Bree Collaborative Meeting

March 18th, 2015 | Seattle Central Library
Introduction of New Chair

Hugh Straley, MD
Retired, Medical Director, Group Health and President, Group Health Physicians
Chief Medical Officer, Soundpath Health
Interim Medical Director, Amerigroup Washington
Agenda

- January 21st Meeting Minutes and Chair Report
- **New Topic Introduction**: Profile of the Fred Hutchinson Institute for Cancer Outcomes Research
- **Current Topic Update**: Coronary Artery Bypass Surgery Bundled Payment Model
- **Current Topic Update**: Prostate Specific Antigen Screening Workgroup
- **Implementation Update**: Bree Implementation Team and The Plan for a Healthier Washington
- **New Topic Introduction**: Washington State Agency Medical Director’s Group Opiate Prescribing Guidelines
- **Membership Spotlight**: The Boeing Company
January 21st Meeting Minutes

Dr. Robert Bree Collaborative Meeting
Wednesday, January 21st, 2015 | 12:30-4:30

Seattle Central Library
Level 4, Room 2 | 1000 Fourth Ave. | Seattle, WA 98104

Members Present
Susie Dade, Washington Health Alliance
David Wiggum, MD (for Stuart Freed), Confluence Health
Tom Fritz
Christopher Kodama, MD, MultiCare Health System
Rick Goss, MD, Harborview Medical Center
Steve Hill, Bree Collaborative Chair
John Espinola,* MD, Premera Blue Cross
Gary Franklin, MD, WA State Labor and Industries
Dan Lessler, MD (for MaryAnne Lindeblad) Health Care Authority
Paula Lozano, MD, Group Health Cooperative
Rick Ludwig, MD (for Joe Gifford), Pacific Medical Centers
Greg Marchand, The Boeing Company
Robert Mecklenburg, MD, Virginia Mason Medical Center
Kim Moore, MD, Franciscan Health System
Carl Olden, MD, Pacific Crest Family Medicine
John Robinson, MD, First Choice Health
Terry Rogers, MD, Foundation for Health Care Quality, Vice Chair
Jeanne Rupert, DO, PhD
Kerry Schaefer, King County
Lani Spencer, RN, Amerigroup
Carol Wagner, RN, MBA, Washington State Hospital Association
Membership Update

Mary Kay O’Neill, MD, MBA
Chief Medical Director
Coordinated Care

Bruce Smith, MD
Medical Director
Regence Blue Shield
HUTCHINSON INSTITUTE FOR CANCER OUTCOMES RESEARCH

IMPROVING VALUE IN CANCER CARE

Karma Kreizenbeck, Project Director
Eliminate cancer and related diseases as causes of human suffering and death.

Improve the effectiveness of cancer prevention, early detection and treatment services provided to patients in ways that reduce the economic and human burden of cancer.
Rising cancer care costs

Cumulative percent increase

- Cancer drugs
- Cancer medical
- Healthcare
- US GDP

Why HICOR? Why now?

Patients are bearing an ever-increasing share of the expense, causing a new side effect called financial toxicity.

There’s great variability in cost and quality of cancer treatments across the health care system.
Risk for Financial Toxicity

Cancer patients have higher rates of bankruptcy than non-cancer patients

Percent filing for bankruptcy

Bankruptcy reform act signed into law, 2005

Bankruptcy reform act goes into effect, 2006

Western Washington, 1995-2010

Health Affairs, 2013
Risk for Financial Toxicity

Cancer patients have higher rates of bankruptcy than non-cancer patients

Percent filing for bankruptcy

- 0.25%
- 0.20%
- 0.15%
- 0.10%

1995 2000 2005 2010

Cancer patients
Matched controls

Bankruptcy reform act signed into law, 2005
Bankruptcy reform act goes into effect, 2006

Western Washington, 1995-2010

Health Affairs, 2013
So, what is HICOR doing

HICOR is building a regional network of providers, payers, patients and researchers committed to improving cancer care through timely reporting of value-driven, clinically relevant, actionable metrics and deployment of high quality interventions designed to improve those metrics.
# How we work

<table>
<thead>
<tr>
<th>ENGAGE NOVEL PARTNERS</th>
<th>LINK DATA SOURCES</th>
<th>TIMELY REPORTING</th>
<th>DATA-DRIVEN TARGETING INTERVENTIONS</th>
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<tbody>
<tr>
<td>HICOR’s Value in Cancer Care Consortium is a regional learning cancer care network including all stakeholders in the cancer care delivery enterprise: clinicians, delivery systems, private and public payers, and patients.</td>
<td>HICOR integrates disparate data sources to accurately characterize cancer care and generate value-based performance metrics in oncology.</td>
<td>Timely reporting of value-driven, clinically relevant, actionable metrics, and deployment of high quality interventions designed to improve those metrics.</td>
<td>Launch high-quality, research-based interventions to improve care where value is low.</td>
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</table>
Data driven insights

The patient story

- CANCER REGISTRY, pathological outcomes
Data driven insights

The patient story

- CANCER REGISTRY, pathological outcomes
- CLAIMS, utilization and costs

Pre-diagnosis | Initial care | Continuing care | Last year of life
The patient story

Data driven insights

- CANCER REGISTRY, pathological outcomes
- CLAIMS, utilization and costs
- EMR (Electronic Medical Forms), clinical results
The patient story

Data driven insights

- CANCER REGISTRY, pathological outcomes
- CLAIMS, utilization and costs
- EMR (Electronic Medical Forms), clinical results
- PROs (Patient Reported Outcomes) quality of life and patient experience

Pre-diagnosis | Initial care | Continuing care | Last year of life
Timely reporting of insights

HICOR IQ: An interactive Oncology Informatics Platform
HICOR Model

- Treatment patterns
- Guideline adherence
- Utilization
- Cost
- Survival
- Benchmarking relative to region

Characterize oncology care

- Evaluate expected change in practice patterns, patient outcomes, costs, and value

Prioritize areas for improvement

- High variation in well defined treatment settings
- Low-value care
- Poor patient outcomes

Align care with best practices

Design programs

- Provider & patient behavior change
- Delivery system process change
- Financing models
- Incentives

Evaluate outcomes

- Improve outcomes for patients and families
- Reduce economic burden
Our Model at Work

5 things physicians and patients should question

HICOR is the first in the nation to generate clinic-level adherence to Choosing Wisely metrics.
Example

How metrics drive targets interventions

CHOOSING WISELY #4

SURVIVORSHIP: BREAST SURVEILLANCE

Don’t perform surveillance testing (biomarkers) or imaging (PET, CT, and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.

- Surveillance testing with serum tumor markers or imaging has been shown to have clinical value for certain cancers (e.g., colorectal). However, for breast cancer that has been treated with curative intent, several studies have shown there is no benefit from routine imaging or serial measurement of serum tumor markers in asymptomatic patients.
- False-positive tests can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.
Breast cancer tumor markers associated with increased total cost of care

The percent increase in total costs of care among patients receiving at least one tumor marker test relative to those with no tumor marker tests.

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Percentage Increase</th>
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<tbody>
<tr>
<td>3 to 12 months after diagnosis</td>
<td>0.0%</td>
</tr>
<tr>
<td>13 to 24 months after diagnosis</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Journal of Clinical Oncology, October 20, 2014
Breast cancer tumor markers associated with increased total cost of care

The percent increase in total costs of care among patients receiving at least one tumor marker test relative to those with no tumor marker tests.

3 to 12 months After diagnosis
- 31.4%
- 38.0%

13 to 24 months After diagnosis
- 24.9%
- 31.9%

Source: Journal of Clinical Oncology, October 20, 2014
Intervention based on performance metrics

SURVIVORSHIP: BREAST SURVEILLANCE

6 SCCA Affiliated clinics

Retrospective audit of clinic adherence in 6-month prior to study

PHYSICIAN

Physician-to physician education seminar

PATIENT

Patient education video & survey

Post-intervention guideline adherence at clinic level

Patient survey of knowledge, QOL and perceived impact of video
# Performance metrics portfolio

<table>
<thead>
<tr>
<th>Conceptual</th>
<th>Indevelopment/ Specification/ Assessments</th>
<th>Ready for stakeholder review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biomarker and molecular testing</td>
<td>Place of death</td>
<td>Rate of chemotherapy at end of life</td>
</tr>
<tr>
<td>Adherence to guidance for primary therapy</td>
<td>Use of advanced imaging at end of life</td>
<td>Rate of radiation therapy at end of life</td>
</tr>
<tr>
<td>Use of navigator, care coordinator, case manager</td>
<td>Use of narcotic at end of life</td>
<td>Use of advanced imaging for staging in prostate cancer</td>
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<tr>
<td></td>
<td>Access to palliative care services</td>
<td>Use of advanced imaging and tumor markers for surveillance in low-risk breast cancer</td>
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<tr>
<td></td>
<td>Emergency visits and hospitalization during treatment</td>
<td>Appropriate use of colon stimulating factors</td>
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<tr>
<td></td>
<td>Appropriate use of targeted therapies</td>
<td>Use of hospice prior to death</td>
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<tr>
<td></td>
<td></td>
<td>Emergency department visits, inpatient admissions and ICU stays at end of life</td>
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Our aspirations

HICOR Value in Cancer Care Consortium

• All cancer care delivery systems, public and private payors and providers will participate in the Value in Cancer Care Consortium.

• Consortium will serve as a regional demonstration of data-driven cancer care delivery research.

• Public reporting of performance metrics for the benefit of patients, providers, payers and the health care system.

• Develop tools for patients to understand the financial aspects of care decisions.

• Decrease costs for patients, families and society.

• Decrease variation in care for well-established therapies and procedures.
Value in Cancer Care Summit

MARCH 30, 2015

Forum for individuals from across the healthcare spectrum to convene and collaborate on improving outcomes and increasing value in cancer care.

Date: March 30, 2015, 8:00 AM – 5:00 PM

Location: Bell Harbor International Conference Center, Seattle, WA

Keynote Address: Dr. Arnold Milstein, Director of the Clinical Excellence Research Center at Stanford University

Register Today: Registration closes on Monday, March 16, 2015

Questions? Email valuesummit@fredhutch.org
Thank you
DESIGN TEAM

- **Providers**
  1. Bob Mecklenburg, MD, Virginia Mason, Co-Chair
  2. Drew Baldwin, MD, FACC, Virginia Mason (Cardiologist, COAP)
  4. Vinay Malhotra, MD, Cardiac Study Center (Cardiologist, WSMA)
  5. Glenn Barnhart, MD, Swedish Medical Center (Cardiac Surgeon, WSHA)
  6. Gregory Eberhart, MD, FACC, CHI Franciscan Health (Cardiologist, WSHA)
  7. Jay Pal, MD, University of Washington, (Cardiac Surgeon, WSMA)

- **Purchasers**
  1. Kerry Schaefer, King County, Co-Chair
  2. Marissa Brooks, SEIU Healthcare NW Benefits
  3. Greg Marchand/Theresa Helle, The Boeing Company
  4. Thomas Richards, Alaska Airlines

- **Health Plans**
  1. Dan Kent, MD, Premera Blue Cross
  2. Gregg Shibata, Regence Blue Shield

- **Quality Organizations**
  1. Susie Dade, Washington Health Alliance
  2. Jeff Hummel, MD, Qualis Health
  3. Shilpen Patel, MD, FACRO, COAP
OVERVIEW

- **WARRANTY**: Aligning payment with safety

- **BUNDLED PAYMENT MODEL**: Aligning payment with quality

- **PROCESS**: Brings overall transparency to providers, purchasers, and patients
BUNDLE: FOUR COMPONENTS
EACH SEQUENTIAL COMPONENT IS REQUIRED

1. Document disability despite non-surgical therapy
2. Ensure fitness for surgery
3. Provide all elements of high-quality surgery
4. Facilitate rapid return to function
Document disability despite non-surgical therapy

1. Document disability: Canadian Cardiovascular Society grade of angina pectoris, Seattle Angina Questionnaire-7, PROMIS-10


3. Begin risk factor modification unless need for urgent intervention: 2012 ACCF, et.al. Guidelines – e.g., cardiac diet, statins, blood pressure, smoking cessation

4. Stratify prior to determining appropriate intervention: e.g., heart team/multi-disciplinary conference
Physical preparation and patient engagement

1. Document requirements related to patient safety: e.g., BMI <40, Hemoglobin A1c <8%, screen for untreated depression

2. Document patient engagement: e.g., shared decision-making, care partner

3. Document optimal preparation for surgery: e.g., perform pre-operative history, relevant consultations, collect patient-reported measures
Cycle III: Surgery
  - Measures to improve outcomes
Cycle IV: Recovery
  - Rapid return to function
Quality Measures
  - Align with COAP
Warranty
The Dr. Robert Bree Collaborative:
PSA Testing Workgroup

March 9th, 2015
Members

**Providers**
- Rick Ludwig, MD (Chair), Accountable Care Organization, Providence Health & Services
- Eric Wall, MD, MPH, UnitedHealthcare
- Shawn West, MD, Edmonds Family Medicine

**Urology**
- John Gore, MD, MS, University of Washington Medicine
- Jonathan Wright, MD, MS, FACS, University of Washington/Fred Hutchinson Cancer Research Center

**Patient Advocates**
- Steve Lovell, Patient and Family Advisory Council

**State Agencies**
- Leah Hole-Marshall, JD, Department of Labor & Industries

**Insurers**
- Matt Handley, MD, Group Health Cooperative
“To identify evidence-based best practice for prostate cancer specific antigen testing for prostate cancer screening and propose recommendations to the full Bree Collaborative.”
The Bree Collaborative
Prostate Cancer Screening Workgroup Charter

Problem Statement
The prostate specific antigen (PSA) test has been used to test asymptomatic men for prostate cancer along with the digital rectal exam since FDA approval in 1994.\(^1\) After a systematic review in 2012, the United States Preventive Services Task Force recommended “against prostate specific antigen-based screening for prostate cancer” concluding “that many men are harmed as a result of prostate cancer screening and few, if any, benefit.”\(^2\) Variation in PSA testing and high rates of PSA testing may expose men to increased risk of harm, lower quality of life, and undue cost. Despite these recommendations, those of the American Urological Association, and others, PSA testing is common.

Aim
To align with evidence-based best practice and standardize the use of prostate specific antigen testing for prostate cancer screening in Washington State.

Purpose
To identify evidence-based best practice for prostate cancer specific antigen testing for prostate cancer screening and propose recommendations to the full Bree Collaborative.
Definition: The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.

Table. PSA-Based Screening for Prostate Cancer

**Why not screen for prostate cancer?**

Screening may benefit a small number of men but will result in harm to many others. A **person** choosing to be screened should believe that the possibility of benefit is more important than the risk for harm. The USPSTF assessment of the balance of benefits and harms in a screened **population** is that the benefits do not outweigh the harms.

**What are the benefits and harms of screening 1000 men aged 55–69 y† with a PSA test every 1-4 y for 10 y?**

<table>
<thead>
<tr>
<th>Possible benefit of screening</th>
<th>Men, n</th>
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</thead>
<tbody>
<tr>
<td><em>Reduced 10-y risk for dying of prostate cancer</em></td>
<td>5 in 1000</td>
</tr>
<tr>
<td>Die of prostate cancer with no screening</td>
<td>4–5 in 1000</td>
</tr>
<tr>
<td>Die of prostate cancer with screening</td>
<td>0–1 in 1000</td>
</tr>
<tr>
<td>Do not die of prostate cancer because of screening</td>
<td></td>
</tr>
</tbody>
</table>

| Harms of screening                                                                           |              |
| *At least 1 false-positive screening PSA test result*                                        | 100–120 in 1000 |
| Most positive test results lead to biopsy. Of men having biopsy, up to 33% will have moderate or major bothersome symptoms, including pain, fever, bleeding, infection, and temporary urinary difficulties; 1% will be hospitalized. |              |

| *Prostate cancer diagnosis*                                                                  | 110 in 1000  |
| Although a diagnosis of prostate cancer may not be considered a harm, currently 90% of diagnosed men are treated and, thus, are at risk for the harms of treatment. A large majority of the men who are being treated would do well without treatment. A substantial percentage of these men would have remained asymptomatic for life. |              |

| *Complications of treatment (of those who are screened)‡*                                     |              |
| Develop serious cardiovascular events due to treatment                                       | 2 in 1000    |
| Develop deep venous thrombosis or pulmonary embolus due to treatment                         | 1 in 1000    |
| Develop erectile dysfunction due to treatment                                                 | 29 in 1000   |
| Develop urinary incontinence due to treatment                                                 | 18 in 1000   |
| Die due to treatment                                                                          | <1 in 1000   |
American Academy of Family Physicians

Don’t routinely screen for prostate cancer using a prostate-specific antigen (PSA) test or digital rectal exam.

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.

American Society of Clinical Oncology

Don’t perform PSA testing for prostate cancer screening in men with no symptoms of the disease when they are expected to live less than 10 years.

- Since PSA levels in the blood have been linked with prostate cancer, many doctors have used repeated PSA tests in the hope of finding “early” prostate cancer in men with no symptoms of the disease. Unfortunately, PSA is not as useful for screening as many have hoped because many men with prostate cancer do not have high PSA levels, and other conditions that are not cancer (such as benign prostate hyperplasia) can also increase PSA levels.
- Research has shown that men who receive PSA testing are less likely to die specifically from prostate cancer. However when accounting for deaths from all causes, no lives are saved, meaning that men who receive PSA screening have not been shown to live longer than men who do not have PSA screening. Men with medical conditions that limit their life expectancy to less than 10 years are unlikely to benefit from PSA screening as their probability of dying from the underlying medical problem is greater than the chance of dying from asymptomatic prostate cancer.


Guideline Statement 1: The Panel recommends against PSA screening in men under age 40 years. (Recommendation; Evidence Strength Grade C)

Guideline Statement 2: The Panel does not recommend routine screening in men between ages 40 to 54 years at average risk. (Recommendation; Evidence Strength Grade C)

Guideline Statement 3: For men ages 55 to 69 years the Panel recognizes that the decision to undergo PSA screening involves weighing the benefits of preventing prostate cancer mortality in 1 man for every 1,000 men screened over a decade against the known potential harms associated with screening and treatment. For this reason, the Panel strongly recommends shared decision-making for men age 55 to 69 years that are considering PSA screening, and proceeding based on a man's values and preferences. (Standard; Evidence Strength Grade B)

Guideline Statement 4: To reduce the harms of screening, a routine screening interval of two years or more may be preferred over annual screening in those men who have participated in shared decision-making and decided on screening. As compared to annual screening, it is expected that screening intervals of two years preserve the majority of the benefits and reduce over diagnosis and false positives. (Option; Evidence Strength Grade C)

Guideline Statement 5: The Panel does not recommend routine PSA screening in men age 70+ years or any man with less than a 10 to 15 year life expectancy. (Recommendation; Evidence Strength Grade C)

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.
Action Item:
Approve Prostate Cancer Screening Charter and Roster
2015 AMDG Opioid Guideline Update

Bree Collaborative
March 18, 2015

Gary M. Franklin, MD, MPH
Research Professor
Departments of Environmental Health, Neurology, and Health Services
University of Washington

Medical Director
Washington State Department of Labor and Industries
Process for Update of AMDG Guideline

• Members are invited and assigned to one of three workgroups based on expertise
  – Group 1 addressed opioid use during acute and sub-acute phase, clinically meaningful improvements & alternatives to opioids
  – Group 2 provided guidance on opioid use during perioperative phase
  – Group 3 focused on when to discontinue chronic opioid therapy & initiate addiction treatment

• Drafts will be circulated to the full Committee for feedback & approval – April 2015

• Final draft will be published for public comments – May 2015

• Conference on Evidence-Based Pain Care: Featuring a new opioid guideline from the Washington State Agency Medical Directors’ Group – June 2015
## AMDG Guideline Advisory Committee

### Clinicians
- David Beck – Grays Harbor Clinic
- Randi Beck – Group Health Cooperative
- Malcolm Butler – Columbia Valley Community Health
- Phillip Capp – Swedish Medical Center Family Practice
- Greg Carter – St. Lukes Rehabilitation
- Dianna Chamblin – Everett Clinic
- Pamela Davies – UW/Seattle Cancer Care Alliance Supportive & Palliative Care
- Dermot Fitzgibbon – UW/Seattle Cancer Care Alliance
- Andrew Friedman – Virginia Mason Medical Center
- Debra Gordon – Harborview Anesthesiology & Pain Medicine
- Lucinda Grande – Pioneer Family Practice
- Chris Howe – Valley Medical Center
- Ray Hsiao – Seattle Children’s Hospital/UW Department of Psychiatry and Behavioral Sciences
- Gordon Irving – Swedish Pain and Headache Center
- Joseph Merrill – UW/Harborview Medical Center
- Patricia Read-Williams – UW Neighborhood Clinics
- Richard Ries – UW/Harborview Medical Center Division of Addictions
- Andrew Saxon – VA Puget Sound Health Care System/Center of Excellence in Substance Abuse Treatment and Education (CESATE)/UW Addiction Psychiatry Residency Program

### Health Plans
- Ken Hopper – Amerigroup, Washington
- James Luciano & Thomas Paulson – Wellpoint Companies
- Mary Kay O’Neill – Coordinated Care/Bree

### State Agencies
- Stephen Hammond - DOC
- Kathy Lofy - DOH
- Gary Franklin, Lee Glass, Nicholas Reul & Hal Stockbridge - L&I
- Dan Lessler & Charissa Fotinos - HCA

### Boards and Commissions
- Richard Brantner - MQAC

### Additional Members
- Michael Schatman – Foundation for Ethics in Pain Care
- Mark Sullivan – UW Center for Pain Relief/Department of Psychiatry and Behavioral Sciences
- David Tauben – UW Center for Pain Relief/Division of Pain Medicine
- Greg Terman – UW Department of Anesthesiology
- Stephen Thielke – Seattle VAMC Geriatric Research, Education and Clinical Center
- Michael Von Korff – Group Health Cooperative
Risk of Overdose Events

Risk Ratio vs. Dose in mg MED

- Dunn 2010
- Bohnert 2011
- Gomes 2011
- Zedler 2014

Dose categories:
- <20 mg/day
- 20-49 mg/day
- 50-99 mg/day
- >=100 mg/day
Opioid Dosing Policies Since 2007

- 2007: WA AMDG recommended consultation at 120 mg/day MED
- 2009: CDC recommended consultation at 120 mg/day MED
- 2010: WA ESHB 2876 directed DOH Boards and Commissions to establish dosing guidance and best practices
- 2012: CT workers comp recommended a threshold at 90 mg/day MED
- 2013: OH Medical Board recommended a threshold at 80 mg/day MED
- American College of Occupational and Environmental Medicine recommended a threshold at 50 mg/day MED
- 2013: IN recommended a threshold at 60 mg/day MED
- 2014: CA Medical Board recommended a yellow flag at 80 mg/day MED
  [http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf](http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf)
- 2014: CO Department of Regulatory Agencies recommended a threshold at 120 mg/day MED
  [http://1.usa.gov/1DNPaxT](http://1.usa.gov/1DNPaxT)
Dosing Threshold

• Do NOT prescribe chronic opioid therapy (COT) if the patient has any FDA or clinical contraindications (e.g. current substance use disorder)

• Use great CAUTION at any dose if the patient has certain risk factors (e.g. mental health disorder)

• Avoid exceeding 50 mg/day MED for patients with any risk factors if they are not already above this dose

• Do NOT prescribe more than 120 mg/day MED without first obtaining a pain management consult
Clinically Meaningful Improvement

• Clinically meaningful improvement is improvement in pain and function of at least 30%
• Assess and document function and pain using validated tools at each visit where opioids are prescribed
• Recommend use of quick and easy tools to track function and pain
  – PEG: Pain intensity, interference with Enjoyment of life, and interference with General activity
  – Graded Chronic Pain Scale: Pain intensity and pain interference
Non-Pharmacologic Alternatives

• Do NOT pursue diagnostic tests unless risk factors or specific reasons are identified
• Use interventions such as listening, providing reassurance, and involving the patient in care
• Recommend graded exercise, cognitive behavioral therapy, mindfulness based stress reduction (MBSR), various forms of meditation and yoga or spinal manipulation in patients with back pain
• Refer patient to a multidisciplinary rehabilitation program if s/he has significant, persistent functional impairment due to complex chronic pain
Pharmacologic Alternatives

• Use acetaminophen, NSAIDs or combination for minor to moderate pain
• Consider antidepressants (TCAs/SNRIs) and anticonvulsants for neuropathic pain, other centralized pain syndromes, or fibromyalgia
• Avoid carisoprodol (SOMA) due to the risk of misuse and abuse. Do NOT prescribe muscle relaxants beyond a few weeks as they offer little long-term benefit
• Prescribe melatonin, TCAs, trazodone, or other non-controlled substances if the patient requires pharmacologic treatment for insomnia
Prescription Monitor Program (PMP)

- Check the PMP with the first prescription to ensure that the patient’s controlled substance history is consistent with report
- Check the PMP if prescribing opioids during the sub-acute phase
- Check the PMP at a frequency based on the patient’s risk category during chronic therapy to identify aberrant behavior such as multiple prescribers or early fills
Opioid Use in the Acute

• Do NOT prescribe opioids for non-specific low back pain, headaches and fibromyalgia
• Help the patient set reasonable expectations about recovery
• Reserve opioids for pain from severe injuries or medical conditions, surgical procedures or when alternatives are ineffective. If prescribed, shortest duration and lowest necessary dose
• Consider tapering off opioids by 6 weeks as acute episode resolved or if CMIF hasn’t occurred
Opioid Use in the Sub-acute

• Do NOT prescribe opioids if use during acute phase doesn’t lead to CMIF
• Screen for depression, anxiety and opioid risk using validated tools
• Avoid prescribing new benzodiazepines and sedative-hypnotics
• Discontinue opioids if there is no CMIF, treatment resulted in severe adverse outcome or patient has a current substance use disorder or a history of opioid use disorder
Opioid Use During Perioperative

- Develop a coordinated time-limited treatment plan for managing postoperative pain, including responsible prescriber
- Avoid escalating the opioid dose before surgery
- Do NOT discharge patient with more than 2 weeks supply of opioid. Continued opioid therapy will require appropriate reevaluation by the surgeon
- Taper off opioids added for surgery as surgical healing takes place
  - Major surgeries should be able to be tapered to preoperative doses or lower by 6 weeks
  - For some minor surgeries, it may be appropriate to discharge patients on acetaminophen, NSAIDs only or with a very limited supply of short-acting opioids (e.g. 2-3 days)
Opioid Use in the Chronic

• Prescribe COT only if the patient has sustained CMIF, no contraindications and has failed the use of non-opioid alternatives

• Use extreme caution when prescribing COT in high risk patients. For new starts, do not exceed 50 mg/day MED

• Use best practices to ensure effective treatment and minimize potential adverse outcomes

• Avoid methadone unless the provider is knowledgeable of the drug and is willing to perform additional monitoring
When to Discontinue Opioids

- Patient request
- No CMIF as measured by validated instruments for at least 3 months during COT
- Risk from continued treatment outweighs benefit, including decrease in function or concomitant medications
- Severe adverse outcome or overdose event
- Non-compliance with DOH’s pain management rules or AMDG Guideline
- Urine drug tests (UDT) results and/or patient-specific PMP data are aberrant or unexpected
- Drug-seeking, aberrant, or diversion behaviors
How to Taper Opioids

• Start with a taper of ≤10% per week. Rate depends on concurrent treatments or modalities
  – Consider a compulsory taper (2-3 weeks) if the patient does not agree to a voluntary taper or patient with substance use disorder refuse treatment referral
• Prescribe clonidine for withdrawal symptoms such as restlessness, sweating, or tremor
• Use adjunctive therapy during taper or discontinuation (e.g. counseling, psychopharmacological support, SIMP)
• Do NOT reverse taper but it can be slowed. Taper needs to be unidirectional
• Refer patients with opioid use disorder to treatment
When to Access Addiction Treatment

• Assess for opioid use disorder or refer for an assessment if a patient demonstrates aberrant behavior

• Refer patient to an addiction disorder specialist. If that cannot be done, consult directly with a specialist to identify a treatment plan
  – Combination of medication and behavioral therapies has been found to be most successful
  – Medication assisted treatment with either buprenorphine (office-based) or methadone (federally licensed opioid treatment program)
Opioid Use in Special Populations

- Cancer survivors – Model pain treatments after chronic non-cancer pain strategies, rather than palliative therapies
- During pregnancy and neonatal abstinence syndrome – Counsel women on COT to assess potential risk of teratogenicity
- Children and adolescents – Avoid opioids in the vast majority of chronic non-malignant pain problems in children and adolescents
- Older adults - Initiate opioid therapy at a 25% to 50% lower dose than that recommended for younger adults
THANK YOU!

For electronic copies of this presentation, please e-mail Laura Black
ljl2@uw.edu
For questions or feedback, please e-mail Gary Franklin
meddir@u.washington.edu
Preferred Partnership

March, 2015
Preferred Partnership Overview

What is Preferred Partnership?
• Partnership with two health systems in Puget Sound to drive:
  • Improved *Quality* and *Member Experience*
  • More *Affordable* Coverage
• Partnership Includes:
  • *Providence-Swedish* & their partners
  • *UW Medicine* & their partners

Key Issues for employees:
• Lower out-of-pocket Expense and Improved Care Delivery
• Must receive care in the Partnership Network to get the highest benefit level
• Emergency Care is always covered at the highest benefit level
• Primary Care Provider (PCP) is encouraged but not required

More Affordable Coverage
• Lower Paycheck Contributions for TMP/Select
• Higher Company-Funded HSA for Adv+
• $0 Primary Care Office Visit Copays*
• $0 Generic Prescription Drugs*

*After deductible on Advantage+

healthpartnershipoptions.com
Key Quality and Service Elements

Quality Improvement

Contractual Measures
- Clinical Outcomes
- Preventive Screenings
- Health Status
- Member Satisfaction

Care Transformation
- Embedded Medical Home (IOCP)
- Reduction in Readmissions
- Care at Appropriate Place of Service
- Leverage EMRs

Member Service
- Quicker Access to PCPs and Specialists
- Treatment Decision Support
- After Hours Care
- Call Center for Triage, Scheduling and Issue Resolution
- ACO Website for Medical Records, Provider Search
- Enhance Mobile Technology
ACO Build Elements

Member Experience
• Boeing Website – Cost Models, Provider Search, FAQ
• Provider Website – Provider Search, Health Records
• Call Centers – Scheduling, Issue Resolution, etc.

Data
• Timely delivery to ACO

Partnerships with other Facilities
• Geographic Coverage
• Risk/Savings Sharing
• Balance Access vs. Care Integration

Integration Opportunities
• Insurance Carriers
• Well Being Programs
• Onsite/Near-site
BREE IMPLEMENTATION TEAM UPDATE

Dan Lessler, MD
Chief Medical Officer, WA Health Care Authority
Chair, Bree Implementation Team
The NWHPC is a new non-profit organization that provides small and mid-size purchasers (employers and others) in eastern Washington and northern Idaho the opportunity to speak with a common voice and influence the delivery and cost of healthcare in this region.
MAJOR ACTIVITIES

Compare Bree recommendations to current activities and plans

Analyze data and reach agreement on key measures

Identify actions that each participant will take to implement recommendations

Implement at organizational level

Implement collaborative activities (e.g. public education campaigns)

2016 Benefit Year
How can my organization get involved?

We encourage employers and other purchasers to use our recommendations as a guide for their own health care purchasing. Additionally, the Bree Implementation team is working to facilitate adoption of our recommendations. Please contact us for more information and resources to implement any of our recommendations.

- Addiction and Dependence Treatment
- Bundled Payment and Warranty: Total Knee and Total Hip Replacement
- Bundled Payment and Warranty: Lumbar Fusion
- Cardiology
- End-of-Life Care
- Low Back Pain
- Hospital Readmissions
- Obstetrics
- Spine SCOAP

GET INVOLVED

Members of the general public are welcome to attend all Bree Collaborative meetings.

ATTEND A MEETING

Sign up for the listserv. You will receive occasional updates about Bree meeting dates and materials, opportunities for public comment on the reports, and final reports and recommendations.

JOIN OUR MAILING LIST

Ginny Weir, MPH
THE ROLE OF HCA AS A PURCHASER

- “No pay” policy in contracts for Early Elective Delivery
- HCA Accountable Care Program (ACP) request for applications (RFA):
  - Expectation that ACP will standardize around Bree “Bundle” recommendations; initially requires collecting data, monitoring and reporting with respect to appropriateness for the procedure
  - Expectation that ACP will incorporate Bree Low Back Pain recommendations into primary care clinic work flows, data collection and reporting
  - Expectation that ACP hospitals will participate in Foundation for Health Care Quality outcome assessment programs (COAP; SCOAP; OB-COAP)
Build conceptual framework for implementation of current and future topics into recommendations

Convene subgroup to identify elements to include

Review change management literature
THE PLAN FOR A HEALTHIER WASHINGTON

Build healthier communities through a collaborative regional approach
- Fund and support Accountable Communities of Health.
- Use data to drive community decisions and identify community health disparities.

Ensure health care focuses on the whole person
- Integrate physical and behavioral health care in regions as early as 2016, with statewide integration by 2020.
- Spread and sustain effective clinical models of integration.
- Make clinical and claims data available to securely share patient health information.

Improve how we pay for services
- Measure, improve and report common statewide performance measures.
- As purchaser for Apple Health and state employees, drive market toward value-based models.

Implementation tools: State Innovation Models grant, state funding, potential federal waiver, philanthropic support
Legislative support: HB 2572, SB 6312
HEALTHIER WASHINGTON

Plan for implementation:
- Year 1: Design Work
- Year 2: Launch
- Year 3: Learning and Refinement
- Year 4: Evaluation

*Years 2-4 Rapid Cycle Improvement*
HEALTHIER WASHINGTON GRANT

TIMELINE

Year 1: Design Work

Year 2: Launch

Year 3: Learning and Refinement

Years 2 to 4: Testing and rapid-cycle improvement

Year 4: Evaluation

February 1, 2015 – January 31, 2019
2014: Opportunity to develop and implement process to certify decision aids
  - Healthier Washington Initiative
  - Gordon and Betty Moore Foundation

March 2015: Identify and test draft certification criteria, from IPDAS checklist

April 2015: Outline process for ongoing certification

May 2015: Engage stakeholders to provide input

Mid-2015: Finalize and begin certifying maternity decision aids

2016: Begin implementation of certified decision aids and begin certifying joint replacement/spine care aids