

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

**Implementation Survey Results**

Hospitals, Medical Groups, Health Plans

**April 2017**

Table of Contents

[Introduction 2](#_Toc482002115)

[Scale 2](#_Toc482002116)

[Hospitals 4](#_Toc482002117)

[Participating Hospitals 4](#_Toc482002118)

[Obstetrics Care 5](#_Toc482002119)

[Cardiology: Appropriate Percutaneous Coronary Intervention (PCI) 6](#_Toc482002120)

[Coronary Artery Bypass Graft Surgical Bundle 7](#_Toc482002121)

[Low Back Pain 13](#_Toc482002122)

[Spine Surgical Care and Outcomes Program (SCOAP) Participation 14](#_Toc482002123)

[Lumbar Fusion Surgical Bundle 15](#_Toc482002124)

[Total Knee/Total Hip Replacement Surgical Bundle 21](#_Toc482002125)

[Prostate Cancer Screening 26](#_Toc482002126)

[Oncology Care 26](#_Toc482002127)

[Addiction and Dependence Treatment 27](#_Toc482002128)

[Prescribing Opioids for Pain 28](#_Toc482002129)

[End-of-Life Care 30](#_Toc482002130)

[Potentially Avoidable Hospital Readmissions 32](#_Toc482002131)

[Factors Affecting Adoption 33](#_Toc482002132)

[Medical Groups 34](#_Toc482002133)

[Participating Medical Groups 34](#_Toc482002134)

[Obstetrics Care 35](#_Toc482002135)

[Low Back Pain 36](#_Toc482002136)

[Prostate Cancer Screening 37](#_Toc482002137)

[Oncology Care 38](#_Toc482002138)

[Prescribing Opioids for Pain 39](#_Toc482002139)

[Addiction and Dependence Treatment 41](#_Toc482002140)

[Potentially Avoidable Hospital Readmissions 43](#_Toc482002141)

[End-of-Life Care 44](#_Toc482002142)

[Factors Affecting Adoption 46](#_Toc482002143)

[Health Plans 47](#_Toc482002144)

[Participating Health Plans 47](#_Toc482002145)

[Value-Based Provider Reimbursement Models 48](#_Toc482002146)

[Obstetrics Care 49](#_Toc482002147)

[Low Back Pain 49](#_Toc482002148)

[Prostate Cancer Screening 50](#_Toc482002149)

[Oncology Care 50](#_Toc482002150)

[Prescribing Opioids for Pain 51](#_Toc482002151)

[End-of-Life Care 52](#_Toc482002152)

[Potentially Avoidable Hospital Readmissions 53](#_Toc482002153)

[Factors Affecting Adoption 54](#_Toc482002154)

# Introduction

Bree Collaborative staff developed a comprehensive survey to assess implementation of recommendations across care settings and health plans. The survey included 13 topics that had been approved at least six months prior to the time the survey was conducted. We asked key leaders from Washington hospitals, medical groups, and health plans to complete the survey, which included specific recommendations for each topic. Participation was voluntary, and responses were self-reported.

This report summarizes results of these implementation surveys, completed by Washington State hospitals, medical groups, and health plans in 2016, to assess implementation of recommendations developed by The Bree Collaborative. Overall average and the range of scores for implementation are shown below.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Hospitals | Medical Groups | Health Plans |
| Addiction and Dependence Treatment | 1.4 (0.9-2.6) | 1.4 (0.0-2.4) | 1.9 (1.2-2.4) |
| Lumbar Fusion Surgical Bundle | 1.9 (0.3-2.9) | - | 0.7 (0.0-2.0) |
| Low-Back Pain  | 2.0 (1.0-3.0) | 1.8 (0.5-2.8) | 1.2 (0.7-1.7) |
| Prostate Cancer Screening | 2.3 (2.0-3.0) | 1.6 (0.0-2.8) | 0.7 (0.0-3.0) |
| End-Of-Life Care | 2.2 (1.7-2.6) | 1.7 (0.0-2.5) | 1.8 (1.0-3.0) |
| Avoidable Hospital Readmissions | 1.6 (0.0-3.0) | 2.5 (1.8-3.0) | 2.7 (2.0-3.0) |
| Prescribing Opioids for Pain | 2.5 (2.1-2.5) | 1.8 (0.0-2.7) | 1.7 (1.0-2.0) |
| Oncology Care | 2.1 (1.8-2.7) | 2.2 (0.0-3.0) | 1.4 (0.0-3.0) |
| Coronary Artery Bypass Graft Surgical Bundle  | 2.2 (2.0-2.8) | - | 0.4 (0.0-1.0) |
| Knee and Hip Replacement Surgical Bundle | 2.3 (1.7-3.0) | - | 1.0 (0.0-2.0) |
| Obstetrics Care | 2.8 (1.9-3.0) | 2.8 (2.4-3.0) | 2.0 (1.0-3.0) |
| Spine Surgical Care and Outcomes Measurement Program (SCOAP) | 2.8 (2.0-3.0) | - | - |
| Cardiology: Appropriate PCI | 3.0 (3.0-3.0) | - | - |

We made efforts to contact the largest 50 hospitals in the state that, combined, represent over 95% of total patient discharges according to state Comprehensive Hospital Abstract Reporting System (CHARS) data. Large and mid-sized medical groups were also included, as well as health plans operating in the state. We also invited Federally Qualified Health Centers (FQHC) provider organizations serving underserved populations to participate.

## Scale

We measured adoption of specific recommendations using 0-3 point scale, self-assessed by each organization (i.e., hospital, medical group, or health plan).

|  |  |
| --- | --- |
| 0 - No action taken | * No leadership awareness of Bree Collaborative Topics
 |
|   | * No team formed
 |
|   |  |
| 1 - Actively considering adoption | * Bree topics, aims and components have been discussed
 |
|   | * Education, assessment, information gathering
 |
|   | * Changes planned but not tested
 |
|   | * Information gathering and baseline measurement begun
 |
|   |  |
| 2 - Some/similar adoption | * Initial test cycles completed for more than one element
 |
|   | * Quality metrics and data available demonstrating adoption/effectiveness
 |
|   | * Other similar (Bree-like) changes adopted for this topic
 |
|  |  |
| 3 - Full adoption | * Changes implemented in all areas
 |
|   | * All components integrated into care process (i.e. orders, etc.)
 |
|   | * Partial or complete closure of gap between baseline & target outcomes
 |

On the following pages, we present responses by hospitals, medical groups, and health plans on the 13 topics surveyed including the written responses. Numeric scores and written responses are blinded by responding organization.

# Hospitals

## Participating Hospitals

CHI Franciscan Health

 Highline Medical Center

 St. Elizabeth Hospital

 St. Francis Hospital

 St. Joseph Medical Center

 Harrison Medical Center

Confluence Health-Central Washington Hospital

The Everett Clinic (surgical bundle topics)

MultiCare

Tacoma General Hospital

Good Samaritan Hospital

Auburn Medical Center

Covington Hospital

Mary Bridge Children’s Hospital

UW

 Harborview

 Valley Medical Center

 Northwest Hospital

 University of Washington Medical Center

Swedish

 First Hill

 Cherry Hill

 Issaquah

 Ballard

 Edmonds

Virginia Mason Medical Center

## Obstetrics Care

14 Hospitals Reporting

Read the full report here: [www.breecollaborative.org/wp-content/uploads/bree\_ob\_report\_final\_080212.pdf](http://www.breecollaborative.org/wp-content/uploads/bree_ob_report_final_080212.pdf)

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| Obstetrics quality improvement program is in place | *2.64* |
| Policy is in place that limits deliveries before the 39th week that includes: |  |
| * If induction between 37 and 39 weeks occurs, indication was on the Joint Commission or Washington State Perinatal Collaborative/WSHA project list
 | *2.86* |
| * For clinical situations not on the two lists above, consultation occurs and agreement is obtained that the clinical situation required delivery
 | *2.86* |
| * Data, including baseline, on early elective delivery is collected
 | *3.00* |
| Policy for scheduling inductions between 39-41 weeks includes: |  |
| * The cervix is favorable (Bishop score of 6 or greater)
 | *2.43* |
| * A consent form specific to the risk and benefits of induced compared with spontaneous labor has been signed by the patient
 | *2.86* |
| * Data, including baseline, on elective inductions is collected
 | *3.00* |
| Policy for Cesarean-Sections includes: |  |
| * Admitting only spontaneously laboring women at term who present with no fetal or maternal compromise when the cervix is 4 centimeters or more dilated
 | *2.36* |
| * Allowing first stage labor arrest cesarean (reassuring fetal and maternal status but lack of progress of labor) to be performed only in the active phase (equal to or more than 6 centimeters dilation)
 | *2.71* |
| * Allowing adequate time in the active phase (4 to 6 hours) with use of appropriate clinical interventions before making a diagnosis of active phase arrest
 | *2.71* |
| * Allowing sufficient time with appropriate clinical interventions in the 2nd stage before diagnosis of 2nd stage arrest or “failure to descend”
 | *2.71* |
| * Data on C-sections, including baseline, is collected
 | *3.00* |
| Data and feedback are provided to clinicians  | *2.93* |
| Public reporting on obstetrics procedure data (through existing website such as WSHA) is supported | *3.00* |
| Patients are provided with education and shared decision-making on maternity care options and risks of pre-term births, elective deliveries, and C-sections  | *2.79* |
| Additional Comments: | * *creation of an outpatient pregnancy pathway*
* *updated prenatal information booklet and put online*
* *standardized consents for OB care*
* *We provide a free downloadable app (application) with evidence-based information and expert opinion guiding them through their pregnancy, postpartum and first year of baby’s life.*
* *Patients provided with education & SDM as described above. Implementing SDM-certified tools for attempted VBAC in the next year.*
* *Data/feedback provided to clinicians in aggregate. Considering individual-level feedback.*
* *following the WSHA Safe Deliveries Roadmap labor management bundle, currently meeting the labor management bundle at a rate of 60-75% compliance.*
* *We participate in the WSHA MDC.*
 |

## Cardiology: Appropriate Percutaneous Coronary Intervention (PCI)

8 Hospitals Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/bree\_bc\_cardiology\_final.pdf](http://www.breecollaborative.org/wp-content/uploads/bree_bc_cardiology_final.pdf)

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

|  |  |
| --- | --- |
|   | **AVERAGE****SCORE** |
| Hospital participates in the Clinical Outcomes Assessment Program (COAP, [www.coap.org](http://www.coap.org)) | *3.00* |
| Appropriateness of percutaneous coronary intervention is measured and reported to COAP using the American College of Cardiology’s Appropriate Use Criteria | *3.00* |
| Results are allowed to be transparently published with the COAP program | *3.00* |
| Additional Comments: | * *fully participate in COAP, are in good standing with data submitted and transparently share our results.*
* *full adoption at all our hospitals.*
 |

## Coronary Artery Bypass Graft Surgical Bundle

4 Hospitals Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/CABG-Bundle-Final-15-09.pdf](http://www.breecollaborative.org/wp-content/uploads/CABG-Bundle-Final-15-09.pdf)

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

|  |  |
| --- | --- |
|   | **AVERAGE****SCORE** |
| **I: DISABILITY DESPITE NON-SURGICAL THERAPY** |  |
| 1. **Document disability**
 |  |
| 1. Grade of angina (I-IV) documented according to Canadian Cardiovascular Society grade of angina pectoris
 | *1.50* |
| 1. Disability documented according to the Seattle Angina Questionnaire-7
 | *1.00* |
| 1. Self-reported loss of function documented with Patient Reported Outcomes Measurement Information System-10® (PROMIS-10)
 | *1.33* |
| 1. **Myocardial ischemia documented with appropriate non-invasive stress testing according to 2012 ACCF, et.al. Guidelines & 2014 Guidelines Focused Update**
 | *2.00* |
| 1. **Risk factor modification begun according to ACCF Guideline above unless need for urgent intervention**
 |  |
| 1. Patient education begun with a goal of empowering and improving participation in shared decision-making
 | *2.25* |
| 1. Cardiac diet begun or maintained, with attention to:
 |  |
| 1. Weight management to maintain or achieve a BMI between 18.5 and 24.9 kg/m2;
 | *1.75* |
| 1. Blood pressure management;
 | *2.50* |
| 1. Lipid management
 | *2.75* |
| 1. Appropriate physical activity advised:
 |  |
| 1. Estimate risk of physical activity;
 | *2.00* |
| 1. 30-60 minutes moderate-intensity activity recommended daily for low risk patients;
 | *1.50* |
| 1. Medically supervised exercise considered for higher-risk patients
 | *1.75* |
| 1. Overuse of alcohol screened and manage if needed
 | *2.00* |
| 1. Patient assisted with smoking cessation if needed
 | *2.75* |
| 1. Diabetes managed with target HbA1c between 7-9% depending on risk/benefit
 | *2.00* |
| 1. Depression screened and treated if positive
 | *1.75* |
| 1. Stress management considered and assistance given if indicated
 | *1.75* |
| 1. Dementia screened and managed as necessary if positive
 | *1.75* |
| 1. Immunize against influenza annually
 | *1.75* |
| 1. Statin medication prescribed unless contraindicated
 | *3.00* |
| 1. Blood pressure managed according to March 2015 guideline update from AHA/ACC/AHS, including anti-hypertensive drugs for BP above guideline goals
 | *2.75* |
| 1. Antiplatelet therapy prescribed unless contraindicated
 | *3.00* |
| 1. Beta blocker therapy prescribed unless contraindicated
 | *3.00* |
| 1. Renin-angiotensin-aldosterone blocker therapy prescribed, per ACCF Guideline
 | *3.00* |
| 1. Anti-anginal therapy prescribed as tolerated, with two or more of the following agents as needed: a) Beta blockers; b) Calcium channel blockers when beta blockers are contraindicated or unsuccessful; c) Long acting nitrates; d) Ranolazine
 | *3.00* |
| 1. **Patients stratified prior to determining appropriate intervention**
 |  |
| 1. Multidisciplinary Heart Team approach used in decision making for patients with complex coronary artery disease composed of an interventional cardiologist, a cardiac surgeon, and other consultants, as needed
 | *1.75* |
| 1. Interventions based on the 2012 ACCF Guidelines (<http://content.onlinejacc.org/article.aspx?articleid=1201161> )
 | *2.25* |
| 1. STS score used to assist with decision for intervention
 | *2.25* |
| 1. Additional factors considered such as left main disease, diabetes with multi-vessel disease, and severity of symptoms related to ischemia
 | *2.50* |
| **II: FITNESS FOR SURGERY** |  |
| 1. **Requirements documented related to patient safety (if compatible)**
 |  |
| 1. Body Mass Index less than 40
 | *1.67* |
| 1. Hemoglobin A1c less than 8% in patients with diabetes
 | *2.00* |
| 1. Adequate nutritional status to ensure healing
 | *1.33* |
| 1. Sufficient liver function to ensure healing
 | *2.33* |
| 1. Pre-operative plan for management of opioid dependency, if patient has taken opioids for more than three months
 | *0.33* |
| 1. Avoidance of smoking for at least four weeks pre-operatively
 | *1.67* |
| 1. Alcohol abuse screened for with management plan if screen is positive
 | *1.33* |
| 1. Depression screened for with management plan if positive
 | *1.33* |
| 1. Dementia screened for with management plan if positive
 | *1.33* |
| 1. Pre-operative plan developed for post-operative return to function
 | *2.33* |
| 1. Risk for co-occurring cerebrovascular disease assessed; including imaging carotid circulation (ultrasound or MRA) for clinically high-risk patients
 | *2.33* |
| 1. Patients with high-risk carotid arterial disease treated according to ACC/AHA guidelines, 2012
 | *2.67* |
| 1. **Patient engagement documented**
 |  |
| 1. Patient participates actively in shared decision-making with full knowledge of risks, benefits, alternatives, and preferences; this requirement is in addition to informed consent
 | *2.00* |
| 1. Patient engages in a discrete shared decision-making process with a credentialed health coach or equivalent
 | *0.50* |
| 1. Validated shared decision-making aid included such as those certified by the Washington State Health Care Authority, if available
 | *0.50* |
| 1. During this encounter, the patient and coach addresses:
 |  |
| 1. Issues related to an active, life-limiting condition that would likely cause death before recovery from surgery
 | *0.50* |
| 1. Disability from an unrelated condition that would severely limit the benefits of surgery
 | *0.50* |
| 1. Dementia that would interfere with recovery from surgery; performing surgery on a patient with such dementia requires preauthorization, informed consent of a person with durable power of attorney for health care, and a contract with the patient’s care partner regarding accountability for care aligned with the patient’s care plan and made available to the purchaser
 | *0.50* |
| 1. For patients 65 years and older, the ASCERT calculator may be used to assess likelihood of survival from CABG
 | *0.50* |
| 1. Patient’s preference documented for treatment as part of this encounter
 | *0.50* |
| 1. Patient designates a personal care partner; patient and care partner actively participate in the following:
 |  |
| 1. Surgical consultation
 | *2.00* |
| 1. Pre-operative evaluation
 | *2.00* |
| 1. Pre-surgical class and/or required surgical and anesthesia educational programs
 | *2.00* |
| 1. In-hospital care
 | *2.00* |
| 1. Post-operative care teaching patients home care and exercise program
 | *2.00* |
| 1. Assessment of home-based physical and psychosocial hazards that may interfere with recovery
 | *2.00* |
| 1. End-of-life planning offered to patient, including completion of an advance directive, designation of durable power of attorney for health care, and participation in an option for organ donation
 | *2.00* |
| 1. Patient encouraged to participate in the COAP registry with two years follow-up data collection
 | *1.00* |
| 1. **Optimal preparation for surgery documented**
 |  |
| 1. Pre-operative history, physical, and screening lab tests performed based on review of systems:
 |  |
| 1. Pulmonary fitness evaluated;
 | *2.25* |
| 1. Basic lab profile, plasma glucose, prothrombin time, complete blood count, urinalysis with culture, obtained if indicated;
 | *3.00* |
| 1. Nasal passages cultured to identify staphylococcal carrier state and treat accordingly;
 | *2.25* |
| 1. Screens done for predictors of delirium
 | *1.00* |
| 1. Relevant consultations obtained:
 |  |
| 1. Evaluating for good dental hygiene in high-risk patients;
 | *2.25* |
| 1. Referrals are made to Anesthesia for pre-operative assessment including identification and management of conditions such as sleep apnea and pulmonary hypertension;
 | *1.75* |
| 1. Other consultations requested, as necessary
 | *2.50* |
| 1. Post-operative care plan reviewed, including cardiac rehabilitation
 | *2.75* |
| 1. Patient started or continued on statin therapy (unless contraindicated) according to current guidelines
 | *2.50* |
| 1. Beta-blocker administered during the perioperative period for all patients on beta-blocker therapy prior to surgery
 | *2.75* |
| 1. Beta blockers administered at least 24-hours before CABG to all patients without contraindications to reduce the incidence of complications of post-operative atrial fibrillation
 | *2.00* |
| 1. Aspirin begun or continued unless contraindicated
 | *2.75* |
| 1. Patient-reported measures collected to confirm lack of significant response to non-surgical treatments using:
 |  |
| 1. General health questionnaire PROMIS-10;
 | *0.25* |
| 1. Condition-specific/standard disability questionnaire: Seattle Angina Questionnaire-7
 | *0.75* |
| **III. CABG PROCEDURE** |  |
| “2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery” guideline followed or more recent if possible:[http://circ.ahajournals.org/content/124/23/e652.full.pdf+html](http://circ.ahajournals.org/content/124/23/e652.full.pdf%2Bhtml)  | *3.00* |
| 1. **General standards for a surgical team performing surgery**
 |  |
| 1. Cardiac surgeons board certified or board eligible by the American Board of Thoracic Surgery or certified by a reciprocal and equivalent credentialing organization
 | *2.75* |
| 1. Surgeon outcome metrics are within two standard deviations, away from the desired direction, of the community standard (e.g., mean) of the Clinical Outcome Assessment Program (COAP) Level I quality indicators; these include: mortality, post-operative stroke, and renal insufficiency requiring dialysis based on at least 25 open heart surgeries (elective and urgent) to ensure statistical reliability
 | *2.75* |
| 1. Members of the surgical team have documented credentials, training, and experience
 | *3.00* |
| 1. Consistency ensured in roster of the surgical team
 | *3.00* |
| 1. Surgery performed in an inpatient facility
 | *3.00* |
| 1. Policies aligned with the American College of Surgeons Statement on Health Care Industry Representatives in the Operating Room in facilities in which surgery is performed
 | *3.00* |
| 1. **Elements of optimal surgical process**
 |  |
| 1. Pain management and anesthesia optimized:
 |  |
| 1. Anesthesia management format used to minimize sedation and encourage early extubation and recovery;
 | *3.00* |
| 1. Use of opioids minimized and prescribed according to Washington State Agency Medical Director’s Group Opioid Prescribing Guidelines, 2015 Interagency Guidelines or more recent if available
 | *2.75* |
| 1. Infection avoided:
 |  |
| 1. Appropriate peri-operative course of antibiotics administered according to guidelines set forth in the Surgical Care Improvement Project (SCIP): SCIP-Inf-1b, 2b, 3b; CMS Measure 1, 2, 3;
 | *3.00* |
| 1. Urinary catheter use restricted to less than 48 hours per SCIP guidelines: SCIP-Inf-9;
 | *3.00* |
| 1. Appropriate method for hair removal used, shaving avoided: SCIP-Inf-6;
 | *3.00* |
| 1. Appropriate skin prep used by patient prior to surgery
 | *3.00* |
| 1. Bleeding and low blood pressure avoided:
 |  |
| 1. Standardized protocols administered using appropriate medications to limit blood loss;
 | *3.00* |
| 1. Institution-based standard IV fluid and inotrope protocols used including those implemented by RNs post-operatively with appropriate supervision and monitoring
 | *2.25* |
| 1. Deep venous thrombosis and embolism avoided according to guidelines set forth in the SCIP VTE-2, CMS Measure 4
 | *3.00* |
| 1. Avoiding hyperglycemia: Standardized protocol used to maintain optimal glucose control, SCIP-Inf-4
 | *2.75* |
| 1. Perioperative temperature managed, SCIP-Inf-10
 | *2.75* |
| 1. **Participation in registries**
 |  |
| 1. Participating in the Washington State Clinical Outcomes Assessment Program (COAP) for cardiovascular surgery
 | *3.00* |
| **IV. POST-OPERATIVE CARE AND RETURN TO FUNCTION** |  |
| 1. **Standard process for post-operative care**
 |  |
| 1. A rapid and durable recovery track utilized to mobilize patients following surgery:
 |  |
| 1. Cardiac rehabilitation provided, including early ambulation during hospitalization, outpatient prescriptive exercise training, and education;
 | *3.00* |
| 1. Patient-oriented visual cue provided to record progress on functional milestones required for discharge;
 | *2.25* |
| 1. Risk factor modification reinforced;
 | *3.00* |
| 1. Care Partner instructed to assist with home care
 | *2.25* |
| 1. Access provided to hospitalists or appropriate medical consultants for consultation to assist with complex or unstable medical problems in the post-operative period
 | *3.00* |
| 1. Post-operative nursing and rehabilitative needs addressed for patients that meet Medicare standards and will be discharged to a skilled nursing facility
 | *3.00* |
| 1. Follow-up call scheduled by the surgical team to patient and family 24 to 48 hours and seven days post discharge.
 | *3.00* |
| 1. **Standardized hospital discharge process used, aligned with Washington State Hospital Association (WSHA) toolkit**
 |  |
| 1. Follow up arranged with outpatient care team according to WSHA toolkit
 | *2.50* |
| 1. Social and resource barriers evaluated based on WSHA toolkit
 | *2.00* |
| 1. Smoking cessation program continued for previous nicotine users
 | *3.00* |
| 1. Medications reconciled to ensure essential medications are started or continued:
 |  |
| 1. Anti-platelet medication: CMS Measure 10;
 | *2.67* |
| 1. Statins;
 | *3.00* |
| 1. Aspirin
 | *3.00* |
| 1. Patient and family/caregiver education provided with plan of care:
 |  |
| 1. Signs or symptoms that warrant follow-up with provider;
 | *2.33* |
| 1. Guidelines for emergency care and alternatives to emergency care;
 | *2.67* |
| 1. Contact information for cardiac care team and primary care provider
 | *2.67* |
| 1. Post-discharge phone call ensured to patient by care team to check progress, with timing of call aligned with WSHA toolkit
 | *2.67* |
| 1. Hospital discharge kit provided upon discharge according to WSHA toolkit
 | *1.00* |
| 1. **Home care arranged**
 |  |
| 1. Patient and care partner provided with information regarding home care
 | *2.75* |
| 1. Additional home health services arranged as necessary
 | *2.75* |
| 1. **Post-operative care arranged**
 |  |
| 1. Post-discharge summary sent to primary care provider within three business days of discharge
 | *2.75* |
| 1. Cardiac rehab scheduled to be managed as clinically appropriate
 | *2.75* |
| 1. Follow up appointments scheduled as appropriate
 | *2.75* |
| 1. Patient-reported functional outcomes measured with standard instrument at three months:
 |  |
| 1. SAQ-7;
 | *0.33* |
| 1. PROMIS-10.
 | *0.33* |
| 1. If opioid use exceeds six weeks, a formal plan for opioid management is developed
 | *0.75* |
| Additional Comments: | * *care plan is not based on Bree Collaborative statewide*
* *Currently working on design and implementation, focused particularly on cycles 1 & 2 and impact on electronic medical record.*
 |

## Low Back Pain

8 Hospitals Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/spine\_lbp.pdf](http://www.breecollaborative.org/wp-content/uploads/spine_lbp.pdf)

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

|  |  |
| --- | --- |
| COMPONENT | **AVERAGE** **SCORE** |
| A low back pain quality improvement program that includes measuring patients’ functional status over time using the Oswestry Disability Index is supported or sustained | *2.00* |
| A validated screening tool such as the STarT Back tool or Functional Recovery Questionnaire is used no later than the third visit to identify patients that are not likely to respond to routine care | *1.63* |
| Evidence-based guidelines, scripts, shared decision making, and patient education materials are integrated into clinical practice and workflow (e.g., electronic medical record, a clinical decision support tool such as UpToDate, etc.) | *2.13* |
| Comprehensive patient education and effective messaging are integrated into clinical practice and workflow for low back pain patients | *2.13* |
| Additional Comments: | * *currently working on STarT Back Tool and Oswestry Disability Index, also screen for depression (PHQ-9) and anxiety (GAD-7) across our spine service areas including primary care.*
* *have extensive referral relationships both externally as well as within our integrated system*
* *delivering educational multimedia content and decision aids for chronic and acute low back pain*
* *have had a MRI ordering tool in place since 2005 for appropriate MRI ordering across our organization*
* *developed a robust multidisciplinary LBP Care Pathway, which was implemented 2016.*
* *have defined PT, chiropractor, pain physician, and surgeon roles and has been rolled out in select primary care sites, which we will be evaluating multiple metrics and outcomes*
* *defined the role of a LBP Care Navigator and are seeking to hire*
* *implemented a case conference whereby surgical decision-making is shared as a multidisciplinary committee, with a subset of our surgeons participating*
* *working with our IT department, we now have the ODI and Keele entered into EMR and can mine this data and trend it*
* *working in partnership to develop related research questions and publish our experience with patient reported outcomes (PROs), resource use, and other metrics associated with our program*
* *our surgical colleagues are investigating measuring PROs and a wide variety of SCOAP and other metrics through the Tonic platform*
* *building infrastructure to implement standard workflows around risk stratification and assessment of function in patients diagnosed with acute and chronic low back pain in primary care*
* *work still in design/pilot phase –expect full adoption in 2017*
* *our challenges are clinical decision support within LBP imaging orders, getting buy-in from all surgical colleagues, determining how to measure adherence to our pathway, others*
 |

## Spine Surgical Care and Outcomes Program (SCOAP) Participation

5 Hospitals Responding

Read the endorsement here: <http://www.breecollaborative.org/wp-content/uploads/bree_bc_spine_scoap_rec.pdf> and revision here: <http://www.breecollaborative.org/wp-content/uploads/spine_scoap_recommendation.pdf>

  **0** –No action taken; **1** –Actively considering adoption; **2** –Some/similar adoption; **3** –Full adoption

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| Hospital participates in the Spine Surgical Care and Outcomes Assessment (SCOAP) program ([www.scoap.org](http://www.scoap.org)) | *2.8* |

## Lumbar Fusion Surgical Bundle

12 Hospitals Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Bundle-Final-14-09.pdf](http://www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Bundle-Final-14-09.pdf)

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| **I. DISABILITY DESPITE NON-SURGICAL THERAPY** |  |
| 1. **Documentation made of disability due to either neurologic symptoms and/or signs of back pain with without neurological findings**
 |  |
| 1. Disability according to standard outcome score: Oswestry Disability Index (ODI) documented
 | *1.50* |
| 1. Self-reported loss of function documented with Patient Reported Outcome Measuring System-10® (PROMIS-10®) or other validated scale
 | *1.25* |
| 1. Standardized baseline physical function documented by physical therapist using the Therapeutic Associates Outcome Score
 | *1.75* |
| 1. **Documentation made of imaging findings of lumbar instability on a standard scale that correlates with symptoms and signs**
 |  |
| 1. Adequate standing flexion/extension views are taken utilizing techniques that minimize the potential contribution of hip motion to perceived lumbar flexion or extension
 | *2.00* |
| 1. At least 4mm of anterior/posterior translation at L3-4 and L4-5, or 5mm of translation at L5-S1 or 11 degrees greater end plate angular change at a single level, compared to an adjacent level
 | *1.75* |
| 1. A departure from these guidelines requires discussion and resolution by the collaborative care team as defined below
 | *1.00* |
| 1. **Documentation made of at least three months of structured non-surgical therapy, as delivered by a collaborative team (a physiatrist, an appropriate spine surgeon, the primary care provider, physical therapist, care partner, and others as needed)**
 |  |
| 1. Trial of the following non-surgical measures conducted: a) Patient education; b) Active physical therapy; c) Behavioral therapies aimed at improving self-efficacy with an emphasis on effectively addressing important psychosocial elements such as fear avoidance, catastrophizing, and low expectations of recovery; d) Identification and management of associated anxiety and depression
 | *1.50* |
| 1. Trial of one or more of the following medications conducted if not contraindicated: a) Acetaminophen; b) Oral non-steroidal anti-inflammatory drugs; c) Tricyclic antidepressants; d) Other appropriate and evidence-based medications, as indicated
 | *2.00* |
| 1. Spinal manipulation or other evidence-based non-surgical therapies used at the discretion of the collaborative care team
 | *1.75* |
| 1. **Documentation of persistent disability despite non-surgical therapy**
 |  |
| 1. Formal consultation with collaborative team led by board certified physiatrist to confirm appropriateness, adequacy, completeness, and active participation in non-surgical therapy and need for lumbar fusion; at least two of the following should be considered in defining persistent disability: a) Greater than 20% disability as defined by the Oswestry Disability Index; b) Persistent disability according to PROMIS indicators; c) Persistent disability on baseline physical function by physical therapist using the Therapeutic Associates Outcome Score, defined as equal to or greater than 20% disability
 | *0.88* |
| 1. Confirmation made that the degree and location of pain and/or physical impairment matches the anatomic location of imaging abnormalities
 | *2.13* |
| 1. Departures from these standards are reviewed by the collaborative care team
 | *0.88* |
| **II. FITNESS FOR SURGERY** |  |
| 1. **Documentation of requirements related to patient safety**
 |  |
| Patient should meet the following minimum requirements prior to surgery:  |  |
| 1. Body Mass Index less than 40
 | *1.38* |
| 1. Hemoglobin A1c less than 8% in patients with diabetes
 | *1.38* |
| 1. Adequate nutritional status to ensure healing
 | *1.38* |
| 1. Sufficient liver function to ensure healing
 | *1.88* |
| 1. Pre-operative plan for management of opioid dependency, if patient has taken opioids for more than three months
 | *1.75* |
| 1. Avoidance of smoking for a minimum of four weeks pre-operatively with six to eight weeks preferred
 | *2.00* |
| 1. Screen for alcohol abuse; manage if screen is positive
 | *2.13* |
| 1. Absence of an active, life-limiting condition that would likely cause death before recovery from surgery
 | *2.13* |
| 1. Absence of severe disability from an unrelated condition that would severely limit the benefits of surgery such as severe osteoporosis
 | *2.13* |
| 1. Absence of dementia that would interfere with recovery – performing surgery for a patient with such dementia requires preauthorization, informed consent of a person with Durable Power of Attorney for Health Care, and a contract with the patient’s care provider
 | *1.50* |
| 1. Screen for untreated depression or psychiatric disorder; manage if screen is positive
 | *1.63* |
| 1. Complete a pre-operative plan for post-operative return to function
 | *1.63* |
| 1. Screen for osteoporosis in high-risk individuals; manage if screen is positive
 | *1.75* |
| 1. **Documentation of patient engagement**
 |  |
| 1. Patient must participate in shared decision-making validated decision aid such as those approved by Washington State; this requirement is in addition to informed consent
 | *1.25* |
| 1. Patient must designate a personal Care Partner; patient and Care Partner must actively participate in the following: a) Surgical consultation; b) Pre-operative evaluation; c) Pre-surgical class and/or required surgical and anesthesia educational programs; d) In-hospital care; e) Post-operative care teaching; f) Patient’s home care and exercise program
 | *1.25* |
| 1. Patient must participate in end of life planning, including completion of an advance directive and designation of durable power of attorney for health care
 | *1.25* |
| 1. Patient agrees to participate in a registry with two years follow-up data collection
 | *1.25* |
| 1. **Documentation of optimal preparation for surgery**
 |  |
| 1. Pre-operative history, physical, and screening lab tests performed based on review of systems:
 |  |
| a) Cardiac and pulmonary fitness evaluated;  | *2.25* |
| b) Basic lab profile, plasma glucose, prothrombin time, complete blood count, and/or urinalysis with culture obtained, if indicated;  | *2.50* |
| c) Nasal passages cultured to identify staphylococcal carrier state;  | *2.00* |
| d) A1c less than 8% ensured in patients with diabetes;  | *1.25* |
| e) Relevant imaging performed if not performed within previous six months;  | *2.63* |
| f) Predictors of delirium screened for | *1.25* |
| 1. Relevant consultations obtained:
 |  |
| a) Good dental hygiene evaluated for with dental consultation as necessary;  | *2.00* |
| b) Anesthesia referred to for pre-operative assessment including identification and management of such conditions such as sleep apnea and pulmonary hypertension;  | *2.13* |
| c) Physical therapist(s) consulted to instruct in improving return to function;  | *1.63* |
| d) Additional consults requested as necessary | *2.13* |
| 1. Patient-reported measures collected to confirm lack of significant response to nonsurgical treatments using:
 |  |
| a) General health questionnaire: PROMIS-10 collected; | *1.50* |
| b) Standardized disability survey: ODI collected | *1.63* |
| **III. SPINAL FUSION PROCEDURE** |  |
| 1. **General standards for a surgical team performing surgery followed:**
 |  |
| 1. The spine surgeon has performed a minimum of twenty lumbar fusion surgeries in the previous twelve months; neurosurgeons are board certified or board eligible; orthopedic surgeons have successfully completed a spine fellowship
 | *2.38* |
| 1. Members of the surgical team have documented credentials, training, and experience; the roster of the surgical team is consistent
 | *2.63* |
| 1. Surgical team may include two attending surgeons to reduce anesthesia time and blood loss particularly in complex cases
 | *1.50* |
| 1. Elective spine surgery is scheduled to begin before 5:00 pm
 | *1.38* |
| 1. Surgery is performed in an inpatient facility
 | *2.63* |
| 1. Facilities in which surgery is performed have policies that align with the American College of Surgeons Statement on Health Care Industry Representatives in the Operating Room
 | *1.88* |
| 1. **Elements of optimal surgical process**
 |  |
| 1. Pain management and anesthesia optimized:
 |  |
| 1. Multimodal pain management format used to minimize sedation and encourage early ambulation
 | *2.25* |
| 1. Use of opioids minimized
 | *2.50* |
| 1. Infection avoided:
 |  |
| a) Appropriate peri-operative course of antibiotics administered according to guidelines set forth in the Surgical Care Improvement Project (SCIP);  | *3.00* |
| b) Use of urinary catheter restricted to less than 48 hours per SCIP guidelines;  | *2.75* |
| c) Chlorhexidine skin prep used by patient prior to surgery if no contraindication | *2.38* |
| 1. Bleeding and low blood pressure avoided:
 |  |
| a) Standardized protocols administered using appropriate medications to limit blood loss;  | *2.13* |
| b) Standardized IV fluid protocols used including those implemented by RNs postoperatively with appropriate supervision and monitoring. | *2.38* |
| 1. Deep venous thrombosis and embolism avoided according to guidelines set forth in the SCIP
 | *1.83* |
| 1. Hyperglycemia avoided: Standardized protocol used to maintain optimal glucose control
 | *2.13* |
| 1. Bone morphogenic protein: If bone morphogenic protein is used it is in accordance with Washington Health Technology Program policy: <http://www.hca.wa.gov/hta/Documents/findings_decision_bmp.pdf>
 | *1.83* |
| 1. **Participation in registries**
 |  |
| 1. Hospital participates in the Spine SCOAP registry with results available to purchasers
 | *2.75* |
| 1. Providers maintain a registry of patients undergoing lumbar fusion and collect prospective patient reported outcome measures as specified elsewhere in this document
 | *1.83* |
| **IV. POST-OPERATIVE CARE AND RETURN TO FUNCTION** |  |
| 1. **Standard process for post-operative care**
 |  |
| 1. Standardized and rapid recovery track utilized to mobilize patients following surgery:
 |  |
| 1. Accelerated physical therapy and mobilization provided if regional pain control is acceptable;
 | *1.88* |
| 1. Patient-oriented visual cue provided to record progress on functional milestones required for discharge;
 | *1.38* |
| 1. Patients are instructed in home exercise, use of walking aids, and precautions;
 | *2.38* |
| 1. Care Partners are instructed to assist with home exercise regimen
 | *1.25* |
| 1. Patients that meet CMS standards for placement in a skilled nursing facility have their post-operative nursing and rehabilitative needs addressed
 | *2.25* |
| 1. Hospitalists or appropriate medical consultants are available for consultation to assist with complex or unstable medical problems in the post-operative period
 | *2.38* |
| 1. **Standardized hospital discharge process used, aligned with Washington State Hospital Association (WSHA) toolkit**
 |  |
| 1. Follow up arranged with care team according to WSHA toolkit and Bree Collaborative Potentially Avoidable Hospital Readmissions Report and Recommendations
 | *1.88* |
| 1. Social and resource barriers evaluated based on WSHA toolkit
 | *1.88* |
| 1. Medications reconciled
 | *2.75* |
| 1. Patient and family/caregiver provided education with plan of care regarding:
 |  |
| a) Signs or symptoms that warrant follow up with provider;  | *2.13* |
| b) Guidelines for emergency care and alternatives to emergency care;  | *2.13* |
| c) Contact information for the spine surgeon and primary care provider | *2.13* |
| 1. Post-discharge phone call ensured to patient by care team to check progress, with timing of call aligned with Bree Collaborative Potentially Avoidable Hospital Readmissions Report and Recommendations
 | *2.13* |
| 1. Post-discharge summary sent to primary care provider or after care provider within three business days of discharge
 | *2.13* |
| **C. Home health services arranged** |  |
| 1. Patient and Care Partner provided with information about medically recommended home exercises
 | *1.63* |
| 1. Arrange additional home health services as necessary
 | *2.13* |
| **D. Follow up appointments scheduled** |  |
| 1. Return visits scheduled as appropriate
 | *2.63* |
| 1. Patient-reported functional outcomes measured with standard instrument
 | *1.75* |
| 1. If opioid use exceeds six weeks, a formal plan for opioid management is developed
 | *1.75* |
| Additional Comments: | * *attempt to collect patient-reported outcomes on all patients with room for improvement in increasing the capture both pre and post-surgery*
* *any deviation in standards are discussed in the context of the multidisciplinary spine conference*
* *Fitness for Surgery, question B4: We are administering the ODI and Promis-10 to patients pre-operatively, with intent of administering post-operatively for 2 years but we are not asking patients to agree to participate in a registry.*
* *Spinal Fusion Procedure, question B4: SCIP was not intended for Spine cases, but rather for Hip/Knee Replacement, Hysterectomy and Abdominal surgeries. This question does not apply so we did not answer.*
* *Spinal Fusion Procedure, question B6: The link to the Washington Health Technology Program policy does not work. We were not able to view so were unable to answer the question.*
* *Spinal Fusion Procedure, question C1 & 2: As far as we know, SCOAP registry results are not available to purchasers. We do participate in SCOAP.*
* *Post-Operative Care and Return to Function, question C1: We provide recommended home exercises to patients but are not always able to provide to a care partner, as not all our patients have a care partner*
* *There is no response to indicate that the organization has performed a process prior to the Bree bundle and, therefore, hasn’t needed to implement what the Bree outlines (ex: chlorhexidine skin prep). In these cases, we responded with a “3” even though this definition doesn’t reflect that we had independently implemented the process.*
* *The fitness for surgery recommendations are exhaustive, expensive, and unproven in providing better surgical outcome therefore full adoption has not been adopted. Agree with recommendations on BMI, smoking cessation etc.*
* *As part of our ACN work, we’ve determined it best for the Low Back Pain Work Group to address Part 1.*
* *Agreed upon consensus that adoption will take place – but work is still early in design phase. We expect full adoption in 2017.*
 |

## Total Knee/Total Hip Replacement Surgical Bundle

11 Hospitals/ 1 Medical Group Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/tkrthr\_bundle.pdf](http://www.breecollaborative.org/wp-content/uploads/tkrthr_bundle.pdf)

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| **I. DISABILITY DUE TO OSTEOARTHRITIS DESPITE CONSERVATIVE THERAPY** |  |
| 1. **Disability documented**
 |  |
| 1. Disability documented according to Knee Osteoarthritis Outcome Score (KOOS) or Hip Osteoarthritis Outcome Score (HOOS)
 | *1.58* |
| 1. Self-reported productivity loss documented related to usual activity (absenteeism and presenteeism)
 | *1.50* |
| 1. **Osteoarthritis documented**
 |  |
| 1. Standard x-ray of the affected joint reviewed and interpreted according to Kellgren-Lawrence scale. Total joint replacement therapy generally requires a grade of 3 or 4
 | *2.42* |
| 1. **Conservative therapy for at least three months documented unless symptoms are severe and x-ray findings show advanced osteoarthritis**
 |  |
| 1. Patient-customized conservative treatments carried out for at least three months, focusing on improving functionality and helping patients adapt to persisting functional limitations
 | *2.42* |
| 1. One or more of the following physical measures conducted: a) Strengthening exercises; b) Activity modification; c) Assistive devices; d) Bracing if judged appropriate; e) Weight loss, if indicated
 | *2.00* |
| 1. Trial of one or more of the following medications conducted: a) Acetaminophen; b) Oral non-steroidal anti-inflammatory drugs; c) Topical non-steroidal anti-inflammatory drugs; d) Intra-articular injection of corticosteroids
 | *2.67* |
| 1. **Failure of conservative therapy documented**
 |  |
| 1. Lack of improvement in pain and/or function documented as indicated by re-measurement of HOOS/KOOS scores
 | *1.58* |
| 1. X-ray findings supporting need for surgery documented: a) Grade 3 or 4 on Kellgren-Lawrence scale, if not previously documented; b) Avascular necrosis of subchondral bone with or without collapse; c) Angular deformity of limb with threatened stress fracture
 | *2.42* |
| 1. Informed decision making documented after maximal effort and benefit of conservative treatment
 | *2.00* |
| **II. FITNESS FOR SURGERY** |  |
| 1. **Requirements related to patient safety documented**
 |  |
| Patient meets the following minimum requirements prior to surgery:  |  |
| 1. Body Mass Index less than 40;
 | *2.17* |
| 1. Hemoglobin A1c less than 8% in patients with diabetes;
 | *2.25* |
| 1. Adequate peripheral circulation to ensure healing;
 | *2.42* |
| 1. Adequate nutritional status to ensure healing;
 | *1.83* |
| 1. Sufficient liver function to ensure healing;
 | *1.83* |
| 1. Control of opioid dependency, if present;
 | *1.92* |
| 1. Avoidance of smoking for at least four weeks pre-operatively;
 | *2.08* |
| 1. Absence of an active, life-limiting condition that would likely cause death before recovery from surgery;
 | *2.50* |
| 1. Absence of severe disability from a condition unrelated to osteoarthritis that would severely limit the benefits of surgery
 | *2.50* |
| 1. Absence of dementia that would interfere with recovery – performing TKR/THR surgery for a patient with such dementia requires preauthorization, informed consent of a person with Durable Power of Attorney, and a contract with the patient’s care provider
 | *2.50* |
| 1. **Patient engagement documented**
 |  |
| 1. Patient participates in Shared Decision-making with WA State-approved Decision Aid
 | *1.42* |
| 1. Patient designates a personal Care Partner
 | *2.00* |
| 1. Patient and Care Partner actively participate in the following:
 |  |
| 1. Surgical consultation;
 | *2.25* |
| 1. Pre-operative evaluation;
 | *2.25* |
| 1. Joint replacement class and/or required surgical and anesthesia educational programs;
 | *2.50* |
| 1. In-hospital care;
 | *2.58* |
| 1. Post-operative care teaching;
 | *2.58* |
| 1. Patient’s home care and exercise program
 | *2.58* |
| 1. Patient participates in end of life planning, including completion of an Advance Directive and designation of Durable Power of Attorney
 | *1.67* |
| 1. **Optimal preparation for surgery documented**
 |  |
| 1. Pre-operative history, physical, and screening lab tests based on review of systems:
 |  |
| 1. Evaluate for cardiac and pulmonary fitness;
 | *2.42* |
| 1. Obtain basic lab profile, plasma glucose, prothrombin time, complete blood count, urinalysis with culture, if indicated;
 | *2.67* |
| 1. Culture nasal passages to identify staphylococcal carrier state;
 | *2.58* |
| 1. Ensure A1c 8% or less in patients with diabetes;
 | *2.50* |
| 1. Perform x-rays of knee or hip, if not performed within previous 12 months;
 | *2.67* |
| 1. Screen for predictors of delirium
 | *1.83* |
| 1. Relevant consultations obtained
 |  |
| 1. Evaluate for good dental hygiene with dental consultation as necessary;
 | *2.17* |
| 1. Refer to Anesthesia for pre-operative assessment;
 | *2.50* |
| 1. Consult Physical Therapy to instruct in strengthening of upper and lower extremities;
 | *1.83* |
| 1. Request additional consults as necessary
 | *2.58* |
| 1. Patient-reported measures collected:
 |  |
| 1. General health questionnaire completed: Patient Reported Outcomes Measurement Information System-10 (PROMIS-10);
 | *1.17* |
| 1. HOOS/KOOS survey completed
 | *1.64* |
| **III. REPAIR OF THE OSTEOARTHRITIC JOINT** |  |
| 1. **General standards for a surgical team performing TKR/THR surgery are followed:**
 |  |
| 1. The surgeon performs at least 50 joint replacements a year
 | *2.75* |
| 1. Members of the surgical team have documented credentials, training and experience; the roster of the surgical team is consistent
 | *2.67* |
| 1. Elective joint arthroplasty is scheduled to begin before 5:00 pm
 | *2.33* |
| 1. Facilities in which surgery is performed have policies that align with the American College of Surgeons Statement on Health Care Industry Representatives in the Operating Room
 | *2.75* |
| 1. **Elements of optimal surgical process**
 |  |
| 1. Pain management and anesthesia optimized:
 |  |
| 1. Multimodal pain management format used to minimize sedation and encourage early ambulation
 | *2.75* |
| 1. Opioid use minimized
 | *2.75* |
| 1. Other anesthesia-related risk factors such as sleep apnea and pulmonary hypertension are assessed and managed
 | *2.67* |
| 1. Infection avoided:
 |  |
| 1. Application of chlorhexidine skin prep by patient required at bedtime and morning prior to surgery;
 | *2.75* |
| 1. Surgical hoods or laminar flow technique used with closed or limited access to operating room;
 | *2.33* |
| 1. Appropriate peri-operative course of antibiotics administered according to Centers for Medicare and Medicaid Services (CMS) guidelines set forth in the Surgical Care Improvement Project;
 | *2.75* |
| 1. Use of urinary catheter restrict to less than 48 hours
 | *2.75* |
| 1. Bleeding and low blood pressure avoided:
 |  |
| 1. Standardized protocols administered using appropriate medications to limit blood loss;
 | *2.75* |
| 1. Standardized IV fluid protocols used including those implemented by RNs postoperatively with appropriate supervision and monitoring;
 | *2.42* |
| 1. Deep venous thrombosis and embolism avoided according to CMS guidelines set forth in the Surgical Care Improvement Project
 | *2.75* |
| 1. Hyperglycemia avoided: Standardized protocol used to maintain optimal glucose control
 | *2.42* |
| 1. **Selection of the surgical implant**
 |  |
| 1. Providers select an implant that has a <5% failure rate at ten years
 | *2.58* |
| 1. To track outcomes, all implants are registered with a national joint registry such as the American Joint Replacement Registry
 | *2.58* |
| 1. Informed consent includes the experience level of the surgeon with the device
 | *1.75* |
| **IV. POST-OPERATIVE CARE AND RETURN TO FUNCTION** |  |
| 1. **Standard process for post-operative care**
 |  |
| 1. A rapid recovery track is utilized to mobilize patients on the day of surgery:
 |  |
| 1. Accelerated physical therapy and mobilization provided if regional pain control is acceptable;
 | *2.58* |
| 1. Patient-oriented visual cue provided to record progress on functional milestones required for discharge;
 | *2.17* |
| 1. Patients instructed in home exercise, use of walking aids and precautions;
 | *2.67* |
| 1. “Care partner” instructed to assist with home exercise regimen
 | *2.33* |
| 1. Patients that meet Medicare standards for placement in a skilled nursing facility have their post-operative nursing and rehabilitative needs addressed.
 | *2.42* |
| 1. Access to hospitalists or appropriate medical consultants provided for consultation to assist with complex or unstable medical problems in the post-operative period
 | *2.67* |
| 1. **Standardized hospital discharge process used is aligned with Washington State Hospital Association (WSHA) toolkit**
 |  |
| 1. Follow up with care team arranged according to WSHA toolkit
 | *2.08* |
| 1. Social and resource barriers evaluated based on WSHA toolkit
 | *2.08* |
| 1. Medications reconciled
 | *2.67* |
| 1. Patient and family/caregiver educated with plan of care regarding:
 |  |
| 1. Signs or symptoms that warrant follow up with provider;
 | *2.50* |
| 1. Guidelines for emergency care and alternatives to emergency care;
 | *2.42* |
| 1. Contact information for orthopedist and primary care provider
 | *2.67* |
| 1. Post-discharge phone call to patient done by care team to check progress, with timing of call aligned with WSHA toolkit
 | *2.25* |
| 1. Hospital discharge kit provided upon discharge according to WSHA toolkit
 | *2.08* |
| 1. **Home health services arranged**
 |  |
| 1. The patient and Care Partner are provided with information about home exercises that should be done three times daily
 | *2.67* |
| 1. Additional home health services are arranged as necessary
 | *2.67* |
| 1. **Follow up appointments scheduled**
 |  |
| 1. Return visits scheduled as appropriate
 | *2.75* |
| 1. Patient-reported functional outcomes are measured with KOOS/HOOS instrument
 | *1.58* |
| 1. If opioid use exceeds six weeks, a formal plan is developed for opioid management
 | *1.58* |
| Additional Comments: | * *Care Partners are not mandated and are included if present. Partial adoption of (KOOS Jr. and HOOS Jr.) tool used on 45% of patients.*
* *we spent 3 years focused on integrating the Bree recommendations for joint replacement across our organization, including building all components directly into our care process and medical record*
* *we still have room for improvement in areas given the breadth of elements included in the bundle. Implementation has EHR-based clinical decision support tools to document the Bree components and track them over the course of the patient’s episode*
* *we attempt to collect patient-reported outcomes on all patients with room for improvement in increasing the capture both pre and post-surgery*
* *currently have test patients that we are trialing the total knee bundle on*
 |

## Prostate Cancer Screening

3 Hospitals Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/Prostate-Cancer-Recommendations-Final-15-11.pdf](http://www.breecollaborative.org/wp-content/uploads/Prostate-Cancer-Recommendations-Final-15-11.pdf)

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| There is support for communication and education of patients that accurately reflects the most recent medical knowledge on PSA testing for prostate cancer screening | *2.33* |
| Discussions are encouraged between clinicians and patients about the potential harms, benefits, and conflicting evidence for PSA testing for prostate cancer screening. Only men who express a definite preference for screening should have PSA testing | *2.33* |
| Additional Comments: | * *The PSA controversy has been a big discussion amongst the Urologists. They agree with some of the guidelines and disagree with others.*
 |

## Oncology Care

6 Hospitals Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/Oncology-Care-Final-Recommendations-2016-03.pdf](http://www.breecollaborative.org/wp-content/uploads/Oncology-Care-Final-Recommendations-2016-03.pdf)

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| The American Society of Clinical Oncology’s (ASCO) Choosing Wisely recommendations are followed including: |  |
| PET [positron emission tomography], CT [computed tomography] and radionuclide bone scans are not used in the staging of early prostate cancer at low risk of spreading | *1.50* |
| PET, CT, and radionuclide bone scans are not used in the staging of early breast cancer that is at low risk of spreading | *1.50* |
| Palliative care is offered alongside active anti-cancer care, as needed | *2.67* |
| Oncology care is aligned with a patient’s individual goals and values and follows the American Society of Clinical Oncology’s (ASCO) position statement of key elements for individualized cancer care | *2.67* |
| Patients are apprised of the harms, benefits, evidence, and potential impact of chemotherapy, radiation, molecular therapy, immunotherapy, and surgery at all stages in their illness trajectory | *2.33* |
| Goals of treatment are discussed at beginning of treatment | *1.67* |
| Additional Comments: | * *opportunity to engage non employed providers (providing care at our facilities) to follow best practices*
 |

## Addiction and Dependence Treatment

8 Hospitals Responding

Read the full report here: www.breecollaborative.org/wp-content/uploads/ADT-Final-Report.pdf

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| All emergency room patients over age 13 are screened for alcohol and other drug misuse using a validated and scaled screening tool or pre-screen followed by a validated full screen | *1.00* |
| **Staff are educated on:** |  |
| a) The prevalence of alcohol and other drug misuse;  | *1.42* |
| b) Current trends in alcohol and other drug misuse;  | *1.42* |
| c) The impact of alcohol and other drug misuse on health conditions,  | *1.42* |
| d) That substance use disorder is a chronic, relapsing-remitting disease on a continuum, and | *1.42* |
| e) The importance of screening for alcohol and other drug misuse | *1.50* |
| Health care providers and other appropriate staff are trained to provide non-judgmental, empathetic, culturally competent, and accepting conversations about and screen for alcohol and other drug misuse | *1.42* |
| Staff are trained to provide brief intervention and, if possible, brief treatment | *1.33* |
| Adolescents with addictions are managed collaboratively with child and adolescent addiction specialists, if available | *1.09* |
| Wherever possible, coordinated, wrap-around care for pregnant women is provided with appropriate primary, addiction, obstetric, and pediatric providers. | *2.17* |
| Staff are trained how to do a 42 CFR part 2 compliant release of information | *1.30* |
| Additional Comments: | * *screening in the ED but not using validated questions recommended by the Bree Collaborative*
* *training for brief intervention is primarily focused in the inpatient psychiatric service line, or through use of social workers trained in a variety of intervention methods*
* *for 42 CFR Part 2 compliant release of information –staff are aware of the heightened confidentiality needs related to substance use treatment. This regulation appears to apply specifically to drug treatment facilities.*
* *We have a SBIRT contract that finances 4 FTE. Three of these FTE are dedicated to providing consultation services to the ED and medical/surgical areas of the hospital. One of the goals of the contract is to promote universal screening in the ED. The structure of the contract has not been ideal for implementing this goal, but there is acknowledgment of the need and value for this type of service by hospital leadership and staff as well as BHO leadership and staff.*
* *We do not use a specific tool for screening for drug/alcohol abuse, but we have 24/7 MSW coverage who are trained in and provide evaluation as well as behavioral health/substance abuse evaluations and screening on all pediatric patients.*
* *We instituted a brief drug and alcohol intervention and provision of resources which is included in the discharge instructions of all patients who tested positive for drugs/alcohol (or who were obviously intoxicated on arrival).*
* *The 42 CFR part 2 is known and followed, but there is not specific training on it.*
* *Have used some screening with the chronic pain process*
 |

## Prescribing Opioids for Pain

6 Hospitals Responding (In 2 Systems)

Read the endorsement here: [www.breecollaborative.org/wp-content/uploads/2015AMDGOpioidGuideline.pdf](http://www.breecollaborative.org/wp-content/uploads/2015AMDGOpioidGuideline.pdf) and summary here: [www.agencymeddirectors.wa.gov/Files/FY16-288SummaryAMDGOpioidGuideline\_FINAL.pdf](http://www.agencymeddirectors.wa.gov/Files/FY16-288SummaryAMDGOpioidGuideline_FINAL.pdf)

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| **All pain phases** |  |
| Non-opioid therapies are used, such as behavioral intervention, physical activity and non-opioid analgesics when appropriate | *3.00* |
| Opioids are avoided if the patient has significant respiratory depression, current substance use disorder, history of prior opioid overdose, or a pattern of aberrant behaviors | *2.83* |
| Function and pain are assessed and documented using a validated tool at each visit where opioids are prescribed | *2.83* |
| Opioids are not prescribed with benzodiazepines, carisoprodol, or sedative-hypnotics | *2.83* |
| **Acute phase (0–6 weeks)** |  |
| The state’s Prescription Monitoring Program (PMP) is checked before prescribing | *2.83* |
| Opioids are not prescribed for non-specific back pain, headaches, or fibromyalgia | *2.83* |
| The lowest necessary dose is prescribed for the shortest duration | *2.83* |
| **Perioperative pain** |  |
| Patients are evaluated thoroughly preoperatively: the PMP is checked and the patient is assessed for over-sedation and difficult-to-control pain risk | *2.00* |
| Patient is discharged with acetaminophen, NSAIDs, or very limited supply (2–3 days) of short-acting opioids for some minor surgeries | *1.17* |
| Patients on chronic opioids have doses tapered to preoperative levels or lower within 6 weeks following major surgery | *1.17* |
| **Subacute phase (6–12 weeks)** |  |
| Patients are not continued on opioids without clinically meaningful improvement in function and pain | *2.83* |
| Patients are screened for comorbid mental health conditions and risk for opioid misuse using validated tools | *2.83* |
| If opioids are prescribed beyond 6 weeks, PMP is rechecked and a baseline urine drug test is administered | *1.17* |
| **Chronic phase (>12 weeks)** |  |
| Opioids are continued to be prescribed only if there is sustained clinically meaningful improvement in function and pain, and no serious adverse events, risk factors, or contraindications | *2.83* |
| PMP checked and urine drug test are rechecked at frequency determined by the patient’s risk category | *2.00* |
| Opioids are prescribed in 7-day multiples to avoid ending supply on a weekend | *2.83* |
| 120 mg/day morphine equivalent dose is not exceeded without a pain management consultation | *3.00* |
| Additional Comments: | * *Have convened multi-stakeholder team to address all the above issues and guiding team and work plan in place to get these to full adoption across the organization*
 |

## End-of-Life Care

12 Hospitals Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/EOL-Care-Final-Report.pdf](http://www.breecollaborative.org/wp-content/uploads/EOL-Care-Final-Report.pdf)

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| **Health care providers and staff are educated on:** |  |
| 1. How to have empathetic, realistic, and patient- and family-centered (e.g., using lower literacy materials if appropriate) advance care planning conversations;
 | *1.50* |
| 1. How to be reimbursed for these conversations;
 | *1.50* |
| 1. The difference between an advance directive and POLST, and patients for whom each would be acceptable;
 | *2.42* |
| 1. How to refer patients to community-based advance care planning resources if appropriate;
 | *2.00* |
| 1. Explaining the terms on an advance directive and POLST to family and friends at the end of a patient’s life;
 | *2.42* |
| 1. Supporting the patient, family, and friends during a time of crisis.
 | *2.42* |
| Organization has worked with your community’s organizations (e.g., churches, non-profits focused on end-of-life care) to promote community-wide discussions about how to have conversations regarding personal goals of care and the type of care desired at the end of life with family members, friends, health care providers; the importance of having an advance directive that includes a living will (also known as a health care directive), a durable power of attorney for health care, and a written personal statement about health care goals and values; and the difference between POLST and an advance directive | *1.92* |
| Organization’s protocol has been reviewed regarding asking about and honoring advance directives to decrease barriers to patients’ wishes being honored at the end of life | *2.83* |
| An advance care planning tool is in used across your system. Examples include Honoring Choices Pacific Northwest or the Institute for Health Care Improvement’s Conversation Ready. | *2.08* |
| Advance directives and/or POLST are entered into the patient’s medical record once completed. | *2.83* |
| Advance directives and/or POLST that originate in the hospital are communicated back to the patient’s primary care provider. | *2.25* |
| Awareness of the value of hospice is promoted, with encouragement of appropriate hospice referrals. | *2.67* |
| Hospice referrals that originate in the hospital are communicated back to the patient’s primary care provider. | *2.25* |
| A quality improvement program is implemented to encourage greater adherence to patients’ requests as outlined in advance directives and POLST if accurate and applicable to the current situation | *2.17* |
| Family and friend satisfaction with end-of-life care are measured by widespread use of an after-death survey tool similar to that used by hospice agencies | *1.67* |
| Patients are supported as they navigate care between different health care facilities and systems including facilitation of information sharing and patient and family outreach during times of crisis | *2.08* |
| Additional Comments: | * *We began implementing Honoring Choices Pacific Northwest in July 2016. We have work to be done to spread efforts organization-wide in our hospital and clinics, specifically in providing advance care planning tools beyond our efforts to have individuals complete advance directives, POLST and DPOAs.*
* *We have participated in the “Your life, your choices” program, the Conversation Project and 5 wishes initiative with a focus on the populations in highest need of advance care planning. We plan to use Honoring Choices participation as a stepping stone to organization-wide adoption of recommendations made by the Bree Collaborative and other authorities.*
* *We are participating in advanced planning through the Honoring Choices pilot. We look forward to starting with sites as test of change and then iteratively growing to be more inclusive of our whole system.*
* *Work is in Pilot phase (hence the 2 rating) – plans for system deployment in 2017/2018.*
 |

## Potentially Avoidable Hospital Readmissions

15 Hospitals Responding

Read the full report here: www.breecollaborative.org/wp-content/uploads/Readmissions-Report-FINAL-14-0730.pdf

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| There is participation in a hospital readmission collaborative recognized by WSHA or Qualis Health | *1.47* |
| Washington State Hospital Association’s Care Transitions Toolkit has been adopted, as clinically appropriate | *1.80* |
| Additional Comments: | * *TCM calls, warm handover, provider warm handover, modeling of standard discharge summary template*
* *We have a post-acute network that aims at forming relationships with post-acute service organizations to ease the transitions of patients to and from post-acute settings. While WHSA/Qualis have not been active members of our individual recurring quality collaborative meetings, we have had their representation & involvement in our joint summit meetings. We have utilized the WSHA Care Transitions Toolkit as a consistent guide to measure our progress in developing the structures/processes needed to improve our readmission rates. We have conducted an updated gap analysis to inform our continued efforts into 2017.*
 |

## Factors Affecting Adoption

11 Hospitals & Medical Groups Responding

Factors that were identified as barriers to, or enablers of adoption. Ranked in order 1-5. Additional factors mentioned are included.

|  |  |  |
| --- | --- | --- |
| **Factor** | **Top 5 Barriers to Adoption****(rank 1-5)** | **Top 5 Enablers to Adoption****(rank 1-5)** |
| Internal awareness/support of Bree Recommendations |  | *3* |
| Sufficient market share/volume |  |  |
| Business case- evidence of economic reward | *3- tie* | *2* |
| Contract partners interest in value-based purchasing | *2* |  |
| Existing forum to discuss value-based purchasing |  |  |
| Consensus on what constitutes quality of care | *5* | *4* |
| Availability and credibility of data | *1* |  |
| Individual provider-level performance and feedback |  | *5* |
| Burden/ease of collecting or obtaining data | *3- tie* |  |
| Consistency in findings across multiple measures. |  |  |
| Existing organizational improvement program for minimizing errors & waste |  | *1* |
| Consumer awareness of quality health plans and providers |  |  |
| Regulatory constraints, i.e. HIPPA, etc. |  |  |
| Other factors mentioned: |  |  |
| *Historical and current provider practice variability*  | *✓* |  |
| *Small scale value-based reimbursement opportunities and provider compensation malalignment*  | *✓* |  |
| *Multiple Competing Priorities*  | *✓* |  |
| *Lack of alignment between Bree and other state and national QI initiatives*  | *✓* |  |
| *Complexity of operationalization*  | *✓* |  |
| *Employers* | *✓* |  |
| *Communication and agreement among providers*  | *✓* |  |
| *Effectiveness in improving health- Impact*  | *✓* | *✓* |
| *American College of Physicians: Preventative Visits Recommendations* |  | *✓* |
| *Alignment with organizational vision to provide quality, evidence-based and appropriate care for populations*  |  | *✓* |

# Medical Groups

## Participating Medical Groups

Confluence Health

The Everett Clinic

Evergreen Health Partners

Group Health Cooperative

Northwest Physicians Network

Polyclinic

Providence: Pacific Medical Centers

Providence Medical Group: SE Region

Providence: Swedish Medical Group

Vancouver Clinic

Virginia Mason

MultiCare

## Obstetrics Care

8 Medical Groups Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/bree\_ob\_report\_final\_080212.pdf](http://www.breecollaborative.org/wp-content/uploads/bree_ob_report_final_080212.pdf)

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

|  |  |
| --- | --- |
|  | AVERAGESCORE |
| Medical group supports policies that limit deliveries before the 39th week including:* If induction between 37 and 39 weeks occurs, indication is on the Joint Commission or Washington State Perinatal Collaborative/WSHA project list
* For clinical situations not on the two lists above, consultation occurs and agreement obtained that the clinical situation required delivery
* Data, including baseline, on early elective delivery is collected
 | *3.0* |
| Medical group supports policies for scheduling inductions between 39 and 41 weeks including:* The cervix is favorable (Bishop score of 6 or greater)
* A consent form specific to the risk and benefits of induced compared with spontaneous labor has been signed by the patient
* Data, including baseline, on elective inductions is collected
 | *2.75* |
| Medical group supports policies for Cesarean-Sections including: * Admitting only spontaneously laboring women at term who present with no fetal or maternal compromise when the cervix is 4 centimeters or more dilated
* Allowing first stage labor arrest cesarean (reassuring fetal and maternal status but lack of progress of labor) to be performed only in the active phase (equal to or more than 6 centimeters dilation)
* Allowing adequate time in the active phase (4 to 6 hours) with use of appropriate clinical interventions before making a diagnosis of active phase arrest
* Allowing sufficient time with appropriate clinical interventions in the 2nd stage before diagnosis of 2nd stage arrest or “failure to descend.”
* Data on C-sections, including baseline, is collected
 | *2.63* |
| Medical group supports public reporting on obstetrics procedure data through existing website such as WSHA | *2.71* |
| Patients are provided with education and shared decision-making on maternity care options and risks of pre-term births, elective deliveries, and C-sections | *2.86* |
| Additional Comments: | * *The items listed above are all occurring at the hospital; the inpatient delivery system has prompted full adoption of these parameters and has been doing so for providing data to providers. It is not clear to me if this is from Bree collaborative, however.*
* *Obstetrics care is provided by our Family Practice providers.*
* *Our hospital partners handle public reporting.*
* *For employed providers – a strong 3; For independent/community providers – a strong 2.*
 |

## Low Back Pain

12 Medical Groups Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/spine\_lbp.pdf](http://www.breecollaborative.org/wp-content/uploads/spine_lbp.pdf)

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

|  |  |
| --- | --- |
|  | AVERAGESCORE |
| Evidence-based guidelines and tools are used, including the joint American College of Physicians and American Pain Society (ACP/APS) guidelines and the Oswestry Disability Index to track functional status | *1.58* |
| Validated screening tool like the STarT Back tool or Functional Recovery Questionnaire (FRQ) are used no later than the 3rd visit to identify patients that are not likely to respond to routine care | *1.17* |
| Referral relationships exist with physical medicine and rehabilitation physicians, also known as physiatrists | *2.67* |
| Comprehensive patient education and expectation-setting is integrated into care for low back pain patients, particularly when the patient is requesting care that is not recommended by evidence-based guidelines | *1.83* |
| Additional Comments: | * *Currently in our design phase in implementation of the STarT Back Tool for low back pain. Historically, we have collected the Oswestry Disability Index as well as screen for depression (PHQ-9) and anxiety (GAD-7) across our spine service areas including primary care.*
* *We have extensive referral relationships both externally as well as within our integrated system and deliver educational multimedia content and decision aids for chronic and acute low back pain through a vendor.*
* *We have had a MRI ordering tool in place since 2005 for appropriate MRI ordering across our organization.*
* *Have not implemented the STarT Back tool into routine care*
* *Physiatrists are using Oswestry, this has not yet been integrated into primary care, per se. Many primary care docs do item #4 (from seeing each other patients), but no organizational work has been done.*
* *By Department:*
	+ *In Occupational Medicine: all injured workers evaluated by Van Korff Pain and Function two questions and at each recheck.*
	+ *In Comprehensive Pain Center: PEG*
	+ *In Ortho Spine: Oswestry*
	+ *In Physical Therapy Dept.: Oswestry plus others as indicated by condition.*
	+ *\*\*FRQ is administered by L&I for State fund new claims*
	+ *\*\*\*Hard stops in EMR so physiatry consult required before spine surgeon consult in the absence of red flags.*
	+ *\*\*\*\*Hard stops in EMR so advanced imaging cannot be ordered prior to conservative care path, in absence of red flags.*
* *Patient education is integral in our practice but has not been shown to be more effective than treatment with education combined which is our standard of care. Start Back and FRQ are not evidence based and declining to help patients with major deficits is below the standard of care.*
* *General adherence to this approach but not formally standardized.*
* *We are just beginning to look at care pathways. Care is largely FFS and as coordinated as that is.*
* *Work is still in design/pilot phase – we expect full adoption by employed providers in 2017 and across the network by 2018.*
 |

## Prostate Cancer Screening

11 Medical Groups Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/Prostate-Cancer-Recommendations-Final-15-11.pdf](http://www.breecollaborative.org/wp-content/uploads/Prostate-Cancer-Recommendations-Final-15-11.pdf)

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

|  |  |
| --- | --- |
|  | AVERAGESCORE |
| For average-risk men between 55 and 69 years old: Only men who express a definite preference for screening after discussing the advantages, disadvantages, and scientific uncertainty are screened with prostate specific antigen (PSA) testing | *1.82* |
| For high-risk men: Men who are at higher risk of prostate cancer because of African American descent, a family history or first degree male relative diagnosed with prostate cancer prior to age 65, Agent Orange exposure, or having a known or suspected familial genetic predisposition to breast, ovarian cancer, or prostate cancer (e.g. BRCA1, BRCA2) are given the opportunity to discuss the harms, benefits, and scientific uncertainty about PSA testing using a formal and documented shared decision-making process including conversations about increased risk; This conversation can begin earlier than age 55; Only men who express a definite preference for screening have PSA testing | *1.73* |
| Patients are not screened: * At average risk 70 years and older
* At average risk under 55 years old
* Who have significant co-morbid conditions, or with a life expectancy less than 10 years
 | *1.91* |
| Clinicians are trained on the shared decision-making process | *1.55* |
| Patient decision aids available for PSA testing | *1.55* |
| Tracking of the shared decision-making process within the patient’s medical record is allowed | *1.20* |
| Additional Comments: | * *Low rate of adoption of SDM aid in visits, but working to move this upstream before the patient is seen in a clinic. Health Maintenance Module in EMR is programmed for opt-in PSA screening at ages 50-75. We have variation among providers in their use of Health Maintenance Module during visits.*
* *No organizational action taken on this topic, but screening overall has decreased dramatically from reviewing data. Large variation remains, but most physicians have adopted the guidelines from their specialty guidelines and recent USPSTF. This is occurring outside of Bree.*
* *This is a topic that has been discussed by our Quality Committee and there are tools in our EMR to assist in managing screening for those who may benefit (age 55-70). The use of patient decision aids and tracking of shared decision-making is not standardized across the organization; it is done on an individual provider basis.*
* *Not yet on the agenda*
* *Opportunity exists within SDM and engaging community (non-networked) partners*
 |

## Oncology Care

11 Medical Groups Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/Oncology-Care-Final-Recommendations-2016-03.pdf](http://www.breecollaborative.org/wp-content/uploads/Oncology-Care-Final-Recommendations-2016-03.pdf)

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

|  |  |
| --- | --- |
|  | AVERAGESCORE |
| The American Society of Clinical Oncology’s (ASCO) Choosing Wisely recommendations are followed including: |  |
| PET [positron emission tomography], CT [computed tomography] and radionuclide bone scans are not used in the staging of early prostate cancer at low risk of spreading | *2.23* |
| PET, CT, and radionuclide bone scans are not used in the staging of early breast cancer that is at low risk of spreading  | *2.22* |
| Palliative care is offered alongside active anti-cancer care, as needed  | *2.23* |
| Oncology care is aligned with a patient’s individual goals and values and follows the American Society of Clinical Oncology’s (ASCO) position statement of key elements for individualized cancer care | *2.18* |
| Patients are apprised of the harms, benefits, evidence, and potential impact of chemotherapy, radiation, molecular therapy, immunotherapy, and surgery at all stages in their illness trajectory | *2.23* |
| Goals of treatment are discussed at beginning of treatment | *2.09* |
| Additional Comments: | * *Our organization has not focused on our oncology department. However, PCPs remain very involved in cancer care of our patients and are familiar with shared decision making and palliative care.*
* *Processes are not monitored specifically through Bree, but rather through participation in QOPI, ACOS COC, HICOR, and monitoring and use of NCCN guidelines.*
* *None of this is done on the group level. Doesn’t mean it hasn’t already been implemented by the practitioners involved.*
 |

## Prescribing Opioids for Pain

10 Medical Groups Responding

Read the endorsement here: <http://www.breecollaborative.org/wp-content/uploads/2015AMDGOpioidGuideline.pdf> and summary here: <http://www.agencymeddirectors.wa.gov/Files/FY16-288SummaryAMDGOpioidGuideline_FINAL.pdf>

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

|  |  |
| --- | --- |
|  | AVERAGESCORE |
| **All pain phases** |  |
| Non-opioid therapies, such as behavioral intervention, physical activity and non-opioid analgesics, are used when appropriate | *2.20* |
| Opioids are avoided if the patient has significant respiratory depression, current substance use disorder, history of prior opioid overdose, or a pattern of aberrant behaviors | *2.00* |
| Function and pain are assessed and documented using a validated tool at each visit where opioids are prescribed | *1.50* |
| Opioids are not prescribed with benzodiazepines, carisoprodol, or sedative-hypnotics | *1.60* |
| **Acute phase (0–6 weeks)** |  |
| The state’s Prescription Monitoring Program (PMP) is checked before prescribing | *1.70* |
| Opioids are not prescribed for non-specific back pain, headaches, or fibromyalgia | *2.10* |
| The lowest necessary dose is prescribed for the shortest duration  | *2.20* |
| **Perioperative pain** |  |
| Patients are evaluated thoroughly preoperatively: the PMP is checked and the patient is assessed for over-sedation and difficult-to-control pain risk | *1.50* |
| Patient is discharged with acetaminophen, NSAIDs, or very limited supply (2–3 days) of short-acting opioids for some minor surgeries  | *1.70* |
| Patients on chronic opioids have doses tapered to preoperative levels or lower within 6 weeks following major surgery | *1.80* |
| **Subacute phase (6–12 weeks)** |  |
| Patients are not continued on opioids without clinically meaningful improvement in function and pain | *1.60* |
| Patients are screened for comorbid mental health conditions and risk for opioid misuse using validated tools | *1.70* |
| If opioids are prescribed beyond 6 weeks, PMP is rechecked and a baseline urine drug test is administered | *1.40* |
| **Chronic phase (>12 weeks)** |  |
| Opioids are continued to be prescribed only if there is sustained clinically meaningful improvement in function and pain, and no serious adverse events, risk factors, or contraindications | *1.70* |
| PMP checked and urine drug test are rechecked at frequency determined by the patient’s risk category | *1.70* |
| Opioids are prescribed in 7-day multiples to avoid ending supply on a weekend  | *1.90* |
| 120 mg/day morphine equivalent dose is not exceeded without a pain management consultation | *2.20* |
| **Discontinuing** |  |
| Prescriptions discontinued:* At the patient’s request
* No CMIF
* Risks outweigh benefits
* Severe adverse outcome or overdose event
* Substance use disorder identified (except tobacco)
* Aberrant behaviors exhibited
* To maintain compliance with DOH rules or consistency with AMDG guideline
 | *2.10* |
| **Considerations are made prior to taper:** |  |
| Patient helped to understand that chronic pain is complex and opioids cannot eliminate pain  | *2.10* |
| Outpatient taper considered if the patient isn’t on high-dose opioids or doesn’t have comorbid substance use disorder or other active mental health disorder  | *2.11* |
| Consultation obtained if the patient failed previous taper or is at greater risk for failure due to high-dose opioids, concurrent benzodiazepine use, comorbid substance use disorder or other active mental health disorder | *1.90* |
| **How to discontinue**  |  |
| Opioids tapered first if patients are also on benzodiazepines  | *1.60* |
| Unless safety considerations require a more rapid taper, taper is started with 10% per week and adjust based on the patient’s response  | *1.60* |
| Reverse taper avoided; it can be slowed or paused while managing withdrawal symptoms  | *1.70* |
| Unmasked mental health disorders are watched for, especially in patients on prolonged or high-dose opioids | *1.70* |
| **Recognizing and treating opioid use disorder** |  |
| Patient assessed for opioid use disorder and/or referred for a consultation if the patient exhibits aberrant behaviors | *2.10* |
| Patients are helped to get medication-assisted treatment along with behavioral therapies | *1.90* |
| Naloxone prescribed (especially if heroin use suspected) and patient’s contacts educated on how to use it | *1.50* |
| **Special populations**  |  |
| Women counseled before and during pregnancy about maternal, fetal, and neonatal risks  | *2.10* |
| For children and adolescents, prescribing opioids avoided for most chronic pain problems  | *2.20* |
| In older adults, opioids initiated at 25–50% lower dose than for younger adults  | *1.80* |
| For cancer survivors, recurrence or secondary malignancy ruled out for any new or worsening pain | *1.90* |
| Additional Comments: | * *Have convened multi-stakeholder team to address all the above issues and guiding team and work plan in place to get these to full adoption across the organization*
* *Organizational work is just getting started. Pain tools in the EMR were provided to all physicians with passage of WA state law back in 2011. CDC guideline information recently distributed. PMP is very clunky for providers to use, but many of them know about EDIE and “med recon” in EMR which provides information on meds prescribed if PBM was used.*
* *Full implementation of AMDG & CDC guidelines and registry tracking metrics is currently in development.*
 |

## Addiction and Dependence Treatment

9 Medical Groups Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/ADT-Final-Report.pdf](http://www.breecollaborative.org/wp-content/uploads/ADT-Final-Report.pdf)

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

|  |  |
| --- | --- |
|  | AVERAGESCORE |
| All patients over age 13 are screened for alcohol and other drug misuse at the first visit and annually using a validated and scaled screening tool or pre-screen followed by a validated full screen |  *1.11* |
| **Staff are educated on:** |  |
| a) The prevalence of alcohol and other drug misuse  | *1.44* |
| b) Current trends in alcohol and other drug misuse  | *1.44* |
| c) The impact of alcohol and other drug misuse on health conditions  | *1.44* |
| d) That substance use disorder is a chronic, relapsing-remitting disease on a continuum | *1.33* |
| e) The importance of screening for alcohol and other drug misuse | *1.56* |
| Health care providers are trained how to have non-judgmental, empathetic, culturally competent, and accepting conversations about alcohol and other drug misuse | *1.56* |
| Primary care providers and other appropriate staff are trained to provide brief intervention and if possible brief treatment | *1.44* |
| Patient results from alcohol and other drug misuse screens are tracked over time | *1.00* |
| Follow-up takes place with patients who have received brief intervention or brief treatment, as appropriate | *1.44* |
| Providers able to triage patients to appropriate level of care if not improving | *1.50* |
| Providers have access to qualified behavioral health providers | *1.89* |
| Providers are knowledgeable of appropriate chemical dependency treatment facilities | *1.67* |
| Adolescents with addictions are managed collaboratively with child and adolescent addiction specialists, if available | *1.63* |
| Coordinated, wrap-around care for pregnant women is provided with appropriate primary, addiction, obstetric, and pediatric providers, wherever possible | *1.57* |
| Staff are trained how to do a 42 CFR part 2 compliant release of information | *1.33* |
| Working relationships are established and maintained with chemical dependency treatment facilities to facilitate referrals and ensure appropriate communication | *1.89* |
| Patient referrals to a chemical dependency treatment facility are facilitated | *1.78* |
| Patients are contacted after they have been referred to chemical dependency treatment to address any barriers to accessing treatment | *0.89* |
| Verbal communication takes place with the chemical dependency treatment facility to follow-up on any referrals and assess whether treatment was initiated and/or completed | *0.78* |
| When provided with a patient’s hospital discharge information, results are recorded of screening, brief intervention, brief treatment and/or referral to treatment and follow-up with the patient and the chemical dependency treatment facility to which the patient has been referred to assess whether treatment was initiated and/or completed | *1.44* |
| The patient’s perspective is included as work is done to increase the capability of the chemical dependency system | *0.78* |
| Staff are educated about opioid use disorders | *1.33* |
| Staff are educated about medication-assisted treatment and appropriate counseling | *1.22* |
| Primary care providers have increase capacity to prescribe medication-assisted treatment for alcohol and other drug misuse as for other chronic conditions (e.g., increase Buprenorphine, Methadone, Naltrexone including extended-release injectable, treatment availability) | *1.22* |
| Inappropriate opioid prescribing has been decreased for non-cancer, non-terminal pain | *1.67* |
| Appropriate staff are trained to screen, engage, and facilitate both on-site opioid medication-assisted treatment and/or facilitate coordinated care with offsite specialized chemical dependency treatment | *1.22* |
| The Prescription Monitoring Program is utilized to evaluate a patient’s controlled substance history for potential risks | *1.89* |
| Additional Comments: | * *Task force has been convened. Education has been distributed.*
* *We do not offer this service*
* *We have formed a multidisciplinary team to provide education, guidance and support to the practice regarding safer opiate prescribing.*
* *Widely practiced in the community, NOT on the organization level agenda per se as of yet.*
* *Agreed upon consensus that adoption will take place – but work is still early in design phase. We expect early adoption by employed providers in 2017 – full adoption by 2018.*
 |

## Potentially Avoidable Hospital Readmissions

11 Medical Groups Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/Readmissions-Report-FINAL-14-0730.pdf](http://www.breecollaborative.org/wp-content/uploads/Readmissions-Report-FINAL-14-0730.pdf)

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

|  |  |
| --- | --- |
|  | AVERAGESCORE |
| Primary Care Providers receive notification of patients admitted to a hospital, or are seen in the hospital’s Emergency Department; Necessary medical information is provided to the hospital care team | *2.73* |
| Primary Care Providers receive notification of patients discharged from a hospital, with a care plan, for patients at a high or moderate risk for readmission; Follow-up appointments are scheduled | *2.83* |
| Primary Care Providers have an effective process for obtaining medication lists and conducting medication reconciliation for discharged hospital patients | *2.55* |
| Primary Care Providers have a process for providing necessary follow-up visits for discharged hospital patients who do not currently have an established PCP | *1.91* |
| Additional Comments: | * *Full adoption for elements 1-3. Within our EHR environment all providers are notified of admissions and discharges, along with standard processes for obtaining outside records when an individual is admitted to an outside facility. We have tested processes for individuals without an established PCP, but recognize some improvements to be made in this area.*
* *ADT notification in EMR. No formal work in this area. Our re-admits continue to be low according to all of our payers.*
* *We have full adoption for patients admitted to our local hospital. We do receive discharge summaries from other hospitals, but no notice of admit. We do receive medication lists from the hospital. Medication reconciliation is not always conducted. We have a solid process for follow up visits for PCP established patients only.*
* *We have a Population Health team and nurse case managers who help to track patient discharges so that we can successfully perform Transitional Care Management visits as defined by CMS.*
* *We do not care for un-established patients*
* *processes described exists for all providers (employed and community) the action/response of the provider varies greatly – opportunity exists to better engage our community PCPs.*
 |

## End-of-Life Care

10 Medical Groups Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/EOL-Care-Final-Report.pdf](http://www.breecollaborative.org/wp-content/uploads/EOL-Care-Final-Report.pdf)

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

|  |  |
| --- | --- |
|  | AVERAGESCORE |
| **Health care providers and staff are educated on:** |  |
| 1. How to have empathetic, realistic, and patient- and family-centered (e.g., using lower literacy materials if appropriate) advance care planning conversations
 | *1.60* |
| 1. How to be reimbursed for these conversations
 | *1.50* |
| 1. The difference between an advance directive and Physician Orders for Life Sustaining Treatment (POLST), and patients for whom each would be acceptable
 | *1.80* |
| 1. How to refer patients to community-based advance care planning resources if appropriate
 | *1.80* |
| All patients over the age of 18 are encouraged to consider having a conversation about advance care planning with the content of those conversations appropriate to the patient’s age, health status, literacy level, and readiness | *1.10* |
| Advance care planning tool(s) or program(s) are adopted and use is standardized across your clinic or health care system. Possible examples include Honoring Choices: Pacific Northwest or the Institute for Health Care Improvement’s Conversation Ready | *2.10* |
| Documentation is available in the medical record that the provider has used a standardized advance care planning tool | *2.00* |
| **Documentation is made of the results of advance care planning discussions with easily understandable and culturally appropriate advance directives that include:** |  |
| 1. A living will (also called a health care directive) that stipulates specific treatment preferences (if known and applicable to the situation)
 | *1.90* |
| 1. A durable power of attorney for health care that names a surrogate and indicates the amount of leeway the surrogate should have in decision-making, a written personal statement that articulates the patient’s values and goals regarding end-of-life care
 | *1.40*  |
| 1. Physician Orders for Life Sustaining Treatment (POLST), if appropriate
 | *2.20* |
| Standardized protocols developed on how to transfer information contained in the advance directive or POLST to hospitals in your community such as through the advance directive/POLST registry, if in existence | *1.40* |
| Patients are supported as they navigate care between different health care facilities and systems, including facilitation of information sharing and patient and family outreach during times of crisis | *1.80* |
| Hospice care is promoted and appropriate hospice referrals are encouraged | *2.10* |
| Additional Comments: | * *We began implementing Honoring Choices Pacific Northwest in July 2016. We have work to be done to spread efforts organization-wide and specifically in providing advance care planning tools beyond our efforts to have individuals complete advance directives, POLST and DPOAs. We have participated in the “Your life, your choices” program, the Conversation Project and 5 wishes initiative with a focus on the populations in highest need of advance care planning. We plan to use Honoring Choices participation as a stepping stone to organization-wide adoption of recommendations made by the Bree Collaborative and other authorities.*
* *We are dedicating our next Medical Staff meeting (4 hours on a Saturday morning) to this topic to be lead by Dr Ira Byock and his team.*
* *We are a participant in honoring choices and have a dedicated outpatient palliative care clinic*
* *We are a leader locally in this, but in the FFS world, not yet begun within our group.*
* *Work is in Pilot phase at two clinic sites – plans for system deployment in 2017/2018 for employed providers; no plans at this time to deploy to community/independent practices.*
 |

## Factors Affecting Adoption

11 Hospitals & Medical Groups Responding

Factors that were identified as barriers to, or enablers of adoption. Ranked in order 1-5. Additional factors mentioned are included.

|  |  |  |
| --- | --- | --- |
| **Factor** | **Top 5 Barriers to Adoption****(rank 1-5)** | **Top 5 Enablers to Adoption****(rank 1-5)** |
| Internal awareness/support of Bree Recommendations |  |  *3* |
| Sufficient market share/volume |  |  |
| Business case- evidence of economic reward | *3- tie* | *2* |
| Contract partners interest in value-based purchasing | *2* |  |
| Existing forum to discuss value-based purchasing |  |  |
| Consensus on what constitutes quality of care | *5* | *4* |
| Availability and credibility of data | *1* |  |
| Individual provider-level performance and feedback |  | *5* |
| Burden/ease of collecting or obtaining data | *3- tie* |  |
| Consistency in findings across multiple measures. |  |  |
| Existing organizational improvement program for minimizing errors & waste |  | *1* |
| Consumer awareness of quality health plans and providers |  |  |
| Regulatory constraints, i.e. HIPPA, etc. |  |  |
| Other factors mentioned: |  |  |
| Historical and current provider practice variability  | *✓* |  |
| Small scale value-based reimbursement opportunities and provider compensation malalignment  | *✓* |  |
| Multiple Competing Priorities  | *✓* |  |
| Lack of alignment between Bree and other state and national QI initiatives  | *✓* |  |
| Complexity of operationalization  | *✓* |  |
| Employers | *✓* |  |
| Communication and agreement among providers  | *✓* |  |
| Effectiveness in improving health- Impact  | *✓* | *✓* |
| American College of Physicians: Preventative Visits Recommendations |  | *✓* |
| Alignment with organizational vision to provide quality, evidence-based and appropriate care for populations  |  | *✓* |

# Health Plans

## Participating Health Plans

Aetna

Amerigroup

Community Health Plan of Washington

First Choice Health Plan

Group Health Cooperative

Molina Healthcare of Washington

Premera Blue Cross

## Value-Based Provider Reimbursement Models

7 Health Plans Responding

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| Fee for service with bonus payments for quality reporting  | *0.80* |
| Fee for service with bonus payments for quality performance  | 1.86  |
| Bundled payment or condition specific capitation with quality criteria and/or bonus: |  |
| * Coronary Artery Bypass Graft Surgical Bundle (excluding urgent or emergent)
 | *0.43* |
| * Lumbar Fusion Surgical Bundle
 | *0.71* |
| * Total Knee/Hip Replacement Surgical Bundle
 | *1.00* |
| Warranty: |  |
| * Coronary Artery Bypass Graft Surgical Bundle (excluding urgent or emergent)
 | *0.20* |
| * Lumbar Fusion Surgical Bundle
 | *0.40* |
| * Total Knee/Hip Replacement Surgical Bundle
 | *0.60* |
| Full capitation with quality criteria and/or bonus | *2.17* |
| Additional Comments: | * *Please note Managed care adoption for bundled payment contingent upon HCA FFS adaptation with claims and encounters*
* *Implementation of bundled payments with warranties continues to be challenging where we do not find significant receptivity or adoption in the market.*
* *Bundled payment for oncology benefit differential. Also shared savings & total cost of care model, case mgmt. model, Hospital Quality Incentive, PCP value based, Benefit Differential program (COE)*
* *Our primary Value Based Payment model includes shared savings and quality (HEDIS, shared risk and quality, and global risk and quality. We believe this creates, along with quality and utilization reporting tools, ample incentives for providers to coalesce and collaborate on various model of care innovations and strategies, including bundled payments.*
 |

## Obstetrics Care

7 Health Plans Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/bree\_ob\_report\_final\_080212.pdf](http://www.breecollaborative.org/wp-content/uploads/bree_ob_report_final_080212.pdf)

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| Obstetrics reimbursement structure is aligned with: |  |
| * Eliminating all elective deliveries before the 39th week of pregnancy (for which there is no appropriate documentation of medical necessity)
 | *2.17* |
| * Decreasing elective inductions of labor between 39 and up to 41 weeks
 | *2.00* |
| * Decreasing unsupported caesarian sections for women who have never had a C-section.
 | *2.17* |
| * Collaborating with other health plans in Washington to create a quality incentive program, using the quality criteria outlined in the report (e.g. induction rates, total and primary C-section rates, etc.)
 | *1.40* |
| Additional Comments: | * *monitoring the performance of network providers, adoption of guidelines by partner systems, and sharing comparative data and outcomes across the markets.*
 |

## Low Back Pain

7 Health Plans Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/spine\_lbp.pdf](http://www.breecollaborative.org/wp-content/uploads/spine_lbp.pdf)

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

|  |  |
| --- | --- |
| COMPONENT | **AVERAGE** **SCORE** |
| Providers are required to use a screening tool (such as STarT Back or FRQ) as part of the management of patients for imaging, spinal injections, and/or spinal surgery  | *0.50* |
| Complex cases (e.g., a patient who is getting opioid prescriptions from multiple doctors) are identified and referred to a provider or a case manager who can oversee their care  | *1.83* |
| Benefit design increases access to multidisciplinary care for patients at risk of developing chronic back pain  | *1.17* |

## Prostate Cancer Screening

7 Health Plans Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/Prostate-Cancer-Recommendations-Final-15-11.pdf](http://www.breecollaborative.org/wp-content/uploads/Prostate-Cancer-Recommendations-Final-15-11.pdf)

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| Clinicians are reimbursed for engaging patients in a formal and documented shared decision-making process (using a Washington State-approved patient decision aid when available) for PSA testing for prostate cancer screening.specific antigen (PSA) testing | *0.71* |

## Oncology Care

7 Health Plans Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/Oncology-Care-Final-Recommendations-2016-03.pdf](http://www.breecollaborative.org/wp-content/uploads/Oncology-Care-Final-Recommendations-2016-03.pdf)

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| The health plan securely provides patient enrollment and claims data to the Hutchinson Institute for Cancer Outcomes Research (HICOR) for linkage with the Cancer Surveillance System and comprehensive statewide comparison. | *1.40* |
| Appropriateness of advanced imaging care is aligned with proper reimbursement that includes safeguards for individual patient exceptions.  | *1.86* |
| Practice leadership has been engaged as advocates for Choosing Wisely recommendations. | *1.67* |
| Additional Comments: | * *We an active program to review oncology clinical trials for appropriateness and benefit coverage.*
* *All advanced imaging determinations are managed through a central unit within our organization. Coordination with provider practices on a local level to increase efficiency of authorizations, provide direct lines of contact to the AI team, and safeguard individual exceptions when required, is evolving.*
 |

## Prescribing Opioids for Pain

7 Health Plans Responding

Read the endorsement here: <http://www.breecollaborative.org/wp-content/uploads/2015AMDGOpioidGuideline.pdf> and summary here: <http://www.agencymeddirectors.wa.gov/Files/FY16-288SummaryAMDGOpioidGuideline_FINAL.pdf>

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| Please provide any programs, policy or reimbursement changes pertaining to opioid prescribing your health plan has made in recent years. | *1.71* |
| Additional Comments: | * *Have convened multi-stakeholder team to address all the above issues and guiding team and work plan in place to get these to full adoption across the organization*
* *Leader in opioid use in delivery, work to flag high dose patients in plan*
* *Currently developing programs in combination with PBMs to reduce inappropriate opioid prescribing.*
* *Current organization activities and programs:*
	+ *1. Safety Edits include quantity limits on narcotics. All opioids have quantity limits based on manufacturer’s direction; they are also member centric, not provider centric (e.g. prohibit a member from getting more than the limit regardless of the number of prescriptions).*
	+ *2. RxCheck, retrospective drug utilization review with several components that focus on opioids and notifies physician and pharmacy of findings*
	+ *3. Controlled Substance Utilization Program (CSUP) – monitors for opioid prescriptions from multiple prescribers and pharmacies and notifies prescribers of findings. Patients are referred to behavioral health if appropriate.*
	+ *4. Top Prescriber Letter campaign – Launched by office of Chief Medical Director on July 15, 2016. Letters sent to top 1% of prescriber who our data indicate are outliers in their opioid prescribing patterns. The prescriber list is based on the Physician’s refill-to-fill ratio, as this metric has strong correlation to patient overdoses in our claims data. Additionally the communication includes CDC checklist for prescribing opioids for chronic pain*
	+ *5. Successful Lobbying Campaign –combined forces with another national plan to successfully lobby for the expansion of the number of patients a doctor can treat with suboxone from 100 to 275, saying the previous cap had limited the number of members who could obtain medication assisted treatment. Medication assisted treatment with suboxone, methadone, or vivitrol, has been shown in multiple studies to reduce substance-use much more effectively than abstinence.*
* *We have not specifically adopted the Agency Medical Directors Guidelines, but some of our policies/programs are consistent or compatible with parts of the Agency Medical Directors Guidelines, specifically our Medical Policy on Opioid Analgesics, our Medical Policy on Medical Necessity Criteria for Medication Safety: Controlled Substances Utilization Service Program, and the actual Controlled Substances Utilization program.2*
* *We are actively engaged in community-based activities to educate providers as to the AMDG Opioid Guidelines and general awareness regarding the potential consequences of opioid prescribing. We also collaborate with regional experts to promote the education of community leaders/legislators. We participate in the BREE Collaborative and work closely with the HCA and other MCOs on developing a cohesive approach to the dissemination of the AMDG opioid prescribing guidelines as well as developing standard criteria.*
 |

## End-of-Life Care

7 Health Plans Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/EOL-Care-Final-Report.pdf](http://www.breecollaborative.org/wp-content/uploads/EOL-Care-Final-Report.pdf)

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| Counseling and discussion regarding advance directives or end-of-life care planning and decisions, with patients and their surrogate decision makers is reimbursed | *2.71* |
| Providers and health care facilities have been educated on how to appropriately bill for advance care planning conversations | *1.14* |
| Hospitals, nursing homes, and other applicable settings are encouraged to implement a quality improvement program focused on greater adherence to patients’ requests as outlined in advance directives and POLST if accurate and applicable to the current situation | *1.71* |
| Family and friend satisfaction with end-of-life care is measured by widespread use of an after-death survey tool similar to that used by hospice agencies. | *0.71* |
| Inclusive and comprehensive benefits for care of patients with serious illness at the end of life have been developed allowing them to receive care consistent with their wishes and goals even if not eligible for hospice. | *2.28* |
| Patients are supported as they navigate care between separate health care facilities and systems including facilitation of information sharing and patient and family outreach during times of crisis. | *2.42* |
| Additional Comments: | * *Our Compassionate Care Program is a national model – a permanent case management and allows for both hospice and curative treatment at the same time.*
* *We support the Snohomish County Health Leadership Coalition – who supports and measures this activity.*
* *An End of Life Planning campaign has been developed for 2017. This includes informing and encouraging providers to counsel, and educate their patients regarding end of life planning, and appropriately bill for these discussions. Communication to providers with all appropriate billing codes is part of this Quality initiative. Additional activities include expanding member support and engagement in pediatric palliative care programs, and use of Case Management to facilitate dissemination of information and access for members eligible for palliative care or hospice services.*
 |

## Potentially Avoidable Hospital Readmissions

7 Health Plans Responding

Read the full report here: [www.breecollaborative.org/wp-content/uploads/Readmissions-Report-FINAL-14-0730.pdf](http://www.breecollaborative.org/wp-content/uploads/Readmissions-Report-FINAL-14-0730.pdf)

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

|  |  |
| --- | --- |
|  | **AVERAGE****SCORE** |
| Please provide any programs, policy or reimbursement changes pertaining to hospital readmissions your health plan has made in recent years. | *2.71* |
| Additional Comments: | * *HCA has directed MCO’s to pay for all hospital readmissions, with retro recovery from hospitals*
* *Lead the state in readmission, nurse case managers as health plan*
* *Recoup on readmissions*
* *Most of the hospitals in our network already have active programs to reduce potentially avoidable hospital readmissions.*
* *We do not reimburse for any readmission within 30 days of initial discharge (with some exceptions). In our VBC contracts, Potentially Avoidable Hospital Readmissions is an efficiency metric (Hospital P4P plus attribution based contracts).*
* *Review and denial of payment if readmission at same facility deemed preventable for same condition.*
* *30 Day Readmission policy for CMS. Prior to 1/1/2016 we used the state policy on readmissions within 14 days.*
 |

## Factors Affecting Adoption

7 Health Plans Responding

Factors that were identified as barriers to, or enablers of adoption. Ranked in order 1-5. Additional factors mentioned are included.

|  |  |  |
| --- | --- | --- |
| **Factor** | **Top Barriers to Adoption****(rank 1-3)** | **Top Enablers to Adoption****(rank 1-4)** |
| Internal awareness/support of Bree Recommendations |  | *1* |
| Sufficient market share/volume | *1* | *2* |
| Business case- evidence of economic reward | *3* | *4* |
| Contract partners interest in value-based purchasing |  | *3* |
| Existing forum to discuss value-based purchasing |  |  |
| Consensus on what constitutes quality of care |  |  |
| Availability and credibility of data |  |  |
| Individual provider-level performance and feedback |  |  |
| Burden/ease of collecting or obtaining data | *2* |  |
| Consistency in findings across multiple measures. |  |  |
| Existing organizational improvement program for minimizing errors & waste |  |  |
| Consumer awareness of quality health plans and providers |  |  |
| Regulatory constraints, i.e. HIPPA, etc. |  |  |