Health Home Program
Washington

# Health Home Care Coordinators Basic Training

January 2024

Washington State Department of Social & Health Services
Transforming lives

Washington State Health Care Authority

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> "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*

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## Introductions

Your **name**?

What is your **job** title?

What **agency** do you work for?

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

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

One question from the **modules** that you want clarification on.

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## Learning Objectives and Agenda Overview

- Review 12 learning modules
- Vignette Activities
- Administration of Phreesia's Patient Activation Measures ® and how to use the level of activation to develop a Health Action
- HAP completion (Initial and on-going)

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## The 12 Modules:

1. Health Home Fundamentals
2. Six Health Home Services
3. Health Home Tiers
4. PRISM Overview and Access
5. Outreach
6. Health Action Plan (HAP)
7. Motivational Interviewing and SMART Goals
8. Initial Engagement
9. Comprehensive Care Transitions
10. Documentation and QA
11. Health Home Care Coordination
12. Health Home Forms and Documents

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## Module 1 – Fundamentals

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## 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 to **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.

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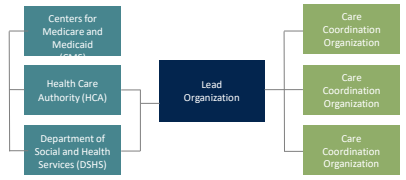
## Washington State Model of Health Home

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## Let's Pause to Check for Understanding

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

What questions remain from the Fundamentals module?

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# Module 2 – Six Health Home Services

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## 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

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## Keys to Successful Care Coordination

| | | | | |
|---|---|---|---|---|
| Engage the client and build a trusting relationship! | Help to organize and navigate multiple providers and services | Communicate and collaborate with providers and supports | Provide consistent and regular contacts | Provide transitional care support |
| Work to streamline a client's healthcare goals and activities | Encourage and increase client confidence and skill building for self-management of chronic disease(s) | Build and provide resources | Complete and follow-up with referrals (help with access) | Culturally attuned |

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## Let's Pause to Check for Understanding

Do you have any questions about the six core services or the role of a Care Coordinator in incorporating these six core services?

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## Module 3 – Health Home Tiers

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## Health Home Tiers

| Tier One | Tier Two | Tier Three |
|---|---|---|
| Initial engagement and action planning | High Intensity | Low Intensity |

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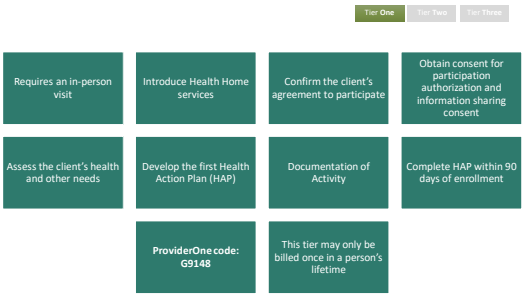
## Tier One Services

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## Tier **Two**

High Intensity

## Tier **Three**

Low intensity

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## Tier Two Client Characteristics

| | | | | |
|---|---|---|---|---|
| The client, the client's caregivers/ supports, and the Care Coordinator are actively engaged in the HAP | The client is participating in activities that are in support of improved health and well-being | The client and the Care Coordinator identify that the client has not achieved a sustainable level of self-management for their chronic conditions | The client's engagement, through goals and action steps, shows a low level of activation and does not demonstrate self-management and self-advocacy | The client's Patient Activation Measure (PAM, CAM, PPAM) level is typically a 1 or 2 |

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## Tier Three Client Characteristics

| | | | | |
|---|---|---|---|---|
| Client has demonstrated self- awareness and confidence | Client is goal oriented | Client has the ability to interact with Providers | Client is a good self-manager | The client's Patient Activation Measure (PAM, CAM, PPAM) level is typically a 3 or 4 |

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## Tier Two & Tier Three Recap

The Tier Level of the client is intended to reflect the overall level of:

- Engagement and activation level of the client and/or their caregivers
- Activity in the Health Action Plan
- Provision of at least one of the qualified Health Home services
- Frequency and content of contacts (face-to-face visits, phone calls, referrals, or care coordination)

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## Movement Between Tiers

**The Health Home Tier system was not designed to have clients changing Tiers month to month based solely on the number or types of contacts.**

Typically:

- After Tier One activity of establishing the HAP is completed a client will move to the Tier Two. In some cases, based on the preference of the client, and their individual needs, they may move directly from Tier One to Tier Three.
- The Tier will not change from month to month between Tier Two and Tier Three. However, the tier could change when the client and/or their caregivers consistently demonstrate an *intensive* or *low* level Health Home need.

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## Movement from Tier **Two** to Tier **Three**

**Examples of moving a client from Tier Two to Tier Three include:**

- The client's Patient Activation Measure (PAM) score has stabilized over the past four-month period with optimal level of activation and HAP goals have been achieved.
- The client's PRISM risk score is under 1.0 for eight months **and** the client's PAM Level is at least a three.
- A client has met their goals and is actively sustaining self-management activities.
- Client's goals are relegated to maintenance of treatment and lifestyle changes as they have achieved and demonstrated self-management of their diagnoses. Goals may be modified, or new goals added in collaboration by the client with the Care Coordinator.
- The client requests a lower level of care coordination.

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## Moving from Tier **Three** to Tier **Two**

**Examples of moving a client from Tier Three to Tier Two include:**

- An adverse health condition or new diagnosis resulting in increased emergency department use, hospital admissions, readmissions, escalation or exacerbation of a behavioral health or social concern or increased primary care or specialist visits.
- The client expresses a desire to set a new HAP goal.
- Environmental or psychosocial changes trigger a need for more intensive Health Home services.
- Life events trigger a need for higher Health Homes services.

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## Let's Pause to Check for Understanding

Do you have any questions about the 3 payment tiers?

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# Module 4 – PRISM
Predictive Risk Intelligence SysteM

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## 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

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## 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
  - Clients who need PCP
  - Clients receiving LTSS and who is the case manager
  - Other care opportunities

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## 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
- 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

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## Keys for Effective PRISM Use (cont.)

- 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
- 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?

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## Sacha's PRISM Report – Homework

1. Who is the Care Manager in the Sacha example?
2. How many inpatient admissions in 2012?
3. How many times was Insulin Aspart (an Rx) filled in 2014? How about Insulin Glargine (Rx)?
4. Are there any gaps noted in Rx (prescriptions) being filled that you can identify?
5. What is their PRISM risk score?
6. What is their IP admit risk score?
7. How many times have they been to the ER in 2014?
8. Which PRISM screen do you believe (now) will be most helpful in your new role?
9. What is Sacha's address according to PRISM?
10. What disease category is Sacha's highest risk factor?
11. Review the claims tab. Is there anything you would want to know more about? What might a barrier be for Sacha?
12. Which Provider has 3 claims submitted?
13. What type of LTC has Sacha received in 2013?

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## Let's Pause to Check for Understanding

- Have you used PRISM in the past and what was your experience? How did you use the information about your client? Which screens did you find most helpful?
- Do you have any questions?

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## Module 5 – Outreach

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## Client Outreach

- Using "smart assignment" the Lead will provide the CCO with a list of eligible clients
- 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
- The Care Coordinator, support staff or Outreach Specialist will contact the client by phone or in person to schedule the first face-to-face visit

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## 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?

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## Vignette Activities

We will use these vignettes throughout our training activities:


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## Small Group Work – PRISM & Outreach

**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?
- What potential care coordination opportunities with providers do you see?

**Review the materials for your client & record the following:**

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

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# Module 7 - Motivational Interviewing and SMART Goals

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## 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

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## 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

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## 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…"

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## 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

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## Join the Client on their Health Path

**Explore:**


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## Join the Client on their Health Path (cont.)

**Five Steps for Success:**


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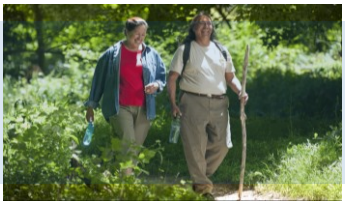
## The Patient Activation Measure® Coaching and Action Plan Development



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## Review of the Patient Activation Measure®

**The PAM[1] 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

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

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## 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

Insignia Health® a Phreesia company

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## 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

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## 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

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## PAM 13 Question Survey

**Let's review the 13 Patient Activation Measure Statements now**

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## 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

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## 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

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## 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

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## 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

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## Tips for Administering the Assessment Tool (cont.)

- If a client is unable to complete the survey or refuses it, 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

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## 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

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## Interpret PAM Responses

| 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. |

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## 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**

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## 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.

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## 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.

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## 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

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## 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?

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## 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

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## 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.

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## 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 they may be interested in pursuing

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

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## 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

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## 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

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## 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 emerging issues with the new behavior goals

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## 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

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## 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

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## Where Do I Get Copies of the Tools?

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

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

- Website address
- User name
- Password

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## 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
  - Document the date the screening was offered AND the reason the PAM was not completed for 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

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## Caregiver Activation Measure

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

- Caregivers may be informal, formal, paid, or unpaid
- 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

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## 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 document the date the assessment was offered and the reason the parent/guardian did not complete the screening

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## 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**?

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## 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?

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## 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

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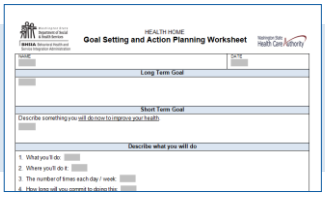
## A Tool for Starting the Conversation

The Goal Setting and Action Planning Worksheet


HEALTH HOME
Goal Setting and Action Planning Worksheet
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:

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## 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

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## 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

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## 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

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## 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?

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## 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

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## 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

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## The Health Action Plan (HAP)

**Establishes:**

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

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## 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, coping and resiliency skills

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

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## 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

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## 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

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## Use Active and Reflective Listening

Assure them that you can see their point of view

Acknowledge the struggles or difficulty involved

Acknowledge their successes, skills, abilities, and strengths
- Thoughts
- Beliefs and values - **link these values to their long term goals, short term goals, and action steps**
- Behaviors

Use **you** statements – strength-based approach

"You sound determined."

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## 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

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## Identify Barriers to Change

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

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## 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.

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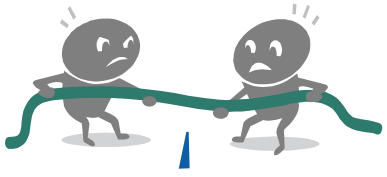
## Resistance

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



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## 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 likely to last.

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## 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

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## 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 it 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?

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## 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.

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## 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?

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## Learning Module 6 - HAP

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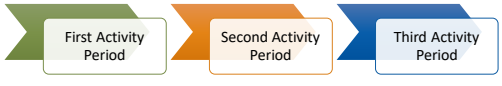
## Activity Periods




- There are three activity periods in a yearly (12 month) cycle
- Each activity period 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

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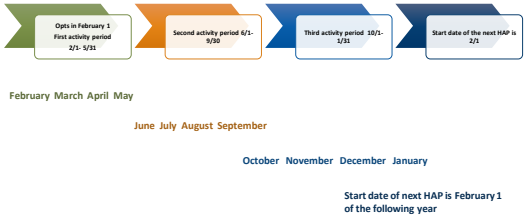
## Activity Periods Example

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## Required Screenings

- Patient, Parent or Caregiver Activation Measure – PAM® from Phreesia
- PHQ-9: Patient Health Questionnaire with nine questions to screen for depression and suicide (age 18 & older)
- PSC-17: Pediatric Symptoms Checklist for children (age 4 – 17)
- Katz ADL: activities of daily living to take care of themselves
- BMI: Body Mass Index to determine if they are a healthy weight

Note: the client, parent and caregiver reserve the right to decline to complete any of these assessments

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## Additional Screenings

- AUDIT: Alcohol Use Disorders Identification Test
- DAST: Drug Abuse Screening Test
- Falls Risk: My Falls Free Plan
- GAD-7: General Anxieties Disorder test for stress
- Pain scales: FLACC, Wong-Baker or Numeric

Note: The client, parent and caregiver reserve the right to decline to complete any of these assessments.

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## When to complete an additional 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**

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## Follow-up to screenings

- Elevated score
- Any jump in score from previous HAP
- Referrals
- When in doubt, error on the side of caution and notify providers of assessment scores

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## Quick Reference

| Form or Screening Tool | Age |
|---|---|
| Participation Authorization & Information Sharing Consent | All |
| Adolescent Information Sharing Consent (in addition to above) | 13-17 |
| PAM – Patient Activation Measure | 18 and older |
| CAM – Caregiver Activation Measure | 18 and older |
| PPAM – Parent Patient Activation Measure | Under 18 |
| Katz ADL – Activities of Daily Living | 18 and older |
| PHQ-9 – 9 Item Depression Screening | 18 and older |
| PSC-17 – Pediatric Symptoms Checklist for Mood & Behaviors | 4-17 |
| BMI – Body Mass Index | 2 years and older |

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## What if Client Refuses Assessments

**Clients have the right to refuse to participate in the required and additional assessments. If this is the case, it is best practice to incorporate the following steps:**

- Ask the client why they are refusing
- **Document** the reason for the client declining assessments
  - Indicate the date and reason for the refusal
- If the client doesn't feel like completing assessments at the time of the visit, reschedule a time to complete the assessments at a later date
  - A reminder that assessment can be completed at anytime during that HAP activity period

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## Help Identify a Long-Term Goal

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

- What would they like to have happen as a result of their health changes?
- What would they like to 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?

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
- Increase their sense of their own well-being

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## 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?"

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## 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


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## The Health Action Plan (HAP)

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

**S**pecific
**M**easurable
**A**chievable
**R**elevant
**T**ime-limited


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## 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
  - Emailed 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

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# Module 8 – Initial Engagement

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## First visit

- The first visit is a lot about making connections and giving the client time to tell you what they need. Try not to inundate them too much with information
- Create a folder to take with you that includes everything you will need for the client
- Review tips for safety before leaving the office and when you arrive at the home from the *Initial Engagement Module*
- Visiting facilities – bring along the "Residential Introduction Letter"

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## Small Group Work – HAP

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

- Complete a HAP (make up scores as needed for this activity)
- Record the following:
  - **One long-term goal**
  - **At least two short-term goals**
  - **Actions steps to reach each 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?**

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## Let's Pause to Check for Understanding

What experiences have you had offering, administering and providing follow-up to these screenings in the past?

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

Do you have any questions about the HAP?

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## Module 9 – Comprehensive Transitional Care

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## 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

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## Comprehensive Transitional Care

How will you know if a client has been hospitalized?

Review PRISM risk scores and planning in advance of ED or in-patient visits

Social/Resource Barriers Assessment

Discharge planning instructions and client, family, and caregiver follow-up

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## Let's Consider Our Vignettes

- Brainstorm steps a Care Coordinator would take when a client needs a care transition -
  - If your client was hospitalized, what transition services might you provide?
  - How would you work with your client if they admit to the hospital, transfers to a nursing facility and is now returning home?

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

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## 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?

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# Module 10 – Documentation and Quality Assurance

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## Something to Consider

- If someone assumed your case, would they know where to pick up?
- Does the case narrative indicate which of the six Health Home core service/s was provided during the month?
- Does the documentation support the tier that is being billed?
- Were forms completed?
- Were required and additional screenings completed with appropriate follow-up?
- Are person-centered goals and action steps addressed?
- Were all fields of HAP completed?
- Was HAP offered and shared?

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## 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
- Monthly in-person and telephonic interactions with the client
- Completion and update of the HAP (including screenings) at least once during every activity period or when there was change in the client's health status, needs, or preferences

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## Key Considerations to Document (cont.)

- Provision of services in a culturally competent manner with equal access for clients with language and communication barriers
- Services are delivered
  - In the client's primary language (document if interpreter is used)
  - Recognizing cultural differences and obstacles faced by persons with a developmental disability
  - Recognizing the dynamics of substance use
- Provision of services tailored to special needs such as functional impairment or environmental factors

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## 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
- Provision of individual and family support through care coordination and care transition activities
- Development and/or coordination of multidisciplinary teams to provide assistance as needed

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## 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

  Note: Document any educational information sent out in client's preferred language if other than English
- Use of peer supports to increase the client's knowledge about their health conditions and adherence to treatment

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## 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
- Referrals to available community resources to help achieve health action goals

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## Key Considerations to Document (cont.)

- Process for notification of the client's admission or discharge from an emergency department or 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
- 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

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## 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 Point Click Care 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

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## 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?

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## Re-HAPs
## 4-month, 8-month or Annual

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## The Health Home Program Considers:

- The client's perspective
- Results from assessment and screening tools
- PRISM risk factors
- A client's level of activation

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## Monthly Visits (Non-HAP)

- Review short-term goals and action steps
- Perform a needs assessment
- Follow-up of referrals or action items
- Relationship building
- Listen for any changes that the client wants to make
  - Even if it is not aligned with goals and action steps
  - Consider updates to goals and action steps as needed

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## Small Group Work – HAP Update

**The 4-month, 8-month or annual HAP - Considering your client's PRISM results, PAM responses and Level of Activation:**

- Update your HAP (make up scores as needed for this activity)
- Record the following:
  - Update one of the short-term goals and action steps based on client not completing the action steps
  - Update one of the short-term goals and action steps based on the client's resistance to the action step and/or goal
  - Which of the 6 Health Home services might the client need now?
  - Which optional screenings might be helpful for your client?
  - Document your visit including follow-up from previous contact

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## Module 11 – Care Coordination

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## Components of Care Coordination

- Understand the client's needs, goals, health condition(s) and interventions
- Streamline access to services and providers (medical and non-medical)
- Engage the client
- Strong communication with the client, their providers and supports to accommodate their needs

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## Role of Care Coordinator

- Provides support to implement the HAP
- Encourages and monitors progress toward meeting goals and action steps in the HAP
- Coordinates with service providers
- Provides monthly face-to-face visits and phone calls as needed to support the Health Action Plan
- Participates in multidisciplinary care

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## Let's Pause to Check for Understanding

Do you have any questions in regards to performing a re-HAP?

Do you have any questions regarding care coordination activities during a visit on a non-HAP month?

Any questions about care coordination or your role as a care coordinator?

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# Module 12 – Forms and Documents

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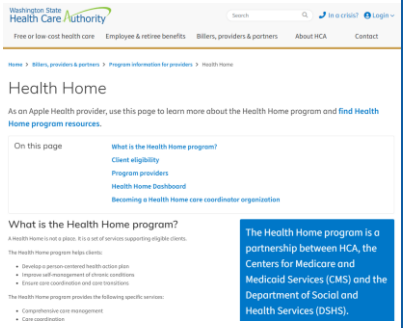
https://www.hca.wa.gov/billers-providers-partners/program-information-providers/health-home

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## Navigating the DSHS Website

- Where to find resources
- Where to find documents
- Where to find assessment screening tools
- Training
- Invitations
- Health Home Herald

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## The DSHS Website

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


**Training resources and webinar PowerPoints are located on the DSHS website**

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## Care Coordinator's Toolkit

Contains resources including:

- Resources about chronic conditions for care coordinators
- Educational materials for coaching and educating clients and collaterals
- Links to other online resources
- Links to DSHS programs and information
- Training opportunities and materials https://www.dshs.wa.gov/altsa/home-and-community-services/care-coordinator-toolkit

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## Additional Training

- State offered training
  - Special learning topics are located at the DSHS Health Home website. Has both required and optional training: https://www.dshs.wa.gov/altsa/home-and-community-services/washington-health-home-program-going-training
  - Monthly webinars hosted by DSHS – invites at https://www.dshs.wa.gov/altsa/washington-health-home-program-%E2%80%93-training-invitations
- Your agency or Lead training
  - HIPAA Training
  - IT Security Training
  - Mandatory Reporting
  - Network training

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## Let's Pause to Check for Understanding

Do you have any final questions?

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## Review of What We've Learned Today

- The 12 learning modules (Subject Specific)
- Administration of Phreesia's Patient Activation Measures ® and how to use the level of activation to develop a Health Action
- HAP completion (Initial and on-going)

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## Please Complete the Training Evaluation

**We appreciate your feedback!**

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Celebration


Certificate of Completion
Health Home Program
Washington
8 Hours of Continuing Education
Health Home Basic Care Coordinator Training
Insert participant's name here
Insert training date and year here

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