Bree Collaborative Meeting

November 16, 2022| Zoom Meeting

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

November 16th, 2022 | Bree Collaborative Meeting

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

Aim

To increase evidence-informed screening, diagnosis, monitoring, and treatment for pediatric asthma to improve pediatric asthma control in Washington state.

Draft Focus Areas

Potential Focus Areas	Description
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)

Health Delivery Systems

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 amanagement 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.

Schools and School Nurses

<u>School Setting:</u>

- 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.

<u>Clinical and Home Settings:</u>

- 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.

Payers and Purchasers

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.

Public Health Agencies

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

November 16, 2022 | Bree Collaborative Meeting

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, Hepattis 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 Comment Overview

- 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

Focus Area	Goals
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: General

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

BREE COLLABORATIVE RECOMMENDATIONS IMPLEMENTATION WORK

BREE COLLABORATIVE MEETING 11/16/22

OVERVIEW

Goal: Uptake of Bree Recommendations into practice

Charge: Bree Collaborative to support collaborative learning and targeted technical assistance for QI initiatives

THEMES

- General Feedback
- Barriers
- Bree Topics
- Bree Recommendation Format
- Implementation
- Lessons Learned
- Success
- Awareness of roles
- Levers
- New Topic Ideas or Other Thoughts

STAKEHOLDER INTERVIEW THEMES

General Feedback on Recommendations

- Not being implemented
- Too broad
- What Can We Stop Doing?

"They end up on a bookshelf somewhere."

Barriers

- Staff
- Cost
- Time
- Applicability to Rural Health

"Need to determine what are the largest barriers to transformation?"

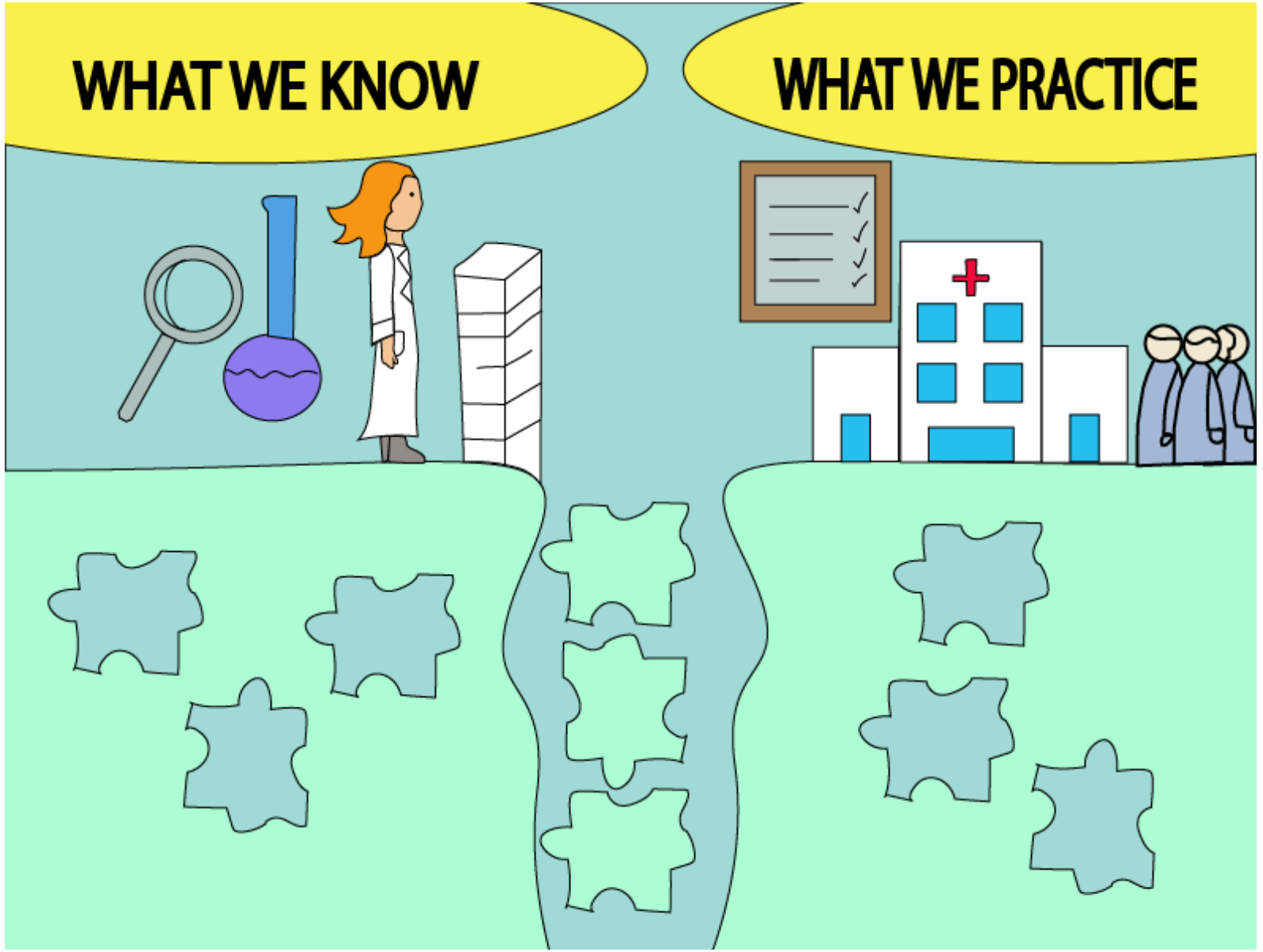
"I do not know if I have ever seen them well implemented"

"Address the barriers and search for alignment."

How do we know they [guidelines] are making a difference?

"What can we stop doing?"

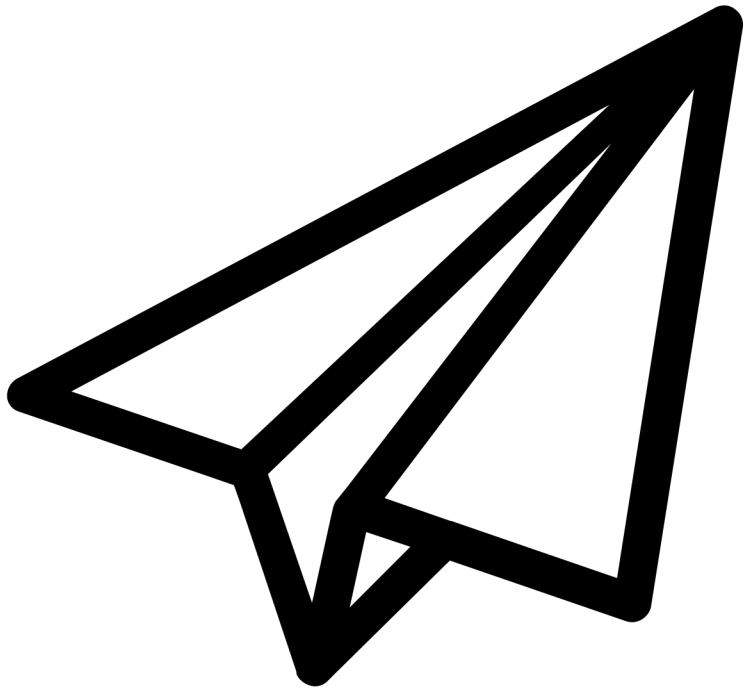
"How do we create systems that allow people to do the right thing?"



THE KNOW-DO GAP

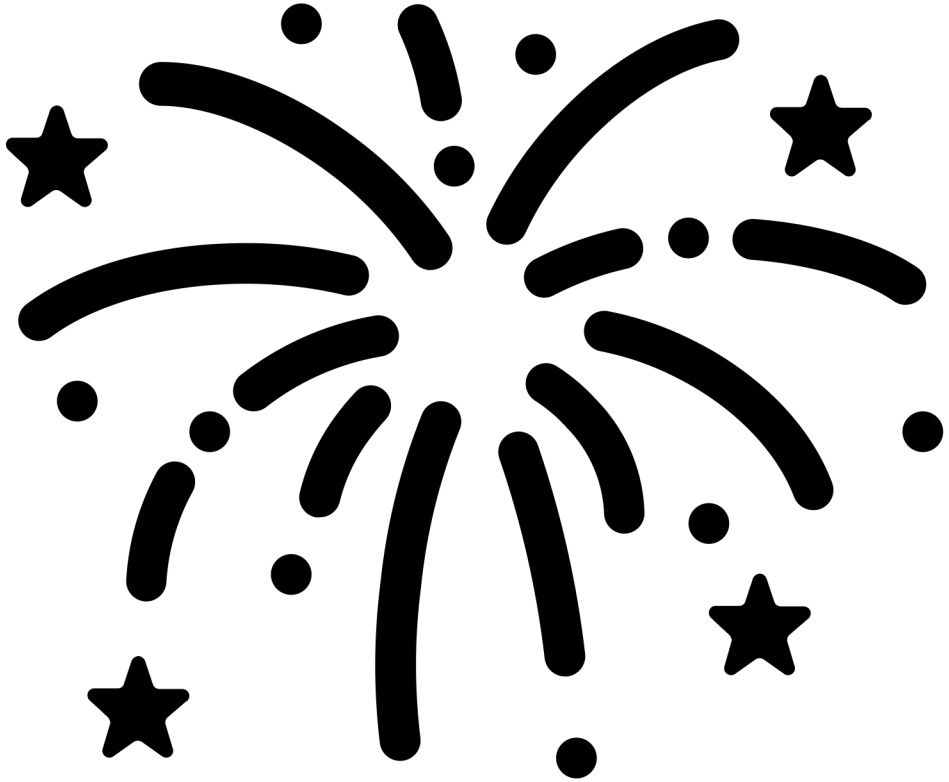
Current Bree Recommendation Process "The Know"

- Topic of Interest
- Bree Collaborative Members Approval
- Work Group
- Recommendation



SUCCESSES

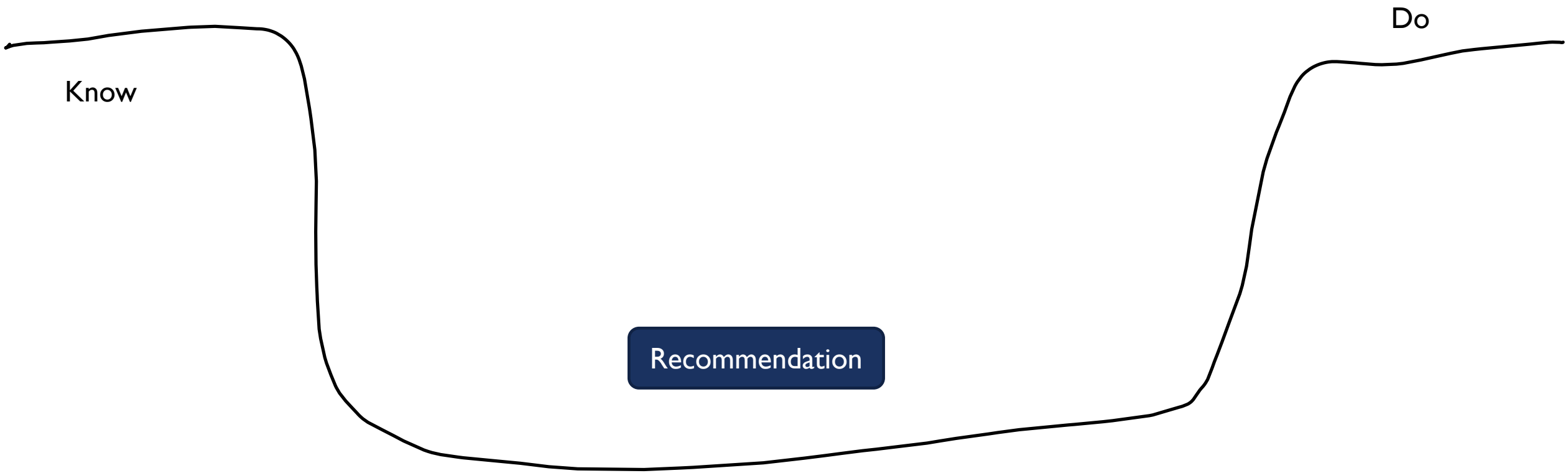
- 40+ recommendations
- Additions to HCA contracts
- Total Hip/Knee Replacement Bundle
- Perinatal Health Bundle
- Opioid Prescribing
- Opioid prescribing in Dental Care
- LGBTQ recommendations in EHE
- What else?



Bree Recommendations Know-Do Gap

- Topic of Interest
- Bree Collaborative Members Approval
- Work Group
- Recommendation

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



HOW TO CROSS THE GAP?

ADDRESSING THE KNOW-DO GAP

Topic of Interest

Bree Collaborative Members Approval

Work Group

Recommendation

Bree Recommendations Know-Do Gap

HCA

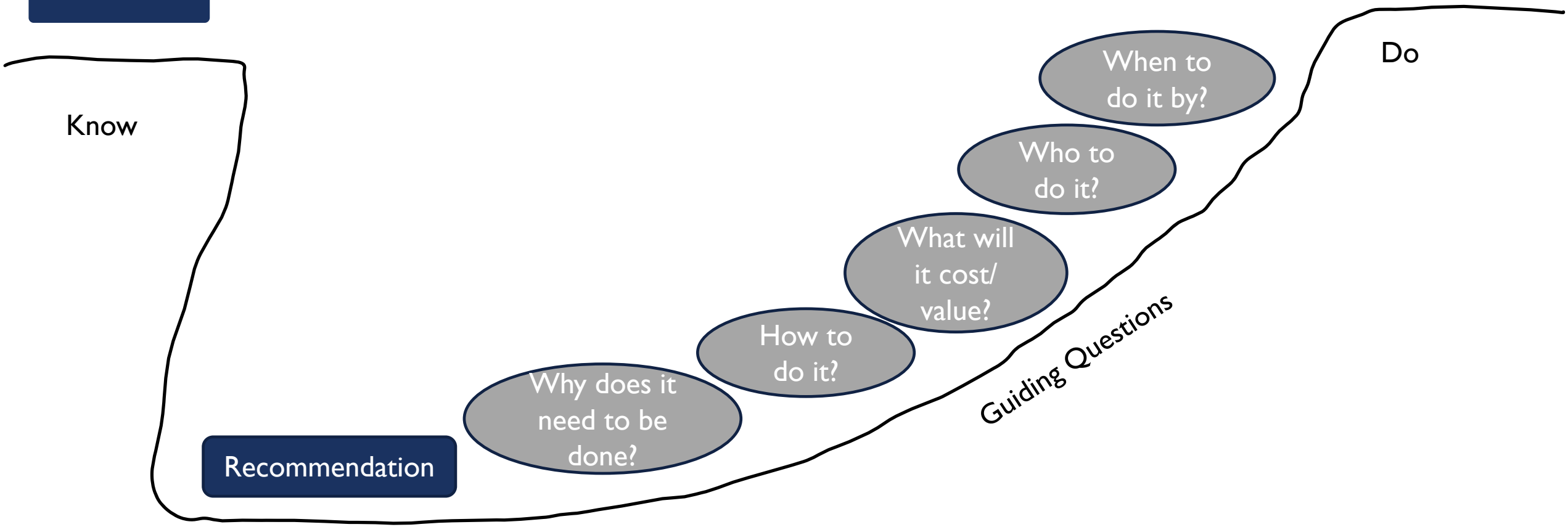
Opioid Prescribing

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

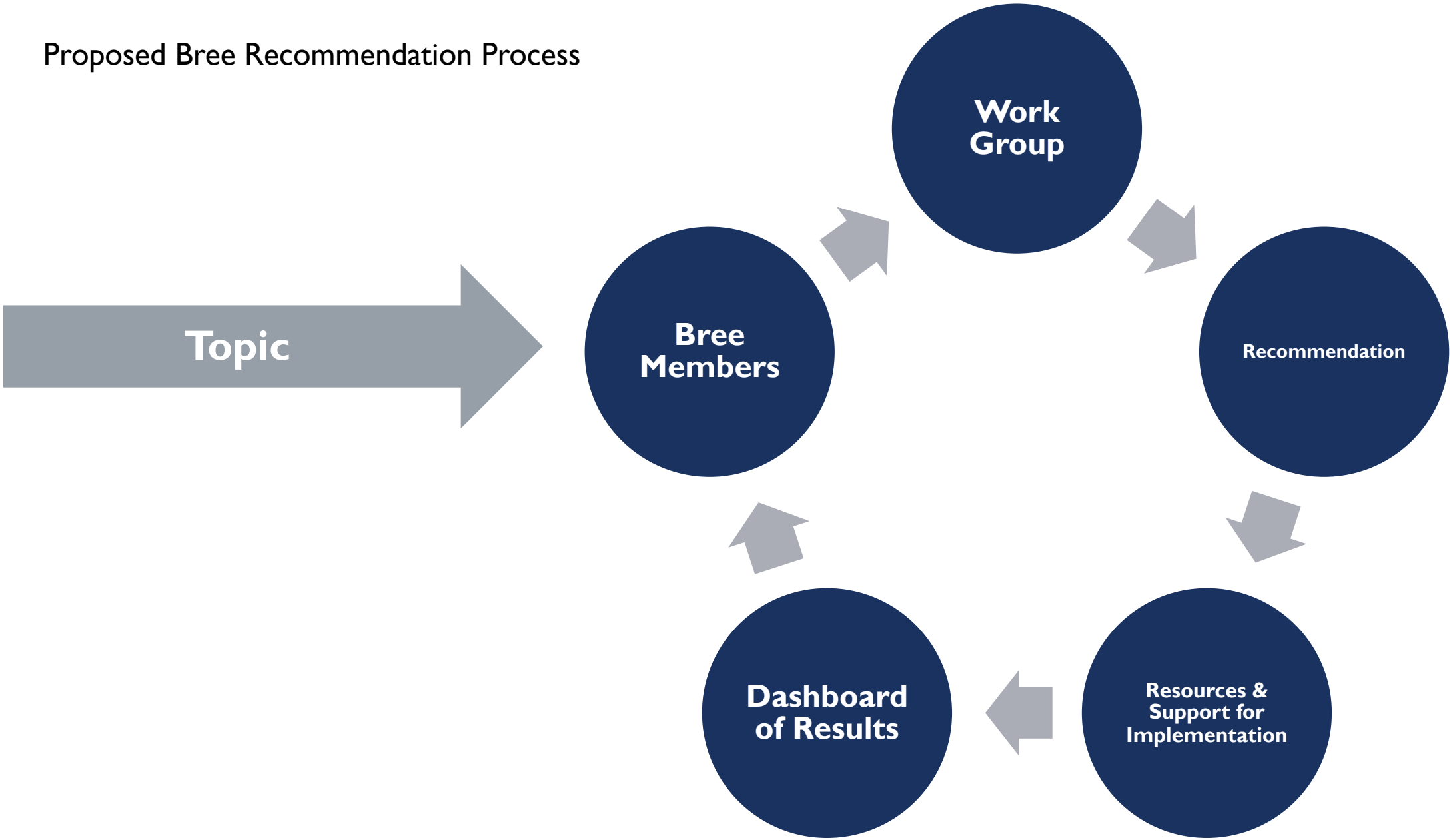
Website information accessible by population

Community Organizations | Patients and Family | Health Plans | Health Care Professional | Private Purchasers | Public Purchasers | Delivery Sites | QI Organizations | Public Health

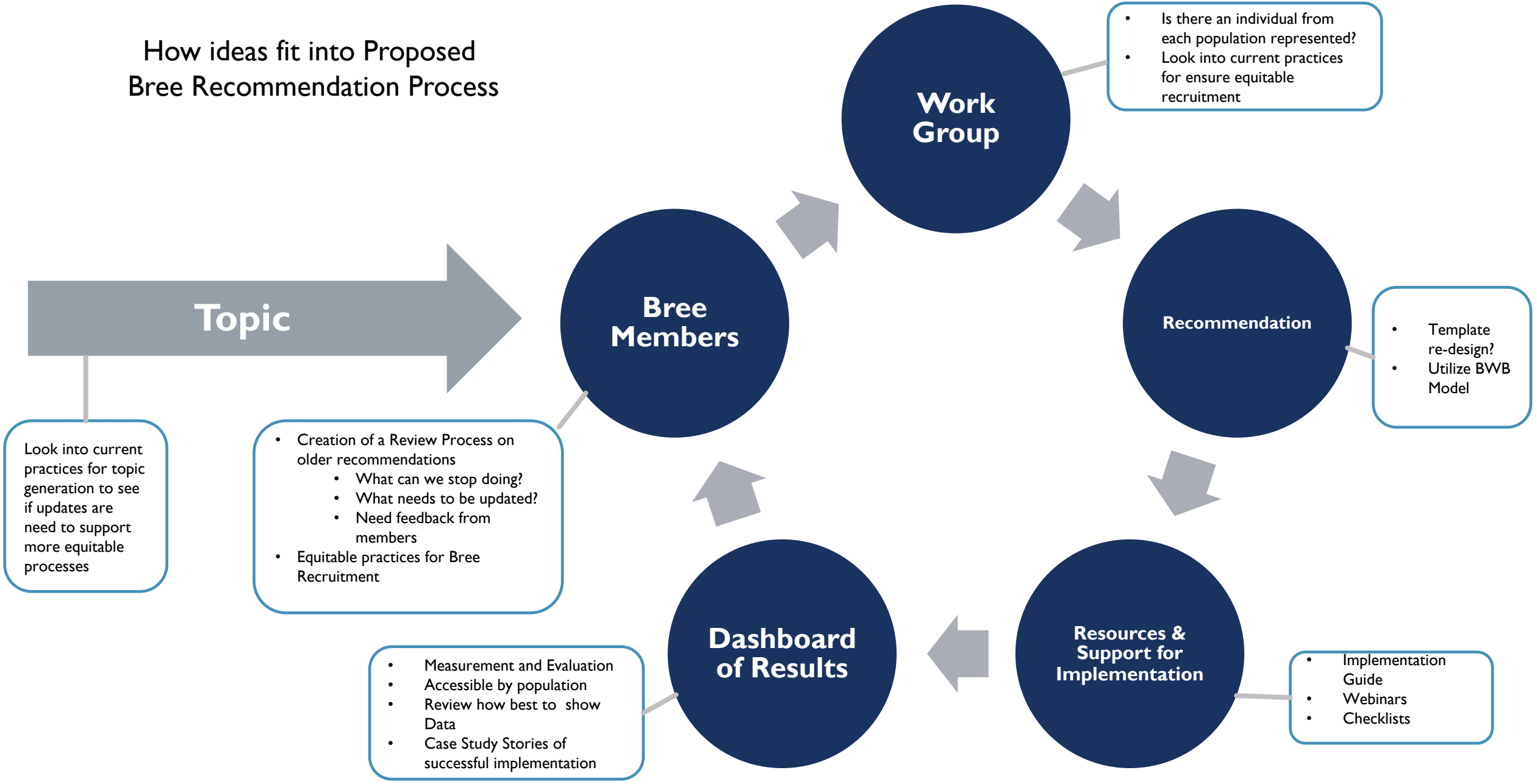
IDEAS TO SHOW WHAT CHANGE OCCURRED

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

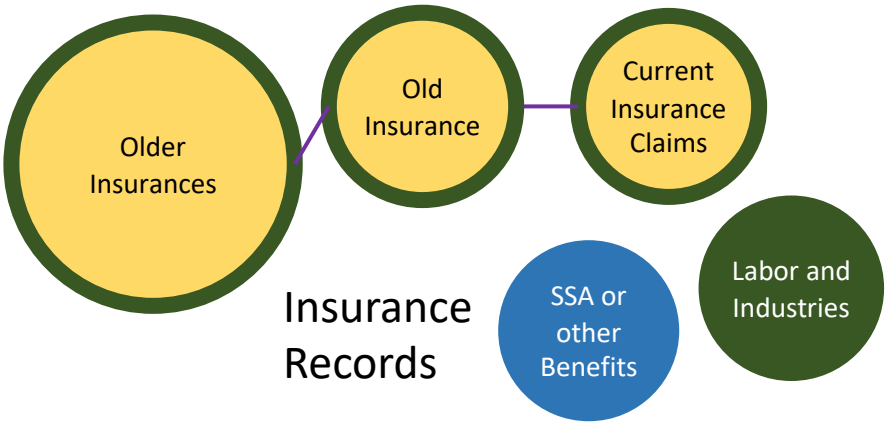
Proposed Bree Recommendation Process

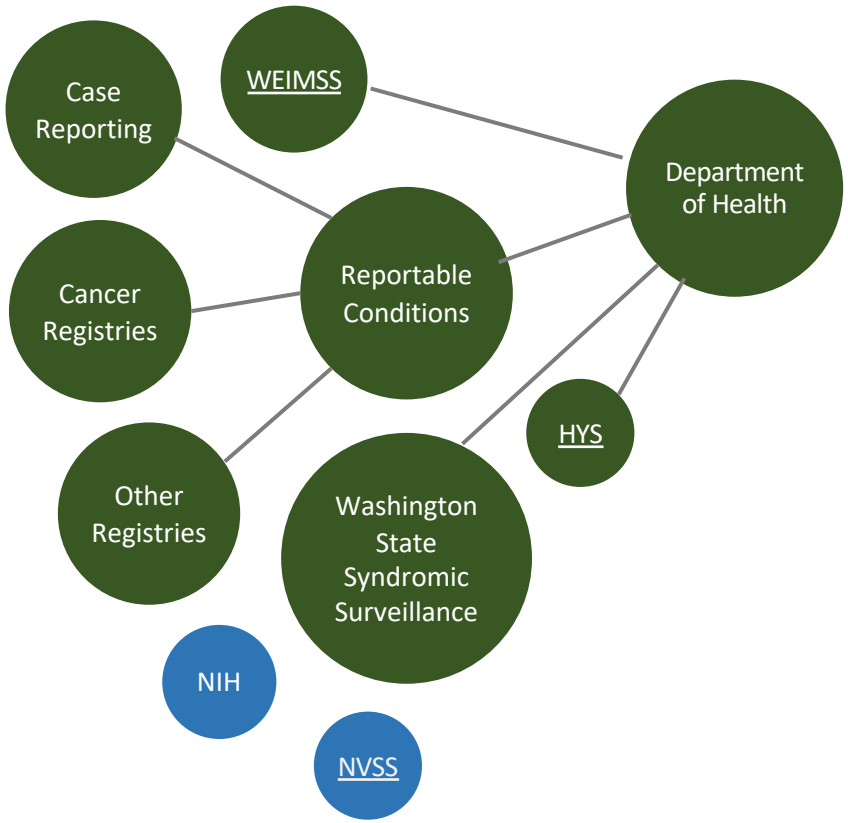


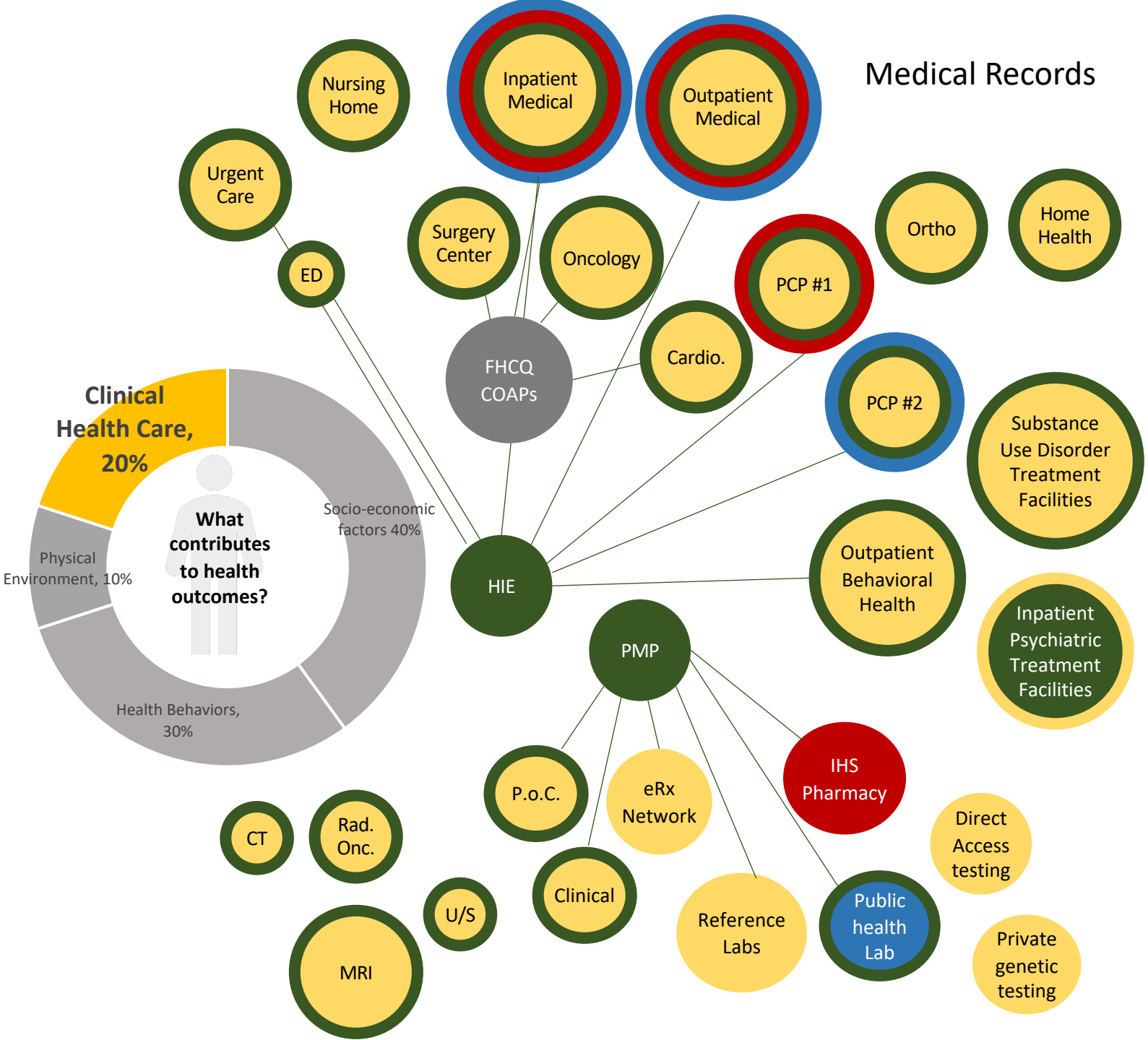
How ideas fit into Proposed Bree Recommendation Process

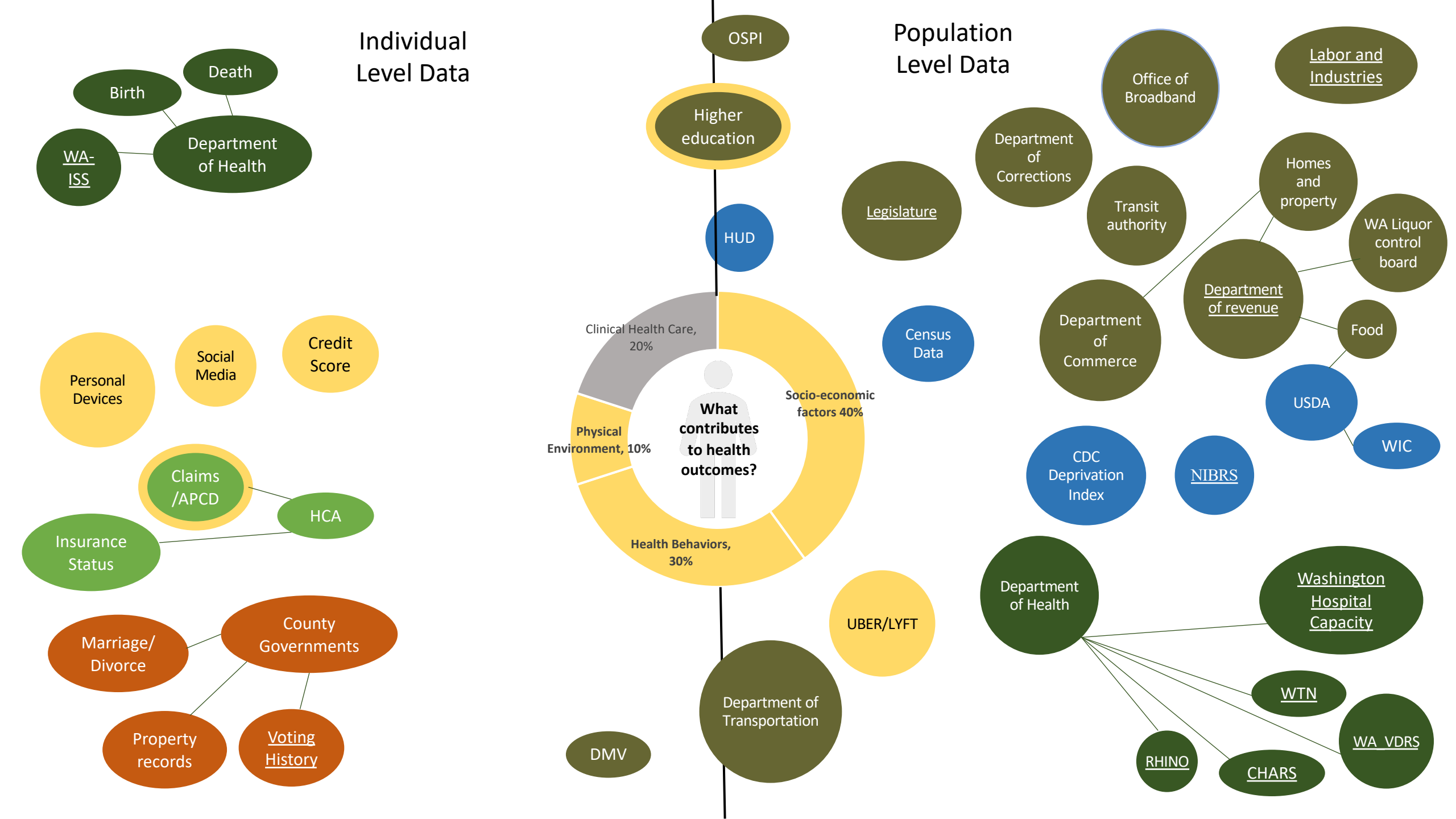


DATA SOURCES

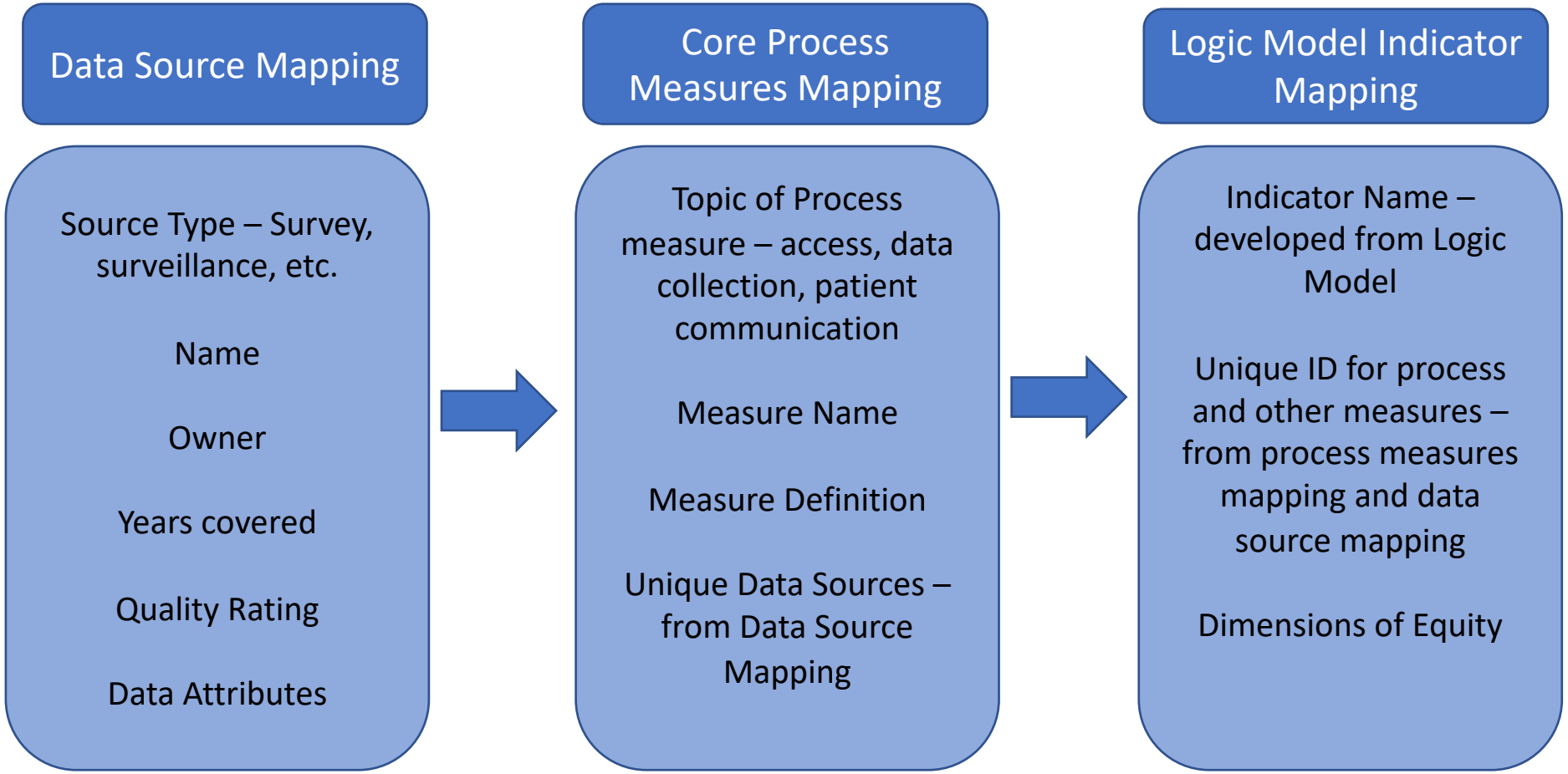

Older Insurances
Old Insurance
Current Insurance Claims
Labor and Industries
SSA or other Benefits
Insurance Records


Case Reporting
WEIMSS
Department of Health
Cancer Registries
Reportable Conditions
Other Registries
Washington State Syndromic Surveillance
HYS
NIH
NVSS
Surveillance


Medical Records
Nursing Home
Inpatient Medical
Outpatient Medical
Urgent Care
ED
Surgery Center
Oncology
Ortho
Home Health
PCP #1
FHCQ COAPs
Cardio.
PCP #2
Substance Use Disorder Treatment Facilities
Clinical Health Care, 20%
What contributes to health outcomes?
Socio-economic factors 40%
Physical Environment, 10%
Health Behaviors, 30%
HIE
Outpatient Behavioral Health
Inpatient Psychiatric Treatment Facilities
PMP
P.o.C.
eRx Network
IHS Pharmacy
CT
Rad. Onc.
Clinical
Direct Access testing
U/S
Reference Labs
Public health Lab
MRI
Private genetic testing


Individual Level Data
Death
Birth
WA-ISS
Department of Health
Personal Devices
Social Media
Credit Score
Claims /APCD
HCA
Insurance Status
Marriage/ Divorce
County Governments
Property records
Voting History
OSPI
Higher education
HUD
Clinical Health Care, 20%
Socio-economic factors 40%
What contributes to health outcomes?
Physical Environment, 10%
Health Behaviors, 30%
UBER/LYFT
Department of Transportation
DMV
Population Level Data
Office of Broadband
Labor and Industries
Department of Corrections
Legislature
Transit authority
Homes and property
WA Liquor control board
Department of revenue
Department of Commerce
Census Data
Food
USDA
WIC
CDC Deprivation Index
NIBRS
Department of Health
Washington Hospital Capacity
WTN
WA_VDRS
RHINO
CHARS

Data Mapping
How will we bring all this information together?
Adapted from the WHO Implementation Guide



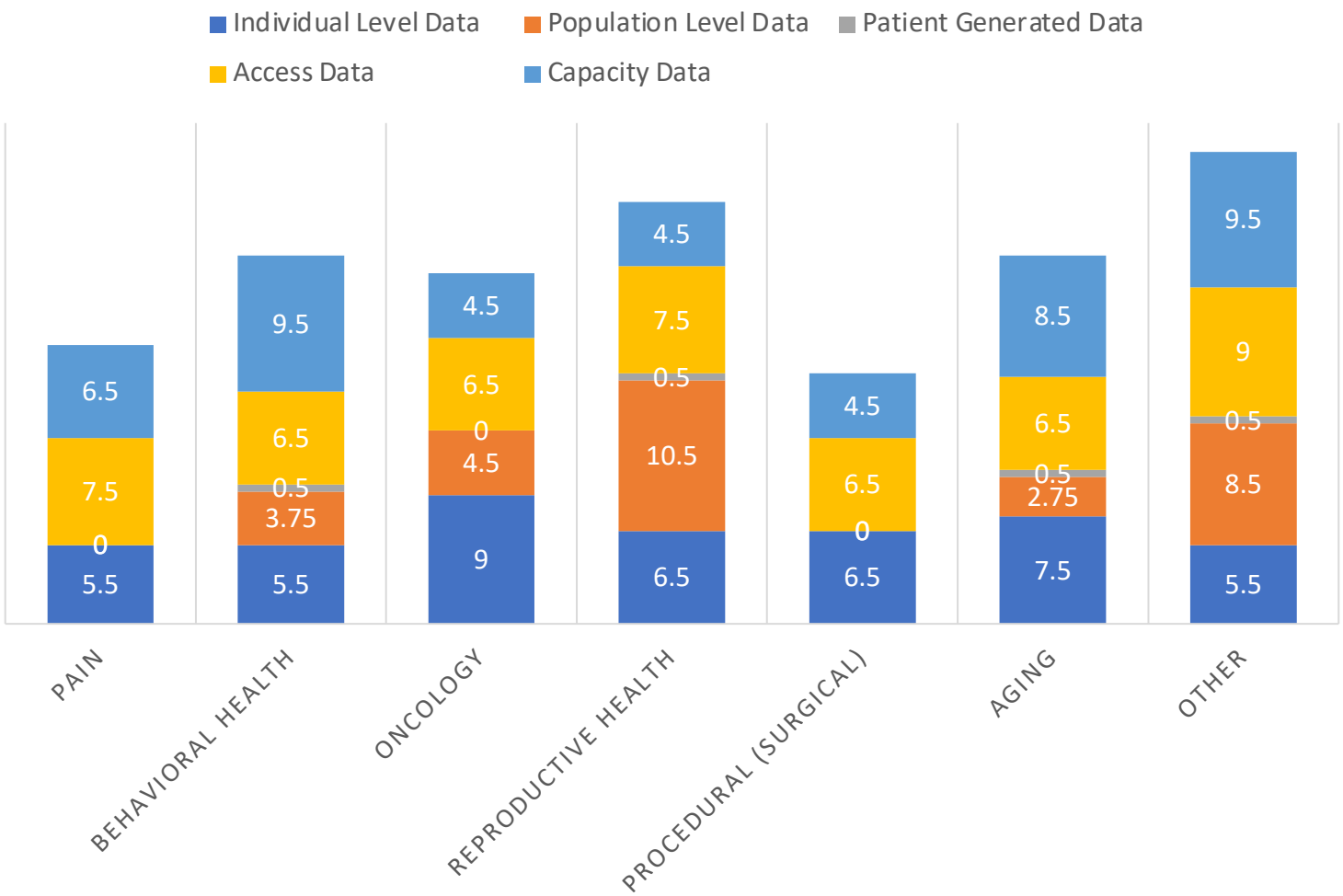
Step by step

- 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 aspect that are relevant to our evaluation such as equity, geography, and cost.

	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)	**Ease of access** (how easy or inexpensive is it to get the data)	**Score**
	3 tier scale (1-3)	Qualitative scale (1-3)	Specificity scale (1-3)	3 tier scale (1-3)	Average
Claims data	Medium	Limited race and ethnicity, age, limited gender, income,	Address	Medium	2.25
Medical Records	High	Age, sex at birth, insurance status	Address	Low	1.75
UDS	Medium	Race, ethnicity, age, gender, Sexual orientation, homelessness, income, insurance status, employment status	State, zip code	High	2.5
Prescription Reporting	High	Age, sex at birth, insurance status		Medium	1.25
Disease Registries Data	High	Age, sex at birth, insurance status	Washington State, County, zip code, address	Medium	2.5
Washington Healthy Youth Survey	High	Age, sex at birth, insurance status		Medium	1.25

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:

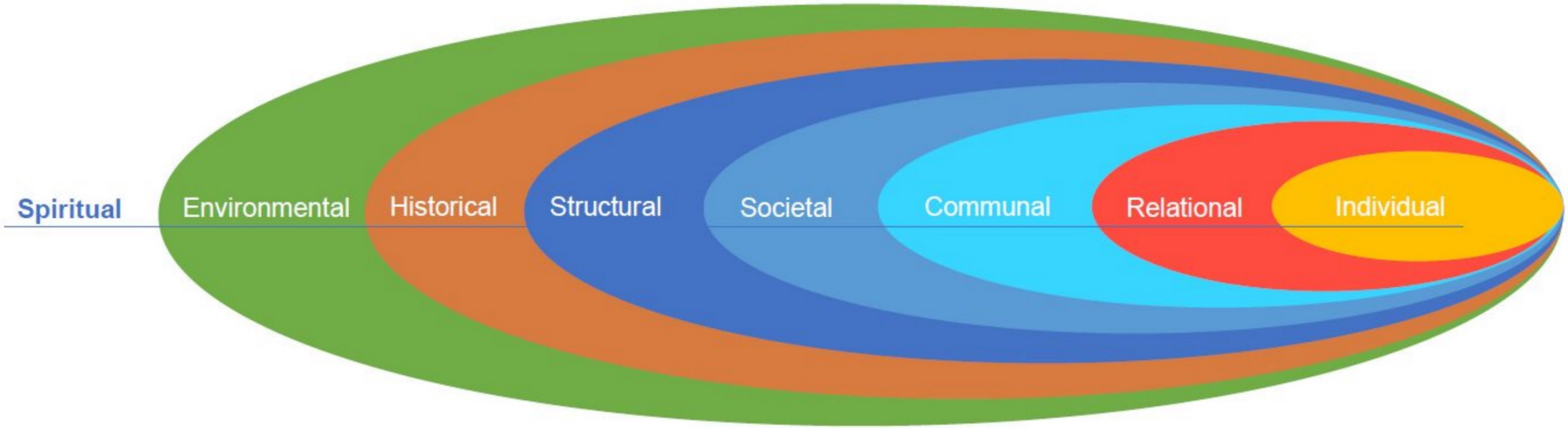
- Although we have lots of outcome data, it is not always aligned with measures for access, capacity and equity.
- For some areas we have a lot of high-quality data, like system capacity.
- In other areas we are still lacking robust identified sources, such as patient generated, or patient reported data.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

QUESTIONS

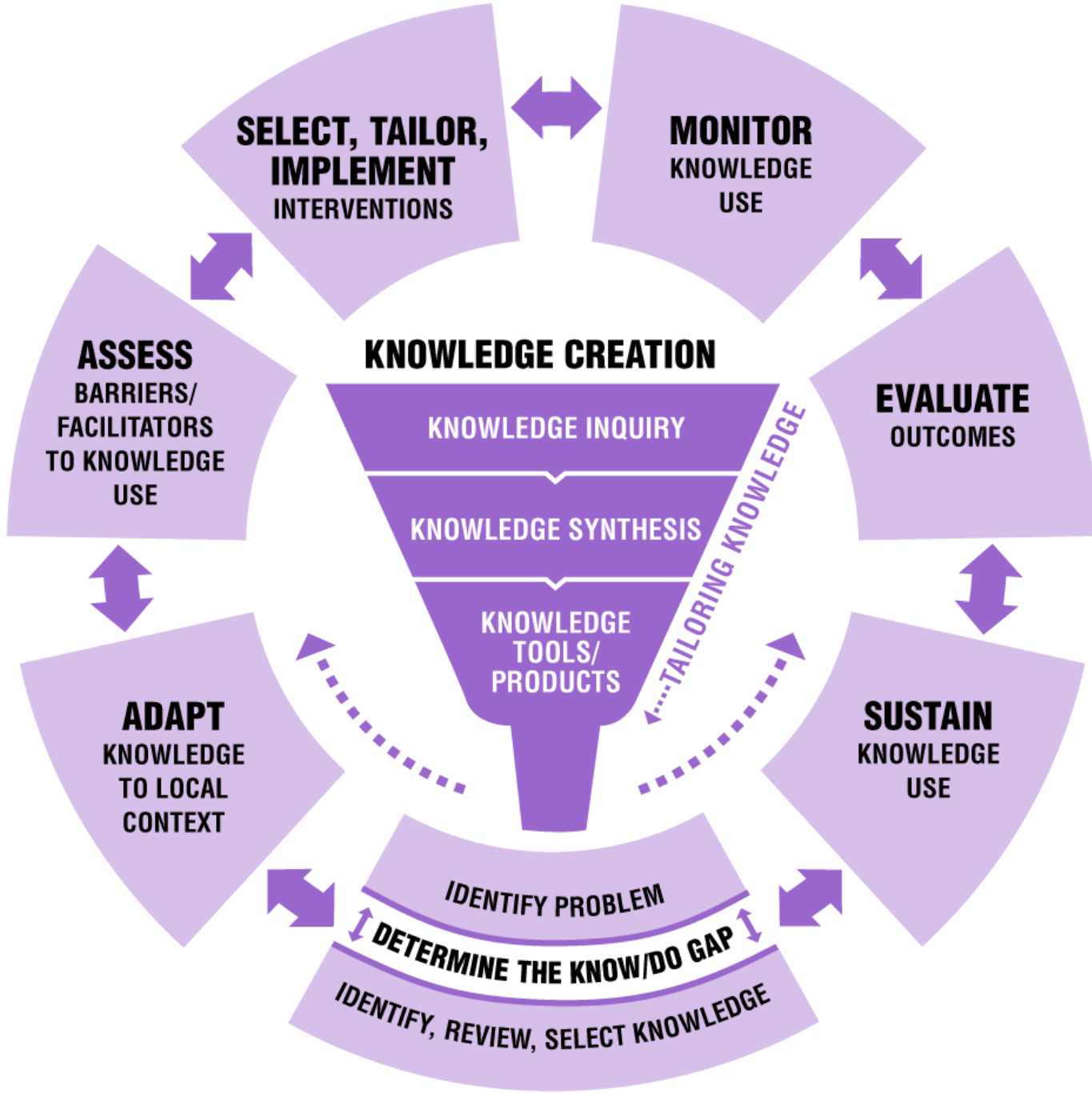
FRAMEWORKS

FOR POSSIBLE USE IN DESIGN

Black Women's Blueprint Culturally Specific Model




REACH
How do I reach the targeted population?
EFFECTIVENESS
How do I know my intervention is effective?
MAINTENANCE
How do I incorporate the intervention so it is delivered over the long term?
RE-AIM
Translating Research into Action
re-aim.org
ADOPTION
How do I develop the institutional support to deliver my intervention?
IMPLEMENTATION
How do I ensure the intervention is delivered properly?

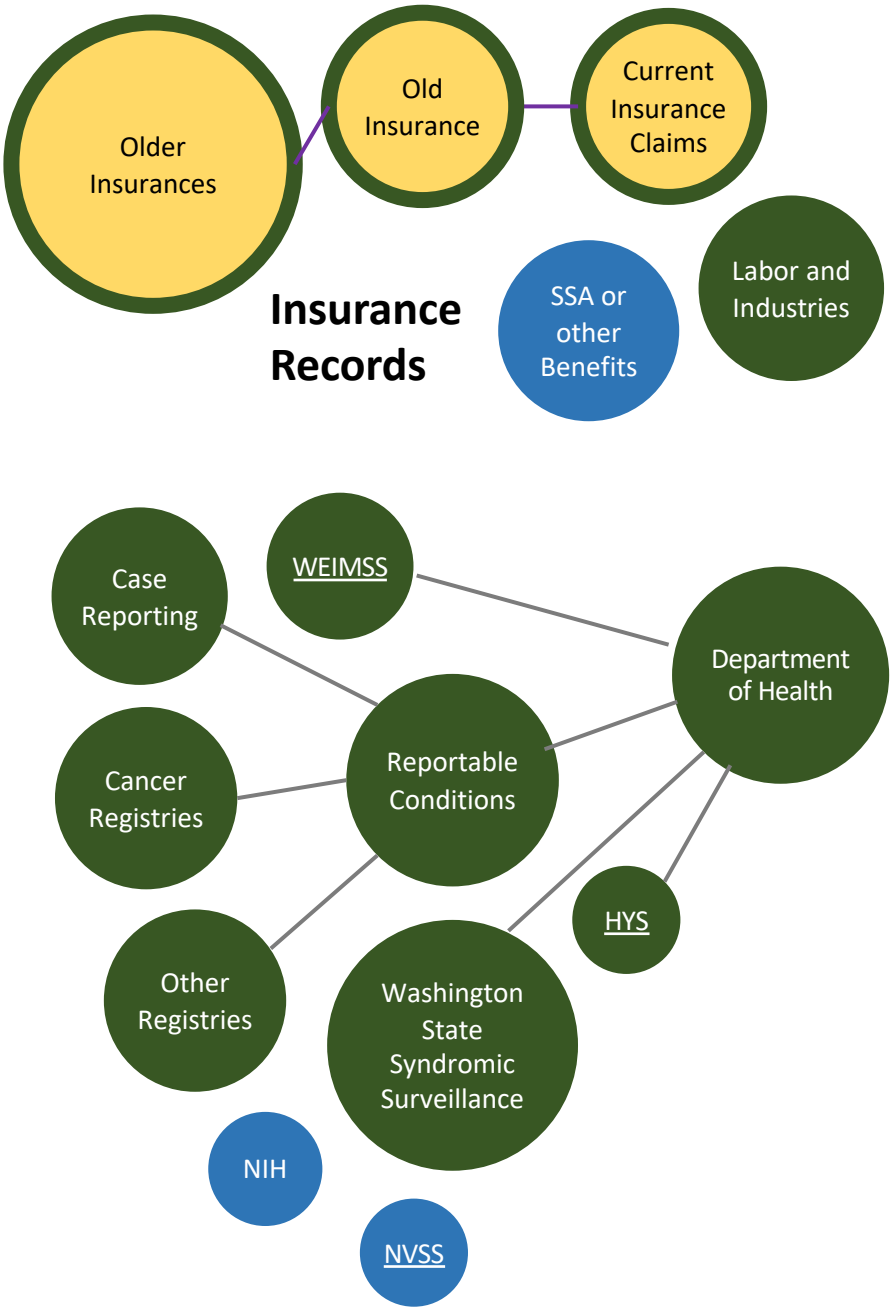


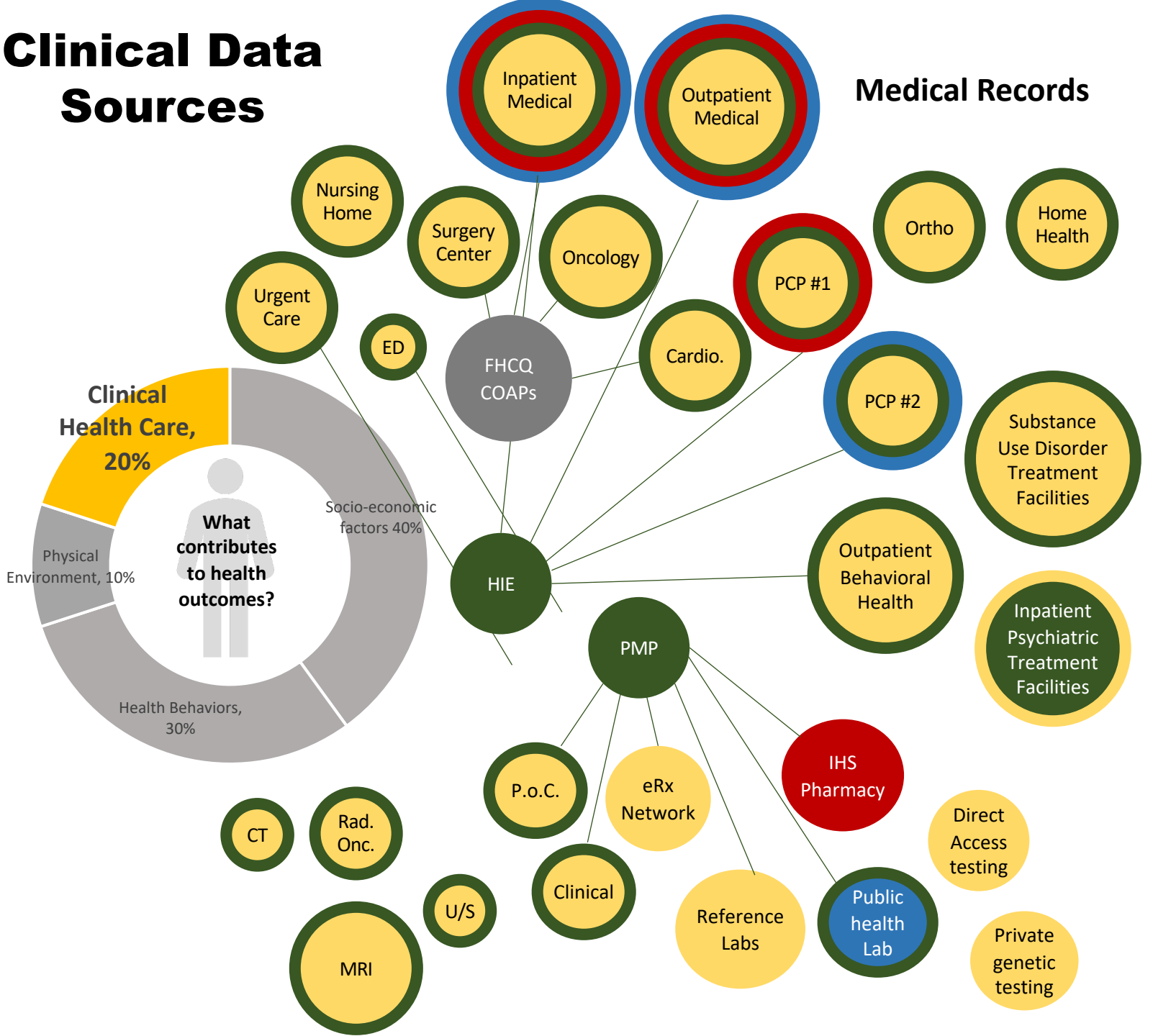
Knowledge-to-Action Framework (Graham et al., 2006). Used with permission.

DATA SOURCES

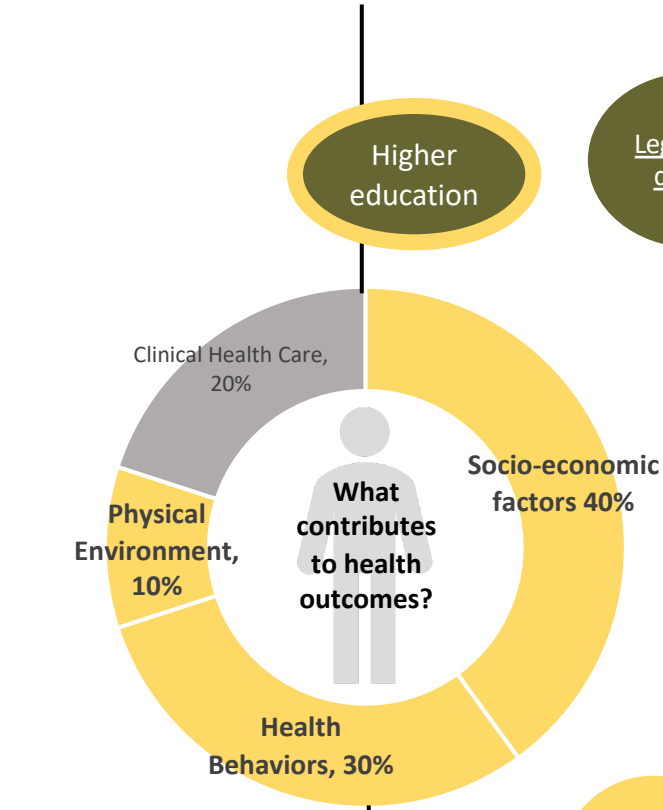
STRATEGIES FOR MEASUREMENT

Clinical Data Sources





Socio-economic, Environmental, and Behavioral Data Sources



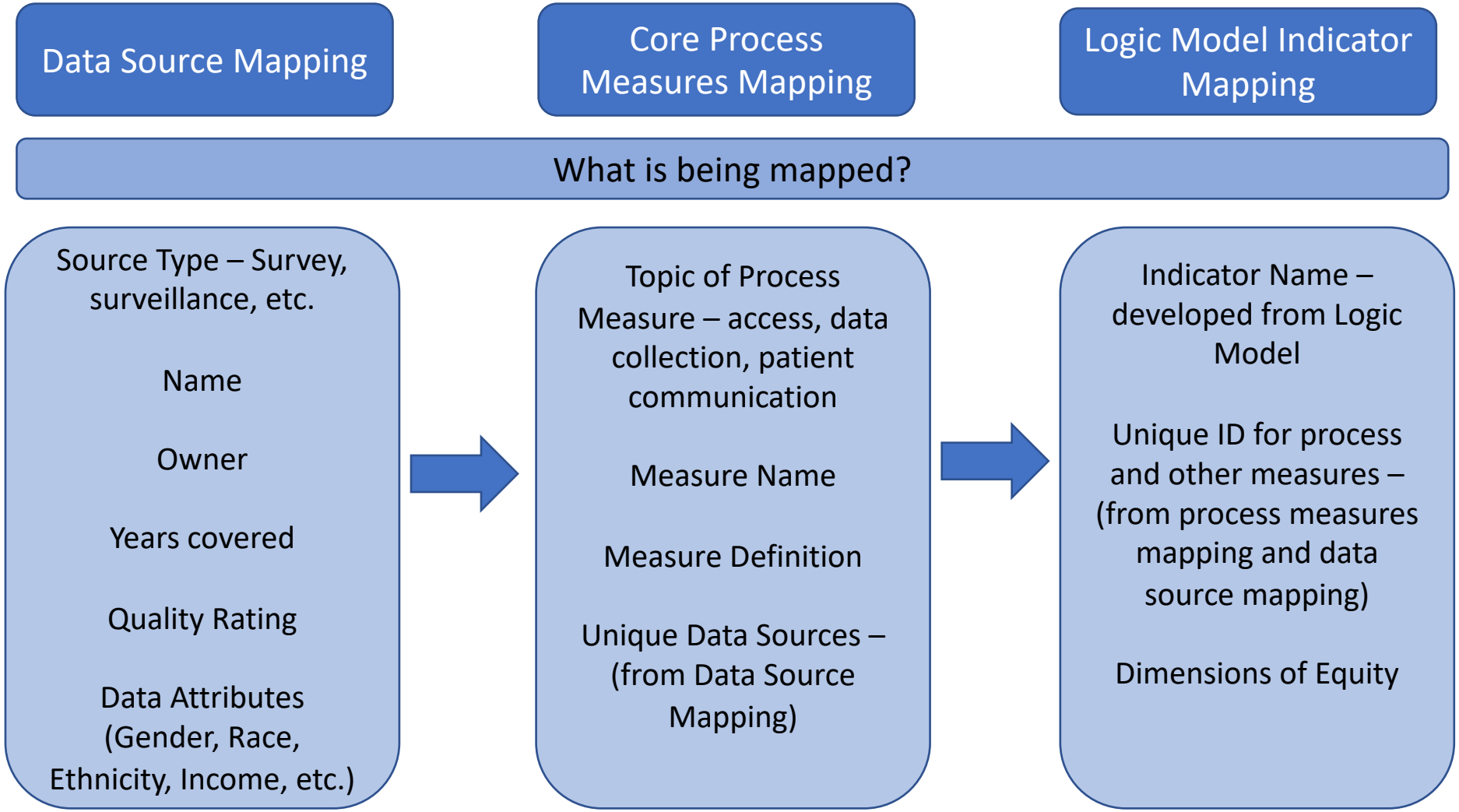
Individual Level Data

- Marriage/ Divorce
- Death
- Birth
- WA-ISS
- Personal Devices
- Social Media
- Claims
- HCA
- Insurance Status
- APCD
- Voting History
- Property records
- Credit Score

Population Level Data

- Higher education
- Legislative district
- Office of Broadband
- Labor and Industries
- Department of Corrections
- Transit authority
- Homes and rentals
- WA Liquor control board
- Department of revenue
- Food
- HUD
- Census Data
- USDA
- NIBRS
- CDC Deprivation Index
- Washington Hospital Capacity
- WIC
- Washington State Homeless Survey
- WTN
- RHINO
- CHARS
- WA_VDRS
- OSPI
- UBER/LYFT
- DMV
- Department of Transportation

Data Mapping
How will we bring all this information together?
Adapted from the WHO Implementation Guide



Step by step

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- Complete data quality assessment method
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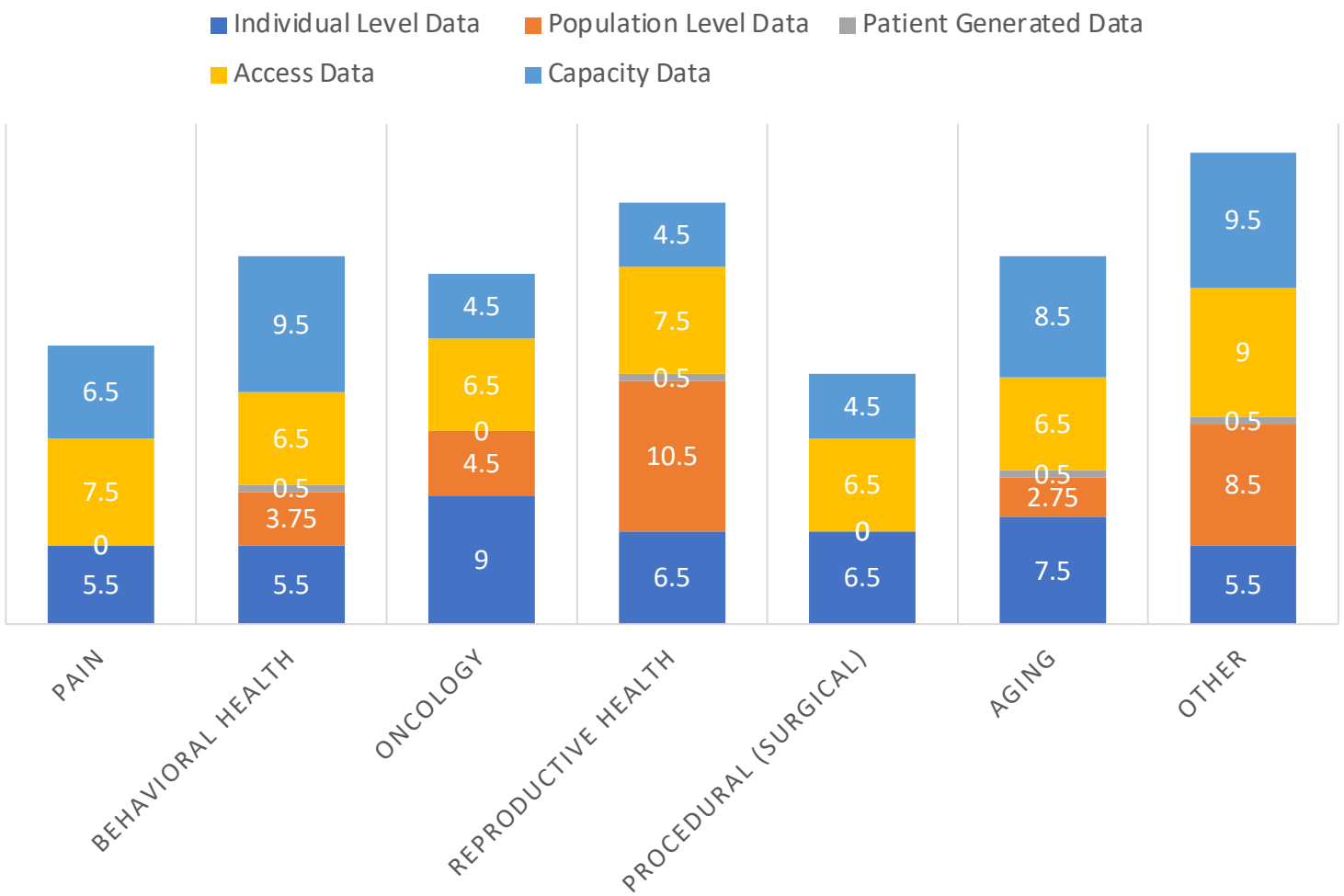
Assessing the Quality of the Data

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 aspect that are relevant to our evaluation such as equity, geography, and cost.

	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)	**Ease of access** (how easy or inexpensive is it to get the data)	**Score**
	3 tier scale (1-3)	Qualitative scale (1-3)	Specificity scale (1-3)	3 tier scale (1-3)	Average
Claims data	Medium	Limited race and ethnicity, age, limited gender, income,	Address	Medium	2.25
Medical Records	High	Age, sex at birth, insurance status	Address	Low	1.75
UDS	Medium	Race, ethnicity, age, gender, Sexual orientation, homelessness, income, insurance status, employment status	State, zip code	High	2.5
Prescription Reporting	High	Age, sex at birth, insurance status		Medium	1.25
Disease Registries Data	High	Age, sex at birth, insurance status	Washington State, County, zip code, address	Medium	2.5
Washington Healthy Youth Survey	High	Age, sex at birth, insurance status		Medium	1.25

Example of 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 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.

QUESTIONS