Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Dr. Robert Bree Collaborative Annual Report

November 15, 2016

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

Dr. Robert Bree Collaborative Annual Report

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

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Executive Summary

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

This is the fifth annual report submitted by the Health Care Authority (HCA) on behalf of the Dr. Robert Bree Collaborative (Bree Collaborative or Collaborative) to the Washington State Legislature as directed in Engrossed Substitute House Bill 1311 (ESHB 1311), Section 3, and enacted as chapter 313, Laws of 2011. This report describes the achievements of the Bree Collaborative from November 2015 through October 2016.

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

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

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

Since its formation in August 2011, the Bree Collaborative has successfully pursued its mission to provide a mechanism through which public and private health care stakeholders can work together to improve health care quality, patient outcomes, and affordability in Washington State.

Year five accomplishments included supporting **five active workgroups**, developing recommendations for four topics, and drafting, adopting and receiving approval from the Health Care Authority on **two sets of recommendations**. Specific accomplishments include:

- Developing an evidence-based, community-supported bundled payment model and warranty for bariatric surgery.
- Developing recommendations related to behavioral health integration into primary care.
- Working to facilitate adoption of the Washington State Agency Medical Director's Group Guidelines on Prescribing Opioids for Pain.
- Developing recommendations to align pediatric antipsychotic prescribing with evidence-based practice.
- Working to communicate with the health care community and public through newsletters, website, blog, and social media.
- Working with the State of Washington and other stakeholders to encourage adoption of Bree Collaborative recommendations across diverse communities.

Background

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

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

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

Overview of ESHB 1311

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

All Collaborative meetings are open to the public and follow the Open Public Meetings Act. Senate Bill 5144, Chapter 21, Laws of 2015, amended RCW 70.250.050 and clarified the original legislation to add "*All meetings of the collaborative, including those of a subcommittee, are subject to the open public meetings act.*"

The Bree Collaborative is charged with annually identifying up to three areas of health care services for which substantial variation exists in practice patterns and/or increases in care utilization are not accompanied by better care outcomes. Both of these trends may be indicators of poor quality and potential waste in the health care system. Health care services for review are solicited from the Washington State Agency Medical Directors Group, community partners, the public at large, the Legislature, and Bree Collaborative members.

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

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

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

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

Bree Collaborative Formation

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

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

The Chair is advised by a steering committee comprised by Bree Collaborative members representing health care purchasers, health plans, health care systems, and quality improvement organizations. See **Appendix C** for a current list of steering committee members.

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

The Bree Collaborative has held twenty-four meetings since late 2011. Meetings are held on a bi-monthly basis with future meetings scheduled for November 16, 2016 and into 2017 on the third or fourth Wednesdays of the month: January 18, March 22, May 24, July 19, September 27, and November 15. Agendas and materials for all Collaborative meetings are posted in advance on the Bree Collaborative website: www.breecollaborative.org. All Collaborative meetings are open to the public and follow the Open Public Meetings Act.

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

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

Summary of Recent Work

Collaborative work in year five from November 2015 to October 2016 has focused on developing new evidence-based recommendations and working to facilitate implementation of existing recommendations through Health Care Authority contracting, work with a staff implementation consultant, and community outreach and education. The Prostate Cancer Screening and Oncology Care workgroups completed their recommendations and workgroups were formed to develop recommendations around Accountable Payment Models: Bariatric Surgery, Pediatric Psychotropic Drug Prescribing, Behavioral Health Integration, and to implement the Agency Medical Directors Guideline on Prescribing Opioids for Pain. The workgroups are profiled on the following pages.

The Collaborative:

- **Supported five active workgroups**
- **Adopted two sets of recommendations**
- **Disseminated two sets of recommendations for public comment**
- **Received approval from the Health Care Authority for two recommendations**

The Bree Collaborative approved and sent **two** sets of recommendations to the Health Care Authority:

- **Prostate Cancer Screening** (November 2015)
    - Available: www.breecollaborative.org/wp-content/uploads/Prostate-Cancer-Recommendations-Final-15-11.pdf
- **Oncology Care** (March 2016)
    - Available: www.breecollaborative.org/wp-content/uploads/Oncology-Care-Final-Recommendations-2016-03.pdf

At the July meeting, Bree Collaborative members selected six new topics to investigate further as potential new topics for 2017 and to re-review the Total Knee and Total Hip Replacement Bundle and Warranty. Topics were evaluated across 11 criteria (e.g., whether data is available, previous quality improvement work, current stakeholder engagement, activities at the State and National level, whether shared decision making is applicable) and discussed at the September meeting. Members selected **Alzheimer's Disease and Other Dementias**, **Hysterectomy**, and **Opioid Use Disorder Treatment**.

The Bree Collaborative will continue to select new topic areas on an annual basis.

Accountable Payment Models: Bariatric Bundled Payment Model and Warranty

Background

Our current health care system mainly reimburses providers, hospitals, and others for the number or units of services provided rather than on quality of care or for an episode of care. This can lead to unnecessary services, poorly coordinated services that do not support patients including no information being shared between providers (e.g., surgical team and physical therapy), and poor patient outcomes. Bundled payments offer a mechanism to improve and standardize this care and have been shown to reduce cost along while improving patient health.[4]

Our Work

The Accountable Payment Models workgroup develops models to tie reimbursement for a surgery to an entire episode of care, including pre and post-operative care, with no additional payment for complications due to the original surgery.

The workgroup has convened since February 2016 to develop a bundled payment model and warranty for bariatric surgery using the three previous models on elective total knee and total hip replacement, elective lumbar fusion, and coronary artery bypass surgery as models. The Bariatric Surgical Bundle provides a voluntary, community-based, evidence-informed standard for production, purchasing, and payment of health care based on quality.

The National Institutes of Health (NIH) defines obesity as a BMI of equal to or greater than 30 kg/m^2.[5] According to this NIH definition, over one third of adults are obese in the United States. Obesity is associated with increased likelihood of type 2 diabetes, high blood pressure, hyperlipidemia, cardiovascular disease, obstructive sleep apnea, osteoarthritis, and gastroesophageal reflux (heartburn). The national annual cost of obesity and its consequences approaches $150 billion annually.[6] While there is no reliable long-term cure, even modest reductions in weight loss by any of a number of methods can convey benefit by controlling associated conditions such as diabetes, high blood pressure, and high cholesterol.

This bundle includes bariatric surgery as a treatment option for select individuals, requiring a holistic approach in which surgery is but one possible component of care. The first cycle is an appropriateness standard, outlining requirements for a trial of non-surgical care. The second cycle, also focused on appropriateness, lists requirements for patient fitness for surgery. The third cycle specifies elements of best practice surgery and the forth lists components of care to return patients to their lives with decreased comorbidities.

The Report and Recommendations were approved to be disseminated for public comment at the September 2016 meeting. Documents will be available for public comment for a four-week period and the workgroup will reconvene in November to review comments and make changes to the document prior to presenting for final approval at the November meeting.

Pediatric Psychotropic Use

Background

Antipsychotic prescribing rates have dramatically and consistently increased for adolescents and young adults.[7] Nationally, between 2002 and 2007, there has been a 62% increase in atypical antipsychotic (or second-generation) use among children enrolled in Medicaid.[8] These high numbers of prescriptions are problematic and potentially harmful as evidence shows that atypical antipsychotic use is associated with patient harms including obesity, suicidality, tics, and other effects on the developing brain.[9] Additionally, long-term research on the effects of atypical antipsychotic use in youth is lacking.

The United States Food and Drug Administration (FDA) has approved antipsychotic medications for use in children and adolescents with schizophrenia, bipolar disorder (manic/mixed) and irritability with autistic disorder. In addition to the FDA-approved indications, antipsychotics have been found to be helpful in reducing disruptive behavior in children and adolescents *without* psychosis, allowing the child or adolescent to remain in school, in home, and receptive to other forms of therapy. These off-label uses of antipsychotic agents (i.e., for conditions not approved by the FDA) include aggressive, impulsive, and disruptive behaviors, often in patients with attention-deficit hyperactivity disorder (ADHD), in the absence of psychosis.[10]

Our Work

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

The combination of high impact symptoms and poor access to non-pharmacologic treatments can lead providers to prescribe antipsychotic agents for these off-label uses. Washington State has a gap between evidence-based, patient-centered care and common practice for children under 21 diagnosed with aggressive, impulsive, and disruptive behaviors in the absence of psychosis. Many do not receive a validated mental health assessment, referral to psychosocial care as the first-line intervention, monitoring of symptoms, and if antipsychotics are prescribed, monitoring of side effects.

Focus areas of the Report and Recommendations include:

- Conducting an initial medical evaluation using evidence-based assessment tools.
- Ensuring that the patient and family have access to comprehensive, family-centered psychosocial care.
- Using evidence-based, best practice prescribing of antipsychotic drugs such as from the American Academy of Child and Adolescent Psychiatry

- If antipsychotics are prescribed, managing of side effects including monitoring for changes in weight and metabolic changes (baseline and at regular intervals).

The Report and Recommendations were approved to be disseminated for public comment at the September 2016 meeting. Documents will be available for public comment for a four-week period and the workgroup will reconvene in November to review comments and make changes to the document prior to presenting for final approval at the November meeting.

Behavioral Health Integration

Background

Approximately 16-23% of Americans experience a major depressive episode in their lifetimes, 7.6% in any two-week period.[11,12,13] On average, 80 million Americans visit an ambulatory care center with major depressive disorder as their primary diagnosis.[13] Episodes of major depressive disorder typically last 16 weeks, almost all being clinically significant.[12] Somatic symptoms, including fatigue and pain, are associated with depression and anxiety, leading to high use of medical care.[14] Depression is especially common among those with a chronic illness, such as diabetes, resulting in lower adherence to clinical recommendations, worse physical functioning, and higher cost.[15]

However behavioral health, encompassing mental health and substance abuse, has traditionally been siloed from physical health care. There is far greater stigma attached to mental health and substance abuse diagnoses than for other conditions; a less developed infrastructure for measuring and improving care quality; the need for connecting a greater variety and number of clinicians, specialists, and organizations; lower use of health information technology; and barriers in the health insurance marketplace.[16] Partially due to these barriers and to a lack of education and training among clinicians, screening for and comprehensive access to treatment for depression happen infrequently.[17] This is especially true in Washington State which has been ranked 48th on measures of need for mental health services compared to access.[18] Additionally, best practice care management processes are used less often for depression than for asthma, diabetes, or congestive heart failure in primary care, showing a gap both in comprehensive assessment and evidence-based, supportive treatment.[19]

Our Work

This workgroup has been meeting since April 2016 to develop recommendations on integration of behavioral health services into primary care. Integration has been shown to increase access to behavioral health services through decreased reliance on and better access to appropriate and appropriately timed specialty care and to be more patient-centered, cost-saving, and result in healthier patients and healthier populations.[20] This report aims to describe and lay a pathway for implementation of minimum standards for integration of behavioral health into primary care. Focus areas include:

- Screening for depression within primary care
- Defining integrated approaches focused on enhancing behavioral health access and outcomes
- Referring to treatment for depression
- Best practices for overcoming barriers to patient-centered behavioral health care
- Measuring improvements and access to behavioral health care

Workgroup meetings are scheduled into 2016 and early 2017 with a final Report and Recommendations expected in early 2017.

Implementation

Bree Collaborative recommendations have been championed by the Health Care Authority and supported and spread by Bree Collaborative member organizations and many other community organizations.

In alignment with the Healthier Washington goal to move health care payment from volume to value and deliver more coordinated, whole person care, Bree Collaborative recommendations are now included for a growing number of contracts. Beginning this January 2016, public employees can choose from two Accountable Care Network options: the Puget Sound High Value Network led by Virginia Mason Medical Center and the University of Washington Accountable Care Network. Both Networks have met the contractual obligation to submit quality improvement plans for obstetrics, total knee and total hip replacement, lumbar fusion, care coordination for high-risk patients, hospital readmissions, cardiology, low back pain, end-of-life care, and addiction and dependence treatment. Going forward, plans will be submitted annually.

Continuing the emphasis on paying for value, the Health Care Authority has designated Virginia Mason Medical Center as the Center of Excellence for total joint replacement surgery using the Bree Collaborative's total knee and hip replacement bundled payment as a model. State employees enrolled in the Public Employee Benefits Board Program Uniform Medical Plan will be able to select Virginia Mason for this procedure starting January 2017. The bundle will be administered by Premera Blue Cross.

Implementation of recommendations has been a focus of the Bree Collaborative since October 2013 first through the Implementation Team led by Dr. Dan Lessler, Chief Medical Officer, Health Care Authority, and currently through an implementation consultant.

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

- Education of stakeholders on content within the bundled payment models and methods of adopting the elective total knee and total hip bundled payment methodologies and warranties.
- Outreach to community groups (e.g., WSHA, WSMA, the Urban Indian Health Institute, NeighborCare, the Washington Dental Service Foundation, and Delta Dental).
- Participation in multiple Healthier Washington meetings and workgroups (e.g., Agency for Healthcare Research and Quality Shared Decision Making workshop)
- Speaking at multiple conferences and stakeholder groups to educate about the Bree Collaborative and specific, relevant recommendations (e.g., Hutchinson Center for Cancer Outcomes Research Value in Cancer Care Summit, Surgical Care and Outcomes Assessment Program annual meeting, Funders Oral Health Policy Group, Washington State Medical Association's Chief Medical Officer Safe Tables, Molina Healthcare).
- Increased Collaborative visibility broadly through upkeep of the website, www.breecollaborative.org, maintenance of a blog with posts published monthly or bi-

monthly highlighting relevant Collaborative topics or implementation strategies, and using social medial to engage the community. Examples of blog posts include Bringing Transparency and Quality Standards to Bariatric Surgery describing our previous work and reasons for developing bundled payments and highlighting the unique requirements of doing so for bariatric surgery.

Community Partners

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

- *Obstetrics*: Both the Obstetrics Clinical Outcomes Assessment Program (OB-COAP) and the Washington State Hospital Association's Safe Deliveries Roadmap have worked to align existing program expectations and data collection with Bree Collaborative recommendations for member hospitals.
- *Cardiology*: The Clinical Outcomes Assessment Program (COAP) continues to monitor insufficient information around percutaneous coronary intervention and was a keystone member in the development of a robust, community-based Bundle and Warranty for Elective Coronary Artery Bypass Graft Surgery.
- *Bundled Payments*: The Puget Sound High Value Network led by Virginia Mason Medical Center and the University of Washington Accountable Care Network are implementing the clinical components of the total knee and total hip replacement bundled payment model and lumbar fusion bundled payment model. Virginia Mason Medical Center will offer the total knee and total hip replacement as a bundle to public employees starting in January 2017.
- *Spine Care:* The Spine Surgical Care and Outcomes Assessment Program (SCOAP) has had six new member hospitals join and has made length of stay, radiologic verification of surgical level, and smoking use transparently available on their website as of August 2014.
- *Hospital Readmissions*: Qualis Health has been actively facilitating hospital readmissions collaboratives in Washington State communities since August 2014.
- *End-of-Life Care*:
    - Bree staff presented to the Joint Legislative Executive Committee on Aging and Disability on End-of-Life Care Recommendations on June 20th about how to increase the number of people in Washington State receiving end-of-life care aligned with their goals and values.
    - The Physician Orders for Life Sustaining Treatment (POLST) Taskforce is engaged with working to increase the number of patients who appropriately complete a POLST order. Bree staff is working to research the feasibility of a state-wide registry with POLST taskforce volunteers.
    - WSHA and WSMA have developed a statewide strategy to spread advance care planning at a health system and community-level aligned with the Bree Collaborative's recommendations. The two associations are working to promote

patient-centered end-of-life conversations through Honoring Choices®: Pacific Northwest.
    - Many other organizations are also promoted advance care planning conversations aligned with Bree Collaborative recommendations, increasing quality of care in our State.
- *Oncology*: Collaborative staff have participated in the Hutchinson Center for Cancer Outcomes Research Value in Cancer Care Intervention working group since its formation in late 2015 and spoke at the annual Value in Cancer Care Summit on the workgroup panel. The workgroup is focused on integrating goals of care conversations into oncology care and is aligned with both the Bree Collaborative's End-of-Life Care recommendations and with the Oncology Care Recommendations and focused on end-of-life care for cancer patients.

Implementation Consultant

In May 2016 the Bree Collaborative secured funding through Healthier Washington to hire an implementation consultant to provide strategic and technical expertise in support of the assessment and development of implementation strategies and supportive materials to facilitate adoption of Bree Collaborative recommendations across health care entities within Washington State. A consultant was hired in June 2016 for a nine month position lasting until February 2017. The consultant's role is to:

- Conduct an assessment of the Washington State health care community's adoption of Bree Collaborative recommendations and specifically to identify sites where adoption has and has not occurred and strategies or barriers within those sites that helped to facilitate or hinder adoption.
- Develop recommendations for multiple stakeholders, including Collaborative staff and leadership, on how to facilitate implementation uptake in the form of a comprehensive roadmap portfolio. Recommendations will be flexible enough to accommodate variability in the Washington State health care marketplace.
- Develop a comprehensive dashboard showing comparative progress on state-wide adoption of Bree Collaborative recommendations.
- Work closely with Collaborative Program Director to conduct educational outreach to health plans, provider groups, hospitals, and others across Washington State about Collaborative history, structure, mission, and recommendations.

Agency Medical Director's Group Opioid Prescribing Guidelines

The Bree Collaborative endorsed the Washington State Agency Medical Directors Guideline on Prescribing Opioids for Pain in July 2015 and subsequently developed a workgroup to design and carry out strategies to implement the Guidelines. The workgroup includes a diverse representation of health care stakeholders from Washington State agencies, health plans including Medicaid Managed Care Organizations, University of Washington, the Washington State Dental Association, and others and is chaired by chaired by Gary Franklin, MD, medical director, Washington State Labor and Industries.

The workgroup has prioritized:

- Reducing acute prescribing of opioids in dentistry (including by oral maxillofacial surgeons), primary care, emergency rooms, and in specialty care.
    - Outreach to the dental community has been a key component of this work including to the Dental Foundation, Delta Dental, the Washington State Dental Society, the Washington State Dental Commission, and the University of Washington, School of Dentistry. Collaborative staff and workgroup members and staff have published two articles in the Dental Commission newsletter and presented to the Dental Commission and to the University of Washington School of Dentistry in July 2016.
- Working to increase use of the Prescription Monitoring Program.
    - Workgroup members and staff have convened to develop concrete analytics measures to be used statewide (using State data and private health plan data) to uniformly track the scope of opioid use in Washington State. Metrics will be used to track the state of the State and by other health care stakeholders for quality improvement and population health.
- Developing protocols for reporting of non-fatal overdoses back to the initial prescriber using the Emergency Department Information Exchange (EDIE).
- Clinician education.

Further information about this workgroup is available on the Bree Collaborative website here: www.breecollaborative.org/topic-areas/opioid/

Summary of Work in the First Four Years

The engagement and dedication from our workgroup members has led to multiple high-quality and well-received sets of recommendations. From the Collaborative's founding in 2011 to November 2015 we have developed recommendations to improve obstetric care; cardiology; bundled payment models for elective total knee and total hip replacement, elective lumbar fusion, elective coronary artery bypass surgery; spine surgery; low back pain management; potentially avoidable hospital readmissions; end-of-life care; addiction and dependence screening; prostate cancer screening; and oncology care. Topics are discussed in this order.

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

Contents

Obstetric Care

Background

When initially looking at health services needing comprehensive recommendations, the Bree Collaborative found substantial variation in obstetric care practice patterns and services across providers and facilities in Washington State despite local and national quality improvement efforts. In 2012, the percent of deliveries performed between 37 and 39 weeks that were not medically necessary varied significantly across Washington hospitals, from zero to 18.5%.[21]

Our Work

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

- **Elective deliveries**. Eliminate all non-medically necessary deliveries before the 39th week (those deliveries for which there is no appropriate documentation of medical necessity).
- **Elective inductions of labor.** Decrease elective inductions of labor between 39 and up to 41 weeks.
- **Primary Cesarean-sections.** Decrease unsupported variation among Washington hospitals in C-section rate of women who have never had a C-section.

The Bree Collaborative adopted the Obstetric Care Report and Recommendations in August 2012 with approval by the HCA director following in October 2012.

The Obstetric Care Report and Recommendations is available here:
www.breecollaborative.org/wp-content/uploads/bree_ob_report_final_080212.pdf

Implementation work has focused on aligning incentives, education, and coordination across programs. Most notably, the HCA has implemented a non-payment policy for early elective deliveries. This advancement built off previous work to educate clinicians and health care stakeholders statewide and presentations given to Medicaid health plans and allow for lasting improvements in maternal and infant health.

Of hospitals part of the Obstetrics Clinical Outcomes Assessment Program, the percent of primary cesarean rate has decreased from 18.1% in 2014 to 17.5% as of June 2016. The percent of spontaneously laboring women admitted at 4cm dilated or more has increased from 61.5% to 66.2%.

The Washington State Hospital Association reports a 94.2% reduction in early elective deliveries from quarter three of 2010 to quarter one of 2016, resulting in 5,340 babies allowed to fully mature and saving $52.1 million. This was accomplished by WSHA Safe Table Learning Collaboratives which share best practices and one-on-one support to those hospitals with challenges.

Cardiology

Background

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

Our Work

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

- **Step 1:** Appropriate use insufficient information report with 2012 data by hospital posted on the COAP members-only section of the COAP website.
    - *Completed August 2012.*
- **Step 2**: COAP provides feedback and tools to hospitals to reduce insufficient information in data.
    - *Completed August to December 2012.*
- **Step 3**: Updated appropriate use insufficient information report based on 4th Quarter 2012 data only, by hospital, given to Collaborative and hospitals to review. Hospitals had the option not to be identified.
    - *Completed May 2013.*
- **Step 4**: After hospitals employed methods for improvement, an updated report based on 4th Quarter 2012 data only was posted on the public section of the COAP website. The Bree Collaborative also asked the Washington State Alliance to post COAP data on its Community Checkup website, which compares data on health care services across the State. Hospitals had the option to not be identified.
    - *Completed June 2013.*

The Cardiology Report and Recommendations was adopted by the Bree Collaborative in January 2013 and approved by the HCA Director in January 2014. COAP continues to monitor rates of insufficient information and PCI appropriateness to assess the impact of public disclosure and has partnered with the Bree Collaborative in other areas as well.

The Cardiology Report and Recommendations is available here:
www.breecollaborative.org/wp-content/uploads/bree_bc_cardiology_final.pdf

The average rate of *insufficient information to determine appropriate use of non-acute PCI* has reduced from 29% in 2011 to 24% in 2015.

Accountable Payment Models: Elective Total Knee and Total Hip Replacement

Background

Total knee and total hip replacements are frequent surgical procedures, but also have high facility-to-facility variability in how surgery is performed. This variability can lead to variation in readmission rates, quality, cost, and patient health.

> **Hospital readmission rates for total knee and total hip replacements are posted on the Bree Collaborative website here:** www.breecollaborative.org/wp-content/uploads/bree_summary_CHARS_Analysis.pdf

Our Work

The Accountable Payment Models workgroup develops models to tie reimbursement for a surgery to an entire episode of care, including pre and post-operative care, with no additional payment for complications due to the original surgery. The workgroup developed both a warranty and a bundled payment model for elective total knee and total hip replacement. The warranty defines complications and timeframes after surgery in which complications can be attributed to the original surgery in order to track clinical and financial accountability for additional care needed to diagnose, manage, and resolve complications.

The surgical bundle defines expected components of pre-operative, intra-operative, and post-operative care needed for successful total knee and total hip surgery. Quality standards are included that correspond to the surgical components and are required to be reported to the purchaser and health plans. The bundle is presented in four stages:

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

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

> **The TKR/THR Warranty Model is available here:** www.breecollaborative.org/wp-content/uploads/bree_warranty_tkr_thr.pdf
> **The TKR/THR Surgical Bundle is available here:** www.breecollaborative.org/wp-content/uploads/tkrthr_bundle.pdf
> **The evidence table is available here:** www.breecollaborative.org/wp-content/uploads/tkr_thr_evidence.xls

The TKR/ THR bundle and warranty have been incorporated into the Health Care Authority's Accountable Care Network contracts and offered to public employees starting January 2016. Virginia Mason Medical Center will offer the bundle and warranty to public employees as the Health Care Authority-contracted Center of Excellence starting January 2017.

Accountable Payment Models: Elective Lumbar Fusion

Background

While there is clinical agreement that lumbar fusion can be appropriate in cases of spinal instability from major trauma or congenital abnormalities, the surgery has the highest regional variation of any major surgery in the United States, with a 20-fold difference between geographic regions.[22] Lumbar fusion also has the highest inpatient cost for public employees with Uniform Medical Plan at an average cost of $80,000-$120,000. Additionally, lumbar fusion is associated with high rates of complications, high cost to patients, and some studies show the surgery may not result in better health than non-surgical alternatives.[23,24]

Our Work

The Accountable Payment Models workgroup re-formed with new membership and met from January 2014 to August 2014 to develop surgical standards and payment methodologies for elective lumbar fusion. The workgroup adapted the previously developed elective total knee and total hip replacement model. As in the previous case, to improve safety for patients, performance for providers, and affordability for purchasers, the workgroup proposed a four-stage model requiring:

- Documentation of disability despite explicit non-surgical care
- Meeting fitness requirements for patients prior to surgery
- Adherence to standards for best-practice surgery
- Implementation of a structured plan to rapidly return patients to function

The primary intent of the warranty is to set a high priority on patient safety while balancing financial gain with accountability for providers and institutions performing lumbar fusion surgery. The models is an attempt to align purchasing and payment with best practices to lead to safer care, better outcomes, and lower costs. The final products serves as a guide for quality- and value-based purchasing for both public and private sectors.

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

The Lumbar Fusion Bundle is available here: www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Bundle-Final.pdf

The Lumbar Fusion Warranty is available here: www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Warranty-Final.pdf

The supporting evidence table is available here: www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Evidence-Table-Final.pdf

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

Accountable Payment Models: Coronary Artery Bypass Surgery

Background

Coronary artery disease occurs due to plaque build-up on arterial walls and is the leading cause of death in the United States.[25] This is often treated with coronary artery bypass graft surgery (CABG). CABG surgery has high variation in price, utilization, and in complication rates between providers and institutions.[26] Bundled payments offer a mechanism to improve and standardize this care and have been shown to reduce cost along with improving patient outcomes.[27]

Our Work

The workgroup convened from February 2015 to September 2015 to develop a bundled payment model and warranty for elective CABG using the previous two models on elective total knee and total hip replacement and elective lumbar fusion as a model. The intent of the CABG surgical bundle is to provide a community-based, evidence-informed standard for production, purchasing, and payment of health care based on quality.

The four-stage bundle extends beyond the surgical procedure itself and includes both comprehensive care prior to and rehabilitative care after the surgery. The first stage documents the need for intervention and deploys non-surgical care, if appropriate. The second stage ensures that patients who do not improve with non-surgical care could safely undergo surgery, such as focusing on stopping smoking. The third stage describes elements of best-practice surgery and the fourth is aimed at the ultimate outcome, rapid return to function.

COAP, the Foundation for Health Care Quality program described in the Cardiology section previously, was instrumental in the development of a comprehensive set of quality measures to align with the four stages. All hospitals that perform CABG in Washington State report data to COAP.

> **The CABG Bundle is available here:** www.breecollaborative.org/wp-content/uploads/CABG-Bundle-Final-15-09.pdf
>
> **The CABG Warranty is available here:** www.breecollaborative.org/wp-content/uploads/CABG-Warranty-Final-15-09.pdf
>
> **The supporting evidence table is available here:** www.breecollaborative.org/wp-content/uploads/CABG-Evidence-Table-Final-15-09.pdf

The CABG Surgical Bundle and Warranty were adopted by the Bree Collaborative in September 2015 and approved by the Health Care Authority Director October 2015.

Low Back Pain and Spine Surgery

Background

Low back pain is a common and costly condition with significant variation in diagnosis and treatment. Frequent use of costly treatments has not been shown to improve patient symptoms and effective management can be difficult as the majority of patients have no identifiable anatomic or physiologic cause.[28,29,30] For most patients with acute low back pain, symptoms improve with conservative treatment such as physical activity but some patients are at higher risk of developing chronic pain. If patients do develop chronic pain, more intense treatment options become necessary such as lumbar fusion surgery, described on the previous page.

Our Work

The Bree Collaborative chose a two-pronged strategy to address both acute and chronic low back pain:

- Form a workgroup to develop recommendations for preventing the transition of acute pain to chronic pain.
- Recommend that all hospitals participate in Spine SCOAP, a clinician-led quality improvement collaborative for hospitals in Washington State and a program of the Foundation for Health Care Quality, to improve surgical outcomes for spine surgery.

In March 2013, the Bree Collaborative submitted recommendations to the Health Care Authority "*strongly recommend[ing] participation in Spine SCOAP as a community standard, starting with hospitals performing spine surgery with the following conditions:*

- *Results are unblinded.*
- *Results are available by group.*
- *Establish a clear and aggressive timeline.*
- *Recognize that more information is needed about options for tying payment to participation*."

Spine SCOAP has seen six new hospitals join. Starting August 2014 length of stay, radiologic verification of surgical level, and smoking use have been transparently available on the website.

The Low Back Pain workgroup met from November 2012 to October 2013. Focus areas include increasing:

- Appropriate evaluation and management of patients with new onset and persistent acute low back pain and/or nonspecific low back pain not associated with major trauma (no red flags) in primary care
- Early identification and management of patients that present with low back pain not associated with major trauma (no red flags) but have psychosocial factors (yellow flags) that place them at a high risk for developing chronic low back pain
- Awareness of low back pain management among individual patients and the general public

The Bree Collaborative adopted the recommendations in November 2013 and the Health Care Authority approved the recommendations in January 2014.

The Low Back Pain Report and Recommendations is available here:
www.breecollaborative.org/wp-content/uploads/spine_lbp.pdf

Potentially Avoidable Hospital Readmissions

Background

Avoidable hospital readmissions are common and costly events, negatively impacting patient health and wellbeing. The estimated national cost for unplanned Medicare hospital readmissions was $17.4 billion in 2004.[31] While not all hospital readmissions are preventable, reducing readmission rates through greater community collaboration among diverse stakeholders, implementation of standard processes within the hospital, and better communication represents a great opportunity to improve health care quality, outcomes, and affordability.

Our Work

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

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

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

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

II. **Toolkit:** Support for the tools and techniques to reduce readmissions in Washington State, especially the WSHA's *Care Transitions Toolkit, second edition*, the work done by Qualis Health, and the work done by the Washington Health Alliance. The Bree Collaborative recognizes the consensus work based on best available evidence that went into the *Care Transitions Toolkit* and recommends that hospitals adopt the *Toolkit* in its entirety. It is understood that some variation may be appropriate based on clinically compelling reasons.

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

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

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

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

The Potentially Avoidable Hospital Readmissions Report and Recommendations is available here: www.breecollaborative.org/wp-content/uploads/Readmissions-Report-FINAL-14-0730.pdf

Qualis Health is actively facilitating readmissions collaboratives in five of the sixteen identified (by Qualis Health using Medicare FFS beneficiary healthcare service use patterns) Washington State communities since August 2014, with more to be added in the coming year. Qualis Health also provides data reports and technical assistance upon request to all sixteen communities. Communities participating in the Collaboratives include representatives of hospitals, nursing homes, outpatient providers, pharmacies, emergency medical service providers (Fire Departments), social service agencies such as Area Agencies on Aging, patients, and others. To the extent practicable, the Qualis Health team tracks participation in recurring or ad-hoc community and provider meetings, and conducts proactive outreach to under-represented groups to help assure robust community participation in events.

Charters reflect the length of expected participation in the work. All recruited cohorts must continue with Qualis Health through the end of the current QIN-QIO contract (July 31, 2019). Cohort A (South King County, Pierce County and the CHOICE community) was recruited in 2014; Cohort B (Southwest Washington/Vancouver and Snohomish County) was recruited in 2015, and Cohort C will be selected shortly.

The Washington State Hospital Association reports a 27.9% reduction in readmissions per 1,000 eligible Medicare beneficiaries from quarter one of 2011 to quarter four of 2015, resulting in 23,459 fewer patients being readmitted and saving $363 million. This was accomplished through WSHA Safe Table Learning Collaboratives, WSHA Smooth Transitions Toolkit, and one-on-one support. Regional groups were also set up to support local issues and help patients who have frequent readmissions and need a coordinated approach to services.

End-of-Life Care

Background

End-of-life care in the United States and within Washington State is strikingly variable and often misaligned with patient preference.[32,33] Although the majority of patients report wanting to spend the last part of their lives at home, in reality much of this time is spent in a hospital or nursing home.[34] Family members of patients at the end of their life also report care not aligning with patient wishes, in many cases due to unwanted aggressive treatment, and significant financial impact of in-hospital deaths.[35,36]

Surviving family members have been shown to have symptoms of post-traumatic stress disorder after the death of a loved one in an intensive care unit.[37] Care that is at odds with patient and family wishes negatively impacts quality of patients' life, increases cost to families, and seriously overburdens patients and their families. Appropriately timed advance care planning conversations between providers and patients and between patients and their families and/or caregivers and expressing end-of-life wishes in writing with advance directives and Physician Orders for Life Sustaining Treatment (POLST) if appropriate, can increase patient confidence, sense of dignity, and the probability that patient wishes are honored at the time of death.[38,39]

Our Work

The workgroup met from January 2014 to November 2014 with the goal that all Washingtonians are informed about their end-of-life care options, communicate their preferences in actionable terms, and receive end-of-life care that is aligned with their and their family members' goals and values. The workgroup developed the following five focus areas corresponding to how an individual would ideally experience advance care planning for the end of life.

- Increase awareness of advance care planning, advance directives, and POLST in Washington State
- Increase the number of people who participate in advance care planning in clinical and community settings
- Increase the number of people who record their wishes and goals for end-of-life care using documents that: accurately represent their values; are easily understandable by all readers including family members, friends, and health care providers; and can be acted upon in the health care setting
- Increase the accessibility of completed advance directives and POLST for health systems and providers
- Increase the likelihood that a patient's end-of-life care choices are honored

The Report and Recommendations was adopted by the Bree Collaborative in November 2014 and approved by the Health Care Authority Director December 2014.

The End-of-Life Care Report and Recommendations is available here:
www.breecollaborative.org/wp-content/uploads/EOL-Care-Final-Report.pdf

Advance care planning conversations are now reimbursable by Medicaid in clinical settings. Private health plans including Premera, Group Health Cooperative, Regence and others are also reimbursing for advance care planning conversations.

The Bree Collaborative has also been part of the efforts of the Washington State Hospital Association and Washington State Medical Association to develop a statewide strategy to spread advance care planning conversations and ensure that "everyone will receive care that honors personal values and goals in the last chapters of life." Called Honoring Choices® Pacific Northwest, this initiative is using national best practices to transform culture through health care organization and community engagement. "Statewide engagement includes large and small, urban and rural medical groups and hospitals. Participation is expanding to community groups. As of September 2016, there are 95 Facilitators in 23 organizations actively having advance care planning conversations. Additionally, Honoring Choices Pacific Northwest developed free state-wide patient engagement materials, including an advance directive, wallet card, informational sheets and education guides."[40] One participant in the advanced care planning conversations reported "This session was invaluable for me. [The trainer] took some very complex topics and helped me really understand them." Learn more here: www.honoringchoicespnw.org

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

Addiction and Dependence Treatment

Background

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

Our Work

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

- Reduce stigma associated with alcohol and other drug screening, intervention, and treatment
- Increase appropriate alcohol and other drug use screening in primary care and emergency room settings
- Increase capacity to provide brief intervention and/or brief treatment for alcohol and other drug misuse
- Decrease barriers for facilitating referrals to appropriate treatment facilities
- Address the opioid addiction epidemic

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

The Addiction and Dependence Treatment Report and Recommendations is available here: www.breecollaborative.org/wp-content/uploads/ADT-Final-Report.pdf

In July 2015, Bree Collaborative members adopted the Agency Medical Director's Interagency Guide for Prescribing Opioids for Pain and a workgroup has been meeting since December 2015 to implement the Guidelines. Recommendations for screening, brief intervention, and referral to treatment have also been incorporated into the Health Care Authority's Accountable Care Network contracting.

Prostate Cancer Screening

Background

Prostate cancer is the most common type of cancer diagnosed among men.[46] Men have a lifetime risk of 14% with an average five year survival of 98.9%.[47] The prostate specific antigen (PSA) test is commonly used to screen men for prostate cancer. However, evidence conflicts as to whether the PSA test when used for prostate cancer screening has been associated with reduction in prostate cancer mortality.[48,49] The potential for overtreatment, treatment when no disease is present, is high.[50] The majority of harms from prostate cancer screening occur due to psychological consequences of a positive test, in those that do have a positive test, harms from biopsy, and in those that have a positive biopsy, harms from the treatment itself. Prostatectomy and radiation are common forms of treatment in the United States, resulting in serious complications (e.g., heart attack, stroke, impotence, urinary incontinence).[51]

Guidelines on using the PSA test for routine prostate cancer screening differ on whether health care providers should initiate a discussion about PSA testing with all men in an appropriate age range (e.g., 55- 69) and risk category or discuss screening only at the patient's request.[52,53] Most guidelines recommend shared decision making prior to a PSA test. Despite these recommendations and those of others, use of a shared decision-making process is uncommon and variable and many men given the test are not informed of the potential harms, benefits, and scientific uncertainty.

Our Work

The workgroup met from March to November 2015. The Bree Collaborative recommends that all men be evaluated by their provider for family history and factors that may elevate the risk of prostate cancer (e.g., first or second degree relative with a prostate or breast cancer diagnosis, race). The Bree Collaborative recommends against routine screening with PSA testing for average risk men 70 years and older, under 55 years old, who have significant co-morbid conditions, or with a life expectancy less than 10 years.

For primary care clinicians, the Bree Collaborative recommends two possible pathways depending on the physician's interpretation of the evidence. Clinicians who believe there is overall benefit from screening with PSA testing should order this test for average risk men between 55-69 years old only after a formal and documented shared decision-making process. Clinicians who believe there is overall harm from screening with PSA testing may initiate testing of average-risk men aged 55-69 at the request of the patient after a formal and documented shared decision-making process. Only men who express a definite preference for screening after discussing the advantages, disadvantages, and scientific uncertainty should have screening with PSA testing.

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

The Prostate Cancer Screening Report and Recommendations is available here:
www.breecollaborative.org/wp-content/uploads/Prostate-Cancer-Recommendations-Final-15-11.pdf

Oncology Care

Background

Cancer death rates have declined in the United States from 2002-2011, due in part to great advances in cancer prevention and treatment.[54] However, cost of care has increased significantly, resulting in financial burden on patients and families. National surveys show significant financial impact on patients and families due to cancer treatment where of those surveyed 25% used up most or all of their savings.[55] Cost and quality can also vary, indicating need for greater standardization and reduction in procedures that do not result in better patient health.[56,57]

Significant variation in diagnosis, treatment, and supportive care for patients promotes poor outcomes and excessive cost for patients and the health care system.[58] In 2012, the American Society of Clinical Oncology (ASCO) and the American Board of Internal Medicine partnered as part of Choosing Wisely to identify five tests or procedures "whose necessity is not supported by high-level evidence" and developed guidelines including around therapeutic effectiveness and palliative care and use of advanced imaging for staging of low risk breast and prostate cancer.[59]

Our Work

The workgroup met from May 2015 to March 2016 to develop recommendations and implementation strategies around two of the ASCO Choosing Wisely guidelines: advanced imaging for staging of low-risk breast and prostate cancer and palliative care. For prostate cancer, as part of Choosing Wisely, ASCO recommends: Do not use PET [positron emission tomography], CT [computed tomography] and radionuclide bone scans in the staging of early prostate cancer at low risk of spreading. For breast cancer as part of Choosing Wisely, ASCO recommends: Do not use PET, CT, and radionuclide bone scans in the staging of early breast cancer that is at low risk of spreading.

In alignment with the End-of-Life Care Recommendations, the Bree Collaborative recommends that oncology care be aligned with a patient's individual goals and values. Patients should be appraised of harms, benefits, evidence, and potential impact of chemotherapy and radiation at all stages in their illness trajectory. We encourage clinicians and care teams to regularly ask patients, their family members, and friends to discuss their goals of care and work with the care team to tailor care to patient goals.

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

The Oncology Care Report and Recommendations is available here:
www.breecollaborative.org/wp-content/uploads/Oncology-Care-Final-Recommendations-2016-03.pdf

Collaborative staff have participated in the Hutchinson Center for Cancer Outcomes Research Value in Cancer Care Intervention working group since its formation in late 2015 and spoke at the annual Value in Cancer Care Summit on the workgroup panel. The workgroup is focused on integrating goals of care conversations into oncology care.

Looking Forward to Year Six

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

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

The Bariatric Bundled Payment Model and Pediatric Psychotropic Use workgroups will meet in November to discuss public comments and make changes to the documents based on the comments. The workgroups will present the Bundled Payment Model and Warranty and the Pediatric Psychotropic Use Report and Recommendations to the Bree Collaborative for final adoption in November 2016. The Behavioral Health Integration workgroup anticipates finalizing recommendations for presentation at the January 2017 meeting

The Bree Collaborative will convene a workgroup to re-review the Total Knee and Total Hip Replacement Bundle and Warranty, continue to convene the Agency Medical Director's Group Opioid Prescribing Guidelines, and will also form workgroups in early 2017 for **Alzheimer's Disease and Other Dementias**, **Hysterectomy**, and **Opioid Use Disorder Treatment**.

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Appendix A: Bree Collaborative Background

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

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

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

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

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

Appendix B: Bree Collaborative Members

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

Appendix C: Steering Committee Members

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

Appendix D: Workgroup Members

Accountable Payment Models: Bariatric Surgery Workgroup Members

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

Accountable Payment Models: Coronary Artery Bypass Surgery

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

Accountable Payment Models: Lumbar Fusion

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

Accountable Payment Models: Total Knee and Total Hip Replacement

Member	Title	Organization
Susie Dade MS	Deputy Director	Washington Health Alliance
Joe Gifford MD	Chief Strategy and Innovation Officer for Western Washington	Providence Health and Services
Bob Herr, MD	Medical Director, Government Programs	Regence Blue Shield
Tom Hutchinson	Practice Administrator	PeaceHealth
Rich Maturi	Senior Vice President, Health Care Delivery Systems	Premera Blue Cross
Gary McLaughlin	Vice President of Finance	Overlake Hospital

Robert Mecklenburg, MD (Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Kerry Schaefer	Strategic Planner For Employee Health	King County
Julie Sylvester	Vice President of Quality and Safety Initiatives	Qualis Health
Jay Tihinen	Assistant Vice President, Benefits	Costco

Addiction/Dependence Treatment

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

Behavioral Health Integration

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

Bree Implementation Team

Member	Title	Organization
Neil Chasan	Physical Therapist	Sports Reaction Center
Susie Dade MS	Deputy Director	Washington Health Alliance
Cezanne Garcia	Program Manager, Community and School-Based Partnerships	Public Health Seattle – King County
Ellen Kauffman MD	OB-COAP Medical Director	Foundation for Health Care Quality
Dan Lessler MD (Chair)	Medical Director	Health Care Authority

Alice Lind RN	Manager, Grants and Program Development	Health Care Authority
Jason McGill JD	Health Policy Advisor	Governor's Office
Larry McNutt	Sr. Vice President	Northwest Administrators, Inc
Mary Kay O'Neill MD, MBA	Chief Medical Director	Coordinated Care
Steven Overman MD	Director	Seattle Arthritis Clinic
Terry Rogers MD	Chief Executive Officer	Foundation for Health Care Quality
Claudia Sanders	Senior Vice President, Policy Development	Washington State Hospital Association
Kerry Schaefer	Strategic Planner for Employee Health	King County
Jeff Thompson MD	Senior Health Care Consultant	Mercer
Shawn West MD	Family Physician	Edmonds Family Medicine
Karen Wren	Benefits Manager	Point B

End-of-Life Care

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

Bruce Smith MD (Vice Chair)	Associate Medical Director, Strategy Deployment	Group Health Physicians
Richard Stuart DSW	Clinical Professor Emeritus, Psychiatry	University of Washington

Hospital Readmissions

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

Low Back Pain

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

Kelly Weaver MD	Physiatrist	The Everett Clinic

Obstetric (Maternity) Care

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

Oncology Care

Member	Title	Organization
Jennie Crews MD	Medical Director	PeaceHealth St. Joseph Cancer Center
Bruce Cutter MD	Oncologist	Medical Oncology Associates
Patricia Dawson MD, PhD	Director	Swedish Cancer Institute Breast Program and True Family Women's Cancer Center
Keith Eaton MD, PhD	Medical Director, Quality, Safety and Value	Seattle Cancer Care Alliance
Janet Freeman-Daily	Patient Advocate	

Christopher Kodama MD, MBA (Chair)	President, MultiCare Connected Care	MultiCare Health System
Gary Lyman MD, MPH	Co-Director	Hutchinson Institute for Cancer Outcomes Research
Rick McGee MD	Oncologist	Washington State Medical Oncology Society
John Rieke MD,FACR	Medical Director	MultiCare Regional Cancer Center
Hugh Straley MD	Chair and Oncologist	Bree Collaborative
Richard Whitten MD	Medical Director	Noridian

Opioid Prescribing Guideline Implementation

Name	Title	Organization
Chris Baumgartner	Director Prescription Monitoring Program	Washington State Department of Health
David Buchholz, MD	Medical Director of Provider Engagement	Premera
Tanya Dansky, MD	Chief Medical Officer	Amerigroup
Gary Franklin, MD, MPH (Chair)	Medical Director	Washington State Department of Labor and Industries
Charissa Fontinos, MD	Deputy Chief Medical Officer	Washington State Health Care Authority
Frances Gough, MD	Chief Medical Officer	Molina Healthcare
Kathy Lofy, MD	Chief Science Officer	Washington State Department of Health
Jaymie Mai, PharmD	Pharmacy Manager	Washington State Department of Labor and Industries
Mark Murphy, MD	Addiction Medicine	MultiCare Health System
Shirley Reitz, PharmD	Clinical Pharmacist Client Manager	OmedaRx, Cambia
Gregory Rudolph, MD	Addiction Medicine	Swedish Pain Services

Michael Schiesser, MD	Addiction Medicine	EvergreenHealth Medical Center
Danny Stene, MD	Medical Director	First Choice Health
Mark Stephens	President	Change Management Consulting
Hugh Straley, MD	Chair	Bree Collaborative
David Tauben, MD	Chief of Pain Medicine	University of Washington Medical Center
Gregory Terman MD, PhD	Professor	Department of Anesthesiology and Pain Medicine and the Graduate Program in Neurobiology and Behavior, University of Washington
Emily Transue, MD	Chief Medical Director	Coordinated Care
Michael Von Korff, ScD	Senior Investigator	Group Health Research Institute
Melet Whinston, MD	Medical Director	United Health Care

Prostate Cancer Screening

Member	Title	Organization
John Gore MD, MS	Urologist, clinician, surgeon, researcher	University of Washington Medicine
Matt Handley MD	Medical Director, Quality	Group Health Cooperative
Leah Hole-Marshall JD	Medical Administrator	Department of Labor & Industries
Steve Lovell	Retired	Patient and Family Advisory Council
Wm. Richard Ludwig MD (Chair)	Chief Medical Officer	Providence Accountable Care Organization
Bruce Montgomery MD	Clinical Director of Genitourinary Medical Oncology	Seattle Cancer Care Alliance
Eric Wall MD, MPH	Market Medical Director	UnitedHealthcare

Shawn West MD	Family Physician	Edmonds Family Medicine
Jonathan Wright MD, MS, FACS	Assistant professor of urology/affiliate researcher	University of Washington/Fred Hutchinson Cancer Research Center

Pediatric Psychotropic Use

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