Dr. Robert Bree Collaborative Meeting

March 19th, 2014
Agenda

- Welcome
- Chair Report & Approval of Minutes
- Potentially Avoidable Readmissions Update
- Bree Implementation Team Update
- End of Life/Advance Directives Workgroup Update
- Accountable Payment Models Workgroup Update
- Addiction/Dependence Treatment Workgroup Update
- Bree Collaborative Evaluation
- Planning Ahead
- Marketing and Communications
- Good of the Order/Opportunity for Public Comment
Chair Report and Approval of Minutes
BREE COMMITTEE
READMISSIONS PROPOSAL:
WORK-IN-PROGRESS

PRESENTED BY: RICK GOSS, MD, MPH, FACP
HARBORVIEW MEDICAL CENTER / UW MEDICINE
MARCH 19, 2014
Why is this important for the Bree Committee?

1. Triple Aim: High Quality Care, Population Health, Cost-Effective
2. Value-Based Purchasing
3. Active leadership and facilitation in Washington State: WSHA, Qualis, WHA
Why is the Bree Collaborative necessary?

- “Washington State, along with the rest of the country, is working to identify and promote strategies that improve patient outcomes and the quality of health care services while reducing costs. Achieving these goals requires collaboration, and the Bree fills this need by providing a forum in which this collaboration can be successful.” (Bree Website)

- No better example of the need for community collaboration than recognizing the reality of a shared continuum of care.
SUB-COMMITTEE MEMBERS

- Rick Goss, MD, MPH
- Mara Zabari, RN, MPH-HA
- Sharon Eloranta, MD
- Bob Mecklenburg, MD
- Dan Lessler, MD, MHA
- Leah Hole-Marshall, JD
PROPOSAL-IN-PROGRESS

1. Endorse / expect participation in the collaborative model process;
2. Recognize WSHA and Qualis as state-level facilitators;
3. Encourage use of consensus-driven and evidence-based tools and techniques (Toolkit, hospital data reports, etc…) ;
4. Encourage Medicaid Incentive Readmission Bundle;
5. Identify opportunities for transparency;
6. Recognize and reward engagement and participation.
BREE IMPLEMENTATION TEAM (BIT) UPDATE

Dan Lessler, MD
Chief Medical Officer, WA Health Care Authority
Chair, Bree Implementation Team

March 19th, 2014
Endorsed Spine SCOAP recommendation:

- Spine SCOAP Recommendation: HCA submitted the Spine SCOAP recommendations to our sister agencies for feedback. All agencies support community participation in Spine SCOAP and recognize the value for continued data collection efforts for back surgeries. We continue to work on implementation strategies, internally and with the Bree Implementation Team (BIT), to support greater hospital participation in this effort.

Also endorsed cardiology recommendations:

- Cardiology Report: HCA submitted this report and its recommendations to our sister agencies and again all agencies support this work and these recommendations. We share concerns with variability and limited transparency and support the efforts of COAP to bring to light the appropriateness of procedures that are affecting many individuals in Washington.
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
Creation of crisp business/purchaser and clinical case for participation in Spine SCOAP

Contact hospital systems at the corporate level (as opposed to individual hospitals)

Reach out to clinical leadership at target hospitals

Promote interest, understanding and engagement by having the hospital join the annual Spine SCOAP meeting

For hospitals still choosing not to participate, have in-person meeting with representatives of Bree/purchasers/plans
Being able to compare against Spine SCOAP benchmarks is valuable for QI efforts

- “Nobody wants to be an outlier in a registry and those who are actively work to change it.”
- Enables a better understanding of outcome from spine surgery,

Physician buy-in is the biggest hurdle to overcome

- “…naturally skittish about sharing sensitive data…”
- BUT
- Participating clinicians feel obligation to participate on behalf of their patients

Important to be really clear about what info Spine SCOAP makes publicly available
PREVIOUS REPORTS AND RECOMMENDATIONS

- Obstetrics
  Accepted: October 24, 2012

- Cardiology Topic
  Accepted: January 28, 2014

- Spine SCOAP
  Accepted: January 28, 2014
- Currently undergoing inter-agency review (Medicaid, Public Employees Benefits Board, Department of Corrections, Department of Labor and Industries)
- Bree will be notified of the result late March 2014
CRITERIA FOR CHOOSING THE ORDER OF TOPICS

- Degree of development of Bree guidance
- First-in first-out
- High-value, low-effort
- Mortality rates
- Timeliness to practice innovation and related visibility
- Cost-trend drivers
End of Life/Advance Directives Workgroup Update

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

March 19th, 2014
Common Problems with Advance Directives

- Not completing AD forms
- AD inaccurate or too vague
- AD not available to ER, paramedics, PCP, and the hospital
- Completed ADs not used in EOL care
Possible solutions for:
Not completing AD forms

- Promote community wide conversation (talking points).
- Provide incentives to providers to discuss EOL plans
- Focus on specific groups: Medicare, Medicaid, Duals, Retirement Communities, risk stratified groups, faith communities
- Educate providers on living wills and durable power of attorney forms.
- Getting people (not just docs) comfortable with the conversation
- Train volunteer facilitators to help people fill out the ADs
- Promote the tools available, including videos
- Develop a roadmap for patients to use to develop and maintain their AD
Possible solutions for: AD inaccurate or too vague

- Train volunteer facilitators to help people fill out the ADs correctly
- Develop a Resource Library for ADs
- Encourage patients to use informed surrogates to talk with their providers on behalf of the patient
- Develop and encourage state adoption of a standardized AD form (like Wisconsin)
Possible solutions for: AD are not available when and where needed

- Registry for ADs and POLST forms
- Standardize the availability in EMRs
Possible solutions for:
Completed ADs are not used in EOL care

• Determine the barriers to use and possible solutions
Questions? Comments?
ACCOUNTABLE PAYMENT MODELS WORKGROUP

ROBERT MECKLENBURG
APM WORKGROUP CHAIR,
BREE COLLABORATIVE MEMBER
MARCH 19TH, 2014
Provide update on developing warranty and bundle for lumbar fusion.
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: defining a quality standard for healthcare 1) production, 2) purchasing, and 3) payment.
CHARTER OF AIM

1. Select condition
2. Recruit the team
3. Establish clinical content
4. Establish quality metrics
5. Feedback, audit and editing
6. Approval
Lumbar fusion
CHARTER ITEM #2
RECRUIT THE TEAM

- Providers
  1. Bob Mecklenburg, MD, Virginia Mason, Chair
  2. Peter Nora, MD, Swedish Medical Center

- Administrators
  1. April Gibson, Proliance
  2. 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
  4. Mary Kay O’Neill, MD, Regence
3. Establish clinical content
   - Review existing standards related to each condition
     - NC: BCBS policy (2013)
   - Use four-cycle model developed for total joint replacement
   - Identify common medical interventions for each condition to create a standardized patient care pathway.
   - Use evidence search and appraisal methods to assess the value of each intervention and eliminate non-value-added care
ESTABLISH CLINICAL CONTENT
THE FOUR-CYCLE PATHWAY

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) and document impairment
2. Identify an imaging standard: L&I standard
3. Document appropriate trial of conservative therapy
4. Document failure of conservative therapy on ODI
1. Meet 10 requirements relating to patient safety
2. Patient engagement: shared decision-making, designated care partner, advance directive
3. Document optimal preparation for surgery
4. Enrollment in Spine SCOAP
ESTABLISH CLINICAL CONTENT
BEST PRACTICE SURGERY

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
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
Addiction/Dependence Treatment Workgroup Update

Tom Fritz
CEO, Inland Northwest Health Services
Chair, Addiction/Dependence Treatment Workgroup

March 19th, 2014
Workgroup Members

- Tom Fritz, CEO, Inland Northwest Health Services (Chair)
- Charissa Fotinos, MD, MS, Deputy Chief Medical Officer, Health Care Authority
- Jim Walsh, MD, Addiction Medicine, Family Medicine w/Obstetrics Swedish
- Scott Munson, Executive Director, Sundown M Ranch
- Ken Stark, Director, Snohomish County Human Services Department
- Linda Grant, MS, CDP, Director, Evergreen Manor
- Ray Chih-Jui Hsiao, MD, Co-Director, Adolescent Substance Abuse Program, First Vice President of the WSMA, Seattle Children’s Hospital
- Tim Holmes, MHA, Vice President of Outreach Services and Behavioral Health Administration, MultiCare
- Mark Sullivan, MD, PhD, Adjunct Professor, University of Washington

Observers
- Terry Rogers, MD, Foundation for Health Care Quality
Charter: Aim

• To improve and standardize the screening and referral process for drug and alcohol addiction and dependence in Washington State.
Charter: Purpose

• To propose recommendations to the full Bree Collaborative on evidence-based standards to improve screening for drug and alcohol addiction and dependence.
  ▫ **Focus initially on optimal drug and alcohol screening protocol.**
  ▫ **Encourage widespread adoption of standardized drug and alcohol screening.**
  ▫ **Increase measurement and reporting of drug and alcohol screening.**
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 late 2014.
Recommendation

- **Adopt** Addiction/Dependence Treatment Charter
Questions? Comments?
The Population Health Implications of Health Technology Legislation in Washington State

Larry Kessler, Sc.D.
Professor and Chair
Department of Health Services
UW School of Public Health
The goal of this program is to build the evidence for and increase the use of effective regulatory, legal and policy solutions—whether statutes, regulations, case law or other policies—to protect and improve population health and the public health system.

Application deadline April 15, 2014

Grants initiated November 1, 2014

Limit of $150,000 or $200,000 with justification
Original Aims

1. Collaborate the HTA program and the Bree Collaborative to develop the conceptual model that relates the work of these programs to changes in health care and improvements in patient outcomes.

2. Measure the effect of selected reports from HTA and Bree using a pre-post design and using data from state-funded programs, including the Medicaid program and the Uniform Benefits Plan in the WA.

3. Measure relative effect of these efforts by using a national claims-level data base available to the UW (Truven’s MarketScan data) as a control.

4. Use both qualitative and quantitative approaches to find problems in implementation of each program.

5. Perform an evaluation of laws and approaches taken in both programs.

6. Make recommendations as to model legislation and implementation.
Feedback from RWJF

• Need to rephrase focused on population health terms, NOT health care terms

• This sits squarely on the boundary of Health Care Law and Population Health Law, you need to frame this as if you care about the outcomes “outside” the walls of the hospital, so population health outcomes
Framework for Evaluation

• Use published principles for conduct of health technology assessments as a guide
• Perform key informant interviews with representatives of stakeholders in WA State
• Select sentinel recommendations for data evaluation
• Pre-post interrupted time series analysis
• Development of control group analysis
Principles Against Which to Measure

STRUCTURE OF THE HTA PROGRAM

1. The Goal and Scope of the HTA Should Be Explicit and Relevant to Its Use
2. HTA Should Be an Unbiased and Transparent Exercise
3. HTA Should Include All Relevant Technologies
4. A Clear System for Setting Priorities for HTA Should Exist
Principles Against Which to Measure

METHODS OF HTA

1. Should Incorporate Appropriate Methods for Assessing Costs and Benefits
2. Should Consider a Wide Range of Evidence and Outcomes
3. A Full Societal Perspective Should Be Considered
4. Characterize Uncertainty Surrounding Estimates
5. Consider and Address Issues of Generalizability and Transferability
Principles Against Which to Measure

Processes for Conducting HTA

1. Those Conducting HTAs Should Actively Engage All Key Stakeholder Groups
2. Those Undertaking HTAs Should Actively Seek All Available Data
3. The Implementation of HTA Findings Needs to Be Monitored
Principles Against Which to Measure

USE OF HTA IN DECISION MAKING

1. HTA Should Be Timely
2. HTA Findings Need to Be Communicated Appropriately to Different Decision Makers
3. Link Between HTA Findings and Decision-Making Processes Needs to Be Transparent and Clearly Defined
Select Sentinel Recommendations

• Develop criteria for selecting sentinel recommendations for detailed evaluation
  – For example, those that available data may reveal *population health outcome changes*
  – Have sufficient time to show changes
  – Possible examples:
    • Glucose Monitoring for Insulin Dependent Individual Under 19 Years of Age
    • Spinal Fusion and Discography for Chronic Low Back Pain and Uncomplicated Lumbar Degenerative Disc Disease
Analysis Plan

• Pre-post interrupted time series analysis
  – A strong design for certain observational data over time
  – Need to understand other related factors

• Development of control group analysis
  – Need to seek data from national or state-level sources to strengthen analysis and control for contemporaneous effects
Next Steps

• Talk with Health Care Authority about data availability
• Concentrate on HTA program for this grant
• Develop a plan where looking at Bree process and outcomes can be added to this project
• Develop model legislation based on these analytic efforts
Planning Ahead

Steve Hill
Chair, Bree Collaborative

March 19th, 2014
Current Topics

Bree Implementation Team
*Ongoing*

Accountable Payment Models: Lumbar Fusion
*Summer 2014*

End of Life/Advance Directives
*Fall 2014*

Addiction/Dependence Treatment
*Winter 2014*
New Topic Selection

• Retreat

• Legislative Topic Suggestions
  ▫ Appropriate Breast Imaging
  ▫ Antibiotic Resistant Bacteria
Increasing Bree Visibility

- Working with a consultant to develop a comprehensive marketing and communications strategy
- Recruited a graduate student from the UW to help with website content strategy
- Goal: new and improved website launch March 31st
Marketing

• Key drivers, guidelines, and limitations
• Target markets
• Product – “What we offer our market”
• Marketing objective
  ▫ Adoption of Bree Collaborative recommendations
Marketing Cont.

- Marketing strategies – Three core strategies
  - Personal
  - Digital
  - Recognition

- Communications objective

- Communications strategy
  - Stakeholders working together to improve health care quality, patient outcomes, and cost effectiveness in Washington State.

- Three key program initiatives
  - Echo the three strategies
Bree Members

Personal Presentation Strategy: *Proactive, coordinated participation*

- Bree Collaborative Participation Form

Digital Strategy: *Referring/sharing, contributing*
New Logo
Website

- First-person, easy to understand language
- Mobile-friendly
- Focus on involving the user
  - Get Involved Tab
  - Get Involved on each page
- Ability to donate through the site
- Connected to social media
Sitemap

  - About Us - [http://breecollaborative.org/about](http://breecollaborative.org/about)
    - Background - [http://breecollaborative.org/about/background](http://breecollaborative.org/about/background)
    - Reports - [http://breecollaborative.org/about/reports](http://breecollaborative.org/about/reports)
  - Our Work - [http://breecollaborative.org/topic-areas](http://breecollaborative.org/topic-areas)
    - Obstetric care - [http://breecollaborative.org/topic-areas/obcare](http://breecollaborative.org/topic-areas/obcare)
    - Cardiology - [http://breecollaborative.org/topic-areas/cardiology](http://breecollaborative.org/topic-areas/cardiology)
    - Potentially Avoidable Readmissions - [http://breecollaborative.org/topic-areas/par](http://breecollaborative.org/topic-areas/par)
    - Accountable Payment Models - [http://breecollaborative.org/topic-areas/apm](http://breecollaborative.org/topic-areas/apm)
    - Spine/Low Back Pain - [http://breecollaborative.org/topic-areas/spine](http://breecollaborative.org/topic-areas/spine)
    - End of Life Care - [http://breecollaborative.org/topic-areas/eol](http://breecollaborative.org/topic-areas/eol)
    - Addiction/Dependence Treatment - [http://breecollaborative.org/topic-areas/adt](http://breecollaborative.org/topic-areas/adt)
  - Members - [http://breecollaborative.org/members](http://breecollaborative.org/members)
    - Collaborative - [http://breecollaborative.org/members/collaborative](http://breecollaborative.org/members/collaborative)
    - Workgroups - [http://breecollaborative.org/members/workgroup](http://breecollaborative.org/members/workgroup)
  - Meetings - [http://breecollaborative.org/meetings](http://breecollaborative.org/meetings)
    - Materials - [http://breecollaborative.org/meetings/materials](http://breecollaborative.org/meetings/materials)
  - Get Involved - [http://breecollaborative.org/events](http://breecollaborative.org/events)
  - Contact Us - [http://breecollaborative.org/contact-us](http://breecollaborative.org/contact-us)
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