



Member Roundtable

**Driving Market Change Through Multi-Stakeholder
Collaboration**

Featuring the Washington Health Alliance

May 23, 2022

Housekeeping Reminders

- This is a Zoom meeting.
- Please **mute** yourself when you are not actively speaking.
- Please use the **raise hand** function to chime in with questions or comments and/or use the **chat** to share.
- Please share video if you are able.

Agenda

- **Welcome and Civitas Updates** - *Jolie Ritzo*
- **Member Presentation** – The Washington Health Alliance, *Denise Giambalvo, Director of Purchaser Strategies, Mark Pregler, Director, Data Management and Analytics*
- **Q&A/Discussion**

Civitas Updates

Just
announced!

SPEAKER ANNOUNCEMENT

KEYNOTE SPEAKERS:



CARA JAMES, PHD
PRESIDENT AND CHIEF EXECUTIVE
OFFICER, GRANTMAKERS IN HEALTH



DORA HUGHES, M.D., M.P.H.
CHIEF MEDICAL OFFICER,
CMS INNOVATION CENTER



#TOGETHER4HEALTH2022



The Civitas Networks for Health 2022 Annual Conference, a Collaboration with the DirectTrust Summit



[More event info on the Civitas website.](#)

Event Information

Conference Registration

We're pleased to present a hybrid 2022 conference with options for both in-person and virtual attendance. Snag the Early Bird rate before Friday, May 27.

Please view our [Conference Event Safety, Code of Conduct and Policies here.](#)

[REGISTER NOW](#)

Hotel Reservations

Take advantage of our discounted hotel room block for conference attendees at the San Antonio Marriott Rivercenter.

Discounted room rate:

\$159/night

Reservations must be made on or before July 22.

[RESERVE A ROOM](#)

Sponsor Prospectus

Be part of one of the most anticipated health data conferences of the year. Join us as a sponsor!

There are options at every price point.

[VIEW PROSPECTUS](#)

A man with short dark hair and glasses, wearing a dark suit jacket over a light blue shirt, is looking down at a white smartphone in his hands. He is sitting in a conference room, with other people blurred in the background. The lighting is warm and focused on him.

Let's get the word out!

- We have a [conference communications toolkit](#).
- Please retweet and repost content! Share when you register and highlight other aspects of the conference you are excited about.
- Use our hashtag **#Together4Health2022**

Upcoming Civitas Event

Our next **Collaboratives in Action: *It's December 2023 – Do you know where your data are? The definitive guide to ePHI, EHI Export, and Designated Record Sets*** is on June 9 from 1-2:30 pm.

Featuring:

- Elisabeth Myers, ONC
- Lauren Riplinger, AHIMA
- Lisa Bari, Civitas Networks for Health
- Richard Gibson, Comagine Health
- Steven Lane, Sutter Health

Registration is open!



Driving Market Change through Multi-stakeholder Collaboration

Civitas Networks for Health

May 23, 2022

Denise Giambalvo

Mark Pregler

Mission and Vision

The mission of the Washington Health Alliance is to build and maintain a strong alliance among purchasers, providers, health plans, and consumers **to promote health and improve the quality and affordability of the health care system in Washington state.**

Our vision is that physicians, other providers and hospitals in Washington will achieve **top 10% performance in the nation** in the delivery of equitable, high quality, evidence-based care and in the reduction of unwarranted variation, resulting in a significant reduction in the rate of medical cost trend.

Diverse Stakeholder Membership



Today at the Alliance: We Have Three Main Functions

We are a **TRUSTED CONVENER** for stakeholders, promoting a collective conversation to transform care delivery and financing in Washington state



Driving **ACTION**:
Promote and align strategies to have impact and improve performance based on data-driven insights



Promoting **TRANSPARENCY**:
Performance measurement and reporting is a core competency of the Alliance

Phase 1: Aligning to Drive Value

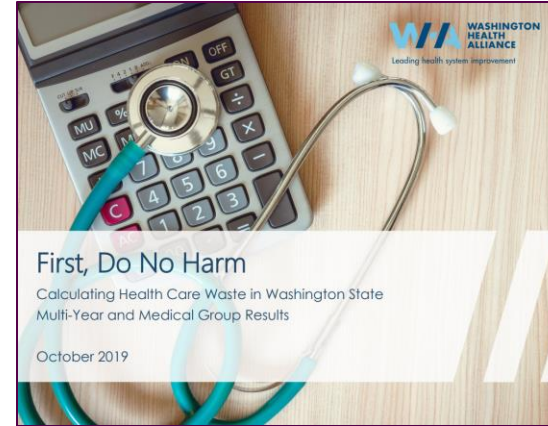
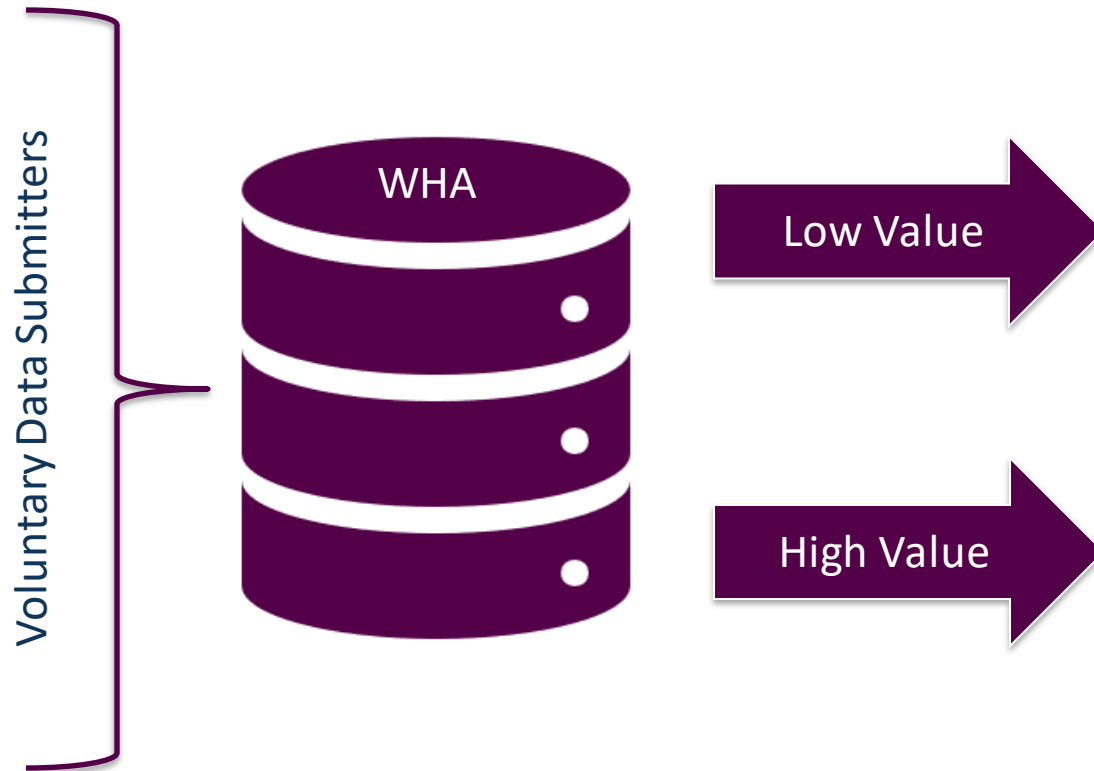
Overall Aim:

Use data and convening to inform and motivate purchasers to act individually and collectively to improve the value of care for their plan participants.

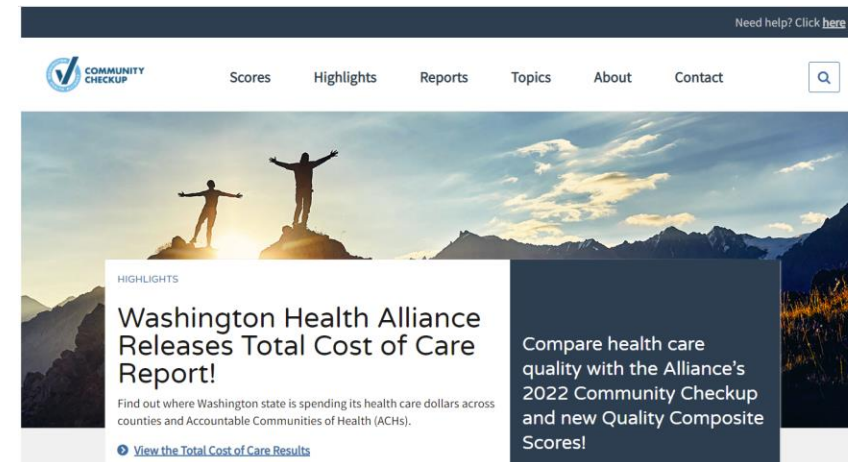
Driving Value Project



Using data to drive action



*Produced using the Milliman MedInsight Health Waste Calculator™



Health Waste Calculator Top Low-Value Services

Measure	WA State	A	B	C	D	E	F	G	H
Annual EKG or cardiac screening in individuals who are low-risk and without symptoms (M)	1	1	1	2	3	1	1	2	2
Opiates for acute low back pain (H)	2	2	2	1	1	5	4	1	1
Antibiotics for acute URI and ear infections (L)	3	4	4	4	2	2	2	3	3
Pre-operative baseline lab studies prior to low-risk surgery in healthy individuals (L)	4	5	5	3	5	3	3	4	4
PSA screening for prostate cancer in men (M)	5	3	3	10	4	4	5	5	5
Imaging tests for eye disease (L)	6	6	8	5	6	6	7	10	9
Too frequent cervical cancer screening in women (M)	7	7	7	7	10	8	8	9	7
Routine general health checks in adults 18-64 (L)	8	9	9	15	7	7	9	8	8
Screening for vitamin D deficiency (L)	9	8	6	6	8	9	6	6	6
NSAIDs prescribed for adults with hypertension, heart failure or chronic kidney disease (M)	10	10	11	8	9	11	11	11	10
Imaging for low back pain within 6 weeks of diagnosis (M)	11	11	10	11	11	10	10	7	11
Too frequent colorectal cancer screening adults 50-74 (L)	14	13	16	9	19	15	12	22	16

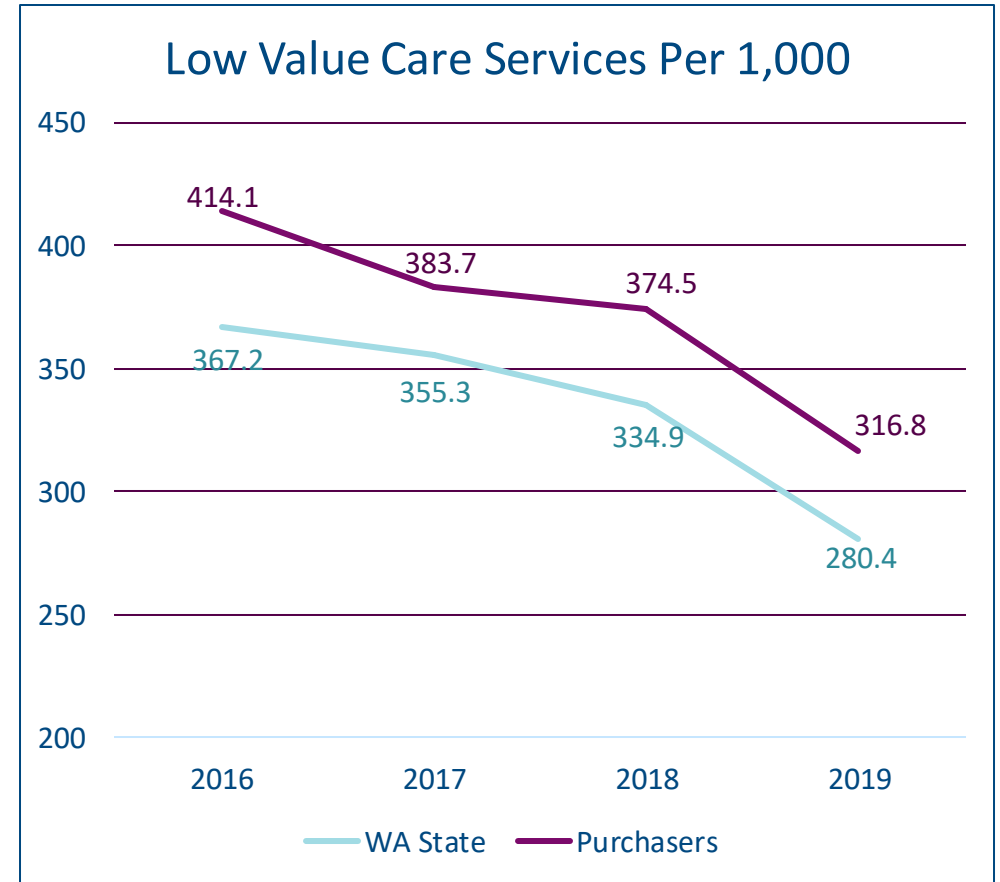
What We Found In The Data on Low Value Care

(42-month period from 1/1/2016 – 6/30/2019)

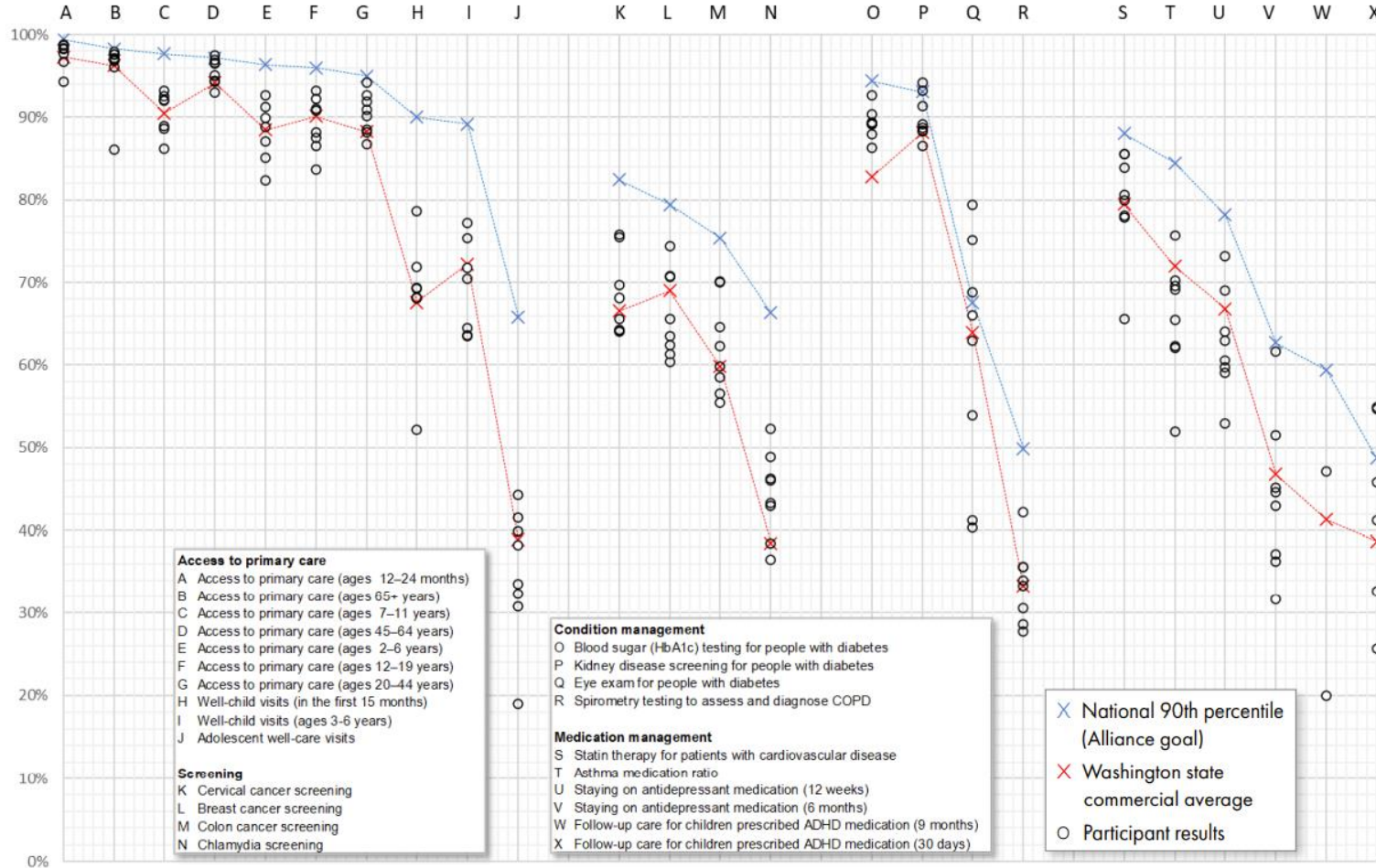
~20% individuals received at least one low-value service

> \$320 million was spent on low-value care by these eight purchasers

The average cost per low-value service is ~ \$129.00



What We Found in the Data on High Value Care



Phase 2: Taking Action on Low Back Pain

Overall Aim: Advancing the market to improve the value of care for all patients with low back pain in Washington state.



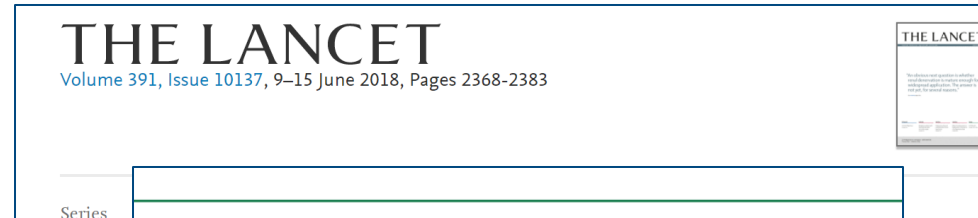
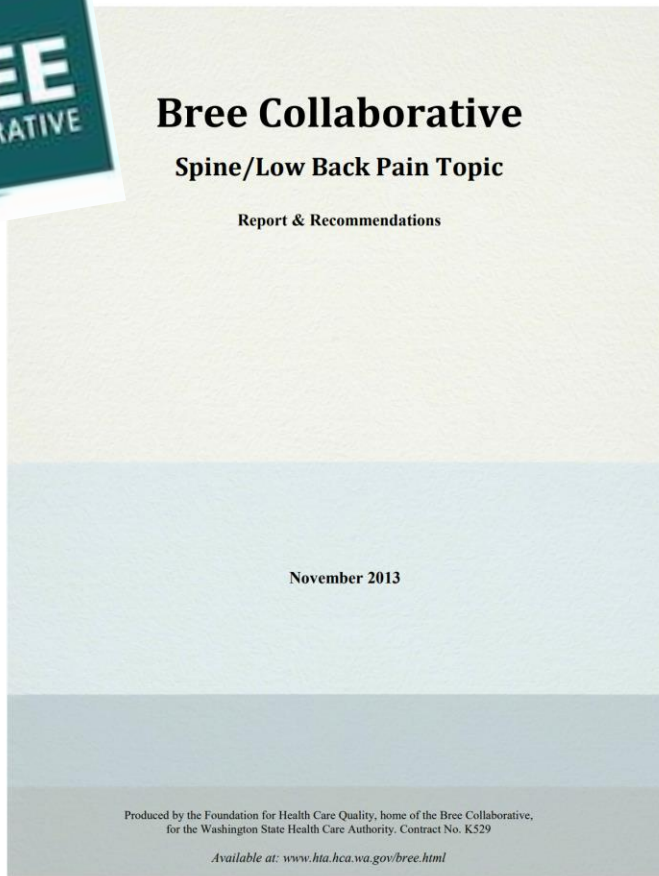
Low Back Pain: The Problem in Washington State

In 2020, more than 72,000 Washington residents received low-value care:

- more than 140,000 low-value services (inappropriate opioid prescriptions and unnecessary X-rays, MRIs and CT scans)
- at an estimated cost of nearly \$10 million*

*Data from the Alliance's All-Payer Claims Database.

Strong Evidence-Base With Poor Implementation



The management of LBP de-
 cal examination findings.² Most
 ng cause.³ Low back pain is
 an 12 weeks.² Because non-
 health care expenditures, clin-
 based medical care.^{4,5}

Invitations to Participate

Communicated the markers for success:

- aligns incentives for patients and providers,
- addresses equity concerns,
- ensures maximum adoption of the well-established evidence, and
- informs policies and/or market actions that break down barriers to implementation.

Participation Agreement commitments:

- implement benefit design, provider payment, and /or educational strategies by 2023;
- allocate corporate resources capable of committing on behalf of the organization; and
- participate in collaborative work starting in Feb. 2022 and lasting through March 2023.

Multi-Stakeholder Participants-14 Purchasers

- Association of Washington Cities
- Bloodworks Northwest
- The Boeing Company
- City of Seattle
- Davis Wright Tremaine
- King County
- Point B
- Port of Seattle
- SEIU 775 Health Benefits Group
- Seattle Metropolitan Chamber of Commerce/
- Business Health Trust
- Teamsters
- UFCW 21
- Washington Health Benefit Exchange
- Washington State Health Care Authority

Multi-Stakeholder Participants- 7 Providers

- Confluence Health
- MultiCare Health System
- Proliance Surgeons
- UW Medicine
- Virginia Mason Franciscan Health
- Washington Optum Care
- WA State Chiropractic Association

Multi-Stakeholder Participants

4 Health Plans

- Aetna
- Kaiser Permanente Washington
- Premera Blue Cross
- Regence BlueShield

5 Affiliates

- American Physical Therapy Association
- Aon
- Dr. Robert Bree Collaborative
- WA Acupuncture and Eastern Medicine Association
- Washington State Department of Labor and Industries

Progress to Date-Launch

February 3rd

- Resources
- Education by subject matter experts
- Facilitated breakout sessions to share key ideas and identify actions

Aligning to Drive Value

- Using Data
- Relying on Evidence
- Building on Trust

W-HA WASHINGTON HEALTH ALLIANCE

Low Back Pain Implementation Collaborative Charter
 Advancing the market to improve the value of care for patients with low back pain in Washington State
 December, 2021

How Can the Intractable Problem of Chronic Musculoskeletal Pain (CMP) Be Effectively Managed? The Need for a Well-Integrated Systems Approach
 Daniel C. Cherkin, PhD
 Kaiser Permanente Washington Health Research Institute, Seattle, WA, USA

CLINICAL GUIDELINE **ACP American College of Physicians**

Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians

Anir Dasgupta, MD, PhD, MHA, Timothy J. Wiliam, MD, MPH, Robert M. McLean, MD, and Mary Ann Faries, MD, for the Clinical Guidelines Committee of the American College of Physicians*

Description: The American College of Physicians (ACP) developed this guideline to present the evidence and provide clinical recommendations on noninvasive treatment of low back pain.

Methods: Using the ACP grading system, the committee based these recommendations on a systematic review of randomized, controlled trials and systematic reviews published through April 2015 on noninvasive pharmacologic and nonpharmacologic treatments for low back pain. Updated searches were performed through November 2016. Clinical outcomes evaluated included reduction or elimination of low back pain, improvement in back-specific and overall function, improvement in health-related quality of life, reduction in work disability and return to work, global improvement, number of back pain episodes or time between episodes, patient satisfaction, and adverse effects.

Target Audience and Patient Population: The target audience for this guideline includes all clinicians, and the target patient population includes adults with acute, subacute, or chronic low back pain.

Recommendation 1: Given that most patients with acute or subacute low back pain improve over time regardless of treatment, clinicians and patients should select nonpharmacologic treatment with superficial heat (moderate-quality evidence), massage, acupuncture, or spinal manipulation (low-quality evidence). If pharmacologic treatment is desired, clinicians and patients should select nonsteroidal anti-inflammatory drugs or skeletal muscle relaxants (moderate-quality evidence). (Grade: strong recommendation)

Recommendation 2: For patients with chronic low back pain, clinicians and patients should initially select nonpharmacologic treatment with exercise, multidisciplinary rehabilitation, acupuncture, mindfulness-based stress reduction (moderate-quality evidence), tai chi, yoga, motor control exercise, progressive relaxation, electromyography biofeedback, low-level laser therapy, operant therapy, cognitive behavioral therapy, or spinal manipulation (low-quality evidence). (Grade: strong recommendation)

Recommendation 3: In patients with chronic low back pain who have had an inadequate response to nonpharmacologic therapy, clinicians and patients should consider pharmacologic treatment with nonsteroidal anti-inflammatory drugs as first-line therapy or tramadol or duloxetine as second-line therapy. Clinicians should only consider opioids as an option in patients who have failed the aforementioned treatments and only if the potential benefits outweigh the risks for individual patients and after a discussion of known risks and realistic benefits with patients. (Grade: weak recommendation, moderate-quality evidence)

Low back pain is one of the most common reasons for physician visits in the United States. Most Americans have experienced low back pain, and approximately one-quarter of U.S. adults reported having low back pain lasting at least 1 day in the past 3 months (1).

Low back pain is associated with high costs, including those related to health care and indirect costs from missed work or reduced productivity (2). The total costs attributable to low back pain in the United States were estimated at \$100 billion in 2006, two-thirds of which (3).

Paying for More Generous Coverage of High Value Care: Reduce Spending on Low Value Care

- Increase premiums – politically not feasible
- Raise deductibles and copayments – ‘tax on the sick’
- Reduce spending on low value care

\$345 BILLION

Examples include:

- Vitamin D screening tests
- Diagnostic tests before low-risk surgery
- PSA screening for men 70 and older
- Branded drugs when identical generics are available
- Low-back pain imaging within 6 weeks of onset

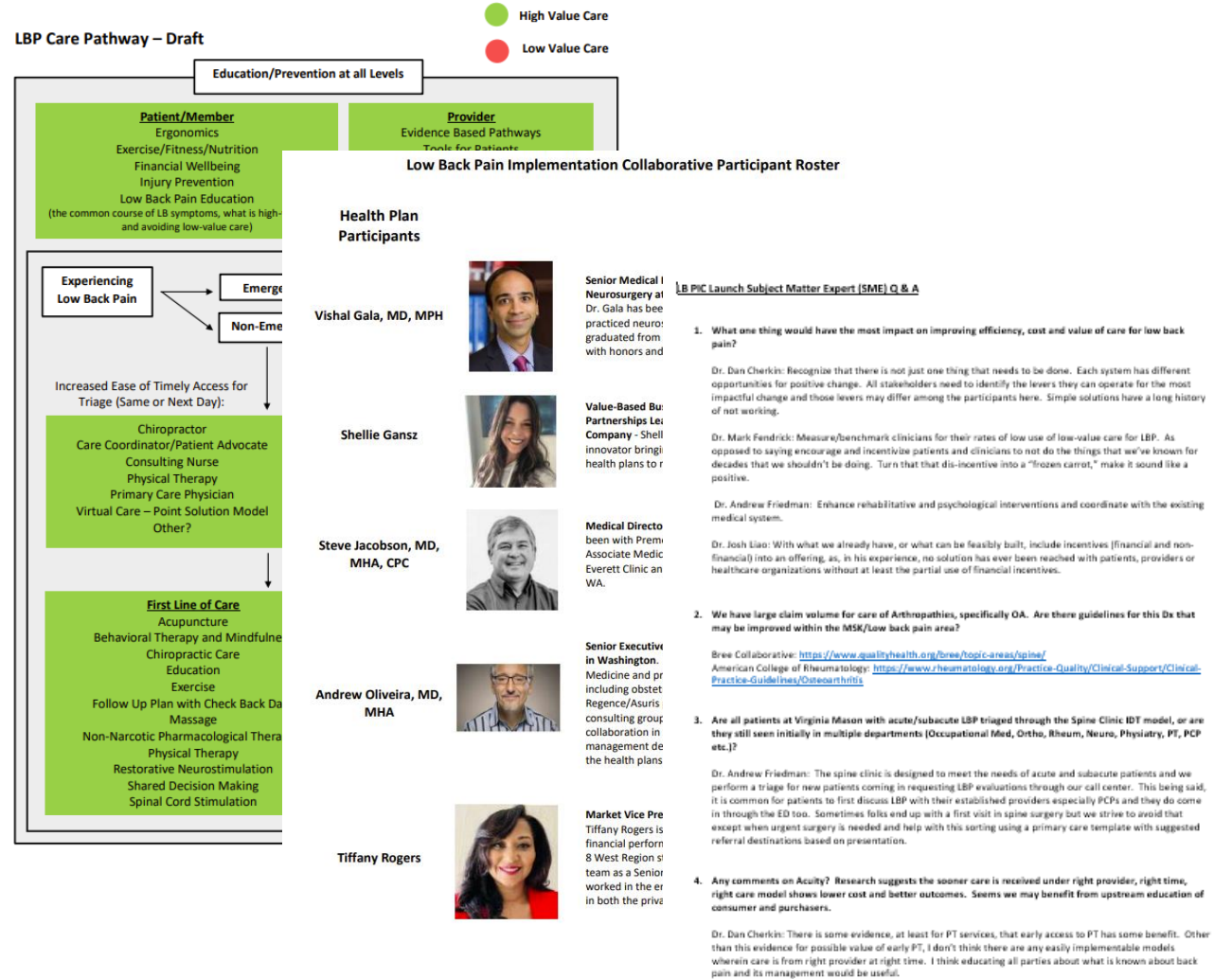
OPTIONS FOR LOW BACK PAIN

contact e.g. primary care or
 element best – practice care
 avoid unnecessary care
 ced imaging should be based
 ations
 lid have access to
 multidisciplinary teams for patients needing higher
 level care e.g. red flags, yellow flags, failure to progress

Progress to Date-Stakeholder Meetings

March 8, 9, and 10

- Care Pathway
- Participant roster
- Follow up Q & As from launch



Progress to Date- Multi-Stakeholder Meetings

April 16

- Bright spots since launch
- Gain consensus on Care Pathway
- Collaborative breakout sessions

Bright Spots



Kristin Villas



Drew Oliveira, MD
Claire Verity

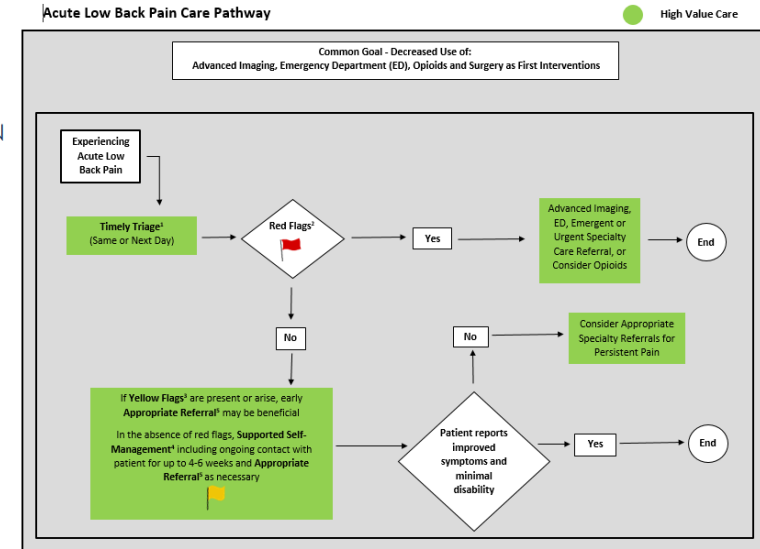


Long Nguyen, DO
Lindsey Whitney, RN

LB PIC All-Stakeholder Meeting 4/26/2022 – Break Out Session Questions

Now that we have agreed to the care pathway for people with acute low back pain in Washington, let's explore the ways we can work together collaboratively through a multi-stakeholder team to drive significant market change.

1. We all agree that the start of a person's journey matters and sets the course for strong evidence-based care. What actions can we take to ensure that patients get timely triage and appropriate access to high-value care options (as depicted in the care pathway)?
 - Coverage (Discuss the LBP Episode of Care payment model that exists and are purchasers adding it to their plan?)
 - Enhanced access/same day appointments; virtual care/triage; email option for patient/provider communication, etc.
 - Incentives (financial and non-financial, outside-of-the box)
2. The recent survey responses show collective interest in educating members/employees, patients and providers. Opportunities to provide supportive tools to all stakeholders also exist. What are the best modes of communication for this to be most effective? Would you agree to a coordinated effort across stakeholders?
3. What changes will you make and how will you measure advancing the agreed upon care pathway within your organization?
4. What do you anticipate being your greatest barrier to your stakeholder group? And what barriers will other stakeholder groups experience? What is the Collective's greatest barrier to success of this initiative?



Questions?

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Leading health system improvement

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