

**The Lewin Group**  
**Hard-to-Reach Populations: Innovative Strategies to Engage People with Mental Health Conditions  
or Substance Use Disorders**  
**February 24, 2017**  
**12:00 p.m. EST**

**Karen Cheung:** Hello everyone. My name is Karen. I am with the Lewin Group, and we are supporting the Medicare and Medicaid Coordination Office at the Centers for the Medicare and Medicaid Services to ensure that dually eligible beneficiaries have access to seamless high quality healthcare.

This webinar is part of our 2017 Meaningful Member Engagement series. Today's session will include a 60 minute presentation from four experts followed by a Q&A discussion between you and the presenters. This session is being recorded and a video replay, along with the slide presentation, will be available on our website at <https://resourcesforintegratedcare.com/>.

This webinar is presented by the Lewin Group and Community Catalyst and supported through MMCO. MMCO is developing technical assistance and actionable tools based on successful innovations and care models such as this webinar. To learn more about our efforts and resources, please visit our website or follow us on Twitter for more details. Our Twitter handle is @Integrate\_Care.

We have a packed agenda, and I think you will all take away some key learnings from each of our presenters including innovative strategies and interventions used by providers working with Medicare-Medicaid beneficiaries and others with mental health conditions or substance use disorders. Our presenters will also describe their person-centered approach for working with these populations and provide examples from a variety of settings, such as in hospital, within an ACO, and treatment centers.

At this time, I would like to introduce our moderator, Rosa Palacios. Rosa is a Consumer Engagement Advisor at the Center for Consumer Engagement and Community Catalyst. In this role, she develops approaches to engaging individual consumers as well as hospitals and plans. Rosa has experienced working with older adults and people with disabilities. Prior to joining Community Catalyst, she was the head of the Department of Health Education and Caregiving training at Commonwealth Care Alliance.

**Rosa Palacios:** Thank you, Karen, and welcome everyone. Thank you for joining us today for our first webinar about meaningful member engagement. As Karen mentioned, I work for the Center for Consumer Engagement and Health Innovation at Community Catalyst. The center is devoted to teaching, learning and sharing knowledge to bring the consumer voices to the forefront of health innovation.

Let's go ahead and walk through the agenda for today's discussion. First, we are going to begin with Commonwealth Care Alliance and their strategies for a patient-centered experience. Then, we will hear from UPMC for You health plan and we will discuss innovative strategies of engagement.

Next, Trilogy Inc. will have a conversation around engaging clients in mental health, substance use, and integrated treatment and last, Camden Coalition of Healthcare Providers will talk about their community-based multidisciplinary care management for vulnerable populations. At this time, I would like to introduce you to our presenters for this presentation.

Barbara Herbert is a doctor and a fellow of the American society of Addiction Management. She is also the Medical Director of Addiction Services at Commonwealth Care Alliance. She practices community-based medicine under a demonstration grant that serves Medicare and Medicaid patients.

The grant also includes a methadone clinic and a mental health practice. Dr. Herbert received her M.D. from State University of New York at Stony Brook. She completed a surgical internship at the University of Pennsylvania and emergency medicine residency at Johns Hopkins Hospital and in family medicine at Harvard University. In 2010, she became a fellow of the American Society for Addiction Medicine and shortly thereafter, a diplomat of the American Board of Addiction Medicine. Dr. Herbert served on a number of policies for Governor Patrick and several Massachusetts legislators. She sits on the quality improvement council, MMS task force and is the current president of the Massachusetts chapter of AC.

John Lovelace is the president of UPMC *for You* health plan, a managed care organization that serves medical assistance and medical specialist residents in 40 counties in Pennsylvania. John provides leadership, direction, and administration for the services provided by UPMC *for You*, which offers coverage to eligible medical assistance residents through Pennsylvania Department of Public Welfare as well as for Medicare beneficiaries also enrolled in the Pennsylvania medical assistance program. He is the Chief Program Officer at Community Care Behavioral Health Organization, a behavioral health managed care organization that is part of the UPMC insurance services division. John has degrees in counseling from the State University of New York in Buffalo as well as in information services from the University of Pittsburgh.

Amy Joiner is the Director of outpatient recovery services and intake at Trilogy Inc. Trilogy is a nonprofit integrated Community Health Center in Chicago. She is a licensed clinical professional counselor and a certified alcohol and drug counselor in Illinois. Amy Joiner began her career at Trilogy as a case manager in the mental health field. In this role, she realized her passion for working with older adults suffering from persisting mental illness and disorders. She became the Director at Trilogy in May 2014 and is currently focusing her efforts on approaching adult child and adolescent outpatient and recovery services throughout the Chicago area. Amy received her MA in counseling and psychology from Northwestern University and holds a B.S. in psychology from Loyola University in Chicago.

Bill Nice is a social work coordinator. His primary role involves directly working with patients who are homeless or are at risk for homelessness by connecting them to local services and community resources. This includes providing advocates for individuals who can assist with navigating the social services when necessary. Bill has worked in the city of Camden for the past six years and is currently a member of the Executive Board of the southern New Jersey Continuum of Care. He has a BA in communications from Loyola University and recently graduated with a degree in social work from Rogers University. Now I would like to hand the webinar over to Dr. Barbara Herbert.

**Dr. Barbara Herbert:** Thank you very much, Rosa. Some of you may be surprised that I used patient-centered rather than person-centered experience. I know many of us move back and forth with the language. So I'm moving back and forth to emphasize one of the great successes that we've had at Commonwealth Care Alliance, and I think may be the biggest single key to getting people into care or holding them in care, is seeing them as individuals. I adopted this to remind us to think of the individual and the quality of their experience when caring for these people.

I'm going to talk about five strategies. The first is maintaining asset based engagement. I am going to talk about using modified motivational interview tools that I am sure are available to many of you and many of you already use. Then, I'm going to talk about identifying people at high risk and articulating the risk. I'm going to talk more about the articulation to the individual and the use of the tools to find them.

Then, my third point is collaboration, which is probably the single most important point that we have. My fourth strategy is meeting the affected person where the person is, and then fifth is offering meaningful

social support.

When we talk about maintaining asset based engagement, probably the single most valuable thing that we have to offer is authenticity to our patients. They get to feel that we are truly engaged for them. Since they are difficult patients, I think it allows us to be able to articulate ways they are difficult. We will want to express these through reflective listening, avoiding argument and direct confrontation, adjusting to the person's resistance rather than opposing it, and being straightforward with how we see and what we see in front of us.

Then when we talk about maintaining asset based engagement, there are three arenas that we do not always include. The first is the issue of spirituality. For people with addictions, there is often a spiritual or rational deficit that is contributing or is owned by their addiction and exploring historic or current spirituality. By this, I mean raising questions about whether a patient has engaged with traditional religious organizations. More of our patients than we know of may have had strong religious engagement because we often do not ask about it. For many of our other patients, the experience of their familial spirituality, for example their grandmother's favorite saint or their sense of closeness to an elder's practice who is no longer alive, brings another dimension of hope into our engagement.

The next piece is that many of our most difficult patients suffer from loss of purpose or meaning and are interested in being able to collaborate or produce something of value in the community. That may be a way that we encourage them to join groups or take up extra activities, but the desire to be altruistic cannot be underestimated in the population of the most hopeless and hard to reach.

Then finally we need to search for whatever areas of optimism they experience in their lives, relationships with other people or specifically with animals. We have had some success bringing animals into encounters as a way of allowing our members to experience hope again. Also, connection with any creative endeavor and a history of creativity has helped. Many of our members have had surprising experiences of success with putting up a painting or paintings in a shelter or even self-publishing poetry. All of these become tools for us to see the whole person and for them to trust us more.

The second piece is identifying people at high risk. CMS reports of high opiate users and insurance claims data tell us about extensive emergency department use for paying and so-called doctor shoppers. We need to be able to say to our people how they are seen and how we are finding them.

One of the things I found useful is not to talk about behaviors that put people at risk for overdoses. We know many people who have overdosed do not see themselves as people who have overdosed. Instead, we talk about reactions to opioid safety or accidental overdose.

We need to be open to the fact that prescription monitoring programs mean that every time they request opioids, everyone is going to know everywhere they have gotten opioids previously unless they are in a methadone addiction program because those opioid addiction programs do not show up on the PNP.

Now, in terms of collaboration, I doubt I have to suggest to this audience that we use all human sources we can to try to find people we are reaching out to. Service providers are often the point of contact, but there is another source we often do not necessarily engage with and that is family. More of our patients have some relationship with family than we expect. This can be tricky; we have to assess for the safety of engaging any other family member, particularly I am thinking about an intimate partner, violence or other kinds of family toxicity. Many of our patients have networks of kin-folk or other people who are engaged in their lives who will be helpful to us as we try to get people into care and hold them in care.

I believe this sculpture of two homeless people captures my kin-folk idea and the notion of us going out to where people are. Mobile teams that can meet people where they actually are living is valuable, but meeting where they are also thinking about common informed care, thinking about what's going on with them culturally and acknowledging both the social stigma and the right to refuse care and coming back to people who have refused care and still acknowledging their right to refuse care is even more valuable. So, I am going to talk about two more examples of. First is obvious to me because it's geo-graphic.

In my experience probably more than 90 percent of the women I see have had some experience of trauma. If you are opioid addicted and female, even if you did not have an experience of trauma before you came opioid addicted, it is very difficult for you to have carried on without having some experience of trauma.

What does it mean for us to think about trauma informed care? It is imminent to say, as our Chief of Psychiatry often says, thinking about trauma informed care is a lens that gives us a greater understanding, tolerance, and interest in the context of a person's life. Trauma informed care does not mean that we do not hold people accountable because when we fail to hold our members accountable, we fail to believe they can change. Instead, it means that some of the most frustrating and irritating aspects of our encounters can be processed differently by us. So, I am only going to talk about the five guiding principles; first is safety. At the beginning, anybody dealing with trauma needs to feel that they have a safe space to do it. Safety, for us as providers, means that we do not take risks in circumstances that are unsafe.

The next is authenticity, which is the trustworthiness and transparency people can feel from us. That is part of why we need to be able to say to someone you are going to be characterized as a “Dr. Shopper” because this is what the PNP does and that's what's happening in in this time.

The next is peer support. This is one of the primary ways we encourage people to use twelve step meetings, for example, by saying our patients deserve the support of other people who have been through them. No one can do this by themselves, neither our members nor our workers. Peer supports work to enhance empowerment and voice for our patients and, in the same way, holding onto a lens that includes looking at cultural, historical, and gender issues as they play out in our patient's lives.

Then, of course, this culturagram suggests the range of ways to think about context. One of the best ways for us to be able to engage with people, if we are going to be trustworthy, is to offer meaningful resources. Most often, this is through our outreach staff which includes outreach workers, recovery coaches, case coordinators, and care partners.

I am listing examples of services that we can offer, but also each time we engage across a service, it gives us a chance to bring the same kinds of member-centered respect such as when we help someone find a food pantry or go with them because they have difficulty transporting the food back to their house. We treat them with respect and engage people in the food pantry with respect. We help to break some of the stigma that makes it so hard for people to come and see us.

Finally, we have to take care of one another. The patients we are trying to reach out to have been highly stigmatized and often react to any kindness with bitterness and anger. We know that actually getting people into treatment works, and we know hopelessness is our worst enemy in this. We also have to remember to take care of one another. That is the other most critical arena of collaboration. All of us carry vulnerabilities that can be enhanced by our engagement with difficult patients/complex members unless we care particularly for ourselves.

Thank you very much for listening, and now I'm going to turn it over to John.

**John Lovelace:** Thank you, Barbara. That was a wonderful launching pad for what the rest of us are going to talk about. I appreciate your effort in helping provide the token to this.

Some of the common themes you heard from Barbara were treating people with respect, the importance of peers, and the importance of providing services to recipients that are beneficial to them, like concrete services as well as therapeutic and helpful services.

I am going to talk about a couple of interventions that UPMC health plan has implemented for high risk consumers. These are not entirely limited to people who are Medicaid recipients and special needs duals, but the majority of recipients are either chronically ill Medicaid recipients or people dually eligible with some significant health and life challenges.

UPMC is an integrated health system in Pittsburgh. It is a thirteen billion-dollar business that operates hospitals, a whole continuum of clinical care, with about 4,000 employed physicians. We have a large insurance division. We are about 3 million members in total and primarily in Pennsylvania; Medicaid makes up 410,000 folks and Medicare makes up 160,000; about a fifth are dually eligible. Part of this integration on the clinical and health plan side gives us a unique perspective in terms of integration of care and services. We are not a Kaiser, so the health plan has many other network members other than UPMC. UPMC health system has significant number of other payers in addition to the health plan. It is an open network model, but most of what drives us is an integrative delivery system whether with ourselves or other healthcare partners.

We are going to talk this afternoon about the population of people we are trying to reach, challenges with those folks, and some strategies around identify and engaging people with services. I will also present examples of concrete things we have done with services and outcomes.

This is a description of UPMC's special needs population; it would look no different than the disabled population of Medicaid. More than a third of the people have serious mental illness. That is not necessarily how they got into the program. They may have other comorbidities. The top DRG for admissions is psychosis in part because that population is large but also because readmission rates are high for this population.

Then you can see here a list of the medical complications associated with this. There are a significant number of people who also have longstanding substance use disorder problems. The overlap of people with serious mental illness and substance use disorder is pretty profound. Overall, about 80% of our enrollees who are none-seekers have either serious mental illness or substance use disorder. Most people have both.

Our enrollment is about 62% non-seniors and 38% seniors in this special needs population. Everyone is low-income. Two-thirds of the people have disabilities. A third of the people are aged and some of those have disabilities as well. Mental illness is evenly spread among the population.

The challenge, as Barbara suggested, is to think about what is it that engages people? Many folks do not see this as their primary problem. Outreach is more effective when it is focused on things important to the person rather than things important to us. At some point, we hope those things converge, but they may not. So, we look for hooks, if you will, that have a benefit from the person's point of view. That is often something such as needing help with a gas bill rather than needing help with their diabetes. Diabetes

might come later. It is related to the person's goals; everyone has goals. It may not be the goals you have, but people have, even in their worst of times, goals related to their families, children, jobs, partners or a variety of other social issues.

For most people, the idea of slowing the progression of one's diabetes is a long-term goal, and it does not have enough quick feedback to make it back. Finding goals that have both long and short-term impacts is key. It might be that their gas is turned on, or it might be that they filled both of their prescriptions. The general themes of engaging folks are in these three areas.

We use an analytic technique to identify priorities of people. A variety of data information is stored into one large data warehouse that the health plan operates. It includes the daily feed from our hospitals that run a discharge of the transfers. It is electronic and goes into a warehouse; no one sits and reads the paper. We are lucky we do not have to stand by the fax machine waiting for pieces of paper to arrive. This happens in real-time as the patient is being discharged, the results are being sent every day to the health plan.

We get some of the data from consumers directly. For example, we receive people's comments of their health risk assessments, comments from providers, and comments from case managers. All of these feed into our predictive models around who is in trouble now, who is likely to be in trouble later, and what are the signs of pending readmissions. We also have a whole series, if you look on the right-hand side of the slide, related to relatively real-time data we get from people who are willing to engage in remote monitoring and home base systems, wearable things, or cell phone text messages. Others come more spontaneous.

The health economics review team helps us prioritize folks, not only in terms of who is high-need, but who is more likely to be reachable and impactable. There are plenty of high-risk people who you cannot help too much with, but there are also plenty of people with whom you can.

One of our interventions is the development of community-based teams. Like many health plans 15 years ago, we were primarily telephonic. We were fairly slow learners. There were many years of not reaching people or leaving messages and not hearing back. We still do telephonic care medicine for whom that is useful. This group of populations is more focused on seeing people where they are.

About five years ago, we moved into the development of community-based teams. They are currently teams of nurses and community health workers. Community workers are those that are non-licensed and mostly people who have lived experience with substance abuse disorders, serious mental illness or disability who work in the field and reach the highest number of folks. We see about 500 people, and they are pretty high caseloads. These are temporary relationships for most people. We try to reach people and reconnect them to services and help them move forward.

Our engagement rate is around 30% of the people we try to call. In this case, we reach about 71% of people and engage about 2/3 of the people we reach. About half of the people we are trying to find or reach, we can actually engage with. Engagement means we have a conversation.

You can see on the right side of the slide the kind of efforts we work on. Generally, we are engaging folks who are engaged initially while they are in a hospital, and we follow-up with home reconciliation and care plans.

This is just a brief picture of the satisfaction results of this service. We have some nice improvements

around people's connection to services. The horizontal axis is initiation and Time 2 is about three months into the process. This shows you that as people get into this process their satisfaction continues to increase. Not everybody is perfectly happy, of course, but we see a nice trend. The more people are engaged, the more satisfied they are with what they are getting with us. This has to do with concrete results.

A common problem is opioid drugs. Most people start opioid drugs through prescriptions. That is the most common way people begin to interact with the system. Sometimes the patient themselves receives the prescription, sometimes the prescription is for someone else and the person takes it, and sometimes they buy it. You will see on the graph how that distribution tends to work out, but as in most cases, the opioid services get more sophisticated and push people towards illicit drugs and towards combination of drugs that are fatal.

HEDDS UP is a UPMC clinical management program, which focuses on trying to find people who are high emergency department users who, as Barbara talked about earlier, doctor shop. It does not mean they are necessarily criminals. Some people doctor shop because they have unremitting pain, addiction disorders, or maybe both. They may have chronic anxiety, COPD, or go to the ER for a whole variety of issues. We are focused on people who we think have addiction disorders.

The goal of the program is to engage people. This is not something you do for people who are resistant to treatment, but more for people who have trouble with pain management. We connect people to care managers who provide more effective primary care usage and better care coordination around things like chronic pain. We have positive goals around trying to reduce ED visits, costs, as well as such things as radiation exposure. We have had people who have as many as 40 CT scans a year. They go to a different place and get another CT scan, which has direct consequences and secondary consequences.

We have about a 20% success rate. We certainly want to continue to improve this. Outreach is both with providers and consumers. Due to the acceptance process of looking at this engagement, we have proactive efforts from consumers who want to help link themselves to effective treatment. There are more treatment options than there were even ten years ago.

If you look on the next slide, you see trends in comparing the utilization of services for people before and after the service. The vertical axis is visits, and the horizontal axis is time. On the CT scan graph, the vertical axis is incidence of CT scans, and the horizontal axis is time. The lower graph, across the bottom, shows decreases of inpatient admissions for people engaged in the process. These are the things you would want to be seeing.

The second intervention is a pregnancy recovery center. This has gone well enough that the state of Pennsylvania has encouraged people to build these services in a variety of other settings in maternity hospitals across the state. Basically, this is a maternal care prevention program for women addicted to opioids and managed with care management and the on-going behavioral health treatment.

Lastly, I will talk about the peer navigator program. Peers are important in this process and goal to engage people more effectively when they are in the hospital for a non-SUD related or SMI related issue. For example, if someone is in the hospital and fell down the stairs, perhaps they were drunk or following an auto accident. The peers are trained people who have lived experience in recovery themselves. There is one to each hospital. They consult with the patient, the patient's families, or with the staff. There are lovely stories of peer supports engaging people because they have more time than the medical staff to sit with a patient, talk about their own experience, help people identify their goals, and get them into

treatment.

On my last slide, you will see the impact of this rather small scale project on three hospitals. These are 3UPMC hospitals in the greater Pittsburgh areas. You will see the number of people touched and discharged to visits. With that, I think I'll wrap up and turn this over to Amy.

**Amy Joiner:** Thank you, John. I appreciate it.

Trilogy is a trauma-informed community health center serving adults across the Chicago area. Our mission is to support people and their recovery from mental illness by helping them discover and reclaim their capabilities, life direction, and well-being.

In the last year, Trilogy served more than 2,000 adults with mental illness and co-occurring substance abuse disorders in the Chicago land area. This includes all of Chicago and then a couple of the northern suburbs such as Evanston and Skokey. About 60% of our current client population are male, and 40% are female. A majority of our clients have a high school degree or some college. Most of them are between the ages of 36 and 65. 99% of our current clients are well below the federal poverty level. Most of our clients' average annual income is less than \$6,500.

Our current clients have either some form of a Medicaid managed care plan or have Medicaid-Medicare plans. Right now, Illinois has five different Medicaid-Medicare plans, and Trilogy accepts all of those.

At intake, about 18% of our clients are homeless, and about 40% require linkage to medical care and 75% require linkage to psychiatric care.

So, Trilogy receives referrals from a lot of different places. We also get a lot of self-referrals through word of mouth. I am going to talk a little bit later about our open access intake, but we tend to get more and more people just through word of mouth knowing that they are able to come in and get seen the same day.

We have pretty much wrap around services. We have different outreach teams, which I'll talk about a bit later in this presentation. We have Latino services, a variety of outpatient services, supported employment services, housing coordination, residential services, integrated healthcare services, Williams and Colbert Consent Decree, and also occupational therapy. Basically, we aim for Trilogy to be a one stop shop. Our north side is our main location. It is the one that has been there since 1971. We have the full array of services. Depending on what the client's needs are and what they are wanting, they can access all of these different services plus some additional ancillary services.

As I mentioned a couple slides ago about our intake services, a couple years ago to get a client in for an intake appointment, it was all done by phone. There would be a phone screening where someone may call you back, and then maybe it would be weeks later that the client would get their first appointment. We had about a 50% show rate, which is typical for intake departments.

So across the nation, through help from SAMHSA, National Council, and different trainings, we came across open access. Basically, open access has the ability to offer same-day intake. Since about the summer of 2015 at our main campus, we have had open access from 9:00 a.m. to 3:00 p.m. If an individual presents during any of those times, they will be seen by an administrative assistant who will check their insurance, and then they will be seen by a clinician who will begin their intake and start their assessment, and then they will have a follow-up appointment. Throughout this process, we have seen over

100 individuals pass through our intake every single month. Obviously, this gets rid of the no-show rate as well.

It quickly got moving once the hospitals and other organizations found out. Managed care organizations found out they could send their client who would get seen the same day. As long as they had some version of Medicaid and/or Medicare, we would be able to open them to services and get them linked to one of our teams.

Our integrated healthcare service started back in 2010. We had a SAMHSA grant, and we partnered with Heartland Health Center to provide wrap-around psychiatry health services. Our main clinic location is also on the north side, although we have a clinic on our west side, and we are looking to expand that to the northwest side as well.

In that clinic, we have psychiatrists working together with medical providers, doctors, APNs, and nursing students. We are able to do lab services there as well. Most recently, we opened a pharmacy there as well as on the north side location. So, it makes it easier for a client to access all of these services at the same place, and the collaboration and coordination between all their providers is more seamless than it ever was before.

One of the things that also happened is that the state of Illinois was sued, and through a settlement with this class action lawsuit, we began the Williams and Colbert Consent Decree program. The state of Illinois was sued for housing adults with severe and chronic mental health in something similar to a nursing home setting. The ADA said that most of these adults could be living in the community on their own with the right support. So, the state of Illinois settled, and because of this, places like Trilogy were brought in to provide transition services to these adults to get them in their own apartment in the community, link them with services at that same agency, and to provide the services that they need and want.

Many of these clients, who we have moved out of the nursing home into their own apartments, ended up meeting a community team, which is ACT (Assertive Community Team) services. ACT services are available seven days a week, 24 hours a day. They have on-call services, and people can always get in touch with the staff member as needed. Also, this is an evidence-based practice. Each ACT team at Trilogy has a nurse on team, psychiatrist associated with it, an employment specialist, a certified alcohol and drug counselor, a team leader, a peer specialist, and at least one recovery counselor. Right now, we have eight ACT teams across the Chicago area and soon be adding a ninth as we are expanding into the northwest side of Chicago.

For some of these clients and other clients that come in through open access, they may not need that high level of care. For them, we provide Community Support Team (CST). This is also a team model but is limited to eight staff including one team leader, one peer specialist, and six recovery counselors. They are also 24 hour on-call, but staff are generally available five days a week, Monday through Friday, and not really on the weekends. These are different from ACT as there is not a complete wrap-around service within the team. So CST teams utilize other ancillary programs to provide clients with the services they want such as supported employment, dual support treatment, therapy groups, etc. Like ACT, we have many CST teams. We have seven right now and are about to add an eighth team to expand to the north side.

I mentioned supported employment, which is one of those evidence-based practices Trilogy adopted years ago and received state and national recognition. It follows the IPS or individual placement services

fidelity model. For many of our clients, this is what they want the most. They want to work and get a job. They want to have that meeting day to day just as anyone else does. All of our clients, no matter what level of care, team, or program, have access to supported employment. The supported employment specialists are integrated throughout all of the teams; they go to the parent-team meetings and are part of that team, but they are specialized in helping clients find and access jobs that they want. They help to ensure there are not any hoops or hurdles for those clients to go through in order to get a job.

Some other ancillary services we provide are wellness services. Right now, we have our in-shape program, which consists of free mental health professionals and also personal trainers. It also provides a variety of other wellness services that the integrated health staff and counselors collaborate on, whether that means in groups or individually.

As John mentioned, we also have peer staff. The peer led drop-in center at our north side location is open 365 days a year, and we also offer the in-home peer recovery support services. Trilogy is adaptable and flexible and is often involved in new initiatives in Illinois. It has become the go-to for outside organizations in the state, city, different partnerships, and collaborations to ensure implementation of these programs.

These are few of the Diversion Pilot Programs that recently began. The aim of these is for us to go in and work with social workers in the ER and divert those from ending up in a nursing home back into the community with the right support from Trilogy.

The next slide is on training partnerships. This is just trying to continue to build on our staff. For trainings, we bring in a bunch of different outside collaborators to help with that. Lastly, we also provide community training for mental health first aid. We have been working with Presence Health, which is a huge hospital in Chicago, to offer these trainings. We have trained over 200 community members in 2016.

That is it for me. Thank you so much, and next up is Bill.

**Bill Nice:** Thanks, Amy; I appreciate it.

A lot of the information I will be mentioning has been referenced in a lot of the other presentations. The Camden Coalition of Healthcare Provider is a nonprofit organization working in the city of Camden to improve health and reduce costs. We are a citywide coalition of hospitals, primary care providers and community representatives that collaborate to deliver better healthcare to our most vulnerable citizens. We believe if we can improve care and reduce healthcare costs here in Camden, then it could be done for everyone and everywhere in America.

We innovate and test healthcare delivery models to improve patient outcomes and reduce the cost of their care using data driven human-centered practices. We draw on the experiences of our clinical teams and patients. Our coalition staff also work to transform healthcare cost and delivery at the policy level. Since 2002, we have been demonstrating that human-centered coordinated care, combined with smart use of data, can improve patient's quality of care and reduce expenses and affect inpatient stays and emergency room visits, which is better for everyone.

So, the Camden Coalition members share information through the Camden Health Information Exchange. With relevant real-time data across disciplines, our care teams connect quickly with people who have high rates of hospitalizations and emergency use and help them address their complex needs. Our care teams

include registered nurses, licensed practical nurses, health workers, social workers, and a clinical psychologist who assists the team as a behavioral health consultant. All of our engagements center around the idea that therapeutic relationships start with a framework of acceptance. To build trust and collaboration, we view those around us with unconditional regard. We are practicing unconditional positive regard, which means that we are accepting and respecting others as they are without judgment or evaluation. To continue to build that therapeutic relationship, we need to show empathy. We need the ability to understand and share the feelings of another by remembering a time when we felt similar emotions.

To promote safety, we also recognize patient's self-determination. We use harm reduction as a set of practical strategies and ideas aimed at reducing consequences of various human behaviors, legal and illegal but especially those associated with drug use. The final features focus on the prevention of harm rather than the prevention of drug use or harmful behavior itself. The focus is on people who enact the behaviors.

To help the person identify their own personal motivation, you use motivational interviewing as a conversational treatment that engages the patient's motivation to change based on his or her needs or wants rather than a provider's goals or our own care team goals.

We also use a trauma-informed care approach to patient engagement. This framework for care realizes the prevalence of trauma in a population. It recognizes the presence of trauma symptoms in an individual and acknowledges the role trauma has played in the patient's life and seeks to avoid re-traumatization.

We also discuss childhood events. These topics, such as abuse, neglect, witnessing parental conflict, mental illness and substance abuse, have profound consequences on one's health and behavior. Each event increases the level of stress impeding their healthy development and resilience. Remembering that something as simple as a touch or closing the door can trigger somebody's thought of a previous event. Re-traumatizing the patient is important to consider when we are working with our patients.

So, we take these factors into consideration to provide a holistic biopsychosocial centered approach that looks at the person as a whole and meets them where they are. We, then, use an engagement framework called COACH to move through our intervention. This is an acronym that shows how we interact with patients and take people from where they are to where they want to be. Each letter stands for a different philosophy or tangible tool that our teams have used in the field.

We basically start with checking the backwards plan. What does the person want to work on? We use that information to connect tasks with the visions and priorities they identify as important to them. Backwards planning is meant to address how to build a care plan. As far as how many people will be building the care plan? No one. Instead, this is a tool for starting to work with patients. It is a physical tool to highlight the patient's priorities and to begin to discuss where the person wants to be. What do I mean when I say that? Well, I would like to share an image and a story with you.

This is a picture of Michael, a previous patient of ours. We recognized a number of years ago that there was a disconnect. Our care teams thought something was important and wanted to work on that, and the patient thought something else was important and he wanted to work on that. We entered this tug of war scenario that many of us might be familiar with. So, we stopped and said, Mike, write down every single thing you would like us to help you with, no exceptions. It does not have to be medically based; just write down everything you want us to work on.

If you look at what he wrote down, you will notice there are only two things that are medical. This was our “aha” moment where we saw where the tension had been coming from with our patients. We had been addressing their needs the wrong way.

We started to ask all of our patients to do this. When we would sit down with them, we compiled all our answers, and we boiled these down to 14 distinct care plan domains we could use to help identify what was important to work on and how we go about doing that.

If we take a second to orient ourselves to the backwards planning board, we see the left side of the board defines what participants feel they need to work on and what they do not. If we look at the top of the board, that determines when they would like to work on something, now or later. By breaking these into quadrants, we see the upper left-hand square highlights what the person identifies as being important to work on right now and the lower-right square is what does not need any work in the eyes of the patient. This can be used to highlight their strengths and successes for all of the things they have already completed prior to us working with them.

The top right and bottom left include opportunities for discussion and help us to get to know the person's thoughts better. Why does somebody want to work on this later? Why does somebody feel this is not something they need to address right now? That creates an opportunity for robust discussions, and it has been a useful tool.

When we are looking at a sample backwards planning board, we see domains including things like identification, having transportation, seeing if they qualify for insurance or other benefits, and maybe food and nutrition. There are many more, some that are socially based and some medically based. When we connect the task with something bigger in their life, and when I say something bigger I mean more than just staying out of the hospital, we start to ask what is really important to you? Understanding these larger visions for their life can be powerful because when we are deep in the work, and maybe struggling to get through the different goals we have set forth with them, we can start to tie the smaller tasks to the bigger picture for what they want for their life. We can ask them to remind us why they want to get a job. I know it was not just because of money. This is a way to motivate people in difficult times and figure out why they want to do these things.

What was interesting was when we started to look at these wants or goals with the domains, we noticed something. We found there were three common themes that came up repeatedly when we talked to our participants. Basically our patients wanted first to feel significant. They had this deep desire to feel important and recognized and to feel that they are contributing to society in some way. They wanted a sense of love and belonging, a deep desire to feel loved and cared for. They also wanted certainty and safety. They had a deep desire to have controlled surroundings.

It is about having a plan and knowing what is coming next in your life. So, we show these test tubes that can be full or empty. These tubes are not meant to categorize people in an absolute sense. They are not meant to label and judge people, but instead they give comments, so we can start to think about how we can best help our patients stay healthy. These are not simple test tubes that impact our patients. We have all experienced moments where we may have felt low insignificance or love and belonging or certainty and safety. For us to be therapeutic with a patient and to show true empathy, we have to consider what that was like in our own life. When we have also been low in that test tube, we have to remember those feelings and recognize that that is what our patients are going through. However, doing so requires us to go through the case with incredible vulnerability, which can be a good thing because it allows us to connect with other people, but it can be painful for us as well.

That period of vulnerability may be too painful, and if that is the case, it may be difficult to help our patients if we are both identifying as being low in the same test tube. It is okay to have those triggering events, but we need to be aware of what is going on with our test tubes as well as the patient's for us to give the best care possible.

After we connect task to vision using the backwards plan, we move on to observing our normal routine. We had to figure that if somebody wanted help, we need to figure out how best to accomplish those tasks. While observing somebody's normal routine is a simple idea, it is much harder to implement in practice.

The idea is that before we step in and try to fix a problem and before we look for solution in our own way, we need to step back and ask questions. This can be really powerful. What stood out to me when I started working in Camden and working at the coalition is that our patients are incredibly resilient. They are resourceful and have been managing their health and social needs well before I or an organization came into the picture.

Now, that does not always mean they were doing so in a healthy way, but I think it is important to know that our patients have systems in place. They have ways of doing things they are already comfortable with. Stepping back allows us to find out what has worked for them in the past, so we can ultimately build on what they already do well and what they could maybe use improvement on.

Through problem solving, we are helping them to build the capacity to maintain these systems once we are gone. They are finding new ways to solve problems instead of us having to solve problems for them or equip them.

How do we help someone build a path they need to solve problems on their own? Since the primary focus of our intervention is to set patients up with the knowledge, tools, or skills so they can manage their own health needs when we are no longer in the picture, we had to figure out how to get them to that point. Not to simplify the patient provider relationship, but we recognize that the process is actually not that different from coaching somebody in any given sport.

So, we will use soccer as an example. Let's say that you want to learn how to do a new move. What do you do? First, you watch your coach. They demonstrate the activity. You watch to learn what the coach is doing, and you take that in during the process. Second, you practice that activity, and you do so under the guidance of your coach, so they can show you what you are doing well and maybe what you need to improve. Lastly, if you practice enough, sometimes for a short period of time, sometimes a long period of time, you develop the ability to perform the skill on your own.

So, we look at our patient's routines and what is working for them and what is not working for them. Then, we assume a coaching staff where we model the skill. We let the patient watch so they understand how they can accomplish this. We do the skill together while filling in some gaps or we have them demonstrate it, which allows the patient to lead their own problem solving, and we are there just providing support and acknowledging their strengths. By tailoring our coaching style, we can help patients develop long-term problem solving skills.

Lastly we move on to highlighting the person's progress data. Let's think about a situation we are all familiar with, whether it is personal or from what you see online or on TV. When people want to get in shape and lose weight, what are some of the things they do? You often see people have a before and after picture and, a lot of times, pictures in between. Why are they doing this? Well, apart from wanting to show off to their family and friends, they want tangible evidence of the progress they are making because

the evidence will continue them towards reaching their goal.

We can apply the same mind-set to our patients. During our intervention, we can adjust it as needed to meet changing circumstances, and before graduation, we can review all of the goals we had set in the beginning, discuss what has been completed, and what is left to work on. This shows somebody what they have done and what they are capable of accomplishing. This show that they can actually do this on their own. By accepting those we work with for who they are, helping them make plans based on where they are, and developing a vision based on where they want to be, we can build therapeutic relationships that help our patients with complex needs accomplish their goals while also accomplishing ours.

That is it for me. Thank you.

**Karen Cheung:** Thank you so much, Bill, and thank you to Dr. Herbert, John, and Amy as well for your presentations. I want to thank you all the participants today.

At this time if you have any questions for our speakers, please submit them using the chat feature on the lower left of the presentation. You can go ahead and type in your comments and submit it and we'll go ahead and start with the Q&A portion of this Webinar.

Someone had asked about getting a certificate of attendance. We are not offering CEUs for this webinar, but if you would like a certificate for attending today's webinar, you can go ahead and e-mail RIC@Lewin.com, and we will send you a certificate for attendance.

We have a question for John about admissions by DRG. I believe there was a slide in your presentation with psychosis being the top DRG. That data was from 2011 and 2012, and one of our audience members was wondering are those patterns the same today?

**John Lovelace:** Yes, they are.

**Karen Cheung:** Great, and I have a question for all of the presenters. Dr. Herbert John, Amy, and Bill, if you want to go ahead and chime in. In cases where individuals have mental health and co-occurring substance abuse, do you use different tools or strategies for each condition? Can we apply the same tools and strategies for both?

**John Lovelace:** I think you can apply the same to both understanding each person is different but the same idea should work pretty broadly.

**Dr. Barbara Herbert:** I think that is actually a really complex question. We know that there is data for people who have alcohol use disorder and depression. If you treat their depression while you are treating their alcohol use disorder, they have a better outcome of being able to get into recovery. I think the intersections are actually quite complex. In my individual care, I often talk to patients who have substance abuse disorders and use a metaphor that part of their brain has been high jacked. If part of their brain is also not working because of underlying mental health issues, this is complicated for people to absorb. So, I think we need to be distinctive in what we are doing and to use tools wherever we can. In Massachusetts, many of the overdoses that we are seeing now include non-opioid substances. Of course, they include benzodiazepines in many of the fatal overdoses, but we are also seeing overdoses that include things like Adderall or atypical anti-psychotic medications.

Substance abuse disorders is about the person, not about the substance. I think this terrain is much more

complicated to negotiate than we would like it to be, and I feel like the person who raised that question probably has that experience.

**Karen Cheung:** Thank you so much, and here is a question for Bill. Just curious as to how some of your clients react to the backwards planning board? How receptive are they to this idea?

**Bill Nice:** Most of our patients appreciate it because we are not focused on, for example, telling them to stay out of the hospital or that we need to keep them out of the emergency room. What we are really asking of them is what is important right now, and then we listen to them. Oftentimes, we find that our patients feel like they are not necessarily being listened to; that they are being talked at and directed to do certain things without understanding the full complexity of the environment they live in and the situations that may be occurring in their life. The backwards plan allows them to bring up certain topics that other people may not be asking about. If somebody needs to get to a doctor's appointment, but they do not have transportation, are people saying they need to go to their primary care physician without asking if they have a way to get there? It is also important to take that second step to not just ask if they have a way to get there but also how they normally get there.

That backwards planning allows them to tell their story and gives us a great chance to see some of their challenges. It also highlights some of their successes and their resiliency to create that relationship bond. We are able to say to them, "I see you are struggling, but maybe you are not giving yourself enough credit as well. This is what you do really, really well, and I think you can use that in other areas that you want to work on."

**Karen Cheung:** Great. Thank you so much. We have time for one last question. I think motivational interviewing was mentioned across a couple of the presentations today. Do any of you have articles you can recommend for those in the audience as a reference or tools that you would recommend that others use if they were interested in starting to use motivational interviewing with their clients or patients?

**Dr. Barbara Herbert:** Well, the expert tools such as screening, brief intervention and referral to treatment (SBIRT) that are widely available provide a good framework for being able to ask about alcohol use disorder, and to some degree, they set us up to be able to create a model for motivational interviewing. There is a strong federal support for SBIRT.

**Karen Cheung:** Thank you, Dr. Herbert. The slides for today, the recording and transcript will be available on our website shortly.

A huge thank you to all our speakers. This was very informative, and thank you to all our participants for attending and participating.