



SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Tips from the Graduating Class

Behavioral Health Network

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Cohort V

Tips from the Graduating Class

General Overview

General information:

- Behavioral Health/Substance Use Treatment across a number of settings
- Number of Staff: 6
- Adults with severe mental illness. High prevalence of co-occurring substance use disorders, poverty, limited educational background, social stressors and trauma
- IPAT level: 4-Close collaboration on-site with some systems collaboration

Primary care provision

- Partnership with FQHC in our behavioral health clinic; plus a partnership providing PBHCI services at a Community Health Center
- Number of days per week that primary care services are provided: 1 at our behavioral health clinic
- Staffing and other costs provided by partner: The cost of Primary Care services and staffing are covered primarily through 3rd party revenue with a small grant subsidy
- Types of services on site: PCP and Lab services

Accomplishments

Challenges:

- Meeting census requirements
- Needing to adapt and modify our model of care and staffing pattern on multiple occasions

Achievements:

- Meeting SAMHSA census and assessment requirements
- Providing integrated care to clients at our Behavioral Health Location: Primary Care, Care Management, Tobacco Treatment, Health and Wellness Groups
- Improved collaboration between Behavioral Health and Primary Care staff

If I Knew Then What I Know Now...

Expect the unexpected: Monitor progress/KPI regularly.
Adapt quickly.

Develop and utilize method for tracking and monitoring referrals to help meet census requirements.

Ensure you have a collaborative relationships with your PCP partner and other BH Program Leadership.

Moving Forward

What will change about your model/services?

- Our goal is to expand our on-site Primary Care services
- Our Program Coordinator is now a Certified Tobacco Treatment Specialist. We will utilize her to provide these services rather than our Primary Care partner staff
- Some clients are ineligible for continued care management services. However, due to growth in our care management programs we have an increased capacity to provide these services to the “Dual Eligible's” and some Medicaid clients
- Our Day Treatment Programs will continue providing Health and Wellness Groups after the grant ends

Describe biggest challenge and efforts to sustain services

- Uncertainty with Primary Care partner and their ability to provide increased coverage
- Some clients not eligible to received continued care management services

Tips from the Graduating Class:
Connecticut Mental
Health Center

New Haven, CT

Hiawatha Wright, Health Navigator
Martha Staeheli, Ph.D., Evaluator

General Overview

General information:

- CT Department of Mental Health and Addiction Services (DMHAS) Local Mental Health Authority
- Urban community mental health center
- Serves around 5,000 clients per year with wide range of behavioral health disorders
- Offers recovery-oriented treatment and services, support, outreach, rehabilitation,
- Partnership with Yale University, Dept of Psychiatry for education/training & research
- IPAT level 4

General Overview

Primary care provision:

- Partnership with Cornell Scott Hill Health Center (CS-HHC), an urban FQHC with extensive experience operating co-located care sites
- Services provided 4 days a week (2 full days, 2 half days)
- Staff: .6 FTE APRN, .6 FTE Medical Assistant, 1 LPN, .8 FTE Medical Receptionist, 2 Health Navigators (Health Navigators employed by CMHC but embedded in primary care clinic)
- Staffing provided on in-kind basis by CS-HHC includes medical, operational and administrative oversight and coordination
- Types of services: PCP, acute care, lab work, specialty referrals, peer health navigation

Accomplishments

- Engaged around 700 patients, with almost 500 current, active clients
- High level of patient satisfaction: recovery orientation, patient centeredness, patient rights, comfort, respect
- Patient reported:
 - Increased overall health, functioning,
 - Reduction of substance abuse, distress and homelessness

If I Knew Then What I Know Now...

What is one piece of start-up advice you would give to cohort VIII or future grantees?

If partnering, choose your partner carefully because so much of the success (or lack of it) depends on the ability and willingness of BOTH organizations, on multiple levels, to collaborate, and on a commitment to working out the inevitable issues and problems in a collaborative manner

What would you recommend grantees NOT do?

- Don't underestimate the critical importance of the medical reception/scheduling function
- Don't underestimate the challenges of communication/coordination between primary care and BH providers, even if co-located
- Don't underestimate the importance of eliciting ongoing feedback from all parties involved, including clients, clinicians and administrators
- Don't underestimate the challenges of engaging clients in health promotion groups and activities, even with incentives

What is one recommendation to newer grantees regarding sustainability?

Pay close attention to the basics (payer mix, volume, % of kept appointments) from the outset

Moving Forward

What will change about your model/services?

- Continued partnership between CMHC and CS-HHC with some adjustments (after careful analysis of utilization data and service patterns) to staffing to assure sustainability
- Increased engagement of other CMHC clients, especially those associated with the Medicaid Behavioral Health Home
- Consideration of providing some on-site appointments for specialty care

Describe biggest challenge and efforts to sustain services

- Coordination of inter-organizational client data
- Coordination of care due to limitations inherent in IPAT level 4



SSTAR



Stanley Street Treatment and Resources Fall River, Massachusetts

Paula J. Beaulieu
Project Director

Cohort V

General Overview

- SSTAR opened in 1977 with an alcohol detox and outpatient counseling program. Today, we offer a full range of services including an 80 bed inpatient addiction treatment facility, Outpatient Mental Health and Addiction services, IOP, an FQHC, several MAT services, prevention programs, HIV services, and a Women's Center. We have 300 employees.
- Our PBHCI program is called HIP, the Health Integration Project. We had four care managers, one bilingual Spanish, working with enrolled clients. We have had over 900 referrals and over 500 enrolled so far.
- Our IPAT level is 4.
- We are fortunate to have an onsite community Health Center, with two locations, open five days a week. We have a lab onsite, staffed by a local hospital system.

Accomplishments

Care Manager Teamwork

- Four care managers worked as a team with clients and workload; initially understaffed; added two care managers who were also certified phlebotomists to help with bloodwork requirements; added a Spanish speaking care manager which increased participation in wellness groups for that population.

Wellness programming

- Walking groups; Wellness groups on Open Access schedule; Evidence based groups for weight loss and tobacco; Monthly Health Events; Monthly Newsletter; Connection to Community resources

Integrated Health Record

- Moving from NextGen and SATIS to TOPAZ

If I Knew Then What I Know Now.....

- Begin contact for follow-ups at the start of the 60 day reassessment window. Continually monitor list.
- Stress Importance of H Data Collection and ways to improve collection. Added Lipid machine and all equipment at both agency locations.
- Would have focused more of the use of peers.
- Have adequate staffing level. Focus on reaching targets early as staff begin to leave for other positions as the grant is ending. Try to retain grant staff at the agency so that their knowledge and experiences with integrated care will continue to influence the agency.

Moving Forward

- We will continue to have primary care services on site with the increased awareness of the importance of physical health to overall health.
- Staff have been trained in EBPs related to wellness and many wellness related groups will continue.
- Screening for physical health with the DUKE will continue in the behavioral health assessments.
- Biggest challenge to sustaining services will be some of the wellness related programming. We will not have the staff and grant funds to send out client newsletters nor the monthly health events although we hope to continue some events through other programs.