COACH MANUAL

The Camden Coalition of Health Care Providers

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Manual prepared in partnership with PolicyLab, Children’s Hospital of Philadelphia.

Camden Coalition of Healthcare Providers
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This document is a training manual for COACH, a set of techniques and tools used by a health care team as part of a short-term, intensive care management intervention (CMI) for medically and socially complex populations.

Definitions for **bolded terms** can be found in the **GLOSSARY OF KEY CONCEPTS**.

BACKGROUND OF THE CAMDEN COALITION OF HEALTHCARE PROVIDERS (THE COALITION)

The Camden Coalition of Healthcare Providers (Coalition) seeks to improve the quality, capacity, coordination, and accessibility of healthcare for Camden’s most medically and chronically complex individuals. The Camden Coalition uses a technique called “hotspotting” to identify patients with extreme health care use based on real-time health care data, and offers them an intensive CMI to help manage their complex medical and social needs.¹ Targeting the hospital-to-home transition, the Coalition’s intervention emphasizes the importance of an **Authentic Healing Relationship** between the Care Team and the patient as a means to drive behavior change. In addition to individual clinical services, the Coalition works at the systems-level to improve the integration of, and collaboration between, health care systems and social service agencies in the city of Camden.

[For more information on healthcare hotspotting, refer to the Coalition’s Healthcare Hotspotting Toolkit at http://healthcarehotspotting.com.]

Dr. Jeff Brenner, the Coalition’s founder and Director, began this work (in its earliest form) in the 2000s because of what he observed, initially through his clinical work as a family physician in Camden and then through data analysis: the highest-need patients had the most frequent emergency room visits and hospital admissions.² As is common across the country, 30 percent of hospital costs in Camden were coming from only 1 percent of patients.³ Further analyses found that many of these patients with frequent utilization not only habitually frequented the emergency room and hospital in-patient wards for easily treatable conditions, but were often seeking care for advanced conditions that could have

been prevented if diagnosed and treated earlier.\textsuperscript{4} Dr. Brenner brought together a citywide coalition of hospitals, primary care providers, and community representatives to address the health of patients facing the most complex medical and social challenges. Simultaneously, he partnered with a nurse practitioner and a social worker to begin providing intensive care management services to individuals experiencing frequent utilization that addressed their complex medical and social needs.\textsuperscript{5} Between October 2012 and December 2015, the Coalition served 604 patients.

The Coalition identifies individuals experiencing frequent utilization through its own citywide health information exchange that flags patients who have been admitted to the hospital two or more times in six months (see \textbf{OVERVIEW OF COACH} for full eligibility criteria). The Coalition’s interdisciplinary \textbf{Care Management Teams (Care Teams)} work with these patients within a targeted CMI that averages 90 days. However, there is no hard stop or cut off date. The Care Teams, which now include a nurse, a community health worker, and a social worker use the \textbf{COACH model} to work with patients on a weekly basis to address their complex medical and social needs. The ultimate goal is to reduce hospital admissions by supporting the patient in finding ways to best manage their health conditions and engage in preventive care. As attention on healthcare hotspotting grows, the Coalition organizes learning collaboratives, provides trainings and releases toolkits to help other organizations build intensive CMIs. Drawing on clinical team experiences with patients, Coalition staff also work at the policy level to transform health care payment and delivery models.

\textbf{FIGURE 1. THE COALITION’S INTENSIVE CARE MANAGEMENT INTERVENTION (CMI)}

\textsuperscript{4} Ibid.

OVERVIEW OF COACH

History and Theoretical Background

COACH is a framework of techniques and tools employed by health providers to be used as part of an intensive care management intervention. A foundation of the framework is the development of an **Authentic Healing Relationship** between the patient and the **Care Management Team (Care Team)**. The ultimate goal of the COACH framework is to support patients to attain behavior change toward long-term health management. Historically, care planning at the Coalition was done as a time-intensive, artisanal practice, which lacked the documentation and methodology required to advance the model with reliability, efficiency, and scale.\(^6\) Understanding this need, the Coalition spent two years studying and adapting best practices from business, qualitative methods, and patient-centered care to define and develop a CMI for its patient population.\(^7\) Care planning is local, specific, and tailored to the needs of the population being served.

**AUTHENTIC HEALING RELATIONSHIP**

The Authentic Healing Relationship is a respectful, trusting and non-judgmental partnership between the Care Team and the patient that serves as the foundation for progress toward long-term health management. Through interviews with former patients, the Coalition found that the relationships between Care Team Members and patients were the major driver for sustainable patient behavior change. This supports best practice literature that has identified the provider-patient relationship as a core element of home visiting programs, and literature that found that a non-judgmental approach motivates patients to make positive change. The Coalition identified three core elements of Authentic Healing Relationships through patient interviews: security, genuineness, and continuity.

The COACH framework was developed by several founding Coalition staff as a way to train **Care Teams** on techniques and tools to use in the care planning process. Building on a staff member’s prior experience in Teach for America, the COACH model trains practitioners as empowerment coaches rather than solely as providers for the patients. This means that Coalition staff are trained to work with patients to develop an individualized care plan around their own long-term vision and goals. This framework recognizes that all patients function within their own larger social and community systems, and encourages them to identify long-term supports from their doctor’s office, social service organizations, and/or family and personal relationships who can provide continued support beyond the intensive CMI.


\(^7\) Ibid.
COACH incorporates elements of the following well-established theories of behavior change:

- **Empowerment Theory**: Empowerment theory states that individuals have the strength and competency within themselves to define and fulfill their own success. A central tenant of COACH is training Coalition staff to work with patients to build confidence in their own strength and ability to manage their health and social challenges.

- **Unconditional Positive Regard**: COACH encourages Care Team members to assume an approach of Unconditional Positive Regard, the theory that clinicians should take a non-judgmental and accepting approach toward the patient in order for behavior change to happen. This theory is particularly important to COACH as medically and socially complex patients often face judgment within health systems, social services, and the criminal justice system for the common challenges they face, including substance use, mental health issues, and homelessness.

- **Transtheoretical Theory (Stages of Change)**: COACH incorporates elements of Transtheoretical Theory to explain the progression of behavior change. This theory states that the motivation to change behavior happens in six stages: pre-contemplation, contemplation, preparation, actions, maintenance, termination. By educating staff on phases of change, the COACH framework creates a guide toward patient empowerment and successful chronic health management that recognizes the importance of preparation and reinforcement to long-term change.

The next section of the manual describes the specific components of the COACH framework, including how patients are identified for the CMI and who is hired as part of the Care Team.

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Overview of COACH

COACH is a five-part framework that trains staff to be empowerment coaches in order to problem-solve with patients to determine how to effectively manage their chronic health conditions and reduce preventable hospital admissions. COACH is not a linear model. The tools and techniques that are incorporated within the framework are meant to be fluid, overlapping at times, and repeated and revisited throughout the intervention. The five-part framework is:

- **C:** Connect Plan with Vision and Priorities
- **O:** Observe the Normal Routine
- **A:** Assume a Coaching Style
- **C:** Check the Backwards Plan
- **H:** Highlight Progress with Data

These five parts are not meant to be performed sequentially, and the timing may vary depending on the patient’s unique needs (See ADMINISTERING COACH’S TECHNIQUES AND TOOLS for more details on the timing of these techniques across the intervention). The COACH framework can be sorted into two categories: techniques and tools (See FIGURE 2). The techniques are the approach used by the Care Team in their interactions with patients; the tools help the patient and Care Team track goals and progress.

**FIGURE 2. COACH TECHNIQUES AND TOOLS**
**GOALS OF COACH**

Using COACH as part of the CMI allows Care Team Members to work effectively with the patient to:

- Build confidence and find ways to independently manage their health care and social needs, either by performing tasks themselves or with long-term supports (person or system).
- Connect and maintain a relationship with a Primary Care Physician (PCP).

The techniques and tools are designed to help Care Team members develop an **Authentic Healing Relationship** with patients – a respectful, trusting and non-judgmental partnership between the Care Team Member and the patient. COACH is incorporated, practiced, and normed throughout patient interactions and among the team. Practitioners do home visits and accompany patients to other meetings related to the management of health and social challenges, including primary care appointments, social service agencies, and pharmacies. While COACH is designed to support a short-term care management intervention (average of 90 days), the duration and sequencing of the intervention varies according to the complexity of the case. In addition, since COACH techniques are focused on relationships and trust-building, there are not time-limited expectations put on each of the five components, and the timing of when techniques are used is catered toward the unique needs of each patient. Refer to **ADMINISTERING COACH'S TECHNIQUES AND TOOLS** for more details on how to execute COACH.

From the beginning of the intervention, COACH trains practitioners to work with the patient to identify a **long-term support/strategy**, which could be a person within the patient's primary care office, a person within a social service organization, a personal relationship, and/or a long-term care facility. COACH practitioners work to integrate this long-term support into the intervention, to ensure that the patient has a support system beyond the intervention.
IDENTIFYING A LONG-TERM SUPPORT/STRATEGY

A key element of COACH is working with the patient from the beginning of the intervention to identify a long-term support who can support the patient in managing his/her complex medical and social needs beyond the intervention. Some patients may not be able to manage specific aspects of their complex health and social needs, and the long-term support is critical to ensuring that the progress gained during the intervention is sustained after the Care Team stops making weekly home visits. A long-term support can be a person within the patient’s primary care office (primary care doctor, nurse, social worker), a person within a social service organization (case manager), a personal relationship (family member, spouse, friend, neighbor), and/or a long-term care facility (Adult Day program or recovery program). Refer to OBSERVE NORMAL ROUTINE for more information on how Care Team members help patients identify a long-term support. Once identified and with patient consent, Care Team staff work with the long-term support throughout the intervention to ensure that he/she is included in the Care Plan, and informed of the patient’s progress and challenges.

Target Population and Inclusion Criteria

The COACH approach was developed in the context of the Coalition’s CMI for individuals experiencing frequent healthcare utilization. Over time, experience with patients and lessons learned about which techniques and practices worked best with patients evolved into COACH. As part of their “hotspotting work,” the Coalition uses a citywide Health Information Exchange (HIE) to identify patients in real-time who have been admitted to the hospital in the last 24 hours, who also had a previous hospital admission within the past 6 months. The HIE includes information from major health providers in Camden. For a full list of participating providers and more information on the Coalition’s HIE, visit: https://www.camdenhealth.org/programs/health-information-exchange/.

To be a part of the Coalition’s CMI, patients must have 2 or more chronic conditions. They also meet at least two of the following criteria:

- Be taking 5 or more outpatient medications
- Have difficulty accessing services
- Lack social support
- Experience mental health comorbidity
- Be actively using drugs or substances.
- Be experiencing homelessness.
Additional eligibility criteria include patients who are: ages 18-80, still admitted to the hospital at time of triage, have public or private insurance, and are willing and able to consent to participate. Once identified, Care Team staff visit the patient in the hospital to invite them to participate in the intervention. After consent has been granted, the Care Team makes their first weekly home visit within three days of hospital discharge.

**Graduation**

The goal of the Coalition’s CMI is to use the techniques and tools outlined in COACH to support the patient in completing the program, or “graduating.” A patient is considered ready to graduate when he/she is able to conduct the tasks necessary for managing his/her critical medical and social needs independently, or in partnership with a long term support (see OVERVIEW OF COACH). See ASSUME A COACHING STYLE in for a description of this process. On average, graduation happens within a 90-day period. But, the length of time it takes patients to graduate depends on patients’ individual needs and their degree of medical and social complexity, and the model is sufficiently flexible to accommodate this. At the point of graduation, the patient is connected with and able to access preventive health services that prevent him/her from being regularly admitted to the hospital. As part of the graduation process, the Care Team hopes it will be able to make a “warm handoff” to the primary care and/or specialty provider who will care for the patient over the long-term. This is not always possible, but is an ongoing goal of the Care Team.

**Staffing and Hiring**

When hiring new staff, the Coalition places a high value on attitude and natural patient-centered approach. Because of this, there is three-part interview process. Phase 1 is a group interview where the candidates watch a harm reduction documentary and then are asked various questions in response to what they viewed, and are asked to work through a case study. In Phase 2 a candidate interviews individually with managers, and is asked a range of questions to assess emotional intelligence and self-awareness. Finally, in Phase 3 a candidate will shadow a Care Team in the community for a half day, and also interview with departmental and organizational leadership.

The staff roles and members of the Care Team used by the Coalition are identified below. However, because COACH represents an approach to interacting with patients or clients, it could be adapted and used in a variety of contexts (e.g. social services, education, corrections, etc.). Thus, teams that use COACH can vary.
The Coalition’s Care Management Team (Care Team)

The Care Team is the team responsible for executing the CMI. Led by a nurse, the Care Team visits the patient at bedside and then conducts subsequent home visits using the COACH model. The Care Team reports to the Supervisory Team, and is supported by the Clinical Support Team. Two key members of the Care Team are:

- **Nurse Care Coordinator**: The Nurse Care Coordinator leads the Care Team. The nurse performs ongoing assessments of medical needs, and provides medical education around health issues, such as medication management and nutrition. The nurse also accompanies the patient to appointments and specialty visits, and performs case management tasks, such as signing up for health insurance, in partnership with the Community Health Worker.

- **Community Health Worker**: The Community Health Worker supports the nurse by helping prepare for the visit, communicating with the patient’s social service providers and pharmacist, and supporting other operational components of the model (e.g., helping with transportation, when needed).

Clinical Support Team

The Clinical Support team provides specialized clinical support to Care Team members. This team works with all Care Teams to problem-solve and address patient clinical needs

- **RN Clinical Manager**: The Clinical Support Team is led by the RN Clinical Manager, who oversees the Care Team’s daily tasks and care management. The RN Clinical Manager holds weekly check-in meetings with individual Care Teams and monthly check-ins with all clinical staff to review cases and problem-solve challenges. Refer to **SUPERVISION AND TRAINING** for a full description of these meetings.

- **Social Work Manager**: The Social Work Manager oversees and provides clinical support to the Care Teams to ensure all of the non-medical needs of patients are met.

- **Social Work Coordinators (2)**: The Social Work Coordinators work with patients, families, hospital staff, and community agencies to provide intensive discharge care planning and coordination, and assist with support, planning, coordination and advocacy as needed to improve the quality of life and care for patients.
• **Behavioral Health Consultant:** The Behavioral Health Consultant has a leadership role in developing and delivering staff training, and evaluating and coordinating care for patients with significant behavioral health issues.

• **Hospital Social Worker:** The Hospital Social Worker, who is employed by the Coalition, is responsible for performing the "enrollment process" at the bedside and gathering supplemental information, which is then communicated to the Care Team. The Hospital Social Worker also meets with Coalition patients during readmissions, during which time he/she communicates with the patient’s Care Team and advocates for the patient’s needs. One of the biggest undertakings for the Hospital Social Worker is building relationships with the floor Social Workers who are employed by the Hospital.

• **Enrollment Specialist:** The Enrollment Specialist serves as the first point of contact for hospitalized patients who are eligible for the Coalition’s CMI, engaging and enrolling them into the intervention at the bedside. They also assist in scheduling follow up appointments for the patient with the PCP while they are still admitted.

**Supervisory Team**

The Supervisory Team oversees and supports the Clinical Support Team. Led by the organization’s Clinical Director and program management, the Supervisory Team provides oversight on tracking patient outcomes, care management strategy, and program development.

See **SUPERVISION AND TRAINING** for information on staff training.
The tools and techniques outlined in each of COACH’s five parts are not meant to be performed sequentially, and the timing may vary depending on the patient’s unique needs. Each part is described in the following sections. The skills outlined in COACH can be sorted into two categories: techniques and tools (see FIGURE 2).

**Techniques:**
- Observe a Normal Routine
- Connect Tasks with Vision and Priorities
- Assume a Coaching Style

**Tools:**
- Check a Backwards Plan
- Highlight Progress with Data

While COACH’s five-part framework cannot be sorted into defined sessions, Observe a Normal Routine serves as a foundation for the other techniques and tools, and is the first step in developing an Authentic Healing Relationship (See GLOSSARY OF KEY CONCEPTS) with the patient. The goal of Observe a Normal Routine is for the Care Team to have an understanding of the patient’s challenges and strengths, which is essential to taking a strengths-based and patient-centered approach toward developing the Backwards Plan and Assume a Coaching Style. The fact that there is built-in time to observe and understand the patient is part of what makes COACH unique compared to other health intervention models, and allows Care Team members to act as “empowerment coaches” rather than traditional health care providers.

Staff begin creating the Backwards Plan during the first home visit, in order to have benchmarks by which to track patient progress, and ensure that the intervention is catered toward the patient’s unique needs and strengths. The Backwards Plan is a dynamic tool, and can change throughout the intervention as more information is gathered. Highlight Progress with Data, tracks progress throughout the Backwards Plan, and is therefore used after the plan has been developed.

The reality of COACH is that the timing of the techniques and tools varies per the unique needs of each patient. This timing should be an ongoing discussion between Care Team members, and with supervisors. See FIGURE 2 for a visual of COACH’s techniques and tools.
In the following sections, the following components of each part are described: the overall goal; key terms; instructions for how and when to execute key activities; examples; preparation and materials needed (if any); and some markers of success to gauge whether the patient and Care Team are hitting certain milestones in the intervention process.
Overall Goal

The goal for *Connect Plan with Long-Term Vision and Priorities* is for the Care Team, the patient, and the patient’s identified long-term support to have a shared understanding of the question “What does the patient want for him/herself?” In other words, the purpose is to link individual parts of a Care Plan to the larger vision a patient has for his/her life.

This approach of connecting the patient’s care plan with his/her long-term vision also asks Care Team members to have a shared understanding of what the Coalition refers to as the patient’s “dominant core need.” The Coalition recognizes that the main drivers of motivation are: “I want” and “I can.” Interviews by the Camden Coalition with early clients found Care Teams did their jobs better when they understood what core need or desire motivated a client to change, in other words, addressing the patient’s “I want” motivation driver. Three major “dominant core needs” emerged from the Coalition’s experience working with clients: 1) significance, 2) love and belonging, and 3) certainty and safety. Clients are not diagnosed by the Care Team as having one need and not another, but it provides a helpful point of reflection when the team and patient are working toward a long-term vision of health. Care Team members are asked to reflect on their own core needs as a way to understand their own priorities and biases and how that might shape their work with a client. This reflection also helps Care Team members address “tug of war” scenarios. More details and scenarios involving dominant core needs can be found below.

Key Terms

*Dominant core need*

Dominant core needs are underlying needs and desires that affect motivation and behavior. Core needs fall into three categories:

- **Significance**: Deep desire to feel important or recognized.
- **Love and Belonging**: Deep desire to feel accepted and have social support.
- **Certainty and Safety**: Deep desire for stability, a plan, and controlled surrounding.

It is important for Care Team members to understand the patient’s dominant (primary) core need and to help the patient identify strategies or resources that fulfill that need. Clients are not diagnosed by the Care Team as having one need and not another, but it provides a helpful point of reflection when the Team and client are working toward a long-term vision of health. Supervisors also think about “core needs” when a Care Team
member has hit a road block with a patient. In this scenario, Care Team members might be asked to take a step back and think about their own core needs and what might be triggering their reaction to the difficult situation. The goal is to create Care Team members who are self-aware, and able to regulate their reactions to complex patient situations.

“Tug of war” scenario

“Tug of war” scenarios occur when the priorities of the Care Team do not align with that of the patient, or the patient is not making progress in the Care Planning Domains identified as priorities. To avoid and/or overcome these scenarios, it is important for the Care Team to identify the patient’s dominant core need and be able to articulate it back to the patient while connecting smaller tasks to the broader vision. Furthermore, the Care Team should continue to highlight small wins or progress that the patient has made thus far in the identified domains.

Preparation and Materials Needed

No materials are needed. Staff should refresh their memory of the three dominant core needs before initiating the intervention with a new patient, and during a “tug of war” scenario.

Instructions

In order to answer the question “What does the patient want for him/herself?” this section provides instructions for: identifying the patient’s long-term vision for him/herself, and identifying the patient’s dominant core need.

Identifying the patient’s long-term vision for him/herself

To identify patients’ long-term vision and goals use open-ended questions and reflective language to understand what a patient truly wants for him/herself beyond being healthy and staying out of the hospital.

Examples of open-ended questions:

• What makes you want to stay out of the hospital?
• What would you like to see different about your current situation?
• What do you envision for yourself in 5 years?
Examples of reflective language:
- I hear you saying that you want to spend more time with your grandchildren.
- It sounds like...
- It seems as if...
- I get the sense that...

Identifying and connecting the long-term vision with the patient’s dominant core need

Care Team members identify the patient’s dominant core need through observation and conversation done as part of Observe Normal Routine. Recognizing the patient’s dominant core need is important to take into consideration when care planning, but it is particularly important in “tug of war” scenarios when patient progress feels “stuck.” In this case, Care Team members can directly address a patient’s long-term vision and identified priorities in order to demonstrate the importance of short-term tasks and progress. See examples below.

When Do You Use It?

Connecting the plan with the patient’s vision should be used throughout the intervention, particularly in the following two situations:

At the beginning of the intervention in sessions 1 or 2

It is important for the Care Team to identify the patient’s goals and dominant core need early in the intervention to take into consideration when creating weekly tasks in the patient’s care plan (See CHECK BACKWARDS PLAN). That said, identifying patient needs and priorities should happen throughout the intervention to be responsive to the dynamic and changing needs of the patient over time.

During a “tug of war” scenario

“Tug of war” scenarios occur when something is triggering a Care Team member in his/her work with a patient. When this happens, a Supervisor will encourage a Care Team member to take a step back and try to understand what about the situation is getting in the way of their work with the patient. In some cases, it can be because the Care Team member and patient prioritize needs differently. Care Team members are supported by their colleagues and supervisors to work through roadblocks with patients.
EXAMPLES
CONNECTING WITH PATIENT’S LONG-TERM VISION & DOMINANT CORE NEED

Scenario
A patient regularly uses the emergency room for routine care, which usually ends in being admitted to the hospital. She often misses routine appointments with her primary care doctor. This patient often feels that her family is not involved enough in her health management, since they rarely attend appointments with her. The patient identifies that if she was able to spend more time with her grandchildren, her relationship with her family would improve.

Example 1: Connecting with a patient’s long-term vision
The patient’s long-term vision is to be healthy enough to spend more time at home with her grandchildren. When developing a care plan with this patient, you can connect her attendance to routine appointments and improved health management with her ability to spend more time with her grandchildren.

You say:
“I hear you saying that would you like your family to be more involved in helping you manage your health.”
“How would you like this to be different?”
“What could you and your family do to make this situation better?”

Example 2: Connecting with a patient’s dominant core need
You identify the patient’s core need as love and belonging. You say:
“I know it’s important to you to spend time with your grandchildren. We want to make sure that you’re healthy enough to see them. An important part of being healthy is going to see your primary care doctor. This will help you visit your grandchildren more.”
Markers of Success

**Patient**

- The patient articulates their goals and priorities for the intervention period and beyond.
- The patient reports that the Care Team understands and is working toward their goals and priorities (i.e., the patient reports a shared understanding of the Care Plan with the Care Team).
- The patient’s identified long-term support has a shared understanding of, and can articulate, the patient’s long-term vision (beyond their immediate health goals) and their dominant core need (i.e., they can articulate why the patient wants to achieve certain goals).

**Care Team**

- The Patient’s long-term vision and dominant core need is recorded in the Care Plan, and incorporated into the patient’s Care Plan (See **CHECK BACKWARDS PLAN**).
- Care Team is able to identify, and has a shared understanding of, the patient’s dominant core need throughout the intervention (Love and Belonging; Significance; Certainty & Safety). This is an active process, and the dominant core need may change throughout the intervention.
- Care Team members identify their own dominant core needs in order to reflect on how this affects interaction with the patient, and are able to understand whether and how their own priorities and biases influence the Care Plan (again, this is used as a reflective exercise so the Care Team can check in on their own motivations).
EXAMPLES: “TUG OF WAR” SCENARIOS

The Care Team’s priorities do not align with patient’s priorities:

**Scenario**
A patient is experiencing addiction issues with heroin. You are concerned for the patient, and want her to address her addiction immediately. The patient refuses to attend the rehabilitation program you suggest. She has left you several voice messages asking what her options are for stable housing. You are frustrated that she is not listening to you.

**Response**
As the Care Team member, this is a moment for you to step back and consider what the patient’s self-identified vision and goals are. In this case, the patient is making it clear that her priority is to secure stable housing. While your priority may be different (to treat her addiction), the patient’s goals are the driver for the interventions. You let the patient know that you will be looking into housing options that align with her needs. At the same time, you continue to explore the best clean needle and treatment options for her, and change your framing to include her desire for stable housing. For example, “It is important to find a treatment option that works best for you because that will open up more safe and stable housing opportunities.”

A Care Team member’s dominant core need clashes with patient’s core need:

**Scenario**
A patient you are serving is a first generation immigrant to the United States. A few months ago, the patient’s parents, who were undocumented, were picked up by immigration and deported. The patient does not know who reported them. This patient is reluctant to share personal information during home visits, and remains distant from you and the other Care Team members. You have recently returned to work after a close family member passed away, and during a home visit you find yourself becoming increasingly agitated and frustrated that the patient is not responding to your questions.

**Response**
Since you recognize that you are becoming frustrated, you take time after the home visit to reflect with the Care Team. In discussion with your fellow Care Team members, you identify that the patient’s dominant core need is *Certainty and Safety* due to mistrust of officials. You then reflect that your own dominant core need is *Love and Belonging*, as you’re still coping with the loss of a close family member. You realize that your need to connect with the patient combined with the patient’s mistrust is what felt so frustrating to you. With this understanding and perspective, you enter the next home visit prepared to not let your personal frustration get in the way of the intervention.
Overall Goal

The goal of “Observe Normal Routine” is for the Care Team, the patient, and the patient’s long-term support to have a shared understanding of how the patient manages his/her health and social challenges, including scheduling, transportation, medication use, and emergency care. The goal of observing the patient’s normal routine is to identify the patient’s challenges and strengths before proceeding with the CMI, which is important to taking a strengths-based approach that encourages incremental, but lasting and meaningful change. Observing a patient’s normal routine can also help the Care Team to identify the patient’s long-term support, which could be a provider (primary care doctor, pharmacist, social service agency), a personal connection (family member, friend, neighbor), and/or a long-term care facility (Adult Day program or recovery program).

Key Terms

High stakes moment

High stakes moments can happen during Observe Normal Routine and Assume a Coaching Style. A high stakes moment occurs when the patient is facing a situation that needs immediate action or resolution. In these moments, even if the patient is working towards greater independence as evidenced through the Care Team’s observation of the patient’s normal routine, the most prudent move is for the Care Team to intervene and problem-solve. Examples of high stakes moments are:

• Events that are unlikely to happen again soon, e.g., the patient is about to miss a medical appointment that is critical to their health needs. Care Teams may find that these events occur more often at the beginning of an intervention when the patient and Care Team are just starting to work with each other.

• A medical emergency or another situation in which the task must be completed urgently and the patient is not ready to complete the task alone, e.g., the patient feels like they need to go to the emergency room and does not know how to call 911. Note: In cases of medical emergencies, it is important to trust the patient’s judgment of their own health.

Preparation and Materials Needed

No materials are needed.
Instructions

To observe the patient’s normal routine, Care Team members:

- Watch the patient go about their usual routine without intervening.
- Ask the patient to show them how they perform relevant health management tasks (e.g., taking medication, arranging transportation to appointments, etc.) before intervening.
- Use active listening and reflective language.
- Ask investigative questions to gain additional information.
- Do not pass any judgment about how the patient manages their care (i.e., employing the principles of Unconditional Positive Regard (See OVERVIEW OF COACH).

Common questions for the Care Team to ask as they “Observe a Normal Routine”:

Questions related to health care management:
- How would you normally get to an appointment?
- How do you usually keep track of your medication?
- Can you show me where you keep your medication?
- How do you usually schedule your appointments?
- How do you keep track of when you need to refill your prescriptions?

Questions related to identifying a long-term support:
- Who would you have called if I did not pick up the phone?
- Who usually goes with you to appointments?
- When you have a question about your medication, whom do you ask?

When do you use it?

Care Team members should observe a patient’s normal routine on the first visit and throughout in order to get to know the patient before assuming a coaching style and proceeding with the intervention. Observing a normal routine is also useful throughout the intervention to gather as much information as possible about the patient’s specific needs and strengths. Observing may be particularly useful if the Care Team feels the patient is not progressing or communication becomes difficult.
EXAMPLES: OBSERVING THE NORMAL ROUTINE

Example 1:

Scenario
A patient is diabetic and also an amputee. She needs to arrange transportation to get to one of her appointments and does not know how to arrange it. You know she is enrolled in Medicaid.

Response
Instead of arranging the transportation for her, or giving her a cab voucher, you ask:

• “How do you normally get to appointments?”
• “Who would you ask if I was not here?”
• “How would you look it up?”

Once you know how the patient goes about their activities and what they are capable of completing on their own, you can determine how you can best partner with the patient to incrementally develop greater independence.

Example 2:

Scenario
A patient has had a brain tumor that has caused issues with his memory. This issue is affecting his ability to remember primary care appointments.

Response
Instead of coming up with your own system for the patient, you observe the patient go throughout his day to observe how he remembers other important things in his life. You ask:

• “How do you normally remember appointments and other events in your day?”
• “Who would ask for help if I was not here?”
• “What do you think a good strategy is for remembering appointments?”

You observe the patient going throughout his day, and notice that he uses his cell phone alarm to remember to pick up his kids from school. You work with the patient to use this system to keep track of his appointments. For the next appointment, the patient sets an alarm on his cell phone to remind himself to leave.
EXAMPLE: HIGH STAKES MOMENTS WHEN YOU SHOULD INTERVENE AND NOT OBSERVE

When a **high stakes moment** occurs, the Care Team should *not observe* the patient's normal routine, but should *intervene* and problem-solve for the patient. This moment could be, but is not always, a medical emergency. These moments include an event with a strict deadline, and an event that is unlikely to happen again soon.

**Example 1**

*Scenario:* A patient calls you on a Friday afternoon at 5pm and says that they need a medication refill and do not know how to get it.

*Response:* Unless you are aware of a 24/7 medication service, you will intervene to ensure that the patient has medication over the weekend since you will not be available again until Monday.

**Example 2**

*Scenario:* You are on a home visit and while speaking with the patient, he becomes short of breath. He immediately expresses that he needs to go to the emergency room.

*Response:* It is important to trust patient’s health decisions. If the patient is unable to call 911, you should intervene to help the patient get to the emergency room.
Markers of Success

**Patient**
- Patient identifies a long-term support – a person who can provide continued support beyond the intervention. See **OVERVIEW OF COACH** for more information on the long-term support.
- Patient can explain how he/she manages his/her health and social needs including scheduling, transportation, obtaining medication and equipment, and emergency care.
- Patient is able to answer the question “What would you/the patient do if the Camden Coalition team wasn't here?” And, “How do you/the patient problem-solve differently since working with the Care Team?”
- Patient feels supported and empowered by a Care Plan that is catered toward his/her strengths.

**Care Team**
- Care Team has a shared understanding of the identified long-term support.
- Care Team identified and has a shared understanding of patient strengths/areas needing support.
- Care Team plans activities/goals based on unique needs of patient, and culturally appropriate services are sought to reflect those needs.
- Care Team appropriately identifies and intervenes at **high stakes moments** – events not likely to happen again soon.
- Care Team asks patient for feedback on progress – what has helped, what has not helped, and suggestions for moving forward.
A: ASSUME A COACHING STYLE

Overall Goal

The goal of Assume a Coaching Style is for the Care Team to appropriately support the patient based on the patient level of independence for the task at hand. The Coalition breaks down its coaching style into three stages: “I do,” “We do,” and “You do,” which were adapted from a Coalition staff member’s previous experience with the Teach for America framework. Here is what they mean:

- "I do": The patient cannot perform the task on his/her own and/or has a limited social support system.
- "We do": The patient is able to start the task but gets stuck at an intermediary step.
- "You do": The patient is able to complete the task on his/her own.

The goal of choosing a coaching style is for the patient to move toward independence, and for the patient to gain confidence in performing key activities related to his/her chronic health management and systems navigation (for example, arranging transportation, making an appointment, taking medication, etc.). The first step is to assess the patient’s level of independence for a designated task and his/her overall level of social support, which will determine which of the three coaching styles to assume. The assessment is done through Observe the Normal Routine. The Care Team’s goal is that by the end of the CMI, the patient will be a "You do" or a "We do" in partnership with the identified long-term support, for all tasks that are essential to managing the patient’s chronic health condition and social issues/barriers. Progressing from one stage of coaching to the next can be an incremental process, and the most important behavioral change that the patient is trying to make. It is likely that the patient will be at different stages of independence depending on the activity or goal. For example, the patient might be fully independent as far as making follow up appointments (a “You Do”) but feels unable to secure transportation to get to that appointment (an “I do”).

Key Terms

Coaching style: (“I do” “We do”, “You do”)

- **"I do"**: (“Can you show me?”) The patient cannot perform the task on his/her own and/or has a limited social support system. The task could also involve a highly bureaucratic system. The Care Team performs the task and models it for the patient.
- **"We do"**: (“Can we do it together?”) The patient is able to start the task but gets stuck at an intermediary step. There are gaps in the patient’s ability to complete the task. The Care Team performs the task with the patient.
- **"You do"**: (“I can do it.”) The patient is able to complete the task on his/her own. Note that patients who are at the “You Do” stage may be able to complete the task, but still lack confidence about long-term success or their ability to master the task over time. Here, the Care Team observes the patient completing the task to provide positive reinforcement to build confidence in the patient for long-term success.

High Stakes Moment

High stakes moments can happen during **Observe Normal Routine** and **Assume a Coaching Style**. A high stakes moment occurs when the patient is facing a situation that needs immediate action or resolution. In these moments, even if the patient is working towards greater independence as evidenced through the Care Team’s observation of the patient’s normal routine, the most prudent move is for the Care Team to intervene and problem-solve. Examples of high stakes moments are:

- Events that are unlikely to happen again soon, e.g., the patient is about to miss a medical appointment that is critical to their health needs. Care Teams may find that these events occur more often at the beginning of an intervention when the patient and Care Team are just starting to work with each other.

- A medical emergency or another situation in which the task must be completed urgently and the patient is not ready to complete the task alone, e.g., the patient feels like they need to go to the emergency room and does not know how to call 911. **Note**: In cases of medical emergencies, it is important to trust the patient’s judgment of their own health.

Preparation and Materials Needed

No materials are needed. Care Team members should refresh their memory of the three coaching styles, and discuss with their supervisors their coaching style decision related to key activities to ensure a shared understanding. This should be a dynamic part of the
intervention so regular team check-ins are a critical part of success. Refer to SUPERVISION AND TRAINING for more information on team check-ins.

Instructions

After observing the patient’s normal routine, Care Team members will choose a coaching style for designated tasks based on the patient’s level of independence. The following indicators help identify which coaching style is most appropriate for designated tasks:

"I DO"

Patient: Cannot perform the task on his/her own and:
• Has never done it before.
• The task is complicated.
• The patient is in a fragile state with limited or no support system.

Care Team Member Response:
• Models the task for the patient.
• Performs the task while explaining each step to the patient.

EXAMPLE: “I DO” COACHING STYLE

Scenario
You are at a patient’s home with the intention of making a cardiology appointment. When you sit down by the phone the patient states that she lost the doctor’s phone number and she does not have the internet at home so cannot look it up. You ask what the patient normally does (“Observe Normal Routine”). The patient states that she would not make the appointment.

Response
This is an “I do” because the patient admits that she would normally do nothing if she was faced with this situation. You model what to do when this situation arises. You say, “Losing things is a fact of life. Let’s look at this stack of business cards you have and see if there’s anyone we can reach out to that would have your cardiologist’s number.” You make the appointment for the patient, while walking her through each step you are doing. In this way, you model how she can do it the next time. You set up a time when you can schedule a follow up appointment together (“We do, moving incrementally toward “You do”).
“WE DO”

**Patient:**
- Starts the task but gets stuck.
- There are gaps in the patient’s ability to complete the task.

**Care Team Member Response:**
- Performs the task with the patient. Allows the patient to perform what she/he is comfortable doing and fills in the gaps.

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**EXAMPLE: “WE DO” COACHING STYLE**

**Scenario**
You are in a patient’s home on a Monday afternoon. Almost immediately when you walk in the door, he tells you that he is sure he has an appointment this week, but cannot remember the date or time. You watch him call the doctor’s office, but as soon as he is placed on hold, he gets very agitated and hangs up the phone. He says, “I can’t stand it when they put me on hold like that. I’m not going to the appointment.”

**Response**
“We do” is the appropriate coaching style for this situation because the patient has the number for the doctor’s office and is able to make the call, but is facing some challenges in terms of following through to make the appointment. Through questions framed in the style of Motivational Interviewing (for examples of reflective listening and open-ended questions, see CONNECT PLAN WITH LONG-TERM VISION AND PRIORITIES), you explore why waiting on hold is so difficult, and if this happens routinely. You work with the patient to practice waiting on hold to make sure this is no longer a barrier to making appointments, and perhaps, work to help the patient with waiting in other contexts of his life.
“YOU DO”

Patient:
• Patient can perform the task on his/her own or has a support system in place that is actively engaging and assisting the patient.
• Patient may lack confidence in their ability to perform the task, but is able to do it.

Care Team Member Response:
• Supports the patient in performing the task from the sidelines.
• Reinforces the patient’s ability to do the task.
• Allows the patient to lead the problem solving when there is a challenge.
• Helps the patient build confidence so that he/she can have lasting success in performing the task.

EXAMPLE: “YOU DO” COACHING STYLE

Scenario
A patient calls you after he takes his medicine out of the refrigerator. He tells you the name of the insulin, and describes that it is usually clear, but now he sees “floaty things in it.” As per “Observing Normal Routine,” you ask him who he would have called if he had not called you. He says he would have called his pharmacist.

Response
You say, “That’s a great idea. Please give me a call back after you speak with your pharmacist to let me know how it goes.”

Note: Even in cases where a patient is at the “You do” stage, it is appropriate and important to follow up with the patient in order to ensure the task has been successfully performed, and to discern that they will be able to perform this task routinely over the long-term.

Note: If there is an issue with a patient’s medication that must be taken immediately, or is at risk for no longer being available, this may turn into a “high stakes moment.” This would mean that you intervene to figure out if the medication can still be ingested, and if not, how the medication can be replaced right away. Once the medication question is resolved, you can revisit the incident with the patient to coach and problem-solve.
EXAMPLES: EXCEPTIONS (HIGH STAKES MOMENTS)

If a patient feels that he/she is having a health emergency and has a plan to get help, the Care Team member should treat it as an exception and NOT coach. The Care Team member should support the patient in following up as they see fit (ex. calling 911). If the patient is questioning their decision and asking for help, then it might be an opportunity to coach. Care Team members should trust their instincts on what is most appropriate for these situations.

**Example 1:**

**Scenario**
You and a fellow staff member arrive at Pedro’s home. He says he is having chest pain, and appears very distressed. He has a phone in his hand and is calling 911. You know that chest pain has resulted in many emergency room visits for Pedro in the past. You know that a goal of the CMI is to reduce hospital visits and that they are being tracked. How should you proceed?

**Response**
You do NOT stop Pedro from calling. Despite what your opinion might be as a health provider, your role is to support Pedro in his decision and trust his own judgment of his health. You should let him call, and offer to go with him to the emergency room.

**Example 2:**

**Scenario**
You are working with a patient who is obese and often gets short of breath. When you visit him at home he’s dizzy and is worried. He asks you what he should do.

**Response**
Since the patient is reaching out and asking you whether or not it is an emergency, this is an opportunity for coaching to help the patient problem-solve and to decide with them whether this is an emergency.
When Do You Use It?

It is important for Care Team members to first observe and understand the patient’s normal routine before choosing a coaching style. As noted above, the choice of coaching style will be discussed throughout the intervention, and may vary based on the task at hand.

Markers of Success

Patient

- Patient reports they are receiving the appropriate support that builds on their strengths.
- Patient progresses toward completing health-related tasks independently (is at the “You do” stage), or completes the task in partnership with a long-term support (is at the “We do” stage).
- Patient views Care Team as support but does not depend on them for regular activities associated with the management of their health care.

Note: At the point of graduation, the patient should be successfully at the “You do” or “We do” stage with a long-term support on all tasks that are critical to managing their health and social needs. See OVERVIEW OF COACH for more information on graduation.

Care Team

- Care Team has a shared understanding of the patient’s strengths based on observing the patient’s normal routine.
- Care Team has a shared sense of where patient can perform on their own and where they need help.
- For activities where the patient is still at the “We Do” stage of coaching, the Care Team has engaged the patient's long-term support who knows that they will be called upon to help the patient when needed.
- Care Team can describe when they chose NOT to coach based on patient’s circumstances and needs.
C: CHECK A BACKWARDS PLAN

Overall Goal

The overall goal of Check a Backwards Plan is for the Care Team, the patient, and the patient’s long-term support to create a collaborative care plan driven by the patient’s own priorities and vision for him/herself. Staff begin using the Backwards Plan during the first patient visit. By starting with the patient’s vision and underlying core need(s), the Care Team is able to work backwards to develop a clear, realistic plan for meeting the patient’s long-term health and social needs. In other words, the Care Team and patient have a shared plan about the patient’s priorities and goals for CMI and shared understanding of how they are going to use the intervention. To develop a Backwards Plan, patients are asked to select from a set of “care planning domain” cards (e.g., health, transportation, legal issues, medication support, etc.). The domain cards are prioritized by the patient with the support of the Care Team based on his/her immediate and long-term needs and goals.

Key Terms

Backwards Plan
The Backwards Plan starts with a conversation with the patient to get a better understanding of their goals and priorities. The Care Team uses “care planning domains,” as described in greater detail below, to help with this process. With an understanding of this vision, the Care Team develops a clear, realistic plan with the patient for meeting the patient’s short-term and long-term health and social needs.

Care Planning Domains
Care Planning Domains are health-related social needs that may affect the patient such as transportation, legal issues, and medication support. As part of creating the Backwards Plan, the Care Team reviews “domain cards” with the patient, which are a set of cards with one card for each Care Planning Domain (See APPENDIX). This allows patients and Care Team Members to have a meaningful discussion around patient priorities, and develop a mutually agreed upon care plan.

The Coalition’s Care Planning Domains:
- Addiction
- Advocacy and Activism
- Benefits and Entitlements
- Reproductive Health and Internatal Care
Education and Employment Opportunities
Family, Personal, Peer Support
Food and Nutrition Support
Health Maintenance, Management, and Promotion
Housing and Environment
Identification Support
Legal Assistance
Medication and Medical Supplies
Mental Health Support
Care Team Member Relationship Building
Transportation Support
Patient-Specific Wildcard

Note: The Coalition’s Care Planning Domains each have detailed descriptions that outline the recommended approach to care (ex. Life Course model for reproductive health), and a detailed resource database for follow up. Refer to APPENDIX for a brief description of each domain.

Care Planning Domains should be specific to the mission of the Care Team’s agency. Refer to the Coalition’s Care Planning for Patients with Frequent Hospitalizations Toolkit (available upon request) for guidance on the development of domains relevant to your patient population and agency.

Preparation and Materials Needed

- Care Planning Domain Cards (See APPENDIX)
- Backwards Plan matrix (See APPENDIX)

Instructions

Backwards Plan

- Use domain cards to conduct an active conversation with patient to develop a care plan and identify steps necessary to achieving long-term goals.
- Flip through each domain card with the patient and ask the patient to identify where each domain falls on the Backwards Plan matrix (See TABLE 1).
- Use the Backwards Plan to monitor patient’s progress (See HIGHLIGHT PROGRESS WITH DATA).
TABLE 1. CARE PLANNING DOMAIN MATRIX

NOTE: See APPENDIX for a printable copy of the matrix.

<table>
<thead>
<tr>
<th></th>
<th>Right Now</th>
<th>Later</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Need to Work On</strong></td>
<td>Domains that are:</td>
<td>Domains that:</td>
</tr>
<tr>
<td></td>
<td>• Crises</td>
<td>• The patient needs to work on but are not immediate needs</td>
</tr>
<tr>
<td></td>
<td>• Under a deadline</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• A top priority</td>
<td></td>
</tr>
<tr>
<td><strong>Don't Need to Work on</strong></td>
<td>Domains that the patient feels are currently stable, but may have the potential to become unstable at a later date.</td>
<td>Domains that the patient feels are stable and do not need to be addressed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> This is an opportunity to highlight patient strengths.</td>
</tr>
</tbody>
</table>

Active Discussion

Care Team members use reflective listening and open-ended questions, techniques of Motivational Interviewing, to have an active discussion with patients around the care planning domains.

Examples of open-ended questions:
• I noticed you put this card in the “Need to Work On Right Now” section of the matrix. Why did you choose to put it there?
• What is your current living situation?
• I noticed that you weren’t sure where to put “transportation.” What is transportation usually like for you?
• Please describe that for me.

Examples of reflective language:
• I hear you saying that you want . . .
• It sounds like...
• It seems as if...
• I get the sense that...
When Do You Use It?

Care Team members work with patients to create a Backwards Plan within the first few home visits or community visits, after the Care Team has Observed a Normal Routine and learned the priorities of the patient, and their long-term vision for themselves. The Backwards Plan is then used to track progress and adjusted accordingly throughout the intervention according to the patient’s needs and development.

Like other parts of this framework, the Backwards Plan is a dynamic tool. The plan might have to change during the intervention because the patient’s circumstances may change. In addition, the plan should consider who will be providing support to the patient when the CMI ends (See Long Term Support/Strategy in OVERVIEW OF COACH). For example, at 45 days, the Care Team should be thinking about a Backwards Plan into the future, which means when the Patient has graduated from the CMI. The point of routinely thinking ahead about priorities and goals is that the Care Team and patient are working jointly toward a situation where the patient has greater independence. For this reason, engaging long-term supports is an integral part of a Backwards Plan.

Markers of Success

**Patient**

- Patient participates in the development of the Backwards Plan and tracks progress throughout the intervention.
- Patient prepares for transition to independence and partnership with the long-term support at end of intervention.
- Patient and long-term support have a shared understanding and can describe the main components of the initial Backwards Plan, and ongoing Backwards Plan when CMI concludes (i.e., how the patient will use the long-term support for help when s/he needs it).

**Care Team**

- Care Team has a shared understanding and can describe the main components of the initial Backwards Plan, including which domains are priorities for the patient.
- Care Team adapts the Backwards Plan, if needed, to reflect changing circumstances of the patient.
- Care Team engages a long-term support in Backwards Plan, especially as patient moves towards end of CMI.
- Care Team works with the patient on an ongoing Backwards Plan, which will be used by the patient when they graduate from the CMI.
H: HIGHLIGHT PROGRESS WITH DATA

Overall Goal

The goal of Highlight Progress with Data is for the Care Team to use the Backwards Plan to assist patients in visualizing and tracking what they have accomplished over the course of the intervention. Tracking and highlighting progress throughout the intervention empowers and motivates the patient, and provides the Care Team with data for its continuous quality improvement efforts.

Key Terms

Data
In the context of Highlight Progress with Data, data includes patient behavior, attitude, and health outcomes. Most often, this technique is used in the context of the patient’s identified care planning domains. For example, if transportation is identified as a patient priority, the Care Team would track the patient’s ability to manage his/her own transportation needs and highlight progress (obtaining a bus pass, keeping track of the bus schedule, successfully taking the bus to an appointment, etc.).

Preparation and Materials Needed

- Care Planning Domain Cards (See APPENDIX)
- Highlight Progress with Data Worksheets (See APPENDIX)

Instructions

Care Team members can highlight progress with data at anytime by pointing out patient progress in patient behavior, attitude, and health outcomes. This can happen through informal conversation with the patient, or in the context of the Highlight Progress with Data Worksheets.

Highlight Progress with Data Worksheets

Care Team members use this worksheet to highlight patient’s progress in their identified care planning domains. More specifically:

- Care Team members fill in the patient’s vision for him/herself as identified through Connect Tasks with Vision and Priorities.
• Care Team uses the worksheet to have a conversation with the patient about progress and goals on identified care domains, and what the patient would like the Care Team’s help with. This tool allows the patient to track his/her own progress through the Backwards Plan.

• The Care Planning Domain cards can be used as part of this conversation, to highlight where the patient has made progress since the domains were first identified (Refer to CHECK BACKWARDS PLAN).

When Do You Use It?

“Highlight progress with data” is used throughout the intervention, when the Care Team member notices and points out progress in the patient, however big (ex. the patient moves from “I do” to “You do”), or small (ex. patient’s attitude and outlook has improved since the last home visit).

In particular, Highlight Progress with Data is used to identify progress in the domains prioritized in the Backwards Plan to motivate the patient. This technique can also be used in moments where the Care Team feels there is difficulty in communication or that they have gotten “stuck” with a patient. Highlighting prior progress can motivate a patient to make further change.

Markers of Success

**Patient**

• Patient understands identified metrics used to track their improvement.

• Patient and long-term support have a shared understanding of improvement metrics (i.e., what improvement looks like).

• Patient is motivated by progress and can point to specific examples of progress.

• Patient is achieving improved physical health and behavioral health.

**Care Team**

• Care Team identifies and understands metrics used to track patient improvement.

• Care Team has a shared understanding of patient strengths and progress.

• Care Team records and monitors the patient’s medical, social, and psychological history and needs throughout the intervention.

• Care Team periodically reviews and has a shared understanding of their own progress.

• Care Team periodically reviews and has a shared understanding of patient trends over time.
SUPERVISION AND TRAINING STRATEGY

Supervision

Daily Huddle

All clinical staff meet to share a patient success story, and goal to be accomplished for the day. Huddles are used for a variety of reasons, e.g., to boost team morale, to prioritize patient needs and tasks, to explore a specific clinical topic, or even just to support a colleague. The huddles are a dynamic part of the model, changing focus based on team and client needs.

Weekly case planning meetings

These weekly meetings are led by the Clinical Manager with each Care Team. The purpose of the meeting is for Care Team members to review the status of each open patient case, any barriers to care, and next steps. The Clinical Director provides feedback and supervision for Care Team members, which includes helping them problem-solve and also providing support in difficult cases. These meetings last 2 hours.

Patient cases are reviewed in the following order, in order to prioritize cases that need the most attention:

- Patients who have been recently readmitted to the hospital.
- Patients with which Care Team members are experiencing barriers to care or frustration.
- Remaining patients, beginning with those who have been in the intervention the longest.

Bi-weekly complex case conferences

Complex Case Conferences are facilitated by the Clinical Manager, and attended by all clinical staff (Care Team and the Clinical Support Team). Three members of the Care Team choose a case in which they are experiencing successes and barriers to care, and provide a short verbal overview of the case for the group. The overview includes:

- Patient age
- State of physical and mental health
- How long the patient has been with the Camden Coalition
• The current Coaching Style the Care team member is assuming for this patient (“I do,” “you do,” “we do”).
• The goal(s) of the patient (identified domains) and the patient’s dominant core needs
• Patient strengths, and challenges to care, including system-level factors (lack of homeless housing availability), institution-level factors (insurance does not cover medication), and patient-level factors (resistance to attending the primary care physician).

Staff are then invited to ask questions and give input into how to address the presented issue. This meeting serves as both a problem-solving and a peer support session. Led by the Clinical Director, the group comes to consensus on next steps based on the discussion. The case debrief and discussion takes approximately 1 hour. This meeting time with all staff is also used for professional development opportunities. The Clinical Director and leadership also bring in experts to provide continuing education for staff on relevant topics, such as trauma, community resources, and family-centered care. This professional development usually takes 1 additional hour.

Training

Staff and community trainings are led by the Coalition’s Cross-site Learning and Workforce Development team

Initial training

As part of the on-boarding process, new Care Team staff are trained in COACH before beginning clinical work. These trainings include a review of COACH’s five-part framework, the presentation of real cases, and role-play.

On-going trainings

Staff receive regular ongoing refresher trainings to:
• Review core COACH principles and techniques associated with each component.
• Discuss overarching questions or recurring issues in executing COACH.
• Provide and educate on any updates or new tools associated with COACH.
The Coalition’s Strategy & Information Department is responsible for integrating process tracking and analysis and qualitative methods into the Coalition’s work. The following section describes two ways in which the Coalition tracks COACH’s outcomes: TrackVia and a randomized controlled trial being conducted by the Massachusetts Institute of Technology’s (MIT) Abdul Latif Jameel Poverty Action Lab.

**TrackVia**

TrackVia is a HIPAA-compliant, web-based application that the Coalition uses to capture and store data, prompt workflow, and track progress of individual patients and Care Teams. All Care Team members and supervising staff have access to patient records in TrackVia. TrackVia is used for tracking patient progress across identified care planning domains, and tracking organizational progress on defined metrics.

**Tracking patient progress across identified care planning domains**

Each patient has a dashboard, where the Care Team records the goals of the individualized care plan and patient progress across the care planning domains. Progress in these domains is recorded according to behavior (ex. “Patient obtained bus pass and successfully used the bus to get to her appointment.”), and according to coaching (ex. “Patient was a ‘we do’ on transportation. The community health worker helped her find the bus route map and schedule.”). Care Team members are responsible for updating TrackVia after each patient encounter. In this way, the application is used to ensure Care Team members are up to date with patient progress and have a shared understanding of the Care Plan.

In addition to identifying patient needs, Care Team use TrackVia to identify patients’ strengths. In this way, the individual dashboard is a useful tool for **Highlight Progress with Data**.

**Tracking organizational progress on defined metrics**

Twice per week data is tabulated into a scorecard to track trends over time, and track the progress of Care Teams as a whole. These score cards can identify organizational trends, gaps, and areas for improvement.
The system is also used to track the Coalition’s identified organizational metrics over time. These metrics include:

- Descriptive statistics (ex. Mean number of chronic conditions per patient; Number of patients with social co-morbidities that increase risk level)
- Process metrics (ex. In-person patient encounters; Care coordination hours)
- Utilization outcomes (ex. Medication reconciliation post-discharge, initial PCP visit post-discharge), and;
- Quality outcomes (ex. Client Perception of Coordination Questionnaire).

Randomized controlled trial (RCT):

The Camden Coalition is working with health economists at Massachusetts Institute of Technology’s (MIT) Abdul Latif Jameel Poverty Action Lab to conduct a Randomized Controlled Trial (RCT) that evaluates the impact of the Coalition’s Care Management Intervention. Researchers are analyzing the effect of the Coalition’s care management intervention on participants’ hospital readmission rate, compared to that of a control group receiving routine care. The RCT began in April 2014 and is scheduled to end in 2017.
• Authentic Healing Relationship: The Authentic Healing Relationship is a respectful, trusting partnership built between the Care Team Member and the patient that serves as the foundation for patient behavior change. Authentic Healing Relationship are defined by three core elements: security, genuineness, and continuity. When one of these elements is missing, Authentic Healing Relationship lose their positive impact.

• Backwards Plan: The Backwards Plan starts with the identification of patient priorities, and the patient’s vision for him/herself. With an understanding of this vision and underlying core need(s), the Care Team develops a clear, realistic plan with the patient for meeting the patient’s short-term and long-term health and social needs.

• Camden Health Information Exchange: The Camden Health Information Exchange (HIE) is a collaborative data-sharing effort to improve care delivery in Camden. The Camden HIE is a web-based technology offering participating local and regional health care providers secure, real-time access to shared medical information.

• Care Planning Domains: Care Planning Domains are health-related social needs that may affect the patient such as transportation, legal issues, and medication support. As part of “creating the Backwards Plan,” the Care Team reviews “domain cards” with the patient. This allows patients and Care Team Members to have a meaningful discussion around patient priorities, and develop a mutually agreed upon care plan.
  - Addiction
  - Advocacy and Activism
  - Benefits and Entitlements
  - Reproductive Health and Internatal Care
  - Education and Employment Opportunities
  - Family, Personal, Peer Support
  - Food and Nutrition Support
  - Health Maintenance, Management, and Promotion
  - Housing and Environment
  - Identification Support
  - Legal Assistance
  - Medication and Medical Supplies
  - Mental Health Support
  - Provider Relationship Building
  - Transportation Support
  - Patient-Specific Wildcard
- **Care Management Team (Care Team):** The Care Team is made up of a nurse, a community health worker, and a social worker.

- **Coaching Styles:** The goal of choosing a coaching style is for the patient to become independent and confident in performing key activities related to his/her chronic health management and systems navigation (for example, arranging transportation, making an appointment, taking medication, etc.). The first step is to assess the patient’s level of independence for a designated task and his/her overall level of social support, which will determine which of three coaching styles to assume:
  - **“I do”:** The patient cannot perform the task on his/her own and/or has a limited social support system. The task could also involve a highly bureaucratic system. The Care Team performs the task and models it for the patient.
  - **“We do”:** The patient is able to start the task but gets stuck at an intermediary step. There are gaps in the patient’s ability to complete the task. The Care Team performs the task with the patient.
  - **“You do”:** The patient is able to complete the task on his/her own but may lack the confidence necessary to complete the task. The Care Team observes the patient completing the task to provide positive reinforcement and build confidence in the patient.

- **Chronic Health Condition:** The Camden Coalition defines a chronic health condition as a health condition that requires ongoing management by health professionals, including a primary care physician.

- **Dominant Core Need:** Dominant core needs are underlying needs and desires that affect motivation and behavior. It is important for Care Team staff to actively identify both the patient’s and his/her own dominant (primary) core need throughout the intervention. The purpose of identifying the patient’s core needs is to create a common language around the patient’s broader vision and to identify strategies or resources to fulfill that vision. Core needs fall into three categories:
  - **Significance:** Deep desire to feel important or recognized.
  - **Love & Belonging:** Deep desire to feel accepted and have social support.
  - **Certainty & Safety:** Deep desire for stability, a plan, and controlled surroundings.

- **High Stakes Moment:** A high stakes moment occurs when the Care Team should not observe the patient’s normal routine, but rather intervene and problem-solve for the patient in that particular moment. These moments include an event with a strict deadline, an event that is unlikely to happen again soon, and a medical emergency.
• **Hotspotting:** Healthcare hotspotting is a data-driven process for the timely identification of extreme patterns in a defined region of the healthcare system. It is used to guide targeted intervention and follow-up to better address patient needs, improve care quality, and reduce cost. Most often the data in question are hospital reimbursement claims that bring together high-stakes diagnostic, temporal, financial, spatial, and demographic data in a single set of records. Through hotspotting, claims data can help reveal both a community’s healthcare problems and their solutions. Refer to the [Coalition’s Healthcare Hotspotting Toolkit](http://healthcarehotspotting.com).

• **Individuals Experiencing Frequent Utilization:** Individuals experiencing frequent utilization are individuals with complex, chronic issues that cause high rates of hospital admission. The Coalition defines “frequent utilization” as an individual who is admitted to the hospital 2 or more times, or has experienced 5 or more Emergency Department visits in a 6-month period.

• **Long-Term Support System/Strategy:** The long-term support system/strategy is identified by the patient as the system/strategy that can support the patient in managing his/her chronic health condition and social issues/barriers beyond the Coalition’s intervention. This can be a person within the patient’s primary care office (primary care doctor, nurse, social worker), a person within a social service organization (case manager), a personal relationship (family member, spouse, friend, neighbor), and/or a long-term care facility (Adult Day program or recovery program). Ideally, the patient will identify more than one long-term support person and/or resource.

• **Motivational Interviewing:** Motivational Interviewing is a patient-centered, evidence-based method of facilitating behavior change. Motivational interviewing uses empathy, reflective listening, open-ended questions, and a collaborative relationship to inspire motivation to change.

• **TrackVia:** TrackVia is a HIPAA-compliant, web-based application that the Coalition uses to capture and store data, and track progress of clients and Care Teams.

• **“Tug of War” Scenario:** “Tug of war” scenarios occur when the priorities of the Care Team do not align with that of the patient, or the patient is not making progress in the Care Planning Domains identified as priorities. To avoid and/or overcome these scenarios, it is important for the Care Team to identify the patient’s dominant core need and be able to articulate it back to the patient while connecting smaller tasks to the broader vision. Furthermore, the Care Team should continue to highlight small wins or progress that the patient has made thus far in the identified domains.
APPENDIX

A. Care Management Enrollment Intake

B. Care Planning Domain Descriptions

C. Creating a Backwards Plan Instructional Guide

D. Highlight Data with Progress Templates (3)
   a. Template 1
   b. Template 2
   c. Template 3

E. Bi-Weekly Case Conferencing Script

F. Care Management Triage Worksheet
A. Care Management Enrollment Intake
CARE MANAGEMENT ENROLLMENT INTAKE

Client Name: ________________________________________________________________

DOB: ___________________________ Hospital Discharge Date:____________________

INSURANCE INFORMATION

Primary Insurance Type:

□ Medicare □ Medicaid-United □ Medicaid-Amerigroup □ Medicaid-Horizon □ Medicaid-Other □ Private □ None □ Other □

Secondary Insurance Type:

□ Medicare □ Medicaid-United □ Medicaid-Amerigroup □ Medicaid-Horizon □ Medicaid-Other □ Private □ None □ Other □

Primary Insurance ID#: _____________________________________________________

Secondary Insurance ID#: ___________________________________________________

Pharmacy Name: _____________________________________________________________

MEDICAL/HEALTH NEEDS

*Would you say that in general your health is:

□ Excellent □ Very Good □ Good □ Fair □ Poor

*Now thinking about your physical health, which includes physical illness & injury, for how many days during the past 30 days was your physical health not good?

# of days ____________

MENTAL HEALTH & ADDICTION
MENTAL HEALTH/SUBSTANCE ABUSE CONDITIONS (PHQ-4 and NIDA Substance Abuse Screen)

Over the last 2 weeks, how often have you been bothered by the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not At All</th>
<th>Several Days</th>
<th>More than half of the days</th>
<th>Nearly Every Day</th>
<th>Prefer not to say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling nervous, anxious, or on edge</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Not being able to stop or control worrying</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

*Now thinking about your mental health, which includes stress, depression, and emotional problems, for how many days during the past 30 days was your mental health not good?*

# of days __________

In the past year, how many times have you used any of the following?

<table>
<thead>
<tr>
<th>Substance</th>
<th>Never</th>
<th>Once or twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
<th>Prefer not to say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol (Men &gt; 5 drinks/day, Women &gt; 4 drinks/day)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Tobacco products (cigarettes, cigars, chew, etc)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Recreational drugs (marijuana, cocaine, heroin, etc)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Prescription drugs (for reasons other than prescribed)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Comments:

SBQ-R SUICIDE SCREEN
Have you ever thought about or attempted to kill yourself (check ONE answer only)?

- □ Never
- □ It was just a brief passing thought
- □ I have had a plan at least once to kill myself but did not try to do it
- □ I have had a plan at least once to kill myself and really wanted to die
- □ I have attempted to kill myself but did not want to die
- □ I have attempted to kill myself and really hoped to die

How often have you thought about killing yourself in the past year (check ONE answer only)?

- □ Never
- □ Rarely (1 time)
- □ Sometimes (2 times)
- □ Often (3-4 times)
- □ Very often (5 or more times)

Have you ever told someone that you were going to commit suicide, or that you might do it (check ONE answer only)?

- □ No
- □ Yes at one time but did not really want to die
- □ Yes at one time and really wanted to die
- □ Yes more than once but did not want to do it
- □ Yes more than once but really wanted to do it

How likely is it that you will attempt suicide someday (check ONE answer only)?

- □ Never
- □ No chance at all
- □ Rather unlikely
- □ Unlikely
- □ Likely
- □ Rather Likely
- □ Very Likely

FOOD AND NUTRITION

Do you follow a special diet?

- □ Yes
- □ No
- □ Not Sure
- □ Prefer Not to Say

In the past three months, have you gained or lost more than 10 pounds without trying?

- □ Yes
- □ No
- □ Not Sure
- □ Prefer Not to Say

Do you have trouble affording food on a regular basis?

- □ Yes
- □ No
- □ Not Sure
- □ Prefer Not to Say

Based on the following statements which answers do you agree with?

In the last year I worried that we would run out of food before we had the money to buy more:

- □ Often True
- □ Sometimes True
- □ Never True
- □ Not Sure/Prefer Not to Say
In the last year we ran out of the food we bought and we did not have money to buy more:

☐ Often True  ☐ Sometimes True  ☐ Never True  ☐ Not Sure/Prefer Not to Say

FAMILY, PERSONAL, & PEER SUPPORT

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

# of days ____________

Are you LIMITED in any way in any activities because of any impairment or health problem?

☐ Yes  ☐ No  ☐ Not Sure  ☐ Prefer Not to Say

**IF NO, UNSURE, or REFUSED, skip to Housing and Environment**

What is the MAJOR impairment or health problem that limits your activities? (CHECK ONLY ONE)

☐ Arthritis/rheumatism  ☐ Hearing problem
☐ Back or neck problem  ☐ Heart problem
☐ Cancer  ☐ Hypertension (High Blood Pressure)
☐ Depression/anxiety/emotional problem  ☐ Lung/breathing problem
☐ Diabetes  ☐ Stroke
☐ Eye/vision injury  ☐ Walking problem
☐ Fractures, bone/joint injury  ☐ Other Impairment/Problem ________________
☐ Not Sure  ☐ Prefer Not to Say

For HOW LONG have your activities been limited because of your major impairment or problem?

☐ Days  ☐ Weeks  ☐ Months  ☐ Years  ☐ Not Sure  ☐ Prefer Not to Say

_____  _____  _____  _____  _____

Do you need the help of other people with your PERSONAL CARE needs, such as eating, bathing, dressing, or getting around the house?

☐ Yes  ☐ No  ☐ Not Sure  ☐ Prefer Not to Say

Do you need the help of other people in handling your ROUTINE needs, such as household chores, doing necessary business, shopping, or getting around for other purposes?

☐ ☐ ☐
Are you receiving any of the following support services? (Check All That Apply)

- Visiting nurse
- Home health aid
- Speech therapy
- Physical therapy
- Occupational therapy
- Prefer not to say
- Social worker
- Adult daycare
- Home delivered meals
- Other: __________________________
- None of the above services

If any of the above are checked, please list agency/provider for each:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

What is Your Religious Preference?:
- Agnostic
- Apostolic
- Atheist
- Baptist
- Buddhist
- Catholic
- Christian Scientist
- Episcopal
- Hindu
- Jehovah’s Witness
- Jewish
- Lutheran
- Methodist
- Mormon
- Muslim
- Non-denominational Christian
- Presbyterian
- Pentecostal
- Roman Catholic
- Sikh
- Spiritual, but not religious
- Zoroastrian
- Prefer not to say
- None
- Other: __________________________

Comments

HOUSING & ENVIRONMENT
Where are you living right now?

- House/Apartment/Room
- With friend/relative
- Shelter/boarding home
- Streets/abandoned home
- Other: ____________________________
- Prefer not to say

Do you plan on moving out of Camden?

- Yes
- No
- Not Sure
- Prefer not to say

When do you plan on moving out of Camden? __________________________________________

Comments:

EDUCATION & EMPLOYMENT; BENEFITS & ENTITLEMENTS

Do you have a source of income and/or entitlements?

- Yes
- No
- Prefer Not to Say

What is your source of income? (Check All That Apply)

- Work, “on the books” (earned income)
- Work, “off the books” (under the table income)
- Supplemental Security Income (SSI)
- Social Security Disability Insurance (SSDI/SSA)
- SNAP/Food Stamps
- Unemployment
- Plasma Center
- Pension/Retirement
- Sex Work/Trade
- Drug Trade
- Recycling/Scraping
- Panhandling
- Veteran’s Administration (VA) Benefits
- No Income
- Other: ____________________________
LEGAL

Do you have a Power of Attorney?

☐ Yes  ☐ No  ☐ Not Sure  ☐ Prefer Not to Say

Do you have any current charges (or a trial) pending?

☐ Yes  ☐ No  ☐ Not Sure  ☐ Prefer Not to Say

Are you on probation/parole?

☐ Yes  ☐ No  ☐ Not Sure  ☐ Prefer Not to Say

Do you have any felony convictions?

☐ Yes  ☐ No  ☐ Not Sure  ☐ Prefer Not to Say

IDENTIFICATION

Do you have a state identification card (license, non-driver’s ID, etc)?

☐ Yes  ☐ No  ☐ Not Sure  ☐ Prefer Not to Say

Do you have a Social Security card?

☐ Yes  ☐ No  ☐ Not Sure  ☐ Prefer Not to Say

Do you have a Birth Certificate or Passport?

☐ Yes  ☐ No  ☐ Not Sure  ☐ Prefer Not to Say

Where were you born?

TRANSPORTATION

Page 7 of 10
How do you get around, including getting to your medical appointments? (Check All That Apply)

- □ I drive a car.  □ I walk, ride a bike, or ride a scooter.
- □ My friends or family drive me.  □ I cannot get around easily.
- □ I take public transportation or a taxi.  □ I take medical transportation (i.e. Logisticare)
- □ Prefer not to say
- □ Other: __________________________

Comments:

MEDICATION & MEDICAL SUPPLIES

CURRENT DURABLE MEDICAL EQUIPMENT: check all that apply

- □ Apnea Monitor                      □ Nebulizer
- □ Bath bench/shower chair            □ Oxygen
- □ Bedside commode                    □ Peak flow
- □ Blood pressure equipment           □ Scales
- □ Cane                                □ Trach supplies
- □ CPAP/biPAP                          □ Walker
- □ Feeding pump                        □ Wheelchair
- □ Glucometer                         □ None
- □ Grab bars                          □ Other: __________________________
- □ Hospital bed

DURABLE MEDICAL EQUIPMENT NEEDED: check all that apply

- □ Apnea Monitor                      □ Nebulizer
- □ Bath bench/shower chair            □ Oxygen
- □ Bedside commode                    □ Peak flow
- □ Blood pressure equipment           □ Scales
- □ Cane                                □ Trach supplies
- □ CPAP/biPAP                          □ Walker
- □ Feeding pump                        □ Wheelchair
- □ Glucometer                         □ None
- □ Grab bars                          □ Other: __________________________
- □ Hospital bed

PAIN NEEDS:
Are you currently taking any medications for pain management (e.g. Percocet, Oxycontin, Vicodin, etc)?

☐ □ □ □
Yes No Not Sure Prefer not to say

Are you currently seeing a pain specialist for treatment?

☐ □ □ □
Yes No Not Sure Prefer not to say

If yes, specify provider: ____________________________________________________________

How bad is your pain? (circle a face)

[Scale with faces from happy to sad]

0 1 2 3 4 5 6 7 8 9 10

No Symptoms Mild Symptoms Moderate Symptoms Severe Symptoms

Where is your pain? ________________________________________________________________

Comments:

MEDICATIONS:

Are you allergic to any medications?
If yes, specify medications:

Current Medications:

**Use med rec sheet attached to complete med reconciliation **

*Please make sure that the med reconciliation form is complete and now complete the CPCQ Questionnaire
B. Care Planning Domains
<table>
<thead>
<tr>
<th>Domain</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction</td>
<td>Communicate concepts necessary to address a chronic, often relapsing brain disease related to alcoholism or licit or illicit drugs. Base core concepts in a harm reduction framework and work to build trust and understanding while also addressing safety and health concerns. Connect patient to available treatment resources as requested. Approach patient with unconditional positive regard.</td>
</tr>
<tr>
<td>Advocacy and Activism</td>
<td>Empower patient to share story and advocate for better care for themselves and community (i.e., condemning patient approaches patient with unconditional positive regard). Also addressing safety and health concerns. Connect patient to available treatment resources as requested. Base story on concepts in a harm reduction framework and work to build trust and understanding while also addressing safety and health concerns.</td>
</tr>
<tr>
<td>Benefits &amp; Entitlements</td>
<td>Assess eligibility for and connect patients to government entitled safety net programs including but not limited to: food stamps, social security, Medicaid, VA benefits, and unemployment compensation.</td>
</tr>
<tr>
<td>Family, Personal and Peer Support</td>
<td>Assist patient and family to access and secure supportive resources that bolster patient and caregiver well-being (i.e., home health aides, senior care, personal care attendant). Connect individuals with common illnesses and or life experiences to share knowledge, mutual support and guidance.</td>
</tr>
<tr>
<td>Food and Nutrition</td>
<td>Assist patient to gain immediate access to food, and connect patient to a sustainable support to receive long term access to food. Communicate and teach concepts related to healthy food choices.</td>
</tr>
<tr>
<td>Education and Employment Connection</td>
<td>Assists patient in accessing resources for reproductive life planning. Care planning for women of reproductive age uses the Life Course model and aims to ensure safety for current pregnancies and to assist in the planning of future pregnancies to reduce risks to mother and child.</td>
</tr>
<tr>
<td>Camden Delivers (Reproductive) Health</td>
<td>Assist patient in accessing resources for reproductive life planning. Care planning for women of reproductive age uses the Life Course model and aims to ensure safety for current pregnancies and to assist in the planning of future pregnancies to reduce risks to mother and child.</td>
</tr>
<tr>
<td>Health Maintenance, Management, and Promotion</td>
<td>Communicate and teach concepts necessary to self-manage their chronic diseases on a day-to-day basis, with a particular emphasis on concepts delivering a safety net to patients. Grow patients' ability to self-manage their health.</td>
</tr>
<tr>
<td>Housing and Environment</td>
<td>Assess patient's present living conditions of the home and identity and work to address immediate issues with self-managing their health.</td>
</tr>
<tr>
<td>Identification</td>
<td>Assess if patient has access to government issued state ID, birth certificate and social security card for the purposes of verifying eligibility requirements that may be required in other domains. Assist patient in gaining access to this information and helping the patient to access it.</td>
</tr>
<tr>
<td>Legal</td>
<td>Assist patient to address current legal issues (i.e., criminal charges, warrants, parole, probation, child support, financial, etc.) that are interfering access to services quality of life and overall well-being. Connect patient to resources.</td>
</tr>
<tr>
<td>Support</td>
<td>Access patient to gain immediate access to food, and connect patient to a sustainable support to receive long term access to food. Communicate and teach concepts related to healthy food choices.</td>
</tr>
<tr>
<td>Field, Personal and Peer Support</td>
<td>Assist patient and family to access and secure supportive resources that bolster patient and caregiver well-being (i.e., home health aides, senior care, personal care attendant). Connect individuals with common illnesses and or life experiences to share knowledge, mutual support and guidance.</td>
</tr>
<tr>
<td>Education and Employment</td>
<td>Programs and employment opportunities. Access to educational and employment opportunities including but not limited to GED programs, college courses, trade programs and employment opportunities.</td>
</tr>
<tr>
<td>Food and Nutrition</td>
<td>Assist patient to gain immediate access to food, and connect patient to a sustainable support to receive long term access to food. Communicate and teach concepts related to healthy food choices.</td>
</tr>
<tr>
<td>Health Maintenance, Management, and Promotion</td>
<td>Communicate and teach concepts necessary to self-manage their chronic diseases on a day-to-day basis, with a particular emphasis on concepts delivering a safety net to patients. Grow patients' ability to self-manage their health.</td>
</tr>
<tr>
<td>Housing and Environment</td>
<td>Assess patient's present living conditions of the home and identity and work to address immediate issues with self-managing their health.</td>
</tr>
<tr>
<td>Identification</td>
<td>Assess if patient has access to government issued state ID, birth certificate and social security card for the purposes of verifying eligibility requirements that may be required in other domains. Assist patient in gaining access to this information and helping the patient to access it.</td>
</tr>
<tr>
<td>Legal</td>
<td>Assist patient to address current legal issues (i.e., criminal charges, warrants, parole, probation, child support, financial, etc.) that are interfering access to services quality of life and overall well-being. Connect patient to resources.</td>
</tr>
<tr>
<td>Provider Relationship Building</td>
<td>Mental Health</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Assist patient in gaining access to resources to address mild, moderate or severe mental health diagnoses, in many instances this may involve coordinating patient’s resources to get an accurate diagnosis or a prescribed mental health treatment.</td>
<td>Examples of diagnoses include depression, anxiety or other long-term diagnoses such as major depression, bipolar disorder, post-traumatic stress disorder, schizophrenia or other mental health issues. Patient may have more than one mental health issue and treatment to manage this illness whether in a primary care or outpatient mental health setting.</td>
</tr>
<tr>
<td>Patient voice and concerns about his/her healthcare.</td>
<td>Patient voice and concerns about his/her healthcare.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transportation</th>
<th>Patient Specific Wildcard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicable and each concepts is patient about available transportation resources, connected patient to as well as to and from medical and social services.</td>
<td>Any task or activity that does not fall into another, established domain.</td>
</tr>
<tr>
<td>Communicable and each concepts is patient about available transportation resources, connected patient to as well as to and from medical and social services.</td>
<td>Any task or activity that does not fall into another, established domain.</td>
</tr>
<tr>
<td>Patient’s voice and concerns about his/her healthcare.</td>
<td>Patient’s voice and concerns about his/her healthcare.</td>
</tr>
</tbody>
</table>
C. Creating a Backwards Plan
Create a Backwards Plan: Instructional Guide

The purpose of backwards planning is to develop a care plan based off patient priorities. The cards help highlight different health goals. The board will help patients organize their health goals according to what they deem as important.

- Domain cards placed in the top left square represent items of high priority.
- Domain cards placed in the top right or bottom left square represent items of lower priority. These squares offer an opportunity to openly discuss why a patient feels they are of lesser importance.
- Domain cards placed in the bottom right square most likely represent items the patient has managed well in the past. This square offers an opportunity to highlight past accomplishments and/or progress.

Preparation

- Print domain cards on cardstock
  - Left column: Domain names - front of card
  - Right column: possible prompts - back of card
- Cut out each domain name and prompts (cut across each domain– not down the center)
  - Fold cards in half
  - Tape/staple to secure
- Print board on cardstock

Activity

1) Take out cards and board and explain their purpose.
2) Read through each domain card with the patient (use prompts on back if you need a conversation starter).
3) Have the patient place domain cards in the squares that corresponds to the domain’s importance. Example: need to work on now vs. need to work on later.
4) Develop care plan based off domain card titles and placement on board.
<table>
<thead>
<tr>
<th>DONT NEED TO WORK ON</th>
<th>NEED TO WORK ON</th>
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<tr>
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</tbody>
</table>
| Get a job and/or go back to work | • Have spending money  
• Get an education  
• Work hard at a job I like |
| (Education & Employment) |
| Have medical equipment & medication | • Find medications that work for me  
• Get medical equipment that will help me manage my conditions |
| (Medication & Equipment Support) |
| Legal issues | • Stay out of jail  
• Get help with a legal issue I am facing  
• Get a lawyer |
| (Legal Assistance) |
| Get a job and/or go back to work | • Have spending money  
• Get an education  
• Work hard at a job I like |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Education &amp; Employment)</td>
<td></td>
</tr>
</tbody>
</table>
| Have medical equipment & medication | • Find medications that work for me  
• Get medical equipment that will help me manage my conditions |
| (Medication & Equipment Support) |                                                                 |
| Legal issues | • Stay out of jail  
• Get help with a legal issue I am facing  
• Get a lawyer |
| (Legal Assistance) |                                                                 |
| Talk to someone about my mental health | • To feel better about myself  
• To have more energy and motivation  
• Have fun and not worry all the time |
| --- | --- |
| Have transportation | • Find ways to get to and from medical appointments  
• Not have to rely on others to get places |
| Have a better living situation | • Have a safe place to live  
• Make improvements to where I stay  
• Find housing I qualify for |
| **Talk to someone about my mental health**  
  *(Mental Health Support)* | • To feel better about myself  
  • To have more energy and motivation  
  • Have fun and not worry all the time |
|---|---|
| **Have transportation**  
  *(Transportation Support)* | • Find ways to get to and from medical appointments  
  • Not have to rely on others to get places |
| **Have a better living situation**  
  *(Housing Support)* | • Have a safe place to live  
  • Make improvements to where I stay  
  • Find housing I qualify for |
| Have a better relationship with my doctors & nurses | • Feel at ease in my health care providers office  
(Provider Relationship) • Feel comfortable telling my provider when I don’t understand something they say |
|---------------------------------------------------|------------------------------------------------------------------------------------------------|
| Learn more about _______ (COPD, Diabetes, etc...) | • Better control my pain  
(Health Management) • Learn more about managing my health on a day-to-day basis  
• Be physically fit |
| See if I qualify for insurance and other government programs | • Apply for assistance  
(Benefits & Entitlements) • Apply for health insurance  
• Figure out if I qualify for additional income |
| Have a better relationship with my doctors & nurses  | • Feel at ease in my health care providers office  
| (Provider Relationship) | • Feel comfortable telling my provider when I don’t understand something they say |
| Learn more about ________ (COPD, Diabetes, etc...) | • Better control my pain  
| (Health Management) | • Learn more about managing my health on a day-to-day basis  
|  | • Be physically fit |
| See if I qualify for insurance and other government programs | • Apply for assistance  
| (Benefits & Entitlements) | • Apply for health insurance  
|  | • Figure out if I qualify for additional income |
| Help people in my community | • Get involved with/organize a local interest group  
|                           | • Let people know about issues happening in our community  
|                           | • Use my story to raise awareness |
| Identification            | • Get a photo ID  
|                           | • Get a driver’s license  
|                           | • Get a social security card  
|                           | • Get a birth certificate  
|                           | • Get proof of income |
| Have support              | • Socialize with friends and family  
|                           | • Find a good friend  
|                           | • Feel like my life matters to someone else |
| Help people in my community (Advocacy & Activism) | • Get involved with/organize a local interest group  
• Let people know about issues happening in our community  
• Use my story to raise awareness |
|-------------------------------------------------|-------------------------------------------------------------------------------------------------|
| Identification (ID Support)                      | • Get a photo ID  
• Get a driver’s license  
• Get a social security card  
• Get a birth certificate  
• Get proof of income |
| Have support (Family, Personal, & Peer Support)  | • Socialize with friends and family  
• Find a good friend  
• Feel like my life matters to someone else |
| Talk to someone about my drug or alcohol use  | • Learn more about how a drug or alcohol I use affects my chronic condition  
  (Addiction, Assessment, & Connection)  | • Find someone I can talk to about my alcohol or drug use |
|---------------------------------------------|-------------------------------------------------------------------------------------------------|
| Food & Nutrition                            | • Get access to healthy food  
  • Eat better  
  • Learn how to cook healthy food                                                                 |
|                                            |                                                                                                                                 |
D. Highlight Progress with Data Templates (3)
I want to be healthy and stay out of the hospital because...

I’ll reach my vision by:

<table>
<thead>
<tr>
<th>Action</th>
<th>Support Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting a job and/or going back to work</td>
<td></td>
</tr>
<tr>
<td>Having medical equipment and/or medication</td>
<td></td>
</tr>
<tr>
<td>Getting help with legal issues</td>
<td></td>
</tr>
<tr>
<td>Talking to someone about my mental health</td>
<td></td>
</tr>
<tr>
<td>Having transportation</td>
<td></td>
</tr>
<tr>
<td>Having a better living situation</td>
<td></td>
</tr>
<tr>
<td>Have a better relationship with my doctors and nurses</td>
<td></td>
</tr>
<tr>
<td>Learning more about my health conditions</td>
<td></td>
</tr>
<tr>
<td>Seeing if I qualify for insurance or government programs</td>
<td></td>
</tr>
<tr>
<td>Helping people in my community</td>
<td></td>
</tr>
<tr>
<td>Having support</td>
<td></td>
</tr>
<tr>
<td>Talking to someone about my drug or alcohol use</td>
<td></td>
</tr>
<tr>
<td>Having access to healthy food</td>
<td></td>
</tr>
</tbody>
</table>

My care team can help me by...

When I struggle to reach my vision, I will...
I want to be healthy and stay out of the hospital because...

My main goal:

<table>
<thead>
<tr>
<th>My progress</th>
<th>You do (Can you show me?)</th>
<th>We do (Can we do it together?)</th>
<th>I do (I can do it!)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit 1</td>
<td>_________________________</td>
<td>____________________________</td>
<td>_________________</td>
</tr>
<tr>
<td>Visit 2</td>
<td>_________________________</td>
<td>____________________________</td>
<td>_________________</td>
</tr>
<tr>
<td>Visit 3</td>
<td>_________________________</td>
<td>____________________________</td>
<td>_________________</td>
</tr>
<tr>
<td>Visit 4</td>
<td>_________________________</td>
<td>____________________________</td>
<td>_________________</td>
</tr>
<tr>
<td>Visit 5</td>
<td>_________________________</td>
<td>____________________________</td>
<td>_________________</td>
</tr>
<tr>
<td>Visit 6</td>
<td>_________________________</td>
<td>____________________________</td>
<td>_________________</td>
</tr>
<tr>
<td>Visit 7</td>
<td>_________________________</td>
<td>____________________________</td>
<td>_________________</td>
</tr>
<tr>
<td>Visit 8</td>
<td>_________________________</td>
<td>____________________________</td>
<td>_________________</td>
</tr>
<tr>
<td>Visit 9</td>
<td>_________________________</td>
<td>____________________________</td>
<td>_________________</td>
</tr>
</tbody>
</table>

Graduation! Date: ____________________________

My care team can help me by...
I want to be healthy and stay out of the hospital because...

---

<table>
<thead>
<tr>
<th>I want to work on:</th>
<th>I want to work on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You do ___</td>
<td>You do ___</td>
</tr>
<tr>
<td>We do ___</td>
<td>We do ___</td>
</tr>
<tr>
<td>I do ___</td>
<td>I do ___</td>
</tr>
<tr>
<td>(Can you do it?)</td>
<td>(Can you do it?)</td>
</tr>
<tr>
<td>(Can we do it?)</td>
<td>(Can we do it?)</td>
</tr>
<tr>
<td>(I can do it!)</td>
<td>(I can do it!)</td>
</tr>
</tbody>
</table>

Wins:

---

<table>
<thead>
<tr>
<th>I want to work on:</th>
<th>I want to work on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You do ___</td>
<td>You do ___</td>
</tr>
<tr>
<td>We do ___</td>
<td>We do ___</td>
</tr>
<tr>
<td>I do ___</td>
<td>I do ___</td>
</tr>
<tr>
<td>(Can you do it?)</td>
<td>(Can you do it?)</td>
</tr>
<tr>
<td>(Can we do it?)</td>
<td>(Can we do it?)</td>
</tr>
<tr>
<td>(I can do it!)</td>
<td>(I can do it!)</td>
</tr>
</tbody>
</table>

Wins:

---

<p>| My care team can help me by... |</p>
<table>
<thead>
<tr>
<th>I want to work on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You do ___</td>
</tr>
<tr>
<td>We do ___</td>
</tr>
<tr>
<td>I do ___</td>
</tr>
<tr>
<td>(Can you do it?)</td>
</tr>
<tr>
<td>(Can we do it?)</td>
</tr>
<tr>
<td>(I can do it!)</td>
</tr>
</tbody>
</table>

Wins:

---

| When I struggle to reach my goal, I will... |
E. Bi-Weekly Case Conferencing Script
Case Presentation Script

(Pseudonym)* is a (Age) (Race/Ethnicity) (Male/Female) with driving medical diagnoses of: (List patient’s medical conditions). Patient also has the following mental health diagnoses: (List patient’s mental health diagnoses).

(Pseudonym) has been enrolled in our services (number of days Pt. has been with your team). This patient has had (# of Readmissions) since our services began. We are scheduled to see the Pt. on (Date of next scheduled interaction with patient).

(Pseudonym) main drivers are (List what the patient wants to work on from his/her perspective). (His/Her) barriers are: (List barriers/issues you are facing with patient). (His/Her) strengths are: (List strengths you have noticed with patient).

The patient responded well when (list interventions/techniques you have used with the patient). The patient did not respond well when (list interventions/techniques you have used with the patient).

I would like help with (list areas of treatment/intervention).

*Alter patient-identifying information unless you have authorization from your patient.
F. Care Management Triage Worksheet
Care Management Triage Form

MRN: ________________  Utilization: ED ___ INP ___ Days _____

Initials: ___________  Age: ________________  (Rule out patients over 80)

Date of Selection / Non-selection: ____________________________

Date of Admission: ____________________________

Primary Care Practice: ____________________________

Insurance: ____________________________

Draft Qualitative Instrument for adults (more than 18 years of age):

**Part 1:**

<table>
<thead>
<tr>
<th>Does the patient have 2 or more admissions in the last 6 months?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong> (continue to Part 2)</td>
</tr>
</tbody>
</table>

**Principal Diagnosis Admission 1:**

**Principal Diagnosis Admission 2:**

**Part 2:**

<table>
<thead>
<tr>
<th>Is the primary reason for admissions oncology related?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the primary reason for admissions due to pregnancy?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is the primary reason for admissions due to a surgical procedure for an acute problem?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are the admissions due to complications of a progressive chronic disease that has limited treatment?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are the admissions for mental health only with no comorbid conditions?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are the admissions to treat acute diseases only?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Any answers of Yes in Part 2 exclude the patient from the intervention. If all answers are No, proceed to Part 3.

Other reason for non-selection or notes regarding selection: ____________________________

__________________________________________

__________________________________________
Part 3:

C/A means “cannot assess.” Please read corresponding notes.

<table>
<thead>
<tr>
<th>Does the patient have 2 or more chronic conditions?</th>
<th>Yes</th>
<th>No</th>
<th>C/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which conditions?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is the patient taking 5 or more medications</th>
<th>Yes</th>
<th>No</th>
<th>C/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient have difficulty accessing services? (language barrier, low health literacy, labeled “non-compliant”)</td>
<td>Yes</td>
<td>No</td>
<td>C/A</td>
</tr>
<tr>
<td>If yes, what barrier(s)?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does the patient have lack of social support at home or in the community?</th>
<th>Yes</th>
<th>No</th>
<th>C/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social support or lack thereof:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does the patient have any mental health diseases?</th>
<th>Yes</th>
<th>No</th>
<th>C/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient actively using drugs?</td>
<td>Yes</td>
<td>No</td>
<td>C/A</td>
</tr>
<tr>
<td>Is the patient homeless?</td>
<td>Yes</td>
<td>No</td>
<td>C/A</td>
</tr>
<tr>
<td>Is the patient uninsured?</td>
<td>Yes</td>
<td>No</td>
<td>C/A</td>
</tr>
</tbody>
</table>

Three or more “yes” responses in Part 3 indicate the patient is at high risk for readmission / high utilization and will qualify for one of our interventions.