Transformation to Health
Home Care Management:
The Critical Role of Supervisors

May, 2012
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Webinar Objectives

1. Supervisors will be able to speak to staff about the NYS transition plan and how the role of Health Home Care Managers will be similar/different from the traditional case manager role.

2. Supervisors will understand the goals and expectations of this training initiative.

3. Supervisors will identify how they can support staff with transition to Health Home Care Management.
Key Content Areas Throughout Training Initiative

1. Working within Health Homes

2. Recovery-Oriented, Culturally Competent, Person-Centered Practices

3. Comprehensive and Integrated Care
What is a Health Home?

• Not a place

• Uses a care manager to coordinate a range of services, in order to enhance quality and reduce costs.

• Serves Medicaid recipients with Chronic Health Conditions.

For more info:

http://www.health.ny.gov/health_care/medicaid_program/medicaid_health_homes/
Recovery Oriented, Culturally Competent, Person-Centered Practices

• Strength based
• Individualized
• Promotes Wellness
• Hope
• Empowerment

Core Values, Hallmarks, Guiding Principles

For more info: [http://www.samhsa.gov/](http://www.samhsa.gov/)

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Comprehensive and Integrated Care

People with mental disorders: 25% of adult pop.

People with medical conditions: 58% of adult pop.

68% of adults with mental disorders have medical conditions

29% of adults with medical conditions have mental disorders

Source: National Comorbidity Survey, 2003

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Co-Morbid Medical Illness in Individuals with Serious Mental Illness (SMI) and Substance Abuse (SA)*

*from Morbidity and Mortality in People with Serious Mental Illness, NASMHPD 2006 (Maine data) (c) 2012 NYCCP, Inc.
NYS Medicaid Recipients  (NYS DOH, 2012)


- Developmental Disabilities
  - 52,118 Recipients
    - $10,429 PMPM

- Mental Health and/or Substance Abuse
  - 408,529 Recipients
    - $1,370 PMPM

- Long Term Care
  - 209,622 Recipients
    - $4509 PMPM

- All Other Chronic Conditions
  - 306,087 Recipients
    - $698 PMPM

$6.5 Billion
50% Dual
10% MMC

$6.3 Billion
16% Dual
61% MMC

$10.7 Billion
77% Dual
18% MMC

$2.4 Billion
20% Dual
69% MMC

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## Demographics of NYS Health Home Eligible Enrollees

### Health Homes Mental Health/Substance Abuse and Other Chronic Population - 8/31/11

#### Calendar Year 2010 Socio-Demographics

<table>
<thead>
<tr>
<th></th>
<th>Individuals with MH/SA</th>
<th>Individuals with other chronic conditions</th>
<th>Total</th>
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<tbody>
<tr>
<td><strong>Non-TCM/Act TCM/Act</strong></td>
<td></td>
<td></td>
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<tr>
<td>Non-TCM/Act</td>
<td>95.9%</td>
<td>97.3%</td>
<td>96.6%</td>
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<td>TCM/Act</td>
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<tr>
<td><strong>0-18 yrs</strong></td>
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<td>19-64 yrs</td>
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<td>65+ yrs</td>
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<td><strong>Male</strong></td>
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<td>58.7%</td>
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<td>21%</td>
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<td>Hispanic</td>
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<td>27%</td>
<td>26.4%</td>
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<tr>
<td><strong>White</strong></td>
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<tr>
<td>White</td>
<td>41.2%</td>
<td>24.6%</td>
<td>33.3%</td>
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<tr>
<td>Other</td>
<td>11.7%</td>
<td>27.6%</td>
<td>19.3%</td>
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<td><strong>FFS Only MMC</strong></td>
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<td>FFS Only</td>
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<td>29.7%</td>
<td>29.7%</td>
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<tr>
<td>MMC</td>
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<td>70.3%</td>
<td>70.3%</td>
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<tr>
<td><strong>Non SSI SSI</strong></td>
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<tr>
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<td>SSI</td>
<td>48.4%</td>
<td>42.3%</td>
<td>45.5%</td>
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http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mental_health_sub_abuse.htm
Health Homes Require Whole System Engagement
Health Homes: Testing the Waters Vs. Diving In

• What do supervisors need to do to support transformation?

• How can supervisors make the biggest impact/splash?

• How do your current supervisory skills apply to this new Health Home world?

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Leading with Pride

The skills of our workforce are critical to a successful Health Home future
NYS Care Management Training Initiative

• Training Awards from NYS Health Workforce Retraining Initiative

• Collaborative Training Partners
  – NYAPRS and NYS Council for Community Behavioral Healthcare
  – MHA of Nassau and Clubhouse of Suffolk
  – TechLeaders Consulting
  – NYCCP

• 900 Slots for Training
  – 700 Upstate NY, 200 Long Island
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.

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## Training Deliverables

<table>
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<tr>
<th>Time Frame</th>
<th>Deliverable</th>
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<tr>
<td>April, 2012</td>
<td>Development of Training Website <a href="http://www.healthhometraining.com">www.healthhometraining.com</a></td>
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<tr>
<td>May, 2012</td>
<td>Registration and Pre-Assessment</td>
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<tr>
<td>May 16, 2012</td>
<td>“Kick Off” Webinar for Supervisors</td>
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<td>June - Sept, 2012</td>
<td>5 Webinars</td>
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<td>Sept-Dec, 2012</td>
<td>Face to Face Training Day #1</td>
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<td>Jan-April, 2013</td>
<td>4 Webinars</td>
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<td>April-June, 2013</td>
<td>Face to Face Training Day #2</td>
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<tr>
<td>June, 2013</td>
<td>Post-Assessment</td>
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Participant Requirements

• Year long commitment to training initiative
  – Attendance will be tracked for all training components
  – Participants must log in to webinars/training with an assigned ID number/region
  – NYS pays on a per student basis - absence results in loss of funding

• Reporting on outcomes associated with workforce retention and integrated care skills improvement
Registering Staff

• Please provide an agency contact person via: https://www.surveymonkey.com/s/NYSCMTI or by contacting Andrea Hopkins at Clubhouse of Suffolk Andrea.Hopkins@clubhouseofof Suffolk.

• Training staff will contact the agency representative for a list of all the individuals you wish to enroll in the training.

• Upon completion of registration, we will let you know which of your staff have been accepted as a “full participant” or as an “alternate participant”.
• After acceptance, and before the first care manager webinar in June, each participant will need to complete a brief pre-training assessment.

• Grant funding requires that there be a certain number of participants trained in each area of the state for which it is funded.

• With this in mind, a waiting list will be developed to manage requests beyond the designated slots (“alternative participant”).
Key Training Components

- Working within Health Homes
- Recovery-Oriented, Culturally Competent, Person-Centered Practices
- Comprehensive and Integrated Care
Key Training Components

Working within Health Homes

- Understanding health homes and the needs of the target population
- Roles and responsibilities of health home care managers
- Critical elements and processes that support change/transformation
- Using Best Practices to improve outcomes
- Using HIT to improve outcomes
- Interacting with MCOs and other systems of care

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Key Training Components

Recovery-Oriented, Culturally Competent and Person-Centered Practices

- Seeking to deeply understand individuals
- Outreach, engagement and development of partnerships
- Developing integrated and coordinated care plans that reflect the person’s strengths, interests, preferences and priorities
- Linkages to formal and informal supports
- Supporting individual choice
Key Training Components

Comprehensive and Integrated Care

• Addressing key behavioral and physical health issues
• Understanding health disparities
• Facilitating health behavior change
• Promoting health
• Navigating systems of care

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Case Management Supervisors as Leaders in the Health Home Environment

Supervisor Skills

Meaningful Supervision

Management of Complex Change

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Supervisor Role

• Many styles and definitions.
  – Team Leader, Project Manager, Supervisor, Program Manager, Executive

• Supervisor is a person who oversee the work of others.

• Most challenging supervisor position is front line supervisor as they must mediate between high level managers/executives and front line staff members “on the street”.

• Supervisors have significant influence on shaping the health home “culture”.
Health Homes will focus on...

**Community Based Care**
- Transitions
- Facilitating Health Behavior Change
- Recovery and Person-Centered Practices
- Addressing the “Whole” Person
- Engaging in Partnerships with Consumers

**Use of Data and Technology**
- Outreach & Engagement
- Use of Natural Supports

**Team Based Care**
- Accountability for Outcomes
- Family Support

**Wellness and Prevention**
- Integrated Physical/Behavioral Health Care

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Roles/Skills of the Successful Supervisor

- Navigator
- Team Builder
- Problem Solver
- Delegator
- Conflict Negotiator
- Implementer of Change
- Evaluator of Performance
- Guide/Mentor
- Good Listener
- Decision Maker
- Able to set goals
- Leader
- Coach and Counselor
- Prioritizes and Manages Time
- Trainer and Professional Developer
- Detail Oriented
- Good Oral and Written Communicator
- Bridger between Sr. Leaders and Direct Care Staff
Supervision

• Supervision is the cooperative relationship between a leader and people who accomplish particular purposes through teaching.
  – Teaching involves advising, helping, inspiring, leading and empowering others.

• Better supervised work groups are better performing work groups.
Objectives of Meaningful Supervision

• To assist with development of staff to their highest potential.

• To interpret policies, objectives, and needs of program /organization.

• To develop standards of services.

• To coordinate service provision.

• To evaluate staff and services delivered.

• To deliver high quality health care services.

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Good Supervision = Leadership

Tasks linked most closely with good supervision fall into leadership category:

• Listen and show empathy
• Identify growth, training and development needs
• Promote teamwork
• Address work-related conflict among staff
• Respect supervisees
Managing Complex Change: Understanding How to Engage Staff in the Change Process

**Change**: to make, cause or become different

- Change is the event or situation

**Transition**: the process of going from one thing to another which is not the same

- Transition is what most people have trouble with/struggle with
- Transition is psychological, emotional

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Process of Transition

Three phases people go through as they internalize and come to terms with details of the new situation:

• First is “letting go” of what was, the old way of doing business

• Second is a Neutral zone or “limbo” where the old is gone but the new is not fully operational

• Third is the New Beginning, more positive

What stage of transition is your staff?
Letting Go...

- Give permission for staff to talk or define what they will miss, what was positive - their role, identity, comfort of old ways, etc.

- Ask staff to create a list of what they accomplished to “honor” the past

- Identify and discuss strengths/positives of the new model

- Focus on what skills, tasks and experiences staff can bring forward in this new environment

- Communicate, communicate, communicate!
Leading People thru the Neutral Zone

• Normalize feelings of fear and anxiety
• Focus on each person’s strengths, qualities, interests
• Keep staff informed and educate them on each new development
• Identify short term goals for you/ your team to accomplish
• Foster learning, embrace creativity and encourage experimentation
• Maintain perspective
Leading People thru the Neutral Zone (con’t)

Six characteristics that foster successful culture change in your program:

1. Low Anxiety
2. Emotional Stability
3. Action Oriented
4. Confidence
5. Openness
6. Risk Tolerance
The New Beginning

To initiate a new beginning, you will need several elements to support successful change:

• Vision
• Skills
• Incentives
• Resources
• Action plan
Vision + Skill + Incentive + Resources + Action Plan = Successful Change

However:
If vision is missing, there can be confusion.
If skills are missing, there can be anxiety.
If incentives are missing, there can be a reduction of speed and stalling of the process.
If resources are missing there will be frustration.
If action plan is missing, there will be false starts.

All elements together create the formula for successful complex change!
Critical Role of Supervisors

• Learn as much as you can about Health Homes, embrace its evolving development.
• Support staff throughout their role transition, support development of knowledge and skills.
• Actively network with others.
• Embrace the journey- no template to follow- participate in cultivating a new era of care management!
• Continuously assess the process and outcomes.
• Take care of yourself so that you can be of support to others!
Questions
Next Steps...

• Please complete the follow up survey
• Log on to the NYS Care Management Training Initiative website and review available resources at www.healthhometraining.com
• Register staff for the training series
• Talk with staff about Health Homes:
  – Where are they at in the transition process?
  – What is needed in terms of vision, skills, incentives, resources and an action plan?
  – What do they need in terms of support from you?
• Talk with your leaders addressing the same questions above for yourself.

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