Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Dr. Robert Bree Collaborative Annual Report

Engrossed Substitute House Bill 1311; Section 3; Chapter 313; Laws of 2011

November 15, 2018

DR. ROBERT BREE COLLABORATIVE

Washington State Health Care Authority

Dr. Robert Bree Collaborative Annual Report

Acknowledgments

Thank you to our Bree Collaborative chair, Dr. Hugh Straley, and our dedicated Bree Collaborative members and many workgroup members who have donated countless hours to improve health care quality, outcomes, and affordability in Washington State.

Foundation for Health Care Quality
705 Second Ave, Suite 410
Seattle, WA 98104
Phone: (206) 204-7377
www.breecollaborative.com

Clinical Quality and Care Transformation
P.O. Box 45502
Olympia, WA 98504
Phone: (360) 725-0473
Fax: (360) 586-9551
www.hca.wa.gov

Table of Contents

Dr. Robert Bree Collaborative Annual Report 2
Table of Contents 3
Executive Summary 5
Background 6
Overview of ESHB 1311 6
Summary of Recent Work 8
Accountable Payment Models: Lumbar Fusion Re-Review 10
Collaborative Care for Chronic Pain 11
LGBTQ Health Care 12
Suicide Care 13
Opioid Prescribing Guideline Implementation 15
Implementation 16
Summary of Work in the First Six Years 18
Obstetric Care 19
Cardiology 21
Low Back Pain and Spine Surgery 22
Potentially Avoidable Hospital Readmissions 23
End-of-Life Care 24
Addiction and Dependence Treatment 26
Accountable Payment Models: Coronary Artery Bypass Graft Surgery 27
Prostate Cancer Screening 28
Oncology Care 29
Accountable Payment Models: Bariatric Surgery 30
Pediatric Psychotropic Use 31
Behavioral Health Integration 32
Accountable Payment Models: Total Knee and Total Hip Replacement Re-Review 33
Alzheimer's Disease and Other Dementias 34
Opioid Use Disorder Treatment 35
Opioid Prescribing Guideline Implementation 36
Hysterectomy 38
Looking Forward to Year Eight 41
References 42

Appendix A: Bree Collaborative Background 47
Appendix B: Bree Collaborative Members 49
Appendix C: Steering Committee Members 50
Appendix D: Workgroup Members 51

Executive Summary

Stakeholders working together to improve health care quality, outcomes, and affordability in Washington State.

This is the sixth annual report submitted by the Health Care Authority (HCA) on behalf of the Dr. Robert Bree Collaborative (Bree Collaborative or Collaborative) to the Washington State Legislature as directed in Engrossed Substitute House Bill 1311 (ESHB 1311), Section 3, and enacted as Chapter 313, Laws of 2011. This report describes the achievements of the Bree Collaborative from November 2017 through October 2018.

HCA is the sponsoring agency of the Bree Collaborative, a public/private consortium created to give health care stakeholders the opportunity to improve health care quality, patient outcomes, and affordability in Washington State through recommendations regarding specific health care services.

ESHB 1311, Section 3 calls for the Bree Collaborative to:

> "… report to the administrator of the authority regarding the health services areas it has chosen and strategies proposed. The administrator shall review the strategies recommended in the report, giving strong consideration to the direction provided in section 1, chapter 313, Laws of 2011 and this section. The administrator's review shall describe the outcomes of the review and any decisions related to adoption of the recommended strategies by state purchased health care programs. Following the administrator's review, the Bree Collaborative shall report to the legislature and the governor regarding chosen health services, proposed strategies, the results of the administrator's review, and available information related to the impact of strategies adopted in the previous three years on the cost and quality of care provided in Washington state. The initial report must be submitted by November 15, 2011, with annual reports thereafter."

Since its 2011 formation, the Bree Collaborative has successfully pursued its mission to improve health care quality, patient outcomes, and affordability in our state. Year six accomplishments included supporting six active workgroups, drafting and adopting two sets of recommendations, and receiving approval from HCA on one set of recommendations.

This year we have:

- Revised the bundled payment model and warranty for lumbar fusion with updated evidence and more efficient processes.
- Developed recommendations for supportive, collaborative care for chronic pain.
- Developed recommendations to improve the quality and equity of care given to patients who identify as lesbian, gay, bisexual, transgender, or questioning or queer (LGBTQ).
- Developed recommendations to prevent suicide and connect people with appropriate and needed resources.
- Engaged with the surgical and pain specialty community to develop more specific and actionable recommendations on post-operative opioid prescribing.

- Worked with health care purchasers, health plans, provider groups, and the State of Washington to encourage adoption of Bree Collaborative recommendations.

Background

The American health care system continues to have poorer health outcomes, including shorter life expectancy and higher prevalence of chronic disease, and be more expensive than many other high-income countries.[1] Many of the dollars spent in health care are wasted, not adding to patient health or quality of care.[2,3] In Washington State alone, $282 million was spent on unnecessary or low-value health care services in one year.[4] Variation in health care delivery between individual hospitals or clinicians and high rates of use of specific health care services can indicate poor quality, inappropriate services, and potential waste.

Governor Jay Inslee, the Legislature, and the people of Washington State expect and deserve a high-quality, affordable health care system that serves their needs and goals. Washington State government and the Legislature are working to achieve these goals through innovative work such as the Health Technology Assessment program, the Prescription Drug Program, Healthier Washington, and the Dr. Robert Bree Collaborative. The Bree Collaborative is structured after the work of the Advanced Imaging Management (AIM) project and named in memory of Dr. Robert Bree. Dr. Bree was a pioneer in the imaging field and a key member of the AIM project working to reduce inappropriate use of advanced imaging (e.g., CT, PET, and MRI scans) in Washington State.

The Bree Collaborative's work is a key part of Healthier Washington, providing evidence-based standards of care and purchasing guidelines for high-variation, high-cost health care services. The Center for Medicare and Medicaid Innovation (CMMI) State Innovation Models grant to HCA has spread the improvements and strategies developed by the Bree Collaborative, increased health care transparency, and supported the Bree Collaborative's continued development of high-quality recommendations.

Overview of ESHB 1311

The Washington State Legislature established the Bree Collaborative in 2011 to provide a process for public health care purchasers for Washington State, private health care purchasers (self-funded employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations to work together to identify and recommend evidence-based strategies to improve health care quality, outcomes, and affordability. ESHB 1311 amended RCW 70.250.010 (Advanced Diagnostic Imaging Workgroup definition) and 70.250.030 (Implementation of Evidence-Based Practice Guidelines or Protocols); added a new section to chapter 70.250 RCW; created a new section; and repealed RCW 70.250.020.

All Collaborative meetings are open to the public and follow the Open Public Meetings Act.

The Bree Collaborative is charged with annually identifying up to three areas of health care services for which substantial variation exists in practice patterns and/or increases in care utilization that are not accompanied by better care outcomes. Health care services for review are solicited from Bree Collaborative members, the Legislature, the Washington State Agency Medical Directors Group, state associations, other community partners, and the public.

See **Appendix A** for more detail about the Bree Collaborative's background.

The Bree Collaborative consists of the following Governor-appointed expert stakeholders:

- Two representatives of health carriers or third party administrators
- One representative of a health maintenance organization
- One representative of a national health carrier
- Two physicians representing large multispecialty clinics with 50 or more physicians, one of which is a primary care provider
- Two physicians representing clinics with fewer than 50 physicians, one of which is a primary care provider
- One osteopathic physician
- Two physicians representing the largest hospital-based physician groups in the state
- Three representatives of hospital systems, at least one of whom is responsible for quality
- Three representatives of self-funded purchasers
- Two representatives of state-purchased health care programs
- One representative of the Washington Health Alliance (previously the Puget Sound Health Alliance)

See **Appendix B** for a current list of Bree Collaborative members. See **Appendix C** for a list of steering committee members.

Summary of Recent Work

In the Bree Collaborative's seventh year — November 2017 to October 2018 — the group focused on developing new evidence-based recommendations and working to implement existing recommendations through developing surveys and outreach materials, through HCA contracting, and through community outreach and education.

The Bree Collaborative formed workgroups to develop recommendations around collaborative care for chronic pain, Lesbian, Gay, Bisexual, Transgender, and Questioning or Queer (LGBTQ) health care, lumbar fusion bundled payment and warranty re-review, and suicide care.

The Opioid Guideline Implementation workgroup continued to meet. These workgroups are profiled on the following pages.

The Bree Collaborative:

- ✓ Supported six active workgroups
- ✓ Adopted seven recommendations
- ✓ Distributed four recommendations for public comment
- ✓ Received HCA approval on five recommendations

The Bree Collaborative approved and submitted the following recommendations to the HCA:

- **Alzheimer's Disease and Other Dementias** (Adopted November 2017)
  - Available: www.breecollaborative.org/wp-content/uploads/Alzheimers-Dementia-Recommendations-Final-2017.pdf
- **Opioid Use Disorder Treatment** (Adopted November 2017)
  - Available: www.breecollaborative.org/wp-content/uploads/OUD-Treatment-Final-2017.pdf
- **Total Knee and Total Hip Replacement Re-Review** (Adopted November 2017)
  - Available: www.breecollaborative.org/wp-content/uploads/TKRTHR-Bundle-Warranty-Final-2017.pdf
- **Hysterectomy** (Adopted January 2018)
  - Available: www.breecollaborative.org/wp-content/uploads/Hysterectomy-Final-Report-2018.pdf
- **Post-operative opioid prescribing** (Adopted July 2018)
  - Available: http://www.breecollaborative.org/wp-content/uploads/Supplemental-Bree-AMDG-Postop-pain-18-0718.pdf
- **LGBTQ Health Care** (adopted September 2018)
  - Available: http://www.breecollaborative.org/wp-content/uploads/LGBTQ-Health-Care-Report-and-Recommendations01.pdf
- **Suicide Care** (Adopted September 2018)
  - Available: http://www.breecollaborative.org/wp-content/uploads/Suicide-Care-Report-and-Recommendations-Final01.pdf

At the July meeting, Bree Collaborative members selected new topics for 2019 including:

- Continuing the opioid prescribing work with a focus on recommendations specific to patients on chronic opioid therapy,
- To address the 2018 budget proviso directing the Bree to develop recommendations for patients with homicidal or suicidal ideation, and for
- Creating a maternity care bundle,
- Shared decision making, and
- Palliative care.

Accountable Payment Models: Lumbar Fusion Re-Review

The workgroup has been meeting monthly since January 2018, and continues developing these recommendations.

> **Learn more about the workgroup and see all past meeting materials:**
> www.breecollaborative.org/topic-areas/apm/

Background

The Accountable Payment Models workgroup develops models to tie reimbursement for a surgery to an entire episode of care, including pre- and post-operative care, with no additional payment for complications due to the original surgery. Bundled payments offer a mechanism to improve and standardize care, and have been shown to reduce cost while improving patient health. This is a re-review of the Lumbar Fusion Bundle and Warranty developed and adopted by the Bree Collaborative in 2014.

While there is clinical agreement that lumbar fusion can be appropriate in cases of spinal instability from major trauma or congenital abnormalities, the surgery has the highest regional variation of any major surgery in the United States, with a 20-fold difference between geographic regions.[5] For some diagnoses, studies show that the surgery may not result in better health than non-surgical alternatives.[6] Lumbar fusion also has the highest inpatient cost for Washington state public employees enrolled in Uniform Medical Plan at an average cost of $80,000-$120,000. Additionally, lumbar fusion is associated with high rates of complications and high cost to patients. [7]

Our Work

The health care community in 2017 asked the Bree Collaborative to revise the lumbar fusion bundle. They asked for expanded inclusion criteria to increase clinical impact (e.g., moving from a limit of single-level fusion to allow for second surgeries, multi-level fusions, and complex fusions). They also sought greater flexibility in administering the bundle to improve access in rural areas.

Other changes to the criteria include greater flexibility for provider or hospital selection of patient-reported outcomes, better definitions of conservative therapy, clinical updates based on newly available evidence, and changes to the clinical pathway to facilitate more efficient care. The 2018 bundle also includes revisions to the quality standards and a warranty but retain the structure of the four cycle model of:

I. Disability despite non-surgical therapy
II. Fitness for surgery
III. Spinal fusion procedure
IV. Post-operative care and return to function

Collaborative Care for Chronic Pain

The workgroup has been meeting monthly since January 2018, and is making progress.

> **Learn more about the workgroup and see all past meeting materials:**
> www.breecollaborative.org/topic-areas/chronic-pain/

Background

About 11 percent of Americans experience chronic pain, defined as pain lasting three months or longer. Some surveys have estimated chronic pain to impact closer to 30 percent of our population.[8,9] Treating chronic pain is widely variable, with high financial and human cost. Research shows that moving to a collaborative or team-based approach to managing complex pain, based on models of care designed to manage chronic illness and depression, results in improved patient outcomes.[10,11] Additionally, researchers recommend multidisciplinary care (or using more than one approach) due to the complexity of pain.[12] However, most approaches to pain management, including chronic opioid therapy, involved siloed health care providers. There is also a lack of consensus around which elements of a systems-based model are critical and which resources are necessary to support the model.

Our Work

The workgroup aims to develop collaborative care standards and recommendations for prevention and treatment of chronic pain, including a stepped care approach to acute and chronic pain. The collaborative care model was developed in reaction to a siloed model of care centered around clinical or provider need rather than patient need.

The workgroup's goal is a collaborative model of care for chronic pain centered on the patient and built on patient self-management in the context of a biopsychosocial model. Goals are improved function, increased quality of life, and greater patient autonomy rather than pain relief. The workgroup strove to define areas within collaborative care unique to chronic pain while also developing a system to recognize and limit the transition from acute and subacute pain to chronic pain. Ideally, both acute and chronic pain will be managed and treated over time using a systems approach to allow patients to stay within primary care while being supported by collaborative care elements including:

- Patient identification and population management
- Care team
- Care management
- Evidence-based care
- Supported self-management

LGBTQ Health Care

The workgroup has been meeting monthly since January 2018, presented draft recommendations to Bree Collaborative members at the July 2018, and disseminated recommendations for public comment. Recommendations were adopted by the Bree Collaborative at the September 2018 meeting.

> **Learn more about the workgroup and see all past meeting materials:**
> www.breecollaborative.org/topic-areas/lgbtq-health-care/

Background

Approximately 3.5 percent of Americans identify as lesbian, gay, or bisexual and 0.3 percent of American adults are transgender.[13] People in these populations have distinct health care needs.[14] In particular, men who have sex with men and transgender people who have sex with men are at elevated risk for human immunodeficiency virus (HIV) and other sexually transmitted infections. Additionally, people who are lesbian, gay, bisexual, transgender, and questioning or queer (LGBTQ) experience elevated rates of depression, sexual abuse, smoking, and other substance use over those who do not identify as such.[15,16] Stigma and lack of provider training and competency serve as barriers to providing consistent, high-quality medical care.[17]

Our Work

The workgroup's recommendations seek to decrease health disparities and align care delivery with existing evidence-based, culturally sensitive standards of care for LGBTQ people in Washington State. The workgroup's recommendations also focus on whole-person care by recognizing that a person's many individual experiences (e.g., behavioral health, past trauma, race/ethnicity) should be considered without being identity- or diagnosis-limiting. Focus areas include:

- Communication, Language, and Inclusive Environments
  - Use of patient's chosen pronouns, name, gender identity and respectful terms
  - Support from electronic health record and health plan data.
  - Onsite access to gender-neutral restrooms.
  - Staff use of preferred pronouns on badges.
  - Use of diverse images.
  - Non-discrimination reflected in forms and protocols.
- Screening and Taking a Social and Sexual History
  - Screening for behavioral health concerns such as depression and anxiety, intimate partner violence, tobacco use.
  - Taking a sexual history with questions about sexual partners and types of sexual encounters.
- Areas Requiring LGBTQ-specific Standards and Systems of Care
  - Appropriate referrals and follow-up based on needs defined through screening and clinical evaluation (e.g., depression, other health concern).
  - Other areas including sexually transmitted infection (STI) screening, immunizations, HIV pre-exposure prophylaxis based on risk assessment, HIV treatment, etc.

Suicide Care

The workgroup has been meeting monthly since February 2018, presented draft recommendations to Bree Collaborative members at the July 2018 meeting, and disseminated recommendations for public comment. Recommendations were adopted by the Bree Collaborative at the September 2018 meeting.

> **Learn more about the workgroup and see all past meeting materials:**
> www.breecollaborative.org/topic-areas/suicide-prevention/

Background

Suicide rates are increasing due to complex factors, and rates within Washington State are higher than the national average.[18] Suicide is the second leading cause of death among those aged 15-34 and the fourth leading cause of death among those aged 35-44. This means approximately one person dies of suicide every 12 minutes.[19,20] Approximately 50 percent of American adults know someone who died of suicide, which increases the likelihood they will experience anxiety, depression, and post-traumatic stress.[21] Suicide rates are relatively higher among males, non-Hispanic whites, American Indians/Alaska Natives, the middle-aged, veterans, and those who live in rural areas.[3] Sexual minority youth (i.e., those who identify as lesbian, gay, bisexual, transgender, or queer) experience relatively higher rates of suicidal ideation and suicide attempts.[22] Suicide is a response to multiple factors, both internal (e.g., depression, substance abuse) and external (e.g., lack of social support, financial stress), indicating the need to intervene through the health care system.[23]

Our Work

The workgroup developed recommendations for in- and out-patient care settings including for care transitions, behavioral health providers and clinics, and specialty care (e.g., oncology) around the following focus areas:

- Identification of Suicide Risk
    - Screen all patients over 13 annually for behavioral health conditions (i.e., mental health, substance use), associated with increased suicide risk using a validated instrument(s), including for depression, suicidality (i.e., suicidal ideation, current plans, past attempts), alcohol misuse, anxiety, and drug use
- Assessment of Suicide Risk
    - Based on results from identification above, further identify risk of suicide with a validated instrument and identify additional risk factors including mental illness diagnosis , substance use disorder(s), stressful life event, and other relevant psychiatric symptoms or warning signs (at clinician's discretion)
- Suicide Risk Management
    - Ensure individuals at risk of suicide have pathway to timely and adequate care (e.g. follow-up contact same day or later as indicated by suicide risk assessment).
    - Keep patients in an acute suicidal crisis in an observed, safe environment.

    - Address lethal means restriction.
    - Engage patients in collaborative safety planning.
    - If possible, involve family members or other key support people in suicide risk management.
- Suicide Risk Treatment
    - Use effective evidence-based treatments provided onsite that directly target suicidal thoughts and behaviors rather than focusing on specific mental health diagnoses through integrated behavioral health or off-site with a supported referral.
    - Document patient information related to suicide care and referrals.
- Follow-up and Support After a Suicide Attempt
    - Provide contact and support during transition from inpatient to outpatient sites.
    - Ensure supported pathway to adequate and timely care, as outlined above (e.g., collaborative safety planning, onsite or referral to offsite behavioral health)
- Follow-up and Support After a Suicide Death
    - Follow-up and support for family members, friends, and for providers involved in care including screening for depression, suicidality, anxiety, alcohol misuse, and drug use.

Opioid Prescribing Guideline Implementation

This is an ongoing workgroup focused on implementing the Washington State Agency Medical Directors Guideline on Prescribing Opioids for Pain, endorsed by the Bree Collaborative in July 2015. The workgroup has met since December 2015.

Learn more about the workgroup and see past meeting materials:
www.breecollaborative.org/topic-areas/opioid/

Perioperative Opioid Prescribing

The Perioperative Opioid Prescribing guideline supplements the AMDG (Agency Medical Directors' Group) Interagency Guideline on Prescribing Opioids for Pain postoperative opioid recommendations, and the best practices from the AMDG/Bree Dental Guideline on Prescribing Opioids for Acute Pain Management. The included evidence represents a rapidly evolving literature on appropriate postoperative opioid prescribing. The recommendations in this supplement are based on the current best available clinical and scientific evidence from the literature and a consensus of expert opinion, and should be seen as an addition to, rather than a replacement of, the guidelines for opioid prescribing for postoperative pain in the 2015 guideline.

For all surgery types, we recommend the clinician prescribe non-opioid analgesics (e.g., nonsteroidal anti-inflammatory drugs (NSAIDs), acetaminophen, and non-pharmacologic therapies as first line therapy. Rationale for any exceptions should be well documented in the record. Even in these exceptions the initial prescription should not exceed two weeks. Bree classifications are constructed around evidence to date to serve as a guide for procedures with similar degrees of expected post-op pain and include:

- People younger than 24 years old
    - Dental extractions (e.g., third molar, wisdom tooth removal)
- Adults
    - Type I – Expected rapid recovery
        - Dental extractions or simple oral surgery (e.g., graft, implant)
        - Procedures such as hernia repair, laparoscopic appendectomy, inguinal hernia repair, carpal tunnel release, thyroidectomy, laparoscopic cholecystectomy, breast biopsy/lumpectomy, meniscectomy, lymph node biopsy, vaginal hysterectomy
    - Type II –Expected medium term recovery: Procedures such as ACL repair, rotator cuff repair, discectomy, laminectomy, open or laparoscopic colectomy, open incisional hernia repair, open small bowel resection or enterolysis, wide local excision, laparoscopic hysterectomy, simple mastectomy, cesarean section
    - Type III – Expected longer term recovery: Procedures such as lumbar fusion, knee replacement, hip replacement, abdominal hysterectomy, axillary lymph node resection, modified radical mastectomy, ileostomy/colostomy creation or closure, thoracotomy
- Patients on Chronic Opioid Analgesic Therapy

Implementation

HCA champions Bree Collaborative recommendations, which also are supported and spread by Bree Collaborative member organizations and many other community organizations.

In alignment with the Healthier Washington goal to move health care payment from volume to value and deliver more coordinated, whole person care, HCA includes Bree Collaborative recommendations in the two Public Employees Benefits Board (PEBB) Program Accountable Care Network options: Uniform Medical Plan (UMP) Plus—Puget Sound High Value Network, led by Virginia Mason Medical Center, and UMP Plus—University of Washington (UW) Medicine Accountable Care Network. Both networks have met the contractual obligation to submit quality improvement plans for obstetrics, total knee and total hip replacement, lumbar fusion, care coordination for high-risk patients, hospital readmissions, cardiology, low back pain, end-of-life care, and addiction and dependence treatment.

Continuing the emphasis on paying for value, HCA designated Virginia Mason Medical Center as the Center of Excellence for total joint replacement surgery using the Bree Collaborative's total knee and hip replacement bundled payment as a model. Since January 2017, enrollees in the PEBB Program's Uniform Medical Plan Classic or UMP Consumer-Directed Health Plan can select Virginia Mason for this procedure. Premera Blue Cross administers the bundle. As of January 2018, 97 surgeries have been completed with no reported complications, high member satisfaction, and an overwhelming majority of referrals meeting appropriateness criteria. In early 2018, the HCA released a request for proposals for a lumbar fusion bundled payment center of excellence aligned with the Bree Collaborative recommendations, and in July, 2018 selected two Centers of Excellence for lumbar fusion, Capital Medical Center and Virginia Mason Medical Center.

Collaborative implementation activities focus on education, consensus-building, outreach, and engagement including:

- Outreach to community groups (e.g., the Washington State Hospital Association (WSHA), the Washington State Medical Association (WSMA), the University of Washington, and the Washington Health Alliance).
- Participation in multiple Healthier Washington meetings and workgroups (e.g., Health Innovation Leadership Network, Healthier Here/King County Accountable Community of Health Opioid Medicaid Demonstration Project).
- Speaking at multiple conferences and stakeholder groups to educate about the Bree Collaborative and specific, relevant recommendations (e.g., Surgical Care and Outcomes Assessment Program annual meeting, the Washington State Public Health Association conference).
- Increasing Collaborative visibility through the website (www.breecollaborative.org), maintaining a blog with monthly or bi-monthly posts highlighting Collaborative topics or implementation strategies, and using social media to engage the community.

Community Partners

Many dedicated community organizations have also contributed to the implementation of Bree Collaborative recommendations:

- *Addiction Screening*: The two HCA Accountable Care Programs, the Puget Sound High Value Network, led by Virginia Mason Medical Center, and the UW Medicine Accountable Care Network, have started training on the Screening, Brief Intervention, and Referral to Treatment model and integrated a tool to screen for alcohol use into electronic medical records and workflow.
- *Behavioral Health Integration*: HCA used Bree Collaborative standards for integrating behavioral health into primary care to inform the development of required Accountable Communities of Health projects under the Medicaid Transformation Project.
- *Cardiology*: The Clinical Outcomes Assessment Program (COAP) continues to monitor insufficient information around percutaneous coronary intervention and was a keystone member in the development of a robust, community-based Bundle and Warranty for Elective Coronary Artery Bypass Graft Surgery.
- *End-of-Life Care*: WSHA and WSMA are still actively spreading advance care planning at the health system and community levels, aligned with the Bree Collaborative's 2014 recommendations. The two associations are working to promote patient-centered end-of-life conversations through Honoring Choices®: Pacific Northwest.
- *Spine Surgery:* Spine Surgical Care and Outcomes Assessment Program (SCOAP) has increased enrollment from 16 to 18 hospitals. As of August 2014, length of stay, radiologic verification of surgical level, and smoking use have been available on the website, with data expected to be updated again in fall 2018.
- *Obstetrics*: Both the Obstetrics Clinical Outcomes Assessment Program (OB-COAP) and WSHA's Safe Deliveries Roadmap have aligned existing program expectations and data collection with Bree Collaborative recommendations for member hospitals.
- *Oncology*: Collaborative staff have participated in the Hutchinson Center for Cancer Outcomes Research Value in Cancer Care Intervention workgroup since its formation in late 2015 and participate in the annual Value in Cancer Care Summit. The workgroup is focused on integrating goals of care conversations into oncology care and is aligned with both the Bree Collaborative's 2014 End-of-Life Care recommendations and with the 2015 Oncology Care Recommendations and focused on end-of-life care for cancer patients.
- *Opioid Prescribing*: All metrics are being used by the Washington State Department of Health to track opioid prescribing. Three metrics (new opioid patients transitioning to chronic opioids, patients prescribed high-dose chronic opioid therapy, new opioid patients' days' supply of first opioid prescription) have been adopted and will be included in the State Common Measure Set (i.e., a statewide set of measures that is part of Healthier Washington meant to increase health care accountability and performance) by the Performance Measures Coordinating Committee.

Summary of Work in the First Six Years

The Bree Collaborative workgroup members' engagement and dedication has yielded multiple high-quality and well-received sets of recommendations since its founding in 2011.

See Appendix D to see a list of workgroup members for each of these topics.

Recommendation topics to date include:

- Obstetric care
- Cardiology
- Spine surgery
- Low back pain management
- Potentially avoidable hospital readmissions
- End-of-life care
- Elective coronary artery bypass surgery
- Addiction and dependence screening
- Prostate cancer screening
- Oncology care
- Bariatric surgery
- Pediatric psychotropic use
- Behavioral health integration
- Bundled payment models for elective total knee and total hip replacement (re-reviewed in 2017)
- Elective lumbar fusion (re-reviewed in 2018 and included in the previous section)
- Alzheimer's disease and other dementias
- Opioid use disorder treatment
- Hysterectomy

Obstetric Care

Adopted August 2012 | Approved by HCA October 2012

- **Read the report here:** www.breecollaborative.org/wp-content/uploads/bree_ob_report_final_080212.pdf
- **Learn more about our workgroup here:** www.breecollaborative.org/topic-areas/obcare/
  - Workgroup met from December 2011 to July 2012
- **Our recommendations**
  - Elective deliveries. Eliminate all non-medically necessary deliveries before the 39th week (those deliveries for which there is no appropriate documentation of medical necessity).
  - Elective inductions of labor. Decrease elective inductions of labor between 39 and up to 41 weeks.
  - Primary Cesarean-sections (C-sections). Decrease unsupported variation among Washington hospitals in C-section rate of women who have never had a C-section.
- **Implementation**
  - HCA has implemented a non-payment policy for early elective deliveries in Apple Health.
  - The 2016 implementation survey found high rates of recommendation adoption among hospitals and medical groups:
    - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
      - Hospital average: 2.8 Range: 1.9-3.0
      - Medical Group average: 2.8 Range: 2.4-3.0
      - Health Plan average: 2.0 Range: 1.0-3.0
  - Of hospitals participating in the Obstetrics Clinical Outcomes Assessment Program, primary (first-time) cesarean section rate (term, singletons) has varied, from 15.6% in 2014, to 15.5% in 2016, to 16.8% in 2017 (for hospitals participating continuously from 2014-2017). The overall hospital primary cesarean rate was 17.7% in 2017 for hospitals participating in 2016-2017. The percent of spontaneously laboring women admitted at 4cm dilated or more has increased from 61.4% in 2014 to 68.9% in 2017.
  - The Safe Deliveries Roadmap program at the WSHA continues to track data for early elective deliveries prior to 39 weeks, primary term singleton vertex (PTSV) Cesarean section rates and non-medically indicated induction of labor with an unfavorable cervix. The early elective delivery rate for Washington hospitals for 2017 was 1.32% (81% reduction from 2011 baseline). While the PTSV Cesarean section rates through the first half of 2017 have risen slightly from the 2016 rate (13.8% to 14.0%), 14% is still lower than the Results Washington goal of 14.7% and the baseline 2010 rate of 16.1% (data provided by the Health Care Authority Delivery Statistics Report). The 2017 Washington state rate for near-field magnetic induction (NMI) with unfavorable cervix is 0.3%.
  - The Safe Deliveries Roadmap efforts have included partnering with multiple stakeholders to develop best practice bundles, robust monthly virtual education for

hospital staff, in-person Safe Table conferences, hospital site visits and quarterly data reports. Their focus is now to assist those hospitals who are still struggling with higher rates to identify possible challenges and opportunities.

Cardiology

Adopted January 2013 | Approved by HCA January 2014

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/bree_bc_cardiology_final.pdf
- **Learn more about the process:** www.breecollaborative.org/topic-areas/cardiology/
- **Four-step process**
    - **Step 1:** Appropriate use insufficient information report with 2012 data by hospital posted on the COAP members-only section of the COAP website. (*Completed August 2012)*
    - **Step 2**: COAP provides feedback and tools to hospitals to reduce insufficient information in data. (*Completed August to December 2012)*
    - **Step 3**: Updated Appropriate Use Insufficient Information report based on 4th Quarter 2012 data only, by hospital, given to Collaborative and hospitals to review. Hospitals had the option not to be identified. (*Completed May 2013)*
    - **Step 4**: After hospitals employed methods for improvement, an updated report based on 4th Quarter 2012 data only was posted on the public section of the COAP website. The Bree Collaborative also asked the Washington Health Alliance to post COAP data on its Community Checkup website, which compares data on health care services around the state. Hospitals had the option to not be identified. (*Completed June 2013)*

- **Implementation**
    - The 2016 implementation survey found hospitals reporting full adoption (3 out of a possible 3).
    - Non-acute percutaneous coronary intervention (PCI) appropriateness use measures statewide using COAP data for 2017 show 62% appropriate (from 41.1% in 2012), 28.6% may be appropriate (from 38.1% in 2012), 9.3% rarely appropriate (from 20.2% in 2012), and 26.5% unclassified (from 36.4% in 2012)
    - COAP continues to monitor rates of insufficient information and PCI appropriateness to assess the impact of public disclosure and has partnered with the Bree Collaborative in other areas as well.

Low Back Pain and Spine Surgery

Adopted November 2013 | Approved by HCA January 2014

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/spine_lbp.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/spine/
  - Workgroup met from November 2012 to October 2013.
- **Our recommendations**
  - Appropriate evaluation and management of patients with new onset and persistent acute low back pain and/or nonspecific low back pain not associated with major trauma (no red flags) in primary care
  - Early identification and management of patients that present with low back pain not associated with major trauma (no red flags) but have psychosocial factors (yellow flags) that place them at a high risk for developing chronic low back pain
  - Awareness of low back pain management among individual patients and the general public
- **Implementation**
  - The 2016 implementation survey found high rates of adoption of the recommendations among hospitals and low rates among medical groups and health plans.
    - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
      - Hospital average: 2.0 Range: 1.0-3.0
      - Medical Group average: 1.8 Range: 0.5-2.8
      - Health Plan average: 1.2 Range: 0.7-1.7
  - The Washington Health Alliance Community Checkup reports a 2017 statewide rate for avoiding X-ray, magnetic resonance imaging (MRI), and computed tomography (CT) for low-back pain of 81% for commercial insurance and 76% for Medicaid.[24]
- **Community Partner: Spine Surgical Care and Outcomes Assessment Program**
  - In March 2013, the Bree Collaborative submitted recommendations to HCA strongly recommending participation in Spine SCOAP as a community standard and requiring that information be transparent.
  - Implementation
    - As of spring 2018, Spine SCOAP has increased enrollment to 18 from 16 hospitals.
    - As of August 2014, length of stay, radiologic verification of surgical level, and smoking use have been transparently available on the Spine SCOAP website. Data will be updated again in late fall 2018.

Potentially Avoidable Hospital Readmissions

Adopted July 2014 | Approved by HCA in August 2014.

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Readmissions-Report-FINAL-14-0730.pdf
- **Read the 30-day, all-cause re-hospitalization rates at Washington State hospitals data here:** www.breecollaborative.org/wp-content/uploads/combined-chars-report-13-1114.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/par/
  - The workgroup met from April to June 2014.
- **Our recommendations:**
  - Forming Collaboratives: Hospital readmissions collaboratives to be recognized by a formal charter, meeting participation, and recognition by WSHA or Qualis Health.
  - Toolkit: Support for the tools and techniques to reduce readmissions in Washington State, especially the WSHA's *Care Transitions Toolkit, second edition*, the work done by Qualis Health, and the work done by the Washington Health Alliance.
  - Measurement: Two hospital-specific measures aligned with the Medical Quality Incentive Program measured by WSHA for specific conditions for (a) patient discharge information to primary care provider and (b) documented follow-up phone call.
- **Implementation:**
  - The 2016 implementation survey found medium rates of adoption of the recommendations among hospitals and high rates among medical groups and health plans.
    - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
      - Hospital average: 1.6 Range: 0.0-3.0
      - Medical Group average: 2.5 Rage: 1.8-3.0
      - Health Plan average: 2.7 Range: 2.0-3.0
  - Qualis Health reports that across Washington State, there has been a 5.4% decrease in 30-day rehospitalizations in Medicare Fee-for-Service claims comparing quarter two 2016 data to 2014 data.[25] This ranges from a 9.4% increase in Walla Walla county to a 16.6% decrease in Yakima county.
  - As part of work as the Medicare Quality Innovation Network-Quality Improvement Organization for Washington State, Qualis Health facilitates readmissions collaboratives in eight of the sixteen identified (by Qualis Health using Medicare FFS beneficiary health care service use patterns) Washington State communities. These eight were recruited as three separate cohorts, the first beginning in late 2014, the second in late 2015 and the third at the end of 2016. Each cohort continues to receive technical assistance with goals of improving transitions of care, reducing readmission and admission rates, and increasing community tenure for Medicare beneficiaries. This assistance is provided through support of community coalitions, as well as data driven direct work with individual providers.

End-of-Life Care

Adopted November 2014 | Approved by HCA in December 2014

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/EOL-Care-Final-Report.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/eol/
    - Workgroup met from January to November 2014.
- End-of-life care in the United States and within Washington State is strikingly variable and often misaligned with patient preference.[26,27] Although the majority of patients report wanting to spend the last part of their lives at home, in reality much of this time is spent in a hospital or nursing home.[28]
- **Our recommendations**
    - The workgroup's goal that all Washingtonians are informed about their end-of-life care options, communicate their preferences in actionable terms, and receive end-of-life care that is aligned with their and their family members' goals and values.
    - **Focus areas**
        - Increase awareness of advance care planning, advance directives, and Physician Orders for Life-Sustaining Treatment (POLST) in Washington State.
        - Increase the number of people who participate in advance care planning in clinical and community settings.
        - Increase the number of people who record their wishes and goals for end-of-life care using documents that accurately represent their values, are easily understandable by all readers (including family members, friends, and health care providers), and can be acted upon in the health care setting.
        - Increase the accessibility of completed advance directives and POLST for health systems and providers.
        - Increase the likelihood that a patient's end-of-life care choices are honored.
- **Implementation**
    - The 2016 implementation survey high rates of adoption of the recommendations among hospitals and medium rates among medical groups and health plans.
        - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
            - Hospital average: 2.2 Range: 1.7-2.6
            - Medical Group average: 1.7 Range: 0.0-2.5
            - Health Plan average: 1.8 Range: 1.0-3.0
    - Advance care planning conversations are now reimbursable by Medicaid in clinical settings. Private health plans including Premera, Regence, and others have been reimbursing for advance care planning conversations since January 2016.
    - Honoring Choices® Pacific Northwest (PNW), a joint initiative of WSHA and WSMA, has been working to ensure everyone will receive care that honors personal values and goals at the end of life. Since 2016, Honoring Choices PNW has partnered with 27 teams at 49 sites to provide advance care planning in individual and group settings. To date, over 2,300 First Steps® facilitated conversations have occurred,

with the health care agent or proxy there 60% of the time. 39% of people who have a facilitated conversation return a completed advance directive—a 62.5% increase over the state and national averages. To support this work, 85% of participating health care organizations have adapted their electronic medical records (EMRs) for better storage and retrieval of submitted advance directives. Earlier this year, Governor Inslee issued a proclamation recognizing April 16, 2018 as "Healthcare Decisions Day," increasing awareness about advance care planning and advance directives. In the coming year, Honoring Choices PNW will focus efforts on community partnerships, provider education, advocacy and a central repository for advance directives and POLST. For more information visit www.honoringchoicespnw.org.

- HCA has incorporated recommendations for advance care planning in primary and hospital care into the PEBB Program Accountable Care Network contracts.

Addiction and Dependence Treatment

Adopted January 2015 | Approved by HCA in February 2015

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/ADT-Final-Report.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/adt/
  - Workgroup met from April 2014 to January 2015.
- Alcohol and drug abuse disorders lead to many debilitating health, economic, interpersonal, and social consequences with potentially long-lasting effects if left untreated. In Washington State, alcohol use leads to 11.1% of deaths of working age adults, higher than the national average.[29] Medicaid clients with a substance use disorder had significantly higher physical health expenditures and hospital admissions.[30]
- **Our recommendations**
  - Recommendations focus on the integration of screening, brief intervention, and referral to treatment in primary, prenatal, and emergency room settings rather than specific treatment modalities or therapies through adoption of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model. SBIRT is an evidence-based paradigm seeking to encourage health care providers to systematically "identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs."[31] The strength of the SBIRT model is providing early motivational conversations with people prior to alcohol and other drug misuse overly impacting their lives.
  - **Focus areas**
    - Reduce stigma associated with alcohol and other drug screening, intervention, and treatment.
    - Increase appropriate alcohol and other drug use screening in primary care and emergency room settings.
    - Increase capacity to provide brief intervention and/or brief treatment for alcohol and other drug misuse.
    - Decrease barriers for facilitating referrals to appropriate treatment facilities
    - Address the opioid use disorder epidemic.
- **Implementation**
  - The 2016 implementation survey found the lowest overall rate of adoption.
    - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
      - Hospital average: 1.4 Range: 0.9-2.6
      - Medical Group average: 1.4 Range: 0.0-2.4
      - Health Plan average: 1.9 Range: 1.2-2.4
  - The two HCA Accountable Care Programs have started training on the SBIRT model and integrated a screening tool for alcohol use into electronic medical records and workflow.

Accountable Payment Models: Coronary Artery Bypass Graft Surgery

Adopted September 2015 | Approved by HCA in October 2015

- **Read the CABG Bundled Payment Model here:** www.breecollaborative.org/wp-content/uploads/CABG-Bundle-Final-15-09.pdf
- **Read the CABG Warranty here:** www.breecollaborative.org/wp-content/uploads/CABG-Warranty-Final-15-09.pdf
- **Read the evidence table here:** www.breecollaborative.org/wp-content/uploads/CABG-Evidence-Table-Final-15-09.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/apm/
    - Workgroup met from February to September 2015
- **Background**
    - Coronary artery disease occurs due to plaque build-up on arterial walls is the leading cause of death in the United States.[32] This is often treated with coronary artery bypass graft surgery (CABG). CABG surgery has high variation among providers and institutions in price, utilization, and complication rates.[33] Bundled payments offer a mechanism to improve and standardize this care and have been shown to reduce cost along with improving patient outcomes.[34]
- **Our recommendations**
    - The workgroup used the previous two models on elective total knee and total hip replacement and elective lumbar fusion as a model. The intent of the CABG surgical bundle is to provide a community-based, evidence-informed standard for the production, purchasing, and payment of health care based on quality. The workgroup proposed a four-stage model requiring:
        - Disability despite non-surgical therapy
        - Fitness for surgery
        - The CABG procedure
        - Post-operative care and return to function
- **Implementation**
    - The 2016 implementation survey found high rates of adoption of the recommendations among hospitals and low rates among health plans.
        - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
            - Hospital average: 2.2 Range: 2.0-2.8
            - Health Plan average: 0.4 Range: 0.0-1.0

Prostate Cancer Screening

Adopted November 2015 | Approved by HCA in January 2016

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Prostate-Cancer-Recommendations-Final-15-11.pdf
- **Learn more about the workgroup:** www.breecollaborative.org/topic-areas/prostate-cancer-screening/
    - Workgroup met from March to November 2015.
- Prostate cancer is the most common type of cancer diagnosed among men.[35] The prostate specific antigen (PSA) test is commonly used to screen men for prostate cancer. However, evidence conflicts as to whether the PSA test when used for prostate cancer screening has been associated with reduction in prostate cancer mortality.[36,37] The potential for overtreatment or treatment when no disease is present is high.[38]
- **Our recommendations:**
    - All men be evaluated by their provider for family history and factors that may elevate the risk of prostate cancer (e.g., sibling or parent with a prostate or breast cancer diagnosis, race).
    - To not do routine screening with PSA testing for average risk men 70 years and older, under 55 years old, who have significant co-morbid conditions, or with a life expectancy less than 10 years.
    - For primary care clinicians, two possible pathways, depending on the physician's interpretation of the evidence.
        - Clinicians who believe there is overall benefit from screening with PSA testing should order this test for average risk men between 55-69 years old only after a formal and documented shared decision-making process.
        - Clinicians who believe there is overall harm from screening with PSA testing may initiate testing of average-risk men aged 55-69 at the request of the patient after a formal and documented shared decision-making process.
    - Only men who express a definite preference for screening after discussing the advantages, disadvantages, and scientific uncertainty should have screening with PSA testing.
- **Implementation**
    - The 2016 implementation survey found high rates of adoption for hospitals, medium rates for medical groups, and low rates for health plans.
        - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
            - Hospital average: 2.3 Range: 2.0-3.0
            - Medical Group average: 1.6 Range: 0.0-2.8
            - Health Plan average: 0.7 Range: 0.0-3.0

Oncology Care

Adopted March 2016 | Approved by HCA in April 2016

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Oncology-Care-Final-Recommendations-2016-03.pdf
- **Learn more about the workgroup:** www.breecollaborative.org/topic-areas/oncology-care/
    - Workgroup met from May 2015 to March 2016.
- While cancer death rates have declined due in part of advances in prevention and treatment, cost of care has increased significantly, resulting in financial burden on patients and families. [39] Cost and quality can also vary, indicating the need for greater standardization and reduction in procedures that do not result in better patient health.[40,41] In 2012, the American Society of Clinical Oncology (ASCO) identified five tests or procedures "whose necessity is not supported by high-level evidence" and developed guidelines around therapeutic effectiveness and palliative care and use of advanced imaging for staging of low risk breast and prostate cancer.[42]
- **Our recommendations:**
    - For prostate cancer, as part of Choosing Wisely, ASCO recommends: Do not use PET [positron emission tomography], CT [computed tomography] and radionuclide bone scans in the staging of early prostate cancer at low risk of spreading.
    - For breast cancer, as part of Choosing Wisely, ASCO recommends: Do not use PET, CT, and radionuclide bone scans in the staging of early breast cancer that is at low risk of spreading.
    - In alignment with the End-of-Life Care Recommendations, oncology care should be aligned with a patient's individual goals and values. Patients should be appraised of harms, benefits, evidence, and potential impact of chemotherapy and radiation at all stages in their illness trajectory. We encourage clinicians and care teams to regularly ask patients, family members, and friends to discuss goals of care and work with the care team to tailor care to goals.
- **Implementation**
    - The 2016 implementation survey found high rates of adoption for hospitals and medical groups.
        - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
            - Hospital average: 2.1 Range: 1.8-2.7
            - Medical Group average: 2.2 Range: 0.0-3.0
            - Health Plan average: 1.4 Range: 0.0-3.0
    - The Hutchinson Center for Cancer Outcomes Research found rates for chemotherapy in the last 14 days of life, multiple emergency department visits in the last 30 days of life, and hospice care for three or more days prior to death to be 5.8%, 12.6%, 20.2%, and 62.5% statewide using insurance data, indicating greater need for palliative care.[43]

Accountable Payment Models: Bariatric Surgery

Adopted November 2016 | Approved by HCA in February 2017

- **Read the Bariatric Surgical Bundled Payment Model here:** www.breecollaborative.org/wp-content/uploads/Bree-Bariatric-Bundle-Final-2016.pdf
- **Read the Bariatric Surgical Warranty here:** www.breecollaborative.org/wp-content/uploads/Bariatric-Warranty-Final-2016.pdf
- **Read the evidence table here:** www.breecollaborative.org/wp-content/uploads/Bariatric-Evidence-Table-Final-2016.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/apm/
    - Workgroup met from February to November 2016
- **Background**
    - The National Institutes of Health (NIH) defines obesity as a body mass index of equal to or greater than 30 kg/m^2.[44] According to this NIH definition, more than one third of adults in the United States are obese. Obesity is associated with increased likelihood of type 2 diabetes, high blood pressure, hyperlipidemia, cardiovascular disease, obstructive sleep apnea, osteoarthritis, and gastroesophageal reflux (heartburn). The national annual cost of obesity and its consequences approaches $150 billion.[45]
    - While there is no reliable long-term cure, even modest reductions in weight loss can convey benefit by controlling associated conditions such as diabetes, high blood pressure, and high cholesterol.
- **Our recommendations**
    - The workgroup used the three previous models for elective total knee and total hip replacement, elective lumbar fusion, and coronary artery bypass surgery as models. The Bariatric Surgical Bundle provides a voluntary, community-based, evidence-informed standard for production, purchasing, and payment of health care based on quality.
    - The four proposed cycles include:
        - Eligibility due to obesity despite non-surgical therapy
        - Fitness for surgery
        - Bariatric surgery
        - Post-operative care and return to function

Pediatric Psychotropic Use

Adopted November 2016 | Approved by HCA in January 2017

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Antipsychotic-Recommendations-Final-2016.pdf
- **Learn more about the workgroup:** www.breecollaborative.org/topic-areas/psychotropics/
    - Workgroup met from January to November 2016.
- **Background**
    - Antipsychotic prescribing rates have dramatically and consistently increased for adolescents and young adults.[46] Nationally, between 2002 and 2007, there has been a 62% increase in atypical antipsychotic (or second-generation) use among children enrolled in Medicaid.[47] High numbers of prescriptions are problematic and potentially harmful, as evidence shows that atypical antipsychotic use is associated with patient harms including obesity, suicidality, tics, and other effects on the developing brain.[48] Additionally, long-term research on the effects of atypical antipsychotic use in youth is lacking.
    - The United States Food and Drug Administration (FDA) has approved antipsychotic medications for use in children and adolescents with schizophrenia, bipolar disorder (manic/mixed), and irritability with autistic disorder. In addition to the FDA-approved indications, antipsychotics have been found to be helpful in reducing disruptive behavior in children and adolescents *without* psychosis, allowing the child or adolescent to remain in school, in home, and receptive to other forms of therapy. These off-label uses of antipsychotic agents (i.e., for conditions not approved by the FDA) include aggressive, impulsive, and disruptive behaviors, often in patients with attention-deficit hyperactivity disorder (ADHD), in the absence of psychosis.[49]
- **Our recommendations**
    - Targeted at children and adolescents under age 21 without a diagnosis of an FDA-approved indication for an antipsychotic prescription.
    - **Focus Areas**
        - Conduct initial medical and psychological evaluation using appropriate assessment.
        - Ensure that the patient and family has access to comprehensive, family-centered psychosocial care whether within the primary care setting through integrated behavioral health care or through a supported referral.
        - Use evidence-based, best practice antipsychotic prescribing recommendations such as from the American Academy of Child and Adolescent Psychiatry.
        - If antipsychotics are prescribed, manage side effects including monitoring for changes in weight blood glucose (HgA1C), cholesterol, and other metabolic changes (baseline and at regular intervals).

Behavioral Health Integration

Adopted March 2017 | Approved by HCA in April 2017

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf
- **Learn more about the workgroup:** www.breecollaborative.org/topic-areas/behavioral-health/
    - Workgroup met from April 2016 to March 2017.
- **Background**
    - Approximately 16-23% of Americans experience a major depressive episode in their lifetimes, 7.6% in any two-week period.[50,51,52] Depression is especially common among those with a chronic illness, such as diabetes, resulting in lower adherence to clinical recommendations, worse physical functioning, and higher cost.[53]
    - There are many barriers to services, such as: far greater stigma attached to mental health and substance abuse diagnoses than for other conditions; a less developed infrastructure for measuring and improving care quality; lack of connectivity between clinicians, specialists, and organizations; lower use of health information technology; and barriers in the health insurance marketplace.[54]
- **Our recommendations**
    - Focused on integrating behavioral health care services into primary care for those with behavioral health concerns and diagnoses for whom accessing services through primary care would be appropriate.
    - The workgroup defined integrated behavioral health care to create a common vocabulary and focused on using available evidence and existing models to develop eight common elements that outline a minimum standard of integrated care meant to bridge the different models used throughout Washington State and across the country and include structural and process definitions for:
        - Integrated care team
        - Patient access to behavioral health as a routine part of care
        - Accessibility and sharing of patient information
        - Practice access to psychiatric services
        - Operational systems and workflows to support population-based care
        - Evidence-based treatments
        - Patient involvement in care
        - Data for quality improvement
- **Implementation**
    - Bree Collaborative standards for integrating behavioral health into primary care to inform the development of required Accountable Communities of Health projects under our Medicaid Transformation Project.

Accountable Payment Models: Total Knee and Total Hip Replacement Re-Review

Adopted November 2017 | Approved by HCA December 2017

- **Read the Bundle and Warranty here:** www.breecollaborative.org/wp-content/uploads/TKRTHR-Bundle-Warranty-Final-2017.pdf
- **Read the evidence table here:** www.breecollaborative.org/wp-content/uploads/20171031_VM-EvidenceTables_TKR-THR.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/apm/
    - Workgroup met from December 2016 to November 2017.
    - This workgroup was a re-review of bundle and warranty originally developed in 2012.
- **Background**
    - Published hospital readmission rates for total knee and total hip replacements October 2013 available here: www.breecollaborative.org/wp-content/uploads/bree_summary_CHARS_Analysis.pdf
    - The total knee and total hip replacement bundle and warranty were originally adopted in July 2013 and November 2013 and approved by the HCA Director in April 2014.
    - The topic was selected for re-review in July 2016 and the revised version was adopted in November 2017 and approved by the HCA Director in December 2017.
- **Our recommendations**
    - The workgroup's goal is to improve patient safety, performance for providers, and affordability for purchasers through a four-stage model requiring:
        - Documenting disability despite explicit non-surgical care
        - Meeting fitness requirements for patients prior to surgery
        - Adhering to standards for best-practice surgery
        - Implementing a structured plan to rapidly return patients to function
- **Implementation**
    - The 2016 implementation survey found high rates of adoption of the 2012 recommendations among hospitals and low rates among health plans.
        - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
            - Hospitals Average 2.3 Range: 1.7-3.0
            - Health Plans Average: 1.0 Range: 0.0-2.0
    - Virginia Mason Medical Center serves as a Center of Excellence for PEBB Program members enrolled in Uniform Medical Plan for total knee and hip replacement with a waived co-insurance and travel and lodging reimbursement starting January 2017. As of January 2018, 97 surgeries have been completed with no reported complications, high member satisfaction, and an overwhelming majority of referrals meeting appropriateness criteria.

Alzheimer's Disease and Other Dementias

Adopted November 2017 | Approved by HCA in December 2017

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Alzheimers-Dementia-Recommendations-Final-2017.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/alzheimers/
    - Workgroup met from January to November 2017.
- **Background**
    - The decline in memory and other cognitive functions and corresponding loss of independence because of dementia is a growing concern in our aging population. Age is the biggest risk factor for dementia with prevalence rates of 13.9% in those 71 and older increasing to 37.4% for those 90 and older.[55] The majority of cases are due to Alzheimer's disease.[1] Washington State has the third highest rate of death from Alzheimer's disease of any state and Alzheimer's is the third highest age-adjusted cause of death within the state overall.[56] The number of people diagnosed with dementia is expected to increase 40% in next 10 years and 181% over the next 30 years.[5] However, in many practices in Washington State, there are no guidelines to address quality of care for diagnosis or ongoing supportive care.[57]
- **Our recommendations**
    - The workgroup's goal is to align care delivery with the existing evidence-based standard of care for each stage of disease and across health care settings for both for patients and their families and caregivers and build off the previous work within Washington State, specifically the Washington State Plan to Address Alzheimer's Disease and Other Dementia.
    - The workgroup recommends early detection of mild cognitive impairment to better support patients and family members, but does not recommend population-level screening of older adults. The workgroup also recommends using a strengths-based approach that empowers both the patient and the caregiver.[58]
    - **Focus Areas**
        - Diagnosis.
        - Ongoing care and support or management.
        - Advance care planning and palliative care.
        - Need for increased support and/or higher levels of care.
        - Preparing for potential hospitalization.
        - Screening for delirium risk.

Opioid Use Disorder Treatment

Adopted November 2017 | Approved by HCA in December 2017

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/OUD-Treatment-Final-2017.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/oud-treatment/
    - Workgroup met from December 2016 to November 2017.
- **Background**
    - Drug overdose is the leading cause of accidental death in the United States, driven predominantly by opioid addiction.[59] Among those under 50 years of age, drug overdose is the leading cause of death. In 2016, the number of annual deaths increased 19% to exceed 59,000.[60] High schoolers who receive only one opioid prescription are 33% more likely than those who do not receive such a prescription to misuse opioids between the ages of 18-23 years.[61]
- **Our recommendations**
    - The workgroup's goal is a health care system that identifies people with opioid use disorder and facilitates access to comprehensive, evidence-based treatment with the patient at the center of care. This approach works to ensure that care is available when a patient is ready.
    - The workgroup endorses a "no wrong door" approach for patients wanting to access opioid use disorder treatment from a variety of settings. To support this, the workgroup developed recommendations to guide providers delivering care within a variety of settings. The goal for all settings is that patients receive the care they need at the time and in the setting of their choice, reduce illicit opioid use, and have no overdose events.
    - **Focus areas**
        - Access to Evidence-Based Treatment
            - Medication treatment: buprenorphine, methadone, naltrexone (e.g., increase geographic reach, increase number of providers).
            - Reduction in stigma associated with treatment.
        - Referral Information
            - Providers and patients know where to access care.
            - Accessible inventory of buprenorphine and methadone prescribers.
            - Referral infrastructure that supports patients and providers.
        - Integrated Behavioral and Physical Health to Support Whole-Person Care
            - Treatment of comorbid conditions including multiple substance use, mental illness, and physical health in line with Behavioral Health Integration Report and Recommendations.

Opioid Prescribing Guideline Implementation

This is an ongoing workgroup focused on implementing the Washington State Agency Medical Directors Guideline on Prescribing Opioids for Pain, endorsed by the Bree Collaborative in July 2015. The information below profiles the workgroup's products from December 2015 to October 2017. Two primary focus areas have been to develop opioid prescribing metrics and a guideline on prescribing opioids in dentistry.

Learn more about the workgroup here: www.breecollaborative.org/topic-areas/opioid/

Opioid Prescribing Metrics

Adopted August 2017 | Approved by HCA in August 2017

- **See the Opioid Prescribing Metrics here:** www.breecollaborative.org/wp-content/uploads/Bree-Opioid-Prescribing-Metrics-Final-2017.pdf
- The metrics were designed to be limited in number, have a strategic focus, and to be used for quality improvement. The first six metrics focus on guideline-concordant prescribing including chronic opioid use, opioid dose, concurrent chronic sedative use, and transition from short-term to long-term opioid use. The last three metrics focus on mortality, overdose morbidity, and prevalence of opioid use disorder.
- One of the primary goals of this metric set is to be short and actionable. The workgroup discussed other potential metrics that are of high interest but are not yet ready for specification and implementation and are out of the scope of a workgroup focused on prescribing practices. These and other metrics may be developed at a future date. Outreach to the Washington State health care community to adopt the metrics is ongoing.
- **Implementation**
    - All metrics are being used by the Washington State Department of Health with a dashboard by county to be available in summer 2018 for multiple stakeholders.
    - Three metrics (i.e., new opioid patients transitioning to chronic opioids, patients prescribed high-dose chronic opioid therapy, new opioid patients' days' supply of first opioid prescription) have been adopted and will be included in the State Common Measure Set by the Performance Measures Coordinating Committee.
    - HCA has implemented opioid prescribing policy consistent with Bree recommendations in Medicaid and Uniform Medical Plan.
    - The Oregon Health Authority has added the Bree Collaborative definition for percent of patients transitioning from acute to chronic opioid prescribing to their Opioid Data Dashboard: www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/data.aspx

Dental Guideline on Prescribing Opioids for Pain

Adopted September 2017 | Approved by HCA in October 2017

- **Read the guideline here:** www.breecollaborative.org/wp-content/uploads/Dental-Opioid-Recommendations-Final-2017.pdf
- The guideline was developed in collaboration with a broad advisory group of academic leaders, pain experts, and dentists in general care and specialty areas in response to the growing epidemic of opioid-related overdoses. The guideline supplements the Agency Medical Director's Group (AMDG) Interagency Guideline on Prescribing Opioids for Pain. Work will continue to encourage adoption of the recommendations.
- **Implementation**
    - The Department of Labor and Industries help conferences in Spokane and Seattle in April 2018 to educate the dental community about the guidelines.

Clinician Outreach

- **See the Guidelines on Prescribing Opioids for Acute Pain for Providers fact sheet:** wahealthalliance.org/wp-content/uploads/2017/01/Opioid-Prescribing-Guidelines-for-Providers.pdf
- **See Opioid Medication and Pain: What You Need to Know fact sheet for patients:** wahealthalliance.org/wp-content/uploads/2017/01/Opioid-Medication-Pain-Fact-Sheet-revised.pdf
- The Bree Collaborative partnered with the Washington Health Alliance to develop a call to action for health care systems and for health insurance plans to follow responsible opioid prescribing coupled with fact sheets for providers and for patients aligned with AMDG Opioid Prescribing Guidelines.
- These materials were made available online and through dissemination to health systems, hospitals, and plans in January 2017.
- **Implementation**
    - HCA shared joint Bree Collaborative/Washington Health Alliance communications about opioid prescriptions with providers and patients.
    - The State of Alaska Department of Health and Social Services has adopted the fact sheets for their community and are using the materials widely.
    - Seattle King County Department of Health has posted the fact sheets on their website and translated them into 21 languages here: www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/task-forces/heroin-opiates-task-force.aspx#documents

Hysterectomy

Adopted January 2018 | Approved by HCA in February 2018

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Hysterectomy-Final-Report-2018.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/hysterectomy/
    - Workgroup met from March 2017 to January 2018.
- **Background**
    - Hysterectomy is one of the most common surgical procedures in the United States, with approximately 600,000 performed annually.[62] Hysterectomy rates are highly variable by hospital and by region, indicating overuse.[63] Washington Health Alliance analysis reveals that rates are also highly variable based on location in Washington State.[64]
- **Our recommendations**
    - The workgroup's goal is to promote appropriate use of hysterectomy, including pre-surgical counseling and evaluation, while recognizing individual variation based on clinical opinion and patient preference. Workgroup members developed the recommendations to encourage clinicians to review guidelines with patients prior to hysterectomy to reduce unnecessary or inappropriate hysterectomies.
    - The recommendations are applicable for uterine leiomyoma (fibroids), abnormal menstrual bleeding, endometriosis, uterine prolapse, adenomyosis, and pain. For each of the inclusions, the workgroup has developed protocols for assessment, medical management, and uterine sparing procedures.
    - The recommendations exclude pregnancy, cancer and cancer prevention, emergencies (e.g., due to trauma, childbirth), gender reassignment surgery, and incidental hysterectomy with indicated oophorectomy.
    - **Focus Areas**
        - Assessment and medical management, by indication
        - Uterine sparing procedures, by indication
        - Surgical procedure including follow-up care, emphasizing the enhanced recovery after surgery protocol and use of a minimally invasive approach. The Enhanced Recovery After Surgery (ERAS) protocol fits well with gynecological surgery and has been associated with reduced opioid use, length of stay, and cost; stable readmission; incidence of side effects; and improved patient satisfaction.[65,66]

Implementation Survey

In 2016 Bree Collaborative staff developed a comprehensive survey to assess implementation of recommendations across care settings and health plans. The survey included 13 topics that had been approved at least six months prior to the time the survey was conducted.

See the survey tools: www.breecollaborative.org/implementation/

Staff asked key leaders from Washington hospitals, medical groups, and health plans to complete the survey, which included specific recommendations for each topic. Participation was voluntary, and responses were self-reported. A numeric scale was used to rate implementation of specific recommendations including: 0-No action taken; 1-Actively considering adoption; 2-Some/similar adoption; and 3-Full adoption.

The survey found varying degrees of adoption. Recommendations for obstetrics care, cardiology, and the Spine SCOAP program were most fully implemented. All these recommendations work with or within existing, established programs. Among hospitals and medical groups, screening and treatment for alcohol and substance use disorder showed the lowest level of adoption. Among health plans, the surgical bundles were least adopted. Within the topic-specific recommendations, the survey found trends including low adoption of patient screening and assessment tools and patient decision aides. Specific implementation scores are shown in Table 1.

Table 1: Implementation scores by topic

Topic	Hospitals	Medical Groups	Health Plans
Addiction and Dependence Treatment	1.4 (0.9-2.6)	1.4 (0.0-2.4)	1.9 (1.2-2.4)
Lumbar Fusion Surgical Bundle	1.9 (0.3-2.9)	-	0.7 (0.0-2.0)
Low-Back Pain	2.0 (1.0-3.0)	1.8 (0.5-2.8)	1.2 (0.7-1.7)
Prostate Cancer Screening	2.3 (2.0-3.0)	1.6 (0.0-2.8)	0.7 (0.0-3.0)
End-Of-Life Care	2.2 (1.7-2.6)	1.7 (0.0-2.5)	1.8 (1.0-3.0)
Avoidable Hospital Readmissions	1.6 (0.0-3.0)	2.5 (1.8-3.0)	2.7 (2.0-3.0)
Prescribing Opioids for Pain	2.5 (2.1-2.5)	1.8 (0.0-2.7)	1.7 (1.0-2.0)
Oncology Care	2.1 (1.8-2.7)	2.2 (0.0-3.0)	1.4 (0.0-3.0)
Coronary Artery Bypass Graft Surgical Bundle	2.2 (2.0-2.8)	-	0.4 (0.0-1.0)
Knee and Hip Replacement Surgical Bundle	2.3 (1.7-3.0)	-	1.0 (0.0-2.0)
Obstetric Care	2.8 (1.9-3.0)	2.8 (2.4-3.0)	2.0 (1.0-3.0)
Spine Surgical Care and Outcomes Measurement Program (SCOAP)	2.8 (2.0-3.0)	-	-
Cardiology	3.0 (3.0-3.0)	-	-

Implementation Roadmap

The implementation roadmap outlines steps that provider organizations and health plans can take to implement Bree Collaborative recommendations, and strategies to overcome implementation barriers.

See the Implementation Roadmap here: www.breecollaborative.org/wp-content/uploads/Bree-Implementation-Roadmap-Final-17-04.pdf

Table 2: Top enablers and barriers affecting recommendation implementation

	Top Enablers	Top Barriers
Providers	Existing organizational improvement program for minimizing errors and waste	Lack of availability and credibility of data, and the burden of collecting it
	Business case- evidence of economic reward	Business case- no economic reward, and lack of contract partners interested in value-based purchasing
	Consensus on what constitutes quality of care	Lack of consensus on what constitutes quality of care
	Individual provider-level performance feedback	
Health Plans	Sufficient market share/volume	Insufficient market share/volume
	Contract partners interest in value-based purchasing	Burden/ease of collecting or obtaining data
	Consistency in findings across multiple measures	Business case- evidence of economic reward

Looking Forward to Year Eight

The Bree Collaborative will continue to be a key part of building a Healthier Washington. Bree Collaborative recommendations have had a direct impact on HCA's purchasing strategies, influencing our Accountable Care Networks contract, the Center of Excellence for total knee and total hip replacement bundled payment model, and an upcoming lumbar fusion bundled payment model.

Bree Collaborative staff looks forward to receiving feedback about recommendations from the Accountable Care Networks, Centers of Excellence, and others and revising as necessary. Staff will continue to work with additional interested stakeholders to further adoption of the recommendations.

The LGBTQ and Suicide Care workgroups will meet in September to discuss public comments and make changes to the documents based on the comments. These workgroups will present recommendations to the Bree Collaborative for final adoption in November 2018.

The Bree Collaborative will continue to convene the Agency Medical Director's Group Opioid Prescribing Guidelines workgroup and will also form workgroups in early 2019 to address the 2018 budget proviso directing the Bree to develop recommendations for patients with homicidal or suicidal ideation, and for maternity care, shared decision making, and palliative care.

References

[1] Squires D, Anderson C. U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries, The Commonwealth Fund, October 2015. Available: www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective

[2] Institute of Medicine. 2012. Best care at lower cost: The path to continuously learning health care in America. Washington, DC: The National Academies Press.

[3] Berwick DM, Hackbarth AD. Eliminating Waste in US Health Care. *JAMA*. 2012 Apr 11;307(14):1513-6.

[4] Washington Health Alliance. First, Do No Harm Calculating Health Care Waste in Washington State. February 2018. Available: www.wacommunitycheckup.org/media/47156/2018-first-do-no-harm.pdf

[5] Weinstein JN, Lurie JD, Olson PR, Bronner KK, Fisher ES. United States' trends and regional variations in lumbar spine surgery: 1992-2003. Spine *(Phila Pa 1976).* 2006 Nov 1;31(23):2707-14.

[6] Brox JI, Sørensen R, Friis A, Nygaard Ø, Indahl A, Keller A, Ingebrigtsen T, Eriksen HR, Holm I, Koller AK, Riise R, Reikerås O. Randomized clinical trial of lumbar instrumented fusion and cognitive intervention and exercises in patients with chronic low back pain and disc degeneration. Spine (Phila Pa 1976). 2003 Sep;28(17):1913-21.

[7] Centers for Medicare and Medicaid Services. Medicare provider utilization and payment data. Viewed on: 22 April 2014 (page last modified 04/11/2014 10:57am). www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier.html

[8] National Center for Complementary and Integrative Health. Pain in the U.S., August, 2015. Available: https://nccih.nih.gov/news/press/08112015.

[9] Johannes CB, Le TK, Zhou X, Johnston JA, Dworkin RH. The prevalence of chronic pain in United States adults: results of an Internet-based survey. J Pain. 2010 Nov;11(11):1230-9. doi: 10.1016/j.jpain.2010.07.002.

[10] Katon WJ, Lin EH, Von Korff M, Ciechanowski P, Ludman EJ, Young B, Peterson D, Rutter CM, McGregor M, McCulloch D. Collaborative care for patients with depression and chronic illnesses. N Engl J Med. 2010;363:2611-20.

[11] Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness: the chronic care model, Part 2. JAMA. 2002;288:1909-14

[12] Peterson K, Anderson J, Bourne D, Mackey K, Helfand M. Evidence Brief: Effectiveness of Models Used to Deliver Multimodal Care for Chronic Musculoskeletal Pain. VA Evidence-based Synthesis Program Evidence Briefs [Internet]. Washington (DC): Department of Veterans Affairs (US); 2011- 2017 Jan.

[13] Gates G. How many people are lesbian, gay, bisexual, and transgender? The Williams Institute University of California, Los Angeles. April 2011. Available: http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf

[14] Purcell DW, Johnson CH, Lansky A, et al. Estimating the population size of men who have sex with men in the United States to obtain HIV and syphilis rates. The open AIDS journal 2012; 6:98-107.

[15] Russell ST, Fish JN. Mental Health in Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth. Annu Rev Clin Psychol. 2016 Mar 28; 12: 465–487.

[16] Mayer KH, Bradford JB, Makadon HJ, Stall R, Goldhammer H, Landers S. Sexual and Gender Minority Health: What We Know and What Needs to Be Done. American Journal of Public Health. 2008;98(6):989-995.

[17] Whitehead J, Shaver J, Stephenson R. Outness, Stigma, and Primary Health Care Utilization among Rural LGBT Populations. Newman PA, ed. PLoS ONE. 2016;11(1):e0146139.

[18] American Association of Suicidology. USA Suicide 2016; Final Data File. Accesed: February 2018. Available: www.suicidology.org/Portals/14/docs/Resources/FactSheets/2016/2016datapgsv1b.pdf?ver=2018-01-15-211057-387

[19] Kochanek KD, Murphy SL, Xu J, Arias E. Mortality in the United States, 2016. NCHS Data Brief No. 293. December 2017. Available: www.cdc.gov/nchs/data/databriefs/db293.pdf

[20] Murphy SL, Xu J, Kochanek KD, Curtin SC, Arias E. Deaths: Final Data for 2015. Centers for Disease Control and Prevention. National Vital Statistics Reports. Volume 65, Number 4. June 30, 2016. Available: www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_06.pdf.

[21] Cerel J, Maple M, van de Venne J, Moore M, Flaherty C, Brown M. Exposure to Suicide in the Community: Prevalence and Correlates in One U.S. State. Public Health Reports. 2016;131(1):100-107.

[22] Stone DM, Luo F, Ouyang L, Lippy C, Hertz MF, Crosby AE. Sexual orientation and suicide ideation, plans, attempts, and medically serious attempts: evidence from local Youth Risk Behavior Surveys, 2001-2009. Am J Public Health. 2014;104(2):262-271.

[23] Stone D, Holland K, Bartholow B, Crosby A, Davis S, Wilkins N. Preventing Suicide: A Technical Package of Policy, Programs, and Practices. 2017. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Available: www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf.

[24] Community Checkup. Washington Health Alliance. Available: https://www.wacommunitycheckup.org/compare-scores/compare-results/

[25] Qualis Health. 30-Day Rehospitalizations. Accessed: June 2018. Available: http://medicare.qualishealth.org/sites/default/files/medicare.qualishealth.org/CommunityRange.pdf

[26] Barnato AE, Herndon MB, Anthony DL, Gallagher PM, Skinner JS, Bynum JP, Fisher ES. Are regional variations in end of life care intensity explained by patient preferences?: A Study of the US Medicare Population. *Med Care.* 2007 May;45(5):386-93.

[27] Goodman DC, Esty AR, Fisher ES, Chang CH. Trends and Variation in End of life Care for Medicare Beneficiaries with Severe Chronic Illness. The Dartmouth Atlas Project. April 12, 2011. Available: www.dartmouthatlas.org/downloads/reports/EOL_Trend_Report_0411.pdf

[28] Raphael C, Ahrens J, Fowler N. Financing end of life care in the USA. *J R Soc Med.* 2001 September; 94(9): 458–461.

[29] Stahre M, Roeber J, Kanny D, Brewer RD, Zhang X. Contribution of Excessive Alcohol Consumption to Deaths and Years of Potential Life Lost in the United States. Prev Chronic Dis 2014;11:130293.

[30] Clark RE, Samnaliev M, McGovern MP. Impact of substance disorders on medical expenditures for Medicaid beneficiaries with behavioral health disorders. *Psychiatr Serv*. 2009 Jan;60(1):35-42.

[31] SBIRT: Screening, Brief Intervention, and Referral to Treatment. Substance Abuse and Mental Health Services Administration. Department of Health and Human Services. Available: www.integration.samhsa.gov/clinicalpractice/SBIRT. Accessed: November 2014.

[32] Centers for Disease Control and Prevention. Prevalence of Coronary Heart Disease. October 14, 2011. Available: www.cdc.gov/mmwr/preview/mmwrhtml/mm6040a1.htm

[33] 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.

[34] 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

[35] Siegel R, Ma J, Zou Z, Jemal A. Cancer statistics, 2014. CA Cancer J Clin. 2014;64:9-29.

[36] Schröder FH, Hugosson J, Roobol MJ, Tammela TL, Zappa M, Nelen V, et al. Screening and prostate cancer mortality: results of the European Randomised Study of Screening for Prostate Cancer (ERSPC) at 13 years of follow-up. Lancet. 2014 Dec 6;384 (9959):2027-35.

[37] Andriole GL, Crawford ED, Grubb RL 3rd, Buys SS, Chia D, Church TR, et al. Prostate cancer screening in the randomized Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial: mortality results after 13 years of follow-up. J Natl Cancer Inst. 2012 Jan 18;104(2):125-32.

[38] Gulati R, Inoue LY, Gore JL, Katcher J, Etzioni R. Individualized estimates of overdiagnosis in screen-detected prostate cancer. J Natl Cancer Inst. 2014 Feb;106(2):djt367

[39] Kohler BA, Sherman RL, Howlader N, Jemal A, Ryerson AB, Henry KA, Boscoe FP, Cronin KA, Lake A, Noone AM, Henley SJ, Eheman CR, Anderson RN, Penberthy L. Annual Report to the Nation on the Status of Cancer, 1975-2011, Featuring Incidence of Breast Cancer Subtypes by Race/Ethnicity, Poverty, and State. J Natl Cancer Inst. 2015 Mar 30;107(6):djv048.

[40] Kolodziej M, Hoverman JR, Garey JS, Espirito J, Sheth S, Ginsburg A, et al. Benchmarks for Value in Cancer Care: An Analysis of a Large Commercial Population. *JOP*. 2011 Sep;7(5):301-306.

[41] Schroeck FR, Kaufman SR, Jacobs BL, Skolarus TA, Hollingsworth JM, Shahinian VB, Hollenbeck BK. Regional variation in quality of prostate cancer care. *J Urol*. 2014 Apr;191(4):957-62.

[42] Schnipper LE1, Smith TJ, Raghavan D, Blayney DW, Ganz PA, Mulvey TM, Wollins DS. American Society of Clinical Oncology identifies five key opportunities to improve care and reduce costs: the top five list for oncology. J Clin Oncol. 2012 May 10;30(14):1715-24.

[43] Hutchinson Institute for Cancer Outcomes Research. Community Cancer Care in Washington State: Quality and Cost Report 2018. 2018 Fred Hutchinson Cancer Research Center, Seattle, WA. Available: https://www.fredhutch.org/content/dam/public/labs-projects/hicor/CCCReport/HICOR%20Community%20Cancer%20Care%20Report%20May%202018.pdf

[44] Jensen MD, Ryan DH, Apovian CM, Ard JD, Comuzzie AG, Donato KA, et al. 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society. Circulation. 2014 Jun 24;129(25 Suppl 2):S102-38.

[45] Finkelstein EA, Trogdon JG, Cohen JW, Dietz W. Annual Medical Spending Attributable To Obesity: Payer-And Service-Specific Estimates. Health Aff (Millwood). 2009 Sep-Oct;28(5):w822-31.

[46] Birnbaum ML, Saito E, Gerhard T, Winterstein A, Olfson M, Kane JM, Correll CU. Pharmacoepidemiology of antipsychotic use in youth with ADHD: trends and clinical implications. Curr Psychiatry Rep. 2013 Aug;15(8):382.

[47] Matone M, Localio R, Huang YS, dosReis S, Feudtner C, Rubin D. The relationship between mental health diagnosis and treatment with second-generation antipsychotics over time: a national study of U.S. Medicaid-

enrolled children. Health Serv Res. 2012 Oct;47(5):1836-60.

[48] Seida JC, Schouten JR, Mousavi SS, Hamm M, Beaith A, Vandermeer B, et al. First- and Second Generation Antipsychotics for Children and Young Adults. Rockville (MD): Agency for Healthcare Research and Quality (US); 2012 Feb. Report No.: 11(12)-EHC077-EF.

[49] Olfson M, King M, Schoenbaum M. Treatment of Young People With Antipsychotic Medications in the United States. JAMA Psychiatry. 2015 Sep;72(9):867-74.

[50] National Institutes of Mental Health. Major Depression Among Adults. [Online] August 2015. www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adults.shtml.

[51] Kessler RC, Berglund P, Demler O, Jin R, Koretz D, Merikangas KR, Rush AJ, Walters EE, Wang PS and Replication, National Comorbidity Survey. The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). JAMA. 289, 2003 Jun 18, Vol. (23), pp. 3095-105.

[52] National Center for Health Statistics. FastStats Homepage Depression. Centers for Disease Control and Prevention. [Online] April 2016. http://www.cdc.gov/nchs/fastats/depression.htm

[53] Ciechanowski PS, Katon WJ, Russo JE. Depression and diabetes: impact of depressive symptoms on adherence, function, and costs. Arch Intern Med. 160, 2000 Nov 27, Vol. (21), pp. 3278-85.

[54] Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive. *Improving the Quality of Health Care for Mental and Substance-Use Conditions.* Washington DC : National Academies Press, 2006.

[55] Plassman BL1, Langa KM, Fisher GG, Heeringa SG, Weir DR, Ofstedal MB, et al. Prevalence of dementia in the United States: the aging, demographics, and memory study. Neuroepidemiology. 2007;29(1-2):125-32. Epub 2007 Oct 29.

[56] Alzheimer's Association. Alzheimer's Statistics Washington. Available: www.alz.org/documents_custom/facts_2016/statesheet_washington.pdf

[57] Washington State Department of Social and Health Services. Washington State Plan to Address Alzheimer's Disease and Other Dementias. January 1, 2016. Available: www.dshs.wa.gov/sites/default/files/SESA/legislative/documents/2016%20WA%20Alzheimer%27s%20State%20Plan%20-%20Full%20Report%20Final.pdf

[58] Crum AJ, Leibowitz KA, Verghese A. Making mindset matter. BMJ. 2017 Feb 15;356:j674.

[59] American Society of Addiction Medicine. Opioid Addiction 2016 Facts and Figures. Available: http://www.asam.org/docs/default-source/advocacy/opioid-addiction-disease-facts-figures.pdf

[60] Katz, J. Drug Deaths in America Are Rising Faster Than Ever. The New York Times. June 5, 2017. Available: www.nytimes.com/interactive/2017/06/05/upshot/opioid-epidemic-drug-overdose-deaths-are-rising-faster-than-ever.html?rref=collection%2Fsectioncollection%2Fupshot&action=click&contentCollection=upshot&region=rank&module=package&version=highlights&contentPlacement=4&pgtype=sectionfront&_r=0

[61]Miech R, Johnston L, O'Malley PM, et al. Prescription opioids in adolescence and future opioid misuse. Pediatrics. 2015; 136(5):e1169-77. doi: 10.1542/peds.2015-1364

[62] Wu JM1, Wechter ME, Geller EJ, Nguyen TV, Visco AG. Hysterectomy rates in the United States, 2003. Obstet Gynecol. 2007 Nov;110(5):1091-5.

[63] Wennberg J, Gittelsohn. Small area variations in health care delivery. Science. 1973 Dec 14;182(4117):1102-8.

[64] Washington Health Alliance. Different Regions, Different Health Care: Where you Live Matters. January 2015. Available: http://wahealthalliance.org/wp-content/uploads.php?link-year=2015&link-month=01&link=Different-Regions-Different-Care.pdf. Accessed: August 2015.

[65] Nelson G, Altman AD, Nick A, Meyer LA, Ramirez PT, Achtari C, Antrobus J, Huang J, et al. Guidelines for pre- and intra-operative care in gynecologic/oncology surgery: Enhanced Recovery After Surgery (ERAS®) Society recommendations--Part I. Gynecol Oncol. 2016 Feb;140(2):313-22.

[66] Kalogera E, Bakkum-Gamez JN, Jankowski CJ, Trabuco E, Lovey JK, Dhanorker S, et al. Enhanced Recovery in Gynecologic Surgery. Obstet Gynecol. 2013 August ; 122(2 0 1): 319–328.

Appendix A: Bree Collaborative Background

The Bree Collaborative has had great success working with many Washington State organizations to solicit nominations of experienced and engaged community leaders as Bree Collaborative members. In August 2011, the WSHA, the Washington State Medical Association (WSMA), the Association of Washington Healthcare Plans (AWHP), large employers, and other community stakeholders nominated health care experts who served as the Bree Collaborative's first 23 members after appointment by former Governor Chris Gregoire.

Steve Hill served as the Bree Collaborative's first Chair. Mr. Hill is the former director of the Washington State Department of Retirement Systems and former director of the HCA. In November 2014 Mr. Hill announced his retirement as Chair of the Bree Collaborative, and in March 2015 Governor Jay Inslee appointed Dr. Hugh Straley as chair. Dr. Straley is board certified in both internal medicine and medical oncology and served in many leadership roles at Group Health Cooperative. He retired as medical director and president of Group Health Physicians in 2008 and served as chief medical officer for Soundpath Health and as interim medical director and consultant to Amerigroup Washington.

A steering committee advises the Chair. The committee is comprised of Bree Collaborative members representing a health care purchaser, health plan, health care system, and quality improvement organization. See **Appendix C** for a current list of steering committee members.

The Bree Collaborative has been housed in the Foundation for Health Care Quality since its inception. The Foundation provides project management and is responsible for employing staff. Funding from the HCA has been secured through June 2020 as part of the state's budget process through a four-year grant.

The Bree Collaborative has held thirty six meetings since 2011. Meetings are held on a bi-monthly basis with future meetings scheduled for November 14, 2018, and into 2019 on January 23, March 20, May 15, July 24, September 18, and November 20. Agendas and materials for all Collaborative meetings are posted in advance on the Bree Collaborative website: www.breecollaborative.org. All Collaborative meetings are open to the public and follow the Open Public Meetings Act.

At the November 2012 meeting, the Bree Collaborative adopted bylaws to set policies and procedures governing the Bree Collaborative beyond the mandates established by the legislation (ESHB 1311). Bylaws were revised at the September 2014 meeting.

> **Current bylaws are available here:** www.breecollaborative.org/wp-content/uploads/bylaws-final.pdf

After the Bree Collaborative identifies a focus area, it must identify and analyze evidence-based best practices to improve quality and reduce variation in practice patterns. The Bree Collaborative must also identify sources and methods for data collection and reporting to establish baseline utilization rates and measure the impact of strategies reviewed by the Collaborative. To the extent possible, the Bree Collaborative must minimize the cost and administrative burden of reporting and use existing data resources.

The Bree Collaborative must also identify strategies to increase the use of evidence-based practices. Strategies may include:

- Goals for appropriate utilization rates
- Peer-to-peer consultation
- Provider feedback reports
- Use of patient decision aids
- Incentives for the appropriate use of health services
- Centers of Excellence or other provider qualification standards
- Quality improvement systems
- Service utilization or outcome reporting

The Governor must appoint the chair of the Collaborative, and the HCA must convene the Collaborative. The Bree Collaborative must add members or establish clinical committees as needed to acquire clinical expertise in particular health care service areas under review. Each clinical committee shall include at least two members of the specialty or subspecialty society most experienced with the health service identified for review.

ESHB 1311, Section 3 calls for the Bree Collaborative to *"report to the administrator of the authority regarding the health services areas it has chosen and strategies proposed. The administrator shall review the strategies recommended in the report, giving strong consideration to the direction provided in section 1, chapter 313, Laws of 2011 and this section. The administrator's review shall describe the outcomes of the review and any decisions related to adoption of the recommended strategies by state purchased health care programs. Following the administrator's review, the Bree Collaborative shall report to the legislature and the governor regarding chosen health services, proposed strategies, the results of the administrator's review, and available information related to the impact of strategies adopted in the previous three years on the cost and quality of care provided in Washington State."*

Appendix B: Bree Collaborative Members

Member	Title	Organization
1. Susie Dade, MS	Deputy Director	Washington Health Alliance
2. Peter Dunbar, MB, ChB, MBA	CEO	Foundation for Health Care Quality
3. John Espinola, MD, MPH	Executive Vice President, Health Care Services	Premera Blue Cross
4. Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
5. Stuart Freed, MD	Chief Medical Officer	Confluence Health
6. Richard Goss, MD	Medical Director	Harborview Medical Center, University of Washington
7. Jennifer Graves, RN, MS	Senior Vice President, Patient Safety	Washington State Hospital Association
8. Christopher Kodama, MD	President, MultiCare Connected Care	MultiCare Health System
9. Daniel Lessler, MD, MHA	Chief Medical Officer	Washington State Health Care Authority
10. Wm. Richard Ludwig, MD	Chief Medical Officer, Accountable Care Organization	Providence Health and Services
11. Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
12. Robert Mecklenburg, MD	Medical Dir., Center for Health Care Solutions	Virginia Mason Medical Center
13. Kimberly Moore, MD	Associate Chief Medical Officer	Franciscan Health System
14. Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
15. Mary Kay O'Neill, MD, MBA	Partner	Mercer

Member	Title	Organization
16. John Robinson, MD, SM	Chief Medical Officer	First Choice Health
17. Terry Rogers, MD (Vice Chair)	Chief Executive Officer	Foundation for Health Care Quality
18. Jeanne Rupert, DO, PhD	Medical Dir., Community Health Services	Public Health, Seattle and King County
19. Kerry Schaefer, MS	Strategic Planner for Employee Health	King County
20. Lani Spencer, RN, MHA	Vice President, Health Care Management Services	Amerigroup
21. Hugh Straley, MD (Chair)	Retired	Medical Dir. , Group Health Coop.; President, Group Health Physicians
22. Shawn West, MD	Family Physician	

Appendix C: Steering Committee Members

Member	Title	Organization
1. Stuart Freed MD	Chief Medical Officer	Confluence Health
2. Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
3. Jason McGill JD	Health Policy Advisor	Governor's Office
4. Robert Mecklenburg MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
5. Mary Kay O'Neill MD, MBA	Partner	Mercer
6. Terry Rogers MD	Retired	
7. Lani Spencer, RN, MHA	Vice President, Health Care Management Services	Amerigroup

Appendix D: Workgroup Members

Accountable Payment Models: Lumbar Fusion Re-Review

Member	Title	Organization
1. Lydia Bartholomew, MD	Senior Medical Director, Pacific Northwest	Aetna
2. Jonathan Carlson, MD, PhD	Neurosurgeon	Inland Neurosurgery & Spine Associates
3. Arman Dagal, MD	Medical Director	Spine SCOAP
4. Farrokh Farrokhi, MD	Neurosurgeon	Virginia Mason Medical Center
5. Gary Franklin MD, MPH	Medical Director	Washington State Department of Labor and Industries
6. Mark Freeborn, MD	Neurosurgeon	
7. Andrew Friedman, MD	Physical Medicine and Rehabilitation	Virginia Mason Medical Center
8. Michael Hatzakis, MD	Physiatrist	Overlake Medical Center
9. Sara Groves-Rupp	Asst. Administrator, Performance Improvement	University of Washington Medicine
10. Robert Mecklenburg, MD (Co-Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
11. Kerry Schaefer, MS (Co-Chair)	Strategic Planner for Employee Health	King County
12. Marcia Peterson	Manager of Benefits Strategy and Design	Washington State Health Care Authority

Accountable Payment Models:
Total Knee and Total Hip Replacement Re-Review

Member	Title	Organization
1. Lydia Bartholomew, MD	Senior Medical Director, Pacific Northwest	Aetna
2. Todd Bate	Administrator, Orthopaedics & Sports Medicine Service Line	MultiCare
3. Shawn Boice, RN, BSN, MHA	Nurse Navigator, MSK Administration	Evergreen Health Care
4. Greg Brown, MD, PhD	Orthopedic Surgeon	CHI Franciscan
5. Sharon Eloranta, MD	Medical Director, Quality and Safety Initiatives	Qualis Health
6. Andrew Friedman, MD	Physiatrist	Virginia Mason Medical Center
7. Mike Glenn	CEO	Jefferson Healthcare, Pt. Townsend
8. Kevin Macdonald, MD	Orthopedic Oncology, Adult Reconstruction	Virginia Mason Medical Center
9. Robert Mecklenburg, MD (Co-Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
10. Linda Radach	Patient Advocate	
11. Kerry Schaefer, MS (Co-Chair)	Strategic Planner for Employee Health	King County
12. Jacqui Sinatra, MPA, FACHE	Service Line Director of Sports, Spine, & Ortho Health Svc	University of Washington Medical Center
13. Gaelon Spradley	Chief of Clinic Operations	Mason General Hospital
14. Theresa Sullivan	CEO	Samaritan Healthcare, Moses Lake

Accountable Payment Models: Bariatric Surgery Workgroup Members

Member	Title	Organization
1. David Arterburn, MD, MPH	Physician, Internal Medicine Group Health Research Institute Senior Investigator	Group Health Cooperative
2. Sharon Eloranta, MD	Medical Director, Quality and Safety Initiatives	Qualis Health
3. Kristin Helton, PhD	Consumer	
4. Jeff Hooper, MD	Medical Director, Weight Loss Program	MultiCare Health System
5. Dan Kent, MD	Chief Medical Officer	United Health Care
6. Saurabh Khandelwal, MD	Bariatric Surgeon	University of Washington
7. Robert Mecklenburg, MD 8. (Co-Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
9. Robert Michaelson, MD, PhD, FACS, FASMBS	President	Washington State Chapter, American Society for Metabolic and Bariatric Surgery
10. Thien Nguyen, MD	Bariatric Program Medical Director	Overlake Medical Center
11. Tom Richards	Consumer	
12. Kerry Schaefer, MS (Co-Chair)	Strategic Planner for Employee Health	King County
13. Jonathan Stoehr, MD/ Jeff Hunter, MD	Endocrinologist/ Bariatric Surgeon	Virginia Mason Medical Center
14. Brian Sung, MD	Bariatric Surgery Director	Swedish Medical Center

Member	Title	Organization
15. Tina Turner	Senior Internal Consultant	Premera Blue Cross
16. Richard Thirlby, MD	Medical Director	Surgical Care and Outcomes Assessment Program (SCOAP)

Accountable Payment Models: Coronary Artery Bypass Surgery

Member	Title	Organization
1. Drew Baldwin, MD, FACC	Cardiologist	Virginia Mason Medical Center
2. Glenn Barnhart, MD	Cardiac Surgeon	Swedish Medical Center
3. Marissa Brooks	Director of Health Improvement Programs	SEUI Healthcare Northwest Benefits
4. Susie Dade, MS	Deputy Director	Washington Health Alliance
5. Gregory Eberhart, MD, FACC	Medical Director, Cardiology	CHI Franciscan Health
6. Theresa Helle	Manager of Health Care Quality and Efficiency Initiatives	The Boeing Company
7. Bob Herr, MD	Physician	US HealthWorks
8. Jeff Hummel, MD	Medical Director, Health Care Informatics	Qualis Health
9. Dan Kent, MD	Medical Director, Quality & Medical Management	Premera Blue Cross
10. Robert Mecklenburg, MD (Co-Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
11. Vinay Malhotra, MD	Cardiologist	Cardiac Study Center
12. Kerry Schaefer, (Co-Chair)	Strategic Planner for Employee Health	King County
13. Gregg Shibata	Manager, Accountable Health Implementation	Regence Blue Shield
14. Shilpen Patel, MD, FACRO	Medical Director	Clinical Outcomes Assessment Program

Member	Title	Organization
15. Thomas Richards	Managing Director, Employee Benefits	Alaska Airlines

Accountable Payment Models: Lumbar Fusion

Member	Title	Organization
1. Susie Dade, MS	Deputy Director	Washington Health Alliance
2. Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
3. April Gibson	Administrator	Puget Sound Orthopaedics
4. Dan Kent, MD	Medical Director, Quality & Medical Management	Premera Blue Cross
5. Bob Manley, MD	Surgeon	Regence Blue Shield
6. Gary McLaughlin	Vice President of Finance, Chief Financial Officer	Overlake Hospital
7. Robert Mecklenburg, MD (Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
8. Peter Nora, MD	Chief of Neurological Surgery	Swedish Medical Center
9. Charissa Raynor	Executive Director	SEIU Healthcare NW Benefits
10. Kerry Schaefer, MS	Strategic Planner for Employee Health	King County
11. Julie Sylvester	Vice President of Quality and Safety Initiatives	Qualis Health
12. Jay Tihinen	Assistant Vice President Benefits	Costco Wholesale

Accountable Payment Models:

Total Knee and Total Hip Replacement

Member	Title	Organization
1. Susie Dade, MS	Deputy Director	Washington Health Alliance
2. Joe Gifford, MD	Chief Strategy and Innovation Officer for Western Washington	Providence Health and Services
3. Bob Herr, MD	Medical Director, Government Programs	Regence Blue Shield
4. Tom Hutchinson	Practice Administrator	PeaceHealth
5. Rich Maturi	Senior Vice President, Health Care Delivery Systems	Premera Blue Cross
6. Gary McLaughlin	Vice President of Finance	Overlake Hospital
7. Robert Mecklenburg, MD (Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
8. Kerry Schaefer	Strategic Planner For Employee Health	King County
9. Julie Sylvester	Vice President of Quality and Safety Initiatives	Qualis Health
10. Jay Tihinen	Assistant Vice President, Benefits	Costco

Addiction/Dependence Treatment

Member	Title	Organization
1. Charissa Fotinos, MD, MSc	Deputy Chief Medical Officer	Health Care Authority
2. Tom Fritz (Chair)	Chief Executive Officer	Inland Northwest Health Services
3. Linda Grant	Chief Executive Officer	Evergreen Manor
4. Tim Holmes	Vice President of Outreach Services and Behavioral Health Administration	MultiCare Health System
5. Ray Hsiao, MD	Co-Director, Adolescent Substance Abuse Program	Seattle Children's Hospital
6. Scott Munson	Executive Director	Sundown M Ranch
7. Rick Ries, MD	Associate Director	Addiction Psychiatry Residency Program, University of Washington
8. Terry Rogers, MD	Chief Executive Officer	Foundation for Health Care Quality
9. Ken Stark	Director	Snohomish County Human Services Department
10. Jim Walsh, MD	Physician	Swedish Medical Center

Alzheimer's Disease and Other Dementias

Name	Title	Organization
1. Kimiko Domoto-Reilly, MD	Alzheimer's Research Center	University of Washington Medicine
2. Richard Furlong, MD	Primary Care	Virginia Mason Medical Center
3. Barak Gaster, MD	Professor of Medicine	University of Washington Medicine
4. Kelly Green, LICSW	Social Worker	Evergreen Health
5. Debbie Hunter	Family Caregiver	
6. Nancy Isenberg, MD, MPH, FAAN	Neurologist, Clinical Associate Professor of Neurology, Center for Healthy Aging & Memory	Virginia Mason Medical Center
7. Arlene Johnson	Family Caregiver	
8. Kerry Jurges, MD	Primary Care	Confluence Health
9. Eric Larson, MD, MPH	Vice President for Research and Health Care Innovation	Kaiser Foundation Health Plan of Washington
10. Todd Larson	Family Caregiver	
11. Myriam Marquez	Patient Advocate	
12. Shirley Newell, MD	Chief Medical Officer	Aegis Living
13. Darrell Owens, DNP, ARNP	Clinic Chief, Director	University of Washington Outpatient Primary, Palliative and Supportive Care Program
14. Kristoffer Rhoads, PhD (Chair)	Primary Neuropsychologist, Memory and Brain Wellness Center	University of Washington Medicine
15. Tatiana Sadak, PhD, ARNP	Psychiatric Nurse Practitioner	University of Washington Medical Center
16. Bruce Smith, MD	Medical Director	Regence Blue Shield

Behavioral Health Integration

Member	Title	Organization
1. Brad Berry	Executive Director	Consumer Voices Are Born
2. Regina Bonnevie, MD	Medical Director	Peninsula Community Health Services
3. Mary Hodge-Moen, MSW, LMHC, CDP, CCM	Sr. Manager, Clinical Review	Premera
4. Rose Ness, MA, LMHC, CDP	Behavioral Health Expert	Sound Integration for Behavioral Healthcare
5. Mary Kay O'Neill MD, MBA	Partner	Mercer
6. Joe Roszak	CEO	Kitsap Mental Health Services
7. Anna Ratzliff, MD, PhD/ Anne Shields, MHA, RN	Director of the UW Integrated Care Training Program, Associate Director for Education/Associate Director	AIMS Center, University of Washington
8. Brian Sandoval, PsyD	Behavioral Health Manager, Oregon and Washington Services	Yakima Valley Farmworkers Clinics
9. Lani Spencer, RN, MHA	Vice President	Health Care Management Services, Amerigroup – Washington
10. Emily Transue, MD, MHA	Senior Medical Director	Coordinated Care

Bree Implementation Team

Member	Title	Organization
1. Neil Chasan	Physical Therapist	Sports Reaction Center
2. Susie Dade, MS	Deputy Director	Washington Health Alliance
3. Cezanne Garcia	Program Manager, Community and School-Based Partnerships	Public Health Seattle – King County
4. Ellen Kauffman, MD	OB-COAP Medical Director	Foundation for Health Care Quality
5. Dan Lessler, MD (Chair)	Medical Director	Health Care Authority
6. Alice Lind, RN	Manager, Grants and Program Development	Health Care Authority
7. Jason McGill, JD	Health Policy Advisor	Governor's Office
8. Larry McNutt	Sr. Vice President	Northwest Administrators, Inc.
9. Mary Kay O'Neill, MD, MBA	Chief Medical Director	Coordinated Care
10. Steven Overman, MD	Director	Seattle Arthritis Clinic
11. Terry Rogers, MD	Chief Executive Officer	Foundation for Health Care Quality
12. Claudia Sanders	Senior Vice President, Policy Development	Washington State Hospital Association
13. Kerry Schaefer, MS	Strategic Planner for Employee Health	King County
14. Jeff Thompson, MD	Senior Health Care Consultant	Mercer
15. Shawn West, MD	Family Physician	

Member	Title	Organization
16. Karen Wren	Benefits Manager	Point B

Collaborative Care for Chronic Pain

Member	Title	Organization
1. LuAnn Chen, MD, MHA, FAAFP	Medical Director	Community Health Plan of Washington
2. Lynn DeBar, PhD, MPH	Senior Investigator	Kaiser Permanente Washington Health Research Institute
3. Stuart Freed, MD	Chief Medical Officer	Confluence Health
4. Andrew Friedman, MD	Physiatrist	Virginia Mason Medical Center
5. Leah Hole-Marshall, JD (chair)	Counsel and Chief Strategist	Washington Health Benefit Exchange
6. Mary Kay O'Neill, MD, MBA	Partner	Mercer
7. Jim Rivard, PT, DPT, MOMT, OCS, FAAOMPT	President	MTI Physical Therapy
8. Kari A. Stephens, PhD	Assistant Professor – Psychiatry & Behavioral Sciences	University of Washington Medicine
9. Mark Sullivan, MD, PhD	Professor, psychiatry; Adjunct professor, anesthesiology and pain medicine	University of Washington Medicine
10. Emily Transue, MD, MHA	Associate Medical Director	Washington State Health Care Authority

End-of-Life Care

Member	Title	Organization
1. Anna Ahrens	Director of Patient and Family Support Services	MultiCare Health System
2. J. Randall Curtis, MD, MPH	Professor of Medicine, Director	University of Washington Palliative Care Center of Excellence
3. Trudy James	Chaplain	Heartwork
4. Bree Johnston, MD	Medical Director, Palliative Care	PeaceHealth
5. Abbi Kaplan	Principal	Abbi Kaplan Company
6. Timothy Melhorn, MD	Internist	Yakima Valley Memorial Hospital (YVMH) and the Memorial Foundation
7. Joanne Roberts, MD	Chief Medical Officer, NMR Administration	Providence Everett Regional Medical Center
8. John Robinson, MD (Chair)	Chief Medical Officer	First Choice Health
9. Bruce Smith, MD (Vice Chair)	Associate Medical Director, Strategy Deployment	Group Health Physicians
10. Richard Stuart, DSW	Clinical Professor Emeritus, Psychiatry	University of Washington

Hospital Readmissions

Member	Title	Organization
1. Sharon Eloranta, MD	Medical Director, Quality and Safety Initiatives	Qualis Health
2. Stuart Freed, MD	Medical Director	Wenatchee Valley Medical Center
3. Rick Goss, MD, MPH (Chair)	Medical Director	Harborview Medical Center – University of Washington
4. Leah Hole-Marshall, JD	Medical Administrator	Washington State Department of Labor and Industries
5. Dan Lessler, MD, MHA	Medical Director	Health Care Authority
6. Robert Mecklenburg, MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
7. Amber Theel, RN, MBA	Director, Patient Safety Practices	Washington State Hospital Association

Hysterectomy

Name	Title	Organization
1. Pat Kulpa, MD,MBA	Medical Director	Regence BlueShield
2. Sharon Kwan, MD, MS	Interventional Radiologist	University of Washington Medical Center
3. John Lenihan, MD	Medical Director of Robotics and Minimally Invasive Surgery	MultiCare Health System
4. Jennie Mao, MD	Clinical Assistant Professor, Department of Obstetrics and Gynecology	University of Washington Medical Center
5. Sarah Prager, MD	Chair	Washington State Section of ACOG
6. Kevin Pieper, MD	Chief, Women's and Children's	Providence Regional Medical Center Everett
7. Kristin Riley, MD, FACOG	Assistant Professor, Department of Obstetrics and Gynecology	University of Washington Medical Center
8. Jeanne Rupert, DO, PhD (Chair)		
9. Anita Showalter, DO, FACOOG	Associate Professor and Chair, Women's Health	Pacific Northwest University of Health Sciences
10. Susan Warwick, MD	Obstetrics and Gynecology	Kaiser Permanente

LGBTQ Health Care

Member	Title	Organization
1. Olivia Arakawa, MSN, CNM, ARNP, RN	Parent Advocate	
2. Scott Bertani	Director of Policy	Lifelong AIDS Alliance
3. Kathy Brown, MD	Provider	Kaiser Permanente
4. LuAnn Chen, MD, MHA, FAAFP	Medical Director	Community Health Plan of Washington
5. Michael Garrett, MS, CCM, CVE, NCP	Principal	Mercer
6. Chris Gaynor, MD, MA, FAAFP	Family Practice Clinician	Capitol Hill Medical
7. Matt Golden, MD	Professor, Director, PHSKC STD Control Program	University of Washington
8. Kevin Hatfield, MD	Family Practice Clinician	The Polyclinic
9. Corinne Heinen, MD	Physician Lead, UW Transgender Clinical Pathway	Department of Internal Medicine, Allergy & Infectious Disease, University of Washington
10. Tamara Jones, MPH	End AIDS Washington Policy and Systems Coordinator	Department of Health
11. Dan Lessler, MD, MHA (Chair)	Chief Medical Officer	Washington State Health Care Authority

Low Back Pain

Member	Title	Organization
1. Dan Brzusek, DO	Physiatrist	Northwest Rehab Association
2. Neil Chasan	Physical Therapist	Sport Reaction Center
3. Andrew Friedman, MD	Physiatrist	Virginia Mason
4. Leah Hole-Curry, JD	Medical Administrator	Washington State Department of Labor and Industries
5. Heather Kroll, MD	Rehab Physician	Rehab Institute of Washington
6. Chong Lee, MD	Spine Surgeon	Group Health Cooperative
7. Mary Kay O'Neill, MD, MBA (Chair)	Executive Medical Director	Regence Blue Shield
8. John Robinson, MD, SM	Chief Medical Officer	First Choice Health
9. Michael Von Korff, ScD	Psychologist & Researcher	Group Health Research Institute
10. Kelly Weaver, MD	Physiatrist	The Everett Clinic

Obstetric (Maternity) Care

Member	Title	Organization
1. Theresa Helle	Manager, Health Care Quality & Efficiency Initiatives	The Boeing Company
2. Ellen Kauffman, MD	OB-COAP Medical Director	Foundation for Health Care Quality
3. Robert Mecklenburg, MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
4. Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
5. Mary Kay O'Neill, MD, MBA	Executive Medical Director	Regence Blue Shield
6. Dale Reisner, MD	Obstetrician/Gynecologist	Swedish Hospital Perinatologist
7. Terry Rogers, MD	Chief Executive Officer	Foundation for Health Care Quality
8. Roger Rowles, MD	Obstetrician/Gynecologist	Yakima Memorial OB-GYN

Oncology Care

Member	Title	Organization
1. Jennie Crews, MD	Medical Director	PeaceHealth St. Joseph Cancer Center
2. Bruce Cutter, MD	Oncologist	Medical Oncology Associates
3. Patricia Dawson, MD, PhD	Director	Swedish Cancer Institute Breast Program and True Family Women's Cancer Center
4. Keith Eaton, MD, PhD	Medical Director, Quality, Safety and Value	Seattle Cancer Care Alliance
5. Janet Freeman-Daily	Patient Advocate	
6. Christopher Kodama, MD, MBA (Chair)	President, MultiCare Connected Care	MultiCare Health System
7. Gary Lyman, MD, MPH	Co-Director	Hutchinson Institute for Cancer Outcomes Research
8. Rick McGee, MD	Oncologist	Washington State Medical Oncology Society
9. John Rieke, MD,FACR	Medical Director	MultiCare Regional Cancer Center
10. Hugh Straley, MD	Chair and Oncologist	Bree Collaborative
11. Richard Whitten, MD	Medical Director	Noridian

Opioid Prescribing Guideline Implementation

Name	Title	Organization
1. Chris Baumgartner	Director Prescription Monitoring Program	Department of Health
2. David Buchholz, MD	Medical Director of Provider Engagement	Premera
3. Tanya Dansky, MD	Chief Medical Officer	Amerigroup
4. Gary Franklin, MD, MPH (Chair)	Medical Director	Department of Labor and Industries
5. Charissa Fotinos, MD, MSc	Deputy Chief Medical Officer	Health Care Authority
6. Frances Gough, MD	Chief Medical Officer	Molina Healthcare
7. Kathy Lofy, MD	Chief Science Officer	Department of Health
8. Jaymie Mai, PharmD	Pharmacy Manager	Department of Labor and Industries
9. Mark Murphy, MD	Addiction Medicine	MultiCare Health System
10. Shirley Reitz, PharmD	Clinical Pharmacist Client Manager	OmedaRx, Cambia
11. Gregory Rudolph, MD	Addiction Medicine	Swedish Pain Services
12. Michael Schiesser, MD	Addiction Medicine	EvergreenHealth Medical Center
13. Danny Stene, MD	Medical Director	First Choice Health
14. Mark Stephens	President	Change Management Consulting
15. Hugh Straley, MD	Chair	Bree Collaborative
16. David Tauben, MD	Chief of Pain Medicine	University of Washington (UW) Medical Center

Name	Title	Organization
17. Gregory Terman MD, PhD	Professor	Dept. of Anesthesiology and Pain Medicine; Graduate Program, Neurobiology and Behavior, UW
18. Emily Transue, MD	Chief Medical Director	Coordinated Care
19. Michael Von Korff, ScD	Senior Investigator	Group Health Research Institute
20. Melet Whinston, MD	Medical Director	United Health Care

Opioid Use Disorder Treatment

Name	Title	Organization
1. Jane Ballantyne, MD, FRCA	Professor, Department of Anesthesiology and Pain Medicine	University of Washington School of Medicine
2. Caleb Banta-Green, PhD, MPH, MSW	Senior Scientist	Alcohol and Drug Abuse Institute, University of Washington
3. David Beck, MD	Immediate Past President	Washington Society of Addiction Medicine
4. Ryan Caldeiro, MD	Chief Chemical Dependency Services and Consultative Psychiatry	Kaiser Permanente
5. Mary Catlin, BSN, MPH	Institutional Nurse Consultant	Department of Health
6. Charissa Fotinos, MD, MSc (Co-Chair)	Deputy Medical Officer	Health Care Authority
7. Nancy Lawton, MN, ARNP, FNP	President	ARNPs United of Washington State
8. Darin Neven, MD, MS	President and Founder	Consistent Care
9. Richard Ries, MD	Director, Addiction Psychiatry Residency Program	University of Washington
10. John Robinson, MD, SM	Chief Medical Officer	First Choice Health
11. John Roll, PhD	Professor & Vice Dean for Research, Elson S. Floyd College of Medicine	Washington State University
12. Terry Rogers, MD	Medical Director	Lakeside Milam Recovery
13. Vania Rudolf, MD, MPH	Addiction Recovery Services	Swedish Medical Center
14. Andrew Saxon, MD (Co-Chair)	Director, Center of Excellence in Substance Abuse Treatment and Education (CESATE)	VA Puget Sound Health Care System
15. Mark Stephens	President	Change Management Consulting

Name	Title	Organization
16. Milena Stott, LICSW, CDP	Chief Of Inpatient Services	Valley Cities Counseling

Prostate Cancer Screening

Member	Title	Organization
1. John Gore, MD, MS	Urologist, clinician, surgeon, researcher	University of Washington Medicine
2. Matt Handley, MD	Medical Director, Quality	Group Health Cooperative
3. Leah Hole-Marshall, JD	Medical Administrator	Department of Labor & Industries
4. Steve Lovell	Retired	Patient and Family Advisory Council
5. Wm. Richard Ludwig, MD (Chair)	Chief Medical Officer	Providence Accountable Care Organization
6. Bruce Montgomery, MD	Clinical Director of Genitourinary Medical Oncology	Seattle Cancer Care Alliance
7. Eric Wall, MD, MPH	Market Medical Director	UnitedHealthcare
8. Shawn West, MD	Family Physician	Edmonds Family Medicine
9. Jonathan Wright, MD, MS, FACS	Assistant professor of urology/affiliate researcher	University of Washington/Fred Hutchinson Cancer Research Center

Pediatric Psychotropic Use

Member	Title	Organization
1. Shelley Dooley	Parent Advocate	
2. Nalini Gupta, MD	Pediatrician	Developmental and Behavioral Pediatrics, Providence Health and Services
3. Robert Hilt, MD	Director, Community Leadership; Director of Partnership Access Line	Seattle Children's
4. Paula Lozano, MD, MPH (Chair)	Medical Director, Research and Translation	Group Health Cooperative
5. Liz Pechous, PhD	Clinical Director	ICARD, PLLC
6. Robert Penfold, PhD	Co-investigator, Mental Health Research Network	Group Health Research Institute
7. James Polo, MD, MBA	Chief Medical Officer	Western State Hospital
8. David Testerman, PharmD	Pharmacy Director	Amerigroup
9. Mark Stein, PhD, ABPP	Director of ADHD and Related Disorders	Seattle Children's
10. Donna Sullivan, PharmD, MS	Chief Pharmacy Officer	Washington Health Care Authority

Suicide Care

Member	Title	Organization
1. Kate Comtois, PhD, MSW	Psychologist	Harborview Medical Center
2. Karen Hye, PsyD	Clinical Psychologist	CHI Franciscan Health
3. Matthew Layton, MD, PhD, FACP, DFAPA	Clinical Professor, Department of Medical Education and Clinical Sciences	Elson S. Floyd College of Medicine, Washington State University
4. Neetha Mony, MSW	Statewide Suicide Prevention Plan Program Manager	Washington State Department of Health
5. Julie Rickard, PhD	Physician & Healthcare Consultant	Confluence Health
6. Julie Richards, MPH	Research Associate	Kaiser Permanente Washington Health Research Institute
7. Hugh Straley, MD (chair)	Chair	Bree Collaborative
8. Jennifer Stuber, PhD	Associate Professor	University of Washington School of Social Work
9. Jeffrey Sung, MD	Member	Washington State Psychiatric Association