

Dr. Robert Bree Collaborative annual report

**Working together to improve health
care quality, outcomes, equity, and
affordability.**

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

November 15, 2021

Dr. Robert Bree Collaborative annual report

Acknowledgements

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 in Washington State.

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Executive summary

This is the tenth annual report submitted by the Health Care Authority (HCA) on behalf of the Dr. Robert Bree Collaborative (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 efforts of the Collaborative from November 2020 through October 2021 to develop evidence-informed community standards and to foster adoption of those standards.

HCA is the sponsoring agency of the Collaborative, a public/private group 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 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 forming in 2011, the Collaborative has successfully worked to improve health care quality, patient outcomes, affordability, and equity in our state. Year ten accomplishments include:

Developing new evidence-informed community standards for cervical cancer screening

Delivery of care through telehealth

Revising the total knee and total hip replacement bundled payment model

Opioid prescribing for older adults

Facilitating adoption broadly and specifically for behavioral health integration into primary care

Moving the health care system from volume to value

Background

Disparities in health outcomes that existed before the COVID-19 (SARS-COV-2) pandemic have been magnified over the last year.ⁱ Despite spending nearly twice that of comparable countries, the United States has shorter life expectancy, higher chronic disease rates, higher obesity rates, and higher suicide rates.ⁱⁱ Many of the dollars spent do not add to patient health or quality of care and are considered wasted.^{iii,iv} Over a four-year period in Washington State alone, \$703 million was spent on unnecessary or low-value health care services.^v Prices for medical services vary widely, from \$7,000 to over \$20,000 for a cesarean section delivery.^{vi} Variation in price, processes, and outcomes within health care delivery and high rates of use of specific health care services can indicate poor quality, inappropriate services, and potential waste.

Washington State has prioritized increasing the quality, equity, affordability of health care through the [Health Technology Assessment program](#), the [Prescription Drug Program](#), [Healthier Washington](#), and the [Collaborative](#). The Collaborative's work is a key part of [Healthier Washington](#), providing evidence-informed community standards of care and purchasing guidelines for high-variation, high-cost health care services. The 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 leader 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.

Since first convening in 2012, the Collaborative has developed 34 sets of clinical guidelines. See Appendix A for more detailed background for the Collaborative. See Appendix B for a list of current Collaborative members.

ESHB 1311 overview

The Washington State Legislature established the 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. Engrossed Substitute House Bill 1311 (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](#).

Summary of recent work

The Collaborative's tenth year from November 2020 to October 2021 focused on developing new evidence-based recommendations for cervical cancer screening, delivery of care through telehealth, revising the total knee and total hip replacement bundled payment model, and opioid prescribing for older adults; and facilitating adoption broadly and specifically for behavioral health and value-based care.

The four active workgroups are profiled on the following pages.

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

- Colorectal Cancer Screening (Adopted November 2020)
 - [Final report](#)
- Oncology Care (Adopted November 2020)
 - [Final report](#)
- Reproductive and Sexual Health (Adopted November 2020)
 - [Final report](#)
- Primary Care (Adopted January 2021)
 - [Final report](#)
- Revised Perinatal Bundle (Adopted January 2021)
 - [Final bundle](#)
- Cervical Cancer Screening (Adopted July 2021)
 - [Final report](#)
- Telehealth (Adopted September 2021)
 - [Final report](#)

At the September meeting, Collaborative members selected four new topics for 2022 including:

- Hepatitis C
- Infection control
- Low back pain
- Pediatric asthma

Cervical cancer screening

The Collaborative convened a workgroup from January to July 2021 with the goal of decreasing incidence of mortality and morbidity from cervical cancer. The guidelines discuss primary prevention through HPV vaccination, appropriate screening, and structured follow-up on abnormal results. Working group members are listed in Appendix C.

Background and guideline framework

Cervical cancer deaths have decreased over the past 40 years because of the Papanicolaou (Pap) test to screen for pre-cancer and cancerous cells and the human papillomavirus (HPV) vaccine leading to reductions in HPV infection and incidence of precancer.^{vii,viii ix} However, cervical cancer remains the second most common cancer type for those with cervical tissue between the ages of 15 and 44 and only 50-66% of people are up to date on screening.^x Being up to date varies significantly by race and ethnicity, where a person lives, and the person's income and insurance status resulting in disparities in cervical cancer incidence and mortality across population groups due to differential access to cervical cancer screens and appropriate follow-up.^{xi,xii}

Focus areas

Address primary prevention through the HPV vaccine, the screen itself, and relevant follow-up including:



HPV vaccine: awareness, addressing myths, school-based requirements and interventions, and tracking.



Cervical cancer screen: communication, tracking, trauma-informed care, addressing disparities, measuring, outreach.



Colposcopy: trauma-informed care, referral information, cost-share revision.



Abnormal result follow-up: workflow revision, system-patient communication.

Opioid use in older adults

The Collaborative convened a workgroup that started meeting in January 2021 to address opioid use in those over 65. Opioids in this population pose specific risks and challenges related to changing physiology and pharmacokinetics, increasingly complex interactions among polypharmacy use of drugs, especially other controlled substances (benzodiazepines, sedative hypnotics) or drugs such as gabapentinoids, presence of severe co-morbidities, declining cognitive function, and increasing social isolation and complex care support needs. Working group members are listed in Appendix C.

Background and guideline framework

An Agency for Healthcare Research and Quality 2018 report highlighted increasing rates of opioid-related hospitalizations, with the highest reported median rates in Oregon and Washington.^{xiii} While opioid prescribing and mortality specific to prescribed opioids have fallen in recent years, between 2017-2018, the CDC reported that the specific opioid related mortality rate for persons ≥ 65 years increased by 4.8%.^{xiv}

Pharmacokinetic changes and enhanced pharmacodynamic sensitivity (i.e., more pronounced effects at equivalent doses used in younger adults) occur with all opioids with age,^{xv,xvi} leading to recommendations to start opioid therapy with about 50% of the usual adult dosage.^{xvii} The American College of Surgeons Best Practices Guidelines for Acute Pain Management in Trauma Patients (2020) recommends a decrease in the initial dose of an opioid by 25% in 60-year-old patients, and by 50% for 80-year-old patients; but to administer at the same intervals.

Focus areas

The framework focuses on areas of concern and intervention including:

-  Acute prescribing including acute injuries and peri-operative to prevent transition to long term opioid use.
-  Co-prescribing with opioids (e.g., sedative hypnotics, gabapentinoids, z-drugs) to reduce impacts on cognition, falls, delirium.
-  Non-opioid pharmacologic pain management.
-  Non-pharmacologic pain management.
-  Types of opioid therapy-intermittent, low dose, short acting vs others to reduce use of long-acting opioids and chronic opioid therapy.
-  Tapering/deprescribing to advise on differentiators with recent Collaborative recommendations for legacy patients.

Telehealth

The Collaborative convened a workgroup that met from January to September 2021 to address concerns about appropriateness, efficacy, and unintended consequences of care delivery absent in-person observations. This rapid acceleration of telehealth has identified a knowledge gap among physical and behavioral health providers in how to determine if a service is appropriate for delivery over telehealth. Telehealth also raises unique issues related to confidentiality and access. Uncertainties remain about whether services delivered over telehealth are equivalent to services delivered in-person in how those clinical visits contribute to a person's overall health and specific health outcomes and/or whether telehealth leads to additional downstream health care utilization due to continued unmet need (i.e., how well a person's concern can be addressed virtually).

Background and guideline framework

Availability of telehealth services has been trending upward due to increased availability of computers, smart phones and supporting software capable of transmitting high-quality video for the last decade. Telehealth then rapidly increased in use in early 2020 due to SARS-COV-2 restricting in-person interactions to reduce viral transmission.^{xviii} Approximately 34.5 million telehealth services were delivered nationally to Medicaid and Children's Health Insurance Program (CHIP) beneficiaries from March through June 2020, representing an increase of 2,632% compared to March through June 2019.^{xix} Broadly, literature shows that costs and benefits are dependent on the health care service, the patient, and the overall health context.^{xx}

Focus areas

The workgroup developed focus areas based on Agency for Healthcare Research and Quality's (AHRQ) Institute of Medicine framework, available evidence, and expert opinion to define a community standard for telehealth including:



Appropriateness: Clear criteria coupled with clinical judgement



Person-Centered Interaction(s): developing shared expectations, workflow guidance



Measurement and Follow-up: modern data infrastructure, stratified metrics to look for and intervene on disparities

Total knee and total hip replacement bundled payment model

The Collaborative convened a workgroup that met from January to September 2021 to update the 2017 total knee and total hip replacement bundled payment model first developed in 2013.

Background and bundle framework

Surgical bundles produced by the Collaborative align healthcare delivery, purchasing and payment with an evidence-informed community standard for quality. As such, they provide an alternative to fee-for-service reimbursement and facilitate value-based contracting. The total knee and total hip replacement bundle and warranty is primarily designed for osteoarthritis. The four-cycle bundle extends well beyond the surgical procedure itself. Elements of the bundle are supported by an evidence table that includes over 130 appraised citations. Where medical evidence is absent or of marginal quality, the working group defined standards based on consensus of stakeholders.

The four cycles

The bundle consists of four cycles, including an appropriateness standard for total joint replacement, outlining requirements for diagnosis and a trial of non-surgical care.

First cycle

- Unless highly disabling osteoarthritis is evident at the time the patient first seeks medical attention, a trial of conservative therapy is appropriate.

Second cycle

- The second cycle sets forth requirements for fitness for surgery. Prior to surgery, candidates for joint replacement therapy should meet minimal standards to ensure their safety and commitment to participate actively in return to function.
- If a patient does not meet fitness for surgery standards the case should be discussed in a multidisciplinary conference with members relevant to the standard in question as chosen by the care team.

Third cycle

- The third cycle specifies elements of best practice surgery.

Fourth cycle

- The fourth cycle lists components of care aimed at our ultimate outcome, rapid return to function, optimizing hospital length of stay, and avoiding unnecessary readmissions.

Implementation

The Collaborative has developed 34 sets of recommendations from 2012 to present. Many of these health care services areas overlap and augment one another. Many guidelines are structured around workflow redesign that is not possible to track through available claims data. Therefore, uptake of Bree recommendations may be more extensive than what is known through the partnerships or projects discussed below.

HCA champions Collaborative recommendations, which also are supported and spread by Collaborative member organizations and many other community organizations. Moving from a fee-for-service to a value-based reimbursement structure has been a key part of HCA's focus.

The Collaborative also engages with many diverse stakeholders to move toward adoption of the recommendations. In from 2019 through 2021, the Collaborative received supplemental funds from the Legislature to conduct targeted implementation efforts and has thus far focused on augmenting primary care through integration of behavioral health.

Paying for value

Value-based payment, and specifically the four surgical bundled payment models, has seen the HCA act as a first mover followed by Premera, Washington's largest health plan, adopting a similar center of excellence contracting model. Further, this implementation effort will dovetail with the provision of Cascade Care, the Washington State public option.

The Collaborative and the HCA are aligned in the effort to move health care payment from volume/fee-for-service to value in order to increase health care coordination and whole-person care. HCA includes 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 Franciscan Health.
- **UMP Plus**—University of Washington (UW) Medicine Accountable Care Network. Both networks have met the contractual obligation to submit quality improvement plans in alignment with corresponding Collaborative recommendations 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 Franciscan Health as the center of excellence for total joint replacement surgery using the 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 who select Virginia Mason Franciscan Health for this procedure pay no coinsurance (with the exception of UMP CDHP members who are required by IRS rules to meet their deductible first). Premera Blue Cross administers the centers of excellence program.

In May 2019, Premera Blue Cross announced a contract with Providence St. Joseph Health naming seven facilities as centers of excellence for total joint replacement following the Collaborative guidelines, showing the move from publicly purchased insurance to success in adapting to the commercial market. Since January 2019, HCA has contracted with two centers of excellence for spine care and surgery, Capitol Medical Center and Virginia Mason Franciscan Health.

In addition to direct contracting, the Collaborative received additional funding from the Legislature to develop a targeted implementation plan. Leadership elected to jointly focus on integration of behavioral health into primary care and on moving the health care system to value from volume. Work to integrate behavioral health is outlined below.

Behavioral health integration

Behavioral health has broad potential for increasing population health, especially in the wake of the SARS-COV-2 pandemic and economic downturn's impact on increasing behavioral health need, as well as broad community support. Behavioral health integration includes:

- One-to-one practice coaching to a group of primary care practices.
- A less targeted and broader learning community; engagement with health plans to support funding for behavioral health integration and value-based payment.
- Assessment of multiple health care stakeholders.
- The creation of a learning community for value-based payment.

Collaborative staff recruited ten primary care clinics to receive one-to-one practice coaching for 18 months (extended to 24 months due to the pandemic) from January 2020 to December 2021. Practices were selected for regional representation. Each clinic developed six-month action plans of three to four quality improvement projects based on identified gaps within their assessment. Collaborative staff worked with the primary care pilot group to complete the Maine Health Access Foundation (MeHAF) assessment and a Collaborative-specific assessment in:

- January/February, 2020
- January/February 2021
- Late 2021.

Note: The planned assessment in June 2020 was delayed due to the pandemic.

Each clinic identified an internal team to complete assessments and develop action plans of three to four quality improvement projects based on identified gaps within assessments. Teams consisted of a variety of staff roles (e.g., provider, medical assistant, nurse, administrative, information technology, front desk) to provide a wide range of perspectives related to the patient experience.

Pilot clinics, county, project focus areas

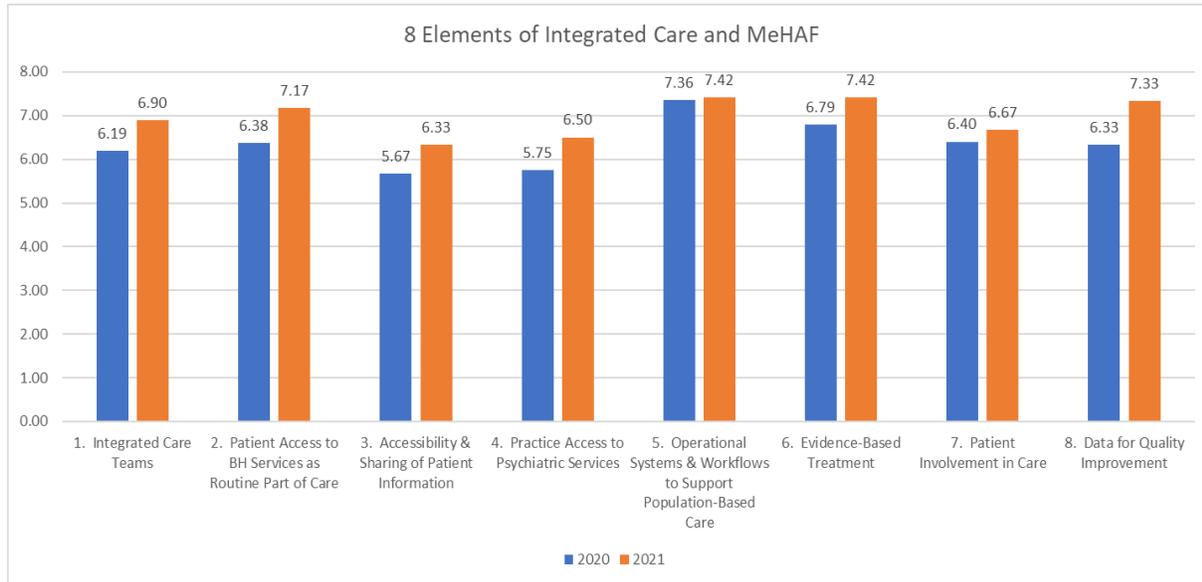
Table 1: The ten pilot clinics, their geographic range by county, and the focus of their diverse projects

Practice Name	County	Project Focus
Aberdeen Family Medical Clinic – Harbor Medical Group	Grays Harbor	<ul style="list-style-type: none"> On hold
Bremerton – Kitsap Medical Group	Kitsap	<ul style="list-style-type: none"> Population health. Collaborative safety planning. Opioid use disorder screening.
Brewster Jay Avenue Clinic – Family Health Centers	Okanogan	<ul style="list-style-type: none"> Integrated care teams: team huddles. Shared care plans. Warm hand-off process.
Community Health Centers of Snohomish County	Snohomish	<ul style="list-style-type: none"> Screening tool(s). Shared care plan. Warm hand-off process.
Family Care of Kent – Health Management Services Organization	King	<ul style="list-style-type: none"> Integrated care teams: team huddles. Trauma informed care staff training. Referral process.
Nisqually Tribal Health Clinic	Pierce	<ul style="list-style-type: none"> On hold
Pullman Family Medicine	Whitman	<ul style="list-style-type: none"> Social determinants of health screening. Naloxone prescribing and tracking. Depression screening.
Seattle Children’s Clinic at Harborview	King	<ul style="list-style-type: none"> Shared care plan. Attention deficit hyperactivity disorder population health. Reporting structure to support situation, background, assessment, recommendation for additional behavioral health staff.
Shoreline – International Community Health Services	King	<ul style="list-style-type: none"> Screening, brief intervention, and referral to treatment workflow. Access to psychiatric care. Integrated care teams.
Snoqualmie Ridge Medical Clinic	King	<ul style="list-style-type: none"> On hold

Assessment results: 2020 compared to 2021

See Appendix D for a crosswalk of the MeHAF and Collaborative guideline. Please note there are no specific Collaborative guideline questions, as these have been addressed with the completion of a MeHAF assessment.

Image 1: The eight elements of integrated care and MeHAF



Collaborative staff have hosted monthly webinars or large meetings, during this reporting period to support broad community learning. All webinars featured community partners describing overcoming barriers to implementation and overall strategy as well as an overview of the Collaborative recommendations and available resources to drive implementation. All recordings are available on the [Foundation for Health Care Quality YouTube](#) channel and are outlined in the table on the next page.

Webinars

Table 2: A list of Collaborative hosted webinars and Summits

Month, Year	Title	Speakers
November, 2020	Value-based care summit	<ul style="list-style-type: none"> Donald Berwick, MD, MPP, FRCP Sue Birch, BSN, RN, MBA, director, HCA Judy Zerzan-Thul, MD, MPH, chief medical officer, HCA David Muhlestein, PhD, JD, chief strategy and research officer, Leavitt Partners, LLC Lloyd David, MBA, president, Optum Western Washington, CEO, Polyclinic Rebecca Kavoussi, MPP, president-West, Landmark Health David LaMarche, MBA, chief administrative officer, Eastside Health Network

Month, Year	Title	Speakers
		<ul style="list-style-type: none"> • Karen Schartman, vice president of strategy, Kaiser Permanente Washington
January, 2021 (moved from December due to holiday)	Identifying health disparities, striving for health Equity	<ul style="list-style-type: none"> • Michael Garrett, MS, CCM, CVE, principal, Mercer
January, 2021	Mobilizing collective action around social determinants of health	<ul style="list-style-type: none"> • Sara Singleton, principal, Leavitt Partners, LLC • Alison Poulson, executive director, Better Health Together Accountable Community of Health
February, 2021	Building recovery ecosystems: collaborative approaches to health and housing	<ul style="list-style-type: none"> • Milena Stott, LICSW, CMHS, CDP, outreach and engagement manager, Fletcher Group
April, 2021	Interoperability: removing barriers to value-based success	<ul style="list-style-type: none"> • Julia Adler-Milstein, PhD, professor, director, Center for Clinical Informatics and Improvement Research, University of California San Francisco • Vishal Chaudhry, chief data officer, HCA • Cathie Ott, information technology strategic advisor, HCA • Elya Prystowsky, PhD, executive director, Rural Health Collaborative • Jeremia Bernhardt, MD, provider, Iora Primary Care, Renton • Randy Coughlan, MBA, director of population health, Embright LLC
May, 2021	Screening for colorectal cancer	<ul style="list-style-type: none"> • Beverly Green, MD, MPH, senior investigator, family physician, Kaiser Permanente Washington Health Research Institute and Kaiser Permanente Washington • Casey Eastman, MPH, Washington State Department of Health
June, 2021	Addressing health through housing and employment	<ul style="list-style-type: none"> • Melanie Pazolt, HCA

Month, Year	Title	Speakers
July, 2021	Aligning quality measures: can we measure what matters?	<ul style="list-style-type: none"> • Dorothy Teeter, MHA, former director, HCA • Alicia Berkemeyer, executive vice president, Arkansas Blue Cross Blue Shield. • DC Dugdale, MD, University of Washington Medical Center • Rebecca Etz, PhD, co-director, Larry A. Green Center • Drew Olivera, MD, Regence Blue Shield • Tony Butruille, MD
August, 2021	Supporting Housing for SUD Populations	<ul style="list-style-type: none"> • Melodie Pazolt, Health Care Authority
October, 2021	Implementing Aligned Payment Model	<ul style="list-style-type: none"> • Lisa Dulsky Watkins, MD, Milbank Memorial Fund • Tiffany Mattingly, MSN, RN, The Health Collaborative • Emily Transue, MD, MHA, Health Care Authority • Angie Sparks, MD, American Academy of Family Physicians • Christine Palermo, MD, Common Spirit • Mike Myint, MD, Multicare

Community partnerships

Collaborative implementation activities aside from those above focus on communication, education, and consensus-building including:

- Outreach to community associations including the Washington State Hospital Association (WSHA), the Washington State Medical Association (WSMA), the Washington Health Alliance, as well as speaking at in-person and virtual events including University of Washington School of Public Health, American Cancer Society meeting, Accountable Community of Health meetings, Northwest Regional Primary Care Association Annual Conference, Northwest Regional Telehealth Resource Center Annual Conference, Performance Measures Coordinating Committee, and Washington Association of Community Health learning collaborative.
- Increasing Collaborative visibility through the [website](#), maintaining a [blog](#) with monthly or bi-monthly posts highlighting Collaborative topics or implementation strategies, and using social media to engage the community.

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

- **Addiction Screening:** The two HCA Accountable Care Programs; the Puget Sound High Value Network, led by Virginia Mason Franciscan Health; and the UW Medicine Accountable Care Network routinely train and utilize the screening, brief intervention, and referral to treatment model and have integrated a tool to screen for alcohol use into electronic medical records and workflow.
- **Behavioral Health Integration:** HCA used 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 Cardiac Clinical Outcomes Assessment Program (COAP) continues to monitor insufficient information around percutaneous coronary intervention.
- **End-of-Life Care:** WSHA and WSMA are still actively spreading advance care planning at the health system and community levels, aligned with the recommendations. The two associations are working to promote patient-centered end-of-life conversations through Honoring Choices[®]: Pacific Northwest.
- **Spine Surgery:** Spine Care Outcomes Assessment Program has 11 hospitals enrolled. As of August 2014, length of stay, radiologic verification of surgical level, and smoking use have been available on the website.
- **Obstetrics:** Both the Obstetrics Care Outcomes Assessment Program (OB COAP) and WSHA's Safe Deliveries Roadmap have aligned existing program expectations and data collection with Collaborative recommendations for member hospitals.
- **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.

Appendix A: Collaborative detailed background

The Collaborative has had great success working with many Washington State organizations to solicit nominations of experienced and engaged community leaders as 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 Collaborative's first 23 members after appointment by former Governor Chris Gregoire.

Steve Hill served as the 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 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. He has also 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 Collaborative members representing a health care purchaser, health plan, health care system, and quality improvement organization.

The Collaborative is housed in the Foundation for Health Care Quality. The Foundation provides project management and is responsible for employing staff.

The Collaborative has held meetings since 2011. Meetings are Find agendas and materials for all Collaborative meetings on the Collaborative [website](#). All Collaborative meetings are open to the public and follow the Open Public Meetings Act.

At the November 2012 meeting, the Collaborative adopted bylaws setting policies and procedures governing the Collaborative beyond the mandates established by the legislation (ESHB 1311). The Collaborative revised bylaws in September 2014. Find current bylaws [here](#).

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

The 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 appoints the chair and the convenes the Collaborative. The Collaborative must add members or establish clinical committees, as needed, to acquire clinical expertise in specific 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.

Recommendation topics to date include:

- Accountable Payment Models
 - Bariatric Surgery (2016)
 - Coronary Artery Bypass Graft Surgery (2015)
 - Lumbar Fusion (2014, re-reviewed 2018)
 - Total Knee and Total Hip Replacement Re-Review (2013, re-reviewed 2017, undergoing current re-review)
- Addiction and Dependence Treatment (2014)
- Alzheimer's Disease and Other Dementias (2017)
- Cardiology (2013)
- Collaborative Care for Chronic Pain (2018)
- Colorectal Cancer Screening (2020)
- Behavioral Health Integration (2016)
- End-of-Life Care (2014)
- Hysterectomy (2017)
- Lesbian, Gay, Bisexual, Transgender, and Questioning or Queer Health Care (2018)
- Low Back Pain and Spine Surgery (2013)
- Maternity Bundled Payment Model (2019)
- Obstetric Care (2012)
- Oncology Care (2015)
- Oncology Care: Inpatient Care Use (2020)
- Opioid Prescribing
- Dental Care (2017)
- Metrics (2017)
- Long-Term Opioid Therapy (2020)
- Post-operative Care (2018)
- Opioid Use Disorder Treatment (2016)
- Palliative Care (2019)
- Pediatric Psychotropic Use (2016)
- Potentially Avoidable Hospital Readmissions (2014)
- Primary Care (2020)
- Prostate Cancer Screening (2015)
- Reproductive and Sexual Health (2020)
- Risk of Violence to Others (2019)
- Shared Decision Making (2019)
- Suicide Care (2018)

Appendix B: Collaborative members

Members are listed below:

- Susie Dade, MS, patient advocate
- David Dugdale, MD, MS, medical director, University of Washington Medicine
- Gary Franklin, MD, MPH, medical director, Washington State Department of Labor and Industries
- Stuart Freed, MD, chief medical officer, Confluence Health
- Mark Haugen, MD, provider, Walla Walla Clinic
- Darcy Jaffe, MN, ARNP, NE-BC, FACHE, senior vice president, safety and quality, Washington State Hospital Association
- Karen Johnson, PhD, director, performance improvement and innovation, Washington Health Alliance
- Norifumi Kamo, MD, MPP, provider, Virginia Mason Franciscan Health
- Dan Kent, MD, chief medical officer, community plan, UnitedHealthcare
- Wm. Richard Ludwig, MD, provider, Providence Health and Services
- Greg Marchand, director, benefits, policy, and strategy, The Boeing Company
- Kimberly Moore, MD, associate chief medical officer, Franciscan Health System
- Carl Olden, MD, provider, Pacific Crest Family Medicine, Yakima
- Drew Oliveira, MD, executive medical director, Regence BlueShield
- Mary Kay O'Neill, MD, MBA, partner, Mercer
- Kevin Pieper, MD, chief medical officer, Kadlac Medical Center
- Susanne Quistgaard, MD, medical director, provider strategies, Premera Blue Cross
- John Robinson, MD, SM, chief medical officer, First Choice Health
- Jeanne Rupert, DO, PhD, provider, The Everett Clinic
- Angela Sparks, MD, medical director, clinical knowledge development and support, Kaiser Permanente Washington
- Hugh Straley, MD, chair
- Shawn West, MD, medical director, Embright, LLC
- Laura Kate Zaichkin, MPH, director, health plan performance and strategy, SEIU 775 Benefits Group
- Judy Zerzan, MD, MPH, chief medical officer, Washington State Health Care Authority

Appendix C: Working group members

Cervical cancer screening

- Chair: Laura Kate Zaichkin, MPH, SEIU 775 Benefits Group
- Virginia Arnold, DNP ARNP, Neighborcare Health at Pike Place Market
- Diana Buist, PhD, MPH, Kaiser Permanente Washington Health Research Institute
- LuAnn Chen, MD, MHA, FAAFP, Community Health Plan of Washington
- Colleen Haller, MPH, Community Health Plan of Washington
- Beth Kruse, CNM, Public Health Seattle King County
- Jordann Loehr, MD, Toppenish Medical-Dental Clinic
- Constance Mao, MD, University of Washington School of Medicine
- Sophia Shaddy, MD; Sandra White, MD, CellNetix Pathology

Opioid prescribing in older adults

- Co-chair: Gary Franklin, MD, MPH, WA Department of Labor and Industries
- Co-chair: Darcy Jaffe, MN, ARNP, NE-BC, FACHE, Washington State Hospital Association
- Co-chair: Mark Sullivan, MD, PhD, University of Washington
- Co-chair: Judy Zerzan-Thul, MD, MPH, Washington State Health Care Authority
- Jason Fodeman, MD; Jaymie Mai, PharmD, Pharmacy Manager, Washington State Department of Labor and Industries
- Carla Ainsworth, MD, MPH, Iora Primary Care – Central District
- Rose Bigham, Patient advocate
- Denise Boudreau, PhD, RPh, MS, Kaiser Permanente Washington Health Research Institute
- Siobhan Brown, MPH, CPH, CHES; Yusuf Rashid, RPh, Community Health Plan of Washington
- Pam Davies, MS, ARNP, FAANP, University of Washington
- Elizabeth Eckstrom, MD, Oregon Health Sciences University
- James Floyd, MD, University of Washington School of Medicine
- Nancy Fisher, MD, Ex officio
- Debra Gordon, RN, DNP, FAAN, University of Washington School of Medicine
- Shelly Gray, PharmD, University of Washington
- Wayne McCormick, MD, University of Washington
- Kushang Patel, MD, University of Washington
- Elizabeth Phelan, MD, University of Washington
- Dawn Shuford-Pavlich, Department of Social and Health Services
- Angela Sparks, MD, Kaiser Permanente Washington
- Gina Wolf, DC, Wolf Chiropractic Clinic

Telehealth

- Chair: Shawn West, MD, FAAFP, Embright
- Christopher Cable, MD, Kaiser Permanente Washington
- Sarah Levy, MD, Kaiser Permanente Washington
- Mandy A. Weeks-Green, Washington State Office of the Insurance Commissioner
- Tracey Hugel, MSN, RN, Regence Blue Cross
- Lydia Bartholomew, MD, MHA, FAAPL, FAAFP, CHIE, Aetna

- Stephanie Shushan, MHA, Health Plan of Washington
- Omar Daoud, PharmD, Community Health Plan of Washington
- Lindsay Mas, PhD, SEIU 775 Benefits Group

Total Knee and Total Hip Replacement Bundle

- Chair: Bob Mecklenburg, MD, retired from Virginia Mason Medical Center
- Matt Albright, Kevin Fleming, MBA, Michael Griffin; Providence St. Joseph Health
- Lydia Bartholomew, MD, MHA, FAAPL, FAAFP, CHIE, Aetna
- LuAnn Chen, MD, MHA, Community Health Plan of Washington
- Michael Chen, Premera Blue Cross
- Andrew Friedman, MD; Kevin Macdonald, MD, Virginia Mason Franciscan Health
- Paul Manner, MD, University of Washington
- Cat Mazzawy, RN, Washington State Hospital Association
- Linda Radach, Patient advocate
- Tom Stoll, MD, Kaiser Permanente Washington
- Emily Transue, MD, MHA, Health Care Authority

Appendix D: MeHAF and Collaborative guideline crosswalk

Table 3: MeHAF and Collaborative guideline crosswalk

Note: Items marked with ** were not in original crosswalk of the Collaborative guideline as adopted in 2017.

Element of integration	MeHAF question
Integrated care teams	II-1. Organizational leadership for integrated care.** II-2. Patient care team for implementing integrated care. II-3. Providers' engagement with integrated care ("buy-in"). II-8. Physician, team and staff education and training for integrated care. II-9. Funding sources/resources for integrated care. **
Patient access to behavioral health as a routine part of care	I-1. Co-location of treatment for primary care and mental/behavioral health care. I-12. Accessibility and efficiency of behavioral health practitioners.
Accessibility and sharing of patient information	I-3. Treatment plan(s) for primary care and behavioral/mental health care. II-4. Continuity of care between primary care and behavioral/mental health.
Practice access to psychiatric services	II-5. Coordination of referrals and specialists.
Operational systems and workflows to support population-based care	I-2. Screening/Assessment of emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse). I-7. Follow-up of assessments, tests, treatment, referrals and other services. I-11. Tracking of vulnerable patient groups that require additional monitoring and intervention.
Evidence-based treatments	I-4. Patient care that is based on (or informed by) best practice evidence for behavioral health and primary care. I-10. Patient care based on (or informed by) best practice for prescribing of psychotropic medications.
Patient involvement in care	I-5. Patient/family involvement in care plan. I-6. Communication with patients about integrated care. I-8. Social Support and potential barriers to care. ** I-9. Linking to community resources. ** II-7. Patient/family input to integration management.
Data for quality improvement	II-6. Data systems/patient records.

Appendix E: References

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