Michigan Association of Community Mental Health Boards

SUMMER 2012

Connections
for communities that care

Partnering With Hackley Community Care Center

David R. Parnin, Chief Operating Officer, CMH Services of Muskegon County

In 2010, the Michigan Association of Community Mental Health Boards partnered with the Michigan Primary Care Association. The rationale was simple: members of MPCA are Federally Qualified Health Centers (FQHC) which provide primary care to many of the same individuals for whom we provide behavioral health care. In areas where FQHCs are present, the value of integrated health care has initiated collaboration. In this issue you will see, through several sets of eyes, inside a FQHC, Hackley Community Care Center (HCCC), in Muskegon. Although the main concentration of skill sets at HCCC addresses primary care needs, it becomes obvious that we share a core value. When we focus on quality care, the individual becomes the driver. It is this perspective that begs, even demands, collaboration between providers that address the various needs of that individual so we can treat them as whole persons.

I am deeply indebted to Sheri Weglarz, COO, for arranging the interviews for this issue. I wish I could transfer the warmth I felt during the time I spent in HCCC with these people! When I left, I was thinking, I hope individuals walking into our agencies feel as welcomed as I have.

–Clint Galloway, Editor

Hackley Community Care Center and CMH of Muskegon County have had a partnership that spans at least 20 years in meeting the health care needs for the Medicaid and indigent population of Muskegon County. That relationship has been a real plus as we continue to partner our systems in preparation for healthcare reform. At CMH, we have counted it a privilege to have community partners such as Hackley Community Care Center (HCCC). At any given time, we average about 4,200 open cases in the CMH system. Of those 4,200, approximately 25% of those identify HCCC as the source of their primary care services. In order for CMH to assure that those individuals we work with are also engaged with their primary care physician, we needed to work on co-locating staff in each system.

Pictured above, from left, are Integrated Health Clinic staffers Suzanne Beckeman, RN, a CMH employee; and Karel Schram, PAC, employed by HCCC. The Clinic is a partnership between HCCC and CMH Services of Muskegon County.

In 2010, CMH placed one (full time equivalent) MSW in the HCCC in order to provide behavioral health services. It probably took about six months to achieve, but eventually the cost of this staff member was covered 100% through reimbursable funding. Having a CMH staff member working within the FQHC was beneficial with providing behavioral health services within their facility, but it also gave the FQHC a liaison where they could better understand the CMH system. We had spent many months prior to this staff placement addressing all of the challenges and barriers of working with an agency with a different culture, including unique funding streams and entrance criteria. Over the years, CMH has found that HCCC is always putting the health care needs of individuals within the community at the forefront of any planning and development. HCCC models persistence in being a provider that is committed to quality care. I can say in all honesty that my staff at CMH truly enjoy partnering with HCCC whenever possible because of their "can do" attitude.

Beginning in January of 2012, HCCC placed one of their medical providers in the CMH Mental Health Center in order to deliver primary care services to individuals with high behavioral health issues and primary care needs. These would be individuals who are currently not receiving primary care. It is our hope that through early identification of health care concerns, that early preventative treatment can keep medical conditions from turning into a chronic health condition. We hope to build upon providing primary care services through our Agency in the future and look to HCCC as having a primary provider role with us.

It's All Centered on Relationships

Interview with Wayne Kohn, DO, Medical Director, Hackley Community Care Center

Connections: Thanks so much for taking the time to sit down with us. Let me start by asking when Hackley Community Care Center (HCCC) achieved the status of being a 'patient centered medical home'?

Kohn: HCCC received NCQA (National Committee for Quality Assurance) Level 3 Patient Centered Medical Home designation in January 2011 and from Blue Cross Blue Shield in July 2011. HCCC has been an FQHC since 1996. This next summer we're celebrating our 20th anniversary and I've been here since 2003, so this will be 9 years for me. I was at Muskegon Family Care, which was the other federally qualified health center (FQHC) in town. I was there from 1994 to 2003. It didn't start out as a FQHC, but I was there through the transition. Then in 2003 I transitioned from there into the medical director's position here at HCCC. So I've been with community health centers since 1994.

C: What do you see as the core principles of becoming a 'patient centered medical home'?

Kohn: It's part of distinguishing who we are. It can mean many things depending on from which position you're looking at that sign. Are you looking from the outside in or the inside out? Depending on your position it can mean different things. I think it is foundationally a way for primary care centers, not just FQHCs, but the primary health care delivery system in our country, to consolidate around a central theme, or central process that brings standardization and quality to the delivery system itself. That's what I see a 'patient center medical home' being like. It really relates back to the word I used when we started this conversation, "relationships." Foundationally I think it's all centered on relationships. CMH institutions have recognized that for many years. I think now primary care is recognizing that as well. Our health care delivery system needs to move from more of an esoteric, scientific based process into more of an understanding of the relationships that develop between individuals, and not just providers and individuals. After all, all of humankind starts with a relationship, does it not? If you look at Genesis 1, that tells us right from the beginning that it's all about relationships and I think it's wonderful now to hear that medicine is finally starting to get to that point. I do believe that most studies will show that people who are happy are healthy. People who have love, joy, peace, patience, kindness, goodness, gentleness in their lives are much healthier populations.

The people that we see in these under-served communities and under-served populations, you tend not to find those gifts in these people. Recently we've [HCCC] started to look at that aspect as 'the missing link," and to me the missing link in medical care has been the spiritual health of individuals. How do we tap into that? And again I go back to making a Biblical reference, because that's foundationally where my thinking starts. In Galatians it tells us that the fruits of the spirit are love, joy, peace, patience, kindness, goodness, gentleness, faithfulness and self-control.

I got to thinking one day, and you know what? I look at my whole patient population and those are missing in a lot of individuals. I'm writing prescriptions, running laboratory tests, I'm doing x-rays, I'm doing all the things I'm supposed to do as a physician, and yet, after 20 plus years of practicing medicine, I'm frustrated like a lot of primary care doctors in that I don't seem to be able to elevate or get my patients to a point of health as we would prescribe health for them. They're stuck! What are the pieces that are missing? And it occurred to me that is the piece that's missing. So I personally, as well organizationally here, have now begun an approach of trying to incorporate spiritual health into the primary care world as well. And what that actually did then was open up the doors toward saying, "You know what? Behavioral health is right there along with it."

We've looked at the mental and emotional state of our patients, we looked at the physical well-being of our patients, but neither discipline has taken it–in my opinion anyway–deeply enough into the spiritual realm of our patients. Spiritually they seem to be empty. So, how do we get there? How do we incorporate that? My thinking is that we need to begin to integrate more fully and deeply the behavioral, emotional and psychological aspects of our patients into their physical well-being, my hope is that these two disciplines together then will be able to open up the door to say, "How is their spiritual well-being?"

"...if the individuals are not healthy, the community is not going to be healthy..."

C: Sounds to me like you're recognizing that it's more than just connecting with the resources of behavioral health – but it's bringing in other community resources, including the faith community, etc.

Kohn: Absolutely. We had discussions at our director and board levels. I said, "We put a lot of emphasis behind the word 'health,' but we are known as a 'community' health center. I think it's time we shift the emphasis to community." The community needs to be involved in the health, not just the clinic. We're a community health clinic, but we haven't really focused on that word "community" enough. So we need to encompass all of that because if the individuals are not healthy, the community is *(see* **Kohn** *page 8)*

A Behavioral Health Care View

Interview with Carmel McKentry, MA, LLPC, Hackley Community Care Center

Connections: We in the behavioral health field recognize we need to be assuring that the people we serve are also receiving primary care. As a result, a year ago the Michigan Association of Community Mental Health Boards started collaborating with the Michigan Primary Care Association (MPCA), which is the association of federally qualified health centers (FQHC.) Since then I've been trying to get a story from the inside of a FQHC so we can better understand them. I deeply appreciate the cooperation I've received from Hackley Community Care Center (HCCC), a FQHC. Carmel, it is my understanding that you are a provider for people with behavioral health problems for people who have come to HCCC for primary care.

McKentry: Yes, that is correct.

C: What number of people who come in the door do you think have some behavioral health problems?

McKentry: As far as the population we serve, I would say a good 75% because I think the population that we serve has a number of environmental stressors and other things going on in their lives that contribute to their difficulties in functioning on a daily basis.

C: How adequately do you feel you're able to address these problems?

McKentry: Sometimes I think it can be difficult. I think it is wonderful that we do have the whole integration piece that helps us tag-team and work collaboratively, but you can't change their home environment; you can't change their economic situation, so sometimes it's difficult to really have a large impact. But I think that we still have a significant impact as far as helping them get through the day, helping them to look forward, and helping them to try to move forward in whatever ways that they can to have power in their environment.

C: When you speak of having that "integrated piece," what does that involve?

McKentry: Working with the physicians. A lot of our charts and a lot of our connection is directly through our computer system. They look at our charts and see what we're doing and we look at their charts and see what they're doing. As far as communicating face to face, we talk directly to share what's going on from our perspective with this patient that might be contributing to the physical conditions, or what might be going on from their perspective that could be contributing to the emotional or mental health. And we advocate for other services. As far as connecting them with other resources, we have a lot of different programming here at our office that connects families and people with other resources outside in the community as well.

C: What are some of those resources?

McKentry: Well, we have a referrals department–whether they need referrals to any kind of specialty services–they take care of all of that. We have a patient's assistance program that assists patients that are on a sliding fee scale in getting some of their medications at low or no cost. I'm sure there are more than what I know of, but there are quite a few services that we offer. We have OB that does a lot of in-home maternal health support services. There are lots of wrap-around services. We've been collaborating with Community Mental Health, and we have the Teen Health Center at the school site that pulls in the kids to teach them and help them be healthier. So there are lots of different things that we offer here that I think help people in various settings.

C: I understand that Keith Van Dyke, who is an employee of CMH of Muskegon County is also a provider here. What is his unique role?

McKentry: His unique role is working with a lot of the substance abuse clients. Those referrals go to Keith a lot of the time. There are also those who have previously received services at CMH whose cases were closed. Since they have been receiving their primary care here, they often return when they have a mental health issue. Keith works with a lot of those people but he also assists in the transitioning of the CMH folks back into our health system as well.

C: Who does the initial assessment that would identify a behavioral health problem? Is it a primary care provider?

McKentry: Yes. Usually they are coming to us for primary care. We have "real-time visits" where if the doctor is with a patient and sees that the patient is going through some things and having a hard time with something, they will call us in while they're doing their visit. We will meet the patient and do a crisis intervention. That gives us an opportunity to meet the primary care provider and to see what it's all about. They can recommend either follow up or not. A good number of people, I think, actually follow up after our real-time visits. So that's how we usually come into contact with them. Or, the medical provider may say to the patient, "You know, I think you probably need to see a behavioral health person so we need to get you set up for a session."

C: What kind of training do they have to identify behavioral health problems?

McKentry: They have knowledge of the DSM IV, they know the symptoms of depression and anxiety, they have some scales and some documents that they use to assess a patient's need in those areas. We have a patient health questionnaire that all providers give their patients that screens for *(see* **McKentry** *page 10)*

You Gotta Keep Going!

Interview with Theresa Stidham, Hackley Community Care Center Patient

Connections: I'd like to begin, Theresa, with you telling me what it is that gives you the most joy in your life.

Stidham: It's gotta' be my kids, it really does. I've got four kids. I've got two girls and two boys. My oldest is 24, my baby is 14. They're pretty good kids. I've got three graduated; my youngest is in high school.

C: And three have graduated.?

Stidham: Yup. I got three graduated; one starts college this month. My oldest is also disabled. She's got a mental disability, more than physical. She's slow.

C: Is she receiving some support or services?

Stidham: Oh, yeah. She's fine on most counts. It's like the little stuff you've gotta' watch out for. When she goes into a panic attack she wants Mom. You know, she gets frustrated, she runs to Mom. And to an extent she's ten years behind herself, so she's got the mind on the level of a 14 year old. So you put my 14 year old and her together – they're fine for a while, but then they start buttin' heads. But otherwise I can't yell. I've got four wonderful kids, and they've all turned out really well. I see them going places, you know. They're just terrific kids.

C: Do they live with you?

Stidham: No. Sondra lives over by me in Bayview Towers, which is another apartment complex. We're in walking distance of each other. My son Curtis, last I knew, lived in The Heights, and my two youngest are in Florida right now, so they're down by their Dad.

C: So you live alone?

Stidham: Yup. Have been for twelve years now, since I split up with my ex.

C: So how is that going for you?

Stidham: Oh, I love it. The only thing I missed was being, you know, with my kids when we split up because he got physical custody, but it's working out pretty good.

C: What's your favorite time of the day?

Stidham: Oh I love the sunset, evening, early evening. I'm not a morning person.

C: That's why you said, "Let's not make it before nine." [I had to smile, remembering the conversation.]

Stidham: Me? Try and get up at 6:00 in the morning to hit a 9:00 appointment? It's really fun! *[then explaining]* It's my back. I have problems with my back.

C: How long have you had a connection with Hackley Community Care Center?

Stidham: I actually started when they moved in here on Peck Street 18 years ago. Yes, I've been here ever since. I took a year off, but you figure 17 years I've been with this facility.

C: What did you originally come in for?

Stidham: Originally? I couldn't tell ya' from a hole in the ground. I think it was just getting a doctor established, you know, here in Muskegon. And then right after I started with these guys, I got pregnant with my 18 year old Cody, so I'd been here a couple months before I got pregnant with him.

C: So it became your health home.

Stidham: Yes and then I found out I was diabetic, so now I'm here for the diabetes, the depression and the back problems.

C: When did the depression set in?

Stidham: It got really bad after I split up with my ex. I was depressed with him, but it really hit when I was able to get away from him 'cause I had a real hard time with him.

C: How severely depressed did you get before getting services ?

Stidham: I got to the point where I just wanted to sit and cry all the time, ya' know, withdraw from everybody. I wanted just to be left alone–screw it–I'm done, you know? And then I talked to Tawna [physician assistant at HCCC)] about it and she's the one that got me going on the depression pills, and now I see Carmel.

C: How's that going?

Stidham: Oh, I love that woman, she is so sweet! Her and I clicked right off the bat and it was like, let's go!

C: What made it click?

Stidham: It's like both of our demeanors get along real well, more the laid back type and she ain't treatin' me like a professional – well, she does but she ain't the snotty type. I like her attitude, I like her demeanor. She's just a wonderful person.

C: So you feel like a person yourself.

Stidham: Yes! I was able to work a lot out with her, still am, and I see her today after I'm done with you. I'm here for a double appointment, so I get done here and go back upstairs [laugh] and sign in for her.

C: How has she helped you?

Stidham: I have what they call seasonal depression on top of just the regular depression, and when I *(see* **Stidham** *page 10)*

Recovery Embraces Crisis as a Time of Danger and Yet Opportunity

Bradley Will, MDiv, MA, LPC, Emergency Services/Clinical Supervisor, and Terry Pechacek, LMSW, Operations Manager, Northern Lakes Community Mental Health

The Chinese symbol for crisis means danger and opportunity

After attending the MACMHB 2010 Winter Conference plenary by Amy Long, LPN, on recovery and belonging, and reading SAMSHA's Practice Guidelines: *Core Elements for Responding to Mental Health Crises*[1], Greg Paffhouse, Chief Executive Officer of Northern Lakes Community Mental Health (NLCMH), was inspired to look at how NLCMH could help its staff make a shift to implement the concepts, values and principles of recovery in emergencies as a significant step in furthering recovery system change.

Conversations among staff galvanized resolve and resulted in utilizing MDCH Culture Change to Recovery block grant funds to secure the services of Amy Long for consultation and guidance in developing a more recovery focused crisis intervention system at NLCMH. Amy Long has worked for four years in a Community Crisis Stabilization Unit in Massachusetts, a hospital alternative, and is affiliated with the National Empowerment Center as an Educator/Trainer. Her unique credentials as a person with lived experience and as a trained mental health professional made her a perfect fit to assist us with this process.

The Chinese symbol highlights the shift from approaching crisis intervention as primarily a screening for inpatient hospitalization to an opportunity to focus on the recovery of the person in crisis—to build relationships, share decision-making, and make deeper connections.

In 2011 Amy visited NLCMH three times—meeting with persons served, network providers, and staff—to gain an understanding of current practices and identify opportunities to improve. As an added bonus during one of her visits, Amy served as a keynote speaker for our annual recovery celebration for consumers, staff and community partners, and also participated in the development of an orientation video which welcomes persons into service and has become part of our recovery toolkit.

In November, an initial recovery-oriented crisis intervention curriculum was finalized and Amy modeled a pilot curriculum presentation for NLCMH Emergency Services staff in an all-day session.

The training agenda focused on three main topics: 1) Viewing "crisis" as an opportunity for growth and connection; 2) Core elements for responding to mental health crises (SAMHSA Practice Guidelines); and 3) Recovery-oriented crisis intervention tools and techniques.

The training opened with exploring how we need to think and listen differently. Participants were asked to write three things that are most important to them (e.g. meaningful work, family, and friends) on cards. The cards were exchanged and others randomly crossed off one of the items. The cards were returned and participants shared how it felt to have someone else decide what is important, or not important, in their lives. This exercise was intended to illustrate the importance of a consumer's dreams, wishes and desires in the context of person-centered treatment planning. Who better knows the priorities of one's life than the individual whose life it is?

Amy provided two lists of expectations: one for individuals not identified as having a mental illness, and another for individuals identified as having a mental illness. The first list *("What We Expect for Us")* included items such as "life worth living," "a real job," financial independence," "having hope for the future," "giving back," and "being needed." The second list *("What We Expect for Them")* included items such as "compliance with treatment," "decreased symptoms and clinical stability," "better judgment," and "decreased hospitalization." This illustrated how embedded are our traditional ways of thinking and helped raise our awareness of the importance of making a shift in our thinking toward a recovery focused approach in our treatment interventions.

In viewing "crisis" as an opportunity for growth and connection, Amy shared that the goal isn't about returning to baseline, but moving forward. It's about establishing rapport, expanding the conversation, and responding to feelings rather than "fixing it," acknowledging positive change, no matter how small; and building a relationship to understand more fully the person's lived experience. How we phrase our questions elicits a different response: "Help me understand…" or "What makes that ...so hard/scary?"

Recovery focused crisis intervention involves redefining "help." We shift our approach from being a "helper" to being a "learner." Rather than approaching a crisis situation as an "expert," the mental health professional and person in crisis collaborate and learn together about the circumstances that have contributed to the emergency. A helper often assumes that the other person has something wrong with them, or has a problem, while a learner does not assume that there is a problem or that the focus is necessarily on mental health. A helper often comes with the helper's agenda, and perhaps predetermined outcomes, while a learner may be more open to possibilities that are new. A helper can create a power imbalance, while learning together doesn't assume that one of you is an expert. Through the process of learning together, the focus shifts from the individual in crisis to the relationship between the clinician and the individual. When the focus is on the relationship, both people contribute to mutual learning, they learn how to communicate with honesty and openness, and this relationship becomes a model for other relationships. The focus is no longer on the

[1]Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, *2009.*

individual's problems or what is "wrong with them," but rather on eliciting the person's strengths and resources from within; it is no longer on the helper's solutions, but rather on the mutual collaboration and respect, together discovering what will work for both parties; and lastly, sensitivity to reviewing and updating the intervention with the goal of one day not having to go to crisis mode to have one's needs heard and met.

The training highlights tools and resources for clinicians to explore and develop in their clinical practice as they work with people in crisis. These resources include the use of a Wellness Recovery Action Plan (WRAP), the development of a crisis plan, the use of advance directives, Dialectical Behavioral Therapy, and shared decision-making. It also includes the services and perspectives of people with lived experience, such as Certified Peer Support Specialists.

The response to the training has been very positive. Jim Talbott, MS, LLP, and 28 year veteran of Emergency Services, voiced his optimism in the use of recovery based crisis intervention by saying, "If we are provided the proper resources and alternatives, we could probably avoid 70% of the inpatient psychiatric admissions we provide."

Joe Barkman, MA, LLP, a relative newcomer to Emergency Services, found Amy Long's strong leadership to be inspirational. "I appreciate her emphasis on turning the focus of crisis intervention techniques to the person in crisis rather than my expertise."

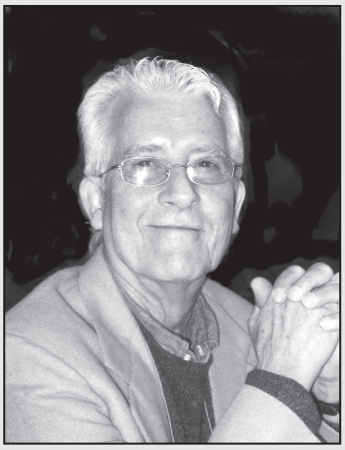
Anne Baase, MA, LPC, with many years of experience in Emergency Services said, "This training is a very good reminder to focus on people's strengths and resources, rather than just their deficiencies and problems."

Many participants felt affirmed in their work, because while most already use this approach and these techniques regularly, they also appreciated the emphasis and reminder to develop their skills to be even more recovery focused. Ruth Pilon, RN with 11 years of experience in Emergency Services said, "I appreciate that Amy comes at it from both sides: as a clinician and consumer. I think she was able to clearly articulate some of the things we do well, but also what needs to improve."

Bridget Klaasen, MA, LLPC, shared Ruth's appreciation for Amy's approach to recovery "as something we all can use: recovery is a better way of life."

There is still much work to do. One of the challenges is the lack of resources to provide alternatives to locked, inpatient psychiatric facilities for people experiencing a crisis. An ongoing challenge is in working with other community resources and systems which may not yet understand the recovery based approach to crisis intervention, other workers and departments within the organization, and sometimes even the individual in crisis and/or their natural supports.

With feedback from the pilot training, the curriculum was revised and launched for use with training other NLCMH staff this spring. Next steps will be to explore developing a process to receive feedback and suggestions from individuals who have experienced a crisis and to review and improve our crisis intervention services in a systematic, regular way. We will also be looking for creative alternatives to inpatient psychiatric hospitalization, such as crisis residential services and the use of natural supports.



Embracing Our Challenges

Bob Dillaber

We all face many challenges in life–whether or not we have been dealt a mental or developmental disorder. If the truth be told, most so-called "normal" people struggle with life's challenges too, often daily.

It is easy to consider ourselves very different from others because of our unique challenges. We really are not. Perhaps we have radical mood swings. Perhaps we have a more difficult time doing things "normal" people seem to do more easily. Perhaps we struggle with depression. Perhaps we sometimes lose touch with the reality of every day life.

"Normal" people face their own challenges, too. Maybe not as severe or as often, but they also struggle. Unfortunately, for many of them, they do not have the support systems we have when we reach out and ask for help. "Normal" people must make the best of their difficulties on their own. I don't have to make it alone anymore. I did that for years and it didn't work at all well for me.

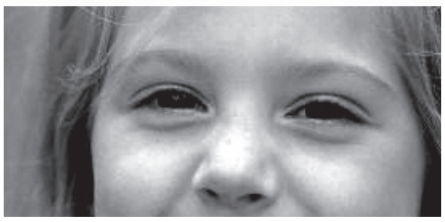
I think it is important for us to acknowledge the reality that having a mental or developmental disorder is often accompanied by many gifts—gifts such as empathy, intelligence, creativity. I have met many, many people who are abundantly blessed in this regard. What gifts have you been blessed with that you may not fully appreciate?

Over my 72 years, I have come to realize that we human beings are more alike than different. We all share the same fate. We are born, we live life in the best way we can, and then we die. With great conviction, I believe that most of us strive to be the best we can be and live an honorable life. Each of us has our own unique skills that we use to the best of our ability.

Challenges? Yes, we certainly experience them. Mistakes? Yes, we make those, too. But so, too, does everyone else on earth. Sometimes we are blown down by the turbulent winds of challenge, but sooner or later, we pick ourselves up, dust ourselves off, and move forward once again. As we embrace and overcome our challenges, we grow ever stronger. Who could ask for anything more?

For many years Bob Dillaber has been a very articulate advocate for individuals with mental illness. He has served as a board member for Oakland County CMH.

Through the Eyes of the Individual



Lynda Zeller, Deputy Director
Behavioral Health and Developmental Disabilities Administration
Michigan Department of Community Health

It is time to embrace the opportunity of change. There are complex problems with access to service for many Michiganders that we need to make a way to address. It is sobering and unacceptable that life expectancy for persons with mental illness is two plus decades less than the general population. It remains very difficult and often impossible for a person with a substance abuse disorder to receive psychiatric services unless diagnosed with a serious and persistent mental illness. Access to behavioral health services for veterans is a high priority for improvement and yet extremely complex to address. The great strength of community driven systems of care also results in legitimate criticism in terms of inconsistent access to services from CMH to CMH and community to community. Funding, assessment systems, rate and cost variances from locality to locality are often noted as exacerbating these access inequities. Even with all of these examples of the challenges at hand, there is much to celebrate. There is increasing awareness by decision makers and the health care sector of the importance of community based specialty services systems as core to this next generation of integrated health systems for persons with developmental disabilities, mental illness, serious emotional disturbances and addiction disorders. This awareness is especially exciting as the state and nation prepare for Medicaid expansion and Medicare/Medicaid dual eligible system integration. The need for change is real and compelling. The opportunity to influence that change is ours to grasp.

As we work to influence change we need keen and constant focus through the eyes of the individual. Whether we are considering the need for separate governance or decision making structures or best ways for collaborating with physical health care systems and health plans, we need to evaluate our current system and every potential change first through the eyes of the individual/family in the locality served.

- Does this system change being considered make it more or less likely that this individual or family would receive consistent services regardless of locality?
- Does this change make it easier for a person to meet their physical health care goals and objectives, in addition to their person centered planning goals and continued successful recovery, or less?
- Does this change make it easier or more difficult for an individual to get needs crossing the systems of substance abuse, mental health and developmental disability?
- Does this change promote maximum resources going to services to the individual while ensuring solid, state-of-the-art managed care systems supporting those services?

There are of course many more questions that can and must be asked. Again, the opportunity for change is ours to grasp, and is best evaluated first through individual eyes.

In closing, I want to thank all of you for your partnership and active involvement during this important time. I thank you in advance for continuing to grasp the opportunity to influence change and evaluate keenly and consistently through individual eyes. At the end of this month (July), I will be completing my first year with DCH Behavioral Health and Developmental Disabilities Administration. I continue to be inspired by your dedication, creativity and hard work. I look forward to the change that together we can influence for the good of our communities and state.

Kohn *(from page 2)* not going to be healthy, and vice-versa.

C: We need to have community wellness.

Kohn: Absolutely. And so, what are those things that create that wellness? And I think many communities are at the point where they're recognizing this. I know the community here in Muskegon is. I know our CEO [Linda Juarez, MPH] is now involved in a program called *One in Twenty-One*. We want to be the number one county in health in Michigan by the year 2021. That's a program that's going on that you will want to watch.

I'm beginning to look at what we here at HCCC need to do if we integrate ourselves into the health of the community. There are other people outside that are looking into their agencies. I know the local county health department has been involved. And our CEO, as I said, is heavily involved in it as well. I see these forces and disciplines starting to merge and come together. If you think about our health care delivery system, it has been so fragmented for so many years because the driver of our system has been the payer. Who's payin' the bill? Who's payin' the bill?

Well, the people who are payin' the bill finally found out that if we don't change the way we deliver, we're probably going to continue to pay the bills that are going to get bigger and bigger. We have to change the way we deliver health in order to sustain the payer system.

C: On my trip over here to Muskegon, I drove by an elaborate complex of medical buildings in Grand Rapids. It reminded me of an analogy I've heard of our medical system. It looks a lot like the Grand Canyon with all the sick people huddled at the top like lemmings. When we get really sick, we fall into the canyon lined with these amazing medical technological facilities that have fees that match their impressive services. What we need, to control the costs, is an investment in care at the rim of the canyon to prevent people from falling off.

"We're dealing with a population that's been moved from one social service agency to another, from one resource to another without anybody intervening and getting the patient involved."

Kohn: Absolutely. We're recognizing that here. Our delivery system is upside down, and it will be very unfortunate if we don't change. There's a shortage that's developing out there because this work is becoming more and more difficult as more and more demands are being placed on primary care and family docs. I think that's part of the driver behind more integration as well. We're looking for other resources and other disciplines to help. One of the biggest frustrations our primary care deliverers have here goes right back to what I just said: they appreciate the challenge and are trained to take on the pathology that we see–to understand the medications and the pharmaceuticals that are involved, to fix the sprains and the strains and to cure the headaches–but the biggest frustration is in dealing with the behaviors that come in with the pathology. The behaviors surrounding the pathology too often get in the way of healing.

C: You mentioned the payer system as being one of the impediments we have to address. How would you restructure the payer system so it would incentivize the collaborative relationships in our communities that would develop community wellness?

Kohn: I think you need a new payment system, and when I say payment system, I think there's a tangible and intangible payment system. I think the patients need to be involved in it at some point. We move patients around here from department to department like they're some chess piece. You asked me about the patient centered medical home; I think that's the right course. The patient centered medical home is getting the patient involved in their health care, involving their decision making. That involvement not only needs to be about making decisions, it needs to be about making commitments. We're not getting commitments from patients for their own health. We're dealing with a population that's been moved from one social service agency to another, from one resource to another without anybody intervening and getting the patient involved. They need to be able to feel either the financial pain or the physical pain or some kind of consequence, maybe pain is not the right word. They need to be involved in the process at some point.

C: I've been reading a little about some innovative systems that build relationships more directly with the patient, particularly the high utilizers. One of them appeared in the January 24th issue of The New Yorker Magazine *entitled "The Hot Spotters" and describes how they addressed high utilizers who present some of these "frustrating" behaviors. There seems to be some innovative strategies that can be very promising.*

Kohn: I agree one hundred per cent. We're setting up a lot of different systems, however, I think we need to be careful. Are we really just shifting cost, or are we maximizing our efficiencies and saving costs? The team approach is what we're looking at here, too. Last summer we went and studied the Inuit [native tribal group] model up in Anchorage, Alaska. They're far ahead of most folks in terms of a delivery system. Of course they have a specified population that they're dealing with, but then they also have non-Inuit folks up in Anchorage. They utilize a team approach that we're trying to replicate. It involves health coaches, it involves case managers, it involves care managers, and it involves the physician. The physician is just another member of the team. And then you determine who takes care of what piece of that patient's primary care needs. It takes a lot of the frustration, a lot of the anxiety and a lot of the stressed-out workload off the primary care physician. So we're looking at that and we're already seeing some tangible results in terms of morale and support systems being put in place for the deliverers of health care. There's a shortage of primary care physicians. Medical students begin to see how much work this involves and say, "I don't want any part of this." The demographics of the makeup of the profession has changed over the last twenty-five years that I've been in it.

C: Where does CMH Services of Muskegon County come into this?

Kohn: We started discussions with them about five or six years ago. Our initial discussions were based upon the fact that the CMH agency is always looking for somebody to take care of the primary care needs of their clients. These were people who were severely mentally ill, but they also had significant physical issues and pathologies as well. Their goal was obvious: they wanted the pri-

mary care doctor working in their facility. It was interesting, the gamesmanship that we both played with each other for a number of years. Our primary health care centers goal was obvious: we wanted a behavioral health specialist to be in our primary care centers. So each was looking for the other to come on over. And I think for a few years we did that gamesmanship, sparring back and forth. If you think of the reason we did it that way it was because everybody was protecting their funding source. There again you've got two different funding sources that are directing a certain delivery system. We've got the same issue with FQHCs.

Billions of dollars are being spent on 300 plus clinics across the country to provide primary care services for under served populations. But at the same time you've got Congress and the federals funding the VA system as well, which is found in numerous communities across the nation. We spend billions of dollars on the VA system, we spend billions of dollars on the FQHC systems. Aren't there some efficiencies to be gained by looking at combining these clinics? I take care of several veterans here in my clinic now, and they still go to the VA Center in Grand Rapids. There's duplication of services here, and there's duplication of efforts on a national scale. Somebody needs to look at this. I'm just a little primary care doctor here in Muskegon. Why am I seeing this? Somebody must be seeing this up there. It's this protection game that we play with these different funding sources.

C: At the last Executive Board meeting of MACMHB, a conversation similar to this came up. When we serve veterans for substance use disorders, why can't we directly bill the VA system for it?

Kohn: Right. Exactly, and because some of my patients can't get frequent appointments at the VA system for their high blood pressure or their diabetes, they come to me for the appointments. I write the prescriptions for them, they take it back to the VA Center and get their medicine. So what kind of sense does that make? Our system is fragmented.

C: So how has your relationship with CMH evolved?

Kohn: Well, let me get back to your question here, I kind of strayed from that. Our relationship over the years was simply to keep the talks going, just keep the talks going. It's no different than getting to know your patient. You have to get to know who your neighbors are. Again, it's foundationally based on relationships—relationships of organizations, just like relationships between individuals.

As you get to know each other better, you understand what their needs are and you understand what resources they have available. So as you begin to understand each other's needs and the resources you have, you also begin to understand that you do have a common goal. The cultures may remain different, but I think the missions begin to meld. So again, it is the recognition of that word "community" that is in community mental health and in our community care clinic. So it is about "community" and I think we need to put the emphasis on that word rather than on "clinic" or "mental health." It's the same patients who are visiting both places. It's not like we have unique patients. It's a community need. And so we, in my mind anyway, need to practice the Covey method of "where do we find a win-win?" What's the "win-win-win"? What's the win for primary care providers? What's the win for the mental health providers? What's the win for the patients and the win for the community?

We adopted that in our clinic on the leadership level by saying that any process or project we undertake should be intentional and it should address the questions, "Is it good for the patient, is it good for the staff, is it good for the organization, and is it good for the community?" If we can be affirmative on all of those questions, it's probably worth doing. And why wouldn't we do it? As this continued, it became essential to solidify a relationship with CMH to the point where now, several years later, we have mental health workers positioned in our primary care clinic, and now we are very excited about one of our physician assistants being stationed in the CMH building.

C: I've heard about that.

Kohn: We just had a meeting with him yesterday. We're getting the space in the facility all fixed up to provide two days of physician assistant over there. So I think once the ball starts rolling it starts to take off, and I think more and more people at the federal level, who are the funding sources again, are beginning to recognize this. I think it is the future. We're going to have to consolidate. It's my understanding as well as somebody who's signing these checks at the federal level, that these agencies need to be working together at the federal level just like we are working together at the local level. We can't have all these different agencies that are asking for money and sending out checks to one building that's only six blocks away from another building that's receiving another check from another agency. What's with that?

C: In the behavioral health field, particularly with children's services, we are recognizing the need to address this 'silo' complex and attempt to establish blended funding that can then be focused on the multiple needs of individual complex cases.

Kohn: Well, you know there are many different models of funding that are out there; it's just that I think we need to keep moving forward to find out what is the best model. If, again, you're going to be a community health center, and you are interested in the health of the community–in terms of mental, behavioral, spiritual–perhaps it all goes to a community funding chest where all of these agencies then practice at a certain level of efficiency so that we all get funded from the same source. I don't know.

C: What about a model where you would be given a set amount of money for each individual who is diagnosed with a particular illness? For example, you would receive a certain amount for each individual you served that was diagnosed with diabetes. Managing that person's diabetes was now your responsibility. And by the way, if they end up in the emergency room or the hospital, you have to cover the cost.

"So, as you begin to understand each other's needs and the resources you have, you also begin to understand that you do have a common goal."

(see Kohn page 12)

McKentry *(from page 3)*

depression. So they look at the symptoms and some of the things that the patient presents with, and from their knowledge base, they decide whether this person would be a good candidate for behavioral health.

C: What kind of symptoms would you perhaps identify as warranting a referral over to Community Mental Health?

McKentry: Any kind of psychotic symptoms, as well as deep-seated or long-lasting depression that doesn't seem to be getting any better with our treatment, and any persistent mental illness service that we feel we really aren't equipped to deal with because we don't have the same screening tools or the same ability to assist those patients. We try to get them more intensive services if we can, because here we're not really intensive–we're trying to manage and help them do better, but we can't offer real intensive services like CMH.

C: I understand you are a patient-centered medical home. This is where people come when they have a health issue. There has been some activity to try to get specialty care providers, like a CMH, qualified as a health home. In other words that's where people with complex needs around behavioral health go whenever they had a medical issue. What is your take on that?

McKentry: As far as them being centered at CMH?

C. Yes.

McKentry: I think it probably would make good sense, but I think the whole collaboration thing would still need to be a big part of it because I think it all has to work together: the spiritual, the emotional, the physical. Kind of all has to work together.

C: Spiritual. You mentioned that. What kind of collaboration would you do to address the spiritual needs of people?

McKentry: Well, I think we don't try to push it on folks, but I believe, from what I know of the providers that are here as far as behavioral health, that we all are spiritual in nature. And so if the client is open to those kinds of things we will delve into that and have a conversation and maybe encourage them to try and get connected with churches in the community. We also have some new things that are coming, like a spiritual advisor whom we're trying to connect with some of the people we serve. I believe there's actually a program that Dr. Kohn can tell you a little more about. The board has been discussing the spiritual well-being of not only our patients, but our providers, our nurses, everybody, because they see that as a big factor in someone's overall well-being. So we're trying to do more collaboration as far as that goes. We even have a lady that comes and meets with our employees on a regular basis, and she does a half-hour morning workshop session where they talk a little bit about spiritual needs.

C: Sounds like you really value collaboration around the multiple needs of a person.

McKentry: I think it's essential. I think that's the only way you can have overall health. You can't just touch one piece and then think that everything else is going to come together. I think that you've got to be working on all of those areas in order to have a fully integrated person so you can function in the way you need to accomplish your life's purpose, whatever that might be.

C: What are the greatest hurdles that you run into in terms of being a collaborator?

McKentry: A lot of times it is the limitation in what is available here and the resources that we have to make the connections with outside resources. We have a lot, but sometimes our clients just don't fit. And sometimes as far as trying to arrange other services, if the provider knows they're already working with somebody or have certain things already in place, they hesitate to overload themselves by taking on more. Sometimes it's just being able to get that person out to another referral source to address an insurance issue or whatever the issue might be, that would complete the wrap-around of services they need. But that takes time.

Stidham *(from page 4)*

started with her I was really depressed again. A lot was building up, you know, emotionally for me. So talking to her, and between her and Tawna getting things changed. They got me on the right depression pills where I've actually come out of it. About the time I start getting depressed and it's startin' to get to me, here's the appointment with Carmel, so I come here and unload and talk to her about it, and after I leave it just seems to work out better.

C: How frequently do you see Tawna?

Stidham: It averages about every three months, unless something goes wrong and I call in and say, "Hey, I need to see Tawna." Then they'll schedule me and then I let them know what's going on. Just makes it easier.

C: I understand that you also participate in some groups, or a group?

Stidham: Yeah, I've had physical therapy through them and I took their Chronic Health Class too. It helped dealing with chronic pain. And then I took their diabetes class.

C: Chronic pain, was this your back?

Stidham: Yes. I've got degenerative disc disease in my back, and I can't walk very far without the walker. I can walk around like in my apartment or in here, but to go out and take a walk—just to walk—I can't do it without the walker anymore. So makes it tougher. I can't be on my feet a lot 'cause you know, it hurts.

C: You said you also attended a class on diabetes. How did that go?

Stidham: Oh, I loved the diabetes class because they taught me the stuff I had never learned. You know, to understand how to read labels, you know, for my carbs and everything that I need to take care of myself. So, yeah they taught me a lot.

C: I understand that you have shared some of your experiences with others.

Stidham: Yeah. I don't mind helping people, I'm a real outgoing person; I don't mind helping if I can help.

C: Do you have any activities that you engage in out in the community?

Stidham: I try and get out. Down the road from where I live there is a park, and I get out and go down during the summer for our building where we do stuff cause I was on the council board in my building.

C: So it sounds like you're active within your own building complex? Are you still on the Council Board?

Stidham: No, not right now, but everybody knows me and it's a case of if they need help they come and get me. I actually had one friend, she didn't know how to work her phone from a hole in the ground, so it's, "Theresa, come and help." She knew how to dial my number and, "Help. I can't do this and it won't stop doing that!" You know.

C: How many residents are in the building?

Stidham: There's 160 apartments. So you deal with a lot of people, a lot of different things. Um, with the diabetics in the building, if I recognize somebody's going into a sugar attack or something, I've got like my monitor and check their sugar. I keep track of some elderly people living on my floor. I try at least to see them so I know they're doing OK. I'm a floor captain in my building so basically I just keep tabs on the residents, and if I don't see one for a few days, either I knock on the door or go to the office and see if anybody's seen them. I kinda know who to check. I know the whole building, the office, and I get along with everybody.

C: But you have been able to develop some relationships there?

Stidham: Yeah, and I don't mind talking. I like to know who my neighbors are in case I have to yell for help because I fall, or something. Most of them know I use the walker so it's a case of we keep an eye on each other. I'm just lucky I've got good people up on my floor.

C: Sounds like you'd like to make some changes there.

Stidham: I'd like to see a lot of changes there, but it's getting the right people, the residents—you got your good ones and you got your bad ones. It's part of any community you're gonna run into, 'cause there are at least 160 different attitudes, backgrounds and everything else, so yeah, you're gonna find your conflict. But the good people outweigh the bad. I've got friends in the building, and we can sit and have a lot of fun and talk and get together and watch movies.

C: That really improves the quality of your life, doesn't it.

Stidham: I learned from Carmel that if you get in a depressed state it doesn't help to sit and dwell on it or you end up in worse shape. Carmel taught me not to dwell on it–get it out, get it over with, be done with it. You gotta' keep going. And I figured out, too, that I like to take care of others. When I moved into the building I actually took care of a longtime friend of mine until he died. I'm very independent, but it's nice to have those that I can depend on and that's what I have there in the building. I've got some really good friends in the building. Two of them I've known over ten years. At least I know I've got somebody to talk to.

C: Can you imagine your life without some close friends like that?

Stidham: No. No. I need my friends around.

C: And they need you.

Stidham: Yup. We really do; there's me and two others that are really tight. We see each other almost every day.

C: That's your family.

Stidham: Yeah, my street family. I have more street family than I do my own.

C: So do you think that's kind of common with people?

Stidham: Yeah, and I love it.

C: Is there any other wisdom about life that you'd like to share?

Stidham: *[pondering thoughtfully before responding]* Don't be afraid to get the help you need if you have health problems. Get the help you need. I've learned to voice it. If I'm depressed, I work with Carmel and my doctor. Get the help, don't sit there and ignore your problems 'cause they ain't gonna go away. I'm diabetic for the rest of my life. I'll have back pain the rest of my life. I'll have the depression the rest of my life. Keep your chin up and go for it—keep going. Everything I've dealt with, yeah, I could have tried suicide, but it wasn't worth it. I've kept going. When my friend died I had people around me to keep me going. I took care of him at home until he died. There were no monitors, nothin' hooked up to him, just me and him. Seeing that changed me a lot.

C: How did it change you?

Stidham: I've dealt with funerals, I'm used to funerals. But to deal with somebody right up until they die, it's a whole different mentality. If you've ever been in a hospital, next to somebody when they've died, it changes you. You can't always explain it, but I miss that guy. It was a male friend of mine. I miss him dearly, but it scared me bad because it was the first time I ever dealt with seeing an adult that I've known die. I knew he wouldn't want me to stay depressed and go nuts or anything. He'd want me to keep going, and I had enough people around me that I was able to work it out, cry it out.

C: So even though he died, there must have been a sense of his presence still there to keep you going saying "You gotta keep going".

Stidham: There had to have been now that I look at it–it'll be four years for him in June. He was actually cremated and I've got the ashes. So with them still around, I think that's what kinda' keeps me going a little bit, that sense of security that he's there, cause we were friends for over 20 years. He was the main reason I moved into where I'm at now because he needed somebody to take care of him and I was there 24 hours a day with him.

C: That was his home.

Stidham: Yeah, when I originally moved into that building, I moved into his apartment, filled out the app to get my own place there, and the office let me stay with him until I got my apartment. So it worked out. I got my own place the summer after he died.

C: So one of the significant roles he played in your life was finding a place for you to carry on?

Stidham: Yeah. And then I've gone on and done so much after he died. Yeah it really kinda worked out for the best. I quietly thank him for it now, you know. Hey I've got a roof over my head, I can afford the rent and I can afford to live there. So yeah, it worked out really nice. I always look at it this way: God puts some people in your life for a reason. There was a reason for it–and look where I am today.

C: What is the reason for your being here today?

Stidham: I think a lot of it's to be here for friends, to be a part of their lives. If someone has diabetes, the office knows I've learned a lot about diabetes and they can put us into touch with one another. Yeah, it works out. I like the fact I can help somebody.

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Kohn *(from page 9)*

Kohn: I think unless you find some way to get a commitment and accountability from the patient themselves it won't work. They have to play a role in this. I don't think we can leave the patient out of the picture. There needs to be a stimulus or incentive for them to stay healthy. There are some people who don't seem to want to be healthy, for whatever reason, and that's where we would run into problems. But the model you're speaking of, I believe, is the exact model that the Inuit Foundation up in Anchorage is using. I believe their CEO went to congress and said, "Look, either you're going to continue to pay me Medicare money piece by piece by billing piece or, here's what you've paid in the past…I'm just asking you for this amount. Give it to me all up front and don't pay me another cent."

C: And I get to keep part of the savings.

Kohn: I'll keep the savings and we'll produce the system that will generate health care and savings for everybody and be successful. And they were successful at it. Now, can you do that in every community? It's an interesting concept. I'm not going to say 'no', but I'm not going to say 'yes'.

C: You have brought up the issue that somehow we have to get the patient to be responsible, we can't leave them out of the loop. So now the problem becomes how can we motivate people. We need to acquire new skills. Perhaps those of a health coach are part of the answer. But I believe there are strategies that have been developed in the fields of social work and human ecology that focus on community and human resource development. We are not the first to ask how do you go into a community and wake it up and get it to take care of itself.

I believe you've nailed it right on the head, we need to focus on community wellness and that requires the ability to get people to take responsibility.

Kohn: We're into generations and generations of folks who have not really been trained in self-discipline, self-fulfillment, it's a foreign behavior. We create more and more dependency, passivity, and we take people's pride away from them. When I talk about spiritual health, well it's no wonder they aren't in touch spiritually. I mean where is their pride? You have to get right down foundationally to each individual.

C: The core of the individual, the heart.

Kohn: Exactly.

C: It has been voiced by some that in the next few years we're going to have absolutely irrefutable evidence that there are ways to reduce health care costs and they are high touch and they are at the level of care. What would you say to that?

Kohn: I agree, we need the "high touch."

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