Care Coordination Fundamentals

Student Exercise Book

Course created by Primary Care Development Corporation and 1199 SEIU Training and Employment Funds

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Primary Care Development Corporation

Managing Director

Peter Cucchiara, BSMIS, MBA

Primary Authors and Course Design

Karla Silverman, RN, CNM, MS
Sarah Blust, LMSW, MPH

Contributing Authors

Maia Bhirud, MPH
Deborah Johnson Ingram
Alan Mitchell
Julie Peskoe, MBA, MPH
Therese Wetterman, MPH

Project Coordinator and Graphic Design

Kimberly Mirabella

1199 SEIU Training & Employment Funds

Sandi Vito, Director
1199SEIU/League Training and Upgrading Fund
Greater New York Education Fund

Rebecca Hall, Assistant Director, Fund Sponsored Education Programs

Ellen Ray, Program Specialist III

Eric Johnson, Assistant Director, Admissions & Counseling, HC4 Program

Todd Bennett, Field Coordinator I

Forward by Ronda Kotelchuck, CEO, Primary Care Development Corporation

(from original Care Coordination Fundamentals Course)

Since it was founded in 1993, the Primary Care Development Corporation (PCDC) has worked to fulfill its mission of ensuring every community has access to high quality primary care. Part of that mission is ensuring we have an adequate and well-trained primary care workforce.

The new health care environment requires team-based, coordinated care, where every member of the staff - receptionist, call center worker, social worker, nurse, doctor and maybe others – will be involved in direct patient care. In the past, silos grew around different staff roles. Today, however, every member of the team is an essential part of the patient's care, and must be accountable to each other, as well as the patient, to ensure that patients get the best treatment and services available.

Indeed, "front line" staff are often overlooked. Yet these members of the health care team–who are in contact with the patient first and most often--will play a crucial role in ensuring better health outcomes, greater patient satisfaction and lower costs, but only if they understand what it means to be part of a care coordination team.

PCDC is delighted to have partnered with 1199 SEIU Training and Employment Funds to develop "Care Coordination Fundamentals." This course will help front line health care workers understand and better participate in this new health care environment. It covers the things every front-line worker should know, including chronic disease and mental health and wellness issues, communication skills, health coaching and follow up, care transitions, electronic medical records, and quality improvement. We have successfully pilot-tested the course and it is now being given widely throughout the New York metropolitan area.

We are pleased to broadly offer these tools, which promise that front-line workers will better understand what it means to be part of a care team and be better prepared for an exciting future in primary care. And most importantly, patients will be better served.

Sincerely,

Ronda Kotelchuck
Chief Executive Officer
Primary Care Development Corporation

About This Course

To succeed in today's emerging healthcare models such as health homes, patient centered medical homes and accountable care organizations, frontline healthcare staff members are being asked to serve as a bridge between patients and providers. To accomplish this, frontline staff members require more advanced skills and training than they have received in the past. Specifically, they will need patient navigation and care coordination skills.

Our "Introduction to Healthcare and Care Coordination" curriculum consists of eighteen two-hour classes that are structured to build on one another sequentially. Medical assistants, community health workers, case managers, educators, and health coaches working in team-based healthcare environments can all benefit from this course.

The curriculum introduces staff to the concepts of patient navigation and care coordination, and helps them develop the practical skills needed to provide these services.

Students will experience a highly interactive class environment tailored to adult learners. Our approach strengthens students' critical thinking skills by engaging them in discussion, individual exercises, and group activities. Students will complete the course prepared to assist patients in navigating the healthcare system, and will be strong, productive members of healthcare teams that provide coordinated, patient-centered care.

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Orientation: Care Coordination Basic Skills - Part 1

AGENDA

1. WELCOME AND EXPECTATIONS
2. POWER POINT WITH DISCUSSION:
   WHAT IS CARE COORDINATION?
3. VIDEO:
   UIC SCIENCE BYTES: PATIENT NAVIGATORS
4. POWERPOINT WITH DISCUSSION:
   WHERE DID PATIENT NAVIGATION COME FROM?
5. VIDEO:
   EYE TO EYE: DR. HAROLD FREEMAN
6. VIDEO DISCUSSION
7. POWERPOINT WITH DISCUSSION:
   WHAT SKILLS AND QUALITIES SHOULD STAFF PROVIDING CARE COORDINATION HAVE?
8. BREAK
9. VIDEO:
   KINGS COUNTY PATIENT NAVIGATORS: HEALTHBEAT BROOKLYN
10. VIDEO DISCUSSION
11. GROUP EXERCISE:
    CASE STUDY - MR. A.B.
12. INDIVIDUAL EXERCISE:
    CARE COORDINATION QUIZ
13. WRAP-UP, QUESTIONS, HOMEWORK REVIEW

GROUP EXERCISE: CASE STUDY - MR. A.B.

A.B. is a retired 69-year-old man with a 5-year history of type 2 diabetes.

Referred by his family physician to the diabetes specialty clinic, A.B. presents with recent weight gain, uncontrolled diabetes, and foot pain. Today he has a visit with the diabetes nurse practitioner (N.P.)

Sylvia, the patient navigator, is assigned to A.B. to help him arrange any appointments he might need and answer any questions he might have. After seeing the nurse practitioner, A.B. meets with Sylvia.

In speaking with A.B., Sylvia learns that A.B. does not test his blood glucose levels at home, and expresses doubt that this procedure would help him improve his diabetes control. "What would knowing the numbers do for me?" he asks. "The doctor already knows the sugars are high." A.B. states that he has "never been sick a day in my life."

Although both his mother and father had type-2 diabetes, A.B. has limited knowledge regarding diabetes self-care management, and states that he does not understand why he has diabetes since he never eats sugar. In the past, his wife has encouraged him to treat his diabetes with herbal remedies and weight-loss supplements, and she frequently scans the Internet for the latest diabetes remedies.

During the past year, A.B. has gained 22 lb. He has never seen a dietitian, and has not been instructed in self-monitoring of blood glucose (SMBG).

The N.P. has given him a prescription for a blood glucose meter and test strips, a referral to the diabetes educator who will show him how to use the blood glucose meter, and a referral to the registered dietitian. She has asked him to make a follow up visit with her in one month.

A.B. also has a diagnosis of high blood pressure. The nurse practitioner has started him on medication to control it, and asked him to start checking his blood pressure between visits if possible. The N.P. had suggested there might be a place in his neighborhood such as a senior center or drugstore where he could check it for free but A.B. is unsure where he might do this.

EXERCISE:

As a group, identify the main issues in the scenario. After your group has identified the issues, work together to brainstorm, discuss and decide how staff members providing care coordination would approach and resolve barriers faced by the patient and how to facilitate his care. Remember, there may be more than one way to eliminate or reduce barriers faced by the patient.

Adapted from: Spollett, G., Case Study: A Patient with Uncontrolled Type 2 Diabetes and Complex Comorbidities Whose Diabetes care is Managed by and Advanced Practice Nurse, Diabetes Spectrum, Volume 16, Number 1, 2003

INDIVIDUAL EXERCISE: CARE COORDINATION QUIZ

As a staff member providing care coordination services, I will:

1. Identify any barriers or possible barriers to care.	True	False
2. Streamline appointments and paperwork.	True	False
3. Get involved with direct "hands-on" medical care.	True	False
4. Assist with obtaining financial counseling and services and other resources as needed.	True	False
5. Keep communication open with providers, caregivers and patients in order to coordinate services.	True	False
6. Offer opinions about a diagnosis or health care services.	True	False
7. Provide recommendations or opinions on physicians.	True	False
8. Link patients, caregivers and families with needed follow-up services.	True	False
9. Provide therapy.	True	False

Adapted from: Colonoscopy Patient Navigator Program Orientation Manual, page 9, NYCDOHMH

HOMEWORK FOR NEXT CLASS

Read the article: Medical Report, "Can we lower medical costs by giving the neediest patients better care?" Atul Gawande, The New Yorker, January 24, 2011

Review the discussion questions below as you read the article, since these questions will be discussed in the next class.

http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande

1. What do you think Dr. Brenner means when he says, "emergency room visits and hospital admissions should be considered failures of the healthcare system until proven otherwise."

2. Dr. Brenner's calculations revealed that just 1 percent of the hundred thousand people who made use of Camden's medical facilities accounted for 30 percent of its costs. Why might this be? What is Dr. Brenner's basic approach to helping the patients who are the sickest and are in and out of the hospital multiple times? Does it involve a lot of technology and testing? What does it require?

3. The article mentions a patient with developmental disabilities, high blood pressure and diabetes, who said he was taking his medications, but really wasn't. What intervention did Dr. Brenner's team see as crucial to helping the patient get better?

4. “High-utilizer work is about building relationships with people who are in crisis,” Brenner said. “The ones you build a relationship with, you can change behavior. Half we can build a relationship with. Half we can’t.” What do you think this means? How would this be applicable to your work as a medical assistant or patient service representative?

5. The Special Care Center in Atlantic City employs eight health coaches. What do these health coaches do with patients? What does Fernandopulle say are the most important attributes for a health coach to have?

6. “We recruit for attitude and train for skill,” Fernandopulle said. “We don’t recruit from health care. This kind of care requires a very different mind-set from usual care.” What does Fernandopulle mean?

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http://www.cdc.gov/socialdeterminants/Definitions.html

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A Patient Navigator Manual for Latino Audiences: The Redes En Accion Experience, Institute for Health Promotion Research, UT Health Science Center, San Antonio, Texas

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NIH fact sheets-health disparities:
http://report.nih.gov/nihfactsheets/viewfactsheet.aspx?csid=124

National Quality Forum, NQF-Endorsed Definition and Framework for Measuring Care Coordination, 2006

Safety Net Medical Home Initiative. Horner K, Schaefer S, Wagner E. Care Coordination: Reducing Care Fragmentation in Primary Care. 1st ed. Phillips KE, ed. Seattle, WA: The MacColl Center for Health Care Innovation at the Group Health Research Institute and Qualis Health; April 2011.

Spollett G, Case Study: A Patient with Uncontrolled Type 2 Diabetes and Complex Comorbidities Whose Diabetes care is Managed by Advanced Practice Nurse, Diabetes Spectrum, Volume 16, Number 1, 2003

VIDEOS

UIC Science Bytes: Patient Navigators

http://www.youtube.com/watch?v=GX3mgKyW0sQ

Eye to Eye: Dr. Harold Freeman

http://www.youtube.com/watch?v=DQhUIliZ0N4&feature=related

Kings County Patient Navigators: Healthbeat Brooklyn

http://www.youtube.com/watch?v=DtkcnXrIzpc&feature=related

Orientation: Care Coordination Basic Skills - Part 2

AGENDA

1. WELCOME, FEEDBACK FROM FIRST CLASS
2. HOMEWORK DISCUSSION:
   ATUL GAWANDE ARTICLE
3. POWERPOINT WITH DISCUSSION:
   THE STATE OF HEALTHCARE TODAY:
   CHRONIC DISEASE, NEW MODELS OF HEALTHCARE
4. VIDEOS:
   WITHOUT A MEDICAL HOME;
   WITH A MEDICAL HOME
5. VIDEO DISCUSSION
6. BREAK
7. POWERPOINT WITH DISCUSSION:
   RELATIONSHIPS AND CARE COORDINATION
8. GROUP EXERCISE:
   CARE COORDINATION DUTIES QUIZ
9. POWERPOINT WITH DISCUSSION:
   LEGAL/ETHICAL CONSIDERATIONS
10. GROUP EXERCISE:
    IS THIS A HIPAA VIOLATION?
11. REVIEW HOMEWORK FOR NEXT CLASS,
    WRAP UP

GROUP EXERCISE: CARE COORDINATION DUTIES QUIZ

Read through each scenario and decide whether it would be within your job description to do the following:

1. A 50-year-old woman with asthma and cardiovascular disease has an appointment with a cardiologist and a pulmonologist. You make sure that she understands when and where her appointments are. You confirm that she will be able to take time away from her job to go them. You make sure that her Medicaid managed care plan will cover these visits, and you talk with her about how she will get to these visits. You arrange transportation for her if she needs assistance.

   ___True ___False

2. A 60-year old man with depression tells you that he's really been feeling down lately. You agree to meet with him at the coffee shop down the street so that you can hear about his problems.

   ___True ___False

3. A young woman with obesity and schizophrenia was just referred to a new therapist since her old one has changed jobs. She's upset about having to see this new therapist and tells you that she's not sure if she can make it to the appointment since she's "been so busy lately." You get her home phone number and cell phone number and ask if it would be alright if you called her to see how she is doing. She's says that would be ok. You call her twice over the next week to check on her, and also to remind her that she has an appointment with her therapist coming up and that it's really important that she keep this appointment.

   ___True ___False

4. A 17-year-old pregnant patient has been to the ER three times during the first three months of her pregnancy with severe asthma attacks where she had significant trouble breathing. When you speak to her she tells you that she has not been taking the asthma medication prescribed to her by the nurse-midwife who she sees for prenatal care. Her friend, who is also pregnant, told her the asthma medication would harm her baby. You meet with the patient and recommend that she explain her concerns about the asthma medication to the midwife, and in a prenatal team meeting you explain to the midwife that the patient is not taking her asthma medication because she believes it will harm her baby.

   ___True ___False

5. A 45-year-old man with chronic obstructive pulmonary disease repeatedly misses his appointments with his primary care provider. He was also seen in the ER recently after feeling short of breath and dizzy. You call him at home and speak with him. When you ask the patient why he has been missing his appointments with his doctor, he states that the doctors have his diagnosis wrong and that he is just tired and needs a rest. You meet with his primary care doctor and tell the doctor that he must have the diagnosis wrong for the patient and then make a referral to a specialist.

   ___True ___False

6. A 50-year-old woman recently diagnosed with HIV tells you that she "thinks her life is over" and she is not going to take her medications because "what's the point?" You make sure that she sees the social worker today in the office before she goes home, letting the social worker know that it is "urgent." You also let the patient know that there is a free HIV support group that meets once a week at the church down the street.

   ___True ___False

GROUP EXERCISE:
IS THIS A HIPAA VIOLATION?

Read through each scenario and decide whether it is a HIPAA violation or not.

1. You are riding the elevator with your co-worker at your work. You mention to her that you saw the patient, Sarah Smith and that you feel so sad because she told you that she was just diagnosed with cancer.

2. You work with another patient service representative who has also been having appointments with a doctor at the clinic where you both work. You are curious about why she is seeing the doctor. You pull up her medical record even though she doesn't have a visit that day and look at the notes from her medical visits. You don't share what you learned with anyone.

3. You send patient information to a specialist through a secure encrypted email system that your agency uses for this purpose. The patient has consented in writing to have this information sent to this specialist.

4. A famous person comes to the office where you work. You ask if you can take his picture and he says yes. You post this picture on your Facebook page.

5. In a procedure room for patients there is a list posted on the wall of all the procedures to be done for the day with the full name of each patient next to the time and type of procedure.

6. This conversation takes place at the front desk loud enough for everyone in the waiting room to hear:
Staff: What's your birthday?
Patient: September 23, 1956
Staff: Is your name Peter Jones?
Patient: Yes
Staff: Are you still at 560 west drive?
Patient: Yes

7. A friend of yours says that he knows that his girlfriend went to your doctor's office last week and he is concerned be he doesn't know why she went. He asks if you could "just find out why she was there" and let him know.

8. You are a medical assistant triaging a patient. Your are asking some questions about why the patient is here today. You scroll through his chart and read some of the notes from previous visits and look to see what the medication list from his last visit looks like.

HOMEWORK FOR NEXT CLASS

Read the following for next class:

The Community Health Worker's Sourcebook: A Training Manual for Preventing Heart Disease and Stroke, U.S. Department of Health and Human Services CDC

http://www.cdc.gov/dhdsp/programs/nhdsp_program/chw_sourcebook/pdfs/sourcebook.pdf

Handout 9-1, Handout 9-2.1, Handout 9-2.2, Handout 9-2.3, Handout 9-4, Handout 9-5, Handout 9-6, Handout 9-7, Handout 9-8, Handout 9-9, Handout 9-10, Handout 9-11.1, Handout 9-11.2, Handout 9-11.3, Handout 9-11.4, Handout 9-11.5

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Colorado Patient Navigator Training Program:
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Preventable Hospitalizations in California: Statewide and County Trends in Access to and Quality of Outpatient Care, Measured with Prevention Quality Indicators (PQIs), 1999-2000:
http://www.oshpd.ca.gov/hid/products/preventable_hospitalizations/pdfs/PH_REPORT_WEB.pdf

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Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier. http://www.cancer.gov/dictionary

Safety Net Medical Home Initiative. Horner K, Schaefer S, Wagner E. Care Coordination: Reducing Care Fragmentation in Primary Care. 1st ed. Phillips KE, ed. Seattle, WA: The MacColl Center for Health Care Innovation at the Group Health Research Institute and Qualis Health; April 2011.

VIDEOS

Life With and Life Without a Medical Home:
http://www.youtube.com/watch?v=r6ODEYrh4_I

Common Chronic Diseases - Part 1
Diabetes

AGENDA

1. QUIZ AND DISCUSSION:
   DIABETES, HYPERTENSION AND CARDIOVASCULAR DISEASE
2. POWERPOINT WITH DISCUSSION:
   "CLINICAL" ROLE OF STAFF PROVIDING COORDINATION SERVICES
3. POWERPOINT WITH DISCUSSION:
   BASICS OF DIABETES
4. VIDEO:
   DIABETES - MADE SIMPLE
5. POWERPOINT WITH DISCUSSION:
   DIABETES TESTS, SPECIALISTS, DANGER SIGNS AND SYMPTOMS
6. BREAK
7. VIDEO:
   MAKING SENSE OF DIABETES-TUDIABETES
8. VIDEO DISCUSSION
9. POWERPOINT WITH DISCUSSION:
   COPING WITH A CHRONIC DISEASE
10. POWERPOINT WITH DISCUSSION:
    TALK TO YOUR DOCTOR
11. VIDEO:
    NDEP - GETTING READY FOR YOUR DIABETES CARE VISIT
12. GROUP EXERCISE:
    HELPING A PATIENT GET READY FOR A VISIT TO THE DOCTOR
13. WRAP-UP, QUESTIONS, HOMEWORK ASSIGNMENT

QUIZ: DIABETES, HYPERTENSION, AND CARDIOVASCULAR DISEASE

1. 5% of the US population has diabetes.	True	False
2. The risk for stroke is 2 to four times higher for people who have diabetes.	True	False
3. If you have diabetes it can only be controlled through insulin injections.	True	False
4. Heart failure always comes on quickly.	True	False
5. In the US each year, diabetes causes more than 82,000 people to lose a limb, especially a foot.	True	False
6. Not being physically active puts a person at risk for heart disease.	True	False
7. You can have high blood pressure and feel no symptoms and not know that you have it.	True	False
8. Cigarette smoking raises your cholesterol level.	True	False
9. Having diabetes can damage your eyes and your mouth, teeth and gums.	True	False
10. People with diabetes can prevent or delay some complications by keeping their blood glucose under control	True	False

Created from: The Community Health Worker's Sourcebook: A Training Manual for Preventing Heart Disease and Stroke www.cdc.gov/dhdsp

SMALL GROUP EXERCISE:
HELPING PREPARE A PATIENT FOR A DOCTOR'S VISIT

As a staff member providing coordination services you can help patients to have more productive medical visits with their providers.

Break into groups of 3-4 and brainstorm the answers to these questions and write down your answers-on paper or a white board. Be prepared to report out to the group.

Before the visit:

What information is important for doctors to have when they meet a new patient?

In addition to telling a doctor what is wrong with them today, what other information should patients make sure to tell their providers, especially new providers?

What should patients bring with them to a healthcare visit?

What arrangements does a patient need to make regarding past medical records?

During the visit:

How should a patient behave during a visit to make sure they understand everything that is said?

What things could make it easier for a patient to remember what is said during a healthcare visit?

What could help them remember important information about diagnoses, medications and tests?

After the visit:

What should a patient do if they still have questions when they get home?

What problems should they make sure to let the provider know about and not wait until their next visit?

What should patients expect to be contacted about after a healthcare visit?

Preparing for a medical provider's visit — checklist of things to do and ask the medical/care team

Before the visit:

- ✓ List of all doctors they have seen in the last five years, and type of doctor, including any emergency room visits or admissions to the hospital
- ✓ List of all medications they take or bring all pill bottles
- ✓ List of symptoms they've been experiencing
- ✓ Health diary
- ✓ Make sure that the doctor has their medical records

What to do during the visit:

- ✓ Ask questions
- ✓ Write down or record the answers
- ✓ Take home information
- ✓ Ask for written instructions

After the visit:

- ✓ Did they understand everything that was told to them at the visit?
- ✓ Call the provider's office if they:
    - Have problems following the provider's advice
    - Have any questions
    - Experience worsening of symptoms
    - Experience danger signs and symptoms
    - Have questions about taking their medications
    - Have problems with the medications
    - Had tests done and didn't hear back about the results
- ✓ Write down any answers they get when they call and speak to someone at the provider's office
- ✓ Do they have your number if they have questions?

HOMEWORK FOR NEXT CLASS:

Read the following handouts on hypertension, high blood cholesterol, and asthma.

Hypertension: The Community Health Worker's Sourcebook: A Training Manual for Preventing Heart Disease and Stroke, U.S. Department of Health and Human Services CDC
http://www.cdc.gov/dhdsp/programs/spha/chw_sourcebook/pdfs/sourcebook.pdf

Handout 7-1, Handout 7-2, Handout 7-3, Handout 7-4, Handout 7-5, Handout 7-7

High blood cholesterol: The Community Health Worker's Sourcebook: A Training Manual for Preventing Heart Disease and Stroke, U.S. Department of Health and Human Services CDC
http://www.cdc.gov/dhdsp/programs/spha/chw_sourcebook/pdfs/sourcebook.pdf

Handout 8-1, Handout 8-2, Handout 8-3, Handout 8-4, Handout 8-5

CDC: Asthma
http://www.cdc.gov/asthma/impacts_nation/AsthmaFactSheet.pdf

Pages 1 - 4

Asthma Action Plan
http://www.nhlbi.nih.gov/health/public/lung/asthma/asthma_actplan.pdf

NOTES:

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American Diabetes Association
www.diabetes.org

The Community Health Worker's Sourcebook: A Training Manual for Preventing Heart Disease and Stroke, U.S. Department of Health and Human Services CDC
http://www.cdc.gov/dhdsp/programs/nhdsp_program/chw_sourcebook/pdfs/sourcebook.pdf

Diabetes Resources
1 800 DIABETES

National Heart, Lung and Blood Institute, National Institutes of Health; Department of Health and Human Services
http://www.nhlbi.nih.gov/

VIDEOS

Diabetes Made Simple
http://www.youtube.com/watch?feature=endscreen&v=MGL6km1NBWE&NR=1

Making Sense of Diabetes-Tudiabetes
http://www.youtube.com/watch?v=29bng1H4XTs

NDEP| Getting Ready for Your Diabetes Care Visit
http://www.youtube.com/watch?v=r5gBffSrn4s

Common Chronic Diseases - Part 2
Hypertension/High Cholesterol/Asthma

AGENDA

1. POWERPOINT WITH DISCUSSION:
   BASICS OF HYPERTENSION
2. VIDEO:
   MANAGING HYPERTENSION WITH LIFESTYLE CHANGES
3. POWERPOINT WITH DISCUSSION:
   BASICS OF HIGH CHOLESTEROL
4. GROUP EXERCISE:
   SATURATED FAT IN FOODS
5. GROUP EXERCISE:
   ROSA'S DILEMMA
6. BREAK
7. POWERPOINT WITH DISCUSSION:
   ASTHMA
8. VIDEO:
   LIVING WITH AND MANAGING ASTHMA
9. VIDEO DISCUSSION
10. SMALL GROUP EXERCISE:
    HEALTHY BEHAVIORS: DIET/EXERCISE/SMOKING QUIZ
11. WRAP-UP, QUESTIONS, HOMEWORK ASSIGNMENT

GROUP EXERCISE: ROSA'S DILEMMA: A REAL-LIFE STORY

Rosa is married and has two sons, ages 7 and 10. Her husband Tomás works for a construction company, Monday through Friday. He leaves for work at 6:30 a.m., and returns home at 4:00 p.m. Rosa works Monday through Friday at a restaurant. She leaves home at 10:00 a.m. and returns around 7:00 p.m.

Rosa prepares the family's dinner after she comes home from work every night. Many times, she is too tired to cook, so she often picks up a pepperoni pizza, burgers and fries, or fried chicken on her way home.

Rosa sees that the whole family is gaining weight. Tomás wants her to make traditional Latino dinners. Rosa has tried to get her husband to help with dinner, but he is also very tired. Besides, he thinks that cooking is the woman's job.

What can Rosa do?

Write down some ideas for Rosa to try:

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From: Your Heart, Your Life a Lay Educator's Manual
http://www.nhlbi.nih.gov/health/prof/heart/latino/eng_mnl.pdf

GROUP ACTIVITY:
HEALTHY BEHAVIORS — DIET/EXERCISE/SMOKING QUIZ

Work in groups of 3-4 people to test your knowledge about healthy behaviors and risk factors for diabetes, hypertension, stroke, and asthma.

Circle all the correct answers - there may be more than one.

1. Examples of physical activity include:
   - a. Walking at a brisk pace
   - b. Using the stairs
   - c. Watching television
   - d. Riding a bike
2. Risk factors for diabetes and hypertension include:
   - a. Cigarette smoking
   - b. Being overweight
   - c. Not being physically active
   - d. Not managing stress well
3. For some people, asthma can be triggered by:
   - a. Cockroaches
   - b. Mold inside a house
   - c. Plastic
   - d. Pollen
4. Being more physically active can:
   - a. Improve sleep
   - b. Help reduce stress
   - c. Help lose or maintain a healthy weight
   - d. Give more energy
5. As a person gets older:
   - a. They should reduce the amount of physical activity they do
   - b. They can develop health problems if they are not physically active
   - c. They are at greater risk for heart disease
   - d. They are at lower risk for diabetes
6. Moderate high blood pressure may be controlled or lowered by:
   - a. Reducing the amount of sodium in your diet
   - b. Increasing how physically active you are
   - c. Learning how to manage your stress
   - d. Drinking lots of alcohol
7. The majority of the sodium that we eat and that r raises blood pressure comes from:
   - a. Salt that we add to food
   - b. Canned soup and vegetables
   - c. Frozen dinners
   - d. Salty chips
8. The recommended daily intake for sodium is no more than:
   - a. 2400 milligrams per day
   - b. 3000 milligrams per day
   - c. 1000 milligrams per day
   - d. 6000 milligrams per day

9. Other ways to lower blood pressure are:

a. Doing headstands

b. Eating more fresh fruits and vegetables

c. Eating whole wheat bread

d. Eating low fat dairy products

10. If you have high blood cholesterol:

a. Your risk of having a stroke is increased

b. Your risk of having a heart attack is not increased

c. You will be able to feel it

d. You may need medication to bring it down

11. There are two types of fat — saturated and unsaturated fat. Which of the following are true of these types of fats:

a. Both types of fat are equally bad for you

b. Unsaturated fat is the worst for you

c. Too much saturated fat will raise your cholesterol and risk of heart disease

d. Saturated fat is found mainly in animal products such as meat, whole milk, cheese, butter, lard, ice cream and pastries

12. Some oils are also very high in saturated fat including:

a. Olive oil

b. Palm oil

c. Coconut oil

d. Canola oil

13. Foods that are lower in saturated fat include:

a. Fish, chicken without skin

b. Rice and Beans

c. Fruits and vegetables

d. Cheese

14. Ways to improve your diet include:

a. Cooking more at home

b. Using fewer pre-prepared foods

c. Bringing your lunch from home

d. Eating at fast food restaurants

15. People who smoke:

a. Can always quit when they want to

b. Are negatively affecting the health of those around them

c. Usually need a game plan for managing stress if they are planning to quit cigarettes

d. Can be helped by joining a smoking cessation program if they want to quit

16. Tobacco companies:

a. Target young people in their ads because they know they are likely to be lifelong smokers

b. Go to community events and festivals to promote their products by giving away free merchandise and cigarettes

c. Target particular racial groups who they believe are more likely to take up smoking

d. Are unaware of the thousands of people who die each day from disease related to cigarette smoking

17. When people smoke they are at higher risk for developing:

a. Cancer

b. Emphysema

c. Stroke

d. Wrinkles

18. A diagnosis of high blood pressure is given for people with two separate blood pressure readings that are:

a. Between 110/60 and 120/80

b. Less than 70/50

c. Greater than 140/90

d. Between 135/88 and 139/89

19. A diagnosis of diabetes is given when a fasting blood glucose test result is:

a. > 126

b. < 126

c. > 200

d. Between 100 and 126

20. A reason that patients need to check their blood sugar when they have diabetes is:

a. To avoid complication such as long term complications such as nerve damage, kidney damage and eye damage

b. To toughen up their fingers

c. So they can assess if their diabetes is under control or not

d. So they can adjust their diet and/or medications if their blood glucose is too high or too low

21. In general, asthma treatment involves two types of medicine:

a. Medicine to control and prevent asthma, and quick-acting relief medicine

b. Medicine to clean out the lungs, and quick acting relief medicine

c. Medicine that is taken daily for control and prevention, and medicine that is used to calm and suppress an asthma attack

d. Medicine that is in pill form and medicine that is in inhaler form

22. Carbohydrate intake should be limited for someone who has diabetes. The following are high in carbohydrates:

a. Cheese and nuts

b. Bread and pasta

c. Cakes, donuts, and pastries

d. Fish

NOTES:

RESOURCES

The Community Health Worker's Sourcebook: A Training Manual for Preventing Heart Disease and Stroke,
http://www.cdc.gov/dhdsp/programs/nhdsp_program/chw_sourcebook/pdfs/sourcebook.pdf

CDC: Asthma:
http://www.cdc.gov/asthma/

CDC: Heart Disease and Stroke prevention:
http://www.cdc.gov/heartdisease/

Nutrition and Physical Activity:
http://www.cdc.gov/nutrition/

Tobacco:
http://www.cdc.gov/tobacco/

American Heart Association:
www.americanheart.org

Your Heart, Your Life: A Community Worker's Manual for the Hispanic Community
http://www.nhlbi.nih.gov/health/prof/heart/latino/english/overview.htm

VIDEOS

Managing Hypertension with lifestyle changes
http://www.youtube.com/watch?v=DT2DmGVa2SY

Living With and Managing Asthma
http://www.youtube.com/watch?v=ImYZd6KxO8c

Common Chronic Diseases - Part 3
Heart Disease/Stroke

AGENDA

1. POWERPOINT WITH DISCUSSION: OVERVIEW: HEART DISEASE AND STROKE
2. VIDEO: LIVING WITH AND MANAGING CORONARY ARTERY DISEASE
3. VIDEO: ALL OF OUR STORIES ARE RED: JENNIFER'S STORY
4. VIDEO DISCUSSION
5. POWERPOINT WITH DISCUSSION: HEART ATTACK
6. POWERPOINT WITH DISCUSSION: STROKE
7. VIDEO: STROKE HEROES ACT FAST
8. SMALL GROUP EXERCISE: CULTURE AND CARDIOVASCULAR DISEASE
9. BREAK
10. POWERPOINT WITH DISCUSSION: TAKING MEDICATION
11. SMALL GROUP EXERCISE: HELPING PATIENTS TAKE MEDICATION
12. EXERCISE: JOB DESCRIPTION MATCHING GAME
13. HOMEWORK FOR NEXT CLASS

SMALL GROUP EXERCISE: CULTURE AND CARDIOVASCULAR DISEASE

Break into small groups and discuss the following questions. Be prepared to report back to the group.

1. **How much awareness do you think there is in your community about risk factors and causes of heart attack and stroke? List the things you think people know and don't know.**

2. **Now that you are aware of some of the risk factors and behaviors that can lead to heart attack and stroke, list some things you might do as a staff member.**

3. **List any problems you think you might face when working with patients who have had heart attacks or strokes. For example, issues with taking medicine, fears about tests and procedures, disbelief and denial about risks, differences in perception about heart disease and stroke with men versus women.**

4. **Now for each of the things listed above brainstorm how you might handle the issue and write it below.**

SMALL GROUP EXERCISE: HELPING PATIENTS TAKE MEDICATION

Break into small groups and list all the ways in which healthcare staff might help someone take their medications as prescribed.

Think about how you could help patients be organized, understand more about their medications, keep track of when and how to take them, access resources or specialists who might help them, supply them with guidance on what to do when they are confused, address financial concerns, involve family, etc.

Be prepared to report back to the group.

SMALL GROUP EXERCISE: JOB DESCRIPTIONS MATCHING GAME

Patients who have a chronic disease or diseases often need to see a team of doctors and specialists. As a staff member providing care coordination, you want to be familiar with all of them. Please refer to the list of healthcare staff members who work closely with those patients who have diabetes, hypertension, cardiovascular disease, asthma, cancer, depression schizophrenia, and HIV. Working in small teams, match the job title with the definitions on the second page. Be prepared to report back to the class.

1. Primary Care Physician ____

2. Specialist ____

3. Nurse Practitioner, Nurse Midwife, Physician Assistant ____

4. Nurse ____

5. Medical Assistant ____

6. Social Worker ____

7. Radiologist ____

8. Endocrinologist ____

9. Cardiologist ____

10. Pulmonologist ____

11. Surgeon ____

12. Oncologist ____

13. Administrator ____

14. Certified Diabetes Educator ____

15. Podiatrist ____

16. Registered Dietitian ____

17. Rehabilitation Specialist ____

18. Pharmacist ____

19. Dentist ____

20. Physical Therapist ____

21. Vascular Surgeon ____

22. Pathologist ____

23. Home Health-aid ____

24. Psychiatrist ____

25. Staff member providing care coordination ____

A. Physician who specializes in the diagnosis and treatment of disorders of the heart and heart disease.

B. Doctors who oversee a patients' general health and their treatment. They order tests, make diagnoses, refer to specialists, and follow patients through the process of treatment.

C. Assist patients with activities of daily living-such as eating, bathing, walking- in their home.

D. Diagnoses and treats patients who have specific conditions or diseases. May focus on one particular body system or type of disease.

E. Take vital signs, sometimes obtain patient history, obtain testing results, set up rooms, and send out reminder letters to patients.

F. Have master's degrees and are trained to provide counseling and individual and group therapy for patients and their families. Can be a useful resource for finding support groups and community resources.

G. Doctor who specializes in the reading and interpretation of X-rays and other medical images.

H. Doctor who specializes in the diagnosis and treatment of respiratory disorders.

I. Doctors who specialize in performing surgery, sometimes needed to perform amputations for patients with diabetes.

J. Doctor who specializes in treating patients who have cancer.

K. Oversees patients' general health and treatment. They order tests, make diagnoses, refer to specialists and follow through the process of treatment. They do similar work to doctors but with a more limited scope. They usually have a collaborating physician they work with.

L. Clinic coordinators, schedulers, medical records, medical billing, center directors, office managers.

M. Provide education on diabetes, help patients learn how to self-manage their diabetes and prevent it from getting worse.

N. Treat problems of the feet, prescribe corrective devices, medication, or recommend physical therapy. Some perform foot surgery.

O. Diagnose diseases by examining body tissues.

P. Provide information to patients about nutrition and diet.

Q. A healthcare professional who helps people recover from an illness or injury, such as a stroke or cancer, and return to daily life. Examples of rehabilitation specialists are physical therapists and occupational therapists.

R. Usually in charge of carrying out the plan the doctor has put in place for the patient. Administer medications, monitor side effects, provide education, obtain testing results, monitor patient symptoms, triage.

S. Fill prescriptions and help patients understand medication related side effects.

T. Work with patients to “navigate” the healthcare system and help them overcome barriers to receiving timely care.

U. Support oral health and treat problems of the mouth and teeth.

V. Help patients recover from a stroke or serious injury. They help patients restore the functioning of their body by providing hands on treatment such as stretching and strengthening exercises.

W. Physician whose specialty is surgical solutions to diseases of the body’s blood vessels, including the heart and lymph systems. Treat patients for lymphatic diseases, stroke, aneurysms, varicose veins and other conditions.

X. Doctor who specializes in the health of the endocrine system. They diagnose and treat hormone imbalances including diabetes, thyroid disease, menopause, infertility, bone disease, weight issues, pituitary gland disorders, growth disorders, lipid disorders, cancers of the endocrine glands, metabolic disorders, and hypertension.

Y. A physician who specializes in mental, emotional, or behavioral disorders, licensed to prescribe medication and provide verbal-based psychotherapy.

HOMEWORK FOR NEXT CLASS: HEPATITIS AND HIV

Read the following handouts on hepatitis and HIV.

The ABCs of Hepatitis:

http://www.cdc.gov/hepatitis/resources/professionals/pdfs/abctable.pdf

Hepatitis A:

http://www.cdc.gov/hepatitis/A/PDFs/HepAGeneralFactSheet_BW.pdf

Hepatitis B:

http://www.cdc.gov/hepatitis/HBV/PDFs/HepBGeneralFactSheet-BW.pdf

Hepatitis B and sexual health:

http://www.cdc.gov/hepatitis/HBV/PDFs/HepBSexualHealth-BW.pdf

Hepatitis C:

http://www.cdc.gov/hepatitis/HCV/PDFs/HepCGeneralFactSheet-BW.pdf

Living with Chronic Hepatitis C:

http://www.cdc.gov/hepatitis/HCV/PDFs/HepCLivingWithChronic-BW.pdf

Basic HIV facts:

http://www.cdc.gov/hiv/topics/basic/print/index.htm

HIV trends:

http://www.cdc.gov/hiv/topics/testing/print/trends.htm

HIV challenges:

http://www.cdc.gov/hiv/topics/testing/print/challenges.htm

Condoms and STDs:

http://www.cdc.gov/condomeffectiveness/docs/CondomFactsheetInBrief.pdf

NOTES:

REFERENCES

The Community Health Worker's Sourcebook: A Training Manual for Preventing Heart Disease and Stroke:
http://www.cdc.gov/dhdsp/programs/nhdsp_program/chw_sourcebook/pdfs/sourcebook.pdf

Heart Disease and Stroke Prevention:
www.cdc.gov/dsdsp/

American Heart Association:
www.americanheart.org

American Stroke Association:
www.strokeassociation.org

National Heart, Lung, and Blood Institute:
www.nhlbi.nih.gov

Your Heart, Your Life: A Lay Educator's Manual:
http://hp2010.nhlbihin.net/salud/pa/session2/yhyl_sess2.pdf

VIDEOS

Living With and Managing Coronary Artery Disease
http://www.youtube.com/watch?v=V8lEEqTvBk4

All of Our Stories are Red: Jennifer's Story
https://www.youtube.com/watch?v=I0Rt9qupncM

Stroke Heroes Act Fast
http://www.youtube.com/watch?v=YHzz2cXBlGk

Common Chronic Diseases - Part 4 Hepatitis/HIV

AGENDA

1. HOMEWORK REVIEW/FEEDBACK ON LAST CLASS
2. POWERPOINT WITH DISCUSSION: HEPATITIS A, B, AND C
3. VIDEO: HEPATITIS C MADE SIMPLE: KNOW YOUR STATUS
4. VIDEO DISCUSSION
5. VIDEO: GEORGE'S STORY: HEPATITIS C
6. VIDEO: SU WANG: FACES OF HEPATITIS
7. VIDEO DISCUSSION
8. POWERPOINT WITH DISCUSSION: BASICS OF HIV
9. BREAK
10. VIDEO: FACES OF HIV: KAMARIA'S STORY
11. VIDEO DISCUSSION
12. VIDEO: LIVING WITH HIV
13. GROUP EXERCISE: LIVING WITH HIV
14. HOMEWORK FOR NEXT CLASS

GROUP EXERCISE:
LIVING WITH HIV/STANDING IN THE PATIENT'S SHOES

Imagine that you are HIV positive:

1. What do you think would be the three biggest challenges for you about being HIV positive?

2. What barriers do you think you might face trying to get care for your HIV?

3. What do you think would be the hardest thing about taking care of yourself?

HOMEWORK: FAMILY RELATIONSHIP TO HEALTHCARE

Take a few moments to jot down some descriptions about your family's relationship to healthcare while you were growing up. Be prepared to discuss your answers at the beginning of our next class.

a) When you were young, what did your family do if you had a fever? What, if anything, would they do to try to bring your temperature down?

b) When did you/your family members see a doctor? Did you go for regular appointments or only when you were sick?

c) How did you/your family feel about your regular doctor, if you had one? How did you/your family feel about hospitals?

NOTES:

REFERENCES

CDC:

Hepatitis: http://www.cdc.gov/hepatitis/

CDC: HIV:

http://www.cdc.gov/hiv/default.htm

Mayo Clinic: HIV/AIDS

http://www.mayoclinic.com/health/hiv-aids/DS00005/DSECTION=treatments-and-drugs

PubMed: Hepatitis:

http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002139/

Web MD: A man with HIV infection:

http://www.webmd.com/hiv-aids/guide/man-hiv

Web MD: A woman with HIV:

http://www.webmd.com/hiv-aids/guide/woman-hiv?page=3

Connecting HIV Infected Patients to Care: A Review of Best Practices, The American Academy of HIV Medicine, 1/20/2009

http://www.aahivm.org/Upload_Module/upload/Provider%20Resources/AAHIVMLinkagetoCareReportonBestPractices.pdf

VIDEOS

Hepatitis C Made Simple: Know Your Status

http://www.youtube.com/watch?v=Zl_kw8qHGTI

George’s Story: Hepatitis C

http://www.youtube.com/watch?v=hx33Px8D4yM

Video: Su Wang: Faces of Hepatitis

http://www.youtube.com/watch?v=WeMCoNrX5RM

FACES of HIV: Kamaria’s Story

http://www.youtube.com/watch?v=iQ28d3e3K2k

Living with HIV

http://www.youtube.com/watch?v=uyvovQ_o66A

Bias, Culture, and Values in Healthcare

AGENDA

1. HOMEWORK REVIEW
2. POWERPOINT WITH DISCUSSION:
   CULTURAL COMPETENCE DEFINITIONS
3. EXERCISE:
   VALUES CLARIFICATION
4. POWERPOINT WITH DISCUSSION:
   CULTURAL IDENTITY
5. VIDEO:
   CULTURAL HUMILITY: PEOPLE,
   PRINCIPLES, AND PRACTICES
6. VIDEO DISCUSSION
7. BREAK
8. POWERPOINT WITH DISCUSSION:
   CULTURAL COMPETENT INTERVIEW
   TECHNIQUES
9. ACTIVITY:
   CULTURAL COMPETENCY ROLE PLAY
10. WRAP UP, HOMEWORK FOR
    NEXT CLASS

ROLE-PLAY: CROSS CULTURAL STRATEGIES IN PRACTICE

CARE COORDINATORS

You are a care coordinator who is meeting a patient for the first time. Your new patient was recently diagnosed with diabetes. It's now time to conduct a care coordination intake, in order to understand their specific situation so you can get them what they need. Begin by asking the questions below and follow up with other questions of your own as appropriate. Be sure to occasionally ask open-ended questions. Try to maintain a non-judgmental and neutral attitude — no matter what the patient decides to tell you.

Remember: Respect - Curiosity - Empathy.

- What is your full name and your primary language?
- Tell me about yourself.
- Who lives in the home with you?
- Are you involved in a relationship? (If they say yes, Say: Tell me about it.)
- What kind of work do you do?
- What race do you identify yourself as?
- Can you describe what your current illness or surgery means to you?
- Can you tell me about any special things or processes that you use as a form of relaxation or medication?
- Who (in or outside your family) helps you make decisions about your illness or surgery?
- Can you share your spiritual beliefs including their influence (if any) on your current illness?

ROLE-PLAY: CROSS CULTURAL STRATEGIES IN PRACTICE

Patient

Your name is Martin/Maria Smith. You have been recently diagnosed with diabetes. This is not a huge surprise to you, as many people in your family and community also have diabetes, but you are not happy about this diagnosis. Today you are at the clinic to meet someone new from your care coordination team. You understand that they will be doing an intake in order to figure out what services you need.

Note to student: *You will be asked many questions as part of this assessment. Please feel free to "ad lib" as much as you want; do not provide your own personal information if you do not want to. A helpful approach may be to think about patients you have worked with in the past and bring their stories to this role play. The goal of this role play is to increase the ability of your "care coordinator" to remain respectful, empathic and curious — no matter what you tell them.*
Good luck!

HOMEWORK FOR NEXT CLASS

Read the article:

"Broad Racial Disparities Seen in America's Ills" by Donald G. McNeil Jr.

www.nytimes.com/2011/01/14/health/14cdc.html

We will discuss the article next class.

NOTES:

REFERENCES

Missouri People to People Training Manual, 2008
http://peer.hdwg.org/sites/default/files/Level%201%20Instructor%20Manual.pdf

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Quick Guide to Health Literacy.
http://health.gov/communication/literacy/quickguide/quickguide.pdf

American Psychological Association. Reflections on Cultural Humility. August 2013.
http://www.apa.org/pi/families/resources/newsletter/2013/08/cultural-humility.aspx

Module 1; Ending Invisibility: Better Care for LGBT Populations. The Learning Modules on LGBT Health. The National LGBT Health Education Center, The Fenway Institute, Fenway Health, 2009
http://www.lgbthealtheducation.org/training/learning-modules/

Module 2; Knowing Your Patients: Taking a History and Providing Risk Reduction Counseling. The Learning Modules on LGBT Health. The National LGBT Health Education Center, The Fenway Institute, Fenway Health, 2009
http://www.lgbthealtheducation.org/training/learning-modules/

VIDEO

Cultural Humility: People, Principles and Practices – Part 1 of 4
https://www.youtube.com/watch?v=_Mbu8bvKb_U

Health Disparities

AGENDA

1. POWERPOINT WITH DISCUSSION:
   HEALTH DISPARITIES AND SOCIAL DETERMINANTS OF HEALTH
2. HOMEWORK DISCUSSION:
   BROAD RACIAL DISPARITIES SEEN IN AMERICAN'S ILLS ARTICLE
3. VIDEO:
   UNNATURAL CAUSES…IS INEQUALITY MAKING US SICK?
4. VIDEO DISCUSSION
5. VIDEO:
   LIVING IN DISADVANTAGED NEIGHBORHOODS IS BAD FOR YOUR HEALTH
6. VIDEO DISCUSSION
7. BREAK
8. POWERPOINT WITH DISCUSSION:
   THE ROLE OF CARE COORDINATION IN REDUCING HEALTH DISPARITIES
9. SMALL GROUP EXERCISE:
   HOW CAN CARE COORDINATION DECREASE HEALTH DISPARITIES?
10. EXERCISE DEBRIEF & POWERPOINT
11. POWERPOINT WITH DISCUSSION:
    HEALTH LITERACY & LANGUAGE ACCESS
12. EXERCISE:
    REVIEWING TREATMENT PLANS WITH PATIENTS
13. WRAP-UP

SMALL GROUP EXERCISE: HOW CAN CARE COORDINATION REDUCE HEALTH DISPARITIES?

GROUP #1: PREVENTION & EARLY DETECTION

Brainstorm with your group about what you would do (as care coordination staff) to help your patients get prevention and early detection services. Assign one group member to be a note taker, so you can report back to the group.

SMALL GROUP EXERCISE:
HOW CAN CARE COORDINATION REDUCE HEALTH DISPARITIES?

GROUP #2: HEALTHCARE ACCESS & COORDINATION

Brainstorm with your group about what you would do (as care coordination staff) to ensure your patients have ACCESS to healthcare and coordinated care. Assign one group member to be a note taker, so you can report back to the group.

SMALL GROUP EXERCISE:
HOW CAN CARE COORDINATION REDUCE HEALTH DISPARITIES?

GROUP #3: INSURANCE COVERAGE AND CONTINUITY

Brainstorm with your group about what you would do (as care coordination staff) to ensure your patients can get insurance coverage and insurance continuity. Assign one group member to be a note taker, so you can report back to the group.

SMALL GROUP EXERCISE:
HOW CAN CARE COORDINATION REDUCE HEALTH DISPARITIES?

GROUP #4: DIVERSITY AND CULTURAL COMPETENCY

Brainstorm with your group about what you would do (as care coordination staff) to ensure your patients receive culturally competent services. Assign one group member to be a note taker, so you can report back to the group.

EXERCISE: REVIEWING TREATMENT PLANS WITH PATIENTS

Instructions: In pairs, have one person play the role of the care coordinator, and the other play the role of the patient. As the "care coordinator," pretend to review one of the treatment plans with the "patient" using simple language and checking in with the patient to ensure that he/she understands. Then switch roles and move on to a new treatment plan.

Patient 1

Assessment:

- Uncontrolled Hypertension

Plan:

1-begin Hydrochlorothiazide 25 mg orally once daily

2-referral to primary care doctor within 7 days

3-DASH diet, speak with nutritionist today

4-RTC x 6 months

Patient 2

Assessment:

- Normal IUP at 26 weeks

Plan:

1-GCT , CBC next visit

2-s/s of pre-term labor reviewed with patient

3-RTC x 2 weeks

Patient 3

Assessment:

- + group A strep

Plan:

1-Begin Zithromax 1 tab po qd times x 5days

2-side effects of Zithormax reviewed with patient

3-RTC if no improvement

Patient 4

Assessment:

- Abnormal uterine bleeding

1-begin Alesse today, 1 tab po qd x 3 months

2-side effects, risks, benefits of ocps discussed with patient

3-RTC if bleeding is not reduced or gone within seven days

4-RTC in 3 months

NOTES:

REFERENCES

CDC Health Disparities and Inequalities Report — United States, 2011
http://www.cdc.gov/minorityhealth/CHDIReport.html

Brach C., Fraser I. Reducing disparities through culturally competent health care: An analysis of the business case. Quality Management in Health Care 10(4):15-28, 2002.

Dahlgren, G. and Whitehead, M. (1991). Policies and Strategies to Promote Social Equity in Health. Stockholm: Institute for Futures Studies.

Garrity J. Cultural competence in patient education. Caring Magazine. 32(8): 18-20, Mar. 2000.

Goode T.C. "Self-Assessment checklist for personnel providing primary health care services," from Promoting Cultural Competence and Cultural Diversity for Personnel Providing Services and Supports to Children with Special Health Care Needs and Their Families. Georgetown University Child Development Center (revised 2004).

Improving Patient Safety Systems for Patients with Limited English Proficiency: A Guide for Hospitals.
http://www.ahrq.gov/sites/default/files/publications/files/lepguide.pdf

Joint Commission (2006). Providing culturally and linguistically competent healthcare. Joint Commission, Oakbrook Terrace, IL.

Natale-Pereira, A. et al. The Role of Patient Navigators in Eliminating Health Disparities. Cancer. 117(15): 3543 – 3552. Aug. 2011.

VIDEOS

Unnatural Causes…Is Inequality Making us Sick?
https://www.youtube.com/watch?v=uE7v5cHlHDQ

Living in Disadvantaged Neighborhoods is Bad for Your Health
http://www.youtube.com/watch?v=pzafgHG7EFE

Basic Communication Skills

AGENDA

1. POWERPOINT WITH DISCUSSION: WHAT ARE "EXCELLENT" COMMUNICATION SKILLS?
2. VIDEO: POOR COMMUNICATION
3. VIDEO DISCUSSION
4. POWERPOINT WITH DISCUSSION: BASIC COMMUNICATION SKILLS
5. EXERCISE: ACTIVE LISTENING
6. BREAK
7. POWERPOINT WITH DISCUSSION: COMMUNICATING AS PART OF AN INTERDISCIPLINARY TEAM
8. EXERCISE: CREATING YOUR ELEVATOR SPEECH
9. POWERPOINT WITH DISCUSSION: COMMUNICATING BY PHONE
10. POWERPOINT WITH DISCUSSION: COMMUNICATING BY EMAIL
11. EXERCISE: CONFLICT - HOW DO YOU SEE IT?
12. POWERPOINT WITH DISCUSSION: CARE COORDINATION, CUSTOMER SERVICE, AND CONFLICT MANAGEMENT
13. HOMEWORK REVIEW

ACTIVITY:
CREATING AN ELEVATOR SPEECH ABOUT YOUR ROLE

You can't just expect to be able to explain what you do if you don't think about it ahead of time and practice it. Being able to give an "elevator speech"— a short, simple summary that would only take as long as an elevator ride — about what a staff member who provides care coordination does, is essential to ensuring that you are able to do a good job in your role, and that the staff and the patients you work with know when, and about what, to communicate with you.

A prepared and practiced elevator speech is also a good thing to have for future career advancement. You will want to make it easy for people to understand the skills that you have, how those skills can help patients, how those skills can help a team deliver better care and in what particular way you provide services that other team members don't or can't.

In the space below:

1. Write a short summary of what a staff member who provides care coordination does. Try to provide one or two examples of what kinds of things a staff member who provides care coordination might do, when, and for whom. ***5 min***

____

____

____

2. Make a list of all the positive qualities that you think you in particular bring to the job. Make sure to think about what makes you different and valuable compared to other healthcare team members. List your best attributes (i.e. calm under pressure, friendly, extremely organized)
   Don't forget to list those qualities or skills that are helpful for a coordinator to have (i.e. knowledge of another language, have lived in the same community as the patients for over 20 years, previously worked as a referral coordinator so familiar with all the specialists in the area, etc.) ***5 min***

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3. Now put #1 and #2 together and write your elevator speech. ***5 min***

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ACTIVITY:
CONFLICT - HOW DO YOU SEE IT?

1. How do you define conflict?

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2. What is your typical response to conflict?

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3. What is your greatest strength when dealing with conflict?

____

____

4. If you could change one thing about the way you handle conflict, what would it be? Why?

____

____

5. What is the most important outcome of conflict?

____

____

From: The Big Book of Conflict Resolution Games, Mary Scannell, 2010.
http://www.institutik.cz/wp-content/uploads/2010/10/The-big-book-of-conflict-resolution-games.pdf

HOMEWORK FOR NEXT CLASS

Read “What Can Mississippi Learn from Iran?”

Hand out printed copies or refer students to:

http://www.nytimes.com/2012/07/29/magazine/what-can-mississippis-health-care-system-learn-from-iran.html

HOMEWORK QUESTIONS FOR DISCUSSION

While reading “What Can Mississippi Learn from Iran?” think about the following questions and be prepared to discuss:

1. Did you like the article?
2. What did you find interesting about the article?
3. When Ms. Cox learns that Ms. Wells has been suffering from asthma symptoms at the beginning of the article, she suggest that perhaps something in the house is triggering asthma attacks. What resources does Ms. Cox find to follow up on this idea?
4. In one word, how would you describe Ms. Cox’s approach to care?
5. How do Iranians boost primary care in rural Iran where there are a limited number of doctors?
6. What are similarities between community health workers described in the article and staff who provide care coordination services?

NOTES:

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Addressing Chronic Disease through Community Health Workers

http://www.cdc.gov/dhdsp/docs/chw_brief.pdf

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http://www.nhpf.org/library/issue-briefs/IB846_CHW_09-17-12.pdf

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http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Team-Based-Care.pdf

Conflict Resolution: What Nurses Need to Know, Pam Marshall, May 2006

http://www.mediatecalm.ca/pdfs/what%20nurses%20need%20to%20know.pdf

Customer Service in Health Care Optimizing Your Patient’s Experience by Karen A. Meek

http://pacificmedicalcenters.org/images/uploads/KCMS_Customer_Service_in_Healthcare.pdf

Hope for Customer Service in Health Care?

http://www.cbsnews.com/news/hope-for-customer-service-in-health-care/

The Big Book of Conflict Resolution Games, Mary Scannell, 2010.

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VIDEOS

Poor Communication

http://www.youtube.com/watch?v=W1RY_72O_LQ&feature=related

Accessing Patient Resources

AGENDA

1. HOMEWORK DISCUSSION
2. POWERPOINT WITH DISCUSSION:
   HELPING PATIENTS ACCESS RESOURCES
3. VIDEO:
   MORE THAN A PLACE TO LIVE
4. VIDEO:
   HEALTH ANGELS - HELP FOR SOCIETY'S MOST VULNERABLE PEOPLE
5. VIDEO DISCUSSION
6. POWERPOINT WITH DISCUSSION:
   CREATING A RESOURCE DIRECTORY
7. BREAK
8. POWERPOINT WITH DISCUSSION:
   MAKING COMMUNITY CONNECTIONS
9. EXERCISE:
   GETTING ORGANIZED TO PROVIDE CARE COORDINATION

CARE COORDINATION INTAKE FORM AND TRACKING TOOL

Adapted and copied here with permission from Kansas Cancer Partnership,

www.cancerkansas.org

(Complete this form with the patient at the initial visit.)

Are you the: __ Patient ___Loved One ___Caregiver

Name:

Address:

Telephone number(s):

Email:

Can messages from this office be left at this phone number? ___Yes ___No

Can texts from this office be sent to this number? ___Yes ___No

Can emails be sent from this office to your email? ___Yes ___No

Emergency contact person:

Telephone number:

1. Why were you referred to the care coordination program?

____

____

____

____

____

____

2. How were you referred to the care coordination program?

__ Physician	Name:
__Hospital	Name:
__Clinic	Name of clinic:
__Screening center	Name of center:
__Nurse	Name and department:
__Social worker	Name:
__Other	Please explain below:

____
____
____
____

3. What concerns might keep you from getting to all of your appointments

(for example: child care or transportation needs, job responsibilities, or finances)?

[Note to care coordinator: Refer to list of possible barriers to help patient identify concerns.]

____
____
____
____

4. How do you feel care coordination can best help you?

5. Do you have health insurance? __Yes ___No

If yes, is it: ___ Private/Commercial____ Medicare ___ Medicaid ___Other:

If no, are you currently working on getting health insurance?

(for example: Medicaid, COBRA, etc.)? ___Yes ___No

Please explain: ____
____
____
____
____

6. Are you a citizen of the United States? ___Yes ___No

If no, please provide information about your residency:

____
____
____
____

LEARNING PREFERENCES

7a. What is your native language?____

b. What other languages do you speak?____

What other languages do you write?____

What other languages do you read?____

c. In what language(s) do you feel the most comfortable when you are hearing new information?

____

8. Which of the following methods is most helpful when learning about your health?

(When they are in your preferred language)

(Check all that apply.)

___ Reading ___Watching a video

___ Listening (person-person) ____ Personal demonstration

SUPPORT SYSTEM

9. Who do you have available to help you at this time with issues such as transportation, child care, support, etc.? ____

____

____

10. Who is available to help you at home?

____

____

____

11. How have your family or other loved ones responded when you have needed help?

____

____

____

____

(For Care Coordinator Use Only)

POTENTIAL PROBLEMS/BARRIERS TO CARE

This list is to be used to help you to identify patient concerns at the initial visit and at each follow-up visit. It will help you develop a plan of action, including referrals to appropriate departments.

Health Insurance/Financial Concerns

- Inadequate or lack of insurance coverage
- Pre-certification problems
- Difficulty paying bills
- Need for financial assistance from Medicaid/Medicare
- Confusing financial paperwork
- Need for prescription assistance
- Need for medical equipment or supplies (wheelchairs, dressings)
- Citizenship problems/undocumented status
- Other: ____

Transportation To and From Treatment

- Public transportation needed
- Private transportation needed
- Ambulette (independent ambulance transportation) services required
- Other: ____

Physical Needs

- Child/elder care
- Housing/housing problems
- Food, clothing, other physical needs
- Vocational support (job skills, employment skills)
- Extended care needs: home care, hospice, long-term care
- Other: ____

Communication/Cultural Needs

- Primary language other than English
- Inability to read/write
- Poor health literacy
- Cultural barriers (i.e., effect on lifestyle choices)
- Other: ____

Disease Management

- Treatment compliance issues (missed appointments, unwillingness to take medicine)
- Needs help with obtaining a second opinion (if desired by patient)
- Mental health services needed
- Does not understand treatment plan and/or procedures
- Needs to talk to provider (physician, nurse, therapist, etc.)
- Wants more information about:
- Other: ____

Note to care coordinator: Add to this list as you encounter other barriers to care.

Below is a list of support services. For some of these you may need to suggest that the patient ask his or her health care provider about a referral. For others you may be able to set up an appointment directly. Check with your organization.

Supportive Services for Referrals

- Social workers
- Clergy
- Nutritionists
- Genetic counselors
- Financial counselors
- Physical, occupational, and speech therapists
- Psychologists
- Educators
- Housing
- Substance abuse counselors
- Support groups
- Food pantry
- Specialty Providers____
- Dentist
- Eye doctor

TRACKING TOOL

Refer to POTENTIAL PROBLEMS/BARRIERS TO CARE to explore patient concerns.

Record the results of each intervention or visit with the patient.

Patient name and identification: ____

Date: ____

Reason for visit: ____

Barrier/concern identified: ____

Action to be taken: ____

____

____

Desired result: ____

Resolution and date: ____

Additional comments: ____

____

____

NOTES:

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A Patient Navigator Manual for Latino Audiences: The Redes En Accion Experience. Institute for Health Promotion Research, UT Health Science Center. San Antonio, Texas.

Eat Well Play More Tennessee. Tennessee Statewide Nutrition and Physical Activity Plan: A comprehensive plan to reduce obesity and chronic disease in Tennessee, 2010-2015. Tennessee Department of Health, Authorization No. 343047, Sept. 2010.

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VIDEOS

More Than a Place to Live: The Corporation for Supportive Housing:

http://www.youtube.com/watch?v=X3fvPh7b7HE

Health Angels: Help for Society's Most Vulnerable People

http://www.youtube.com/watch?v=zN5TcrOQ-hs&feature=autoplay&list=PL980E23206527EC51&playnext=2

Basics of Mental Illness and Crisis Management - Part 1

AGENDA

1. INTRODUCTION - CHRONIC DISEASE AND MENTAL HEALTH
2. POWERPOINT WITH DISCUSSION: MENTAL HEALTH AND HEART DISEASE
3. POWERPOINT WITH DISCUSSION: MENTAL HEALTH AND DIABETES
4. VIDEO: WHAT IS DEPRESSION?
5. VIDEO DISCUSSION
6. POWERPOINT WITH DISCUSSION: DEPRESSION
7. VIDEO: HOW IS DEPRESSION TREATED?
8. VIDEO DISCUSSION
9. THE END OF THE DEPRESSION SPECTRUM - SUICIDAL IDEATION
10. ACTIVITY: MYTHS ABOUT SUICIDAL IDEATION
11. BREAK
12. VIDEO: STORIES OF HOPE & RECOVERY - THE JORDAN BURHAM STORY
13. POWERPOINT WITH DISCUSSION: SUICIDAL IDEATION
14. PATIENT HEALTH QUESTIONNAIRE REVIEW
15. ACTIVITY: “PATIENT M” ROLE PLAY
16. POWERPOINT WITH DISCUSSION: ROLE OF CARE COORDINATION IN MENTAL HEALTH
17. WRAP-UP/HOMEWORK

ACTIVITY: MYTHS ABOUT SUICIDAL IDEATION

Decide if the statements below are TRUE or FALSE:

True or False?

People who die from suicide don't warn others.

True or False?

Discussing suicide may cause someone to consider it or make things worse.

True or False?

In a depressed person, once the emotional state improves, the risk of suicide is over.

True or False?

People who talk about suicide are only trying to get attention. They won't really do it.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________ DATE:______________

Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	___ +	___ +	___
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	________
Somewhat difficult	________
Very difficult	________
Extremely difficult	________

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A2663B 10-04-2005

ROLE PLAY: THE PHQ-9

Instructions: Divide into pairs. Decide who will role play as the "Health Professional" and who will role will play as the "Patient." Take a moment to get into character and then begin.

Health Professional

You are a health professional providing care coordination to patients who have chronic disease. You work as part of a care team, including a Care Manager (RN), an MD, a social worker (LCSW), a patient care technician (PCT) and patient care associate (PCA).

You have met "M" before during her check-ups at the hospital. During a care team meeting, the MD expresses frustration that M does not seem to be checking glucose and does not appear to be taking her health very seriously. You have noted on previous visits that while M tells the MD that everything is fine, she does not look happy. You mention this in the care team meeting. The social worker suggests that you screen her for depression at your upcoming home visit. Upon discussion with the care team, it is agreed that you should screen the patient for depression using the PHQ-9. If the patient's symptoms are mild to moderate, you will schedule the patient for a follow-up visit with the social worker. If the patient's symptoms are severe, you will schedule the patient to see the social worker the following day. If the patient expresses suicidal ideation, you will call the social worker for an immediate consultation and not leave the patient alone.

Today you are visiting M in her home for the first time. Even though its 4 PM, you notice that she is still in her bathrobe, her hair hasn't been brushed and it doesn't look like the apartment has been cleaned for weeks. You begin by asking her about the glucose checks.

ROLE PLAY EXERCISE: THE PHQ-9

Instructions: Divide into pairs. Decide who will role play as the "Health Professional" and who will role will play as the "Patient." Take a moment to get into character and then begin.

Patient "M"

You are an older patient (mid-60's) with uncontrolled diabetes. You were diagnosed with diabetes six years ago and can hardly function because of your depression. You are angry about the diagnosis and only find comfort in staying on your sofa and watching your fish swim in its tank. While you are very depressed, you have not had any thoughts about hurting yourself.

You have hardly checked your blood sugar for months and continue to eat candy while taking medicine to help your body handle the sugar. At your regular check-ups, you tell your doctor that "everything's fine." However, today you are getting a home visit from the care coordinator from your hospital care team. You have met the care coordinator before and you like him/her. You haven't told him/her (or anyone) about your feelings of anger and fear about the diagnosis. But maybe today is the day.

NOTES:

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Psych Central – website for patients, advocates and health professionals
http://psychcentral.com/disorders/schizophrenia/

National Institute of Mental Health
http://www.nimh.nih.gov/health/publications/schizophrenia/complete-index.shtml

VIDEOS

What is Depression? – Brooklyn College and Graduate Center, City University of New York
http://www.youtube.com/watch?v=IeZCmqePLzM

How is Depression Treated? - Brooklyn College and Graduate Center, City University of New York
http://www.youtube.com/watch?v=aqCsnXWQlyc

Stories of Hope and Recovery - The Jordan Burnham Story
http://www.youtube.com/watch?v=4EtpEmFDL3Y

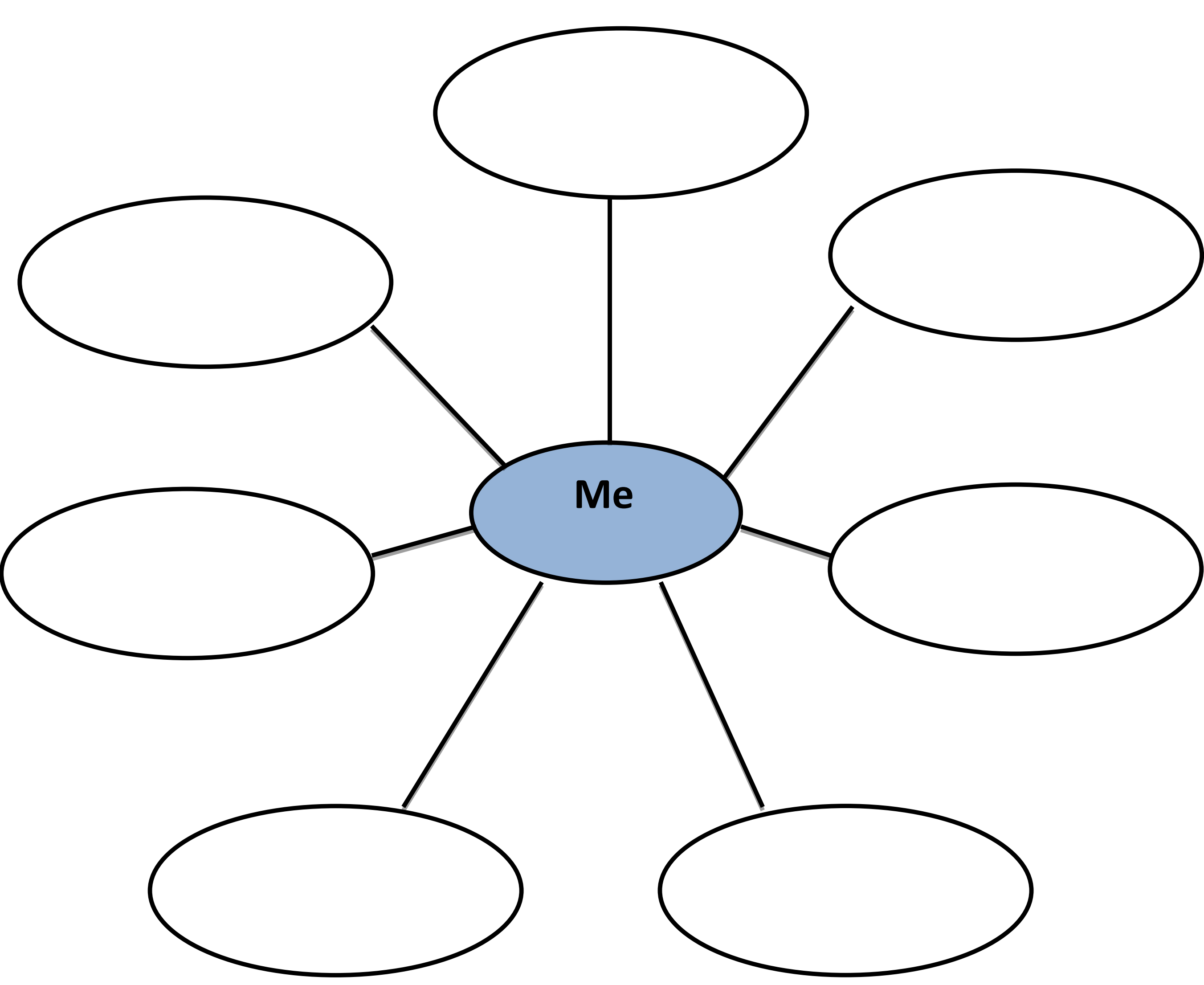
Basics of Mental Illness and Crisis Management - Part 2

AGENDA

1. HOMEWORK REVIEW
2. VIDEO:
   ASHLEY'S STORY
3. VIDEO DISCUSSION
4. POWERPOINT WITH DISCUSSION:
   SCHIZOPHRENIA
5. VIDEO:
   CHOICES IN RECOVERY -
   PHYSICIAN'S PERSPECTIVES
6. VIDEO DISCUSSION
7. POWERPOINT WITH DISCUSSION:
   SOCIAL SUPPORT
8. ACTIVITY:
   IDENTIFY YOUR SOCIAL SUPPORT
   NETWORK
9. POWERPOINT WITH DISCUSSION:
   ASSESSING A PATIENT'S SOCIAL
   SUPPORT SYSTEM
10. POWERPOINT WITH DISCUSSION:
    IMPROVING A PATIENT'S SOCIAL
    SUPPORT SYSTEM
11. POWERPOINT WITH DISCUSSION:
    OVERVIEW OF CRISIS MANAGEMENT
12. WRAP UP

ACTIVITY: IDENTIFY YOUR SOCIAL SUPPORT NETWORK

Instructions: In the spaces below, describe who is in your social support network. We will then discuss how these influences support you in your daily life.



Social Support

The following questions are about how much support you can count on from people around you. People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it?

Please circle one number on each line

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Someone you can count on to listen to you when you need to talk	1	2	3	4	5
Someone to give you good advice about a problem	1	2	3	4	5
Someone to take you to the doctor if you needed it	1	2	3	4	5
Someone to have a good time with	1	2	3	4	5
Someone to help you understand a problem when you need it	1	2	3	4	5
Someone to help you with daily chores if you are sick	1	2	3	4	5
Someone to share your most private worries and fears with	1	2	3	4	5
Someone to do something enjoyable with	1	2	3	4	5
Someone to love and make you feel wanted	1	2	3	4	5

Who helps you the **most** in caring for your diabetes?

- ☐ Spouse
- ☐ Other family members
- ☐ Friends
- ☐ Paid helper
- ☐ Nurse
- ☐ Other health care professional
- ☐ Community Health Worker
- ☐ Other (please specify)
- ☐ No one
- ☐ Doctor
- ☐ Case manager

This product was developed by the Advancing Diabetes Self Management project at La Clinica de La Raza, Inc. in Oakland, CA with support from the Robert Wood Johnson Foundation® in Princeton, NJ.

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National Clearinghouse for Alcohol & Drug Information
http://www.samhsa.gov/

HelpGuide.org
http://helpguide.org/about.htm

VIDEOS

Living with Schizophrenia – Ashley's Story

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Choices in Recovery – Physician's Perspectives

http://www.youtube.com/watch?v=kU7p0u3LOeQ&feature=relmfu

Basics of Mental Illness and Crisis Management - Part 3

AGENDA

1. ACTIVITY:
   WHAT SHOULD I DO?
2. POWERPOINT WITH DISCUSSION:
   COPING STRATEGIES
3. ACTIVITY:
   COPING STRATEGIES BRAINSTORM
4. ACTIVITY DISCUSSION
5. GROUP ACTIVITY:
   CRISIS MANAGEMENT - CHRONIC DISEASE DIAGNOSIS
6. BREAK
7. POWERPOINT WITH DISCUSSION:
   CRISIS MANAGEMENT - SUBSTANCE ABUSE
8. ACTIVITY:
   CRISIS MANAGEMENT - DV/IPV
9. WRAP UP

ACTIVITY: "WHAT DO YOU DO?"

In your role as front-line staff, either behind the front desk or as a medical assistant, you may be working with clients who are going through some type of crisis. While it is not your role to fix the problem for the patient, it is your responsibility to respond sensitively and professionally. Since it can be hard to know what to do in the moment, it is good to think about these kinds of scenarios ahead of time and do some thinking about how to respond to possible tough situations so you are more prepared when they do happen.

Also, remember that you work as part of a team. When thinking about ways to respond to tough patients, think about how to use your team or supervisor so that you are not alone in handling this situation.

Patient Scenarios

A patient is sitting in the waiting room, waiting for her appointment with the provider. You are in charge of registration and processing the patient's paperwork. At some point, you notice this patient is crying. She continues to cry for quite some time and other patients are beginning to look at her. What do you do?

You are working at the front desk in the clinic. A patient is on his cell phone in the waiting area, having a very loud conversation with a partner. The patient is very upset and is using a lot of profanity. The waiting room is full of families, including small children, and you can tell that other patients are getting very uncomfortable. What do you do?

You are working at the front desk in the clinic. It's a very busy day at the clinic and patients have been waiting for hours to see their providers. One patient has been getting very upset with the wait time and has been coming up to the desk many times to ask you when she will be seen. She is now at the desk again and she begins to yell at you about how the services here are terrible and she demands to be seen NOW. What do you do?

You are working as a medical assistant. You start working with a patient, ask her some basic medical questions and take her height and weight. At some point you notice a terrible bruise on her arm. The bruise looks like a handprint on her skin. When she sees you looking at the bruise, she quickly covers her arm with her sweater. What do you do?

You are working as a medical assistant. When you call your next patient back to examining room, her partner tries to come back with her. When you tell him about the clinic policy and how patients are usually examined alone by their provider, the partner gets very angry. He starts to yell at you and demands to be in the room during the exam. When you look at the patient, she says nothing but it's clear she is uncomfortable with her partner's behavior. What do you do?

You are working as a medical assistant. You start working with a patient, ask him some basic medical questions and take his height and weight. At some point, you notice a strong scent of alcohol. When you talk to your patient, you can tell that he is slurring his words and seems very out of it. What do you do?

You are working at the front desk and the waiting room is full, as usual.   You hear a patient yelling at her child to sit down and behave. She slaps the child and the child starts to cry. As the child continues to cry, the patient gets more agitated and yells at the child repeatedly. She hits the child again. Other patients are watching the situation and it's clear they are uncomfortable. What do you do?

COPING STRATEGIES BRAINSTORM

Instructions: What are examples of positive and negative techniques of coping? List them on this handout.

Positive Techniques (Adaptive or Constructive Coping):

- ____
- ____
- ____
- ____
- ____
- ____

Negative Techniques (Maladaptive Coping or Non-Coping):

- ____
- ____
- ____
- ____
- ____
- ____

NOTES:

REFERENCES

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http://www.nnedv.org

National Clearinghouse for Alcohol & Drug Information
http://www.samhsa.gov/

HelpGuide.org
http://helpguide.org/about.htm

Home Visits

AGENDA

1. EXERCISE:
   OPEN FORUM SHARED EXPERIENCES
2. POWER POINT WITH DISCUSSION:
   PRINCIPLES OF HOME VISITING
3. GROUP EXERCISE:
   CASE STUDY - MR. DIAZ
4. POWERPOINT WITH DISCUSSION:
   HOW TO PLAN, CONDUCT AND
   DE-BRIEF HOME VISITS
5. VIDEO:
   NURSE HOME VISITING AT
   COMMONWEALTH CARE ALLIANCE
6. VIDEO DISCUSSION
7. POWERPOINT WITH DISCUSSION
   HOME VISIT BEST PRACTICES
8. GROUP EXERCISE:
   CASE STUDY - MS. JONES

OPEN FORUM: SHARED EXPERIENCES

In your group, assign a note-taker and discuss the following questions. You will be asked to report back on what you discussed.

- Pretend for a moment that you are a patient about to receive a home visit from a care coordinator for help in managing your chronic disease. What would you hope to gain from this visit?
  What would you fear?

- What is the purpose of a home visit when working with patients with chronic illness?

- As a health professional providing care coordination services, how would you facilitate a positive home visit?

- Do home visits differ whether they are for diabetic care, prenatal care or mental health (behavioral health) care? If so, what are some of the differences?

- What are some key areas one should always keep in mind when providing a home visit?

GROUP EXERCISE: HOME VISIT CASE STUDY – MR. DIAZ

Mr. E. Diaz is a 45-year-old man with manic-depressive disorder. He resides independently in a supportive housing apartment program. Mr. Diaz also works part-time; three times a week and participates in a clubhouse program on his off days.

Mr. Diaz is expecting his first home visit from his new care coordinator, Eddie. Mr. Diaz is very anxious and nervous to meet Eddie and hopes this visit goes better than his last visit with his last worker. In preparation for the visit, Mr. Diaz makes an elaborate early dinner for his 5 pm scheduled home visit. Mr. Diaz sets the dining table for two; for him and Eddie.

Upon arrival to the apartment building, Eddie forgets some important documents he needs for the visit. Feeling a bit overwhelmed, Eddie decides not to contact the office to retrieve the documents though he still has a half-hour before the home visit. These forms included a new care coordinator emergency contact list, client information (programming/work schedule) and optional weekend program activity schedule.

Eddie rings the bell to the apartment and receives no response. He waits about 2-5 minutes and rings it again; no answer. Eddie decides to call Mr. Diaz and on the first rings, Mr. Diaz says “You are really early; I can’t allow you in the apartment until 5 pm” and then hangs up.

Eddie is a bit turned off by Mr. Diaz’s response and decides to review Mr. Diaz’s profile and is concerned that Mr. Diaz does not seem “himself” based on what he read. Eddie is 20 minutes early, but figured he could get the visit in early and then head home. But, now he is waiting outside Mr. Diaz’s apartment, Mr. Diaz is refusing to let him in and he is getting really concerned about Mr. Diaz.

EXERCISE:

As a group, identify the main red flags on this potential new home visit. After your group has identified the issues, brainstorm, discuss and decide on how a health professional providing patient care coordination would approach and resolve some of the issues faced by the patient. How can this visit be conducted? If you decide the visit should not be conducted, why not?

GROUP EXERCISE:
HOME VISIT CASE STUDY – MS. JONES

Karen Jones is a 37-year-old diabetic patient who receives ongoing home care services. She currently works part time (three days a week) at a neighborhood coffee shop. Ms. Jones is on a low-sodium, low-fat nutritional diet and has a goal to lose 25 lbs in the next five months. As part of her care plan, home visits are required by a care coordinator every six weeks. Home visits are typically scheduled weeks in advance to accommodate both Ms. Jones and the care coordinators busy schedule.

Jean Smith is Ms. Jones' care coordinator and has worked with Ms. Jones over the last two years. They have developed a great working relationship, which is built on support and trust. Jean feels comfortable talking to Ms. Smith about her health and about any other issues that may compromise her health.

Currently, Ms. Jones is on a very strict medication regimen that requires her to take her medication daily and adhere to her dietary needs. Ms. Jones resides with her husband, her two adolescent children and her mother in-law in a three-bedroom house. Her family's diverse eating habits have made it quite difficult for Ms. Jones to consistently stick to her doctor's orders. Ms. Jones expressed on the previous home visit that she was feeling very stressed about her family's needs and did not know what else to do. Ms. Jones also expressed that her home was not as tidy as she would like it to be; and would appreciate additional support from her family. Jean is anticipating a positive home visit; she hopes Ms. Jones has lost weight and is keeping up with her nutritional diet. Jean will be quite disappointed if Ms. Jones has not kept up with her end of the deal.

Upon entering the home, Jean discovers that fast food containers and bags are on the dining room table and kitchen counter. As she enters the living room area, piles of junk mail and clothes are stacked in the corner of the home. There's a foul odor in the air and her children are arguing with one another in a nearby bedroom. Ms. Jones' mother in-law is snoring on the couch, where the home visit conversations between Ms. Jones and Jean typically occur. Ms. Jones expressed that her husband is working late again.

EXERCISE: As a group, identify areas of concerns for this home visit. As a care coordinator, how should Jean support and facilitate care for her patient? What are the barriers to care? Are there things that Jean should be doing differently? Please discuss and brainstorm on specifics ways to resolve some of the issues mentioned at this visit.

REFERENCES

Effective Use of Home visits: A Supervisor's Companion Guide Developed by the Institute for Human Services for the Ohio Child Welfare Training Program, August 2011

RESOURCES

Making the Most of Home Visits

www.healthychild.net/InSicknessandHealth.php?article_id=98

The "Home Ranger" Rides Again: Making Home Visits Safer and More Effective

http://hpp.sagepub.com/content/9/4/323.full.pdf

Home Visitor's Handbook

www.ehsnrc.org/PDFfiles/EHS-Home-VisitorHdbk.pdf

VIDEOS

Video: Nurse Home Visiting at Commonwealth Care Alliance

http://www.youtube.com/watch?v=emjy2w9RJM0&feature=related

Transitions of Care

AGENDA

1. SMALL GROUP EXERCISE:
   TRANSITIONS OF CARE CASE STUDY
2. VIDEO:
   CIRCLE OF CARE: RETURNING HOME FROM THE HOSPITAL
3. VIDEO DISCUSSION
4. POWER POINT WITH DISCUSSION:
   WHAT IS A CARE TRANSITION?
5. GROUP EXERCISE:
   POOR TRANSITIONS OF CARE
6. BREAK
7. VIDEO:
   UNIVERSITY OF UTAH HEALTH CARE TRANSITIONS PROGRAM
8. VIDEO DISCUSSION
9. POWERPOINT WITH DISCUSSION:
   WHAT CAN CARE COORDINATION DO TO IMPROVE CARE TRANSITIONS?
10. VIDEO:
    COACHING FOR SAFER HEALTHCARE TRANSITIONS
11. VIDEO DISCUSSION
12. GROUP EXERCISE:
    HELPING PATIENTS HAVE BETTER TRANSITIONS OF CARE?
13. VIDEO:
    NORTHERN PIEDMONT COMMUNITY CARE
14. VIDEO DISCUSSION
15. SUMMARY & WRAP-UP

SMALL GROUP EXERCISE: TRANSITIONS OF CARE CASE STUDY

A 40-year-old woman named Gladys who took medication for hypertension, was suffering with dizziness and a severe headache. She went to the ER, because she didn't know she could get a same day appointment with her primary care provider.

In the ER, her blood pressure was very high. She was given another medication to get it under control, in addition to what she was already taking. She was discharged home from the ER and advised to follow up with her doctor.

At home, Gladys was confused. Was she supposed to now take two medications for her high blood pressure? Or was she supposed to just take the new medication that the hospital had given her?

Gladys decided to take only the new medication since she was feeling better and she didn't like the idea of taking two. That seemed like a lot of medication.

A week later, Gladys was rushed to the ER with a stroke that was most likely brought on by extremely high blood pressure that occurred after she stopped taking the first medication prescribed by her primary care provider.

Gladys's primary care provider didn't know that she'd be in the ER or that she'd had a stroke and been in the hospital.

Gladys's primary care provider found out all that had happened to Gladys when she came in to see them for some allergy medicine three months later and a nurse noticed that Gladys was walking with a limp and asked her what had happened.

List all the things that went wrong with this care transition:

GROUP EXERCISE: POOR TRANSITIONS OF CARE

What about each of the scenarios below is not good for the patient and for the healthcare team?

- You or the providers don't know the specialists or offices to whom the patients are being referred.

- Your organization waits for patients to come back to see them before you look for referral reports/There is no system to track referrals.

- Patients complain that the specialist didn't seem to know why they were there for a visit.

- The specialist duplicates tests that the primary care provider has already performed.

- Nobody at your organization knows when one of your patients was seen in the ER.

- Nobody at your organization knows when one of your patients was hospitalized.

- If a patient is being transferred from the hospital to a nursing home or rehabilitation facility your organization may not know about it.

- There is no standard policy at your organization to call a patient recently discharged from the hospital to see how they are doing and schedule a follow up visit for them.

Adapted from The Patient-Centered Medical Home: Care Coordination, Ed Wagner, MD, MPH, MACP, MacColl Institute for Health-care Innovation, Group Health Research Institute

GROUP EXERCISE:
HOW CAN A HEALTHCARE STAFF MEMBER PROVIDING CARE COORDINATION HELP PATIENTS HAVE BETTER TRANSITIONS OF CARE?

Break into small groups. Take a few minutes and think about each scenario. List all of the ways that you think a staff member providing care coordination could help transitions of care be better for patients in the following situations. Be prepared to report out.

- **What tasks will you need to carry out?**
- **What problems might you anticipate?**
- **What resources will these patients possibly need?**

A middle aged patient referred to a specialist

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An adolescent discharged from the hospital

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An elderly patient moving from the hospital to a nursing home

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A young homeless woman discharged from a psychiatric facility

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NOTES:

REFERENCES

Getting to Impact: Harnessing health information technology to support improved care coordination, December 2012
http://statehieresources.org/wp-content/uploads/2013/01/Bright-Spots-Synthesis_Care-Coordination-Part-I_Final_010913.pdf

Coordinating Care: A Perilous Journey through the Health Care System, Thomas Bodenheimer MD, August 2007

Key Changes and Resources for Care Coordination (Reducing Care Fragmentation in Primary Care) MacColl Institute for Healthcare Innovation Group Health Research Institute,
www.improvingchronicillnesscare.org

Reining in Readmissions: Out-of-the-box strategies that get results, March 2011
http://todayshospitalist.com/index.php?b=articles_read&cnt=1184

Safety Net Medical Home Initiative. Long A, Wagner E. Care Coordination: Strategies to Reduce Avoidable Emergency Department Use. Burton T, Phillips KE, eds. Seattle, WA: Qualis Health and MacColl Center for Health; February 2012 Care Innovation

Taking the Pulse of Healthcare Systems: Experiences of Patients with Health Problems in Six Countries." Health Affairs Web Exclusive, November 3, 2005, W5-509-5252

Wagner, E. MD, MPH, MACP, The Patient-Centered Medical Home: Care Coordination, MacColl Institute for Healthcare Innovation, Group Health Research Institute

VIDEOS

Circle of Care: Returning Home from the Hospital
http://www.youtube.com/watch?v=98LTiOWq7VQ&list=PLqF-bKPCi6Cqr2PoNBURCNggW4RYX8qpX&index=2

U of U Health Care- Transitions Program
http://www.youtube.com/watch?v=HClzQLCBRz4&list=PLqF

Northern Piedmont Community Care
http://www.youtube.com/watch?v=Gxfxo3ejP8c&list=PLqF-bKPCi6Cqr2PoNBURCNggW4RYX8qpX

Coaching for Safer Healthcare Transitions
http://www.qualishealthmedicare.org/about-us/results/stepping-stones-(care-transitions-project-of-whatcom-county)/project-videos

Electronic Health Records

AGENDA

1. POWERPOINT WITH DISCUSSION: ELECTRONIC HEALTH RECORDS SYSTEMS
2. VIDEOS:
   EMR TECHNOLOGY IS LIFE CHANGING
   EMR: HELPING DELIVER BETTER PATIENT CARE
3. VIDEO DISCUSSION
4. POWER POINT WITH DISCUSSION:
   EHR AND QUALITY IMPROVEMENT
5. ACTIVITY:
   EHR MATCHING GAME
6. POWER POINT WITH DISCUSSION:
   POPULATION MANAGEMENT AND EHR
7. BREAK
8. POWERPOINT WITH DISCUSSION:
   HEALTH INFORMATION EXCHANGE
9. VIDEO:
   HEALTH INFORMATION EXCHANGE:
   MAKING A DIFFERENCE
10. VIDEO DISCUSSION
11. POWERPOINT WITH DISCUSSION:
    PATIENT PORTALS
12. VIDEO:
    PATIENT PORTALS: PATIENT'S PERSPECTIVES
13. VIDEO DISCUSSION
14. RECAP ACTIVITY
15. POWERPOINT WITH DISCUSSION:
    PRIVACY AND SECURITY
16. VIDEO:
    EHR: PRIVACY AND SECURITY
17. VIDEO DISCUSSION
18. SUMMARY & WRAP-UP

ACTIVITY: EHR MATCHING GAME

Instructions: Match the terms on the left to the definitions on the right.

Term

1. Interoperability _______
2. Electronic Prescribing ______
3. Meaningful Use ______
4. Health Information Exchange _____
5. Personal Health Tools _____

Definition

A. A federal program where bonus payments are provided to doctors and hospitals that meaningfully use EHRs to improve the quality of care, reduce medical errors, and improve efficiency.

B. A function that allows your doctor to enter your prescription into a computer database. The order for the medication is then sent over a network to your pharmacy, which can fill it immediately.

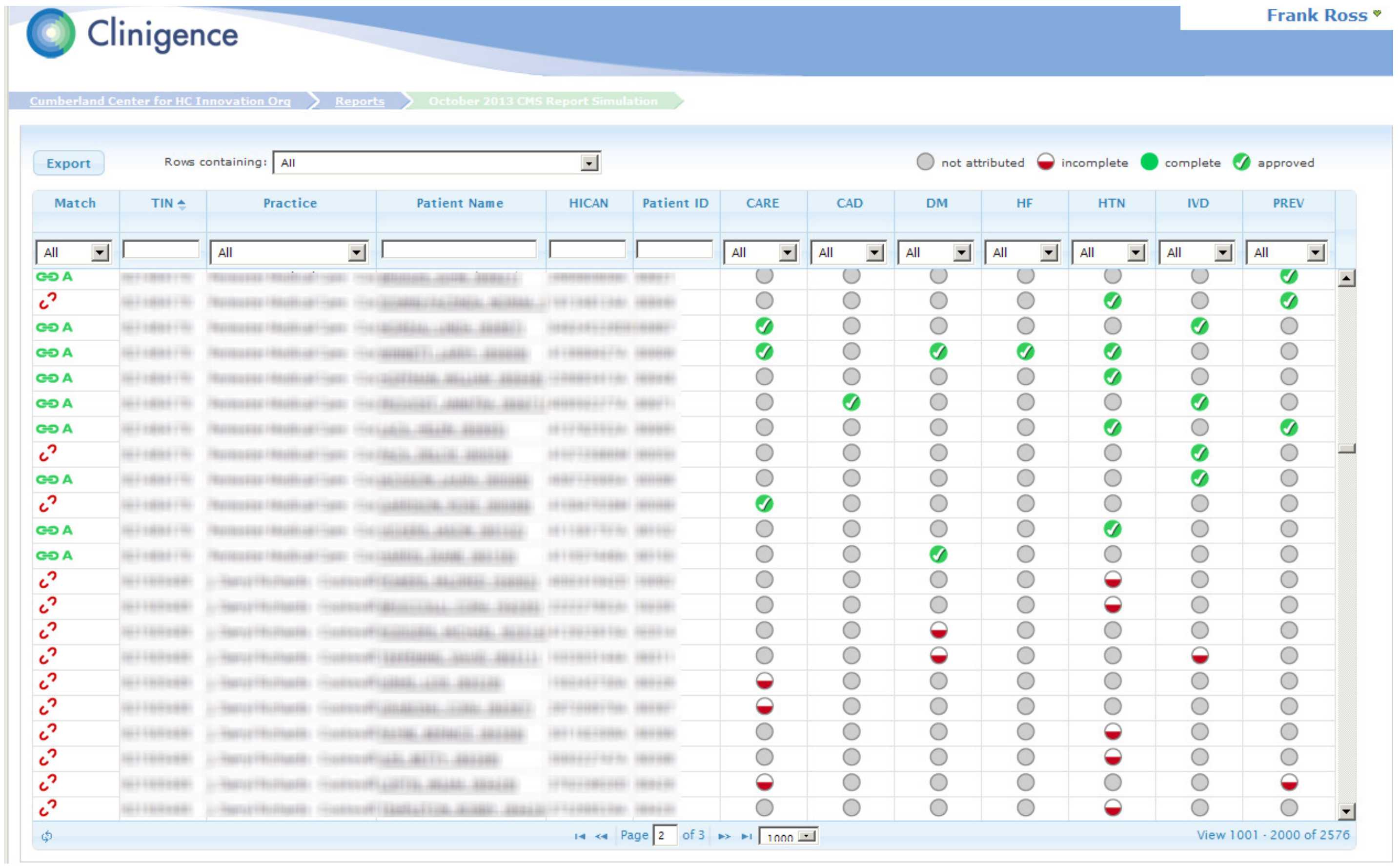
C. The ability of two or more systems to communicate -- or exchange -- information and to use the information that has been exchanged.

D. Functions that help you check your health, get feedback, and keep track of your progress to better manage your health.

E. The movement of health information electronically across multiple organizations

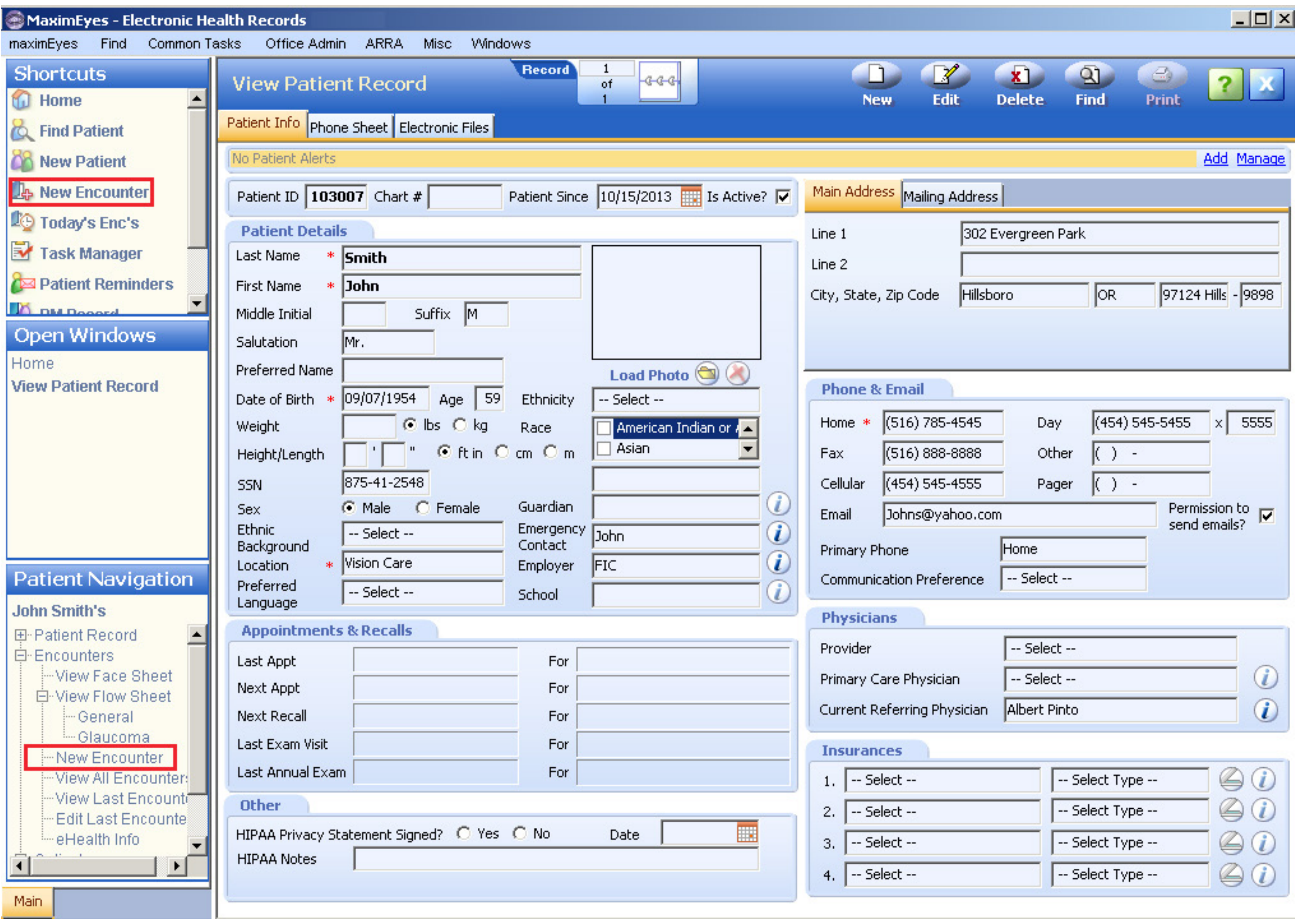
Registries and Population Management

This is a list of patients (blurred out) with indications of services that they may be due for depending on their condition or age and gender.



Collecting Demographic Information

This is a screenshot of a typical demographic template in an EMR.



NOTES:

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Office of the National Coordinator for Health Information Technology

http://healthit.gov

HIPAA

http://www.hhs.gov/ocr/privacy/index.html

Agency for Healthcare Research and Quality (AHRQ)

http://www.ahrq.gov/

VIDEOS

EMR technology is life changing for Markham Family Health Team patient

http://www.youtube.com/watch?v=qwY6E3icOn0

Electronic Medical Records helping deliver better patient care in Markham

http://www.youtube.com/watch?v=lLwD7p7xM90

Video: Health Information Exchange: Making a Difference

http://www.youtube.com/watch?v=fmrgAjJXHUU

Video: Patient Portal: Patients' Perspective

https://www.youtube.com/watch?v=czYtXwbaM58

Video: Electronic Health Records: Privacy and Security

http://www.youtube.com/watch?v=SMUFa5amPKs

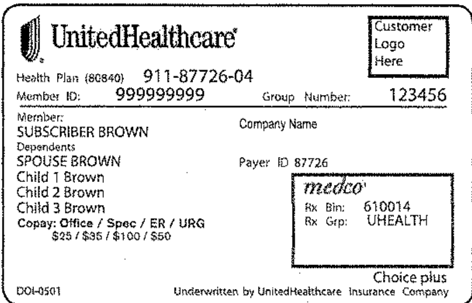
Navigating the Insurance System & Helping the Uninsured

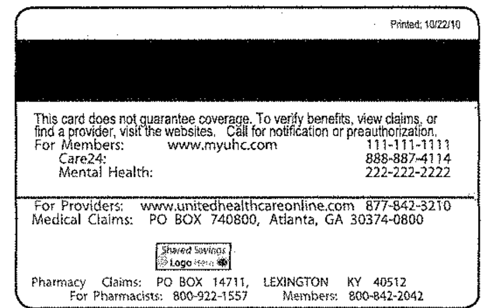
AGENDA

1. POWER POINT WITH DISCUSSION: WHAT IS HEALTH INSURANCE?
2. VIDEO WITH DISCUSSION: WHY IS HEALTHCARE SO EXPENSIVE?
3. POWER POINT WITH DISCUSSION: PUBLIC AND PRIVATE INSURANCE
4. VIDEO WITH DISCUSSION: THE AFFORDABLE CARE ACT
5. BREAK
6. POWERPOINT WITH DISCUSSION: HELPING PATIENTS USE THEIR INSURANCE
7. VIDEO WITH DISCUSSION: PRIOR AUTHORIZATIONS AND REFERRALS
8. POWERPOINT WITH DISCUSSION: HELPING PATIENTS USE THEIR INSURANCE (CONTINUED)
9. EXERCISE: HELPING YOUR PATIENTS NAVIGATE THE INSURANCE SYSTEM
10. POWERPOINT WITH DISCUSSION: HELPING UNINSURED PATIENTS NAVIGATE THE INSURANCE SYSTEM
11. SUMMARY & WRAP-UP

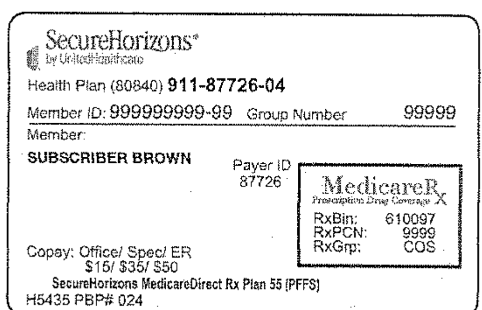
Samples of Commercial, Medicare and Medicaid Health Care ID cards

Commercial Plans – Sample Cards

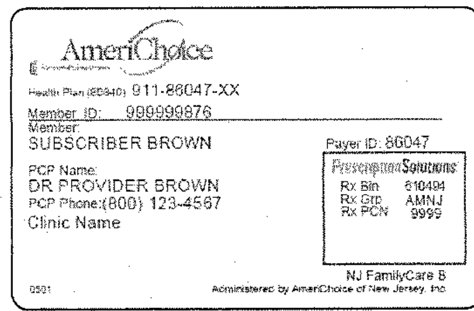


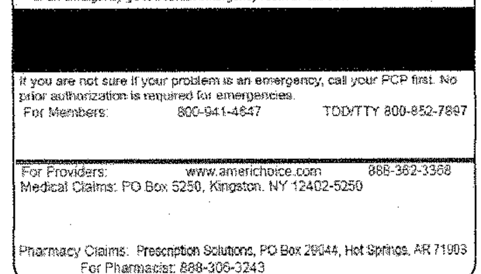


Medicare Plans – Sample Cards



Medicaid Plans – Sample Cards





HEALTH INSURANCE GLOSSARY MATCHING GAME

Match the health insurance term with the definitions on the next page.

1. Commercial Insurance ____
2. Fee for Service ____
3. Managed Care Plans ____
4. Medicare ____
5. Medicaid ____
6. Networks ____
7. Prior Authorization ____
8. Primary Care Provider (PCP) ____
9. Referral ____
10. Sliding Fee Scale ____

A. A tool used by Community Health Centers, Family Planning Centers and other nonprofit organizations to provide services to the community based on their ability to pay for those services. In some cases, it may be necessary to for a patient to prove their income to obtain services using this tool.

B. From the patient's perspective, an important feature of all of these types of plans is that they in some way restrict or limit coverage for the providers and hospitals that a plan participant can use. Plan types include Health Maintenance Organizations, Preferred Provider Organizations, Independent Practice Associations, etc.

C. Managed care plans and some Fee for Service plans limit their insured patients' access to provider by providing financial incentive to use a specific group of providers and hospitals.

D. A public health insurance program for individuals and families of low socioeconomic status that is run by both the federal and state governments.

E. A public health insurance program for citizens aged 65 years and older and disabled citizens that is run by the federal government.

F. Plans are generally less restrictive health insurance plans (than Managed Care Plans) that allow patients to select providers and services. Patients can chose which providers they want to use (without respect to their insurance) and providers are compensated for service they provide. In some cases, these plans restrict the level of coverage or the group of providers a patient can see.

G. In addition to a Referral from a Primary Care Provider, some procedures or services require the permission of a patient's health insurance or managed care plan. This permission is usually required in advance of the patient receiving the services.

H. Insurance plans offered through employers or paid for by individuals on their own. This includes plans that are offered through professional associations, alumni groups and COBRA.

I. The medical professional assigned or selected by the patient to be their primary point of contact within a Managed Care Plan. This professional is both a provider of services and a point of contact for specialty services.

J. Primary Care Providers send patients to see specialists or receive tests.

NOTES:

REFERENCES

Medline Plus: Health Insurance
http://www.nlm.nih.gov/medlineplus/healthinsurance.html

Medicare.gov: "Welcome to Medicare"
http://www.medicare.gov/people-like-me/new-to-medicare/welcome-to-medicare-visit.html

Kaiser Family Foundation: Key Facts about the Uninsured Population
http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

Medicaid.gov
http://www.medicaid.gov

Healthcare.gov
http://www.healthcare.gov

VIDEOS

Why healthcare is so expensive
http://money.cnn.com/video/news/economy/2014/10/21/we-the-economy-this-wont-hurt-a-bit.cnnmoney/

Get ready for Obamacare
http://www.youtube.com/watch?v=JZkk6ueZt-U

Prior authorizations and referrals
http://www.youtube.com/watch?v=mqExWvoOqIQ

Motivational Interviewing - Part 1

AGENDA

1. POWERPOINT WITH DISCUSSION:
   WHAT IS MOTIVATIONAL INTERVIEWING?
2. VIDEO:
   DR. WILLIAM MILLER: MOTIVATIONAL INTERVIEWING
3. VIDEO DISCUSSION
4. POWERPOINT WITH DISCUSSION:
   WHAT IS MOTIVATIONAL INTERVIEWING - CONTINUED
5. VIDEO:
   HOW NOT TO DO MOTIVATIONAL INTERVIEWING: A CONVERSATION WITH SAL
6. VIDEO DISCUSSION
7. BREAK
8. POWERPOINT WITH DISCUSSION:
   MOTIVATIONAL INTERVIEWING TECHNIQUES
9. GROUP EXERCISE:
   REFLECTIVE LISTENING
10. VIDEO EXERCISE:
    MOTIVATIONAL INTERVIEWING:
    A CONVERSATION WITH SAL
11. VIDEO DISCUSSION

GROUP ACTIVITY:
REFLECTIVE LISTENING – BREAST CANCER SCREENING

	Patient	Care Coordinator
Repeating (Used to diffuse resistance)	"I don't want to have a mammogram."	"You don't want to have a mammogram."
Rephrasing (Slightly alters what the patient says to provide the patient with a different point of view)	"I want to have a mammogram but last time I did it, it hurt too much."	"Having a mammogram is important to you."
Empathic reflection (Provides understanding for the patient's situation)	"You've probably never had to deal with anything like this."	"It's hard to imagine how I could possibly understand."
Reframing (Helps the patient think about his or her situation differently)	"I keep trying to schedule a mammogram, but I don't have the time because of the kids and my job."	"You are persistent, even when things are really difficult. Getting a mammogram is important to you."

OARS Coding Sheet

Open Questions	
Affirmations	
Reflections	
Summaries	

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NOTES:

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Rollnick S, Miller W, Butler C. Motivational Interviewing in Health Care; Helping Patients Change Behavior. NY: Guilford Press.

Rosengren, D. Building Motivational Interviewing Skills; A Practitioner Workbook. NY: Guilford Press.

WEB RESOURCES

http://www.motivationalinterview.org/
http://motivationalinterviewing.org/about_mint

VIDEOS

Video: Dr. William Miller, "Motivational Interviewing" www.pyschotherapy.net
http://www.youtube.com/watch?v=cj1BDPBE6Wk

Video: How Not to Do Motivational Interviewing: A Conversation with Sal about managing his asthma
http://www.youtube.com/watch?v=kN7T-cmb_l0

Video: Motivational Interviewing: A Conversation with Sal about managing his asthma
http://www.youtube.com/watch?v=-RXy8Li3ZaE

Motivational Interviewing - Part 2

AGENDA

1. POWERPOINT WITH DISCUSSION:
   SPIRIT OF MI, OARS AND CHANGE TALK
2. VIDEO EXERCISE:
   THE EFFECTIVE PHYSICIAN
3. VIDEO DISCUSSION
4. POWERPOINT WITH DISCUSSION:
   BRIEF NEGOTIATED INTERVIEWING (BNI)
5. VIDEO:
   BNI CASE STUDY; DOCTOR A
6. VIDEO:
   BNI CASE STUDY; DOCTOR B
7. VIDEO DISCUSSION
8. BREAK
9. POWERPOINT WITH DISCUSSION:
   BNI STEPS
10. GROUP ACTIVITY:
    MI/BNI PRACTICE SESSION
11. MI/BNI PRACTICE SESSION DE-BRIEF

OBSERVER SCENARIO: MI PRACTICE SESSION

You are about to observe a practice session on Motivational Interviewing between a “Health Coach” and “Patient K.” Patient K has a history of diabetes and high blood pressure and has not been able to quit drinking, which is a major risk factor for heart attacks. The focus of this session will be to address Patient K’s ambivalence about quitting drinking.

Please observe the session and make hash/tally marks below when you see the Health Coach using the following MI techniques – Open-ended Questions, Affirmative Statements, Reflective Listening, and Summary Statements. Please share with your group once the session is complete. This will let the “Health Coach” know how much they have incorporated MI techniques into their work.

Open-ended Questions

Affirmative Statements

Reflective Listening

Summary Statements

PATIENT "K" SCENARIO: MI PRACTICE SESSION

You are a patient at Hospital X. Several years ago, you were diagnosed with diabetes.   Recently, your doctor told you that you have high blood pressure and recommended that you start meeting with the hospital health coach to manage your blood pressure and diabetes.

So far, you have met with the health coach twice, and together, you have developed a plan to help improve your diet, such as eating more fruits and vegetables, and exercising.   However, you know that your alcohol use is also a problem. You have been told that you shouldn't drink alcohol because of your high blood pressure and diabetes, but you are finding it hard to stop. Right now you are experiencing a lot of stress at work and having a few drinks with your co-workers after hours seems to help relieve your stress. Also, since your friends (including your partner) all like to drink when you get together, your social life revolves around drinking. Sometimes you wake up with a hangover, but for the most part, you feel you have your drinking under control. It is something you enjoy, but you know it's not good for you.

At the last visit with the health coach, he/she asked if it would be okay to talk about drinking at your next visit. You are here for that visit today and you are not looking forward to this conversation.

HEALTH COACH SCENARIO: MI PRACTICE SESSION

You are a Health Coach at Hospital X. You work with patients who have chronic diseases, such as diabetes and help them make any lifestyle changes that would help them stay healthy.

You have recently begun working with Patient "K." K was diagnosed with diabetes several years ago and was recently told by the doctor that he/she has high blood pressure. K's doctor has told you that she is concerned particularly about K's social binge drinking and how this could affect K's blood pressure. While you have worked with K on a few lifestyle changes, such as diet and exercise, you know that you need to address the issue of alcohol. When you mentioned alcohol to K at a previous visit, you could tell that K was very ambivalent about reducing/quitting drinking. You have decided that using Motivational Interviewing techniques might help K explore K's ambivalence and help K think about making some changes.

Using the Brief Negotiated Interview (BNI) Scoring Sheet, you will conduct a health coaching session with K, using Motivational Interviewing techniques. Work through the checklist one by one. As you listen to K, try to use OARS; Open-ended questions, Affirmative Statements, Reflective Listening, and Summary Statements. Besides K, you will have an "Observer" in your group, who will note how many of these techniques you use in this session. The Observer will provide this feedback to you at the end of your session.

Note: *The BNI scoring sheet is used in the field by community health workers and uses a harm reduction approach. When sharing information and discussing, you should talk to K about how to reduce unhealthy behaviors safely, as many people find it easier to reduce/modify behaviors rather than stopping completely. You can let K know that:*

- *Diabetics taking medication to control blood sugar levels should first ask their doctor if it is okay to drink alcohol with their specific medication.*
- *For those taking medication, it is recommended to limit alcohol intake to one drink for women and two drinks for men. Even two ounces of alcohol can interfere with the liver's ability to produce glucose.*
- *The American Diabetes Association recommends that diabetics never drink on an empty stomach in order to protect themselves from low blood sugar -- drinking only after a meal or a snack.*
- *The Association also recommends that diabetics who have had something to drink check their blood sugar before going to sleep. They also recommend "eating a snack before you retiring to avoid a low blood sugar reaction while you sleep."*

Brief Negotiated Interview (BNI) Scoring Sheet
(Adapted from the BNI-ART Institute)

Note: this outline uses the example of drinking alcohol, but "drinking alcohol" can be replaced with any other potentially harmful action, for example "skipping doses of medication," "sex without protection," or "drinking soda."

1. Day in the life
   - ☐ Ask for permission to talk about drinking.
   - ☐ How does drinking fit into your life?
   - ☐ What does drinking mean for you?

2. Pros and cons
   - ☐ What are the good things about drinking?
     - o What are some more good things about drinking?
   - ☐ What the not so good things about drinking?
     - o What are some more not so good things about drinking?
   - ☐ Summarize in the patient's own words
   - ☐ So where does that leave us?

3. Sharing information and discussion
   - ☐ Ask permission to share some information about safe drinking
   - ☐ Share information
   - ☐ What do you think about this information?

4. Assess readiness to change
   - ☐ Use readiness to change ruler
     - o How ready are you to make a change?
   - ☐ Reinforce positives
   - ☐ Why not less?
   - ☐ Ask about other reasons for changing
   - ☐ Ask about strengths and supports. Past experiences.

0	1	2	3	4	5	6	7	8	9	10
Not Ready			Unsure			A little ready			Very ready	

5. Set a goal
   - ☐ Ask about specific steps needed to make a change
   - ☐ Summarize in the patient's own words
   - ☐ Commitment (prescription for change sheet or non-written alternative)

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http://familymedicine.medschool.ucsf.edu/cepc/pdf/HealthCoachTrainingCurriculumMay08.pdf

Lorig, Holman, et al, Living a Healthy Life with Chronic Conditions. Boulder, Colorado, Bull Publishing, 2006.

Barnes, J. Slavin, S. HOPE (HIV Outreach & Patient Empowerment)/PACT (Prevention & Access to Care & Treatment) Training: Motivational Interviewing for Accompaniment in HIV Care, 2012

Boston University, BNI-ART Institute
http://www.bu.edu/bniart/sbirt-in-health-care/

VIDEOS

BNI Case Example; Doctor A, Boston University, BNI-ART Institute
http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-videos/

BNI Case Example; Doctor B, Boston University, BNI-ART Institute
http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-videos/

The Effective Physician: Motivational Interviewing Demonstration
http://www.youtube.com/watch?v=URiKA7CKtfc

Demonstration of the motivational interviewing approach in a brief medical encounter. Produced by University of Florida Department of Psychiatry. Funded by Flight Attendant Medical Research Institute Grant #63504 (Co-PIs: Gold & Merlo).

Health Coaching and Patient Care Follow-Up Part 1

AGENDA

1. POWERPOINT WITH DISCUSSION:
   HEALTH COACHING AND CARE PLANS
2. VIDEO:
   COACHING PATIENTS FOR SUCCESSFUL SELF-MANAGEMENT
3. VIDEO DISCUSSION
4. POWERPOINT WITH DISCUSSION:
   THE SPECIFIC TASKS OF A HEALTH COACH
5. BREAK
6. VIDEO (SECOND HALF):
   COACHING PATIENTS FOR SUCCESSFUL SELF-MANAGEMENT
7. VIDEO DISCUSSION
8. EXERCISE:
   SETTING AGENDAS WITH PATIENTS
9. HOMEWORK REVIEW

EXERCISE: SETTING AGENDAS WITH PATIENTS

Dialogues reprinted here with permission from Dr. Bodenheimer from:
Bodenheimer, T. Training Curriculum for Health Coaches, May 2008
http://familymedicine.medschool.ucsf.edu/cepc/pdf/HealthCoachTrainingCurriculumMay08.pdf

DIALOGUE 1

Caregiver: Hello. It's good to see you. I want to talk about your cholesterol.

Patient: What's wrong with my cholesterol? I have a very bad headache.

Caregiver: Your LDL cholesterol has gone up to 150. We need to get it down.

Patient: Oh.

Caregiver: I'm going to give you some pills called Pravastatin. Take one every day and try to stay away from fried foods, cheese and butter. I'll see you again in a month.

Patient: My headache…

Caregiver: We'll deal with that next time

DIALOGUE 2

Caregiver: Hello. It's good to see you. Let's figure out how we can best spend our time together.

Patient: I have a bad headache.

Caregiver: OK. We'll talk about that. Are there other things you are concerned about?

Patient: I don't think so.

Caregiver: There is one other thing I'd like to talk about, which is your cholesterol. Would that

be OK after we deal with the headache?

Patient: OK.

DIALOGUE 3

Caregiver: Hello. It's good to see you. What brings you here today?

Patient: I have a bad headache. And my right leg is swollen.

Caregiver: OK. We'll talk about those things. Is there anything else you are concerned about?

Patient: My favorite sister was just told she has cancer. I'm scared that I might have it too. And I have this form to fill out for my night school class.

Caregiver: OK. It seems that there are 4 things on your mind: headache, right leg, worry about having cancer, and a form to fill out. I don't think we can do all this in the 15 minutes that we have together. Why don't we talk about the headache and the leg, and order some tests to make sure your general health is OK so that we can talk about our worry about cancer next time. Can the school form wait until next time?

DIALOGUE 4

Caregiver: Hello. It's good to see you. What brings you here today?

Patient: You told me to come. Is there something really wrong with me?

Caregiver: I wanted to talk about your cholesterol. It's gone up again. But why don't we see first

if you have any other concerns that you want to talk about?

Patient: How can I get my cholesterol back down? I need to get it down. My father had a heart attack when he was 51 years old.

Caregiver: OK. [They discuss the cholesterol.] Why don't you get a blood test in a month and then see me about the cholesterol.

Patient: OK.

Caregiver: (opening the door to leave): See you next time.

Patient: By the way, I have blood in my urine.

HOMEWORK FOR NEXT CLASS

Read the following article for next class:

Victoria Ngo, BA, Hali Hammer, MD, and Thomas Bodenheimer, MD, Health Coaching in the Teamlet Model: A Case Study, Department of Family and Community Medicine, University of California, San Francisco, CA, USA.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2988157/pdf/11606_2010_Article_1508.pdf

Keep the following questions in mind while you read. We will discuss next class.

1. When does the health coach Victoria Ngo meet or interact with the patient?

2. What things do Dr. Hammer and Victoria do to improve communication and anticipate how to best address patients' concerns?

3. What might the health coach do between visits with patients?

4. What operational challenges did Dr. Hammer and Victoria Ngo run into?

5. In the stories presented, what are some of the strategies that the coaches use to foster trust with their patients?

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http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2988157/pdf/11606_2010_Article_1508.pdf

VIDEOS

Coaching patients for successful self-management
http://youtube/DmNBOVykeoM

Health Coaching and Patient Care Follow-Up Part 2

AGENDA

1. POWERPOINT WITH DISCUSSION:
   GAINING TRUST AS A HEALTH COACH
2. HOMEWORK DISCUSSION
3. POWERPOINT WITH DISCUSSION:
   PROVIDING HEALTH COACHING
4. EXERCISE:
   MAKING BEHAVIOR-CHANGE ACTION PLANS WITH THE PATIENT
5. BREAK
6. POWERPOINT WITH DISCUSSION:
   PROBLEM SOLVING AS A COACH
7. POWERPOINT WITH DISCUSSION:
   MEDICATION TRAINING
8. VIDEO:
   HEALTH COACHING (MEDICATION RECONCILIATION)
9. VIDEO DISCUSSION
10. EXERCISE:
    CLOSING THE LOOP

EXERCISE: MAKING BEHAVIOR CHANGE ACTION PLANS WITH THE PATIENT

<u>**Dialogue 1**</u>

Caregiver: Your last test shows your HbA1c has gone up to 9.2. What do you think about that?

Patient: I don't know. I'm taking my pills, I thought if I took them I didn't have to worry about eating candy and sweets every day; the pills are supposed to protect me.

Caregiver: What is it you like about eating candy?

Patient: I love chocolate; it's kind of comforting, I have all these things that stress me out, but I know that chocolate is one thing in my day I will definitely enjoy.

Caregiver: That makes sense. Is there anything you don't like about eating chocolate?

Patient: Well, it messes up that sugar. But I don't want to give it up, it makes me happy.

Caregiver: Is there anything else you enjoy doing that reduces your stress but doesn't get your HbA1c so high?

Patient: Maybe walking around the block a couple of times.

Caregiver: Do you want to give that a try?

Patient: Sure, but I'm not promising to give up chocolate.

Caregiver: I understand. Let's do a reality check? How sure are you that you can walk around the block a couple of times when you feel stress? Let's use a "0 to 10" scale: "0" means you aren't sure you can succeed and "10" means you are very sure you can succeed.

Patient: I can do it; I'm 100% sure.

Caregiver: Why don't we call it your action plan -- you will walk around the block two times when you feel the stress coming on. When do you want to start?

Patient: We'll see.

Caregiver: Do you want to start this week?

Patient: That might work

Caregiver: OK. Why don't we agree that you will walk around the block two times when you feel stress? Could I call you next week to see how it's going?

Patient: OK.

Discussion

When the patient mentions an unhealthy behavior (chocolate), the caregiver doesn't challenge it, but uses a Motivational Interviewing technique: what do you like and what don't you like about the unhealthy behavior. This encourages the patient, not the caregiver, to talk about change (what he/she *doesn't* like). This may uncover a topic for an action plan – in this case, relieving stress.

The caregiver does not judge the patient's behavior. When the patient says: "I'm not promising to give up chocolate," the caregiver doesn't make a judgment, but says: "I understand," and moves on. It wouldn't make sense to lecture the patient on why chocolate is not healthy because the patient already knows ("it messes up that sugar thing").

The action plan should be simple and specific. The 0 to 10 scale estimates the patient's confidence that he/she can succeed at the action plan. The purpose of the action plan is to *increase self-efficacy* (self-confidence that the patient can change something). The goal is success. It doesn't matter how small the behavior change is; the important thing is that the patient succeeds, thereby increasing self-efficacy. **To maximize the chance of success, the patient should have high confidence, at least 7 out of 10, that he/she can succeed.** If, for example, a sedentary patient proposes an action plan to walk 5 miles a day, with a low level confidence (2 out of 10) that he/she can succeed, the caregiver should suggest a more achievable action plan.

At the end of the dialogue, the caregiver tries to make the action plan more specific ("When do you want to start?"), but the patient resists ("we'll see" and "that might work"). **Rather than challenging the patient, the caregiver "rolls with the resistance" and goes with what the patient is willing to do.** Sometimes the patient will not want to make an action plan at all.

Dialogue 2

Caregiver: Hello. I was just looking at your lab tests. Your LDL cholesterol is back up to 145.

Do you know what your goal is for cholesterol?

Patient: I don't remember

Caregiver: Since you had a heart attack 3 years ago, your LDL cholesterol goal is to be below

100. Now you are 145. Do you know why it has gone up again? I'll bet you haven't been taking your pills.

Patient: Sometimes I forget to take the pills. I feel good and it doesn't seem like I need the pills every day.

Caregiver: We need to make an action plan. You have to take your cholesterol pills every day.

OK?

Patient: I guess so.

Caregiver: starting today, your action plan is to take your pills every day without fail. I'll call you on Thursday to check.

Discussion

Clearly, the patient was not involved in making this action plan.

Dialogue 3

Caregiver: We just checked your BMI and it's gone up from 29 to 31. Do you know what that means?

Patient: I don't even know what a BMI is.

Caregiver: It is a measure of your weight in relation to your height. It is the best measure of whether your weight is too high. We call a BMI under 25 normal, between 25 and 30 as overweight, and over 30 as obese. You are now 31.

Patient: Are you saying that I'm obese? I don't like that.

Caregiver: That's what over 30 means.

Patient: I hate that. I'm going to lose 20 pounds. When I come back next month, my BMI will be way down below 30.

Caregiver: That's great. I'll see you next month. I'm sure you can do it.

Discussion

The motivation of the patient is great, but the caregiver probably should have asked for a reality check using the 0 to 10 scale. While praising the patient's motivation, the caregiver might have made a shorter term realistic action plan to start to move toward the goal of losing 20 pounds.

Dialogue 4

Caregiver: hello. I wanted to give you your lab test results. Your HbA1c has gone up from 8.2 to 9.2. Do you know what that means?

Patient: that means my sugar is getting higher. I know it is supposed to be 7 or below.

Caregiver: do you want to do something about that?

Patient: yes, I do. I need to get it down.

Caregiver: we believe in patient self-management. So you need to say how you will get your HbA1c down.

Patient: but I'm not sure what to do.

Caregiver: give it a try. What would you like to do?

Patient: I don't like this self-management thing. My doctor in Russia would tell me what I need to do and that's what I like.

Caregiver: This isn't Russia.

Discussion

The caregiver did not help the patient in formulating an action plan. When patients indicate that they prefer a caregiver to make a decision for them, it is best to suggest a course of action to the patient and check to see if the patient agrees. Action plans are a partnership – part patient and part caregiver.

Discussion

Goal-setting/action-planning will not work without regular and sustained follow-up with problem solving.

Dialogue 5

Caregiver: Hello Mr. Tang. It's good to see you. How are things going?

Patient: Good

Caregiver: Would it be OK to check on the action plan we made last week?

Patient: OK

Caregiver: How are you doing with exercising 30 minutes every day after lunch?

Patient: I'm doing fine. I'm doing 45 minutes every day.

Caregiver: That's terrific. So, do you think there is anything else we might do to get your cholesterol down? The LDL is still running around 150. Would you like to discuss healthy eating?

Patient: I'll keep exercising and that should take care of it.

Discussion

It is not unusual for a coach to doubt that the patient is actually carrying out his/her action plan. However, one needs to take the patient at face value and accept what the patient says he/she is doing. On the other hand, if the LDL does not go down next time it is checked, the caregiver might suggest that exercise is not enough and healthy eating and/or medication is needed.

Dialogue 6

Caregiver: Hello. How are you?

Patient: I'm fine.

Caregiver: Did you see this chart of your HbA1c? It went up from 8 to 10.

Patient: I really feel good.

Caregiver: We've talked a lot about the importance of having your HbA1c at 7. Would you like to try to get it down?

Patient: I really feel fine.

Caregiver: Would you like to talk about an action plan to get your diabetes in better control?

Patient: I eat well, I exercise, I take my pills, and I feel very well. Thank you for taking good care of me.

Discussion

It is not appropriate to make an action plan with this patient. The patient needs much more education on diabetes, its long-term consequences, what can be done to avoid those consequences, and that having high sugar does not necessarily make people feel bad. The patient has made it clear that the time for this education is probably not right now.

Dialogue 7
Caregiver: Hello. How are you?

Patient: I'm worried. My doctor told me my sugar is too high. I need to get it down.

Caregiver: Do you know how you can get your sugar down?

Patient: I could eat less, exercise more, or take pills.

Caregiver: That's right. Do you know what you would like to do?

Patient: I need to eat less. I eat 2 bowls of rice every meal. Big bowls. I know it keeps my sugar up.

Caregiver: do you think you could do something about that?

Patient: I'm going to stop eating rice. No more rice for me.

Caregiver: That's great. I'll call you to see how it's going.

Discussion
Similar to a previous scenario, it might be best for the caregiver to do a reality check using the 0 to 10 scale, while not undermining the patient's motivation to change.

Action plan follow-up/problem-solving dialogue

Caregiver (on telephone): Hello. Is this a good time to talk for a few minutes?

Patient: OK

Caregiver: Do you remember the action plan we talked about in the office last week?

Patient: I was supposed to walk 15 minutes every afternoon. But I didn't do it. I'm scared because we just had a shooting in the neighborhood.

Caregiver: [After discussing the shooting for a few minutes] Would you like to try to make another action plan to do some exercise?

Patient: Yes, I need to do that.

Caregiver: Do you have any ideas what you might do? [Give the patient the opportunity to suggest an idea; if that doesn't work, the caregiver would suggest a few ideas]

Patient: My son visits me every week. Maybe he could drive me somewhere and we could walk together instead of going to McDonald's the way we always do.

Caregiver: Maybe the first action plan could be to ask your son if that is OK. What do you think?

Patient: I'll ask him tomorrow. [Here the caregiver might assess this new action plan with a 0 to 10 confidence scale. In this case, that might not be necessary]

Caregiver: That's great. Is it OK if I call you in a couple of days to see what happened?

Discussion

Goal-setting/action-planning will not work without regular and sustained follow-up with problem solving.

Dialogues and discussion activities reprinted here from with permission from Dr. Bodenheimer: Bodenheimer, T. Training Curriculum for Health Coaches, May 2008 http://familymedicine.medschool.ucsf.edu/cepc/pdf/HealthCoachTrainingCurriculumMay08.pdf.

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VIDEOS

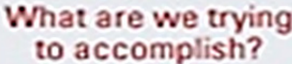
Health Coaching: (Medication Reconciliation) Techniques to Deliver Patient Centered Care
http://www.youtube.com/watch?v=3UpzkL_aYU

Quality improvement and Outcomes

AGENDA

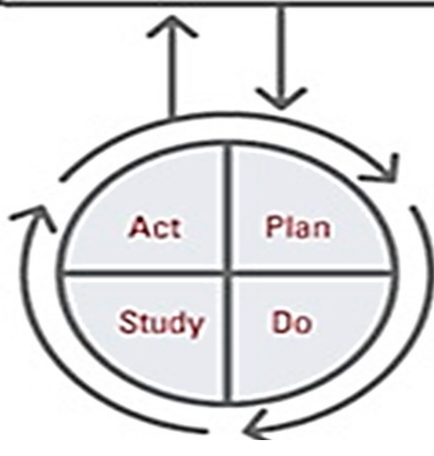
1. POWERPOINT WITH DISCUSSION: INTRO TO QUALITY IMPROVEMENT
2. VIDEO: COMPARING HEALTH CARE QUALITY: A ROADMAP TO BETTER CARE
3. VIDEO DISCUSSION
4. POWERPOINT WITH DISCUSSION: QUALITY IMPROVEMENT PROCESSES
5. GROUP EXERCISE: QUALITY IMPROVEMENT FOR THE POSTPARTUM VISIT – PART 1
6. POWERPOINT WITH DISCUSSION: STAFF ROLES AND TEAMWORK IN CQI
7. BREAK
8. VIDEO: CARE TEAMS IMPROVING QUALITY, ACCESS AND RELATIONSHIPS FOR PATIENTS
9. VIDEO DISCUSSION
10. POWERPOINT WITH DISCUSSION: CQI DATA
11. POWERPOINT WITH DISCUSSION: PATIENT EXPERIENCE
12. GROUP EXERCISE: QUALITY IMPROVEMENT FOR THE POSTPARTUM VISIT – PART 2
13. WRAP UP

PDSA CYCLE



How will we know that a change is an improvement?

What changes can we make that will result in improvement?



Setting Aims
Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected.

Establishing Measures
Teams use quantitative measures to determine if a specific change actually leads to an improvement.

Selecting Changes
All improvement requires making changes, but not all changes result in improvement. Organizations therefore must identify the changes that are most likely to result in improvement.

Testing Changes
The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting — by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method used for action-oriented learning.

GROUP ACTIVITY: QUALITY IMPROVEMENT FOR THE POSTPARTUM VISIT – PART 1

Your Medical Director has asked for your help with a new quality improvement initiative. According to her last report, only 25% of all prenatal patients are returning to the center for their 6-week postpartum visit. This is a real problem, as this is an important visit for new mothers. The Medical Director wants your help in coming up with a quality improvement initiative to increase the return rate for these patients. Working in your group, go through the QI steps below and come up with a strategy that you think could improve this indicator.

1. Get the data – this informs you of the problem.

Right now, all the Medical Director knows is that the current 6 week postpartum visit rate is 25%. What other information would help you better understand the problem? How would you go about getting this information?

2. **Your colleague in the data analytics department was able to provide you the following additional information:**
   - Of the patients who did not receive their 6 week postpartum visit:
     - The average no-show rate for prenatal visits for this population was 55%, indicating that they tend to struggle to make their appointments
     - 70% of these patients have at least one other child at home
     - 30% of these patients are uninsured, compared to only 2% of the patients who did receive their 6 week postpartum visit.

   Given this additional information, what do you think are the root causes of the problem? What are some possible disparities in care that you can see in this information?

3. **Set your aim for this quality improvement project. Create a SMART goal for your quality improvement initiative. SMART = specific, measureable, achievable, relevant, and time-bound.**

GROUP ACTIVITY:
QUALITY IMPROVEMENT FOR THE POSTPARTUM VISIT – PART 2

1. Look at your goal from part 1 of this exercise. What intervention do you want to put into place to reach your goal? Who will need to be involved? Hint: consider the information you were given by the data analyst and think about the parts of the problem you could reasonably address.

2. How will you know that your intervention is successful? Identify at least one process and one outcome measure. Hint: think about the different types of measures reviewed in the lecture.

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http://youtube.com/watch?v=5seWqqYBL4s

Care Teams Improving Quality, Access and Relationships for Patients
https://www.youtube.com/watch?v=YW75-IxF58E

Professional Boundaries - Part 1

AGENDA

1. POWERPOINT WITH DISCUSSION:
   PERSONAL BOUNDARIES
2. EXERCISE:
   A TIME WHEN YOU HAD TROUBLE MAINTAINING BOUNDARIES
3. POWERPOINT WITH DISCUSSION:
   10 TIPS FOR SETTING BOUNDARIES
4. VIDEO:
   TENSIONS BETWEEN PERSONAL AND PROFESSIONAL BOUNDARIES
5. VIDEO DISCUSSION
6. BREAK
7. POWERPOINT WITH DISCUSSION:
   PROFESSIONAL BOUNDARIES
8. EXERCISE:
   PROFESSIONAL BOUNDARIES IN HEALTHCARE

EXERCISE: A TIME WHEN YOU EXPERIENCED TROUBLE MAINTAINING BOUNDARIES

Think about a time when you had trouble maintaining boundaries in your professional or personal life.

i.e. Saying "no" to someone, sticking to a set time to meet with a patient or to end a meeting with a patient, feeling stressed out by a co-worker or by a patient who was demanding.

How did you know that you were having trouble?

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Who was involved?

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Why do you think it was hard?

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How might you handle it differently next time?

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EXERCISE: PROFESSIONAL BOUNDARIES IN HEALTHCARE

Think about the following statements and then we will take a poll about your opinion. You can raise your hand to say whether you agree, aren't sure, or disagree with the statement and then we'll discuss.

1. Mark asks Jane if he can trade patient assignments so he can care for a patient he likes working with

2. Julie likes to grab a cup of coffee with one of her patients after work since she knows her from the neighborhood.

3. Hugging a patient is sometimes acceptable.

4. Accepting a cash gift from a patient is sometimes ok.

5. Flirting with a patient at work is alright if you are not obvious about it.

6. The other day in the waiting room, John the patient got into an argument with another patient, Jack. Susie, the care coordinator, took John's side and let everyone know that she did. This is ok because Jack is difficult and provocative.

7. It’s ok to sometimes move your favorite patients in front of other scheduled patients to see the doctor so they don’t have to wait as long as everyone else.

8. Peter, the community health worker, sometimes places his hand on a female patient’s shoulder when he’s talking to them.

9. If a patient threatens to hurt me or other staff it would be wrong to get help or call security. The patient probably doesn’t really mean it and is just upset.

10. If a patient wants to keep talking longer than the allotted time for the visit, you should let them because they probably really need to talk.

11. It’s usually better not to care for a friend and ask that they be assigned to another staff member.

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VIDEOS

Video: Tensions between personal and professional boundaries
https://www.youtube.com/watch?v=74kKWrhTKbI

Professional Boundaries - Part 2 & Wrap up

AGENDA

1. POWERPOINT WITH DISCUSSION: THE RELATIONSHIP BETWEEN BOUNDARIES AND BURN-OUT
2. POWERPOINT WITH DISCUSSION: CHALLENGES OF MAINTAINING BOUNDARIES WHILE PROVIDING CARE COORDINATION
3. EXERCISE: YOUR TRIGGERS AT WORK
4. POWERPOINT WITH DISCUSSION: STRESS MANAGEMENT
5. BREAK
6. POWERPOINT WITH DISCUSSION: HEALTH & WELLNESS
7. EXERCISE: SIMPLE WELLNESS PRACTICES
8. WRAP UP DISCUSSION
9. EVALUATION COMPLETION
10. FINAL CELEBRATION/ CERTIFICATE DISTRIBUTION

PACT Training and Technical Assistance Institute

Simple Wellness Practices

1. **Get moving:** some exercise or fresh air daily (take a walk, swim, dance, go to gym, yoga class.) Regular exercise helps us manage mood, weight, & energy level. Even a 15-minute stroll at lunchtime can help us feel less stressed & more grounded.

2. **Spend quiet time in nature:** go to the park, beach, woods or if you can't get there, go to a quiet place in nature during meditation. Put some pictures of places you love in your work space so you can remember them when you're feeling stressed.

3. **Plan a weekly "fun" activity:** go with a friend, colleague, or family member. Find free fun things to around town or have folks over for dinner or a game night.

4. **Practice gratitude:** think of 3 things that you feel grateful for everyday upon waking or before bed. Notice how you feel when you appreciate the good things you already have.

5. **Body care:** try acupuncture, massage, or hot tub soak for relaxation. We hold our stress in our bodies! Many places have affordable services if you work with a student or trainee.

6. **Pray:** when you feel tempted to worry about a person/situation in your life, prayer may be helpful. This does not need to be "religious" but instead a way of releasing the fear to a "Higher Power" and developing trust that things will work out ok. Focus on wishing well to the person/problem rather than building up stressful feelings or sit in quiet reflection.

7. **Help someone else:** volunteer, help a friend, clean the office kitchen. Often the simple act of recognizing we have much to offer or that another person is struggling with something we are not helps us feel better and appreciative of what we have.

8. **Ask for help & graciously receive it:** this takes courage! As caregivers, we often have a hard time taking help (or recognizing that we need it). Give someone the gift of being able to help you. It usually feels good to the other person and gives us a big boost, as well as brings us closer in the connection.

9. **Do something you love that brings you joy every day:** It could be something different and simple every day: a bubble bath, talk with a good friend, cook a meal you enjoy, buy a fancy coffee, work in the garden, listen to favorite music in the car, good sex, take a nap.

10. **Honor yourself:** we all have limitations and amazing strengths. Notice what you're good at & what you like about yourself & focus on it a few minutes daily. Smile at yourself in the mirror!

11. **Express yourself:** write in a journal, draw/paint/sing, or do something creative as a way to express your feelings & get yucky stuff out of your system.

12. **Build community**: consider participating in a group that's meaningful to you (AA, church, sports team). Spending time with people you enjoy & with whom you share values/interests helps us feel more connected & supported as we face life stressors.

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NOTES:

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