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, 2017

DR. ROBERT BREE COLLABORATIVE

Dr. Robert Bree Collaborative Annual Report

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.

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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 2016 through October 2017.

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 five active workgroups, drafting and adopting five sets of recommendations, and receiving approval from the Health Care Authority on five sets of recommendations. We're also working on:

- Developing Washington State and Centers for Disease Control and Prevention guideline-concordant opioid prescribing metrics.
- Engaging the dental community and developing guidelines on prescribing opioids in dental care.
- Developing recommendations to improve the quality of care given to patients with Alzheimer's disease and other dementias while supporting family members and caregivers.
- Developing recommendations to identify people with opioid use disorder and facilitate access to comprehensive, evidence-based treatment.
- Developing recommendations for appropriate and minimally-invasive hysterectomies.
- Revising the bundled payment model and warranty for total knee and total hip replacement.
- Working with the State of Washington and other stakeholders to encourage adoption of Bree Collaborative recommendations across diverse communities.

Background

The American health care system falls short on basic dimensions of quality, outcomes, cost, and equity. Every year many health care dollars are wasted, up to $992 billion per year.[1] This results in little to no improvement to a patient's health outcomes or to their quality of care.[1,2] Excess cost in public programs, Medicare and Medicaid, make up about one third of this amount.[3] Variation in how health care is practiced from hospital-to-hospital or clinician-to-clinician and high rates of use of specific health care services can indicate poor quality, inappropriate services, and potential health care waste.

Governor 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, MRI scans) in Washington State.

The Bree Collaborative's work is a key part of the Plan for a 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) grant to the HCA will help spread the improvements and strategies developed by the Bree Collaborative, increase health care transparency, and support 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 mechanism 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. Senate Bill 5144, Chapter 21, Laws of 2015, amended RCW 70.250.050 and clarified the original legislation to add "*All meetings of the collaborative, including those of a subcommittee, are subject to 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. Both of these trends may be indicators of poor quality and potential waste in the health care system. 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 at large.

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.

Bree Collaborative Formation

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 Washington State Hospital Association (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 Washington State Health Care Authority. 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.

The Chair is advised by a steering committee 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 Health Care Authority 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 meetings since late 2011. Meetings are held on a bi-monthly basis with future meetings scheduled for November 15th, 2017 and into 2018 on the second, third, or fourth Wednesday of the month: January 24, March 21, May 23, July 25, September 26, and November 14. 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

Summary of Recent Work

Collaborative work in year six from November 2016 to October 2017 focused on developing new evidence-based recommendations and working to facilitate implementation of existing recommendations through surveying the health care community, developing implementation roadmaps, through Health Care Authority contracting, and through community outreach and education. The Pediatric Psychotropic Use, Accountable Payment Models: Bariatric Surgery, and Behavioral Health Integration workgroups completed their recommendations and the Opioid Prescribing Guideline Implementation workgroup completed Opioid Prescribing metrics and a Dental Guideline on Prescribing Opioids for Pain. Workgroups were formed to develop recommendations around Alzheimer's Disease and Other Dementias, Opioid Use Disorder Treatment, Hysterectomy, and to re-review the Total Knee and Total Hip Replacement Bundle and Warranty. These workgroups are profiled on the following pages.

The Bree Collaborative:

- ✓ Supported 5 active workgroups
- ✓ Adopted 5 recommendations
- ✓ Distributed 5 recommendations for public comment
- ✓ Received Health Care Authority approval on 5 recommendations

The Bree Collaborative approved and submitted **five** recommendations to the Health Care Authority:

- **Pediatric Psychotropic Use** (Adopted November 2016)
  - Available: www.breecollaborative.org/wp-content/uploads/Antipsychotic-Recommendations-Final-2016.pdf
- **Bariatric Surgical Bundle and Warranty** (Adopted November 2016)
  - Available: www.breecollaborative.org/wp-content/uploads/Bree-Bariatric-Bundle-Final-2016.pdf and www.breecollaborative.org/wp-content/uploads/Bariatric-Warranty-Final-2016.pdf
- **Behavioral Health Integration** (Adopted March 2017)
  - Available: www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf
- **Opioid Prescribing Metrics** (Adopted July 2017)
  - Available: www.breecollaborative.org/wp-content/uploads/Bree-Opioid-Prescribing-Metrics-Final-2017.pdf
- **Dental Guideline on Prescribing Opioids for Pain** (Adopted September 2017)
  - Available: www.breecollaborative.org/wp-content/uploads/Dental-Opioid-Recommendations-Final-2017.pdf

At the September meeting, Bree Collaborative members selected new topics for 2018 including: LGBTQ health care, collaborative care for chronic pain, suicide prevention, endorsing the WSHA blood product use project, and re-reviewing the lumbar fusion bundled payment model and warranty.

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

These recommendations are currently in progress of being finalized. The workgroup has been meeting monthly since December 2016 and presented draft recommendations to Bree Collaborative members at the September 2017 meeting that were approved to be disseminated for public comment. Following this four-week public comment period, the workgroup will convene in November 2017 to address the public comments and to develop the final recommendations to be presented to Bree Collaborative members at the November meeting.

Learn more about the workgroup: 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 this care and have been shown to reduce cost while improving patient health.[4]

Our Work

The Accountable Payment Models workgroup developed the original Total Knee and Total Hip Replacement Warranty and Bundled Payment model in July and November 2013, respectively. This first iteration has since been used to develop a bundled payment model and corresponding warranty for lumbar fusion, coronary artery bypass graft surgery, and bariatric surgery in 2014, 2015, and 2016, respectively.

The warranty defines complications and timeframes after surgery in which complications can be attributed to the original surgery in order to track clinical and financial accountability for additional care needed to diagnose, manage, and resolve complications. The surgical bundle defines expected components of pre-operative, intra-operative, and post-operative care needed for successful total knee and total hip surgery. Quality standards are included that correspond to the surgical components and are required to be reported to the purchaser and health plans. The bundle is presented in four stages or cycles:

- Impairment due to osteoarthritis despite non-surgical therapy
- Making sure the patient is fit for surgery and would benefit from the surgical procedure (e.g., stopping smoking)
- Repair of the osteoarthritic joint
- Post-operative care and return to function

Alzheimer's Disease and Other Dementias

These recommendations are currently being finalized. The workgroup has been meeting monthly since January 2017 and presented draft recommendations to Bree Collaborative members at the September 2017 meeting that were approved to be disseminated for public comment. Following this four-week public comment period, the workgroup will convene in November 2017 to address the public comments and to develop the final recommendations to be presented to Bree Collaborative members at the November meeting.

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

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.[5] 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.[6] 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.[7] This is costly to the health care system and overly burdensome to primary care clinicians, patients, caregivers, and the community.

Our Work

The Bree Collaborative Alzheimer's Disease and Other Dementias Workgroup endorses and aims to build off previous work within Washington State. Specifically, the 2016 Alzheimer's State Plan. Recommendations aim to align care delivery with existing evidence-based standard of care for each stage of disease and across health care settings for patients, families, and caregivers.

The workgroup has developed recommendations in six areas:

1. Diagnosis;
2. Ongoing care and support;
3. Advance care planning and palliative care;
4. Transitions to higher levels of care;
5. Transitions between community and hospital; and
6. Post-surgical delirium.

The workgroup recommends early detection of mild cognitive impairment (MCI) to better support patients and family members but does not recommend population-level screening of older adults. Early detection allows patients and families to plan for future cognitive changes. The workgroup also recommends using a strengths-based approach that empowers both the patient and the caregiver.[8]

Opioid Use Disorder Treatment

These recommendations are currently being finalized. The workgroup has been meeting monthly since December 2016 and presented draft recommendations to Bree Collaborative members at the September 2017 meeting that were approved to be disseminated for public comment. Following this four-week public comment period, the workgroup will convene in November 2017 to address the public comments and to develop the final recommendations to be presented to Bree Collaborative members at the November meeting.

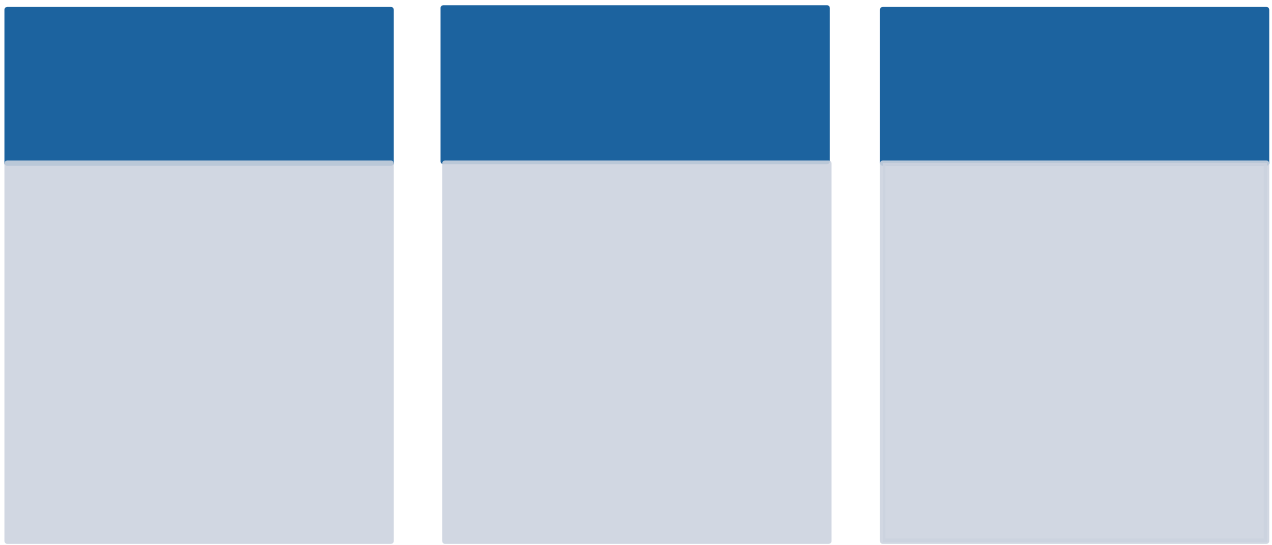
Learn more about the workgroup: www.breecollaborative.org/topic-areas/oud-treatment/

Background

Drug overdose is the leading cause of accidental death in the United States, driven predominantly by opioid addiction.[9] 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.[10] 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.[11]

Our Work

The workgroup's ultimate aim is a health care system that identifies people with opioid use disorder and facilitates access to comprehensive, evidence-based treatment using a harm reduction strategy with the patient at the center of care. A harm reduction strategy was selected due to its emphasis on patient (rather than provider) readiness to change. Key focus areas include:



Our 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 on pages 13-16. 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.

Hysterectomy

These recommendations are currently being finalized. The workgroup has been meeting monthly since March 2017 and plans on presenting draft recommendations to Bree Collaborative members at the November meeting to be disseminated for public comment.

> **Learn more about the workgroup:** www.breecollaborative.org/topic-areas/hysterectomy/

Background

Hysterectomy is one of the most frequent surgical procedures in the United States with approximately 600,000 performed annually.[12] Hysterectomy rates are highly variable by hospital and by region, being one of the first published surgical procedures with rates differing primarily based on location, indicating overuse.[13] Cost of hysterectomy also varies by region, from an average of $9,661 (range $6,243-$15,335) in the Mid-Atlantic to $22,534 (range $15,380-$33,797) in the Pacific region.[14] Washington Health Alliance analysis reveals that rates are also highly variable based on location in Washington State.[15]

Our Work

The workgroup's goal is that women undergo hysterectomies when appropriate with the understanding that some individual variation is appropriate based on clinical opinion. Workgroup members developed recommendations to encourage clinicians to go through the thought process of what to do prior to a hysterectomy, thereby reducing unnecessary or inappropriate hysterectomies.

The workgroup reviewed clinical practice guidelines, available evidence, and relied on clinical expertise where evidence was lacking. The two primary workgroup focus areas were on implementing broad use of appropriateness standard to manage symptoms or conditions prior to considering hysterectomy and, if a hysterectomy is to proceed, using minimally invasive procedures. 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, emergencies (e.g., due to trauma, childbirth), gender reassignment surgery, and oophorectomy.

The workgroup encourages following the enhanced recovery after surgery (ERAS) protocol and using a minimally invasive approach, when appropriate. The 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.[16,17] Multiple studies have shown a minimally invasive approach has fewer complications (e.g., infection, urinary tract injuries) and a shorter hospital stay for the patient.[18,19]

Opioid Prescribing Guideline Implementation

Opioids have been prescribed at too high a dose, for too many days following surgery—or for inappropriate conditions—fueling the opioid epidemic. This is an ongoing workgroup focused on implementing the Washington State Agency Medical Directors Guideline on Prescribing Opioids for Pain, endorsed by the Collaborative in July 2015. The workgroup has met since December 2015. Two primary focus areas have been to develop opioid prescribing metrics and a guideline on prescribing opioids in dentistry.

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

Opioid Prescribing Metrics

The Opioid Prescribing Metrics were adopted by Bree Collaborative members in July 2017 and endorsed by the Health Care Authority in August 2017. 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.

See the Opioid Prescribing Metrics: www.breecollaborative.org/wp-content/uploads/Bree-Opioid-Prescribing-Metrics-Final-2017.pdf

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.

The Oregon Health Authority has already 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

The Dental Guideline on Prescribing Opioids for Pain were adopted by Bree Collaborative members in September 2017 and endorsed by the Health Care Authority in October 2017. Acute pain management poses many challenges to providers regarding treatment decisions, improving quality of recovery, and identifying patients at risk for poor pain management or uncontrolled pain. Assessing patients and proposing pain management plans that minimize risk while optimizing benefits is incumbent on providers. Good practice involves skilled initial patient assessment, individualized pain management strategies, effective intervention, and re-assessment as necessary.

See the Guideline: 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.

Clinician Outreach

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.

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

Implementation

Bree Collaborative recommendations have been championed by the Health Care Authority and 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, Bree Collaborative recommendations are included in the two Accountable Care Network options: UMP Plus—Puget Sound High Value Network, led by Virginia Mason Medical Center, and UMP Plus—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, the Health Care Authority 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. Starting January 2017, state employees enrolled in the Public Employee Benefits Board Program's Uniform Medical Plan Classic or UMP Consumer-Directed Health Plan can select Virginia Mason for this procedure. The bundle will be administered by Premera Blue Cross.

Implementing recommendations has been a focus of the Bree Collaborative since October 2013. This process includes work by the Implementation Team led by Dr. Dan Lessler, Chief Medical Officer, Health Care Authority, and through a comprehensive implementation survey and roadmap, and community engagement. Collaborative implementation activities focus on education, consensus-building, outreach, and engagement including:

- Outreach to community groups (e.g., WSHA, WSMA, the Washington Dental Service Foundation, Delta Dental, the Washington State Public Health Association, Kaiser Permanente, CHI Franciscan).
- Participation in multiple Healthier Washington meetings and workgroups (e.g., Clinical Engagement Accelerator Committee, 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, Washington Health Alliance Purchasers Affinity Group, National Attorneys General Training and Research Institute, Cambia Grove Episodes of Care Summit, Washington Patient Safety Coalition Northwest Patient Safety Conference).
- Increasing Collaborative visibility through keeping the website relevant (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:

- *Obstetrics*: Both the Obstetrics Clinical Outcomes Assessment Program (OB-COAP) and the Washington State Hospital Association's Safe Deliveries Roadmap have worked to align existing program expectations and data collection with Bree Collaborative recommendations for member hospitals.
- *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.
- *Bundled Payments*: The Puget Sound High Value Network, led by Virginia Mason Medical Center, and the UW Medicine Accountable Care Network have implemented the clinical components of the total knee and total hip replacement bundled payment model and lumbar fusion bundled payment model. Virginia Mason Medical Center now offers the total knee and total hip replacement as a bundle to qualifying public employees.
- *Spine Care:* Spine SCOAP has maintained enrollment at 16 hospitals. As of August 2014, length of stay, radiologic verification of surgical level, and smoking use have been transparently available on the website, with data expected to be updated again in late Fall 2017. Over the past year, the program has been active with multiple quality improvement projects and papers, primarily on the topics of glucose control, opioids, and smoking cessation. The program has also moved forward with preliminary research on a predictive model of spine surgery outcomes, with a goal to identify patients who would most likely benefit from spine surgery.
- *Hospital Readmissions*: Qualis Health has been actively facilitating hospital readmissions collaboratives in Washington State communities since August 2014.
- *End-of-Life Care*: WSHA and WSMA have developed a statewide strategy to spread advance care planning at the health system and community levels, aligned with the Bree Collaborative's recommendations. The two associations are working to promote patient-centered end-of-life conversations through Honoring Choices®: Pacific Northwest.
- *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 End-of-Life Care recommendations and with the Oncology Care Recommendations and focused on end-of-life care for cancer patients.

Implementation Survey

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 links to 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 focuses on implementing Bree Collaborative recommendations and providing guidance and support for clinicians, medical groups, hospitals, health plans, and purchasers based on implementation science, interviews, and surveys of these and other stakeholders for recommendations developed from 2012 to mid-2016 (thirteen topics).

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

For each of the recommendations, the Roadmap outlines steps that provider organizations and health plans can take to move from the current state to the ideal state. The Roadmap lists transition activities and methods to sustain best-practice care including tools for assessment, communication, and planning to help facilitate adoption of our recommendations into clinical practice.

Common elements that support and hinder implementation were found for hospitals, medical groups, and health plans. The Roadmap includes strategies to overcome barriers and highlights methods that practices have used for successful implementation. The lack of a business case or financial incentive were top barriers for care providers while insufficient market share was a top barrier for health plans. Multiple health plans, each with their own performance measures and incentives, individually have diminished influence in a fragmented system. To address this barrier, the Roadmap describes efforts within Washington State and includes examples from other states where health plans have combined efforts to create a shared, common set of performance measures and financial incentives. The most commonly reported factors that facilitate or stand in the way of adoption of Bree Collaborative recommendations as reported in the survey are shown below for providers and for health plans.

Table 2: Top facilitators 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

Summary of Work in the First Five Years

The engagement and dedication from our workgroup members has led to multiple high-quality and well-received sets of recommendations. From the Collaborative's founding in 2011 to November 2017 we have developed recommendations to improve obstetric care; cardiology; bundled payment models for elective total knee and total hip replacement; elective lumbar fusion; elective coronary artery bypass surgery; bariatric surgery; spine surgery; low back pain management; potentially avoidable hospital readmissions; end-of-life care; addiction and dependence screening; prostate cancer screening; oncology care; pediatric psychotropic use; and behavioral health integration. Topics are discussed in this order.

See **Appendix D** for a complete list of Collaborative workgroup members.

Contents

Obstetric Care

The Obstetric Care Report and Recommendations was adopted by the Bree Collaborative adopted in August 2012 and approved by the Health Care Authority in October 2012.

> **Read the Report here:** www.breecollaborative.org/wp-content/uploads/bree_ob_report_final_080212.pdf

Background

Initial Bree Collaborative conversations found substantial variation in obstetric care practice patterns and services across providers and facilities in Washington State despite local and national quality improvement efforts. In 2012, the percent of deliveries performed between 37 and 39 weeks that were not medically necessary varied significantly across Washington hospitals, from zero to 18.5%.[20]

Our Work

The Obstetric Care workgroup met from December 2011 to July 2012. Workgroup members represented multiple groups including clinicians with expertise in obstetrics and gynecology and those representing various delivery systems in Washington State. The report identified three focus areas and goals for obstetric care improvement:

- **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.** Decrease unsupported variation among Washington hospitals in C-section rate of women who have never had a C-section.

Implementation

The Health Care Authority has implemented a non-payment policy for early elective deliveries. The 2016 implementation survey found high rates of recommendation adoption among hospitals and medical groups (see Table 3).

Table 3: Obstetric care recommendation adoption rates

	Hospitals	Medical Groups	Health Plans
Obstetric Care	2.8 (1.9-3.0)	2.8 (2.4-3.0)	2.0 (1.0-3.0)
0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption			

Of hospitals participating in the Obstetrics Clinical Outcomes Assessment Program, primary cesarean rate has continued to decrease, from 18.1% in 2014, 17.4% in 2015, to 17.0% in 2016 (for hospitals participating continuously). The overall hospital primary cesarean rate was 19.3% in 2016 including hospitals newly joining the program. The percent of spontaneously laboring women admitted at 4cm dilated or more has increased from 61.5% in 2014, 66.2% in 2015, to 68.7% in 2016.

The Safe Deliveries Roadmap program at the Washington State Hospital Association reports an early elective delivery rate of 1.2% for quarter four 2016 representing a 92% reduction in early elective deliveries from the 2010 baseline of 15.5%. In addition, the primary term cesarean section rate (provided by Health Care Authority) decreased 14% from baseline for the same time period. These achievements can be attributed to a collaborative effort involving data reports to facilities, Safe Table conference education, and peer learning opportunities.

Cardiology

The Cardiology Report and Recommendations was adopted by the Bree Collaborative in January 2013 and approved by the Health Care Authority in January 2014.

> **Read the Report and Recommendations here:** www.breecollaborative.org/wp-content/uploads/bree_bc_cardiology_final.pdf

Background

Percutaneous coronary intervention (PCI), also known as angioplasty, is a non-surgical procedure used to treat excess plaque in the arteries. While the majority of these procedures are done appropriately and successfully as needed for emergency cardiovascular conditions, a significant number are done electively and may not benefit patients in the same way. Data from the Clinical Outcomes Assessment Program (COAP), a program also housed within the Foundation for Health Care Quality, shows wide variation in the appropriateness of PCI procedures as defined by national guidelines. However, availability and transparency of appropriateness data had been a major issue across Washington State hospitals.

Our Work

In February 2012, the Bree Collaborative asked the COAP management committee to publicly post hospitals' insufficient information reports and appropriateness of PCI results rather than supplying this data only to individual hospitals. The Cardiology Report and Recommendations, developed in partnership with the COAP management committee, recommended a four-step process that provided time for hospitals to improve practices before data became publicly available:

- **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 across 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). 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. The average rate of *insufficient information to determine appropriate use of non-acute PCI* has continued to decrease from 29% in 2011 to 24% in 2015 to 22.6% in 2016.

Accountable Payment Models: Elective Total Knee and Total Hip Replacement

Previous Work

Total knee and total hip replacements are frequent surgical procedures, but also have high facility-to-facility variability in how surgery is performed. This variability can lead to variation in readmission rates, quality, cost, and patient health. Bree Collaborative members in October 2013 elected to publish hospital readmission rates for total knee and total hip replacements.

> **Read the hospital readmission rates for total knee and total hip replacements here:** www.breecollaborative.org/wp-content/uploads/bree_summary_CHARS_Analysis.pdf

The warranty was formally adopted by the Bree Collaborative in July 2013 and the bundle in November 2013. Both were approved by the Health Care Authority Director in April 2014.

> **Read the Bundled Payment Model here:** www.breecollaborative.org/wp-content/uploads/tkrthr_bundle.pdf
> **Read the Warranty here:** www.breecollaborative.org/wp-content/uploads/bree_warranty_tkr_thr.pdf
> **Read the evidence table here:** www.breecollaborative.org/wp-content/uploads/tkr_thr_evidence.xls

Implementation

The 2016 implementation survey found high rates of adoption of the recommendations among hospitals and low rates among health plans.

Table 4: Total Knee and hip replacement recommendation adoption rates

	Hospitals	Medical Groups	Health Plans
Knee and Hip Replacement Surgical Bundle	2.3 (1.7-3.0)	-	1.0 (0.0-2.0)
0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption			

The total knee and total hip replacement bundle and warranty have been incorporated into the Health Care Authority's Accountable Care Network contracts and offered to public employees starting January 2016. Virginia Mason Medical Center now offers the bundle and warranty to public employees as the Health Care Authority-contracted Center of Excellence as of January 2017.

Accountable Payment Models: Elective Lumbar Fusion

The Lumbar Fusion Surgical Bundle and Warranty were adopted by the Bree Collaborative in September 2014 and approved by the Health Care Authority in October 2014.

> **Read the Lumbar Fusion Bundled Payment Model here:** www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Bundle-Final.pdf
> **Read the Lumbar Fusion Warranty here:** www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Warranty-Final.pdf
> **Read the evidence table here:** www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Evidence-Table-Final.pdf

Background

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.[21] Lumbar fusion also has the highest inpatient cost for public employees with 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. [22] Some studies show that the surgery may not result in better health than non-surgical alternatives.[23]

Our Work

The Accountable Payment Models workgroup re-formed with new membership and met from January 2014 to August 2014 to develop surgical standards and payment methodologies for elective lumbar fusion. The workgroup adapted the previously developed elective total knee and total hip replacement model. As in the previous case, to improve patient safety, performance for providers, and affordability for purchasers, the workgroup proposed 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 medium rates of adoption of the recommendations among hospitals and low rates among health plans.

Table 5: Elective lumbar fusion recommendation adoption rates

	Hospitals	Medical Groups	Health Plans
Lumbar Fusion Surgical Bundle	1.9 (0.3-2.9)	-	0.7 (0.0-2.0)
0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption			

The lumbar fusion bundle and warranty have been incorporated into the Health Care Authority's Accountable Care Network contracts and offered to public employees starting January 2016.

Accountable Payment Models: Coronary Artery Bypass Graft Surgery

The Coronary Artery Bypass Graft (CABG) Surgical Bundle and Warranty were adopted by the Bree Collaborative in September 2015 and approved by the Health Care Authority 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

Background

Coronary artery disease occurs due to plaque build-up on arterial walls and is the leading cause of death in the United States.[24] This is often treated with (CABG). CABG surgery has high variation in price, utilization, and complication rates between providers and institutions.[25] Bundled payments offer a mechanism to improve and standardize this care and have been shown to reduce cost along with improving patient outcomes.[26]

Our Work

The workgroup convened from February to September 2015 to develop a bundled payment model and warranty for elective CABG surgery using 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.

Table 6: Coronary artery bypass graft surgery recommendation adoption rates

	Hospitals	Medical Groups	Health Plans
Coronary Artery Bypass Graft Surgical Bundle	2.2 (2.0-2.8)	-	0.4 (0.0-1.0)
0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption			

Accountable Payment Models: Bariatric Surgery

The Bariatric Surgical Bundled Payment Model and Warranty were adopted by the Bree Collaborative in November 2016 and approved by the Health Care Authority 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

Background

The National Institutes of Health (NIH) defines obesity as a BMI of equal to or greater than 30 kg/m^2.[27] According to this NIH definition, over one third of adults are obese in the United States. 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 annually.[28] While there is no reliable long-term cure, even modest reductions in weight loss by any of a number of methods can convey benefit by controlling associated conditions such as diabetes, high blood pressure, and high cholesterol.

Our Work

The workgroup met from February to November 2016 to develop a bundled payment model and warranty for bariatric surgery using 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

The Bariatric Bundled Payment Model was adopted in late 2016 and therefore not included in the 2016 implementation survey.

Low Back Pain and Spine Surgery

The Low Back Pain Report and Recommendations was adopted by the Bree Collaborative in November 2013 and approved by the Health Care Authority in January 2014.

> **Read the Report and Recommendations here:** www.breecollaborative.org/wp-content/uploads/spine_lbp.pdf

Background

Low back pain is a common and costly condition with significant variation in diagnosis and treatment. Frequent use of costly treatments has not been shown to improve patient symptoms and effective management can be difficult as the majority of patients have no identifiable anatomic or physiologic cause.[29,30,31] For most patients with acute low back pain, symptoms improve with conservative treatment, such as physical activity, but some patients are at higher risk of developing chronic pain. If patients do develop chronic pain, more intense treatment options such as lumbar fusion surgery, described previously become necessary.

Our Work

The Bree Collaborative chose a two-pronged strategy to address both acute and chronic low back pain to first form a workgroup to develop recommendations for preventing the transition of acute pain to chronic pain and also recommend that all hospitals participate in Spine SCOAP, a clinician-led quality improvement collaborative for hospitals in Washington State and a program of the Foundation for Health Care Quality, to improve surgical outcomes for spine surgery.

In March 2013, the Bree Collaborative submitted recommendations to the Health Care Authority strongly recommending participation in Spine SCOAP as a community standard and requiring that information be transparent. The Low Back Pain workgroup met from November 2012 to October 2013. Focus areas include increasing:

- 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.

Table 7: Low back pain and spine surgery recommendation adoption rates

	Hospitals	Medical Groups	Health Plans
Low-Back Pain	2.0 (1.0-3.0)	1.8 (0.5-2.8)	1.2 (0.7-1.7)
0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption			

Spine SCOAP has maintained enrollment at 16 hospitals. As of August 2014, length of stay, radiologic verification of surgical level, and smoking use have been transparently available on the website. Data will be updated again in late Fall 2017.

Potentially Avoidable Hospital Readmissions

The Potentially Avoidable Hospital Readmissions Report and Recommendations was adopted by the Bree Collaborative in July 2014 and approved by the Health Care Authority in August 2014.

> **Read Report and Recommendations here:** www.breecollaborative.org/wp-content/uploads/Readmissions-Report-FINAL-14-0730.pdf

Background

Avoidable hospital readmissions are common and costly events, negatively impacting patient health and wellbeing. The estimated national cost for unplanned Medicare hospital readmissions was $17.4 billion in 2004.[32] While not all hospital readmissions are preventable, reducing readmission rates through greater community collaboration among diverse stakeholders, implementation of standard processes within the hospital, and better communication represents a great opportunity to improve health care quality, outcomes, and affordability.

Our Work

The Potentially Avoidable Readmissions workgroup met from May to September 2012 and made available 30-day, all-cause readmission rates by hospital.

> **Read the 30-day, all-cause re-hospitalization rates at Washington State hospitals from 2011 CHARS data here:** www.breecollaborative.org/wp-content/uploads/combined-chars-report-13-1114.pdf

The workgroup re-formed from April to June 2014 to develop more comprehensive recommendations including:

I. **Forming Collaboratives**: Hospital readmissions collaboratives to be recognized by:
   a. Formally writing a charter including participating organizations, shared expectations for best practices, and measures of success.
   b. Demonstrating evidence of participation in recurring meetings.
   c. Recognition by WSHA or Qualis Health as an active member. WSHA or Qualis Health will recognize collaboratives for a period of one year after which time the organizations will reevaluate their roles.

II. **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. The Bree Collaborative recognizes the consensus work based on best available evidence that went into the *Care Transitions Toolkit* and recommends that hospitals adopt the *Toolkit* in its entirety. It is understood that some variation may be appropriate based on clinically compelling reasons.

III. **Measurement:** Two hospital-specific measures aligned with the Medical Quality Incentive Program measured by WSHA. Percent of inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition) with:

a. A patient discharge information summary provided to the primary care provider (PCP) or aftercare provider within three business days from the day of discharge.

b. A documented follow-up phone call with the patient and/or family within three business days from the day of discharge**.**

Implementation

The 2016 implementation survey found medium rates of adoption of the recommendations among hospitals and high rates among medical groups and health plans.

Table 8: Potentially avoidable hospital readmissions recommendation adoption rates

	Hospitals	Medical Groups	Health Plans
Avoidable Hospital Readmissions	1.6 (0.0-3.0)	2.5 (1.8-3.0)	2.7 (2.0-3.0)
0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption			

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 receives technical assistance from the Qualis Health team with the 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.

The Qualis Health team assists the cohort communities in establishing, facilitating, and sustaining community coalitions focused on care transitions. Membership in the coalitions include representatives of hospitals, nursing homes, outpatient providers, pharmacies, emergency medical service providers (Fire Departments), social service agencies such as Area Agencies on Aging, patients, and others. The Qualis Health team uses data to identify populations at highest risk for readmissions and encourages communities and providers to focus efforts on those populations experiencing inequity in readmission rates. Qualis Health also provides data reports and technical assistance upon request to all sixteen communities and serves as a subcontractor to the WSHA HIIN, partnering with the WSHA team to provide deep-dive assistance to hospitals in their care transitions/reducing readmissions efforts. The work under the CMS QIN-QIO contract will continue through mid-2019.

In 2016, the Washington State Hospital Association reported a 4.76% relative reduction in readmissions per 100 Medicare discharges from WSHA's 2014 baseline. This was accomplished through the Washington State Hospital Association's partnership with Qualis Health by holding Safe

Table Learning Collaboratives and working one-on-one with hospitals to improve care transitions and reduce readmissions.

End-of-Life Care

The End-of-Life Care Report and Recommendations was adopted by the Bree Collaborative in November 2014 and approved by the Health Care Authority in December 2014.

> **Read the Report and Recommendations here:** www.breecollaborative.org/wp-content/uploads/EOL-Care-Final-Report.pdf

Background

End-of-life care in the United States and within Washington State is strikingly variable and often misaligned with patient preference.[33,34] 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.[35] Family members also report end-of-life patient care not aligning with patient wishes, such as unwanted aggressive, treatment and the significant financial impact of in-hospital deaths.[36,37]

Surviving family members have been shown to have symptoms of post-traumatic stress disorder after the death of a loved one in an intensive care unit.[38] Care that is at odds with patient and family wishes negatively impacts patient quality of life, increases cost to families, and seriously overburdens patients and their families. Appropriately timed advance care planning conversations between providers and patients and between patients and their families and/or caregivers, and expressing end-of-life wishes in writing with advance directives and Physician Orders for Life Sustaining Treatment (POLST) if appropriate, can increase patient confidence, sense of dignity, and the probability that patient wishes are honored at the time of death.[39,40]

Our Work

The workgroup met from January to November 2014 with the 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. The workgroup developed the following five focus areas corresponding to how an individual would ideally experience advance care planning for the end of life.

- Increase awareness of advance care planning, advance directives, and 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.

Table 9: End-of-life care recommendation adoption rates

	Hospitals	Medical Groups	Health Plans
End-Of-Life Care	2.2 (1.7-2.6)	1.7 (0.0-2.5)	1.8 (1.0-3.0)
0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption			

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, a joint initiative of the Washington State Hospital Association and Washington State Medical Association, has been progressing toward the vision that everyone will receive care that honors personal values and goals in the last chapters of life. During the initial, 18-month implementation phase, over 700 individuals have participated in a facilitated advance care planning conversation at 46 "test of change" sites in 26 healthcare organizations. Impressively, individuals who have a First Steps® facilitated conversation at an Honoring Choices PNW partner location return completed advance directives at a rate of 34% to 42% higher than the state and national average; conversations include the health care agent or proxy 51% of the time, the gold standard for ensuring wanted care occurs. Participants place high value and significance on their facilitated conversation, rating their level of satisfaction with the experience at an average of 4.9 out of 5 and often encourage loved ones to schedule a facilitated conversation as well. The second phase of the initiative will begin broadening advance care planning by spreading within established organizations, adding additional health care sites, and partnering with select community groups for grassroots development. For more information visit www.honoringchoicespnw.org.

Recommendations for advance care planning in primary and hospital care have also been incorporated into the Health Care Authority's Accountable Care Network contracting.

Addiction and Dependence Treatment

The Addiction and Dependence Treatment Report and Recommendations was adopted by the Bree Collaborative in January 2015 and approved by the Health Care Authority in February 2015.

> **Read the Report and Recommendations here:** www.breecollaborative.org/wp-content/uploads/ADT-Final-Report.pdf

Background

Alcohol and drug abuse disorders lead to many debilitating health, economic, interpersonal, and social consequences with potentially long-lasting effects if left untreated. Excessive use of alcohol is the fourth leading cause of preventable death in the United States and is strongly associated with higher risk of multiple types of cancers, hypertension, liver cirrhosis, chronic pancreatitis, injuries, and violence.[41,42] In Washington State, alcohol use leads to 11.1% of deaths of working age adults, higher than the national average.[43] Medicaid beneficiaries with a substance use disorder had significantly higher physical health expenditures and hospital admissions.[44] Nationally, the economic cost of illicit drug use is more than $193 billion, including the impact on crime (e.g., criminal justice system, crime victims), health (e.g., hospital and emergency room costs), and productivity (e.g., labor participation, premature mortality).[45] High variation and lack of standardized screening protocols for alcohol and drug use in our state show opportunities for improvement.

Our Work

The workgroup met from April 2014 to January 2015 and developed five focus areas to increase appropriate screening, brief intervention, brief treatment, and facilitated referral to treatment in primary care clinics and emergency room settings to address the underutilization of drug and alcohol screening and treatment within Washington State. Each focus area is supported by multi-stakeholder recommendations.

- 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 addiction epidemic

Implementation

The 2016 implementation survey found the lowest overall rate of adoption.

Table 10: Addiction and dependence treatment recommendation adoption rates

	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)
0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption			

Recommendations for screening, brief intervention, and referral to treatment have been incorporated into the Health Care Authority's Accountable Care Network contracting.

Prostate Cancer Screening

The Prostate Cancer Screening Report and Recommendations was adopted by the Bree Collaborative in November 2015 and approved by the Health Care Authority in January 2016.

> **Read the Report and Recommendations here:** www.breecollaborative.org/wp-content/uploads/Prostate-Cancer-Recommendations-Final-15-11.pdf

Background

Prostate cancer is the most common type of cancer diagnosed among men.[46] Men have a lifetime risk of 14% with an average five year survival of 98.9%.[47] 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.[48,49] The potential for overtreatment or treatment when no disease is present is high.[50] The majority of harms from prostate cancer screening occur due to psychological consequences of a positive test, in those that do have a positive test, harms from biopsy, and in those that have a positive biopsy, harms from the treatment itself. Guidelines on using the PSA test for routine prostate cancer screening differ on whether health care providers should initiate a discussion about PSA testing with all men in an appropriate age range (e.g., 55-69) and risk category or discuss screening only at the patient's request.[51,52] Despite these recommendations and those of others, use of a shared decision-making process is uncommon and variable and many men given the test are not informed of the potential harms, benefits, and scientific uncertainty.

Our Work

The workgroup met from March to November 2015. The Bree Collaborative recommends that all men be evaluated by their provider for family history and factors that may elevate the risk of prostate cancer (e.g., first or second degree relative with a prostate or breast cancer diagnosis, race). The Bree Collaborative recommends against 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, the Bree Collaborative recommends 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.

Table 11: Prostate cancer screening recommendation adoption rates

	Hospitals	Medical Groups	Health Plans
Prostate Cancer Screening	2.3 (2.0-3.0)	1.6 (0.0-2.8)	0.7 (0.0-3.0)
0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption			

Oncology Care

The Oncology Care Report and Recommendations was adopted by the Bree Collaborative in March 2016 and approved by the Health Care Authority in April 2016.

> **Read the Report and Recommendations here:** www.breecollaborative.org/wp-content/uploads/Oncology-Care-Final-Recommendations-2016-03.pdf

Background

Cancer death rates have declined in the United States from 2002-2011, due in part to great advances in cancer prevention and treatment.[53] However, cost of care has increased significantly, resulting in financial burden on patients and families. National surveys show significant financial impact on patients and families due to cancer treatment; 25% of those surveyed used up most or all of their savings.[54] Cost and quality can also vary, indicating the need for greater standardization and reduction in procedures that do not result in better patient health.[55,56]

Significant variation in diagnosis, treatment, and supportive care for patients promotes poor outcomes and excessive cost for patients and the health care system.[57] In 2012, the American Society of Clinical Oncology (ASCO) and the American Board of Internal Medicine partnered as part of Choosing Wisely to identify five tests or procedures "whose necessity is not supported by high-level evidence" and developed guidelines including around therapeutic effectiveness and palliative care and use of advanced imaging for staging of low risk breast and prostate cancer.[58]

Our Work

The workgroup met from May 2015 to March 2016 to develop recommendations and implementation strategies around two of the ASCO Choosing Wisely guidelines: advanced imaging for staging of low-risk breast and prostate cancer and palliative care. 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, the Bree Collaborative recommends that oncology care 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, their family members, and friends to discuss their goals of care and work with the care team to tailor care to patient goals.

Implementation

The 2016 implementation survey found high rates of adoption for hospitals and medical groups.

Table 12: Oncology care recommendation adoption rates

	Hospitals	Medical Groups	Health Plans
Oncology Care	2.1 (1.8-2.7)	2.2 (0.0-3.0)	1.4 (0.0-3.0)
0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption			

The Hutchinson Center for Cancer Outcomes Research is working on integrating goals of care conversations into oncology care.

Pediatric Psychotropic Use

The Pediatric Psychotropic Use Report and Recommendations was adopted by the Bree Collaborative in November 2016 and approved by the Health Care Authority in January 2017.

> **Read the Report and Recommendations here:** www.breecollaborative.org/wp-content/uploads/Antipsychotic-Recommendations-Final-2016.pdf

Background

Antipsychotic prescribing rates have dramatically and consistently increased for adolescents and young adults.[59] Nationally, between 2002 and 2007, there has been a 62% increase in atypical antipsychotic (or second-generation) use among children enrolled in Medicaid.[60] These 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.[61] 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.[62]

Our Work

This workgroup met from January to November 2016 to develop recommendations targeted at children and adolescents under age 21 without a diagnosis of an FDA-approved indication for an antipsychotic prescription. The workgroup has focused on evidence-based first-line treatments for aggressive, impulsive, and disruptive behaviors in the absence of psychosis, including psychosocial therapies. However, there is a lack of alternative effective and low-harm pharmacotherapy options or accessible and cost-effective behavioral therapy options, especially outside of urban areas. Focus areas include:

- 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).

These recommendations were adopted in late 2016 and therefore not included in the 2016 implementation survey.

Behavioral Health Integration

The Behavioral Health Integration Report and Recommendations was adopted by the Bree Collaborative in March 2017 and approved by the Health Care Authority in April 2017.

> **Read the Report and Recommendations here:** www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf

Background

Approximately 16-23% of Americans experience a major depressive episode in their lifetimes, 7.6% in any two-week period.[63,64,65] On average, 80 million Americans visit an ambulatory care center with major depressive disorder as their primary diagnosis.[63] 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.[66]

Behavioral health, encompassing mental health and substance abuse, has traditionally been siloed from physical health care. There is 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; the need for connecting a greater variety and number of clinicians, specialists, and organizations; lower use of health information technology; and barriers in the health insurance marketplace.[67] Partially due to these barriers and to a lack of education and training among clinicians, screening for and comprehensive access to treatment for depression

happen infrequently.[68] This is especially true in Washington State which has been ranked 48th on measures of need for mental health services compared to access.[69]

Our Work

The workgroup met from April 2016 to March 2017 to develop recommendations to integrate 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. Our workgroup found it important to define 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. These eight elements are meant to bridge the different models used throughout Washington State and across the country and include:

- 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

These recommendations were adopted in 2017 and therefore not included in the 2016 implementation survey.

Looking Forward to Year Seven

The Bree Collaborative will continue to be a key part of building a Healthier Washington. The Bree Collaborative has a direct relationship to Health Care Authority contracting through the Accountable Care Networks and the Center of Excellence for total knee and total hip replacement bundled payment model. Through a strong partnership with the practice transformation support hub, Healthier Washington's practice change dissemination and implementation center, the Bree Collaborative will continue to educate and transform health care delivery to improve health care quality, outcomes, and affordability in Washington State.

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 Accountable Payment Models: Total Hip Replacement Re-Review, Alzheimer's Disease and Other Dementias, and Opioid Use Disorder Treatment will meet in November 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 2017. The Hysterectomy workgroup anticipates finalizing recommendations for presentation at the January 2018 meeting.

The Bree Collaborative will continue to convene the Agency Medical Director's Group Opioid Prescribing Guidelines workgroup and will also form workgroups in early 2018 for LGBTQ health care, collaborative care for chronic pain, suicide prevention, and to re-review the lumbar fusion bundled payment model and warranty.

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Appendix A: Bree Collaborative Background

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 Health Care Authority 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
Susie Dade MS	Deputy Director	Washington Health Alliance
John Espinola MD, MPH	Executive Vice President, Health Care Services	Premera Blue Cross
Gary Franklin MD, MPH	Medical Director	Washington State Department of Labor and Industries
Stuart Freed MD	Chief Medical Officer	Confluence Health
Richard Goss MD	Medical Director	Harborview Medical Center – University of Washington
Jennifer Graves, RN, MS	Senior Vice President, Patient Safety	Washington State Hospital Association
Christopher Kodama MD	President, MultiCare Connected Care	MultiCare Health System
Daniel Lessler MD, MHA	Chief Medical Officer	Washington State Health Care Authority
Paula Lozano MD, MPH	Associate Medical Director, Research and Translation	Kaiser Permanente
Wm. Richard Ludwig MD	Chief Medical Officer, Accountable Care Organization	Providence Health and Services
Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
Robert Mecklenburg MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Kimberly Moore MD	Associate Chief Medical Officer	Franciscan Health System
Carl Olden MD	Family Physician	Pacific Crest Family Medicine, Yakima
Mary Kay O'Neill MD, MBA	Partner	Mercer
John Robinson MD, SM	Chief Medical Officer	First Choice Health
Terry Rogers MD (Vice Chair)	Chief Executive Officer	Foundation for Health Care Quality
Jeanne Rupert DO, PhD	Medical Director, Community Health Services	Public Health – Seattle and King County
Kerry Schaefer	Strategic Planner for Employee Health	King County
Bruce Smith MD	Medical Director	Regence Blue Shield
Lani Spencer RN, MHA	Vice President, Health Care Management Services	Amerigroup
Hugh Straley MD (Chair)	Retired	Medical Director, Group Health Cooperative; President, Group Health Physicians
Shawn West MD	Family Physician	Edmonds Family Medicine

Appendix C: Steering Committee Members

Member	Title	Organization
Stuart Freed MD	Chief Medical Officer	Confluence Health
Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
Jason McGill JD	Health Policy Advisor	Governor's Office
Robert Mecklenburg MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Mary Kay O'Neill MD, MBA	Partner	Mercer
Terry Rogers MD	Retired	
Bruce Smith MD	Medical Director	Regence Blue Shield

Appendix D: Workgroup Members

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

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

Accountable Payment Models: Bariatric Surgery Workgroup Members

Member	Title	Organization
David Arterburn, MD, MPH	Physician, Internal Medicine Group Health Research Institute Senior Investigator	Group Health Cooperative
Sharon Eloranta, MD	Medical Director, Quality and Safety Initiatives	Qualis Health
Kristin Helton, PhD	Consumer	
Jeff Hooper, MD	Medical Director, Weight Loss Program	MultiCare Health System
Dan Kent, MD	Chief Medical Officer	United Health Care
Saurabh Khandelwal, MD	Bariatric Surgeon	University of Washington
Robert Mecklenburg, MD (Co-Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Robert Michaelson, MD, PhD, FACS, FASMBS	President	Washington State Chapter, American Society for Metabolic and Bariatric Surgery
Thien Nguyen, MD	Bariatric Program Medical Director	Overlake Medical Center
Tom Richards	Consumer	
Kerry Schaefer (Co-Chair)	Strategic Planner for Employee Health	King County
Jonathan Stoehr, MD/ Jeff Hunter, MD	Endocrinologist/ Bariatric Surgeon	Virginia Mason Medical Center
Brian Sung, MD	Bariatric Surgery Director	Swedish Medical Center
Tina Turner	Senior Internal Consultant	Premera Blue Cross
Richard Thirlby, MD	Medical Director	Surgical Care and Outcomes Assessment Program (SCOAP)

Accountable Payment Models: Coronary Artery Bypass Surgery

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

Accountable Payment Models: Lumbar Fusion

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

Accountable Payment Models: Total Knee and Total Hip Replacement

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

Addiction/Dependence Treatment

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

Alzheimer's Disease and Other Dementias

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

Behavioral Health Integration

Member	Title	Organization
Brad Berry	Executive Director	Consumer Voices Are Born
Regina Bonnevie, MD	Medical Director	Peninsula Community Health Services
Mary Hodge-Moen, MSW, LMHC, CDP, CCM	Sr. Manager, Clinical Review	Premera
Rose Ness, MA, LMHC, CDP	Behavioral Health Expert	Sound Integration for Behavioral Healthcare
Mary Kay O'Neill MD, MBA	Partner	Mercer
Joe Roszak	CEO	Kitsap Mental Health Services
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
Brian Sandoval, PsyD	Behavioral Health Manager, Oregon and Washington Services	Yakima Valley Farmworkers Clinics
Lani Spencer, RN, MHA	Vice President	Health Care Management Services, Amerigroup – Washington
Emily Transue, MD, MHA	Senior Medical Director	Coordinated Care

Bree Implementation Team

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

End-of-Life Care

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

Hospital Readmissions

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

Hysterectomy

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

Low Back Pain

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

Obstetric (Maternity) Care

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

Oncology Care

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

Opioid Prescribing Guideline Implementation

Name	Title	Organization
Chris Baumgartner	Director Prescription Monitoring Program	Department of Health
David Buchholz, MD	Medical Director of Provider Engagement	Premera
Tanya Dansky, MD	Chief Medical Officer	Amerigroup
Gary Franklin, MD, MPH (Chair)	Medical Director	Department of Labor and Industries
Charissa Fontinos, MD, MSc	Deputy Chief Medical Officer	Health Care Authority
Frances Gough, MD	Chief Medical Officer	Molina Healthcare
Kathy Lofy, MD	Chief Science Officer	Department of Health
Jaymie Mai, PharmD	Pharmacy Manager	Department of Labor and Industries
Mark Murphy, MD	Addiction Medicine	MultiCare Health System
Shirley Reitz, PharmD	Clinical Pharmacist Client Manager	OmedaRx, Cambia
Gregory Rudolph, MD	Addiction Medicine	Swedish Pain Services
Michael Schiesser, MD	Addiction Medicine	EvergreenHealth Medical Center
Danny Stene, MD	Medical Director	First Choice Health
Mark Stephens	President	Change Management Consulting
Hugh Straley, MD	Chair	Bree Collaborative
David Tauben, MD	Chief of Pain Medicine	University of Washington (UW) Medical Center
Gregory Terman MD, PhD	Professor	Dept. of Anesthesiology and Pain Medicine; Graduate Program, Neurobiology and Behavior, UW
Emily Transue, MD	Chief Medical Director	Coordinated Care
Michael Von Korff, ScD	Senior Investigator	Group Health Research Institute
Melet Whinston, MD	Medical Director	United Health Care

Opioid Use Disorder Treatment

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

Prostate Cancer Screening

Member	Title	Organization
John Gore MD, MS	Urologist, clinician, surgeon, researcher	University of Washington Medicine
Matt Handley MD	Medical Director, Quality	Group Health Cooperative
Leah Hole-Marshall JD	Medical Administrator	Department of Labor & Industries
Steve Lovell	Retired	Patient and Family Advisory Council
Wm. Richard Ludwig MD (Chair)	Chief Medical Officer	Providence Accountable Care Organization
Bruce Montgomery MD	Clinical Director of Genitourinary Medical Oncology	Seattle Cancer Care Alliance
Eric Wall MD, MPH	Market Medical Director	UnitedHealthcare
Shawn West MD	Family Physician	Edmonds Family Medicine
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
Shelley Dooley	Parent Advocate	
Nalini Gupta MD	Pediatrician	Developmental and Behavioral Pediatrics Providence Health and Services
Robert Hilt MD	Director, Community Leadership; Director of Partnership Access Line	Seattle Children's
Paula Lozano MD, MPH (Chair)	Medical Director, Research and Translation	Group Health Cooperative
Liz Pechous PhD	Clinical Director	ICARD, PLLC
Robert Penfold PhD	Co-investigator, Mental Health Research Network	Group Health Research Institute
James Polo MD MBA	Chief Medical Officer	Western State Hospital
David Testerman PharmD	Pharmacy Director	Amerigroup
Mark Stein PhD, ABPP	Director of ADHD and Related Disorders	Seattle Children's
Donna Sullivan PharmD, MS	Chief Pharmacy Officer	Washington Health Care Authority