RCW 70.250.050 Robert Bree collaborative—Duties—Membership.

(1) Consistent with the authority granted in RCW 41.05.013, the authority shall convene a collaborative, to be known as the Robert Bree collaborative. 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.

(2) For each health care service identified, the collaborative shall:

(a) Analyze and identify evidence-based best practice approaches to improve quality and reduce variation in use of the service, including identification of guidelines or protocols applicable to the health care service. In evaluating guidelines, the collaborative should identify the highest quality guidelines based upon the most rigorous and transparent methods for identification, rating, and translation of evidence into practice recommendations.

(b) Identify data collection and reporting necessary to develop baseline health service utilization rates and to measure the impact of strategies adopted under this section. Methods for data collection and reporting should strive to minimize cost and administrative effort related to data collection and reporting wherever possible, including the use of existing data resources and nonfee-based tools for reporting.

(c) Identify strategies to increase use of the evidence-based best practice approaches identified under (a) of this subsection in both state purchased and privately purchased health care plans. Strategies considered should include, but are not limited to: Identifying goals for appropriate utilization rates and reduction in practice variation among providers; peer-to-peer consultation or second opinions; provider feedback reports; use of patient decision aids; incentives for appropriate use of health care services; centers of excellence or other provider qualification standards; quality improvement systems; and service utilization and outcomes reporting, including public reporting. In developing strategies, the collaborative should strongly consider related efforts of organizations such as the Puget Sound health alliance, the Washington state hospital association, the national quality forum, the joint commission on accreditation of health care organizations, the national committee for quality assurance, the foundation for health care quality, and, where appropriate, more focused quality improvement efforts, such as the Washington state perinatal advisory committee and the Washington state surgical care and outcomes assessment program. The collaborative shall provide an opportunity for public comment on the strategies chosen before finalizing their recommendations.

(3) If the collaborative chooses a health care service for which there is substantial variation in practice patterns or a high or low utilization trend in Washington state, and a lack of evidence-based best practice approaches, it should consider strategies that will promote improved care outcomes, such as patient decision aids, provider feedback reports, centers of excellence or other provider qualification standards, and research to improve care quality and outcomes.

(4) The governor shall appoint twenty members of the collaborative, who must include:

(a) Two members, selected from health carriers or third-party administrators that have the most fully insured and self-funded covered lives in Washington state. The count of total covered lives includes enrollment in all companies included in their holding company system. Each health carrier or third-party administrator is entitled to no more than a single position on the collaborative to represent all entities under common ownership or control;

(b) One member, selected from the health maintenance organization having the most fully insured and self-insured covered lives in Washington state. The count of total lives includes enrollment in all companies included in its holding company system. Each health maintenance organization is entitled to no more than a single position on the collaborative to represent all entities under common ownership or control;

(c) One member, chosen from among three nominees submitted by the association of Washington health plans, representing national health carriers that operate in multiple states outside of the Pacific Northwest;

(d) Four physicians, selected from lists of nominees submitted by the Washington state medical association, as follows:

(i) Two physicians, one of whom must be a practicing primary care physician, representing large multispecialty clinics with fifty or more physicians, selected from a list of five nominees. The primary care physician must be either a family physician, an internal medicine physician, or a general pediatrician; and

(ii) Two physicians, one of whom must be a practicing primary care physician, representing clinics with less than fifty physicians, selected from a list of five nominees. The primary care physician must be either a family physician, an internal medicine physician, or a general pediatrician;

(e) One osteopathic physician, selected from a list of five nominees submitted by the Washington state osteopathic medical association;

(f) Two physicians representing the largest hospital-based physician systems in the state, selected from a list of five nominees submitted jointly by the Washington state medical association and the Washington state hospital association;

(g) Three members representing hospital systems, at least one of whom is responsible for quality, submitted from a list of six nominees from the Washington state hospital association;

(h) Three members, representing self-funded purchasers of health care services for employees;

(i) Two members, representing state purchased health care programs; and

(j) One member, representing the Puget Sound health alliance.

(5) The governor shall appoint the chair of the collaborative.

(6) The collaborative shall add members to its membership or establish clinical committees for each therapy under review by the collaborative for the purpose of acquiring clinical expertise needed to accomplish its responsibilities under this section and RCW 70.250.010 and 70.250.030. Membership of clinical committees should reflect clinical expertise in the area of health care services being addressed by the collaborative, including clinicians involved in related quality improvement or comparative effectiveness efforts, as well as nonphysician practitioners. Each clinical committee shall

include at least two members of the specialty or subspecialty society most experienced with the health service identified for review.

(7) 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.

(8) A person serving on the collaborative or any of its clinical committees shall be immune from civil liability, whether direct or derivative, for any decisions made in good faith while pursuing activities associated with the work of collaborative or any of its clinical committees.

(9) 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 in any cause of action occurring as a result of health care.

(10) The collaborative shall actively solicit federal or private funds and in-kind contributions necessary to complete its work in a timely fashion. The collaborative shall not accept private funds if receipt of such funding could present a potential conflict of interest or bias in the collaborative's deliberations. Available state funds may be used to support the work of the collaborative when the collaborative has selected a health care service that is a high utilization or high-cost service in state purchased health care programs or the health care service is undergoing evaluation in one or more state purchased health care programs and coordination will reduce duplication of efforts. The collaborative shall not begin the work described in this section unless sufficient funds are received from private or federal resources, or available state funds.

(11) No member of the collaborative or its committees may be compensated for his or her service.

(12) The proceedings of the collaborative shall be open to the public and notice of meetings shall be provided at least twenty days prior to a meeting.

(13) All meetings of the collaborative, including those of a subcommittee, are subject to the open public meetings act.

(14) The collaborative shall 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. [2015 c 21 s 1; 2011 c 313 s 3.]

Findings—Intent—2011 c 313: "(1) The legislature finds that:

(a) Efforts are needed across the health care system to improve the quality and cost-effectiveness of health care services provided in Washington state and to improve care outcomes for patients.

(b) Some health care services currently provided in Washington state present significant safety, efficacy, or cost-effectiveness concerns. Substantial variation in practice patterns or high utilization trends can be indicators of poor quality and potential waste in the health care system, without producing better care outcomes for patients.

(c) State purchased health care programs should partner with private health carriers, third-party purchasers, and health care providers in shared efforts to improve quality, health outcomes, and cost-effectiveness of care.

(2) The legislature declares that collaboration among state purchased health care programs, private health carriers, third-party purchasers, and health care providers to identify appropriate strategies that will increase the effectiveness of health care delivered in Washington state is in the best interest of the public. The legislature therefore intends to exempt from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine, for activities undertaken pursuant to efforts designed and implemented under this act that might otherwise be constrained by such laws. The legislature does not intend and does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state and federal antitrust laws including, but not limited to, agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services.

(3) The legislature intends that the Robert Bree collaborative established in section 3 of this act provide a mechanism through which public and private health care purchasers, health carriers, and providers can work together to identify effective means to improve quality health outcomes and cost-effectiveness of care. It is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers." [2011 c 313 s 1.]