

Taking a Road Less Traveled: Evolution of an Integrated Delivery System

***Santa Fe Summit on Behavioral Health
The American College of Mental Health Administration
March 15, 2007***







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



*Cherokee Health Systems:
Merging the Missions of
CMHC's and FQHC's*

Cherokee Health Systems

A Federally Qualified Health Center and
Community Mental Health Center

Corporate Profile

Founded: 1960

Services:

Primary Care - Community Mental Health - Dental

Locations:

21 clinical locations in 14 Tennessee Counties

Behavioral health outreach at numerous other sites including primary care clinics, schools and Head Start Centers

Number of Clients: 45,000+ unduplicated individuals served

FY 2006 Revenue: \$36,600,000 New Patients: 15,000+ Patient Visits: 282,551

Number of Employees: 526

Provider Staff:

Psychologists – 39

Primary Care Providers – 39

Master's level Clinicians – 59

Case Managers - 34

Pharmacists - 6

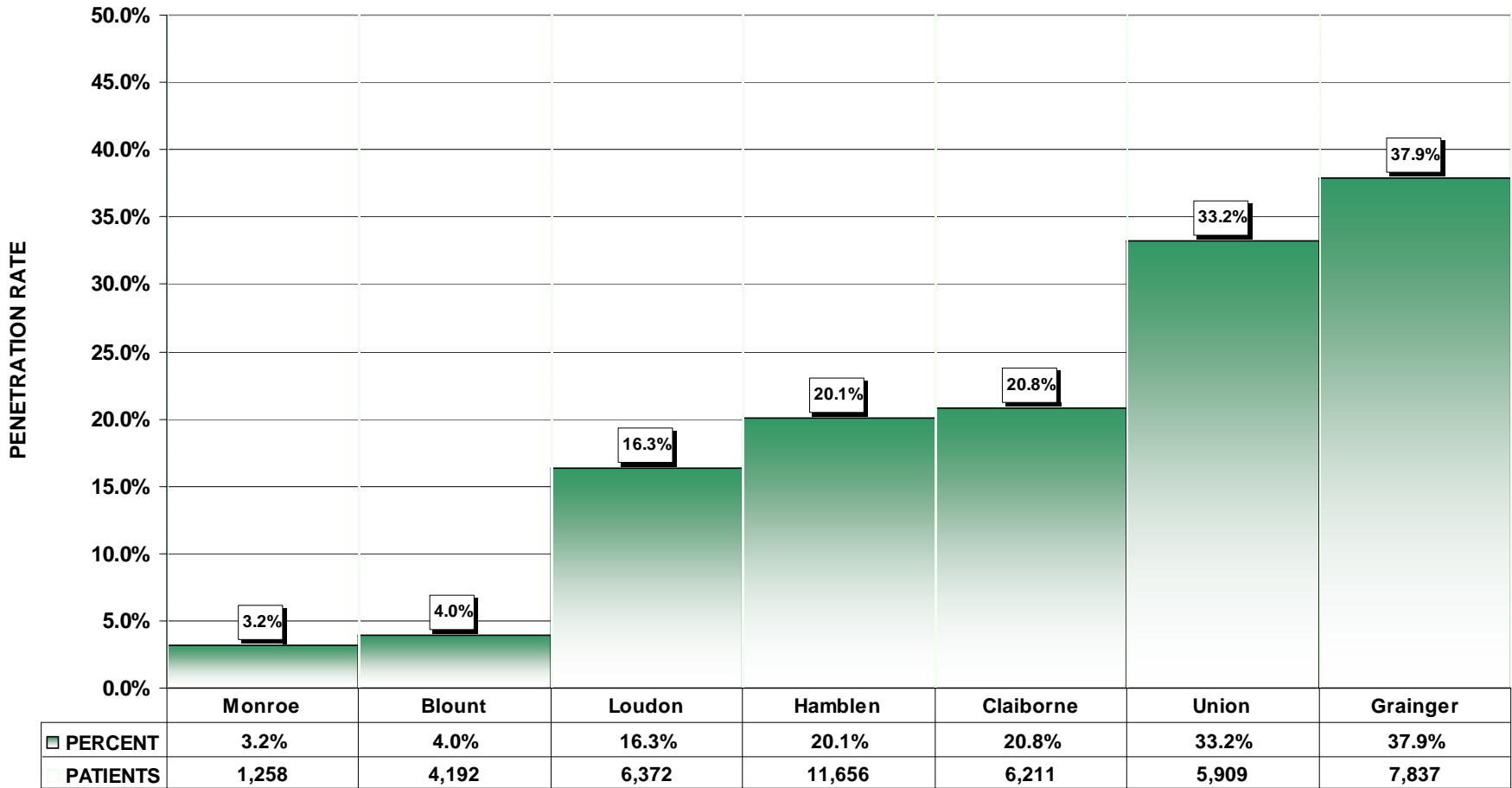
Dentists - 2

Psychiatrists - 13



Cherokee Health Systems

Patients Served by County 2004-2006



Blending Behavioral Health into Primary Care **Cherokee Health Systems' Clinical Model**

Behaviorists on the Primary Team

The Behavioral Health Consultant (BHC) is an embedded, full-time member of the primary care team. The BHC is a licensed Health Service Provider in Psychology. A Psychiatrist is available, generally by telephone, for medication consults.

Service Description

The BHC provides brief, targeted, real-time interventions to address the psychosocial aspects of primary care.

Typical Service Scenario

The Primary Care Provider (PCP) determines that psychosocial factors underlie the patient's presenting complaints or are adversely impacting the response to treatment. During the visit the PCP "hands off" the patient to the BHC for assessment or intervention. Typically, there will be four or fewer 15-minute follow-up visits, often in tandem with the PCP. As a member of the Primary Care Team, the BHC will see 8 to 15 patients per day and will likely be consulted on a similar number by members of the Primary Care Team.

The Behavioral Health Consultant in Primary Care

- Management of psychosocial aspects of chronic and acute diseases
- Application of behavioral principles to address lifestyle and health risk issues
- Emphasis on prevention and self-help approaches, partnering with patients in a treatment approach that builds resiliency and encourages personal responsibility for health
- Consultation and co-management in the treatment of mental disorders and psychosocial issues

Impact of BHC on Subsequent CHS Service Utilization

- 28% decrease in medical utilization for Medicaid patients
- 20% decrease in medical utilization for commercially insured patients
- 27% decrease in psychiatry visits
- 34% decrease in psychotherapy sessions
- 48% decrease in crisis visits

Forks in the Road

- Committing to provide primary care
- Choosing the primary care culture
- Providing open access, every patient our priority
- Retaining a biopsychosocial care model
- Sticking with population-based care
- Accepting FQHC funding

Conclusions

- An FQHC is the best available platform for community mental health programming
- Integrated care is our best anti-stigma strategy
- Co-location is necessary, but not sufficient for integrated care
- Not every helpful clinical act translates to an available CPT code
- When integrated care is done well, the patient benefits and someone saves \$\$

Parting Shots

- Until we reach consensus of the optimal integrated care model, government policies - including reimbursement schema - lack force and focus.
- The academic community must wake up to their responsibility to prepare behavioral clinicians for new roles in the primary care environment.
- We must build, or reconfigure safety net organizations to provide a care model that addresses the complex needs presented in the clinical encounter.
- Why do we have 2 community-based safety net systems when the patients of each generally need the services of both?

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