Dr. Robert Bree Collaborative

BYLAWS

Legislation enacted in 2011 (HB 1311) created the Bree Collaborative (the Collaborative) to improve health care quality, outcomes and cost trends.

The Collaborative is a consortium of employers, health plans, providers, delivery systems, and quality improvement organizations working together to identify concerns with quality in health care and recommend evidence-based strategies for improvement. It is named in honor of the late Dr. Robert Bree, a key member of a previous group that focused on improving advanced imaging for our state.

In addition to the law and any administrative rules, these bylaws govern the organization and processes of the Collaborative.

Contents

1. Purpose and Mandate

1.1. There is broad recognition that efforts are needed across the health system to improve quality, outcomes for patients and cost-effectiveness of care. Some health care services currently provided in Washington State present significant safety, efficacy or cost-effectiveness concerns. Substantial variation in practice patterns or high utilization trends can be indicators of poor quality and potential waste in the health care system, without producing better care outcomes.

1.2. The purpose of the Bree Collaborative (Collaborative) is for health care purchasers, health carriers, providers and quality improvement experts to work together to identify topics with variation or quality concerns, and recommend up to three evidence-based strategies to improve quality and cost-effectiveness of care per year.

2. Membership and Terms

2.1. *Appointing Authority*

2.1.1. Per RCW 70.250.050(4) the Governor appoints members from specified sectors. This will be the exclusive method for appointment to the Collaborative.

2.1.2. Per RCW 70.250.050(6) the Collaborative "shall add members to its membership or establish clinical committees for each topic under review by the collaborative for the purpose of acquiring clinical expertise needed to accomplish its responsibilities." The Collaborative elects to meet this requirement by establishing clinical committees with the necessary expertise.

2.2. *Chair, Vice-Chair and Steering Committee*

2.2.1. Per RCW 70.250.050(5) the chair is appointed by the Governor.

2.2.2. A vice-chair will be selected by the chair.

2.2.3. The chair will form a steering committee to provide strategic advice to the chair and approve advisory groups, workgroup and clinical committee members. Membership will include the vice-chair and at least one representative from employers, health plans, providers, health systems/hospitals, and quality organizations.

2.2.4. The vice-chair shall act as the chair in the event the chair is unable to carry out his or her duties.

2.3. *Clinical Committees and Advisory and Work groups*

2.3.1. The Collaborative will establish clinical committees for each selected health care topic under review by the Collaborative for the purpose of acquiring clinical expertise needed to accomplish its responsibilities per RCW 70.250.010 and 70.250.030.

2.3.2. All clinical committees and workgroups will follow the Open Public Meetings Act per RCW 42.30.

2.3.3. Membership of clinical committees should reflect clinical expertise in the area of health care services being addressed by the Collaborative, including clinicians involved in related quality improvement or comparative effectiveness efforts, as well as non-physician practitioners.

2.3.4. Each clinical committee shall include at least two members of the specialty or subspecialty society most experienced with the health service identified for review.

2.3.5. The chair may establish temporary ad hoc advisory and work groups if specialized expertise is needed to review a particular topic.

2.3.6. Clinical committee membership must be approved by the Collaborative by majority vote.

2.3.7. Once formed and approved by the Collaborative, clinical committees and advisory and work groups shall create a charter, including objectives, tasks, and work plan, and ask for review and approval by the Collaborative.

2.3.8. Clinical committees and advisory and work groups will report back to the Collaborative.

2.3.9. Subject to funding, clinical committees, advisory and work groups will have project management support; project management support includes scheduling meetings, recording meeting minutes, research support and distributing meeting minutes for approval of advisory and workgroup members.

2.3.10. Clinical committees and advisory and work groups terms end when their final product(s) are completed and adopted by the Collaborative.

2.3.11. The Collaborative may elect by a majority vote of appointees to use committees and processes of other organizations (e.g. the Washington Health Alliance or Foundation for Health Care Quality) to meet the requirements of this section of the bylaws and RCW 70.250.050(6) as long as those committees have the appropriate numbers of specialty members. Any committees or processes used from other organizations are subject to the rules laid out in 2.3.5, 2.3.6, 2.3.7, 6.2.1, 6.2.2, and 6.2.3.

2.4. *Terms*

2.4.1. Collaborative members are initially appointed for a 3, 4 or 5-year term.

2.4.2. In the second year of the Collaborative, fall 2012, member term end dates will be drawn by lot so that approximately a third of the members' terms will end in the fall 2014, 2015 or 2016.

2.4.3. Newly appointed members will be assigned term limits drawn by lot to expire in the fall of 3, 4, or 5 years from the year of their appointment.

2.4.4. At the end of their term, members can be subject to re-nomination and appointment by the Governor for a 3-year term.

2.5. *Change in Collaborative membership*

2.5.1. If a member's organizational affiliation changes, he or she shall resign from the Collaborative.

2.5.2. The organization that was responsible for the original nomination has authority to nominate replacements for the departing members.

2.5.3. Nominated replacements shall be considered and appointed by the Governor.

3. Responsibilities

3.1. Topic Selection

3.1.1. Annually, "the Collaborative shall identify and select up to three health care services for which there is substantial variation in practice patterns or high utilization trends in Washington State, without producing better care outcomes for patients, which can be indicators of poor quality and potential waste in the health care system" per RCW 70.250.050(1).

3.1.2. The Collaborative shall consider items of priority recommended by the Washington Agency Medical Director Group for state payers.

3.1.3. Final products may be selected for re-review annually or if "new evidence suggests the need for modification of clinically important recommendations (e.g., if new evidence shows that a recommended intervention causes previously unknown substantial harm, that a new intervention is significantly superior to a previously recommended intervention from an efficacy or harms perspective, or that a recommendation can be applied to new populations)" one year after adoption.[i]

3.2. Development of Strategies and Recommendations for Selected Topics

3.2.1. The Collaborative will establish clinical committees for each selected health care topic under review by the Collaborative for the purpose of acquiring clinical expertise needed to accomplish its responsibilities per RCW 70.250.010 and 70.250.030. As mentioned previously, the Collaborative elects to meet this requirement by establishing clinical committees with the necessary expertise.

3.2.2. Per RCW 70.250.050(2)(a)(b)(c) for each health care service identified, the Collaborative shall [through the clinical committees and advisory and work groups]:

3.2.2.1. "Analyze and identify evidence-based best practice approaches to improve quality and reduce variation in use of the service, including identification of guidelines or protocols applicable to the health care service. In evaluating guidelines, the collaborative should identify the highest quality guidelines based upon the most rigorous and transparent methods for identification, rating, and translation of evidence into practice recommendations."

3.2.2.2. "Identify data collection and reporting necessary to develop baseline health service utilization rates and to measure the impact of strategies adopted under this section. Methods for data collection and reporting should strive to minimize cost and administrative effort related to data collection and reporting wherever possible, including the use of existing data resources and non-fee-based tools for reporting."

3.2.2.3. "Identify strategies to increase use of the evidence-based best practice approaches identified under (a) of this subsection in both state purchased and privately purchased health care plans."

3.2.3. Per RCW 70.250.050(2)(c), strategies considered should include, but are not limited to:

3.2.3.1. Identifying goals for appropriate utilization rates and reduction in practice variation among providers.

3.2.3.2. Peer-to-peer consultation or second opinions; provider feedback reports; use of patient decision aids; incentives for appropriate use of health care services.

3.2.3.3. Centers of excellence or other provider qualification standards.

3.2.3.4. Quality improvement systems.

3.2.3.5. Service utilization and outcomes reporting, including public reporting.

3.2.4. Per RCW 70.250.050(2)(c), if the Collaborative chooses a health care service for which there is substantial variation in practice patterns or a high or low utilization trend in Washington State, and a lack of evidence-based best practice approaches, it [through the Clinical Committees and Advisory and Work groups] should consider strategies that will promote improved care outcomes, such as:

3.2.4.1. Patient decision aids.

3.2.4.2. Provider feedback reports.

3.2.4.3. Centers of Excellence or other provider qualification standards.

3.2.4.4. Research to improve care quality and outcomes.

3.2.5. In developing strategies, the Collaborative [through the clinical committees and advisory and work groups] will consider related efforts of other organizations.

3.3. Final Products

3.3.1. For each topic selected, the Collaborative [through the clinical committees and advisory and work groups] will create a final product such as a letter or report with its recommendations or strategies.

3.3.2. All recommendations and final products of clinical committees and advisory and work groups must be approved by the Collaborative by majority vote.

3.3.3. Draft products will be posted on the Bree Collaborative website or a suitable alternative if the Bree Collaborative website is unavailable at least one week prior to consideration by the Collaborative. This posting will be announced on the Bree Collaborative listserv and individuals will be instructed to direct feedback to the Program Director at least 48 hours in advance of the next Collaborative meeting. Contact information for the Program Director will be included on the website and in the listserv email announcement.

4. Reporting and Review Requirements

4.1. Collaborative to the Washington State Health Care Authority administrator

4.1.1. Per RCW 70.250.050(1) the Collaborative is convened by the Washington State Health Care Authority (HCA).

4.1.2. The Collaborative will report status and topics selected to the HCA administrator regularly and at least by October 1st each year.

4.1.3. The Collaborative will update the HCA administrator of topics selected and changes to topic selections through minutes, or reports from the chair.

4.1.4. The Collaborative will provide its written topic reports and supporting materials to the HCA administrator. Per RCW 70.250.050(13) the administrator shall review the strategies recommended by the Collaborative. "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."

4.2. *Annual Report to the Legislature and Governor*

4.2.1. Per RCW 70.250.050(13) the Collaborative shall provide an annual report to the Legislature and the Governor regarding chosen health services, proposed strategies, and the results of the administrator's reviews.

5. Meetings and Meeting Materials

5.1. *Bree Collaborative Meetings*

5.1.1. The Collaborative meetings are public meetings and shall be conducted in an open and transparent manner so as to comply with the Open Public Meetings Act, RCW 42.30, as amended. An executive session is permissible during a regular or special meeting to consider proprietary or confidential non-published information when conducted according to RCW 42.30.110(1)(l), as amended.

5.1.2. Meetings will be at least quarterly, but may occur at other times at the discretion of the chair. Meetings shall be held at a time and place determined by the chair.

5.1.3. Advance notice of the date, time, location, and agenda or topics shall be published to the Bree Collaborative website or a suitable alternative if the Bree Collaborative website is unavailable.

5.1.4. If members are unable to attend, they may appoint a proxy.

5.1.5. Quorums, motions and voting will follow Roberts Rules of Order.

5.1.6. Collaborative meeting agenda, minutes, determinations, final products and other appropriate materials shall be published to the Bree Collaborative website or a suitable alternative if the Bree Collaborative website is unavailable.

Clinical Committee, Advisory Group and Work Group Meetings

5.1.7. If members are unable to attend, they may appoint a proxy.

5.1.8. Quorums, motions and voting will follow Roberts Rules of Order.

5.1.9. Frequency of meetings will be established by committee members and the committee chair.

5.1.10. Work papers between members of the committee may be posted for public review at the discretion of the committee chair.

6. Other

6.1. *State antitrust laws*

6.1.1. Per RCW 70.250.050 the legislature provided for exemption from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine, for activities undertaken pursuant to efforts designed and implemented under this act that might otherwise be constrained by such laws.

6.2. *Conflict of Interests*

6.2.1. Per RCW 70.250.050(7) members of the Collaborative or any of its committees may not have personal financial conflicts of interest that could substantially influence or bias their participation.

6.2.2. If a Collaborative or a committee member has a personal financial conflict of interest with respect to a particular health care service being addressed by the Collaborative, he or she shall disclose such an interest.

6.2.3. The Collaborative will determine whether the member should be recused from any deliberations or decisions related to that service.

6.3. *Liability*

6.3.1. Per RCW 70.250.050(8) a person serving on the Collaborative or any of its committees shall be immune from civil liability.

6.4. *Compensation*

6.4.1. Per RCW 70.250.050(11) no member of the Collaborative or its committees may be compensated for his or her service.

6.5. *Collaborative Member Reimbursement*

6.5.1. Collaborative members will not be reimbursed for meeting attendance or for travel expenses.

Funding

6.5.2. RCW 70.250.050(10) the Collaborative may solicit federal or private funds and in-kind contributions necessary to complete its work in a timely fashion.

6.5.3. Members may seek contributions from their respective employers/organizations or constituencies.

6.5.4. The Collaborative shall not accept private funds if receipt of such funding could present a potential conflict of interest or bias in the Collaborative's deliberations.

6.6. *Amendment*

6.6.1. These bylaws may be amended by the Collaborative by majority vote.

Appendix A: Definitions

The following additional definitions are applicable to these bylaws:

1) "Safety" means avoidance of harm or errors.
2) "Efficacy" means that the health technology produces the intended results and the expected benefits outweigh potential harmful effects under either ideal circumstances or real world clinical settings.
3) "Cost-effectiveness" means the health benefits and harms relative to costs gained by using a health technology, as compared to its alternatives (including no intervention); an efficient use of resources, cost-effectiveness does not necessarily mean lowest price.
4) "Evidence-based" means the objective, ordered, and explicit use of the best available evidence when making a coverage or reimbursement determination. Greatest weight is given to the evidence determined, based on objective factors, to be the most valid and reliable, considering the nature and source of the evidence, the empirical characteristic of the studies or trials upon which the evidence is based, and the consistency of the outcome with comparable studies. Additional evidentiary valuation factors such as recency (date of information); relevance (the applicability of the information to the key questions presented or participating agency programs and clients); and bias (conflict of interest or political considerations) may also be considered.

[i] Institute of Medicine of the National Academies. Standards for Developing Trustworthy Clinical Practice Guidelines. Released: 3/23/2011. Available: http://iom.edu/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust/Standards.aspx