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

http://www.integration.samhsa.gov/pbhci-learning-community/webinars

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## Got Questions?

Please type your questions into the question box and we will address them.




## Poll Questions

**Our organization has successful strategies in place for consumer engagement**.

True False

**We are reaching our enrollment goals.**

True False

**We are reaching our reassessment goals.**

True False

**We would like to learn more about the following engagement strategies:**

Marketing Consumer Report Cards Clinical Strategies Other

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## Today's Presenters

**Cheryl Stine, LPC, CAC III**
Senior Manager
AspenPointe

**Rick Jewel**
Practice Transformation Manager
AspenPointe

**Angie Berg, PLMHP**
Program Manager
Community Alliance
Omaha, Ne



## What we will cover:

- Engaging the workforce
- Engaging consumers
- Lessons from grantees
  - AspenPointe
  - Community Alliance

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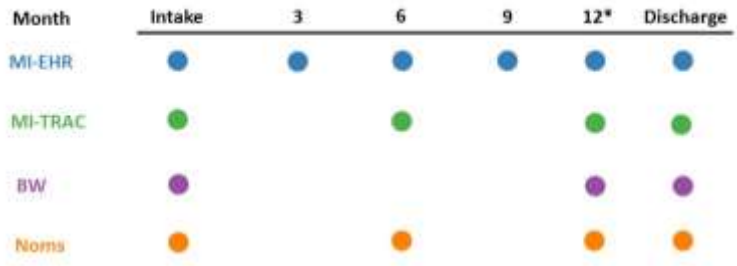
## Engagement Opportunities…..others?



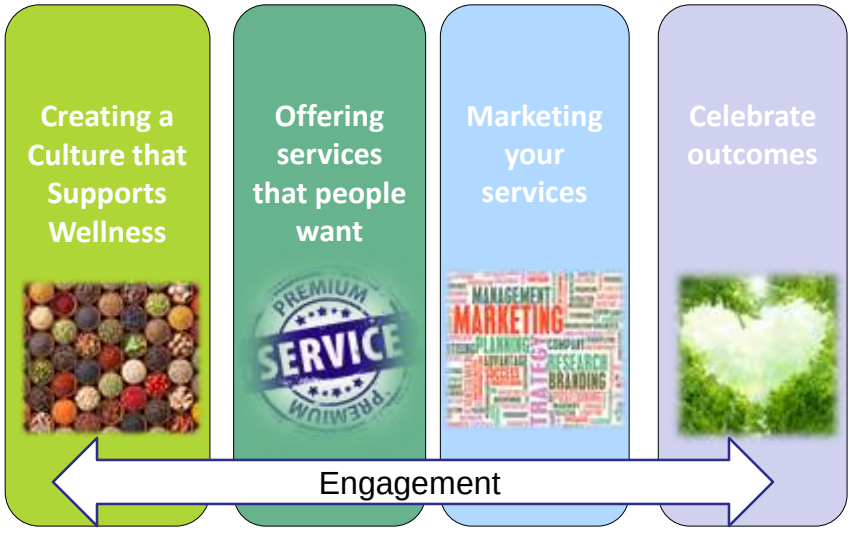

MI-EHR: Collect mechanical Indicators; store in electronic health record
MI-TRAC: Collect mechanical Indicators; **enter in TRAC**
BW: Collect blood work; store in electronic health record, **enter in TRAC**
Client DCI: Conduct NOMs interview, **enter in TRAC**

*Continue same pattern until discharge



## Engaging Consumers

- How does your workflow promote engagement?
- Who completes the NOMs?
- How is engagement discussed at team meetings?
- What incentives do you use for consumer engagement and how often are they used?





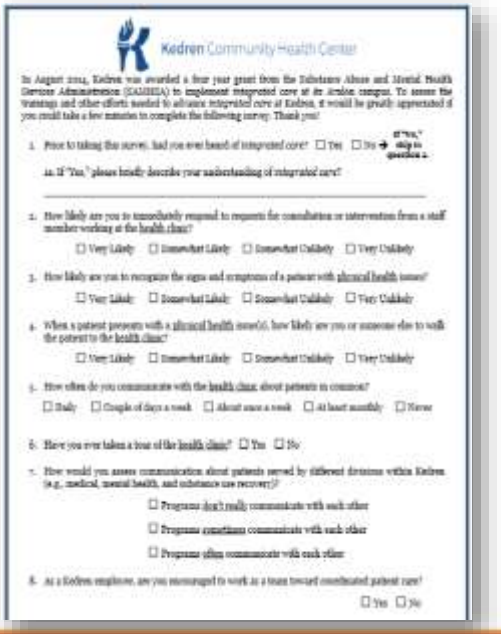

## Strategies to keep people engaged

A good 1st experience

A plan that is person-centered

Rapid follow up

## Engaging the Workforce



Kedron Community Health Center

In August 2014, Kedron was awarded a four year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement integrated care at its Avalon campus. To assess the trainings and other efforts needed to advance integrated care at Kedron, it would be greatly appreciated if you could take a few minutes to complete the following survey. Thank you!

1. Prior to taking this survey, had you ever heard of integrated care? ☐ Yes ☐ No → If "No," skip to question 4.

   a. If "Yes," please briefly describe your understanding of integrated care?

   _____

2. How likely are you to immediately respond to requests for consultation or intervention from a staff member working at the health clinic?

   ☐ Very Likely ☐ Somewhat Likely ☐ Somewhat Unlikely ☐ Very Unlikely

3. How likely are you to recognize the signs and symptoms of a patient with physical health issues?

   ☐ Very Likely ☐ Somewhat Likely ☐ Somewhat Unlikely ☐ Very Unlikely

4. When a patient presents with a physical health issue(s), how likely are you or someone else to walk the patient to the health clinic?

   ☐ Very Likely ☐ Somewhat Likely ☐ Somewhat Unlikely ☐ Very Unlikely

5. How often do you communicate with the health clinic about patients in common?

   ☐ Daily ☐ Couple of days a week ☐ About once a week ☐ At least monthly ☐ Never

6. Have you ever taken a tour of the health clinic? ☐ Yes ☐ No

7. How would you assess communication about patients served by different divisions within Kedron (e.g., medical, mental health, and substance use recovery)?

   ☐ Programs don't really communicate with each other

   ☐ Programs sometimes communicate with each other

   ☐ Programs often communicate with each other

8. As a Kedron employee, are you encouraged to work as a team toward coordinated patient care?

   ☐ Yes ☐ No



## Wellness Report

**Glenn County Health Care Collaborative**

INDIVIDUAL WELLNESS REPORT

*Name* **Ben Well**
*Clinician* **John Smith**
*Case Manager* **Jane Doe**

☐ Normal*
☐ Caution
☐ At Risk

**Progress on Key Health Indicators**

| Category | Indicator (Goal) | Baseline *August 2012* | 6-Month Reassessment *February 2013* | 12-Month Reassessment *July 2013* |
|---|---|---|---|---|
| Lungs | Breath CO (0-6) | 23 | 8 | 5 |
| Weight | BMI (18.5-24.9) | 25.8 | 28.1 | 25.3 |
| | Weight | 161.0 | 174.0 | 158.0 |
| | Waist Circumference | 31.5 | 31.5 | 32.2 |
| Blood Pressure | Systolic BP (90-140) | 133 | 135 | 134 |
| | Diastolic BP (60-90) | 88 | 75 | 80 |
| Blood Sugar | Fasting Glucose (70-99) | 115 | - | 115 |
| | Hemoglobin A1C (4.0-5.6) | 7.4 | - | 7.4 |
| Heart Health | Total Cholesterol (125-200) | 197 | - | 189 |
| | LDL Cholesterol (20-129) | 111 | - | 103 |
| | HDL Cholesterol (40+) | 78 | - | 73 |
| | Triglycerides (30-149) | 72 | - | 84 |

**Client Wellness Goal(s):**

Ben Well will lose 5 pounds within 6 months.

Ben Well will maintain her excellent progress in reducing/stopping her tobacco use.

**Client Mental Health Goal(s):**

Ben Well will sleep at least 7 hours each night to decrease symptoms of depression.

Action Step(s):


## AspenPointe

- PBHCI Wellness Integration Program Cohort V
- Primary care in a behavioral health setting
- Peak Vista, FQHC
- AspenPointe, BHO

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## Lessons Learned

1. Leadership commitment at all levels
2. “Boots on the ground” management is imperative
3. Right people in the right roles
4. Continual process improvement: Plan, Do, Check, Act
5. Morning huddles for prep & coordination for patients
6. Open and direct communication across partnerships
7. Data informs the process
8. Use resources: GPO, National Council trainings, other grant recipients, list serve



## Strategies for Engagement

1. Relationships: individuals served and staff
2. Individual at the center: Respect, caring, trust, remember people’s names
3. Individual wellness plan: listen, understand, partner
4. Set positive expectation: hope engendered by sharing successes
5. Primary Care visible: lobby, team meetings, intake packets, signage
6. Morning huddles: identify new patients, coordinate care and strategies for engagement
7. Peer Health Coaches: at point of service, connection and coordination of care
8. Incentives for engagement in wellness programing: snacks, crock pots, subway cards, pedometers, calendars

# Reassessment Window Tracking Report

| Ehrnie ID | Baseline | Window | WindowStart | DueDate2 | WindowEnd | PeerHealthCoach |
|---|---|---|---|---|---|---|
| 9482919 | 1/8/2015 | 12 Month | 12/4/2015 | 1/3/2016 | 2/2/2016 | PHC 1 |
| 9483278 | 7/14/2014 | 18 Month | 12/6/2015 | 1/5/2016 | 2/4/2016 | PHC 1 |
| 9463774 | 7/14/2014 | 18 Month | 12/6/2015 | 1/5/2016 | 2/4/2016 | PHC 1 |
| 9456837 | 7/28/2014 | 18 Month | 12/20/2015 | 1/19/2016 | 2/18/2016 | PHC 1 |
| 9402359 | 9/18/2014 | 18 Month | 2/10/2016 | 3/11/2016 | 4/10/2016 | PHC 2 |
| 9472475 | 9/24/2014 | 18 Month | 2/16/2016 | 3/17/2016 | 4/16/2016 | PHC 1 |
| 1720510 | 10/7/2014 | 18 Month | 2/29/2016 | 3/30/2016 | 4/29/2016 | PHC 2 |
| 9476091 | 5/1/2014 | 24 Month | 3/21/2016 | 4/20/2016 | 5/20/2016 | PHC 1 |
| 9429234 | 4/27/2015 | 12 Month | 3/22/2016 | 4/21/2016 | 5/21/2016 | PHC 1 |



# Strategies for Reassessment

1. Clients needing reassessment identified in morning huddle.
2. PHCs complete reassessments as part of checking in with clients.
3. Assessments due reviewed weekly in supervision.
4. Clients not engaged are closed.
5. Reassessments completed by phone (may need GPO approval).

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CENTER for INTEGRATED
HEALTH SOLUTIONS

## Community Alliance

**Angie Berg, PLMHP**
Program Manager
Community Alliance
Omaha, Ne

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## Community Alliance
## Omaha, NE

- PBHCI Wellness Integration Program Cohort V
- Primary care in a behavioral health setting
- OneWorld, FQHC
- Community Alliance, BHO

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## Strategies for Engagement –First Visit

- Trauma Informed Care, explore past experiences with prior providers - both good and bad
- Referral forms, we make it simple and allow for self referrals
- Warm hand offs, referring party is present at the first visit and we offer tour and introductions to clinic staff
- Illicit feedback, “how does that make you feel” we learn a lot about fears this way.”Does this mean I’ll loose my leg like my dad?”
- Personal Connection, we make every effort to greet every patient by name and we have a very engaging and welcoming front desk staff!



## Partnerships with Referring Programs

- Built on what is going well, most referring parties are already utilizing whole health wellness approaches.
- Increase health literacy, happens with both staff and clients, learning together, knowledge is powerful.
- Effective Communication, will ensure better follow through with client
- Communication is the key, we utilize EHR, shared treatment plans, emails, attending appointments if possible, utilize worksheets given at PCP appointments.
- Integrated Care, is not just between providers, it’s between all team members internal and external.

## Consumer Input

- Advisory board, our board include active clients of the program
- Client panel, we have groups of clients talk to the behavioral health and physical health care teams. They share positive and negative experience and suggest improvements.
- Utilize this board to review satisfaction data, develop new satisfaction surveys or suggestions.
- Utilize board to do "mock" intakes, walk troughs, to better understand what areas can be improved for the client experience and engagement.
- Clients as marketing tool, we have clients talk about their experiences during Health Fairs and program orientations to market our services.



## Resources

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

- Consumer engagement
  www.integration.samhsa.gov/health-wellness/consumer-engagement
- Motivational Interviewing
  http://www.integration.samhsa.gov/clinical-practice/motivational-interviewing

**National Council for Behavioral Health**

- Motivational Interviewing
  www.thenationalcouncil.org/areas-of-expertise/motivational-interviewing/
- MTM – Same Day / Next Day Access
  http://www.thenationalcouncil.org/areas-of-expertise/same-day-access/
- Case-to-Care Management
  http://www.thenationalcouncil.org/training-courses/moving-case-management-to-care-management/

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