Overview of Presentation

Summarize workgroup activity

Review draft spine report

Proposal: Approve posting draft spine report for public comment
Workgroup Activity

Has met 11 times since November

Active participation by workgroup members:

• Mary Kay O’Neill MD, Executive Medical Director, Regence (Chair)
• Dan Brzusek DO, Physiatrist, Northwest Rehab Association
• Neil Chasan, Physical Therapist, Sports Reaction Center
• Andrew Friedman MD, Physiatrist, Virginia Mason
• Leah Hole-Marshall JD, Medical Administrator, L&I
• Heather Kroll MD, Rehab physician, Rehab Institute of WA
• Chong Lee MD, Spine surgeon, Group Health Cooperative
• John Robinson MD, Chief Medical Officer, First Choice Health
• Michael Von Korff, Psychologist/researcher, Group Health
• Kelly Weaver, Physiatrist, Everett Clinic
Overview of Process

Several brainstorming sessions

Review of most widely used evidence-based guidelines

• Joint Guideline from ACP/APS
• NICE (from the UK, used in NHS)
• ICSI (Institute for Clinical Systems Improvement)

Presentations by guest speakers

• Andrew Haig MD, Priority Health experiment from Michigan
• Bob Mecklenburg MD, VMMC and Intel’s approach to spine care
• Judy Turner PhD, Research projects with Group Health and L&I
Focus Areas

Increase appropriate evaluation and management of patients with new onset and persistent acute low back pain (LBP) and/or nonspecific low LBP not associated with major trauma (no red flags) in primary care.

Increase early identification and management of patients that present with LBP not associated with major trauma (no red flags) but have psychosocial factors (yellow flags) that place them at a high risk for developing chronic LBP.

Increase awareness of LBP among individual patients and the general public.
Report Outline

I. The Bree Collaborative and its charge
II. Problem statement
III. Areas of focus and goals
IV. Low back pain is a common and costly condition
V. Practices vary widely in the diagnosis and management of acute LBP
VI. Overview of recommendations
   A. Guidelines: translating evidence-based guidelines into practice
   B. Screening tools: matching patients with appropriate care
      • Case study: Spine Clinic at Virginia Mason Medical Center
   C. Patient education: increasing awareness and managing expectations
I. The Bree Collaborative and its charge

Brief summary of Bree history/purpose

Two-pronged strategy

• Formed a workgroup to develop recommendations for preventing the transition of acute pain to chronic pain

• Recommended that all hospitals participate in Spine SCOAP to improve surgical outcomes for chronic low back pain patients
II. Problem statement

Need for change

- High utilization rates for costly, non-value-added modalities
- Management of acute LBP is difficult
- Significant variation in provider practices
- Small % of acute LBP patients need complex management to avoid chronic LBP
III. Areas of focus and goals

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Specific Goals</th>
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<tbody>
<tr>
<td>#1 – Increase appropriate evaluation and management of patients with new</td>
<td>• Increase adherence to evidence-based guidelines</td>
</tr>
<tr>
<td>onset and persistent acute low back pain (LBP) and/or nonspecific low</td>
<td>• Increase provider awareness of key messages (e.g. patient activation)</td>
</tr>
<tr>
<td>LBP not associated with major trauma (no red flags) in primary care</td>
<td>• Reduce use of non-value-added modalities for LBP (e.g. MRIs)</td>
</tr>
<tr>
<td>#2 – Increase early identification and management of patients that present</td>
<td>• Increase use of screening tools to triage acute LCP patients to appropriate</td>
</tr>
<tr>
<td>with LBP not associated with major trauma (no red flags) but have</td>
<td>care providers</td>
</tr>
<tr>
<td>psychosocial factors (yellow flags) that place them at a high risk for</td>
<td>• Restore patient function more quickly</td>
</tr>
<tr>
<td>developing chronic LBP</td>
<td></td>
</tr>
<tr>
<td>#3 – Increase awareness of LBP among individual patients and the general</td>
<td>• Increase the proportion of the population that agrees with key LBP messages</td>
</tr>
<tr>
<td>public</td>
<td>(e.g. stay active)</td>
</tr>
</tbody>
</table>
IV. Low back pain is a common and costly condition

Leading cause of disability in the United States

- Approximately 20-30% of the adult population has LBP at any given time

High costs – both direct (medical care) and indirect (days lost from work)

- KingCare (King County health plan) spent >$31 million for interventions for LBP in 2010

Acute LBP is the most prevalent type of LBP and frequently recurs

- In long-term follow-up, about 1/3 of patients report intermittent or persistent pain of at least moderate intensity
V. Practices vary widely in the diagnosis and management of acute LBP

- Overuse of unnecessary, non-evidence-based treatments
- Barriers to operationalizing evidence-based guidelines
- Lack of access to multidisciplinary teams and intensive care
- Different provider types offer a broad variety of options
- Patient demand for unnecessary/expensive treatments
VI. Overview of Recommendations

Guidelines: translating evidence-based guidelines into practice

Screening tools: matching patients to appropriate care

Patient education: increasing awareness and expectations
Guidelines: General Recommendations

Recommend the widespread adoption of ACP/APS guidelines in primary care settings in Washington

- Joint clinical guidelines from American College of Physicians (ACP) and the American Pain Society (APS)
- Selected by Guideline Development Group from the State of Oregon in 2011

Overview of Guideline Development Group (GDG) Methods

1. 17 guidelines identified
2. 10 guidelines met all criteria (evidence-based, comprehensive, widely available in English)
3. 5 guidelines rated as Good methodologic quality
4. 2 guidelines identified as the highest quality & most comprehensive (ACP/APS & NICE)
5. ACP/APS guideline selected

Notes: NICE = National Institute for Health and Clinical Excellence. The GDG preferred the ACP/APS guideline over the NICE guideline because the latter did not address treatment in the first six weeks, contain algorithms that would aid implementation, or include patients with leg pain or radiculopathy.

Sidebar: Guideline for prescribing opioids to treat pain in injured workers, L&I
Guidelines: General Recommendations

Recommend the use of the Oswestry Disability Index (ODI) to track functional status

- Specifically the version currently used by Spine SCOAP
- Already commonly used across Washington
- 3-item PEG scale is another good option for practices that require a shorter tool

Recommend the implementation of clinical decision support systems in both hospitals and clinics to increase the adoption of evidence-based practices

Sidebar: Guideline for prescribing opioids to treat pain in injured workers, L&I
# Guidelines: Specific Recommendations

<table>
<thead>
<tr>
<th>Hospitals/ Clinics</th>
<th><strong>High priority</strong>: support or sustain a LBP quality improvement program that includes measuring patients’ functional status over time using the Oswestry Low Back Pain Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Take steps to integrate evidence-based guidelines, scripts, shared decision making, and patient education materials into clinical practice and workflow (e.g. EMR)</td>
</tr>
<tr>
<td>Individual Providers</td>
<td><strong>High priority</strong>: Commit to using evidence-based guidelines and tools recommended by the Bree Collaborative, including the ACP/APS guidelines and Oswestry</td>
</tr>
<tr>
<td></td>
<td>Establish referral relationships with physiatrists</td>
</tr>
</tbody>
</table>
Guidelines: Specific Recommendations

HCA/ Medicaid/ DOH/L&I

High priority: Design and implement a payment structure for LBP that incentivizes providers to adopt evidence-based practices

Health Plans

None for this section
## Guidelines: Specific Recommendations

<table>
<thead>
<tr>
<th>Employers/ Purchasers</th>
<th><strong>High priority</strong>: Encourage providers to track and report how frequently providers are administering tools to measure return to function scores</th>
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<tbody>
<tr>
<td></td>
<td><strong>High priority</strong>: Negotiate tiered networks or other types of benefit design that encourage patients to go to providers that have demonstrated they use evidence-based practices</td>
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<tr>
<td></td>
<td>Support time-limited intensive care for complex back pain with a different payment model to allow for higher touch and more with patients by care team</td>
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</table>
Screening Tools: Overview

Concept of subgroup & targeting for primary care low back pain

- Psychological obstacles to recovery
  - Enhanced package of care (complex)

- Physical obstacles to recovery
  - Face to face ‘conservative’ treatment

- Low risk of chronicity
  - Advice, reassurance & medication

- Targeted treatments
  - Patients are not all the same

Source: Keele University SBST Website (http://www.keele.ac.uk/sbst/)
Screening Tools: General Recommendation

Recommend two tools that are particularly robust and evidence-based:

<table>
<thead>
<tr>
<th>STarT Back Screening Tool (SBST)</th>
<th>Functional Recovery Questionnaire (FRQ)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 9-item tool</td>
<td>• 5-item tool</td>
</tr>
<tr>
<td>• Divides patients into 3 categories of risk for developing persistent, disabling back pain</td>
<td>• Identifies injured workers that are at an increased risk of chronic, disabling pain (FRQ+)</td>
</tr>
<tr>
<td>• Treatment depends on group</td>
<td>• L&amp;I is currently piloting – workers who have missed 2 weeks of work take FRQ and FRQ+ workers receive additional care (e.g. address fear avoidance beliefs)</td>
</tr>
<tr>
<td>• RCT evidence of benefits – larger improvement in function, fewer days of work lost, and higher levels of patient satisfaction</td>
<td></td>
</tr>
</tbody>
</table>
### Screening Tools: Specific Recommendations

<table>
<thead>
<tr>
<th>Hospitals/ Clinics</th>
<th><strong>High priority</strong>: Use a validated screening tool like the SBST or FRQ no later than the 3rd visit to identify patients that are not likely to respond to routine care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Providers</td>
<td>Same as above</td>
</tr>
</tbody>
</table>
Screening Tools: Specific Recommendations

**Health Plans**

**High priority**: Require providers to demonstrate that they have had patients complete a screening tool as part of the prior authorization process for imaging, spinal injections, and/or spinal surgery.

**High priority**: Identify complex cases (e.g., a patient who is getting opioid prescriptions from multiple doctors) and refer them to a provider or a case manager that can oversee their care.
Screening Tools: Specific Recommendations

If a provider prefers to use a screening tool other than the SBST or FRQ, the alternative tool should meet the following criteria:

- Validated tool with strong evidence of predictive power
- Using and scoring the tool is both fast and easy
- No cost to access or use the tool and any scoring materials
- Evidence that using the tool leads to improved outcomes (preferred, not required)
Case Study: Spine Clinic at Virginia Mason

- Phone screening to match with appropriate providers
- Same-day visits with a physical therapist and physiatrist
- Controls on MRI ordering
- “Abnormal findings” language included in lumbar MRI reports

Note: The following findings are so common in people without low back pain that while we report their presence, they must be interpreted with caution and in the context of the clinical situation. (Reference-- Jarvik et al, Spine 2001)

Findings (prevalence in patients without low back pain)
Disc degeneration (decreased T2 signal, height loss, bulge) (91%)
Disc T2 -- signal loss (83%)
Disc height loss (56%)
Disc bulge (64%)
Disc protrusion (32%)
Annular tear (38%)
Patient Education: Overview

Patient beliefs and expectations affect outcomes

- Addressing patient fears and encouraging them to resume normal activities is usually an important 1st step

Mass media educational campaigns can change attitudes about LBP

- Evidence from campaigns in Australia, Scotland, Norway, and Canada

Source: [http://backactive.ca/resources.html](http://backactive.ca/resources.html)
## Patient Education: Specific Recommendations

<table>
<thead>
<tr>
<th>Individual Providers</th>
<th><strong>High priority</strong>: Incorporate comprehensive patient education and expectation-setting into care for LBP patients, particularly when patient is requesting care that is not recommended by evidence-based guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals/ Clinics</td>
<td>Take steps to integrate comprehensive patient education and effective messaging into clinical practice and workflow for LBP patients</td>
</tr>
</tbody>
</table>
Patient Education: Specific Recommendations

<table>
<thead>
<tr>
<th>HCA/ Medicaid/ DOH/L&amp;I</th>
<th>High priority: Coordinate an evidence-based education campaign about LBP (ideally modeled after Australian campaign)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employers/ Purchasers</td>
<td>Provide recommended patient education materials about LBP to all employees and their families</td>
</tr>
</tbody>
</table>
List of Appendices

| A. | List of Bree Collaborative and Spine/Low Back Pain Workgroup Members |
| B. | Initiatives to Improve Low Back Pain Care (Acute and Chronic) and Organizations that Apply Best Practices |
| C. | Evaluation and Management Algorithms from the ACP/APS Guidelines |
| D. | Opioid Authorization Forms from Washington State Department of L&I |
| E. | Recommended Version of Oswestry Disability Index (ODI) |
| F. | 9-item STarT Back Screening Tool (SBST) |
| G. | Functional Recovery Questionnaire (FRQ) |
| H. | Materials from Functional Recovery Interventions Pilot at L&I |
| I. | Potential Uses of Technology for Strengthening Public Education Efforts |