Achieving Patient Well-Being at Lower Cost
Population Health through Mental Health Integration and Team-Based Care

NJAMHAA 2018 Annual Conference
“Creating Balance through Integrated Care”
April 10 & 11, 2018

Brenda Reiss-Brennan, PhD, APRN
Mental Health Integration Director
Presentation Agenda

I. American health care: What is successful integration?
   Health & Social Care Complexity

II. Importance of leading health care reform with courage towards change
   National & global emergence of innovative delivery models

III. Intermountain Healthcare’s integrated Team-Based Care solution
   MHI is Population Health: Impact on Cost, Quality, Utilization, Patient & Staff Experience

“Mental Health is Everyone’s Business”
Mental Health Integration Team-Based Care: More Than Just a Program

“My doctor was the first person to treat me as a whole person...”

Culture of Relational Reciprocity

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American Healthcare

Amazing Successes and Tragic Failures

Rescue Care

VS.

Prevention and Effective Management of Chronic Conditions
43 Million suffer mental illness  18%

20 Million suffer substance use disorders 8.4%

1 death every 20 seconds from suicide by 2020
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
- **~42,000** Opioid deaths in 2016
- **1** suicide death every 40 seconds (2014)

The costliest medical conditions ($B, 2013)

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Cost ($B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart conditions</td>
<td>147</td>
</tr>
<tr>
<td>Trauma</td>
<td>143</td>
</tr>
<tr>
<td>Cancer</td>
<td>122</td>
</tr>
<tr>
<td>Pulmonary conditions</td>
<td>95</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>91</td>
</tr>
<tr>
<td>Normal birth</td>
<td>67</td>
</tr>
<tr>
<td>Diabetes</td>
<td>62</td>
</tr>
<tr>
<td>Kidney disease</td>
<td>54</td>
</tr>
<tr>
<td>Hypertension</td>
<td>52</td>
</tr>
</tbody>
</table>

>5% national depression screening rate in U.S. in 2017

Source: APA

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Mission

Helping people live the healthiest lives possible®

HOSPITALS & CLINICS Urban-Rural
- 22 Hospitals
  (including pediatric and orthopedic)
- 2,700 Beds
- 185 Intermountain Clinics

OUR TEAM
- 5000 Affiliated Physicians
- 1,400 Medical Group doctors & advanced practice clinicians
- 36,000 Employees
- 3,000 Volunteers

CLINICAL PROGRAMS
- Behavioral Health
- Cardiovascular
- Intensive Medicine
- Oncology
- Pediatrics
- Primary Care
- Surgical Services
- Women & Newborns
- Musculoskeletal
- Neurosciences

HOMER WARNER CENTER
- 80 Current informatics projects

ENTERPRISE DATA WAREHOUSE
- SYSTEM WIDE data warehouse: financial, clinical, laboratory, pharmacy, and other departmental systems.

OFFICE OF RESEARCH
- 1600 Clinical research open studies

HEALTH INSURANCE
- 750,000 Members
The Intermountain Culture: Clinical Integration

- Improved Quality and Service
- Evidence-Based Practice
- Systematic Approach: measure & improve

Always do the right thing!

SUCCESS: Always led by clinical but including operational, financial and even governance!
What is Mental Health?

“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”

Integration

To form, coordinate, or blend into a functioning or organized whole: Unite

Team Co-Production
Functioning in a group with standard clinical line of thought (CPM) and contributing assets to holistic results
Mental Health Clinical Integration: Prevention & Management of Complex Chronic Conditions in Primary Care

Mental Health Integration Infrastructure

<table>
<thead>
<tr>
<th>Diabetes, Asthma, Heart Disease, Depression, Hypertension, ADHD, Obesity, Chronic Pain, SUD, etc.</th>
<th>2/3 – cared for routinely in primary care</th>
<th>1/6</th>
<th>1/6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient &amp; Family, PCP, and Care Manager (CM) as needed</td>
<td>PCP, CM + mental health as needed</td>
<td>PCP with MHI Specialist Consult</td>
<td></td>
</tr>
</tbody>
</table>

Primary Care Physician (PCP) includes:
General Internist, Family Practitioner, Pediatrician, Geriatricians
Specialty includes OBGYN, Sleep Endocrinology, Spine, Cardiology
Mental Health Integration (CPM) provides evidence-based team approach and tools for caring for patients/persons and families. A standardized clinical and operational team relational process that incorporates mental health as a complementary component of wellness & healing.
Our focus should be on the conditions for good health

“The circumstances in which people live and work are related to their risk of illness and length of life”

American Healthcare: Population Health

Time to Move towards Providing Prevention & Effective Holistic Care Management
Market Industry innovations offer solutions

Industry Snapshot

Service Providers

Tech enabled platforms

Practice Management

Focused EMRs

Outcomes Tracking

Patient & Families
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
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)
- 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)
- (20 minutes and lots of energy used up)
“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)
I was left to figure it out on my own, we never talked about it, he just refilled my meds (p < .01) Non-MHI Clinic
**Mental Health Integration TBC Model**

<table>
<thead>
<tr>
<th>MHI Team:</th>
<th>Integrated Medical Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Manager</td>
<td></td>
</tr>
<tr>
<td>Health Advocate</td>
<td>Primary Care Clinician</td>
</tr>
<tr>
<td>Care Guide</td>
<td>Clinic Staff:</td>
</tr>
<tr>
<td>Social Worker</td>
<td>RN, MA, Reception, Billing</td>
</tr>
<tr>
<td>Psychiatrist or Psychiatric NP</td>
<td>Clinic Manager</td>
</tr>
<tr>
<td>Therapist (Psychologist, LCSW, LPC)</td>
<td></td>
</tr>
</tbody>
</table>

**Community Resources:**
- Peer Support
- NAMI
- Community Therapists
- Pharmacists
- Physical Therapists
- Nutritionists

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Differences in patient-perceived coordinated team interactions by Mental Health Integration (MHI) clinic phase.
Understanding the MHI Model and Resource Allocation

Clinic MHI Team

Primary Care Clinician

Psychiatrist / APRN

Therapist

Clinic Manager

Care Manager

Care Advocate

Care Guide

Social Worker

Clinic Staff: RN, MA, Reception, Billing

Community Resources

Pharmacists

Peer Mentors

Community Therapists

Nutritionists

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Team-based Care (TBC) Uses Standardized Training MHI Screening, Assessment & Follow up Tools

- PHQ-2 & 9
- MHI Packet – Patient Story Once
  - Acuity, social determinants, risk stratification, assessing diagnosis, family engagement – treatment cascade, trauma, SBIRT, child-adolescent version
- Care process models
  - MHI TBC CPM & Training
  - Condition Specific: ADHD, Diabetes, Depression, Anxiety, Hypertension, Eating Disorder, Substance Use, Suicide Prevention, Lifestyle Weight Management
- Team-based care scorecard and dashboard
- Team Huddles & Difficult Case Conferences

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Teams and Tools MHI Family Relationship Engagement Training

- Family Pattern Profile
- ‘Who do you most commonly go to or talk to when you are distressed ?
  - Disconnected/Avoidant “no one”
  - Confused/Chaotic “exhausted”
  - Balanced/Secure “spouse, friend, etc.”

- Relationship Competence Training (RCT)
- Natural style of engaging in helping relationship
- Provider & Support Staff Empathy
- Family engagement & match care management

or do not feel well ?’
Matching Right Level of Team Resource to Complexity of Patient and Family Story

**NEEDS**
- Patients & Families

**Workflow**

**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

**MHI Treatment Cascade**
- Case Identification
- Shared Decision Making

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

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### Your Risk Data

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
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<tbody>
<tr>
<td>Previous mental health history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide attempt</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Chronic pain</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Sleep</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Medications</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Family history</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Abuse/trauma</td>
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<td></td>
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<tr>
<td>Substance abuse</td>
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</tbody>
</table>

**Risk Factors:**
- Previous mental health history
- Suicide attempt
- Chronic pain
- Sleep
- Medications
- Family history
- Abuse/trauma
- Substance abuse

**Risk Levels:**
- Low Risk
- Moderate Risk
- High Risk

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### Your Current Status

**Current Status:**
- Patient's Name: [Name]
- Date of Birth: [DOB]
- NPI: [NPI]
- PCP: [PCP]
- Care Manager: [Care Manager]

### Your Diagnosis

- **Diagnosis:** [Diagnosis]
  - [Condition 1]
  - [Condition 2]

### Your Team Treatment Choices

- **Treatment Choices:**
  - Medication plan
  - Case management
  - Education/skill management plan
  - Follow-up plan

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Actionable Data Helps Support Decision-Making & Care Improvement

**Clinical Process**

- **MHI Treatment Cascade**
- **Case Identification**
- **Shared Decision Making**
- **Standardized Assessment Tools**
  - PHQ-2, PHQ-9, & MHI Packet

**TEAM FEEDBACK**

- **MHI Dashboard**
- **Depression Registry**
  - **Depression registry n = 604,160**
  - **Accurately captures “active” depression patients**
  - **Includes various process & outcomes measures**
  - **Aligned with iCentra EHR**

**Data Input**

- **Registry (EDW) – 1999 to present**

**Depression Registry**

- **Accurately captures “active” depression patients**
- **Includes various process & outcomes measures**
- **Aligned with iCentra EHR**
2010 – Cost and Quality Impact of Intermountain’s Mental Health Integration Program

• Brenda Reiss-Brennan, Pascal C. Briot, Lucy A. Savitz, Wayne Cannon, and Russ Staheli
### A Cultural Pathway towards Team Routinization  \( N = \frac{120}{185} \)

<table>
<thead>
<tr>
<th><strong>Planning Score: 9-25</strong></th>
<th><strong>Adoption Score: 26-41</strong></th>
<th><strong>Routine Score: 42-51</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leadership &amp; Culture</strong></td>
<td><strong>Workflow Integration</strong></td>
<td><strong>Information Systems</strong></td>
</tr>
<tr>
<td>Committed Leadership</td>
<td>Design patient workflow</td>
<td>Complete team scorecard</td>
</tr>
<tr>
<td>Identify Population</td>
<td>Identify Patient &amp; Family</td>
<td>Design MHI Dashboard</td>
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<tr>
<td>Complexity</td>
<td>Complexity</td>
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</tr>
<tr>
<td><strong>Financing &amp; Operations</strong></td>
<td>Implement strategies to address barrier</td>
<td>Providers assign complexity &amp; stratification</td>
</tr>
<tr>
<td>Review &amp; Track clinical</td>
<td>Develop care management</td>
<td>Dashboard identifies gaps &amp; chronic</td>
</tr>
<tr>
<td>&amp; operational reports</td>
<td>strategy</td>
<td>disease action plans</td>
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<td>quarterly; Team FTE</td>
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<tr>
<td><strong>Community Resources</strong></td>
<td><strong>Leadership &amp; Culture</strong></td>
<td><strong>Workflow Integration</strong></td>
</tr>
<tr>
<td>Inventory of potential</td>
<td>Implement staffing &amp;</td>
<td>Design patient workflow</td>
</tr>
<tr>
<td>partners</td>
<td>provider needs</td>
<td>Identify Patient &amp; Family</td>
</tr>
<tr>
<td>Identify support groups &amp; classes</td>
<td>Assign all roles relative to MHI CPM</td>
<td>Complexity</td>
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<td></td>
<td>Routine Meetings</td>
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<td></td>
<td></td>
<td>Monitored adherence</td>
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<td>Continuous training &amp;</td>
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<td></td>
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<td>support provided</td>
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<td></td>
<td></td>
<td>Champions leading</td>
</tr>
<tr>
<td></td>
<td>Identified workflow gaps;</td>
<td>Tracked patient complexity</td>
</tr>
<tr>
<td></td>
<td>Improved process</td>
<td>data</td>
</tr>
<tr>
<td></td>
<td>Engaged providers w/</td>
<td>Dashboard used to target outcomes results</td>
</tr>
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<td></td>
<td>treatment cascade</td>
<td></td>
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<td></td>
<td>Difficult case conferences</td>
<td></td>
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<td></td>
<td></td>
<td>Reports used to improve performance</td>
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<tr>
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<td></td>
<td>Data used to target</td>
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<tr>
<td></td>
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<td>utilization &amp; cost gaps</td>
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<tr>
<td></td>
<td>Gaps identified &amp;</td>
<td>Documented community</td>
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<tr>
<td></td>
<td>action plans developed</td>
<td>referrals</td>
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<tr>
<td></td>
<td>Refine meaningful tools – TBC ROI</td>
<td>Engage new</td>
</tr>
<tr>
<td></td>
<td></td>
<td>partners; patient mentors</td>
</tr>
</tbody>
</table>
The Infrastructure for Performing Population Health
What makes Intermountain’s Team-Based Care model unique?

**Holistic Patient Care Management**
Screening & treating patients for complex mental illness & supporting all chronic disease states

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

**Patient Assessment & Stratification**
Identifying, assessing, & stratifying patients based upon complexity & severity of condition, while allocating appropriate care resource to support them

**Organized Team Co-Production**
Functioning in a group with standard clinical line of thought (CPM) and contributing assets to holistic results

**Accountable Performance Measurement**
Tracking and measuring key performance processes, operations, finances, and patient outcomes with a focus on providing high quality, efficient, accountable care

**MHI - Depression Registry (1999-current)**
Depression registry n = 604,160 10% pediatrics
- Accurately captures “active” patients
- KPI process & outcomes measures
- Aligned with EHR
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 explain and give them 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
Emma Story – Key MHI Assessment 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
What is MHI-TBC?

Teams Working Together – On the Same Page

Who, when, and how long

- Organized around PCP; Monitored by operations manager
- Trained in holistic patient care plan with measureable outcomes
- Followed care process model protocols - linked to EMR
- Clinical support derived from longitudinal, disease-specific patient registries
- Patients have access to effective team members accountable for team-based care
Getting to routinized team-based care (r-TBC), Timeline and Relevant Analytic Periods
(Study period 2003 – 2013)

Intermountain Healthcare’s Team-based Care (TBC) Journey

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

2000
2003
2005
2010 PPC Started
2013
2016

Patient Cohort Identified
(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)

2003 – 2009 BASELINE MHI

MHI Program
primary care practices 16 years

MHI +
Personalized Primary Care (PPC)

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.
Routinized Team-Based Care (TBC) Intervention

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 based on Roger’s diffusion of innovation levels and MHI scorecard:

- Level 0: No MHI
- Level 1: Planning (score 1 – 20)
- Level 2: Adoption (score 21 – 40)
- Level 3: Routinized (score 41 – 63)

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)
Clinical Study Results
Team-Based Care (TBC) vs. Traditional Practice Management (TPM)


<table>
<thead>
<tr>
<th></th>
<th>TBC</th>
<th>TPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-YEAR STUDY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants</td>
<td>113,452</td>
<td></td>
</tr>
<tr>
<td>Primary care</td>
<td>113</td>
<td></td>
</tr>
<tr>
<td>Team-based care</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Traditional</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>medical practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADHERED TO DIABETES PROTOCOL</td>
<td>46.1%</td>
<td>24.1%</td>
</tr>
<tr>
<td>SCREENED FOR DEPRESSION</td>
<td>48.4%</td>
<td>8.7%</td>
</tr>
<tr>
<td>DOCUMENTED SELF CARE PLAN</td>
<td>24.6%</td>
<td>19.5%</td>
</tr>
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Intermountain Healthcare System
Largest in Intermountain West
Clinical Study Results

Team-Based Care (TBC) vs. Traditional Practice Management (TPM)


- 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)
Difference of $115.00 (PPYR)

Intermountain Healthcare Investment $22 (PPYR)
PMPY Impact (Delivery System Payments) by # of Chronic Conditions

**Routinized TBC vs. No TBC**

<table>
<thead>
<tr>
<th>All Patients</th>
<th>None</th>
<th>1 condition</th>
<th>2 conditions</th>
<th>3 conditions</th>
<th>4 conditions</th>
<th>&gt;5 conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>$-115$</td>
<td>$-72$</td>
<td>$-191$</td>
<td>$-285$</td>
<td>$-981$</td>
<td>$-745$</td>
<td>$-1349$</td>
</tr>
<tr>
<td>$p=0.008$</td>
<td>$p=0.184$</td>
<td>$p=0.010$</td>
<td>$p=0.025$</td>
<td>$&lt;0.0001$</td>
<td>$p=0.029$</td>
<td>$p=0.060$</td>
</tr>
</tbody>
</table>

**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*
Team-Based Care: Meeting Patients & Families Where They Perceive Value

- **Total Pop:** 3M
- **Non-Intermountain Pop:** 1.365M
  - **Non-IM Using IM Specialty Care Pop:** 285K
  - **Intermountain Pop:** 1.35M
- **TBC Clinics**
  - **TBC Clinics**
    - **TBC Pop:** 513K
  - **Non-TBC Clinics**
    - **372K**
    - **193K**

**Value Added:** $13M in Savings

**Virtual Team-Based Care (Telehealth):**

**TBC Clinics/Total Clinics = 121/185**

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<table>
<thead>
<tr>
<th>What makes Alluceo unique</th>
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<tbody>
<tr>
<td>Solution with documented peer reviewed outcomes</td>
</tr>
<tr>
<td>Unique algorithm assembles a personalized care team for each patient and their family</td>
</tr>
<tr>
<td>Best in class integrated digital solution</td>
</tr>
</tbody>
</table>

| 10 years of Intermountain data on clinical and cost outcomes |
| Practice management to assess and optimize resources |
| Holistic and integrated suite of care tools |
Engaging integrated digital app for patients...

Engaging Patient screening

Care plan

Patient and family centered care team

In-app communication with care team

Engaging self care materials and tools

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... and seamless tools for providers and managers

- Patient & Practice Outcome tracking
- Secure team communication
- Appointment scheduling
- EMR integration

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The Ongoing Journey of Emma’s story

• Returned to work
• Following diabetes nutrition plan
• Going to AA meetings with her husband
• Improved mood and PHQ – 9 less Cranky
• She is considering participating in a community support group at the clinic for patients with diabetes & depression
• She can text her care management team and doesn’t have to come to the office as much
• Her husband is an active patient advisor for the clinic
Health Care is Delivered Through Relationships

Brent James MD, 2011

MHI Story of Building Continuous Relationships Overtime
What Matters Most
N = 59

They Care  Being Heard  Trust Competent
Staying Well  We matter

What Is Value?

“Getting to the root of the problem, making it affordable, accessible and successful”
Mental Health is Everyone’s Business

*Multiple Team Touches*

Approx. 43 Million Adults in the U.S. suffer with mental illness.

18% of total population

1 death every 20 seconds from suicide by 2020

$4 Billion Potential U.S. healthcare Annual Savings