

TRANSCRIPT OF AUDIO FILE:

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BEGIN TRANSCRIPT:

MODERATOR: Good afternoon everyone. Welcome to today's webinar for the SAMHSA-HRSA Center for Integrated Health Solutions – Client Recruitment and Retention. And this is for all the MAI Continuum of Care Grantees. We want to welcome you to today's webinar.

My name is Victor Ramirez. And before we begin, I do want to, uh—I do want to wait a couple more minutes just to give other grantees a final opportunity to log in. So, if you can just hold on for a couple more minutes and we will begin promptly at 1:02 p.m. Thank you very much.
[00:00:46 — 00:02:06]

MODERATOR: Okay, good afternoon everyone – or good morning if you're in the West Coast. My name is Victor Ramirez and I'd like to welcome you to today's client and recruitment— Client Recruitment and Retention webinar. This webinar is brought to you by the SAMHSA-HRSA Center for Integrated Health Solutions. (CIHS) Before we get started, I'd like to draw your attention to some important webinar logistics.

An audio version of the entire webinar will be available on the CIHS website within 48 hours and a PDF of the presentation will be available on the website at the MAI-CoC Grantee online community.

You are currently in listen-only mode. If you're listening on your phone, please enter the audio pin number from the control panel on the right of your screen onto your phone's keypad. (pause) Sorry about that. You may send us questions for the speakers at any time during the webinar. Simply type your question into the dialogue box to the right of your screen and send it to the organizer. We will answer as many of your questions as time allows. We're going to have two question and answer sessions: The first one after the first presentation; and then the second one after the second presentation almost at the end of the webinar.

Now if you experience any technical difficulties at any point during the webinar, please call Citrix tech support at 888-259-8414. I repeat, it's 888-259-8414. [00:04:07]

Now for our Client Recruitment and Retention webinar today, I want to provide a few words of introductions for the two presentations. Our two presenters today cover a variety of perspectives that pertain to the MAI-CoC grantees. Although neither specifically likes (ph) MAI-CoC grantee integrating HIV and hepatitis screening and care to behavioral health programs, we believe that you will gain valuable insights from their work. You should recognize the length and the connections needed in your own project in both presentations. Both are involved in intensive partnership linkages, planned recruitment, and (inaudible at 00:04:50) in one project—you know, for client participation—and the project health program. Their recruitment and retention to care needs for HIV and AIDS as well as for clients with serious mental health disorders will be especially notable.

The presenters are first, Ms. Erin Nortrup. She's the Senior Program Manager for Access to Care at AIDS United and AIDS services organizations who (ph) provide HIV AIDS care and support services.

And secondly, with a comprehensive mental health care and supportive service program, Mr. Freddie Smith, who serves as the integrative care manager with Alameda County Behavioral Healthcare Services. This site recently integrated the health and wellness program which had sustained their PBHCI grants.

Now, before I turn it over to Ms. Erin Nortrup, we want to say a few words. [00:05:51]

Ms. Nortrup currently serves as the Senior Program Manager for Access to Care with AIDS United. Working in the HIV care and prevention field for over 10 years, she also served as Support Services Director for the Cascade AIDS Project in Portland, Oregon. Earlier work in community-based organizations include serving as director of programs at the Sexual Minority Youth Assistance League in Washington, DC managing all direct service programs including HIV testing and counseling, prevention intervention, and linkage to care for lesbian, gay, bisexual, transgender, and questioning youth—ages 13 to 21.

Ms. Nortrup's local work in public health includes serving as Public Health Supervisor in Clackamas County managing HIV prevention, school-based health centers, and tobacco prevention programs. She is a licensed clinical social worker and completed the Robert Wood Johnson Foundation Ladder to Leadership program for emergent community health leaders in 2010/2011.

So without further delay, um—let me see—okay. Um, Ms. Nortrup, can you hear us?

ERIN NORTRUP: I can. Can you hear me okay?

MODERATOR: We can hear you perfectly.

ERIN NORTRUP: Great. Thank you so much. I'm really pleased to be joining you on the webinar today, and I really appreciate the invitation from the National Council on Behavioral Health to be part of this presentation.

I'm going to be talking today about recruitment and retention in HIV care, and I'm going to be drawing from our experience at AIDS United with a couple different interventions or initiatives that we have. One is on Access to Care and the other is on Retention and Care. My perspective on Recruitment and Retention is also informed by my experience in working in community-based HIV services—so particularly in managing navigation programs for people living with HIV who have numerous barriers to care. Next slide please? [00:07:54]

So just a little bit about the two initiatives that I'm going to be drawing some information from—our Access to Care Initiative through AIDS United included 12 organizations around the country that are implementing innovative, public-private partnerships focused on improving individual health outcomes and strengthening local service systems. Their emphasis is on hard-to-reach populations—particularly those living in poverty and those who know their HIV status but are not in care. And their innovative approaches are driven by their local epidemic and gaps in linkage and retention. And this is through funding that AIDS United receives from the Corporation for National and Community Service's Social Innovation Fund and numerous foundations. And through the Access to Care Initiative, at our last report our organizations—collaborating organizations—had served over 4,100 people.

Some of the other aspects of the Access to Care and Retention in Care Initiatives are that many of them have a peer navigation component. They also focus on care coordination with a clinical partner and involve collaborative partnerships that seek to make change at the systems-level as well as supporting individual folks living with HIV. The next slide please?

So the next slide is our Retention in Care Initiative. [It's a] little smaller cohort of seven organizations around the country—many similarities with the Access to Care Initiatives. They're focused on identifying, documenting, and evaluating innovative, emerging, or promising program models for retention care. There's a national evaluation monitoring improvement in individual health, systems change, and cost effectiveness. And this funded through a grant from the M-A-C AIDS Fund. And at this point, there are about 4 to 500 folks who are enrolled in Retention and Care Initiative. Next slide please? [00:10:02]

So for both of these initiatives there's a pretty robust evaluation component. We work with Johns Hopkins University to conduct the evaluation. And it includes data collection at six, twelve, and eighteen months after initial enrollment as well as at the initial enrollment point. And data collected includes demographic information, health outcomes, needs and barriers, self-reported health status—so whether folks identify their health as excellent, good, average, or poor. And then the timeframe that it takes to engage people into care once they're enrolled in the programs. Next slide please?

So, some of the information that I thought would be helpful to share from the evaluation in terms of recruitment and retention and HIV care is around barriers to engagement and care. I've included some of the top barriers to care here that have emerged from our evaluation, and some of these may not be surprising to you all but, um—the first one is transportation. And, you know, often transportation is the top barrier that comes out in Ryan White jurisdictions' assessments of their clients' needs and barriers, as well.

Numbers two and three—lack of money and lack of stable housing speak to the huge barrier that’s presented by not having basic needs met. In working with folks who are disconnected from care and who have basic needs going unmet, the process of engagement into HIV care and other services often starts with identifying what that individual’s goals are—whether it’s locating stable housing or getting into drug and alcohol treatment services—and starting there rather than immediately working on the connection to medical care. And addressing these barriers, obviously, is so important to client stability—particularly housing stability—which is the single most important factor when it comes to retention and stability in HIV care. [00:11:53]

I think it’s interesting to see that “didn’t want to think about HIV and denial” and also “forgot to go or missed appointment” came up as major barriers to care. And I’ll talk about an intervention a little bit later in the presentation that we’ve found is really helpful in terms of these particular barriers. Next slide please?

So this is some data from our Access to Care. We sometimes use this as the acronym for Social Innovation Fund. So it’s a subset of the participants from the Access to Care Initiative, and this just shows the number of people from that subset who reported the barriers that are shown on the slide. So again, transportation comes up as the number one barrier but almost half of the participants cited that as a barrier to their engagement in care.

Again, “forgot to go,” “missed appointment,” “didn’t want to think about HIV,” “in denial” are high up on that list. And then things that I think are indicative of HIV-related stigma such as “wanting to avoid being seen at the clinic” – 23 percent. So one in four listed that (inaudible at 00:13:05) think. It’s just interesting to see the list and the breakout of how many people identified which barriers. Next slide please?

And then I just wanted to include this data because I think it’s pretty important. The impact of HIV-related stigma remains strong. So at baseline assessment for our Access to Care participants, almost one in five participants recorded that they sometimes are always avoided treatment because someone might find out about their HIV status. And again, this is preliminary data from our national evaluation for the Access to Care Initiative. Next slide please?

So with that data in mind, I wanted to talk about some of the recruitment strategies that have been successfully used by organizations in our Access to Care and Retention in Care cohorts and other navigation programs. [00:13:56]

So referral relationships are obviously an important source for recruitment into HIV care—as well as other support services that enable people to engage in care. HIV counseling and testing providers are a natural referral source. They are a primary identifier of newly diagnosed individual—CDC placing a stronger and stronger emphasis on linkage to care by testing providers. It’s important on their end also to have those established relationships—referral relationships in place to link newly—newly diagnosed individuals.

Referral relationships with medical providers can also provide a good avenue for recruitment. In the area I worked in in HIV care services, 20 percent of newly identified positive individuals

who were identified through public testing. That means that 80 percent were identified through private providers. So that was a really important place to have referral relationships in place to link people to HIV specialty care and other support services.

Local hospital systems—some hospital systems are implementing routine HIV testing in their emergency department as a way to identify people with HIV who may not have been offered a test in the past or may not be in routine medical care, and so may be in a position to identify folks who are newly positive and need linkage to care. And then disease intervention specialists—as probably aware—do the case follow-up with sexual and needle-sharing partners of people who've been newly diagnosed with HIV, so are often in the position to identify people who are newly diagnosed and in need of linkage to care and support services. Next slide please?

So some additional recruitment strategies are to establish a relationship with your local jail or prison system, if possible. Different systems obviously work in different ways, but some systems have a case manager or staff person who's assigned to pre-release planning for people with particular medical needs, including HIV. So it (ph) can be good resources for referrals.

[00:16:01]

According to data from The Bureau for Justice statistics, between 45 percent and 64 percent of incarcerated persons has some time of mental health concerns. So this is a population that could greatly benefit from coordinated support around HIV care and mental health and/or substance abuse treatment services.

In terms of local and state health departments, some are undertaking efforts to get a more accurate count of their out of care numbers, and through that are generating lists of the people that are categorized as out of care and then working with community organizations to figure out whether folks have moved out of the area—whether they're truly out of care—and then in the process are identifying folks who are out of care and in need of services.

And then back to local hospital systems—one of our grantees works with a local hospital system in a similar way where they identify a list of folks who are out of care and then collaborate with the hospital systems so that they can identify when those folks come through the hospital system and are able to touch base with them at that point to link them to care if they're interested in that linkage system. There can be some challenges around that in terms of respecting folks' confidentiality and having that conversation, but they've found it to be a helpful technique in reaching folks that they haven't been able to reach otherwise.

And then finally, social media outreach—that is a whole other webinar on its own but is a great venue for reaching out to folks through postings and banner ads on social media sites to publicize services programs. Next slide please?

So I wanted to cover just a couple strategies for retentions that we've seen to be really effective with our collaborating organizations. So these are peer navigation services, trauma-informed care, addressing the barriers to retention in care, and coordination of care. Next slide please?

[00:18:06]

So I just wanted to share a quote from one of the peer navigators working in one of our collaborating programs, because I think it speaks so well to how important this work is. So they say: “As a client turned employee, I believe the value of a peer navigator is incomparable. The overwhelming support and information I received from my peer helped me to overcome the anxiety and fear of being newly diagnosed HIV positive. The positive impact she made on me and my life is what led me to my passion to become a peer navigator. I only hope to be as supportive, loving, and helpful for my clients as she was for me.” Next slide please?

So the first approach I want to talk about is peer services. As I said, most of the Access to Care and Retention to Care sites include a peer navigation component. AIDS United is in the very final stages of a Best Practices paper on Integrating Peers into HIV Care, and it should be up on our website—which is AIDSUnited.org—in the next three to four weeks. I wish I could provide you with a link right now, but it will be up there very soon.

Peers are uniquely suited to address some of the major barriers to HIV care that we’ve talked about. And as with many other fields, the HIV field is increasingly using peers as supports and navigators are people living with HIV—and often with really strong results. The Access to Care and Retention to Care Initiative organizations were charged with creating innovative interventions in their communities, and many felt like a peer component would be a really important part of that.

And just—as far as a definition for how we’ve define peers in terms of HIV services—is folks who are HIV positive, medication-adherent role models living with a shared experience and a shared community membership [with] the populations they work with. As such, they’re uniquely suited to address some of the barriers to HIV care and specifically HIV stigma and that denial around HIV. [00:20:12]

And I just wanted to include this one piece of data from our Retention in Care participants. So of folks who had an HIV medical visit in the past six months, 75 percent found peer navigation services to be very helpful or extremely helpful in helping them to attend HIV medical appointments. So I think that just speaks to the importance of this intervention and from a claim perspective of how helpful they’ve found that in terms of retention in care. Next slide please?

So, some of the—and this will probably be familiar to many of you who work with peer navigation programs, but—some of the many benefits of peer services are trust and rapport-building based on shared lived experience. Peers typically have more flexibility than do case managers who are usually unable to work outside the office. And in my experience working with navigation programs, peers can learn so much from their interactions outside of the office with their clients and then are able to share that information with the medical team and other service providers, which brings fantastic insights into what’s really going on in a client’s life. They may also be able to identify really salient issues that wouldn’t have been—come to light otherwise.

So one of the common issues that the peer navigators I worked with had to navigate with their clients was in their transition from homelessness to being housed. It’s a huge transition for clients obviously, and many of the coping skills that they used while homeless don’t work as well once they get into housing. For example, relying on their community of other folks who are

experiencing homelessness is a great support when they are homeless, but once they get into housing, bringing those folks into their new housing situation can present a real issue for their landlords. And this is something the peer navigators were able to see really clearly by going out and working with their clients in the field—were able to bring in those insights to the housing worker, case worker, and the medical team, and also intervene at the landlord level to make sure that folks were able to stay housed. It can also provide really valuable insights into cultural factors that might impact on the provider relationship that might not otherwise come to light. [00:22:36]

And then the very last thing that I always like to say about peer navigators is that they provide hope for the folks that they work with. They provide a vision of someone who has dealt with similar issues, who is living a healthy life, is able to give back to their community. And that hope is so important for folks as they're figuring out so many things that need to happen in terms of their HIV care. And then if they're dealing with substance abuse or mental health issues as well, that hope can be really a lifeline for folks. Next slide please?

Another important strategy that I wanted to highlight is the really critical need for trauma-informed care. There's been an increasing attention at a high degree of history of trauma—particularly for women living with HIV. So some of the statistics here speak to that. So the rate of intimate partner violence among HIV-positive women is double the national rate. Rates of childhood sexual abuse and physical abuse are more than double the national rate. And these are associated with poorer health outcomes.

There's not a great deal of research on other (inaudible at 00:23:50) populations' experience of living with HIV around trauma, but we'd expect—just from our experience with partner organizations—that it would be high as well. So the strategies that people developed while in the midst of traumatic experiences may have served them well at that time, but might pose problems for engagement in retention and care. So designing services so that they're in trauma-informed can ease this process. And I saw that SAMHSA has great resources for trauma-informed care on their website through the National Center for Trauma-Informed Care, including principles of trauma-informed care and trauma-specific interventions.

And then, I'm going to go—oh, next slide please? I'm going to go through the last slide fairly quick—last couple slides. So just to think about the other barriers to retention in working with your clients around retention and care—so given that transportation seems to always come up as a top barrier, some of the potential solutions to look at are co-location of services. So if clients have to travel to a location for services, at least they can access multiple services in that one location. It's also great for a warm handoff between providers.

We have one collaborating organization that uses telemedicine—which I know is not an easily accessible intervention necessarily. But if you have that as a possible way to reach clients, they've found it to be really helpful for providing medical checkups as well as mental health and pharmacy services, and has made those services accessible for folks in rural areas—and then just assistance with transportation. Next slide please?

And then just to think and keep in mind the barriers to retention and care that we discussed: HIV-related stigma; addressing multiple competing priorities like lack of stable housing—lack of money; that client goal plans should include comprehensive support around stabilization; and that coordination of care across all providers is really critical—especially for folks who experienced high levels of trauma. For them not to have to tell their story multiple times across different providers is really helpful. Next slide please? [00:26:04]

So there—that’s my contact information. I know we have some time for questions. I’m going to turn it back over to Victor to facilitate any questions that have come in.

MODERATOR: Alright, thank you very much, Erin. Again, for all the grantees, if you have a question or you have a comment, you can type it in the question—in the question dialogue box that’s in your control panel. The control panel should be to the right of your screen. So any questions or comments—we’ll wait a couple of minutes. (long pause)

Again if any grantee has a question or if you have a comment that you would want to share with the rest of the MAI-CoC grantees, you can type it on—into the question dialogue box on your control panel. (long pause)

We do have one question. The question asks, “Are a pattern of missed appointments tracked and then targeted for follow-up?”

ERIN NORTRUP: Okay. So I can—I can speak to that from my experience in HIV care direct services. So one of the—the HIV clinic that we collaborated with most closely with our navigation services would track missed appointments. And they—they would initially reach out to folks if they had missed appointments through phone calls and things like that. Once the client had been out of care for a period of six months or more, they would refer them for more intensive navigation services that would do more intensive outreach including going to the client’s home to try to reach them and re-engage them into care. So that, I think, helped. The clinic can certainly help with the coordination with navigation services to keep a close track of the missed appointments and patterns around that.

MODERATOR: And thank you, Erin. We do have another—we have another question. What is your advice for working with community partners that may perceive your program as a threat?

ERIN NORTRUP: Hmm. (pause) Let’s see. I mean, I think it probably is about knowing the community partners well and what their services provide and what they don’t provide, and if there are complimentary services that you can offer. Or if there are a greater number of clients—people living with HIV in the area—that could really be served by that program, even within their focus area, so that if they’re viewing your program as competition for them, you can figure out a way to provide a service that’s complimentary or serve clients that maybe wouldn’t already have been served. That would be sort of my general advice around that.

MODERATOR: Uh, we have one—one more question. Uh, do you have any suggestions for working specifically with prisons or jails at release? [00:29:52]

ERIN NORTRUP: At release? Um—so, one of the things that we found to be really helpful—one of the navigation programs I worked with through NASO was charged with doing connection to care from prison at the point when folks are released from prison and jail. And building a relationship with the person who is most involved in that release planning is really key—and being able to strategize with folks directly. So with people who are living with HIV and are incarcerated, if it's possible to meet with them prior to their release so that you can put a plan in place for stability once they're released, that we found to be really helpful—particularly around housing. So if folks obviously are released and go back to the very same environment that they were in prior to their incarceration, that may not be the most conducive to their stability. But if you can work with them prior to their release and get services in place for them once they are released [that] they can connect to pretty quickly, that really helps to keep them stable and keep them from getting re-arrested and back into incarceration.

MODERATOR: Alright. Thank you very much. Uh, we have one comment, and after this comment we'll move on to the next presentation. The comment is, "I agree that the need for trauma-informed care is needed as we are enrolling more women in the program that require domestic violence groups." So I think that—that—you know, that's in reference to your presentation where you mentioned domestic violence and women in domestic violence groups. Um— (overlapping talking)

ERIN NORTRUP: Yeah. (overlapping talking) That's also a great place for collaboration. If you can work with domestic violence services in your area to screen for HIV, and likewise working with women who are living with HIV to screen for experiences of violence so that folks can get both of those services if they're needed. [00:32:04]

It looks like there's one question about texting or other electronic assistance? I don't know if that's visible to everyone. But just really quickly, I think that's a great way to do reminders and reach out to folks—particularly younger people who really like use cell phones and texting a great deal. So we found that very helpful in working with youth to remind them of appointments.

MODERATOR: Okay. And with that comment—that question—okay Ms. Nortrup will be back. We will have another 10 minutes at the end of the—towards the end of the present—uh, of the webinar. So please, if you have any additional comments for Ms. Nortrup, please keep them coming in your question box. But right now—um, again, thank you very much Ms. Nortrup. We'll have you back in a little while. But right now, what I would like to do is present Mr. Freddie Smith. He is our next presenter. And just a little bit about Mr. Smith.

Freddie Smith has served for over 30 years in public health clinics and community health centers focused on providing primary care and behavioral health care services to underinsured and uninsured residents. Currently, he is completing the final month of a four-year term on a collaborative community planning council under the office of AIDS Administration for Alameda/Contra Costa counties to [incisional] (ph) grant area. His administrative work spans the area for personnel policies and procedures, budget preparation and monitoring, and compliance with state and federal government licensing regulations. He also served six years on the West Oakland Health Council Board of Directors in Oakland, California. Mr. Smith has a Master's degree in Public Health Administration and Planning from the School of Public Health from the

University of California Berkeley. So without further delay, Mr. Smith—let me un-mute you. Mr. Smith, are you there? [00:34:18]

FREDDIE SMITH: Yes, I am. Mm hmm.

MODERATOR: Okay. Turn it—now it's your turn.

FREDDIE SMITH: Okay. Uh, first I would like to say thank you to HRSA's Center for Integrated Health Solutions over at the National Council. And also to SAMHSA's MAI project officers for the opportunity to share with you some of the tools that we use as a SAMHSA grantee and implementing integration by bringing primary care services into our mental health service clinics.

With that, um—you know, although most of all of you in the audience are HIV providers, many of our clients face very similar challenges when it comes to receiving services. And, for example, the issue of stigma—many of our clients have to deal with facing stigma dealing with mental health issues. The complexity of health issues that they're having to deal with, and also, many of them have the same similar challenges of getting into care such as lack of transportation, being—having many barriers in terms of fear of the accessing care, housing issues, living in unsafe neighborhoods, and also having very low income. But with that, I think there are some techniques that we can share today that will be beneficial to you and at the same time, help your programs to be more successful as you go on and implement your new four-year program as a grantee of SAMHSA. [00:35:55]

The Alameda County Behavioral Health Care Services is a specialty net—specialty service that provides service—mental health services and substance use services for the most seriously mentally ill and [underserved] (ph) populations of Alameda County. Our county is the safety net provider for over 31,000 clients, and at the same time, um—Victor, you can go ahead and change the next slide.

We have a—our population is approximately 36 percent Black, 34 percent White, 11 percent Latino, 15 percent Asian/Pacific Isler—Islander, and 3 percent other. But yet, out of that 31,000, there's about 3,700 individuals that have been identified due to our centers—our county center's intake and referral service—that are basically [in need of] specialty mental health and need to have what they call Community Support Center Service Team services. And these individuals are ones that have high hospitalizations due to their mental illness, as well as they have to access the ER's quite often. So they're the real high-cost utilizers of our health care delivery system in Alameda County.

When they become a member of the service team, they are case-managed, and both case managers on those service teams are expected to not only provide mental health services but also assist them with legal issues, housing, getting them connected to physical and other health care specialty services, and also make sure that their benefits stay in order, such as their Medi-Cal or their general assistance—which they receive services or their SSI—and also help them resolve any type of money issues that they may have. Next slide please? [00:37:52]

Our next slide shows you what is the psychiatric profile of our clients. As you can all see that basically in our adult system of care, we serve mainly 18 to 65-year-olds, and as you can see that the majority of our clients that we serve on our community support service teams are schizophrenic and have—and bipolar, and also have depressive disorders. Next slide?

But again, in 2006, a lot of research started being released that showed that people with serious mental illness, and also high substance use, were dying earlier than the general population. One of the things that many of these individuals were dying from were not from mental health issues or substance use, but were mainly from preventable medical conditions. So many of them were losing 25 to 30 years of life, and there were things that could be changed and corrected with better access to care. When we compared our clients to the general population that were enrolled in our county's public mental health managed care plan, we found that the clients served at our service centers were 28—228 percent more likely to be diagnosed with diabetes; 62 percent more likely to be diagnosed with hypertension; 61 percent more likely to be diagnosed with asthma; and 53 percent to be diagnosed with heart disease.

Our mental health clients were usually dying at age—around 53—and those clients that were dying due to substance use issues were dying around age 45. So again, if we could change some of the ways that our clients were accessing physical health services and also try to reduce their modifiable risk factors, such as reduced smoking, improve their diet, help them address their obesity issues, and improve their ability to handle stress, it could have an impact on their overall health. Next slide? [00:40:12]

So, in around 2009, SAMHSA released a new initiative, and it was called the Primary Care Integration Project—PBHCI—and in 2010, we applied for a grant and were funded, and they're a part of what they call Cohort 2. And with that, you know, our goals were to provide primary care in two of our adult service team sites: One in northern Alameda County and one in southern Alameda County. And with the goals of many improving their access to physical health service and creating a medical home for consumers where they could improve their health indicators, but also they could get their behavioral health and physical health care at one location, at one time. And at the same time, that would save them from having to travel distances to their different primary care clinics. Next slide please?

So, when we looked at these issues, you know, we were trying to take into account all the barriers such as stigma of mental illness, lack of transportation, and also in Alameda County, most of our clients had a long wait time to see a primary care provider. And that currently, right now it takes about six weeks for a regular appoint—to get a regular appointment within our community-based clinic, and our clients don't have the ability to wait that long. So often, they would—what they would do is just access the emergency room.

So what happened is that when we looked at before the grant, what the number of average primary care visits were for our clients, we found that most of our enrolled program participants were accessing primary care services about .5 per year. So less than, you know, one visit a year. [00:42:06]

After integration—one year into our grant—we were able to see that our clients were now averaging about five visits per year. And over the overall grant for the four years that we had the SAMHSA Grant, we were able to show improvements in their blood pressure, keeping their blood glucose level down, and also improving their body mass index due to getting them more physically active. Next slide?

Now, each of our service teams' sites—so our community support centers have three teams. And they meet weekly to discuss client mental health concerns and recommendations for follow-up. But due to the SAMHSA Grant, we were able to now have a nurse care coordinator be a part of those team meetings, a peer counselor, and a representative from the primary care partner. The nurse was able to talk about referrals with a case manager and psychiatrist who specialty care for their client. Peer counselors let the mental health staff know about different appointments that they had and that they were having problems with transportation or other problems at their residency in terms that might cause them to have a “no show.” And also, you know, we talked about the health and wellness activities that their client could participate in and may need their active support in getting them to enroll. With our clinic coordinator, they talked about the data collection issues that were involved in collecting health information that [was] required for our grant. Next slide? [00:43:49]

Now one of the biggest things that made our grant really successful was having a good variety of health and wellness activities. And these were peer-led activities by our peer counseling staff. They took control of the leadership of this—uh, these activities—and they planned which ones to offer. But at the same time, they also developed a calendar of the monthly activities so clients could see. And it was colorful calendar. They would take field trips to like farmers' markets in their community connections classes. They had walking groups. And also, there was a—a class that I think I—and I want to highly recommend to all of you—is the Whole Health Action Management Plan – WHAM – which was developed by SAMHSA's—uh, HRSA's Center for Integrated Health Solutions. It's a class that is—and training—that is peer-focused and driven by peers. And it also helps peers look at how they can set up support groups as well as help clients develop health goals that they can use to improve their overall health.

We also have tobacco cessation and we have meditation groups and “lunch and learns” that are medical and our psychiatric staff provided discussions on a topic and they answer client questions. And then even—we even set aside a separate area for what we call our PATH Café where clients can socialize and relax after exams or some wellness activities. Next slide?

Client retention strategies—one of the things that I most definitely recommend to all of you is to develop an advisory board that consists of clients, family members, and your staff, that meets monthly. These advisory board meetings can give you valuable information on what's working and what's not working, but also just, you know, talk to you about what feedback they're hearing from their clients. [00:45:57]

Schedule a periodic “de-brief.” It's one thing to have all of you from different disciplines that are working together, but unless you sit around together to talk about what's happening and problem-solve, that integration is not going to work. You're going to still be isolated, and you're

going to be more focused on your discipline. But definitely by having a de-brief session, you improve peer coordination and also you improve in your relationships with each other.

The “lunch and learns” are very supportive and really help in client retention because that gets the client coming back into the center and sharing about, you know, what’s happening with them. The providers or the person that presents the topic—you know, they can have the discussion afterwards. And clients really feel, you know, less isolated and they feel more comfortable in those settings in terms of asking questions.

One of the things that we did for new clients that were enrolled at our center was that we taught them—we had a little session led by a peer that talked about how to effectively use the services in the program. And that really kind of gets a new client on the right foot. It allows them to ask questions in a very comfortable setting where they can really address some issues that they otherwise would not be willing to talk about up front.

Get your peer counselors and your volunteers involved early-on in the service delivery system. Help them and allow them to help you in [developing] educational materials about your program and even design brochures and naming classes. Next slide?

One of the greatest things that we did and one of the most successful things we did was have an annual visioning retreat. And this is when we would invite stakeholders such as our consumers, our PATH staff, our family members, and also—we also invited some of our primary care representatives to come in and talk about what’s working and what are some of the things that we need to do on—as far as to improve our services. [00:48:00]

We talk about our health and education wellness activities, how we can better recruit clients and also retain clients, better outreach efforts, and also we talked about the clinic operation issues with, you know, “no show” appointments. And also, what we found out with the data—we shared a little bit about what’s happening with data.

One of the things that—one of the things that came out of our annual vision retreats this last June was that one of the case managers was saying that now he’s more productive. His productivity has gone up by having a co-integrated program because now he doesn’t have to sit in a waiting room at a community clinic to get his cli—waiting for his client to be seen by a doctor. With having a primary care clinic on site, it allows him to do other work and serve other clients, so he’s able to be more productive.

But also, when we have—we were able to talk about the number of clients that were continually no-showing at appointments. And one of the things that we came out with in terms of a strategy was to have a clinic session on what we called check day. And those are the days that clients get their little stipend from their case managers, and clients that never show up at the clinic will show up to get that money. And when they show up to pick up those checks, we also have some open access slots in our primary care schedule so that we can get them in and they can be seen by a doctor, even if it’s just to check their blood pressure or do a blood draw, it gets them in to the clinic.

So, again, it's a very successful tool and I really highly recommend it—an opportunity where you all have a retreat and just talk about what's working and what's not working. Next slide?

Challenges that impact retention—you know, in a county-operated service, one of the things that's really difficult is the bureaucracy. Hiring to replace staff—hiring new staff takes a lot of time. We have challenges in, you know, getting data back in a timely basis. And yet our—our case managers have to work extra hard in documenting the requirements for specialty mental health. [00:50:16]

For our consumers, staff changes can be really, really upsetting. So one of the things that we try to do is make sure that we try to hire the right staff at the right—at that time—so we don't have a large amount of turnover or constant turnover.

And then there's the whole issue of substance abuse. Substance abuse always kind of can undermine your treatment services and definitely having your substance abuse providers available to provide feedback to your case managers and your primary care staff is very, very important.

And also look at, you know, the issues of challenges with transportation, limited access to healthy food, housing issues—because again, most of our clients live in unlicensed board and care where there's a lot of smoking and also drug use. So, next slide please?

Work with your evaluator to talk about what data do you want to share with your advisory board and your staff, and make sure you're able to get that data back to you in a timely basis.

Track the number of primary care visits that your clients are having and also, what major health issues they're facing.

Chart on a data wall. You know, right there in the middle of our clinic, we have a big wall and a bulletin board that shows the successes of our client and the issues and challenges. Clients that have been able to reduce their smoking—we put a picture of them on the wall. So those clients that, for the first time, are able to get an apartment on their own, you know, we celebrate those types of small special occasions because our clients are making progress.

And again, I recommend that PATH Café where it's just a place for clients to just relax and chill. And get them involved in artwork and also doing materials for outreach. Next slide? [00:52:08]

Have your social work interns and your peer counselors, you know, rename classes so that it's more attractive to your clients. Like for smoking cessation, we renamed that “Bye Bye Butts.” Stress management became “Fun and Games.” And our relaxation/meditation class became “Feel Good Fridays.” And I also highly recommend that you start a cooking class. Next—next slide?

There's nothing like celebrating food. This is the cover of our program brochure that was designed by one of our advisory board members who was a peer in our program. By all means, you never know how much talent you have in your program until you start asking for volunteers.

And our clients and our peers are always willing to step forward and help out. And so please ask them to contribute and you'll be wonderfully surprised at what you get in return. Next slide?

Now this is really key in terms of, you know, integration and also when you—as a new grantee in SAMHSA, work as a collaborative team and also use collaborative leadership skills and working with your staff and also your other providers that you work with. All of your staff needs to know, “What does it take to be a success in your program?” Because again, the four years of your SAMHSA Grant will go fi—fast. Know if it's billable patient visits—you know, try to keep a lid on the revenues and expenses, and also what's the “break-even.” Build trust among your providers and all your staff so that you have reliable, strong, dependable working relationships.

And always be willing to listen to each other about solving problems. You're a collaboration and it makes your program more effective. [00:54:08]

And all staff should be willing to take leadership to make a program successful. Don't just sit and wait for the supervisor to take those extra steps. All staff should be willing to try to take that extra step and be a leader.

When you hit barriers and often in a bureaucracy you're going to do that. Show some patience and persistence, but always try to think outside of the box. You know, that's what's key—thinking outside of the box. Next slide?

I'd like—any questions and answers? And I want to thank you all for giving me the opportunity to share what's worked for us. Thank you.

MODERATOR: Thank you very much. (clears throat) Excuse me. Thank you very much, Mr. Smith, um, for your presentation. At this point, again, I would like to invite all the grantees—if you have any questions, any comments, for Mr. Smith or for Ms. Nortrup—and you can use the question box on your control panel on the right side of your screen. Let me un-mute Ms. Nortrup right now. (pause) Okay, you're un-muted—in case we have any questions or comments coming in. (long pause) [00:56:08]

We had one comment that came in at the tail end of the first Q&A, and I just want to take this chance to say it. The comment was regarding the domestic violence group. It was from the same grantee, Ms. Dana Coleman—the same grantee who had submitted the comment regarding the domestic violence groups, and she states that, “We have planned to offer seeking safety groups, but there is a need for a separate domestic violence group.” And she wanted to thank you, Ms. Nortrup, for the presentation. So I just wanted to take the chance to say this comment.

But then in the grantees, if you have any questions—any additional questions or any additional comments, please use the control panel in the question box. (pause) We have another comment. Um, “Thank you so much.” This was, uh, Mr. Smith. “You shared a lot of great information. We are just starting our program and you discussed possible solutions to issues that I'm sure we may encounter.”

FREDDIE SMITH: You're more than welcome. And we are a resource. You have my contact number and my e-mail address. If you have—any of you have additional questions, I'll be glad to share. But I also want to say to all the grantees—use The Center for Integrated Health Solutions for some great training resources. They offer great support in terms of addressing problems and barriers and issues that you may come up against in your program during these next four years. And definitely, please use them as a great resource. They're there to help you. [00:58:08]

MODERATOR: I also want to remind the grantees, if you have any—any additional questions for Ms. Nortrup or for Mr. Smith, you can e-mail them or you can e-mail us, you know, through the (inaudible at 00:58:27)—through the, uh, MAI-CoC TA e-mail address. It's the same e-mail address where you receive all the notices. If you have any questions, you can also e-mail us and we will—we can relay those messages to, uh—to the presenters today. (pause)

Oh, here's another—okay, here's another question—again, a comment (inaudible at 00:58:56) presentation. “During the presentation, there was some discussion about staff retention. I was wondering if the presenter can elaborate on the reasons for high staff turnover and how to overcome this problem.

FREDDIE SMITH: One of the big issues that we have as a provider, and especially our primary care team, is that when you contract with other CDO's, many of their staff have other employment opportunities in terms of going after better jobs. With the, I guess you say, healthcare reform, more people now have insurance. And with that, many of the other health organizations such as Keiser, federal hospital systems—your big managed care systems—can hire more staff—more of our staff, and pay them higher salaries. [00:59:52]

So we—we lose staff due to other opportunities or their career development, and at the same time, we have a hard time filling them. We don't always offer the highest salaries, but at the same time, we offer great learning opportunities to grow and at the same time, develop professionally. So one of the things that we try to do to help the staff is that we try to make it interesting, and that's one of the things I talk about is trying to make sure that it's—well [coming] into work for them is fun and they have a collaborative working relationship with their other staff members.

So as a leader, to me it's very important to keep morale up, to keep staff focused, and at the same time feel that they're doing something worthwhile and making a great contribution to the project. So, do some things that are going to increase morale. Have peers involved. I can't—I can't overemphasize the importance of peers and how they can make your program and your work of your professional staff a lot easier by getting feedback. Many of the feedback they go, for example, was on STD's of our clients that many of our professional primary care providers were hearing nothing about. So, again, work as a team. Have time to share information back and forth as a team because that makes your program stronger.

ERIN NORTRUP: I would totally agree with that. And also, look at wellness for your staff as well as for your clients and think about wellness activities you can implement for your staff and volunteers. It's really consistent with trauma-informed care, as well. And it, I think, helps to increase staff retention, too.

MODERATOR: Thank you. We have a couple more comments, uh—a comment for Mr. Smith. “I like the idea of the de-briefing suggestion for staff. We’ll use this—we will use this suggestion. Overall, this webinar had great information and suggestions. I will take it back to my team and agency.” [01:02:00]

FREDDIE SMITH: Thank you. Thank you. It works. It works because again, often primary care providers, mental health providers, and substance abuse providers never get an opportunity to sit together and talk about clients and really what should be the next step in terms of care. When you have that de-brief session, it allows everybody to give input and recommendations on what should be the next step up for a client. And there’s better care coordination. It helps the client to be more successful.

MODERATOR: Alright, thank you (inaudible at 01:02:37). And this will be the last question before we sign off. “Any suggestions about creating a welcoming environment if the facility has limited space?”

FREDDIE SMITH: One—one of the things that you can do is just posters—pictures of clients. When they—like, for example—when you have posters and you have pictures of clients that are doing something successful—one of our clients had a very difficult time with cutting down their cigarettes because in his board and care home smoking was a part of the normal routine. And what we did is that when that client was able to reduce the number of cigarettes he was smoking, we put a picture of him on the wall. And again, everybody was able to celebrate that.

Whenever you have a—like I said, the food—having food around—even if it’s just snacks for your client—and an opportunity to share—you know, the meet—the “Lunch and Learn.” Those are things that you can do. And at the same time, make sure your staff at the reception desk are warm and welcoming to your clients. There’s nothing more important [than] making sure that your reception staff are the first people that—first point of contact for your clients—and you want to make sure that they give them a warm smile and make sure that when they leave there, they’re given a warm goodbye. That means a lot. [01:04:01]

So please make sure that the front office staff and your reception area is also nice and cozy because clients—just like me and you—want to feel welcome whenever we go to, you know, get care.

MODERATOR: Alright. Thank you very much, Mr. Smith. Uh, Ms. Nortrup—thank you very much, as well. I would like to thank both of them for taking time after busy schedules and for presenting, you know, taking the time to develop the slides and sharing their information—the wealth of information that they have—to all of us who are the MAI-CoC grantees.

A reminder—you know, like—like Mr. Smith said. I mean, you need any more information—any more resources—please feel free to visit the SAMHSA-HRSA Center for Integrated Health Solutions. There you will find a lot of information on integration of health care services that it’s relevant to a lot of MAI-CoC grantees. And, of course, the MAI-CoC grantees—you have your own online community where information for you will also be posted.

Again, thank you for joining us today. Please take a moment to provide feedback and completing the survey at the end of today's webinar. And please be, uh—be on the lookout for forthcoming information for our May webinar. It will be on, I think, the third Tuesday of May. I don't have the number in front of me. I think the 19th of May if I recall correctly. But that information will be forthcoming. And again, please also be on the lookout for more information coming up through the MAI-CoC (inaudible at 01:05:53).

Again, thank you very much everybody for joining us today, and we look forward to seeing you online next month. Thank you. Bye bye.

FREDDIE SMITH: Thank you. Mm hmm.

ERIN NORTRUP: [Thank] you.

MALE: Thank you.

[01:06:06]

END TRANSCRIPT