NYS Care Management Training Initiative

New York State Council for Community Behavioral Healthcare

Effective Outreach, Engagement and Partnerships with Individuals, Providers and Community Supports

August, 2012
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Goal of the NYS Care Management Training Initiative

To provide education, training,

and ongoing support to care

managers who are in transition of their workforce responsibilities

in a way that utilizes their existing knowledge, skills and strengths

so that individuals with complex needs can improve their health and wellness and realize their full potential.

Today's Webinar Objectives

As a result of today's workshop, CM will have:

- Increased understanding of the roles and responsibilities as it pertains to outreach within health homes.
- Increased understanding of skills related to development of effective engagement and partnerships.
- Increased understanding of how these skills are transferrable between work with health home enrollees, providers and other community supports.

Skills of a Health Home CM

Outreach	Finding the person: (a) Being an “investigator” (b) Explaining health homes (c) Maintaining safety (d) Understanding community	Finding people, resources and supports for the individual/family/system within his/her community and cultural context
Engagement	(a) Understanding your own culture and how it influences engagement (b) Understanding the basic and unique needs of the individual, developing rapport, using MI, and using peer supports	Understanding the basic and unique needs of the family/provider/ system/community to engage in person’s care plan
Partnership	Engaging individual as an active participant in their care plan	Engaging and facilitating effective health home teams of family/providers/ community supports

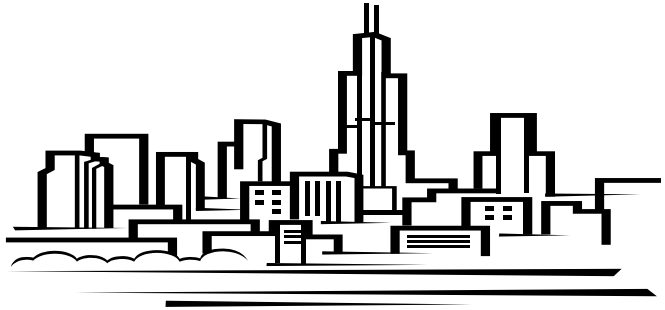
1. Individual Outreach

- Outreach begins when the care manager learns about the community they have been assigned and leaves the office to engage with community members in order to locate and inform individuals about their eligibility for health homes.

- Health home information about the individual is limited and therefore requires "investigative" skills.

How/Where do you look?

Phone calls, letters, and your agency records are a start… real outreach takes you to:



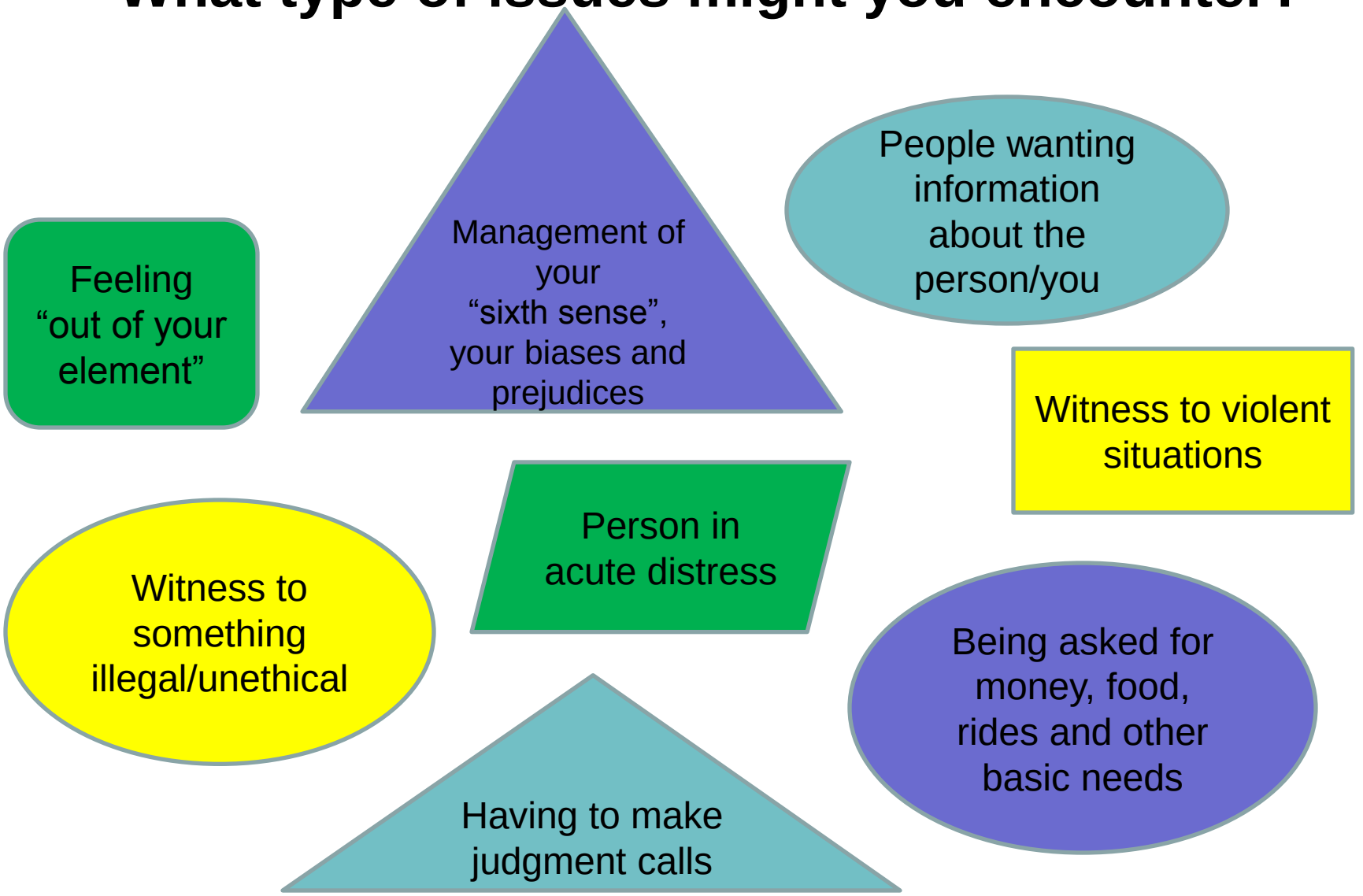
- Person's home/neighbors/landlord
- Community locations (corner store, drop in centers, faith based organizations, streets)
- Last known service providers (doctors, hospitals, dentist, etc.)
- Family members (who is listed as next of kin or emergency contact?)
- Homeless shelters/social service providers
- Jail
- SPOA and other community networking groups

Effective Outreach

What makes outreach effective?

- Compassion: caring deeply about the people targeted for health home care management
- Persistence/Diligence: being willing to search thoroughly for the person
- Interactive/Relational: building of relationships with other people on the streets and in the community where people are likely to be
- Informative: clearly explaining the eligibility and benefits of health home care management/ providing written information that can be understood
- Non-Judgmental/Accepting: knowing and understanding each person's/group's cultural perspectives and biases, as well as your own, avoidance of stereotyping, understanding the individual where they are at – receiving health care and connecting with a health home may not be their priority; priority may be food, shelter, etc.
- Empowering: assist person to feel in control over their health outcomes and the choices of the services he/she will use to help achieve those outcomes

What type of issues might you encounter?



TIPS for Enhancing Safety

Safety must be a consideration for both the care manager and person.

Many of these safety tips can/should be included in policy and procedure manuals at your agencies.

- Have a plan/schedule: Make sure someone knows where you are and when you will be back
- Conduct outreach in pairs- especially in remote and high risk places
- Get organized before you go
- Don’t wear/carry valuables, wear your agency ID
- Be aware of surroundings/use your common sense/recognize your “sixth sense”/position yourself near exits/be aware of weather conditions
- Know when you are putting the person and his/her family at risk
- When financially feasible, use smart phones
- Carry snacks/water
- Know when to approach/avoid
- Do what you say you are going to do
- Develop a self care plan

Outreach to Providers and Other Community Supports

- Outreach is happening when the Health Home Care Manager reaches out to a broad range of providers and community supports in order to meet the needs of the individual and family.
- There are vast resources available for the Health Home Care Manager to discover and utilize.

Learning about Community Resources: Where do I start?

- Talk with the individual/family/current providers about resources they may know
- Get to know “grass root” organizations and other outreach workers for resources
- Gather as many “resource guides” as possible to make your own
- Use existing relationships to foster new connections
- Using local newspapers, the internet and community efforts to find resources
- Use state, county, health home, and managed care company contacts

2. Individual Engagement

- Engagement includes the level of interaction, involvement, interest between the individual and the health home care manager.
- The level of engagement can be influenced by many factors (within your control and outside of your control).
- It is important for all providers and supports to understand the basic and unique needs of individuals within their cultural context in order to successfully engage.

Engagement of Providers and Community Supports

- Engagement includes the level of interaction, involvement, interest individuals have in working as health home care management team (which includes natural and community supports).

- The level of engagement can be influenced by many factors (within your control and outside of your control).

- It is important for HH CM to understand the basic and unique needs of providers/systems/communities in order to successfully engage.

The most important thing is to build the relationship first!

What can CM's bring to individual and community relationships?

- Hope
- Shared power
- Availability
- Openness to a wide variety of interventions
- Flexible boundaries (which is why the supervisor and team are so important)
- Courage to deal with the complexities and uniqueness of each person

Borg, M., & Kristiansen, K. (2004). Recovery-oriented professionals: Helping relationships in mental health services. *Journal of Mental Health 13(5), 493-505.*

What is most important in a relationship?

"The ability to act as holders of hope for those who cannot hold it themselves, as well as having the courage to give it back, is critical to good practice"

Helen Glover (2002)

Why are some folks more challenging to engage ?

- Pervasive lack of trust
- Lack of confidence in the services
- Want to feel respected and valued

What are some things you can do to build trust and show respect?

- Relate *to* people—not “at,” “on,” or “down to” them*
- Negotiate strategies, rather than having solutions*
- Pose more questions than answers- listen carefully*
- Create mutual and shared goals*
- Leave personal decisions to the person*
- Design and implement services and supports that are unique to the person*
- Provide trauma informed care

*Adapted from Michael Kendrick

Definition of Trauma-Informed Care

- Care that incorporates:
  - An appreciation for the high prevalence of traumatic experiences in persons who receive behavioral health services (and sometimes, the persons who provide the services).
  - A thorough understanding of the **profound neurological, biological, psychological, and social effects** of trauma and violence on the individual.
  - Care that addresses these effects, and is collaborative, supportive, and skill-based.

(Jennings, 2004)

Key Features of Trauma-Informed Care Systems

- Presume that every person referred to you has been exposed to abuse, violence, neglect, or other traumatic experiences.

  *Especially consider trauma in people with **complex illness who have been the most challenging to engage into services.**

- Recognize that service environments are often traumatizing, both overtly and covertly*
- Value the individual and his/her culture in all aspects of care
- Utilize neutral, objective, and supportive language- ask “What happened to you?” vs. “What is wrong with you?”
- Develop individually flexible (person centered) plans and approaches
- Avoid shame or humiliation at all times

*Please take some time to look at the Sanctuary Model
http://www.sanctuaryweb.com/trauma-informed-systems.php

When you meet someone new…

Ponder…

1. What is the role of trauma in his/her life?
2. Could trauma be central to the behavioral and physical health conditions?
3. How can I intervene in a trauma informed way?
4. Ask the person, “How do you want me to work with you?” “What helps you feel safe?”

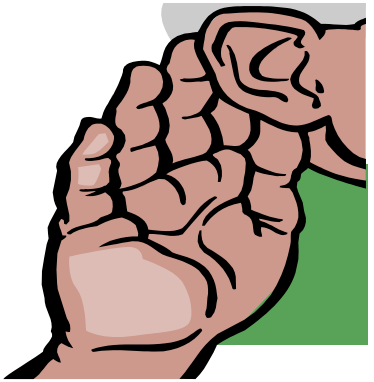
Using Motivational Interviewing to Engage Individuals

- Motivational Interviewing is a person-centered approach for responding to ambivalence.

- The Spirit of Motivational Interviewing is:
  - Collaborative
  - Evocative
  - Supports Autonomy
  - Compassionate
  - “Directional” rather than “directive”

Why does MI emphasize listening?

- When the person feels heard, they also feel:
  - Affirmed (understood)
  - Accepted (open, not defensive)
  - Approachable (willing to talk more)



- By listening, we understand the person's dilemma/ambivalence and values

Engagement is the relational foundation in MI: Using OARS

- Ask OPEN questions / Minimize closed questions
- AFFIRM the person-strengths, effort, intention, values
- REFLECT
- SUMMARIZE - a “bouquet” of the person’s own perspectives

Reflections- Seek to understand what the person means

Simple Reflections:

- Repeat: Restatement of what the person said
- Rephrase: Same thing with slightly different words

Complex Reflections *(Paraphrase):*

- Double sided reflection: Includes both client *sustain talk* and *change talk*, usually with the conjunction “and”.
- Amplified reflection: Reflect back in an exaggerated form, avoiding sarcasm
- Metaphor: A story of comparison
- Affective reflection: Affective reflection looks at what the person feels as a result of a personal experience

Sometimes silence is the best response

Providing Outreach and Engagement with Peer Support

What is peer support?

Peer support=

*sharing of experiential knowledge, skills and learning

*encouraging and engaging each other in recovery

*providing a sense of belonging, support, value and community

Valuable Responsibilities during Outreach and Engagement

Initiating non-threatening conversation

Maintaining repeated contact over time

Developing a trusting relationship

An advocate offering support and gentle guidance

http://www.illinoismentalhealthcollaborative.com/consumers/education/Role_of_Peer_Support_in_the_New_Mental_Health_Services_083007.pdf

The peer can be…

- A liaison between the person being served and the professional who is providing the service
- An ‘interpreter’ between the service recipient and professional (or family)
- A mediator/advocate
- A source of compassion and unconditional support
- A role model

Peers can also…

Recognize and challenge:

- Stigma
- Discrimination
- Biases
- Need for full community participation and not just symptom management

In Summary about Peer Services…

Peer support can:

- Improve outreach and engagement
- Influence provider attitudes
- Influence quality of professional services
- Reduce costs

Who is your health home partnering with to provide peer support?

3. Partnerships

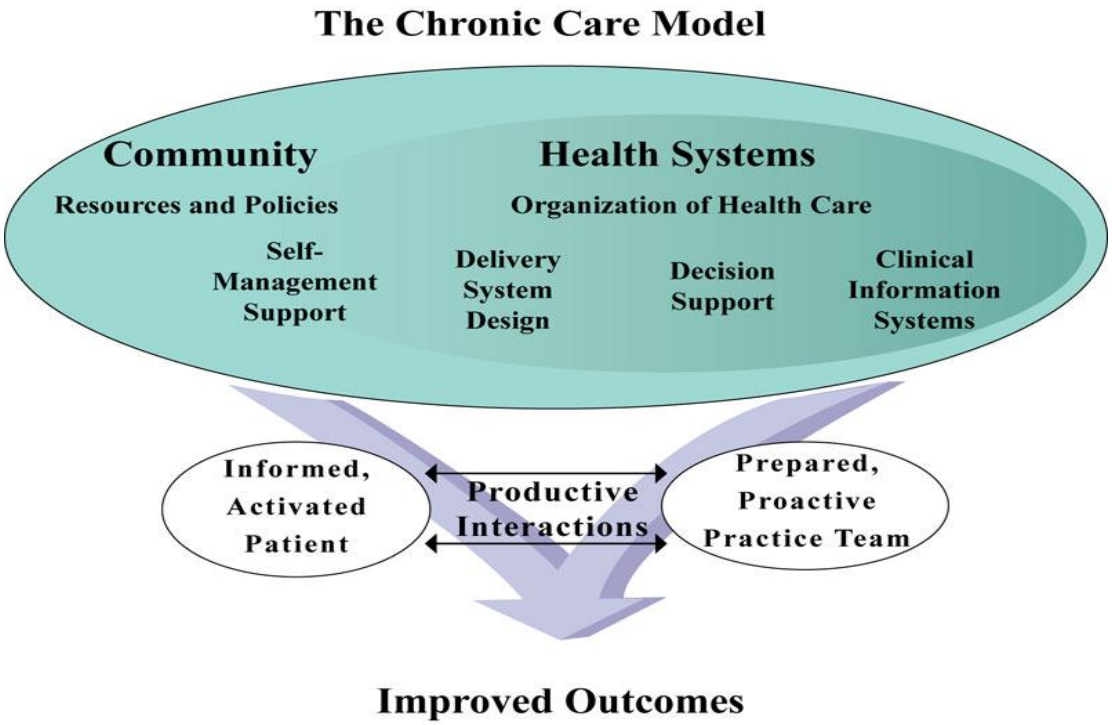
Health Homes are encouraging us to focus on partnerships like never before:

- Partnerships between service provider and service recipient
- Partnerships between providers
- Partnerships among providers, supervisors, and administrators
- Partnerships with communities

Chronic Health Care Model

Part of the model includes:

- To educate and support the individual in becoming a partner in healthcare decision making



Shared Decision Making (SDM)

Many believe SDM is a basic human right that:

- changes the power imbalance
- shifts responsibility for understanding and making decisions to the person being served
- upholds the autonomy of health care recipients

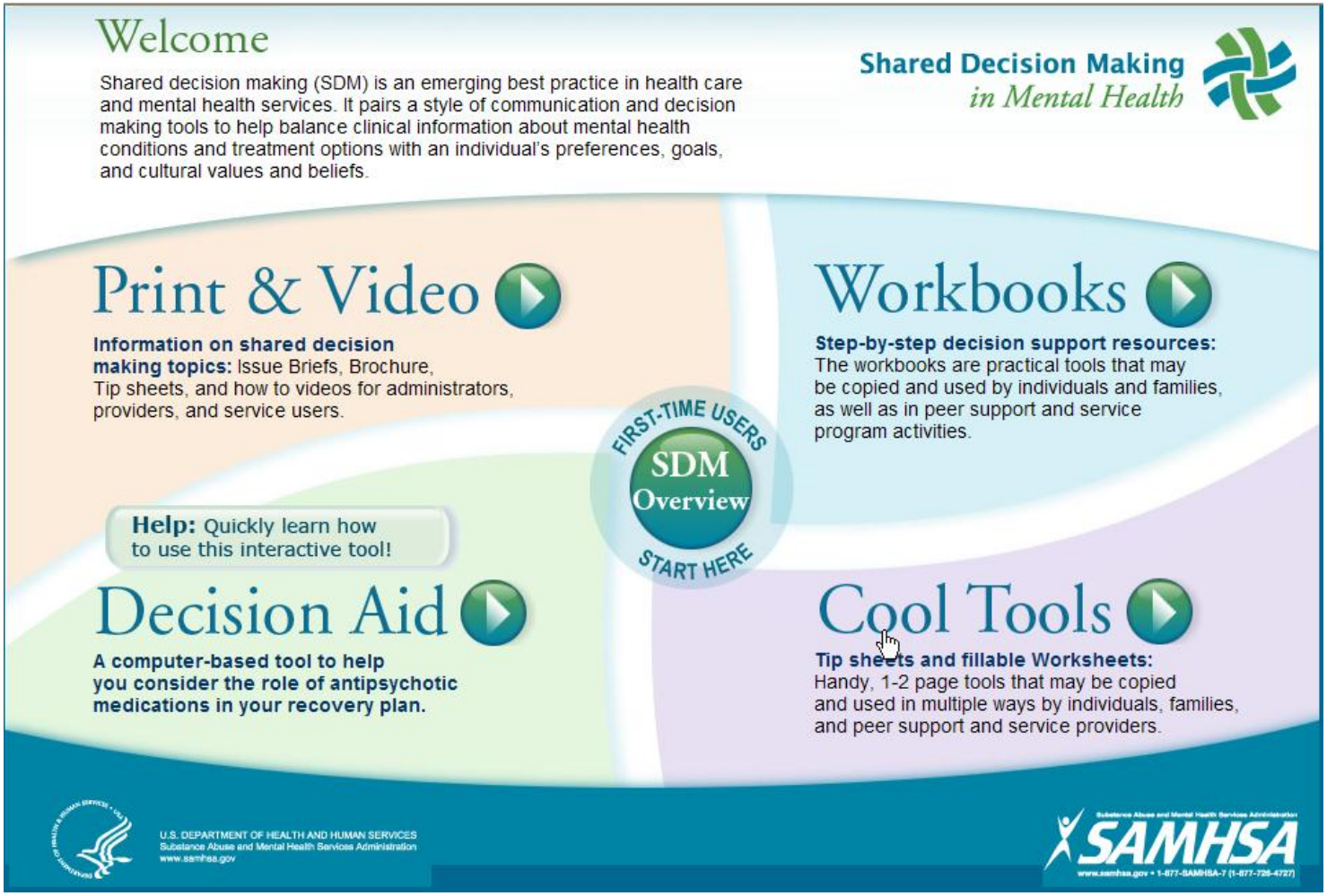
-Shared Decision Making in Mental Health: Practice, Research and Future Directions, SAMHSA, 2010

The Practice of Shared Decision Making

1. Recognize a decision needs to be made
2. Identify the participants as equals
3. View all options as equals
4. Explore understanding and expectations
5. Identify preferences
6. Negotiate
7. Share the decision
8. Evaluate outcomes

Deegan, 2007

New Shared-Decision-Making Resource



http://www.samhsa.gov/consumersurvivor/sdm/StartHere.html

Balancing Equally Valued Elements of Shared Decision Making

What can the professional bring to shared decision making?

Information related to:

- Options
- Risks
- Benefits

What can the individual bring to shared decision making?

Expertise related to their:

- Values
- Preferences
- Goals

SDM Considerations

1. Decisional Conflict

When is it most common?

- When benefits of treatment are not well known
- When there is a significant risk of side effects

Effective Negotiation

- Conflict resolution requires skill in effective negotiation
- Negotiation is the process by which two or more parties with different needs and goals work to find a mutually acceptable solution to the issue
- Negotiation is an interpersonal process influenced by each party's skills, attitudes, and style

Principles for Meaningful Conversations

- Acknowledge one another as equals
- Stay curious about one another
- Recognize we need each other's help to become better listeners
- Slow down to have time to think and reflect
- Remember that conversation is the natural way humans think together
- Expect it to be messy at times

From: Margaret J. Wheatley, Turning to One Another.

Negotiation Tips

- Seek the other person's perspective
- State your needs
- Prepare options beforehand
- Avoid arguing—maintain emotional control
- Consider timing—avoid negotiation when tempers are flaring or if the process will be rushed
- Move thinking from "either/or" to "and"

Barriers to Negotiation

- Viewing negotiation as a confrontation
- Needing to win
- Becoming emotional
- Resistance in understanding the other perspective
- Blaming
- Focusing on personalities, not issues

2. Adherence and Coercion

Can include seclusion, restraint, forced medication

Impacts person's sense of ability to truly participate in care decisions

"A clear majority of mental health consumers are fully capable of making decisions about their care."

—A. Kathryn Power, Former CMHS Director

3. Person-Centered Care

Focuses on getting to know the individual in terms of their attributes/capacities, interests/preferences, culture, priorities, what good support looks like/who this is, people who are in their life, where they are connected in the community and their values/ideals

What can care managers do?

Support and guide the person in achieving the meaningful goals he/she sets

4. Self-directed Care and Personal Medicine

Focuses on rights and responsibilities of person being served

Provider's participation may or may not be needed by the individual

Personal medicine might include golfing, reading scripture, care giving for others, repairing cars, running, cooking, playing games (spades, dominoes), going top the beauty parlor/barber, volunteering, etc.

Care Management Role in SDM

- Support/advocate when a decision needs to be made
- Assist with coordinating/facilitating care planning meetings
- Support/assist individuals to negotiate their needs
- Assist person to use decision-making tools
- Fully embrace strengths-based approach
- Assist person to identify his/her personal medicine
- Participate in evaluation of the outcomes

Care manager can:

- Develop skills of agenda setting, reflective listening, presenting advantages and disadvantages of options, collaborative decision-making

http://www.patdeegan.com/commonground/about

In Summary…

HH CM have a vitally important role to play:

- Outreach to non-traditional settings for persons who might otherwise be ignored or underserved
- Engagement of "hard to serve" individuals
- Partnering with providers/others in the community to support/guide the recovery goals of persons being served
- Advocating for trauma informed services
- Understanding the cultural nuances of yourself, the person and his/her family, and the community
- Lending hope and possibility!

Next Steps

Please share your feedback via the webinar survey

Log on to the NYS Care Management Training Initiative website to review additional resources at www.healthhometraining.com

Identify an outreach practice that is unfamiliar to you and engage in dialogue about it at your next team meeting

Review policies and procedures related to safety- implement new processes as needed

Practice using MI skills: OARS, Reflections

Identify 3 new providers/resources you will be working with as a Health Home CM and focus on building a relationship with them

Explore the peer supports in your community

Explore SAMHSA's SDM website and tools

Perfect your conflict negotiation skills

Questions?