Today’s Presenter

• Cathy McAvoy, MPA
  – Training Program Managers for Health Homes
  – Department of Social and Health Services
  – Office of Service Integration

  Cathy.mcavoy@dshs.wa.gov

The Six Health Home Services

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care
5. Individual and family support
6. Referral to community and social support services
Comprehensive Care Management

Comprehensive Care Management can be provided in combination with any of the other five services.

Purpose:
Describe the activities that constitute Comprehensive Care Management

Learning Objectives
• Examine the activities included in comprehensive care management
• Define Tier 1 services
• Discuss health action planning as it pertains to comprehensive care coordination
Your Value as a Care Coordinator (CC)

- CCs have a unique understanding of the communities they serve
  - Including an awareness of its culture, language, ethnicity, and values
- Established relationships with local providers and services

Resource from the Basic Training Manual

DSHS Website

https://www.dshs.wa.gov/bhsia/office-service-integration/office-service-integration
Service Tiers

Health Home Service Tiers
Comprehensive care management can be provided at all tiers

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<th>Tier 1</th>
<th>Tier 2</th>
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<td>Initial engagement and action planning</td>
<td>Intensive level of care coordination</td>
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Tier 1 Activities
Must be completed within 90 days of referral to the Lead Organization and includes:

- Outreach and Engagement
  - Contacting by telephone and/or letter
  - Review of PRISM
- Face-to-face visit (required)
  - Introduce the client to Health Home Services
  - Assess the client’s health and other needs
  - Confirm the client’s agreement to participate
Tier 1 Activities (cont.)

Signed consent to participate and share information

Completion of required and optional screenings

Completion of the Goal Setting and Action Planning Worksheet (optional)

Tier 1 Activities (cont.)

Development of the Health Action Plan (HAP)

Periodic phone calls and visits as needed

Document activities

May be billed one time only

1 Comprehensive Care Management

1. Begins with assessment
   • Review of PRISM (Predictive Risk Intelligence System)
   • Review of other existing database information
     • CARE, medical records, etc.
1. **Comprehensive Care Management**

2. Outreach and engagement
   - Initial outreach may include:
     - Telephone outreach
       - May be completed by other staff including clerical support staff, community health workers, peer support specialists, case managers for other programs
     - Scheduling a face-to-face visit

3. Provides in-person periodic follow-up using face-to-face visits and telephone calls

4. Includes state approved required and optional screenings and assessments

5. Assesses beneficiary readiness for self-management and promotes self-management skills so the beneficiary is better able to engage with health and service providers
6. Monthly contacts:
   - Provide continuity of care
   - Support the achievement of self-directed health goals
   - Improve functional or health status, or prevent or slow declines in functioning

7. Coordinate care transitions:
   - From hospitals
   - Nursing facilities
   - Other institutions

8. Coordination of primary care:
   - Work with PCP and other members of the client’s health team to coordinate services
   - Identify gaps in services and assist with meeting other needs such as dental and vision
9. Provision of other core services:
   - Comprehensive care transitions
   - Promotion of health literacy and education
   - Referral to LTSS and other social services
   - Health promotion and coaching
   - Individual and family support
   - Referral to community and social support services

10. Create a relapse plan or crisis plan:
    - One of our roles is to coach and model how to handle medical and other crisis during evenings and weekends

Moving Toward Health Action Planning
Consider the clients responses by reviewing and discussing the activation measure, required screenings, and optional screenings

Responses may provide a clue as to changes the client would like to make

Consider using the Goals Setting and Action Planning Worksheet
Goal Setting and Action Planning Worksheet

A Tool for Starting the Conversation

Goal Setting and Action Planning Worksheet

Coaching and Action Planning

Goal Setting and Action Planning Worksheet

• Start where the individual is
• Determine what the individual wants to change
• The action plan is negotiated and is based on the client’s level of activation
Coaching and Action Planning (cont.)

Goal Setting and Action Planning Worksheet

• The action plan is something achievable given the individual's level of activation
• At Levels 1 and 2 action plans focus on knowledge, belief, awareness, and pre-behaviors
• At Levels 3 and 4 action plans focus on the initiation of new behaviors and maintaining behaviors

Developing an Action Plan

Coach the client to select the Action Steps with the least number of barriers and prioritize them.

Save the list of Action Steps so alternatives can be tried if the first ones are not successful; reassure client that many problems are not easily solved and may take time and multiple approaches.
Develop Action Steps

Describe
- What the client has agreed to do
- What the Care Coordinator has agreed to do
- Where they will do it
- How often (each day/week)?
- For how long?

Consider the Client

1. How important is the goal?
2. How confident is the client?
3. How ready is the client?

Coaching and the Health Action Plan

Use your “Coaching for Activation” training and professional skills to guide the individual to:
- Appropriate choices
- Attainable goals
- Action steps
- Improved health
The Health Action Plan (HAP)

Establishes:
✓ Client and Care Coordinator identified:
  ✓ Long term goal
  ✓ Short term goal/s
  ✓ Action steps

Health Action Planning

Fostering hope is the most important element of coaching and planning

Help the individual engage in their health and their healthcare by taking an active role in the process

Key Skills for Health Action Planning

Demonstrate a positive belief in the individual’s ability to accomplish appropriate goals and action steps

Emphasize stress management and coping skills
Key Skills for Health Action Planning

Active and reflective listening
Guiding; not directing
Gain understanding of individual’s values and priorities
Helping each individual identify strengths, abilities, and successes
Collaborate to improve self-efficacy and capacity

Elicit

- Elicit the client’s story
- Build rapport
- Obtain a behavioral history, including past attempts to change behavior
- Identify barriers
  - Use open ended questions
  - Focus on feelings
  - Use reflections

Analyze!

What do you think drives poor health and high costs for your client?

Consider:
- Client’s perspective
- Results from assessment and screening tools
- PRISM data
- Patient Activation Measures
Explore Barriers

- Ambivalence?
- Understanding?
- Support system?
- Energy levels/sleep quality/pain?
- Depression?
- Health literacy?
- Financial?
- Confidence?
- Social Isolation?

Client-centered Practice and Client Directed Care

Consider how much risk the client is willing to assume
- What can you suggest to mitigate the risk?

What is the client’s ability to make decisions?
- What is the role of collaterals?

How much can the client direct their services?

What can you do to empower the client?
**Required Screenings**

Enter the dates and scores of the screening on the HAP

- PHQ-9 – Patient Health Questionnaire (Depression Screening) or
- Pediatric Symptom Checklist – 17 (PSC-17) (ages 4-17)
- BMI – Body Mass Index
- Katz Activities of Daily Living
- Patient Activation Measure
  - Patient Activation Measure (PAM) or
  - Caregiver Activation Measure (CAM) or
  - Parent Patient Activation Measure (PPAM)

**Optional Screenings**

Enter the dates and scores of the screenings on the HAP

- DAST – Drug Abuse Screening
- GAD-7 – Generalized Anxiety Disorder 7 item scale
- AUDIT – Alcohol Use Disorders Identification
- Falls Risk – Standardized measure of falls risk
- Pain Scales – Administration of appropriate pain scale

**Four Month Updates**
Four Month Review

- Administration of the required screenings
- Administration of clinically indicated optional screenings
- Reviewing and updating the HAP
- Care coordination and other Health Home services

Health Home Tiers

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Tier Two Services

- Tier One may be billed only once
- Four month updates to provide comprehensive care management is then billed as a Tier 2
Getting Support

Working with allied and affiliated staff:

- Outreach specialists
- Peer support specialists
- Community connectors
- Community health workers
- Medical leads
- Case aides
- Wellness coaches

Summary

Bringing it all together

Important Takeaways

Assessment is a continuing process

The Health Action Plan is a living fluid document

Ensure that all activities are client-centered

When documenting consider which of the six services you are providing

Complete required screenings

Consider which optional screenings are clinically indicated
Informational Websites

Health Care Authority:
http://www.hca.wa.gov/Pages/health_homes.aspx

DSHS Health Homes:
https://www.dshs.wa.gov/bhsia/office-service-integration/office-service-integration

Need further information?
Check with your Lead Organization

E-mail your questions to:
Health Care Authority:
HealthHomes@HCA.wa.gov

Contact Information

Cathy McAvoy
Integration Projects Training Manager
– mcavocm@dshs.wa.gov
– 360-725-2637
Join Us

Next Webinar

– Thursday, May 14, 2015
– 9:00 AM – 10:30 AM
– Topic: Care Coordination

Make your reservation now at:
https://attendee.gotowebinar.com/rt/2336104130912005121

Post Webinar Discussion

• What techniques have you used to engage the client to complete the required and optional screenings?

• What experience have you had using the Goal Setting and Action Planning Worksheet? Is it helpful?

• How do you manage your caseload? What techniques or tools do you use to remind you to make periodic contacts and visits to your clients?

• What types of affiliated staff do you use with care coordination? Do you work with any of the following: outreach specialists, community health workers, peer support specialists, community connectors, wellness coaches?

Certificate of Completion

Comprehensive Care Management
presented by Cathy McAvoy, MPA
Health Homes Program Manager
Integration Services - DSHS
Webinar aired on: April 9, 2015 in Lacey, Washington
for Health Home Care Coordinators

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Your Signature                            Date Reviewed

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Supervisor’s Signature                    Date