



Tennessee Health Link Curriculum

June 2019



Training Module Overview

The curriculum includes the training modules listed below, which encompass the key areas for Health Link organization transformation.

Table 1: Modules Overview

No.	Module
Intro	Initial Assessment Results
1.	Transformation Overview and Basics
2.	Change Management
3.	Physical Health Integration
4.	Risk Stratification
5.	Organizational Workflow and Redesign
6.	Team Based Care and Organization
7.	Knowing and Managing Your Member Population
8.	Patient-Centered Access and Continuity
9.	Quality Improvement
10.	Measuring Performance with Data
11.	Care Management and Support
12.	Member Self-Management and Support
13.	Care Coordination and Care Transitions
14.	Care Giver Support
Appendix	Link to Health Link webinars

Module Sessions

Materials in [blue font](#) are available on the SharePoint site.

Module (Intro)

MODULE (INTRO)	INITIAL ASSESSMENT RESULTS
SESSION (INTRO)	<i>Organizations will have a clear understanding of the initial assessment results and the domains in which they may require assistance to be successful with the Health Link program.</i>
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> • Organizational management • Health Link lead/s • Site Supervisors • Any other key personnel overseeing implementation/training for Health Link development 	
1	Understands Health Link organization’s initial assessment results (cover this learning objective only if it has not already been completed in a previous session).
2	Understands the role of the Health Link coach in the transformation process.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> • Complete a review of the initial assessment. <ul style="list-style-type: none"> ○ Review assessment results and discuss agreements on priority areas/objectives. ○ Complete a “<i>stoplight</i>” diagram (establishing strengths shown in green, risks shown in yellow and weaknesses shown in red) in the organization that will impact readiness for change, recognizing which “red light” barriers need to be addressed early to set the stage for change. Establish next steps for addressing these “red light areas.” • Review organization’s pre-established Health Link implementation strategies (e.g., new services, workflows, etc.) and adjust accordingly. • Establishing organizational roles with coach (main contact, scribes, minutes, follow-up, etc.) specific to organizing and documenting during sessions. • Identify “Health Link” champions, both leaders and key staff members who will drive progress. This should include “front line” champions who will play a role with clinical coaching efforts.
2	<ul style="list-style-type: none"> • Review TennCare Health Link Coaching Overview and discuss the roles of each member of the transformation team and the general improvement model. <ul style="list-style-type: none"> ○ Review the role of the coach on slide 7 and identify where expectations align/misalign.
ADDITIONAL RESOURCES (documents on SharePoint site):	
	Health Link Provider Initial Assessment (Not on the Curriculum SharePoint Site, Coach to Provide)
	MCO Health Link Practice Review Reports (Not on the Curriculum SharePoint Site, Coach to Provide)
	TennCare Health Link Curriculum Overview
	The Population Management in Community Mental Health Center-Based Health Homes

Module 1

MODULE 1	TRANSFORMATION OVERVIEW AND BASICS
SESSION 1A	<i>Organizations will have a clear understanding of the requirements of the Tennessee Health Link program.</i>
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
RECOMMENDED ATTENDEES: <ul style="list-style-type: none"> • Organizational management • Health Link lead/s • Site Supervisors • Any other key personnel overseeing implementation/training for Health Link development 	
1	Understands the activity requirements of the Health Link program.
2	Understands Health Link modifiers for the activity requirements.
3	Understands the Health Link Program’s Quality and Efficiency Measures.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> • Review key features and sources of value of the Health Link program. Tennessee Health Link: Provider Operating Manual: Pgs. 2-4, emphasis on “Sources of Value” table • Review activity requirements of the Health Link program. Tennessee Health Link: Provider Operating Manual: Pgs. 35-44, emphasis on Quality Metrics and Required Activities • Understand leadership and staff roles relative to Health Link model. <ul style="list-style-type: none"> ○ Complete a diagram of which staff complete which Health Link activities. ○ Complete tour of physical plant “according to member flow” – walk the facilities as a member to understand flow and level of integration. Coach will document this flow and complete this exercise at satellite sites as well.
2	<ul style="list-style-type: none"> • Review Health Link modifiers. Present the information to the organization and then: <ul style="list-style-type: none"> ○ Ask provider to give an example of each type of activity that would fall in each category (e.g. Member, Collateral, Face-to-Face, Indirect) Tennessee Health Link: Provider Operating Manual: Pg. 36-37, emphasis on “Activity Encounter Codes” table
3	<ul style="list-style-type: none"> • Review the Health Link Program’s Quality and Efficiency Measures (Module 10 covers this topic more in-depth). <ul style="list-style-type: none"> ○ Ask provider if they know which measures are being used in the program and how they are used. ○ Review PCMH and Tennessee Health Link Quality Thresholds and Efficiency Thresholds Guidance ○ Review quality and efficiency metrics in TN Health Link DBR Appendix v0.3 ○ Review the measures and how they are used in the program. ○ Review how a provider can monitor their performance in these measures: <ul style="list-style-type: none"> - Provider operating manual - MCO quarterly reports - Care Coordination Tool (CCT) (e.g., can the organization effectively use the CCT to identify and address gaps in care for members) ○ Identify 2-3 quality measures for focused improvement. • Offer future coaching session on improvement of Quality and Efficiency measures. • Based on the TennCare Measures, review how the areas of coaching may affect the performance of those metrics and review MCO trends with organization to set the stage for clinical focus areas.

MODULE 1	TRANSFORMATION OVERVIEW AND BASICS
SESSION 1A	<i>Organizations will have a clear understanding of the requirements of the Tennessee Health Link program.</i>
	ADDITIONAL RESOURCES (documents on SharePoint site):
	Tennessee Health Link: Provider Operating Manual: Pgs. 15-17
	Health Link Provider Initial Assessment (Not on the Curriculum SharePoint Site, Coach to Provide)
	MCO Health Link Practice Review Reports (Not on the Curriculum SharePoint Site, Coach to Provide)
	Tennessee Health Link Overview
	Module 1: Transformation Overview PPT: Slides 28-31, 34
	Care Coordination Tool Overview
	5 A's Behavior Change Model
	The Stages of Change

Module 2

MODULE 2	CHANGE MANAGEMENT: THE ROLE OF LEADERSHIP
SESSION 2A	<i>The organization's leadership seeks to bring about change using a model that creates a positive climate for change, engages & enables the organization to change, allows for a full implementation, and creates change that is sustainable.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> • Organizational management • Health Link lead/s • Site Supervisors • Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Understand the factors of change and why it is necessary.
2	Identify members of the team and those members who will serve as change champions.
3	Develop a plan for how leadership can effectively talk with staff who may be resistant to change.
4	Re-establish "what success means" in context of moving from Level II Case Management to Health Link care coordination.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site) ¹	
1	<ul style="list-style-type: none"> • Review change management process to date within the organization. <ul style="list-style-type: none"> ○ Training and development ○ Communication strategies ○ Summarize the current progress and goals • Review Kotter's Change Model with leadership to increase understanding of the change process • Diagram historic strategies for change – what has worked, and what hasn't? • Discuss common elements to historical success in change initiatives • Establish required updates to documented strategies and procedures, what is required to implement these changes?

¹ Some strategies from Session 2A will overlap with Session 2B.

MODULE 2	CHANGE MANAGEMENT: THE ROLE OF LEADERSHIP
SESSION 2A	<i>The organization’s leadership seeks to bring about change using a model that creates a positive climate for change, engages & enables the organization to change, allows for a full implementation, and creates change that is sustainable.</i>
	<ul style="list-style-type: none"> • Strategies for Guiding PCMH Transformation from Within² (slides 9 – 14) – Review selected strategies, and facilitate organizational selection of 1-2 new strategies that could be implemented. • Review SAMHSA’s Change Management slide deck (slides 2 – 6)
2	<ul style="list-style-type: none"> • Diagram the impact of change across an organizational chart. Identify the following: <ul style="list-style-type: none"> ○ Roles which are experiencing the most change ○ How change is occurring at various levels ○ Steps to focus on high impact roles and drive change adoption • Identify staff champions across workflows and departments – who drives change in the organization? Establish what those individuals have in common. • Have leadership conduct a focus group and obtain 3-5 recommendations from the identified champions for improving change strategies to be reported back to coach.
3	<ul style="list-style-type: none"> • Ask how leadership demonstrates to staff that they are leading by example. How is leadership accountable? How have meetings changed to accommodate Health Link concepts? • Ask how often leadership is eliciting feedback from frontline staff. • Create easy channels for communication – anonymous feedback boxes, employee surveys, “town hall meetings”, open-door policies, etc. • Complete an “anticipating objections” exercise with management – conduct roleplay to hone messaging across leadership and champions. • Review concepts of “change fatigue”. • Shadow team meetings and staff meetings to identify how communication can be adjusted or optimized. • Review Change Management (AHRQ)
4	<ul style="list-style-type: none"> • Review need for evidence-based training implementations (i.e. Case to Care), develop implementation plan and identify training champions. • Operationalize examples of small, tangible “successes” for the organization to increase staff buy-in, with focus on front-line Health Link staff
ADDITIONAL RESOURCES (documents on SharePoint site):	
What Are Core Components...And Why Do They Matter? (SAMHSA) https://www.samhsa.gov/capt/tools-learning-resources/core-components-why-they-matter	
Kotter’s 8 Steps of Change	
Working with and Supporting Practice Leaders (AHRQ)	

MODULE 2	CHANGE MANAGEMENT: THE IMPORTANCE OF TEAM BUY-IN
SESSION 2B	<i>The organization seeks to bring about change particularly through increased focus on frontline staff to garner buy-in to fully promote the success of Health Link concepts with the organization’s members.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> • Organizational management • Health Link lead/s • Site Supervisors 	

² This is a PCMH-specific source. Health Link coaches will modify the source as necessary to align it with the Health Link program requirements and its desired outcomes.

<ul style="list-style-type: none"> Any other key personnel overseeing implementation/training for Health Link development. 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Understand the importance of changing from Level II Case Management to Health Link.
2	Identify members of the team who may be resistant to change.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)³	
1	<ul style="list-style-type: none"> Review the changes between case management and care coordination. Ask staff what they know about their new responsibilities and expectations. Review slides 5 – 8 of Making the Case for Care Coordination Discuss the intended health outcomes for the organization’s members engaged in Health Link. Discuss the importance of care coordination in a behavioral health setting and introduce the concepts of physical health integration and the importance of health integration (see Module 3 for more detailed information).
2	<ul style="list-style-type: none"> Conduct focus group with care coordinators and other staff with a high level of role change – gain understanding of what they like/dislike about current change efforts. Share feedback from front-line staff with the management team – conduct a review of current communications processes and organizations and identify 2-3 improvements that can be made in communication strategies (see Module 2A). Create a concept of “ownership” for care coordinators – the program will not be successful without them because they are the ones on the ground leading the change. Review concepts of “change fatigue”. Change Management (AHRQ) (pages 5 – 7)
ADDITIONAL RESOURCES (documents on SharePoint site):	
Developing and Running a Primary Care Practice Facilitation Program ⁴	
Strategies for Guiding PCMH Transformation from Within (Improving Chronic Care) ⁶ (pages 53 – 69)	

Module 3

MODULE 3	PHYSICAL HEALTH INTEGRATION: PROMOTING WHOLE PERSON CARE
SESSION 3A	<i>The organization has a robust understanding of the components of physical health integration including the resources required to promote integration and whole person care.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> Organizational management Health Link lead/s Site Supervisors Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Understand how physical and behavioral health interface.
2	Identify resources to promote physical and behavioral health integration.
3	Understand organizational impacts to daily processes with integration.
4	Understand the physical health measures for which the organization is responsible.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	

³ Some strategies from Session 2B will overlap with Session 2A.

⁴ This is a PCMH-specific source. Health Link coaches will modify the source as necessary to align it with the Health Link program requirements and its desired outcomes.

MODULE 3	PHYSICAL HEALTH INTEGRATION: PROMOTING WHOLE PERSON CARE
SESSION 3A	<i>The organization has a robust understanding of the components of physical health integration including the resources required to promote integration and whole person care.</i>
1	<ul style="list-style-type: none"> • Review organization’s population demographics and the most common physical health conditions <ul style="list-style-type: none"> ○ Ask about increased physical health condition needs (e.g., what conditions are most common in the organization, what staffing needs have been identified, what are the gaps in knowledge about integration) ○ Provide training to non-medical team members on the most common physical health conditions such as hypertension, diabetes, asthma and chronic obstructive pulmonary disease (COPD) and high cholesterol, as well as education on nutrition, exercise and tobacco cessation. Review Physical Health Integration slide deck ○ Provide Population Health Infographics during session and discuss the transition to the new model. • Ask organization to log-in to the Care Coordination Tool (CCT) and demonstrate how staff identifies who has a chronic health condition (e.g., all members with diabetes). • Review health literacy resources in Session 7B
2	<ul style="list-style-type: none"> • Discuss current staff and/or plans to hire additional staff to assist with integration experience (e.g., physicians, mid-level practitioners, nurses, etc.). • Conduct focus group with nursing staff to maximize participation with care coordination – understand physical health training (i.e., nurses with both physical health conditions and psychiatric experience are ideal for the exercise). • Discuss the provider’s Primary Care Provider collaborative relationships that are currently in place and how they are working. <ul style="list-style-type: none"> ○ Provide list of participating TennCare PCMHs https://www.tn.gov/assets/entities/hcfa/attachments/PCMHOrganizationList.pdf • Additional resources in Session 7D
3	<ul style="list-style-type: none"> • Review the organization’s assessment tool(s) to determine how well they address the following domains: <p><i>Does the Comprehensive health assessment (CHA) include all the following?</i></p> <ul style="list-style-type: none"> A. Medical history of member and family B. Mental health/substance use history of member and family C. Family/social/cultural characteristics D. Communication needs E. Behaviors affecting health F. Medication management and health literacy G. Social Functioning H. Social Determinants of Health I. Developmental screening using a standardized tool J. Member’s Perspective of Care K. Patient-Centered Approach to Self-Management • Shadow staff during assessment administration – are they asking the “right” questions to drill down to the appropriate health information? • Review a sampling of care plans and team documentation – identify where documentation can be strengthened, and establish training topics related to communicating via formal documentation.
4	<ul style="list-style-type: none"> • Review the Health Link quality measures related to physical health conditions Tennessee Health Link Provider Operating Manual, pg. 22-23 <ul style="list-style-type: none"> ○ Discuss which measures for which behavioral health is responsible and for which primary care is responsible.

MODULE 3	PHYSICAL HEALTH INTEGRATION: PROMOTING WHOLE PERSON CARE
SESSION 3A	<i>The organization has a robust understanding of the components of physical health integration including the resources required to promote integration and whole person care.</i>
	ADDITIONAL RESOURCES (documents on SharePoint site):
	Behavioral Health Homes for People with Mental Health & Substance Use Conditions
	Changing Patient Behavior: The Next Frontier in Healthcare Value
	The Stages of Change
	Health Link Webinar Behavioral Health Providers and Chronic Disease Management

MODULE 3	PHYSICAL HEALTH INTEGRATION: STRATEGIES FOR IMPROVING HEALTH OUTCOMES AND CONTROLLING COSTS
SESSION 3B	<i>The organization has a thorough understanding of the importance of whole person care for improving member outcomes and has strategies in place to maximize health outcomes and control costs of members with comorbid physical and behavioral health conditions.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> Organizational management Health Link lead/s Site Supervisors Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Understand ways in which chronic and acute physical health conditions affect members' behavioral health outcomes.
2	Identify ways in which the Health Link team can support members' physical health needs.
3	Understand the impact of physical health integration on cost of care.
4	Understand the benefit of prevention and early intervention on member outcomes.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> Provide team with an overview of Wagner's Chronic Care Model to illustrate the importance of a whole person approach to care. Ask team to use CCT to show coach how they look at members with different chronic diseases. Discuss team's knowledge of how physical health conditions affect behavioral health. Review Physical Health Integration slides deck slide 8 – 10. <ul style="list-style-type: none"> Identify gaps in knowledge and coaching opportunities. Identify 2-3 topic areas that clinical staff can support care coordinators with via enhanced training, develop a plan for delivering training within a set timeframe.
2	<ul style="list-style-type: none"> Brainstorming exercise to identify ways in which the Health Link team can support members' physical health conditions. Appoint champion(s) to monitor implementation of identified interventions/action items. Group activity for identifying ways in which the Health Link team can provide support to members with comorbid physical and behavioral health conditions <ul style="list-style-type: none"> Each team member will identify a member with a physical health condition and develop a strategy for providing support Have team use CCT to pull members with physical health conditions and use Wagner's Model of Care to develop strategies.

MODULE 3	PHYSICAL HEALTH INTEGRATION: STRATEGIES FOR IMPROVING HEALTH OUTCOMES AND CONTROLLING COSTS
SESSION 3B	<i>The organization has a thorough understanding of the importance of whole person care for improving member outcomes and has strategies in place to maximize health outcomes and control costs of members with comorbid physical and behavioral health conditions.</i>
	<ul style="list-style-type: none"> Review of 2-3 case files after training to identify effectiveness of training and utilization of interventions for physical health.
3	<ul style="list-style-type: none"> Review of literature on the costs associated with untreated physical health conditions – document organizational “takeaways”. Ask organization about Total Cost of Care (TCOC) reports. Identify 1-3 areas where improvement is needed to reduce TCOC. Set a manageable goal for reduction (work with organization to determine this), based on actions established. A manageable goal, for “well-designed” programs based on research, is approximately a 20 percent reduction in TCOC. Adjust this percentage accordingly based on the organization’s needs and integration progress. Integrated Behavioral Health Care.
4	<ul style="list-style-type: none"> Exercise on developing strategies and talking points for promoting prevention and early intervention with members. Complete an “anticipating objections” workshop – develop scripts through roleplay that staff can use when working with members to drive prevention and early intervention. Document scripts and develop a one-page flyer for team reference in the field. Complete a physical health integration “capstone” project with the team using the information from all of Module 3. Have team select a member with a physical health condition using the CCT, discuss how the member’s diagnoses affect behavioral health conditions and outcomes, walk through what to include in the member’s care plan based on the information from the CCT including future prevention strategies.
ADDITIONAL RESOURCES (documents on SharePoint site):	
Morbidity and Mortality of People with Serious Mental Illness	
Overview of Diabetes slide deck	
AHRQ Lexicon for Behavioral Health and Primary Care Integration	
A Standard Framework for Levels of Integrated Healthcare	
Behavioral Health Homes for People with Mental Health & Substance Use Conditions	

Module 4

MODULE 4	RISK STRATIFICATION IN A POPULATION HEALTH MODEL
SESSION 4A	<i>The organization understands the benefits of risk stratification for a behavioral health population.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> Organizational management Health Link lead/s Site Supervisors Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Understand risk stratification and its role in a behavioral health environment.
2	Understand how to organize and provide appropriate care based on risk level.

COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> Briefly review with the organization how risk stratification is completed in primary care to understand the overall concepts. Risk Stratification in Population Health Review why risk stratification is important for Health Link. <ul style="list-style-type: none"> Discuss challenges for risk stratification in a behavioral health environment (e.g., lack of knowledge, lack of technology, population more difficult to diagnoses in some cases, etc.). Discuss caseload balancing and how risk stratification can assist in streamlining care coordinators' workloads.
2	<ul style="list-style-type: none"> Review how organization is already stratifying members. <ul style="list-style-type: none"> Does the organization already stratify by chronic conditions? If not, has the team started making plans for this? Does the organization use the CCT to stratify members by risk? If not, has the team started making plans for this? Begin to identify the different levels of care needed based on potential categories of risk (the organization may have a method in place or not, and, if not, begin the
ADDITIONAL RESOURCES (documents on SharePoint site):	
Risk-Stratification Methods for Identifying Members for Care Coordination	
CPC Program Year 2016 Implementation and Milestone Reporting Summary Guide, pg. 7-19	
My Members Training Guide	

MODULE 4	RISK STRATIFICATION
SESSION 4B	<i>The organization has a formal methodology for identifying and grouping its population into risk levels.</i>
RECOMMENDED ATTENDEES: <ul style="list-style-type: none"> Organizational management Health Link lead/s Site Supervisors Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Review risk stratification tool options. ⁵
2	Identify administrative changes for implementation of risk stratification.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> Discuss risk scores in CCT. The CCT uses a risk stratification model called the Chronic Illness and Disability Payment System (CDPS). This model does not account for social determinants of health. How is the organization accounting for these factors with risk stratification? <ul style="list-style-type: none"> Use or modify its Comprehensive Health Assessment to risk stratify. Use a separate Health Link Assessment with assigned scores to quickly risk stratify. New Jersey Case Management Workbook, pg. 13 Develop strategy for integrating risk stratification into: <ul style="list-style-type: none"> Enrollment Electronic health records Shadow risk stratification administration and develop training with organization. Develop action plan and timeline for risk stratifying existing panel.
2	Comprehensive policy and procedure review and updates.

⁵ If an organization is interested in developing a tool for risk stratification, try as much as possible to modify existing assessments or other means the organization already has in place. The organization should not have to develop a complicated method for this since the CCT already assigns risk scores.

	<ul style="list-style-type: none"> Assist organization in developing caseload balancing method and incorporate into a system – either manual or EHR driven. Set required contact intervals by level.
	ADDITIONAL RESOURCES (documents on SharePoint site):
	Risk-Stratification Methods for Identifying Members for Care Coordination
	CPC Program Year 2016 Implementation and Milestone Reporting Summary Guide, pg. 7-19
	Care Coordination Tool Overview: https://www.tn.gov/content/dam/tn/tenncare/documents2/CareCoordinationToolOverview.pdf
	Chronic Illness and Disability Payment System (CDPS) Webinar Slides
	Chronic Illness and Disability Payment System (CDPS) Webinar Recording: https://www.youtube.com/watch?v=2E7EYXWYtRU&feature=youtu.be

Module 5

MODULE 5	ORGANIZATION WORKFLOW AND REDESIGN
SESSION 5A	<i>The organization uses workflow mapping and process observation techniques to understand current performance, identify opportunities for improvement, and develop a framework for process future state.</i>
RECOMMENDED ATTENDEES: <ul style="list-style-type: none"> Organizational management Health Link lead/s Site Supervisors Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Determine the organizational culture.
2	Conduct a critical review of daily organizations to identify areas where efficiency or impact can be driven.
3	Recognize areas for change in current workflows to ensure staff are working at their level of licensure.
4	Understand how to design and redesign workflows.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> Identify “champions” – leaders of workflows with power to enact change and “cheerleaders” – leaders of allied work streams that will be impacted by changing a workflow. <ul style="list-style-type: none"> Refer to Intro Module which covers the initial assessment. Review score on Question #1 Commitment of senior leadership. If the score was a “1” or “2”, ask the organization if individuals have been identified to fill these roles. Are there gaps in workflows because of leadership deficiencies?
2	<ul style="list-style-type: none"> Develop “perfect world” scenario end-to-end for a member including timeframes to holistically visualize the member experience and various workflows Discuss the following processes: <ul style="list-style-type: none"> Perceived process (what the organization thinks is happening) Reality process (what the process actually is) Ideal “perfect world” process
3	<ul style="list-style-type: none"> Review coaching deployment and “drill down” points for workflows, where are changes needed? <ul style="list-style-type: none"> Review case study for no-show rates from Enhanced Access – Providing the Care Members Need, When They Need It pg. 8. How is the organization addressing this?

	<ul style="list-style-type: none"> ○ Review case study for front desk workflows from Enhanced Access – Providing the Care Members Need, When They Need It pg. 21. ● Identify where medical assistants, peer support specialists and other unlicensed personnel can be introduced to manage tasks not requiring skilled workforce.
4	<ul style="list-style-type: none"> ● Watches IHI Introduction to Flow Charting (7 minutes) http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard11.aspx ● Review the AMA Flowchart Toolkit ● Engages in a training activity by producing a flow chart. ● Reviews the Process Mapping – Swim Lane Diagram document ● Engages in a training activity by producing a swim lane diagram. ● Diagram workflows on paper to visualize the various areas and organizational staff required for a particular workflow.
ADDITIONAL RESOURCES (documents on SharePoint site):	
Flowchart Template	
Swim Lane Template	
Process Mapping (32 minutes) https://www.youtube.com/watch?v=LJwKZuQUb7g	
AHRQ Mapping and Redesigning Workflow	

Module 6

MODULE 6	TEAM-BASED CARE AND ORGANIZATION: OVERVIEW
SESSION 6A	<i>The organization is committed to transforming into a sustainable Health Link. Members of the care team serve specific roles as defined by the organizational structure and are equipped with the knowledge and training necessary to perform those functions. The organization seeks to enhance targeted team approaches by facilitating appointments and clinical advice based on members' needs.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> ● Organizational management ● Health Link lead/s ● Site Supervisors ● Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Designates Health Link team members.
2	Defines organizational structure and staff responsibilities/skills to support team based care Health Link functions.
3	Involves members / families / caregivers in the organization's governance structure or on stakeholder committees.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> ● Training: Why care teams? <ul style="list-style-type: none"> ○ Why a Team Based approach matters ○ Provider Workload Diagram ○ Goals of Team Based Care ○ IHI Jelly Bean Activity ● Discussion with Quality Improvement (QI) Team: What are the characteristics of an effective care team? ● Team Based Care Diagram ● Share TeamSTEPPS-Care Teams PowerPoint with the QI team & with all staff ● Work with the organization to identify a provider champion (e.g., MD/DO, NP, PA, etc.) and a Health Link Administrator if needed.

2	<ul style="list-style-type: none"> Refer to Intro Module which covers the initial assessment and review results for “Section 1: Support Systems and Capacity” questions. Does the organization report a solid organizational structure and team members in place to support the transition to Health Link? Ask how the teams are organized. Develop an org. chart with the QI Team that define the primary and extended care team roles. IHI in a Perfect World Activity Review current role descriptions. Conduct a team role clarification exercise. Brainstorm with the organization how to ensure staff are working at the top of their licensure &/or skill. Map current workflow and assess for efficiency. Brainstorm tactics to implement as part of a team based care workflow. Change Tactics Team Based Care
3	<ul style="list-style-type: none"> Survey organization leadership to identify opportunities to engage members/families. <ul style="list-style-type: none"> Discuss current meetings – who goes to them and when/where they’re held? Brainstorm opportunities with the QI Team to involve members/families. Review Change Tactics for involving members in practice governance. Have the organization agree on at least one opportunity for members/families to interact either as a part of the governance structure or on a committee. Implement one Plan Do Study Act (PDSA) cycle that involves having a member/family participate on an organization committee.
ADDITIONAL RESOURCES (documents on SharePoint site):	
AHRQ Implementing Care Teams	
FAQs: Why Involve Members & Families?	

MODULE 6	TEAM-BASED CARE AND ORGANIZATION: COORDINATING MEMBER CARE
SESSION 6B	<i>Communication among staff is organized to ensure that member care is coordinated, safe and effective.</i>
RECOMMENDED ATTENDEES: <ul style="list-style-type: none"> Organizational management Health Link lead/s Site Supervisors Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	The regular care team meetings or a structured communication process is focused on individual member care.
2	Care team staff is involved in the organization’s performance evaluation and quality improvement activities.
3	At least one care manager is qualified to identify and coordinate physical health needs.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	

1	<ul style="list-style-type: none"> • Crosswalk schedules – identify how care team schedules can best accommodate meetings, ensure current meeting schedule is appropriate to staff needs. • Determines if a ‘structured’ communication process is in place (e.g., team meeting, huddles). • If communication does not happen in a structured format, agrees on a format to implement. Team Huddles are an effective means of structured communication and can be added into the clinical workflow with less disruption than meetings or more formal techniques. Huddles: <ul style="list-style-type: none"> ○ TeamSTEPPS-Communication Huddles ○ Communication-Huddle Outline ○ Communication-Huddle ○ Daily Huddle Checklist ○ Huddle Policy Example ○ Huddle Example <p>Team Meeting: Structured Communication-Staff Meeting Notes SBAR: SBAR Communication Tool</p> <ul style="list-style-type: none"> • Use PDSA to evaluate the structured communication process. • Trains staff on the new communication process.
2	<ul style="list-style-type: none"> • Explores current ways care team staff are involved in the organization’s performance evaluation and quality improvement work. • Brainstorms ways to enhance involvement of care team staff: <ul style="list-style-type: none"> ○ Posts performance metrics where staff can view results. ○ Identifies care team staff member(s) to participate on organization QI team. ○ Engages staff through the use of surveys and suggestion boxes. • Trains staff on the IHI Model for Improvement and encourages staff to participate in PDSA cycles within their work areas.
3	Identify partnerships with primary care or other physical health providers. If outside behavioral health providers are serving members, develop a strategy for them to attend meetings (telephonically, one day a month, via video-chat, etc.).
ADDITIONAL RESOURCES (documents on SharePoint site):	
Huddles Improve Office Efficiency	

MODULE 6	TEAM-BASED CARE AND ORGANIZATION: COMMUNICATION
SESSION 6C	<i>Communication is organized to ensure that member care is coordinated, safe and effective.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> • Organizational management • Health Link lead/s • Site Supervisors • Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Implement a process for informing members/ families/caregivers about the role of Health Link.
2	Provides members/families/caregivers materials that contain the information (e.g., after-hours access, organization scope of services, evidence-based care, education and self- management support).
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	

1	<ul style="list-style-type: none"> Reviews the current process for informing members/families/caregivers about the role of the Health Link. Examines the venues currently used for sharing information (e.g., organization website, paper documents, text messaging, waiting room TV, social media, organization portal, etc.). Involves members/families/caregivers, via random interview or survey, by asking about their preferences for receiving information. Identifies opportunities to enhance, or establish, the process for informing about the role of the medical home. Develops a script and other tools to be used with each venue selected.
2	<ul style="list-style-type: none"> Review Health Link’s existing materials for communicating with members/families/caregivers. Brainstorm what can be improved? What works and what doesn’t? Shadow a member introduction to Health Link amongst several staff. Hold a briefing after shadowing and conduct mock session to help staff develop their “elevator speech.”
ADDITIONAL RESOURCES (documents on SharePoint site):	
FAQs Why Involve Members & Families	

Module 7

MODULE 7	KNOWING AND MANAGING YOUR MEMBER POPULATION
SESSION 7A	<i>Organization routinely collects comprehensive data on members to understand background and health risks. Organization uses information on the population to implement needed interventions, tools and supports for the organization as a whole and for specific individuals.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> Organizational management Health Link lead/s Site Supervisors Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Documents an up-to-date problem list for each member with current and active diagnoses.
2	Identifies the predominant conditions and health concerns of the member population using: Comprehensive health assessment includes: <ul style="list-style-type: none"> Medical history of member and family Mental health/substance use history of member and family Family/social/cultural characteristics Communication needs Behaviors affecting health Social Functioning Social Determinants of Health SHVS Social Determinants HMA July2017 Developmental screening using a standardized tool.
3	Conducts behavioral health screenings and/or assessments using a standardized tool. <ul style="list-style-type: none"> Anxiety Depression Alcohol Use Disorder Substance Use Disorder Pediatric Behavioral Health Screening

	<ul style="list-style-type: none"> • Post-Traumatic Stress Disorder • ADHD
4	<p>Identifies strategies for addressing Co-Occurring Mental Health and Substance Use Disorders</p> <ul style="list-style-type: none"> • Reviews SAMHSA's Co-Occurring Disorders page https://www.samhsa.gov/disorders/co-occurring • Reviews SAMHSA's Integrating Treatment for Co-Occurring Disorders (pages 10 – 12)
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> • Gather clinical leadership to identify how they document active problems. <ul style="list-style-type: none"> ○ Use the information gathered from the comprehensive health assessment answers to determine areas to build self-management skills. Have organization document areas of strengths and weaknesses seen within the population. This information can be used to build out more targeted materials for the organization's Health Link population. • Determine the process for keeping the problem list up to date – are they recording active diagnosis in the problem list at every visit? Is the diagnosis duplicated throughout the problem list? • Talk to Clinical leadership about developing a process for cleaning up the problem so that there is only one of each active diagnosis – historical diagnoses should be documented in as part of the past medical history. • Use process mapping to outline the necessary steps to ensure problem list remains up to date and free of clutter. • Implement process.
2	<ul style="list-style-type: none"> • Crosswalk tools to Health Link requirements. <ul style="list-style-type: none"> ○ Use CCT to identify individuals in an organization's member panel. • Ask the organization and staff about their current tool implementation process and shadow staff/administration to see how well tools are implemented. • Evaluate materials/tools for education to members. <ul style="list-style-type: none"> ○ Potentially talk to members, peer support specialist. • For each step ensure the organization is collecting this information for all new members and is updating this information <i>at least</i> annually. • Consider structured fields that will populate the Facesheet (i.e., main demographics page within EHR/documentation). • Develop a plan with the organization for what information they will collect, what method and what visit they will collect this information and where they will document in the EHR. • PDSA the process with one provider. • Adjust process based upon the results of the PDSA. • Implement process across the organization. • Develop a process for at least two screenings using a standardized screening tool.
3	<ul style="list-style-type: none"> • Crosswalk tools to Health Link requirements. <ul style="list-style-type: none"> ○ Use CCT to identify individuals in an organization's member panel. • Ask the organization and staff about their current tool implementation process and shadow staff/administration to see how well tools are implemented. • Evaluate materials/tools for education to members. <ul style="list-style-type: none"> ○ Potentially talk to members, peer support specialist. • For each step ensure the organization is collecting this information for all new members and is updating this information <i>at least annually</i>. <ul style="list-style-type: none"> • Consider structured fields that will populate the Facesheet (i.e., main demographics page within EHR/documentation). • Develop a plan with the organization for what information they will collect, what method and what visit they will collect this information and where they will document in the EHR. • Evidence based screening tools to share with the organization: <ul style="list-style-type: none"> ○ AUDIT for alcohol

	<ul style="list-style-type: none"> ○ DAST for drugs ○ CRAFFT for adolescents ○ MCHAT–R for developmental screening ● Discuss the percentage of the organization’s EPSDT population and the organization’s needs with this population. <ul style="list-style-type: none"> ○ Identify population using the CCT. ● Develop a process for depression screening using a standardized screening tool. ● Examples of standardized depression screening tools: <ul style="list-style-type: none"> ○ PHQ2 (Patient Health Questionnaire 2 v1.0 2014) ○ PHQ_9; PHQ_9_Instructions ○ PHQ_9 Teen Screen ● Ask organization about how it screens for suicide risks – discuss policies and procedures if a member has a positive screening. <ul style="list-style-type: none"> ○ Interview Questions for Assessment of Suicidal Ideation and Plan http://pda.rnao.ca/content/interview-questions-assessment-suicidal-ideation-and-plan ○ Risk Assessment Questions http://www.square.org.au/risk-assessment/risk-assessment-questions/ ○ SQUARE Program (Suicide, Questions, Answers and Resources) ○ National Suicide Prevention Lifeline: 1-800-273-8255 ● PDSA the process with one provider. ● Adjust process based upon the results of the PDSA. ● Implement process across the organization. ● Develop a process for at least two screening using a standardized screening tool.
	ADDITIONAL RESOURCES (documents on SharePoint site):
	SBIRT Annual Screen
	Child and Adolescent BH Screening Toolkit
	TNAAP EPSDT Manual
	TNAAP Recommendations for Preventive Pediatric Health Care
	Managing Populations, Maximizing Technology: https://www.integration.samhsa.gov/news/PCPCC_Population_Health_FINAL_e-version.pdf
	Expert Consensus Survey on Digital Health Tools for Patients With Serious Mental Illness: Optimizing for User Characteristics and User Support: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6019847/#ref1
	Increasing the Capacity of Primary Care Through Enabling Technology: https://rd.springer.com/article/10.1007/s11606-016-3952-3
	Making the Most of Portals: How the Technology Can Improve Patient Communication: http://www.medicaleconomics.com/sites/default/files/legacy/mm/digital/media/me071018_ezine.pdf
	Engaging Behavioral Health Patients Through Digital Tools: https://www.modernhealthcare.com/article/20180804/TRANSFORMATION01/180809977
	KidCentral TN: https://www.kidcentraltn.com/

MODULE 7	KNOWING AND MANAGING YOUR POPULATION: UNDERSTANDING THE NEEDS OF A DIVERSE POPULATION
SESSION 7B	<i>The organization seeks to meet the needs of a diverse population by understanding the population’s unique characteristics and language needs. The organization uses this information to ensure linguistic and other member needs are met.</i>

RECOMMENDED ATTENDEES: <ul style="list-style-type: none"> Organizational management Health Link lead/s Site Supervisors Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Assesses the disparities often seen in behavioral health populations such as: <ul style="list-style-type: none"> A. Racial and ethnic groups B. Lesbian, gay, bisexual, transgender and questioning (LGBTQ) populations C. People with disabilities D. Transition-age youth (i.e., those transitioning into adult services)
2	Assesses the language needs of its population.
3	Identifies and addresses population-level needs based on the diversity of the organization and the community. <ul style="list-style-type: none"> A. Target population health management on disparities in care. B. Address health literacy of the organization. C. Educate organization staff in cultural competence.
4	Understands social determinants of health for members, monitors at the population level and implements care interventions based on these data.
5	Evaluates member population demographics/communication preferences/health literacy to tailor development and distribution of member materials.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> Work with the QI team to identify different sub-populations within Health Link. Consider items that are documented in a structured field within the EHR to ensure that you can run a report. Run a report in the organization EHR that outlines the percentage of the member population that represents each race, ethnicity and another aspect of diversity. Update records for any members that do not have these fields completed. Develop a process for ensuring that these fields are completed on all new members. Consider the use of a flow chart or a scope of work document to share with staff. Ensure the cultural competence of employees to address unique healthcare attitudes <ul style="list-style-type: none"> Review Step 8: Provide Culturally Responsive Case Management (pages 70 – 71) in SAMHSA's Improving Cultural Competence
2	<ul style="list-style-type: none"> Run a report in the organization EHR that outlines the percentage of the member population that represents each language. Update records for any members that do not have these fields completed Develop a process for ensuring that these fields are completed on all new members. Consider the use of a flow chart or a scope of work document to share with staff. Develop a process for ensuring that language services and other needed strategies are available and used for members who do not speak English. <ul style="list-style-type: none"> Review Language Services (pages 88 – 90) in SAMHSA's Improving Cultural Competence

3	<ul style="list-style-type: none"> • Have QI team explore the diversity and language reports: <ul style="list-style-type: none"> ○ Ask what cultures are present that they may need to learn more about? ○ How do different cultures view healthcare? Reviews Behavioral Health Treatment for Major Racial and Ethnic Groups (pages 101 – 103) in SAMHSA's Improving Cultural Competence ○ What other languages are spoken aside from English? ○ Which populations may be vulnerable to disparities in care? • Plan training sessions for all staff, and ensure there is an opportunity for discussion and Q&A.
4	<ul style="list-style-type: none"> • Sort the EHR file in Excel (Pivot Tables are ideal) to identify how many of each social determinant there are – sort from high to low to identify the most prominent member needs, if the organization has this capability. Areas for social determinants are: <ul style="list-style-type: none"> ○ Economic Stability ○ Education ○ Health and Healthcare ○ Neighborhood and Built Environment ○ Social and Community Context • Assist the QI team in determining necessary care interventions for the most prominent member needs. • Collect feedback regarding what interventions they already have in place and what interventions they need to add. • Develop a process for implementation.
5	<ul style="list-style-type: none"> • Ensure the organization is collecting relevant demographic data on members and that it is updated at each visit and documented in a structured field. Consider DOB, sex, zip code, occupation, legal guardian/caregiver. • Use a swim lane diagram to develop a future process with the QI Team if this process is not currently in place. • Sort the demographics EHR file in Excel (Pivot Tables are ideal) to look at the different demographics that exist in the organization. • Gather QI Team to determine how to tailor and distribute member materials to these demographics. <ul style="list-style-type: none"> ○ Assess demographic information as determined above. ○ What methods have worked for the organization in the past? • Identify what materials the organization is distributing. • Identify demographics that the organization may not have any relevant materials for and designate a member of the QI team to research appropriate materials and resources. • Develop and implement a plan for delivering member materials to appropriate demographics. • Gather QI team to evaluate if the organization is currently assessing health literacy for individual members. <ul style="list-style-type: none"> ○ If not, assess if they are interested. ○ If they want to pursue this, use a swim lane diagram to develop a future process with the QI Team – ensure responses are entered in to a structured field so an EHR report can be run. • Gather the QI team or clinical leadership to determine necessary care interventions for the most prominent member needs. • Collect feedback regarding what interventions they already have in place and what interventions they need to add. • Develop a process for implementation. • Reviews Talking Points About Health Literacy • Reviews Short Assessment of Health Literacy • Reviews Rapid Assessment of Adult Literacy in Medicine
<p>ADDITIONAL RESOURCES (documents on SharePoint site):</p>	

	10 Attributes of Health Literate Healthcare Organizations (IOM)
	AHRQ Health Literacy Universal Precautions toolkit
	Alliance for Health Reform Toolkit
	Cultural Competence Resource Guide
	The SHARE Approach: Overcoming Communication Barriers with Your Patients (AHRQ) (pages 3 – 5)

MODULE 7	KNOWING AND MANAGING YOUR POPULATION: EVIDENCE-BASED DECISION SUPPORT
SESSION 7C	<i>The organization incorporates evidence- based clinical decision support across a variety of conditions to ensure effective and efficient care is provided.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> Organizational management Health Link lead/s Site Supervisors Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	<p>Implements evidence-based guidelines for care of:</p> <ul style="list-style-type: none"> Mental health condition Substance use disorder Chronic medical conditions An acute condition A condition related to unhealthy behaviors Well child or adult care Overuse/appropriateness issues
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> Works with the QI team to identify conditions that the organization wants to address. Identifies the source of the evidence-based guidelines for each condition. Identifies elements that the organization wants to incorporate into the EHR, if feasible, to be reminded of when the member comes in to the office. <p>Examples of evidence-based guidelines could be:</p> <ul style="list-style-type: none"> Reminders that pop up or alert the care team of a member need such as when a member with Depression comes into the office the EHR may alert staff to ensure a PHQ-9 is completed. Templates or shortlists (examples provided in Additional Resources) that act as a checklist – for example a bipolar shortlist that the care team opens when a member with bipolar disorder comes in to the office that walks them through the evidence-based details of that type of visit. <ul style="list-style-type: none"> Other conditions will require customization. Develops a workflow for the use of evidence-based guidelines. Ensure that triage has access to these reminders – if a member calls for a non-regular behavioral health visit, staff can identify other services they are overdue for and ensure that enough time is scheduled to complete all services.
ADDITIONAL RESOURCES (documents on SharePoint site):	
	Annual Registry Schedule example (pediatric)
	Population Health Management Examples List
	Example Patients Needing Services Outreach via Portal
	Example EHR Preventative Services

	Annual Registry Schedule Example
	Example EHR Lists Needing Chronic Care Follow-Up
	AHRQ The Medical Home – What We Know
	Behavioral Health Homes for People with Mental Health & Substance Use Conditions, pgs. 10-11

MODULE 7	KNOWING AND MANAGING YOUR POPULATION: COMMUNITY RESOURCES
SESSION 7D	<i>The organization identifies/considers and establishes connections to community resources to collaborate and direct members to needed support.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> Organizational management Health Link lead/s Site Supervisors Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Uses information on the population served by the organization to prioritize needed community resources.
2	Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs, faith-based organizations, and schools.
3	Provides primary care (inclusive of oral health) education resources to members.
4	Adopts shared decision-making aids for preference-sensitive conditions.
5	Engages with schools or intervention agencies in the community.
6	Routinely maintains a current community resource list.
7	Assesses the usefulness of community support resources.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> Identifies community resources that are available to support the population served by the organization. Prioritizes resources based upon the percentage of the organization’s population that may use the resource (high priority = resources most likely to be used by population served). Works with the QI team to develop a workflow for how the organization will give the appropriate resource to the appropriate member population. Determines how the organization will track resources that are given to the members – is there a way to document this in a structured field in the EHR?
2	<ul style="list-style-type: none"> Identifies available educational resources. Ensures that these resources are up to date. Sets up a process to update this resource list regularly. Makes note of resources that take insurance or have other eligibility criteria. Works with the QI team to develop a workflow for how the organization will give the appropriate resource to the appropriate member population. Example of educational resources and self-management tools for a member in a behavioral health home could include things such as linkages to community resources or strategies such as mood journaling for members with depression.
3	<ul style="list-style-type: none"> Identifies available primary care resources. Ensures that these resources are up to date. Sets up a process to update this resource list regularly. Makes note of resources (e.g., which providers accept TennCare or have other eligibility criteria).

	<ul style="list-style-type: none"> Works with the QI team to develop a workflow for how the organization will give the appropriate resource to the appropriate member population.
4	<ul style="list-style-type: none"> Determines member populations that may benefit from a shared decision-making tool. Reviews evidence-based shared decision-making tools from https://decisionaid.ohri.ca/AZinvent.php. Identifies tools that meet the population needs Develops a workflow for how the organization will use the decision-making tool and support the member in understanding it and completing it.
5	<ul style="list-style-type: none"> Identifies if the organization currently: <ul style="list-style-type: none"> Has a relationship with a school nurse, social worker or counselor? Is a member of a school board or advocacy group? Has a partnership with DSS, mediation agencies, non-profit groups that support underserved children such as Head Start or County Partnerships for Children? If not, identifies if the community has a Student Services Director who may be able to support the organization in identifying opportunities for the organization to connect with healthcare-related programs or initiatives in the community. Assigns QI Team member(s) to meet with directors of identified programs to discuss how the organization and the school or agency can support each other. Identifies opportunities to collaborate at each meeting and work towards developing a workflow that can support the partnership. Ensures there is a follow up meeting at least annually to maintain the relationship.
6	<ul style="list-style-type: none"> Develops a list of current community resources. Be aware that resources change frequently. Sets up a process to maintain this list regularly. Consider the use of established community resource lists. (e.g., Tennessee 2-1-1 http://tn211.mycommunitypt.com/) SQUARE Program (Suicide, Questions, Answers and Resources) National Suicide Prevention Lifeline: 1-800-273-8255 Refer to resources in Session 7A Strategy 3
7	<ul style="list-style-type: none"> Gathers feedback from members about the resources to which they have been referred. Uses member satisfaction survey or qualitative feedback. Uses this feedback to initiate PDSAs that assess and direct resources appropriately.
ADDITIONAL RESOURCES (documents on SharePoint site):	
	Tennessee Continua of Care Regions https://www.tn.gov/behavioral-health/mental-health-services/housing---homeless-services/housing---homeless-services/tennessee-continua-of-care-regions.html
	Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home – Challenges and Solutions (AHRQ)
	Obesity Education
	Care Coordination for Children with Complex Special Health Care Needs
	Obesity Self-Management Tracking Tool
	Cope-Cake: Coping Skills Worksheets and Game
	Positive Self-Talk / Coping Thoughts Worksheet
	Have I Got a Problem: How to Improve Coping Skills https://www.haveigotaproblem.com/download/191/How-To-Improve-Coping-Skills
	99 Coping Skills

Module 8

MODULE 8	PERSON-CENTERED ACCESS AND CONTINUITY
SESSION 8A	<i>The organization seeks to enhance access by providing appointments and clinical advice based on members' needs.</i>

RECOMMENDED ATTENDEES:	
	<ul style="list-style-type: none"> Organizational management Health Link lead/s Site Supervisors Any other key personnel overseeing implementation/training for Health Link development
1	Review processes for assessing needs and preferences of the member population.
2	Develop a process for same-day appointments
3	Develop a process for after-hour crisis care service and coordination
4	Review process for providing timely clinical advice by telephone
5	Documents clinical advice in member records.
6	Review process for scheduling routine appointments, requesting prescription refills, and referrals
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> Consider developing a Patient Advisory Group/Committee Review care plan Work with organization to develop a member satisfaction survey to gather member qualitative feedback to determine new areas of focus
2	<ul style="list-style-type: none"> Ask organization about its availability for same-day appointment access <ul style="list-style-type: none"> If organization does not have same-day appointment assess how can this service be offered Have organization run a report for no-shows or ask how this is being tracked if a report is unavailable. <ul style="list-style-type: none"> Discuss the reason for no-show appointments and how same-day access is beneficial if not already implemented Review Open Access Scheduling Have organization develop a same-day scheduling policy if one is not in place. Member Access Same Day Appointment Policy Discuss how to appropriately notify members about same day appointment availability. <ul style="list-style-type: none"> Develop/review same-day transportation issues or concerns <ul style="list-style-type: none"> Using informal supports Contacting the MCO transportation line Collaboration with Care Coordinator Other agency transportation options Reassess member preferences and needs regularly to ensure needs are met. <ul style="list-style-type: none"> Discussion during check-in visits Discussion during team meetings During review of treatment plan

3	<ul style="list-style-type: none"> • Have organization determine member and/or caregiver needs and preferences for after-hours care. • Review of crisis services in the area • Discuss how members and/or caregivers will be made of aware of their local crisis provider • Discuss how to educate members and/or caregiver about when and how to utilize crisis services. • Discussion of how care coordinator will follow-up with crisis provider to get updated information • Review policy for adding crisis episode to member's EHR • Ensure there is a process for care coordinator to follow-up with member and/or caregiver after crisis episode • Develop safety plan if necessary/Review and/or revise current safety plan if needed. • Develop a process for using the CCT to check the ADT feeds
4	<ul style="list-style-type: none"> • Have organization develop a policy that states the organization's defined response time to providing clinical advice by phone during office hours: Member Access Same Day Appointment Policy <ul style="list-style-type: none"> ○ Review best practices regarding care coordinator's availability • Discuss how organization ensures members are aware of the expected response time. • Work with organization to tracks (at least annually) the organization's response rate to assess if the organization is meeting the policy requirements: Clinical Advice Response Time Log • Evaluate data and reassess workflow or defined response time as needed.
5	<ul style="list-style-type: none"> • Have organization perform random chart audits to identify if clinical advice is being documented in EHR • Have organization interview staff to find out if there are common barriers to documentation that can be addressed by the QI Team.
6	<ul style="list-style-type: none"> • Have organization identify their process for scheduling appointments • Have organization identify how they notify members and/or caregivers about how they can schedule appointments with the organization • Have organization identify how they educate members and/or caregivers about how they can request prescription refills • Have organization identify how they evaluate data and reassess workflow or defined response time as needed
ADDITIONAL RESOURCES (documents on SharePoint site):	
FPM The Outcomes of Open Access Scheduling	
AHRQ Open Access Scheduling	
Member Access Survey	
Risk Stratification Information	

Module 9

MODULE 9	QUALITY IMPROVEMENT: THE QUALITY IMPROVEMENT TEAM
SESSION 9A	<i>The organization has a quality improvement team whose structure and function is effective in improving quality and bringing about change.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> Organizational management Health Link lead/s Site Supervisors Organizational quality improvement personnel Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Determines current state of quality improvement efforts within the organization.
2	Clarifies the definition of quality improvement.
3	Develops a Charter for the QI team that explains the purpose of the team and the member composition of the team; ensures that there is an engaged provider champion on the team.
4	Develops roles & responsibilities for the team.
5	Employs start up strategies that enhance the ability of the team to be successful.
6	Establishing a quality improvement point person at the MCOs for the organization.
7	Implements ongoing process for identification of rapid-cycle improvement initiatives for the quality improvement plan.
8	For organizations without a quality improvement team, determines opportunities for establishing a team for addressing strategies for improving quality and bringing about change.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<p>Reviews the Health Link organization's responses to the TennCare Health Link Initial Assessment, Section 2 Quality Improvement (QI) Optimization, with the Health Link Administrator/lead.</p> <ul style="list-style-type: none"> Determine whether the responses represent the accurate current state of quality improvement activities within the organization. Have the Health Link Administrator/lead provide an overview of the organization's quality improvement process, and any updates to quality improvement activities within the organization based on Health Link requirements, if applicable.
2	<p>Review the principles of quality improvement.</p> <ul style="list-style-type: none"> Share Institute for Healthcare Improvement (IHI) video: Dr. Mike Evans: An Illustrated Look at Quality Improvement (http://www.ihl.org/resources/Pages/AudioandVideo/MikeEvansVideoQIHealthCare.aspx) Works with QI team to understand the importance of quality improvement for successful integrated health models of care
3	<p>Works with the Health Link Administrator and QI lead with the broader QI team and select others from the organization to develop a QI Team Charter. The Charter should identify:</p> <ul style="list-style-type: none"> Who is leading the team? Who are the team members? Who is the psychiatric provider champion? What is the purpose of the team? What is the scope of the work? What measure(s) will show success? What is the timeline for this work?

MODULE 9	QUALITY IMPROVEMENT: THE QUALITY IMPROVEMENT TEAM
SESSION 9A	<i>The organization has a quality improvement team whose structure and function is effective in improving quality and bringing about change.</i>
	<p>How to complete a Project Charter; Template Project Charter</p> <ul style="list-style-type: none"> • Have the Health Link Administrator/lead and the Provider Champion to share the project charter with the organization’s providers and staff. • Educates the QI Team on the responsibilities of each role on the team. <p>QI Team Roles & Responsibilities</p>
4	<ul style="list-style-type: none"> • Works with the Health Link Administrator/lead and other key organization leadership staff to identify a provider champion for the Health Link project. • Establishes a plan that ensures the Health Link provider champion is knowledgeable about Health Link, and about his/her role in the process. This could be done in a one on one training session or with all the members of the QI team learning together. <p>QI Team Roles & Responsibilities</p>
5	<ul style="list-style-type: none"> • Reviews Forming a Quality Improvement Team at a Practice in AHRQ Practice Facilitation Handbook https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod14.html • Reviews IHI Open School Measuring for Improvement for establishing measures
6	<ul style="list-style-type: none"> • Ensures efficient meetings by following the preparation schedule as described in the Anatomy of a Meeting document. • Develops team rules to guide meetings and enhance conversation. <p>Team Ground Rules</p> <ul style="list-style-type: none"> • Uses an agenda for every meeting. Agenda Template • Uses evidence based techniques for assuring team consensus. <p>Consensus Seeking Model of Decision Making</p>
7	Works with the QI Team to develop process for identifying opportunities to improve and provides examples of typical processes that will likely contribute to the success of Health Link providers.
8	Reviews Forming a Quality Improvement Team at a Practice in AHRQ Practice Facilitation Handbook https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod14.html
ADDITIONAL RESOURCES (documents on SharePoint site):	
The Team Handbook , authored by Scholtes, Joiner & Streibel	
Getting Ready for Change Self-Assessment	
Project Charter	
PHiIT Activities Aligned with NCQA 2017 PCMH Standards (TNAAP)	
Aligning PHiIT Activities with NCQA 2017 PCMH Standards Practice Support Call slide deck 1/11/18 (TNAAP)	

MODULE 9	QUALITY IMPROVEMENT: METHODS AND TOOLS
SESSION 9B	<i>The organization uses proven quality improvement methodologies and tools to bring about change and positively impact outcomes.</i> <i>Driver Diagrams, Institute for Healthcare Improvement (IHI) Model for Improvement & the Plan, Do, Study, Act (PDSA) Cycle</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> • Organizational management • Health Link lead/s 	

<ul style="list-style-type: none"> • Site Supervisors • Organizational quality improvement personnel • Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1.	The organization uses an evidence based structured quality improvement methodology, like the IHI Model for Improvement to bring about change.
2.	The organization uses evidence based tools, like the Driver Diagram, to guide the quality improvement process.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> • Educates the QI Team on the use of the IHI's Model for Improvement and the use of PDSA cycles in quality improvement. Share the PDSA Tip Sheet. • Performs the Mr. Potato Head PDSA Activity with the QI Team. • Reviews the ACP Quality Connect PDSA Planning Worksheet with the QI team, highlighting the need for planning and the need for a measure of improvement. Have the QI Team select a PDSA cycle form to document the organization's PDSA cycles. PDSA Cycle Worksheet. • Shares the Goal Sheet example PDSA. PDSA Examples PDSA – Member Self-Management
2	<p>Uses the following tools to support the QI team in making successful changes to transform care:</p> <ul style="list-style-type: none"> • Driver Diagram: The driver diagram shows the relationships among goals, the primary drivers that contribute to achieving those goals, and the subsequent factors that are necessary to achieve the primary drivers. It is used to drive transformation efforts on a larger level with PDSA cycles built into the secondary drivers and associated change concepts. Share Dr. Don Goldmann's 6-minute video: How do you use a driver diagram? https://youtu.be/yfcE_Q-IRFg Example – Key Driver Diagram 10 Things you can do with a Driver Diagram TCPI Change tactics & driver diagrams⁶ • Aim Statement: An aim statement clearly articulates both the foundation and the focus of the problem-solving effort. A clearly worded aim statement answers the question "What are we trying to achieve?" See the examples in the Aim Statement document. • Communication Plan: The communication plan sets the standards for how and when communication takes place. It ensures that all stakeholders are equally informed of how, when, and why communication will happen. Communication is a very effective way to solve problems, deal with risks, and ensure that tasks are completed on time. Successful communication plans identify stakeholders, the information to be communicated, and how this information will be communicated. Communication Plan Template • Gantt Chart: A Gantt chart, commonly used in project management, is a popular and useful way of showing activities (tasks or events) displayed over time. On the left of the chart is a list of the activities and along the top is a suitable time scale. Each activity is represented by a bar; the position and length of the bar reflects the start date, duration and end date of the activity. This allows you to see at a glance: <ul style="list-style-type: none"> ○ What the various activities are. ○ When each activity begins and ends. ○ How long each activity is scheduled to last. ○ Where activities overlap with other activities, and by how much.

⁶ This document is 32 pages long, but each portion will be relevant depending on the coaching session focus within QI. The coach should review this document and identify the information most relevant for the organization's focus.

	<ul style="list-style-type: none"> ○ When an activity has been completed. <p>Gantt Chart Template</p> <ul style="list-style-type: none"> ● Gap Analysis: A gap analysis helps identify opportunities for improvement. The gaps between what is happening now (Current State) and what the process should look like (Future State) lead to identification of solutions that can be tested with PDSA cycles. <p>Gap Analysis Worksheet</p> <ul style="list-style-type: none"> ● Cause & Effect Diagram (Fishbone / Ishikawa Diagram): The cause & effect diagram is a visual picture that shows factors that may be contributing to the problem. The head of the fish is the problem and the scales are possible causes. This is a helpful qualitative, brainstorming team activity tool. <p>Cause and Effect Diagram / ISHIKAWA Template</p> <ul style="list-style-type: none"> ● With the QI Team, initiate a PDSA cycle (start the PDSA Cycle Worksheet) around integrating one or more of these QI evidence based tools into the team's daily work.
	ADDITIONAL RESOURCES (documents on SharePoint site):
	IHI Model for Improvement
	Quality Improvement Using Plan Do Study Act
	QI 104 IHI Improvement Project Roadmap
	Gap Analysis
	Implementation Plan

MODULE 9	QUALITY IMPROVEMENT: MEASURING OUTCOMES
Session 9C	<i>The organization uses validated measurement tools and techniques to understand current performance and identify opportunities for improvement.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> ● Organizational management ● Health Link lead/s ● Site Supervisors ● Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	The organization uses operational definitions when describing measures of success.
2	The organization uses a balanced set of measures for improvement efforts: Structure, Process, Outcome, Satisfaction, and Balancing measures.
3	The organization uses graphs and charts to display data and to identify opportunities for improvement.
COACHING STRATEGIES: Delivery Methods & Activities	
<i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor. (Documents on SharePoint Site)</i>	
1	<ul style="list-style-type: none"> ● IHI Activity – How do you measure the banana? Operational definitions & the purpose of measurement in improvement. <p>http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/QI-Games-How-Do-You-Measure-the-Banana.aspx.</p> <ul style="list-style-type: none"> ● Reviews the Tennessee Health Link: Provider Operating Manual, Chapter 8 “How Will Quality and Efficiency Be Measured?” and discusses the Health Link Quality Metrics. Do these definitions provide a clear understanding of what is being measured?

2	<ul style="list-style-type: none"> Reviews the definitions of the different measure types. <ul style="list-style-type: none"> Shares page 1 of the Measures for Improvement Efforts document. Shares page 1 of the Introduction to Quality Measures document. Brainstorms examples for each of the major types of measures.
3	<p>Uses the following graphs and charts to support the QI team in identifying opportunities and monitoring change activities over time:</p> <ul style="list-style-type: none"> Run Chart: Run charts are linear graphs that allow you to track improvements by displaying data in a time sequence. Time is generally displayed on the horizontal (x) axis and the measure that you are tracking is displayed on the vertical (y) axis. Using a run chart allows you to see if improvement is really taking place by displaying a pattern of data that you can observe as you make changes to your process. Uses the IHI Coin Spinning Activity and IHI Coin Spinning Worksheet to collect real time data and develop a run chart.^{7,8} http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/QI-Games-Learn-How-to-Use-PDSA-Cycles-by-Spinning-Coins.aspx. Run Chart Module Run Chart definition and example Run Chart Example IHI Run Chart Template QI 106 Run Chart Template Control Chart: A Control chart is also used to study how a process changes over time. Unlike the run chart, the control chart also includes three reference lines which are determined by historical data: a central line which represents the average, an upper line which represents the upper control limit (UCL), and a lower line which represents the lower control limit (LCL). By comparing current data to the reference lines, you can assess whether the process variation is in control (consistent) or out of control (unpredictable). Control Chart Example Pie Chart & Bar Chart: Rather than tracking data over time, Pie charts and Bar charts are used to visually represent snapshots of data. Pie Chart Example Bar Chart Example
ADDITIONAL RESOURCES (documents on SharePoint site):	
Introduction to Quality Measures⁹	
IHI Open School Measuring for Improvement	
Getting Started Measuring	
Excel Formulas	
IHI Whiteboard Video – Family of Measures (7 minutes) http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard15.aspx	
IHI Whiteboard Video – Pareto Analysis (7 minutes) http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard20.aspx	
IHI Whiteboard Video - Control Charts (6 minutes) http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard13.aspx	

⁷ The coach will need to watch the IHI video prior to the coaching session to learn how to conduct the IHI Coin Spinning activity.

⁸ This module includes a couple examples of run charts. Coaches may use either depending on an organization's needs and/or preferences.

⁹ This is a document used in the TCPi program, in which some organizations have participated. Coaches may need to explain that the PCMH program is separate from the TCPi program although materials are being shared between the two.

IHI Whiteboard Video – Run Chart (7 minutes) http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard7.aspx
2017 HEDIS Value Set Directory
Project Evaluation and Debriefing

MODULE 9	QUALITY IMPROVEMENT: SUSTAINING IMPROVEMENT
SESSION 9D	<i>The organization implements tools and techniques to ensure that improvements are sustained.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> Organizational management Health Link lead/s Site Supervisors Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Documents the process change.
2	Initiates a Process Dashboard.
3	Transfers ownership and knowledge of the process to the process owner and/or process team tasked with monitoring the change.
4	Shares the knowledge gained on the process improvement project with everyone in the organization.
COACHING STRATEGIES: Delivery Methods & Activities	
<i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor. (Documents on SharePoint Site)</i>	
1	<ul style="list-style-type: none"> Decides how the QI team wants to pass the new process structure on to the other organization staff, especially those who work in the process. Documents using a flowchart, a standard operating procedure (SOP) document or in a policy. Policy Template Policy Template Instructions Policy Writing Dos and Don'ts Sample Policy – Test Tracking SOP Template Example SOP Referral Process
2	Monitors results over time with run charts or control charts.
3	<ul style="list-style-type: none"> Identifies a role within the organization that is responsible for monitoring the process and notifying the QI team and leadership team if a negative trend is identified. Meets with the process owner to ensure that he/she understands the process and his/her role in process monitoring.
4	<ul style="list-style-type: none"> Has a member(s) of the QI team and an organization leader communicate the new/revised process to all staff at a staff meeting. Identifies opportunities to adapt or adopt the process change into other workflows.
ADDITIONAL RESOURCES (documents on SharePoint site):	
IHI Sustaining Improvement White Paper	
Monitoring Progress for Sustainable Improvement	
Toolkit for Using the AHRQ Quality Indicators	
Overview of IHI Tools http://www.ihl.org/resources/Pages/Tools/default.aspx	

Module 10

MODULE 10	MEASURING PERFORMANCE WITH DATA
SESSION 10A	<i>The organization understands how to measure current performance and to identify opportunities for improvement using the Care Coordination Tool (CCT).</i>
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Understands the importance of Health Information Technology in transformation.
2	Uses the information available in the CCT to enhance care coordination and care management services within the organization. This includes using the CCT to identify and address gaps in care and for prioritizing member's care coordination needs.
3	Monitors all Health Link quality and efficiency measures using the CCT.
4	Reports organization-level or individual clinician performance results within the organization for all measures.
5	Achieves improved performance on performance measures.
COACHING STRATEGIES: Delivery Methods & Activities <i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor. (Documents on SharePoint Site)</i>	
1	<ul style="list-style-type: none"> • Shares examples of HIT use in transformation. • HIT and Workflow Opportunities • Helping Practices Optimize EHRs for Member (AHRQ) – page M27-4 • Brainstorms current HIT use by the organization. To what degree is the organization using the EHR? Are there opportunities to enhance current use? Are there other health information technologies available to the organization in addition to the CCT (e.g., telemedicine, HIE)? How can the functionality of the CCT be integrated into other health information technologies available?
2	<ul style="list-style-type: none"> • Views the Care Coordination Tool training videos in the Training Materials section of the State's CCT website: https://www.tn.gov/tenncare/health-care-innovation/primary-care-transformation/care-coordination-tool.html <ul style="list-style-type: none"> ○ My Members Training (Video 1 and Video 2) ○ Quality Measures Training ○ Dashboard Training ○ Practice Administrator User Role Training ○ Admission, Discharge, and Transfer (ADT) Training • Views the Care Coordination Tool demonstration videos in the Demos section of the State's CCT website: https://www.tn.gov/tenncare/health-care-innovation/primary-care-transformation/care-coordination-tool.html <ul style="list-style-type: none"> ○ Assigning a Care Member in the CCT ○ Export to Excel from My Members ○ Risk Stratification in My Members ○ Finding Claims Based Medication Information ○ Using Global Search Parameters in My Members ○ Finding Dual Program Members Information • Uses the following training guide documents and identifies opportunities to incorporate the information into current workflow: <ul style="list-style-type: none"> ○ My Members – This tab is useful for viewing members' health record summaries, risk stratifying members, or sorting members by primary health condition or quality indicators. <ul style="list-style-type: none"> ▪ Exercise: In a small group provides a hands-on walk-through of the successful development of at least one stratification of members report and lists of members sorted by primary care condition. Each team member will demonstrate competency.

	<ul style="list-style-type: none"> ○ Quality Measures – This tab is useful for identifying and managing individual members’ gaps in care. <ul style="list-style-type: none"> ▪ Exercise: In a small group, provides a hands-on walk through of how to use the CCT for identification of gaps in care and to review quality measures data. Each team member will demonstrate competency. ○ ADT – This tab allows for review of care transition events for members who have had hospital events. <ul style="list-style-type: none"> ▪ Exercise: Demonstration of using the CCT for reviewing care transition events and how to use this information for improving member outcomes by proactively engaging with other providers in facilitating transitions, maintaining communication with members, and communicating transition event information to the treatment team for care follow-up purposes. Each team member will demonstrate competency. ○ Dashboards – This tab allows for review of quality data on a member population level. <ul style="list-style-type: none"> ▪ Exercise: Demonstration of using the CCT to review population level gaps in care. Each team member will demonstrate competency. <ul style="list-style-type: none"> ● Identifies at least one opportunity to enhance workflow by using the CCT. (e.g., identifying members for care management). ● Implements a PDSA cycle to test the process on the use of the CCT in the identified process.
3	<ul style="list-style-type: none"> ● Reviews how the organization currently monitors quality and efficiency. ● Training: How to read the MCO Provider Reports; Reviews webinar recording Health Link” How to Read Your Report” http://stateofennessee.adobeconnect.com/p893h30ml0u/ ● Training: How to use data to track gaps in care using the CCT. ● Discusses with QI Team: How to use Data to Track Performance and provides practical examples of how this can be done. ● Facilitates the prioritization of quality measure from the MCO Provider Reports for tracking and reporting by the QI Team.
4	<ul style="list-style-type: none"> ● Using the CCT, works with the QI team to identify which organization-level or individual performance results will be reported. ● Develops a plan for how the selected performance results will be shared, identifying to whom each of the reports will be distributed (e.g., some reports would be specifically for leadership vs. non-leadership), and including the frequency of each report. ● Implements the plan to share results within the organization (An example of this would be sharing performance in the organization’s break room or in a team huddle.) ● Defines the process for sharing these data on a regular basis.
5	<ul style="list-style-type: none"> ● Selects performance measures to improve upon based on quality data in the CCT. ● Brainstorms ways to improve performance measures. ● Sets a goal for each of the performance measures. ● Guides the QI Team in the implementation of one PDSA for each of the selected measures. ● Tracks the performance measures over time using the CCT. ● Identifies improvement or opportunities that lead to meeting the organization goal.
<p>ADDITIONAL RESOURCES (documents on SharePoint site):</p>	

	Helping Practices Optimize EHRs for Member (AHRQ)¹⁰
	An Introduction to Electronic Health Records and Meaningful Use (AHRQ)¹¹
	Health Link Provider Operating Manual 2018
	MCO Provider Reports (not available on SharePoint Site, received from MCOs)
	Care Coordination Tool (CCT) (not available on SharePoint Site)
	PCMH and Tennessee Health Link Quality Thresholds and Efficiency Thresholds Guidance
	TN Health Link DBR Appendix v0.3
	Reporting Timeframes
	CCT Data Sources

MODULE 10	USING THE MCO PROVIDER REPORTS TO IMPROVE OUTCOMES
SESSION 10B	<i>The organization utilizes the MCO Provider Reports to improve quality of care.</i>
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Understands how to use the MCO Provider Reports for improving quality of care.
2	Analyzes MCO Provider Reports to develop strategies for improving quality of care.
3	Implements effective strategies for improving quality of care.
4	Understands how the organization can impact the Total Cost of Care (TCOC).
5	Monitors at least two measures of resource stewardship; for example: <ul style="list-style-type: none"> Measures related to care coordination. Measures affecting health care costs (e.g., TCOC).
COACHING STRATEGIES: Delivery Methods & Activities	
<i>The following are tools and techniques for achieving the objectives referenced above. These strategies are to be accomplished by the QI Team with the coach serving as a work facilitator and mentor. (Documents on SharePoint Site)</i>	
1	<ul style="list-style-type: none"> Views the following webinar on how to read the quality report: https://stateoftennessee.adobeconnect.com/a828793869/p45mxc7psxq/?launcher=false&fcsContent=true&pbMode=normal (38 minutes). Reviews the organization's quality report to identify how to apply the information learned during the webinar. Uses the coding reference guides as needed to interpret results.
2	<ul style="list-style-type: none"> The QI team analyzes the MCO Provider Reports to identify opportunities for improvement, identifying and targeting the quality and efficiency measures that provide the best opportunity for improving member outcomes and earning quality and efficiency stars. Reviews PCMH and Tennessee Health Link Quality Thresholds and Efficiency Thresholds Guidance 12-17
3	The QI Team identifies processes and implements strategies for using the MCO Provider Reports for improving member outcomes. <ul style="list-style-type: none"> Implements a PDSA cycle for testing the processes.
4	The QI Team implements PDSA cycles to determine which of the identified strategies are effective in successfully impacting the TCOC. <ul style="list-style-type: none"> The QI Team identifies a team member to provide regular updates to the QI Team.
5	<ul style="list-style-type: none"> Reviews how the organization currently measures resources related to health care costs (e.g., Total Cost of Care (TCOC)).

¹⁰ This is a PCMH-specific source. Health Link coaches will modify the source as necessary to align it with the Health Link program requirements and its desired outcomes.

¹¹ This is a PCMH-specific source. Health Link coaches will modify the source as necessary to align it with the Health Link program requirements and its desired outcomes.

	<ul style="list-style-type: none"> • Reviews how to view the Total Cost of Care (TCOC) in the organization's MCO Provider Reports. • Provides examples of measures that affect health care costs: <ul style="list-style-type: none"> ○ Promoting Good Stewardship in Clinical Practice – Top 5 in Family Medicine ○ Promoting Good Stewardship in Clinical Practice – Top 5 in Pediatrics ○ Promoting Good Stewardship in Clinical Practice – Top 5 in Internal Medicine • Brainstorms ways to measure resources related to health care costs with the QI Team. • Facilitates the selection of one measure that affects health care costs within the organization.
ADDITIONAL RESOURCES (documents on SharePoint site):	
	Health Link Provider Operating Manual 2018
	MCO Provider Reports (not available on SharePoint Site, received from MCOs)
	PCMH and Tennessee Health Link Quality Thresholds and Efficiency Thresholds Guidance 12-17
	TN Health Link DBR Appendix v0.3

Module 11

MODULE 11	CARE MANAGEMENT AND SUPPORT
SESSION 11A	<i>The organization systematically differentiates risk through the use of the CCT risk scores to identify Health Link members that would benefit most from care management.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> • Organizational management • Health Link lead/s • Site Supervisors • Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	<ul style="list-style-type: none"> • Considers the following in establishing a systematic process and criteria for identifying Health Link members who may benefit from care management (organization should include at least three in its criteria): <ul style="list-style-type: none"> • Behavioral health conditions • High cost/high utilization • Poorly controlled or complex conditions • Social determinants of health • Referrals by outside organizations (e.g., insurers, health system, ACO), organization staff or member/family/caregiver.
2	Monitors the percentage of the total Health Link member population identified through its process and criteria.
3	Uses CCT risk scores to identify and direct care management and support resources appropriately for the Health Link population.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	

1	<ul style="list-style-type: none"> • Reviews the AAFP-Risk Stratification document. • Maps current process for identifying members for care management. • Identifies if there are pre-defined criteria. <ul style="list-style-type: none"> ○ If there are no pre-defined criteria, brainstorms criteria to use based upon the organization's Health Link member population. ○ Ensure that pre-defined criteria include at least three of the criteria listed above. • Maps a 'future state' process that includes the pre-defined criteria for identifying members who may benefit from care management. • PDSAs the future state process and adjusts the process based upon the results of the PDSA. • Trains staff on the new/revised process for identifying members for care management.
2	<ul style="list-style-type: none"> • Develops a monitoring plan for reviewing the total Health Link member population and what percentage of the population may benefit from care management. • Uses an Excel spreadsheet or other data sharing/graphing tool to report on the results. • Percent of Population spreadsheet • Defines a frequency for review.
3	<p>Using the CCT, stratifies the total Health Link member population based on risk score to identify members in need of care management and support.</p> <ul style="list-style-type: none"> • Assigns care coordinators caseloads based on member risk scores to ensure equal distribution.
ADDITIONAL RESOURCES (documents on SharePoint site):	
Choosing High Risk Populations	
Population Health Management Infographic	
Risk Stratification & Team Based Care	

Module 12

MODULE 12	MEMBER ENGAGEMENT
SESSION 12A	<i>The organization engages members in their own health care planning and decision making to improve health outcomes.</i>
RECOMMENDED ATTENDEES: <ul style="list-style-type: none"> • Organizational management • Health Link lead/s • Site Supervisors • Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Uses evidence based strategies to engage members in their health care. (e.g., Motivational Interviewing).
2	Uses evidence based communication interventions (tools) to promote stronger engagement. (e.g., Teach-Back, sending standardized letters, post cards, and/or emails).
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	

1	<ul style="list-style-type: none"> • Discuss which evidence based strategies the organization currently uses to engage members in their health care. • If the organization is not using an evidence based strategy to engage members, identify one or more evidence based strategy below and work with the QI Team to begin developing training materials for member engagement. <ul style="list-style-type: none"> ○ Share the Building a Therapeutic Alliance Infographic with the QI Team. ○ Share the Motivational Interviewing using OARS Infographic with the QI Team. ○ Share the SMART Goal Setting Infographic with the QI Team. • Have the organization vet and approve training for their clinical teams. • Have the QI Team train the clinical staff on the use of strategies to engage members using the organizational approved training. • Have the organization staff record their training using sign in sheets. • Have the QI team integrate the training on evidence based communication interventions such as WRAP, CBT, and DBT into new employee orientation. (Reference Health Link Webinar Behavioral Health Providers and Chronic Disease Management in Session 3A)
2	<ul style="list-style-type: none"> • Discuss the communication tools which are currently being used in the organization for member engagement. • If the organization is not currently using communication tools: <ul style="list-style-type: none"> ○ Share the Why Teach Back infographic with the QI Team. ○ Share the What is Teach Back infographic with the QI Team. ○ Share the Ruler of Change infographic with the QI Team. • Vet and approve which communication intervention tool will be used to promote stronger member engagement with the organization team. • QI Team trains the clinical staff on the communication intervention tool identified by the organization. • Organization staff records their training using sign in sheets. • QI team integrates the training on evidence based communication interventions into new employee orientation.
ADDITIONAL RESOURCES (documents on SharePoint site):	
Dancing, not wrestling. Motivational interviewing helps case managers cultivate relationships and elicit change	
Member Engagement Whitepaper	
Motivational Interviewing for Better Health Outcomes	
The Stages of Change	
Health Link Member Engagement Webinar	

MODULE 12	MEMBER SELF-MANAGEMENT SUPPORT
SESSION 12B	<i>For members identified for care management, the organization consistently uses member information and collaborates with members/families/caregivers to develop care plans that address barriers and incorporates member preferences and lifestyle goals documented in the member's chart. Demonstration of such may be through reports, file review or live demonstration of case examples.</i>

RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> Organizational management Health Link lead/s Site Supervisors Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Organization's current processes for supporting the physical health needs of members.
2	Establishes a person-centered care plan for members identified for care management.
3	Provides written care plan to the member/family/caregiver for members identified for care management.
4	Documents member preference and functional/lifestyle goals in individual care plans.
5	Identifies and discusses potential barriers to meeting goals in individual care plans.
6	Organization has practices in place and resources for member self-management support.
7	Includes a self-management plan in individual care plans.
8	Care plan is integrated and accessible across settings of care.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> Review organization's current processes for supporting the physical health needs of members. Determine whether the organization's current processes are sufficient for supporting the physical health needs of members.
2	<ul style="list-style-type: none"> Walk the QI Team through their current process for development and documentation of a person-centered care plan. Delegate assigned homework to an organization QI Team member(s) to: <ul style="list-style-type: none"> Research examples of Brief Action Planning on <i>YouTube</i> or other resource. Share 3 examples with organization team members that best represent the organization's population. Introduce and share the Goal Setting form instructions document with the QI Team. Identify if the sample Goal Setting Form works for the organization or needs modification. Delegate revisions to the Goal Setting Form to the QI Team based on their feedback. Discuss how the approved Goal Setting Form can be integrated into the member encounter and into the EHR. With the QI Team, develop a process for the identification, selection, and documentation of a member centered goal. Perform PDSAs that test the process for establishing a care plan for the identified population needing care management. Develop strategies to verify that care planning is consistently occurring with the identified member population.
3	<ul style="list-style-type: none"> Ask the question: Is a written care plan provided to the member/family/caregiver? Discuss the value of a written care plan that can be sent home with the member. Share the 7 activities involved in Self-Management Support Infographic. Develop a process for the provision of a written care plan, including a member centered goal, with the QI Team.

4	<ul style="list-style-type: none"> Have the QI team perform an audit of the care planning process to see if member preferences and functional/lifestyle goals are documented in the care plan. If it is found that member preferences are not being documented in the care plan brainstorm ways with the team to resolve this issue, for example: <ul style="list-style-type: none"> Staff trainings on the importance of member preferences & lifestyle goals Adding a new section to the care plan that speaks specifically to member preferences and lifestyle goals. Perform a root cause analysis (RCA) to focus the team in on the best option for change. Use The 5 Whys technique. Perform a PDSA that implements the best option for change and evaluate the
5	<ul style="list-style-type: none"> Have the QI team perform an audit of the care planning process to see if potential barriers are assessed and documented in the care plan. If it is found that barriers are not assessed and document following the brainstorming, RCA, and PDSA process in #3.
6	<ul style="list-style-type: none"> Assess organization's current resources available and current practices for member self-management support. <ul style="list-style-type: none"> Share the Readiness Ruler on page 23 of SBIRT Brief Intervention. Share Decisional Balance on page 22 of SBIRT Brief Intervention. Assess organization's current practices for member self-management support.
7	<ul style="list-style-type: none"> Discuss the essential elements of a self-management plan with the QI Team. <ul style="list-style-type: none"> Share The 7 activities involved in Self-Management Support Infographic. Assign staff member(s) to identify evidence-based self-management support tools to support the member populations. Self-Management Support Resources Have organizational leaders vet and approve the self-management tools. Work with the organization to integrate the tools into the workflow. Access resources embedded in EHR as available for member self-management support.
8	<ul style="list-style-type: none"> Discuss use of the EHR portal for member access to their personal health records. Identify if organization provides the individualized care plan through the member portal. Brainstorm ways to provide the care plan to members and how to further integrate care plans across settings of care with the QI Team. Perform PDSAs that test alternate ways of providing care plans across settings of care to determine feasibility.
ADDITIONAL RESOURCES (documents on SharePoint site):	
Dancing, not wrestling. Motivational interviewing helps case managers cultivate relationships and elicit change.	

Module 13

MODULE 13	CARE COORDINATION WITH PRIMARY CARE AND OTHER SPECIALTY PROVIDERS
SESSION 13A	<i>The organization collaborates with primary care providers and other specialty providers to ensure that member care is coordinated to ensure optimal outcomes.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> Organizational management Health Link lead/s Site Supervisors Any other key personnel overseeing implementation/training for Health Link development 	

COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Identifies the primary and specialty providers that the organization most frequently coordinates with on behalf of Health Link members.
2	Works with primary and specialty providers to set expectations for information sharing and member care.
3	Works with external behavioral healthcare providers with whom the organization frequently collaborates to set expectations for information sharing and member care.
4	Documents co-management arrangements in the member's medical record.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> • QI Team develops list of primary care and specialty providers the organization has collaborated with historically. • QI Team creates a spreadsheet of primary care and specialty providers and the frequency of each used by the organization in a given time frame, broken out by specialty. • Share the list of primary care and specialty providers the organization most commonly collaborates with.
2	<ul style="list-style-type: none"> • Educates primary care and specialty providers with whom the organization frequently collaborates about the Tennessee Health Link program, sharing program documents as indicated: <ul style="list-style-type: none"> • Health Link Introduction • Diabetes Quick Reference Guide • Pediatric Quick Reference Guide • 2018 TennCare Health Link Quality Measures Coding Reference • Works with primary care and specialty providers with whom the organization frequently collaborates to establish a list of expectations for information sharing and member care to share with primary care and specialty providers. • Examples of an expectation: <ul style="list-style-type: none"> ○ We expect a follow-up report within 2 weeks of the member's visit or if there is a worsening of symptoms. ○ We expect to be notified if the member does not show up for scheduled visit Policy-Outbound Consult and Mental Health Referrals. • Agreed upon expectations are documented with copies available for all parties involved. • Ensures effective referrals so that they are tracked from beginning to end of process. Review the following: <ul style="list-style-type: none"> Closing the Referral Loop Toolkit Make Referrals Easy (AHRQ) Behavioral Health Agency Request for Information template Sample Referral Form (AAFP)
3	<ul style="list-style-type: none"> • Works with behavioral healthcare providers with whom the organization frequently collaborates to set expectations for information sharing and member care. • Examples of an expectation: <ul style="list-style-type: none"> ○ We expect a follow-up report within 2 weeks of the member's visit or if there is a worsening of symptoms. ○ We expect to be notified if the member does not show up for the scheduled visit • Agreed upon expectations are documented with copies available for all parties involved.

4	<ul style="list-style-type: none"> • Determines if the organization currently obtains co-management agreements from primary care and other specialty providers. • Shares a sample of a co-management agreement with the QI team to be shared with the organization: Behavioral Health Co-Management Agreement • Defines the elements of a co-management agreement. • Develops a process for obtaining co-management agreements. • Identifies where the co-management arrangements will be documented in the EHR. • Educates staff that will be documenting the co-management arrangements in the medical record following the identified process. • Implements the process.
ADDITIONAL RESOURCES (documents on SharePoint site):	
Agency for Healthcare Research and Quality: Care Coordination	
Coordinating Care in the Medical Neighborhood	
Referral and Communication presentation	
Health Link Webinar: Making the Case for Care Coordination	

MODULE 13	CARE COORDINATION THROUGHOUT CARE TRANSITIONS
SESSION 13B	<i>The organization connects with other health care facilities to support member safety throughout care transitions. The organization receives and shares necessary member treatment information to coordinate comprehensive member care.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> • Organizational management • Health Link lead/s • Site Supervisors • Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	
1	Systematically identifies members with unplanned hospital admissions and emergency department visits using the CCT.
2	Shares clinical information with admitting hospitals and emergency departments.
3	Contacts members/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.
4	Systematic ability to coordinate with acute care settings after hours through access to current member information.
5	Exchanges member information with the hospital during a member's hospitalization.
6	Implements process to consistently obtain member discharge summaries from the hospital and other facilities.
7	Collaborates with the member/family/caregiver to develop/implement a written care plan for complex members transferring in to/out of the organization (e.g., transitioning from pediatric care to adult care).
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	

1	<ul style="list-style-type: none"> • QI Team maps current process to identify members with unplanned hospitalizations and emergency department visits. • Based upon the process mapping, identifies gaps in workflow. • Brainstorms opportunities for improvement. <ul style="list-style-type: none"> ○ Design/revise the organization's information infrastructure to track and manage transitions. The information infrastructure includes: <ul style="list-style-type: none"> ▪ The Care Coordination Tool's Admission, Discharge, and Transfer (ADT) feeds. ▪ The EHR. ▪ Staff assigned to track the ADT feeds on a regular basis (e.g., daily). ▪ Staff assigned to make phone calls and document interactions. • QI Team documents the process. • Implements process
2	<ul style="list-style-type: none"> • Maps current process for sharing information with the admitting facility. • Based upon the process mapping identifies gaps in workflow. • Brainstorms opportunities for improvement. <ul style="list-style-type: none"> ○ Investigate the potential of shared EHRs with the hospital. ○ Develop relationships (agreements) with key primary care providers, specialty providers and hospitals – include verbal or written agreements that include guidelines and expectations for the transition processes. ○ Designate an organization care coordinator to outreach to acute care facilities and be responsible for the exchange of member information. • Documents the process. • Implements process.
3	<ul style="list-style-type: none"> • Reviews current process for outreach to members after hospitalization or emergency department visit. • Defines the time period in which members should be contacted. Time period can be set based upon diagnosis and/or whether visit was an inpatient, observation or ED stay. Important to note if all members with a hospital stay are contacted and a follow up visit scheduled or if it is a subset. The same with ED visits. • Documents the process of member follow-up and appointment scheduling after an inpatient, observation or ED visit including the details of: who will contact, within what time frame, which members will be contacted and what the time frame is for a follow-up visit. • QI Team uses CCT to identify members with frequent unplanned hospitalizations and emergency department visits. • QI Team develops strategies for interfacing with identified members with frequent unplanned hospitalizations and emergency department visits and explore potential barriers to care with the member, such as no primary care provider, scheduling, convenience, transportation, etc. • QI Team conducts a PDSA for refining the process. • QI Team documents process. • Process is implemented.
4	<ul style="list-style-type: none"> • Evaluates organization's current ability to coordinate care with acute care facilities after hours. • If this is not happening, or gaps are identified, brainstorms opportunities for improvement: <ul style="list-style-type: none"> ○ Enhanced use of triage nurse to provide information to acute care facilities after hours. ○ Plan for how on call provider(s) will interact with acute care facilities when information is needed. ○ Evaluates the EHR for opportunities to enhance two-way electronic communication with the hospital (e.g., shared EHR access). • QI Team develops new/revise process.

	<ul style="list-style-type: none"> • QI Team completes a PDSA to identify changes needed for the process. • Documents the process.
5	<ul style="list-style-type: none"> • Flowcharts means by which information is exchanged with the hospital during a member hospitalization. • Identifies current gaps, if any, and brainstorms improvement opportunities based on gaps. <ul style="list-style-type: none"> ○ Develop relationships (agreements) with key hospitals – include verbal or written agreements that include guidelines and expectations for communication before, during and post-hospitalization. ○ Utilize organization care coordinator to monitor hospitalizations and have conversations with key hospital staff about member progress (e.g., in member care managers and discharge planners). • QI Team develops new/revised process. • to identify changes needed for the process PDSAs new/revised process • Documents process for providing hospitals and ERs with clinical information AND for obtaining discharge summaries (flowchart, policy, standard operating procedure, etc.).
6	<ul style="list-style-type: none"> • Reviews current process for obtaining discharge summaries. Identifies current gaps, if any, and brainstorms improvement opportunities based on gaps. • Evaluates ability to obtain summaries via an electronic process – EHR, Fax. • Develops/revise process for obtaining member discharge summaries. • PDSAs new/revised process. • Documents process for providing hospitals and ERs with clinical information AND for obtaining discharge summaries (flowchart, policy, standard operating procedure, etc.).
7	<ul style="list-style-type: none"> • For complex members transferring in to/out of the organization, follows the process for developing a person-centered care plan and providing the plan of care to the member/family/caregiver.
8	<ul style="list-style-type: none"> • Discusses health information exchange options such as a regional health information organization (RHIO) or other providers or care facilities for care transitions. • Discuss any MOUs in place. If none, identify other organizations to approach. • If no EHR information exchange in place, evaluates the ability of the current organization EHR to engage in information exchange with any of the above.
ADDITIONAL RESOURCES (documents on SharePoint site):	
Care Transition Interventions in Mental Health	

Module 14

MODULE 14	CAREGIVER SUPPORT
SESSION 14A	<i>The organization effectively delivers support and empowerment tools to caregivers of members. The organization demonstrates ability to gauge the needs of caregivers across populations, and target education and supports to them to enhance member self-management and Health Link care plan progress.</i>
RECOMMENDED ATTENDEES:	
<ul style="list-style-type: none"> • Organizational management • Health Link lead/s • Site Supervisors • Any other key personnel overseeing implementation/training for Health Link development 	
COACHING OBJECTIVES: Fundamental Organization Building Blocks	

1	Organization demonstrates effective engagement of caregivers and is able to assess caregivers' needs and burden. Caregiver needs are documented appropriately, and caregiver support action steps are included in the member's person-centered plan.
2	Organization identifies list of available resources for caregiver support and engagement.
3	Organization refers caregivers to available community based resources for areas such as respite services, support groups, counseling and other supportive services.
4	Organization is able to track and report on progress with caregivers.
5	Organization optimizes the use of peer support and programming to deliver caregiver supports directly, as needed.
COACHING STRATEGIES: Delivery Methods & Activities (documents on SharePoint site)	
1	<ul style="list-style-type: none"> Assist organization with developing or incorporating a pre-existing caregiver assessment tool into the care coordination process. Develop workflows for input and documentation of assessment. (Sample tool: Family Caregiver Assessment) Identify need for caregiver-focused staff role within the organization. Develop job description for the caregiver-focused staff role.
2	<ul style="list-style-type: none"> Assist organization in developing list of available resources for caregiver support. Identification of internal and external peer support resources. Crosswalk organization to available community based resources, facilitate sessions with community partners such as local respite resources, the local area agency on aging, etc. to learn more about available resources.
3	<ul style="list-style-type: none"> Assist organization in development of a process flow for connecting caregivers to resources. Assist organization in selecting the evidence based program for caregivers that best aligns with the needs of the organization. Assist organization to develop a plan for funding and implementation.
4	<ul style="list-style-type: none"> Assist organization in development and implementation of process for tracking referrals and progress of caregivers.
5	<ul style="list-style-type: none"> Direct QI Team to conduct a caregiver focus group with caregivers to gain insights on needs and opportunities to enhance service delivery to informal supports. QI Team to make recommendations to leadership based on outcome of caregiver focus group.
ADDITIONAL RESOURCES (documents on SharePoint site):	
http://www.caregiverstress.com/	
https://www.tn.gov/aging/our-programs/caregiving.html	
Guidebook for Caregivers of Children and Adolescents with Serious Emotional Disorders	

APPENDIX
2018 Health Link Webinars
Health Link Webinar: Behavioral Health Providers and Chronic Disease Management Webinar recording
Health Link: Comprehensive Care Management Webinar recording
Health Link: Essentials of Care Coordination Infrastructure for Pediatric Provider Organizations Webinar recording
A Review of NCQA Accreditation and HEDIS Webinar recording
Health Link: Health Promotions Webinar recording
How to Succeed with THL Quality Metrics Webinar recording
Health Link Webinar: Transitional Care Webinar recording
2019 Health Link Webinars
Member Status: Discharging from the Tennessee Health Link Program Webinar recording
Supporting Wellness in Tennessee Health Link Members Webinar recording
Addressing Self-Harm and Self-Injury Among THL Members Webinar recording