A CMH’s Role in Primary Care Delivery: Many Strategies, One Goal

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Honor Potvin
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Genesee County Community Mental Health
2nd BH/Primary Care Conference 5 December 2012
None of the presenters has any professional or personal relationships to report in the last 12 months that would bias the material contained in this presentation.
Objectives

• Understand the role of in-community partners and sources of support outside the community
• Understand the “flaw” in the traditional idea of “health home,” even an “integrated” one, and why CMH has an answer
• Describe the components of a “community-centered health home” expressed in a public entity CMH
• List at least three strategies any CMH can use to move toward improved health status for its consumers
• Articulate at least three reasons why a Michigan CMH should not to pursue 330 funding or even look-alike status
Why We Applied for 330 Funding

• “It seemed like a good idea at the time”
  – Dan Russell
• Growing need in the county (still)
• Expands the safety net
• Appeared to be a steadily growing funding stream (really does have bipartisan support)
• Potential for new federal money and jobs in a “dying” area
Would We Do It Again?

• Probably. Maybe.
• Application was extremely difficult (2010)
• Post award is even harder (2012)
• A two-year delay between application and award created something of a derailment; most plans and agreements had gone by the wayside
• Closer timing probably won’t be as bad
A picture is worth a hundred thousand HRSA words. For example:

Program office has acknowledged your request to not implement the proposed change to the scope of project.

Submission Tracking Number: SCPV003579
Grant Number: H80CS24106
Grantee Name: Genesee County
Additional Comments: N/A

System User
I haven’t seen my table in two years.
Pat and HRSA. Not a re-enactment.
Tim Lawther, GCHC CEO.
10/3/12. OTJ 2 weeks; 5 days to opening.
Yes, that’s a bag of chocolate chips*

*Honor’s desk at CMH. At home: 2 more computers, 3 more screens, + iPhone.
Why “medical home” misses the point

Per Doug Eby MD*

Primary care, at its best, is a set of functions, roles, and relationships that are “built optimally into everyday life...focused on the household and the whole person, [their] values, [their] goals, [their] entire health journey...”

Primary care, at its worst, is a place where medical things are done to patients, no matter how friendly and colorful and even if certified as a “patient centered medical home”.

see www.southcentralfoundation.com
What’s better than PCMH?

Per Clem Bezold PhD*

• The GOAL is better *health*, not better *healthcare*
• The point is to recognize and address underlying factors (motivators) that shape patterns of illness, to improve health equity across patient populations, and prevent illness in the first place
• “Community-centered health home” is better
• New models for CHCs to move beyond clinic walls to address population health, and to integrate community prevention into patient care; i.e., community mental health – *the experts at safety-net, in-community integrated care!*

*see [www.preventioninstitute.org](http://www.preventioninstitute.org)
The reason for integrated care

Paraphrasing Doug Eby ~
The “primary medical diagnosis” is the individual’s social situation – his isolation, his hopelessness, his depression. To connect with “what gets him up in the morning” is to set the stage for successfully addressing his chronic conditions – his COPD, his CHF, his diabetes.

Plus, as a bonus: ↑HEDIS, etc., ↓cost

Ideal: GCHC’s care team model with embedded SW.
Bird or Rock?

Control: Who really makes the decisions

1. Control – who makes the final decision influencing outcome?
2. Influences – family, friends, co-workers, religion, values, money
3. Real opportunity to influence health costs/outcomes – influence on the choices made – behavioral change
4. Current model – tests, diagnosis, treatment (meds or procedures)

90% of care
Why it’s about birds, not rocks

http://www.youtube.com/watch?v=tLnZ3_AccoU
Other considerations

• PCMH isn’t a bad place to start, we just can’t stop there

• Quality care starts at the reception desk and moves right on through from the exam room to the pharmacy (whether onsite or not) to the follow up

• Developing a comprehensive training plan is key. Think big picture, don’t stop with all staff. What about community education?
Pre-award chronology

**2009:** Community analysis, meetings with MPCA & DCH, conversations with other PE FQHCs in other states, site visits to other PEs.

**2010:** Further needs assessment; established referral agreements; attended trainings; TA conference calls; document prep; presentation to GCCMH Board; NAP announced *(HRSA-11-017)*, due Grants.gov 11/17/10; HRSA EHBs due 12/15/10; GCCMH Board voted to support application; hired SPH consultant to (a) perform geo-mapping and in-depth data analysis, (b) conduct surveys, and (c) solicit members for the board and advisory groups; decided to pursue 330(h) and 330(i) only; CEO presented plan to the Genesee County BOC (extra step for public entity).

**2011:** Received letter of non-selection for 330 funding 10-2-11. All 22 Michigan applications rejected. But received ACA Health Center Planning Grant *(HRSA-11-021)* on 9-15-11 for 330(e) effective 9-1-11; one of only five mental health agencies in the country. Hired SPH grad students to assist with the HCPG grant, and hired an Epidemiologist, who eventually updated the two-year old stats in the 330 NAP narrative.
Post-award happenings

• June 20 – Kathleen Sibelius comes to Detroit to make an announcement of NGAs; we are included. We receive the NGA dated June 13, not to be confused with the start of the project which was June 1
• The NGA tells us our Project Officer’s name; the PO is not our PO, but rather the yet-to-be named PO’s supervisor, and he can’t tell us when the 120 days actually started
• The actual Year 1 money was reduced to 11 months, unclear why.
• Our real PO was named 7/23 and is new to the job, new to NAP grantees, and new to PE
• The NGA names a “condition” related to fixing the co-applicant agreement, but no one can tell us what’s wrong with it
• Communication is poor; EHB rarely works
The 120 Day Story

- It took 90 days to recruit the CEO; 90 days to find a new Homeless site when the planned site fell through; HRSA has yet to approve the new address*
- It took 115 days to recruit the CMA, Office Manager, FNP, and MD preceptor; the FNP started two weeks after opening (with interim help from community partner Hurley Medical Center!)
- We hired an LLMSW when we couldn’t find an LMSW
- We still don’t have the PH site settled with HUD (who has difficulties with HRSA)
- We applied for 340B pharmacy, but they deleted our application after 60 days without telling us because the new address* isn’t approved; we have to start over and now wait until April 2013
- EHR was RFP’d and selected (NextGen, with support from Virtual CHC (MPCA)); original estimates of go-live *greatly* underestimated; we started with paper.
The essential point: “Omnishambles”*

Everything takes MUCH longer and is MUCH harder than you expect, so allow double quadruple the time anticipated in order to meet your deadlines.

*Oxford Dictionary UK Word of the Year for 2012, meaning “messed up in everyway from the very start.”
Key Compliance Problem Areas for MI CMHs (and others)

- Governing board (waivers, etc.) and governance in general is extremely problematic.
- PE model is not understood or liked; there is NO ONE at HRSA who can succinctly advise PEs.
- Addressing conditions (specific and grant-related).
- Re-writing the NAP addressing “weaknesses” that are not explained anywhere.
- Verifying “scope” (not easy, not clear); e.g., physical sites, key staff, services to be provided.
- Commencing the CIS process, which required the EHB to *work* (it didn’t), and us to understand the proper sequence (we didn’t/don’t).
Many, many iterations of governance design
Barriers

• Registration/entry deadlines are not laid out anywhere and the sequence of events is not clear (e.g., do the 340B AFTER CIS)
• Inspections and permits need to be verified (we lost a site because we made an assumption)
• Licensing requirements are complicated (lab, pharmacy)
• Recruitment challenges especially NPs, MDs/DOs, and LMSWs. Lots of CMAs and office staff.
Barriers (cont’d)

• Communication is extremely time consuming with multiple federal agencies that do not communicate with each other (e.g., within HRSA: staff vs. consultants vs. policy people vs. program people vs. grant management people; HUD vs. HRSA)
• Emails bombard you and have to be read in detail by all team members
• HRSA CIS and prior approvals do not have a defined timetable -- it can take “weeks or longer;” and there is an elaborate, unspecified domino effect
• EHB is awful
What the EHB feels like
Barriers

• $$$
• A 330 grant award is insufficient for start-up
• A significant grantee match is expected
• The CMH funding mechanism, as is, does not support paying for primary care and activities related to primary care, including the start-up of a CHC with or without 330 funding
• At present a CMH can only use unrestricted funds.
Budgeting: “Social Work Math”

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<th>YR1</th>
<th>YR2</th>
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<tbody>
<tr>
<td>NAP</td>
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</tbody>
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**YR1 Real**

- pro (20) →
- 100 + 5 →
- 90 + 5 →

**YR2 Real**

- 70
dot

**Childcare**

- 60 + 22.5
- 35
- 20

- 40
- 225
Genesee Community Health Center
Budget in Grant

• Year 1: $608,333 from HRSA; $590,337 non-federal
• Year 2: $650,000 from HRSA; $916,875 non-federal
Genesee Community Health Center

• Expected numbers served:

<table>
<thead>
<tr>
<th>Location</th>
<th>Year 1</th>
<th>Year 2</th>
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</thead>
<tbody>
<tr>
<td>Center City (Homeless)</td>
<td>1400</td>
<td>2,530</td>
</tr>
<tr>
<td>Atherton (Public Housing)</td>
<td>550</td>
<td>1,150</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,950</td>
<td>3,680</td>
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• ~30% of the homeless population in Genesee County are children (in families)
• Atherton is 90% single mothers with children
• Clinic hours of operation: 32-35 hours between 8:00 a.m. and 5:00 p.m. to start
Resources

• Endless webinars and TA
  – MPCA
  – HRSA
  – NACHC (not so much for special pops or PE)
  – NATIONAL COUNCIL (BH)
  – NATIONAL HEALTHCARE FOR THE HOMELESS COUNCIL
  – COMMUNITY HEALTH PARTNERS FOR SUSTAINABILITY (Support for Public Housing Grantees)
  – SAMHSA-HRSA Center for Integrated Health Solutions

• But very little advance notice; almost nothing related to PE status
What You Will Need

- A dedicated team of people to go offline from their day jobs for WEEKS to write the NAP or look-alike application
- Plus a minimum of 6 months of intensive community engagement, relationship building, and research prior to writing the NAP
- A lot of money (consultants, TA, formal needs assessment, start up, match, etc.)
What to Do First

• Envision and locate your space(s)
• Determine your staffing model (MD/DO, FNP, etc.),
hours, plan for outreach, service delivery model; e.g.,
CCHH or PCMH, plan for accreditation
• Determine your scope of directly provided services;
make sure you can pay for them
• Dental, dental, dental, and dental
• Sort referral arrangements from contracts
• Read Policy Information Notices (PINs), Program
Assistance Letters (PALs), guidances, HRSA website
(EVERYTHING); do not attempt to interpret alone
• Do not just trust bullets in anyone’s pptx, even this one
What to Also Do First

• Select an EHR (this takes much longer than you think)
• Talk to existing area FQHCs re: service area overlap and talk to MPCA
• Think about serving special populations (or not); we would NOT exclude (e) if we had a do-over
• Think about capacity when Michigan expands Medicaid
Layout and Building Design

• Considered a variety of different service delivery models and space layouts
• Found the “integrated team office pod” to be very appealing and aligned with Patient Centered Medical and Community-Centered Health Home best practices (see Southcentral Foundation (AK), Cherokee (TN), and Covenant (Detroit)); read Prevention Institute papers
• Sharing space vs. separate offices allows for open team communication and patient care coordination
• “Talking rooms” are multi-purpose and provide the most flexibility
Outreach

• Engaged a broad array of stakeholders in outreach plan – e.g., we are using MI PATH & CMH Access
• Incorporated into expanded needs assessment to capture the input of our target population
• Don’t forget to budget for signage $$$
• Think carefully about timing
• Designed an outreach worker position for a resident of the public housing site
Other starting points for CMHs

• Don’t just identify your hot-spotters, get to know them very well
• Relationships, relationships, relationships
• Integrated health care training for everyone
• Track data on the chronic health conditions that are most prevalent in your community
• The act of tracking and displaying outcomes alone often triggers some positive movement, for example...
Retrospective Observations

• Appears to be much, much easier when not a “paper start” as far as dealing with HRSA

• Look-alike is thus a possibly better way to go (if you can afford to operate without the 330 grant money to start), and is a very good choice when NAP is not available

• 501(c)3 is much better, easier, and far more acceptable to HRSA, NACHC, and pretty much everyone else
In summary, the life of a CMH who wants to be an FQHC...

"Yea, though I walk through the valley of the shadow of death, I will fear no evil" Psalm 23
WHAT IS THE GENESEE COMMUNITY HEALTH CENTER?

- Complete Health Care for Adults and Children
- Health Screenings, Well-Child Visits, Physicals
- Care for Diabetes, Asthma, Blood Pressure and Cholesterol
- Access to Lab and X-ray Services
- Access to Mental Health and Substance Abuse Services
- Access to Dental Care

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810.496.5777
www.genchc.org
info@genchc.org
Genesee County Community Mental Health has received a grant from Health Resources and Services Administration (HRSA), a division of the U.S. Department of Health and Human Services, to support the creation of a health center with two sites in Flint. The grant will support the beginning of a Federally Qualified Health Center (FQHC) in Flint that is called Genesee Community Health Center.

The grant was awarded in the amount of $608,333; with non-governmental sources include $590,337 for a total budget of $1,198,670.

In Flint, over 56,000 low-income residents are unserved by a primary health care provider. According to a recent estimate by HRSA, Flint needs at least 50 more full-time doctors to meet the needs of the current unserved population in the city which includes a large number of women and children. The Genesee Community Health Center will focus on the health care needs of the homeless and those in public housing that are currently not being served. One clinic will be located in the Center for Hope – a one stop center for community services that includes a warming center for the homeless; the other will be housed within a public housing complex. The expectation is that these sites will serve an additional 3,700 people within two years.

This still leaves many without care, but will increase the availability of care for those unserved individuals within the city. “We are very excited to bring additional resources to our community,” says Danis Russell, CEO of GCCMH. “We often see the great need of our citizens, and will be able to provide a great many people with additional care.”
Ta da!
Signs are up!
More signage
Waiting Room
Reception Area: Emily!
Exam room
Brian’s box of stuff for Tim
WE WON A HUGE GOVERNMENT GRANT.

NOW WE NEED TO FOLLOW ALL OF OUR COMPANY POLICIES PLUS EVERY GOVERNMENT PROCUREMENT RULE.

I FEEL LIKE I'M BEING SMOTHERED BY A DAMP MATTRESS!

THAT'S WHAT VICTORY FEELS LIKE!
Questions
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