Bree Collaborative Meeting

May 25, 2022| Zoom Meeting

Agenda

- **Welcome and Introductions**
  - Adopt March Meeting Minutes
  - COVID-19 Check-In
  - New Topics Selection Process for 2023
- **Discussion:** Maternity Bundle Process and Plan
- **Public Comment:** Opioid Prescribing in Older Adults
- **Topic Update**
  - Infection Control
  - Hepatitis C
  - Pediatric Asthma
- **Discussion and Update:** Bree Implementation Plans
- **Next Steps and Close**

March 23rd Meeting Minutes

Dr. Robert Bree Collaborative Meeting Minutes
March 23rd, 2022 | 1:00-3:00
Held Virtually

Members Present

Hugh Straley, MD, Bree Collaborative (Chair)
Norifumi Kamo, MD, MPP, Virginia Mason Franciscan Medical Center
Susane Quistgaard, MD, Premera Blue Cross
Sharon Eloranta, WHA
Mark Haugen, MD, Physician, Walla Walla Clinic
Carl Olden, MD, Pacific Crest Family Medicine
Kevin Pieper, MD, MHA, Kadlec Regional Medical Center
Mary Kay O'Neill, MD, MBA, Merc
Susie Dade, MS, Patient Representative
Kimberly Moore, MD, Franciscan Health System
John Robinson, MD, SM, First Choice Health
Rick Ludwig, MD, Providence Health
Darcy Jaffe, MN, ARNP, NE-BC, FACHE, Washington State Hospital Association
Jaymie Mai, PharmD, (for Gary Franklin), Washington State Department of Labor and Industries

Members Absent

Dan Kent, MD, United Health Care
DC Dugdale, MD, MS, University of Washington Care Medical Center
Angie Sparks, MD, Kaiser Permanente
Judy Zerzan, MD, MPH, Washington State Health Care Authority
Jeanne Rupert, DO, PhD, The Everett Clinic
Stuart Freed, MD, Confluence Health
Greg Marchand, The Boeing Company

Washington Maternity Value-Based Purchasing (VBP) Model Update

Bree Collaborative Meeting

May 25, 2022

Washington State Health Care Authority

Bree Collaborative and working with NORC under the Innovation Accelerator Program

- The Bree Collaborative's work on a maternity bundled model for the state, including a 2019 report, helped lead HCA to seek technical assistance from the NORC team via the federally funded Innovation Accelerator Program (IAP)

- Under IAP, from March 2020-August 2020 the NORC team provided Medicaid policy and financial modeling technical assistance to advance a maternity episode of care model in Washington

Maternity VBP Model in development

- HCA is now contracting with the NORC team (NORC, Aurrera Health Group and Actuarial Research Corporation) from March-December 2022
- The NORC team is helping with the design, specification, financial modeling and stakeholder engagement guidance for the maternity VBP model building on the Bree Collaborative's work
- NORC team introductions

Maternity VBP model goals

- Incentivize high-quality, high-value care that improves perinatal health outcomes and addresses racial and ethnic disparities
  - Increase utilization and improve quality of prenatal and postpartum care
  - Reduce racial and ethnic disparities
  - Reduce maternal morbidity and mortality, leverage 12mo of PP coverage
  - Improve birth outcomes
  - Increase care coordination between care teams for birthing/postpartum people and infants
  - Improve maternal physical and behavioral health outcomes

June 7, 2022 “kick-off” webinar

During the webinar we will:

- Introduce model goals and model development process and high-level timeline
- Provide an overview of the stakeholder engagement process
- Obtain initial input on model goals

We will not:

- Solicit input on specific details of model design

Avenues for future feedback during the design phase

- Stakeholder engagement process
- Tribal consultation
- Written input – on HCA's maternal care model webpage
  - https://www.hca.wa.gov/about-hca/clinical-collaboration-and-initiatives/maternal-care-model

Approve for Public Comment:
Opioid Prescribing in Older Adults

DR. ROBERT BREE COLLABORATIVE

May 25, 2022 | Bree Collaborative Meeting

Workgroup Members

- Gary Franklin, MD, MPH (Co-chair), Washington State Department of Labor and Industries
- Darcy Jaffe, MN, ARNP, NE-BC, FACHE (Co-chair), Washington State Hospital Association
- Mark Sullivan, MD, PhD (Co-chair), University of Washington
- Judy Zerzan-Thul, MD, MPH (Co-chair), Washington State Health Care Authority
- Carla Ainsworth, MD, MPH, Iora Primary Care - Central District
- Denise Boudreau, PhD, RPh, MS, Kaiser Permanente Washington Health Research Institute
- Siobhan Brown, MPH, CPH, CHES, Community Health Plan of Washington
- Rose Bingham, Patient Advocate
- Pam Davies, MS, ARNP, FAANP, University of Washington / Seattle Pacific University
- Elizabeth Eckstrom, MD, Oregon Health Sciences University
- James Floyd, MD, University of Washington School of Medicine
- Nancy Fisher, MD, Ex Officio
- Jason Fodeman, MD, Washington State Department of Labor and Industries
- Debra Gordon, RN, DNP, FAAN, University of Washington School of Medicine
- Shelly Gray, PharmD, University of Washington
- Clarissa Hsu, PhD, Kaiser Permanente Washington Research Institute
- Michael Parchman, MD, Kaiser Permanente Washington Research Institute
- Jaymie Mai, PharmD, Washington State Department of Labor and Industries
- Wayne McCormick, MD, University of Washington
- Kushang Patel, MD, University of Washington
- Elizabeth Phelan, MD, University of Washington
- Yusuf Rashid, RPh, Community Health Plan of Washington
- Dawn Shuford-Pavlich, Department of Social and Health Services
- Steven Stanos, DO, Swedish
- Angela Sparks, MD, Kaiser Permanente Washington
- Gina Wolf, DC , Wolf Chiropractic Clinic

Background

- 2018 – AHRQ highlighted increasing rates of opioid-related hospitalizations in older adults, with the highest reported median rates in Oregon and Washington.
- While opioid prescribing and mortality specific to prescribed opioids have fallen between 2017-2018, the CDC reported that the specific opioid related mortality rate for persons ≥65 years increased by 4.8%.

Wilson N, Kariisa M, Seth P, et al. Drug and opioid-involved overdose deaths, United States, 2017-2018. Morb Mortal Wkly Rep 2020; 69:290–297. URL: http://dx.doi.org/10.15585/mmwr.mm6911a4external icon, Accessed 4/1/2021

Opioid-related harms are increasing among older adults

- Even when using as directed more likely to experience
  - Adverse drug reactions
  - Falls and fractures
  - ED visits, hospitalizations, and death,
- Exacerbate pre-existing conditions
  - Cognitive impairment
  - Compromised respiration
  - Hypogonadism
  - Osteoporosis
  - Frailty (or diminished physical reserve)
  - Other substance (e.g., alcohol) use disorders.

Unrecognized cognitive decline may lead to accidental poisoning or overdose

https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/opioids-older-adults-techbrief.pdf

Unique Challenges for Assessment and Management

- Age-related changes in pain perception and thresholds
  - Differential aging effects = more or less vulnerability
- Responses to medication
  - higher peak drug levels, delayed clearance, longer duration of action and higher rates of side effects
- Comorbidities (medical and psychological), resulting in polypharmacy
- Psychosocial concerns, and lack of care coordination

Take home message

An integrated, coordinated, and individualized approach may be particularly important in the Medicare population to assure optimal pain management

Focus Areas

1. **Acute prescribing including acute injuries and peri-operative**
   Goal: Prevent transition to chronic prescribing
2. **Co-prescribing with opioids** (e.g., sedative hypnotics, gabapentinoids, z-drugs)
   Goal: Reduce impacts on cognition, falls, delirium
3. **Non-opioid pharmacologic pain management**
   Goal: Evidence base and risk/benefit
4. **Non-pharmacologic pain management**
   Goal: Evidence base and risk/benefit (e.g., CBT, active exercise)
5. **Intermittent opioid therapy**

   Goal: Allow very intermittent use for chronic/recurrent pain
6. **Tapering/deprescribing in this population**
   Goal: Differentiators with recent Bree recommendations for legacy patients

Summary

- There is little high-grade evidence on opioid prescribing/use specific to advancing age by decade of life
  - ~6% opioid naïve adults ≥ 65 transitioned to chronic opioid use
- Approaches to opioid prescribing and pain management should be focused on function and safety
- Start low, go slow and “stop soon”
- Key recommendations:
  - Make use of non-pharmacologic pain management modalities
  - Individual care plans
  - Perform comprehensive medication review
  - Coordinate care
  - Use pharmacists in multidisciplinary teams

Health Care Site or Delivery System Recommendations

Expand Access

- Provide adequate access to at least some nonpharmacologic modalities, including connecting older adults to community resources
- Expand coverage for topical medications

Track and Monitor Prescribing

- Track prescribing practices and drug-related adverse outcomes
- Set the expectation for standardized medication review, including reviewing the Prescription Monitoring Program (PMP)

Comprehensive Medication Review

- Provide clinical decision support tools within the Electronic Health Record, including integrating the PMP into the EHR
- Establish the infrastructure to provide Medication Therapy Management, including annual comprehensive medication reviews

Health Care Site or Delivery System Recommendations (continued)

Team-Based Care

- Develop multidisciplinary, collaborative teams to support older adults with acute or chronic pain.
- Improve access to specialty care for patients beginning opioid tapers.

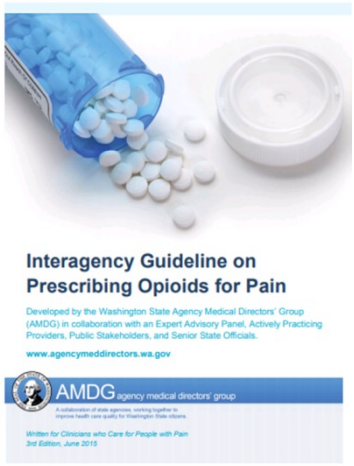
Education

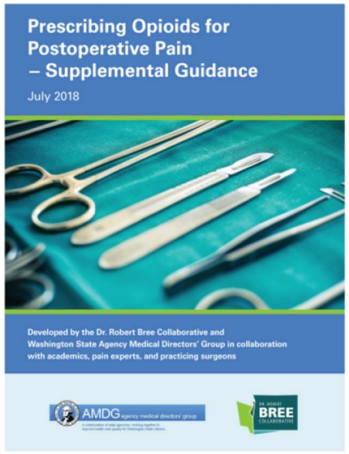
- Educate older adults and their caregivers about non0opioid pharmacologic pain management options. This should include education on the potential dangers of polypharmacy and benefits of deprescribing.

Acute Prescribing Recommendations

Prior to procedure and prescribing:

- **Perform a risk assessment for severe acute pain and adverse effects** of opioids prior to prescribing
- **Engage in proactive pain management planning, including pharmacologic and nonpharmacologic methods** of pain management. Establish realistic goals and expectations with the patient and family or caregiver (if present)
- **Designate provider to be responsible for managing ongoing acute or postoperative pain**, including prescribing any opioids, policy on opioid refills, patient reassessment





Acute Prescribing Recommendations

When considering dosing:

- **Start at 25%-50%** of what would be initiated in a younger adult and **extend the dosing intervals**
- **Use lowest dose for shortest duration** possible, prescribing <7 days (ideally ≤3 days) (consistent with CDC guidelines and WA pain rules).
- **Avoid complicated regimens**. Consider the person's other medications (e.g., muscle relaxers, antihistamines, anticholinergics)
- **Use caution with morphine** due to variable renal function and potential accumulation of active metabolites.
- **Avoid using long-acting opioids for acute pain** (methadone, levorphanol, fentanyl patch or opioid delivered by extended-release forms)

Acute Prescribing Recommendations

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During discharge and follow-up:

- **Maintain a high vigilance for exaggerated side effects**
- **Track opioid use and signs of potential misuse** including the emergence of opioid use disorder during acute recovery and related functional status with outcome measures
- **Be attentive to varying degrees of cognitive impairment** that may impact opioid and other medication safety. Provide clear oral and readable written instructions on:
  - The risks, safe use, and storage of opioids and proper disposal of controlled substances through Safe Medication Return Program.
  - Which provider will be responsible for managing ongoing acute or postoperative pain, including who will be prescribing any opioids, the policy for refills and follow-up evaluations
  - Planned taper of acute opioids, including a timeline for return to preoperative or lower opioid dosing for those on chronic opioids
- **Perform medication review and reconciliation** at follow up visits to ensure the patient is not continuing medication that s/he no longer needs

Intermittent Opioid Therapy

Recommendations based primarily on consensus of expert opinion due to lack of published evidence

- Consider prescribing intermittent opioid therapy for chronic conditions with **sporadic pain flares** (e.g., relapsing remitting MS) **only if it improves physical and social engagement.**
- Use the **lowest dose of short-acting** opioids possible, avoiding prolonged (more than a few days) and continuous (around-the-clock) use
- **Re-evaluate frequently for risk** of falls, sedation, and other opioid-related adverse effects, as risk changes with advancing age and use of other CNS-active medications and alcohol.

Co-Prescribing with Opioids

- **Consider non-pharmacologic modalities** for pain management to prevent co-prescribing opioids with CNS-active medications
- If opioids are determined to be necessary**, perform a targeted medication review for benzos, Z-drugs, skeletal musc le relaxants, and gabapentinoids.** Identify reason for use and determine whether medication(s) are still needed.
- **Taper other medications, if possible, prior to prescribing opioids** to limit exposure to co-prescribing. If available, use a collaborative team-based approach.
- If **benzodiazepines are prescribed by a provider who is not a behavioral health specialist**, consult with a psychiatrist or psychiatric ARNP for alternatives.
- **Avoid combining opioids with gabapentinoids**. Guidelines make **exceptions for co-prescribing when transitioning from opioid therapy to gabapentinoids or when using gabapentinoids to reduce opioid dose**. Carefully monitor patient for potential harmful side effects.
- **Educate patients and caregivers on the risk of opioids in combination** with benzodiazepines, Z-drugs, skeletal muscle relaxants, and gabapentinoids, including instructions to be vigilant for adverse drug effects
- **Deprescribe CNS-active drug combinations**, whenever possible.

Co-Prescribing with Opioids

Patients already using long-term opioids with other CNS-active drugs

- **Re-evaluate chronic pain care plan** with patient and their family, if available, at a routinely **with frequency based on risk assessment** and look for opportunities to deprescribe targeted CNS-active drug combinations.
- For qualifying Medicare patients, encourage participation in a **Medication Therapy Management program**, thereby ensuring access to annual Comprehensive Medication Review and quarterly Targeted Medication Reviews, as indicated.
- **Monitor for adverse effects** from opioids and other CNS-active medications. When an adverse effect is identified, re-evaluate risks vs potential benefits and the chronic pain care plan.
- **Optimize non-pharmacologic modalities** with the patient, especially prior to deprescribing CNS-active drugs.
- **Educate older patients and caregivers on the risk** of opioids in combination with benzodiazepines, Z-drugs, skeletal muscle relaxants and gabapentinoids. Provider, patient and/or caregiver should participate in shared decision-making to minimize risk of drug-related adverse outcomes.

Non-opioid Pharmacologic Pain Management

- **Avoid systemic polypharmacy** whenever possible
- **Give first line consideration to acetaminophen and non-systemic topical medications** such as topical non-steroidal anti-inflammatory drugs (NSAIDs), capsaicin, and topical lidocaine
- **Educate patient and family/caregivers on the potential harms** of polypharmacy and benefits of deprescribing when considering non-opioid medications
- **Use shared decision-making** with the patient and consider existing co-morbidities and current medications when selecting non-opioid medications for pain.
- **Regularly screen for and assess risk** for medication related adverse events
- **Give particular attention to renal function** (estimated glomerular filtration rate) when prescribing non-opioid medications for pain.

Non-opioid Pharmacologic Pain Management

- **Consult professional resources such as the *Beers Criteria*** *for Potentially Inappropriate Medication Use in Older Adults* for guidance in selection and dosing of non-opioid medications for pain.

Initial non-opioid medications

- **Acetaminophen**
- **Topical analgesics**

Medications to use with caution

- **NSAIDs**
- **Serotonin norepinephrine reuptake inhibitors (SNRIs)**
- **Gabapentinoids** (should be avoided in combination with opioids)

Medications to avoid

- **Tricyclic antidepressants**
- **Muscle relaxants**

Nonpharmacologic Chronic Pain Management

- Strong recommendation to make available at least several modalities as safer alternatives to pharmacologic therapy
- Some modalities can be accessed via insurance or alternative resources such as community organizations
- CBT and exercise have strongest support for multiple chronic pain conditions
- Consideration for multimodal approaches that may have benefits beyond improving pain and function (eg, tai chi may help both pain and balance, thus reducing risk of falls)

Nonpharmacologic Chronic Pain Management

Recommend:

- **Refer to cognitive-behavioral therapy (CBT)**
- **Regular aerobic and strength** training exercise.

Consider:

- **Chiropractic care**, including spinal manipulation, in-office and home-based therapeutic exercise
- **Mindfulness-based Stress Reduction (MBSR)**
- **Regular tai chi practice** for pain reduction in multiple chronic pain syndromes.
- **Yoga**, either alone or coupled with other pain management strategies
- **Heat therapy**, both as adjunctive therapy with other complementary therpaies and as a self-care measure at home
- **Acupuncture** for pain management either alone or in combination with other modalitie
- **Therapeutic massage**, either alone or coupled with multi-modal pain management
- **Acceptance and Commitment Therapy (ACT)** as an adjunctive therapy with multidisciplinary pain management

Tapering and Deprescribing

- **Risks of too rapid tapers** include: illicit opioid use, opioid overdose, suicide or other mental health crisis.
- Review the **2020 Bree Collaborative Guideline on Long-Term Opioid Therapy** that walks through patient engagement, assessment, and possible treatment pathways:
- **Ensure tapers are negotiated** with patients, and the **speed of the taper does not exceed guideline-recommended** taper speeds.
- Ensure that all providers offer patients a variety of **nonpharmacologic** pain treatments.
- Ensure that all providers **assess for OUD and offer OUD/MOUD treatment** when indicated.
- **Assess each patient for anxiety, depression, suicidality, and insomnia**. Refer to behavioral health, preferably integrated. Use CBT and non-addictive psychotropic medications, when indicated.
- Develop **tapering/deprescribing plans that are collaborative and multidisciplinary**, that include pharmacy, behavioral health, and patient voice. **Follow patients closely** during the taper process.
- **Consider transition to buprenorphine for patients at high risk** who are unable or unwilling to taper regular opioids.

Action Steps

Adopt for Public Comment

Topic Updates

Outpatient Infection Control

Hepatitis C

Pediatric Asthma

May 25, 2022 | Bree Collaborative Meeting

Outpatient Infection Control Members

- **Chair:** Mark Haugen, MD, Walla Walla Clinic & Surgical Center
- Anne Sumner, BSN, MBA, Boyer Boyer Bank
- Cathy Carrol, WA Health Care Authority
- Faiza Zafar, DO, FACOI, Community Health Plan of Washington
- Larissa Lewis, MPH, CIC, Washington State Department of Health
- Lisa Hannah, RN, CIC, Washington State Department of Health
- Lisa Waldowski, DNP, CIC, Kaiser Permanente
- Rhonda Bowen, Comagine Health
- Stephanie Jaross, BSN, RN, Proliance Center for Outpatient Spine and Joint Surgery
- Seirra Bertolone-Smith, Pacific Northwest University of Health Sciences

Next Steps

✓ January - Scope and Charter

✓ February - Finalize Charter and Draft Framework

✓ March – Draft Framework, Review Draft Recommendations

✓ April – Outpatient Health Systems

✓ May – Employers and Insurers

June – Public Health and Community Organizations

July – Review Recommendations

August – Public Comment

Current Draft Recommendations

Audience	Goals	Sample Recommendations
Outpatient Health Systems	Provide a framework for infection control that can be generalized to all outpatient settings and will supplement existing recommendations from local, state, and federal public health.	• Educate and encourage appropriate vaccination for patients, staff and providers based on the CDC Immunization Schedule and ACIP Vaccine Recommendations. Consider motivational interviewing to address vaccine hesitancy. • Coordinate with appropriate level of public health for reportable infectious diseases. (Notifiable conditions for Washington state can be found here.) • Develop a workflow to minimize exposure from currently infected, at-risk, and low-risk patients. • Ensure physical environment is optimized in consideration of infection prevention and control, including placement, and spacing of furniture and ability to clean furniture and other shared items. • Practice proper reprocessing and sterilization of reusable devices (CDC)

Current Draft Recommendations

Audience	Goals	Sample Recommendations
Employers	Ensure employers/benefits are encouraging population health and benefit structures support infection control practices.	• Provide incentives for vaccination as a preventative measure (OSHA). Educate and encourage appropriate vaccination based on the CDC Immunization Schedule and ACIP Vaccine Recommendations. Provide educational sessions with experts and trusted community leaders to address vaccine hesitancy and misinformation. • Create workflows to minimize exposure using virtual meetings, work from home and physical distancing • Educate workers on Infectious Disease policies and procedures in accessible formats (OSHA)
Insurers	Ensure insurance plan coverage and reimbursement structures incentivize infection control activities	• Consider increase physician payment for patient infectious disease control measures, and vaccine education including addressing hesitancy. • Consider continuing telehealth reimbursements • Cover prophylactic treatments for high-risk populations • Consider waiving copays or deductibles for patients who are currently symptomatic or have been exposed

Thank you!

Questions or Comments?

Pediatric Asthma Members

- Brad Kramer, MPA, Public Health, Seattle & King County
- Dave Ricker, MD, FAAP, MultiCare
- Doreen Kiss, MD, University of Washington
- Edith Shreckengast, MS, Community Health Plan of Washington
- Kate Hastings, Scientific Consulting Group
- Katie Paul, MD, MPH, Kaiser Permanente
- LuAnn Chen, MD, MHA, Community Health Plan of Washington
- Mark LaShell, MD, Kaiser Permanente
- Michael Dudas, MD, Virginia Mason Medical Center
- Sheryl Morelli, MD, MS, Seattle Children's Care Network

Timeline

✓ January – Scope and Charter

✓ February – Brainstorming

✓ March – Focus Areas

✓ April – Diagnosis and Clinical Control

✓ May – Home Environment and Care Coordination

June – School-Based Programs and Integration

July – Community Environment

August – Funding

September – Draft Recommendations

Focus Areas

Potential Focus Areas	Description
Clinical Control	• Appropriately diagnosing new asthma cases • Improving access to and implementation of treatment protocols • Improving medication adherence and coordination with pharmacists
Home Environment/Care Coordination	• Improving care coordination and increasing access to community health workers • Asthma support programs not delivered in the clinical setting
School Environment	• Improving communication between healthcare and school-based programs • Supporting asthma diagnosis and control in the school setting.
Community Environment	• Understanding how environment impacts asthma including climate change and air quality • Mitigating asthma triggers/exposures in the community environment.
Funding	• Developing sustainable funding for pediatric asthma interventions • Considering new payment models, including bundled payments.

Clinical Control

- Diagnosis
  - Determine symptoms of recurrent airway obstruction are present based on history and exam. For children over 5 years old, use spirometry to determine lung function.
- Assessing Severity
  - Assess for severity at the initial evaluation to initiate therapy. Assess for control at all subsequent visits
- Asthma Management Plan
  - Develop an asthma management action plan that takes into account medication therapy , environmental exposure mitigation, and immunotherapy
- Planned Preventative Visits and Control
  - Develop an asthma control plan to reduce impairment and risk. Normalize routine asthma control visits
- Metrics
  - Track and measure asthma prevalence. Track severity and control using ICD-10 codes. Measure the asthma medication ratio as a quality metric.

Home Environment/Care Coordination

- Home-based multi-trigger, multicomponent interventions involve:
  - Assessment of the home environment, trigger-abatement interventions, and motivational interviewing to improve asthma self-management
- Program Operation
  - Follow existing guidelines to support and train community health workers including recruitment via community-based avenues and ensuring sustainable funding.
- Care Coordination and Communication
  - Develop bi-directional care coordination solutions
- Initial Funding Recommendations
  - Consider alternative payment models to support care coordination and interventions provided outside of the clinic, including bundled payment and multipayer initiatives.

Thank you!

Questions or Comments?

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

Working Through Hep C Clinical Priorities

The Hep C workgroup continues to work through existing priority areas from the Hep C Free Washington Coordinating Committee. Planned priority areas include:

1. Creating Alignment for HCV Metrics
2. Expanding Access to Case Management for Treatment

3. Integrate Pharmacists into the Care Team
4. Improving Local Public Health Jurisdiction Capacity
5. Expanding Low-Barrier Treatment Access

Alignment on HCV Metrics

- The workgroup discussed potential metrics to cover HCV screening and starting on treatment.
  - Screening: Percentage of patients age >= 18 years who received one-time screening for hepatitis C virus (HCV) infection
  - Treatment: Focus on the percentage of positive HCV patients who are started on treatment. Potential indicators for starting on treatment include direct-acting antivirals (DAA) prescriptions from claims or pharmaceutical data
- HCV metrics were last considered for the Statewide Common Measures Set in 2020 but were ultimately not incorporated due to lack of alignment from national sources.
- There is the opportunity to work on a metric at the state-level

Expanding Access to Case Management

- The workgroup discussed three different models for care coordination/case management
  - Provider Counseling
    - UW Echo
  - Nurse (or other provider) Navigation Model
    - Hep Education Project Medical Case Management Toolkit
  - Peer-Support Model
    - HepC Cures at SeaMar/Southwest ACH

- Ongoing conversations about how to provide sustainable funding to expand access, particularly through Medicaid
  - Title XIX funds for targeted medical case management similar to HIV
  - 1115 Transformation Waiver funds

Thank you!

Comments or Questions?

Discussion and Update: Implementation Plans

May 25, 2022 | Bree Collaborative Meeting

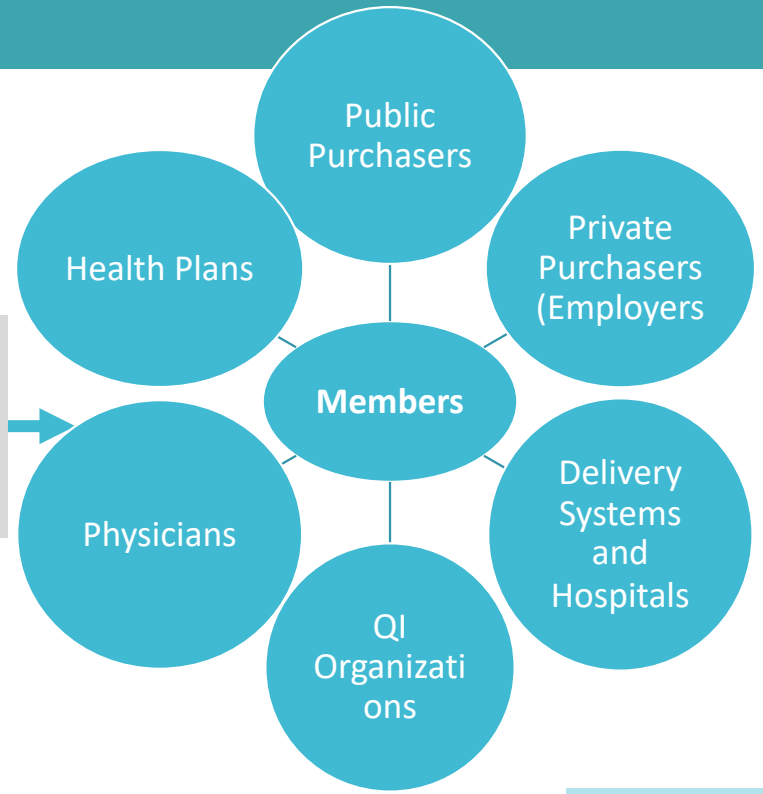
Implementation Funds July 2022 – June 2024

Page 321, line 16 of the Conference Report:

"$300,000 of the general fund—state appropriation for fiscal year 2022 and $300,000 of the general fund—state appropriation for fiscal year 2023 are provided solely for the Bree collaborative to support **collaborative learning** and **targeted technical assistance for quality improvement initiatives**."

Framework for Guideline Development

House Bill 1311 (2011)



Annually prioritize health care services/diagnoses with

- **Variation**
- **High utilization/ poor outcomes**
- **Inequity**
- **Patient safety**

Clinical Committee

Public Comment

Clinical community standards/guidelines to improve health care quality, outcomes, affordability, and equity

WA State Agencies

- Care delivery
- Contracting
- Coverage/ reimbursement

Implementation

WA State Agencies

- Care delivery
- Contracting
- Coverage/ reimbursement

Our Guidelines

- **Pain (chronic and acute)**
  - *Collaborative care for chronic pain (2018)*
  - *Low back pain management (2013)*
  - *Opioid prescribing metrics (2017)*
  - *Opioid prescribing for postoperative pain (2018)*
  - *Opioid prescribing in dentistry (2017)*
  - *Long-term opioid prescribing management (2019)*
  - *Opioid prescribing in older adults (2021)*
- **Behavioral Health**
  - *Integrating behavioral health into primary care (2016)*
  - *Addiction and substance use disorder screening and intervention (2014)*
  - *Suicide care (2018)*
  - *Treatment for opioid use disorder (2016)*
  - *Prescribing antipsychotics to children and adolescents (2016)*
  - *Risk of violence to others (2019)*
- **Oncology**
  - *Oncology care: breast and prostate (2015)*
  - *Prostate cancer screening (2015)*
  - *Oncology care: inpatient service use (2020)*
  - *Colorectal cancer screening (2020)*
  - *Cervical cancer screening (2021)*
- **Procedural (surgical)**
  - *Bundled payment models and warranties:*
  - *Total knee and total hip replacement (2013, re-review 2017, rereview 2021)*
  - *Lumbar fusion (2014, re-review 2018)*
  - *Coronary artery bypass surgery (2015)*
  - *Bariatric surgery (2016)*
  - *Hysterectomy (2017)*
  - *Data collection on appropriate cardiac surgery (2013)*
  - *Spine SCOAP (2013)*
- **Reproductive Health**
  - *Obstetric care (2012)*
  - *Perinatal bundle (2019-2021)*
  - *Reproductive and sexual health (2020)*
- **Aging**
  - *Advance care planning for the end-of-life (2014)*
  - *Alzheimer's disease and other dementias (2017)*
- ***Palliative care (2019)***
- ***Hospital readmissions (2014)***
- ***LGBTQ health care (2018)***
- ***Shared decision making (2019)***
- ***Primary care (2020)***
- ***Telehealth (2021)***
- *Infection Control (2022)*
- *Hepatitis C (2022)*
- *Pediatric Asthma (2022)*

2016 | 1 FTE

Adoption Survey

0-3 Scale of all topics – Plans, Providers, Systems, Barriers, Facilitators

Roadmap

TOPIC	HOSPITALS	MEDICAL GROUPS	HEALTH PLANS
Addiction and Dependence Treatment	1.4 (0.9-2.6)	1.4 (0.0-2.4)	1.9 (1.2-2.4)
Lumbar Fusion Surgical Bundle	1.9 (0.3-2.9)	-	0.7 (0.0-2.0)
Low-Back Pain	2.0 (1.0-3.0)	1.8 (0.5-2.8)	1.2 (0.7-1.7)
Prostate Cancer Screening	2.3 (2.0-3.0)	1.6 (0.0-2.8)	0.7 (0.0-3.0)
End-Of-Life Care	2.2 (1.7-2.6)	1.7 (0.0-2.5)	1.8 (1.0-3.0)
Avoidable Hospital Readmissions	1.6 (0.0-3.0)	2.5 (1.8-3.0)	2.7 (2.0-3.0)
Prescribing Opioids for Pain	2.5 (2.1-2.5)	1.8 (0.0-2.7)	1.7 (1.0-2.0)
Oncology Care	2.1 (1.8-2.7)	2.2 (0.0-3.0)	1.4 (0.0-3.0)
Coronary Artery Bypass Graft Surgical Bundle	2.2 (2.0-2.8)	-	0.4 (0.0-1.0)
Knee and Hip Replacement Surgical Bundle	2.3 (1.7-3.0)	-	1.0 (0.0-2.0)
Obstetrics Care	2.8 (1.9-3.0)	2.8 (2.4-3.0)	2.0 (1.0-3.0)
Spine Surgical Care and Outcomes Measurement Program (SCOAP)	2.8 (2.0-3.0)	-	-
Cardiology: Appropriate PCI	3.0 (3.0-3.0)	-	-

Website Tools

	Top enablers	Top barriers
Providers	Existing organizational improvement program for minimizing errors and waste	Lack of availability and credibility of data, and the burden of collecting it
	Business case- evidence of economic reward	Business case- no economic reward, and lack of contract partners interested in value-based purchasing
	Consensus on what constitutes quality of care	Lack of consensus on what constitutes quality of care
	Individual provider-level performance feedback	
Health Plans	Sufficient market share/volume	Insufficient market share/volume
	Contract partners interest in value-based purchasing	Burden/ease of collecting or obtaining data
	Consistency in findings across multiple measures	Business case- evidence of economic reward

Adoption Feedback from Dr. Mecklenburg (2019)

- Provider groups have constrained resources
  - Implementation competes for **funding** and **leadership time** with two important priorities: meeting regulatory requirements and pursuing market opportunities
  - Analytics and information technology required by some Bree requirements are particularly costly
  - Some Bree guidelines are very time-consuming for providers. One provider estimated implementing “end of life” standards requires 45 minutes per patient
  - Some pertain to small numbers of patients = operational and financial challenges and difficulties demonstrating clinical benefit.
  - Some providers disagree with medical evidence behind Bree guidelines
  - Tend to favor providers in large medical centers
- Few employers are engaged in value-based purchasing using Bree products
- Health plans have been slow to incorporate Bree standards into their business practice

2019-2021

- **1 FTE | Behavioral Health + Value-Based Payment**

Core Measures

BH Integration, Opioid Use Disorder, Suicide Care, Alcohol and Substance Use Disorder, LGBTQ

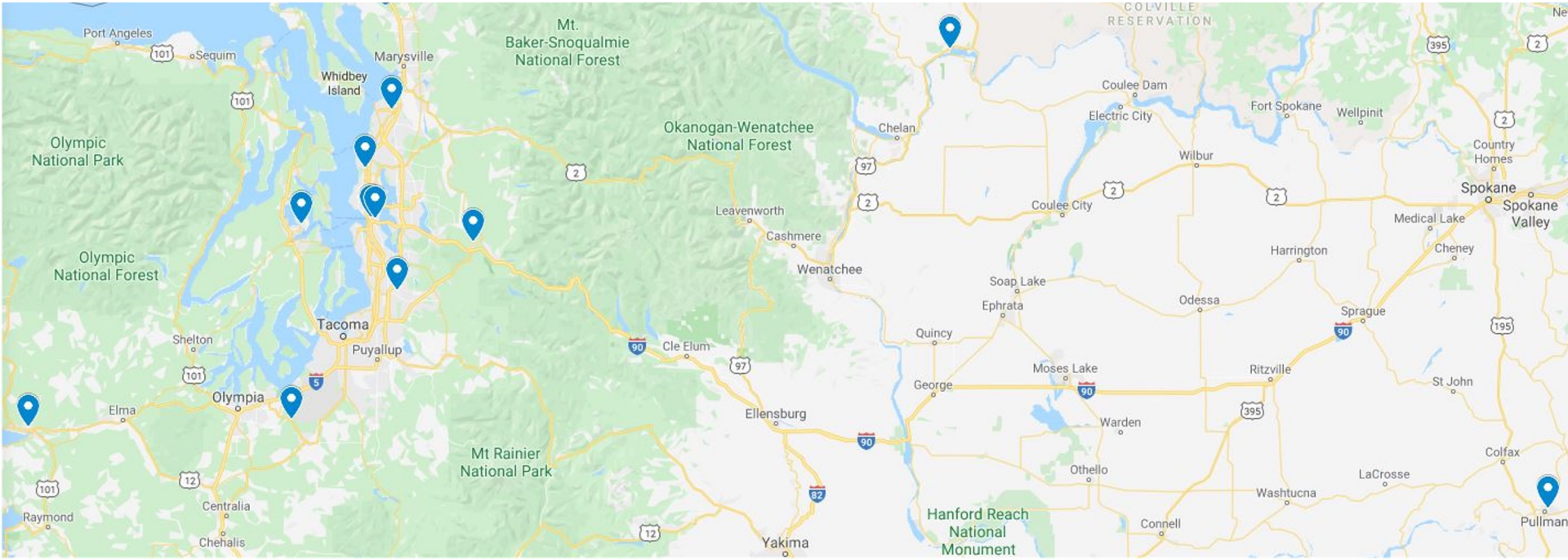
Website Tools

Primary Care Pilot Sites (10)

Learning Collaborative

Summits

Monthly Webinars




Value-Based Care

Enablers AND Barriers of Value-Based Adoption

From highest to lowest impact:

Payers

n=10

Top 5 enablers
Trusted partnerships and collaboration*
Aligned incentives/contract requirements*
Aligned quality measures/definitions*
Interoperable data systems*
Cost transparency

Top 5 barriers
Lack of interoperable data systems*
Payment model uncertainty*
Attribution*
Disparate incentives/contract requirements*
Disparate quality measures/definitions

Providers

Top 5 enablers
Development of medical home culture with engaged providers (15)
Ability to understand and analyze payment models (15)
Access to comprehensive data on patient populations* (14)
Common clinical protocols and/or guidelines associated with training for providers (13)
Sufficient patient volume by payer to take on clinical risk (12)

Top 5 barriers
Misaligned incentives and/or contract requirements* (24)
Lack of timely cost data to assist with financial management* (28)
Lack of access to comprehensive data on patient populations* (22)
Lack of interoperable data systems* (31)
Insufficient patient volume by payer to take on clinical risk* (20)

Source: https://www.hca.wa.gov/assets/program/2021-p4v-survey-results-webinar.pdf

*consistent with 2020 survey


Social Determinants of Health
Interoperability
Shared Data Definitions
Multipayer Initiatives

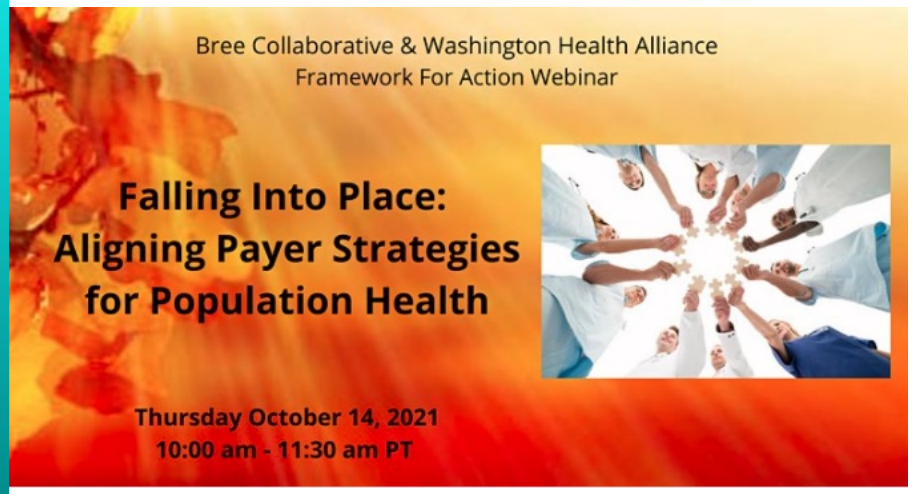
Accelerators for Change

Pledge to Take One Meaningful Step in 2022

1. Social Determinants of Health
2. Interoperability
3. Aligned Quality Measurement
4. Multi-Payer Payment Strategies

2020 – VBP Summit

2021 – VBP Framework for Action Webinar Series



2022 - Change in Action Webinar Series

Change in Action Webinar Series Part III
Brought to you by the Foundation for Health Care Quality and the Washington Health Alliance

July 21, 2022 | 10:00-11:30AM PT

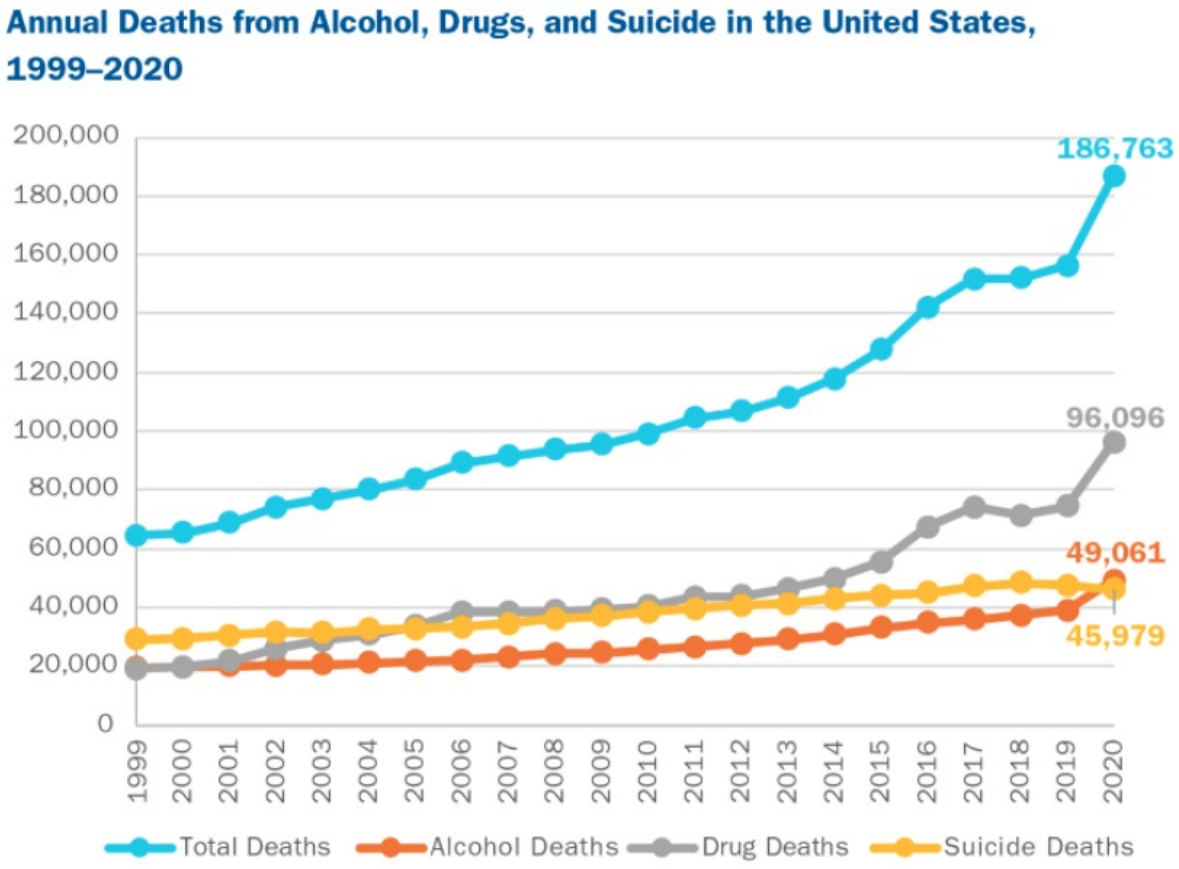
Aligning Quality Measurement: Measuring What Matters

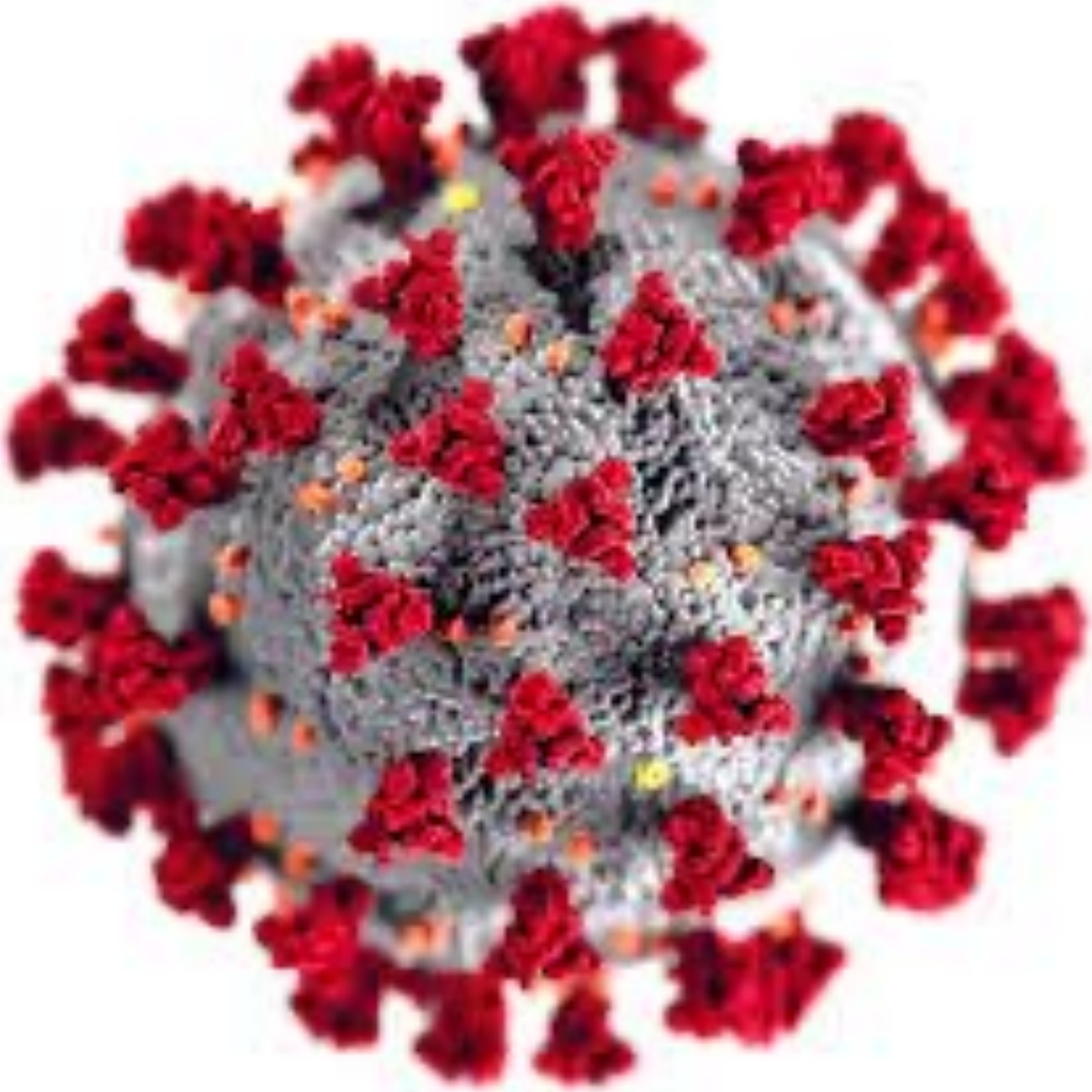
FOUNDATION FOR Health Care Quality | DR. ROBERT BREE COLLABORATIVE | WHA WASHINGTON HEALTH ALLIANCE

Pain in the Nation 2022: U.S. Experienced Highest Ever Combined Rates of Deaths Due to Alcohol, Drugs, and Suicide During the First Year of the COVID-19 Pandemic

https://www.tfah.org/report-details/pain-in-the-nation-2022/

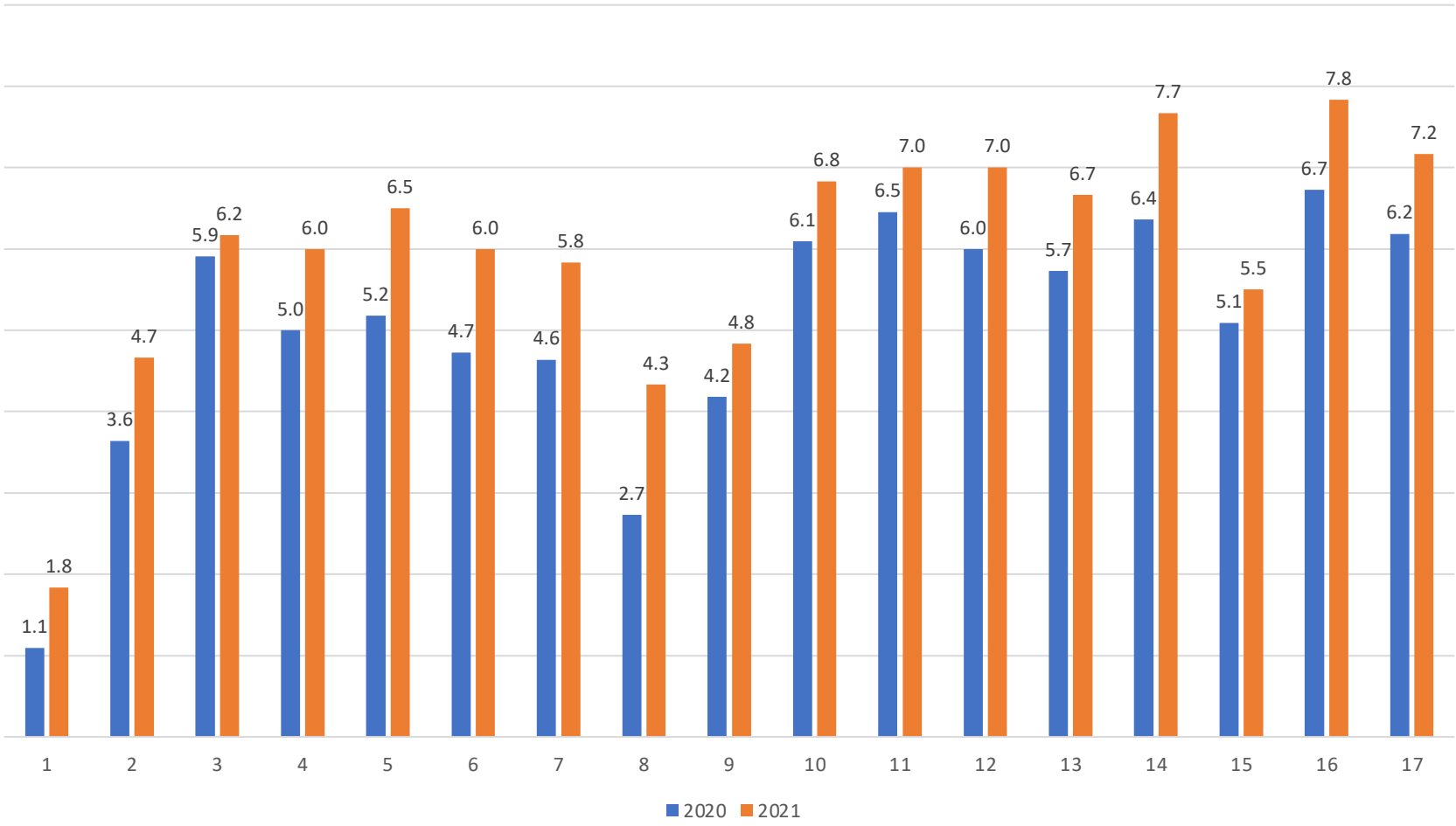
TFAH and Well Being Trust's annual report found that deaths spanned ages, racial and ethnic groups, and geography but disproportionally harmed young people and people of color. Solutions are known and must be implemented.





1. Staff awareness of Bree Collaborative Guidelines
2. Buy-in/Interest in Implementation of Bree Collaborative Guidelines
3. Use of screening tool(s) with targeted suicide identification question
4. Collaborative safety planning
5. Lethal means safety conversation after suicide risk
6. Suicide risk treatment follows an evidence-based framework (dialectical behavior therapy, suicide-specific cognitive behavioral therapy, and/or collaborative assessment and management of suicidality (CAMS)
7. Follow-up support for patient after suicide attempt
8. Follow-up support for Providers after a patient death by suicide
9. Training and education for staff on stigmatizing language and perceptions about alcohol and drug misuse
10. Use of screening tool(s) to identify drug misuse
11. Use of screening tool(s) to identify alcohol use
12. Brief intervention occurs after identification of alcohol or drug misuse
13. Brief treatment occurs after identification of alcohol or drug misuse
14. Referral to appropriate treatment facilities
15. Primary care providers, including ARNPs and PAs, are waivered to prescribe buprenorphine
16. Referral to medication-assisted treatment (MAT)
17. Patients with an opioid use disorder diagnosis receive a Naloxone prescription

Bree Collaborative Behavioral Health Integration Assessment



Activities

Visual settings

Edit

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

Reactions to Previous Efforts

No responses received yet. They will appear here...

July 2022 – June 2024

1 FTE: Evaluation

1 FTE: Equity and Partnerships (or practice transformation or quality)

Proposal: Focus on **equity** as a cross-cutting issue

Data standards, Reporting standards, Screening Best Practice

Race, Ethnicity, Language, Disability, Gender Identity, Sexual Orientation, Sex