Michigan Back Collaborative (MIBAC)

Blue Cross Blue Shield of Michigan

Henry Ford Health System

Overview

- Burden of Back Pain
- What Problems Does MIBAC Address?
- Potential Impact and Savings
- Role of PCPs and Chiropractors
- Three Levels of Participation
- Training through Spine Care Partners
- Program Structure
- Questions/Discussion

Burden of Back Pain

- Prevalence
  - 84% of adults will experience at least one episode of LBP serious enough to require medical attention at some point in their lifetimes
  - 15-20% experience a LBP episode in any one year.
  - In any given year, LBP is the second most-common reason for visits to primary care physicians and is the top reason for visits to chiropractors

United States Bone and Joint Decade: *The Burden of Musculoskeletal Diseases in the United States*. Rosemont, IL: American Academy of Orthopaedic Surgeons;4th edition 2019.

Burden of Back Pain

- Rising costs
  - The annual direct medical care costs of LBP nationally have been estimated at up to $134 billion
  - Costs rising faster than inflation
  - Estimates of the indirect costs of spine related disorders (lost productivity, disability, etc.) are estimated at 3-5X the direct costs
- Disability days – costs to employers
  - LBP ranks as the number one cause of disability – either by self-report, days missed from work, or actual disability claims

United States Bone and Joint Decade: *The Burden of Musculoskeletal Diseases in the United States*. Rosemont, IL: American Academy of Orthopaedic Surgeons;4th edition 2019.

Burden of Back Pain

- Variation in care
  - rates of spine surgery across the U.S. vary by geography, socioeconomic status, where the surgeon was trained, by specialty (ortho vs neuro), rural or urban practice
- Guideline-discordant care
  - more than 10 evidence-based, international guidelines on back pain calling for reduced opioids, reduced imaging, reduced specialist visits, increased NSAIDs
  - Mafi (2013) showed that among primary care and spine specialists the opposite behavior was occurring: more opioids, more imaging, more specialist visits, fewer NSAIDs

www.DartmouthAtlas.org 2018

Mafi J, JAMA Int Med 2013

Burden of Back Pain

- Opioid crisis
  - Escalating use of opioids for back pain: 50% of opioid prescriptions are for back pain
  - For chronic back pain, OA of knee or hip, opioids less effective than OTC medications

Krebbs EE, JAMA 2018

Treating Low Back Pain

- Role of primary care physicians and chiropractors
  - Primary care physicians see 50% of back pain as ‘first touch’
  - According to survey of primary care physicians, the majority do not like managing back pain nor do they feel they have been adequately trained in musculoskeletal medicine
  - Doctors of Chiropractic see 35% of back pain as ‘first touch’ yet are often ignored in developing solutions

Bernstein J, J Bone Joint Surg Am 2007

Matheny JM, et al. Confidence of graduating family practice residents in their management of musculoskeletal conditions. Am J Orthop 2000;29(12):945-52.

Matzkin E, et al. Adequacy of education in musculoskeletal medicine. J Bone & Joint Surgery 2005;87-A(2):310-4.

Freedman &Bernstein. Educational deficiencies in musculoskeletal medicine. J Bone Joint Surg 2002;84(4):604-8

What Problems Does MIBAC Address?

- Patient dissatisfaction
- Clinician dissatisfaction
- #1 'Ask' of employers: better spine care

What Problems Does MIBAC Address?

- Rising costs
  - Inappropriate imaging
  - Inappropriate referrals
  - Inappropriate procedures
  - Inappropriate medications
  - Guideline-discordant care

- Rising disability
  - Too many acute episodes become chronic
  - Time lost from work

What Problems Does MIBAC Address?

- Clinicians' need for an expanded "toolbox"
  - Examples of appropriate communication
  - Tools for biopsychosocial evaluation (e.g., fear avoidance beliefs)
  - Templates for biopsychosocial interventions

- "Silo-based" practice with little interaction between physicians and chiropractors

What Help Does MIBAC Offer?

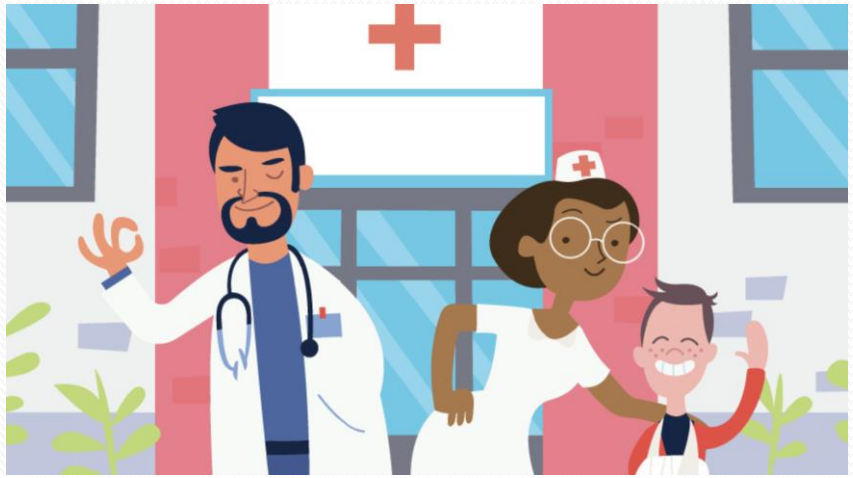
- Training of PCPs (50% first contact) and DCs (35-40% first contact)
  - 2-hour on-line or in-person training for PCPs
  - 12-hour on-line or in-person training for DCs or interested PCPs
  - Leveraging of technology to provide peer-to-peer interaction among providers
  - On-line “provider toolbox" delivering evidence-derived materials for immediate practice use
- Collaborative Quality Improvement
  - Analysis and feedback of data from a prospective registry
  - In-person meetings to review data, share “best practices”, and identify opportunities for organized QI initiatives
  - Support for QI activities from a centralized Coordinating Center

What MIBAC is NOT

- A “top-down”, mandated approach to care of low back pain
- A mechanism for collecting data on providers and making it available to BCBSM
- An attempt to stifle creativity and innovation
- An effort focused mainly on cost reduction – this is about better patient outcomes

Potential Benefit to Clinician Participants

- Access to evidence-based training at no cost
- CME opportunity at no cost
- Expanding participation and opportunities for success in the Physician Group Incentive Program (PGIP)
- Professional growth through active collaboration with peers
- Become part of the large and growing set of statewide improvement collaboratives supported by BCBSM
- Increases in incentives tied to improving quality of care and utilization metrics (VBR)
- Better patient outcomes and more satisfied patients



Role of PGIP Physician Organizations

- Identify PCPs and Chiropractors within the PO as potential participants
- Encourage participation in Level 1 training and support activities for all potential participants
- Work with Coordinating Center staff to identify potential participants for Levels 2 and 3 activities that involve prospective data collection
- Identify one or more clinical "champions" for MIBAC who will:
  - Oversee participation within the PO
  - Participate in ongoing governance and substantive QI activities of the collaborative (e.g., Executive Committee)
  - Attend collaborative-wide meetings and conference calls
- Work with BCBSM and CC staff to create and manage financial incentive opportunities linked to MIBAC participation and success

Role of Practices within POs

- Have members register for, and then complete, two-hour or twelve-hour training
  - PCPs as well as NPs or PAs who work with PCPs (two-hour)
  - Chiropractors (twelve-hour)
- Encourage members to use “toolkit” resources available after initial training
- Work with MIBAC Coordinating Center to discuss opportunities for involvement in Levels 2 and 3 of MIBAC
  - Promotion of patient-reported outcome data collection in Level 2
  - Prospective data collection for registry and active participation in collaborative quality improvement in Level 3

Three Levels of Participation

- All are voluntary
- No obligation to participate in second or third levels following participation in first level
- Second and third levels involve greater investment of time and effort by participants – reimbursement from BCBSM for participation costs
- Primary care practices and individual clinicians (PCPs or chiropractors) start with Level 1 – may be able to participate in levels 2 or 3 depending on practice structure

Level 1 Participation - Provider Training

- On-line training of providers in pathway-based, evidence-derived spine care (could be live and in-person after COVID)
- Providers shown known solutions in spine care management
- Biopsychosocial model of spine care management
- Techniques to foster inter-professional and doctor/patient partnership using common language and toolbox
- Efficient and effective exam and history procedures
- Tools and approaches for enhanced patient engagement

Unique Feature – Protocols Already in Place

- In most CQIs, QI opportunities and potential practice changes are identified by the group, through analysis of registry data. This may take several years.
- For MIBAC, there is an existing "change program" and set of treatment protocols already in place.
  - Excellus and Spine Care Partners
- Program then involves both training in existing back pain treatment protocols AND longer-term collaborative QI activities

Excellus/SCP Spine Health Program : 2 Hour PCP Pathway Training Survey Results

Overall, **98%** thought the workshop was beneficial and would recommend to a colleague

90% agreed the presentation will positively impact their ability to treat patients

0% found the presentation was commercially biased

27 out of the 45 respondents interested in a 24-hour CME course on the evidence of optimal first encounter. An additional **8** might be interested.

Attendees comments:

- I have to word things different to patients
- Discussion of language with patient around MRI
- Less imaging, utilize more of non-pharmacological treatments
- Use of mindfulness, communication strategies for patients
- Excellent patient handouts
- **Every primary care provider should be mandated to attend this presentation**

Excellus/SCP Spine Health Program

"Conservative spine care pathway implementation is associated with reduced health care expenditures in a controlled, before-after observational study."

Weeks, Donath, Pike, Fiacco, Justice, *Journal of General Internal Medicine Aug 2019*

- A 90 minute PCP training program achieved a 28 percent reduction in costs for the treatment of back pain in 12 months. The control group actually saw an 8 percent increase in costs**.**

- Very significant (p-value <0.0001) reductions against the trend in PMPM were seen in total **spine care, surgery and opioid treatment**.

Level 1 Collaboration - MPN

- Starts with completion of training materials
- Completion of training leads to membership in MIBAC Provider Network (MPN)
- Interactive functions linked to same web platform that provides training and toolbox resources
  - Message boards
  - Chat rooms
  - Planned meetings
- Does not require participation in the active prospective data collection associated with Levels 2 and 3

Levels 2 and 3 – Prospective Data Collection

- Long and successful history of Collaborative Quality Improvement (CQI) program in Michigan - BCBSM
- Other CQIs are practice-based or Physician Organization -based (MUSIC, MOQC, etc.)
- PCPs and Chiropractors – Chiropractors may have formal or informal connection to PO
- Participation incentives through PGIP

Level 2 – Patient-Reported Outcomes

- Collect basic data on pain, functional status, and employment status
  - Baseline and regular intervals after first visit
- Use of standardized survey instruments (e.g., PROMIS)
- Use of smart phone app as primary data collection tool
- Uses of PRO data
  - Feed MIBAC registry for data analysis and quality improvement
  - Feedback to clinicians on patient outcomes
  - Feedback to patients themselves on change over time

Level 3 – Clinical Data for Registry

- Clinic-based abstraction of basic elements of patient characteristics and treatments
- Essential for QI
  - Identify variation in key outcomes and process variables
  - Identify potential “best practices” in both clinical and administrative areas of spine-care
  - Track progress on key metrics
- Modeled after MSSIC (spine surgery collaborative) and American Spine Registry
  - Baseline, treatment details, and follow-up at least at 90 days and 1 year
  - Patient-reported outcomes are central
- Links to MSSIC or Michigan Value Collaborative to allow analysis of cost and possible transition from back pain to surgery

Level 3 Collaborative QI Activities

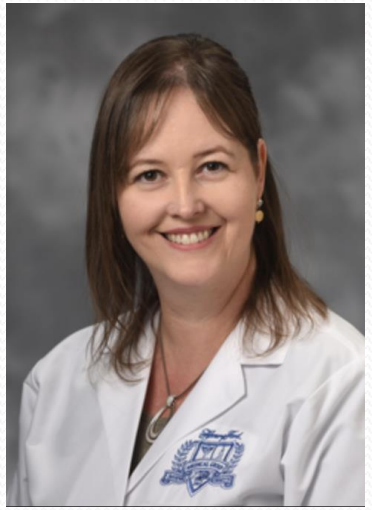
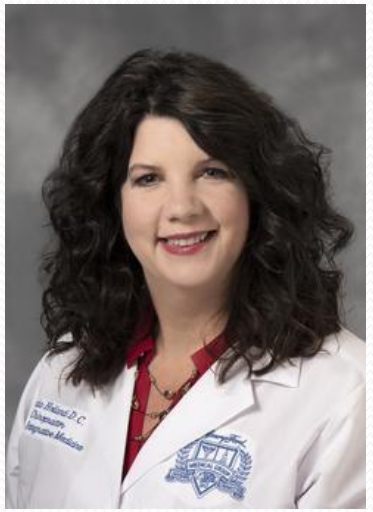
- The traditional essence of the BCBSM CQI program
- Regular analysis of registry data to show variation in practice and key quality metrics
- In-person meetings of participating practices to review data, share experiences, present “best practices”, and hear from external experts
  - May have to be virtual for some or all of 2021
- Interval conference calls
- Possible site visits to top-performing sites

Coordinating Center

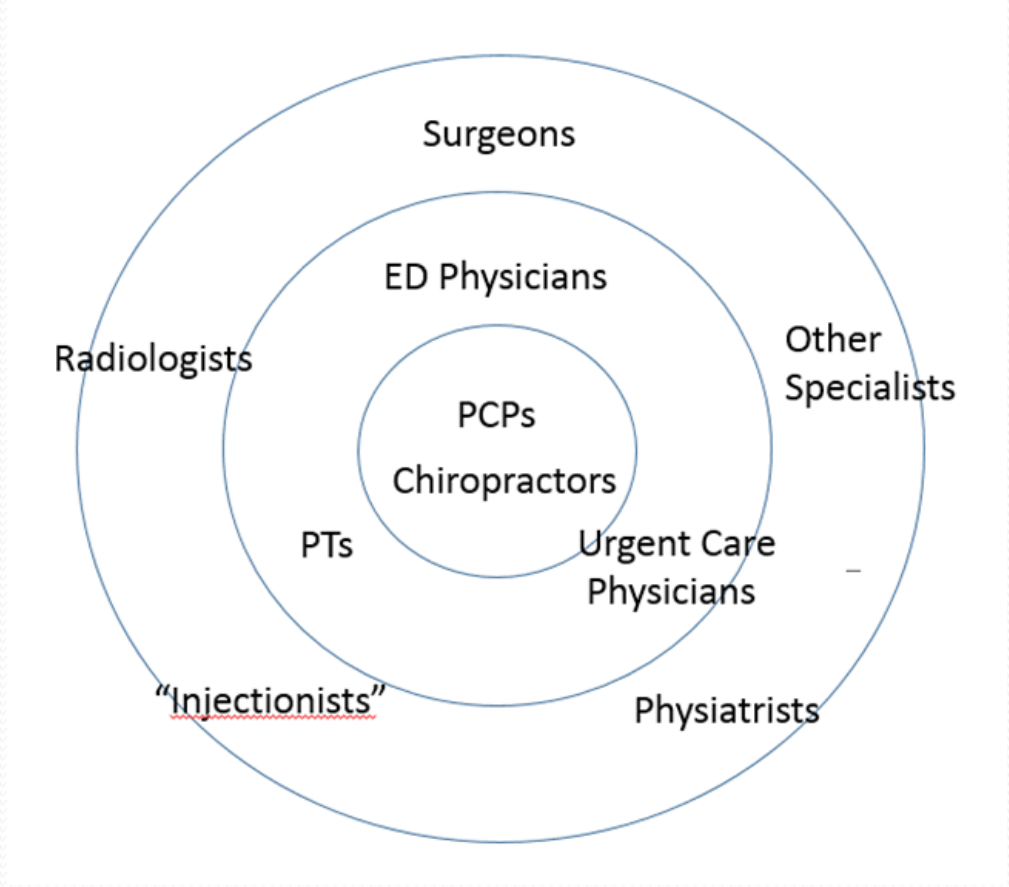
- Home organization for program leadership
- Home organization for registry, although the software may be based elsewhere (e.g., REDCap at Vanderbilt)
- Home organization for key support staff – QI lead, statistician(s), auditor(s), etc.
- Holds primary responsibility for program success
- Works with BCBSM to define goals, deliverables, and budget
- Serves as “glue” to hold project together – schedules meetings and conference calls, works with individual sites on QI initiatives, organizes collaborative-wide QI initiatives

MIBAC Leadership Structure

- Program Director – Carrie Stewart, MD (Physiatry/Neurosurgery)
- Associate Director – Linda Holland, DC (Center for Integrative Medicine)
- Associate Director – Marjan Moghaddam, DO (Family Practice)
- Spine Care Partners Subcontractor Lead - Thomas Neuner, DC, JD
- National Blues Liaison – Brian Justice, DC
- Program Manager - To be determined


Broader Impact/Program Evolution



Why become involved?

- Better patient outcomes and more satisfied patients
- Continuing education opportunities funded by BCBSM
- “Seat at the table” in a statewide initiative on care of patients with low back pain
- Enhanced standing within the patient and provider community for your practice – commitment to evidence-based care and quality improvement
- Join a rich 25-year history of collaborative quality improvement in Michigan
- Platform for innovation and care process improvement
- <u>Better patient outcomes and more satisfied patients</u>

Questions/Discussion