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Dr. Robert Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 *"…to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State."* The Bree Collaborative was modeled after the Washington State Advanced Imaging Management (AIM) project and named in memory of Dr. Robert Bree, a pioneer in the imaging field and a key member of the AIM project.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying up to three health care services annually that have substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice, evidence-based approaches that build upon existing efforts and quality improvement activities to decrease variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State's largest health care purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

Treatment of pain is widely variable with high financial and human cost. Moving to a collaborative or team-based approach to managing complex pain has been shown to result in better patient outcomes. The Bree Collaborative elected to address this topic and a workgroup convened to develop recommendations from January 2018 to X.

See **Appendix B** for the Collaborative Care for Chronic Pain workgroup charter and a list of members.

See **Appendix C** for results of the Guideline and Systematic Review Search Results.

Background

Chronic pain, pain lasting three months or longer, is experienced by an approximate 11.2% of Americans, although some surveys have estimated this to be closer to 30%.[1,2] Chronic pain is more prevalent for women than men, tends to increase with age, is mainly attributed to low back followed by osteoarthritis pain, and is reported as severe for about a third of respondents.[2] In some populations the prevalence of chronic pain may be higher, such as in up to 50% of those who are veterans.[3] Chronic pain is complex and unique to individual patients, often occurring along with comorbidities including obesity, depression, anxiety, and post-traumatic stress disorder.[4,5,6]

Treatment of chronic pain is also widely variable with high financial and human cost. The Washington State Agency Medical Directors Group Guideline on Prescribing Opioids for Pain and the Centers for Disease Control and Prevention recommend against opioids for chronic pain as a first-line or routine therapy.[7,8] Moving to a collaborative or team-based approach to managing complex pain, based in models of care designed to manage chronic illness and depression, has been shown to result in improved patient outcomes.[9,10] Additionally, due to the complexity of pain, multidisciplinary care, or using more than one approach, has been recommended.[11] However, most approaches to pain management including chronic opioid therapy involved siloed health care providers. There is also a lack of consensus around which elements of a systems-based model are critical and which resources are necessary to support the model.

This workgroup aims to develop collaborative care standards and recommendations for prevention and treatment of chronic pain, including a stepped care approach to acute and chronic pain.

Collaborative Care Models

The collaborative care model was developed in reaction to a siloed model of care centered around clinical or provider need rather than patient need. Current iterations of collaborative care as a system draw heavily from quality improvement strategies those for chronic illness, especially diabetes, and for depression.[12] Many are conceptually based on the Chronic Care Model developed by Wagner and colleagues in 2001; an integrated system of interventions focused on patients with chronic illness (e.g., diabetes, asthma) moving along a continuum from minimal integration to fully integrated care.[13,14] This framework includes delivery system redesign linked to domains including:

- The community,
- The health system,
- Self-management support,
- Delivery system design,
- Decision support, and
- Clinical information systems.

More information here. Specifics of this model and others are outlined in **Appendix D**.

The Veterans Administration Evidence-Based Synthesis Program conducted an evidence brief on effectiveness of models used to deliver multimodal care for treating chronic musculoskeletal pain in primary care.[15] Interventions differed due based on intensity, length, frequency of interactions, and other factors but shared the four system intervention components:

- Decision support: Enhance provider education and treatment planning (e.g., provider to provider interaction, stepped care algorithms)
- Additional care coordination resources (e.g., health information technology support, case manager)
- Improving patient education and activation
- Increasing access to multi-modal care

The University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center uses five principles to define Collaborative Care:[16]

- Patient-centered team care: Collaboration between primary and behavioral health care providers using a shared care plan
- Population-based care: Defined patient group tracked in a registry with consultation from specialists
- Measurement-based treatment to target: Treatment plans based on patient goals and evidence-based tools (e.g., PHQ-9)
- Evidence-based care: Use of therapeutic techniques shown to work in primary care (e.g., problem-solving treatment, cognitive behavioral therapy) and medication management
- Accountable care: Reimbursement for quality and outcomes

Read more about these principles here

The Bree Collaborative convened a workgroup to develop standards around integrating behavioral health into primary care for those with behavioral health concerns and diagnoses for whom accessing services through primary care would be appropriate.[17] The workgroup developed eight common elements that outline a minimum standard of integrated care that are meant to bridge the different models used throughout Washington State and across the country and include:

- Integrated Care Team
- Patient Access to Behavioral Health as a Routine Part of Care
- Accessibility and Sharing of Patient Information
- Practice Access to Psychiatric Services
- Operational Systems and Workflows to Support Population-Based Care
- Evidence-Based Treatments
- Patient Involvement in Care
- Data for Quality Improvement

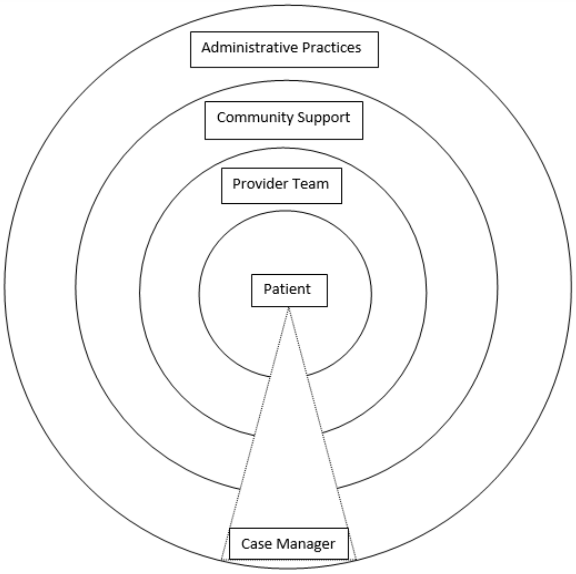
Read the Report and Recommendations here.

The Learning from Effective Ambulatory Practice project was a multi-state effort to implement clinic re-design focused on clinical care teams for patients with chronic non-cancer pain who were being prescribed opioids.[18] Six building blocks for successful implementation were developed from this pilot including:[19]

- Leadership and building consensus
- Revise policies and standard work
- Tracking patients on chronic opioid therapy (i.e., registry)
- Prepared, patient-centered visits
- Caring for complex patients
- Measuring success.

Recommendations

The workgroup's goal is a collaborative model of care for chronic pain centered on the patient and built on patient self-management in the context of a biopsychosocial model. Goals are improved function, increased quality of life, and greater patient autonomy rather than pain relief.[1] The workgroup strove to define areas within collaborative care unique to chronic pain while also developing a system to recognize and limit the transition from acute and subacute pain to chronic pain. Ideally, both acute and chronic pain will be managed and treated over time using a systems approach to allow patients to stay within primary care supported by the elements of collaborative care as summarized below.



As seen in image 1, the patient is at the heart of care with case management intersecting with the patient, provider team, community support, and administrative practices to support the patient.

The workgroup's goal is that these elements below can be used within and complementary to other models of care including the 2016 Bree Collaborative Behavioral Health Integration Recommendations and adapted by a wide variety of systems, clinics, and locations. We define care coordination using the Agency for Healthcare Research and Quality's definition: "*Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services [to meet the patient's needs and preferences in the delivery of high quality, high value care]. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.*"[20]

Patient Identification and Population Management	Patient meets one or more of the following criteria and is tracked in a registry: - Screening Questionnaires with positive biophyscosocial variables, or pain beliefs: Tampa Scale of Kinesiophobia (TSK), Pain Catastrophizing Scale (PCS), Pain Coping Inventory (PCI), Pain Attitudes (SOPA), Pain Self Efficacy Questionnaire (PSEQ).

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[1] Adapted from MultiCare's vision mantra.

	• Screening Questionnaires related to mood states associated with chronic pain: • Screening Questionnaires for Neuropathic Pain: Douleur Neuropathique en 4 Questions (DN4), Leeds Assessment of Symptoms and Signs (LANSS), Neuropathic Pain Questionnaire (NPQ), painDETECT, ID Pain, Neuropathic Pain Scale • Medical diagnosis consistent with chronic pain (ie., ????) • Pain medication dependency / self medication • Failed usual care – (ie, timeline in physical medicine rehabilitation)
Care Team	• Defined roles for care team members • Access to specialty pain consultation
Evidence-Based Care	• Preventing the transition from acute to chronic pain through screening with a brief, validated instrument for psychosocial barriers to recovery (e.g., STarT Back Tool for low back pain, reporting adverse childhood experiences) • Trauma-informed care • NSAIDs as first line treatment rather than opioids.
Care Management	• Coordination of the collaborative care process • Facilitation of referrals, if needed • Management of medication • Proactive outreach
Education: Pain Neuroscience Education	***SHOULD THIS BE PART OF SELF-MANAGEMENT*** • Evidence based approach to pain education: delivered one-on-one, written (including email), online video, telehealth, group lecture. • Understanding of cycle of pain
Supported Self-Management	• Addressing anxiety and anger • Removing barriers to physical activity • Shift from reactive to creative • Take back your life

Table 1: Collaborative Care Definitions

	Element	Patient Perspective	Operational Details for Integrating Behavioral Health Care into Primary Care
	Patient Identification		
	Integrated Care Team	*I can see how my care team takes my chronic pain concerns into consideration when making treatment decisions. The team will be able to answer my questions and help me get treatment if I choose to.*	**Usual Care:** Chronic pain support is managed by the primary care provider, who may not feel adequately supported or adequately trained to address the patient's needs. **Steps Toward Integration**: Behavioral health professionals are onsite or available remotely but do not participate in clinic-level workflows and are not part of the usual patient care. Behavioral health may closely coordinate and follow up with the primary care provider on all patients that are referred to them for treatment. **Integrated Care:**
	Care Management	*I know who is organizing my care and who to contact if I have questions. I feel that my needs are being addressed and that someone is listening to me.*	
	Supported Self-Management	*I understand my role in the treatment for chronic pain and feel empowered by my care team and care plan. I understand pain management and feel that I have the skills to work toward my own*	

		quality of life, engage in physical activity, and set my goals.	
	Evidence-Based Interventions	*I understand the reasons for the treatments I receive.*	

Recommendations for Stakeholder Actions and Quality Improvement Strategies

Persons Who Have Chronic Pain

- Talk to your primary care provider and other care team members about any concerns that you have regarding your pain or other issues including feeling low or depressed, feeling anxious, concerns about drinking or drug use.
- Ask to see your care plan if you would like.
- Talk to your providers about your concerns with accessing the type of care that you need.
- Track progress on treatment for chronic pain in the same way that you would track something like blood pressure.
- Ask your care team about the reasons or evidence for the types of treatments that you receive.
- Give your feedback about your experience at the practice.

Primary Care Providers

- Shift focus of discussion from pain to function and talk about previous experience with physical therapy or any fears of movement.

Primary Care Practices and Systems

- Clearly define roles for integrated care team members, including primary care and behavioral health clinicians and staff.
- Structure typical practice activities to facilitate involvement by all members of the integrated care team (e.g., team meetings, daily huddles, pre-visit planning, quality improvement meetings).
- Motivational interviewing training.
- Facilitate patient access to behavioral health and primary care services on the same day as much as feasible.
- At a minimum, ensure that for each patient with an identified behavioral health need, a plan is developed on the same day that includes continuous patient engagement in ways that are convenient for patients, in person or by phone or videoconferencing.
- Ensure that the integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care.
- Ensure that clinicians work together via regularly scheduled consultation and coordination to jointly address the patient's shared care plan.
- Facilitate access to psychiatric consultation services in a systematic manner to assist the care team in developing a treatment plan and adjusting treatments for patients who are not improving as expected under their current plan.
- Coordinate specialty behavioral health services for patients with more severe or complex symptoms and diagnoses.
- Proactively identify and stratify patients for targeted conditions.
- Use systematic clinical protocols based on screening results and other patient data, like ER use, that help to characterize patient risk and complexity of needs.
- Track patients with target conditions to make sure patient is engaged and treated-to-target/remission and have a proactive follow-up plan to assess improvement and adapt treatment accordingly.

- Use age-appropriate measurement-based interventions for physical and behavioral health interventions that are adapted to the specific needs of the practice setting.
- Use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether patients are improving.
- Include appropriate self-management support in care.
- Use patient goals to inform the care plan.
- Communicate effectively with the patient about treatment options and include patient goals, perspectives, and informed treatment decisions into treatment plans.
- Track system-level data regarding access to behavioral care, the patients' experience, and patient outcomes. If system goals are not met, use quality improvement efforts to achieve patient access goals and outcome standards.

Health Plans

Partially adapted from SAMHSA's *ACAP Fact Sheet Safety Net Health Plan Efforts to Integrate Physical and Behavioral Health at Community Health Centers*[21]

- Reimburse for Medicare primary care providers participating in a collaborative care program or receiving other integrated behavioral health services as outlined in CMS Federal Register Final Rule for Docket Number CMS-1654-F (e.g., G0502, G0503, G0504).
- Work with health care purchasers to identify and provide data on outcome measurements relevant to their population to better ensure treatment efficacy and patient access (e.g., NCQA behavioral health treatment within 14 days, NCAQ anti-depressant medication management).
- Develop and maintain strong, respectful relationships with practices including sharing information, decision making, costs, and savings as appropriate.
- Work with the Accountable Communities of Health to measure quality and outcomes including traditional clinical measures but also data beyond care delivery and claims: arrests/recidivism, housing status, employment, if possible.

Employers

- When designing benefits, work to eliminate inadvertent barriers to behavioral health care services and integrating care for employees including equalizing benefit structures for behavioral health and physical health care.
- If an employee assistance program is offered, promote employee understanding of behavioral health benefits.
- Include behavioral health-related components in employee wellness programs (e.g., stress and anxiety reduction, interventions around alcohol consumption).

Washington State Health Care Authority

- Certify patient decision aids around treatment options for common behavioral health conditions (e.g., depression, anxiety, alcohol use, substance abuse).

Details on Elements

Care Management

The workgroup defines the role of care management as flexible to belong to one care manager or to be shared across multiple staff members. In some paradigms this is referred to as case management as in the Veterans Administration Evidence-Based Synthesis Program.

A job description of a behavioral health care manager from the University of Washington AIMS Center is available here. The role is descripted as a *"behavioral health professional, typically a counselor, clinical social worker, psychologist or psychiatric nurse, who performs all of the care management tasks including offering psychotherapy when that is part of the treatment plan."*[22]

Supported Self-Management

(Draft #3 3-13-2018, Michael Von Korff Kaiser Permanente Washington Health Research Institute)

A road map for chronic pain self-management

[Adapted from David Hanscomb's Back in Control, Vertus Press, Seattle WA (2012)

Address anxiety. Pain increases anxiety. Through the use of mind–body principles it is possible to diminish pain-related anxiety, to reduce pain, and to foster more effective approaches to managing chronic pain.

Deal with anger. Chronic pain is frustrating and can engender anger about having chronic pain and about people or health care professionals who do not seem to understand the difficulties in living with chronic pain.

Shift from reactive to creative. Living with chronic pain can put patients in "survival mode" trying to get by day-to-day through conserving energy and minimizing pain. A key task is becoming engaged in living again, developing ways of reengaging in life activities, and shifting focus from pain to activities that are engaging, meaningful, and enjoyable.

Take back your life. Chronic pain can result in isolation, wherein friendships and family relationships become strained or atrophy because the person does not feel able to engage in activities or because limits on what he or she is able to do may conflict with what friends and family members want to do. A key task is restoring or building new nurturing relationships with friends and family.

Live a rich, full life. A person with chronic pain who has become inactive and passive needs to find ways of regaining hope for the future and reconnecting with activities that give life meaning and purpose.

The patient's role is to manage these challenges in managing chronic pain to reduce suffering and enhance quality of life. The role of health care providers is to offer patients effective tools, skills, knowledge and support in their journey to achieve these goals. The following toolkit offers evidence-based tools for reducing pain and enhancing quality of life for persons with chronic pain.

TASK	TOOL	WHAT YOU NEED TO KNOW
Understand pain management	Understanding that pain is influenced by your thoughts emotions and activities.	Your brain and spinal cord actively produce the experience of pain through interactions among thoughts, emotions and activities that increase or reduce pain signals from your body.
Use your mind and emotions to manage pain and to restore your quality of life	Mindfulness meditation	Mind-body techniques can modify brain networks to reduce bodily pain by reducing fear, anger and depression that often accompany chronic pain. Mind-body techniques can also help you engage in rewarding life activities to improve your quality of life.
	Deep breathing, progressive muscle relaxation mini-practices	
	Identify and manage thoughts that increase pain	
	Identify and manage emotions that increase pain	
	Engage in enjoyable life activities	
	Attention and diversion	
Engage in physical activities that reduce pain and increase your quality of life.	Heat/cold, counter-stimulation (e.g. pinching other body parts)	These physical activities compete with bodily pain and activate brain chemicals that reduce pain. They can also help you resume life activities that contribute to your quality of life.
	Aerobic, stretching, strengthening activities	
	Yoga	
	Massage	
Use of emotions, thoughts and physical activities in combination to manage pain and enhance your quality of life.	Pleasant events scheduling	These approaches combine psychological and physical techniques for controlling pain, managing negative thoughts and emotions that accompany chronic pain, resuming life activities, and enhancing quality of life.
	Increasing activity levels gradually, step by step	
	Cognitive-behavioral therapy	
	Acceptance & commitment therapy	
Safe and effective use of analgesics	Over the counter (non-prescription) analgesics	Analgesics can be helpful when used to reduce pain to tolerable levels so that you can be more active and employ mental, emotional and physical activities to reduce pain and enhance quality of life.
	Medically prescribed analgesics	
	Topical analgesics, balms, etc.	
Recovery	Peer support	These approaches can help persons with chronic pain re-engage in rewarding life activities and resume their roles in work, community and family life.
	Goal setting and creative problem-solving	
	Activity-rest cycling, pacing	
	Workplace, environmental accommodations	
	Mobility and physical aids	

Health care team	Case manager, coach, PT/OT, Nurse, Physician, Psychologist, Chiropractor, Acupuncturist, Massage therapist, Rehabilitation specialist, etc.	Your health care team often can’t cure chronic pain, but they may be able to support you in carrying out tasks and learning skills for managing chronic pain and restoring quality of life.

Other Work in Washington State

Low Back Pain Recommendations **(November 2013)**

- Increase appropriate evaluation and management of patients with new onset and persistent acute LBP and/or nonspecific LBP not associated with major trauma (no red flags) in primary care
    - Increase adherence to evidence-based guidelines
    - Increase provider awareness of key messages that emphasize physical activity, return to work, patient activation, etc.
    - Reduce use of non-value-added modalities in the diagnosis and treatment of LBP (e.g., inappropriate use of MRIs)
- 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 use of STarT Back Tool, FRQ, or a similar screening instrument to triage acute LBP patients to appropriate care providers
    - Restore patient function more quickly
- Increase awareness of LBP management among individual patients and the general public
    - Increase the proportion of the population that agrees with key LBP messages (e.g., LBP is common, LBP symptoms often improve without treatment, there is no magic bullet, stay active, etc.)

Measurement

Healthy People 2020

AOCBC-12	Reduce activity limitation due to chronic back conditions
AOCBC-13	(Developmental) Decrease the prevalence of adults having high impact chronic pain
AOCBC-14	(Developmental) Increase public awareness/knowledge of high impact chronic pain
AOCBC-15	(Developmental) Increase self-management of high impact chronic pain
AOCBC-16	(Developmental) Decrease the impact of high impact chronic pain on family/significant others

Appendix C: Guideline and Systematic Review Search Results

Source	Guidelines or Systematic Reviews
AHRQ: Research Findings and Reports	(2017) Research Protocol: Noninvasive, Nonpharmacological Treatment for Chronic Pain (2015) Systematic Review: Treatments for Fibromyalgia in Adult Subgroups (2014) Systematic Review: The Effectiveness and Risks of Long-Term Opioid Treatment of Chronic Pain (2012) Noncyclic Chronic Pelvic Pain Therapies for Women: Comparative Effectiveness (2011) Multidisciplinary Pain Programs for Chronic Noncancer Pain
Cochrane Collection	(2015) Consultation liaison in primary care appears to improve mental health practice and outcomes for people with a mental disorder (2013) Collaborative care approaches for people with severe mental illness (2012) Collaborative care for people with depression and anxiety (2009) Psychosocial interventions for the prevention of disability following traumatic physical injury
Specialty Society Guidelines (via Guideline Clearinghouse including Choosing Wisely)	(2017) Department of Defense, Department of Veterans Affairs, Veterans Health Administration VA/DoD clinical practice guideline for the management of posttraumatic stress disorder and acute stress disorder (2016) Department of Defense, Department of Veterans Affairs, Veterans Health Administration VA/DoD clinical practice guideline for the management of major depressive disorder (2016) Institute for Clinical Systems Improvement: Adult depression in primary care (2015) Program in Evidence-based Care The management of depression in patients with cancer. (2014) C17 Council Guideline for primary antifungal prophylaxis for pediatric patients with cancer or hematopoietic stem cell transplant recipients (2012) Expert Commentary Primary Care Depression Guidelines and Treatment Resistant Depression: Variations on an Important but Understudied Theme
Health Technology Assessment Program	(2017) Chronic migraine and chronic tension-type headache Treatment of chronic migraine with OnabotulinumtoxinA is a covered benefit with conditions. Treatment of chronic tension-type headache with OnabotulinumtoxinA is not a covered benefit. Treatment of chronic migraine or chronic tension-type headache with acupuncture, massage, trigger point injections, transcranial magnetic stimulation, or manipulation/manual therapy is not a covered benefit. (2016) Spinal injections Spinal injections are a covered benefit with conditions. (2010) Spinal cord stimulation Spinal Cord Stimulation for chronic neuropathic pain is not a covered benefit. (2009) Electrical neural stimulation (ENS) Electrical Neural Stimulation is a non-covered benefit. This decision applies to use of durable medical equipment ENS device and supplies outside of medically supervised facility settings (e.g. in home use). (2008) Discography Discography for patients with chronic low back pain and lumbar degenerative disc disease is not a covered benefit, with exceptions by diagnosis.
Centers for Disease Control and Prevention	(2016) Centers for Disease Control and Prevention: CDC guideline for prescribing opioids for chronic pain

Institute for Clinical and Economic Review	(2017) Cognitive and Mind-Body Therapies for Chronic Low Back and Neck Pain: Effectiveness and Value Acupuncture, cognitive behavioral therapy, mindfulness-based stress reduction, tai chi, and yoga (2011) Management Options for Low Back Pain Disorders
BMJ Clinical Evidence Systematic Overview	0 systematic reviews for collaborative care
Veterans Administration Evidence-based Synthesis Program	(2017) Evidence Brief: Effectiveness of Models Used to Deliver Multimodal Care for Chronic Musculoskeletal Pain (2015) Mapping the Evidence: Sex Effects in High-impact Conditions for Women Veterans – Depression, Diabetes, and Chronic Pain (2012) Group Visits Focusing on Education for the Management of Chronic Conditions in Adults: A Systematic Review

Appendix D:

MacColl Model		Bree Behavioral Health Integration	Peterson (VA Multi-Model Review)	Unutzer	Parchman
Community - Mobilize community resources to meet patient need					
Health System - Create a culture, organization, and mechanisms that promote safe, high quality care	Health System Requirements:				Leadership
Promote effective improvement strategies aimed at comprehensive system change.	Leadership Support for system changed and continuous monitoring				
Provide incentives based on quality of care	Incentives aligned to support intervention				
Clinical Information System - Organize patient and population data to facilitate efficient and effective care.	Clinical Information System:				
Provide timely reminders for providers and patients	CIS - Appropriate reminders		Decision support		
Identify relevant subpopulations for proactive care. Facilitate individual patient care planning.	CIS - Population idenfication; risk assessment	Operational Stystems and Workflows to support Population based care		Population Registry	Population registry
Share information with patients and providers to coordinate care.	CIS - Support Patient and provider communication; telehealth	Accessibility and Sharing of Patient Information			
Monitor performance of practice team and care system.	CIS - Measure and monitor and feedback	Data for Quality Improvement		Outcome Measures	Measurement
Delivery System Design - Assure the delivery of effective, efficient clinical care and self-management support	Delivery System				
Define roles and distribute tasks among team members	Identify /Define roles for primary care provider; care manager; and expert consultation	Integrated Care Team		Practice Team	
Use planned interactions to support evidence-based care.	Standard workflow with CIS support for stepped, EBM protocols and care	Evidence Based Treatments	Treatment planning		Planned visits
Provide clinical case management services for complex patients	Care Manager		Additional care coordination	Care manager	Complex patient resources
Ensure regular follow-up by the care team	See CIS				
Give care that patients understand and that fits with their cultural background	See Patient Empowerment				
Decision Support - Promote clinical care that is consistent with scientific evidence and patient preferences					
Embed evidence-based guidelines into daily clinical practice.	See Delivery System	Operational systems and workflows to support population based care		Treatment Protocols	Policy and Workflow

Share evidence-based guidelines and information with patients to encourage their participation						Increasing access to multi-modal care				
Use proven provider education methods.						Increasing access to multi-modal care				
Integrate specialist expertise and primary care		See Delivery system		patient access to behavioral health as a routine part of care; Practice access to Psychiatric services		Increasing access to multi-modal care				
Self-Management Support - Empower and prepare patients to manager their health and health care		Patient Empowerment				Improving Patient Education and Activation				
Emphasize the patient's central role in managing their health.										
Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up.		Self-Management Support		Patient involvement in care						

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