

Bree Collaborative

New Topics Discussion 2014

Contents

Mental Health Integration 1

Opioids 3

Sleep Therapy..... 4

Prostate Specific Antigen Screening Testing..... 6

Oncology 8

Coronary Artery Disease Bundle 12

Hepatitis C Management 15

Bree Collaborative New Topic Selection

Mental Health Integration

Topic: Mental Health Integration | Champion: Mary Kay O’Neill

Category	Description	Rating 1=low; 5=high
Variation in practice patterns/ High utilization - Waste and inefficiency	Different levels of integration across Washington. “The Epidemiologic Catchment Area (ECA) Study and articles based on survey data, reported that about 50% of care for common mental disorders was delivered in general medical settings. However, many subsequent studies have shown that these disorders may be undiagnosed or under-treated.” ¹	
Patient Safety/Poor Health Outcomes	Untreated anxiety and depression are associated with poor health outcomes and people with depression or anxiety tend to have more severe symptoms, difficulty adapting to medical conditions, and a harder time managing conditions. ²	
Cost (Direct & Indirect)	“Depression and anxiety can increase overall health care costs by 50-100%, larger in those with multiple conditions. Long-term analyses have demonstrated that \$1 spent on Collaborative Care saves \$6.50 in health care costs.” ³	
Proven means/strategies to address topic*	<p>SAMHSA-HRSA Center for Integrated Health Solutions – “Four Quadrant Model for mental health (MH) and substance abuse/addiction (SA) service integration, as initially conceived by state mental health and substance abuse directors describes differing levels of MH and SA integration and clinician competencies based on the four-quadrant model, divided into severity for each disorder.”¹</p> <p>Implementation Guide from the AIMS Center:⁴ Lay the Foundation; Plan for Clinical Practice Change; Build your Clinical Skills; Launch your Care; Nurture your Care.</p> <p>“Washington State Mental Health Integration Program (MHIP) - ~200 community health centers and community mental health centers in the state of Washington participate in this program funded by the state legislature with additional support for King County clinics provided by Public Health Seattle and King County. Over 35,000 individuals have received integrated mental health services through this program since its inception in January 2008.</p>	

¹ Mauer BJ. Behavioral Health/Primary Care Integration Models, Competencies, and Infrastructure. Available: http://www.integration.samhsa.gov/about-us/Mauers_Behav_Health_Models_Competencies_Infra.pdf.

² National Institute of Mental Health. What is Depression? Available: <http://www.nimh.nih.gov/health/publications/depression/index.shtml>.

³ AIMS Center. Dollars and Sense. 2014. Available: <http://aims.uw.edu/collaborative-care/dollars-sense>.

⁴ AIMS Center. Collaborative Care: A step by step guide to implementing the core model. 2014. Available: <http://aims.uw.edu/sites/default/files/CollaborativeCareImplementationGuide.pdf>.

Bree Collaborative New Topic Selection

	MHIP uses a patient registry (CMTS) to track and measure patient goals and clinical outcomes, and facilitate treatment adjustment if a patient is not improving as expected.” ⁵ Good results from Collaborative Care for Adolescents With Depression in Primary Care: A Randomized Clinical Trial: “Among adolescents with depression seen in primary care, a collaborative care intervention resulted in greater improvement in depressive symptoms at 12 months than usual care.” ⁶	
Data is Available	Yes – Data from existing programs exists, but difficult to compare across programs.	
Bree Uniquely Positioned for Impact	Problem of siloed disciplines, as a multi-stakeholder group, the Bree can recommend methods of payment reform and methods of integration across groups.	
Shared-Decision Making Available	Shared decision making tools and protocols exist for mental health disorders, “The current literature shows that SDM can play a role in the mental health treatment process from entry into care to recovery.” ⁷	
Health Technology Assessment Topic	No	
Choosing Wisely Available	No	
Implement-ability	Specific steps for implementation from organizations such as the AIMS Center at the University of Washington. Could build on Washington's Mental Health Integration Program that “incorporates a pay-for-performance component in which 25 percent of the payment for the program is tied to effective treatment. Since the pay-for-performance component was introduced in 2008, the effectiveness of the program has substantially improved.” ⁵	

⁵ AIMS Center. Washington State’s Mental Health Integration Program. 2014. Available: <http://aims.uw.edu/washington-states-mental-health-integration-program-mhip>.

⁶ Richardson LP, Ludman E, McCauley E, Lindenbaum J, Larison C, Zhou C, Clarke G, Brent D, Katon W. Collaborative care for adolescents with depression in primary care: a randomized clinical trial. JAMA. 2014 Aug 27;312(8):809-16.

⁷ Patel SR, Bakken S, Ruland C. Recent advances in shared decision making for mental health. Curr Opin Psychiatry. 2008 Nov;21(6):606-12

Bree Collaborative New Topic Selection

Opioids

Champion: Gary Franklin

Category	Description	Rating 1=low; 5=high
Variation in practice patterns/ High utilization - Waste and inefficiency	Extremely high utilization and variation in prescribing practice. “Geographic variation in prevalence of prescribed opioids is large, greater than variation observed for other healthcare services...Wide variation in prescribing opioids reflects weak consensus regarding the appropriate use of opioids for treating pain, especially chronic non-cancer pain. Patients’ demands for treatment have increased, more potent opioids have become available, an epidemic of abuse has emerged, and calls for increased government regulation are growing.” ⁸	
Patient Safety/Poor Health Outcomes	Epidemic of mortality, overdose morbidity and a host of serious adverse events, dependence, addiction	
Cost (Direct & Indirect)	Medium for drugs per se, extremely high for adverse outcomes	
Proven means/strategies to address topic*	Labor and Industries has successfully implemented guidelines similar to those being developed by the AMDG group	
Bree Uniquely Positioned for Impact	The Bree would have a unique ability to widely disseminate the AMDG guidelines, and the payers would be able to implement the recommendations	
Shared-Decision Making Available	The opportunity to implement shared decision making tools, such as the patient treatment agreement, is modest	
Health Technology Assessment Topic	No	
Choosing Wisely Available	American Academy of Neurology - Don’t use opioid or Butalbital treatment for migraine except as a last resort. ⁹ American Society of Anesthesiologists - Don’t prescribe opioid analgesics as first-line therapy to treat chronic non-cancer pain; Don’t prescribe opioid analgesics as long-term therapy to treat chronic non-cancer pain until the risks are considered and discussed with the patient. ¹⁰	
Implement-ability	Medium-high capacity to implement recommendations	

⁸ McDonald DC, Carlson K, Izrael D. Geographic variation in opioid prescribing in the U.S. J Pain. 2012 Oct;13(10):988-96.

⁹ American Academy of Neurology. American Academy of Neurology: Five Things Physicians and Patients Should Question. Available: <http://www.choosingwisely.org/doctor-patient-lists/american-academy-of-neurology/>

¹⁰ American Society of Anesthesiologists. American Society of Anesthesiologists (ASA) releases Choosing Wisely® list for pain medicine. Available: <http://www.choosingwisely.org/american-society-of-anesthesiologists-asa-releases-choosing-wisely-list-for-pain-medicine/>.

Bree Collaborative New Topic Selection

Sleep Therapy

Champion: Terry Rogers

Sleep apnea is a chronic condition in which patients have “one or more pauses in breathing or shallow breaths while [they] sleep...the most common cause is obstructive sleep apnea. In this condition [where] the airway collapses or becomes blocked during sleep...causing shallow breathing or breathing pauses.” The less common type, central sleep apnea, “...occurs if the area of the brain that controls breathing doesn't send the correct signals to breathing muscles.”¹¹ Approximately 3%-7% of adults have obstructive sleep apnea and it is associated with older age, male sex, obesity, family history, menopause, craniofacial abnormalities, and health behaviors such as smoking and alcohol.¹² For 2008–2009, 27.6% of Washington adults reported not getting enough sleep on ≥ 14 days in the past 30 days.¹³ Sleep apnea can cause excessive daytime sleepiness.¹¹

Category	Description	Rating 1=low; 5=high
Variation in practice patterns/ High utilization - Waste and inefficiency	Issue of a lack of a proper diagnosis and treatment. Only ~1% of obstructive sleep apnea (OSA) patients are receiving treatment.	
Patient Safety/Poor Health Outcomes	Sleep deprivation is associated with injuries, chronic diseases, mental illnesses, poor quality of life and well-being, increased health care costs, and lost work productivity. Sleep problems are critically under-addressed contributors to some chronic conditions, including obesity, diabetes, cardiovascular disease, and depression. ^{14,13}	
Cost (Direct & Indirect)	There is considerable evidence of the cost-effectiveness of treating patients with obstructive sleep apnea, especially considering its high prevalence, morbidity, mortality, and concomitant health care consumption.	
Proven means/strategies to address topic*	Education, screening, diagnostic testing leading to treatment.	
Data is Available	Insufficient data. Part of the workgroup's report would be to increase data collection.	
Bree Uniquely Positioned for Impact	Very little other work around sleep apnea done in Washington State.	

¹¹ National Heart, Lung, and Blood Institute. What is sleep apnea? US Departments of Health and Human Services. Updated: July 10th, 2012. Available: <http://www.nhlbi.nih.gov/health/health-topics/topics/sleepapnea/>

¹² Runjabi N. The Epidemiology of Adult Obstructive Sleep Apnea. Proceedings of the American Thoracic Society, Vol. 5, No. 2 (2008), pp. 136-143.

¹³ Centers for Disease Control and Prevention. Insufficient Sleep Among Washington Adults. Available: http://www.cdc.gov/sleep/pdf/states/Insufficient_Sleep_Fact_Sheet_2011_WA.pdf

¹⁴Centers for Disease Control and Prevention. Sleep and Sleep Disorders. Updated: July 1, 2013. Available: http://www.cdc.gov/sleep/about_us.htm

Bree Collaborative New Topic Selection

Shared-Decision Making Available	Yes - http://ce.effectivehealthcare.ahrq.gov/continuing-education/CER16/Guidance-for-Informed-and-Shared-Decision-Making-about-Diagnostic-Tools-and-Treatments-for-Obstructive-Sleep-Apnea And www.academyhealth.org/files/SQII/WASharedDecisionMakingCollaborative.pdf	
Health Technology Assessment Topic	Sleep Apnea Diagnosis and Treatment in Adults. Concerns about efficacy, effectiveness and safety regarding treatments for OSA. Important questions remain regarding diagnosis of OSA; the linkage between OSA and other conditions and/or risks; whether intervention reduces negative outcomes; whether treatments such as CPAP and surgical procedures should be used as (1) preventive; (2) treatment for established conditions; or (3) avoidance of bad outcomes for established disease; effectiveness of interventions. Sleep apnea diagnosis and treatment is covered benefit with conditions consistent with the criteria identified in the reimbursement determination. ¹⁵	
Choosing Wisely Available	Choosing Wisely: Don't routinely order sleep studies (polysomnogram) to screen for/diagnose sleep disorders in workers suffering from chronic fatigue/insomnia. ¹⁶	
Implement-ability	Difficult	

¹⁵ Health Technology Clinical Committee. Sleep Apnea Diagnosis and Treatment. Washington State Health Care Authority. Adopted: May 18th, 2012. Available: [http://www.hca.wa.gov/hta/documents/finding%20 decision_sleep_apnea.pdf](http://www.hca.wa.gov/hta/documents/finding%20decision_sleep_apnea.pdf)

¹⁶ American Family Physician. Choosing Wisely: Don't routinely order sleep studies (polysonmoogram) to screen for/diagnose sleep disorders in workers suffering from chronic fatigue/insomnia. 2014. <http://www.aafp.org/afp/recommendations/viewRecommendation.htm?recommendationId=191>

Prostate Specific Antigen Screening Testing

Champion: Leah Hole-Marshall

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

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

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

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

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

Category	Description	Rating 1=low; 5=high
Variation in practice patterns/ High utilization - Waste and inefficiency	<p>A 2010 study of 11,892 men with localized prostate cancer treated at 36 different clinical sites concluded that “Substantial variation exists in management of localized prostate cancer that is not explained by measurable factors... data suggest both overtreatment of low-risk disease and under-treatment of high-risk disease”¹⁷</p> <p>State agencies recommend PSA testing topic for Bree review and recommendation.</p>	
Patient Safety/Poor Health Outcomes	<p>For every 1,000 men who are screened with the PSA test:¹⁸</p> <ul style="list-style-type: none"> • 30 to 40 men will develop erectile dysfunction or urinary incontinence due to treatment • 2 men will experience a serious cardiovascular event, such as a heart attack, due to treatment • 1 man will develop a serious blood clot in his leg or lungs due to treatment <p>For every 3,000 men who are screened with the PSA test:</p> <ul style="list-style-type: none"> • 1 man will die due to complications from surgical treatment 	

¹⁷ Cooperberg MR, Broering JM, Carroll PR. Time trends and local variation in primary treatment of localized prostate cancer. J Clin. Oncol. 2010; 28(7): 1117-23

¹⁸ US Preventive Services Task Force. USPDTF Prostate Cancer Screening Recommendation What are the benefits and hards of prostate cancer screening? Available: <http://www.uspreventiveservicestaskforce.org/prostatecancerscreening/prostatecancerinfo.pdf>

Bree Collaborative New Topic Selection

Cost (Direct & Indirect)	Prostate cancer treatment accounted for \$9.9 billion in health care costs in the United States in 2006. Costs of care vary markedly with choice of initial treatment option. ¹⁹ In one study following a cohort of over 13,000 men over age 66 for five years, 5-year incremental costs of care ranged from \$9,130 for patients whose initial management approach was watchful waiting, to \$26,896 for those whose initial management was hormonal therapy. ²⁰	
Proven means/strategies to address topic*	Yes, Adopt community standard based on evidence, ideally aligned with other trusted recommendations (e.g. USPSTF, AAFP). Encourage shared decision making.	
Data is Available	State agencies can provide data on PSA testing costs and treatment costs. Significant clinical literature is available on PSA testing and treatment harms, benefits, and costs.	
Bree Uniquely Positioned for Impact	Can bring community together to endorse community standard and recommend to the legislature	
Shared-Decision Making Available	Han PK, Kobrin S, Breen N, Joseph DA, Li J, Frosch DL, Klabunde CN. National evidence on the use of shared decision making in prostate-specific antigen screening. <i>Ann Fam Med.</i> 2013 Jul-Aug;11(4):306-14. Li J, Berkowitz Z, Richards TB, Richardson LC. Shared decision making in prostate-specific antigen testing with men older than 70 years. <i>J Am Board Fam Med.</i> 2013 Jul-Aug;26(4):401-8.	
Health Technology Assessment Topic	Was chosen as an HTA topic, but decision was made to not move forward due to likely conflict with current mandated state coverage.	
Choosing Wisely Available	Yes “Do not routinely screen for prostate cancer using a prostate-specific antigen (PSA) test or digital rectal exam.” ²¹ <ul style="list-style-type: none"> • There is convincing evidence that PSA-based screening leads to substantial over-diagnosis of prostate tumors. • Many tumors will not harm patients, while the risks of treatment are significant. • Physicians should not offer or order PSA screening unless they are prepared to engage in shared decision making that enables an informed choice by patients. 	
Implement-ability	<ul style="list-style-type: none"> • Propose to adopt evidence based recommendation and propose new legislation. • Propose community standard of widespread use of evidence-based shared decision making prior to testing. 	

¹⁹ National Cancer Institute. Cancer Trends Progress Report – 2009/2010 Update. <http://progressreport.cancer.gov/>, retrieved September 11, 2011.

²⁰ Claire F. Snyder, Kevin D. Frick, Amanda L. Blackford, Robert J. Herbert, Bridget A. Neville, Michael A. Carducci, and Craig C. Earle. How does initial treatment choice affect short-term and long-term costs for clinically localized prostate cancer? *Cancer*, 2010; DOI: 10.1002/cncr.25517

²¹ American Academy of Family Physicians. Prostate Cancer Screening Using a Prostate-specific Antigen (PSA) Test or Digital Rectal Exam Choosing Wisely Recommendation. Available: <http://www.aafp.org/patient-care/clinical-recommendations/all/cw-prostate-cancer.html>.

Oncology

Jeffery Thompson, MD MPH Mercer

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

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

Bree Collaborative New Topic Selection

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

Bree Collaborative New Topic Selection

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

References

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Bree Collaborative New Topic Selection

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Coronary Artery Disease Bundle

Champion: Bob Mecklenburg

“Coronary artery disease (CAD) is the most common type of heart disease. CAD happens when the arteries that supply blood to heart muscle become hardened and narrowed... due to the buildup of cholesterol and other material, called plaque, on their inner walls.²² In 2010, the prevalence of CHD was greatest among persons aged ≥65 years (19.8%) and among men (7.8%).”²³

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

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

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

²² US National Library of Medicine. Coronary Artery Disease. Available: <http://www.nlm.nih.gov/medlineplus/coronaryarterydisese.html>

²³ Centers for Disease Control and Prevention. Prevalence of Coronary Heart Disease. October 14, 2011. Available: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6040a1.htm>

Bree Collaborative New Topic Selection

Patient Safety/Poor Health Outcomes	CAD is the leading cause of death in the United States in both men and women and claims more lives each year than the next four leading causes of death combined—cancer, chronic lower respiratory diseases, accidents, and diabetes mellitus. ^{17,24}	
Cost (Direct & Indirect)	The direct and indirect cost of coronary artery disease exceeds \$108B per year and claims more lives each year than cancer, chronic lung disease, accidents and diabetes combined. ²⁰	
Proven means/strategies to address topic*	Bundled payment models offer a path toward improvement in quality and affordability. Such models, pioneered by Geisinger Health Systems, achieved a 10% reduction in hospital readmissions, shorter length of stay and reduced hospital charges. The experience of CMS with a bundled payment model for CABG, initiated in 2013, saved \$42.3B in demonstration hospitals. ²⁵	
Data is Available	Data on utilization available through COAP.	
Bree Uniquely Positioned for Impact	No other groups developing publically-accessible bundled payment models.	
Shared-Decision Making Available	The Washington Health Care Authority identifies CABG as a priority for Shared Decision Making. Yes, many are available: Mayo Clinic: http://www.mayoclinic.org/diseases-conditions/coronary-artery-disease/expert-answers/coronary-artery-disease/FAQ-20058302?p=1	
Health Technology Assessment Topic	Cardiac Nuclear Imaging: http://www.hca.wa.gov/hta/Pages/nuclear.aspx Carotid Artery Stenting: http://www.hca.wa.gov/hta/Pages/cas.aspx Cardiac Stent: http://www.hca.wa.gov/hta/Pages/stent.aspx	
Choosing Wisely Available	CABG is a focus of several recommendations by Choosing Wisely. Society of Cardiovascular Computed Tomography. Available: http://www.choosingwisely.org/doctor-patient-lists/society-of-cardiovascular-computed-tomography/ . Society for Cardiovascular Magnetic Resonance. Available: http://www.choosingwisely.org/doctor-patient-lists/society-for-cardiovascular-magnetic-resonance/ . Heart imaging tests before surgery: When you need them—and when you don't.	

²⁴ Cleveland Clinic Center for Continuing Education. Coronary Artery Disease. Available: www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/cardiology/coronary-artery-disease/.

²⁵ Delbanco S. The Payment Reform Landscape: Bundled Payment. Health Affairs Blog. July 2, 2014. Available: <http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment/>

²⁵ US National Library of Medicine. Coronary Artery Disease. Available: <http://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html>

²⁵ Centers for Disease Control and Prevention. Prevalence of Coronary Heart Disease. October 14, 2011. Available: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6040a1.htm>

²⁵ Maddox TM, Chan PS, Spertus JA, Tang F, Jones P, Ho PM, Bradley SM, Tsai TT, Bhatt DL, Peterson PN6. Variations in coronary artery disease secondary prevention prescriptions among outpatient cardiology practices: insights from the NCDR (National Cardiovascular Data Registry). J Am Coll Cardiol. 2014 Feb 18;63(6):539-46.

²⁵ Cleveland Clinic Center for Continuing Education. Coronary Artery Disease. Available: www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/cardiology/coronary-artery-disease/.

²⁵ Delbanco S. The Payment Reform Landscape: Bundled Payment. Health Affairs Blog. July 2, 2014. Available: <http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment/>

Bree Collaborative New Topic Selection

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

Hepatitis C Management

Champion: Dan Lessler

In 2009, there were an estimated 16,000 acute Hepatitis C virus (HCV) infections reported in the United States, at 1.6% of the population. An estimated 3.2 million persons in the United States have chronic Hepatitis C virus infection. Approximately 75%–85% of people who become infected with Hepatitis C virus develop chronic infection.²⁶ “The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection and offering one-time screening for HCV infection to adults born between 1945 and 1965.”²⁷

Category	Description	Rating 1=low; 5=high
Variation in practice patterns/ High utilization - Waste and inefficiency	Variation in who is offered screening and how they are treated. “Most people do not know they are infected because they don’t look or feel sick.” ²⁷	
Patient Safety/Poor Health Outcomes	Chronic Hepatitis C is a serious disease that can result in long-term health problems, including liver damage, liver failure, liver cancer, or even death. It is the leading cause of cirrhosis and liver cancer and the most common reason for liver transplantation in the United States. Approximately 15,000 people die every year from Hepatitis C related liver disease. ²⁷	
Cost (Direct & Indirect)	Sovaldi costs \$84,000 for a course of treatment. ²⁸	
Proven means/strategies to address topic* & Implement-ability	Sovaldi is the first drug that has demonstrated safety and efficacy to treat certain types of HCV infection without the need for co-administration of interferon, and is the second drug approved by the FDA in the past two weeks to treat chronic HCV infection. ²⁹	
Data is Available	Prevalence of disease; cost, efficacy and safety of treatments; clinical policies across commercial and public payers	
Bree Uniquely Positioned for Impact	The cost of DAA’s is prohibitive, and decisions about which patients with hepatitis C should be prioritized for treatment will need to be made. The American Association of the Study of Liver Diseases (AASLD) and the Infectious Disease Society of America (IDSA) have jointly developed a guideline regarding who should be treated. Bree’s endorsement of an approach to who should be prioritized for treatment could possibly help assure care is provided in a way that optimizes population health and the allocation of societal resources.	

²⁶ Centers for Disease Control and Prevention. Hepatitis C information for the public. Available: <http://www.cdc.gov/hepatitis/c/cfaq.htm#cFAQ21>.

²⁷ US Preventative Services Task Force. Screening for Hepatitis C Virus Infection in Adults. June 2013. Available: <http://www.uspreventiveservicestaskforce.org/uspstf/uspshcpc.htm>

²⁸ Reuters. Insurers Worry that \$84,000 Hepatitis C Drug Sovaldi could break the bank. May 28th, 2014. Available: <http://www.newsweek.com/insurers-worry-84000-hepatitis-c-drug-sovaldi-could-break-bank-252539>

²⁹ US Food and Drug Administration. Approval of Sovaldi (sofosbuvir) tablets for the treatment of chronic hepatitis C. Available: <http://www.fda.gov/forconsumers/byaudience/forpatientadvocates/ucm377920.htm>

Bree Collaborative New Topic Selection

Shared-Decision Making Available	Shared decision-making around treatment options. Available: http://www.hcvadvocate.org/hepatitis/factsheets_pdf/Treatment_Decision_Guide.pdf Development of a Shared Decision Making Aid for Hepatitis C Treatment. Available: http://www.hsrdr.research.va.gov/research/abstracts.cfm?Project_ID=2141702419	
Health Technology Assessment Topic	No	
Choosing Wisely Available	American Association for the Study of Liver Diseases - Don't repeat hepatitis C viral load testing outside of antiviral therapy. ³⁰ Nothing on treatment.	
Implement-ability	Unknown	

³⁰ American Association for the Study of Liver Diseases. Five things Physicians and Patients Should Question. Available: www.aasld.org/patients/Documents/choosewisely.pdf.