Dr. Robert Bree Collaborative Meeting Minutes
March 27th 2024 | 1:00-3:00
Hybrid

Members Present

Emily Transue, MD, Comagine Health, *(chair)*
Judy Zerzan-Thul, MD, Washington HCA
Nicole Saint Clair, MD, Regence BlueShield
Kimberly Moore, MD, Franciscan Health System
Gary Franklin, MD, Washington State Department of Labor and Industries
Carl Olden, MD, Pacific Crest Family Medicine
Angie Sparks, MD, United Healthcare
Susanne Quistgaard, MD, Premera Blue Cross
Norifumi Kamo, MD, MPP, Virginia Mason Franciscan Medical Center
Sharon Eloranta, MD, Washington Health Alliance

Members Absent

Colin Fields, MD, Kaiser Permanente
Greg Marchand, The Boeing Company
June Alteras, MN, RN, Multicare
Colleen Daly, PhD, Microsoft
Darcy Jaffe, MN, ARNP, FACHE, Washington State Hospital Association
Kevin Pieper, MD, MHA, Kadlec Regional Medical
Patricia Egquatu, DO
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
Jake Berman, MD, University of Washington
Terry Lee, MD, Community Health Plan of Washington
Christopher Chen, MD, Washington HCA
Charissa Fotinos, MD, Washington HCA
Dara Smith
Cora Espina
Amy Florence
Kristin Villas
Audrey K (Regence)

WELCOME, INTRODUCTIONS

Dr. Emily Transue welcomed everyone and opened the meeting. Dr. Jake Berman from the University of Washington introduced himself to the group after being nominated by WSMA to represent the seat previously occupied by D.C. Dugdale. Dr. Berman is not yet officially appointed by the governor. Dr. Transue reviewed the last meeting's minutes.

> ***Motion:*** Approve January Minutes
> ***Outcome:*** Unanimously approved January Minutes

Bree 2024 Report Updates

Extreme Heat & Wildfire Smoke

Dr. Christopher Chen provided an update to the Bree members on the progress of the workgroup. The workgroup has convened three times and determined the focus areas of vulnerable populations, workforce capacity development and education, proactive public education and awareness, finance and infrastructure, and data and measurement. Dr. Chen also reviewed the changes to the charter highlighting the increased importance of addressing both heat and wildfire smoke across the state. Given the recommended actions are usually similar to mitigate the health impact of both of these climate change-related events, the group felt it would be important to address both without expanding the scope to far.

> ***Motion:*** Approve updates to the charter for the Health Impacts of Extreme Heat & Wildfire Smoke workgroup
> ***Outcome:*** Unanimously approved updates to charter

Behavioral Health Early Interventions for Youth

Dr. Terry Lee provided an update to the Bree members on the progress of the workgroup. The workgroup has convened three times and continued conversations around scope. Dr. Lee reviewed some data on the lifetime prevalence of different behavioral health diagnoses, those with the most mature evidence base and those with access to free or low-cost trainings for clinicians in the state, including depression, anxiety, trauma/PTSD, disruptive behaviors and substance use disorders. Dr. Lee then reviewed the focus areas the group has identified, including patient/caregiver education, provider training and capacity building, identification and assessment, treatment and management, and interdisciplinary coordination and communication. The workgroup also intends to focus on primary care, school-based care and community settings.

Question: Angie asked is there alignment between this workgroup and the Treatment for OUD Revision workgroup on OUD treatment for youth?

- Dr. Lee has not spoken to Dr. Fotinos yet, but that will be arranged.

Question: What is the prevalence of OUD among youth?

- Dr. Lee stated he is uncertain of exact data, but the effects are devastating for adolescents that have OUD. The Department of Health might have some information on this.
- Data found by Ginny Weir: National Survey on Drug Use and Health - highest prevalence of opioid misuse was 4% in 2018.

Question: Norris asked if there is any consideration for the group to create criteria for individuals providing care through private companies providing behavioral health services for children. Some companies are under investigations for mis-prescribing stimulants through video visits and having pressure to prescribe stimulants.

- Dr. Lee responded he is also worried about the quality of services, our state doesn't have a lot of qualitative measures at this time over quantity of services delivered. We also have lots of private for-profit hospitals that have identified quality concerns. As part of this group we will address quality of services and evidence-based practices.

Question: Norris asked if there is consideration for ADHD in the guidelines?

- ADHD is so prevalent, and it seems there's not too much society guidance – it seems the rise in prevalence and misdiagnosis. It's also comorbid with lots of mood disorders, so it should probably be addressed.
- **Emily Nudelman**: as we are working on keeping the scope more manageable, do you see ADD/ADHD to be appropriate to be a part of this report or worth it's own report in the future?
- **Norris**: it's a large enough topic to be its own.
- **Emily T**: there's constant tension to balance broad and focused scope – we've grouped topics together and can continue them as series potentially through identifying further topics.

Treatment for OUD Revision

Beth Bojkov, MPH, RN, provided an update to Bree members on the progress of the workgroup. The workgroup has added several members including from opioid treatment programs and an individual at the HCA emergency BRIDGE program. The workgroup's original focus areas of access to evidence-based medicine, referral information and integrated behavioral and physical health to support whole-person care are still relevant, just with updated goals. The group plans to review new formulations of MOUD, especially buprenorphine formulations, tailored approaches to initiation based on the severity of OUD and comorbid conditions, transitions of care between settings and between medications, core elements of behavioral health integration for innovative new models and nontraditional settings, and payment models that support whole-person health across all plans in Washington state. The group has expressed interest in utilizing ED/inpatient hospitalization as a key avenue to intervene and initiate MOUD, and address issues with data & measurement as an additional focus area. Dr. Charissa joined after the update and answered questions.

- **Judy**: feel that this is very straightforward, and more clear-cut than previous report

Question: Norris had a question about methadone clinics being owned by private equity now, wondering what the state of that in the state?

- Charissa: Most methadone clinics in Washington are nonprofit or tribally owned – handful are Acadia. They do generally well, do accept Medicaid clients although most of their patients tend to be insured or self-pay. The laws are easier to cite methadone clinics now, but there is still a fair amount of public complaints so generally we would have a heads up if any were coming into the state.

IMPLEMENTATION SURVEY RESULTS

Karie Nicholas, MA, GDip, reviewed results of a look-back evaluation. Over several years we've conducted 3 different surveys looking at concordance of care, usefulness of the guidelines and identifying data capacity needs. The surveys are voluntary and self-reported. Some of the scores look low because some organizations chose not to answer for certain guidelines even if they had those services.

- Usefulness of the guidelines survey
    - Key Takeaways
        - Health plans viewed our guidelines as more useful and implementable
        - Smaller organizations struggle more with implementing our guidelines
        - Health plans felt the cost of implementing our guidelines were more manageable
- Data capacity survey
    - Ask some questions about the data collection guidelines
    - Key takeaways
        - Asked head of IT departments and asked them about understanding the ability to implement data sharing and analytic guidelines
- Concordance of Care survey
    - This survey asked participants to look through each guideline from each report
    - Karie showed geographically we miss responses from rural organizations
    - In 2016, the Bree did an evaluation and Karie looked at the difference when possible in 2023. For most guidelines, participants answered the same or improved their implementation over time.
    - Previously, we did not ask about equity or stratifying measurements. This time, we asked some questions such as stratifying metrics, using stratification in QI projects, etc. Not everyone answered the equity tab. Most answered at least a 2 on a scale of 0-3 for implementing guidelines on equity.
- Top barriers and enablers to adoption
    - Barriers and challenges

        - Multiple critical business needs that may not align with work of the Bree
        - Lack of a business case
        - Regulatory constraints
        - Internal awareness/support of Bree Collaborative
        - Availability and credibility of data
        - Burden or ease of collecting data
    - Key success factors
        - A clear business case and internal awareness of the Bree guidelines were also seen as key factors in the successful implementation of guidelines, especially for health care providers. Other enabling factors varied by the type of organization. For health plans partnerships for value-based purchasing was also a key factor in their ability to implement guidelines.
- Key Lessons
    - Variability still exists between rural and urban areas, lower among health plans. The extent to which HCA adoption is a driver of change in health systems should be further explored
    - Once fully adopted, most Bree guidelines were sustainable. In general, guidelines that are not hospital centric are adopted if their scope is narrow enough and/or if the actions are primarily aimed at health plans
    - The Bree guidelines are very respected, and interest is high but internal awareness is low. This is similar to the findings from the 2016 evaluation. The Bree staff is working on strategies to spread awareness of their guidelines.
    - Data collection and data sharing of patient information outside of claims data remain a difficult challenge for organizations, creating cost/time burdens. Metrics were the least adopted guidelines, with the exception of the opioid metrics. Two barriers to data use were identified that require system-wide change rather than individual organizational change:
        - Standardization of data elements and metrics
        - Data extractions from EHRs
    - Lack of a business case for many Bree guidelines remains a challenge to adoption. It may be valuable for the Bree to consider how to support development of business cases for future guidelines.

Question: Dr Berman asked what the benchmarks would be for an assessment like this? Can we look at other guideline generating organizations to see typical uptake to get a sense of how successful we are?

- Karie: As we look forward to further guideline development, we plan to add some of that in. Talking to other guideline organization would get a sense of what successful uptake would look like. There might be noise between different organizations and guidelines themselves, but would still be helpful.

Question: Did any of the respondents give any specific feedback regarding data sharing and collection, and what is their current source of data?

- A lot of the respondents said things like “this measure doesn’t apply to us” or “we collect something different,” and the HCA already requires us to do this. They were not specific about data sources. That is something we want to look forward to find more information about that for future guidelines. The best data we have was about their HL7 data models which is in the report.

REPORT REVIEW PROCESS

Dr. Emily Transue then presented information about the report review process, this connects to some of our conversations around focusing our efforts around implementation and measurement, balanced with the challenge of the sheer amount of information we have published.

- There are over 40 reports out there
- What are the issues
    - No mechanism to understand where each report stands
    - Need a way to update reports without convening a whole workgroup
- Need to have a way to make it clear for people what we stand by, what reports have caveats and what reports do we need to update
- Guidelines International Network has a series of labels that indicates the status of the guidelines. It could be helpful to do something like that for our guidelines.
- Potential labels include the following:

Label	**Definition**	**Example**
Active	Active and relevant report and guidelines	Diabetes Care
In Development	New topic currently undergoing the workgroup process	Extreme Heat & Wildfire Smoke
Needs Major Revision	New evidence emerged in the field to require a revision; Fundamental shift in approach to care	Alzheimer's and Other Dementias
Under Major Revision	Currently being revised by the workgroup process	Treatment for OUD
Needs Mintor Revision	Minor updates including regulatory changes, link updates or updates in clinical guidelines referenced in the document.	
Retired	Report is not longer relevant, or the topic is no longer appropriate for the Bree Collaborative	

- The minor revision label indicates that the report has outdated information or links but there is not new information that requires the convening of experts to decide on new guidance.
- We could also retire reports for which we don't think we would ever go back and pick it as a topic again
- Minor revision steps
    - Bree Collaborative members identify report as needing a minor revision
    - Bree staff would connect with small informal group of experts to confirm the updates needed
    - Bree staff would draft updates to the report with feedback
    - Bree staff would put the report up for public comment for one month
    - After that, staff would hold an open public meeting to review updated guidelines and provide feedback.
    - Updates would be presented to Bree Collaborative members at a meeting for approval

Question: Sharon asked looking at deck of slides, are these clincal practice guidelines or recommendations? Several of the older guidelines had warranties or value equations, so unclear.

- Emily: there has been a movement away from calling them recommendations because it was felt to be paternalistic, and so that is why we've moved towards calling it a guideline. However, it's not a clinical practice guideline which is a very specific box around the way providers take care of patients, and these guidelines are intended to be broader than that.
- Norris: put a link to the website, which shares what a report is and what a guideline is.

- Beth: the report is the document, the guidelines are the action steps under each audience member.
- Emily T: it's a small g guideline
- Sharon: small G guideline makes sense, because clinical practice guideline has more expectation tied to it.

- The idea is that we would revisit reports every few years and indicate whether we want the report to stay active or potentially go through a revision process/be retired.
- Feedback shared on the process and lifecycle of a report.
    - Norris: think it is a good process, and we can retain the workgroup as the brain trust for the particular topic, and potentially hear from the chairs again if there are changes in the field
    - Carl: we've had a bit of discussion already on obstetrics needing to be updated, and think if the members of the original group are willing to participate again in that revision that would be great. If there aren't enough bodies we could recruit new folks.
    - Judy: I like this approach a lot, thanks for working on it.
- **This plays into the topic selection process**
    - We're beginning to think about topic selection this year
    - We are planning on releasing the survey in April and reviewing the Bree Collaborative member survey in May.
    - The reason we are doing it a bit earlier, the staff felt it was important to give a bit more time.
- **Ask**: answer the Bree Collaborative survey when it is sent out in April.
- Norris: we should have rounds of voting before we finalize, something similar to the Delphi model.
    - Emily T: good idea, will take that into consideration.

IMPLEMENTATION UPDATES

Dr. Emily Nudelman then provided some updates on implementation of Bree reports and guidelines. She previewed what we did last year and what we plan to do this year:

- Webinars
    - Hosted three spotlight webinars in February 2024 on the three 2023 reports and topics, about 50 people in attendance for each
    - Our Diabetes webinar had over 135 views on Youtube
- Checklists have been developed for our 2023 reports and are available online
    - We organize the guidelines into a level system (levels 1-3 according to difficulty in implementing) with feedback from workgroup members
- Resource Library
    - Developed lots of tools through the health equity action collaborative to support implementation and they are all online now
- Implementation Guide
    - Hoping to have this up by late spring or early summer
    - This guide includes specific resources for each guideline the publication status which will align with the label previously mentioned, and a date of last evidence search or review.
    - Under the resource and tools section, we'll add the spotlight webinars there
    - The idea being that the implementation guide is a one-stop shop for the guidelines
    - Hoping to develop case studies and collect those stories on our website – **please let us know if you have any examples of work within your organization that we should highlight**

- Program planning for 2024
    - We are working to understand the landscape of each topic, but we are still trying to balance scope and what is already going on in those areas
    - We don't want to duplicate efforts or take away from efforts that already exist
    - We are also trying to be mindful of capacity for participating in different activities
    - Staff capacity – we are a team of three, so being intentional about what we can provide that is high quality
- Strengths of Bree – trying to build off these for future program planning
    - Neutral convener
    - Breaking down silos
    - Connections
    - Reliable source of information
    - Collective action
    - Across the healthcare ecosystem
- Blending Quality Improvement and Health Equity
    - Often quality improvement and health equity tend to be separated in other organizations, but we are leaning into the phrase "we can't have quality without equity"
    - We are focusing on encouraging organizations to include equity in their quality improvement efforts
- Learning Labs
    - We are creating learning lab events for the coming months
    - We try to uplift people that are doing things in the state that align with guidelines, and then provide breakout rooms for attendees to share what they are working on and get feedback on how to improve.
    - First event April 24th – Diabetes screenings at Adios COVID clinic
    - second on May 16th – Social needs screening at CHAS FQHC
    - CME is available for free at the **LIVE EVENTS ONLY**
    - We record the presentation
- Perinatal Behavioral Heath Summit
    - We are looking to co-host and support a summit this fall with Washington Society of Addiction Medicine
    - Fall 2024 – date TBD
    - Funding to support this through legislation
    - There are so many people working on this, so the summit is intended to continue the conversations around what is happening in the state and create those connections across different sectors
- Health Equity Action Collaborative (HEAC) 2023 Recap
    - 10 organizations participated
    - 7 report topics, 7 months long
        - BHI, colorectal cancer screening, LGBTQ+, obstetric care, pediatric asthma, reproductive health and SDOH/Health Equity
    - The participants had opportunity to learn quality improvement skills, build connections with across the healthcare system and work on their projects
    - Overwhelmingly positive feedback on the participation survey
    - Continuing to meet in 2024 on quarterly basis
- HEAC 2024
    - Host from May – December
    - 7-8 meetings

    - Actively recruiting
    - About 6 groups already signed up to participate
- Monthly Newsletter
    - We send out ways to connect to us in the middle of the month to stay up to date on what we're doing
    - Please share within your organization and externally.

CLOSING, PUBLIC COMMENT AND NEXT STEPS

Dr. Transue thanked those who attended, provided an opportunity for public comment and closed the meeting. At the next meeting, Bree staff will present the winners of our 2024 awards, hear more updates on the 2024 workgroups, more in depth information on the evaluation, and review initial results from the Bree Collaborative survey. **Next Bree Collaborative Meeting:** May 22nd, 2024 1-3:PM HYBRID