Chair Report, Approval of July 17th Meeting Minutes, Bylaws
Open Public Meetings Act Training
Accountable Payment Models (APM) Workgroup
  • Vote to Adopt
End of Life Workgroup Update
  • Vote to put out for public comment
Bree Implementation Team Update
\textbf{BREAK}
Addiction/Dependence Treatment Workgroup Update
Presentation of Proposed New Topics
  • Choose three new topics
Next Steps and Close
Welcome New Members

• **John Espinola** MD, MPH, Vice President, Quality and Medical Management and Provider Engagement, Premera Blue Cross
  • One of two representatives of health carriers or third party administrators

• **Kimberly Moore** MD, Associate Chief Medical Officer, Franciscan Health System
  • One of three representatives of hospital systems, at least one of whom is responsible for quality
Conflict of Interest

Permanent and ad hoc members of the collaborative or any of its committees may not have personal financial conflicts of interest that could substantially influence or bias their participation. If a collaborative or committee member has a personal financial conflict of interest with respect to a particular health care service being addressed by the collaborative, he or she shall disclose such an interest. The collaborative must determine whether the member should be recused from any deliberations or decisions related to that service.
A relationship is considered as

1. Receipt or potential receipt of anything of monetary value, including but not limited to, salary or other payments for services such as consulting fees or honoraria in excess of $10,000.

2. Equity interests such as stocks, stock options or other ownership interests in excess of $10,000 or 5% ownership, excluding mutual funds and blinded trusts.

3. Status of position as an officer, board member, trustee, owner or employee of a company or organization representing a company, association or interest group.

4. Loan or debt interest; or intellectual property rights such as patents, copyrights and royalties from such rights.

5. Manufacturer or industry support of research in which you are participating.

6. Any other relationship that could reasonably be considered a financial, intellectual, or professional conflict of interest.

7. Representation: if representing a person or organization, include the organization’s name, purpose, and funding sources (e.g., member dues, governmental/taxes, commercial products or services, grants from industry or government).

8. Travel: if an organization or company has financially paid your travel accommodations (e.g., airfare, hotel, meals, and private vehicle mileage).
# July 17th Minutes

## Dr. Robert Bree Collaborative Meeting

**Thursday, July 17th, 2014**

**12:30-5:00**

**Providence Health and Services**

1801 Lind Ave SW | Renton, WA 98057

### Members Present

<table>
<thead>
<tr>
<th>Susie Dade, Washington Health Alliance</th>
<th>Carl Olden, MD, Pacific Crest Family Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tom Fritz, Inland Northwest Health Services</td>
<td>Mary Kay O’Neill, MD, Regence Blue Shield</td>
</tr>
<tr>
<td>Rick Goss, MD, Harborview Medical Center</td>
<td>John Robinson, MD, First Choice Health</td>
</tr>
<tr>
<td>Steve Hill, Bree Collaborative Chair</td>
<td>Terry Rogers, MD, Foundation for Health Care Quality (FHCO), Vice Chair</td>
</tr>
<tr>
<td>Leah Hole-Marshall (for Gary Franklin, MD), WA State Labor and Industries</td>
<td>Jeanne Rupert, DO, PhD, Skagit Valley Hospital</td>
</tr>
<tr>
<td>Dan Lessler, MD (for MaryAnne Lindeblad, MD) Health Care Authority</td>
<td>Kerry Schaefer, King County</td>
</tr>
<tr>
<td>Rick Ludwig (for Joe Gifford, MD), Providence Health &amp; Services</td>
<td>Bruce Smith, MD, Group Health Cooperative</td>
</tr>
<tr>
<td>Greg Marchand, the Boeing Company</td>
<td>Lani Spencer, RN, Amerigroup</td>
</tr>
<tr>
<td>Robert Mecklenburg, MD, Virginia Mason</td>
<td>Carol Wagner, RN, MHA, Washington State Hospital Association</td>
</tr>
<tr>
<td></td>
<td>Shawn West, MD, Edmonds Family Medicine</td>
</tr>
</tbody>
</table>

### Members Absent

<table>
<thead>
<tr>
<th>Rori Chauhan, MD, Premera Blue Cross</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stuart Freed, MD, Wenatchee Valley Medical Center</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Christopher Kodama, MD, MultiCare Health System</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Jay Tihinen, Costco</td>
</tr>
</tbody>
</table>

### Staff/Guests

<table>
<thead>
<tr>
<th>Jackie Barry, Physical Therapy Association of Washington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bob Perna, Washington State Medical Association</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Mary Cleston</td>
</tr>
</tbody>
</table>
2.4. Terms
2.4.1. Collaborative members are initially appointed for a 3, 4 or 5-year term.
2.4.2. In the second year of the Collaborative, fall 2012, member term end dates will be
drawn by lot so that approximately a third of the members’ terms will end in the fall
2.4.3. Newly appointed members will be assigned term limits drawn by lot to expire in
the fall of 3, 4, or 5 years from the year of their appointment.
2.4.4. At the end of their term, members can be subject to re-nomination and
appointment by the Governor for a 3-year term.

2.5. Change in Collaborative membership
2.5.1. If a member’s organizational affiliation changes, he or she shall resign from the
Collaborative.
2.5.2. The organization that was responsible for the original nomination has authority to
nominate replacements for the departing members.
2.5.3. Nominated replacements shall be considered and appointed by the Governor.
3.3. Final Products

3.3.1. For each topic selected, the Collaborative [through the clinical committees and advisory and work groups] will create a final product such as a letter or report with its recommendations or strategies.

3.3.2. All recommendations and final products of clinical committees and advisory and work groups must be approved by the Collaborative by majority vote.

3.3.3. Draft products will be posted on the Bree Collaborative website or a suitable alternative if the Bree Collaborative website is unavailable at least one week prior to consideration by the Collaborative. This posting will be announced on the Bree Collaborative listserv and individuals will be instructed to direct feedback to the Program Director at least 48 hours in advance of the next Collaborative meeting. Contact information for the Program Director will be included on the website and in the listserv email announcement.
Open Government Training
Public Meetings

Dr. Robert Bree Collaborative Meeting
September 19, 2014

Presented by
Melissa Burke-Cain, Senior Counsel
Office of the Attorney General of Washington
Washington’s Open Public Meetings Act (OPMA)

- Passed in 1971; RCW 42.30; “sunshine law.”
- Public is Sovereign; Government is accountable.
- Their actions and deliberations conducted openly;
- Allows the public to view the “decision-making process.”
OPMA Applies To:

- **Multi-member** public state and local agencies, such as boards and commissions created by statute.
- Bree Collaborative is created by RCW 70.250.050.
- Municipal corporations or political subdivisions of Washington—Local government;
- Sub agencies of a public agency which is created by or pursuant to statute or ordinance.
OPMA Does **Not** Apply To:

**Entities—**
- Courts;
- Legislature;
- Agencies governed by a single individual;
- Private organizations.

**Activities—**
- Licensing/permitting;
- Quasi-judicial matters;
- Matters governed by the Washington Administrative Procedure Act, RCW 34.05;
- Collective bargaining.
What is a Governing Body?

• The *multimember board* or other policy or rule-making body

OR

• *Any committee* of such public agency when:
  – the committee acts on behalf of the governing body,
  – conducts hearings, or
  – takes testimony or public comment

~ RCW 42.30.020
Action

• “Action” means the transaction of the official business of the public agency and includes but is not limited to:
  • Public testimony
  • All deliberations
  • Discussions
  • Considerations
  • Reviews
  • Evaluations
  • Final actions

The requirements of the OPMA are triggered whether or not “final” action is taken.
Final Action

- “Final action” is a collective positive or negative decision, or an actual vote, by a majority of the governing body, or by the “committee thereof”.
- Must be taken in public, even if deliberations were in closed session.
- Secret ballots are not allowed.
Travel and Gathering

• A majority of the members of a governing body may travel together or gather for purposes other than a regular meeting or a special meeting, so long as no action is taken.

• Discussion or consideration of official business would be action, triggering the requirements of the OPMA.
“Regular” Meetings

• “Regular meetings” are recurring meetings held in accordance with a periodic schedule by ordinance, resolution, bylaws or other rule.

• A state public agency must:
  • File a schedule of regular meetings each year including time and place. (Code Reviser)
  • Publish changes to regular meeting schedule at least 20 days prior to new date. (State Register)
“Regular” Meetings (Website Posting)

• Effective June 12, 2014, new agenda notice requirements for regular meetings.
• OPMA now requires the regular meeting agenda be posted online 24 hours in advance of the published start time of the meeting.

But:
• Exempts agencies without a website or fewer than 10 full-time employees.
• Allows changes to agenda
• Legal actions taken are still valid without posting.
• Does not satisfy public notice requirements in other laws.
• Does not provide a basis to award attorneys fees or seek court order under OPMA.
“Special” Meetings

• A “special meeting” is a meeting that is not a regular meeting (not a regularly scheduled meeting).
• Called by presiding officer or majority of the members
• **Notice - timing:** 24 hours before the special meeting, **written** notice must be given to:
  
  • Each **member** of the governing body;
  • Each **local newspaper of general circulation, radio, and TV station** which has a notice request on file;
  • Posted on the **agency’s website** --- with certain exceptions.
  • **Displayed at the main entrance** of the Agency’s headquarters and the meeting site (if different location).
“Special” Meetings

- **Notice - contents**: The special meeting notice must specify:
  - Time and Place;
  - Business to be transacted (agenda);
  - Final disposition shall not be taken on any other matter at such meeting.
Public Attendance and Participation

• No condition precedent to attend — such as a sign in, provide other information, or complete a questionnaire.
• Reasonable rules of conduct can be set
• Cameras and tape recorders are permitted unless disruptive.
• No “public comment” period required by OPMA; but “public comment” is a best practice and may be required by other laws.
Interruptions and Disruption

- The OPMA details procedure for dealing with meeting interruptions.
- If orderly conduct of the meeting is unfeasible, and order cannot be restored by removal of the disruptive persons.
- Meeting room can be cleared and meeting can continue, or meeting can be moved to another location.
- Final action limited to matters on the agenda.
Executive Session

• Part of a regular or special meeting that is closed to the public
• Limited to specific purposes set out in the OPMA
• Executive session purpose, authority, and the time it will end must be announced by the presiding officer before it begins; time may be extended by further announcement
Executive Sessions
Specified purposes set out in OPMA. Examples:

• National security

• Publicly bid contracts.
  • Review negotiations on performance.
  • Public knowledge would like increase costs.

• Evaluate qualifications of applicant for public employment.

• Meet with legal counsel regarding enforcement actions, litigation or potential litigation.
Court Imposed Penalties for OPMA Violations

- A court can impose a $100 civil penalty against each member (personal liability).

- Court will award costs and attorney fees to a successful party seeking the remedy.

- Action taken at meeting can be declared null and void.
Summary—

- Multi-member commissions generally do business in public view. OPMA and other laws may govern.
- OPMA defines “Action” broadly.
- “Final Action” *always* taken in public; no secret ballots.
- Avoid taking “action” during travel and breaks; don’t create a “virtual” meeting.
- Specific notice is required for “Regular” and “Special” Meetings.
- Public is allowed to attend with no preconditions; OPMA does not *require* public comment.
- Board can impose rules of conduct; OPMA has processes for disruptions.
- Executive sessions occur only in specific, limited situations.
- Personal liability can be a consequence if OPMA is violated.
Lumbar Fusion Bundle and Warranty Development Timeline

- January 19th – Accountable Payment Models workgroup charter approved by the Bree Collaborative
- January to August – Monthly Meetings
- March 19th, May 21st – Presentations on the workgroup’s progress to the Bree Collaborative
- July 17th – Bundle and Warranty presented to the Bree Collaborative and approved for public comment
- July 28th to August 19th – Public comment period
  - Publicized through multiple organizations – WSHA, WSMA, DOH, HCA, the Alliance, etc
- August 25th – Workgroup meeting to address public comments and make changes to the documents
- September 17th – Presentation to the Bree Collaborative for adoption
LUMBAR FUSION BUNDLE AND WARRANTY
REVIEW OF PUBLIC COMMENTS ON FINAL DRAFT REPORT

ROBERT BREE COLLABORATIVE
WARRANTY AND BUNDLED PAYMENT MODELS
SEPTEMBER 17, 2014
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. Marissa Brooks, SEIU Healthcare NW Benefits

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

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

- Consultants
  1. Andrew Cole, MD, Swedish Health Services
  2. Farrokh Farrokhi, MD, Virginia Mason Medical Center
  3. Andrew Friedman, MD, Virginia Mason Medical Center
  4. Mary Kay O’Neill, MD, Regence
  5. Peter Rigby, Northwest Hospital
  6. Fangyi Zhang, MD, University of Washington
More than 60 respondents submitted a total of over 200 comments
Comments by providers, employers, health plans, patients, and patient advocates
Responses from the American Association of Neurologic Surgeons and the Congress of Neurological Surgeons
Direct conversation with officers of Washington State and national neurosurgical specialty societies and with the Washington State Hospital Association
Comments reviewed in detail by work group on August 25th
REVIEW OF PUBLIC COMMENTS
SIX SUBSTANTIVE ISSUES

1. Cycle 1: limits to interpretation of imaging (I/B/3)
2. Cycle 1: the spine surgeon as a member of the collaborative team supervising delivery of non-surgical care (I/C)
3. Cycle 1: inclusion of acupuncture in non-surgical care (I/C/3)
4. Cycle 1: documentation of persistent disability before consideration of surgery (I/D/1)
5. Cycle 2: requirement of 20 cases per year for surgeon (III/A/1)
6. Cycle 2: alternative of national registries to Spine SCOAP (III/C/1)
Workgroup agreed that imaging standards are not absolute.

Draft (I/B/3 – page 4) changed to: “a departure from these (imaging) guidelines requires discussion and resolution by the collaborative team...”
Workgroup agreed that acupuncture is supported by evidence as a component of non-surgical care (citations 28 and 29 on evidence table).

Draft (I/C/3 – page 5) changed to: “...other evidence-based non-surgical therapies may be used at the discretion of the collaborative care team.”
Workgroup agreed that bundle should explicitly include spine surgeon is a member the collaborative team.

Draft (I/C – page 4) changed to: “...the care team should include...an appropriate spine surgeon... to ensure delivery of comprehensive non-surgical care...”
Workgroup agreed that definition should be more explicit.

Draft (I/D/1 – page 5) changed to: “At least two of the following should be considered in defining persistent disability:

a. Greater than 20% disability as defined by the Oswestry Disability Index
b. Persistent disability according to PROMIS indicators
c. Persistent disability on baseline physical function by physical therapist using the Therapeutic Associates Outcome Score, defined as equal to or greater than 20% disability.”
Workgroup agreed that outcome data is an option for satisfying the requirement for surgeons with less than 20 cases per year.

Draft (III/A/1 – page 7) changed to: “If the surgeon performs less than twenty lumbar fusion surgeries in the previous 12 months, an alternative is presenting the results of the quality indicators as specified in this bundle.”
Workgroup agreed that registries are an essential element of improving quality. Registries are also costly. Spine SCOAP is a local community standard. Other national registries in which providers are participating may also meet the Spine SCOAP standard.

Draft (III/C/1 – page 8) changed to: “Hospitals should participate in the Spine SCOAP registry or an equivalent national registry that meets or exceeds Spine SCOAP standards with results available to purchasers.”
1. Medicaid should fund the elements of the bundle. (Page 2)
2. Smoking avoidance for a minimum of four weeks. (Page 5)
3. Facility codes for lumbar fusion added to warranty.
Use sign-up sheet
RECOMMENDATION

- Adopt Lumbar Fusion Surgical Bundle and Warranty
End-of-Life Care Workgroup Update

John W. Robinson, MD
EOL Workgroup chair,
Bree Collaborative member,
CMO First Choice Health

September 17th, 2014
The Bree Collaborative’s End-of-Life Care goal is that all Washingtonians are informed about their end-of-life options, communicate their preferences in actionable terms, and receive end-of-life care that is aligned with their and their family members’ goals and values.
# Workgroup Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Robinson, MD (Chair)</td>
<td>Chief Medical Officer</td>
<td>First Choice Health</td>
</tr>
<tr>
<td>Bruce Smith, MD (Vice Chair)</td>
<td>Associate Medical Director, Strategy Deployment</td>
<td>Group Health Physicians</td>
</tr>
<tr>
<td>Anna Ahrens</td>
<td>Director of Patient and Family Support Services</td>
<td>MultiCare Health System</td>
</tr>
<tr>
<td>J. Randall Curtis, MD</td>
<td>Professor of Medicine</td>
<td>UW Palliative Care Center of Excellence</td>
</tr>
<tr>
<td>Trudy James</td>
<td>Chaplain</td>
<td>Heartwork</td>
</tr>
<tr>
<td>Bree Johnston, MD</td>
<td>Medical Director, Palliative Care</td>
<td>PeaceHealth</td>
</tr>
<tr>
<td>Abbi Kaplan</td>
<td>Principal</td>
<td>Abbi Kaplan Company</td>
</tr>
<tr>
<td>Timothy Melhorn, MD</td>
<td>Internist</td>
<td>Yakima Valley Memorial Hospital (YVMH) and the Memorial Foundation</td>
</tr>
<tr>
<td>Joanne Roberts, MD</td>
<td>Chief Medical Officer, NMR Administration</td>
<td>Providence Everett Regional Medical Center</td>
</tr>
<tr>
<td>Richard Stuart, DSW</td>
<td>Clinical Professor Emeritus, Psychiatry</td>
<td>University of Washington</td>
</tr>
</tbody>
</table>

**Observers**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanya Carroccio</td>
<td>Director, Quality &amp; Performance Improvement</td>
<td>Washington State Hospital Association</td>
</tr>
<tr>
<td>Jessica Martinson</td>
<td>Director, Clinical Education and Professional Development</td>
<td>Washington State Medical Association</td>
</tr>
</tbody>
</table>
End-of-Life Care Goals

- Health care provider reimbursement for advance care planning
- Provider education about conducting advance care planning with patients and families
- Community engagement in advance care planning
- Patient and family education and empowerment to engage in advance care planning
- Writing wishes down as a result of advance care planning
- Increase the availability of advance directives and POLST during time of crisis (e.g., registry)
- Implementation of protocols to increase the likelihood that patient’s wishes are followed at the time of death
Focus Areas

1. Increase awareness of advance care planning, advance directives, and POLST in Washington State

2. Increase the number of patients who participate in advance care planning in the clinical and community settings

3. Increase the number of patients who record their wishes and goals for end-of-life care using documents that: accurately represent their values; are easily understandable by patients, family members, and health care providers; and can be acted upon in the health care setting

4. Increase the accessibility of completed advance directives and POLST for health systems and providers

5. Increase the likelihood that a patient’s end-of-life care choices are honored
## Advance Directives VS POLST

<table>
<thead>
<tr>
<th></th>
<th>Advance Directive</th>
<th>Physician Orders for Life-Sustaining Treatment (POLST)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appropriate Population</strong></td>
<td>Durable Power of Attorney for Health Care</td>
<td>All adults</td>
</tr>
<tr>
<td><strong>Timeframe</strong></td>
<td>Future care</td>
<td>Future care</td>
</tr>
<tr>
<td><strong>Where Completed</strong></td>
<td>Any setting</td>
<td>Any setting</td>
</tr>
<tr>
<td><strong>Product</strong></td>
<td>Legal designation of a health care decision-making surrogate that is</td>
<td>Description of an individual's health care wishes for</td>
</tr>
<tr>
<td></td>
<td>part of an advance directive in alignment with Washington State law RCW 11.94.010</td>
<td>the end of life for a time when that individual is</td>
</tr>
<tr>
<td></td>
<td></td>
<td>unable to communicate those wishes that is part of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>an advance directive in alignment with Washington</td>
</tr>
<tr>
<td></td>
<td></td>
<td>State law RCW 70.122.030</td>
</tr>
<tr>
<td><strong>Surrogate Role</strong></td>
<td>Surrogate cannot complete</td>
<td>Surrogate cannot complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Responsible for Portability</strong></td>
<td>Currently patient or family</td>
<td>Currently patient or family</td>
</tr>
<tr>
<td><strong>Responsible for Review</strong></td>
<td>Patient or family</td>
<td>Patient or family</td>
</tr>
</tbody>
</table>
1. Increase awareness of advance care planning, advance directives, and POLST in Washington State

- Promote community-wide discussions about how to have conversations regarding personal goals of care and the type of care desired at the end of life with family members and health care providers
- Promote the importance of having an advance directive that includes a living will (also known as a health care directive), a durable power of attorney for health care, and a personal statement about health care goals and values
- Increase awareness in the difference between POLST and an advance directive
2. Increase the number of patients who participate in advance care planning in the clinical and community settings

- Encourage the use of evidence-based advance care planning tools and programs
- Encourage patients and health care providers to involve family members in advance care planning and designate a legal durable power of attorney for health care
- Encourage appropriate timing of advance care planning conversations
- Revise reimbursement policy to pay for HCPCS Code S0257, counseling and discussion regarding advance directives or end-of-life care planning and decisions, with patients and their surrogate decision makers
(Cont’d) 2. Increase the number of patients who participate in advance care planning in the clinical and community settings

- Educate health care professionals on how to engage patients and their families in advance care planning and how to refer to appropriate community-based advance care planning resources
- Promote awareness of the value of hospice and enhance opportunities for hospice referrals
- Train qualified advance care planning facilitators
3. Increase the number of patients who record their wishes and goals for end-of-life care using documents that: accurately represent their values; are easily understandable by patients, family members, and health care providers; and can be acted upon in the health care setting.

- Encourage the documentation of advance care planning discussions with easily understandable and culturally appropriate advance directives that include:
  - a **living will** (also called a health care directive) that stipulates specific treatment preferences (if known and applicable to the situation)
  - a **durable power of attorney for health care** that names a surrogate and indicates the amount of leeway the surrogate should have in decision-making
  - a **personal statement** that articulates the patient’s values and goals regarding end-of-life care

- Adopt resources meant to engage low-literacy patients in advance care planning and creation of advance directives.
4. Increase the accessibility of completed advance directive and POLST for health systems and providers

- Contract with an existing registry to store and make accessible advance directives and POLST
- Work with the Department of Motor Vehicles to add text indicating the presence of an advance directive on the Washington State driver’s license with the additional option of putting a QR code on the back of the driver’s license to gain direct access to the registry
5. Increase the likelihood that a patient’s end-of-life care choices are honored

- Implement quality improvement programs within hospitals, nursing homes, and other settings to encourage greater adherence to patients’ requests as outlined in advance directives and POLST if accurate and applicable to the current situation.

- Encourage providers and facilities to measure family satisfaction with end-of-life care by widespread use of an after-death survey tool similar to that used by hospice agencies.
Recommendation

Approve posting draft End-of-Life Care Report and Recommendations for public comment
Questions or Comments?
Look-Back

* April - Welcome, introductions, review charter
* May
  * Washington Screening, Brief Intervention, and Referral to Treatment Programs
  * Medicaid and Apple Health Screening Requirements
* June
  * Addiction screening at the Veterans Administration and Group Health Cooperative
  * Community Health Plan of Washington
* July
  * Reviewed Who Can Screen, Screening Tools, Tracking Patient Screens, Motivating Patients
* August
  * AIMS Center, University of Washington
  * Chemical Dependency Professionals at Evergreen Manor
Variation

Alcohol Dependence or Abuse in the Past Year among Persons Aged 12 or Older

Illicit Drug Dependence or Abuse in the Past Year among Persons Aged 12 or Older


Screening Tools

Prescreen
The prescreen questions are asked to patients annually. They are typically asked:

- On the new/annual patient form handed out at the front desk
- Annually by the Medical Assistant or Nurse while rooming the patient
- At triage in the Emergency Department

Full Screens
After prescreening positive a patient will receive a full screen. The patient will either be:

- Handed the full screens on paper to fill out while waiting for the provider
- Verbally asked the full screens by the Medical Assistant or Nurse

Mental Health Screens
Because mental health issues and substance use are often co-occurring, WASBIRT-PCI recognizes the importance of screening for depression and anxiety as well.

For all patients who full screen positive on the AUDIT and/or DAST 10:

Screen with the AUDIT for ALCOHOL
AUDIT (English) AUDIT (Spanish)

Screen with the DAST 10 for DRUGS
DAST (English) DAST (Spanish)

Screen with the PHQ9 for DEPRESSION
PHQ9 (English) PHQ9 (Spanish)

Screen with the GAD7 for ANXIETY
GAD7 (English) GAD7 (Spanish)

Source: http://www.wasbirt.com/
Proposed Approach

Substance Use Disorder Framework

- Ultra Severe
- Moderate to Severe Substance Use Disorder
- Low to Moderate Substance Use Disorder
- No use

Withdrawal Management

- Assertive Community Treatment
  - Case Management
  - Healthcare Linkage
  - MAT
  - Benefits Management
  - Housing
  - Mobile Teams

- Treatment
  - 12-Step Facilitation
  - MAT

- Education & Re-enforcement
  - Risk Assessment
  - Brief intervention
  - Motivational Interviewing
  - Harm Reduction

Harm Reduction → Total Abstinence

Integrated Treatment within and across disciplines
- Medical
- Behavioral Health
- Social Service Supports

Abstinence
- 12-Step Facilitation
- Inpatient
- Outpatient

Harm Reduction
- Syringe Exchange
- Bread Distribution of Naloxone
- PUP
- Overdose Prevention

Medication Assisted Treatment
- Buprenorphine
- Methadone
- Acamprosate

Withdrawal Management
- Inpatient Hospital
- Detox facility
- Outpatient
- Treatment NAG

Assertive Community Treatment
- Case Management
- Healthcare Linkage
- Housing
- MAT
- Benefits Management

Resource Requirements

*Prescription Monitoring Program
*Medication Assisted Treatment
*Neonatal Abstinence Syndrome
Focus Areas

- Increase appropriate screening in primary care clinics and emergency room settings with validated drug and alcohol screening tools
- Increase capacity to provide brief intervention and/or brief treatment for alcohol and drug abuse
- Increase capacity to facilitate referral to appropriate treatment center.
- Reduce stigma associated with drug and alcohol screening and referral to treatment
Known Barriers

- Provider comfort with screening
- Interview-based screening
  - Time
  - Errors
  - Bias
- One-size fits all treatment
- Coordination of care and follow-up
BREE IMPLEMENTATION TEAM (BIT) UPDATE

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

Wednesday, September 17th, 2014
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
**Warranty**

- Includes significant complications attributable to procedures
- Imposes complication-specific financial accountability for readmissions

**Bundle**

- States explicit and transparent quality specifications
- Appropriateness standards integrated into care pathway
- Four Cycles: Disability due to osteoarthritis despite conservative therapy, fitness for surgery, repair of the osteoarthritic joint, and post-operative care and return to function
Bundled Payment PPO Contract Model for Joint Replacement*  
Hospital as general contractor

Health Plan

Hospital

Physician Organization

PPO amendment includes new “exception clause”: physicians look to hospital for payment

Physician organization contracts with other non-employed physicians (e.g., anesthesiologists)

Contracts with medical device vendor

New contract between hospital and physician organization
Hospital acts as administrator for payment

*This project was supported by grant number R18HS020098 from the Agency for Healthcare Research and Quality. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality.

RESOURCES

    - Episode Definitions
    - Contract Templates
How are hospitals represented on the Bree?

There are five membership seats dedicated to representatives from the hospital setting:

- Two physicians representing the largest hospital-based physician groups in the state submitted jointly by the Washington State Medical Association and the Washington State Hospital Association. Currently:
  - Christopher Kodama, MD, MultiCare
  - Robert Mecklenburg, MD, Virginia Mason Medical Center
- Three representatives of hospital systems, at least one of whom is responsible for quality submitted by the Washington State Hospital Association. Currently:
  - Joe Gifford, MD, Providence Health and Services
QUESTIONS?
COMMENTS?
New Topics

September 17th, 2014 | 12:30pm – 4:30pm
Mandate

The collaborative shall 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.
• Champion: Mary Kay O’Neill

• About 50% of care for common mental disorders was delivered in general medical settings. However, many subsequent studies have shown that these disorders may be undiagnosed or under-treated.

• Depression and anxiety can increase overall health care costs by 50-100%, larger in those with multiple conditions.

• Long-term analyses have demonstrated that $1 spent on Collaborative Care saves $6.50 in health care costs.

Champion: Gary Franklin

“Geographic variation in prevalence of prescribed opioids is large, greater than variation observed for other healthcare services...Wide variation in prescribing opioids reflects weak consensus regarding the appropriate use of opioids for treating pain, especially chronic non-cancer pain. Patients’ demands for treatment have increased, more potent opioids have become available, an epidemic of abuse has emerged, and calls for increased government regulation are growing.”

Labor and Industries has successfully implemented guidelines similar to those being developed by the AMDG group

The Bree would have a unique ability to widely disseminate the AMDG guidelines, and the payers would be able to implement the recommendations

**Sleep Therapy**

- **Champion: Terry Rogers**

- Issue of a lack of a proper diagnosis and treatment. Only ~1% of obstructive sleep apnea (OSA) patients are receiving treatment.

- Associated with injuries, chronic diseases, mental illnesses, poor quality of life and well-being, increased health care costs, lost work productivity, obesity, diabetes, cardiovascular disease, and depression

---

Obstructive Sleep Apnea is a significant, yet under-diagnosed and under-treated chronic disease in the US

OSAS is defined as frequent episodes of apnea and/or hypopnea and functional impairment (e.g., excessive sleepiness).

US population: 307M

- OSA Syndrome (OSAS) 12M
  - OSA with AHI ≥ 15 excl. OSAS 11M
  - Mild OSA with AHI ≥ 5 29M

Diagnosed: 4.1M

- CPAP: ~80%^3 3.3M
- Surgery: ~40%^3 0.2M
- Other devices, Rx / OTC: ~10%^3 0.4M
- Lifestyle: ~100%^3 4.1M

Undiagnosed: 18.9M

Compliant: 2.0M

Non-compliant: 1.3M

1. OSAS prevalence: 3 - 5%; OSA prevalence with AHI ≥ 15: 6.5 - 8.5%; mild OSA prevalence 9 - 24% (assumed 17%)
2. OSAS diagnosis rates are estimated to be 15-20%
3. Estimate from expert discussions and literature research. Lifestyle changes are suggested for almost all patients.


https://sleep.med.harvard.edu/file_download/100
Economic cost of unmanaged moderate-severe OSA in the US estimated between ~$65B and $165B

Estimated annual economic cost of OSA/OSAS in the US
$ Billions

**Public health costs**
1. Diagnosis and treatment: 2-10
   - MD visits, polysomnography diagnostic, CPAP device, CPAP titration, and disposables
2. Hidden healthcare costs: 45-80
   - Incremental medical costs of co-morbidities and OSAS-linked traffic/workplace accidents

**Public safety costs**
3. Traffic accidents: 10-40
   - All nonmedical traffic accident costs related to OSAS (e.g., lost wages, property damage)
4. Workplace accidents: 5-20
   - All nonmedical, nonmotor vehicle workplace accident costs associated with OSAS
5. Loss of productivity: 5-15+
   - Cost of OSAS-driven absenteeism (poor on-the-job performance not estimated)
6. Other: Unknown
   - Societal costs of disrupted lives (e.g., family turmoil, increased divorce, child development)

**Total**: 67-165+

SOURCE: Academic papers, expert interviews, market reports

Moderate – severe OSA has significant economic cost relative to other diseases, yet requires a relatively inexpensive treatment approach.

<table>
<thead>
<tr>
<th>Estimated annual total costs by disease</th>
<th>Prevalence</th>
<th>Cost/person</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ Billions</td>
<td>Million people</td>
<td>$000s</td>
</tr>
<tr>
<td>Cancer</td>
<td>264</td>
<td>11</td>
</tr>
<tr>
<td>Diabetes</td>
<td>260</td>
<td>21</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>175</td>
<td>17</td>
</tr>
<tr>
<td>Moderate-severe OSA</td>
<td>115 ± 50</td>
<td>20-26^2</td>
</tr>
<tr>
<td>Hypertensive disease</td>
<td>80</td>
<td>72</td>
</tr>
<tr>
<td>Stroke</td>
<td>75</td>
<td>6</td>
</tr>
<tr>
<td>Heart failure</td>
<td>40</td>
<td>5</td>
</tr>
<tr>
<td>Asthma</td>
<td>20</td>
<td>23</td>
</tr>
</tbody>
</table>

1 Total cost estimation approach varies by disease in ways that cannot be easily compensated for (e.g., inclusion of mortality and/or morbidity costs).
2 Estimates for diseases other than OSA largely included less costs.

SOURCE: American Heart Association; American Diabetes Association; National Heart, Lung and Blood Institute, American Cancer Society.

https://sleep.med.harvard.edu/file_download/100
Prostate Specific Antigen Screening Testing

- **Champion: Leah Hole-Marshall**
- The US Preventative Services Task Force concludes that many men are harmed as a result of prostate cancer screening and few, if any, benefit. A better test and better treatment options are needed. Until these are available, the USPSTF has recommended against screening for prostate cancer.
- State agencies recommend PSA testing topic for Bree review and recommendation.

Jeffery Thompson, Mercer

Cancer is typically in the top 1-3 health care expenditures for an employer, both public and private. Small and medium size employers, covering the majority of the insured, often see one to two cases per year that fall under the category of a high cost claimants costs exceeding ($100,000 dollars).
Coronary Artery Disease Bundle

- **Champion: Bob Mecklenburg**

- A high-prevalence, high cost treatment of coronary artery disease is coronary artery bypass surgery (CABG). CABG is characterized by: 1) variation in utilization not clearly related to need, 2) variation in price, and 3) variation in complication rates among health care providers.

- The prevalence of CABG, its aggregate cost and its avoidable complication rates have made this surgical procedure a priority for public and private sectors as well as the broader community. Bree knows how to use warranties and bundled payments to improve appropriateness, safety and affordability by facilitating market based health care reform. We now have the opportunity to apply our model to CABG surgery.

Next Meeting

Thursday, November 20th

Providence Health & Services
Main Building, System Office
1801 Lind Ave SW
Renton, WA 98057