The Dr. Robert Bree Collaborative Meeting

May 21st, 2014 | 12:30pm – 4:30pm
Agenda

- Chair Report & Approval of March 19th Meeting Minutes
- Update from the Governor’s Office
- Potentially Avoidable Readmissions Update
- Member Profile: Wenatchee Valley Medical Center
- Bree Implementation Team (BIT) Update
- End of Life/Advance Directives (EOL) Workgroup Update
- Accountable Payment Models (APM) Workgroup Update
- Addiction/Dependence Treatment Workgroup Update
- Retreat Planning
- Good of the Order/Opportunity for Public Comment
Update from the HCA

- Endorsed Spine/Low Back Pain Report and Recommendation
- Endorsed the Total Knee and Total Hip Replacement Surgery Bundle and Warranty

Thank you and the Bree Collaborative members for the Spine/Low Back Pain Report and Recommendations and the Bree Collaborative Warranty and Bundle for Elective Total Knee and Total Hip Replacement (TKR/THR) Surgery received December 2 and December 4, 2013, respectively. Both recommendations are impressive and align with Washington State’s Innovation Plan work to better align safety, appropriateness, and quality in Washington State.
Website Launch
www.breecollaborative.org
Update from the Governor’s Office

- Bob Crittenden, MD
- Governor Jay Inslee’s Health Policy Advisor
POTENTIALLY AVOIDABLE HOSPITAL READMISSIONS PROPOSAL

RICK GOSS, MD, MPH, FACP
HARBORVIEW MEDICAL CENTER / UW MEDICINE
MAY 21, 2014
VARIATION IN READMISSIONS NATIONALLY
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
1. Endorse / expect participation in the collaborative model process;

2. Recognize WSHA and Qualis as state-level facilitators;

3. Encourage use of consensus-driven and evidence-based tools and techniques (Toolkit, hospital data reports, etc…);

4. Encourage Medicaid Incentive Readmission Bundle;

5. Identify opportunities for transparency;

6. Recognize and reward engagement and participation.
FEEDBACK AND ACTION ITEMS
FROM 3/19/14 BREE MEETING

1. General support for proposal
2. More explicit evidence supporting best practices including correlation with AHRQ recommendations
3. Limited number of high value performance targets
4. Support for WSHA Toolkit and Qualis analysis
5. Revisions to Medicaid Bundle
6. Support for ‘community collaborative’ model
7. Need for objective criteria when defining terms
1. Endorsement of the Washington State collaborative model

2. Endorsement of tools and techniques to reduce readmissions in Washington State

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 two days
   - Follow-up phone call within two days
RECOMMENDATION 1
COLLABORATIVE MODEL

Collaboratives will be recognized by:

1. Formally writing a charter, draft charter included, with list of participating organizations, shared expectations for best practices, and measures of success

2. Demonstrating evidence of participation in recurring meetings

3. Recognition by WSHA or Qualis Health as an active member

Ideally, will work to follow the Institute for Healthcare Improvement’s collaborative model.
RECOMMENDATION II
ENDORSEMENT OF STATEWIDE TOOLS AND TECHNIQUES

- Acknowledgement of community initiatives to reduce potentially avoidable hospital readmissions and support for the continuation of this work.
  - The Washington State Hospital Association: *Care Transitions Toolkit*
  - Qualis Health’s data reports and technical assistance
  - The Washington Health Alliance work to increase data transparency
RECOMMENDATION III: MEASUREMENT DISCHARGE INFORMATION SUMMARY

- Medical discharge summary (preliminary is acceptable if it is noted on the document) or another form of documentation as consistent with Joint Commission

- **Numerator:** Number of inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition) for which there is a discharge information summary sent to the primary care provider (PCP) or aftercare provider within two days of discharge.

- **Denominator:** Total number of inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition).
RECOMMENDATION III: MEASUREMENT FOLLOW-UP PHONE CALL

- Documentation of a discharge phone call to patient or caregiver after discharge. If patient or care provider was not available, documentation of attempt as consistent with the hospital’s protocol (e.g., call three times).

- **Numerator:** Number of inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition) for which there is a documented follow-up phone call.

- **Denominator:** Total number of inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition).
RECOMMENDATION III: MEASUREMENT
INCLUSIONS AND EXCLUSIONS

- **Inclusions**
  - All inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition).

- **Exclusions**
  - Discharged against medical advice
  - Elopement: patient leaves without knowledge of care team or hospital staff
  - Patient expires during current medical stay
  - Patients admitted for a short stay surgical procedure
  - Patients admitted for obstetric services
RECOMMENDATION

- Approve draft Potentially Avoidable Hospital Readmissions Report and Recommendations for posting for public comment.
QUESTIONS OR COMMENTS?
70% Medicare/Medicaid, geographically dispersed need, over 12,000 sq. miles.

How will healthcare survive in NCW?
Accountable Care Organizations are Provider Organizations caring for a minimum of 5,000 Medicare beneficiaries.

- Care must be organized in a proscribed methodology as spelled out in the ACA.
- Payment is via the Medicare “Shared Savings Plan”.
  - Savings are benchmarked to the average total cost of care per Medicare Beneficiary per year for your region.
  - The cases are not indexed by severity.
  - Medicare keeps 50% of savings and provides the remainder as payment to the ACO, provided that quality targets are met.
Challenges to the ACO model for NCW.

- We are already a low cost area.
  - The average total cost per Medicare Beneficiary in the US is $7,200 per year. The Cost in Wenatchee is $6,500 per year. (Lowest cost areas are near $5,200 per year and the highest are over $15,000 per year!)

- No severity index.
  - Sicker, more complex patients are more difficult and more expensive to care for.
    - Severity indexing is an objective rating of the patient’s complexity and serves as a way to “weight” the payment or cost of patients based on their complexity.
More organized.

- We cannot afford to provide care in isolation.
- We must communicate and coordinate care much more effectively than before.

  - Ineffective transitions of care (outpatient to inpatient, inpatient to outpatient or extended care) accounts for significant medical errors and tremendous cost in our system.

    - Drug/drug interactions, due to poor medication reconciliation accounted for $4.2 Billion in medical expense in 2011.

More reliable.

- We must build more reliable care processes.

  - Americans receive the recommended care for preventive health or management of chronic disease only 50% of the time.
More like a “team”.

- The combination of an aging population and a shortage in critical medical professionals (Doctors, nurses, techs), will drive the need for all healthcare workers to perform “at the top of their license”.
  - The age of the “cowboy” is over. We now need “the pit crew”.
    - “Atul Gawande” Ted Talks

More accountable for **risk**.

- Regardless of the payer or whether a provider is in an ACO, Hospital Group, Multispecialty Group or Private Practice; we will no longer simply be paid to do “more”. We will be challenged to demonstrate that our quality and service to our patients meets a standard and take risk for the cost of the care we provide.
The affiliation of Wenatchee Valley Medical Center and Central Washington Hospital.

Why?

- Vertical integration of care provides more opportunities to enhance the Value of Care.
- There were significant synergies related to duplicate services and infrastructure at both institutions.
- Affiliation allows for greater overall market strength and for the preservation of specialty services.
- Vertical integration of clinical systems allows for enhanced care management and managed care performance.
Who We Are:

- Confluence Health is an integrated rural healthcare delivery system, including inpatient and outpatient services
- Formed in 2013 as an affiliation between Central Washington Hospital & Wenatchee Valley Medical Center
- Largest multi-specialty medical center and regional hospital in North Central Washington, with clinics in 10 communities
Why this structure?

- Tax implications
  - Physician group moving to “non-profit” status would trigger a significant “toll tax”, due to current assets.
- WVH is a Rural Hospital
- CWH is a DSSH “dish” Hospital
  - Important to maintain both hospitals as separately licensed entities.
Culture

- Both organizations have a long, successful history as relative competitors.
- CWH has a traditional Hospital management structure, prone to “silos” of control.
- WVMC has a “Physician Centric” culture in which the Physicians were owners of the group and worked as successful “independent practices” within the group.
Recent patient safety issues

- CWH Operating Rooms suffered 5 significant adverse events in 2012.
  - “Culture of Safety Survey” done in June 2012, shows CWH below the 10% nationally in overall staff and Physician impressions of the Hospital’s focus on safety.
- CWH has had 11 medication errors of significance since January 1, 2013.
- WVMC Physicians are the Attending Physicians on the majority of these patients.
- WVMC’s current Managed Care performance is poor, primarily related to low RIS scores.
Clearly articulate the Vision, Mission and actionable goals for Confluence Health to all staff.

- Clearly articulate the reasons for the affiliation and what we will do for our patients and our community as a result of this work.
- Clearly articulate, “what do we expect of them and what should they expect of leadership?”
  - We used “standard work” with the development of a PowerPoint and video presentation; given in rotation by senior leadership.
  - This was done for all staff in 45 separate meetings over the summer. The meetings were 1 hour for the presentation and 1 hour Q and A.
Confluence Health, plan of action

- Adopt a **new management structure for the entire organization.**
  - Contracted with Virginia Mason Institute to serve as our mentor in a journey toward a working knowledge and application of “Lean”.
  - Clear expectations given to all Directors and Management re: transparency of process and utilization of standard management processes.
    - 180 leaders and managers schedule to complete “Lean” training by the end of 2013. All will be expected to lead performance improvement events after training.
    - A KPO office was established and fully functional by 2013.
Plan of action

- **Patient Safety is job #1.** Not as a statement but as demonstrated action.
  - All surgery staff and Physicians required to participate in 4 hour safety training led by Mike Leonard MD (national OR safety expert).
    - This went very well!!

- **Policy #1, “Speak Up”**
  - This is a policy for all staff to “speak up” in the event that patient care is threatened or otherwise interrupted.
    - Events are “triaged” into three levels of urgency.
    - The most urgent events require a senior leader “on call” to respond, in person within 30 min.
Other changes; “flattening the organization”

- Restructure of organizational leadership into “dyads”.
  - Each department manager is partnered with a Physician Manager
  - All Physician and Practice/Department Managers are required to complete Lean Basic, including leadership responsibility for at least one improvement event per year.
  - All Physician and Practice/Department Managers are going through a two year management training curriculum, put on by the Advisory Board.
Results so far

- Far more employee input and involvement into our improvement systems. (>300 involved so far)
  - >50 Kaizen and or RPIW events to date.
  - Two, “3P” events so far.
    - Addressing “Indirect Care” as an enhancement to the Primary Care Value Stream.
  - OR space and process redesign (with NPPJ)
  - 5 Value Streams currently in focused review.
    - Primary Care
    - Peri-operative and OR work flow
    - Revenue cycle, (inpatient)
    - ER
    - Inpatient Discharge from Medical and ICU.
Results so far

- **Indirect Care Center**
  - Improved schedule access (Primary Care)
  - Improved Rx refill accuracy
  - Improved nurse phone advice management and documentation
  - Increased capacity in back office staff, leading to improved reliability of “Direct Care” processes.

- **Primary Care Value Stream**
  - Improved reliability of Pre-visit prep for chronic care and health maintenance visits.
  - Increased productivity (in departments using the new process)

- **Hospital Discharge**
  - Improved reliability of d/c med reconciliation and patient adherence.
  - Improved reliability of hospital f/u appointing in a timely fashion.
challenges

- **Spread**
  - Making this part of daily management
    - More reliable use of daily and weekly team meetings and use of the “people link” boards to improve accountability and communication.

- **Burden of work**
  - Too many good ideas!
    - Many are imposed from outside but we must apply more discipline to our own desires to “take on” new challenges, projects.
      - “you learn much more on the shop floor than in any meeting”

- **Risk performance**
So yes, I do think we are positioned to survive and even thrive in a new era.

- **If we:**
  - Work to coordinate care.
  - Engage the entire “team” in caring for our patients.
  - Embrace “risk” and collaborate to minimize it.
  - Create business opportunities that incentivize
    - Better Care
    - Fewer Complications
    - Higher Value.

- **If we do all this, we can transform care in North Central Washington and be a National Leader in Healthcare Delivery.**
UPDATE FROM HCA

Endorsed Spine/Low Back Pain Report and Recommendation

Endorsed the Total Knee and Total Hip Replacement Surgery Bundle and Warranty

Thank you and the Bree Collaborative members for the Spine/Low Back Pain Report and Recommendations and the Bree Collaborative Warranty and Bundle for Elective Total Knee and Total Hip Replacement (TKR/THR) Surgery received December 2 and December 4, 2013, respectively. Both recommendations are impressive and align with Washington State’s Innovation Plan work to better align safety, appropriateness, and quality in Washington State.

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
SPINE SCOAP STRATEGY

Target: Capture 90% of Spine Surgeries Performed in WA by 6/1/2014

Strategy 1: Talk to Hospitals
- Target Hospitals: Why haven’t you joined? How can we help you overcome those barriers?
- Participating Hospitals: Why did you join? How can we improve our messaging to target hospitals?

Strategy 2: Increase Visibility of Bree
Creation of crisp business/purchaser and clinical case for participation in Spine SCOAP

Contact hospital systems at the corporate level (as opposed to individual hospitals)

Reach out to clinical leadership at target hospitals

Promote interest, understanding and engagement by having the hospital join the annual Spine SCOAP meeting

For hospitals still choosing not to participate, have in-person meeting with representatives of Bree/purchasers/plans
We are contacting you today as representatives of the Dr. Robert Bree Collaborative about joining the Spine Surgical Care and Outcomes Assessment Program (SCOAP). The Bree Collaborative – which is legislatively charged with identifying and recommending best practice approaches to healthcare delivery – has strongly recommended participation in Spine SCOAP as a community standard.

Spine SCOAP is a clinician-led, collaborative, and non-regulatory health care quality improvement program that uses clinical data to improve outcomes for patients having spine surgery in Washington State. Spine SCOAP’s main goal is to improve quality by reducing variation in outcomes and process of care by encouraging hospitals to voluntarily submit data to a regional database. SCOAP was developed by physicians, is housed within the Foundation for Health Care Quality, and is leading the country by focusing on functional outcomes. Read more about the program here, www.scoap.org.
Support a new payment structure or structures for obstetric care.

Collaborate with other health plans in Washington to create a quality incentive program, using the same quality criteria.
OBSTETRICS BIT SUBGROUP

- Focused on benefit design to support the recommendations
  - Ellie Kauffman, MD, Medical Director, OB COAP
  - Claudia Sanders, SM, Senior Vice President, Policy Development, Washington State Hospital Association
  - Pat Kulpa, MD, MBA, Medical Director, Regence

- Met once by phone, subsequent meeting scheduled
- Emphasize the importance of belonging to a quality improvement initiative.
OTHER OBSTETRICS WORK

- Identified as priority collaboration area by Summit Group
- Led to an OB Coordination Team moderated by Christina Hulet
  - Susie Dade
  - Ellie Kauffman
  - Dan Lessler
  - Terry Rogers
  - Kristin Sitcov
  - Bat-Sheva Stein
  - Carol Wagner
  - Ginny Weir
  - Mara Zabari

Working to:
- Coordinate messages across organizations
- Coordinate data across organizations
- Provide tools and resources
- Facilitate common patient expectations
Have heard presentation from Bob Mecklenburg, Chair of the Accountable Payment Models Workgroup

Will most likely be next topic.
End of Life/Advance Directives Workgroup Update

John Robinson, MD
Chair, EOL Workgroup
Bree Collaborative Member
Chief Medical Officer, First Choice Health

May 21st, 2014
The Patient Self-Determination Act

- Part of the Federal Omnibus Budget Reconciliation Act passed by Congress in 1990

- Advance directive definition: “A written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.”

Advance Directives

- Completed by about a third of Americans
- More likely to be older
  - 25% of 35-49 year olds
  - 36% of 50-59 year olds
  - 47% of those 60 years of age and older
- More likely to be white non-Hispanic
  - 41% of white, non-Hispanic
  - 19% of black, non-Hispanic
  - 25% of Hispanic adults report having written down end of life wishes

(American Association of Retired Persons, 2008; Pew Research Center, 2013)
Advance Directives

• Higher levels of education
  ▫ 42% of college graduates or higher education
  ▫ 37% of those with some college
  ▫ 29% with a high school degree or less

• Higher income
  ▫ 43% of those with annual family incomes of $75,000 or more
  ▫ 36% with $30,000-$74,999
  ▫ 26% of those under $30,000 report having their wishes written down

(American Association of Retired Persons, 2008; Pew Research Center, 2013)
National Example
Respecting Choices®

- Gundersen Medical Foundation in La Crosse, WI
- Started in 1991 as a collaboration between leaders from major health organizations
- Mix of printed material, videos, and trained staff
- After two years, 85% of those who died had an advance directive, 95% of those in the medical record
  - Majority requested treatment be forgone which occurred in 98% of deaths
- After 12 years, increased to 90% with 99.4% available in the medical record

(Hammes BJ and Rooney BL, 1998; Hammes BJ, et al., 2010)
Respecting Choices®

• Designed as an “ongoing process of communication, integrated into the routine of patient-centered care” that incorporates “community engagement, professional education, and organization/standards of practice”
• Have worked to spread the model outside of WI
The Bree Collaborative End of Life Workgroup

- Anna Ahrens, MultiCare Health System
- Tony Back, MD, Seattle Cancer Care Alliance
- Trudy James, Heartwork
- Abbi Kaplan, Abbi Kaplan Company
- Timothy Melhorn, MD, Yakima Valley Memorial Hospital and the Memorial Foundation
- Richard Stuart, DSW, University of Washington

Tonya Carroccio, Washington State Hospital Association
Bree Johnston, MD, PeaceHealth
Jessica Martinson, Washington State Medical Association
Joanne Roberts, MD, Providence Everett Regional Medical Center
John Robinson, MD, First Choice Health
Bruce Smith, MD, Group Health Physicians
Ginny Weir, The Bree Collaborative

Honoring Patient Choices

- David Becher, MD, MultiCare Health System
- Kate Brostoff, Community Health Plan of Washington
- David Bucher, Kitsap County (WA) Cross Continuum Care Transitions
- Lisa Butler, RN, Washington State Hospice and Palliative Care Organization
- Randy Curtis, MD, University of Washington
- Julianne Dickelmers, Whatcom Alliance for Health Advancement
- Katie Evermann Druffel, MSW, Pullman Regional Hospital
- Shannon Figgenshaw, ARNP, Washington POLST Task Force
- Velda Flizen, Partners in Palliative Care
- Scott Forslund, Premera
- Matt Handley, MD, Group Health
- Eileen Hanson, Spiritual Care—Snohomish Co.
- Becca Hawkins, RN, Providence Health & Services
- Meg Jacobson, MD, Hospice & Palliative Care Bellingham
- Marilyn "Mimi" Petlison, MD, Franciscan Hospice & Palliative Care
- Mary Ann Percy, Whatcom Alliance for Health Advancement
- Terry Rogers, MD, Foundation for Healthcare Quality
- Donna Smith, MD, Virginia Mason Medical Center
- Helene Stark, PhD, University of Washington
- Gregg VandeKieft, MD, Providence Palliative Care
- John Vassall, MD, Swedish Health Services
- Carol Wagner, WSHA
- Hose Wechkin, MD, EvergreenHealth
Focus on Overcoming Barriers for ADs

- Not completed
- Inaccurate or too vague
- Not available when and where they are needed
- When completed, are not used in end of life care

What the Evidence Says

- Advance directives should be written at a low-literacy level
- Direct, interactive, and in-person patient-provider conversations
  - Over multiple visits
  - Targeted to the patient’s specific life-stage
  - Focus on outcomes of treatment, how life will be
- Initial conversations prepare patients for future communication and decision-making

(Bravo G et al, 2008; Fried TR, et al., 2007; Patterson C, et al., 1997; Ramstroop SD, et al., 2007; Spoelhof GD, et al., 2012; Sudore & Fried, 2010; Sudore RL, et al., 2007)
Welcome to PREPARE!

PREPARE is a program that can help you:
- make medical decisions for yourself and others
- talk with your doctors
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You can view this website with your friends and family.

Click the NEXT button to move on.

www.preporeforyourcare.org
Questions? Comments?
INTERIM REPORT: LUMBAR FUSION BUNDLE AND WARRANTY

ROBERT BREE COLLABORATIVE
WARRANTY AND BUNDLED PAYMENT MODELS
MAY 21, 2014
CHARTER ITEM #2
RECRUIT THE 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, Puget Sound 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

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

90 days
a. Mechanical complications related to surgical procedure
b. Deep wound infection involving hardware
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
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
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 x-ray findings severe

4. Document failure of conservative therapy on above scales with required review and recommendation for surgery by care team
Fitness for surgery: physical preparation and patient engagement

1. Standards relating to patient safety: BMI ≤40, A1C ≤ 8%, no smoking for 4 weeks, management of opioids, nutritional status, accommodation for dementia, absence of a near-term life-limiting illness or other severe disability preventing benefit of TJR, screen for emotional disorders

2. Patient engagement: shared decision-making

3. Designated care partner to assist patient throughout course

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

a. Minimum annual volume for surgeon: 20 cases
b. Two attending surgeons
c. Multimodal anesthesia to minimize sedation and promote early ambulation
d. Measures to avoid infection as specified by CMS (Surgical Care Improvement Project)
e. Measures to avoid bleeding/low BP (such as tranexamic acid and RN fluid protocols)
f. Measures to avoid thromboembolism as specified by CMS (SCIP)
g. Measures to maintain optimal blood sugar
h. Selection of surgical implant
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. Discharge process from WSHA toolkit
3. Standardized disposition planning
4. Standardized follow up communication and appointments
5. Measurement of functional outcomes
QUALITY MEASURES

A guide to purchasing
QUALITY MEASURES
REPORTED TO PURCHASERS OF BUNDLE

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, bleeding, and hyperglycemia

3. Rapid return to function: PT in first 24 hours, ODI and PROMIS-10

4. Patient care experience: HCAHPS

5. Affordability: nine complications listed in warranty and 30-day all cause readmissions for lumbar fusion patients
Addiction/Dependence
Treatment Workgroup Update

Terry Rogers, MD
CEO, The Foundation for Health Care Quality

May 21st, 2014
Workgroup Members

- **Chair**: Tom Fritz, CEO, Inland Northwest Health Services
- Charissa Fotinos, MD, MS, Deputy Chief Medical Officer, Health Care Authority
- Linda Grant, MS, CDP, Director, Evergreen Manor
- Tim Holmes, MHA, Vice President of Outreach Services and Behavioral Health Administration, MultiCare
- Ray Chih-Jui Hsiao, MD, Co-Director, Adolescent Substance Abuse Program, First Vice President of the WSMA, Seattle Children’s Hospital
- Scott Munson, Executive Director, Sundown M Ranch
- Rick Ries, MD, University of Washington
- Terry Rogers, MD, Foundation for Health Care Quality
- Ken Stark, Director, Snohomish County Human Services Department
- Jim Walsh, MD, Addiction Medicine, Family Medicine w/Obstetrics Swedish
Summary of Work

- Members
- Meetings
- Primary Aims
Evidence-Based Standards to Improve Screening

1. Focus initially on optimal drug and alcohol screening protocol.
2. Encourage widespread adoption of standardized drug and alcohol screening.
3. Increase measurement and reporting of drug and alcohol screening.
Have Discussed

- The need for a clear, clinical referral pathway
- US Preventive Services Task Force recommendations
- Screening tools (e.g., AUDIT, CRAFFT, DAST)
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
  - Including the [www.wasbirt.com](http://www.wasbirt.com) website
- Medicaid and Apple Health screening requirements
- Screening in Snohomish county
US Preventive Services Task Force

- **Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse**
  - The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
  - Grade: B Recommendation.
  - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse in adolescents.
  - Grade: I Statement.

- **Screening for Illicit Drug Use**
  - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use.
  - Grade: I Statement.
What is SBIRT?

SBIRT stands for Screening, Brief Intervention, and Referral to Treatment. SBIRT is a universal public health approach to integrate behavioral and primary health care. It's a way to increase awareness that substance abuse is preventable and that treatment works. SBIRT can be provided in a wide variety of medical and community healthcare settings.
SBIRT services must be provided by, or under the supervision of, a certified physician or other certified, licensed health care professional within the scope of their practice.

The following is a health care professionals who can provide SBIRT services under Medicaid once they have received training:

- Advanced Registered Nurse Practitioner
- Chemical Dependency Professional
- Licensed Practical Nurse
- Mental Health Counselor
- Marriage and Family Therapist
- Independent and advanced Social Worker
- Physician
- Physician Assistant
- Psychologist
- Registered Nurse
- Dentist
- Dental Hygienists

All licensed healthcare professionals must:

- Provide SBIRT services under the supervision of a certified physician or other certified health care professional if they are not eligible to bill. See "Who can bill for SBIRT services under Medicaid?" below.
- Be trained on SBIRT in order to provide and/or supervise individuals providing SBIRT services.
- Have a minimum of 4 hours of SBIRT training provided by an Health Care Authority (HCA) approved training entity.

There are many training options available. Visit our Training page for a complete list of agencies that can provide SBIRT training.

All health care professionals that complete an SBIRT training need to receive a certificate documenting the training. This certificate must be submitted to HCA, along with your National Provider Identifier (NPI) number, prior to billing for SBIRT services. If HCA has not received a copy of your SBIRT training certificate and NPI, your submitted SBIRT claims will be denied. Healthcare professionals with SBIRT training who are not enrolled with HCA may enroll as a Washington Apple Health (Medicaid) provider to offer SBIRT services.
Preliminary Conclusions

- All patients should be screened annually starting at age 12
- Tracking through EMRs
- Screening should occur at all visits, especially important for adolescents
- Positive pre-screen should be followed by a full screen
- The full screen should be provided by on-site staff able to provide brief interventions, referrals to treatment, and possibly brief therapy
Questions or Comments?
Retreat Planning

Steve Hill
Bree Collaborative Chair

May 21st, 2014
### Commonwealth Fund Scorecard on State Health System Performance, 2014

<table>
<thead>
<tr>
<th>RANKING SUMMARY</th>
<th>2014 Scorecard</th>
<th>2009 Revised¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</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</td>
<td>20</td>
<td>31</td>
</tr>
<tr>
<td>Healthy Lives</td>
<td>7</td>
<td>11</td>
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</tbody>
</table>

¹ Revised from the original scorecard.
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
Table: 

<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 purpose of the Bree is clear to me</td>
<td>13</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.72</td>
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<tr>
<td>I have a solid understanding of my role on the Bree</td>
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<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>4.61</td>
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<tr>
<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>
<td>4.33</td>
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<tr>
<td>The Foundation for Health Care Quality provides effective project management support to the Bree</td>
<td>6</td>
<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>
<td>5</td>
<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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<tr>
<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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<tr>
<td>Bree Collaborative meetings are productive</td>
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<td>10</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>3.94</td>
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<tr>
<td>The Bree is an effective mechanism for improving quality health outcomes</td>
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<td>10</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>3.94</td>
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</table>
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>
<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>
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<td>13</td>
<td>4</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>
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<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>
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<tr>
<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>
</tr>
<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>
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<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>
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<td>9</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3.27</td>
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<tr>
<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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<tr>
<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>
<td>5</td>
<td>2.71</td>
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</tbody>
</table>
Proposed Agenda July 17th, 2014

- Regularly-scheduled Bree work (hospital readmissions, accountable payment models)
- Review of previous and current work
- Working together effectively
- Perspective of the Health Care Authority
- Future topics
- State Agency Medical Director perspectives
- Bree organizational feedback
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 exists
- Health Technology Assessment Topic
- Equity Issue
Good of the Order
Opportunity for Public Comment
Next Meeting: July 17th, 2014

Providence Health & Services
Main Building, System Office
Room: WA Gamelin VC Vancouver C
1801 Lind Ave SW
Renton, WA 98057