th>Hip/Knee Readmit</th>
<th>Hospital-wide Readmit</th>
</tr>
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<tbody>
<tr>
<td>National Average</td>
<td>16</td>
<td>21.7</td>
<td>16.7</td>
<td>4.2</td>
<td>15.3</td>
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<tr>
<td>Washington State Average</td>
<td>15.3</td>
<td>20.8</td>
<td>15.9</td>
<td>3.8</td>
<td>14.4</td>
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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.

Readmission recommendations should be expanded to include more focus on person and family engagement and improving health equity.
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<th>Topic</th>
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<tr>
<td>Chemotherapy and Emergency Department/Hospital Use</td>
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<tr>
<td>Primary Care</td>
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<tr>
<td>Opioid Prescribing/Chronic Pain</td>
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<tr>
<td>Vitamin D Screening</td>
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<tr>
<td>Institutional Racism and Unconscious Bias</td>
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<tr>
<td>Colorectal Cancer Screening</td>
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<tr>
<td>Updating Avoidable Hospital Readmissions</td>
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Break
Workgroup Update: Opioid Prescribing: Supporting Patients on Chronic Opioid Therapy

Gary Franklin, MD, MPH
Medical Director, Washington State Department of Labor and Industries

July 24th, 2019 | Bree Collaborative Meeting
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
## Vancouver, WA Conference August 9th
### Patient-Centered Approach to Chronic Opioid Management

<table>
<thead>
<tr>
<th>Time</th>
<th>Time &amp; Lead</th>
<th>Topic</th>
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<tbody>
<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>Michelle Marikos</td>
<td>Peer support and experience of a patient on chronic opioid therapy</td>
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<tr>
<td>8:30-9:00</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>9:00-9:30</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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<tr>
<td>9:30-10:00</td>
<td>Roger Chou, MD</td>
<td>Reviewing the evidence on outcomes of opioid tapers</td>
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<tr>
<td>10:15-10:45</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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<tr>
<td>10:45-11:15</td>
<td>Michael Von Korff, ScD</td>
<td>Using validated instruments to assess effectiveness, risk of harm, and dependence/opioid use disorder of patients on chronic opioid therapy</td>
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<tr>
<td>11:15-11:45</td>
<td>Jane Ballantyne, MD</td>
<td>Differentiating dependence and opioid use disorder</td>
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<tr>
<td>11:45-12:15</td>
<td>Steven Stanos, DO</td>
<td>Identifying patients who benefit from chronic opioid therapy</td>
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<tr>
<td>1:15-1:45</td>
<td>Joe Merrill, MD</td>
<td>Opioid agonist/antagonist therapy</td>
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<tr>
<td></td>
<td>Mark Sullivan, MD, PhD – Moderator</td>
<td>Panel: Engaging providers and patients</td>
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<tr>
<td>1:45-2:15</td>
<td>Michelle Marikos</td>
<td>• Engaging patients</td>
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<td>Andrew Suchocki, MD, MPH</td>
<td>• Engaging primary care providers</td>
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<td>Pamela Davies, ARNP, MS, ACHPN</td>
<td>• Addressing the geriatric patient on chronic opioids</td>
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<td>Rose Bigham, Patient Advocate</td>
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<tr>
<td>2:15-2:45</td>
<td>Stuart Freed, MD – Moderator</td>
<td>Panel: Pain care innovations in health care systems</td>
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<td></td>
<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>• Columbia Valley Community 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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<td>3:00-4:00</td>
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<tr>
<td>4:00-4:30</td>
<td>Drs. Franklin, Fotinos, and Saxon</td>
<td>Summary and closing remarks</td>
</tr>
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Developing the Guidelines

- Supplement is designed to help primary care and other providers managing patients with chronic pain.
- Overall goal is to develop best practice recommendations on patient engagement, assessment, treatment pathways, and health system interventions related to improving outcomes for patients on chronic opioid therapy.
- Providing appropriate opioid therapy and pain management for these patients should be individualized and focus on goals of clinically meaningful improvement in function, as well as improved quality of life, and greater patient functional independence rather than on pain relief.
- Patient safety and avoidance of serious adverse outcomes is a priority.
Focus Areas

• Patient Engagement and Support
• Assessment
• Develop a Treatment Plan
• Treatment Pathways
  • Maintain and Monitor
  • Taper (Wean)
    • Many guidelines recommend 5-10% per month. Tapering should be based on function with the PEG done at each visit.
  • Transition to medication-assisted therapy

• Health Systems


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

Benefits > Risks
Document Risk Benefit Assessment (RBA)
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

Source: Mark Stephens, Change Management Consulting. www.oregonpainguidance.org
Workgroup Update: Risk of Violence to Others

Kim Moore, MD
Associate Chief Medical Officer, CHI Franciscan

July 24, 2019 | Puget Sound Regional Council
Workgroup Members

- **Chair:** Kim Moore, MD, Associate Chief Medical Officer, 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
- **NEW:** Amanda Ibaraki Stine, MFT, Member, Washington Association for Marriage and Family Therapists
- Marianne Marlow, MA, LMHC, Member, Washington Mental Health Counseling Association
- Adrianne Tillery, Harborview Mental Health and Addiction Services (Certified Counselor)
This 2016 Washington State Supreme Court decision alters the scope of the ‘duty to warn or protect’.

- now clearly applies to clinicians in voluntary inpatient and outpatient settings

- persons to ‘warn or protect’ now includes those who are ‘foreseeable’ victims, not ‘reasonably identifiable’ victims subject to an *actual* threat

**Background:**
Presentation and Literature Review

- **Dr. Piel Presentation:** “Duty to Protect: Historical Review and Current Considerations”

- **Keywords:** homicide, homicidal ideation, violence. Excluding intimate partner violence interventions directed at the recipient

- **59 articles reviewed, variably applicable**

- **Included review of WA Involuntary Treatment Act (ITA) statute**

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### Table: Article Review

<table>
<thead>
<tr>
<th>Source</th>
<th>Citation</th>
<th>Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne A. Roen</td>
<td>Homicide background paper draft 2017</td>
<td>Under review</td>
</tr>
</tbody>
</table>

*AMPS: Familicide is a multiple victim homicide in which the perpetrator is usually the intimate partner of the deceased victim. The AMPS instrument is designed to assist in identifying factors related to the perpetration of familial homicide. The instrument includes questions related to the victim's and perpetrator's demographic characteristics, mental health, physical health, and social support.*

*AMPS: Familicide is a multiple victim homicide in which the perpetrator is usually the intimate partner of the deceased victim. The AMPS instrument is designed to assist in identifying factors related to the perpetration of familial homicide. The instrument includes questions related to the victim's and perpetrator's demographic characteristics, mental health, physical health, and social support.*

*ITM investigations: Can standardized assessment instruments assist in decision making?*
Review Problem Statement, Aim, Purpose

Problem Statement

- Patients may be reluctant to engage with health care providers about their violence risk.
- Health care providers may be uncertain about how to meet their legal obligations.

Aim

- To recommend evidence-based, clinical best practices for patients with risk of violence

Purpose

To recommend evidence-based, clinical best practices for:

- assessing risk for violence
- identifying risk factors for violence
- reconciling the right to confidentiality, least restrictive environment, and the duty to protect
- actions to take when there is a risk for violence concern
- means for discharging patients based on treatment setting
- record-keeping to decrease variation in practice patterns in these areas
Workgroup Discussion

- Difficulty with setting **actionable recommendations** in light of the Volk decision
- Clinicians with **different levels of mental health training**
- Definition of **foreseeable**
- Clinicians **cannot predict impending violent acts with certainty**
- **How to discharge duty** to warn or protect
- Patients’ right to both **confidentiality** and also to care in the **least restrictive environment**
- Duty to **protect the community**
Focus Areas & Next Steps

- Initial identification of increased risk for violence
- Further assessment of violence risk
- Violence risk management
- Community protection
Workgroup Update: Maternity Bundled Payment Model

Carl Olden, MD
Family Physician, Pacific Crest Family Medicine

July 24th, 2019 | Puget Sound Regional Council
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
Bundle Structure

- Retrospective risk adjustment based on patient-specific factors
- Triggered at delivery to begin 270 days prior to delivery and ending 84 days (3 months) post delivery
  - The workgroup’s ideal is to implement a perinatal bundle that will last 365 days (12 months) post-delivery (total 635 days) that also includes pediatric care for 12 months.
- Including prenatal care, labor and delivery, postpartum services for both facility and professional services
- Obstetric care provider or group is the accountable entity
- Exclusion criteria:
  - Incomplete claims within episode time
  - Age: younger than 16, older than 40
  - Cost below first percentile or higher than ninety-ninth percentile
  - Diagnoses within the episode window or 90 prior to episode window: cancer under active management, CNS infection and poliomyelitis, Coma or brain damage, Cystic fibrosis, etc (see Ohio bundle example)
  - Death within episode window
Care Pathway
Prenatal Care

- **Intake visit** as soon as possible after a patient contacts the provider or group with a positive pregnancy test. At a minimum, the intake visit should happen in the first trimester. (e.g., insurance, nutrition, dating ultrasound, behavioral health screenings)

- Monthly visits up to 28 weeks gestation at minimum

- Biweekly visits up to 36 weeks gestation at minimum.

- **Content:**
  - Cardiovascular disease
  - Behavioral Health Screening
  - Infectious Disease Screening
  - Gestational Diabetes Screening
  - Vaccination
  - Third trimester education (e.g., breastfeeding, birth spacing, shared decision making as appropriate)
  - Social Determinants of Health
Care Pathway
Labor Management and Delivery

- Aligning with the Washington State Hospital Association’s labor management guidelines
- Emphasizing a physiologic birth when safe (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
Care Pathway
Postpartum Care

- At least two visits with additional visits as needed (e.g., if higher-risk)
  - By three weeks
  - Before 12 weeks – assessment of mood (e.g., depression, anxiety), infant care, sleep, physical recovery, vaccines etc.

<table>
<thead>
<tr>
<th>Primary maternal care provider</th>
<th>assumes responsibility for woman’s care through the comprehensive postpartum visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact with all women within first 3 weeks</td>
<td>Ongoing follow-up as needed 3–12 weeks</td>
</tr>
<tr>
<td>BP check 3–10 days</td>
<td>High risk f/u 1–3 weeks</td>
</tr>
<tr>
<td>Wks</td>
<td>0</td>
</tr>
<tr>
<td>Traditional period of rest and recuperation from birth 0–6 weeks</td>
<td>6-week visit</td>
</tr>
</tbody>
</table>

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. ⇐
Workgroup Update: Shared Decision Making

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

July 24th, 2019| Bree Collaborative Meeting
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
Focus Areas

• A common understanding and shared definition of shared decision making
• Endorsing ten priority areas as first steps for the health care community
• Endorsing a best practice implementation framework while accepting others
• Documentation, coding, and reimbursement structure to support broad use
Goal

• State-wide movement toward greater use of shared decision making in clinical practice at a care delivery site and organizational level.

• All care delivery sites to move toward greater adoption using a stages of change framework (i.e., precontemplation, contemplation, preparation, action, maintenance).
  • In some locations will be starting in the precontemplations (e.g., leadership engagement and buy-in) while others will be ready to start action (e.g., pilots of shared decision making in one health service area such as abnormal uterine bleeding), and others will be maintaining or spreading use.
• Shared decision making is appropriate for preference-sensitive conditions in which there is high-quality clinical evidence for more than one treatment or management option or screening or lack of clinical consensus due to lack of evidence and not appropriate when clinical evidence highly favors one process or treatment such as for immunization against measles, mumps, rubella (MMR) or against antibiotics for a common cold.

• In all clinical interactions good communication is a key component of high-quality care.

• At an organization level, a patient decision aid is necessary for reliability.

Appropriateness of Shared Decision Making

More than one clinically appropriate treatment option, Preference sensitive, (Individualized Decisions)

Evidence For (offer the intervention to all or almost all)
- e.g., MMR vaccine
- Setting a broken bone

Evidence Against (Do not offer the intervention)
- e.g., Antibiotics for a common cold

Shared Decision Making
- e.g., Hip or knee osteoarthrosis,
- Advance care planning, PSA test

USPSTF Grade A
USPSTF Grade B
USPSTF Grade C
USPSTF Grade D

Selected Health Care Services

• Surgical/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
By Stage

I - Existing pilots to widely used
• Knee and Hip Osteoarthritis
• Advanced Care Planning
• Spine Surgery
• Trial of Labor After Cesarean Section

II (none) - Certified, not widely used

III - Aids available, not certified, not widely used
• Abnormal Uterine Bleeding
• PSA Testing
• Depression Treatment
• ADHD Treatment
• Breast Cancer Screening

IV - No aids available or few aids (want to incentivize creation of aids)
• Opioid Use Disorder Treatment
National Quality Partner’s Playbook: Shared Decision Making in Healthcare is a comprehensive, pragmatic framework. The Playbook organizes the process into implementation fundamentals, each which include basic, intermediate, and advanced steps for healthcare organizations. The eight fundamentals include:

- Leadership and culture
- Patient education and engagement
- Healthcare team knowledge and training
- Action and implementation
- Tracking, monitoring and reporting
- Accountability

The Agency for Healthcare Research and Policy (AHRQ) developed the SHARE (Seek, Help, Assess, Reach, and Evaluate) approach
## Health Care Delivery Organizations and Systems

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Steps</th>
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| **Precontemplation** | • Review your organization’s mission, vision and values.  
                        • Define how shared decision making can help support your organizational goals and align with regional, state-wide, and Federal programs and expectations. |
| **Contemplation**   | • Define a framework with which to implement shared decision making. If using the NQF Playbook, review the basic implementation examples for all 6 fundamentals. Implement the components of examples within basic Leadership and Culture implementation (page 6).  
                        • Identify clinical champions who will be willing to help educate their peers.  
                        • Select an appropriate training for your providers and staff about shared decision making. See list of training programs in Appendix X. |
| **Preparation**     | • Spread awareness about shared decision making broadly within your organization. Use the definitions and materials within this report.  
                        • Review the Playbook’s basic to advanced Healthcare Team Knowledge and Training examples (page 12) and implement components of basic Knowledge and Training.  
                        • Work with your clinical champion(s) to educate providers about the value of shared decision making and how to have a good conversation that uses the patient decision aid or references the patient decision aid if the aid will be distributed to patients prior to the visit.  
                        • Select one of the ten clinical areas to pilot (e.g., breast cancer screening).  
                        • Select a patient decision aid or aids to integrate into the care stream. If using a patient decision aid that has not been certified by the HCA, the workgroup recommends using the IPDAS-based criteria adapted by the HCA within Appendix X.  
                        • Define where in the care stream to use the aid (e.g., prior to visit via email).  
                        • Clearly identify roles for care team members. Non-clinical staff can have a shared decision making conversation and/or patients can be send the patient decision aid prior to the visit.  
                        • Assist clinicians by providing templates for documentation of use of shared decision-making.  
                        • Conduct clinic- or system-wide training.  
                        • Performance metrics (TBD) |
| **Action**          | • Implement your shared decision making pilot.  
                        • Review the Playbook’s Fundamental 4: Action and Implementation (page 15) and implement the components under basic. |
| **Maintenance**     | • Evaluate use of the shared decision making process including feedback on the specific patient decision aid.  
                        • Review the Playbook’s basic to advanced Tracking, Monitoring, and Reporting examples (page 18) and implement components under basic.  
                        • Decide whether to change any components within the pilot of not working.  
                        • Spread to another clinical area. |
Workgroup Update: Palliative Care

John Robinson, MD, SM
Chief Medical Officer, First Choice Health

July 24th, 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
Focus Areas

• Common definitions
• Cultural awareness and understanding of local community
• Advance care planning
• Goals of care conversations
• Defining primary and specialty palliative care
• Per member per month palliative care benefit
Definitions

- Serious illness is a condition that “negatively impacts quality of life and daily function, and/or is burdensome in symptoms, treatments, or caregiver stress... [and] carries a high risk of mortality.”

- “Palliative care focuses on expert assessment and management of [symptoms including] pain...assessment and support of caregiver needs, and coordination of care [attending] 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.”

Primary V Specialty Palliative Care

• **Primary palliative care.** Care delivered within primary and relevant sub-specialty care to meet physical, functional, psychological, practical, and spiritual consequences of a serious illness. Providers should refer patients to specialty palliative care when needs cannot be met within primary palliative care.

• **Specialty palliative care.** An interdisciplinary team that includes or has access to a care coordination function and is able to meet medical, psychological, and spiritual care needs. Access (e.g., telemedicine) to 24/7 specialty expertise is highly recommended. The National Consensus Project for Quality Palliative Care National Coalition for Hospice and Palliative Care **Clinical Practice Guidelines for Quality Palliative Care, 4th edition** eight domains outline the ideal components of palliative care.
Assessment and Management

- Goals of Care conversations including around hospitalization
- Advance care planning
- Cognitive impairment
- Medical care – symptoms that impact quality of life
- Caregiver needs
- Behavioral health (i.e., depression, anxiety, suicidality, others)
- Functional needs
- Spiritual care

+ Care Coordination
+ Urgent Issues
Per Member Per Month Benefit

- For diverse specialty palliative care services that support seriously ill patients
- Defining the patient population using existing criteria such as that developed by 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).

Based on CMS Seriously Ill Population (SIP) Alternative Payment Model Option

- A one-time payment for the first visit with a patient that includes chart review of records often from multiple institutions, the visit, and coordinating efforts following the visit
- A monthly per patient payment for up to 12 months
- A per-visit payment for each face-to-face clinician visit
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, September 18th, 2019
12:30 – 4:30

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