
Bree Collaborative | Collaborative Care for Chronic Pain Workgroup

February 9th, 2018 | 3:00-4:30

Foundation for Health Care Quality

Members Present

Ross Bethel,* MD, Selah Family Medicine
Lynn DeBar,* PhD, MPH, Kaiser Permanente
Washington Health Research Institute
Andrew Friedman, MD, Virginia Mason
Medical Center
Leah Hole-Marshall, JD, Washington State Labor
and Industries (Chair)
Stu Freed,* MD, Wenatchee Valley Medical
Mary Kay O'Neill, MD, MBA, Mercer
Jim Rivard, PT, DPT, MOMT, OCS, FAAOMP,
MTI Physical Therapy

Kari A. Stephens, PhD, University of
Washington Medicine
David Tauben, MD, 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

Staff and Members of the Public

Adam Burkey,* MD, MSCE, Anesis Spine & Pain
Care
Peter Dunbar, Foundation for Health Care
Quality

Christopher Tag Veal,* MD, Pacific Anesthesia
Ginny Weir, MPH, Bree Collaborative
Emily Wittenhagen, Bree Collaborative

* By phone/web conference

WELCOME AND APPROVAL OF JANUARY 12TH MINUTES

Leah Hole-Marshall, JD, L&I opened the meeting and those present introduced themselves. A motion was made to approve the minutes from the previous meeting.

Motion: Approve 1/12/2018 Minutes.

Outcome: Passed with unanimous support.

BUILDING ON PRELIMINARY SCOPE OF WORK AND DEVELOPING FOCUS AREAS

Ginny Weir, MPH, Bree Collaborative, went over the meeting's agenda and materials, including the latest Purpose Statement, Focus Areas, and sample frameworks, and the group discussed:

- Looking at Care Coordination Models, as well as other relevant guidelines that have been developed by organizations, such as [International Association for the Study of Pain \(IASP\)](#) and National Committee for Quality Assurance (NCQA), for reference in this group's recommendations.
- Ms. Hole-Marshall announced that the Charter was approved at the most recent Bree meeting.
- Ways this scope of this work goes beyond musculoskeletal chronic pain, including neuropathic, pelvic, low back pain, fibromyalgia, etc. and agreement that broad inclusion would make the recommendations more applicable.
 - Acknowledging relevant comorbidities, particularly behavioral health.
- Looking at the McCall Model, which Ms. Hole-Marshall has begun developing into a sheet aimed at outlining the McCall, Peterson (VA Multi-Model Review), Unutzer, and Parchman models, covering five areas: Health Systems, Clinical Information Systems, Delivery Systems, Decision Support, and Self-Management Support.

- Working to determine what each model entails and exploring whether to blend elements of the models, or choose one to focus on.
- Possible next steps of successful outcomes for management of people with chronic pain in the primary care setting to develop a baseline. Need to determine if all of the elements of a model are adequate or if incorporating elements of different models is more feasible.
- Looking at treatment-to-target measures.
- Considering the resources available to get to the best outcome.
- The evidence for these models to effectively impact the triple aim.
- Keeping in mind patients most in need as we develop a systematic approach.
- Agreeing on outcomes first and working from there in applying the model(s) to our goals.
- Using access criteria to identify potential bias in the delivery system.
- Using the quadruple aim rather than the triple aim, to incorporate more practitioners.
- Mirroring the Behavioral Health Integration model in order to highlight parallels, and ensure a manageable scope.
- Whether the “no wrong door” approach can apply here, and considering the potential roles of telehealth and other alternative treatment models.

Ms. Weir walked through the Behavioral Health Integration Recommendations and the group discussed:

- The benefits of modeling the Collaborative Care for Chronic Pain Recommendations on this framework for ease of comprehension in disseminating both models in close conjunction.
- Looking at who delivers care in terms of what models are applied.
- Acknowledging unique barriers particular to those with multidimensional diagnoses/ comorbidities, as well as other barriers such as financial.
- [Joan Romano](#) of UW’s studies these topics.
- Acknowledging patients who can’t fully participate.
 - Encouraging incorporation of family, caregivers, patient advocates, and proxies as care partners especially in these cases (while these roles can serve as both a help and a hindrance, depending on the situation).
 - Addressing cases in which the patient and family/caregiver/patient advocate are not aligned on the patient’s situation and needs and can benefit from having the provider/care team provide a safe space for these issues to be aired and addressed.
- Who is allowed to make a diagnosis or assessment in a multidisciplinary team.
- Aligning on prescription, diagnoses, duration, dosage, timing, and treatment plans in a shared care plan, as well as among care teams.
- The definitions of case management depending on setting, and its parallel to care coordination.
- What kind of practical applications and financial models/resources can be put in place to help primary care physicians, care managers, and specialists to get to recommended outcomes.
- Ensuring that the care team periodically queries and keeps the patient’s goal for treatment in mind (such as ability to be self-sufficient), and that all of the care team is aware of the goals.
- Looking at relevant proof points that can help translate into dollars saved to incent collaborative care, and conversely, the cost of not building/following collaborative care models.
- Building in “protected time” for providers to implement elements of these models.
- Possible reduction in clinician burnout when these models are supportive of providers and meet patient needs.

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.