Achieving Patient &Family Well-Being
Opportunities for Improving Quality at Lower Cost

Reflections on Scaling the Complexity Science of Mental Health Integration & Integrated Team-Based Care

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We are on a Measured Implementation Journey to Scale Relational Team Networks Organized Around Common Good

“Helping people live the healthiest lives possible®”

“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”

David Satcher, M.D.
Surgeon General of the United States

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

Transforming the Value of Primary Care

Investment in Economic-Social Infrastructure for Reciprocal Trusting Relationships

Mental Health Integration Team Infrastructure		
Diabetes, Asthma, Heart Disease, Depression, Suicide 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

Complexity of Mental Health Integration Science

A standardized clinical and operational team relational processes that incorporate mental health as a routine complementary driving component of wellness & healing

Routinized Integrated Teams Implementation Ecosystem

1	**Leadership and culture** – champions establishing core value of accountable cooperative relationships 'mental health is everyone's business'
2	**Clinical Workflow** – engaging patients and families on the team and matching their complexity and need to the right level of support & training
3	**Information systems** - EDW, registries, EMR, dashboards, technology to support team decision making, communication, performance and outcome benchmarking and quality &cost monitoring
4	**Financing and operations** – projecting, budgeting and sustaining team FTE to measure matching stratification, workforce ROI, adoption maturity
5	**Community resources** – who are our community partners to help us engage our population in scaling sustaining wellness and increasing social connectedness, disseminate findings reward impact

Establishing, Understanding & Connecting Roles Responsibilities of Clinical Team Social Network - TBC Playbook

Matching Right Level of Team Resource to Complexity of Patient and Family Lived Experience

NEEDS

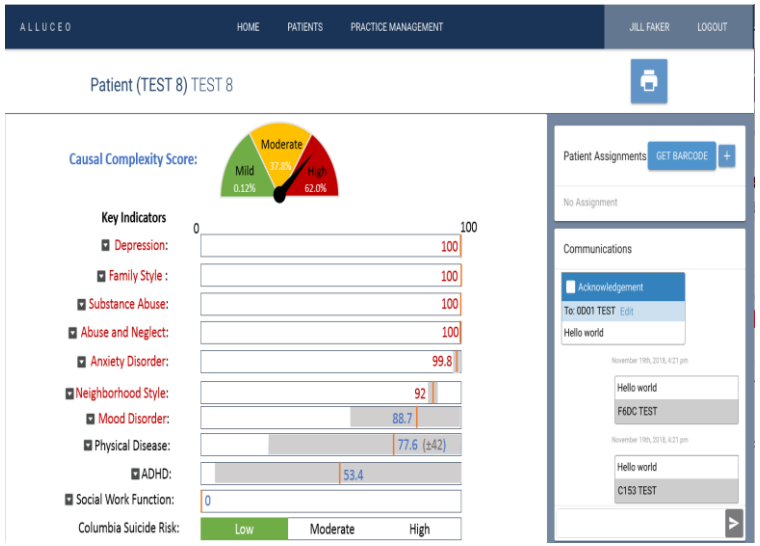
Patients & Families

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

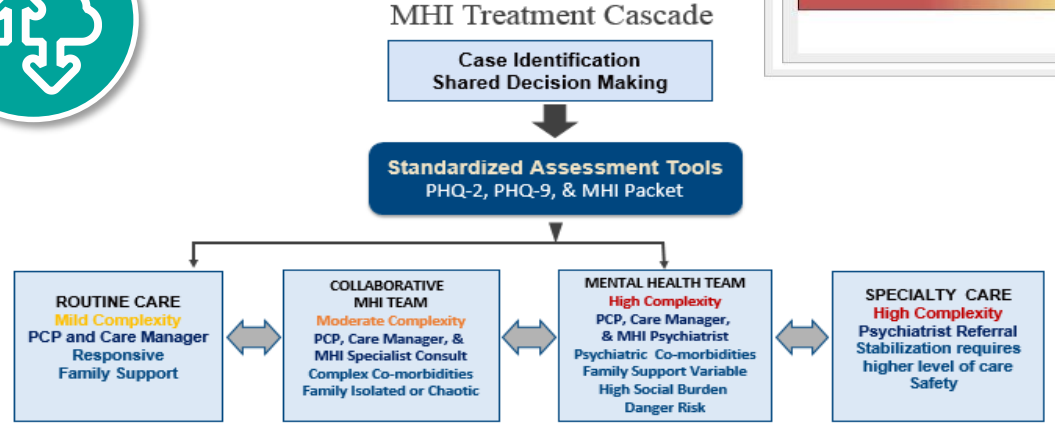
COLLABORATIVE MHI TEAM
Moderate Complexity
PCP, Care Manager, & MHI Specialist Consult
Complex Co-morbidities
Family Isolated or Chaotic

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

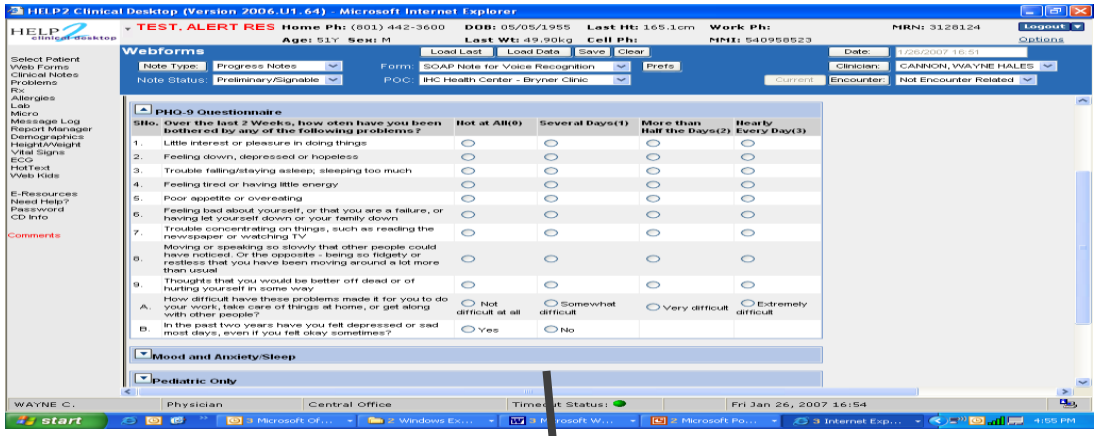
SPECIALTY CARE
High Complexity
Psychiatrist Referral
Stabilization requires higher level of care
Safety

Actionable Data Supports Collective Decision-Making, Care Improvement & Adoption

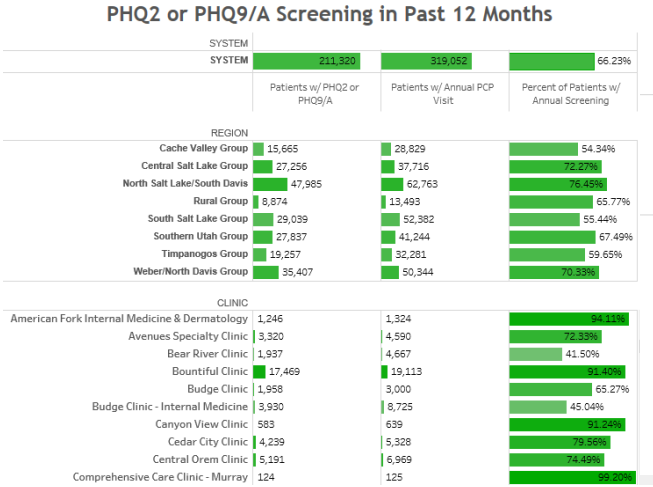
Clinical Process

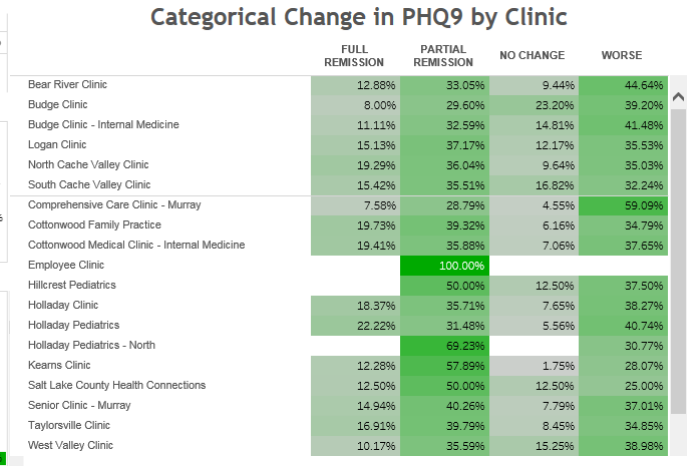


Data Input



Team Feedback / MHI Dashboard





Actionable Data Creation

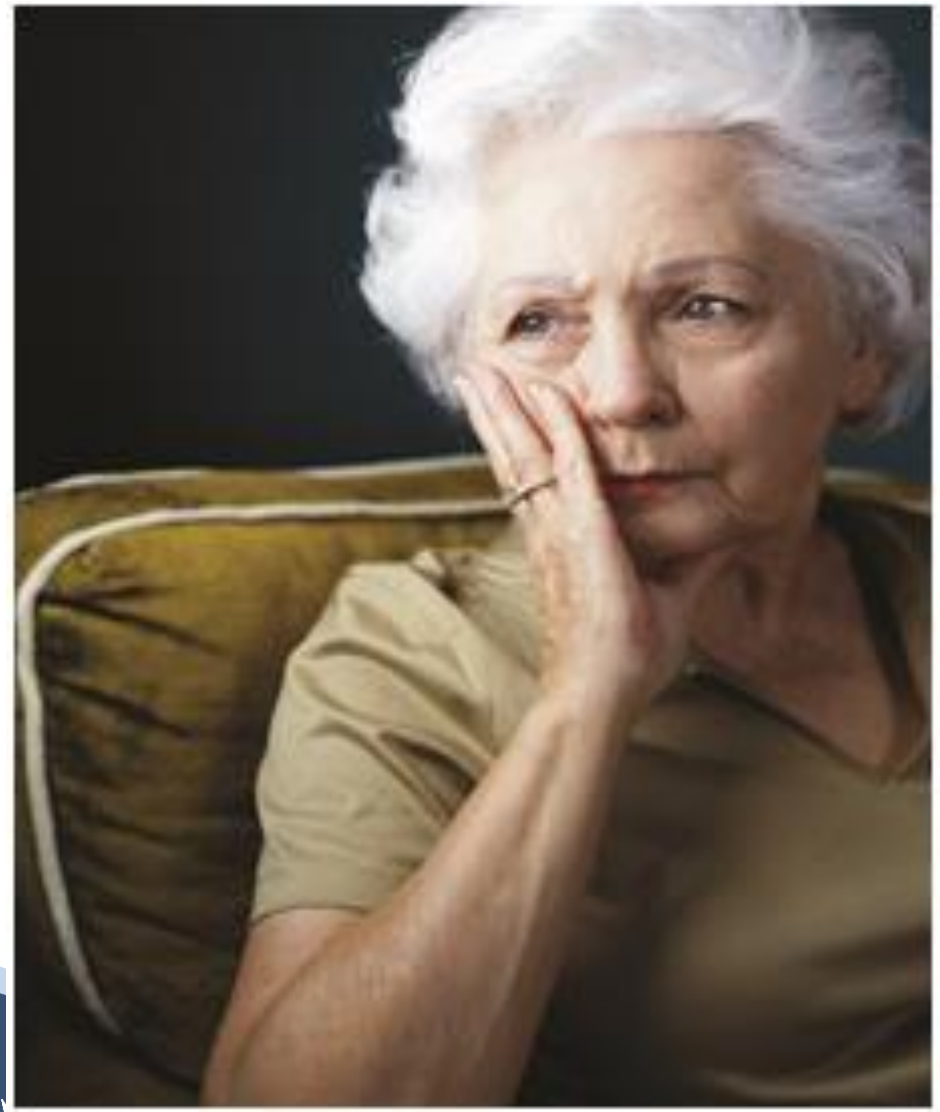
Registry (EDW) – 1999 to present

Depression Registry

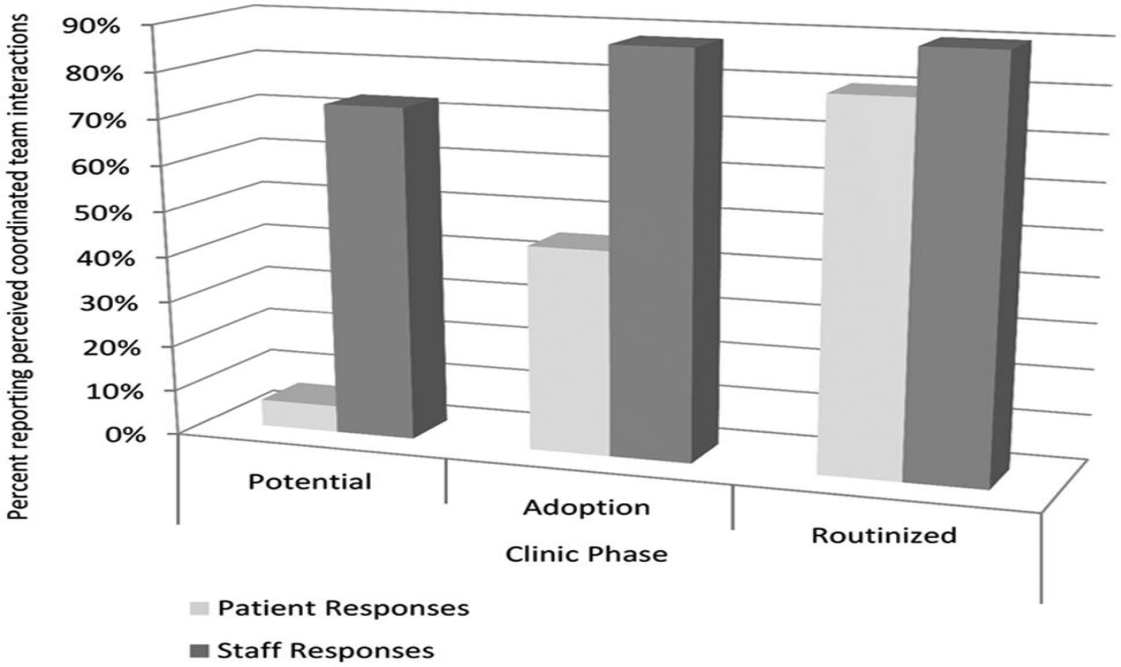
Depression registry n = 704,160

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

Implementation Roadmap - Culture of 'Relational Reciprocity'



Patient-perceived coordinated team interactions by level of TBC maturity



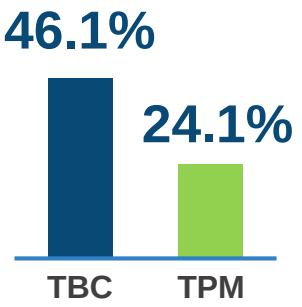
'My doctor was the first person to treat me as a whole person' ($p < .001$)

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

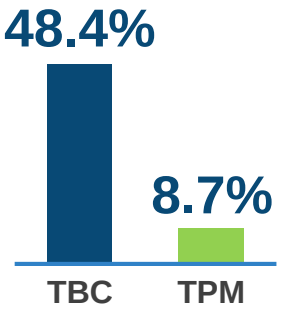
'Being on the same page I get better results' ($p < .01$)

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

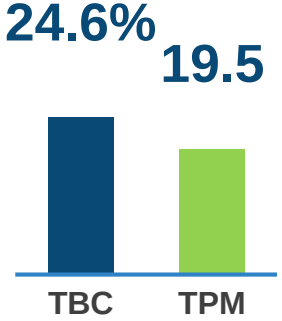
10-YEAR STUDY	
113,452	Participants
113	Primary care providers
27	Team-based care (TBC) medical practices
75	Traditional practice management (TPM) medical practices



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

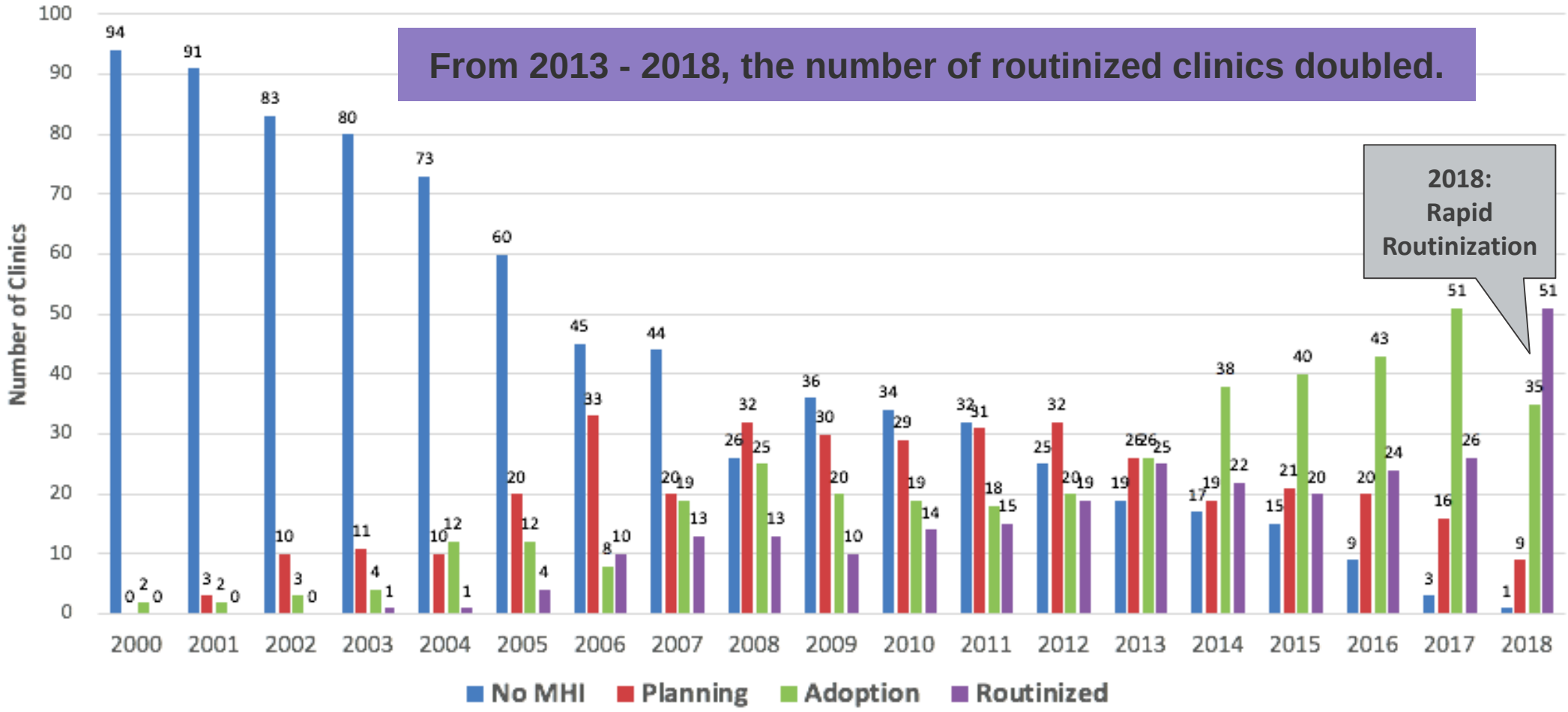
Intermountain® Healthcare

Intergrated Team-Based Care Scorecard

Local stakeholders and Leadership access to Transparent Outcomes

JAMA High Quality Care evidence published (2016)

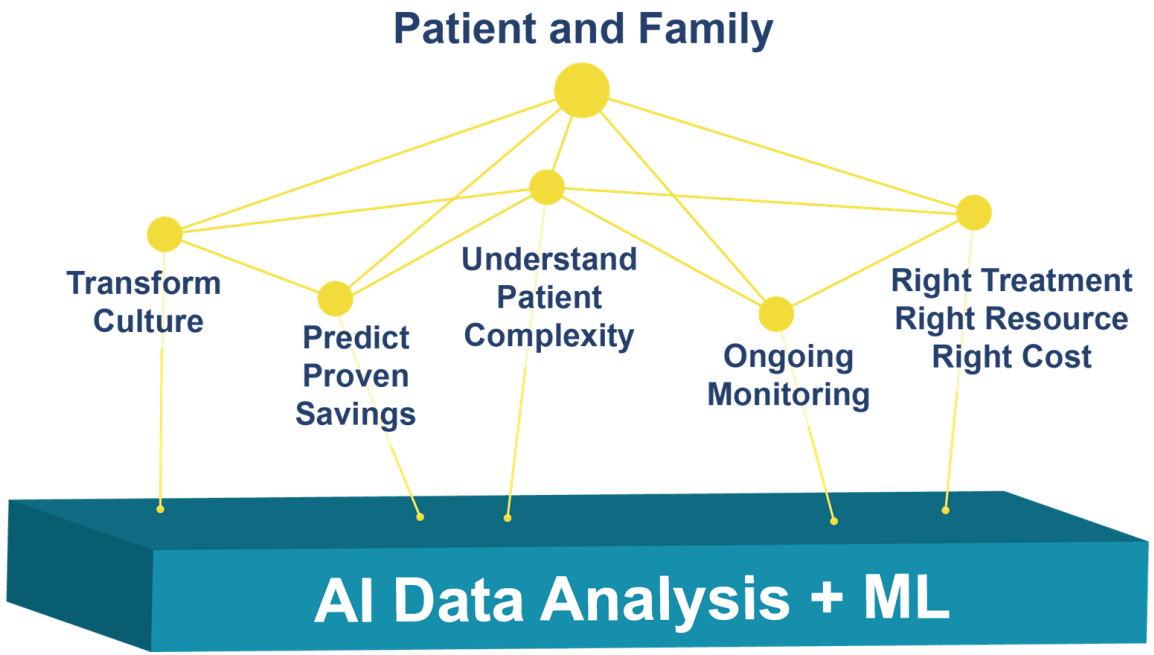
TBC/MHI resources expanded, rapid adoption and routinization followed



Layering intuitive technology on top of TBC/MHI can even further accelerate a clinic's timeline between adoption and routinization.

Future – Scaling Successful Innovations Beyond ‘Bright Spots’ Equitable Integrated Virtual Team Based Care as a ‘Common Good’

Our future roadmap will build upon the patient/practice experience and existing AI/ML analysis as well as sustainable partnerships driving integration opportunities that make ***‘doing good – good business’***



Patient/Family Care Life course Journey

Practice Enablement

Data Intelligence and interoperability

Whole Body Ecosystem and Social Networks

Connectivity through Community Partnership

Key System Implementation Findings
Investing in a Culture of Relational Reciprocity

Cultural Vision Alignment

Do all patients & families have access to experience social norm ‘know/me/us’?

Equitable Workflow

Do all team members voices contribute ‘local say’ to design and implementation?

Complex Data Transparency

Does institution have matching methods to allocate/assess integrated resources?

Continuous Trusting Relationships

Do patients, families, staff, leaders experience meaningfull connections?

Connecting Outcomes Overtime

Does Institution have clear rules for collective action, monitoring & enforcement?