WHATCOM COUNTY
Health Department

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WHATCOM GRACE

GROUND-LEVEL RESPONSE AND COORDINATED ENGAGEMENT

Program Team

February 2, 2018, 10:30- 12PM

St Luke's Health Education Center Room E

AGENDA

		Agenda Item	Facilitator
1.	5 min	Welcome and Introductions	Jackie
2.	15 min	• Review Program Team function within GRACE & Goal of the Meeting • Update of Engagement Subcommittee results	Jackie
3.	50 min	Review and Discuss: • GRACE eligibility update • Referral process & system	Dean
4.	15 min	Review and Discuss: • Grace Logic Model Framework	Jackie
5.	5 min	Conclusion and Next Steps	Dean

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WHATCOM GRACE

GROUND-LEVEL RESPONSE AND COORDINATED ENGAGEMENT

Engagement and Motivation Subcommittee Meeting

11/13/17

Members Present:

- Donna Wells, (Catholic Community Services, Recover Center)
- Monte Thompson (Whatcom Community Detox / Pioneer Human Services)
- Laura Woods (Whatcom Alliance for Health Advancement, Intensive Case Management)
- Andrea Tafoya (SeaMar/PeaceHealth Community Health Connector)
- Lukas Smith (Western Washington University)
- Dean Wight (Whatcom County Health Department, Human Services)
- Andrea Northey (Opportunity Council, Homeless Outreach Team)
- Elizabeth Anderson (NW Regional Council, Health and Human Services Planner)
- Conner Darlington (Opportunity Council, Homeless Outreach Team)
- Perry Mowery (Whatcom County Health Department, Human Services)
- Bridget Reeves (Lighthouse Mission, Director of Programs)
- Malora Christensen (Catholic Community Services, Associate Director of Housing- Whatcom & Skagit)

Health Department Staff Present:

- Dean Wight (GRACE Project Manager)
- Jackie Mitchell (Behavioral Health Program Specialist)
- Anne Deacon (Human Services Manager)
- Perry Mowery (Human Services Supervisor)

Summary of Meeting:

The goal of the meeting was to provide input on best practices for engagement/motivation strategies used with future GRACE participants. Dean Wight provided an overview of the Hub and Spoke Model proposed to the North Sound Accountable Community of Health. The Hub and Spoke is the basis from which GRACE is developed.

Multiple stakeholders attended the meeting and provided the following feedback. In general, this workgroup suggested best practices for enhancing the likelihood of success with "familiar faces" admitted to GRACE that should include the following: Training to understand and empathize with the plight of participants, and to work with vulnerable populations; a culture of strength, resiliency, and hope without stigma; shared, common language amongst agencies which will benefit participants; contingency management or other best practice incentives which promote extrinsic motivation while opening opportunities leading to internalized motivation; individualized and shared care plans with client choice; surveying participants to determine needs, and a system for measuring success.

The subcommittee also indicated that the GRACE system must be very flexible and ready to take advantage of key opportunities to "move the needle" with certain individuals. Details provided below:

TRAINING

- Contingency management training for providers
- Find out what the familiar faces want
- Motivational interviewing
    - Regular follow-ups or ongoing consultants available to providers
- Ongoing training and support of GRACE model
- Using same language throughout the system
- Working effectively with personality disorders, especially bipolar disorder
- Clearly defined roles and responsibilities of various spokes
- Trauma informed care
- De-escalation

REFERRAL STRATEGIES

- Regular meetings to be on same page
- Reframe – No dropouts, no firing allowed
- Single access point
- No wrong door
- Screening for eligibility and prioritization

INCENTIVES AND TOOLS OF ENGAGEMENT

- Reach out to housing partners to offer incentives
- Pay for extra phone minutes
- Flex funds for buying meals
- Solicit businesses to provide vouchers
- Transportation – give rides & bus passes
- Client Survey – Find out what works
- Access to dental/medical care
- Shower Van
- Laundry services
- Cards and words of strength/hope
- Use same plan for multi-dimensional team
- Provide nurturing environment
- Meet person where they are
- Building relationships
    - Listening & Bonding

INCENTIVES AND TOOLS OF ENGAGEMENT (Con't)

- Graduation
- Educational / Vocational opportunities
- Meaningful work/activities
- Taking opportune moments
- Accessibility to assistance

INFLUENCE, DIGNITIY/RESPECT/STIGMA

- Training to understand people
- No judgement or preconceptions
- Understand harm reduction

OUTCOMES/MEASURES

- All "spokes" know and implement their part of the "plan" for each GRACE participant
- Patient activation measure (PAM)
- Service Engagement scale
- Reduction in 911 calls and ER visits
- Reduced jail time
- Memberships, surveys
- Point system

MODELS (TEAM AND OUTREACH)

- Establish common language in approach & communication with providers' communication system (no milieu building)
- On-site supervision for continual and immediate guidance
- Person-centered planning (individualized)
- Team self-care strategies/ plan implementation
    - Clear roles/boundaries for each team member
    - Mutual support among team members
- Multi-pronged coordinated response/intervention/support
- Establish token economy

WHATCOM G R A C E

GROUND-LEVEL RESPONSE AND COORDINATED ENGAGEMENT

Status Report
January 29, 2018

Target Population Definition

An initial goal toward defining the target population for GRACE was to focus on two major considerations:

1. Individuals who currently utilize crisis services across systems with unusually high frequency, yet do not experience improvement in their health or problematic behaviors
2. Individuals who would most likely experience improved health, fewer crises, and fewer law enforcement responses if provided the intensive and coordinated service system of GRACE

Key informant interviews were conducted with Bellingham Police Department (BPD), Whatcom County Sheriff, Whatcom County Jail, and the Whatcom Homeless Service Center (WHSC). Specific behavioral characteristics of the individuals they identified as "familiar faces" are noted below.

BPD:

1. 5 – 61 incident reports in a single year
2. Behaviors indicating active symptoms of mental illness (hallucinations, delusional statements)
3. Generalized aggression over several incident reports
4. Repeated officer contacts where no incident report was filed

Sheriff:

1. Largest concentration of frequent contacts noted in East County/Maple Falls area
2. Active symptoms of mental illness noted
3. Incident reports not always filed for contacts with Dispatch, but no subsequent outreach

Jail:

1. Frequent bookings, often for misdemeanors
    a. Retail theft, harassment or disputes with others, FTA
2. Not all display symptoms of mental illness

WHSC:

1. Homeless or newly housed, especially in 24/7 staffed housing programs
2. High BPD interface
3. Symptoms of mental illness and substance use

Health Care Entities such as the Community Paramedic program and the hospital, as well as direct service providers (Whatcom Alliance for Health Advancement (WAHA) and EMS units), can provide aggregate information and general behavior characteristics as a starting point. Federal and state regulations for confidentiality prohibit sharing of Personal Health Information (PHI) without Releases of Information (ROI) signed by individual clients. We have anecdotal information on behavioral characteristics.

Issues & Opportunities Surrounding Information Sharing

The Health Department is researching database platforms that can be used for GRACE client information sharing. The Department is also researching confidentiality laws under the federal (HIPAA (45 CFR), and Substance Use Disorder (42 CFR)) and state laws to determine how to facilitate optimal communication among the participating partners of a GRACE client team.

The sharing of PHI for the purposes of "Care Coordination" is allowed only between Health Care Entities even when a ROI does not exist. And any PHI which is shared should only be that which is necessary for the stated purpose. A Business Associate Agreement (BAA) is used to facilitate sharing between Health Care Entities. The definition of "Health Care Entities" typically implies agencies that provide direct health care to individuals.

Limited sharing of PHI can occur between health care agencies and Law Enforcement without an ROI such as when an individual is currently "in custody" and for the purpose of promoting appropriate care, treatment, and referral.

The Leadership Team will address this and other concerns during the meeting on January 29th.

Draft GRACE Logic Model 2/2/18 DRAFT

Inputs/ Resources	Activities/Services/Outputs	Measures	Process Measures	Long Term Outcomes
1. Program Manager/Care Coordinator/Supervisor **2. 2 FTE Care Coordinators, possibly a third.** **3. Database Administrator Analyst**	1. Ensure coordinated care for familiar faces 2. Ensure partnerships with pathway spokes which are fluid and versatile 3. Provide data collection and analysis of the system 4. Facilitation of H&S network meetings 5. Implementation of information sharing processes for shared care. 6. Creation of strategies where no current "best practice" is working for an individual	1. # of dispatches from 911 2. # of jail bookings 3. # of people chronically homeless who have failed in housing 4. # of ED visits 5. # of psych hospitalizations	1. Release RFQ and secure Hub organization 2. Provide training to all GRACE partners as needed 3. Identify and develop clear pathways for health and recovery (i.e. crisis system pathway, integrated care pathway, housing, etc.) 4. Set up systems for motivational incentives 5. Communication Process	1. Reduce the incidence of people using multiple systems inefficiently 2. Promote healthy behaviors and well-being of GRACE participants
1. Leadership Team	1. Familiar Faces selection criteria 2. Determines outcomes and performance measures 3. Sets program policy 4. Oversight and accountability 5. Provides resources for Hub & Spokes to do their jobs 6. Ensures flexible approach to barriers within system			
1. Program Team	1. Case staffing 2. Care and intervention planning 3. Recommendation program policies, operating procedures, and service improvements 4. Care coordination 5. Information sharing 6. Develop engagement strategies, including incentives, training, and referral strategies			

Draft GRACE Logic Model 2/2/18 DRAFT

Assumptions	External Factors (Things we can't control)
#1. Healthcare reform in WA State continues along a path of ensuring healthcare for those who are most vulnerable. #2. Each spoke acts in "good faith" to keep working with individuals in their systems (no firing policy) #3. Barriers will be brought to the Leadership Team for discussion and resolution #4. Leadership Team will provide adequate resources and remove barriers when necessary #5. Not all clients will be initially interested in services, but each has the potential to be engaged	State and federal changes to infrastructure for behavioral health services There is a lack of housing for people being released from institutions Although we can work within the context of cultural/familial issues, we can't change the person's cultural/familial orientation; certain conditions or circumstances are difficult to change Shortage of Behavioral Health workforce

Definitions and Measures in separate document