



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

Implementation Roadmap

April 2017

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Executive Summary

The Bree Collaborative aims to play an integral role in improving health care quality, outcomes, affordability, and therefore value in Washington State. We engage public and private health care leaders to transform the health care delivery system through:

- Identifying health care services with high variation, that have high use and poor outcomes (i.e., low value), or patient safety issues,
- Gaining consensus around evidence-based best practice protocols, and
- Supporting the shift to rewarding value.

While the legislation that founded the Bree Collaborative, House Bill 1311, lays a framework for comprehensive and collaborative development of guidelines, we hope to move from guideline development to guideline implementation through purchasers and health plans incorporating recommendations into contracts. This supports the business case for our guidelines. This report focuses on implementation of Bree Collaborative recommendations, providing guidance and support for clinicians, medical groups, hospitals, health plans, and purchasers based on implementation science, interviews, and surveys of these and other stakeholders for recommendations developed from 2012 – mid 2016 (thirteen topics).

This report is supported by a webpage that will be updated to reflect current recommendations here: www.breecollaborative.org/implementation/.

Assessing the Community

We surveyed medical group, hospital, and health plan implementation of Bree Collaborative recommendations and found varying degrees of adoption. We discuss level of implementation for all of our topics and acknowledge that some providers had already adopted clinical best practices on their own corresponding to our recommendations. Recommendations within the obstetrics topic and topics that worked within existing, established programs such as hospitals participating in outcomes registries for heart surgery were most fully implemented. Among hospitals and medical groups, screening and treatment for alcohol and substance use disorder showed the lowest level of adoption. Among health plans the surgical bundles were least adopted. Within the topic-specific recommendations, we found trends such as low adoption of patient screening and assessment tools and patient decision aides.

Addressing Barriers and Enablers to Implementation

Common elements that support and hinder implementation were found for hospitals, medical groups, and health plans. Our report includes strategies to overcome barriers and highlights the methods that practices have used for successful implementation. The lack of a business case or financial incentive was among the top barriers to implementation for care providers while insufficient market share was a top barrier for health plans. Multiple health plans, each with their own performance measures and incentives, individually have diminished influence in a fragmented system. To address this barrier, we describe efforts within Washington State and include examples from other states where health plans

have combined efforts to create a shared, common set of performance measures and financial incentives. Through collaboration and alignment, health plans will not only enhance the effectiveness of incentives, they will also simplify reporting requirements of providers.

Table 1: Top implementation barriers and enablers for providers (hospitals and medical groups) and health plans

	Top <u>enablers</u>	Top <u>barriers</u>
Providers	<ul style="list-style-type: none"> Existing organizational improvement program for minimizing errors and waste 	<ul style="list-style-type: none"> Lack of availability and credibility of data, and the burden of collecting it
	<ul style="list-style-type: none"> Business case- evidence of economic reward 	<ul style="list-style-type: none"> Business case- no economic reward, and lack of contract partners interested in value-based purchasing
	<ul style="list-style-type: none"> Consensus on what constitutes quality of care 	<ul style="list-style-type: none"> Lack of consensus on what constitutes quality of care
	<ul style="list-style-type: none"> Individual provider-level performance feedback 	
Health Plans	<ul style="list-style-type: none"> Sufficient market share/volume 	<ul style="list-style-type: none"> Insufficient market share/volume
	<ul style="list-style-type: none"> Contract partners interest in value-based purchasing 	<ul style="list-style-type: none"> Burden/ease of collecting or obtaining data
	<ul style="list-style-type: none"> Consistency in findings across multiple measures 	<ul style="list-style-type: none"> Business case- evidence of economic reward

Next Steps to Implementation

This report outlines a roadmap to implement existing Bree Collaborative recommendations, the how and why of adoption. The first step on our roadmap toward broad adoption is awareness, followed by gaining buy-in from the health care community, assessing the current state (part of this document), transitioning to the ideal state (e.g., through pilot projects), and finally sustainability. For each of our recommendations we outline steps that provider organizations and health plans can take to move from the current state to the ideal state. We list transition activities and methods to sustain best-practice care. We include tools for assessment, communication, and planning to help facilitate adoption of our recommendations into clinical practice.

Dr. Robert Bree Collaborative: Background and Purpose

The Washington State Legislature established The Dr. Robert Bree Collaborative in 2011 “...to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.”

Members, appointed by the Washington State Governor, include:

- Public health care purchasers for Washington State,
- Private health care purchasers (employers and union trusts),
- Health plans,
- Physician representatives from hospital and medical groups, and
- Quality improvement organizations.

Bree Collaborative members annually select health care services with highly variable cost and quality outcomes, misalignment between high cost and poor outcomes, or that have patient safety issues and convene expert workgroups that develop comprehensive recommendations based on literature review and evidence-based best practices. Recommendations are approved by Bree Collaborative members and then sent to the Washington State Health Care Authority for review, approval, and implementation through purchasing contracts for Medicaid enrollees, public employees, and others.

See **Appendix A** for a list of Bree Collaborative Members.

The Bree Collaborative is a resource for the health care system to identify specific opportunities and focus collective efforts on discrete health care services from the bottom-up. We rely on the engagement and clinical expertise of our Washington State health care community. The Bree Collaborative is funded by the Washington Health Care Authority, and housed within the Foundation for Health Care Quality a Seattle non-profit organization.

More information can be found at our website: www.breecollaborative.org

The Bree Collaborative has successfully developed reports and recommendations in more than 15 clinical topics. Initial work started with obstetrics care, and later lower back pain care, end-of-life care planning and others. In 2013, work began on bundled payment models for major surgeries, including warranties, to impact high rates of readmission and high variation in readmission. Recent work includes integrating behavioral health into primary care and aligning opioid prescribing with best practice.

A full list of completed topics and their reports and recommendations can be found on our website: www.breecollaborative.org/topic-areas/

Patient Benefits

Implementation of Bree Collaborative recommendations benefits many stakeholders. Patients are at the heart of our recommendations as we move toward a more patient-centered health care system supportive of the patient’s own goals of care. Patients benefit through improved quality of care (e.g.,

increased use of appropriate screening processes and treatments, improvements to patient-provider communication and shared decision-making), increased reliability and safety, reduction in harmful processes that show little clinical benefit, and increased affordability.

Provider and Hospital Benefits

Our work is driven by care providers, payers, and stakeholders across our state. We facilitate a process to drive bottom-up, pragmatic solutions to pressing health care issues from the health care community to inform health care policy. We work to recognize hospitals and clinics showing best practice, evidence-based care and facilitate rewarding high-value care, support of patient-provider shared-decision making, and increased access to appropriate specialty care (e.g., psychiatric services) to support providers in busy care settings.

Health Plan and Purchaser Benefits

Both health plans and health care purchasers (i.e., employers or private purchasers and entities that serve as public health care purchasers for the State of Washington) benefit from higher value care, or improved quality at a reduced cost, with specific metrics designed for evaluation and transparent reporting to the community.

Together, Bree Collaborative recommendations help to build a healthier Washington State with improvements in health care quality, outcomes, and affordability.

Implementation Efforts to Date

Our collaborative model allows for broad consensus and buy-in on guidelines for best practice. However, guidelines alone do not emphasize the steps necessary to move recommendations into clinical practice. To address this gap, the Bree Collaborative convened a workgroup, the Bree Implementation Team, focusing on broad adoption of recommendations. The group met from October, 2013 to February, 2015. Important lessons learned by this group include the importance of:

- Communication
- Education
- Getting buy-in
- Developing champions inside organizations
- Broadly adopted and well-defined metrics to drive success

In most cases, the Implementation Team's efforts were directed towards specific stakeholders to align care delivery with Bree Collaborative recommendations. One example is working with the Clinical Outcomes Assessment Program (COAP) to obtain data on appropriateness of cardiac procedures.

We wish to thank the volunteer members of The Bree Collaborative, the many expert members of our workgroups, and organizations across the state who participated in our implementation surveys. Your engagement, participation and support have been invaluable. And finally, our real progress comes from those working on the front lines towards making improvements in the health care provided to Washington patients.

Pathway to Implementation

The Bree Collaborative encourages care providers, health plans and other stakeholders to approach practice transformation thoughtfully. Development of guidelines relies on community participation and consensus. Implementation depends on communication, buy-in, well-managed transition, and sustainability. We have developed recommendations for individual stakeholder groups within each of the reports and recommendations, from which this implementation pathway builds. We present detailed adoption recommendations for all topics approved by the Bree Collaborative prior to mid-2016.

Our approach towards broad adoption begins with awareness, followed by gaining buy-in from the health care community, assessing the current state (part of this document), transitioning to the ideal state (e.g., through pilot projects), and finally sustainability.

In this section we:

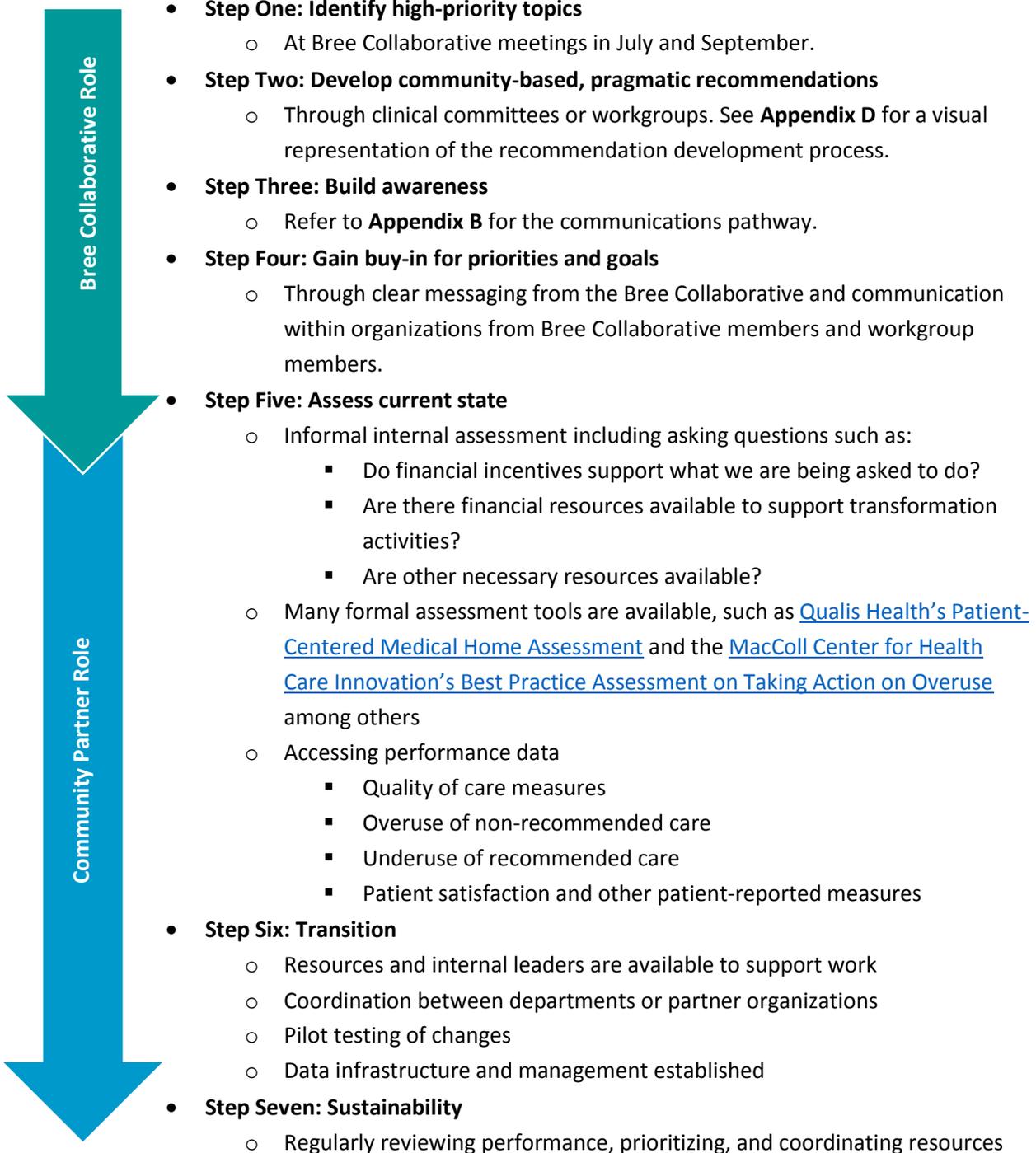
- Outline a general phased strategy for implementation showing work done by the Bree Collaborative and that of community partners.
- A summary of our implementation survey.
- Present our thirteen topics in the order of those that have been least to most implemented by providers, according to our implementation survey. We include steps that hospitals, clinics, individual clinicians, and health plans can take to move from the current state to the ideal state and transition activities and methods to sustain best-practice care along with other next steps for the health care community including purchasers.

The Bree Collaborative has a general communications strategy to build general awareness outlined in **Appendix B**.

For further background, we also lay out the science of implementation and evidence-based methods to promote uptake in **Appendix C**.

Bree Collaborative General Strategy

We outline the following generalized steps to implementation below:



Implementation Survey

Bree Collaborative staff developed a comprehensive survey to assess implementation of recommendations across care settings and health plans. The survey included 13 topics that had been approved at least six months prior to the time the survey was conducted. See links to the survey tools on our website here: www.breecollaborative.org/implementation/.

We asked key leaders from Washington hospitals, medical groups, and health plans to complete the survey, which included specific recommendations for each topic. Participation was voluntary, and responses were self-reported. A numeric scale was used to rate implementation of specific recommendations, summarized below:

- 0 -No action taken
- 1 -Actively considering adoption
- 2 -Some/similar adoption
- 3 -Full adoption

We made efforts to contact the largest 50 hospitals in the state that, combined, represent over 95% of total patient discharges according to state Comprehensive Hospital Abstract Reporting System (CHARS) data. Large and mid-sized medical groups were also included, as well as health plans operating in the state. We also invited Federally Qualified Health Centers (FQHC) provider organizations serving underserved populations to participate.

Responding provider organizations included:

- CHI Franciscan Health:
 - Highline Medical Center
 - St. Elizabeth Hospital
 - St. Francis Hospital
 - St. Joseph Medical Center
 - Harrison Medical Center
- Confluence Health:
 - Hospital
 - Medical Group
- The Everett Clinic
- Evergreen Health Partners
- Group Health Cooperative
- Northwest Physicians Network
- The Polyclinic
- Swedish Medical Center:
 - Ballard
 - Cherry Hill
- First Hill
- Edmonds
- Issaquah
- Pacific Medical Centers
- Providence Health Systems:
 - SE Region Medical Group
- University of Washington Medical System:
 - Harborview
 - Northwest Hospital
 - UW Medical Center
 - Valley Medical Center
- The Vancouver Clinic
- Virginia Mason Medical Center:
 - Hospital
 - Medical Group

Responding health plans included:

- Aetna, Inc.
- Amerigroup
- Community Health Plan of Washington
- First Choice Health
- Group Health Cooperative
- Molina Healthcare of Washington
- Premera Blue Cross

Table 2 provides a summary of survey results, showing overall average and range of implementation ratings for topic for medical groups, hospitals and health plans. Topics are arranged in order of implementation score, averaged for providers (hospitals and medical groups).

Table 2: Average (and range) of Implementation Scores by Topic

TOPIC	HOSPITALS	MEDICAL GROUPS	HEALTH PLANS
Addiction and Dependence Treatment	1.4 (0.9-2.6)	1.4 (0.0-2.4)	1.9 (1.2-2.4)
Lumbar Fusion Surgical Bundle	1.9 (0.3-2.9)	-	0.7 (0.0-2.0)
Low-Back Pain	2.0 (1.0-3.0)	1.8 (0.5-2.8)	1.2 (0.7-1.7)
Prostate Cancer Screening	2.3 (2.0-3.0)	1.6 (0.0-2.8)	0.7 (0.0-3.0)
End-Of-Life Care	2.2 (1.7-2.6)	1.7 (0.0-2.5)	1.8 (1.0-3.0)
Avoidable Hospital Readmissions	1.6 (0.0-3.0)	2.5 (1.8-3.0)	2.7 (2.0-3.0)
Prescribing Opioids for Pain	2.5 (2.1-2.5)	1.8 (0.0-2.7)	1.7 (1.0-2.0)
Oncology Care	2.1 (1.8-2.7)	2.2 (0.0-3.0)	1.4 (0.0-3.0)
Coronary Artery Bypass Graft Surgical Bundle	2.2 (2.0-2.8)	-	0.4 (0.0-1.0)
Knee and Hip Replacement Surgical Bundle	2.3 (1.7-3.0)	-	1.0 (0.0-2.0)
Obstetrics Care	2.8 (1.9-3.0)	2.8 (2.4-3.0)	2.0 (1.0-3.0)
Spine Surgical Care and Outcomes Measurement Program (SCOAP)	2.8 (2.0-3.0)	-	-
Cardiology: Appropriate PCI	3.0 (3.0-3.0)	-	-

Key: 0=No action taken; 1=Actively considering adoption; 2=Some/similar adoption; 3=Full adoption

Survey Limitations

While our intention was to get feedback from a broad representative sample of hospitals and medical groups across the state, responses were mostly from large, urban and suburban organizations, multi-hospital systems, and medium to large size medical groups. We invited smaller organizations, Federally Qualified Health Centers, and community health centers to complete our survey, but none responded. Furthermore, comments mentioned that implementation for some recommendations is left up to individual physicians, and they were not assessed at the hospital or medical group level. In these cases, implementation may have been rated low, when in fact it was unknown.

Topic-Specific Implementation Strategies

On the following pages we present our 13 topics and the steps to adoption for each topic. Topics are listed in order of those that have been least to most implemented by providers, according to our implementation survey. For each topic we present:

- A roadmap to move from the **current state** (e.g., variable care, high cost, poor outcomes, patients not supported), **transition activities** to move toward implementation (e.g., training, education, pilot projects), and describe the **ideal or goal state** and strategies for sustainability (e.g., data feedback).
- Summarize findings from the implementation survey showing areas that have been easier or more difficult to adopt (e.g., shared decision making).
- Steps that hospitals, clinics, individual clinicians, and health plans can take to move from the current state to the ideal state
- Transition activities and methods to sustain best-practice care along with other next steps for the health care community including purchasers.

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Addiction and Dependence Treatment

Rank: 1 (lowest provider adoption)

Survey Responses- Hospitals: 12

Medical Groups: 10

Health Plans: 7

Adopted January 2015 | 23 months from adoption to survey

Read the Report and Recommendations here: www.breecollaborative.org/wp-content/uploads/ADT-Final-Report.pdf

Roadmap to Implementation

Current State	Transition Activities	Ideal State and Sustainability
Hospitals, Clinics, and Individual Clinicians		
<ul style="list-style-type: none"> • Patients with alcohol and substance use disorders may experience stigma in the health care setting. • Neither patients nor health care providers feel comfortable discussing alcohol or any substance use disorder. • There is no routine patient screening for alcohol use and substance use disorder • Staff are not trained or prepared to screen for alcohol use and substance use disorder • Staff are not qualified for providing and charging for brief intervention • There is no referral relationship in place to community chemical dependency treatment professionals • Insufficient resources for addiction treatment and rehabilitation 	<ul style="list-style-type: none"> • Staff are educated on alcohol and other drug misuse • Staff are trained in Screening, Brief Intervention, Referral to Treatment (SBIRT) as well as release of information rules • Screening tools are put into use • A patient registry is developed for tracking, follow-up, and results reporting • Referral relationships established with chemical dependency providers 	<ul style="list-style-type: none"> • Patients with alcohol and substance use disorders are identified and supported • Care providers are engaged in routine patient screening • Brief intervention, a reimbursable service, is provided to all qualifying patients • Screening results are tracked, with follow-up for patients referred to outside treatment • Routine quality improvement activities are conducted, and include patient input
Health Plans		
No provider monitoring or feedback on SBIRT	Achieve compliance with American Society of Addiction Medicine patient placement or equivalent criteria	Cost and utilization trends for chemical dependency treatment are tracked

Background

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and other drugs. The protocol is intended for use in medical care settings, such as hospital emergency departments and primary care offices. SBIRT enables care providers to screen and assist patients whose substance use may cause complications in their ability to handle health, work, or family issues.

From 2004 to 2009, the Washington State Screening, Brief Intervention and Referral to Treatment (WASBIRT) Program worked to implement screening in nine hospital emergency departments statewide. In the grant funded program, more than 100,000 patients agreed to participate in screening for drug and alcohol use. Of these, 49% qualified to receive a brief intervention, and 3% went on to either brief therapy or chemical dependency treatment with follow-up. The program was expanded into primary care through a continuing grant, from 2011 to 2016. Partner clinics in five counties participated and established a sustainable, reimbursable SBIRT system, in which more than 85,000 additional patients were screened. During this time, Medicare, Medicaid, and private insurers started reimbursing SBIRT in the state of Washington. Read more about the program here: www.wasbirt.com

Implementation Survey Results

Among the hospitals and medical groups we surveyed, this topic scored lowest, though some organizations mentioned promising first steps. Some were educating clinical and administrative staff, and in one case piloting an alcohol and drug screening process in the clinic. Some hospitals have implemented screening in the emergency department or select inpatient units. Nonetheless, other providers mentioned that they do not currently offer this service in their setting.

Specific components of the recommendation scoring lowest on the survey include:

Hospitals and Medical Groups:

- Patients are contacted after they have been referred to chemical dependency treatment to address any barriers to accessing treatment
- Verbal communication takes place with the chemical dependency treatment facility to follow-up on any referrals and assess whether treatment was initiated and/or completed
- Patient results from alcohol and other drug misuse screens are tracked over time
- The patient's perspective is included as work is done to increase the capability of the chemical dependency system

Health Plans:

- The health plan declines to contract with medical providers (e.g., primary care, prenatal, hospitals) that do not provide screening, brief intervention, brief treatment, and referral to treatment

Next Steps

- **Working with existing, accepted programs.** We encourage the growth and spread of the successful Washington Screening, Brief Intervention and Referral to Treatment (WA-SBIRT) program through financial incentives and reporting on required metrics.
 - More information: www.wasbirt.com
 - More information on billing for SBIRT: www.wasbirt.com/sites/default/files/Washington%20State%20billing%20brief_Sept2015_0.pdf
 - **Measurement.** Use health plan claims data to track SBIRT utilization. Health plan claims data on current utilization would show where SBIRT is taking place and where it is not. Measurement of total patients screened and referred to treatment can bring a clearer picture of population needs and ensure that patients receive appropriate substance use treatment. The Substance Abuse and Mental Health Services Administration provides useful information and data and outcomes measurement for this topic.
 - More information: www.samhsa.gov
 - **Incentivize screening and brief intervention.** Purchasers and health plans explore incentives for providers and hospitals aimed at developing screening processes and brief intervention within primary care and the emergency room setting. Medicare, as part of its Merit-based Incentive Payment System (MIPS), has three measures aligning with substance use disorder.
 - Preventive Care and Screening: Unhealthy Alcohol Use- Screening and Brief Counseling
 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
 - Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance UseMore information: www.qpp.cms.gov
- Clinicians eligible for MIPS participation can consider these measures for reporting to Medicare, which would help them qualify for financial bonuses. Other payers and health plans can consider aligning incentives with these metrics.

Surgical Bundles and Warranties

We present our three surgical bundles developed prior to mid-2016 (i.e., lumbar fusion, coronary artery bypass surgery, and total knee and total hip replacement) together as the adoption strategies are similar.

Roadmap to Implementation

Current State	Transition Activities	Ideal State and Sustainability
Hospitals, Clinics, and Individual Clinicians		
<ul style="list-style-type: none"> • Patient care quality and outcomes depend on the hospital performing the surgery and vary significantly • Inappropriate surgical procedures are performed with no measurement of whether a patient has had the opportunity to try conservative therapy • Patients may be unsafe for surgery • Patients experience a surgery as disjointed with unclear roles, poor communication, and poor coordination • Patients receive multiple bills from multiple providers • Total costs of care vary significantly and are unrelated to quality or outcomes 	<ul style="list-style-type: none"> • Staff are educated on value-based payment and the purpose and goals of bundled payment are clear and supported by leadership • Providers understand current state and have access to access to trusted data (e.g., participation in a registry, feedback reports) • Providers understand gap between current state and clinical pathways outlined in the bundled payment models • A multidisciplinary care team has been defined and designated to ensure appropriate and complete care • A system is in place to measure and monitor outcomes • Relationships are developed with community referral partners • Concerns and questions by staff and community partners are addressed 	<ul style="list-style-type: none"> • Patients feel that their episode of care is designed around supporting their needs • The clinical pathway is followed and supported by a data infrastructure • Providers feel supported in offering care within the defined surgical pathway • Hospitals are incentivized to meet quality and cost targets including standards for: <ul style="list-style-type: none"> ○ Appropriateness of care ○ Fitness for surgery ○ Surgical safety ○ Post-operative care and return to function ○ Cost and other quality metrics
Health Plans		
	<p>Early conversations with provider organizations about average surgical episode cost</p>	<ul style="list-style-type: none"> • Payments are tied to fixed target cost and quality standards • A warranty covers hospital readmissions and other avoidable complications

Background

All Bree Collaborative surgical bundle topics are organized into four cycles of the care process: 1) disability despite non-surgical therapy; 2) fitness for surgery; 3) the surgical procedure; and 4) post-operative care and return to function. Detailed specifications are also available for the warranties, designed to specify cases in which payers or patients are not charged for hospital readmissions in for conditions determined to be attributable to the procedure. Surgical bundles are designed to accommodate a fixed payment amount for total care, including pre- and post-surgical care costs that are traditionally billed separately by providers.



Implementation Survey Results: Lumbar Fusion Surgical Bundle and Warranty

Rank: 2 (lower provider adoption)

Survey Responses- Hospitals: 12

Medical Groups: 0

Health Plans: 7

Adopted September 2014 | 26 months from adoption to survey

Read our Lumbar Fusion Surgical Bundle www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Bundle-Final-14-09.pdf and Warranty

www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Warranty-Final-14-09.pdf

Of the three surgical bundles, the lumbar fusion bundle was lowest scoring on our implementation survey. While all three surgical bundle recommendations showed moderate adoption by hospitals, there was very low adoption by health plans.

Hospital survey comments mentioned challenges with using screening tools and tracking patient outcomes. Some comments questioned the “exhaustive” criteria regarding fitness for surgery, and difficulty in gaining support for their use.

Bree Collaborative recommendations scoring lowest on the implementation survey for this topic in hospitals include:

- Cycle 1:
 - Formal consultation with collaborative team led by board certified physiatrist to confirm appropriateness, adequacy, completeness, and active participation in non-surgical therapy and need for lumbar fusion; etc. ...
 - Departures from (non-surgical therapy) standards are reviewed by the collaborative care team
 - A departure from (lumbar instability measurement) guidelines requires discussion and resolution by the collaborative care team as defined

- Reported loss of function; Patient-Reported Outcomes Measurement Information System (PROMIS-10)
- Cycle 2:
 - Patient must participate in shared decision-making validated decision aid such as those approved by Washington State
 - Patient must designate a personal care partner; patient and care partner must actively participate in (various activities)...
 - Patient must participate in end-of-life planning...
 - Patient agrees to participate in a registry with two years follow-up data collection
- Cycle 4:
 - Care partners are instructed to assist with home exercise regimen

Implementation Survey Results: Coronary Artery Bypass Graft Surgical Bundle and Warranty

Rank: 9 (medium provider adoption)

Survey Responses- Hospitals: 4

Medical Groups: 0

Health Plans: 7

Adopted September 2015 | 14 months from adoption to survey

Read our Coronary Artery Bypass Graft (CABG) Surgical Bundle www.breecollaborative.org/wp-content/uploads/CABG-Bundle-Final-15-09.pdf and Warranty www.breecollaborative.org/wp-content/uploads/CABG-Warranty-Final-15-09.pdf

Coronary Artery Bypass Graft (CABG) Surgery is a common type of cardiac surgery that improves blood flow to the heart. Like the Lumbar Fusion Bundle previously described, this bundle is again organized in to four phases of the care process.

Only four hospitals completed assessment surveys for the CABG bundle topic, the lowest number for any topic. Generalizing the results to hospitals statewide is difficult, but surveys will remain available, posted on the Bree Collaborative website, for hospitals choosing to complete in the future. Again, while adoption of recommendations by the responding hospitals was moderate, adoption of bundled payments by health plans was particularly low, accounting for the low overall ranking for this topic.

Recommendations scoring lowest on the implementation survey in hospitals pertain to the use of specific screening and shared-decision making tools. This is a common theme throughout several Bree Collaborative topics, where hospitals and physicians have not formed consensus for their use. Hospitals mentioned specific efforts on Cycle 1 and 2 recommendations, in one case through a design workshop. Most recommendations in the topic have at least one hospital with a rating of 3, or full adoption, but in many cases the rest of the hospitals have a lower adoption rating. This indicates that most recommendations have been adopted at least at a single hospital, an encouraging start. Recommendations in Cycles 3 and 4 showed consistently high implementation scores for responding hospitals.

Bree Collaborative recommendations scoring lowest on the implementation survey for this topic include:

- Cycle 1:

- Disability documented according to the Seattle Angina Questionnaire-7
- Cycle 2:
 - Pre-operative plan for management of opioid dependency, if patient has taken opioids for more than three months
 - Patient engages in a discrete shared decision-making process with a credentialed health coach or equivalent
 - Validated shared decision-making aid included such as those certified by the Washington State Health Care Authority, if available

Implementation Survey Results: Knee Hip Replacement Surgical Bundled Payment Model and Warranty

Rank: 10 (higher provider adoption)

Survey Responses- Hospitals: 11

Medical Groups: 1

Health Plans: 7

Surgical bundle adopted November 2013 and Warranty adopted July 2013 | 37 months from adoption to survey

Read our Total Knee and Total Hip Replacement Bundle www.breecollaborative.org/wp-content/uploads/tkrthr_bundle.pdf and Warranty http://www.breecollaborative.org/wp-content/uploads/bree_warranty_tkr_thr.pdf

Twelve hospitals completed our implementation survey for the joint replacement surgical bundle. Implementation scores for hospitals were fairly high, but low adoption of bundled payments by health plans accounted for a lower overall ranking for this topic.

Hospital responses showed difficulty in adoption of assessment tools that are to be completed by patients. The Patient-Reported Outcomes Measurement Information System (PROMIS-10) is a self-report measure instrument for adult patients based on a ten question survey that measures function, such as ability to carry out usual daily activities, and symptoms, such as pain, along with other general health factors. Similar assessment tools focus on hip and knee pain and function (i.e., hip disability and osteoarthritis outcome score (HOOS) and knee injury and osteoarthritis outcome score (KOOS) surveys), also completed by patients. Incorporating these surveys into routine care not only requires collecting patient data at one point in time, but at multiple points in the care process, and tracking these over time. Use of these tools for this purpose were among the less adopted recommendations for this bundle.

Bree Collaborative recommendations scoring lowest on the implementation survey for this topic in hospitals include:

- Cycle 2:
 - General health questionnaire completed: Patient Reported Outcomes Measurement Information System-10/PROMIS-10
 - Cycle 2: Patient participates in shared decision-making with Washington State-approved Decision Aid Cycle 2: HOOS/KOOS survey completed
- Cycle 4:
 - Patient-reported functional outcomes are measured with KOOS/HOOS instrument

- If opioid use exceeds six weeks, a formal plan is developed for opioid management

Next Steps

- **Financial incentives.** Payers, health plans and providers continue to look for opportunities for bundled contracting using Bree Collaborative recommendations.
- **Clinical pathway redesign.** Review transition activities, above.
- **Measurement.** Hospitals track important metrics including:
 - Patients receiving shared decision making aids pre-operatively
 - Patient reported quality of life and pain/function using recommended tools
 - Patients receiving measures to manage pain and avoid complications
 - Patients receiving timely therapy and other care to return to normal function
 - Patients readmitted to the hospital
 - Patient reported quality of life, satisfaction with care, and return to function
- **Participating in a registry.** Purchasers and health plans encourage all hospitals performing lumbar fusion surgeries to participate in the Spine SCOAP program, so that comprehensive, comparative outcomes are available.
- **Refining current bundles.** The Accountable Payment Models workgroup is currently evaluating changes to the Total Knee and Total Hip Replacement Bundle and Warranty, including simplified but equally valid patient surveys tools, which may make adoption easier. The Health Care Authority's recent contract with Virginia Mason Medical Center will provide the first robust trial of Bree Collaborative recommendations in a bundled care contract.
- **Federal alignment.** CMS has launched bundled payment models, the structure of which could be adapted to include Bree Collaborative recommendations. Unlike Bree Collaborative models, the CMS models do not include appropriateness standards, which may result in overuse and inappropriate use.
 - **Total Joint Replacement.** The Centers for Medicare and Medicaid Services implemented a mandatory total joint replacement bundle in April 2016 in 67 geographic areas, including Seattle-Tacoma-Bellevue. Hospitals will be financially accountable for quality and cost of the episode of care. The episode of care begins with admission and ends 90 days post-discharge. Both our bundle and the CMS bundle include reporting of patient reported function measures, although this is voluntary under the CMS model. More information: innovation.cms.gov/initiatives/cjr
 - **CABG.** CMS also launched an initiative for CABG bundled payment to begin July 2017, which includes hospitals in Washington State. The model holds participant hospitals financially accountable for the quality and cost of a CABG episode of care and incentivizes coordination of care among hospitals, physicians, and post-acute care providers. Hospitals receive single bundled payments for CABG related treatment and extending care for 90 days post-discharge. More information: innovation.cms.gov/initiatives/cabg-model

Low Back Pain

Rank: 3 (lower provider adoption)

Survey Responses- Hospitals: 8

Medical Groups: 12

Health Plans: 7

Adopted November 2013 | 37 months from adoption to survey

Read the Report and Recommendations here: www.breecollaborative.org/wp-content/uploads/spine_lbp.pdf

Roadmap to Implementation

Current State	Transition Activities	Ideal State and Sustainability
Hospitals, Clinics, and Individual Clinicians		
<ul style="list-style-type: none"> • Patients with low back pain feel unsupported and unheard by the medical system • Patients receive non-recommended diagnostic testing such as x-ray, CT and MRI, potentially leading to inappropriate diagnosis and surgery • No tracking of patient self-reported pain and function • Limited access/use of multidisciplinary care for patients at risk of developing chronic back pain 	<ul style="list-style-type: none"> • Staff are educated on American College of Physicians and the American Pain Society guidelines • Scripts, shared decision making, and patient education materials are integrated into clinical practice and workflow • The Oswestry Disability Index tool is used to measure and track functional status over time 	<ul style="list-style-type: none"> • Patients understand how to conservatively treat their own low back pain (e.g., walking) • Patients who present with “red flags” for high risk spine disorders are identified and treated appropriately • Inappropriate diagnostic tests, plain x-ray, CT, MRI, are not used in initial evaluation, unless appropriate • Patient reported function and pain are tracked systematically and routinely over time • Patients are educated on risks and benefits of treatment options • Physical therapy and physiatry are routine treatment options for low back pain
Health Plans		
		<ul style="list-style-type: none"> • Providers are incentivized to use screening tools • Patients have access to multidisciplinary providers such as physical therapy and physiatrists.

Background

Recommendations for low back pain address high variability in testing and treatment. Particular attention is given to imaging tests that have become more routine in recent years. The American College of Physicians (ACP) and the American Pain Society (APS) developed guidelines for appropriate testing and treatment suggesting imaging is appropriate only in limited cases, not as a routine practice. Nonetheless, use of these tests and procedures has increased significantly yet outcomes have not improved with increased use. Recommendations include the use of validated screening tools to measure pain and disability along with patient education and shared decision-making.

The Washington Health Alliance's report *Less Harm, Less Waste: Choosing Wisely in Washington State report (2016)* concluded that 20% of Washington patients with low-back pain had potentially unnecessary imaging tests. Measurements at the county level shows wide variation in imaging rates, ranging from 8% to 25% of patients receiving imaging tests.

- More information on the Washington Health Alliance: www.wahealthalliance.org
- More information on the Choosing Wisely Taskforce www.wahealthalliance.org/alliance-reports-websites/choosing-wisely/

Implementation Survey Results

Both hospitals and clinics responding to our survey commented on the use of screening tools for ordering imaging tests in their organizations. At least one organization has a screening step built in to existing electronic ordering systems, where a message is indicated when a non-recommended test is ordered for patients with low back pain. Some providers developed referral systems that allow patients access to appropriate and recommended care, such as physical therapy. Several hospitals are in design, development, or piloting stages in their low back pain care programs, involving physical therapists, chiropractors, pain physicians, and surgeons.

Bree Collaborative recommendations scoring lowest on the implementation survey for this topic include:

Hospitals and Medical Groups:

- Evidence-based guidelines and tools are used, including the joint American College of Physicians and American Pain Society (ACP/APS) guidelines and the Oswestry Disability Index to track functional status
- Validated screening tool like the STarT Back tool or Functional Recovery Questionnaire (FRQ) are used no later than the third visit to identify patients that are not likely to respond to routine care
- Comprehensive patient education and expectation-setting is integrated into care for low-back pain patients, particularly when the patient is requesting care that is not recommended by evidence-based guidelines

Health Plans:

- Providers are required to use a screening tool (such as STarT Back or FRQ) as part of the management of patients for imaging, spinal injections, and/or spinal surgery

Next Steps

- **Working with existing, accepted programs.** The Choosing Wisely program includes comparative measures for imaging in uncomplicated low back pain. This can serve as a starting point for identifying geographic areas of potential overuse. Future evaluations can focus on the provider group, or even the individual physician level.
 - More information: www.choosingwisely.org
 - www.choosingwisely.org/patient-resources/imaging-tests-for-back-pain/
- **Measurement.** Purchasers and health plans can examine costs of care for low-back pain to identify opportunities for improvement and consider using information available in the Choosing Wisely program for their employees or members. Performance measures for appropriate imaging tests for low-back pain patients are included in the Common Measure Set, managed by the Washington Health Alliance.
- **Financial incentives.** Financial incentives are considered for use of appropriate testing.
- **Certify patient decision aids.** In their ongoing work to certify patient decision aids, The Washington State Health Care Authority's plans includes treatment and care for low back pain, as recommended by the Bree Collaborative.

Prostate Cancer Screening

Rank: 4 (lower provider adoption)

Survey Responses- Hospitals: 3

Medical Groups: 12

Health Plans: 7

Adopted November 2015 | 13 months from adoption to survey

Read the Report and Recommendations here: www.breecollaborative.org/wp-content/uploads/Prostate-Cancer-Recommendations-Final-15-11.pdf

Roadmap to Implementation

Current State	Transition Activities	Ideal State and Sustainability
Hospitals, Clinics, and Individual Clinicians		
<ul style="list-style-type: none"> • Patients are given a prostate specific antigen (PSA) test based on clinician preference and are not given the opportunity to talk through harms, benefits, and scientific uncertainty of the test • Facilities have no clear standards on appropriate PSA testing, with risk of over-diagnosis and overtreatment 	<ul style="list-style-type: none"> • Providers are trained on shared-decision making, documentation, and tracking • The facility adopts a patient decision aid that outlines the harms, benefits, and uncertainty about PSA testing 	<ul style="list-style-type: none"> • Both patients and providers feel comfortable having conversations about potential harms, benefits, and scientific uncertainty of PSA testing • Patient decision aids are used for PSA testing and documented in the patient medical record • For average-risk men between 55 and 69 years old only men who express a definite preference for screening after discussing the advantages, disadvantages, and scientific uncertainty are screened with PSA testing
Health Plans		
		Clinicians are reimbursed for using approved patient decision aids

Background

Prostate cancer is the most common type of cancer diagnosed among men. The PSA test is commonly used to screen men for prostate cancer. However, evidence conflicts as to whether the PSA test when used for prostate cancer screening reduces prostate cancer mortality. After a systematic review in 2012, the United States Preventive Services Task Force (USPSTF) recommended “*against prostate specific antigen-based screening for prostate cancer*” concluding “*that many men are harmed as a result of prostate cancer screening and few, if any, benefit.*”¹ Evidence highlights that overuse of the test exposes men to increased risk of harm and excess costs. A re-review in 2017, published after the recommendations, “*recommends that clinicians inform men ages 55 to 69 years about the potential benefits and harms of prostate-specific antigen (PSA)–based screening for prostate cancer*” and that the decision be individual to the patient.² Bree Collaborative recommendations focus on patient education and decision making.

Implementation Survey

In our implementation survey, disagreement over PSA testing guidelines was reported among some hospital urologists. Patient decision aids, designed to guide discussions between providers and patients that elicit the patient’s goals and values while discussing the potential harms, benefits, and conflicting evidence, are being tested or used in in about one third of the responding clinics. In some cases, clinics are attempting to make decision aids available for men in advance, before the patient comes in for their exam. Some clinics use health maintenance tracking systems, where routine screenings and tests are tracked electronically and used for automated reminders. After a provider discusses the PSA testing risks and benefits, the system can be switched on or off for future routine PSA tests, according to the patient’s preference and risk factors.

Bree Collaborative recommendations scoring lowest on the implementation survey for this topic include:

Hospitals and Medical Groups:

- Clinicians are trained on the shared decision-making process
- Patient decision aids available for PSA testing

Health Plans:

- Clinicians are reimbursed for engaging patients in a formal and documented shared decision-making process (using a Washington State-approved patient decision aid when available) for PSA testing for prostate cancer

Next Steps

- **Measurement.** Use the Healthcare Effectiveness Data and Information Set (HEDIS) measure for Prostate Cancer Appropriateness/Overuse in Older Men. The measure includes men 70 years and older who were screened unnecessarily for prostate cancer using PSA testing. HEDIS does not address men aged 55-69 years old, however state level measurement should determine the

percentage of patients being given a PSA test that includes a documented discussion of risk of harm as well as benefits (i.e. through a shared decision making aid).

- **Feedback.** Targeted feedback followed by education and support is given to providers with higher screening rates.
- **Working with existing programs.** The Choosing Wisely program focuses on avoiding wasteful or unnecessary medical tests, treatments, and procedures and has developed materials focused on PSA testing for prostate cancer screening. Employers can also use patient education materials and other resources provided by Choosing Wisely. Finally, the Choosing Wisely Taskforce working can consider including PSA testing in future topics they might address.
 - More information: www.choosingwisely.org
 - PSA Testing for Prostate Cancer www.choosingwisely.org/patient-resources/psa-test-for-prostate-cancer/
 - Tools and Techniques for Employers www.consumerhealthchoices.org/implementation-guide/#employers
- **Certify PSA Shared Decision Aids.** The Washington State Health Care Authority continues to certify patient decision aids, and the Bree Collaborative recommends including PSA testing for prostate cancer. These will serve as useful communication resources for caregivers and patients.

End-of-Life Care

Rank: 5 (medium provider adoption)

Survey Responses- Hospitals: 12

Medical Groups: 10

Health Plans: 7

Adopted November 2014 | 25 months from adoption to survey

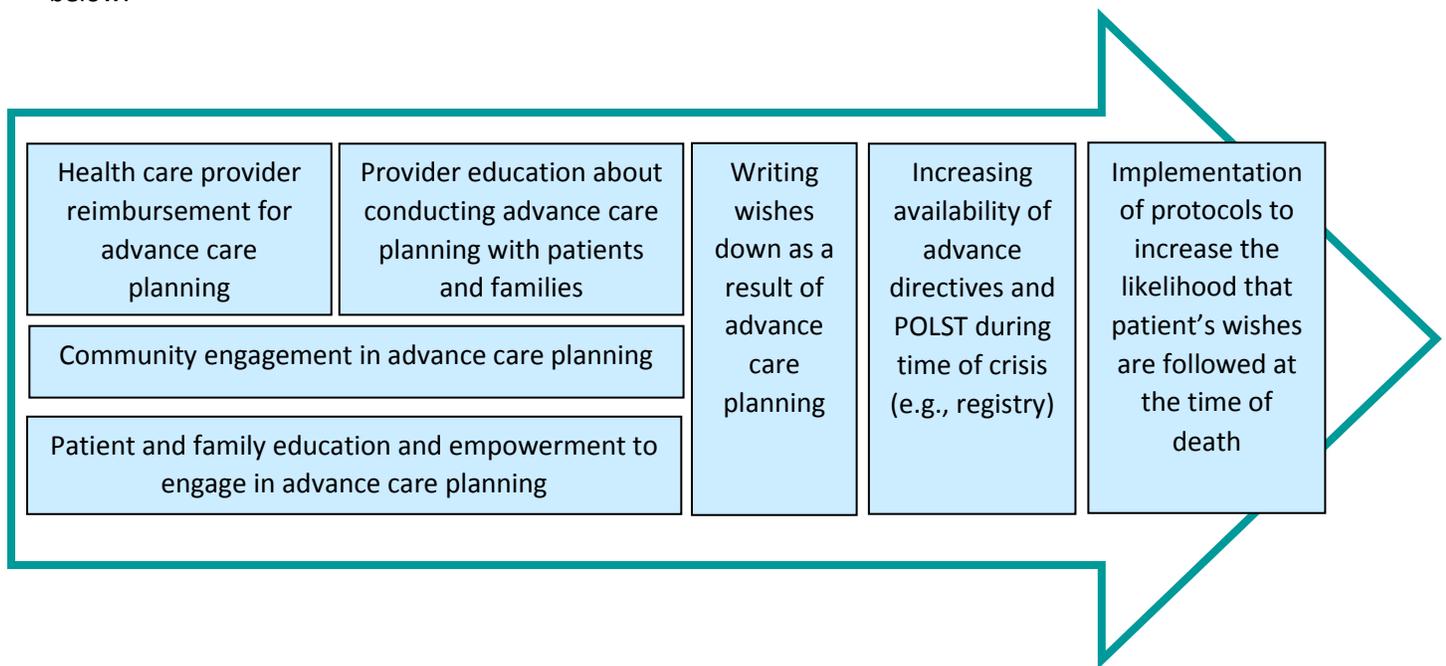
Read the Report and Recommendations here: www.breecollaborative.org/wp-content/uploads/EOL-Care-Final-Report.pdf

Roadmap to Implementation

Current State	Transition Activities	Ideal State and Sustainability
Hospitals, Clinics, and Individual Clinicians		
<ul style="list-style-type: none"> • Patients do not receive the care that they want at the end of life • Physicians and staff are not trained on how to have a conversation about advanced care planning, how to help the patient draft an advance directive, or document patient goals of care in the medical record • Advance care planning conversations are not reimbursed • Advance directives are not completed 	<ul style="list-style-type: none"> • Clinic or hospital participates in a training program such as <i>Honoring Choices: Pacific Northwest</i> • Staff are trained to discuss advanced care planning • Referral relationships and communication are established with hospice and other community care providers • Training for appropriate billing codes for advanced care is conducted 	<ul style="list-style-type: none"> • Patients receive care at the end of life that aligns with their goals and values, including hospice care • Patients are given the opportunity to discuss their advance care plans with their clinician • Physicians are comfortable discussing advance care planning • Specific billing codes are used for advanced care planning • Family members and friends, at the patient’s request, are included in the advance care planning conversation • Advanced directives and Physician Orders for Life Sustaining Treatment (POLST) are documented and available when needed • Appropriate hospice and other end-of-life care is promoted and referred • A quality improvement program tracks adherence to patient goals of care and outcomes
Health Plans		
		Counseling regarding advanced directives and end-of-life planning is reimbursed

Background

The Bree Collaborative's goals are that all Washingtonians be informed about end-of-life care options, that care preferences are communicated in actionable terms, and that care is aligned with patient goals and values and those of family members, at the patient's request. The workgroup developed five focus areas corresponding to how an individual would ideally experience advance care planning for end-of-life including increasing: community awareness, advance care planning conversations, recording end-of-life care goals and wishes, accessibility of completed advance directives and POLST for health systems and providers, and the likelihood that patients' goals and wishes are honored at the end of life. The workgroup created the following implementation model to better align end-of-life care with patient preference while taking into account how patients interact with the health care system, as shown in below:



The Washington State Hospital Association and Washington State Medical Association have developed a statewide strategy to spread advance care planning conversations and ensure that *“everyone will receive care that honors personal values and goals in the last chapters of life.”* Called Honoring Choices® Pacific Northwest, this initiative is using national best practices to transform culture through health care organization and community engagement. *“Statewide engagement includes large and small, urban and rural medical groups and hospitals. Participation is expanding to community groups. As of September 2016, there are 95 Facilitators in 23 organizations actively having advance care planning conversations. Additionally, Honoring Choices Pacific Northwest developed free state-wide patient engagement materials, including an advance directive, wallet card, informational sheets and education guides.”* Learn more here: www.honoringchoicespnw.org

Implementation Survey Results

Several hospitals and clinics in our assessment survey indicated they have begun active participation in *Honoring Choices: Pacific Northwest*[®]. Some provider organizations are participating in other advance care planning programs including *Five Wishes*; *Your Life, Your Choices*; and *The Conversation Project*.

Several internal pilot programs are mentioned in survey responses. One large medical group dedicated a four-hour medical staff meeting to educate physicians, with a nationally known physician expert speaking on the subject. Others offer patient classes on the subject. However, several said that community engagement has been difficult.

Bree Collaborative recommendations scoring lowest on the implementation survey for this topic include:

Hospitals and Medical Groups:

- All patients over the age of 18 are encouraged to consider having a conversation about advance care planning with the content of those conversations appropriate to the patient's age, health status, literacy level, and readiness.
- 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 includes a written personal statement that articulates the patient's values and goals regarding end-of-life care.
- Standardized protocols developed on how to transfer information contained in the advance directive or POLST to hospitals in your community such as through the advance directive/POLST registry, if in existence.

Health Plans:

- Family and friend satisfaction with end-of-life care is measured by widespread use of an after-death survey tool similar to that used by hospice agencies.

Next Steps

- **Reimbursement.** Health plans responding to our survey indicate they are educating providers on how to bill for advance care planning. However, responses from hospitals and medical groups indicate less progress in educating front-line caregivers on how to bill.
- **Measurement.** Billing data might be the most useful source of data to assess adoption and can be considered for further analysis. Although data collection and measurements may exist for local pilot efforts, more comprehensive state-wide measures would be beneficial.
- **Establish a state-wide, easily accessible registry.** An advance care planning document and POLST registry will help ensure that a patient's advance directive instructions are available to caregivers at the time they are needed.
- **Working with existing, accepted programs.** Financial support for *Honoring Choices: Pacific Northwest*[®] is provided by several hospitals, clinics, and health plans, along with associations and foundation contributions. These efforts should continue to be supported, and progress monitored. The program works to engage hospitals and medical groups across the state, and has

already produced a growing cohort of trained facilitators able to lead advanced planning conversations with patients and their health care agent. In some cases, patient satisfaction with the program is measured and has shown to be very positive. These will build on the progress already described.

- Learn more: www.honoringchoicespnw.org
- Program Report: <http://www.wsha.org/articles/honoring-choices-progress-valuing-wishes/>

Avoidable Hospital Readmissions

Rank: 6 (medium provider adoption)

Survey Responses- Hospitals: 15

Medical Groups: 12

Health Plans: 7

Adopted July 2014 | 29 months from adoption to survey

Read the Report and Recommendations here: www.breecollaborative.org/wp-content/uploads/Readmissions-Report-FINAL-14-0730.pdf

Roadmap to Implementation

Current State	Transition Activities	Ideal State and Sustainability
Hospitals, Clinics, and Individual Clinicians		
<ul style="list-style-type: none"> • Patients are routinely readmitted to a hospital following discharge • There is no active monitoring of hospital readmissions • There are no actions or plans for reducing readmissions 	<ul style="list-style-type: none"> • Hospital participates in a hospital readmission collaborative, i.e. Washington State Hospital Association (WSHA) or through Qualis Health • The WSHA Care Transitions Toolkit is adopted 	<ul style="list-style-type: none"> • Patient risk is assessed for adverse event and readmission post-discharge • Primary care providers are notified and follow-up occurs post-discharge • Patient medications are properly managed post-discharge • Communication is effective when a patient is transferred to another facility
Health Plans		
		Reimbursements are aligned with reducing readmissions

Background

Hospital readmissions have received significant attention since Medicare applied payment penalties for cases where patients are re-admitted within 30 days of a previous discharge, a program that began in 2012. This has put more attention on transitions of care after being released from a hospital, and how coordination takes place between primary and long-term care providers. Bree Collaborative recommendations for reducing readmissions focus on participation in collaborative programs offered by the Washington State Hospital Association (WSHA) and Qualis Health, use of the WSHA Care Transitions Toolkit, and establishment of comparative, hospital-specific performance measures.

Implementation Survey Results

Bree Collaborative recommendations scoring lowest on the implementation survey for this topic for hospitals and medical groups include:

- Primary care providers have a process for providing necessary follow-up visits for discharged hospital patients who do not currently have an established primary care provider
- There is participation in a hospital readmission collaborative recognized by WSHA or Qualis Health

Next Steps

- **Working with existing, accepted programs.** A significant number of responding hospitals mentioned using the WSHA Care Transitions Toolkit. Bree Collaborative recommendations also included participation in a collaborative improvement program, such as the program run by WSHA and Qualis. The two organizations sponsor *Safe Tables* training sessions and webinars focused on readmissions. Some hospitals indicated that they intend to join, while others made no mention of participating. Even so, hospitals mentioned working on implementing the WSHA Toolkit on their own, particularly focusing on communication with transitional care facilities and primary care doctors who will follow-up with patients. These efforts should be continued.
- **Financial incentives.** Payment penalties for avoidable readmissions, along with public reporting of readmission rates provide incentives for improvement. Most health plans in our survey include financial penalties for preventable hospital readmission, often within 30 days of discharge. These policies provide incentive for hospitals to continue work on measuring and improving.
- **Measurement.** The Washington State Hospital Association, the Washington Health Alliance, and Qualis Health publishing hospital readmission rates that are available to the public.
 - See Washington Health Alliance hospital readmission rates:
<http://wahealthalliance.org/alliance-reports-websites/alliance-reports/hospital-readmissions>
 - See Qualis Health hospital readmission rates:
www.medicare.qualishealth.org/resources/community-readmissions
 - See Washington Hospital Association hospital readmission rates:
<http://wahospitalquality.org/compare/category/general-other-readmissions>

Prescribing Opioids for Pain

Rank: 7 (medium provider adoption)

Survey Responses- Hospitals: 6

Medical Groups: 11

Health Plans: 7

Adopted July 2015 | 17 months from adoption to survey

Read the Washington State Agency Medical Directors Interagency Guideline on Prescribing Opioids for Pain here: www.breecollaborative.org/wp-content/uploads/2015AMDGOpioidGuideline.pdf

Implementation Roadmap

Current State	Transition Activities	Ideal State and Sustainability
Hospitals, Clinics, and Individual Clinicians		
<ul style="list-style-type: none"> • Patients receive inappropriate opioid prescriptions and are not educated on the risk of opioids • After procedures, patients have leftover prescriptions • Providers unsure how their prescribing practice compares 	<ul style="list-style-type: none"> • Providers are educated on the: <ul style="list-style-type: none"> ○ AMDG Guideline on Prescribing Opioids for Pain ○ The Prescription Monitoring Program (PMP), how to put data into the PMP, and how to access data from the PMP 	<ul style="list-style-type: none"> • AMDG Guidelines are followed for all phases of pain, including acute, perioperative, subacute and chronic pain • PMP is routinely queried prior to opioid prescribing • Population prescribing tracked using Bree Collaborative metrics
Health Plans		
		<ul style="list-style-type: none"> • Prescribing guidelines are used provider contracting as a quality/safety goal • Claims data is used to identify individual patients who appear to be high utilizers and identify patterns of potential overprescribing from clinicians • Number of prescriptions for opioids, and deaths from overdose are significantly reduced throughout the state

Background

The Bree Collaborative endorsed recommendations developed by the Washington State Agency Medical Director's Group (AMDG) and developed a workgroup focused on implementing the guidelines. Work has expanded to look at prescribing in the dental setting. An important tool in AMDG's recommendations is the Prescription Monitoring Program (PMP). This database records opioids and other controlled substances dispensed in the state of Washington. The database allows prescribing physician to be aware of other drugs dispensed for a patient, avoiding multiple prescriptions for the same medication, or prescribing drugs that have dangerous interactions. Work continues on opioid use at the federal, state and local levels.

Implementation Survey Results

Recommendations scoring lowest on the implementation survey for this topic in hospitals and medical groups include:

- All pain cases:
 - If opioids are prescribed beyond 6 weeks, PMP is rechecked and a baseline urine drug test is administered
 - Function and pain are assessed and documented using a validated tool at each visit where opioids are prescribed
 - Opioids are not prescribed with certain pain-reducing medications and other drugs deemed to be dangerous when combined with opioids
- Surgical pain:
 - Patients are evaluated thoroughly preoperatively: the PMP is checked and the patient is assessed for over-sedation and difficult-to-control pain risk
 - Patient is discharged with a safer type of pain reliever, or very limited supply (2–3 days) of short-acting opioids for some minor surgeries
 - Patients on chronic opioids have doses reduced to preoperative levels or lower within 6 weeks following major surgery

Other than these lower scoring recommendations, the AMDG recommendations scored well on our implementation survey, with the majority of recommendations rated a 3, or fully adopted. Nonetheless, opioid addiction and overdoses continue to be a problem both locally and nation-wide and our response rate was low.

Next Steps

The Bree Collaborative has convened a workgroup that is developing population based measures on opioid prescriptions. This will allow better monitoring of prescribing practices and trends, and planning further improvements. More information on the workgroup is available here:

www.breecollaborative.org/topic-areas/opioid/

Oncology Care

Rank: 8 (medium provider adoption)

Survey Responses- Hospitals: 6

Medical Groups: 12

Health Plans: 7

Adopted March 2016 | 9 months from adoption to survey

Read the Report and Recommendations here: www.breecollaborative.org/wp-content/uploads/Oncology-Care-Final-Recommendations-2016-03.pdf

Implementation Roadmap

Current State	Transition Activities	Ideal State and Sustainability
Hospitals, Clinics, and Individual Clinicians		
<ul style="list-style-type: none"> • Patients receive unnecessary imaging in monitoring early prostate and breast cancers • Patients are not informed of the harms, benefits, and potential impacts of tests and treatments • Patients who would benefit from palliative care services do not receive needed support • Patients goals of care are not known and not part of the care plan 	<ul style="list-style-type: none"> • Staff are educated on American Society of Clinical Oncology’s (ASCO) position statement of key elements for individualized cancer care and Choosing Wisely recommendations • Choosing Wisely recommendations are used to guide testing and treatment decisions • Hutchinson Institute for Cancer Outcomes Research (HICOR) data is used to understand current use of advanced imaging and chemotherapy or radiation therapy at the end of life 	<ul style="list-style-type: none"> • PET, CT, and radionuclide bone scans are not used in the staging of early breast and prostate cancers that are at low risk of spreading • Patients are apprised of the harms, benefits, evidence, and potential impact of tests and treatments • Palliative care is offered alongside active anti-cancer care, as needed • Oncology care is aligned with a patient’s individual goals and values and follows the American Society of Clinical Oncology’s (ASCO) position statement of key elements for individualized cancer care
Health Plans		
		<ul style="list-style-type: none"> • Claims data is provided to HICOR to allow measurement of appropriate imaging tests • Financial incentives are considered for use of appropriate imaging tests

Background

Recommendations for Oncology Care are informed by the American Society of Clinical Oncology (ASCO). ASCO recommends that imaging tests, including CT, PET and bone scans, not be used for staging, or determining the extent of early breast and prostate cancers. Recommendations also specify that palliative care be offered alongside active anti-cancer care, as needed. Oncology care should be aligned with a patient's individual goals and values and follow ASCO's position statement of key elements for individualized cancer care. Patients should be apprised of the harms, benefits, evidence, and potential impact of chemotherapy, radiation, molecular therapy, immunotherapy, and surgery at all stages in their illness trajectory.

In 2012, ASCO partnered with the Choosing Wisely program to develop doctor and patient friendly information, education and decision tools. These were in turn recommended by the Bree Collaborative for use by patients and cancer care providers.

Implementation Survey Results

According to survey results, the majority of providers offer palliative care, and align individual care goals per ASCO defined elements. A barrier for this topic has been data to show overuse or underuse of appropriate oncology tests and treatments.

Bree Collaborative recommendations scoring lowest on the implementation survey for this topic include:

Hospitals and Medical Groups:

- Positron Emission Tomography (PET), Computed Tomography (CT) and radionuclide bone scans are not used in the staging of early prostate cancer at low risk of spreading
- PET, CT, and radionuclide bone scans are not used in the staging of early breast cancer that is at low risk of spreading
- Oncology care is aligned with a patient's individual goals and values and follows the American Society of Clinical Oncology's (ASCO) position statement of key elements for individualized cancer care

Health Plans:

- The health plan securely provides patient enrollment and claims data to the Hutchinson Institute for Cancer Outcomes Research (HICOR) for linkage with the Cancer Surveillance System and comprehensive statewide comparison.

Next Steps

- **Work with existing, accepted programs.** The Fred Hutchinson Cancer Research Center, through The Hutchinson Institute for Cancer Outcomes Research (HICOR) program works with health plan claims data provided by Premera and Regence from 2007 through 2015 to link patients tracked in the Fred Hutch cancer patient registry over the same period. Results can be calculated at the ordering provider level, which shows significant variation among physicians. This work represents significant

opportunity for targeting physicians with high use of non-recommended imaging procedures. HICOR's database also reports use of chemotherapy or radiation therapy and hospice use at the end-of-life. Results show significant variability in end-of-life treatments, such as chemotherapy the last 30 days of life. HICOR's results demonstrate the opportunity for reduction of non-recommended care targeted in Choosing Wisely recommendations.

- More information: Hutchinson Institute for Cancer Outcomes Research
www.fredhutch.org/en/labs/hicor/hicor-iq.html
- **Measurement.** Work with HICOR, and individual provider data, to further investigate overused tests for cancer patients, particularly for physicians with undesirable rates. Health plans would benefit from further work on this issue as well, and providing claims data to HICOR for their own cancer patients would make the database and reports even more robust.
- **Financial incentives.** Payment incentives for appropriate testing could be considered.

Obstetrics Care

Rank: 11 (higher provider adoption)

Survey Responses- Hospitals: 14

Medical Groups: 8

Health Plans: 7

Adopted August 2012 | 52 months from adoption to survey

Read the Report and Recommendations here: www.breecollaborative.org/wp-content/uploads/bree_ob_report_final_080212.pdf

Implementation Roadmap

Current State	Transition Activities	Ideal State and Sustainability
Hospitals, Clinics, and Individual Clinicians		
<ul style="list-style-type: none"> • Patients receive early elective delivery, early inductions, and caesarian sections based on clinician or hospital-specific factors, not based on patient need • No policy is in place limiting induced deliveries • No active monitoring of early inductions or cesarean section rates • No use of patient decision aids 	<ul style="list-style-type: none"> • Hospital policies are adopted for early inductions and cesarean sections • Indications for inductions are on the Joint Commission or Washington State Perinatal Collaborative/ WSHA project list • Clinicians use a patient decision aid for maternity care patients explaining options and risks 	<ul style="list-style-type: none"> • C-sections, indications, and early deliveries are performed appropriately, based on patient need • Data on early elective delivery and C-sections is collected and feedback provided to clinicians • Public reporting of performance is supported
Health Plans		
	Remove financial incentives for unnecessary C-sections and early inductions	

Background

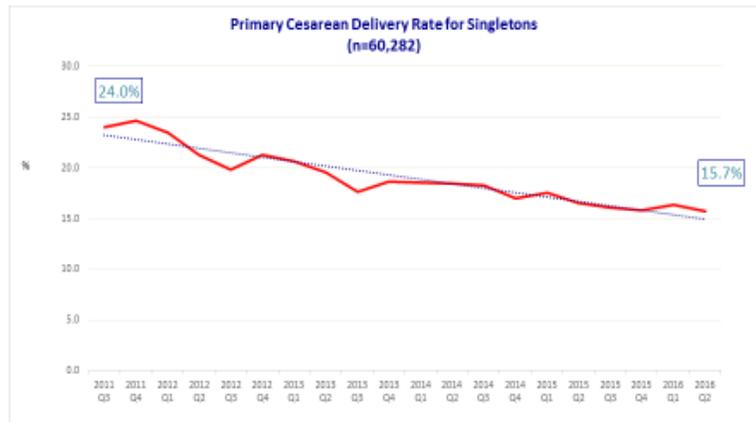
Obstetrics was the Bree Collaborative’s first topic. Focus areas include eliminating elective deliveries before the 39th week of pregnancy, decreasing elective inductions of labor between 39 and up to 41 weeks, and decreasing unsupported variation among Washington hospitals in the caesarian section (C-section) rate for women who have never had a C-section.

Implementation Survey Results

For the 14 hospitals responding to our implementation survey, the vast majority of responses were a rating of three, or full implementation of the Bree Collaborative recommendation. While this is encouraging for the responding hospitals, it does not provide us information for the remaining Washington hospitals that did not reply to our survey. Responding hospitals mentioned continued work

on pregnancy care pathway planning, use of shared decision-making aids, consent forms, and patient education materials, including a smartphone app.

Recommendations include participation in an obstetrics quality improvement program. As part of their new contracts with accountable care organizations, the Washington State Health Care Authority (HCA), requires all contracted hospitals to participate in the Obstetrics Clinical Outcomes Assessment Program (OB-COAP), housed at the Foundation for Health Care Quality. OB-COAP tracks induction and cesarean section rates, along with more measures reflecting specific Bree Collaborative recommendations. 16 hospitals participate in OB-COAP, as well as The Midwives Association of Washington State. The Washington State Hospital Association Safe Deliveries Roadmap includes tools such as provider guidelines for hospitals working on improving obstetrics care, as well as collaborative workgroups and webinars. WSHA also provides comparative reports on hospital induction rates, cesarean section rates, and other indicators on their public website. Many survey responders mentioned participation in these programs.



Analyses of chart abstracted records of 60,272 singletons without a history of cesarean for 11 hospitals (6 level I, 2 level II, 3 level III) throughout Washington State over the time frame Q3 2011 - Q2 2016 show the following changes: **Outcome-** reduction in the primary cesarean rate from 24.0% to 15.7%

Bree Collaborative recommendations scoring lowest on the implementation survey for this topic include:

Hospitals and Medical Groups:

- Policy for scheduling inductions between 39-41 weeks includes: The cervix is favorable- Bishop score of 6 or greater
- Policy for Cesarean-Sections includes: Admitting only spontaneously laboring women at term who present with no fetal or maternal compromise when the cervix is 4 centimeters or more dilated

Health Plans:

- Collaborating with other health plans in Washington to create a quality incentive program, using the quality criteria outlined in the report (e.g. induction rates, total and primary C-section rates, etc.)

Next Steps

- **Measurement.** Health plans and purchasers encourage or require hospitals to participate in a collaborative improvement program and to publicly report performance data.
- **Financial incentives.** Consider financial incentives. Washington’s Medicaid program no longer reimburses physicians and hospitals for elective birth inductions before 39 weeks without documented medical necessity. Innovative approaches are also being used in other states. In California, payers aligned financial incentives for hospitals working to reduce C-section rates. The participating hospitals agreed on a “blended” case rate for deliveries that reimbursed physicians and hospitals a single flat rate regardless of delivery method (cesarean or vaginal). This is similar to the bundled payment topics discussed elsewhere in this report. In the California case, hospitals reduced their C-section rates by 20% and were able to share in the resulting financial savings.³ A similar program Horizon Blue Cross Blue Shield of New Jersey saw a reduction in C-section rates of 32% with bonus payments paid to providers.⁴
- **Patient decision aids.** Reimburse or require patient decision aids, such as those certified by the state of Washington.

Spine Surgical Clinical Outcomes Assessment Program (SCOAP)

Rank: 12 (higher provider adoption)

Survey Responses- Hospitals: 5

Medical Groups: n/a

Health Plans: n/a

Adopted March 2013 | 45 months from adoption to survey

Read the recommendation here: www.breecollaborative.org/wp-content/uploads/spine_scoap_recommendation.pdf

Implementation Roadmap

Current State	Transition Activities	Ideal State and Sustainability
Hospitals		
No tracking of spine surgery clinical performance, quality of care, outcomes, and opportunities for quality improvement	Hospitals participate in the Spine Surgical Care and Outcomes Assessment Program (SCOAP)	Hospital uses calculated measures, results, state benchmarks, and quality improvement information to improve spine surgery

Background

The Bree Collaborative recommends that all hospitals performing spine surgery participate in the Spine Surgical Care and Outcomes Assessment Program (Spine SCOAP), a clinician-led quality improvement program, as a community standard and that the results be unblinded and available by group. Spine SCOAP staff estimate that 75% of current hospitals performing spinal fusion surgery in Washington are enrolled in the program.

Implementation Survey Results

The five hospitals responding to our survey participate in the Spine SCOAP program, although one is just beginning. While this results in a high overall score for our survey, it does not account for the large number of non-responding hospitals.

Next Steps

- **Measurement.** Purchasers and health plans require hospitals performing spine surgery to participate in Spine SCOAP. Purchaser requirements in similar programs, such as obstetrics, have been effective in increasing participation. Participation ensures that important quality and safety information is available for spine surgeries performed in our state. SCOAP is an opportunity for hospitals to work as a community to improve quality of care.
 - More information: Surgical Care and Outcomes Assessment Program (SCOAP) www.scoap.org/

Cardiology: Appropriate Percutaneous Coronary Intervention (PCI)

Rank: 13 (highest adoption)

Adopted January 2013 | X months from adoption to survey

Read our Report and Recommendations here: www.breecollaborative.org/wp-content/uploads/bree_bc_cardiology_final.pdf

Implementation Roadmap

Current State	Transition Activities	Ideal State and Sustainability
Hospitals		
<ul style="list-style-type: none"> • PCIs are performed for non-acute indications, with limited or no evidence of appropriateness • Patients experience excess costs and added risks due to unnecessary care • There is variable measurement of PCI procedures meeting American College of Cardiology’s Appropriate Use Criteria 	<p>Hospitals participate in the Clinical Outcomes and Assessment Program (COAP)</p>	<ul style="list-style-type: none"> • Medical therapy and PCI occur based on current evidence of appropriateness • Hospital tracks and reports to COAP measurement of appropriate PCI procedures • Utilization and costs for PCI are significantly reduced across the state

Background

Recommendations for Appropriate Percutaneous Coronary Intervention (PCI), also known as coronary angioplasty, focus on documentation of appropriate use of the procedure as part of the Clinical Outcomes Assessment Program (COAP), a program of the Foundation for Health Care Quality. COAP tracks multiple cardiac surgery measures in addition to appropriate PCI. PCI is considered appropriate when the expected benefits exceed the expected negative consequences of the procedure, in terms of survival or health outcomes (e.g., reduction of symptoms, improvement in the quality of life, etc.). Currently, all state hospitals that perform PCI procedures report their data to COAP. The detailed clinical information used to measure appropriate use is complex and some hospitals had difficulty in submitting complete data. As a result, a large proportion of PCI tests were determined to have insufficient information. As such, appropriateness cannot be fully measured.

The recommendations included an aggressive timeline

- 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 Collaborative and hospitals to review. Hospitals had the option not to be identified.
 - Completed May 2013.
- Step 4: After hospitals employed methods for improvement, an updated report based on 4th Quarter 2012 data only was posted on the public section of the COAP website. The Bree Collaborative also asked the Washington State Alliance to post COAP data on its Community Checkup website, which compares data on health care services across the State. Hospitals had the option to not be identified.
 - Completed June 2013.

For 2012, approximately 28% of PCI cases had insufficient information. In 2013, that was improved to a rate of approximately 23%.

Implementation Survey Results

Our implementation survey addressed three recommendations for hospitals. These included participation in COAP, reporting of necessary information to determine appropriate PCI, and for allowing COAP results to be shared publicly. All of the eight hospitals responding to our survey scored a three on each recommendation, or fully implemented, making this the only topic on our implementation survey with a perfect score. Nonetheless, a significant number of hospitals did not complete the survey, making the ranking less conclusive. More hospital participation is needed to achieve the goal.

More recently, the COAP program has been working through additional reporting challenges. One was to change the “home grown” calculation method for appropriate PCI, and also the calculation of “insufficient data,” to align with national definitions used by the American College of Cardiology (ACC), who sponsors a similar outcomes registry called the National Cardiology Data Registry (NCDR). Changing to the ACC definitions allows streamlined reporting for hospitals, and consistent definitions between the NCDR and SCOAP. These changes, along with SCOAP staff changes, resulted in a temporary “pause” in reporting, while programming and other adjustments are made. The changes are in progress and are expected to be finished soon. Once complete, the COAP program will be able to show a more accurate rate for appropriate PCI as well as insufficient data.

Next Steps

- **Measurement.** Participating hospitals work with the COAP program to explore ways to improve data reporting to track PCI appropriateness.
- **Financial incentives.** Health plans and purchasers consider financial incentives for complete reporting, as well as performing well on appropriate use measures.

Barriers and Enablers for Practice Transformation

An important goal of the assessment survey was to understand why some recommendations are more easily adopted into clinical practice by specific care sites than others. We searched literature for factors that contribute to or enable practice transformation and those that work against change. Based on work of the Commonwealth Fund, we asked respondents to rank the top five barriers and enablers.⁵

Hospitals and Medical Groups

- **Existing organizational improvement infrastructure.** A top enabler for both hospitals and medical groups was an existing organizational improvement infrastructure. Such a program provides a vehicle for improvement work and often involves a resource team with expertise in quality improvement, team facilitation, metrics, and project management. A growing number of organizations have dedicated improvement departments or programs. In some cases, these are based on approaches such as Lean and Six-Sigma.
- **Business case for change.** The business case for change, which ranked high as both an enabler and a barrier, addresses the fact that implementation is an investment on part of the provider organization. It requires staff time, resources, and opportunity costs for setting other priorities aside. Being able to earn a return on that investment is important. In the prior section, we outlined examples of how financial incentives can be used for specific Bree Collaborative topics.
- **Consensus on what constitutes quality of care.** Consensus on what constitutes quality of care also appeared as an enabler and a barrier, indicating the important work the Bree Collaborative is doing to build consensus among stakeholders. Specific care guidelines, comprised of evidence-based best practices, and consensus among stakeholders are essential. A key feature of Bree Collaborative recommendations is the participation of multiple clinical experts, as well as health plans, purchasers, and others in their development.
- **Individual provider feedback.** Individual provider feedback, where a physician or care team has quality measures based on their own patients, was another important enabler. Feedback, with reflection on current care practices, and action planning for improvement have been shown to be an essential factors in improvement.⁶ While a growing number of performance measures are available to the public at the hospital or clinic level, these are far less common at the individual physician level.
- **Lack of data.** Finally, a lack of data was a barrier. Data gathering can often be a burden, and the credibility and accuracy of data can be questioned in representing a physician's actual practice. This issue underscores the importance of continued work on making accurate, actionable performance data available for providers, not only at the institutional level but at the individual practice level.

Table 1 on the following page summarizes factors helping and hindering change for provider organizations.

Table 1: Barriers and enablers for hospitals and medical groups

Top enablers	Top barriers
Existing organizational improvement program for minimizing errors and waste	Lack of availability and credibility of data, and the burden of collecting it
Business case- evidence of economic reward	Business case- no economic reward, and lack of contract partners interested in value-based purchasing
Consensus on what constitutes quality of care	Lack of consensus on what constitutes quality of care
Individual provider-level performance feedback	

Next Steps

Organizations wanting to assess the capabilities of their own quality improvement efforts might find a self-assessment tool, developed by the Institute for Healthcare Improvement, useful for this purpose. Resource: IHI Improvement Capability Self-Assessment Tool:

www.ihl.org/resources/Pages/Tools/IHIImprovementCapabilitySelfAssessmentTool.aspx

Health Plans

- **Market share.** Market share appeared on top as both barrier and enabler to implementation for health plans. This indicates a fragmented, multi-payer market, where doctors and hospitals typically contract with multiple health plans, and fewer individual health plans have significant influence. To address this, health plans should consider aligning incentives with Medicare, Medicaid, and with one another in using a shared quality incentive program with common performance measures. This is already happening in other states. In California’s Integrated Healthcare Association, 10 health plans are using a common measure set to pay performance incentives to over 200 provider groups. Financial agreements and payments remain between the individual health plan and provider groups, but the performance measures share a common platform (see more discussion on common measures in the following section- consistency of findings across multiple measures). Not only do common measures improve the influence of the health plans, it also streamlines data reporting for care providers.
 - More information on value-based pay-for-performance in California from [Integrated Healthcare Association](http://IntegratedHealthcareAssociation) here www.ihl.org/sites/default/files/resources/vbp4p-fact-sheet-final-2016.pdf

- **Willing contract partners.** Health plans also indicate that willing contract partners (such as employers as purchasers, and health care providers) as important in implementing changes. As traditional fee-for-service payment transitions to newer, value oriented contracts, providers assume more accountability for cost and quality outcomes. Examples include financial incentives based quality performance, bundled payment contracts, and accountable care organizations. As doctors and hospitals gain experience with these types of contracts, health plans are likely to have greater number of willing partners in value-oriented contracts.
- **Consistency in findings across multiple measures.** With the growing number of sources available to measure and compare health care quality, consistency in findings across multiple measures was identified as another enabler. When different sources come to the same conclusion on quality performance, there is more confidence in quality data. Reporting sources based on larger, more comprehensive data will have more validity and weight compared to sources based on limited data, such as results from a single health plan. Programs helping to provide broad-based, independent comparative performance data for Washington providers include work done by the Washington Health Alliance, who produces the most comprehensive quality reports. Others include the Washington State Hospital Association, the Foundation for Health Care Quality, and the Hutchinson Institute for Cancer Outcomes Research (HICOR). Several of these reports align with Bree Collaborative recommendations and are mentioned elsewhere in this report.
 - **Washington Health Alliance.** Using health plan claims and other data, The Alliance produces comparative quality reports on medical groups, hospitals, as well as geographic variations in care. Working with the state government, private health care purchasers, provider groups and other stakeholders, the Alliance produced a Common Measure Set for measuring and reporting quality of care performance.
 - More information: www.wahealthalliance.org
 - **Washington State Hospital Association.** For hospital care, the Washington State Hospital Association (WSHA) provides detailed quality reports on hospital care on a public website.
 - More information: www.wsha.org and www.wahospitalquality.org
 - **The Foundation for Health Care Quality** produces reports for obstetrics, cardiac surgery, and other surgical procedures based on medical record information to show precise quality measures for targeted types of hospitalizations.
 - More information: www.qualityhealth.org
 - **Hutchinson Institute for Cancer Outcomes Research.** The Fred Hutchinson Cancer Research Center, through The Hutchinson Institute for Cancer Outcomes Research (HICOR) program, is working on quality value-based measures of treatment and care.
 - More information: www.fredhutch.org/en/labs/hicor/hicor-iq.html

Table 3 summarizes health plan enablers and barriers identified in our survey.

Table 3: Barriers and enablers for health plans

Top enablers	Top barriers
Sufficient market share/volume	Sufficient market share/volume
Contract partners interest in value-based purchasing	Burden/ease of collecting or obtaining data
Consistency in findings across multiple measures	Business case- evidence of economic reward

Financial Incentives for High-Quality Care

Public and private payers can reward continuous improvement through outcome- and value-oriented payment models, contracting policies, and benefit designs. Payment models can adequately incentivize and support high-quality team-based care focused on the needs and goals of patients and families. Likewise, provider organizations can reward continuous learning and improvement using internal incentives.⁷

Contractual agreements based in evidence between payers and providers are key to value-based purchasing. We found that a lack of a business case to be a top barrier to implementation of recommendations by providers. Value-based purchasing creates this business case, and directly aligns payment to quality and outcomes in a way that traditional fee-for-service reimbursement fails to accomplish.

Various forms of value-based purchasing are currently being used. Medicare’s payment reform program is implementing several value-based incentive programs, ranging from a fee-for-service incentive known as the Merit-based Incentive Payment System (MIPS) to the Advanced Alternative Payment Model (APM) for capitated payments to health care systems. As part of this work, Medicare developed a useful framework to describe types of payment reform. Their model covers a progression of alternative payment models outlined in **Table 4** on the following page.

Table 4: CMS/Medicare Alternative Payment Framework

Category 1 Fee for Service- No Link to Quality & Value	Category 2 Fee for Service- Link to Quality & Value	Category 3 Alternative Payment Models Built on Fee-for- Service Architecture	Category 4 Population Based Payment
	A Foundational Payments for Infrastructure & Operations	A Advanced Payment Models with Upside Gainsharing	A Condition-Specific Population Based Payment
	B Pay for Reporting	B Advanced Payment Models with Upside and Downside Gainsharing	B Comprehensive Population-Based Payment
	C Rewards for Performance		
	D Rewards and Penalties for Performance		

At the state level, Washington State Health Care Authority is also implementing value-based payment reforms. Already, hospitals can earn financial incentives for meeting quality targets for Medicaid patients. For individuals enrolled in the Public Employee Benefits Board (PEBB) Program Uniform Medical Plan requiring knee and hip replacement, the HCA contracted with Virginia Mason hospital to provide joint replacement surgery at a fixed cost, in a bundle arrangement, based on Bree Collaborative recommendations. Both state and federal payers have goals to increase their use of value-based payments in the coming years.

Bree Collaborative topics are well suited for use throughout the CMS framework. Purchasers, health plans and provider organizations should evaluate where contracting and payment structures can accelerate adoption of Bree Collaborative recommendations.

Our survey indicates that nearly all are either using or implementing incentives in their fee-for-service provider contracts that include a quality bonus based on performance. These are often based on well-established measures in the Healthcare Effectiveness Data and Information Set (HEDIS), created by the National Committee for Quality Assurance (NCQA).

Bundled or episode-based payments involve a set fixed price for multiple services grouped into a single episode of care. It is a less common strategy, though growing in use. In some cases, a retrospective review of costs is conducted, and providers who achieve a total cost below the target price can receive a financial bonus. Payments can also be made up-front in advance of treatment, which often require significant billing process changes and added complexity for health plans and providers. Medicare is testing bundled payments in pilot programs and is expanding use in several markets.

Most of the health plans in our survey were not implementing bundled payments. A few were beginning early implementation. The costs of programming information, tracking performance, and getting buy in from providers were significant barriers of plan adoption of bundled payment. Both Medicare and the Washington Health Care Authority are early adopters of bundled payments.

In our survey, four of seven health plans indicated they were considering use or piloting the Bree Collaborative joint replacement bundles. There was less adoption of the lumbar fusion bundle, and least adopted of the three bundles was the coronary artery bypass graft (CABG) surgical bundle.

Overall, Bree Collaborative topics and recommendations are well suited for use in value-based purchasing. A cross-walk of Bree Collaborative topics with value-based payment types that can be considered is shown below:

Category 2A: Foundational Payments for Infrastructure & Operations

- Opioid Prescriptions
- End-Of-Life Care

Category 2B: Pay for Reporting

- Obstetrics Care
- Cardiology: Appropriate PCI
- Spine SCOAP
- Low-Back Pain
- Addiction and Dependence Treatment

Category 2C(&D): Rewards (and Penalties) for Performance

- Oncology Care
- Avoidable Hospital Readmissions
- Prostate Cancer Screening
- Addiction and Dependence Treatment

Category 3A(& B): Advanced Payment Models with Upside (and Downside) Gainsharing

- CABG Surgical Bundle
- Lumbar Fusion Surgical Bundle
- Knee/Hip Replacement Surgical Bundle
- Obstetric Care

Category 4A : Condition-Specific Population Based Payment

- Same as previous section

Plans for Continued Tracking

Hospitals, medical groups and health plans completed implementation surveys between August 2016 and January 2017. The results appearing in **Table 2** of this report serve as a reference baseline in adoption of Bree Collaborative recommendations for participating organizations. The surveys remain posted on the Bree Collaborative website and available for additional organizations to complete. Future assessments are recommended using the same surveys, at the discretion of the Bree Collaborative, in order to track progress.

Toolkit

Definitions, specifications, and measurement of health care quality are becoming more routinely used. Many of the topics addressed in this report were discussed at a high level. The following resources provide further background information and details. Include are practice assessment surveys, patient education materials, quality reporting resources, and value-based purchasing resources. Also included are organizations dedicated to promoting health care quality improvement and value-based purchasing.

Bree Collaborative

www.breecollaborative.org

Reports and information regarding new and existing topics will continue to be posted on the Bree Collaborative website. Medical groups, hospitals, health plans and purchasers can find the most current information here as the program evolves.

- Assessment Surveys
www.breecollaborative.org/bree-assessment-survey/
- Purchaser Fact Sheets
(Coming to our website soon)

Washington Health Alliance

www.wahealthalliance.org

The Alliance creates reports showing comparative performance measures on Washington health care providers and health plans. Information most closely aligned with Bree Collaborative topics include:

- Hospital Readmissions
www.wahealthalliance.org/alliance-reports-websites/alliance-reports/hospital-readmissions/
- Choosing Wisely Taskforce & Reports
www.wahealthalliance.org/alliance-reports-websites/choosing-wisely/

Choosing Wisely

www.choosingwisely.org

The Choosing Wisely program supports conversations between physicians and patients to improve care, and ensure high-quality, cost-effective care for patients. Information most closely aligned with Bree Collaborative topics include:

- Cancer Care
 - www.choosingwisely.org/patient-resources/cancer-tests-and-treatments/
 - www.choosingwisely.org/patient-resources/care-at-the-end-of-life-for-advanced-cancer-patients/
- Low-Back Pain
 - www.choosingwisely.org/patient-resources/imaging-tests-for-back-pain/

Qualis Health

Qualis Health is a national leader in improving care deliver and patient outcomes. Qualis has partnered with Washington State’s “Healthier Washington” initiative and provides support for health care practices in integration of physical and behavioral health, as well as moving towards value-based payment systems. Information most closely aligned with Bree Collaborative topics include:

- Hospital Readmissions
 - www.medicare.qualishealth.org/projects/care-transitions/news-and-progress/specific-communities/performance-reports
- Behavioral Health Integration
 - www.safetynetmedicalhome.org/change-concepts/organized-evidence-based-care/behavioral-health

Leapfrog

www.leapfroggroup.org/

Leapfrog was established by a group of large U.S. companies to influence quality and affordability of health care. Leapfrog information most closely aligned with Bree Collaborative topics include:

- C-Sections Rate
 - www.leapfroggroup.org/ratings-reports/rate-c-sections

Medicare Quality Payment Program

www.qpp.cms.gov

Medicare is rolling out a performance-based payment adjustment program to physicians and other practitioners caring for Medicare patients. Care providers can choose from a large menu of optional measures, based on the types of patients they care for. They submit performance data for their patients, and Medicare determines if they earned a payment adjustment based on performance. Medicare quality payment measures most closely aligned with Bree Collaborative topics include:

- Addiction & Dependence Treatment
 - Performance-based payment measure

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Measure Number:
 - eMeasure ID: CMS137v5
 - eMeasure NQF: N/A
 - NQF: 0004
 - Quality ID: 305
- Preventive Care Screening: Unhealthy Alcohol Use: Screening & Brief Counseling Measure Number
 - eMeasure ID: N/A
 - eMeasure NQF: N/A
 - NQF: 2152
 - Quality ID: 431

Integrated Healthcare Association www.iha.org

The Integrated Healthcare Association aligns financial incentives of purchasers, payers, and providers to achieve the most positive outcomes of healthcare. Their programs most closely aligned with Bree Collaborative topics include:

- Bundled Payment (including contract templates)
www.iha.org/our-work/insights/bundled-payment
- Value-Based Pay for Performance
www.iha.org/sites/default/files/resources/vbp4p-fact-sheet-final-2016.pdf

Washington State Health Care Authority www.hca.wa.gov

The Washington State Health Care Authority purchases health care for more than 2 million Washington residents. As the largest health care purchaser in the state, the agency plays an active role in transforming health care, helping ensure Washington residents have access to better health and better care at a lower cost. The HCA provides funding for the Bree Collaborative and uses their recommendations to guide state health care purchasing and contracting requirements. The agency also certifies Patient Decision Aids, including those recommended by the Bree Collaborative.

- Patient Decision Aids
www.hca.wa.gov/about-hca/healthier-washington/patient-decision-aids-pdas

Additional Resources

The following organizations are resources for value-based purchasing, payment redesign, quality improvement.

Institute for Healthcare Improvement www.ihl.org

Improving health and health care worldwide

Pacific Business Group on Health www.pbgh.org

Articles, tools, and research for health care purchasers

The International Patient Decision Aid Standards <http://ipdas.ohri.ca/>

Shared, evidence-informed framework for patient decision aids

Health Transformation Alliance www.htahealth.com

Purchasers collaborating to improve health care outcomes and efficiency

Health Care Incentives Improvement Institute www.hci3.org

Incentives for care redesign

Appendix A: Bree Collaborative Members

Member	Title	Organization
Susie Dade MS	Deputy Director	Washington Health Alliance
John Espinola MD, MPH	Executive Vice President, Health Care Services	Premera Blue Cross
Gary Franklin MD, MPH	Medical Director	Washington State Department of Labor and Industries
Stuart Freed MD	Chief Medical Officer	Confluence Health
Richard Goss MD	Medical Director	Harborview Medical Center – University of Washington
Christopher Kodama MD	President, MultiCare Connected Care	MultiCare Health System
Daniel Lessler MD, MHA	Chief Medical Officer	Washington State Health Care Authority
Paula Lozano MD, MPH	Associate Medical Director, Research and Translation	Group Health Cooperative
Wm. Richard Ludwig MD	Chief Medical Officer, Accountable Care Organization	Providence Health and Services
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	Partner	Mercer
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	Medical Director, Community Health Services	Public Health – Seattle and King County
Kerry Schaefer	Strategic Planner for Employee Health	King County
Bruce Smith MD	Medical Director	Regence Blue Shield
Lani Spencer RN, MHA	Vice President, Health Care Management Services	Amerigroup
Hugh Straley MD (Chair)	Retired	Medical Director, Group Health Cooperative; President, Group Health Physicians
Carol Wagner RN, MBA	Senior Vice President for Patient Safety	The Washington State Hospital Association
Shawn West MD	Family Physician	Edmonds Family Medicine

Appendix B: Communication Pathway

Communication and community engagement steps after adoption of Bree Collaborative Report and Recommendations. See [links](#) for examples.

Within:



- Draft and publish a [blog post](#) giving an overview of recommendation focus areas and key goals and outlining their development. The blog should easily understandable to a wide audience (e.g., simple language, short sentences, bullets).
- Announce adoption on **social media** channels with a link to the blog post - [Twitter](#), [Facebook](#), and [LinkedIn](#).
- Begin brainstorming **infographic** fact sheet(s) for [providers](#) and other relevant audiences, such as [patients](#). Infographics break down the key lessons and goals of the recommendations in a visual way – something that could be handed out or hung on a wall. Assign if needed and set a one-month deadline.



- Create a set of [talking points](#) for workgroup members. **Talking points** are a bulleted distillation of the recommendations designed to keep the messaging consistent as workgroup members may begin communicating the recommendations to their professional networks. They also serve as a good platform for creating the press release. Send these to the workgroup and let them know a formal press kit will be forthcoming and ask them to hold off on formal announcements until then.



- Create a [press release](#). This is a further distillation of the talking points directed at communicating the newsworthy points of the recommendations.
- Work to finalize **infographic(s)** by week four.
- Write some recommended **social posts** to include in press kit intended for Bree Collaborative members to share with their networks on Twitter, Facebook, and LinkedIn. This is another way to keep the messaging consistent.



- Finalize **infographic(s)**.
- Send **press kit** to our media contacts containing the press release, infographic(s), and a link to the blog post.
- Send **press kit** to workgroup and the larger Bree Collaborative containing press release, infographic(s), a link to the blog post, and recommended social posts.

Appendix C: The Science of Implementation

Clinical innovations famously take an average of 17 years from published research to the point of benefiting an individual patient.⁸ The Bree Collaborative sits between the space where clinical research has been adopted into pilot translational activities and broader adoption to policy steps to impact population health. We highlight areas where published clinical best practices have been adopted on a small scale and work to foster adoption state-wide, looking at clinical variation, patient safety issues, potential waste when selecting a health service to implement. Below we briefly summarize practice transformation research, and use the frameworks and suggestions to adapt our recommendations to individual implementation roadmaps.

Practice transformation experts have argued that large systems, such as hospitals, have more in common with living creatures than machines. Large systems are complex and do not have a 1:1 ratio of cause and effect.⁹ Barriers to adopting new clinical protocols, such as those developed by the Bree Collaborative, include natural inertia, broader political structure, organizational culture, lack of clinical champions or leadership engagement, reimbursement protocols, conflicting agendas, electronic medical records, availability and reliability of data, and other factors.¹⁰ Low success rate of organization change is not limited to health care, an estimated 70% of all change initiatives fail.¹¹

Foundational concepts of implementation science include: diffusion (i.e., passive spread of interventions as through journal articles), dissemination (i.e., planned and targeted outreach), implementation (i.e. the clinical changes), adoption (i.e., degree of new idea uptake), and sustainability (i.e., maintenance of change state and assessment).¹² Evidence-based best practice must be disseminated to the correct audience, implemented at the right time, and evaluated for impact. The implementation portion of the five-cycle model described above is paramount, necessitating a mix of streamlining economic value and fostering organizational capability through consistent leadership vision, reinforcement of change through incentives, engaged employees, and a dual focus on systems/structural and softer culture change.²

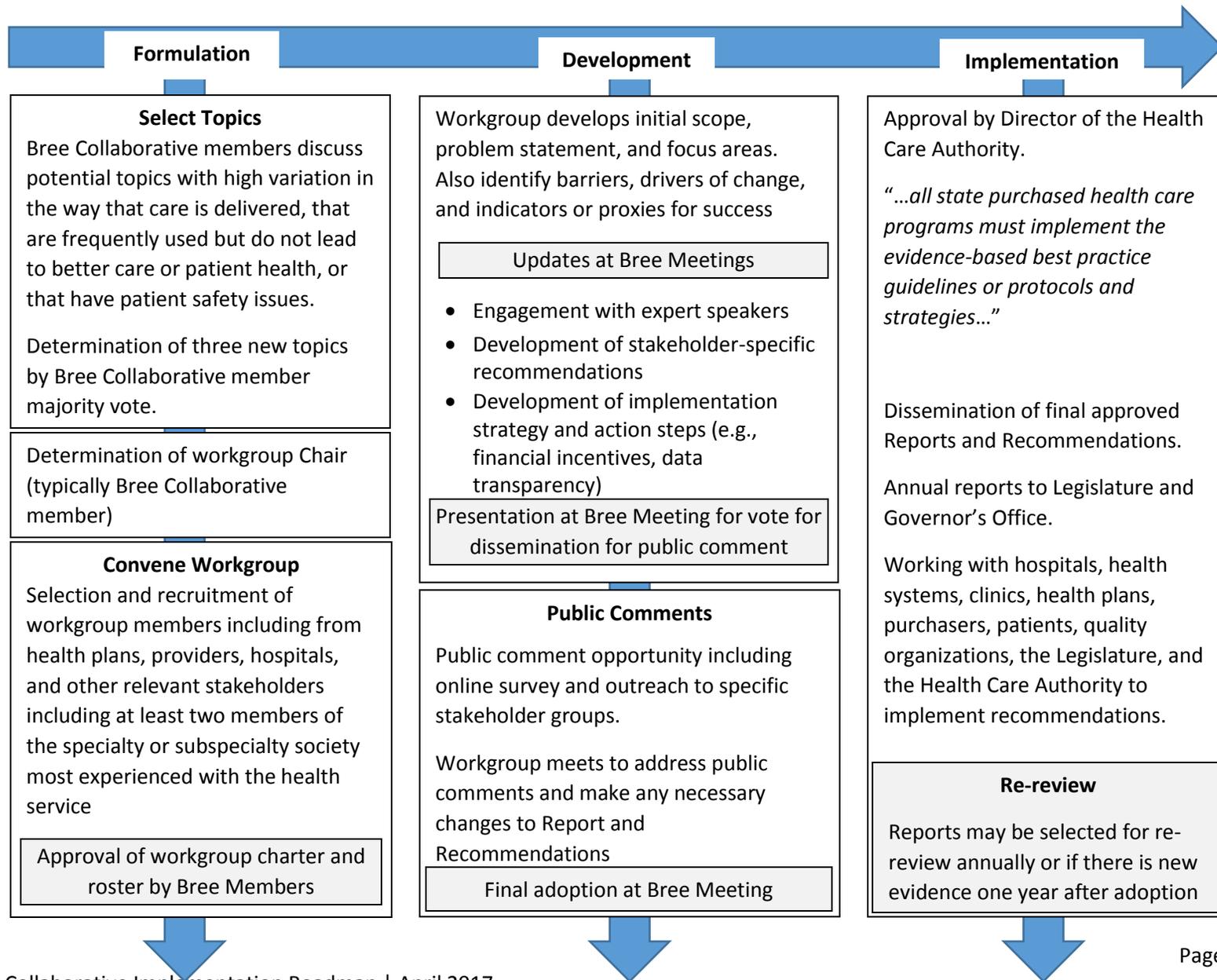
A literature review of best practices for research dissemination and implementation argues for using already tried and true methods of implementation, especially using models of change from other disciplines such as business for health services.¹³ One of these frameworks, the health promotion research center framework defines the role of the researcher, the disseminating organization, and the end user organization as collaborative and argues for an expanded researcher role that can: assess readiness of user organizations, balancing adherence to research framework and flexible adaptation of recommendations, monitor and evaluate, and test dissemination approaches.¹⁴ More information about the Health Promotion Research Center can be found here: <http://depts.washington.edu/hprc/>

The RE-AIM framework works to assist sustainable adoption and implementation of evidence-based intervention that:

- Reach the target population
- Effectiveness or efficacy
- Adoption by target staff, settings, or institutions
- Implementation consistency, costs and adaptations made during delivery
- Maintenance of intervention effects in individuals and settings over time

RE-AIM steps to improve adoption include understanding the health care system that will take up the change, including organizational decision-makers in early stages of change definition and development including understanding barriers and strategies to overcome barriers, and providing data back to the organization.⁷ More information about adoption can be found here: <http://re-aim.org/about/what-is-re-aim/adoption/improving-adoption/> RE-AIM steps to improve implementation include working with staff and others who will eventually deliver the program, providing resources including an implementation manual and recommending ways to keep everyone on track while allowing for flexibility, and including training and technical support that is collaborative and informative.⁷ More information about RE-AIM implementation can be found here: <http://re-aim.org/about/what-is-re-aim/implementation/improving-implementation/>

Appendix D: Recommendation Development Process



Appendix E: Quality Improvement Strategies

Effective organization-wide change management begins with leadership. The leadership team must communicate improvement as a priority and dedicate resource to improvement efforts. These efforts include problem solving, experimentation, and using measurement to gage progress and motivate further improvements.¹⁵

Many health care leaders have adopted the triple aim to focus improvement efforts. Developed by the Institute for Health Care Improvement, the triple aim is to 1) improve the health of the population, 2) improve patient experience, including quality and satisfaction, and 3) reduce the cost of health care. More recently, a fourth aim has been incorporated improving clinician and staff satisfaction.¹⁶ With this purpose in mind, improvement leaders should make use of a systematic problem solving approach, grounded in the scientific method. This requires that staff work in teams to identify a problem, uncover underlying factors behind the problem, create a plan to address those factors, implement a solution, and measure whether the solution is achieving desired results.¹⁷ Results rely on data, which might include information from scientific research, patient care processes and outcomes, financial results, or other operational metrics. Leaders at all levels need to practice evidence-based management, with data from continuous improvement cycles, interpreting these data to evaluate changes, and incorporating successful changes into routine care.¹⁸

Some health care organizations employ more extensive systems engineering based methods for performance improvements. The Lean methodology, rooted in Japanese manufacturing companies including Toyota, puts emphasis on defining work activities as either value-adding or waste, and working methodically to eliminate waste.¹⁹ Six Sigma, introduced in the U.S. in the 1980's, is based on use of statistical methods in identifying and removing causes of defects and variation in work processes. W. Edwards Deming, a quality improvement pioneer who worked in the U.S. and Japan, promoted the Plan-Do-Study-Act, (PDSA) improvement cycle, which focuses on measurement and systematic testing of improvements in which teams create a plan for change, implement the change, study the effects of the change and then repeat based on lessons learned. Often lead by specially trained staff, combinations of these approaches are also used.

In recent years, improvement teams have developed common tools that are being implemented in health care practices. These tools help in reducing variation and improving reliability in testing and treatment, and enable more patient centered care. Workgroups developing Bree Collaborative recommendations have used many of these tools in their recommendations. They are intended for rapid adoption by care teams.

Common quality improvement tools include:

- **Evidence-based clinical practice guidelines**- knowledge based recommendations based on proven research.
- **Checklists**- reminders intended to improve reliability and make providers' jobs easier.
- **Clinical decision support**- These tools translate guidelines into a format usable by clinicians at the point of care. Digital decision support tools might be incorporated into order entry systems to guide decisions when ordering tests or treatments.
- **Patient decision aids**- designed to assist patients in communicating with their clinicians about patient needs, values, goals, and preferences in clinical decisions. They help weigh the benefits and harms of treatment options. Some of these are "certified" patient to ensure that they are accurate, unbiased, and understandable.
- **Patient reported outcomes**- Patient surveys that captures a patient's self-assessment of health, including mental or physical health status, function, symptoms, and health-related quality of life. Use of these tools allows evaluation of treatment outcomes as well as overall patient satisfaction.

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