

Dr. Robert Bree Collaborative Meeting Minutes
November 15th, 2023 | 1:00-3:00
Held Hybrid

Members Present

Emily Transue, MD, Comagine Health (Chair)	Norifumi Kamo, MD, MPP, Virginia Mason
Hugh Straley, MD, Bree Collaborative (Former Chair)	Franciscan Medical Center
Susie Dade, MS, Patient Representative	Greg Marchand, The Boeing Company
Colleen Daly, PhD, Microsoft	Kimberly Moore, MD, Franciscan Health System
June Alteras MN, RN, MultiCare	Carl Olden, MD, Pacific Crest Family Medicine
Sharon Eloranta, MD, Washington Health Alliance	Kevin Pieper, MD, MHA, Kadlec Regional Medical
Gary Franklin, MD, Washington State Department of Labor and Industries	Susane Quistgaard, MD Premera Blue Cross
Colin Fields, MD, Kaiser Permanente	Angie Sparks, MD, UnitedHealthcare
Darcy Jaffe, MN, ARNP, FACHE, Washington State Hospital Association	Nicole Saint Claire, MD, Regence BlueShield
	Judy Zerzan-Thul, MD, MPH, Washington State Health Care Authority

Members Absent

Patricia Egwuatu, DO	Mary Kay O'Neill, MD, MBA, Mercer
Mark Haugen, MD, Walla Walla Clinic	

Staff, Members of the Public

Beth Bojkov, MPH, RN
Karie Nicholas, MA, GC, FHCQ
Emily Nudelman, DNP, RN, FHCQ
Ginny Weir, MPH, FHCQ
Summer Duman RBS
Audrey J, Regence
Kristina Petsas, CMO, UHC
Rodica Pop, MultiCare
Drew Oliveira, WHA
Shelby Wiedmann, WSMA
Ji Young Nam, L&I

WELCOME, INTRODUCTIONS

Beth Bojkov, MPH, RN, welcomed everyone and opened the meeting. Ms. Bojkov welcomed Dr. Emily Transue as new Bree Chair.

Ms. Bojkov reviewed the last meeting's minutes.

Motion: Approve September Meeting Minutes

Outcome: Passed with unanimous support

Ms. Bojkov went over the report review process and voting for public comment. Each report presentation will have 15 minutes to overview the content of each report, then 8 minutes for Q&A including public comment and 2 minutes for voting. All members present in person voted out loud, all members present online were asked to put their vote in the Zoom chat.

Complex Discharge

Darcy Jaffe, MN, ARNP, FACHE, Washington State Hospital Association, and chair of the Complex Patient Discharge Workgroup provided a general overview of the workgroup members, the aims of the workgroup, and the highlights of recommendations for each audience.

- Darcy highlighted that getting to a common definition for a complex patient discharge and a complex patient discharge barrier list was impactful for the group and took significant time to develop.
- A comment was made that the title of DSHS, HCS and DDA was confusing as HCS and DDA are within DSHS - > **Action:** change name to DSHS only.

Q & A Section:

- In person group:
 - Question: what is the current situation on demand and patients waiting in the hospital right now?
 - Darcy answered 10-20% of beds are complex discharge patients but has been increasing over time
 - Question: are there best practices identified for these patients?
 - Darcy answered yes, and that the Governor's office appointed a Complex Discharge Taskforce that will be piloting a model of care coordination based off Harborview Medical Center's Discharge Readiness program. Other issues include regulation, like the guardianship process, and policies that lengthen the process.
 - Question: Do we know why people are stuck? What are the most common barriers?
 - Behavioral health concerns, geriatric complex patients and bariatric patients with bariatric needs are common
 - Darcy identified that the #1 barriers are usually behaviors, like individuals might be difficult with other residents, guardianship processes and substance use disorder concerns.
 - **Action:** add appendix to report before putting up for public comment on other conversations and taskforces already underway
 - Question: Is there a top 2-3 actions that people can take? How will we measure progress on these recommendations and if they've had an impact?
 - Measures will be discussed at the upcoming workgroup meetings and finalized before presentation in January.
 - There aren't a lot of measures available, but plan to talk more with workgroups in December in the attempt to have identified needs. Communication and coordination is key but measuring that is difficult.
 - Question: Is there a reporting tool to report number of patients who meet this definition?
 - Darcy stated WSHA has a tool that they use twice a year to see how many patients meet this definition, but it's difficult to use in real-time
 - There are still unanswered questions on how to measure how we improved on implementation of these recommendations and if they helped the situation
 - Question: Is there a way to get a monthly reporting of the current definition from every hospital?

- Darcy stated it might be possible, but monthly would be difficult. A group member asked if the Department of Health should be involved in this, and Darcy said she is not sure but they do not have a measurement on complex patient discharge yet.
- A comment was made from the in person group that lack of care coordination and paying for care coordination should be prioritized
 - Another Bree member commented that this is already happening in MCOs, and care coordinators are not going to fix the system if they are doing everything they can to coordinate but there is no one to help them or no capacity at post-acute facilities.
 - A bree member mentioned that funding mechanisms are outside the scope of the report.
- Online comments were made including:
 - June Alteras asking if the group could measure percent of beds. This might be a way to consistently show that improvement is being made
 - Other measures could include percent of boarded patients, and serious safety events in Emergency departments. Serious safety events increase as boarded patients increase and has been well described in the literature.
 - Kevin added a comment that this report might be a good opportunity to call out the lack of resources available to discharge these patients when needing a SNF or behavioral health bed. It doesn't address post-acute capacity or that post-acute facilities cannot afford to take the more complex patients based on their reimbursement.
 - June Alteras also commented that she tracks inpatient boarded patients daily and complex discharge weekly, and that serious safety events are correlated with the number of boarded patients. This information is readily available to us.

Motion: The members voted to approve the document for public comment.

Outcome: approved for public comment.

Diabetes

Norris provided general overview of report and summary of recommendations for each audience in the report, including clinicians and health professionals, ambulatory care systems, inpatient settings, health plans, dental plans, employer purchasers, public health agencies, schools, the State Legislature, dentists and dental clinics and eye care professionals and eye clinics.

- Question: Is a recommendation for a dental registry in this report?
 - Not currently, but we have contacts in dental world that can provide more detailed information
 - Action: Follow up with contacts at Delta Dental before report is finalized to discuss the dental registry.
- Question: Have you considered what kinds of metrics to use to evaluate whether the report has made improvements?
 - This is a goal of the December workgroup meetings and will be addressed before the final report. Emphasis on not reinventing the wheel when it comes to evaluating the guidelines.
- Question: Is there a difference between the collaborative care model and team based care?
 - Yes, collaborative care is a form of team-based care with a specific model. We're not recommending a specific model but are recommending that a team is utilized, including members like an RN and a clinical pharmacist.
- Question: This is a rather large document - where does someone start?

- Dr. Nudelman is working on developing some checklist tools to help stakeholders with their process of implementing the guidelines.
- Public Comments;
 - Comment from the public: NDPP programs are standardized programs but there's a 3-4 fold difference in costs between vendors. Why should the HCA cover any willing provider of NDPP?
 - Action: Follow up with Diabetes workgroup members to understand cost differences and implications for this report – to be addressed before finalization in January.
 - Suggested metrics: <https://wahealthalliance.org/how-does-washington-state-perform-on-diabetes-care/>

Motion: The members voted to approve document for public comment.

Outcome: approved for public comment

Perinatal Behavioral Health

Colleen provided general overview of report, focus areas and summary of recommendations for each audience in the report, including perinatal providers, providers and clinics working with pediatric patients, outpatient perinatal care clinics and facilities, birthing hospitals, health plans, purchasers, public health agencies and urban Indian health organizations, and the State Legislature.

- Question: Is there a default for who to take care of individuals who care for parents identified with postpartum depression? What about pediatricians?
 - Pediatricians might not feel comfortable since they are not the
 - Integrated behavioral health is vital for this population, and something we have referenced and recommend.
- Question: There's a lack of resources in this area. Is there a default in who takes care of the postpartum person? What is the role of a Pediatricians?
 - No default although there are several options
 - Pediatricians are very engaged but have not gotten to the point where there are systems of care coordination set up.
- Question: Is there any evidence of which clinicians are best equipped to provide post-natal care for mothers in the first year postpartum? OB? Family Practice? Internal Medicine? All of the above?
 - Family practice is a strong model because they can care for the children and the birthing person
 - However, often the parents may not be getting themselves to the doctor but may be getting their child to the doctor,
- Question: is there any information or literature on the transition of postpartum depression into long term depression?
 - This issue was raised but it is outside the scope of this report. There is language already in the integrated behavioral health with primary care report supporting the identification of people more at risk.
 - We've identified in the report that postpartum clinicians should do a warm handoff to the mother's PCP.
 - There are markers during this period that may indicate severity of behavioral health before and continuation of behavioral health concerns after the postpartum period
 - Supporting people who have a BH diagnosis pre-pregnancy to transition to pregnancy and post-pregnancy.
 - Follow up question: For very severe cases of behavioral health, what does the report state?
 - Report goes into variable states based on the response to screening.

- Comment from chat: Pre-existing behavioral health issues combined with high risk SDOH issues are clearly linked to more severe/significant postpartum behavioral health issues, and in the MMRP reviews responsible for the majority of maternal deaths in the first year postpartum. For individuals who develop postpartum psychosis, the greatest risk factor is personal or family history of bipolar disorder or prior psychotic episode at any point during life
- **Action for final report:** develop specific language pertaining to severe/significant postpartum behavioral health issues as they are responsible for the majority of maternal deaths in the first year postpartum
- Question: What about coverage for midwifery care?
 - Currently this is not universal from our understanding. The office of the Governor is proposing coverage of doula care. The governor is creating a proposal on payment for doula care.
- Question: Did you consider mothers with substance use disorder, particularly opioid use disorder, and ensuring continuity of care with MAT?
 - Yes, parents with substance use disorder and ensuring continuity of care with MAT are included in this report
- Question: Is there a comment on standardization for all providers prescribe MAT with waiver removal?
 - Sub-bullet page 11 “Include protocols and procedures for all prescribers to be empowered to prescribe medications for opioid use disorder, as an x waiver is no longer required to prescribe.”

Motion: The members voted to approve document for public comment.

Outcome: approved for public comment

Bree 2024 Report Topic Updates

- Heat-related illness workgroup will be chaired by Dr. Chris Chen
- Treatment for OUD is being chaired by Dr. Charissa Fotinos
- Early BH Interventions for Youth—still seeking a chair and are in the works for finalizing.

Evaluation

- Scorecards: working on contacting organizations to get information on the existing guidelines
- Evaluation Survey Question Bank: want to leverage any evaluations that have happened in organizations already, so created bank, one organization is using this tool and has shared their information with us already. We encourage everyone to share these tools with your organization – if your organization has conducted an evaluation, we’d love to know that information.
- Other surveys: released the Health System Survey in the spring, will be adding it to reports in the first quarter of next year; using the qualitative section to evaluate all guidelines going forward to understand barriers and facilitators to adopting and implementing these guidelines
- Dashboards: currently developing the dashboards for guidelines, and difficult to do since guidelines are very different.
- Imbedding evaluation into guideline development: want to develop a structure to evaluate these reports as they are being developed – evaluation is an ongoing activity in the future, and want to have some predetermined schedule so that we can revisit in a couple years and understand what has happened with the guidelines thus far.

Implementation

Emily Nudelman, DNP, RN gave updates on implementation efforts by Bree Collaborative.

- Checklists: we heard feedback from our community on how they appreciate our reports but would value guidance on where to begin. Checklists translates the Bree guidelines into action steps for that sector (i.e., clinician, health delivery site, health plan, purchaser, etc.). The action items have been arranged into levels 1, 2, and 3 to correspond to the difficulty level of implementing the action into the sectors' setting. HCV has been developed and working on others.
- Health Equity Action Collaborative: 10 organizations are participating in this HEAC to translated one Bree guideline into their practice settings. This will wrap up next month. We have received positive feedback on this group.
- Looking into opportunities for 2023 reports: will provide further feedback and updates on this in an upcoming meeting.
- Working on identifying the Bree identity for implementation and sustainability of the work.

NEXT STEPS AND CLOSING COMMENTS

Upcoming event on December 5 on GLP1 Discussion. Please email bree@qualityhealth.org for more information.

Bree staff and members thanked out former Bree Chair Dr. Hugh Staley for his years of leadership as the Bree Member Chair.

Bree staff will post the Bree Reports on the Bree website for public comment, workgroups will review and finalizing reports. At next meeting, Bree members will vote to finalize reports. identify workgroup chairs and recruit participation to engage in workgroups. Dr. Nudelman thanked those who attended and closed the meeting.

Next Bree Collaborative Meeting: January 24th, 2024