Bree Collaborative | Collaborative Care for Chronic Pain Workgroup
January 12th, 2018 | 3:00-4:30
Foundation for Health Care Quality
705 2nd Avenue, Suite 410 | Seattle, WA 98104

Members Presen

Ross Bethel,* MD, Selah Family Medicine
Lynn DeBar, PhD, MPH, Kaiser Permanente Washington Health Research Institute
Mary Engrav,* MD, Molina Health Care
Andrew Friedman,* MD, Virginia Mason Medical Center
Leah Hole-Marshall, JD, L&I (Chair)
Mark Murphy,* MD, Washington Society of Addiction Medicine
Jim Rivard, PT, DPT, MOMT, OCS, FAAOMP, MTI Physical Therapy
Kari A. Stephens, PhD, University of Washington Medicine
Nancy Tietje,* Patient Advocate
Emily Transue, MD, MHA, Washington State Health Care Authority
Mark Sullivan,* MD, PhD, University of Washington Medicine
Michael Von Korff, ScD, Group Health Research Institute
Arthur Watanabe,* MD, Washington Society of Interventional Pain Physicians

Staff and Members of the Public

Ginny Weir, MPH, Bree Collaborative
Emily Wittenhagen, Bree Collaborative

* By phone/web conference

WELCOME AND INTRODUCTIONS

Leah Hole-Marshall, JD, L&I and Ginny Weir, MPH, Bree Collaborative opened the meeting and those present introduced themselves.

BREE COLLABORATIVE OVERVIEW

Ms. Weir presented a background of the Bree Collaborative, how meetings are run, the process of developing recommendations, and how recommendations are disseminated, covering Robert's Rules of Order, House Bill 1311, stakeholders involved, the role of the Health Care Authority, past and current work, the Open Public Meetings Act (OPMA), and the potential language for the aim and charter of the workgroup.

Action Item: Ms. Weir to send the OPMA materials to the group.

PRELIMINARY SCOPE OF WORK

Ms. Weir went over the Collaborative Care for Chronic Pain Workgroup Charter and Roster and the group discussed:

- The prominence of concern for pain treatments alternative to opioids and better payment models for those alternatives treatments.

Charter: Purpose

- RE: "Best practices for recognizing and preventing the transition from acute and subacute pain to chronic pain…" – Making sure goals to reduce or prevent acute pain from developing into chronic pain, returning people to function are realistic.
- Recognizing different types of pain patterns and the role of opioids and other interventions in these patterns.

- Demonstrating to the community the impact that these types of initiatives can make on outcomes, if it's in scope.
- Identifying pain generators to assess the necessity of opioids and the potential for other treatments such as physical therapy to be effective.
- Looking at evidence around appropriate screening and assessment.
- A suggestion to revise the language of the first bullet to include "limiting" or "disabling" chronic pain.
- Recognizing that collaborative care doesn't happen in a bubble, and possibly including that recognition in the charter if it doesn't creep too far out of scope.
- Identifying the patient's health home and addressing methods integrated care within that home to the extent possible (e.g., behavioral health).
- Defining the parameters of collaborative pain care in terms of whether treatments like physical therapy, behavioral health, acupuncture, and massage therapy are part of the collaborative care model or fall outside of it.
- Directing acknowledgment to the patient as being part of the care team as their own advocate.
- Acknowledging cases in which patients are not able to participate in their own pain care; adding "patient advocacy and engagement" to the second bullet.
- Working to reduce situations where patients are assessed by multiple providers without proper collaboration and feel passed off.
- Assuring that patients with pain, especially complex pain, have a primary medical home with a PCP who can keep track of multiple conditions/treatments and how they might impact each other.
- Looking at the grey area that exists where some patients' medical homes may be ancillary to primary care, such as behavioral health or physical therapy providers, and acknowledging the variation that exists between providers in terms of training and willingness to work with pain patients.
- Incorporating training models where needed as we develop these recommendations.
- Being clear about what collaborative care isn't in order to define scope of recommendations.
- Adding "over time" and "care management" to the third bullet.

Models for Pain Care Delivery Materials

- Ms. Hole-Marshall shared this collection of materials, including the Principles of Effective Collaborative Care graph and System Redesign through COHE and the group discussed:
    - Co-locating not always being a necessity.
    - Defining what level we mean when we talk about core elements.
    - Offering one or two models and identify elements of them with explanation for why they were chosen.
    - Not remaining too laser focused on pain and pain scores.
    - Making sure to include the opioid prescribing recommendations where appropriate.

NEXT STEPS AND PUBLIC COMMENTS

Ms. Hole-Marshall and Ms. Weir thanked all for attending and asked for final comments and public comments. The meeting adjourned.