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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: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 project 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

Focus Areas

- Areas within collaborative care that are unique to chronic pain.
- Recognizing and limiting the transition from acute and subacute pain to chronic, disabling pain (e.g., screening and appropriate interventions screened using a brief, validated instrument for psychosocial barriers to recovery).
- Managing and treating chronic pain over time using a systems approach to allow most patients to stay within a primary care model (e.g., effective use of resources, care management, stepped care interventions, patient advocacy and engagement).
- Self-management approaches to chronic pain.

Example: Table 1: Specifications for Collaborative Care

	Element	Specifications	Patient Perspective	Operational Details for Integrating Behavioral Health Care into Primary Care
1	Integrated Care Team	Each member of the integrated care team has clearly defined roles for both physical and behavioral health services. Team members, including clinicians and non-licensed staff, understand their roles and participate in typical practice activities in-person or virtually such as team meetings, daily huddles, pre-visit planning, and quality improvement.	<i>I can see how my care team takes my concerns into consideration when making treatment decisions and can talk to members of my integrated care team about any of my concerns, including feeling low or depressed, or concerns about my drinking. The team will be able to answer my questions and help me get treatment if I choose to.</i>	<p>Usual Care: Behavioral health support is provided by the primary care provider, who may not feel adequately supported or adequately trained in managing all behavioral health conditions in his/her patient panel.</p> <p>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.</p> <p>Integrated Care: Practices are committed to developing and maintaining a culture of integration and teamwork including both engaging providers in integrated approaches to care proven to help patients get better and achieve their treatment goals and cross-training providers on behavioral health and primary care. The integrated care team utilizes shared workflows to systematically screen and treat common behavioral health conditions and uses measurement-based behavioral health scales and tools to screen and track patient progress toward treatment goals. Behavioral health professionals participate in primary care workflows. Behavioral health professionals may be practice-based, (i.e., located in the same physical space as the integrated care team) or telemedicine-based (i.e., available to the practice onsite on a regular but not daily basis and available by phone, pager or videoconference) to assist primary care providers and patients during practice hours when they are not onsite.</p>

Persons who have chronic pain

Example from Behavioral Health Integration

Patients and Family Members

- Review **Table 1: Roadmap to Integrated Care**. You should be receiving care that addresses both physical and behavioral health needs. Read through the patient perspective on the eight elements.
- Talk to your primary care provider or other care team members about any concerns including feeling low or depressed, feeling anxious, concerns about drinking or drug use, or any other concerns about behavioral health.
- 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 behavioral health diagnosis 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 Practices and Systems (including Primary Care and Behavioral Health Care Providers)

Review **Table 1: Roadmap to Integrated Care**. The following list includes key action items from the Roadmap.

- 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).
- 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*²⁰

- 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., NCAQ 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).

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	<p>(2017) Research Protocol: Noninvasive, Nonpharmacological Treatment for Chronic Pain</p> <p>(2015) Systematic Review: Treatments for Fibromyalgia in Adult Subgroups</p> <p>(2014) Systematic Review: The Effectiveness and Risks of Long-Term Opioid Treatment of Chronic Pain</p> <p>(2012) Noncyclic Chronic Pelvic Pain Therapies for Women: Comparative Effectiveness</p> <p>(2011) Multidisciplinary Pain Programs for Chronic Noncancer Pain</p>
Cochrane Collection	<p>(2015) Consultation liaison in primary care appears to improve mental health practice and outcomes for people with a mental disorder</p> <p>(2013) Collaborative care approaches for people with severe mental illness</p> <p>(2012) Collaborative care for people with depression and anxiety</p> <p>(2009) Psychosocial interventions for the prevention of disability following traumatic physical injury</p>
Specialty Society Guidelines (via Guideline Clearinghouse including Choosing Wisely)	<p>(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</p> <p>(2016) Department of Defense, Department of Veterans Affairs, Veterans Health Administration VA/DoD clinical practice guideline for the management of major depressive disorder</p> <p>(2016) Institute for Clinical Systems Improvement: Adult depression in primary care</p> <p>(2015) Program in Evidence-based Care The management of depression in patients with cancer.</p> <p>(2014) C17 Council Guideline for primary antifungal prophylaxis for pediatric patients with cancer or hematopoietic stem cell transplant recipients</p> <p>(2012) Expert Commentary Primary Care Depression Guidelines and Treatment Resistant Depression: Variations on an Important but Understudied Theme</p>
Health Technology Assessment Program	<p>(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.</p> <p>(2016) Spinal injections Spinal injections are a covered benefit with conditions.</p> <p>(2010) Spinal cord stimulation Spinal Cord Stimulation for chronic neuropathic pain is not a covered benefit.</p> <p>(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).</p> <p>(2008) Discography Discography for patients with chronic low back pain and lumbar degenerative disc disease is not a covered benefit, with exceptions by diagnosis.</p>
Centers for Disease Control and Prevention	<p>(2016) Centers for Disease Control and Prevention: CDC guideline for prescribing opioids for chronic pain</p>

<p>Institute for Clinical and Economic Review</p>	<p>(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</p>
<p>BMJ Clinical Evidence Systematic Overview</p>	<p>0 systematic reviews for collaborative care</p>
<p>Veterans Administration Evidence-based Synthesis Program</p>	<p>(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</p>

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 identification; risk assessment	Operational Systems 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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