- Established by the State Legislature
- Goal to improve quality, health outcomes, and cost-effectiveness of care in Washington State
- Bring together member clinicians, Washington State agencies, hospitals, health care systems, health insurance plans, and quality improvement organizations
- Select health care topics every year and develop evidence-based recommendations by convening workgroups of clinical experts, administrative experts, patients, and others
- Recommendations guide health care purchasing for Washington State agencies and set a community standard of care.

Why Chronic Pain?

Many people experience chronic pain and those who do often experience frustrating, disjointed health care. This can be hard for clinicians too because of barriers in referring to other types of providers and lack of support within an organization to help patients with chronic pain.

Why Collaborative Care?

Research shows us that a collaborative or team-based approach to managing complex is associated with better patient outcomes when compared to traditional, siloed care. This helps address the gaps in care that patients experience. Our workgroup looked at the different ways that chronic pain is treated in our state and developed a collaborative care model to support patients, providers, and our health care system.

Our Report and Recommendations:

- Are built on supporting patient self-management in the context of a biopsychosocial model with a focus on primary care as the medical home for acute and chronic pain treatment and management through a systems-based approach.
- Directed at patients with chronic pain with life activity impacts with the goal of improved function, increased quality of life, and greater autonomy rather than just pain relief.
- Encourage system-wide incremental steps supported by adequate reimbursement.

Minimum Standards

Patient identification and population management	• Identifying patients with persistent pain with life activity impacts • Minimizing the transition from acute to chronic pain with life activity impacts through screening with a brief, validated instrument for psychosocial barriers to recovery • Tracking patients in a registry and using a dashboard • Using patient-reported outcome measures
Care team	• Defined roles for care team members with a patient point of contact • Collaborative treatment between specialty pain and/or behavioral health • Standard workflow with planned interactions supported by systems (e.g., technology) • Identifying, supporting, and enhancing what patients are already doing
A care management function	• Coordination of the care process including facilitation of care team access • Identifying diverse resources and for patients interventions including referral facilitation • Medication management • Proactive outreach
Evidence-informed care	• Using trauma-informed care; medication-assisted treatment, if needed; integrative health practices (e.g., massage, acupuncture, spinal manipulation); and movement and body awareness strategies • Developing and improving pain management skills (e.g. relaxation) • Conventional medical treatment options
Patient-centered supported self-management	• Goals for resuming life activities, addressing barriers • Pain education including understanding of the cycle of pain • Addressing anxiety and anger and shifting thoughts from reactive to creative • Focusing on abilities, preferences, assets and existing efforts and identifying resources