Bree Collaborative Meeting

January 15th, 2020 | Puget Sound Regional Council

Agenda

- **Welcome and Introductions**
- **Chair Report and Meeting Minutes**
  - Action Item: Approve minutes
- **Clinical Information Exchange in Washington State**
- **Cascade Care**
- **Final Adoption:** Risk of Violence to Others
  - Action Item: Final Adoption
- **Final Adoption:** Maternity Bundle
  - Action Item: Final Adoption

- **BREAK**

- **Retreat**
- **Next Steps and Close**

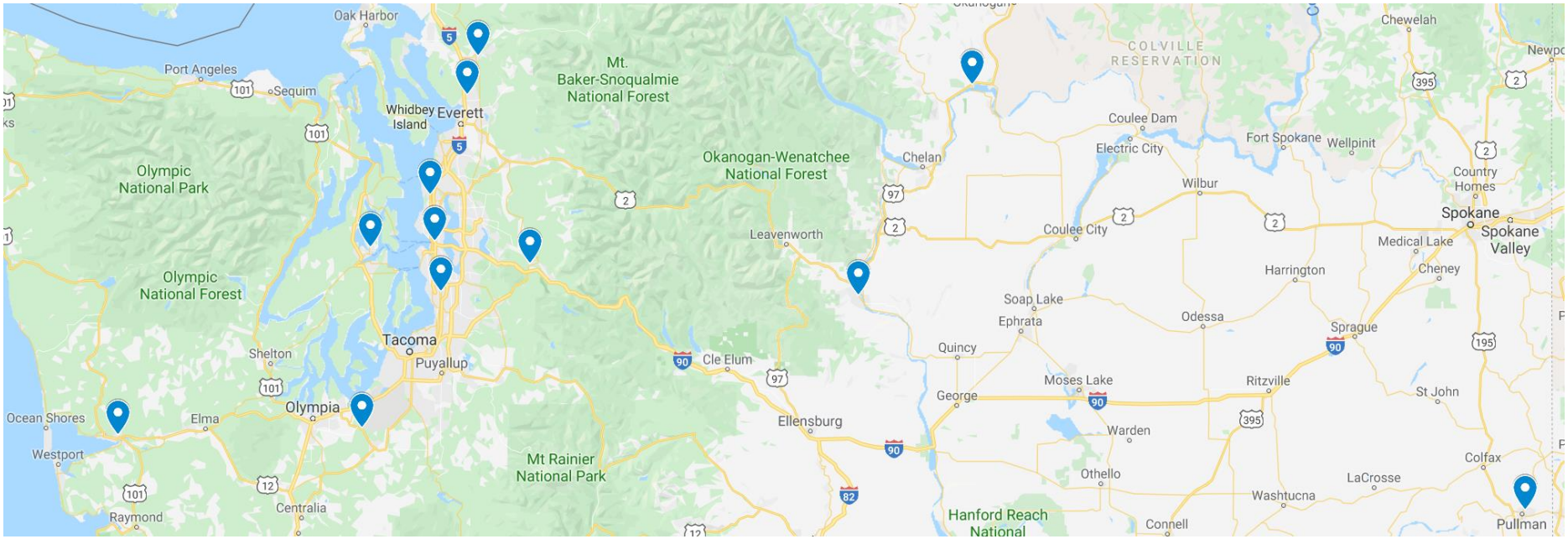
November 20th Meeting Minutes

Dr. Robert Bree Collaborative Meeting Minutes
November 20th, 2019 | 12:30-4:00
Puget Sound Regional Council
1101 Western Ave | Seattle, WA 98104

Members Present

Hugh Straley, MD, (Chair)
Susie Dade, MS, Washington Health Alliance
Peter Dunbar, MB ChB, MBA, Foundation for Health Care Quality
Gary Franklin, MD, Washington State Department of Labor and Industries
Darcy Jaffe, MN, ARNP, NE-BC, FACHE, Washington State Hospital Association
Sonja Kellen, Global Health & Wellness Benefits, Microsoft
Rick Ludwig, MD, Providence Health Accountable Care
Greg Marchand, Benefits & Policy, The Boeing Company
Robert Mecklenburg, MD, Virginia Mason Medical Center
Kimberly Moore, MD, Franciscan Health System
Carl Olden, MD, Pacific Crest Family Medicine
Drew Oliveira, MD, Regence
John Robinson, MD, SM, First Choice Health
Jeanne Rupert,* DO, PhD, Provider, One Medical
Laura Kate Zaichkin, MPH, SEIU 775 Benefits Group
Dan Kent, MD, United Health Care
Angie Sparks, MD, Kaiser Permanente
Judy Zerzan, MD, MPH, Washington State Health Care Authority
Mary Kay O'Neill MD, MBA, Mercer

Behavioral Health Integration Initiative



Kitsap Medical Group – Bremerton
International Community Health Services – Shoreline
Highline Medical Services Organizations
Nisqually Tribal Health Clinic
Snoqualmie Ridge Medical Clinic
Confluence Health – Wenatchee
Community Health Centers of Snohomish County
Children's Clinic at Harborview - Seattle
Marysville Family Medicine
Harbor Medical Group – Aberdeen
Family Health Centers – Brewster
Pullman Family Medicine

Behavioral Health Integration Guideline CHECKLIST

DR. ROBERT BREE COLLABORATIVE

8 ELEMENTS OF INTEGRATION

INTEGRATED CARE TEAM

- ❑ Clearly defined roles for all team members, including clinicians and non-licensed staff
- ❑ Shared workflows between primary care and behavioral health teams
- ❑ Huddles, team meetings, and pre-visit planning include all team members (on-site or virtual)

PATIENT ACCESS TO BEHAVIORAL HEALTH AS A ROUTINE PART OF CARE

- ❑ Clear referral and scheduling process for behavioral health services
- ❑ Same day access to behavioral health services (on-site or virtually); minimum same day care plan
- ❑ Services scheduled in a way that best meet the patients need, especially in first month of treatment (in person, phone, or virtual)

ACCESSIBLITY AND SHARING OF PATIENT INFORMATION

- ❑ Patient health information and shared care plan accessible by all care team members through EHR or shared clinical care management system at the point of care
- ❑ Regularly scheduled consultations between clinicians to jointly address shared care plan
- ❑ System in place to track progress and progress toward patient treatment goals

PRACTICE ACCESS TO PSYCHIATRIC SERVICES

- ❑ Systematic access to psychiatric consultation services to assist primary care provider and team with treatment plan development and adjustments (on-site or virtual)
- ❑ Clear referral and coordination process to specialty care for complex symptoms and diagnoses
- ❑ Bi-directional communication for all referrals

SYSTEMS & WORKFLOWS TO SUPPORT POPULATION-BASED CARE

- ❑ Clear workflow to regularly screen patients for alcohol use disorder, substance use disorder, and select mental health conditions
- ❑ System in place to record, track and follow-up on screening results
- ❑ System in place to track patients with clinic identified target conditions (i.e. registry)

EVIDENCE-BASED TREATMENTS

- ❑ Patient care is age, language, culturally, and religiously appropriate
- ❑ Evidence-based interventions adapted for patient population to support appropriate self-management
- ❑ Patient improvement is measured using a symptom rating scale

PATIENT INVOLVEMENT IN CARE

- ❑ Patient input is valued and patient feels like a partner in care plan/goal development
- ❑ Shared decision making, where appropriate
- ❑ System in place to identify and assist with barriers to care (e.g. social determinants of health)

DATA FOR QUALITY IMPROVEMENT

- ❑ System in place to track organizational data
- ❑ System in place to capture patient feedback
- ❑ Quality improvement structure to achieve access goals and outcome standards

Bree Collaborative Behavioral Health Integration Assessment

General (Circle one NUMBER for each characteristic)									
Staff awareness of Bree Collaborative Guidelines	…no awareness of Bree Collaborative Guidelines	…basic level of awareness; content not known			…general awareness; some specific content known			…advanced knowledge of awareness; content known and staff interest in implementation	
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Buy-in/Interest in Implementation of Bree Collaborative Guidelines	…no interest in Guideline Implementation	…actively considering Guideline Implementation			…some steps taken toward Guideline Implementation; test cycles beginning			…actively working toward Guideline Implementation; team formed and test cycles ongoing	
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Suicide Care									
Use of screening tool(s) with targeted suicide identification question	…does not occur	…is an organizational goal, but not in use			…is done sporadically but no formal process exists or tracking system in place			…is part of standard practice; a formal process is in place and used by all care teams	
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Collaborative safety planning	…does not occur	…is an organizational goal, but not in use			…is done sporadically but no formal process exists or tracking system in place			…is part of standard practice; a formal process is in place and used by all care teams	
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Lethal means safety conversation after suicide risk	…does not occur	…is an organizational goal, but not in use			…is done sporadically but no formal process exists or tracking system in place			…is part of standard practice; a formal process is in place and used by all care teams	
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Applying Clinical Information to Improve Health Care Quality

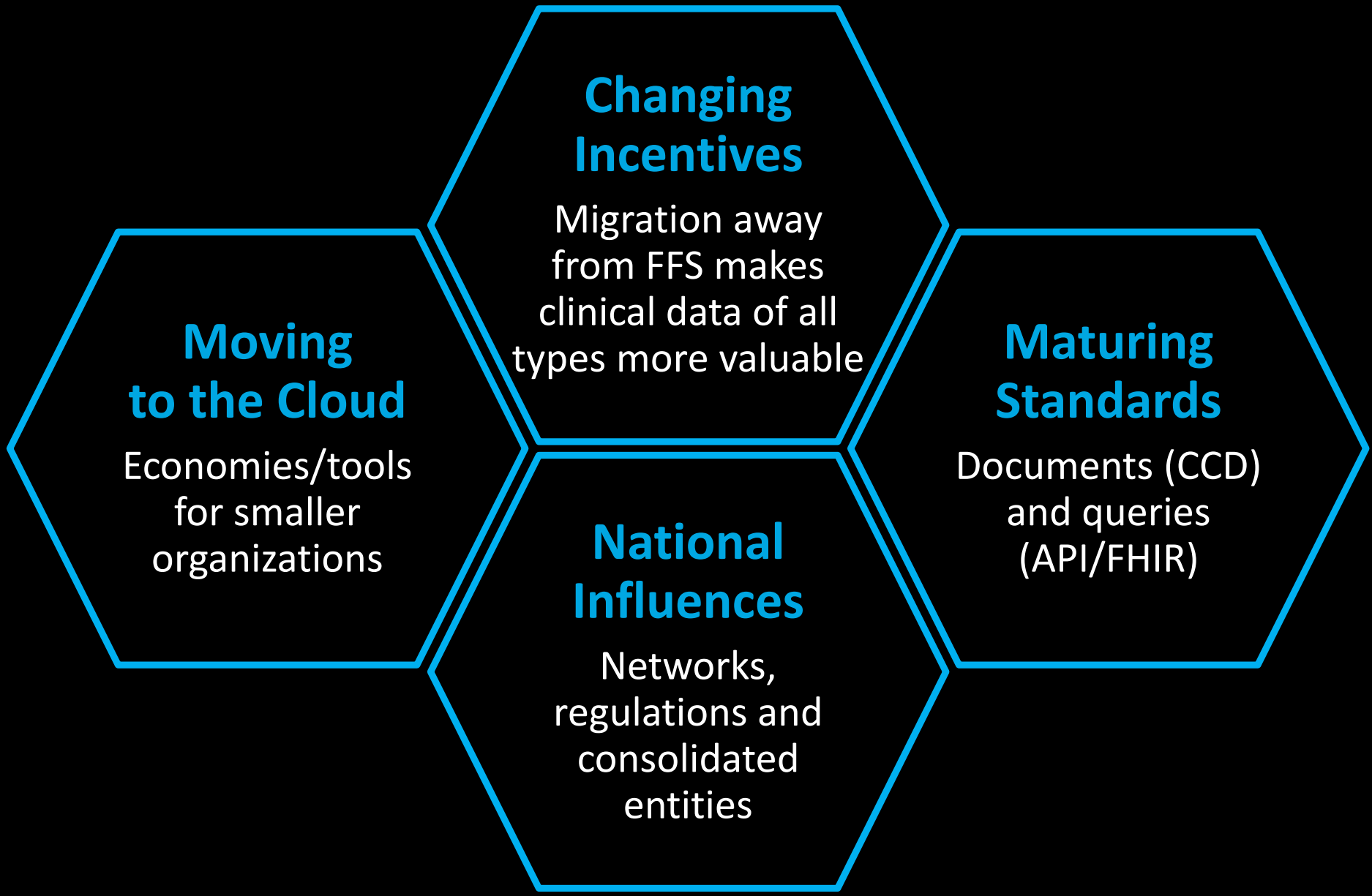
1. A Little Bit About OneHealthPort
2. The Emerging Clinical Information Space
3. Opportunities for Bree – Today and Tomorrow

Created in 2002, by and for the local healthcare community, OneHealthPort solves information exchange and workflow problems shared across healthcare organizations

- Collaborative, open to all, transparent and neutral
- Public/Private Partnership Built on Lead Organization
- Filling the gaps, leveraging Shared Capabilities

Clinical Information Space

Making progress – no longer have to rely solely on claims, able to leverage clinical data streams for multiple purposes


Changing Incentives
Migration away from FFS makes clinical data of all types more valuable
Moving to the Cloud
Economies/tools for smaller organizations
Maturing Standards
Documents (CCD) and queries (API/FHIR)
National Influences
Networks, regulations and consolidated entities

How useful are standard clinical information documents for Quality Improvement?

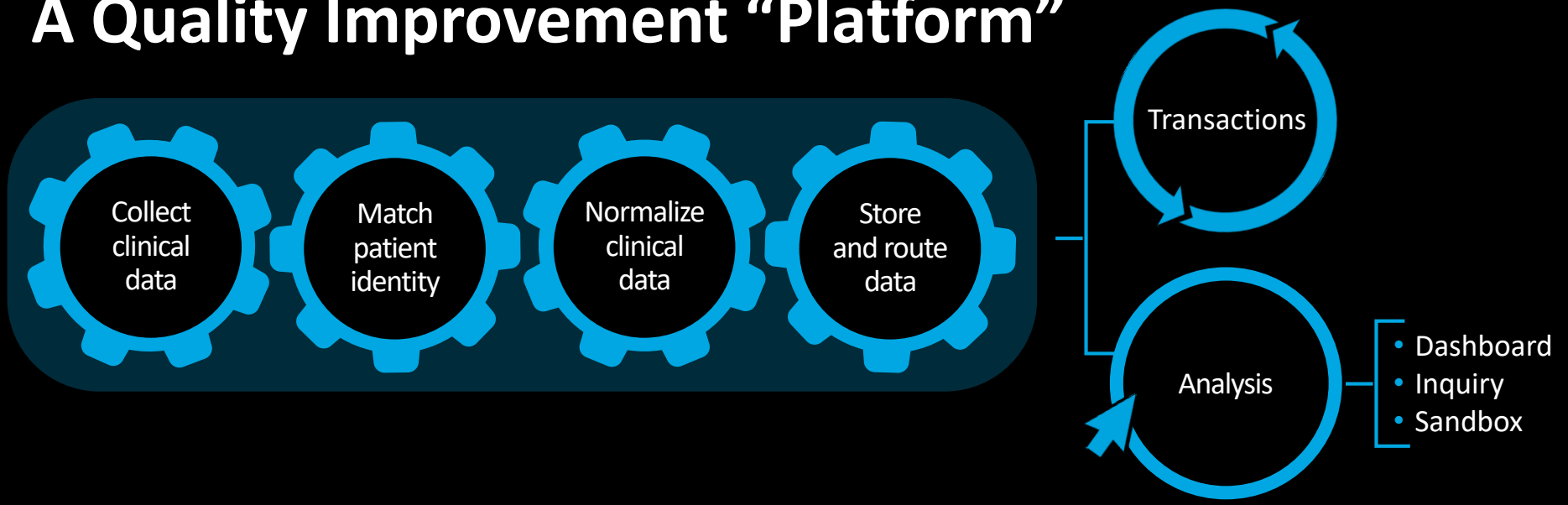
- OneHealthPort worked with OB COAP to assess ability to populate OB COAP data dictionary
- Eligibility data, CCDs, discharge summaries got to 88% – adding claims got it up to 96%

Then comes the key step – application of intelligence

Opportunities Today and Tomorrow

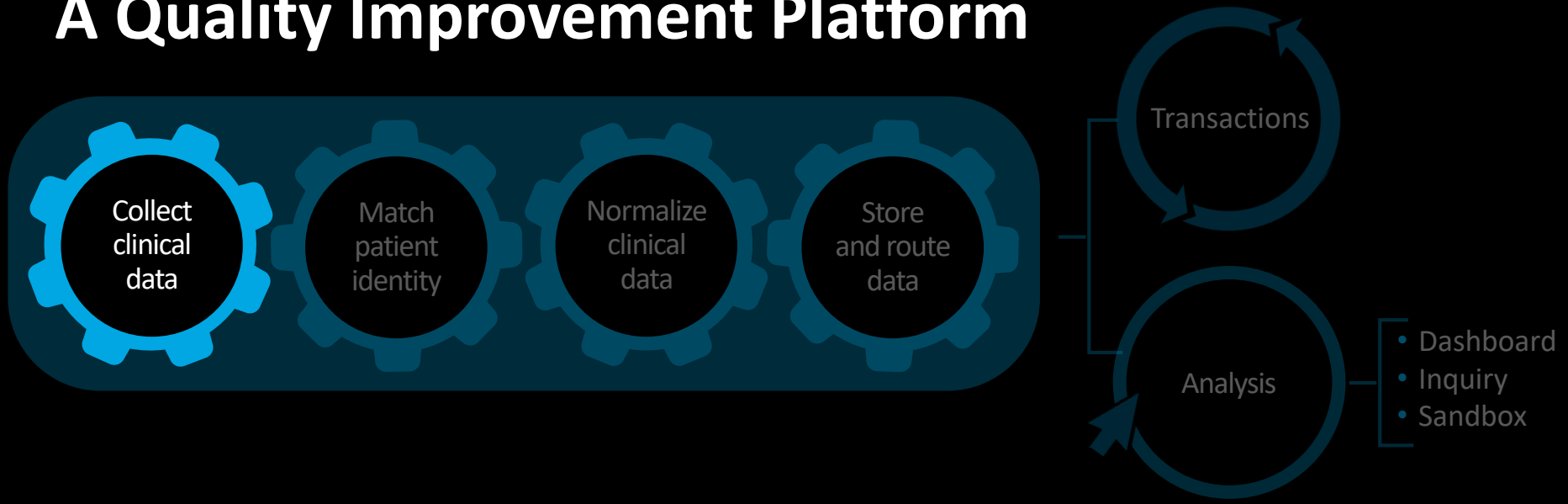
What do you want to know? What questions do you want to answer?

A Quality Improvement “Platform”



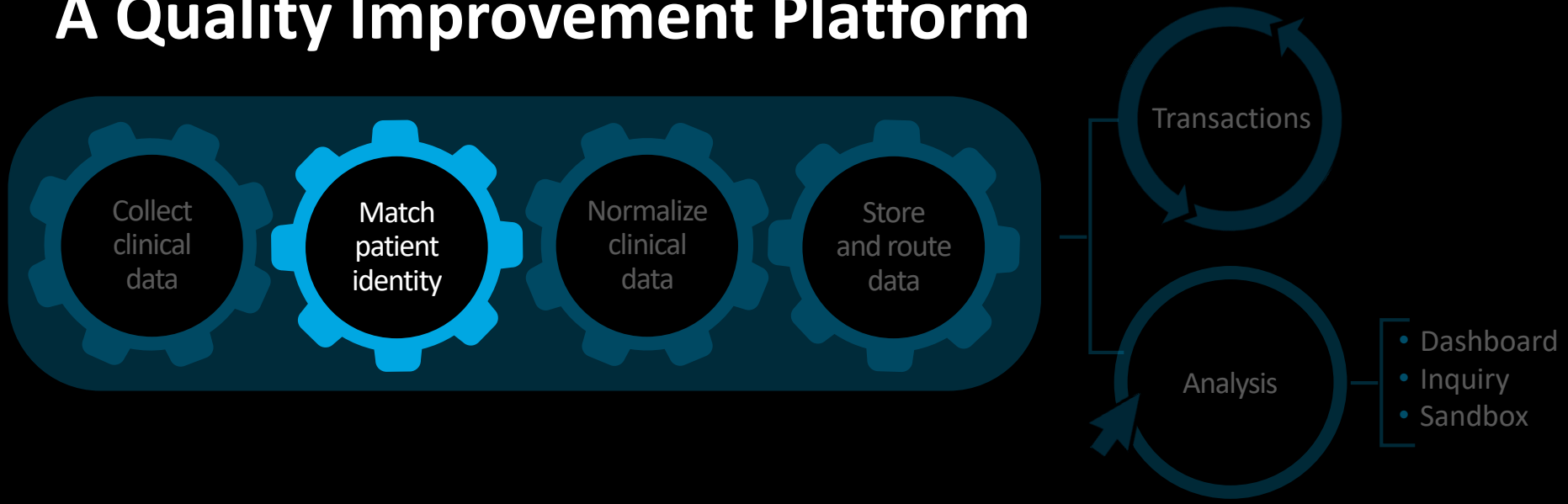
Applying clinical information to help answer questions about quality and health – OneHealthPort capabilities are one example

A Quality Improvement Platform



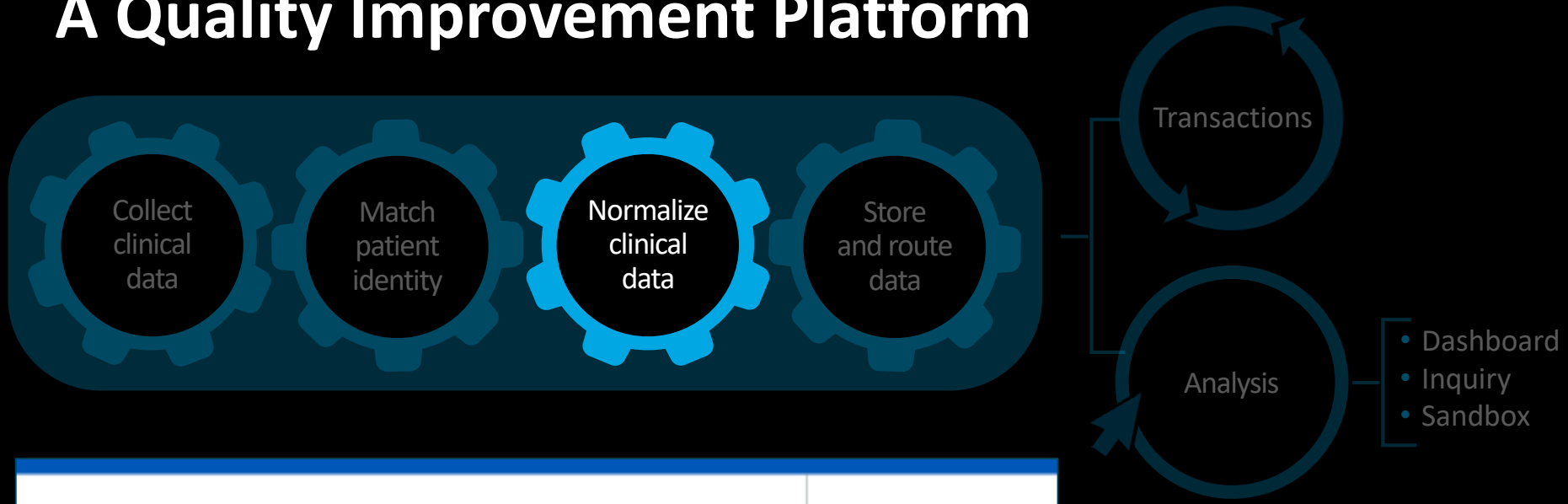
- OneHealthPort has connected to many of the major WA clinical organizations for CCD exchange
- There are over 13,000,000 CCDs in the Clinical Data Repository
- CCD exchange currently limited to Medicaid Managed Care patients

A Quality Improvement Platform



- Linking patient records is an industry wide-challenge
- OneHealthPort has a Master Person Index (MPI) to help link records
- MPI currently populated with payer (Medicaid) eligibility data to improve match rates

A Quality Improvement Platform



Clinical Data Challenges

Lab Results

Blood hemoglobin A1c/total hemoglobin ratio

Glycohemoglobin

Hemoglobin A1C, POCT

%A1c

Hgba1c %

Hemoglobin A1c

Glycolated Hgba1c

Hemoglobin A1c (Glyco HGB)

HEMOGLOBIN A1C/HEMOGLOBIN.TOTAL:MFR:PT:BLD:QN:HPLC

Discharge Meds

97157 atorvastatin
597970 atorvastatin 10 MG
617318 Lipitor 20 MG Oral Tablet
597968 atorvastatin 20 MG
63629-3366-1 Lipitor 80, film coated
329299 atorvastatin 80 MG
"UNK" LIPITOR
617312 atorvastatin 10 MG Oral Tablet
42291-143 atorvastatin calcium 10 mg Oral
617311 atorvastatin 40 MG Oral Tablet
259255 atorvastatin 80 MG Oral Tablet
153165 Lipitor
617314 Lipitor 10 MG Oral Tablet
617310 atorvastatin 20 MG Oral Tablet
617320 Lipitor 40 MG Oral Tablet
262095 Lipitor 80 MG Oral Tablet
83366 atorvastatin calcium
1483793 atorvastatin calcium propylene glycol solvate
1297766 atorvastatin calcium trihydrate
63629-3366 Lipitor 80 mg Oral Tablet
597983 atorvastatin 40 MG
"OTH" atorvastatin pill

+ hundreds more

Diameter Health

confidential

DiameterHealth.com

Normalized and Enhanced Data

HbA1c (Bld) [Mass fraction] (LOINC = 4548-4)

Laboratory (Chemistry)

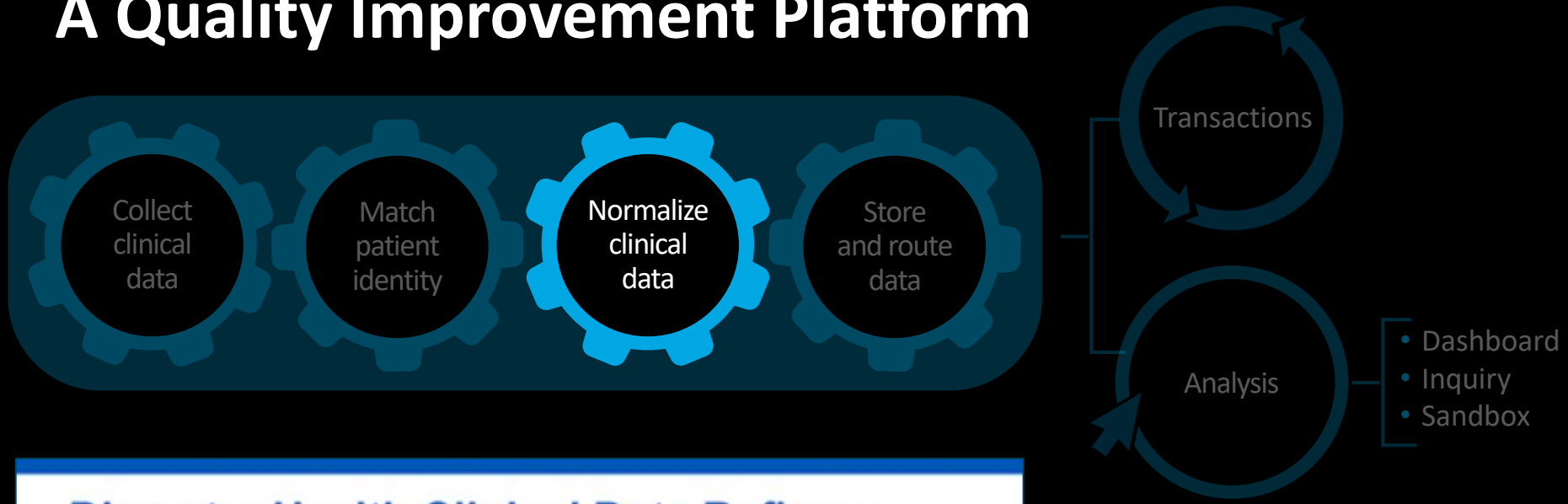
atorvastatin

(RxCUI = 83367)

HMG CoA Reductase Inhibitor

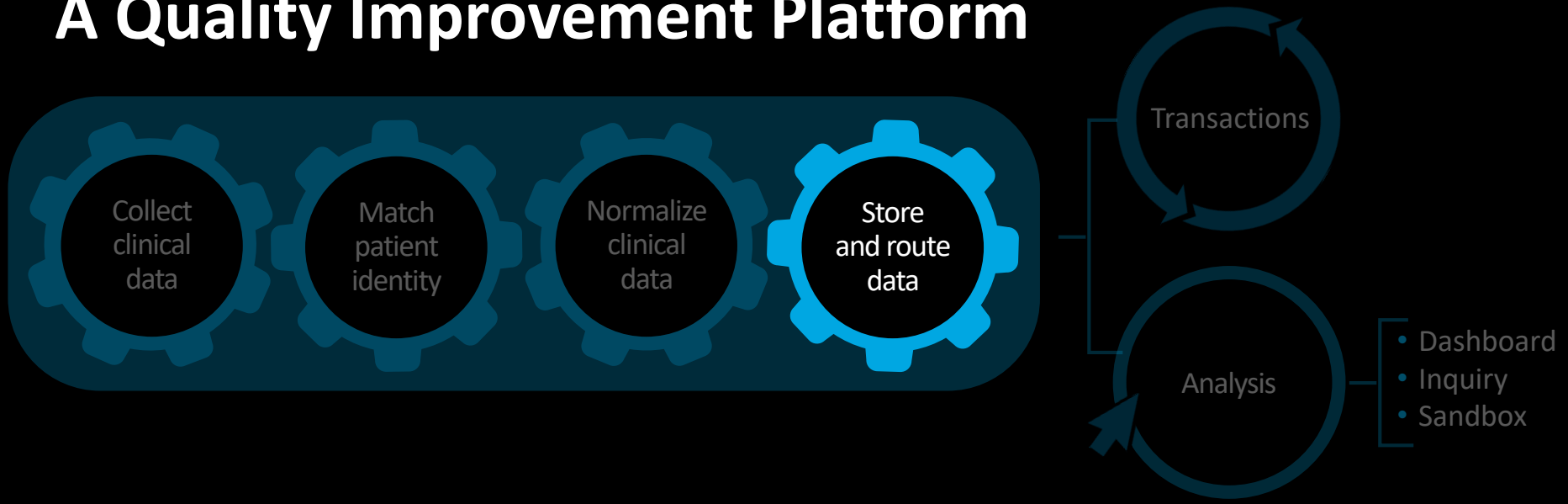
OneHealthPort purchases data improvement services from Diameter Health

A Quality Improvement Platform



Reduces significant levels of variation across submitters

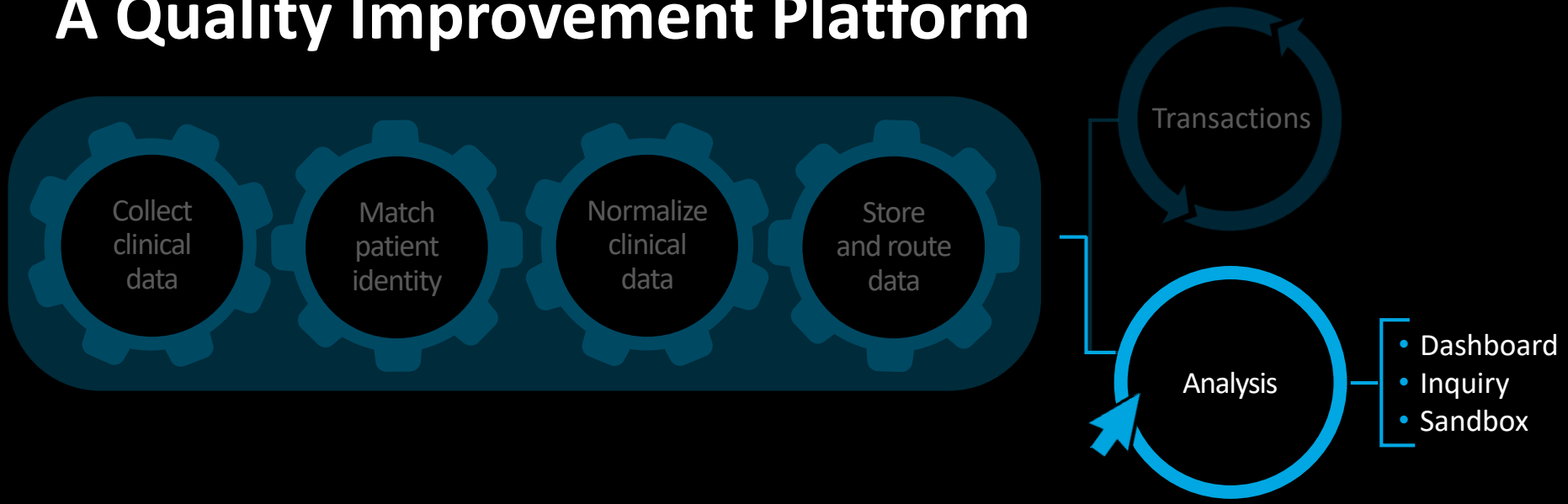
A Quality Improvement Platform



Normalized, matched records are stored centrally and can be routed either for:

- Transactional use – care/management of individual patients by providers/plans (not our focus today)
- Analytical use – understanding of correlation and trends across a population

A Quality Improvement Platform



- Dashboard – examining results/trends using de-identified data
- Inquiry – diving into the detail on specific identified patients or populations
- Sandbox – services that support direct access to the data base

MENDS Pilot in Washington

WA DOH, HCA, OneHealthPort, collaborating on deployment of MENDS (Multi-state EHR-Based Network for Disease Surveillance) WA pilot

Go live: Q1 2020

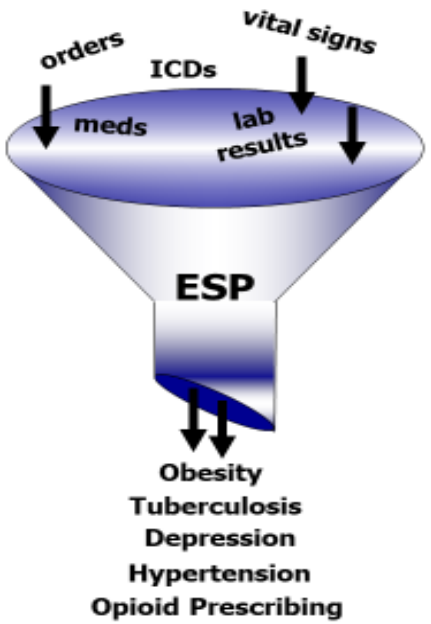
MENDS Pilot in Washington

- To support public health professionals in tracking chronic disease
- OneHealthPort deploying revised MENDS tools in Azure Cloud
- 1st phase, leverage Medicaid CCDs normalized through Diameter, to populate Dashboard
- Future phases likely to focus on inquiry capabilities and additional conditions

An example

MENDS Pilot in Massachusetts

Application of intelligence to clinical data – in this case to enable public health surveillance



Diabetes Mellitus

- Hemoglobin A1C ≥ 6.5
- Fasting glucose ≥126
- Random glucose ≥200 on two or more occasions
- Prescription for INSULIN outside of pregnancy
- ICD9 code 250.x (DM) on two or more occasions
- Prescription for any of the following:
  - GLYBURIDE, GLICLAZIDE, GLIPIZIDE, GLIMEPIRIDE
  - PIOGLITAZONE, ROSIGLITAZONE
  - REPAGLINIDE, NATEGLINIDE, MEGLITINIDE
  - SITAGLIPTIN
  - EXENATIDE, PRAMLINTIDE

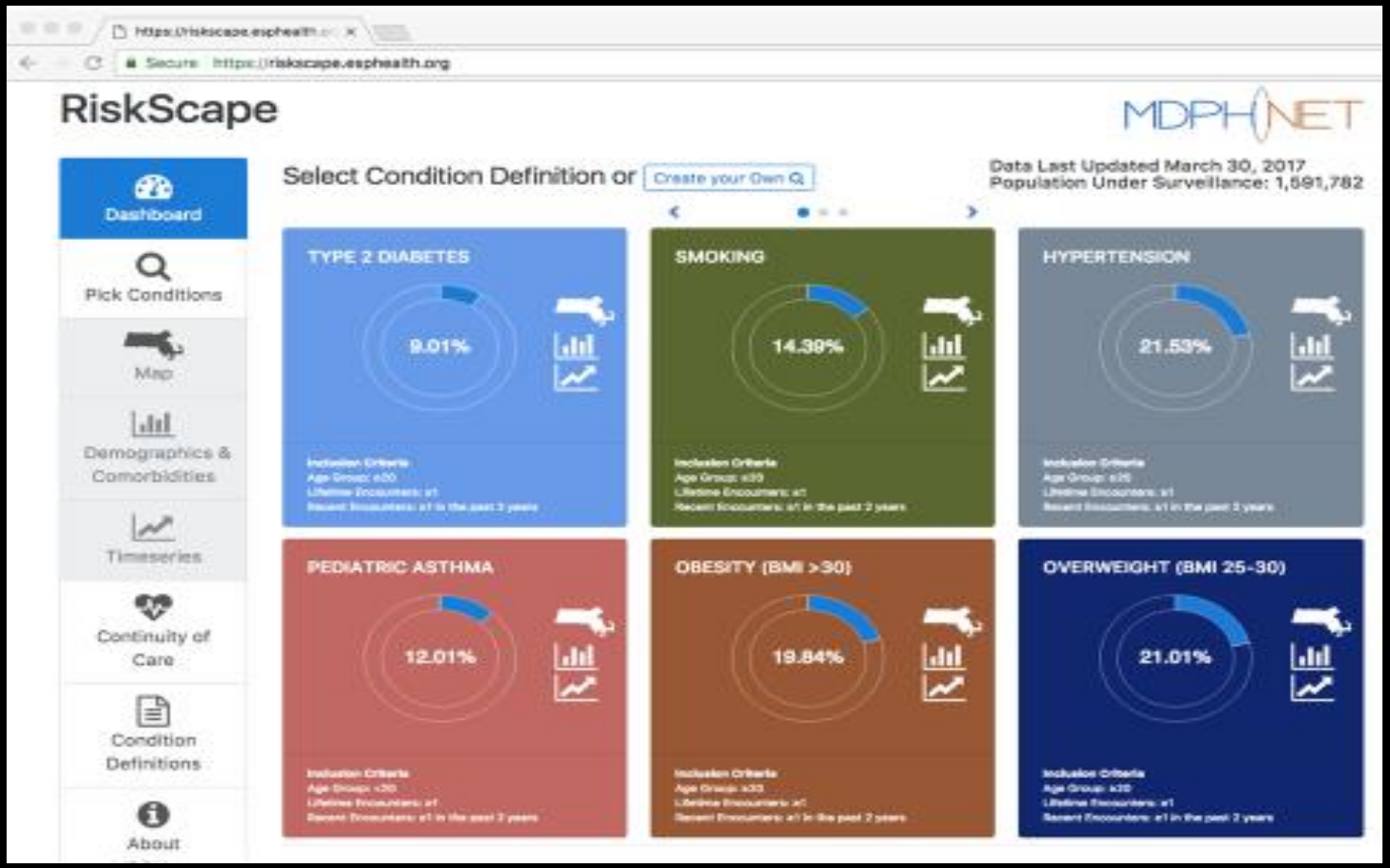
Diabetes Care 2013;36:914-21

From presentation by Michael Klompas MD, MPH, Department of Population Medicine, Harvard Medical School and Harvard Pilgrim Health Care Institute to National Academy of Medicine, Digital Learning Collaborative, July 13, 2017

An example

MENDS Pilot in Massachusetts

Dashboard tool for viewing de-identified data



From presentation by Michael Klompas MD, MPH, Department of Population Medicine, Harvard Medical School and Harvard Pilgrim Health Care Institute to National Academy of Medicine, Digital Learning Collaborative, July 13, 2017

What would a Bree Quality Improvement Dashboard look like?

Any interest in a pilot?

- HCA asking OneHealthPort to explore opportunities for applying clinical data to assist Bree and other FHCQ programs

What's on the horizon for tomorrow?

1. Moving beyond Medicaid – adding more CCD's and lives

2. Consumer facing services – exploring a community solution

3. Event driven architecture – subscribe to a topic, get notified

Market Readiness

Intellectual Leadership

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Technical Capabilities

Cascade Care

Leah Hole-Marshall, WA Health Benefit Exchange
& Rachel Quinn, WA Health Care Authority

Bree Collaborative

January 15, 2020

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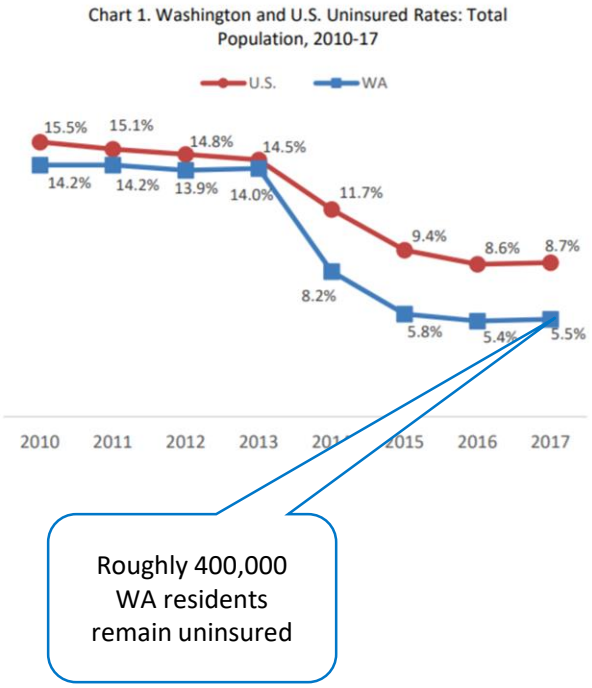
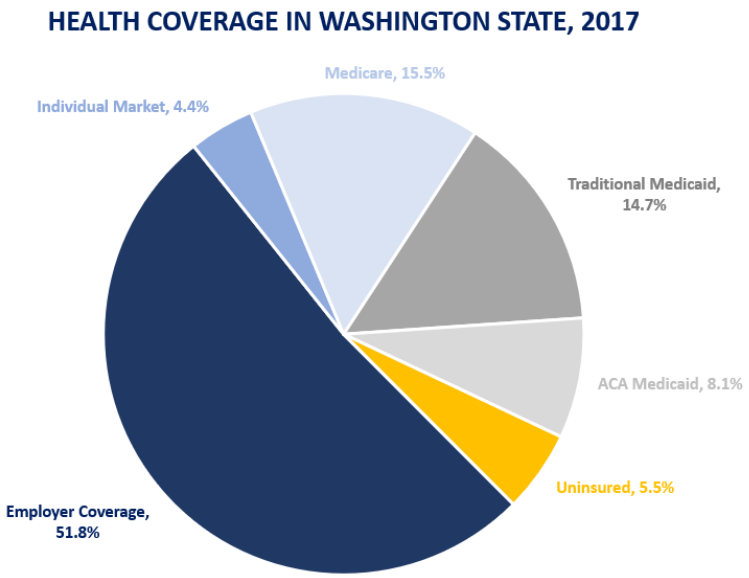
Washington State Health Care Authority

Agenda

- Background
- Standard plan designs for Cascade Care
- HCA contract and procurement role in Cascade Care
- Proposed Cascade Care purchasing standards and HCA approach
- Timeline and next steps
- Affordability requirements
- Q&A

Health Coverage in Washington





Office of Financial Management
Forecasting & Research Division

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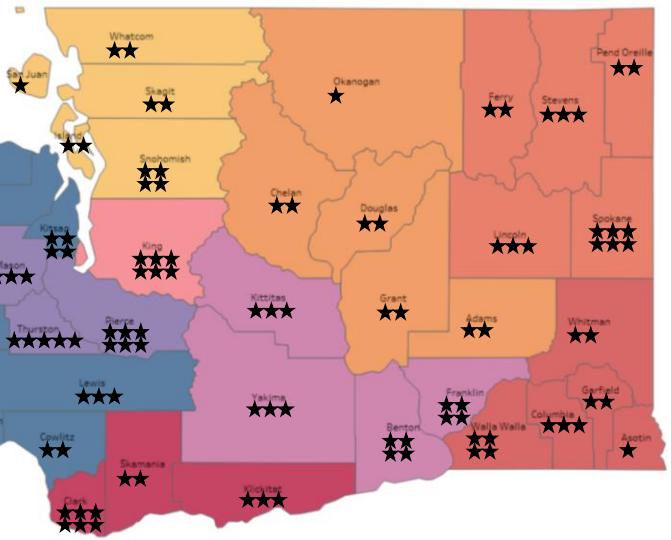
Washington State Health Care Authority

Washington State Exchange Individual Market Overview

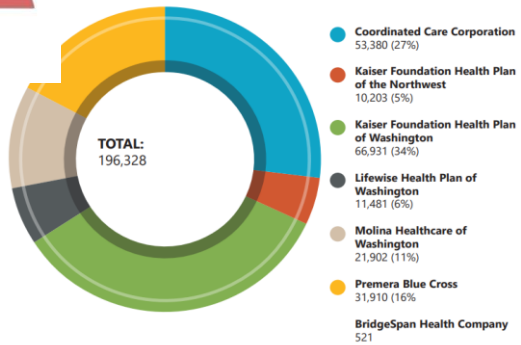
Color Key	Region	Relative Cost
	West	0.70%
	South Sound	-1.41%
	South Central	-6.19%
	King	0.00%
	North West	-1.69%
	North Central	2.23%
	North East	-9.50%
	South East	-1.43%
	South	0.82%

★ Number of Carrier(s) per county

OIC Geographic Rating Regions and 2020 Number of Carriers by County offered on the Exchange



2019 Exchange Individual Market Enrollment By Carrier and Total



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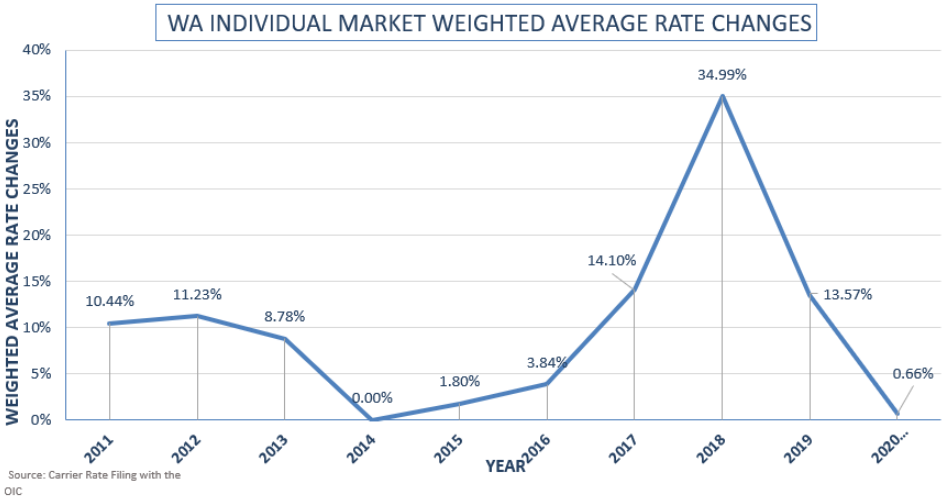
Market Challenges: Instability

Federal Action	WA Proposed or Final Response
Limit open enrollment period and reduce ACA marketing	State response: Extend Open Enrollment and use state funding for marketing
Cost-sharing reduction (CSR) payments to carriers terminated	State response: Allow carriers to build cost of CSR's into silver plan premiums
Expanding short-term limited duration (STLD) insurance policies	State response: OIC rules to limit STLD medical plans to 3 months. Minimum standards set.
Zeroing out of individual mandate penalty	*State mandate proposed in 2018 and 2019 session – not successful*
Discontinuation of federal reinsurance program	*State reinsurance program proposed in 2018 session* - Not successful based on financing
Expand association health plans	OIC emergency rules and WA in multi-state legal challenge.
Allow use of HRA to pay for individual health plans	Under review.
Repeal non-discrimination rule *(Section 1557)*	Existing WA State law does not allow discrimination based on gender identity.
Public Charge Rule and Presidential Proclamation	WA leads multi-state legal challenge.

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE



Source: Carrier Rate Filing with the OIC

Methodology: This graph represents the annual change in rate for continuing plans on the individual market as approved (rather than requested) by OIC. Year 2020 weighted average rate change is projected based on the market share of 2019. The average rate changes are weighted by observed enrollment as of March of the earlier year and expected enrollment for the following year.

Year	QHP Enrollment
2014 OE 1	139,700
2015 OE 2	152,517
2016 OE 3	166,098
2017 OE 4	204,334
2018 OE 5	209,802
2019 OE 6	196,328

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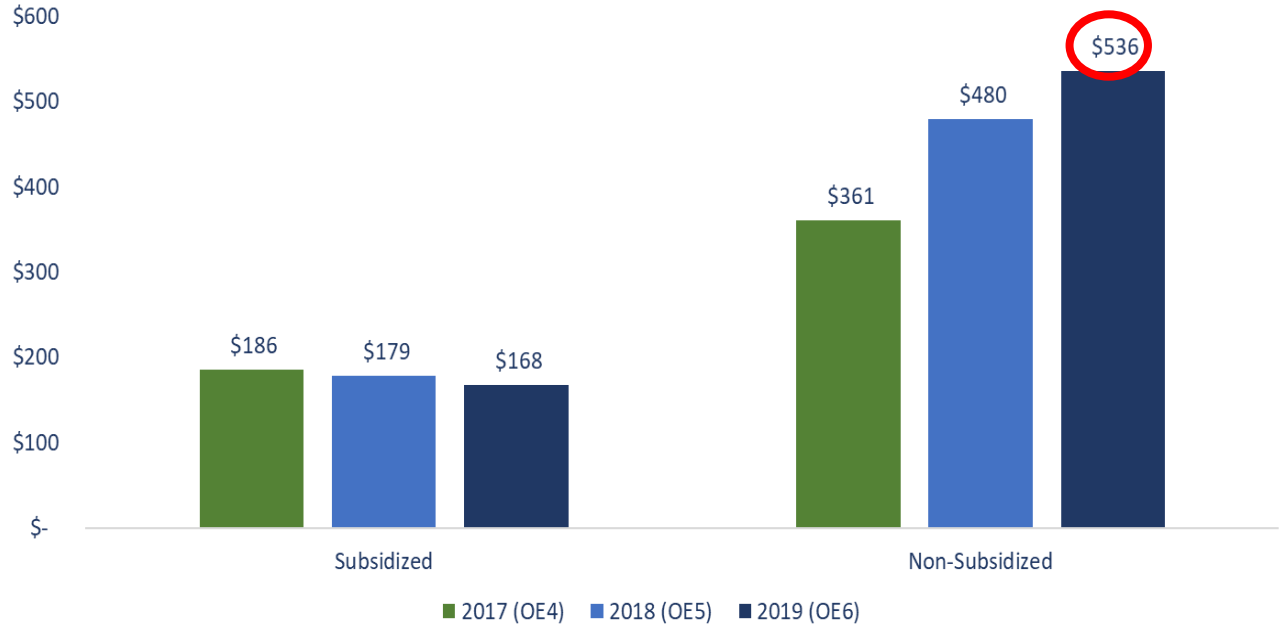
Affordability at Risk

Significant Premium Increases for Non-Subsidized



- Nearly 60k Enrollees in Plan with >$9k Deductible
- 37% of consumers who dropped coverage reported that it didn't meet their budget

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Cascade Care (Senate Bill 5526) three main parts

1. Standard Plans: Goal to make care more accessible by lowering deductibles, making cost-sharing more transparent, and providing more services before the deductible.

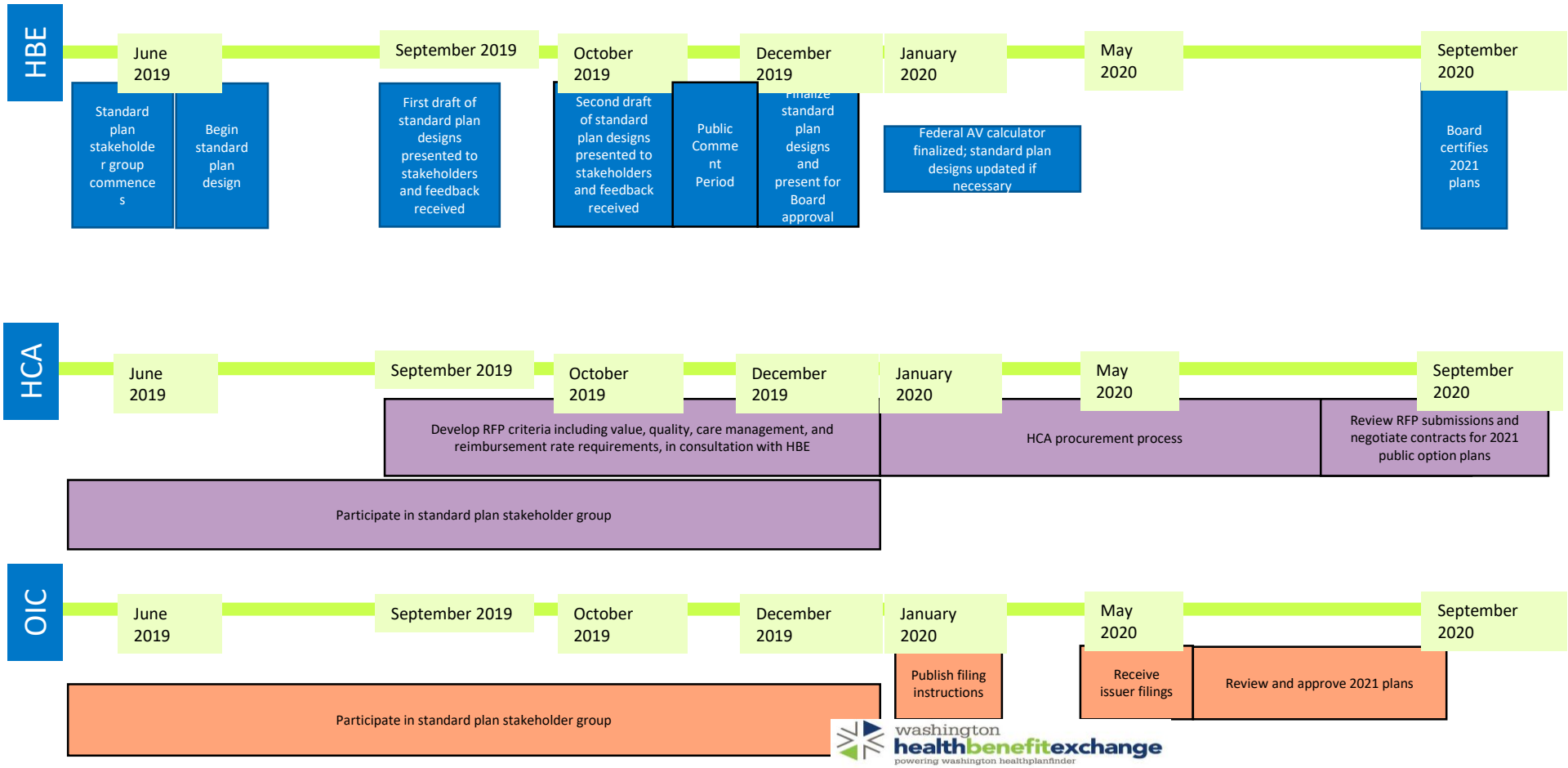
2. Public Option Plans: Goal to make more affordable (lower premium) options available across the state, that also include additional quality and value requirements

3. Subsidy Study: Goal to develop and submit a plan for implementing premium subsidies through Exchange for individuals up to 500% FPL (due to Legislature by Nov. 15, 2020)

Multi-agency effort

- Joint agency effort
  - Health Care Authority, Health Benefit Exchange, and the Office of the Insurance Commissioner
    - Interdependent parts of the development, different phases of work
    - Joint workgroup, multiple sub-groups, and multiple stakeholder groups

At a glance: Interagency Cascade Care Implementation Timeline



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Cascade Care – Standard Plans

- Starting in plan year 2021, Exchange carriers must offer at least one gold and one silver standard plan, and one standard bronze if carrier offers bronze
- Carriers may continue to offer non-standard plans on the Exchange
- Standard plan designs will be basis for state-procured public option plans
- Exchange will update standard plan designs annually
- Open and transparent process – all materials available at: https://www.wahbexchange.org/about-the-exchange/cascade-care-2021-implementation

Three Different Types of Health Plans in the Exchange in 2021: Non-Standard Plans, Standard Plans, and Public Option Plans

	Non-Standard Plans	Standard Plans	Public Option Plans (Standard Plans Plus)
Offered through the Exchange and eligible for federal tax subsidies	✓	✓	✓
Subject to full regulatory review by OIC, including network adequacy and rate review requirements	✓	✓	✓
Adheres to 19 Exchange certification criteria for QHPs	✓	✓	✓
Meets federal actuarial value requirements for metal levels	✓	✓	✓
Includes Essential Health Benefits	✓	✓	✓
Uses plan design with deductibles, co-pays, and co-insurance amounts set by Exchange for each metal level (bronze, silver, gold)		✓	✓
Some services guaranteed to be available before the deductible		✓	✓
Allows consumers to easily compare plans based on premium, network, quality, and customer service		✓	✓
Procured by HCA (Could result in one or more plans per county)			✓
Required to incorporate Bree Collaborative and Health Technology Assessment program recommendations			✓
Caps aggregate provider reimbursement at 160% of Medicare			✓
Subject to a floor on reimbursement for primary care services (135% of Medicare) and reimbursement of rural hospitals (101% of cost)			✓
Requires carriers to offer a bronze plan (in addition to silver and gold)			✓
Carriers required to offer to participate in the Exchange		✓	

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2021 Standard Plan Designs: Key Outcomes

- Lower deductibles
- Ensure access to services before the deductible
  - Including preventive care, primary care, urgent care, mental/behavioral health services, and generic drugs
- Include co-pays to provide transparency and predictability of costs for consumers
- Provide bronze plans that include high-value services before the deductible, at a potentially lower price point
- Provide high-value options for consumers in every county
- Maximize federal premium tax credits (silver plan design)
- Establish a strong foundation for the public option

Washington State Health Care Authority

2021 Standard Plan Designs

Benefits	Standard Gold	Standard Silver	Standard Bronze
Deductible ($)	$500	$2,400	$5,700
MOOP ($)	$5,750	$7,900	$8,150
Emergency Room Services	$400	$800	40%
Urgent Care	$35	$65	$100
All Inpatient Hospital Services (inc. MH/SUD,Maternity)	$500*	$800*	40%
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$15	$25	$45
Specialist Visit	$35	$65	$90
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	$15	$25	$45
Advanced Imaging (CT/PET Scans, MRIs)	$300	30%	40%
Speech Therapy	$20	$40	40%
Occupational and Physical Therapy	$20	$40	40%
Preventive Care/Screening/Immunization	$0	$0	$0
Laboratory Outpatient and Professional Services	$15	$35	40%
X-rays and Diagnostic Imaging	$25	$60	40%
Skilled Nursing Facility	$300**	$800**	40%
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$300	$600	40%
Outpatient Surgery Physician/Surgical Services	$50	$200	40%
Generics	$10	$20	$30
Preferred Brand Drugs	$55	$70	40%
Non-Preferred Brand Drugs	$90	$200	40%
Specialty Drugs (i.e. high-cost)	$90	$200	40%
Ambulance	$375	$375	40%
Routine Eye Exam for Children	$0	$0	$0
All Other Benefits	20%	30%	40%
Federal AV	81.74%	71.2	

***Per day copay, limit of 5 copays per stay; ** Per day copay**
Shaded items are not subject to the deductible

washington healthbenefitexchange
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Washington State Health Care Authority

HCA procurement role in Cascade Care

- State Procured Standard Qualified Health Plans (QHPs):
  - Requires HCA, in consultation with HBE, to contract with health carriers to offer state procured standard QHPs (public option plans) for 2021 plan year
    - Plans to be available through the Health Benefit Exchange, maintain all federal and state requirements for QHPs
  - Carriers that choose to participate must offer gold, silver, and bronze standard benefit designs approved by HBE Board
  - Plans must include aggregate reimbursement cap and certain quality and value requirements

Cascade Care quality, value, affordability standards

- Affordability opportunity - Legislation outlines reimbursement caps and floors for health carrier payments to providers:
  - Cap set at aggregate of 160% of Medicare
  - Floors set such that primary care physicians may not be paid less than 135% of Medicare, and rural critical access hospitals or sole community hospitals not less than 101% of Medicare (allowable costs)
- Quality and value participation requirements:
  - Must incorporate recommendations of the Robert Bree Collaborative and health technology assessment program
  - Additional requirements that align to state agency value-based purchasing (VBP), focus on maintaining and improving health

HCA approach in developing Cascade Care quality, value and affordability standards

Guiding principles for program development:

- Strive to increase affordability and value, while aligning with state purchasing standards
- Success is dependent on carrier and provider participation; administrative barriers to participation should be minimized
- Program development and refinement will be a continual process; initial development will lay the groundwork for phasing in additional requirements/standards

Draft Standards Released 12/20/19 for public comment

- 4 proposed quality and value standards
- 3 required affordability standards
- Public Comment period closes January 17th:
  https://www.surveymonkey.com/r/LTBRF7C

Proposed Bree Collaborative Standards

- Cascade Care Statute requires carrier implementation of Bree Recommendations
- There are currently 22 Bree recommendations
- Each carrier will be required to report on the five topics, AND
- Each carrier will be required to choose and report on three (3) additional Bree recommendations. Carriers are encouraged to select topics where there's opportunity of improvement and/or significant efforts are already underway. Carriers will be required to declare their three topics and provide a rationale for selection in their procurement response.

Proposed Bree Collaborative recommendation requirements – all carriers


Elective Total Knee and Total Hip Replacement Bundle and Warranty (2013 and 2017)*


Hospital Readmissions (2014)*


Behavioral Health Integration (2017)*


Opioid Use Disorder Treatment (2017)


Low Back Pain (2013)*

* Link to Bree health plan implementation guidance

Washington State Health Care Authority

Additional Bree Collaborative topic areas


Obstetrics (2012)*


Cardiology (2012)*


Elective Lumbar Fusion Bundle and Warranty (2014 and 2018)*


Elective Coronary Artery Bypass Surgery Bundle and Warranty (2015)


Bariatric Surgical Bundled Payment Model and Warranty (2016)


Spine SCOAP (2013)*


End-of-Life Care (2014)*


Addiction and Dependence Treatment (2015)*


Prostate Cancer Screening (2016)*


Pediatric Psychotropic Drug Use (2016)*


Guidelines for Prescribing Opioids for Pain (2015-Present)*


Alzheimer's Disease and Other Dementias (2017)


Hysterectomy (2017)


LGBTQ Health Care (2018)


Collaborative Care for Chronic Pain (2018)


Suicide Care (2018)

Washington State Health Care Authority

Proposed HTA Standards

- Participating Cascade Care public option carriers are required to provide a baseline report on alignment of their coverage criteria to Health Technology Clinical Committee (HTCC) decisions in their procurement response.
- For year one, carrier is expected to be aligned with at least 50% of decisions and submit a plan for aligning to HTCC decisions.
  - Currently there are about 80 coverage decisions published on HCA website

Proposed Quality and Value Standards: Quality Metrics

- In addition to the Quality Rating System (QRS) measures required for all plans offered on the Exchange, participating Cascade Care public option carriers are required to report on 13 metrics from the Washington State Common Measure Set, reporting each metric by region, sex, and age group, and, to the extent the carrier is in possession of the data, by race, ethnicity, and language

- Comprehensive Diabetes Care (CDC) – Blood Pressure Control (<140/90 mm Hg)
- Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
- Follow-up After Emergency Department Visit for Mental Illness (FUM)
- Asthma Medication Ratio (AMR)
- Mental Health Service Penetration (Broad Version)
- Oral Health: Primary Caries Prevention Offered by Primary Care
- Patient Experience with Primary Care: How Well Providers Communicate with Patients
- Patient Experience with Primary Care: How Well Providers Use Information to Coordinate Patient Care
- Inpatient 30-day Psychiatric Inpatient Readmissions
- Statin Therapy for Patients with Cardiovascular Disease
- Substance Use Disorder Service Penetration
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

Proposed Measures:

- Ambulatory Care (AMB) – Emergency Department Visits per 1,000

Proposed Quality and Value Standards: Population Health and VBP

- Additional participation requirements to reduce barriers to maintaining and improving health and align to state agency value-based purchasing.
- May include, but are not limited to:
  - Standards for utilization management to reduce administrative burden;
  - Increase transparency and clinical effectiveness;
  - Population health management;
  - High-value, proven care; health equity;
  - Primary care; care coordination and chronic disease management; and
  - Wellness and prevention; prevention of wasteful and harmful care; and patient engagement.

Affordability Approach- Legislative Requirements

- **A Ceiling on Provider Reimbursement**: Average Statewide reimbursement for medical services under the Cascade Care network(s), excluding pharmacy, may not exceed 160% of the total amount Medicare would have reimbursed providers, and facilities for the same or similar services.
- **A Floor on Rural Hospitals**: Either sole community hospitals (SCH) or critical access hospitals (CAH) as certified by the Centers for Medicare and Medicaid Services (CMS), must be paid at least 101% of their allowable costs. Allowable costs reimbursement is similar to the amount of reimbursement from Medicare, without consideration for sequestration or final cost settlement adjustments.
- **A Floor on Primary Care Services:** Physician reimbursement must be at least 135% of the amount Medicare would have reimbursed.

The common thread through each of these cost criteria for the Cascade Care network is measurement of the actual reimbursement relative to Medicare.

Proposed Affordability Approach (Summary from Milliman Public Option Plan – Medicare Methodology Discussion (DRAFT) posted on HCA website)

- Starting with the data fields within the processed claims
- Assign every medical claim a Medicare Allowed Amount

$$Required\ Allowed\ Reimbursement\ \%\ of\ Medicare = \frac{Insurer\ Allowed\ Claim\ Amount}{Medicare\ Allowed\ Amount}$$

- Assigning Medicare to every claim leads to considerations/issues such as:
  - Identification of National Provider Identification code and Medicare Certification Number
  - Determination of the applicable fee schedule year
  - Identification of Medicare covered fee schedule amount
  - Outlier adjustments
  - Procedures not covered by Medicare
  - Calculation of a Cost to Charge Ratio (CCR) for those facilities that are paid as a percent of cost

Proposed Primary Care definition to Measure Primary Care Reimbursement Floor

Legislatively mandated standard:

- Reimbursement for primary care services, as defined by HCA, provided by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine

Proposed approach:

- HCA has developed a primary care definition for a Medicaid/PEBB/SEBB primary care spend contract requirement, starting in 2020;
- Primary care definition includes provider type and service-base (e.g., ambulatory setting)
- HCA will provide codes and definitions in procurement

Proposed Affordability Approach (Summary from Milliman Public Option Plan – Medicare Methodology Discussion (DRAFT) posted on HCA website)

- Every medical claim is assigned a Medicare Allowed Amount
- Fee schedule year: CMS schedule as of 10/1/2020 for FFY 2021 to price any CY 2021 claims data
- Pricing Methodology
  - Inpatient facility
    - Medicare Prospective Payment System (IPPS)
  - Outpatient (outpatient or Ambulatory Surgical Center)
    - Medicare Outpatient Prospective Payment System (OPPS)
  - Professional
    - Medicare Professional fee schedule Assignment

Next steps – snap shot of procurement timeline

Tasks	Date
Procurement updates and presentations to stakeholder work groups	(June – December) October – December
Detailed rating methodology discussions, modeling	December - January
Public comment period on draft concepts	December 20th - January 17th
Procurement/Solicitation released	February 2020
HCA review of procurement	Spring 2020
OIC review and approval of plans	May 2020 filing; September 2020 approval
HBE board certification	September 2020

Appendix

- Public Comment and draft procurement standards
  - https://www.surveymonkey.com/r/LTBRF7C
- HCA Cascade Care site:
  - www.hca.wa.gov/about-hca/cascade-care

Cascade Care General Questions:

HCA: HCACascadeCare@hca.wa.gov

HBE: StandardPlans@whbexchange.org

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Washington State Health Care Authority

Final Adoption:
Risk of Violence to Others

Kim Moore, MD
Associate Chief Medical Officer,
CHI Franciscan

DR. ROBERT BREE COLLABORATIVE

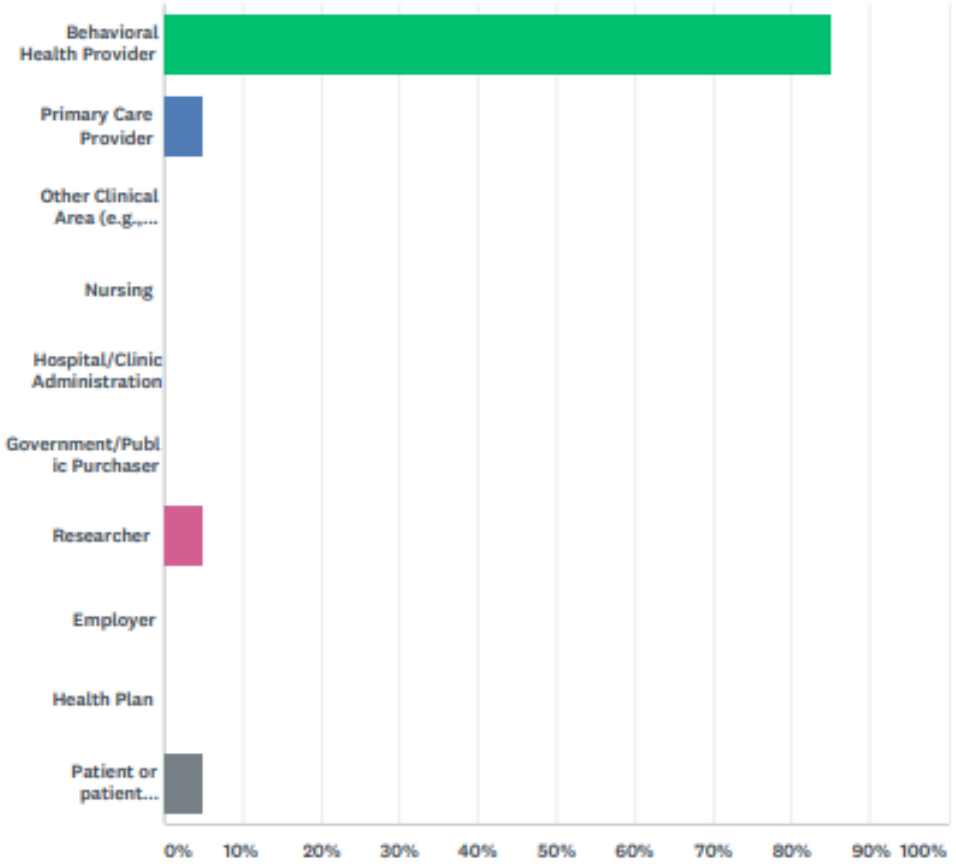
January 15th, 2020 | Puget Sound Regional Council

Workgroup Members

- **Chair:** Kim Moore, MD, Associate Chief Medical Officer, CHI Franciscan
- Ann Allen, MSW, Member, National Association of Social Workers, Washington Chapter
- G. Andrew Benjamin, JD, PhD, ABPP, Clinical Psychologist, Affiliate Professor of Law, University of Washington
- Jason Fodeman, MD, Labor and Industries
- Jaclyn Greenberg, JD, LLM, Policy Director, Legal Affairs, Washington State Hospital Association
- Laura Groshong, LICSW, Clinical Social Work, Private Practice
- Ian Harrel, MSW, Chief Operating Officer, Behavioral Health Resources
- Katerina LaMarche, JD, Policy Analyst, Washington State Medical Association
- Kelli Nomura, MBA, Behavioral Health Administrator, King County
- Mary Ellen O'Keefe, ARNP, MN, MBA, Clinical Nurse Specialist - Adult Psychiatric/Mental Health Nursing; President Elect, Association of Advanced Psychiatric Nurse Practitioners
- Jennifer Piel, MD, JD, Psychiatrist, Department of Psychiatry, University of Washington
- Julie Rickard, PhD, Program Director, American Behavioral Health Systems – Parkside
- Samantha Slaughter, PsyD, Member, WA State Psychological Association
- Jeffery Sung, MD, Member, Washington State Psychiatric Association
- Amanda Ibaraki Stine, MFT, Member, Washington Association for Marriage and Family Therapists
- Marianne Marlow, MA, LMHC, Member, Washington Mental Health Counseling Association
- Adrianne Tillery, Harborview Mental Health and Addiction Services (Certified Counselor)

Public Comments

- 20 survey responses
- 4 letters
  - Washington State Medial Association
  - Washington State Hospital Association



Public Comments Summary

- More content about risk of heightened violence due to intimate partner violence and separation
- Consideration of additional factors leading to violence (e.g., debts, uncontrolled gambling)
- Suggestions for additional violence scales
- Need clarification on whether warning to third party is required if patient is being involuntarily committed
- Need clarification on what reasonably identified means and what are reasonable steps to contact potential victims
- Recommendations to family members informing providers of threats
- Clarification on display preventive messaging around safe storage of firearms
- Changes to legislature language

Changes to Report and Recommendations

- Pg. 8: Change: ego-syntonic
- Pg. 9: Add:
  - History of criminal acts including intimate partner violence
  - History of being the victim of abuse including intimate partner violence
- Pg. 11: Add
  - Note: The steps below are provided as guidance and are not meant as a checklist or as a decision tree.
  - At any time, if the provider decides that issuing a warning is needed…
- Pg. 12: Add: At each decision point, document actions taken in the health record, other options considered, and the clinical rationale for the actions taken
- Pg. 13: Change: Display preventive messaging around secure storage of firearms. (Was safe)

Changes to Report and Recommendations

- Pg. 14-15: Change: Define one standard to address the duty to protect third parties across all treatment settings:
  - The group of mental health professionals subject to the duty to protect as a psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or licensed independent social worker, and any person licensed by the department of health as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate
  - The duty to protect only arises when the patient has communicated an actual threat of physical violence that poses a serious and imminent threat to the health or safety of a reasonably identifiable person or persons
  - Options for discharging the duty to protect including when the identifiable person or persons and law enforcement are warned or taking reasonable precautions to provide protection
- Pg.19: Clarify: More intensive treatment paradigms such as Assertive Community Treatment, a program directed towards those with severe mental illness, have been shown to be effective in reducing health service use and homelessness but an effect on reduction in violent acts was not studied and are more difficult to implement in a community setting.
- Pg. 21: Clarify: Due to the ruling it is unclear whether statute or common law requirements apply to clinicians who see patients who may be dangerous, but do not meet criteria for involuntary commitment in an emergency department or have a first-time encounter and have no ongoing relationship with the patient.

Background
Volk v. DeMeerleer
187 Wn.2d 241, 386 P.3d 254

This 2016 Washington State Supreme Court decision alters the scope of the 'duty to warn or protect'.

- now clearly applies to clinicians in voluntary inpatient and outpatient settings

- persons to 'warn or protect' now includes those who are 'foreseeable' victims, not 'reasonably identifiable' victims subject to an *actual* threat

- Source: www.phyins.com/uploads/file/Volk%20recs-FINAL.PDF

Legal Background

The current legal framework in Washington state makes the implementation of a mental health provider's duty of care and duty to protect untenable.

In all likelihood, this environment will have negative downstream effects on the community.

However, these negative impacts to access and quality of care can be remedied with changes in the laws to reduce the ambiguity presented by the *Volk* decision and the conflicting laws as outlined on page 12.

Review Problem Statement, Aim, Purpose

Problem Statement

- **Patients may be reluctant** to engage with health care providers about their violence risk.

- **Health care providers may be uncertain** about how to meet their legal obligations.

Aim

- To recommend evidence-based, clinical **best practices for patients with risk of violence**

Purpose

To recommend **evidence-based, clinical best practices for:**

- assessing **risk for violence**
- identifying **risk *factors* for violence**
- reconciling the **right to confidentiality**, **least restrictive environment**, and the **duty to protect**
- **actions to take** when there is a risk for violence concern
- **means for discharging patients** based on treatment setting
- **record-keeping** to decrease variation in practice patterns in these areas

Focus Areas

- Identification of increased risk for violence 
- Further assessment of violence risk 
- Violence risk management 
- Protection of third parties 

Identification of increased risk for violence

- Screen all patients over 18 years for the following behavioral health conditions:
  - Depression
  - Suicidality
  - Alcohol misuse and drug use
  - For youth ages 14-18, use developmentally appropriate screening tools
- Other observations that may increase risk for violence (e.g., acute agitation)
- Screen for thoughts of doing physical harm to others
- Past history of violent acts
- Document identification in the record including low risk of violence to others

Further Assessment of Violence Risk

- Historical risk and/or triggering factors (e.g., history of criminal acts) including intimate partner violence
- Clinical risk factors (if not already identified previously)
- Protective factors that may mitigate risk (e.g., community and family ties)
- Other relevant psychiatric symptoms or warning signs at clinician's discretion (e.g., texting, stalking)
- If appropriate, arrange for a second opinion risk assessment
- If appropriate for further assessment, use a validated instrument (e.g., Historical Clinical Risk Management-20)
  - Training
  - Developmentally appropriate
- Document results in the health record

Violence Risk Management

- Match level of risk for violence with management plan.
- If patient in acute crisis or acutely agitated, first ensure personal safety
- Evidence-based treatment plan, if present, including medication, if indicated.
- Consultation
- Additional management strategies:
  - More frequent visits.
  - Medication compliance/changes
  - Lethal means safety.
  - Involving others
  - Referral
  - Hospitalization
- Addressing non-adherence
- Addressing termination of therapeutic relationship
- At each clinical decision point, document actions taken in the health record.

Protection of Third Parties

Note: The steps below are provided as guidance and are **not** meant as a checklist or as a decision tree.

- If in an acute crisis, attempt to keep patient in an observed, safe, and appropriate environment
- Consider voluntary admission
- If needed, contact Designated Crisis Responder (DCR) for assessment for involuntary commitment.
- At any time, if the provider decides that issuing a warning is needed, current law permits the clinicians to notify law enforcement before notifying potential victim(s). The clinician may follow RCW 70.02.230 as needed.
- If needed and feasible, contact potential victim or victims including relatives, or parent or guardian if the potential victim is a minor, is a vulnerable adult, or has been adjudicated incompetent, employers, or household members of the patient, if reasonably identified.
- At each decision point, document actions taken in the health record, other options considered, and the clinical rationale for the actions taken.

Recommendations to Washington State Legislature

- Define one standard to address the duty to protect third parties across all treatment settings:
  - The group of mental health professionals subject to the duty to protect as a psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or licensed independent social worker, and any person licensed by the department of health as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate
  - The duty to protect only arises when the patient has communicated an actual threat of physical violence that poses a serious and imminent threat to the health or safety of a reasonably identifiable person or persons
  - Options for discharging the duty to protect including when the identifiable person or persons and law enforcement are warned or taking reasonable precautions to provide protection

Key Takeaway Points

- Violent **acts that harm others are of social and clinical significance**
- The majority of patients with **mental health conditions do not engage** in violent behavior
- **Substance use disorder** more strongly associated with risk of violence, especially when present with a mental illness diagnosis
- Clinicians **cannot predict impending violent acts with certainty**
- Patient's have a right to **confidentiality** and also to care in the **least restrictive environment**
- Clinicians have a duty to **protect the community**
- Clinicians can **identify/assess/manage** those at risk of violence
- **Clinicians cannot possibly warn all** those who are 'foreseeable' victims, but are not 'reasonably identifiable' victims subject to an *actual* threat

Recommendation

Adopt Report and Recommendations

Final Adoption: Maternity Bundled Payment Model

Carl Olden, MD
Family Physician,
Pacific Crest Family Medicine

DR. ROBERT BREE COLLABORATIVE

January 15th, 2020 | Puget Sound Regional Council

Workgroup Members

- **Chair:** Carl Olden, MD, Family Physician, Pacific Crest Family Medicine
- Andrew Castrodale, MD, Family Physician, Coulee Medical Center
- Angela Chien, MD, Obstetrics and Gynecology, EvergreenHealth
- Neva Gerke, LM, President, Midwives Association of Washington
- Molly Firth, MPH, Patient Advocate
- Lisa Humes-Schulz, MPA/Lisa Pepperdine, MD, Director of Strategic Initiatives/ Director of Clinical Services, Planned Parenthood of the Great Northwest and Hawaiian Islands
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- Ellen Kauffman, MD, Medical Director Emeritus, Obstetrics Clinical Outcomes Assessment Program
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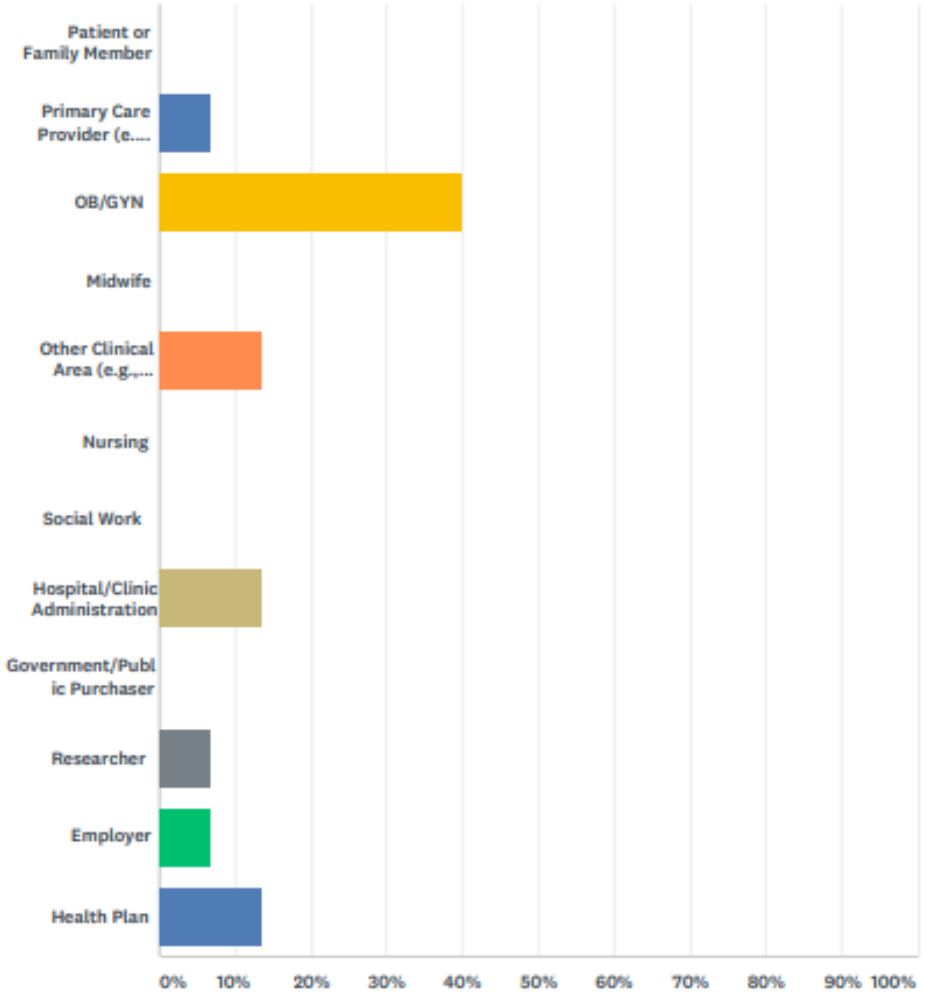
- Dale Reisner, MD, Obstetrics and Gynecology, Swedish Medical Center
- Janine Reisinger, MPH, Director, Maternal-Infant Health Initiatives, Washington State Hospital Association
- Mark Schemmel, MD, Obstetrics and Gynecology, Spokane Obstetrics and Gynecology, Providence Health and Services
- Vivienne Souter, MD, Research Director, Obstetrics Clinical Outcomes Assessment Program
- Judy Zerzan, MD Chief Medical Officer Washington State Health Care Authority

Public Comments

- 15 survey responses
- Comments from WSHA



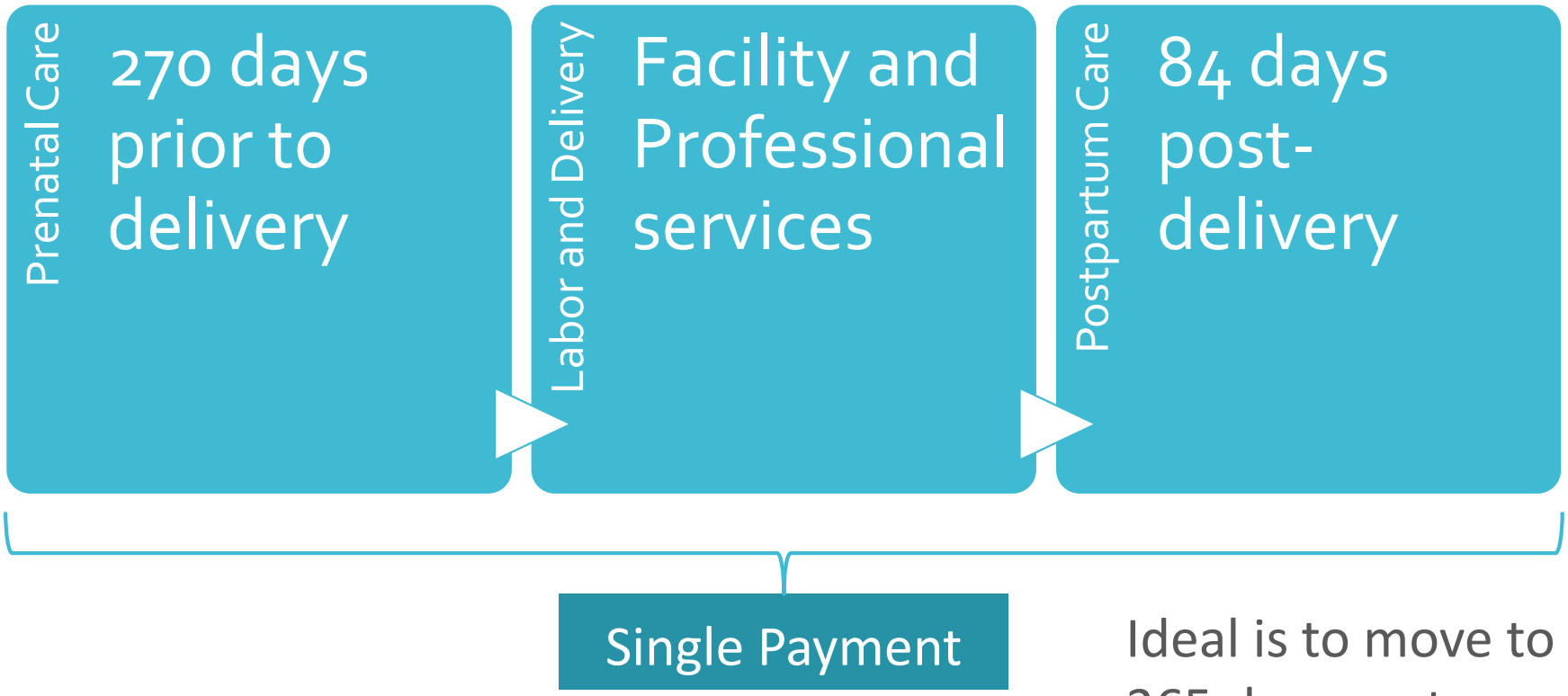
Public Comments Summary

- Whether to include pediatric services
- Whether obstetric care provider should be accountable entity
- Administrative burden
- Inclusions and exclusions: Clarify whether anesthesia, contraception device and/or counseling, genetic testing, pediatric services are included
- Patient population: BMI as exclusion criteria
- More information needed about how reimbursement will occur
- Whether home births are included
- Prenatal care: allow prenatal visits 6 weeks apart up to 28 weeks
- Quality metrics: do not include cost, c-section, severe neonatal outcomes

Changes to Bundled Payment Model

- Pg 5:
  - Add: If and when Medicaid extension to 12 months occurs, this bundle should extend to 12 months postpartum. Pediatric care should be family-centered
  - Clarification: Exclude anesthesia, insertion of contraceptive device, contraceptive device, and genetic testing, and pediatric services
  - Add: The workgroup does not recommend basing exclusion criteria on behavioral health diagnoses including substance use disorder or drug use and/or <=45 body mass index (BMI).
  - Add: All services not explicitly addressed in the bundle should be discussed during contracting.
  - Add: Cost of care should be tracked but is not a quality metric.
- Pg. 6: Change: At a minimum, visits every four to six weeks up to 28 weeks gestation. Visits may be done as a group.
- Pg. 8: Clarification – use contraceptive counseling language from labor and delivery
- Pg. 10: Add/Clarification: the following services related to pregnancy and labor and delivery, and not unrelated services
- Pg. 11: Add: For Health Plans – Offer a bundled payment model aligned with the framework described in these recommendations.
- Pg. 13:
  - Remove cost.
  - Change Unexpected Severe Complications in Term Newborns (PC-06) to Unexpected Complications in Term Newborns - Severe Rate (PC-06.1)
- Pg. 23: Add: The following are meant as examples
- Pg: 24: Remove “anesthesia/epidural”
- Pg. 28: NEW: **Appendix G: Behavioral Health Treatment**
- Throughout: gestational parent

Overview



Ideal is to move to 365 days post delivery including pediatric care

Structure

- Fee-for-service with retrospective reconciliation initially
  - The workgroup recommends moving toward a prospective payment model
- Exclude anesthesia, insertion of contraceptive device, contraceptive device, and genetic testing, and pediatric services
- Risk adjustment based on patient-specific factors
- Including prenatal care, labor and delivery, postpartum services for both facility and professional services
- Obstetric care provider or group is the accountable entity
- Exclusion criteria:
  - Age: younger than 16, older than 40
  - Cost below first percentile or higher than ninety-ninth percentile
  - Diagnoses within the episode window or 90 prior to or after episode window as determined by the payer or purchaser based on high-cost claims. See **Appendix D** for Exclusion criteria examples. The workgroup does not recommend basing exclusion criteria on behavioral health diagnoses including substance use disorder or drug use and/or <= 45 body mass index (BMI).
  - Death within episode window

Care Pathway
Prenatal Care

- **Intake visit** as soon as possible after a patient contacts the provider or group with a positive pregnancy test. At a minimum, the intake visit should happen in the first trimester. (e.g., insurance, nutrition, dating ultrasound, behavioral health screenings)
- At a minimum, visits every four to six weeks up to 28 weeks gestation at minimum
- At a minimum, biweekly visits up to 36 weeks gestation at minimum.
- Content:
  - Cardiovascular disease
  - Behavioral Health Screening
  - Infectious Disease Screening
  - Gestational Diabetes Screening
  - Vaccination
  - Third trimester education (e.g., breastfeeding, birth spacing, shared decision making as appropriate)
  - Social Determinants of Health

Care Pathway
Labor Management and Delivery

- Emphasizing a physiologic birth when safe (e.g., spontaneous onset and progression of labor, vaginal birth of the infant and placenta)
- Shared decision making, where appropriate
- Endorse standards within the Washington State Hospital Association Labor Management Bundle
- 2012 Bree Collaborative Obstetric guidelines
- Comprehensive, client-centered contraceptive counseling (including LARC)

Care Pathway
Postpartum Care

- At least two visits with additional visits as needed (e.g., if higher-risk)
  - Three weeks postpartum visit
  - Additional comprehensive visit prior to 12 weeks postpartum including
- Assessment of mood and emotional well-being including screening with a validated tool for depression (e.g., PHQ-9, Edinburgh Postnatal Depression Scale), anxiety (e.g., GAD), suicidality, and tobacco, alcohol, marijuana, and other drug use.
- Sexuality including contraception
- Infant care and feeding including breastfeeding
- Sleep and fatigue
- Patient support
- Postpartum discharge summary
- Connection to primary care

Other stakeholder groups

- **Health Care Purchasers (Employers and Union Trusts)**
  - Investigate moving to value-based reimbursement in partnership with other purchasers such as the Washington State Health Care Authority.
  - High-deductible health plans = moving the deductible above a specified allowance for the perinatal episode.
- **Emergency Department and Urgent Care**
  - **Cardiovascular Disease.** Assess all women of childbearing age for recent pregnancy and last menstrual period. Women may be at higher risk for cardiovascular disease up to five months postpartum and may present with shortness of breath, chest pain, unresolved cough or swelling.
- **Department of Health**
  - Link the gestational parent's member ID and newborn ID.
  - Resources around social determinants of health
- **Washington State Health Care Authority**
  - Extend Washington State Medicaid eligibility to 12 months (365 days) postpartum at the same income level as for pregnancy.

Quality Metrics

Reflect clinical priorities, process and outcome, balance w/ unexpected outcomes

- PC-O2 Cesarean Birth
- PC-O6.1 Unexpected Complications in Term Newborns
- O1: Severe Maternal Morbidity
- Chlamydia Screening
- Group B Streptococcus Screening
- Postpartum Visit Scheduled
- Behavioral Health Risk Assessment

Recommendation

Adopt Bundled Payment Model

Retreat

January 15th, 2020 | Bree Collaborative Meeting

ESHB 1311 - 2011

AN ACT Relating to establishing a public/private collaborative to improve health care quality, cost-effectiveness, and outcomes in Washington state.

The collaborative shall identify health care services for which there are substantial variation in practice patterns or high utilization trends in Washington state, without producing better care outcomes for patients, that are indicators of poor quality and potential waste in the health care system. On an annual basis, the collaborative shall identify up to three health care services it will address.

By January 1, 2012, and every January 1st thereafter, all state purchased health care programs must implement the evidence-based best practice guidelines or protocols and strategies identified under section 3 of this act, after the administrator, in consultation with participating agencies, has affirmatively reviewed and endorsed the recommendations.

28 sets of recommendations + 4 for 2020

- **Pain (Chronic and Acute)**
  - *Collaborative care for chronic pain (2018)*
  - *Low back pain management (2013)*
  - *Opioid prescribing metrics (2017)*
  - *Opioid prescribing for postoperative pain (2018)*
  - *Opioid prescribing in dentistry (2017)*
  - *Long-term opioid prescribing management (2019)*
- **Behavioral Health**
  - *Integrating behavioral health into primary care (2016)*
  - *Addiction and substance use disorder screening and intervention (2014)*
  - *Suicide care (2018)*
  - *Treatment for opioid use disorder (2016)*
  - *Prescribing antipsychotics to children and adolescents (2016)*
  - *Risk of Violence to Others (2019)*
- **Oncology**
  - *Oncology care (2015)*
  - *Prostate cancer screening (2015)*
  - *Chemotherapy (2020)*
  - *Colorectal cancer screening (2020)*
- **Procedural (surgical)**
  - *Bundled payment models and warranties:*
  - *Total knee and total hip replacement (2013, re-review 2017)*
  - *Lumbar fusion (2014, re-review 2018)*
  - *Coronary artery bypass surgery (2015)*
  - *Bariatric surgery (2016)*
  - *Hysterectomy (2017)*
  - *Data collection on appropriate cardiac surgery (2013*
- **Reproductive Health**
  - *Obstetric care (2012)*
  - *Maternity Bundle (2019)*
  - *Reproductive Health (2020)*
- **Aging**
  - *Advance care planning for the end-of-life (2014)*
  - *Alzheimer's disease and other dementias (2017)*
- ***Palliative Care (2019)***
- ***Hospital readmissions (2014)***
- ***LGBTQ health care (2018)***
- ***Shared Decision Making (2019)***
- ***Primary care (2020)***

Four Goals

- Goal 1: To provide a setting in which collaboration between diverse health care stakeholders can be successful to improve health care quality, health outcomes, and cost effectiveness of care in Washington State
- Goal 2: To annually identify health care services with high variation in the way that care is delivered, that are frequently used but do not lead to better care or patient health, or that have patient safety issues
- Goal 3: To develop comprehensive recommendations to improve health care services for our identified areas taking into account existing quality improvement programs, expert opinion, existing guidelines, and other strategies
- Goal 4: To integrate our recommendations into the Health Care Authority's contracts and promote strategies for community implementation of the recommendations

Member Role

- **Legislation:** *The governor shall appoint twenty members of the collaborative…*
- **Goal 1:** To provide a setting in which collaboration between diverse health care stakeholders can improve health care quality, health outcomes, and cost effectiveness of care in Washington State.
- **Process:** Bree Collaborative members are nominated as defined in the legislation. Bree Collaborative meetings occur every other month. Members are expected to attend meetings or appoint a proxy to attend.

Selecting Topics

- **Legislation:** *The collaborative shall identify health care services for which there are substantial variation in practice patterns or high utilization trends in Washington State, without producing better care outcomes for patients, that are indicators of poor quality and potential waste in the health care system. On an annual basis, the collaborative shall identify up to three health care services it will address.*
- **Goal 2:** To annually identify health care services with high variation in the way that care is delivered, that are frequently used but do not lead to better care or patient health, or that have patient safety issues
- **Current Process:** When we select topics we ask for recommendations from our members, from the State Agencies, from community organizations, and from the public broadly. We consider all these suggestions equally, comparing across a variety of factors including: availability of data, variation, patient safety, cost, if there is a proven strategy for improvement, whether Bree has a unique role, if shared decision-making is applicable, impact on improving health equity, and other variable issues. We then select topics over the course of two meetings, starting with a broad discussion, narrowing down our list to 7-8 topics that are presented in more detail at a following meeting usually with the input of clinical experts. Members then vote on 4-5 topics for the subsequent year.

Developing Recommendations

- **Legislation:** *(2) For each health care service identified, the collaborative shall: (a) Analyze and identify evidence-based best practice approaches to improve quality and reduce variation in use of the service… (b) Identify data collection and reporting necessary to develop baseline health service utilization rates and to measure the impact of strategies adopted (c) Identify strategies to increase use of the evidence-based best practice approaches (3) …strategies that will promote improved care outcomes, such as patient decision aids, provider feedback reports, centers of excellence or other provider qualification standards, and research to improve care quality and outcomes.*
- **Goal 3:** To develop comprehensive recommendations to improve health care services for our identified areas taking into account existing quality improvement programs, expert opinion, existing guidelines, and other strategies.
- **Current Process:** Workgroup members approach us to be involved, are recommended through their organization or sector, are recommended by a community partner, or are recruited based on a specific expertise/research interest. Workgroups meet from January onward for 10-12 months. A charter is developed by the workgroup and presented to the Bree Collaborative members for feedback and approval. The chair of the workgroup reports on progress and content to the Bree Collaborative at most meetings for information sharing and feedback.

Implementation

- **Legislation:** *(1) No later than September 1, 2009, all state purchased health care programs shall, except for state purchased health care services that are purchased from or through health carriers as defined in RCW 28 48.43.005, implement evidence-based best practice guidelines or protocols applicable to advanced diagnostic imaging services, and the decision support tools to implement the guidelines or protocols, identified under ((RCW 70.250.020)) section 3 of this act.*
- *(2) By January 1, 2012, and every January 1st thereafter, all state purchased health care programs must implement the evidence-based best practice guidelines or protocols and strategies identified under section 3 of this act, after the administrator, in consultation with participating agencies, has affirmatively reviewed and endorsed the recommendations. This requirement applies to health carriers, as defined in RCW 48.43.005 and to entities acting as third-party administrators that contract with state purchased health care programs to provide or administer health benefits for enrollees of those programs. If the collaborative fails to reach consensus within the time frames identified in this section and section 3 of this act, state purchased health care programs may pursue implementation of evidence-based strategies on their own initiative.*
- **Goal 4:** To integrate our recommendations into the Health Care Authority's purchasing contracts and promote strategies for community implementation of the recommendations.
- **Current Process:** Education through community partners, outreach

Summit:

Tuesday, March 17th, 2020

SeaTac Airport Conference Center

DR. ROBERT BREE COLLABORATIVE