Community Supports Webinar Series
CONNECTING THE DOTS
How to Co-Manage an Individual with Complex Health Needs
June 21, 2023
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AGENDA

- Welcome and Introductions
- Learning Objectives
- Part A: Building Relationships with Individuals with Complex Needs
- Part B: Co-Managing with the Enhanced Care Management providers
- Appendix

Welcome and Housekeeping

This webinar is being recorded

Attendance will be tracked via log-in

Send a message to the host if you cannot hear or see the slides

After the webinar you will get a copy of the PowerPoint and recording link

Participants are automatically MUTED. Please communicate via the chat

If we are unable to address your questions in today's webinar, we will address your questions in an upcoming forum

WELCOME AND INTRODUCTIONS

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Today's Presenters

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Learning Objectives

Build Relationships with Individuals with Complex Needs

1. Describe two examples of the types of individuals that a Community Supports (CS) provider may be asked to serve.
2. Describe one or two types of techniques to defuse situations as well as work with the individuals.
3. Discuss how Community Supports providers can make referrals to Enhanced Care Management (ECM) for individuals with complex needs they may already serve.

Co-manage with ECM Providers

1. Describe the varied roles of Community Health Workers in working with individuals with complex health needs.
2. Describe the role of Community Supports providers in contributing to the ECM person-centered care planning.

Part A

Building Relationships with Individuals with Complex Needs

Enhanced Care Management (ECM) is focused on Individuals with Complex Needs

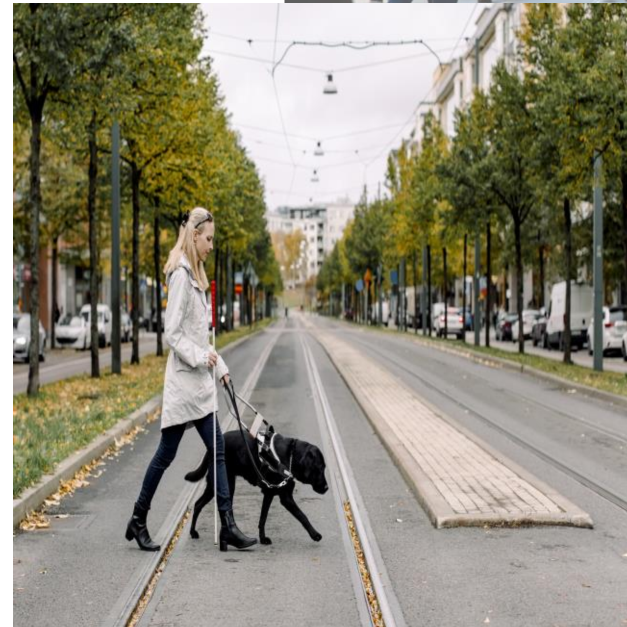
Who are Individuals with Complex Needs?

- Complex Physical Health Issues
- Complex Behavioral Health Issues
- Multiple Social Health-Related Needs
- Combinations of all the above

May engage with several different delivery systems to access care; may use the crisis services or the emergency room frequently.

They are at high risk of requiring frequent hospitalization, institutionalization and other higher cost services.

They interact with a variety of social service agencies and other support entities in addition to the ECM program such as child welfare, county specialty mental health system, long-term services and supports (LTSS), and/or the justice system.



Rosie – an individual with complex needs

1. Has a complex trauma history and has been diagnosed with Bipolar Disorder and Alcohol Use Disorder
   - Does not like her most recent mental health medication so she stopped taking it
   - No current treatment for her SUD
2. Has Diabetes
3. Likes to work but struggles to maintain employment when symptoms return
4. Becomes overstimulated in crowded/loud spaces
5. Just lost her job due to missing work from diabetes complications, and having an emotional outburst toward a customer when she returned to work
6. Must find employment quickly in order to maintain housing

Care Coordination

- Care coordination can be challenging for those with complex needs
- Enhanced Care Management serves as the quarterback for the gameplan
- Community Support Providers offer the concrete resources the client may need
- Care coordination ensures that all aspects of the client’s health are being considered:
    - Physical health
    - Mental health
    - SUD
    - Housing
    - Financial stability
    - Other

Considerations

- People with complex needs have many, complex stressors that they are juggling
  - These may affect behavior and stress management
- Assume Trauma
  - 95% of those seeking treatment for SUD report a trauma history[1]
  - 90% of people with SMI report a trauma history[2]

[1] Childhood trauma among individuals with co-morbid substance use and post traumatic stress disorder - PMC (nih.gov)

[2] The Effects of Disaster on People with Severe Mental Illness - PTSD: National Center for PTSD (va.gov)

Why do we escalate?

- What types of things do you consider to be stressful?
- What types of things do your clients consider to be stressful?

Emotional Escalation

WHY?

- We feel threatened
- We feel out of control
- We feel angry, afraid, confused, or overwhelmed
- There is a high level of subjective discomfort
- We have been hurt
- Trust is disrupted
- We are experiencing a trauma trigger that may or may not be within our awareness

WHAT?

- Pacing
- Agitation
- Shouting at others
- Crying
- Isolation
- Return to use
- Panic Attack
- Sense of Urgency

De-escalation

- Be mindful of personal space
  - The amount of space we all need is different and changes according to situation
  - Always maintain *at least* an arm's length from a person who is exhibiting signs of anxiety
  - Be aware that your voice is a part of perception of individual space
    - If a person is already activated, volume of voice will escalate the situation.

DE-ESCALATION

- Be Aware of Body Position
  - Hard eye contact can be triggering and intimidating
  - Eye-to-Eye and Toe-to-Toe positions often trigger fight-or-flight reactions
  - It’s best to be at an angle or off to the side with an agitated person
  - Sit in a quiet space if you are able.

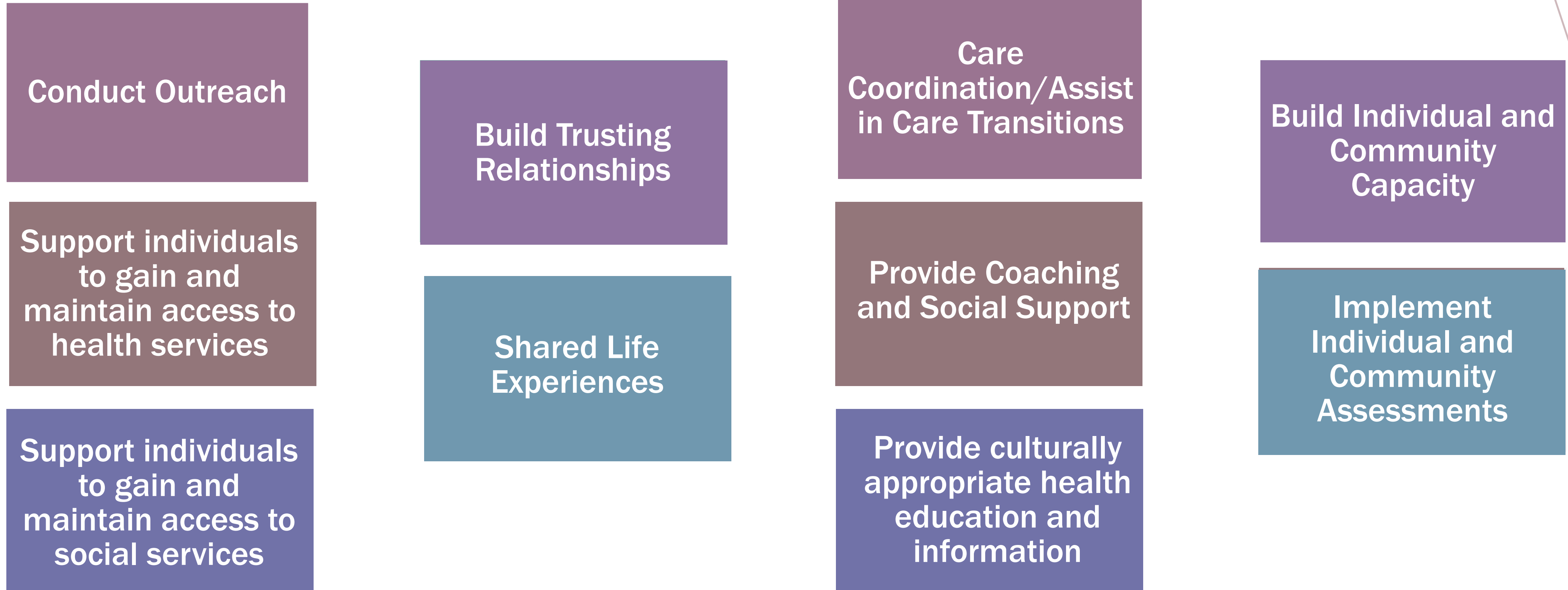
DE-ESCALATION

- Set Boundaries as Needed for Safety
  - If a client becomes belligerent, defensive or disruptive, establish limits and directives clearly and concisely.
    - There are peaks and valleys in intensity- boundaries should be communicated in the valleys
  - When setting limits, offer simple, clear choices and consequences to the acting-out
    - “I want to help you figure this out, but we have to stop yelling so I can better understand.”
  - If you are feeling activated, step away

Part B

Co-Manage with ECM providers the Individuals with Complex Needs

Community Health Workers: Wide Range of Roles to Co-Manage and Engage the Individual with Complex Needs



From: Advancing California's Community Health Worker & Promotor Workforce in Medi-Cal (chcf.org)

Engaging Individuals with Complex Needs through Community Health Workers

- The ECM or the individuals’ managed health plan may have a CHW engaged with the person and their family already.
  - The CHW will have built trust with the individual so connecting with the CHW first, ahead of outreach by the Community Support provider, can lead to a successful warm hand-off and more understanding of the individual/family/caregivers.

- Alternatively, the Community Support provider may have been working with the individual already or plans to outreach to the individual via an CHW.
  - Keeping the ECM care manager/coordinator connected to that CHW will help in care planning, and supporting in-home education, home visits, health promotion/prevention activities or other activities they could collaborate on.

ECM person-centered care planning: Role of Community Support provider

The ECM provider is responsible to incorporate clinical and non-clinical resources and needs into the development of a member's care plan. They need to work with the member to assess risks, needs, goals, and preferences.

The Care Plan's focus is broad and includes:

- Physical and developmental health
- Mental Health and Substance Use Disorder
- Community-based Long-Term Service and Supports
- Oral Health
- Palliative Care
- Trauma-Informed Care
- Necessary Community-based and social services
- Housing and other Community Supports
- Social Determinants of Health

All the Community Support Providers are important links for the ECM provider in care planning

Support to the Individual with Complex Needs' Person-Centered Care Planning

Community Support Providers can play many roles in support of the Care Plan in collaboration with the ECM provider.

Examples include:

- *The housing case managers, meal delivery drivers, volunteers, etc. are providing valuable 'wrap-around' care that complements the clinical side of care*
- *Can engage in wellness discussions with harder-to-reach individuals who may not be traditionally engaged with the healthcare system*
- *Can engage and provide support to the caregivers of individuals with complex needs who are playing a critical role in keeping someone healthy*
- *Participate in case conferences*
- *Regular communication with the individual's ECM Care Manager/Care Coordinator*

Care Planning- Role of CS provider

- If you or your staff have worked with ECM providers or managed care plans on Care Planning, how have you contributed?
  - Provided input to the ECM manager on services provided or other input for the care plan?
  - Provided education or coaching to the individual?
  - Attended a case/care conference?
  - Coordinated with the ECM or managed care plans' Community Health Workers
  - Other ways?

A Mission-Driven Organization

Our Mission

Partners shapes the evolving health system by developing and spreading high-value models of community-based care and self-management

PARTNERS IN CARE FOUNDATION: THE SOCIAL DETERMINANTS INNOVATORS

- Our work serves as a bridge between medical care and what a person accomplishes in their own home.
- We manage the gaps in non-medical care that affect a person's recovery and overall health.
- We represent a California network of community-based organizations (CBOs)—Partners at Home.

The result is happier, healthier people cared for, at lower expense, in their own homes

ADDRESSING SOCIAL DETERMINANTS OF HEALTH THROUGH COLLABORATIVE STRATEGIES

Partner

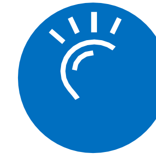
with hospitals, skilled nursing facilities, physicians & heath plans

Focus

The home

Payers

- Medi-Cal
- Medicare
- Private health plans



New Directions

transforming Medicare and Medi-Cal

ECM’s Seven Core Services

- Outreach & Engagement
- Comprehensive assessment and care management plan
- Enhanced Coordination of Care
- Health Promotion
- Comprehensive Transitional Care
- Member and Family Supports
- Coordination of a referral to community and social support services

ECM IMPLEMENTATION BEST PRACTICES – SETTING UP A STRONG FOUNDATION

- Identifying your strengths as an ECM Provider – What makes you unique?
- Developing a plan to leverage your strengths during ECM implementation
- Hiring best practices – Lead Care Manager/Care Coordinator/CHW models
  - Geographical Locations
  - Language
  - Diversity – Lived experience, education, etc.
- Identifying subject matter experts on your team
  - *Partners* Innovation – Navigator Roles
- Partnerships are key

OUTREACH & ENGAGEMENT: ENGAGING A HARD-TO-REACH POPULATION

- Telephonic Outreach (Go above and beyond minimum requirements when possible)
  - *Partners Innovation:* Engagement Center
- Letters
  - Information Packets (people on the fence with engagement)
- Leverage Technology
  - Text Campaigns
  - Email
  - Telehealth Video Platforms
- Utilization of Software Platforms
  - HMIS
  - CHIP
  - LANES
  - Collective Medical
- Street Outreach
  - Bring Incentives
  - Remember Safety
- Use different times/days/people for outreach

CARE PLAN DEVELOPMENT & IMPLEMENTATION – CREATIVE STRATEGIES FOR SUCCESS

- *Partners* innovative approaches to care coordination
  - Community-based model of care – Meeting participants in their homes or the community
  - Formal partnerships with providers– SNF's, Hospitals, Medical Groups, Housing, Managed Care Plans, FQHC Clinics, etc.
  - Meeting ECM participants where they are – Combining traditional service delivery approaches with the latest technology and innovations
  - Using current events to guide care coordination and conversations
    - Natural Disasters
    - Pandemic
    - Critical incidents in the community
    - Tragedies in the participants life

Key Takeaway

- Creativity & Patience

ECM AS A "GATEWAY" SAFETY NET PROGRAM – BRIDGING GAPS IN CARE

Thinking of ECM as "Medium Term Support Services"

- Partnering with short-term programs (health education workshops, health coaching, etc.)
- Partnering with Long Term Support Service (LTSS) Waiver Programs

EXAMINING LESSONS LEARNED

- Remember: YOU are the experts in ECM
- Data is critical in examining the outcomes and success of ECM – Gather as much as you can and start early
- Zoom In – Sit in on case conferencing, learn participant's stories, understand the experience of your staff in the field
- Zoom Out – Look for trends in the data, think critically about what quality improvements are needed along the way and refine your approach with time
- Identify barriers and gaps within ECM – Policy, structure, workflows, etc.
- Advocate & Partner – We are in this together
- Remember your mission – Personally, as a team, and ECM as a whole

Wrap Up

Community Support providers are an integral part of the success of the Enhanced Care Management program and improve the lives of individuals with complex needs –

- **Can appreciate that some individuals have multiple complex health and social needs – and need to engage with both the health care system and the social service and community supports**
- **Can defuse tough situations and be safe**
- **Can connect individuals and their families with the ECM program and other community supports**
- **Can build strong relationships and support engagement with the individual**
- **Can participate in care planning to ensure it is person-centered**

THANK YOU!!!!
Before You Go...

Please Complete the Evaluation of Today's Session

Complete the pop-up questions on your screen!

Save the Date!!!!! July 19, 10 am

The next Webinar will be on "Working with individuals with Substance Use Disorders within the Community Supports model."

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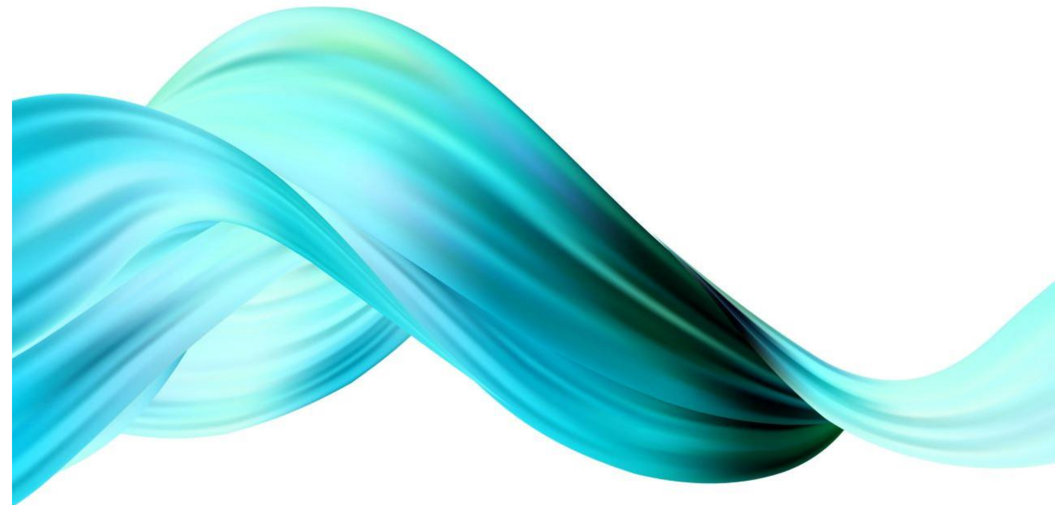
GLOSSARY OF TERMS

- CS – Community Supports
- DC - Discharge
- EAA – Environmental Accessibility Adaptions
- ECM – Enhanced Care Management
- HHSS – Homeless and Housing Support Services
- HMIS – Homeless Management Information System
- HUD – Housing and Urban Development
- MCP – Managed Care Plan
- PCP – Primary Care Provider



RESOURCES/LINKS

- CS Policy Guide: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf
- CalAIM for Providers: https://www.healthnet.com/content/healthnet/en_us/providers/support/calaim-resources.html
- CalAIM for Members: https://www.healthnet.com/content/healthnet/en_us/members/medi-cal/calaim-resources.html

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