Hello. The time is now 12:30 pm Eastern, the official start time for today's broadcast. The topic today is Integrating Care for the Whole Person. And now, without further ado, I would like to turn things over to your host Dr. Adrienne Mims, Chief Medical Officer and Vice President of Alliant Quality. Doctor, the floor is yours.

Good afternoon and welcome to our program today. We are so excited that you use your time be with us and learn more how you can care for your patient. We have an exciting program here to share with you.

I would first like to let you know about the free technical assistance we provide here at Alliant Quality. Since you have signed up to be part of our learning collaborative, we can help you with resources and tools to improve your billing practices for the depression and alcohol screening. We can help you understand where to refer patients you are not able to treat or how to manage them in the primary care environment. Joining with us in our ongoing learning collaborative and we can share the evidence-based practices.

Also, I want to remind you about the available billing codes screening for depression. Remember Medicare pays for screenings for depression on a yearly basis if it occurs in one of the codes listed by the specialist that are listed on the slide and I encourage you to make use of these and make sure your patients are screened well for this condition.

And today I welcome our presenter, Dr. Paul Ciechanowski. He has served in academic positions at the University of Washington for the past 20 years and continues to serve an affiliate role as clinical associate professor. He is Chief Medical Officer with Samepage Health, a company that he founded. It provides services and software for improving healthcare communication, behavior change, and patient engagement. He founded [*inaudible*] Exchange, a program at the center of commercialization at the University of Washington. It provides national training and dissemination of evidence-based intervention for treating chronic conditions. He serves as a key psychiatrist, and head of behavioral health for the University of Washington diabetes care center for 17 years. And since 1997, he was a principal investigator or co-investigator in several clinical trials funded by NIH or CDC. His areas of focus is collaborative care for depression, diabetes and heart disease, epilepsy and MD geriatric patient populations. He also received a career development award through NIDDK on exploring the influences of attachment styles on treatment outcomes and diabetes. He has written over 100 articles including numerous book chapters. Dr. Ciechanowski has earned his medical degree from [*inaudible*] University in Montréal and completed residency in both family medicine and psychiatry. He currently serves as a member of the community leadership board for the American Diabetes Association in Washington state. I know that you will be very pleased with what you will learn from him today. His wealth of knowledge is here to be shared. Thank you, and l turn it over now to Dr. Paul Ciechanowski.

Well thank you very much Dr. Mims, and I want to also thank Alliant Quality for this opportunity. Most importantly I want to thank all of you for taking time out of your day to participate today in this dialogue we will have time at the end for discussion and questions but today what I am going to be talking about is integrating care for the whole person: collaborative teams for behavioral health and medical conditions. The goals and objectives of my presentation today are to review core components of collaborative care about specifically about multi-condition collaborative care, so not only focusing on depression but focusing on multiple chronic conditions, medical and behavioral. I am going to define clinical inertia as a concept I think we should all know about and finally I am going to review the clinical trial basis as we review the components, the necessary components that need to be in place for

providing this kind of care that really has been shown in multiple trials to address the triple aim if not the quadruple aim of CMS.

We have been talking about a lot of chronic conditions and focusing on the whole person and particularly people with multiple disorders and conditions. I want to start by talking about the most important disorder of all. This is a disorder that is sweeping the nation and I guarantee you that you are dealing with this disorder in your organization as well. If we do not understand and start to deal with this disorder, then we are not serving our patients well or cost-effectively. That disorder is called clinical inertia. It is an institutional disorder, and the definition of clinical inertia, if you have not heard it, it is defined as a lack of treatment intensification in a patient not at evidence-based goals for care. Furthermore, it is a major factor that contributes to inadequate chronic disease care in patients with frankly any chronic condition including these listed here. The way we know about clinical inertia is from great studies that were done. Here is one by Schmittdiel and colleagues looking at 160,000 patients with diabetes. They went into this very thorough chart review both electronic records and paper charts and they were anticipating finding patterns of poor treatment adherence and poor self-management. They were surprised because they found that actually the majority of patients had adequate adherence The real problem was this lack of treatment intensification by the healthcare team and in other words not recognizing what should be done using guideline level algorithms and not making recommendations in a timely manner and not closing the loop on those action steps. In some ways it is like looking in a mirror and all of the things we expect from our patients as clinicians or healthcare systems which is patients do the right thing and follow the best treatment they actually engage in something they close the loop on the action steps so we can check a box they are doing things in the very things we expect of our patients we need to start expecting of ourselves and because of competing demands and because of limited resources it is very difficult, we all know this. Yet I think this is a very critical thing we need to look at. I would like to not only look in the mirror but a two way mirror where we can both look at what we're expecting from our patients but also see a little reflection in helping us understand we too have a play card in this. This is really looking at the ecosystem within which we are treating our patients with multiple chronic conditions. As an example, what this may look like is this, Mrs. Jones is coming to see her healthcare provider in earnest, you know four or six times a year. She has diabetes, hypertension, hypercholesterolemia and depression and she cannot get her A1C [*inaudible*] in target. We call the bundled benchmark and we look at national data, [*inaudible*] sadly 81% of those with diabetes in this country fail to achieve that benchmark. 81% of those with diabetes fail to achieve the ABC bundled benchmark. That is astonishing. It is really a reflection of the fact that as these authors say, to achieve the healthcare system required improved methods to improve adhere [*inaudible*] medications and treatment of physical activity, dietary choice and so on, access to support including motivation and maintenance of behavior change.

I ask in a seven to 15 minute visit every two to three months, how do we achieve this? How do we achieve this? Of course there are all kinds of ideas and plans and today what I am going to tell you about is a proven plan shown in dozens and dozens of clinical trials and in fact now up to 80 clinical trials that have shown proven the concept and proven it works and there are very exciting things that have happened in January just over a month ago where there is a new physician fee schedule with new reimbursement codes for this which I will talk about in the discussion and try to touch on it during the conversation as well.

The other thing you probably already know, if you look at individuals with diabetes as an example and look at those that also have untreated depression the cost or two or three times higher. That is great for CFO or for someone in the hospital who is worried about cost but for clinicians, and I am a clinician

for us we also want to worry about that because we cannot get traction with patients. Patients languish and we are struggling to get the outcomes we would like with patients with diabetes and don't forget individuals with diabetes 90% have at least one other chronic condition. So very quickly you have polychronic patients with multiple chronic conditions that are languishing and we are not doing them any services by using our old model of one patient one provider every two or three months for people with five or six chronic conditions on 15 medications and we will talk about that more in a moment.

I guess the only other thing I would say about that is depression, the prevalence of depression in people with diabetes is double what it is in people without diabetes and you can look at cross chronic conditions and see similar patterns. When we look at the epidemiological triangle and look at who we are focusing on it is not the generally healthy or the rising risk of pre-diabetics, we are looking at the complex chronic patients, individuals with multiple chronic conditions and what we now call upstream effects. Social determinants of health and those make up the top between 5% and 10% of patients and as we know the 550 rule which is 5% of patients that cost 50% of the healthcare dollar or 10% that costs two thirds of the healthcare dollar and not only is this important from a standpoint of understanding where resources are going but the better we can be at reducing cost and being more efficient the more money we have to address the rising risk and have preventative programs. These are national data I am showing you here that really just show you the map.

The solution I am going to talk about today is called collaborative care. This is an evidence-based program as you heard in the preamble and I have conducted clinical trials with teens at the University of Washington and around the country looking at utilizing this model not only in depression care but in people with hypertension and epilepsy and hyperlipidemia and hypercholesterolemia and diabetes. It is a team with a shared mission using improved clinical systems to deliver improved care to a patient population supported by operational and financial systems. Such care is continuously evaluated through improvement processes and effectiveness measurement.

Before I forget, I want to encourage you and I've given a link to Alliant Quality and they will have it up, there was a recent article in New England Journal of Medicine about the new billing codes for collaborative care for psychiatric care and it is about $140 per patient per month for the first month and $120 subsequently and it covers care management and psychiatrics oversight so keep that in mind. In the article you will also find reference number to that goes to the federal registry for the new physician fee schedule and these are G code, G0502 all the way to G0504. I will stop talking about it at this point but I encourage you to look into this that tells you what needs to be in place.

The way this works is if you think about the old model, the old model being the PCP the primary care provider and the patient and I jokingly called this so 1990s. Actually it is 1950s and 1920s. Really, we cannot continue to pretend we are treating people with multiple chronic conditions with very infrequent visits and without any support. We all know that I am sure this is not a surprise to any of you. Thankfully we have layered on care management and extended the care and now focusing on between healthcare visits, addressing patient needs where they are which is the right thing to do. What we have discovered in our 20 years of clinical trials however is there is one other component. That is called systematic case review and in this case what we're talking about is both psychiatric and medical case review. Now you are probably thinking my God there is no psychiatrist anywhere and this is going to be very expensive and what I will tell you right away the model actually just requires two hours per week for a whole caseload of patients of 50 patients of each of the psychiatric and medical case reviewers. Two hours per week and this can be done remotely and leveraging telemedicine and all

kinds of various new technologies to do this and what you essentially are doing is leveraging the use of those have care providers to review the caseload. It makes all the difference. It addresses the triple aim that are quality of care and access to care, increases and I'll show you evidence about the outcomes you achieve, and it reduces healthcare costs. We have evidence of that from our clinical trials and we should also talk about the quadruple aim which is it also improves the quality of caring, in other words for all of the burned out, demoralized healthcare providers and I wish it was not true but there are many reports as you know saying this is becoming untenable and we need to care for our healthcare providers as well. This system actually improves the quality of that experience of caring for these complex patients.

We published this a few years ago in New England Journal of Medicine, this is a collaborative care trial where we looked at people in nine different clinics in the Puget Sound area at group health cooperative and essentially what we found is with one care manager in this case a nurse care manager in the past we use social workers we were able to achieve the ABCD as outcomes. And we were able to significantly reduce each of those. Here is just a little more detail on that. The shaded column shows the effects of our program, compared to the right of the shaded column which is the meta-analyses in any one of those indicators like depression, just looking at depression or just looking at A1C or systolic blood pressure whereas we looked in our trial at all three of these at the same time and we were able to get comparable if not better results. The difference in depression care taking care of peoples medical issues, we had a .65 effect size. Effect size is difference between means divided by standard deviation and that is a very robust effect size. We were able to reduce LDL significantly and at the end of the day we saved $1100 in lower outpatient cost and did not report on inpatient cost and if we did in subsequent analyses it could be even higher if you had just imagined what inpatient cost and ED visits cost, but here we were looking at outpatient cost and the improvement there.

One of the mechanisms by which this works if we think about it is it helps to improve the adjustments we make, the titrations we make, in antidepressants or hypoglycemic insulin. I want to show you this is in the New England Journal paper we conducted and as you can see there is a significant improvement and this is the proportion of patients with one or more medical adjustments in 12 months and what you can see in the intervention, the blue bar was significantly better than control but I think the real message here is this was a great system of care in one of the best and still what we find is the antidepressants and people with major depression only 30% had an adjustment in their medications in 12 calendar months or people with A1C over 8 percent only 30% had an adjustment in their insulin.

In a subsequent program, and 17 or 24 weeks, and this case 17 and other examples were 24 weeks, not only were we able to improve A1C testing and reduce depression 74% amongst this population, but we were able to increase proportion of patients achieving HEDIS goals for A1C and blood pressure by 69 and 29 percent, respectively and without a transitional care program in place but just by virtue of the contact we were able to reduce emergency department visits by 50% and that alone more than payed for a program in a value-based system. Remember the billing codes I told you about earlier were fee-for-service so whether you are engaging in value-based care or even fee-for-service you can offset some of it with the fee-for-service and look up the details of that. Let’s quickly go over the components starting at 12 o'clock. We identify goals but not in the traditional way of identifying patient goals we also have our own goals and we are accountable to them on a weekly basis and we check them off and if we do not do them or fulfill those goals we do not enclose the loop and we have to report why not and there is documentation of that so that we are accountable and we have evidence based behavioral strategies like motivational interviewing, like problem solving treatment, like behavioral activation. You will be pleased when you look at the details of the behavioral health codes that all of those methods

are suggested in that kind of treatment. We monitor progress and it is treat-to-target and measurement-based care and we has systematic case review I told you it happens once a week where we review all cases and I will tell you more about that. The last thing I want to say about the components is the PCP is involved on a weekly basis. This is not a siloed program where the PCP finds out about recommendations in three months rather every week they are apprised of any recommendations, curbside suggestions based on most recent information and it only becomes an action step and only executed if the PCP agrees. That is the way we do it.

This is all vested within a framework where we use opportunity analytics, claims and EMR data to identify patients, enroll them -put them through the program and return them to regular care. This is not forever. This is to bring people back to usual care and once they have achieved their outcomes and may have gotten a better handle on their disease and their depression is treated and so on we can talk more in details. Just a schematic about the systematic case review if you can't see I will point you to the two red arrows and that is the key point. Data in data out. The data in is most recent values may be weekly PHQ-9 and of course every two or three months A1C and blood pressure possibly on a weekly basis and LDLs of course longer and GAD-7 could be weekly; point is we have data at hand and we have a systematic case review process. The top three people there are the core – psychiatric case reviewer, care managers, and PCP case reviewer and data out - that means one or three action steps convey to the PCP on a weekly basis. We will review 40 to 60 cases which is one or two hours and basically this is population management at its best, we utilized treat-to-target strategies. I want to show you this because this came from Fortney and colleagues where they looked at Medicaid examples, FQHCs, and they use practice-based versus telemedicine-based programs and what they found when they focused on depression using this collaborative care program is you actually got better outcomes, lower depression, quicker reductions in depression using a telemedicine-based system versus practice-based. And part of the reason we know this from working with many healthcare systems is there are so many competing demands and so many needs for what embedded care manager is doing in the clinics you cannot maintain the skillset and you cannot keep the focus on these highly comorbid patients as a way of getting these outcomes and following the model.

The last few slides then we will go to questions, we are addressing depression and comorbidities. The care managers learn about psycho-education, administering screens, screening for comorbid conditions in self-harm, reviewing and titrating meds and addressing side effects and evidence based behavioral strategies like problem-solving and behavioral activation and decisional balance and self-management and relapse prevention.

This is all part of what the care managers on the front lines do whether they are social workers and/or nurses and in this case with multiple chronic conditions we use nurses. So in summary we address depression and anxiety in a setting of comorbid medical conditions in another words also addressing the co-morbid medical conditions like blood pressure and cholesterol and diabetes. There's been such a focus on the what addressing gaps -- we have been identified and we have fancy pie charts but the question is how do we actually address those gaps? So really what this does is addresses the how to the analytics what and we cannot close gaps if we do not know how to do it and do it efficiently and cost-effectively. The other thing is we inadvertently continue to perpetuate silos of [*inaudible*] and behavioral health as though that was something that did not impact medical problems and we have to start addressing health behaviors and not behavioral health. This is where we need to go and this is a model that provides health behavior and focusing on behavioral activations and self-management support not only for depression but for chronic conditions and truly population health and we address patients based on opportunity analytics and not just indexing them to the time they are discharged.

That is a limited model and a wonderful model but let's look at patients in a whole cohort not just when they get discharged from a hospital or admitted. Again that is not wrong and we do that but we have to expand this beyond just that. The benefits are patients rapidly improve and reduced silos of care and use a bio-psycho-social approach, we include PCPs every step of the way. It is a built-in curbside consultation you get from psychiatry in internal medicine and maybe pharmacy and social work if you add those and it works. We have proved concepts over and over and over and we know it works so why don't we use something that has incredible evidence based and not only for treating depression and anxiety but also other medical conditions. I am going to stop there for questions. Thank you.

Thank you Dr. Ciechanowski. We do have one question for you but what is the health profession background of the care manager's for example to care manager's need to be a nurse?

Yes. Exactly, so that is a great question and I think one of the challenges always in implementing this is when you work in a system as opposed to in a clinical trial you have to go what are the realities of the system, what is the constellation of providers, and how do we ensure we get the quality outcomes, achieve the triple or quadruple aim given the circumstances we have. What we have learned is you can utilize various constellations of providers including nurses or pairing up with social workers or patient navigators and there are many different ways to do it as long as the fundamental core components are in place and you do not provide the model and have it cut corners. So in this model, in the clinical trials we use nurses but in many clinical trials before that we have used social workers and even bachelor level providers and there are all kinds of variations on the team.

Thank you very much for your presentation. A few closing words from Dr. Mims.

Thank you for joining us today. We have learned a wealth of information we can take today and make use of in our healthcare team. This will allow our patients to be safer and we can work better as a team. Feel free to contact me my information is here and if you have other questions about the programming or this Learning and Action Network. Please mark your calendar now for the upcoming presentation on March 16, 2017 at our usual time 12:30-1. Plan to join us next month.