Improving Health and Wellness via New York State Health Homes: Day One Training

Trainer Name Here:
Training Location:
Date:
Learning Objectives

• Demonstrate understanding of the role and responsibilities of a Health Home Care Manager

• Integrate and apply theoretical concepts and information from training webinars to practice based scenarios

• Understand Person Centered Thinking skills and use the Important to/Important for tool

• Identify and practice Care Management skills

• Collaborate and share information with other Health Home Care Managers
What are Health Homes?

- Not a residence........

- Section 2703 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) adds a new section 1945 to the Social Security Act. This section allows States to amend their State Medicaid Plans to provide “Health Homes” to enrollees with chronic conditions, including mental health conditions, substance abuse disorders, asthma, diabetes, heart disease and being overweight (BMI > 25).

- A Health Home is a care management service model whereby all of an individual’s caregivers communicate with one another so that all of a patient’s needs are addressed in a comprehensive manner. This is done primarily through a “care manager” who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared (either electronically or paper) among providers so that services are not duplicated or neglected. The health home services are provided through a network of organizations—providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual “Health Home”.

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

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What are Health Homes (con’t)

- The health home model of service delivery expands on the traditional medical home model to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, with the main focus on the needs of persons with multiple chronic illnesses.

- Health home services include:
  - comprehensive care management
  - care coordination
  - health promotion
  - comprehensive transitional care, including appropriate follow-up from inpatient to other settings
  - patient and family support
  - referral to community and social support services, and
  - use of health information technology to link services

- Expect that use of the health home service delivery model will result in lower rates of emergency room use, reduction in hospital admissions and re-admissions, reduction in health care costs, less reliance on long-term care facilities, and improved experience of care and quality of care outcomes for the individual.
What makes up a Health Home?

- Physical Health/Specialty Health Services
- Mental Health Services
- Substance Use Services
- Housing
- Social Services
- Community and Natural Supports
- Managed Care Organizations
- Pharmacy
- Educational/Vocational Services
- Legal Services
- Developmental Disability Services
- Peer Support/Services

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Health Homes will focus on...

**COMMUNITY BASED CARE**

- Facilitating Health Behavior Change
- Transitions
- Recovery and Person-Centered Practices

**Use of Data and Technology**

- Outreach & Engagement
- Use of Natural Supports

**Team Based Care**

- Accountability for Outcomes
- Family Support

**COORDINATED CARE**

- Engaging in Partnerships with Consumers
- Integrated Physical/Behavioral Health Care

**Wellness and Prevention**

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Roles/Responsibilities of HH Care Managers

Used with Permission from Margy Meath

COORDINATOR

FACILITATOR

TEAM BUILDER

BROKER

QUALITY ASSURANCE

INVESTIGATOR

PERSON with HOPES and DREAMS

PHYSICAL

EMOTIONAL

SOCIAL

SPIRITUAL

CULTURAL

ENVIRONMENTAL

???
For people being supported by services, it is not person centered planning that matters as much as the pervasive presence of person centered thinking. If people who use services are to have positive control over their lives, if they are to have self directed lives within their own communities then those who are around the person, especially those who do the day to day work need to have person centered thinking skills.”

Helen Sanderson and Associates
How do I know if I am doing person-centered work?

• Handouts:
  – Core Values of Person-Centeredness
  – Hallmarks of Person-Centered Practice
  – Guiding Principles of Recovery-Oriented, Person-Centered Systems of Care

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Understanding what is **important to** and **important for** people is a core person-centered thinking skill!

- ELP Learning Community, www.elpnet.net
Tool: Important To/Important For

**Important “To”**
the person

Things that resonate with the person regarding:

- Values and ideals
- Personal preferences
- Interests
- Talents
- Dreams and aspirations

**Important “For”**
the person

Things that must be kept in mind regarding issues of:

- Health and safety
- What is needed to be a valued member of his or her community of choice
Important To:

All Choice, No Responsibility
Important For:

Health and Safety Dictate Lifestyle
Person-Centered Practices...

Gives equal priority to what is important to and what is important for the individual
Today’s plan

• We will spend most of today in small groups and will work through a single case scenario.

• This scenario will give us an opportunity to explore the various roles and responsibilities of a Health Home Care Manager.
#1 – REFERRAL/OUTREACH

- Your agency receives a new list of eligible participants from DOH. You are asked to outreach to John---the only information you have is his name/DOB/address and last 5 Medicaid contacts. You attempt to call his phone number and it is disconnected. You also drive to the address listed, knock on the door and learn that John moved 6 weeks ago. The person answering the door has no idea where John went.
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
#2 – ENGAGEMENT/FIRST VISIT

• You finally locate John and have a brief phone discussion with him. He is open to meeting with you and you schedule an appointment to see him at his home the next day.
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.

• Empowerment: 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
#3 – ENGAGEMENT/DEVELOPING PARTNERSHIPS/ASSESSMENT

Handouts
Case Scenario
Important To/For
The most important thing is to build the relationship first!

What can CM’s bring to the relationship?

• 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

# 4 – COORDINATING CARE and DEVELOPING A TEAM APPROACH

• John agrees to be part of the health home and expresses some interest in working with you and others. He is willing to see a Primary Care Physician but states “I don’t want nobody trying to lecture me about smoking. It’s a free country and I can smoke if I want to”.

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Helping people make the best of their doctor visits

Provide them with this information:

BEFORE the appointment

1. Write down the topics you want to discuss—think about any changes in your health since your last visit!
2. Write down any questions or concerns you have
3. Get to know as much as you can about your family history
4. Remember to bring your written list (with a list of all medications you take, plans of care, etc.)
DURING the appointment

1. Ask about recommended screening exams for your age group
   - Adult Preventive Care Guidelines
   - General Health Screenings/Immunizations for Women
   - Recommended screening, tests and immunizations for Women with High Risk Factors
   - General Health Screenings/Immunizations for Men

2. Communicate your preferences and priorities

3. Determine what your responsibilities are as part of your treatment plan

4. Ask any questions you have about the plan
AFTER the appointment

1. Schedule any follow up appointments
2. Know how you will receive any test results
3. Know what you can do to improve your health (include fitness and nutrition)
4. Read more about any conditions you may have
# 5 – SUPPORTING TRANSITIONS

- You receive a call from a local hospital that John has been hospitalized on a medical unit after a mild heart attack. He will be discharged in the next day and the social worker inquires about how you will be of assistance in his discharge.
# 6 EXPANDING THE TEAM

- In follow up to his recent hospitalization, John reluctantly agrees to attend outpatient appointments with a cardiologist and mental health provider. As happened with the PCP appointment, he tells you in no uncertain terms; “if they don’t listen to me or start pushing meds, I am gonna walk out.” You know that he is serious about this.
During your next appointment with John, he indicates that he has been ‘really down’, has been sleeping almost around the clock and is not eating much at all. He compares these feelings as being similar to the last time he was in the Psychiatric Inpatient Unit and adds, “nothing ever gets better for me”. He expresses some mild benefit from his first appointment with the mental health therapist. You mention something about the idea of “Recovery” and John looks at you quizzically.
SAHMSA’S RECOVERY DEFINITION

“A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”

http://www.samhsa.gov/
What supports Recovery?

- Health
- Home
- Purpose
- Community

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Guiding Principles of Recovery...

• Emerges from hope
• Is person-driven
• Occurs via many pathways
• Is holistic
• Is supported by peers and allies
• Is supported through relationships and social networks
• Is culturally based and influenced
• Is supported by addressing trauma
• Involves individual, family and community strengths and responsibility
• Is based on respect
You’ve been working with John for several weeks now and he has had a first appointment plus a follow up with his new PCP and cardiologist. He was recently started on beta blocker post heart attack as well as a new oral medication to control his glucose levels – he is not quite sure how this works or why it’s important.

John is also indicating some beginning awareness of his need for better nutrition and exercise to manage his diabetes and hypertension but says “there’s nothing I can do – I don’t really have any money so I can’t join a gym and I gotta buy food that is cheap so I can still have money for smokes”.

During this discussion, John relates that he HAS cut down on smoking but he is ‘not ready to quit’. You sense some ambivalence on his part about the potential for change.
Your role in doing this...

• Engage the individual in a trusting, collaborative relationship
• Re-visit what issues are IMPORTANT TO/FOR (as these can change for individuals over time)
• Elicit from the individual what they already know, what they want to know, and what they are willing/interested to do.
• Empower individual to be a self-manager.
What makes an effective self-manager?

• Knowledgeable about the condition and what can be done to enhance quality of life
• Motivated to self-manage using information and support
• Follows a personal care plan
• Shares in decision-making
• Monitors and manages symptoms
• Problem solves or seeks help as needed
• Adopts a healthy lifestyle
• Has access to support and uses it
New Shared-Decision-Making Resource

Welcome

Shared decision making (SDM) is an emerging best practice in health care and mental health services. It pairs a style of communication and decision making tools to help balance clinical information about mental health conditions and treatment options with an individual’s preferences, goals, and cultural values and beliefs.

Print & Video

Information on shared decision making topics: Issue Briefs, Brochure, Tip sheets, and how to videos for administrators, providers, and service users.

Workbooks

Step-by-step decision support resources:
The workbooks are practical tools that may be copied and used by individuals and families, as well as in peer support and service program activities.

Decision Aid

A computer-based tool to help you consider the role of antipsychotic medications in your recovery plan.

Cool Tools

Tip sheets and fillable Worksheets:
Handy, 1-2 page tools that may be copied and used in multiple ways by individuals, families, and peer support and service providers.

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http://www.samhsa.gov/consumersurvivor/sdm/StartHere.html
#9 – ONGOING ASSESSMENT

• A week later you’re meeting with John and he is in a VERY upbeat mood. John shares with you that he has recently started dating a woman who he met while waiting at a bus stop. He says: “I’m really happy- she’s great and we’re spending a lot of time together”.

• He indicates some disappointment about not having enough money to take his new girlfriend out on a ‘real date’ and makes a passing reference to the high cost of cigarettes while quickly saying, “I don’t know if I could ever really quit smoking”.

• John also says something about being sexually active with his new girlfriend and you suddenly realize that you’ve not talked with him about STD’s, HIV, etc.
#10 – UPDATING PLANS/EXPANDING THE TEAM

• You have worked with John for almost 5 months now. He seems to have developed a good relationship with his PCP. He is now regularly taking an oral medication to control his blood sugar and is self-testing his glucose once a day except for when he ‘forgets’. He seems to be motivated to continue with this medication but still somewhat uncertain as to why testing his glucose is important. He no longer needs any follow up with the cardiologist.

• John has also started to do some part time (“under the table”) work and is pleased to be making some extra money. He tells you that “the guy I work for might put me on payroll but I don’t know if I should do that”. He relates that he has developed a few new friends through work and that ‘one guy told me he used to be like me but now he’s married, working a lot and making a lot of money’.

• John has seen his MH therapist 3 times and he has an appointment to see the Psychiatrist next week. He remains adamant about not wanting to take psychiatric medications explaining that some of what he took in the past caused impotence.

• He is still dating his girlfriend and she has become an important support for John – they are talking about moving in together to a new apartment. John has started to get some regular exercise (mostly walking to and from his girlfriend’s apartment). He has cut down his smoking but has not completely quit. He tells you he doesn’t smoke when he is with his girlfriend as she ‘hates cigarettes’ and jokingly adds: “I might have to get serious about quitting if we move in together”. John is also beginning to recognize that smoking less has given him more money to spend on other things.
#11- BILLING FOR HEALTH HOME SERVICES

What examples were discussed in which a health home care manager would bill for:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Transitional Care
- Individual/Family Support
- Referral to community/social support
Questions/Feedback

• What did you like about today’s training?
• What are the most important things you learned?
• What could be improved?
• Other thoughts, ideas, etc?