Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Dr. Robert Bree Collaborative Annual Report

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

November 15, 2019

DR. ROBERT BREE COLLABORATIVE

Washington State Health Care Authority

Dr. Robert Bree Collaborative Annual Report

Acknowledgments

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

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Executive Summary

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

This is the eighth annual report submitted by the Health Care Authority (HCA) on behalf of the Dr. Robert Bree Collaborative (Bree Collaborative or Collaborative) to the Washington State Legislature as directed in Engrossed Substitute House Bill 1311 (ESHB 1311), Section 3, and enacted as Chapter 313, Laws of 2011. This report describes the achievements of the Bree Collaborative from November 2018 through October 2019.

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

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

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

Since its 2011 formation, the Bree Collaborative has successfully pursued its mission to improve health care quality, patient outcomes, and affordability in our state. Year eight accomplishments included supporting seven active workgroups, drafting and adopting two sets of recommendations, and receiving approval from HCA on two sets of recommendations.

This year we have:

- Developed recommendations to support adoption of shared decision making.
- Developed a bundled payment model and care pathway including prenatal care, labor and delivery, and postpartum care with defined time limits.
- Developed recommendations to improve the quality and accessibility of palliative care.
- Developed recommendations in response to a Legislative budget proviso for cases in which a patient may be at risk of violence to others.
- Engaged with the pain specialty and patient advocate community to develop patient-centered recommendations to support patients on long-term opioid therapy.
- Worked with health care purchasers, health plans, provider groups, and state agencies to encourage adoption of Bree Collaborative recommendations.

Background

The American health care system continues to have poorer health outcomes for higher cost than many other high-income countries - including shorter life expectancy and higher chronic disease prevalence.[1] Many of the dollars spent do not add to patient health or quality of care, and are wasted.[2,3] Over a one-year period in Washington State alone, $282 million was spent on unnecessary or low-value health care services.[4] Prices for medical services vary widely, from $7,000 to over $20,000 for a cesarean section delivery.[5] Variation in price, processes, and outcomes within health care delivery and high rates of use of specific health care services can indicate poor quality, inappropriate services, and potential waste.

Washington State has prioritized increasing the quality and affordability of health care through innovative work such as the Health Technology Assessment program, the Prescription Drug Program, Healthier Washington, and the Dr. Robert Bree Collaborative. The Bree Collaborative's work is a key part of Healthier Washington, providing evidence-based standards of care and purchasing guidelines for high-variation, high-cost health care services. The Bree Collaborative is structured after the work of the Advanced Imaging Management (AIM) project and named in memory of Dr. Robert Bree. Dr. Bree was a leader in the imaging field and a key member of the AIM project working to reduce inappropriate use of advanced imaging (e.g., CT, PET, and MRI scans) in Washington State. See Appendix A: Bree Collaborative Background for more information.

ESHB 1311 Overview

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

All Collaborative meetings are open to the public and follow the Open Public Meetings Act.

The Bree Collaborative is charged with annually identifying up to three health care service areas in which there are differences in how care is delivered between clinics, facilities, or providers or higher use of care that do not cause better outcomes for patients. Collaborative staff seeks direction for which health care services to select from Bree Collaborative members, the Legislature, the Washington State Agency Medical Directors Group, state associations, other community partners, and the public.

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

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

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

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

Summary of Recent Work

In the Bree Collaborative's eighth year — November 2018 to October 2019 — the Collaborative focused on developing new evidence-based recommendations and working to foster adoption of existing recommendations.

The Bree Collaborative formed workgroups to develop recommendations for a maternity care bundled payment model and clinical pathway, shared decision making, palliative care, risk of violence to others, and for patients on chronic opioid therapy. These workgroups are profiled on the following pages.

The Bree Collaborative:

- ✓ Supported seven active workgroups
- ✓ Adopted two recommendations
- ✓ Received HCA approval on two recommendations

The Bree Collaborative approved and submitted the following recommendations to the HCA:

- **Collaborative Care for Chronic Pain Report and Recommendations**
  (Adopted January 2019)
  - www.breecollaborative.org/wp-content/uploads/Recommendations-Chronic-Pain-Final-2018.pdf
- **Lumbar Fusion Bundle and Warranty Re-Review**
  (Adopted January 2019)
  - www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Bundle-and-Warranty-Final-2018.pdf

At the July meeting, Bree Collaborative members selected four new topics for 2020 including:

- Reproductive health as outlined in Senate Bill 5602
- Chemotherapy and emergency department or hospital use
- Primary care
- Colorectal cancer screening

Maternity Bundled Payment Model

The workgroup has been meeting monthly since January 2019 and continues to develop these recommendations.

> **Learn more about the workgroup and see all past meeting materials:**
> www.breecollaborative.org/topic-areas/current-topics/maternity-bundle/

Background

The United States has the highest maternal death rate among developed nations with more than 50,000 mothers having life-threatening complications annually.[6,7] Mortality also differs greatly based on race with black mothers being three to four times as likely to die in childbirth than white mothers.[6,8] Black mothers are more likely to suffer complications that lead to injury.[6,8] Further, childbirth is the single largest cost for state Medicaid and also most commercial health plans.[9]

Bundled payment models can address some of these preventable complications and various models are currently being used across the country.[10] Many of these models cover low-risk pregnancies, limiting their impact on health equity while others exclude the highest and lowest cost episodes and select conditions.[5,11]

Our Work

The workgroup is developing a clinical pathway supported by an episode-based payment model. The pathway builds on existing perinatal work within Washington State that includes prenatal care, labor and delivery, and postpartum care. The greatest areas of impact include cardiovascular disease screening and intervention, behavioral health screening and treatment, continued engagement with care postpartum (especially for substance use disorder), support of a low-intervention birth[12], and more individualized, frequent postpartum visits. The workgroup is prioritizing health equity, high-quality and evidence-based perinatal and pediatric care, and inclusive criteria defined as:

- Beginning 270 days prior to delivery and ending 84 days (3 months) post-delivery. The workgroup's ideal is to implement a perinatal bundle that will last 365 days (12 months) post-delivery (total 635 days).
- Including prenatal care, labor and delivery, and postpartum services for both facility and professional services.
- Designating the obstetric care provider as the accountable entity.

Opioid Prescribing

This is an ongoing workgroup focused on implementing the Washington State Agency Medical Directors' Guideline on Prescribing Opioids for Pain, endorsed by the Bree Collaborative in July 2015. This iteration of the workgroup has been meeting since December 2018, is continuing to develop recommendations, and held a conference on August 9, convening national experts to discuss the state of the science for people who have been prescribed opioids chronically.

Learn more about the workgroup and see all past meeting materials:
www.breecollaborative.org/topic-areas/current-topics/opioid/

Background

In 2007, in response to the increased number of deaths from opioid overdoses, the medical directors of the Washington State Agencies developed Guidelines on Prescribing Opioids for Pain.[13] These guidelines were revised in 2010 and again in 2015. The Centers for Disease Control and Prevention (CDC) developed and disseminated similar national guidelines in 2016.[14]

Our Work

For all patients, care should be individualized and thoughtful. Care should focus on improved function, increased quality of life, and greater patient autonomy rather than a primary focus on pain relief (as this may not be realistic for many people). Opioids should not be suddenly discontinued.[15]

- Patient engagement
    - Build a trusting relationship. Start by engaging the patient in care, discussing their goals (e.g., "what are your expectations," "what do you hope to accomplish"), preferences, and needs.
- Assessment
    - Complete a history and directed physical exam as indicated including pain-related diagnoses and past experiences with pain interventions.
    - Assess functional status.
    - Behavioral health screening and referral (i.e., depression, anxiety, suicidality, alcohol and drug use).
- Develop a treatment plan
    - Treatment plans should be developed in collaboration with the patient, and family or others if appropriate.
    - Treat opioid use disorder, if present, using evidence-based protocols including medication-assisted treatment (MAT).
    - Review non-opioid management of chronic pain.
    - Determine together with the patient, and families or others if appropriate, whether to stay on opioids or to reduce opioid prescriptions at a rate consistent with their clinical and social situation.

Palliative Care

The workgroup has been meeting monthly since January 2019 and continues to develop these recommendations.

> **Learn more about the workgroup and see all past meeting materials:**
> www.breecollaborative.org/topic-areas/current-topics/palliative-care/

Background

People with serious or advanced illness often experience increases in symptoms coupled with a decrease in function. Traditional life-prolonging or curative care often does not meet a person's range of needs as illness progresses or as a person nears the end of life. Fragmented care delivery and frequent transitions between care settings, unmet symptoms such as pain, and responsibilities put on family members and other caregivers create undue stress and burden on the individual.[16] Palliative care fills the gap between intensive curative care and supportive care to better meet patient need by "focus[ing] on expert assessment and management of [symptoms including] pain…assessment and support of caregiver needs, and coordination of care [attending] to the physical, functional, psychological, practical, and spiritual consequences of a serious illness."[17]

Provision of palliative care consistently shows improved outcomes for patients in both in- and out-patient settings.[18] Palliative care has been associated with reduction in symptom burden, higher satisfaction with care, higher referrals to hospice, and lower days in a hospital.[19,20]

Our Work

This workgroup acknowledges the great amount of work that has gone into defining palliative care and setting standards by other organizations and has endorsed and adapted some of these for Washington State. Further, the workgroup chose to focus on the functions of palliative care rather than assign specific clinical roles to allow greater adaptability based on local resources. Focus areas include:

- Defining palliative care using the standard definition developed by the National Consensus Project including appropriateness of primary and specialty palliative care
- Spreading awareness of palliative care
- Clinical best practice provision of palliative that is:
    - Responsive to local cultural needs
    - Includes advance care planning as outlined in the 2014 Bree Collaborative End-of-Life Care Report and Recommendations including appropriateness of an advance directive and Physician Orders for Life-Sustaining Treatment (POLST), and
    - Incorporates goals of care conversations into the medical record and plan of care
- Availability of palliative care through revision of benefit structure such as a per member per month (PMPM) benefit

Risk of Violence to Others

The workgroup has been meeting monthly since January 2019 and continues to develop these recommendations.

> **Learn more about the workgroup and see all past meeting materials:**
> www.breecollaborative.org/topic-areas/current-topics/risk-of-violence/

Background

Acts of interpersonal violence, especially homicide, while statistically rare, represent a high public health and clinical priority due to the potential for tragic outcomes. The vast majority of behavioral health patients are not violent. However, a small percentage of those with a behavioral health diagnosis may be at an increased risk for violence. Violent acts are more strongly associated with drug and alcohol use than a mental health diagnoses.[21]

The 1976 California Supreme Court Case decision *Tarasoff v Regents of the University of California* established therapists' duty to protect third parties from violent behavior of a patient.[22] Subsequent clarifying cases and legislation refined the duty to protect identifiable victims who face an imminent threat of serious harm. The 2016 Washington State Supreme Court decision *Volk v DeMeerleer* held that a mental health professional who establishes a special relationship with a patient has a duty to protect any foreseeable victim from a patient's dangerous propensities.[23,24]

In 2018, the Washington State Legislature included a budget proviso for the Bree Collaborative to address the clinical uncertainty resulting from the 2016 Washington State Supreme Court *Volk v. DeMeerler* decision. This work builds upon the 2017 Collaborative recommendations to integrate behavioral health into primary care and the 2018 recommendations on suicide care.

Our Work

The workgroup is clear that clinicians can identify and monitor an individual's risk factors for violence, make a reasonable assessment based on those known risk factors, and make decisions for clinical management, but cannot predict violent acts with certainty. The workgroup is also concerned with setting actionable recommendations in light of the standards set out in the *Volk* decision. Notwithstanding those concerns, the workgroup prioritizes a patients' right to both confidentiality and also to care in the least restrictive environment, and recognizes the need to balance those priorities with the duty to protect the community. Documentation at each clinical decision point should be part of the clinical record. Focus areas include:

- Identification of increased risk for violence
- Further assessment of violence risk
- Violence risk management
- Community protection

Shared Decision Making

The workgroup has been meeting monthly since January 2019 and continues to develop these recommendations.

Learn more about the workgroup and see all past meeting materials:
www.breecollaborative.org/topic-areas/current-topics/shared-decision-making/

Background

Shared decision making is a key component of patient-centered care, "a process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences."[25] Shared decision making is appropriate for preference-sensitive conditions in which there is high-quality clinical evidence for more than one treatment, management option, or screening or where there is lack of evidence and no clinical consensus on the best option. This necessitates communication between a provider and patient, and in some cases family members or others, about risks, benefits, and exploration of values and goals. Unfortunately, involving patients as equal partners in health care decisions that have multiple clinically appropriate options by fully discussing risks and benefits remains limited within clinical practice. Barriers to implementing shared decision making into clinical practice include provider time; overwork; lack of training; lack of structural support, including through electronic health records and general workflow; fear of revenue loss; and decision aids not being available or applicable to a specific patient or clinical situation.[26,27]

HCA has worked to certify patient decision aids since April 2016.[28] Washington State law allows for shared decision making to meet enhanced informed consent standards and supports the shared decision making process.[29]

Our Work

The workgroup prioritized ten health conditions for which shared decision making is appropriate and categorized uptake of shared decision making within the areas. The Shared Decision Making workgroup's goal is movement toward greater use of shared decision making in clinical practice; and that all clinical sites move towards action. Focus areas include:

- A common understanding and shared definition of shared decision making and the benefit of shared decision making
- Ten priority areas as first steps for the health care community:
    - Abnormal Uterine Bleeding
    - Advance Care Planning
    - Attention Deficit Hyperactivity Disorder Treatment
    - Breast Cancer Screening
    - Depression Treatment
    - Knee and Hip Osteoarthritis
    - Opioid Use Disorder Treatment
    - Prostate Specific Antigen Testing, Spine Surgery (Lumbar Fusion)
    - Trial of Labor After Cesarean Section

- Highly reliable implementation using an existing framework customized to an individual organization
- Documentation, coding, and reimbursement structure to support broad use

Implementation

HCA champions Bree Collaborative recommendations, which are supported and spread by Bree Collaborative member organizations and many other community organizations.

In alignment with the Healthier Washington goal to move health care payment from volume to value and deliver more coordinated, whole person care, HCA includes Bree Collaborative recommendations in the two Public Employees Benefits Board (PEBB) Program accountable care network options: Uniform Medical Plan (UMP) Plus—Puget Sound High Value Network, led by Virginia Mason Medical Center, and UMP Plus—University of Washington (UW) Medicine Accountable Care Network. Both networks have met the contractual obligation to submit quality improvement plans for obstetrics, total knee and total hip replacement, lumbar fusion, care coordination for high-risk patients, hospital readmissions, cardiology, low back pain, end-of-life care, and addiction and dependence treatment.

Continuing the emphasis on paying for value, HCA designated Virginia Mason Medical Center as the center of excellence for total joint replacement surgery using the Bree Collaborative's total knee and hip replacement bundled payment as a model. Since January 2017, enrollees in the PEBB Program's Uniform Medical Plan Classic or UMP Consumer-Directed Health Plan who select Virginia Mason for this procedure pay no coinsurance (with the exception of UMP CDHP members who are required by IRS rules to meet their deductible first). Premera Blue Cross administers the centers of excellence program. As of January 2019, 166 surgeries have been completed with no reported complications, high member satisfaction, and an overwhelming majority of referrals meeting appropriateness criteria. In May 2019, Premera Blue Cross announced a new contract with Providence St. Joseph Health naming seven facilities as centers of excellence for total joint replacement following the Bree Collaborative guidelines.

In early 2018, the HCA released a request for proposals for a lumbar fusion bundled payment center of excellence aligned with the Bree Collaborative recommendations. In July 2018, HCA selected two centers of excellence for lumbar fusion bundled payment: Capital Medical Center and Virginia Mason Medical Center. The Spine Care Center of Excellence program went live for Uniform Medical Plan at these two sites on January 1, 2019.

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

- Outreach to community groups (e.g., the Washington State Hospital Association [WSHA), the Washington State Medical Association [WSMA], the Washington Health Alliance)
- Participation in multiple Healthier Washington meetings and workgroups (e.g., Health Innovation Leadership Network, HealthierHere Accountable Community of Health)
- Speaking at multiple conferences and stakeholder groups to educate about the Bree Collaborative and specific, relevant recommendations (e.g., Surgical Care and Outcomes

Assessment Program annual meeting, Washington State Public Health Association conference)
- Increasing Collaborative visibility through the website (www.breecollaborative.org), maintaining a blog with monthly or bi-monthly posts highlighting Collaborative topics or implementation strategies, and using social media to engage the community

Community Partners

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

- **Addiction Screening**: The two HCA Accountable Care Programs; the Puget Sound High Value Network, led by Virginia Mason Medical Center; and the UW Medicine Accountable Care Network routinely train and utilize the Screening, Brief Intervention, and Referral to Treatment model and have integrated a tool to screen for alcohol use into electronic medical records and workflow.
- **Behavioral Health Integration**: HCA used Bree Collaborative standards for integrating behavioral health into primary care to inform the development of required Accountable Communities of Health projects under the Medicaid Transformation Project.
- **Cardiology**: The Clinical Outcomes Assessment Program (COAP) continues to monitor insufficient information around percutaneous coronary intervention.
- **End-of-Life Care**: WSHA and WSMA are still actively spreading advance care planning at the health system and community levels, aligned with the Bree Collaborative's 2014 recommendations. The two associations are working to promote patient-centered end-of-life conversations through Honoring Choices®: Pacific Northwest.
- **Spine Surgery***:* Spine Clinical Outcomes Assessment Program (SCOAP) has 18 hospitals enrolled. As of August 2014, length of stay, radiologic verification of surgical level, and smoking use have been available on the website.
- **Obstetrics**: Both the Obstetrics Clinical Outcomes Assessment Program (OB-COAP) and WSHA's Safe Deliveries Roadmap have aligned existing program expectations and data collection with Bree Collaborative recommendations for member hospitals.
- **Oncology**: Collaborative staff have participated in the Hutchinson Center for Cancer Outcomes Research Value in Cancer Care workgroup since its formation in late 2015. Staff also participates in the annual Value in Cancer Care Summit.
- **Opioid Prescribing**: All metrics are being used by the Washington State Department of Health to track opioid prescribing. Three metrics (new opioid patients transitioning to chronic opioids, patients prescribed high-dose chronic opioid therapy, new opioid patients' days' supply of first opioid prescription) have been adopted and will be included in the state Common Measure Set (i.e., a statewide set of measures that is part of Healthier Washington meant to increase health care accountability and performance) by the Performance Measures Coordinating Committee.

Summary: First Seven Years

The Bree Collaborative workgroup members' engagement and dedication has yielded multiple high-quality and well-received sets of recommendations since its founding in 2011.

See Appendix D to see a list of workgroup members for each of these topics.

Recommendation topics to date include:

- Accountable Payment Models
  - Bariatric Surgery (2016)
  - Coronary Artery Bypass Graft Surgery (2015)
  - Lumbar Fusion (2014, re-reviewed 2018)
  - Total Knee and Total Hip Replacement Re-Review (2013, re-reviewed 2017)
- Addiction and Dependence Treatment (2014)
- Alzheimer's Disease and Other Dementias (2017)
- Cardiology (2013)
- Collaborative Care for Chronic Pain (2018)
- Behavioral Health Integration (2016)
- End-of-Life Care (2014)
- Hysterectomy (2017)
- Lesbian, Gay, Bisexual, Transgender, and Questioning or Queer Health Care (2018)
- Low Back Pain and Spine Surgery (2013)
- Obstetric Care (2012)
- Oncology Care (2015)
- Opioid Prescribing Guideline Implementation (2015, 2016, 2017)
- Opioid Use Disorder Treatment (2016)
- Pediatric Psychotropic Use (2016)
- Potentially Avoidable Hospital Readmissions (2014)
- Prostate Cancer Screening (2015)
- Suicide Care (2018)

Accountable Payment Models: Bariatric Surgery

Adopted November 2016 | Approved by HCA in February 2017

- **Read the Bariatric Surgical Bundled Payment Model here:** www.breecollaborative.org/wp-content/uploads/Bree-Bariatric-Bundle-Final-2016.pdf
- **Read the Bariatric Surgical Warranty here:** www.breecollaborative.org/wp-content/uploads/Bariatric-Warranty-Final-2016.pdf
- **Read the evidence table here:** www.breecollaborative.org/wp-content/uploads/Bariatric-Evidence-Table-Final-2016.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/apm/
    - Workgroup met from February to November 2016
- **Background**
    - The National Institutes of Health (NIH) defines obesity as a body mass index of equal to or greater than 30 kg/m^2.[30] According to this NIH definition, more than one third of adults in the United States are obese. Obesity is associated with increased likelihood of type 2 diabetes, high blood pressure, hyperlipidemia, cardiovascular disease, obstructive sleep apnea, osteoarthritis, and gastroesophageal reflux (heartburn). The national annual cost of obesity and its consequences approaches $150 billion.[31]
    - While there is no reliable long-term cure, even modest reductions in weight loss can convey benefit by controlling associated conditions such as diabetes, high blood pressure, and high cholesterol.
- **Our recommendations**
    - The workgroup used the three previous models for elective total knee and total hip replacement, elective lumbar fusion, and coronary artery bypass surgery as models. The Bariatric Surgical Bundle provides a voluntary, community-based, evidence-informed standard for production, purchasing, and payment of health care based on quality.
    - The four proposed cycles include:
        - Eligibility due to obesity despite non-surgical therapy
        - Fitness for surgery
        - Bariatric surgery
        - Post-operative care and return to function

Accountable Payment Models: Coronary Artery Bypass Graft Surgery

Adopted September 2015 | Approved by HCA in October 2015

- **Read the CABG Bundled Payment Model here:** www.breecollaborative.org/wp-content/uploads/CABG-Bundle-Final-15-09.pdf
- **Read the CABG Warranty here:** www.breecollaborative.org/wp-content/uploads/CABG-Warranty-Final-15-09.pdf
- **Read the evidence table here:** www.breecollaborative.org/wp-content/uploads/CABG-Evidence-Table-Final-15-09.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/apm/
    - Workgroup met from February to September 2015
- **Background**
    - Coronary artery disease occurs due to plaque build-up on arterial walls is the leading cause of death in the United States.[32] This is often treated with coronary artery bypass graft surgery (CABG). CABG surgery has high variation among providers and institutions in price, utilization, and complication rates.[33] Bundled payments offer a mechanism to improve and standardize this care and have been shown to reduce cost along with improving patient outcomes.[34]
- **Our recommendations**
    - The workgroup used the previous two models on elective total knee and total hip replacement and elective lumbar fusion as a model. The intent of the CABG surgical bundle is to provide a community-based, evidence-informed standard for the production, purchasing, and payment of health care based on quality. The workgroup proposed a four-stage model requiring:
        - Disability despite non-surgical therapy
        - Fitness for surgery
        - The CABG procedure
        - Post-operative care and return to function
- **Implementation**
    - The 2016 implementation survey found high rates of adoption of the recommendations among hospitals and low rates among health plans.
        - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
            - Hospital average: 2.2 Range: 2.0-2.8
            - Health Plan average: 0.4 Range: 0.0-1.0

Accountable Payment Models: Lumbar Fusion

Re-Review Adopted January 2019 | Approved by HCA February 2019

Originally Adopted September 2014 | Approved by HCA October 2014

- **Read the bundle and warranty here:** www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Bundle-and-Warranty-Final-2018.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/previous-topics/apm/
    - Workgroup met from January to December 2018.
- **Background**
    - There is broad agreement that lumbar fusion surgery is appropriate to mitigate the immediate threat of spinal instability from major trauma, tumor, infection, or congenital anomalies. Lumbar fusion also clearly conveys benefit for some patients with less pressing indications. However, when we reviewed this topic in 2014, we also found a disproportionate rise in lumbar fusion compared to other spine surgeries, high variation in quality and billed charges, and evidence that for many patients considered candidates for elective lumbar fusion, there was no clear benefit of surgery compared to non-surgical care.
    - The health care community in 2017 asked the Bree Collaborative to revise the lumbar fusion bundle. They asked for expanded inclusion criteria to increase clinical impact (e.g., moving from a limit of single-level fusion to allow for second surgeries, multi-level fusions, and complex fusions). They also sought greater flexibility in administering the bundle to improve access in rural areas.
- **Our recommendations:**
    - Changes included greater flexibility for provider or hospital selection of patient-reported outcomes, better definitions of conservative therapy, clinical updates based on newly available evidence, and changes to the clinical pathway to facilitate more efficient care. The 2018 bundle also includes revisions to the quality standards and a warranty but retain the structure of the four cycle model of:
        - Disability despite non-surgical therapy. Specification of the degree of functional impairment, imaging findings confirming lumbar instability that correlate with the symptoms and signs, at least three months of structured non-surgical therapy delivered by a collaborative team, shared decision making.
        - Fitness for surgery. Minimum standards to ensure safety and commitment to participate actively in return to function.
        - Spinal fusion procedure. General standards for the surgical team, elements of the surgical process, participation in registries.
        - Post-operative care and return to function
- **Implementation**
    - In July 2018, HCA selected two centers of excellence for lumbar fusion bundled payment aligned with the Bree Collaborative recommendations, Capital Medical Center and Virginia Mason Medical Center.

Accountable Payment Models: Total Knee and Total Hip Replacement Re-Review

Adopted November 2017 | Approved by HCA December 2017

Originally Adopted July 2013 | Approved by HCA October 2013

- **Read the bundle and warranty here:** www.breecollaborative.org/wp-content/uploads/TKRTHR-Bundle-Warranty-Final-2017.pdf
- **Read the evidence table here:** www.breecollaborative.org/wp-content/uploads/20171031_VM-EvidenceTables_TKR-THR.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/apm/
  - Workgroup met from December 2016 to November 2017.
- **Background**
  - Published hospital readmission rates for total knee and total hip replacements October 2013 available here: www.breecollaborative.org/wp-content/uploads/bree_summary_CHARS_Analysis.pdf
  - The total knee and total hip replacement bundle and warranty were originally adopted in July 2013 and November 2013 and approved by the HCA Director in April 2014.
  - The topic was selected for re-review in July 2016 and the revised version was adopted in November 2017 and approved by the HCA Director in December 2017.
- **Our recommendations**
  - The workgroup's goal is to improve patient safety, performance for providers, and affordability for purchasers through a four-stage model requiring:
    - Documenting disability despite explicit non-surgical care
    - Meeting fitness requirements for patients prior to surgery
    - Adhering to standards for best-practice surgery
    - Implementing a structured plan to rapidly return patients to function
- **Implementation**
  - The 2016 implementation survey found high rates of adoption of the 2012 recommendations among hospitals and low rates among health plans.
    - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
      - Hospitals Average 2.3 Range: 1.7-3.0
      - Health Plans Average: 1.0 Range: 0.0-2.0
  - Since January 2017, Virginia Mason Medical Center serves as a center of excellence for PEBB Program members enrolled in Uniform Medical Plan for total knee and hip replacement with a waived co-insurance and travel and lodging reimbursement.
  - In May 2019, Premera Blue Cross announced a new contract with Providence St. Joseph Health naming seven facilities as centers of excellence for total joint replacement following the Bree Collaborative guidelines.

Addiction and Dependence Treatment

Adopted January 2015 | Approved by HCA in February 2015

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/ADT-Final-Report.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/adt/
  - Workgroup met from April 2014 to January 2015.
- Alcohol and drug abuse disorders lead to many debilitating health, economic, interpersonal, and social consequences with potentially long-lasting effects if left untreated. In Washington State, alcohol use leads to 11.1 percent of deaths of working age adults, higher than the national average.[35] Medicaid clients with a substance use disorder had significantly higher physical health expenditures and hospital admissions.[36]
- **Our recommendations**
  - Recommendations focus on the integration of screening, brief intervention, and referral to treatment in primary, prenatal, and emergency room settings rather than specific treatment modalities or therapies through adoption of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model. SBIRT is an evidence-based paradigm seeking to encourage health care providers to systematically "identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs."[37] The strength of the SBIRT model is providing early motivational conversations with people prior to alcohol and other drug misuse overly impacting their lives.
  - **Focus areas**
    - Reduce stigma associated with alcohol and other drug screening, intervention, and treatment
    - Increase appropriate alcohol and other drug use screening in primary care and emergency room settings
    - Increase capacity to provide brief intervention and/or brief treatment for alcohol and other drug misuse
    - Decrease barriers for facilitating referrals to appropriate treatment facilities
    - Address the opioid use disorder epidemic
- **Implementation**
  - The 2016 implementation survey found the lowest overall rate of adoption.
    - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
      - Hospital average: 1.4 Range: 0.9-2.6
      - Medical Group average: 1.4 Range: 0.0-2.4
      - Health Plan average: 1.9 Range: 1.2-2.4
  - The two HCA Accountable Care Programs regularly train on the SBIRT model and have integrated a screening tool for alcohol use into electronic medical records and workflow.

Alzheimer's Disease and Other Dementias

Adopted November 2017 | Approved by HCA December 2017

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Alzheimers-Dementia-Recommendations-Final-2017.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/alzheimers/
    - Workgroup met from January to November 2017.
- **Background**
    - The decline in memory and other cognitive functions and corresponding loss of independence because of dementia is a growing concern in our aging population. Age is the biggest risk factor for dementia with prevalence rates of 13.9 percent in those 71 and older increasing to 37.4 percent for those 90 and older.[38] Washington State has the third highest rate of death from Alzheimer's disease of any state and Alzheimer's is the third highest age-adjusted cause of death within the state overall.[39] The number of people diagnosed with dementia is expected to increase 40 percent in the next 10 years and 181 percent over the next 30 years.[5] However, in many practices in Washington State, there are no guidelines to address quality of care for diagnosis or ongoing supportive care.[40]
- **Our recommendations**
    - The workgroup's goal is to align care delivery with the existing evidence-based standard of care for each stage of disease and across health care settings for patients and their families and caregivers and build off the previous work within Washington State, specifically the Washington State Plan to Address Alzheimer's Disease and Other Dementia.
    - The workgroup recommends early detection of mild cognitive impairment to better support patients and family members, but does not recommend population-level screening of older adults. The workgroup also recommends using a strengths-based approach that empowers both the patient and the caregiver.[41]
    - **Focus Areas**
        - Diagnosis
        - Ongoing care and support or management
        - Advance care planning and palliative care
        - Need for increased support and/or higher levels of care
        - Preparing for potential hospitalization
        - Screening for delirium risk
- **Implementation**
    - The 2019 budget included funding for two areas related to the recommendations:
        - A dementia ECHO project to spread access to experts in dementia care to primary care sites in Washington State.
        - For part time staff within Aging and Long Term Support Administration, Developmental Disabilities Administration, Department of Health and HCA to improve communication and collaboration among these agencies and integrate dementia into strategic plans and efforts.

Cardiology

Adopted January 2013 | Approved by HCA January 2014

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/bree_bc_cardiology_final.pdf
- **Learn more about the process:** www.breecollaborative.org/topic-areas/cardiology/
- **Four-step process**
    - **Step 1:** Appropriate use insufficient information report with 2012 data by hospital posted on the COAP members-only section of the Clinical Outcomes Assessment Program (COAP) website. (*Completed August 2012)*
    - **Step 2**: COAP provides feedback and tools to hospitals to reduce insufficient information in data. (*Completed August to December 2012)*
    - **Step 3**: Updated Appropriate Use Insufficient Information report based on 4th Quarter 2012 data only, by hospital, given to Collaborative and hospitals to review. Hospitals had the option not to be identified. (*Completed May 2013)*
    - **Step 4**: After hospitals employed methods for improvement, an updated report based on 4th Quarter 2012 data only was posted on the public section of the COAP website. The Bree Collaborative also asked the Washington Health Alliance to post COAP data on its Community Checkup website, which compares data on health care services around the state. Hospitals had the option to not be identified. (*Completed June 2013)*

- **Implementation**
    - The 2016 implementation survey found hospitals reporting full adoption (3 out of a possible 3).
    - COAP uses data specifications and definitions from the American College of Cardiology's National Cardiovascular Data Repository (NCDR) in tracking processes and outcomes for patients receiving percutaneous cardiac intervention (PCI). NCDR released a new PCI registry version Q2 2018 with significant changes to the data metrics. The Appropriate Use Criteria (AUC) metrics were the only metrics not released and are still in development by NCDR. Currently, COAP has Appropriate Use data through Q1 2018 only. The most recent rolling four quarters of data available (Q2 2017-Q1 2018) showed that of the 3,443 Non Acute PCIs performed in Washington State, 23.8 percent could not be classified due to insufficient testing and/or documentation (from 36.4 percent in 2012). Of those 2,623 cases that were classified, 60.6 percent were Appropriate (from 41.1 percent in 2012), 26.8 percent were May Be Appropriate (from 38.1 percent in 2012), and 12.5 percent were Rarely Appropriate (from 20.2 percent in 2012). COAP will provide the remainder of 2018 AUC data once the new metrics have been released by NCDR and specifications have been built into the data system.

Collaborative Care for Chronic Pain

Adopted January 2019 | Approved by HCA in December 2017

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Recommendations-Chronic-Pain-Final-2018.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/previous-topics/chronic-pain/
    - Workgroup met from January to November 2018.
- **Background**
    - About 11 percent of Americans experience chronic pain, defined as pain lasting three months or longer. Some surveys have estimated chronic pain to impact closer to 30 percent of our population. [42,43] Treating chronic pain is widely variable, with high financial and human cost. Research shows that moving to a collaborative or team-based approach to managing complex pain, based on models of care designed to manage chronic illness and depression, results in improved patient outcomes.[44,45] Additionally, researchers recommend multidisciplinary care (or using more than one approach) due to the complexity of pain.[46] However, most approaches to pain management, including chronic opioid therapy, involved siloed health care providers. There is also a lack of consensus around which elements of a systems-based model are critical and which resources are necessary to support the model.
- **Our recommendations**
    - This workgroup developed recommendations for collaborative care specific to chronic pain with life activity impacts. The recommendations are built on supporting patient self-management in the context of a biopsychosocial model and acknowledge the high number of people with unmet need due to gaps in or lack of comprehensive care.
    - Collaborative care uses primary care as the medical home for acute and chronic pain treatment and management through a systems-based approach with goals of improved function, increased quality of life, and greater patient autonomy rather than a primary focus on pain relief.
    - Focus areas include:
        - Patient identification and population management
        - A care team
        - A care management function
        - Basing treatments in evidence-informed care
        - Patient-centered supported self-management

Behavioral Health Integration

Adopted March 2017 | Approved by HCA April 2017

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf
- **Learn more about the workgroup:** www.breecollaborative.org/topic-areas/behavioral-health/
    - Workgroup met from April 2016 to March 2017.
- **Background**
    - Approximately 16-23 percent of Americans experience a major depressive episode in their lifetimes, 7.6 percent in any two-week period.[47,48,49] Depression is especially common among those with a chronic illness, such as diabetes, resulting in lower adherence to clinical recommendations, worse physical functioning, and higher cost.[50]
    - There are many barriers to services, such as: far greater stigma attached to mental health and substance abuse diagnoses than for other conditions; a less developed infrastructure for measuring and improving care quality; lack of connectivity between clinicians, specialists, and organizations; lower use of health information technology; and barriers in the health insurance marketplace.[51]
- **Our recommendations**
    - Focused on integrating behavioral health care services into primary care for those with behavioral health concerns and diagnoses for whom accessing services through primary care would be appropriate.
    - The workgroup defined integrated behavioral health care to create a common vocabulary and focused on using available evidence and existing models to develop eight common elements that outline a minimum standard of integrated care meant to bridge the different models used throughout Washington State and across the country and include structural and process definitions for:
        - Integrated care team
        - Patient access to behavioral health as a routine part of care
        - Accessibility and sharing of patient information
        - Practice access to psychiatric services
        - Operational systems and workflows to support population-based care
        - Evidence-based treatments
        - Patient involvement in care
        - Data for quality improvement
- **Implementation**
    - Bree Collaborative standards for integrating behavioral health into primary care to inform the development of required Accountable Communities of Health projects under the Medicaid Transformation Project.

End-of-Life Care

Adopted November 2014 | Approved by HCA in December 2014

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/EOL-Care-Final-Report.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/eol/
    - Workgroup met from January to November 2014.
- End-of-life care in the United States and within Washington State is strikingly variable and often misaligned with patient preference.[52,53] Although the majority of patients report wanting to spend the last part of their lives at home, in reality much of this time is spent in a hospital or nursing home.[54]
- **Our recommendations**
    - The workgroup's goal that all Washingtonians are informed about their end-of-life care options, communicate their preferences in actionable terms, and receive end-of-life care that is aligned with their and their family members' goals and values.
    - **Focus areas**
        - Increase awareness of advance care planning, advance directives, and Physician Orders for Life-Sustaining Treatment (POLST)
        - Increase the number of people who participate in advance care planning in clinical and community settings
        - Increase the number of people who record their wishes and goals for end-of-life care using documents that accurately represent their values, are easily understandable by all readers (including family members, friends, and health care providers), and can be acted upon in the health care setting
        - Increase the accessibility of completed advance directives and POLST for health systems and providers
        - Increase the likelihood that a patient's end-of-life care choices are honored
- **Implementation**
    - The 2016 implementation survey indicates high rates of adoption of the recommendations among hospitals and medium rates among medical groups and health plans.
        - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
            - Hospital average: 2.2 Range: 1.7-2.6
            - Medical Group average: 1.7 Range: 0.0-2.5
            - Health Plan average: 1.8 Range: 1.0-3.0
    - Advance care planning conversations are reimbursable by Medicaid in clinical settings. Private health plans including Premera, Regence, and others have been reimbursing for advance care planning conversations since January 2016.
    - Honoring Choices® Pacific Northwest (PNW), a joint initiative of WSHA and the WSMA Foundation, has been working to ensure everyone will receive care that honors personal values and goals at the end of life. Since 2015, Honoring Choices PNW has partnered with 42 teams at 31 organizations to provide advance care planning in individual and group settings. To date, over 12,000 meaningful ACP

conversations have occurred. The largest areas of growth are in educational presentations and group ACP conversations, which reach more people more efficiently; a win-win given limited health care resources. For the second year in a row, Governor Inslee issued a proclamation recognizing April 16, 2019 as "Healthcare Decisions Day," increasing awareness about advance care planning and advance directives. Honoring Choices PNW promoted a social media campaign and contest that resulted in over 1,000 ACP interactions during Healthcare Decisions Day. Honoring Choices PNW staff developed new curricula to improve the clinical skills of frontline health care providers on basic ACP and POLST conversations and to spread knowledge and start conversations in the communities. As envisioned early on, community groups are increasingly engaged in ACP work. Staff are pleased to have diverse partners, ranging from AARP to individual church groups. In the coming year, Honoring Choices PNW will focus efforts on community partnerships, provider education, advocacy, and a central repository for advance directives and POLST. For more information visit www.honoringchoicespnw.org.

- HCA has incorporated recommendations for advance care planning in primary and hospital care into the PEBB Program Accountable Care Network contracts.

Hysterectomy

Adopted January 2018 | Approved by HCA February 2018

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Hysterectomy-Final-Report-2018.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/hysterectomy/
    - Workgroup met from March 2017 to January 2018.
- **Background**
    - Hysterectomy is one of the most common surgical procedures in the United States, with approximately 600,000 performed annually.[55] Hysterectomy rates are highly variable by hospital and by region, indicating overuse.[56] Washington Health Alliance analysis reveals that rates are also highly variable based on location in Washington State.[57]
- **Our recommendations**
    - The workgroup's goal is to promote appropriate use of hysterectomy, including pre-surgical counseling and evaluation, while recognizing individual variation based on clinical opinion and patient preference. Workgroup members developed the recommendations to encourage clinicians to review guidelines with patients prior to surgery to reduce unnecessary or inappropriate hysterectomies.
    - The recommendations are applicable for uterine leiomyoma (fibroids), abnormal menstrual bleeding, endometriosis, uterine prolapse, adenomyosis, and pain. For each of the inclusions, the workgroup has developed protocols for assessment, medical management, and uterine sparing procedures.
    - The recommendations exclude pregnancy, cancer and cancer prevention, emergencies (e.g., due to trauma, childbirth), gender reassignment surgery, and incidental hysterectomy with indicated oophorectomy.
    - **Focus Areas**
        - Assessment and medical management, by indication
        - Uterine sparing procedures, by indication
        - Surgical procedure including follow-up care, emphasizing the enhanced recovery after surgery protocol and use of a minimally invasive approach. The Enhanced Recovery After Surgery (ERAS) protocol fits well with gynecological surgery and has been associated with reduced opioid use, length of stay, and cost; stable readmission; incidence of side effects; and improved patient satisfaction.[58,59]

Lesbian, Gay, Bisexual, Transgender, and Questioning or Queer Health Care

Adopted September 2018 | Approved by HCA November 2018

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/LGBTQ-Health-Care-Report-and-Recommendations01.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/previous-topics/lgbtq-health-care/
    - Workgroup met from December 2017 to September 2018.
- **Background**
    - Building a health care system that allows everyone to have a fair opportunity to be healthier is a goal across Washington State. Approximately 3.5 percent of Americans identify as lesbian, gay, or bisexual and 0.3 percent of American adults are transgender. LGBTQ people share common challenges and have health care needs distinct from those who do not identify as LGBTQ.[60] While all people share baseline health care needs, the LGBTQ population is also at a higher risk for specific medical problems.[61] Those who identify as LGBTQ are diverse and from many socioeconomic backgrounds, races, ethnicities, and cultures. Disparities can be magnified when LGBTQ persons are also part of a racial or ethnic minority, a fact important to policy initiatives and clinical care.[62]

- **Our recommendations**

    - These recommendations seek to align care delivery with existing evidence-based, culturally sensitive standards of care for LGBTQ people in Washington State and through that effort to decrease health disparities. The workgroup based recommendations in a whole-person care framework, taking into consideration a person's multiple individual factors that make up health, wellness, and experience (e.g., behavioral health, past trauma, race/ethnicity) in such a way that is not identity or diagnosis-limiting. We organize the recommendations under three focus areas:
        - Communication, Language, and Inclusive Environments
        - Screening and Taking a Social and Sexual History
        - Areas Requiring LGBTQ-Specific Standards and Systems of Care
    - We recommend that all health care encounters occur using non-judgmental, non-stigmatizing language, body language, and tone.

Low Back Pain and Spine Surgery

Adopted November 2013 | Approved by HCA January 2014

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/spine_lbp.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/spine/
  - Workgroup met from November 2012 to October 2013.
- **Our recommendations**
  - Appropriate evaluation and management of patients with new onset and persistent acute low back pain and/or nonspecific low back pain not associated with major trauma (no red flags) in primary care
  - Early identification and management of patients that present with low back pain not associated with major trauma (no red flags) but have psychosocial factors (yellow flags) that place them at a high risk for developing chronic low back pain
  - Awareness of low back pain management among individual patients and the general public
- **Implementation**
  - The 2016 implementation survey found high rates of adoption of the recommendations among hospitals and low rates among medical groups and health plans.
    - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
      - Hospital average: 2.0 Range: 1.0-3.0
      - Medical Group average: 1.8 Range: 0.5-2.8
      - Health Plan average: 1.2 Range: 0.7-1.7
  - The Washington Health Alliance Community Checkup reports a 2017 statewide rate for avoiding X-ray, magnetic resonance imaging (MRI), and computed tomography (CT) for low-back pain of 81 percent for commercial insurance and 76 percent for Medicaid.[63]
- **Community Partner: Spine Surgical Care and Outcomes Assessment Program**
  - In March 2013, the Bree Collaborative submitted recommendations to HCA strongly recommending participation in Spine COAP as a community standard and requiring that information be transparent.
  - Implementation
    - As of spring 2019, 18 hospitals are enrolled in Spine SCOAP.
    - As of August 2014, length of stay, radiologic verification of surgical level, and smoking use have been transparently available on the Spine SCOAP website.

Obstetric Care

Adopted August 2012 | Approved by HCA October 2012

- **Read the report here:** www.breecollaborative.org/wp-content/uploads/bree_ob_report_final_080212.pdf
- **Learn more about our workgroup here:** www.breecollaborative.org/topic-areas/obcare/
  - Workgroup met from December 2011 to July 2012
- **Our recommendations**
  - Elective deliveries. Eliminate all non-medically necessary early elective deliveries before the 39th week (those deliveries for which there is no appropriate documentation of medical necessity for early elective delivery).
  - Elective inductions of labor. Decrease elective inductions of labor between 39 and up to 41 weeks.
  - Primary Cesarean-sections (C-sections). Decrease unsupported variation among Washington hospitals in C-section rate of women who have never had a C-section.
- **Implementation**
  - HCA has implemented a non-payment policy for early elective deliveries for Medicaid.
  - The 2016 implementation survey found high rates of recommendation adoption among hospitals and medical groups:
    - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
      - Hospital average: 2.8 Range: 1.9-3.0
      - Medical Group average: 2.8 Range: 2.4-3.0
      - Health Plan average: 2.0 Range: 1.0-3.0
  - The Bree Collaborative is currently convening a workgroup to develop a bundled payment model for maternity care that will include and revise some of these recommendations.
  - The 7 hospitals continuously participating in the Obstetrics Clinical Outcomes Assessment Program (OB COAP) from 2014-2018 had an increase from 2014 to 2018 in primary cesarean rate (patients with no prior history of cesarean section) from 17.1 percent to 19.1 percent. Primary term, singleton, vertex (PTSV) Cesarean section rate rose from 13.1 percent to 14.5 percent, and in cervix on admission >=4cm from 61.1 percent to 68.5 percent.
  - The Safe Deliveries Roadmap (SDR) program partners with all 58 Washington non-military birthing hospitals in improving maternal and infant health outcomes through innovative programs combining data collection, analysis and reporting, monthly education from subject matter experts, peer to peer coaching calls, in-person learning collaboratives, implementation of evidence-based best practices and hospital site visits. During site visits SDR staff review hospital data, identify areas of success and discuss opportunities.
  - The Safe Deliveries Roadmap program at WSHA continues to collect and report data for early elective deliveries prior to 39 weeks, primary term singleton vertex (PTSV) Cesarean section rates and induction of labor with an unfavorable cervix. The early

elective delivery rate for Washington hospitals for 2018 was 1.4 percent (80 percent reduction from 2011 baseline). Washington hospitals' PTSV Cesarean section rates have increased slightly from 2017 to 2018 with a rate of 14.5 percent (note: 85 percent of hospitals reporting) the rate is still slightly lower than the Results Washington goal of 14.7 percent and the baseline 2010 rate of 16.1 percent. The 2018 Washington state rate for induction of labor with unfavorable cervix is 0.3 percent.

Oncology Care

Adopted March 2016 | Approved by HCA in April 2016

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Oncology-Care-Final-Recommendations-2016-03.pdf
- **Learn more about the workgroup:** www.breecollaborative.org/topic-areas/oncology-care/
    - Workgroup met from May 2015 to March 2016.
- While cancer death rates have declined due in part of advances in prevention and treatment, cost of care has increased significantly, resulting in financial burden on patients and families. [64] Cost and quality can also vary, indicating the need for greater standardization and reduction in procedures that do not result in better patient health.[65,66] In 2012, the American Society of Clinical Oncology (ASCO) identified five tests or procedures "whose necessity is not supported by high-level evidence" and developed guidelines around therapeutic effectiveness and palliative care and use of advanced imaging for staging of low risk breast and prostate cancer.[67]
- **Our recommendations:**
    - As part of Choosing Wisely, ASCO recommends:
        - Do not use PET [positron emission tomography], CT [computed tomography] and radionuclide bone scans in the staging of early prostate cancer at low risk of spreading.
        - Do not use PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk of spreading.
    - In alignment with the End-of-Life Care Recommendations, oncology care should be aligned with a patient's individual goals and values. Patients should be appraised of harms, benefits, evidence, and potential impact of chemotherapy and radiation at all stages in illness trajectory and should regularly discuss goals of care and work to tailor care to goals.
- **Implementation**
    - The 2016 implementation survey found high rates of adoption for hospitals and medical groups.
        - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
            - Hospital average: 2.1 Range: 1.8-2.7
            - Medical Group average: 2.2 Range: 0.0-3.0
            - Health Plan average: 1.4 Range: 0.0-3.0
    - The Hutchinson Center for Cancer Outcomes Research (HICOR), at Fred Hutchinson Cancer Research Center, works to improve quality and lower oncology cost by reporting data of WA's largest public and commercial insurance providers. Change in metrics related to palliative care from last year (2014-2016) to this year (2015-2017) include: chemotherapy in the last 14 days of a person's life from 5.6 percent to 5.7 percent, two or more emergency department visits in the last 30 days 15.4 percent to 16.4 percent, intensive care unit stay in the last 30 days from 24.1

percent to 24.5 percent, and hospice at least three days prior to death from 61.6 percent to 61.7 percent.

Opioid Prescribing Guideline Implementation

This is an ongoing workgroup focused on implementing the Washington State Agency Medical Directors Guideline on Prescribing Opioids for Pain, endorsed by the Bree Collaborative in July 2015. The information below profiles the workgroup's products from December 2015 to October 2018. Two primary focus areas have been to develop opioid prescribing metrics and a guideline on prescribing opioids in dentistry.

Learn more about the workgroups here: www.breecollaborative.org/topic-areas/opioid/

Opioid Prescribing Metrics

Adopted August 2017 | Approved by HCA August 2017

- **See the Opioid Prescribing Metrics here:** www.breecollaborative.org/wp-content/uploads/Bree-Opioid-Prescribing-Metrics-Final-2017.pdf
- The metrics were designed to be limited in number, have a strategic focus, and to be used for quality improvement. The first six metrics focus on guideline-concordant prescribing including chronic opioid use, opioid dose, concurrent chronic sedative use, and transition from short-term to long-term opioid use. The last three metrics focus on mortality, overdose morbidity, and prevalence of opioid use disorder.
- One of the primary goals of this metric set is to be short and actionable. The workgroup discussed other potential metrics that are of high interest but are not yet ready for specification and implementation and are out of the scope of a workgroup focused on prescribing practices. These and other metrics may be developed at a future date. Outreach to the Washington State health care community to adopt the metrics is ongoing.
- **Implementation**
    - All metrics are being used by the Washington State Department of Health with a dashboard by county that is available using data from the Prescription Monitoring Program at the WA State department of Health. www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/OpioidPrescriptionsandDrugOverdosesCountyData. Rates shown below are per 1000 showing change from quarter 1 2012 to quarter 4 2018
        - Any opioid prescription decreased from 98.2 to 68.7 per 1000
        - Chronic opioid prescription decreased from 19.3 to 17.1 per 1000
        - High-dose chronic opioid prescriptions decreased from 7.6 to 5.4 per 1000
        - Concurrent opioid and sedative prescriptions decreased from 19.5 to 11.2 per 1000
    - Three metrics (i.e., new opioid patients transitioning to chronic opioids, patients prescribed high-dose chronic opioid therapy, new opioid patients' days' supply of first opioid prescription) have been adopted and will be included in the State Common Measure Set by the Performance Measures Coordinating Committee.

- HCA has implemented opioid prescribing policy consistent with Bree recommendations in Medicaid and Uniform Medical Plan.
- The Oregon Health Authority has added the definition for percent of patients transitioning from acute to chronic opioid prescribing to their dashboard.

Dental Guideline on Prescribing Opioids for Pain

Adopted September 2017 | Approved by HCA October 2017

- **Read the guideline here:** www.breecollaborative.org/wp-content/uploads/Dental-Opioid-Recommendations-Final-2017.pdf
- The guideline was developed in collaboration with a broad advisory group of academic leaders, pain experts, and dentists in general care and specialty areas in response to the growing epidemic of opioid-related overdoses. The guideline supplements the Agency Medical Director's Group (AMDG) Interagency Guideline on Prescribing Opioids for Pain. Work will continue to encourage adoption of the recommendations.
- **Implementation**
  - The Department of Labor and Industries held multiple conferences in Spokane and Seattle in 2018 educate the dental community about the guidelines.

Perioperative Opioid Prescribing

Adopted July 2018 | Approved by HCA August 2018

- See the Perioperative Opioid Prescribing Guideline here: www.breecollaborative.org/wp-content/uploads/Final-Supplemental-Bree-AMDG-Postop-pain-091318-wcover.pdf
- The included evidence represents a rapidly evolving literature on appropriate postoperative opioid prescribing. The recommendations in this supplement are based on the current best available clinical and scientific evidence from the literature and a consensus of expert opinion, and should be seen as an addition to, rather than a replacement of, the guidelines for opioid prescribing for postoperative pain in the 2015 guideline.
- For all surgery types, we recommend the clinician prescribe non-opioid analgesics (e.g., nonsteroidal anti-inflammatory drugs (NSAIDs), acetaminophen, and non-pharmacologic therapies as first line therapy. Rationale for any exceptions should be well documented in the record. Even in these exceptions the initial prescription should not exceed two weeks. Bree classifications are constructed around evidence to date to serve as a guide for procedures with similar degrees of expected post-op pain and include:
  - People younger than 24 years old. Dental extractions (e.g., third molar, wisdom tooth removal)
  - Adults
    - Type I – Expected rapid recovery: dental extractions or simple oral surgery (e.g., graft, implant); procedures such as hernia repair, etc
    - Type II –Expected medium term recovery: Procedures such as ACL repair, rotator cuff repair, etc.
    - Type III – Expected longer term recovery: Procedures such as lumbar fusion, knee replacement, etc.

- Patients on Chronic Opioid Analgesic Therapy

Clinician Outreach

- **See the Guidelines on Prescribing Opioids for Acute Pain for Providers fact sheet:** wahealthalliance.org/wp-content/uploads/2017/01/Opioid-Prescribing-Guidelines-for-Providers.pdf
- **See Opioid Medication and Pain: What You Need to Know fact sheet for patients:** wahealthalliance.org/wp-content/uploads/2017/01/Opioid-Medication-Pain-Fact-Sheet-revised.pdf
- The Bree Collaborative partnered with the Washington Health Alliance to develop a call to action for health care systems and for health insurance plans to follow responsible opioid prescribing coupled with fact sheets for providers and for patients aligned with AMDG Opioid Prescribing Guidelines.
- These materials were made available online and through dissemination to health systems, hospitals, and plans in January 2017.
- **Implementation**
    - HCA shared joint Bree Collaborative/Washington Health Alliance communications about opioid prescriptions with providers and patients.
    - The State of Alaska Department of Health and Social Services has adopted the fact sheets for their community and are using the materials widely.
    - Seattle King County Department of Health has posted the fact sheets on their website and translated them into 21 languages here: www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/task-forces/heroin-opiates-task-force.aspx#documents

Opioid Use Disorder Treatment

Adopted November 2017 | Approved by HCA December 2017

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/OUD-Treatment-Final-2017.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/oud-treatment/
    - Workgroup met from December 2016 to November 2017.
- **Background**
    - Drug overdose is the leading cause of accidental death in the United States, driven predominantly by opioid addiction.[68] Among those under 50 years of age, drug overdose is the leading cause of death. In 2016, the number of annual deaths by drug overdose increased 19 percent over the previous year to exceed 59,000.[69] High schoolers who receive only one opioid prescription are 33 percent more likely than those who do not receive such a prescription to misuse opioids between the ages of 18-23 years.[70]
- **Our recommendations**
    - The workgroup's goal is a health care system that identifies people with opioid use disorder and facilitates access to comprehensive, evidence-based treatment with the patient at the center of care. This approach works to ensure that care is available when a patient is ready.
    - The workgroup endorses a "no wrong door" approach for patients wanting to access opioid use disorder treatment from a variety of settings. To support this, the workgroup developed recommendations to guide providers delivering care within a variety of settings. The goal for all settings is that patients receive the care they need at the time and in the setting of their choice, reduce illicit opioid use, and have no overdose events.
    - **Focus areas**
        - Access to Evidence-Based Treatment
            - Medication treatment: buprenorphine, methadone, naltrexone (e.g., increase geographic reach, increase number of providers)
            - Reduction in stigma associated with treatment
        - Referral Information
            - Providers and patients know where to access care
            - Accessible inventory of buprenorphine and methadone prescribers
            - Referral infrastructure that supports patients and providers
        - Integrated Behavioral and Physical Health to Support Whole-Person Care
            - Treatment of comorbid conditions including multiple substance use, mental illness, and physical health in line with Behavioral Health Integration Report and Recommendations

Pediatric Psychotropic Use

Adopted November 2016 | Approved by HCA January 2017

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Antipsychotic-Recommendations-Final-2016.pdf
- **Learn more about the workgroup:** www.breecollaborative.org/topic-areas/psychotropics/
    - Workgroup met from January to November 2016.
- **Background**
    - Antipsychotic prescribing rates have dramatically and consistently increased for adolescents and young adults.[71] Nationally, between 2002 and 2007, there has been a 62 percent increase in atypical antipsychotic (or second-generation) use among children enrolled in Medicaid.[72] High numbers of prescriptions are problematic and potentially harmful, as evidence shows that atypical antipsychotic use is associated with patient harms including obesity, suicidality, tics, and other effects on the developing brain.[73] Additionally, long-term research on the effects of atypical antipsychotic use in youth is lacking.
    - The United States Food and Drug Administration (FDA) has approved antipsychotic medications for use in children and adolescents with schizophrenia, bipolar disorder (manic/mixed), and irritability with autistic disorder. In addition to the FDA-approved indications, antipsychotics have been found to be helpful in reducing disruptive behavior in children and adolescents *without* psychosis, allowing the child or adolescent to remain in school, in home, and receptive to other forms of therapy. These off-label uses of antipsychotic agents (i.e., for conditions not approved by the FDA) include aggressive, impulsive, and disruptive behaviors, often in patients with attention-deficit hyperactivity disorder (ADHD), in the absence of psychosis.[74]
- **Our recommendations**
    - Targeted at children and adolescents under age 21 without a diagnosis of an FDA-approved indication for an antipsychotic prescription.
    - **Focus Areas**
        - Conduct initial medical and psychological evaluation using appropriate assessment
        - Ensure that the patient and family has access to comprehensive, family-centered psychosocial care whether within the primary care setting through integrated behavioral health care or through a supported referral
        - Use evidence-based, best practice antipsychotic prescribing recommendations such as from the American Academy of Child and Adolescent Psychiatry
        - If antipsychotics are prescribed, manage side effects including monitoring for changes in weight blood glucose (HgA1C), cholesterol, and other metabolic changes (baseline and at regular intervals)

Potentially Avoidable Hospital Readmissions

Adopted July 2014 | Approved by HCA in August 2014.

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Readmissions-Report-FINAL-14-0730.pdf
- **Read the 30-day, all-cause re-hospitalization rates at Washington State hospitals data here:** www.breecollaborative.org/wp-content/uploads/combined-chars-report-13-1114.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/par/
    - The workgroup met from April to June 2014.
- **Our recommendations:**
    - Forming Collaboratives: Hospital readmissions collaboratives to be recognized by a formal charter, meeting participation, and recognition by WSHA or Comagine Health (previously Qualis Health)
    - Toolkit: Support for the tools and techniques to reduce readmissions in Washington State, especially the WSHA's *Care Transitions Toolkit, second edition*, the work done by Qualis Health, and the work done by the Washington Health Alliance
    - Measurement: Two hospital-specific measures aligned with the Medical Quality Incentive Program measured by WSHA for specific conditions for (a) patient discharge information to primary care provider and (b) documented follow-up phone call
- **Implementation:**
    - The 2016 implementation survey found medium rates of adoption of the recommendations among hospitals and high rates among medical groups and health plans.
        - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
            - Hospital average: 1.6 Range: 0.0-3.0
            - Medical Group average: 2.5 Rage: 1.8-3.0
            - Health Plan average: 2.7 Range: 2.0-3.0
    - The Washington State Hospital Association reports on Washington state average rates for hospital-specific measures including readmissions in general and readmissions for specific conditions as compared to the national average as follows: heart attack 15.3 percent compared to 16 percent, heart failure 20.8 percent compared to 21.7 percent, pneumonia 15.9 percent compared to 16.7 percent, hip and knee replacement 3.8 percent compared to 4.2 percent, and hospital-wide 14.4 percent compared to 15.3 percent.
    - As part of their hospital quality improvement efforts, CMS contracted QIOs to establish and support coalitions in reducing hospital readmissions. Comagine Health currently supports six coalitions across the state working on care transitions and patient safety via data reports, facilitation, content development and technical assistance. The coalitions have diverse participation, ranging from hospitals, skilled nursing facilities (SNF), community-based organizations and other post-acute facilities. Their efforts and focuses vary across the state, but often, they choose

topics and/or projects that other coalitions have had success with. They learn about other coalition efforts through the Comagine Health hosted quarterly Coalition Leadership Roundtable Call. This call brings together leaders of community care transitions coalitions across Idaho and Washington. The calls are designed to encourage discussion around priority topic areas and promote successful community projects aiming to improve care transitions.

Prostate Cancer Screening

Adopted November 2015 | Approved by HCA in January 2016

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Prostate-Cancer-Recommendations-Final-15-11.pdf
- **Learn more about the workgroup:** www.breecollaborative.org/topic-areas/prostate-cancer-screening/
    - Workgroup met from March to November 2015.
- Prostate cancer is the most common type of cancer diagnosed among men.[75] The prostate specific antigen (PSA) test is commonly used to screen men for prostate cancer. However, evidence conflicts as to whether the PSA test when used for prostate cancer screening has been associated with reduction in prostate cancer mortality.[76,77] The potential for overtreatment or treatment when no disease is present is high.[78]
- **Our recommendations:**
    - All men be evaluated by their provider for family history and factors that may elevate the risk of prostate cancer (e.g., sibling or parent with a prostate or breast cancer diagnosis, race).
    - To refrain from routine screening with PSA testing for average risk men 70 years and older, under 55 years old, who have significant co-morbid conditions, or with a life expectancy less than 10 years.
    - For primary care clinicians, two possible pathways, depending on the physician's interpretation of the evidence.
        - Clinicians who believe there is overall benefit from screening with PSA testing should order this test for average risk men between 55-69 years old only after a formal and documented shared decision-making process.
        - Clinicians who believe there is overall harm from screening with PSA testing may initiate testing of average-risk men aged 55-69 at the request of the patient after a formal and documented shared decision-making process.
    - Only men who express a definite preference for screening after discussing the advantages, disadvantages, and scientific uncertainty should have screening with PSA testing.
- **Implementation**
    - The 2016 implementation survey found high rates of adoption for hospitals, medium rates for medical groups, and low rates for health plans.
        - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
            - Hospital average: 2.3 Range: 2.0-3.0
            - Medical Group average: 1.6 Range: 0.0-2.8
            - Health Plan average: 0.7 Range: 0.0-3.0

Suicide Care

Adopted September 2018 | Approved by HCA October 2018

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Suicide-Care-Report-and-Recommendations-Final.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/previous-topics/suicide-care/
    - Workgroup met from March 2017 to January 2018.
- **Background**
    - Suicide is both a preventable outcome and a public health issue.[79] The effect of a suicide on family members, friends, and clinical providers is long-lasting and profound.[80,81] Rates of suicide have increased in nearly every state from 1999 to 2016 with a 19 percent increase in Washington State.[82] Suicide is the second leading cause of death among those aged 15-34 and the fourth leading cause of death among those aged 35-44, resulting in approximately one death every twelve minutes.[83] Rates of suicide are higher among those who are non-Hispanic American Indian/Alaska Native, middle-aged adults, those who live in rural areas, and veterans and other military personal and show great geographic variation.[84,85]
- **Our recommendations**
    - The workgroup worked closely with and built from the Washington Suicide Prevention Plan released in January 2016 and the previous Bree Collaborative recommendations on integrating behavioral health into primary care released in March 2017. Recommendations are applicable to in- and out-patient care settings including for care transitions, behavioral health providers and clinics, and for specialty care (e.g., oncology).
    - **Focus Areas**:
        - Identification of suicide risk
        - Assessment of suicide risk
        - Suicide risk management
        - Suicide risk treatment
        - Follow-up and support after a suicide attempt
        - Follow-up and support after a suicide death

Implementation Survey

In 2016 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.

See the survey tools: www.breecollaborative.org/implementation/

Staff 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. A numeric scale was used to rate implementation of specific recommendations including: 0-No action taken; 1-Actively considering adoption; 2-Some/similar adoption; and 3-Full adoption.

The survey found varying degrees of adoption. Recommendations for obstetrics care, cardiology, and the Spine SCOAP program were most fully implemented. All these recommendations work with or within existing, established programs. Among hospitals and medical groups, screening and treatment for alcohol and substance use disorder showed the lowest level of adoption. Among health plans, the surgical bundles were least adopted. Within the topic-specific recommendations, the survey found trends including low adoption of patient screening and assessment tools and patient decision aides. Specific implementation scores are shown in Table 1.

Table 1: Implementation scores by topic

Topic	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)
Obstetric 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	3.0 (3.0-3.0)	-	-

Implementation Roadmap

The implementation roadmap outlines steps that provider organizations and health plans can take to implement Bree Collaborative recommendations, and strategies to overcome implementation barriers.

See the Implementation Roadmap here: www.breecollaborative.org/wp-content/uploads/Bree-Implementation-Roadmap-Final-17-04.pdf

Table 2: Top enablers and barriers affecting recommendation implementation

	Top Enablers	Top Barriers
Providers	Existing organizational improvement program for minimizing errors and waste	Lack of availability and credibility of data, and the burden of collecting it
	Business case- evidence of economic reward	Business case- no economic reward, and lack of contract partners interested in value-based purchasing
	Consensus on what constitutes quality of care	Lack of consensus on what constitutes quality of care
	Individual provider-level performance feedback	
Health Plans	Sufficient market share/volume	Insufficient market share/volume
	Contract partners interest in value-based purchasing	Burden/ease of collecting or obtaining data
	Consistency in findings across multiple measures	Business case- evidence of economic reward

Looking Forward to Year Nine

The Bree Collaborative received funding to focus on implementation for 2020 and 2021 and looks forward to holding conferences to kick-off these two implementation focused years, and hiring staff for technical assistance. Additionally, the Collaborative will continue to be a key part of building a Healthier Washington. Bree Collaborative recommendations have had a direct impact on HCA's purchasing strategies, influencing the Accountable Care Networks contract, the center of excellence for total knee and total hip replacement bundled payment model, and for lumbar fusion and have helped inform contracting for private health plans.

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

The active workgroups will continue to meet and will present recommendations to the Bree Collaborative in fall 2019. New workgroups will convene in early 2020 to develop recommendations.

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Appendix A: Bree Collaborative Background

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

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

A steering committee advises the chair. The committee is comprised of Bree Collaborative members representing a health care purchaser, health plan, health care system, and quality improvement organization. See **Appendix C** for a current list of steering committee members.

The Bree Collaborative is housed in the Foundation for Health Care Quality. The Foundation provides project management and is responsible for employing staff. Funding from the HCA is secure through June 2020 as part of the state's budget process through a four-year grant.

The Bree Collaborative has held meetings since 2011. Meetings are Find agendas and materials for all Collaborative meetings on the Bree Collaborative website: www.breecollaborative.org. All Collaborative meetings are open to the public and follow the Open Public Meetings Act.

At the November 2012 meeting, the Bree Collaborative adopted bylaws setting policies and procedures governing the Bree Collaborative beyond the mandates established by the legislation (ESHB 1311). The Collaborative revised bylaws in September 2014.

Find current bylaws at: www.breecollaborative.org/wp-content/uploads/bylaws-final.pdf

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

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

- Goals for appropriate utilization rates
- Peer-to-peer consultation

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

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

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

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

Appendix B: Bree Collaborative Members

Member	Title	Organization
1. Susie Dade, MS	Deputy Director	Washington Health Alliance
2. Peter Dunbar, MB, ChB, MBA (Vice-Chair)	CEO	Foundation for Health Care Quality
3. Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
4. Stuart Freed, MD	Chief Medical Officer	Confluence Health
5. Richard Goss, MD	Medical Director	Harborview Medical Center, University of Washington
6. Wm. Richard Ludwig, MD	Chief Medical Officer, Accountable Care Organization	Providence Health and Services
7. Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
8. Robert Mecklenburg, MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
9. Kimberly Moore, MD	Associate Chief Medical Officer	Franciscan Health System
10. Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
11. Drew Oliveira, MD	Executive Medical Director	Regence BlueShield
12. Mary Kay O'Neill, MD, MBA	Partner	Mercer
13. John Robinson, MD, SM	Chief Medical Officer	First Choice Health
14. Jeanne Rupert, DO, PhD	Provider	One Medical
15. Angela Sparks, MD	Medical Director Clinical Knowledge Development and Support	Kaiser Permanente Washington

Member	Title	Organization
16. Hugh Straley, MD (Chair)	Retired	Medical Director, Group Health Cooperative; President, Group Health Physicians
17. Shawn West, MD	Medical Director	Premera BlueCross
18. Laura Kate Zaichkin, MPH	Director of Health Plan Performance and Strategy	SEIU 775 Benefits Group
19. Judy Zerzan, MD, MPH	Chief Medical Officer	Washington State Health Care Authority

Appendix C: Steering Committee Members

Member	Title	Organization
1. Peter Dunbar, MD, ChB, MBA	CEO	Foundation for Health Care Quality
2. Stuart Freed, MD	Chief Medical Officer	Confluence Health
3. Greg Marchand	Director, Benefits and Policy and Strategy	The Boeing Company
4. Robert Mecklenburg, MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
5. Drew Oliveira, MD	Executive Medical Director	Regence BlueShield
6. Mary Kay O'Neill, MD, MBA	Partner	Mercer

Appendix D: Workgroup Members

Accountable Payment Models: Lumbar Fusion Re-Review

Member	Title	Organization
1. Lydia Bartholomew, MD	Senior Medical Director, Pacific Northwest	Aetna
2. Jonathan Carlson, MD, PhD	Neurosurgeon	Inland Neurosurgery & Spine Associates
3. Arman Dagal, MD	Medical Director	Spine SCOAP
4. Farrokh Farrokhi, MD	Neurosurgeon	Virginia Mason Medical Center
5. Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
6. Mark Freeborn, MD	Neurosurgeon	
7. Andrew Friedman, MD	Physical Medicine and Rehabilitation	Virginia Mason Medical Center
8. Michael Hatzakis, MD	Physiatrist	Overlake Medical Center
9. Sara Groves-Rupp	Asst. Administrator, Performance Improvement	University of Washington Medicine
10. Robert Mecklenburg, MD (Co-Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
11. Kerry Schaefer, MS (Co-Chair)	Strategic Planner for Employee Health	King County
12. Marcia Peterson	Manager of Benefits Strategy and Design	Washington State Health Care Authority

Accountable Payment Models:
Total Knee and Total Hip Replacement Re-Review

Member	Title	Organization
1. Lydia Bartholomew, MD	Senior Medical Director, Pacific Northwest	Aetna
2. Todd Bate	Administrator, Orthopaedics & Sports Medicine Service Line	MultiCare
3. Shawn Boice, RN, BSN, MHA	Nurse Navigator, MSK Administration	Evergreen Health Care
4. Greg Brown, MD, PhD	Orthopedic Surgeon	CHI Franciscan
5. Sharon Eloranta, MD	Medical Director, Quality and Safety Initiatives	Qualis Health
6. Andrew Friedman, MD	Physiatrist	Virginia Mason Medical Center
7. Mike Glenn	CEO	Jefferson Healthcare, Pt. Townsend
8. Kevin Macdonald, MD	Orthopedic Oncology, Adult Reconstruction	Virginia Mason Medical Center
9. Robert Mecklenburg, MD (Co-Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
10. Linda Radach	Patient Advocate	
11. Kerry Schaefer, MS (Co-Chair)	Strategic Planner for Employee Health	King County
12. Jacqui Sinatra, MPA, FACHE	Service Line Director of Sports, Spine, & Ortho Health Svc	University of Washington Medical Center
13. Gaelon Spradley	Chief of Clinic Operations	Mason General Hospital
14. Theresa Sullivan	CEO	Samaritan Healthcare, Moses Lake

Accountable Payment Models: Bariatric Surgery Workgroup Members

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

Accountable Payment Models: Coronary Artery Bypass Surgery

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

Accountable Payment Models: Lumbar Fusion

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

Accountable Payment Models:

Total Knee and Total Hip Replacement

Member	Title	Organization
1. Susie Dade, MS	Deputy Director	Washington Health Alliance
2. Joe Gifford, MD	Chief Strategy and Innovation Officer for Western Washington	Providence Health and Services
3. Bob Herr, MD	Medical Director, Government Programs	Regence Blue Shield
4. Tom Hutchinson	Practice Administrator	PeaceHealth
5. Rich Maturi	Senior Vice President, Health Care Delivery Systems	Premera Blue Cross
6. Gary McLaughlin	Vice President of Finance	Overlake Hospital
7. Robert Mecklenburg, MD (Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
8. Kerry Schaefer	Strategic Planner For Employee Health	King County
9. Julie Sylvester	Vice President of Quality and Safety Initiatives	Qualis Health
10. Jay Tihinen	Assistant Vice President, Benefits	Costco

Addiction and Dependence Treatment

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

Alzheimer's Disease and Other Dementias

Name	Title	Organization
1. Kimiko Domoto-Reilly, MD	Alzheimer's Research Center	University of Washington Medicine
2. Richard Furlong, MD	Primary Care	Virginia Mason Medical Center
3. Barak Gaster, MD	Professor of Medicine	University of Washington Medicine
4. Kelly Green, LICSW	Social Worker	Evergreen Health
5. Debbie Hunter	Family Caregiver	
6. Nancy Isenberg, MD, MPH, FAAN	Neurologist, Clinical Associate Professor of Neurology, Center for Healthy Aging & Memory	Virginia Mason Medical Center
7. Arlene Johnson	Family Caregiver	
8. Kerry Jurges, MD	Primary Care	Confluence Health
9. Eric Larson, MD, MPH	Vice President for Research and Health Care Innovation	Kaiser Foundation Health Plan of Washington
10. Todd Larson	Family Caregiver	
11. Myriam Marquez	Patient Advocate	
12. Shirley Newell, MD	Chief Medical Officer	Aegis Living
13. Darrell Owens, DNP, ARNP	Clinic Chief, Director	University of Washington Outpatient Primary, Palliative and Supportive Care Program
14. Kristoffer Rhoads, PhD (Chair)	Primary Neuropsychologist, Memory and Brain Wellness Center	University of Washington Medicine
15. Tatiana Sadak, PhD, ARNP	Psychiatric Nurse Practitioner	University of Washington Medical Center
16. Bruce Smith, MD	Medical Director	Regence Blue Shield

Behavioral Health Integration

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

Bree Implementation Team

Member	Title	Organization
1. Neil Chasan	Physical Therapist	Sports Reaction Center
2. Susie Dade, MS	Deputy Director	Washington Health Alliance
3. Cezanne Garcia	Program Manager, Community and School-Based Partnerships	Public Health Seattle – King County
4. Ellen Kauffman, MD	OB-COAP Medical Director	Foundation for Health Care Quality
5. Dan Lessler, MD (Chair)	Medical Director	Health Care Authority
6. Alice Lind, RN	Manager, Grants and Program Development	Health Care Authority
7. Jason McGill, JD	Health Policy Advisor	Governor's Office
8. Larry McNutt	Sr. Vice President	Northwest Administrators, Inc.
9. Mary Kay O'Neill, MD, MBA	Chief Medical Director	Coordinated Care
10. Steven Overman, MD	Director	Seattle Arthritis Clinic
11. Terry Rogers, MD	Chief Executive Officer	Foundation for Health Care Quality
12. Claudia Sanders	Senior Vice President, Policy Development	Washington State Hospital Association
13. Kerry Schaefer, MS	Strategic Planner for Employee Health	King County
14. Jeff Thompson, MD	Senior Health Care Consultant	Mercer
15. Shawn West, MD	Family Physician	
16. Karen Wren	Benefits Manager	Point B

Collaborative Care for Chronic Pain

Member	Title	Organization
1. LuAnn Chen, MD, MHA, FAAFP	Medical Director	Community Health Plan of Washington
2. Lynn DeBar, PhD, MPH	Senior Investigator	Kaiser Permanente Washington Health Research Institute
3. Stuart Freed, MD	Chief Medical Officer	Confluence Health
4. Andrew Friedman, MD	Physiatrist	Virginia Mason Medical Center
5. Leah Hole-Marshall, JD (chair)	Counsel and Chief Strategist	Washington Health Benefit Exchange
6. Mary Kay O'Neill, MD, MBA	Partner	Mercer
7. Jim Rivard, PT, DPT, MOMT, OCS, FAAOMPT	President	MTI Physical Therapy
8. Kari A. Stephens, PhD	Assistant Professor – Psychiatry & Behavioral Sciences	University of Washington Medicine
9. Mark Sullivan, MD, PhD	Professor, psychiatry; Adjunct professor, anesthesiology and pain medicine	University of Washington Medicine
10. Emily Transue, MD, MHA	Associate Medical Director	Washington State Health Care Authority

End-of-Life Care

Member	Title	Organization
1. Anna Ahrens	Director of Patient and Family Support Services	MultiCare Health System
2. J. Randall Curtis, MD, MPH	Professor of Medicine, Director	University of Washington Palliative Care Center of Excellence
3. Trudy James	Chaplain	Heartwork
4. Bree Johnston, MD	Medical Director, Palliative Care	PeaceHealth
5. Abbi Kaplan	Principal	Abbi Kaplan Company
6. Timothy Melhorn, MD	Internist	Yakima Valley Memorial Hospital (YVMH) and the Memorial Foundation
7. Joanne Roberts, MD	Chief Medical Officer, NMR Administration	Providence Everett Regional Medical Center
8. John Robinson, MD (Chair)	Chief Medical Officer	First Choice Health
9. Bruce Smith, MD (Vice-Chair)	Associate Medical Director, Strategy Deployment	Group Health Physicians
10. Richard Stuart, DSW	Clinical Professor Emeritus, Psychiatry	University of Washington

Hospital Readmissions

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

Hysterectomy

Member	Title	Organization
1. Pat Kulpa, MD, MBA	Medical Director	Regence BlueShield
2. Sharon Kwan, MD, MS	Interventional Radiologist	University of Washington Medical Center
3. John Lenihan, MD	Medical Director of Robotics and Minimally Invasive Surgery	MultiCare Health System
4. Jennie Mao, MD	Clinical Assistant Professor, Department of Obstetrics and Gynecology	University of Washington Medical Center
5. Sarah Prager, MD	Chair	Washington State Section of ACOG
6. Kevin Pieper, MD	Chief, Women's and Children's	Providence Regional Medical Center Everett
7. Kristin Riley, MD, FACOG	Assistant Professor, Department of Obstetrics and Gynecology	University of Washington Medical Center
8. Jeanne Rupert, DO, PhD (Chair)		
9. Anita Showalter, DO, FACOOG	Associate Professor and Chair, Women's Health	Pacific Northwest University of Health Sciences
10. Susan Warwick, MD	Obstetrics and Gynecology	Kaiser Permanente

LGBTQ Health Care

Member	Title	Organization
1. Olivia Arakawa, MSN, CNM, ARNP, RN	Parent Advocate	
2. Scott Bertani	Director of Policy	Lifelong AIDS Alliance
3. Kathy Brown, MD	Provider	Kaiser Permanente
4. LuAnn Chen, MD, MHA, FAAFP	Medical Director	Community Health Plan of Washington
5. Michael Garrett, MS, CCM, CVE, NCP	Principal	Mercer
6. Chris Gaynor, MD, MA, FAAFP	Family Practice Clinician	Capitol Hill Medical
7. Matt Golden, MD	Professor, Director, PHSKC STD Control Program	University of Washington
8. Kevin Hatfield, MD	Family Practice Clinician	The Polyclinic
9. Corinne Heinen, MD	Physician Lead, UW Transgender Clinical Pathway	Department of Internal Medicine, Allergy & Infectious Disease, University of Washington
10. Tamara Jones, MPH	End AIDS Washington Policy and Systems Coordinator	Department of Health
11. Dan Lessler, MD, MHA (Chair)	Chief Medical Officer	Washington State Health Care Authority

Low Back Pain

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

Maternity Bundled Payment

Member	Title	Organization
1. David Buchholz, MD	Medical Director, Collaborative Health Care Solutions	Premera
2. Andrew Castrodale, MD	Family Physician	Coulee Medical Center
3. Francie Chalmers, MD	Pediatrician, Member	Washington Chapter of the American Academy of Pediatrics
4. Angela Chien, MD	Obstetrics and Gynecology	EvergreenHealth
5. Neva Gerke, LM	President	Midwives Association of Washington
6. Molly Firth, MPH	Patient Advocate	
7. Lisa Humes-Schulz, MPA/ Lisa Pepperdine, MD	Director of Strategic Initiatives/ Director of Clinical Services	Planned Parenthood of the Great Northwest and Hawaiian Islands
8. Rita Hsu, MD, FACOG	Obstetrics and Gynecology	Confluence Health
9. Carl Olden, MD (Chair)	Family Physician	Pacific Crest Family Medicine
10. Dale Reisner, MD	Obstetrics and Gynecology	Swedish Medical Center
11. Janine Reisinger, MPH	Director, Maternal-Infant Health Initiatives	Washington State Hospital Association
12. Mark Schemmel, MD	Obstetrics and Gynecology	Spokane Obstetrics and Gynecology, Providence Health and Services
13. Vivienne Souter, MD	Research Director	Obstetrics Clinical Outcomes Assessment Program
14. Judy Zerzan, MD	Chief Medical Officer	Washington State Health Care Authority

Obstetric (Maternity) Care

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

Oncology Care

Member	Title	Organization
1. Jennie Crews, MD	Medical Director	PeaceHealth St. Joseph Cancer Center
2. Bruce Cutter, MD	Oncologist	Medical Oncology Associates
3. Patricia Dawson, MD, PhD	Director	Swedish Cancer Institute Breast Program and True Family Women's Cancer Center
4. Keith Eaton, MD, PhD	Medical Director, Quality, Safety and Value	Seattle Cancer Care Alliance
5. Janet Freeman-Daily	Patient Advocate	
6. Christopher Kodama, MD, MBA (Chair)	President, MultiCare Connected Care	MultiCare Health System
7. Gary Lyman, MD, MPH	Co-Director	Hutchinson Institute for Cancer Outcomes Research
8. Rick McGee, MD	Oncologist	Washington State Medical Oncology Society
9. John Rieke, MD,FACR	Medical Director	MultiCare Regional Cancer Center
10. Hugh Straley, MD	Chair and Oncologist	Bree Collaborative
11. Richard Whitten, MD	Medical Director	Noridian

Opioid Prescribing Guideline Implementation

Member	Title	Organization
1. Chris Baumgartner	Director Prescription Monitoring Program	Department of Health
2. David Buchholz, MD	Medical Director of Provider Engagement	Premera
3. Tanya Dansky, MD	Chief Medical Officer	Amerigroup
4. Gary Franklin, MD, MPH (Chair)	Medical Director	Department of Labor and Industries
5. Charissa Fotinos, MD, MSc	Deputy Chief Medical Officer	Health Care Authority
6. Frances Gough, MD	Chief Medical Officer	Molina Healthcare
7. Kathy Lofy, MD	Chief Science Officer	Department of Health
8. Jaymie Mai, PharmD	Pharmacy Manager	Department of Labor and Industries
9. Mark Murphy, MD	Addiction Medicine	MultiCare Health System
10. Shirley Reitz, PharmD	Clinical Pharmacist Client Manager	OmedaRx, Cambia
11. Gregory Rudolph, MD	Addiction Medicine	Swedish Pain Services
12. Michael Schiesser, MD	Addiction Medicine	EvergreenHealth Medical Center
13. Danny Stene, MD	Medical Director	First Choice Health
14. Mark Stephens	President	Change Management Consulting
15. Hugh Straley, MD	Chair	Bree Collaborative
16. David Tauben, MD	Chief of Pain Medicine	University of Washington (UW) Medical Center
17. Gregory Terman MD, PhD	Professor	Dept. of Anesthesiology and Pain Medicine; Graduate Program, Neurobiology and Behavior, UW
18. Emily Transue, MD	Chief Medical Director	Coordinated Care
19. Michael Von Korff, ScD	Senior Investigator	Group Health Research Institute
20. Melet Whinston, MD	Medical Director	United Health Care

Opioid Use Disorder Treatment

Member	Title	Organization
1. Jane Ballantyne, MD, FRCA	Professor, Department of Anesthesiology and Pain Medicine	University of Washington School of Medicine
2. Caleb Banta-Green, PhD, MPH, MSW	Senior Scientist	Alcohol and Drug Abuse Institute, University of Washington
3. David Beck, MD	Immediate Past President	Washington Society of Addiction Medicine
4. Ryan Caldeiro, MD	Chief Chemical Dependency Services and Consultative Psychiatry	Kaiser Permanente
5. Mary Catlin, BSN, MPH	Institutional Nurse Consultant	Department of Health
6. Charissa Fotinos, MD, MSc (Co-Chair)	Deputy Medical Officer	Health Care Authority
7. Nancy Lawton, MN, ARNP, FNP	President	ARNPs United of Washington State
8. Darin Neven, MD, MS	President and Founder	Consistent Care
9. Richard Ries, MD	Director, Addiction Psychiatry Residency Program	University of Washington
10. John Robinson, MD, SM	Chief Medical Officer	First Choice Health
11. John Roll, PhD	Professor & Vice Dean for Research, Elson S. Floyd College of Medicine	Washington State University
12. Terry Rogers, MD	Medical Director	Lakeside Milam Recovery
13. Vania Rudolf, MD, MPH	Addiction Recovery Services	Swedish Medical Center
14. Andrew Saxon, MD (Co-Chair)	Director, Center of Excellence in Substance Abuse Treatment and Education (CESATE)	VA Puget Sound Health Care System
15. Mark Stephens	President	Change Management Consulting
16. Milena Stott, LICSW, CDP	Chief Of Inpatient Services	Valley Cities Counseling

Palliative Care

Member	Title	Organization
1. John Robinson, MD, SM (Chair)	Chief Medical Officer	First Choice Health
2. Lydia Bartholomew, MD	Senior Medical Director, Pacific Northwest	Aetna
3. George Birchfield, MD	Inpatient Hospice	EvergreenHealth
4. Raleigh Bowden, MD	Director	Okanogan Palliative Care Team
5. Mary Catlin, MPH	Senior Director	Honoring Choices, Washington State Hospital Association
6. Randy Curtis, MD, MPH	Director, Cambia Palliative Care Center of Excellence	University of Washington Medicine
7. Leslie Emerick	Director of Public Policy	Washington State Hospice and Palliative Care Organization
8. Ross M Hays, MD	Director, Palliative Care Program	Seattle Children's
9. Greg Malone, MA, Mdiv, BCC	Mgr Palliative Care Services, & Spiritual Care Provider	Swedish Medical Center
10. Kerry Schaefer, MS	Strategic Planner for Employee Health	King County
11. Bruce Smith, MD	Medical Director of Providence Hospice of Seattle	Providence Health and Services
12. Richard Stuart, DSW	Psychologist	Swedish Medical Center – Edmonds Campus
13. Stephen Thielke, MD	Geriatric Psychiatry	University of Washington
14. Cynthia Tomik, LICSW	Manager, Palliative Care	EvergreenHealth
15. Gregg Vandekieft, MD, MA	Medical Director for Palliative Care	Providence St. Peter Hospital
16. Hope Wechkin, MD	Medical Director, Hospice and Palliative Care	EvergreenHealth

Prostate Cancer Screening

Member	Title	Organization
1. John Gore, MD, MS	Urologist, clinician, surgeon, researcher	University of Washington Medicine
2. Matt Handley, MD	Medical Director, Quality	Group Health Cooperative
3. Leah Hole-Marshall, JD	Medical Administrator	Department of Labor & Industries
4. Steve Lovell	Retired	Patient and Family Advisory Council
5. Wm. Richard Ludwig, MD (Chair)	Chief Medical Officer	Providence Accountable Care Organization
6. Bruce Montgomery, MD	Clinical Director of Genitourinary Medical Oncology	Seattle Cancer Care Alliance
7. Eric Wall, MD, MPH	Market Medical Director	UnitedHealthcare
8. Shawn West, MD	Family Physician	Edmonds Family Medicine
9. Jonathan Wright, MD, MS, FACS	Assistant professor of urology/affiliate researcher	University of Washington/Fred Hutchinson Cancer Research Center

Pediatric Psychotropic Use

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

Risk of Violence to Others

Member	Title	Organization
1. G. Andrew Benjamin, JD, PhD, ABPP	Clinical Psychologist, Affiliate Professor of Law	University of Washington
2. Kate Comtois, PhD, MPH	Professor	Department of Psychiatry and Behavioral Sciences Harborview Medical Center
3. Jaclyn Greenberg, JD, LLM	Policy Director, Legal Affairs	Washington State Hospital Association
4. Laura Groshong, LICSW	Private Practitioner	Washington State Society for Clinical Social Work
5. Ian Harrel, MSW	Chief Operating Officer	Behavioral Health Resources
6. Marianne Marlow, MA, LMHC	Member	Washington Mental Health Counseling Association
7. Neetha Mony	State Suicide Prevention Plan Program Manager, Injury & Violence Prevention, Prevention and Community Health	Washington State Department of Health
8. Kim Moore, MD (Chair)	Associate Chief Medical Director	CHI Franciscan
9. Kelli Nomura, MBA	Behavioral Health Administrator	King County
10. Mary Ellen O'Keefe, ARNP, MN, MBA	Clinical Nurse Specialist – Adult Psychiatric/Mental Health Nursing; President Elect	Association of Advanced Psychiatric Nurse Practitioners
11. Jennifer Piel, MD, JD	Psychiatrist	Department of Psychiatry, University of Washington
12. Jeffrey Sung, MD	Member	Washington State Psychiatric Association
13. Samantha Slaughter, PsyD	Member	WA State Psychological Association
14. Adrian Tillery		Harborview Mental Health and Addiction Services
15. Amanda Ibaraki Stine, LMFT	Member	Washington Association for Marriage and Family Therapists

Shared Decision Making

Member	Title	Organization
1. David Buchholz, MD	Medical Director	Premera
2. Sharon Gilmore, RN	Risk Consultant	Coverys
3. Leah Hole-Marshall, JD	General Counsel and Chief Strategist	Washington Health Benefit Exchange
4. Steve Jacobson MD, MHA, CPC	Associate Medical Director Care Coordination	The Everett Clinic, a DaVita Medical Group
5. Dan Kent, MD	Medical Director	United Health Care
6. Andrew Kartunen	Program Director, Growth & Strategy	Virginia Mason Medical System
7. Dan Lessler, MD, MHA	Physician Executive for Community Engagement and Leadership	Comagine Health
8. Jessica Martinson, MS	Director of Clinical Education and Professional Development	Washington State Medical Association
9. Karen Merrikin, JD	Consultant	Washington State Health Care Authority
10. Randy Moseley, MD	Medical Director of Quality	Confluence Health
11. Martine Pierre Louis, MPH	Director of Interpreter Services	Harborview
12. Karen Posner, PhD	Research Professor, Laura Cheney Professor in Anesthesia Patient Safety	Department of Anesthesiology and Pain Medicine, University of Washington
13. Angie Sparks, MD	Family Physician and Medical Director Clinical Knowledge Development	Kaiser Permanente
14. Anita Sulaiman	Patient Advisor and Consultant	IBEX
15. Emily Transue, MD, MHA (Chair)	Associate Medical Director	Washington State Health Care Authority

Suicide Care

Member	Title	Organization
1. Kate Comtois, PhD, MSW	Psychologist	Harborview Medical Center
2. Karen Hye, PsyD	Clinical Psychologist	CHI Franciscan Health
3. Matthew Layton, MD, PhD, FACP, DFAPA	Clinical Professor, Department of Medical Education and Clinical Sciences	Elson S. Floyd College of Medicine, Washington State University
4. Neetha Mony, MSW	Statewide Suicide Prevention Plan Program Manager	Washington State Department of Health
5. Julie Rickard, PhD	Physician & Healthcare Consultant	Confluence Health
6. Julie Richards, MPH	Research Associate	Kaiser Permanente Washington Health Research Institute
7. Hugh Straley, MD (Chair)	Chair	Bree Collaborative
8. Jennifer Stuber, PhD	Associate Professor	University of Washington School of Social Work
9. Jeffrey Sung, MD	Member	Washington State Psychiatric Association