Dr. Robert Bree Collaborative Meeting

January 29th, 2014
Agenda

- Welcome
- Chair Report & Approval of Minutes
- Accountable Payment Models Workgroup
- Consumers Union Safe Patient Project
- Bree Implementation Team
- End of Life/Advanced Directives Workgroup
- The Role of Anesthesiology in the Perioperative Surgical Home
- Addiction/Dependence Treatment Topic Area
- Good of the Order/Opportunity for Public Comment
ACCOUNTABLE PAYMENT MODELS WORKGROUP

BOB MECKLENBURG, MD
VIRGINIA MASON MEDICAL CENTER
APM WORKGROUP CHAIR,
BREE COLLABORATIVE MEMBER
JANUARY 29TH, 2014
1. Approve charter of workgroup.

2. Provide update on bundle for spine surgery.
CHARTER: AIM

- To recommend reimbursement models including warranties and bundled payments that align with patient safety, appropriateness, evidence-based quality, timeliness, outcomes, and the patient care experience.

In short: a framework explicitly defining quality for production, purchasing and payment.
1. Select condition

- Select conditions in which variation in practice and price is not commensurate with quality of outcomes.

2. Recruit the team.

- Recruit appropriate team of content experts and opinion leaders.
- Consult members of WSHA, WSMA and other stakeholder organizations and subject matter experts.
3. Establish clinical content

- Define scope of work for each medical condition.
- Review existing standards related to each condition, particularly CMS.
- Identify common medical interventions for each condition to create a standardized patient care pathway.
- Use standardized evidence search and appraisal methods to assess the value of each intervention.
- Eliminate interventions that are not value-added to create a future-state patient care pathway.
4. Establish quality metrics

- Develop explicit quality metrics to assess performance of providers to guide payment and purchasing.

5. Feedback, audit and editing

- Solicit feedback from stakeholders to improve the care pathway, evidence appraisal and quality metrics.

6. Approval

- Present the final draft to the Bree Collaborative for approval.
SELECTION OF TOPIC

- Spine surgery
WORKGROUP MEMBERS

- Providers
  1. Bob Mecklenburg, MD, Virginia Mason, Chair
  2. Peter Nora, MD, Swedish Medical Center
  3. Tom Hutchinson, WSMA/WSMGMA
  4. Gary McLaughlin, Overlake

- Purchasers
  1. Kerry Schaefer, King County
  2. Jay Tihinen, Costco
  3. Gary Franklin, MD, L&I

- Health Plans
  1. Bob Manley, MD, Regence
  2. Dan Kent, MD, Premera

- Quality Organizations
  1. Susie Dade, Puget Sound Health Alliance
  2. Julie Sylvester, Qualis Health

- Consultants
  1. Farrokh Farrokhi, MD, Virginia Mason Medical Center
  2. Andrew Friedman, MD, Virginia Mason Medical Center
  3. Fangyi Zhang, MD, University of Washington
SCOPE: NARROWING FOCUS

- Common spine surgery with high direct and indirect costs.
- Variability of care an issue.
- Evidence base available to inform decision rules.
- Guidelines available from authoritative groups.

Lumbar fusion meets these specifications.

Choice is supported by provider and health plan content experts and is a focus of both CMS and the Washington Health Alliance.

Scope excludes trauma, cancer and systemic disease.
1. Document disability despite conservative therapy.
2. Ensure fitness for surgery.
3. Apply key processes for best practice surgery.
4. Ensure safe and effective post-op care and return to function.
1. Measure disability on standard scale: Oswestry Disability Index (ODI).
2. Identify an imaging standard.
3. Document appropriate trial of conservative therapy.
4. Document failure of conservative therapy on ODI.
1. Meet 10 requirements relating to patient safety.
4. Enrollment in Spine SCOAP.
1. Standards for surgical team performing surgery: minimum case volume for surgeon, avoiding late start time for surgery.

2. Elements of optimal surgical process: measures to control pain and infection, bleeding and low blood pressure, threatening blood clots, and elevated blood sugar.
1. Use standardized post-op care process.
2. Use standardized hospital discharge process aligned with WSHA toolkit.
3. Arrange home health services as necessary.
4. Schedule appropriate follow-up appointments.
Approve APM Charter and Roster
Lisa McGiffert  
**www.SafePatientProject.org**  
Consumers Union  
512-651-2915  
lmcgiffert@consumer.org
End secrecy, save lives

Focus on ending medical harm; public transparency as a catalyst for change

• medical implant safety
• Eliminating health care-acquired infections and medical errors
• Improved oversight and information about physicians
Medical Harm: 3rd leading cause of death
Response fails to align with scope of the problem

3 recent studies: 1 in 4 to 1 in 3 hospital patients; 27% Medicare; 9 million harmed annually

- Harm/errors: infections, medication errors, burns, surgical errors, bedsores, falls

Estimated 400,000 deaths/year (J of Patient Safety)
Preventable medical errors: no meaningful tracking, not on death certificates

Resources devoted to prevention by hospitals, states & federal governments dwarfed by scope of this mostly preventable problem
U.S. Hospital infections by the numbers

- Nearly 2 million hospital patients are infected each year
- 1 in 20 hospital patients get an infection while there for treatment of something else
- Annually nearly 100,000 patients die from hospital infections
- National hospital costs related to hospital-acquired infections: $45 billion
- Average hospital cost of a serious infection following surgery: $57,000 (AHRQ)
- 76% of hospital infections were billed to Medicare (67%) and Medicaid (PHC4)
Safe Patient Project work

• 2003 Model bill: require hospitals to publicly report infection rates
  – 30 states require; in 2012 hospitals from all states are reporting on Hospital Compare
  – Variation among states – WA is one that does more
    • 2013: defended hip and knee infection reports

• 2011 Model bill: require hospitals to publicly report medical errors; penalties for failure to report
  – 26 states require hospitals to report; only 6 states require public reporting; none are validated
Impact of Public Reporting
National (CDC)

• Catalyst for change: Widespread tracking of HAIs

• 2001-2009: 58 % drop in central line associated bloodstream infections in ICUs
  – Period of time during which more than half of the states required disclosure of that measure

• 2008-2011:
  – 41% reduction of ICU CLABSIs
  – 17% reduction in surgical site infections
  – 7% fewer catheter associated UTIs
Impact of Public Reporting - States


- **New York**: many hospitals decreased certain surgical infections from 2006-2009; 39% reported zero infections for hip surgery; significant reductions documented in NY for CLABSI. Director of NY Dept of Health's bureau of health–care–associated infections: "I do believe it is because of reporting."

- **Colorado**: 43% decrease in CLABSI in adult ICUs from 2008-2010; similar decreases in neonatal ICUs and long-term acute care hospitals; “These data suggest that public reporting of infections may enhance individual facilities’ accountability and focus on reducing infections.”

- **Washington**: Hip and knee replacements: 2011 – 250 HAIs; 2012: 190 HAIs; 5 years of reporting before expires
Physician Safety-Oversight & Information

• 2009 CU model Physician Profile Disclosure Act
• Information available varies by state
  – Disciplinary orders
  – Competency issues
• National Practitioner Data Bank
  – Public Use Data File
  – Change federal law - publish names
• State work – Medical boards
  – CA: Monitoring board meetings; more transparency & allow for more public input, oversight of outpatient surgical centers, substance abusing doctors
  – WA (2009): More access to information and input by patients who file complaints
Actions to a million consumers signed up through all of our campaigns

Change this medical device bill for the better!

You have a lot of power right now because your Senator sits on the committee shaping the final medical device safety bill.

While stronger than the House version, this bill needs to have real, tangible safety standards. It needs to close the gaping loopholes that allow unsafe devices to be implanted in Americans.

Implants should be tested safe before going on the market, and they should be registered so anyone with one can be quickly notified if they go bad. Everything from cars to toasters have serial numbers so customers can be notified if they’re recalled – why wouldn’t medical implants?

We laid out the safety improvements needed in the bill below. You can send it to your Senator as is, or if you would like to add your own thoughts or personal experience with a medical device, please do so in the box below.

Stephen Tower, M.D., was injured by the same artificial hip he implanted in patients.
We collect stories from people who have personal experiences with medical harm. Recruit to expand the reach of our work & help theirs.
Consumer Reports
Importance of translators

• Infection ratings – call out high rates

• Surgical safety ratings – 2013
  – Some complaints and some thanks/used to motivate improvements

• Safety composite score (begun in 2012):
  – avoiding infections,
  – avoiding readmissions,
  – communicating about medications and discharge,
  – appropriate use of chest and abdominal scanning, and
  – avoiding serious complications.
### Safety Score Components

<table>
<thead>
<tr>
<th>Component</th>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoiding bloodstream infections</td>
<td>🔴</td>
<td>Communication about hospital discharge</td>
</tr>
<tr>
<td>Avoiding surgical-site infections</td>
<td>🔴</td>
<td>Communication about drug information</td>
</tr>
<tr>
<td>Avoiding readmissions</td>
<td>🔴</td>
<td>Appropriate use of abdominal scanning</td>
</tr>
<tr>
<td>Avoiding serious complications – compared with average</td>
<td>🔴</td>
<td>Appropriate use of chest scanning</td>
</tr>
<tr>
<td>Avoiding mortality – compared with average</td>
<td>-</td>
<td></td>
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### Patient Outcomes

<table>
<thead>
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<th>Component</th>
<th>Rating</th>
<th>Description</th>
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<tbody>
<tr>
<td>Avoiding bloodstream infections</td>
<td>🔴</td>
<td>This hospital reported 0 bloodstream infections in the 919 days that its ICU patients had central lines between 01/01/2011 and 12/31/2011.¹</td>
</tr>
<tr>
<td>Avoiding surgical-site infections</td>
<td>🔴</td>
<td>This hospital reported 0 surgical-site infections in 96 surgical procedures among its patients between 01/01/2010 and 12/31/2010.²</td>
</tr>
<tr>
<td>Avoiding readmissions</td>
<td>🔴</td>
<td>Heart-attack patients have a 21% chance of being readmitted to the hospital within 30 days. Heart-failure patients have a 24% chance of being readmitted to the hospital within 30 days. Pneumonia patients have a 20% chance of being readmitted to the hospital within 30 days.³</td>
</tr>
<tr>
<td>Avoiding serious complications</td>
<td>🔴</td>
<td>This compares the rate of preventable serious complications with the national average.⁴</td>
</tr>
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Medical Device Safety

• Incredibly fast-growing market
• American public assumes complex and high risk implants are tested for safety
• Over 90% of devices are cleared for sale through fast track process that only requires the manufacturer to show it is similar to an existing device, called a “predicate”
  – Not required to provide clinical studies for safety
  – 78% of highest risk (Class III) devices cleared this way
• The predicate can even be a device that has been recalled for safety reasons
  – FDA cannot ask if the new device has addressed the safety issues
Medical Device Safety – cont’d

• No unique identifier for tracking devices...yet
• No national registries – fragmented, professionals control, not public
• Poor systems for collecting adverse events
• FDA can “order” studies but limited enforcement tools for the highest risk, slow timelines, data not readily available to public
Why we need warranties for hip and knee Implants

- Weak oversight: approval process & post market oversight
- Implanted in the body
- Younger patients; more active elders who will live longer
- Patients often not given information about the device manufacturer or model; no guarantee of how long the device will last
- Most hip/knee implants work fine, but some fail (MoM hips – 750,000 at risk)
DePuy Orthopaedics
Hip replacements.
A heritage of over 40 years.

As an avid cyclist, riding in charity events had become one of John's greatest passions. When joint disease threatened to take that away from him, he turned to surgery for help. His orthopaedic surgeon recommended a PINNACLE™ Hip from DePuy Orthopaedics.

In fact, a recent multicenter clinical study conducted by leading orthopaedic surgeons showed that eight years after surgery, 96.1% of patients still depend on their PINNACLE Hip replacements in their daily lives. John has tested his PINNACLE Hips for 8 years and is gearing up for a 7-day charity bike ride. He'll tell you he feels like a new man.

For other Real Life Tested stories, visit RealLifeTested.com

Important Safety Information: Hip replacement is not for everyone. There are potential risks. Recovery time and success depend on factors like age, weight, and activity level. Only an orthopaedic surgeon can tell if hip replacement is right for you.
• 5 top selling hip/knee implant makers: Zimmer, DePuy (J&J), Biomet, Smith & Nephew, Stryker
• Product only – Provider warranty + product = ideal
• Actions:
  • Letter to companies requesting warranty and meeting
  • Consumer emails (58,000 to each company)
  • Patient stories – nearly 3000
  • Media coverage (including CR)
  • Enlist allies: surgeons, employers, health plans, states/federal government
  • Bree collaborative? A national model?
Standards for a good warranty

• Covers the implant for at least 20 years
• Covers full replacement costs of a flawed device, including the device, surgeon and hospital costs, as well as the related patient out of pocket costs.
• Does not require the failed device be replaced with the same product if it has been recalled by FDA or the company, is the subject of FDA warnings, is under investigation by the FDA or if the product is no longer being sold by the company.
• Has a clear system for patients to use, including a toll-free number and a registration number to track the claims process, with physicians charging the device company, not the patient.
• Does not require the patient pay out-of-pocket expenses; for example, the patient should not have to pay the device maker or surgeon first and get reimbursed later.
• Provides the patient with full information concerning a warranty claim denial and provides a process to allow the patient to appeal the decision.
• Does not limit or eliminate a patient’s right to sue if they use the warranty.
• Does not disqualify patients across the board because they have specific diseases or illnesses that are not related to the failure of a device.
• Does not disqualify patients for normal activities, including falls.
• Does not disqualify patients due to information that is not routinely available to them, such as information that is on the device packaging or placed into their medical records and not routinely provided directly to the patients in the course of getting the implant.
Goals of campaign

• Make devices safer
• Make device makers accountable for performance
• Provide a warranty similar to other products
• Inform patients of true lifespan of implants
• provide a standard and guaranteed process for patients if devices fail
You're stuck paying when implants fail.

Really!?
BREE IMPLEMENTATION TEAM (BIT) UPDATE
KEY NUMBERS

17 Members

3 Meetings

2 Topics Tackled
Final (revised) recommendation:

April 15, 2013

“To approve the Spine SCOAP proposal – that the Collaborative strongly recommends establish participation in Spine SCOAP as a community standard, starting with hospitals performing spine surgery¹ - with the following conditions:

1) Results are unblinded.
2) Results are available by group.
3) Establish a clear and aggressive timeline.
4) Recognize that more information is needed about options for tying payment to participation.”

No formal response received from HCA
**GENERAL SPINE SCOAP STRATEGY**

**Target:**
Capture 90% of Spine Surgeries Performed in WA by 6/1/2014

**Strategy 1: Talk to Hospitals**
- **Target Hospitals:** Why haven't you joined? How can we help you overcome those barriers?
- **Participating Hospitals:** Why did you join? How can we improve our messaging to target hospitals?

**Strategy 2: Increase Visibility of Bree**
CURRENT ACTION ITEMS

Draft up the business case for *purchasers* to encourage or require participation
- Lead: Larry McNutt, Carpenters Trusts of Western WA

Draft up the business case for *hospitals* to participate
- Lead: Mary Kay O’Neill MD, Regence

Develop a strategy for engaging with clinical leadership
- Lead: Dan Lessler MD, Health Care Authority
NEXT STEPS

- Finalize and disseminate both business cases for participation
- Recruit champions from participating hospitals to help with messaging
- Schedule face-to-face meetings with clinical leadership at target hospitals
Another registry, but different challenges

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Target(s)</th>
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<tr>
<td>Maintain 100% participation in COAP</td>
<td>Maintain &gt;90% of eligible procedures from 100% of eligible hospitals being captured by COAP</td>
</tr>
<tr>
<td>COAP will continue to publish hospital-specific results for insufficient</td>
<td>Maintain 100% identification and continue to report trends over time</td>
</tr>
<tr>
<td>information for non-acute PCI, and the trends over time, on its public website</td>
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</tr>
<tr>
<td>Hospitals should improve the documentation and submission of sufficient data</td>
<td>• &lt;15% insufficient data reported for non-acute PCI procedures overall&lt;br&gt;• 50% reduction in all individual hospitals which have &gt;40% insufficient information for non-acute PCI</td>
</tr>
<tr>
<td>from which an analysis of appropriateness of care can be made for non-acute PCI</td>
<td></td>
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<tr>
<td>procedures</td>
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Kristin Sitcov, COAP Program Director, will present a proposed role for the BIT in the implementation of COAP recommendations at the February BIT meeting.
At its next meeting, the BIT will define criteria for selecting the order in which it takes up topics.

Next topic will likely be Obstetrics or Accountable Payment Models.
End of Life/Advanced Directives Workgroup Update

John Robinson, MD
Chair, EOL Workgroup, Bree Collaborative Member
Chief Medical Officer, First Choice Health

January 29th, 2014
Workgroup Members

- John Robinson, MD, First Choice Health (*Chair*)
- Bruce Smith, MD, Group Health Physicians (*Vice Chair*)
- Anna Ahrens, MultiCare Health System
- Tony Back, MD, Seattle Cancer Care Alliance
- Trudy James, Heartwork
- Bree Johnston, MD, PeaceHealth
- Abbi Kaplan, Abbi Kaplan Company
- Timothy Melhorn, MD, Yakima Valley Memorial Hospital (YVMH) and the Memorial Foundation
- Joanne Roberts, MD, Providence Everett Regional Medical Center
- Richard Stuart, DSW, University of Washington
- *Observers*
  - Tanya Carroccio, Washington State Hospital Association
  - Jessica Martinson, Washington State Medical Association
Charter: Aim

• Improve quality of life and reduce unnecessary cost of care delivered at the end of life in Washington State and to empower patients to work with their physicians and others participating in their care to develop advanced directives in accordance with their preferences.
Charter: Purpose

• To propose recommendations to the full Bree Collaborative on how to improve care, improve quality, and reduce unnecessary variation at the end of a patient’s life through greater utilization of advanced directives.
  ▫ Focus initially on end-of-life planning discussions.
  ▫ Encourage widespread adoption of advanced directives.
  ▫ Increase measurement and reporting of advanced directives.
Summary of First Meeting

• Introduced members and the Bree Collaborative’s history.

• Importance of coordinating efforts with other local, regional, and national initiatives (e.g., the Last Chapter project, the POLST task force, the University of Washington Palliative Care Training Center, etc.).

• Possible ideas to achieve our goal (e.g., incentivizing physicians to have the end of life discussion, a state-wide registry, community activation).
Workgroup Next Steps

• Recurring monthly meetings.
• Further coordination with other entities and initiatives.
• Narrowing and finalizing scope of work.
• Finishing work in nine months – one year, writing final report in the fall of 2014.
Recommendation

- Adopt End of Life/Advanced Directives Charter and Roster
Questions? Comments?
Perioperative Surgical Home

It's all about the triple aim

Bree Collaborative Wednesday January 29th 2014
Triple Aim

- Better Patient Experience
- Better Healthcare
- Lower costs
To Summarize

The Perioperative Surgical Home (PSH) is a new patient-centered model that is designed to provide seamless continuity of care for the surgical patient, from the point of the decision for surgery through recovery and beyond.

Through shared decision-making and physician-led, team-based care, the vision of the PSH is to achieve the triple aim of better health outcomes, a better experience of healthcare for patients, and reduced cost of care.
WHY oh WHY are anesthesiologists doing this

- We have almost perfected intra-op care—safety wise
- The only way to improve the surgical experience is though CQI and systems thinking
- In the OR we witness inefficiencies in care (that we could change)
- Business as Usual – is a going to fail us because it will de-professionalize us
Transition of Anesthesia Care Models

- Value Driven Coordinated Care
  - Perioperative Surgical Home
  - Clinical integration network
  - Accountable care organization

- Volume Driven Fragmented Care
  - P4P
  - Service line co-management
  - Shared savings
  - Bundled payments

- Medical directors
- Physician practice support
- Professional service agreement
- Employment

- Fee for service

Care Delivery

Status Quo
Getting Started
Transitioning Forward
Advancing to Future

Degrees of Integration
Face to Face Patient Experience

- Includes everything anesthesia does today and more
  - All, pre, intra and post op care
  - Enhanced Recovery After Surgery initiatives
  - Advanced Pre-op exams
  - Long term opioid and pain recovery clinics
  - Intensive care
Measuring Quality

- PSH is designed for a world where we will be paid to deliver quality (as opposed to quantity)
  - So Quality needs measured
  - In needs to be tracked and calculated
  - And it needs to be continuously improved
- Easy to say but the challenges of measurement are well known
- There needs to be investment of resources, that investment will only come if there is a direct connection between quality and revenue
Coordinated Team Leadership

- **Perioperative Surgical Home**
- **OR management committee with executive authority**
  - Anesthesia, Surgeons, Nursing
  - Facility and senior leadership (“C level”) buy in
- **Coordinated Scheduling across**
  - Cases
  - Staff
  - Resources (including supplies, and personnel)
- **Responsible for ensuring the smooth safe efficient throughput of surgical and other interventions.**
  - Ideally having P&L responsibility for revenue and expense – including resources, materials management and salaries
The Output

• **The Triple Aim**
  – Better Patient Experience
  – Better Surgical/interventional Care
  – More efficient surgical care

• **We believe Payers want better value.**
  – The present system is perfectly designed to thwart that goal.
  – The PSH aligns incentives to create a health care ecosystem where there is competition to excel

• **Early adopters have the chance to be tomorrows leaders at every point in the value chain**
Evidence of success and commitment

- Michigan Surgical Collaborative
- Texas Surgical Collaborative
- University California Irvine –Urological SH and Orthopedic SH
- University of Alabama
- Mayo Clinic
- ASA sponsoring national learning collaborative
- Literature reviews
Bree should consider the PSH because

- Surgical / interventional care accounts for 60% of hospital expenditures.
- Advances in anesthesia have increased safety, but perioperative patients are still at risk for
  - Excessive pain and discomfort,
  - Slow recovery from interventions (increased LOS)
  - Unnecessary pre-operative testing (Ostrom-Thilen Seattle times)
  - Excessive re-admissions.
- Current 60 year old model of payment does not value coordination of care— with predictable results.
The Ask

• This long term project, a complex project
• Cooperation between multiple stakeholders needed
• Encourage discussions payers to talk with Health care organizations that are willing to try out the Perioperative Surgical Home.
• We want to come to your table to design a state-wide project.
Questions?

Peter J Dunbar MB ChB MBA
Vice Chair, ASA Committee on Future Models of Anesthesia Practice
Director of Finance
Department of Anesthesiology and Pain Medicine
University of Washington, Seattle
pjdunbar@uw.edu
PSH has Five Goals

• Provide a portal of entry to perioperative care and ensure continuity
• Identify and manage patient populations according to acuity, comorbidities, risk
• Deliver evidence-based clinical care before, during and after the procedure
• Manage and coordinate perioperative care across specialty lines
• Measure and improve performance and cost-efficiency.
The PSH Learning Collaborative is designed to help organizations close that gap by creating a structure in which qualified organizations can easily learn from each other and from recognized experts in topic areas where they want to make improvements.

The PSH Learning Collaborative is a one year learning system that brings together a large number of teams from healthcare organizations to seek improvement in perioperative care.

First key to a successful PSH is a strong alignment model among all stakeholders within the perioperative environment, including the participating facility (Team concept).

Primary Metric(s) and QI Initiatives:

- Mortality rates
- Morbidity
- Complications following surgery
- Preventing surgical site infections (SSI)
- Myocardial Injury Project
- Colectomy Project

Results:

- 2.6% reduction in complications following surgery (2005-2009)
- 1.6% reduction in surgical site infections (2008-2011)
- 15% reduction in length of stay (2005-2008)
Over a 3 year period, four programs sponsored by BCBS-M to improve the quality of common procedures performed in Michigan Hospitals have produced **$232.8 million** in health care cost savings.

**Michigan Surgical Quality Collaborative (general surgery)**
2009-2010: $85.9 million statewide savings; $49.2 million BCBSM savings

**Michigan Society of Thoracic and Cardiovascular Surgeons (cardiac surgery)**
2009-2010: $30.3 million statewide savings; $2.4 million BCBSM savings

**Michigan Cardiovascular Consortium - Percutaneous Coronary Intervention (angioplasty)**
2008-2010: $102 million statewide savings; $13.8 million BCBSM savings

**Michigan Bariatric Surgery Collaborative (bariatric surgery)**
2008-2010: $14.6 million statewide savings; $4.7 million BCBSM savings
Addiction/Dependence Treatment Topic Area

Steve Hill
Chair, Bree Collaborative

Ginny Weir
Program Director, Bree Collaborative

January 29th, 2014
Background

- Chosen as a new Bree Collaborative topic at the June 2013 retreat.
  - With suggested foci of management of chronic pain/opioids; treatment of dependence and addiction.
- Substantial variation in practice patterns.
  - High variation in treatment for addiction and dependence.
  - Many with addiction problems go undiagnosed.
- Proven strategies to address the topic.
Significant direct and indirect costs

• Total financial cost of drug use disorders to US estimated to be $180 billion.

• The economic costs of alcohol abuse were $184.6 billion in 1998.

Substance Abuse Fact Sheet, SAMHSA, HHS, April 2009.
Good of the Order
Opportunity for Public Comment