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Dr. Robert Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 “...to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.” The Bree Collaborative was modeled after the Washington State Advanced Imaging Management (AIM) project and named in memory of Dr. Robert Bree, a pioneer in the imaging field and a key member of the AIM project.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying up to three health care services annually that have substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice, evidence-based approaches that build upon existing efforts and quality improvement activities to decrease variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State’s largest health care purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

Stigma and lack of provider training and competency serve as barriers to providing consistent, high-quality medical care for people who identify as lesbian, gay, bisexual, transgender, and questioning or queer (LGBTQ). The Bree Collaborative elected to address this topic and a workgroup convened to develop recommendations from December 2017 to X.

See **Appendix B** for the LGBTQ Health Care workgroup charter and a list of members.

See **Appendix C** for results of the Guideline and Systematic Review Search Results.

Purpose Statement

Approximately 3.5% of Americans identify as lesbian, gay, or bisexual and 0.3% of American adults are transgender,¹ with distinct healthcare needs.² In particular, men who have sex with men (MSM) and transgender persons who have sex with men are at elevated risk for HIV and other sexually transmitted infections. Additionally, lesbian, gay, bisexual, transgender, and questioning or queer (LGBTQ) persons can experience elevated rates of depression, sexual abuse, smoking, and other substance use.^{3,4} Stigma and lack of provider training and competency serve as barriers to providing consistent, high-quality medical care.⁵

Recommendations

Focus Areas

- Communication
- Prevention

Example: Table 1: Recommendations for Optimal Alzheimer’s Disease and Other Dementia Care

	Focus Area	Patient Perspective	Operational Details
1	Communication	<i>I am asked about my sexual history and behaviors in a non-judgemental way and I feel comfortable discussing my sexuality and gender identity with my provider and care team.</i>	<p>Current State:</p> <p>Intermediate Steps:</p> <p>Optimal Care:</p>
2	Prevention		<p>Current State:</p> <p>Intermediate Steps:</p> <p>Optimal Care:</p>

Example from Dementia recommendations: Diagnosis

- Talk to your health care providers about any concerns you might have about memory or thinking ability. Your care team should ask you a standard set of questions and may set up a follow-up appointment.
- Make sure you can identify your primary care provider or family doctor.
- Review the resources developed by the Washington State Dementia Action Collaborative especially the [Dementia Road Map: A Guide for Family and Care Partners](#). This tool takes patients and caregivers in all stages of cognitive decline through action steps and questions from the early stages of being worried and wondering to late-stage dementia.
- During diagnosis we recommend that your health care provider follow the principles outlined in the Alzheimer’s Association’s Principles for a Dignified Diagnosis. You can see these principles that have been developed by patients here: www.alz.org/national/documents/brochure_dignified_diagnosis.pdf and also listed in **Appendix E** on page X.

Primary Care Practices and Systems (including Primary Care Providers)

Review **Table 1**

Example from Dementia Recommendations: Diagnosis

- Identify the patient’s primary care provider and be sure the patient and family members know who this is.
- Provide care as part of an interdisciplinary team where all members have been trained in how to talk about a dementia diagnosis that is tailored to the patient’s individual and cultural needs and goals of care including language. This may include support staff in primary care provider office, specialists such as neurology consultation, and community partners. The patient and family or other caregivers should be included as part of the care team and supported along with the patient.
- Assess for and appropriately address hearing loss (e.g., hearing aids, personal amplifiers). Hearing loss can complicate dementia identification and treatment.
- When talking to patients and family members, follow the Alzheimer’s Association’s Principles for a Dignified Diagnosis in **Appendix E**. Be truthful about any diagnosis. At the patient’s request, purposefully include family members or other caregivers in any conversation and work to be sure they feel supported and that their concerns are heard as well as those of the patient.
- Work with information technology, billing/coding and other practice resources to add the G0505 code to your electronic health record and learn how to use it. More information: www.alz.org/documents_custom/the%20cognitive%20assessment%20toolkit%20copy_v1.pdf

Hospitals

Example from Dementia Recommendations

- Educate staff about Alzheimer’s disease and other dementias including on disease progression, care needs, communication, involving the family and other caregivers in decisions, and potential impact on hospitalization.
- Screen all at-risk (e.g., ≥ 65 years old) patients on admission for risk of delirium using a brief cognitive test (e.g., Confusion Assessment Method or CAM)
 - If delirium is detected, provide targeted, multimodal prevention strategies aligned with the NICE clinical guidelines. This should include the use of bedside tests daily in the first days after surgery (e.g., Confusion Assessment Method-Intensive Care Unit or CAM-ICU, Delirium Detection Score).
 - Incorporate results into the medical record and confirm care team is aware of results.
 - Talk to the patient and family about the risk for delirium after surgery, what symptoms might look and feel like, management strategies, and what delirium might mean for recovery.

Health Plans

Example from Dementia Recommendations

- Increase member awareness of how to maintain overall heart and brain health with age, about the difference between age-related changes in memory and the warning signs of dementia, and about the benefits of timely diagnosis of Alzheimer’s disease and other dementias.
- Encourage hospitals, nursing homes, and other applicable settings to implement a quality improvement program focused on greater adherence to patients’ requests as outlined in advance directives and POLST if accurate and applicable to the current situation
- Develop inclusive and comprehensive benefits for patients with Alzheimer’s disease or other dementia allowing them to receive care consistent with their wishes and goals even if not eligible for hospice (e.g., palliative care).
- Support patients as they navigate care between separate health care facilities and systems including facilitation of information sharing and patient and family outreach during crisis.

Employers

Example from Dementia Recommendations

- Recognize that many employees may be serving as informal caregivers to their family members or others. Incorporate caregiver supports into employee assistance programs.
- Educate your employees about how to have conversations regarding personal goals of care and the type of care desired at the end of life with family members, friend, and health care providers;

Washington State Health Care Authority

- Promote awareness and utilization of advance care planning at multiple levels of health care delivery systems.

Background

Other Work in Washington State

- End AIDS Washington

Measurement

[Healthy People 2020](#) includes two Lesbian, Gay, Bisexual, and Transgender Health related metrics:

- Increase the number of population-based data systems used to monitor Healthy People 2020 objectives that include in their core a standardized set of questions that identify lesbian, gay, bisexual, and transgender populations
- Increase the number of states, territories, and the District of Columbia that include questions that identify sexual orientation and gender identity on state level surveys or data systems

Additionally, Healthy People 2020 acknowledges intersections with other topic areas including: breast cancer screening, bullying among adolescents, cervical cancer screening, condom use, educational achievement, health insurance coverage, HIV testing, illicit drug use, mental health and mental illness, nutrition and weight status, tobacco use, and [having a] usual source of care.

Appendix C: Guideline and Systematic Review Search Results

Source	Guidelines or Systematic Reviews
AHRQ: Research Findings and Reports	Improving Cultural Competence to Reduce Health Disparities (2016)
Cochrane Collection	Multi-media social marketing campaigns to increase HIV testing uptake among men who have sex with men and transgender women (2011) Behavioral interventions to reduce HIV transmission among sex workers and their clients in high-income countries (2011) Behavioral interventions can reduce unprotected sex among men who have sex with men (MSM) (2008)
Specialty Society Guidelines (via Guideline Clearinghouse including Choosing Wisely)	U.S. Preventive Services Task Force: Behavioral and pharmacotherapy interventions for tobacco smoking cessation in adults, including pregnant women (2015) International Association of Providers of AIDS Care: IAPAC guidelines for optimizing the HIV care continuum for adults and adolescents (2015) U.S. Preventive Services Task Force: Screening for suicide risk in adolescents, adults, and older adults in primary care (2014) Health Care for the Homeless (HCH) Clinician's Network: Adapting your practice: treatment and recommendations for unstably housed patients with HIV/AIDS (2013) Society of Obstetricians and Gynaecologists of Canada: Female sexual health consensus clinical guidelines (2012) British Association for Sexual Health and HIV: United Kingdom national guideline for gonorrhoea testing 2012 (2012) New York State Department of Health: Care of the HIV-infected transgender patient (2012)
Health Technology Assessment Program	n/a
Center for Disease Control and Prevention	Lesbian, Gay, Bisexual, and Transgender Health
Institute for Clinical and Economic Review	n/a
BMJ Clinical Evidence Systematic Overview	HIV: primary and secondary prophylaxis for opportunistic infections (2010)
Veterans Administration Evidence-based Synthesis Program	Do have general guidelines for suicide prevention, adult mental health, and health disparities among adults with mental illness that cite studies including lesbian and gay participants. Not specific.
Gay and Lesbian Medical Association	Guidelines for the care of lesbian, gay, bisexual, and transgender patients (2006)

References

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- ¹ Gates G. How many people are lesbian, gay, bisexual, and transgender? The Williams Institute University of California, Los Angeles. April 2011. Available: <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf>
- ² Purcell DW, Johnson CH, Lansky A, et al. Estimating the population size of men who have sex with men in the United States to obtain HIV and syphilis rates. *The open AIDS journal* 2012; 6:98-107.
- ³ Russell ST, Fish JN. Mental Health in Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth. *Annu Rev Clin Psychol.* 2016 Mar 28; 12: 465–487.
- ⁴ Mayer KH, Bradford JB, Makadon HJ, Stall R, Goldhammer H, Landers S. Sexual and Gender Minority Health: What We Know and What Needs to Be Done. *American Journal of Public Health.* 2008;98(6):989-995.
- ⁵ Whitehead J, Shaver J, Stephenson R. Outness, Stigma, and Primary Health Care Utilization among Rural LGBT Populations. Newman PA, ed. *PLoS ONE.* 2016;11(1):e0146139.