

Bree Collaborative Meeting



September 28th, 2022 | Zoom Meeting

Agenda



- **Welcome and Introductions**
 - Welcome new Bree staff!
 - Adopt July Meeting Minutes
 - COVID-19 Check-In
- **Final Adoption:** Outpatient Infection Control
- **Public Comment:** Hepatitis C Virus
- **Discussion:** New Topics Selection Process for 2023
- **Next Steps and Close**

Approve Final Draft 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

Public Comment Overview



- Public Commenters represented public health and infection control specialists from health delivery systems.
- The workgroup reviewed 45 comments
 - Clarifying language
 - Defining audiences
 - Changes to "minimizing exposure" section
 - Address equity

Focus Areas



Focus Areas	Clinical Goal(s)
Preventative Measures	<ul style="list-style-type: none">• Institute proper precautions and procedures for infection prevention.• Use of proper PPE and physical distancing as needed.• Encouraging vaccines as a preventative measure or to reduce severity of acute or chronic illness.• 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 cleaned regularly and facilitates infection prevention and 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 or reduce the severity of acute or chronic illness.

Public Comments: Clarifying Language



Public Comments

1. The terms “infection prevention” and “infection control” are used interchangeably throughout the document. The standard phrase should be “infection prevention and control (IPC).”
2. Several times the document mentions vaccines as a preventative measure, although vaccines are also useful for reducing the severity of disease.
3. Some recommendations are overly broad and could be misinterpreted by regulators, administrators, and accreditation groups.

Workgroup Response

1. All references to “infection prevention” or “infection control” were changed to “infection prevention and control” or “IPC”
2. Vaccine language was changed to “encourage vaccines as a preventative measure or to reduce severity of acute or chronic illness”
3. Language was added to the background section to clarify that this guideline is not meant to add to regulatory burden, but to ensure that sites follow guidance from their regulatory agency.

Public Comments: Audiences



Public Comments:

1. Recommend splitting up “Health Administration” and “Healthcare Providers and Staff” as two different audiences under “Outpatient Delivery Systems.”
2. Employer section seems like a lot of duplicated information from outpatient health delivery system administration section.

Workgroup Response:

1. Split Outpatient Delivery System into two separate audiences – Administration and Providers/Staff. Administration focuses on delivery system changes (adding dedicated FTE for IPC activities) while Providers/Staff focuses on individual action (hand hygiene).
2. Added clarifying language to Employer section to define how employers can facilitate outpatient infection control. There will be some overlap, but having a separate section helps target recommendations toward different sectors.

Public Comment: Minimizing Exposure



Public Comments:

1. High-risk vs. low-risk patients involve a lot of overlap. How do we clarify between the groups? Many of the recommendations are the same.
2. There are many other recommendations that can be made toward outpatient health systems administration for minimizing exposure.

Workgroup Response:

1. Suggested workflow for potentially infected patients was simplified.
2. New recommendations added to minimizing exposure that focus on preventing exposures from potentially infected staff members through alternative work options and design of common spaces.

Public Comment: Equity



Public Comments:

1. Add more language about equitable community engagement for infection control – especially for issues like vaccine distribution.

Workgroup Response:

1. Added a sentence to the background section about infection control disparities and a definition of equity. Included language about equitable distribution of vaccines, coverage for other preventative measures, and staff benefits for infection control and prevention.

Thank you!



Action: Approve Final Draft

Approve for Public Comment Hepatitis C



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Hep C Members



- Abha Puri, MPH, Community Health Plan of Washington
- Angelica Bedrosian, MSW, Hepatitis Education Project
- Emalie Huriaux, MPH, Washington State Department of Health
- John Scott, MD, MSc, University of Washington
- Jon Stockton, MHA, Washington State Department of Health
- Judith Tsui, MD, MPH, University of Washington
- Melda Velasquez, Kadlec Regional Medical Center
- Michael Ninburg, MPA, Hepatitis Education Project
- Omar Daoud, PharmD, Community Health Plan of Washington
- Patrick Judkins, Thurston County Health Department
- Ryan Pistoiresi, PharmD, MS, Washington State Health Care Authority
- Wendy Wong, BSc, Providence Health and Services
- Vania Rudolph, MD, MPH, Swedish Health Centers
- Yumi Ando, MD, Kaiser Permanente

Focus Areas: Aligned with Hep C Free Washington and DHHS



Focus Area	Goals
Metrics	<ul style="list-style-type: none">• Incorporate Hepatitis C Virus (HCV) metrics into value-based contracts.• Track incidence and treatment of HCV in Washington.• Encourage increased screening and treatment for HCV.
Care Coordination and Expanding Access	<ul style="list-style-type: none">• Provide appropriate care for HCV patients, especially those with complex social needs or other barriers to accessing care.• Address barriers in the care cascade from screening to treatment.
Embed HCV Access at Community Sites	<ul style="list-style-type: none">• Increase the availability of HCV services outside of traditional clinical sites.• Develop partnerships between providers, care coordinators, and community sites including syringe service programs and addiction treatment facilities.
Utilizing Non-Traditional Models	<ul style="list-style-type: none">• Expand scope of practice of pharmacists and APPs• Adopt clinical models that involve telemedicine access• Use innovative contracts and reimbursement models to increase the availability of HCV treatment.
Engaging Providers	<ul style="list-style-type: none">• Ensure providers are willing and able to provide non-stigmatizing treatment to HCV patients.

Health Delivery Systems



Metrics:

- Develop and incorporate two measures for HCV – one for screening and one for starting patients on treatment.
 - Incorporate the measures into contracts for value-based patients

Care Coordination:

- Review current resources on HCV case management. Offer or expand case management services for HCV patients.

Embed HCV Access in Community Sites:

- Embed HCV services outside of traditional clinical settings, including partnerships with OUD/SUD treatment centers.

Utilize Non-Traditional Models:

- Develop collaborative drug therapy agreements to allow pharmacists to treat HCV patients. Expand access to clinics and providers that treat HCV, including accepting walk-in patients, offering clinic hours outside of the workday, and offering telehealth visits.

Engaging Providers:

- Educate physicians and pharmacists on treatment for HCV patients, especially those that treat related conditions.
- Develop targets to treat patients with HCV and designate providers to reach these targets.

Providers – Clinicians and Pharmacists



Care Coordination:

- Accept new patients living with HCV, especially when referred from care coordinators or case managers.
- Follow AASLD/IDSA guidelines for treating HCV, adopting a person-centered, non-stigmatizing approach.

Embed HCV Access in Community Sites:

- Provide HCV services outside of traditional clinical settings, including syringe-service programs and OUD/SUD treatment facilities.

Utilize Non-Traditional Models:

- Connect pharmacists and physicians through CDTAs. Consider piloting pharmacist-led HCV treatment clinics.

Engaging Providers:

- Engage with interdisciplinary networks for treating HCV that include clinicians, pharmacists, and care coordinators.
- Use provider resources like Project ECHO or UW Hepatitis C online training to understand how to treat HCV patients.

Health Plans



Metrics:

- Develop and incorporate two measures for HCV – one for screening and one for starting patients on treatment.
 - Incorporate the measures into contracts for value-based patients

Care Coordination:

- Offer risk-adjusted pool payments or other alternative payment models for HCV to help support care coordination activities.
- Provide equitable and accessible care coordination services.

Embed HCV Access in Community Sites:

- Embed HCV services outside of traditional clinical settings, including partnerships with OUD/SUD treatment centers.

Utilize Non-Traditional Models:

- Develop contracts that incentivize screening for HCV at community sites.

Engaging Providers:

- Provide educational material to providers about treating patients living with HCV
- Incentivize HCV treatment through novel reimbursement pathways.

Public Health Agencies



Metrics:

- Develop and incorporate two measures for HCV – one for screening and one for starting patients on treatment.
 - Consider adding HCV metrics to the Common Measures Set

Care Coordination:

- Consider providing sustainable funding for HCV care coordination and case management. Ensure funding for HCV care coordination can be used to conduct non-clinical work for connecting patients to resources.

Embed HCV Access in Community Sites:

- Partner with community-based organizations to expand HCV services to community sites. Provide funding for HCV testing events at community sites.

Utilize Non-Traditional Models:

- Continue discounted drug therapy agreements. Provide funding for pharmacists to provide HCV services.

Engaging Providers:

- Develop a region-specific provider outreach campaign with plans, providers, and local public health agencies.

Thank you!



Action Steps: Approve for Public Comment

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 in a 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.

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.

Bree New Topic Criteria

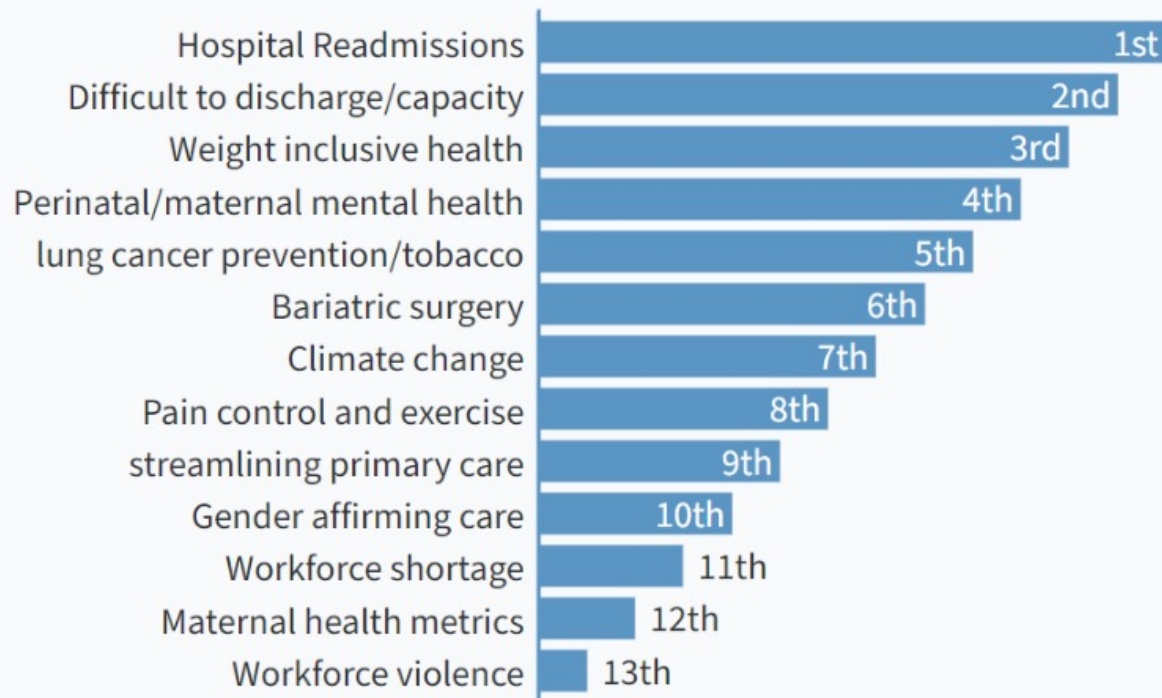


“The Bree Collaborative is charged with identifying health care services annually with **substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues**. For each health care service, the Bree Collaborative identifies and recommends best-practice, **evidence-informed approaches** that build upon existing efforts and quality improvement activities to decrease variation.”

July Meeting Rankings



Rank topics for 2023



Eight Proposed Topics



- Hospital readmissions
- Difficult to discharge/hospital capacity
- Weight inclusive health
- Perinatal/maternal mental health
- Lung cancer prevention/tobacco
- Bariatric surgery
- Climate change
- Diabetes


Preliminary Rankings



- Based on our previous conversation, please rank the proposed topics for 2023.
- This ranking will help guide our conversation on potential topics and next steps, this is not a final vote.

Pollev.com/fhcq900



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

Preliminary Rankings for 2023 Topics

Climate Change

Difficult to Discharge/Capacity

Weight Inclusive Health

Bariatric Surgery

Hospital Readmissions

Lung Cancer Prevention/Tobacco Use

Perinatal/Maternal Mental Health

Diabetes

Weight inclusive health



- Stigma and bias toward those with higher body mass leads to poor physical and mental health. Research has shown that provider obesity bias results in a lower quality of care.
- Weight-inclusive health views health and well-being as multifaceted and directs efforts toward health access and reducing weight stigma.

Bariatric surgery



- The American Society for Metabolic and Bariatric Surgery estimates that 228,000 people in the US underwent a weight loss operation in 2017.
- The Health Care Authority currently considers bariatric surgery to be a “covered benefit with conditions.”

Lung cancer prevention/tobacco



- According to IHME, tobacco use is the #1 risk factor for death and disability, and lung cancer is the second leading cause of death in Washington state.
- According to the American Lung Association, WA state receives in “F” in funding for tobacco prevention and cessation services.

- Diabetes mellitus (DM) affects an estimated 29.1 million people in the United States and is the 7th leading cause of death.
- Approximately 582,000 people in Washington, or 9.7% of the adult population, have diabetes, with an estimated additional 164,000 people in Washington living with undiagnosed diabetes.

Perinatal/maternal mental health



- Perinatal mood and anxiety disorders are among the most common complications that occur in pregnancy or in the first 12 months after delivery.
- Lingering gaps in insurance coverage for behavioral health prevention and treatment as well as stigma and bias are barriers to care.

Climate change



- Potential effects of climate change on human health include higher rates of respiratory and heat-related illness, increased prevalence of vector-borne and waterborne diseases, food insecurity, and malnutrition.
- According to the WHO, between 2030 and 2050, climate change is expected to cause approximately 250,000 additional deaths per year.

Hospital Readmissions



- Hospital readmissions are associated with unfavorable patient outcomes and high costs.
- In 2015, the Washington Health Alliance found that Washington's readmission rate for the commercially insured was 8.7% higher (worse) than NCQA's 90th percentile rate
- The Bree previously addressed "Potentially Avoidable Hospital Readmissions" in January 2014

Difficult to discharge pts/hospital capacity



- Discharging patients to an appropriate and safe environment can be complicated by complex physical, behavioral, or social needs. Solutions will require coordination and collaboration across multiple agencies.
- In 2019 the HCA and DSHS described difficulty to discharge in a joint report, citing lack of coordination with insurance, low reimbursement rates, and staffing shortages.

Eight Proposed Topics



- Hospital readmissions
- Difficult to discharge/hospital capacity
- Weight inclusive health
- Perinatal/maternal mental health
- Lung cancer prevention/tobacco
- Bariatric surgery
- Climate change
- Diabetes

Comments or Questions?

Final Vote Instructions



- We will give 3 – 5 minutes for individual voting.
- Use the link: Pollev.com/fhcq900
- New topic voting is restricted to Bree members.
- Voting is multiple choice – choose up to three new topics.
- This vote will determine the Bree's 2023 topics.



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

Final Vote: Bree 2023 Topics

Climate Change
Difficult to Discharge/Capacity
Weight Inclusive Health
Bariatric Surgery
Hospital Readmissions
Lung Cancer Prevention/Tobacco Use
Perinatal/Maternal Mental Health
Diabetes

Next Steps



Comments or Questions?

Next Meeting

November 16th, 2022

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