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, 2014

Washington State Health Care Authority
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The Collaborative consists of the following Governor-appointed expert stakeholders:

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

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

Bree Collaborative Formation

In August 2011, former Governor Gregoire appointed 23 health care experts to serve on the Bree Collaborative in accordance with the requirements laid out in the Collaborative legislation (ESHB 1311). Collaborative members were selected by former Governor Gregoire from nominations put forth by the Washington State Hospital Association (WSHA), the Washington State Medical Association (WSMA), the Association of Washington Healthcare Plans (AWHP), and other community stakeholders. See **Appendix B** for a current list of Bree Collaborative members. Former Governor Gregoire appointed Steve Hill to serve as the Collaborative Chair. Mr. Hill is the former director of the Washington State Department of Retirement Systems, past chair of the Washington Health Alliance (formerly the Puget Sound Health Alliance,) and served as a member of former Governor Gregoire's health care cabinet.

A steering committee was created and appointed by the Chair to provide strategic advice and guidance. See **Appendix C** for a current list of steering committee members.

The Collaborative secured initial funding for project management using a Federal State Health Access Program grant through the end of 2012. The Foundation for Health Care Quality was selected to provide project management for the Collaborative and hire appropriate staff. Additional funding for project management was identified and secured through June 2015 as part of the State's budget process.

The Collaborative has held eighteen meetings (one in 2011, six in 2012, six in 2013, and five thus far in 2014). Meetings are held on a bi-monthly basis with future meetings scheduled for November 20, 2014 and into 2015 on the third Wednesdays of the month: January 21st, March 18th, May 20th, July 15th, September 16th, and November 18th. Meeting agendas and materials for all Collaborative meetings are posted in advance on the Collaborative's website: www.breecollaborative.org.

At its November 2012 meeting, the Collaborative adopted bylaws to set policies and procedures governing the Collaborative beyond the mandates established by the Collaborative legislation (ESHB 1311). Bylaws were revised at the September 2014 meeting.

> **Current bylaws are available, here:** www.breecollaborative.org/wp-content/uploads/bylaws-final.pdf

Summary of Work in the First Two Years

During its first two years, the Collaborative developed recommendations on obstetric care, cardiology, potentially avoidable hospital readmissions (profiled under recent work), accountable payment models (profiled here and under recent work), spine surgery, and low back pain. Topics are discussed in the order in which recommendations were developed. See **Appendix D** for a complete list of members of the Collaborative's workgroups.

Obstetric Care

A large body of evidence and administrative data shows substantial variation in obstetric care practice patterns and services across providers and facilities in Washington State despite local and national quality improvement efforts. In 2012, the percent of deliveries performed between 37 and 39 weeks that were not medically necessary varied significantly across Washington hospitals, from zero to 18.5%.[4]

The Collaborative chose to address this variation and formed an obstetrics workgroup in fall 2011 to review data and recommend a strategy to effectively decrease variation and improve maternity care outcomes. The workgroup included representatives from multiple stakeholder groups including clinicians with expertise in obstetrics and gynecology representing various delivery systems in Washington State. The workgroup met from December 2011 to July 2012. The report identified three focus areas and goals for obstetric care improvement:

- **Elective deliveries**. Eliminate all elective deliveries before the 39th week (those deliveries for which there is no appropriate documentation of medical necessity).
- **Elective inductions of labor**. Decrease elective inductions of labor between 39 and up to 41 weeks.
- **Primary Cesarean-sections**. Decrease unsupported variation among Washington hospitals in the primary C-section rate.

The Collaborative adopted the Obstetrics Care Report and Recommendations in August 2012 and the Report and Recommendations was approved by the HCA director in October 2012.

The Obstetrics Care Report and Recommendations is available, here:
http://www.breecollaborative.org/wp-content/uploads/bree_ob_report_final_080212.pdf

Implementation work has focused on:

- Disseminating the report statewide to obstetrics and health care quality stakeholders
- Presenting the recommendations to Medicaid health plans
- Working to align existing program expectations and data collection including the Obstetrics Clinical Outcomes Assessment Program and the Washington State Hospital Association's Safe Deliveries Roadmap to the recommendations
- Increasing collaboration across existing projects as an active member of the Obstetrics Coordination Team with representatives from the Obstetrics Clinical Outcomes Assessment Program (OB-COAP), the Washington State Hospital Association, the Health Care Authority, the Department of Health, and the Washington Health Alliance
- The Health Care Authority is working to adopt a non-payment policy for early elective deliveries.

Between January and December 2013, elective deliveries between 37 and 39 weeks averaged 1.5% (range zero to 11.2%), a decrease from 5.4% in the 4th quarter of 2011.[4] Among hospitals participating in OB-COAP, primary C-section rate decreased from 21.4% in 2012 to 19.6% in 2013.

Cardiology

Percutaneous coronary intervention (PCI), also known as angioplasty, is a non-surgical procedure used to treat excess plaque in the arteries. While the majority of these procedures are done appropriately and successfully as needed for emergency cardiovascular conditions, a significant number are done electively and may not benefit patients in the same way. One way to improve patient care and outcomes is to look at data on appropriateness of past PCI procedures. Data from the Clinical Outcomes Assessment Program (COAP), a program also housed within the Foundation for Health Care Quality, shows wide variation in the appropriateness of PCI procedures as defined by national guidelines. However, availability and transparency of appropriateness data is a major issue across Washington State hospitals.

In February 2012, the Collaborative asked the COAP management committee to publicly post hospitals' insufficient information reports and appropriateness of PCI results. At that point, hospital-specific data and analyses were only available within the password-protected member's section. The Collaborative believes that making this data publicly available would incentivize hospitals to improve data collection and documentation. The COAP management committee approved the Collaborative's request and agreed to provide technical assistance to hospitals to reduce the amount of missing data and improve the ability to classify the appropriateness of procedures. The Cardiology Report and Recommendations recommends a four-step process that provided time for hospitals to improve practices before data became publicly available:

- **Step 1:** Appropriate use insufficient information report with 2012 data by hospital posted on the COAP members-only section of the 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 Bree Collaborative and hospitals to review. Hospitals will have 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 Collaborative also asked the Washington State Alliance to post COAP data on its Community Checkup website, which compares data on health care services across the Puget Sound region. Hospitals had the option to not be identified.
    - *Completed June 2013.*

The Cardiology Report and Recommendations was adopted by the Collaborative in January 2013 and approved by the HCA director in January 2014.

The Cardiology Report and Recommendations is available, here:
http://www.breecollaborative.org/wp-content/uploads/bree_bc_cardiology_final.pdf

The average rate of insufficient information for PCI appropriate use criteria has dropped from 29% in 2011 to 23% in 2013.

COAP continues to monitor rates of insufficient information and PCI appropriateness to assess the impact of public disclosure as well as other areas to partner with the Collaborative.

Accountable Payment Models: Elective Total Knee and Total Hip Replacement

The current American model of health care typically reimburses based on number of services, rather than quality of care. To address this issue, the Collaborative formed an Accountable Payment Model (APM) subgroup in November 2012 to make recommendations based on one of the Hospital Readmission workgroup's focus areas to*, research and recommend components and structures essential to creating a successful potentially avoidable hospital readmission accountable payment model that aligns incentives, including warranty pricing, bundled payments, and other innovative payment methodologies*. The APM workgroup develops recommendations that tie reimbursement to an entire episode of care, including pre and post-operative care, with no additional payment for avoidable complications

The APM workgroup began by creating an accountable payment model for total knee and hip replacement (TKR/THR) surgery. The workgroup chose to first focus on knee and hip replacements due to the high volume of these procedures and the high variability in how the procedures are performed.

> **Readmission rates for total knee and total hip replacements are posted on the Bree Collaborative's website, here:** http://www.breecollaborative.org/wp-content/uploads/bree_summary_CHARS_Analysis.pdf

The TKR/THR warranty defines complications and time-frames after surgery during which complications should be attributed to the original surgery. The purpose of the warranty is to track clinical and financial accountability for the extra care needed to diagnose, manage, and resolve those complications. The intent is to distribute financial risk across professional and facility components in proportion to the revenue generated by the procedure. The model is an attempt to align purchasing and payment with best practices that lead to safer care, better outcomes, and lower costs. The final products will serve as a guide for quality- and value-based purchasing for both public and private sectors.

The surgical bundle defines the expected components of pre-operative, intra-operative, and post-operative care needed for successful TKR/THR surgery in four stages and includes quality standards:

- Disability due to osteoarthritis despite conservative therapy
- Fitness for surgery
- Repair of the osteoarthritic joint
- Post-operative care and return to function

The TKR/THR Warranty Model is available, here: www.breecollaborative.org/wp-content/uploads/bree_warranty_tkr_thr.pdf

The TKR/THR Surgical Bundle is available, here: www.breecollaborative.org/wp-content/uploads/tkrthr_bundle.pdf

The supporting evidence table is available, here: www.breecollaborative.org/wp-content/uploads/tkr_thr_evidence.xls

The warranty was disseminated for public comment for two weeks in June and formally adopted by the Bree Collaborative at the July 2013 meeting. The surgical bundle was disseminated for public comment for two weeks in October and formally adopted at the November 2013 meeting. Both the TKR/THR surgical bundle and warranty were approved by the Health Care Authority Director in April 2014.

Implementation of the TKR/THR Bundle and Warranty is discussed under the work of the Bree Implementation Team.

Spine Surgery and Low Back Pain

Low back pain is a common and costly condition. Significant variation exists in diagnosis and treatment of patients with low back pain, with high utilization rates for many costly modalities that have not been shown to improve health outcomes.[5,6] Effective management of patient's low back pain can be difficult as the majority of patients have no identifiable anatomic or physiologic cause.[7] For most patients with acute low back pain, symptoms improve with conservative treatment such as physical activity. Other patients are at a higher risk of developing chronic low back pain. If patients do develop chronic pain, more intense treatment options become necessary such as lumbar fusion surgery, which has the highest regional variation of any major surgery in the US, with a 20-fold difference between geographic regions.[8] Lumbar fusion is the number one inpatient cost for Uniform Medical Plan (public employees), at an average cost of $80,000-$120,000.

The Collaborative chose a two-pronged strategy to address both acute and chronic low back pain:

- Form a workgroup to develop recommendations for preventing the transition of acute pain to chronic pain.
- Recommended that all hospitals participate in Spine SCOAP, a clinician-led quality improvement collaborative for hospitals in Washington State and a program of the Foundation for Health Care Quality, to improve surgical outcomes for spine surgery.

In March 2013, the Collaborative submitted recommendations to the Health Care Authority "strongly recommend[ing] participation in Spine SCOAP as a community standard, starting with hospitals performing spine surgery with the following conditions:

- Results are unblinded.
- Results are available by group.
- Establish a clear and aggressive timeline.
- Recognize that more information is needed about options for tying payment to participation."

The charter and roster for the Spine Surgery and Low Back Pain workgroup were approved in October 2012. The workgroup met from November 2012 to October 2013 and included Collaborative members as well as physiatrists, rehabilitation specialists, and pain experts. The workgroup reviewed the current best practice literature, compared widely-used evidence-based guidelines, and invited guest speakers to present innovative research in low back pain evaluation and management. Based on this research and the expertise of workgroup members, the workgroup developed a report with specific recommendations for hospitals, clinics, individual providers, government agencies, health plans, and employers or health care purchasers.

Focus areas and specific goals of the Report and Recommendations include:

Focus Area	Specific Goals
1. Increase 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	• Increase adherence to evidence-based guidelines • Increase provider awareness of key messages that emphasize physical activity, return to work, patient activation, etc. • Reduce use of non-value-added modalities in the diagnosis and treatment of low back pain

	(e.g., inappropriate use of MRIs)
2. Increase 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	• Increase use of STarT Back Tool, FRQ, or a similar screening instrument to triage acute low back pain patients to appropriate care providers • Restore patient function more quickly
3. Increase awareness of low back pain management among individual patients and the general public	• Increase the proportion of the population that agrees with key low back pain messages (e.g., low back pain is common, low back pain symptoms often improve without treatment, there is no magic bullet, stay active, etc.)

The Spine Surgery and Low Back Pain Report and Recommendations is available, here: www.breecollaborative.org/wp-content/uploads/spine_lbp.pdf

The draft Report and Recommendations were disseminated for public comment for two weeks in October 2013. The Collaborative adopted the recommendations in November 2013 and the Health Care Authority approved the recommendations in January 2014.

Implementation of the Spine Surgery and Low Back Pain Report and Recommendations and the Spine SCOAP Recommendation are discussed under the work of the Bree Implementation Team.

Summary of Recent Work

November 2013 to October 2014 has seen great progress. Work to develop recommendations was done in four health care service areas and to develop implementation strategies for existing recommendations through the Bree Implementation Team.

The following workgroups actively developed recommendations in this last year:

1. Bree Implementation Team
2. Accountable Payment Models: Lumbar Fusion Surgical Bundle and Warranty
3. Potentially Avoidable Hospital Readmissions
4. End-of-Life Care
5. Addiction and Dependence Treatment

The Collaborative:

- **Supported five active workgroups**
- **Adopted four sets of recommendations**
- **Received approval from the Health Care Authority for five recommendations.**

The Collaborative approved and sent **four** sets of recommendations to the Health Care Authority:

- **Elective Total Knee and Total Hip Replacement**
  (November 2013)
  - Surgical Bundle. Available: www.breecollaborative.org/wp-content/uploads/tkrthr_bundle.pdf
- **Spine Surgery and Low Back Pain Report and Recommendations**
  (November 2013)
  - Available: www.breecollaborative.org/wp-content/uploads/spine_lbp.pdf
- **Potentially Avoidable Hospital Readmissions Report and Recommendations**
  (July 2014)
  - Available: www.breecollaborative.org/wp-content/uploads/Readmissions-Report-FINAL-14-0730.pdf
- **Elective Lumbar Fusion**
  (September 2014)
  - Surgical Bundle. Available: www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Bundle-Final.pdf
  - Warranty. Available: hwww.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Warranty-Final.pdf

At its July meeting, the Collaborative selected seven potential topics for the upcoming year and evaluated the topics across 11 criteria. After further discussion, the four topics garnering the most votes were:

- Developing a bundled payment model around coronary artery bypass surgery
- Prostate specific antigen screening
- Opiate recommendations from the Washington State Agency Medical Directors Group
- Oncology treatment

The Collaborative will continue to select new topic areas on an annual basis.

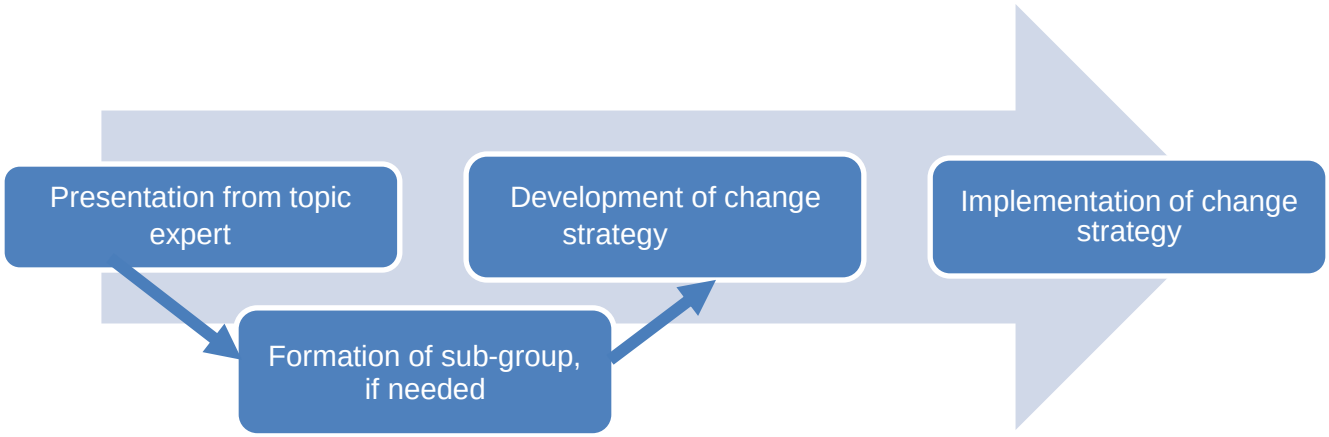
Bree Implementation Team

The Collaborative identified implementation of its recommendations as an area needing dedicated resources and focus in July 2013 and approved a charter and roster for a Bree Implementation Team in September 2013. The Bree Implementation Team has been meeting regularly from October 2013 to present.

The Implementation Team's purpose is to design and implement strategies to successfully encourage stakeholders to implement recommendations developed by the Collaborative through focusing on the following areas:

- Provider payment redesign
- Care delivery organization
- Benefit design
- Patient engagement
- Transparency and performance indicators

The Collaborative specified that the Implementation Team include at least one representative from each of the major stakeholder groups and at least one member of every topic area workgroup to provide content expertise. Dr. Dan Lessler, HCA Chief Medical Officer, serves as Implementation Team chair. The Implementation Team will approach a topic for implementation after the topic has been approved by the Health Care Authority. The Implementation Team's approach to implementation begins with presentation from a topic expert, development and convening of a sub-group if necessary, development of a comprehensive change strategy, and implementation of that change strategy, as illustrated below:



The Implementation Team has worked to encourage non-participating hospitals to join Spine SCOAP, implement the obstetrics recommendations, encourage uptake of the bundled payment models for total knee and total hip replacements, and increase visibility of the Bree Collaborative broadly.

The Implementation Team has worked to engage non-participating hospitals in Spine SOCAP through certified letters, phone calls, invitations to the Spine SCOAP annual meeting, and invitations to other relevant meetings. Bree Collaborative program staff have created a crisp business and clinical case for participation in Spine SCOAP, contacted hospital systems at the corporate level and individual levels, reached out to clinical leadership at target hospitals, developed educational materials for patients, and to develop educational materials about low back pain and spine surgery into a visually appealing format.

Bree Collaborative program staff convened an obstetrics subgroup to discuss benefit design changes to support the Bree recommendations. The group discussed financial incentives for belonging to an obstetric quality improvement programs with a preference for one with the capability to share data across sites. Additional coordination effort includes actively participating in the obstetrics subgroup of the Summit Group, health care stakeholders working to overcome entrenched cross-organizational barriers. Obstetrics was identified as a priority collaboration area by the Summit Group along with end of life care. Membership includes Bree program staff, the Health Care Authority, the Foundation for Health Care Quality, the Department of Health, the Washington State Hospital Association, and the Washington State Medical Association. The subgroup is working to coordinate messages across organizations, coordinate data across organizations, provide tools and resources, and facilitate common patient expectations.

Implementation of the bundled payment models for total knee and total hip replacements has involved discussing the technicalities of the bundle and warranty and how the bundle may be supported by the emphasis on payment reform within the State Health Care Innovation Plan. The Implementation Team has formed a subgroup to develop tactics to engage providers in the bundle and has researched lessons learned from bundled payment programs implemented in other states (e.g., in California, nationally).

The Bree Collaborative has developed a new logo and a new website written in first-person, easy to understand language. The website is mobile-friendly, focuses on involving users and educating the public with a *Get Involved* section, and is integrated with social media. The revised website, www.breecollaborative.com, has helped to increase the visibility of the Bree Collaborative online. Ongoing work involves developing one page “plain English” handouts about each of the completed topics and re-working the “Get Involved” webpage to include a sub-tab for patients, purchasers, and payers for use by the Implementation Team.

Potentially Avoidable Hospital Readmissions

Background

Avoidable hospital readmissions are common and costly events, negatively impacting patients' health and wellbeing. The estimated national cost for unplanned Medicare hospital readmissions was $17.4 billion in 2004.[9] Unplanned and potentially avoidable hospital readmissions are a complex problem with multiple influences. Readmissions are reflective of a local health care system's ability to coordinate care for patients across settings and are often a sign of inadequate discharge planning, lack of coordination with community-based care, and lack of follow-up with patients.[10] Individual and neighborhood socioeconomic status, income inequality, as well as low education, being older, and being unmarried have been found to be associated with higher readmission rates.[11,12,13,14] While not all hospital readmissions are preventable, reducing readmission rates through greater community collaboration among diverse stakeholders, implementation of standard processes within the hospital, and better communication between the hospital and community health care providers and the hospital, patients, and family represents a great opportunity to improve health care quality, patient outcomes, and the affordability of health care in Washington State.

Our Work

The Bree Collaborative approved the Potentially Avoidable Readmissions (PAR) workgroup charter in May 2012. The workgroup met from May to September 2012 and identified three strategies:

1. *Alignment with Local Readmissions Activities*: Identify alignment opportunities where the Collaborative can promote and augment current evidence-based, quality improvement initiatives aimed at reducing PARs including effective communication, coordination of care, and 'patient hand-offs' during transitions in care settings.
2. *Measurement, Transparency, and Reporting*: Support use of current process and outcome measures for reducing PARs and transparency of methodologies and readmissions rates, by hospital and physician group, in a semi-public manner.
3. *Accountable Payment Model*: Research and recommend components and structures essential to creating a successful PAR accountable payment model that aligns incentives, including warranty pricing, bundled payments, and other innovative payment methodologies. See the discussion on development of a total knee and total hip replacement bundled payment model and warranty and lumbar fusion bundle and warranty for a summary of the Accountable Payment Models Workgroup.

Although the workgroup was dissolved in November 2013, the group recommended that the Bree Collaborative endorse the Washington State Hospital Association's (WSHA) and its community partners' work to develop a standardized toolkit and process that both hospitals and community providers can use to reduce the rate of readmissions and make available 30-day, all-cause readmission results, by hospital. The PAR workgroup was reconvened after the March 2014 Bree Collaborative meeting and met in April and June 2014.

> **The 30-day, all-cause rehospitalization rates at Washington State hospitals from 2011 CHARS data is available, here:** www.breecollaborative.org/wp-content/uploads/combined-chars-report-13-1114.pdf

The reconvened workgroup drafted a Potentially Avoidable Hospital Readmissions Report and Recommendations with three focus areas representing a first step for our community working together to reduce potentially avoidable hospital readmissions.

I. Support for the collaborative model as used in Washington State. The Bree Collaborative recommends that at a minimum, hospital readmissions collaboratives be recognized by the following three items:
   a. Formally writing a charter that includes a list of participating organizations, shared expectations for best practices, and measures of success.
   b. Demonstrating evidence of participation in recurring meetings.
   c. Recognition by WSHA or Qualis Health as an active member. WSHA or Qualis Health will recognize collaboratives for a period of one year after which time the organizations will reevaluate their roles.

II. 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. The Bree Collaborative recognizes the consensus work based on best available evidence that went into the *Care Transitions Toolkit* and recommends that hospitals adopt the *Toolkit* in its entirety. It is understood that some variation may be appropriate based on clinically compelling reasons.

III. Two hospital-specific measures to be measured by WSHA for the percent of inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition) for which there is:
   a. A patient discharge information summary provided to the primary care provider (PCP) or aftercare provider within three business days from the day of discharge.
   b. A documented follow-up phone call with the patient and/or family within three business days from the day of discharge.

The five conditions were selected to align with the Medicaid Quality Incentive Program to reduce the reporting burden for individual hospitals.

> **The Potentially Avoidable Hospital Readmissions Report and Recommendations is available, here:** www.breecollaborative.org/wp-content/uploads/Readmissions-Report-FINAL-14-0730.pdf

The Report and Recommendations were available for public comment for a three week period May to June during which time over 45 public comments were received. The Potentially Avoidable Hospital Readmissions Report and Recommendations was adopted by the Bree Collaborative in July 2014 and approved by the Health Care Authority Director in August 2014.

Accountable Payment Models: Elective Lumbar Fusion

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. In many other circumstances, however, there is there is less accord concerning the benefit of lumbar fusion. Search and appraisal of scientific, economic and policy literature indicates that lumbar fusion surgery is associated with a substantial complication rate, is costly to patients and purchasers, and for many, is of uncertain benefit compared with non-surgical care.[15,16] Despite these concerns, the number of patients undergoing lumbar fusion is increasing rapidly and disproportionately to other spine surgeries. The regional rate for lumbar fusion among CMS patients varies by a factor of 20 with a nearly three-fold difference in charges billed to CMS nationwide for this surgery.[7,15] Standards for appropriateness, fitness for surgery, best surgical practice, and methods to ensure return to function are rudimentary, fragmented, and inconsistent. When clinical standards for reimbursement for elective lumbar fusion are relaxed, rates of fusion, complications, and reoperation rates all increase as does inpatient cost.[17]

Our Work

The workgroup formed with new membership in January 2014 and met until August 2014 to develop a bundled payment model for lumbar fusion based off the model developed for total knee and total hip replacement. As for the previous model, the final products are expected to serve as a guide for quality- and value-based purchasing for both public and private sectors. The surgical bundle defines the expected components of pre-operative, intra-operative, and post-operative care needed for successful lumbar fusion surgery.

To improve safety for patients, performance for providers and affordability for purchasers, the workgroup proposed a four-cycle model requiring:

- Documentation of disability despite explicit non-surgical care
- Meeting fitness requirements for patients prior to surgery
- Adherence of standards for best practice surgery
- Implementation of a structured plan to rapidly return patients to function

The primary intent of the warranty is to set a high priority on patient safety. It is also intended to balance financial gain for providers and institutions performing lumbar fusion surgery with financial accountability for complications attributable to these procedures. In this warranty the intent is to distribute financial risk across professional and facility components in proportion to the revenue generated by the procedure.

> **The Lumbar Fusion Bundle is available, here:** www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Bundle-Final.pdf
> **The Lumbar Fusion Warranty is available, here:** www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Warranty-Final.pdf
> **The supporting evidence table is available, here:** www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Evidence-Table-Final.pdf

The documents were available for public comment for a three week period in July-August during which time over 60 public comments were received. The Lumbar Fusion Surgical Bundle and Warranty were adopted by the Collaborative at the September 2014 meeting and approved by the Health Care Authority Director in October 2014.

End-of-Life Care

Background

End-of-life care in the United States and within Washington State is strikingly variable and often misaligned with patient preference.[18,19] 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.[20] In Washington State in 2012, 30.51% of deaths occurred in a general hospital, 25.44% in a nursing home, 6.04% in a hospice facility, and only 32.6% at home.[21] Family members of patients at the end of their life also report care not aligning with patient wishes, in many cases due to unwanted aggressive treatment, and significant financial impact of in-hospital deaths.[22,23] Additionally, surviving family members have been shown to have symptoms of post-traumatic stress disorder after the death of a loved one in an intensive care unit.[24] Care that is at odds with patient and family wishes negatively impacts quality of patients' life, increases cost to families, and seriously overburdens patients and their families.

Appropriately timed advance care planning conversations between providers and patients and between patients and their families and/or caregivers and expressing end-of-life wishes in writing with advance directives and Physician Orders for Life Sustaining Treatment (POLST) if appropriate, can increase patient confidence, sense of dignity, and the probability that patient wishes are honored at the time of death.[25,26] The Bree Collaborative's goal is 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.

Our Work

End-of-life care was identified by the Bree Collaborative as an area with high variation and poor patient outcomes and Collaborative elected to form a workgroup to address end-of-life care issues. The workgroup met from January 2014 to November 2014 with the goal that all Washingtonians be informed about their end-of-life options, communicate their preferences in actionable terms, and receive end-of-life care aligned with their and their family members' goals and values. The workgroup developed the following five focus areas corresponding to how an individual would ideally experience advance care planning for the end of life. Each focus area is supported by multi-stakeholder recommendations.

Focus Area	Specific Goals
1. Increase awareness of advance care planning, advance directives, and POLST in Washington State	• Promote community-wide discussions about how to have conversations regarding personal goals of care and the type of care desired at the end of life with family members and health care providers; the importance of having an advance directive that includes a living will (also known as a health care directive), a durable power of attorney for health care, and a written personal statement about health care goals and values; and the difference between POLST and an advance directive
2. Increase the number of people who participate in advance care planning in the clinical and community settings	• Educate health care professionals on how to engage individuals and their families in advance care planning and how to refer to appropriate community-based advance care planning resources • Encourage the use of evidence-based advance care planning tools and programs • Encourage people and health care providers to involve family members and friends in advance care planning and

	designate a legal durable power of attorney for health care • Encourage appropriate timing of advance care planning conversations • Revise reimbursement policy to pay for advance care planning counseling and discussion with patients and their surrogate decision makers • Promote awareness of the value of hospice and encourage appropriate hospice referrals • Train qualified advance care planning facilitators
3. 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	• Encourage the documentation of advance care planning discussions with easily understandable and culturally appropriate advance directives that include: a living will (also called a health care directive) that stipulates specific treatment preferences (if known and applicable to the situation), a durable power of attorney for health care that names a surrogate and indicates the amount of leeway the surrogate should have in decision-making, and a written personal statement that articulates the patient's values and goals regarding end-of-life care • Adopt resources meant to engage low-literacy patients in advance care planning and creation of advance directives
4. Increase the accessibility of completed advance directives and POLST for health systems and providers	• Contract with an existing registry to store and make accessible advance directives and POLST • Work with the Department of Motor Vehicles to add text indicating the presence of an advance directive on the Washington State driver's license with the additional option of putting a QR code on the back of the driver's license to gain direct access to the registry
5. Increase the likelihood that a patient's end-of-life care choices are honored	• Implement quality improvement programs within hospitals, nursing homes, and other settings to encourage greater adherence to patients' requests as outlined in advance directives and POLST if accurate and applicable to the current situation • Encourage providers and facilities to measure family satisfaction with end-of-life care by widespread use of an after-death survey tool similar to that used by hospice agencies • Enact legislation providing legal immunity to health care providers who honor a patient's POLST, comparable to existing protections for providers who honor a patient's advance directive

The final End-of-Life Care Report and Recommendations is available, here:
www.breecollaborative.org/wp-content/uploads/EOL-Care-Final-Report.pdf

The Report and Recommendations was available for public comment for a four week period in September-October and received over 35 comments. The Report and Recommendations was adopted by the Collaborative at the November 2014 meeting.

Addiction and Dependence Treatment

Background

Alcohol and drug abuse disorders lead to many debilitating health, economic, interpersonal, and social consequences with potentially long-lasting effects if left untreated. Excessive use of alcohol is the fourth leading cause of preventable death in the United States and is strongly associated with higher risk of: multiple types of cancers; hypertension; liver cirrhosis; chronic pancreatitis; injuries; and violence.[27,28] In Washington State, alcohol use leads to 11.1% of deaths of working age adults, higher than the national average.[29]

Death from opioid pain relievers has increased substantially every year, rising to 100 deaths daily in 2008.[30] Substance abuse disorders are a leading cause of unnecessary hospitalizations and in 2007 an estimated 329,000 hospitalizations in Washington were associated with alcohol and drug use, comprising of over half of all hospitalizations that year.[31] Medicaid beneficiaries with a substance use disorder had significantly higher physical health expenditures and hospital admissions.[32] Nationally, the economic cost of illicit drug use is more than $193 billion including the impact on crime (e.g., criminal justice system, crime victims), health (e.g., hospital and emergency room costs), and productivity (e.g., labor participation, premature mortality).[33]

Almost 90% of individuals with identified substance dependence or abuse do not receive appropriate care or treatment partially due to alcohol and substance abuse disorders being highly stigmatized, unscreened, and patients not being likely to receive or seek treatment themselves.[34] High variation and lack of standardized screening protocols for alcohol and drug use within Washington State show opportunities for improvement.

Our Work

The workgroup met monthly from April 2014 to present and developed five focus areas to increase appropriate screening, brief intervention, brief treatment, and facilitated referral to treatment in primary care clinics and emergency room settings to address the underutilization of drug and alcohol screening and treatment within Washington State. Each focus areas is supported by multi-stakeholder recommendations.

Focus Area	Specific Goals
Reduce stigma associated with alcohol and other drug screening, intervention, and treatment	• Train health care staff how to have non-judgmental, empathetic, and accepting conversations about alcohol and drug misuse • Train health care staff on the prevalence of alcohol and other drug misuse, the impact of alcohol and other drug misuse on other health conditions, and the importance of screening for alcohol and other drug misuse • Increase the number of people who see alcohol and other drug misuse screening as a usual part of care and are comfortable discussing alcohol and other drug misuse
Increase appropriate alcohol and other drug use screening in primary care and emergency room settings	• Increase the number of appropriately trained staff who provide screening • Increase annual alcohol and other drug misuse screening, starting with an initial primary care visit, using validated, scaled screening tools • Implement universal alcohol and other drug misuse screening in emergency rooms (ER)
Increase capacity to provide brief intervention and/or brief treatment for alcohol	• Increase the number of appropriately trained staff who provide brief intervention and/or brief treatment in the primary care and ER settings

and other drug misuse	• Increase the number of patients who screen positive for alcohol and other drug misuse who receive appropriate brief intervention and/or brief treatment • Follow-up with patients as appropriate who have received brief intervention and/or brief treatment • Manage adolescents with addictions collaboratively with child and adolescent addiction specialists, if possible • Enhance ability to triage patients to appropriate level of care if not improving • Increase accessibility of consulting with qualified behavioral health providers
Decrease barriers for facilitating referrals to appropriate treatment facilities	• Increase the number of patients who screen positive who are referred to and receive care at an appropriate chemical dependency treatment facility consistent with the American Society of Addiction Medicine criteria • Track patients as they receive appropriate recovery care • Contact patients after they receive appropriate treatment to facilitate rapid return to function • Increase cross-site communication and data sharing • Increase chemical dependency resources sufficient to facilitate successful patient recovery
Address the opioid addiction epidemic	• Decrease inappropriate opioid prescribing for non-cancer, non-terminal pain • Increase capacity for primary care providers to prescribe medication assisted treatment • Train appropriate primary care and emergency room staff to screen, engage, and facilitate both on-site opioid medication assisted treatment and/or facilitate coordinated care with offsite specialized chemical dependency treatment. • Extend state and private capacity and support for opioid medication assisted treatment (e.g., increase Buprenorphine treatment availability) • Facilitate referrals and decrease barriers to opioid addiction treatment (specialized vs on-site addiction treatment) • Track changes to the number of admissions, cost, morbidity, and mortality in emergency room, hospital, and outpatient settings in patients using opiates to evaluate change over time

The draft Addiction and Dependence Treatment Report and Recommendations is available, here: www.breecollaborative.org/wp-content/uploads/Final-ADT-Draft.pdf

The Addiction and Dependence Treatment Report and Recommendations was presented to the Bree Collaborative at the November 2014 meeting and will be available for public comment for a four week period in December.

Looking to Forward to Year Four

The Addiction and Dependence Treatment workgroup will meet to discuss public comments and make changes to the documents based on those comments in January 2015. The workgroup will present the Report and Recommendations to the Bree Collaborative for final adoption in January 2015.

The Implementation Team will continue to facilitate adoption of the Bree Collaborative's recommendations in our community and monitor rates of adoption.

The Collaborative will form workgroups around the newly selected topics shortly and will begin drafting recommendations. New topics include:

- Developing a bundled payment model around coronary artery bypass surgery
- Prostate specific antigen screening
- Opiate recommendations from the Washington State Agency Medical Directors Group
- Oncology treatment

Collaborative chair, Steve Hill, announced his retirement from the Bree Collaborative at the November 2014 meeting; to be effective when a new chair is appointed by the Governor. Mr. Hill has served as the chair of the Dr. Robert Bree Collaborative from September 2011 to present and been instrumental to the Collaborative's success. Mr. Hill guided the Collaborative through three years of crafting recommendations, worked with community partners and other stakeholders to disseminate the Collaborative's work, and helped to develop a shared understanding of the Collaborative throughout Washington State.

The Collaborative anticipates a new chair in late 2014 or early 2015.

References

[1] Institute of Medicine. 2012. Best care at lower cost: The path to continuously learning health care in America. Washington, DC: The National Academies Press.

[2] Berwick DM, Hackbarth AD. Eliminating Waste in US Health Care. *JAMA*. 2012 Apr 11;307(14):1513-6.

[3] Health Policy Brief: Reducing Waste in Health Care. *Health Affairs*. December 13, 2012.

[4] Elective Deliveries between 37 and up to 39 weeks not medically necessary (Q1 through Q4 2012), Washington State Hospital Quality Indicators, Washington State Hospital Association. Available: www.wahospitalquality.org

[5] Mafi JN, McCarthy EP, Davis RB, Landon BE. Worsening trends in the management and treatment of back pain. *JAMA Intern Med.* 2013 Sep 23;173(17):1573-81.

[6] Deyo RA, Mirza SK, Terner JA, Martin BI. Over treating chronic pain: time to back off*? J Am Board Fam Med.* 2009;22:62-68.

[7] Walker BF, Williamson OD. Mechanical or inflammatory low back pain. What are the potential signs and symptoms? *Man Ther.* 2009;14(3):314-320.

[8] Weinstein JN, Lurie JD, Olson PR, Bronner KK, Fisher ES. United States' trends and regional variations in lumbar spine surgery: 1992-2003. Spine *(Phila Pa 1976).* 2006 Nov 1;31(23):2707-14.

[9] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med.* 2009 Apr 2;360(14):1418-28.

[10] Goodman DC, Fisher ES, Chang CH, The Dartmouth Institute for Health Policy and Clinical Practice. After Hospitalization: A Dartmouth Atlas Report on Post-Acute Care for Medicare Beneficiaries. Available: www.dartmouthatlas.org/downloads/reports/Post_discharge_events_092811.pdf. Accessed: April 2014.

[11] Hu J, Gonsahn MD, Nerenz DR. Socioeconomic status and readmissions: evidence from an urban teaching hospital. *Health Aff (Millwood).* 2014 May;33(5):778-85.

[12] Lindenauer PK1, Lagu T, Rothberg MB, Avrunin J, Pekow PS, Wang Y, Krumholz HM. Income inequality and 30 day outcomes after acute myocardial infarction, heart failure, and pneumonia: retrospective cohort study. *BMJ.* 2013 Feb 14;346:f521.

[13] Arbaje AI, Wolff JL, Yu Q, Powe NR, Anderson GF, Boult C. Postdischarge environmental and socioeconomic factors and the likelihood of early hospital readmission among community-dwelling Medicare beneficiaries. *Gerontologist.* 2008 Aug;48(4):495-504.

[14] Foraker RE, Rose KM, Suchindran CM, Chang PP, McNeill AM, Rosamond WD. Socioeconomic status, Medicaid coverage, clinical comorbidity, and rehospitalization or death after an incident heart failure hospitalization: Atherosclerosis Risk in Communities cohort (1987 to 2004). *Circ Heart Fail.* 2011 May;4(3):308-16.

[15] Brox JI, Sørensen R, Friis A, Nygaard Ø, Indahl A, Keller A, Ingebrigtsen T, Eriksen HR, Holm I, Koller AK, Riise R, Reikerås O. Randomized clinical trial of lumbar instrumented fusion and cognitive intervention and exercises in patients with chronic low back pain and disc degeneration. *Spine (Phila Pa 1976)*. 2003 Sep 1;28(17):1913-21.

[16] Centers for Medicare and Medicaid Services. Medicare provider utilization and payment data. Viewed on: 22 April 2014 (page last modified 04/11/2014 10:57am). http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier.html

[17] Martin BI, Mirza SK, Franklin GM, Lurie JD, MacKenzie TA, Deyo RA. Hospital and surgeon variation in complications and repeat surgery following incident lumbar fusion for common degenerative diagnoses. *Health Serv Res.* 2013 Feb; 48(1): 1-25. PMID: 22716168

[18] Barnato AE, Herndon MB, Anthony DL, Gallagher PM, Skinner JS, Bynum JP, Fisher ES. Are regional variations in end of life care intensity explained by patient preferences?: A Study of the US Medicare Population. *Med Care.* 2007 May;45(5):386-93.

[19] Goodman DC, Esty AR, Fisher ES, Chang CH. Trends and Variation in End of life Care for Medicare Beneficiaries with Severe Chronic Illness. The Dartmouth Atlas Project. April 12, 2011. Available: www.dartmouthatlas.org/downloads/reports/EOL_Trend_Report_0411.pdf

[20] Raphael C, Ahrens J, Fowler N. Financing end of life care in the USA. *J R Soc Med.* 2001 September; 94(9): 458–461.

[21] Center for Health Statistics, Washington State Department of Health, December 2013.

[22] Lynn J, Teno JM, Phillips RS, Wu AW, Desbiens N, Harrold J, Claessens MT, Wenger N, Kreling B, Connors AF Jr. Perceptions by family members of the dying experience of older and seriously ill patients. SUPPORT Investigators. Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments. *Ann Intern Med*. 1997 Jan 15;126(2):97-106.

[23]Collins LG, Parks SM, Winter L. The state of advance care planning: one decade after SUPPORT. Am J *Hosp Palliat Care*. 2006 Oct-Nov;23(5):378-84.

[24] Azoulay E, Pochard F, Kentish-Barnes N, Chevret S, Aboab J, Adrie C, Annane D, Bleichner G, Bollaert PE, Darmon M, Fassier T, Galliot R, Garrouste-Orgeas M, Goulenok C, Goldgran-Toledano D, Hayon J, Jourdain M, Kaidomar M, Laplace C, Larché J, Liotier J, Papazian L, Poisson C, Reignier J, Saidi F, Schlemmer B; FAMIREA Study Group. Risk of post-traumatic stress symptoms in family members of intensive care unit patients. *Am J Respir Crit Care Med*. 2005 May 1;171(9):987-94.

[25] Hammes BJ, Rooney BL, Gundrum JD. A comparative, retrospective, observational study of the prevalence, availability, and utility of advance care planning in a county that implemented an advance care planning microsystem. *JAGS*. 2010;58:1249-1255.

[26] Brinkman-Stoppelenburg A, Rietjens JA, van der Heide A. The effects of advance care planning on end of life care: A systematic review. *Palliat Med*. 2014 Sep;28(8):1000-1025.

[27] Bouchery EE, Harwood H, Sacks JJ, Simon CJ, Brewer RD. Economic costs of excessive alcohol consumption in the US, 2006. *Am J Prev Med.* 2011;41(5):516–24.

[28] Corrao G, Bagnardi V, Zambon A, La Vecchia C. A meta-analysis of alcohol consumption and the risk of 15 diseases. *Prev Med*. 2004 May;38(5):613-9.

[29] Stahre M, Roeber J, Kanny D, Brewer RD, Zhang X. Contribution of Excessive Alcohol Consumption to Deaths and Years of Potential Life Lost in the United States. Prev Chronic Dis 2014;11:130293. DOI: http://dx.doi.org/10.5888/pcd11.130293.

[30] Centers for Disease Control and Prevention. Vital Signs: Overdoses of Prescription Opioid Pain Relievers --- United States, 1999—2008. Morbidity and Mortality Weekly Report. 2011; 60: 1-6. Available: www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm.

[31] Washington State Statistical Analysis Center. The Impact of Drugs in Washington State. June 2009. Available: www.ofm.wa.gov/sac/nchip/substance.pdf/

[32] Clark RE, Samnaliev M, McGovern MP. Impact of substance disorders on medical expenditures for Medicaid beneficiaries with behavioral health disorders. *Psychiatr Serv*. 2009 Jan;60(1):35-42.

[33] National Drug Intelligence Center. The Economic Impact of Illicit Drug Use on American Society. May 2011. Department of Justice, Washington, DC.
Available: www.justice.gov/archive/ndic/pubs44/44731/44731p.pdf.

[34] Center for Behavioral Health Statistics and Quality. (2014). Results from the 2013 National Survey on Drug Use and Health: Summary of national findings (HHS Publication No. 14-4863, NSDUH Series H-48). Rockville MD: Substance Abuse and Mental Health Services Administration. Available: www.samhsa.gov/data/NSDUH/2013SummNatFindDetTables/NationalFindings/NSDUHresults2013.htm.

Appendix A: Bree Collaborative Background

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

The 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 chair of the Collaborative, and the HCA must convene the Collaborative. The Collaborative must add members or establish clinical committees as needed to acquire clinical expertise in particular 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 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 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
Susie Dade MS	Deputy Director	Washington Health Alliance
John Espinola MD, MPH	Vice President, Quality and Medical Management and Provider Engagement	Premera Blue Cross
Gary Franklin MD, MPH	Medical Director	Washington State Department of Labor and Industries
Stuart Freed MD	Medical Director	Wenatchee Valley Medical Center
Tom Fritz	Chief Executive Officer	Inland Northwest Health Services, Spokane
Joe Gifford MD	Chief Executive, ACO of Washington	Providence Health and Services
Richard Goss MD	Medical Director	Harborview Medical Center – University of Washington
Steve Hill (Chair)	Retired	Previously Director, Department of Retirement Systems, and Chair, Puget Sound Health Alliance
Christopher Kodama MD	Medical Vice President, Clinical Operations	MultiCare Health System
MaryAnne Lindeblad RN, MPH	Director, Medicaid Program	Health Care Authority
Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
Robert Mecklenburg MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Kimberly Moore MD	Associate Chief Medical Officer	Franciscan Health System
Carl Olden MD	Family Physician	Pacific Crest Family Medicine, Yakima
Mary Kay O'Neill MD, MBA	Executive Medical Director	Regence Blue Shield
John Robinson MD, SM	Chief Medical Officer	First Choice Health
Terry Rogers MD (Vice Chair)	Chief Executive Officer	Foundation for Health Care Quality
Jeanne Rupert DO, PhD	Director of Medical Education	Skagit Valley Hospital
Kerry Schaefer	Strategic Planner for Employee Health	King County
Bruce Smith MD	Associate Medical Director, Strategy Deployment	Group Health Physicians
Lani Spencer RN, MHA	Vice President, Health Care Management Services	Amerigroup
Jay Tihinen	Assistant Vice President Benefits	Costco Wholesale
Carol Wagner RN, MBA	Senior Vice President for Patient Safety	The Washington State Hospital Association
Shawn West MD	Family Physician	Edmonds Family Medicine

Appendix C: Steering Committee Members

Member	Title	Organization
Stuart Freed MD	Medical Director	Wenatchee Valley Medical Center
Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
Jason McGill JD	Health Policy Advisor	Governor's Office
Robert Mecklenburg MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Mary Kay O'Neill MD, MBA	Executive Medical Director	Regence Blue Shield
Terry Rogers MD	Chief Executive Officer	Foundation for Health Care Quality

Appendix D: Workgroup Members

Accountable Payment Models

Member	Title	Organization
Susie Dade* MS	Deputy Director	Washington Health Alliance
Gary Franklin* MD, MPH	Medical Director	Washington State Department of Labor and Industries
April Gibson	Administrator	Puget Sound Orthopaedics
Dan Kent MD	Medical Director, Quality & Medical Management	Premera
Bob Manley MD	Surgeon	Regence
Gary McLaughlin	Vice President of Finance, Chief Financial Officer	Overlake Hospital
Robert Mecklenburg* MD (Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Peter Nora MD	Chief of Neurological Surgery	Swedish Medical Center
Marissa Brooks	Director of Health Improvement Programs	SEIU Healthcare NW Benefits
Kerry Schaefer*	Strategic Planner for Employee Health	King County
Julie Sylvester	Vice President of Quality and Safety Initiatives	Qualis Health
Jay Tihinen*	Assistant Vice President Benefits	Costco Wholesale

Addiction/Dependence Treatment

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

Bree Implementation Team

Member	Title	Organization
Neil Chasan	Physical Therapist	Sports Reaction Center
Susie Dade* MS	Deputy Director	Washington Health Alliance
Cezanne Garcia	Program Manager, Community and School-Based Partnerships	Public Health Seattle – King County
Ellen Kauffman MD	OB-COAP Medical Director	Foundation for Health Care Quality
Dan Lessler MD (Chair)	Chief Medical Officer	Health Care Authority
Alice Lind RN	Manager, Grants and Program Development	Health Care Authority
Jason McGill JD	Health Policy Advisor	Governor's Office
Larry McNutt	Plan Administrator	Carpenters Trusts of Western Washington
Mary Kay O'Neill* MD, MBA	Executive Medical Director	Regence
Steven Overman MD	Director	Seattle Arthritis Clinic
Terry Rogers* MD	Chief Executive Officer	Foundation for Health Care Quality
Claudia Sanders	Senior Vice President, Policy Development	Washington State Hospital Association
Kerry Schaefer*	Strategic Planner for Employee Health	King County
Jeff Thompson MD	Senior Health Care Consultant	Mercer
Shawn West* MD	Medical Director	Coordinated Care
Karen Wren	Benefits Manager	Point B

End-of-Life Care

Member	Title	Organization
Anna Ahrens	Director of Patient and Family Support Services	MultiCare Health System
Tony Back MD	Medical Oncologist	Seattle Cancer Care Alliance
Trudy James	Chaplain	Heartwork
Bree Johnston MD	Medical Director, Palliative Care	PeaceHealth
Abbi Kaplan	Principal	Abbi Kaplan Company
Timothy Melhorn MD	Internist	Yakima Valley Memorial Hospital (YVMH) and the Memorial Foundation
Joanne Roberts MD	Chief Medical Officer, NMR Administration	Providence Everett Regional Medical Center
John Robinson* MD (Chair)	Chief Medical Officer	First Choice Health
Bruce Smith* MD (Vice Chair)	Associate Medical Director, Strategy Deployment	Group Health Physicians
Richard Stuart DSW	Clinical Professor Emeritus, Psychiatry	University of Washington

Obstetrics (Maternity) Care

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

Potentially Avoidable Hospital Readmissions

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

Spine and Low Back Pain

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

*Bree Collaborative member