



Session Objectives

Participants will be able to:

1. Define two types of integrated care delivery models.
2. Recognize two basic steps in charting care collaboration.
3. Describe one or more challenges to relationship building.
4. State two factors driving the use of integrated care delivery model.



Factors Driving Movement Toward Integrated Care Delivery Model



- Reduced Treatment Costs
- Medicaid & Medicare Funding moving towards Integrated Model/Capitation
- Improved patient outcomes- increase life expectancy

US life expectancy 78.7 years

(taken from 2009 World Bank, World Expectancy Indicators)



January 2010 - August 2011 Death Report

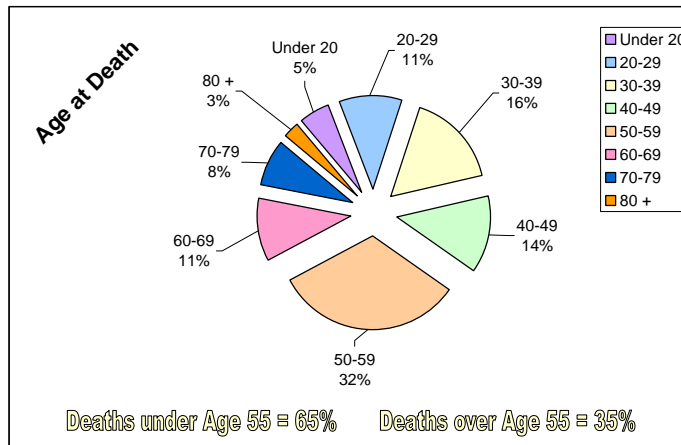
of Deaths: 37

Age of Clients:

Age #	Under 20	20-29	30-39	40-49	50-59	60-69	70-79	80 +
	2	4	6	5	12	4	3	1

Causes of Death

Accidental - 3 Suicide - 5 Natural Causes - 9 Unknown - 5 Other - 1 (house fire)



Working Together Agencies History



- MHCECK/FHCHC National Recognition for FQHC
- 2009 Partnered to Provide MH Counseling to Uninsured
 - An action plan for the Integrated Care Model was discussed and adopted by the MHCECK Governing Board Strategic Plan 1/09
- Teamed to Participate in State Integrated Care Pilot - 2011



Getting
to
know
the
Partners





Chase
Coffey
Greenwood
Lyon
Morris
Osage
Wabaunsee

Mental Health Center of East Central Kansas

-Comprehensive Services Offered-

▪ **Adult Services**

- Outpatient Services
- Community Support Services



▪ **Alcohol/Drug Services**

- Outpatient Services
- A/D Information Schools
- Regional Prevention Center of the Flint Hills (RPCFH)

▪ **Children's Services**

- Outpatient Services
- Community Based Services
- Family Solutions
- School Based Programs

▪ **Emergency Services**

- 24-hour access

▪ **Medication Clinic**

- Evaluate/Prescribe Meds
- Medication Monitoring Program



Flint Hills Community Health Center

▪ **Clinics**

- Primary Care
- Public Health
- Dental
- Family Planning
- Maternal & Infant
- Pediatrician




▪ **Services**

- WIC
- Social Services
- Project Teen
- Diabetic Collaborative
- Behavioral Health
- Early Detection Works


▪ **Environmental Health**

▪ **Licensing & Regulation**

- Child Care Facilities



Integrated Care Models

What does Integrated Care look like 

- The integration of physical and behavioral health care will be a critical component of the new Health Reform Law.
- According to a report in the June issue of *Psychiatric Services*, as many as 70% of primary care visits stem from psychosocial issues.
- This report highlights 8 models of care:

#1 Improved Collaboration

Providers practice separately with separate administrative and financial systems



#2 Co-location



This approach shares space with the mental health clinicians and primary care, but run as a separate service.



#3 Disease Management

- Chronic care model
 - An integrated system of interventions to:
 - Optimize functioning of patients
 - Impact the overall cost of the disease burden



#4 Unified Primary Care and Behavioral Health

- At the Clinical Level Primary Care and Behavioral Health staff:
 - interact regularly
 - typically have an integrated medical record and single treatment plan.



#5 Collaborative System of Care

For patients with high mental health care needs and those who require specialized mental health services.



#6 Primary Care Behavioral Health

The Behavioral Health clinician does not take responsibility for client treatment but rather co-manages with the physician who makes the referral.



#7 Medically Provided Behavioral Health Care



Only medical providers are directly involved in service delivery.



#8 Reverse Co-location

Seeks to improve health care for persons with severe and persistent mental illness.



Integrated Care Initiative Journey Begins

Charting Our Course



#1 Intra Agency Actions

- Developed and Implemented new Tools and Position/Roles
- Medical History
- Treatment Plan – ID Medical Conditions
- Created New Position – Special Needs LPN Case Manager



#2 Building Relationships & Interagency Communications

- Identified Clients as Potential Participants
- Obtained Authorizations to Disclose PHI
- Interagency Referral Process
- Medical Records Supplemental Info Exchange
- Primary Care Physician/Provider Office Visit Continuing Care Communication Record
- Team Meetings
- Case Conferences



#3 Mapping Clinical Guidelines & Measuring Patient Outcomes

- Obesity
- Diabetes
- Cardiovascular: BP & Cholesterol
- Other



Disease Management

- Chronic care model
 - An integrated system of interventions to:
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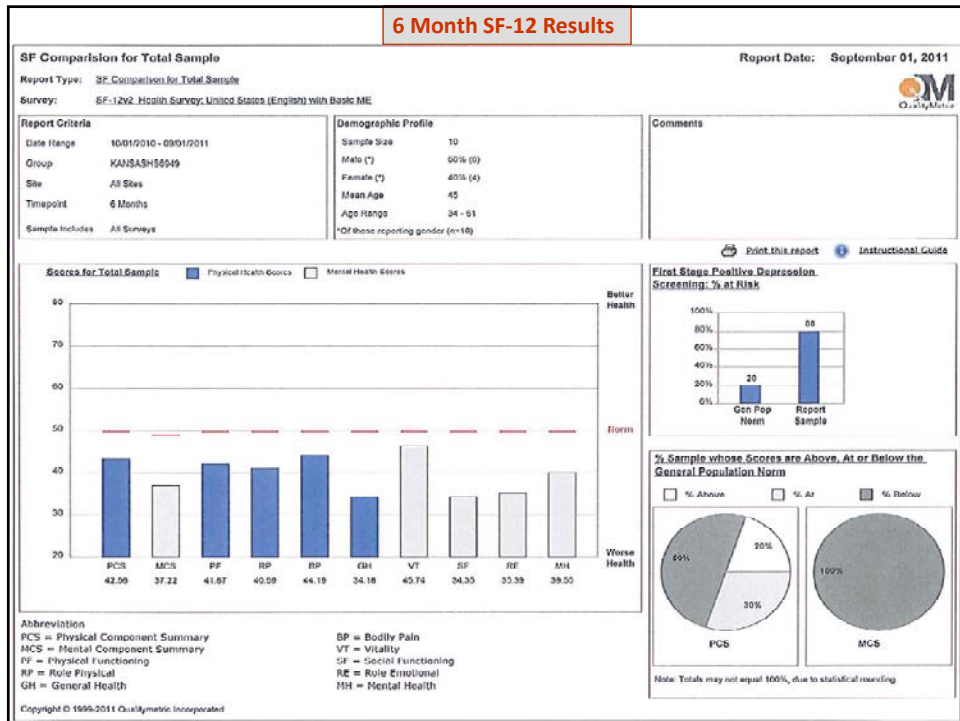
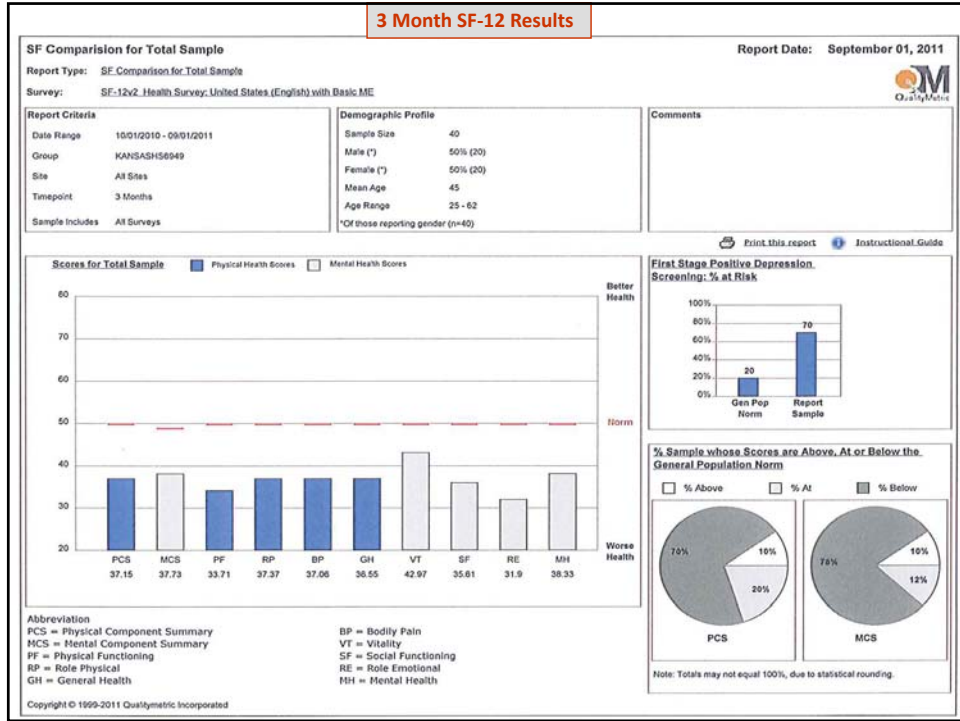



Changing Directions & New Partners Come on Board

KHS/KAMU Emporia Integrated Care Team

- Quarterly Reports
- Participants In Doctoral Research Project
- SF12 Survey









Identifying the Challenges and Opportunities

- Increased Visibility



- Community & Other Healthcare Providers Education



Bringing Other Healthcare Partners & Community on Board

- Other Primary Care Providers



- Home Health & Hospice

- Other Substance Use and Drug Services

