



March 17, 2015

Chairman Shirkey and Members of the Senate Health Policy Committee:

Thank you for the opportunity to address the Committee with our serious concerns regarding **Senate Bill 68**.

My name is Jonathan Henry, I am a psychiatrist, trained at Michigan State University, and board certified in general psychiatry and geriatric psychiatry. I divide my time between private practice in East Lansing and community psychiatry at Community Mental Health for Central Michigan in Mount Pleasant and at the Traumatic Brain Injury Clinic at Hope Network, also in East Lansing. I was formerly medical director of the Clinton Eaton Ingham CMH. I am also president of the Michigan Psychiatric Society.

I began my career as a family practice physician. I was not long into that practice when I realized that I wished to attend to the whole person, as my ill patients frequently presented with mental health needs. Moreover, I quickly recognized just how complex an endeavor patient care is, and how the optimum delivery of it requires the coordinated efforts of a whole team of professionals, not just a physician, providing the needed care for any patient. I saw it everywhere I went in my training and in my early career as a family practitioner: in the hospital and in office settings – quite literally **everywhere**.

Becoming a psychiatrist has provided me with the skills to attend to the needs of patients, and frequently in consultation and collaboration with other health care professionals. Yet, the quandary of fragmented care and systems in separate silos became even more apparent to me. I've come to believe that **integrated care** holds the promise of an effective solution.

The task set before us as a nation as we try to overhaul and improve our health system is a most difficult one. The goals of this effort are perhaps best summarized in an article from the journal *Health Affairs* that has been widely cited in discussions such as these. These goals have been referred to as **The Triple Aim**, which is to improve the **experience of care**, improve the **health of populations**, and **reduce per capita costs of health care**. Trying to accomplish these goals is made all the more difficult with the influx of new patients into the healthcare system, through the Affordable Care Act nationally, and through the Healthy Michigan Plan in our state.

Differing approaches to managing this dilemma have been advanced, some more likely to succeed than others. One approach, such as the one currently under discussion as embodied in SB 68, proposes a solution that involves multiplying the numbers of individual practitioners to meet the burgeoning need. Another approach, that of team-based care, recognizes that the problem requires a more complex solution. Simply expanding the scope of non-physician professionals may actually worsen some of the problems we are already facing. What is needed is the skillful application of all of our **workforce resources** in a coordinated, team-based approach, an approach also fostered by other developments in health care transformation, such as Accountable Care Organizations and patient-centered behavioral health homes.

Dr. Atul Gawande, a practicing surgeon and professor at Harvard Medical School and Harvard School of Public Health, is a widely published and accepted authority in health policy. Two of his articles, "The Cost Conundrum" and "The Hot Spotters" have been especially examined as they relate to issues of quality and cost.

In "The Cost Conundrum," Dr. Gawande advocates for the coordination of efforts between physicians of various specialties, in the style of the Mayo Clinic, where physicians are incentivized to work together as opposed to separately, thereby significantly expanding the expertise of the team. Teamwork divides the task and multiplies the success, when success is measured in the language of the Triple Aim: improved care experience, improved cost, and improved health quality.

In discussing his ideas on how to improve healthcare, Dr. Gawande has observed "what's hard to understand is that we are transitioning from getting our care from individual clinicians to getting our care from teams of people." He goes on to note that no individual clinician is capable of doing everything for patients well. He observes, "We now have 13,600 diagnoses identified." For these diagnoses effective measures have been developed to improve people's lives that include 6000 drugs and 4000 procedures. He goes on to assert that "getting people the right diagnosis, the right care, safely, without errors or wasted resources, and with some kindness along the way" is more than any one clinician can do. The clinical care of patients is becoming ever more complex, and we need all the expertise we can find to bring to bear upon the problem.

In a recent interview with the Robert Wood Johnson Foundation, Dr. Gawande further commented, "of course, if all you do is scale up a dysfunctional organization, then you just scale up dysfunction and that doesn't solve anything." We believe that Dr. Gawande's views and recommendations have relevance in directing health policy in Michigan. We need to do the hard work of organizing our approach in teams, and not simply expand the individual scope of one class of clinician or another. This is among the reasons that we oppose SB 68 as an inadequate response to our problems, and instead advocate for the development of health policy that incorporates the basic principles of team-based care.

In our own system, there are many models, including a pilot program in Michigan's CMH system that is trying to put into practice some of these principles. Faced with an expanding Medicaid population, the ability of psychiatrists alone to manage the mental health needs of this group is hopelessly outmatched. The shortage of psychiatrists in the country is well documented, and the need is certainly acutely felt in Michigan. At this CMH, one adult psychiatrist, one physician assistant, one nurse practitioner, and three nurses are trying to manage the treatment needs of the hundreds of patients in the agency's medication clinic. The training, education, and expertise of each clinician are matched to the patient's needs. Methods to improve the functioning of the team include face-to-face team meetings using videoconferencing when needed, telephone availability of the physician for questions and problems and the availability of the physician for difficult cases and second opinions.

This effort represents an effective response to the clinical and cost needs of the healthcare system and its patients. Coordination and integration of effort in a team model where the roles of the individual team members are well defined and mutually agreed upon, is the guiding principal, consistent with the Triple Aim. Further fragmentation by merely increasing the numbers of isolated clinicians works in opposition to this effort—in effect, 'scaling up the dysfunction.' This result would be a step backwards, and leads us to conclude that SB 68 is an insufficient effort to address our healthcare system's problems and needs.

We urge that the committee not advance SB 68 in its current form and to instead work with us to further define and refine a better alternative: **team-based care**.