



SAMHSA-HRSA Center for Integrated Health Solutions

Project Management and Creating Your Infrastructure

**Jennifer K. Crawford, JD, LCSW-C, Deputy Director
Colleen O'Donnell, MSW, PMP, Project Associate**

SAMHSA-HRSA Center for Integrated Health Solutions
National Council for Community Behavioral Healthcare



Topics Covered Today

- Creating your weekly action plan
- Memoranda of Understanding with partners
- Designing your project for integration and sustainability
- Hiring staff and creating a team
- The role of leadership
- Thoughts space design
- Startup checklist from a former project director

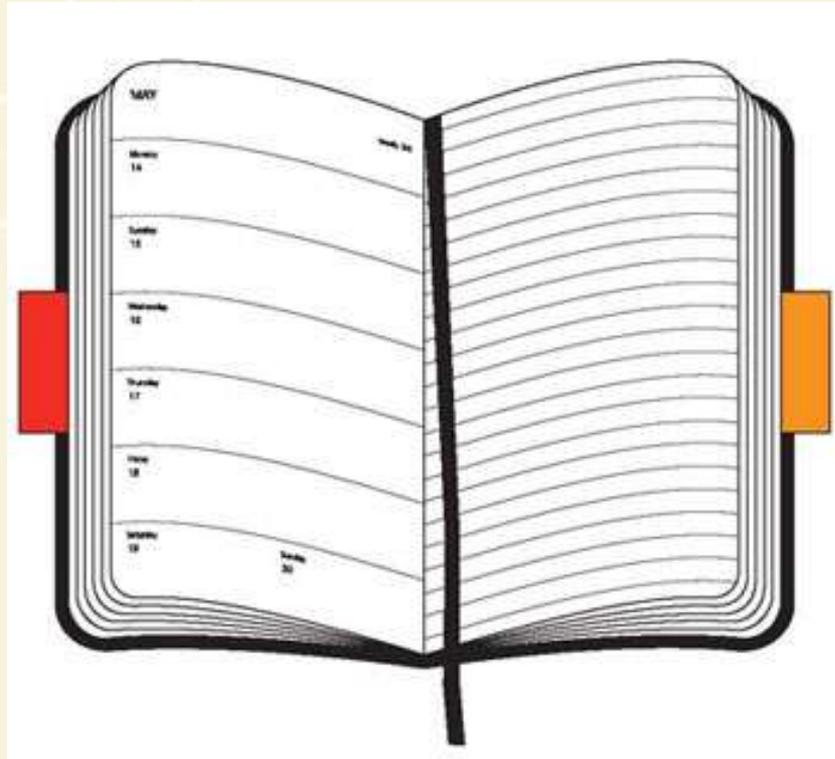


Project Plan – 3 Essential Components

- 1) Project Management Schedule
- 2) Risk Management Plan
- 3) Communication Plan



Creating A Weekly Action Plan

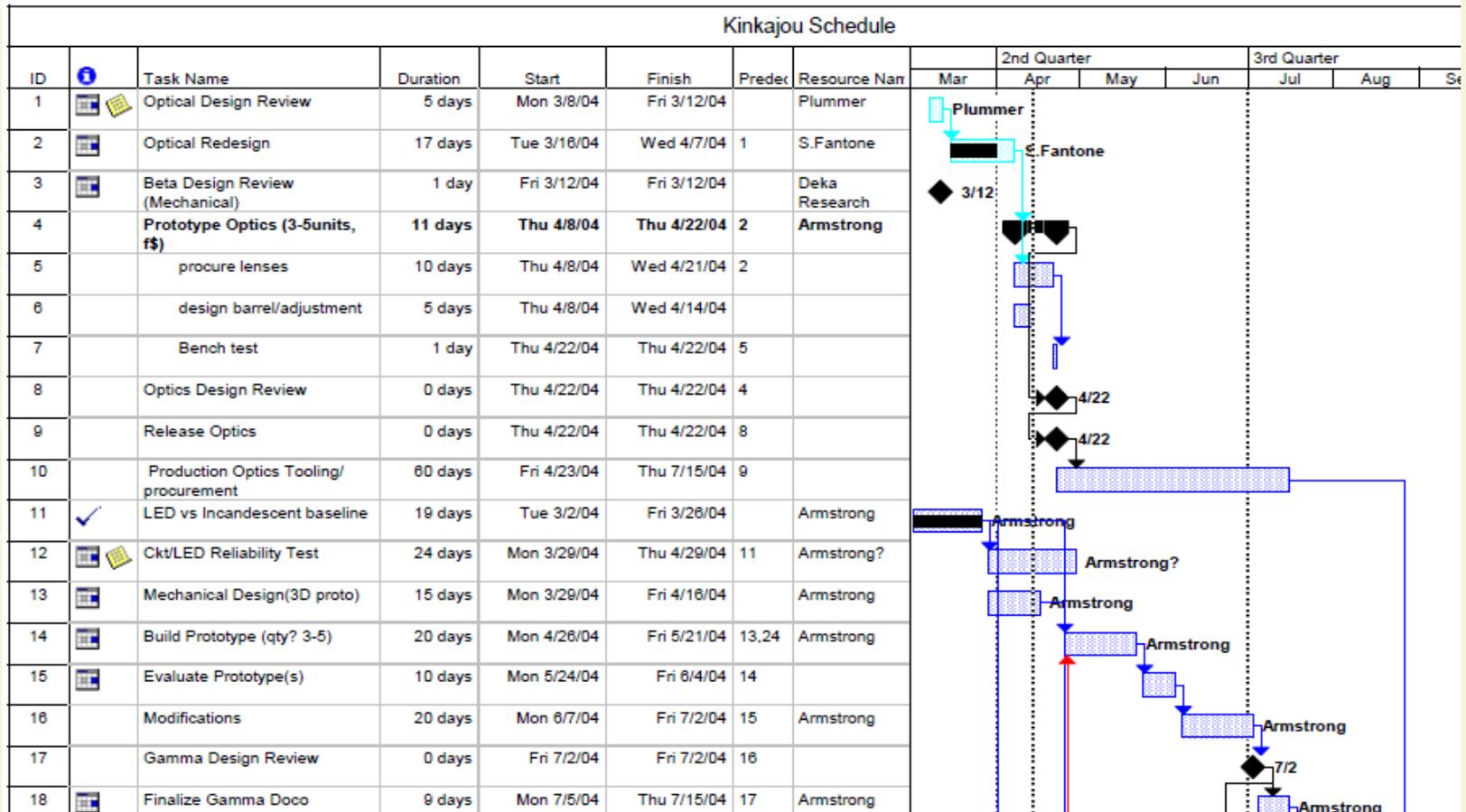


Project Management Schedule

- Lists activities that have to be completed to meet milestones and deliverables (check the response to the RFA – and the RFA!)
- Individual steps to completing the activities are broken out into tasks
 - Estimated start/finish date
 - “Contingencies”
 - A way to show progress towards completion
 - Identified “owner” responsible for ensuring the task is completed
 - Gantt chart to track progress easily



Project Schedule, Specialized Software



Example of PBHCI Project Activities/Tasks

% Cmpl	EXAMPLE OF PBHCI PROJECT ACTIVITIES	Cont.	Start Date	Finish Date	Dur	Oct 16-31	Nov 1- 15	Nov 16-30	Dec 1-15	Dec 1-31	Jan 1-15	Jan 16-30	1-Feb
	1 Modify Facilities		10/25/12	2/1/13	68								
0%	1.1 Review completed project plan for needed modifications to facility		10/25/12	10/26/12	2								
0%	1.2 Confirm estimated costs for implementation		10/29/12	11/5/12	6								
0%	1.3 Confirm estimated timeframe for completion of		10/29/12	11/5/12	6								
0%	1.4 Review final plan with stakeholders (doctors, BH case managers and therapists) for workflow efficiency, effectiveness and maximum integration between BH and PC)		11/7/12	11/15/12	7								
0%	1.5 Modify and finalize costs and time estimates	1.4	11/16/12	11/17/12	1								
0%	1.6 Obtain final internal approval		11/18/12	11/19/12	1								
0%	1.7 Finalize procurement plan		11/20/12	11/21/12	2								
0%	1.8 Contractor to apply for and obtain permits	1.7	11/22/12	12/22/12	21								
0%	1.9 Insert milestones for construction into project plan with contingencies identified and begin modifications	1.8	12/23/12	1/15/13	15								
0%	1.10 Monitor progress to completion		12/23/12	1/15/13	15								
0%	1.11 Prepare space and staff	1.10	1/16/13	1/31/13	11								
0%	1.12 Enrollment / Start up	1.11	2/1/13	2/1/13	1								



Risk Management Plan

Identifies the factors that may interfere with project success in time, cost and scope

- Details the actual nature of the risk
- Specific strategy for how to address that risk
 - Mitigate
 - Manage
 - Avoid
- Central to communicating around issues that may impede or are actually impeding progress



Communication Plan

Defines the communication requirements for the project and how information will be distributed.

- Role-based
- What information will be communicated
- How the information will be communicated
- When will information be distributed
- Who does the communication
- Who receives the communication
- Centralized information



Weekly Action Plan Guidelines

- Review the RFA requirements with your implementation team
- Brainstorm all action steps with your core team
- Start on your “go live” date even if you’re not fully ready...
- Design your workflows to maximize billings



Weekly Action Plan Guidelines (cont.)

- Set up a workflow and responsibilities for enrolling clients and for collecting and entering all data into TRAC
- Set up a **separate** workflow for capturing all health-related data for your own use.
- Design your partnerships, space, and workflow for maximum integration



Q & A?

Please type your questions in the chat box.





SAMHSA-HRSA Center for Integrated Health Solutions

Greater Nashua Mental Health Center PBHCI / Healthy Connections

Mara H. Huberlie

Director of Project Implementation



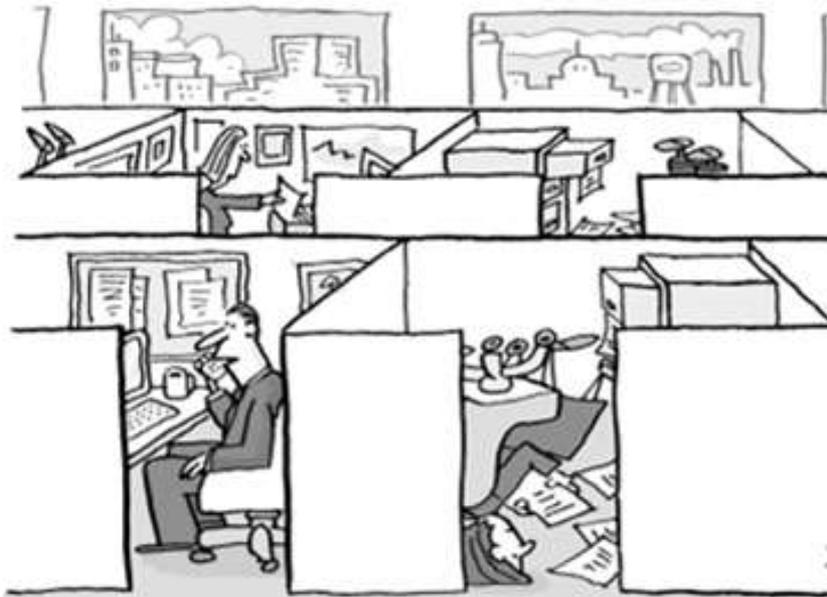
Starting a Partnership



- Integrated healthcare partnership is similar to a marriage. Put in the time it takes to build a trusting relationship.
- Communication is critical – use emails to document, and phone calls and face-to-face meetings to reduce misunderstandings.
- Regularly scheduled meetings are critical. If necessary specify time in the agreement.



Integrating Cultures



“Well, for two companies with such different corporate cultures, I think the merger’s going surprisingly well!”

- Expect/plan for differences in work cultures
- Flexibility is critical—eliminate “That’s the way we do it mentality”
- Minimize the use of acronyms – the same letters may mean something entirely different in primary care



Before You Sign...

- Be very specific about the range of services the health partner will provide. Are services such as nutrition and diabetes counseling included?
- Define how coverage is provided in case of illness or vacation
- Clearly outline the reporting expectations (monthly or quarterly) for billing and revenue generation and patient utilization numbers
- Specify how revenue generated will be returned to the grant and a time schedule



Additional Considerations

- Are there extra costs associated with providing specific reports?
- Establish system to communicate promptly if problem exists with client Medicaid/Medicare or private insurance to ensure maximum billing potential
- If primary care partner is responsible for patient billing, make certain that the consumer/client understands he/she may receive a bill/statement from a different entity



Partnering with an FQHC

- Many benefits to partnering with FQHC but since they have to abide by numerous regulations, designing an agreement can be time consuming
- A “Change of Scope” application must be filed in order to provide coverage at a new location – can be a lengthy process
- FQHCs may request a financial arrangement through a “Community Benefit Grant.” It is a way to provide an anti-kickback “Safe Harbor” for collaborations between health centers and other providers



FQHC Continued

- If the on-site provider is a P.A. or a APRN, think seriously about requiring some MD time for complex patient cases.
- FQHCs are required to collect a lot of different kinds of data, tap into this expertise and then use it to build the case for additional funding sources.
- An excellent white paper that explains the different collaborations “Assessing and Addressing Legal Barriers to the Clinical Integration of Community Health Centers and Other Community Providers” – www.commonwealthfund.org



Sustainability Tips

- In setting up an onsite primary care office, see if hospitals or other large practices have gently used equipment
- If possible, work closely with a Peer Support Agency
- Take advantage of any trainings offered by SAMHSA/Center for Integrated Care
- Do collaboration/outreach into the community to attract volunteers for wellness programs
- As soon as possible put together a “pro-forma” to see how the new model can be sustained



Additional Resources

Sample MOUs

<http://www.integration.samhas.gov/operations-administration/contracts-mous>

Considerations for BH and FQHC partnerships

<http://www.integration.samhsa.gov/images/res/CMHC%20FQHC%20Checklist%20v2.pdf>



Q & A?

Please type your questions in the chat box.



What level of integration will you implement?



Doherty, Baird, Reynolds, McDaniel Scale

The Consumer and Staff Perspective/Experience

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On Site	Close Collaboration/ Partly Integrated	Fully Integrated/ Merged
Access	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs, integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants	Q1 and Q3 one physician prescribing with consultation; Q2 and Q4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers; one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, Q2, Q3, and some Q4; two physicians for some Q4; one set of lab work
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility

© 2006 Kathleen Reynolds (Integrated Care Adaptation only) Adapted From: Doherty, McDaniel and Baird, 1995.
 Doherty, McDaniel, & Baird (1996). Five levels of primary care/behavioral healthcare collaboration. Behavioral Healthcare Tomorrow, October 1996. Also appears as Doherty (1995), The why's and levels of collaborative family healthcare. Family Systems Medicine, 1995, Vol. 13, No.3/4.



Doherty, Baird, Reynolds, McDaniel Scale (cont.)

The Consumer and Staff Perspective/Experience

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On Site	Close Collaboration/ Partly Integrated	Fully Integrated/ Merged
Governance	Separate systems with little or no collaboration; consumer is left to navigate the chasm	Two governing boards; line staff work together on individual cases	Two governing boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing boards that meet together periodically to discuss mutual issues	One governing board with equal representation from each partner
EBP	Individual EBPs implemented in each system	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBPs around high utilizers (Q4); some sharing of knowledge across disciplines	Sharing of EBPs across systems; joint monitoring of health conditions for more quadrants	EBPs like PHO9, IDDT, diabetes management; cardiac care provider across populations in all quadrants
Data	Separate systems, often paper based; little if any sharing of data	Separate data sets; some discussion with each other of what data shows	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated (electronic) health record with information available to all practitioners on need-to-know basis; data collection from one source

© 2006 Kathleen Reynolds (Integrated Care Adaptation only) Adapted From: Doherty, McDaniel and Baird, 1995. Doherty, McDaniel, & Baird (1996). Five levels of primary care/behavioral healthcare collaboration. Behavioral Healthcare Tomorrow, October 1996. Also appears as Doherty (1995), The why's and levels of collaborative family healthcare. Family Systems Medicine, 1995, Vol. 13, No.3/4.



Polling question: How would you describe the degree to which your organization and your primary care partners have a shared vision of the PBHCI initiative?

- We have a clear and consistent shared vision of what it means to be an integrated healthcare system
- There are some areas of shared understanding
- There is little opportunity to develop a shared vision
- We have a different and inconsistent vision of the PBHCI initiative from our primary care partners



Staffing the Project: Management, Health Coordination, Wellness, and Evaluation

Hire staff with:

- Persistence
- Creativity and flexibility
- Enthusiasm for learning
- Strong patient advocate
- Willingness to be interrupted
- Ability to work in a team



Staffing (cont.)

- Choose credentialed staff who will be billable in your state (e.g., RNs in Maryland)
- Interview staff for great social skills and passion
- Consider joint interviews for all project staff
- Project directors need a significant amount of time for this project, enthusiasm and credibility both internally and externally
- Project directors need to understand both the BH and PC cultures and vocabulary and help bridge the gaps



Core Implementation Team (including Peers)



- Create project norms
- Respond quickly
- Open communication
- Celebrate success
- Don't get stuck



Core Implementation Team (cont.)

- Create clarity about who is on the planning and implementation team vs. line staff.
- Are the CEOs on your core implementation team?
- Your core implementation team might include: project director, wellness coordinator, peer leader, care managers, **senior BH and PC staff**, and an evaluator
- Some of these staff will attend the regional and annual meetings. Which ones?
- How often will your core Implementation team meet? Weekly? Monthly? Quarterly?
- Discuss in advance how you will resolve differences!



Core Implementation Team (cont.)

What authority does this team have?

- Budget review
- Planning for future grant years
- Hiring key staff
- Re-creating workflows
- Acting as champions of the project
- Problem solving and celebrating



Considerations for the Role of an Evaluator/Data Analyst

Jeff Capobianco –
Evaluation and Performance Measurement
jeffc@thenationalcouncil.org



Working with an Evaluator

- Types of Evaluators
- Role of an Evaluator
- How to Engage your Evaluator



The Role of Leadership-CEO

- **Communicate a sense of urgency for “buy-in”**
 - Examples: “adults with SMI are dying early” or “adults with SMI have inadequate access to primary care” or “we are working to save lives”
 - Forge relationship between behavioral health and primary care leadership—invite both to present to your boards of directors
 - Share the health status, stories, and data with boards, community, media, policy makers, and funders
 - Review compliance with grant requirements periodically



The Role of Leadership-Project Director

- Provide the CEOs with accurate information about the purpose, importance, and success of the PBHCI initiative
- Ensure that the both the BH and PC workforce supports the aims of the PBHCI initiative
- Ensure that the primary care partners understand, value, and act in ways that are likely to engage consumers
- Capture the stories—binder, power points, newsletters
- Celebrate successes and compliment any resistors when you see an opportunity



Steps leaders take to successfully implement change



Based on the work of J. Kotter (2002), The Heart of Change.

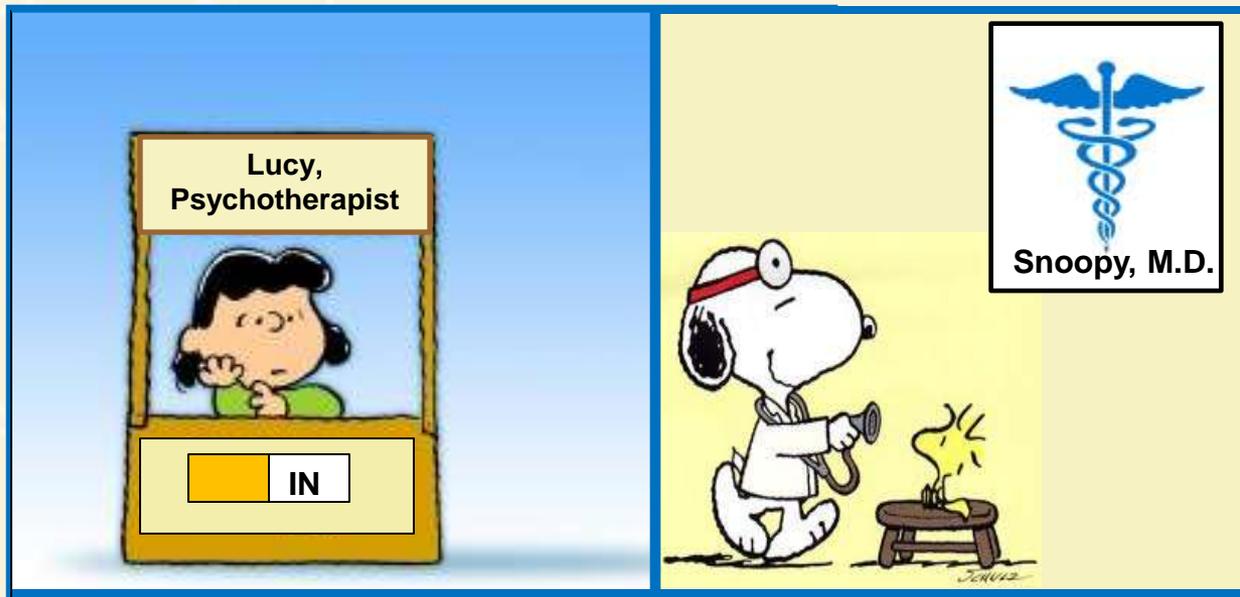


Polling Question: Describe the degree to which the organization has communicated a sense of urgency

- No urgency communicated around the PBHCI initiative
- Some urgency
- Moderate urgency
- Clear and consistent communication of urgency
- Optimal urgency including reinforcing supportive staff and confronting non-supportive staff



Co-locating Project Staff \neq Integration



Thinking and Rethinking Space Design

- Does the space promote relationships with clients?
- Does the space allow for teamwork/consultation and collaboration between primary care and behavioral health staff?
- Is the space easily accessible for both consumers and referral sources?
- Is the space equipped to handle all of the PBHCI requirements?
- “Across the street,” “upstairs,” “different wing” = **huge barriers**



Thinking About Space

- Locating primary care providers very close to the behavioral health staff encourages fast “warm handoffs” without a loss in productivity
- Will your space allow lab work?
- Wellness Space—physical exercise, classes/groups for diabetes, nutrition, stress management education



SAMHSA-HRSA
Center for Integrated Health Solutions



Grantee: Navos
Primary Care Partner: Public Health—Seattle/King County
Cohort IV - Region 1 - Seattle, Washington
Contact: Paul Tegenfeldt
paul.tegenfeldt@navos.org
(206) 933-7154



Steps to Consider Before Kickoff

- ✓ Create a weekly action plan
- ✓ Hire the “right” staff and have them start planning together
- ✓ Review or modify your MOU with partners
- ✓ Design or change your space or staff offices so that BH and PC staff are close to each other
- ✓ Include peers in the planning, design and workflows
- ✓ Start the process for all legal steps early:
licenses/permits for space, state licenses for new staff



Steps to Consider Before Kickoff (cont.)

- ✓ Request licenses/arrangements if needed for blood draws and lab pick ups
- ✓ Make sure all BH and PC staff know why integrated care is important and understand their role
- ✓ Review and consolidate all forms (e.g., can new enrollees enroll as a behavioral health and a FQHC client at the same time?)
- ✓ Designate someone to review, understand, and create a workflow for all grant data requirements.



Steps to Consider Before Kickoff (cont.)

- ✓ If partnering with an FQHC, find out if the FQHC needs to submit a “change in scope” for types of services and locations... this takes time
- ✓ Create excitement for the project with client meetings, staff meetings, newsletters, posters, banners, table tents, buttons, open houses, and more
- ✓ Conduct a “run through” with staff role playing as clients as well as maybe asking a client to participate and share feedback



Steps to Consider Before Kickoff (cont.)

- ✓ Sign up for TRAC¹ training and decide on client ID numbers
- ✓ Write or update all project staff job descriptions
- ✓ Create satisfaction surveys for clients and for BH and PC staff
- ✓ Create your wellness programming—all in house or are some activities contracted out?
- ✓ Create an Advisory Board or Governance Board

¹TRansformation ACcountability System: web-based data entry and reporting system that provides a data repository for CMHS program performance measures



Space Design Resources

Primary Behavioral Healthcare Toolkit

<http://www.mdhelpsd.org/downloads/Partners-in-Health.pdf>

Promising Practices in Safety-Net Clinic Design: An Overview

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PromisingPracticesClinicDesignOverview.pdf>

Designing Safety-Net Clinics for Innovative Care Delivery Models

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20DesigningClinicsInnovativeCareDeliveryModels.pdfPromisingPracticesClinicDesignOverview.pdf>

Read more: <http://www.chcf.org/publications/2011/03/promising-practices-clinic-design#ixzz2AGhBMjq5>



Space Design Resources (cont.)

Designing Safety-Net Clinics for Flexibility

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/D/PDF%20DesigningClinicsFlexibility.pdf>

Designing Safety-Net Clinics for Cultural Sensitivity

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/D/PDF%20DesigningClinicsCulturalSensitivity.pdf>

Clinic Design: Transforming Primary Care Environments Through Evidence-Based Design

<http://www.healthdesign.org/clinic-design>



Q & A?

Please type your questions in the chat box.



Reminders

Next Week's Webinar:

Engaging Consumers and Developing Workflows

November 1, 2012 2:00-4:00 p.m.

Please complete the survey that follows





SAMHSA-HRSA Center for Integrated Health Solutions

Thank you

Jennyc@thenationalcouncil.org

202-684-7457, ext 284



NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE



www.integration.samhsa.gov