

Washington State Health Homes

Care Coordinators Webinar

Goal Setting and Action Planning

February 12, 2015



Client and Care Coordinator prioritized action items

Client identified goals (Long Term and Short Term)

Goal Outcome status

Action Steps



Each client is in charge of their

- Own health;
- Action plans; and
- Whether or not they make lifestyle changes.

Most people desire better health and quality of life

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Coaching and the HAP

- Use your coaching and Motivational Interviewing Training and professional skills to guide the individual to:
 - Appropriate choices
 - Attainable goals
 - Action steps
 - Improved health

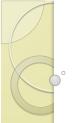


- Active and reflective listening
- Guiding; not directing
- •Gain understanding of individual's values and priorities
- •Helping each individual identify strengths, abilities and successes
- Collaborate to improve self-efficacy and capacity

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Key Skills for health action planning include:

- Helping the individual start to engage in their health and healthcare by taking an active role in the process
- Demonstrate positive belief in the individual's ability to accomplish the Patient Activation Measure Level-appropriate goals and action steps
- Emphasize stress management and coping skills

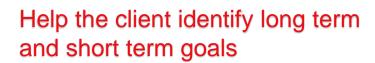


Emphasize Problem Solving

Care Coordination requires solving problems!

Adults learn best by "doing" rather than through reading materials or hearing information.

Working through a problem with a coach increases and enhances retention.



Tell me about your health concerns?

Which concerns are having the biggest impact on your life?

Which concerns do you feel you are managing well?

What would you like to do to improve your health?



Explore possible solutions

Ask the client to review possible solutions, but not make a decision just yet ...

Ask the client to identify possible solutions; "do you have any ideas on how you could solve this problem?"

Ask the client if they would like you to share your thoughts and/or provide ideas using Health Home resources.

Ask the client if they would like you to provide additional health education information; if so, review and discuss the information with them at the next visit.

Ask the client how their caregivers and/or family can support them in their plan.



- Ambivalence?
- Understanding?
- Support system?
- Energy levels?
- Depression?
- Health literacy?
- Financial?
- Confidence?
- Social Isolation?





Active and Reflective Listening

- Use active & reflective listening skills
 - What are the client's values?
 - Acknowledge successes and what is right with the client.
 - Encourage client to identify "what are the barriers to change?"



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Long Term Goal

What would they like to happen as a result of their care?

- What would they like be able to do that they can't currently do?
- What is the most important thing they want to achieve related to their chronic disease? For example, client states:
 - "I want to feel better."
 - "I want to be able to travel to Florida for a family reunion next year."
 - "I want to see my grandchildren grow up."
- Connect the Long Term goal with the Short Term Goal(s).



Short Term Goal

The client identified goal(s) should be specific, measurable, attainable, relevant, and time based and must be mutually agreed upon.

For example:

- Client wants to cut back on smoking over the next three months
- Client wants to understand how to use her blood pressure medication by the end of March.
- Client wants to be able to communicate with PCP and address questions and concerns at next medical appointment.

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The Health Action Plan

- The HAP is a dynamic tool
 - A road map for the client, their care providers and the care coordinator
 - A record of required and optional screenings.
 - Needs to be updated when there is improvement, decline or a change in the client's care needs/condition.

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.
- Use the Goal Setting and Action Planning Worksheet.

Action Steps

The action steps the client and/or the Care Coordinator plan to take to achieve the client's Short Term Goal.

- The Care Coordinator (CC) will document planned client, CC, personal care worker and health care provider action steps on the HAP.
- These interventions should be established mutually with the client recognizing the client's abilities and readiness for change and teaching. (Refer to PAM coaching guide for appropriate level of action steps for client to consider).
- The CC will enter the Start Date and Completion Date for each Action Step.



Action Steps Examples

- Care Coordinator to attend PCP appointment with client to review treatment options for COPD.
- Client and Care Coordinator will prepare list of questions to bring to the PCP appointment.
- Review with client and their caregiver the "Three Questions" brochure to help client prioritize needs with MD.
- The AskMe3 Website is located at: http://www.npsf.org/?page=askme3

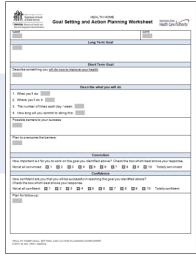


The Three Questions

- What is my main problem?
- What do I need to do?
- Why is this important for me to do this?





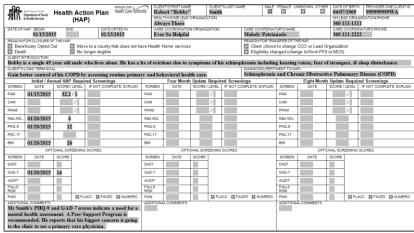


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Goal Setting and Action Planning Worksheet

- Use this tool to support the client in establishing an action plan.
 - What can you do now to improve your health?
 - What, where, frequency, duration
 - Possible barriers and plans
 - Conviction and confidence
 - Plan for follow up

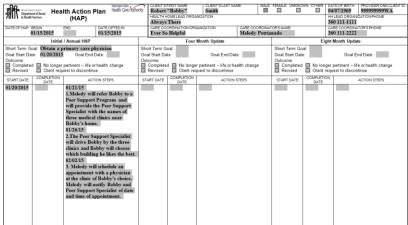




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HAP Example: page 2





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01/15/2015 END DATEOPTEDIN 01/15/2015		Melody Petrianado 360 111-2222
Initial / Annual HAP	Four Month Update	Eight Month Update
Goal Start Date: 01/20/2015 Goal End Date: Dutcome: Completed No longer pertinent – life or health change	Short Term Goal: Goal Start Date: Outcome: Completed No longer pertinent – life or healt! Revised Client request to discontinue	Outcome:
START DATE COMPLETION ACTION STEPS	START DATE COMPLETION ACTION STE	TEPS START DATE COMPLETION ACTION STEPS
02.03.15 4. Melody will contact the clinic to tell them that Bobby will be virining the waiting room over the next few weeks. Two times 3 week for trow weeks Bobby and the Peer Support Specialist will sit as the waiting room of the clinic for an increasing the first via waiting room of the first via will be st ten minutes. 02.03.2015 5. Bobby will wash up prior to going to the clinic with the Peer Support Specialist. 02.03.2015 6. Bobby will go to the clinic and his selected primary care physician will meet him in the waiting room for an introduction.		

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HAP Example: page 4

Department of Social Head to Employee Burners of Social to Employee Burners of Social to Employee Burners of Employee Burners	Ith Action Plan (HAP) END DATE OPTED IN 01/15/2015	CLIENT'S FIRST NAME Robert "Bobby" HEALTHHOME LEAD O Always There CARE COORDINATION Ever So Helpful		CARE COORDINAT Melody Petria		□ 0 3	ATE OF BIRTH PROVIDER ONE CLIENT 99999999WA 1407/1969 99999999WA 14070 PHONE 60 111-1111 ARE COORDINATORS PHONE 60 111-2222			
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START DATE COMPLETION DATE	ACTION STEPS 03/02/2015	START DATE COMPLETE	'ART DATE COMPLETION ACTION STEPS				ACTION STEPS			
	7. Bobby will wait in the variing room with his Peer Support Specialist and the Support Specialist and the private of the Support Specialist and the private of the private of the private of the Support Specialist will come to the exam room to say hello. 30.3042 Poer Support Specialist with ramport Bobby to his first appointment and his primary physician will do a brief exam. 30.3052015 2. Moboly will call Bobby after his appointment to check in.									

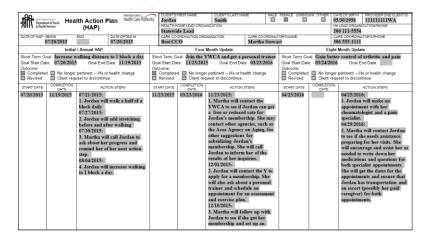


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ADDITIONAL COMMENTS Met for first HAP and goal setting. Jordan reports a moderate level of pain due to arthritis. She reports she is afraid of failure due to her painful joints but is ready to work on achieving her loss term goal.				ADDITIONAL COMMENTS JORDAN WORKER hard in partnership with her personal trainer at the Y. She is beginning to see some progress, especially with weight loss, stamina, pain, and independence with ADLs; she can mow transfer by herself.				Jos me ho	ADDITIONAL COMMENTS Jordan relates that her pain has decreased. She is able to be more active for longer periods of time. She has established home exercise program and a program at the Y designed by her trainer. She is planning a brief camping trip in June.						

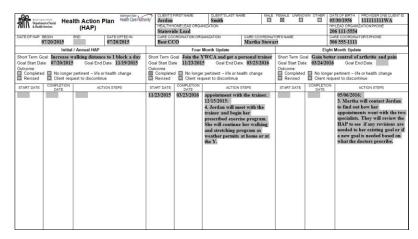
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HAP Example: page 2







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Certificate of Completion

Goal Setting and Action Planning

presented by Candace Goehring, RN, MN
Office Chief
Office of Service Integration - DSHS

Webinar aired on: February 12, 2015 in Lacey, Washington for Health Home Care Coordinators

Please sign and date this slide to attest that you attended this training Webinar

Your Signature Date Reviewed

Supervisor's Signature Date