



**Health Home Care  
Coordinators Training**

Health Promotion and Wellness Coaching



HealthPath  
Washington

December 10, 2015



This presentation is one in a series of special topics on the six health home services for Health Home Care Coordinators and allied staff which aired in Lacey Washington on December 10, 2015.

# Today's Presenter

- **Ann Rider, MSW, MHP, CPRP, CPC**
  - Executive Director
  - Capital Recovery Center
- **Cathy McAvoy, MPA**
  - Training Program Manager for Health Homes
  - Department of Social and Health Services



**Purpose:**

**Describe the activities that constitute Health Promotion and discuss the concepts and activities involved in Wellness Coaching**



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Today we will focus on Health Promotion and provide some valuable information about health promotion and wellness coaching.

I am joined by Ann Rider who previously was the Care Coordinator trainer for Optum. She has worked with:

- Recovery Innovations in Arizona, developing and implementing peer support training
- Recovery Empowerment Network in Arizona, a peer-run behavioral health provider agency
- Optum Pierce RSN as the Recovery & Resiliency Manager
- Developing Wellness Coaching training for Optum Health Homes

# Learning Objectives

Discuss health promotion: a core health home service

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Discuss health action planning as it pertains to health promotion, education, and coaching

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Present information and resources for Wellness Coaching

# 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

If you have participated in previous webinars you may recall that over the past few months we have been highlighting one of the six core Health Home services.



# Health Promotion

Roles and Activities



## 3 Health Promotion

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

An example of self-management principles would be applying what has been learned if a client attends the Chronic Disease Self-Management Program. This program is disease specific and teaches those with particular diagnoses about their disease, treatments, and techniques for managing symptoms.

## 3 Health Promotion (cont.)

3. Provides opportunities for mentoring and modeling communication with healthcare providers
  - By participating in joint office visits
  - Modeling or monitoring phone conversations with healthcare staff

## 3 Health Promotion (cont.)

4. Provides customized educational materials in combination with the enrollee's level of confidence, self-management abilities and health literacy

We will look at the new Wellness letters that clients receiving services from the Community First Choice program are now receiving each month.

## 3 Health Promotion (cont.)

5. These activities may become short term goals and action steps as part of the Health Action Plan

# Role of the Care Coordinator as Health Promoter

Review PRISM and other data systems to identify diagnosis of new diseases and conditions

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Review PAM, PPAM, and/or CAM to identify level/s of activation and motivation to tailor your approach

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Assist client in understanding their chronic diseases

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Provide health promotion through health education to the client, caregiver, and family

For example: encouraging the parent of a child to keep the child's immunizations up to date and to access other routine care, such as well child visits

## Role of the Care Coordinator as Health Promoter cont.

- Model appropriate use of healthcare resources to decrease dependence on Emergency Department care and prevent avoidable hospital readmissions
  - Increase their understanding of the course of their chronic disease/s and the need for routine care by a primary care physician or specialists
  - Reduce Medicare and/or Medicaid expenditures by slowing the progression of chronic diseases and accessing lower cost healthcare
  - Delay the onset of additional chronic conditions

## Role of the Care Coordinator as Health Promoter cont.

Support and educate the client, family and caregiver in a culturally relevant manner to promote wellness and increase health literacy

Supportive counseling and harm reduction

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Educate on how to navigate the healthcare system

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Prepare for relapse and develop a resiliency plan

Identify resources for crisis intervention such as behavioral health support services

# Wellness: a Health Home Concept

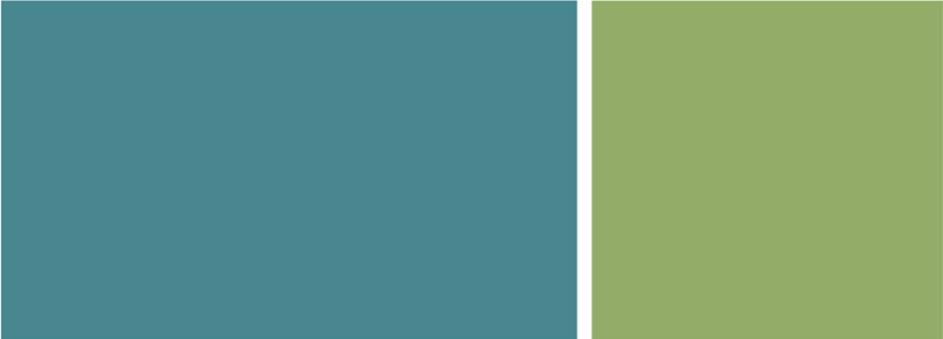
Clients may respond better to the concept of **wellness** rather than health. Wellness coaching is a very dynamic process and is influenced by many variables.



# The Goal Setting and Action Planning Worksheet

- Tool for accessing behavioral change:
  - Conviction
  - Confidence
  - Readiness

Completing the Goal Setting and Action Planning Worksheet with your client may provide an opportunity to identify areas for improving wellness which can be used to develop the Health Action Plan.



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# Wellness Coaching

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Presented by Ann Rider.

# One Definition of Wellness

“Wellness is living your life consciously  
in ways that improve your health  
and well being.”

Arloski, M. (2014). *Wellness Coaching for Lasting Lifestyle Change, 2<sup>nd</sup> Edition*,  
Duluth Minnesota: Whole Person Associates, Inc.

## Who/What is a Wellness Coach?

Preferably—but not exclusively—a peer support role

In other words, a Wellness Coach has lived experience with one or more chronic conditions and is willing to share their story about managing chronic conditions

Lived experience is not required but is very valuable

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My expertise in this matter comes partly from 15 years' experience in peer support training and work. It also comes from the fact that I have lived with family members who had multiple chronic conditions, and I myself live with several chronic health conditions which require some active management on my part. As a Wellness Coach who has experience living with chronic conditions, I can empathize from a place of shared experience; I can share strategies for juggling multiple problems and a myriad of doctors and specialists; and perhaps more important, I serve as a model for how someone can live with chronic conditions. Too many people are told that their chronic condition will require them to give up their hopes and dreams, their job, their education, and/or their plans for family life. And many people start to believe that on their own they don't have the health literacy to wade through a mountain of information and make healthy decisions. While many of us will have to make some sacrifices, we can also choose to learn strategies that help us reclaim more of the life we want for ourselves.

# Training Wellness Coaches

Wellness Coach training is often graduate level—at least in some disciplines

Not considered an “adjunct” role or less important but a crucial member of the team

Most important skill: the ability to be mutual

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How do you prepare Wellness Coaches to do this work? Mayo Clinic sees this as graduate level work and gives graduate school credit for the course. In Washington, the Certified Peer Counselor training offered by DSHS may be a good tool to help prospective Wellness Coaches understand their role. As part of the peer support training, individuals will learn communication skills, ethics and boundaries, ways to support recovery and resiliency, understanding systems of care, cultural sensitivity and other general topics. Primarily, the Wellness Coach must be able to be an equal to the beneficiary: someone who is seen as supportive, not directive; someone who is seen as caring, rather than instructing or directing.

Sometimes Wellness Coaches have been seen as just the person who makes phone calls and schedules appointments. The Wellness Coach is an important member of your team. They should be involved with the beneficiary from early on. Based on the beneficiary's PAM score, a Wellness Coach can start coaching work that will help the beneficiary understand his or her chronic conditions and how behavior and habits impact wellness, moving into more active roles of self-care. Keep the focus on “wellness” rather than “cure.” It's easier to reach a goal when we're moving toward something specific, than it is to get better when we're focused on what's not working.

## Mayo Clinic uses Wellness Coaches

Their training emphasizes the “peer coaching” aspect as key

Studies demonstrate the effectiveness of coaching in improving health literacy

Wellness Coaches help people identify *personal reasons* for pursuing wellness

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While looking for the citation that I know I’ve seen on the effectiveness of wellness coaching, I stumbled across the Mayo Clinic’s Nicotine Dependence Education Program. This program uses and trains Wellness Coaches, whose role is explicitly peer support. They offer some great descriptions of the role, including this one:

“Wellness coaches work together with others within the interdisciplinary team. They focus on helping clients who are well to stay well and assisting others not only to recover from illness but also to discover their best selves with a new emphasis on wellness. The role of the coach is to **help the individual identify personal reasons** for pursuing greater wellness and to enhance motivation for behavior change using evidence-based strategies.”

In other words, the Wellness Coach allows the individual to identify a long-term goal that is important enough to do the hard work of making a change.

Let’s face it: changing our lives is hard work. It’s especially hard when we already don’t feel well, and we’re asked to make major changes in our diet, exercise levels, and other daily activities. Nobody changes because they “should.” Think about a time in your life when you made a major change. What was your reason for doing it? How did that reason keep you moving toward your goal?

# Care Coordinator's Role

- “Walk beside the client”
  - May not share personal information about own chronic disease/s
- Strengths-based
- Non-judgmental
- Solution focused
- Supportive and encouraging
- Mentoring and modeling

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If you are a Care Coordinator you will want to approach Wellness Coaching from a position of support. You may not need to share your own experience with chronic disease management. You may be able to share stories about how other clients have approached chronic disease self-management to provide examples of approaches the client may wish to consider.

# Counseling versus Coaching

| Counseling                | Coaching   |
|---------------------------|--|
| Diagnostic                | Increased insight and awareness                        |
| Therapeutic               | Action driven  |
| Prescriptive              | Client choice  |
| Consultative              | A partnership supporting choice and self-determination |
| Focus is on what is wrong | Focus is on what is right                              |
| Focus on past behaviors   | Focus is on future behaviors                           |
| Guided                    | Client takes responsibility and determines course      |
| Limited contact           | Ongoing consistent contact                             |
| Confidential              | Sharing information among others, self-disclosure      |
| Professional agenda       | Personal agenda  |
| Expert                    | Collaborative  |
| Focus on past and present | Focus on future  |
| Fixing                    | Support and guidance                                   |
| Client needs a cure       | Positive belief in the client                          |
| Outcome unknown           | Outcome is specific                                    |

If you are starting to feel responsible for the client's outcomes you may have stepped into a more therapeutic role.

This image highlights some of the differences between counseling and coaching. Of course, there may be overlap at times. Coaching is a person-centered practice in which the client determines their own path to wellness.

# Attributes of a Wellness Coach

**Reliable** and predictable: consistent contacts

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**Empathetic**: listens and evokes using an MI approach

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**Guides**: walks beside the client

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**Acknowledges** all success: cheerleader and nonjudgmental

# Wellness Defined

‘ Wellness is not just a single condition but a complex made up of overlapping levels of wellness.’

Dunn, H.L. (1957, July). Points of Attack for Raising the Level of Wellness. *Journal of the National Medical Association*, 211, 225-235.

So what is wellness? Halbert Dunn provides us with one definition.

# Quality of Life: Areas to Consider When Coaching

- Spirituality/religion
- Family
- Friends and others
- Work and volunteerism
- Environment, housing, neighborhood
- Exercise, fitness, movement, endurance, flexibility and/or strength
- Connection with nature
- Diet
- Pain
- Relaxation
- Recreation/hobbies
- Emotional wellbeing
- Intellectual stimulation
- Sleep

# Tasks

- Engage
- Explore
- Envision
- Experiment
- Evolve



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Continuing in the strengths-based model, Wellness Coaches will:

- Engage — build a trusting relationship with individuals and their family members. Of course all members of the team should be able to do this. However peers, acting as Wellness Coaches, share experiences and offer mutuality which clients often find is easier in working together because of their connection.
- Explore — assist beneficiaries in identifying their values and desires (this will lead you to a good long-term goal, something that is important enough for them to make a change)
- Envision — facilitate a vision for wellness. Can the HAP and its implementation offer an avenue for moving toward this vision?
- Experiment — employ communication strategies to enhance self-efficacy and to transform values and desires into action (helping to improve the PAM score, using coaching strategies consistent with the PAM score)
- Evolve — support lasting change (again—improving the PAM score, while helping people enrich their lives and improve their health). Remember to keep the focus on wellness. Most of your clients will have no expectation that they will be “cured,” but they can improve their lives.

# Assessing Readiness for Change

The Patient Activation Measure:

- **Level I: precontemplative:** consequences for behavior are not bad enough to consider change. Education may be important at this level as well as awareness of pre-behaviors (e.g. considering portion size)

# Assessing Readiness for Change cont.

The Patient Activation Measure:

- **Level 2: contemplation:** clients are considering taking action, have acquired some knowledge and self-awareness

# Assessing Readiness for Change cont.

The Patient Activation Measure:

- **Level 3: action:** clients are starting to take action with the support and coaching from their Care Coordinator, Wellness Coach and other allied staff

# Assessing Readiness for Change cont.

The Patient Activation Measure:

- **Level 4: maintenance:** clients have assimilated new habits and behaviors into their daily lives. Plans for addressing slips or relapse must be developed to support in times of stress or to respond to triggers.

# Forces of Influence

External or extrinsic: values and traditions of family, care providers and others

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Internal or intrinsic: self-image, self talk, inner voice, values and experiences

# Client Tools

- Creation of a **wellness vision** or new self-image: what will they look like? How will they know when they have succeeded?
- **Tracking**: measuring and recording
- **Journaling**
- Peer **support**/support groups
- Health action **planning**
- **Assessments**
- **Education** about chronic diseases

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These are a few of the tools you may wish to suggest to your client as they consider not only how to go about changing their behavior but also how they will sustain their new behavior, especially after they have achieved their goals.

# Maintaining Behavioral Change

Achieving and sustaining behavioral change:

Takes time: months to years. They are reprogramming their subconscious mind.

Relapse is a part of normal life and learning to recover from slips and slides is a part of learning and maintaining behavioral change

# Maintaining Behavioral Change cont.

## The power of habit or routine

- Extinguishing a habit or routine takes time
- Consider self-talk and the influence of the subconscious mind
  - Consider affirmations, resiliency plans, relapse is a part of learning and internalizing new behaviors and habits

# Identify and Plan for Responses to Triggers

Social events and holidays

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Peer pressure

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Boredom, pain, fatigue, hunger, stress, or loneliness

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Have a plan: where to turn during off-hours

# Identify and Plan for Responses to Triggers cont.

- Quotes and **affirmations**
- Keeping a **log**
- **Anchors**: symbols, rituals
- Emotional **touchstones**: consider other times the client was successful, how did it feel?
- Peer **support** and support groups, mentors or sponsors

# Addressing Resistance

Resistance or barriers are opportunities to explore, provide clarity and seek recommitment to or revision of the goals

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Time for review: are the goals and action steps specific, time limited and achievable?

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Are the goals appropriate for the client given where they are at right now?

# Addressing Resistance cont.

## Working with non-commitment:

- **How** will the client and you know when they are not making progress?
  - How will success be measured? What will it look or feel like?
- **Accountability:** again if the HAP is person-centered it will hold the client accountable for outcomes
- **Support:** what will the Care Coordinator do to support the client and check on their progress – clearly defined in the action steps
- Will the client **share** their plans with others to increase accountability for the outcomes and garner support?
- Use challenges to success in achieving goals as an **opportunity** for self-examination and reflection
- Identify internal **strengths** - promote greater self-knowledge

# Addressing Resistance cont.

## Working with non-commitment:

- **Revisit the HAP:**

- Are the goals SMART: specific, measurable, attainable, realistic and time limited?
- Are the goals too high or no longer appropriate?
- Do the action steps need revision?
  - For example, should the Care Coordinator or allied staff assume more responsibility for completing the action steps if the client doesn't follow through? Is more knowledge and/or support needed? What natural supports exist and how can they be accessed?



# Resources

Programs, websites and books



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The following are some resources that may be helpful to you when you offer health promotion and coaching.

# Resources: LTSS - \*COPES

## *The Chronic Disease Self-Management Program (CDSMP)*

- May be offered by a variety of agencies and individuals
- This training program teaches clients about specific chronic diseases, how to self-manage their health condition, carry out normal activities and manage emotional changes
- See your local Area On Aging Agency for a list of qualified and contracted vendors

\*Community Options Program Entry System

# Resources: LTSS \*COPES

## *Client Support Training Service*

- Training needs are identified in the CARE assessment or in a professional evaluation.
- This service is provided in accordance with a therapeutic goal in the plan of care and includes but is not limited to:
  - Adjustment to serious impairment;
  - Maintenance or restoration of physical functioning;
  - Self-management of chronic disease;
  - Acquisition of skills to address minor depression;
  - Management of personal care; and
  - Development of skills to work with care providers including behavior management.

\*Community Options Program Entry System

# Resources: LTSS \*CFC

## ▪ *Skills Acquisition Training (SAT)*

- Functional Skills Training to accomplish, maintain, or enhance daily tasks
- The personal care task should be accomplished during the training including
  - Cooking and preparing meals
  - Shopping
  - Housekeeping and Laundry
  - The following personal hygiene tasks:
    - Dressing, applying deodorant, applying make up, brushing teeth/dentures, shaving with an electric razor, brushing/styling hair, menses care
    - Washing hands, face, hair, bathing (except transfer)

\* Community First Choice Program

Tracey Rollins a Program Manager for this program presented our webinar on this program this past August. The PowerPoint for the presentation can be found on the DSHS Health Home Care Coordinator training website on the Ongoing Training page. This benefit offers training to the client so they can learn how to complete some of their ADLs or IADLs to become more independent.

# Informational Websites

Wellness Worksheets site:

<http://www.integration.samhsa.gov/health-wellness/wellness-strategies/WELLNESS.pdf>

International Coaches Federation:

[www.coachfederation.org](http://www.coachfederation.org)

National Wellness Institute:

[http://www.nationalwellness.org/?page=Six\\_Dimensions](http://www.nationalwellness.org/?page=Six_Dimensions)

National Consortium for Credentialing Health and Wellness Coaches:

[www.ncchwc.org](http://www.ncchwc.org)

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The first site offers 126 Wellness Worksheets which may be of value in working with clients and caregivers: <http://www.integration.samhsa.gov/health-wellness/wellness-strategies/WELLNESS.pdf>. This document prints 265 pages so take this into consideration before printing. You may wish to save it to your desktop.

The Internet Resources List was attached to the webinar reminder e-mail. It lists some valuable sites which contain health promotion and educational materials that you may want to share with your client, family members or caregivers.

## Informational Websites cont.

American Holistic Health Association:

<http://www.ahha.org>

My Fitness Pal app:

[www.myfitnesspal.com](http://www.myfitnesspal.com)

Lifestyle Medicine:

[www.lifestylemedicine.org](http://www.lifestylemedicine.org)

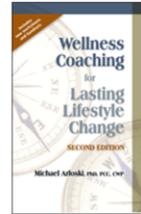
American Diabetes Association:

[www.diabetes.org](http://www.diabetes.org)

# Books

*Wellness Coaching for  
Lasting Lifestyle Change, 2<sup>nd</sup>  
Edition*

by Michael Arloski, PhD,  
PCC, CWP

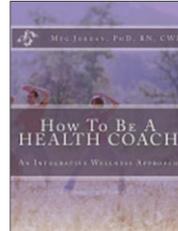


Here are just a few books that can provide more information about the profession of Wellness Coaching and behavioral change.

## Books cont.

*How To Be A  
Health Coach:  
an Integrative  
Wellness  
Approach*

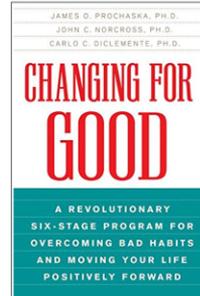
by Meg Jordan,  
PhD, RN, CWP



## Books cont.

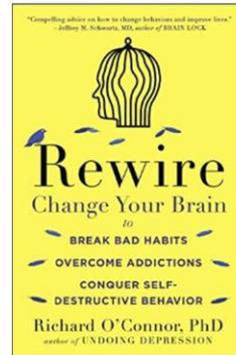
*Changing for Good:  
A Revolutionary  
Six-Stage Program  
for Overcoming Bad  
Habits and Moving  
Your Life Positively  
Forward*

by Prochaska,  
Norcross, and  
DiClemente



## Books cont.

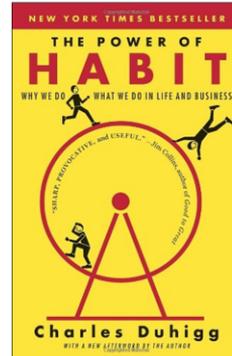
*Rewire: Change Your Brain to Break Bad Habits, Overcome Addictions, Conquer Self-Destructive Behavior*  
by Richard O'Connor, PhD



## Books cont.

*The Power of  
Habit: Why We  
Do What We Do  
in Life and  
Business*

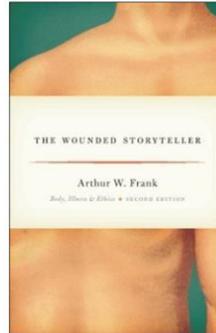
by Charles  
Duhigg



## Books cont.

*The Wounded  
Storyteller:  
Body, Illness,  
and Ethics*

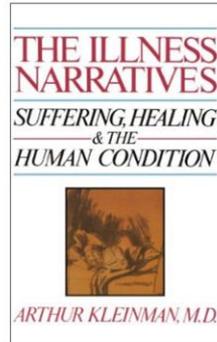
by Arthur W.  
Frank



## Books cont.

*The Illness  
Narratives: Suffering,  
Healing and the  
Human Condition*

by Arthur Kleinman,  
M.D.



# Wellness Education

Monthly personalized Wellness Education for CFC clients



Clients receiving Community First Choice personal care services now receive these monthly letters that are individualized to the client's chronic diseases and care needs. They provide an opportunity for you as Care Coordinators and allied staff to discuss and educate your clients about their chronic diseases.

# Wellness Worksheets

*Wellness  
Worksheets,  
Twelfth Edition*  
by Paul M. Insel  
and Walton T.  
Roth

Name \_\_\_\_\_ Section \_\_\_\_\_ Date \_\_\_\_\_

**WELLNESS WORKSHEET 1**  
Evaluate Your Lifestyle

All of us want optimal health. But many of us do not know how to achieve it. Taking this quiz, adapted from one created by the U.S. Public Health Service, is a good place to start. The information covered in this test is recommended for most Americans. Some of them may not apply to people with certain diseases or disabilities or to pregnant women, who may require special advice from their physicians. After you take the quiz, add up your score for each section.

|  | Points | Max | Score |
|--|--------|-----|-------|
| <b>Tobacco Use</b>   |        | 4   | 0     |
| 1. I avoid smoking cigarettes.   | 4      | 1   | 0     |
| 2. I avoid using a pipe or cigars.   | 2      | 1   | 0     |
| 3. I avoid spit tobacco.   | 2      | 1   | 0     |
| 4. I think and respond to environmental tobacco smoke.   | 2      | 1   | 0     |
| <b>Tobacco Score:</b>  |        |     |       |
| <b>Alcohol and Other Drugs</b>   |        | 4   | 0     |
| 1. I avoid alcohol or I drink no more than 1 (woman) or 2 (men) drinks a day.  | 4      | 1   | 0     |
| 2. I avoid using alcohol or other drugs as a way of handling stressful situations or problems in my life.                      | 2      | 1   | 0     |
| 3. I am careful not to drink alcohol when taking medications, such as for colds or allergies, or when pregnant.                | 2      | 1   | 0     |
| 4. I read and follow the label directions when using prescription and over-the-counter drugs.                                  | 2      | 1   | 0     |
| <b>Alcohol and Other Drugs Score:</b>  |        |     |       |
| <b>Nutrition</b>   |        | 5   | 0     |
| 1. I eat a variety of foods each day, including some or more servings of fruits and vegetables, depending on my caloric needs. | 5      | 1   | 0     |
| 2. I limit the amount of total fat and saturated and trans fat in my diet.   | 2      | 1   | 0     |
| 3. I avoid skipping meals.   | 2      | 1   | 0     |
| 4. I limit the amount of salt and added sugar I eat.   | 2      | 1   | 0     |
| <b>Nutrition Score:</b>  |        |     |       |
| <b>Exercise/Fitness</b>  |        | 4   | 0     |
| 1. I engage in moderate intensity exercise for 150 minutes per week.   | 4      | 1   | 0     |
| 2. I maintain a healthy weight, avoiding being overweight or underweight.  | 2      | 1   | 0     |
| 3. I do exercises to develop muscular strength and endurance at least twice a week.  | 2      | 1   | 0     |
| 4. I spend some of my leisure time participating in physical activities such as gardening, hiking, golf, or baseball.          | 2      | 1   | 0     |
| <b>Exercise/Fitness Score:</b>   |        |     |       |

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This document can be found on the SAMSHA website. It is copyrighted and may be purchased but is not bound. It may provide some ideas you can use while working with your clients on issues related to their chronic disease and wellness.

## In closing: important takeaways

- The Health Action Plan is a fluid document:
  - health promotion and education may become a part of the HAP
- Changes in the client's condition provide a perfect opportunity to provide health promotion
- Focus on "wellness," not "cure"

# Contact Information

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360-357-2582

# Post Webinar Discussion

What experiences have you had providing health promotion to your client, their family and/or caregivers?

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What educational resources have you used?

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Have you provided wellness coaching and which approaches have worked with your clients?

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What other skills do you think Wellness Coaches need?

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# Certificate of Completion

## Health Promotion and Wellness Coaching

presented by Ann Rider, MSW, MHP, CPRP, CPC  
Capital Recovery Center  
Executive Director

and  
Cathy McAvoy, MPA  
Behavioral Health and Service Integration Administration – DSHS  
Health Home Training and Quality Assurance Program Manager

**Webinar aired on: December 10, 2015 in Lacey, Washington  
for Health Home Care Coordinators and Staff  
Training Credit of 1.5 Hours**

Please sign and date to attest that you reviewed this training Webinar

\_\_\_\_\_

Your Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Supervisor's Signature

\_\_\_\_\_

Date



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