M7: Integrating Mind and Body Healing into Primary Care: A Team Approach

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This presenter has nothing to disclose.

What is Mental Health Integration?

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

* Mental Health includes Substance Abuse Recovery
Intermountain Medical Group

1,056 physicians

342 primary care (Peds, FM, IM)
55 behavioral health

265 advanced practice clinicians
Intermountain’s Strategy: Clinical Integration

“...high-quality care at costs below average.”
Barack Obama

Focus on the Six Dimensions of Extraordinary Care:
- Clinical Excellence
- Operational Excellence
- Service Excellence
- Physician Engagement
- Employee Engagement
- Community Stewardship

Clinical Integration: Management of Complex Chronic Disease Primary Care Clinical Program

<table>
<thead>
<tr>
<th>Mental Health Integration Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes, Asthma, Heart Disease, Depression, Obesity, Chronic Pain, SA, etc.</strong></td>
</tr>
<tr>
<td>2/3 – cared for routinely in primary care</td>
</tr>
<tr>
<td>Patient &amp; Family, PCP, and Care Manager (CM) as needed</td>
</tr>
</tbody>
</table>

*Primary Care Physician (PCP) includes: General Internist, Family Practitioner, Pediatrician*
Summary of Published Outcomes

Rapid spread (85 Intermountain primary care clinics, 4 specialty clinics, and 49 non IH clinics)
Sustained team-based redesign
Improved patient health outcomes
Improved physician, staff and patient satisfaction
Decreased ER utilization & overall medical expense to health plan (Reiss-Brennan et al., 2010 Journal of Managed Health Care)

Normalized Team Care Improves Patient Outcomes (Reiss-Brennan, 2013 Journal of Primary Care and Community Health)

Savings to Commercial Insurance
Patients who have depression have their diabetes in better control when treated at an MHI clinic (p < 0.01)
“Getting to the root of the problem”
Four Habits of High-Value Health Care Organizations
Bohmer, R. NEJM, December, 2011

Specification and Planning
Infrastructure Design
Measurement and Oversight
Self-Study

The Quality Challenge

The Right Care  For The Right Person  At The Right Time

Transitioning From Volumes to Value
Social Context Challenge
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…”

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Emma

Missed 5 days work
Not sleeping, not eating much
Not going out of the house
Cranky
Husband exhausted

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)
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, 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)

What is Mental Health Integration?
Enhancing Primary Care Value
Sustaining Outcomes

To support Primary Care Providers and MHI Team members with best practices in an effort to:
• Reach as many families as possible
• Improve quality of life
• Increase satisfaction
• Reduce practice burden
• Decrease costs to the system
• Engage community resources
The Triple Aim and Shared Accountability

MARTY

Clinical Quality
Medical Directors

NAN

Cost of Care
RNC, Care Manager

SOLOMON

Primary Care Clinical Program

Routinized Progress by Region
Summary Report
Mental Health Integration
5 Key Components

- Culture Leadership
- Community Resources
- Financing Operations
- Information System
- Workflow

I. Leadership & Cultural Integration
   What is the mind body spirit context of your practice?

II. Work Flow Integration
   How do you decide who the patient sees and how often?

III. Information Technology/EMR/Population Data Integration
   How will you monitor and communicate your progress?

IV. Operations & Financing Integration
   What will be the cost to your clinic without?

V. Community Resource Integration
   Who else locally cares about this value cost?

Our Patients and their Families
   What matters to you?
I. Leadership & Cultural Integration

Quality Investment
Local Champions
Practice Teams
Accountability
Co-production
- Train all
- Treat all
- Connect all

Shared care

II. Work Flow: MHI Team Roles

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

Clinic Manager

Personalized Primary Care

Our Patients and their Families

Clinic Staff:
RN, MA, Reception, Billing

Information Technology / EMR / Data / Telehealth

Community Resources:
- CHADD
- NAMI
- Community Therapists
- Physical Therapists
- Nutritionist
- Pharmacists
**II. Work Flow: MHI Treatment Cascade**

- **Case Identification**
  - Shared Decision Making

- **MHI Packets**

- **Routine 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

**Family Engagement Patterns**

"Who do you most commonly go to or talk to when you are distressed or don’t feel well?"

Can we understand our patients better if we know where they are coming from?

- "Isolated"
  - Disconnected/Avoidant

- "Available in use"
  - Balanced/Secure

- "Burnt out"
  - Confused/Chaotic
II. Patient and Family Care Planning Worksheet

Team Roles

Patient and Family

Seek care from you

Fill out packet and return it to the clinic

Treatment Decisions

Self management

Follow up

Lifestyle Changes
Team Roles
Primary Care Provider and Support Staff

- Screen, diagnose, and treat
- Use MHI Tools, Screening packets, PHQ-9
- Activate and introduce other team members based on diagnosis and severity
- Use the EMR to communicate with team members and collect data
- Prepare patient and family for MHI

Team Roles
Care Manager

Help with follow up:
- Family adherence
- Patient and family education
- Outcome measures
- Self Care plans

Help with MHI Tools
Use the EMR to communicate with team members and collect data
Mentor office staff in PPC process
Team Roles

Health Advocate

Review Patient Schedules & fill out the Preventative/Social Tab
Contact new patients check to see how they are doing on their new medications etc.
Meet with patients that the physicians asks us to; teaching them specifics about the diagnosis they have; do a care plan with them.
Assist patients with obtaining discounted medications

Team meetings with both the physician, MA’s and a front office staff member who is involved with specific patient care.

Team Roles

Psychiatrist / APRN

Screen, diagnosis and treat
Review and use MHI Packet
Collaborate with patient, primary care clinician, and care manager in developing treatment plan
Prescribing psychotropic medications
Clinician and staff education
Use the EMR to communicate with team members and collect data
70/30 productivity/communication
Team Roles

Therapist

PhD, LCSW, EAP
Screen, diagnosis, and treat
Review and use MHI Packet
Collaborate with patient, primary care clinician, and care manager in developing treatment plan
Psychotropic medication knowledge
Clinician and staff education
Use the EMR to communicate with team members and collect data
70/30 productivity/communication

Team Roles

Community Resources

Vary by location and system
- NAMI – Peer Mentors
- CHADD
- Local clinicians
- EAP

Important partners and trained patient advocates
Family support
No cost service
Family classes
Mental Health Integration

Option 2: MHI

Obtain more history, explain MHI team (3 min)

Assess suicide risk (3 min)

You agree this is very important and would like to help with it. You give them an 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

call this family in 3 days, help with packet and appointment

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III. Information System Integration

to support monitoring clinical improvement communication, and operation needs

Information for population based quality improvement

Financing and clinic operation needs

Information Systems
The Flow of Information: Team Message Log

Case Identification

Use of EMR

Routine Care
PCP + Oil任tonise Family Support +8n.13 also Complex

Collaborative MHI Team
Complex Co + iCo + oloing Charyst 0.6+4.6 Moderate Complexity

MHI
Psych Co Volatility Family Support + Burden Danger Risk G0=67 Severe Complexity

Team Feedback: MHI dashboard

Registry (EDW) – 1999 to June 2013

Depression registry n = 416,433
148,527 currently active (in the last 12 months)
70,074 unique patients with phq9 and 53,316 with phq2 for patients in depression registry with a total of 183,175 phq9 and 164,502 phq2
106,784 unique patients with phq9 and 153,637 with phq2 for all patients with a total of 234,705 phq9 and 382,048 phq2
7.2% of patients not seen in primary care or behavior health
67% female 48% private insurance

A streamlined implementation process has resulted in exponential growth in MHI clinics (N = 82)
MHI dashboard

Measures:
- ED rate and cost for all dx and MH dx
- Hospitalization rate and cost for all dx and MH dx
- Total cost of care for SelectHealth patients only
- Screening rate for depression
- Change in PHQ9
- No show rate

http://edwtabtest/views/MHI-ERUtilization/ER?embed=y&:tabs=no&:display_count=no

Linking Cost and Quality Outcomes

<table>
<thead>
<tr>
<th>PHQ-9 Initial Severity</th>
<th>Decrease of &gt;=5 points within 3 months</th>
<th>Decrease of &gt;=5 points within 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-27 points</td>
<td>70.9% *</td>
<td>62.6 %*</td>
</tr>
<tr>
<td>15-19 points</td>
<td>65.1% **</td>
<td>50.8 %</td>
</tr>
<tr>
<td>6-14 points</td>
<td>48.7% *</td>
<td>38.8 %</td>
</tr>
</tbody>
</table>

*Difference between significant improvement and no significant change is <0.001
**Difference between significant improvement and no significant change is <0.01

Significant Functional Improvement
54% Reduction in ER utilization
For depressed patients treated in MHI Clinics
IV. Operations & Financing Integration
Value Incentives and Sanctions

- Achieve a sustainable MHI program all regions
- Saving to System (ACO, SAO, Community)
- Value Foundation for ‘Medical/Health Home’
- Routinized MHI sites establish-baseline best practice
- **TEAM FTE**
  - Identify operational barriers and plan operational resources for 2013-2014 budgets
- Disseminate evidence to communities

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Team Roles – Regional Accountability

*Operations Director / RN Consultants / RMDs*

- Mentoring Champions
- Recruiting
- Staffing
- Finance
- Payer Contracting
- Implementation Change Agents
Rogers, E. *Diffusion of Innovations*, 1995—discussion of stages

**Primary Care Clinics by Stage of MHI Implementation**

- 76
- 24
- 65
- 9

Urban
Rural
Uninsured School Based

**MHI Team Operational Score Card**

*5 dimensions:*
- Leadership and culture
- Workflow integration
- Information system
- Finance / Cost of care
- Community Resource

**Method:**
- Clinics self-report on the 5 dimensions and receive a score measuring their evolution towards routinization

**Example:**
- Detail of score card and results at Salt Lake Clinic
**Implementation Scorecard: MHI at Salt Lake Clinic**

<table>
<thead>
<tr>
<th>Key Components</th>
<th>Beginning Score</th>
<th>Current Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Outcomes</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>1. Leadership and Culture</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>2. Workflow Integration</td>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>3. Information Systems</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>4. Finance/Cost of Care</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>5. Community Resource</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>52</strong></td>
</tr>
</tbody>
</table>

**Team Performance Goals**

- **Planning Score:** 25
- **Adoption Score:** 50
- **Routine Score:** 75
V. Community Resource Integration

Vary by location and system
- NAMI
- CHADD
- Local clinicians
- EAP

Important partners and trained patient advocates

Family support

Consumers as leaders and developers of high value care
V. National Communities Diffusing MHI Common Set of Value Measures (2013)
Study Aims: identify the key factors in patient and staff social interactions underlying the improved outcomes observed in the MHI clinics.

How MHI:

a) improves outcomes for patients
b) furthers an effective team approach among staff
c) alters the culture of health care delivery

<table>
<thead>
<tr>
<th>Positive Outcomes</th>
<th>Total N = 59</th>
<th>Potential N = 19</th>
<th>Adoption N = 20</th>
<th>Routine N = 20</th>
<th>p</th>
<th>p trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved Life Functioning</td>
<td>.92</td>
<td>.89</td>
<td>.85</td>
<td>100</td>
<td>.2173</td>
<td>.2306</td>
</tr>
<tr>
<td>Thinking Clearly</td>
<td>.31</td>
<td>.16</td>
<td>.25</td>
<td>.50</td>
<td>.0547</td>
<td>.0134*</td>
</tr>
<tr>
<td>Established Personal Relationship</td>
<td>.55</td>
<td>.37</td>
<td>.65</td>
<td>.65</td>
<td>.1260</td>
<td>.0792</td>
</tr>
<tr>
<td>Treatment Works</td>
<td>.66</td>
<td>.53</td>
<td>.55</td>
<td>.90</td>
<td>.0209*</td>
<td>.0130*</td>
</tr>
<tr>
<td>Connect Mind Body “Same Page”</td>
<td>.34</td>
<td>.16</td>
<td>.25</td>
<td>.60</td>
<td>.0084**</td>
<td>.0035**</td>
</tr>
<tr>
<td>Location Convenient</td>
<td>.20</td>
<td>.21</td>
<td>.25</td>
<td>.15</td>
<td>.7312</td>
<td>.0948</td>
</tr>
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</table>

Pearson’s chi squared test and p for trend Chi square **p < 0.01 *p < 0.05
## Promoting Factors Reported by Staff

<table>
<thead>
<tr>
<th>Promoting Factors</th>
<th>Total N = 50</th>
<th>Potential N = 15</th>
<th>Adoption N = 17</th>
<th>Routine N = 18</th>
<th>p</th>
<th>p trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Self Confidence</td>
<td>.36</td>
<td>.06</td>
<td>.23</td>
<td>.67</td>
<td>.0007**</td>
<td>.0002**</td>
</tr>
<tr>
<td>Engage Patient</td>
<td>.72</td>
<td>.86</td>
<td>.53</td>
<td>.78</td>
<td>.1188</td>
<td>.6520</td>
</tr>
<tr>
<td>Mental Health Comfort</td>
<td>.46</td>
<td>.33</td>
<td>.35</td>
<td>.78</td>
<td>.0129*</td>
<td>.0088**</td>
</tr>
<tr>
<td>Staff Confidence</td>
<td>.72</td>
<td>.80</td>
<td>.73</td>
<td>.72</td>
<td>.8887</td>
<td>.8337</td>
</tr>
<tr>
<td>Connected Staff</td>
<td>.54</td>
<td>.40</td>
<td>.59</td>
<td>.61</td>
<td>.1297</td>
<td>.0648</td>
</tr>
<tr>
<td>In House Team</td>
<td>.50</td>
<td>0</td>
<td>.80</td>
<td>.72</td>
<td>.00002**</td>
<td>N/A</td>
</tr>
<tr>
<td>Using Tools &amp; Team</td>
<td>.36</td>
<td>.33</td>
<td>.17</td>
<td>.94</td>
<td>.00001**</td>
<td>.0002**</td>
</tr>
<tr>
<td>Timely Response</td>
<td>.36</td>
<td>.13</td>
<td>.41</td>
<td>.50</td>
<td>.0792</td>
<td>.0313*</td>
</tr>
</tbody>
</table>

Pearson’s chi squared test and p for trend Chi square **p < 0.01 *p < 0.05
What is MHI on the frontline?

<table>
<thead>
<tr>
<th>Staff MHI</th>
<th>Total N =50</th>
<th>Potential N = 15</th>
<th>Adoption N = 17</th>
<th>Routine N = 18</th>
<th>p</th>
<th>p trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organized Process</td>
<td>.50</td>
<td>.13</td>
<td>.47</td>
<td>.83</td>
<td>.0002**</td>
<td>.0001**</td>
</tr>
<tr>
<td>Available Support</td>
<td>.72</td>
<td>.33</td>
<td>.88</td>
<td>.88</td>
<td>.0032**</td>
<td>.0647</td>
</tr>
<tr>
<td>Empowered to provide better care</td>
<td>.62</td>
<td>.26</td>
<td>.88</td>
<td>.66</td>
<td>.0024**</td>
<td>.0272*</td>
</tr>
<tr>
<td>Regular Expectation</td>
<td>.56</td>
<td>.13</td>
<td>.88</td>
<td>.61</td>
<td>.0001**</td>
<td>.0100*</td>
</tr>
</tbody>
</table>

Pearson’s chi squared test and p for trend Chi square **p < 0.01 *p < 0.05

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

“My doctor was the first person to treat me as a whole person......”
Common MHI Team Process Steps
Patient & Staff Convergence

Summary

Normalizing mental health as an organized team process within the context of primary care offers promising results for improving outcomes for patients with chronic disease.

The screening, team management and follow-up care for depression that patients were receiving were the intended steps of the MHI program and described engaged patient experiences in routinized clinics.

Using the patients’ perception of their outcomes and their team care experience to improve health care quality is essential for health reform towards patient centered care.
Multiple Team Touches
\( (p < .001) \)

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 and successful”
Impact of MHI on diabetes bundle compliance

- Statistically significant: P < 0.01
- Confidence Intervals
- Odds Ratio

OR = 1.49, CI = (1.11, 2.01)

OR = 2.19, CI = (1.33, 3.60)
The Value Challenge
Population Health

- Defined around patient experience
- Cost measured
- Outcomes Achieved

Our Job is Not Over

- Expanding team work requires institutional will
- Will patient outcomes last?
- Will this reduce overall healthcare cost?
- Lifetime gains require finding ways to broaden team support to family and community
- You manage what you measure
- A key factor in our health is the health of others around us
Success.