



Health Home Care Coordinators Basic Training

June 2018



“I diagnosed ‘abdominal pain’ when the real problem was hunger, I confused social issues with medical problems in other patients, too. I mislabeled the hopelessness of long-term unemployment as depression and the poverty that causes patients to miss pills or appointments as noncompliance. In one older patient, I mistook the inability to read for dementia. My medical training had not prepared me for this ambush of social circumstance. Real-life obstacles had an enormous impact on my patients’ lives, but because I had neither the skills nor the resources for treating them, I ignored the social context of disease altogether.”

—Laura Gottlieb, MD
University of California San Francisco

2

Introductions

Your **name**?

What do you **do**?

What **agency** do you work for?

What **Lead Organization/s** will you work with?

Briefly state, your **relevant work experience**.

3

Purpose

Provide the core curriculum for Health Homes in Washington State for Lead Organizations and Care Coordination Organizations (CCOs)

4



Learning Objectives and Agenda Overview

The six Health Home services

Outreach and engagement strategies

Care coordination key components and delivery mechanisms

Administration of Insignia's Patient Activation Measures® and how to use the level of activation to develop a Health Action Plan

5

TRAINING



Learning Objectives and Agenda Overview (cont.)

Administration of mandatory screens and optional screens

Documentation of the delivery of Health Home Services in progress notes and Health Action Plans

Required elements for Care Transitions

6



Overview of the Curriculum

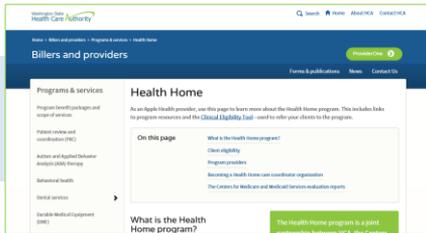
Classroom Training Manual with important forms and documents

Location of the manual on the DSHS training Website:
<https://www.dshs.wa.gov/altsa/stakeholders/washington-health-home-program-core-training>

7

The Health Care Authority (HCA) Website

<http://www.hca.wa.gov/billers-providers/programs-and-services/resources-0#care-coordinator-training>



Training materials may be accessed from the HCA website

8

The DSHS Website

<https://www.dshs.wa.gov/altsa/washington-health-home-program>



Training, resources, and webinar presentations are located on the DSHS ALTSA website

9

Fundamentals

Health Homes and the Affordable Care Act

Washington's model

Eligibility

The Health Home services

Health Home tiers and billing

10



What are Health Home Services?

Clients receiving Health Home services will be assigned a Health Home Care Coordinator who will partner with client, their families, doctors and other agencies providing services to ensure coordination across these systems of care.

The primary role of the Health Home Care Coordinator is to work with their client do develop a Health Action Plan that is person-centered.

In addition, the Health Home Care Coordinator will make in-person visits and be available by telephone to empower the client to take charge of their wellness.

11



Let's look at a sample Health Action Plan (HAP)



12

TRAINING

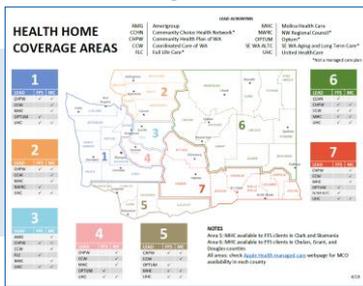


Washington State Model of Health Home



16

Health Home Coverage Areas



17

Who May Become a Health Home Care Coordinator?

Care Coordinators may be employed by:

- Lead Entity or
- Care Coordination Organization that has contracted with a Lead

Required education or licensure:

- Registered nurse, licensed practical nurse, bachelor or master's prepared social worker, licensed social worker, licensed mental health counselor, chemical dependency counselor, certified medical assistants with an Associate Degree, and Indian Health Services Certified Community Health Representative

18

Who May Be Covered By Health Homes?

1. Dual Eligible

- Eligible for Medicare and Medicaid
 - Uses Fee-For-Service (FFS) traditional Medicare/Medicaid providers

2. Apple Health

- Managed Care Organizations (MCO) plans

3. Fee-for-Service: traditional Medicaid coverage for those not dually eligible

19



Eligibility for Health Home Services

- Must have one chronic condition and
- Must have a PRISM score of 1.5 or higher
 - Indicates a risk for a second chronic condition

Note: includes all ages

20



The Health Home Services

Health Home services are designed to:

- ✓ Conduct screenings to identify health risks and referral needs
- ✓ Set person-centered goals that will improve client's health and service access
- ✓ Improve management of health conditions through health action planning, education, and coaching

21



The Health Home Services (cont.)

- ✓ Support changes to improve client's ability to function in their home and community and increase self-management of their chronic disease/s
- ✓ Slow the progression of disease and disability
- ✓ Access the right care, at the right time, the right place, and the right provider

22



The Health Home Services (cont.)

- ✓ Successfully transition from hospital to other care settings and get necessary follow-up care
- ✓ Reduce avoidable health care costs
- ✓ Make health care decisions during evenings or weekends when the Health Home Care Coordinator is not available

Note: Health Home services do not duplicate other services

23



Let's Pause to Check for Understanding



Do you have any experience with the program that you wish to share?

Do you have any questions?

24



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

25

TRAINING

1 Comprehensive Care Management

- 1. Provides in-person periodic follow-up using face-to-face visits and telephone calls
- 2. Includes state approved required and optional screenings and assessments

26

1 Comprehensive Care Management (cont.)

- 3. Assesses the client's readiness for self-management and promotes self-management skills so the client is better able to engage with health and service providers
- 4. Initiates discussion about advance care planning and assists the client and family (with the client's consent) to access assistance if they wish to pursue advance care planning or an advanced directive

27

1 Comprehensive Care Management (cont.)

5. Monthly (or more often as needed) contacts:
- Provides continuity of care
 - Supports the achievement of self-directed health goals
 - Improves functional or health status or prevent or slow declines in functioning

28

2 Care Coordination

1. Provides cross-system care coordination to assist the client to access and navigate needed services
2. Uses the Health Action Plan (HAP) as the person-centered care management plan

29

2 Care Coordination (cont.)

3. Fosters communication between the providers of care including:
- Primary Care Physicians (PCPs)
 - Medical and behavioral health specialists
 - Entities authorizing behavioral health and Long Term Services and Supports (LTSS)

30

2 Care Coordination (cont.)

- 4. Bridges all of the client's systems of care, including non-clinical support such as food, housing, legal services, transportation, etc.



31



2 Care Coordination (cont.)

- 5. Coordinates and may supervise the work of allied, lay, or administrative staff
- 6. Provides informed interventions that recognize and are tailored to the medical, behavioral, social, economic, cultural, and environmental factors impacting a client's health and health care choices

32



2 Care Coordination (cont.)

- 7. Promotes:
 - Optimal health outcomes through health action planning
 - Outreach and engagement activities that support the client's participation in their care
- 8. Uses peer supports, support groups, and self-care programs to increase the client's knowledge about their health care conditions and improve adherence to prescribed treatment

33



2 Care Coordination (cont.)

9. Provides opportunities for mentoring and modeling communication with health care and other providers by:
- Modeling or monitoring phone conversations with health care staff and others
 - Rehearsing a visit with a provider to prepare the client for their appointment
 - Participating in joint office visits and appointments

34



3 Health Promotion

1. Uses self-management, recovery, and resiliency principles including supports identified by the client
2. Considers the client's activation level to determine the coaching, teaching, and support plan for the client

35



3 Health Promotion (cont.)

3. Provides wellness and prevention education to include routine and preventative care (e.g. immunizations)
4. Links the client with resources to promote a healthier lifestyle

36



4 Comprehensive Transitional Care

1. Prevents avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment facility, or residential habilitation setting)
2. Ensures proper and timely follow-up care

37



5 Individual and Family Support

1. Recognizes the unique role the client may give family, identified decision makers and caregivers in assisting the client to access and navigate the health care and social service delivery system
2. Supports health action planning

38



5 Individual and Family Support (cont.)

3. Identifies the role that families, informal supports, and paid caregivers provide to:
 - Educate and support self-management, self-help, and recovery
 - Achieve self-management and optimal levels of physical and cognitive function

39



5 Individual and Family Support (cont.)

4. Educates and supports family informal supports and caregivers
- Increases their knowledge of chronic conditions
 - Promotes the client's engagement and self-management
 - Helps the client adhere to their prescribed medications and treatments

40



5 Individual and Family Support (cont.)

5. Includes:
- Discussions about advance care planning with clients and their families
 - Communication and information sharing with clients and their families and other caregivers
 - Consideration of language, activation level, literacy, numeracy, and cultural preferences

41



6 Referral to Community and Social Support Services

1. Provides assistance to obtain and maintain eligibility for health care services, disability benefits, housing, LTSS, and legal services
2. Completes referrals to community and social support services to support the client in achieving health action goals including:
- LTSS
 - Mental health and substance use disorder providers
 - Other community and social services support providers as needed

42



6 Referral to Community and Social Support Services (cont.)

- 3. Provides support by:
 - Identifying community based resources
 - Actively managing referrals
 - Advocating and assisting on behalf of the client to access care and community and social supports

43



Multidisciplinary Care Teams and Allied Staff

- As a Care Coordinator you may coordinate and facilitate multidisciplinary care teams:
 - Establishing a team to provide cross systems care coordination on behalf of the client
 - Establishing or working with an existing multidisciplinary care team to discuss discharge planning with hospitals, nursing facilities, and other institutions
- As a Care Coordinator you may work with allied staff:
 - Care Coordinators may enlist the help of allied staff including:
 - Community Health Workers, mental health peer support specialists, outreach specialists, Community connectors, patient navigators, wellness coaches, and other lay staff

44

TRAINING



Health Home Tiers

Tier One	Tier Two	Tier Three
Initial engagement and action planning	Intensive level of care coordination	Low level of care coordination

45

TRAINING



Tier One Services

Tier One Tier Two Tier Three

Requires a face-to-face visit to:

- ✓ Introduce Health Home services
- ✓ Assess the client’s health and other needs
- ✓ Confirm the client’s agreement to participate
- ✓ Obtain signatures for participation authorization and information sharing consent
- ✓ Complete required and optional screenings

46



Tier One Services (cont.)

Tier One Tier Two Tier Three

- ✓ Develop the first Health Action Plan (HAP)
- ✓ Document activities
- ✓ Complete the HAP within 90 days that the client was assigned to your agency
- ✓ Bill **one time** only

47



Tier Two Services

Tier One Tier Two Tier Three

- ✓ Requires at least one face-to-face visit each month
- ✓ Typically includes multiple calls to client, family, caregivers, legal representatives, and providers
- ✓ Includes other activities as needed:
 - Health education and coaching
 - Referrals to providers
 - Care transitions planning and follow up
 - Consultation with care providers and medical and behavioral healthcare providers

48



Tier Three Services

Tier One Tier Two Tier Three

- ✓ Low level Health Home care coordination
 - Care Coordinator supports maintenance of the client’s self-management skills with periodic face-to-face visits and/or phone calls
- ✓ Client may request fewer contacts
 - Movement to this tier is not for the Care Coordinator’s convenience
- ✓ The client’s chronic condition stabilizes and demonstrates a high level of activation in self-management of health

49



Tier Three Services (cont.)

Tier One Tier Two Tier Three

- ✓ The HAP must be reviewed with every contact:
 - The HAP is the foundation of your relationship
 - Review progress toward goals
 - Identify new or unidentified care opportunities
- ✓ At least one of the six Health Home services must be provided:
 - When a client requests fewer contacts they may not want to be contacted each month so do not bill for months when no contact or no services were provided

50



Billing for Services

- Contact may not occur monthly depending on the client’s needs and the Health Action Plan (HAP)
 - Bill only for months when service was provided
- The HAP must be reviewed at least once during each four month activity period or more often as needed to monitor and update the goals and action steps and administer the required screenings
- Document the core service/s provided to support billing

51



Let's Pause to Check for Understanding



Do you have any questions about the six core services or the 3 payment tiers?

52



Outreach

- Client outreach
- Client enrollment materials
- Consent and opting out
- Client engagement

53



Client Outreach

Using "smart assignment" the Lead Organization will provide the CCO with a list of clients who meet the eligibility requirements for Health Home services

The Health Care Authority (HCA) will send **Fee-for-Service** clients the Health Home letter and "Your Washington State Health Home Booklet"

Lead Organizations that are **Managed Care Organizations (MCO)** will send their enrollment materials to their members

Care Coordinator, support staff, or Outreach Specialist may make first contact and schedule a face-to-face visit

54

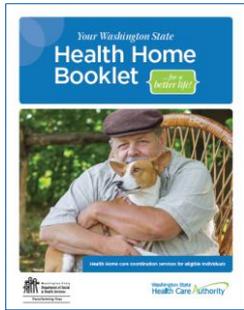


Welcome Booklet for Fee-for-Service Clients

Flyers and brochures are available under the HCA's website:

<http://www.hca.wa.gov/billers-providers/programs-and-services/resources-0#care-coordinator-training>

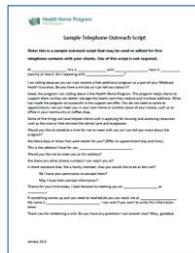
55



Sample Outreach Script

Tips for effective outreach calls:

- ✓ Keep it **brief**
- ✓ Don't rush
- ✓ Ask questions and **listen**
- ✓ Ask if someone else should be present at the first visit
- ✓ **Wrap up**, confirming the visit date and time
- ✓ **Thank** them for their time and interest



56

TRAINING

Participation Authorization and Information Sharing Consent Form



57

TRAINING

Part 1 of the form

Participation Authorization portion of the form must be signed

58

Part 2 of the form:

Information Sharing Consent portion of the form must be signed in order to release information to any party listed on the back of the form

59

Participation Authorization and Information Sharing Consent Form

- Best practice is to take it to face-to-face visits and appointments to amend as needed
 - If able, scan a copy into the client electronic health record (EHR) for other staff and providers to access
- Use the back of the form to add and delete providers
 - Enter the date and have the client initial

60

Outreach to Foster and Adoptive Children

- The DSHS Fostering Well Being Unit (FWB) must be contacted before contacting foster parents
 - Foster parent contact information is confidential and can only be released by the Children's Administration Social Worker
 - The FWB unit can identify the social worker assigned to the child so care coordinators can reach out to them regarding the child
- Adoptive Children
 - The Foster Care Medical Team at HCA can also assist with identifying the child's adoptive parents. Call the HCA's Customer Service line at: 1-800 562-3022 Ext. 15480 (you will need your agency's NPI number in order to speak to a representative)
- Most adoptive and foster care children receive managed care through Coordinated Care of Washington

61

Special Release of Information for Adolescents

Children ages 13 through 17 years must sign a consent form to release their information related to:

- Mental health
- Reproductive health
- Chemical dependency



62

Adolescent Consent Form

For children 13–17 years of age

63

TRAINING

Motivational Interviewing and Coaching

67



The Spirit of Motivational Interviewing (MI)

- Empathic “way of being”
- Collaborative – Partnership of experiences
- Evocative – Draws out, elicit ideas, identifies barriers, and explores solutions
- Encourages autonomy and provides support

68



Engagement – Setting the Agenda

Begin with an attitude of curiosity and a desire to understand more

Learn how the client’s behaviors or concerns fit into the person’s situation or world view

Be transparent and communicate your intentions and purpose

69



Join the Client on their Health Path

Explore:



70



Join the Client on their Health Path (cont.)

Five Steps for Success:



71



Keys to Successful Care Coordination

- Meeting the client where they are
- Engagement
- Collaboration
- Consistent and regular contacts
- Transitional care supports
- Confidence and skill building for self-management of chronic disease/s

72



Due Diligence



73

TRAINING

Due Diligence (cont.)

Three telephone calls must be attempted: note in narrative

One introduction letter must be mailed

Document your actions and discuss with your Lead if unable to contact

74

Opting Out

Clients have the right to:

- Opt out of the program before services begin
- Opt out at any time after services begin
- If your client requests to re-enroll in the program the Care Coordinator can contact the Lead to request re-enrollment

75

Opt Out Form

- The client may complete and sign the form or the Care Coordinator or allied staff may complete the form on the client's behalf
- Mail a copy to the client because it contains information on how to re-enroll in the program if they change their minds

76

TRAINING

Client Vignettes

We will use these vignettes throughout our training activities:



77

TRAINING

Small Group Work



Review the profile of your client

Record the following on your flip chart:

- Client profile: briefly describe your client
- What actions would you take to reach out to the client and engage them in the program?

78

TRAINING

Let's Pause to Check for Understanding



What experiences have you had when you have initially contacted new clients in the past? What worked or didn't work?

Do you have any questions?

79



PRISM A Care Coordination Tool

Predictive Risk Intelligence System

80



Today's Presenter

Candace Goehring, MN, RN

- Director of Residential Care Services
- Dept. of Social and Health Services
- Aging and Long Term Support Administration



81



PRISM

A Decision Support tool designed to support care management interventions for high-risk clients

- ✓ Identification of clients most in need of comprehensive care coordination based on risk scores developed through predictive modeling and other indicators
- ✓ Integration of information from medical, social service, behavioral health, and long term care payments and assessment data systems
- ✓ Intuitive and accessible display of client health and demographic from administrative data sources

82



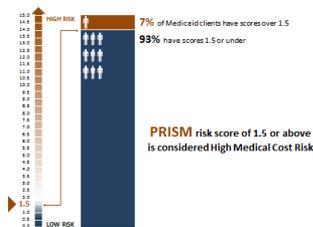
Risk Tools

- 1. Future Medical Cost Risk Score**
Calculates expected level of future costs relative to a comparison group
- 2. Inpatient Admission Probability**
Calculates the probability of an inpatient admission in the next 12 months
- 3. Mental Illness Flag**
- 4. Substance Use Flag**

83



Defining High Future Medical Cost Risk



84

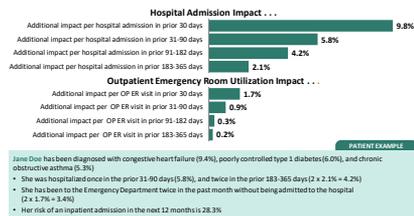


Prospective Inpatient Admission Probability



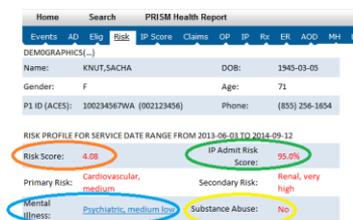
85

Prospective Inpatient Admission (cont.)



86

Risk Profile



87

Risk Factors

Disease Category	Most Recent Drug or Diagnosis	Risk Factor	Claims	Live/Total	Risk Score	Rank
Cardiovascular	DIABETES UNCONTROLLED 250 MG	DIABETES_UNCONTROLLED	1	2015-02-08	1.73	17%
Stroke	CHRONIC KIDNEY DISEASE/RENAL TENDR 100	RENAL_MEDICAL	2	2015-04-28	1.62	18%
Stroke	RHEUMATOID ARTHRITIS	DIAGNOSIS_MEDICAL	4	2015-04-28	1.42	19%
Fractures	PULMONARY COLLAPSE	DIAGNOSIS_MEDICAL	2	2015-02-08	1.32	20%
Substitutable	CONVULSION OF LIMB NOS	DIAGNOSIS_MEDICAL	6	2015-03-08	1.24	2%
CDI	DIABETES TYPE 2 800 MG	DIAGNOSIS_MEDICAL	6	2015-02-08	1.2	4%
Diagnosis	FLUOROURACIL 500 MG QD FOR 1 YRS	DIAGNOSIS_MEDICAL	3	2015-03-18	1.2	4%
Diagnosis	DM2 HYPERTENSION COMA ADULT	DIAGNOSIS_MEDICAL	7	2015-03-08	1.18	4%
CDI	DOXYPENICILIN HYDROCHLORIDE	DIAGNOSIS_MEDICAL	13	2015-03-08	1.18	4%
Diagnosis	METFORMIN HCL 1000 MG	DIAGNOSIS_MEDICAL	11	2015-03-17	1.17	4%
Substitutable	MEDULINE HCL 100 20 MG	DIAGNOSIS_MEDICAL	8	2015-03-28	1.17	4%
Substitutable	DIURETIC OSMOTIC DELAYED RELEASE 20 MG	DIAGNOSIS_MEDICAL	2	2015-07-28	1.15	2%
Diagnosis	HYPERHIDROSIS	DIAGNOSIS_MEDICAL	3	2015-04-03	1.11	2%
Diagnosis	DIURETIC HCL 100 20 MG	DIAGNOSIS_MEDICAL	6	2015-03-28	1.08	2%
Diagnosis	ASTHMA/ONCH 100 20 MG	DIAGNOSIS_MEDICAL	3	2015-03-31	1.04	1%



88

Risk Factor Methodology for Identifying Eligible Clients:

- Medical expenditure risk factors include the following:
 - Age
 - Gender
 - Diagnoses
 - Prescriptions

Note: the Health Home program was designed only to identify the top 5-7% of the Medicaid population and cannot accommodate everyone who could benefit from care coordination

89

Why Do We Focus on Risk?



90

What We Have Learned About Dual-Eligible Clients

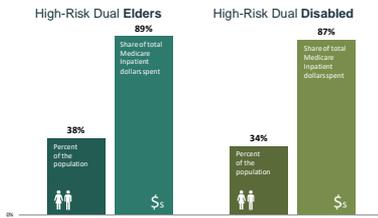
Chronic conditions are more prevalent for dual-eligible clients



91

Duals with High Risk Scores

Disproportionate share of Medicare Inpatient costs



92

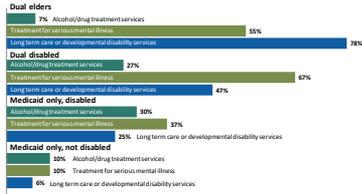
Pharmacy Profiles: High-risk Dual Eligibles

Persons with at least 1 month of dual Medicaid/Medicare enrollment in SFY 2010

THERAPY CLASS	SUMMARY DRUG DESCRIPTIONS	Elders Percent	Disabled Percent
Cardiac	Ace inhibitors, beta blockers, nitrates	85.5%	69.5%
Pain	Narcotics	61.3%	72.2%
Depression/Anxiety	Antidepressants, anti-anxiety	61.2%	73.2%
Hyperlipidemia	Antihyperlipidemics	51.2%	43.2%
Gastric Acid Disorder	Cimetidine	58.7%	60.2%
Diabetes	Insulin, sulfonylureas	38.1%	34.8%
Asthma/COPD	Inhaled glucocorticoids, bronchodilators	36.0%	41.1%
Seizure disorders	Anticonvulsants	28.0%	48.0%
Psychotic illness/Bipolar	Antipsychotics, lithium	20.1%	31.8%
Alzheimer's	Tacrine	13.9%	1.5%
Anti-coagulants	Heparins	18.3%	11.5%
Multiple Sclerosis/Paralysis	Baclofen	11.5%	33.8%

93

Why Focus on Coordination Across Delivery Systems? High-risk clients are likely to have service needs in multiple delivery systems



94

Accessing PRISM

95

PRISM User Responsibilities

- Your Lead Organization’s PRISM coordinator will:
 - Instruct you on the registration process
 - Determine the type of access you receive
- Keep contents confidential and private
- Don’t share your password
- Annually update your agency’s IT security and HIPAA confidentiality training
- Contact your Lead Organization if your profile information changes

96

PRISM Use

- Only access, use, and disclose the minimum amount of data to perform your job and assist the client
- Report suspected or actual security breaches to your Lead Organization immediately
- PRISM is monitored continuously and access may be suspended or terminated for unusual or potentially unauthorized activity
- Violations of RCW and HIPAA may result in severe criminal or civil penalties

97



How Do I Use PRISM in my Role as a Care Coordinator?

98



Uses of PRISM

- Triaging high-risk populations to efficiently allocate scarce care management resources
- Identification of health risk indicators for high-risk patients
- Identification of behavioral health needs
- Medication adherence monitoring
- Identification of other potential barriers to care
 - Homelessness
 - Hearing impairment
 - Limited English proficiency

99



Uses of PRISM (cont.)

- Access to treating and prescribing provider contact information for care coordination
- Creation of health summary reports to share with providers
- Identification of care opportunities



100



Keys for Effective PRISM Use

- **Be bold!** You can't hurt anything
- Check eligibility tab to determine completeness and coverage gaps
- Consider possibility of false positive diagnoses
 - Can include "Rule Out" diagnoses
 - Diagnoses reflect standard uses of medications, not off-label uses

101



Keys for Effective PRISM Use (cont.)

- Consider lag times – PRISM updates weekly but providers may be slow to submit their claims
- Out of pocket payments or private insurance payments will not display in PRISM
- Alcohol and drug treatment services are redacted and will not appear. If alcohol or substance use have been noted by a provider in other health services events then a flag (yes) will display

102



Keys for Effective PRISM Use (cont.)

- Mental Health: this is created as a flag that the client may need mental health services. It is based on either prescriptions or diagnoses from other health service events.
- Tailor how you will use PRISM data with your client
 - How much information will you share?
 - Will this information serve to activate your client and reinforce their changes?

103



PRISM Data

104



PRISM Screens

- Events** ————— Event timelines for Inpatient, Outpatient, ED, Medicare and Medicaid
- AD** ————— Drug adherence timelines for all prescription drugs
- Risk Factors** ————— Key Medical and Behavioral Health Risk Areas
- Eligibility** ————— Detailed eligibility and demographic data
- Claims** ————— All medical claims and encounters
- OP** ————— Outpatient claims
- RX** ————— Prescriptions filled
- IP** ————— Inpatient admissions
- ER** ————— Outpatient emergency room visits
- LTC** ————— Long term care services
- Lab** ————— Laboratory
- Providers** ————— Provider list with links to contact information
- MH** ————— Mental health services
- CARE** ————— Long-term care functional assessments
- HRI** ————— Health risk indicators (for Children)

105



Let's Look at a De-identified Case



106

TRAINING

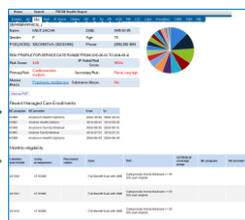
PRISM Screens

PRISM can assist you in your care coordination duties

107

Use the Eligibility Screen to Verify Current Coverage and Gaps

- Has the client been previously covered by another MCO?
 - If so there may be a HAP already in the system
- Is the client currently eligible?
 - Are there any gaps in coverage?



108

Identifying Long Term Care Services: the CARE Tab

Long Term Care Assessments

ID	Type	Status	Date	Problem Description
123220	Assess	Current	2012-01-08	Assess/Reassess services as ordered/diagnosed
123220	Significant Change	History	2012-01-08	Significant Change/assess due to death and not at risk of reg.
123220	Assess	History	2012-01-08	Assess/Reassess services as ordered/diagnosed
123220	Significant Change	History	2012-01-08	Significant Change

109



Long Term Care Payments

Nursing facility or hospice services

Service Start Date	Service End Date	Service Description	Perk Amount	Service Units	Unit Type
2013-01-01	2013-01-31	COPYED-Home Therapy	\$22,000	1	HR
2013-01-01	2013-01-31	COPYED-CARE Agency	\$22,000	110	HR
2013-01-01	2013-01-31	COPYED-HOME Respite Services	\$22,000	1	MOH
2013-01-01	2013-01-31	COPYED-HOME Respite Services	\$22,000	1	MOH
2013-01-01	2013-01-31	COPYED-HOME Respite Services	\$22,000	1	EA
2013-01-01	2013-01-31	COPYED-Home Therapy	\$22,000	1	HR

110

Payments may also be located under Claims screens



Identifying the LTSS Case Manager

Behaviors (4) [Fall\(1\)](#) [Pain\(2\)](#) [Limitations\(2\)](#) [Client](#) [Worker](#) [PCP](#)

111



How to Make a Referral

- If a Care Coordinator identifies someone who may benefit from Health Home services the Care Coordinator may:
 - Contact your Lead Organization
 - Leads have universal access and can access all client records
 - If the client does not have a PRISM score of 1.5 consider if there are recent major changes to health which may qualify them
 - Refer the case to their Lead Organization and include any additional information that may support the referral

115



How to Make a Referral (cont.)

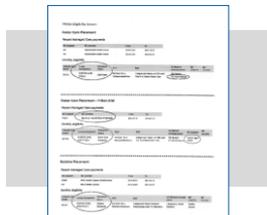
- The Lead will submit the referral to the Health Care Authority (HCA)**
- The Lead may be aware that the client is already assigned to another CCO
 - The Lead may refer the case to a different CCO if HCA approves services
 - The HCA may not approve the services
 - The HCA may choose to refer the case to another Lead

116



Reminder: Contact Requirements for Foster Children

- To identify if a child is receiving foster care check the PRISM eligibility screen
- Contact Children's Administration, not the foster parent for initial outreach



117

TRAINING



Where to Turn for Assistance

Contact your Lead Organization

PRISM Support (DSHS Research and Data Analysis)
prism.admin@dshs.wa.gov

Health Care Authority Health Home Program
healthhomes@HCA.wa.gov

121



Practice Using PRISM

Let's return to our vignettes and begin our small group activity



122

TRAINING



Small Group Work



Navigate and review the Excel spreadsheet to analyze your client's use of services

- What is PRISM Risk Score and IP Admit Risk Score?
- What did you note about your client in reviewing the screens in PRISM?
- What issues or gaps in care* did you identify that you would like to discuss with your client?

*Gaps in care means the identification, coordination, and processing of needed referrals to meet a client's medical, behavioral health, and social service needs.

123



Let's Pause to Check for Understanding



If you have used PRISM in the past which screens did you find most helpful?

Do you have any questions?

124



The Patient Activation Measure® Coaching and Action Plan Development



125



Review of the Patient Activation Measure®

The PAM¹ is a behavior measurement tool that

- Reliably measures activation and the behaviors that underlie activation
- Provides insight into how to improve unhealthy behaviors and grow/sustain healthy behaviors
- Allows us to improve activation levels /behaviors, lower medical spending and improve health

¹All references to the Patient Activation Measure in this presentation are the property of Insignia Health (copy and trademark). Parts of this presentation were adopted from Insignia Health training materials.

126



Types of PAMs

- Patient Activation Measure – PAM®
 - assesses the client's activation level
- Caregiver Activation Measure – CAM®
 - assesses the caregiver's activation level in caring for their client
- Parent Patient Activation Measure – PPAM®
 - assesses the parent's activation level in caring for their child



127

TRAINING

What is Client Activation?

Having the knowledge, skills, emotional support, and belief to:

- Self manage health
- Collaborate with providers
- Maintain function and prevent declines
- Access appropriate high quality care

128

Administering the PAM

Emphasize that the tool is a **health** survey

It is all about helping the client

It is neither used to judge nor reduce or deny any benefits

129

PAM 13 Question Survey

Let's review the 13 Patient Activation Measure Statements now

130

TRAINING

Tips for Administering the Assessment Tool

- It does not require a face-to-face contact to complete
- This survey can be administered over the telephone
- It could be mailed and completed in advance of the first face-to-face visit
- Check with your Lead regarding their policies related to administering this and other assessments

131

Tips for Administering the Assessment Tool (cont.)

- Some people do a better job completing it themselves
- Consider asking the caregiver to complete a CAM if the client is unable to respond
- If a client refuses offer again at a later date
- You could provide a copy of the tool and ask the questions and record the answers
 - This is helpful for clients with limited reading ability

132

Tips for Administering the Assessment Tool (cont.)

- Ask the client how much they agree or disagree with the 13 statements
- Always start with strongly disagree to strongly agree
- Always ask the questions in order
- Do not change the questions
- Statements become increasingly more difficult to agree with

133



Tips for Administering the Assessment Tool (cont.)

- Do not discuss responses to the statements while administering the PAM – this may improve scores
- Allow the client to consider the statements, silence may indicate that they are thinking about their response

134



Tips for Administering the Assessment Tool (cont.)

- If a client is unable to complete the survey or refuses document in the HAP
 - The date the assessment was offered and declined
 - If known, the reason the assessment was not administered
- When a client, caregiver, or parent do not complete the tool offer it at a subsequent visit

135



Tips for Administering the Assessment Tool (cont.)

- Use the client’s responses as a springboard for further discussion (only after they have completed the survey)
 - Consider using the responses to individual statements as a starting place for discussing health concerns which the client may wish to address in their HAP

136



Interpret PAM Results

Client Response	Interpretation
Agree Strongly	Yes – the question is true about me. This is a definite “yes”.
Agree	Sometimes this is true about me or is potentially true about me.
Disagree/Strongly Disagree	This is not true for me.
NA	This does not apply to me. I do not know how to answer. I refuse to answer.

137



Scoring

- Scoring is the same for the PAM, CAM, and PPAM
- Ask your Lead Organization for the scoring guide
 - Most Leads have software that will score the tool
- The activation **score** is converted to an activation **level**

138



PAM Segmentation Characteristics

Level 1: Disengaged and overwhelmed

Starting to take a role. Clients do not yet grasp that they must plan to take an active role in their own health. They are disposed to being passive recipients of care.

Level 2: Becoming aware, but still struggling

Building knowledge and confidence. Clients lack the basic health related facts or have not connected these facts into larger understanding of their health or recommended health regimen.

139



PAM Segmentation (cont.)

Level 3: Taking action

Clients have the key facts and are beginning to take action but may lack confidence and the skill to support their behaviors.

Level 4: Maintaining behaviors and pushing further

Clients have adopted new behaviors but may not be able to maintain them in the face of stress or health changes.

140



PAM Segmentation Characteristics

Roughly 45 to 50% of all Medicaid clients who have completed the measure score at a Level 1 or Level 2

- Level 1: Disengaged and overwhelmed
 - Level 2: Becoming aware, but still struggling
-
- Review the client's activation score and level to tailor coaching that is appropriate to the client.

141



Elicit the Client's Story Using Responses to PAM Questions

Select an item where their answers begin to move away from strongly agree. Help the client discover:

- What led them to select the response?
- Why this level and not a lower level?
- What would it take to reach the next level?
 - Is this something we could work on together?

142



Elicit the Client's Story Using Responses to PAM Questions (cont.)

With self-reflection the client makes an assessment of:

- What the problem is
- What will have to happen to alter this assessment
- How the Care Coordinator can coach the client to pursue behavioral changes

143



Tailor Your Coaching

Use responses to individual PAM items to get them to explain what is going on.

The client will make statements indicating what they think are the barriers or challenges.

Use perceived barriers to jointly problem solve throughout the coaching process.

144



Analyze the Results Incorporating Motivational Interviewing Techniques

Notice when your client begins to disagree or strongly disagree with the statements

This can be a good place to begin discussion about identifying areas where the client or representative may want to consider the type of goal them may be interested in pursuing

Consider using motivational interviewing techniques to draw the client or representative out

145



Motivational Interviewing Strategies

Start with where the person is and try to understand how the client understands their own situation

Be empathetic and ask open ended questions

Listen and do reflective listening

- "It sounds like you are feeling..."
- "So, you are saying that you believe..."

146



Motivational Interviewing Strategies (cont.)

Express acceptance and affirmation of the client's freedom of choice and self-direction

Elicit and selectively reinforce the client's own self motivational statements, expressions of problem recognition, concerns, desire, intention to change, and ability to change

147



PAM Activation Level 1

GOAL

Build self-awareness and confidence

Examples

- Self-monitoring and awareness (e.g. how much they walk or how they cope with stress)
- Start pre-behaviors (e.g. reading labels on food)
- Cope with stress
- Understand their role in the care process

148



PAM Activation Level 2

GOAL

Increase knowledge, confidence, and initial skill development

Examples

- Make sure the knowledge dots are connected
- Start with small behavioral steps (one step at a time)
- Stress management and coping skills
- Build problem solving skills

149



PAM Activation Level 3

GOAL

Initiation of new behaviors and develop problem solving skills

Examples

- Initiation of specific realistic behaviors (e.g. walking 10 minutes 3 times a week)
- Problem solving as it relates to the issues that emerge with the new behavior goals

150



PAM Activation Level 4

GOAL

Maintain behaviors and techniques to prevent relapse

Examples

- Build confidence for coping and problem solving when situations throw them off track; self-monitor for those situations (e.g. new staff at the doctor's office)
- Plan for handling a specific type of situation (e.g. using medications while traveling)
- Problem solve together

151

Perspectives on the PAM

The initial PAM score can be higher than subsequent PAM scores
The client does not know what they do not know

It is important to place the surveys side by side over time and work with the client on changed responses
Look and listen for change talk and change opportunities

Anticipate if the client may experience a decline or improvement in score to coach and support them
Be aware of individual successes and failures and how they impact confidence with developing new or different skills

152

Where Do I Get Copies of the Tools?

Lead Organizations are required to purchase a license for these products through Insignia

For copies of the PAM, PPAM and CAM, the translated tools and scoring guide contact your Lead to get Insignia's:

- Website address
- User name
- Password



153

Website Hosting PAM Versions



Ask your Lead Organization for the following to access this site:

URL: <https://healthhomes.insigniahealth.com>

User Name: - - - - -

Password: - - - - -

154



PAM® Small Group Work



- What is the PAM® **score** for your client?
- What is the client's or parent's **Level of Activation**?
- What did you note about his/her **responses** to the PAM/PPAM®?
- If available should the **caregiver** complete the CAM®?
- How would you begin to work with your client in relation to their responses and **Level of Activation**?

155



Let's Pause to Check for Understanding



How will awareness of a client's PAM level help you work with your client?
Do you have any questions?

156



Goal Setting

Moving Toward Health Action Planning

157



Moving Toward Health Action Planning

Consider the client's responses by reviewing and discussing the activation measure results

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

Consider using the Goal Setting and Action Planning Worksheet

158



A Tool for Starting the Conversation

The Goal Setting and Action Planning Worksheet

The thumbnail shows a worksheet titled "HEALTH HOME Goal Setting and Action Planning Worksheet" with logos for the Department of Health and the Health Care Authority. It includes sections for "Long Term Goal" and "Short Term Goal", and a section for "Describe something you will do now to improve your health" with a table for "Describe what you will do" containing four numbered rows.

159

TRAINING



Coaching and Action Planning

Goal Setting and Action Planning Worksheet

- Start where the client is
- Determine what the client wants to change
- The action plan is negotiated and tied to the discussion about the level of activation

160



Coaching and Action Planning (cont.)

Goal Setting and Action Planning Worksheet

- The action plan is something achievable given the client'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

161



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

162



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?

163



Questions to Consider

How important is it for you right now to...? On a scale from 0 - 10... what number would you give yourself?

0 _____ 10
CONVICTION SCALE

If you did decide to change, how confident are you that you would succeed? On a scale from 0 - 10... what number would you give yourself?

0 _____ 10
CONFIDENCE SCALE

If you did decide to change, how ready are you to make this change? On a scale from 0 - 10... what number would you give yourself?

0 _____ 10
READINESS SCALE

164



Coaching and the Health Action Plan

Use a coaching for activation approach to guide the client to:

- Appropriate choices
- Attainable goals
- Action steps
- Improved health

165



The Health Action Plan (HAP)

Establishes:

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

166



Key Skills for Health Action Planning

Demonstrate positive belief in the client’s ability to take an active role to accomplish appropriate goals and action steps

Emphasize stress management and coping and resiliency skills

Ask the client to recall a former success: how did it feel?

167



Key Skills for Health Action Planning (cont.)

- 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

168



Analyze!

- **What do you think drives poor health and high costs for your client?**
 - 85% of avoidable costs are due to behavioral, not medical factors
- Consider:**
- Client’s perspective
 - Results from assessment and screening tools
 - PRISM Risk Factors
 - Client’s Level of Activation

169



Use Active and Reflective Listening

Assure them that you can see their point of view

Acknowledge the struggles or difficulty involved

- Acknowledge their success and their skills, abilities, and strengths
- Thoughts
 - Beliefs and values
 - Behaviors

Use **you** statements – strength based approach

170 “You sound determined.”



Consider What Values Lie Behind These Statements

- I want to feel better
- I want to be more independent
- I want to be able to attend church with my family
- I want to see my grandchildren grow up

Keep these in mind so you can later link these values to their long term goals, short term goals, and action steps

171



Emphasize Problem Solving

A Health Action Plan requires addressing problems through "action steps"

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

Working through a problem using health coaching increases and enhances retention

Identify their capacity for change and self-efficacy

172



Identify Barriers to Change

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

173



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.

174



Resistance

It's human nature! Taking one side of a conflict can cause a person to take the opposite stance. It's normal...



175



Behavioral Change

Trying to convince another person to make a behavior change can actually cause the person to be **less likely** to make a change.

Even if you are successful in convincing someone to make a behavioral change, the change is not be likely to last.

176



Resist the Righting Reflex Exercise

Pair up and take turns as the speaker and the listener



Speaker

Share your thoughts and feelings about a behavioral change you have thought about making or a change you previously made but are having trouble maintaining

Listener

- Ask open-ended questions
- No closed-end questions
- Neither agree nor disagree
- Avoid sharing your opinions or experiences

177



How Did It Go?

- What was it like to be the listener... did you want to interject your experiences or thoughts?
- Were there times when you wanted to jump in and offer advice or "fix it"?
- What was that like for you as the speaker... did you feel understood?
- How did it feel to have someone place all of their focus on you and your concerns for even 5 minutes?
- What did you learn from this interaction about your own style?

178



Cultivate a Sense of Hope

Demonstrating a **positive belief** in your client has a positive impact on the client's ability to accomplish their goals and action steps and sustain behavioral change.

Hope is one of the greatest contributions you make to your client as their Care Coordinator.

179



The Day in Review

Health Home fundamentals

Client outreach and engagement

PRISM

The Patient Activation Measure

Goal setting and action planning: moving toward the Health Action Plan

180



Let's Pause to Check for Understanding



How is the role of a Care Coordinator different than those you have had in the past?
 What benefits do you see for your clients who engage in the program?
 Do you have any questions about what we covered today?

181



Planning for Day Two

- Start time for training
- Location
- Topics to cover
 - The Health Action Plan
 - Comprehensive Care Transitions
 - Documentation
 - Quality Assurance
 - Resources and websites
 - Ongoing training requirements
 - Six required topics

182



Welcome to Day Two

Do you have any questions about what we covered on Day One?

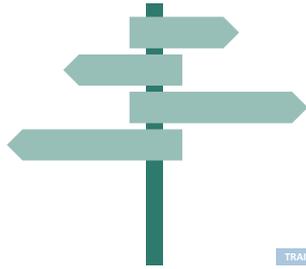


- HH Fundamentals
- Outreach and engagement
- PRISM
- PAM
- Moving toward health action planning

183



The Health Action Plan



184

TRAINING

Most People Desire Better Health and Quality of Life

Each client is in charge of their own health

Their own Health Action Plan, and

Whether or not they make lifestyle changes



185

Help Identify a Long Term Goal

Use a **person-centered** approach to help the client identify:

- What would they like to happen as a result of their health changes?
- What would they like be able to do that they can't currently do?
- What their level of activation is and how it will help or hinder their ability to achieve their goal/s?

186

Help Identify a Long Term Goal (cont.)

Long term goals may relate more to social goals but by achieving them the client may:

- Reduce medical costs
- Slow the progression of chronic disease
- Delay the onset of another chronic disease
- Reduce avoidable ED visits and hospital admissions and readmissions

187

Health Action Plan: Page 1

Note: most Lead Organizations have a data platform that is used to capture the HAP. These platforms can print the HAP but it may not look like the paper form.

188

TRAINING

HAP Instructions



189

TRAINING

Additional Training on the HAP

- Your Lead/s will provide operational training on how to use their software programs
- Don't hesitate to ask for technical assistance
- Meetings are sponsored by the Leads to supplement this training
- DSHS sponsors monthly webinars and a quarterly newsletter with information related to the program and your work

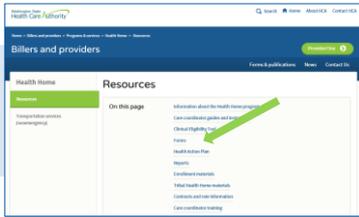
190



HAP Form and Instructions

The revised HAP and Instructions are located at the HCA Website:

<https://www.hca.wa.gov/billers-providers/programs-and-services/resources-0>



191



HAP Form Instructions

Each HAP spans a 12 month enrollment period consisting of three separate four month updates or activity periods

All other documentation goes in the client record or file

192

TRAINING



HAP Form Instructions (cont.)

The Health Action Plan is updated and modified at each monthly contact by the Care Coordinator and when necessary to support a care transition or when the client opts-out of the Health Home program.

The Health Action Plan is updated and modified as needed according to:

- A change in the client’s condition
- New immediate goals to be addressed
- Completion of a short term goal and action steps

193



What is an Activity Period?

194



Activity Periods



- There are three activity periods in a yearly (12 month) cycle
- Each activity period or trimester is four months
- There are 120 to 123 days within an activity period
 - Number of days in a month varies from 28 or 29 days for February and 30 to 31 days for other months

195

TRAINING



Activity Periods Example



196

Individual or Group Activity



Activity Periods Worksheet



197

TRAINING

Worksheet 3: Activity Periods



If the client opts in May 1, 2018:

1. What are the dates for the first activity period?
2. What are the dates for the second activity period?
3. What are the dates for the third activity period?
4. What is the start date for the next HAP year cycle?

January February March April May June July August September October November December
198

Worksheet 3: Activity Periods



May 1 thru August 31

September 1 thru December 31

January 1, 2019 thru April 30

May 1, 2019

January February March April May June July August September October November December
199

Worksheet 3: Activity Periods



If the client opts in July 13, 2018:

1. What are the dates for the first activity period?
2. What are the dates for the second activity period?
3. What are the dates for the third activity period?
4. What is the start date for the next HAP year cycle?

January February March April May June July August September October November December
200

Worksheet 3: Activity Periods



July 13 thru November 12

November 13 thru March 12, 2019

March 13 thru July 12

July 13, 2019

January February March April May June July August September October November December
201

Worksheet 3: Activity Periods

- 1. What is the end date of the HAP if the client notifies the Care Coordinator that he no longer wants to participate in the program during a phone call on May 10, 2018?

May 10, 2018

- 2. The Care Coordinator made several calls to the client and sent a letter with no response from the client and the Lead approves closure of the HAP. The letter was mailed to the client on August 13, 2018 and the final call was made on August 17, 2018. What is the end date for the HAP?

August 17, 2018

202

HAP Form Instructions (cont.)

Demographic data fields for name, gender, date of birth and ProviderOne ID

Date the HAP begins

Date the client Opts-in

- This is the date the client agrees to participate in the program and begins development of the HAP.
- This date becomes the client's anniversary date. It triggers the start of a new HAP for the next HAP reporting year.

203

TRAINING

HAP Form Instructions (cont.)

Date the HAP ends:

- At the end of a one year cycle (do not prepopulate this field)
- The day the client opts out of the program
- The date the HAP ends for other reasons as listed in the Reason for Closure of the HAP data field (check the appropriate box if one of the reasons apply)

204

HAP Form Instructions (cont.)

If a client is transferring for one of the reasons listed, then do not enter a HAP end date as the HAP is still active until the end of the one year cycle even though it may be transferred.

Reasons for transfer of the HAP include:

- Client choice to change CCO or Lead Organization
- Eligibility changed:
 - Client was enrolled with a Managed Care Organization (MCO) and transferred to a Fee-for-Service (FFS) Health Plan
 - Was enrolled with as FFS and transferred to an MCO Health Plan

| Health Plan (HAP) |
|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|
| NAME | TYPE | CLASSIFICATION | CLASSIFICATION | CLASSIFICATION | CLASSIFICATION |
| CLASSIFICATION | CLASSIFICATION | CLASSIFICATION | CLASSIFICATION | CLASSIFICATION | CLASSIFICATION |

205

HAP Form Instructions (cont.)

Options for gender include:

CLIENT'S FIRST NAME	CLIENT'S LAST NAME	DATE OF BIRTH	SEX						

Because clients have a right to change Lead Organizations or Care Coordination Organizations the names and phone numbers are provided

206

HAP Instructions (cont.)

CLIENT IDENTIFICATION	CLIENT'S LONG TERM GOAL	DISORDER/TREATMENT TO THIS

Write a brief statement about the client

Develop a long term goal that is person-centered, based on what the client wants to achieve

Enter the diagnosis or diagnoses that are pertinent to the long term goal

207

Help the Client Identify Long Term and Short Term Goals

“Physically, what can you do best?”

“When are you strongest?”

“Who do you contact when you aren’t feeling well?”

“Which health concerns have the biggest impact on your life?”

“What are some ways you may increase your wellness?”

208



HAP Form Instructions (cont.)

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)

209



HAP Form Instructions (cont.)

Enter the date the screening was completed or offered but declined

Enter the activation score and level of activation for each type of activation measure completed

If the client, caregiver or family decline or are unable to complete the screening enter the date and the reason the screening was not completed

Screening must be completed at least once during each four month activity period or more often as clinically indicated

Screening Measure	Initial/Current HAP Required Screenings				Four Month Update Required Screenings				Eight Month Update Required Screenings			
	Date	Score	Level	Notes	Date	Score	Level	Notes	Date	Score	Level	Notes
PHQ-9												
PSC-17												
BMI												
Katz ADL												
PAM												
CAM												
PPAM												

210



Patient Activation Measures

The PAM is required for clients

- Note the date, the activation score and activation level on the HAP
- If the client cannot complete the PAM
 - Note the date the screening was offered and note the reason the PAM was not completed on the HAP OR
 - Complete the CAM or PPAM (see next slides)
 - The PAM dates may not be the same as the start date of the HAP or updates for each four month activity period

211



Caregiver Activation Measure

The CAM may be administered when the client is unable or unwilling to complete the PAM

- Caregivers may be informal or formal caregivers, or paid or unpaid caregivers
- Document in the case record the name and relationship of the person who completed the CAM
- Note the date the CAM was completed, the activation score, and activation level on the HAP

212



Parent Patient Activation Measure

The PPAM must be administered to the parent or guardian of children under the age of 18 years

- Parents include: biological, adoptive, or foster
- Note the date the PPAM was completed, the activation score and activation level on the HAP
- Document in the case record the name and relationship of the person who completed the PPAM
- If the parent or guardian declines to complete the PPAM note the date the assessment was offered and the reason the parent/guardian did not complete the screening

213



The Katz ADL

Score one point for each of the six ADLs that client reports that they can perform independently without assistance

If a client indicates that they are dependent and could use assistance with two or more ADLs consider a discussion about applying for LTSS

Referring the client to the DSHS Developmental Disabilities Administration or Home and Community Services Office in your area is an appropriate service for you to offer

214

Katz Activities of Daily Living (ADLs)



Link to 29 minute training video:
<https://consultgeri.org/try-this/general-assessment/issue-2>

ACTIVITIES (Katz's 6 ADL)	INDEPENDENCE	DEPENDENCE
ADLs: 1. <input type="checkbox"/> ADLs: Ability to undress or dress completely without assistance. 2. <input type="checkbox"/> ADLs: Ability to transfer from bed to chair or toilet and vice versa, including use of crutches, walker, or other devices.	ADLs: 1. <input type="checkbox"/> ADLs: Ability to undress or dress completely without assistance. 2. <input type="checkbox"/> ADLs: Ability to transfer from bed to chair or toilet and vice versa, including use of crutches, walker, or other devices.	ADLs: 1. <input type="checkbox"/> ADLs: Inability to undress or dress completely without assistance. 2. <input type="checkbox"/> ADLs: Inability to transfer from bed to chair or toilet and vice versa, including use of crutches, walker, or other devices.
SHowering: 1. <input type="checkbox"/> ADLs: Ability to bathe, wash, or shower without assistance. 2. <input type="checkbox"/> ADLs: Ability to dress and undress while in the shower or tub.	ADLs: 1. <input type="checkbox"/> ADLs: Ability to bathe, wash, or shower without assistance. 2. <input type="checkbox"/> ADLs: Ability to dress and undress while in the shower or tub.	ADLs: 1. <input type="checkbox"/> ADLs: Inability to bathe, wash, or shower without assistance. 2. <input type="checkbox"/> ADLs: Inability to dress and undress while in the shower or tub.
Dressing: 1. <input type="checkbox"/> ADLs: Ability to dress and undress completely without assistance. 2. <input type="checkbox"/> ADLs: Ability to dress and undress with assistance.	ADLs: 1. <input type="checkbox"/> ADLs: Ability to dress and undress completely without assistance. 2. <input type="checkbox"/> ADLs: Ability to dress and undress with assistance.	ADLs: 1. <input type="checkbox"/> ADLs: Inability to dress and undress completely without assistance. 2. <input type="checkbox"/> ADLs: Inability to dress and undress with assistance.
Continence: 1. <input type="checkbox"/> ADLs: Ability to control bladder and bowels without assistance. 2. <input type="checkbox"/> ADLs: Ability to use toilet or commode without assistance.	ADLs: 1. <input type="checkbox"/> ADLs: Ability to control bladder and bowels without assistance. 2. <input type="checkbox"/> ADLs: Ability to use toilet or commode without assistance.	ADLs: 1. <input type="checkbox"/> ADLs: Inability to control bladder and bowels without assistance. 2. <input type="checkbox"/> ADLs: Inability to use toilet or commode without assistance.
Walking: 1. <input type="checkbox"/> ADLs: Ability to walk without assistance. 2. <input type="checkbox"/> ADLs: Ability to walk with assistance.	ADLs: 1. <input type="checkbox"/> ADLs: Ability to walk without assistance. 2. <input type="checkbox"/> ADLs: Ability to walk with assistance.	ADLs: 1. <input type="checkbox"/> ADLs: Inability to walk without assistance. 2. <input type="checkbox"/> ADLs: Inability to walk with assistance.

215

PHQ-9 and PSC-17 Screens

Patient Health Questionnaire: nine item screening tool for depression
 18 years and older

Pediatric Symptom Checklist: 17 item screening tool for moods and behaviors
 Ages 4 through 17 years

216

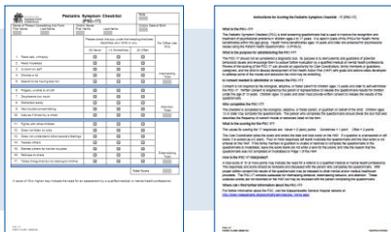
Pediatric Symptom Checklist – 17

- The PSC-17 must be completed for children ages 4 to 17 years of age
- The screening is completed by the parent or guardian
 - Scoring is based on the parent's report of current behaviors
- A child age 13 and over may self-administer the screening
- Note in the comment section the name of the person who completed the screening and their relationship to the child. Enter the parent's score in the HAP and note the child's score in the case narrative

220



DSHS Form 10-509 PSC-17 & Instructions



221

TRAINING



PSC-17 Considerations

The screening tool should not be used for diagnosing

A score of 15 or higher may indicate the need for further evaluation by a qualified professional

The screening tool offers three subscales for:

- Internalizing behavior
- Externalizing behavior
- Attention

222



PSC-17 Website

For translations of the tool visit the Massachusetts General Hospital website located at:
http://www.massgeneral.org/psychiatry/services/psc_home.aspx



223



Body Mass Index (BMI)

This is required on the HAP

- BMI chart is located in the Classroom Training Manual
- BMI is not required for children under 2 years of age
- If you are unable to get a recent or accurate weight record the BMI and make a comment in the comment box

224

TRAINING



BMI Online Charts

BMI Calculator for Children and Teens (2-19)
<http://nccd.cdc.gov/dnpabmi/Calculator.aspx>

BMI Calculator for Adults
http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html

225



HAP Form Instructions (cont.)

Optional screenings

Enter the dates and scores of the screenings on the HAP

- DAST – Drug Abuse Screening Test
- GAD-7 – Generalized Anxiety Disorder 7 item scale
- AUDIT – Alcohol Use Disorders Identification Test
- Falls Risk – My Falls-Free Plan identifies risk and provides suggestions to prevent falls
- Pain Scales – Administration of appropriate pain scale

226

TRAINING

When to complete an optional screening

- Use your clinical judgment to determine the need and frequency for offering additional screenings
 - Examples:
 - If a client identifies a goal related to pain: one of the three pain screenings
 - If a client voices concerns about their use of alcohol or drugs: the AUDIT or DAST
 - If a client reports falls or fractures: falls risk
 - If a client identifies a goal to reduce stress or anxiety: GAD-7
- If the HAP includes goals or action steps related to one of the optional screenings then the screening must be offered and documented on the HAP

227

PHQ-9 and GAD-7

Anxiety and depression are the most common mental disorders and often appear together. Screening tools often used include:

- The PHQ-9 which can identify potential depression
- GAD-7 which can help identify potential anxiety
- Both tools are most reliable when self-administered
- A positive screening for either or both should lead to a referral to a behavioral health provider or PCP depending on client preference

228

HAP: Pages 2 Through 7

232

Short Term Goals

- Enter the short term goal
- Enter the short term goal begin date
- When a goal ends enter the date and check the reason the goal ended
- Enter the action steps, specifying who will complete the step and the start date
- Goals that are not completed may be carried over to the next four month activity period
- Goals may be revised at any time to reflect changes with the client

233

The Health Action Plan (HAP)

Develop goals and action steps that are **SMART**:

- Specific
- Measurable
- Achievable
- Relevant
- Time-limited



234

Health Action Plan – First Short Term Goal

Long Term Goal

Participate in church activities with my family.

Short Term Goal # 1

Debbie would like to improve stamina and gain strength and be able to remain out of her bed for four hours or more each day.

Action Steps

1. Debbie and Care Coordinator will brainstorm common events in Debbie's life that promote activity as well as those that promote inactivity.
2. Debbie will maintain activity log for two weeks and review with Care Coordinator during next visit on 10/7/18.

235



Health Action Plan – Second Short Term Goal

Long Term Goal

Participate in church activities with my family.

Short Term Goal # 2

Debbie would like to decrease use of pain medication.

Action Steps

1. Debbie will document use of pain medications, her activity, and functional ability daily starting 12/1/18 using the pain log provided by the Care Coordinator.
2. Debbie will make an appointment with PCP to discuss chronic pain management options by 12/20/18.
3. Care Coordinator will review the pain log and inquire about Debbie's appointment with her PCP during the home visit schedule on 12/28/18.

236



Let's Pause to Check for Understanding



What experiences have you had offering and administering these screenings in the past?

Do you have any questions?

237



Small Group Work



Considering your client's PRISM results, PAM responses and Level of Activation:

- Fill out the HAP form (make up scores as needed for this activity)
- Write the following on the flip chart:
 - One long-term goal
 - One short-term goal
 - Actions steps to reach the short-term goal
 - Who will complete the step and by when?
 - Which of the 6 health home services might the client need now and in the near future?
 - Which optional screenings might be helpful for your client?

238



Maintaining Behavioral Change

Sustaining the gains with healthy strategies

Maintaining behavioral change takes time (usually 6 months to two years)

Monitoring using relapse prevention and resiliency planning

Progressing by realizing that relapse is one step forward on the client's journey

Pursuing new goals and activities

239



Final Notes About the HAP

- Provide the HAP information to the client, or with the client's consent, to the caregiver and family
- The HAP may be:
 - Printed and mailed
 - Delivered at the face-to-face visit
 - E-mailed using secure mail and/or encryption
- Each face-to-face visit or telephone contact provides an opportunity to discuss and review progress on the HAP
- The HAP is a fluid document that changes with the client's needs and preferences

240



Let's Pause to Check for Understanding



How can you work with your client to increase the value of the HAP?

Do you have any questions about the HAP?

241



Care Transitions "Health Care Without Complications"



All materials in this section are adopted from the "Reducing Readmissions: Care Transitions Toolkit" from the WASHINGTON STATE HOSPITAL ASSOCIATION. To download a copy of the toolkit go to

<http://www.wsha.org/wp-content/uploads/WSHACareTransToolkit.pdf>

242

TRAINING



Hospital Readmissions

As of January 1, 2017, our region's 30-day readmission rate of 31.3 per 1,000 Medicare beneficiaries is better than the national average (52.5 per 1,000).

Research shows that 20% of patients in the U.S. are re-hospitalized within 30 days of discharge.

Addressing social and resource barriers early in the admission not only prevents unnecessary readmissions, but also proactively prevents delayed discharges and unnecessary increases in the length of stay

243



What Causes Readmissions?

- Unresolved social or resource issues:
 - Medical issues are not always the reason
- Lack of strategies that incorporate both social and medical factors resulting in poorly executed transitions and poor outcomes for the client which impact:
 - Family and support systems
 - Caregivers: paid and unpaid
 - Client's health and stability



244



Washington State Care Transitions

Washington State "Care Transitions" is a state-wide initiative to foster safe, timely, effective, and coordinated care as clients move between settings

Care Coordination includes collaborating on the discharge Plan of Care with the primary care physician (PCP) and multidisciplinary care team

245



How Will You Know if a Client Has Been Hospitalized?

Review PRISM data: there is a lag in submission of billing claims

Emergency Department Information Exchange (EDIE): find out if your Lead or agency subscribe to this service

Some Leads use PreManage, a system that notifies them of emergency department visits and hospital admissions and discharges

Find out who at your agency receives these alerts

246



Six Strategies for Care Transitions

- 1 Consistent plan of care with the PCP and home health care (if applicable) upon arrival and discharge from the hospital
- 2 Coordinated follow up call or visit at discharge
- 3 Timely visit to PCP
- 4 Reconciliation of medications soon after transition
- 5 Client, family, and caregiver education coordinated between settings
- 6 Support through increased care management for high-risk clients

247



Social/Resource Barriers Assessment

Evaluate, assess, and complete a needs assessment of client's home-going needs and barriers to care including support requirements.

The Katz ADL may be used as a tool for assessing the client's abilities and care needs.

248



Social and Resource Barriers

- Personal care needs
- Other disabilities
- Limited income
- Financial reserves
- Unstable or unsafe housing
- Inaccessible housing
- Coping skills
- Employment
- Health literacy or numeracy
- Lack of an advance directive
- Religious or spiritual support
- Education
- Substance use history
- Psychiatric history
- Availability of mental health or SUD services
- Demands on other family members or caregivers
- Transportation

249



Client, Family, and Caregiver Follow-up



- What are the discharge orders?
- Do they have a copy of the discharge orders and do they understand them?
- What warning signs or symptoms should be reported to the healthcare provider? Do they have the phone number to the 24 hour nurse line?
- What follow-up is necessary?
- Have the follow-up appointments been scheduled?
- Is the client aware of these appointments and do they need transportation and/or an escort to the appointment/s?
- What are the current medications?

250

Does the Client or Caregiver Know Which Red Flags May Require a Call to the Provider?

- Chest pain or palpitations
- Cough
- Infection
- Blurred vision, loss of vision
- Headache
- Fatigue
- Insomnia or problems sleeping
- Discharge
- Warmth to an affected area
- Fever
- Pain
- Nausea and/or vomiting
- Poor appetite
- Weight loss or weight gain
- Bleeding
- Constipation or diarrhea
- Difficulty urinating or no urination
- Dizziness
- Falls

251

Triage Grid for Follow Up With PCP

Patient	Criteria	Appointment Needed with	Provider Handoff	Plan of Care Transfer
High Risk	<ul style="list-style-type: none"> • Admitted 2 or more times in the past year • Unable to reach back • Low likelihood to follow treatment plan • High likelihood patient readmitted within 30 days 	48 Hours	Doctor to Doctor	Phone and FAX
Moderate Risk	<ul style="list-style-type: none"> • Admitted once in the past year • Moderate likelihood to follow treatment plan • Moderate likelihood patient readmitted within 30 days 	5 – 7 days	Hospital to PCP Team	EMR or FAX
Low Risk	<ul style="list-style-type: none"> • No other admission in the past year • Able to reach back • Low likelihood patient readmitted within 30 days 	As Needed	Hospital to PCP Team	EMR or FAX

Clients who are at very high risk need a quicker and stronger communication process between providers while those at lower risk do not need as intensive of care.

Created by WA physicians and hospitals with evidence from the Institute for Healthcare Improvement
252

Medication Reconciliation Defined

Medication reconciliation is:

A **process of comparing** the medications a client took prior to admission to a hospital, nursing facility, or other in-patient center with those ordered by the physician at the time of discharge.

Should also be completed when the client visits their PCP to ensure that the medication record is **accurate and up to date**.

Reduces the potential for administering the wrong dosage, administering a discharged medication, taking the same medication more than once (e.g. taking the name brand and the generic of the same medication), and/or using expired medications.

253



Medication Reconciliation

- During the hospital stay: anticipate needs
- Care Coordinator will provide or ensure that it is completed by a qualified professional

Note: clients who discharge from a facility against medical advice (AMA) do not receive their prescribed medications when they exit the facility. The need to follow up on medication orders and to fill prescriptions becomes even more critical.

254



Medication Reconciliation (cont.)

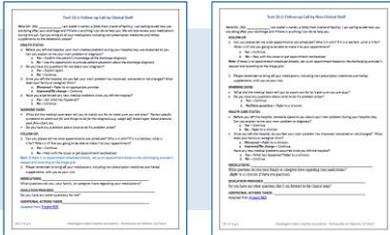
Who can help reconcile medications?

- Primary care physicians (PCP)
 - The PCP's nurse or physician's assistant (PA)
- Family members
- Pharmacists
- Pharmacies that deliver bubble-packed medications to adult family homes
- Home Health nurses
- Adult Day Health Centers
- Nurses in nursing facilities, assisted living, adult family homes, and other institutions

255



Follow-up Scripts from “Reducing Readmissions: Care Transitions Toolkit”



256

TRAINING

“Teach Back”

Literature shows “Teach Back” is one of the most effective methods for educating clients. Teach Back involves asking the patient, family, or caregiver to recall and restate in their own words what they thought they heard during education or other instructions.

Be aware of the client or caregiver activation level when teaching or using “teach back” techniques.

An example of teach back is to ask your client if they can show you how to locate the number for the 24-hour nurse helpline

257

TRAINING

Let’s Consider Our Vignettes

- If Carmella was hospitalized what transition services might you provide?
- How would you work with Sacha if she admits to the hospital and then to the nursing facility and is returning home?

NOTE: when entering a hospital, nursing facility, or other institution introduce yourself to staff each time you enter the facility so staff is aware of your role and services you may offer.

258

Let's Pause to Check for Understanding



What experience have you had professionally or personally with effective discharge from a hospital or other inpatient setting?
Do you have any questions about Care Transitions?

259



Documentation, Quality Assurance, and Time Management



260



Documentation Guidelines

- These are general guidelines
 - Suggested practices
- Ask your Lead/s for their guidelines
 - Data platforms will vary
 - Ask for their client file checklist
- Consult your supervisor
 - What are your agency's requirements?
 - What are best practices?
- Professional standards for your credential and experience



261

TRAINING



General Format for Documentation

- Name and title of writer
- Date
- Type of contact
- Core service provided
- Highlights from the conversation
- Objective observations
- Other relevant comments
- Plan for next steps or conclusion
 - Specify due dates and who is responsible

262



Something to Consider

- If another staff read your narrative would they understand the acronyms you use?
- If someone assumed your case could they find a case history?
- Would they know where to pick up after the previous Care Coordinator or allied staff?
 - What referrals need to be completed or need to be managed?
 - What actions steps are the client, Care Coordinator, or others doing and by when?

263



Quality Assurance

- Leads complete their audits for client records
 - Ask for their case file checklist
- Health Care Authority (in partnership with DSHS)
 - Audits 10-15 client files each year
 - Proficiency rate is usually 90%
 - Nine out of ten records reviewed meet the requirement
- Leads often use the results of their internal audits and findings from HCA to develop training
 - Ask your Lead for technical assistance

264



Core Services

- Does the case narrative indicate which core service/s was provided during the month?
 - If a core service was provided by another entity note this and describe how the Care Coordinator is coordinating services with other providers
 - Care Coordinators do not duplicate services
 - Indicate services provided by allied staff under the supervision or coordination of the Care Coordinator
 - If allowed, allied staff should document their activities in the case narrative

265



Completion of Forms

- Was the Participation Authorization and Information Sharing Consent Form completed, signed, and dated?
 - If not is there a note in the case narrative citing the reason the form was not completed and signed by the client, parent, or guardian?
 - Were additions and deletions dated and initialed by the client, parent, or client representative (POA, guardian)?
- Was the Opt-Out Form completed, signed, and dated?
 - If the client does not complete the form is there a narrative documenting the client's verbal request to opt-out?
 - Was a copy of the completed form mailed to the client (whether completed by the client or the Care Coordinator)

266



Required and Optional Screenings

- Document the date required screenings were completed and the score (and level for the Patient Activation Measures ®)
 - If the client, parent, or guardian decline to complete a screening document the date it was offered. Also include the reason if known
 - For example, a parent declined the PPAM ® because the child was ill and needed the parent's care
 - Optional screenings are required when applicable to the client's health needs
 - If the client, parent, or guardian decline to complete the optional screening document the date it was offered and the reason if known

267



HAP

- Were all fields completed?
 - If not, is there an explanation?
- Were person-centered short and long term goals created?
- Was HAP information shared with the client, parent, family member, or guardian?
 - Formats vary depending on the Lead

268



Key Considerations to Document

- In-person visit with the client to develop and finalize the HAP
- Completion of the HAP within 90 days of enrollment with the Care Coordination Organization
- Case narrative supports the Tier that was billed

269



Key Considerations to Document (cont.)

- Periodic in-person and telephonic interactions with the client
- Initial score and level for PAM®, CAM®, or PPAM® as appropriate
- Required screenings for the BMI, Katz ADL, PHQ-9 or PSC-17 scores or a reason the client declined the assessment or screening tool

270



Key Considerations to Document (cont.)

- Completion of required screenings and update of the HAP at least once during every four month activity period or when there was change in the client's health status, needs, or preferences
- Completion of optional screenings to assist in determining gaps in care or changes in the client's health

271



Key Considerations to Document (cont.)

- Action steps to achieve the client's prioritized short term goal and who is responsible to complete each step
- Provision of services in a culturally competent manner with equal access for clients with language and communication barriers
- Provision of services tailored to special needs such as functional impairment or environmental factors

272



Key Considerations to Document (cont.)

- Services are delivered
 - In the client's primary language
 - Recognizing cultural differences and obstacles faced by persons with a developmental disability
 - Recognizing the dynamics of substance use
- Development and/or coordination of multidisciplinary teams to provide assistance as needed

273



Key Considerations to Document (cont.)

- Communication and coordination between the client and the client's service providers and other support systems to address barriers and achieve health action goals
- Development and execution of a cross-system team *as needed*
- Provision of individual and family support through care coordination and care transition activities

274



Key Considerations to Document (cont.)

- Provision of educational materials that:
 - promote improved clinical outcomes
 - increase self-management skills
 - are appropriate to the level of activation
- Use of peer supports to increase the client's knowledge about their health conditions and adherence to treatment

275



Key Considerations to Document (cont.)

- Discussion about advance care planning with the client, parent, or collateral
 - Within the first year that the client agrees to participate in the Health Home Program
 - If this was not completed by a previous Care Coordinator then document that a discussion was offered to the client, parent, family member, or guardian
- Assistance provided to maintain the client's eligibility for programs and services as needed

276



Key Considerations to Document (cont.)

- Referrals to available community resources to help achieve health action goals
- Process for notification of the client’s admission or discharge from an emergency department or an inpatient setting
 - Because we do not duplicate benefits, if another agency, such as the MCO, is providing care transitions, note this in the case narrative

277



Key Considerations to Document (cont.)

- Provision of care transition to prevent avoidable readmissions after discharge from an inpatient facility and ensure proper and timely follow-up care
- Participation by the Care Coordinator in all *appropriate* phases of care transition

278



What Were the Six Strategies for Care Transitions?

- 1 Consistent plan of care with the PCP and home health care (if applicable) upon discharge
- 2 Coordinated follow up call or visit at discharge
- 3 Timely visit to PCP
- 4 Reconciliation of medications soon after discharge
- 5 Client, family, and caregiver education coordinated between settings
- 6 Support through increased care management for high-risk clients

279



Time Management



- Plan your day/week by scheduling time for:
 - Outreach calls and letters
 - Face-to-face visits
 - Follow-up calls
 - Making and actively managing referrals
 - Working with allied staff and multidisciplinary care teams
 - Documentation
- Schedule time for responding to EDIE or PreManage alerts
 - Carve out time in your schedule and if no one has been hospitalized or admitted in the ED use this time for the above activities

280



Let's Pause to Check for Understanding



What tips can you share that have helped you better manage your caseload?

Do you have any questions?

281



Resources

282



Advanced Home Care Aide Specialist Pilot Program

- Care Coordinators will be notified if their client enrolls in the program
- Care Coordinators may need to answer questions about the program
- Care Coordinators may work with the case manager, Individual Provider (IP), and client to incorporate the IP into the HAP



283

TRAINING

Community Integration Program

- Adult Family Homes (AFH) may receive a rate increase to participate with qualifying residents
 - Provider may assist their client to better integrate into their local communities
- Possible roles for the Care Coordinator:
 - Educate the client, family, or collaterals about this benefit
 - Research opportunities for the client in their community
 - Discuss with the AFH provider options
 - Who will provide transportation?
 - Who will make a referral or complete an application if needed?
 - Integrate the activity into the HAP if appropriate
 - Establish a short term goal and action steps

284



Non-emergency Medical Transportation (NEMT) Program

- Transportation may be provided to Health Home clients for services when the client is homeless or lives in an unhealthy or unsafe environment
- A Care Coordinator may request NEMT to alternate locations to conduct care coordination services such as:
 - obtaining consent to participate
 - administering health assessments
 - developing the HAP

285

TRAINING

DSHS Health Home Website Quick Links: Care Coordinators Links

- Contains Guide Sheets
 - Advance Care Planning
 - Advanced Home Care Aide Specialist Pilot
 - Depression Screening and Intervention
- Training schedules and invitations to monthly webinars
- Educational materials for health promotion
- Classroom Training Manual and PowerPoint Handout

289



Developing Relationships and Resources

Lead Organizations have completed outreach activities with local hospitals and institutions

Care Coordination Organizations are encouraged to complete their own outreach to community partners and medical and behavioral health providers to establish working relationships to aid in their care coordination activities

Be prepared to educate case managers and staff at HCS, DDA, AAAs, and other agencies about the program and your role

290

Review of the Learning Objectives

What are the six core Health Home Services?

Describe outreach and engagement strategies you will use.

Describe the key uses of PRISM in care coordination.

How could you use the results of the patient, parent, or caregiver activation measures in working with your client or their collaterals?

291

Review of the Learning Objectives (cont.)

What are the required and optional screens used in the HAP?

How does the HAP support the client to improve their health and self-management?

What are the crucial activities of comprehensive transitional care?

292



Let's Pause to Check for Understanding



Do you have any questions about what we covered during Day One or Day Two?

293



Additional Training

Required Special-topic Training

Optional Training

294



Required Training for Fee-for-Service and MCO Health Home Program

Special topic PowerPoints are located at the DSHS Duals website at: <https://www.dshs.wa.gov/altsa/home-and-community-services/washington-health-home-program-going-training>

The mandated topics are:

1. [Outreach and Engagement Strategies](#)
2. [Navigating the LTSS System: Part 1](#)
3. [Navigating the LTSS System: Part 2](#)
4. [Cultural and Disability Competence Considerations](#)
5. [Assessment Screening Tools](#)
6. [Coaching and Engaging Clients with Mental Health Needs](#)
7. [Medicare Grievance and Appeals](#) (required if working for Duals)

295

Register and Join for Our Monthly Webinars

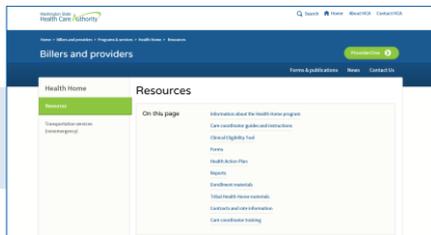
Ask your Lead for the link to register for each quarterly series or visit the DSHS Care Coordinators website



296

HCA Website is Located At:

<https://www.hca.wa.gov/billers-providers/programs-and-services/health-homes>



297

DSHS Website is Located At:
<https://www.dshs.wa.gov/altsa/washington-health-home-program>



Resources for
Care Coordinators
and Allied Staff

298

Let's Pause to Check for Understanding



Do you have any final
questions?

299

Please Complete the Training Evaluation

We appreciate
your feedback!

300

TRAINING
