Public Meeting Notice

- Please note this meeting is open to the public and is being recorded.
- Anything said during this meeting may be part of the public record.

I Can Help You!
Serving Populations with Complex Behavioral Health Needs.

COLORADO
Department of Health Care Policy & Financing

COLORADO
Behavioral Health Administration

HMA
Health Management Associates

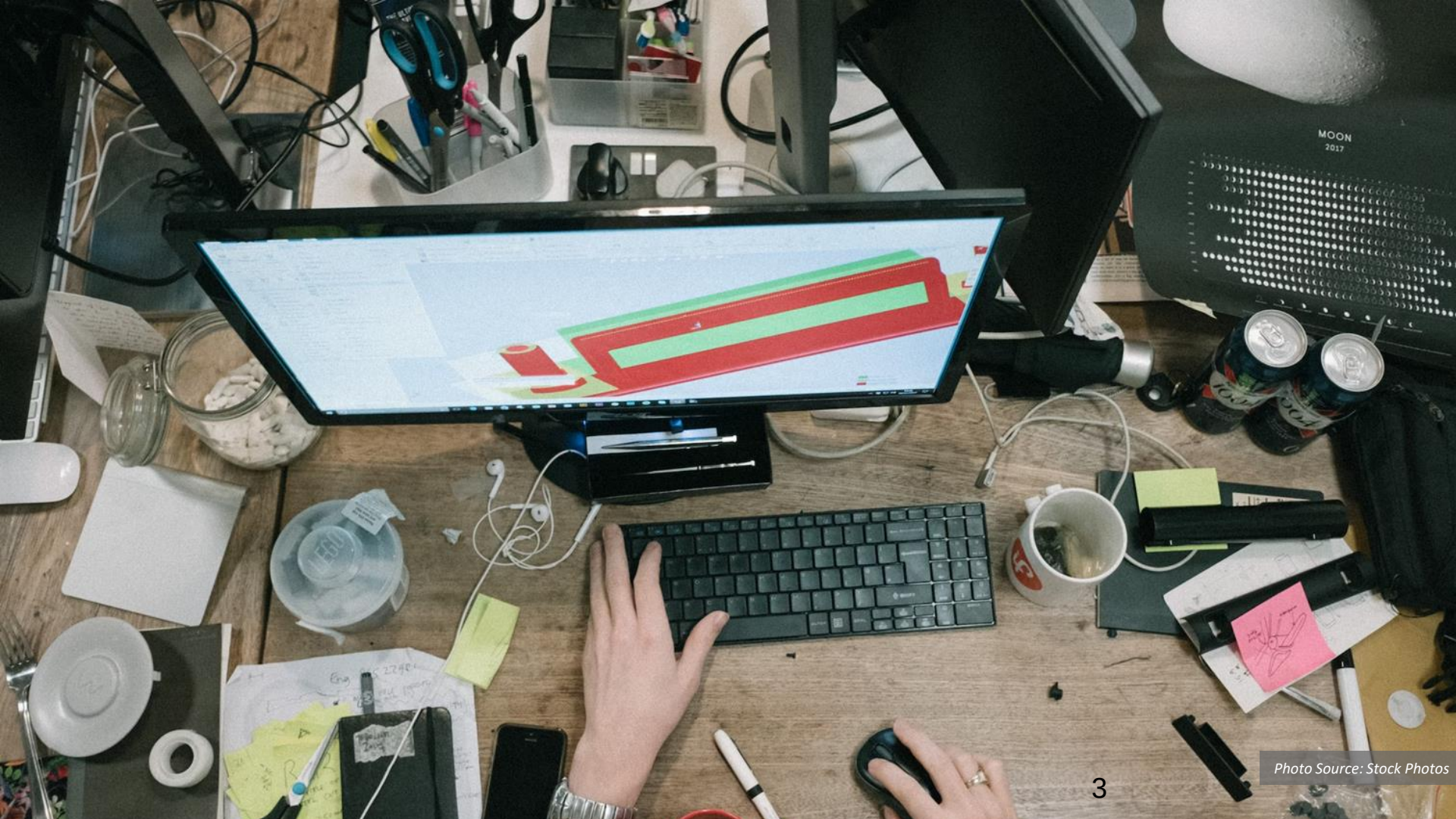

Photo Source: Stock Photos

We invite you to be present

- Turn on your camera
- Hide self view
- Go full screen
- Avoid multitasking
- Turn off additional monitors
- Put away your cell phone
- Breathe

Introductions

- Name
- Organization
- Role
- **What motivates you today?**

Learning Objectives

At the end of this presentation, participants will be able to:

- Describe at least two examples of complex needs.
- Define at least two challenges commonly experienced by Behavioral Health providers serving populations of people with complex needs.
- Explain at least three best practice approaches to working with individuals with complex needs.

Tina

- 58-year-old female
- High school graduate, never married, no children
- Cares for, and resides with, her 83-year mother
- Lives in a rental unit on a 3rd floor walk up
- Lives with Bipolar Disorder, Cardiomyopathy, and high blood pressure
- Unemployed; receives Social Security Income (SSI) and Medicaid
- Does not drive
- Social isolation
- Smokes ½ pack cigarettes daily; alcohol misuse
- Likes soap operas, cats, Journey, and library events
- Connected to family, travels independently, articulates her needs well

Chatter Fall #1

After we share our question -

Please take a minute to type your response in the Zoom chat

DO NOT click enter

When instructed, please click enter

Chatter Fall #1 (cont.)

What are Tina's challenges and strengths?

Tina's Challenges and Strengths

Strengths

- High school graduate
- Caring – mother, cats and extended family
- Resourceful
- Independent
- Hobbies and interests

Challenges

- Multiple BH and medical conditions
- Alcohol and cigarette use
- Doesn't drive
- 3rd floor walkup apartment
- Primary support for aging mother

Complex Needs

Definition & Prevalence

Definition of complex needs

"Millions of people worldwide have complex care needs resulting from multiple concurrent chronic conditions, functional and cognitive impairments, mental health challenges and social vulnerability. Illness has a significant impact on the lives of individuals, over and above managing treatments and medicines including social participation, relationships and societal contributions."

Colorado prevalence

66.8% of adults have a chronic condition

39.8% of adults have more than one chronic condition

Chronic diseases cause **55%+** of all annual deaths

Challenges Providers Face While Supporting People with Complex Needs

Chatter Fall #2

Reminder -

After we share our question --

Please take a minute to type your response in the Zoom chat

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When instructed, please click enter

Chatter Fall #2 (cont.)

How is your work impacted by individuals with complex conditions?

Roadblocks to Addressing Complex Conditions

- Privacy, HIPAA, Confidentiality
- Uncompensated Time
- Limited Resources
- Lack of Knowledge
- Frustration
- Nonadherence
- Attitudes
- *"It's someone else's job"*

Photo Source: Stock Photos

Barriers to Access

- Trauma
- Culture / Language / Communication
- Stigma
- Social Determinants of Health (SDOH)
- Fragmented Behavioral Health, Substance Use and Healthcare Provider Systems

Photo Source: Stock Photos

What is Trauma?

"Trauma results from an event, series of events, or a set of circumstances that an individual experiences as physically or emotionally harmful or threatening, which may have lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

Culture / Language / Communication

- Health communication is as important as clinical skills
- Recognize and address unique culture, language and health literacy
- Language barriers:
  - Lead to miscommunication
  - Decrease the quality of healthcare delivery
  - Adversely impact the provider-client relationship

Stigma

- Decrease quality of life and prevent proper medical treatment
- Medical conditions, mental illness and substance use disorders
  - Moral failing
  - Lacks self control
  - People with these conditions are at fault
- Biases experienced by:
  - Providers
  - Family
  - Community
  - Media
  - People with disorders

Social Determinants of Health (SDOH) *aka* Health Related Social Needs (HRSN)

Physical condition of a person's neighborhood	Lived experience such as being in poor health	Low income, food insecurity
Housing insecurity	Unstable employment or education opportunities	Living in crowded /unsafe conditions
	Discrimination, such as racism, sexism and classism	

System Complications

- Despite numbers of people with complex health and social needs…
  - Health systems deliver care that generally focus on one illness at a time
  - Medical care prioritized over social care
  - Management of disease and symptoms rather social care support
- Primary barriers for integration include
  - Fragmented services
  - Misalignment among state agencies
  - Lack of a clear vision for integration
  - Funding models
- ***The result***: the opposite of whole person care

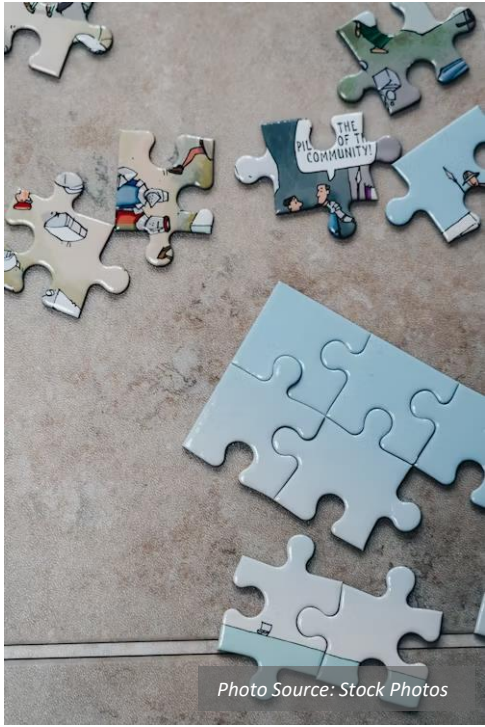

Photo Source: Stock Photos

Best Practice Approaches

Prevention

Barriers

- Cost
- Not having a primary care provider
- Distance to provider (ie time, transportation)
- Lack of awareness
- Stigma, fear, anxiety, discomfort, embarrassment

Opportunities

- Assessment
- Early intervention
- Health education and support
- Disease management
- Assess members readiness to change
- Care coordination, referrals and community resources

Integrated Services

Integrated Services often involve

- Warm hand-offs
- Seamless navigation
- Regular follow ups and emergency responses
- Opportunities to improve quality
- Reduced administrative burden
- Increased efficiencies
- Reduced costs

Opportunities include

- Patient Centered Medical Homes
- Program colocation
- Integrated licensure
- Shared electronic health records or Regional Health Exchange
- Care navigation/care coordination
- Certified Community Behavioral Health Clinics (CCBHCs)
- Federally Qualified Health Centers (FQHC)

Person Centered Services

- Care that's guided and informed by an individual's goals, preferences, and values
- Success measured by person-reported outcomes
- Integrated and coordinated care across health systems, providers and settings
- Relationships built on trust and a commitment to long-term well-being

Actionable Solutions to Person Centeredness

- Preferences, needs, goals and priorities
- Individualized wellness plans across eight Dimensions of Wellness
- Collaborative / supported decision-making
- Relationships through compassionate communication
- Dignity of Risk vs. Duty to Serve
- Facilitate information sharing and coordination of care
- Person first language
- Psychiatric Advance Directives

Eight Dimensions of Wellness

What is Trauma Informed Care?

"TIC takes a trauma informed approach to the delivery of behavioral health services that includes an **understanding of trauma and an awareness of the impact it can have across settings, services, and populations.**

TIC views trauma through an **ecological and cultural lens** and recognizes that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic.

TIC involves **vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma.** TIC upholds the importance of **consumer participation** in the development, delivery, and evaluation of services."

Strategies for a Trauma Informed Approach

- Anticipate & reduce triggers
- Focus on cross-cultural communication
- Take a strengths-based approach and use strengths-based language
- Use trauma-informed listening skills
- Create a trauma informed organization
  - Cultural Humility
  - Put aside individual culture, values, assumptions
  - Recognize that others are the expert of their own culture, values and beliefs
  - Ask others to share their experiences, knowledge and resources
  - Collaboration and learning from each other
  - Lifelong commitment to reflection & self-evaluation
  - Promote a culture of safety, empowerment and healing

Peer Support

- Organizational framework for peer support workers
- Agency culture oriented toward recovery
- Peers with lived experience help others manage the same condition
- Offer connectedness, purpose, experiential knowledge
- Share experiences, hope, coaching and empowerment
- Key principles
  - Respect
  - Shared decision making
  - Mutual understanding

Disabled And Here: This photo was taken by Chona Kasinger

Care Management / Care Coordination


Stock Photo: Posed by Models

- Comprehensive
  - Care coordination and health promotion
  - Comprehensive transitional care between settings
  - Individual and family support
  - Referral to community and social support services
  - Health information technology to link services
- Reduces healthcare use and cost
- Decreased reliance on emergency services
- Increased medication adherence
- Increased preventive screening and routine care
- Positive results based on frequent engagement

Chatter Fall #3

Reminder -

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Chatter Fall #3 (cont)

Let’s think about Tina

How would you proceed?

Pulling it Together

- Tina-Centered planning
- SDOH evaluation
- What are her goals?
  - Education? Volunteer? Employment?
- Assess for trauma
- Access to peer groups, activities or services
- Assess for Care Management, both medical and BH
- SBIRT
- Current and ongoing living needs

To better inform our future trainings as well as request topics for office hours, please complete this short survey. Use the QR code or short URL to access it. Your feedback is important. Thank you!

https://bit.ly/bhprovidertrainingsurvey

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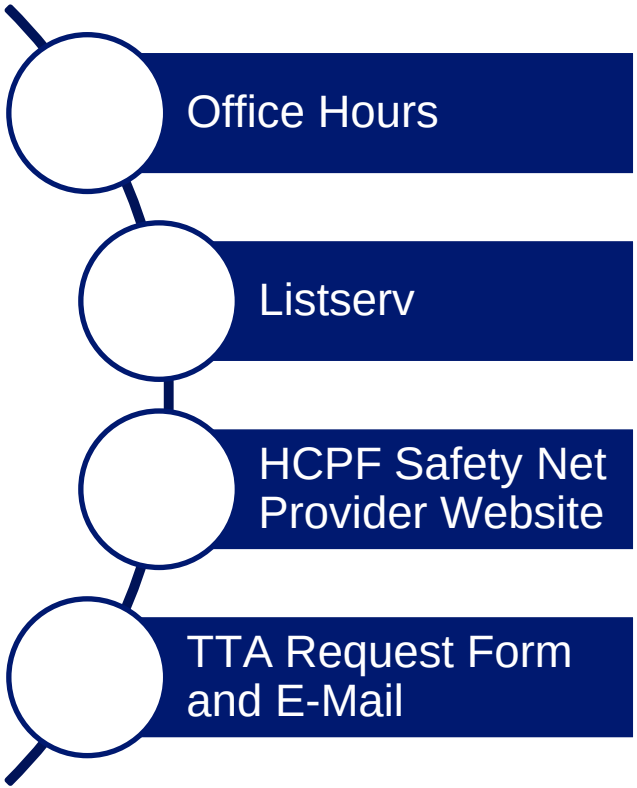
Appendix A: Additional Resources



Friday, April 26 at 12 p.m. Register Here

Join the Listserv to receive notifications of trainings, technical assistance, and other stakeholder engagement opportunities: Register Here

Visit the website for details on upcoming training topics and announcements, training recordings and presentation decks, FAQs and more: https://hcpf.colorado.gov/safetynetproviders

Request TTA support or share your ideas, questions and concerns about this effort using the TTA Request Form or e-mail questions and comments to: info@safetynetproviders.com

Appendix B: References

- Social Stigma Surrounding Chronic Illness, THINQ at UCLA https://medium.com/thinq-at-ucla/social-stigma-surrounding-chronic-illness-c11358d3ccd0#:~
- NIH National Library of Medicine https://www.ncbi.nlm.nih.gov/pmc/articles
- Healthy People 2030 https://health.gov/healthypeople/objectives-and-data/browse-objectives/preventive-care
- Chronic Disease State Plan 2022-2030 https://drive.google.com/file/d/1w4vf0zG5_oPocsM3A1Y56EZe379ZJe8g/view
- Penn State Social Science Research Institute https://ssri.psu.edu/news/new-research-highlights-role-and-impact-integrated-health-systems-us
- Disabledandhere https://affecttheverb.com/disabledandhere/

Appendix B: References (continued)

- Agency for Healthcare Research and Quality https://hcup-us.ahrq.gov/reports/statbriefs/sb240-Co-occurring-Physical-Mental-Substance-Conditions-Hospital-Stays.jsp
- CMS Key Concepts https://www.cms.gov/priorities/innovation/key-concepts/person-centered-care
- Substance Abuse and Mental Health Services Administration Trauma-Informed Care in Behavioral Health Services
- Substance Abuse and Mental Health Services Administration Practical Guide for Implementing a Trauma-Informed Approach