Together 2 Goal®

AMGA Foundation
National Diabetes Campaign

Monthly Campaign Webinar

May 16, 2019

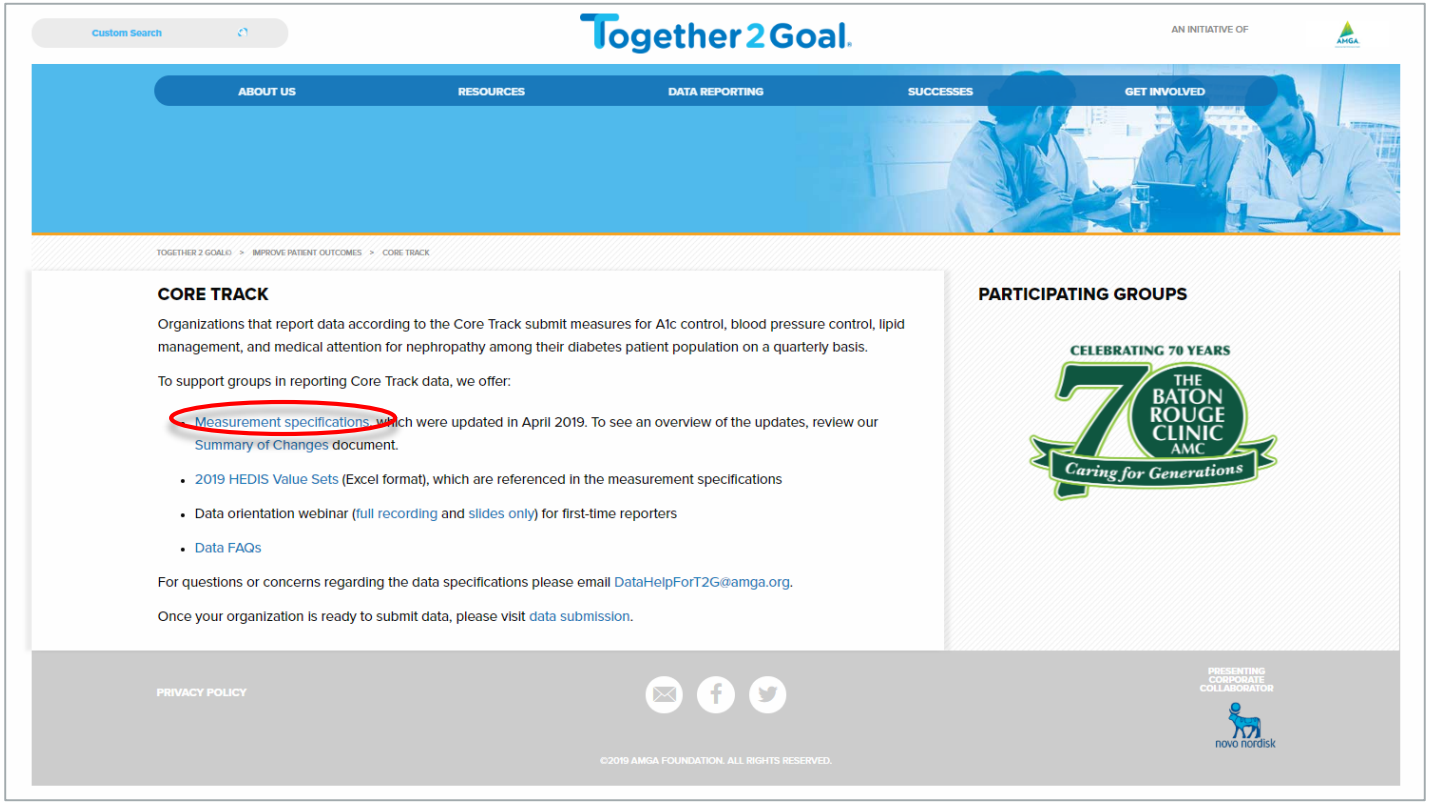
Today's Webinar

- Together 2 Goal® Updates
  - Updated Data Specifications
  - Webinar Reminders
  - Webinars at Work
- Mental Health Integration and Diabetes Management
  - Brenda Reiss-Brennan, Ph.D., APRN of Intermountain Healthcare
  - Mark Greenwood, M.D. of Intermountain Healthcare
- Questions

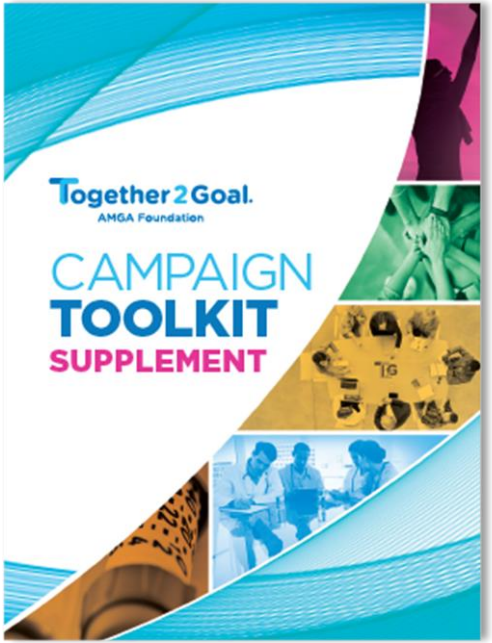
Webinar Reminders

- Webinar will be recorded today and available the week of May 20th
  - www.Together2Goal.org
- Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen

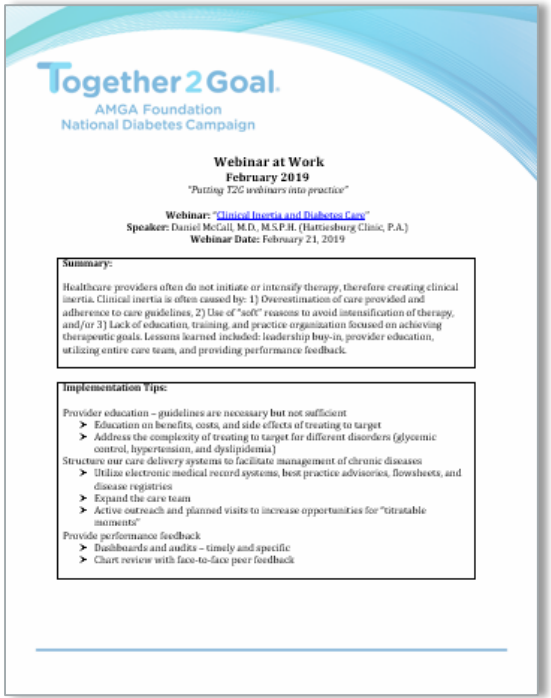
Updated Data Specifications



New Offering: Toolkit Supplement



“Webinars at Work”



Together 2 Goal.
AMGA Foundation
National Diabetes Campaign

Webinar at Work
February 2019
"Putting T2G webinars into practice"

Webinar: "Clinical Inertia and Diabetes Care"
Speaker: Daniel McCall, M.D., M.S.P.H. (Hattiesburg Clinic, P.A.)
Webinar Date: February 21, 2019

Summary:

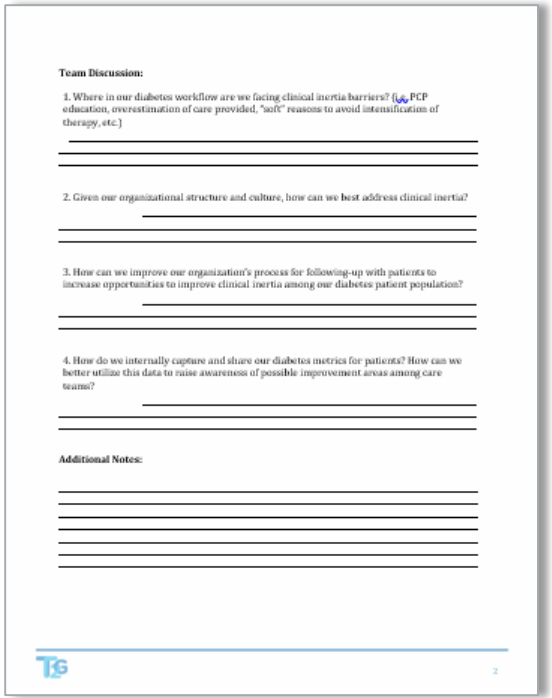
Healthcare providers often do not initiate or intensify therapy, therefore creating clinical inertia. Clinical inertia is often caused by: 1) Overestimation of care provided and adherence to care guidelines, 2) Use of "soft" reasons to avoid intensification of therapy, and/or 3) Lack of education, training, and practice organization focused on achieving therapeutic goals. Lessons learned included: leadership buy-in, provider education, utilizing entire care team, and providing performance feedback.

Implementation Tips:

Provider education – guidelines are necessary but not sufficient
- Education on benefits, costs, and side effects of treating to target
- Address the complexity of treating to target for different disorders (glycemic control, hypertension, and dyslipidemia)

Structure our care delivery systems to facilitate management of chronic diseases
- Utilize electronic medical record systems, best practice advisories, flowsheets, and disease registries
- Expand the care team
- Active outreach and planned visits to increase opportunities for "titratable moments"

Provide performance feedback
- Dashboards and audits – timely and specific
- Chart review with face-to-face peer feedback



Team Discussion:

1. Where in our diabetes workflow are we facing clinical inertia barriers? (i.e. PCP education, overestimation of care provided, "soft" reasons to avoid intensification of therapy, etc.)

2. Given our organizational structure and culture, how can we best address clinical inertia?

3. How can we improve our organization's process for following-up with patients to increase opportunities to improve clinical inertia among our diabetes patient population?

4. How do we internally capture and share our diabetes metrics for patients? How can we better utilize this data to raise awareness of possible improvement areas among care teams?

Additional Notes:

Today's Featured Presenters

Mark Greenwood, M.D.
Medical Director for the Family Medicine Service Line
Intermountain Healthcare

Brenda Reiss-Brennan, Ph.D., APRN
Director of Mental Health Integration
Intermountain Healthcare

Achieving Patient Well-Being at Lower Cost

Population Health through Mental Health Integration and Team-Based Care

Holistic Management of Diabetes

AMGA Webinar

May 16, 2019

Intermountain Healthcare
Healing for life®

Brenda Reiss-Brennan, PhD, APRN

Mark Greenwood, MD

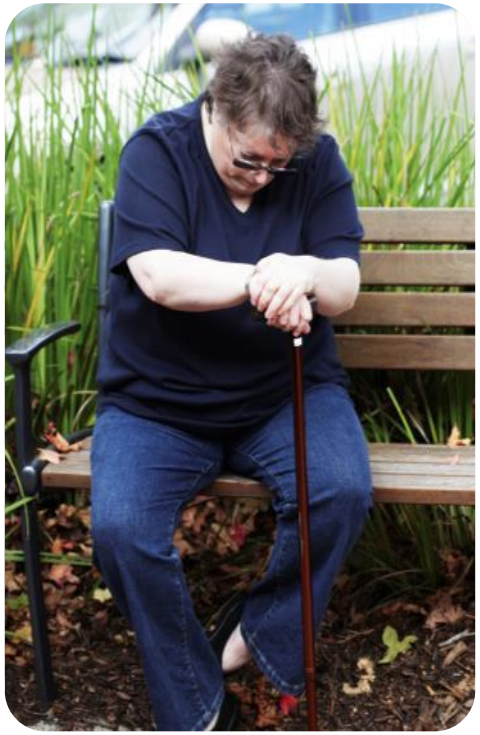
American Healthcare

Amazing Successes and Tragic Failures

Rescue Care

VS.

Prevention and Effective Management of Chronic Conditions



One Intermountain

We are on a Measured Journey –

“Helping people live the healthiest lives possible®”

A Rich History of Innovation, Improvement, and Excellence

- System-wide standards (quality, management)
- First clinical & financial information systems
- Added new hospitals

- Continuum of care
- Health plans
- Vertical integration strategy
- Continuous Quality Improvement

- Medical Group
- Clinical Programs
- Clinical Board goals

- Supply Chain Organization
- Revenue Cycle Organization
- Patient Flow
- Efficiency improvements
- New care process models

Intermountain Foundation

- Population Health
- iCentra
- New Mission Statement
- National brand
- Zero Harm
- New business development
- Reorganization
- Partnering for Success

Culture of Learning Builds Values

Common Vision | Clinical Work Processes | Data and Evaluation Transparency

Supporting mental health is a growing global priority

Global Health Priority

43M
Americans suffer a form of mental illness

300M
People worldwide live with depression

68% of adults
with mental disorders have other medical conditions

Significant cost

$200 billion
annually, exceeding all medical conditions

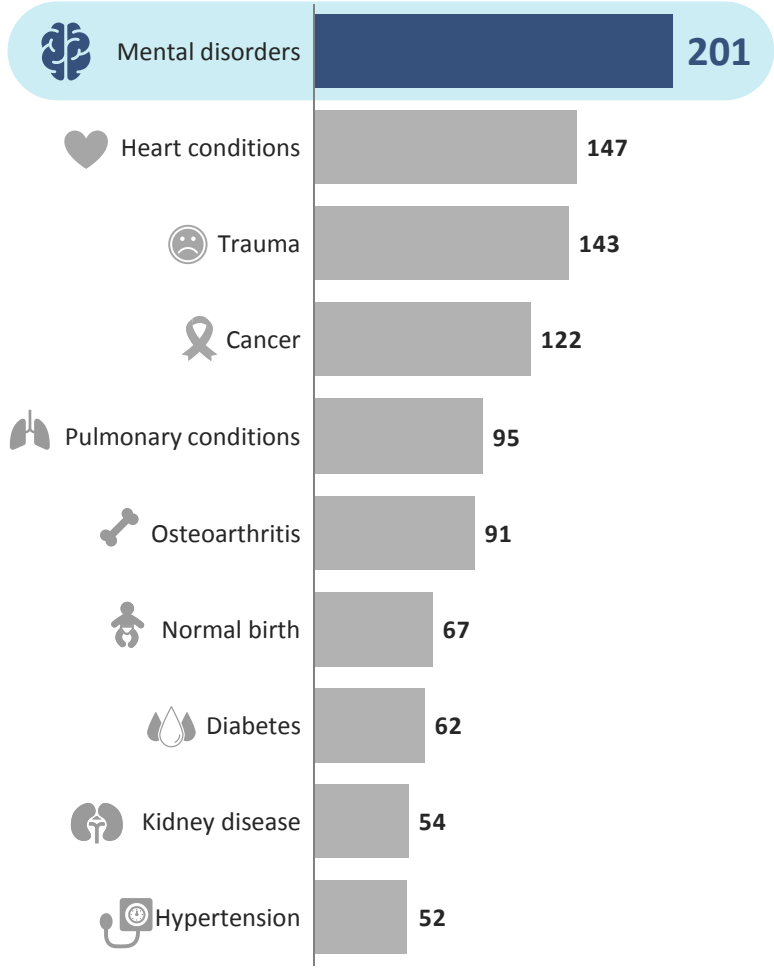
Rising death toll

20M
Americans suffer from substance mental illness of substance abuse

~64,000
drug overdose deaths annually in 2016

1
suicide death every **40 seconds**
(2014)

The costliest medical conditions ($B, 2013)



Mental health is a state of successful performance of mental and physical functioning, resulting in productive activities, fulfilling relationships with others, and the ability to adapt to change and cope with adversity

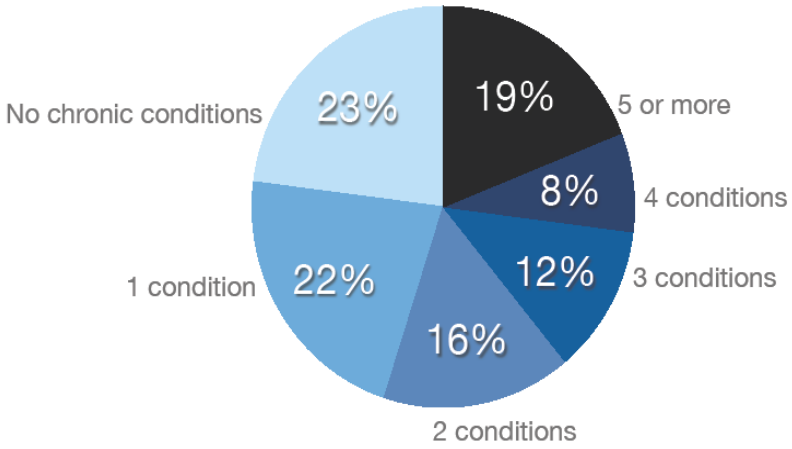
Team based MHI is focused on prevention and access via normalizing mental and behavioral health as routine medical care through unified connected team interactions

US Surgeon General report on mental health

Multiple Conditions Increase Complexity

Chronic health conditions are often interrelated

A survey of 120,000 employees found:



Source: IBI

Our journey is focused on enhancing the conditions for good health

"The circumstances in which people live and work are related to their risk of illness and length of life" – Marmot (2004) The Status Syndrome

Emma

63 year old who has hip and knee pain, questions about 2 of her 18 meds,

“no energy”, has a ten minute appointment

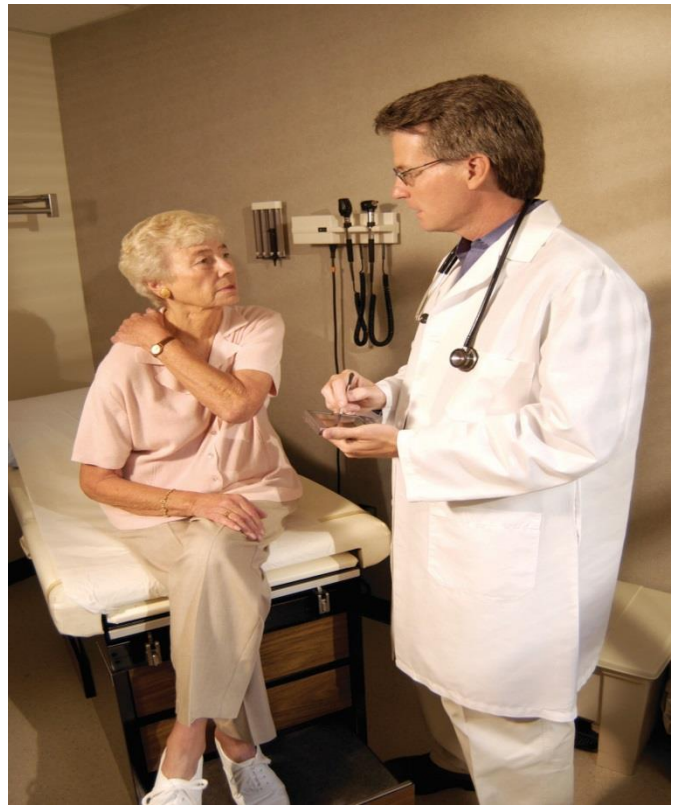
at 3:30 pm

Diabetes, Hypertension, MCI, Arthritis, CHF

Exam is unremarkable except for slight low blood sugar

You talk about management of diabetes for a few minutes, answer the med questions wish them well, stand to leave, and with one hand on the door the husband says

“Um, before you go, we need to ask you about one other thing we are really worried about…”



Emma

Missed 5 days work

Not sleeping, not eating much

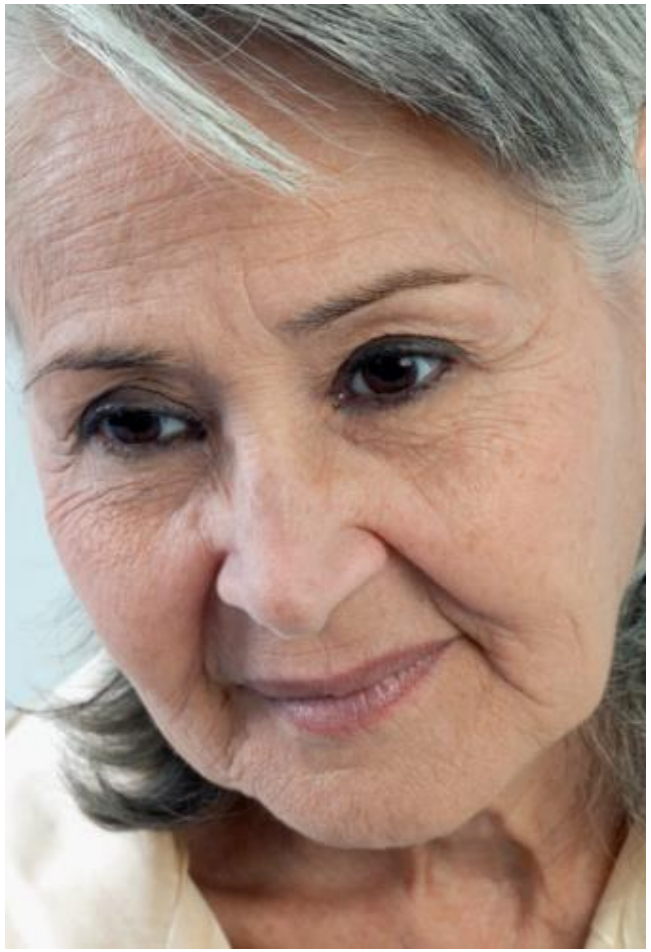
Not going out of the house

Cranky

Husband exhausted and has relapsed

Your 3:40 is in a room and waiting, and your 3:50 is here early because they have to pick up a grandchild from soccer practice 20 minutes from now

The rest of Emma’s story



Usual Care

Option 1: Traditional Usual Care

You obtain some more history (3 min)

Assess suicide risk (3 min) positive

Explore treatment options, insurance, access to care, will the family even follow up…(5 to 25 minutes if you include all staff time)

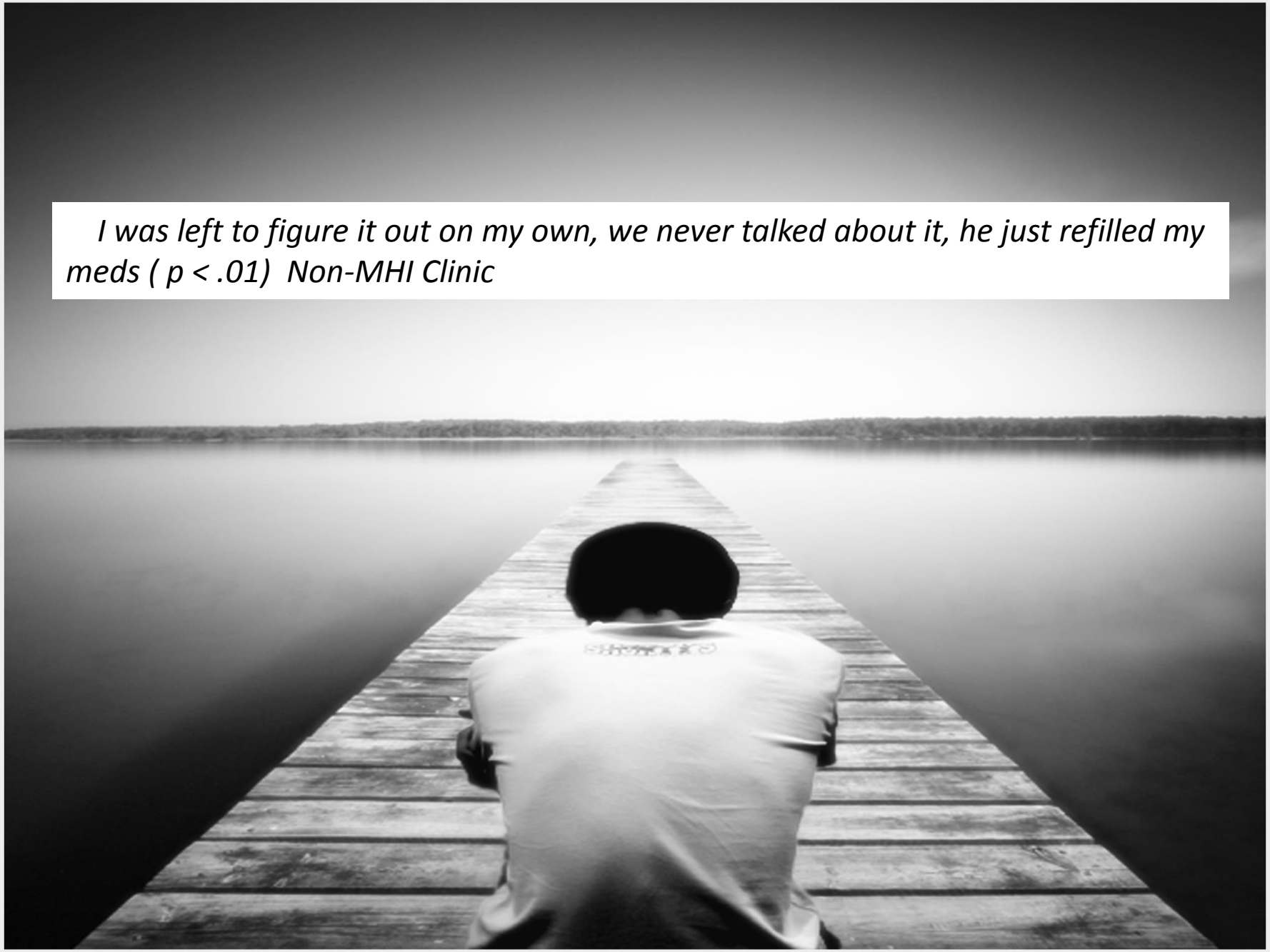
Staff gives patient drug samples, referral names, husband given number for the ER ,Emma is on her own

Your 3:50 yelled at staff and left very upset

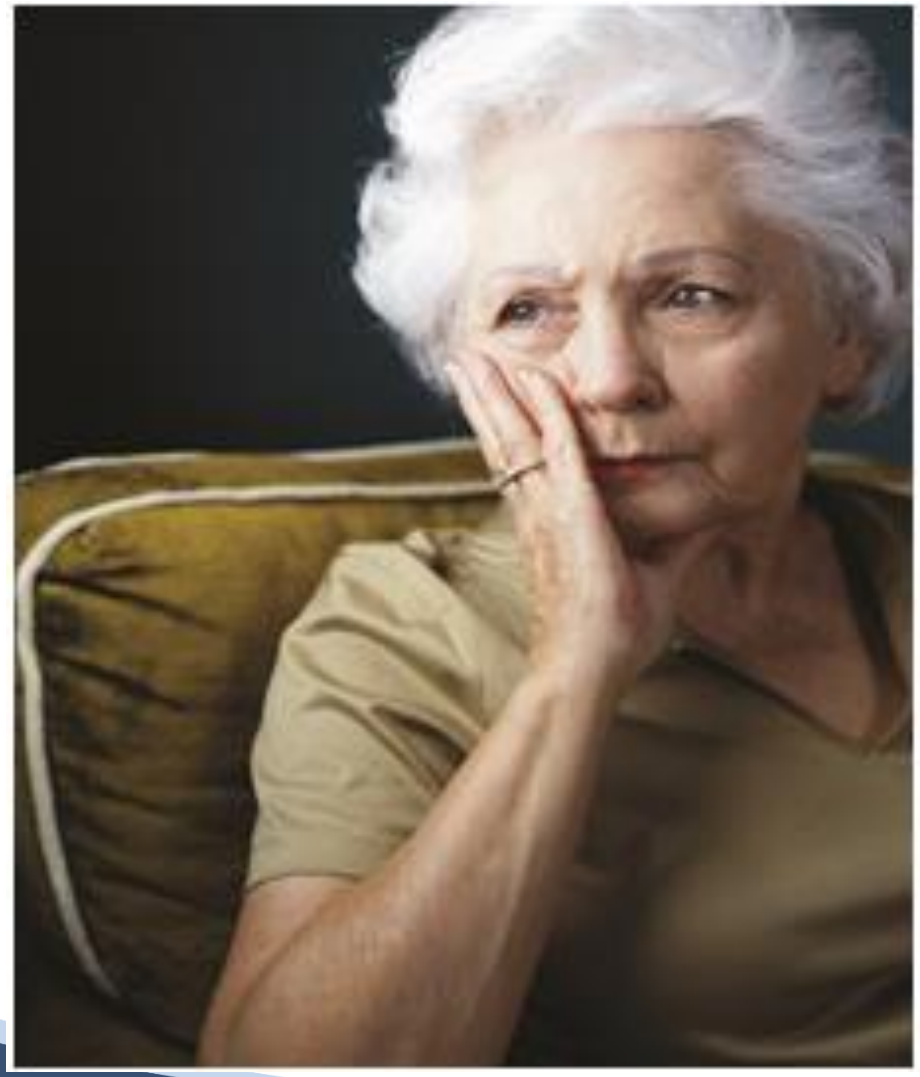
Your receptionist has tried to reassure three other patients (4:00, 4:20, 4:30) that the doctor will be in soon (5 to 10 minutes and

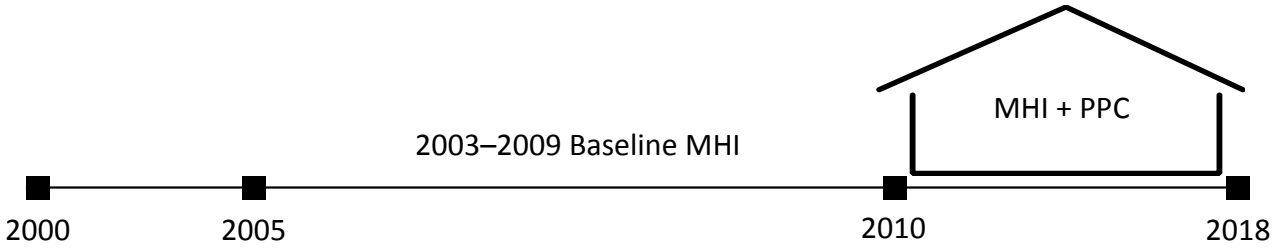
“If I don’t do it, who else will? I am all they have. I have been forced to treat depression alone.”

(PCP Non-MHI Clinic)



Mental Health Integration Team-Based Care: More Than Just a Program





Culture of Relational Reciprocity

'My doctor was the first person to treat me as a whole person' (p <.001)

'I am connected to a team that talks to each other' (p < .05)

'Being on the same page I get better results' (p <.01)

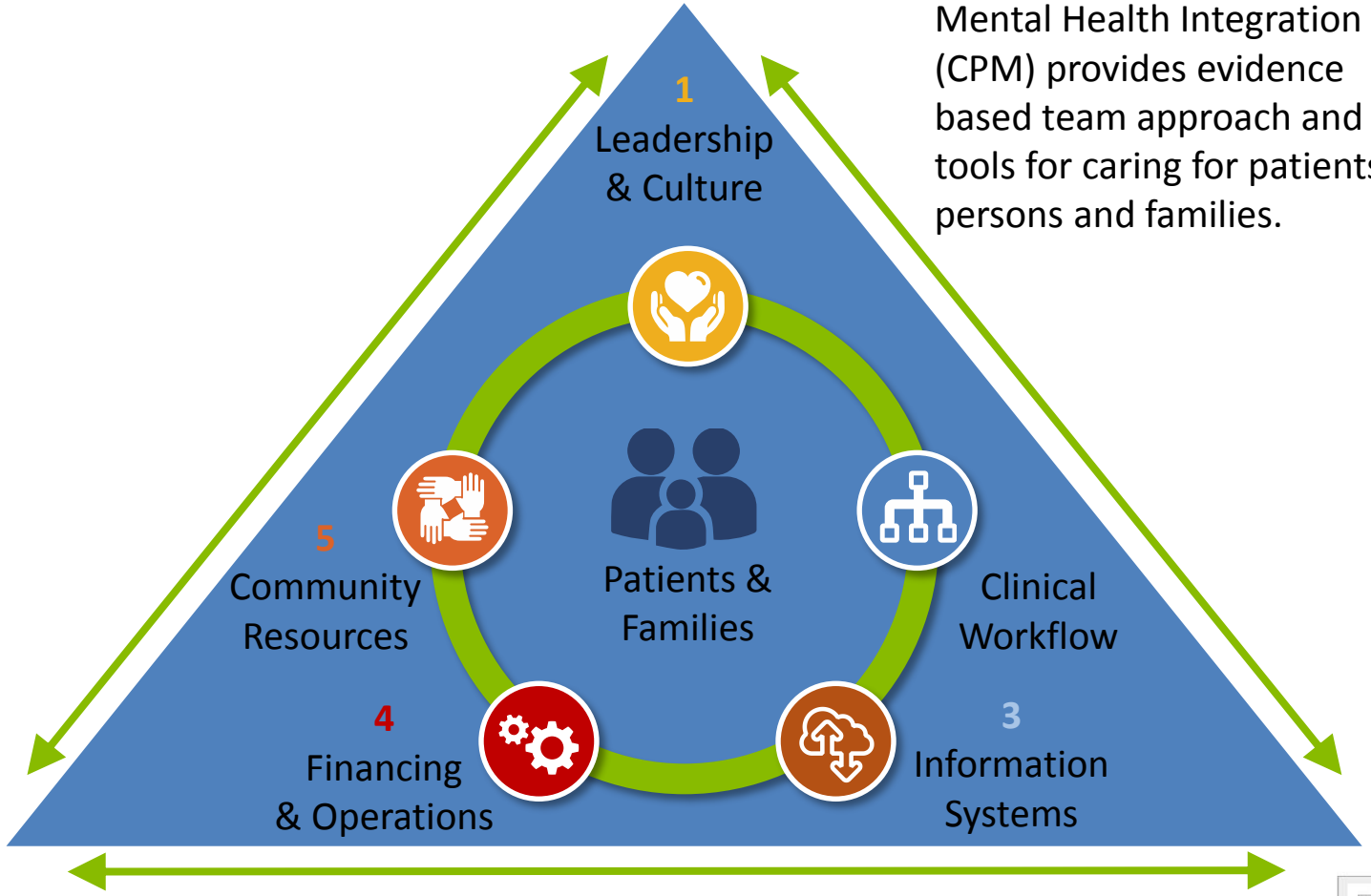
Intermountain® Healthcare

Mental Health Clinical Integration: Management of Complex Chronic Disease in Primary Care - including Substance Use Disorders

Mental Health Integration Infrastructure		
Diabetes, Asthma, Heart Disease, Depression, Hypertension, ADHD, Obesity, Chronic Pain, SUD, etc.		
2/3 – cared for routinely in primary care	1/6	1/6
Patient & Family, PCP, and Care Manager (CM) as needed	**PCP, CM + mental health as needed**	**PCP with MHI Specialist Consult**

*Primary Care Physician (PCP) includes:
General Internist, Family Practitioner, Pediatrician

What Is Mental Health Integration? (MHI)



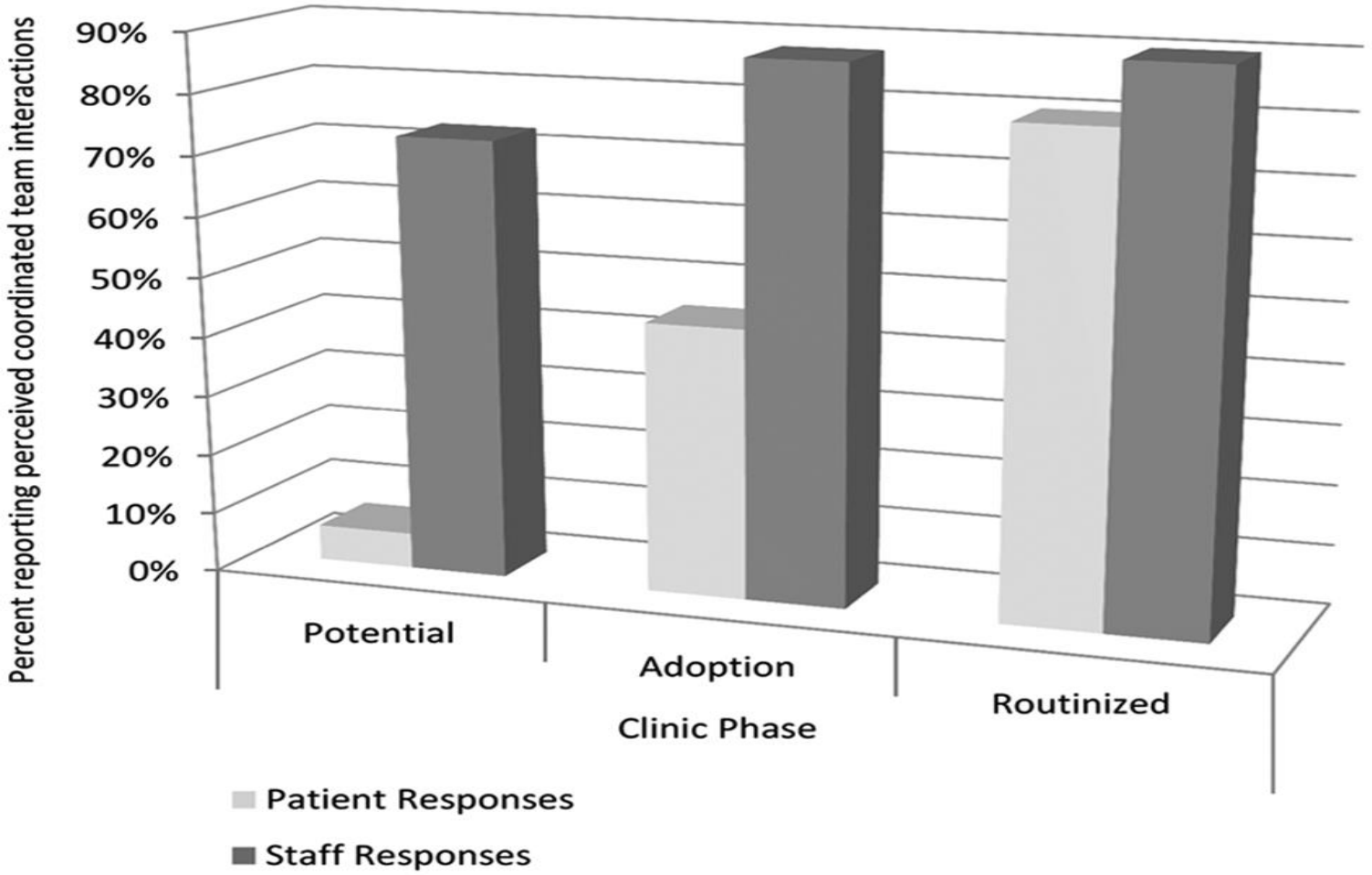
Mental Health Integration (CPM) provides evidence based team approach and tools for caring for patients/ persons and families.

Essential Integrated Elements

1	Leadership and culture – champions establishing a core value of accountable and cooperative relationships
2	Clinical Workflow – engaging patients and families on the team and matching their complexity and need to the right level of support
3	Information systems – EMR, EDW, registries, dashboard to support team communication and outcome tracking
4	Financing and operations – projecting, budgeting and sustaining team FTE to measure the ROI
5	Community resources – who are our community partners to help us engage our population in sustaining wellness

A standardized clinical and operational team relational process that incorporates mental health as a complementary component of wellness & healing.

Differences in patient-perceived coordinated team interactions by Mental Health Integration (MHI) clinic phase.



Establishing & Understanding Roles & Responsibilities of Clinic Team

Matching Right Level of Team Resource to Complexity of Patient and Family Story

NEEDS

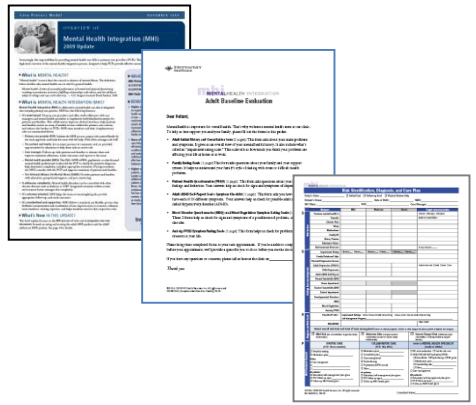
Patients & Families

2 Workflow

MHI Treatment Cascade

Case Identification
Shared Decision Making

Standardized Assessment Tools
PHQ-2, PHQ-9, & MHI Packet



ROUTINE CARE
Mild Complexity
PCP and Care Manager
Responsive
Family Support

COLLABORATIVE MHI TEAM
Moderate Complexity
PCP, Care Manager, &
MHI Specialist Consult
Complex Co-morbidities
Family Isolated or Chaotic

MENTAL HEALTH TEAM
High Complexity
PCP, Care Manager,
& MHI Psychiatrist
Psychiatric Co-morbidities
Family Support Variable
High Social Burden
Danger Risk

SPECIALTY CARE
High Complexity
Psychiatrist Referral
Stabilization requires
higher level of care
Safety

Emma - Mental Health Integration

Using MHI TBC Model and Workflow

MA administers PHQ-2 & PHQ 9 (positive)

Obtain more history, explain MHI team (3 min)

Assess suicide risk (3 min)

You agree this is very important and would like to and can help. You expla

MHI packet and instructions to complete it prior to a follow up visit next week (2min)

Emma and husband leave with treatment started and hope

You see your 3:50 at 4:00, apologizing for the delay (she makes it to practice on time)

You send a message to your care manager to call

this family in 3 days, help with packet and schedule

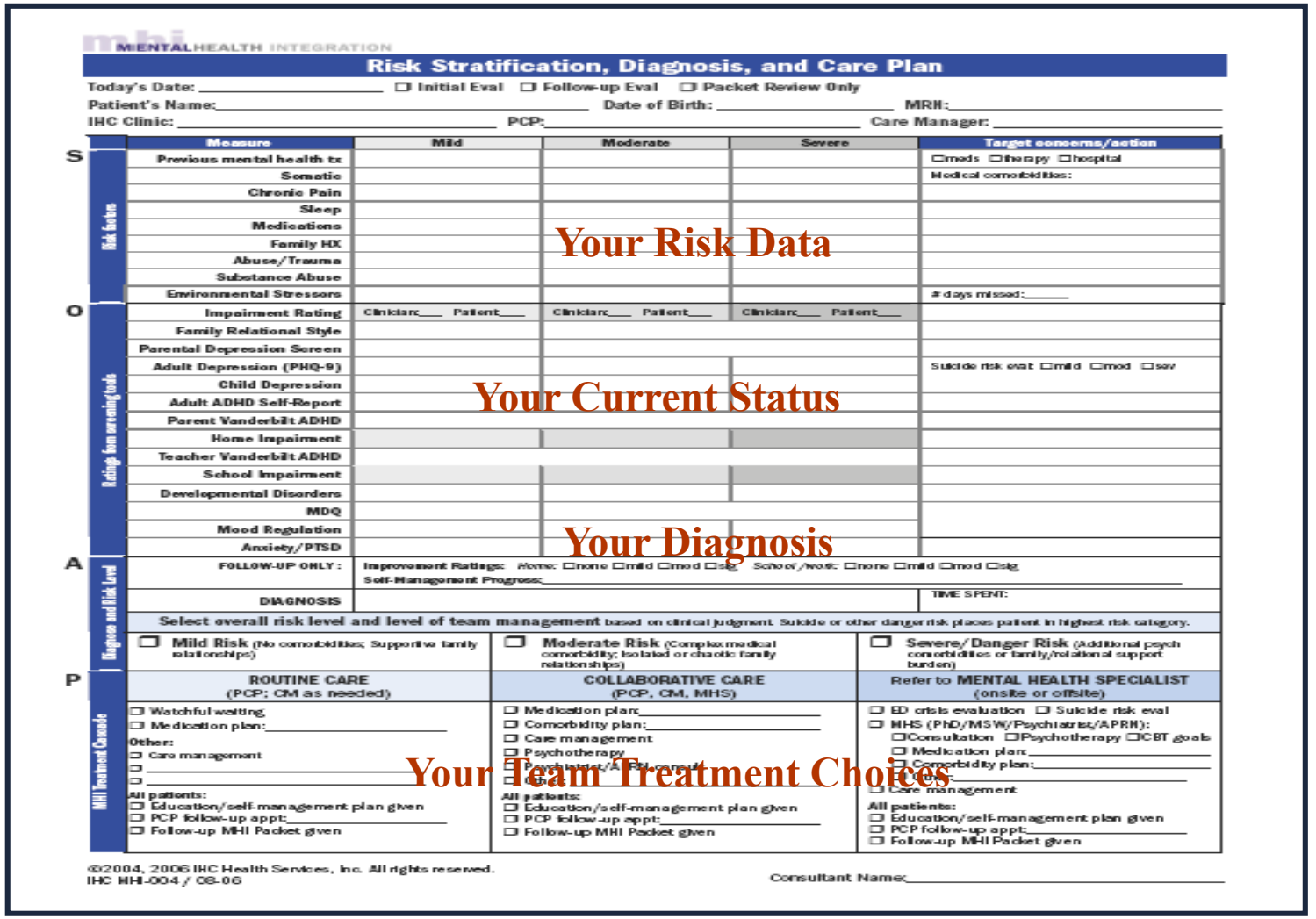
appointment follow with PCP or MHI provider

Patient return packet (paper or online) and provider

review

* Determine complexity and activate team care plan protocol

II. Patient and Family Care Planning Worksheet



MENTAL HEALTH INTEGRATION

Risk Stratification, Diagnosis, and Care Plan

Today's Date: _____ ☐ Initial Eval ☐ Follow-up Eval ☐ Packet Review Only

Patient's Name: _____ Date of Birth: _____ MRN: _____

IHC Clinic: _____ PCP: _____ Care Manager: _____

		Measure	Mild	Moderate	Severe	Target concerns/action
S	Risk factors	Previous mental health tx				☐meds ☐therapy ☐hospital
		Somatic				Medical comorbidities:
		Chronic Pain				
		Sleep				
		Medications				
		Family HX				
		Abuse/Trauma				
		Substance Abuse				
		Environmental Stressors				# days missed: _____
O	Ratings from screening tools	Impairment Rating	Clinician: ___ Patient: ___	Clinician: ___ Patient: ___	Clinician: ___ Patient: ___	
		Family Relational Style				
		Parental Depression Screen				
		Adult Depression (PHQ-9)				Suicide risk eval: ☐mild ☐mod ☐sev
		Child Depression				
		Adult ADHD Self-Report				
		Parent Vanderbilt ADHD				
		Home Impairment				
		Teacher Vanderbilt ADHD				
		School Impairment				
		Developmental Disorders				
		MDQ				
		Mood Regulation				
		Anxiety/PTSD				
A	Diagnosis and Risk Level	FOLLOW-UP ONLY:	Improvement Ratings: Home: ☐none ☐mild ☐mod ☐sig School/work: ☐none ☐mild ☐mod ☐sig Self-Management Progress: _____			
		DIAGNOSIS				TIME SPENT:

Select overall risk level and level of team management based on clinical judgment. Suicide or other danger risk places patient in highest risk category.

	☐ Mild Risk (No comorbidities; Supportive family relationships)	☐ Moderate Risk (Complex medical comorbidity; Isolated or chaotic family relationships)	☐ Severe/Danger Risk (Additional psych comorbidities or family/relational support burden)
P MHI Treatment Cascade	ROUTINE CARE (PCP; CM as needed)	COLLABORATIVE CARE (PCP, CM, MHS)	Refer to MENTAL HEALTH SPECIALIST (onsite or offsite)
	☐ Watchful waiting ☐ Medication plan: _____ Other: ☐ Care management ☐ _____ ☐ _____ All patients: ☐ Education/self-management plan given ☐ PCP follow-up appt: _____ ☐ Follow-up MHI Packet given	☐ Medication plan: _____ ☐ Comorbidity plan: _____ ☐ Care management ☐ Psychotherapy ☐ Psychiatrist/APRN consult ☐ _____ All patients: ☐ Education/self-management plan given ☐ PCP follow-up appt: _____ ☐ Follow-up MHI Packet given	☐ ED crisis evaluation ☐ Suicide risk eval ☐ MHS (PhD/MSW/Psychiatrist/APRN): ☐Consultation ☐Psychotherapy ☐CBT goals ☐ Medication plan: _____ ☐ Comorbidity plan: _____ ☐ _____ ☐ Care management All patients: ☐ Education/self-management plan given ☐ PCP follow-up appt: _____ ☐ Follow-up MHI Packet given

IHC MHI-004 / 08-06

Consultant Name: _____

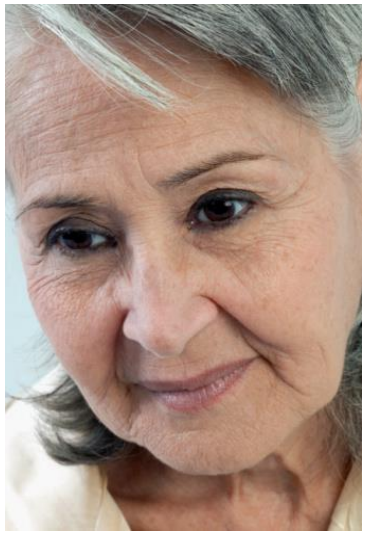
Your Risk Data

Your Current Status

Your Diagnosis

Your Team Treatment Choices

Emma Story – Key Packet Findings Moderate Complexity



63 y/o fatigue, sleep problems, “private” and withdrawn, poor appetite

Sleep 6/10 5 hours night

Family History of depression, suicide, bipolar

Risk of losing job

Isolated family support – avoidant engagement style

+ HX sexual abuse – affecting now

PHQ-9 of 20

Bipolar Screen 11/13

Does not like taking medication

Doesn’t like to talk with anyone about her problems

“I do not like taking medication or talking with anyone about my problems”

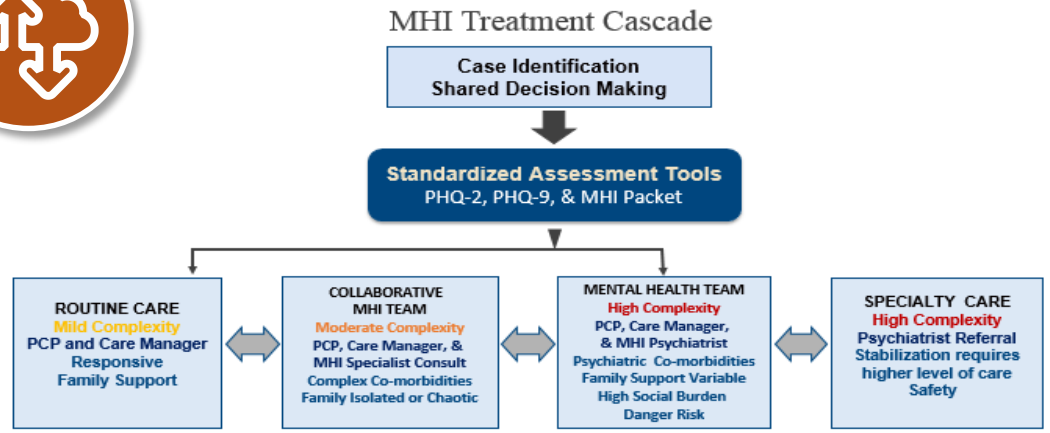
Primary Care Strategies for Care Planning with Patient

[PCP, Emma & her Husband, CM, MHI Consult]

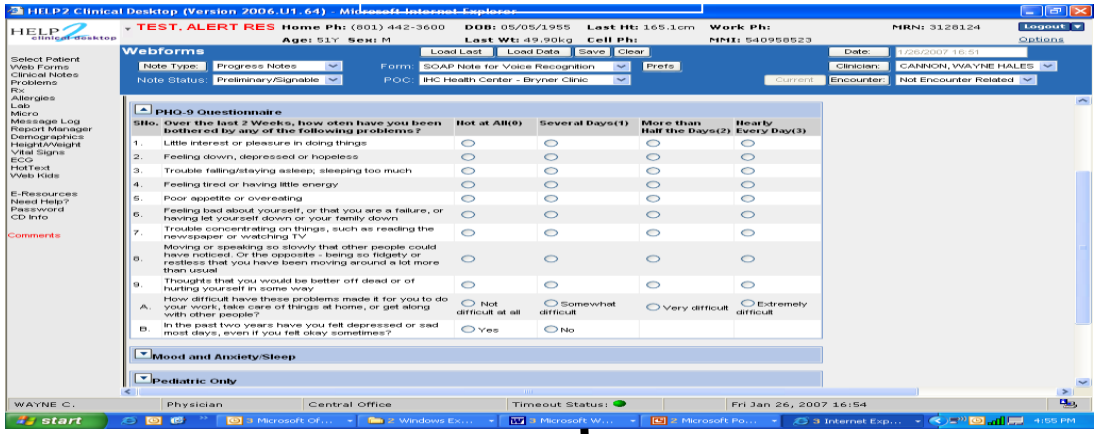
- Illness fact - Depression, Diabetes, Bipolar
- Assertive proactive PCP contact
- Adjust FU to match preference for self-relian
- Introduce Care Manager for education & FU
- Engage MHI team – trust

Actionable Data Helps Support Decision-Making & Care Improvement

Clinical Process



Data Input



Actionable Data Creation

Registry (EDW) – 1999 to present

Depression Registry

Depression registry n = 604,160

- Accurately captures "active" depression patients
- Includes various process & outcomes measures
- Aligned with iCentra EHR

Team Feedback: MHI Dashboard

PHQ2 or PHQ9/A Screening in Past 12 Months

	Patients w/ PHQ2 or PHQ9/A	Patients w/ Annual PCP Visit	Percent of Patients w/ Annual Screening
SYSTEM			
SYSTEM	211,320	319,052	66.23%
REGION			
Cache Valley Group	15,665	28,829	54.34%
Central Salt Lake Group	27,256	37,716	72.27%
North Salt Lake/South Davis	47,985	62,763	76.45%
Rural Group	8,874	13,493	65.77%
South Salt Lake Group	29,039	52,382	55.44%
Southern Utah Group	27,837	41,244	67.49%
Timpanogos Group	19,257	32,281	59.65%
Weber/North Davis Group	35,407	50,344	70.33%
CLINIC			
American Fork Internal Medicine & Dermatology	1,246	1,324	94.11%
Avenues Specialty Clinic	3,320	4,590	72.33%
Bear River Clinic	1,937	4,667	41.50%
Bountiful Clinic	17,469	19,113	91.40%
Budge Clinic	1,958	3,000	65.27%
Budge Clinic - Internal Medicine	3,930	8,725	45.04%
Canyon View Clinic	583	639	91.24%
Cedar City Clinic	4,239	5,328	79.56%
Central Orem Clinic	5,191	6,969	74.49%
Comprehensive Care Clinic - Murray	124	125	99.20%

Categorical Change in PHQ9 by Clinic

	FULL REMISSION	PARTIAL REMISSION	NO CHANGE	WORSE
Bear River Clinic	12.88%	33.05%	9.44%	44.64%
Budge Clinic	8.00%	29.60%	23.20%	39.20%
Budge Clinic - Internal Medicine	11.11%	32.59%	14.81%	41.48%
Logan Clinic	15.13%	37.17%	12.17%	35.53%
North Cache Valley Clinic	19.29%	36.04%	9.64%	35.03%
South Cache Valley Clinic	15.42%	35.51%	16.82%	32.24%
Comprehensive Care Clinic - Murray	7.58%	28.79%	4.55%	59.09%
Cottonwood Family Practice	19.73%	39.32%	6.16%	34.79%
Cottonwood Medical Clinic - Internal Medicine	19.41%	35.88%	7.06%	37.65%
Employee Clinic		100.00%		
Hillcrest Pediatrics		50.00%	12.50%	37.50%
Holladay Clinic	18.37%	35.71%	7.65%	38.27%
Holladay Pediatrics	22.22%	31.48%	5.56%	40.74%
Holladay Pediatrics - North		69.23%		30.77%
Kearns Clinic	12.28%	57.89%	1.75%	28.07%
Salt Lake County Health Connections	12.50%	50.00%	12.50%	25.00%
Senior Clinic - Murray	14.94%	40.26%	7.79%	37.01%
Taylorsville Clinic	16.91%	39.79%	8.45%	34.85%
West Valley Clinic	10.17%	35.59%	15.25%	38.98%

Intermountain Data Transparency

Data Snapshot

MHI Registry

- The total MHI Registry includes approximately 604,160 patients. 164,416 are active patients.
- PHQ (2 or 9) has been given to approximately 110,993. 55,562 are active patients.

Gender/Age

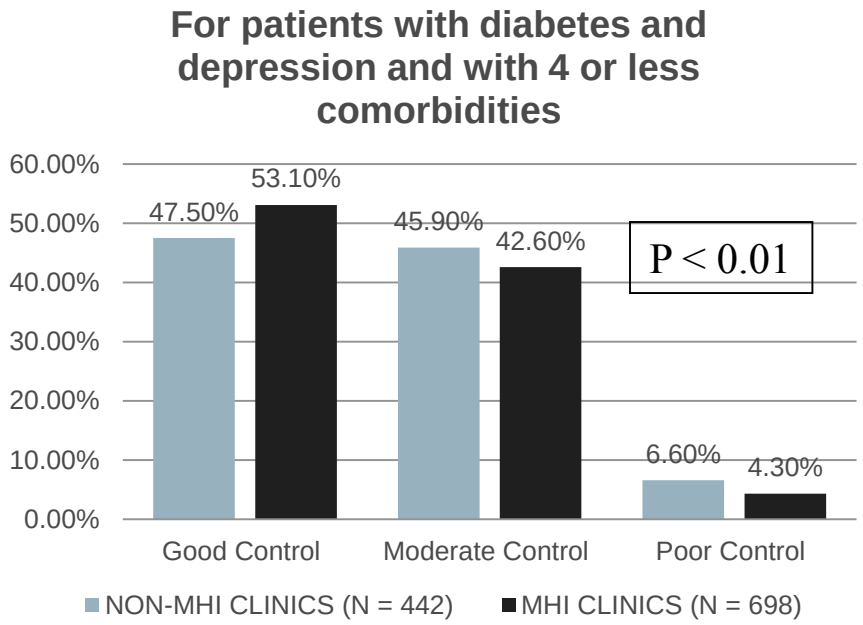
- Female = Approximately 320,000 patients
- Male = Approximately 187,000 patients
- Children = 10% < 18 years

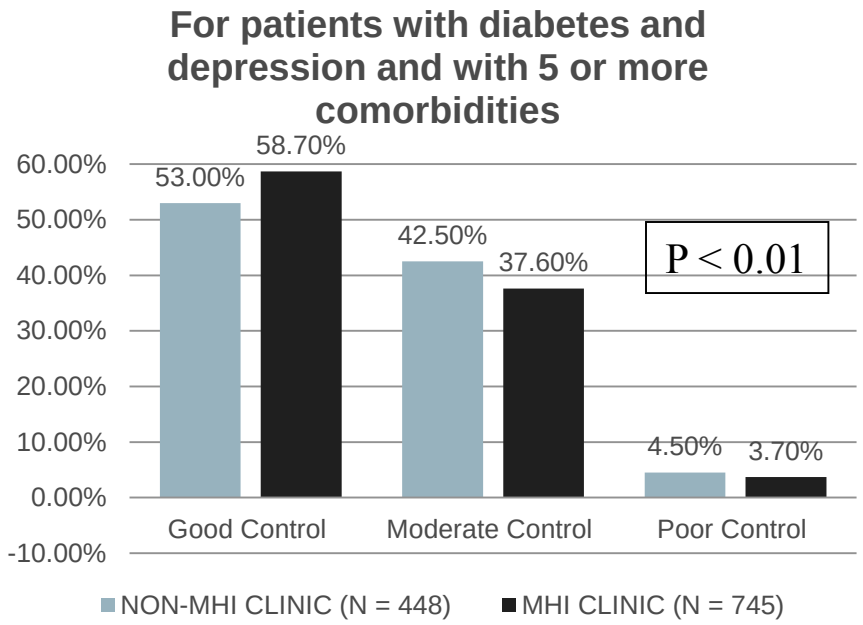
Other Chronic Disease Registries

- Diabetes: Approximately 33,593 patients
- Asthma: Approximately 13,611 patients
- Coronary Disease: Approximately 6,726 patients
- Cancer: Approximately 4,455 patients

Source: **Primary Care Clinical Program; February 29, 2016**

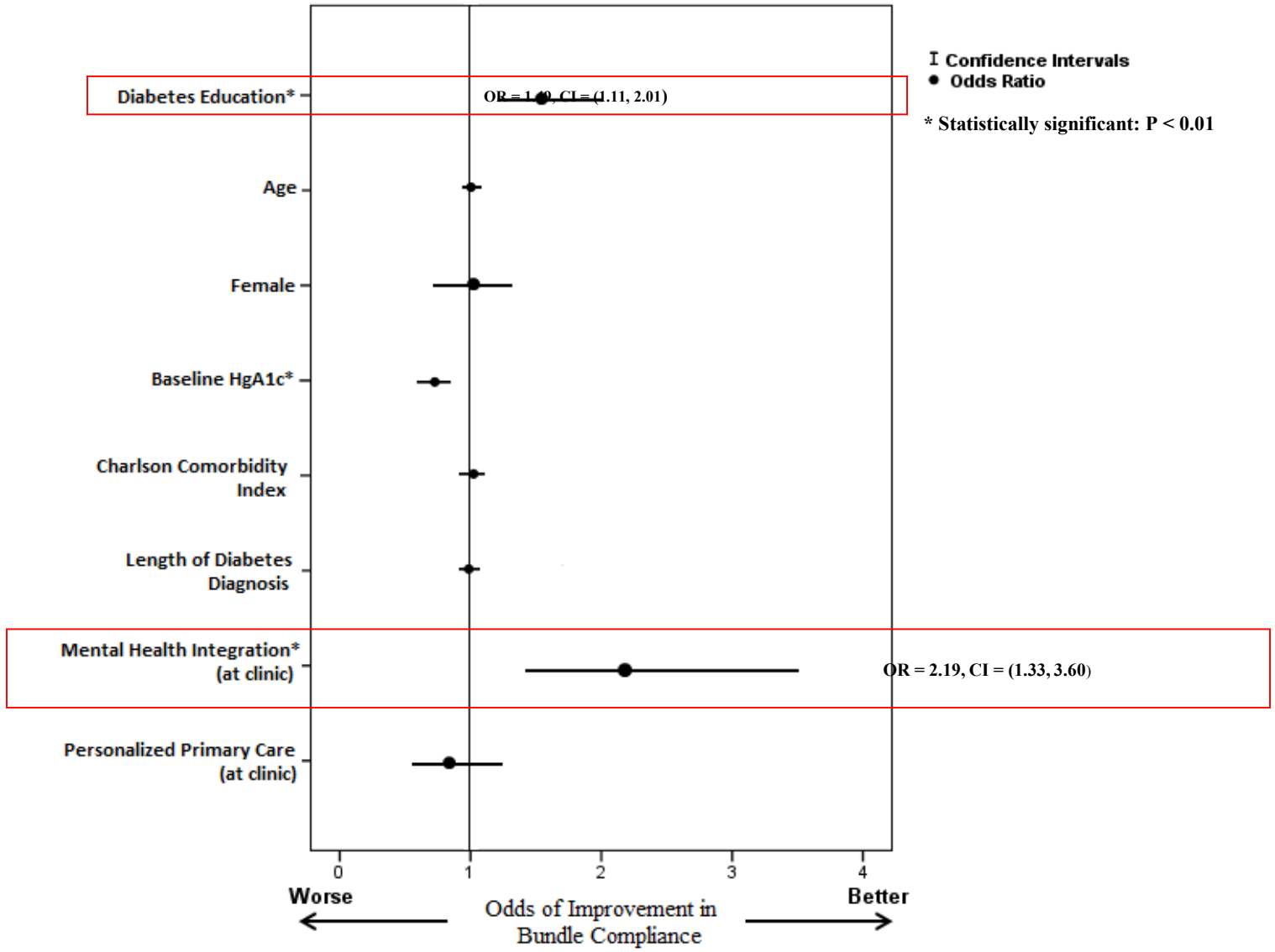
Distribution of patients treated at MHI and non-MHI clinics By diabetes control and comorbidity



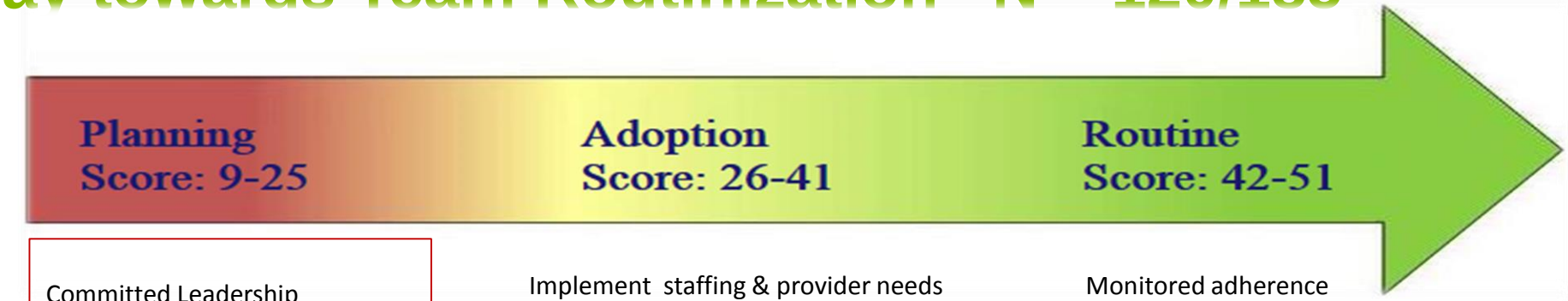


Patient who have depression have their diabetes in better control when treated at an MHI clinic ($p < 0.01$)

Impact of MHI on diabetes bundle compliance

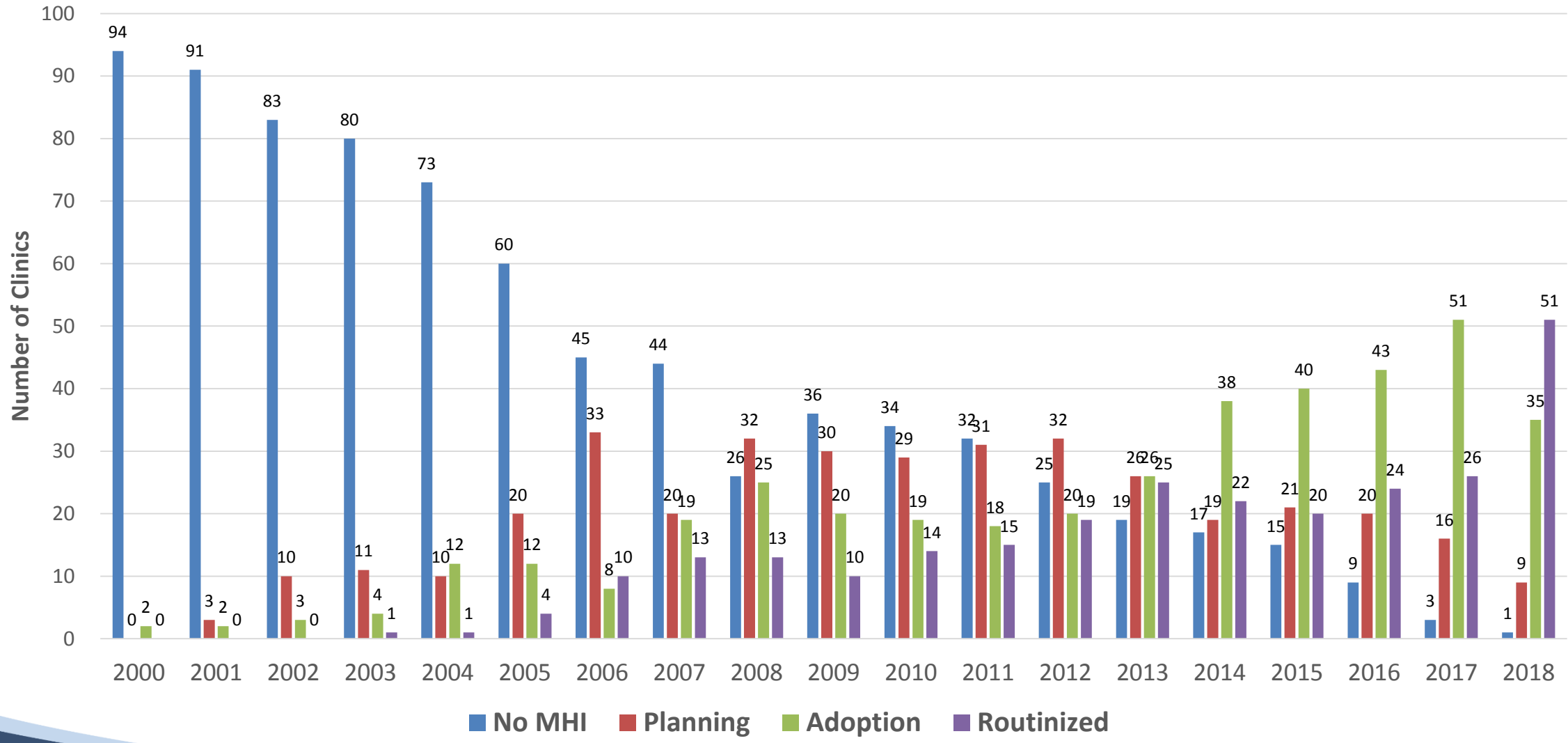


A Cultural Pathway towards Team Routinization N = 120/185



	Planning Score: 9-25	Adoption Score: 26-41	Routine Score: 42-51
Leadership & Culture	Committed Leadership Identify Population Complexity	Implement staffing & provider needs Assign all roles relative to MHI CPM Routine Meetings	Monitored adherence Continuous training & support provided Champions leading
Workflow Integration	Design patient workflow Identify Patient & Family Complexity	Implement strategies to address barrier Develop care management strategy	Identified workflow gaps; Improved process Engaged providers w/ treatment cascade Difficult case conferences
Information Systems	Complete team scorecard Design MHI Dashboard	Providers assign complexity & stratification Dashboard identifies gaps & chronic disease action plans	Tracked patient complexity data Dashboard used to target outcomes results
Financing & Operations	Review & Track clinical & operational reports quarterly ; Team FTE	Gaps identified & action plans developed Refine meaningful tools – TBC ROI	Reports used to improve performance Data used to target utilization & cost gaps
Community Resources	Inventory of potential partners Identify support groups & classes	Process developed to provide resources Team link patients to groups, classes, peer support	Documented community referrals Engage new partners; patient mentors

Steady Progress: MHI Performance 2000-2018



Integrated Team-based Care (TBC) Cultural Journey

Getting to routinized team-based care

(Study period 2003 – 2013)

Started Mental Health Integration (MHI)
Physical and mental health interdisciplinary teams in patient care.

2003 – 2009 BASELINE MHI

MHI + Personalized Primary Care (PPC)

MHI Program
primary care practices
18 years

Patient Cohort Identified
(aged < 18 years) (aged ≥18 years)
Patients had to have at least 1 outpatient visit with a primary care physician (family medicine, internal medicine, geriatric, or pediatric specialty)

r-TBC Study Period
Continuous Encounters
Differences associated with their exposure to TBC compared with TPM

MHI tools are deployed system-wide throughout our **22** hospitals, **185** clinics and **59** urgent care/emergency departments using a common **electronic health record and screening tools**. Healthcare providers communicate with each other via notes in the patient record and track results as a united team. Total patients annually **967,445**.

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The MHI Scorecard Measures Routinized Team-Based Care (TBC)

Characteristics of Routinized TBC

- Physician engagement
- Care coordination & established routine protocols
- Team communication through EMR and reporting tools
- Operational efficiency and monitoring
- Outreach to family and community

MHI exposure is based on Roger's diffusion of innovation levels and MHI scorecard:

- Level 0: No MHI
- Level 1: Planning (score 9 – 25)
- Level 2: Adoption (score 26 – 41)
- Level 3: Routinized (score 42 – 51)

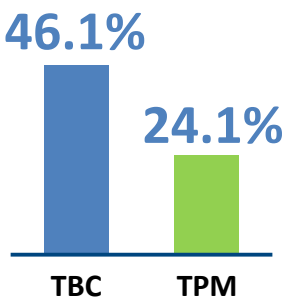
PPC exposure based on modified NCQA self assessment tool:

- Level 0: No PPC
- Level 1: Planning (score 35 – 64)
- Level 2: Adoption (score 65 – 84)
- Level 3: Routinized (score >= 85)

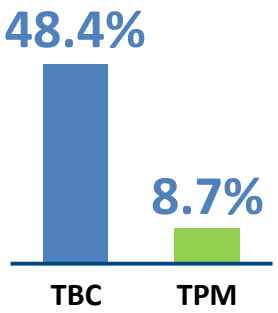
Note: *Each practice was given an MHI and PPC exposure level by year (2003 to 2013)*

Research Impact — Study shows that integrating mental and physical health through primary care teams results in better clinical outcomes and lower costs.

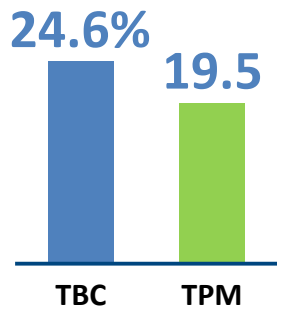
10-YEAR STUDY 2003-2013	
113,452	Participants
113	Primary care providers
27	Team-based care (TBC) medical practices
75	Traditional practice management (TPM) medical practices



SCREENED FOR DEPRESSION



DOCUMENTED SELF CARE PLAN



ADHERED TO DIABETES PROTOCOL

EMERGENCY ROOM VISITS

Reduced **23%**

HOSPITAL ADMISSIONS

Reduced **10.6%**

PRIMARY CARE ENCOUNTERS

Reduced **7%**

PAYMENTS TO PROVIDERS

Reduced **3.3%**

($3,401 for TBC vs. $3,516 for TPM)

Savings of **$115.00** Per patient per year (PPYR)

Savings of over **$13 Million** per year

Brenda Reiss-Brennan, PhD, APRN, et al. 2016 JAMA

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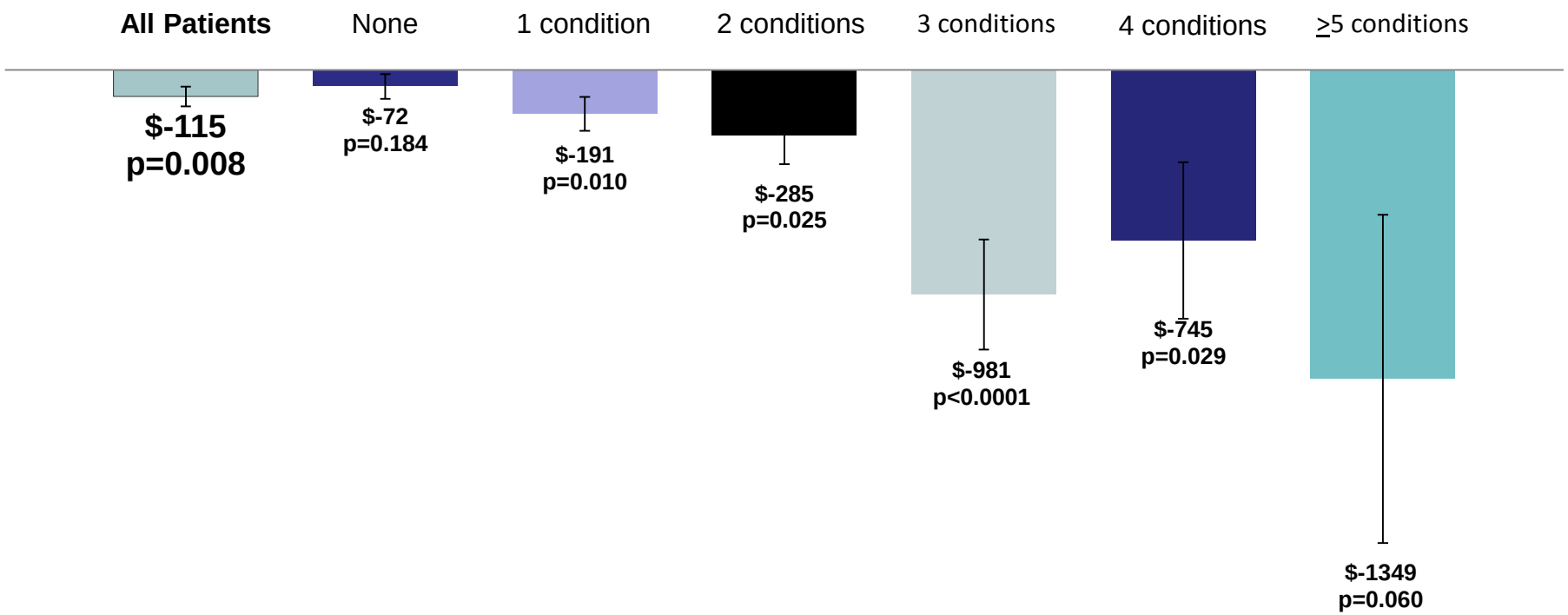
PMPY Impact (Delivery System Payments) by # of Chronic Conditions

Routinized TBC vs. No TBC



Total Savings From Analyzed Sample:

- Aggregate PMPY Payment Savings for the Routinized TBC Group is ≈ $20 Million
- Routinized TBC Group is roughly between 7-8% of Total Medical Group Patients

What Is the Real Cost?

“ Providing integrated mental health and primary care is the right thing to do for the sake of the patient, but the resultant financial benefits of reduced resource utilization accrue to someone else — the employer who pays for health insurance, the insurance company itself, or a large health system — and not to the practice that bears the expense and reduced reimbursement.”

JAMA Editorial: Integrated Behavioral and Primary Care, “What Is the Real Cost?”
Thomas L. Schwenk, MD

ACO Advances Value-based Practice at Intermountain Healthcare

MHI-TBC & Intermountain's ACO - Targeted Integrated TBC

- Launched new Medicare Accountable Care Organization (ACO) on January 1, 2018
- Called Intermountain Accountable Care
- Includes approx. 53,000 Medicare members
- Involves employed physicians and advanced-practice clinicians from Intermountain
- Contracted with open-staff physicians and APCs
- Skilled nursing facilities (from Intermountain's Skilled Nursing Facility Quality Initiative)
- ReImagined Primary Care- Alluceo Pilot – **At Risk Opportunities**

"Having a Medicare ACO advances our mission, supports our vision to be a model health system, and is another step toward value-based care,"

Mikelle Moore, Intermountain's Senior Vice President of Community Health and the President of Intermountain Accountable Care, LLC.

Reimagined Primary Care - Enhancing TBC

Reimagined Primary Care Focuses on Aligning PCPs towards Better Patient Management

- Premise is to keep people well and keep them out of the hospital
- Launched in summer of 2018
- 6 primary care clinics
- Salaried physicians
- Approximately 700 to 800 patients in a panel

"What's been unique in this setting is thinking about a team and teaming. It's a different mindset. It requires a growth mindset to be part of the team. I think this is a shift for physicians, in being able to really trust each member that the team is doing their work. We're all working together with a common purpose."

Dr. Anne Pendo, Medical Director – Population Health, Intermountain Healthcare

Not only does it make financial sense to apply TBC/MHI to high risk patients, but it is the right thing to do

EDITORIAL

Integrated Behavioral and Primary Care
What Is the Real Cost?

Thomas L. Schwenk, MD

"**Integrated TBC is clearly superior to TPM for patients with complex mental illness and chronic medical disease**, consistent with the increasing recognition that this type of care is best applied to higher-risk patients with substantial disease burden. **It would be unethical from this point on to randomize this type of high-risk patient** to usual care **when integrated care has been shown** in many studies and many types of health systems **to be superior to traditional care.**"

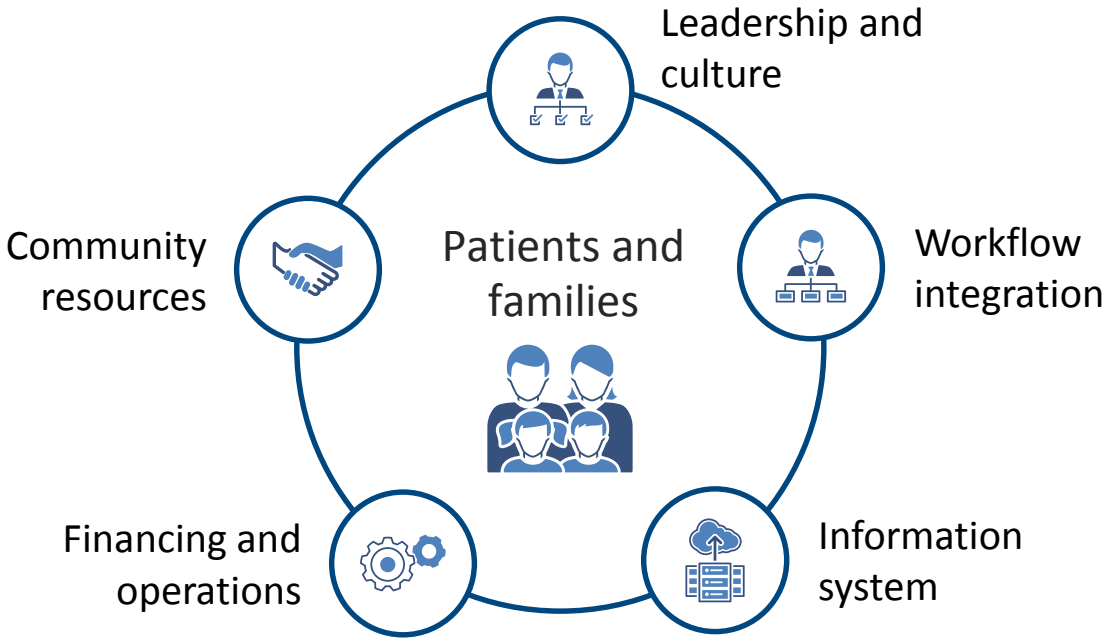
JAMA August 23/30, 2016 Volume 316, Number 8

Scaling Population Health & Well Being

Time to Move towards Providing Prevention

& Effective Management through Holistic Care Teams

MHI digital science five integral components



Alluceo

All five key features are highly linked and interdependent. Must have all of them to create optimal MHI process

Alluceo analyzed two “routinized” TBC/MHI primary care clinics (asset lite & high risk complexity) to assess capacity

		er Mix				
Primary Care Clinic Name	Level of MHI Integration	Medicaid	Medicare	Other Commercial	SelectHealth	Uninsured
Alta View Clinic Internal Medicine	Adoption	1%	44%	27%	25%	3%
Alta View Clinic Senior	Planning	0%	86%	7%	6%	1%
Avenues Clinic Internal Medicine	Routine	1%	41%	27%	29%	2%
Budge Clinic Internal Medicine	Adoption	2%	54%	30%	12%	2%
Cottonwood Clinic Internal Medicine	Routine	2%	50%	22%	24%	1%
Holladay Clinic Internal Medicine	Adoption	1%	53%	20%	25%	1%
Hurricane Valley Clinic Family Practice	Routine	7%	43%	31%	14%	5%

“Routinized” MHI primary care clinics, as defined by the 2016 JAMA article*, have the following attributes:

- **Engaged physicians** who have embraced normalizing mental health and NCQA accreditation
- **Care coordination** for chronic disease with **established routine workflows** and protocols
- **Knowledge of team roles** with consistent use of standard assessment and decision support tools
- **Communication through EMR**
- **Patient engagement** in care planning
- **Family & community** outreach

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*Reiss-Brennan B, Brunisholz KD, Dredge C, et al. Association of Integrated Team-Based Care With Health Care Quality, Utilization, and Cost. *JAMA.* 2016;316(8):826–834. doi:10.1001/jama.2016.11232

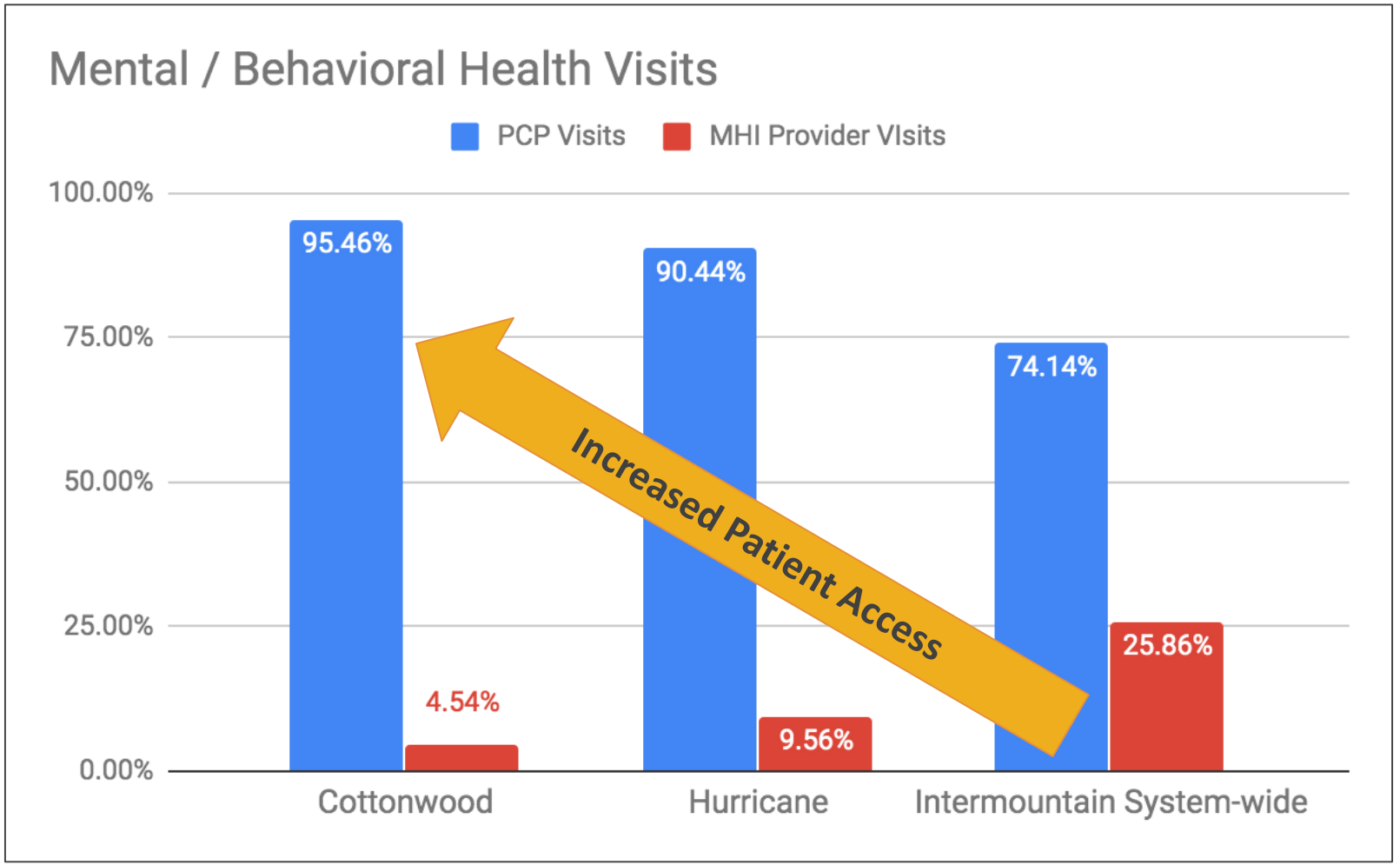
In the two routinized TBC/MHI clinics, primary care providers and staff are able to treat >90% of mental health concerns

Alluceo believes similar results are possible for all primary care clinics, when combined with:

- Adequate care team training
- Intuitive technology that facilitates team based care
- Telehealth consultative services for both primary care providers and patients

There are 2 types of MHI Providers:

- **Prescriber:** Psychiatrist or Psychiatric Nurse Practitioner (APRN)
- **Therapist:** Psychologist or Licensed Clinical Social Worker (LCSW)



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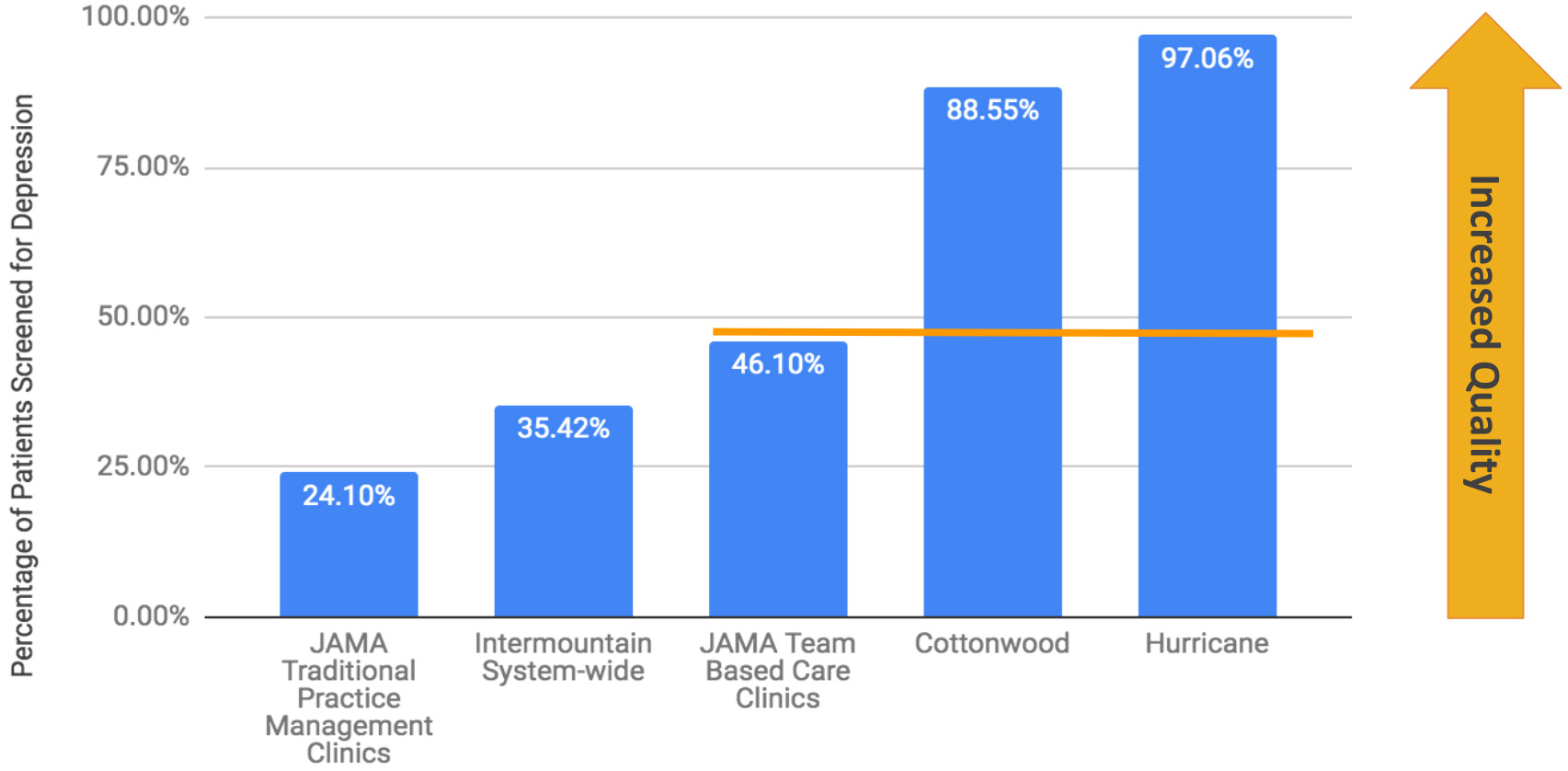
The routinized TBC/MHI clinics surpassed the JAMA baseline for depression screening



PHQ2, PHQ9/1, or EPDS Screening in Past 12 months. System-wide, Cottonwood and Hurricane data run on 4/9/19.

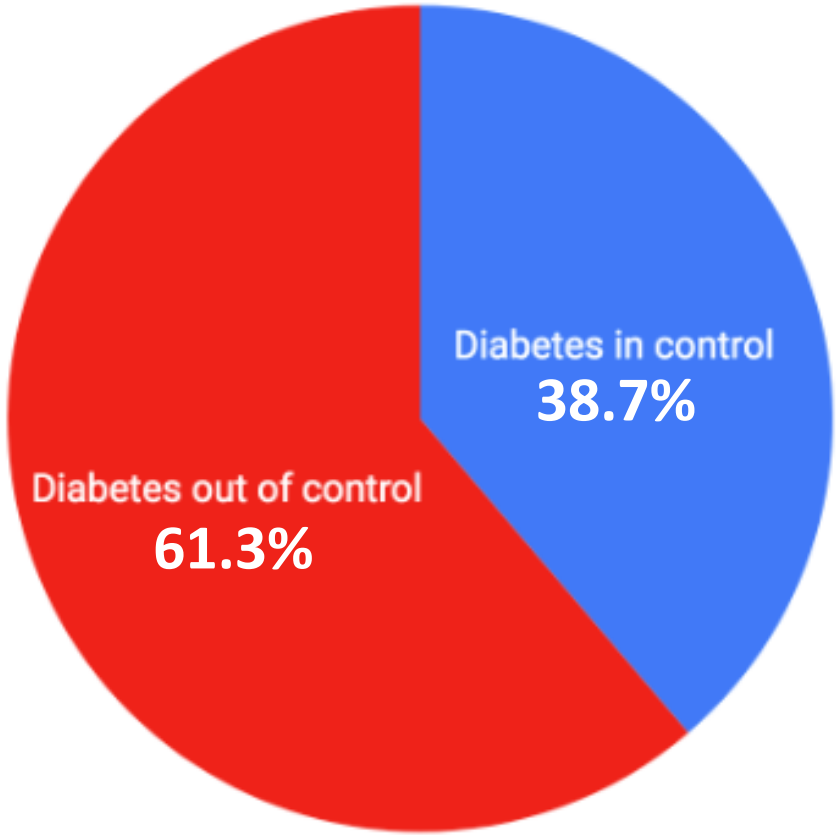
A technology, quality improvement opportunity also exists for increasing the percentage of controlled diabetes patients

Mark R. Greenwood, MD

FAMILY MEDICINE

"I keep telling my docs that we keep pining away at the medical reasons for uncontrolled diabetes, and we are missing identifying the psychosocial factors - even with MHI in our clinics." - Mark Greenwood, MD

"My patient was having panic attacks with every finger prick due to an experience in early childhood. The CGM reduced her anxiety - not meds - and her A1c was < 8 for the first time in 8 years."
- Karen Hill-Garrett, MD



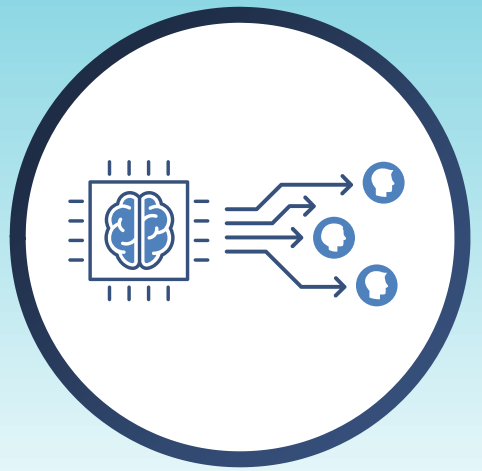
Intermountain System-wide

What makes Alluceo unique

Only solution with documented peer reviewed outcomes

10 years of Intermountain data on clinical and cost outcomes

Unique algorithm assembles a personalized care team for each patient and their family

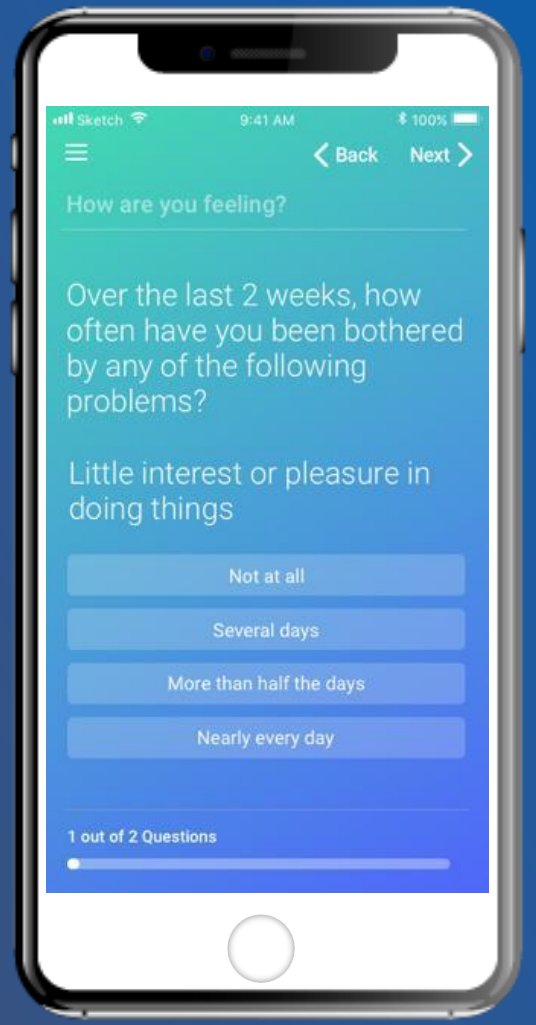


Practice management to assess and optimize resources

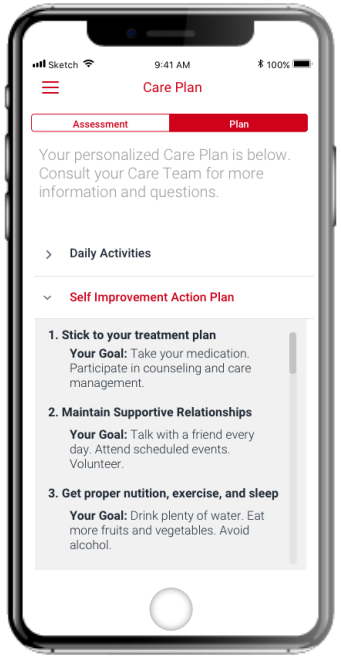
Best in class integrated digital solution

Holistic and integrated suite of care tools

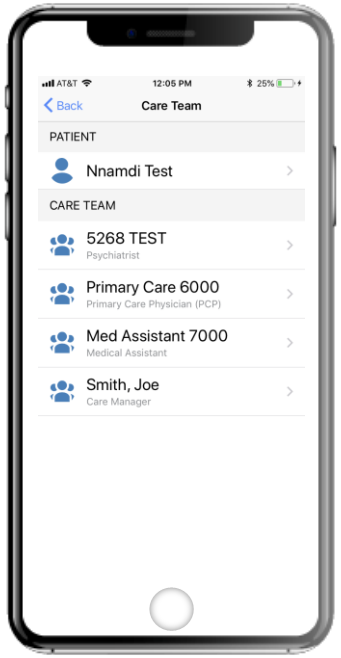
The digital app for patients is intuitive and engaging …



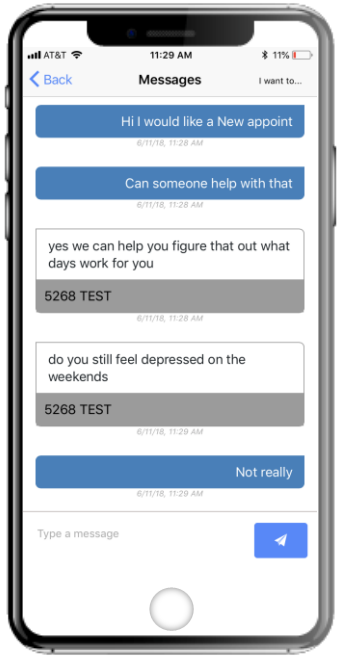
Engaging Patient screening



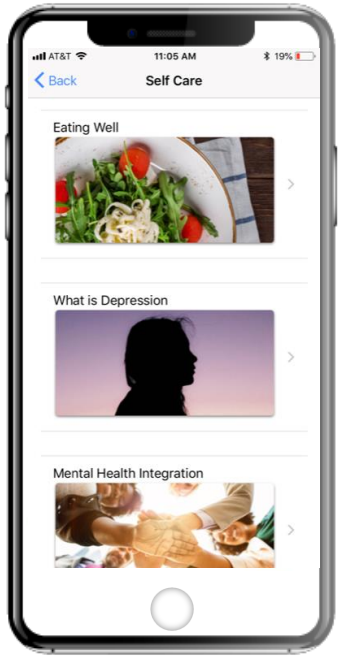
Care plan



Patient centered care team



In-app communication with care team



Engaging self care materials and tools

… with seamless desktop tools for providers

Patient Outcome tracking

Secure team communication

Care plan and care team formation[1]

EMR integration[2]

1. Covers the practice management 2. Not in scope for MVP, but on the roadmap

Multiple Team Touches ($p < .001$)

Continuous relationships over time

‘we are on the same page‘

Normalizing Mental Health is Everyone's Business

Multiple Team Touches

Adults in the U.S suffer with mental Illness

18% of total population

1 death every

seconds from **suicide** by **2020**

$4 Billion Potential U.S. healthcare **Annual Savings**

JAMA: Association of Integrated Team-Based Care with Health Care Quality, Utilization, and Cost, 2016;316(8):826-834. doi:10.1001/jama.2016.11232

June Webinar

- **Date/Time**: June 20, 2019 from 2-3pm Eastern
- **Topic**: Identifying High Risk Patients Using a Population Health Tool

Questions