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# **Learning Collaborative**

## **Kansas Medicaid Health Homes Initiative**

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October 24, 2014

Rolling Hills Zoo Conference Center

Salina, KS

# Welcome!



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# Why are we here?

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To celebrate successes,  
conquer challenges,  
and build a quality Health Homes system.



# What we've heard so far...

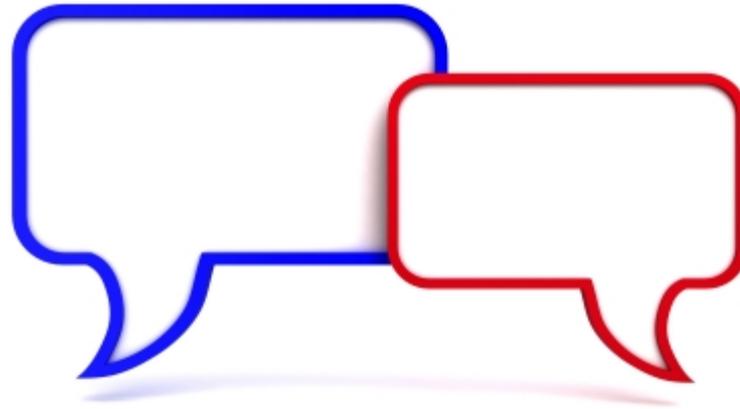
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- Member engagement strategies
  - Strategies for initial appointment
- Health assessment/screening tools
- Provider engagement strategies
- Billing issues
- Health promotion
- Working with Lead Entities
- Health literacy assessment tools and strategies



# What else?

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“Participation in the Health Homes Learning Collaborative will be meaningful to me and my agency if...”



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# Readiness to Change

## Its Importance to Patient Engagement

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Cindy Hochart RN, MBA, PMP  
Regional Director, Health Homes  
United HealthCare

# Agenda

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- Change
- Transtheoretical Model (TTM)
- Decision Model
- Self Efficacy
- Stages of change
- Process of Change
- Tools for Assessment of Readiness to Change

# Readiness to Change

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- Change is a process
- Takes place over time
- Applies to broad scope of environs – i.e., organizational readiness to change
- In health care– usually it’s about **Motivation** to change behaviors
- Often paired with motivational interviewing
- Demonstrated effectiveness in broad areas
  - Smoking cessation, weight loss, medication adherence

# Transtheoretical Model

## for Behavior Change

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- Developed by James Prochaska and University of RI in 1977
- Uses multiple theoretical models of psychology
  - stages of change
  - processes of change
  - decisional balance
  - self-efficacy

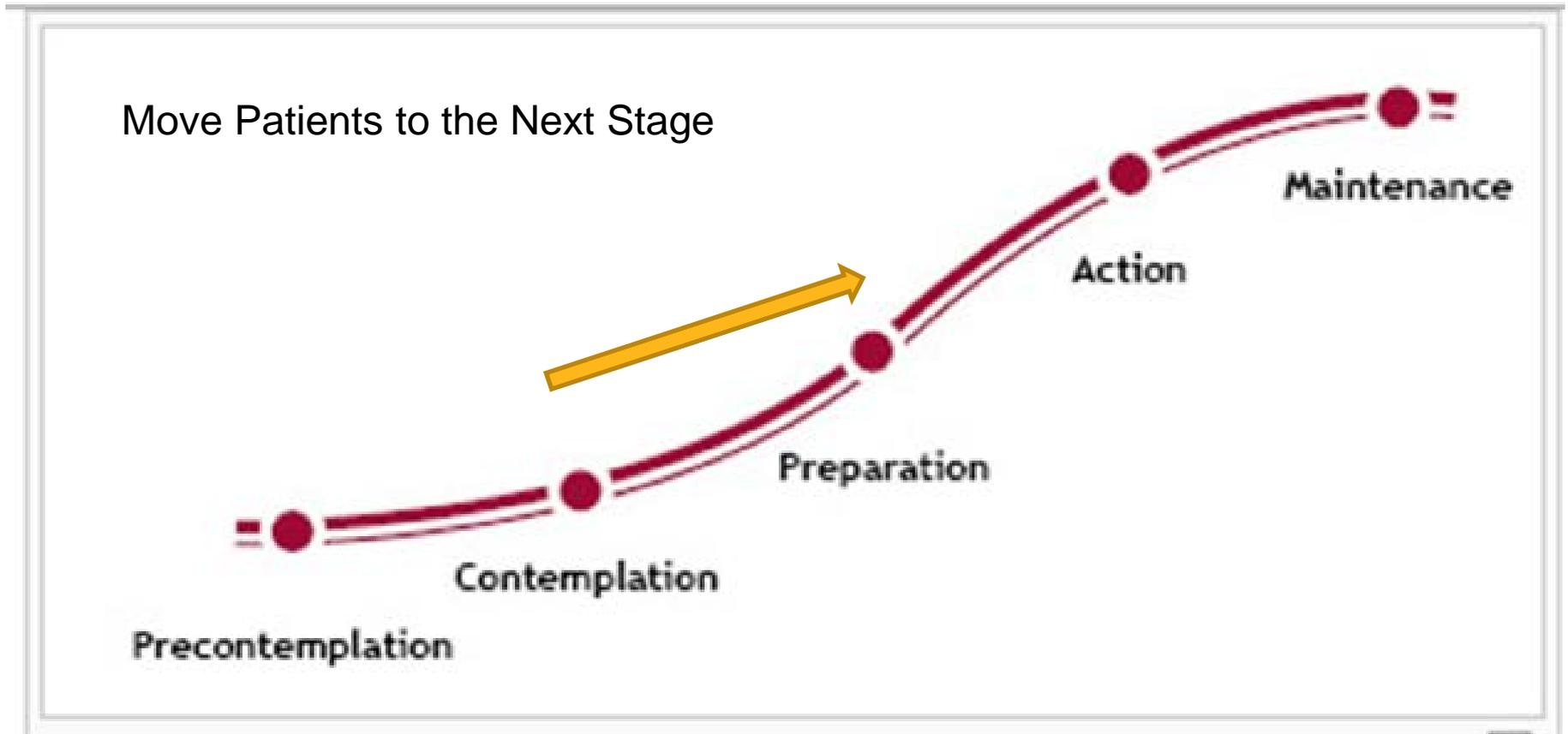
# The Problem is with Humans

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- Health care professionals become frustrated with non-compliant patients
  - Repetitive education
  - Just Do it
  - Give up on them or write them off
- Fear of offending/losing the patient
- Stages of Change Approach to Helping Patients Change Behavior
  - Gretchen Zimmerman Psy.D and Cynthia Olson MD  
American Family Physician 2000; Mar 1;61(5):1409-1416
  - Discussed evaluating patients on readiness to change
  - Change the goal to movement on readiness to change cycle

# More Realistic Goals = Greater Success

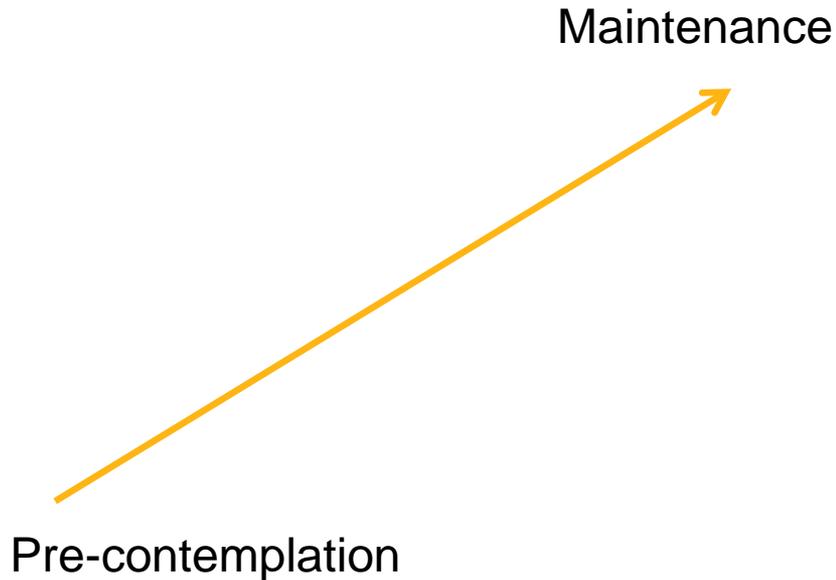
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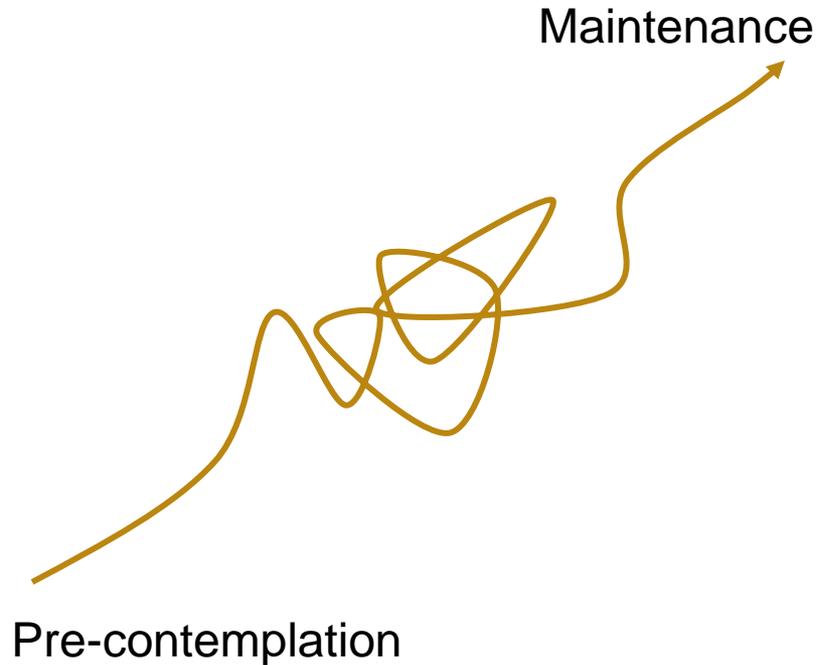
# Path to Success is not Linear

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What we think path to success looks like:



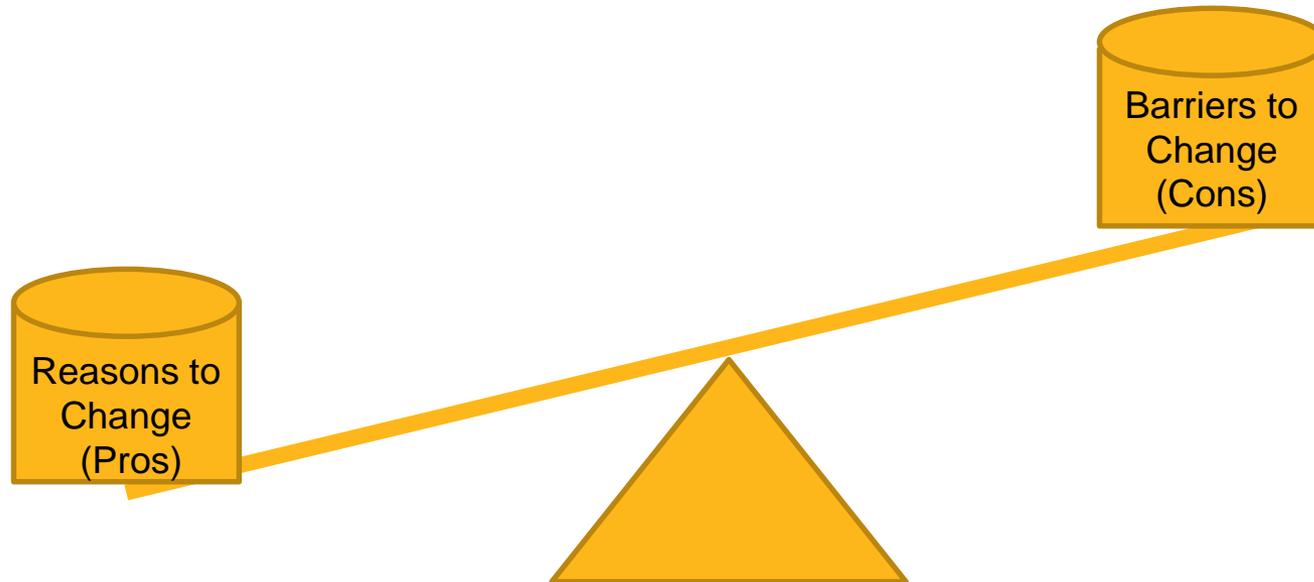
What it's really like:



# Decision Balance

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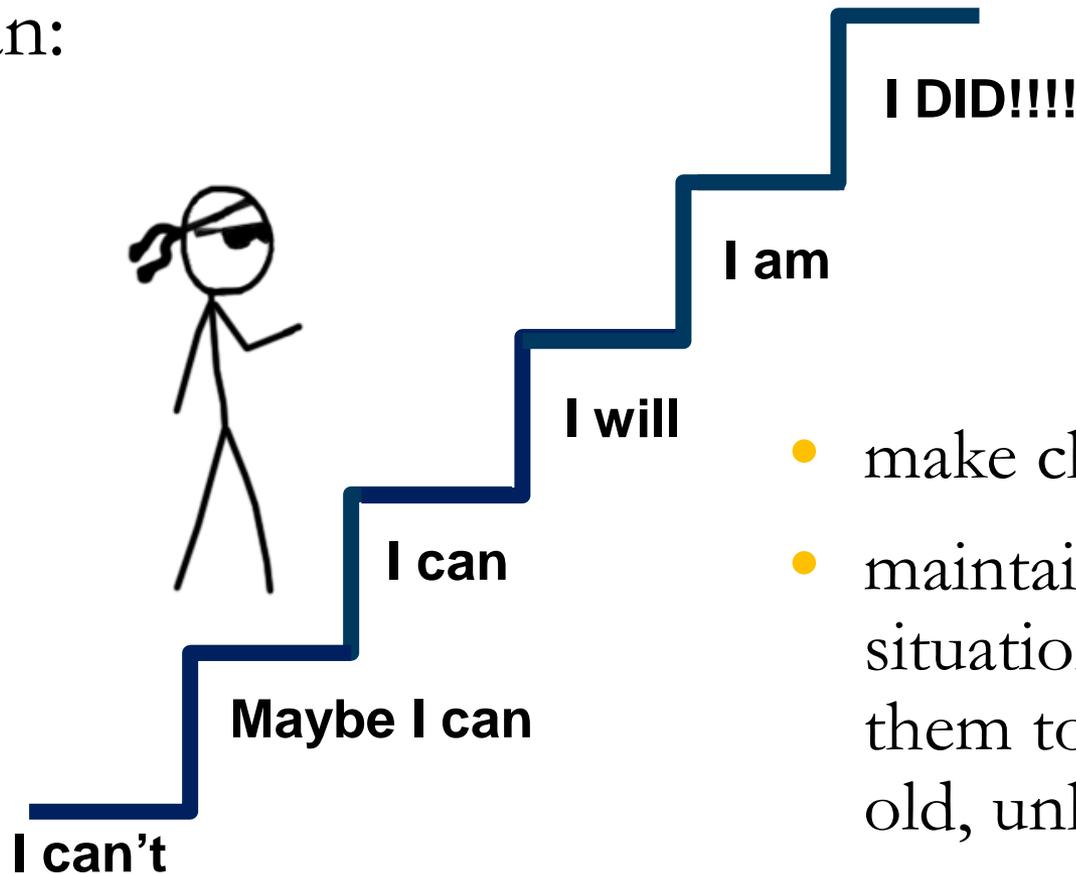
People begin to change when reasons to make the change outweigh the barriers not to change



# Self Efficacy

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Developing confidence that they can:



- make changes
- maintain changes in situations that tempt them to return to their old, unhealthy behavior.

# Stage 1: Pre-contemplation

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- Not Ready
- Unaware/Denial
- Under estimate value of changing
- Not motivated to change
- Goals – Learn about healthy behavior
- Encourage to think about Pros and Cons of change
- Encourage mindfulness about behaviors

# Recognize Pre-contemplation

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- Example:
  - BMI 40, sedentary lifestyle
  - Complains of chronic fatigue and aching knees and ankles
  - Thinks obesity is about genetics
  - Posts on Facebook about newest recipe for Cheesy Macaroni Bake and fried Twinkies

# Stage 2: Contemplation

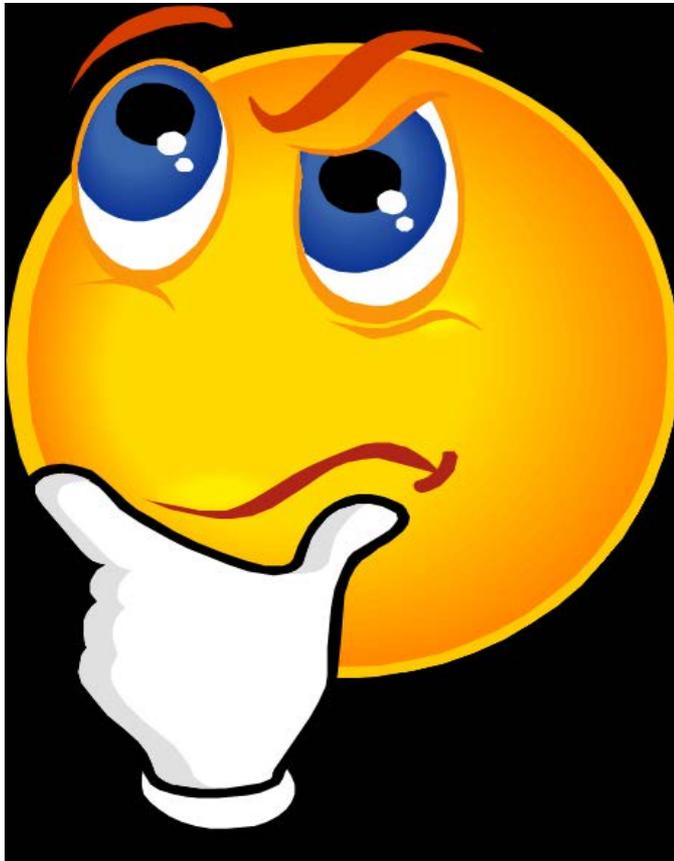
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- Considering change
- Intending to begin health behavior
- Pros are equal to Cons in decision balance
- Can put off making change
- I know I need to, but...
- Encourage development of a vision for the results of change
- Encourage work to minimize barriers or cons
- Emphasize cost/impact of not changing
- Develop support system

# Recognize Contemplation

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?????



- Assessing barriers
  - Cost of gym membership
  - Weighing exercise options like walking trails
  - Time commitment
  - Cost of healthy foods or healthy eating or “diet” programs
  - Nicotine patches and side effects
  - Fear of failure

# Stage 3: Preparation

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- Ready to start taking action in 30 days
- Start taking small steps like talking about making a change
- Experimenting with change
- Encourage support from others
- Group visits or support groups
- Help them set realistic expectations and goals
- Positive re-enforcement for experimental changes

# Recognize Preparation

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- “I can diet really well 4 hours at a time”
- Trying new health foods or exercise classes
- Switching brands or cutting down on cigarettes
- Decrease drinking

# Stage 4: Action

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- Have changed behaviors
- Working hard on strengthening the commitment
- Fighting urges to back-slide
- Positive re-enforcement
- Suggest substitutions of healthy behaviors for non healthy ones
- Celebrate successes
- Avoid people/situations that tempt them to resume former behaviors

# Recognize Action

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- Exercising regularly
- Quit smoking/drinking/drugs
- Following healthy eating plan
- Working hard on changed lifestyle

# Stage 5: Maintenance

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- Changed behaviors are at least 6 months old
- May still be tempted to resume former behaviors especially under stress
- Slips can discourage and may quit healthy behavior
- Encourage avoiding tempting situations
- Encourage socializing with people who have healthy behaviors
- Coach around accepting “slips” and get back on the path

# Recognize Maintenance

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- Urge for drink/smoke/Fried Food may not completely disappear
- Occasional slips followed by mental self-abuse



# Stages of Change Summary

**TABLE 6. STAGES-OF-CHANGE CHARACTERISTICS AND STRATEGIES**

STAGE	CHARACTERISTICS	STRATEGIES
<b>Precontemplation</b>	The person is not even considering changing. They may be "in denial" about their health problem, or not consider it serious. They may have tried unsuccessfully to change so many times that they have given up.	Educate on risks versus benefits and positive outcomes related to change
<b>Contemplation</b>	The person is ambivalent about changing. During this stage, the person weighs benefits versus costs or barriers (e.g., time, expense, bother, fear).	Identify barriers and misconceptions Address concerns Identify support systems
<b>Preparation</b>	The person is prepared to experiment with small changes.	Develop realistic goals and timeline for change Provide positive reinforcement
<b>Action</b>	The person takes definitive action to change behavior.	Provide positive reinforcement
<b>Maintenance and Relapse Prevention</b>	The person strives to maintain the new behavior over the long term.	Provide encouragement and support

Source: Zimmerman et al., 2000; Tabor and Lopez, 2004

# Processes of Change

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## Consciousness-Raising

Increasing awareness, education

## Dramatic Relief

Fear of negative result OR  
Inspiration for vision of  
positive result



## Stages of Change

- Pre-Contemplation
- Contemplation
- Preparation
- Action
- Maintenance

# Processes of Change

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## Self-Reevaluation

Realize healthy behaviors are part of who they want to be

## Environmental Re-evaluation

Assessing impact on others and how their behavior change can help

## Stages of Change

- Pre-Contemplation
- Contemplation
- Preparation
- Action
- Maintenance

# Processes of Change

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## Social Liberation

Realizing their world can be supportive of healthy behavior



## Self-Liberation

Believing they can change and follow through

## Stages of Change

- Pre-Contemplation
- Contemplation
- Preparation
- Action
- Maintenance

# Processes of Change

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## Helping Relationships

finding people to support their change

## Counter-Conditioning

Substituting unhealthy habits for healthy ones



## Stages of Change

- Pre-Contemplation
- Contemplation
- Preparation
- Action
- Maintenance

# Processes of Change

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## Reinforcement Management

Develop healthy rewards for positive choices



## Stimulus Control

Using reminders and cues that encourage healthy choices and limiting negative



## Stages of Change

- Pre-Contemplation
- Contemplation
- Preparation
- Action
- Maintenance

# Tools for Assessment: Readiness to Change Ruler

## READINESS RULER

Below, mark where you are now on this line that measures your change in \_\_\_\_\_.

Are you not prepared to change, already changing or somewhere in the middle?



Not ready  
to change

Already  
changing

# Tools for Assessment: Patient Activation Measure (PAM)



Name	
ID	
Date	

- 13 questions
- Licensed from Insignia
- Valid and Reliable
- To be integrated in both our Community Care and Care Manager

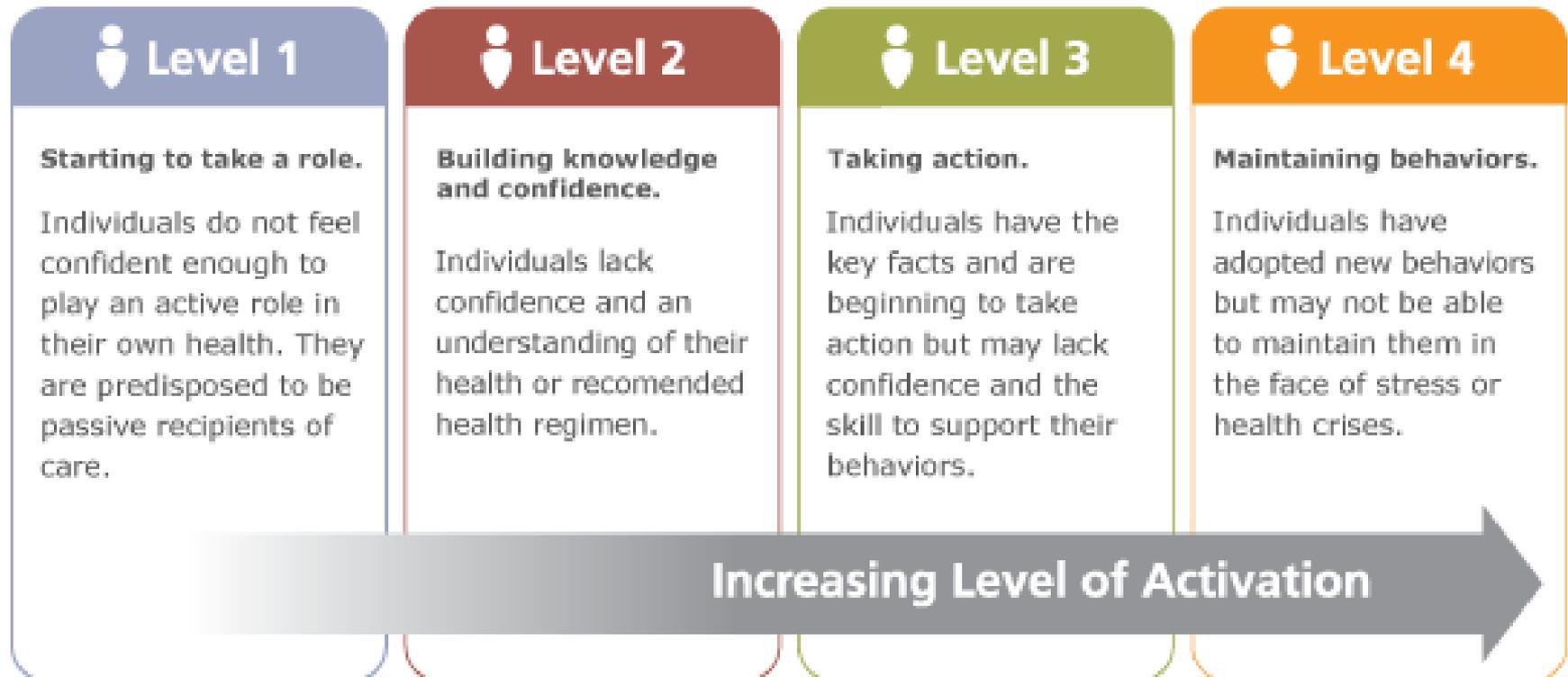
Below are statements people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally.

Circle the answer that is most true for you today. If the statement does not apply, select N/A.

1.	When all is said and done, I am the person who is responsible for taking care of my health.	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
2.	Taking an active role in my own health care is the most important thing that affects my health.	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
3.	I am confident I can help prevent or reduce problems associated with my health.	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
4.	I know what each of my prescribed medications do.	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
5.	I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
6.	I am confident that I can tell a doctor concerns I have even when he or she does not ask.	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
7.	I am confident that I can follow through on medical treatments I may need to do at home.	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
8.	I understand my health problems and what causes them.	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A

# Tools for Assessment: Patient Activation Measure (PAM)

Results = Level 1-4







Time for lunch!

# Lessons learned from community care management

Anne Nelson and Monica Flask  
October 24, 2014  
Salina, KS

# Central Plains Health Care Partnership

- ▶ Established in 1998--Nonprofit affiliate of the MSSC
- ▶ Our mission is to improve the health of our community, especially vulnerable patient populations
- ▶ *We connect people in need of health care with those who provide it*
  - Project Access
  - Coalition Test Project
  - ACA navigation
  - Care management programs
    - High utilizers of hospital emergency departments
    - Enhanced Care Management—Medicaid population

# Care management outcomes

- ▶ Hospital ED CM
  - Improved self-reported health status
  - 53% reduction in ED use for primary care needs
  - Established primary care homes
  - High rates of patient satisfaction
- ▶ Enhanced Care Management
  - Improved self-reported health status
  - Higher PCP and Rx utilization
  - Reduced hospital admissions compared to similar Medicaid population in Wyandotte County
  - Reduced HC utilization post-enrollment compared to pre-enrollment

# Program characteristics

# Interdisciplinary collaboration

## Create a collaborative environment

- ▶ Nurses/social service staff all have expertise
- ▶ Weekly team meetings
- ▶ Do medical/social assessments together
- ▶ Develop care plans together
- ▶ Share success stories and celebrate together
- ▶ Pay attention to staff morale – this is hard work!

# Patient-staff relationships are key

## Patient-centered care

- ▶ Nonjudgmental staff (hire for this trait)
- ▶ Patients decide where to start with multiple problems
- ▶ Partner with the patient to solve problems
- ▶ Strengthen social services and social networks
- ▶ Healthy boundaries

# Home visits are ideal

What you can learn at home:

- ▶ Who else is in the home?
- ▶ What other medications are in the home?
- ▶ Is the environment physically safe? (steps, etc.)
- ▶ Are other people supportive of the patient?
- ▶ What is the patient's routine? Neighborhood?

Meet in the community if home is not safe.

# Consultants provide support to staff

Some patients have BIG social/medical problems

- ▶ Addiction, abuse, violence
- ▶ Consultants provide CEU training for staff
- ▶ Use consultants for specific case consultation
- ▶ Consultants can also help shape policies and procedures

# Motivational interviewing

- ▶ A technique to assess readiness and prepare people to make life changes
- ▶ Reinforces the patient-centered quality of the relationship
- ▶ Professional and patient partner to identify barriers to change, which reduces resistance
- ▶ *Motivational Interviewing* by Miller & Rollnick

# Truly individualized care plans

- ▶ Keep the goals simple and measurable
- ▶ Don't overwhelm the patient – strive for a maximum of only 3 goals/objectives at a time
- ▶ Include patient education throughout
- ▶ Make the care plans a tool – use them with the patient to plan and evaluate
- ▶ Include social services in the care plan
- ▶ Utilize informal social networks when possible

# Frontload, frontload, frontload

Invest quickly in the patient relationship

- ▶ Weekly visits are appropriate at first
- ▶ Attend to the patient's crisis first
- ▶ Make calls to physicians & get thorough history
- ▶ Assess medical and social needs at first visit(s)
- ▶ Help utilize formal and informal social supports
- ▶ Help the patient see tangible results quickly

Monthly visits work best for maintenance.

## Coordination of primary/specialty care

- ▶ Find your role to help support the PCP's plan
- ▶ Check to be sure the patient tracks the appointments correctly (transportation needs?)
- ▶ CMs serve as bi-directional liaisons/"interpreters" between patients *and* providers
- ▶ Point out "red flags" to the physician
- ▶ Go to targeted provider appointments

# A little education goes a long way

- ▶ How to check blood sugar (many don't know)
- ▶ What IS a bladder?
- ▶ Tools to track daily results (blood pressure, etc.)
- ▶ How to work with the doctor's office and schedule appointments
- ▶ Teaching tools – DVDs, brochures, log books (phone apps?)

# A little flexible funding goes a long way

## \$50 or less will buy:

- ▶ Blood pressure monitor/glucometer
- ▶ Bus pass for 20 rides with transfers
- ▶ Swimming sessions at a neighborhood church
- ▶ A scale
- ▶ Free weights/exercise bands
- ▶ What else?

# To sum it up.....

- ▶ Tried to hire the right staff
- ▶ Set up an environment that was collaborative
- ▶ Supported/educated staff with consultants
- ▶ Focused on patient-centered relationships (at home)
- ▶ Did thorough assessments
- ▶ Created useful care plans – and used them
- ▶ Primary tasks were:
  - education
  - care coordination/strengthening links to providers
  - connection to social resources
- ▶ Small targeted purchases often were very helpful

# Lessons...

- ▶ Create effective outreach processes
  - Multiple attempts to reshape our invitation materials; client response informed our language, artwork, etc.
  - Follow-up phone calls, second letters, multiple attempts, Learned how to demonstrate the value of the program to our clients
    - Make an offer in the beginning, motivate to engage
    - Helped the client see progress

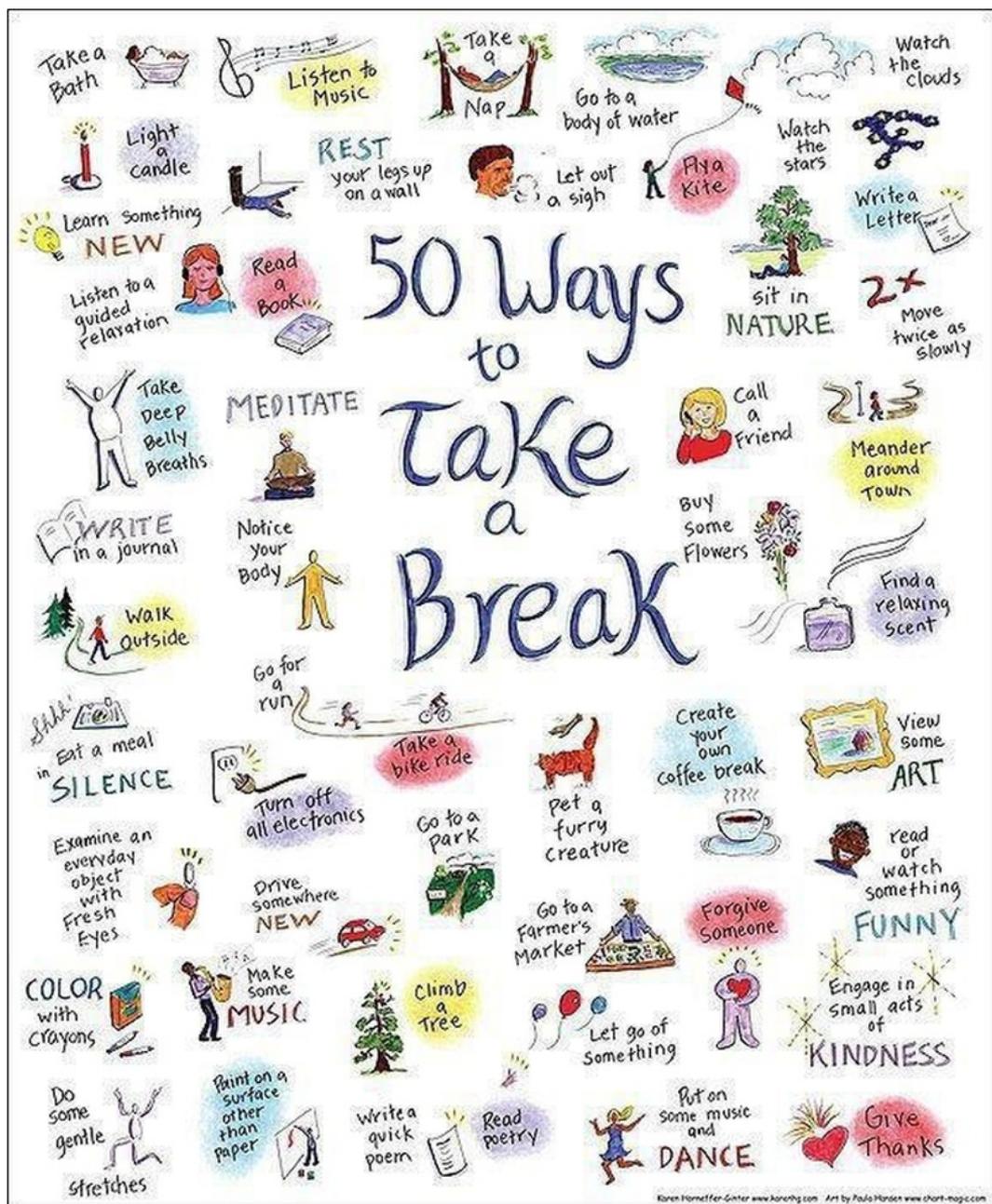
# Lessons...

- ▶ Holistic, client-centered service model
  - Carefully selected our new hires with a similar frame of reference
  - Prioritized social issues, especially early in the CM process, along with health issues
  - Significant education about self care techniques in between doctors' appointments
    - Spent resources educating staff how to educate clients

# Lessons...

- ▶ Must build strong relationships with health care providers
  - Marketed the new program, letters, newsletter articles, letters with each new established patient; built credibility among health care providers
  - Regular communication with provider offices essential, CMs are establishing those positive relationships along with the patients









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# Health Risk Assessments

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# Assessment Resources

Making Integrated Care Work CONTACT US: 202.684.7457 search

## SAMHSA-HRSA Center for Integrated Health Solutions

eSolutions newsletter

About Us Integrated Care Models Workforce Financing Clinical Practice Operations & Administration Health & Wellness

Glossary Facebook Twitter Listserve Ask a Question Email

Home / Clinical Practice / Screening Tools Print

### SCREENING TOOLS

#### Screening Tools

Despite the high prevalence of mental health and substance use problems, too many Americans go without treatment — in part because their disorders go undiagnosed. Regular screenings in primary care and other healthcare settings enables earlier identification of mental health and substance use disorders, which translates into earlier care. Screenings should be provided to people of all ages, even the young and the elderly.

- Resources
- Depression Screening Tools
- Drug & Alcohol Use Screening Tools
- Bipolar Disorder Screening Tools
- Suicide Risk Screening Tools
- Anxiety Disorders Screening Tools
- Trauma Screening Tools

#### RESOURCES

Screening Tools

Shared Decision Making

Motivational Interviewing

Substance Use

SBIRT

MAT

Pain Management

Health Disparities

Health Indicators

# Assessment Resources

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## **Fall Risk Assessment & Screening Tool (FRAST):**

<http://www.co.missoula.mt.us/healthpromo/FallPrevention/PDF/FRASTComplete2011.pdf>

## **FLACC Behavioral Pain Assessment Scale:**

<http://wps.prenhall.com/wps/media/objects/3103/3178396/tools/flacc.pdf>

## **Wong-Baker FACES Pain Rating Scale:**

<http://www.partnersagainstpain.com/printouts/A7012AS6b.pdf>

## **Brief Pain Inventory:**

<http://www.partnersagainstpain.com/printouts/A7012AS8.pdf>

## **Katz Index of Independence in Activities of Daily Living (ADL):**

[http://consultgerirn.org/uploads/File/trythis/try\\_this\\_2.pdf](http://consultgerirn.org/uploads/File/trythis/try_this_2.pdf)

## **Barthel Index of Activities of Daily Living:**

<http://www.healthcare.uiowa.edu/igec/tools/function/barthelADLs.pdf>

## **Intimate Partner Screening Tools (Research Article)**

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2688958>

## **HITS Intimate Partner Screening Tool**

[http://orchd.com/violence/documents/HITS\\_eng.pdf](http://orchd.com/violence/documents/HITS_eng.pdf)

# Assessment Resources (Substance Abuse)

TOOL	Target Population	Purpose	Time to Administer	Substances Covered	URL
<b>AUDIT (Alcohol Use Disorders Identification Test)</b>	Adults (Adolescents)	Screens for harmful or hazardous alcohol consumption	2-5 minutes (10 items)	Alcohol	<a href="http://www.integration.samhsa.gov/clinical-practice/screening-tools">http://www.integration.samhsa.gov/clinical-practice/screening-tools</a>
<b>AUDIT -C</b>	Adults	Screen to identify persons with hazardous drinking or active alcohol use disorders	3 items	Alcohol	<a href="http://www.integration.samhsa.gov/clinical-practice/screening-tools">http://www.integration.samhsa.gov/clinical-practice/screening-tools</a>
<b>NIDA-Modified ASSIST</b>	Adults	Current and lifetime use of substances	Dependent upon answers to initial questions (up to 8 questions)	Alcohol and other drugs	<a href="http://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf">http://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf</a>
<b>ASSIST</b>	Adults	Interview for use of alcohol, tobacco, and other drugs	8 items each with numerous sub-questions	Alcohol, tobacco, and other drugs	<a href="http://www.who.int/substance_abuse/activities/assist_v3_english.pdf?ua=1">http://www.who.int/substance_abuse/activities/assist_v3_english.pdf?ua=1</a>
<b>DAST-10 (Drug Abuse Screening Test)</b>	Adults	Screening to detect drug use disorders	2 minutes (10 items)	Drugs other than alcohol	<a href="http://www.sbirtoregon.org/resources/SBIRT%20-%20DAST.pdf">http://www.sbirtoregon.org/resources/SBIRT%20-%20DAST.pdf</a>
<b>MAST (Michigan Alcoholism Screening Test)</b>	Adults. Adolescents	Assess alcohol use, lifetime alcohol-related problems	8 minutes (25 items)	Alcohol	<a href="http://www.integration.samhsa.gov/clinical-practice/sbirt/screening-page/MAST_Alcohol_Test.html">http://www.integration.samhsa.gov/clinical-practice/sbirt/screening-page/MAST_Alcohol_Test.html</a>
<b>CRAFFT</b>	Adolescents	Assess substance use	6 items	Alcohol	<a href="http://www.integration.samhsa.gov/clinical-practice/sbirt/screening-page">http://www.integration.samhsa.gov/clinical-practice/sbirt/screening-page</a>
<b>5 Ps</b>	Pregnant Women	Assessment of substance use in pregnant women	4 items	Alcohol, tobacco, drugs	<a href="http://www.sbirtoregon.org/screening.php">http://www.sbirtoregon.org/screening.php</a>



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# UHC Required Assessments

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## Requirement for NetSmart and Community Care Platform Users only

- Patient Health Questionnaire (**PHQ-9**)
- Functional Assessment of Cancer Therapy –  
General Population AND Functional Assessment of  
Chronic Illness Therapy (**FACT GP**)
- Patient Activation Measure (**PAM**)
  - Tool is web based and will be made available mid- to late  
November

# PHQ-9

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## What is the PHQ 9?

- Personal Health Questionnaire
- Consists of a 9 item depression scale
- Assists with diagnosing depression and monitoring treatment response

## Advantages of this tool

- Shorter than other depression rating scales
- Can be administered in person, by phone or self-administered
- Provides assessment of symptom severity
- Proven Effective in a geriatric population
- Question 9 screens for the presence and duration of suicide ideation

# Scoring of PHQ-9

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- Rates the frequency of the symptoms which factors into the scoring severity index
- Not everyone with an elevated PHQ-9 score will have major depression and the tool is not a substitution for evaluation by a clinician
- The PHQ-9 is a tool that will assist care coordinators with identifying depression and ensuring the members receive appropriate care

# FACT-GP

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## What is the FACT-GP?

- An assessment that is made up of two sets of questions that are then combined for scoring purposes
  - First set of questions is the FACT-GP from the FACIT (Fact Assessment of Chronic Illness Therapy (FACIT) Measurement System
  - Second set of six questions are specific to Health Homes that provide additional measures of functional status and of homelessness

## Advantages of this tool

- Administered in an interview format allowing the member to clarify questions
- Assist the care coordinators in focusing on the member's functional capabilities

# Scoring of FACT-GP

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- Overall, the higher the score the healthier the member
- The first 5 Health Home questions assess parts of the member's functional status
- The value range for each question is 0 – 4 and varies according to the member's interpretation of their situation
- The last Health Home question asks if the member is homeless. This question is weighted heavier due to the impact that homelessness has on chronic health conditions

# PAM

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## What is PAM?

- Questionnaire with 13 items that measures an individual's ability to be in charge of their own health and care

## Advantages of this tool

- Provides insight to a person's behavior; the more an individual is engaged the less likely they will be admitted to the ER or become hospitalized
- Identifies members at risk, and provides personalized support at the member's level
- Allows for evaluation of coaching and support programs



**Kim Brown**

Vice President, Marketing &  
New Business Development  
Mirror, Inc.

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# Assessment of Health Home Members



- Mirror Inc. utilizes a person-centered bio-psycho-social assessment that assists the Care Coordinators in gathering information regarding the members but, as importantly, assists in the development of a relationship with the member.
- Initial focus is to begin building a relationship with the member so they will feel comfortable in sharing personal information and begin to trust the Care Coordinator.
- Focus is on the member's strengths, desires, interests, aspirations, experiences, talents, knowledge, resiliency and NOT on their deficits

# Assessment of Health Home Members



- The initial meeting with member lasts about 2 hours.
- Care Coordinators are trained to make the assessment process more of a conversation than a question/answer session.
- Care Coordinators meet with the member in their home, the office, or other location of the member's choice.
- Member is informed that they may have anyone at the meeting that they wish.
- As the discussion continues, the Care Coordinator listens for items that will lead to the development of the Health Action Plan.

# Assessment of Health Home Members



- Care Coordinators use laptops and cell phones during appointments with members. Their cell phone is their hot spot so they are connected to our network via the internet and enter the assessment directly into our Electronic Health Record (EHR) during the appointment.
- We have found that some situations are not conducive to this, however. Therefore, Care Coordinators always carry a paper assessment as back up.
- Topics of discussion during the assessment include transportation, health, leisure time activities, housing, and medications.
- The following slides are screen shots of our assessment tool, which is built into our EHR

Client , Test						Save	Cancel	
Housing / Sense of Home		Behavioral Health Screening		Medical History and Physical Exam		Transportation	Financial/Insurance	
Vocational/Educational 1			Vocational/Educational 2			Vocational/Educational 3		
Social Supports, Intimacy, and Spirituality			Social Supports, Intimacy, and Spirituality 2			Social Supports, Intimacy, and Spirituality 3		
Health		Health 2	Leisure time, Talents, Skills		Leisure time, Talents, Skills 2		Prioritizing	Invisibles

### Person Centered Case Management Assessment

Date

Staff

**Housing / Sense of Home**

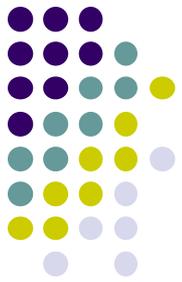
Where are you living now?

What do you like about your current living situation?

For now, do you want to remain where you are, or would you like to move?

Describe the housing situation you have had in the past that has been the most satisfying for you.

Enter date of assessment



Client , Test

Save

Cancel

Housing / Sense of Home

Behavioral Health Screening

Medical History and Physical Exam

Transportation

Financial/Insurance

Vocational/Educational 1

Vocational/Educational 2

Vocational/Educational 3

Social Supports, Intimacy, and Spirituality

Social Supports, Intimacy, and Spirituality 2

Social Supports, Intimacy, and Spirituality 3

Health

Health 2

Leisure time, Talents, Skills

Leisure time, Talents, Skills 2

Prioritizing

Invisibles

### Behavioral Health Screening

**Add New Behavioral Health Screening**

Date





**Client , Test** **Assessment Update** **Save** **Cancel**

Screening **Problems List**

Date of Screening  Staff

Screening Dimensions	Score	Guidelines
Dangerousness	<input type="text"/>	<input type="text"/> Guidelines
Functional Status GAF	<input type="text"/>	<input type="text"/> Guidelines
Functional Status Learning Capacity	<input type="text"/>	<input type="text"/> Guidelines
Medical & Psychiatric Co-Morbidity	<input type="text"/>	<input type="text"/> Guidelines
Recovery Environment - Level of Stress	<input type="text"/>	<input type="text"/> Guidelines
Recovery Environment - Level of Support	<input type="text"/>	<input type="text"/> Guidelines
Treatment and Recovery History	<input type="text"/>	<input type="text"/> Guidelines
Attitude & Engagement	<input type="text"/>	<input type="text"/> Guidelines

0 - 8 Minimal Need for Services  
9 - 16 Mild Need for Services  
17 - 24 Moderate Need for Services  
25 - 32 Significant Need for Services  
33 - 40 Urgent Need for Services

COMPOSITE SCORE

Client , Test

Save

Cancel

Housing / Sense of Home

Behavioral Health Screening

Medical History and Physical Exam

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Prioritizing

Invisibles

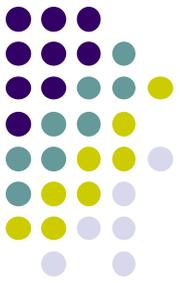
### Medical History and Physical Exam

**Add New History and Physical Exam**

Date

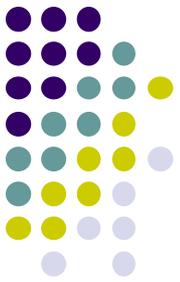


# Information for Physical Exam



- The information for the physical exam section of the assessment is obtained from the member's PCP or other health care provider.





Client , Test Assessment Update Save Cancel

Page 1 Page 2 Page 3 Page 4 Page 5 Page 6

Major Physical Disability If yes, explain

Sensorium  Alert  Somnolent  Stuporous

**Medical History**

<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Anemia	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Stroke	<input type="checkbox"/> Renal Disease	<input type="checkbox"/> Neoplasm	<input type="checkbox"/> Major Surgery
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Allergy	<input type="checkbox"/> Hypertension	<input type="checkbox"/> ENT
<input type="checkbox"/> TB	<input type="checkbox"/> GI	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eyes
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Dental	<input type="checkbox"/> Endocrine Disorder	<input type="checkbox"/> Injuries

**Family Medical History**

Relation	History	Living	Age
	[No Title]		



Client , Test **Assessment Update** **Save** **Cancel**

Page 1 | Page 2 | Page 3 | Page 4 | Page 5 | Page 6

**Allergies**

**Add New**

Date	Allergy Type	Allergy	Reaction

**Vitals**

**Add New**

Date	Time	Temperature	Pulse	Respirations	Blood Pressure

**Height/Weight**

**Add New**

Date	Weight	Height



Client , Test

Assessment Update Save Cancel

Page 1 Page 2 Page 3 Page 4 Page 5 Page 6

**General Appearance**

SKIN	
HEAD: Skull	
Eyes	
Nose	
Ears	
Mouth	
Pharynx	
Neck	
Breasts	
Chest	
Cardiovascular	
Abdomen	
Genitalia	
Musculo-Skeletal	
Extremities	
Peripheral Vascular System	



Client , Test Assessment Update Save Cancel

Page 1 Page 2 Page 3 Page 4 Page 5 Page 6

**Nervous System**

General

**Reflexes**

	Right	Left		Right	Left
Biceps	<input type="text"/>	<input type="text"/>	Triceps	<input type="text"/>	<input type="text"/>
Radial	<input type="text"/>	<input type="text"/>	Abdominal	<input type="text"/>	<input type="text"/>
Cremasteric	<input type="text"/>	<input type="text"/>	Knee	<input type="text"/>	<input type="text"/>
Ankle	<input type="text"/>	<input type="text"/>	Ankle Clonus	<input type="text"/>	<input type="text"/>
Hoffman	<input type="text"/>	<input type="text"/>	Babinski	<input type="text"/>	<input type="text"/>

Lymph Nodes

Rectum



Client , Test

Assessment Update Save Cancel

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**Impressions/Summary**

**Treatment Recommendation**

Client , Test

Save

Cancel

Housing / Sense of Home

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Social Supports, Intimacy, and Spirituality 2

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Health

Health 2

Leisure time, Talents, Skills

Leisure time, Talents, Skills 2

Prioritizing

Invisibles

### Transportation

What are all the different ways you get to where you want or need to go?

Would you like to expand your transportation options?

What are some of the ways you have used in the past to get from place to place?

If you could travel anywhere in the world, where would you go? Why?



Housing / Sense of Home

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Leisure time, Talents, Skills 2

Prioritizing

Invisibles

**Financial/Insurance**

What are your current sources of income, and how much money do you have each month to work with?

What are your monthly financial obligations?

Do you have a guardian, conservator, or payee to help you with your finances?

What do you want to happen regarding your financial situation?

What was the most satisfying time in your life regarding your financial circumstances?



Housing / Sense of Home

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Leisure time, Talents, Skills 2

Prioritizing

Invisibles

**Vocational/Educational**

Are you employed full or part time currently? If so describe where you work and what you do at your job.

What does your job mean to you? If you do not have a job now, would you like to get one?

Describe why you would or would not like to get a job at this time.

What activities are you currently involved in where you use your gifts and talents to help others?

What kinds of things do you do to make you happy and give you a sense of joy and personal satisfaction?



Client , Test

Save

Cancel

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Leisure time, Talents, Skills 2

Prioritizing

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### Vocational/Educational Continued

If you could design the perfect job for yourself what would it be? Indoors or outdoors? Night or day? Travel or no travel?

Alone or with others? Where there is smoking or no smoking? Where it is quiet or noisy?

What was the most satisfying job you ever had?

Is it harder for you to get a job, or harder for you to keep a job? Why do you think this is so?

Are you currently taking classes that will lead to a degree or taking classes to expand your knowledge and skills?



Client , Test

Save

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Leisure time, Talents, Skills 2

Prioritizing

Invisibles

### Vocational/Educational Continued

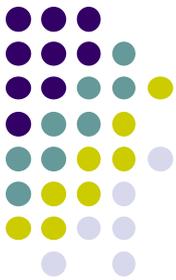
What would you like to learn more about?

How far did you go in school? What was your experience with formal education?

What are your thoughts and feelings about returning to school to finish a degree, learn new skills,  
or take a course for the sheer joy of learning new things?

Do you like to teach others to do things?

Would you like to be a coach or mentor for someone who needs some specialized assistance?



Client , Test

Save

Cancel

Housing / Sense of Home

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Leisure time, Talents, Skills 2

Prioritizing

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### Social Supports, Intimacy, and Spirituality

Describe your family.

What are the ways that members of your family provide social and emotional support for you, and help to make you feel happy and good about yourself?

Is there anything about your relationships with family that make you feel angry or upset?

What would you like to see happen regarding your relationships with family?



Housing / Sense of Home	Behavioral Health Screening	Medical History and Physical Exam	Transportation	Financial/Insurance	
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Social Supports, Intimacy, and Spirituality	Social Supports, Intimacy, and Spirituality 2	Social Supports, Intimacy, and Spirituality 3			
Health	Health 2	Leisure time, Talents, Skills	Leisure time, Talents, Skills 2	Prioritizing	Invisibles

**Social Supports, Intimacy, and Spirituality Continued**

Where do you like to hang out and spend time? Why do you like it there?

What do you do when you feel lonely? Do you have a friend that you can call to talk to or do things with?

If not, would you like to make such a friend?

Do you have the desire to be close to another in an intimate way? Would you like to have this type of relationship?

What meaning, if any, does spirituality play in your life?

If this area is important to you, how do you experience and express your spiritual self?





Client , Test						Save	Cancel
Housing / Sense of Home	Behavioral Health Screening	Medical History and Physical Exam	Transportation	Financial/Insurance			
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Social Supports, Intimacy, and Spirituality	Social Supports, Intimacy, and Spirituality 2	Social Supports, Intimacy, and Spirituality 3					
Health	Health 2	Leisure time, Talents, Skills	Leisure time, Talents, Skills 2	Prioritizing	Invisibles		

**Social Supports, Intimacy, and Spirituality Continued**

What are your thoughts and feelings about nature?

Do you like animals? Do you have a pet? If not, would you like one? (If so, describe) Have you ever had a pet?



Client , Test						Save	Cancel
Housing / Sense of Home	Behavioral Health Screening	Medical History and Physical Exam	Transportation	Financial/Insurance			
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Social Supports, Intimacy, and Spirituality	Social Supports, Intimacy, and Spirituality 2	Social Supports, Intimacy, and Spirituality 3					
Health	Health 2	Leisure time, Talents, Skills	Leisure time, Talents, Skills 2	Prioritizing	Invisibles		

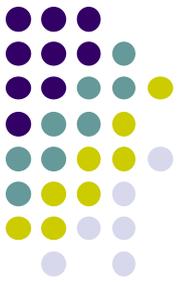
**Health**

How would you describe your health these days?

Is being in good health important to you? Why or why not?

What kinds of things do you do to take care of your health?

What are your patterns regarding smoking? Using alcohol? Using caffeine? What effect do these drugs have on your health?



Client , Test								Save	Cancel
Housing / Sense of Home	Behavioral Health Screening		Medical History and Physical Exam		Transportation	Financial/Insurance			
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Health	Health 2	Leisure time, Talents, Skills		Leisure time, Talents, Skills 2		Prioritizing	Invisibles		

**Health Continued**

What prescription medications are you currently taking? How do these medications help you?

How do you know when you are not doing too well? What is most calming and helpful for you during these times?

What limitations do you experience as a result of health circumstances?

What do you want and believe that you need in the area of health?



Client , Test						Save	Cancel
Housing / Sense of Home	Behavioral Health Screening	Medical History and Physical Exam	Transportation	Financial/Insurance			
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Social Supports, Intimacy, and Spirituality		Social Supports, Intimacy, and Spirituality 2		Social Supports, Intimacy, and Spirituality 3			
Health	Health 2	Leisure time, Talents, Skills	Leisure time, Talents, Skills 2	Prioritizing	Invisibles		

**Leisure time, Talents, Skills**

What are the activities that you enjoy and give you a sense of satisfaction, peace, accomplishment, and personal fulfillment?

Would you like the opportunity to engage more frequently in these activities?

What are the skills, abilities, and talents that you possess? These may be tangible skills such as playing a musical instrument, writing poetry, dancing, singing, painting, etc. or intangible gifts such as sense of humor, compassion for others, kindness, etc.



**Client , Test** Save Cancel

Housing / Sense of Home Behavioral Health Screening Medical History and Physical Exam Transportation Financial/Insurance

Vocational/Educational 1 Vocational/Educational 2 Vocational/Educational 3

Social Supports, Intimacy, and Spirituality Social Supports, Intimacy, and Spirituality 2 Social Supports, Intimacy, and Spirituality 3

Health Health 2 Leisure time, Talents, Skills Leisure time, Talents, Skills 2 Prioritizing Invisibles

**Leisure time, Talents, Skills Continued**

What are the sources of pride in your life?

Are there things you use to do regularly that gave you a sense of joy that you have not done in recent years?

Which of these activities would you consider re-discovering at this time in your life?



Client , Test										Save	Cancel
Housing / Sense of Home		Behavioral Health Screening		Medical History and Physical Exam			Transportation		Financial/Insurance		
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**Prioritizing**

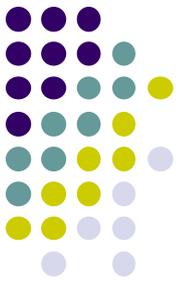
After thinking about all of these areas of your life, what are the two personal DESIRES that are most meaningful for you at this time?

Desire One

Desire Two

# SUCCESS!!!!!!!!!!!!!!!



77 year old female member living alone in Wyandotte County.

- Barriers: Broken pelvis last year in a fall, diabetes, remembering to take insulin, transportation, relationship with children struggling with addiction
- Care Coordination: Connected her to ADRC; got her in-home help, taught her how to use NEMT, helped place insulin reminder, set up counseling



## Questions?

Contact Information:

**Kim Brown**

**Mirror Inc.**

**316-323-8965**

**[kimbrown@mirrorinc.org](mailto:kimbrown@mirrorinc.org)**

# Daphne Brown

Health Home Director

Connections for Life

(High Plains Mental Health Center)

[daphne.brown@hpmhc.com](mailto:daphne.brown@hpmhc.com)



# Health Risk Assessment

---

- 27 questions
- Growth easy to assess
- Combination of multiple valid and reliable health risk assessments
- Input from mental health, physical health and substance abuse staff
- Use it with kids and adults

# Connections for Life Health Risk Assessment

Name:

Date of Birth:

Date:

Assessment type:

Initial

Annual

Discharge

Primary Care Physician:

Please choose any health goals you are currently working on or would like to work on in any of the following areas? Mental Health, Regular Check-ups, Exercise, Healthy Foods, Smoking Cessation, COPD or Asthma, Dental Health

Other \_\_\_\_\_

## Physical Health

Height \_\_\_\_\_

Weight \_\_\_\_\_

Blood Pressure \_\_\_\_\_

Low or normal (at or below 120/80)

Borderline High (120/80 -139/89)

High (140/90 or higher)

Cholesterol \_\_\_\_\_

Desirable (below 200)

Borderline High (200-239)

High (240 or higher)

Blood Glucose \_\_\_\_\_

Desirable (below 100)

Borderline High (100-125)

High (126 or higher)

1. Overall, how would you rate your health during the **past 4 weeks**?

Excellent

Very Good

Good

Fair

Poor

Very Poor

2. During the **past 4 weeks**, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?

Not at all

Very little

Somewhat

Quite a lot

Could not do physical activities

3. During the **past 4 weeks**, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?  
 None at all    A little bit    Some    Quite a lot    Could not do daily work
4. How much bodily pain have you had during the **past 4 weeks**?  
 None    Very mild    Mild    Moderate    Severe    Very Severe
5. During the **past 4 weeks**, how much energy did you have?  
 Very much    Quite a lot    Some    A little    None
6. During the **past 4 weeks**, how often did you eat at least 3-4 servings of vegetables or fruit each day?  
 Not at all    Very little    Sometimes    Quite a lot    All the time
7. During the **past 4 weeks**, how often did you monitor the amount of fatty foods you ate each day?  
 Not at all    Very little    Sometimes    Quite a lot    All the time
8. During the **past 4 weeks**, how often did you engage in some form of exercise?  
 Not at all    Very little    Sometimes    Quite a lot    Very frequently

**Emotional Well-Being**

9. During the **past 4 weeks**, how much did your physical health or emotional problems limit your usual social activities with family or friends?  
 Not at all    Very little    Somewhat    Quite a lot    Could not do social activities
10. During the **past 4 weeks**, how much have you been bothered by **emotional problems** (such as feeling anxious, depressed, irritable or sad)?  
 Not at all    Slightly    Moderately    Quite a lot    Extremely
11. During the **past 4 weeks**, how much did personal or emotional problems keep you from doing your usual work, school or other daily activities?  
 Not at all    Very little    Somewhat    Quite a lot    Could not do daily activities

**Daily Living and Self-Care**

12. During the **past 4 weeks**, how often did you take all of your medications as prescribed?  
 Not at all    Very little    Sometimes    Quite a lot    All the time

# SBIRT Trigger Questions

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14. During the past **4 weeks**, how often did you consume more than four alcoholic beverages in one day?

Never

1-2 days 3-4 days

5-6 days

7+days

15. During the past **4 weeks**, how often have you used an illegal drug or used prescription medicine that was not prescribed to you?

Never

One time

2 times

3 times

4 or more times

16. During the past **4 weeks**, on average, how many alcoholic beverages have you drank per day?

None

1-2

3-4

5-6

more than 6

# Other Successes For Connections for Life

---

- Primary Care Appointments
- Dental Appointments
- Groups
- Community Outreach
- Support



SUN

MON

TUE

WED

THU

FRI

SAT

# October

			1	2	3	4
5	6 Nutrition/ exercise group 2:00-3:30 White House	7 6:00 pm— Computer Skills— Hays Public Library	8 Flu Shot Educa- tion—10-11:30 White House	9 6:00 p.m.—Game Night—Hays Public Library	10 Managing High Blood Pressure 9:30- 10:00 am and 11-12. Diabetes manage- ment—1:30-	11
12	13 Nutrition/ exercise group 10-11 am White House	14 6:00 pm— Computer Skills— Hays Public Library	15 R.N.—Sonja Stice in Osborne Branch Office Call to schedule ap- pointment	16 6:00 p.m.—Game Night—Hays Public Library	17 Managing High Blood Pressure 9:30- 10:00 am and 11-12 Diabetes manage- ment—1:30-2:30	18
19	20 Nutrition/ exercise group 2:00-3:30 White House	21 6:00 pm— Computer Skills— Hays Public Library	22 R.N.—Sonja Stice in Norton Branch Office Call to schedule ap- pointment	23 R.N. Sonja Stice in Phillipsburg Branch office Call to schedule ap- pointment	24 Managing High Blood Pressure 9:30- 10:00 am and 11-12 Diabetes manage- ment—1:30-2:30	25
26	27 Nutrition/ exercise group 2:00-3:30 White House	28 6:00 pm— Computer Skills— Hays Public Library	29 Flu Shot Education 10-11:30 White House	30 6:00 pm—Game Night—Hays Public Library	31	



**UPCOMING**

*Mark Your Calendars*

**EVENTS**



## Learning Collaborative Webcasts:

1<sup>st</sup> Tuesdays 3:00 – 4:00 p.m.

November 4 - Quality Measures and Goals

December 2 - TBD



# Health Action Plan Webinars:

3<sup>rd</sup> Tuesdays 10:00 – 11:30 a.m.

November 18 – The 5 “A”s of Smoking Cessation

December 16 – Health Literacy

# Community of Practice Webcasts:

1:00 – 2:00 p.m. - November 4 and December 2



WICHITA STATE  
UNIVERSITY

*CENTER FOR COMMUNITY SUPPORT  
AND RESEARCH*

# Learning Collaborative

## Kansas Medicaid Health Homes Initiative

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Thank you for joining us!

Please complete your yellow  
evaluation form.