Creating Single Integrated Care Plans Within Health Homes

January, 2013
Diane Grieder, MEd
AliPar, Inc.
www.alipar.org
Goal Of The NYS Care Management Training

To provide education, training, and ongoing support to care managers who are in transition of their workforce responsibilities in a way that utilizes their existing knowledge, skills and strengths so that individuals with complex needs can improve their sheath and wellness and realize their full potential.
Today’s Webinar Objectives

As a result of today’s workshop:

- Participants will understand how recovery beliefs, person centered practices, medical necessity, and readiness for change are necessary elements of individualized planning.
- Participants will understand the technical components of writing a goal, objectives and interventions.
- Participants will learn techniques for translating their conversations with individuals seeking services and other information into the writing of individualized care plans.

Adams & Grieder
A “health home” is a multidisciplinary team of healthcare providers working together to ensure that a person has a regular primary care physician and that their care is coordinated so all other healthcare providers involved know what each other is doing and what a person needs next in order to have the best possible healthcare possible.
The Person-Centered Health Home

- Team based approach
- Includes all providers, the consumer, and family, as appropriate
- At least 2 chronic conditions
- Care management is key
- Supports self-management goals
- Health promotion – prevention
- Health technology to link services
- Promises a better approach/outcomes for people

SAMHSA-HSRA Center for Integrated Health Solutions
Care Coordination

- What does it mean and what does it look like?
Oregon Standards And Measures For Patient Centered Primary Care Homes From A Consumer Perspective

- **Access to Care**: be there when I need you

- **Accountability**: take responsibility for making sure I receive the best possible health care

- **Comprehensive Whole Person Care**: provide or help me get the health care services I need

- **Continuity**: be my partner over time in caring for my health

- **Coordination and integration**: help me navigate the health care system to get the care I need in a safe and timely way

- **Person and Family Centered Care**: recognize that I am the most important member of my care team and that I am ultimately responsible for my overall health and wellness
Vital Competencies For Developing Care Plans

1. Recovery Beliefs and Person Centered Practices
2. Medical Necessity
3. Phase of Change/Staged Matched Interventions
4. Recovery Plan Components (goal, objectives, interventions, etc.)
Thoughts About Recovery Planning and Person-Centered Practices

- Acute illness- people often step away from day to day routine while being treated.

- Chronic illness- people try to maintain/redefine “normal” while being treated.

“...A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”

Mark Ragins, M.D

SAMHSA
Balancing Important To/Important For: Necessary Elements of Recovery Planning

**Important “To” the person**
Things that resonate with the person regarding:

- Values and ideals
- Personal preferences
- Interests
- Talents
- Dreams and aspirations

**Important “For” the person**
Things that must be kept in mind regarding issues of:

- Health and safety
- What is needed to be a valued member of her or his community of choice
The person’s activities, services and supports are based upon her or her dreams, interest, preferences and strengths.

The person and people important to the person are included in lifestyle planning and have the opportunity to exercise control and make informed decisions.

The person has meaningful choices, with decisions based on her or his experiences.

The person uses, when possible, natural and community supports.
Hallmarks Cont.

- Activities, supports and services foster skills to achieve personal relationships, community inclusion, dignity and respect.
- The person’s opportunities and experiences are maximized, and flexibility is enhanced within existing regulatory and funding constraints.
- Planning is collaborative, recurring and involves an ongoing commitment to the person.
- The person is satisfied with her or his activities, supports and services.
The Power Of Language In Care Planning

The Glass Half Empty, The Glass Half Full:

Written and spoken language honors strengths-based foundation

- Using person-first terms
- Avoiding overly negative connotations
- Being careful not to communicate hierarchy/social control

Video: The Gestalt Project
http://www.youtube.com/watch?v=QficvVNIxTI&feature=youtu.be
Language Counts!

- What types of messages might be communicated by these terms?
- For each word, try to re-identify a word and/or phrase.
- What are other examples you can think of?

<table>
<thead>
<tr>
<th>Deficit Based Language</th>
<th>Strength Based Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>A schizophrenic, A paraplegic, A parolee, An addict…</td>
<td>A person with…</td>
</tr>
<tr>
<td>Unmotivated/disengaged</td>
<td>Interests are unclear/Unsure what options are available…</td>
</tr>
<tr>
<td>Delusional/psychotic</td>
<td>Person who experiences…</td>
</tr>
<tr>
<td>High/low functioning</td>
<td>A person’s symptoms interferes with…</td>
</tr>
<tr>
<td>Non-compliant</td>
<td>Not in agreement with/Chooses not to…</td>
</tr>
<tr>
<td>Frequent flyer/revolving door</td>
<td>Person utilizes acute care services/Person who has difficulty engaging with services</td>
</tr>
<tr>
<td>Weaknesses</td>
<td>Areas for improvement/barriers</td>
</tr>
<tr>
<td>Front line staff/in the trenches</td>
<td>Direct care staff/Staff who work with…</td>
</tr>
</tbody>
</table>
2. Medical Necessity

Definition: “The clear demonstration that there is a legitimate clinical need and that the services provided are an appropriate response.” - Adams and Grieder, *Treatment Planning for Person-Centered Care*, 2005

- Symptoms support diagnosis and lead to functional deficits/barriers in the person’s life.
- Treatment/interventions target the functional deficits to reduce or eliminate the impact of the diagnoses.
5 Elements Of Medical Necessity

1. **Indicated**: There is a diagnosis to treat.
2. **Appropriate**: There is a match between the interventions provided and the individual’s need.
3. **Efficacious**: The intervention has been proven to work.
4. **Effective**: The intervention IS working.
5. **Efficient**: Time and resource sensitive
3. Phases Of Change And Stage Matched Interventions

<table>
<thead>
<tr>
<th>Stages of Change</th>
<th>Treatment Focus/Staged Matched Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation:</td>
<td>• Outreach</td>
</tr>
<tr>
<td>Unaware of the problem or do not want</td>
<td>• Practical help</td>
</tr>
<tr>
<td>to fix it.</td>
<td>• Crisis intervention</td>
</tr>
<tr>
<td></td>
<td>• Relationship building</td>
</tr>
<tr>
<td>Contemplation:</td>
<td>• Psycho-education</td>
</tr>
<tr>
<td>Beginning to think change might be a</td>
<td>• Set goals</td>
</tr>
<tr>
<td>good idea.</td>
<td>• Build awareness</td>
</tr>
<tr>
<td>Preparation:</td>
<td></td>
</tr>
<tr>
<td>Readying themselves to do things</td>
<td></td>
</tr>
<tr>
<td>differently regarding the problem.</td>
<td></td>
</tr>
<tr>
<td>Action:</td>
<td>• Counseling</td>
</tr>
<tr>
<td>Doing things differently and is actively</td>
<td>• Skills training</td>
</tr>
<tr>
<td>working to fix the problem.</td>
<td>• Self-help groups</td>
</tr>
<tr>
<td>Maintenance:</td>
<td>• Relapse Prevention Plan/WRAP/Advanced Directives</td>
</tr>
<tr>
<td>Person has sustained identified change.</td>
<td>• Skills training</td>
</tr>
<tr>
<td></td>
<td>• Expand recovery</td>
</tr>
</tbody>
</table>

*Prochaska & DiClemente*
4. Building A Treatment Plan

*Adams & Grieder

- Request for services
- Assessment
- Understanding
- Prioritization
- Goals
- Strengths/Barriers
- Objectives
- Services
- Outcomes
Assessment

A plan is only as good as the assessment.

• Initiates helping relationships
• Ongoing process
• Comprehensive domain-based data gathering
  • Physical, behavioral health, social service needs
  • Hopes, dreams, goals, aspirations
  • Attributes, preferences, priorities
  • Values and ideals
  • Supports and community connections
Developing Understanding (Interpretation): Moving From “What” To “Why”

“Different observers ‘see’ different things in a situation. Perception is not a passive process of observation but an active drawing of distinctions.”

“The distinctions we draw as social workers are profoundly organized by our own story and our own set of cultural “should and shouldn't”.

Madsen, 1999

“Our interpretation guides our intervention”
An Example: Why Does Someone Not Use Medication?

- Person is concerned re: side-effects
- Person does not believe they have an illness/believes meds are “poison”
- Person has religious/cultural objections to taking medications
- Person experiences stigma re: use of psych meds; family/others have advised them not to take it
- Person becomes disorganized/can’t track complex med schedule
PCP Documentation

**GOAL**
as defined by person

**Strengths to Draw Upon**

**Barriers /Assessed Needs That Interfere**

**Short-Term Objective**
- Behavioral
- Achievable
- Measurable

**Interventions/Methods/Action Steps**
- Professional/“billable” services
- MH/SA/Physical health
- Action steps by person in recovery
- Roles/actions by natural supporters
Recovery Goals

- A statement by the person that is meaningful to them about a change they would like to make for themselves—what is important to them...purpose...a hope...a dream
Identify Strengths

- Abilities, Talents, Competencies, Accomplishments
- Values and Traditions
- Interests, Hopes, Dreams, Aspirations and Motivation
- Resources and Assets
- Unique individual attributes (physical, psychological, performance capacities, sense of humor, etc)
- Circumstances at home, school, work, or community that have worked well in the past
- Family members, relatives, friends, other “natural supports” in the community
- Cultural Influences
- Previous successful experiences

*Adams/Grieder

"People are more motivated to change when their strengths are supported"
Saleeby, 2001
Identify Barriers

What factors keep the person from their goals?

- Environmental
- Individual qualities
- Areas needed for skill development
- Intrusive or burdensome symptoms**
- Lack of resources
- Self defeating strategies/interests
- Cultural factors
- Threats to basic health and safety
- Substance use

*Adams/Grieder

Barriers lead to objectives!
Objectives/Short-Term Goals

- The achievable, measurable, time-limited, behavioral change(s) the person will make to take steps toward achieving their goal.

- Overcoming the barriers (the mental health, substance use, physical health challenges the person is experiencing).

- Building on the individual’s strengths.
How To Write Objectives

RUMBA:
Realistic, Understandable, Measurable, Behavioral, Achievable

Template

- Subject
- Verb/Action Word
- What
- When will it be done/timeframe?
- How will it be measured?

Example

- Jason
- will use
- any of his three coping techniques to address anger with parents
- at least once a week over the next month
- as measured by family report log.
Interventions: Action Steps

- *Actions* by staff, family, peers, other natural supports
- Specific to an objective
- Respect recovery choice and preference
- Specific to the stage of change/recovery
- Availability and accessibility of services may be impacted by cultural factors
- Describes medical necessity
The 5 W’s Of Interventions

- **Who:** Which member of the team or support system will provide it.
- **What:** Specifically what will be provided/done.
- **When:** How often, how much time and what is the duration.
- **Where:** Identify the location of the delivery.
- **Why:** Identify the purpose of doing the action. Link the intervention back to the desired outcome.
Goal:
- Is it in the person’s words?
- Is it coordinated with other providers/supports?

Strengths and Barriers:
- Do they relate to identified goal?
- Are there barriers related to functioning as a result of the person’s chronic illness?
Putting It All Together, Cont.

Objectives:
- Do they meet SMART/RUMBA?
- Do they reflect stage of change?
- Do they address barriers?

Interventions:
- Do they meet the 5 W’s?
- Do they reflect where the person is at with their readiness to make change
- Do they address the objective?
**Tips For Translating Conversations**

- Why are you here? What is your goal for treatment? What do you want to see different in your life?
- What are your dreams/desires/wishes for life?
- If the problem that brought you here was to be solved (gone, changed), what would you be doing?

- What is preventing you in accomplishing this goal tomorrow?
  - Environmental
  - Individual qualities
  - Areas needed for skill development
  - Intrusive or burdensome symptoms
  - Lack of resources
  - Self defeating strategies/interests
  - Cultural factors
  - Threats to basic health and safety
  - Substance use

- This becomes the “goal”
- These become the “barriers”
Tips For Translating Conversations

- Have you had a time when things were going well? Tell me about this and what was in place to make it go well?

- Are there resources/people you can draw on to help you?

- Considerations:
  - Abilities, Talents, Competencies, Accomplishments
  - Values and Traditions
  - Interests, Hopes, Dreams, Aspirations and Motivation
  - Resources and Assets
  - Unique individual attributes (physical, psychological, performance capacities, sense of humor, etc.)
  - Circumstances at home, school, work, or community that have worked well in the past
  - Family members, relatives, friends, other “natural supports” in the community
  - Cultural Influences
  - Previous successful experiences

- These become the “strengths”
Tips For Translating Conversations

- What would it take for _____ to be different?
- If barrier x were not a problem for you or in your way any more, what would you be doing differently?
- How would you know that you were making progress toward accomplishing your goal?
- What are the steps that will help you accomplish these steps?
- What do you need to accomplish (objective)?
- What is in the way of accomplishing (objective)?
- How will you know you no longer need to come here to see me?
- Does the criteria reflect the goal the person is trying to accomplish and does it reflect when the person no longer needs the particular level of care?

These become the “objectives”

These become the “interventions”

This becomes the “discharge criteria”
The Care Management Planning Process

- Let’s take a look at “Hypothetical Harriet” and how care management might be provided to her in the best of all possible worlds.

- Think about what steps in the process you are already doing in your day to day work, and what areas could use improvement.
Example 1: “Hypothetical Harriet”

Background information:

- Unmarried, age 40, 5’9” tall, 190 pounds
- Works part time as a mechanic in an auto body shop
- Smokes 2 packs of cigarettes a day
- At age age 23, diagnosed as having schizophrenia
- At age 37, diagnosed as having hypertension
- One year ago diagnosed with adult onset diabetes
Harriet

- Admitted for the 3rd time in the past year to Parks Hospital after coming to the ER for feeling weak, thirsty and light-headed.

- Her blood sugar was 470. After previous discharges from Parks Hospital for Hyperglycemia, she has not followed up with the hospital’s recommendations to schedule a primary care visit to manage her HTN and diabetes. Believes the use of syringes is “dirty” and “unsanitary”.

- Harriet is engaged in services with her CMHC and takes prescriptions for schizophrenia as prescribed.
Initial Engagement For Harriet

- Parks Hospital refers Harriet to a health home for CM.

- Upon assignment, the HH CM:
  - Uses a computer database (Cyber Access) to review Harriet’s medical history for the past 3 years.
  - Learns that Harriet hasn’t been filling all of her prescriptions regularly.
  - Learns that she saw 6 different primary care doctors in 3 years, but hasn’t seen any of them more than twice!
  - Shares information with the hospital to facilitate treatment planning.

- While Harriet is still in the hospital, the HH care manager visits Harriet as soon as her clinical condition permits.
HH Care Manager Visits Harriet

- HH Care Manager goes to the hospital to get to know Harriet, understand her perspective about her health, and to develop/coordinate a transitional care plan in order to avoid unnecessary hospital visits in the future.

- Harriet agrees to accept the HH CM assistance because she wants to get back to her job as a mechanic.
The HH CM meets with Harriet and the hospital staff to learn about her conditions, aftercare recommendations, follow up referrals/appointments made:

- Current conditions and associated medications are reviewed for HTN, diabetes, schizophrenia, and smoking cessation (Harriet has been smoke free for 3 days while hospitalized).
- Harriet is referred to a PCP for management of her HTN and diabetes.
- Appointments are made for Harriet to follow up at the CMHC for follow up of her schizophrenia and to support smoking cessation efforts.

The hospital social worker contacts the HH CM to make discharge plans prior to discharge. Prior to discharge, the hospital faxes Harriet’s after-care plan to the care manager and all the identified care providers/personal supports identified.

The HH CM picks Harriet up from the hospital, gets temporary prescriptions filled, and helps Harriet get settled at home.
Post- Hospital Discharge

Within a few days after being discharged, the HH CM visits Harriet.

- Harriet has had no return visits to the hospital.
- Harriet is planning to return to work part-time the next week. The HH CM coaches Harriet related to smoking cessation and reviews her quit plan.
- They review her upcoming appointments for the primary care physician (in which the HH CM will accompany her to) and to the CMHC.
- They discuss her experience with a home health nurse, and a new referral to a peer-led diabetes management group.
- They review her medications and discuss that Harriet has not yet refilled her prescriptions for HTN medications.
Partnering With People So They Can Be In The Driver’s Seat Of Their Treatment

- PCP is based on a model of PARTNERSHIP…
- Respects the person’s right to be in the driver’s seat but also recognizes the value of professional co-pilot(s) and natural supporters
Visit to the Primary Care Physician

- The Primary Care Physician takes time to get to know Harriet and takes an interest in talking with her about cars.
- He connects Harriet’s physical health to feeling well in order to continue to work, socialize with her friends, and stay out of the hospital.
- The nurse at the doctor’s office helps to fill a daily medicine administration box for Harriet to use at home. She also demonstrates how Harriet should give herself daily insulin injections and discusses methods to maintain sanitation.
- Harriet also meets the peer coach that she will be working with for the diabetes management group.
- Afterwards, Harriet and the care manager go to the pharmacy to fill her prescriptions.
Visiting the CMHC

A week later, the HH CM accompanies Harriet at her CMHC appointment. The following takes place;

- The HH CM care manager and Harriet review the discharge instructions with the psychiatrist. They discuss the impact of her psychiatric medications on her blood pressure and diabetes, Harriet’s interest in following up with physical health recommendations, discuss beliefs related to cleanliness of using syringes, and reinforce the need for managing physical health in order to continue to work as a mechanic.

- The psychiatrist and PCP coordinate plans regarding BMI, blood pressure, cholesterol, triglycerides, and glucose tolerance while being prescribed psychotropic medications.

- An understanding of Harriet as a whole person and the following care plan is entered into the care management system.
Goal: “I Want To Get Back to Work”

**Strengths**
- Actively engaged in mental health treatment to manage her schizophrenia
- Actively willing to take medications for her diagnosis of schizophrenia with support of peers
- Has several friends that she socializes with that have diabetes
- Looking forward to having a home health care manager
- Is interested in the money she can save by not smoking
- Looks forward to returning to work

**Barriers**
- Overweight
- Has had multiple primary care providers
- Doesn’t feel different when taking HTN medications and therefore does not get prescriptions filled regularly
- Co-workers smoke cigarettes
- Beliefs that using syringes to manage her diabetes is “unclean” and “dirty”
- Three recent hospitalizations related to HTN and diabetes
## Barriers, Objectives and Interventions

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Objective</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| Harriet wants to sustain smoking cessation in order to improve her health/continue to work however has co-workers that smoke. | Over the next three months, Harriet will show improved physical health as evidenced by remaining smoke free. | 1. CMHC therapist will provide smoking cessation group for 30 minutes, twice a week, over the next 3 months in order to problem solve barriers faced with smoking cessation at work.  
2. CMHC psychiatrist will meet with Harriet once a month for 20 minutes over the next three months to prescribe and monitor impact of smoking cessation medications.  
3. Frank, Harriet’s co-worker, will go walking with Harriet during work breaks to help her reduce smoking in order to achieve improved health and remain working as a mechanic. |
| Harriet does not feel that the medications for HTN make her feel any different. | Harriet will improve management of her hypertension as evidenced by taking medications daily over the next 3 months. | 1. Health Home Care Manager will provide care coordination between Harriet and her primary care physician three times a month over the next three months to monitor engagement and outcomes of her physical health.  
2. Home Health Nurse will visit Harriet, at her home, once a week over the next three months to provide education, monitor blood pressure and support Harriet’s interest in taking medication as prescribed so she can stay out of the hospital. |
| Harriet has beliefs that using syringes to manage her diabetes is “unclean” and “dirty.” | Harriet will challenge her beliefs related to syringes as evidenced by giving herself daily insulin injections for a period of 2 months during the next 3 months. | 1. Peer Support worker, who also has diabetes, will accompany Harriet to weekly diabetes management group in the community to learn about using syringes and managing diabetes.  
2. Home Health Nurse will visit Harriet, at her home, once a week over the next three months to provide education, monitor diabetes, and assist Harriet in challenging her beliefs related to syringe use in order to avoid unnecessary hospitalization. |
Example #2: Edward

Edward is a 53 year old man who has been living on the streets for the last several years.

Edward is estranged from any of his family.

Edward is familiar to the care manager as he previously once had intermittent case management services for mental illness, alcohol dependence and chronic homelessness.

Edward is not engaged with any health care providers, including a primary care physician. Edward has had several emergency room visits in the last year for medical and behavioral issues.

Emergency records indicate that Edward is diagnosed with Bipolar Illness, Alcohol Dependence and End Stage Liver Disease. He has been given approximately three months to live.
Goal: “I Want To Re-Connect With My Daughter Before I Die”

**Strengths**
- Edward is previously known to this care manager and willing to engage in HH CM services.
- Edward knows how to contact his daughter as she has wanted to reconcile with him in the past.
- Edward has Medicaid for which he can be connected to medical and behavioral health services.
- Edward is willing to find a PCP.
- Edward has connections with other individuals living on the street.

**Barriers**
- Regular appointments are difficult to schedule between Edward and the HH CM due to homelessness.
- Edward has been estranged from his family for 10 years.
- Edward continues to drink alcohol despite a diagnosis of end stage liver failure.
- Edward does not have end of life plans made.
- Has been using the ER for his healthcare needs.
<table>
<thead>
<tr>
<th>Barrier</th>
<th>Objective</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular appointments are difficult to schedule between Edward and the HH CM due to chronic homelessness.</td>
<td>Within the next 2 weeks Edward will agree to a place and time to meet with his HH CM</td>
<td>Lisa Freeman, HH CM will meet with Edward at the Dunkin Donuts (on Anderson Street) twice a week for 30 minutes over the next three months to address physical, behavioral, and social service needs.</td>
</tr>
<tr>
<td>Edward has been estranged from his family for 10 years.</td>
<td>Within 45 days Edward will have made contact with his daughter at least one time</td>
<td>Lisa Freeman, HH CM will make contact with Edward’s daughter in the next two weeks regarding his health and desire to reconcile.</td>
</tr>
<tr>
<td>Edward continues to drink alcohol despite a diagnosis of end stage liver failure.</td>
<td>Within 30 days Edward will reduce the amount of alcohol he is ingesting from ____</td>
<td>Lisa Freeman, HH CM will connect with his family and his friends on the street within 2 weeks to ask them to offer encouragement to Edward to reduce his daily drinking</td>
</tr>
<tr>
<td>Edward does not have end of life plans made.</td>
<td>In the next two months, Edward will have end of life plans in place.</td>
<td>Lisa Freeman, HH CM will work with Edward and his care team over the next two months to monitor the status of his conditions and establish end of life plans of his preference.</td>
</tr>
</tbody>
</table>
PCP Implementation

- “Getting it” vs. “doing it” and “living it”
- Many systems change efforts get derailed by perpetual efforts to help people “get it”
- Sometimes you just have to dive in and do it/live it!!
- My challenge to you: What is ONE thing you might do different from this moment forward?

NEXT STEPS

Please share your feedback via the webinar survey.

Log on to the NYS Care Management Training Initiative website to review additional resources at www.healthhometraining.com.

Use the existing examples of Howard and Edward to identify alternate objectives, interventions.

Write a personal plan with the goal of “developing necessary competencies for integrated health home planning”. Identify your personal strengths, barriers, objectives and interventions.
Developing A Personal Plan

My Goal: “I will develop necessary competencies for integrated health home care planning.”

My Strengths:

My Barriers:

My Objectives: My Interventions: