

Bree Collaborative Meeting



July 27, 2022 | Zoom Meeting

Formal VOTE whether to continue with virtual/remote meetings

Agenda



- **Welcome and Introductions**
 - Adopt May Meeting Minutes
 - COVID-19 Check-In
- **Final Adoption:** Opioid Prescribing in Older Adults
- **Public Comment:** Infection Control
- **Discussion:** New Topics Selection Process for 2023
- **Next Steps and Close**

Final Approval: Opioid Prescribing in Older Adults



July 27, 2022 | Bree Collaborative Meeting

Workgroup Members



- Gary Franklin, MD, MPH (Co-chair), Washington State Department of Labor and Industries
- Darcy Jaffe, MN, ARNP, NE-BC, FACHE (Co-chair), Washington State Hospital Association
- Mark Sullivan, MD, PhD (Co-chair), University of Washington
- Judy Zerzan-Thul, MD, MPH (Co-chair), Washington State Health Care Authority
- Carla Ainsworth, MD, MPH, Iora Primary Care - Central District
- Denise Boudreau, PhD, RPh, MS, Kaiser Permanente Washington Health Research Institute
- Siobhan Brown, MPH, CPH, CHES, Community Health Plan of Washington
- Rose Bingham, Patient Advocate
- Pam Davies, MS, ARNP, FAANP, University of Washington / Seattle Pacific University
- Elizabeth Eckstrom, MD, Oregon Health Sciences University
- James Floyd, MD, University of Washington School of Medicine
- Nancy Fisher, MD, Ex Officio
- Jason Fodeman, MD, Washington State Department of Labor and Industries
- Debra Gordon, RN, DNP, FAAN, University of Washington School of Medicine
- Shelly Gray, PharmD, University of Washington
- Clarissa Hsu, PhD, Kaiser Permanente Washington Research Institute
- Michael Parchman, MD, Kaiser Permanente Washington Research Institute
- Jaymie Mai, PharmD, Washington State Department of Labor and Industries
- Wayne McCormick, MD, University of Washington
- Kushang Patel, MD, University of Washington
- Elizabeth Phelan, MD, University of Washington
- Dawn Shuford-Pavlich, Department of Social and Health Services
- Steven Stanos, DO, Swedish
- Angela Sparks, MD, Kaiser Permanente Washington
- Gina Wolf, DC, Wolf Chiropractic Clinic

Background



- 2018 – AHRQ highlighted increasing rates of opioid-related hospitalizations in older adults, with the highest reported median rates in Oregon and Washington.
- While opioid prescribing and mortality specific to prescribed opioids have fallen between 2017-2018, the CDC reported that the specific opioid related mortality rate for persons ≥ 65 years increased by 4.8%.



Wilson N, Kariisa M, Seth P, et al. Drug and opioid-involved overdose deaths, United States, 2017-2018. *Morb Mortal Wkly Rep* 2020; 69:290–297. URL: <http://dx.doi.org/10.15585/mmwr.mm6911a4external icon>, Accessed 4/1/2021

Opioid-related harms are increasing among older adults



- Even when using as directed more likely to experience
 - Adverse drug reactions
 - Falls and fractures
 - ED visits, hospitalizations, and death,
- Exacerbate pre-existing conditions
 - Cognitive impairment
 - Compromised respiration
 - Hypogonadism
 - Osteoporosis
 - Frailty (or diminished physical reserve)
 - Other substance (e.g., alcohol) use disorders.

Unrecognized cognitive decline may lead to accidental poisoning or overdose

<https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/opioids-older-adults-techbrief.pdf>

Unique Challenges for Assessment and Management



- Age-related changes in pain perception and thresholds
 - Differential aging effects = more or less vulnerability
- Responses to medication
 - higher peak drug levels, delayed clearance, longer duration of action and higher rates of side effects
- Comorbidities (medical and psychological), resulting in polypharmacy
- Psychosocial concerns, and lack of care coordination

Take home message

An integrated, coordinated, and individualized approach may be particularly important in the Medicare population to assure optimal pain management

Focus Areas



- 1. Acute prescribing including acute injuries and peri-operative**
Goal: Prevent transition to chronic prescribing
- 2. Co-prescribing with opioids (e.g., sedative hypnotics, gabapentinoids, z-drugs)**
Goal: Reduce impacts on cognition, falls, delirium
- 3. Non-opioid pharmacologic pain management**
Goal: Evidence base and risk/benefit
- 4. Non-pharmacologic pain management**
Goal: Evidence base and risk/benefit (e.g., CBT, active exercise)
- 5. Intermittent opioid therapy**
Goal: Allow very intermittent use for chronic/recurrent pain
- 6. Tapering/deprescribing in this population**
Goal: Differentiators with recent Bree recommendations for legacy patients

Summary



- There is little high-grade evidence on opioid prescribing/use specific to advancing age by decade of life
 - ~6% opioid naïve adults ≥ 65 transitioned to chronic opioid use
- Approaches to opioid prescribing and pain management should be focused on function and safety
- Start low, go slow and “stop soon”
- **Key recommendations:**
 - Make use of non-pharmacologic pain management modalities
 - Individual care plans
 - Perform comprehensive medication review
 - Coordinate care
 - Use pharmacists in multidisciplinary teams

Public comment issues-mostly minor



- Non-pharm pain management language: For Health Systems-”Provide adequate access to evidence-based nonpharmacologic modalities to manage pain,...”
- Comprehensive medication review-CMS authorized; physician vs health system responsibility
- Availability of Rx and OTC topical meds

Public Comments - General



Commenter	Comments	Response
Shelley Gray	In general, recommend being consistent with how referring to the 2019 AGS Beers Criteria. If want to be more brief, after the first time spelling this out completely, could indicate that these criteria will be referred to as "AGS Beers Criteria" from this point forward. These are referred to differently throughout the document (AGS Beers Criteria, 2019 AGS Beers, etc.)	Replaced references to AGS Beers Criteria with 2019 AGS Beers
Swedish Pain Services	Clinical goals include "Prevent transition to long term opioid use". We suggest modifying this clinical goal to "Prevent unnecessary transition to long term opioid use."	Added suggested language "Prevent unnecessary transition to long term opioid use"

Public Comments – Acute Prescribing



Commenter	Comments	Draft Response
Public Commenter – Opioid Prescriber	<p>"Current mixed opioid agonist/antagonist treatment (e.g. buprenorphine, naltrexone)"</p> <p>Where is the data for this comment coming from? Current literature points away from this being the case. I practice acute pain at Harborview Medical Center in Seattle and commonly take care of people on buprenorphine both for chronic pain and OUD. I do not think that buprenorphine should have a separate row in this table, it should be included in the opioid tolerance row (row 2). Keeping it separate continues the misperception that it is somehow different and more risky than other opioids when in fact it is, if anything, safer</p>	No change. The table was adapted from the 2015 AMDG guideline
Swedish Pain Services	<p>"Risk for Difficult to Control Postoperative Pain"</p> <p>The table is not referenced and if these two categories are actually risks for difficult to control postoperative pain. If these "risks" are not supported by published evidence, we suggest removal from the document.</p>	Added "Adopted from 2015 AMDG Interagency Guideline on Prescribing Opioids for Pain" below table for reference
Public Commenter – Opioid Prescriber	<p>"Track opioid use and signs of potential misuse and related outcomes (e.g., mood, mobility, activities of daily living, sleep, appetite, cognitive impairment, and weight changes)"</p> <p>Many of the things listed above are not relevant for a short <7 day prescription of opioids. It is confusing that things like weight changes, mood, and appetite are listed when they are irrelevant.</p>	Removed examples
Swedish Pain Services	<p>Suggest, "When considering imitating opioids, recommend providing a written treatment plan to patients."</p>	Added to first bullet: "See opioid prescribing rules on acute non- operative and perioperative pain." Added hyperlink to DOH toolkit.

Public Comments – Co-Prescribing



Commenter	Comments	Response
<p>Public Commenter – Opioid Prescriber</p>	<p>"Avoid combining opioids with gabapentinoids. Exceptions are when transitioning from opioid therapy to gabapentin or pregabalin, or when using gabapentinoids to reduce opioid dose, although caution should be used in all circumstances." I agree that one should reduce the co-prescribing of opioids and CNS depressants, however I also know that benzos are much more risky when co-prescribed than gabapentinoids. If gabapentinoids get such strong language, and a point all to themselves, then benzos certainly deserve a bit more!</p>	<p>Clarified bullet 2, sub 2 (page 6) to add at the beginning "Avoid combining opioids with benzodiazepines. If benzodiazepines are prescribed...."</p>
<p>Swedish Pain Services</p>	<p>When co-prescribing with opioids access to behavioral health providers continues to be a significant issues. Recommend including links resources for telehealth options.</p>	<p>Clarified bullet 2, sub 2 to add "provider-to-provider consult..."</p>
<p>Swedish Pain Services</p>	<p>Medication therapy programs are well intended, but continue to create an increased burden on prescribers while offering little guidance with risk assessment and monitoring tools.</p>	<p>Recommend adding language about medication therapy management and referring to health systems recommendations.</p>

Public Comments – Non-Opioid Pharmacologic Pain Management



Commenter	Comments	Response
Public Commenter – Opioid Prescriber	Acetaminophen is rarely indicated for chronic pain as stated page 8 and is also risky	No change. Current language explained the risk associated with acetaminophen
Swedish Pain Services	Last bullet under “Muscle Relaxants”. Consider changing to “In addition, carisoprodol is metabolized to meprobamate, a benzodiazepine metabolite and controlled substance that can contribute to chronic dependency and misuse.”	Added suggested language “In addition, carisoprodol is metabolized to meprobamate, a benzodiazepine metabolite and controlled substance that can contribute to chronic dependency and misuse.”
Shelley Gray	SNRIs are tricky and appear in several recommendations in the Beers. I just wanted to mention that Beers does not recommend to avoid this drug class in most older adults, just in those who have a history of falls (Table 3 of the document—strong recommendation but this applies to ALL antidepressants) and when a person is taking 3 or more CNS active medications (table 5-strong recommendation). This may seem like it is going in the weeds, but I just didn’t want the possibility to exist for someone misunderstanding the recommendation from the Beers Criteria. This might be better phrased as: “The 2019 AGS Beers Criteria has a moderate recommendation to use this class of drugs with caution in older adults. Avoiding SNRIs altogether are recommended in older adults with a history of falls (as with all antidepressants) or those who are taking multiple CNS-active medications.	Kept original language to avoid strong language about avoiding SNRIs altogether.

Public Comments – Non-Opioid Pharmacologic Pain Management



Commenter	Comments	Response
Pam Davies	<p>“Combining gabapentinoids with opioids and benzodiazepines should be avoided, especially in frail older adults, as there is “evidence of substantial harm” with this combination”</p> <p>According to the AGS, combining gabapentinoids with opioids and benzodiazepines should be avoided, especially in frail older adults, as there is “evidence of substantial harm” with this combination (2019, p. 688)</p>	Replaced with “According to 2019 AGS Beers, combining gabapentinoids with opioids and benzodiazepines should be avoided, especially in frail order adults, as there is evidence of substantial harm with this combination.”
Pam Davies	<p>“Since age does not always correlate with physiology, give particular attention to renal function (estimated glomerular filtration rate) when prescribing non- opioid medications for pain.”</p> <p>The first use of abbreviation “GFR” needs to be defined.</p> <p>§ add “eGFR” after mention of: “ (estimated glomerular filtration rate)” on p. 8 § p. 9: abbreviation should be “eGFR” rather than just “GFR” (because a calculation [an estimation] is used for most lab values -- the true GFR is not commonly measured.)</p>	Added “or eGFR” in parenthesis

Public Comments – Tapering



Commenter	Comments	Response
Swedish Pain Services	Again a more robust discussion of the maintain and monitor pathway would be of great assistance to prescribing providers. The focus is on deprescribing and tapering yet in clinical practice many patients cannot be tapered and may need monitoring. This guideline provides little assistance in this regard.	
Marian Wilson	I noticed a redundant bullet point # 2 and 7 about motivational interviewing that can be edited next iteration.	Deleted duplicate bullet 7
Public Commenter – Opioid Prescriber	"Increase use of motivational interviewing approaches to draw on intrinsic motivations to taper." Mentioned twice in same bullet section. You might also refer to the VA's Opioid Taper Decision Tool as a well written and researched tool.	Deleted duplicate bullet 7 and added suggested link
Swedish Pain Services	Consider clarifying definition of "tapering" and "deprescribing" early in the document or deciding to use one, but not both terms.	No change, document defined tapering and deprescribing
Swedish Pain Services	"Transition to medications for opioid use disorder (MOUD)" Suggest "Transition to buprenorphine products as an option for opioid tapering and for patients with needing medication to treat opioid use disorder (MOUD)"	No change. Currently there are 3 FDA-approved medications to treat OUD

Public Comments – Health Delivery Systems



Commenter	Comments	Response
Kara Shirley	<p>“Expand coverage for topical medications.”</p> <p>Most medicare advantage members already have coverage for OTC topical analgesic medications through their medical benefit, although be it plan specific. I would recommend modifying the second bullet to state the following: “1. Individual consideration of topical prescription medication coverage.” I would also recommend a second statement to add however you see fit: 2. “Recommend transparency and ready accessibility of over-the counter- medication benefits for individuals with medicare advantage plans, especially those inclusive of over-the-counter topical and or oral analgesics currently covered.”</p>	<p>Clarified statement with suggested language “Recommend transparency and ready accessibility of over-the counter- medication benefits for individuals with Medicare advantage plans, especially those inclusive of over-the-counter topical and or oral analgesics currently covered.”</p>
Swedish Pain Services	<p>Multidisciplinary pain treatment programs, first dark bullet. Suggest, “Consider creating or collaborating with a multidisciplinary or interdisciplinary pain rehabilitation program, such as Structured Intensive Multidisciplinary Programs (SIMPs) currently offered under L&I coverage, or similar interdisciplinary functional restoration programs that include a rehabilitation-based approach with multiple providers (PT, OT, behavioral health, exercise, pain management, and pain education)</p>	<p>No change. Language came from 2020 Bree Guideline on Long-Term Opioid Therapy</p>

Public Comments – Evidence Review



Evidence Review Section	Commenter	Comments	Response
Acute Prescribing, page 14	Deb Gordon	<p>“Optimal pain control following surgery is important for functional recovery and for reducing the risk of post-surgical complications, and persistent postsurgical pain and is best managed using a multimodal approach.”</p> <p>Suggested edit: Optimal pain control following surgery is important for functional recovery and for reducing the risk of post-surgical complications. Persistent postsurgical pain and is best managed using a multimodal approach.</p>	Clarified statement with suggested language
Co- prescribing, page 18	Swedish Pain Services	<p>The co-prescribing of opioids with CNS-activating medicine is significantly stigmatized in this part of the guideline. The collaborative provides no clear guidance as to when this may be a reasonable option including when encountering patients with psychiatric co-morbidities such as bipolar disorder, post-traumatic stress disorder, severe anxiety, that may or may not be also managed by psychiatry or a behavioral health specialist.</p>	No change
Non- Opioid Pharmacologic: Topical Analgesics, page 22	Swedish Pain Services	<p>Correction. Document states “The use of topical salicylate-containing creams and ointments is widespread and can be confusing; for example, topical diclofenac is marketed under the name Aspercream.” Aspercream contains trolamine salicylate, which is a counter-irritant and not diclofenac.</p>	Removed reference to Aspercream
Non- Opioid Pharmacologic Topical Analgesics, page 23	Pam Davies	<p>p. 23: please add the underlined section to the first words on p.23: <u>§A high dose capsaicin 8% patch (Qutenza®) is also available by prescription</u></p>	Clarified statement with suggested language and removed reference to Brand

Action Steps



Approve Final Draft

Approve for Public Comment Outpatient Infection Control



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Outpatient Infection Control Members



- **Chair:** Mark Haugen, MD, Walla Walla Clinic & Surgical Center
- Anne Sumner, BSN, MBA, Boyer Boyer Bank
- Cathy Carrol, WA Health Care Authority
- Faiza Zafar, DO, FACOI, Community Health Plan of Washington
- Larissa Lewis, MPH, CIC, Washington State Department of Health
- Lisa Hannah, RN, CIC, Washington State Department of Health
- Lisa Waldowski, DNP, CIC, Kaiser Permanente
- Rhonda Bowen, Comagine Health
- Stephanie Jaross, BSN, RN, Proliance Center for Outpatient Spine and Joint Surgery
- Seirra Bertolone-Smith, Pacific Northwest University of Health Sciences

Next Steps



January - Scope and Charter

February - Finalize Charter and Draft Framework

March – Draft Framework, Review Draft Recommendations

April – Outpatient Health Systems

May – Employers and Insurers

June - Public Health and Community Organizations

July - Review Recommendations

August – Public Comment

Focus Areas



Focus Areas	Clinical Goal(s)
Preventative Measures	<ul style="list-style-type: none">• Enact proper precautions and procedures for infection prevention• Use of proper PPE and physical distancing as needed• Encouraging vaccines as a preventative measure• Protect and educate patients and staff
Monitoring/ Surveillance	<ul style="list-style-type: none">• Collect and report data on notifiable conditions• Provide information on circulating infectious diseases to patients and staff• Improve surveillance capacity
Minimizing Exposure	<ul style="list-style-type: none">• Prevent infection from spreading once a positive case is identified• Develop clinical workflows for patients based on their risk or infection status
Environment of Care	<ul style="list-style-type: none">• Ensure clinical environment is regularly clean and facilitates infection control
Sterilization and High-Level Disinfection	<ul style="list-style-type: none">• Practice proper routine device sterilization according to manufacturer instructions• Practice proper high-level disinfection of all devices
Community Spread	<ul style="list-style-type: none">• Partner with patients and communities to mitigate the spread of disease• Educate patients and communities about their risk of disease and what they can do to prevent illness

Audiences



Recommendations are divided based on intended audience. The workgroup made recommendations to:

- Outpatient health systems
- Employers
- Plans
- Public Health Systems
- Patients

Outpatient Health Systems: Prevention



Providers, Staff and Patients

- Inform patients on risk of infection and educate patients on how to mitigate risk
- Enact proper standard, contact, and droplet, and airborne precautions for healthcare providers and staff
- Educate staff on all infection control procedures, including hand hygiene, injection safety, and standard precautions.
- Educate and encourage appropriate vaccination for patients, staff and providers based on the [CDC Immunization Schedule](#) and [ACIP Vaccine Recommendations](#). Recognize common biases and barriers preventing vaccination. Consider motivational interviewing to address vaccine hesitancy.
- Vaccinate staff and providers based on CDC [recommended vaccines for healthcare providers](#) and maintain records of exemptions (required for clinics receiving funding from CMS)
- Staff, providers and patient practice proper hand hygiene, respiratory hygiene/cough etiquette, and mask guidance, injection safety practices
- Treat high-risk populations prophylactically (eg using antivirals and/or monoclonal antibodies) based on current evidence and guidelines.

Outpatient Health Systems: Prevention



Administration

- Assign at least one individual trained in infection prevention to coordinate the outpatient setting's infection control program.
- Provide proper PPE based on standard and transmission-based precautions according to the CDC (Standard Precautions and Transmission-Based Precautions)
- Ensure physical environment is optimized in consideration of infection prevention and control, including placement, and spacing of furniture and ability to clean furniture and other shared items.
- Ensure infection control training and competency for staff (CDC)
- Manage the risk of staff infections according to current guidelines (DOH)
- Provide appropriate time off for infectious disease considering potential incubation period and infectious period (in alignment with DOH recommendations for staff exposure risk and staff shortage requirements)

Outpatient Health Systems: Monitoring



Monitoring/Disease Surveillance

- Provide information to patients about the prevalence of circulating communicable diseases as available from local public health jurisdictions, Washington state Department of Health, the Centers for Disease Control, and other sources.
- Coordinate with appropriate level of public health for reportable infectious diseases. (Notifiable conditions for Washington state can be found [here](#).)
- Consider providing point-of-care testing for patients and staff members or offer resources regarding where testing is available if unavailable in the outpatient setting.

Outpatient Health Systems: Minimizing Exposure



Currently Infected Patients:

In Office Visit

- Encourage patients to notify staff of arrival prior to entry of building
- Encourage online check in
- Take a home test if available to confirm disease

Telehealth

- Offer phone or virtual visit if triage for visit appropriate
- Follow Bree Collaborative Telehealth guidelines

Referral

- Refer to Urgent Care or ER if appropriate and necessary for higher level of care or if infection prevention and control requirements exceed that of the facility.
- Notify receiving entity of patient infection status

Outpatient Health Systems: Environment of Care



Environment of Care:

- Maintain ventilation systems
- Provide easily accessible masks, hand sanitizer, and garbage cans
- Ensure all surfaces are cleanable
- Ensure clear separation between clean and dirty storage
- Appropriate storage of supplies and regular review expiration dates of medications and equipment
- Ensure physical environment is optimized in consideration of infection prevention and control, including placement, and spacing of furniture and ability to clean furniture and other shared items.

Outpatient Health Systems: Environment of Care



Sterilization and High-Level Disinfection

- Develop plans for routine device sterilization and environmental cleaning
- Practice proper reprocessing and sterilization of reusable devices
- Follow nationally recognized and evidence-based guidelines and follow manufacturer's instructions for use (MIFUs)

Community Spread

- Participate in community health meetings and establish relationships prior to an outbreak
- Participate in infection control meetings convened by local public health
- Partner with community leaders and media for information campaigns
- Provide educational material about preventative measures and treatments

Plans



Prevention

- Cover at-home and in-person testing for circulating illness
- Provide incentives for vaccination as a prevention measure. Educate and encourage appropriate vaccination based on the [CDC Immunization Schedule](#) and [ACIP Vaccine Recommendations](#).
- Cover cost of vaccination and administration
- Consider increase physician payment for patient infectious disease control measures, and vaccine education including addressing hesitancy.
- Consider continuing telehealth reimbursements
- Consider infection control targets/measures in value-based purchasing

Other Areas:

- Cover prophylactic treatments for high-risk populations
- Work with infected patients in a declared pandemic to remove financial barriers to treatment such as waiving copays, reducing deductibles, or identifying qualified charity care.
- Participate in educational campaigns to support current preventive measures and treatments

Employers



Prevention

- Provide incentives for testing
- Provide incentives for vaccination as a preventative measure. Educate and encourage appropriate vaccination based on the CDC Immunization Schedule and ACIP Vaccine Recommendations. Provide educational sessions with experts and trusted community leaders to address vaccine hesitancy and misinformation.
- Provide workers with face coverings and surgical masks as appropriate as well as PPE required by the position.
- Provide appropriate paid time off for infectious disease based off transmission time and/or current physical symptoms.
- Follow current guidelines for quarantine or isolation procedures for infected and/or exposed employees and create policy for management and staff.
- Provide appropriate PPE and spacing if deemed necessary for infectious control.
- Implement protections from retaliation for employees who report failures to comply.
- Follow any other applicable mandatory Washington State Labor and Industries and OSHA standards for workplace disease prevention.

Employers



Other Areas:

- Record and report reportable infections and deaths to the appropriate authority, usually the local public health jurisdiction, OSHA, WA Labor and Industries, or the Department of Health
- If a symptomatic employee does need to come to work, consider minimizing exposures through PPE, proper hand hygiene, and encouraging alternative work structures
- Follow other applicable mandatory Washington state Labor and Industry and OSHA standards to minimize workplace exposures.
- Perform routine cleaning and disinfection
- Improve infrastructure for infection control such as spacing and barriers
- Create workflows to minimize exposure during times of high community spread using virtual meetings, work from home and physical distancing as necessary
- Educate workers on Infectious Disease policies and procedures in accessible formats

Public Health



Prevention

- Communicate up-to-date preventative guidelines to other public health agencies, health delivery systems, providers, and patients as appropriate.
- Expand access to vaccines and ensure efficient roll-out of vaccine programs.
- Align/coordinate communication efforts between state- and local- public health
- Consider hiring staff to maintain communication and coordination efforts including alignment with other public health agencies and providing information to the public
- Include local voices from patients and physicians when developing guidelines and revise guidance based on community input.

Other Areas:

- Develop and maintain accessible dashboards for communicable diseases
- Maintain accessible registries of immunization records
- Provide technical assistance and education in a non-regulatory process to outpatient health facilities (ICAR)
- Provide public communication campaigns on infection control and community spread of infectious diseases

Patients/Community Members



Prevention

- Keep appropriate preventative products at home, including hand sanitizer and masks
- Wash your hands or use alcohol-based hand sanitizer frequently
- Wear an appropriate face covering or mask when needed, according to current CDC guidelines
- Get appropriate vaccinations per ACIP schedule

Monitoring/Disease Surveillance

- Have appropriate home tests available and use if you develop relevant symptoms or are in close contact with a confirmed case per testing guidelines
- Stay current on the prevalence of disease in your community using local and national web tools or other available sources.
- Discuss your personal health risk for community infectious diseases with a trusted healthcare provider
- Report your disease status to the appropriate authorities to assist with disease prevalence data if you test positive

Minimizing Exposure

- Follow [CDC mask guidelines](#) or your local county's guidelines when to wear a mask or face covering,
- Follow the [WA Department of Health recommendations](#) for people at higher-risk of serious illness to minimize your exposure
- Stay home or contact your healthcare provider if you have a fever or are contagious within 24 hours before a scheduled appointment.

Thank you!



Action: Approve for Public Comments

External Partner Perspective

July 27, 2022 | Bree Collaborative Meeting



- **Agency Medical Directors Group**
Gary Franklin, MD

- **Washington State Hospital Association**
Darcy Jaffe, MN, ARNP, FACHE

- **Washington Health Alliance**
Sharon Eloranta, MD

Agency Medical Directors Group



- Integrating exercise & behavioral health
- Implementation of Bree guidance
- Skill-level requirements for behavioral health



Washington State Hospital Association

WHA recommendations for Bree topics/areas of focus

- Digital Health
- Behavioral Health
- Reimbursement (value based contracting, bundles)
- Recommendations on benefit design that removes barriers to high value patient care, including access barriers associated with social determinants of health
- Updates to existing Bree initiatives – some have been around for a while and could use a refresh
- Consider Bree recommendations in all State-funded plans.
- Drug pricing, increasing affordability
- Reducing impact of institutional racism on access to care
- Seeking input and expanding USE – get feedback from potential implementers and develop plans to expand use of the recommendations

Offer: WHA's QIC would like to work with the Bree to combine efforts to bring about something that is impactful in moving quality and cost issues forward.

Discussion: New Topics

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Our Guidelines



- **Pain (chronic and acute)**
 - *Collaborative care for chronic pain (2018)*
 - *Low back pain management (2013)*
 - *Opioid prescribing metrics (2017)*
 - *Opioid prescribing for postoperative pain (2018)*
 - *Opioid prescribing in dentistry (2017)*
 - *Long-term opioid prescribing management (2019)*
 - *Opioid prescribing in older adults (2021)*
- **Behavioral Health**
 - *Integrating behavioral health into primary care (2016)*
 - *Addiction and substance use disorder screening and intervention (2014)*
 - *Suicide care (2018)*
 - *Treatment for opioid use disorder (2016)*
 - *Prescribing antipsychotics to children and adolescents (2016)*
 - *Risk of violence to others (2019)*
- **Oncology**
 - *Oncology care: breast and prostate (2015)*
 - *Prostate cancer screening (2015)*
 - *Oncology care: inpatient service use (2020)*
 - *Colorectal cancer screening (2020)*
 - *Cervical cancer screening (2021)*
- **Procedural (surgical)**
 - *Bundled payment models and warranties:*
 - *Total knee and total hip replacement (2013, re-review 2017, rereview 2021)*
 - *Lumbar fusion (2014, re-review 2018)*
 - *Coronary artery bypass surgery (2015)*
 - *Bariatric surgery (2016)*
 - *Hysterectomy (2017)*
 - *Data collection on appropriate cardiac surgery (2013)*
 - *Spine SCOAP (2013)*
- **Reproductive Health**
 - *Obstetric care (2012)*
 - *Perinatal bundle (2019-2021)*
 - *Reproductive and sexual health (2020)*
- **Aging**
 - *Advance care planning for the end-of-life (2014)*
 - *Alzheimer's disease and other dementias (2017)*
- **Palliative care (2019)**
- **Hospital readmissions (2014)**
- **LGBTQ health care (2018)**
- **Shared decision making (2019)**
- **Primary care (2020)**
- **Telehealth (2021)**
- **Infection Control (2022)**
- **Hepatitis C (2022)**
- **Pediatric Asthma (2022)**

What does success look like for the Bree Collaborative?



- Engagement, changes in clinical practice, improvement in outcomes
- The work of the Collaborative is considered valuable to and used by the entire healthcare ecosystem.
- The ability to create high value, high impact practice guidance that can be implemented with measurable impacts
- Having a positive impact on health outcomes through education, awareness and support.
- 2 - 3 initiatives per year that result in measurable improvements to both quality AND affordability.
- I think the Bree Collaborative is successful when it gives very direct, tangible steps with its guidelines especially when the evidence has already been reviewed. Tangible steps will help health systems adopt these recommendations without having to then make additional action plans.
- Evidence of implementation and measures of outcomes for some Bree recommendations.



< Activities



Visual settings



Edit



🌐 When poll is active, respond at PolleEv.com/fhcq900

Describe success for the Bree



No responses received yet. They will appear here...

Should we Revise Previous Topics?



Topic	Votes for Revision	Topic	Votes for Revision
Addiction	2	Obstetrics	2
End of Life	1	Opioids - Dentistry	1
Bariatric	1	Opioids - Metrics	1
Cervical Cancer Screening	1	Perinatal	2
Collaborative Care	1	Antipsychotics	2
Colorectal Cancer Screening	1	Risk of Violence	1
Readmissions	3	Shared Decision Making	1
Behavioral Health	2	Suicide	2
LGBTQ	1	Telehealth	1
Opioid – Chronic	1	Opioid Use Disorder	2
Low Back Pain	1		



< Activities



Visual settings



Edit

🌐 When poll is active, respond at **PollEv.com/fhcq900**

Which of our previous topics should we revise?



No responses received yet. They will appear here...

Given what success looks like, and our past topics, which health care services should be our focus for 2023 (including reviewing old topics)?



Proposed Topic	Goal and Clinical Relevance
Climate Change and Health	Potential effects of a changing climate on human health include increased rates of respiratory and heat-related illness, increased prevalence of vector-borne waterborne diseases, food and water insecurity, and malnutrition.
Maternal Mental Health	Considering our behavioral health and maternal and child health topics
Maternal and Child Health Bundle	Addressing implementation of Maternal and Child bundle with innovation of handheld smart phone technology for interventions and measures.
Gender Affirming Care	Improve surgical standards for providing gender affirming care with a focus on adolescent populations.
Optimizing Telehealth	Address specific telehealth concerns related to rural/vulnerable populations that do not have reliable access and/or standards of care for e-visit

Given what success looks like, and our past topics, which health care services should be our focus for 2023 (including reviewing old topics)?



Proposed Topic	Goal and Clinical Relevance
High-Level Disinfection	Related to our outpatient infection control topic, expanding on high-level disinfection practices.
Health Care Disparities	Identify how organizations can gather information on disparities, process it, and define new equity goals. We can then apply this lens to our clinical topics.
Streamlining Primary Care	Primary care is constantly being given new tasks to incorporate into their visits. Identify areas of care that are outdated now and can be retired from practice
Syphilis	Washington state has increasing rates of syphilis and congenital syphilis. We need health systems to develop a comprehensive plan to combat this epidemic.
Reviewing Adoption of Previous Bundles	Conduct a thorough assessment of recommendation adoption including an assessment of impact on clinical practice and patient health as well as alignment with payer policies



< Activities



Visual settings



Edit



🌐 When poll is active, respond at PollEv.com/fhcq900

Given what success looks like, and our past topics, which health care services should be our focus for 2023 (including reviewing old topics)?



No responses received yet. They will appear here...

Where have we seen the highest adoption and why?



- COE bundles because they are tied to payment
- I can only comment on the adoption of low back pain and total joint replacement topics. In our system, both have had 50-75% adoption which I consider to be a relatively high rate. One factor contributing to this is that there are existing efforts of professional societies in these areas and they are relatively concordant with the Bree recommendations.
- I feel like OB/GYN is a hot topic and that Bree's name/information is presented quite often in this area as well as in Opioid prescribing. The reason is probably because it is popular and there is public buy in on both of these.
- Bundled payments for ortho procedures. Bundled payments include measures to reflect adoption.
- Behavioral Health and Opioid use. These have been aligned with current national guidelines and demand for these is very high at all sites of care.


Where have we seen the least adoption and why?




- Pediatric Asthma. Maybe not as much public interest?
- Areas where provider contracting or employer plan design changes are required
- Oncology, Maternal and Child Health. These are guesses since we don't have any current information regarding uptake, implementation, or adoption by any stake holders.



< Activities

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Next Meeting:

Wed, September 28, 2022

1:00 – 3:00 PM

