~~One Path~~ toward Integrated Care

…Many Paths

Summit Pointe

November 29, 2010

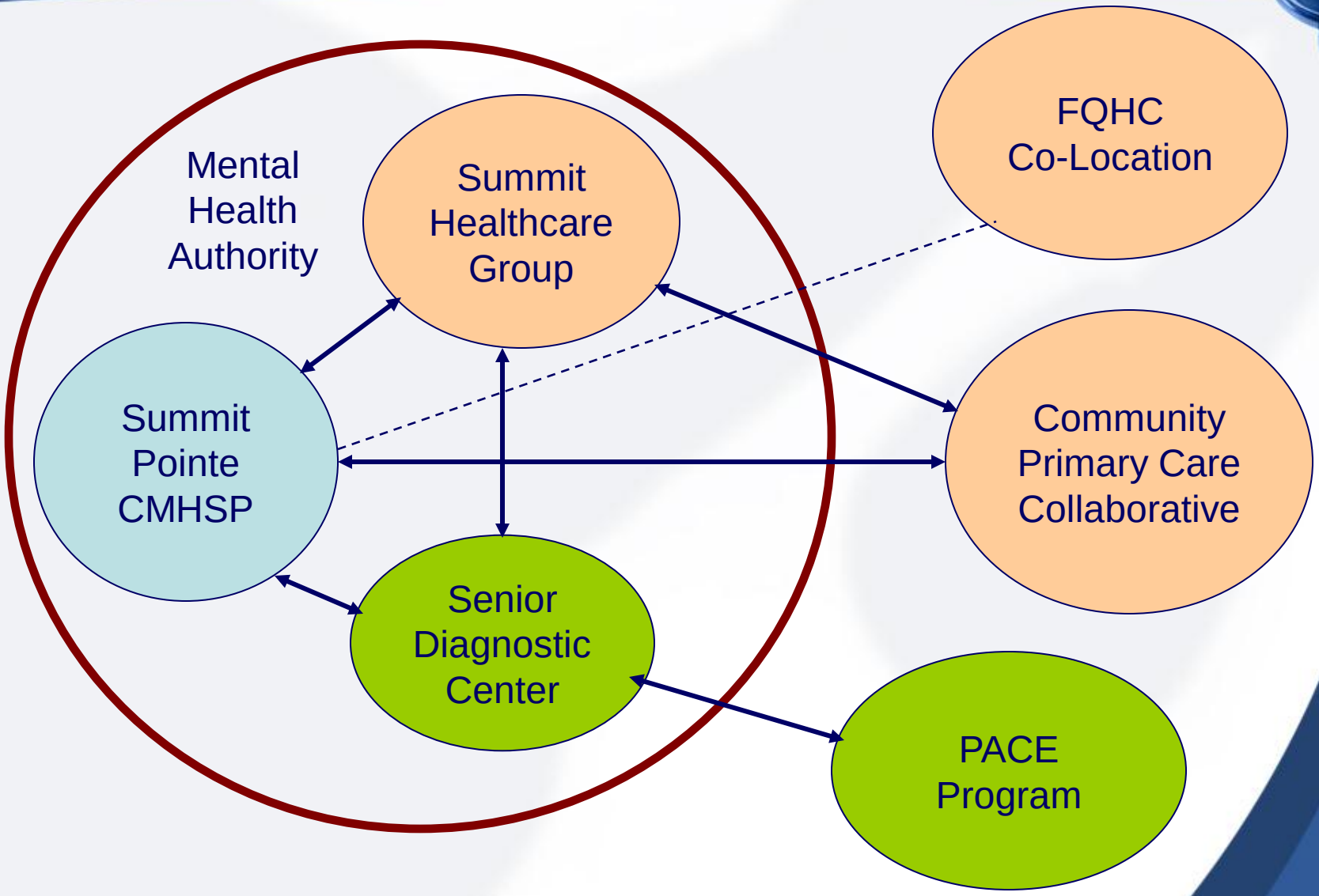
The Elements of the Model

- A Primary Care Practice ***fully owned and operated*** by the CMHSP
- The PCP is ***housed within the CMHSP*** and integrated within its operations
- The Primary Care Practice ***services CMHSP customers AND the general community***
- Staffing:
  - MD
  - ***Physician's Assistant [newly added]***
  - Psy.D/Clinical Psychologist
  - LMSW
  - Peer Support Specialists
- Case Managers and Peer Support Specialists weave BH and PCP services into ***a unified person-directed plan***
- ***Wellness/Illness Management Groups*** (e.g., PATH, WRAP, IDDT) are increasingly delivered in a range of settings
- Aggressive and ***continual health monitoring and referral***
  - Brief Health Check each Med Review (Weight; BP; Temp; BMI)
  - CMHSP → Primary Care
  - Primary Care → CMHSP

A Status Report

- Physician Development on Target
- Primary Care Physician fully integrated into Psychiatric Staff: now a Medical Staff member ***→Joint Case Staffing***
- Enrollment On Target: 125 Customers ***formally*** part of Block Grant [N.B.: 230 served by PCP)
- Baseline Data shows the 6 most frequent Medical Diagnoses identified:
  - Hypertension (31%)
  - Asthma (21%)
  - Osteoarthritis (21%)
  - COPD (14%)
  - Hypothyroidism (14%)
  - Diabetes (10%) → ***additional studies suggest this is an undercount***
- Outcome Study facilitated by Flinn Foundation → ***Baseline Studies are completed***
- Peer Support Specialist involvement growing
  - Providing PATH classes regularly
  - Embedded in ACT, CSM, SBH, OP, and Drop-In Center
  - Serving as system integrators
- Nursing in other units are changing
  - ***More emphasis on physical health elements***
  - Greater satisfaction in roles
  - Desire to build Wellness Services in a multitude of programs
- Greater “legitimacy” in the wider physical healthcare world

Our Current Integrated Health System



Briefings in Preparation

- Pointers on ***Starting a Primary Care Practice*** within a Behavioral Health Center
- ***Avoiding Pitfalls when Blending Cultures***: Primary Care and Behavioral Healthcare
- Marketing the Primary Care Practice for ***Sustainability***
- ***Embedding a Holistic Approach*** in Person-Centered Planning
- What Counts: Measuring Individual Assessment, System Change, and ***Outcomes***
- ***How Case Management Operates in an Integrated Healthcare System***: A New Model
- Peer Support Specialists as ***Drivers of Integrated Healthcare***
- Managing the Abyss: ***Facilitating Information Flow*** within an Integrated Healthcare System
- ***Organizing the Medical Staff*** for Integrated Care: Physicians, Mid-Level Practitioners, Nursing Staff
- ***Lessons*** from the Integrated Health Block Grant: Do-Overs and the Future

Who Are We? Who Shall We Be?

The New World

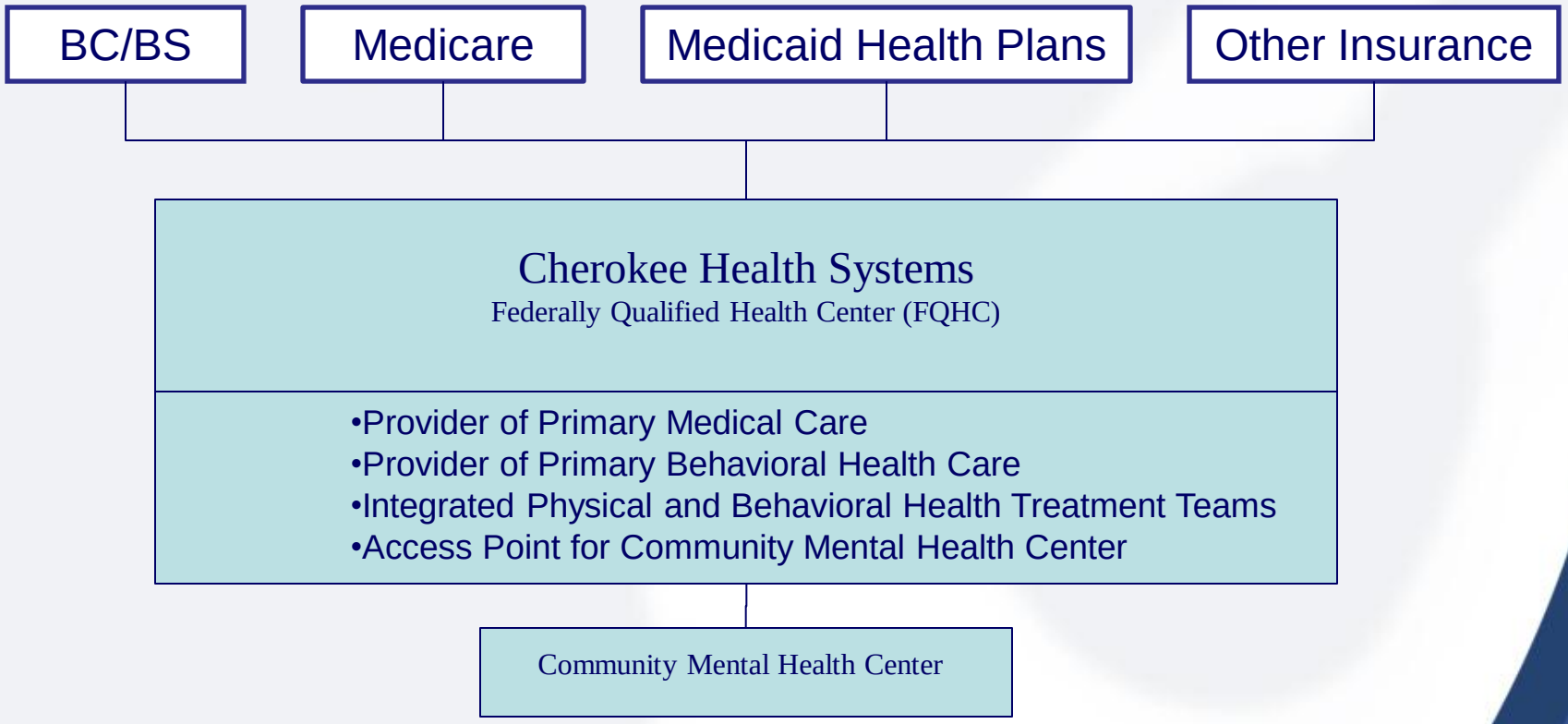
- Impoverished State and Local governments
- Near-elimination of GF Funding
- Fully federalized (i.e., Medicaidized) programs
- Clarity of need for *integrated* healthcare
- Move towards “lean” public safety net
- Planned reduction of administrative structures
- Perception that MH system is “broken”
- Difficulty articulating the benefits of MH
- Difficulty passing MH Parity Bills
- Health Reform Acts privilege FQHCs

Standard Roles

- Specialty Behavioral Health ***Provider***
- ***Facilitator*** of Regional Behavioral Healthcare
- ***Steward*** of fiduciary and clinical resources
- Community and Political ***Troubleshooter***

Will these standard roles work in the healthcare systems of the future?

Cherokee Health Systems

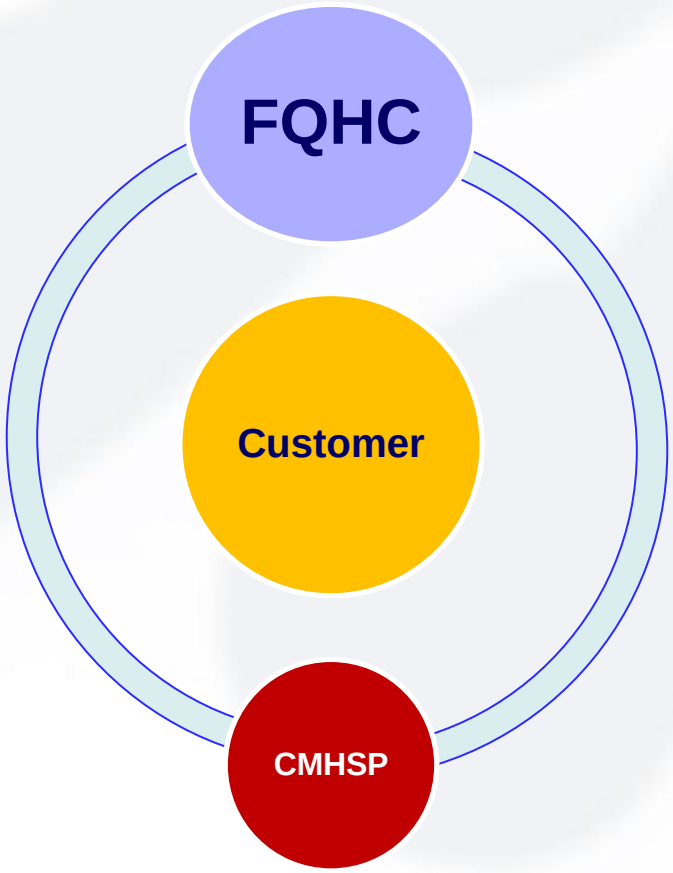


A Changing Self-Definition

- An ***Integrated*** Healthcare System
- Concentrating the ***Provider*** Elements of our Identity on Healthcare Integration
- Building ***Partnership*** with other healthcare providers

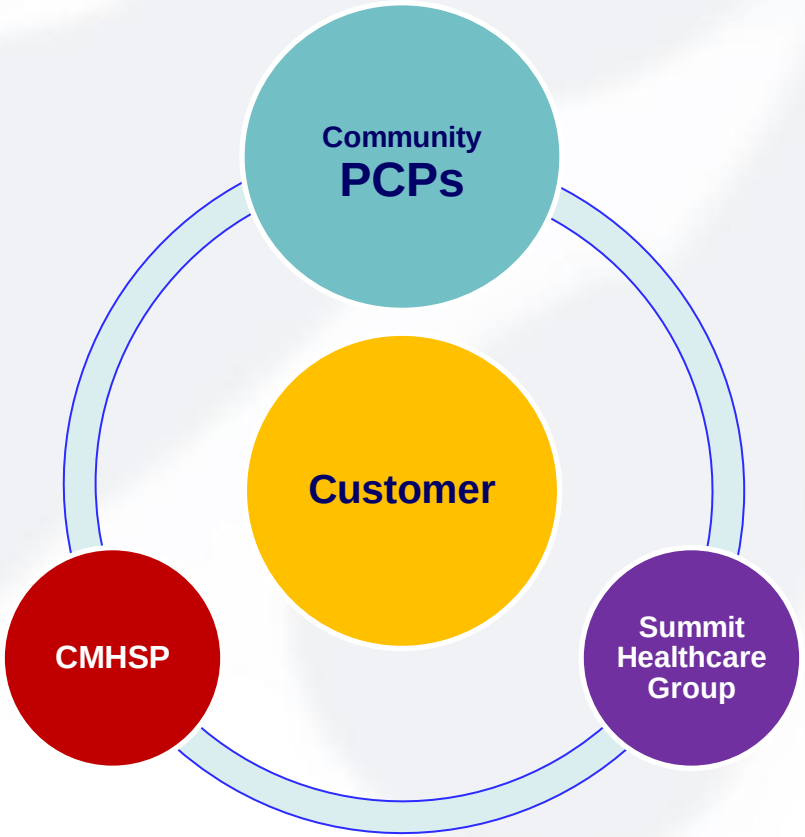
The **FQHC** Focus

- **Increase Co-Location Capacity**
  - 2-3 full-time Behavioral Health Specialists On-Site at FQHC
  - 5-10 Psychiatric hours On-Site and Open Access
  - Psychiatric Telephonic Consultation PRN
- **Manage Shared High Utilizers**
  - Identify Shared Utilizers
  - Stratify Utilizers by Healthcare and Behavioral Risk
  - Develop Protocols for Management of Risk
- **Develop Joint Wellness Services**
  - Use of CPSSs to Provide PATH programs
  - Use of COD Specialists to provide SUD programs
- **Secure Capacity/Access Grants**



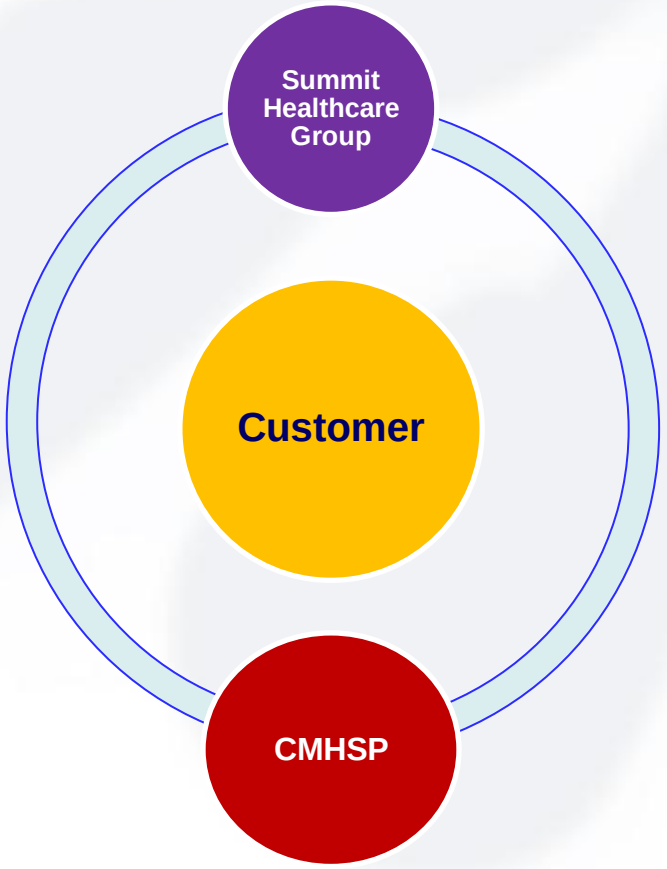
The **Community PCP** Focus

- **Participate in Community Collaborative facilitated by Battle Creek Health Systems**
  - Depression Management Protocols
  - PCP Collaboration regarding other Chronic Care initiatives
- **Adopt a "Washtenaw-Lite" Collaborative Model**
  - Provide Motivational Training at PCP Offices
  - Provide other Behavioral Health Training and Consultation at PCP Offices
  - Develop Protocols for management of health and behavioral issues for shared customers
  - Explore feasibility of psychiatric telephonic consultation



The **CMHSP** Focus

- **Revising the Corporate Goals**
  - All Teams must contribute to the delivery of Integrated Healthcare
  - Regular Tracking and Public Reporting
- **Refocusing Leadership Priorities**
  - Central Focus on integrated care
  - Redeploying Leadership
- **Increasing Support for Healthcare Focus**
  - Expansion of Mid-Level Medical Providers throughout organization
  - Increased Joint Medical Staff Case Conferencing/Peer Review
  - Increased Number and Location of Targeted Wellness Programs
  - Revision of EMR to track Health Status
  - Etc. ,etc.



The Full Court Press for Integration

- Core Change in Self-Identity
- Multiple Approaches
  - Embedded Primary Care Practice
  - Expanded FQHC Partnership
  - A “Washtenaw-Lite” Approach to Community PCPs
  - Reconfiguration of CMHSP as a Primary and Specialty Healthcare Provider

Questions?


SUMMIT HEALTHCARE GROUP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