METS | Members Empowered to Succeed

nh healthy families™

Provider Resource Guide

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CONTENTS

Thank you for your partnership. Please contact your Provider Relations Representative if you have questions or need assistance.

Care Coordination Tip Sheet

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What is Care Coordination?

- The intentional exchange of information between two or more participants (including the member) who are involved in the member's care to facilitate the appropriate delivery of healthcare services.
- Care coordination is an essential element in treatment planning, service titration, and the discharge planning processes.

The Benefits of Care Coordination

- Collaboration between the internal and external treatment team is emphasized to better serve the member.
- The member's needs are supported, and a holistic system of care is integrated.
- It assists in the development of comprehensive treatment planning that leads to more appropriate services titration or referrals.
- Care coordination consists of anything that bridges gaps in the member's recovery.
- A holistic approach to healthcare results in the best outcomes.

Who Should Coordinate Care?

- Care coordination includes a variety of individuals on the treatment team:
- Behavioral health providers (e.g., Counselors, Social Workers, Substance Use Counselors, Psychiatrists)
- Physical health providers (e.g., PCP, Pharmacist, Neurologist)
- Specialty care services (e.g., Physical Therapists, Occupational Therapists, Speech Therapy)
- Educational and community supports (e.g., Teachers, School Psychologists, Mentors)
- Family members (e.g., parent, guardian, spouse, sibling)

Considerations

- Release of information must be signed by the member or their guardian prior to any outreach.
- Method of care coordination is based on each member's needs (e.g., phone, fax, meeting).
- Request and review records from previous or current providers and align care with member needs.
- Notify member and/or guardian about coordination occurring.

What Could Happen If Coordination of Care Does Not Occur?

- Multiple providers may be treating different diagnoses and/or presenting problems.
- Multiple treatment plans with competing goals can complicate or impede the treatment process for the member.
- Symptoms may become exacerbated.
- Duplication of efforts and services provided may occur.

Coordination of Care

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Patient Name: _____ DOB: _____

Service and Start Date: _____ Provider: _____

Is there a Primary Care Physician? ☐ **Yes** ☐ **No** ☐ **Declined**

PCP Name: _____ Phone No.: _____

Fax or Email: _____

Release of Information Signed? ☐ **Yes** ☐ **No** ☐ **Declined**

Is there another Behavioral Health (BH) Clinician involved with member's care? ☐ **Yes** ☐ **No** ☐ **Declined**

BH Clinician's Name/License Type: _____ Phone No.: _____

Fax or Email: _____

Release of Information Signed? ☐ **Yes** ☐ **No** ☐ **Declined**

Is there another treatment provider involved with member's care? ☐ **Yes** ☐ **No** ☐ **Declined**

Provider's Name/License Type: _____ Phone No.: _____

Fax or Email: _____

Release of Information Signed? ☐ **Yes** ☐ **No** ☐ **Declined**

Documentation of Contacts and Attempts to Coordinate Care:

Date	Provider Contacted	Phone, Fax, Email	Information Shared or Discussed

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Discharge Readiness Tip Sheet: Behavioral Health

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Discharge Planning Process for Behavioral Health

- Discharge planning is not a one-time event. It requires collaboration with the entire treatment team including providers, member, family, and additional supports.
- Discharge planning should begin on the first day of treatment and continue to be assessed and frequently discussed with the member.
- The discharge plan should be written clearly and agreed to by the member.
- Titrating services, which is the continuous appraisal of current needs, will also help identify when discharge is appropriate.
- Discharge should occur when: All the treatment goals and needs have been addressed, **OR** member has reached their baseline, **OR** the member has reached the maximum benefit of services for that level of care.

Step-down Planning Process

- Members should begin their step-down plan when they have shown improvement and are meeting their goals and objectives.
- Members should also have been adherent to compliant with treatment recommendations and are no longer severely functionally impaired.
- To prepare for transition, encourage the use of the skills learned in treatment:
  - » Self-care reminders
  - » Coping skills
  - » Medication regimens
  - » Accessing and utilizing support systems
- Recommend potential referrals to connect the member to natural supports prior to discharge to allow practice using services such as:
  - » AA/NA and Sponsors
  - » Senior Centers or respite
  - » Employment programs
  - » Spiritual or religious supports
  - » Community Mentors or Peer Support Specialists
  - » Sports/hobby groups
  - » Online supports (e.g., apps, online groups)
- Discharge plans and instructions on how to return for care if needed should be provided to the member and openly discussed. They should be informed that they can resume services if needed.

Consider Family Readiness

- Refer family to parent education/training, if needed.
- Equip the family with tools and steps to take if the need for treatment arises again.
- Ensure the family's inclusion on discharge planning.

Discharge Readiness Tip Sheet: Substance Use Disorders

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Discharge Planning Process for Substance Use Disorders

- Discharge planning is not a one-time event. It requires collaboration with the entire treatment team including inpatient provider, community-based providers, member, family and additional supports.
- Discharge planning should begin on the first day of treatment and continue to be assessed and frequently discussed with the member.
- The discharge plan should be written clearly and agreed to by the member.
- Discharge should occur when: All the treatment goals and needs have been addressed OR the member has reached the maximum benefit of services for that level of care.

Step-down Planning Process

- Members should begin their step-down plan upon admission.
- Members should be adherent to compliant with treatment recommendations and are no longer severely functionally impaired.
- To prepare for transition, encourage the use of the skills learned in treatment:
  - » Self-care reminders
  - » Coping skills
  - » Medication regimens
  - » Accessing and utilizing support systems
- Connect members to natural supports prior to discharge, including services such as:
  - » 12 Step and other community recovery groups
  - » Senior centers or respite
  - » Employment programs
  - » Spiritual or religious supports
  - » Community Mentors or Peer Support Specialists
  - » Sports/hobby groups
  - » Online supports (e.g., apps, online groups)
- Discharge plans and instructions on how to return for care if needed should be provided to the member and openly discussed. They should be informed that they can resume services if needed.
- Discharge plan should include specific follow-up appointments within days of care transition.

Consider Family Readiness

- Addiction is a family disease; therefore, we recommend the following:
  - » Refer family to parent education/training, family counseling, Al-Anon or Alateen if needed.
  - » Equip the family with tools and steps to take if the need for treatment arises again.
  - » Ensure the family's inclusion on discharge planning.

Improving Patient Engagement in Behavioral Healthcare

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Why is patient engagement important in behavioral healthcare?

- Improves health outcomes and the sustainment of the individual treatment plan
- Fosters patients' desire to be involved in decisions regarding their healthcare
- Encourages patients to be active decision-makers in their treatment planning
- Promotes health literacy, allowing for increased understanding of health information and services
- Provides an open line of communication for questions about their treatment and overall wellbeing

What can you do to help increase patient engagement?

The RESPECT model is widely used by clinicians to develop rapport with patients. The model encourages you to examine your own cultural biases and take them into account when treating patients from all walks of life. This will help with enhancing communication and ultimately improving treatment outcomes.

The RESPECT Model stands for:

R — Rapport

E — Empathy

S — Support

P — Partnership

E — Explanations

C — Cultural Competence

T — Trust

Improving Patient Engagement in Behavioral Healthcare, cont.

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The RESPECT Model

1 | Rapport

- Connect with your patient through open communication and dialogue to assist them in asking questions and bringing up tough or uncomfortable topics
- Try to see the situation from your patient's point of view
- Do not make judgements
- Avoid making assumptions

2 | Empathy

- Remember your patient is there for help
- Seek your patient's rationale for their behavior or illness
- Verbally acknowledge your patient's feelings

3 | Support

- Ask about your patient's barriers to care and adherence to compliance with their healthcare
- Help your patient overcome barriers
- Involve family members or significant others as appropriate
- Reassure your patient you are there to help

4 | Partnership

- Let your patient know you will be working together to address problems

5 | Explanations

- Check with your patient often during the conversation to assess understanding
- Use verbal clarification techniques

6 | Cultural Competence

- Respect your patient and their cultural beliefs
- Understand that your patient's view may be defined by their ethnic or cultural stereotypes
  - » Be aware of your own biases and preconceptions
  - » Know your limitations in addressing behavioral health concerns across different cultures
  - » Recognize if your approach is not working with your patient

7 | Trust

- Self-disclosure may be an issue for some of your patients
- Take the necessary time and work to establish trust

Titration of Services Tip Sheet

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What is Titration?

- Titration implies stepping the member down in their services to match their clinical presentation, progress, baseline, and supports.
  - » **Example:** Member A was receiving therapy 4x/month. Due to member's progress, increase in supports, and coping skills, Member A is being titrated to receive therapy 2x/month. Member will be evaluated with current service package and continue titration of services as progress continues.
- Services should also be reduced slowly when recovery is occurring to avoid worsening of symptoms, feelings of abandonment by the client, and empower the use of skills learned.

Why is Titrating Services Important?

- The largest improvement in symptoms occurs in the first phase of treatment
  - » Studies show that the most improvement occurs during the initial stage of treatment, specifically in the first 6 sessions of therapy.
- Promotes independence and working toward effective independent functioning
  - » Discharge should be discussed with the member openly at the start and throughout treatment. A key goal of therapy is to work toward effective independent functioning.
  - » This process includes helping members identify their natural support systems and assisting with coordination of care to support their step-down plan and access community-based resources.
  - » Studies demonstrate that it is not necessary to be in therapy for years to achieve improvement in symptoms.
- Helps to ensure individualized treatment
  - » Treatment type and duration should always be matched appropriately to the nature and severity of the member's presenting problems.
  - » Length of treatment also varies with the type of treatment provided.
- Discourages unhealthy attachments
  - » Titration helps discourage unhealthy attachments to treatment providers because it promotes independence and monitors the member's progress. It ensures that a member isn't stuck in one level of care or becomes too dependent on a provider or services.

Barriers to Titration Services

- NH Healthy Families recognizes that barriers may be present for providers and members.
- If symptoms worsen, services can be titrated up to increase frequency and duration of services, if the documentation supports the medical necessity of that service and authorization is obtained.

Treatment Plan Development Tip Sheet

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Important Steps of Treatment Planning

- Treatment plan goals should:
  - » Align with assessment, diagnosis, and presenting symptoms
  - » Be member driven and individualized
  - » Serve as a guide towards the client's recovery and be referenced frequently
- Clinical Documentation in a treatment plan should include interventions that are being used, measurable target dates for each goal, and member's strengths.

Creating a Member-Focused Treatment Plan Using Specific, Measurable, Attainable, Relevant, And Time Frame (SMART) Goals

- This method helps goals to be measured and adjusted over time to show incremental progress or regression.
  - » If progress is not occurring, ask yourself, "What can we do differently?" and reflect changes in the updated treatment plan if the goal needs to be amended to improve attainability.
- Goals should have a time frame of no more than 90 days.
  - » Can the goal be met in 1 month, 2 months, or 3 months?
- Goals should be member driven and align with their desired outcome.
  - » Use direct member quotes for identified goals to use member language and ensure their understanding.
- Goals should be strengths based and individualized.
- It is recommended that each goal has two interventions: one for the member and one for the provider.

Tools to Aid in SMART Goal Development

- Biopsychosocial assessment – triage for member's needs
- Diagnosis and presenting problem – clear supportive symptoms and behaviors that align with diagnosis
- In-depth interview with member and support – assess the desired outcome and strengths
- Motivational interviewing – consider stage of change the member is in and how they want treatment to help them

Considerations

- Baseline behaviors and what is attainable for the member
- Barriers to meeting the goal
- Developmental age and stage of the member
- Goals should be updated after a crisis, hospitalization or change in diagnosis
- Ensure that the timeframe and interventions for the goal align
- Goal should be tangible and able to answer "yes" or "no" if the goal was met at the treatment review

Source: Mutha, S., Allen, C., & Welch, M. (2002). Toward culturally competent care: A toolbox for teaching communication strategies. San Francisco, CA: Center for the Health Professions, University of California, San Francisco.