• Welcome and Introductions
  • Action Item: Adopt Minutes
• Update: HCA Maternal Bundle
• Member Spotlight: Washington Health Alliance
• Topic Updates
  • Diabetes Care
  • Difficult to Discharge
  • Perinatal/Maternal Mental Health
• Discussion: Upcoming Events and Bree Member Roles
• Next Steps and Close
Advancing the market to improve the value of care for all patients with low back pain in Washington State
How Will We Accomplish This?

Three Important Elements:

• Multi-stakeholder effort

• Focus on changes that address reductions in low-value care and improvements in high-value care. Implement evidence-based care throughout the state!

• Address multiple mechanisms/levers for change including patient education, benefit design, provider culture, workflow and payment.
## Participants

<table>
<thead>
<tr>
<th>Purchasers</th>
<th>Providers</th>
<th>Health Plans</th>
<th>Affiliates</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWC Benefit Trust</td>
<td>Confluence Health</td>
<td>Aetna, a CVS Health Company</td>
<td>American Physical Therapy Association WA</td>
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<tr>
<td>Bloodworks Northwest</td>
<td>MultiCare Health System</td>
<td>Kaiser Permanente Washington</td>
<td>Aon</td>
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<td>The Boeing Company</td>
<td>Proliance Orthopedics and Sports Medicine</td>
<td>Premera Blue Cross</td>
<td>The Bree Collaborative – Foundation for Health Care Quality</td>
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<td>Business Health Trust</td>
<td>UW Medicine</td>
<td>Regence Blue Shield</td>
<td>Spine Care Partners</td>
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<td>City of Seattle</td>
<td>UW Medicine, Valley Medical Center</td>
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<td>WA Acupuncture and Eastern Medicine Association</td>
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<td>Davis Wright Tremaine</td>
<td>Virginia Mason FH</td>
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<td>WA State Department of L&amp;I</td>
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<td>King County</td>
<td>WA Optum Care</td>
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<td>Point B</td>
<td>WA State Chiropractic Association</td>
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<td>Port of Seattle</td>
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<td>SEIU 775 Health Benefits Group</td>
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<td>UFCW 3000</td>
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<td>WA State Health Care Authority</td>
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<td>WA Teamsters Welfare Trust</td>
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Why acute low back pain?

• One of the top reasons why our employees or members seek care
• Combined with neck pain, it’s the most expensive health condition in America
• Major impact on the productivity of our businesses
• Impacts the quality of life for those for whom we buy care
• Strong clinical evidence and evidence-based care guidelines available
• The importance of Purchaser, Provider and Health Plan collaboration
Structure of the work: the “magic”

- Based on IHI Breakthrough series model: all teach, all learn

- Leads to “breakthrough” improvements

- Four all-stakeholder sessions in 2022, one wrap-up in 2023

- Inter-session contacts: stakeholder-specific meetings; information gathering/summarizing for additional learning
Sources and resources

- **Faculty**: WHA staff and Subject Matter Experts (volunteer and paid)
- **Expertise**:
  - Medical (what is acute LBP and its usual course); what we know about what works and what doesn’t
  - Value based purchasing, incentivizing behavior, equity
  - Integrative health

- **Resources**:
  - ACP Guidelines for the Evaluation and Treatment of Low Back Pain 2008
    [http://www.annals.org/cgi/content/full/147/7/478](http://www.annals.org/cgi/content/full/147/7/478)
  - University of Michigan
    2010  [http://www.med.umich.edu/FHP/Guidelines](http://www.med.umich.edu/FHP/Guidelines)
  - Bree Collaborative – State of WA
    Lumbar Fusion Bundle
Guideline Main Recommendations

1. Perform a history and physical examination and screen for red flags

2. Identify persons at risk for chronic disability and intervene early

3. Pursue conservative treatment for 4-6 weeks
   - Self-care, advice to remain active, simple analgesics, avoid opioids

4. Refer to complimentary and alternative care providers—Acupuncture, CBT, manipulation, Tai Chi, exercise therapies including PT

5. Avoidance of early imaging. Perform imaging when LBP is severe, progressive neurological deficits or suspicion of systemic disease - or when pain is persistent with radicular or claudicatory pain
Established Recommendations

• Promote guideline adherence

• Limit imaging for early or non-specific LBP

• Reduce low-value surgery

• Avoid opioids in LBP
Over the next 18 months:

- Action period stakeholder meetings (some joint meetings)
- Monthly requests to teams for action updates including equity action
- Moving towards “all teach, all learn”
Acute Low Back Pain Care Pathway

Common Goal — Decreased Use of: Advanced Imaging, Emergency Department (ED), Opioids and Surgery as First Interventions

1. **Timely Triage** (Same or Next Day)
   - If **Red Flags** are identified, go to **Advanced Imaging (MRI or CT)**, ED, Emergent or Urgent Speciality Care Referral, or Consider Opioids.
   - If **Red Flags** are not identified, go to **End**.

2. **Red Flags** (use for 4-6 weeks and Appropriate Referral as necessary):
   - Pain
   - Proximal fracture risk
   - History of malignancy
   - Suspicion of cancer
   - Intestinal obstruction
   - High pain or escalating pain
   - Sensory
   - Neurologic issues
   - Unintentional weight loss
   - Cardiac symptoms
   - Infection (from neurological deficits and/or bowel/bladder incontinence)

3. **Yellow Flags** — Indicators for Risk of Long Term Disability and Work Loss
   - Belief that pain and activity are harmful
   - History of work, pain, sleep, mood, and chronic disease
   - History of chronic pain or multiple pain points
   - Low or negative work, social withdrawal
   - Compromised ability to work or family
   - Problems at work, poor job satisfaction
   - Sexual pain, illness or disability, altered and lose
   - Restricted role
   - Unemployment or disability

4. **High Value Care**
   - In the absence of red flags, **Supported Self-Management** is appropriate.
   - Consider intervention (physical therapy, etc.) to help eliminate pain and restore function and lifestyle.

5. **Appropriate Referral** to specialty care is determined according to the patient’s condition and care preferences.

---

**For Providers:**
- **Support for the Support of Supported**
- **Health Care**
- **Physicians**
- **Occupational Therapy**
- **Physical Therapy**
- **Emergency Care**
- **Primary Care**
- **Urgent Care**

---

**For Patients:**
- **Support for the Support of Supported**
- **Health Care**
- **Physicians**
- **Occupational Therapy**
- **Physical Therapy**
- **Emergency Care**
- **Primary Care**
- **Urgent Care**

---

**Education:**
- **Support for the Support of Supported**
- **Health Care**
- **Physicians**
- **Occupational Therapy**
- **Physical Therapy**
- **Emergency Care**
- **Primary Care**
- **Urgent Care**

---

**Funding:**
- **Support for the Support of Supported**
- **Health Care**
- **Physicians**
- **Occupational Therapy**
- **Physical Therapy**
- **Emergency Care**
- **Primary Care**
- **Urgent Care**
Website Resources

Pathway Tools

Supported Self-Management for Patients with Acute Low Back Pain

Available members in the Acute Low Back Pain Care Pathway, if all of your back problems are over the first few weeks. A self-management plan, including non-pharmacological approaches such as education, exercise, and medication management, can help patients to more effectively manage their condition.

Guidelines for Patient Shared-Decision Making for Acute Low Back Pain

Evaluating patients about conditions they are experiencing and including them in the decision-making process around care choices can both engage and empower them. Research shows that patients involved in Shared Decision-Making (SDM) are more likely to carry out their initial recommendations, follow up on care plans and incorporating more informed decisions designed to prevent recurrence of symptoms. They ultimately obtain less unnecessary, low-value care and have better patient reported outcomes.

Element of Supported Self-Management for Patients with Acute Low Back Pain

- Establish a plan of contact and visit for regular care counseling with the patient after their initial visit. This needs to be done by someone who is ideally able to re-evaluate the red flags and yellow flags after the initial brief visit and patient engagement and consent document. The patient must have access to information that is clear and relevant but not in too much detail.
- Communication must be clear and active and simple examples must be considered.
- Patients should be advised on what to consider when seeking care in the future.
- The support for a Supported Self-Management can come from Primary Care, Pain, PT, DC, and/or Social Workers, as appropriate. It should not interfere with the doctor's roles.

Options for the Support in Supported Self-Management (See chart below)

- Physical therapy
- Occupational therapy
- Physician
- Social worker
- Nurse
- Physical therapist
- PT/OT
- Primary care
- Urgent care

Other High Value, Evidence-Based care that could be considered part of self-management (See chart below)

- Physical therapy
- Occupational therapy
- Physician
- Social worker
- Nurse
- Physical therapist
- PT/OT
- Primary care
- Urgent care

Engagement Steps to Include Patients in Their Care Choices

Listen
- Allow patients and their care advisors time to ask questions, share their concerns, discuss their symptoms, their level of pain, and their degree of which it is interfering with their daily activities of living, etc. Allow them to review their feelings about conservative, high-risk treatment options, advanced treatment options, and outcomes, cost, quality, and appropriateness.

Inform
- Inform and educate patients on the commercialization of back pain, to arm themselves against the loss of income, the use of medications, use of ESI, etc. When they are not educated, they take less effective courses of action.

Ask
- Ask patients about their current barriers to obtaining appropriate care. What times do they schedule their time to make an appointment? What is the transportation goal? What is available at the time of need? Do they need to obtain information? Do they need to make an appointment? Do they need to make an insurance referral? Do they need to write a prescription? Do they need to make an appointment for a follow-up appointment?

Present Options
- Present patients with multiple options before they make a decision. This can help patients to choose the options that are appropriate for them.

Make a Plan
- Make a plan to review the next course of action. Provide clear information about what to do next and when. This can help patients to make decisions that are appropriate for their needs.

Evaluating patients about conditions they are experiencing and including them in the decision-making process around care choices can both engage and empower them. Research shows that patients involved in Shared Decision-Making (SDM) are more likely to carry out their initial recommendations, follow up on care plans and incorporating more informed decisions designed to prevent recurrence of symptoms. They ultimately obtain less unnecessary, low-value care and have better patient reported outcomes.

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Patient Hand Out Templates

Understanding and Treating Low Back Pain

Back pain can be stressful and scary. It can keep us from our jobs and from time with family and friends. It may also make people afraid that something is seriously wrong. It is very common and nearly everyone will experience lower back pain at some point. (Please see bottoms of page for advice about when to seek emergency assistance.)

The good news
Did you know that 95% of back pain improves a lot over the first couple of weeks? It may take up to two months to feel completely better. Research shows that strong pain does not equal bad injury and it is likely that YOU can manage this with some support.

Where can you get help?
You have options! Reaching out to one of the following when you notice pain will help you feel better faster:

- Doctor/Chiro
  - Appointment
  - Insert customized information for your organization

- Doctor/Nurse
  - Insert customized information for your organization

- Employment
  - Program for back pain
  - Insert customized information for your organization

- Insurance
  - Program for low back pain
  - Insert customized information for your organization

- Physical Therapist
  - Appointment
  - Insert customized information for your organization

What can help?
- Stay active (bad rest is not recommended)
- Gentle stretches
- Ice or heat (or alternate them)
- Short term, over the counter pain relievers
- Good sleep
- Reduce stress
- Good posture while sitting, standing, and sleeping
- Gentle massage
- Supportive shoes (avoid heals)
- Acupuncture
- Yoga
- Tai Chi

Check back with your care team after 3 weeks, or sooner if you have questions or concerns. Keep them in the loop!

What likely won’t help?
- Prolonged rest
- Imaging before 6 weeks (for example: x-rays, CT scans or MRIs)
- Ask your care team if this is necessary since the cause of back pain cannot usually be seen on imaging.
- Opioid medication

When to seek emergency assistance:
- You experience weakness in your legs
- You have difficulty controlling your bladder or bowels
- You develop a fever
- You are unsteady on your feet

Thank you:
Amanda Hutchinson, City of Seattle
Dr. Usoltseva, UW Medicine
Vietnam Health Clinic
Somali Health Board
Participant actions

• **Purchaser:** Measuring opioid utilization for acute LBP - 38% decline from 2016-2021. (8% in 2016 to less than 5% in 2021.) Challenges lie in figuring out current state in order to then move forward, also in access to a uniform Point Solution because we have more than one carrier.

• **Payer:** Collaboration with Spine Care Partners to review member and provider education tools. Decision on integration pending. Nurse Triage team is incorporating Care Pathway into their work. Produced ad-hoc data report on use of ED, advanced imaging and opioid use for acute LBP, room to improve and add it to regular report cycle, challenged by lack of resources to do so. Also working to incorporate race, ethnicity and language data into regular reporting. Will share patient education hand out with team to see how they can provide it for members.

• **Provider:** Looking to establish acute spine care program with Timely Triage and quick access to treatment by Chiropractor or Physiatrist. Challenged currently by lack of access – working with administration to recruit another Chiropractor. Several administrators are on board; next step is to make the financial case to CFO. Future actions will involve rolling program info out to primary care team.

• **Ally:** On a state and national level, we’ve committed (and seem to be sticking with) efforts to diversify the profession and to increase health equity for patients.
Equity actions

• Point solution with **zero copay for patients and 24-hour access** eliminates cost barrier and scheduling barrier to first level care.

• We deploy **bi-lingual navigator staff** (with emphasis on communities with large populations of people with limited English proficiency). We also review access data to identify areas in the state with the greatest need.

• Patient **education materials in multiple languages, appropriate to different levels of education** and available digitally and as printed material provide multiple communication options to more effectively reach a much larger number of patients.

• We are working to initiate **system-wide unconscious bias training**.

• We use **data reporting to identify baselines of low value care. We have requested reporting that includes race, ethnicity and language filters** so that we can investigate to determine if larger gaps in care exist for specific populations and target efforts to those populations.

• Our DEI Committee meets monthly to assess needs of the organization and we are working to **implement a Social Determinants of Health screening tool in our patient engagement platform**.
Random thoughts

- Have explicit metrics (process, outcome, balancing) prior to project start (even if the funder doesn’t require these).

- Spread the message even when it’s not done (e.g., HRSA HEC conference).

- Constant contact is the key.

- Have fun! For example, headliner exercise, word clouds
Update: HCA Maternal Bundle
Member Spotlight: WA Health Alliance
2023 Topic Updates
Diabetes Care
Members

- **Chair**: Norris Kamo, MD, MPP, Virginia Mason Medical Center
- Susan Buell, YMCA of Tacoma and Pierce County
- LuAnn Chen, MD, MHA, Community Health Plan of Washington
- Sharon Eloranta, MD, Washington Health Alliance
- Rick Hourigan, MD, Cigna
- Carissa Kemp, MPP, American Diabetes Association
- Vickie Kolios, MSHSA, CPHQ, Foundation for Health Care Quality
- Robert Mecklenburg, MD, Virginia Mason Medical Center
- Mamantha Palanati, MD, Kaiser Permanente
- Kheimerly Schoenacker, RDN, CD, WA Department of Health
- Cynthia Stilson, RN, BSN, Community Health Plan of Washington
- Sally Sundar, The Y of Greater Seattle
- Nicole Treanor, RD, Virginia Mason Franciscan Health
Aim

Improve health care quality, outcomes, affordability, equity, and workforce sustainability related to diabetes care in Washington state.
<table>
<thead>
<tr>
<th>Quintuple Aim Groups</th>
<th></th>
<th>Authors</th>
</tr>
</thead>
</table>
| **Cost/Value**                        | Investigate funding mechanisms for high-quality diabetes care. Remove barriers to funding access. Address rising costs of insulin, management technology, and coverage options for people living with diabetes. | • Sharon Eloranta  
• Robert Mecklenburg  
• Jonathon Harris |
| **Care Experience**                   | Ensure high-quality care for people living with diabetes. Determine metrics for high-quality care. Ensure people living with diabetes are offered a wide variety of treatment options, including referrals to community organizations providing education and care management. | • Nicole Treanor  
• Norris Kamo  
• Vickie Kolios |
| **Population Health**                 | Identify at-risk populations and improve screening for pre-diabetes and gestational diabetes. Improve prevention activities including risk identification, education, and management programs. | • Mamatha Palanati  
• Susan Buell  
• Emily Robson  
• LuAnn Chen |
| **Burnout and Wellbeing**             | Increase efficacy of diabetes care and reduce administrative burden. Collaborate across sectors and reduce care silos. Ensure skill-task alignment for all members of the care team. | • Norris Kamo  
• Mamatha Palanati |
| **Equity**                            | Increase equitable access to testing, treatment, and medications. Address social determinants of health that impact diabetes care and disparities in diabetes outcomes for priority communities. Consider food access and the built environment | • Cyndi Stilson  
• Jonathon Harris  
• Nick Locke |
Common Themes

- Providing team-based care to every patient with diabetes
- Addressing affordability of medication and supplies
- Highlighting the needs of priority populations (rural, uninsured, migrant workers)
- Closing gaps that disrupt optimal care (excessive co-pays, insurance plan transitions, etc.)
Next Steps

- Brainstorm opportunities for action and determine sub-group goals.
- Consolidate research questions for evidence review.
- Review evidence and draft recommendations at future workgroup meetings.
Thank you!
Complex Discharge
Members (partial list)

- **Chair:** Darcy Jaffe, BSN, MN, Washington State Hospital Association
- Shelley Bogart, DSHS-DDA
- Gloria Brigham, EdD, MN, RN, Washington State Nursing Association
- Colin Maloney, MPH, WA Department of Health
- Jason McGill, JD, WA Health Care Authority
- Sara Williams, RN, PeaceHealth
- Jeff Foti, MD, Seattle Children’s
- Catherina McInroe, MSW, Providence
- Linda Keenan, PhD, MPA, RN-BC, United Healthcare
- Jen Koon, MD, Premera
- Amer May, MD, Kaiser Permanente
- Kim Petram, BSN, CPHM, Valley Medical
- Jennifer Triggs, MSW, Virginia Mason Memorial Hospital
- Cyndi Stilson, RN, BSN, Community Health Plan of Washington
- Zosia Stanley, JD, MHA, Washington State Hospital Association
- Billie Dickinson, Washington State Medical Association
- Janice Tufte, PICORI West Ambassador/Hassanah Consulting
Increase evidence-informed practices for appropriately and equitably discharging people from acute care facilities in order to increase access to acute care and improve quality of life for non-acute patients.
To propose evidence-based recommendations to the full Bree Collaborative on:

- Aligning definitions and language around difficult to discharge and defining responsibilities.
- Identifying barriers to discharge
- Identifying practices for improving the discharge process
- Defining “appropriate” post-acute care
- Identifying practices and partnerships to increase access to appropriate post-acute care
- Implementation of discharge protocols
- Forming recommendations for further collaboration and investigation on difficult to discharge.
- Consider system transformation toward a high quality post-acute care continuum
Opportunities for Impact

- Developing common definitions and metrics.
- Describe the post-acute care continuum and clarify discharge pathways to various settings.
- Best practices for engaging a discharge team and improving communication between hospital, plan, and post-acute care representatives.
- Consider current infrastructure for the post-acute care continuum and how to develop greater capacity.
• Common definition for “Difficult to Discharge”
  • Switched to “Complex Discharge” which everyone agrees focuses on the barriers patients face.
  • A **complex discharge** occurs when a patient has complex care needs that require support from inter-departmental teams.
  • Separate but related to the complex discharge definition is **avoidable days**: the number of days that a patient is medically ready for discharge but remains hospitalized.
Aligning Metrics

- Current Data on Difficult to Discharge Patients
  - Focused on the patient’s payer as a barrier to discharge
  - Sometimes includes number of days medical necessity not met
  - Some hospitals collect categories of discharge barriers (i.e. “behavioral health,” “substance use disorder,” “lack of housing”)

- Point of collection and data aggregation
  - A few organizations collect aggregate discharge data (HCA, MCOs, WSHA), but the data often reflects different definitions and priorities.
  - One opportunity for impact is to define specific metrics for alignment.
Recommendation

Adopt Charter
Members (partial list)

- **Chair:** Colleen Daly, PhD, Microsoft
- Patricia Morgan, ARNP, Evergreen Health
- Trish Anderson, MBA, BSN, Washington State Hospital Association
- Elizabeth Tinker, PhD, MPH, MN, RN, WA Health Care Authority
- Emelia Udd, MD, Kaiser Permanente
- Aphrodyi Antoine, MPH, MPA, Health Related Services Administration
- Kristin Hayes, MSW, Evergreen Health
- Kay Jackson, CNM, ARNP, Off the Grid Midwifery
- Gina Legaz, MPH, WA Department of Health
- MaryEllen Maccio, DM, Valley Medical Center
- Melissa Rubin, DNP, ARNP, Sound Family Psychiatry
- Sheryl Pickering, WA Department of Health, WIC
- Billie Dickinson, Washington State Medical Association
- Cindy Gamble, MPH, American Indian Health Commission
- Ellen Kauffman, MD
Aim

To improve the mental health care continuum along the reproductive or family building journey including the perinatal and postpartum period.
To propose evidence-based recommendations to the full Bree Collaborative on:

- Identifying at-risk populations and increasing screening activities.
- Advancing equity and addressing inequities in perinatal/maternal mental health prevention, resources, and supports.
- Identifying mechanisms for following-up with brief interventions, treatment, or referrals to mental health services.
- Addressing structural determinants and other barriers to perinatal/maternal mental health.
Scope Conversations

- Prevention
- Family Planning
- Pregnancy Support
- Birth
- Postpartum Services

Broader Support Ecosystem
Care/Support Continuum

Link: https://coloradomaternalmaternalhealth.org/resources/resources-for-providers/perinatal-continuum-of-care.html
Recommendation

Adopt Charter
Bree Implementation Update: Interoperability Pilot Survey
Stage 1 Pilot Testing

**Stage 1 Pilots**
- Bree Collaborative member pilots
- Revisions to assessment tools based on pilots

**Stage 2 Pilot**
- Bree Collaborative contributor pilots
- Final revisions to assessment tools
- Pilot paper publication/distribution

**Stage 3 Release**
- Release of assessment tool and documentation for use with the Bree Collaborative Implementation Guide
- Report to Bree Steering Committee
- Report to HCA
Stage 1 Pilot Testing

- **February**
  - Plan pilot test and evaluation

- **March**
  - Introduce Connectivity and Interoperability and Health Literacy assessment tools to Bree Collaborative Members

- **April**
  - Recruit for pilots from Bree Collaborative Member cohort
  - Implement pilots

- **May**
  - Revisions to assessment tools and prep for Stage 2 Pilots
  - Stage 1 pilot documentation

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**Stage 1 Pilots**

- Bree Collaborative member pilots
- Revisions to assessment tools based on pilots
Stage 2 Pilot Testing

- June
  - Introduce Connectivity and Interoperability and Health Literacy assessment tools to Bree Collaborative work group members

- July
  - Recruit for stage 2 pilots
  - Implement Stage 2 pilots and data collection

- August
  - Second revisions to assessment tools
  - Stage 2 pilot documentation and paper

- September
  - Plan for general release and community promotion

Stage 2 Pilot

- Bree Collaborative contributor pilots
- Final revisions to assessment tools
- Pilot paper publication/distribution
Stage 3 Release

- Release Assessment in Implementation Guide
- Release supporting documentation in Implementation Guide
- Report to Bree Steering Committee and HCA

- Introductory webinar
- How are we going to continue to spread the word?

- Assessment point?

- Validation Study Planning