Mental Health Integration
Team Based Care Value
Connecting Relationships Overtime

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Objectives

• Intermountain Healthcare Culture of Learning

• Impact of Mental Health Integration-Team Based Care on Quality and Cost

• Key Lessons - Social Cooperation & Value
Highly Integrated Health System

Since 1975
• 22 hospitals
• 2,784 licensed beds

Since 1983
• Health plans
• 700,000+ members

Since 1994
• 1,200 employed physicians
• 558 advanced practice clinicians

Since 1997
• 10 key service lines

Our Charge: To become a “Model Healthcare System”
Evidence-based Care Models
Improving Outcomes and Lowering Costs
What Shapes Population Health?

- Lifestyle 51%
  - Smoking
  - Obesity
  - Stress
  - Nutrition
  - Blood pressure
  - Alcohol
  - Drug use
- Human Biology 20%
- Environment 19%
- Health Care 10%

1 death every 20 seconds by 2020  (WHO, 2014)
Our efforts are ultimately centered around what matters most to our patients, families, employees, members and communities.

**Core Business**
- Perfecting the Clinical Work Process
- Best clinical care in the world doesn’t matter if no one can afford it.
- Always do the right thing!

**The Intermountain Way**
- Improved quality & service
- Evidence-based practice
- Systematic approach—measure & improve

**Culture of Learning**

**Success is always led by clinical team but must include operational, financial, governance and patient engagement**
Mental Health Integration Care Process: Intermountain team-based approach and tools for caring for patients/persons and families.

What is Mental Health Integration?

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

Integration Steps

1. **Leadership and culture** – champions establishing a core value of accountable and cooperative relationships
2. **Workflow** – engaging patients 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
Leaders accountable for cultural performance

• Measured by
  “balanced scorecard”
• Fosters cooperation
“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
Our framework for Mental Health Integration is focused on clinical quality, the patient experience and decreasing overall costs.

Strategy: Mental Health Integration – A team approach to clinics.

Integration
- Care Manager
- Health Advocates
- Psychiatrist or Psychiatric NP
- Therapist (Psychologist, LCSW, EAP)
- Peer Mentor
- Clinic Manager

Personalized Primary Care

Our Families & Patients

Community Resources
- Specialty Care
- NAMI
- Community Therapists
- Physical Therapists
- Nutritionist
- Pharmacists

Clinical Staff (RN, MA, Reception, Billing)

Information Technology / EMR / Data / TeleServices
Work Flow - Match Population Social Needs

MHI Treatment Cascade

Case Identification
Shared Decision Making

MHI Packets

ROUTEINE CARE
Mild Complexity
PCP and Care Manager
Responsive
Family Support
GS=1-3

COLLABORATIVE
MHI TEAM
Moderate Complexity
Complex Co-morbidities
Family Isolated or Chaotic
GS=4-5

MENTAL HEALTH TEAM
High Complexity
Psychiatric Co-morbidities
Family Support Variable
High Social Burden
Danger Risk
GS=6-7
Everyone sees measurement, all accountable
Triple Aim
Patient Experience of TBC
Common MHI Team Process Steps
Patient & Staff Convergence

- Cumulative count of patients or staff who reported steps
- Potential Patient (N = 19)
- Potential Staff (N = 15)
- Adoption Patient (N = 20)
- Adoption (N = 17)
- Staff Routine Patient (N = 20)
- Routine Staff (N = 18)

- FU plan
- Sort team
- Meds
- Discuss options
- Talk results
- Screen
- Explain

- p < 0.0001
- p = 0.0007
- p = 0.198
Multiple Connected Team Touches
(p < .001)

‘we are on the same page’
“A scientific step towards planning for the future needs of our populations”

**Key Research Aim**

“Do clinics with high performing team-based care provide greater value compared to other clinics operating under a more traditional patient management approach—as measured by quality/clinical outcomes, cost, utilization, patient and family service and staff outcomes?”
MHI-TBC Performance 200-2014

Number of Clinics

- No MHI
- Planning
- Adoption
- Routinized

<table>
<thead>
<tr>
<th>Year</th>
<th>No MHI</th>
<th>Planning</th>
<th>Adoption</th>
<th>Routinized</th>
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Team-Based Care (TBC) Intervention

**Characteristics of Routinized TBC**
- Physician/patient engagement
- Care coordination and established routine protocols
- Team communication through EMR and reporting tools
- Outreach to community

**MHI exposure based on Rodger'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)
Deliver System Study: Design and Methods - Summary

DELIVERY SYSTEM COHORT

Longitudinal closed cohort
- At least one visit to IMG PCP within 2003 – 2005.
- Adult patients (≥ 18 years of age).

Stable, consistent relationship with Intermountain
- Patients accessed care within Intermountain facilities/clinics for ≥10 years; allowing 1 gap year.

Size ≈ 130,000 patients
Triple Aim
Quality Outcomes of TBC

Quality

1. Culture Leadership
2. Workflow
3. Information System
4. Financing Operations
5. Community Resources

Our Patients and their Families
### Delivery System Study: % Change in Quality (All Payers)

**Routinized TBC vs. No TBC**

<table>
<thead>
<tr>
<th></th>
<th>Annual visit with PCP</th>
<th>PHQ9 Screen</th>
<th>Adherence to DM Bundle</th>
<th>HTN In Control</th>
<th>Advanced Directives</th>
<th>Self Care Plans</th>
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<tr>
<td><strong>No TBC Rate / 1000 pt yrs</strong></td>
<td>527.2</td>
<td>119.5</td>
<td>121.2</td>
<td>569.4</td>
<td>100.8</td>
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<td><strong>TBC Rate / 1000 pt yrs</strong></td>
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<td><strong>TBC Difference / 1000 pt yrs</strong></td>
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*Self-Care Plans were also evaluated (outcome = 559%, p<0.0001); but was not included in graphic due to scale differences*
Delivery System Study: % Change in Utilization (All Payers)

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<th>Emergency Visits</th>
<th>Hospital Admissions</th>
<th>Ambulatory Sensitive Admissions</th>
<th>PCP Visits</th>
<th>InstaCare Visits</th>
<th>Specialty Care Visits</th>
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<td>Est. PMPY Pmt Savings</td>
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<td>-$111.1</td>
<td>-$7.5</td>
<td>-$10.6</td>
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Triple Aim
Cost Outcomes of 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
MHI Team-Based Care Value: More Than Just a Program

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

- Continuous Connected Relationships
- Normalized
- High quality
- Lower cost
- Global payments
Redesigning Care

Engaging Patients and Members

Aligning Financial Incentives

Shared Accountability

Population Health

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COMMON VISION