

## Public Comments Summary

### Coronary Artery Graft Surgical Bundle and Warranty

We appreciate the many valuable and constructive comments by over 35 respondents during our public comment period. We see the bundle as setting a best practice guideline for a total episode of care while accounting for individual clinical judgement. Patient safety is our highest priority, and we appreciate the opportunity to work with our community to improve the CABG bundle.

We present the bundle as a model for willing buyers and willing sellers and encourage health care purchasers to account for essential services such as a care partner through sufficient reimbursement.

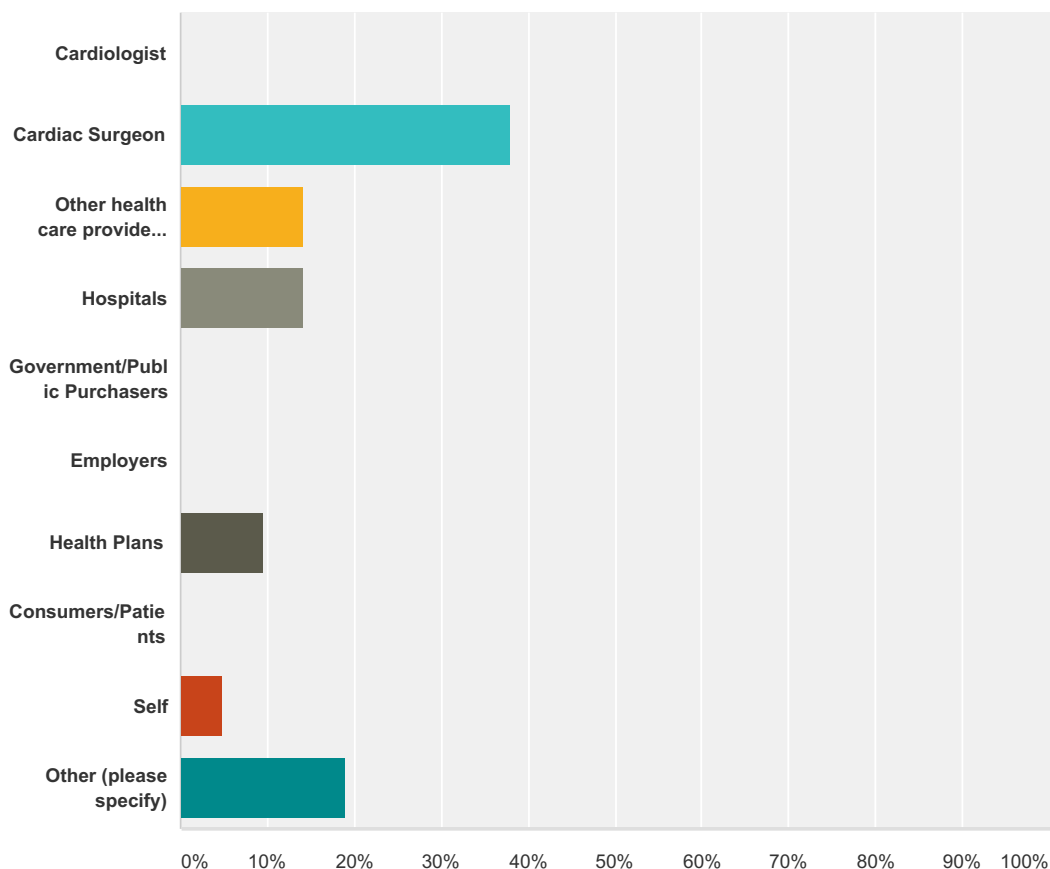
As a result of these comments the workgroup:

- On page 1: Adding “We encourage purchasers to contribute to the success of this bundle by reimbursing for essential services (e.g., health coach, care coordination).” To the introduction.
- On page 3: Using STS risk assessment instead of Euroscore.
- On page 4: Change language in the introduction to Cycle II to acknowledge the importance of clinical judgement and patient safety to read, “If compatible with patient safety, providers should assess the following minimum requirements prior to surgery to minimize the risk of complications. Meeting these requirements should not delay urgent or emergent surgery (e.g., threatening coronary anatomy, heart failure, increase in symptoms).”
- On page 5:
  - Changing our language around the care partner to read “Patient and care partner *should* actively participate in the following:
  - Adding that “The care partner may also be supplied by the facility.”
- On page 6:
  - Adding that cardiac surgeons can also be “board eligible” or “certified by a reciprocal and equivalent credentialing organization”
  - Clarifying that the 25 surgeries to ensure statistical reliability are all open heart and include both elective and urgent surgeries
  - Adding that “COAP may audit the data reported by provider groups”
  - Adding language around a pathway for surgeons to re-qualify for the bundle “If the surgeon has been disqualified as a supplier of the bundle, eligibility may be reinstated on the basis of achieving performance metrics within two standard deviations of 25 subsequent surgeries.”
- On page 9 under quality metrics adding that “Data may change based on available evidence. We have included COAP level I and level II metrics as of September 2015. Metrics will be revisited and aligned with current COAP metrics when available. COAP metrics can be found here: [www.coap.org/participating-hospitals/participating-hospitals-publicly-released-coap-data-cabg](http://www.coap.org/participating-hospitals/participating-hospitals-publicly-released-coap-data-cabg)”

While we anticipate that some provisions of the bundle and warranty remain areas in which there are differences of opinion, comments were reviewed by our workgroup and weighed against available medical evidence.

## Q1 What sector do you represent? (Choose the option that is the best fit.)

Answered: 21 Skipped: 0



Answer Choices	Responses	
Cardiolgologist	0.00%	0
Cardiac Surgeon	38.10%	8
Other health care providers (primary care physicians, physical therapists, nurses, etc.)	14.29%	3
Hospitals	14.29%	3
Government/Public Purchasers	0.00%	0
Employers	0.00%	0
Health Plans	9.52%	2
Consumers/Patients	0.00%	0
Self	4.76%	1
Other (please specify)	19.05%	4
<b>Total</b>		<b>21</b>

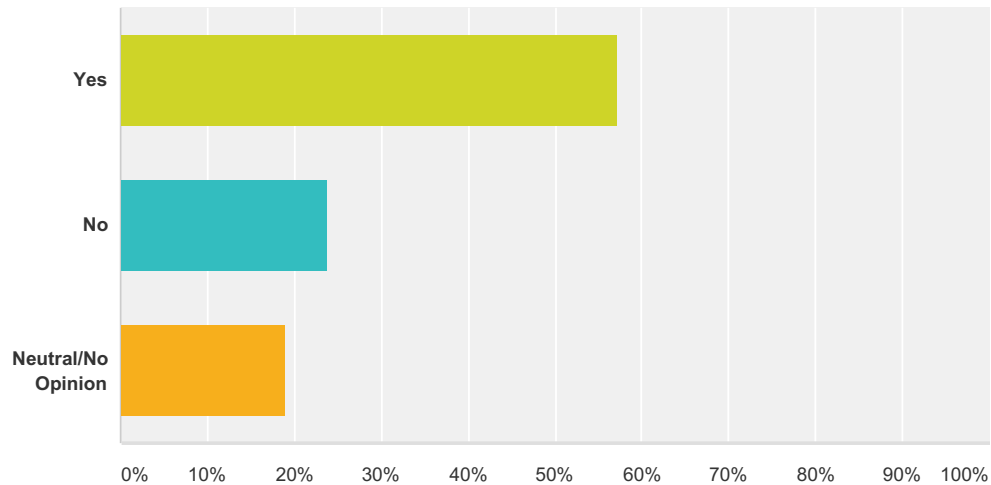
#	Other (please specify)	Date
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## Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment

1	Physician association	8/21/2015 4:25 PM
2	Primarily hospitals and other health care providers	8/21/2015 4:17 PM
3	Bundled payment consultants	8/20/2015 2:31 PM
4	cardiac anesthesiologist	8/19/2015 4:04 PM

### Q2 Do you support the concept of a bundled payment model for CABG?

Answered: 21 Skipped: 0



Answer Choices	Responses
Yes	57.14% 12
No	23.81% 5
Neutral/No Opinion	19.05% 4
<b>Total</b>	<b>21</b>

### Q3 Do you have any comments about the bundled payment concept?

Answered: 8 Skipped: 13

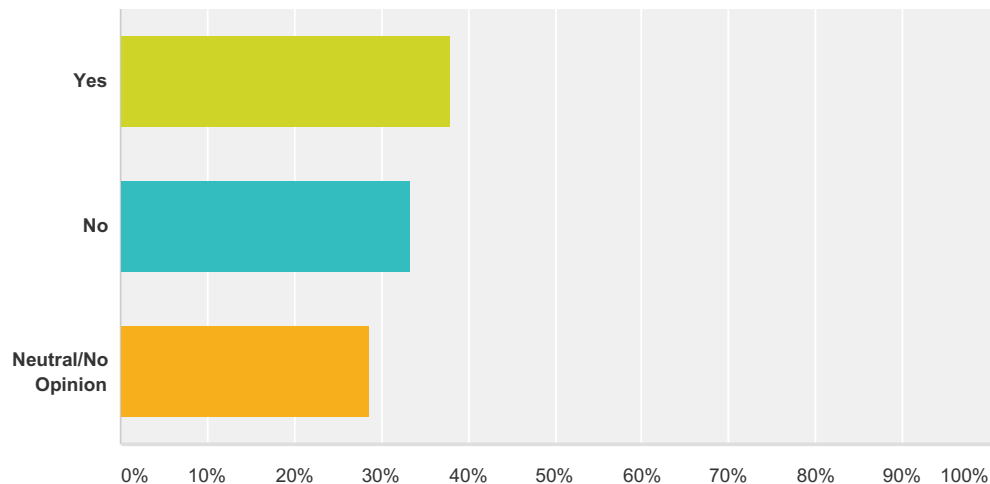
#	Responses	Date
1	While the model holds promise, early evidence in the literature appears to be mixed [ Health Affairs - 2014; Center for Healthcare Quality and Payment Reform - "Bundling Badly" - 2015 ]. Refining the model and applying its use to appropriate settings, and possibly in a piloted project, will be key to its success.	8/21/2015 4:25 PM

## Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment

2	<p>• The concept of a fixed payment for a bundle of services is a potentially promising payment approach which has gained attention by both commercial and public sectors. The unnecessary overuse of CABGs is a serious issue and WSHA fully supports efforts to improve care and reduce costs. We are also aware that recent reports illustrate issues in developing and successfully operationalizing a bundle payment (Health Affairs, 2014). Coordinating payment across different systems and across different provider types will be challenging. Adoption in integrated systems may be simpler than in those with independent physicians and facilities. Given some of the challenges, WSHA suggests Bree Collaborative consider a one to two year pilot test of the bundle before major policy and payment reforms are adopted. A pilot period would allow stakeholders to disseminate and gain comfort with best practices, develop the appropriate technical infrastructure and links between providers while providing useful data on challenges or opportunities with the bundle. The information gained from the pilot period would aid the Bree Implementation Team in their efforts gain adoption of the bundle across Washington State. WSHA also would suggest the Bree Collaborative consider if there can be amendments to the specific proposed bundle that would still meet the state's objectives, if a system or payer adopts a similar but not identical model. Is there a process to review alternative configurations? We also note that Medicare has started development of payment bundles. We believe this promotes the need to revisit bundles periodically or to maintain flexibility to allow variations so that providers can provide consistent care and measures across major payers. We have specific comments on each of the sections as well. (WSHA)</p>	8/21/2015 12:34 PM
3	I am not against the idea of a bundled payment concept. However when the quality metrics which are used to compare surgeons and institutions are voluntarily reported (COAP) and no attempt is made to ensure the accuracy of the reporting (audits, etc), the entire system would be subject to potential "gaming".	8/20/2015 11:47 PM
4	As physicians become a work force, bundled payments continue an ongoing trend of removing bargaining power from physicians.	8/20/2015 2:46 PM
5	I would be more supportive if the collaborative factored in patient non compliance as a possible reason for post operative complications.	8/19/2015 4:04 PM
6	I have been in and employed physicians my entire professional career. If bundled payments are the most efficient way for hospitals and physicians to be reimbursed, I am in favor of it.	8/18/2015 4:34 PM
7	No	8/12/2015 10:41 AM
8	It is ridiculous. We are separate entities. I don't bundle payments for anything else in my life	7/31/2015 11:45 AM

### Q4 Do you agree with the proposed components of the first section (Disability Despite Non-Surgical Therapy)?

Answered: 21 Skipped: 0



Answer Choices	Responses
Yes	38.10% 8
No	33.33% 7

## Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment

Neutral/No Opinion	28.57%	6
<b>Total</b>		<b>21</b>

### Q5 Any comments about the first section?

Answered: 12 Skipped: 9

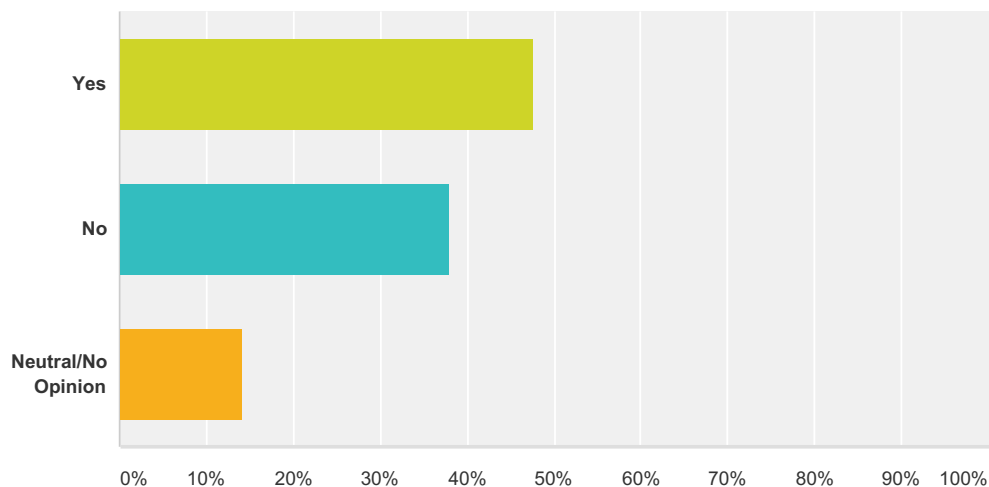
#	Responses	Date
1	Similar to comments offered previously on the joint replacement bundle, there is a concern that patients could experience diminished access to qualified locally available care, if patients are restricted from obtaining such care locally. Such diminished access could adversely impact the patient's clinical course by imposed greater travel requirements, disruption of their management of their personal lives, etc.	8/21/2015 4:25 PM
2	<ul style="list-style-type: none"> <li>• WSHA supports many of the concepts identified in the first section. We have specific concerns and questions with some components as they relate to access to care. These are noted in the subsequent section of the survey.</li> <li>• Access to care. We fully support thorough pre and postoperative evaluations, but are concerned about how the recommendations could impact access, especially in rural areas. We would encourage development or support of a system where the non-surgical portions of the bundle (i.e., cycles 1, 2, and 4) may be offered at facilities close to where a patient lives, rather than only through the facility performing the surgery. If care is centered only at one site, this could place an additional burden on rural residents who may be required to make multiple trips over an extended period to a facility outside of their community. This could drive up health care costs for patients and have unintended consequences. Providing access to health services close to where patients live is important, and local community hospitals have a place in delivering care even if they don't perform the surgery. We recommend a balanced approach with options for non-surgical portions of the bundle to be performed outside of the hospital/system performing the surgery. Under the current bundle, it appears as if a local facility would have to make arrangements with a referral facility to provide these services, instead of being able to offer them independently. This may be difficult for the local facility to accomplish without the support of Bree since many larger organizations are not going to spend time and resources contracting with multiple small alternatives in local areas that often do not have significant volume. (WSHA)</li> </ul>	8/21/2015 12:34 PM
3	Many of the various risk factors addressed should be addressed by the primary care physicians. Addressing all of these risk factors within even an extended consultation time frame would still only be providing lip service to the check box of a proposed metric. The additions of the 2 surveys which must be administered are additional labor intensive for clinic staff.	8/20/2015 11:47 PM
4	How is the patient held responsible for risk factor modification such as smoking cessation?	8/20/2015 5:58 PM
5	no	8/20/2015 5:24 PM
6	What would be the liability for care providers for cardiac events that occur during this time period? We knew you had a degree of significant disease but we chose to address this non-medically and then, ie plaque rupture.	8/20/2015 2:46 PM
7	This is one of the first bundled payment definitions that we have seen that require proof of morbidity escalation despite non-surgical therapy. However, it is not clear how these relate to the payment mechanism and the feasibility of gathering this documentation across multiple providers.	8/20/2015 2:31 PM
8	Surveys are too difficult to track, manage and report on. Maintain BMI between 18.5 and 24.9 kg/m2. almost 60% of the US's men are outside of this range. Are we treating weight?	8/19/2015 1:01 PM

## Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment

9	1. We're being asked to keep track of angina score, disability score, and patient self reported loss of function scores in order to document need for surgery. How is this being audited? How do we allow for patients who have atypical ischemic symptoms such as indigestion, neck or jaw pain, back pain, arm pain? 2. In patient's who seem to have stable angina, are we as surgeons expected to place them on and monitor a weight loss program to achieve the desired BMI, manipulate their blood pressure medicines, manipulate their lipid management medications, initiate an exercise program and provide a medically supervised exercise program for higher risk patient's, initiate alcohol treatment, implement smoking cessation, manage diabetes medications, screen for depression and treat as needed, provide stress reduction therapy, screen for dementia, provide immunizations, and initiate beta-blockade therapy in patients that have not previously taken them? How are we to be reimbursed for this increased responsibility and these time-consuming tasks? 3. In the delaying surgery for "stable" patients to accomplish all of these tasks, what do we when the patient is unable to achieve them? Do we refuse to do surgery because the patient can't stop smoking or can't reduce his BMI to a more acceptable level? Are we going to refuse the patients that can't meet these requirements or are we going to delay their surgery until their symptoms become unstable (and their surgical risks higher) and declare them to be urgent or emergent at which time these rules no longer apply. Does the Collaborative understand that it is easier and safer to operate on a stable patient than it is to operate on one who is unstable and may be actively infarcting if surgery is delayed too long? From a litigation standpoint, who is responsible if a patient experiences an adverse outcome (like an MI or a death) because a surgeon was waiting for he or she to lose weight, stop smoking or bring their diabetes under control?	8/18/2015 4:34 PM
10	Define an objective data point for heart team assesment such as STS risk assesment mortality > or = 3% and or mortality and morbidity > or = 15 %. Use STS risk assesment instead of euroscore	8/12/2015 10:41 AM
11	What does disability despite non surgical therapy mean? If you are saying that this stuff needs to be done in some one with documented left main disease or 3 vessel disease prior to surgery then I definitely disagree! They need surgery and all of this stuff can be handled after. IT IS TOO LATE!. Are you saying the multidisciplinary approach with cardiology and surgery should be applied to all stents placed? I have never seen that happen The stents are placed immediately during the initial angiogram in the vast majority of cases.	7/31/2015 11:45 AM
12	Use STS risk assessment M&M score >or = to 15% or Mortality > 3% to trigger heart team evaluate to have objective data point for review	7/28/2015 6:33 AM

### Q6 Do you agree with the proposed components of the second section (Fitness for Surgery)?

Answered: 21 Skipped: 0



Answer Choices	Responses
Yes	47.62% 10
No	38.10% 8
Neutral/No Opinion	14.29% 3

## Q7 Any comments about the second section?

Answered: 12 Skipped: 9

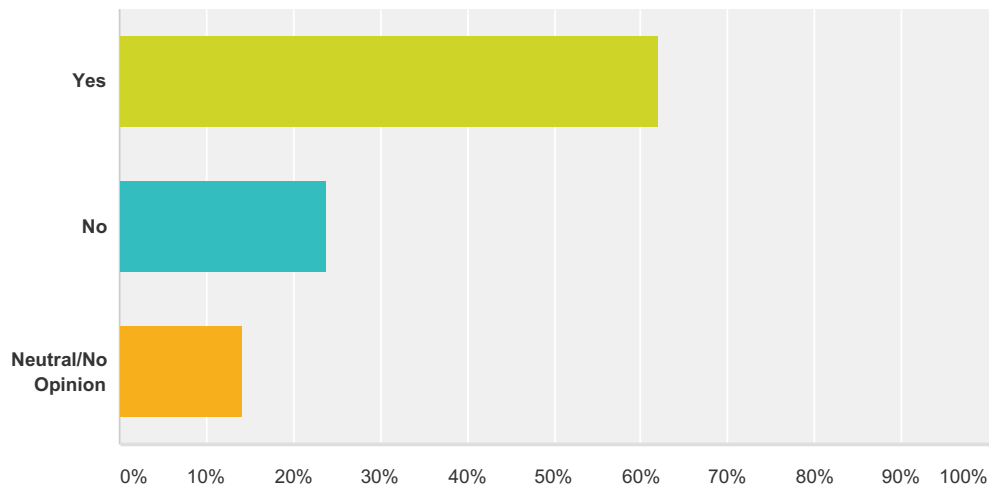
#	Responses	Date
1	Similar to comment above, caution is indicated to avoid imposing requirements and restrictions that may not be realistically achievable for all patients. Some "exception" mechanism should be available to patients, particularly those in less populated areas, to mitigate any potential adverse effects on patients.	8/21/2015 4:25 PM
2	While we understand that designation of a personal care partner is preferred, leaders across our system recognize that the situations of some patients, such as those living away from family or other supports, are otherwise isolated, or oftentimes patients living in poverty, would not allow for this requirement to be met. We believe that this language should be changed to indicate that designation of a personal care partner is "preferred" rather than being a "must" in order to accommodate the social and financial situation of our patients.	8/21/2015 4:17 PM
3	• Access to care. Patient engagement and support from a "care partner" are important components to a healthy recovery and are supported by evidence. However, the report's requirement that a patient "must designate a personal care partner" may be too strong and could impede access to care simply because a patient lives alone or does not have a care partner who can travel to the hospital. This could be especially burdensome for patients in rural communities or low income patients without family able to support them. We recommend allowing more options, by encouraging a care partner while acknowledging individual patient circumstances. (WSHA)	8/21/2015 12:34 PM
4	The language is very vague and it does not ascribe whom is responsible for the patient if the patient has an adverse event (MI) while the physician delays surgery to meet safety requirements. For example if a patient's HgbA1c is 9.5 and you delay surgery for several weeks to optimize the HgbA1c and the patient suffers a massive infarct, who is liable--the surgeon, the "warranty"? What happens if you chose to operate on the patient with an elevated HgbA1c because of unstable angina outside of the "safety requirements" and the patient has a complication--will this be grounds for penalization of reimbursement of the surgeon or institution?	8/20/2015 11:47 PM
5	If the preoperative goal is not met and the patient is not "fit for surgery" is the warranty voided? Is the institution not reimbursed because the patient is still smoking or the A1c is too high? II. C. 8. "confirm lack of significant response to non-surgical treatments" - Does this mean that every elective cabg pt must have a trial of medical therapy and a "General health questionnaire PROMIS-10" or "SAQ-7" to document lack of symptom improvement before we can schedule and perform the cabg?	8/20/2015 5:58 PM
6	By what criteria do we assess nutritional status and liver function "adequate for healing". When do all of these criteria become moot because of "urgency" and how is "urgency" uniformly determined across the spectrum. Do we turn down patients with addictive personality disorders? Is BMI an absolute contraindication to surgery and what literature supports that? To name a few	8/20/2015 2:46 PM
7	We agree with the intent of the components in Cycle II. However, many of the components in Cycle II are not measurable in a reliable way across different providers. The documentation requirements for patient safety and patient engagement are highly dependent on physician documentation and the definition does not address how these will be collected nor applied to the payment mechanism. We do agree that they are important components of an evidenced-based clinical workflow, they do not necessarily translate into the payment mechanism as currently defined. More specifics are needed as to how this information will be collected and by whom, how it will be transmitted to the payor for consideration, and what effect the quality metrics will play in the payment mechanisms.	8/20/2015 2:31 PM
8	I believe that waiting to obtain all of this information and achieving a BMI of less than 40, etc may prolong the admission process and may delay the need for timely surgery. You run the risk of pushing an elective case into becoming an urgent and or emergent procedure by prolonging the screening process.	8/19/2015 4:04 PM
9	Personal care partner may not be available to participate in all of the listed activities. Both surveys are difficult to manage.	8/19/2015 1:01 PM

## Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment

10	1. While I agree in principle that it would be nice to have all of our patient with a BMI less than 40, a hemoglobin A1c less than 8, nutritionally fit, free of opioid dependency, lifelong nonsmoker's, and free of depression or dementia. In practice, most of our patients have not been able to meet these goals. What we do in the morbidly obese patient who can't lose weight, a diabetic patient who can't seem to bring their diabetes under control quickly in preparation for surgery, or the patient with an alcohol history who won't discontinue alcohol prior to surgery? What about those patients who are addicted to methamphetamines and refuse to quit or the alcoholic patient who doesn't think he has an alcohol problem? Are we simply to refuse to operate on them? 2. Do expect the surgeon to implement a weight loss program? Are we to take over management of a poorly controlled diabetic patient? How are we to provide nutritional support to the patient with limited financial resources? How are we to guarantee that a patient has been tobacco free for 4 weeks prior to surgery? In a patient with a history of alcohol abuse who continues to drink, how are we expected to initiate a management plan?once again, how are we to be reimbursed for all these non-operative and time consuming interventions? 3. How is the patient to obtain a credentialed health coach or equivalent? Who is going to pay this health coach to participate in the various meetings and decision-making sessions that will need to take place both prior to surgery and during the hospitalization?	8/18/2015 4:34 PM
11	Who obtains and pays for a health coach? This shouldn't come out of the surgery bundle. I suggest palliative care team	8/12/2015 10:41 AM
12	The vast majority of my patients referred to me have critical stenoses with significant angina. They don't have 4 weeks to stop smoking and probably won't anyway. Are you saying obese patients should lose weight prior to bypass. Most can't exercise because of chest pain and other symptoms associated with severe coronary artery disease	7/31/2015 11:45 AM

### Q8 Do you agree with the proposed components of the third section (CABG Procedure)?

Answered: 21 Skipped: 0



Answer Choices	Responses	
Yes	61.90%	13
No	23.81%	5
Neutral/No Opinion	14.29%	3
<b>Total</b>		<b>21</b>

### Q9 Any comments about the third section?

Answered: 10 Skipped: 11



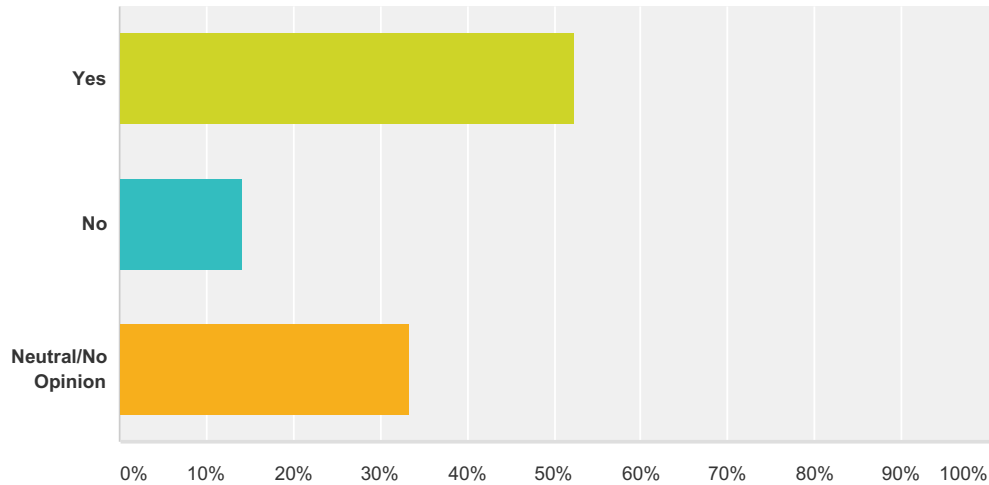
## Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment

#	Responses	Date
1	Silmilar to comments offered previously on the joint replacement bundle, the provider community should be permitted some flexibility as to the choice of vehicle used for reporting agreed-upon quality metrics.	8/21/2015 4:25 PM
2	Reporting quality metrics and the use of registries is beneficial both for improving the performance of the institution and the individual operators. However, we have concerns about dictating COAP as the ONLY registry. While we have a long history of using COAP at some of our facilities, nationally, systems such as ours are judged based on their STS data. Therefore, any single state mandating any single registry to a multi-state system that is trying to pool its quality information would impose an inordinate burden on efforts to track outcomes across a system and would create significant disconnects, which is an unintended consequence of this requirement that we believe the Bree would also want to avoid. Instead, we urge the Bree to allow a "nationally recognized registry" or "use of a registry that adopts metrics recognized by the scientific societies" or some similar language that would allow options for which registry is used is the preferred approach.	8/21/2015 4:17 PM
3	<ul style="list-style-type: none"> <li>• WSHA broadly agrees with the elements of an optimal surgical process, but has concerns regarding the identification of a single quality reporting system. Our concerns are noted in the subsequent section of the survey.</li> <li>• Reporting systems. WSHA fully supports transparency and the collection and reporting of quality metrics. The Collaborative report recommends the Washington State Foundation's COAP as the sole quality reporting system. Our policy position on such matters is that the Collaborative and other similar groups should identify measures that need to be reported to a registry, but that providers should be allowed to choose where they decide to report. We encourage the Collaborative to identify meaningful measures and make a recommendation that hospitals should report these to a transparent registry for quality and benchmarking purposes. (WSHA)</li> </ul>	8/21/2015 12:34 PM
4	I agree with this only if the "at least 25 surgeries to ensure statistical reliability" refers to all open heart operations performed by that surgeon both elective and urgent.	8/20/2015 11:47 PM
5	generally	8/20/2015 5:58 PM
6	All this basically exists already and is supported by the literature. Unlike the first 2 sections which have very little that is evidence supported.	8/20/2015 2:46 PM
7	Again, we agree with the components of Cycle III. It is not clear how all of these components will be tracked and implemented within the bundled payment. Care coordination is an essential component of Cycle III, but how will that be measured? How will the bundle payment be divided to make sure that all participating parties are receiving their portion on the bundle payment and what consequences are there if certain parties do not complete all requirements?	8/20/2015 2:31 PM
8	No mention of minimum case load, please look at pump and OR times.	8/19/2015 1:01 PM
9	This material is fairly straightforward and is all things that we're doing right now.	8/18/2015 4:34 PM
10	I have issues with the DVT prevention. I have never had a CABG patient in 14 years die from a documented pulmonary embolus. I have had patients die or have amputations or renal failure or strokes from a documented case of heparin induced thrombocytopenia.	7/31/2015 11:45 AM

### Q10 Do you agree with the proposed components of the fourth section (Post-Operative Care and Return to Function)?

Answered: 21 Skipped: 0

## Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment



Answer Choices	Responses	
Yes	52.38%	11
No	14.29%	3
Neutral/No Opinion	33.33%	7
<b>Total</b>		<b>21</b>

### Q11 Any comments about the fourth section?

Answered: 9 Skipped: 12

#	Responses	Date
1	As noted above in Q. 5, patients' access to qualified local care should be permitted, to avoid any diminished access to needed services.	8/21/2015 4:25 PM
2	• As noted in section 1, we recommend a balanced approach with options for non-surgical portions of the bundle to be performed outside of the hospital/system performing the surgery. Under the current bundle, it appears as if a local facility would have to make arrangements with a referral facility to provide these services, instead of being able to offer them independently. (WSHA)	8/21/2015 12:34 PM
3	For the post-operative phase and return to function, there must be an element of patient responsibility--the patient participating in cardiac rehab for example rather than simply being referred to cardiac rehab. Smoking cessation and medication adherence should also be enforced upon patients rather than simply penalizing the surgeon and institution if the patient doesn't attempt to improve their own health.	8/20/2015 11:47 PM
4	How is the patient held responsible for not completing rehab that was arranged? If rehab is provided but the patient does not complete the rehab is the institution penalized?	8/20/2015 5:58 PM
5	There is a high variability in resources available to assist with post op management on a program to program basis. What resources will the state of Washington supply to allow programs to comply with these initiatives which are beyond the scope of reach of the participating institution?	8/20/2015 2:46 PM
6	Again, there are no specifics around the actual implementation and provider specific roles within this episode of care. Who is responsible for making sure the discharge process is in line with WSHA? How will that be measured? If this component is not met, is the hospital payment affected? In what way?	8/20/2015 2:31 PM
7	No to survey.	8/19/2015 1:01 PM
8	3 month follow-up questionnaires may be difficult to get responses to especially if there is going to be a percentage for compliance Do we need to quantify satisfactory results and meet some standard..This may be onerous and require extra office personnel	8/12/2015 10:41 AM

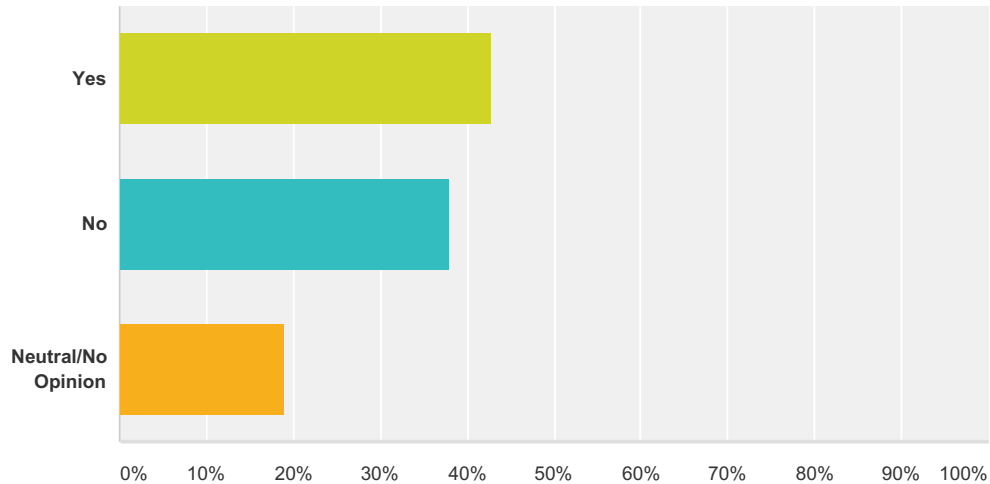
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I don't follow up with my patients at 3 months. Uncomplicated patients are not typically seen past 6-8 weeks

7/31/2015 11:45 AM

## Q12 Do you agree with the proposed quality standards?

Answered: 21 Skipped: 0



Answer Choices	Responses	
Yes	42.86%	9
No	38.10%	8
Neutral/No Opinion	19.05%	4
<b>Total</b>		<b>21</b>

## Q13 Any comments about the standards or other measures that you believe should be included?

Answered: 11 Skipped: 10

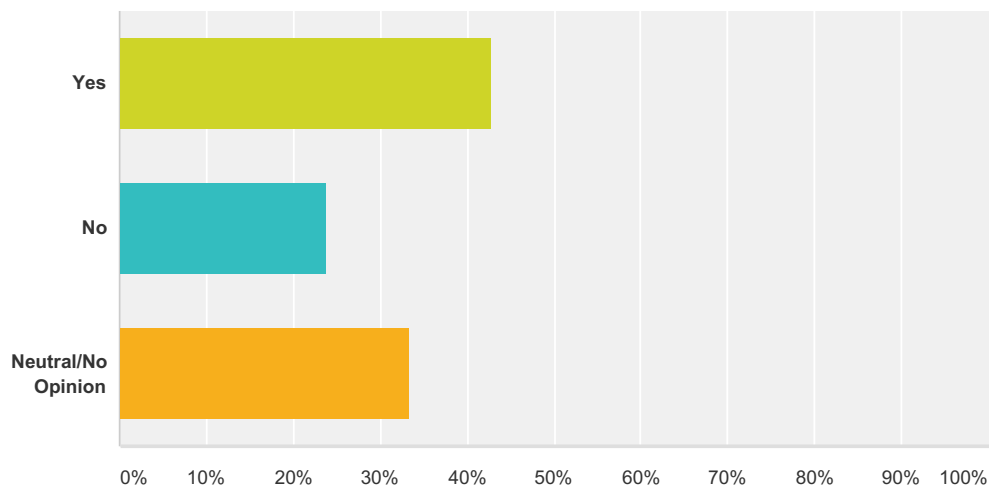
#	Responses	Date
1	Please see above comments regarding the use of COAP as the sole registry. We strongly believe that this language should be changed to acknowledge the use of other nationally-recognized registries as satisfying the requirement.	8/21/2015 4:17 PM
2	No.	8/21/2015 12:34 PM
3	1. I do not feel prolonged intubation >24hrs is a quality metric of a program, but rather a measure of how ill a patient may be--more difficult surgery or higher risk patient due to COPD, pulm HTN, etc. 2. The various "clinic specific" registries will undoubtedly vary slightly between clinics and thus will be difficult to truly compare exact results.	8/20/2015 11:47 PM
4	The collaborative has not considered important evidence regarding transfusion.	8/20/2015 5:58 PM
5	These are the same quality standards we all are pursuing with STS and COAP.	8/20/2015 5:24 PM
6	Evidence based standards are welcome.	8/20/2015 2:46 PM

## Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment

7	It's not clear how the clinic-specific quality metrics will be gathered. Will each of the participating clinics self report? Is there a standardized format for this? Which party will be responsible for compiling this information? What effect do these quality metrics have on the overall bundled payment? Which quality metrics are associated with the cardiologist, surgeon, hospital, etc?	8/20/2015 2:31 PM
8	I have issue with the fact that there are "declared standards" that were approved by mostly non provider "stakeholders". What percentage of the stakeholder group were actual providers and who were they?	8/19/2015 4:04 PM
9	Survey again and no mention of minimum caseload.	8/19/2015 1:01 PM
10	Collecting and collating this data will be time consuming and require extra people in the office. Will the bundled poayment pay for the extra people?	8/12/2015 10:41 AM
11	Why am I penalized for transfusing a patient who preoperatively starts out with a low blood count? The other systems that look at prolong intubation exclude those extubated in the operating room. Will you? A significant number of my patients are extubated in the OR. Why all cause readmission? Some admitted for a GI bleed or a car accident or influenza in the winter is not a measure of the quality of our care. What is your definition of renal failure? Scoring on the basis of return to OR for bleeding may in the end hurt the patient. I have seen surgeons hold off taking some one back because they don't want the "ding" on their record. It is short sighted. I have seen patients struggle because they should have been taking back and washed out. I have never regretted taking someone back to look if I was concerned. I think you are encouraging unsafe practice by penalizing the surgeon for being aggressive in their management in the postop period.	7/31/2015 11:45 AM

### Q14 Do you support the concept of a warranty for CABG?

Answered: 21 Skipped: 0



Answer Choices	Responses	
Yes	42.86%	9
No	23.81%	5
Neutral/No Opinion	33.33%	7
<b>Total</b>		<b>21</b>

### Q15 Do you have any comments about the CABG warranty?

Answered: 10 Skipped: 11

## Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment

#	Responses	Date
1	As noted in the comments in Q. 3, refining the warranty model and applying its use to appropriate settings, and possibly in a piloted project, will be key to its success.	8/21/2015 4:25 PM
2	We hope a warranty drives more attention to the issue of consistently providing appropriate care. (WSHA)	8/21/2015 12:34 PM
3	I do not feel it is fair to have a warranty in which there is no element of patient responsibility. I do not feel that all payment should be withheld if a patient has a complication. This will lead to further risk aversion and moderate and high risk patients who truly should receive a CABG will be turned down out of fear or a complication and losing money.	8/20/2015 11:47 PM
4	CABG is not similar to an orthopedic procedure. We are all applying ourselves to reducing complications. Many of these complications have a facility component, a Surgery component, and also a patient component. The endpoints for the CABG warranty involve a large amount of patient componenet also. If it is a 360lb man with underlying lung disease who does not follow sternal precautions, he is much more likely to have a complication. The patient as an element of this warranty also. We do not get reimbursed double for patients who are twice as likely to have certain complications, but the warranty is asking facilities and physicians to guarantee a procedure that has another component involved.	8/20/2015 5:24 PM
5	The warranty does a great job at breaking out the complications into different time periods. However, there are common complications that do not appear to be included in the warranty, such as pressure ulcers, UTI, MRSA, falls/trauma, foreign objects left in during surgery, etc. The authors of this bundle should include all of the Hospital Acquired Complications as part of this warranty.	8/20/2015 2:31 PM
6	I disagree with the term and concept of a "warranty" when it comes to caring for a human being. I take offense to the term. Additionally, there is no factoring of human non-compliance as possible reasons for post-operative complications.	8/19/2015 4:04 PM
7	I understand that it is operationally difficult to hold the original hospital responsible for charges for the treatment of complications when that treatment occurs at a different facility, but I think we should continue to try to figure that out.	8/19/2015 9:13 AM
8	I think that this is a very serious mistake. The Warranty implies that the surgeon is totally responsible for the outcome. It seems to completely remove the patient from having any responsibility or influence on the overall outcome. In reality, the patient is an essential member of the team in achieving a good outcome. If he continues to smoke or drink or fails to follow an exercise program, follow sternal precautions, or continues to abuse his body in any way, he risks the consequences. I think that the idea of a warranty will give the patient the idea that they can do anything they want, that the surgeon will overcome all of their bad behaviors. While many patients are able to appropriately recognize the difference between healthful and nonhealthful behaviors. They are able to make appropriate choices and participate in their own care. Unfortunately, a large number are not and given the assurance that the surgeon can fix everything (much as a mechanic would fix a car) they will opt to continue the self injurious behavior that contributed to their needing surgery. When the outcome is bad, as it frequently will be, they will pursue litigation while waving this warranty in our faces and in the faces of our defense teams.	8/18/2015 4:34 PM
9	Some percentage of the complications are unavoidable. How do you account for these	8/12/2015 10:41 AM
10	I have a doctor patient relationship which supercedes any "Warranty" This demeans the relationship I have with my patients. Which is my mind is a sacred trust. My patients know that I will do everything in my power for them to have the very best outcome possible. There is no need for this ridiculous warranty	7/31/2015 11:45 AM

### Q16 Do you have any comments about the evidence table?

Answered: 8 Skipped: 13

#	Responses	Date
1	No.	8/21/2015 4:25 PM
2	No.	8/21/2015 12:34 PM
3	The evidence supporting the surgeon and institution volume is overall poor data. It is level III data as it is old, non-randomized, retrospective from administrative database. (Including the Birkmeyer 2003 NEJM study cited by the Bree members). I would not use this level of data to ever change any portion of my practice. The 2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery 5.1.1. "Use of Outcomes or Volume as CABG Quality Measures: Recommendations" should not be omitted from the evidence table.	8/20/2015 11:47 PM
4	no	8/20/2015 5:24 PM

## Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment

5	No	8/20/2015 2:31 PM
6	I do not see very many RCT that were published in first tier journals that support many of these initiatives and measures.	8/19/2015 4:04 PM
7	No	8/12/2015 10:41 AM
8	I dont' know what you mean. I can't find this.	7/31/2015 11:45 AM

### Q17 Please provide any general comments about the documents here:

Answered: 5 Skipped: 16

#	Responses	Date
1	<ul style="list-style-type: none"> <li>Along with our comments to pilot test before implementation we also think there should be future evaluation and reconsideration. WSHA recommends that the Bree Collaborative adopt an appropriate assessment process and revisit the recommendation at a specified interval to gauge the impact of the policy, track quality and assess for any unintended outcomes on access or quality. The Bree Collaborative should make changes to the bundle based on data or changes to evidence-based practice. (WSHA)</li> </ul>	8/21/2015 12:34 PM
2	Although well inteneded, I am uncertain of the practical applicability of this document in my care setting. This initiative rubs right up against the law of diminishing returns. CABG is at most a 2.5% mortality endeavor. The financial burden to ensure compliance and resources necessary to support this initiative would more than likely heavily outweigh any true benefit in outcomes or cost savings. What gains are we trying to achieve, what are the goals and the benefits over what already exists?	8/20/2015 2:46 PM
3	This bundle definition is a great start and it is one of the first definitions that we have seen that incorporate evidenced based practices and disease escalation/surgical appropriateness. However, this bundle definition reads more like a clinical workflow rather than a bundle definition. This definition does not include any information about how the different Cycles or measurements impact a payment mechanism. Nor does it discuss what the payment mechanism should be in terms of which entities hold the risk. The definition lacks depth in many of these important areas, though this is an excellent start. We highly suggest that the Bree working group look at payor/provider groups that have engaged in bundled payments outside of the BPCI program, such as the Medicaid systems of Arkansas and Ohio, commercial insurers such as Horizon Blue Cross Blue Shield of New Jersey and Blue Cross Blue Shield North Carolina. These systems have built bundled payment systems and successfully engaged providers in contracts.	8/20/2015 2:31 PM
4	Cardiac surgery patient's are not orthopedic patient's. Expecting that they will be able to exercise and lose weight, that they will stop self destructive behavior so that they may more safely undergo surgery, and that they will adhere to a complex medical plan in preparation for CABG will result in delays and further delays until the need for CABG becomes an emergency. This will be associated with higher risks, worse outcomes and greater dissatisfaction. While the intent of the collaborative is good, I think the program described here will fail.	8/18/2015 4:34 PM
5	Documentation of all the requirements and retrieval will be difficult	7/28/2015 6:33 AM

### Q18 Name:

Answered: 12 Skipped: 9

#	Responses	Date
1	Bob Perna	8/21/2015 4:26 PM
2	Lauren Platt	8/21/2015 4:18 PM
3	Ian Corbridge	8/21/2015 12:35 PM
4	David Nelson	8/20/2015 5:26 PM
5	R Chris King	8/20/2015 2:47 PM
6	Taylor Pressler Vydra	8/20/2015 2:32 PM
7	Mike Kraemer	8/19/2015 1:01 PM

## Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment

8	Mary Kay O'Neill, MD	8/19/2015 9:14 AM
9	William Reed, MD	8/18/2015 4:35 PM
10	Ronald Quinton MD	8/12/2015 10:39 AM
11	Robert Binford	7/31/2015 11:46 AM
12	Ronald Quinton MD	7/28/2015 6:34 AM

### Q19 Email address:

Answered: 12 Skipped: 9

#	Responses	Date
1	rjp@wsma.org	8/21/2015 4:26 PM
2	lauren.platt@providence.org	8/21/2015 4:18 PM
3	ianc@wsha.org	8/21/2015 12:35 PM
4	David.Nelson@overlakehospital.org	8/20/2015 5:26 PM
5	chris.king@harrisonmedical.org	8/20/2015 2:47 PM
6	taylor.pressler@aver.io	8/20/2015 2:32 PM
7	mike.kraemer@overlakehospital.org	8/19/2015 1:01 PM
8	maoneill@centene.com	8/19/2015 9:14 AM
9	william.reed@harrisonmedical.org	8/18/2015 4:35 PM
10	aspinwall@msn.com	8/12/2015 10:39 AM
11	rbinford@overlakehospital.org	7/31/2015 11:46 AM
12	Aspinwall@ msn.com	7/28/2015 6:34 AM

### Q20 Organization:

Answered: 13 Skipped: 8

#	Responses	Date
1	Washington State Medical Assn.	8/21/2015 4:26 PM
2	Providence Health & Services	8/21/2015 4:18 PM
3	WSHA	8/21/2015 12:35 PM
4	Surgeon from South Sound region. Our practice is also providing additional separate comments we hope will be considered.	8/20/2015 11:48 PM
5	Overlake Hospital	8/20/2015 5:26 PM
6	Harrison Medical Center, Franciscan Medical Group	8/20/2015 2:47 PM
7	Aver, Inc.	8/20/2015 2:32 PM
8	Overlake Hospital	8/19/2015 1:01 PM
9	Coordinated Care	8/19/2015 9:14 AM
10	Harrison Medical Center	8/18/2015 4:35 PM
11	Providence St Peter Hospital	8/12/2015 10:39 AM
12	Overlake Medical Center	7/31/2015 11:46 AM

## Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment

13	Providence St Peter Hospital	7/28/2015 6:34 AM
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## MultiCare Cardiothoracic Surgical Associates Response to BREE Collaborative CABG Warranty

Members of the BREE Collaborative,

The following are concerns that have been raised by the Cardiothoracic Surgeons at MultiCare Tacoma General regarding the Accountable Payment Model for CABG Bundle. It is organized by the four-cycles put forth by the bundle.

**Allen H. Graeve, MD, FACS**

*Cardiothoracic Surgery  
Diplomate of the American Board of Thoracic Surgery  
Diplomate of the American Board of Surgery  
Fellow of the American College of Surgeons  
Society of Thoracic Surgery*

**Daniel E. Mumme, MD, FACS**

*Cardiothoracic Surgery  
Diplomate of the American Board of Surgery  
Fellow of the American College of Surgeons  
Society of Thoracic Surgery*

**Dennis D. Nichols, MD, FACS**

*Cardiothoracic Surgery  
Diplomate of the American Board of Thoracic Surgery  
Diplomate of the American Board of Surgery  
Fellow of the American College of Surgeons  
Society of Thoracic Surgery  
International Society of Heart and Lung Transplantation*

**Keith A Havenstrite, MD, FACS**

*Cardiothoracic Surgery*

**Michael S. Meyer MD, FACS**

*Cardiothoracic Surgery*

**Graham Barr, PA-C**

*Cardiothoracic Surgery*

**Jaylynn Hughes, PA-C**

*Cardiothoracic Surgery*

**Jacob Lynn, PA-C**

*Cardiothoracic Surgery*

**Erin Mallery, PA-C**

*Cardiothoracic Surgery*

**Crystal Weaks, PA-C**

*Cardiothoracic Surgery*

## I. Disability Despite Non-surgical Therapy:

A. Regarding the documenting of disability according to the Seattle Angina Questionnaire, we feel that not only will this add additional workload to ensure completeness, but the creation of “clinic specific” registries will not be precise across various institutions, thus making the data interpretation difficult in the future.

C: Begin Risk factor modification according to ACF Guidelines unless need for urgent intervention.

--Is urgent intervention defined as urgent CABG??

--What happens if we as CT surgeons aren't able to have our patient's HgbA1c <9 or many of the other mentioned risk factors optimally controlled? Is the warranty voided? What happens if we try to delay surgery to further optimize patients within the given guidelines and the patient has a cardiac event—can we be held liable for not offering a patient with unstable angina surgery within a reasonable timeframe while trying to comply with these warranty rules?

--While many of these risk factors would be identified with a thorough history and physical, the management of them certainly would fall in the realm of primary care physicians (influenza immunization, smoking cessation, lipid and hypertension management). It seems unreasonable to ask cardiothoracic surgeons in one or two preoperative clinic visits in which complex surgical decisions and risk/benefit discussions must occur to be able to optimize all these risk factors.

--What happens to the contract if the risk factors are not modified? Can the surgery proceed at all or will the surgeon/institution be penalized if there are post-operative complications?

--Is there any patient accountability in the optimization of risk factors? For example if a patient is counseled on smoking cessation, but does not stop smoking, is the surgeon/institution penalized for post-operative complications? The exact same question exists for glycemic control, BMI, and preoperative medication usage. We feel that the patient must be accountable for some aspects of their health and that if they are not willing or able to attempt risk factor modification, then the surgeon and/or institution should not be penalized for risk factors which were attempted to be optimized.

D. Stratify prior to determining appropriate intervention

We feel that requirement of Syntax score and/or Euroscore would be additionally cumbersome and currently is not recorded/calculated by our cardiologists. We

currently approach all remotely complicated coronary anatomy with several surgeons, cardiologists, and interventional cardiologists all reviewing the films and weighing in on treatment options.

## II. Fitness for surgery

### A. Document requirement related to patient safety:

While we can document the various elements listed and whether they are compatible with patient safety, the implementation of many of the risk factors lies within the patient's compliance, and thus patient accountability should be addressed within the Bundled Package.

Additionally if the patient has a history of drug abuse, we feel the necessity to screen with urine toxicology to ensure abstinence from drug abuse prior to proceeding with surgery. If the patient has a positive drug screen (outside of prescribed or legal substances), we feel the surgeon and/or institution should not be penalized if post-operative complications occur as patients' reliability to comply with medication regimens and sternal precautions must be called into question.

B. Patient Engagement and discrete shared decision making encounter---We feel that creating a separate encounter for the patient to undergo adds additional hurdles. If a credentialed health coach or equivalent is required, we would like this person to be present at the time of the original surgical consultation to lessen the burden of yet another appointment for our patients.

What if a patient who is single with limited family support does not have a Personal Care Partner who can accompany them? Are they still candidates for surgery?

C. Line 8. The requirement of "measures to confirm lack of significant response to non-surgical treatments" using the PROMIS-10 and SAQ-7 would imply that non-surgical treatment is required prior to ever proceeding with surgery or plans thereof. This does not seem safe to potentially delay patients who have been thoroughly evaluated by their referring cardiologist with indications for surgery and we as surgeons delay their surgical revascularization to comply with this questionnaire metric.

## III. CABG Procedure:

We feel that the general standards for a surgical team are fairly reasonable. We would agree that the requirement of "based on at least 25 surgeries to ensure statistical reliability" refers to all open heart operations performed by a single surgeon both electively and urgently. As a side note, the median number of CABG procedures performed by surgeons in WA state is about 40 (both elective and urgent) per year.

We feel the data presented in the Evidence Table supporting these measures is weak data, at best level III data that represents old, non-randomized trials drawn from large databases. This includes the Birkmeyer 2003 NEJM study.

#### IV. Standard process for post-operative care:

##### D. Arrange for post-operative care

We currently refer the majority of our patient to cardiac rehab and feel that this is an integral part of their overall successful recovery. Whether they truly complete cardiac rehab is complex based on patient's access to nearby cardiac rehab, patient compliance, need to return to work, insurance reasons/copay reasons etc.

(Medicare data recently presented at COAP revealed that 70-80% of patients are referred to cardiac rehab, but <30% complete cardiac rehab.) We feel that patients should not just have a "referral to cardiac rehab" as a check box on a discharge summary, but should be provided with an unimpeded access to cardiac rehab and would like this reflected within the Bundled Payment/Warranty as well. Thus, the payer should ensure adequate, unimpeded access to cardiac rehab. Thus, we want the Bundled Payment model to include cardiac rehab, not just a referral to it.

Other considerations:

##### Quality Metrics:

---As previously stated above, the creation of several "clinic specific" registries for patient appropriateness, ensuring rapid return to function and patient experience will be not be precise from clinic to clinic, institution to institution and ultimately further collection at the state level. Thus its reliability as a meaningful metric would be called into question.

---Regarding the use of pRBC transfusion, we ask that following article be added to the Bree Data citation list:

##### "Liberal or Restrictive Transfusion after Cardiac Surgery"

Gavin J. Murphy, F.R.C.S., Katie Pike, M.Sc., Chris A. Rogers, Ph.D., Sarah Wordsworth, Ph.D., Elizabeth A. Stokes, M.Sc., Gianni D. Angelini, F.R.C.S., and Barnaby C. Reeves, D.Phil., for the TITRe2 Investigators\*, NEJM March 2015 Vol 372, No 11

This article is a RMC comparing which found a restrictive transfusion threshold was not superior to a liberal threshold in post cardiac surgery patients for morbidity or health care costs. There were more deaths in the restrictive-threshold group.

---The use of prolonged intubation >24hrs as a measure of quality. We do not feel that this is truly a measure of quality, but rather a measure of how sick of patients upon whom we are operating. We serve a population that has near double the rate

of COPD than the state average and as such many of our patients have significant pulmonary disease, which although attempted to be optimized preoperatively, cannot be. Undiagnosed and untreated pulmonary hypertension in these patients can also delay extubation. While our goal is early extubation, we must take this into context of other comorbid conditions and the extent of an operation.

Additional considerations:

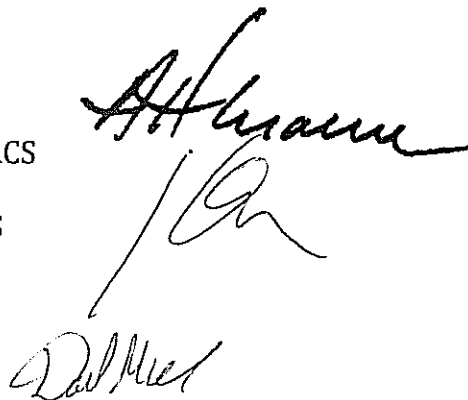
As the COAP database will be used to obtain many of these quality metrics, what is being done to ensure accurate reporting of various institutions? As individual institutions are voluntarily submitting data, and now with significant financial implications of the warranty, what will be done to ensure accurate and complete data recording by all institutions? Will there be audits? If so by whom and funded by whom?

By the additional documentation required from the Bree Collaborative and Warranty, there is implication that you do not trust our judgment as board certified cardiothoracic surgeons who have taken an oath to serve our patients. Why would you trust voluntary reporting of complications?

Finally, as surgeons we are daily faced with the challenge of deciding the best form of coronary revascularization for our individual and often-times high risk patients. PCI and CABG metrics are always analyzed, but medically managed only patients are not represented in the current database. Thus, as we create more standards and expectations for performance, we fear that those higher risk patients who should truly undergo a CABG will be "risk averted" and undergo medical treatment alone.

Sincerely,

Allen Graeve, MD FACS  
Keith Havenstrite, MD FACS  
Mike Meyer, MD FACS  
Daniel Mumme, MD FACS  
Dennis Nichols, MD FACS



# **Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment**

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**1. What sector do you represent? (Choose the option that is the best fit.)**

~~What sector do you represent? (Choose the option that is the best fit.)~~

**Health System: Providence Health & Services.**

\*

**2. Do you support the concept of a bundled payment model for CABG?**

**Do you support the concept of a bundled payment model for CABG?**

**Yes.**

**3. Do you have any comments about the bundled payment concept?**

**As a concept yes. The program should be a win, win, win. A win for the provider, a win for the patient and a win for payor. The design should provide of the provider to: be appropriately rewarded taking on high risk patients; providing a warranty; and providing the care you require that is not standard, evidence-based guidelines.**

\*

**4. Do you agree with the proposed components of the first section (Disability Despite Non-Surgical Therapy)?**

**No.**

**5. Any comments about the first section?**

**Your document should provide for definitions of terms used in your document. Perhaps a reference to the STS definitions for emergent and elective cases. In section A, the three dimension of disability are redundant and don't reflect the current standard of care and defined by the ACC/AHA guidelines. Furthermore, your methodology does not address known coronary anatomy which can have an impact on survival irrespective of symptom class (e.g. left main disease). Many of your components in Section C are not part of the current standard of care and not well studied demonstrating the value of these items (7, 8, and 9) in relationship to cardiac surgery. You certainly found references for them, however, what evidence is there these interventions impact them morbidity and mortality of the patient. They will certainly add to the cost of the care.**

\*

**6. Do you agree with the proposed components of the second section (Fitness for Surgery)?**

No.

**7. Any comments about the second section?**

There are an excess number of parameters in this section related to the screen that are vague and lack meaningful impact in the evaluation of a patient's fitness for surgery. They are not supported by national guidelines and are not the current standard of care. Inclusion of all the items might distract from the truly significant aspects that goes into access a patient's fitness for surgery. In addition, it makes the process overly complex and does not clearly demonstrate an improvement in outcome or a reduction in cost. Specifically B 1) a through c; B 2) a through f; C 1d 8, a and b.

\*

**8. Do you agree with the proposed components of the third section (CABG Procedure)?**

Yes.

**9. Any comments about the third section?**

Suggest adding a requirement that the organization must submit to the STS Adult Surgery Database. Section is robust and complete.

\*

**10. Do you agree with the proposed components of the fourth section (Post-Operative Care and Return to Function)?**

A qualified yes.

**11. Any comments about the fourth section?**

With the exception of post-surgical follow-up of the two questionnaires (Section D #4 1,b). We believe the tools are not standard of care or part of current guidelines and the studies sited do not show sufficient evidence of impacting mobility and mortality. Therefore we do not believe that repeat use of the questionnaire is warranted.

\*

**12. Do you agree with the proposed quality standards?**

No.

**13. Any comments about the standards or other measures that you believe should be included?**

We don't support the metrics for "standards of appropriateness". They are not generally accepted in any definition of appropriateness. We strongly suggest limit appropriateness to the 2012 ACC/AHA guidelines for coronary revascularization. Establishing a new definition for appropriateness that is not peer reviewed and tested simply adds cost without any real value. This is written more like a participation in a research trial. In addition, effort should be made clearly stating the definitions are consistent with STS and COAP whenever possible and call out the definition when it is different from COAP of STS.

\*

**14. Do you support the concept of a warranty for CABG?**

Yes and no.

**15. Do you have any comments about the CABG warranty?**

We support the components of the 7 day and 30 day warranty provisions. However, there are too many patient compliance and clinical conditions that have a much more significant impact in this area than the work done by the surgeon and surgery team. It should go without saying that there is value in a warranty and the bundled payment should reflect that economic value.

**16. Do you have any comments about the evidence table?**

**17. Please provide any general comments about the documents here:**

It appears Bree Collaborative did a comprehensive review of the literature and pulled in support for numerous additions to the current standard of care. Many of the items selected are not currently standard of care in this area or included in the ACC/AHA guidelines for cardiac surgery or well-studied in results of cardiac surgery. Complying with all these provisions will increase the cost of care for the providers. Administrative costs will increase to report and track compliance. We see no evidence that including these items, that are not currently standard of care or supported by national guidelines, will do anything but increase the cost of care.



# **Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment Contact Information (optional)**

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Thanks again for taking the time to provide your feedback.

Please provide your name and email address if you would like to receive future updates from the Bree Collaborative. Providing this information also makes it possible for us to contact you with any follow up questions about the feedback that you provide. Your email address will not be shared with anyone outside of the Bree Collaborative.

**18. Name: Neil Worral, MD & Brad Batkoff, MD, FACC**

Name:

**19. Email address:**

Email address:

**20. Organization: Providence Spokane Heart Institute**

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# **Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment**

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**1. What sector do you represent? (Choose the option that is the best fit.)**

Hospitals.

**2. Do you support the concept of a bundled payment model for CABG?**

Yes.

**3. Do you have any comments about the bundled payment concept?**

No.

**4. Do you agree with the proposed components of the first section (Disability  
Despite Non-Surgical Therapy)?**

Yes.

**5. Any comments about the first section?**

No.

\*

**6. Do you agree with the proposed components of the second section (Fitness for  
Surgery)?**

Yes.

**7. Any comments about the second section?**

No.

**8. Do you agree with the proposed components of the third section (CABG  
Procedure)?**

Yes.

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**9. Any comments about the third section?**

No.

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**10. Do you agree with the proposed components of the fourth section (Post-Operative Care and Return to Function)?**

Yes.

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**11. Any comments about the fourth section?**

No.

\*

**12. Do you agree with the proposed quality standards?**

Yes.

**13. Any comments about the standards or other measures that you believe should be included?**

No.

\*

**14. Do you support the concept of a warranty for CABG?**

Yes.

**15. Do you have any comments about the CABG warranty?**

No.

**16. Do you have any comments about the evidence table?**

No.

**17. Please provide any general comments about the documents here:**

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# **Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment Contact Information (optional)**

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Thanks again for taking the time to provide your feedback.

Please provide your name and email address if you would like to receive future updates from the Bree Collaborative. Providing this information also makes it possible for us to contact you with any follow up questions about the feedback that you provide. Your email address will not be shared with anyone outside of the Bree Collaborative.

**18. Name:**

Name:

**19. Email address:**

Email address:

**20. Organization: Providence Regional Medical Center - Everett**

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# Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment

1. What sector do you represent? (Choose the option that is the best fit.)

CV Administrator

2. Do you support the concept of a bundled payment model for CABG?

Yes.

3. Do you have any comments about the bundled payment concept?

No.

4. Do you agree with the proposed components of the first section (Disability Despite Non-Surgical Therapy)?

Yes.

5. Any comments about the first section?

Appears to be a good plan. I'll support Providence surgeon suggestions regarding any modifications.

\*

6. Do you agree with the proposed components of the second section (Fitness for Surgery)?

Yes, seems like a good plan and fairly standard. Will support Providence surgeon modifications.

7. Any comments about the second section?

No.

8. Do you agree with the proposed components of the third section (CABG Procedure)?

Yes.

**9. Any comments about the third section?**

No.

\*

**10. Do you agree with the proposed components of the fourth section (Post-Operative Care and Return to Function)?**

**11. Any comments about the fourth section?**

No.

\*

**12. Do you agree with the proposed quality standards?**

Yes, per modifications from Providence surgeons.

**13. Any comments about the standards or other measures that you believe should be included?**

No.

\*

**14. Do you support the concept of a warranty for CABG?**

Yes.

**15. Do you have any comments about the CABG warranty?**

Patient needs to have a commitment to follow the prescribed procedures, medications, follow-up, rehab, etc.

**16. Do you have any comments about the evidence table?**

No.

**17. Please provide any general comments about the documents here:**



# **Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment Contact Information (optional)**

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Thanks again for taking the time to provide your feedback.

Please provide your name and email address if you would like to receive future updates from the Bree Collaborative. Providing this information also makes it possible for us to contact you with any follow up questions about the feedback that you provide. Your email address will not be shared with anyone outside of the Bree Collaborative.

**18. Name: Bill Baldwin**

Name:

**19. Email address: [bill.baldwin@kadlec.org](mailto:bill.baldwin@kadlec.org)**

Email address:

**20. Organization: Kadlec Regional Medical Center**

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# Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment

\*

**1. What sector do you represent? (Choose the option that is the best fit.)**

What sector do you represent? (Choose the option that is the best fit.)

Cardiologist  
Cardiac Surgeon

\*

**2. Do you support the concept of a bundled payment model for CABG?**

Do you support the concept of a bundled payment model for CABG?

Yes.

**3. Do you have any comments about the bundled payment concept?**

Do you have any comments about the bundled payment concept?

\*

**4. Do you agree with the proposed components of the first section (Disability Despite Non-Surgical Therapy)?**

Do you agree with the proposed components of the first section (Disability Despite Non-Surgical Therapy)?

Yes.

**5. Any comments about the first section?**

Base heart team referral on risk rather than all; i.e., STS risk assessment with mortality > or = 3%; M&M . or = 15%.

\*

**6. Do you agree with the proposed components of the second section (Fitness for Surgery)?**

Do you agree with the proposed components of the second section (Fitness for Surgery)?

Yes.

**7. Any comments about the second section?**

Who supplies i.e. pays for a health coach and where do find one qualified? ? new role for palliative care team?

\*

**8. Do you agree with the proposed components of the third section (CABG Procedure)?**

Do you agree with the proposed components of the third section (CABG Procedure)?

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Yes.

**9. Any comments about the third section?**

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No.

\*

**10. Do you agree with the proposed components of the fourth section (Post-Operative Care and Return to Function)?**

Do you agree with the proposed components of the fourth section (Post-Operative Care and Return to Function)?

Yes.

**11. Any comments about the fourth section?**

No.

\*

**12. Do you agree with the proposed quality standards?**

Do you agree with the proposed quality standards?

Yes.

**13. Any comments about the standards or other measures that you believe should be included?**

Follow up questionnaires to the patient will be difficult to obtain I think or involve quite a bit of work by phone. I believe most cardiac services only see their post op patients once at 4-6 weeks postop so a 3 or 6 month follow-up survey would have to be by letter which would be low yield or by phone.

\*

**14. Do you support the concept of a warranty for CABG?**

Do you support the concept of a warranty for CABG?

Yes.

**15. Do you have any comments about the CABG warranty?**

I think a preoperative patient compact that we will do our best and the patient agrees to participate and follow our counsel is better.  
Some percentage of complications is unavoidable and should be reimbursed if requires re admit or reop.

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**16. Do you have any comments about the evidence table?**

**No.**

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**17. Please provide any general comments about the documents here:**

**The degree of data required and collation, especially pre-op and follow-up questionnaires will be time consuming and require extra personnel to comply.**

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# **Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment Contact Information (optional)**

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Thanks again for taking the time to provide your feedback.

Please provide your name and email address if you would like to receive future updates from the Bree Collaborative. Providing this information also makes it possible for us to contact you with any follow up questions about the feedback that you provide. Your email address will not be shared with anyone outside of the Bree Collaborative.

**18. Name:** Ronald Quinton

Name:

**19. Email address:** [aspinwall@msn.com](mailto:aspinwall@msn.com)

Email address:

**20. Organization:** Providence St. Peter Hospital

Organization: PSPH : PMG Olympia Cardiac Surgery

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# Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment

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**1. What sector do you represent? (Choose the option that is the best fit.)**

What sector do you represent? (Choose the option that is the best fit.)

Cardiac Surgeon

\*

**2. Do you support the concept of a bundled payment model for CABG?**

Do you support the concept of a bundled payment model for CABG?

Yes.

**3. Do you have any comments about the bundled payment concept?**

No.

\*

**4. Do you agree with the proposed components of the first section (Disability Despite Non-Surgical Therapy)?**

Do you agree with the proposed components of the first section (Disability Despite Non-Surgical Therapy)?

Yes.

**5. Any comments about the first section? No**

\*

**6. Do you agree with the proposed components of the second section (Fitness for Surgery)?**

Yes.

**7. Any comments about the second section?**

No.

\*

**8. Do you agree with the proposed components of the third section (CABG Procedure)?**

Yes.



**9. Any comments about the third section?**

No.

---

\*

**10. Do you agree with the proposed components of the fourth section (Post-Operative Care and Return to Function)?**

Yes.

---

**11. Any comments about the fourth section?**

No.

---

\*

**12. Do you agree with the proposed quality standards?**

Yes.

---

**13. Any comments about the standards or other measures that you believe should be included?**

No.

---

\*

**14. Do you support the concept of a warranty for CABG?**

Yes.

---

**15. Do you have any comments about the CABG warranty?**

No.

---

**16. Do you have any comments about the evidence table?**

No.

---

**17. Please provide any general comments about the documents here:**

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# **Bree - Coronary Artery Bypass Graft Surgery (CABG) Bundled Payment Public Comment**

## **Contact Information (optional)**

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Thanks again for taking the time to provide your feedback.

Please provide your name and email address if you would like to receive future updates from the Bree Collaborative. Providing this information also makes it possible for us to contact you with any follow up questions about the feedback that you provide. Your email address will not be shared with anyone outside of the Bree Collaborative.

**18. Name: Glenn R Barnhart MD**

Name:

**19. Email address: [glenn.barnhart@swedish.org](mailto:glenn.barnhart@swedish.org)**

Email address:

**20. Organization: Swedish Medical center – Cherry Hill**

Organization:

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**From:** Pasala Ravichandran

**Subject:** Re: FW: Bree Public Comment Request: Coronary Artery Bypass Graft Surgical Bundle and Warranty

Hi Drew,

This is really a very interesting document and a lot of efforts have gone through it obviously. This is certainly a start though a lot of criteria set up here including SYNTAX is going to be significantly subjective.

There are two additions I would like to make based on my first look.

1. The statement that all surgeons should be board certified. I am not board certified, I have FRCS Canada in cardiothoracic surgery. I would amend that to read Board certified or equivalent sub-specialty certification.
2. The statement related to RBC transfusion. There are no discussions about preoperative anemia and treatment of these patients.

A few centers here have a blood conservation program. At Portland Adventist here we actually treat all patients with Hct of 40 with Aranesp and Ferrlecit. Frequently it is a fight with insurance company to get the approval for Aranesp. Iron infusions also require repeated admissions for an hour or two for a few days in hospital as out patient. Monitoring someone for blood transfusion without guideline for anemia treatment may not be adequate in my opinion.

Overall this is a good start.

One more thing.

Majority of the problems occurs when the patients are in unstable angina. One should also include these patients in this document as long as we are not dealing with acute coronary syndrome. Then one day we should include NSTEMI also in the multidisciplinary decision making.

## **Point Paper: Critique of the CABG Surgical Bundle**

**William H Reed, MD, FACS**

**R. Christopher King, MD**

**Cardiothoracic Surgeons at Harrison Medical Center**

**Bremerton, WA**

**We have reviewed the Bree Collaborative that was forwarded by the COAP committee and we would like to respond in writing so that our opinions and thoughts can be documented and compared to those of other cardiothoracic surgeons in Washington.**

**This seems like a very ambitious program. The citation list covers over 110 articles or documents that are supposedly in support of this program. Unfortunately, when I review this list, I can't find any that document that this program in this exact form has been put in place and has improved quality, improved outcomes, lowered costs, shortened hospital stays, reduced complications, improved patient satisfaction or in any way advanced the treatment of surgical coronary revascularization. We would be very interested in hearing about or visiting a program that instituted these recommendations so that we could see whether it does positively impact patient care. And we would like to see it in action before we implement it here.**

**This initiative has been utilized in Orthopedic patients undergoing total joint surgery and also in patients requiring back surgery, presumably with good results. Now it is to be extended to the cardiac surgery patients who are undergoing elective coronary bypass procedures. This is a vastly different population. These patients typically have coronary blockages in all three of their coronary arteries, usually multiple lesions. They are thought to be stable but any one of these blockages can become unstable without warning and result in a myocardial infarction and/or hemodynamic collapse. We, as surgeons, have historically expedited their workup and progression to surgery because there is no way of accurately predicting when one of these lesions will become unstable. This is vastly different from the total joint population where patients can wait over a year to undergo surgery with very little in the way of adverse consequence. Furthermore, delaying surgery for an elective patient so that they can lose weight, control their diabetes or stop smoking will mean that surgery may be delayed for weeks or months. While this is a laudable goal, the delay associated with these programs will undoubtedly lead some patients to develop unstable angina, have a myocardial infarction or experience a cardiac arrest while they are trying to meet the demands of the collaborative. In effect, delaying surgery for elective patients will mean that some patients will have delays that result in infarctions, where they lose myocardium or have an episode of sudden cardiac death. The elective surgery that would have ordinarily been done with a mortality risk of less than 1%, will suddenly become a moderate or high risk procedure with a higher mortality risk. In our opinion, delaying CABG surgery in the elective patients until they become urgent or emergent patients means more risk, patients will more likely undergo surgery unexpectedly and that they**

will need to endure more episodes of angina before they can be permitted to have CABG done. How satisfied will the average patient be with that?

Part of the initiative is to offer patients a "Warranty" to assure them that they are covered if certain complications develop within a specified period of time. The warranty does not specify what the coverage is and it does not apply to urgent or emergent CABG procedures. The word warranty is a legal term that implies there is a written guarantee of outcome. The items that are specifically mentioned are relatively straightforward (sternal infection, pneumonia, MI, DVT) but if we are providing a warranty that guarantees outcomes, certainly a death, or a stroke or renal failure is an undesirable result. If a patient who undergoes an elective CABG and dies, are we not admitting culpability for all adverse outcomes with our warranty. Frankly, warranty also implies that there is little or no effort required on the part of the patient, they just have to "show up". The surgeon is guaranteeing him a successful result despite his possible non-compliance with medical recommendations. We think a better term would be "contract" which suggests that both parties will contribute in an agreed upon manner to arrive at a mutually beneficial outcome. This is in keeping with the current practice of open heart surgery. It simply does not matter how good of a surgeon you are or how good of a surgical procedure you perform, it can be destroyed by a patient who fails to follow medical advice.

We are concerned that this program will result in inequalities in patient care. Urban hospitals will be able to draw upon local services like alcohol rehab, smoking cessation, diabetic endocrinology support, weight loss programs, practitioners skilled in the treatment of dementia and depression. Smaller or rural hospitals will likely not have some or all of these services to offer their patients. The rural programs will be less likely to have all of the previously mentioned services as well as the Health Coaches and Care Partners to facilitate shared decision making.

Cycle I recommendations:

#### Weight Management

Ideally patients should have a BMI between 18.5-24.9 kg/m sq. In actuality, nearly all of our patients far exceed that range with BMI's frequently exceeding 40 and even 50. In our experience, even motivated patients who desire to lose weight have difficulty exercising when they get angina pectoris with exercise. Very few are able to maintain a diet and/or exercise program that allows them to lose weight quickly. Additionally, a number of our patients are incapable of exercise programs because of orthopedic problems, respiratory insufficiency or vascular insufficiency. Furthermore, taking a patient to surgery who is in negative nitrogen balance because of an aggressive weight loss program will increase the risks of infection and poor healing. Is it the intent of the collaborative to refuse surgery to patients who are unable or unwilling to lose weight? What about the patients who cannot afford to join gyms or obtain medical supervision so that they can safely lose weight?

#### Blood pressure management and Lipid management

These are reasonable requirements and in most cases, by the time the patient reaches the stage where they need cardiac surgery, their primary care doctor or their cardiologist have already addressed this.

### Alcohol screening

Screening may be done with a questionnaire or by taking a proper history, but how are we as surgeons to “manage” their alcohol use. We are not credentialed as alcohol rehabilitationists and what do we do with the patient who disagrees with our assessment of their “excessive” use of alcohol? Are we to turn these patient down? Or is the goal to wait until they join the urgent-emergent patients where the Bree approach no longer applies. Who is paying for the patient to go through alcohol rehabilitation and who is reimbursing those who "manage" it?

### Smoking Cessation

What about the patient who is unable or unwilling to quit smoking. How are we as surgeons to "manage" their smoking cessation? According to the Cycle II section, they should be off tobacco products for four weeks. Are we taking their word for how long they have been off tobacco? Are we to test for smoking and if so, how? Who is paying for this?

### Diabetes management

**Does the Collaborative seriously expect us to manage diabetic patients? That is far outside of our scope of practice. Are we required to wait until their Hgb A1C is less than 8% and are we to be reimbursed for attempting to manage their diabetes? Additionally, since diabetic patients frequently have atypical or silent ischemia, can we truly trust whether or not they are "elective"? Are we to "override" the recommendations of their physicians who have previously been responsible for their diabetes? Is this ethically or morally the right thing to do?**

### **Cycle II recommendations:**

**BMI must be less than 40: Isn't this unfair to the patient who is unable to lose weight or exercise because of other health concerns? Does this invalidate the "warranty" promising them good healing, no DVT's, no infections, etc?**

**HgbA1C must be less than 8 in patient with diabetes, if this is compatible with patient safety. Of course, it will be compatible right up until it isn't compatible with patient safety. At that point, the patient may be in extremis because we delayed surgery too long. We can't always predict when diabetic patients are going to become unstable.**

Management of smoking cessation, management of opioid dependency, management of alcoholism, management of depression, management of dementia as well as a postoperative plan for return to function. All of these are unreimbursed mandates. They are time consuming, they mostly require specialized training and none of them are unreimbursable

under today's bundled payment system. So will the new bundled payment include additional money to reimburse the surgeon and the hospital to compensate for all of these expanded services?

**Participation in a shared decision making model with the requirement that each patient must have a credentialed health care coach. Who is paying for this "coach"? Is the patient expected to provide this? Is the hospital or the physician? Then the patient must declare a Care Partner, the Care Partner must participate in the surgical consultation, the preoperative evaluation, all preoperative educational programs, the in-hospital care, the postop care teaching and home education. Many of our patients can not afford their meds. How are they to afford to have two people (or even one) who are going to be at their side for virtually every interaction with the care team that is providing CT Surgical care for this individual. Who is paying for this service? Where are these individuals coming from, they are not anywhere in evidence now.**

### **Cycle III recommendations**

**For the most part, these seem like pretty straight forward recommendations and most, if not all, are already in effect in most open heart programs. There are some exceptions, though;**

Regarding the recommendation to minimize use of opioids, it is recommended that we prescribe according to the Washington State Agency Medical Directors Group Opioid Prescribing guidelines. Not every hospital stocks all of the drugs listed in this tome.

### **Cycle IV recommendations**

Most of these recommendations are already in practice, although I'm not aware of any programs (not involved in active research) that tracks outcome data at three, six and twelve months. Is it the intention of the Bree payment bundles to include sufficient reimbursement to cover the cost to hire additional people to collect this data? What is to be done with this data? What is to be done if programs fail to collect this data or what if the data suggest there is a problem? Is there a team that audits all the data that is collected, a team that assures itself that each program is following the rules closely and that their outcomes are comparable to other programs in the state.

**In summary, this is an ultra ambitious program. In our opinion, this program seems to be overly meddlesome and mandates a large number of services that cannot be reimbursed, are time consuming and which will end up delaying the time until the patient can be revascularized. The intent of the program is to assure that patients are receiving good care. We think this particular approach will miss that objective badly and will undermine the "contractual" relationship that physicians and patients have traditionally followed. We have been unable to locate any data or literature that demonstrates that the Bree Collaborative improves the quality of the care that is provided to the open heart surgical patients. Nor do we find any data that it improves outcomes,**

**decreases complications or shortens length of stay. We are deeply concerned by the concept of the medical "warranty" in the open heart patients and we strenuously object to any program that does not enlist the patient's full support in achieving an excellent outcome. We have been unable to find any well known open heart institution that has embraced this collaborative and worked through the shortcomings that are described above. We feel that before there is a mandate that we adopt this program, there should be several "models" (well thought of medical institutions) that have embraced this initiative and have been able to demonstrate an improvement in their quality and outcomes.**

**William H Reed, MD, FACS**

**R Christopher King, MD, FACS**



August 21, 2015

Hugh Straley, MD, Chair ([hstraley@comcast.net](mailto:hstraley@comcast.net))  
Dr. Robert Bree Collaborative

Robert Mecklenburg, MD, Chair ([robert.mecklenburg@vmmc.org](mailto:robert.mecklenburg@vmmc.org))  
Accountable Payment Models Workgroup

Foundation for Health Care Quality  
705 Second Avenue, Suite 410  
Seattle, Washington 98104

Re: Dr. Robert Bree Collaborative – Coronary Artery Bypass Graft Surgical Bundle

Dear Doctors Straley and Mecklenburg,

The Washington State Hospital Association (WSHA) offers the following comments on the draft Coronary Artery Bypass Graft Surgical Bundle.

As an active participant in the Bree Collaborative, WSHA fully supports efforts to improve patient safety and reduce costs associated with Coronary Artery Bypass Grafts (CABGs). WSHA acknowledges the considerable efforts by the Accountable Payment Models (APM) Workgroup in developing the CABG bundle and warranty, which seek to address the potentially unnecessary overuse of CABGs.

The public comment period affords interested stakeholders an opportunity to provide input into the development of Bree Collaborative recommendations. It is in this context that WSHA respectfully submits the following comments on behalf of our 99 member hospitals.

On behalf of our member hospitals we appreciate your attention to these comments and recommendations. We look forward to your response and any opportunity to work more directly with the AMP Workgroup. Should you have any questions, please contact Ian Corbridge, Policy Director, Clinical Issues at (206) 216-2514 or [ianc@wsa.org](mailto:ianc@wsa.org).

Sincerely,



Claudia Sanders  
Senior Vice President, Policy Development  
Washington State Hospital Association

cc: Ginny Weir, Program Director [gweir@qualityhealth.org](mailto:gweir@qualityhealth.org)  
Bob Perna, Senior Director [rjp@wsma.org](mailto:rjp@wsma.org)  
Carol Wagner, Senior Vice President, Patient Safety [carolw@wsa.org](mailto:carolw@wsa.org)

Enclosure

## **Enclosure: CABG Surgery Bundle & Warranty**

WSHA's comments on the Bree Collaborative CABG Bundle and Warranty appear in order and format as they do on the Bree Collaborative public comment survey tool.

**1. What sector do you represent? (Choose the option that is the best fit.)**

- Hospitals/health care

**2. Do you support the concept of a bundled payment model for CABGs?**

- Yes, we think this has promise for improving quality and controlling costs.

**3. Do you have any comments about the bundled payment concept?**

- The concept of a fixed payment for a bundle of services is a potentially promising payment approach which has gained attention by both commercial and public sectors. The unnecessary overuse of CABGs is a serious issue and WSHA fully supports efforts to improve care and reduce costs. We are also aware that recent reports illustrate issues in developing and successfully operationalizing a bundle payment (Health Affairs, 2014). Coordinating payment across different systems and across different provider types will be challenging. Adoption in integrated systems may be simpler than in those with independent physicians and facilities.

Given some of the challenges, WSHA suggests Bree Collaborative consider a one to two year pilot test of the bundle before major policy and payment reforms are adopted. A pilot period would allow stakeholders to disseminate and gain comfort with best practices, develop the appropriate technical infrastructure and links between providers while providing useful data on challenges or opportunities with the bundle. The information gained from the pilot period would aid the Bree Implementation Team in their efforts gain adoption of the bundle across Washington State.

WSHA also would suggest the Bree Collaborative consider if there can be amendments to the specific proposed bundle that would still meet the state's objectives, if a system or payer adopts a similar but not identical model. Is there a process to review alternative configurations?

We also note that Medicare has started development of payment bundles. We believe this promotes the need to revisit bundles periodically or to maintain flexibility to allow variations so that providers can provide consistent care and measures across major payers.

We have specific comments on each of the sections as well.

**4. Do you agree with the proposed components of the first section (Disability despite Non-Surgical Therapy)?**

- WSHA supports many of the concepts identified in the first section. We have specific concerns and questions with some components as they relate to access to care. These are noted in the subsequent section of the survey.

**5. Any comments about the first section?**

- **Access to care.** We fully support thorough pre and postoperative evaluations, but are concerned about how the recommendations could impact access, especially in rural areas. We would encourage development or support of a system where the non-surgical portions of the bundle (i.e., cycles 1, 2, and 4) may be offered at facilities close to where a patient lives, rather than only through the facility performing the surgery. If care is centered only at one site, this could place an additional burden on rural residents who may be required to make multiple trips over an extended period to a facility outside of their community. This could drive up health care costs for patients and have unintended consequences.

Providing access to health services close to where patients live is important, and local community hospitals have a place in delivering care even if they don't perform the surgery. We recommend a balanced approach with options for non-surgical portions of the bundle to be performed outside of the hospital/system performing the surgery. Under the current bundle, it appears as if a local facility would have to make arrangements with a referral facility to provide these services, instead of being able to offer them independently. This may be difficult for the local facility to accomplish without the support of Bree since many larger organizations are not going to spend time and resources contracting with multiple small alternatives in local areas that often do not have significant volume.

**6. Do you agree with the proposed components of the second section (Fitness for Surgery)?**

- Yes. WSHA has an additional general comment in the subsequent section of the survey.

**7. Any comments about the second section?**

- **Access to care.** Patient engagement and support from a "care partner" are important components to a healthy recovery and are supported by evidence. However, the report's requirement that a patient "must designate a personal care partner" may be too strong and could impede access to care simply because a patient lives alone or does not have a care partner who can travel to the hospital. This could be especially burdensome for patients in rural communities or low income patients without family able to support them. We recommend allowing more options, by encouraging a care partner while acknowledging individual patient circumstances.

**8. Do you agree with the proposed components of the third section (CABG Procedures)?**

- WSHA broadly agrees with the elements of an optimal surgical process, but has concerns regarding the identification of a single quality reporting system. Our concerns are noted in the subsequent section of the survey.

**9. Any comments about the third section?**

- **Reporting systems.** WSHA fully supports transparency and the collection and reporting of quality metrics. The Collaborative report recommends the Washington State Foundation's [COAP](#) as the sole quality reporting system. Our policy position on such matters is that the Collaborative and other similar groups should identify measures that need to be reported to a registry, but that providers should be allowed to choose where they decide to report. We encourage the Collaborative to identify meaningful measures and make a recommendation that hospitals should report these to a transparent registry for quality and benchmarking purposes.

**10. Do you agree with the proposed components of the fourth section (Post-Operative Care and Return to Function)?**

- Yes. Please refer to our comments in section 1 regarding access to care.

**11. Any comments about the fourth section?**

- As noted in section 1, we recommend a balanced approach with options for non-surgical portions of the bundle to be performed outside of the hospital/system performing the surgery. Under the current bundle, it appears as if a local facility would have to make arrangements with a referral facility to provide these services, instead of being able to offer them independently.

**12. Do you agree with the proposed quality standards?**

- Yes, however, please see our comment in the subsequent section of the survey.

**13. Any comments about the standards (or other measures that you believe should be included)?**

- No

**14. Do you support the concept of a warranty for CABG?**

- Yes. We hope a warranty drives more attention to the issue of consistently providing appropriate care.

**15. Do you have any comments about CABG warranty?**

- No.

**16. Do you have any comments about the evidence table?**

- No

**17. Please provide any general comments about the documents here:**

- Along with our comments to pilot test before implementation we also think there should be future evaluation and reconsideration. WSHA recommends that the Bree Collaborative adopt an appropriate assessment process and revisit the recommendation at a specified interval to gauge the impact of the policy, track quality and assess for any unintended outcomes on access or quality. The Bree Collaborative should make changes to the bundle based on data or changes to evidence-based practice.