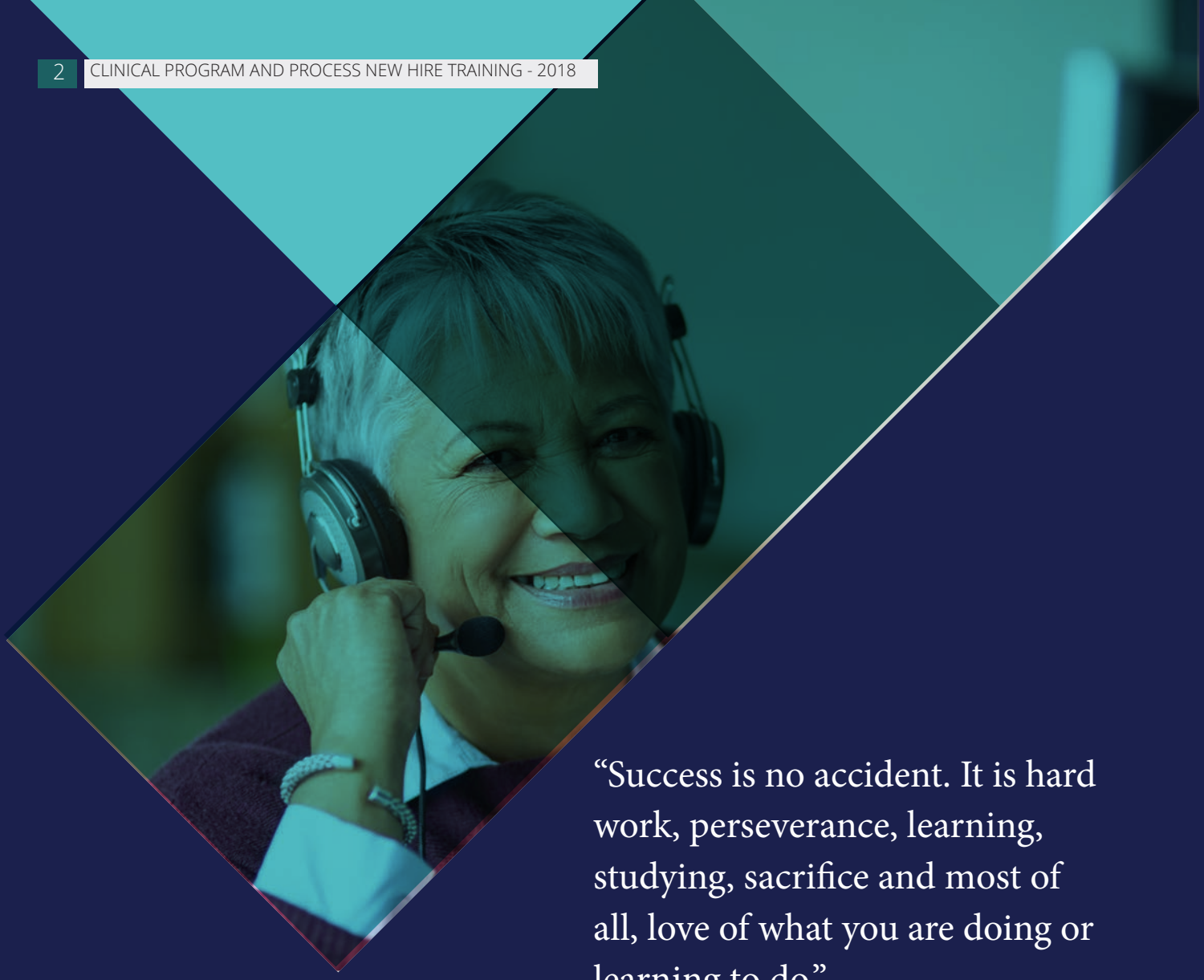
evolent HEALTH

Clinical Program and Process

New Hire Training



"Success is no accident. It is hard work, perseverance, learning, studying, sacrifice and most of all, love of what you are doing or learning to do."

- Pele

Contact ClinicalEducationandDevelopment@evolenthealth,com for further information about this document.

Version 121418

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INTRODUCTION

Course Overview

During this course we will review and provide key skills necessary to perform your job.

Our goal is to make sure you have a clear understanding of:

- Your role
- How you will interact with other care team roles to enhance patient outcomes
- The programs you will provide to the patient
- Program tools and checklists
- How you will provide the patient with self-management support
- How your role plays a part

Course Topics

- Introduction
- The Big Picture
- Components of Identifi Care
- Anatomy of a Program
- PGIs and Care Planning
- Social Determinants of Health
- Self-Management Support
- Behavioral Health

Course Objectives

- Describe your role in managing cases
- Engage patient in various programs and quality initiatives to enhance the patient outcomes
- Describe the steps for managing the patient in various programs
- Locate tools, job aids, and resources to manage cases

RELATABLE CHANGE

In your new role you may find yourself navigating change or managing stressful situations. Change is inevitable, but the way we deal with change makes all the difference.

Instructions

- Document one significant change that has occurred in your life in the space provided below.
- Once you have written your major change, break into small groups. Using the questions, discuss your documented experiences.

Your major change was:

1: _____

_____

_____

Questions:

1. How did you handle the change?
2. What was challenging about the change?
3. How did others manage the change?
4. How were you affected by others reactions and what did you do about it?
5. Did you support others in managing the change? If so, how?

Document Change Skills

Based on previous experiences and the discussion you had, what coping skills do you feel you possess and how can you apply them to the workplace?

_____

_____

_____

THE BIG PICTURE

In this module, we will learn what Population Health is, discuss care gaps, establish the importance of value-based care, explain stratification and predictive modeling, describe the care management programs we use, and take a look at how the various care team roles play a part in the those programs.

WHAT IS POPULATION HEALTH?

Population health is an approach to healthcare delivery that aims to improve the health of an entire population, reduce inequities and waste, and improve quality and health outcomes.

Population Health is Proactive, not Reactive

Population health involves looking at a large group of like individuals who are consumers of healthcare (the population), and working with providers and practices to help support their patients and achieve efficient, quality-driven continuity of care.

Defining Population Health

- Encompasses a broad continuum of care
- Focuses on enhancements to healthcare delivery
- Combines wellness, prevention, and care delivery
- Accommodates individual preferences
- Engages primary care providers (PCPs), care teams, and the patients to work together
- Results in coordinated care across the delivery system
- Driven by robust analytics and maintained by meticulous reporting and documentation

Core Principles of Population Health

CARE GAPS

What are Care Gaps?

A care gap is a discrepancy between the standard best practice of medical care and the care the patient actually receives. Care gaps may be identified when a medical and/or pharmacy claim is not received for care that should have been provided. Ensuring that patients are receiving comprehensive treatment is extremely important in Population Health. The care team member plays a vital role in helping to close care gaps.

Examples of Gaps in Care

- Adult access to preventative or ambulatory care-45 to 64 years
- Adult access to preventative or ambulatory care-65 and older
- Children's access to Primary Care-12 to 24 months
- Children's access to Primary Care-25 months to 6 years
- Children's access to Primary Care-7 to 11 years
- Children's access to Primary Care-12 to 19 years
- Cardiovascular monitoring for people with cardiovascular disease and schizophrenia
- Diabetes monitoring for people with diabetes and schizophrenia

Care Gap Interventions

- Verifying care gaps in the EMR
- Assisting with scheduling appointments
- Coaching the patient to adhere to the provider's plan of treatment
- Providing transportation resources
- Providing financial resources
- Providing other Community Based Organization (CBO) resources

VALUE-BASED CARE

Value-Based Care shifts the healthcare delivery focus from volume to value and redefines financial incentives toward financial responsibility, comprehensive enhanced quality, and patient outcomes.

Fee-For-Service

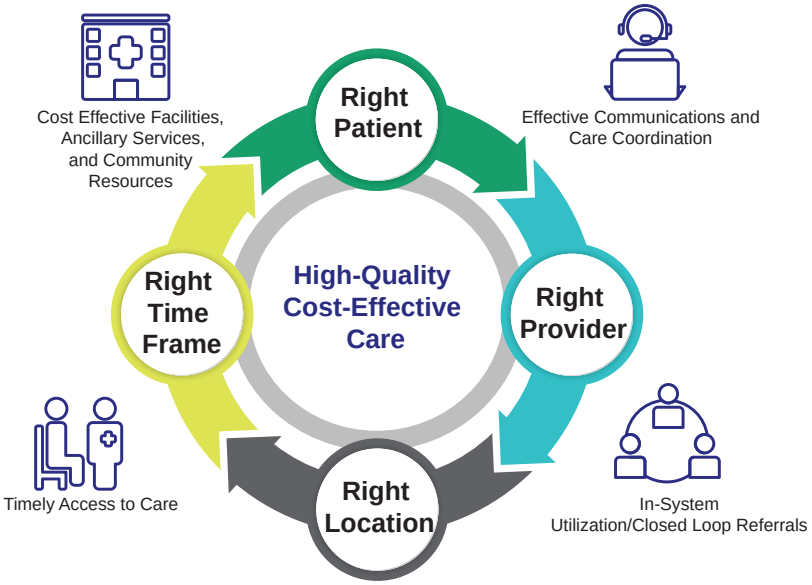
- In today's traditional FFS world, providers/practices receive incentives related to the volume of patients and services provided.

Value-Based-Care

- In the Value-Based Care model, providers/practices receive incentives related to the quality and the effectiveness of care provided.

Value-Based Care Benefits

- Providers/practices have a greater ability to focus efforts on patient populations to make the greatest impact towards improving overall quality and cost of care.
- Providers/practices deliver coordinated care to ensure patients get the right care at the right time while avoiding unnecessary services and procedures.
- Providers/practices have greater access to the expertise, staff, and technologies they need to ensure care is coordinated across all points of service.



What Does the Research Tell Us?

High Team Performance

- Expertly delivered Clinical Interventions
- Adherence to consistent process
- Quality-focused

Improved patient safety

Improved symptom management

Avoided hospital stays

Reduced readmissions

Improved quality of life

Improved Patient Outcomes

Elements of a Successful Care Management Model

- Being truly unique - differentiation and ability to provide a distinctive and relevant point of view
- Workflows and structure developed to support growth
- Implementation of clearly defined processes that lead to efficient and consistent operation
- Effective tools for measurement
- Assessment and management at each level of the business
- Repeatability of intervention
- Being outcome-focused
- Viewed as a trusted partner

Skills and Traits Associated with Success

Document skills and traits you associate with success.

_____

_____

_____

Stratification and Predictive Modeling

What is Stratification?

Stratification or the Stratification Engine is the set of models used to identify impactable patients for care advising programs. Stratification is based on studied predictive indicators and clinical rules, which run against available patient data sources.

Impactable Patients - Outreaching to the right patients at the right time:

- What is an impactable patient?

  A patient who, with our self-management support and his/her own improved self-management skills, can avert unintended consequences associated with his/her condition.

- Which patients are the right patients for outreach today or next week?

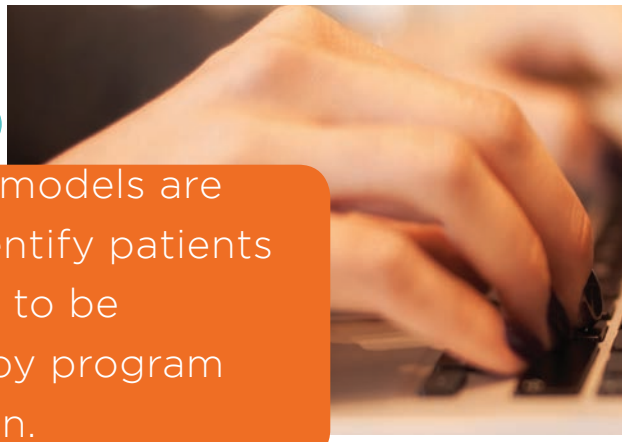
Access to more data and advances in technology are creating a paradigm shift in how we approach identifying patients.

What is Predictive Modeling?

- Predictive modeling is the process of using statistical analysis to predict outcomes – generally future outcomes.
- Predictive modeling uses historical data to make future predictions
- Consider multiple factors or characteristics in calculating anticipated risk or the likelihood of an event.
- Predictive models used in business and health care generally fall in the complex category.

Traditional Strat Models	Predictive Strat Models
Minimal Information	Expanded Information
✓ Claims data	✓ Claims data – inpatient and outpatient
✓ Historical cost and UM data	✓ Medical & pharmacy claims
	✓ Lab values
	✓ EMR clinical notes
	✓ Health Risk Assessments
	✓ Census data
	✓ Total cost of care
	✓ Socio-economic data

PATIENTS MOST LIKELY TO BE IMPACTED BY PROGRAM INTERVENTION



Predictive models are built to identify patients most likely to be impacted by program intervention.

Predictive models are program specific and their outcome variables are tied to program Interventions and Goals, i.e., readmission predictive model is designed to support Transition Care and predicts likelihood of a 30-day all-cause readmission.

Model Inputs: Historical medical and pharmacy claims, clinical indicators of disease progression or severity, Healthcare Effectiveness Data and Information Set (HEDIS) gaps in care and self-reported lifestyle factors and Socio-Economic Status (SES) data.

Model Output: Risk scores indicating patients' risk for program-specific outcome. Sometimes the risk score is a percent likelihood (i.e. readmission model outputs percent likelihood of 30-day readmission); otherwise the risk score is an integer used to prioritize populations (i.e. Complex Care model outputs a score used to identify patients for Complex and Condition Care).

We've shown that when these programs are implemented as intended, they can yield impressive results.

COMPLEX CARE RESULTS

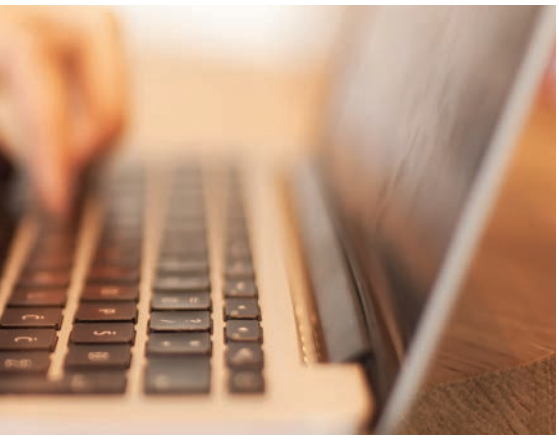
- ↓ 16% Total spend
- ↓ 30% Inpatient admission
- ↓ 48% ED visits
- ↑ 10% PCP visits

Validation by the Care Innovations Validation Institute confirms that Evolent's highly coordinated delivery system has delivered outcomes that so far are unmatched by any other vendor in this segment. Of over one thousand population health vendors, Evolent is one of only 23 to receive this distinction, and is the only one focused specifically on case management.

– Al Lewis, independent reviewer

TRANSITION CARE RESULTS

- ↓ 9.0% PTS. Readmission within 30 days
- ↓ 12.3% PTS. Readmission within 60 days
- ↑ 17.2% PTS. PCP or Specialist visit within 10 days

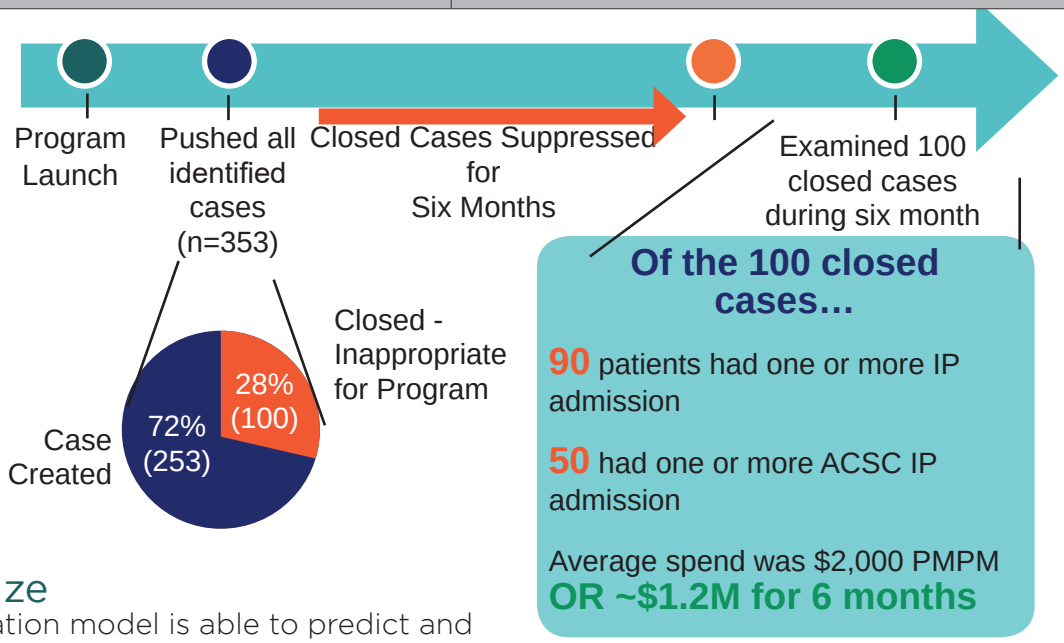


A second study of stratified patients

- 353 patients were stratified for Complex Care.
- 100 of 353 were immediately closed, without any outreach, as "Not Appropriate for Program".
- Within 6 months:
  - 90 of the 100 patients closed as not appropriate had one or more inpatient admission.

Case examples from the 100 patients deemed "inappropriate" and their clinical outcomes six months post-closure.

Stratified into Complex Care and Closed	Six-Month Follow-up Period
55-year old male with diabetes and asthma: • No acute utilization in last 12 months • Additional comorbidities such as hypertension • 17 unique meds including diuretics, steroids, pain meds, and anti-hyperte-sives	He had the following outcomes 1 inpatient admission: • 24 unique medications • Incurred >$35K during the follow-up period
66-year old female with CAD: • No acute utilization in last 12 months • 8 unique medications, including pain meds • Recent prescription of anti-depressants	She had the following outcomes 2 inpatient admissions: • 18 unique medications • Incurred >$35K during the follow-up period



To Summarize

- The stratification model is able to predict and identify "impactable" patients. Outreach to these patients prevents:
  - 1 or more inpatient admissions
  - Millions of dollars of spend
- Adherence to our clinical processes impacts patients by:
  - Reducing ED visits and inpatient stays by 48% and 30%, respectively
  - Reducing 30-day and 60-day readmissions by 9.0% and 12.3%, respectively
  - Increasing provider visits
  - Reducing total spend by 16%


"My mission in life is not merely to survive, but to thrive; and to do so with some passion, some compassion, some humor, and some style."
- Maya Angelou

Care Advising Programs

All Care Advising Programs at Evolent have specific Program Graduation Goals, metrics, processes, and expected durations.

Complex Care

Complex Care is a health coaching/care advising program with a focus on addressing the needs of the highest risk patients who have been diagnosed with one or more of the following health conditions: Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Diabetes Mellitus (DM), and Heart Failure (HF). Complex Care is integrated with behavioral health. The duration of this program is typically 120 days with the member/care advising interactions occurring at a minimum of 10 business days.

Transition Care

Transition Care is an episodic care advising program with a focus on providing care to our most vulnerable patients who are transitioning from the acute care setting to home. The Transition Care program aims to reduce readmissions and promote safe care transitions by focusing on collaboration to execute the discharge plan of care. The program may be initiated while the patient is in the acute care setting or immediately post discharge The duration of the program lasts through the most vulnerable period of 30 days post discharge. Patient outreach occurs a minimum of every five business days.

Catastrophic Care

Catastrophic Care addresses the sickest patients with potentially life-threatening conditions and trauma. Patients with an ICU stay and overall hospital stay greater than six days are part of the program. Diseases/trauma included are CVA, Burns greater than 20% of total body surface, spinal cord injury, ALS, Guillain-Barre, Tumors, ESRD and liver failure. Also, patients with a total medical spend of greater than $100k is also part of Catastrophic Care. The duration of this program is typically 90 days with the member/care advising interactions occurring at a minimum of 10 business days.

Condition Care

Condition Care is a care advising program with a focus on patients who are diagnosed with one of the following health Conditions; Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Diabetes Mellitus (DM), and Heart Failure (HF). There is a separate Condition Care program for each of the targeted conditions listed. Evidence-based medicine and a provider-led team approach are used to empower patients, and support behavior change. The duration of the program is approximately 90 days, with the patient-care advising interactions occurring at least every 15 business days.

Care Advising Programs

Advanced Illness Care (AIC)

Advanced Illness Care (AIC) is an early, pro-active approach to chronic, life-limiting conditions that improve the patients' quality of life. It honors their preferences for care and reduces costs of care. AIC is a fully integrated team approach that addresses collaboration and coordination among the patient/ caregiver, provider(s), specialists and support services. It encourages a collective focus on a shared plan of care with referral to and coordination with client-owned palliative care resources, community resources, and home-based services. Patient outreach occurs for engaged patients at a minimum of every 5 business days and monthly for patients in monitoring status.

Maternity Care

The Maternity Care program targets both low and high-risk pregnancies with an overarching goal of establishing a collaborative relationship between the care advisor and patient that fosters patient engagement and empowers the patient to self-manage their pregnancy; promoting healthy pregnancies and optimal maternal and infant health outcomes with a focus on wellness. Low-risk patients are monitored for complications and receive wellness support and education each trimester and postpartum. High-risk patients receive comprehensive case management and care coordination throughout pregnancy and postpartum. A team approach is used and consists of the patient, care advisor, health educator, and program coordinator. The program duration varies as patients are followed through the postpartum period, and contact is at least monthly.

Serious Mental Illness (SMI)

The SMI program was developed to systematically and comprehensively assess, monitor, measure, evaluate and implement strategies to improve the quality of care and behavioral healthcare services delivered to the patients with Serious Mental Illness (SMI). The program is a system of coordinated healthcare interventions and communications for populations with conditions in which the patient self-care efforts are significant. The behavioral health conditions included are major depression, substance use, schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), psychosis, and anorexia.

Care Advising Programs

Behavioral Health Care

The Behavioral Health Care program was developed to support the provider-patient relationship and plan of care, emphasizing the prevention of exacerbations and complications through evidence-based practice guidelines, and evaluating clinical, the patient experience, and economic outcomes on an ongoing basis with the goal of improving overall health. The behavioral health conditions including, but not limited to, are depression, anxiety, substance use, mood disorder, and social support deficiencies.

Skilled Nursing Facility Transition Care

The Skilled Nursing Facility (SNF) Transition Care program is an episodic care advising program with a focus on providing care to patients who are admitted to a skilled nursing facility, either directly from the acute care setting or the community, and may benefit from the support of an advanced care coordination team during and after their SNF stay. The Skilled Nursing Facility (SNF) Transition Care program aims to reduce SNF length of stay when clinically appropriate, reduce readmissions, promote safe care transitions, and improve the patient experience during and after a SNF stay.

Care Coordination

The Care Coordination program was developed to holistically improve the quality of life for patients through incorporation of the Value-Based Care philosophy of personalized solutions. The overall goal of care coordination is to link patients to services to optimize outcomes. The program identifies Social Determinants of Health (SDoH), and health disparities by employing a patient-centric approach to serve patients throughout the care continuum. The support provided includes, but is not limited to, developing personalized goals and interventions, self-management education, and collaboration with providers/practices and patients to bridge gaps, resolve barriers, and meet identified needs. The Care Coordination program duration is 90 days.

"The strength of the team is each individual member. The strength of each member is the team."

- Phil Jackson

CARE TEAM ROLES

A Care Team consists of the patient/caregiver, providers, Care Advisors/Care Managers/Care Coordinators, Social Workers, Registered Dietitians, Pharmacists, Program Coordinators, Patient Outreach Specialists/ Coordinators, Community Health Workers, Health Coaches/Educators and Population Health Managers. The team connects with patients in a variety of ways including; face to face, phone, e-mail, hospital setting or provider's office. Essentially, however, and wherever the patient needs assistance to improve their health, better understand their illness, and coordinate their care.

Patient(s) and Caregiver(s) *are at the center of the care team.*

He or she is responsible for:

- working with the care team and their provider(s) and/or specialist(s)
- taking an active role in their health, completing screening(s), assisting with barrier and needs identification
- collaborating with the care team to develop and achieve goals and interventions, take steps to better understand their health condition(s) and incorporate self-management

Primary Care provider (PCP)/Specialist

He or she is responsible for:

- collaborating with the care team and the patients to enhance comprehensive care coordination, quality, and outcomes
- enhancing patient engagement and care coordination implementation
- actively participating and supporting practice transformation strategies and efforts, patient self-management, and care gap closure strategies

Care Advisor/Care Manager/Care Coordinator (CA/CM/CC)

He or she is responsible for:

- collaborating with the patient/caregiver and the care team to conduct an extensive and comprehensive assessment that includes the medical, behavioral, pharmaceutical and social needs of the patient as well as identifying gaps in care and barriers to attaining improved health/outcomes
- serving as the contact point, advocate and resource for the patient/caregiver and provider and building effective relationships with trust, respect and communication
- working with the patient in hospital, home settings, provider offices and remotely
- collaborating with the patient, provider, and care team to continually assess the patient's knowledge of their clinical condition(s) and provide education and self-management support based on the patient's unique learning style

CARE TEAM ROLES

Extended Care Team (ECT)

Extended Care Team (ECT) consists of the pharmacist, social worker (SW), behavioral health specialist (BHS) and dietitian (RD). ECT consults are based upon patient's needs and agreement verified via assessments, stratification, and provider or the patient request. The responsibilities include, but are not limited to, the following:

- Pharmacist: identifying patients at high risk for safety concerns and/or adherence issues; identification of cost-savings opportunities and duplication in therapy
- SW: conducting assessments identifying behavioral, psychological and environmental concerns, providing community and government resources, and coordinating behavioral health resources
- BHS: conducting a comprehensive Behavioral Health Care assessment and offering support as needed
- RD: assessing patients based upon determined nutritional needs and providing education and Medical Nutrition Therapy

Program Coordinator (PC)

He or she is responsible for:

- coordinating patient care, in conjunction with other members of the population health team, by providing resources to the patients/caregivers, receiving incoming calls, assisting in referring the patients to appropriate programs, mailing communications to the patient
- maintaining databases
- managing the communication process to and from the patients/caregivers and/or providers

Patient Outreach Specialist/Coordinator (POS/POC)

He or she is responsible for:

- utilizing patient engagement techniques to outreach to the patients/ caregivers telephonically and educate the patient/caregivers on services/ programs offered
- evaluating the patients' willingness to participate in care management programs

CARE TEAM ROLES

Community Health Worker (CHW)

He or she is responsible for:

- Collaborating with the patient/caregiver conducting screenings to address Social Determinants of Health (SDoH), care coordination, and behavioral needs of the patient as well as identifying and addressing care gaps, barriers to resolving needs, coaching and guiding patient/caregiver to meet both personal and clinical goals to attain improved outcomes
- Serving as the contact point, advocate and resource for the patient/caregiver, primary care provider, and care team, facilitating communications across the care team, building effective, trusting relationships
- Working with the patient in home settings, physician offices, community and government offices, and remotely

Health Coach/Educator (HC/HE)

He or she is responsible for:

- providing self-management and care coordination support for the patients with one of the following conditions: Asthma, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease and Diabetes
- conducting regular self-management coaching and education regarding the patient's condition and role in self-management
- coordinating calls with the patients/caregiver, providers, and other community resources
- facilitating care gap closure by educating the patient/caregiver regarding preventative measures

Population Health Manager (PHM)

He or she is responsible for:

- educating and supporting providers, growing strategic relationships to influence decision-making and practice transformation to Value-Based Care, facilitate progress toward the quadruple aim (improved patient experience including quality, improved health of populations, reduction in total cost of care, and improved provider experience)
- functioning as a liaison between the providers to collaborate with the care team, enhancing patient outreach, engagement, support, and outcomes
- supporting providers and their practices to enhance population health management practices and strategies through practice transformation activities (practice assessments, practice goals, PDSAs), enhancing patient and provider quality and outcomes

IDENTIFI

During this module, we will explain Identifi and review commonly used Identifi Care interactions. The topics we cover in this module will serve as the building blocks for using Identifi Care.

WHAT IS IDENTIFI?

Census data

Lab values

Medical & pharmacy claims

Claims data – inpatient and outpatient

EMR clinical notes

Total cost of care

Health Risk Assessments

Socio-economic data

Identifi℠

Care

Configurable care management workflow application to coordinate clinical work across care teams

Engage

Mobile app for secure communication between patient and care team

Practice

Workflow and reporting for practices outside the host EMR

UM

UM workflow and analytics with integrated medical policy decision support

Learning

Embedded on-demand educational materials on Identifi

You will now observe a high-level demo of Identifi Care.

NAVIGATING IDENTIFI

You will now log into the Learning Center https,//evolenthealth.csod,com/client/evolent-health/default.aspx and access your Identifi Training Series course. Once you launch the course, you will complete all of the Components of Identifi Courses.

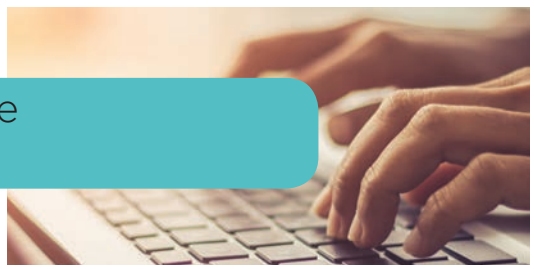
- ☐ Add a Care Note
- ☐ Add a Program
- ☐ Add an Action Item
- ☐ Add a Care Plan
- ☐ Add an Assessment
- ☐ Complete a Med Rec
- ☐ Enter PGIs
- ☐ Communications
- ☐ Patient Details

Differentiate an Action Item from a Care Note

Let's now take the time to learn the differences between an Action Item and a Care Note through an activity. Use your green and orange cards to vote on what you think relates to an Action Item and what relates to a Care Note.

Action Item

Care Note



The Importance of the Program Level

Being able to recognize the difference between the Program Level and the Patient Level is important for accurate reporting within Identifi. Test your ability to recognize the Program Level vs. the Patient Level.

SCAVENGER HUNT

Link to login: https,//training.myidentifi,com/Launcher/#/login
Need Help? Contact Application Support - (888) 959-4031 or support@evolenthealth,com

Work in groups of two. Read through the clues below and navigate to the appropriate location in Identifi Care. Once you locate the answer to the clue, document your process below.

1. Since you will be managing new patients in your role, search for an patient.

Document your patient's name, age, and member number.

_____

_____

2. Details about your patient are important. Locate the tab where you can locate Patient Details.

Document your patient's zip code, insurance eligibility, home phone number, and PCP name.

_____

_____

3. Locate the Patient Eligibility History.

Document the name of the active insurance.

_____

_____

4. Navigate to where you would add Contacts.

Document how you would add a Contact..

_____

_____

5. After you discover the Patient Details, return to the Patient Home Screen.

Document how you navigated to the Patient Home Screen..

_____

_____

SCAVENGER HUNT

6. What is displayed on the Patient Home Screen?

Document your findings.

_____

_____

7. Which tab do you click to view all Programs the patient is currently in or was previously in?

Document your findings.

_____

_____

8. Locate the tab to view all the Care Notes for an patient.

Document your findings.

_____

_____

9. Where would you go to view a completed Assessment?

Document your findings.

_____

_____

10. How do you locate all of your Action Items?

Document how you navigated to your Action Items.

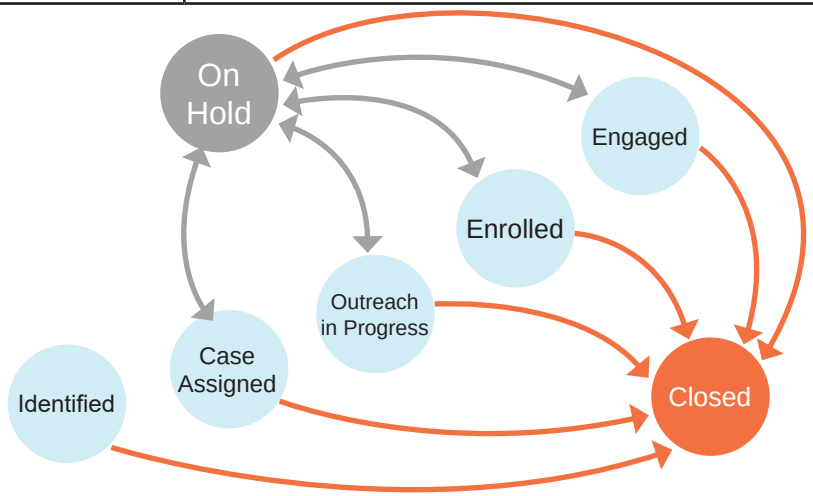
_____

_____

PROGRAM STATUS

Knowing which Program Status to use and when to use it is also important for accurate reporting of the work done in Identifi. Let's review the definitions of Program Statuses listed below. The definitions can also be found in Identifi.

Program Status	
Status	**Definition**
Identified	Initial status when a program is created, whether the program is auto-created or created by a care manager (CM).
Case Assigned	The Action Item is assigned to a care manager and the care manager name is entered into the Primary Staff field.
Outreach in Progress	Patient outreach has started and a Care Note (Phone or Face-to-Face) has been created.
Enrolled	Patient has been reached and agrees to participate.
Engaged	A Phone or Face-to-Face session has occurred with the patient and an Assessment has been submitted.
Closed—Lost Contact	Although previous contact has been successful, patient no longer responds to contact or contact information no longer working.
Closed—Problem Resolved/Goals Met	Patient has met requirements for graduation and no longer requires ongoing Care Management.
Closed—Unable to Reach	Unable to reach the patient or the patient did not respond to outreach by phone, written, or electronic correspondence.
Closed—Declines Participation	Patient declines program participation/enrollment.
Closed—Insurance Terminated	Patient's insurance coverage was terminated.
On Hold—Patient in SNF/Rehab	Program placed on hold because the patient is in a SNF/Rehab.
On Hold—Patient in Transition Care	Program placed on hold because the patient is in Transition Care.



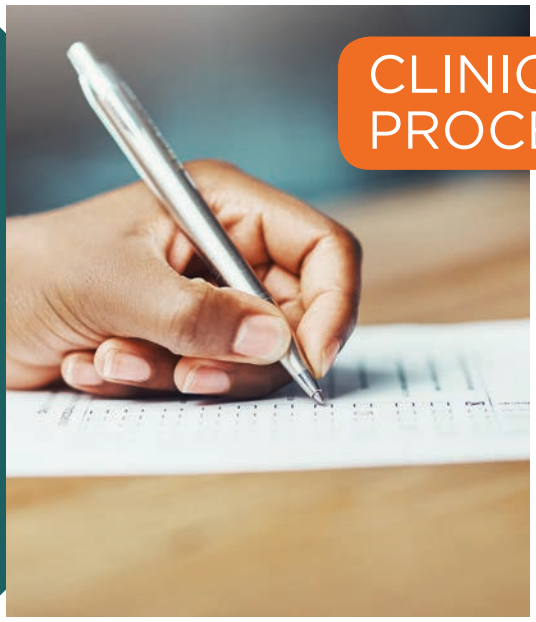
ANATOMY OF A PROGRAM

During this module, we will establish the similarities and difference between the clinical care management programs, show you how to use the clinical program process guides and maps, walk-through the process to manage a clinical care management program using interactive web-based scenarios, review the importance of PGIs, and learn about Medication Reconciliation and Care Plans.

PROGRAM SIMILARITIES AND DIFFERENCES

Program Similarities and Differences	
Tasks or Steps	The Same Across All Programs
Receiving a referral	✔
Confirming eligibility *Notify the provider if the patient is ineligible and close the program.*	✔
Chart review	✔
Initial outreach to explain the program and enroll the patient - *Notify the provider if the patient agrees or disagrees to enroll.* - *Close the program if patient declines participation.*	✔
Follow the Unable to Reach (UTR) process as appropriate	✔
Complete/submit the appropriate assessment	✔
Accept all the Problems and appropriate Action Items triggered	✔
Ongoing Clinical Sessions in the required timeframe to review PGIs	✔
Follow the Lost Contact process as appropriate	✔
Generate a Care Plan	✔
Evaluate patient for graduation	✔
Close program	✔

Tasks or Steps	The Same Across All Programs
Sending a Welcome Packet *(The same for all programs except for Transition Care)*	✘
Time requirements for outreach	✘
Program length and assessments	✘
Graduation Goals need to be completed in order to graduate	✘



CLINICAL PROGRAM PROCESS GUIDE AND MAP

Each clinical program has a corresponding process guide and map to layout the steps in the process for managing care. Each process guide is laid out with the following sections:

- Book Title
- Program Overview
- Program Graduation Goals
- Program Map
- Color Key
- Program Step
- Substeps and Tasks
- Care Activity Notes and Documentation
- Additional Processes

Program Overview

Complex Care Review

Complex Care Overview

Complex Care is focused on addressing the needs of the highest risk patients who have been diagnosed more than one chronic disease which could include the following health conditions; Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Diabetes Mellitus (DM), and H Failure (HF). These patients, based on identified risks, are most likely to incur a disease-specific adverse event.

The program was developed to systematically and comprehensively assess, monitor, measure, evaluate implement strategies to improve the quality of care and healthcare services delivered. These patients ma self-care efforts to be a significant challenge.

Evidence-based medicine and a provider-led team approach are used to: empower patients, support beh change, reduce the incidence of complications, improve physical functioning, and improve emotional wel being. An emphasis is placed on the use of clinical practice guidelines in an effort to prevent exacerbatio condition-related complications, with a goal of improving overall health and self-management. The patien provider relationship, and their agreed upon plan of care, are supported and encouraged. The duration o program is 120 days, with the patient-care advising interactions occurring at least every 10 business day

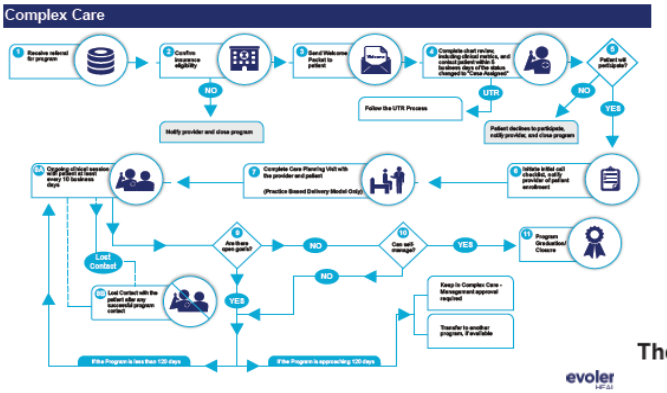
Program Graduation Goals

Program Graduation Goals

Program graduation goals were established when this program was developed. These goals define successful program completion. They represent the goals that the patient should focus on during the program.

Complex Care Program Graduation Goals
Graduation Goal - Patient takes an active role in self-managing condition. Criteria for meeting the graduation goal: • Patient has taken steps to make appropriate lifestyle changes needed to improve condition (diet, physical activity, tobacco cessation, stress management, etc.); • Patient has resources/equipment needed for self-care and monitoring of condition; • Patient verbalizes that taking an active role in his/her own health care is one of the most important things he/she can do to improve his/her health; and • Patient verbalizes confidence in ability to follow through on medical treatments he/she may need to do at home.
Graduation Goal - Patient is adherent to prescribed medication regimen. Criteria for meeting the graduation goal: • Patient follows prescribed medication regimen 6-7 days of the week; • Patient teaches back the reasons and side effects of prescribed medications; and • Patient has overcome barriers to medication adherence.
n Goal - Patient actively works with his/her doctor(s) on treatment plan. r meeting the graduation goal: tient attends planned/wellness visits and conducts necessary testing/examinations as directed by ctor; tient verbalizes confidence in being able to tell the doctor his/her concerns even when not asked; nd tient verbalizes confidence in being able to ask the doctor questions to receive more information en something is unclear.
n Goal - Patient understands and has a plan for managing symptoms and knows when to contact r meeting the graduation goal: tient teaches back the symptoms to look out for and the plan for managing those symptoms; and tient verbalizes confidence in knowing when to go to the doctor and when to take care of a health oblem on his/her own.
n Goal - Patient had no avoidable emergency department visits in 60 days.
n Goal - Patient had no avoidable hospitalizations in 60 days.
n Goal - Patient has been educated and provided information on Advance Directives.

Program Map



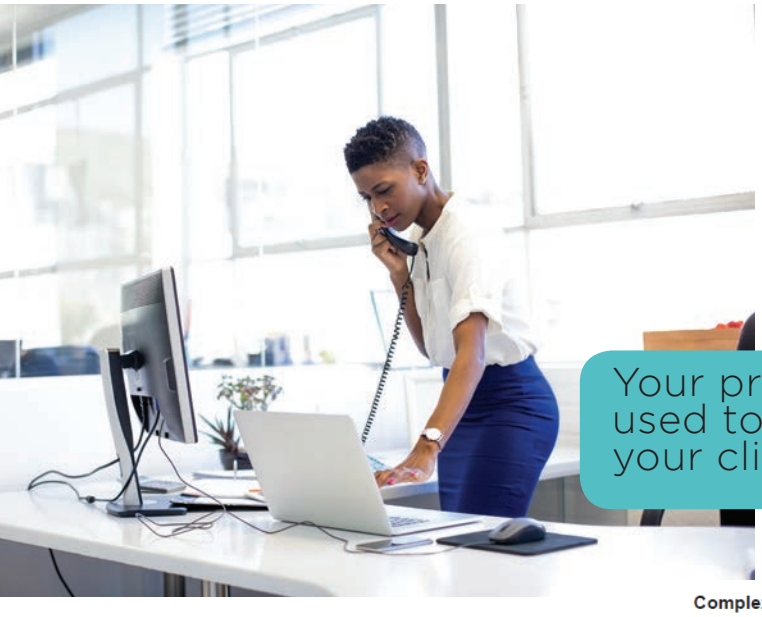
Color Key

The Module Color Code

Red refers to changing a Program STATUS or other important information

Blue refers to adding a Care Note

Green refers to adding an Action Item or Flag



CLINICAL PROGRAM PROCESS GUIDE AND MAP

Your process guide and map will be used to help navigate and manage your clinical programs.

Program Step

Complex Care Process

STEP ONE
Receive referral for program.

Substeps and Tasks

Steps and Documentation
Referrals may be received through automated stratification, roster review, or by referral from another program, a provider, the patient, or other referral sources.
1. Access patient via Patient Search or Action Item.
2. If there is no active Complex Care program listed on the PATIENT HOME page, **add a "Complex Care" program.** If unable to create a program move to STEP TWO and check eligibility.
3. **Enter the appropriate PRIMARY STAFF person's name and select the Program STATUS of "Case Assigned."** If you are unable to create a program due to the patient being ineligible, check with you manager for documentation recommendations.
4. Select the appropriate DELIVERY MODEL: Practice-based, Flex or Remote.
5. If the provider is not listed in the "Provider" section of the Patient Summary, add the provider via Contacts.
6. **Document the provider's decision from the roster**

Care Activity Notes and Documentation

Example of Documentation for Chart Review

Activity Category	Activity Action	Activity With	Response	Care Note
Note	Chart Review	NA	NA	Document pertinent clinical findings

Required Documentation for a Successful Contact with the Patient

Activity Category	Activity Action	Activity With	Response	Care Note
Phone	Outbound Call: Successful Contact OR Inbound Call	Patient	Clinical Session	Document the outcome of the contact
		Other Patient Representative	Contacted	
		Power of Attorney - Healthcare	Clinical Session	Document the outcome of the contact
		Spouse/Partner	Completed	

Additional Processes

Unable to Reach (UTR) Process
The UTR process is initiated immediately upon the first unsuccessful outreach attempt.

First Outreach Call	
Steps	**Completed**
1. **Unsuccessful outreach to the patient is documented in a Care Note with the Activity Action of "Outbound Call: Unsuccessful Contact #1."**	
2. **Add a new Action Item from within the program to follow up with the patient on a different day and at a different time of day within five (5) business days AND** mark today's Action Item as complete.	
Second Outreach Call	
Steps	**Completed**
3. Second outreach is made within five (5) business days of first unsuccessful attempt; and on a different day and at a different time of day. **If this outreach is unsuccessful, document in a Care Note with an Activity Action of "Outbound Call: Unsuccessful Contact #2."**	
4. **Add a new Action Item from within the program to follow up with the patient on a different day and at a different time of day within 5-10 business days of sending the UTR Letter AND** mark today's Action Item as complete.	
5. The UTR Letter must be mailed within no more than three (3) business days of the second unsuccessful call attempt. a. Is there a Program Coordinator or another resource to send the UTR Letter? i. Yes, generate the "GU-Unable-to-Reach-Letter" **AND send an Action Item to the Program Coordinator or other resource to mail the letter; or** ii. No, generate and mail the letter yourself.	
6. If practice-based or flex, contact the provider to advise of UTR. Seek assistance from the practice to outreach to the patient for engagement as applicable. **Document the activity in a Care Note.**	
Third Outreach Call	
Steps	**Completed**
7. A third outreach is made within 5-10 business days on a different day and at a different time of day. If unsuccessful, a message is left, if possible. **Document in Care Note with an Activity Action of "Outbound Call: Unsuccessful Contact #3."**	
8. Mark the Action Item complete.	
9. Notify the provider of UTR, if appropriate **AND document in a Care Note.**	
10. **Close the program by updating Program STATUS as "Closed: Unable to Reach" – when patient has never been contacted.**	

INTERACTIVE SCENARIOS

Process Guide and Map Walkthrough

Use the space provided below to take notes.

You will now log into the Learning Center:
https,//evolenthealth.csod,com/client/evolenthealth/default,aspx

Access your Identifi Training Series course. Once you launch the course, you will start by accessing Scenario One: Preparation. Throughout the class you will be prompted to access the other Scenarios.

01
Scenario
Preparation

During this module you will practice the program process steps you will follow when a new patient referral is made and prepare for the initial outreach to the patient.

☐ Completed

02
Scenario
Initial Outreach

During this module you will practice completing the documentation that accompanies the first call to your patient. You will complete and save the assessment.

☐ Completed

03
Scenario
Ongoing Care

This module focuses on the steps you will follow to continue managing the patient by assessing the patient's problems and needs, and col-laboratively setting Goals and Interventions to address them.

☐ Completed

04
Scenario
Case Closure

This module focuses on the steps you will follow to graduate your patient from the program after they successfully achieve their Program Goals.

☐ Completed

"A checklist cannot fly a plane. Instead, they provide reminders of only the most critical and important steps - the ones that even the highly skilled professional using them could miss. Good checklists are, above all, practical."

- Atul Gawande, The Checklist Manifesto

ASSESSMENTS

Assessing the patient is the first step in identifying what potential problems he or she is experiencing with their healthcare. It is an opportunity to find out what is important to them, what personal Healthcare Goals and needs her or she may have, and what barriers are preventing them from achieving those Goals. Because it is important to get the patient's responses to his or her personal perception of their health status, a Health Risk Assessment (HRA) is completed annually. Additionally, each program will have at least one program specific assessment to be completed in Identifi Care and submitted within a specific timeframe. All questions need to be answered. For each question there is an associated Comments box where further clarification should be provided. A summary of the assessment including all the patients' problems and concerns expressed must be included in the Initial Care Note Template.

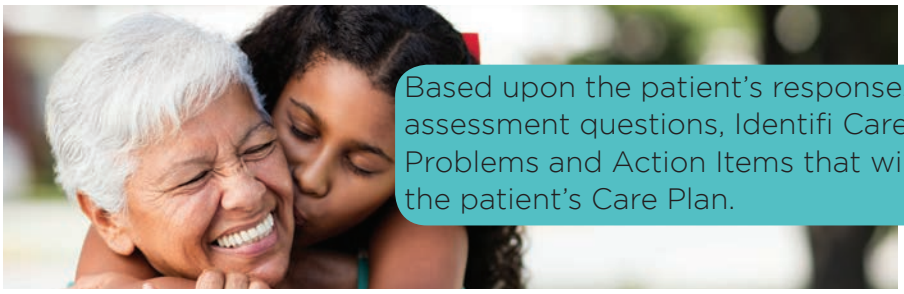
Assessment Question Example	
Q13	In general, compared to others your age, would say your health is:
	Excellent
	Very Good
	Good
✓	Fair
	Poor
	Decline to Answer
	Other
Comments: Patient has undergone small bowel transplant with major complications and is now dealing with multiple issues such as avascular necrosis of joints. Al 25, he feels he had more health issues than most 60 year olds.	

Assessment Question Example	
Q20	What worries you most about your health?
	Repetitive cycle of fixing one issue and than another issue coming up...needing to be on disability and not being able to take care of myself, having to live with my mom.

Assessment Question Example	
Q21	When you think about (patient's primary condition and concern), what comes to mind?
	I'm worried that these issues will never get resolved. I worry that people are judging me-that they look at me and don't believe I'm sick. They just think I just want attention to pain meds.

Assessment Question Example	
Q82	Patient Understands Available Benefits
✓	Yes
	No
	Unsure
	Declined to Answer
	Other
Comments: CA reviewed benefits with patient. He does not feel that "much is covered by his plan." However, during discussions, patient was not able to describe any needs not currently being met by the insurance plan. Available benefits appear to be meeting patient's needs.	

ASSESSMENT JOB AID

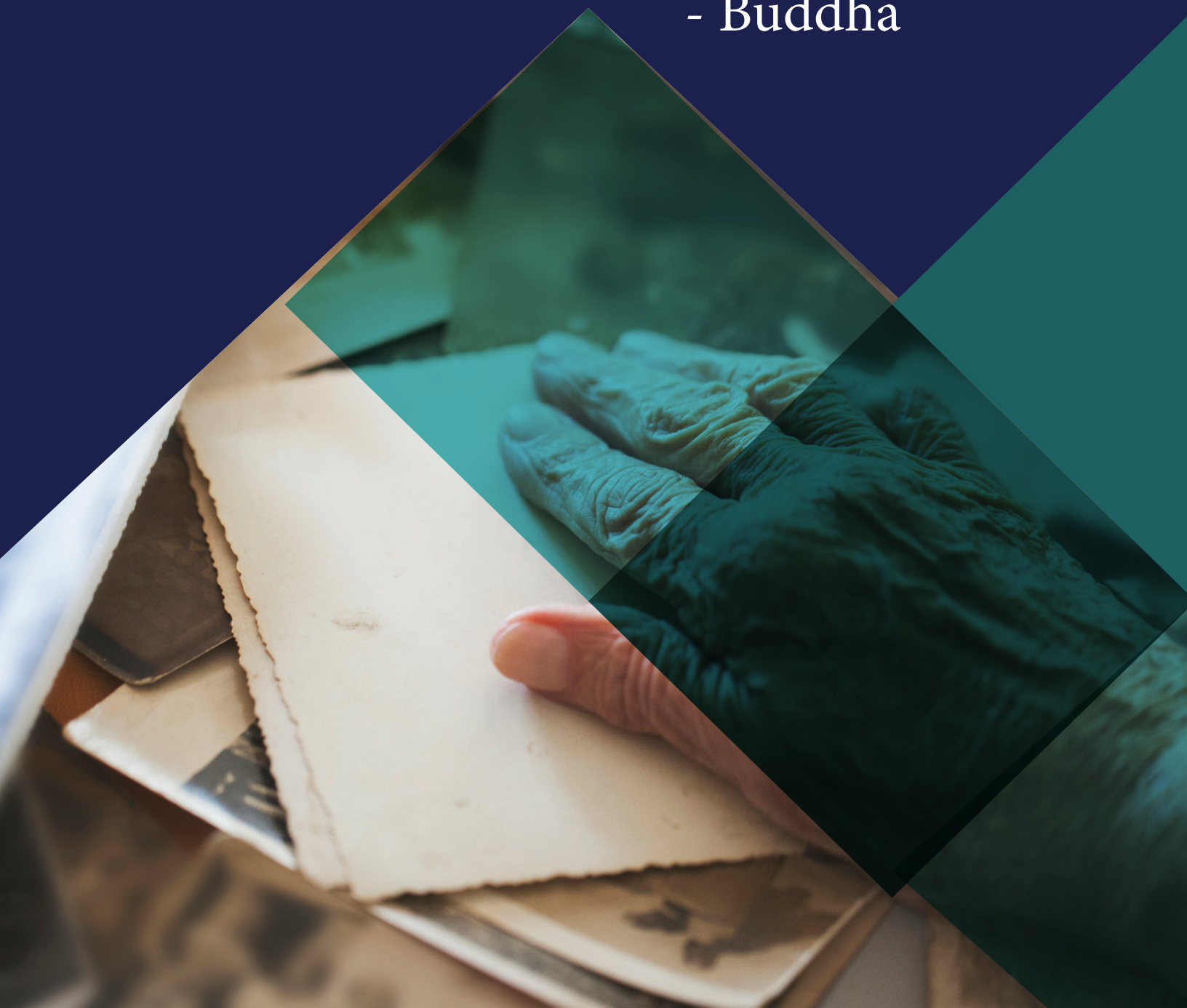


Based upon the patient's responses to the assessment questions, Identifi Care will create some suggested Problems and Action Items that will assist in the development of the patient's Care Plan.

Q #	Question Text	Referrence Text	Response Text	Action Triggered	Action Type or Problem	Skip Logic
6	Over the past few weeks have you developed any new or increasing shortness of breath with rest or activity that persisted for 2 or more days (unable to walk as far as usual without becoming short of breath)? (Provide specifics in COMMENTS box)	If the patient is telling you that they are currently having a new or increased symptom, consider discussing with your clinical supervisor. Provider notification may also be needed.	New shortness of breath	Problem	Symptom/Side Effect Concern	No
				Action Item	Provider Notification	
			Increasing shortness of breath	Problem	Symptom/Side Effect Concern	
				Action Item	Provider Notification	
			Existing shortness of breath unchanged			
			No shortness of breath			
			Unsure			
			Declined to answer			
7	Over the past few weeks have you developed any new or increasing phlegm/mucus (productive cough) or persistent coughing? (Provide specifics in COMMENTS box)	If the patient is telling you that they are currently having a new or increased symptom, consider discussing with your clinical supervisor. Provider notification may also be needed.	New or increasing phlegm production	Problem	Symptom/Side Effect Concern	No
				Action Item	Provider Notification	
			New or increasing cough	Problem	Symptom/Side Effect Concern	
				Action Item	Provider Notification	
			Existing phlegm unchanged			
			Existing cough unchanged			
			No report of phlegm or cough			
			Unsure			
			Declined to answer			
8	Over the past few weeks have you experienced any of the following other Heart Failure symptoms?	If the patient is telling you that they are currently having a new or increased symptom, consider discussing with your clinical supervisor. Provider notification may also be needed.	Chest pain	Problem	Symptom/Side Effect Concern	No
			Fatigue	Problem	Symptom/Side Effect Concern	
			Increased shortness of breath lying flat	Problem	Symptom/Side Effect Concern	
			Lethargy (e.g. decreased ability to perform some or all Activities of Daily Living)	Problem	Symptom/Side Effect Concern	
			Fluid retention (e.g. leg/ankle swelling, tightening of clothes/waist band)	Problem	Symptom/Side Effect Concern	
			Confusion	Problem	Symptom/Side Effect Concern	
			Dizziness/Lightheadedness	Problem	Symptom/Side Effect Concern	
			Unsure			
			No, has not experienced any other Heart Failure			
			Declined to Answer			
			Other			

“Health is the greatest gift, contentment the greatest wealth, faithfulness the best relationship.”

- Buddha



PGIs AND CARE PLANS

PGI stands for Problems, Goals, and Interventions. It is a section in Identifi Care where the care manager will capture a list of Problems that have been identified for your patient, the Goals the patient is working on, including Program Graduation Goals, and the Interventions being used to achieve the Goals. The PGI tab will support you in structuring the clinical sessions that you will have with your patients/caregivers. You will use the PGIs to develop an individualized plan of care and to provide self-management support to your patients as they work toward achieving their Goals. There are four sections you will see when you navigate to the PGI tab.

PGIs and Care Plans

Problems: A Problem is a physical, psychological, financial, or environmental obstacle that prevents the patient from reaching an optimal health status. Problems can be identified by a patient, their provider, or member of the care advising staff. Problems can also be identified by the logic of Identifi Care based on responses to assessment questions or when potential gaps in the standards of care are uncovered.

Gaps in Care: A care gap is a discrepancy between the standard best practice of medical care and the care the patient receives. Care gaps may be identified when a medical and/or pharmacy claim is not received for care that should have been provided.

Goals: A Goal is an outcome that the patient is working to achieve, or what we as the Care Advising team is working to achieve to support and assist the patient. The patient's own goals are important, and therefore something as worthy of investing time and resources to improve.

Program Graduation Goals: Each Care Advising Program has specific Graduation Goals which populate on the PGI screen when the status of the program is changed to either Enrolled or Engaged. The Program Graduation Goals populate in a Pending status and can be marked In Progress as the care manager begins to work on them with the patient. The Program Graduation Goals that are related to self-management have behavioral criteria that must be exhibited by the patient to consider the Goal Met. If not all the behavioral criteria are exhibited, the Goal can be closed as Partially Met.

Interventions: The steps taken to work toward achieving the Goal(s). These steps can be taken by the patient or a member of the Care Advising team. It may take a combination of several Interventions, completed over time by several people, to achieve a Goal. A SMART Goal is a self-management technique. It is the act of setting specific, measurable, action-oriented, realistic, and time-bound short-term goals. In Identifi, SMART Goals are used as Interventions.

Care Plan: A document that captures the plan of care which is developed collaboratively by the patient, the primary care provider and the Care Advising team.

BUILD THE PGI STORY

Identify the PGIs listed below. Organize each topic into the correct box to develop a story for that patient. Be prepared to discuss the rationale behind your pairings.

Choice Bank

Morbid Obesity Improved Nutrition Improved Blood Sugar Control Achieve Weight Loss

Assist in Activity/Exercise Planing High Blood Sugar Review Available Patient Benefits

Tobacco Use Dietitian Referral Provide Education and Materials Quit Smoking

Sleep Apnea

Story 1:

Problem	Goal	Intervention

Story 2:

Problem	Goal	Intervention

Story 3:

Problem	Goal	Intervention

ADDING PROBLEMS

A Problem is a physical, psychological, financial, or environmental obstacle that prevents the patient from reaching an optimal health status. Problems can be identified by a patient, his/her provider, and/or a member of the care advising staff. Problems can also be identified by the logic of Identifi Care based on responses to assessment questions or when potential gaps in the standards of care are uncovered.

Adding Problems

Adding Problems in PGIs can be done in two ways:

1. Auto-generated from the submitted Assessment
2. Manual entry

With a new patient, some Problems may be auto-generated based on the patient's responses to the Assessment questions. You always have the option to add Problems manually that were not auto-generated, or that you identify at a later time after the Assessment has already been submitted.

There are three categories of Problems that are manually entered:

1. Care manager Identified: May be identified by the Care Managing team, the patient or the provider. Examples include unhealthy behaviors, barriers, self-management difficulties or limitations, and inadequate environments or support.
2. Condition: Medical conditions or diagnoses.
3. Gaps in Care: Are identified when there is a discrepancy between the standard best practices of medical care and the care that the patient receives. Often this information is identified when a medical and/or pharmacy claim is not received for care that should have been provided. These are not included in the Assessment and need to be manually added.

ADDING GOALS

A Goal is an outcome that the patient is working to achieve, or what we as the Care Advising team is working to achieve to support and assist the patient.
The patient's own Goals are important, and therefore worthy of investing time and resources to improve.

Adding Goals

Program Goals are:

1. Auto-generated when the Program Status is updated to Enrolled or Engaged.
2. Manually added as Patient Preference, Clinical Guidelines, and/or Gap in Care Goals.

Program Graduation Goals are used to assess whether the patient has met the standards of the program and are ready to graduate. Program Graduation Goals can help guide us to make sure we are consistently addressing the standards with all patients who are in a program. The outcome of the Goal can be captured when the Goal is closed by entering the Goal Closure Reason. When a Goal is auto-generated, the Goal Status will default to Pending. When a Goal is added manually, the Goal Status will default to In Progress.

When a Goal is put In Progress, any appropriate barriers will also be addressed.

The three other types of Goals that are manually entered are:

1. Patient Preference Goals- Encompass areas such as lifestyle, quality of life, support, healthy relationships, barrier management, and treatment. This is where you will find Goals to support the patient in making lifestyle changes, symptom management, communication improvement with health care team, and/or address knowledge gaps related condition or treatment plan. Patient Preference Goals often represent a Goal that the patient has identified.
2. Clinical Guidelines Goals- Evidence-based clinical guidelines that are recommended for each individual condition. When a patient is dealing with a condition that is not well-managed, the Clinical Guideline Goals will help the care manager identify which areas need to be addressed with the patient.
3. Gaps in Care Goals- Once a Gap in Care Problem is identified, there is a correlating Gap in Care Goal which focuses on addressing the gap.

ADDING INTERVENTIONS

Interventions are the steps taken to work toward achieving the Goal(s). These steps can be taken by the patient or a member of the Care Advising team. It may take a combination of several Interventions, completed over time by several people, to achieve a Goal. A SMART Goal is a self-management technique. It is the act of setting specific, measurable, action-oriented, realistic, and time-bound short-term Goals. In Identifi, SMART Goals are used as Interventions.

Adding Interventions

1. Interventions are steps taken by the patient or Care Advising team to help the patient achieve Goals. While Goals usually take weeks or months to achieve, Interventions are often completed in day(s) to week(s), and it may take several Interventions to achieve one Goal. As a result, Goals, and Interventions are connected. Once a Goal is marked In Progress, Interventions can be used to document the activities the patient and/or the care team is working on.

CLOSING PROBLEMS, GOALS, AND INTERVENTIONS

Closing Problems

Some Problems may be resolved, then closed. Follow the same process used to edit the Problems by clicking the blue actions button and selecting close problem. Change the status to closed and select the reason. Document in comments what the resolution was, then save. Once a problem is closed, you will no longer be able to add additional documentation to that Problem. If needed, the Problem can be added again. Another example of closing a Problem is when a Gap in Care Problem has been addressed.

Closing Goals/Interventions

Close Goals/Interventions as they are completed. Interventions may be added and/or closed all within the same interaction. An Intervention may also require follow-up on and closed at a later time.

To close a Goal/Intervention:

1. Add any comments using the Edit button.
5. Click the blue Actions button of the Goal/Intervention being closed and select Close Intervention or Close Goal.
6. Select the most appropriate close reason from the list of drop downs.
7. Ensure Pending Goals are closed (these Goals will need to be marked In Progress and then closed).
8. Once a Goal/Intervention is closed, edits can no longer be made.

MED REC AND CARE PLAN

Medication Reconciliation

The ability to reconcile the patient's medications in Identifi is an important function. Accurate documentation of the patient's current medications is a critical step in patient care.

The benefits of completing a Medication Reconciliation (Med Rec) in Identifi include:

1. Ensures that accurate medications are added to the Care Plan.
5. Ensures that accurate analysis and evaluation of the patient's medications can be performed.
6. Ensures that accurate alerts related to drug-drug interactions, duplicate therapy, and other medication issues are identified.

For every program, a Med Rec must be completed before generating the initial Care Plan. When there are medication changes, a Med Rec must be completed before generating a subsequent Care Plan(s) to ensure the correct medications are listed.

Care Plan

Now that we have learned how to add, update and close Problems, Goals, and Interventions, let's look at how these sections help us to build the Care Plan. The Care Plan section of the PGI page is on the bottom. Before generating the Care Plan, a Med Rec must be completed.

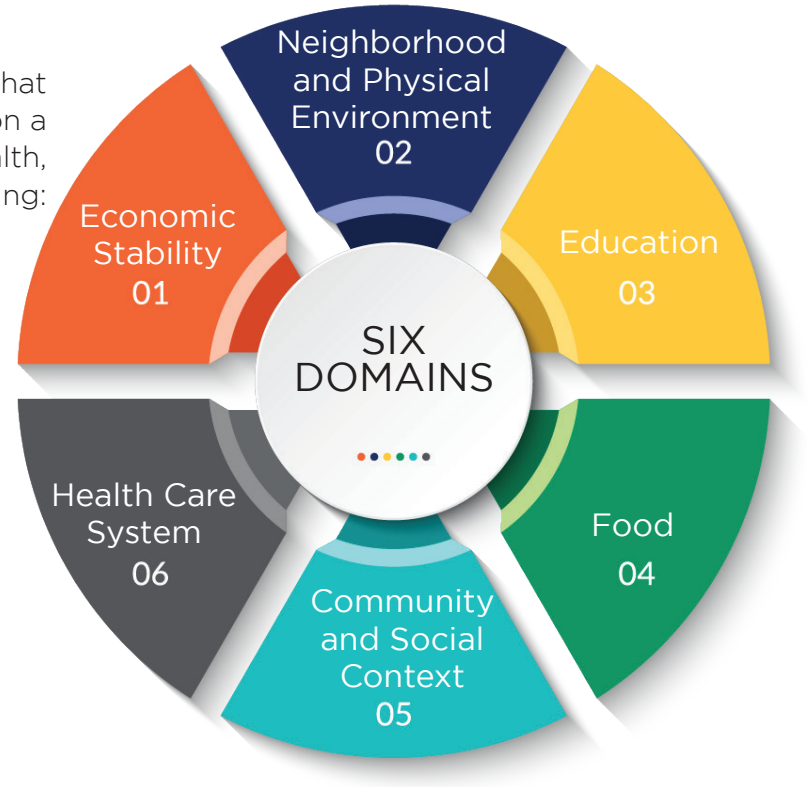
SOCIAL DETERMINANTS OF HEALTH (SDoH) AND HEALTH LITERACY

During this module, we will define Social Determinants of Health (SDoH), explore how to screen for SDoH, review Interventions designed to overcome barriers, and discuss how health literacy can play a part in self-management support.

SOCIAL DETERMINANTS OF HEALTH (SDoH)

According to the World Health Organization, social determinants of health are the conditions in which people are born, grow, live, work, and age. These conditions, along with the quality and accessibility to health care, affect a wide range of health, functioning, and quality of life outcomes and risks. Addressing social determinants of health and disparities is important to help people achieve their best quality of life.

There are six domains that have an impact on a person's health, including:



Making SDOH Real	
Have you or someone you know:	Check If Yes
Been evicted or have been unable to pay the rent?	
Had a violent crime happen in the neighborhood?	
Ever wished for a higher educational degree?	
Worried about not eating healthy?	
Verbalized concern about not going to his/her provider when he/she should?	
Had a bad day in the past month?	

One way to positively impact the population and address these domains is by screening for and addressing unmet health-related social needs such as:

- **Housing instability**

  can occur when someone doesn't have a stable place to live, has a place but is concerned about losing it, or the environment they live in poses a safety concern. Examples of safety concerns may include infestation, lead exposure, mold, inadequate heating or cooling, etc.

- **Food insecurity**

  can occur when someone is concerned about or has run out of food before they could afford to buy more.

- **Transportation problems**

  may prevent a person from attending medical appointments or getting the things they need for daily living. It can also impact their ability to work, go to school, or attend meetings.

- **Utility help**

  may be needed if a person has had their electric, gas, oil, or water shut off or threatened to be shut off in the last year.

- **Financial strain**

  can have a wide impact on other areas and result in a person's difficulty or inability to afford basic needs such as food, housing, and medical care.

- **Employment**

  can provide the income, benefits, and stability necessary to support good health. Unemployment and underemployment are associated with a variety of negative health effects.

- **Family and community support**

  may be needed to meet both physical and emotional needs of an individual. Some people may need help with day-to-day activities like bathing, dressing, preparing meals, shopping, taking medications, and paying bills. It is also important to have adequate emotional support, so they don't feel isolated or lonely.

Education

plays an important role in health. The more educated person typically will experience a lower rate of unemployment, which is associated with worse health. Low education levels are linked with poor health, more stress, and lower self-confidence. Early education is important because it sets the foundation for a healthy life. In addition, language barriers can increase the risk of miscommunication and impact health literacy.

Physical activity

has positive health benefits and lowers the risk of developing many health conditions. Sedentary behaviors can be the result of a lack of understanding of the benefits, the inability to access public green areas or a safe place to walk or play, or cultural beliefs that impact a person's preferences and practices.

Substance use

can involve the use of illegal drugs, inappropriate use of prescribed pain medications, use of tobacco products, or overuse/abuse of alcohol. It can result in interpersonal relationship issues, financial problems, domestic violence, child abuse, failure in school, loss of employment, or legal issues. It can also contribute to negative health outcomes.

Mental Health

conditions can have a negative impact on a person's health, ability to maintain employment, perform necessary day-to-day activities, or follow their medical treatment plan. There is also a higher prevalence of substance abuse among people with mental health conditions, which can result in unstable housing and financial strain. In addition to the impact, mental health conditions can have on an individual, there can be disparities that impact access to appropriate mental health care based on income, education, occupation, race, and ethnicity. This results in poorer outcomes.

Disabilities

can impact a person's employment and financial status. There can be factors that impact their ability to care for themselves, resulting in inadequate caregiver resources or at times, caregiver strain. A disability can also impact a person's overall health and well-being, both physically and mentally.

BARRIERS TO SELF-MANAGEMENT

When assisting patients, you will discover a variety of approaches may be effective and are dependent upon the patient's unique needs, ability and perspective. Some universally effective approaches include but are not limited to, self-management and behavior change strategies, setting Goals and implementing Interventions to resolve barriers, understanding the patient's concerns, and gauging his/her level of confidence.

Some patients needs may require multiple strategies and resources.

Example: A patient with needs regarding transportation to appointments and community resources, shopping, meal preparation, and bathing.

Use the space provided below to list resources and support the patient can seek.

_____

_____

_____

Social determinants have a significant impact on health outcomes. Focusing not only on the medical conditions but on the social conditions can help us work with patient on how they choose the way they want to live and age! Focus patient questions towards "what matters to you?" not "what is the matter with you?" Some social conditions may have a larger impact on quality of life and healthcare spending than a patient's health condition(s), some examples include:

1:

If a patient is being evicted from his/her home, he or she will most likely be more concerned about finding housing instead of following a diabetes treatment plan (diet, exercise, appointments,etc.).

2:

If a patient is struggling financially, he or she may be less likely to make it to his/her provider appointments due to lack of money to pay for transportation.

3:

Those patients who have low health literacy, embarrassment, and/or shame may not be able to understand pertinent medical information such as medication dosages, possibly resulting in more frequent and unnecessary ED visits/hospitalizations.

4:

Loneliness and the stigma of lack of social support can have a significant impact on a patient's mental and physical quality of life, making it difficult to adhere to his/her medication regimen and keeping provider appointments.

HEALTH LITERACY

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic information needed to make appropriate health decisions (U.S. Dept. of Human Resources, Healthy People 2010).
Even though low health literacy is more prevalent among older adults, minority populations, those with lower socioeconomic status, and the medically under-served, it can also present challenges for those with strong literacy skills. You cannot tell a person's literacy level just by looking at them. Higher literacy doesn't guarantee understanding. Other factors can affect one's health literacy. Anxiety may reduce a person's ability to understand health information as well.

The following behaviors may suggest a person has low health literacy:

Low health literacy

- Frequently missed appointments
- Incomplete registration forms
- Unable to navigate the healthcare system
- Unable to give coherent, sequential history
- Asks fewer questions
- Lack of follow-through on tests or referrals

When working with the patient, it is important to focus on what they need to know and need to do.
The following strategies can be used with the patient:
Use simple words and short sentences.
Avoid medical jargon.
Limit information to 3-5 key points.
Be specific and concrete, not general.
Demonstrate, draw pictures, use models.
Repeat and summarize what was discussed.
Use Teach-Back to confirm understanding.
Use a medical interpreter through Language Services Associates, when needed.
Supplement with educational resources.

FOR MORE INFORMATION

Please review the Quick Guide to Health Literacy: Fact Sheets, Strategies and Resources (U.S. Department of Health and Human Services) on Mobius

https,//evolenthealth.sharepoint,com/sites/ClinicalOperations/careadvising/Care%20 Management/Forms/AllItem,.aspx

SELF-MANAGEMENT SUPPORT

During this module, we will review the concepts of Self-Management and Self-Management Support, discuss the Stages of Change, explore the salient belief question, and review how to use SMART Goals.

WHAT IS SELF-MANAGEMENT SUPPORT

Patients may only meet some of their Health Goals while in your care. As a care manager, it is your goal to help the patient gain the skills and knowledge needed to self-manage their health. When we provide Self-Management Support (SMS), we help build the patient's skill and confidence in managing his/her health problems through:

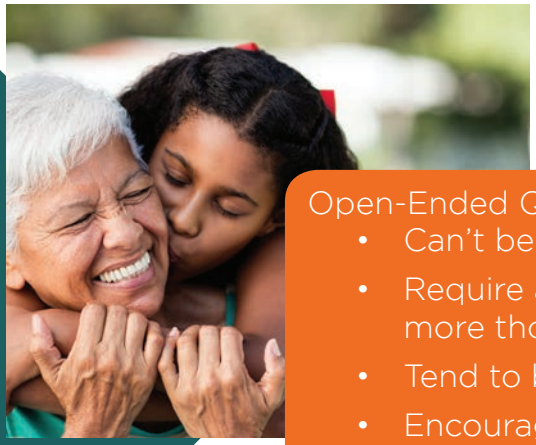
- Regular assessment of progress and problems
- Setting SMART Goals
- Problem-solving support

Self-Management
The patient self-manages

Self-Management Support
Care managers provide patients Self-Management Support

The Patient Journey to Self-Management

As a care team member, you will need to use all of the skills reviewed with the patient throughout their journey to ensure engagement and continued progress towards self-management. Remember the patient journey will progress in the order shown below, however, the patient's stage of change may vary while he/she is in your care. You will need to change your communication style and use various engagement techniques throughout the patient's journey towards effective self-management.



OPEN-ENDED QUESTIONS

Open-Ended Questions:

- Can't be answered with one word or a yes or no
- Require a more in-depth response, and therefore more thought to answer
- Tend to be more objective and less leading
- Encourage the person who is being asked the question to take control of the conversation
- Get the person who was asked the question to talk
- Elicit sharing of opinions and feelings instead of just facts
- May actually be statements instead of questions

Write three open-ended questions.

1. _____

2. _____

3. _____

SALIENT BELIEF

A Salient Belief is the subjective knowledge and feelings that influence a person's perception of an object or situation. Using this technique, you are able to elicit the patient's beliefs and truths about the situation.

Salient Belief Questions

Care Team	"When you think about diabetes, what comes to mind?" "When your provider told you that you (or your loved one) might need surgery, what did you think?" "What does it mean to you that you have been prescribed additional medications?"

We can evaluate a patient's knowledge, understanding, and emotions surrounding things such as:

- Condition or diagnosis
- Current or upcoming situation or event
- Actions or tasks the patient may be facing

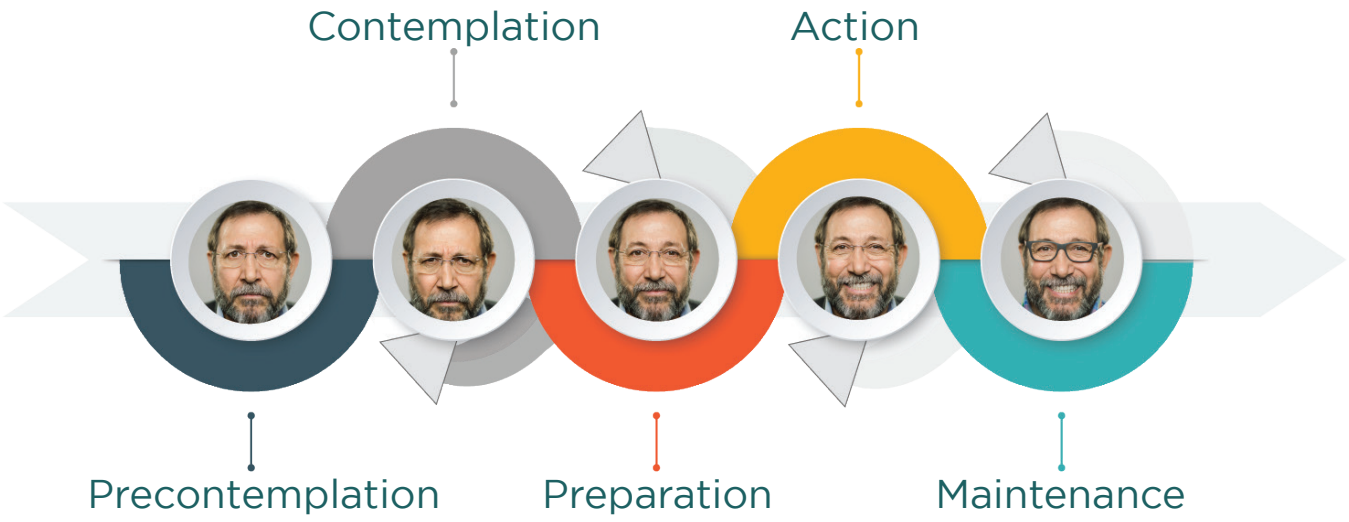
Teachable Moment

Using the patient's response, expand on those beliefs by offering alternative viewpoints. Expand his/her awareness of other outcomes/results.

Care Team	"It sounds like you are worried that you (or your loved one) might lose your vision, like your father did. That certainly is a possibility, but did you know there are things you can do to help prevent vision loss? Would you mind if I told you about a few things that could make that less likely to happen?"

TRANSTHEORETICAL MODEL OF STAGES OF CHANGE

Transtheoretical Model (TTM): Stages of Change (Prochaska and DiClemente) - The TTM proposes that health behavior change involves progress through five stages of change: precontemplation, contemplation, preparation, action, and maintenance. Research demonstrates that tailoring our outreach and intervention to the patient's current stage increases the chances of engaging and leading to positive outcomes.



According to the TTMs Stages of Change concept, behavior change is neither linear nor a single event. An patient moves back and forth through a series of stages when modifying health behavior. The time an patient stays within a stage varies, depending on individual circumstances, however, the tasks required to move to the next stage are not variable. Research has shown that certain principles and processes of change work best within each stage to reduce reluctance, facilitate progress, and minimize recycling to earlier stages. We will look at the characteristics of each stage as well as the skills and strategies which can be used to support a patient's self-management within each stage.

PRECONTEMPLATION

People in the Precontemplation Stage do not intend to take any action in the foreseeable future (usually 6 or more months). Being uninformed or under-informed about the consequences of his or her behavior often causes them to be in the Precontemplation Stage. Multiple unsuccessful attempts at making change can lead to demoralization about his or her ability to successfully make change. Precontemplation is often characterized in other theories as resistant, unmotivated, or not ready for help.

Characteristics

- Not thinking about changing a particular behavior.
- Seeming discouraged or resigned to the status quo.
- Discounting negative consequences of the status quo.
- Expressing lack of control over circumstances.
- Minimizing the relevance of the behavior or changing it.
- Discounting the benefits of change.
- Not interested in discussing the behavior or changing it.

Goals

- Enhance our ability to understand the patient's perspectives about current benefits of his/her behavior and awareness of the possible benefits of change.
- Help the patient begin thinking about the behavior
- Support a conversation around what the patient sees as possible downsides to the status quo and possible positives to change.
- Begin to explore the patient's reluctance to change including any underlying emotions that support the status quo.
- Begin to build a mutually-trusting relationship as a partner and ally in the patient change process.

What Doesn't Help

- Telling the patient that they need to change
- Telling the patient how to change
- Warning the patient of the consequences of the status quo
- Advocating for the benefits of change
- Narrowing the patient's sense of choice and control

What Does Help

- Showing interest and curiosity about the patient's perspective
- Showing the patient we are listening and understanding
- Normalizing reluctance about change
- Supporting the patient's autonomy to decide what's best.
- Keeping the conversation door open
- Supporting the patient to consider general information about the behavior and possible options for change

Key Explorations

- Have you tried to change this behavior in the past?
- What warning signs would tell you it's time to make a change?
- What would your life look like if you did make this change?
- Why do you think your provider wants you to quit smoking?
- How does your spouse feel when you won't take your medications?

CONTEMPLATION

Contemplation is the stage in which people intend to change in the next 6 months. They are more aware of the pros of changing, but are also acutely aware of the cons. In a meta-analysis across 48 health risk behaviors, the pros and cons of changing were equal (Hall and Rossi, 2008). This weighing between the costs and benefits of change can produce profound ambivalence, causing people to remain in this stage for long periods of time. This phenomenon is often characterized as chronic contemplation or behavioral procrastination. Individuals in the Contemplation stage are not ready to act immediately.

Characteristics

- Expressing concern about the behavior and its downsides.
- Expressing insight into possible benefits of change.
- Both reluctant to, as well as interested in, possible change: expressing ambivalence.
- Juggling many priorities in the patient's thought processes, as well as with the potential change.
- Wishful thinking: to go on living as usual with different outcomes.
- Looking for the right time to make a change.

Goals

- Explore the patient's insights about the downsides and benefits of change
- Show that we are listening and understanding the patient's perspective.
- Help the patient enhance a sense of importance and confidence about the possible change.
- Explore the patient's reasons for change
- Explore the strengths and capacities the patient has that would support his/her change.

What Doesn't Help

- Advocating for change
- Telling the patient that they must change and/or how they must change
- Narrowing the patient's sense of choice and control

What Does Help

- Showing interest and curiosity about the patient's perspective
- Showing the patient we are listening and understanding
- Normalizing reluctance about change
- Supporting the patient's autonomy to decide what's best
- Keeping the conversation door open
- Supporting the patient to consider general information about the behavior and possible options for change

Key Explorations

- If you were to make a change, how might you do it?
- What do you think will happen if you don't make this change?
- When you quit smoking in the past, what worked well for you?
- What makes you want to change?

PREPARATION

Preparation is the stage in which people intend to take action in the immediate future, usually measured as the next month. Typically, they have already taken some significant action in the past year. These individuals have a plan of action, such as joining a gym, consulting a counselor, talking to their provider, or relying on a self-change approach.

Characteristics

- Intending to make a change in the near future.
- Identifying a start date.
- Developing and solidifying ideas about how to start.
- Envisioning change.
- Experimenting with small steps.
- Decreasing interest in the status quo
- Looking ahead to the future and benefits of change
- Starting to tell others about the change and plans they have for it
- Underlying reluctance or apprehension about the change process

Goals

- Exploring a patient's change decisions and commitments
- Helping the patient come up with his/her own why, can, what, where and how about change
- Helping the patient enhance importance, confidence and readiness for change
- Helping the patient come up with their own "if-then" plans and back-up plan

What Doesn't Help

- Taking over or prescribing the plan for the patient

What Does Help

- Remaining curious and interested in patient's change process
- Exploring patient's plans specifically and concretely to enhance his/her process
- Understanding and normalizing that the preparation process can be difficult

Key Explorations

- What is the significance of the start date you selected?
- Tell me about your plan for change?
- How have important people in your life been supporting your work?
- Describe your "plan B" if things don't quite work out the way you have envisioned?
- Are there additional barriers to your plan that you have encountered?

ACTION

Action is the stage in which people have made specific and overt lifestyle modifications within the past 6 months. The overall behavior change process can be equated with an activity or action because many of the behaviors are observable. However, in the TTM, Action is used as a specific descriptor for the 4th stage.

Characteristics

- Taking steps to put the change in motion
- Following through with a change plan
- Vulnerable to familiar status quo behaviors, falling back into old habits

Goals

- Supporting the patient in recognizing his/her successes and ideas for building on them
- Supporting the patient in considering possible barriers or challenges to their change.
- Supporting the patient in considering ways to overcome obstacles
- Supporting the patient in identifying re-start opportunities if he or she encounter challenges or lapses

What Doesn't Help

- Taking over or prescribing the plan or solutions to challenges

What Does Help

- Showing the patient we understand his/her perspective
- Validating and affirming the efforts the patient is making
- Helping the patient consider his/her own challenges and solutions

Key Explorations

- What benefits have you noticed already?
- What have you done that has helped you succeed to this point?
- How will you keep going with this change process?
- How will important people in your life support you in this process?
- What challenges can you foresee and how will you address them?
- What will this change allow you?
- If you encounter an obstacle or fall into old habits, how will you restart or reset your change?

MAINTENANCE

Maintenance is the stage in which people make specific and overt modifications in their lifestyles and are working to prevent relapse. However, they do not apply change processes as frequently as people in Action. People are less tempted to relapse and grow increasingly more confident that they can continue their changes while in this stage. Based on self-efficacy data, researchers have estimated that Maintenance lasts from 6 months to about 5 years before the potential for a possible relapse.

Characteristics

- Keeping up with actions for change
- Change begins to seem solidified
- Decreasing interest in change
- Discounting progress made or the difficulty of having made progress
- Underestimating the ability to withstand temptations
- Taking small breaks from the change
- Looking beyond the immediate change to possibilities for other behavior changes
- Enjoying the benefits of efforts already made

Goals

- Supporting the patient's exploration of temptations for old behaviors and solutions to overcome
- Partnering with the patient to identify steps to solidify support for maintenance
- Helping the patient identify new change opportunities

What Doesn't Help

- Taking over the patient's change processes

What Does Help

- Continuing to support and encourage the patient for positive self-management
- Ensuring that all potential barriers to achievement are addressed

Key Explorations

- What can help you keep this change going?
- What else would you like to work on together?
- What can you now do as a result of all of your hard work?
- How have your values been supported by all of your hard work?
- What would you do if you felt tempted to go back to old habits?

INITIAL CALL

Taking one deep breath before initiating a call is vital. Seriously, one deep breath. Before every call. This reduces our stress level and allows us to sound interested and engaged, rather than urgent or pressuring. An patient responds warily to perceived pressure, particularly when they are sorting their own reactions and ideas about program participation, and are more likely to close a door to get away from the pressure, even if they might actually be interested in keeping it open.

Take a deep breath. → Establish a clear and relaxed state of mind. → Make initial call.

Telephone Etiquette

Health Information Portability and Accountability Act (HIPAA) guidelines are a necessary component of telephonic interactions with an patient and the care team. At the beginning of the call, you must confirm that you are speaking with the correct person, this is achieved by verifying their date of birth, and their address.

Incoming Calls

- To confirm you are speaking with the patient, ask them to provide his/her date of birth and address for verification.
- If the patient requests that you speak with someone else, you must document that in a Care Note utilizing the Care Coordination Template with each call until a Personal Representative Designation Form (PRDF) is on file.
- If no one answers the phone and you need to leave a voicemail message, only share your name and that you are a CA and request a call back from the patient at his/her earliest convenience.
- If you are speaking with anyone other than the patient, and the patient is not available, only share your name and that you are a CA and request a call back by the patient at his/her earliest convenience.

Outgoing Calls

- To confirm you are speaking with the patient, ask him/her to verify his/her date of birth and address to you for verification.
- If the patient requests that you speak with someone else, you must document that in a Care Note.
- If someone other than the patient calls, and there is a PRDF on file, you can continue the call as if you were speaking to the patient.
- If someone other than the patient calls, and there is no PRDF on file, notify the caller of the need for the patient's permission to speak to them and request a call from the patient.

INITIAL CALLS

Read the Initial Calls talking points below. Pick a partner and take turns holding mock initial phone calls. Each person should play the role of the patient and the CA doing the initial outreach.

- My name is< staff first +last name>, and I am a care manager who lives in your area, working with your provider.
- This call may be recorded for quality and training purposes.
- I am contacting you to offer assistance with any health questions or problems you may have.
- To ensure your privacy, can you please provide your birth date and address? (Incoming Call)
- To ensure your privacy, can I please verify your birth date and address? (Outbound Call)
    - In the event that a patient would like a family member or caregiver to speak on their behalf, the following message should be relayed to the patient.
    - Your privacy is important to us. I am going to send you a form that will allow me to speak with someone else on your behalf. Once you return the completed, signed, and dated form, I will be able to speak with your representative without obtaining your verbal permission. Until I receive the form, I will need your verbal permission each time.
- As a care manager, working with your provider, my services are a benefit of your health coverage and there is no cost to you. I can:
    - Assist you with problems you may be having with food or housing
    - Assist you with scheduling medical appointments
    - Assist you with medical transportation needs
    - Work with you to develop and achieve your Healthcare Goals

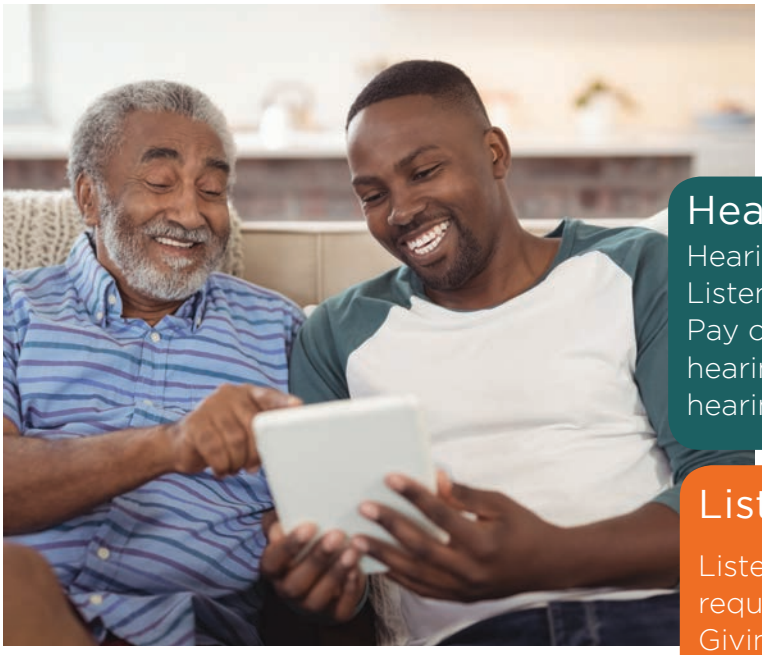
Take a moment and practice writing your own introduction talking points.

ONGOING CALLS

Self-Management Support calls are the ongoing follow-up calls scheduled with the patient. They are scheduled per the program guidelines. Working collaboratively, Goals and Interventions are developed to resolve identified Problems while the patient is working towards self-management.

Below are some talking points to assist with the ongoing clinical session.

- Hello, XXX, this is (staff name and credentials/title). Before we get started, I want to remind you that this call may be recorded for quality and training purposes.
- To ensure your privacy, can you please provide your birth date and address? (Incoming Call)
- To ensure your privacy, can I please verify your birth date and address? (Outbound Call)
- On our last call, you stated you would like to talk about XXX and follow-up on progress/accomplishments of XXX.
    - It is suggested staff set a date/time for the call.
- Have there been any new concerns, or condition/situation changes?
- Is it all right if I update you on what I have been doing for you since the last time we spoke?
- What Goals/Interventions would you like to work on?
- You mentioned you would like to work on XXX, let's review the steps you feel would help you accomplish this Goal (SMART Goal Intervention).
- Let's review your accomplishments or challenges.
- Before we end this call, I would like to review our discussion today and plans for the next call.
    - It is suggested staff set a date/time for the call.
- For your follow up call, is XXX at XXX a good time to call? Great! I look forward to talking with you on XXX at XXX.



ACTIVE LISTENING

Hearing

Hearing is the act of perceiving sound. Listening is to give attention with the ear. Pay close attention for the purpose of hearing. In the absence of impairment, hearing just happens.

Listening

Listening, and especially active listening, requires effort, discipline, and practice. Giving full attention to someone doesn't just happen.

What characteristics describe active listening for meaning?

- Fully concentrating on what is being said
- Giving full attention to the speaker
- Responding in a way that encourages the speaker to continue
- "Listening" with other senses for non-verbal messages
- Listener is seen to be listening
- Listener demonstrates interest by providing encouragement

Active Listening Skills

Active listening is a great way to engage your patient and show you are paying attention. There are verbal and non-verbal indicators that can show the patient you are listening. Below document some verbal and non-verbal indicators you can use to show your patient you are listening.

Verbal Indicators	Non-verbal Indicators
_____	_____
_____	_____
_____	_____

SMART GOALS

Setting SMART Goals can help a patient clarify ideas, focus their efforts, use their time and resources productively, and increase their chances of achieving what they want in life.

Specific	The action must be explicit and detailed.
Measurable	How much are they going to do?
Action-oriented	What are they going to do?
Realistic	When or how often are they going to do it?
Time Bound	For how long are they going to do it?

Physical Activity SMART Goal

I will _____ (what) _____ (when/how often)

_____ (how long)

Medication Adherence SMART Goal

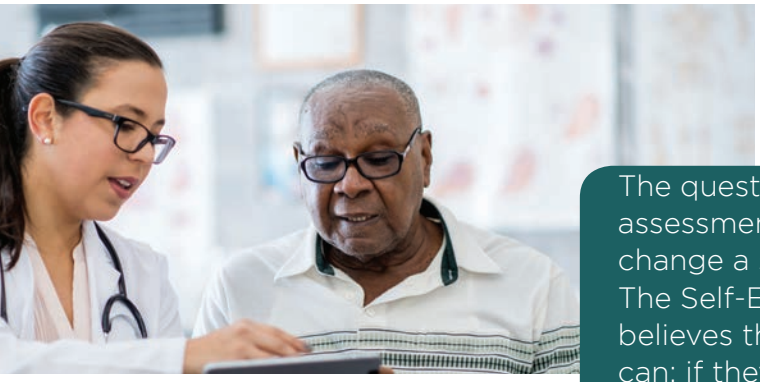
I will _____ (what) _____ (when/how often)

_____ (how long)

Healthy Eating SMART Goal

I will _____ (what) _____ (when/how often)

_____ (how long)



CONFIDENCE RULER

The question of confidence provides a quick assessment of a patient's current motivation to change a specific behavior.
The Self-Efficacy Theory states that if someone believes they can do something, they probably can; if they do not believe they can do something, they probably can't. The use of the Confidence Ruler quickly assesses a patient's current motivation to change a specific behavior and determine how confident or ready the patient is to make the change. Use the Confidence Ruler to assess only one specific activity at a time.

On a scale of 1-10, how likely are you to make the change?

1 2 3 4 5 6

When a patient has a confidence level of 6 or less, it gives you the opportunity to dig a bit deeper by asking the follow-up questions.

7 8 9 10

If the patient tells you his/her confidence level for a specific Goal is a 7 or higher, he or she have a good chance of being successful with that Goal.

Confidence Follow-Up Questions

Based on your patient's response it will be important to follow-up with them. Below are types of follow-up questions you may want to ask.

What makes you a 2 and not a 1?"

"What do you think it would take to move you to a 7?"

"A 7 is pretty good! Let's try it for a week, and when we talk next time, I will ask how it went!"

ENGAGEMENT SKILLS

Agenda Setting

You should always set the agenda each time you speak with the patient, regardless of where they are in the process of change.

Care Team	"We only have 20 minutes to talk today, and I want to be sure that we make time for the things you are concerned about. How about we start with checking in on how the week was, and then spend some time preparing for your upcoming provider's appointment? I will try to leave about 5 minutes at the end to circle back and answer other questions you may have. Does that sound okay?"

Reflecting Statements

Reflect back to the patient what you heard them say so that they are encouraged to continue.

Patient	"We can talk, but I don't know if anything will make a difference."
Care Team	"You don't know if anything will make a difference?" (Repeat) "You're willing to talk?" (Repeat) "You're not sure if it's worth trying?" (Rephrase)

Affirming-Validating-Normalizing Statements

When we recognize and acknowledge emotions, an patient feels heard, understood, and are more willing to collaborate with care team members.

Patient	"I've tried so many different diets and it's discouraging."
Care Team	"You're persistent when something is important to you." (Affirming) "It makes sense to be discouraged when you haven't gotten the results you've wanted yet." (Validating) "I know a lot of patients who also express frustration around this." (Normalizing)

Open Inquiry

Replying to a patient with open-ended questions can help them to expand on his/her thoughts and ideas.

Patient	"I am just not sure I am doing what I should be doing."
Care Team	"In what ways are you already making changes?" "What are some things you have been doing this week toward your Goal?" "What are the good things that might happen if you were to...?

ENGAGEMENT SKILLS

Providing Information: Ask-Provide-Ask

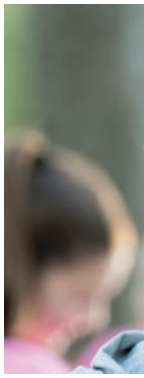
We have a wealth of expertise and information that we hope to share with our patient and caregivers. It is important to be mindful of how we provide this information to ensure that they hear us.

When the patient asks for advice or assistance:	Patient: "I have tried so many different diets, it's all so discouraging. What else can I do?" You can say: "This is pretty important to you, given how much effort you've put in, I can see you'd like some more ideas. Tell me what you've already tried and I can offer you some additional ideas. Together we can sort out a good next step. You'd know best what that would be."
When the patient is struggling:	You can say: "I hear you struggling with this. I've got some ideas I can offer if you'd like, but first I'd like to know what you've tried already." Patient: "I've tried different diets and none of them have worked." You can say: "You've given this a lot of effort. If you'd like, I can share a couple of options that have worked for others and you can tell me what you think might be helpful." Patient: "OK" You can say: "Some patients try different eating plans, some incorporate physical activity, and some try incorporating a medication at the start of the diet. What do you think would work for you? Patient: "Well, I'm not much for medication, but I could see moving around a little while trying to change the way I eat."
When you would like to offer information:	You can state: "May I send you some information about 'XXX' and we can talk about it after you've had a chance to look it over? Many patients have found the ideas helpful, and you can tell me what suits you best."

Rolling With Resistance

Recognize and validate ambivalence. Roll with resistance, rather than opposing it:

Care Team	"It may be true that you decide it's too difficult to make a change right now. That is up to you."



Providing Information: Asking Permission

Care Team	"What do you think might work for you?" "Would it be OK if we talk about your diabetes?" "I'd like to explore your diet if that's OK with you."

Emphasizing Autonomy

Care Team	"There are a number of health topics we could explore today, what are some of the things on your list? We could start with one of your choosing." "Sometimes patients like to explore topics such as diet, exercise, and medications. One of those might be among your priorities or perhaps there's something else more pressing for you right now." "Over time, we'll need to explore diet, exercise, and medications. We can come back to those things another day if you'd like, as you might have a different priority right now."

Summarizing Statements

Care Team	"You've already mentioned several reasons to cut back on smoking, such as saving money, feeling better, breathing easier, and enjoying the taste of food."
Care Team	"Earlier, you talked about a number of strengths such as persistence, willpower, and determination that have allowed you to increase your level of physical activity. I hear those coming up again in the context of changing your diet."

Reducing Discord

Care Team	"I'm sorry I started offering you ideas I thought would work without first asking you what you know and would be interested in trying." "I see you have a lot of capacities already in this area, let's explore how you'd see those being helpful to you." "You're right, no one could make this decision for you, and it really is up to you." "I realize you have some reluctance here and you'd like to give it a bit more thought."

SKILLS PRACTICE

Let's practice using some of the Self-Management skills we have used thus far. You will each play the part of the patient and clinician.

Patient: Think of a patient who wanted to make a change

Clinician: As the clinician, engage the patient and discuss the change they are looking to make. Take a few minutes and record some open-ended questions you would like to ask. Focus on using the Self-Management Support skills we discussed.

In the time provided, use as many skills listed below. As each skill is used, check it off.

- ○ Open-Ended Questions
- ○ Reflective Statements
- ○ Affirming-Validating Normalizing Statements
- ○ Open Inquiry
- ○ Asking Permission
- ○ Ask-Provide-Ask
- ○ Emphasizing Autonomy
- ○ Reducing Discord
- ○ Summarizing Statements

EVALUATING SUCCESS

Review the criteria for the Program Graduation Goals listed below and think about ways to ensure your patient's success.

Goal: Patient takes an active role in self-managing condition.

Criteria:

- Patient has taken steps to make appropriate lifestyle changes needed to improve condition (diet, physical activity, tobacco cessation, stress management, etc.).
- Patient has resources/equipment needed for self-care and monitoring of condition
- Patient verbalizes that taking an active role in his/her own health care is one of the most important things he/she can do to improve his/her health.
- Patient verbalizes confidence in ability to follow through on medical treatments he/she may need to do at home.

Goal: Patient is adherent to prescribed medication regimen.

Criteria:

- Patient follows prescribed medication regimen 6-7 days of the week
- Patient teaches back the reasons and side effects of prescribed medications.
- Patient has overcome barriers to medication adherence.

Goal: Patient understands and has a plan for managing symptoms and knows when to contact provider.

Criteria:

- Patient teaches back the symptoms to look out for and the plan for managing those symptoms.
- Patient verbalizes confidence in knowing when to go to the provider and when to take care of a health problem on his/her own.

CASE CLOSURE AND DISCUSSION

Prior to graduating from our Complex, Condition and Catastrophic Care programs, please review the following information with the patient:

Review of patient's accomplishments and health outcomes during program participation:

- Reflect with the patient on his/her health accomplishments and outcomes during program participation i.e., can the patient articulate examples that their overall health and quality of life have improved?
- Review with the patient any concerns and/or questions they may have so that he or she can continue to be successful upon graduation i.e., does he or she need additional education materials and/or referral information?

Patient Experience Survey

Within 24-48 hours after an patient has graduated from the program, they may get a phone call asking them to participate in a patient experience survey. Please share with the an patient that this will be an automated call that will ask them eight questions about his or her experience in being in the program and working with the nurse care manager. At the end of the survey, if they want to speak to a program coordinator ("live person") to share more information about their experience they can be transferred upon request. We want to encourage the patient to take this survey so that we receive honest feedback on his or her experience in working with the care manager and their participation in the Complex/Condition/Catastrophic care program and perceived health outcomes.
*Check with your preceptor/manager to determine whether your market participates in this survey.

"Mrs. XXX, it appears that you have a better understanding of your XXX (health condition(s))."

- "How do you feel?"
- "Do you have any additional questions for me about your XXX (health condition(s))?"

"Was I able to provide you with information you needed to help you manage your XXX (health condition(s))?"

- "Is there anything else I can provide for you so that you continue to be successful in managing your XXX (health condition(s))?"

"Since you have been in the program, it appears that your overall health and quality of life has improved (provide specific examples)."

- "What are your thoughts?"

"Mrs. XXX, I just want to let you know that you may be getting a request to complete a survey. Could you please take the time to complete the survey? This will help us have a better understanding of whether the program helped you/your child/family member in managing you/your child's/family member's XXX (health condition(s)) and how we can do things better in the future."

INTEGRATED HEALTH CARE

During this module, we will discuss and practice the skills necessary to manage the behavioral health needs of our patients by discussing what Integrated Care is, exploring depression, anxiety, suicide, and substance use, and discussing the assessments that help to identify those health needs.

WHAT IS INTEGRATED HEALTH CARE

What is Integrated Care?

- Care coordination and management for both physical and behavioral conditions within one team.
- Proactive monitoring and intervention using clinical rating scales.
- Regular, systematic case reviews and consultation for an patient who do not show improvement over time.

Who is involved in providing integrated care?

- PCP/providers: family provider, internist, nurse practitioner, provider assistant, specialist, psychiatrist, therapist
- Care management staff: RN, clinical social worker , RD, pharmacy, CHW, and outreach specialist
- Patients and their identified support system/caregivers
- Community-based programs/support service

What is Behavioral Health

- Our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices.
- Biological factors/genetics or brain chemistry, life experiences such as trauma or substance use, family history of mental health problems.

Symptoms

Think about a time an patient, family member, or even yourself, experienced a behavioral health issue. What physical and emotional symptoms were present?

_____

_____

_____

Did you know?

Patients working with an integrated care team are 2x more likely to experience improvement in their depression over a 12-month period. They report less physical pain, better social and physical functioning, and improved quality of life.

DEPRESSION

During this module, we will identify the differences between sadness and depression, review the PHQ-9 and how to use it, and discuss how to support patients who are at risk for suicide.

Depression Statistics	True	False
Only 20% of adult patients with BH disorders are seen by a BH Specialist. Many prefer treatment in primary care settings.		
Between 50-75% of older adults prefer psychotherapy to medications.		
Depression is NOT normal: Many older adults/family members believe that it is 'normal' to become depressed with age.		
Sometimes people feel that there is good reason for them to be depressed ("you would be depressed too if..."), and therefore feel that it doesn't need to be treated. Expected mood reactions from life events are normal—but they are temporary/short term and do not persist like depression does.		
We approach managing depression as an integrated TEAM because more patients get better.		

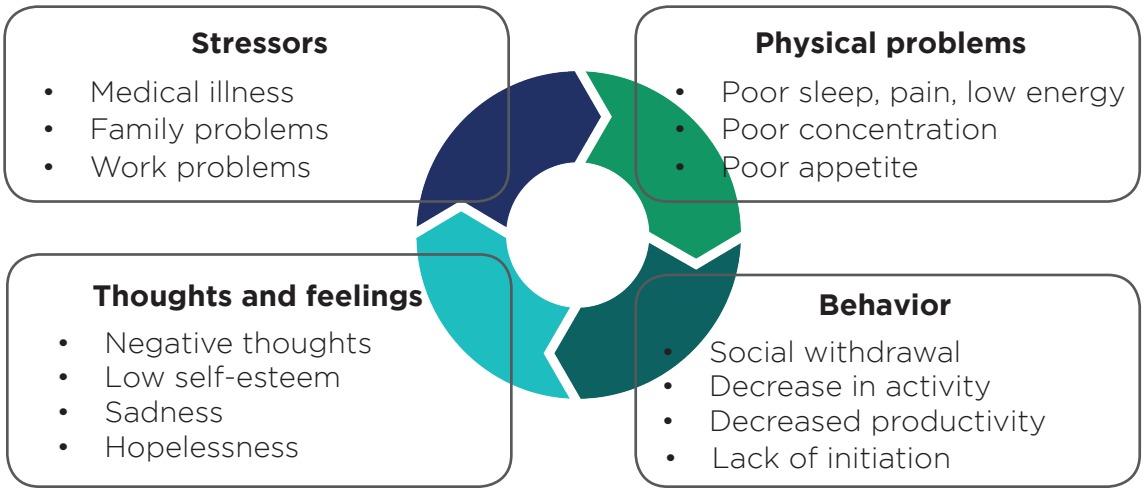
Helpful Facts about Depression

- People with depression may not realize or acknowledge that they're depressed. They might not be aware of the signs and symptoms and may think their feelings are normal or temporary.
- Depression can be severe enough to interfere with one's ability to engage in day-to-day activities (work, school, social activities, relationships with others).
- People may feel ashamed about their depression and believe they should be able to overcome it on their own. But depression rarely improves without treatment and may worsen over time.
- Feelings of sadness or isolation do not go away quickly. They can persist for weeks or months without improvement.
- People with depression often lose interest in areas of life they used to enjoy. They may experience changes in appetite (weight gain or loss) and sleep, feelings of guilt or worthlessness, or have trouble concentrating.
- Depression impacts our physical health- complicating medical conditions, causing increased pain, and lowering motivation to manage our health, stay active and take medications.
- In children, depression is often seen in behaviors such as irritability or anger/acting out.
- Untreated depression can lead to suicidal ideation or someone planning to end his or her life.

DEPRESSION

The Cycle of Depression

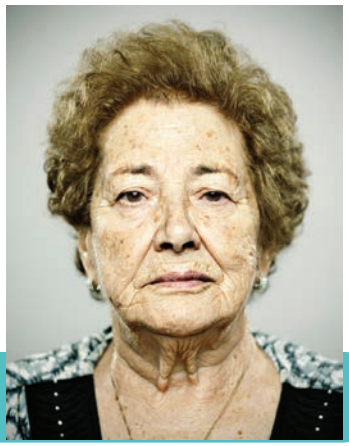
The image below shows the connection between our thoughts, feelings and actions. This model is helpful to share with patients, as they may not realize that the problems they are facing are impacted by how they feel or what they are thinking and/or doing.



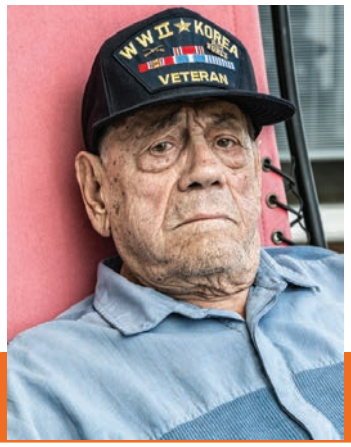
Signs and Symptoms of Depression

- Feelings of sadness, tearfulness, emptiness or hopelessness
- Angry outbursts, irritability or frustration, even over small matters
- Loss of interest or pleasure in most or all normal activities, such as sex, hobbies or sports
- Insomnia or sleeping too much
- Tiredness and lack of energy, so even small tasks take extra effort
- Changes in appetite — reduced appetite and weight loss or increased cravings for food and weight gain
- Anxiety, agitation or restlessness
- Slowed thinking, speaking or body movements
- Feelings of worthlessness or guilt, fixating on past failures or blaming yourself for things that aren't your responsibility
- Trouble concentrating, making decisions and remembering things
- Frequent or recurrent mention of death, suicidal thoughts, suicide attempts or suicide
- Unexplained physical problems, such as back pain or headaches

DEPRESSION



Emma



Cecil

Who is Suffering from Depression?

Develop a profile for one of the patients above. Include genetic and environmental factors that relate to their symptoms of depression.

How do we Screen for Depressive Symptoms?

We use the PHQ-9 to screen for depressive symptoms.

Initial Assessment

You will conduct a PHQ-9 as part of your initial assessment. For individuals ages 11- 17, you will complete the PHQ-A

Ongoing/Reassessment

During the course of care you will complete periodic rescreening to determine stability, worsening or improvement of depression symptoms.

Adults: Using the PHQ-9 for Symptom Monitoring

- The PHQ-9 is a screening tool to track the nine core symptoms of depression over time.
- A response of 3+ on the first two items (PHQ-2) will trigger the remaining questions.
- It is NOT a diagnostic tool. By asking these questions, you are NOT diagnosing an patient.
- The PHQ-9 can be self-administered and can be done in any setting, including over the phone.
- Repeat the PHQ-9 each month with patients scoring 10+ (moderate).
- Track and compare scores over time (trends in previous scores and current score).
- Discuss results with the patient. What is his/her perception of improvement/lack of improvement?
- The PHQ-9 questions must be asked as written and scored as prescribed to maintain the validity and integrity of the tool.

PHQ-9

Using the conditions and profile you wrote for either Emma or Cecil, complete the PHQ-9

Patient Health Questionnaire - 9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
FOR OFFICE CODING	0 +	___ +	___	___

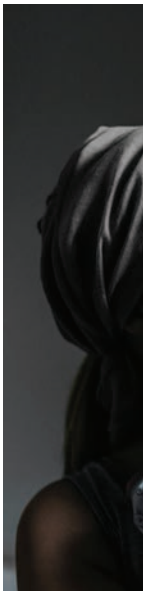
=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

UNDERSTANDING THE PHQ-9 SCORE

Total Score	Depression Severity
5-9	Mild Depression
10-14	Moderate Depression
15-19	Moderately Severe Depression
20-27	Severe Depression



PHQ-9: Using the Score to Guide Intervention

For patients scoring under 10 (Mild Depression):

- Continue to educate and monitor (watchful waiting)
- Provider may prescribe antidepressants
- The patient may be referred to psychotherapy

For patients scoring 10-14 (Moderate Depression):

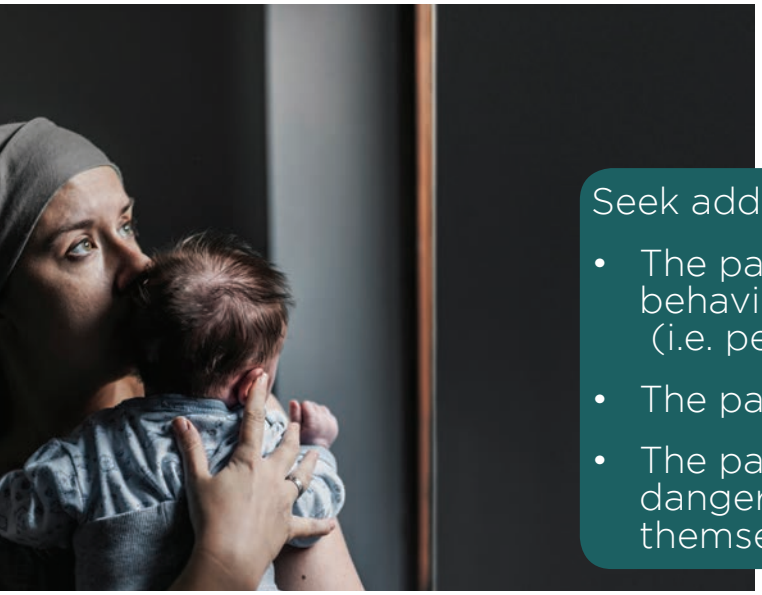
- Short-term Behavioral Activation/Goal Setting
- MI, coaching, and education
- Consultation with/referral to local BH Specialist
- Consider medication and/or Psychotherapy
- Maintenance and relapse prevention
- Reassess monthly to track change in score

For patients scoring 15-19 (Moderately Severe Depression):

- Short-term Behavioral Activation/Goal Setting
- MI, coaching, and education
- Consider medication AND/OR Psychotherapy
- Connect with Behavioral Health Specialist/provider in community
- Maintenance and relapse prevention
- Reassess bi-weekly to track change in score

For patients scoring 20 and over (Severe Depression):

- Refer to behavioral health Specialist/provider in community
- Link to BH vendor partner (if applicable)
- Maintenance and relapse prevention
- Reassess weekly to track change in score



UNDERSTANDING THE PHQ-9 SCORE

Seek additional consultation when:

- The patient has complicated behavioral health diagnoses (i.e. personality disorder or substance use)
- The patient is psychotic.
- The patient is suicidal or homicidal; is in danger of harm from someone else or themselves, or is a risk to others.

Offering Support and Help

- Ask open-ended questions: “How do you feel about that?” or “What can I do to help you?”
- Listen! Sometimes the best intervention is to say nothing at all. It is so valuable for people to feel heard.
- Avoid “Why?”, “I understand,” “Just relax,” or “Things will work out.”: It can minimize how the person is feeling and can sound dismissive. Instead, validate their feelings and reflect back what you heard them say.
- Express concern, and point out what you are noticing: “You’ve seemed a little down the last few times we’ve talked…”; “I noticed that you had missed church group the past few weeks, you always talk about how much you enjoy going. Is everything okay?”. “I am worried that you have stopped taking your daughter’s calls… What’s going on?”.
- Provide education: depression is a condition, just like their medical conditions. It is not a personal weakness or flaw and, like other conditions, can improve with the right treatment.
- Encourage him/her to schedule an appointment with their provider. It can be less anxiety-provoking to see a PCP than meet with a Behavioral Health Specialist at first. PCP’s are a great starting point. They can rule out medical causes of symptoms and provide appropriate referrals.
- Offer to help him/her connect with supportive resources. For someone experiencing low motivation due to depression, it’s a huge help to have assistance making calls and looking into options.
- If someone is not ready to connect with behavioral health support, that’s okay. Check back in with him/her in a few weeks, monitor any changes and keep the door open for education and discussion.
- Be genuine, present and patient. Your relationship is key, it can provide hope and serve as a positive experience.
- Involve significant others to help encourage change. People may be more likely to do things for loved ones before they do something for themselves. Helping people realize they have support, and their depression may be impacting those they love, may be helpful in increasing their level of activation

PHQ-A

Patient Health Questionnaire-9 Modified for Adolescents is a tool that screens for anxiety, eating, mood, and substance use disorders in adolescents. The tool is appropriate for patients 11-17 years of age. This tool may be a component within a larger assessment or screening or can be utilized as a stand-alone screening whenever staff feel it beneficial or appropriate. If a positive screen occurs, staff should repeat this tool in one month.

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor appetite, weight loss, or overeating?					
5.	Feeling tired, or having little energy?					
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Trouble concentrating on things like school work, reading, or watching TV?					
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?					
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

UNDERSTANDING THE PHQ-A SCORE

Total Score	Depression Severity
0-4	None
5-9	Mild Depression
10-14	Moderate Depression
15-19	Moderately Severe Depression
20-27	Severe Depression

Note: If 3 or more items are left unanswered, the total raw score on the measure should not be used. Therefore, the child should be encouraged to complete all of the items on the measure. If 1 or 2 items are left unanswered, you are asked to calculate a prorated score. The prorated score is calculated by summing the scores of items that were answered to get a partial raw score. Multiply the partial raw score by the total number of items on the PHQ-9 modified for Adolescents (PHQ-A)—Modified (i.e., 9) and divide the value by the number of items that were actually answered (i.e., 7 or 8). The formula to prorate the partial raw score to Total Raw Score is:

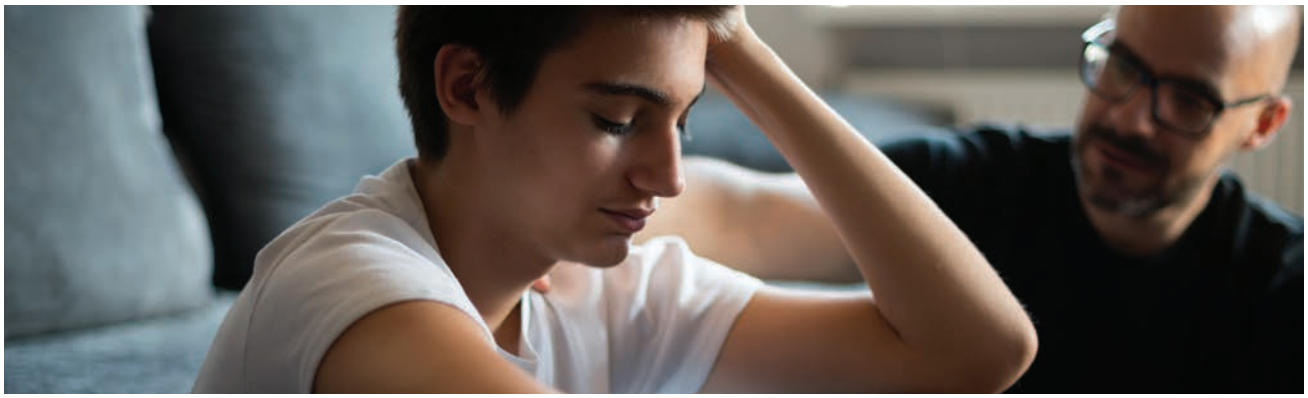
$$\frac{(\text{Raw sum} \times 9)}{\text{Number of items that were actually answered}}$$

If the result is a fraction, round to the nearest whole number.

Frequency of Use

To track changes in the severity of the child's depression over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the child's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the child that might warrant further assessment, treatment, and follow-up. Your clinical judgment should guide your decision.

UNDERSTANDING THE PHQ-A SCORE



PHQ-A: Using the Score to Guide Intervention

For patients scoring under 10 (Mild Depression):

- Continue to educate and monitor (watchful waiting)
- Provider may prescribe antidepressants
- The patient may be referred to psychotherapy

For patients scoring 10-14 (Moderate Depression):

- Short-term Behavioral Activation/Goal Setting
- MI, coaching, and education
- Consultation with/referral to local BH Specialist
- Consider medication and/or Psychotherapy
- Maintenance and relapse prevention
- Reassess monthly to track change in score

For patients scoring 15-19 (Moderately Severe Depression):

- Short-term Behavioral Activation/Goal Setting
- MI, coaching, and education
- Consider medication AND/OR Psychotherapy
- Connect with Behavioral Health Specialist/provider in community
- Maintenance and relapse prevention
- Reassess bi-weekly to track change in score

For patients scoring 20 and over (Severe Depression):

- Refer to behavioral health Specialist/provider in community
- Link to BH vendor partner (if applicable)
- Maintenance and relapse prevention
- Reassess weekly to track change in score

“A big part of depression is feeling really lonely, even if you’re in a room full of a million people.”

- Lilly Singh

DEPRESSION

Your Patient

You have a patient who just scored a 17 on their PHQ-9. What does the discussion look and sound like with your patient?

Treating Depression With Medication:

Medication is common in treating depression and can be effective in managing symptoms.

- Help set realistic expectations around how medications may work:
  - It takes time, some medications can take up to 4-6 weeks to reach therapeutic levels (where one would notice any benefit). Often, people stop their medication in the first few weeks because they think it's not working, or they aren't feeling better. Encourage patients to give the medication time, and only to stop if told to by their provider.
  - People may stop taking their medications once they start to feel better which increases the risk that their symptoms will worsen. Continuing their medication even when they are feeling better, is key.
  - If the patient is verbalizing a desire to stop taking his or her medication, encourage them to talk to their provider prior to making any changes.
- Different medications may be needed to treat depression:
  - Finding the right medication (one with minimal side-effects, that is tolerable, and effective in managing specific symptoms) may take time. Encourage the patient to be patient and continue to work with his or her provider.

(Refer to APPENDIX for COMMONLY PRESCRIBED PSYCHOTROPIC MEDICATIONS)

SUICIDAL IDEATION

Managing Patients at Risk for Suicide

If you think an patient might be considering suicide, talk to him or her about your concerns as soon as possible. Many people feel uncomfortable bringing up the topic but it is the best thing you can do for someone who is thinking about suicide. Talking openly about suicidal thoughts and feelings can save a person's life, so speak up if you're concerned.

Recognizing & treating depression can be the single most effective thing we can do to reduce the risk!

When someone is depressed, suicide is a very real danger. It's important to:

Listen for:

- Talk about suicide, dying, or harming oneself; preoccupation with death
- Expressions of hopelessness or worthlessness: "Nothing matters anymore."

Take note of:

- Dangerous or self-destructive behaviors
- Saying goodbye or getting affairs in order

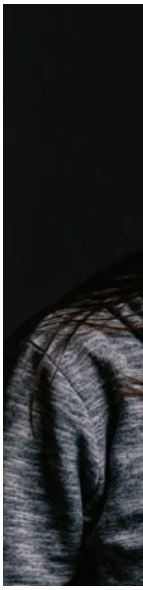
Assess:

- Current suicide ideation (Passive v. Active – thoughts ➔ acts/doing things)
- Suicide intent (how much the person wants to die)
- Recent preparatory behavior(s) (have you planned this out? In what ways have you tried, or practiced these steps?)
- Current plans and means: access to pills, weapons, or other lethal objects
- Past suicidal behavior: history of ideation/attempts and family history

What Do You Do?

What are some common risk factors for suicide in children and older adults, you should look out for?

ANXIETY



What is Anxiety?

- A normal reaction to stress. It can be helpful-alerting us to danger, helping us prepare and pay attention.
- Excessive fear or worry, different from normal feelings of nervousness or anxiousness.
- The most common behavioral health disorder, affecting more than 30 percent of adults at some point in their lives. (More predominant in women).
- Treatable. Most people, with proper treatment, see the resolution of symptoms and lead normal, productive lives.
- Limiting. Causing people to avoid situations that trigger or worsen their symptoms. This often negatively impacts work or school performance, personal relationships and daily functioning.
- To be diagnosed with an anxiety disorder, the fear or worry must:
    - Be out of proportion to the situation
    - Cause significant distress, hindering one's ability to function normally

Risk Factors for Anxiety

- A family history of depression or anxiety.
- Stressful life events may trigger anxiety: job instability, change in living arrangements, pregnancy, and childbirth, family/relationship problems, trauma (surviving an event; or verbal, sexual, physical or emotional abuse), death or loss of a loved one.
- Physical health problems: chronic illness can trigger or complicate the treatment of anxiety, or the physical illness itself. (i.e., overactive thyroid, diabetes, asthma, heart disease).
- Substance use: People feeling anxious may find themselves using substances to cope with the inhibition felt with anxiety. Heavy or long-term use of substances such as alcohol, cannabis, amphetamines or sedatives can also lead to the development of anxiety disorders.

GAD-7

The GAD-7 is an easy-to-use, self-administered patient questionnaire used as a screening tool and severity measure for generalized anxiety disorder symptoms.

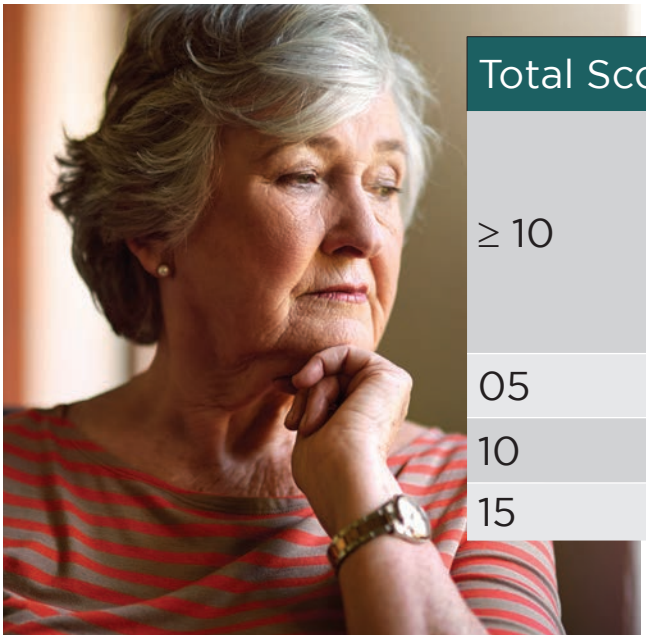
Using the conditions and profile you wrote for either Emma or Cecil, complete the GAD-7

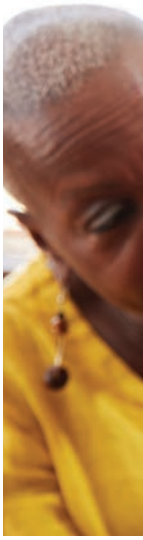
Generalized Anxiety Disorder Questions - 7

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	0	___	___	___

=Total Score: _____

UNDERSTANDING THE GAD-7 SCORE





Total Score	Interpretation
≥ 10	Encourage connection to provider or BH Specialist. Psychological and/or medical treatments are/may be required.
05	Mild anxiety
10	Moderate anxiety
15	Severe anxiety

GAD-7: Using the Score to Guide Intervention

Effective treatment focuses on helping patients learn cognitive behavioral techniques to control their anxiety symptoms. The type of treatment will depend on the frequency, intensity and duration of the symptoms they are experiencing.

For patients scoring under 10 (Mild Anxiety):

- Provide education around ways to manage stress and anxiety.
- Consider lifestyle changes (physical exercise, relaxation techniques) and set related goals.
- Discuss online e-therapies, many of which are free, anonymous and easily accessible for anyone with Internet access.

For patients scoring 10-14 (Moderate Anxiety):

- Consider additional education around treatment options and how to identify triggers.
- Psychological and/or medical treatments are/may be required.

For patients scoring 15-19 (Moderately Severe Anxiety):

- Encourage connection to provider or BH Specialist.
- Psychological and/or medical treatments are/may be required.

ANXIETY

Similarities Between Depression and Anxiety

What are some similarities between depression and anxiety?

Offering Support and Help

- Listen, validate, reflect back what you hear.
- Be transparent and honest: Share why you need to ask specific questions "... it will help me to understand what has been going on and how I can best help you."
- Give him or her an out, i.e. the option to not answer a question if he or she feels uncomfortable.
- Don't tell someone to relax, show them how!
- Avoid telling someone who is anxious to relax. It minimizes what he or she is experiencing. Instead, ask him or her what you can do to help them relax. What has worked for him or her in the past? What do they find to be relaxing? (See Appendix for Progressive Muscle Relaxation and Visualization resources)
- Remember what might seem 'little' or 'no big deal' to you, may feel insurmountable to someone else.
- People living with anxiety often have reactions to thoughts or situations that are disproportional to the event. You may be tempted to reassure someone by saying "it's nothing, don't worry about it," but to them it's HUGE. Validate their feelings and look to provide support through remaining calm and present.

Take Time to be Mindful

Current State	Take a moment to assess your current mental state. How does your mind and body feel? Are you peaceful? Are you stressed? Are you anxious?
Mindful	Take 3 minutes to clear your mind and relax. Let your mind slightly drift and when you start to totally space bring your mind back to consciousness.
Relaxed State	Reassess how your mind and body feels now. Pay attention to the difference in the way you feel. Can this work for your patients?

SUBSTANCE USE

A Few Facts to Know

- Substance use is a spectrum of behaviors, including risky or hazardous alcohol use, resulting in drinking more than the recommended amounts and increasing the risk for health consequences. (Refer to Appendix: Standard Drink Measures).
- The DSM-IV* defines Alcohol Abuse as drinking that leads an individual to fail in major home, work, or school responsibilities. Alcohol abuse can also increase risk in physically hazardous situations or increase likelihood for alcohol-related legal issues.
- Alcohol Dependence* includes physical cravings and withdrawal symptoms, frequent consumption of alcohol in larger amounts than intended over longer periods, and a need for markedly increased amounts of alcohol to achieve intoxication. (This is what is known as addiction).
- Alcohol use is a pervasive issue. It is estimated that 30% of the U.S. population engages in risky use. More than 85,000 deaths per year are attributed to alcohol misuse. It is the third leading cause of preventable deaths in the United States, and often a contributing factor for ED visits.

Substance Use and Behavioral Health

- Behavioral health conditions and substance use often occur together. More than a quarter of the adult population living with behavioral health conditions, also abuse substances. This is especially true for those living with depression and/or anxiety.
- They both share some underlying causes, including changes in brain composition, genetic vulnerabilities, and early exposure to stress or trauma.
- Substance use disorders can refer to substance use (risky use) or substance dependence (addiction). It is important to ask about the type(s), frequency and intensity of someone's use, to gauge the level of intervention and support needed.

** Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*

How will you Recognize There May be Substance Use?

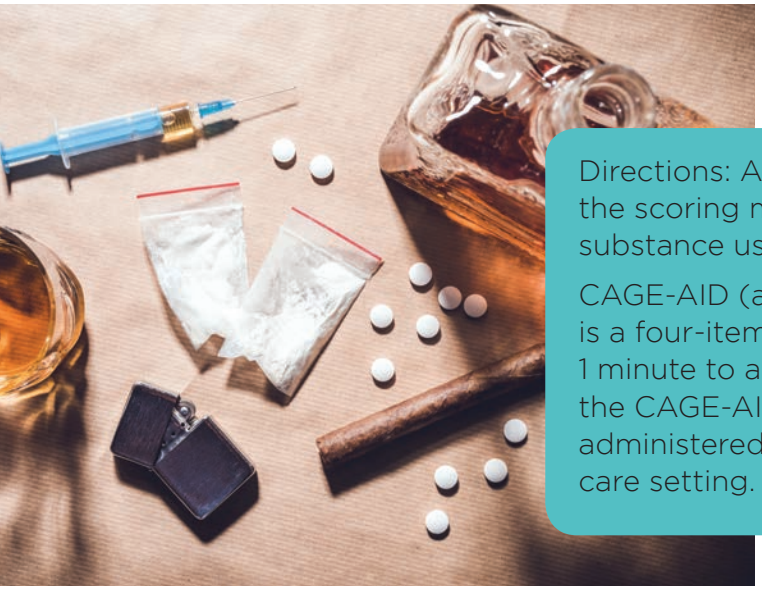
What are some cues that may indicate the patient is using substances in a risky way?

_____

_____

_____

_____



CAGE-AID

Directions: Ask your **patients** these four questions and use the scoring method described below to determine the risk of substance use.

CAGE-AID (a version of the CAGE adapted to include drugs) is a four-item screening tool that takes approximately 1 minute to administer and score. The target population for the CAGE-AID is both adults and adolescents and can be administered by patient interview or self-report in a primary care setting.

Using the conditions and profile you wrote for either Emma or Cecil, complete the CAGE-AID

When thinking about drug use, include illegal drug use and the misuse of prescription drugs.
Questions: Answer either YES NO

1. Have you ever felt that you ought to cut down on your drinking or drug use?_____
5. Have people annoyed you by criticizing your drinking or drug use?_____
3. Have you ever felt bad or guilty about your drinking or drug use?_____
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? _____.

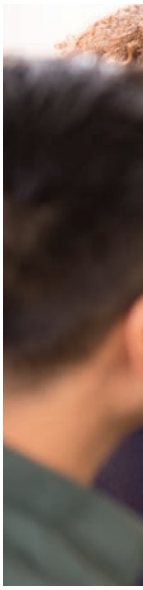
Scoring the CAGE-AID

- Item responses on the CAGE-AID are scored 0 for "no" and 1 for "yes."
- Of the four items, a "yes" answer to one item indicates a possible substance use disorder and a need for further testing by their provider.

What to do with the CAGE-AID Score:

For patients scoring 1 or greater:

- Provide education and reflection on how use may be contributing to issues they are experiencing (health, relationship, work); and
- Explore patient's openness to a referral to his or her provider or behavioral health specialist for additional screening and support.



Talking Points: Offering Support and Help

- By asking substance use screening questions within the comprehensive assessment, we increase the patient's comfort, decrease anxiety, reduce stigma, and it can be perceived as less threatening.
- Remember, we ask these questions to everyone, as it helps us get a sense of ALL the things that may be impacting someone's health. Sharing that these are questions asked to all patients can help them feel less targeted or put 'on the spot.'
- Ask about each specific drug, and ask in the same way you ask about other health behaviors.
    - "Have you ever used marijuana?", "Have you ever used cocaine?", "How about cigarette use?"
    - Document most recent usage; amount used, and frequency at which substance was used.
- People in the Contemplation stage of change: gauge readiness to change drinking habits:
    - "Have you thought about making changes in your drinking?"; "If you were to make a change, what may be something to try first?"
- Be empathic and non-confrontational. Aim to keep the conversation open and non-judgmental.
- Help to identify possible triggers for struggle or relapse, including stressful events, interpersonal conflict, insomnia, chronic pain, craving, or high temptation situations such as a family gathering or large social event.
- Stay engaged and optimistic! Most people with substance use issues who continue to work at recovery, eventually achieve partial to full remission of symptoms, often do so without specialized behavioral treatment.
- Encourage those who have relapsed. Relapse is common, keep trying!
- Abstinence is not required for treatment.
    - While abstaining may be the safest option for most individuals with alcohol use disorders, it is not always the first step someone wants to take in seeking help.
    - If someone is unwilling to stop using but would consider cutting back—do it! There are many support groups/services that help people cut back on their use in safe ways.
- Offer to arrange follow-up provider appointments, including medication management support if needed.

Locating treatment options in your area:

- Contact local hospitals to see which ones offer addiction services.
- Call the National Drug and Alcohol Treatment Referral Routing Service (1-800-662-HELP) or visit the Substance Abuse Facility Treatment Locator Web site at http://findtreatment.samhsa.gov.
- Alcoholics Anonymous (AA) offers free, widely available groups. For contact information for your region, visit www.aa.org.
- Other mutual help organizations that offer secular approaches, groups for women only, or support for family members can be found on the Rethinking Drinking Web site http://rethinkingdrinking. niaaa.nih.gov/ Help-links/

CRAFFT Screening Tool for Adolescent Substance Abuse

The CRAFFT Screening Tool for Adolescent Substance Abuse is utilized for patients 12-18 years of age to screen for high risk alcohol or other drug use disorders. This tool may be a component within a larger assessment or screening, or can be utilized as a stand-alone screening whenever staff feel it beneficial or appropriate. When the word "drug" is used, it refers to the use of prescribed or over-the-counter drugs that are used in excess of the directions and any non-medical use of drugs. The various classes of drugs may include but are not limited to: cannabis (e.g., marijuana, hash), solvents (e.g., gas, paints etc.…), tranquilizers (e.g. Valium), barbiturates, cocaine, and stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., Heroin, OxyContin).

Part A: During the PAST 12 MONTHS, did you:		No	Yes
1.	Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)		
2.	Smoke any marijuana or hashish?		
3.	Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")		
Part B: CRAFFT		No	Yes
1.	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?		
2.	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?		
3.	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?		
4.	Do you ever **FORGET** things you did while using alcohol or drugs?		
5.	Do your **FAMILY or FRIENDS** ever tell you that you should cut down on your drinking or drug use?		
6.	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?		

UNDERSTANDING THE CRAFFT SCORE

Part A: If "yes" to any questions in Part A, ask all 6 CRAFFT questions. If "no" ask CAR question then stop.

Part B: Score 1 point for each "YES" answer.

CRAFFT Score	Degree of problem related to alcohol or other substance abuse	Suggested Action
0-1	No problems reported	None at this time.
+	Potential of a significant problem.	Assessment required.*

References:

- Knight JR, et al. A new brief screen for adolescent substance abuse. Arch Pediatric Adolescent Med. 1999 Jun;153(6):591-6. PMID: 10357299
- Dhalla S, et al. A review of the psychometric properties of the CRAFFT instrument: 1999-2010. Curr Drug Abuse Rev. 2011 Mar 1;4(1):57-64. PMID: 21466499

*Adolescent should be referred to a Behavioral Health/Substance Abuse provider and re-screened in one month

BEHAVIORAL ACTIVATION

Increasing Pleasurable Activities:

- To reduce depression, help **patients** re-engage in pleasant activities.
- Learn new ways of dealing with distress.
- Gradually increase engagement in pleasant/enjoyable activities.
- Reduce avoidant patterns.

Behavioral Activation: Key Components

- Physical activity.
- Social interaction.
- Pleasant events.
- Household activities/projects.
- Social/physical activities tend to be the most potent mood boosters.
- Intervention should focus on increasing daily pleasant events.

What does Behavioral Activation Look Like?

- Start with information regarding what the individual currently does. Write out a few questions that can elicit this information:
- List activities & rate them for pleasure:
  - Choose one and schedule it daily
  - Mentally rehearse the selected activity
  - Identify potential barriers (feasibility, realistic)
- Make a specific, detailed plan:
  - The more detailed the plan, the more likely it is that it will be followed
  - Ask: "How likely are you to do this?", "What will happen if you don't feel like doing it?"

Structuring Follow Up Calls:

Follow Up Call	• Re-screen if needed (at least monthly for **patients** with PHQ score >10; or GAD score >5) • Follow up regarding past behavioral activation plans-What did they try? How did it work? • Ask about medical follow-up (appointments, provider visits), assist with scheduling as needed • Ask about medications–have they been able to take them as prescribed? Any barriers? • Make a new behavioral activation plan- anticipate challenges and problem solve

Addressing Emergent Patient Situations

What do you do if you are on the phone with a patient and an emergency situation occurs? The steps you will take to assist your patient should an emergency arise are on this page.

In the event you are on the telephone with a patient and the patient indicates that he/she is in need of emergent care, or the patient experiences a medical emergency during the phone call, you will need to assess the patient's needs and determine the appropriate course of action.

Steps for an Emergent Situation

1. Send an instant message via Skype to your manager/supervisor or a co-worker if your manager is not on Skype. Indicate you are in the midst of an emergent situation. The message should include the following information:
    a. Crisis call in progress.
    b. Call 911 for (patient name) (address) (phone).
    c. Reason for the emergency (i.e. patient is suicidal/respiratory distress).
2. If Skype is unavailable, send the message via e-mail or utilize another available telephone. BUT DO NOT PUT THE PATIENT ON HOLD or disconnect from the patient.
3. The manager/supervisor/co-worker who responds first is the "key assistant" and will notify the patient's local EMS by dialing 911 or the local number on file for that area. The key assistant will obtain the name and address of the EMS personnel with whom they are speaking.
4. The key assistant will notify the Care Advisor that contact with 911 has been established. The key assistant will maintain communication via Skype or e-mail to keep everyone informed of the status of EMS.
5. You will advise the patient that attempts are being made to contact 911. You shall remain on the line with the patient until there is confirmation that paramedics have arrived at the patient's location.
6. Once the call has ended, the staff will complete the following:
    a. Document the call in Identifi and create an urgent Action Item to follow-up with the patient on the next business day.
    b. Contact the PCP to discuss the situation or confirm with the provider that the appointment was scheduled or that the appointment took place.

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CONTACT US

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