Integrated Health Initiatives

Partnering to help improve lives

New Center Community Mental Health Services

2051 W. Grand Blvd

Detroit, MI 48208

Our Initiative

Since 1979 New Center Community Mental Health Services has been dedicated to providing and promoting quality behavioral health services to North Central Detroit and Highland Park.

In 2007, we partnered with a physical health care provider for onsite behavioral health services in an effort to prevent medical and psychiatric deterioration of at-risk individuals.

OUR PARTNER

Advantage Health Centers/Detroit Health Care for the Homeless is a non-profit agency committed to improving the health of the individuals and communities they serve. Advantage Health Centers helps meets the needs of Detroit as a medically underserved community by offering care to everyone regardless of insurance status or homelessness.

In our partnership

WHO WE SERVE

- Underserved populations
- Difficult to reach/engage individuals
- Individuals who frequent emergency rooms for health care services
- Homeless
- Uninsured

WHAT WE DO

- Primary medical care
- Crisis Intervention
- Clinical Assessment/Therapy
- Psychiatric Evaluation
- Resource/Community Linkage
- Case Management
- Psychiatric Medication Management

Our Staff

- Professional Mental Health Worker
  Provides Initial Screening, Crisis Intervention, Intake Assessments, and ongoing treatment and planning for all consumers receiving mental health services

- Nurse/Case Manager
  Provides nursing and case management referrals for all consumers receiving mental health services.

- Physician Assistant
  Provides updated psychiatric evaluation and ongoing medication management services under the supervision of a New Center CMHS psychiatrist for all consumers who exhibit a need for psychiatric services.

All of the above services are provided in coordination with physical health care providers at Advantage Health Centers

FY 2009-2010 Statistics

- During the 2009 – 2010 Fiscal Year, we provided a full range of mental health services to 110 individuals at our integrated health care site.

Psychosis	92%	Diabetes	20%
Depression	91%	Hypertension	45%
Anxiety	74%	Asthma	36%
Dual Diagnosis	52%	Obesity	26%
Suicide Risk	8%	Nicotine (Reported being a smoker)	59%

Referral and Service Process

- Referral
  - Medical care provider identifies mental health concern
    - Comprehensive assessment during medical service visit
    - Completion of PHQ-9 (Depression Screening)
    - Provides Referral to mental health provider

- Screening/Crisis Intervention
  - Professional Mental Health Worker conducts thorough assessment of current concerns, symptoms, previous treatment and services
  - Addresses any acute symptomatology and/or situations immediately
    - Shelter, food
    - Acute psychosis, suicidal/homicidal ideations

- Intake Assessment
  - Community Mental Health Orientation
  - Consent to Treatment
  - Comprehensive Assessment (Psychosocial Assessment, Medication History, Interim Treatment Plan)
  - Assess for psychiatric services

Referral and Service Process

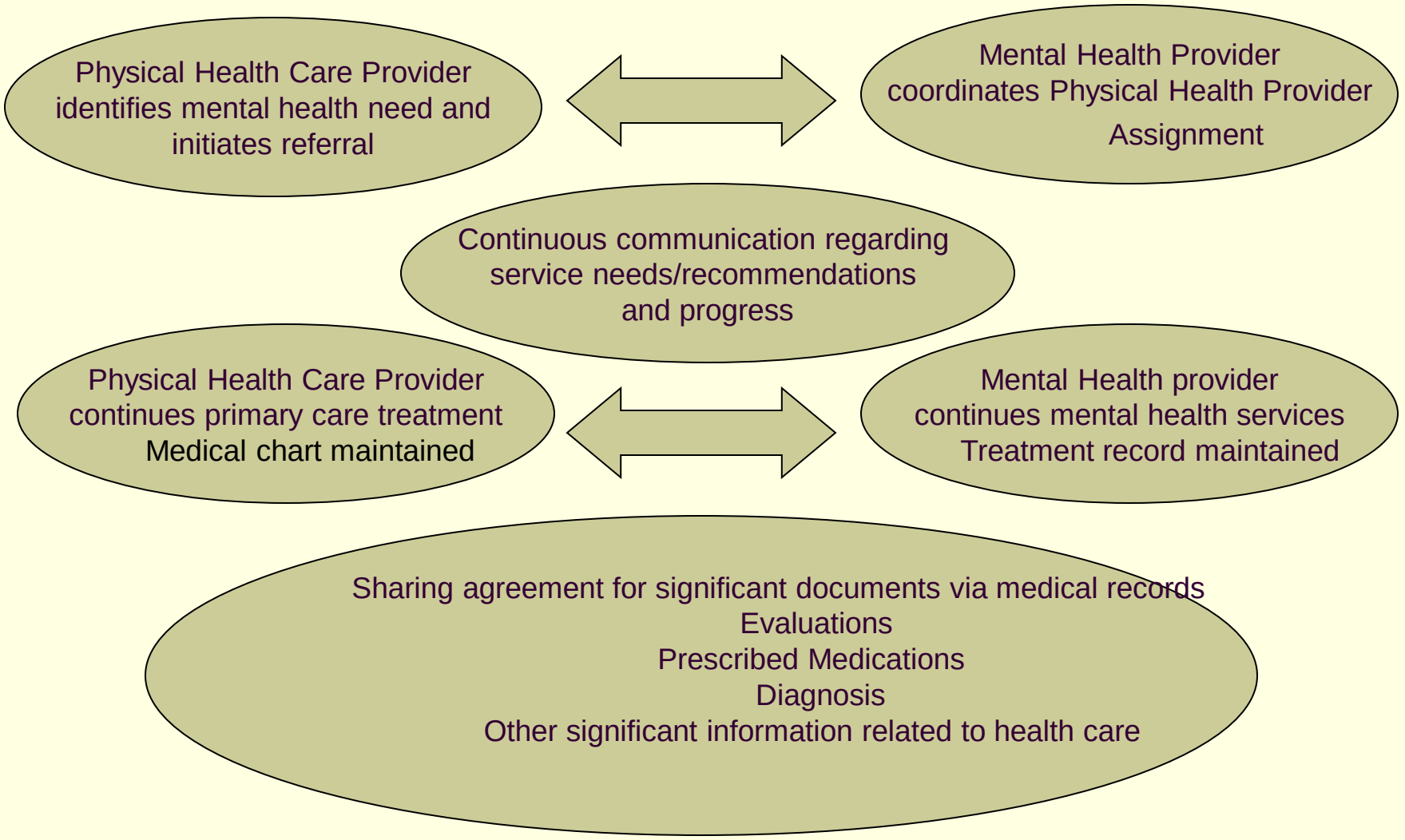
- Psychiatric Evaluation
  - Upon demonstrated need
  - Patient Assistance Program (Uninsured)

- Person Centered Planning (PCP) Process
  - Pre-Planning
    - Consumer identifies goals, wishes, desires, and individuals they would like to invite to participate in their treatment process
  - PCP Meeting
    - Development of goals, treatment modalities, and participants

- IPOS
  - Goals and objectives agreed on by consumer and PMHW

- Ongoing treatment services
  - Individual therapy
  - Case management
  - Medication Management
  - Ongoing Re-assessment

Bi-Directional Model



Peer Whole Led Initiatives

Personal Action Toward Health
(P.A.T.H.)

Participant led workshops designed to provide skills and tools needed by people living with chronic health (both physical and/or mental) conditions to improve their health and manage their symptoms.

- Facilitated by Certified Peer Support Specialist
- Referred by medical and/or mental health professionals
- Outcome data reflects tools used are both helpful and sustainable

Outcomes

The Ethel and James Flinn Foundation is funding a long term study on the integration of health care services in coordination with The University of Michigan (Flinn Foundation Integrated Health Multi-Site Evaluation).

<u>September 2010 Report</u>

- 90% of ten (physical and mental health care) providers reported a positive to very positive impact on their satisfaction with practicing medicine as a result of working with patients who have mental health disorders, addictions, and/or other psychosocial issues.
- All providers were somewhat to extremely satisfied with the ability of the medical staff to address the needs of patients with mental health disorders, addictions, and/or other psychosocial issues and were comfortable being the "first-line" response for people with mental heath disorders, addictions, and/or psychosocial issues.

Outcomes

Between April 2010 – July 2010, 32 patients were surveyed

- 90 % reported agreement and/or satisfaction of services at our integrated site.

Scales included:

- The amount of time spent with the patient during the visit
- Their beliefs about health and well-being were considered
- Their concerns regarding the mental health treatment plan were quickly taken care of
- Treatment and information were provided in a language or way that could easily be understood
- They were comfortable receiving mental health services at the clinic
- They were treated the same as other people who got care at the clinic
- Felt they were learning the skills needed to deal with problems

Outcomes

- 78% of the patients served preferred to receive mental health services at the location where they received medical care
- Slightly fewer (74%) of the patients stated that they would follow through if referred outside the clinic for mental health services
- When asked about what has helped the most in dealing with mental health concerns, responses were generally in three categories: positive feeling about having someone to talk to, medications and personal goals and stressors.

Barriers

- CMH requirements that do not always match our target population
- Inability to enroll these consumers in a Managed Care Provider Network (MCPN) for county clinical and statistical reporting

- Adaptation(s)
  - Changes implemented in Electronic Medical Record (EMR) to allow entry and ongoing documentation for consumers who do not meet the Michigan Mental Health Code of Severely Mentally Ill.

Barriers

- Target population is “hard to reach/engage”
- Limited transportation and family/community supports

- Adaptation(s):
  - One service site increases the possibility of providing multiple services to patients upon contact.
  - Immediate access for mental health and/or medical crisis

Barriers

- Continuity of care between partnering agencies
- Communicating needs and care to multiple providers

- Adaptation(s):
  - Co-Occurring capable services
    - Trained PMHW for treatment of secondary and/or mild to moderate Substance Use Disorders.
    - Case management referrals for severe and/or primary Substance Use Disorder needs
  - Bi-Directional Model
    - Ensuring that patients receive physical and mental health services from partnering agency
    - One site allows immediate access to both discipline's health information

Thank you for your attention!

New Center Community Mental Health Services
Co-Located Programs
Integrated Health Care Initiative

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