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SIE Special Innovation Project Pacing Event

TENNILLE DANIELS: Good afternoon and welcome to today's special innovation projects quarterly pacing event. Before we get started, I wanted to go over a few housekeeping announcements. If you are listening to this call on your -- through your phone and viewing the slides on the platform, please make sure to mute your computer speakers to avoid any background noise. So, we're going to kick off today's pacing event by setting the stage and I would like to introduce Kevin Frazier, who is going to give us our opening remarks. Kevin?

KEVIN FRAZIER: Thank you so much, Tennille. Good afternoon, everyone. Thank you for joining us for today's third special innovations projects quality pacing event. We have another very exciting learning event planned for you today. Our featured improvement topic for this afternoon's event is based on behavioral health. Today we have the HQI-QIN and the Healthcentric Advisors QIN who will share the latest results of the behavioral health projects as part of our 2017 cohort. We are also extremely pleased to have Ms. Rebecca Chickey who is the director for the section for psychiatric and substance abuse services for the American Hospital Association. Rebecca will be serving in the role of reactor for today's pacing event. More formal introductions will be provided momentarily by Charisse Coulombe of our strategic innovation contractor. Before we turn the line over to our deputy group director, Jeneen Iwugo who will share some opening remarks, I would like to thank each of our invited event participant s for the wonderful collaboration with us on today's pacing event. With that being said at this time, I will turn the lines over to Jeneen to share some opening remarks from our leadership. Jeneen, over to you now.

JENEEN IWUGO: Thank you so much, Kevin. Welcome, everyone, to today's call. I'm excited to hear about a high priority for the agency and also a population that's extremely vulnerable and can definitely benefit from all of your innovation and intervention, patients with the behavioral health needs, very unique population, it's at high risk for both E.R. utilization and other co-morbidities, including substance abuse and a whole list of factors that you guys know more about than I do.

So, I'm really excited to hear about the work that's going to be shared today. And I want to thank you all for participating on the call and for your continued interest in expanding our work into areas of untapped innovation so that we can apply those principles and spread them nationally. So, with that, I'll turn it back to you, Kevin, thank you.

KEVIN FRAZIER: Thank you so much, Jeneen. So now I'll turn the line over to Charisse. Over to you.

CHARISSE COULOMBE: Thank you, Kevin. And as Kevin and Jeneen said, certainly behavioral health is a major focus, not just for hospitals, but for outpatient facilities as well. These special innovation projects as well as other projects, the QIN-QIOs are working on and they're looking at new and innovative ways to support the vulnerable populations. We certainly appreciate the support and commitment CMS has for this work as evidenced today by the pacing event.

As Kevin mentioned as part of the pacing event, we're pleased to have the subject matter expert reactor be Rebecca Chickey. She works in the section for psychiatric and substance abuse services. We're happy she's able to join us today. She has many, many years of experience interacting with the hospital, working with them to integrate behavioral health and the medical aspects in to primary care. And has spoken on this topic at many conferences and webinars. We're very pleased she could be able to join us today. So, I'll turn it over to Rebecca if you have any words of wisdom before we start into the project.

REBECCA CHICKEY: Charisse, thank you very much. First of all, it's an honor to be a part of this very important and very challenging work. I did want to say that I think both of these topics that we are going to learn from today are incredibly important because they both address treating the whole person. And just to set up a couple of statistics in your mind, 70% of adults with behavioral health disorders have a co-occurring physical health disorder, and almost 30% of adults with a physical health disorder have co-occurring behavioral health disorders.

So it's my honor today to listen and learn, to be a part of this initiative to identify what works and what doesn't, and to help to spread the -- the work that's due across the country because as a number of you have said, there's a vulnerable population, but it also goes to treating the whole person and too much of the work today and what others are doing on improving the health of communities and addressing population health.

So, with that, Charisse, I turn it back to you and I'm excited to listen and learn.

CHARISSE COULOMBE: Thank you, Rebecca. We certainly appreciate your words and look forward to your reaction today to our projects. So, with that, we'll go ahead and get right into the first project. I'd like to formally introduce Kathleen Calandra. She's the Rhode Island program director talking about implementing interventions in Rhode Island nursing homes to serve residents with behavioral health needs. Kathleen, the floor is yours.

KATHLEEN CALANDRA: Thank you. We appreciate the opportunity to tell you about our project today. So, the next slide right there. Thank you. So, as a result of our anti-psychotic reduction work, a look at the data in more detail revealed that some of the homes struggle with gradual dose reduction had high rates of residents under 65 with psychiatric diagnoses compared to state and national averages. You can see in these graphs, 12 of the homes who rose to the top. 8 of the 12 are above the national average in terms of percent of residents under 65, and 11 of 12 were above the national average for residents with a psychiatric diagnosis. Next slide, please?

We proposed that by increasing staff knowledge, providing them with strategies to manage behavior unique to this population, that there would be a direct impact on job satisfaction with less ER evaluation and unplanned readmissions. Next slide, please? Initiatives focus on separate trainings like professional staff, worker, social workers, administration, and paraprofessionals that include CNA, training staff, and others.

In the training stage, the two groups receive training separately. In a moment, I'll explain how they're brought back together. We partner with the substance use and mental health leadership council in Rhode Island to offer two four-hour in-person trainings during each year. The two-year program. The CEUs were available for nurses and social workers and CE for administrators and there's no limit on participants. Next slide, please?

Our other partner on our steering committee is Rhode Island college. Their institute for education and healthcare and collaboration with their department of psychology developed an evidence-based behavioral health skills curriculum in order to train direct care workers in concepts of behavioral health, and also to help them develop competencies to interact with and serve patients with behavioral health needs. This is a 30-hour course through which participants can earn college credit. Based on feedback obtained during the kickoff, we have been offering this over ten weeks, three hours per week, with an hour own conference space. Next slide, please?

Each of the ongoing development skills learned in training are the two other elements of the project. There's a provision of our team of onsite technical assistance with training faculty present tailored to the needs of the facility and the staff. And we had learning collaboratives, so we do bring -- this is where we bring the training cohorts together. So those of the professional staff and the paraprofessional staff. And in these, we discuss case studies. We further do some problem solving, and, again, both of these are with the -- with the trainers present to help facilitate these meetings.

Next slide, please? So, we're measuring effectiveness with preimposed assessments. These graphs demonstrate the increase in knowledge and confidence levels for the paraprofessional trainings thus far. The charts show the average scores for each question and each pace the average score is increased after the trainings were completed. The questions were combined to what you see here is a composite score in order to determine how many participants had increased knowledge and competence. Overall immediately following the training, 90% of participants had increased knowledge scores and 79% had increased confidence composite scores next slide, please?

These graphs demonstrate an increase in college and confidence for the professional training. Again, the charts demonstrate consistent increases in the average scores for each question after completing the trainings. When we combined the question to determine how many participants had increased knowledge and confidence, 80% had increased knowledge scores and 63% had increased confidence composite scores. We also plan to evaluate the impact of readmission patients in nursing homes with health diagnoses, but we're waiting for the quarter 2, 2018 data, the first cohort of training was in quarter 1 of 2018.

Next slide, please? Another measure includes the ability to deescalate negative behaviors. Three facilities had been collecting the information from the project. Here is our data from January through July of this year. The expectation is that the percent of behaviors positively impacted by staff will increase over time. What we saw there were 87 incidents reported, 70% of the behaviors were improved by staff, again, this is primary data collection, self-reported. The most common behaviors were verbal outbursts at 40%. Physically aggressive or violent behavior was 23%. And then anxiety came in at 14%.

And they were given a -- a legend, so to speak, to identify the behaviors. So, there is hopefully some consistency in how they're identifying this. Next slide, please?

So, we're measuring return on investment from the project based on ER utilization and hospital readmissions. Over the two years of the project, we are targeting a 10% relative improvement rate in both ER utilization and hospital readmissions among behavioral health residents in the participating nursing homes. We have not begun this. We will begin calculating ROI when we receive the reported to claims data in 2018. Next slide, please?

So, here's our question for consideration. Our PDSA cycle to date has been focused on increasing the participation, really, the attendance of the paraprofessional staff. As a result of the feedback from the champions and the actual participants and brainstorming among our own team and partners, we have done things such as modified the curriculum. We've offered classes at different times. We've offered a certificate for those who are at least able to attend five of the ten classes. The feedback from those in attendance is overwhelmingly positive. The post assessments of their knowledge and confidence levels demonstrate the impact of this program. However, despite enhanced communication, use of social media, we still struggle to overcome the reported barriers of nursing home staffing issues. And their ability to support staff who may want to attend these classes. So today we will -- we will ask if you have any other ideas on incentivizing the nursing homes and their staff. And we can talk about that in just a minute.

The last slide, please? So, an innovative idea did come out of this on our on-site collaborative at one of our nursing homes, we further continued to discuss some of their barriers. And the idea of a sensory cart came out of this. So, it is out of the scope of the project, so we are doing it as a separate pilot. It's an off-chute with their therapist and activities director. And we have variables coming to us going to be measuring some of the sensory cart materials on deescalating these behaviors. So, we're -- we're hopeful that this will also be something that we'll be able to share.

Okay, next slide? Questions and discussion.

REBECCA CHICKEY: This is Rebecca. Congratulations. What a fantastic job you have done.

I'll go first to just create a couple of ideas around your questions for consideration regarding attendance for paraprofessionals. And just wondering if it's -- if you think it might be beneficial to pair someone who has not been trained with someone who has been trained. So that they could share the benefits and help the non-trained individual understand how much more comfortable it has made them in working with individuals when they do start having verbal outbursts or physical outbursts. So just food for thought. A second idea might be to work with the nursing homes to somehow show case good case examples of workers who have been able to deescalate. I don't know if it would go -- if it would go as far as employee of the month or something like that, but something in that venue to really just external reward and recognition across their peers. I did have a couple of questions, really, things I'd like for you to extrapolate on if you could and if you don't mind. Loved the pre and post assessment results. For the paraprofessionals and for the professionals, you are making a difference. Could you share with us some of the questions either the paraprofessionals or the professional staff were asked to answer as part of the training?

KATHLEEN CALANDRA: Sure, thank you. I do have a copy of the -- oh, it would be this one? Yeah, okay. All right, yeah. We asked them -- obviously the questions are asked the same, pre and post. They're asked to identify and have a clear understanding of what behavioral health is, confident in my ability to care for a client with behavioral health disorder. I had a clear understanding of the different types of substance use disorders or substance-induced disorders. Confident in the ability to care for a client with a substance abuse disorder. Understand how mental and physical health are linked. You want me to go on? There are nine of these?

REBECCA CHICKEY: No, that gives me a really good idea. And if anyone else on the line is listening would like to learn the other questions, I'm sure they'll write in.

Interested as well on the impact that the program has made in terms of being able to deescalate the situations. It's quite striking. I wonder if you can share with us the interventions that the staff used to improve the behaviors. I'm thinking somewhere along the lines of mental health first aid. I don't know if that was part of the model that you used. But would be interested to learn more about the de-escalation techniques that they're implementing.

KATHLEEN CALANDRA: Sure. The paraprofessionals, their course is over 10 weeks. That's a very interactive course. Actually, just it's worth noting here, it morphed into what they requested over time is they wanted more actual activities, actual things they could do. They wanted to understand it, but they also wanted to tell them how to handle this. So, the curriculum now includes more role playing, strength-based promotions they're calling it. Our project lead actually attends these trainings. If you want more specific, she's also here to say something about that. But we have -- when we go on site for the follow-up meetings, we've done that with some of the nursing homes and we bring the faculty with us. They flush out even more. That's when the faculty are able to give them even more ideas about what they can do to remove them from the situation. They end up talking about drugs even though, you know, we're -- we're focused on gradual dose reductions, it comes up. The instructor gives them an idea of how to approach that with the position. It's all over the place, depends on the paraprofessional or the clinicians, the professionals.

REBECCA CHICKEY: That's helpful, thank you. Your return on investment really piqued my interest. I wonder if you can share with everyone else recent research that has shown the world health organization has released a study back in April of 2016. That they estimated it was a four-to-one return on investment in the United States for treating anxiety and depression. Much of that ROI came from improved health and ability to be productive at work. Another study around collaborative care management which is truly the integration of physical and behavioral health at the primary care setting had a 6-1 return on their investment. Finally, the American psychiatric association had a study that Millman did for them. And they said if they integrated care across the United States between physical and behavioral healthcare, and to your point, and I know to the next study, what you're doing is you're -- the way in which I see you integrating care is to have the staff see the full person. You're not just there for their age or their physical disabilities. You have to address the whole person.

The APA says that we could save somewhere between $26 billion and $48 billion annually in the United States. So that's just to inspire. You're building on the return on investments, but in a way to inspire.

Also, wondering, and I throw this out to the group, if there are others who may have ideas that could be -- can contribute to your return on investment? And one of the ones I thought about was have you had reduced sitter costs? Have the nursing homes had fewer instances of one-on-one sitter costs. Do you happen to know that?

KATHLEEN CALANDRA: I don't. That's a very interesting measure as well. We can probably discuss that with some of the more engaging nursing homes to see what they're finding.

REBECCA CHICKEY: It's been my honor to listen and learn from you. I'm definitely going to share your work, if I may, with my peer at the American Hospital Association who works with all of our cost acute care providers, let us know what's going on. And with that, Charisse, I've seen a number of questions come in on-line, I'm going to turn it back to you to facilitate those.

CHARISSE COULOMBE: Thanks, Rebecca. Thanks, Kathy. A great presentation as Rebecca said and certainly lots of interesting thoughts and questions. We just wanted to allow people if you're only listening via phone to ask a question so, Luke, if you could please provide the information to our listeners if they would like to ask a question via phone?

LUKE TERRY: If you would like to ask a question and you're connected via the phone line, press star and pound on the phone and you'll be placed into the queue to ask a question.

CHARISSE COULOMBE: Thanks, Luke. And while people are doing that, we're going to go to Jacqueline's questions. First, she had a comment about your question, Kathy, related to the other ideas about the paraprofessional. They were incentivized to have them become mid-level providers. So that could be one idea. Another question about defining when you measured the after training and -- or when they were measured and then how long after were they remeasured?

KATHLEEN CALANDRA: So, we do the -- we do the initial post measure right after the training. And then there's a three-month -- a three-month repeat of the measure. There's a couple of other measures too at the nursing home when he goes back and find out what the turnover has been, to see the people trained and if they're still there. Just kind of an indirect way to measure satisfaction with the job, I guess. But the actual pre, post, and three-month post are all the same test. It varies if it's the paraprofessional or a professional.

CHARISSE COULOMBE: Great, great. Thank you. The last question is have the training programs been implemented in nursing homes that are considered greenhouse projects?

KATHLEEN CALANDRA: Yes, actually, in Rhode Island, we do have one that did not rise to the top of the 12 that had the highest rates of under 65 to be able to help with the diagnoses. They are participating. They have professional and paraprofessional staff that have attended the training.

CHARISSE COULOMBE: Thank you.

One last question from Katie and then we go to the phones. Katie wanted to know if you saw a reduction of admissions to the emergency room with behavioral health patients from the nursing homes that were trained under this program?

KATHLEEN CALANDRA: So, we do have a baseline that's the -- that's where we're waiting for -- once we get our quarter 2, 2018 CMS claims data is what we'll have access to this -- trying to see if there's a difference. So that's one of our measures, you're right. We're still waiting for that data.

CHARISSE COULOMBE: Great. Great. Thank you. So, the Luke, I see we have a question in the queue on the phone if we could go to that, that would be wonderful.

JACQUELINE KREINIK: Since the phone was available, I thought I'd go here. What exactly, what other additional proof does the healthcare system need to know that addressing the behavioral health issues will, in fact, help not only physical outcomes but the staff turnover rate in nursing homes? In other words, there's been years and years and years of research and articles, publications, showing how addressing behavioral health has in fact impacted and improved outcome. So, I'm just wondering what needs to be proving, quote/unquote before more changes in behavioral health is implemented as a daily service provided by qualified professionals?

CHARISSE COULOMBE: Jesse or Rebecca? This question is to you.

KATHLEEN CALANDRA: Well, this is the Kathy. One thing we'll say is when we put together our proposal, there wasn't a -- there wasn't really anything that had been done like this in the nursing home environment. And the reason why obviously we were concerned is that at least in Rhode Island and it looks like across the country, it's not uncommon for these patients to be ending up in nursing homes because of lack of any other type of resource. It's the nursing homes that accept the patients who fill the beds. But they're not necessarily qualified. We saw a need and we're addressing at least that environment. Rebecca, you may have other ideas, input?

REBECCA CHICKEY: That's a very, very important question. I wish I had a quick solution or answer. Here are my thoughts. We still have huge stigma around individuals with psychiatric and substance abuse disorders. Not only towards those individuals, but even sometimes within the -- the medical professionals, different medical specialties. Saying, you know, come get your patients, these aren't my patients. Part of this at the core, I think, of this is stigma. And HA has been working very hard to share best practices that other organizations are doing. Two quick examples. Alina health systems, the CEO of that health system about a year ago sent out an e-mail to all ALINA employees and said we're going to work on reducing stigma around psychiatric and substance abuse disorders, not only so that we improve the care that we deliver to our patients and speak to them as individuals with disorders and illnesses, but also so that we can encourage our own employees, one out of every four, one out of every five. So, I think that type of work by key leadership is paramount to moving the needle on this. Because you're right, there are a number of studies that show it's financially important. The push towards value-based purchasing is going to contribute to this. So, and then the other example I would give, next time any of you are in the Boston airport, Logan airport, there's a hall here that's dedicated to bigger than life, the pictures of individuals living in recovery who received treatment at McClain hospital. It's a joint project between McClain and Logan and now the same type of project is popping up in other airports and universities around the country.

It'd work for treating the whole person and getting reimbursed around that. We need be that for better treating individuals. Part of that goes back to stigma.

JACQUELINE KREINIK: I tend to agree. Part of it may be breaking down what we mean by psychiatric and substance abuse. It stems from a growth and development expert, it doesn't -- people don't become addictive overnight. There’re years of behavior that's not being met or acknowledged and I agree with you. It's stigma. But I think the majority of the health professionals do not understand what disappointment means, what fear means, and how that development later on is seen or manifested through substance abuse disorders. So, I think partly it's going back to basics and how do you become dissatisfied. How does an individual become needing and craving some sort of both a physical and psychological support? Comfort food is -- I don't see a baseline understanding of how you become dependent personality or an addictive personality. Or what are you missing? I think that breaking it down would make it understandable that everyone in one part of our life does experience the grief, fear, maybe abuse. And it's just not -- it's not outlined there. Thank you for that. So, I would like to see some programs that map it out step-by-step.

REBECCA CHICKEY: I agree. We need to do more in our clinical training as well as where I see hope is where there's true collaborative care in primary care settings. Rather than just having the behavioral health technician down the hall where you're seeing primary care physicians because they are learning

from the behavioral health specialist in their setting. Becoming more aware of what you've just described. But we've got a lot of work to do.

JACQUELINE KREINIK: The last comment -- reading about Cornell in New York. What they've done now is the chief geriatrician there has invited elders to come and now there had to be a rotation to listen to the elder about what it's like growing older, not just physical problems like you see in the hospitals but talking to a healthy elder. Having someone who experienced grief, depression, and anxiety, to be able to talk to students in all fields might help to demystify and destigmatize to show its adaption to growth and development and challenges. So, I'll just stop there.

CHARISSE COULOMBE: Well, thank you, Jacqueline and Kate, Kathy, and Rebecca. Certainly a wonderful conversation. A lot more to work on. A lot more to come. Greatly appreciate it. So, we're going to move on to the next speaker if we can go to the next slide. That's Virginia Brooks. She's the Vice President of physician services. Her study is looking at reducing obesity by implementing intensive behavioral therapy in primary care practices in both Maryland and Virginia. Virginia, the floor is yours.

VIRGINIA BROOKS: Thank you for having us share our stuff with you today. It's 2017 we just completed year one. And it focuses on reducing obesity by implementing intensive behavioral therapy or IDT in primary care packages in both Maryland and Virginia.

So, we're going to start with a background. The wide spread issue of obesity. More than 30% when looking at ages of 65 to 74. And as we all know, multiple health conditions are either caused by or closely relate to obesity and it's very costly. We know that obesity in general is not an easy condition to improve upon, but in HQI, we're up for a challenge. We thought we'd take on implementing IBT. So, the service is reimbursed by Medicare and most commercial insurers with no deductible or a co-payment. So, for the patient, it's just their time. We looked at claims data and saw that few clinicians in our area billed for the service. It's an underutilized code. It has a rating of C -- (indiscernible) which means it's recommended. And, of course, it is an additional revenue stream for practices. Bringing about $24 for individual session and $12 per person per group session. It has to be performed by a primary care clinician, but it can be done by a med level or -- (indiscernible) the best practices at the mid-levels or others in shared decision making and operating with a license and the practices maximizing operations. It's about the evidence-based framework similarly to the tobacco cessation counseling with a focus on understanding and changing behaviors, setting goals, making and following a plan, and that means through serious patient engagement. So, next slide.

Originally the area with Virginia, contiguous with the eastern shore of Maryland, the coastal regions, and this county had higher rates of obesity. When I say that, 2015, average was 28.8%. Counties above that up to 42%. There's a similar picture in Virginia. So, we always -- (indiscernible) and now we're looking at all counties in Virginia and Maryland and that has obesity greater than 30%.

(Indiscernible) average. Tracking data metrics, practice, practice management and ASR systems, do they have to be savvy enough to run customer reports, emerge data, and the data benefit in the QIO tasks including cardiac diabetes and -- (indiscernible) communities. We asked other QIO members with high levels of engagement. We also looked at who we had a relationship with and -- (indiscernible) and calls with them to understand best practices and their challenges. As we implemented this project, we certainly encountered challenges. For example, implementation was taken a lot longer than was anticipated. We expected it would take a while to start, but, you know, leadership time at the practice

and many other things to keep the -- (indiscernible) the practice of understanding the priority and the delay. But this -- (indiscernible) despite having turnkey interventions, practices are -- (indiscernible) for a variety of reasons including clinician turnover, data issues, and it's a low priority.

Weight loss was slower than expected. Working with the results. Last, there's limitations on the types of providers that can go for IBT for the practice and willingness to participate. A collection of articles came out in December issue of JAMA discussing this and speaking to the -- (indiscernible) you may be in person and the individual session, that means the patient must come in every week for at least 13 minutes. So, for certain, people there are to be transportation issues, a parking charge, a wait as the clinician is running behind. The patient has to be motivated and believe in the outcome. Next slide.

Our approach is to give the complete curriculum for the service, including for the patient element but also for the counseling part. We also have data collection in the systems. But first, we need to run a BMI screening and follow-up measure and identify if they had the right process in place to take the BMI and the resources for the follow-up sessions, which includes for any and is out of normal range. We identify these patients by running the list of patients with the BMI of 30 or above, this is technically a custom report. Next, we developed patient marking materials that are endorsed by the internal feedback and we created the posters for the waiting rooms, poster card sizes for handouts to patients that fit the criteria and start the conversation while in the exam room. We approached the clinical staff to have the conversation starting with counseling and also created a number of different patient resources that are listed here. And we developed a patient satisfaction survey with practices to use for the patient throughout the process. Some patients were not coming back, and they wanted to help the practice identify why and make tweets to the -- tweaks to the survey. Lastly, the -- (indiscernible) for counseling. Consult with a practice to determine what assessment in terms of -- individual or a group, how to keep it on schedule, and we train them on interviewing and a binder for all elements. We also talked about how we can bill for the service, including what could or could not be billed. On how that differed. Next slide. I spoke with you regarding our challenges with patient and weight loss. But we are seeing some results. Basically, for this program, you can have one visit for week and miss one, and then for months 2 through 6, you go to one visit for two weeks. It shows you lost 6 1/2 pounds, you can have one visit per month. So, 22 visits for a 12-month period. In our model, we wanted our patients to be able to continue on, so our goal is for patients to lose the 6 1/2 pounds in six months and continue coverage for IDT. So, with that being said, this slide shows the results of one of our practice's most implemented groups counseling sessions in 2018. They were the first to implement and have the most results. So, group one represents seven percent with a 2.2% reduction in BMI. The goal was 5% reduction. Cohort two represents eight patients, a 1.2% reduction in BMI. With the pounds lost, some patients with no weight change, some lost 20 pounds, some have gained weight. Both of these cohorts have yet to finish the first six months. And with the first at the end of the month and the second only being in the third month of the session. So, the results of the patients from last week, we had six patients that continue to follow for IBT out of the 15 patients, which is 40% and our goal was 25%. So, we have some results, but they are certainly more work to do, because clearly 15 patients isn't going to cut it. So, I think it's important -- get and see what needs to be changed for the next cohort.

So, next slide? This is our investment calculations based on the research paper that found the higher the BMI, the bigger the medical cost savings. Researchers and reduction in BMI and reductions in medical expenditures starting the BMI from 30 to 45. They calculated that a 5% decrease in the BMI equals an annual savings of $500. So, the practices can achieve an average reduction of 5% in the 3,578, the

Medicare beneficiaries, the potential savings are up to 7.9 million annually. The beneficiaries with the BMI greater than 30, (indiscernible) and we've yet to achieve the 5% loss in our cohorts. (Indiscernible) and need to expand the practices, why we do this, and what benefits do we see? Next slide? So, for the questions for consideration, I'd love your thoughts on how to spread our success more rapidly, how do you have provision practices to offer a new service. What makes them have the aha moment that puts them to the top of the list. Given the parameters that you can build, are there other clinicians or stakeholders that we should reach out to? And finally, are there special challenges for adults we should address? For example, older people who live alone don't cook for themselves and we created a guide to fast food eating or prepared meals. Or taking medications makes it harder to lose weight? Hypermobility issues may make it hard to exercise. That's all I have for you and I welcome your thoughts.

REBECCA CHICKEY: Well, congratulations. This is Rebecca. Congratulations. You have taken on a really tough challenge, but one that definitely needs to be addressed. I wanted to first speak to your questions that you raised.

In terms of I'm not sure I have a solution around your question of how you encourage physician practices to offer you services, unless that's colocation and collaborative care. It's really truly embedding staff to help a system. Or perhaps being able to do so through some sort of telehealth platform. I'm not sure if you have the funding for that or the resources for that, but it might be worth discussing and considering and I encourage others to weigh in as well. The question around given the parameters of who can bill, I'm not a billing expert by any means, but wondering if there's an opportunity there, you mentioned that in part, federally qualified health centers, I wonder if you have worked with community mental health centers. Is that something that might be an option?

VIRGINIA BROOKS: Sorry. So, we have not worked with those. The regulations say that you have to be a primary care provider, so we can explore that in terms of, you know, what the max is in our area. If they would approve this claim. But on the surface, I would say no because they're not going to be considered primary care providers. And the other thing is I wanted to back up, looking at -- we can't do telehealth and even if our providers that we're working with are in our area have that functionality, they can't bill for it to be a telehealth visit. That's something that a number of people have expressed interest in that and feel like it could make it significantly more successful if they could do a quick telehealth visit versus having this. Great ideas, the coverage just isn't there for it yet.

REBECCA CHICKEY: Got it. One other note and then perhaps we can do this offline, there are some health centers now that are sort of a blend of federally qualified health center and a community mental health center. CMHCs on steroids. They do have primary care physicians on their settings. If I can identify if those are in your service area that might -- that might open up a lead.

VIRGINIA BROOKS: That would be great, thank you.

REBECCA CHICKEY: Definitely. And then, are there special challenges to weight loss to older adults that we should address? Perhaps you said this, and if I missed it, I apologized. But I'm wondering if you ever organized sort of group settings. You were beginning to -- I think you got at that when you were talking about individuals who live alone, who are isolated, often their meals may not be the healthiest. But wondering if that's something for these individuals, seven or 14 or however many are left in a group to support each other somehow. And I'm wondering if meals on wheels might be something particularly for those individuals who are living alone, perhaps they can be a special link there. And then I was thinking

as well and please don't tell my mother-in-law I said this. She participates -- she's not obese. But she participates through the Silver Sneakers Program through her Medicare Advantage Plan. So, I don't know if there's any exercise component to that that could perhaps be taken advantage of.

VIRGINIA BROOKS: Yeah, those are great suggestions. So, we definitely -- you can do an individual or a group session and we promote to group studies. It can't be done in that environment, but the two cohorts that we showed on our results slide do come from group sessions and we participated in those sessions. And even the camaraderie and the spirit of that is really help bind those people together, it makes them feel less alone. So, I definitely support that. And I think that's the best option. And we have created a community resource list for all of the practices. There are communities that have examples like meals on wheels or silver sneakers or other meet up and walk-type situations that people can ban together. But I appreciate this thought because I think there is more to think about.

REBECCA CHICKEY: This is a tough, tough issue. One I'm so glad you're trying to tackle. I just want to throw out one more idea or thought, when you're looking at the return on investment, I don't know how we would get at this, or how you might get at this. But some of those individuals who may not have lost as much weight and they maintained, how could you measure the fact that -- the reality that in many cases they might have gained weight. Have they not been in this program? That's a difficult thing to get at. It tries to measure something in a's absent. It's realistic. Is there some way to capture that? Mull it over? I think you could lend it in to the ROI.

Charisse, I see we have questions coming in online. Would you like to take it from here?

CHARISSE COULOMBE: Sure. So, Jacqueline said this is a great presentation focusing on the weight loss and having the patients identify their motivation. And she provided a link to a video that helps explain how addressing weight loss addresses multiple health parameters. I think you get back to your thought, Rebecca, in looking at the whole person. Overeaters anonymous, Kim says, also a great resource for support and connection. And Kathy says exercise was a key component and even the clinical weight loss centers have identified the need for addressing the psychiatric component in order for patients to be successful. But there's a common element and certainly very thankful that this project is looking to address this.

VIRGINIA BROOKS: Thank you for the resources.

CHARISSE COULOMBE: Yeah. Absolutely. Luke, can you remind people if they want to call in over the phone how they can do that? I know we're getting a little short on time. But I just Want bed to offer that option.

LUKE TERRY: Once again, ladies and gentlemen, if you do have a question you want to ask over the phone, you can do so by pressing star and pound on your phone key pad.

VIRGINIA BROOKS: Well, thank you.

REBECCA CHICKEY: This is Rebecca again, just very quickly. And perhaps everyone on the line is already familiar with this. But I did not know what the five A's were. So, thanks to Google and Wikipedia, I'll just share with the rest of us. It is because she mentioned the five A's for obesity counseling, it is ask, assess, advise, agree, and assist. So, I thought that was a great framework to think about this work in.

CHARISSE COULOMBE: Great, thank you, Rebecca. I think there's a next slide? So, we have -- we have a lot of requests and offers that came in today throughout the chat. So, I just wanted to thank everyone for that. That's certainly one of the frameworks that we have working with CMS. If there are any other requests or offers that you would like to make, please add them to the chat box so we can capture them as part of this pacing event. And with that, I'm going to turn it back over to Kevin to wrap us up.

KEVIN FRAZIER: Thank you so much, Charisse. The only thing I can say is wow, what a great pacing event. I'm pleased to see the level of knowledge sharing that occurred this afternoon. It's just wonderful. Thank you. Thanks also everyone for all of the great work on today's call. Kathleen, Virginia, very powerful and informative presentations. Thanks so much for that. I would also like to extend a very special thanks to Rebecca for her great work serving as reactor today. Rebecca, I think your reactions were extremely thought provoking as well as inspiring. So, thank you so much for doing this for us. Thanks, also, to all of the attendees for taking time out of your busy schedules today to join us on today's call. Thanks for all of the great questions. And comments and offers that were raised during the course of today's event. This is great. Our next pacing event will be held in January of 2019. So, please continue to have a nice productive day and that concludes our pacing event for today. So, good-bye for now. Signing out. Thank you.