Agenda

- Welcome and Introductions
  - Action Item: Adopt Minutes
- Final Adoption: Hep C
  - Action Item: Adopt Guideline
- Public Comment: Pediatric Asthma
  - Action Item: Disseminate Guideline
- Discussion: Member Feedback and Guideline Adoption
  - Action Item: Adopt Roadmap
- Next Steps and Close
2023 Workgroups

• Diabetes
  • Workgroup Chair: Norris Kamo, VMMC

• Maternal/Perinatal Mental Health
  • Workgroup Chair: Colleen Daly, Microsoft

• Difficulty to Discharge
  • Workgroup Chair: Darcy Jaffee, WSHA
Public Comment: Pediatric Asthma
Members

- Annie Hetzel, MSN, RN, OSPI
- Brad Kramer, MPA, Public Health, Seattle & King County
- Christopher Chen, MD, WA Health Care Authority
- David Ricker, MD, Mary Bridge Children’s
- Doreen Kiss, MD, University of Washington
- Edith Shreckengast, MS, Community Health Plan of Washington
- John Lynch, BSN, Community Health of Central Washington
- Kate Hastings, Scientific Consulting Group
- Katie Paul, MD, MPH, Kaiser Permanente
- Kate Guzowski, RN, Community Health of Central Washington
- LuAnn Chen, MD, MHA, Community Health Plan of Washington
- Mark LaShell, MD, Kaiser Permanente
- Michael Dudas, MD, Virginia Mason Medical Center
- Vickie Kolios, MSHSA, Foundation for health Care Quality
To increase evidence-informed screening, diagnosis, monitoring, and treatment for pediatric asthma to improve pediatric asthma control in Washington state.
## Draft Focus Areas

<table>
<thead>
<tr>
<th>Potential Focus Areas</th>
<th>Description</th>
</tr>
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</table>
| **Clinical Setting**          | • Appropriately establish asthma diagnosis and assess for severity and risk.  
                                | • Develop and follow-up with the asthma management plan.  
                                | • Implement appropriate asthma quality metrics                                                                                                                                                          |
| **Home Setting**              | • Ensure access to home-based interventions for children who need environmental management to achieve control.  
                                | • Offer recommendations to manage asthma home-based interventions.                                                                                                                                       |
| **School Setting**            | • Appropriately manage pediatric asthma in schools.  
                                | • Improve communication between school nurses, school-based health centers, and pediatricians/clinical providers                                                                                      |
| **Environmental Exposure**    | • Mitigate the effects of climate change, air pollution, and other environmental triggers on pediatric asthma.  
                                | • Develop strategies to respond to environmental triggers in the built environment.                                                                                                                    |
| **Funding**                   | • Consider alternative funding models for pediatric asthma that prioritize prevention and control to decrease the use of high-cost emergency care or hospital admissions for asthma. |
Audiences

- Health delivery systems
- Clinicians
- Home-based interventions and community health workers
- Schools and school nurses
- Payers and purchasers
- Public health agencies
- Those receiving care (patients/consumers)
Clinical Setting:
- Develop a population health strategy for managing pediatric asthma that includes a registry of pediatric asthma patients, care coordination, event notification system for hospital visits, and asthma metrics stratified by severity and control.

Home Environment:
- Pediatric patients admitted to the hospital for poorly controlled asthma should be referred to home-based interventions where available.

Environmental Exposure:
- Plan for climate mitigation infrastructure including adequate air filtration. Discuss environmental exposure mitigation when educating patients and family members.

Funding:
- Participate in alternative payment models that incentivize high-quality asthma care, especially risk-adjusted primary care capitation models.
Clinicians

Clinical Setting:
• Appropriately establish an accurate asthma diagnosis.
• Assess for asthma severity and control.
• Develop an asthma management plan that includes education, trigger mitigation, and medication management.
• Schedule planned preventative visits for asthma control at least annually.

Home and School Settings:
• Communicate asthma management plan with external partners and the broader care team including school nurses and community health workers.
• Align educational efforts about inhaler use and asthma management with the school-based asthma care plan.
Community Health Workers

Home Setting:
- Home-based, multi-trigger, multicomponent interventions can reduce exposure to many indoor asthma triggers, including allergens and irritants. These interventions should include home visits by trained personnel.
- Consider including non-environmental activities including motivational interviewing to improve asthma self-management, and coordinated care for the asthma client.

Clinical and School Setting:
- Care coordination (whether home-based interventions, community-based organizations, or public health programs), should coordinate activities across care teams, including primary care providers, health plans, schools/child care, and other service providers.
School Setting:

- Identify students with asthma.
- Develop a care plan for all students with asthma and update at least annually.
- Communicate the student’s care plan with parents/caregivers, the student’s pediatrician or other clinical provider, and other school staff, including teachers.
- Ensure healthy school environments for asthma management and control.

Clinical and Home Settings:

- Establish clear lines of communication with the patient’s pediatrician or regular health care provider. Ask the parent/caregiver to complete a release of information form to allow bi-directional communication about the asthma plan.
Funding:

• Cover routine asthma control visits, corticosteroids/rescue treatment, and annual flu shots for children with asthma.

• Provide coverage for pediatric asthma services along the spectrum from fee for service to population-based payments.

• Explore coverage for “in-lieu of services” or “health-related services” payments to cover additional services such as care coordination or trigger mitigation.

• Leverage the Health Care Authority’s Medicaid 1115 waiver and Primary Care Transformation model to move toward population-based payment for asthma management.
Clinical Setting:
- Collect and report data on the number of pediatric asthma cases.

Home Setting:
- Consider supporting community health worker programs, whether developing new public health programs or providing funding for community or clinic-based programs.

School Setting:
- Consider expanding the school-based health center model.
- Develop best practices for managing asthma at childcare centers.

Environmental Exposure:
- Develop preparedness and mitigation plans for extreme weather events and climate change.
- Partner with weatherization programs to provide products to improve indoor air quality.
Patients, Families, and Caregivers

- Learn more about managing pediatric asthma through reputable resources like the CDC’s asthma resources for kids or the AAFA’s asthma and allergy educational material for parents and caregivers.
- Manage exposure to asthma triggers including purchasing indoor air mitigation products and minimizing second-hand smoke from tobacco, vape products, and cannabis.
Recommendation

Approve for Public Comment
Approve Final Draft
Hepatitis C
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 Pistoresi, 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
Public Commenters represented providers (primary care and emergency medicine) as well as HCV care coordinators.

The workgroup reviewed 15 comments around three main themes:

- Additional language for pharmacists as HCV prescribers
- Better engagement with primary care providers
- Clarifying language about urgency
### Focus Areas

<table>
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<th>Focus Area</th>
<th>Goals</th>
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| **Metrics**                        | • Incorporate Hepatitis C Virus (HCV) metrics into value-based contracts.  
• Encourage increased screening and treatment for HCV.                                                                                       |
| **Care Coordination and Expanding Access** | • Provide appropriate care for HCV patients, especially those with complex life domain issues, who experience stigma or discrimination, or other barriers to accessing care.  
• Address barriers in the cure cascade from screening to treatment.                                                                              |
| **Embed HCV Access at Community Sites** | • Increase the availability of HCV testing and treatment 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** | • Expand HCV testing and treatment opportunities for pharmacists.  
• Adopt clinical models that involve access to HCV care and treatment via telemedicine for communities with limited access.  
• Use innovative contracts and reimbursement models to increase the availability of HCV treatment.                                               |
| **Engaging Providers**             | • Ensure providers are comfortable and willing to provide high-quality HCV care and treatment in their communities.                                                                              |
Public Comments: General

Public Comments

1. We have a rare opportunity to eliminate HCV in WA given the state’s success negotiating a contract with Abbvie so that all Washingtonians living with HCV can be treated and cured. We should not squander this opportunity.

2. Any information on contingency management as an option to promote adherence to treatment?

3. More “direct-to-consumer” advertising is needed. There are many public health messages about HIV/PrEP and COVID vaccines/ Why not HCV?

Workgroup Response

1. Added language to executive summary about the urgency around HCV elimination in Washington state.

2. Contingency management has been explored for HCV, but not enough evidence suggests that it is necessary. Two citations were added to the evidence review section, but no changes were made to recommendations.

3. Instead of recommending “direct-to-consumer” advertising, which is usually initiated by pharmaceutical companies, the workgroup recommends public health engage with priority communities to develop targeted outreach.
Public Comments

1. Encourage clinics and clinical teams to safely store HCV medications for patients who cannot keep these medications on their person.
2. Ensure that recommendations for HCV screening in emergency rooms are not mandatory.

Workgroup Response

1. The recommendation for medication safe storage would encounter liability and regulatory issues in clinical settings. Instead, the workgroup recommends that public health agencies explore safe medication storage options.
2. The workgroup’s ED screening recommendations are drawn from the American College of Emergency Physician’s policy statement, which recommends non-mandatory screening.
Public Comments: Pharmacists

Public Comments:

1. Include recommendations related to pharmacy-procurement of DAAs. This could include: educating pharmacists on how to process prescriptions for DAAs and encouraging commercial and 340b pharmacies to be able to fill prescriptions for DAAs.

2. Educate payers to remove any existing requirements for pharmacist-based DAA-related counseling to patients in favor of guidance that either pharmacists or the clinical team perform counseling.

3. Create and maintain a list of pharmacies that will fill DAA medications, by insurance plans, to guide clinicians on where to send prescriptions.

Workgroup Response:

1. Both recommendations were included, although “340b pharmacies” was amended to “community pharmacies.” Recommend pharmacies be able to fill DAA prescriptions, but do not recommend that all pharmacies stock DAAs.

2. Amended the recommendation to encourage more patient education but did not specify who should perform counseling.

3. Did not include this recommendation as it would not be feasible.
Public Comments: Primary Care

Public Comments:
1. Healthcare system leaders need to send a clear message that primary care providers can/should treat HCV (not just specialists).
2. Could recommend that all provider training programs (medical schools, etc.) provide training in HCV treatment.

Workgroup Response:
1. Added three new recommendations to health delivery systems:
   1. Ensure adequate training and support for all physicians to treat HCV
   2. Recognize and reward providers, teams, and clinics who provide HCV treatment to priority populations.
   3. When possible, allow providers who treat HCV to work at community sites.
2. Elected not to target a recommendation to provider training programs.
Thank you!

Action Steps: Approve Final Draft
OVERVIEW

Goal: Uptake of Bree Recommendations into practice

Charge: Bree Collaborative to support collaborative learning and targeted technical assistance for QI initiatives
<table>
<thead>
<tr>
<th>THEMES</th>
</tr>
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<tbody>
<tr>
<td>General Feedback</td>
</tr>
<tr>
<td>Barriers</td>
</tr>
<tr>
<td>Bree Topics</td>
</tr>
<tr>
<td>Bree Recommendation Format</td>
</tr>
<tr>
<td>Implementation</td>
</tr>
<tr>
<td>Lessons Learned</td>
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<tr>
<td>Success</td>
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<tr>
<td>Awareness of roles</td>
</tr>
<tr>
<td>Levers</td>
</tr>
<tr>
<td>New Topic Ideas or Other Thoughts</td>
</tr>
</tbody>
</table>
STAKEHOLDER INTERVIEW THEMES

General Feedback on Recommendations
- Not being implemented
- Too broad
- What Can We Stop Doing?

Barriers
- Staff
- Cost
- Time
- Applicability to Rural Health

“They end up on a bookshelf somewhere.”

“Need to determine what are the largest barriers to transformation?”
How do we know they [guidelines] are making a difference?

“Address the barriers and search for alignment.”

“What can we stop doing?”

“How do we create systems that allow people to do the right thing?”

“I do not know if I have ever seen them well implemented”
THE KNOW-DO GAP

WHAT WE KNOW

WHAT WE PRACTICE
Current Bree Recommendation Process
“The Know”

1. Topic of Interest
2. Bree Collaborative Members Approval
3. Work Group
4. Recommendation
SUCCESES

- 40+ recommendations
- Additions to HCA contracts
- Total Hip/Knee Replacement Bundle
- Perinatal Health Bundle
- Opioid Prescribing
- Opioid prescribing in Dental Care
- LGBTQ recommendations in EHE
- What else?
Bree Recommendations
Know-Do Gap

Know

Recommendation

Do
HOW TO CROSS THE GAP?

ADDRESSING THE KNOW-DO GAP
Bree Recommendations
Know-Do Gap

Guiding Questions

- Why does it need to be done?
- How to do it?
- What will it cost/value?
- Who to do it?
- When to do it by?

Know

Recommendation

Bree Collaborative Members Approval
Work Group
Recommendation

Topic of Interest

HCA
Opioid Prescribing
THR/TKR Bundle Payments
Perinatal Bundle
Opioid Prescribing in Dental Clinics
LGBT recommendations into EHE
IDEAS

- New workflow
- Mechanism to address outdated guidelines, what did not work, what needs to be added, and what does not need to be done anymore?
  - New committee to review former topics?
- How to support 2022 recommendation implementation?
  - Outreach to workgroup members and Health Ecosystem Recommendations
  - Check-lists
  - Webinars?
  - Learning Labs?
IDEAS TO SUPPORT IMPLEMENTATION

Recommendation
Template Redesign

Implementation Guide

Webinars & Learning Labs

Website information accessible by population
IDEAS TO SHOW WHAT CHANGE OCCURRED

- Need: move away from one off stories to Data driven results and outcomes
- Data Dashboard
- Measurement and evaluation
- Award
- Case Studies of Successful Implementation
Proposed Bree Recommendation Process

- **Topic**
- **Bree Members**
- **Work Group**
- **Recommendation**
- **Dashboard of Results**
- **Resources & Support for Implementation**
How ideas fit into Proposed Bree Recommendation Process

- Creation of a Review Process on older recommendations
  - What can we stop doing?
  - What needs to be updated?
  - Need feedback from members
  - Equitable practices for Bree Recruitment

- Measurement and Evaluation
- Accessible by population
- Review how best to show Data
- Case Study Stories of successful implementation

- Topic
- Work Group
- Bree Members
- Recommendation
- Resources & Support for Implementation

- Is there an individual from each population represented?
- Look into current practices for ensure equitable recruitment

- Template re-design?
- Utilize BWB Model

- Implementation Guide
- Webinars
- Checklists

Look into current practices for topic generation to see if updates are need to support more equitable processes
DATA SOURCES
What contributes to health outcomes?

Clinical Health Care, 20%
Cancer Registries, 30%
Socio-economic factors, 40%
Physical Environment, 10%
Health Behaviors, 30%
What contributes to health outcomes?

- Socio-economic factors (40%)
- Health Behaviors, 30%
- Physical Environment, 10%
- Clinical Health Care, 20%

Individual Level Data
- Birth
- Death
- Department of Health
- Personal Devices
- Social Media
- Credit Score
- Claims/APCD
- HCA
- Insurance Status
- County Governments
- Property records
- Voting History

Population Level Data
- OSPI
- HUD
- Census Data
- HUD
- Socio-economic factors 40%

Higher education
- Department of Health
- Department of Transportation
- DMV
- UBER/LYFT

Insurance Status
- Washington Hospital Capacity
- Department of Revenue
- Food
- WA Liquor control board
- Labor and Industries
- Department of Revenue
- NIBRS
- CDC Deprivation Index
- DEPARTMENT OF HEALTH
- Department of Corrections
- Transit authority
- Homes and property
- USDA
- WIC
- RHINO
- CHARS
- WTN
- WA_VDRS
- Department of Health
- Department of Transportation
- DMV
- UBER/LYFT

What contributes to health outcomes?
Data Mapping

How will we bring all this information together?

Adapted from the WHO Implementation Guide

Data Source Mapping
- Source Type – Survey, surveillance, etc.
- Name
- Owner
- Years covered
- Quality Rating
- Data Attributes

Core Process Measures Mapping
- Topic of Process measure – access, data collection, patient communication
- Measure Name
- Measure Definition
- Unique Data Sources – from Data Source Mapping

Logic Model Indicator Mapping
- Indicator Name – developed from Logic Model
- Unique ID for process and other measures – from process measures mapping and data source mapping
- Dimensions of Equity
Step by step

• Convene appropriate workgroup or committee to:
  • Continue data source identification
  • Continue to identify and develop Core Process Measures from guidelines
  • Identify and develop Indicators in the Evaluations and Monitoring Logic Model

• Complete data quality assessment method
• Identify gaps data source gaps and plan data collection methods to fill them
  • Surveys, reporting systems, qualitative data
This is an example of a draft method of data quality assessment. For the purposes of a guideline's implementation evaluation, quality should mean more than just the quality of the data for its original purpose. It should also include aspects that are relevant to our evaluation such as equity, geography, and cost.

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Quality (how well suited is the data for our needs)</th>
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<th>Ease of access (how easy or inexpensive is it to get the data)</th>
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</thead>
<tbody>
<tr>
<td>Claims data</td>
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<td>Limited race and ethnicity, age, limited gender, income,</td>
<td>Address</td>
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<tr>
<td>Disease Registries Data</td>
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<td>Washington State, County, zip code, address</td>
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</table>
Composite scores of data sources based on quality, equity, geography and access, currently identified, by guideline category

Some of the data sources have already been identified, either in the guidelines or through previous and current work. As we continue identifying data sources, we can use this kind of composite scoring to determine what we still need to collect for certain guidelines or for certain purposes. In this example, guidelines are grouped together, however a more sensitive scoring method would be used for each topics.

For example, this can demonstrate that:

- Although we have lots of outcome data, it is not always aligned with measures for access, capacity and equity.
- For some areas we have a lot of high-quality data, like system capacity.
- In other areas we are still lacking robust identified sources, such as patient generated, or patient reported data.
- For some guidelines we need to identify more data sources or create our own to fill in gaps.
QUESTIONS
FRAMEWORKS
FOR POSSIBLE USE IN DESIGN
Black Women’s Blueprint Culturally Specific Model
Knowledge-to-Action Framework (Graham et al., 2006). Used with permission.
What contributes to health outcomes?

Clinical Health Care, 20%
Health Behaviors, 30%
Physical Environment, 10%
Socio-economic factors 40%

Current Insurance Claims, 40%
Health Behaviors, 30%
Physical Environment, 10%
Clinical Health Care, 20%
Older Insurances, 10%
Labor and Industries, 20%
Other Insurances, 10%
SSA or other Benefits, 20%
What contributes to health outcomes?

**Individual Level Data**
- Personal Devices
- Social Media
- Claims
- HCA
- APCD

**Population Level Data**
- Higher education
- Legislative district
- Department of Corrections
- Transit authority
- Department of revenue
- HUD
- Census Data
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- NIBRS
- CDC Deprivation Index
- Washington Hospital Capacity
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- Washington Hospital Capacity
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- WIC
- WNAISS
- WA-ISS
- Labor and Industries
- Homes and rentals
- WA Liquor control board
- Food

**Data Sources**
- Socio-economic, Environmental, and Behavioral Data Sources
- Socio-economic factors 40%
- Clinical Health Care, 20%
- Physical Environment, 10%
- Health Behaviors, 30%

**Contributors to Health Outcomes**
- Socio-economic factors
- Clinical Health Care
- Physical Environment
- Health Behaviors
Data Mapping

How will we bring all this information together?

Adapted from the WHO Implementation Guide

Data Source Mapping
- Source Type – Survey, surveillance, etc.
  - Name
  - Owner
  - Years covered
  - Quality Rating
  - Data Attributes (Gender, Race, Ethnicity, Income, etc.)

Core Process Measures Mapping
- Topic of Process Measure – access, data collection, patient communication
  - Measure Name
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  - Unique Data Sources – (from Data Source Mapping)

Logic Model Indicator Mapping
- Indicator Name – developed from Logic Model
- Unique ID for process and other measures – (from process measures mapping and data source mapping)
- Dimensions of Equity

What is being mapped?
Step by step

• Convene appropriate workgroup or committee to:
  • Continue data source identification
  • Continue to identify and develop core process measures from guidelines
  • Identify and develop indicators in the Evaluations and Monitoring Logic Model

• Complete data quality assessment method
• Identify gaps data source gaps and plan data collection methods to fill them
  • Surveys, reporting systems, qualitative data
### Assessing the Quality of the Data

This is an example of a draft method of data quality assessment. For the purposes of a guideline's implementation evaluation, quality should mean more than just the quality of the data for its original purpose. It should also include aspects that are relevant to our evaluation such as equity, geography, and cost.

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This table provides a qualitative assessment of various data sources based on several criteria: Quality (how well suited is the data for our needs), Equity (how well does the data capture equity the way we need), Geography (to what level of geography is the data defined), and Ease of access (how easy or inexpensive is it to get the data). Each criterion is rated on a scale from 1 to 3, with 3 being the highest rating.
Some of the data sources have already been identified, either in the guidelines or through previous and current work. As we continue identifying data sources, we can use this kind of composite scoring to determine what we still need to collect data for certain guidelines or for certain purposes, such as measuring capacity. In this example, guidelines are grouped together, however a more sensitive scoring method would be used for each topic.

This can help us better understand what data we have, for example:

- Although we have lots of outcome data, it is not always aligned with measures for access, capacity and equity.
- For some measurement purposes we have a lot of high-quality data, like system capacity.
- In other areas we are still lacking robust identified sources, such as patient generated, or patient reported data.
- For some guidelines we need to identify more data sources or create our own collection systems to fill in gaps.