Washington State Health Care Authority

Report to the Legislature

Bree Collaborative Annual Report

As Required by Engrossed Substitute House Bill 1311
Section 3, Chapter 313, Laws of 2011

November 15, 2013

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Executive Summary

This annual report is submitted by the Health Care Authority (HCA) on behalf of the Dr. Robert Bree Collaborative (Collaborative) to the Washington State Legislature as directed in Engrossed Substitute House Bill 1311 (ESHB 1311), Section 3, and enacted as chapter 313, Laws of 2011. ESHB 1311 amends Chapter 70.250 RCW, the advanced diagnostic imaging workgroup.

HCA is the sponsoring agency of the Collaborative, a public/private consortium created to improve health care quality, cost-effectiveness, and outcomes in Washington State. This is the second annual report submitted by HCA on behalf of the Collaborative. This report describes the achievements of the Collaborative from November 2012 through October 2013.

ESHB 1311, Section 3 calls for the Collaborative to:

> *"report to the administrator of the authority regarding the health services areas it has chosen and strategies proposed. The administrator shall review the strategies recommended in the report, giving strong consideration to the direction provided in section 1, chapter 313, Laws of 2011 and this section. The administrator's review shall describe the outcomes of the review and any decisions related to adoption of the recommended strategies by state purchased health care programs. Following the administrator's review, the collaborative shall report to the legislature and the governor regarding chosen health services, proposed strategies, the results of the administrator's review, and available information related to the impact of strategies adopted in the previous three years on the cost and quality of care provided in Washington state. The initial report must be submitted by November 15, 2011, with annual reports thereafter."*

Since its formation in August 2011, the Collaborative has successfully pursued its mission 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. Year two accomplishments included:

- Forming a Bree Implementation Team to design and implement strategies to successfully encourage stakeholders to implement the recommendations of the Collaborative.
- Partnering with COAP to complete and publish final report on the cardiology topic and increase transparency around appropriate use of an important procedure in cardiac care.
- Publishing hospital-specific, unblinded data about 30-day, all-cause readmissions and blinded data about readmission rates following TKR/THR surgeries in Washington State.
- Developing a robust, evidence-based warranty model for total knee and total hip replacement (TKR/THR) surgeries.
- Providing support for the State Innovations Planning process.
- Producing an evidence-based report with detailed recommendations for improving the evaluation and management of acute low back pain.

The Collaborative had a prolific second year and is taking concrete steps to solidify its position as a change agent. It will continue to leverage its unique position to encourage the adoption of practices that improve the quality of care delivered in Washington State.

Background and History

Despite an explosion in biomedical knowledge and innovation, the American health care system continues to fall short on basic dimensions of quality, outcomes, costs, and equity.[i] Evidence suggests that a substantial proportion of health care expenditures is wasted, leading to little improvement in health outcomes or in the quality of care. National estimates vary on waste and excess health care costs, but they are large: approximately $750 billion in 2009.[ii] Substantial variation in practice patterns or high utilization trends can be indicators of poor quality and potential waste in the health care system.

Governor Inslee, the Legislature and the people of Washington State expect a health care system that is both high quality and affordable, with little waste. The Governor's Office and the Legislature have done extensive work over the past nine years to achieve these goals, including the creation of the Washington State Quality Forum, the Health Technology Assessment program, the Washington State Advanced Imaging Management project, and most recently the Dr. Robert Bree Collaborative (Collaborative). All of these quality efforts were a result of the Washington State Blue Ribbon Commission on Health Care Costs and Access recommendation, which the Legislature was deeply involved in.

The Collaborative is an offshoot of the Washington State Advanced Imaging Management (AIM) project. It is named in memory of Dr. Robert Bree, who was a pioneer in the imaging field and a key member of the AIM project.

Overview of ESHB 1311 – Dr. Robert Bree Collaborative

The Washington State Legislature established the Collaborative in 2011 to provide a mechanism for public and private health care purchasers, health carriers, and providers to work together to identify and recommend evidence-based strategies to improve the quality, outcomes, and cost-effectiveness of health care. ESHB amends RCW 70.250.010 (Advanced Diagnostic Imaging Workgroup definition) and 70.250.030 (Implementation of Evidence-based Practice Guidelines or Protocols); adds a new section to chapter 70.250 RCW; creates a new section; and repeals RCW 70.250.020.

The Collaborative is charged with identifying up to three areas of health care services for which substantial variation exists in practice patterns and/or increases in care utilization are not accompanied by better care outcomes. Both of these trends may be indicators of poor quality and potential waste in the health care system.

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

The Collaborative must also identify strategies to increase the use of evidence-based practices. The strategies may include:

- Goals for appropriate utilization rates;

- Peer-to-peer consultation;
- Provider feedback reports;
- Use of patient decision aids;
- Incentives for the appropriate use of health services;
- Centers of Excellence or other provider qualification standards;
- Quality improvement systems; and
- Service utilization or outcome reporting.

The Collaborative should consist of the following representatives, to be appointed by the Governor:

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

The Governor must appoint the chair of the Collaborative, and the HCA must convene the Collaborative. The Collaborative must add members or establish clinical committees as needed to acquire clinical expertise in particular health care service areas under review. Each clinical committee shall include at least two members of the specialty or subspecialty society most experienced with the health service identified for review.

ESHB 1311, Section 3 calls for the Collaborative to “report to the administrator of the authority regarding the health services areas it has chosen and strategies proposed. The administrator shall review the strategies recommended in the report, giving strong consideration to the direction provided in section 1, chapter 313, Laws of 2011 and this section. The administrator's review shall describe the outcomes of the review and any decisions related to adoption of the recommended strategies by state purchased health care programs. Following the administrator's review, the collaborative shall report to the legislature and the governor regarding chosen health services, proposed strategies, the results of the administrator's review, and available information related to the impact of strategies adopted in the previous three years on the cost and quality of care provided in Washington State.”

No member may be compensated for his or her service. Members of the Collaborative and clinical committees are immune from civil liability for any decisions made in good faith while conducting work related to the Collaborative or its clinical committees. The guidelines or protocols identified under this section shall not be construed to establish the standard of care or duty of care owed by health care providers.

The Collaborative's proceedings must be open to the public and notice of meetings must be provided at least ten days in advance. The Collaborative should actively solicit federal or

private funds and in-kind contributions as needed to complete its work in a timely fashion. The Collaborative may not begin its work unless there are sufficient federal, private, or state funds available.

The Collaborative is exempt from state antitrust laws and is provided immunity from federal antitrust laws through the state action doctrine. It is not the intent of the Legislature to mandate payment or coverage decisions by private health care purchasers or carriers. However, it is the intent of the Legislature that quality indicators recommended by the Bree Collaborative be adopted and used by all private payers in Washington State.

The Creation of the Bree Collaborative

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

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

The Collaborative secured initial funding for project management using the federal SHAP grant through the end of 2012. The Foundation for Health Care Quality was selected to provide project management for the Collaborative and hire a program manager. A program manager was hired in January 2012. Additional funding for project management has been identified and secured through June 2015 as part of the State's budget process.

The Collaborative has held twelve meetings (one in 2011, six in 2012, and five in 2013). Meetings are currently held on a bi-monthly basis; the next meetings are scheduled for November 21, 2013 and January 22, 2014. Meeting agendas and materials for all Collaborative meetings are posted in advance on the Collaborative's website.

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

Bree Collaborative Retreat

Collaborative staff organized a retreat for members on June 4, 2013. The retreat had four objectives:

1. Strengthen the working relationships among Bree members.
2. Clarify the HCA's plans for implementation of the Bree's recommendations.
3. Identify what would constitute success for the Bree over the next three years.

4. Begin work to identify the topics the Bree will address in fall 2013/2014.

Members and staff agreed that the retreat was a success and helped the group refine its focus.

Bree Implementation Team: Overseeing Implementation and Evaluating Impact

At its July 2013 meeting, the Collaborative approved a proposal to form a Bree Implementation Team (BIT) with the following purpose: design and implement strategies to successfully encourage stakeholders to implement the recommendations developed by the topic area workgroups. The BIT will focus on strategies in the following lever areas:

- Payment to providers
- Organization of care delivery
- Benefit design
- Patient engagement
- Transparency/performance indicators

The Collaborative also specified that the BIT include at least one representative from each of the major stakeholder groups and at least one member of every topic area workgroup to provide content expertise. Dr. Dan Lessler, HCA Medical Director, agreed to serve as BIT chair and presented a draft roster and charter at the September 2013 meeting. (*See Appendix A for a list of BIT members*.)

The BIT held its first meeting on October 31st and finalized a draft charter that it will submit for approval by the Collaborative at its November meeting. The BIT is a standing committee that will meet on a monthly basis.

Summary of Progress across the Selected Topic Areas

At its first three meetings, the Collaborative heard presentations by Collaborative members and invited experts on a variety of health topics and procedures showing the most promise for improvement in health outcomes. Based on these presentations and input from the Washington State Agency Medical Directors (AMDG) group, the Collaborative members selected its first four topic areas:

- Obstetrics
- Cardiology (Appropriateness of Cardiac Interventions)
- Potentially Avoidable Readmissions
    - Accountable Payment Model
- Spine Care/Low Back Pain

At its July 2013 meeting, the Collaborative discussed topics to work on over the next 3-5 years. The group considered eight proposed topics that were each evaluated across 11 criteria. After further discussion, the Collaborative members selected its next two topic areas:

1. End of Life/Advanced Planning
2. Addiction/Dependence Treatment

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

Obstetrics

Background

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

The Collaborative formed an obstetrics (OB) workgroup in fall 2011 to review OB data and recommend a strategy for the Collaborative to effectively decrease variation and improve outcomes in OB care. The workgroup included representatives from all stakeholder groups, including four clinicians with expertise in obstetrics and gynecology representing various delivery systems in Washington State. (*See Appendix A for list of OB workgroup members*.)

In August 2012, the Collaborative adopted the final report of the workgroup. The report identified three focus areas and goals for OB improvement:

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

The report also included detailed recommendations for each stakeholder group: hospitals, purchasers, Washington State, individual providers, and health plans. The workgroup organized the recommendations in a quality improvement framework that includes five areas:

1. Strong leadership and commitment to quality improvement.
2. Evidence-based or tested clinical guidelines and protocols.
3. Transparency of selected OB procedures, by facility.
4. Patient education.
5. Realignment of financial and non-financial incentives.

The HCA administrator approved adoption of the recommendations in October 2012 and the final report was sent to over 1,000 OB and quality stakeholders thanks to the help of Collaborative members, the Washington State Department of Health and WSHA.

Progress in Year Two

The HCA has focused its efforts on the implementation of three recommendations from the report: promote widespread adoption of clinical data to capture labor and delivery practices, add Collaborative goals to the Medicaid Quality Incentive Program, and increase patient education. The HCA is also considering the addition of elective C-section rates as a performance measure with Medicaid plans in contracts for 2014.

Mr. Hill and Collaborative staff have also continued to promote the OB report within the community, including a presentation to Medicaid health plans at the HCA Managed Care Operations Meeting on April 12. Several employers have taken steps to implement the

recommendations, including Boeing, Microsoft, King County, Carpenters Trust of WA, and Costco.

Next Steps

The OB workgroup is considering re-opening the OB report to include a recommendation about establishing participation in OB COAP (Obstetric Clinical Outcomes Assessment Program) as a community standard. OB COAP, a statewide quality improvement program housed at the Foundation for Health Care Quality (FHCQ), currently includes about one-third of the deliveries in Washington State. The BIT will consider whether a subgroup should be formed to gather more information and convene a meeting to discuss this further.

Cardiology (Appropriateness of Cardiac Interventions)

Background

Percutaneous Coronary Intervention (PCI) is a critical yet expensive tool in the management of coronary heart disease. Between 12,000 and 15,000 of these procedures are performed in Washington State each year. The majority are done emergently for acute condition, but a significant number are done on an "elective" non-acute basis. Widely accepted national guidelines exist which allow the appropriateness of both emergent and non-acute PCI procedures to be classified if the necessary data is available.

Data from COAP (Clinical Outcomes Assessment Program), another FHCQ program, show that wide variation exists among hospitals in Washington State regarding the proportion of PCIs that are performed appropriately as defined by these national guidelines. Another issue is that some hospitals do not routinely collect or reliably document all of the information necessary to evaluate the appropriateness of a non-acute procedure. Missing or insufficient data thereby hinders efforts to identify appropriate practice patterns and facilitate highly effective and efficient care.

In February 2012, the Collaborative asked the COAP management committee to publicly post hospitals' insufficient information reports and appropriateness of PCI results. At that point, hospital-specific data and analyses were only available within the password-protected member's section. The Collaborative believed that making this data publicly available would incentivize hospitals to improve data collection and documentation. The COAP management committee approved the Collaborative's request and agreed to provide technical assistance to hospitals to reduce the amount of missing data and improve the ability to classify the appropriateness of procedures.

At the Collaborative's recommendation, COAP used a four-step process that provided time for hospitals to improve their practices before data became publicly available:

- Step 1: An appropriate use insufficient information report (2012 data) by hospital will be posted on the COAP members-only section of the COAP website. *Target date: August 1st, 2012.*
- Step 2: COAP will provide feedback to hospitals and tools for reducing the amount of insufficient information in their data. *Target date: August – December 2012.*
- Step 3: An updated appropriate use insufficient information report (based on 4th Quarter 2012 data only), by hospital, will be given to the Bree Collaborative and hospitals to

review. Hospitals will have the option not to be identified. *Target date: April 15th, 2013.*

- Step 4: Once hospitals have been given a chance to employ methods for improvement, and any corrections they might have made have been incorporated, an updated report (based on 4th Quarter 2012 data only) will be posted on the public section of the COAP website. The Bree Collaborative will also ask the Puget Sound Health Alliance to post COAP data on its Community Checkup website, which compares data on health care services across the Puget Sound region, on a quarterly basis. Hospitals will have the option to not be identified. *Target date: May 1st, 2013.*

COAP completed Step 1 in August 2012 and Step 2 in December 2012, as planned.

Progress in Year Two

The Collaborative adopted a final report on its cardiology recommendations on January 31st, 2013. (The report is posted on the Collaborative website here.) The Collaborative submitted the report to the HCA for consideration and review on March 19, 2013.

COAP provided an updated appropriate insufficient information report by hospital (Step 3) in May 2013. Every hospital in the state agreed to be identified in an updated report that was posted on the public section of the COAP website (Step 4) in July 2013.

Next Steps

COAP plans to monitor rates of insufficient information and PCI appropriateness to assess whether public disclosure had any impact. COAP staff will also assess other potential focus areas in which it could partner with the Collaborative.

Potentially Avoidable Readmissions

Background

Potentially avoidable readmissions (PARs) are common and costly events. It is estimated that nationally, the cost for unplanned or potentially avoidable readmissions in 2004 was $17.4 billion. The PAR rate is increasingly seen as a reflection of a local health care system's ability or inability to coordinate care for patients across the health care continuum. A high PAR rate is often a sign of inadequate discharge planning during transitions of care. Reducing PAR is therefore an opportunity to improve quality and reduce health care costs in Washington State.

The Collaborative approved the PAR workgroup charter in May 2012. (*See Appendix A for a list of PAR workgroup members.*) The workgroup identified three strategies to pursue:

1. Alignment with local readmissions activities: Identify alignment opportunities where the Collaborative can promote and augment current evidence-based, quality improvement initiatives aimed at reducing PARs including effective communication, coordination of care and 'patient hand-offs' during transitions in care settings.
2. Measurement, Transparency and Reporting: Support use of current process and outcome measures for reducing PARs and transparency of methodologies and readmissions rates, by hospital and physician group, in a semi-public manner.
3. Accountable Payment Model: Research and recommend components and structures essential to creating a successful PAR accountable payment model that aligns incentives,

including warranty pricing, bundled payments, and other innovative payment methodologies.

The Collaborative formed an Accountable Payment Model (APM) subgroup to make recommendations to the PAR workgroup on the third strategy. The APM group will be discussed in the next section.

Progress in Year Two

The PAR workgroup has met twice in 2013 (seven times total). In January 2013, the Collaborative approved two PAR workgroup recommendations:

1. The Collaborative should say that WSHA and its community partners are on the right track of developing a standardized tool kit and process that both hospitals and community providers can use to reduce the rate of readmissions.
2. Steve Hill should send a letter to Qualis and WSHA on behalf of the Collaborative asking that they publish 30-day, all-cause readmission results, by hospital, in a semi-public manner, starting with the next Hospital Readmission Report.

WSHA sent a letter to Mr. Hill on March 6th declining the request to publish additional readmission data because the currently available data was not risk-adjusted.

Four members of the workgroup have left the Collaborative, including the chair. In May 2013, the PAR workgroup reported that it was in hiatus but planned to pursue two tracks:

1. Wait for the WSHA tool kit to be finalized and pilot results are known and then work on operationalizing it and developing incentives to encourage standardized implementation of it across the state (probably in September).
2. Payment reform, to be carried out by the APM subgroup.

The Puget Sound Health Alliance hosted a meeting in July to review hospital-specific, unblinded CHARS data about 30-day, all-cause readmissions. The Foundation for Health Care Quality had purchased this data from the Washington State Department of Health and Collaborative staff had hired a statistician to conduct the analysis. At this meeting, the group decided to add sample sizes and confidence intervals to the charts before further distribution. The Collaborative approved posting a final version of this unblinded data on the Collaborative website on September 25th, and the data was posted on October 18th. (The data is available here.)

Next Steps

Collaborative staff will prepare a summary report about the PAR workgroup for review at the November meeting. At that time, the group will decide whether the PAR workgroup should be formally dissolved.

Accountable Payment Model

Background

Accountable payment models (APM) such as warranties or bundle payments can be used to

reduce readmissions by creating a stronger incentive for providers to ensure that health care is safe, appropriate, high-quality, and affordable. These models lead to better outcomes and lower costs by aligning purchasing and payment with the adoption of best practices.

The PAR workgroup convened the APM subgroup with the charge of developing a warranty and bundled payment model for one episode of focus. The APM subgroup includes members from three provider groups, two purchasers, two health plans, Qualis, and the Puget Sound Health Alliance. (*See Appendix A for a list of APM subgroup members.*)

The APM subgroup had its first meeting in November 2012 and selected total knee and total hip replacement (TKR/THR) surgery as its episode of focus.

Progress in Year Two

The APM subgroup has now held fifteen meetings. At its December 2012 meeting, the subgroup developed the following criteria for selecting APM models:

- Addresses overall goal: reduces costly avoidable readmissions
- Simple to implement and administer
- Built on evidence/consensus-based best practices
- Field tested (preferred, not required)
- Aligned with proven national metrics & programs
- Performance-based reimbursement
- Includes quality metrics
- Aligned with reducing the cost of care

In developing the draft warranty, the APM subgroup considered existing TKR/THR warranty and bundle payment models and initiatives such as the work of the High Value Healthcare Collaborative, which includes 19 medical centers across the U.S. and the U.S. Department of Defense. The subgroup also reviewed data from both public and private sources (Medicare and Premera) about the prevalence of TKR/THR surgeries in Washington State and the timing and cause of readmissions for TKR/THR patients. Finally, the APM subgroup solicited clinical input from orthopedic leaders across Washington State.

The Collaborative requested public comment on the draft warranty for a two-week period (6/19-7/3) and received responses from 46 people, including 19 orthopedic surgeons. After review of this feedback and subsequent revision, the Collaborative approved the final warranty on July 18th. (The final TKR/THR warranty is available here.) The warranty was formally submitted to the HCA Director on September 10th.

The contents of the draft bundle were informed by a rigorous evidence appraisal process that used a standardized search protocol and included the most reliable evidence sources before proceeding to society guidelines and individual citations. Two reviewers independently evaluated each citation, and the resulting evidence table was posted for public comment along with the bundle for a two-week period (10/11-10/25).

The subgroup also reviewed data about readmission rates following TKR/THR surgery, both by hospital and for the state as a whole. A blinded summary of this data was posted to the

Collaborative website on October 18th and WSHA has helped the Collaborative raise awareness about the availability of this data. Hospitals have also been encouraged to request unblinded data for their own institution; several hospital systems have done so. (The data is available here.)

Summary of TKR/THR Products

Product	Brief Description	Status
Warranty	Does not allow reimbursement for care provided within the warranty period that is the result of an avoidable complication attributed to TKR/THR surgery.	Adopted on July 18th
Bundle – Clinical components	Establishes criteria that should be met before a TKR/THR surgery is performed, including documentation of both disability and fitness for surgery. Defines the value-added components that should be included in a bundled payment for TKR/THR, including the surgery itself and post-operative care.	Public comment period 10/11-10/25
Bundle – Quality standards	Recommends process and outcome measures to guide purchasing decisions related to TKR/THR surgeries.	Public comment period 10/11-10/25
Data about Readmissions following TKR/THR	Provides hospitals with information that they can use to guide quality improvement efforts.	Posted on Collaborative website

Next Steps

After reviewing the feedback from the public comment process, the APM subgroup will produce a final draft for presentation at the November 21st Collaborative meeting. The subgroup members have begun preliminary discussions about whether the group will continue its work beyond TKR/THR and, if so, what episode will be selected.

Spine/Low Back Pain

Background

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

The Collaborative chose a two-pronged strategy that enabled it to address both acute and chronic LBP:

1. Form a workgroup to develop recommendations for preventing the transition of acute pain to chronic pain.
2. Recommended that all hospitals participate in Spine SCOAP, a clinician-led quality improvement collaborative for hospitals in Washington State, to improve surgical outcomes for chronic LBP patients.

The Spine/LBP workgroup was approved in October 2012 and had its first meeting in November 2012. The workgroup includes Collaborative members as well as physiatrists, rehabilitation specialists, and pain experts. (*See Appendix A for a list of Spine/LBP workgroup members.*)

In November 2013, the Collaborative recommended that all hospitals participate in Spine SCOAP as a community standard with the following conditions:

- Results are for prospective-based research.
- 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.

At the time this recommendation was made, sixteen hospitals were participating in Spine SCOAP on a voluntary basis. The goal was to have up to 23-25 hospitals participate (which would account for 80% of spine surgeries), and then expand to ambulatory centers so that all people who get spine surgery in Washington State are included.

Progress in Year Two

In March 2013, the HCA requested clarification from the Collaborative about the language used in the Spine SCOAP recommendation. The Collaborative sent a revised recommendation to the HCA in April 2013 and is awaiting a response. (*See Appendix B for a copy of the revised recommendation.*)

The Spine/Low Back Pain workgroup has met thirteen times. After several brainstorming sessions, the workgroup selected the following focus areas:

1. 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.
2. 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.
3. Increase awareness of LBP among individual patients and the general public.

The workgroup reviewed the current literature about best practices, compared the most widely used evidence-based guidelines, and invited guest speakers to give presentations about their innovative research in LBP evaluation and management. Based on this research and the expertise of the workgroup members, the workgroup developed a draft report that includes

recommendations for hospitals/clinics, individual providers, government agencies, health plans, and employers/purchasers.

The Collaborative approved posting the draft report and recommendations for public comment in September. The public comment period took place 10/17-10/30.

Next Steps

After reviewing the feedback from the public comment process, the Spine/LBP workgroup will produce a final draft for presentation at the November 21st Collaborative meeting.

The Collaborative will continue to engage with the HCA about strategies for increasing participation in Spine SCOAP.

End of Life/Advanced Planning

The Collaborative will review a draft charter for the End of Life/Advanced Planning workgroup at its November 2013 meeting and plans to approve the workgroup membership at its meeting in January 2014.

Addiction/Dependence Treatment

The timing of the Collaborative's work in this area will depend on whether the APM workgroup decides to continue its work with another care episode or dissolve. At current staffing levels, the Collaborative can only maintain two active topic area workgroups in addition to the BIT.

Next Steps – Year Three

The Collaborative plans to complete and publish both the TKR/THR bundle and spine report by the end of 2013. The End of Life/Advanced Planning workgroup is expected to begin meeting in January and produce a report and recommendations in June 2014. Topic selection is expected to take place in July 2014.

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

[ii] IOM. 2010. *The healthcare imperative: Lowering costs and improving outcomes: Workshop series summary*. Washington, DC: The National Academies Press.

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

[iv] Mafi JN, McCarthy EP, Davis RB, Landon BE. Worsening trends in the management and treatment of back pain. *JAMA Intern Med* 2013. Doi:10.1001/jamainternmed.2013.8992. Published online July

29, 2013.

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

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

[vii] Weinstein et al, Spine 2006, 31: 2707-14.

Appendix A

Bree Collaborative Members and Committees

Bree Collaborative Members

Member	Title	Organization
Roki Chauhan, MD	Senior Vice President & Chief Medical Officer	Premera Blue Cross
Susie Dade, MS	Deputy Director	Puget Sound Health Alliance
Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
Stuart Freed, MD	Medical Director	Wenatchee Valley Medical Center
Tom Fritz	Chief Executive Officer	Inland Northwest Health Services, Spokane
Joe Gifford, MD	Chief Strategy and Innovation Officer for Western Washington	Providence Health and Services
Richard Goss, MD	Medical Director	Harborview Medical Center – University of Washington
Steve Hill (*Chair*)	Director & Chair	Department of Retirement Systems Chair, Puget Sound
Christopher Kodama, MD	Medical Vice President, Clinical Operations	MultiCare Health System
MaryAnne Lindeblad	Medicaid Director	Health Care Authority
Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
Robert Mecklenburg, MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
Mary Kay O'Neill, MD, MBA	Executive Medical Director	Regence
Robyn Phillips-Madson, DO, MPH	Dean and Chief Academic Officer	Pacific NW University of Health Sciences
John Robinson, MD, SM	Chief Medical Officer	First Choice Health
Terry Rogers, MD (*Vice-Chair*)	CEO	Foundation for Health Care Quality
Kerry Schaefer	Strategic Planner For Employee Health	King County
Bruce Smith, MD	Physician	Group Health Physicians
Jay Tihinen	Assistant Vice President Benefits	Costco Wholesale

Steering Committee

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

Obstetrics Subgroup

Member	Title	Organization
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Ellen Kauffman, MD	OB-COAP Medical Director	Foundation for Health Care Quality
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Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
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Dale Reisner, MD	Obstetrician/Gynecologist	Swedish Hospital Perinatologist
Terry Rogers, MD	CEO	Foundation for Health Care Quality
Roger Rowles, MD	Obstetrician/Gynecologist	Yakima Memorial OB-GYN

Potentially Avoidable Readmissions (PAR) Workgroup

Member	Title	Organization
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Sharon Eloranta, MD	Medical Director, Quality and Safety Initiatives	Qualis Health
Joe Gifford, MD	Chief Strategy and Innovation Officer for Western Washington	Providence Health and Services
Robert Mecklenburg, MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Kerry Schaefer	Strategic Planner For Employee	King County

Accountable Payment Model (APM) Subgroup

Member	Title	Organization
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Joe Gifford, MD	Chief Strategy and Innovation Officer for Western Washington	Providence Health and Services
Bob Herr, MD	Medical Director, Government Programs	Regence
Tom Hutchinson	Practice Administrator	PeaceHealth
Rich Maturi	Senior Vice President, Health Care Delivery Systems	Premera
Gary McLaughlin	Vice President of Finance & CFO	Overlake Hospital
Robert Mecklenburg, MD (*Chair*)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Kerry Schaefer	Strategic Planner For Employee Health	King County
Julie Sylvester	Vice President of Quality and Safety Initiatives	Qualis Health
Jay Tihinen	Assistant Vice President, Benefits	Costco

Spine/Low Back Pain Workgroup

Member	Title	Organization
Neil Chasan	Physical Therapist	Sport Reaction Center
Dan Cherkin, PhD	Head of Clinical Research at Bastyr & Researcher	Bastyr/Group Health Research Institute
Andrew Friedman, MD	Physiatrist	Virginia Mason
Leah Hole-Curry, JD	Medical Administrator	WA State Labor & Industries
Heather Kroll, MD	Rehab physician	Rehab Institute of Washington
Chong Lee, MD	Spine surgeon	Group Health Cooperative
Mary Kay O'Neill, MD, MBA (*Chair*)	Chief Medical Officer for the PNW	Cigna Healthcare
John Robinson, MD, SM	Chief Medical Officer	First Choice Health
Michael Von Korff, ScD	Psychologist & Researcher	Group Health Research Institute
Kelly Weaver, MD	Physiatrist	The Everett Clinic

Bree Implementation Team

Member	Title	Organization
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Patty Hayes, RN	Director, Community Health Services Division	Public Health – Seattle & King County
Christopher Johnson, PhD	Director of Masters of Health Administration Program	University of Washington
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Alice Lind, RN	Manager, Grants and Program Development	Health Care Authority
Dan Lessler, MD (*Chair*)	Medical Director	Health Care Authority
Jason McGill, JD	Health Policy Advisor	Governor's Office
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Mary Kay O'Neill, MD	Executive Medical Director	Regence
Terry Rogers, MD	CEO	Foundation for Health Care Quality
Claudia Sanders	Senior Vice President, Policy Development	Washington State Hospital Association
Jeff Thompson, MD	Senior Health Care Consultant	Mercer
Shawn West, MD	Medical Director	Coordinated Care
Karen Wren	Benefits Manager	Point B

Appendix B

Letter to Health Care Authority with Revised Spine SCOAP Recommendation

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April 15, 2013

Dorothy Teeter
Administrator
Washington State Health Care Authority
P.O. Box 45502
Olympia, WA 98504-5502

Dear Ms. Teeter:

Thank you for your prompt attention and thorough review of the Bree Collaborative's Spine SCOAP recommendation, sent to the Washington State Health Care Authority (HCA) on January 31, 2013. We appreciate your agency's efforts to solicit input from other state agencies as well as engage the Bree Collaborative in your review and implementation process.

At the March 27th Bree Collaborative meeting, Josh Morse presented HCA's legal and regulatory concerns with the term 'community standard' in the Bree Collaborative's Spine SCOAP recommendation. He explained, "'community standard' exceeds the Bree Collaborative's statutory authority by potentially creating a legal standard and participation mandate such that non-participation could be used in other venues to create a presumed violation of a community standard of care; the net effect could have adverse effects in licensing, contracting, or professional negligence litigation." He also explained that neither the Bree Collaborative nor HCA has the degree of regulatory authority that would support such an action.

To clarify, the intent behind the Bree Collaborative's recommendation was not to require or mandate that all Washington State hospitals and ambulatory surgical centers participate in Spine SCOAP. The Bree Collaborative agrees it does not have regulatory or legal authority to mandate participation in specific programs. However, the Bree Collaborative does believe it can advocate for Spine SCOAP to be a community standard – and it has the authority to do so. While 'community standard' maybe a legal term, it is not exclusively a legal term. The Bree Collaborative represents the citizens of Washington State; it is not precluded from recommending a 'standard' that will ultimately improve the quality of care and health care outcomes for the entire community.

In response to both of our concerns, the Bree Collaborative would like to propose the following modifications (shown in tracked changes, below) to our original Spine SCOAP recommendation:

"To approve the Spine SCOAP proposal – that the Collaborative *strongly recommends* ~~establish~~ participation in Spine SCOAP as a community standard, starting with hospitals performing spine surgery[1] - with the following conditions:

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

We look forward to your written response to our suggested modifications and continued dialogue on this issue. We also look forward to working with and hearing from HCA and other state purchasers about your ideas on how to implement the Bree Collaborative's Spine SCOAP recommendation (collect data on all spine surgeries, starting with all hospitals, into the Spine SCOAP registry). For example, contracting is one idea, but other strategies should be considered.

Thank you again for your ongoing support of the Bree Collaborative and its quality improvement efforts. Please contact me if you have any questions.

Sincerely,

Steve Hill
Chair, Bree Collaborative, on behalf of the Bree Collaborative

Cc: Rachel Quinn, Project Manager, Bree Collaborative
MaryAnne Lindeblad, Medicaid State Director, HCA
Nathan Johnson, Health Care Policy Division Director, HCA
Josh Morse, Project Director, HTA, HCA
Jason McGill, Governor's Executive Policy Advisor, Governor's office
Neal Shonnard, MD, Associate Medical Director, Spine SCOAP
Vickie Kolios-Morris, SCOAP Program Director, Spine SCOAP

Members of the Bree Collaborative

Roki Chauhan, MD, Premera Blue Cross
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Gary Franklin, MD, WA State Labor and Industries
Stuart Freed, MD, Wenatchee Valley Medical Center
Tom Fritz, Inland Northwest Health Services
Joe Gifford, MD, Providence Health and Services
Rick Goss, MD, Harborview Medical Center
Anthony Haftel, MD, Franciscan Health Systems
Beth Johnson, Regence Blue Shield
Greg Marchand, The Boeing Company
Steve Hill, Bree Collaborative Chair
Robert Mecklenburg, MD, Virginia Mason Medical Center

[1] Spine SCOAP will begin with hospitals performing spine surgery and will expand to include procedures done at Ambulatory Surgery Centers as well as other non-hospital facilities such as interventional radiology suites.

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Carl Olden, MD, Pacific Crest Family Medicine
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