AGS19 ANNUAL SCIENTIFIC MEETING

Sustaining Practice Change

What does it take to prevent organizational relapse?

Diane Powers, MBA, MA

University of Washington AIMS Center

Conflicts of Interest

No conflicts to report

Translation & Implementation

Translation

Efficacy to Effectiveness

Implementation

Fidelity vs. Flexibility

Glasgow, et al. “Why don’t we see more translation of health promotion research to practice? Rethinking the Efficacy-to-Effectiveness transition” 2003 Am J Public Health; 93(8): 1261-1267.
Cohen, et al. “Fidelity versus flexibility: translating evidence-based research into practice” *Am J Prev Med* 2008; 35(5):5381-5389.

Maintenance vs. Sustainment

RE-AIM

- Reach
- Effectiveness
- Adoption
- Implementation
- Maintenance

Gaglio, et al. “The RE-AIM Framework: A systematic review of use over time” *Am J Public Health* 2013; 103(6):e38-e46.

Dynamic Sustainability Framework (DSF)

Institutionalization

Responsive to local context

- Institutional
- Cultural
- Ecological System

Continuous quality improvement (CGI)

Stakeholder engagement

Chambers, et al. "The dynamic sustainability framework: addressing the paradox of sustainment amid ongoing change" *Implementation Science* 2013; 8:117.

Depression Treatment

No Treatment






Primary Care

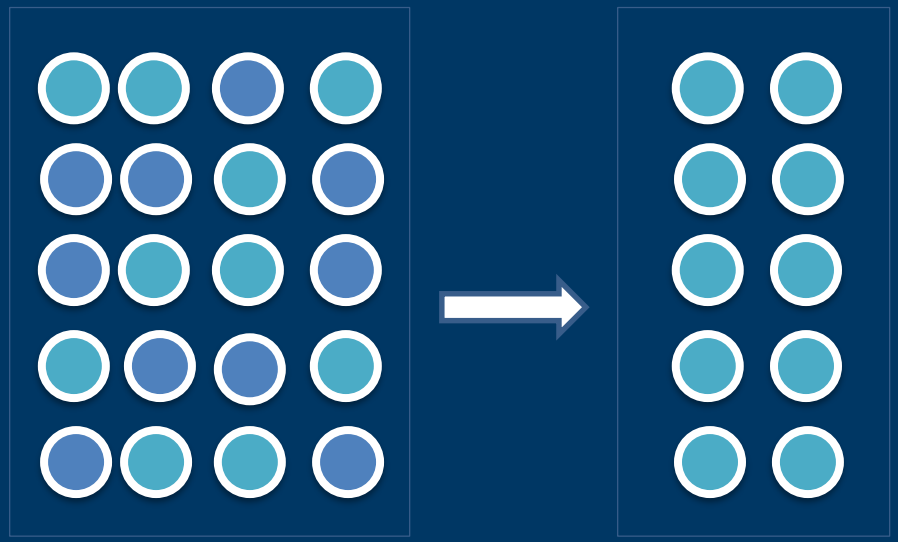



Mental Health

Wang, et al. “Twelve month use of mental health services in the United States: results form the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 2005; 62(6):629-650.

Why Not Just Refer?

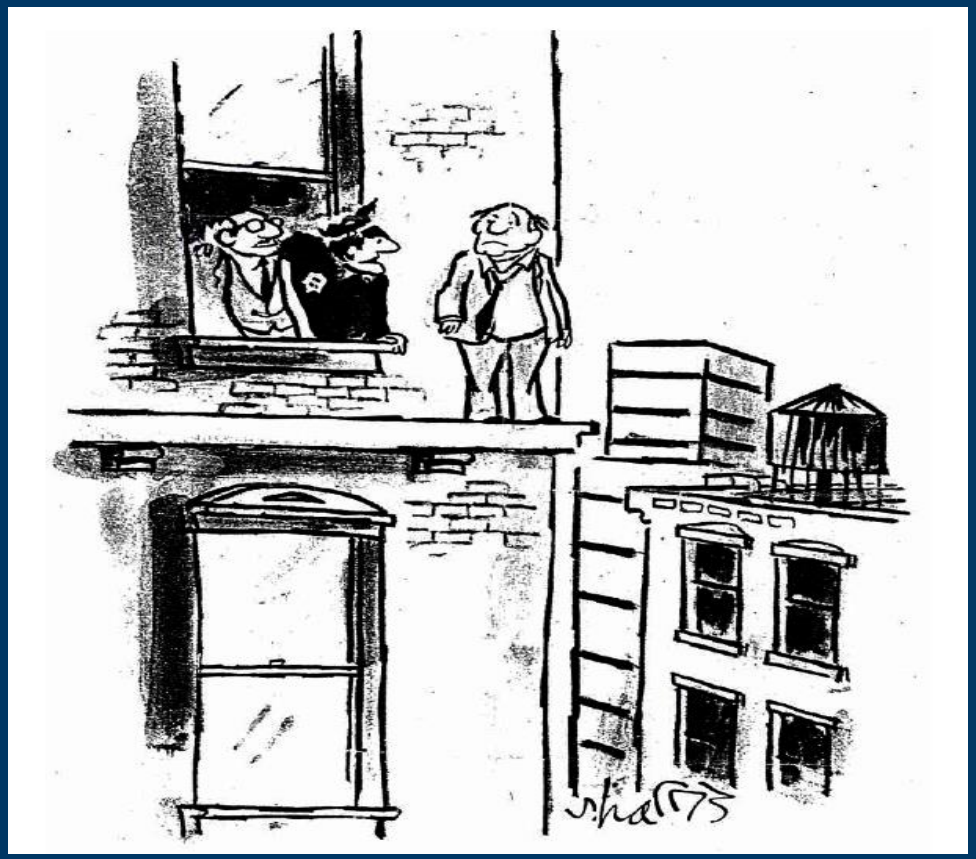
Half don't go



Mean # of visits = 2

Grembowski, et al. "Managed care, access to mental health specialists, and outcomes among primary care patients with depressive symptoms" *J Gen Intern Med,* 2002 Apr;17(4):258-69.
Simon, et al. "Early dropout from psychotherapy for depression with group- and network-model therapists" *Adm Policy Ment Health*, 2012 Nov; 39(6):440-447.

Access to Depression Treatment



Nearly 10% of primary care visits are depression related

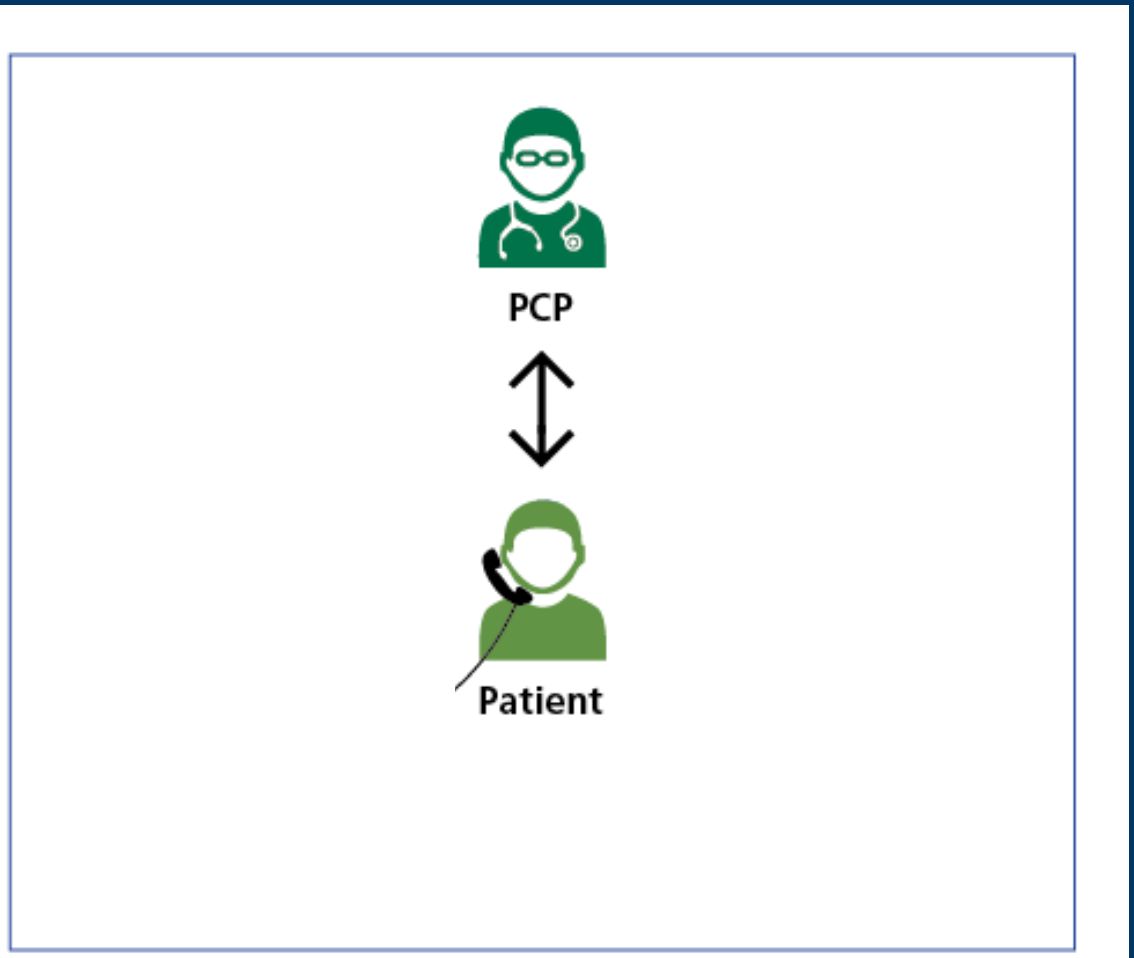
"We couldn't get a psychiatrist, but perhaps you'd like to talk about your skin. Dr. Perry here is a dermatologist."

Quality of Depression Treatment

"Of course you feel great. These things are loaded with antidepressants."

… only 20% improve in primary care after 12 months of treatment

Collaborative Care



IMPACT

1,801 older adults with depression

- 8 health systems in 5 states
- 18 clinics
- Fee-for-service
- Staff model HMO
- VA clinic

Randomized Controlled Trial

- Collaborative Care for 12 months
- Usual Care

Unützer et al. “Improving primary care for depression in late life: the design of a multicenter randomized trial” *Med Care*, 2001 Aug; 39:785-99.

Evidence-based Treatments

Individualized treatment plan includes one or both

Medications

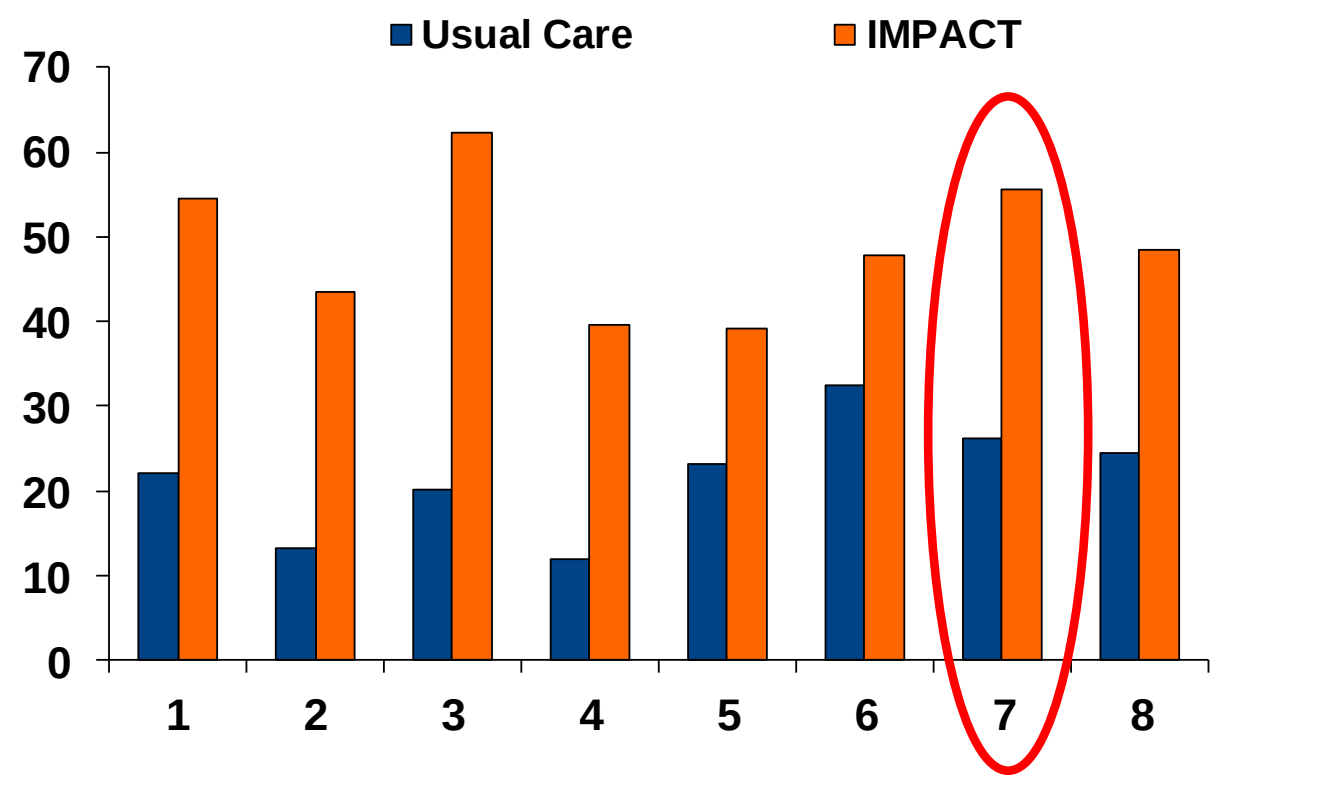
- Consultant helps PCPs expand capacity

Psychotherapy

- Modalities appropriate for primary care
  - Brief
  - Structured
  - Strong evidence

Twice as Effective

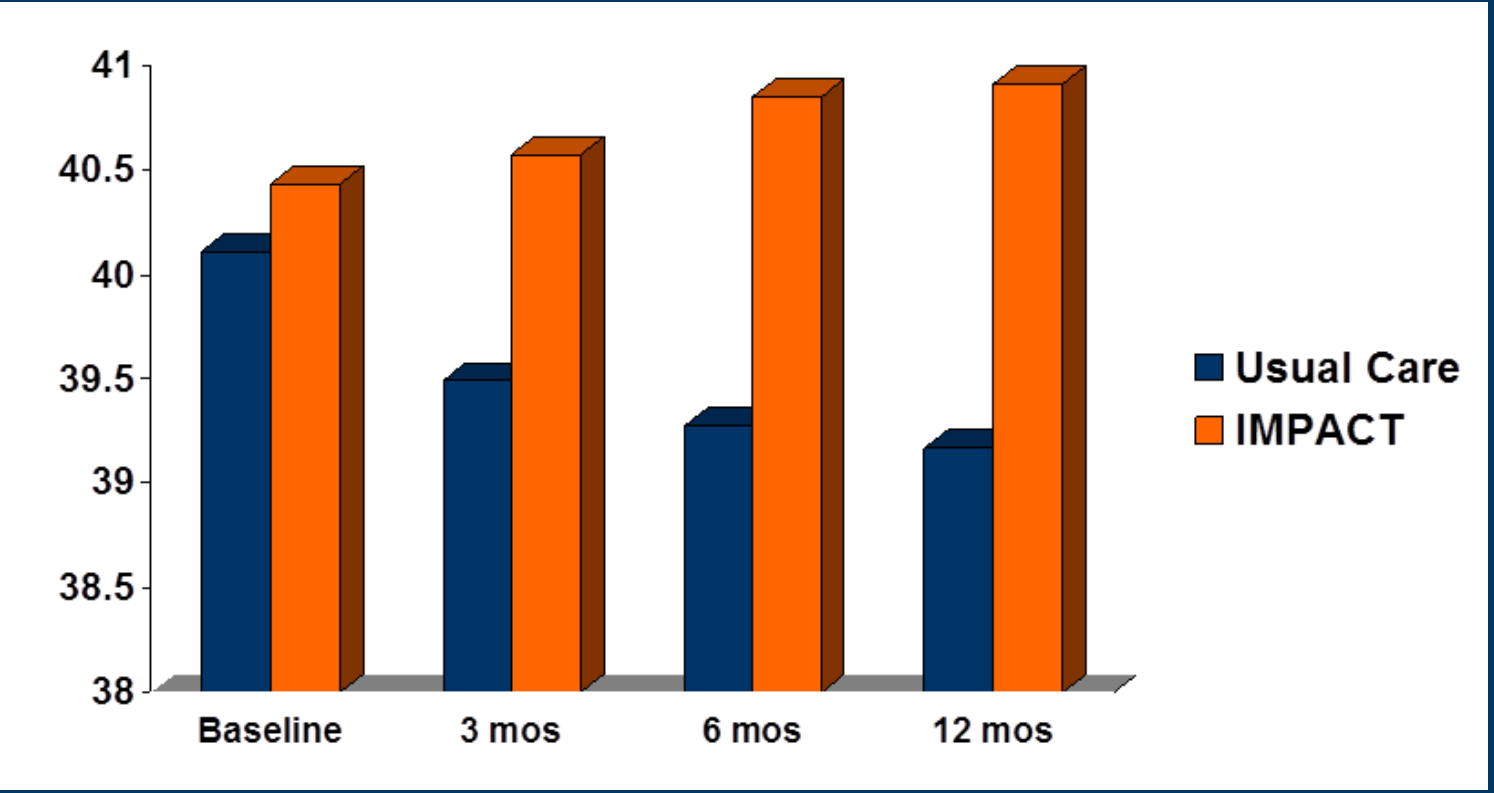
50% or greater improvement in depression at 12 months



Unützer J, et al. "Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial" *JAMA* 2002; 288(22):2836-2845.

Improved Physical Function

SF-12 Physical Function Component Score



Callahan et al. “Treatment of depression improved physical functioning in older adults”, *J Am Geriatrics Soc* 2005; 53:367-373.

Other Outcomes

- Less physical pain
- Higher quality of life
- Provider satisfaction
- Patient satisfaction
- Cost effective

  $6.50 : $1

Levine, et al. “Physicians’ satisfaction with a collaborative disease management program for late-life depression in primary care” *Gen Hosp Psychiatry* 2005;27(6):383-391.
Unützer et al. “Long-term cost effects of collaborative care for late-life depression. Am J Manag Care, 2008; 14(2):95-100.

Older Adults in Community Health Centers

Population	Mean baseline PHQ-9 depression score	Follow-up (%)	Mean number of primary care contacts	% with psychiatric consultation	% with significant clinical improvement (PHQ-9 reduced 50% or more)
Older Adults at baseline (2008) N = 124	15 / 27	63 %	3	18 %	**24 %**
Older Adults in 2012 N = 568	15 / 27	86%	8	69 %	**51 %**

Collaborative Care Evidence

Over 100 research trials worldwide

- Depression, anxiety, PTSD
- Substance use, ADHD, bipolar 2
- Racial / ethnic minority
- Rural, low-income
- Low- and middle-income countries

Archer J, et al. “Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews* 2012; 10:CD006525.
Bower P, et al. “Collaborative care for depression in primary care” *British J of Psychiatry* 2006; 189:484-493.

Key Principles

Population-Based Care

Measurement-Based Treatment to Target

Patient-Centered Collaboration

Evidence-Based Care

Accountable Care

Taking Effective Models to Scale

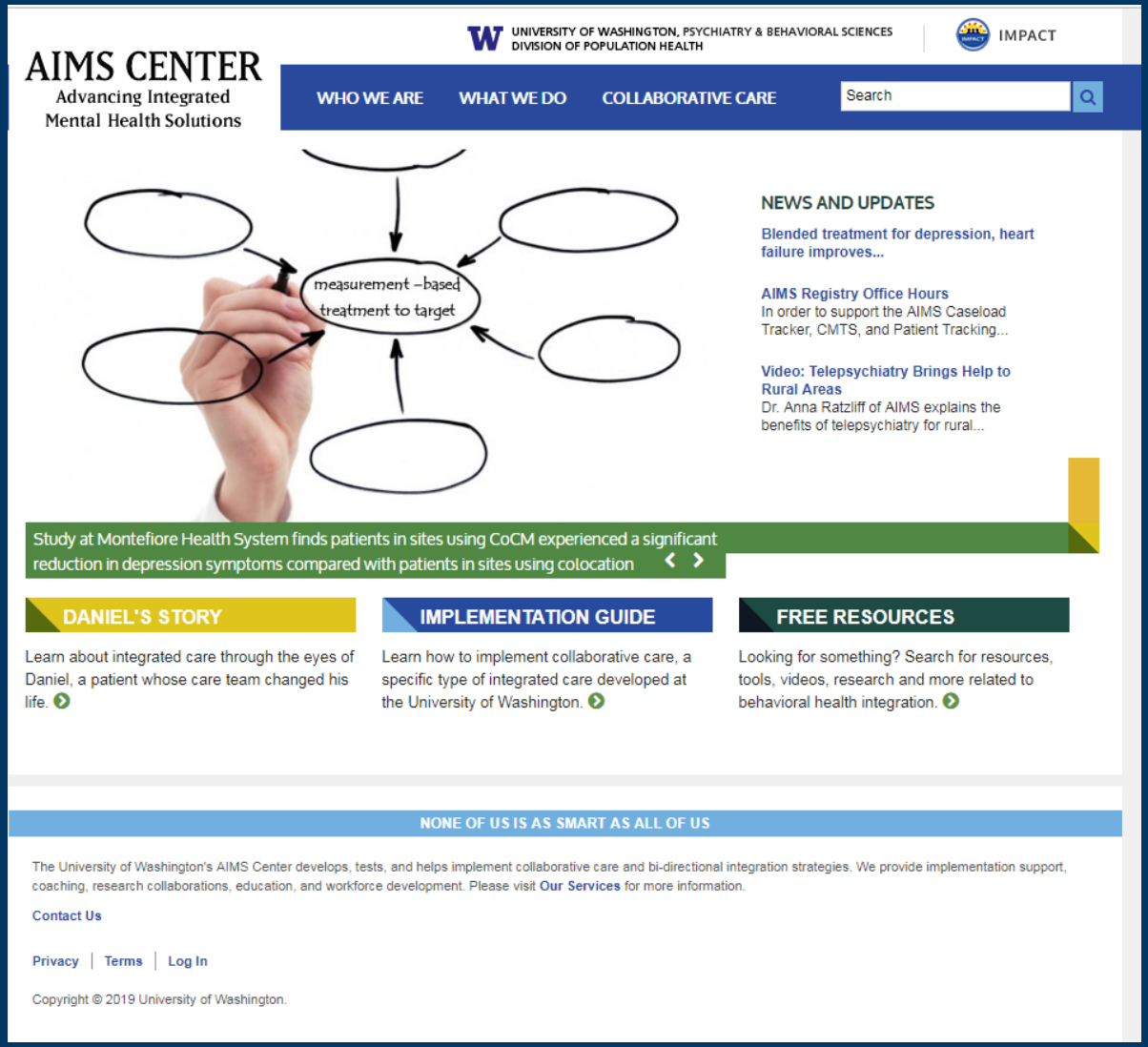
AIMS Center

University of Washington

Training / Tools

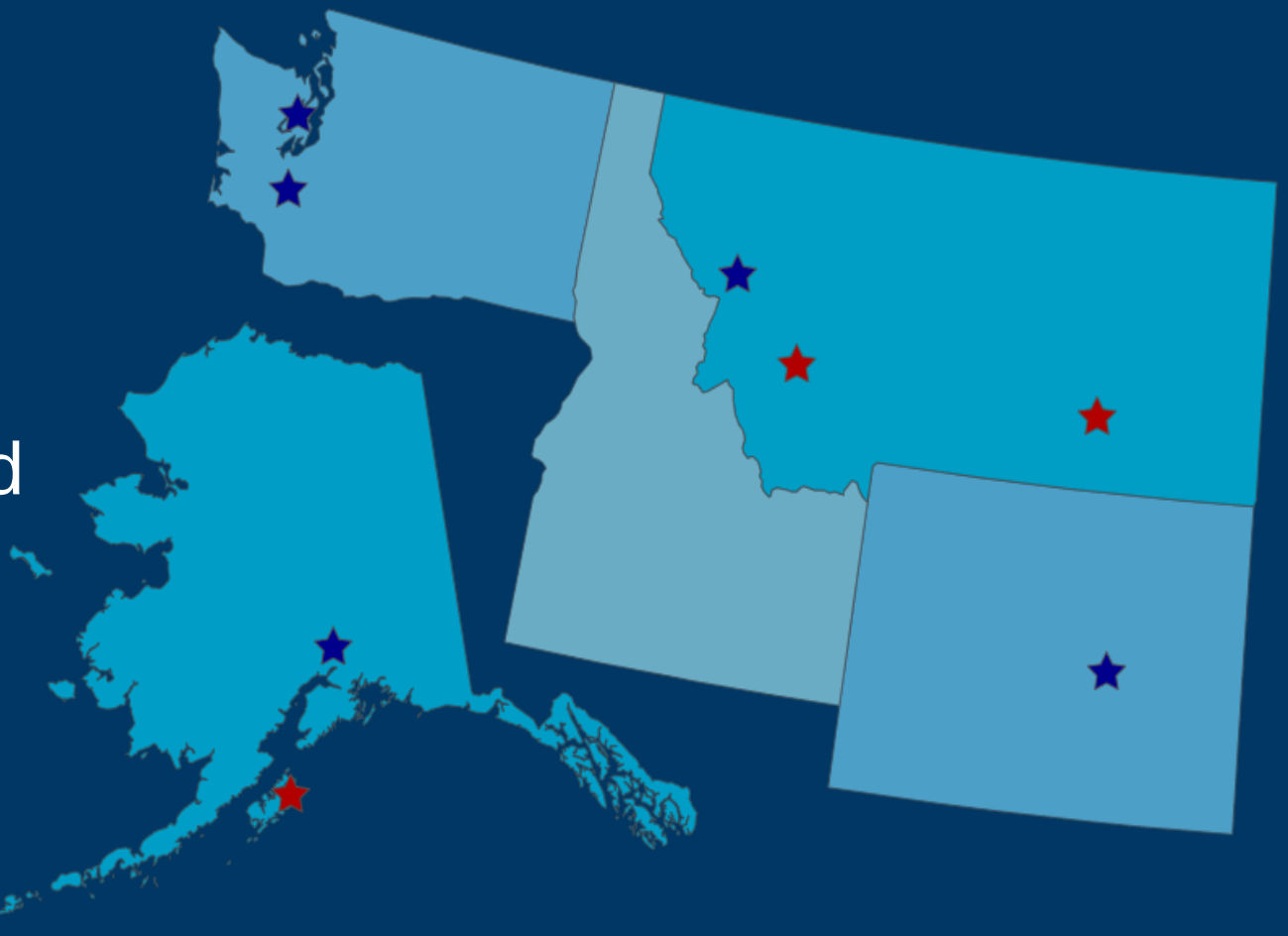
Practice Facilitation

Evaluation / Research



Improving Depression Treatment Access and Quality

- Rural / Frontier FQHCs
- Medically Underserved
- Healthcare Provider Shortage Area



Implementation Process

Roadmap for Implementation

1. Lay the Foundation

Ensure clinic staff watch "Introduction to IMPACT" and "Creating the Collaborative Care Team" webinars (or receive key messages from each webinar).

Understand the five principles of Collaborative Care and how they apply to your organization

Create a vision for IMPACT at your organization with input from key stakeholders

2. Plan For Clinical Practice Change

Schedule pre-launch calls with AIMS Center

Complete Team Building Worksheets and create Action Plan

Create Clinical Workflow chart

Send Action Plan and Clinical Workflow to AIMS Center

Complete CMTS registry license and identify account manager

3. Train Your Clinical Team

Identify who will attend Sept 27-28, 2014 training in Seattle

Complete online registration for attendees

Reserve lodging and make other travel arrangements for attendees

Schedule webinar and/or live Q&A for PCPs unable to attend Seattle training

Ensure clinical staff offering psychotherapy as a treatment complete PST (Problem-Solving Treatment) certification following in-person training

4. Launch Your Care

Select a specific date for launch and communicate this widely to all clinic staff

Ensure all administrative details are in place prior to launch

Begin monitoring implementation process and clinical outcomes

5. Ongoing Maintenance

Block time on care manager(s) & clinical supervisor calendars for bi-monthly case call with all SIF sites

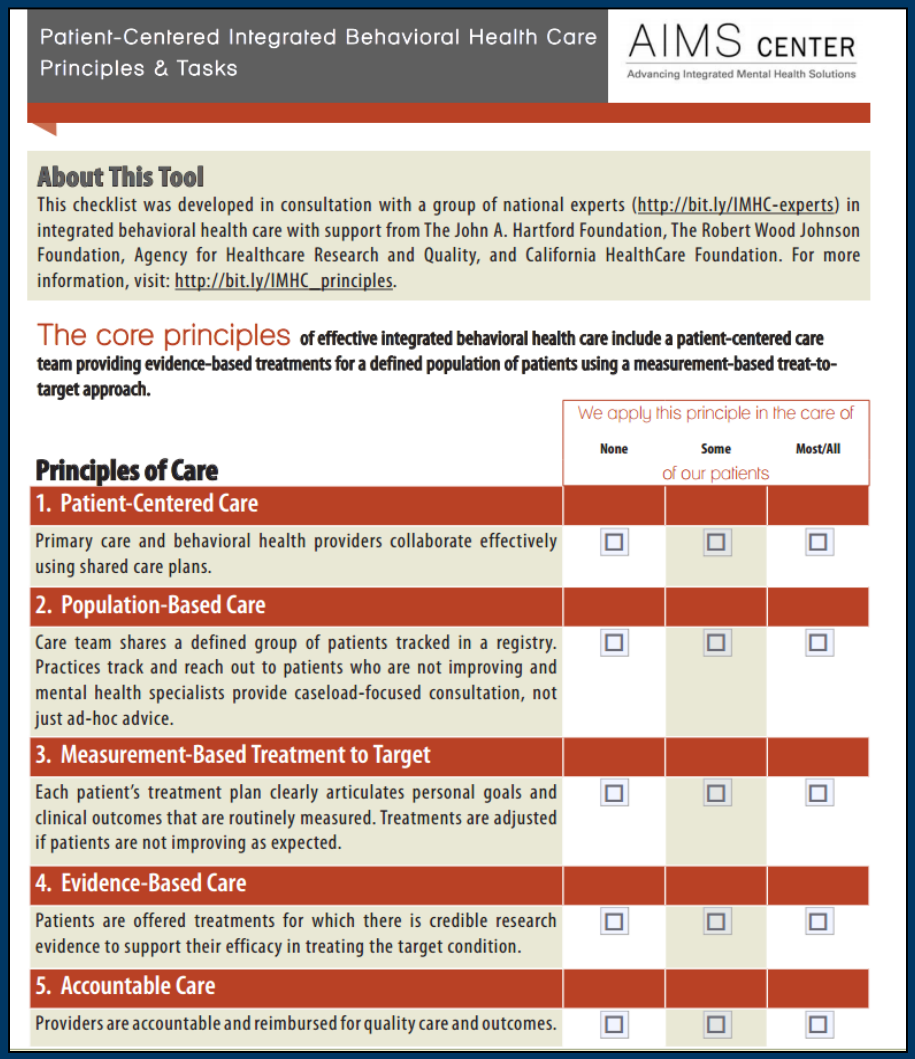
Block program leadership and care manager calendars for monthly implementation technical assistance call

Monitor schedule of bi-monthly topic webinars & block time for participation on calendars of relevant clinic staff

Block psychiatric consultant calendar for quarterly call (all SIF psychiatric consultants and AIMS)

Monitor implementation process and clinical outcomes

Pre-Launch Technical Assistance



Patient-Centered Integrated Behavioral Health Care Principles & Tasks

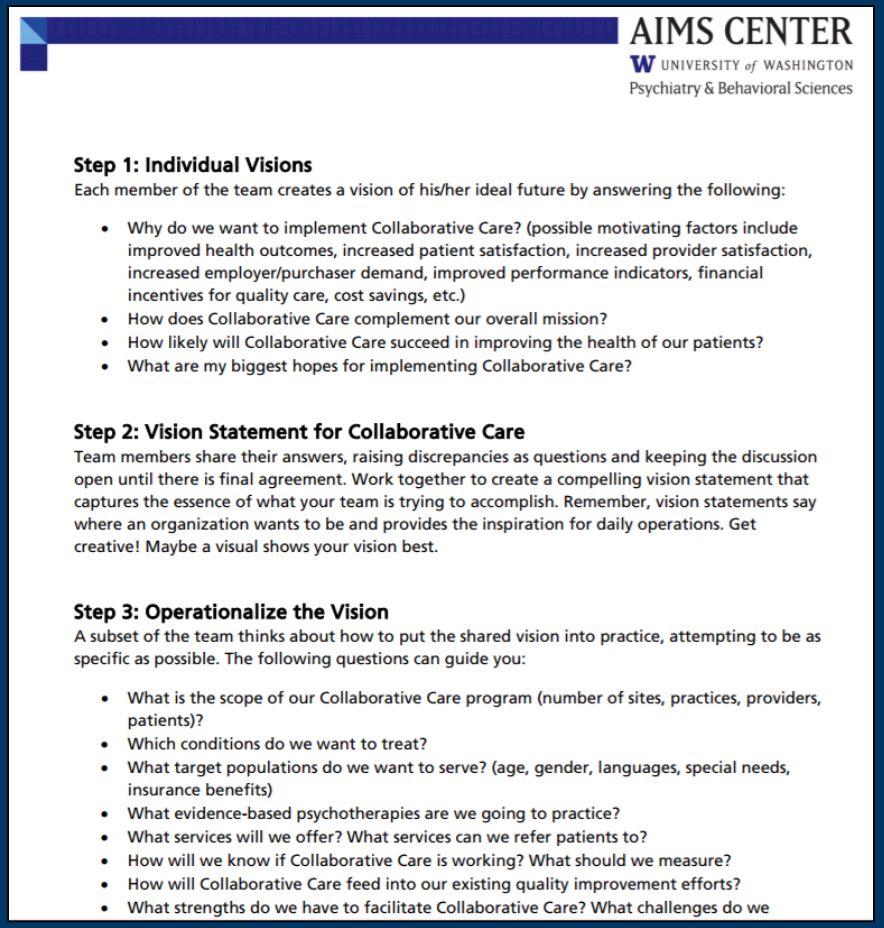
AIMS CENTER
Advancing Integrated Mental Health Solutions

About This Tool

This checklist was developed in consultation with a group of national experts (http://bit.ly/IMHC-experts) in integrated behavioral health care with support from The John A. Hartford Foundation, The Robert Wood Johnson Foundation, Agency for Healthcare Research and Quality, and California HealthCare Foundation. For more information, visit: http://bit.ly/IMHC_principles.

The core principles of effective integrated behavioral health care include a patient-centered care team providing evidence-based treatments for a defined population of patients using a measurement-based treat-to-target approach.

Principles of Care	We apply this principle in the care of … None	Some of our patients	Most/All
1. Patient-Centered Care			
Primary care and behavioral health providers collaborate effectively using shared care plans.	☐	☐	☐
2. Population-Based Care			
Care team shares a defined group of patients tracked in a registry. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.	☐	☐	☐
3. Measurement-Based Treatment to Target			
Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are adjusted if patients are not improving as expected.	☐	☐	☐
4. Evidence-Based Care			
Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition.	☐	☐	☐
5. Accountable Care			
Providers are accountable and reimbursed for quality care and outcomes.	☐	☐	☐



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Psychiatry & Behavioral Sciences

Step 1: Individual Visions

Each member of the team creates a vision of his/her ideal future by answering the following:

- Why do we want to implement Collaborative Care? (possible motivating factors include improved health outcomes, increased patient satisfaction, increased provider satisfaction, increased employer/purchaser demand, improved performance indicators, financial incentives for quality care, cost savings, etc.)
- How does Collaborative Care complement our overall mission?
- How likely will Collaborative Care succeed in improving the health of our patients?
- What are my biggest hopes for implementing Collaborative Care?

Step 2: Vision Statement for Collaborative Care

Team members share their answers, raising discrepancies as questions and keeping the discussion open until there is final agreement. Work together to create a compelling vision statement that captures the essence of what your team is trying to accomplish. Remember, vision statements say where an organization wants to be and provides the inspiration for daily operations. Get creative! Maybe a visual shows your vision best.

Step 3: Operationalize the Vision

A subset of the team thinks about how to put the shared vision into practice, attempting to be as specific as possible. The following questions can guide you:

- What is the scope of our Collaborative Care program (number of sites, practices, providers, patients)?
- Which conditions do we want to treat?
- What target populations do we want to serve? (age, gender, languages, special needs, insurance benefits)
- What evidence-based psychotherapies are we going to practice?
- What services will we offer? What services can we refer patients to?
- How will we know if Collaborative Care is working? What should we measure?
- How will Collaborative Care feed into our existing quality improvement efforts?
- What strengths do we have to facilitate Collaborative Care? What challenges do we

Pre-Launch Training

Web-based Didactics

Module 1: Introduction to Collaborative Care *(25 minutes)*
Description: The rationale and evidence base for integrated behavioral health in primary care; the Care team structure; Key principles of effective Collaborative Care.
Presentation
Slide Handout

Module 2: Key Collaborative Care Tasks *(23 minutes)*
Description: The team tasks of Collaborative Care; Identifying and engaging patients, assessment, initiation of treatment, follow-up and tracking outcomes, relapse prevention.
Presentation
Slide Handout

Required Evaluation training materials are on the Evaluation page.

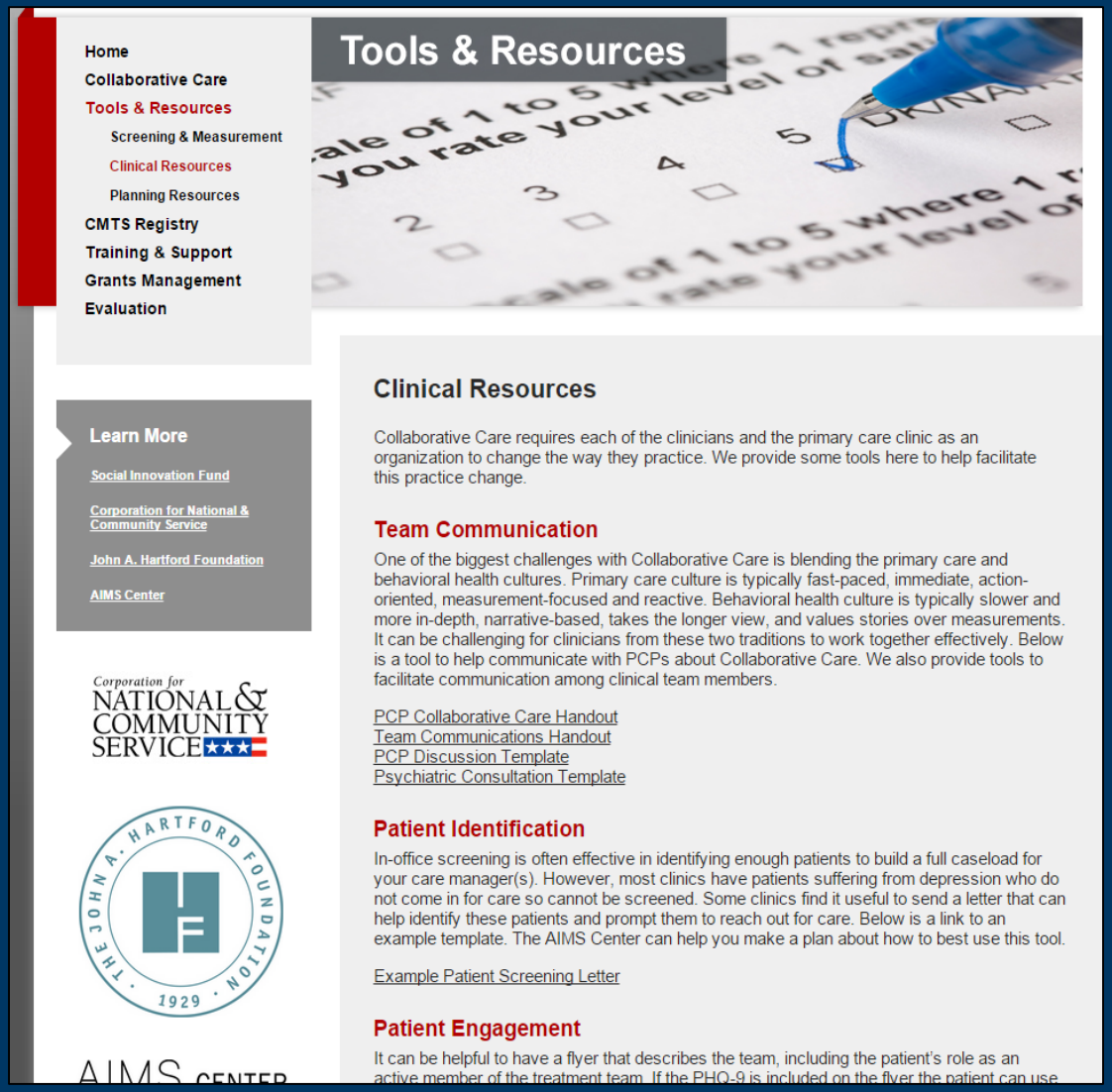
Additional role-specific materials

Module 3: The Care Manager Role *(39 minutes)*
Audience: Primarily the care manager(s), but the content is relevant to the entire clinical team. The care manager role may be filled by a behavioral health provider, nurse or similar professional. At some sites care manager responsibilities are shared with a community health specialist, medical assistant or similar person. This presentation is designed for everyone who will have responsibility for some or all of the care management responsibilities.
Description: The care manager role and tasks; team communication; patient engagement, treatment and outcome tracking.
Presentation
Slide Handout
Description: The short videos below each demonstrate different care management activities.
Initial Visit *(09:19)*
Patient Education *(17:44)*
Behavioral Activation *(05:22)*
Treatment Monitoring *(05:06)*
Antidepressant Education *(03:56)*

Module 4: The PCP Role *(23 minutes)*
Audience: Primarily for Primary Care Providers (PCPs), but the content is relevant to the entire clinical team.
Description: Identifying and engaging patients, prescribing medications, support from the care manager and psychiatric consultant support, depression treatment options.
Presentation
Slide Handout

Module 5: The Psychiatric Consultant Role *(22 minutes)*

Implementation Support Tools



- Screening & Measurement
- Team Communication
- Patient Identification & Engagement
- Relapse Prevention
- Behavioral Activation
- Supporting Medication Therapy

Web-based Registry

Patient | Caseload | Program | Tools | Logout | Search Patient :

Current Patients

Flags	MHITS ID	Popu-lation	Enrollment Date	Sta-tus	Clinical Assessment			# of Sess-ions	Wks in Tx	Last Follow Up Contact				
					Date	PHQ -9	GAD -7			Date	PHQ -9	Dep Impr	GAD -7	Anx Impr
	000279	U	7/24/2012	L1	7/24/2012			2	32	7/24/2012	17			
	000258	F	6/18/2012	L1	3/18/2012	9		2	50	5/18/2012	17			
	000114	G	10/18/2010	L2R	1/18/2011	6		6	111	8/27/2012	17*			
	000156	S	1/25/2012	L1	11/25/2011		18	5	66	4/17/2012	17		14*	
	000245	V	6/14/2012	L1	7/15/2012			2	33	7/23/2012	14			
	000127	UV	5/1/2012	L1	6/14/2012	12	12	5	37	1/9/2013	13*		10	
	000218	G	4/3/2012	L1	4/6/2012			4	47	5/15/2012	12			
	000142	O	1/12/2012	L1	1/12/2012			2	59	2/27/2012	12			
	000277	U	6/8/2012	L1	6/8/2012	9		2	38	6/30/2012	10			
	000210	T	3/27/2012	L1	1/1/2012	25	19	9	61	6/13/2012	9		6	
	000216	U	12/30/2011	L1	11/29/2011	27		9	66	11/28/2012	9			
	000288	V	8/28/2012	L1C	8/16/2012	14		12	28	11/29/2012	6*			
	000232	V	11/16/2011	L1	3/1/2012	25	21	6	52	10/15/2012	5*		2*	
	000231	U	12/6/2011	L2G	1/10/2012	24	20	7	60	5/9/2012	5		5	
	000227	UP	4/3/2012	L1	5/18/2012			1	41					

Post-Launch Training

Diagnosis

Differential Diagnosis & Clinical Communication 5/14/14 – Anna Ratzliff	*53:18*	Recording Slide Handout

Difficult Patients

Working with Difficult Patients 7/8/15 – Rita Haverkamp	*54:58*	Recording Slide Handout
The Difficult Patient Case Call 10/12/15 – Rita Haverkamp	*1:28:57*	*Recording available upon request*

Distress Tolerance

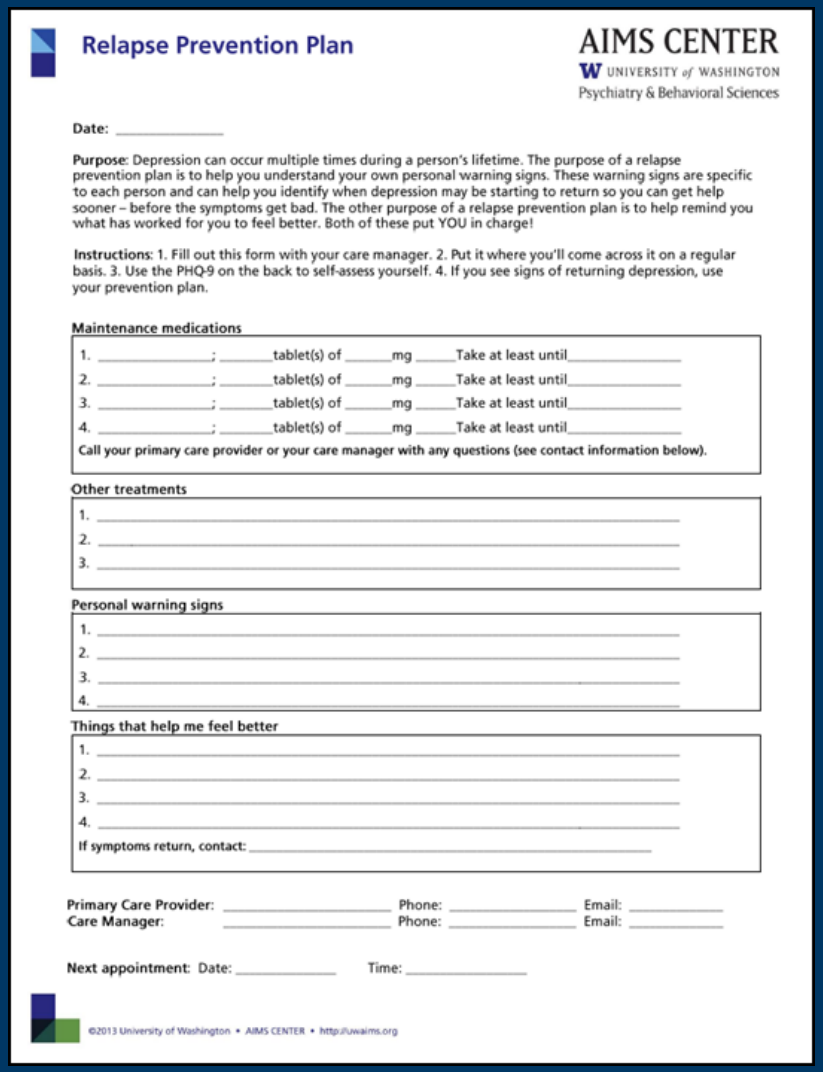
Distress Tolerance Case Call 10/14/15 – Anna Ratzliff	*1:21:06*	*Recording available upon request* Slide Handout Case Presentation Form

Engagement

Patient Engagement Case Call 12/10/14 – Kari Stephens,	*1:24:59*	*Recording available*

Topics delivered according to developmental stage of implementation

Relapse Prevention - Patient



Relapse Prevention Plan

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Date: _____

Purpose: Depression can occur multiple times during a person's lifetime. The purpose of a relapse prevention plan is to help you understand your own personal warning signs. These warning signs are specific to each person and can help you identify when depression may be starting to return so you can get help sooner – before the symptoms get bad. The other purpose of a relapse prevention plan is to help remind you what has worked for you to feel better. Both of these put YOU in charge!

Instructions: 1. Fill out this form with your care manager. 2. Put it where you'll come across it on a regular basis. 3. Use the PHQ-9 on the back to self-assess yourself. 4. If you see signs of returning depression, use your prevention plan.

Maintenance medications

1. _____; _____tablet(s) of _____mg _____Take at least until_____
2. _____; _____tablet(s) of _____mg _____Take at least until_____
3. _____; _____tablet(s) of _____mg _____Take at least until_____
4. _____; _____tablet(s) of _____mg _____Take at least until_____

Call your primary care provider or your care manager with any questions (see contact information below).

Other treatments

1. _____
2. _____
3. _____

Personal warning signs

1. _____
2. _____
3. _____
4. _____

Things that help me feel better

1. _____
2. _____
3. _____
4. _____

If symptoms return, contact: _____

Primary Care Provider: _____ Phone: _____ Email: _____
Care Manager: _____ Phone: _____ Email: _____

Next appointment: Date: _____ Time: _____

- Personal Warning Signs
- Treatments
- Self-management
- Action Plan

Post-Launch Coaching

Social Innovation Fund

IMPACT Expansion in the Rural West

Implementation Overview: 12/29/2016

SITE	Care Mgr FTE	Care Mgr Type	Total Patients Treated	Active Caseload Goal Minimum[1]	Active Caseload[2]	Contact >2 months	Active Caseload: % of Minimum	% >24 Weeks[3]	% Contacts w/ PHQ-9[4]	5+ Point Decrease	50%+ Decrease After at Least 10 Weeks	Psychiatric Consultation[5]
								Goal = <20%	*Goal = ≥80%*	*Goal = ≥50%*	*Goal = ≥40%*	*Goal= ≥75% of active patients*
	1.5	All-in-one	669	75	69	5	92%	22%	94%	64%	54%	81%
	1	Shared	410	90	21	13	23%	12%	99%	62%	67%	9%
	2.25	Shared	1439	203	160	21	79%	32%	70%	51%	54%	53%
	1.8*	All-in-one	787	90	97	0	108%	19%	97%	51%	54%	76%
	1.6*	All-in-one	537	80	79	1	99%	27%	86%	48%	45%	93%
			3842	538	426							
	1	All-in-one	171	50	40	1	80%	12%	83%	71%	92%	63%
	1	All-in-one	259	50	30	4	60%	26%	57%	38%	73%	71%
	1.25	Shared	463	113	75	7	67%	16%	84%	42%	55%	93%
			893	213	145							
TOTAL			4735	750	571							

Stepped implementation support

- Monitor
  - Patient-level clinical outcomes
  - Clinic-level processes of care
- Course corrections
- Tailored support
  - 1:1 phone / web
  - Onsite intensive
- Goal = independent sustainability

Demographics

	n	%
Gender		
Women	**3556**	**68%**
Men	**1711**	**32%**
Age		
<18	**120**	**2%**
18 to 34	**2264**	**43%**
35 to 54	**1991**	**38%**
55 to 74	**965**	**18%**
75+	**52**	**1%**
Race		
American Indian / Alaska Native	**440**	**8%**
Asian	**37**	**1%**
African American	**71**	**1%**
Pacific Islander	**32**	**1%**
White	**4391**	**83%**
Hispanic	**130**	**2%**
Other/Unknown	**291**	**5%**

Depression Outcomes

	Mean	95% CI	Standard Deviation
Depression severity *(range 0-27)*			
PHQ-9 at baseline	16.1	15.9, 16.2	5.7
PHQ-9 at last measurement	10.9	10.8, 11.1	7.2
Change from baseline to last	5.1[a,b]	4.9, 5.3	6.7
Suicidal ideation *(range 0-3)*			
Baseline	0.59	0.57, 0.62	0.90
Last measurement	0.35	0.33, 0.37	0.73
Change from baseline to last	0.25[a,b]	0.22, 0.27	0.77

[a] *P* <0.0001

[b] Paired t-test

Organizational Relapse Prevention

Cohort 1

- 5 clinics
- 4 moved into sustainment

Support phase = 2.5 years

- Typically 12-18 months

Sustainment phase = 12 months

Relapse Prevention

Patient

Pre-Treatment

- Vision
  (shared decision making)
- Treatment Goals

Organization

Pre-Launch

- Vision
  (stakeholders)
- Goals

Relapse Prevention

Patient

Treatment phase

- Measurement-based treatment-to-target
- Treatment changes to meet goal(s)
- Relapse prevention plan

Organization

Support phase

- Measurement
- Adjustments
- Relapse prevention plan

Relapse Prevention

Patient

Maintenance phase

- Periodic measurement
- Action plan

Organization

Sustainment phase

- Periodic measurement
- Action plan

Method

Internal facilitation

- Group webinar
- 1 coaching session per clinic
- Coach available for consultation

Plan development

- 2 months

Presentation

- Coaches, peers
- Accountability

Dynamic Sustainability Framework (DSF)

Institutionalization

Responsive to local context

- Institutional
- Cultural
- Ecological System

Continuous quality improvement (CGI)

Stakeholder engagement

Chambers, et al. "The dynamic sustainability framework: addressing the paradox of sustainment amid ongoing change" *Implementation Science* 2013; 8:117.

DSF - Institutionalization

Prior to Collaborative Care implementation

- Vision
- Roles
- Prior implementation experience

Internal facilitation

- Internal capacity

DSF - Responsive to Context

Institution

- Fidelity to clinical outcomes
- Processes of care = diagnostic
- Workforce considerations; training

Culture

- Fish camp
- American Indian / Alaska Native

Ecological systems

- Financing, policy changes
- Population characteristics

DSF Institution – Outcomes

Clinical Outcomes / Benchmarks

- Response (> 40%)
- Remission (> 25%)

Processes of Care

- Follow-up within first 4 weeks
- Case consultation with psychiatric expert

Bao Y, **et al.** "Unpacking collaborative depression care: Examining two essential tasks for implementation" *Psych Svcs* 2016; 67:418–424
Bower P, et al. "Collaborative care for depression in primary care" *British J of Psychiatry* 2006; 189:484-493.

DSF Institution - Workforce

Care Manager Role

- Shared by licensed and paraprofessional

Psychiatric Consultant

- Psychiatric nurse practitioner
- Shared by clinics

Hoeft, et al. "Task-sharing approaches to improve mental health care in rural and other low-resource settings: a systematic review" *J Rural Health* 2018; 34(1);48-62.

DSF Culture

Rural

- Fierce independence
- Self-reliance
- Stigma

American Indian / Alaska Native

- Stoicism
- Beliefs, healing interventions

Fortney et al. “The association between rural residence and the use, type, and quality of depression care. “ *J Rural Health* 2010:26:205-213.
National Advisory Committee on Rural Health and Human Services. “The 2005 report to the secretary: rural health and human service issues.”

DSF Ecological Context

Financing

- Staffing
- Productivity
- Workflow Optimization
- Direct Revenue
- Indirect Revenue
- Contracting
- Coding/Denials

DSF - Continuous Quality Improvement

Measurements

- Identify / adapt (congruent with vision)
- Benchmarks
- Warning signs

Process

- Leader(s)
- Frequency
- Updates

Problem-Solving

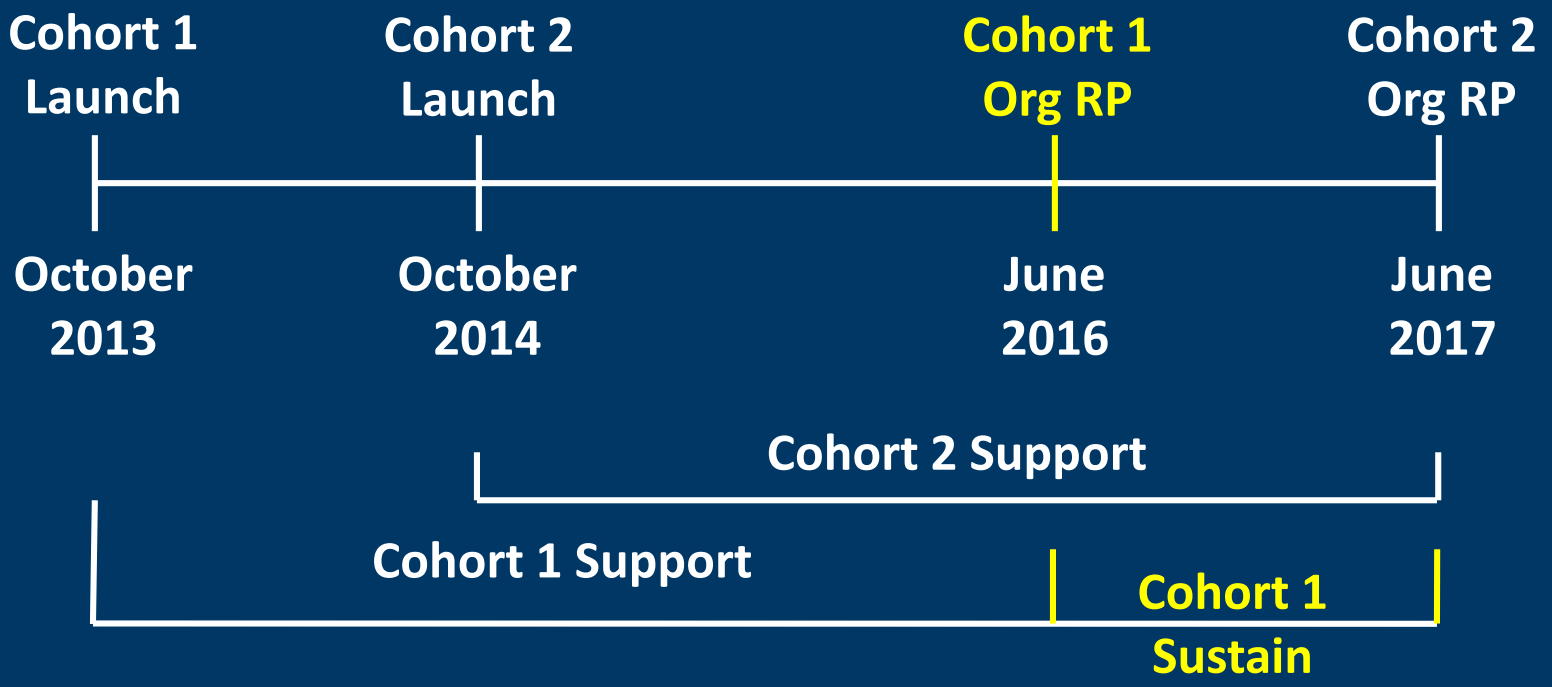
- Rapid testing / learning (PDSA)

DSF - Stakeholder Engagement

Accountability

- Patients
- Providers
- Payers
- Community partners
- Peers

Timeline


Cohort 1 Launch
Cohort 2 Launch
Cohort 1 Org RP
Cohort 2 Org RP
October 2013
October 2014
June 2016
June 2017
Cohort 2 Support
Cohort 1 Support
Cohort 1 Sustain

Sustainment Outcomes

		Support	Sustain	pvalue
		n= 3033	n= 882	
Total Number of Follow-ups	0	449 (14.8)	223 (25.3)	<0.001
First Follow-up within 31 days	Yes	2826 (93.2)	803 (91.0)	0.032
Treatment Duration , months	mean (SD)	2.9 (3.7)	1.8 (2.3)	<0.001
Remission	Yes	738 (24.3)	141 (16.0)	<0.001
Response	Yes	1,505 (49.6)	356 (40.4)	<0.001

Sustainment Outcomes

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		n= 3033	n= 882	
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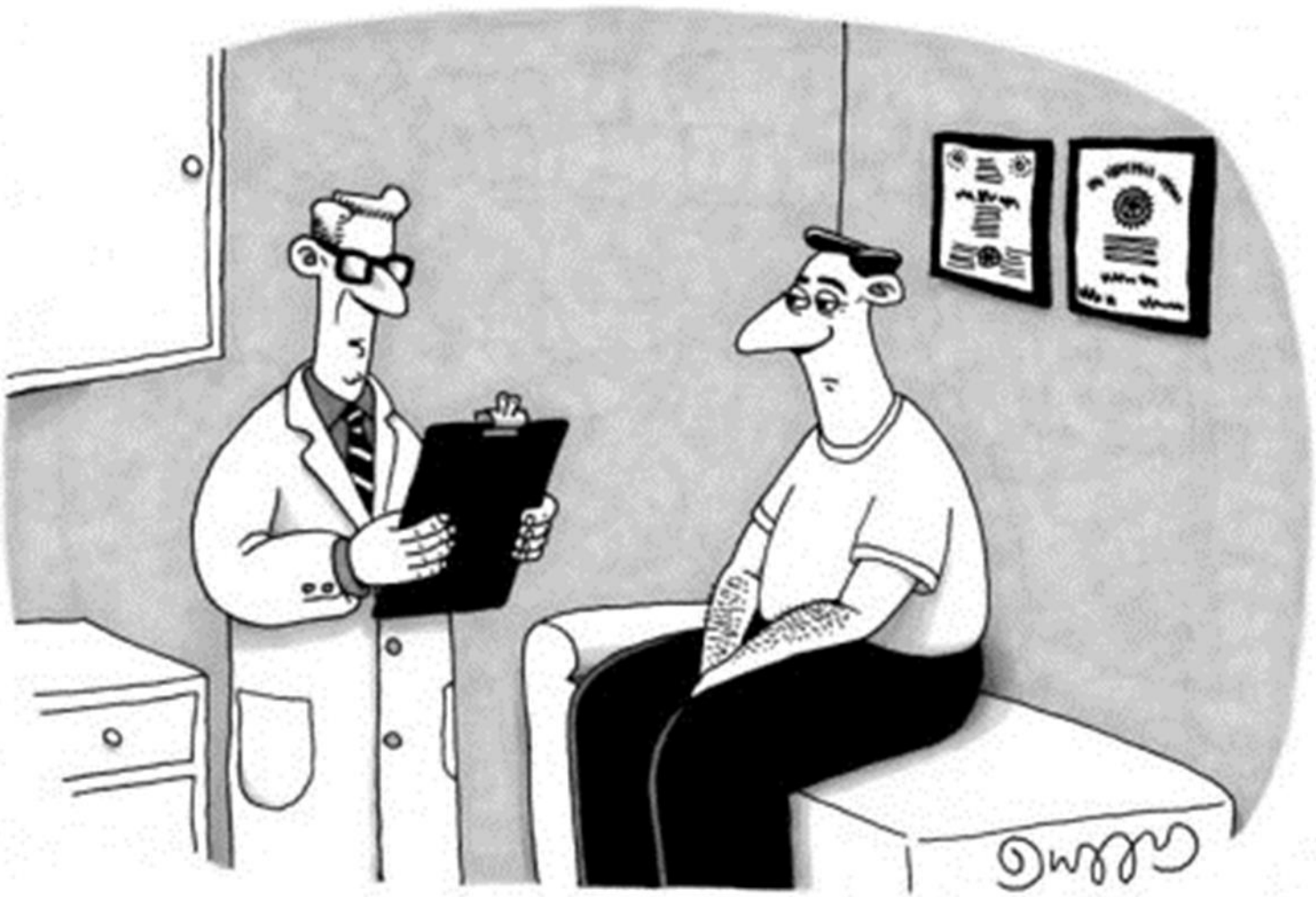
Qualitative Data

“It really opened up discussions to accountability… [but] that’s going to be a slow change.”

“It’s a fluid process and a constant paying attention to different areas….you get one going well then you need to go back and look at another”

“Getting our more traditional care managers out of that traditional counseling role is ongoing.”



"I'm afraid you've had a paradigm shift."

Acknowledgements

Collaborators

Jürgen Unützer, MD, MA, MPH – Principal Investigator
Rita Haverkamp, MSN – Implementation Coach
Joan Russo, PhD – Senior Analyst
Rob Arao, MPH – Data Manager, Analyst

Public Funder

Corporation for National and Community Service
Social Innovation Fund

Private / Philanthropic Funders

John A. Hartford Foundation
Margaret A. Cargill Foundation
Helmsley Charitable Trust
Rasmussen Foundation
Lewis County Commissioners