This presentation is one in a series of special topics on the six health home services which aired on November 12, 2015 in Lacey Washington.

Today's Presenters

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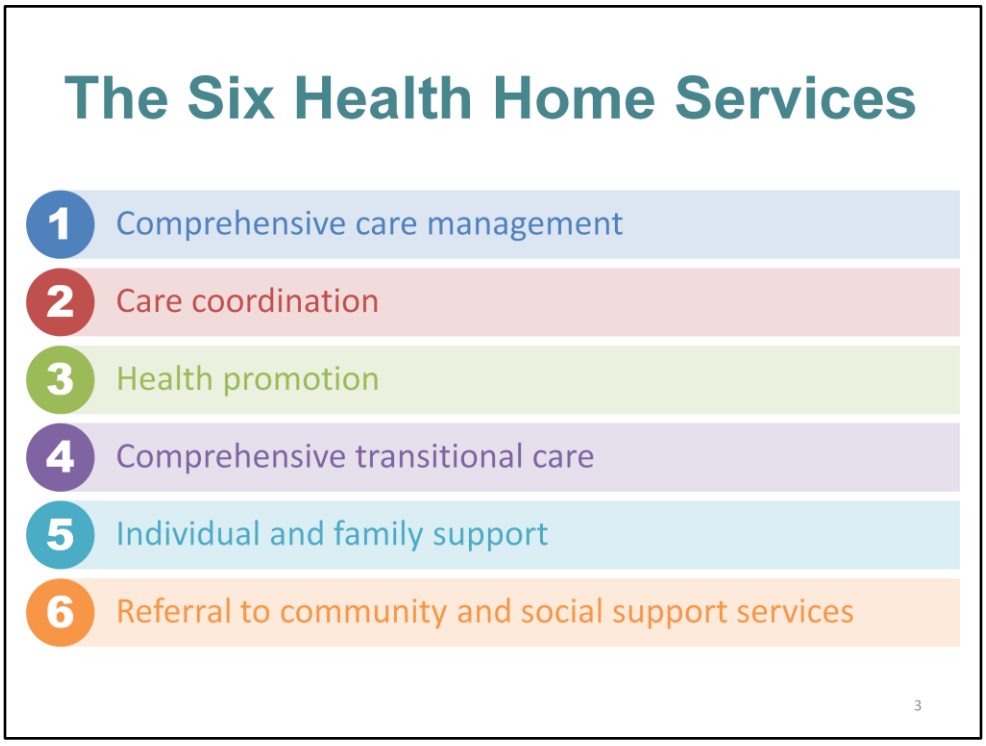

There may be overlap in these services. For example, the Care Coordinator may need to provide a lot of support to the client, family, and caregiver to provide comprehensive care transition services to successfully move a client back to the community.

Purpose:

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Describe the activities that constitute individual and family support – a core Health Home service
Define person-centered planning and how it relates to health action planning

Learning Objectives

- Consider activities that provide individual and family support
- Examine person-centered care coordination
- Discuss person-centered service planning as it pertains to health action planning

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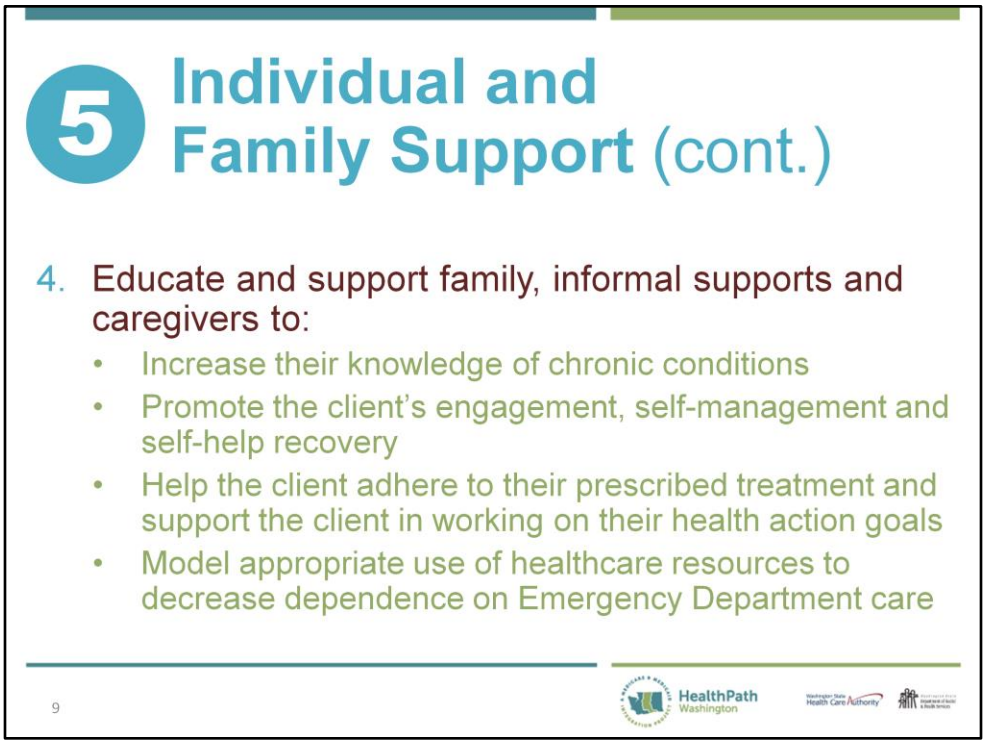
Individual and Family Support

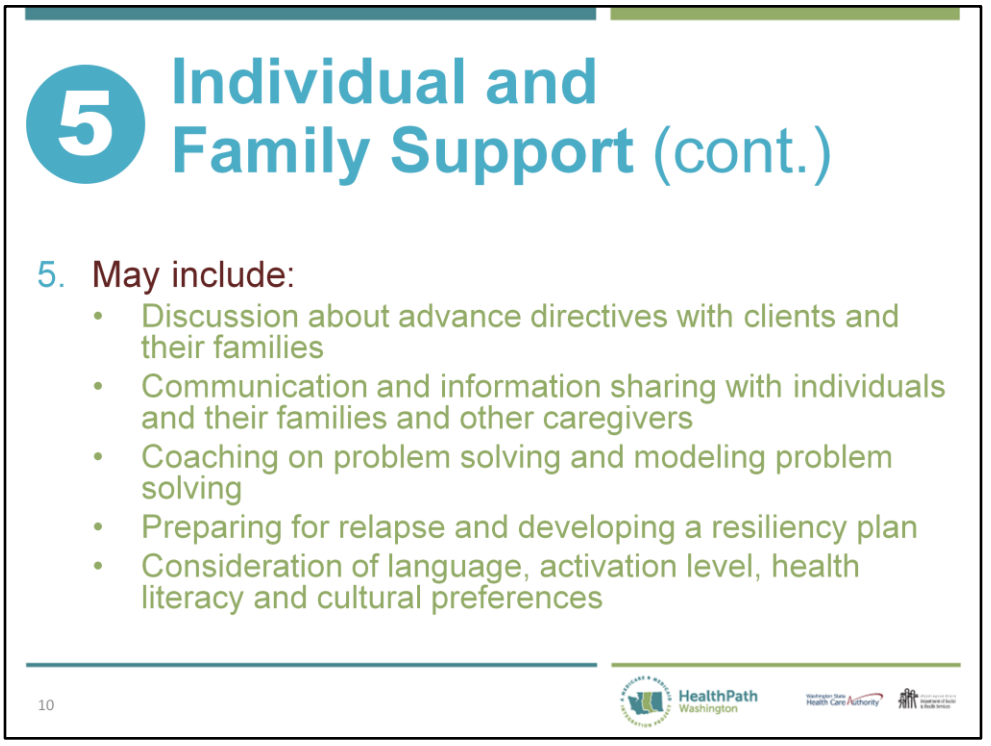
We will briefly review your role and some activities you may participate in while working with clients and/or their families to provide this core service. A good place to start is with the client. How do they define or describe the role of family members, caregivers, and others?

5 Individual and Family Support (cont.)

2. 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



Care Coordinators help increase the client's and caregiver's knowledge of the client's chronic conditions, promote the client's engagement and self-management capabilities and help the client improve adherence to their prescribed treatment.



For example, a Care Coordinator may provide advocacy and act as a cultural mediator between the client, their family and other health and social service providers.

You may conduct outreach on behalf of the client or their family members in order to help them access needed medical care and social services.

You may provide support as the client learns how to self-manage their chronic conditions.

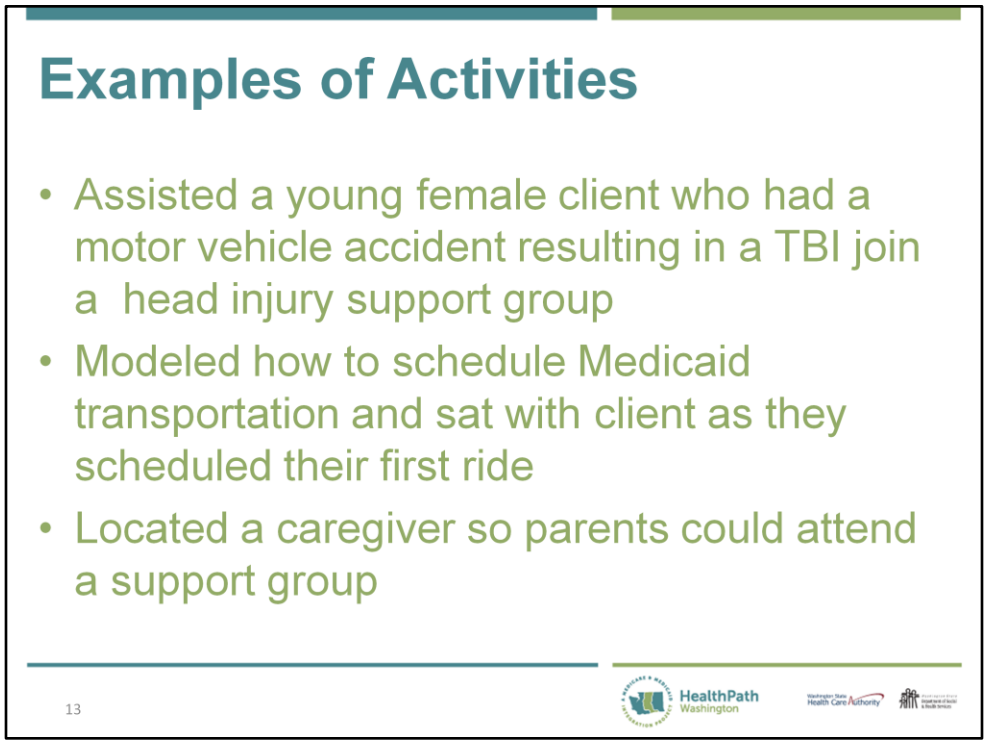
You may increase the individual's capacity to manage their health conditions and provide support as they develop new skills and knowledge in managing their chronic conditions. Your support can be especially helpful as your client attempts to understand the symptoms of a newly diagnosed chronic condition or a change in medications and/or treatments.

5 Individual and Family Support (cont.)

6. Care Coordinator or allied staff may:
   - Act as a cultural mediator or advocate between your client, their family and other health and social service providers
   - Conduct outreach on behalf of your client or their family members
   - Support your client as they learn how to self-manage their chronic conditions

This support can be important when you are working with clients at a PAM Level 3 or 4 who are just beginning or increasing their self-management of their conditions. Supporting them during attempts to self-manage may require revising action steps and short term goals to adapt to changes in their behavior.

You may complete assessments, those that are required or optional, with the client to help them identify their needs and support them to remain independent in their own communities.



These are examples of work that has been done by Care Coordinators across the state.

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First let's consider the three types of conversations we all have:

1. The What conversation
2. The Feelings conversation
3. The Identity conversation

Most crucial conversations are about what has happened or what should happen. Who said what or who did what? Who is right, who meant what, and who's to blame?

Every difficult conversation also asks and answers questions about feelings. Are my feelings valid? Appropriate? Should I acknowledge or deny them, put them on the table or check them at the door? What do I do about the other people's feelings? What if they are angry or hurt?

This is the conversation with ourselves about what this situation means to us. We conduct an internal debate over whether this means we are competent or incompetent, a good person or bad, worthy of love or unlovable. What impact might it have on our self image and self esteem, our future and our well being? Answers to these questions determine in large part whether we feel balanced during the conversation or whether we feel off center and anxious.

Why Person-centered Practice?

- At the heart of health care reform and the Affordable Care Act (ACA)
- Positive influence on quality of care
- Improves the effectiveness of long term services and supports (LTSS)

Core Concept of Person-centered Practice

Important TO and
Important For and the
balance between them.

Crucial Conversations

Values

- **Important To**

  Includes things that help people to be satisfied, fulfilled and happy in their lives

- **Important For**

  Health and safety

What is important to a person and includes those things in life which help us to be satisfied, content, comforted, fulfilled, and happy.

It includes:

People to be with—relationships

Status and control

Things to do and places to go

Rituals or routines

Rhythm or pace of life

Things to have

What is important to a person around the issues of health and safety.

Issues of Health examples:
- Prevention of illness
- Treatment of illness/medical conditions
- Promotion of wellness

Issues of Safety examples:
- Environment
- Well-being—physical or emotional
- Free from fear

Person-centered Practices

- **Important To**

Include those things in life which help us to be satisfied, fulfilled and happy

- **Important For**

Issues of health and safety

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Important TO and FOR are connected

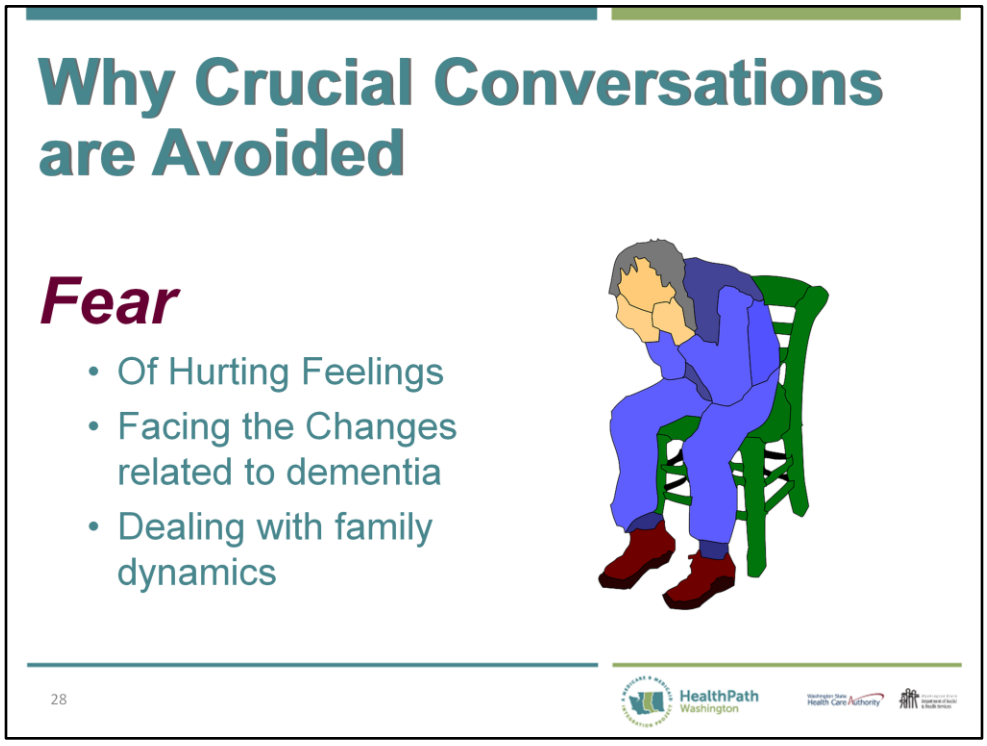
- Important **TO** and important **FOR** influence each other
- No one does anything that is “important for” them unless a piece of it is “important to” them

Finding the Balance

- If important **To** dominates
- Equates to all choice – no responsibility

Finding the Balance

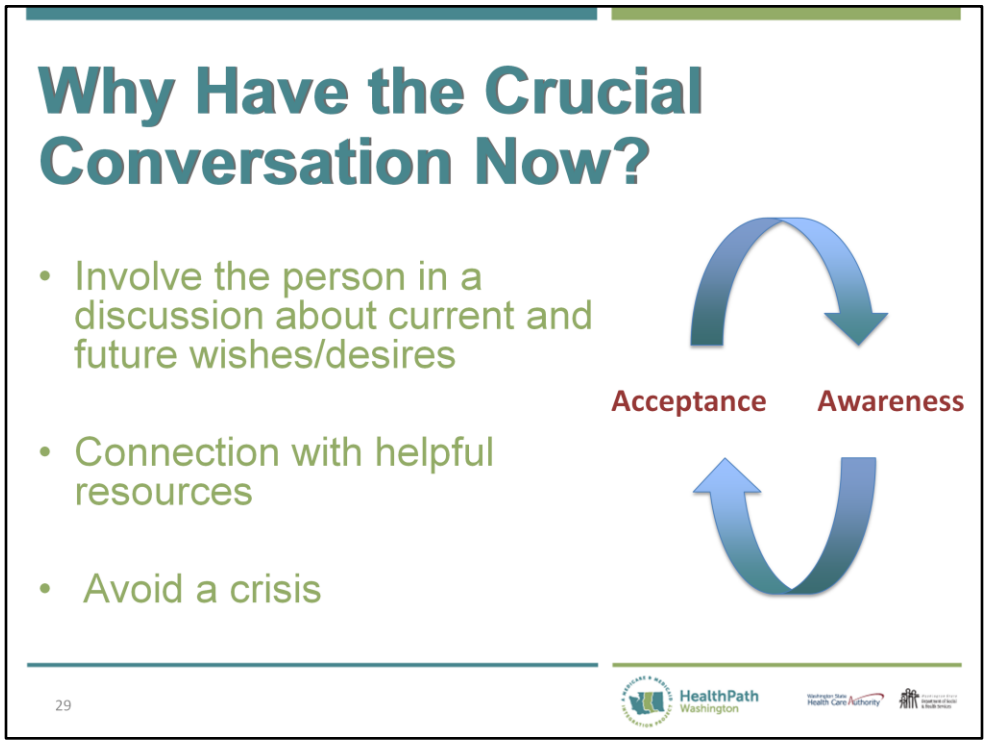
- If important **For** dominates
- Lifestyle will be dictated by health and safety



The following are just some of the reasons your client may not wish to examine their crucial conversations:

- Fear of hurting those we love
- Need to face changes related to aging/memory loss/dementia
- Being “forced” to deal with difficult family dynamics
- A role shift for both parties
- The family member says they don’t need or want help
- The assumption that other family members are taking care of things (long distance sibling assumes those locally are helping)
- The fear of taking away the person’s sense of independence, fear of loss of control and/or independence
- Family disagreements: stressed or estranged relationships
- Cultural traditions, beliefs or stigma about dementia
- Lack of understanding of the disease process and progression
    - Fear of the disease
    - The effects of the disease
    - The disease itself?

Denial is one of the most basic ways humans have to protect themselves from being overwhelmed.



- Many times the person is aware of changes and challenges
- Help to ensure the person's safety and well-being
- Involve the person in a discussion about current and future wishes/desires
- Connection with helpful resources
- Avoid a crisis

We often don't talk to each other and don't want to. And sometimes when we do talk, things only get worse. Feelings such as anger, guilt and hurt escalate. We become more and more sure that we are right and so do those with whom we disagree.

Anytime we feel vulnerable or our self-esteem is implicated, when the issues at stake are important and the outcome uncertain, when we care deeply about what is being discussed or about the people with whom we are discussing it, there is potential for us to experience the conversation as difficult.

We all have conversations that we dread and find unpleasant, that we avoid or face up to like bad medicine.

Then of course, there is the stuff of everyday life, conversations that feel more ordinary. I should be able to talk to a loved one about their memory loss...these conversations cause anxiety.

What makes these conversations situations so hard to face? It's our fear of the consequences--whether to raise the issue or try to avoid it.

Why is it so difficult to decide whether to avoid or to confront? Because at some level we know the truth that if we try to avoid the problem, it will worsen and your loved one may worsen. But if we confront the problem, things might get worse. We may get rejected or attacked; we might hurt the other person in ways we didn't intend and the relationship might suffer.

People who learn new approaches to dealing with their most challenging conversations report less anxiety and greater effectiveness in their conversations.

Sometimes we focus on what to do differently in difficult conversations and fail to break ground or make progress. Shifting from a delivery stance to a learning stance--one where you reach the level of connection with another--where you are truly empathetic because you hear and understand them--you are able to evoke and learn from their perspective.

Difficult conversations are always challenging. Eliminating fear and anxiety is an unrealistic goal but reducing fear and anxiety and learning how to manage are more attainable. Know that when we become vulnerable and enter into empathy we promote resilience.

Why is connecting with others and reaching a level of empathy so important? Because we need to understand and learn the other's perspective--we need to understand not only what is said but also what is not said. We need to understand what the people involved are thinking and feeling but not saying to each other. There is always all of this stuff and other things going on inside.

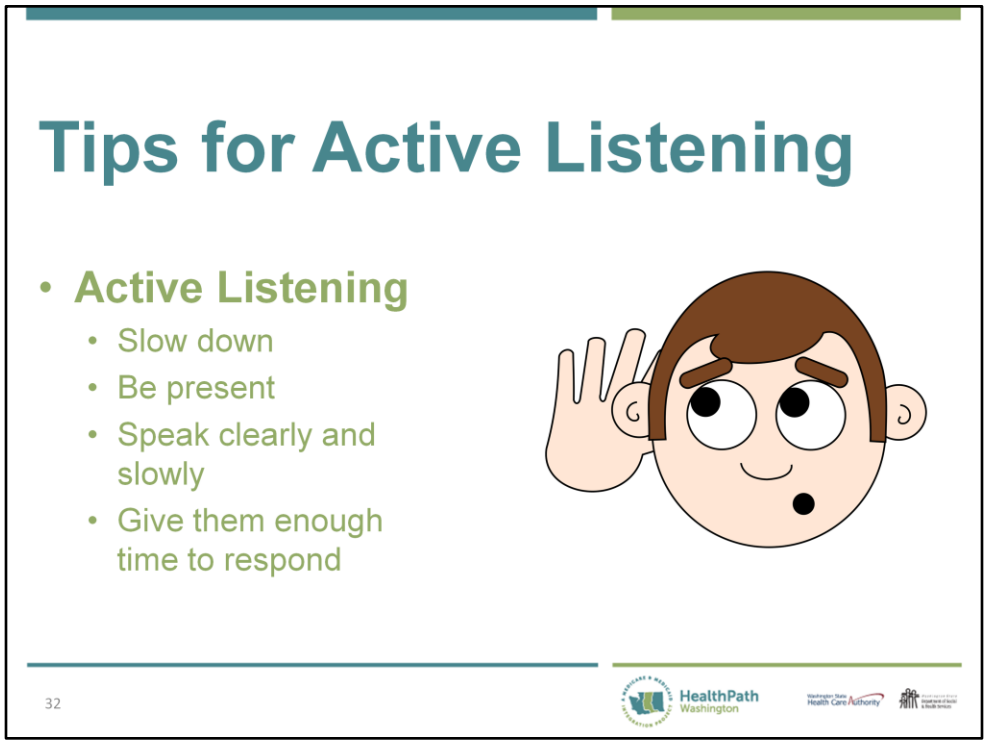
Crucial Conversations

Presence

Live in the moment

Crucial Conversations Require Active Listening

- Uses all senses:
  - Sight/ Vision
  - Taste
  - Touch
  - Smell
  - Hearing



Person-Centered Counseling (PCC) professionals are part of a system of support. They will feel the pressures of balancing responsible use of resources with attention to each individual. It will be important to balance all parts of their roles. However, they will want to maintain the core beliefs and values of PCC. As a reminder, PCC professionals support people of all ages and abilities in:

•Having positive control over the life they desire

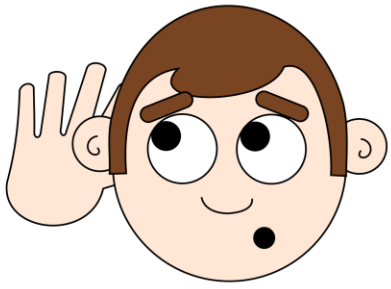
•Being recognized and valued for their contributions (past, current and potential)

•Being provided new and ongoing opportunities to be positively engaged during all phases of their lives

•Being supported through a variety of relationships, both natural and paid, within their communities

Person-centered thinking skills and approaches help guide and organize respectful listening. This ensures that actions and decisions are most likely to be meaningful from the view of the person seeking services and those they involve in their lives. By using Person Centered Therapy (PCT) skills, the professional can support actions that are likely to improve the person's situation in ways that are important to them and still include responsible use of public resources.

Tips for Active Listening cont.



- Use eye contact
- Watch for a client's body language
- Client will observe your body language as well

Balance

Important **TO** =
Important **FOR**

Start your interactions with people in a person-centered way. It's important to know what's important to them. This will help the process of eligibility or other types of screening to go better. By the time a program is being considered, you and the client should have a pretty good idea that this option is one that they are interested in. They should also already have a sense of the processes, including what type of personal information must be shared and in what format. However, during the process, you can assess for discomfort or confusion. A person always has a right to stop the process and look at other options. Make sure to use your diversity awareness to find the right way to approach this process with them.

Be sensitive to people's feeling about being labeled or listing their deficits. Some people might designate a proxy, such as a family caregiver or paid supporter, for this if it distresses them. While we want people engaged in all aspects of making decisions, one decision they may make is to not listen to people discussing their bowel habits or other private issues if their presence is not needed and they do not want to be there. Avoid and explain jargon in these processes. Pace them and schedule them in times, places and ways that work for the person and their important others. Make sure you never unnecessarily use documentation that is labeling or judging. Whenever possible be descriptive and objective and include the person's own words in context.

Importance of Discovery

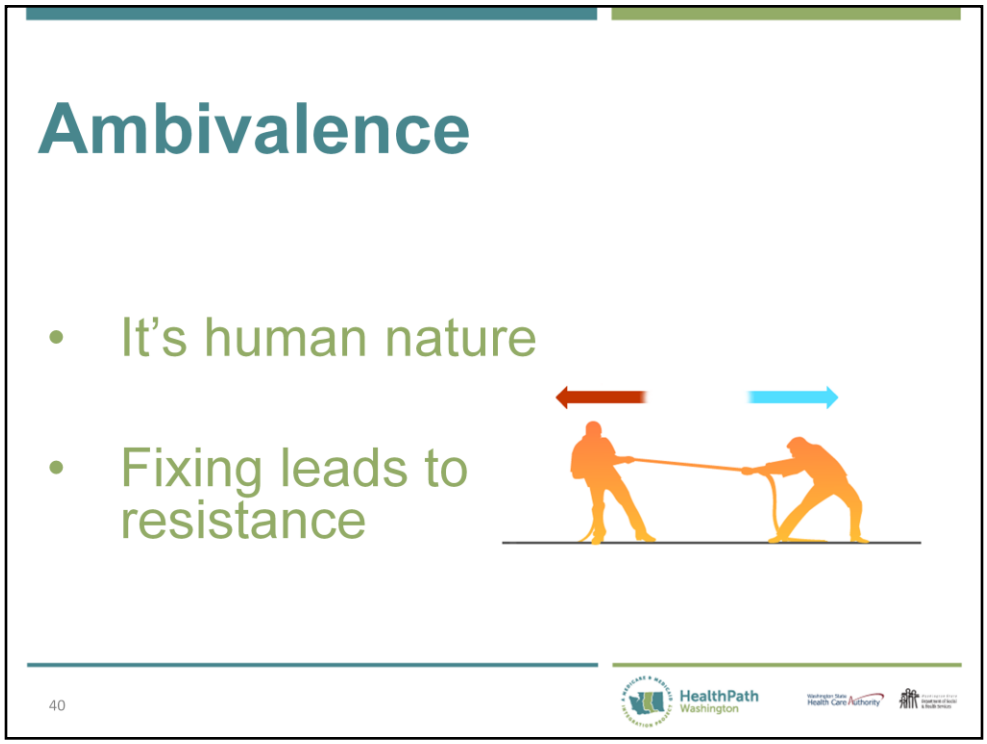
Underlies and guides respectful listening leading to actions and resulting in plans supporting individuals.

Importance of Discovery cont.

- Having positive control over the life they desire
- Being recognized and valued for their past, current and potential contributions to their communities
- Being supported in a web of relationships, both informal and formal, within their communities

When planning—logic can take over the process. Move from a process of fixing to a position that is supporting the client and their family.

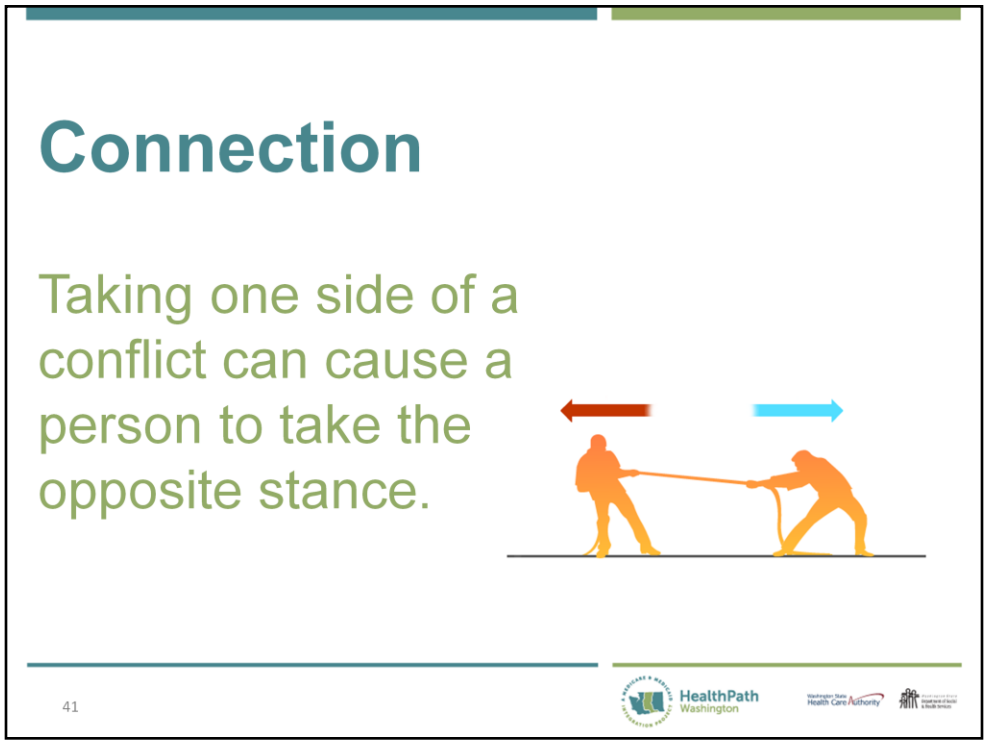
As professionals serving people we may be naturally inclined to help or act on behalf of the client. Often what is really needed is to listen so that the client feels heard and can explore their own solutions.



Most people have conflicting motivation. On the one hand they have good reasons to change current behaviors, but on the other hand they are also aware of benefits and costs associated with both changing and staying the same. This decisional conflict can result in the client being either stuck in a behavior pattern or alternating between engaging in new behavior and slipping back into old behaviors.

Help the client amplify their reasons for change and explore their reasons for staying the same.
Examples:

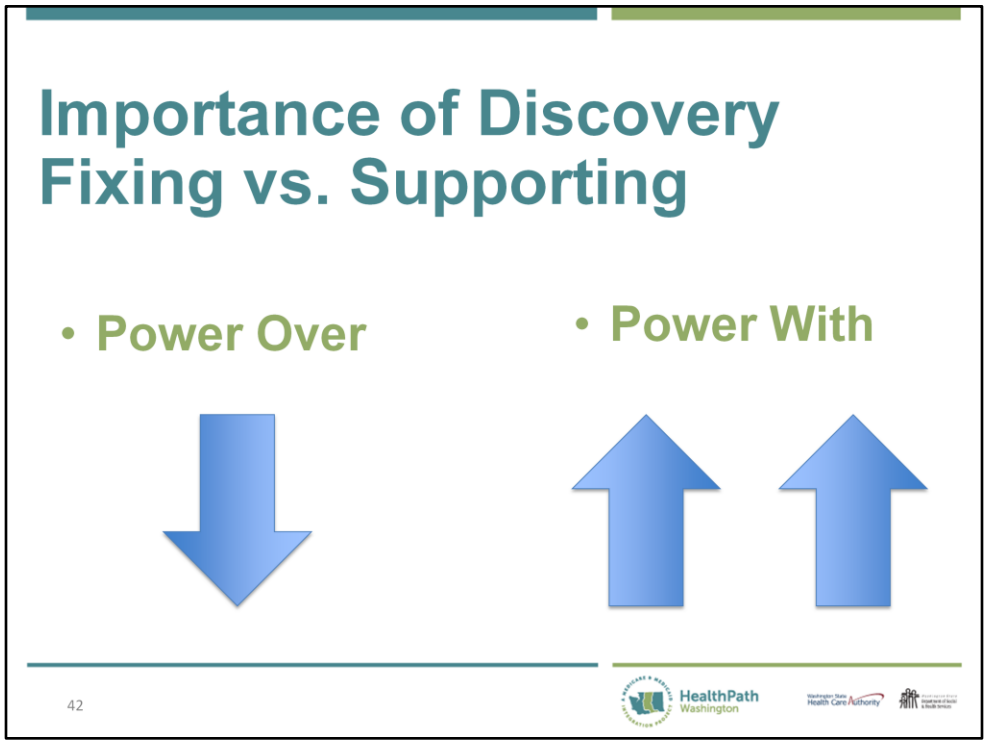
- I want to be healthy, but I like to have treats with my family when we watch TV together.
- I wish I was stronger and could get out more, but I don't have time for exercise.
- I want to be able to breath better; I should quit smoking, but I'll gain weight and that would be another problem!
- I want to be more independent, but I don't want to lose my caregiver and have to do the housework.



Be aware of resistance talk; resistance is normal. Roll with resistance! Imagine that it is no longer your job to persuade or coerce the client to change; rather it is the client's responsibility to decide for themselves whether or not to change and what steps they will take. What if your job was to help the client find their own reasons for change and all you had to do was provide information and support and offer alternative perspectives?

Techniques for responding to resistance:

- Simple reflection
- Amplified reflection
- Double-sided reflection
- Shifting focus
- Reframing
- Emphasizing personal control
- Coming alongside: we walk beside the client in partnership and collaboration
- Agreement followed by reframing



When planning—logic can take over the process.

Video on Empathy

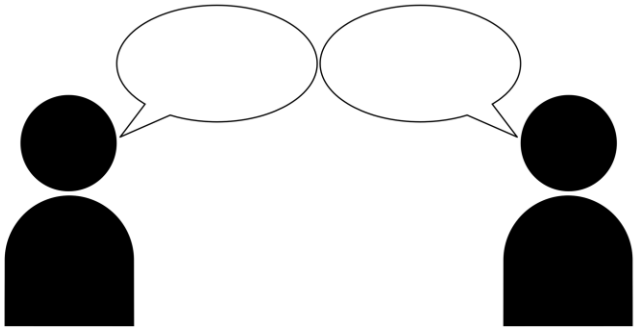
Three minute
video on empathy by
Dr. Brené Brown:

http://www.youtube.com/watch?v=1Evwgu369Jw&sns=em

Listening to people, caring about them and learning about their perspective may be perceived as empathy.

Kindness, caring, listening carefully, reflecting back to the client their point of view and presenting optimism that the client can be successful is the most significant predictor of successful behavior change.

Decision Support



Unbiased Guidance

Don’t Be Tied to Outcomes

Need to stay present in the moment in order to stay present—it is only through this presence that you can truly demonstrate empathy.

The overall spirit of MI has been described as Collaborative, Evocative and Honoring the Client's Autonomy (the ability of the person to make their own decisions).

One way to incorporate MI into your practice is to think about the Spirit of MI. We are going to talk about specific techniques and practices today that you will want to try; through skillful listening and guiding, you can convey a message of acceptance, hope and compassion. MI is not a technique for tricking people into doing what they don't want to do, rather, it is a skillful clinical style for eliciting from the individual their own good motivations for making behavior changes in the interest of their health.

You work in collaboration and partnership with your client.

Common Traps

- Directing
- Persuading
- Rescuing
- Just following the client & getting lost
- Overloading the client with too much information
- Pursuing problems and weaknesses

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It's easy to accidently get into a trap; the more you try to persuade or convince, the less likely they are to have sustained change.
Rescuing clients – it's our nature, many of us in the helping professions want to swoop in and fix everything; we want to take care of it. But with this model it's about empowerment and helping the client take up the cause for themselves.
Another pitfall is to follow the client and get lost in the conversation; it can be difficult to find the direction; try to help the client focus. Getting lost in the conversation is an indicator that the client is also lost in their own train of thought.
Another trap is overloading the client with too much information; the likelihood of that having any impact is low.
The other trap is focusing on their problems and weaknesses; with MI, remember, we are looking for change talk.

Resisting the righting reflex – resist trying to "fix" problems; this actually reduces the likelihood of client change. There is nothing wrong with wanting to help people, the difficulty of the "righting reflex" is that it fails to consider the possibility of ambivalence.
Understand your client's motivation – Motivation comes from within; use MI to find the motivation within and to help the client recognize it. We direct them toward discrepancies that already exist between what they want and how their behavior impacts their goals.
Listen to your client – create an atmosphere in which they can safely explore conflicts and examine realities. Learn from the client what their world viewpoint is; be curious and respectful. Acceptance facilitates change, whereas pressure to change results in increasing resistance.
Empower your client – We support the client's beliefs that they are capable, have ideas for solutions to their problems and can enact changes if they decide to do so. Self efficacy is a targeted perception about one's ability to achieve desired results.
This does not mean that we just agree all the time! They are the experts about themselves and have ideas about potential solutions.
Strategically reinforce and acknowledge:

- That you can see the person's point of view
- The struggles or difficulty involved
- The successes the client has had
- The skills and strengths you perceive in them

Reflective listening itself, the pure listening skill, can be effective in helping people change. Try to offer two reflections for every question you ask.

If your reflections are too similar to what the person said, if there is too much straight repetition, you can go around in circles!

Skillful reflection moves past what the client has said. Reflection is not a passive process. It can be quite directive.

The counselor decides:
- what to reflect and what to ignore
- what to emphasize and de-emphasize
- what words to use in capturing meaning

Reflection can therefore be used to reinforce certain aspects of what a person has said or to alter its meaning slightly. In MI change talk is especially focused on and reflected.

Excerpt from *Motivational Interviewing: Preparing People for Change (second ed)* by William R. Miller and Stephen Rollnick, New York: Guilford Press, 2002. pg 72-73.

Support Self-Efficacy

- Focus on previous success
- Highlight skills and strengths

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Always, always, always support self-efficacy; focus on the client's previous success and focus on their skills.
Many times, it takes 5, 6, 7, even 8 times before a person can sustain a behavioral change. Many of the clients we see have become demoralized by the time we see them. They have the feeling that change is not possible and they feel stuck.

The Balloon of Importance

Importance Balloon

- Includes the **WHY** for the client—related to values
- Inflate balloon **FULLY**—blow up the **IMPORTANT TO**

Confidence Cables

- Strengths, skills, abilities, past success
- What would be helpful to get you to that goal?

Action Planning and Follow Up

- Mutual understanding of roles
- Follow up and check in

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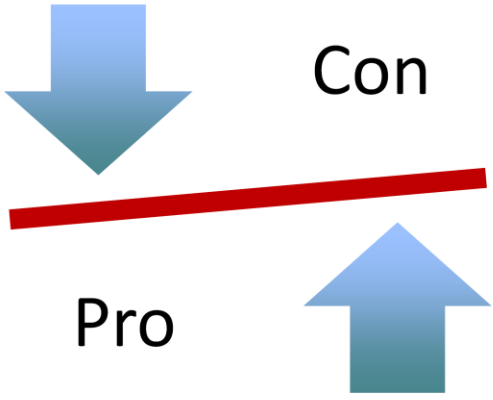
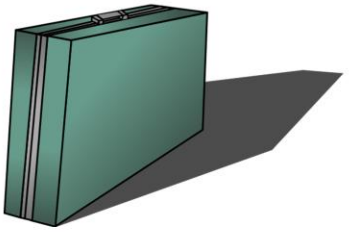
Just to review….

Evaluate Options: Pros and Cons



Case Study

Steven Notfeelingsowell



Diagnoses include:

- Post Traumatic Stress Disorder
- End Stage Renal Disease

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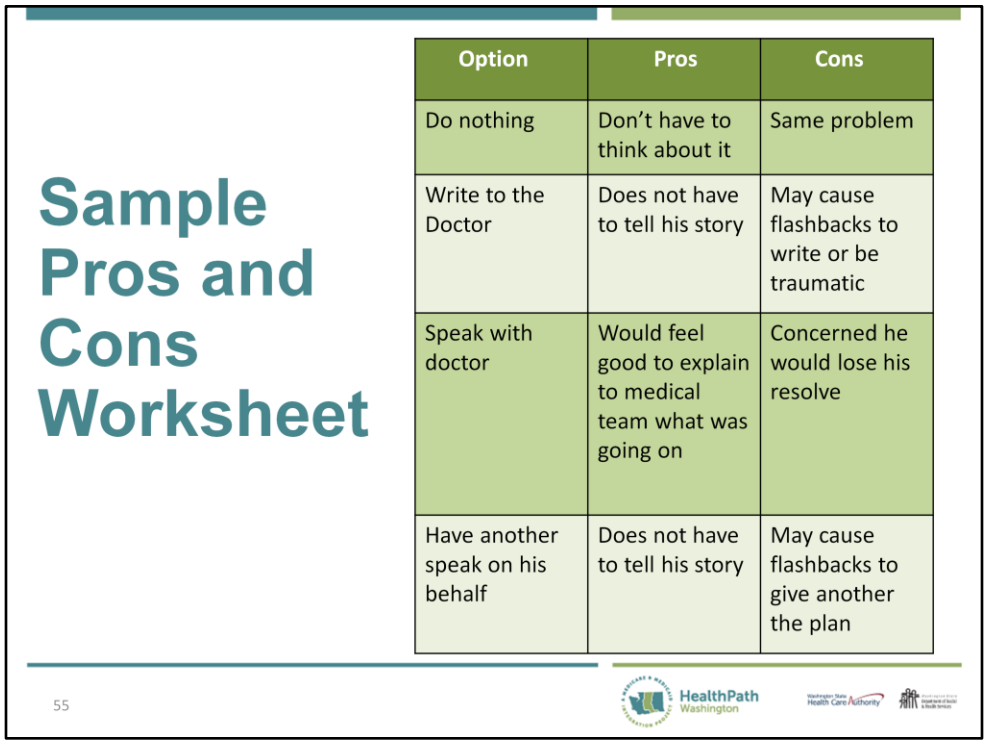
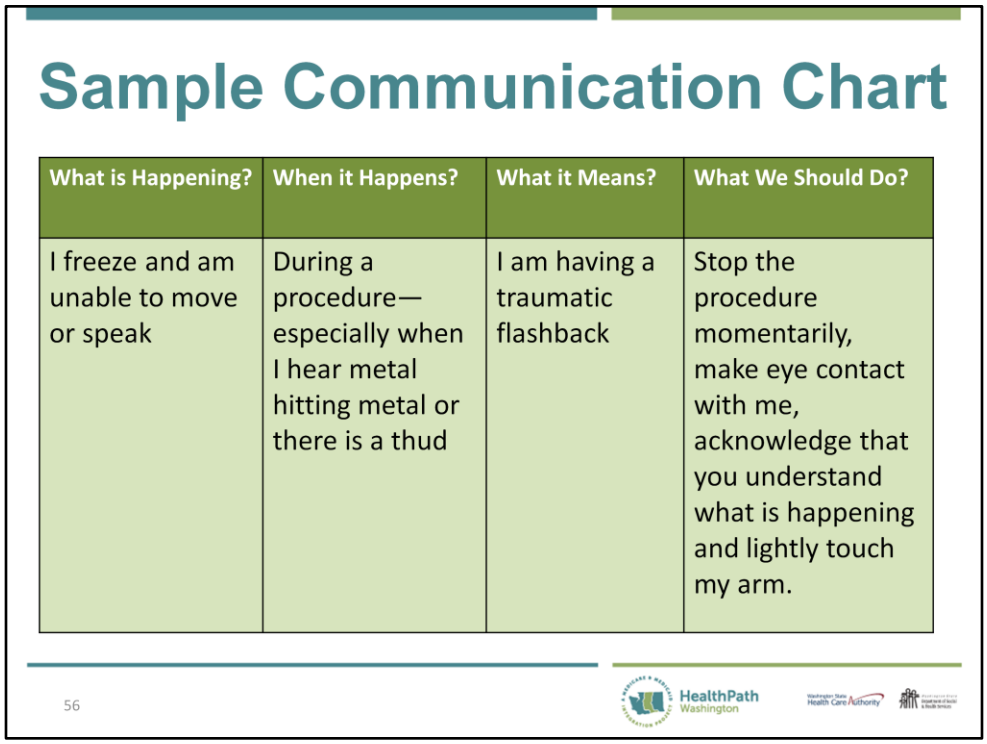
This is not the client's name. It was changed to protect his confidentiality.
This client has diagnoses of PTSD and end stage renal disease. During dialysis and other medical procedure the client become traumatized when he hears the sounds of medical equipment. This trauma resulted in great anxiety by the client and frustration by his medical providers who did not understand the trauma the procedures were inducing in the client.



The social worker met with the client and they discussed the client's options for addressing his fear in communicating with his medical providers.



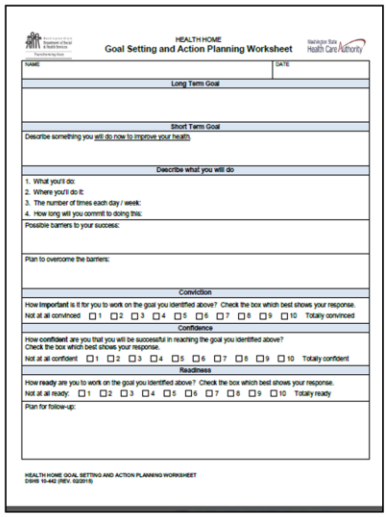
This is an example of a Communication Chart developed by the client with his social worker. It was shared with his various medical providers. It resulted in better understanding of the client's anxiety. By following the action steps providers were able to engage the client and complete the necessary procedures.

Person-centered Health Action Planning

Consider the Client

Discuss the scales on the *Goal Setting and Action Planning Worksheet:*

- How **important** is the goal?
- How **confident** is the client?
- How **ready** is the client?



HEALTH HOME
Goal Setting and Action Planning Worksheet

NAME | DATE

Long Term Goal

Short Term Goal

Describe something you will do now to improve your health.

Describe what you will do

1. What you'll do:
2. Where you'll do it:
3. The number of times each day / week:
4. How long will you commit to doing this:

Possible barriers to your success:

Plan to overcome the barriers:

Conviction

How important is it for you to work on the goal you identified above? Check the box which best shows your response.
Not at all convinced ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Totally convinced

Confidence

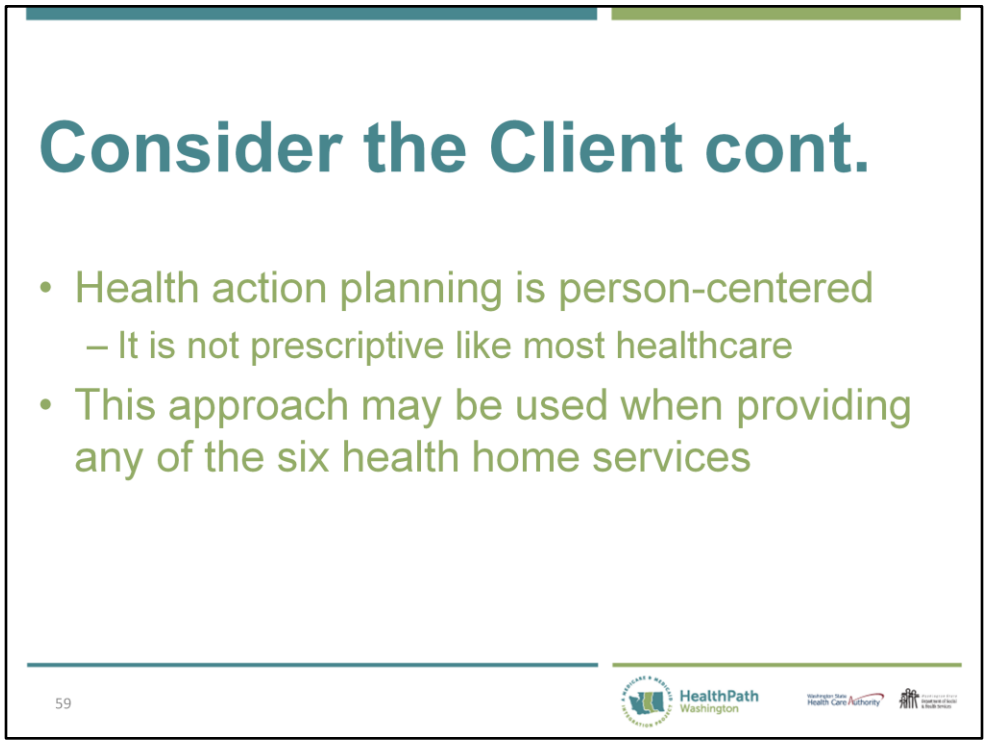
How confident are you that you will be successful in reaching the goal you identified above?
Check the box which best shows your response.
Not at all confident ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Totally confident

Readiness

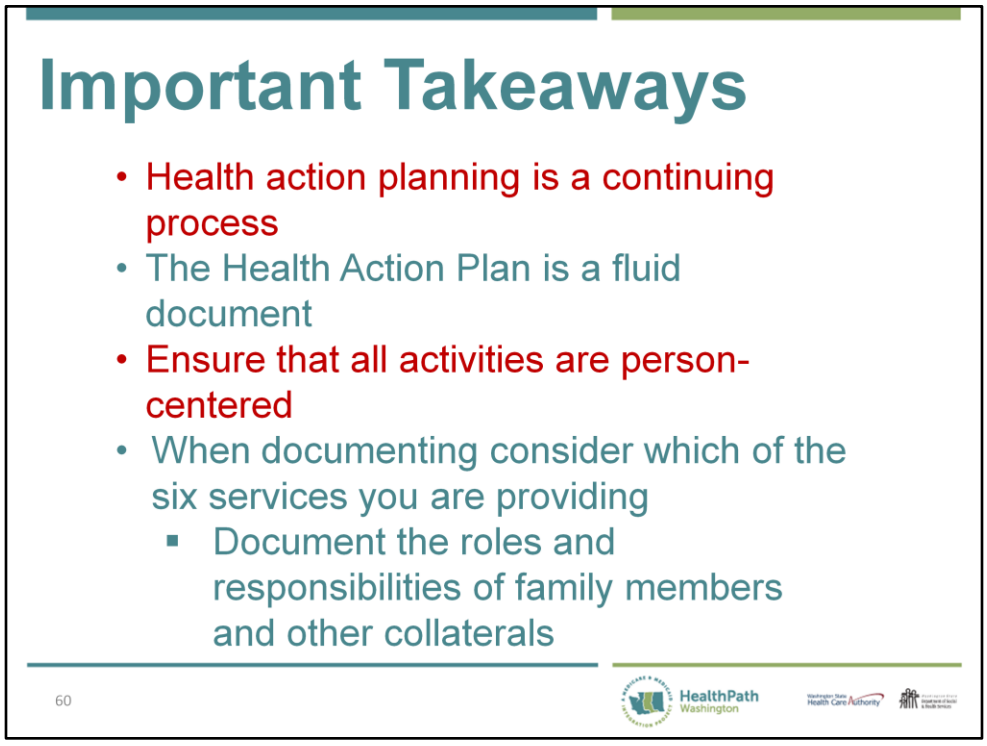
How ready are you to work on the goal you identified above? Check the box which best shows your response.
Not at all ready: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Totally ready

Plan for follow-up:

HEALTH HOME GOAL SETTING AND ACTION PLANNING WORKSHEET
DSHS 10-442 (REV. 02/2013)



Our six core Health Home services can be person-centered.
Comprehensive care management: development of the HAP is person-centered because the goals and action steps are created by the client.
Care coordination: focuses on the client and their priorities which may change between contacts.
Comprehensive care transitions: considers what the client wants when returning to the community.
Health promotion: focuses on the client's chronic disease or symptoms and how they are impacting the client's health according to them.
Referral to community and social service supports: focuses on what the client views as their needs to maintain them in their own home.
Individual and family support: focuses on what the individual feels is important or may want assistance with. It considers how the client or family member would prioritize these needs.

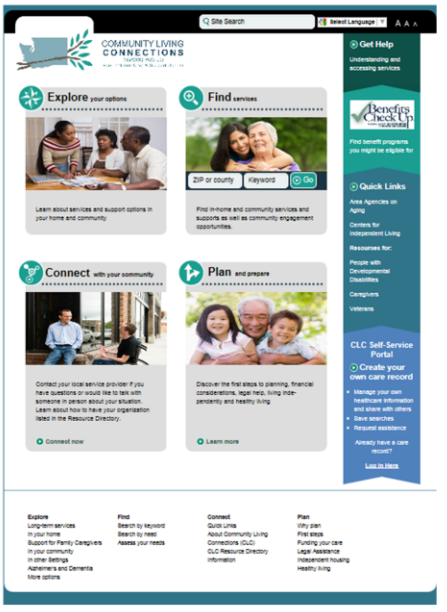


Today we focused on Individual and Family Support – one of the core Health Home Services.

This is a new site which may be of value to you and your clients.

Community Living Connections Website

https://washingtoncommunitylivingconnections.org/consumer/



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The website has four main sections:

Explore your options – site visitors can learn about the full range of private and publicly-paid LTSS options available in most communities.
Find services –includes a resource directory where visitors can enter a service area and search by keyword or need. The resource directory is still under development in some geographic areas. Over the course of time, it will continue to grow and be updated as community needs change and resources are developed. There is also a self-assessment tool that pulls options for addressing needs from the resource directory.
Connect with your community –visitors can use a clickable map see a list of CLCs, DDA offices, HCS offices, Independent Living Centers and VA Medical Centers. In this section are some additional Quick Links to informational documents and webpages and a link to email local CLC offices directly.
Plan and prepare – Consumer's and family members can discover the first steps to planning for LTSS, including financial considerations, legal help, living independently and healthy living. There are several tools available on the site, including one developed by the Developmental Disabilities Council and the ARC of Washington.

Contact Information

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Post Webinar Discussion

- What experience have you had supporting clients?
- How did you support the client? Did you model behaviors and techniques for working with healthcare and other providers?
- Have you attended medical and other appointments with your client?
- What experiences have you had supporting family and others while working with your client?
- How have you used person-centered approaches in your work with clients and family members?
- What techniques or approaches have you used to ensure that your interactions are person-centered while developing and reviewing the Health Action Plan?

Certificate of Completion

Person-centered Health Action Planning and Individual and Family Support

presented by Aime Fink, MSW, MLSP, AbD
Aging and Disability Services Administration - DSHS
ADRC Program Manager
and
Cathy McAvoy, MPA
Behavioral Health and Service Integration Administration – DSHS
Health Home Training and Quality Assurance Program Manager

Webinar aired on: November 12, 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 attended this training Webinar

_____ _____
Your Signature Date

_____ _____
Supervisor's Signature Date

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