

Theme 5: Intervention Research, Dissemination, and Implementation

Developing and Disseminating an Evidence-based Practice Model

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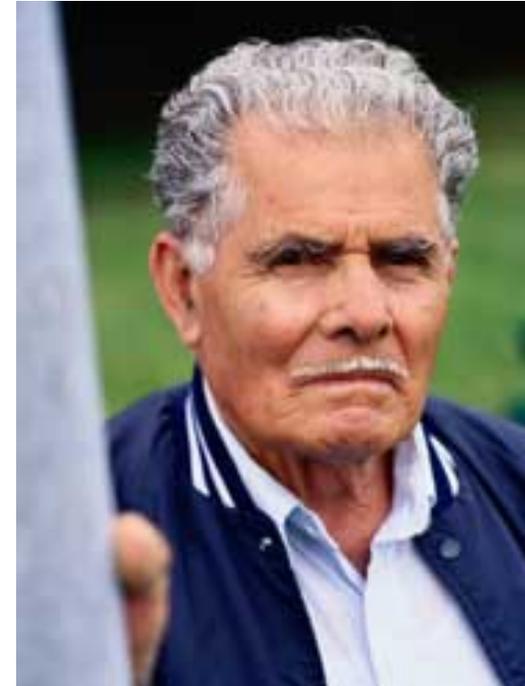
Jürgen Unützer, MD, MPH, MA: Disclosures

- Employment: University of Washington
 - Professor & Chair, School of Medicine; Dept. of Psychiatry and Behavioral Sciences
 - Adjunct Professor, School of Public Health: Depts. of Health Services and Global Health
- Grant funding
 - National Institute of Health
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 - Center for Medicare and Medicaid Innovation (CMMI)
 - Archstone Foundation
- Contracts
 - Community Health Plan of Washington, Public Health of Seattle & King County
- Advisor
 - Substance Abuse and Mental Health Administration (CMHS)
 - World Health Organization
- Royalties
 - Up To Date: Chapter on Late-Life Depression
- NO FINANCIAL RELATIONSHIPS THAT PRESENT A CONFLICT OF INTEREST FOR TODAY'S PRESENTATION



Major Depression in Late Life

- 5-10 % of patients seen in primary care
- Pervasive depressed mood / sadness
- Loss of interest / pleasure
 - Lack of energy, fatigue, poor sleep and appetite, physical slowing or agitation, poor concentration, *physical symptoms (aches and pains), irritability*, thoughts of guilt, and thoughts of suicide
- A miserable state that can last for months or even years



How Good is Current Depression Care?

- Fewer than **2/10** see a psychiatrist or psychologist
- **5/10** receive treatment in primary care
- The '2-minute mental health visit' : Ming Tai-Seale; JAGS 2008.
- 4-5 million older adults receive an antidepressant Rx, but only **20 % improve**
- Few get effective psychotherapy



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



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

2/3 of PCPs
report poor
access to
mental
health
services for
their
patients

How Do We Get Effective Treatment To More People?



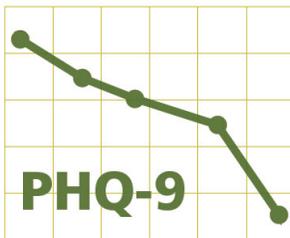


IMPACT Collaborative Care



Primary Care Practice

- Primary Care Physician
- Patient
- +
- Mental Health Care Manager
- Psychiatric Consultant



Outcome Measures

Problem Solving Treatment (PST)
Behavioral Activation (BA)
Motivational Interviewing (MI)
Medications

Treatment Protocols

[ACTIVE PATIENTS]						
Flags	[Patient ID]	[Name]	[Enrollment Date]	[Status]	[Initial Assessment Date]	[Pop. #]
	0001	Test, Test	2/8/2013	[Y]	8/24/2013	
	0008	Test, Suzy	4/2/2013	[Y]	5/21/2013	12
	0010	Test, Test	4/17/2012	[Y]	4/25/2013	18
	0035	Test, Rgp Reminder	1/10/2013	[Y]	1/10/2013	
	0038	Test Patient, Mhvec	1/23/2014	[Y]	1/23/2014	22
	0041	Test, Test	3/4/2014	[Y]	3/4/2014	
	0042	Test, Test	3/7/2014	[Y]	3/7/2014	

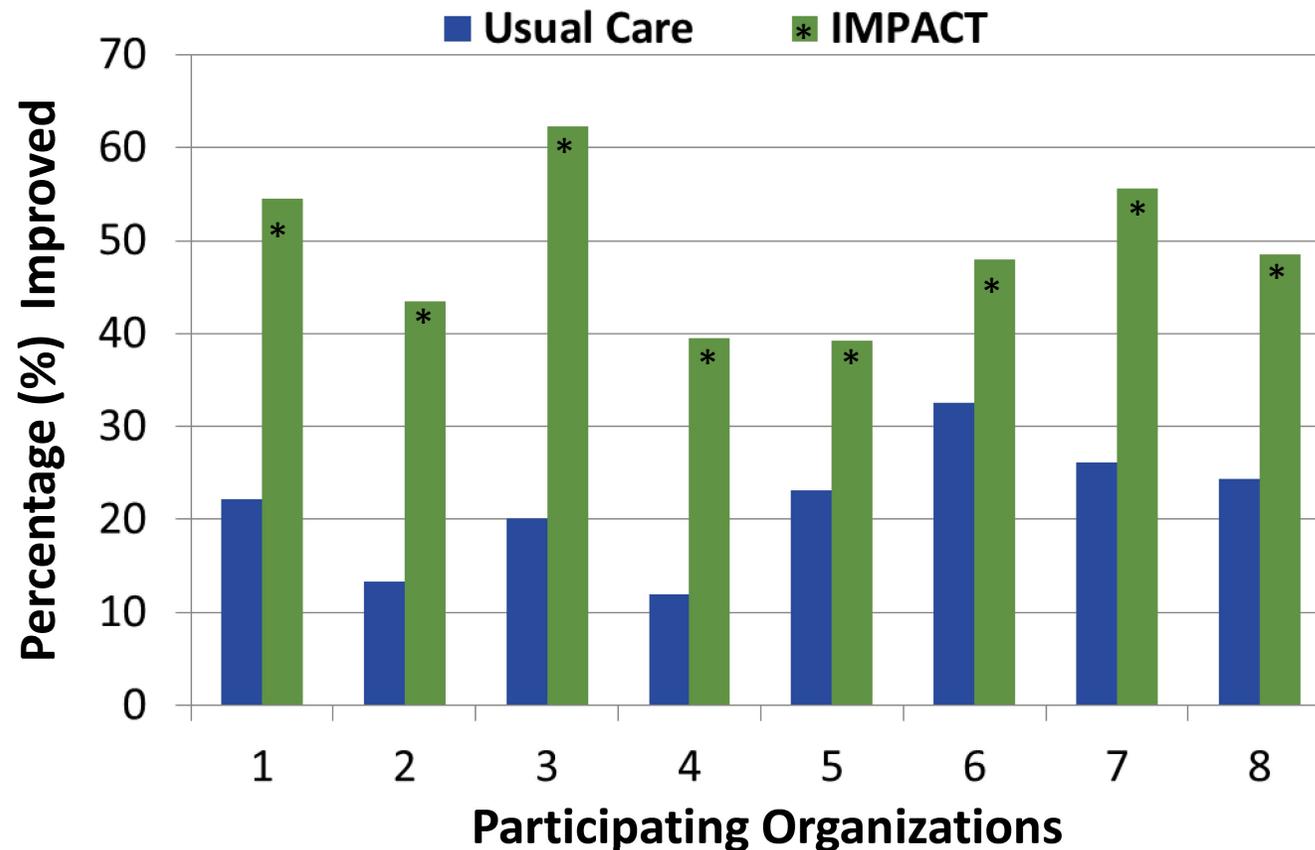
Population Registry



Psychiatric Consultation

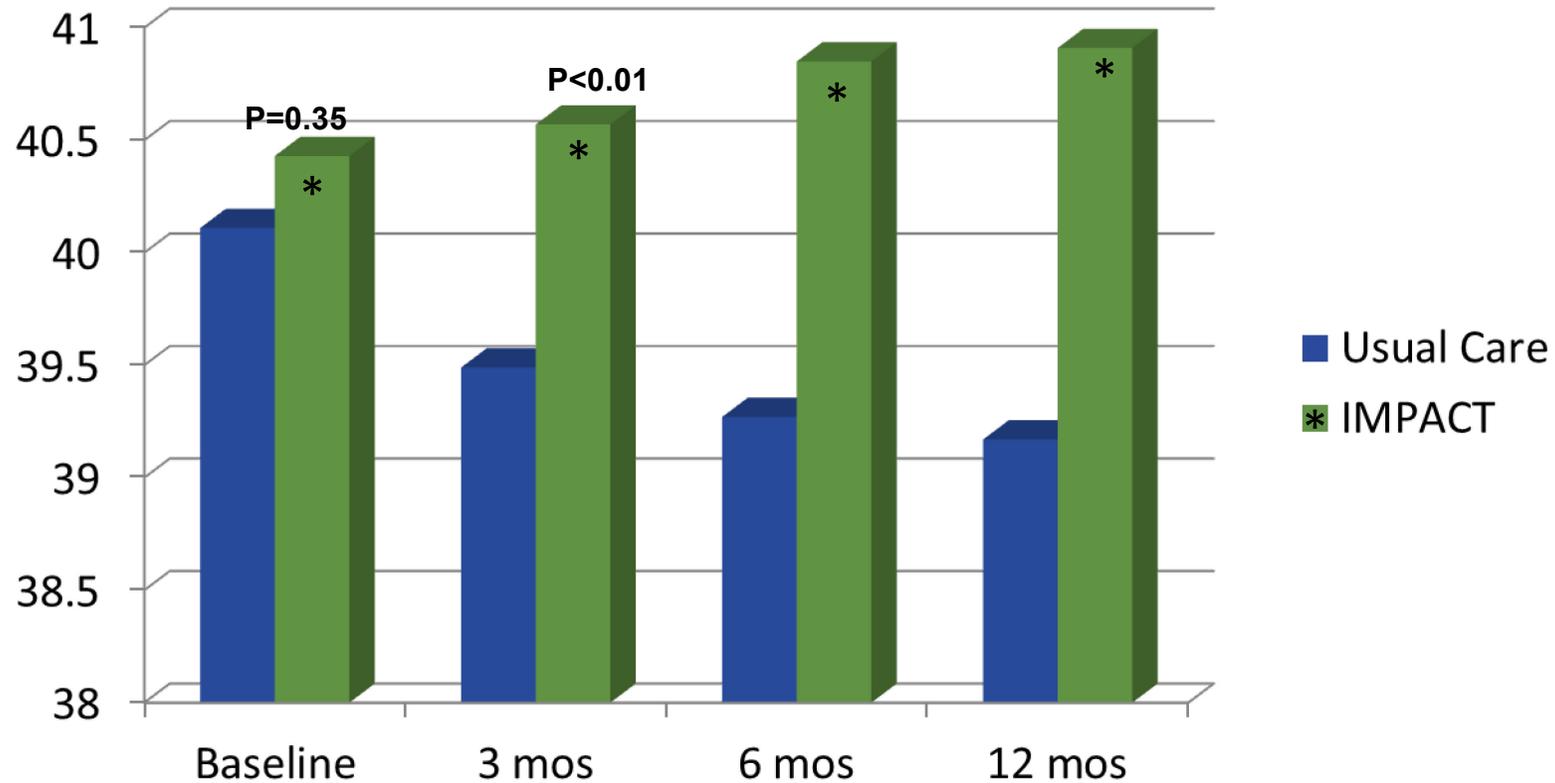
IMPACT Doubles Effectiveness of Care for Depression

50 % or greater improvement in depression at 12 months



IMPACT improves physical function

SF-12 Physical Function Component Summary Score (PCS-12)



Wall Street Journal, Sept 2013



ROI for collaborative depression care: \$ 6.50 for each \$ 1.00 spent

Unutzer et al, *Am J Managed Care*, 2008.

IMPACT: Summary

- **Less depression**
- **Less physical pain**
- **Better functioning**
- **Higher quality of life**
- **Greater patient and provider satisfaction**
- **More cost-effective**

THE QUADRUPLE AIM



“I got my life back”

AIMS CENTER
Advancing Integrated Mental Health Solutions

UNIVERSITY OF WASHINGTON, PSYCHIATRY & BEHAVIORAL SCIENCES
DIVISION OF INTEGRATED CARE & PUBLIC HEALTH

IMPACT

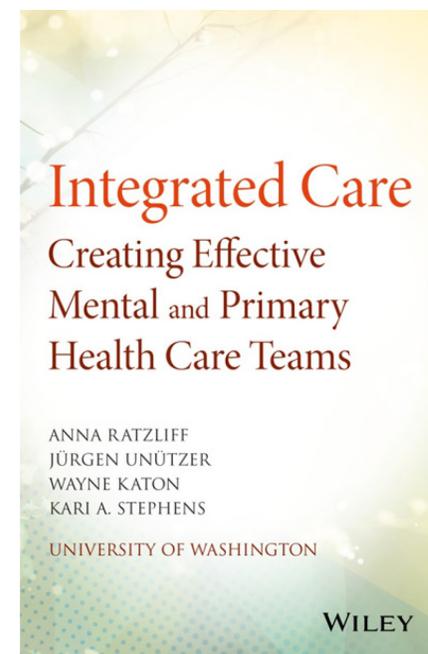
WHO WE ARE WHAT WE DO COLLABORATIVE CARE Search

QUICK LINKS
RESOURCE LIBRARY
IMPLEMENTATION GUIDE
AIMS CENTER NEWSLETTER

DANIEL'S STORY: AN INTRODUCTION TO COLLABORATIVE CARE

Daniel's Story: an Introduction to Collaborative Care
from Integrated Care & Public Health

07:25 HD vimeo



Trained > 5,000 clinicians in ~ 1,000 primary care clinics.

Medicare CPT Payment Summary 2018*

CPT	Description	Payment/Pt (Non-Facilities) Primary Care Settings	Payment/Pt (Fac) Hospitals and Facilities
99492	Initial psych care mgmt, 70 min/month - CoCM	\$161.28	\$90.36
99493	Subsequent psych care mgmt, 60 min/month - CoCM	\$128.88	\$81.72
99494	Initial/subsequent psych care mgmt, additional 30 min CoCM	\$66.60	\$43.56
99484	Care mgmt. services, min 20 min – General BHI Services	\$48.60	\$32.76

*Please note actual payment rates may vary. Check with your billing/finance department.

Older adults served 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 %



Over 3000 psychiatrists trained

TRAIN



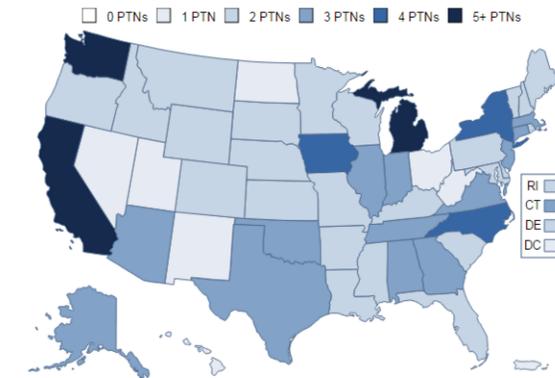
READY



CONNECT/ IMPLEMENT

Practice Transformation Networks

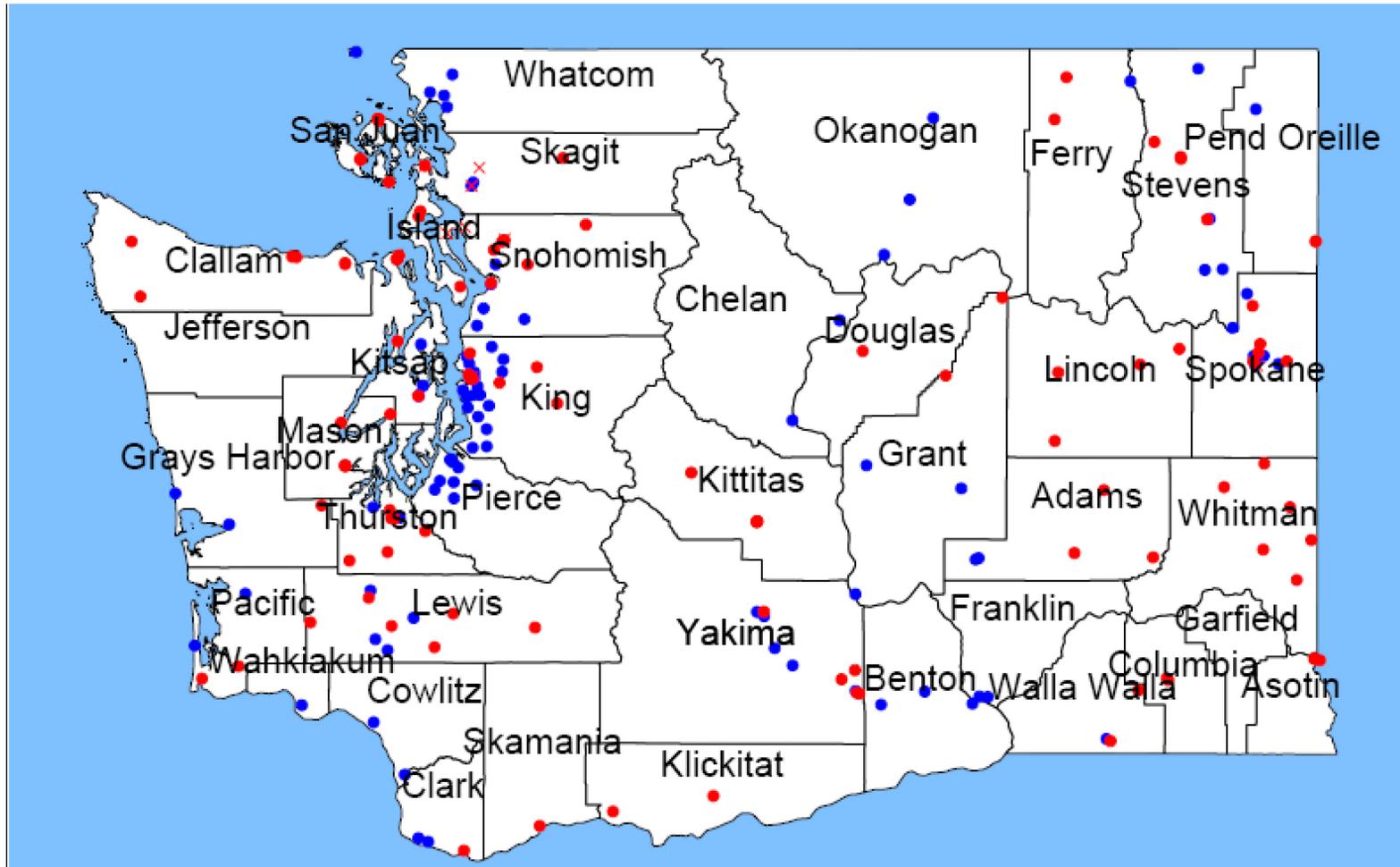
Select anywhere on the map below to view the interactive version



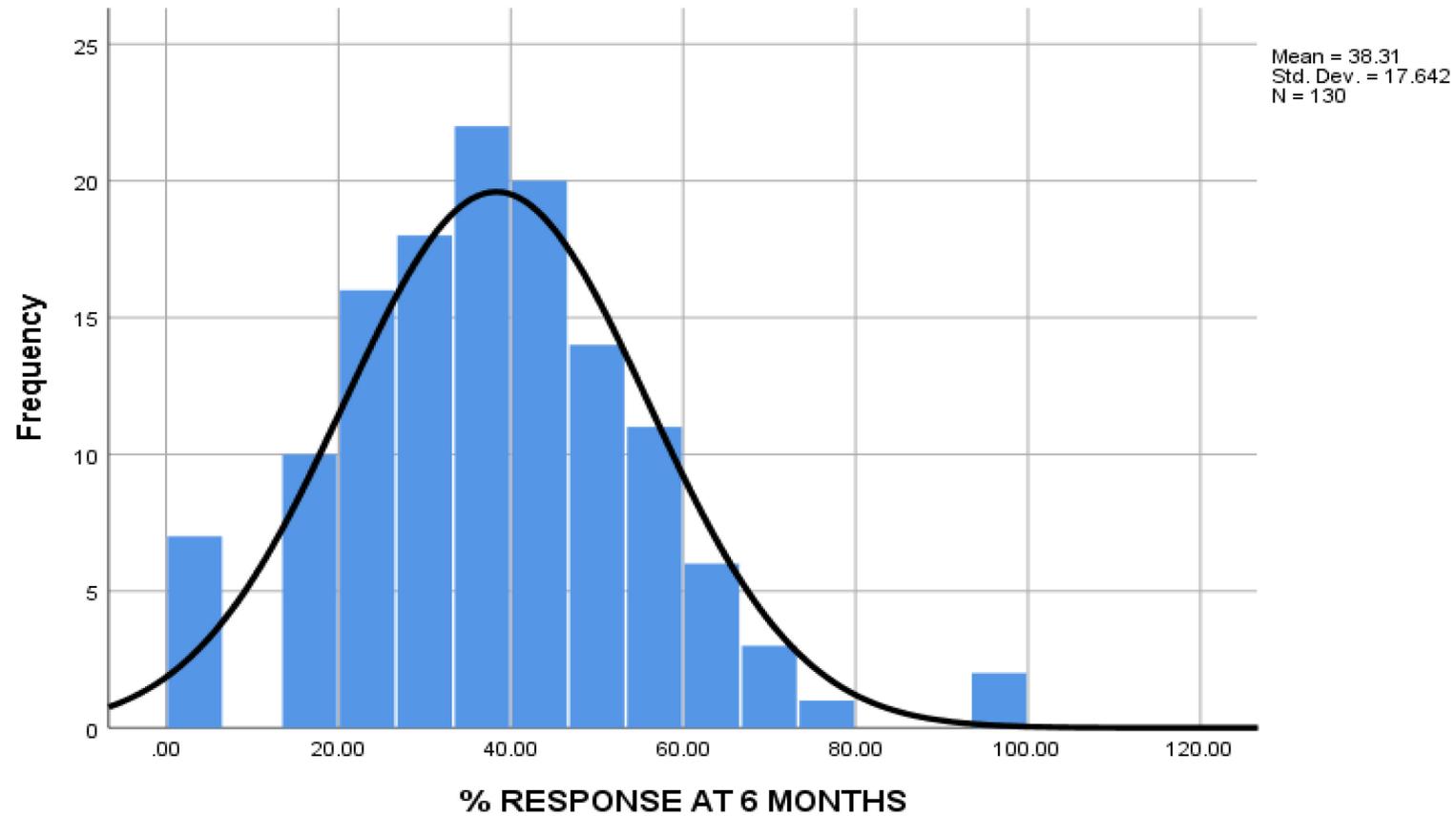
Source: Centers for Medicare & Medicaid Services

WA Mental Health Integration Program

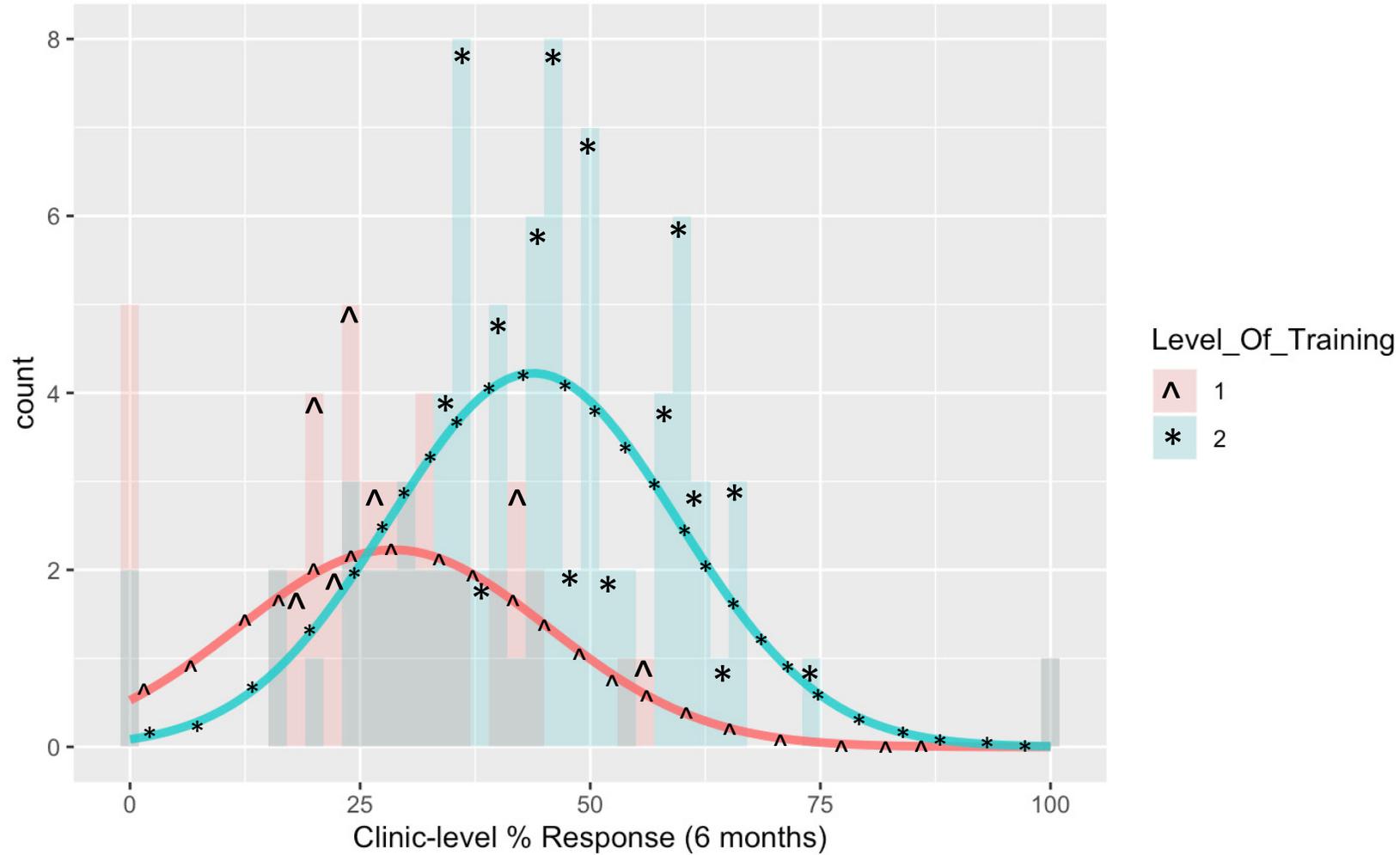
> 50,000 clients served



Clinic-level mean Response at 6-months

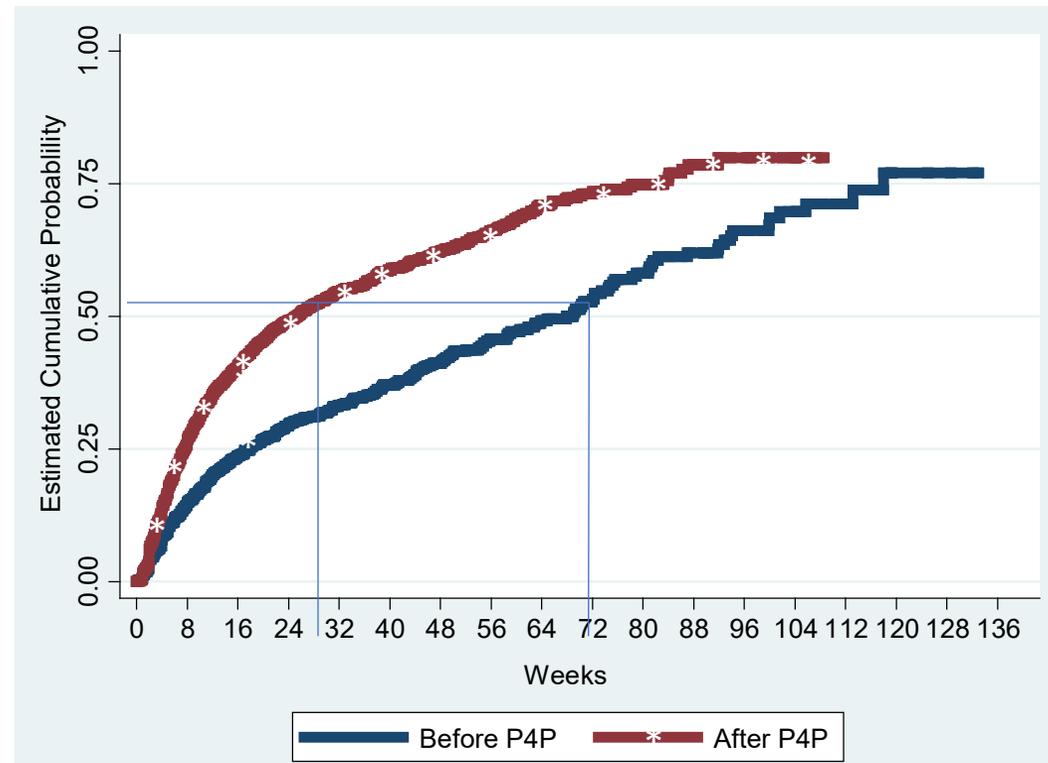


Role of Implementation Support



MHIP: Pay for Performance initiative

cuts median time to depression treatment response in half



Some Lessons

- There is not 'depression care system for older adults' ... only a 'health care system.'
- Research evidence is important but not sufficient for widespread dissemination.
- Money matters: if it can't make us \$, we can't do it.
- Are people asking for this? If not, why not?
- Implementation support matters.
- There are at least 'two valleys of death':
 - Evidence generation ... publication ... implementation.
 - New billing codes ... widespread use.

Thank you.

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Current challenges in implementation science, and implications for improving the care of persons living with dementia

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March 24-25, 2020

Disclosures

- Nothing to disclose

Implementation Science:

How do we put evidence
into practice?

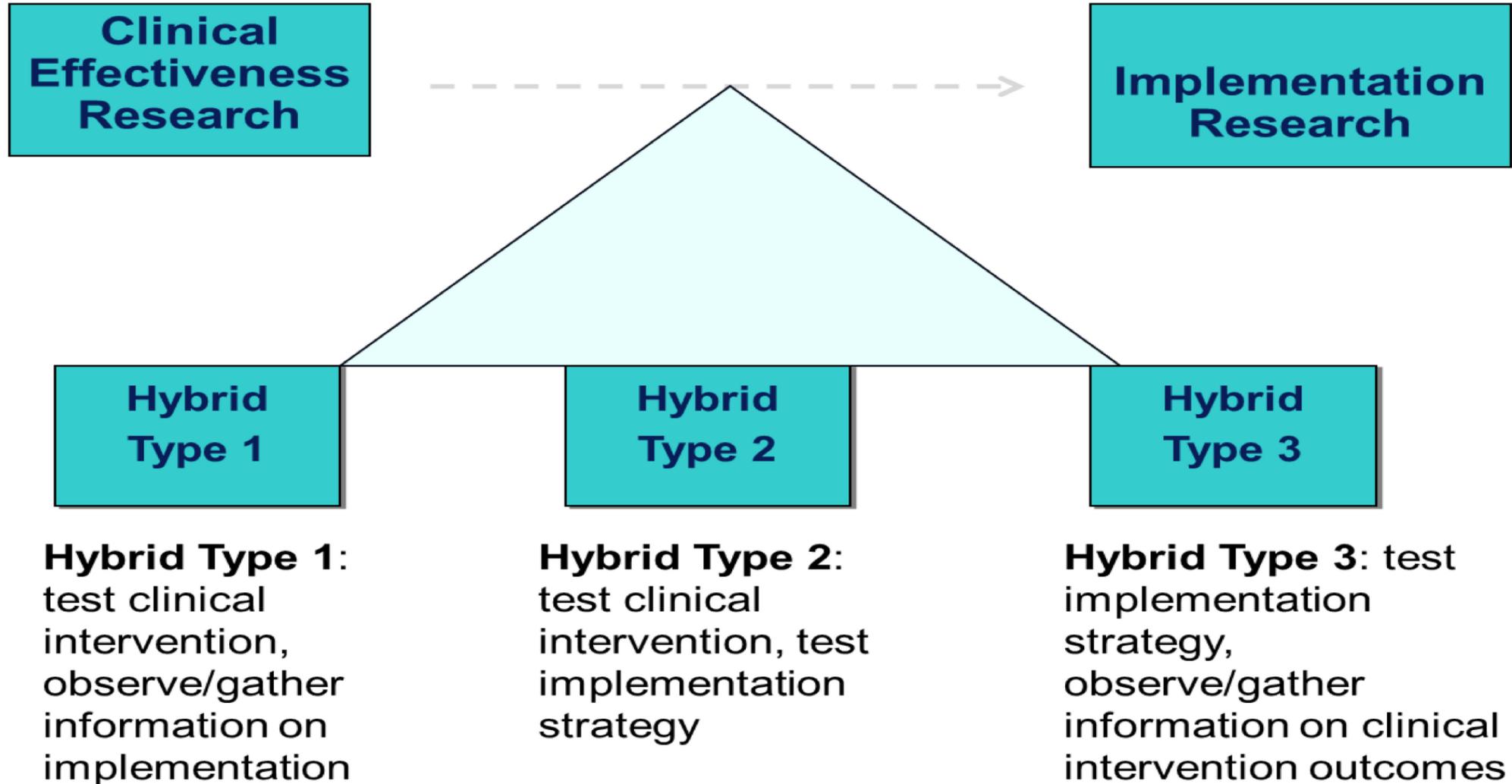
How do we incorporate
evidence into policy?

Our ability to put effective interventions into routine practice remains limited

- Limited evidence base
- Acceptance of services is limited
- Implementation occurs in widely varied contexts

How can we expand our ability
to successfully implement?

Hybrid study designs



Alternative Designs

- Stepped Wedge Designs

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Site 1	Facilitation						Stepdown													
Site 2	Waiting period				Facilitation						Stepdown									
Site 3	Waiting period				Waiting period				Facilitation						Stepdown					

- SMART Designs

- Develop adaptive implementation strategies

Replicating Effective Interventions

Pre-Conditions

Identification of need for new intervention

Identification of effective intervention that fits local settings

Packaging intervention for training and assessment

Pre-Implementation

Orientation

Explain core elements

Customize delivery

Logistics planning

Staff training

Technical assistance

Implementation

Ongoing support of and partnership with community organizations

Booster training

Process evaluation

Feedback and refinement of intervention package and training

Maintenance and Evolution

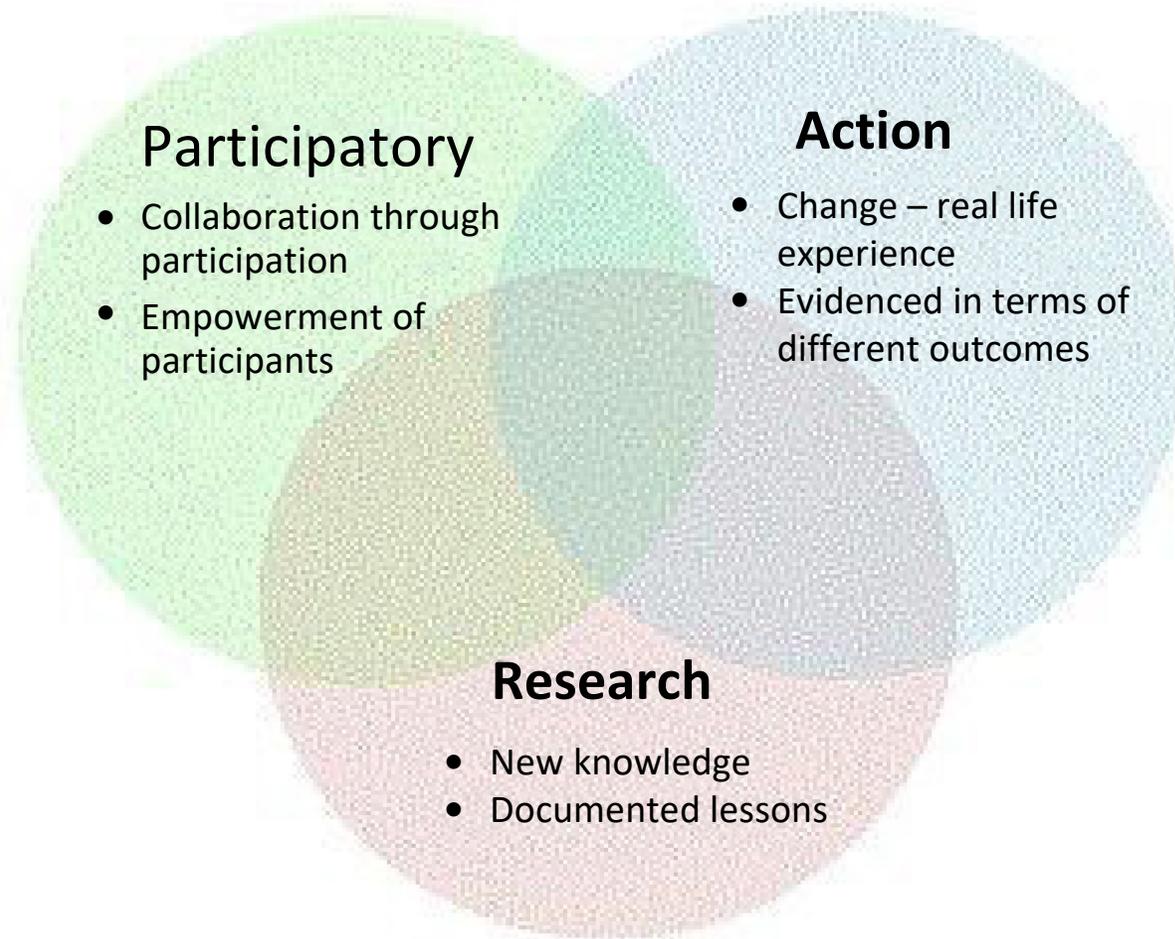
Organizational and financial changes to sustain intervention

Prepare package for national dissemination

Re-customize delivery as need arises

How can we more effectively
engage patients, caregivers,
clinicians?

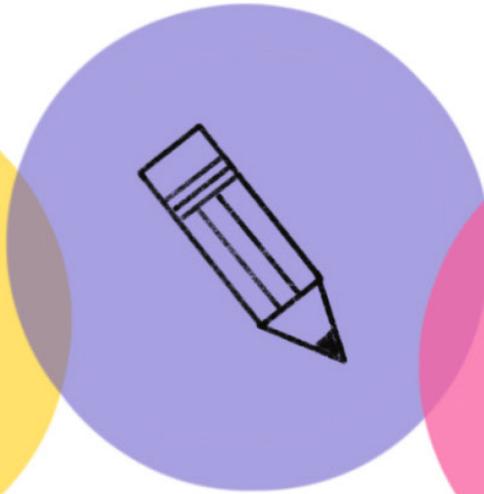
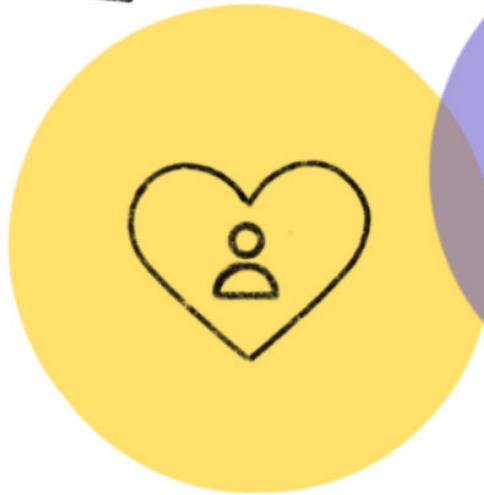
Participatory Approaches



Role of the Caregiver?

- Participant
- Informant
- Proxy
- Partner

EMPATHIZE
↓



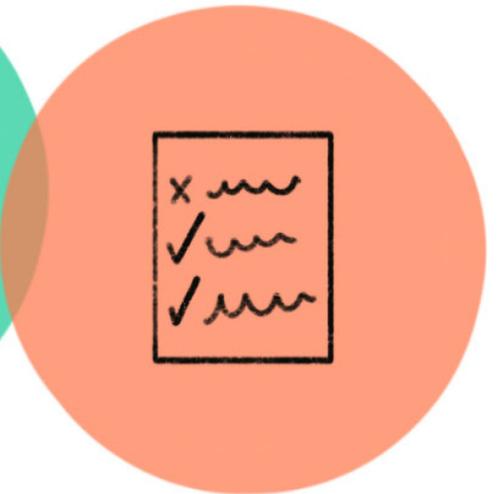
↑
DEFINE

IDEATE
↓



↑
PROTOTYPE

TEST
↓



How do we implement
across widely
different contexts?

What is the
minimum
required
intervention?

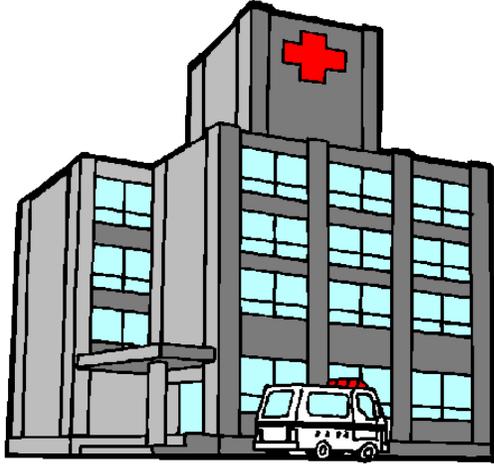


What are the
critical
contextual
factors?

*What are the
emergent interactions
between them?*



Resources



Processes



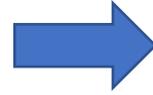
Relationships



Self-organization

Opportunities & Needs

Interplay between
intervention & context



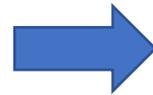
Adaptive interventions
to target microsystem

Partnerships with
patients & caregivers



Participatory, human-
centered approaches

Dynamic assessments
over time



Longer time horizons

Learning Health Systems

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Vice President, Kaiser Permanente Research

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March 24-25, 2020

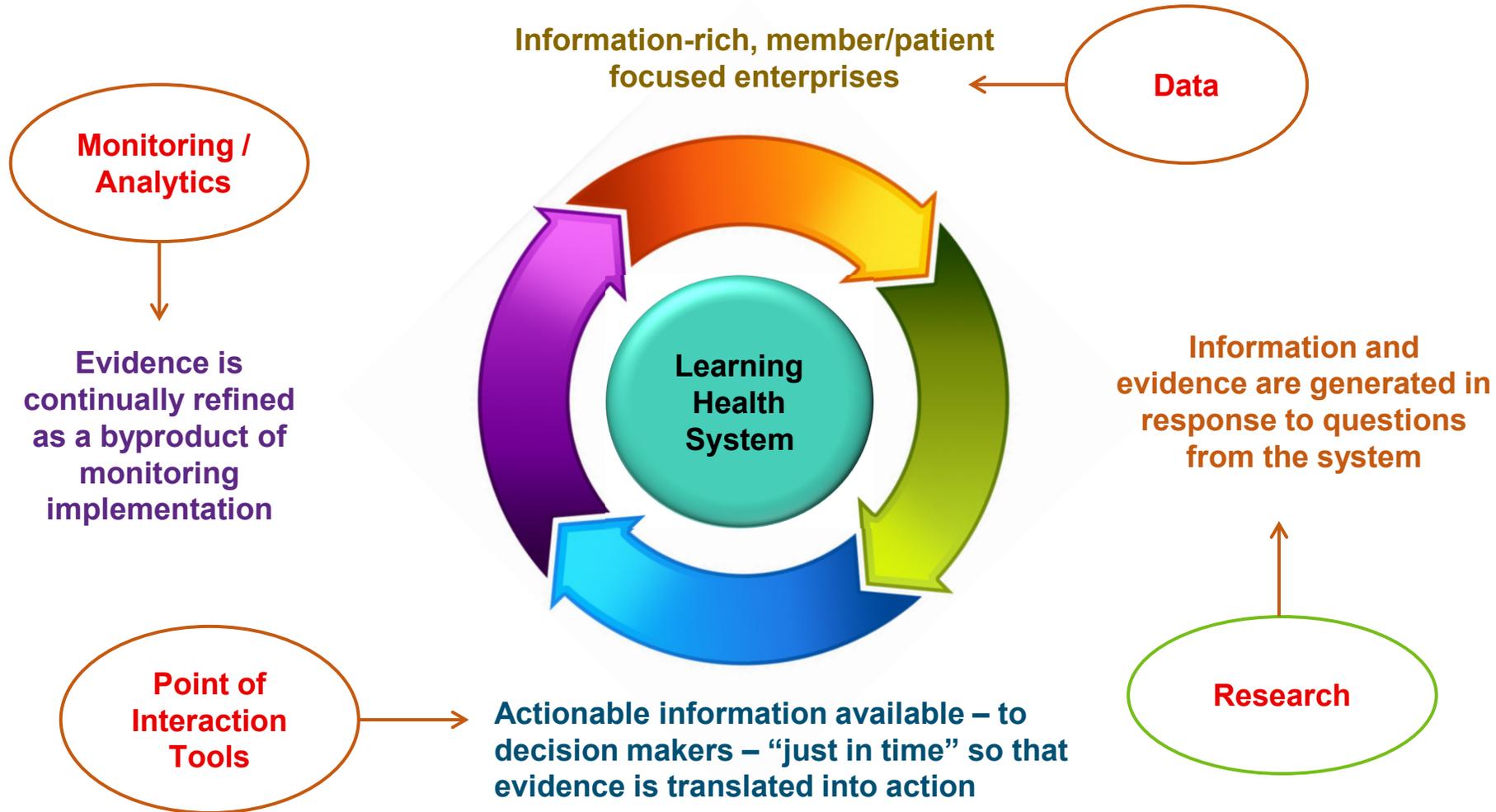
Disclosures

- I am on the Board of Trustees for the American Board of Internal Medicine Foundation
- My husband is the chair of the Providence TrinityCare Hospice Foundation Board

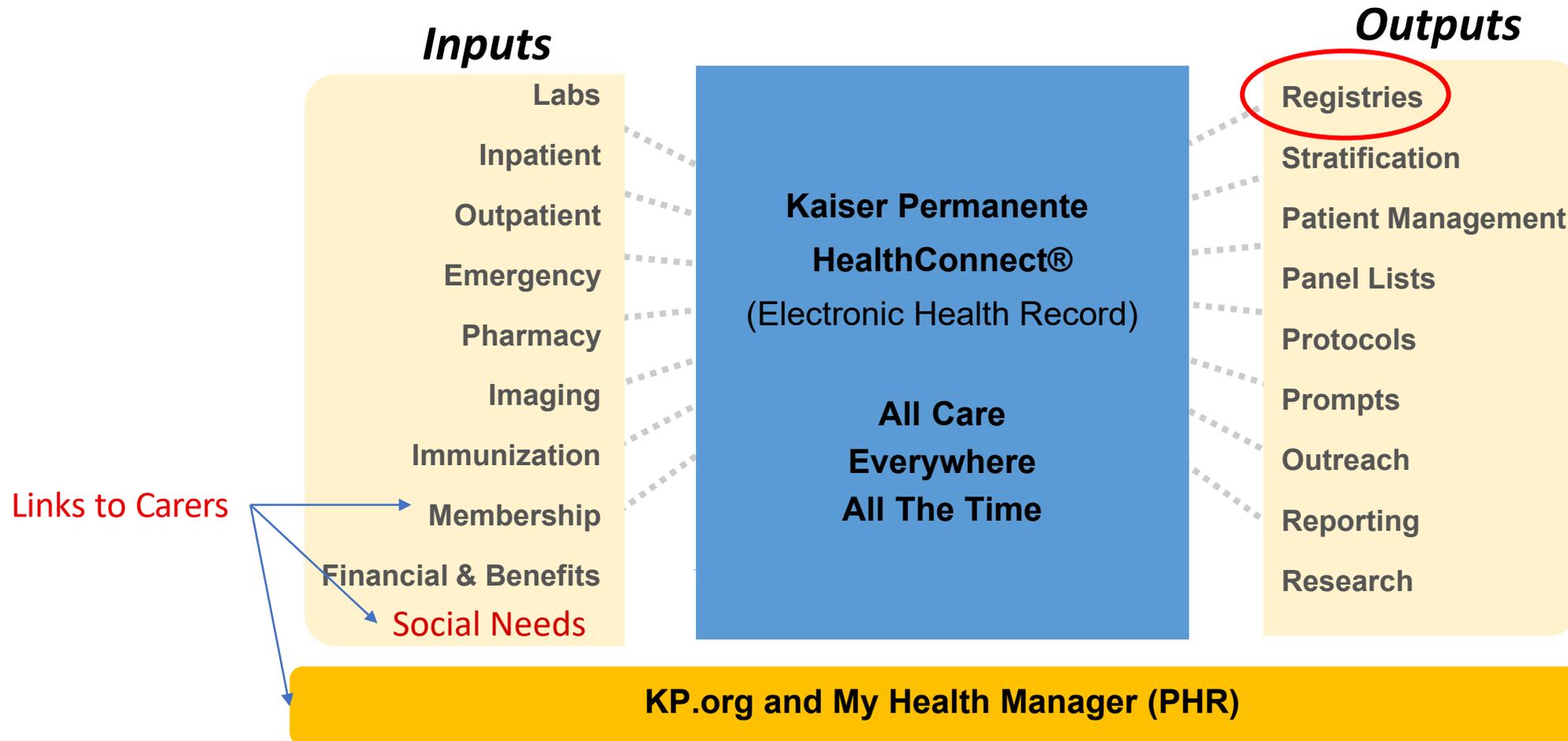
What is a Learning Health System?

- A system in which:
 - Science, informatics, incentives, and culture are aligned for continuous improvement and innovation
 - Best practices are seamlessly embedded in the delivery process
 - New knowledge is captured as an integral by-product of the delivery experience

A Learning Health System Model



In Most Learning Health Systems, the “Data” are From Multiple Sources, Heterogeneous & Require Curation to be Usable



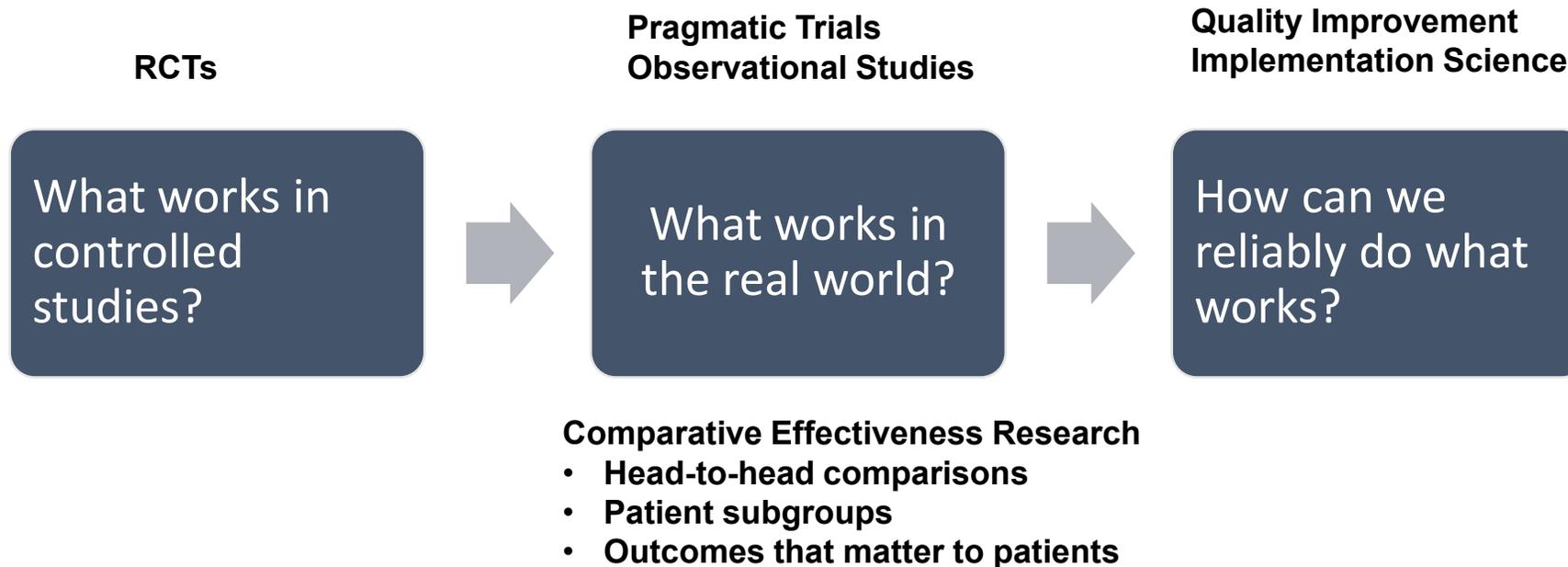
Data are Likely Available on Multiple Classic & Relevant Health Promotion Actions

- Educational attainment
- Hearing status
- Blood pressure control
- Blood sugar control
- Weight management
- Physical activity
- No smoking
- Depression diagnosis and treatment
- Social engagement

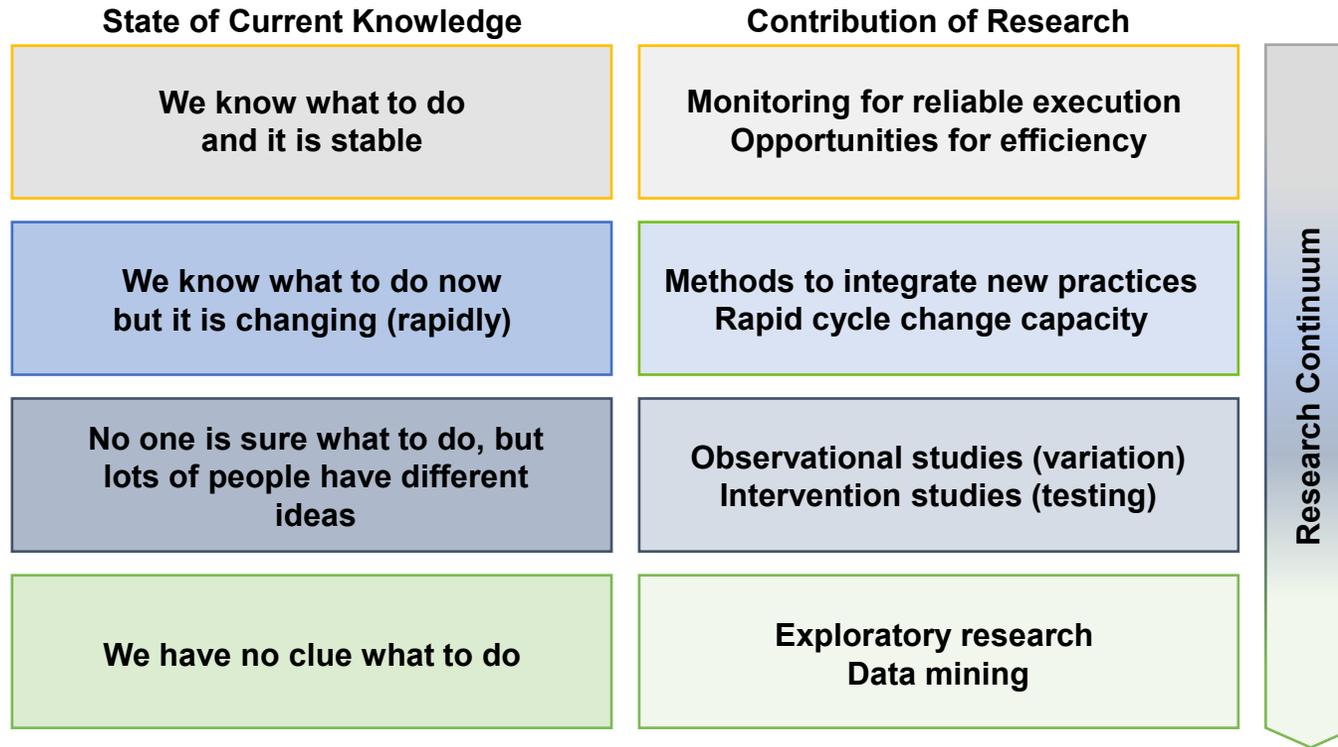
Learning Health System Opportunities Related to Data

- Create registries of patients (observation of natural course, learning from variation, rapid identification of those who would benefit from new treatment)
 - Much of our progress on quality for chronic diseases has leveraged registries
- Determine what data are needed for the questions of interest and figure out how to augment what is already being collection
 - Can include the need to standardize the collection and entry of data
- Take advantage of the growing interest in social needs among health systems to build out data on non-medical needs
 - Emerging tools being integrated in EHRs

Learning Health Systems Can Generate Different Types of Evidence



Research Quality Evidence Is Needed for Learning



Collaborate with Related Efforts (Thrive Local Example)

- Thrive Local is a Kaiser Permanente (KP) initiative to
 - improve the recognition of social risk factors such as housing instability, food insecurity, and lack of transportation
 - to refer those members to community organizations best able to help them address their needs for food and housing support, transportation services, energy assistance etc.
 - to "close the loop" by providing KP information about the resolution of those needs.
- Thrive Local has three main components
 - an accurate resource directory of community organizations that address social risk factors
 - a network of community organizations that can communicate with KP and each other about the complex needs of participating members
 - a secure IT system, managed by a vendor (Unite Us), to enable bidirectional communication between KP and the community network
- Thrive Local is being accompanied by an effort to standardize data collection, storage and reporting across KP regions using the social needs module in our HER
- KP invested its own funds to conduct an internal evaluation over the next 3-7 years augmented by targeted research and evaluation efforts

Point of Care Tools Make Information Available When It is Needed



- Integrated into work flows
 - Diagnosis (structured tools)
 - Needs assessment
 - Referrals (including for non-medical services)
- Puts the right (and same) information in front of anyone on the team
 - Make the right thing easy to do
- Can facilitate action through prompts
- Needs to be presented in a way that is easy to interpret, easy to use
- May offer a mechanism for driving scalability & sustainability

Ongoing Monitoring & Analytics

- Most of the interventions that seem promising are multi-component and complex (particularly if tailored to individual constellation of needs)
- Ongoing monitoring of how these models are implemented in different locations, what adjustments are made over time, what barriers are encountered is critical for understanding outcomes
 - Making changes systematically and intentionally will help with learning
- Dashboards, qualitative assessments, long term outcomes studies can all contribute to the ongoing assessment

Concluding Thoughts

- Learning health systems are a particularly valuable enterprise for advancing real world systems for delivering best in class care for persons with dementia and Alzheimer's
 - Two challenges are developing systematic approaches for engaging with non-medical systems and incorporating family- & carer-based perspectives on service delivery
- Systems of systems would be useful for learning but these have been difficult to implement for a variety of reasons (costs, flexibility, variations in priorities)
- Looking for opportunities to engage with related efforts (increased focus on social needs, attention to patients with medical and social complexity) may result in more scalable and sustainable solutions

Research Gaps and Opportunities

Malaz Boustani, MD, MPH

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Senior Vice President Medicaid & Complex Care and CEO of Social Health Bridge

Centene Corporation

March 24-25, 2020

Disclosures

Malaz Boustani:

Equity ownership in RestUp, LLC, and PHM, LLC

Paid Advisor in Eisai, Merck, and Acadia.

Michael Monson:

Research Gaps and Opportunities

- Identify contextual and structural features that would be needed to create learning laboratories to catalyze interaction, collaboration, and coordination of interdisciplinary teams and organizations to shorten the translation of innovation ADRD care services into widespread use
- Identify factors that create market demand and promote availability of evidence-based tools for the rapid implementation and diffusion of the collaborative ADRD care models within various payment models.
- Develop and evaluate tools, processes, and strategies to incorporate ADRD-focused intervention strategies into the current and future workflow of the busy primary care systems.

Research Gaps and Opportunities

- Develop and evaluate evidence-based tools, processes, and strategies for the most optimal integration of ADRD care services across healthcare delivery and community-based organizations in rural and urban settings.
- Leverage advances in health information technology and network science to develop tools, process and strategies to train, support, and involve family and other caregivers in the care of persons living with ADRD.
- Conduct research to develop and study mechanisms to financially compensate family and other unpaid caregivers of persons living with ADRD when they play essential roles in implementing the care plan of persons living with ADRD.
- Conduct research to understand the effects of strategies to financially compensate community-based organizations that have essential roles in the care of persons living with ADRD.

Research Gaps and Opportunities

- To study how principles of agile design, implementation, and diffusion that integrate science and engineering can promote dissemination of care innovations for persons living with ADRD.
- Develop and evaluate network science tools, processes, and strategies for disseminating evidence-based models of ADRD care in rural areas and within and between demographically diverse populations.
- Develop scalable, sustainable, and actionable ADRD interventions that payers and providers can use “off the shelf” in practice to improve quality, safety, and financial return on investment, with guidelines on how to implement the intervention, including key contextual factors.