

Bree Collaborative Meeting



May 24, 2023 | Zoom Meeting

Agenda



- **Welcome and Introductions**
 - Action Item: Adopt March Minutes
- **Update:** HCA Community Health Worker Reimbursement
- **Topic Updates**
 - Complex Discharge from Hospitals
 - Diabetes
 - Perinatal/Maternal Mental Health
- **Discussion:** Bree Updates and Implementation
- **Next Steps and Close**

Meeting Minutes: March 2023



Dr. Robert Bree Collaborative Meeting Minutes March 22nd, 2023 | 1:00-3:00 Held Virtually

Members Present

Hugh Straley, MD, Bree Collaborative (Chair)
Angie Sparks, MD, UnitedHealthcare
Darcy Jaffe, MN, ARNP, FACHE, Washington State
Hospital Association
DC Dugdale, MD, MS, University of Washington
Sharon Eloranta, MD, Washington Health Alliance
Colin Fields, MD, Kaiser Permanente
Gary Franklin, MD, Washington State Department
of Labor and Industries
Greg Marchand, The Boeing Company

Norifumi Kamo, MD, MPP, Virginia Mason
Franciscan Medical Center
Kimberly Moore, MD, Franciscan Health System
Carl Olden, MD, Pacific Crest Family Medicine
Mary Kay O'Neill, MD, MBA, Mercer
Susane Quistgaard, MD, Premera Blue Cross
Susie Dade, MS, Patient Representative
Judy Zerzan-Thule, MD, MPH, Washington State
Health Care Authority

Members Absent

Colleen Daly, PhD, Microsoft
Mark Haugen, MD, Walla Walla Clinic

Kevin Pieper, MD, MHA, Kadlec Regional Medical

2024 Topics



- Will discuss during meeting in July
- Topics:
 - Revisit 2 former topics
 - 1 new topic
- Bree Member Survey due July 11th

Update: HCA Community Health Worker Reimbursement



March, 2023 | Zoom Meeting

Topic Updates



May 24, 2023 | Zoom Meeting

Complex Discharge from Hospitals



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Members (partial list)



- **Chair:** Darcy Jaffe, BSN, MN, Washington State Hospital Association
- Shelley Bogart, DSHS-DDA
- Gloria Brigham, EdD, MN, RN, Washington State Nursing Association
- Colin Maloney, MPH, WA Department of Health
- Jason McGill, JD, WA Health Care Authority
- Sara Williams, RN, PeaceHealth
- Jeff Foti, MD, Seattle Children's
- Catherina McInroe, MSW, Providence
- Linda Keenan, PhD, MPA, RN-BC, United Healthcare
- Jen Koon, MD, Premera
- Amer May, MD, Kaiser Permanente
- Kim Petram, BSN, CPHM, Valley Medical
- Jennifer Triggs, MSW, Virginia Mason Memorial Hospital
- Cyndi Stilson, RN, BSN, Community Health Plan of Washington
- Zosia Stanley, JD, MHA, Washington State Hospital Association
- Billie Dickinson, Washington State Medical Association
- Janice Tufte, PICORI West Ambassador/Hassanah Consulting

Aim



Increase evidence-informed practices for appropriately and equitably discharging people from acute care facilities in order to increase access to acute care and improve quality of life for non-acute patients.

Brainstorming Complex Discharge Barriers



- Health Insurance
 - Under-funded or under-engaged health insurance.
 - Lack of coverage for required post-acute care need
- Post-Acute Care Capacity and Capability
 - No appropriate post-acute care beds
 - Staffing concerns
- Legal Barriers:
 - Guardianship requirements
 - Other legal barriers related to prior convictions
- Process Barriers:
 - Prior authorization
 - Assessments and eligibility
- Social Need
 - Housing, transportation, food
- Behavioral Health Need
 - Existing diagnosis, SUD, etc.
- Medical Need
 - Complex/specialty services: wound care, dementia, etc.

Data Examples



- Health Care Authority
- DSHS/HCS
- Virginia Mason
- Washington State Hospital Association
- Kaiser Permanente

Data Best Practices



- Align on a definition for avoidable days, even if different parties may calculate avoidable days differently.
 - Current consensus definition: Days where patient does not meet medical necessity and their care needs can be met at a lower level of care.
- Agree to collect standard patient information during the discharge process.
 - Patient characteristic information includes: demographics, geographic data, and information about potential barriers.
- Collect information about discharge barriers, similar to the list presented previously.
 - Different facilities may have their own process, but each site should develop a process for collecting discharge barrier categories.

Next Steps



- Review existing evidence for best practices to address specific barriers.
 - Beginning for medical need barriers, then walking through the other categories.
- Draft evidence-based recommendations to address barriers.

Thank You!



Opportunity for Public Comment

Diabetes



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Members



- **Chair:** Norris Kamo, MD, MPP, Virginia Mason Medical Center
- Susan Buell, YMCA of Tacoma and Pierce County
- LuAnn Chen, MD, MHA, Community Health Plan of Washington
- Sharon Eloranta, MD, Washington Health Alliance
- Rick Hourigan, MD, Cigna
- Carissa Kemp, MPP, American Diabetes Association
- Vickie Kolios, MSHSA, CPHQ, Foundation for Health Care Quality
- Robert Mecklenburg, MD, Virginia Mason Medical Center
- Mamantha Palanati, MD, Kaiser Permanente
- Khimberly Schoenacker, RDN, CD, WA Department of Health
- Cynthia Stilson, RN, BSN, Community Health Plan of Washington
- Sally Sundar, The Y of Greater Seattle
- Nicole Treanor, RD, Virginia Mason Franciscan Health

Aim



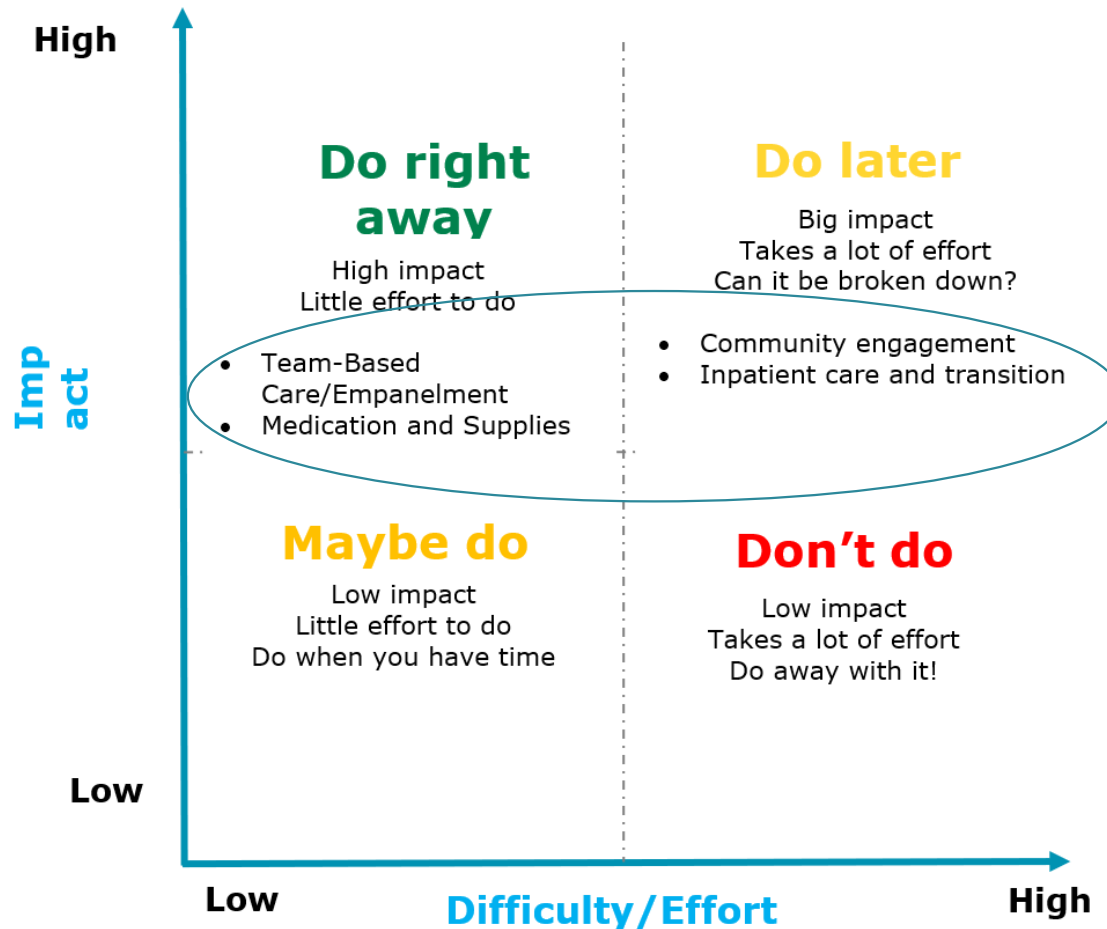
Improve health care quality, outcomes, affordability, equity, and workforce sustainability related to diabetes care in Washington state.

Topic Prioritization



- Inpatient care and transition: what actions are recommended to take while a patient with diabetes is in the hospital and support their transition back into the community.
- Team-based care and empanelment models: who should be a part of the team for different audiences (rural, low-income, uninsured), and recommendations for empanelment.
- Evidence-based medications and supplies: what items are recommended for clients that provide high quality of care and could be advised to be covered with low barriers.
- Engagement with the community: outreach, mobile vans, religious groups—how to connect with the community outside of the formal health care system to provide health promotion and prevention activities while addressing SDOHs. Public Health Service model and IHS model

Impact and Effort Chart



Evidence Review Progress



- Aided by Dr. Mecklenburg and MaryBeth McAteer at Virginia Mason
- Appraised approximately 250 papers to date, screening titles, reviewing abstracts, and selecting appropriate papers.
- Graded evidence using SORT methodology.
- Priorities based on workgroup's key themes and the impact/effort matrix.
- The first round of evidence review includes 15 articles, mostly focused on team-based care (especially related to pharmacists and dietitians leading care), patient-centered medical home models, and medically underserved populations.

Initial Recommendations and Further Questions



- Support Team-Based Care for Diabetes:
 - Who is on the team?
 - How do you support the team?
 - What training/knowledge/certification needs to be represented on the team?
- Patient-Centered Medical Homes:
 - What are the specific certifications/specifications that qualify a PCMH?
 - What are the characteristics of PCMHs that are most beneficial for diabetes outcomes (a Geisinger paper offers a spectrum of PCMH attributes)
 - Are there other attributes for effective diabetes care from other models (especially chronic care models or the HCA primary care transformation model)

Next Steps



- Refine evidence review based on comments from workgroup members.
- Continue evidence review with next topic: evidence-based medication and supplies.
- Draft initial recommendations on team-based care for discussion.

The workgroup heard from the American Diabetes Association that weight management is a priority for diabetes prevention. Members suggested that the topic of weight management (and weight-inclusive health) be considered as a 2024 Bree topic.

Thank You!



Opportunity for Public Comment

Perinatal/Maternal Mental Health



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Members (partial list)



- **Chair:** Colleen Daly, PhD, Microsoft
- Patricia Morgan, ARNP, Evergreen Health
- Trish Anderson, MBA, BSN, Washington State Hospital Association
- Elizabeth Tinker, PhD, MPH, MN, RN, WA Health Care Authority
- Emelia Udd, MD, Kaiser Permanente
- Aphrodyi Antoine, MPH, MPA, Health Related Services Administration
- Kristin Hayes, MSW, Evergreen Health
- Kay Jackson, CNM, ARNP, Off the Grid Midwifery
- Gina Legaz, MPH, WA Department of Health
- MaryEllen Maccio, DM, Valley Medical Center
- Melissa Rubin, DNP, ARNP, Sound Family Psychiatry
- Sheryl Pickering, WA Department of Health, WIC
- Billie Dickinson, Washington State Medical Association
- Cindy Gamble, MPH, American Indian Health Commission
- Ellen Kauffman, MD

Aim



To improve the mental health care continuum along the reproductive or family building journey including the perinatal and postpartum period.

Topic Brainstorming



Clinical Interventions	Midwives and Doulas	Community Supports
<ul style="list-style-type: none"> • Access to maternity care and behavioral health supports. • Efficacy of screening for perinatal mood disorders, substance use disorders, and intimate partner violence. • Referral pathways once a person screens positive. • Motivational interviewing and shared decision making to develop trusting relationships. • Inequities in screening/referral rates based on race/ethnicity • SUD treatment during pregnancy or the postpartum period • Sustainable reimbursement for adequate prenatal/perinatal visits • Access to resources (especially in areas with less access such as rural areas) – impacted services due to people crossing state borders • Language and culturally appropriate services. 	<ul style="list-style-type: none"> • Connecting to doulas. • Initiatives to connect midwives to SUD-treatment providers. • Certification for doulas and differences in outcomes for certified doulas. • Access to doulas for different communities. • Connecting social workers to community midwives and doulas • Sustainable reimbursement for midwives/doulas 	<ul style="list-style-type: none"> • Coordination among community services providers to provide wrap-around services • Coordination between primary care providers and social services, recognizing historical trauma. • Effect of public policies for economic supports for clients/patients on maternal mental health outcomes. • Home-visit programs • Raising awareness and education of maternal mental health at a population level. • State-wide strategic plans and funding at the state level

New Evidence Review Categories



Focus Area	Topics for Review
Clinical Screening and Referral	<ul style="list-style-type: none"> • Efficacy of screening for perinatal mood disorders and SUD and follow-up for referrals to behavioral health • Levels of risk and targeting interventions • Inequities in screening process and outcomes • Clinician education and workflows
Patient-Provider Interactions	<ul style="list-style-type: none"> • Trauma-informed and culturally appropriate care • Motivational interviewing and shared decision making
Clinical Structure and Services	<ul style="list-style-type: none"> • Offering language and culturally appropriate services • Impact of the number of visits and length of visits on mental health outcomes • Home visit programs and other models of care delivery (such as integrated behavioral health
Access and Coordination	<ul style="list-style-type: none"> • Access to clinical providers – doulas, midwives, and/or OBGYNs, behavioral health providers, and other social service resources • Coordinating information between clinical care, behavioral health, and social services • Access to effective perinatal programs (such as home visits or group prenatal care)
Care Team	<ul style="list-style-type: none"> • Certification and professional roles for doulas, midwives, and OBGYNs • Efficacy of team-based care that involves community health aids, doulas, social work, and/or psychiatric care.
Incentives	<ul style="list-style-type: none"> • Reimbursement for perinatal care visits, midwives/doulas, and behavioral health providers • State-wide strategic plans and funding for perinatal mental health • Impact of federal funding and public policies on maternal and child outcomes
Community Initiatives	<ul style="list-style-type: none"> • Public education and awareness campaigns – acknowledge press, education to providers • Cultural programs and initiatives, especially for populations with inequities, including Black/African American and American Indian/Alaskan Native pregnant people.

Evidence Review Process



- 38 citations reviewed, especially related to the first three categories: screening and referrals for perinatal mood disorders, patient and provider relationships, and clinical structure.
- 10 examples of community initiatives reviewed, especially for black/African American mothers, and federal programs for awareness and education.

Further Questions and Next Steps



- Screening:
 - Information about screening for maternal mental health in pediatric practices and details on how to implement screening workflows.
- Patient-Provider Interactions:
 - How to address patient perceived discrimination from providers.
- Clinical Structure
 - Additional clinical models, such as group prenatal care.
 - Additional citations related to integrated behavioral health, specific to maternity care.
- Community Initiatives
 - More programs for vulnerable populations, partner support programs, and domestic violence social services.
- Next Steps:
 - Further review for care team, access, and incentives.
 - Begin drafting screening recommendations.

Thank You!



Opportunity for Public Comment

Bree Updates



Bree Newsletter



**FOUNDATION FOR
Health Care Quality**

**Bree Collaborative Newsletter**

May 2023

**Checklists**

Bree staff collaborated with former workgroup members to help develop the checklists and intend to use the checklists to support the overall assessment of Bree report uptake in our health ecosystem. The checklist tool helps inform users about what the Bree Report is recommending them to do. The guidelines listed in the report have been translated into action items that are specific to the user audience. The actions are organized into three different levels of implementation that help inform a starting point for the users' work and aid in assessing their progress in implementing the Bree report into practice. Checklists have been developed for the Hepatitis C Virus report, and we intend to roll out more for other Bree Report topics soon. Access the checklists [here](#).

Health Equity Action Collaborative—Starting Tuesday, June 13th!

After speaking with interested participants, we have decided to delay our first meeting of the Health Equity Action Collaborative until **Tuesday, June 13th, from 2-4 pm** to give additional time for preparation to engage in the collaborative. If you are interested in participating, please email Emily Robson erobson@qualityhealth.org for more information. During the collaborative, participants will receive support in taking their chosen health project from an idea to developing an implementation plan that can be enacted within their organization. Health equity will be centered in the design process through education, discussion, and peer engagement. The action collaborative is open to individuals working within the healthcare ecosystem.



Join our team


FHCQ is hiring for a role with the Bree Collaborative

We are seeking a director of research and best practice with good communication skills, flexibility, and a collaborative workstyle. This position contributes to the development of organizational and program-specific strategies, policies, and practices to facilitate effective development and implementation of clinical guidelines. This team member will work closely with and report to the CEO. More information [here](#).

Upcoming Bree Collaborative Events



Examining the Complexities of REL Data
Thursday, June 1st, 2023
Health Equity Webinar Series:
Brought to you by Foundation for Health Care Quality,
the Washington Health Alliance, and
Comagine Health



Social Need and Health Equity Summit
Wednesday, June 14th, 2023
9:00 AM - 12:00
Virtual

Examining the Complexities of Race, Ethnicity, and Language, Data Webinar
Thursday, June 1st, 2023, 12-1:30 PM PT
[Register here!](#)

Social Need and Health Equity Summit
Wednesday, June 14th, 2023, 9-12:00 PM PT
[Register here!](#)

Examining the Complexities of Race Ethnicity and Language Data Webinar. Join Foundation for Health Care Quality in collaboration with Washington Health Alliance and Comagine Health in the second webinar of a three-part series focused on health equity! In this webinar, speakers will discuss the ethical and pragmatic challenges to collecting data on Race, Equity, and Language (REL); data storage and prep for analysis; and how data may be used to inform actions to advance equity.

Event Speakers:
-Rosalina James (Lummi/Duwamish), PhD-Director of Evaluation & Research at the United Indian Health Institute
-Jessica Beach, MPH, MPA- Health Equity Director at Molina Healthcare
-DoQuyen Huynh, DNP, FNP, ARNP, FAAN-Health Equity Director at HCA
-Cade Walker, JD, MHA-Rules, Policy & Compliance Section Manager at HCA
-Matthew Jaffy, MD- University of Washington

Join the Foundation for Health Care Quality on June 14th, 2023 for a virtual summit dedicated to taking action on social need and health equity. We will present our upcoming recommendations for social need and health equity and learn from organizations around Washington that are putting best practices into action. We will highlight actions related to social need screening and interventions, sociodemographic data collection, and initiatives to advance equity. We will also talk about strategies to align healthcare and community organizations from local public health and state agencies.

Event speakers: To be announced

Health Equity Action Collaborative

About the Action Collaborative

Join Bree Collaborative Staff as a participant in the Health Equity Action Collaborative! During the collaborative, participants will receive support in taking their chosen health project from an idea to developing an implementation plan that can be enacted within their organization.

Open to individuals working within the healthcare ecosystem (clinicians, delivery sites, QI teams, purchasers, plans, etc.)

Join Us

Contact bree@qualityhealth.org for more information and to sign-up to participate.



The Commitment

- 2-Hour-Long Meetings
- 7 Monthly Meetings
- June-December 2023—beginning June 13th 2-4 Pm PT
- Chosen health topic aligns with a Bree Report

The Benefits of Participating



Development of a health project plan & implementation skills



Equity at the forefront of the design



Networking with peers in WA State

Checklists



- Why checklists?
- Co-created with former workgroup members
- The checklist translates the Bree guidelines into action steps for that sector
- The action items have been arranged into levels 1, 2, and 3 to correspond to the difficulty level of implementing into practice
- Starting place
- Assessment tool

Checklists



Hepatitis C Virus Recommendation Checklist Clinicians & Pharmacists- Level 2



The current state of the issue

The number of acute HCV cases has been steadily increasing in the United States between 2012-2019, with an estimated 133% increase in acute cases reported in 2019 compared to 2012. While the cure cascade for HCV is well-defined, disparities in testing and treatment prevent many patients from accessing treatment. The greatest gap occurs between diagnosis and treatment. In Washington, only an estimated 12% of patients with diagnosed HCV infections start direct-acting antiviral treatment. Together, we can support the screening and treatment of individuals with HCV to reach our goal of eliminating Hepatitis C in Washington State by 2030.

Increase screening opportunities

- ☐ Review the notification process in EHR system, alerting the clinician that the client is due for HCV screening.

Strengthen the capacity to treat and cure individuals

- ☐ Become an HCV clinical champion within your organization to support other providers in managing HCV clients.
- ☐ Mentor and teach Health Professional Trainees and Students on HCV management.
- ☐ Understand that people living with HCV may have complex life domain issues and may need support accessing care and adherence support. Refer people living with HCV who have challenges to care navigation services.

Utilize an interdisciplinary team

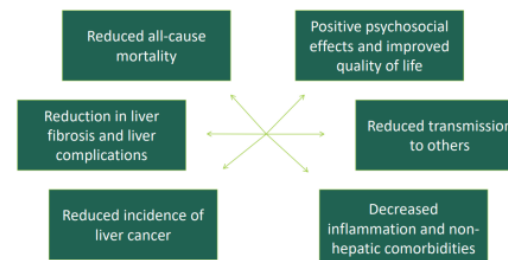
- ☐ Connect pharmacists and physicians to facilitate collaborative drug therapy agreements (CDTAs) to create models of care delivery to treat HCV.
- ☐ Consider providing HCV counseling as a form of medication therapy management (MTM) for reimbursement.
- ☐ Engage with interdisciplinary networks for treating HCV that include clinicians, pharmacists, and care coordinators.

Measure outcomes

- ☐ Support the implementation of two HCV metrics into value-based contracts.
- ☐ One metric on HCV screening for adults aged 18 to 79
- ☐ One metric for connecting people living with HCV to treatment, specifically the prescription of direct-acting antivirals (DAAs)

Created: April 2023

Benefits of Cure of HCV



Resources

- The Bree Report on HCV is meant to supplement these resources.
- Full Bree Report on HCV: <https://www.qualityhealth.org/bree/topic-areas/hep-c/>
- AASLD/IDSA: <https://www.hcvguidelines.org/>
- Hep C Free Washington (DOH): <https://doh.wa.gov/you-and-your-family/illness-and-disease-z/hepatitis-information/hepatitis-c/eliminating-hepatitis-c>
- Hep C Free Washington (HCA): <https://www.hca.wa.gov/about-hca/programs-and-initiatives/clinical-collaboration-and-initiatives/eliminating-hepatitis-c>
- Project ECHO Viral Hepatitis: for UW, contact Pam Landinez at landinez@uw.edu
- UW HCV Training: <https://www.hepatitisc.uw.edu/>
- CDC Hepatitis C Virus: <https://www.cdc.gov/hepatitis/hcv/index.htm>
- Hepatitis C Medical Case Management Toolkit: Creating and Expanding Services: https://hepeducation.org/wp-content/uploads/2021/10/HEP_MCM_Toolkit.pdf

Read the full Bree Report on HCV online by scanning the QR code:



Connect with the Bree Collaborative at bree@qualityhealth.org

References: 1. Centers for Disease Control and Prevention. 2021. Viral Hepatitis Statistics and Surveillance: Figure 3.1 Number of reported acute hepatitis C virus infection cases and estimated infections - United States, 2012-2019. Accessed August 2022. Available: <https://www.cdc.gov/hepatitis/statistics/2019surveillance/Figure3.1.htm>. 2. Hep C Free Washington. 2019. Plan to Eliminate Hepatitis C in Washington State by 2030. Washington Department of Health. <https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/150nonDOH-HepCFreeWA>

Case Studies



In progress:

Delta Dental of Washington, Arcora Foundation, and Healthethnic

- Bree Report: Dental Guideline on Prescribing Opioids for Acute Pain Management

Up-coming:

The Everett Clinic

- Opioid metrics implementation in a clinical setting

2024 Topics



- Will discuss during meeting in July
- Topics:
 - Revisit 2 former topics
 - 1 new topic
- Bree Member Survey due July 11th
- General Public Survey will close in July

Upcoming Events



- Thursday, June 1st 12-1:30 PM PT: Examining the Complexities of REL Data Webinar
- Annual COAP meetings
 - Wednesday, June 7th, 8-4 PM PT: Cardiac COAP Annual Meeting
 - Thursday, June 8th 8-4 PM PT: OB COAP Annual Meeting
- Wednesday, June 14th 9-12 PM: Social Need and Health Equity Summit