Core Care Coordinator Training
Day 2

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Day 2

Core Care Coordinator Training Objectives

By the end of the day, you will be able to:

- Explain how personal values and bias may affect your work with people who have chronic conditions
- Describe person-centered care
- Discuss the purpose of a health risk assessment and best practices for delivering one
- Describe what a care plan is, what the goal of it is and how to use it as a tool to provide care coordination
- Help clients/patients develop SMART goals
- Begin to use Motivational Interviewing skills in your practice
- Begin to use Health Coaching in your practice

Link in the Chain Activity

Values and Bias Activity

Person-Centered Assessment & Care Planning

Person-Centered Assessment & Care Planning

- Person-Centered Care
- Assessment, care planning and their relationship to person centered care
- Best practices for doing a health risk assessment
- Best practices in care planning
- Care planning challenges and solutions

Dimensions of Personhood Activity

Person-Centered Care

Person-Centered Care

- Care that focuses on the "whole person"
- Different from patient-centered care that tends to have a disease or diagnosis specific focus
- Provided to patients over time independent of care for particular conditions
- An approach that recognizes that care is better when it focuses on a person's problems rather than what the diagnosis is

Starfield MD, MPH, B. Is Patient Centered Care the Same As Person-Focused Care?, Perm J. 2011 Spring; 15(2): 63–69. Published online Spring 2011. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140752/

Person-Centered Care

- Accessible, comprehensive continuous over time, and coordinating when patients have to receive care elsewhere.
- Implies a time focus rather than a visit focus.
- Relies on knowledge of the patient that accrues over time, and is not specific to disease-oriented episodes.

Starfield MD, MPH, B. Is Patient Centered Care the Same As Person-Focused Care?, Perm J. 2011 Spring; 15(2): 63–69. Published online Spring 2011. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140752/

Health Risk Assessment

Health Risk Assessment (HRA)

- A systematic approach to collecting information from individuals that identifies risk factors and provides individualized feedback
- Identifies medical, behavioral and social and environmental risks and needs of the person
- Provides baseline
- Often results in giving the person a risk score so that the:
  - Care team and health plan is aware of the level of intervention needed
  - Can decide which team member/care coordinator should work with them

Health Risk Assessment (HRA)

- **Medical/Physical Health:** diagnoses and what they think about them, doctors, hospitalizations, other health problems, medications
- **Mental Health:** current/past treatment, hospitalizations, feelings about diagnoses, medications
- **Substance Use**: smoking, alcohol, substances, treatment programs, stage of change
- **Housing:** current/past situation, housing navigator, housemates, applications to housing programs or assistance
- **Social:** family and support system, history of trauma or violence
- **Legal:** arrests, parole, advanced directives
- **Vocational and Education** : work experience, employment, GED, special skills/training, income assistance

Best Practices for Conducting an HRA

- Use “plain language”
- Do not simply read the questions, particularly if the assessment is lengthy
- The goal of conducting an assessment is not only to collect information, but rather an opportunity to build a trusting relationship with the person
- As assessment done well can further engage a patient/client, an assessment done poorly may be the last time you see the person

Shared Care Plan

- Created after the comprehensive Health Risk Assessment by the care team and the person receiving services and/or his/her family
- Is updated at regular intervals and is a “living” document
- A tool to facilitate communication between all parties involved

- Adapted from DVHA Shared Care Plan Fact Sheet

Shared Care Plan

- It “tells the person’s story,” by describing strengths and interests, short and long-term needs, and personal and clinical goals and priorities.
- Identifies strategies and a timeline for achieving goals, and specifies who is responsible for each part of the plan, e.g. the physician, Lead Care Coordinator, person receiving care, etc.

- From DVHA Shared Care Plan Fact Sheet

Shared Care Plan

My Goals			
Personal Goals	Steps needed to achieve the goal	Person Responsible	Date Completed
1.			
2.			
3.			
4.			
5.			

- Adapted from Burlington Shared Care Plan

Person Centered Care Planning Process

1. Perform a comprehensive assessment
2. Formulate an integrated understanding of the individual
3. Prioritize areas to be addressed
4. Establish goals and a vision for the future
5. Identify strengths and barriers to accomplishing the goals
6. Create objectives that help overcome barriers
7. Describe intervention activities
8. Evaluate progress and outcomes

-Adapted From The Planning Process: Initial Steps to Creating the Individualized Recovery Plan
https://www.omh.ny.gov/omhweb/pros/Person_Centered_Workbook/Chapter2.pdf

Shared Care Plan

- Designed to organize information about a person receiving care or services from multiple organizations.
- Focused on person’s identified priorities
- Contains only information needed to coordinate care, not a treatment record or clinical record
- Contains high-level patient and medical goals and lists strategies and care team members responsible for achieving goals within a specific time frame.
- Uses SMART goals

- From DVHA Shared Care Plan Fact Sheet

Common Care Plan Challenges

- Created once and not looked at again
- Created without the patient/client's input
- Created by the care coordinator and goals only focus on what the care coordinator is comfortable with (social service goals only, clinical goals only, etc.)
- Care plan is never shared with other care team providers

Solutions for Common Care Plan Challenges

- Created once and not looked at again
  - ➢ Update care plan at regular intervals and after "critical" events
- Created without the patient/client's input
  - ➢ First care plan is the end result of a comprehensive assessment and more than one discussion, always involve patient/client in updates
- Created by the care coordinator and goals only focus on what the care coordinator is comfortable with (social service goals only, clinical goals only, etc.)
  - ➢ Work with other staff to get input on goals in all areas-medical, behavioral health, etc.
- Care plan is never shared with other care team providers
  - ➢ Establish clear processes and protocols for how care plans will be shared with care team members

SMART Goals

SMART Goals

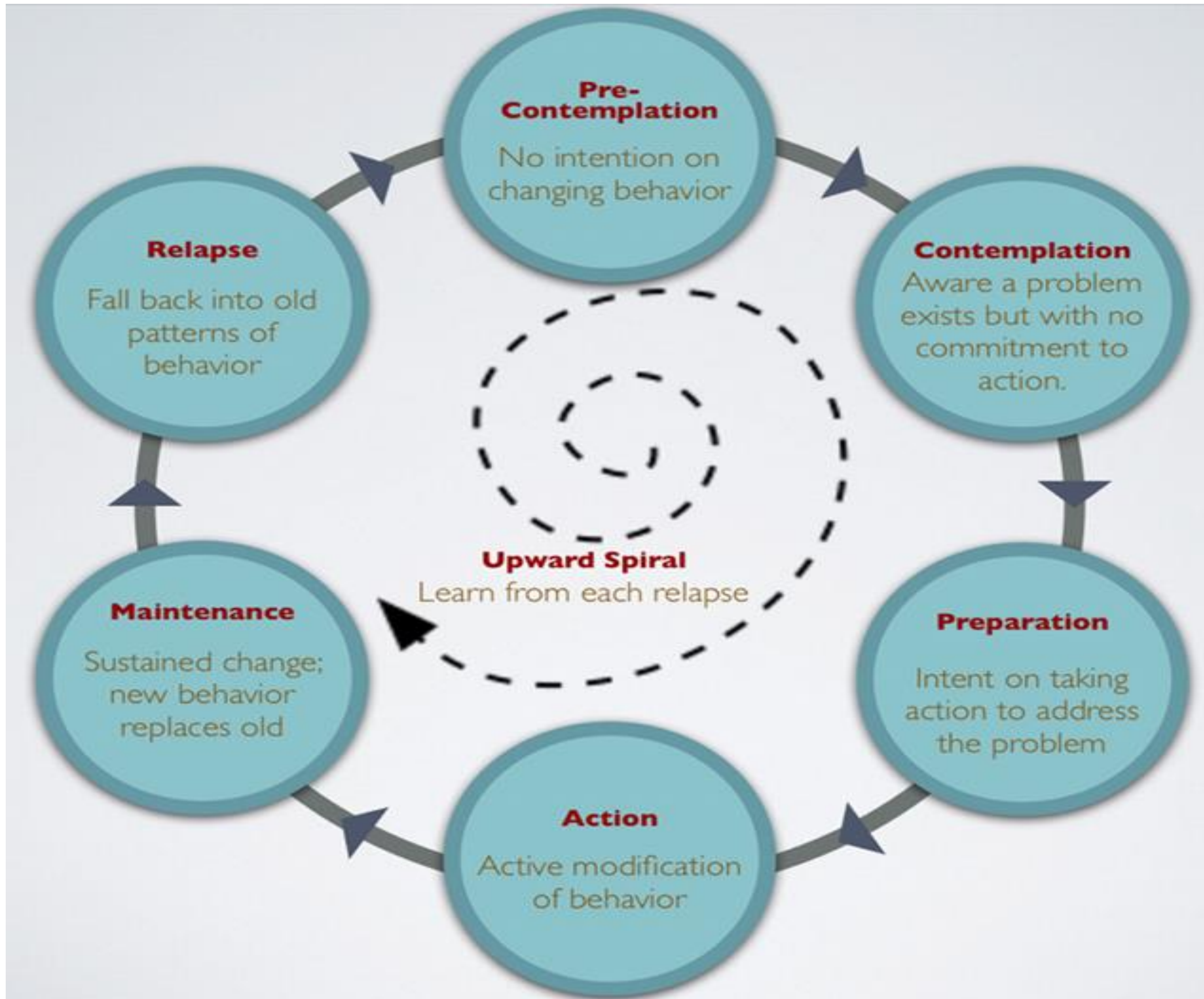
- Specific – What exactly do you want to do?
- Measurable – How will you measure success?
- Action-oriented & Attainable – Can you actually do it?
- Realistic – Is it possible in the context of your life?
- Time-limited – How much time do you need to accomplish the goal?

SMART Goals Activity

Stages of Change

PRIMARY CARE
DEVELOPMENT
CORPORATION

Stages of Change Theory



Stages of Change Activity

SMART Goals & Stages of Change Summary

- Patient/client/person is the lead on creating the goals
- Goals are based on what the patient/client/person wants to work on and what is important to them
- Goals are also based on where the person is regarding their stage of change
- Adults are more successful when they are self-directed
- Goals are realistic and achievable so the patient/client/person is set up to succeed, not fail
- Goals should aim to move people from one stage to the next, not necessarily multiple stages.
- Care Manager provides guidance on how realistic the goals are
- Success follows success

Break

Motivational Interviewing

Motivational Interviewing

- A person- centered counseling style for helping people explore behavior change, overcome barriers, and resolve ambivalence about behavior change

VIDEO - How NOT to do Motivational Interviewing: A conversation with "Sal" about managing his asthma

The TEACH Project
Excellence in Interprofessional Education

teach@camh.net
www.teachproject.ca

https://www.youtube.com/watch?v=kN7T-cmb_l0

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Key Principles of Motivational Interviewing

- Express empathy
- Develop discrepancy
- Roll with resistance
- Support self-efficacy

Source: Motivational Interviewing Guide, Community Care of North Carolina

Express Empathy

- Goal is to understand where the patient is and show them that you understand them
- Helps guide people to understand and listen to themselves
- Ambivalence is normal and important for growth and change
- Examples:
  - "Those are a lot of medications and appointment you have to keep on top of. I can see how that might be hard."
  - "What you are saying is really important to me. Can you tell me more?"
  - "I hear you. How do you feel about talking about that more?"

Develop Discrepancy

- Change is motivated and achieved by helping the person see that there is a disconnect between what they are doing now and their goals for the future
- May ask person to imagine what their life will be like if they continue to do what they are doing and/or if they make a change
- Examples:
  - "One the one hand I hear you saying that you want to get sober so that you can spend more time with your grandchildren. On the other hand, you said that continuing your relationship with your partner is not helping you get sober."
  - "It may be that smoking brings you so much pleasure right now that you are willing to deal with how awful it makes you feel."

Roll with Resistance

- Resistance can sometimes be reframed to create a new momentum to change
- Do not argue for change
- Patient/client is primary decision maker
- Examples:
  - “It sounds like you have tried that before and it didn’t work? Am I understanding? Can you say more about what didn’t work?”
  - On the one hand, you seem to acknowledge the problems here. But on the other hand, the suggestions I am offering are just not acceptable to you right now.”

Support Self-Efficacy

- How capable a person believes they are in making a change (sometimes called health confidence)
- Tell them you believe in them
- Offer tips and strategies for the change
- Confidence is a predictor of change

Spirit of Motivational Interviewing Activity

Motivational Interviewing Spirit

- Collaboration – client/patient/person brings expertise about their life and motivation to process. Care Manager brings a positive environment and expertise.
- Evocation – Care Manager should draw out motivation, method, and barriers for change
- Autonomy – At the end of the day, decision making is up to the patient/client/person. Does not mean you agree with all of their choices. You help them understand all of the possible consequences for any given choice, offer safer alternatives, and support.

Motivational Interviewing Micro-Skills - OARS

- Open-Ended Questions
- Affirmations
- Reflections
- Summary

Open Ended Questions Activity

Open Ended Questions Activity

Adherence to medications	How have you been taking your medications? Tell me about how you take your medications.
How their Chronic Condition Affects their Life	What is it like having COPD? How does having asthma affect your life?
Doctors of Other Providers Seen	What other doctors do you see and for what? Who else helps you manage your health?
Diet	What do you eat on a typical day? What kinds of foods do you eat?
Family Structure/Relationships	What important people do you have in your life? Can you tell me about the people who you are close to and who are important in your life?
Exercise Regimen	What kinds of exercise do you do?
Job	What do you do for work? How do you get money to pay for things?

Open Ended Questions Activity

Living Situation/Housing	Where do you live? What is it like where you live? In what kind of place do you live?
Use of Alcohol/Drugs	Do you ever drink alcohol or use other drugs? What kinds of alcohol or drugs do you use and how often?
Transportation	How do you get around? What kind of transportation do you have or use?
Mental Illness	How do you feel emotionally? Has anyone ever told you have a mental illness? If so, which ones?

Open-Ended Questions

- Allows for more thorough, thoughtful responses
- Shows patient/client/person that you care and are interested in what he/she has to say
- Allows you to understand the patient/client/person's priorities
- Allows people to "tell their stories"
- Gets at more in depth information that may not be shared with closed-ended questions

Affirmations

- Statements of appreciation and acknowledgement of person's strengths and healthy behaviors
- People are often used to hearing about their failures regarding their health. Affirmations allow them to hear something positive
- May lead to increase in self-efficacy
- Can and should be used at any time to show the patient/client/person that they are doing something positive for their health/life, even if it just showing up to talk

Reflective Listening

- Reflecting back to the patient/client/person what they have shared/said through techniques such as repeating, rephrasing, and/or reframing
- Reflecting Feelings – deepest form of listening
- Ensures that person feels heard
- Sometimes you can reflect on body language too
- Deceptively simple – “Listening looks easy, but it’s not simple. Every head is a world” – Cuban proverb
- Some standard phrases:
  - “Sounds like you are saying that…”
  - “You are wondering if…”
  - So, you feel…”

Reflective Listening Activity

Summary Statements

- A concise statement that summarizes the person's intentions, plan, feelings, etc.
- Moves conversation forward and towards conclusion
- May begin with something like:
  - "Let me see if I understand you so far…"
  - "Here is what I have heard. Tell me if I am understanding you right"
- Three Kinds of Summary Statements:
  - Collective Summary – "So, lets go over what we have talked about so far…"
  - Linking Summary – "Earlier, you said you wanted to talk to your partner about how his drinking makes you feel. Maybe now we can talk about how you might try to do that."
  - Transitional Summary – "Ok, so you decided today that you would like me to help you make an appointment with the treatment center, and then you will talk to your partner about the plan to enter rehab."

Lunch

Motivational Interviewing Part 2
Watching Video with the OARS scoring sheet

Health Coaching

A Quick Reminder

- 50% of patients leave without understanding advice given to them
- In only 10% of visits is the patient involved in the decisions made
- Why?
  - The provider was not clear with instruction and so the patient did not understand them
  - The patient was never asked what he/she thought of the treatment plan

Health Coaching

Involves helping clients/patients understand actions that affect their health and collaborating with them to develop strategies to live as fully and productively as possible.

From: Bodenheimer, T. and Ghorob, A. Health Coaching: The Building Blocks of High-Performing Primary Care, UCSF Center for Excellence in Primary Care

Health coaches collaborate with people to:

- Support them in their health and health changes
- Increase knowledge about a condition
- Teach self-management skills
- Increase health confidence/self-efficacy

Source: Bodenheimer, T. and Ghorob, A. Health Coaching: The Building Blocks of High-Performing Primary Care, UCSF Center for Excellence in Primary Care

Evidence for Health Coaching

- In a randomized controlled study, patients with diabetes, hypertension, and/or high LDL cholesterol who worked with medical assistants trained as health coaches significantly improved their A1C and LDL cholesterol after one year compared with non-coached patients.
- Community health workers trained as asthma coaches were able to significantly reduce asthma re-hospitalization among poor, African American children compared with a control group.
- Hospitalized patients with complex healthcare needs receiving post-discharge assistance from a “transition coach” had significantly lower re-hospitalization rates than control patients.

Source: Bodenheimer, T. and Ghorob, A. Health Coaching: The Building Blocks of High-Performing Primary Care, UCSF Center for Excellence in Primary Care

Why do We Need Health Coaches?

- A primary care provider with a panel of 2500 average patients would need:
  - 7.4 hours per day to deliver all recommended preventive care
  - 10.6 hours per day to deliver all recommended chronic care services

Source: Bodenheimer, T. and Ghorob, A. Health Coaching: The Building Blocks of High-Performing Primary Care, UCSF Center for Excellence in Primary Care

Health Coaching Helps People:

- Understand their condition
- Decide and choose treatment
- Adopt, change, and maintain behavior to contribute to their health
- Develop skills and use resources available to support changes
- Cope with health issues
- Overcome barriers to become healthier
- Improves health literacy and quality of life

Coaching tasks

- Help patients set agendas for clinician and other visits
- Make sure people are involved in creating their treatment plan and understand it
- Provide self-management support by helping people develop personal action plans:
  - Identify what the person wants to do (i.e. quit smoking)
  - Describe what, when, where, and how often the identified change will occur
  - Identify and list barriers to behavior change
  - Identify and list strategies to overcome barriers
  - Assess the person's confidence in his/her ability to make the change
  - Document a follow up plan
- Assist patients to improve medication understanding and adherence

Approaches to Health Coaching

- Directive – Tell patients/clients what to do, what they need to do
- Collaborative – Ask patients what changes they want to make and what changes they are ready to make

Traditional Education Vs. Health Coaching

	Traditional Education	Health Coaching
Content	Disease specific information & technical skills	Problem-solving skills that can be applied to any chronic condition
Definition of the Problem	Inadequate control of disease is the problem	Patient/Client determines the problem, which may or may not be directly related to condition
Goal	Patient compliance with prescribed behavior changes will improve clinical outcomes	Increased self-efficacy will improve clinical outcomes
Educator	MD, Nurse, PA, CDE	Health Professional or others (HE's, community health workers, etc.)

When to do Health Coaching

- Before visit with medical or social service provider, health coach and person meet to discuss what is going on, and what needs to be covered in medical or social service visit. Health coach may give a heads up to provider.
- During visit with provider – may advocate for person, ensure everything is covered, and translate provider instructions
- After visit with provider – review what happened, what person needs to do, and figure out how they will do it
- Other meetings or calls with patient/client

Video – Coaching Patients for Successful Self-management

https://www.youtube.com/watch?v=g-6Nxp9DBvo

Medication Reconciliation

- Create a list of medications the person is actually taking
- Educate about prescribed medications – what they are for and how to take correctly
- Assess adherence
- Discover adherence barriers
- Tell medical providers what medications are being taken, how, and what problems the person faces with the medications
- Discover what else they may be doing, taking (traditional medications, herbs, etc.)

Medication Reconciliation

- Do you know the name of this pill?
- Do you know what this pill is for?
- Do you know how many milligrams it is?
- How often should you be taking it?
- Are you taking it?
- If you are not taking it as the doctor prescribed, why not?
- Do you need refills?

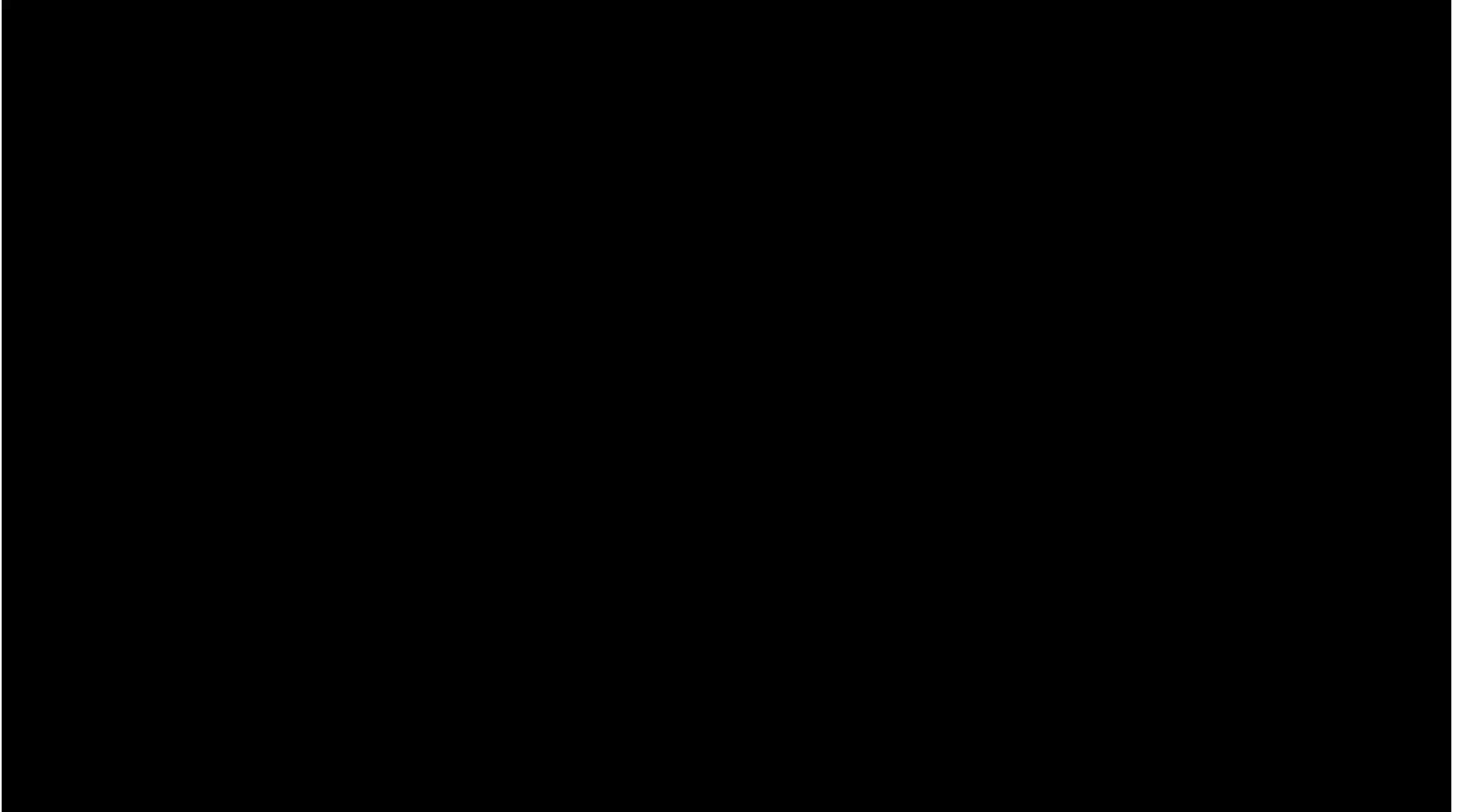
Why is Medication Reconciliation Important?

- 1/3 of US adults take 5 or more medications daily
- Serious, preventable medication errors occur in 3.8 million inpatient admissions and 3.3 million outpatient visits.
- Inpatient preventable medication errors cost approximately $16.4 billion annually
- Outpatient preventable medication errors cost approximately $4.2 billion annually

Source: Preventing Medication Errors: a $21 Billion Opportunity.

http://www.nehi.net/bendthecurve/sup/documents/Medication_Errors_%20Brief.pdf

Video - Northern Piedmont Community Care



https://www.youtube.com/watch?v=Gxfxo3ejP8c

Wrap Up/Evaluations