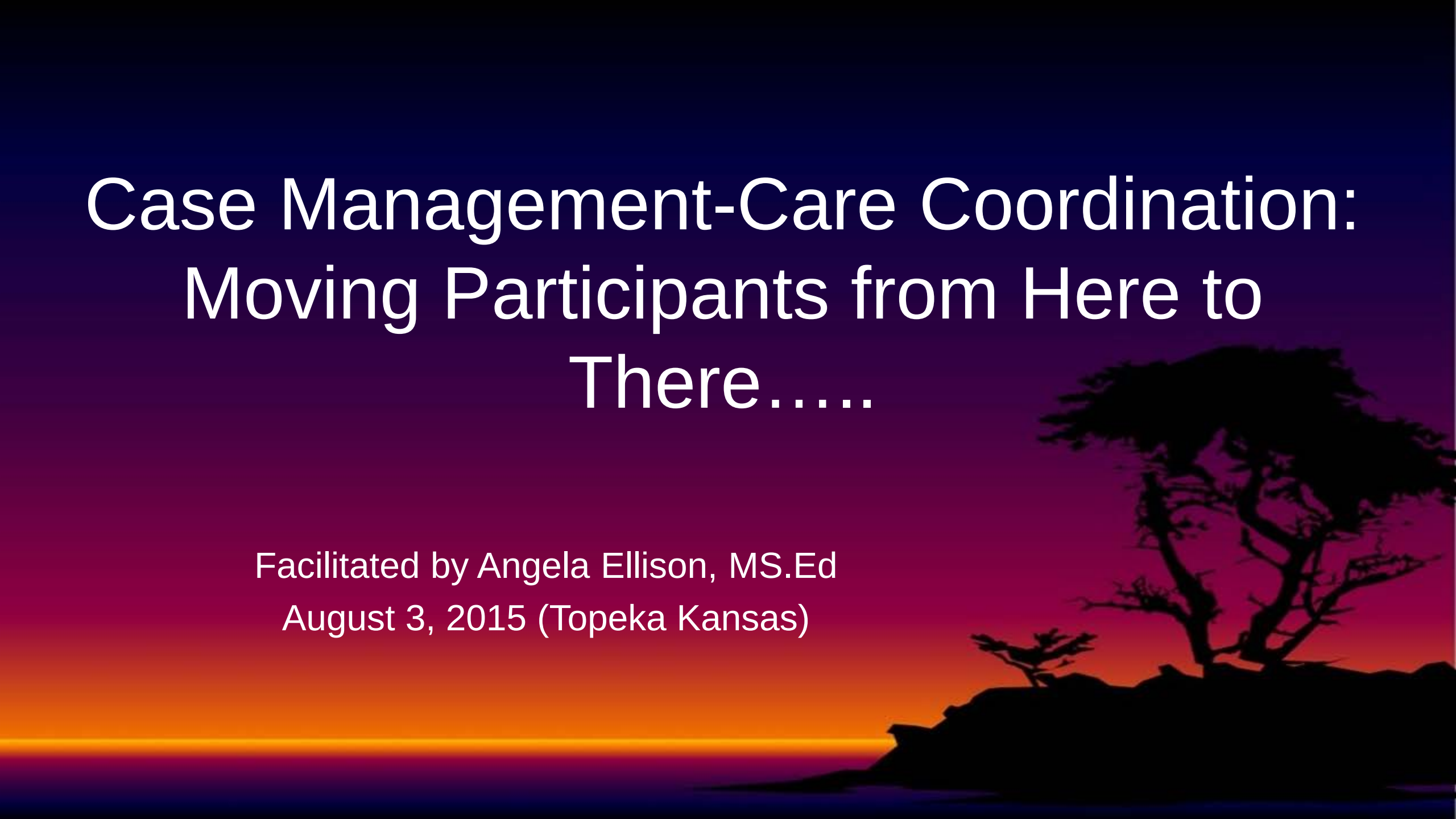
Case Management-Care Coordination: Moving Participants from Here to There…..

Facilitated by Angela Ellison, MS.Ed

August 3, 2015 (Topeka Kansas)



Who is Angela M. Ellison?

- Employed by UIC and SSC
- Master of Science in Education
- Mother of one son
- Former Exec Director of a Community Based Organization
- Believes in Justice For ALL
- Concerned Citizen
- Maintains a strong belief that people can help people if you care enough!!!

Who Am I? I mean Really!!

- Angela Maria Hall Ellison
- A member of Delta Sigma Theta Sorority, Inc.
- Worked with women and children for more than 29 years, been in the maternal and child world since the first program in Illinois,1986.
- A lady who really cares about the people I work with
- A Mom and Baby advocate
- An African American women committed to Christ!!
  "Unashamedly Black and Unapologetically Christian" (TUCC)
- An Educator and a Facilitator by nature and spirit
- I am who you see, a work in process (don't know how to be anybody else)
- A mother, sister, cousin, good friend and listener
- Working every day to make a positive difference in every life I touch
- Mr. Hall's Daughter

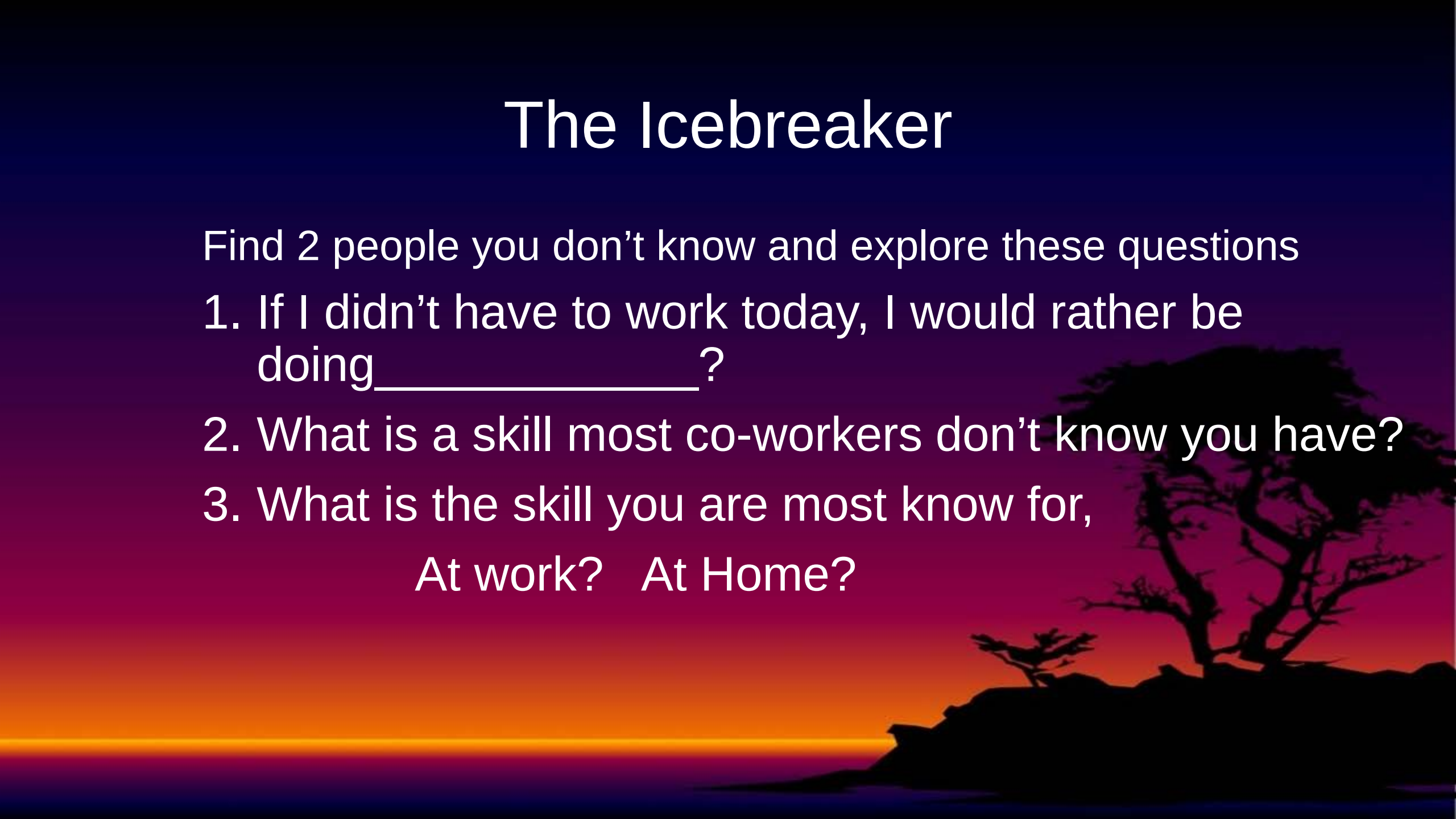
So who am I sharing this space and time with?

The Icebreaker

Find 2 people you don’t know and explore these questions

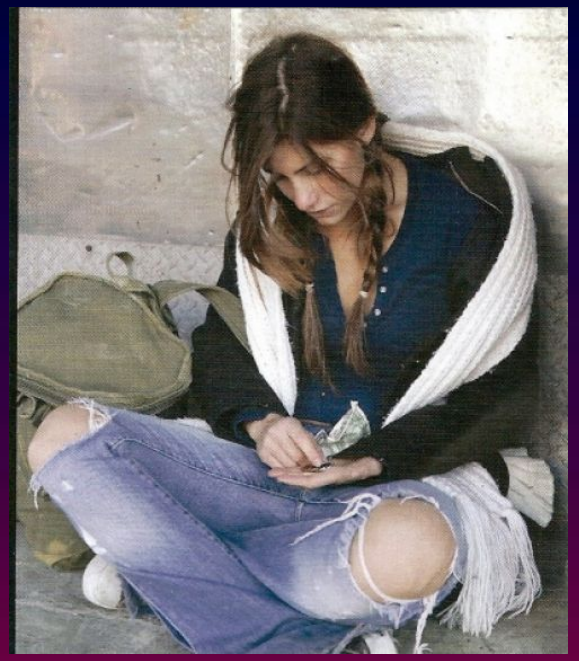
1. If I didn’t have to work today, I would rather be doing_____?
2. What is a skill most co-workers don’t know you have?
3. What is the skill you are most know for,

   At work? At Home?



Today’s Objective

- Deepen Our Understanding of Case Management/Care Coordination in the Healthy Start Framework
- Understand Keys Components of a Successful Care Coordination Model
- Develop part one of a roadmap for improving care Coordination within your Healthy Start



Her Story

After a night’s hospitalization the young woman was discharged with a good bill of health from the main entrance of the hospital. She boarded a bus with the pass she had received and traveled as close to her home as the route could bring her. She walked cautiously along a longer way to her home to avoid the druggies and thugs that she normally encounters on the more direct route.

When she arrived at the small plywood shelter on the lower level of an overpass she was relieved to be home. She thanked her nearest neighbor for watching her stuff. She carefully placed her discharge instructions and medications in her only remaining possession from her days in a real home….. a small suitcase that had seen better times than this. One that had been places where she was welcomed.

She felt down and overwhelmed. She wondered about her chances to get the job she had hoped for before illness prevented her from responding to the sign she had seen in a window on a nearby street. She wanted to work. No, she needed to work.

She heard the familiar rumbling of a disagreement between a man and a woman down the way. What should she do? She saw a police car parked on the bridge further down from her home. She was afraid but not certain who she feared more. So she sat quietly and pretended not to hear.

It was getting colder and she covered herself with her blanket and pages from a newspaper that she had picked up from a seat in the ER hoping that her friend, who was a better reader, would read it to her and help her find work.

She kept an ear open for signs of trouble as she drifted off to sleep wondering about the card the nurse had given her for a return appointment.

The nurse had read it to her several times and asked if she planned to keep the appointment ….stressing how important it was …..telling her they would help her take care of herself and the baby she carried inside her. “Don’t disappoint me” she had said.

She thought about the trip back to the clinic. She thought about the cold, the druggies, the questions, the way people looked at her and about asking someone to watch her stuff again. She thought about the job she might get. She thought about what the nurse would think if she did not show up….

She remembered the doctor asking her about vitamins and medicines they had given her when she first went there. He had looked at her strangely, almost angry, when she thanked him but said she'd rather be natural and take the medicine her elderly neighbor had made from the pot liquor of fresh greens. Her mother had done this and she knew this was better for her. He kept talking but in a fast, unfriendly way so she smiled and tuned him out.

And she drifted off to sleep to the sounds of her community and wondered what they'd really think, what they'd do….

if they really knew her story.

So What's her Story, What do you Hear?

- How do you find her?
- How do you engage her?
- What do you offer her?

Care Coordination” Moving From Here to There….

An Angela Thought

Care Coordination is just Case Management
Dressed up for 2015.

So In Summary

True Care Coordination

- Involves people
- Is coordinated by a single Case Manager/Care Coordinator
- People's readiness to change
- Having the resources needed to facilitate change
  (Internal and External) (Includes your CAN)
- Participant led and involved (Family too)
- Ongoing and Requires attention
- Must be deliberate and outcome focused

Summary Continued

Care Coordination has essentially 7 steps

1. Engagement
2. Assessment
3. Care Plan Development
4. Referral and Connection
5. Monitoring, Follow –Up, Advocacy and Support
6. Case Closure
7. “Caring for the Care Giver” (Although not really a “Step” this one is vital for the whole thing to work)

Care Coordination Moving Participants from Here to There…..

Question

What is the purpose for Care Coordination, as you know it, in Healthy Start?

A Prevention Story

Closing the Gap in Illinois

Closing the Gap - Our Approach (2004 – 2007)

- Provider Evaluation/Education
- Educational Campaign

  (Trained 20 Individuals from the target communities to be CHW's, Training was 21 session long)

- Provide education to the agencies the conducted Intensive Case Management

- Media Campaign

SIDS Educational Messages

Pre- Term Labor Educational Message

Spring 2006 messages


Saving Our Babies...
Saving Our Future.
Take action!
Get early and regular prenatal care.
Place babies to sleep on their backs in a safe crib.
Closing the Gap on Infant Mortality
sids
Common
For more information or help finding a healthcare provider, call 311.

Results……

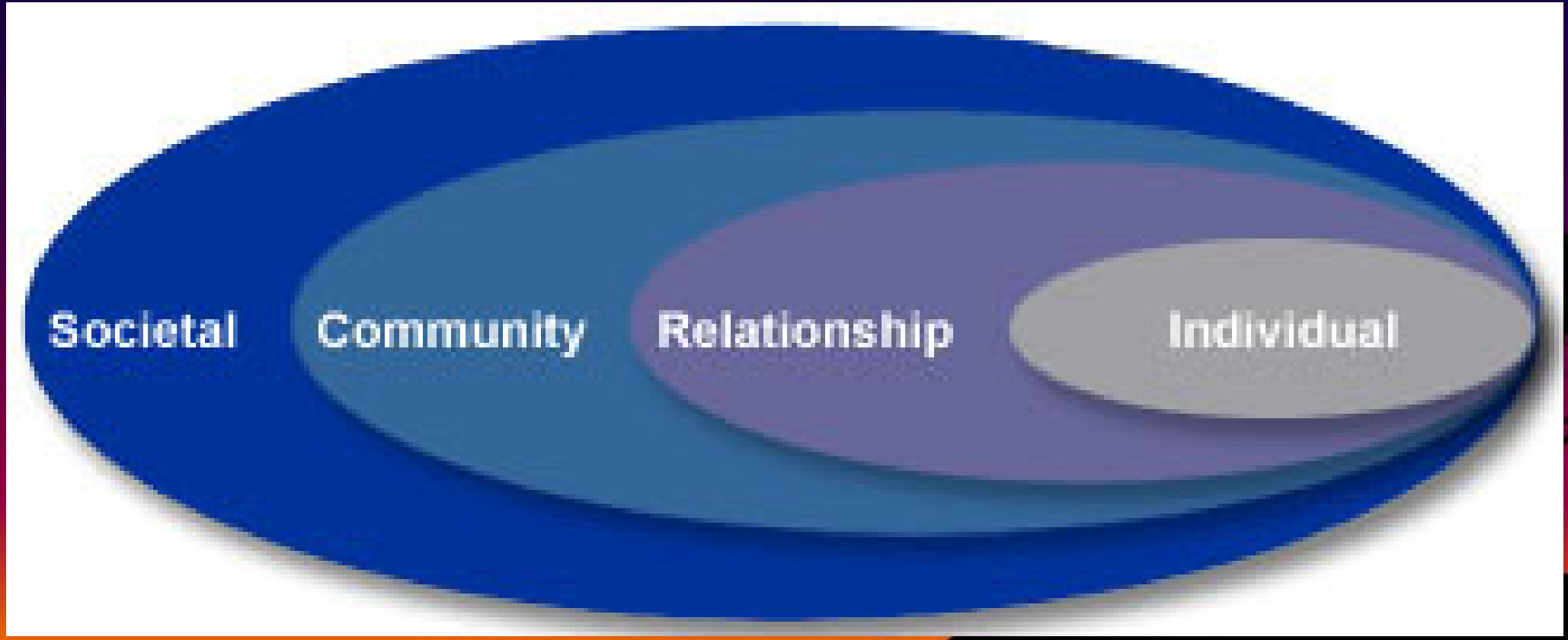
The IMR decreased by 37% in the two target communities through Caring People, Community Education, Partnership and Holistic Approach

Why I think it worked

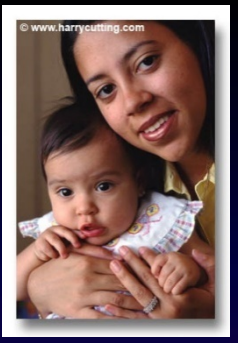
- The people we hired (Passionate about the issues)
- The holistic education focus
- The multi-prong approach to addressing the issue
- The community was involved from the very beginning (Program Design, Media Design)
- Met local legislators and Key Stakeholders prior to program implementation and educated about the problem and the process..

Case Management/Care Coordination, what da people say…..(in my James Brown Voice)

A Person In the Context of the world (Public Health Ecological Model)



Case Management defined
(3 definitions from the internet)



1. The linking of a consumer to the service system and coordinating the various system components in order to achieve a successful outcome. The five case management activities are: (1) assessment, (2) planning, (3) linking, (4) monitoring, and (5) advocacy. Case management's primary goal is service provision for the consumer, not management of the system or its resources.

2. Coordination of services to help meet a patient's healthcare needs, usually when the patient has a condition which requires multiple services from multiple providers.

3. An individualized plan for securing, coordinating, and monitoring the appropriate treatment interventions and ancillary services necessary to treat each offender successfully for optimal justice system outcomes.

Care Coordination Defined Again

- *the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.*
- *Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.*

Care Coordination

Per Kimberlee Wyche Etheridge, MD,MPH WycheEffect LLC

Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care

Another Angela Thought and the Focus of this presentation

Healthy Start Is about……

Reducing Infant Mortality By……

- Improving Lives
- Connecting people and families to needed resources
- Inspiring change
- Providing support
- Teaching participants how to fish
- Moving families and communities from Here to There !!

Before we move on let’s paws and have a little discussion on key roles and responsibilities in the typical Healthy Start Model.

Case Manager/Social Worker – Responsible for Completion of assessment, care plan development and coordination of CHW activities.

This individuals completes progress reports and monthly data report as required by job and/or evaluator. (Please note that for High risk pregnant/parenting women with an infant under 2, this case manager may be a nurse or LCSW)

Case manager

(The conductor)

Under the direction of the Case Manager/Care Coordinator, the CHW is responsible for connecting participants with the resources identified in the Care Plan.

They will follow up on appointments and monitor compliance. In addition they may perform as outreach/ recruitment specialist who will work in the community to identify new program participants, educate them on the process.

In addition, if they CHW has received specialized training, they may also provide group or one on one education around their specialty trained topic.

Community Health Worker

(The Band)

These providers may include but is not limited to the Social Worker, Substance Abuse Counselor, Breastfeeding Educator, Doula, Medical Provider, Nurse Case Manager, etc.

These individuals will provide the services related to their specific area and will participate in Care Staffing as needed to ensure achieving of care plan goals and participant success.

Specialty Providers

(The Harmony)

C.A.N Partners (The Audience)

- In the early stages they may not like your concert. This Audience may come with an agenda and it certainly is not yours.
- However if keep moving, engaging, explaining, you/they will discover there are several areas that intersect in your work. This audience may have some hecklers, but with diligence they can go from a zero contributor to a hero.
- In the beginning it can be like a bad marriage but when it works you begin to see real system change that will impact multiple families not just one.

BREAKTIME!!

My Disclaimer

The following slides address Case Management in very broad stokes. If I was doing an actual Case Management training we would go more into detail on these issues.

(Time keeper needed here, let me know when I get to 3:45)

Now more about Moving from Here….. To …. …….. There!

The Most Important Rule in working with Our Participants is…….

Yep that’s right!!!

Start where they are !

(Not Where YOU want them to be)

Care Coordination: Moving from Here to There…. Step 1

<u>Engagement (in a real way)</u>

- Meeting people where they are….
- Letting them identify their needs
- Its there thing not yours, their agenda not ours… Our goal is reduce IM their goal might be how to pay the rent
- Although we may have the answer (after all we are the professional) we should not give it

If you are wondering why your participants are still engaging in negative behavior or are non-compliant it could be because it's not on their agenda

A West Side Story

- West Side Future (YMCA)
- IMR 28 deaths in 1986
- Illinois Medical District (no lack of health care)
- Three major housing development
- Low income, High crime rate, Substance Abuse/Gang Violence, Primarily single parent household, although the men were present (we addressed this many year later, much to my embarrassment)

So what was the problem? Was it access?

West Side Story…….What we did

- Hired people from the community through referrals from key leaders (even had to let some go, but there is a process, you might have to kiss the ring)
- Listen and learned from the staff
- We recognized that the staff was neighbors to their clients therefore we addressed/trained on burn-out, conflict resolution, ethics, time-management
- Subcontract with key agencies in area
- Formed Workgroups to address the “social determinant of heath) although we did not call it that at the time, (i.e. Parks and Recreations, Employment and Training, Health Care –Modern Day- the Community Action Network

Angela's Rules of Engagement
Rural vs Urban

In many ways the rules are the same.

- ✓The people who are providing the services need to have a **real** understanding/empathy for the people being served. (Culturally competent and sensitive) (Community Health Workers, I'm coming back to this point)
- ✓Meeting people where they are means, in their environment as well as in there head space. (homeless) In rural areas this means driving a lot.
- ✓Connecting with key leaders, organizations, "hot spots" in the area, establish an agreement. (Train people about the issues in the churches etc, nurture midwifes etc)
- ✓Use technology
  - ✓Text Massaging
  - ✓Interactive Education sessions
  - ✓Telehealth
  - ✓Facebook, Twitter etc. for universal messaging

Pardon me while I interrupt this scheduled program for a little commercial…..

When it comes to engagement both rural and urban, I truly believe the answer is <u>Community Health Workers.</u>

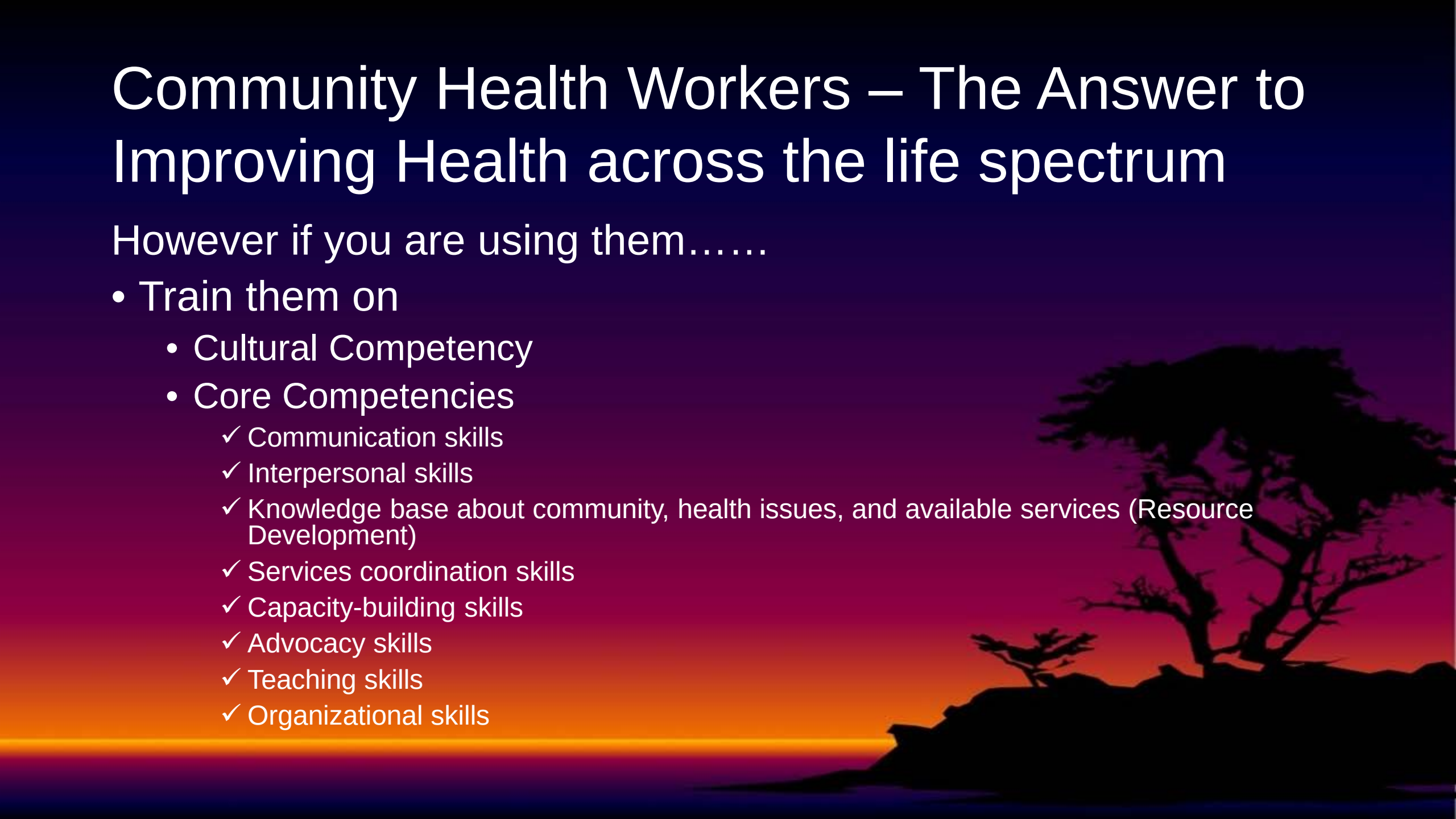
When researching this topic, it was the first and most repeated answer to this issue.

However, some things to remember…

Community Health Workers – The Answer to Improving Health across the life spectrum

However if you are using them……

- Train them on
  - Cultural Competency
  - Core Competencies
    - ✓ Communication skills
    - ✓ Interpersonal skills
    - ✓ Knowledge base about community, health issues, and available services (Resource Development)
    - ✓ Services coordination skills
    - ✓ Capacity-building skills
    - ✓ Advocacy skills
    - ✓ Teaching skills
    - ✓ Organizational skills



Ok Back to the Program……

Care Coordination: Moving from Here to There…. Step 2

Assess Needs and Areas of Potential Need

The challenge here is to not let the paper be your "God"

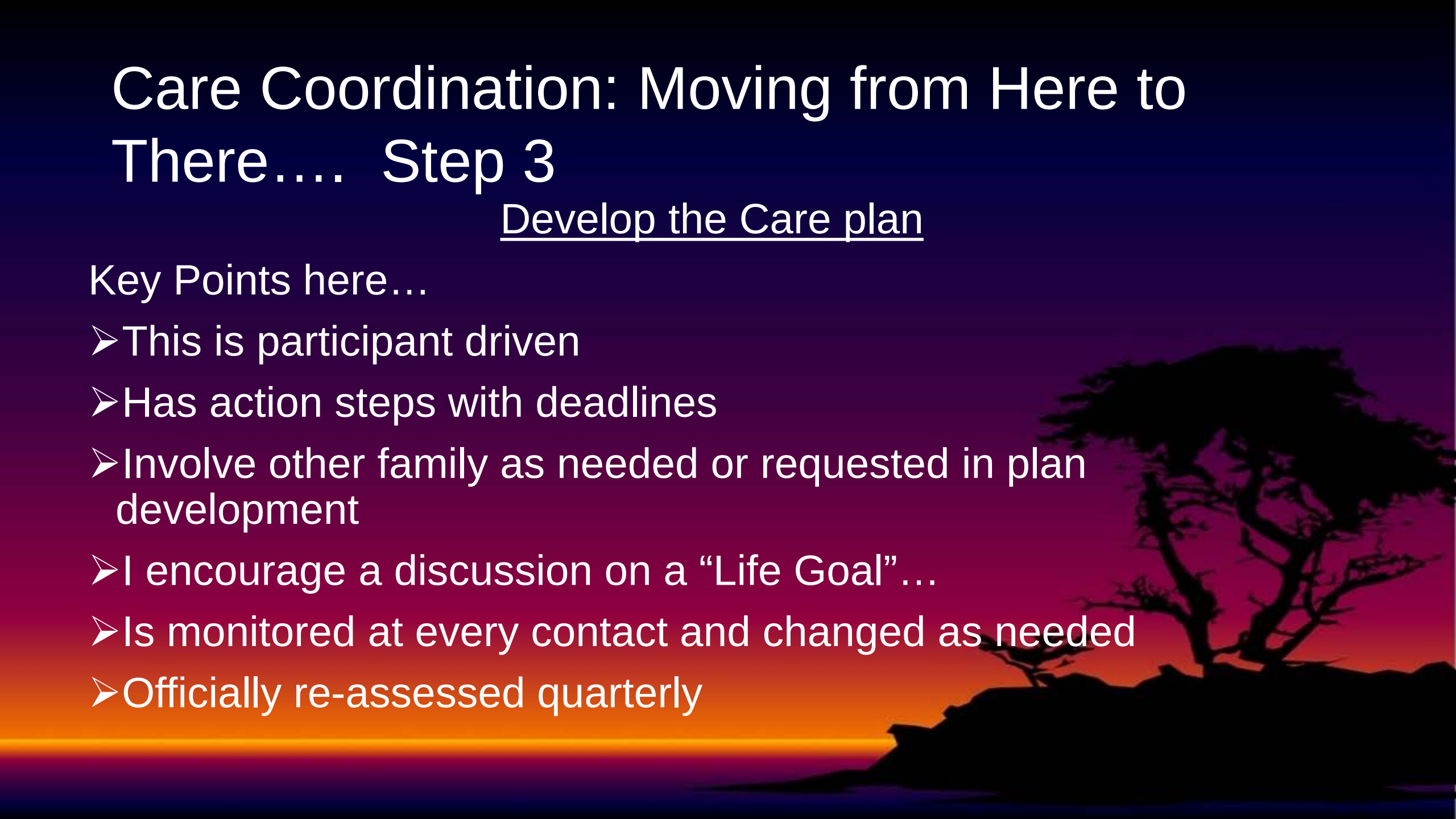
- We need to assess health care, lifestyle, risk factors, barriers, home environment.
- Obtain historical birth information and all other information that HRSA requires
- Some questions can be disturbing and/or intrusive (ask yourself how you would feel if someone asked you that)- so explain its propose and explain and understand participants right to refuse)
- We must obtain information in a sensitive, culturally appropriate and respectful way. (This means it usually will not get done in the first visit)

Care Coordination: Moving from Here to There…. Step 3

Develop the Care plan

Key Points here…

- This is participant driven
- Has action steps with deadlines
- Involve other family as needed or requested in plan development
- I encourage a discussion on a “Life Goal”…
- Is monitored at every contact and changed as needed
- Officially re-assessed quarterly



Care Coordination: Moving from Here to There…. Step 4

Connect to Resources

- Care Coordination involves working with participants and their families, linking them to needed resources so that they can reach the outcome that indicates success for them.
- The Care Coordinator links them to needed resources that, in a perfect world, he or she is comfortable sending someone to because he/she has done their research
- The Care Coordinator must be adapt and flexible working through the complex systems. Navigating the land mines and making the impossible possible.

Care Coordination: Moving from Here to There…. Step 5

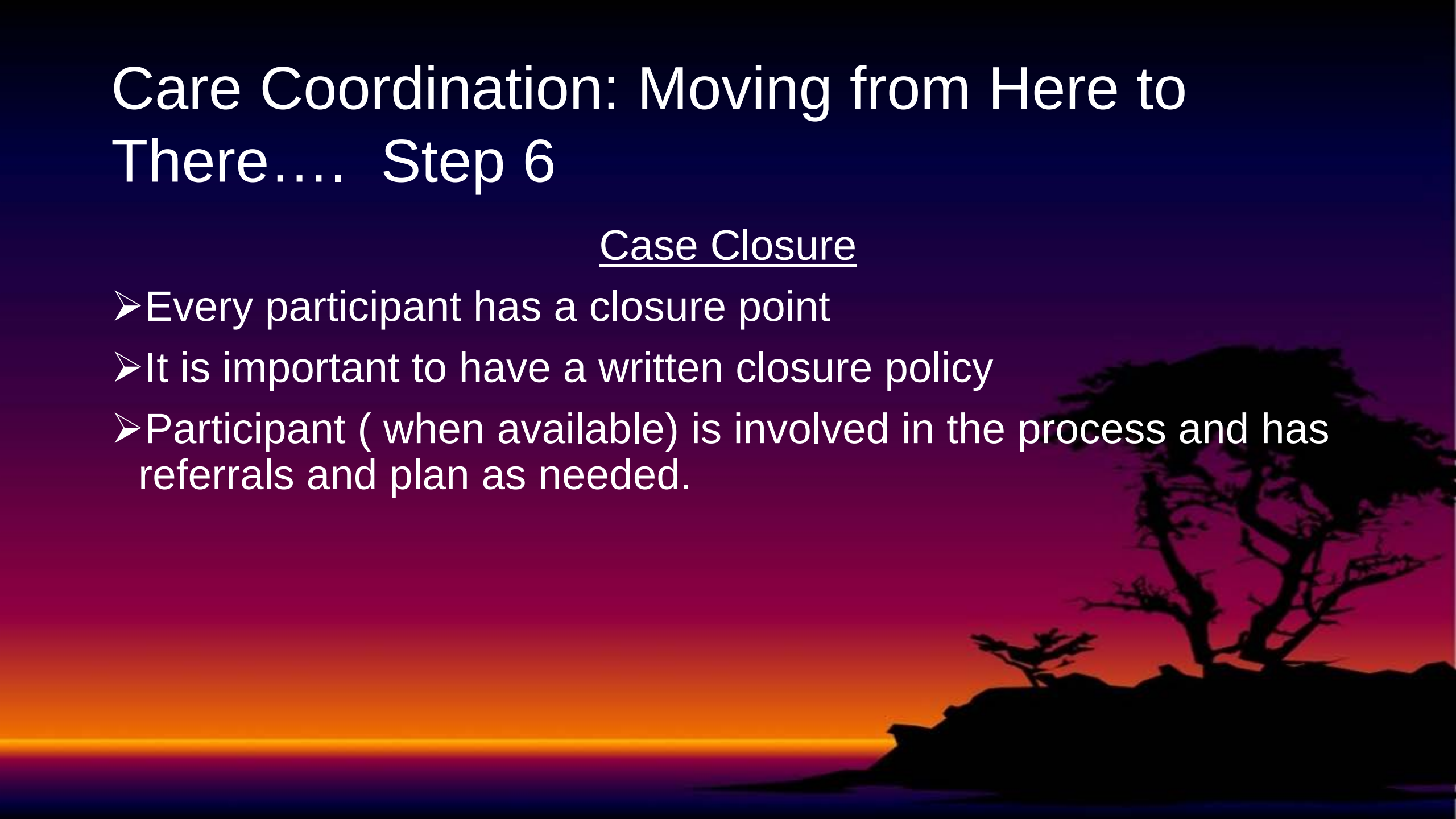
Monitoring, Follow –Up, Advocacy and Support

- Case Management/Care Coordination requires regular follow up times based on participants need/assessed risk level
- It's a well documented process
- Every action taken on behalf of or with the participants is documented
- We don't promise what we can't deliver.

Care Coordination: Moving from Here to There…. Step 6

Case Closure

- Every participant has a closure point
- It is important to have a written closure policy
- Participant (when available) is involved in the process and has referrals and plan as needed.



Care Coordination: Moving from Here to There…. Step 7

<u>Care Coordinator (CC) Takes Care of Self</u>

This is a tough job!

- Good psychological health is vital for the CC
- Understand and recognize burn out
- Rest and relax regularly
- Don’t forget about your family
- Take a break when its time to take a break
- Do something for your self regularly and don’t feel guilty

Care Coordination: Moving from Here to There

Some tools that will help

- An active C.A.N
- Community Partners
- A good resource manual
- Understanding the “Stages of Change”
- Some training/knowledge utilizing Motivational Interviewing

Case Management/Care Coordination Tools… What you need

- Risk Assessment
- Care Plan
- Progress Notes
- Readiness Assessment
- An active Resource Manual
- A Data system that captures outcome and measures improvement/change
- Written Policies and Procedures, Criteria for Case Closure
- Educational Materials for the Participant (Fun/easy to read)
- Ongoing Staff Skill assessment process and training

Healthy Start – Care Coordination Moving from Here to There - Everyone Matters – Summary Part 2

- Care Coordination works on prevention and intervention
- Care Coordination involves people & systems
- Care Coordination requires patience and flexibility
- Care Coordination Involves
  1. Engagement
  2. Support
  3. Listening
  4. Coaching
  5. Repeating 2 -4 often

Care Coordination: Moving Participants from Here to There….. An activity

Lets Brainstorm

What are our current challenges in meeting the needs of our participants,

Facilitating good Care Coordination

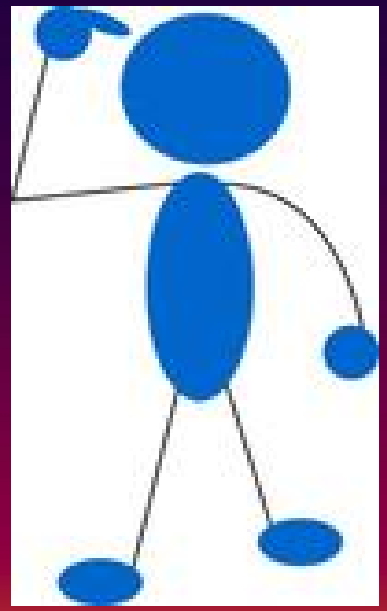
and ultimately moving our Participants from

Here…… …… To ……There

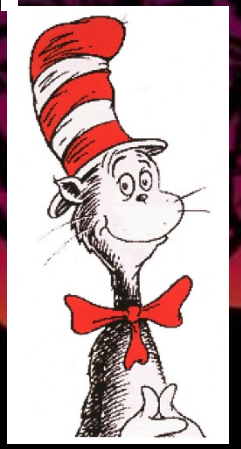
Moving Participants from Here to There…An Activity, A Time of Creative Thinking

1. Divide into your Healthy Start
2. Identify a “recorder” and “reporter”
3. Identify your top 5 “Challenges” that were just discussed
4. Identify your current assets and resources to address the challenges that were discussed in the session before the break
5. Identify your gaps in addressing these challenges
6. Develop at least 2 strategies/action steps to address the gaps identified.

I Leave you with this Thought!!!



UNLESS someone like <u>YOU</u> cares a whole awful lot,
nothing is going to get better.
<u>It's not!!!</u>



Dr. Seuss

Got Questions

Thank You & Thank You for your Time!
Tootles

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Feel Free to call me… I love this stuff!!