The Dr. Robert Bree Collaborative Meeting

July 17th, 2014 | 12:30pm – 4:30pm
Agenda

- Chair Report & Approval of May 21st Meeting Minutes
- Accountable Payment Models (APM) Workgroup Update
- Potentially Avoidable Readmissions Report and Recommendations
- **BREAK**
- State Agency Medical Director Perspectives
- The Bree Collaborative’s Impact
- Review of Previous and Current Work
- Perspective of the Health Care Authority
- Future Topics
- Bree Member Roles and Responsibilities
- Next Steps and Close
- Bree Social Hour
Welcome New Members

- **Christopher Kodama**, MD, Medical Vice President, Clinical Operations, MultiCare Health System
- **MaryAnne Lindeblad**, RN, MPH, Director, Medicaid Program, Health Care Authority
- **Jeanne Rupert**, DO, PhD, Director of Medical Education, Skagit Valley Hospital
- **Lani Spencer**, RN, MHA, Vice President, Health Care Management Services, Amerigroup
- **Carol Wagner**, RN, MBA, Senior Vice President for Patient Safety, The Washington State Hospital Association
- **Shawn West**, MD, Family Physician, Edmonds Family Medicine
DESIGN TEAM

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

- Administrators
  1. April Gibson, Proliance
  2. Gary McLaughlin, Overlake

- Purchasers
  1. Kerry Schaefer, King County
  2. Jay Tihinen, Costco
  3. Gary Franklin, MD, L&I
  4. Charissa Raynor, SEIU Healthcare NW Benefits

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

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

- Consultants
  1. Farrokh Farrokhi, MD, Virginia Mason Medical Center
  2. Andrew Friedman, MD, Virginia Mason Medical Center
  3. Mary Kay O’Neill, MD, Regence
  4. Peter Rigby, Northwest Hospital
  5. Fangyi Zhang, MD, University of Washington
I. A WARRANTY FOR LUMBAR FUSION

Aligning payment with safety
SPECIFICS OF WARRANTY
ADULTS WITH LUMBAR FUSION FOR SPINAL DEFORMITY

Periods of accountability are complication-specific and apply to readmission to the hospital where surgery was performed.

**7 days**
- a. Acute myocardial infarction
- b. Pneumonia
- c. Sepsis/septicemia

**30 days**
- a. Death
- b. Pulmonary embolism
- c. Surgical site bleeding
- d. Wound infection

**90 days**
- a. Infection involving implant
- b. Mechanical complications related to surgical procedure
2. BUNDLED PAYMENT MODEL

Aligning payment with quality
FEATURES OF THE BUNDLE

1. Clinical standard explicitly and transparently defined
2. Content supported by transparent evidence appraisal
3. Appropriateness standards integrated into care pathway
4. Market-relevant quality measured/reported by providers
5. Financial accountability for complications as per warranty
1. Document disability due to spinal abnormality despite conservative therapy
2. Ensure fitness for surgery
3. Provide all elements of high-quality surgery
4. Facilitate rapid return to function
DESIGNING THE BUNDLE

1. Candidate interventions proposed for each cycle of the bundle
2. Standardized evidence search and appraisal method applied to each intervention to determine effectiveness
3. Warranty added to bundle
4. Quality metrics added to bundle
5. Code sets added to warranty
Document disability due to spine abnormality despite conservative therapy

1. Measure disability on standard scales: Oswestry Disability Index (ODI) and PROMIS-10
2. Measure spine abnormality on standard imaging scale: WA Labor and Industries standard
3. Provide explicit evidence-based conservative therapy in a collaborative care model for at least three months unless disability and imaging findings severe
4. Document failure of conservative therapy on above scales with required review and recommendation for surgery by care team
Physical preparation and patient engagement

1. Standards relating to patient safety: BMI < 40; A1C < 8%; no smoking for eight weeks; management of opioids, nutritional status, emotional disorders, osteoporosis and dementia; absence of a near-term life-limiting illness or other severe disability preventing benefit of surgery; complete post-op plan for return to function

2. Patient engagement: shared decision-making

3. Designated care partner to assist patient throughout course

4. Standard preoperative evaluation includes nasal culture, screen for delirium, screen for osteoporosis
CYCLE # 3: SURGERY
MEASURES TO IMPROVE OUTCOMES

1. Minimum annual volume for surgeon: 20 cases in last 12 months
2. Two attending surgeons optional; begin surgery before 5 pm
3. Multimodal anesthesia to minimize sedation and promote early ambulation
4. Measures to avoid infection as specified by CMS (Surgical Care Improvement Project)
5. Measures to avoid bleeding/low BP (such as tranexamic acid and RN fluid protocols)
6. Measures to avoid thromboembolism as specified by CMS (SCIP)
7. Measures to maintain optimal blood sugar
8. Spine SCOAP registry
CYCLE #4: RECOVERY
RAPID RETURN TO FUNCTION

Standard processes in place at facility where surgery performed

1. Standardized post-op care in the hospital
2. Standardized discharge process aligned with WSHA toolkit and Bree recommendations
3. Standardized follow-up communication and appointments
4. Measurement of functional outcomes
A guide to purchasing
After year 1, providers measure and report quarterly

1. Appropriateness: shared decision-making, ODI, PROMIS-10

2. Five elements of evidence-based surgery: multimodal anesthesia; measures to avoid infections, venous thromboembolism, blood loss, and hyperglycemia

3. Rapid return to function: patient-reported measures of disability and quality of life 6 months, 2 years post

4. Patient care experience: HCAHPS

5. Affordability: nine complications listed in warranty and 30-day all cause readmissions for lumbar fusion patients
POTENTIALLY AVOIDABLE HOSPITAL READMISSIONS REPORT AND RECOMMENDATIONS

RICK GOSS, MD, MPH, FACP
HARBORVIEW MEDICAL CENTER / UW MEDICINE
JULY 17TH, 2014
WORKGROUP MEMBERS

- Chair: Rick Goss, MD, MPH
- Sharon Eloranta, MD
- Stuart Freed, MD
- Leah Hole-Marshall, JD
- Dan Lessler, MD, MHA
- Bob Mecklenburg, MD
- Amber Theel, RN, MBA, CPHQ
- Ginny Weir, MPH
WORKGROUP CHRONOLOGY

Draft Proposal to Bree Collaborative
3/19/14

4/23/14
Workgroup meeting framing a three pronged recommendation

Revised proposal presented to Bree Collaborative
5/21/14

5/29/14 – 6/20/14
Public Comment Period

6/30/14
Workgroup meeting to review public comments, make further revisions

Today’s meeting
7/17/14
47 individuals or groups filled out the survey
DETAILS ON “OTHER” CATEGORY

- Physician professional association
- Health system (2)
- Washington State Pharmacy Association
- Home health (4)
- LTC/skilled nursing/assisted living (3)
- Behavioral health
- Government regulator
- Retail pharmacy
- Community mental health (2)
- Consulting
Do you agree with the problem statement?

- Yes: 87.2%
- Neutral/No Opinion: 6.4%
- No: 6.4%
Comments included:

- Broader acknowledgment of the factors that impact readmissions. Socioeconomic influences must be well represented in the discussions around preventing readmissions.

- In addition to a lack of community based care options in some areas, poorly coordinated community based care is also a problem even in settings where services may appear adequate.

- In theory it looks good, in practice...it will be hard to implement.

- Implement community-based programs that address social determinants of health that can lead to hospital readmission.
changes made:

- Added background on the Bree Collaborative.
- Added clear acknowledgement of socioeconomic factors influencing readmission (Hu et al., 2014; Lindenauer et al., 2013; Arbaje et al., 2013; Foraker et al., 2008; Kangovi et al., 2013).
- Added reference to INTERACT quality improvement program and impact of community care facilities (Ouslander et al., 2011; Ouslander et al., 2010).
PUBLIC COMMENTS: RECOMMENDATION I: COLLABORATIVE MODEL

Do you agree with Recommendation I?

- Neutral: 10.6%
- No: 4.3%
- Somewhat: 17%
- Yes: 68.1%
As a patient, I must ask how intentional these initiatives are in seeking out the patient voice. Without it, these work groups are shooting darts at a moving target.

The document could be more explicit as to how the progress and outcomes of the Collaborative Model as a community-wide solution will be assessed over time.

Consider adding clarification that this about framework big picture, as other recommendations are really more about how to start to operationalize.

We found the recommendation too prescriptive. The idea of forming a collaborative is something we completely support. However, details about how often to meet and for how long is beyond the scope of this recommendation.
PUBLIC COMMENTS:
RECOMMENDATION 1: COLLABORATIVE MODEL

Changes made:

- Clarified that this is a first step and that additional tools and techniques (e.g., better integration of behavioral health, home health) may also greatly impact readmissions but are out of the scope of this project.

- Clarified that individual members of a collaborative may be different from site to site and may include many different stakeholders (e.g., hospitals, SNFs, patients, home health, etc.).

- Clarified what the minimum criteria are for a designation of a “Collaborative” and that Bree is not prescribing complete adherence to the IHI’s structured model.
PUBLIC COMMENTS:
RECOMMENDATION II: WA TOOLS AND TECHNIQUES

Do you agree with Recommendation II?

- Yes: 72.3%
- Somewhat: 19.1%
- Neutral: 8.5%
- No: 0%
PUBLIC COMMENTS: RECOMMENDATION II: WA TOOLS AND TECHNIQUES

Comments included:

- The emphasis should be on coordination of the work of these organizations to avoid duplication of efforts.

- The paper needs to address more than Medicare data and Medicare issues. I would recommend that maternity and the 1st year of life be included to bring focus to the employer issues. I also think that like ED over use, attention to outliers (very high rehospitalization rate > 5 per year) need to be addressed. 30 day while a good start ignores the repeated hospitalizations the drive costs up and likely have diminishing value.

- A tool kit is only as good as the source delivering it. If the tool kit results in patients being handed another stack of papers to read, we have not gained anything. If, however, it engages providers with patients in face to face conversation, then the impact will be valid.
Changes made:

- Clarify the consensus work based on best available evidence behind the WSHA Care Transitions Toolkit (the Toolkit).
- Recommend that hospitals adopt the Toolkit in its entirety.
- Acknowledge that some variation may be appropriate based on clinically compelling reasons.
PUBLIC COMMENTS:
RECOMMENDATION III: PROPOSED MEASUREMENT

Do you agree with Recommendation III?

- Neutral: 6.4%
- No: 6.4%
- Somewhat: 25.5%
- Yes: 61.7%
PUBLIC COMMENTS: RECOMMENDATION III: PROPOSED MEASUREMENT MEASUREMENT

Comments included:

- For the follow-up phone call: The description of the metric should be modified to read: A documented phone call within 24 to 72 hours following discharge, based on risk stratification. Also, additional considerations for timeframe of discharge phone call should include patients seen by home care within 48 hours of discharge and patients discharged to a skilled nursing facility.

- We support the proposal to extend the timeframe to three business days post discharge for the measures for both the communication of discharge information, and completion of discharge phone calls.

- Note that the measures recommended by the Bree are a part of the Medicaid Quality Incentive Program and were selected in an effort to promote alignment and reduce reporting burden.

- The proposed measures are process in nature and should sunset or be evaluated at predetermined intervals to assess their value and impact in reducing readmissions.

- An exclusion should be added to the metric to exclude cases where the PCP is the discharging provider.
PUBLIC COMMENTS:
RECOMMENDATION III: PROPOSED MEASUREMENT

- Changes made:
  - Changed time for both metrics to within three business days of discharge
  - Added that these align with the Medicaid Quality Incentive Program to reduce reporting burden
  - Added that the discharge information summary is consistent with the hospital medical staff by-laws or another form of documentation, not “as consistent with the Joint Commission requirements”
  - Added exclusions:
    - Patient discharged to SNF, LTC, assisted living, or prison.
    - Patient refuses phone call.
    - Patient has no phone or no alternative contact number.
  - After initial roll out of six months, sites would be expected to represent numerator/denominator results for both measures publically on the WSHA web site.
  - Added inclusion: If the discharging physician and follow-up care provider are the same, discharge information being provided to the follow-up care provider is still required.
1. Endorsement of the Washington State collaborative model, re-evaluate in one year.

2. Endorsement of tools and techniques to reduce readmissions in Washington State, specifically the WSHA Care Transitions Toolkit.

3. Recommended measurement: Percent of inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition) for which there is:
   - Discharge information summary within three business days
   - Follow-up phone call within three business days
RECOMMENDATION

- Adopt Potentially Avoidable Hospital Readmissions Report and Recommendations
QUESTIONS OR COMMENTS?
Bree Collaborative Topic Selection

The State Agency Medical Director Group Perspective

Daniel Lessler, MD, MHA
Chief Medical Officer
Washington State Health Care Authority
Bree Mandate: Topic Selection

- Substantial variation in practice patterns or high utilization trends in WA, without producing better care outcomes for patients
- The Collaborative should strongly consider related efforts of organizations such as WHA, WSMA...
- ...AMDG can be thought of as such an organization
AMDG Topic Selection: Recommendations

• AMDG opiate prescribing guideline is being updated and expanded:
  – Revise maximum morphine-equivalent dosage
  – Identify if, when and for whom opiates are most appropriate in the treatment of acute, subacute and chronic pain
  – Identify effective alternative pharmacologic and non-pharmacologic interventions
  – Opioid prescribing for perioperative pain
  – When and how to discontinue chronic opioid therapy, including recognition of and community resources for addiction management
AMDG Topic Selection: Recommendations: #1

• Prescription opioid use for pain management c/w Bree criteria (high utilization; variation in practice; poor patient outcomes)

• The Bree Collaborative should review, endorse and promote dissemination of the revised/updated AMDG guideline (completion of the revised guideline anticipated in March 2015);

• Expands the current work of the Bree related to screening for substance disorders
AMDG Bree Topic Selection: Recommendation #2

• Prostate Cancer Screening
  – USPSTF recommends against PSA screening
  – “The benefits of PSA-based screening for prostate CA do not outweigh the harms”
  – “D” recommendation = discourage the use of this service

• Substantial variation in practice patterns or high utilization trends in WA, without producing better care outcomes for patients
AMDG Bree Topic Selection: Recommendation #3

• Support broader adoption of HTA coverage determinations, perhaps beginning with those decisions that are “non-covered” (e.g. hip resurfacing, or that relate to other Bree topics (e.g. cardiac nuclear imaging)

• Substantial variation in practice patterns or high utilization trends in WA, without producing better care outcomes for patients
AMDG: Other Topics Considered

• Oncology
  – Current Bree work relates to palliative care. At the same time, Dr. Scott Ramsey at FHCRC is identifying methods to evaluate cancer care (e.g. chemotherapy in the last 4 weeks of life) Is there a way to connect these two pieces of work?

• Genetic testing

• Biologics

• Endorse trusted sources to inform state-based policy (e.g. USPSTF)
Bree Collaborative Topic Selection

The State Agency Medical Director Group Perspective

Discussion
Review of Previous and Current Work

Ginny Weir
Bree Collaborative Program Director

July 17th, 2014
Looking Back at June 2013 Retreat

- Clarity around the Mission
  - Need elevator speech
  - Implementation partner with HCA and force for change in private market
  - Unique – neutral, state mandate, stakeholder representation

- Purpose
  - Align public and private sectors
  - Leverage through unbiased information
  - Identify variation leading to waste or patient risk
  - Define purchasing and payment standards
  - Catalyst for collection, analysis, and provision of quality data
  - Stakeholder agnostic
Look Back at June 2013 Retreat
Survey Results

On a Scale of 1 = Strongly Disagree and 5 = Strongly Agree, How Do You Respond?

<table>
<thead>
<tr>
<th>Responses to the Statement</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Rating Average</th>
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<tbody>
<tr>
<td>The purpose of the Bree is clear to me</td>
<td>13</td>
<td>5</td>
<td>0</td>
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<td>0</td>
<td>4.72</td>
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<td>I have a solid understanding of my role on the Bree</td>
<td>12</td>
<td>5</td>
<td>1</td>
<td>0</td>
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<td>4.61</td>
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<td>The Bree does work that no other organization or group of organizations can do</td>
<td>9</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>0</td>
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<td>The Foundation for Health Care Quality provides effective project management support to the Bree</td>
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<td>10</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>4.22</td>
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<tr>
<td>The topics the Bree is working on are the most critical to address unwarranted variation</td>
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<td>10</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>4.06</td>
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<tr>
<td>Bree members work together effectively as a group</td>
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<td>9</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4.06</td>
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<td>Bree work group meetings are productive</td>
<td>4</td>
<td>10</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4.00</td>
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<td>Bree Collaborative meetings are productive</td>
<td>4</td>
<td>10</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>3.94</td>
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<td>The Bree is an effective mechanism for improving quality health outcomes</td>
<td>4</td>
<td>10</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>3.94</td>
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### Look Back at June 2013 Retreat Survey Results Cont.

On a Scale of 1 = Strongly Disagree and 5 = Strongly Agree, How Do You Respond (cont’d)?

<table>
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<tr>
<th>Responses to the Statement</th>
<th>5</th>
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<th>3</th>
<th>2</th>
<th>1</th>
<th>Rating Average</th>
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<tbody>
<tr>
<td>The Bree has been successful in fulfilling its mission</td>
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<td>13</td>
<td>4</td>
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<td>The process the Bree uses for developing recommendations to the HCA is clear</td>
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<td>14</td>
<td>1</td>
<td>2</td>
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<td>3.78</td>
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<tr>
<td>The Bree is an effective mechanism for improving the cost effectiveness of care</td>
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<td>9</td>
<td>5</td>
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<td>The Bree is achieving results at an appropriate pace</td>
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<td>10</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3.72</td>
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<td>The process the Bree uses following submittal of recommendations to the HCA is clear</td>
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<td>11</td>
<td>1</td>
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<td>The Bree’s recommendations are very likely to be implemented by the HCA</td>
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<td>7</td>
<td>9</td>
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<td>A Bree member should represent the interests of the sector from which s/he is nominated</td>
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<td>9</td>
<td>2</td>
<td>2</td>
<td>3</td>
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<td>The Bree’s recommendations are very likely to be implemented by healthcare organizations throughout the state</td>
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<td>6</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>3.11</td>
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<td>A Bree member should represent the interests of the organization that nominated him/her</td>
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<td>4</td>
<td>3</td>
<td>3</td>
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</table>
1. Form expert workgroup
2. Identify evidence-based best practice approaches using data
3. Draft report recommends quality improvement strategies
4. Post report for public comment
5. Approval by the Bree Collaborative
Implementation

- WA HCA Director reviews and decides to apply to state-purchased health care programs
  - Medicaid, WA State Employee Health Care Plan, Labor and Industries, Corrections
- Intent for other public and private stakeholders to follow
## Our Timeline

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<th></th>
<th>2011</th>
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<th>2013</th>
<th>2014</th>
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<td><strong>Meetings</strong></td>
<td>ESHB 1311</td>
<td>Workgroup Meetings</td>
<td>Final</td>
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<td><strong>Obstetrics</strong></td>
<td>May Jun Jul Aug Sep Oct Nov Dec</td>
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<td><strong>Hospital Readmissions</strong></td>
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<td><strong>Accountable Payment Models</strong></td>
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<td><strong>Spine/Low Back Pain Implementation</strong></td>
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<td>May Jun Jul Aug Sep Oct Nov Dec</td>
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Areas of Focus and Goals

Elective Deliveries. Eliminate all elective deliveries before the 39th week (those deliveries for which there is no appropriate documentation of medical necessity).

Elective Inductions of Labor. Decrease elective inductions of labor between 39 and up to 41 weeks. Decreasing elective inductions will decrease the primary C-section rate.

Primary C-sections. Decrease unsupported variation among Washington hospitals in the primary C-section rate. Decreasing the unsupported variation of primary C-section rates is necessary in order to make a significant impact on outcome and cost.
Obstetrics
Adopted August 2012

• **Strong leadership and commitment to quality improvement**
  - Hospitals having an OB QI program in place, and measuring and providing data back to providers on their performance
• **Evidence-based or tested clinical guidelines and protocols**
  - Hospitals implementing Bree recommended clinical guidelines, Hard Stop scheduling policy
• **Transparency of selected OB procedures, by facility**
  - Examples: public reporting of Bree’s three focus areas
• **Patient education**
  - Hospitals disseminating March of Dimes materials, employers using March of Dimes tool-kit
• **Realignment of financial and non-financial incentives**
  - Payment reform/bundled payments, benefit design changes
Obstetrics

Where are we now: Reduce Elective Inductions of labor between 39 and 41 weeks

Singletons, 2012/2013, >=39 and <41 Weeks on Delivery

- 2012: no data
- 2013: no data

2012 N=11201
2013 N=13668
Obstetrics

Where are we now: Decrease unsupported variation among WA hospitals in the primary cesarean rate

Singletons, no history CS. 2012/2013

2012 N=12496
2013 N=15454

0% 5% 10% 15% 20% 25% 30%

2012: no data
2012: no data
2012: no data
Obstetrics

Where are we now: Admit Spontaneously Laboring Term Patients with no maternal/fetal compromise when Cervix on Admission =>4

Singletons, 2013, spontaneous labor, >=37 weeks on delivery

Cervix on Admission

- Cx on adm <=3
- Cx on adm >=4

2012 N=5910
- 41%
- 59%

2013 N=9984
- 39%
- 61%

Cesarean

- Cx on adm <=3
- Cx on adm >=4

17%
8%
Where are we now: Allow 1\textsuperscript{st} stage labor arrest cesarean to be performed only in the active phase (>=6 cm dilation)

Singletons, labor=yes, indication for cesarean=Failure to Progress, 2012/2013

2013 N=656
2012: % 1st Stage Labor Arrest Done in Active Phase (>=6cm)

46% 54%

2013 N=665
2013: % 1st Stage Labor Arrest Done in Active Phase (>=6cm)

43% 57%
Where are we now: Allow adequate time in the active phase (4-6 hrs) with use of appropriate clinical interventions before making a diagnosis of active phase arrest.

Singletons, labor=yes, indication for cesarean=Failure to Progress, cervix at cesarean NOT complete, Q1’14

First Stage Labor Arrest <2 hrs: 53%
First Stage Labor Arrest >= 4 hours: 26%
First Stage Labor Arrest >=2 and <4 hrs: 21%

Q1 2014 N=66
Where are we now: Allow sufficient time with appropriate clinical interventions in the 2nd stage before diagnosis of 2nd stage arrest or “failure to descend”

Singletons, labor=yes, indication for cesarean=Failure to Descend, cervix at cesarean=complete, 2012/2013

<table>
<thead>
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<th>Day of Labor (lotcd)</th>
<th>2012 N=453</th>
<th>2013 N=518</th>
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<td>22%</td>
<td>20%</td>
</tr>
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<td>59%</td>
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## Crosswalk: Bree and Safe Deliveries Roadmap

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<thead>
<tr>
<th>Topic</th>
<th>Bree</th>
<th>Safe Deliveries Roadmap Alignment with Bree</th>
</tr>
</thead>
</table>
| **Elective Deliveries Before the 39th Week of Gestational Age** | - Hospitals should implement a policy that limits scheduling deliveries before the 39th week and includes the following two components:  
- The indication must be on The Joint Commission or the Washington State list used in the current elective delivery between 37 and 39 weeks. Washington State Perinatal Collaborative/WSHA project; and  
- For clinical situations not on the two lists noted above, consultation must occur and agreement must be obtained that the clinical situation requires delivery. | YES |
| **Induction of Labor**                     | - Goal: Decrease elective inductions of labor between 39 and up to 41 weeks of gestation  
- Standards for Scheduling Elective Inductions between 39 and up to 41 weeks: Since no widely accepted standard for elective inductions at or over 39 weeks exists, the Bree Collaborative recommends hospitals adopt a protocol similar to that of Swedish Medical Center, Seattle and Magee-Women’s Hospital, Pittsburgh including a patient education component:  
- The cervix must be favorable (Bishop score of >=6) for an elective induction  
- Consent form specific to risks/benefits of induction compared with spontaneous labor signed by patient. | YES – Is more aggressive by using Bishop score of >=9 in nulliparous women and >=6 in multiparous women (no cervical ripening) |
| **Failed Induction of Labor**              | - Not addressed                                                      | Provides specific criteria                |
| **Primary Cesarean Delivery Rate**         | - Goal: Decrease the unsupported variation among Washington hospitals in the primary C-section rate | YES |
| **Spontaneous Labor/First Stage - Latent Phase 4-5cm Cervical dilation** | - Admit only those spontaneously women at term who present with no fetal or maternal compromise when the cervix is 4 centimeters or more dilated  
- Bree statement: “Allow first stage labor arrest cesarean (measuring fetal and maternal status but lack of progress of labor) to be performed only in the active phase (equal to or more than 6 cm dilation)” implies decision to perform C-section should not occur prior to 6cm cervical dilation (excluding concern for maternal/fetal status)  
- No Specific Bree recommendations for management of Latent Phase 4-5cm | YES – provides specific recommendations for management of Latent Phase 4-5cm |
| **First Stage Active Phase Arrest**        | - Allow first stage labor arrest cesarean (measuring fetal and maternal status but lack of progress of labor) to be performed only in the active phase (equal to or more than 6 centimeters dilation)  
- Allow adequate time in the active phase (4 to 6 hours) with use of appropriate clinical interventions before making a diagnosis of active phase arrest | YES |
| **Second Stage Arrest**                    | - Allow sufficient time with appropriate clinical interventions in the 2nd stage before diagnosis of 2nd stage arrest or “failure to descend”. | YES |
Obstetrics
Where are we now: Elective Delivery

The elective delivery data represents discharges from January 2013 through December 2013. The NTSV C-Section data below represents discharges from July 2012 through June 2013. Lower is better.

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>County</th>
<th>Beds</th>
<th>Teaching</th>
<th>Elective Delivery</th>
<th>NTSV C-Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kadlec Regional Medical Center</td>
<td>Benton</td>
<td>235</td>
<td>No</td>
<td>0.5%</td>
<td>21.8%</td>
</tr>
<tr>
<td>Overlake Medical Center</td>
<td>King</td>
<td>347</td>
<td>Yes</td>
<td>0.5%</td>
<td>32.6%</td>
</tr>
<tr>
<td>PeaceHealth St. Joseph Medical Center</td>
<td>Whatcom</td>
<td>253</td>
<td>No</td>
<td>0.6%</td>
<td>27.8%</td>
</tr>
<tr>
<td>Providence Holy Family Hospital</td>
<td>Spokane</td>
<td>197</td>
<td>No</td>
<td>0.8%</td>
<td>20.1%</td>
</tr>
<tr>
<td>Swedish/Edmonds</td>
<td>Snohomish</td>
<td>156</td>
<td>No</td>
<td>0.8%</td>
<td>28.0%</td>
</tr>
<tr>
<td>Providence Sacred Heart Medical Center &amp; Children's Hospital</td>
<td>Spokane</td>
<td>644</td>
<td>Yes</td>
<td>0.9%</td>
<td>21.6%</td>
</tr>
<tr>
<td>St. Francis Hospital</td>
<td>King</td>
<td>134</td>
<td>Yes</td>
<td>0.9%</td>
<td>19.9%</td>
</tr>
<tr>
<td>Sunnyside Community Hospital &amp; Clinics</td>
<td>Yakima</td>
<td>25</td>
<td>No</td>
<td>0.9%</td>
<td>27.6%</td>
</tr>
<tr>
<td>UW Medicine/Northwest Hospital &amp; Medical Center</td>
<td>King</td>
<td>213</td>
<td>Yes</td>
<td>0.0%</td>
<td>26.6%</td>
</tr>
<tr>
<td>Legacy Salmon Creek Medical Center</td>
<td>Clark</td>
<td>220</td>
<td>No</td>
<td>1.3%</td>
<td>24.0%</td>
</tr>
<tr>
<td>Providence St. Mary Medical Center</td>
<td>Walla Walla</td>
<td>87</td>
<td>No</td>
<td>1.3%</td>
<td>22.8%</td>
</tr>
<tr>
<td>EvergreenHealth</td>
<td>King</td>
<td>275</td>
<td>No</td>
<td>1.4%</td>
<td>26.9%</td>
</tr>
<tr>
<td>PeaceHealth Southwest Medical Center</td>
<td>Clark</td>
<td>450</td>
<td>Yes</td>
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<td>24.9%</td>
</tr>
<tr>
<td>Samaritan Healthcare</td>
<td>Grant</td>
<td>47</td>
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<tr>
<td>St. Joseph Medical Center</td>
<td>Bremerton</td>
<td>285</td>
<td>No</td>
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<td>26.3%</td>
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</tbody>
</table>

Source: http://wahospitalquality.org/pf.php
The elective delivery data represents discharges from January 2013 through December 2013. The NTSV C-Section data below represents discharges from July 2012 through June 2013. **Lower is better.**

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>County</th>
<th>Beds</th>
<th>Teaching</th>
<th>Elective Delivery</th>
<th>NTSV C-Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swedish/First Hill</td>
<td>King</td>
<td>461</td>
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<tr>
<td>Swedish/Issaquah</td>
<td>King</td>
<td>120</td>
<td>No</td>
<td>1.9%</td>
<td>25.5%</td>
</tr>
<tr>
<td>MultiCare Auburn Medical Center</td>
<td>King</td>
<td>162</td>
<td>No</td>
<td>2.0%</td>
<td>19.6%</td>
</tr>
<tr>
<td>Group Health Cooperative/Central Hospital</td>
<td>King</td>
<td>14</td>
<td>No</td>
<td>2.1%</td>
<td>23.5%</td>
</tr>
<tr>
<td>Providence Centralia Hospital</td>
<td>Lewis</td>
<td>128</td>
<td>No</td>
<td>2.1%</td>
<td>41.2%</td>
</tr>
<tr>
<td>Providence St. Peter Hospital</td>
<td>Thurston</td>
<td>343</td>
<td>Yes</td>
<td>2.2%</td>
<td>23.6%</td>
</tr>
<tr>
<td>Kittitas Valley Healthcare</td>
<td>Kittitas</td>
<td>25</td>
<td>No</td>
<td>2.6%</td>
<td>22.1%</td>
</tr>
<tr>
<td>Forks Community Hospital</td>
<td>Clallam</td>
<td>25</td>
<td>No</td>
<td>2.7%</td>
<td>20.0%</td>
</tr>
<tr>
<td>PeaceHealth St. John Medical Center</td>
<td>Cowlitz</td>
<td>186</td>
<td>No</td>
<td>2.8%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Capital Medical Center</td>
<td>Thurston</td>
<td>110</td>
<td>No</td>
<td>3.0%</td>
<td>23.4%</td>
</tr>
<tr>
<td>Deaconess Hospital/Rockwood Health System</td>
<td>Spokane</td>
<td>307</td>
<td>Yes</td>
<td>3.2%</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

Source: http://wahospitalquality.org/pf.php
Percutaneous coronary intervention (PCI) is “appropriate” when the “expected benefits, in terms of survival or health outcomes (symptoms, functional status, and/or quality of life) exceed the expected negative consequences of the procedure.” (Appropriate Use Criteria)

1. Appropriate use insufficient information report (2012 data) by hospital posted on COAP members-only section of the COAP website by 8/1/2012.
2. COAP provides feedback to hospitals and tools for reducing the amount of insufficient information in their data by 12/2012.
3. Updated appropriate use insufficient information report (based on 4th Q2012 data only), by hospital, given to the Collaborative and hospitals to review by 4/15/2013
Cardiology: Where are we now?


- University of WA Medical Center
- Kadlec Medical Center
- Swedish Cherry Hill Medical Center
- Providence Regional Medical Center Everett
- PeaceHealth St. Joseph Medical Center
- Providence St. Peter Medical Center
- Providence Sacred Heart Medical Center
- Northwest Hospital & Medical Center
- Deaconess Medical Center/Rockwood Health
- Central WA Hospital
- Overlake Hospital & Medical Center
- Harrison Medical Center
- PeaceHealth St. John Medical Center
- Valley Medical Center
- Virginia Mason Medical Center
- St Francis Medical Center
- Evergreen Medical Center
- Multicare Tacoma General Hospital
- St. Joseph Medical Center Tacoma
- Capital Medical Center
- Walla Walla General Hospital*
- Swedish Issaquah Medical Center*
- Swedish Edmonds Medical Center
- PeaceHealth Southwest Medical Center*
- Multicare Good Samaritan Hospital*
- Multicare Auburn Medical Center*
- Yakima Valley Memorial Hospital (N/A)
- Multicare Auburn Medical Center (N/A)
- Harborview Medical Center (N/A)

* <10 non-acute procedures in 2013
N/A = NO Non-acute PCI’s in 2013
Cardiology: Where are we now?
Appropriate Use Criteria: Insufficient Information for Determining Appropriateness in Non-Acute PCI – 2012-2013

Highline Medical Center*
Unnamed Hospital
Skagit Valley Hospital
Yakima Regional Medical & Heart Center
University of WA Medical Center
Kadlec Medical Center
Swedish Cherry Hill Medical Center
Providence Regional Medical Center Everett
PeaceHealth St. Joseph Medical Center
Providence St. Peter Medical Center
Providence Sacred Heart Medical Center
Northwest Hospital & Medical Center
Deaconess Medical Center/Rockwood Health
Central WA Hospital
Overlake Hospital & Medical Center
Harrison Medical Center
PeaceHealth St. John Medical Center
Valley Medical Center
Virginia Mason Medical Center
St Francis Medical Center
Evergreen Medical Center
Multicare Tacoma General Hospital
St. Joseph Medical Center Tacoma
Capital Medical Center
Walla Walla General Hospital*
Swedish Issaquah Medical Center*
Swedish Edmonds Medical Center
PeaceHealth Southwest Medical Center*
Multicare Good Samaritan Hospital*
Multicare Auburn Medical Center*
Yakima Valley Memorial Hospital (N/A)
St. Anthony Medical Center (N/A)
Harborview Medical Center (N/A)
Cardiology: Where are we now?


* <10 non-acute procedures in 2013
N/A = NO Non-acute PCI’s in 2013
...Strongly recommends participation in Spine SCOAP as a community standard, starting with hospitals performing spine surgery – with the following conditions:

• Results are unblinded
• Results are available by group
• Establish a clear and aggressive timeline
• Recognize that more information is needed about options for tying payment to participation
## Spine SCOAP

### Where are we now?

<table>
<thead>
<tr>
<th>Participating</th>
<th>Not Participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Capital Medical Center</td>
<td>• Deaconess Hospital</td>
</tr>
<tr>
<td>• Central Washington Hospital-Confl</td>
<td>• Harrison Medical Hospital- FHS</td>
</tr>
<tr>
<td>• Evergreen Hospital Medical Center</td>
<td>• Highline Medical Center- FHS</td>
</tr>
<tr>
<td>• Harborview Medical Center- UW</td>
<td>• Island Hospital</td>
</tr>
<tr>
<td>• MultiCare Good Samaritan Hospital-MHS</td>
<td>• Kadlec Regional Medical Center-Prov (as of June 2014)</td>
</tr>
<tr>
<td>• Northwest Hospital- UW</td>
<td>• Legacy Salmon Creek Medical Center-Leg</td>
</tr>
<tr>
<td>• PeaceHealth Saint Joseph Hospital-PH</td>
<td>• Overlake Hospital Medical Center</td>
</tr>
<tr>
<td>• PeaceHealth Southwest Medical Center-PH</td>
<td>• Providence Holy Family Hospital-Prov</td>
</tr>
<tr>
<td>• Providence Regional Medical Center Everett-Prov</td>
<td>• Providence Saint Mary Hospital -Prov</td>
</tr>
<tr>
<td>• Providence Sacred Heart Medical Center-Prov</td>
<td>• Providence Saint Peter Hospital-Prov</td>
</tr>
<tr>
<td>• Saint Francis Hospital- FHS</td>
<td>• Swedish Medical Center – Edmonds-SP</td>
</tr>
<tr>
<td>• Saint Joseph Medical Center- FHS</td>
<td>• Valley Hospital - Spokane</td>
</tr>
<tr>
<td>• Skagit Valley Hospital</td>
<td>• Virginia Mason Medical Center</td>
</tr>
<tr>
<td>• Swedish Medical Center - First Hill/Ballard-SP</td>
<td>• Yakima Regional Medical and Cardiac Center</td>
</tr>
<tr>
<td>• Swedish Medical Center - Cherry Hill-SP</td>
<td>• Yakima Valley Memorial Hospital</td>
</tr>
<tr>
<td>• Swedish Medical Center – Issaquah-SP</td>
<td></td>
</tr>
<tr>
<td>• Tacoma General Allenmore Hospital-MHS</td>
<td></td>
</tr>
<tr>
<td>• University of Washington Medical Center- UW</td>
<td></td>
</tr>
<tr>
<td>• Valley Medical Center- UW</td>
<td></td>
</tr>
</tbody>
</table>
Spine SCOAP
Where are we now?

• Results are unblinded
  • Available for members
  • Hospitals have 4-6 weeks to review their own data
  • Transparency metrics - Smoking among Fusion Patients, LOS among single-level fusions, X-Ray verification of level
• Results are available by group
  • Depends on how hospitals internally review data
• Establish a clear and aggressive timeline
  • Data to be available for public reporting on August 1st, 2014
Total Knee/Total Hip Replacement Bundle and Warranty
Adopted November 2013

Aligns payment for safety, eliminating payment for hospital readmissions for avoidable complications of surgery

- Warranty
  - Imposes financial accountability on providers not explicit quality standards
  - Significant complications attributable to procedures
  - Identifiable in administrative claims data
  - Fair to hospitals and physicians

- Surgical Bundle
  - Designed to provide financial reward for high quality care
  - Defines the value-added components that should be included in a bundled payment for TKR and THR surgery, including both clinical components (disability due to osteoarthritis despite conservative therapy, fitness for surgery, repair of the osteoarthritic joint, and post-operative care and return to function) and quality standards.
Increase appropriate evaluation and management of patients with new onset and persistent acute LBP and/or nonspecific LBP not associated with major trauma (no red flags) in primary care

- Increase adherence to evidence-based guidelines
- Increase provider awareness of key messages that emphasize physical activity, return to work, patient activation, etc.
- Reduce use of non-value-added modalities in the diagnosis and treatment of LBP (e.g., inappropriate use of MRIs)

Increase early identification and management of patients that present with LBP not associated with major trauma (no red flags) but have psychosocial factors (yellow flags) that place them at a high risk for developing chronic LBP

- Increase use of STarT Back Tool, FRQ, or a similar screening instrument to triage acute LBP patients to appropriate care providers
- Restore patient function more quickly

Increase awareness of LBP management among individual patients and the general public

- Increase the proportion of the population that agrees with key LBP messages (e.g., LBP is common, LBP symptoms often improve without treatment, there is no magic bullet, stay active, etc.)
Current Work
Bree Implementation Team

- Chair: Dan Lessler, MD, Health Care Authority
- Working to develop implementation pathways
- First meeting: October 2013
BIT General Strategy

After adoption by the Health Care Authority:

- Presentation from topic expert
- Development of change strategy
- Implementation of change strategy

Formation of sub-group, if needed
Current Work
Potentially Avoidable Hospital Readmissions

- Chair: Rick Goss, MD, Harborview Medical Center
- Completed Report and Recommendations
- Two meetings: April and June 2014
Current Work
Accountable Payment Models: Lumbar Fusion

- Chair: Bob Mecklenburg, MD, Virginia Mason Medical Center
- Lumbar Fusion Warranty and Surgical Bundle ready for posting for public comment
- First meeting: January 2014
- Carried forward same model as for development of TKR/THR bundle and warranty
Current Work
End of Life/Advance Directives

- Chair: John Robinson, MD, First Choice Health
- Focusing on overcoming barriers to advance directive use:
  - Patients do not complete advance directives or advance care planning
  - Not accurate, too vague, lack important elements such as a value statement, or are too limited in directing decisions
  - Not available when and where they are needed (e.g., emergency room)
  - Not used by health care providers when they are available and do exist

- First meeting: January 2014
- Expected report: Fall 2014
Current Work
Addiction/Dependence Treatment

- Chair: Tom Fritz, CEO, Inland Northwest Health Services
- First meeting: April 2014
- Expected report: Winter 2014
Our Purpose

• “...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.”

• “…identify health care services for which there are substantial variation in practice patterns or high utilization trends in Washington state, without producing better care outcomes for patients, that are indicators of poor quality and potential waste in the health care system. On an annual basis, the collaborative shall identify up to three health care services it will address.”
Future Topics

Ginny Weir
Bree Collaborative Program Director

July 17th, 2014
### Commonwealth Fund Scorecard on State Health System Performance, 2014

<table>
<thead>
<tr>
<th>RANKING SUMMARY</th>
<th>2014 Scorecard</th>
<th>2009 Revised^a</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OVERALL</strong></td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Access &amp; Affordability</td>
<td>25</td>
<td>24</td>
</tr>
<tr>
<td>Prevention &amp; Treatment</td>
<td>35</td>
<td>38</td>
</tr>
<tr>
<td>Avoidable Hospital Use &amp; Cost</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Equity^b</td>
<td>20</td>
<td>31</td>
</tr>
<tr>
<td>Healthy Lives</td>
<td>7</td>
<td>11</td>
</tr>
</tbody>
</table>
Topic Selection Criteria

- Substantial variation in practice patterns
  - High utilization/cost growth trends in WA State
  - Source of waste and inefficiency in care delivery

- Patient safety issues or poor health outcomes

- Significant direct and indirect costs

- Proven means or strategies exist to address topic
  - Implement-ability

- No other programs addressing or the Bree is uniquely positioned State input
Topic Selection Criteria
Secondary

- Data or evidence for waste, variation, high utilization, excess costs
- Choosing Wisely
- Shared-decision making
- Health Technology Assessment Topic
- Equity Issue
January 28th, 2014

Ginny Weir, MPH
Program Director, The Bree Collaborative
705 2nd Ave, Suite #703
Seattle, WA 87104

Dear Ms. Weir and the Members of the Bree Collaborative,

We are writing to you to respectfully request that you consider examining the various issues, testing and treatment options associated with breast density. Please see the information below regarding the complexity and necessity of finding a medically necessary and appropriate solution to address appropriate treatment paths, if any when a dense breast is identified:

Background information:

- Breasts are made up of a mixture of fibrous and glandular tissue and fatty tissue. Breasts are considered dense if you have a lot of fibrous or glandular tissue but not much fat. Density may decrease with age, but there is little, if any, change in most women(1).

- Having dense breast tissue may increase the chances of missing early signs by making it more difficult for doctors to spot cancer on mammograms. Dense tissue appears white on a mammogram. Because both breast cancer and mammary glands also appear white, a mammogram can be
Antibiotic-Resistant Bacteria

Dear Representative/Senator,

As medical doctors and health professionals, we are writing to ask for your help in addressing the serious and growing problem of antibiotic-resistant bacteria (“superbugs”) that increasingly threaten public health. We specifically ask for your help to ensure that the Food and Drug Administration (FDA) acts to reduce the misuse of antibiotics in animal agriculture, and we ask you to support legislation enabling FDA to better track and monitor this issue. We need your leadership on this vital issue.

It is hard to think of a problem that could more directly affect your constituents than a serious illness that does not respond to treatment. Antibiotic resistance is compromising the effectiveness of essential human medicines, leading to longer illnesses, more hospitalizations, and deaths when treatments fail. Incidence data published by the Centers for Disease Control and Prevention (CDC) for 2005 suggest that just one kind of antibiotic resistant pathogen, Methicillin-resistant Staphylococcus aureus (MRSA), killed nearly 19,000 Americans, more than HIV/AIDS in that year. A CDC-funded study estimates that antibiotic resistance in the United States results in up to $26 billion a year in excess healthcare costs and up to $35 billion a year in total societal costs.

The overuse of antibiotics in animal agriculture is a critical contributor to the problem of antibiotic resistance. Eighty percent of all antibiotics, and seventy percent of all medically important antibiotics, sold in the United States are for use in livestock. The vast majority are not used to treat any diseases, but are fed regularly to animals to speed growth and compensate for unsanitary and crowded conditions. According to the Centers for Disease Control and Prevention, the scientific literature “establish[es] a clear link between antibiotic use in animals and antibiotic resistance in humans” and “there is a compelling body of evidence to demonstrate this link.” Major medical and public health organizations, such as the American Medical Association, the American Academy of Pediatrics, the Infectious Diseases Society of America, and the American Public Health Association, have called for stronger action to protect life-saving antibiotics in the face of the clear scientific evidence linking the misuse and overuse of antibiotics in food animals and the spread of antibiotic
Other Ideas

- Teaching Nutrition and Physical Activity in Medical School: Training Doctors for Prevention-Oriented Care

- Eliminating/reducing avoidable ED visits
  - Particularly for headache, back pain, UTI, sore throat, URI, bronchitis, ear/eye infection
  - Expensive utilization without better outcomes (i.e., more expensive location for primary care)

- Mental health
- Dental health
- Perioperative surgical home
Our Purpose

- “...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.”

- “...identify health care services for which there are substantial variation in practice patterns or high utilization trends in Washington state, without producing better care outcomes for patients, that are indicators of poor quality and potential waste in the health care system. On an annual basis, the collaborative shall identify up to three health care services it will address.”
MEMBER ROLES AND RESPONSIBILITIES:

FEEDBACK FROM THE BREE IMPLEMENTATION TEAM (BIT)

Dan Lessler, MD
Chief Medical Officer, WA Health Care Authority
Chair, Bree Implementation Team
The purpose of the BIT is to design and implement strategies to successfully *encourage* stakeholders to implement the recommendations developed and approved by the Bree Collaboration.
GENERAL STRATEGY

After adoption by the Health Care Authority:

- Presentation from topic expert
- Development of change strategy
- Implementation of change strategy

Formation of subgroup, if needed
Bi-directional communication/education
Recommend strategies
Champion
<table>
<thead>
<tr>
<th>Responses to the Statement</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Rating Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Bree has been successful in fulfilling its mission</td>
<td>1</td>
<td>13</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>3.83</td>
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<tr>
<td>The process the Bree uses for developing recommendations to the HCA is clear</td>
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<td>14</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3.78</td>
</tr>
<tr>
<td>The Bree is an effective mechanism for improving the cost effectiveness of care</td>
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<td>9</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>3.78</td>
</tr>
<tr>
<td>The Bree is achieving results at an appropriate pace</td>
<td>3</td>
<td>10</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3.72</td>
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<tr>
<td>The process the Bree uses following submittal of recommendations to the HCA is clear</td>
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<td>11</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>3.44</td>
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<td>The Bree’s recommendations are very likely to be implemented by the HCA</td>
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<td>7</td>
<td>9</td>
<td>1</td>
<td>0</td>
<td>3.44</td>
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<tr>
<td>A Bree member should represent the interests of the sector from which s/he is nominated</td>
<td>2</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3.27</td>
</tr>
<tr>
<td>The Bree’s recommendations are very likely to be implemented by healthcare organizations throughout the state</td>
<td>1</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>3.11</td>
</tr>
<tr>
<td>A Bree member should represent the interests of the organization that nominated him/her</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>2.71</td>
</tr>
</tbody>
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