Bree Collaborative
June 4, 2013 Retreat Summary

Taking Stock of the Bree: Clarity around the Mission

- We're not as clear about the mission as we need to be nor are we clear about what the change mechanisms are that will transform the care areas we're working on; we need to work on clarifying both the *what* and the *how*).
- We need to articulate the mission clearly – we need an elevator speech that covers the *what* and *how*! (The legislation has a clear mission statement – let's start with that).
- We need to clarify the Bree's roles as *both* an implementation partner with the Health Care Authority and as a force for change in privately-purchased care. The Bree needs to define consistent approaches and tools for both publicly and privately purchased care.
- We need to harness what makes the Bree distinct: it is a neutral entity, has a mandate *from the state* to improve care; all stakeholder groups are represented; we can discuss the practice of medicine with credibility because all stakeholders are at the table.
- We need to define the Bree's mission and articulate how other organizations working on quality fit together.

Discussion: What is the Bree's Purpose?

- To align the public and private sectors around how to pay for quality and value
- To identify areas of variation that pose risks or don't add value
- To help all stakeholders understand the inputs to patient-centered care episodes that lead to health
- To exert leverage via unbiased information on the best care – safe, cost effective, standardized, appropriate; a *Consumer Reports* approach provides leverage through transparency
- To tap the potential for provider behavior change by defining the levers of change
- To increase consistency and reduce variability in care
- To define standards for purchasing and payment
- To serve as a catalyst for collection, analysis, and provision of quality data
- How do you take good standards of care and operationalize them? This challenge faces all the organizations working to improve quality; the Bree can overcome this problem, in part, through its partnership with the Health Care Authority
- The Bree needs to be **stakeholder agnostic** and overcome special interests at the table

What's Our Progress to Date?

- The OB Workgroup was a good process that tapped into existing groups and best practices; the group came up with well thought out recommendations; it provided good exposure for the Bree.
- There is high engagement and participation at the workgroup level with evidence of the spirit of collaboration filtering down through the participating organizations.
- Members are moving toward serving as representatives of the community and meeting each others' expectations.

What Factors are Limiting the Bree's Success?

- Lack of resources, including staff
- Lack of transparency (in the market place) limits progress toward value purchasing
- Lack of a **nimble**, statewide data base to identify areas of clinical variation
- Data and the funding to produce data (data is expensive!)
- A prioritized list of the most important things to monitor along with the data to monitor them and the regular reporting of the results
- Lack of utilization data
- Lack of quality data
- Lack of process and outcome data
- Challenges deciding whether to go *deep* on issues or go *broad* across issues
- Consensus limits boldness – shouldn't we move forward even if not everyone is on board?
- Can we learn as a group to become comfortable with divisiveness and discomfort?
- What happens if HCA doesn't have the capacity to move forward on implementation?

Clarifying the Implementation Process (MaryAnne Lindeblad and Dan Lessler from HCA led discussion)

- The Bree needs to build implementation into its role, including benefit and payment reform, quality indicators.
- What did/didn't work with the AIM work? The alignment of providers and payors failed (timing might be to blame); but AIM work ultimately influenced state purchasing and reduced inappropriate MRIs.
- What leverage does the Bree have? No one organization can do it itself, so how do we influence each other to build true collaboration and commitment among all sectors to ensure standard implementation of our recommendations?
- We need to identify the barriers to implementation – don't put them under the rug! Identify them and work through them as a group.
- Transparency is needed to drive change; but we need to identify the mechanisms.

- Whose job is it to make implementation happen – it's everyone's – patients, providers, plans, HCA.
- We need to develop a clear implementation strategy for each workgroup's recommendations including feedback loops and how to track implementation ("strategy map"). The Bree should work on implementation of workgroups' recommendations as a group or a form a specific workgroup the focuses solely on implementation.

Laying the Groundwork for Future Topics

Criteria to guide the selection of topics:

- Prevalence
- Costs – direct and indirect
- Potential impact on stakeholder behavior change
- Compelling topic
- Disparities in access to care, results
- Offers prevention opportunities by working upstream from delivery
- Availability of data
- Impact on patient safety
- Preference sensitive
- Perverse incentives exist (and can be changed through levers)

Possible topics to consider:

- Oncology (including end of life/advance care planning and proton beam therapy)
- End of live care/palliative care (as a general topic, not disease-specific)
- Shared Decision Making
- Readmissions standards (e.g., medicine reconciliation standards/processes at discharge)
- Underuse of pain care/opioids
- Transition from inpatient to outpatient
- Emergency room utilization
- Chronic disease management
- Data collection/measurement
- Advanced imaging (revisit AIM work)
- Behavioral health
- Disparities