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 20\textsuperscript{th}
  – 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

CORE TRACK
Organizations that report data according to the Core Track submit measures for A1c control, blood pressure control, lipid management, and medical attention for nephropathy among their diabetes patient population on a quarterly basis.

To support groups in reporting Core Track data, we offer:
- Measurement specifications, which were updated in April 2019. To see an overview of the updates, review our Summary of Changes document.
  - 2019 HEDIS Value Sets (Excel format), which are referenced in the measurement specifications
  - Data orientation webinar (full recording and slides only) for first-time reporters
  - Data FAQs

For questions or concerns regarding the data specifications please email DataHelpForT2G@amba.org.

Once your organization is ready to submit data, please visit data submission.
New Offering: Toolkit Supplement
“Webinars at Work”

Webinar at Work
February 2019
“Putting HCPs in the driver’s seat”

Webinar: “Putting HCPs in the driver’s seat”
Speaker: Brian O’Hara, M.D., BCPS (Pittsburgh, PA)
Webinar Date: February 23, 2019

Summary:
Healthcare providers often need to titrate or intensify therapy, therefore ensuring clinical inertia is broken by 1) demonstrating use of proven and evidence-based care guidelines, 2) using a tool to assess and monitor adherence to care guidelines, and 3) providing an education component and provider education. This webinar will offer a comprehensive approach to improving clinical inertia and adherence to care guidelines.

Implementation Tips:

- Education is easily accessible but not sufficient
- Education needs to be dynamic and adapt to changing needs
- Education needs to be structured to facilitate meaningful interactions
- Education needs to be integrated into hospital or clinic’s infrastructure
- Provide performance feedback
- Feedback should be timely and specific
- Gather user testimonials and feedback

Team Discussion:
1. Where is our diabetes module now and what needs to be done to improve adherence?
2. What are the common barriers to improving clinical inertia and adherence to care guidelines?
3. How can we improve our organization’s process for following up with patients to improve clinical inertia?
4. Are there any new or emerging tools to improve clinical inertia?

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

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
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

1975

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

1980s

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

1990s

- Medical Group
- Clinical Programs
- Clinical Board goals

2000s

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

2010s

- Intermountain Foundation

To Present

Intermountain Healthcare
Culture of Learning Builds Values

Common Vision | Clinical Work Processes | Data and Evaluation Transparency

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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 disorders: 201
- Heart conditions: 147
- Trauma: 143
- Cancer: 122
- Pulmonary conditions: 95
- Osteoarthritis: 91
- Normal birth: 67
- Diabetes: 62
- Kidney disease: 54
- Hypertension: 52
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.
Multiple Conditions Increase Complexity

Chronic health conditions are often interrelated

A survey of 120,000 employees found:

- 23% with no chronic conditions
- 22% with 1 condition
- 16% with 2 conditions
- 12% with 3 conditions
- 8% with 4 conditions
- 19% with 5 or more

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
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

The rest of Emma’s story

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

<table>
<thead>
<tr>
<th>Mental Health Integration Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes, Asthma, Heart Disease, Depression, Hypertension, ADHD, Obesity, Chronic Pain, SUD, etc.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<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>
</tr>
</tbody>
</table>

*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

Clinic MHI Team:

- Primary Care Clinician
- Psychiatrist / APRN
- Social Worker
- Clinic Manager
- Care Manager
- Care Advocate
- Care Guide
- RN, MA, Reception, Billing

Community Resources:

- Peer Mentors
- Care Advocates
- Pharmacists
- Clinic Staff: RN, MA, Reception, Billing

Our Patients and their Families:

- Our Patients and their Families
- Physical Therapists
- Nutritionists
- Therapists

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

**NEEDS**
- Patients & Families

**Workflow**
- 2

### 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 explain and give her the MHI packet and instructions to complete it prior to a follow up visit next week (2 min)

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

<table>
<thead>
<tr>
<th>mhi</th>
<th>mhi</th>
<th>Moderate</th>
<th>Severe</th>
<th>Boston CliniCare</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CliniCare Hospital</td>
<td>Medical Center</td>
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</tbody>
</table>

- **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-reliance
- Introduce Care Manager for education & FU
- Engage MHI team – trust
Actionable Data Helps Support Decision-Making & Care Improvement

Clinical Process
- MH1 Treatment Cascade
  - Case Identification
  - Shared Decision Making
  - Standardized Assessment Tools
    - PHQ-2, PHQ-9, & MHI Packet

Routine Care
- PCP and Care Manager
- Responsive Family Support

Collaborative Care Team
- PCP, Care Manager, & MHI Specialist Consult
- Complex Care Problems: Family Isolated or Chronic

Mental Health Team
- High Complexity
- Psychiatric: General Medical
- Depression: Medication Non-Compliance
- Family Support: Variable High Social Burden
- Danger Risk

Specialty Care
- High Complexity
- Psychiatric: General Medical
- Depression: Medication Non-Compliance
- Family Support: Variable High Social Burden
- Danger Risk

Team Feedback: MHI Dashboard

Data Input

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

<table>
<thead>
<tr>
<th>Depression Registry</th>
<th>Actionable Data Creation</th>
<th>Registry (EDW) – 1999 to present</th>
<th>Data Input</th>
</tr>
</thead>
</table>
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
Patients 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

- Statistically significant: P < 0.01
  - OR = 1.49, CI = (1.11, 2.01)
  - OR = 2.19, CI = (1.33, 3.60)
A Cultural Pathway towards Team Routinization  N = 120/185

**Leadership & Culture**
- Committed Leadership
- Identify Population Complexity

**Workflow Integration**
- Design patient workflow
- Identify Patient & Family Complexity

**Information Systems**
- Complete team scorecard
- Design MHI Dashboard

**Financing & Operations**
- Review & Track clinical & operational reports quarterly; Team FTE

**Community Resources**
- Inventory of potential partners
- Identify support groups & classes

**Planning Score: 9-25**
- Implement staffing & provider needs
- Assign all roles relative to MHI CPM Routine Meetings

**Adoption Score: 26-41**
- Implement strategies to address barrier
- Develop care management strategy
- Providers assign complexity & stratification
- Dashboard identifies gaps & chronic disease action plans
- Gaps identified & action plans developed
- Refine meaningful tools – TBC ROI
- Process developed to provide resources
- Team link patients to groups, classes, peer support

**Routine Score: 42-51**
- Monitored adherence
- Continuous training & support provided
- Champions leading
- Identified workflow gaps; Improved process
- Engaged providers w/ treatment cascade
- Difficult case conferences
- Tracked patient complexity data
- Dashboard used to target outcomes results
- Reports used to improve performance
- Data used to target utilization & cost gaps
- 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)

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.

- **2000**: Started Mental Health Integration (MHI)
  - Physical and mental health interdisciplinary teams in patient care.

- **2003**
  - **2003 – 2009 BASELINE MHI**
  - **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)

- **2005**

- **2010**
  - **2010 PPC Started**

- **2013**
  - **r-TBC Study Period Continuous Encounters**
  - Differences associated with their exposure to TBC compared with TPM

- **2018**
  - **MHI Program primary care practices**
  - **18 years**
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.

<table>
<thead>
<tr>
<th>10-YEAR STUDY 2003-2013</th>
<th></th>
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<tbody>
<tr>
<td><strong>Participants</strong></td>
<td><strong>Primary care providers</strong></td>
</tr>
<tr>
<td>113,452</td>
<td>113</td>
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</table>

<table>
<thead>
<tr>
<th>Screened for Depression</th>
<th><strong>TBC</strong></th>
<th><strong>TPM</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>46.1%</td>
<td>24.1%</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Documented self care plan</th>
<th><strong>TBC</strong></th>
<th><strong>TPM</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>48.4%</td>
<td>8.7%</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Adhered to diabetes protocol</th>
<th><strong>TBC</strong></th>
<th><strong>TPM</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>24.6%</td>
<td>19.5%</td>
<td></td>
</tr>
</tbody>
</table>

**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.

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

Leadership and culture
Workflow integration
Information system
Financing and operations
Patients and families
Community resources

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

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

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)
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
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
- EMR integration

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*

- **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


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June Webinar

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