Disease Management Program Description

Commercial, Exchange, and Medicare Products 2015

Approved by the QMC: Presenting on May 12, 2015
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Overview

The Denver Health Medical Plan, Inc. (DHMP) was incorporated on January 1st, 1997 in Colorado as a not-for-profit corporation for the purpose of providing or arranging for the delivery of healthcare services and related functions through the establishment and operation of a managed care organization (MCO). Purpose of the MCO was defined as delivery of quality, accessible and affordable healthcare services in and around the City and County of Denver, Colorado. Licensed by the State of Colorado as a Health Maintenance Organization, the organization is a wholly owned subsidiary of Denver Health and Hospital Authority (DHHA), an academic, community-based, integrated healthcare system that serves as Colorado’s primary “safety net” system. DHMP offers a full spectrum of healthcare services for members through DHHA’s integrated healthcare system and an expanded network of providers throughout the metro Denver area.

Denver Health Medical Plan includes Commercial, Exchange and Medicare Products for 2015 and will here on out be known as DHMP for the content of this program description.

Denver Health Medical Plan’s (DHMP) STRONG body STRONG mind Disease Management Program Description outlines the basis for selection of the two disease states it manages, the evidence based guidelines related to these conditions, the key elements of the program, the program structure and design as well as interventions implemented including multidisciplinary care management for our highest risk members.

The Mission Statement of Denver Health Medical Plan, Inc. (DHMP)

To provide quality, accessible and affordable healthcare services in the Denver area. In partnership with our providers we continually seek to improve the health and well-being of our members by:

- Promoting wellness and disease prevention
- Providing access to culturally diverse comprehensive health services
- Enabling members to play an active role in their health care
- Delivering our services with responsibility and respect to all

DHMP’s STRONG body STRONG mind Disease Management Program is designed to support the mission of DHMP by improving the quality of care and disease outcomes for the Denver Health Medical Plan members. This is achieved through an assessment of member needs, provision of ongoing care monitoring, implementation of culturally appropriate and individually tailored interventions and provision of self-management support so that members are empowered to play an active role in their health care.

Introduction and Statement of Purpose

The Denver Health Medical Plan STRONG body STRONG mind disease management program aims to improve the quality of care and disease outcomes for the Denver Health Medical Plan members living with diabetes and/or depression. The program uses a multi-faceted approach to help members better manage these chronic conditions. An assessment of member needs, ongoing care monitoring, evaluation, and tailored interventions are utilized to help prevent and/or minimize the effects of the member’s conditions. Through a multidisciplinary approach to care coordination and continuity of care for our highest risk members, as well as self-management support for all of our members to empower them to assume greater responsibility of their health, improvement in health outcomes and a reduction in costs should be realized.
Self-management support has been shown to be an important component of the chronic care model and is supported in the evidence-based guidelines and recommendations. By providing patients the option to choose which type of support they would prefer to receive, it is anticipated that we will be able to achieve a higher level of engagement in our programs. Initial engagement at a lower level support option is also likely to lead to ongoing participation in a more intensive level of support at a later date.

The program has been designed such that all communication related to the outreach, intake, tracking of interventions provided and ongoing monitoring are housed in our Guiding Care™Care Management software system. This will allow for streamlined communication between the multidisciplinary staff providing services related to the STRONG body STRONG mind programs as well as reporting capabilities.

**Basis for Selection**

*Disease State - Diabetes*

Diabetes is widely recognized as one of the leading causes of death and disability in the United States. According to the data from the 2011 National Diabetes Fact Sheet (released Jan. 26, 2011), 25.8 million children and adults in the United States, or 8.3% of the population, have diabetes. This condition accounts for almost 14% of US health care expenditures and it is associated with an increased risk for a number of serious, sometimes life-threatening, complications such as blindness, heart and blood vessel disease, stroke, kidney failure, amputations, and nerve damage. Diabetes control, which is largely achieved through health behavior change, can help reduce the risk of complications and decrease the cost of medical care.

*Disease State - Depression*

Every year, approximately 19 million Americans are affected by clinical depression. Depression affects males and females from all races, regardless of income, age, and ethnic and religious background. However, it is twice as common in women compared to men and three to five times more common in the elderly than in young people.

*Depression and Comorbid Diabetes*

The literature suggests that individuals with diabetes are twice as likely to be depressed as people without chronic disease and that depression is a risk factor for onset of type-2 diabetes. It has been shown to be associated with hyperglycemia, complications, smoking, mortality, and poorer adherence. Moreover, some research has shown that individuals with diabetes and depression are less likely than those without depression to achieve adequate levels of glycemic control.

**Evidence Based Guidelines**

*Diabetes*

The American Diabetes Association’s Standard of Medical Care in Diabetes (2013) states diabetes self-management education (DSME) should be recognized as an integral component of care. Self-management behavior change is the key outcome of DSME and should be measured and monitored as part of care. DSME should address psychosocial issues, since emotional well-being is strongly associated with positive diabetes outcomes. Cardiovascular disease (CVD) is the major cause of morbidity and
mortality for individuals with diabetes and the largest contributor to the direct and indirect costs of diabetes. The common conditions coexisting with type-2 diabetes (e.g., hypertension and dyslipidemia) are clear risk factors for CVD, and diabetes itself confers independent risk.

Depression
According to Denver Health’s Depression Clinical Care Guideline (2014), which is largely based on the HealthTeamWorks clinical guideline, depression increases the risk of cardiovascular disease and patients with depression have a higher mortality rate after myocardial infarction. Depression may lead to poor treatment adherence in patients with diabetes and recognizing depression must begin with symptom identification and diagnosis. Vital components of depression care include patient education, helping patients and their families understand and accept a diagnosis of depression, and activating patients to seek help, adhere to treatment recommendations, and practice healthy behaviors that can promote recovery. The plan for treatment should include Shared Decision Making to tailor the treatment to the patient, provide education on diagnosis, review treatment options, discuss treatment barriers, and educate on importance of adherence. The promotion of the following health behaviors which include, but are not limited to, exercise, social support, faith/spiritual support, cessation of tobacco use, engagement in positive activities, stress management, and use of educational books and online resources is also indicated.

Key Elements

Program Objectives
The STRONG body STRONG mind disease management program is designed to improve the health and quality of care and disease outcomes for our members with diabetes and/or depression by providing specific information and interventions targeted at the management of these conditions, which include, but are not limited to, written patient education materials, audio/visual DVDs, education classes, and one-on-one telephonic management via health coaching, telephonic counseling or complex case management. In addition, the program will strive to ensure members are well-prepared for their office visits, to assist and support members who are not adhering to the recommended treatment plan, and to increase overall patient satisfaction.

As a result, the STRONG body STRONG mind program aims to:

1. Empower patients to manage their health and health care by:
   a. Emphasizing the member’s primary role in managing their health
   b. Using effective self-management support strategies that include assessment, goal setting, action planning, problem-solving and follow-up
   c. Facilitating coordination of internal and community resources to provide ongoing self-management support to members
   d. Encouraging members to communicate with their providers

2. Improve healthcare outcomes through:
   a. Improved adherence to objective condition monitoring
   b. Improved medication and treatment adherence
   c. Identification of medical and behavioral health comorbidities
   d. Identification of barriers including cognitive deficits, physical limitations, and psychosocial issues

3. Lower the impact on financial expenditures through:
   a. Emphasis on appropriate utilization of services
b. Increased primary care visits and decreased urgent/emergent visits

c. Decreased readmissions and/or decreased length of stay of inpatient hospitalizations

**Program Goals**

1. Analytically assess and stratify our member population
2. Identify and communicate gaps in care to our member population
3. Identify, provide and coordinate services
4. Ensure disease management activities which address the assessment and intervention for individual member needs as related to: health status, medical history and identified comorbidities, psychosocial issues, medication adherence and treatment, condition-specific issues, cognitive and mental health status, cultural and physical preferences and limitations, identification of barriers, prioritization of goals and ongoing assessment of progress towards those goals, follow-up, and adherence to self-management action plan
5. With member consent, ensure the involvement of caregivers and provide information regarding the type and methods of support a caregiver can provide
6. Support the ongoing communication between the member and his/her health care team.
7. Provide referrals to resources as necessary
8. Maintain, evaluate and update as needed our disease management processes and resources to address members needs
9. Maintain a care management software system which supports the disease management program by:
   a. providing necessary evidenced-based clinical guidelines, algorithms, assessments, and documentation
   b. automatic prompts for follow-up
   c. automatic documentation of staff demographics, to include, staff members name, title, date and time of input or activity
10. Formal evaluation of the program at least annually, as well ongoing informal review, to identify and monitor performance goals, measure outcomes or effectiveness and analyze results
    a. Action plans will be implemented to address barriers or other opportunities for improvement at the end of each evaluation and prior to the next year’s rollout of the program

**Anticipated Outcomes**

As a result of our diabetes and depression disease management efforts, we anticipate the following outcomes:

1. Decreased HgA1c lab values of those members actively engaged in the health coaching program
2. Decreased PHQ-9 scores of those members actively engaged in the telephonic counseling program
3. Decreased weight/BMI values of those overweight members actively engaged in the health coaching program
4. Decreased tobacco use
5. Decreased ED/urgent care visits
Program Design

Target Population

The **STRONG body STRONG mind** disease management target population is active, adult members who are at risk for or who have been diagnosed with diabetes and/or depression.

Method and Frequency of Member Identification

Members eligible for the **STRONG body STRONG mind** disease management programs are identified at least monthly through the following data sources and referral mechanisms:

1. Claims and/or encounter (medical) data
2. Pharmacy data
3. Health Risk Appraisal (HRA) results
4. Laboratory results
5. Data collected through the Utilization and Case Management process
6. Internal department referrals from Care Support, Health Coaching and/or the Wellness Program
7. Practitioner referrals
8. Member and caregiver referrals

Monthly, a report is generated which provides a list of members who have been diagnosed with diabetes and/or depression on at least two separate occasions in the last year as identified through ICD-9 codes and claims. This report also provides clinical and laboratory information from our data warehouse including HbA1c, BMI, HDL, LDL, triglycerides and smoking status which can be used to stratify the population and identify those members who may be at greater risk based on disease severity or other markers or poorer health. Members who are identified as having a new diagnosis and/or a worsening of their diagnosis since the last data pull are highlighted so that outreach can be made to engage them into the program. Members who exhibit non-adherence to their diabetes and/or depression medications will also be targeted for more active outreach.

Denver Health’s medical records system is available to all care providers in the organization and provides an individual medical record instantly for each patient. Members are incentivized to complete a Health Risk Appraisal annually through our online wellness portal. A report is generated on a monthly basis which identifies members who are at risk for or have either diabetes and/or depression based on specific questions which are positively endorsed in the HRA (i.e., the PHQ-2). Practitioner and self-referrals, as well as referrals made from other medical management departments/programs including Care Support, Utilization and Case Management, Health Coaching and the Wellness Program to the **STRONG body STRONG mind** Disease Management programs are received and tracked through the Guiding Care™ Care Management system.

Members in the **STRONG body STRONG mind** disease management programs are stratified into four levels (low, moderate, high and critical risk) based on GuidingCare’s Risk Stratification Methodology. The GuidingCare system predominantly relies on a combination of claims and pharmacy data to stratify members into various risk levels based on their propensity for future complications and/or costs. The predictive model used within GuidingCare to complete this risk analysis is the CDPS system developed by University of California, San Diego and approved by CMS for use in risk adjusted rate determination and program groupings in more than 12 states. Within this model, an initial Risk Weight for each member is calculated based on the member’s age, sex and program/aid groupings (for Medicaid population only).
Then based on a disease grouper within CDPS, the risk weight for specific condition groups that are active for a member driven from diagnostic codes and pharmacy codes is also added to obtain a holistic risk weight for an individual. The greater the number of conditions that a member has, the higher the overall risk weight will be. The diagnostic groups cover approximately 60 condition categories including both physical health and behavioral health groups and hence, is a holistic estimation of risk across all conditions.

Once this complete risk weight is calculated, outliers are eliminated by applying a standard deviation to the mean risk weight for a health plan’s total membership so that outliers do not skew the risk stratification of the population. Once this is done a final risk score is assigned to each member and then the population is stratified into 4 groups – Critical, High, Moderate and Low Risk Groups based on their risk scores. It must be noted that while in general, there are specific ranges of scores associated with each strata, clients can modify this based on program requirements and available resources to ensure that the right strategy for care management is deployed to the right number of members. In general, 1-3 percent of the population is identified in the critical risk group, 10 percent in the high risk group, 15-20 percent in the moderate risk group and the remaining fall under the low risk group. Where claims and pharmacy data is not available (new members), the system also has the capacity to use health risk assessments (HRA) analysis to determine a risk score that is dependent on the responses to the questions within the HRA.

Risk Levels are as follows based on the GuidingCare Stratification Methodology:
- Level 1 (low risk): Risk Scores ranging from 1-299
- Level 2 (moderate risk): Risk scores ranging from 300-599
- Level 3 (high risk): Risk scores ranging from 600-999
- Level 4 (critical risk): Risk scores above 1,000

Refer to Appendix 1 – Interventions Based on Risk Stratification.

**Enrollment Method**

All Commercial, Exchange, and Medicare members with a current diagnosis of diabetes and/or depression are sent a welcome packet introducing them to the appropriate STRONG body STRONG mind disease management program. This packet of information will provide basic education regarding the importance of having regular visits, exams, testing and screenings to ensure proper management of each of these conditions. Members are able to choose from the following four self-management support options and are sent a self-addressed postage paid return postcard to indicate their choice of intervention(s).

1. Written patient education materials specific to their condition
2. Patient education DVD specific to their condition
3. Participation in a condition-specific education class, if applicable
4. One-on-one telephonic support (a referral will be made to the health coaching, telephonic counseling or complex case management program based on member’s needs)
5. Access to self-management tools in the STRONG body STRONG mind online wellness portal.

In addition to providing a description of the program and how to use the services available, the introductory letter included in this welcome packet also outlines how members become eligible to participate and how they can opt out of the program. At least annually, practitioners are sent a letter which describes the disease management programs, the eligibility requirements and provides information on how to refer their patients. Periodically throughout the year, this same information is
disseminated through our member and provider newsletters, through reminder email blasts and is posted on the plan website as well.

For members who are identified as high and critical risk and/or whose condition significantly worsens over time, an attempt is made to contact members by phone to engage them in the disease management program.

**Monitoring of Active Member Participation**
Active participation is defined as having completed the *STRONG body STRONG mind* Diabetes or Depression Disease Management Intake as this interactive contact requires two-way interaction with the member. Quarterly, a report will is generated from our Guiding Care™ system to identify the members who have completed this questionnaire and is divided by the total number of members identified as eligible for participation in the STRONG body STRONG mind Disease Management programs.

**Interventions**
Depending on the member’s preferred method of self-management support, the following intervention options are available to help them improve the management of their diabetes and/or depression. Members are incentivized for their participation in the program and for demonstrating positive health behavior changes.

*myStrength™ Online Self-Help Program*
In the *myStrength™* self-help program, members can energize their mental and wellness health with proven online tools and tailored resources. These tools and resources are designed to improve their mood every day. *myStrength™* serves as a platform for many programs such as depression, anxiety, and alcohol/drug abuse. To enroll in the *myStrength™* program, members are asked to fill out a wellness profile through a secure online program. All members’ information is kept private. Patients can then access eLearning tools, read articles, watch videos, or simply be inspired by daily quotes and pictures.

*Disease Specific Education Classes*
The four week education classes offer an opportunity for patients with the same condition to meet together to discuss the daily challenges they face while trying to manage a chronic condition. The group format allows for participants to brainstorm and share ideas, it normalizes a patient’s experience; it instills a sense of hope and also helps to build motivation for change. For diabetes specifically, curriculum from the Conversation Maps® is utilized. This is a structured, interactive education program that use images, metaphors, and thought-provoking conversation topics to provide a friendly learning experience for patients. It engages patients in exploring health facts through dialogue and helps them draw their own conclusions.

Bilingual Health Coaches are available to conduct all classes in Spanish.
Individualized Health Coaching

Our Health Coaches work one-on-one with members and/or the member’s caregiver, if applicable and with permission from the member, to provide individualized support and tailored interventions to help members self-manage their chronic illnesses and other health conditions by enhancing motivation and providing support and encouragement to individuals as they address chronic health care needs or lifestyle changes. Lifestyle behaviors including healthy eating, engaging in physical activity, limiting alcohol use and quitting tobacco use are assessed and motivational interviewing and other self-management support techniques are used to increase the member’s intrinsic motivation to improve these behaviors. When a caregiver is identified, and with permission from the member, information about the condition and treatment plan, including the type and methods of support a caregiver can offer, is provided to the respective caregiver.

Bio-psychosocial assessments are conducted to gain a better understanding of the whole person, the barriers that might be preventing them from achieving their health goals, and to help inform the Health Coach of appropriate interventions for each individual. Readiness to change is assessed and a diverse array of psychological and behavioral change tools to empower individuals to become better self-managers of their health are employed. Interventions may include, but are not limited to, motivational interviewing for health behavior change, skills-based training, solution-focused therapy, provision of patient education, provision of information and resources, and facilitation of support groups and group visits focused on medical and behavioral issues.

Health Coaches have diverse educational backgrounds and offer a wide range of clinical expertise. At a minimum, they receive specialized training in the following areas: 1) motivational interviewing for health behavior change, 2) disease education/management, 3) behavior change strategies, 4) cognitive-behavioral therapy, 5) cultural competency and diversity, 6) community resources.

Working 1:1 allows for individualized support that can be tailored to meet the patient’s needs. More in-depth assessments are conducted which help to identify different demographic, socioeconomic, psychosocial and cultural components that may impact the patient’s ability to manage their chronic condition. Patient’s beliefs and concerns about their condition and treatment as well as any perceived barriers, such as access, transportation and financial barriers, to meeting the treatment recommendations are assessed. Information related to pertinent cultural, religious and ethnic beliefs that may impact the patient’s care and treatment is also obtained. Various interventions, including but not limited to, the provision of patient education materials and resources, assistance scheduling transportation and appointments, motivational interviewing to increase self-efficacy and connecting to community and other religious groups/resources are initiated based on the member’s responses to these assessment questions.

Health Coaches consistently support the ongoing communication between the member and his/her health care team. Patient handouts which discuss the importance of the communication and suggest methods of effective communication between patients and practitioners are provided. An annual health education seminar specific to this topic is also offered and presented by a physician.
Telephonic Counseling for Depression and Anxiety

For those members who screen positive for depression and would like further support beyond the STRONG body STRONG mind disease management program, Behavioral Health and Wellness Services will refer these members to the Telephonic Counseling for Depression and Anxiety program. Members receive a comprehensive psychiatric assessment to screen for comorbid mental health conditions as well and 3 outcomes evaluation calls to assess changes in their depression and/or anxiety symptoms. The feedback from each of these telephone calls is provided in a report to the member’s PCP which includes the identified comorbid psychiatric diagnosis(es), depression severity levels and management recommendations. Members have the opportunity to choose from 12 different counseling modules geared towards treating their depression and/or anxiety. The module topics include: Managing Stress and Anxiety, Behavioral Activation, Coping with Illness, Managing Chronic Pain, Changing Negative Thoughts, Improving Sleep, Eating Healthy, Increasing Exercise, Improving Interpersonal Relationships, Grief and Loss, and Problem Solving.

Individualized Complex Case Management

Although complex case managers are capable of, and often do provide health behavior change interventions consistent with those of a health coach, the goal of the program is to target members that require more intensive coordination of services. As such, high-risk members eligible for the program would include those with 1) advanced chronic diseases with multiple co-morbid conditions, 2) complicated acute diseases, 3) high utilization rates, and/or 4) severe psychological, and/or social issues or needs who require complex care coordination as well as assistance obtaining a wide range of resources.

Bilingual Health Coaches, Behavioral Health Clinicians and Complex Case Managers are available to work with our Spanish-speaking members. We also have a 24/7 language line available for medical interpretation of other languages.

Care Coordination Approach for High-Risk Members

The STRONG body STRONG mind program is designed as a collaborative care model with a multidisciplinary team in place to help provide self-management support to our highest risk members. The following teams will work in coordination and will communicate via our Guiding Care™ Care Management platform:

☐ Care Support - a team of patient navigators who are responsible for outreach/intake and initial engagement of the members identified as eligible participants.

☐ Health Coaches – see above.

☐ Behavioral Health Clinicians – a team of master’s level mental health clinicians who are available to provide telephonic counseling for the treatment of depression and anxiety.
ο Complex Case Managers – see above.

ο Pharmacy Case Managers – a team of pharmacists, technicians, intervention managers and nurses who are available to help provide assistance with medication adherence for our members. Referrals to the STRONG body STRONG mind programs are also made directly from this team for members identified through the prior authorization process or other inbound or outbound calls that are made to members for various reasons.

ο Utilization/Case Managers – Nurse case managers responsible for completing prior authorizations, reviewing inpatient hospital stays, assessing and appropriately facilitating discharge planning requests and completing post-discharge assessments.

ο Nurse Advice Line – The Denver Health NurseLine provides specialized nursing advice and triage for patients. 24 hours a day and 7 days a week using triage software and clinical protocols. Registered Nurses collect demographics, medical & medication history, and presenting symptoms. Using clinical guidelines, they assess the caller’s symptoms to provide a comprehensive recommendation for treatment which may include a referral to the STRONG body STRONG mind Disease Management program(s).
### Appendix 1- Interventions Based on Risk Stratification – Depression and Diabetes

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<th>Low Risk</th>
<th>Med Risk</th>
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<th>Critical Risk</th>
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<tbody>
<tr>
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<td>Risk Score 1-299</td>
<td>Risk Score 300-599</td>
<td>Risk Score 600-999</td>
<td>Risk Score &gt;1,000</td>
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<td></td>
<td>A1C &lt; 7</td>
<td>A1C 7-8</td>
<td>A1C 9-10</td>
<td>A1C &gt;10</td>
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<td>PHQ9 &lt; 5</td>
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<td>PHQ9 10-19</td>
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<td>PDC &lt; 80%</td>
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<td>1. Welcome letter and choice of the following:</td>
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<td>• Written educational materials</td>
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<td>• Educational DVD</td>
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<td>• Disease-specific educational class</td>
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<td>• 1:1 telephonic coaching</td>
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<td>2. Ongoing monitoring of claims and other tools to re-assess risk and needs</td>
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<td>3. Receipt of member newsletters with information about health and wellness and disease management programs and how to access services</td>
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<td>4. Episodic educational interventions, as needed</td>
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<td>5. Post hospitalization and emergency room assessment</td>
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<td>6. Access to online wellness portal for self-management support</td>
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<td>7. Health Coaching</td>
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<td>• Bio-psychosocial assessments</td>
<td>Available if self-selected by member</td>
<td>Available if self-selected by member</td>
<td>Additional phone outreach calls are conducted to attempt to engage member in services*</td>
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<td>• Depression screening</td>
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<td>• Identification of barriers preventing one from achieving their health goals</td>
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<td>• Individually tailored interventions, which employ a diverse array of psychological and behavioral change tools to empower individuals to become better self-managers of their health</td>
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<td>• Readiness to change assessments</td>
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<td>• Motivational interviewing for health behavior change</td>
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<td>• Skills-based training</td>
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<td>• Solution-focused therapy</td>
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*Referrals will be made to the Complex Case Management program when appropriate for complex care coordination and assistance obtaining resources.

*Referrals will be made to the Telephonic Counseling for Depression and Anxiety program when appropriate for more intensive therapy and counseling services.