Advanced Integration: The Cherokee Health Systems Story

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A Long Tenured Integrated System

* Trials and Triumphs
Primary Service Area
Our Mission...

To improve the quality of life for our patients through the integration of primary care, behavioral health and substance abuse treatment and prevention programs.

Together...Enhancing Life
* Integration of Behavioral and Primary Care
* Outreach to Underserved Populations
* Training Health Care Providers
* School-Based Health Services
* Telehealth Applications
* Value-Based Contracting

* Strategic Emphases
57 Clinical Locations in 14 East Tennessee Counties

Number of Patients: 63,291 unduplicated individuals

New Patients: 15,325

Patient Services: 484,494
Visits by Payer Source - CY2013

- Medicaid (TennCare): 40%
- Medicare: 15%
- Uninsured: 32%
- Private Insurance: 13%
Number of Employees: 681

Provider Staff:

- Psychologists - 47
- PC Physicians - 24
- NP/PA (Primary Care) - 36
- Psychiatrists - 11
- NP (Psych) - 9
- Nephrology - 1

- Master’s level Clinicians - 81
- Case Managers - 38
- Pharmacists - 9
- Cardiology - 1
- Dentists - 2
- OB-GYN - 4

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Blending Behavioral Health Into Primary Care at Cherokee Health Systems
National Register of Health Service Providers In Psychology, Fall 2007.

A Tale of Two Systems: A Look at State Efforts to Integrate Primary Care and Behavioral Health in Safety Net Settings National Academy for State Health Policy, May 2010.

Integrated Care Update
CareIntegra, February 2007

Evolving Models of Behavioral Health Integration in Primary Care
Millibank Memorial Fund, 2010 Report.

Integrating Mental Health Treatment into the Patient Centered Medical Home AHRQ, June 2010.


Can Primary Care Docs and Behavioral Specialists Work Together?
“As if we all knew where we’re going.”
• Improve the health of a population
• Reduce healthcare disparities
• Improve access
• Focus on wellness and prevention
• Patient centered care
• Evidence based clinical and program decision making

* Integration is a means to an end...
* Rooted in the mission of community mental health
* Circuit riding outreach into primary care
* Primary care operations
* Embedded Behavioral Health Consultant role
* Blending the cultures, becoming an FQHC
* Behaviorally enhanced Healthcare Home

* Cherokee Health Systems
  Forks in the Road

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*Blending Behavioral Health into Primary Care

Cherokee Health Systems’ Clinical Model
Main point of access to care for all healthcare, including behavioral health conditions

Principal setting for treatment of behavioral health conditions

Central stage for the complex and bidirectional interplay between medical and mental health disorders, health behaviors, and social determinants of health

Why Primary Care?
The Reality of Primary Care

Patient Panel Size
Behavioral Comorbidity
Health Complexity
Coordination Demands
Insurance Requirements
Documentation Demands
Accountability

Time
Resources
Reimbursement

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* Functions of care shared across team
* Integrated workflow
* Access to BH expertise “where BH problems show up”
* Improved communication
* Improved care coordination
* Expanded health management support
* Supported patient engagement

* Re-engineering Primary Care: An Integrated Team Model
* Contact - *First line of access*
* Comprehensive - *Anything that walks through the door*
* Coordinated - *Organizes and synchronizes all elements of care*
* Continuous - *Episodes of care within context of longitudinal partnership*

Integrated Behavioral Health MUST fulfill functions of PRIMARY Care

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* Behavioral health is ROUTINE component of medical care
* Behavioral Healthcare must be population based
* BHC panel is the primary care panel
* Efficacy is measured based on the health status and functioning of entire panel, not just those actively receiving behavioral health services

*Translation:*
“It’s got to come out, of course, but that doesn’t address the deeper problem.”
Behavioral Providers on PC Team (BHC, Consulting Psychiatrist, CM)

Shared Patient Panel and Population Health Goals

Shared Space, Workflow, Charts, and Support Staff

Access, Communication, and Collaboration at the point of care

☆ CHS’ Behaviorally Enhanced Healthcare Home

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* Management of psychosocial aspects of chronic and acute diseases
* Application of behavioral principles for prevention, wellness, and health behaviors
* Consultation and co-management in the treatment of mental disorders and psychosocial issues

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Integrating Psychiatry into Primary Care: Goals

* Increase Access to psychopharm expertise for primary care population
* Enhance Skills of Primary Care Colleagues in psych med mgmt
* Improve Quality of psychiatric care in primary care setting
* Organizational Culture
* People
* Organizational Structure
* Communication
* Processes

* Key Factors in Implementation
Mission: Go where the grass is browner

Patient Centered: Clinical model is driver

Innovative/Risk Taking: High rate of failure acceptable

Adaptive Reserve: Resiliency and Persistence

*Organizational Culture

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* Staff Selection: The Right People on the Bus...

* Mission-Minded
* Team-Oriented
* Commitment to Excellence
* Flexible
* Excellent Communication Skills
* Respect and Value of Other Professions
* See the Bigger Picture

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"I like change, as long as it doesn’t affect me."

- Dr. Ex-Cherokee Physician
* Staff Selection: The Wrong People off the Bus...

* Prefer solo practice
* Resistant to change
* Mercenary
* “My turf”
* Narrow lens view
Staffing: Integrated Clinical Team

• 4 Primary Care Providers (or 3 Peds): 1 BHC
• Integrated Psychiatry (3-5 hours/week)
• Specialty Mental Health
• Direct Medical Support (1.75 per FT PCP)
• Direct Admin Support (1.25 X + .75Y = # staff ;  X = PCP FTEs , Y=BH FTEs)
• Clinical Pharmacists, Health Coaches, Care Coordinators, Care Managers, Nutritionists, Specialists - Cardiology, Nephrology, OB-GYN

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Fostering Organizational Change

- Training
- Communication
- Plan Your Work and Work Your Plan
- Leadership
- Teams
- Culture of Change

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Financing

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Placing a VALUE on Integrated Care

Distribution of Resources - TennCare Integrated RFP Databook

- Inpatient: 17%
- Other Services: 14%
- MH Inpatient: 5%
- Home Health: 4%
- Emergency Room: 9%
- Surgery: 16%
- MH Outpatient: 4%
- E & M Services: 16%
- Specialty Services: 17%

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Placing a VALUE on Integrated Care

- Reduced ER Utilization
- Reduced Inpatient Admissions
- Reduced Specialty Referrals
- Increased Patient Satisfaction
- Increased Primary Care Utilization
- Improved Outcomes

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A Balancing Act...

COSTS
- Behaviorally-Enhanced PCMH
- Care Coordination
- Treatment Team
- Psychiatric Consults
- BHC Consults
- Direct Services

REVENUE
- Shared Savings (% of MLR)
- Bonus for Outcomes
- Prospective Payment System (FQHC’s)
- Care Coordination (G-Codes or PMPM)
- Enhanced PCP Productivity
- Fee-For-Service

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A Balancing Act…

Global Payment Model

- Behaviorally-Enhanced PCMH
- Care Coordination
- Treatment Team
- Psychiatric Consults
- BHC Consults
- Primary Care
Contracts MUST support and value integrated primary care and...

You need the WILL to make it work

*The Bottom Line...*
HIT
- Telehealth
- Clinical Informatics
- User-friendly EHR

PCMH 2.0
- Re-engineering operations and clinical flow
- Patient engagement

Payor Partnerships
- New contract structures
- Shared data
- Collaboration

*CHS: What Now?
Meeting Triple Aim

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* Under appreciate the practice transformation required

* Behaviorists are unequipped for integrated practice

* Available payment methodologies don’t encourage integration

* Contracts do not support the care model

* Not in sync with Triple Aim goals

* Why Most Current Integration Initiatives Will Fail
I. Patients always point the way.
II. Never let the manifest demand obscure the unpresented need.
III. Mission is the compass.
IV. Just do it!
V. Developing the care model takes work. Just showing up is not enough.
VI. Not every Behaviorist can make it in primary care.
VII. Friends in high places can be helpful, though not essential.
VIII. Contracting is a high stakes game.
IX. Payment methodology: It’s not the vehicle, merely the fuel.
X. Bring value: Always strive to serve the greater good.

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AHRQ's vision is that the Academy for Integrating Behavioral Health and Primary Care will function as both a coordinating center and a national resource for people committed to delivering comprehensive, integrated healthcare.

The Academy Web Portal – A Resource Hub

Welcome to this new AHRQ Web portal where you will find the resources you need to advance the integration of primary care and behavioral health care and foster a collaborative environment for dialogue and discussion among relevant thought leaders.

This resource center will facilitate the work of the Academy by being a central hub for information, coordination, dissemination, and networking. The portal is structured around seven topics: Research, Education, Policy, Financing & Sustainability, Clinical & Community, Health Information Technology, Resources, and Collaboration.

Information related to integration will include evidence-based practices, descriptions of promising practices, and articles on methods used to acquire evidence. The portal will be enhanced by adding coordination, dissemination, and networking functions including Webinars and forums.

New & Notable items include highlights of current activities of The Academy for Integrating Behavioral Health and Primary Care, as well as new research findings, Federal initiatives and other public and private activities going on in the field of integration. Check New & Notable often for highlights from the Academy.
ONLINE REGISTRATION OPENS IN JUNE!

FROM FRAGMENTATION TO INTEGRATION: A TRIPLE AIM IMPERATIVE
WASHINGTON DC, OCTOBER 16-18, 2014

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