Welcome Cohort IX Grantees

Midwest Regional Meeting
January 26-27, 2017

Health Home - Indiana

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Project Director: Health Home-Indiana
BE Well: Building Exceptional Wellness

- Imbedded clinic: Primary Care & wrap around services
- NP and Medical Director were primary for short time in some instances
- LPNs, Peer, Dietician, Evaluation
- Many people with no health coverage
- Work in tandem with PCP, Specialty, other health to inform treatment
- Groups didn’t work with the exception of WHAM & Aquatics
- Individualized approach improved value
- Not sustainable
  - Where we were successful used this to create health coaching service lined
  - HC: KPIs (vitals, PCP meeting, exercise ROI, wellness sponsor, RCA)
  - diet/nutrition, reduce sedentary behavior, self-management, health literacy, etc

Health Home-Indiana

- Unity didn’t work out (business model, staff didn’t understand population)
  - Financial model wont work unless enhanced rate of payment
- Retained Spence and APN
- Work to build consultation role in house and in community
- Develop metabolic clinic
- Use community providers; when no PCP connection provide PC on-site
- Weekly HH-IN meeting with all health coaches, PCP, NP, Psychiatrist, Evaluation (at end) and pharmacy
- Sustainability: CARF accreditation as health home: care coordination
- Develop population health management tools (Access, fillable NOMS PDF)
- Health Coaching Vitals Form (share handout)
Lessons Learned

- Need access to labs on-site (BE Well had to go across to hospital)
- Fasting labs unreasonable; use POC for screening (*billing code HEDIS)
- You can bill MRO for CM/LST: connection between mental and physical health and the medical necessity of my involvement in care
- How does EMR support integration
- Tele-psychiatry 15 of 16 CSI locations
- Psychiatry staff need to be integrated into integration
  - Separate workflows & processes (vitals form, diagnoses, meds)
- Connecting with HIE in 2013 (ADTs)...root cause analysis, schedule care
- Build relationships, don’t step on toes, Communicate, Collaborate
  - Initially dragon in moat
- Have clear job descriptions and expectations
- It can be hard to have folks from different disciplines, background, personality
- What are the boundaries of your program?

Lesson Learned

- Staff have to the right fit (flexible and adaptable is a must)
- Buy-in must occur at the highest level
- All staff should be trained: what is integration
- Holistic care and whole health treatment planning even if no health coach
- Health coaches should have defined time for care to be able to serve more
- Location of clinic is critical (one stop shop as possible)
- Grants can be viewed as temp (define sustainability plan out the gate)
- Staff can be territorial with their clients (culture shift); break down silos
- Warm hand offs
- Don’t ask PCP if they will work with you inform them that we share patients
- All staff regardless of discipline need MI
- Use journaling (food, mood, sleep, etc for review)
- Partner with MCEs to get access to claims data
- Team based care (therapist, employment, health, peers)
Recommendations

- Publish if you can: Integrated Health in a Community-Based Mental Health Center: A Longitudinal Study of Metabolic Risk Reduction
  - Featured in Mental Health Weekly/IN State Medical Association/Open Minds
  - Participate in Poster Sessions
  - Volunteer to Speak at conferences
  - Learn about other models and take pieces that fit your work
  - OPT IN OR OUT
  - Use the seed money to pilot small projects (CoAction)
  - Present to MCEs and have data to back what you are selling
  - Does your mission and vision statement reflection Integration
  - Integration should be a part of orientation
  - Take care of your team (team building, celebrate successes
  - Technology enabled care
  - Develop Integrated Health Goals & Strategy and review with leadership
  - What is aftercare model for maintenance of behavioral change?

Tips for Success

- Increase visibility
- Be an active presence in teams
- It takes a village (in house and in the community)
- Motivational Interviewing for all staff
- Don’t try to do it all; find your allies
- Clear boundaries and scope of practice
- Top-level support is a must
- Be patient, assertive, resilient
- Have a mentor and a good support system
- Use the knowledge of other grantees; we all want to help and share so the people we serve have a greater quality of life
- We teach other how we want to be treated; Be gentle with yourself
- Be cautiously optimistic, change is a process
- Hire an interpreter for understanding communication between disciplines
THANKS FOR YOUR TIME😊

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Lessons Learned

J. Todd Van Buskirk, LCSW, LCAC
Director, Integrated Care
Project Director – SAMHSA/PBHCI Grant
(Cohort VI July 2013)
...providing primary care for community mental health center clients.

5 Locations...
• 8 locations in Northern Indiana
• 1 inside CMHC
• Mobile Unit

• 8 locations at various locations across the State
• 2 locations inside CMHCs

**Lessons Learned:**

• Relationship, relationship, relationship
  – Staff, providers, community partners, primary care partner
    • Regular clinic meetings (pay attention to transitions)
    • Meet face-to-face with community partners – (check-in)
    • Be involved with State initiatives
  – Internal and external (share data)
    • Manage “up”
    • New way of doing business
    • Identify “Champions” (especially psychiatrist)
  – Policy, Health Information Exchange, Data
Lessons Learned:

• Workforce development
  – Training to support new way to provide care
  – Engagement strategies (MI)
  – Reworked how we delivered care

Lessons Learned...

• Data Management (in-house)
  • Input data to TRAC and SQL Database
  • Patient report card
  • Population level data

• Challenge of building tool --- and usefulness / troubleshoot
  • Takes time – programmer (outside source) – need more time
  • Trial and error
  • Examples on next slide
Data

- Can NOMs questions be incorporated into other tools, and then data extracted to import into TRACS (or the new system) OR does it need to be given in isolation and in order of the questionnaire?
- For NOMs what do we do if patients are seen in languages more than just Spanish and English? I.e. Can we translate the questions into their language, as it is hard to interpret at the same time as translating?
- How do centers incorporate the NOMs into care so as not to repeat questions with patients that happen with Diagnostic Assessments and other mental health requirements?
- How do we collect the recovery measures?
Data

- Data Collection/TRAC NOMS/TRAC IPP/SPARS—(more specifically expectations for data entry)
- Biggest concern right now is where we put data when we begin enrolling patients, and how we are supposed to handle the switch over to the new system
- For our RN care manager. I have scheduled and met with some people and have completed the NOMS, but I struggle with what to do next. What is a good way to move into goal setting and how frequently/how soon should we set to meet again. She knows this is individualized but general guidelines will be helpful
- Examples of how others have tracked data outside of TRAC/SPARS that has worked well

Team-based Care & Staffing

- What are some organizational structures both FQHC/CMH out there? What staffing models work best?
- Our biggest question at this point is workflow! How do we move a person through with two care coordinators? To explain further…we have one care manager, and our primary care partner also has a care coordinator as a part of their work flow. So how does a patient work with two care coordinators?
- Another question would be some framework on huddles – how the patient review list gets set?
Grants Management, Program Design, & SAMHSA Requirements

• If we have primary care on site our patients do not need to go to another clinic to get lab/biometric screenings. Are we required to use other clinics for medical services OR just when a patient chooses to use another clinic?
• If we have a position that is on the grant and a person leaves that position, can we fill the position with a new person without getting prior authorization?
• Wellness programming design and implementation: more specifically program requirements

Grants Management, Program Design, & SAMHSA Requirements

• Examples of how peer support has been used. How has it worked, been sustained (not just financially), barriers that others experienced and how they how overcome them, along with any pitfalls to avoid. Is there curriculum that would be helpful?
• Anything you have regarding Wellness programming design and implementation
• What are some good physical health screening measures?

On page 9 of the (RFA) No. SM-15-005 under required activities for a PBHCI consumer on the PBHCI Coordination Team states, "Grantees are required to establish PBHCI Coordination Teams, which at minimum includes the grantee’s Chief Executive Officer, Chief Financial Officer, Chief Medical Director, primary care lead, PBHCI Project Director, and PBHCI consumer (comprising more than half of the entity)." What does comprising more than half the entity mean?
Sustainability

Specifically billing codes used for primary & behavioral health care integration and care coordination.

Other Questions!

integration.samhsa.gov