SHIP PCMH Transformation Team - Mentorship Webinar Series

Topic: Behavioral Health Integration in a Community Health Center's Patient Centered Medical Home

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Facilitator: Jeanene Smith, PCMH Coach

Moderator: Welcome to the SHIP PCMH Mentorship Webinar around behavioral health integration in a Patient-Centered Medical Home Model with a Focus on Non-FQHC Clinics. This session is being recorded for the purpose of taking notes.

Jeanene Smith: Good morning/afternoon to all of you. Thanks for joining us today. I am one of the PCMH coaches. This is kind of a part two on behavioral health integration (BHI). We had one earlier with a focus on federally-qualified health centers (FQHCs). This is for other settings, for clinics that were considering to hear from a couple of our mentor clinics to talk about what they have done in their sites, and then how to open it up for questions back and forth between you, the audience, and our clinics, and help to build some relationships, to build on some of the efforts already underway. This is part of a series of Mentorship Webinars we have had that started a few months ago and will continue through the end of the year with some additional other topics. If you want more information about the mentorship framework that was developed through the Intermountain Health Care (IHC), there is a link on this slide deck and the slide deck will be available in the portal for all of the clinics.

Just to remind everyone who is considering going forward on the National Heath Care Association (NCQA) 2017, this was an element of the Care Coordination and Care Transitions standard under Competency B and it is an elective credit. There are variations of behavioral health integration that many sites and clinics in Idaho and other states have implemented. These two clinics would probably fit some examples for this. I know it is also an element of the Oregon Patient-Centered Primary Care Home Standards, as well, as the state recently worked to ensure that that was part of the standards in their 2017.

For today, we have two clinics that volunteered to give an overview on what they are doing in their sites, and first we are going to start with Amy Walters, who is a licensed psychologist and the director of behavioral health services in the St. Luke us system, which is scattered amongst Region 3 and Region 4. Then, following that, if we can make sure we have opened her mic, we are hoping to hear from Pam Lowder from Shoshone, but let's start with Amy. I think, Lawrence, if we can move to the next slide it will have sort of the questions that I wanted Amy to kind of try to first answer about what they are doing in their location, so take it away, Amy.

Amy Walters: All right. Thank you very much for having me. I think I can actually come at these questions from two different perspectives. One is as a clinician and the other is as a clinical consultant for St. Luke's Health Partners. I am actually an active, practicing clinician with St. Luke's Humphreys Diabetes Center, and we do an integrated model here with our endocrinologists, dieticians, and certified nurse educators, and so have

been in that role and seeing patients in an integrated setting for about ten years. I am also a clinical consultant with St. Luke's Health Partners, where we have been working to help bring increased integration of behavioral health into primary care settings across the state in various rural clinics by providing training and consultation that way. You'll just have to let me know which hat you want me to wear when I am answering some of these questions.

Jeanene Smith: I think most of our clinics that are in the SHIP are probably the latter aspect and probably do not have this robust of a connection with something like a diabetic educator program, although some of them do have a lot of that developed resources. So I would say probably the latter, predominantly, and then the other.

Amy Walters: Okay, so the clinical settings that we are currently in are pretty vast within the St. Luke's Health System. We have integrated behavioral health providers, all of whom are master's level clinicians in three of our rural clinics, so Fruitland, Baker, and McCall. Then, we are working with partners in a number of different clinics, including the Shoshone clinic, to provide some ongoing support with both the clinical training element and the operational training element. In terms of kind of how our clinics decided how to move forward with this effort, especially in our rural areas, we have just seen a tremendous need for behavioral health services and really a scarcity of services that are available. We also tend to see a very high co-morbidity of behavioral health issues with chronic disease management.

In my clinical practice, I can tell you all patients I see have chronic disease – diabetes or other types of chronic diseases. The vast majority come to me on antidepressants and have been taking antidepressants for 10, 15, 20 years, and the majority have never had any kind of contact with a mental health professional. So definitely this kind of split between the ideas of emotional health and mental health versus physical health, and not really understanding how these two relate. Our physicians are recognizing just how important these emotional behavioral factors are, and really welcoming some kind of integrated system so that they can start addressing these issues right away.

In terms of first steps, in working with our clinics, one of the things that is really important is identifying kind of interest within the clinic, as well as a physician champion who is willing to help smooth the process and champion the work. When we go in to work with a clinic, the first thing that we do is meet with the clinic and talk about kind of their needs and desires and how we can start this process rolling forward. Here at the diabetes center, I was actually an independent practitioner at the time, was talking with the medical director about some of the behavioral health needs in the patients. I was getting referrals in my private practice but no one would show up because they would say, "Well, you know what? I just have diabetes. I do not need a shrink."

Again, that disconnection was very much a barrier for patient care, so first steps were getting the administration onboard with bringing in a behavioral health provider, and really deciding how that works within the individual clinics. Here at the diabetes center, I actually started just one day a week and was able to build a patient panel and expand that to then several days a week, to then a full-time position. Now have a second behavioral health provider here in our clinic because our endocrinologists, Nurse Practitioners (NPs) and Physician Assistants (PAs) all recognize the value of behavioral health services. In some of our rural clinics, in a couple of clinics we obtained grant

funding to be able to fund that position for the startup and get that going, with the agreement that the clinics would then take on the position after that first year of grant funding had decreased.

In some of the clinics, we are working with individuals who were already co-located or who have interest in using a co-located mental health provider, which would then gradually transition to an integrated setting. Let me just pause for a minute. Are you wanting me to go through all of the questions one by one?

Jeanene Smith: Yeah. I am sorry we did not get a chance to talk ahead of time, but that was kind of the idea; give an overview kind of around these, and then we will turn it over to Pam and then we will open it up to questions.

Amy Walters: Okay. Just wanted to make sure. In terms of the financing piece, I think I addressed that a little bit. It really has varied by clinic. Some clinics are willing to take on a behavioral health provider. Our goal is always to have things be budget-neutral. In a few of the clinics, we have been able to actually have it be profitable. But the idea is if we can at least make it budget-neutral, as the payment model moves into more of a population health-based model and payers are paying for patients getting better, not just fee-for-service, that is when a behavioral health clinician is worth their salt. Because we can make some pretty drastic changes in health issues and see better adherence to treatment, fewer ER visits, overall better levels of health, and they can start to pay for things there.

The financing has either been through grant support, through billing for the clinical services, or a mix of those two. Where is the project/program today? As I mentioned, I am here at the diabetes center. We also support a provider in the cystic fibrosis clinic. We have a behavioral health provider over at Caldwell Pediatrics that is part of our program. We have our three behavioral health clinicians in our three rural clinics, and then we have another handful of clinicians who provide support and training in various clinics in Twin Falls, Shoshone, Caldwell, and Glenn Ferry.

The top two challenges or barriers and how did we overcome them? I think one of the biggest challenges as we have been trying to stand up new programs is the cultural shift that has to occur within the clinic. Understanding what a behavioral health provider does, how they can be a member of that team, how to use them effectively within the workflow of the clinic. It has been fascinating to me as we have had additional providers join the diabetes center, I have some who right away understand the value and pull me in regularly to deal with chronic disease management. I have others who will come and get me if someone is crying, and I have heard this from some of our other partners who have integrated clinics, as well.

Some providers struggle with the idea of how behavioral health can be used to really supplement care for our chronic disease patients. They see them as someone to grab when somebody is in crisis with suicide, or someone is depressed or somebody is crying, but do not understand kind of the vastness of the different areas of impact that providers can have, so that is definitely been one. Our other challenge I think has been making sure that we have the right fit with the actual behavioral health provider. Providing integrated behavioral health services is a different animal. It is not the same as traditional therapy, and it is also not the same as traditional medical social work. It is

typically somewhere in between being able to provide group interventions on a number of different areas kind of on an as-needed, flexible basis. Some clinicians take to this complicated model very readily and have done very well with it. We have had other clinicians who have struggled and wanted to return to their roots of kind of traditional mental health or more focused social work, and had difficulty with kind of the consultative role.

Lessons learned are definitely the importance of flexibility when working with clinics, so helping understand the current culture of that clinic, what their needs are, and how to help them move to an integrated behavioral health model. Choosing the right clinicians for those roles, as I was mentioning, helping staff know how to use behavioral health providers, how to introduce behavioral health providers to patients, and really take that team-based approach. Challenges within electronic health records, as well as challenges with billing and getting programs kind of financially sustainable I think have been some of the major challenges, and learning how to navigate the system. The more programs that we have been able to implement, kind of the faster and better we have become at this.

Then, I think the other is just the ongoing need for training and developing a network of providers so that our BHCs are not kind of out there alone but instead have a peer network of people that they can turn to and use as mentors and ways to learn from each other.

Jeanene Smith: Great, great. Your behaviorists out in the rural [areas], are they on call to those providers, or a mix of scheduled times or entirely scheduled?

Amy Walters: It has really varied by clinic and kind of clinic needs. Most are doing kind of a hybrid model, where we have either blocks of the day or 30 minutes on, 30 minutes off for scheduled time versus kind of on-call consultation time. We have done that to help make the program financially sustainable, so we felt like we needed some readily billable hours. Also, access to traditional mental health is really limited in some of these rural areas, so to say, "Gosh, we only do brief consultations and you cannot have a follow-up appointment. We will send you to somebody else," that other person may not be available.

It has really worked best for most of our clinics to have kind of a mix, with the understanding that our behavioral health providers are always available for a quick warm handoff or a quick introduction, so all of therapy sessions can be interrupted. Any of our providers can knock on our door anytime to have us meet a patient, describe our services, and then set a time for follow-up.

Jeanene Smith: Great. Are you able to bill commercial as well as Medicaid, for those, Medicare and Medicaid?

Amy Walters: Yes. We absolutely bill commercial insurance, Medicaid, and Medicare. The biggest challenge has been use of the health and behavior codes, so if someone meets criteria for a mental health diagnosis, we can use those therapy codes. Oftentimes, it is that short therapy session, that [code] 90832. Psychologists can also use the health and behavior codes, so I use those regularly here at the diabetes clinic, with the exception of Medicaid patients. We have not yet been able to get those codes opened up for

Medicaid but are working with the Idaho Psychological Association and the Social Work Association to alleviate that issue.

Jeanene Smith: Yes, that is a challenge in many states, as well. Well, let us turn it over to Pam and let her talk about kind of what she is doing in the rural health setting there at Shoshone, and then we will have some more conversation. Pam?

Pam Lowder: Yes, I am here.

Jeanene Smith: All right. Oh yeah, and you want to introduce your team. I think you said you were going to share some of the answers to the questions.

Pam Lowder: Yeah, we are going to tag-team a little bit. Our team that implemented this is myself – I am Pam Lowder. I am the clinic manager – and Stephanie Roberts is the PA lead in our clinic. Wendy Sedano is the LMSW, and Beth Patten is our care coordinator. Just to describe our clinic a little bit, we are located about 25 miles north of Twin Falls. We are an independent rural health clinic. We are the only medical facility in Lincoln County. Lincoln County is about the size of Rhode Island. The population is about 5,300, and our patient population is about 4,000. We are a PCMH Level 3. On any given day, we have two primary care providers in the clinic, one certified nurse midwife, and two behavioral health providers. The PCPs on any given day see between 15 to 20 patients.

The reason we decided to move forward with this was it is better patient care. A lot of our patients, we would refer them out and it is out of town. It is quite a drive, they would not always show up for their appointments, so they just did not get their behavioral healthcare that they needed. Some of our first steps were St. Luke's Health Partners helped us along the way and helped guide us quite a bit with this. Wendy, do you want to talk some more about that?

Wendy Sedano: Hello. I think one of the first steps was kind of getting that training down and understanding the model, and kind of understanding the flexibility along with Amy. I mean she has been part of that, too, that effort of training us, as well. I think those were the first steps, was kind of understanding the model, but also how we were also going to develop the templates, the screening format, the workflow, and how and what that would look like. Those beginning trainings were really useful and helpful for me to understand what I needed to do, and how to further move this plan forward. I think the key strategies when it came to that was really having people willing to come down and stretch out and be like, "Okay, we are here. We are going to help you. What do you need? What can we help you with?" I think that is been really useful.

Pam Lowder: Financially, it is been kind of burdensome to start this project up with us. We did not have any grant funding, so when we hired Wendy and she was just doing basically warm handoffs and not building the clientele, it has taken a while to get to a breakeven point with this project. But it is well worth it because it is better quality care for our patients.

Beth Patten: This is Beth. I just wanted to kind of chime in. We tried a couple of different things, too, to help on that financial side. In terms of how we scheduled patients, initially we tried to kind of set up blocks throughout the day when Wendy would be available for warm handoffs or when she would be available for traditional counseling sessions. That seemed to be a little bit more problematic, so what we ended up doing most recently is

blocking half of her day for warm handoffs and half of her day for traditional counseling. That is made it a little bit easier to schedule and then to build up that clientele that helps offset the cost somewhat.

Pam Lowder: Steph, do you want to talk some about maybe the challenges we had?

Stephanie Roberts: I am Stephanie Roberts. I am the PA and clinical lead here. I think some of the challenges and barriers that we experienced in this process, first and foremost, Pam has kind of described our location, but to describe what kind of a clinic we have, we actually have an extremely old building. It is a 1910 building. We have only five exam rooms. The thought of trying to find space that we could actually even pretend to do this in was very, very challenging. In fact, we combined offices and we came up with two very small but workable behavioral health rooms. That was an undertaking in and of itself, so I think that was a barrier just in regards to space. I think another barrier and challenge has been sometimes buy-in from the staff and from other clinicians so that everybody is kind of on the same page as far as when we do those screenings, we use that screening tool that we make sure that those referrals happen and that people are not missed. I think that has been a little bit of a challenge and a barrier.

Some of the things that we have done to overcome them, space-wise, I think it came down to our staff being very flexible and willingness to relocate, and also to our behavioral health specialists, that they are willing to work in different spots. The flexibility was really important. In regards to how we overcome the screening, basically we just made it a standard that everybody that came in for a wellness exam got a screening, and we did it at the front desk so it was not left up to a provider or nursing staff to make that judgment call. It was based off of type of visit, and then, again, reiterating to the staff that if you see a positive screen, even before the provider gets there, that you can alert the behavioral health specialists so that we are not missing those.

Pam Lowder: As far as where we are at on our project, we are fully integrated right now. We recently hired our second behavioral health specialist, and so there is a block in the morning and the other one would be open to see patients, and then she would be blocked in the afternoon to get those warm handoffs. Our staff has been really great for change to get this implemented, identifying patients and alerting the behavioral health specialists that they might need a warm handoff with this patient and working with the providers. It has come along really well and I am really proud of our staff for that.

Wendy Sedano I think another thing just to mention that Amy had talked about is that cultural part of it, too, that Steph kind of touched upon on being able to not just the Primary Care Physicians (PCPs) or to see that need, but also the clinic as a whole. I think that was a little bit of a struggle when it came to the workflow. "Hey, this is how we do it. This is what we need to do," but the importance that we are all working together as a team, because without the front desk helping out and the nurses coming in to say, "Hey, they scored on this PHQ 9, they scored on the last question. Just letting you know." It is been a struggle but they have also been willing to work with us and kind of adapt to that new workflow that we are all working cohesively.

I think that cultural part of it has been really important and it is been impactful now that we are getting a little more of those warm handoffs, and we are addressing more, looking at everybody at a holistic view of their whole well-being. I think that is very

important to point out, that that was something that was a barrier, but I think at this point, we have overcome that.

Beth Patten: I am really excited as we move forward to start looking at our quality measures and seeing how we can use this new resource to impact those quality measures. Any of you that are applying for your patient-centered medical home accreditation, that is really important. This is just another tool that you have in your toolbox to impact those measures. It will be interesting to see what happens in this clinic.

Stephanie Roberts I guess when we talk about major lessons learned, I am speaking for myself, but things that I have seen and learning along the way, is making sure that you have a team setup in the beginning that has a similar view of what they want this product to look like, and that you meet on a very regular basis, and that you continue to meet on a very regular basis in order to help facilitate kind of pushing a project through. Because we have been known to start projects and then they kind of lose their momentum. Having a good, structured approach, and again, having St. Luke's Health Partners was integral in our ability to do that, and I really thank them for that. I think also another lesson learned is making sure that PCPs understand how to use this resource.

For me, it was very easy to grab a behavioral health specialist when I have a crisis, someone is crying in my office and they are suicidal or they are going to take an hour of my time that I do not have, and those are the easy patients to figure out. But it is those patients for me that are not reaching their A1c goal, that are not being compliant with medications, or I cannot seem to convince them to stop smoking. Those are those patients that I think that I now look as being an opportunity for where behavioral health specialists can really improve patient care, so not just the major crises. I think we are done.

Jeanene Smith: That is great. When you talked about the team in the beginning, and everybody has got crazy busy clinics, how did you work all that time in to develop your vision, and then how are you monitoring it and tweaking it? You are kind of doing a Plan, Do, Study, Act (PDSA) in some way, a cycle. How did you find enough time to do all that?

Wendy Sedano: I can kind of chime in on that one. Really what it was, because for I think close to a year, I was the only one here doing this by myself, and so a lot of the templating, a lot of that was kind of on my own. But I think a lot of it was the persistence, and if you are excited about it, then it is going to move forward. I liked it, I was excited for it, and I am still excited for it. A lot of it is like, "Hey, if we have this going on," you know, the screening, educating the Medical Assistants (Mas), going one by one like, "Hey, this is what we need to recognize. This is what you're looking at. This is what the screening looks like. If you need help, come and get me." Kind of going and poking at the PCPs like, "Hey, this person, do you think I can maybe work with them?" or whatnot.

Honestly, it takes a lot of persistency with us, and we are a small clinic. I mean it has pros and cons, but I think we are small enough that I felt comfortable enough, too, as well, to be like, "Hey, can we focus on this? Can we maybe look at this?" But they also came to me and said, "Hey, there is a problem here. There is a problem there." We feed off of each other, so that was really helpful to get feedback from them, "Hey, this is not working. How can we fix this?" especially the workflow. I think that that was one of the

things that helped out. It was not necessarily that we carved out time. It was when it needed to be addressed, we addressed it.

Stephanie Roberts: Then to answer your question for myself seeing patients, we dedicated Tuesdays as an opportunity. I personally do not see patients on Tuesdays, and the history of [that] being my day off has now been gone to sacrificing extra time to make something like this happen. I really was saying, "Okay, every fourth Tuesday of the month was dedicated to St. Luke's Health Partners to come in and to really kind of drive that change." Then, again, communicating on a daily basis in regards to things that are working and were not working, and then also working for Dr. Davis. That allows us the opportunity to work on projects like this, because it is not making him any money and costing him probably lots of money to have people like myself not seeing patients in order to be able to have a program like this come forward. But truly, the entire staff has dedicated lots of time. I guess another thing is every month we have a provider meeting that all the providers sit down and we discuss, and behavioral health, they are a standing agenda item. We try and adjust something each month in regards to behavioral health.

Beth Patten: None of us are very good at writing policies or policy manuals, and we were able to rely on St. Luke's Health Partners to help us with some of those pieces, too. Any of you that are going to implement this, those are things that you are going to need. So, being able to reach out and work with someone that had experience in that arena was really helpful, because I can't imagine how much time it would have taken if we would have had to develop all of that from scratch. That kind of goes across the board, too, with any of your medical home stuff that you're working on. We are all kind of in this together, and sometimes if you can lean on another clinic that maybe has expertise in a certain area, or has a manual in place or a screening form already developed, do not try and reinvent the wheel. Reach out to those resources.

Jeanene Smith: Are you guys part of the behavioral health collaborative effort that has been – I know I think St. Luke's is, because of Jennifer Yturriondobeitia.

Pam Lowder: Yes, we are.

Jeanene Smith: Is that a place where folks could get access to sharing some of these policies and procedure manuals, et cetera.

Wendy Sedano: I would say Jen Y., and she is pretty knowledgeable and would know exactly where to go off from there.

Amy Walters: Yeah, I can speak to that. This is Amy. One of the things that we tried to do is create this network for the Idaho Integrated Behavioral Health Network where we have a number of different partners around the state, people who are doing integration, to be a resource. So yes, that is definitely a group that you could reach out to. I can be a contact for that group. Jen Y. can be a contact for that group. We also have the Family Medical Residency of Idaho and Terry Riley, who have both been doing integration for quite some time as well. We all share information and resources on ideas and training with each other. We are trying to make this a place that people can go to obtain information so they are not having to reinvent the wheel, and can learn from people who have been doing it for some time using evidence-based approaches to implement integrated care in Idaho.

Jeanene Smith: Yeah, Jen was on our last call and was not able to attend today, and we did share her contact on the last slide deck, and we can also add it to this one for reference. How did you first approach the provider, be it Dr. Davis or others, because of that sort of upfront kind of investment? Was it just a conversation?

Did you have some statistics or information that really made it, sell it on to them as a return on investment, and also probably in your system there, Amy, at St. Luke's? How would you give some tips to clinics to help convince their providers who are in many ways, many of these practices are small businesses, to see besides improving patient care, which we all want to do, how do you sell the concept?

Amy Walters: Yeah, absolutely. There is definitely a large literature base out there that talks about how behavioral health factors impact overall health. We know that 75 percent of primary care visits have some kind of psychological/emotional behavior component to them. I guess my stance is this is not a hard sell for physicians when it comes to the concept. As soon as you start having conversations about issues with patient treatment adherence, issues with managing depression, as well as all the other medical issues within a 15-minute primary care visit, they very quickly buy into the concept. Most of the physicians we have talked to are very excited to have a behavioral health element in the clinic. It really becomes the financial piece that I think is a challenge, and helping them see how as the payment model shifts, that is going to make it easier and more feasible, but also setting up an initial structure that can at least make this kind of physician budget-neutral while we are waiting for those changes to occur.

Jeanene Smith: Pam and your group, any comments on your side?

Pam Lowder: It is like what Amy said, and ours started out just as a conversation. Doc understood that treating their behavioral health would help with their medical conditions. We are a small practice, and he makes the decisions on his practice. It was pretty easy for him to just jump right in and want to do this.

Jeanene Smith: What do you guys both think, both of your clinics, in terms of patient acceptance? I know especially in Medicare, seniors, talking to somebody about problems is always a challenge , that old mindset that it was not cool to talk to anybody. I know my elderly parents were not always thrilled about that sort of thing, even though they could have used it at times. Especially in the more rural areas, is that a challenge, and is it the warm handoff and the person being right there that makes that difference, as opposed to referring them out, obviously? I mean can you guys talk a little bit about patient acceptance of the model?

Stephanie Roberts: In Shoshone, I think from my personal experience, it has been very welcomed that we introduce Wendy or Tanya as a member of our team that can help with some of those emotional issues and some of those challenges. I talk to my patients about she has different tools and skills that she can help and work with you on. At least from the feedback that I have had, I have not had any patient be upset that I introduced the idea. I have not had any patient not be thankful that there was that opportunity. I mean, this morning was a beautiful example of a family really in a terrible situation, and it had nothing to do with medical. I mean in all honesty, there was nothing from a medical standpoint that I could do to fix that situation. Having Wendy to just say, "Wendy, I need

you," and that family being able to leave here with a tool and a plan was extremely powerful. So I feel, and I think I am speaking for all of us, that it is an extremely positive thing. It has not been a hard sell.

Beth Patten: From a care coordinator standpoint, before we introduced this model, I was dealing with some of those situations with patients, where they really needed that behavioral health specialist on that team. I did not always feel equipped to be able to handle some of those needs with patients, and I knew that we could not make progress on chronic conditions until we addressed the behavioral component. Having that member of my team that I can hand off these patients to to start addressing some of their more immediate needs has been very, very powerful for me. It has helped my job immensely. When I introduced a member of our team and talked to them a little bit about what she is able to bring to the table, they are almost relieved, and they are really glad to meet her and work with her, so it has been a good experience.

Amy Walters: This is Amy. I have a quick comment on that, as well. I think that the language that is used is critical. Being able to provide an initial script for providers about how do you introduce this person is a valuable tool. I love what the ladies from Shoshone were saying, "Yeah, this is a member of our team. This is one of my colleagues." We really want to approach it that way, because that is what we are doing. This is a team-based care approach and we want to take care of the whole person. We know that emotions and behavior have an impact on our health, and patients are much more open to that. If you say, "Oh, I have a mental health provider I want you to meet," that puts up walls right away, or a social worker. People sometimes have had negative experiences with child protection, so we just have to be careful about the language we use.

Also, having that availability for an initial introduction or a warm handoff is critical. It puts a face with a name, they meet the behavioral health provider, find out they are not such a scary person, and definitely increases the likelihood that they are going to follow up and come in and meet with that person. So I think those two elements are really critical.

Jeanene Smith: Some clinics do a lot of their patient-centered homes more in the back office. How have you helped educate the front? The front desk is always on the front line sometimes with challenging patients or the difficult patients to get scheduled or rescheduled, or deal with sometimes. So can you guys talk a little bit about how you've helped the rest of the – and the MAs, I suppose, as well, in addition to the providers and the patients?

Wendy Sedano: I can kind of speak on that. I think one of the things that I kind of learned early on is that I needed to kind of be around, be all over the place, and so up front and just, "Okay, this is what works." They have been very flexible and really workable with me in that, "Hey, we'll schedule people this way," or, "We'll work on this way," and then going back and, "That did not work out, so let us do it this way." So I think what it came down to, it is just having that one-to-one person, "Hey, this is what works," and then kind of trickling it down and just being all over the place I guess is the best way to describe it. That is been helpful for us, and it is been working up until now that I am not just focused on the one thing but trying to kind of be all over and be invisible that, "I am here. If this does not work, let me know how we can work it out, how we can work through it." It is just that workability part.

Jeanene Smith: So you are a resource more than just to the providers. You are a resource to the entire team, overall, including the front, right?

Wendy Sedano: Yes. If it doesn't work out with them then, "Okay, let me know what we can do," and whatnot, and then I go to the right people that I might need to get a little bit of help from. It really is a team because without the front, the nurses and then our providers, I mean I do not think this could be really accomplished at all. Everybody plays a really important part, and we all help each other out. I think that is one of the main things is that we are out there to help versus not helping out or not being part of it. I think I do a big effort to try to include everybody and try to kind of be around and, "Hey, this is what we are doing. Is there something we are not doing? This did not work, this worked." Just kind of everybody be aware so it is not like, "Oh, this is just your job, and this is just this," but more, "Hey, we are all a part of this."

Stephanie Roberts: I think another part of that is continually trying to empower each team member, that they can feel confident that they can go to Wendy if they see something, because as a provider, I see only a small glimpse of their interactions in the entire office. Like they might have had a terrible time getting in the front door and I might not ever hear that. A front staff could pick up on that and catch that, and be able to alert Wendy or to alert me that there is something more going on there. I think making sure that the people on your team are felt empowered to be a part of this, and I hope that we are doing a good job at that.

I hope that we can continue to strive to make sure that all our staff feels that they are vital, which they are, in making this a project that will be successful and sustainable, because I think in our office, our biggest cheerleader is probably our front desk staff, honestly. Lonnie, specifically, is. She is the best selling agent we have for anything from the pharmacy across the street to Wendy's services, so I think that that is really important. I do not know if that answers your question.

Jeanene Smith: No, no, that is great. If you were a clinic that maybe could only think about having one person at first, the way I think Shoshone did, and I assume you only have one, Amy, in some of those rural clinics.

Amy Walters: Yes.

Jeanene Smith: In order to make this financially sustainable, if you did the half-and-half, like I think Shoshone did, how do you deal with the others? Amy said that you could always interrupt. Is that true at Shoshone when you guys just had the one, so that you could still get that coverage in the afternoon for that.

Stephanie Roberts: Yeah, it is absolutely true. I can knock on Wendy's door or Tanya's door and interrupt them. I have never had them or a patient be upset that I pulled them from what they are currently doing. At this point, it hasn't been an issue, and yes, it is kind of an open-door policy.

Stephanie Roberts: We set that expectation up in the beginning with our patients to know that just like they needed Wendy's services that one day, well, somebody else might need them this day. It has been good. It really is knock on the door, and she is available.

Jeanene Smith: Right. You said you did a different approach at first. You said it kind of did not work. Somebody wanted to try to break up the morning or break up the afternoon. What was the challenge there? Why did not that work, versus half-days. did work?

Wendy Sedano: Well, that did not work with one provider. At that time, it was just for me, so what we did is just we alternated. If I had the traditional, then we would block a kiddo for one hour and then an adult the other hour, so we would alternate. I had either a 30-minute session or a 45-minute session every other hour, so I had that leeway of if there's a warm handoff that I needed to do, then I would do that, but I would not be behind on the other already-scheduled appointments. That was the approach that we needed to do, and then we did that for a while, up until we hired the new clinician, and then now we do the blocks, which works out pretty good because there is always someone going to be 100 percent completely available for our providers so we are not doing as many of those interruptions.

But I mean we still prepare then because we might have two warm handoffs at the same time and whatnot, so we still prepare our patients for that. But that was the initial part of it, that you kind of had to – I mean it is going to be different for every clinic. But for us, it did not work out that way at the beginning, so I just took warm handoffs throughout the day up until we recently hired another clinician, like I said. But that was kind of what worked out then, and what's working now is we have the blocks.

Amy Walters: I think that goes back to the issue of flexibility. This is Amy. Each clinic has a different set of providers, a different culture, a different population need, and so I think you start somewhere and see how it works but then you need to be able to adapt based on how that is working and how that is fitting the needs of your clinic.

Jeanene Smith: That is great advice. Yeah, it is truly a PDSA: "Let us start this way and keep tweaking it."

Jeanene Smith: We could probably talk about this all day long. I really want to thank these two clinics. They have been kind enough to give us a point of contact for you, if you want to learn more, and certainly Amy would also be a conduit to the behavioral health integration collaborative, as well, and then Pam and her team via her e-mail or phone numbers to talk more one on one and share. We also had the two clinics last time that were the FQHCs, and that information is posted up on the portal. Really a great thanks to both of your teams to join us today. We really want to get your input on how the session worked for you and any ideas or suggestions of other topics or other mentors.

A reminder: we are aiming for another Mentorship Webinar in November. We are working on some potential sites that talk about how they have kept the culture changed and continued to sustain the PCMH culture. Another topic potentially is risk stratification later on in the year. Please let your SHIP QI specialist or your PCMH coach know if you're interested or want to get some topic on the horizon. My contact information is also available on the following slide if you want to just reach out to me. With that, I think we will conclude today. Again, a big thanks to Amy and Pam and her team for sharing all the great stuff that is going on in their clinics. Thank you all. Thank you.

[End of Audio]