Designing a Population Health Initiative: Engaging with Target Population

July 21, 2022

Objectives

- Describe tools and strategies to use to engage with individuals
- Describe the key components of a person-centered treatment plan
- Describe the key components of a behavioral health home service note

Stages of Change

Meeting the individual “where they are”

People are better persuaded by the reasons they themselves discovered than those that come into the minds of others.

Blaise Pascal

Working with the Individuals We Serve

Motivational Interviewing (MI) is a collaborative, person-centered, guiding method designed to elicit and strengthen motivation for change.

Miller & Rollnick, 2012

Motivational Interviewing

The tasks of MI are to:

- Engage
- Focus on what's important to the patient regarding behavior, health, and welfare.
- Evoke the patient's personal motivation for change
- Negotiate plans

An effective way to talk to people about change.

Motivational Interviewing Skills

Engage

OARS includes a set of four basic communication techniques

- Ask **O**pen-ended questions.
- **A**ffirm strengths and movement in a positive direction.
- **R**eflect what the individual says to convey that you are listening and to confirm understanding.
- **S**ummarize the interaction to bring closure, confirm mutual understanding and next steps.

Eliciting Change Talk

Focus and evoke

Ask for elaboration and examples. *Tell me more. When was the last time that happened?*

Look forward or backward. *How do you see your health in 5 years?*

Use a readiness ruler. *Why are you a 5 and not a 4? Or Why are you a 4 and not a 3?*

Ask about extreme outcomes. *What are the worst/best things that could happen if you do not take care of your diabetes?*

Ask for pros and cons of both changing and not changing. *How will taking your medication lower you risk of going to the hospital? How will another hospital admission impact you?*

Developing a Plan

Planning

Developing a Treatment Plan

“I want to learn how I can be healthy and stay away from diabetes”.

Kathy is at risk of developing diabetes due to her weight, the types of food she eats, and lack of regular exercise. Kathy has a hard time staying active when she feels depressed and states she does not know where she can exercise. She binges on junk food every night while she watches TV.

Over the next 30 days, Kathy will reduce binge eating from 7 times a week to 2 times a week by replacing junk food with air popped popcorn or apples.

Over the next 60 days, Kathy will increase her physical activity by logging at least 1,000 steps on her pedometer two times a week.

Over the next 90 days, Kathy will apply mindfulness techniques to decrease depressive symptoms as evidenced by a score below XX on PHQ9.

Developing a Treatment Plan

“I want to have a better life and feel more confident about what to do for my diabetes”.

Kathy was diagnosed with diabetes 3 months ago. She does not understand the information her doctor told her about what to do for her diabetes but is afraid to ask questions at her appointments. Her doctor has asked her to try and lose weight but she has not be able to. Her next scheduled appointment with her doctor is in two months.

Over the next 30 days, Kathy will cook and rate on a scale of 1 to 10 three recipes that are diabetes friendly.

Over the next 60 days, Kathy will identify 5 questions she has about her diabetes care and pick two she is willing to bring up at her next appointment.

Documentation

- Specify which of the six BHH services you are providing
- Document which ***goal and objective*** on the treatment plan the service is linked to
- Document the ***intervention*** provided and the client's response to the intervention
- Include a specific ***plan for the next time*** you see the client
- Date, time, duration & location of service delivered

Putting It All Together

Comprehensive Care Management

Care Coordination

Comprehensive Transitional Care

Referral to Community Support Services

Health Promotion

Patient and Family Support

Your client has several appointments in the community: 1) a doctor's appointment to and 2) an appointment to see a new apartment. The client will be taking the bus to both appointments. One of the client's goal is to become independent and be able to do the things they like on their own. The client does not drive and gets very anxious riding the bus. Your work today with the client ties to the objective on their treatment plan to take one short bus ride a week.

- You meet with the client, review the bus schedule, work together to determine which bus to take, and develop strategies to remain calm on the ride.

- *What BHH service is being provided?*

BHH Service Example

Documentation

- Met with Kathy today to provide patient support and plan for her trip to the doctor. Kathy has committed to taking one short bus ride a week as a step in her goal of becoming independent. Assisted Kathy in identifying the bus she needs to take and how to get to the bus stop. Developed two activities Kathy can do while on the bus to help with anxiety; she will listen to music on her phone and do a word find puzzle. Kathy was nervous about taking the bus at the beginning of our meeting, but felt much more confident after she identified the activities to use while on the bus. We will meet again in one week to assess how coping skills worked and to plan for the next trip.

Comprehensive Care Management

Care Coordination

Comprehensive Transitional Care

Referral to Community Support Services

Health Promotion

Patient and Family Support

“I want to have a better life and know more about what to do for my diabetes”.

Kathy was diagnosed with diabetes 3 months ago. She does not understand the information her doctor told her about what to do for her diabetes but is afraid to ask questions at her appointments. Her doctor has asked her to lose weight but she has not be able to. She said all the diabetes friendly meals she knows of are gross. Her next scheduled appointment with her doctor is in two months.

Over the next 30 days, Kathy will cook at home and rate on a scale of 1 to 10 three recipes that are diabetes friendly.

You meet with Kathy to assess progress on the above objective.

What BHH service is being provided?

Progress Note

- Met with Kathy to provide care management and assess her progress on cooking and rating three recipes that are diabetes friendly. Kathy relayed she continues to struggle to find recipes and did not cook any diabetes friendly meals last week. Developed two activities Kathy will try this week to see if she can cook meals; she will attend the healthy eating group on Friday and she will go to the library and check out a cook book for those with diabetes. Kathy was down at the beginning of our meeting, but felt much more confident after we identified steps for her to do. We will meet again in two weeks to assess how cooking has gone and Kathy will bring me her favorite recipe.

Resources

- Practical Tools for Behavioral Health Staff Supporting the Medical Care of People with Serious Mental Illness (smiadviser.org)
- Utilizing Next-Generation Digital Health Technology to Improve Care for People with SMI (smiadviser.org)
- Readiness Ruler | Center for Evidence-Based Practices | Case Western Reserve University
- How do you have patient-centered conversations? Motivational Interviewing Basics - Bing video