



# Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



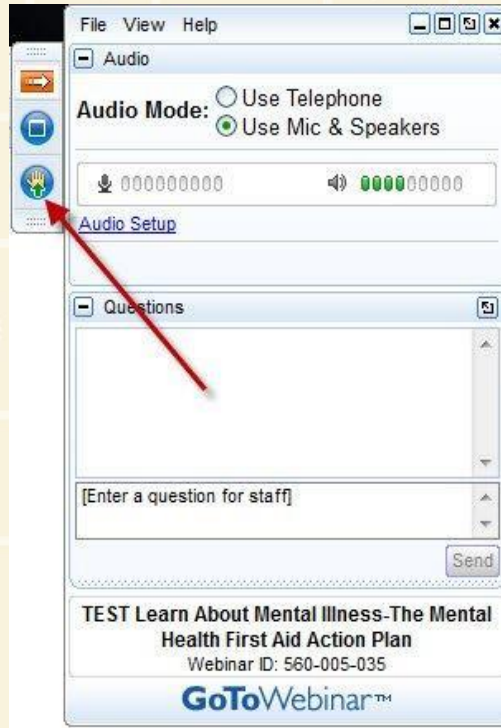
# ***SAMHSA-HRSA Center for Integrated Health Solutions***

## **Integrated Case Management**

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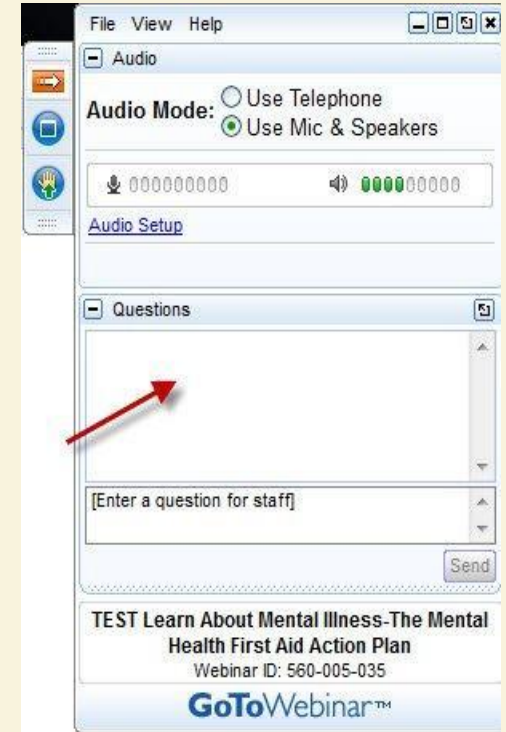
**Monday, July 6, 2015**

# How to ask a question during the CoP



If you dialed in to this webinar on your phone please use the “raise your hand” button and we will open up your lines for you to ask your question to the group. **(left)**

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. **(right)**



**Session is being recorded**



## ***SAMHSA-HRSA Center for Integrated Health Solutions***

**Slides for today's CoP are  
available on the CIHS website at:**

<http://www.integration.samhsa.gov/mai-coc-grantees-online-community/communities-of-practice>



# ***SAMHSA-HRSA Center for Integrated Health Solutions***

## **Integrated Case Management Community of Practice**

**Presented by:**

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**Senior Integration Consultant**

**The National Council for Behavioral Health**

# SESSION ONE - OBJECTIVES

Solidify community identity

Prioritize knowledge needs

Develop plan to satisfy highest priority knowledge need

# Your participation today and in next sessions

1. Share case studies and document examples of both typical and atypical cases
2. Develop policy and procedures templates for cross-continuum team engagement
3. Identify care coordination quality measures that are most relevant to case management

# **We asked you:**

Describe your organization

Describe your greatest challenges

Bring two questions to the group



# River Region Health Services

## BRIEF DESCRIPTION OF YOUR MAI-CoC PROJECT.

- Jacksonville, Florida
- Adult African Americans living with or at risk for HIV/AIDS
- Integrated or Co-located model
- Local organizations providing HIV-related services

## GREATEST CHALLENGES

- Ensure clients keep all appointments, especially health-related appointments
- Keeping in contact with clients – sometimes clients disappear and only reappear if they need something
- Getting other Case Managers to cooperate and share information
- Having clients open up to Medical Case Manager, clients are more comfortable opening up to other Social Services Case Manager

## QUESTIONS THAT YOU BRING TO THE GROUP OR TO THE COMMUNITY of PRACTICE

- How do you engage clients that are guarded and apprehensive about participating in services, particularly medical services?
- How do you engage clients whose priority is housing (and other basic needs) over health?

# Coastal Horizons Center, Inc.

## CONTINUUM OF CARE

- Wilmington, North Carolina/Southeastern North Carolina, includes New Hanover, Pender, and Brunswick Counties
- Providing coordinated and integrated services including behavioral health treatment, prevention, and HIV/HCV medical services for minority communities at high risk
- Target populations include:
  - Persons at risk for/or currently suffer with behavioral health issues
  - Black /African American communities
  - Hispanic/Latino communities
  - LBGTQIA community
  - Veterans who do not access services through traditional Veterans organizations

## **Collaborators – Identified in Grant:**

- Local hospital HIV clinic – New Hanover Regional Medical Center’s CARE TEAM (the only HIV medical clinic in the area)
- Duke Partners In Caring (case management partner for uninsured)
- MedNorth – local FQHC
- New Hanover County Health Department
- El Puente – outreach with Hispanic/Latino community

**New partnerships are being cultivated**

## GREATEST CHALLENGES

- Changing roles of partners
- Building a new team internally
- Building bridges in the community as newcomer program
- Territorialism around clients
- Service distribution is not even in all counties
- Transportation
- Differing community norms and values
- Rural vs. Urban

## QUESTIONS THAT YOU BRING TO THE GROUP OR TO THE COMMUNITY of PRACTICE

- Experience with rural populations?
- Strategies for overcoming territorialism with partners
- Strategies for incorporating continuum of care model *within* an established organization

# VIP Community Services

Bronx location

Target - adult minorities at risk for HIV/HeP C

Integrated care

No collaborators - since VIP has medical and mental health, substance abuse

Greatest challenge – follow up with clients, loss to contact, duplication of services



# SESSION ONE - OBJECTIVES

Solidify community identity

Prioritize knowledge needs

Develop plan to satisfy highest priority knowledge need:

- two upcoming webinars/meetings: needs we identified today
- Are there other needs we haven't talked about?

# Possible outline for our next conversation

Why whole health care management?

How can we expand the thinking/conceptual framework of case managers to think about whole health

What tools are helpful?

How do care managers support HIV/BH integration including how to navigate the system?

How do we partner effectively with primary care?

# For More Information & Resources

Visit [www.integration.samhsa.gov](http://www.integration.samhsa.gov) or  
e-mail [integration@thenationalcouncil.org](mailto:integration@thenationalcouncil.org)





# *SAMHSA-HRSA Center for Integrated Health Solutions*

**Thank you for joining us today.**