CHESTNUT HEALTH SYSTEMS | chestnut.org

Wellness Connections

Presented by:
Emma Melvin, LCSW
Director of Integrated Wellness
Molly McVey, LCSW
Associate Director of Wellness Recovery Services

Cultivating Innovation

Key Areas of Focus:

- Staff qualities, skills, and training
- Programmatic structure
- Client engagement
- Relationship building

Supervisor Skills and Traits

- Tolerance for ambiguity
- Experience providing reflective supervision
- Willingness to spend time on staff development
- Prepared– has resources available upon hire; like cell phone and laptop with remote access

Staff Qualities, Skills, and Training

Hire right! Be direct in the posting.

The Targeted Care Specialist **conducts street outreach** to develop relationships and build rapport with clients. An ideal candidate will use **supportive, strengths-based engagement strategies, including motivational interviewing and harm reduction principles**.

Duties include:

- Assisting individuals with accessing appropriate mental and physical health services, housing, substance use treatment, employment and any other services that assist an individual to improve his/her quality of life.
- Provide screening, triage, crisis intervention, and referral to supportive services, with the goal of assisting individuals with moving towards their recovery goals.
- Candidate must be organized and complete all necessary paperwork to track client progress, and **meet with established clients on a weekly basis** to review, evaluate, and support recovery goals.

Use behavioral based interview questions:

- Tell me about a time you had to make a split second decision. What skills did you use?
- Tell me about a time when you had to be very adaptable in your role.
- Give me an example of a time you had to accommodate unplanned activities or demands.
- Explain what healthy boundaries mean to you and how you've demonstrated them.

“Green flags”

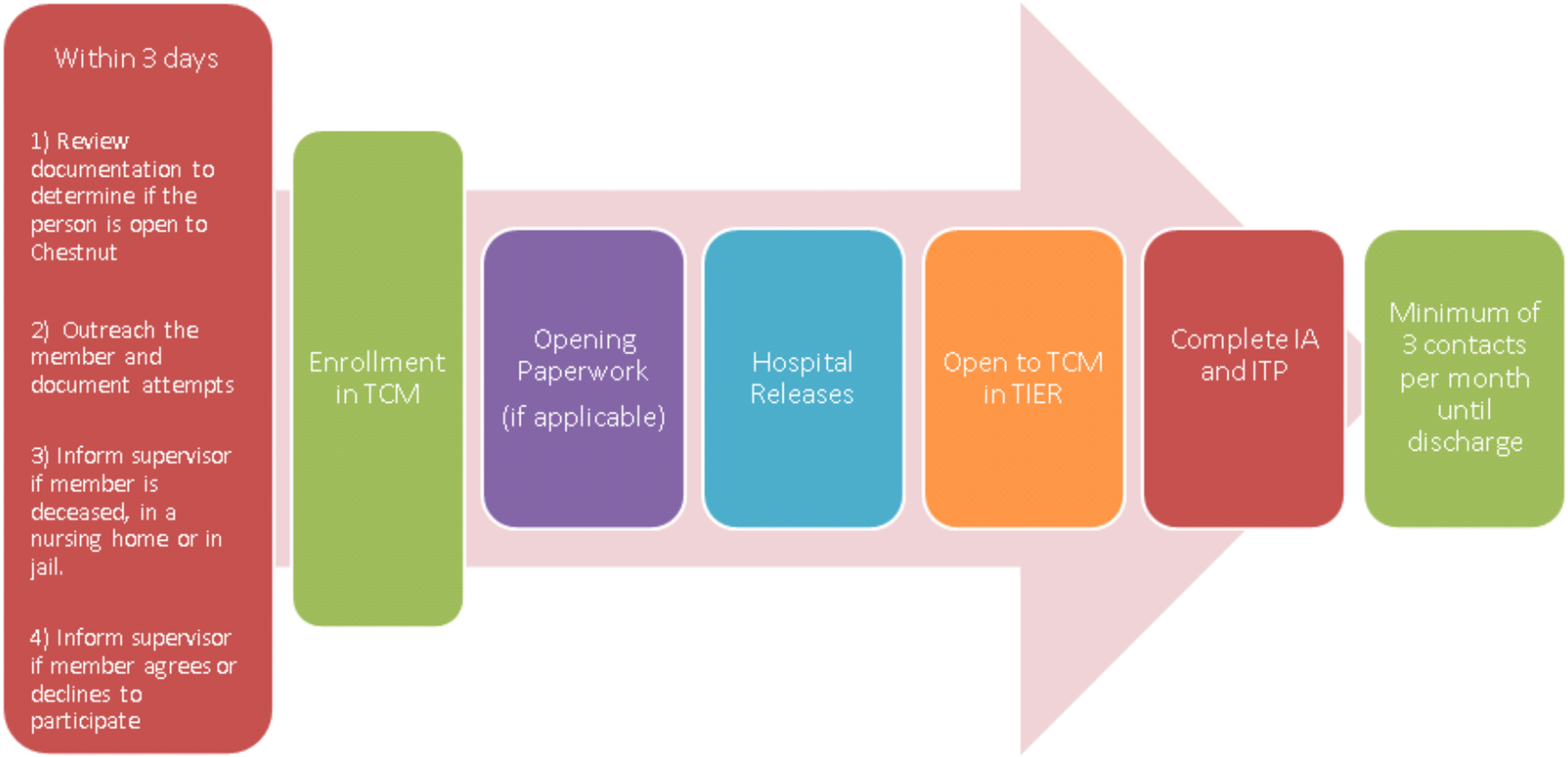
Awareness of and interest in:

- Person- centered, strengths based
- Shared decision making
- Social determinants of health
- Culture of poverty
- Homeless outreach
- Harm reduction philosophy

Structure and Organization

- Tips for getting started
  - Workflows for staff outlining specific responsibilities and timeframes
  - Emphasize organization and task tracking through worksheets, lists, charts, etc.
  - What can your EHR do for you?

TCM Specialist Requirements



Hospitalization- the following protocol is **REQUIRED**, all steps must be documented in TIER

Tracking Engagement

Engagement Log
6/11-6/15

Client	Outreached T/F/Both	Contacted y/n	CRU Stay	Hospitalized/Location	F2F Date	7 day FUH: Name of L	All Notes Completed
Pete Example	Both	Y	N	6/11 GRMC	6/11	6/15 Molly	☒
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐
							☐

Data Collection

Electronic Health Record Report

TCM Summary Of Client Contacts 6/1/2018 to 6/30/2018							
Client ID	Client Name	Number Of Contacts	Number Of Home Visits	Number Of Office Visits	Number Of Phone Contacts	Number Of Attempted Contacts	Number Of Client Centered Consultations
[redacted]	[redacted]	11	4	3	4	1	2
[redacted]	[redacted]	17	5	1	11	1	2
[redacted]	[redacted]	3	2		1		
[redacted]	[redacted]	9	4	1	4		
[redacted]	[redacted]	3			3	4	
[redacted]	[redacted]	1			1	4	
[redacted]	[redacted]	7	4		3		
[redacted]	[redacted]	6	2		4		1
[redacted]	[redacted]	1			1		
[redacted]	[redacted]	3		1	2	2	
[redacted]	[redacted]	6	3	2	1	3	
[redacted]	[redacted]	11	3	1	7		
[redacted]	[redacted]	1	1			4	1
[redacted]	[redacted]	4	3		1	2	2
[redacted]	[redacted]	4			4	1	
[redacted]	[redacted]	6	2		4	2	1
[redacted]	[redacted]	1			1	2	
[redacted]	[redacted]	2			2		
[redacted]	[redacted]	2	1		1	2	
[redacted]	[redacted]						
[redacted]	[redacted]	6		2	4	1	
[redacted]	[redacted]	2			2	2	
[redacted]	[redacted]	7	3	1	3	1	
[redacted]	[redacted]	4	2	1	1	1	2
[redacted]	[redacted]	4	4				
[redacted]	[redacted]					4	
[redacted]	[redacted]	3	1		2	7	
[redacted]	[redacted]	4	3	1			
[redacted]	[redacted]	5		2	3	2	1
[redacted]	[redacted]	1			1	2	

TCM Summary Of Client Contacts

Follow Up after Hospitalization (FUH)

Client Name	Hospital	Reason for Hospitalization	Date of Hospitalization	Initial Visit Completion Status	Date FUH is Due	FUH Completion Status
			Admission: Discharge:	Attempted Completed Insufficient Notice		Pending Attempted 1 2 3 Completed Rehospitalized
			Admission: Discharge:	Attempted Completed Insufficient Notice		Pending Attempted 1 2 3 Completed Rehospitalized
			Admission: Discharge:	Attempted Completed Insufficient Notice		Pending Attempted 1 2 3 Completed Rehospitalized
			Admission: Discharge:	Attempted Completed Insufficient Notice		Pending Attempted 1 2 3 Completed Rehospitalized
			Admission: Discharge:	Attempted Completed Insufficient Notice		Pending Attempted 1 2 3 Completed Rehospitalized
			Admission: Discharge:	Attempted Completed Insufficient Notice		Pending Attempted 1 2 3 Completed Rehospitalized

Difficult to Contact Protocol

Client Name_____

Staff Name_____

Before you can list someone as unable to reach, you must complete and initial all options on this protocol. Each step should have a note completed as well.

Initials:

_ Check in Tier (Master Search & Inquiries)
_ Check with Health Center to see if they're a client
_ Check Hospital Log for recent hospitalizations
_ Check with Genoa for pharmacy claims
_ Reach out to Insurance Company for more information
_ Google/White Pages
_ Probation/Parole
_ Municipal and Circuit Court Systems
  - IL DOC: https://www2.illinois.gov/idoc/Offender/Pages/InmateSearch.aspx
  - Inmate Search: http://www.sheriff.co.st-clair.il.us/corrections/imnage/Pages/default.aspx
_ Sex Offender Registry: https://www.isp.state.il.us/sor/
_ All notes Completed

_____

Clinician Signature

Programmatic Structure
Other considerations

- Flexibility- work hours and location
- Staff autonomy-confidence making decisions on the spot; including setting firm boundaries
- Quick access to resources like hotels, groceries, bus passes, and personal items.
  - Consider setting up accounts for quick access
  - Stock up your petty cash!$!
  - Keep credit cards and cash easily accessible

- Providing transportation
  - Number one need of clients!
  - Invest in agency cars and bus passes

- Support with primary care needs
  - Develop health literacy
  - Have a ‘go–to’ for physical health related questions

- Consider “Wellness Incentives” for clients who meet with staff 3 times each month.

Engagement

- People like to know
  - Who sent you?
  - What do you want?
  - How much is it?
  - Who do I call if I need something?

WELLNESS CONNECTIONS

You have been referred to our program by your insurance provider. All services offered through Wellness Connections are provided at no cost to you! We are available to assist you in meeting life's demands in a variety of ways.

WE CAN HELP YOU WITH:

- Improving your physical health
- Referral to psychiatric care
- Medication needs
- Smoking cessation
- Linkage to housing resources
- Developing employment skills
- Going back to school
- Classes to support wellness
- Spending more time with others
- Planning for crisis situations
- Building supports related to substance use
- Navigating the legal system

To sign up or learn more about
Wellness Connections, please contact:

Molly McVey, LCSW, PFT
618-416-2845 (office)
618-365-05874 (cell phone; call or text)

Chestnut
health systems
chestnut.org

CHS-1496

HOWEVER!

It’s okay to ‘just’ help them meet their immediate needs

- Try to keep things PERSON focused, not SERVICE focused
- **Do not say:** “Do you want services?”

Engagement

- Being comfortable with being honest and direct
- Considering familial needs (employment, family shelter, school)
- Non-traditional forms of client engagement

  “I didn’t talk to him but I talked to the landlord and they talked to his cousin

  giving me the okay to call the cousin and come by.”

Meet Tim

- Tim is a 28 year old, biracial, male experiencing homelessness, substance use, and behavioral health concerns. Tim was flagged by his MCO as having frequent hospitalizations and needing additional support.
- We received Tim's name and contact information on November 1, 2018.
- After several failed attempts to contact Tim…

November

WE FOUND HIM!

…asleep in a staff office.

Through out November, Targeted Care Management staff aided Tim in the following:

- Adding Tim to the housing wait list
- Helping Tim get on the Crisis Residential Unit
- Connecting with Substance Use Disorder services
- Connecting with a pharmacy
- Aiding in discharge planning during Tim's hospitalization.

Tim left the CRU after responding to triggers during a phone call with his mom.

Wait a Minute!

All our workflows and linkages aren't working!

Tim sought support through hospitalization **5** times during November.

What can we do differently?

DECEMBER

Throughout December TCM helps with:

- Reconnecting with Tim
- Helping Tim pursue residential substance use services
- Providing shelter referrals, food, & free cellphone
- Coordinating with his probation officer
- Supporting Tim in seeking employment
- Following up with hospitalizations and discharge planning.

Recovery is a Process

We are starting to build a relationship with Tim! He is starting to feel comfortable reaching out to us when he needs something.

Tim sought support through hospitalization **2** times during December.

January

Throughout January, TCM helps with:

- Switched staff
- Connected Tim to resources that would pay for a hotel stay and provided information on local shelters; Tim chose not to use the options.
- Participated in discharge planning and encouraged Tim to identify his next steps
- Provided hotel stay, food, and filled medications
- Coordinated intake with Salvation Army ARC
- Provided transportation to Springfield; Tim chose to leave after 1 hour.

Tim returned to the hospital after TCM staff stated they would not come pick him up from Springfield.

Tim started testing the relationships he was building and focused on the tangible goods we could provide to him.

Tim accessed the hospital for additional support **3** times in January.

February

Throughout February TCM assists Tim with the following:

- Completion of homeless verification
- Staffed with MCO regarding “secondary gains”
- Provided additional housing options and referrals
- Connected with Med Plus at Chestnut
- Honest and direct conversation about plan sustainability
- Hospital discharge coordination

AND finally…

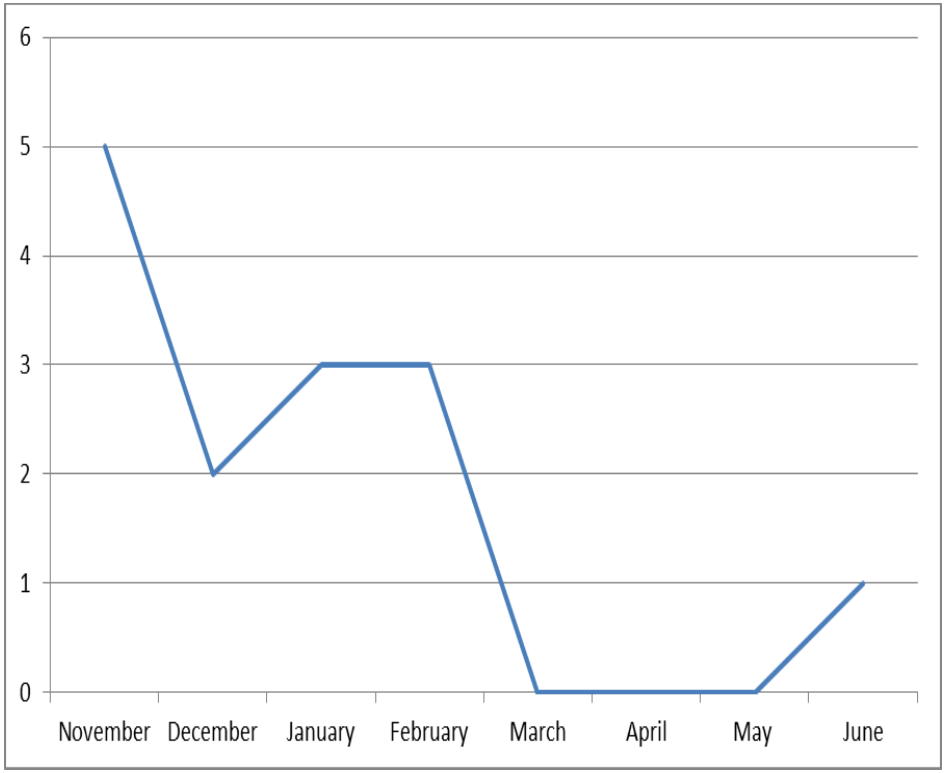
Tim discharged from a hospital in Champaign, renewed his ID, and independently initiated a screening for the Adult Rehabilitation Center in St. Louis.

- TCM staff transported and assisted with admission to the Adult Rehabilitation Center in St. Louis

After **45 days**, Tim left the Adult Rehabilitation Center and paid for his own hotel stay and reached out for assistance getting on the CRU.

Tim accessed the hospital for support:

- November: **5** times
- December: **2** times
- January: **3** times
- February: **3** times
- March: **0** times
- April: **0** times
- May: **0** times
- June: **2** times
- No hospitalizations from July to present!



Relationship Building

Buy in is essential!

- Administrative Departments
- Clinical Departments
- Community Relationships

Administrative Departments

- Medical Records
- Accounting
- Purchasing
- Human resources
- Scheduling
- IT Department/Electronic Health Record

Clinical Departments

- Psychiatric Services
- Housing Administration/Housing Programs
- Pharmacy
- Substance Use Disorder Services
- Crisis Outreach and Residential Unit

Community

- Local Motels
- Shelters
- Hospitals/Emergency Rooms
- Primary Care Providers/FQHC
- Pantries
- Other Community Resources

Our Guiding Principle

Go to the people. Learn from them. Live with them. Start with what they know. Build with what they have. The best of leaders when the job is done, when the task is accomplished, the people will say we have done it

ourselves.

Lao Tzu