Care Coordination Fundamentals

Teacher Guide

"After completing the course, students tell us they feel equipped with the skills they need to provide coordinated care for their patients and to help them navigate the healthcare system."

- Jennifer Nasisi
1199 SEIU Training and Employment Funds

1199 SEIU Funds
Training & Employment

PRIMARY CARE DEVELOPMENT CORPORATION

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

"As a trainer, the opportunity to share information about cultural competency and the possibility of improving empathy among different provider and patient groups is a gratifyingly satisfactory experience. Hearing participants exclaim similar satisfaction is wonderful."

- Makini Niliwaabieni
1199 SEIU Training and Employment Funds

"Our participants demonstrate an eagerness and generosity of spirit that is tremendously gratifying for me as an educator. The relevance and breadth of the material challenges and engages them, and the opportunity to learn with and from peers is clearly invaluable."

- Robin Poley
1199 SEIU Training and Employment Funds

"The Care Coordination Course is not simply a series of lectures. It's highly interactive and generates lots of discussion. The small group activities are especially wonderful for eliciting students' prior knowledge and allowing them to share their experiences with others."

- Jennifer Nasisi
1199 SEIU Training and Employment Funds

Care Coordination Fundamentals. Course created by 1199 SEIU Training and Employment Funds and Primary Care Development Corporation, New York. 2013

Primary Care Development Corporation

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We appreciate the members of the Health Workforce Re-Training Initiative advisory group for providing insight into the core competencies needed by those staff who provide care coordination currently in Patient Centered Medical Homes, Health Homes and various types of ambulatory and primary care settings. The advisory group members included leadership from the Community Health Care Association of New York State (CHCANYS) and the Institute for Family Health.

PCDC is indebted to Ellen Ray, Program Specialist at 1199 SEIU Training and Employment Funds for consistently offering suggestions and improvements based on her experience, and her teams' experience teaching this course in multiple locations across the New York City area.

We are extremely grateful to Kimberly Mirabella, project coordinator at PCDC who spent numerous hours under tight deadlines formatting this course without complaint. She ensured time and again that cuts and additions to the twenty-four classes were coordinated, kept us organized, and caught mistakes that we were too bleary-eyed to notice.

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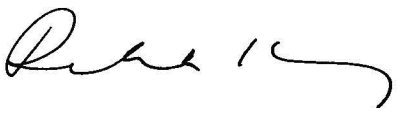
Forward by Deborah King, Executive Director, 1199 SEIU Training & Employment Funds

The 1199 SEIU Training and Employment Funds (TEF) work to support our healthcare industry and its workforce, ensuring that 1199SEIU members and institutions have the skills and resources they need to provide quality patient care. Together, our Funds served over 25,000 members in 2012, making TEF the largest program of its kind in the nation. As a joint labor management initiative, TEF is uniquely situated to identify both healthcare trends and the specific needs of the industry and its institutions.

We are aware of seismic shifts occurring in both the payment structure and care delivery in hospitals, health systems, and emerging health care settings. Health care delivery systems are rapidly changing to achieve better clinical outcomes while also controlling costs. In place of fee for service models, state and federal health care reforms are creating payment systems that reward preventive and primary care. To transition to these new forms of care delivery, care coordination is crucial. We are very excited to present Care Coordination Fundamentals, which will meet the needs of workers in the new healthcare environment.

The National Quality Forum states, "care coordination helps ensure a patient's needs and preferences are understood, and that those needs and preferences are shared between providers, patients, and families as a patient moves from one healthcare setting to another." We are confident that the Care Coordination Fundamentals program is a great opportunity for incumbent health care workers and those seeking to join the field. Participants obtain the skills they need to obtain employment, retain their current positions, and prepare for new responsibilities in emerging health care settings. The training enables workers to best assist patients with multiple physical and/or mental health and chronic diseases, ensuring that they receive optimal healthcare services and enhanced health outcomes.

With funding from the New York State Department of Health, and the support of labor and management at all levels, TEF has trained over 1,000 health care workers from 30 different facilities in Care Coordination Fundamentals since 2012. Our vision is to continue to expand this training so that many more healthcare workers deepen their skills in successfully navigating patients through the modern healthcare environment. Working together, we know that this training engages healthcare workers in an innovative and interactive fashion and directly contributes to quality care and quality jobs.



Deborah King
Executive Director
1199 SEIU Training & Employment Funds

Forward by Ronda Kotelchuck, CEO, Primary Care Development Corporation

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,

Chief Executive Officer
Primary Care Development Corporation

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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 "Care Coordination Fundamentals" curriculum consists of twenty four 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.

How to use this book

Care Coordination Fundamentals is comprised of three books:

- The Care Coordination Teacher Guide
- The Care Coordination Student Exercise Book
- The Care Coordination Student Textbook

The Care Coordination Teacher Guide contains all course content, guidance for lectures, in-class activities/ exercises and homework assignments, including guidance on how to structure and facilitate classes. The CC Student Exercise Book is intended to be used by students in class, while the Care Coordination Student Textbook can be left at home and used for additional review and reading.

NOTES BOX:
Helpful Tips for the facilitator

Purple notes boxes are intended to provide guidance around discussion points, as well as additional background.

INSTRUCTIONS BOX
Instructions to the facilitator

Blue instruction boxes are intended to direct the facilitator on how to carry out activities and exercises.

VIDEO

All videos have been uploaded into the PowerPoint or can be played using the links provided, if there is internet access.

POWERPOINT WITH DISCUSSION

"PowerPoint with Discussion" is the core component of the class. The PowerPoint is specifically designed to elicit discussion from the students through the use of strategically placed questions. While some of the PowerPoint will be lecture on content, the majority of this component should be delivered as an interactive discussion.

MODULE 1

ORIENTATION: CARE COORDINATION BASIC SKILLS - PART 1

OBJECTIVES

- Describe the role and responsibility of staff who provide care coordination
- Explain how care coordination is related to patient navigation
- List typical care coordination services
- Describe the qualities and skills needed by staff members providing care coordination

MATERIALS NEEDED

- PowerPoint file with videos downloaded
- Printed copies of Atul Gawande homework article or refer student to website link http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande

Orientation: Care Coordination Basic Skills - Part 1

AGENDA

1.	WELCOME AND EXPECTATIONS	15 MIN
2.	POWER POINT WITH DISCUSSION: WHAT IS CARE COORDINATION?	15 MIN
3.	VIDEO: UIC SCIENCE BYTES: PATIENT NAVIGATORS	3 MIN
4.	POWERPOINT WITH DISCUSSION: WHERE DID PATIENT NAVIGATION COME FROM?	5 MIN
5.	VIDEO: EYE TO EYE: DR. HAROLD FREEMAN	7 MIN
6.	VIDEO DISCUSSION	10 MIN
7.	POWERPOINT WITH DISCUSSION: WHAT SKILLS AND QUALITIES SHOULD STAFF PROVIDING CARE COORDINATION HAVE?	10 MIN
8.	BREAK	5 MIN
9.	VIDEO: KINGS COUNTY PATIENT NAVIGATORS: HEALTHBEAT BROOKLYN	5 MIN
10.	VIDEO DISCUSSION	10 MIN
11.	GROUP EXERCISE: CASE STUDY - MR. A.B.	20 MIN
12.	INDIVIDUAL EXERCISE: CARE COORDINATION QUIZ	10 MIN
13.	WRAP-UP, QUESTIONS, HOMEWORK REVIEW	5 MIN

1 WELCOME & EXPECTATIONS

Note: Introduce yourself and discuss your background. Students should say something about their work experience, if they have any.

Talk about the class-inclusive approach, questions and discussion encouraged, interactive, etc.

2 POWER POINT WITH DISCUSSION: WHAT IS CARE COORDINATION?

How would you describe our healthcare system?

Patients seeking medical care, particularly treatment for a serious illness, can find the healthcare system to be:

- Confusing
- Dis-empowering
- Inaccessible

How does a patient's perception of the healthcare system affect how they interact with it?

- A patient's experience with the healthcare system, or other life circumstances, may cause patients to avoid or delay healthcare.
- When this happens, and their illness is serious, chance of survival drops and treatment becomes difficult and problematic.

How can we help patients navigate the healthcare system so they have better outcomes and a better experience?

Care coordination.

What is care coordination?

- There is no universally accepted definition
- "…Helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time. Coordination maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe, and high quality patient experiences and improved healthcare outcomes."

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

Goal of Care Coordination

- Reduce fragmentation of care
- Help patients access timely, appropriate care
- Help them to engage more fully in their own care

Health care staff who provide care coordination services can focus on:

Patients and their families

- Help them access care and overcome barriers to quality care

Providers

- Coordinate interactions between providers which will help patients have better continuity of care

Systems

- Ensure that systems are in place to facilitate coordinated care and sharing of information about all aspects of a patient's care

Successful care coordination needs to involve all of these areas: patients, providers and systems.

Care Coordination Fundamentals Course

- Focuses on patients and their families, interactions between providers and systems
- Extra emphasis on understanding what the patient needs and the barriers they face

Other terms very closely related to care coordination

- Collaboration
- Teamwork
- Continuity of care
- Disease management
- Case management
- Chronic care model
- Care navigation or patient navigation

What is patient navigation?

- "Assistance offered to patients in 'navigating' through the complex healthcare system to overcome barriers in accessing quality care and treatment"

Closing the Gap: A Critical Analysis of Quality Improvement Strategies. Agency for Healthcare Research and Quality, US Department of Health and Human Services, June 2007

A staff member providing navigation and coordination services:

- Identifies and reduces barriers to patient care
- Connects patients with resources
- Helps patients understand that it is important to get treatment quickly

Adapted from Colorado Patient Navigator Training Program www.patientnavigatortraining.org

Patient navigation and care coordination can be provided by:

- Medical assistants
- Patient care technicians
- Certified nurse aides
- Community health workers, promotoras
- Nurses
- Providers
- Care coordinators
- Social workers and case managers
- Patient navigators, care managers
- Administrative staff

Care coordination can also reduce health disparities.

What are health disparities?

"A type of difference in health that is closely linked with social or economic disadvantage.

Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health."

The term "health disparities" is closely related to the term "health inequalities."

What are health inequalities?

Differences, variations, and disparities in the health achievements of individuals and groups of people.

http://www.chcact.org/resources/PNmanualfinal.pdf

In other words . . .

Some groups of people have worse outcomes and lower survival rates than other groups with the same diseases.

What factors could cause some groups of people to have worse outcomes and lower survival rates than other groups with the same diseases?

Factors

- Financial situation
- Insurance status
- Cultural background
- Educational background

Health disparities and health inequalities can be a reason for some groups of people to have:

- Inadequate screening for diseases
- Less preventive care
- Delayed diagnoses
- Late or inadequate treatment
- Worse outcomes

Care coordination can help reduce health disparities and health inequalities.

What are Typical care coordination services?

1. Guide patients through healthcare system
2. Help patients arrive at scheduled appointments on time and prepared
3. Identify barriers to care
4. Ensure that abnormal screenings are followed up
5. Link patients, caregivers, and their families with needed follow up services
6. Increase access to culturally appropriate, supportive care
7. Offer patient education materials in several languages
8. Assist patients in filling out forms
9. Identify financial aid options
10. Help arrange patient transportation as needed
11. Maintain regular contact with patients during their care
12. Coordinate services within the healthcare organization, with outside healthcare facilities, and within the community

http://www.chcact.org/resources/PNmanualfinal.pdf

3 VIDEO: UIC SCIENCE BYTES: PATIENT NAVIGATORS

Note: Make sure to explain that most of the videos are about care coordination for cancer patients even though students will be learning how to provide navigation and coordination for all types of patients, many of whom have chronic illnesses.

4 POWERPOINT WITH DISCUSSION: WHERE DID PATIENT NAVIGATION COME FROM?

Who came up with patient navigation?

- Dr. Harold Freeman at Harlem Hospital, NYC
- Began first patient navigator program because of what he learned at hearings held by the American Cancer Society in 1989

American Cancer Society. Cancer in the Poor. A Report to the Nation. Atlanta, GA; American Cancer Society; 1989

Key Findings from 1989 American Cancer Society Hearings

Economically disadvantaged patients with cancer:

- Endure great pain and suffering
- Make extraordinary sacrifices to obtain and pay for care
- Face substantial obstacles in obtaining and using health insurance
- Do not seek care if they cannot pay for it
- Encounter education programs that are culturally insensitive and irrelevant to their situation
- Have fatalistic feelings about diagnosis and treatment

First Patient Navigation Program

- Began at Harlem Hospital in 1990
- Paid for by the American Cancer Society
- Navigators helped patients with low incomes, or those who tended not to get the medical care they needed
- Patients who worked with patient navigators got care faster than those who did not

5 VIDEO: EYE TO EYE: DR. HAROLD FREEMAN

6 VIDEO DISCUSSION QUESTIONS

1. What does Dr. Freeman mean when he says "some people are under-insured?"
   ANSWER: Some people may have insurance that only covers certain treatments or services, or does not cover pre-existing conditions. This was often the case before the Affordable Care Act was passed.

2. What does Dr. Freeman mean when he says that people who are poor and uninsured come in "late" for care?
   ANSWER: People without insurance or who are poor may come in later than they should to receive the full benefit of testing and treatments. By the time these people receive care, they may be too sick to be helped.

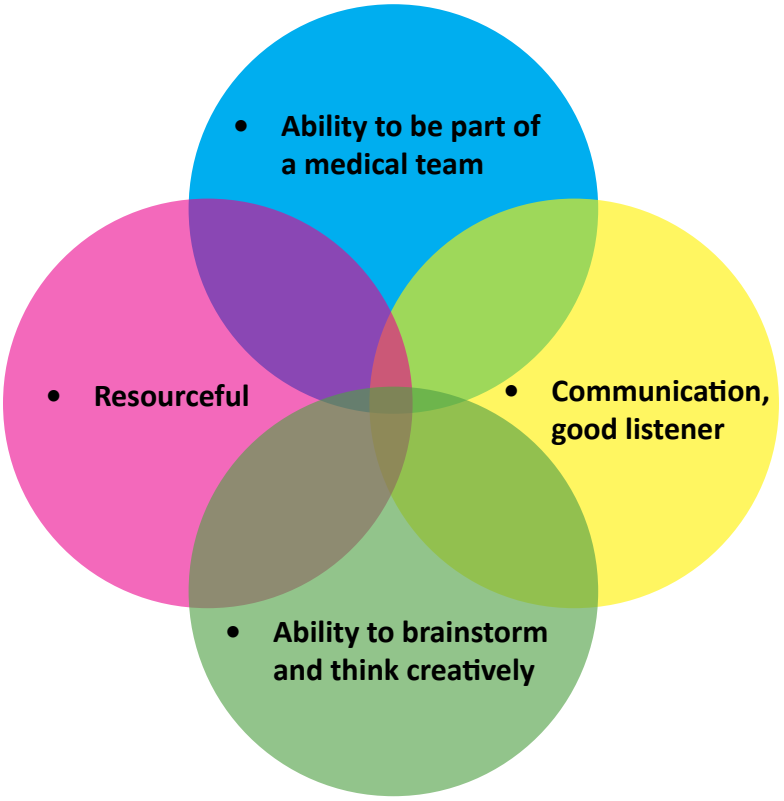
3. What does it mean when we say that people who have had screenings or tests then need "navigation through the system?"
   ANSWER: Once someone has a test, they need follow up. They need to receive their results and be offered treatment if indicated.

4. What does it mean when we say that "it's not enough to tell people to get a test, you have to make sure they can get it?"
   ANSWER: Good healthcare is not just about making the right diagnosis and treatment plan. If a patient doesn't agree with the need for a test or treatment, or can't pay for it, or can't get to it, then they will not get better.

7 POWERPOINT WITH DISCUSSION: WHAT QUALITIES SHOULD STAFF MEMBERS PROVIDING CARE COORDINATION HAVE?

- ✓ Responsible
- ✓ Caring
- ✓ Friendly
- ✓ Trustworthy
- ✓ Positive attitude
- ✓ Organized
- ✓ Resourceful

What skills do staff members providing care coordination services need?



What kinds of knowledge should staff providing care coordination services have?

- How the healthcare system works
- Basic medical information
- Warning/danger signs for when to get help with a patient
- What resources are available in the community

8 BREAK

9 VIDEO: KINGS COUNTY PATIENT NAVIGATORS: HEALTHBEAT BROOKLYN

Note: In the Kings County video, when the patient navigator meets the patient for the first time she kisses her hello on the cheek. Students have given feedback that they feel uncomfortable when they see this as it seems to be modeling behavior that is overly familiar for a professional relationship, as well as for someone you have just met.

We would agree with this feedback and encourage staff members who are providing care coordination to maintain respectful professional boundaries and to take their cues from patients. Because we feel that the video as a whole is valuable for staff members who are learning about providing care coordination, we have kept it in the curriculum.

You may want to have a brief discussion about this part of the video and see what the students believe is appropriate and why. This can be an opportunity to talk about boundaries and the close relationship that staff who are providing care coordination will form with their patients-topics that will be discussed more fully in future classes in this course.

10 VIDEO DISCUSSION

- What do you think this patient navigator did well?
- How does the patient say that she felt when she was first told she had cancer?
- How might this affect her accessing care?
- Even though the patient hasn't decided when she will have her surgical procedure, the navigator brings her to the financial counselor. Why is this important?

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

Instructions: Go around the class and have students read one paragraph aloud then break into groups to work on identifying issues and possible solutions. Encourage students to approach these issues and solutions from the perspective of care coordination staff. Each group will report out to the class on one issue or problem or more depending on time.

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.

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

12 INDIVIDUAL EXERCISE: CARE COORDINATION QUIZ

Say to class: *Here is a quiz to see how much you already know about your role as a staff member who would provide care coordination services. Answer the questions and be prepared to discuss your answers with the group.*

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

ANSWERS

1. True
2. True
3. False
4. True
5. True
6. False
7. False
8. True
9. False

13 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

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

Teacher instructions: Hand out printed copies of the article or refer student to the link in their exercise book. Tell students to review the homework discussion questions in the exercise book, as they read the article, since these questions will be discussed in the next class.

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?

REFERENCES

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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

MODULE 2

ORIENTATION: CARE COORDINATION BASIC SKILLS - PART 2

OBJECTIVES

- Define what a chronic disease is and how it relates to our healthcare system today
- Define patient-centered care
- Describe the new models of healthcare such as Health Homes, Patient-Centered Medical Home, and ACOs
- Explain how relationships are important for coordinating care
- Understand legal and ethical responsibilities in healthcare

MATERIALS NEEDED

- PowerPoint file with videos downloaded
- Printed copies of homework article or refer students to link: 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

Orientation: Care Coordination Basic Skills - Part 2

AGENDA

1.	WELCOME, FEEDBACK FROM FIRST CLASS	5 MIN
2.	HOMEWORK DISCUSSION: ATUL GAWANDE ARTICLE	20 MIN
3.	POWERPOINT WITH DISCUSSION: THE STATE OF HEALTHCARE TODAY: CHRONIC DISEASE, NEW MODELS OF HEALTHCARE	15 MIN
4.	VIDEOS: WITHOUT A MEDICAL HOME; WITH A MEDICAL HOME	10 MIN
5.	VIDEO DISCUSSION	10 MIN
6.	BREAK	5 MIN
7.	POWERPOINT WITH DISCUSSION: RELATIONSHIPS AND CARE COORDINATION	15 MIN
8.	GROUP EXERCISE: CARE COORDINATION DUTIES QUIZ	10 MIN
9.	POWERPOINT WITH DISCUSSION: LEGAL/ETHICAL CONSIDERATIONS	15 MIN
10.	GROUP EXERCISE: IS THIS A HIPAA VIOLATION?	10 MIN
11.	REVIEW HOMEWORK FOR NEXT CLASS, WRAP UP	5 MIN

1 WELCOME, FEEDBACK FROM FIRST CLASS

2 HOMEWORK DISCUSSION: ATUL GAWANDE ARTICLE

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.”

   ANSWER: When people are using the emergency room a lot and are admitted to the hospital frequently for things other than acute conditions, this is an indication that their health conditions are out of control, and that they are not receiving or engaging in preventive services.

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?

   ANSWER: When people get sick enough and have enough multiple conditions without access or engagement in care, their condition can spiral out of control. When patients use ambulances and hospitals, instead of other forms of transportation and primary care, costs can quickly rise. Dr. Brenner’s approach is to sit with the patient and get to know and understand him. Then he and his team work with him, teaching him how to stay healthy through quitting smoking and drugs, weight loss, exercise, and helping him take his medicines. They also coordinate his care and arrange for a social worker to help him get disability insurance so he can find a better housing situation and a consistent set of doctors.

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?

   ANSWER: The team visits his house and discovers that he has a terrible living situation and that he is not really taking his medication. They find him housing where someone can dispense his medication on schedule.

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?

   ANSWER: One of the most important things to do regardless of your role or position in healthcare is to build relationships and trust with patients. Patients may be distrustful or fearful and it is our job to show that they can trust us. Anyone can do this simply by listening well and communicating with respect and empathy.

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?

   ANSWER: The coaches work with the doctors and see their patients at least once every two weeks. Most of the coaches come from their patients’ communities and speak their languages. Many have personal experience with chronic illness. Fernandopulle says the most important attribute for them to have is a “knack for connecting with sick people, and understanding their difficulties.”

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?

   ANSWER: They don’t care if someone has a healthcare background, what they are looking for is someone who has a good attitude and a willingness to solve problems, and a willingness to help and say, “yes” instead of the traditional healthcare response which is, “No”. He hires people for their single minded focus on patient service and fires people even clinically skilled ones such as doctor’s for their lack of this focus.

3 POWERPOINT WITH DISCUSSION: THE STATE OF HEALTHCARE TODAY: CHRONIC DISEASE, NEW MODELS OF DELIVERING HEALTH CARE

The State of Healthcare Today:

- Chronic diseases are a major contributor to health care costs
- The costs of medical care for people with chronic diseases represent 75 percent of the $2 trillion in U.S. annual health care spending.

Institute of Medicine Report, January 2012

What is a chronic disease?

- A disease that persists over a long period.
- Chronic disease may be progressive, result in complete or partial disability, or even lead to death.
- Daily symptoms of chronic disease are sometimes less severe than those of acute phase of same disease.
- May also be called a chronic illness or a chronic condition.

Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier

What are some common chronic diseases in the United States today?

- Diabetes
- Hypertension
- Cardiovascular disease
- Asthma
- Depression
- Schizophrenia
- HIV
- Hepatitis

What are some common challenges that patients with chronic diseases face?

Patients with chronic diseases:

- May need many appointments with multiple doctors, nurses, educators, nutritionists, and therapists
- Need help learning how to self-manage their illness
- Need help handling psychosocial problems like depression and anxiety that they may experience as a result of living with a chronic disease

Patients with multiple chronic diseases:

- Have particular trouble navigating the healthcare system
- Often suffer acute episodes of chronic conditions that could have been managed or prevented if they had been able to access care earlier
- Receive better care in a health center with a medical team who knows them and coordinates their care

One of the most important things a patient with a chronic disease needs is coordinated care.

What is coordinated care?

- All the doctors, nurses, therapists that provide care for a patient are in communication with one another
- Test results are shared between providers, so the same tests are not repeated at different doctors' offices
- Healthcare team makes sure that patients get to their referral appointments and they follow up on the results of those appointments

Coordinated care is also patient-centered care.

What is patient-centered care?

- Partnership between patients, their families and the healthcare team
- Care that respects patients' values, preferences and needs
- Provides patients with education and support so they can make informed decisions and fully participate in their own care

From Colorado Patient Navigator Training Program www.patientnavigatortraining.org

New Models of Healthcare:

- Health Homes
- Patient Centered Medical Homes
- Accountable Care Organizations

Goal of these new models:

- Provide better care at lower costs
- Reduce emergency room visits and hospital admissions

Why do we want to keep people from going to the emergency room or being admitted to the hospital?

What is the emergency room really for?

- Should be for acute, life-threatening issues that can't be handled in an outpatient/clinic setting (i.e. Gunshot wound, accidents)
- Often is used for poorly managed chronic conditions which become acute conditions that require hospitalization (i.e. diabetic foot ulcer infection, severe asthma attacks)

What is a Health Home?

- Network of organizations that work together to provide and coordinate all health and social service needs for patients with multiple chronic conditions

Health Home

- Care manager in lead agency coordinates and tracks care for patients
  - May work as part of a team with care coordinators and outreach workers
- Measures success by lowering rates of emergency room visits and hospital admissions
- In NY, for Medicaid patients only
- Different states have taken different approaches

Health Home Staff

- Provide community outreach to get patients into care
- Develop a care plan with the medical team, network providers, and patient
- Coordinate patient services with internal and external service providers
- Tracks and follows up with patients

What is a Patient-Centered Medical Home (PCMH)?

- A single practice with a primary care physician leading care delivery "team"
- Provides:
  - Coordinated care
  - Increased access to services for patients
  - Focus on patient education and self-management
  - Population management
  - Quality improvement

What is an Accountable Care Organization (ACO)?

- Brings together multiple providers and organizations to deliver coordinated services
- Shared goal of improving quality of care, reducing costs, and improving patient experience
- Care delivery is more efficient and coordinated through establishment of integrated clinical services and a supportive payment system that rewards outcomes, not volume of services
- Unlike a Health Home, does not have to focus only on chronically ill patients

4 VIDEOS: WITHOUT A MEDICAL HOME ("BAD") WITH A MEDICAL HOME ("BETTER")

5 VIDEO DISCUSSION

Life without a medical home

- What access issues does the patient face?
- Does the doctor have records from the ER?
- Does anyone coordinate care for this patient?
- How could a staff member providing care coordination have improved care for this patient?
- What things are not affected by staff providing care coordination?

Life with a medical home

- What does the medical home in this video do that makes the care more patient-centered?
- What other issues besides medical issues does the doctor discuss with the patient? Why is this important?
- What tasks can you see that staff providing care coordination might have done in the medical home shown in this video?

6 BREAK

7 POWERPOINT WITH DISCUSSION: RELATIONSHIPS AND CARE COORDINATION

Without strong relationships you can't do your job of coordinating care.

Why?

What is the most important relationship to maintain?

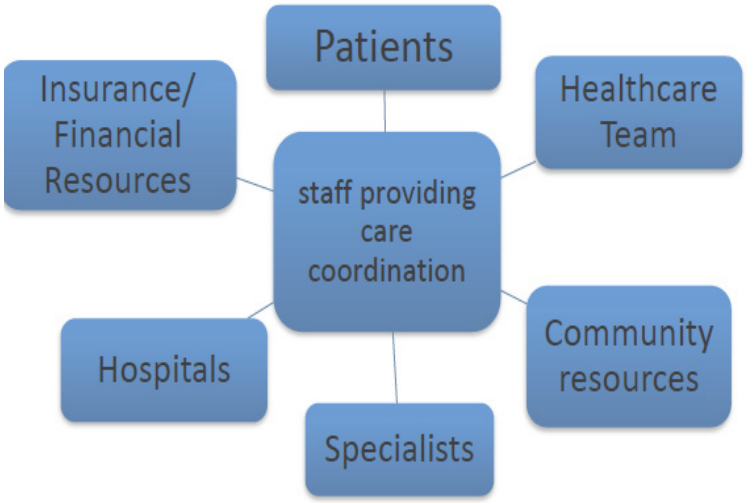
- The most important relationship is with the patient.

How do you build a strong relationship with the patient?

- Show them they can trust you
  - Keep your word (if you say you will call at a certain time, call at that time)
  - Try to be empathetic and compassionate
- Make an effort to understand their background, and respect their culture and community-your ability to help depends on it
- Try to "stand in their shoes"

Who else will you need to build relationships with to provide care coordination?

CARE COORDINATION RELATIONSHIPS



Why do you want a strong relationship with the healthcare team?

- Takes primary responsibility for the patient
- Provides, facilitates and coordinates all patient care
- Facilitate communication and information exchange between healthcare team members as well as between patients and the healthcare team

How can you build a strong relationship with the healthcare team?

- Introduce yourself and explain what you do
- Learn what other team members do
- Ask other team members how you can help them

What are some community resources and why would you need strong relationships with these providers?

- Housing and transportation assistance
- Support groups
- Substance abuse providers
- Food pantries
- Domestic violence support services
- Some patients may not be able to focus on their health if they have more basic needs related to food, shelter, and safety

What might your patients need specialists and hospitals for and why do you need strong relationships with these providers?

- Specialized medical services
- Advanced testing, procedures, surgery
- Coordinating care involves helping patients get needed appointments quickly as well as getting results and reports

What might your patients need insurance and financial resources for?

- Having access to these can be the difference between a patient receiving care or not
- Staff who work in these areas are aware of options or programs available to help patients who are facing financial barriers

8 GROUP EXERCISE: CARE COORDINATION DUTIES QUIZ

Say to the class: True or false: As a staff member providing care coordination services, 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 ANSWERS

1. True
2. False. A patient navigator may behave in a friendly manner and be a good listener but should not be a friend to the patient outside of the work environment.
3. True
4. True
5. False. Patient navigators don't make diagnoses and they are not able to make appointments with specialists unless a doctor or clinician has given the patient a referral.
6. True

9 POWERPOINT WITH DISCUSSION: LEGAL/ETHICAL CONSIDERATIONS

All States have laws (legal responsibilities) about healthcare.

- These laws protect you and everyone else in health care.
- It is important to understand what you are allowed and not allowed to do as a healthcare worker.

Here is a list of some of the most common wrongful acts that can happen in healthcare:

- Malpractice
- Negligence
- Assault and battery
- Invasion of privacy
- False imprisonment
- Abuse

What is malpractice?

- Malpractice is when a mistake or bad action causes a patient injury, loss or damage
- **Examples:**
  - Giving the wrong medicine
  - Operating on the wrong part of the body or on the wrong patient

What is negligence?

- When a healthcare worker does not give the right care that is expected of him or her
- **Examples:**
  - Using non sterile instruments
  - Patient falling out of bed because the bed rails were not up
  - Re-using a needle to draw blood or give an injection

What is assault and battery?

- Threat or an attempt to injure, unlawful touching
- **Examples:**
  - Hitting a patient
  - Threatening a patient

What is invasion of privacy?

- Talking about or telling personal information without the patient's consent
- **Examples:**
  - Telling other people about a patient's diagnosis
  - Posting a picture of a patient on social media without their consent,
  - Not covering a patient during a procedure to protect their privacy

What is false imprisonment?

- Holding someone against their will
- **Example:**
  - Keeping someone in the hospital against their will or using restraints without permission

What is abuse?

- Anything that causes physical harm, pain or mental suffering
- **Example:**
  - Can be physical, verbal, psychological or sexual
- Domestic abuse can refer to any time someone uses power and control over another person-as in child abuse, elderly abuse or partner abuse

Report any signs of abuse that you might see in your patients to your supervisor.

Patient's Bill of Rights

- Not everyone knows that patients have rights.
- Patients may receive a bill of rights when filling out paperwork before an appointment but may not read or understand it.
- As a staff member who works very closely with patients, you want to be aware of the patient's bill of rights in case you need to advocate for your patient.

What do you think are some of the rights that a patient has?

Possible answers:

- Right to high quality care regardless of your ability to pay
- Obtain services without discrimination based on race, ethnicity, language, sex, age, religion, physical or mental disability
- Be treated with courtesy and respect by staff
- Be informed of privacy policies
- Expect that staff will keep all medical information confidential
- Request a different provider if you are dissatisfied with the person assigned to you.
- Receive a complete and accurate explanation of your diagnosis and treatment plan that is easily understood.
- Ask questions at any time regarding diagnosis, treatment and treatment alternatives and risks and receive understandable and clear answers to such questions.
- Receive a copy of your records upon request.
- Receive an itemized copy of the bill for his or her services, an explanation of charges, and description of the services that will be charged to insurance.
- File a grievance or complaint.

What do you think are some responsibilities that a patient has?

Possible Answers:

- Provide accurate personal, financial, insurance and medical information.
- Behaving politely and respectfully to health center staff
- Refraining from rude, harmful or threatening behavior towards staff or other patients in the healthcare organization
- Supervising children while in the healthcare facility
- Keeping all scheduled appointments and arriving on time
- Notifying the center no less than 24 hours prior to the time of an appointment if they cannot kee the appointment or need to reschedule
- Asking questions if they do not understand explanations or information regarding diagnosis, treatment and/or prognosis.

Privacy and HIPAA

HIPAA is a law that was passed in 1996 to protect patient confidentiality

Based on what you already know, what kinds of things do you think are stated in HIPAA?

HIPPA

- Healthcare record are confidential information and legal documents
- They belong to the healthcare provider although patients have a right to a copy of them
- Healthcare record cannot be shared with anyone else outside the healthcare team unless the patient gives written consent
- Records must be kept in a locked area and/or password protected

HIPPA

- If paper records are destroyed they must be shredded
- Errors or changes in a paper record can only be crossed out, never erased
- Errors or changes in an electronic record must be made as an addendum or note
- Patients must give permission before their records are shared with anyone else-insurance, family members, doctors

HIPAA violations can get you fired

Always ask questions to your supervisor if you are unclear if something would be a violation or not.

10 GROUP EXERCISE: IS THIS A HIPAA VIOLATION?

Ask students the following questions:

1. You are riding the elevator with your co-worker at your work. You mention to her that you saw a patient today, Mr. Jones and that you feel so sad because she told you that she was just diagnosed with cancer.
   ANSWER: Yes, this is a HIPAA violation.

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.
   ANSWER: Yes, this is a HIPAA violation.

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.
   ANSWER: No, this is not a HIPAA violation, and you are using a secure encrypted email system that your agency has approved to send patient information.

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.
   ANSWER: Yes: this is a HIPAA violation unless you explicitly got permission to post his 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.
   ANSWER: Yes, this is a HIPAA violation.

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
   ANSWER: Yes, this is a HIPAA violation.

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. Would doing this be a HIPAA violation?

ANSWER: Yes, this would be a HIPAA violation and additionally could put this woman in danger, depending on the motives of the boyfriend.

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.

ANSWER: No, this is not a HIPAA violation assuming you don't share this information. You are doing your job.

11 HOMEWORK FOR NEXT CLASS

Teacher Instructions: Hand out printed copies or refer students to the link in their exercise books.

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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VIDEOS

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

MODULE 3

COMMON CHRONIC DISEASES - PART 1 DIABETES

OBJECTIVES

- Review definitions of Health Homes and Patient-Centered Medical Homes
- Understand the "clinical" role of staff providing care coordination
- Understand the basics of diabetes: most common diagnostic tests and treatments, specialists that patients with these conditions commonly need to see, and danger signs and symptoms
- List different ways that patients cope with having a chronic disease
- Know how to help patients talk to their doctors and prepare them for productive medical visits

MATERIALS

- PowerPoint file with videos downloaded
- Printed copies of homework handouts or refer students to the links located in their exercise book

Common Chronic Diseases - Part 1
Diabetes

AGENDA

1. QUIZ AND DISCUSSION: DIABETES, HYPERTENSION AND CARDIOVASCULAR DISEASE	10 MIN
2. POWERPOINT WITH DISCUSSION: "CLINICAL" ROLE OF STAFF PROVIDING COORDINATION SERVICES	5 MIN
3. POWERPOINT WITH DISCUSSION: BASICS OF DIABETES	15 MIN
4. VIDEO: DIABETES - MADE SIMPLE	5 MIN
5. POWERPOINT WITH DISCUSSION: DIABETES TESTS, SPECIALISTS, DANGER SIGNS AND SYMPTOMS	15 MIN
6. BREAK	5 MIN
7. VIDEO: MAKING SENSE OF DIABETES-TUDIABETES	5 MIN
8. VIDEO DISCUSSION	10 min
9. POWERPOINT WITH DISCUSSION: COPING WITH A CHRONIC DISEASE	15 min
10. POWERPOINT WITH DISCUSSION: TALK TO YOUR DOCTOR	5 MIN
11. VIDEO: NDEP - GETTING READY FOR YOUR DIABETES CARE VISIT	3 MIN
12. GROUP EXERCISE: HELPING A PATIENT GET READY FOR A VISIT TO THE DOCTOR	22 MIN
13. WRAP-UP, QUESTIONS, HOMEWORK ASSIGNMENT	5 MIN

1 QUIZ: DIABETES, HYPERTENSION AND CARDIOVASCULAR DISEASE

Ask students to refer to exercise book. They have 5 minutes to complete the quiz.
5 minute discussion follows.

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

ANSWERS TO QUIZ

1. **False.** As of 2010, 13.7 % of the population had diabetes.

2. **True.** High levels of blood sugar over time damage the arteries.

3. **False.** Sometimes people can control their diabetes by changing what they eat, being more active, and losing weight. If that's not enough, they need medication in addition, either oral or by injection.

4. **False.** Heart failure (when the heart does not pump blood as well as it should and often caused by narrowing or blockage of the arteries) usually takes years to develop. People who are at risk for it can be taught that making changes in their lifestyle can help prevent it.

5. **True.**

6. **True.** Physical inactivity increases your risk of high blood pressure, high cholesterol, and diabetes. Children and adults should do 30 minutes or more of physical activity every day.

7. **True.** Many people do not feel any symptoms of high blood pressure

8. **True.** Smoking raises your bad cholesterol LDL and lowers your good cholesterol HDL

9. **True.** High glucose levels in the blood can damage the blood vessels in the eyes and make people more susceptible to gum infections because of problems with blood flow

10. **True.** Studies show that keeping blood glucose levels close to normal helps prevent or delay complications of diabetes such as kidney disease, nerve damage, and serious foot problems

2 POWERPOINT WITH DISCUSSION: "CLINICAL" ROLE OF STAFF PROVIDING CARE COORDINATION SERVICES

Recap: What's a Patient-Centered Medical Home?

- A single practice with a primary care physician leading care delivery "team"
- Provides:
  - Coordinated care
  - Increased access to services for patients
  - Focus on patient education and self-management
  - Population management
  - Quality improvement

What's a Health Home?

- For Medicaid patients with multiple chronic conditions
- A network of organizations that work together to provide and coordinate care
- Uses a care management service model
- Done primarily through a "care manager" who oversees and coordinates access to all of the services
- Measures success by lowering rates of emergency room visits and hospital admissions for patients

Why do patients with multiple chronic illnesses need a different approach for their care?

- Highest costs
- Seen in the Emergency Room frequently
- Admitted to the hospital more than other patients
- Extensive care coordination needs
- Difficulty with self-management of their illnesses

Health Homes' chronic disease focus:

- Diabetes
- Hypertension
- Heart disease and stroke
- HIV
- Asthma
- Depression
- Schizophrenia

What is the "clinical" role of staff providing coordination of services for a patient?

"Clinical" role of staff providing care coordination

Yes!

- Understand basics of patient's illness(es)
  - improve communication with them
  - improve your ability to understand what services they may need
- Know danger signs for these diseases
- Understand when you need to connect the patient with a licensed professional

No!

- Diagnose
- Offer medical advice
- Change or ignore the medical team's plan of care

If the patient has concerns, support them and make sure that they are connected back to the appropriate medical team member(s)

3 POWERPOINT WITH DISCUSSION: BASICS OF DIABETES

WHAT IS IT?

TOO MUCH GLUCOSE, OR SUGAR, IN THE BLOOD

Where does glucose come from?

- Our cells need nutrients
- Blood supplies nutrients to all cells in our body
- Food we eat is turned into glucose
- Glucose = blood sugar
- Glucose is one of the nutrients our body needs
- Glucose can't enter and feed cells in our bodies without the help of insulin

What is insulin?

Insulin & the pancreas

- Insulin is a hormone made by the pancreas to help glucose get into our body's cells
- The pancreas is an organ near your stomach

What happens when a person has diabetes?

- Glucose can't get into a person's cells and builds up in their blood

Are there different types of diabetes?

Types of Diabetes

Type 1:

- Usually diagnosed when the person is a child
- Pancreas produces little to no insulin
- Must use insulin daily to stay alive

Type 2:

- Most people have this type - 9 out of 10 people with diabetes
- Pancreas still makes insulin, but either doesn't make enough or the body isn't able to use it very well, or both

Type 3: Gestational Diabetes

- Affects some women during pregnancy

Type 2 Diabetes

- Most people with type 2 diabetes find out they have it after age 30 or 40 although it can happen to younger people
- Type 2 diabetes has become more common in recent years in people in their 30's and 40's

Why do you think diabetes has become more common in recent years in people in their 30's and 40's?

More people are less active

- Using cars, instead of walking
- Watching more television and playing video games
- Spending more time on the computer/internet

Higher obesity rates

- More people eating more high calorie foods and processed fast foods

What are risk factors for diabetes?

- Family history
- Lack of physical activity
- Being overweight
- African American, American Indian, Alaska Native, Hispanic/Latino, or Asian/Pacific Islander heritage
- Being a woman who had gestational diabetes during any pregnancies

4 VIDEO: DIABETES MADE SIMPLE

5 POWERPOINT WITH DISCUSSION: DIABETES TESTS, SPECIALISTS, DANGER SIGNS AND SYMPTOMS

How is diabetes diagnosed?

- Fasting blood glucose (FBG)
  - < 100 (mg/dl) = normal
  - 100 to 125, pre-diabetes
  - 126 or > on two different days = diabetes
- Should be done in the morning, nothing to eat or drink eight hours before
- Drawn from vein in arm

What is pre-diabetes?

- Blood sugar higher than normal, but not yet high enough to be diagnosed as diabetes
- FBG 100-125
- Some long term damage can occur to heart and blood vessels
- Losing weight and increasing physical exercise can prevent or delay diabetes and may return blood sugar to normal

If someone has diabetes why is it important to manage blood sugar levels?

- Hypoglycemia: blood sugar too low
  - Can be caused by other medicines
  - Too much insulin/not enough food
- Hyperglycemia: blood sugar too high
  - Too much food, too little insulin
  - Infection, illness or stress
- Both conditions left untreated can be dangerous, even life threatening

Long term problems from diabetes

- Over time it damages organs and other parts of the body such as:
  - Eyes
  - Kidneys
  - Nerves
  - Blood vessels
  - Heart
  - Feet
  - Teeth and gums

How can staff providing care coordination help diabetic patients prevent long term problems?

Teach patients how they can reduce their risk

- Control their blood sugar by
  - Improving diet
  - Exercising
  - Quitting smoking
  - Taking prescribed medications

Ensure that patients get to their specialist appointments

- Cardiology:
  - For problems with the heart and blood vessels
  - #1 problem for diabetics, walls of arteries become thick and clogged, leading to heart disease
- Ophthalmology:
  - For problems with the eyes
  - Blood vessels of eyes injured by high blood sugar
- Nephrologist:
  - For problems with the kidneys
  - High blood sugar can cause kidneys to stop working, meaning patients will need dialysis

- Podiatrist, infectious disease, neurologist:
  - For problems with nerve damage
  - High blood sugar can damage nerves, leading to loss of sensation in feet and hands, which can cause infections, the main cause of amputations in diabetics
- Dentist:
  - For problems with teeth and gums
  - Problems with blood flow can cause gum infections and disease

Routine care for diabetes patients

Twice a year

- Blood pressure check
- Weight check
- Foot check
- A1c- test that measures a person's average blood glucose level over the past 2 to 3 months
- Dental exams

Once a year

- Cholesterol
- Dilated eye exam
- Complete foot exam
- Urine and blood tests to check for kidney problems
- Flu shot

6 BREAK

7 VIDEO: MAKING SENSE OF DIABETES

8 VIDEO DISCUSSION

1. **What were some of the challenges that these people with diabetes were coping with?**

   ANSWER:

   - Calculating carbohydrates instead of enjoying a meal
   - Medicine with a distinctive odor
   - Testing glucose levels
   - Painful finger sticks
   - Feeling like your life depends on battery operated glucose monitors

2. **One of the people with diabetes in this video says that they were "Living each day as my last." In what different ways could this attitude affect this person's health?**

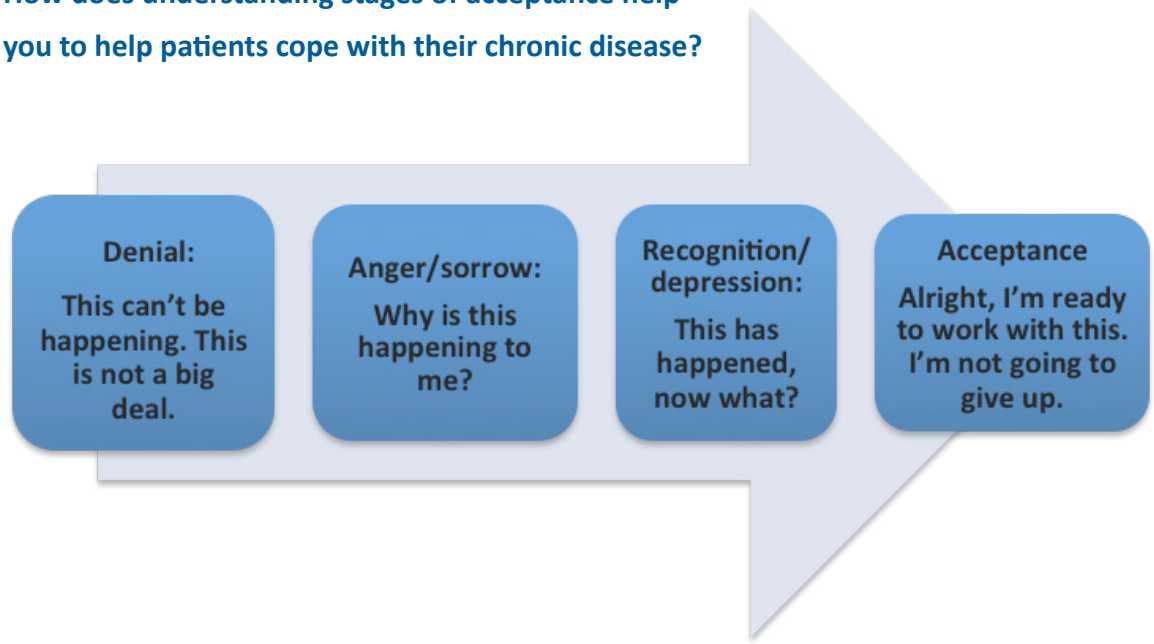
   ANSWER:

   - On the positive side this could make a patient live their life more fully, connect with their loved ones, understand what's important in their life, etc.
   - On the negative side this could mean that patients could live recklessly and not take care of themselves since they assumed they wouldn't live long

9 POWERPOINT WITH DISCUSSION: HOW DO PEOPLE COPE WITH HAVING A CHRONIC DISEASE?

- Receiving a chronic disease diagnosis can be overwhelming
- Patients cope in different ways and often may be confused, overwhelmed and unsure
- Some patients with diabetes, hypertension and cardiovascular disease may not think of themselves as having a chronic disease since these conditions are so common

How does understanding stages of acceptance help you to help patients cope with their chronic disease?



Coping with a Chronic Disease

- Not everyone diagnosed with a chronic illness goes through all of these stages or in this exact order
- A patient may be in one of these stages for days, months or years
- Throughout these phases and particularly when entering the acceptance phase, patients need information, support and services

What are some examples of support that you could offer your patients to help them cope with their chronic conditions?

- Disease specific support groups
- Helping the patient make a plan
- Arranging specialty appointments
- Helping enroll them in financial assistance programs or insurance
- Coaching on self-management
- Information about substance and alcohol abuse counselors or groups
- Education and nutrition specialist

10 POWERPOINT WITH DISCUSSION: TALK TO YOUR DOCTOR

How comfortable do you feel talking to your doctor?

How comfortable do your family members feel?

Helping patients talk to their medical providers

- In the past, most people considered their doctor "the boss"
- Expected to do what the doctor said — no questions asked
- Role of the patient in health care has changed — patients are doctor's partner in health care
- May have more than one doctor and other health care staff such as nurses as part of their medical team

How can you help patients to have better communications with medical providers?

Encourage patients to:

- Ask questions until they are certain they understand what the doctor is saying
- Take notes
- Give complete and honest information to the doctor so that they can help diagnose and treat the patient's health problems

Three main questions a patient should ask the medical provider:

- What is my main health problem?
- What do I need to do about it?
- Why is it important for me to do these things?

11 VIDEO: NDEP — GETTING READY FOR YOUR DIABETES CARE VISIT

12 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

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?

13 WRAP-UP, QUESTIONS, HOMEWORK FOR NEXT CLASS:

Refer students to the link in their exercise book or hand out printed copies of the items below.

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/nhdsp_program/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/nhdsp_program/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

REFERENCES

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

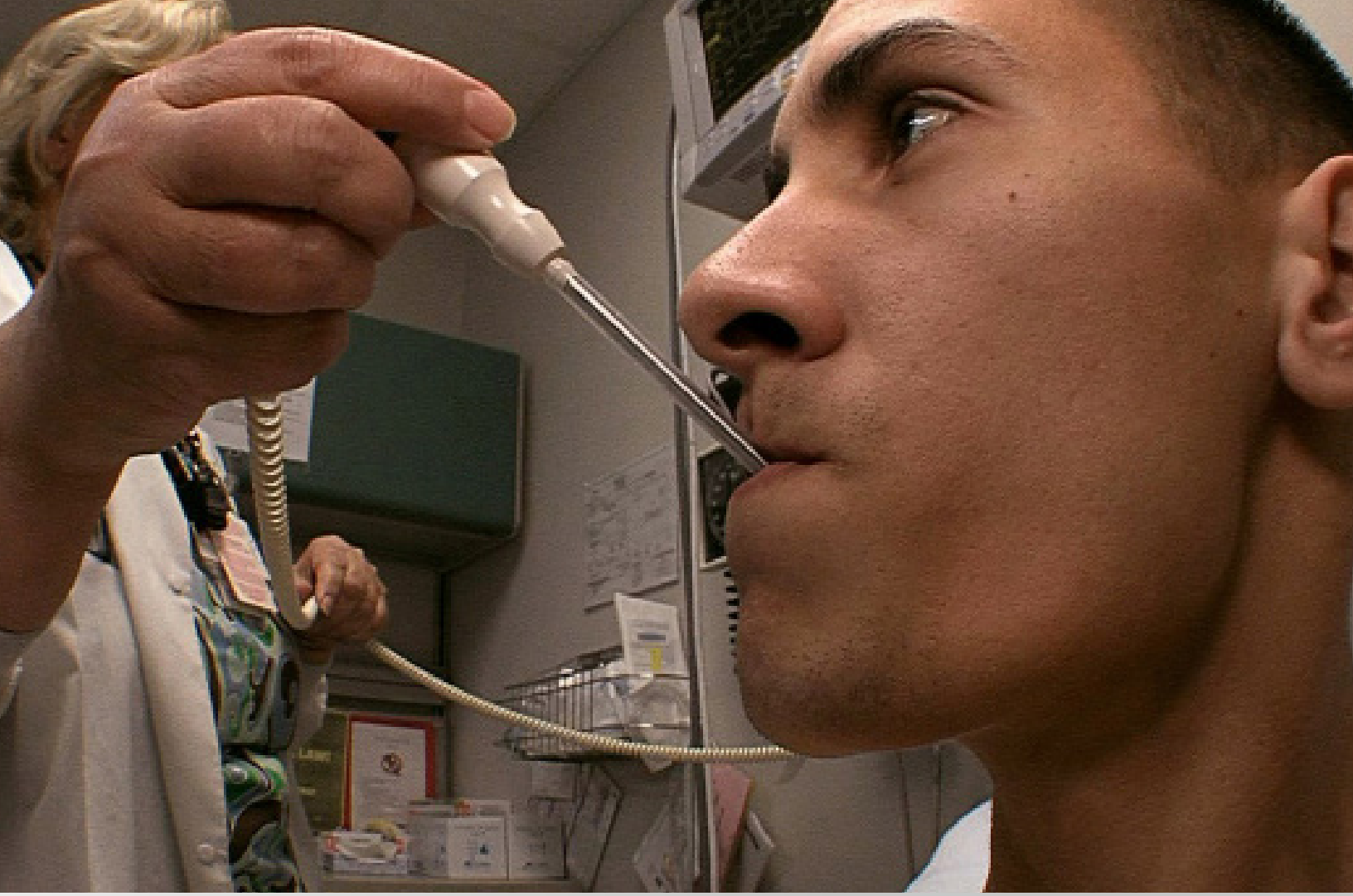
National Heart, Lung and Blood Institute, National Institutes of Health; Department of Health and Human Services
http://www.nhlbi.nih.gov/

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



MODULE 4

COMMON CHRONIC DISEASES - PART 2 HYPERTENSION/HIGH CHOLESTEROL/ASTHMA

OBJECTIVES

- Understand the basics of hypertension
- Understand the basics of high cholesterol
- Understand the basics of asthma
- Describe healthy behaviors and risk factors related to diet, exercise, and smoking

MATERIALS NEEDED

- PowerPoint file with videos downloaded
- Print copies of the homework handouts or refer students to the links located in their exercise books

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

AGENDA

1.	POWERPOINT WITH DISCUSSION: BASICS OF HYPERTENSION	10 MIN
2.	VIDEO: MANAGING HYPERTENSION WITH LIFESTYLE CHANGES	5 MIN
3.	POWERPOINT WITH DISCUSSION: BASICS OF HIGH CHOLESTEROL	10 MIN
4.	GROUP EXERCISE: SATURATED FAT IN FOODS	15 MIN
5.	GROUP EXERCISE: ROSA'S DILEMMA	20 MIN
6.	BREAK	5 MIN
7.	POWERPOINT WITH DISCUSSION: ASTHMA	15 MIN
8.	VIDEO: LIVING WITH AND MANAGING ASTHMA	5 MIN
9.	VIDEO DISCUSSION	5 MIN
10.	SMALL GROUP EXERCISE: HEALTHY BEHAVIORS: DIET/EXERCISE/ SMOKING QUIZ	25 MIN
11.	WRAP-UP, QUESTIONS, HOMEWORK ASSIGNMENT	5 MIN

1 POWERPOINT WITH DISCUSSION: BASICS OF HYPERTENSION

What is blood pressure?

Blood Pressure is:

- The force of blood against artery walls as it is pumped through the body.
- Blood pressure helps get blood to all parts of the body.

What is high blood pressure (hypertension)?

High Blood Pressure/Hypertension:

- Heart has to pump harder than normal for blood to get to all parts of the body
- Blood pressure is too high when the heart works too hard, or the arteries that carry the blood around the body, are too narrow
- A heart that has to work harder than normal for a long time gets weaker

High Blood Pressure/Hypertension

- Increases a person's risk of heart related problems including:
  - Heart attack
  - Stroke

What causes high blood pressure (hypertension)?

- Too much salt in the diet
- Being overweight or obese
- Lack of physical activity
- Heavy alcohol consumption
- Smoking
- Diabetes and kidney disease
- Risk factors: African American race, male gender
- Stress - especially anger and hostility

How is high blood pressure (hypertension) diagnosed?

Blood Pressure is measured as part of your regular physical exam and visits to a medical provider

- Normal blood pressure is less than 120/80
- High blood pressure is > than 140/90
- 140-159/90-99 = stage 1 hypertension
- > 160/100 = stage 2 hypertension which often requires more than one medication

What are the signs of high blood pressure?

It is possible to have high blood pressure, but experience no symptoms at all:

- A person can be calm and relaxed and have high blood pressure
- Many people have high blood pressure for years and don't know it.
- "The silent killer"

Signs of high blood pressure

- Tiredness
- Confusion
- Nausea
- Vision problems
- Nosebleeds
- Headache
- Dizziness
- Anxiety, palpitations
- Impotence

Why is high blood pressure harmful?

- Causes the heart to work harder than it normally would
- Increases a person's risk of heart attacks, strokes, kidney damage, eye damage, heart failure and atherosclerosis (hardening of the arteries)

How can high blood pressure be prevented or controlled?

- Eat less salt and sodium
- Aim for a healthy weight
- Eat a low fat diet that includes lots of fruits and vegetables
- Be active for at least 30 minutes most days
- Limit amount of alcohol you drink (< 1 drink a day for women, < 2 for men)
- Quit smoking
- Take prescription medications as prescribed

2 VIDEO: MANAGING HYPERTENSION WITH LIFESTYLE CHANGES

3 POWERPOINT WITH DISCUSSION: BASICS OF CHOLESTEROL

A high level of cholesterol in the blood is a leading risk factor for heart disease and stroke. About 100 million people in the United States have cholesterol levels high enough to pose a serious risk to their health.

What is high blood cholesterol?

- Cholesterol: fatty substance in bloodstream and cells made by the liver and is needed for the body to function normally
- High blood cholesterol: too much cholesterol in the blood, contributes to the build-up of plaque along walls of blood vessels
- Plaque: Thick hard layer of cholesterol that can narrow blood vessels and clog arteries

Is there such a thing as good cholesterol and bad cholesterol?

HDL and LDL

- HDL (high-density lipoprotein) is "good" cholesterol
- LDL (low-density lipoprotein) is "bad" cholesterol
- You want the highs to be high (HDL) and the lows to be low (LDL)

What are Triglycerides?

- Another type of fat in the blood that adds to overall cholesterol levels
- A diet high in calories, carbohydrates, or trans-fat causes your body make more triglycerides

What causes high blood cholesterol?

- Inactivity
- Obesity
- Diet high in saturated fat and trans fat
- Age
- Family history/genetics
- Stress and how it's managed

How do smoking and high blood pressure relate to high cholesterol?

- High cholesterol combined with smoking and high blood pressure add to your risk of developing heart disease
- Smoking and high blood pressure damage blood vessel walls making it more likely that cholesterol will collect along walls and cause them to narrow and harden
- Smoking raises triglyceride and LDL

What are the symptoms of high blood cholesterol?

No symptoms

How is high cholesterol diagnosed?

Blood tests

- Finger stick
- Lipid profile test (fasting test)

What are normal cholesterol levels?

- Total cholesterol <200
- LDL < 130, or <100 if a person has diabetes or heart disease
- HDL > 40
- Triglycerides <150

How is high blood cholesterol treated?

- Dietary changes
  - Reduce saturated fat and trans fat
- Quit smoking
- Increase activity and exercise
- Lose weight
- Medications

4 GROUP ACTIVITY: SATURATED FATS IN FOODS

Ask the class: *What are some examples of food that are high in saturated fats?*

Remember, foods that come from animals are often high in saturated fats, but other foods, such as french fries, which are fried in fat, can also be high in saturated fats and trans fat.

(You could have someone write the students responses on a whiteboard or flipchart if you have one available.)

Possible responses are:

- Whole milk, butter, cream, and high-fat cheeses
- Lard, pork fat, shortening, and oils such as coconut and palm
- Fatty meat, such as ribs, hot dogs, sausage, pork rinds, liver, and lunch meats such as bologna and salami
- Tacos, french fries, and fried foods from fast-food restaurants
- Pastries, donuts, cakes, pies, chips, and other snack food

Ask the class: *What kinds of foods do you think are lower in saturated fats or have no saturated fats?*

Possible responses are:

- Fish
- Chicken and turkey without skin
- Beans and brown rice
- Fruits and vegetables
- Fat-free and low-fat milk
- Fat-free cheese, cottage cheese, and yogurt
- Some oils (canola, olive, peanut, soybean, safflower, corn, sunflower, flaxseed)

5 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:

_____

_____

_____

_____

_____

_____

_____

_____

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

Possible answers/suggestions for Rosa:

- Cook meals over the weekend for some of the week
- Take turns preparing meals for the family
- Prepare parts of a meal in advance like sauces to add to chicken, fish, veggies, and rice
- Freeze some meals
- Share meal preparation tasks — try to include her spouse and children in preparing meals and/or clean-up
- Plan weekly meals based on her family's schedule
- If she has to go to fast food restaurants try to make healthier choices like grilled chicken, salad with dressing on the side, rice and beans with salsa and without cheese, smaller portions of high saturated fat foods like French fries or baked potato instead, water or seltzer instead of soda
- Look for Latino restaurants instead of American fast food which tends to be higher in saturated fat
- Keep healthy snacks on hand

6 BREAK

7 POWERPOINT WITH DISCUSSION: ASTHMA

- In the United States, more than 22 million people have asthma
- Nearly 6 million of these people are children

What is asthma?

- Chronic lung disease that inflames and narrows the airways
- Airways are swollen and sensitive
- Tend to react strongly to certain substances that are breathed in
- When airways react, muscles around them tighten, airways narrow further, and less air flows into the lungs
- Cells in the airways then make more mucus than normal

What are the symptoms of asthma?

- Wheezing (a whistling sound when you breathe)
- Chest tightness
- Shortness of breath
- Coughing

What's an asthma attack?

- Wheezing, chest tightness, shortness of breath, and coughing get worse
- Symptoms may get more intense, and additional symptoms may appear
- Needs to be treated
- May require emergency care
- If attack is very severe, can cause death

What are the causes and risk factors for asthma?

- Exact cause unknown
- Theory: combination of family genes and environmental exposure
- Different factors may be more likely to cause asthma in some than in others
- Most people who have asthma, although not all, also have allergies

What are the main medicine treatments for asthma?

- Long term control medicines:
  - Help reduce airway inflammation and prevent future asthma symptoms
- Quick-relief, or "rescue," medicines
  - Relive asthma symptoms when they flare up

Goal of asthma treatment

- Control the disease & prevent asthma attacks
  - Prevent chronic and troublesome symptoms such as coughing and shortness of breath
  - Reduce need for quick relief medications
  - Help maintain good lung function
  - Be able to maintain normal activities such as sleeping through the night and exercising
  - Prevent attacks that could make someone have to go to the emergency room or be admitted to the hospital

What are asthma triggers?

- Things that make a particular person's asthma worse or trigger an asthma attack

Asthma triggers

- Allergens:
  - Animal dander
  - Dust mites
  - Cockroaches
  - Mold
- Irritants:
  - Cigarette smoke
  - Smoke
  - Strong odors
  - Sprays
- Other causes:
  - Vacuum cleaning
  - Cold air
  - Sulfites
  - Other medicines

What's an asthma action plan?

- Gives personalized guidance on:
  - When and how to take medications
  - Avoiding factors that worsen a person's asthma
  - Tracking a person's level of asthma control
  - How to respond to worsening asthma
  - When to seek emergency care
- Many people do not have an action plan

What's a peak flow meter and what is it used for?

- Hand held device that measures air flow (how fast air is blown out of the lungs)
- Patients can use peak-flow meters to measure their own air flow regularly
- The use of a peak-flow meter allows patients to obtain a much earlier indication of an oncoming attack
- Allows a patient to gauge how under control their asthma is

http://www.medterms.com

Danger signs and symptoms of asthma

- Trouble walking and talking due to shortness of breath
- Lips or fingernails are blue
- If these symptoms exist, patient should use quick relief medicine AND go to the hospital or call 911

8 VIDEO: LIVING WITH AND MANAGING ASTHMA

9 VIDEO DISCUSSION

What happens to your airways when you have asthma?

- They become inflamed

What is the goal of asthma treatment?

- To control the symptoms

What's on an asthma action plan?

- How to manage your asthma every day
- What medications to take and when
- What kind of monitoring to do
- What to do if your symptoms are getting worse
- What to do if you're not getting better

10 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. NOTE: there may be more than one for each question.

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

ANSWER KEY FOR HEALTHY BEHAVIORS: DIET/EXERCISE/SMOKING QUIZ

1. a, b, d
2. a, b, c, d
3. a, b, d
4. a, b, c, d
5. b, c
6. a, b, c,
7. a, b, c, d
8. a
9. b, c, d
10. a, d
11. c, d
12. b, c
13. a, b, c
14. a, b, c
15. b, c, d
16. a, b, c
17. a, b, c, d
18. c
19. a
20. a, c, d
21. a, c, d
22. b, c,

11 WRAP-UP, QUESTIONS, HOMEWORK REVIEW FOR NEXT CLASS: RELATED TO HEART DISEASE AND STROKE

Distribute printed copies of the handouts below or refer students to the link in their exercise book.

Homework 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

Heart disease and stroke overview: Handout 1-1, Handout 1-2, Handout 1-3

Stroke: Handout 2-1, Handout 2-2, Handout 2-3, Handout 2-4

Heart Attack: Handout 3-1, Handout 3-2 Act in Time, Heart Attack Signs, Handout 3-3 What is cardiac rehabilitation?

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

MODULE 5

COMMON CHRONIC DISEASES - PART 3 HEART DISEASE/STROKE

OBJECTIVES

- Understand the basics of heart disease
- Understand the basics of stroke
- Be able to discuss how culture and cardiovascular disease can be related
- List ways to support patients taking their medications

MATERIALS

- PowerPoint file with videos downloaded
- Print copies of homework handouts or refer students to the links located in their exercise books

Common Chronic Diseases - Part 3
Heart Disease/Stroke

AGENDA

1.	POWERPOINT WITH DISCUSSION: OVERVIEW: HEART DISEASE AND STROKE	10 MIN
2.	VIDEO: LIVING WITH AND MANAGING CORONARY ARTERY DISEASE	4 MIN
3.	VIDEO: ALL OF OUR STORIES ARE RED: JENNIFER'S STORY	3 MIN
4.	VIDEO DISCUSSION	5 MIN
5.	POWERPOINT WITH DISCUSSION: HEART ATTACK	15 MIN
6.	POWERPOINT WITH DISCUSSION: STROKE	15 MIN
7.	VIDEO: STROKE HEROES ACT FAST	3 MIN
8.	SMALL GROUP EXERCISE: CULTURE AND CARDIOVASCULAR DISEASE	20 MIN
9.	BREAK	5 MIN
10.	POWERPOINT WITH DISCUSSION: TAKING MEDICATION	5 MIN
11.	SMALL GROUP EXERCISE: HELPING PATIENTS TAKE MEDICATION	15 MIN
12.	EXERCISE: JOB DESCRIPTION MATCHING GAME	15 MIN
13.	HOMEWORK FOR NEXT CLASS	5 MIN

1 POWERPOINT WITH DISCUSSION: OVERVIEW: HEART DISEASE AND STROKE

What is heart disease?

Heart Disease

- Any disease or condition that affects or damages the heart or blood vessels
- Also called cardiovascular disease
  - Cardio: related to the heart
  - Vascular: related to the blood vessels

What is stroke?

Stroke

- When a blood vessel in the brain becomes blocked or bursts open and blood can no longer reach the brain
- The blockage or rupture from a stroke can cause brain damage
- Also called cerebrovascular disease
  - Cerebro: related to the brain
  - Vascular: related to the blood vessels

What medical conditions can lead to heart disease and stroke?

Medical conditions that can lead to heart disease and stroke

- High blood pressure
- High blood cholesterol
- Diabetes

Are risk factors for heart disease and stroke the same?

YES

- Reducing your risk for heart disease will reduce your risk for stroke
- Lifestyle changes that reduce your risk for stroke improve your heart's health

What lifestyle changes can prevent or reduce risk of heart disease and stroke?

- Eat healthy foods
- Become more physically active
- Keep or work towards a healthy body weight
- Don't use tobacco
- Stress management

Some facts about heart disease and stroke:

- Heart disease is the number one cause of death in the United States
- Stroke is the third leading cause of death in the United States
- Together heart disease and stroke cause more than half of all deaths in America

Heart disease and stroke can equal permanent disability:

- Heart disease and stroke are the leading cause of permanent disability among working-age adults
- Doesn't just affect men and older people
- Leading cause of death in women, and people in the prime of their life.

Staff who provide care coordination services can play an important role in preventing heart attack and stroke in their patients

2 VIDEO: LIVING WITH AND MANAGING CORONARY ARTERY DISEASE

3 VIDEO: ALL OF OUR STORIES ARE RED: JENNIFER'S STORY

4 VIDEO DISCUSSION

- What did you think of these videos?
- Were you aware that the number on killer of women is heart disease?
- Do you think that your friends and family are aware of that?

5 POWERPOINT WITH DISCUSSION: HEART ATTACK

Educating your patients about the warning signs of heart attack

If someone is having a heart attack, does it make a difference how quickly they receive medical treatment?

Timing is important

- Heart attack = blood supply to heart is blocked
- Blood supply blocked, heart muscle begins to die and heart rhythms may become irregular
- Irregular heart beat can mean that heart cannot pump enough blood
- If heart cannot pump enough blood a person can die or become disabled
- The sooner a heart attack is treated, the greater a person's chance of surviving!

What are the warning signs of a heart attack?

Warning signs of a heart attack:

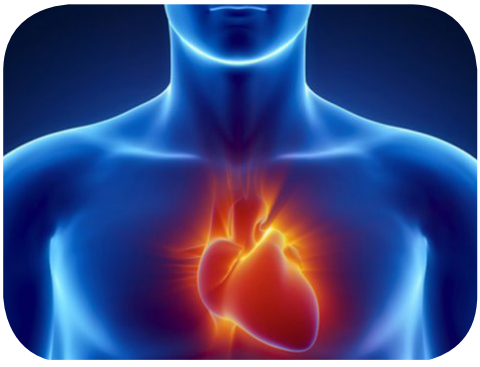
- Sudden chest pain (chest hurts or feels squeezed)
- Sudden pain or pressure in one or both arms (back, neck, jaw)
- Sudden shortness of breath
- Sudden breaking out in a cold sweat, feeling nauseated, or feeling light headed

Warning signs of a heart attack:

- Sometimes there are no warning signs at all
- Symptoms may come and go
- Women often have less common warning signs and symptoms
  - Fatigue
  - Inability to sleep
  - Shortness of breath
  - Indigestion
  - Anxiety

Teach your patients

- It is important to recognize the signs of heart attack
- If you think you or someone else is having a heart attack, call 911 immediately
- Chances of surviving a heart attack/limiting damage to heart are best if person receives treatment within first hour after a heart attack
- Many “clot-busting” medications can quickly stop heart attack by restoring blood flow to the heart



How is heart attack diagnosed?

- Reviewing a person’s medical history, including risk factors
- Physical exam
- An electrocardiogram (EKG or ECG) to test for damage to the heart
- Blood tests to detect abnormal levels of certain substances in blood that can show that heart has been damaged

How is heart attack treated?

- Clot busting drugs if heart attack occurred within last three hours
- Coronary artery bypass surgery
  - Cut and sew veins or arteries to a place past the blockage
- Coronary angioplasty
  - Pass a thin tube through an artery to the blocked artery in the heart
  - Balloon inflated to open the blocked artery or a small wire mesh tube called a stent put in place to hold artery open

After a heart attack:

Patients may feel:

- Scared
  - Uncertain about the future - fearful of loss of income, worried about how bills will be paid
- Overwhelmed
  - Too many things to remember, too many changes to make in their life
- Helpless
  - Feeling that they can’t do anything to control their health
- Angry that it happened to them
- Relieved at having a chance to start over

Cardiac rehab

- Takes place in hospital or community facility
- Helps patient change their lifestyle habits
- Usually patient sees a team of healthcare professionals:
  - Doctors
  - Nurses
  - Physical therapists
  - Nutritionists
  - Social workers
- Exercise therapy, strength training
- Stress management techniques
- Help quitting smoking

6 POWER POINT WITH DISCUSSION: STROKE

Educating your patients about the warning signs of stroke

If someone is having a stroke, does it make a difference how quickly they receive medical treatment?

Timing is important

- Stroke = blood flow to brain is disrupted and brain is unable to function properly
- Without blood flow to provide oxygen to brain, brain cells die in a few minutes and cannot be replaced
- The sooner a stroke is treated, the greater a person's chance of surviving!

What are the warning signs of a stroke?

Warning signs of a stroke:

- Sudden numbness or weakness of face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking, or trouble understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness or loss of balance or coordination
- Sudden severe headache with no known cause

Warning signs of a stroke:

- Symptoms can last a few minutes to a few hours
- A stroke can take place without a person knowing it is happening
- Patient may know right away they are having a stroke or they might not notice that something is wrong until hours or days after they have had the stroke

Teach your patients

- It is important to recognize the signs of a stroke
- If you think you or someone else is having a or has had a stroke, call 911 immediately
- There are medicines and treatments that can greatly improve recovery, but only if they are started soon after the stroke has occurred

How is a stroke diagnosed?

How do medical staff diagnose a stroke?

- Ask about the warning signs that the person felt
- Ask the person about their health history
- Order certain blood tests
- Do a physiological and neurological (brain) exam
- Do other tests to get an idea of what is happening in the brain such as CAT or CT scans, MRIs, and blood flow tests

How is a stroke treated?

- For many strokes, chance of recovery is good if treatment is given within a few hours
- New medicine available that dissolves clots but must be given within three hours of the start of the stroke to be effective
- Other medicines to prevent blood clots and lower blood pressure if it's high
- Surgery to remove a blockage or stop bleeding
- Devices that are inserted into blocked arteries

What are the results of a stroke?

Damage from stroke:
Depends on location and size of damage in brain

- Patients may recover completely or only partially from a stroke
- A person who suffered a stroke is likely to face emotional problems in addition to the physical ones
- A stroke survivor may cry easily or may have sudden mood swings often for no clear reason

Disabilities caused by a stroke include:

- Paralysis or inability to move
- Vision problems
- Memory loss
- Difficulty talking or understanding what others are saying
- Change in behavior, such as asking question after question, over and over
- Depression

What is stroke rehab?

- To recover from disabilities caused by stroke, a person always needs rehab or therapy
- Four main types:
  - Physical therapy:
    relearning how to walk, move, maintain balance
  - Occupational therapy:
    relearning basic activities of daily living such as bathing and dressing
  - Speech therapy:
    relearning how to speak
  - Emotional support therapy:
    "talk therapy" and medicines for depression, learning stress management

7 VIDEO: STROKE HEROES ACT FAST

8 SMALL GROUP EXERCISE: CULTURE AND CARDIOVASCULAR DISEASE

Say to the class: *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.**

9 BREAK

10 POWER POINT WITH DISCUSSION: HELPING PATIENTS TAKE THEIR MEDICINE

What are some reasons why people do not take their medicines as advised by their doctor?

- Don't understand what the medicine is supposed to do
- Not sure how to take their medicines
- Cannot afford their medicines so they don't get them
- To save money they cut their pills in half or take them every other day
- Taking so many already that they don't want to take any new ones
- Don't feel well and think the medicine isn't helping
- Feel that the medicine is giving them side effects that they don't like
- Forget to take their medicines
- Think they can do without their medicines
- Don't have anyone to help them or support them taking their medicines

Why is it important to take medicines exactly as prescribed by the doctor or provider?

- Medicines work best when taken exactly as prescribed
- Skipping doses can be harmful and lead to a patient's health getting worse
- If a patient is not feeling well while taking a particular medication they should contact their doctor or nurse
- Abruptly stopping certain medications can be dangerous

How can a healthcare provider know if the medicine is working?

Confirming the medicine is working

- Clinicians often have to make minor adjustments to medications that patients take
- After starting a medicine, a patient will be tested regularly to make sure that the medicine is working
- If it's not working as well as it should, the patient may be given a higher or lower dose or switched to a different medication

11 SMALL GROUP EXERCISE: HELPING PATIENTS TAKE MEDICATION

Say to class: *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.

12 SMALL GROUP EXERCISE: JOB DESCRIPTIONS MATCHING GAME

Say to class: *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.

JOB DESCRIPTIONS MATCHING GAME ANSWER KEY

1. Primary care physician	B
2. Specialist	D
3. Nurse Practitioner, Nurse Midwife, Physician Assistant	K
4. Nurse	R
5. Medical Assistant	E
6. Social Worker	F
7. Radiologist	G
8. Endocrinologist	X
9. Cardiologist	A
10. Pulmonologist	H
11. Surgeon	I
12. Oncologist	J
13. Administrator	L
14. Certified Diabetes Educator	M
15. Podiatrist	N
16. Registered Dietitian, Nutritionist	P
17. Rehabilitation Specialist	Q
18. Pharmacist	S
19. Dentist	U
20. Physical Therapist	V
21. Vascular Surgeon	W
22. Pathologists	O
23. Home Health-aid	C
24. Psychiatrist	Y
25. Staff member providing care coordination	T

13 HOMEWORK REVIEW FOR NEXT CLASS: HEPATITIS AND HIV

Hand out printed copies of homework handouts or refer students to links in exercise book.

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

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

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

MODULE 6

COMMON CHRONIC DISEASES - PART 4 HEPATITIS/HIV

OBJECTIVES

- Understand the basics of Hepatitis A, B, C
- Understand the basics of HIV
- Describe how care coordination can help patients with HIV and Hepatitis

MATERIALS NEEDED

- PowerPoint file with videos downloaded

Common Chronic Diseases - Part 4
Hepatitis/HIV

AGENDA

1.	HOMEWORK REVIEW/FEEDBACK ON LAST CLASS	5 MIN
2.	POWERPOINT WITH DISCUSSION: HEPATITIS A, B, AND C	10 MIN
3.	VIDEO: HEPATITIS C MADE SIMPLE: KNOW YOUR STATUS	7 MIN
4.	VIDEO DISCUSSION	5 MIN
5.	VIDEO: GEORGE'S STORY: HEPATITIS C	2 MIN
6.	VIDEO: SU WANG: FACES OF HEPATITIS	3 MIN
7.	VIDEO DISCUSSION	13 MIN
8.	POWERPOINT WITH DISCUSSION: BASICS OF HIV	15 MIN
9.	BREAK	5 MIN
10.	VIDEO: FACES OF HIV: KAMARIA'S STORY	6 MIN
11.	VIDEO DISCUSSION	15 MIN
12.	VIDEO: LIVING WITH HIV	4 MIN
13.	GROUP EXERCISE: LIVING WITH HIV	25 MIN
14.	HOMEWORK FOR NEXT CLASS	5 MIN

1 HOMEWORK REVIEW/ FEEDBACK ON LAST CLASS

2 POWERPOINT WITH DISCUSSION: HEPATITIS A, B, AND C

What is Hepatitis?

- Hepa = liver
- Titis = inflammation
- Inflammation of the liver

What does the liver do?

- A vital organ
- Processes nutrients
- Filters the blood, removes toxins
- Fights infection

How might inflammation affect the function of the liver?

- Makes it work less effectively
- Damages and scars it

What causes Hepatitis?

- Usually caused by a virus
- Heavy alcohol use, some medications, toxins and some medical conditions

What are the different types of Hepatitis?

- Hepatitis A
- Hepatitis B
- Hepatitis C
- Hepatitis D and E (less common)

What is Hepatitis A?

- Spread by objects, food, or water contaminated with virus
- Fecal-oral route, hand washing lowers risk
- Acute infection lasts weeks to months
- Fever, fatigue, vomiting, jaundice
- Treatment: rest, nutrition, fluids, monitoring
- Vaccine available

What is Hepatitis B?

- Spread through blood, body fluids
- Sexual activity, contaminated needles, contact with blood
- From an infected mother to her baby at birth
- Some can clear acute infection completely
- Vaccine available

What does it mean if a person has chronic Hepatitis B?

- Many people with lifelong chronic infection were infected at birth
  - High rates in Asia and Africa
- May feel no symptoms for many, many years
- 15-25% with chronic disease develop serious liver disease, liver damage, liver failure
- 3,000 people die every year in the US from Hepatitis B related liver disease
- Treatment: regular monitoring, medication, good nutrition, alcohol/drug avoidance
- There is no cure

www.cdc.gov/hepatitis

What is Hepatitis C?

- Spread mainly through blood and less so through sexual activity
- Sharing needles to inject drugs, or unsterilized/ reused needles i.e. for tattoos
- Estimated 3.2 million in US have chronic Hepatitis C
- Most people with Hepatitis C are unaware of it
- Now kills more Americans than HIV
- No vaccine
- Small percentage can clear acute infection completely
- 75-85% of those infected develop chronic infection
- Many feel no symptoms for many, many years
- Can lead to liver damage, liver failure, liver cancer, cirrhosis
- Fever, nausea, vomiting, jaundice, joint pain

How is Hepatitis C treated?

- 6-12 months of antiviral medications for some patients
- Medications can cause side effects: flu like symptoms, weight loss, depression, rash, insomnia
- New medication available that may reduce length of treatment
- For many people medication can result in virus becoming undetectable and they are “cured”
- A smaller percentage of patients don’t respond to medication and their viral load remains detectable
- Alcohol/drug avoidance

www.cdc.gov/hepatitis

How does a person find out if they have Hepatitis?

- Blood tests
- Hepatitis blood tests are not typically done during a routine physical exam
- People at risk should ask for test
- If Hepatitis test is positive, usually more tests are done to see if it is acute or chronic and if the liver has been affected

How can care coordination help patients with Hepatitis?

- Provide education and support
- Encourage them to get tested if they might be at risk
- Help them get to specialty appointments
- Connect them with support groups or social work if needed
- Link with community resources

3 VIDEO: HEPATITIS C MADE SIMPLE: KNOW YOUR STATUS

4 VIDEO DISCUSSION

- Did you learn anything new from this video?
- Was anything a surprise to you?

5 VIDEO: GEORGE'S STORY: HEPATITIS C

6 VIDEO: SU WANG: FACES OF HEPATITIS

7 VIDEO DISCUSSION

1. What does George say "his journey" for recovering from Hepatitis C was?
   ANSWER: Getting educated and getting his family involved.

2. What does George say his objective is with his support groups?
   ANSWER: Not to get people to get treatment, but to get people to get tested.

3. What does Dr. Wang think is the reason that Hepatitis B and Hepatitis C has not received a lot of attention?
   ANSWER: Because Hepatitis B and C are diseases disease that primarily affect minorities, people "think it doesn't affect the mainstream."

4. What cancer does Dr. Wang say is growing because of Hepatitis?
   ANSWER: Liver cancer.

8 POWERPOINT WITH DISCUSSION: BASICS OF HIV

What is HIV?

- Human Immunodeficiency Virus
- Virus that can lead to AIDS
- Destroys CD4 T cells which are essential to help the body fight disease

What is AIDS?

- Late stage of HIV infection
- Person's immune system is severely damaged
- Person has trouble fighting diseases and certain cancers

How do people get HIV?

- Sexual contact
- Sharing needles or syringes
- Contact with infected blood
- Being born to an infected mother

What increases people's risk of getting HIV?

- Having multiple sex partners
- Having an untreated sexually transmitted infection (STI) or a partner with an untreated STI
- Risky sex

Why types of sex are the most risky and least risky: oral, vaginal or anal sex?

- All types of sex can spread STIs and HIV but:
  - Oral sex is the least risky
  - Anal sex is the most risky

What other things would be classified as "risky sex"?

- Sex without protection (condoms)
- Contact when there are open sores
- "Rough sex" that might cause bleeding or tears
- Sex under the influence of alcohol or drugs

From Community Outreach Patient Empowerment: Protecting Ourselves from HIV and other STIs

What are some ways that HIV *cannot* be spread?

- Through air or water
- Insects, including mosquitoes
- Saliva, tears, or sweat
- Casual contact: shaking hands or sharing dishes
- Closed mouth or "social" kissing

What are ways to prevent the spread of HIV?

- Limit your number of sex partners
- Use condoms, use them correctly, and use them ***every time***
- Don't use injection drugs or get tattoos with unsterilized instruments
- Get tested and treated for STDs and insist that your partners do too
- Know your HIV status, get tested

How can you tell if someone has HIV?

- You can't
- HIV test

How do HIV tests work?

- Detects antibodies to HIV in a person's blood

What are antibodies?

- If someone has HIV or any other infection, the immune system produces antibodies:
  - Chemicals that are part of the immune system
  - Recognize invaders like bacteria and viruses
  - Mobilize the body's attempt to fight infection

Why would the HIV test look for antibodies in a person's blood?

- In the case of HIV, these antibodies cannot fight off the infection, but their presence is used to tell whether a person has HIV in his or her body

If someone tests negative, does that mean that their partner is negative as well?

- No. A person's HIV test result reveals only their HIV status
- A negative test result does not indicate whether or not someone's partner has HIV
- H\IV is not necessarily transmitted every time a person has sex, so taking an HIV test should not be seen as a method to find out if your partner is infected

If someone has sex or shares needles with someone who is HIV +, and they get an HIV test right away, will it be able to tell them if they got HIV?

- Not always
- A person could have been infected with the HIV virus but it will not show up at first on an HIV test

How long can it take for a person to test positive after exposure to HIV?

- Up to three months

What are early symptoms of HIV?

- Many people don't experience any symptoms at first when they get HIV
- Some get: fever, headache, sore throat, rash

What are later symptoms of HIV?

- Years later, some still feel fine
- Other people may feel sick:
  - More infections, colds, pneumonias
  - Sores in mouth
  - Shingles (painful rash on one side of body)
  - Other rashes and skin infections
  - Fever, weight loss, sweating at night, weakness

How is HIV treated?

Treatment

- No cure
- Variety of drugs can be used to control the virus

Treatment is life long

- Can be difficult, but new medications make it much less burdensome than in the past
- Side effects can include: nausea, vomiting, diarrhea, abnormal heartbeats, shortness of breath, skin rash, weakened bones

Co-diseases and Co-treatments

- Some meds that are for age related diseases such as cardiovascular, metabolic and bone related diseases may not interact well with HIV meds

How do medical providers know when treatment is working for a person with HIV?

Treatment Response

- Response to HIV treatment is measured by viral load and CD4 counts
- CD4 count should go up (immune system strengthening)
- Viral load should go down to undetectable (suppressed virus)
- HIV not gone, but under control
- Body stronger and healthier

What happens if a patient doesn't take their medication every day?

Skipping HIV meds

- HIV can get worse and become AIDS
- Develops resistance to the medications
- Need to start new meds because old ones stop working

How can care coordination help patients with HIV?

- Provide support
- Help them navigate the system
- Help get them to specialty appointments
- Link them to social services and support groups if desired
- Link to financial resources
- Link to community resources

9 BREAK

10 VIDEO: FACES OF HIV: KAMARIA'S STORY

11 VIDEO DISCUSSION

1. What does Kamaria say were her first thoughts and fears when she was told her diagnosis?
   ANSWER: "When am I going to die, when is my baby going to die, who's going to take care of us?"

2. How does Kamaria say that her diagnosis has changed her?
   ANSWER: Life is not about me, can help someone else who doesn't have a support system, was headed down a n "insecure and dark road" that might have put other people at risk, thankful for her diagnosis, made her able to turn her life around.

3. What is a good or great "day with HIV" for Kamaria?
   ANSWER: A day where she doesn't think about it, or when she can help someone else who is either newly diagnosed or has been struggling with it for a long time.

4. What does Kamaria mean when she says "we've gone to the other end of the spectrum where everybody was in a panic, but now everyone is complacent and thinks that you just have to 'pop a pill' and everything will be ok?"
   ANSWER: The reality of taking meds, relationships, insurance, paying for medications.

5. What does Kamaria want people to know about HIV?
   ANSWER: It can happen to anybody, only takes one incident to get it. It's indiscriminate. You can hurt other people as well if you have it

12 VIDEO: LIVING WITH HIV

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

Teachers can conduct the following exercise in one of two ways:

1. Anonymously, everyone turns in their answers. The teacher reads the answers and leads a discussion.
2. Ask for volunteers to read their answers, then teacher leads discussion with class.

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?

14 HOMEWORK: FAMILY RELATIONSHIP TO HEALTHCARE

Say to class: *For homework, please refer to your exercise book. 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?

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

MODULE 7

BIAS, CULTURE, AND VALUES IN HEALTHCARE

OBJECTIVES

- Describe how personal bias and culture can impact the way people interpret illness and interact with the medical system.
- Identify your own biases and how they affect your role as a staff member providing care coordination.
- Demonstrate effective interviewing skills by describing the types of questions you would ask to better understand a patient's culture.

MATERIALS

- PowerPoint file with videos downloaded
- Printed Values Clarification Exercise hand outs
- Print out homework article or refer students to the link in their exercise book: "Broad Racial Disparities Seen in American's Ills" by Donald G. McNeil Jr. We will discuss the article at the next class.
  http://www.nytimes.com/2011/01/14/health/14cdc.html

Bias, Culture, and Values in Healthcare

AGENDA

1.	HOMEWORK REVIEW	10 MIN
2.	POWERPOINT WITH DISCUSSION: CULTURAL COMPETENCE DEFINITIONS	5 MIN
3.	EXERCISE: VALUES CLARIFICATION	25 MIN
4.	POWERPOINT WITH DISCUSSION: CULTURAL IDENTITY	10 MIN
5.	VIDEO: CULTURAL HUMILITY: PEOPLE, PRINCIPLES, AND PRACTICES	7 MIN
6.	VIDEO DISCUSSION	8 MIN
7.	BREAK	5 MIN
8.	POWERPOINT WITH DISCUSSION: CULTURAL COMPETENT INTERVIEW TECHNIQUES	20 MIN
9.	ACTIVITY: CULTURAL COMPETENCY ROLE PLAY	25 MIN
10.	WRAP UP, HOMEWORK FOR NEXT CLASS	5 MIN

1 HOMEWORK REVIEW

Discussion Questions:

1. What do your answers reveal about your family's relationship to the healthcare system?
2. How did these beliefs affect how you/your family accessed the healthcare system?
3. How does this information relate to your job as a staff member providing care coordination?

2 POWERPOINT WITH DISCUSSION: CULTURAL COMPETENCE DEFINITIONS

What is culture?

- **Culture:** thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

What is cultural competence?

- **Cultural Competence:** Having the capacity to work effectively and interact with people from cultures different than our own.

What is cultural awareness and cultural sensitivity?

- **Cultural Awareness:** A general understanding of what another group is like and how it functions.

- **Cultural Sensitivity:** Accepting and appreciating the differences that exist between cultures without assigning judgments (good/bad, right/wrong) to those differences. This usually involves internal changes in one's attitudes and values

Missouri People to People Training Manual, 2008

3 VALUES CLARIFICATION EXERCISE

Note to teacher: In preparation for class, make copies of the Values Clarification Exercise on the following page. Enough for each student to have one.

This exercise offers an opportunity to examine individual beliefs and attitudes which support and get in the way of providing culturally competent care. Ultimately, the objective of this exercise is to help students identify ways to create a comfortable environment for clients to access services. While this exercise is meant to foster discussion and understanding about different points of view, it may also be necessary for the teacher to make sure that the discussion does not maintain misconceptions about different groups.

1. Ask students to refer to the "Values Clarification Exercise" handout. Ask the students to take a moment to complete by answering how much they "agree," "strongly agree," "disagree" or "strongly disagree" with each statement.
   Tell the class that their answers will remain anonymous and that you will randomly hand out completed surveys throughout the room in order to share the group's responses.
   No one should write their names on the surveys.
2. After participants complete their surveys, collect them, shuffle them, and hand them back out to participants in random order. Let participants know that it's OK if they get back their own survey, they should just not let anyone else know so the surveys can remain anonymous.
   Emphasize that there are no right or wrong answers, only opinions. Everyone has a right to express an opinion, and no one will be put down for having a different value than others have.
3. Read the first statement, "Psychiatric disorders like depression and schizophrenia..."
   - Ask students to raise their hands if the response on their handout is "Strongly Agree"; then "Agree"; then "Disagree"; and finally "Strongly Disagree"
   - Ask for volunteers to talk about why they think people would agree or disagree with the statement.
4. Follow up with the suggested discussion questions listed below, when appropriate.
   - Why would someone feel this way?
   - If a patient/client knew that a staff member felt this way, how would it impact how comfortable he/she feels getting services?
   - Regardless of how we feel, what can care coordination staff do to create a comfortable environment for clients to access services.
5. Repeat this process for all remaining statements and guide discussion as appropriate. In general, the take-home message should be that while we can all have different opinions about our client/patient lifestyles, as health professionals we need to leave these opinions at the door so we can support our clients and reduce barriers to care.

VALUES CLARIFICATION EXERCISE

This activity offers an opportunity to examine individual beliefs and attitudes which support and get in the way of providing culturally competent care. Please take a moment to read the following statements and then check off whether you agree or disagree. Please do not write your name on this handout — your responses will remain confidential. Once everyone has turned in their responses, the handouts will be shuffled and handed out to the class for a group discussion.

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
Psychiatric disorders like depression and schizophrenia are not true medical illnesses like heart disease and diabetes.				
A husband/father should always play a role in making healthcare decisions for the family.				
Parents should always know what kinds of healthcare services their adolescents are getting.				
Every patient is entitled to choose whether they want to see a male or female provider.				
A patient should always be told what their diagnosis is before their family members are told.				
People who think taking herbs will help control their hypertension are crazy.				
If someone has diabetes or heart disease it is their own fault because they did not take care of themselves.				

4 POWERPOINT WITH DISCUSSION: CULTURAL IDENTITY

Cultural Identity

Culture and language have a significant impact on health care.

As care coordination staff, you can address the cultural and language differences that may create barriers to quality health care.

What are some factors that affect a person's cultural identity?

- Language
- Ethnicity or race
- Geography
- Socioeconomic status
- Age
- Gender
- Sexual Orientation
- Disability
- Religion

Cultural Identity

To be successful at care coordination, we want to be aware of issues that patients may face related to cultural, physical and linguistic differences.

These differences can become barriers that make it difficult or frustrating for patients to access the care they need. During the rest of the class, we'll discuss how this can play out.

However, can anyone be truly "culturally competent?"

Note to instructor:
Being "culturally competent" implies there is an endpoint or point at which someone has enough knowledge to be deemed "competent."
Ask class if they feel this is realistic, and why it might not be.

Say to class:
Culture and language have a significant impact on health care. As a staff member providing care coordination, you will address the cultural and linguistic differences that can create barriers to quality health care.

5 BREAK

6 VIDEO: CULTURAL HUMILITY: PEOPLE, PRINCIPLES, AND PRACTICES (Part 1 of 4)

7 VIDEO DISCUSSION

1. What do they mean when they say cultural humility is "a lifelong learning process?" How is this different from "cultural competence?"
2. How can being culturally humble mitigate power imbalances in healthcare? How can you help mitigate these power imbalances in your role providing care coordination services?

Note to instructor:

If students are struggling to come up with an answer for question 1, review the example of the African American nurse, the Latina patient, and the Latino doctor. Explain that this shows how cultural competence is often though of as having an endpoint where someone is deemed "competent." Cultural humility assumes that human beings are complex and each may interpret his or her culture differently. It is impossible to know everything about a culture.

8 POWER POINT WITH DISCUSSION: CROSS CULTURAL INTERVIEW STRATEGIES

Principles of Cultural Humility

- Lifelong learning and critical self-reflection
- Recognize and change power imbalances
- Institutional accountability

How Cultural Competency and Cultural Humility Intersect

- Cultural competency requires humility to develop and maintain mutually respectful partnerships with patients and communities
- Cultural competency requires humility from healthcare staff so that they can address the power imbalances that may exist in their staff/patient relationships
- Cultural competency requires a commitment to life-long learning and being reflective of how care is provided to diverse patient populations
- Both involve improving the dynamics of staff/patients communication by using client-focused interviewing and care

A Construct for Caring: Providing Cross Cultural Care

Respect – Curiosity – Empathy

Say to class:

While cultural competence is a very worthy goal, it may be a lot to expect that all healthcare staff will have knowledge of the unique and nuanced aspects of the lives of people from every different cultural background or sexual orientation. In addition there are many differences among patients that may transcend culture. Nevertheless, all healthcare staff should be able to provide nonjudgmental, respectful care to all patients, regardless of culture. In this context it may be feasible to think of providing meaningful cross-cultural care rather expecting that all healthcare staff will always be culturally competent for all of their patients.

This slide provides a model for cross-cultural care. The model suggests that when caring for patients of any background different from your own, it is vitally important to maintain curiosity, respect, and empathy. More specifically:

- *Be curious about the patient's beliefs, practices, fears, and customs. Patients usually are happy that you're interested.*
- *Have empathy towards your patients -- put yourself in their position and try to think about why they are acting in a certain way. Don't just dismiss things that are different from what you would like or expect.*
- *Be respectful of what you may hear.*

(Green, 2002)

How can care coordination staff apply these cross cultural care principles of "curiosity", "respect" and "empathy"?

Get to Know Your Patient:

- Get to know your patient as a person (e.g., partners, children, jobs)
- Listen to their story and imagine what it would be like to be "in their shoes"

Don't Make Assumptions:

- Ask open-ended questions to gain more information about assumptions and expectations
- Remain non-judgmental when information given is different from expected [response]
- Take communication cues from the patient regarding touch, eye contact, and so on

Adapted from: Garrity, J.: Cultural Competence in Patient Education. CARING Magazine 32(8): 18-20, Mar. 2000.

Follow Your Patient's Lead:

- How do they describe themselves? Their partners?
- If in doubt, ask patients what terms they prefer. Be curious without worrying about offending patients
- If you "slip up", apologize and ask the patient what they prefer. Patients will appreciate your sincerity and good intentions!

The Fenway Institute, 2009

Try to understand the following about your patients:

- Values
- Meaning of his or her illness
- Language barriers and literacy
- Sexual orientation (i.e., lesbian, gay, bisexual, queer)
- Gender Identity (i.e., female, male, transgender)
- Cultural myths taboos, and folk beliefs
- Alternative medical practices
- Spirituality
- Immigration status and country of origin
- Education level
- Relationships with others (such as family or friends)

Say to class:

You can't be expected to know about each culture you encounter in your work, but there are some guidelines for cross-cultural communication.

What are some questions care coordination staff can ask to help provide good cross cultural care?

Cross cultural questions to ask:

- 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?
- 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?

Cross Cultural Focus: Sexual Orientation

- Instead of “Are you married?” or “Do you have a boyfriend/girlfriend?” ask:
  - Do you have a partner or a spouse?
  - Are you currently in a relationship?
  - If yes, “Tell me about it.”
- Do not assume a patient calls himself/herself “gay” if he/she has sex with same sex partner. The patient may consider himself/herself heterosexual, bisexual, or some other identity.
- If a female patient refers to her wife, or a male patient refers to his husband, healthcare staff should also say wife/husband, even if the couple is not legally married.

The Fenway Institute, 2009

Cross Cultural Focus: Gender Identity

- Gender identity is distinct from sexual orientation
- It is important to understand both in order to understand your patient
- Do not always assume a patient’s gender identity. People who present as male may identify as female and vice versa. When appropriate, ask, “What is your preferred gender pronoun, for example, she or he?”

9 ACTIVITY: CULTURAL COMPETENCY ROLE PLAY

Ask the students to break into pairs and decide who would like to be the "patient" and who would like to be the "care coordinator." Refer students to their exercise books for activity. If time allows, ask the following questions to debrief the exercise:

- **Care Coordinators:** Did any of the information that you heard from your patients surprise you? Were you able to remain non-judgmental? What helped you do that?
- **Patients:** Did you feel respected by your health care staff? Did you feel like your care coordinator understood your perspective? Why or why not?

STUDENT EXERCISE BOOK

ACTIVITY: CULTURAL COMPETENCY ROLE PLAY

CARE COORDINATORS

You are a care coordination staff person 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:: 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?

ACTIVITY: CULTURAL COMPETENCY ROLE PLAY

PATIENT

Your name is Martin/Maria Smith. You have recently been 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 care coordination intake. 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 coordination staff person" to remain respectful, empathic and curious — no matter what you tell them. Good luck!*

10 WRAP-UP, HOMEWORK FOR NEXT CLASS

Hand out printed copies of the below article or refer students to the link in their exercise books.

Read the article: "Broad Racial Disparities Seen in American's Ills" by Donald G. McNeil Jr.
We will discuss the article at the next class.

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

REFERENCES

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

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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

MODULE 8

HEALTH DISPARITIES

OBJECTIVES

- Define health disparities and the social determinants of health, and describe their causes.
- Describe how care coordination staff can help decrease social and cultural barriers to care and reduce health disparities.

MATERIALS NEEDED

- PowerPoint file with videos downloaded

Health Disparities

AGENDA

1.	POWERPOINT WITH DISCUSSION: HEALTH DISPARITIES AND SOCIAL DETERMINANTS OF HEALTH	10 MIN
2.	HOMEWORK DISCUSSION: BROAD RACIAL DISPARITIES SEEN IN AMERICAN'S ILLS ARTICLE	10 MIN
3.	VIDEO: UNNATURAL CAUSES...IS INEQUALITY MAKING US SICK?	5 MIN
4.	VIDEO DISCUSSION	10 MIN
5.	VIDEO: LIVING IN DISADVANTAGED NEIGHBORHOODS IS BAD FOR YOUR HEALTH	5 MIN
6.	VIDEO DISCUSSION	10 MIN
7.	BREAK	5 MIN
8.	POWERPOINT WITH DISCUSSION: THE ROLE OF CARE COORDINATION IN REDUCING HEALTH DISPARITIES	5 MIN
9.	SMALL GROUP EXERCISE: HOW CAN CARE COORDINATION DECREASE HEALTH DISPARITIES?	15 MIN
10.	EXERCISE DEBRIEF & POWERPOINT	15 MIN
11.	POWERPOINT WITH DISCUSSION: HEALTH LITERACY & LANGUAGE ACCESS	5 MIN
12.	EXERCISE: REVIEWING TREATMENT PLANS WITH PATIENTS	20 MIN
13.	WRAP-UP	5 MIN

1 POWERPOINT WITH DISCUSSION: HEALTH DISPARITIES AND SOCIAL DETERMINANTS OF HEALTH

What are health disparities?

- "Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."

National Institutes of Health, Strategic Research Plan and Budget to Reduce and Ultimately Eliminate Health Disparities, Volume I , Fiscal Years 2002-2006 U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES FY 2002

What are social determinants of health?

- "…the conditions in which people are born, grow, live, work and age… These circumstances are shaped by the distribution of money, power and resources at global, national and local levels…
- Mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries"

World Health Organization, http://www.who.int/topics/social_determinants/en/ (last accessed February 14th, 2013)

People's socioeconomic circumstances strongly influence their health.

- Income/poverty, being uninsured
- Where a person lives, community behavior, safety of the neighborhood
- Where they work
- Not having a primary care provider, not receiving or seeking preventive services
- Educational attainment, literacy level

In the United States, as elsewhere, the risk for:

- Mortality: risk of death
- Morbidity: risk of illness and injury
- Unhealthy behaviors
- Reduced access to health care
- Poor quality of care

...increases with decreasing socio-economic status

CDC Health Disparities and Inequalities Report — United States, 2011

Health disparities exhibit themselves by a constellation of risk factors and behaviors that cluster together for some groups of people more than others.

Factors include:

- Poor diet, smoking, substance abuse, lack of seatbelt use
- Unsupportive family or social environments
- Mental illness, family disruption
- Poverty, unemployment, discrimination, and historical trauma
- Interpersonal violence, homicide, domestic violence
- Historical racism

2 HOMEWORK DISCUSSION: BROAD RACIAL DISPARITIES SEEN IN AMERICAN'S ILLS ARTICLE

1. Based on what you see from your patients and community, did any of these health disparities sound familiar to you? What was surprising?

2. While the article did not provide any specific reasons for these disparities, what are your thoughts on why they might exist? For example, higher infant mortality among African American infants? Higher rate of car crashes among American Indians?

ANSWERS: (from CDC Health Disparities and Inequalities Report — US, 2011)

- Racial/ethnic differences in infant mortality rates might reflect, in part, differences in maternal socio-demographic and behavioral risk factors. For example, infant mortality rates are higher than the U.S. average among infants born to mothers who are adolescents, unmarried, smokers, have lower educational levels, had a fourth or higher order birth, or did not obtain adequate prenatal care.
- Substantial racial/ethnic disparities in income and access to health care also might contribute to differences in infant mortality. Risk factors associated with infant mortality rates are also risk factors for preterm or low birth-weight delivery and can affect infant mortality either directly or through the mechanism of preterm or low birth-weight delivery. In 2006, the percentage of infants born preterm (<37 completed weeks' gestation) was substantially higher for non-Hispanic black (18.5%), Puerto Rican (14.4%), and American Indian/Alaska Native (14.2%) mothers than for non-Hispanic white mothers (11.7%).
- During a motor vehicle crash, seat belts are one of the most effective tools available for avoiding severe injury and saving lives. Seat belt use has increased during the past two decades, from 58% in 1994 to 84% in 2009; however, millions of vehicle occupants still do not use belts. Racial/ethnic groups with the highest death rates also have higher proportions of risky motor vehicle behaviors, including seat belt non-use and alcohol-impaired driving. For example, among persons killed in crashes, American Indian/Alaska Natives had the highest percentage of seat belt non-use (75% of passenger vehicle occupants) followed by blacks (62%); Asian/Pacific Islanders had the lowest percentage of non-use (31%).

Mathews TJ, MacDorman MF. Infant mortality statistics from the 2006 period linked birth/infant death data set. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics; 2010. National Vital Statistics Reports Vol. 58, no. 17. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_17.pdf.

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8 National Highway Traffic Safety Administration (NHTSA). Research note: national occupant protection use survey—1996: controlled intersection study. Washington, DC: US Department of Transportation, NHTSA; 1997. Available at http://ntl.bts.gov/lib/000/700/799/00303.pdf.

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3. How could care coordination possibly decrease some of these health disparities?

Suggested reading for teachers on this subject:

CDC Health Disparities and Inequalities Report — United States, 2011
http://www.cdc.gov/mmwr/pdf/other/su6001.pdf

3 VIDEO: UNNATURAL CAUSES…IS INEQUALITY MAKING US SICK?

4 VIDEO DISCUSSION:

- If we just look at how much we spend on healthcare, living in America should be "the ticket to good health." However, as we see from this video, having good health is much more complicated. What are some of the forces that can affect our health?
- What is the film suggesting that we need to address in order to ensure that Americans are healthier?

5 VIDEO: LIVING IN DISADVANTAGED NEIGHBORHOODS IS BAD FOR YOUR HEALTH

6 VIDEO DISCUSSION

- This video talks about how people who live in disadvantaged neighborhoods are at an increased risk for heart disease because of chronic stress. How could this knowledge impact how you provide care coordination services to people from low-income/depressed neighborhoods?
- This video also talks about the "vicious cycle" of what happens when neighborhoods start to go downhill. Is this something you were aware of already, or has this caused you to think differently about the reasons behind why we have "bad" and "good" neighborhoods?

7 BREAK

8 POWER POINT WITH DISCUSSION: THE ROLE OF CARE COORDINATION IN REDUCING HEALTH DISPARITIES

What Health Disparities Can Be Decreased by Care Coordination?

While staff that provides care coordination can use many strategies to help their patients, 4 strategies in particular have been shown to actually reduce health disparities:

- Prevention and early detection
- Health care access and coordination
- Insurance coverage and continuity
- Diversity and cultural competency

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

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

Ask students to count off 1, 2, 3, 4. Group 1 will be asked to work on the prevention and early detection exercise in the Student Exercise Book. Group 2 will work on access, Group 3 will work on insurance coverage and Group 4 will work on cultural competency. Ask the groups to brainstorm specific ways in which care coordination can be used to achieve the strategy.

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.

10 EXERCISE DEBRIEF & POWERPOINT

Ask Group #1 to report back on their suggestions for how care coordination staff can assist in prevention and early detection. Then, review the following PowerPoint slides.

1. Care coordination staff can translate evidence based guidelines.
2. Care coordination staff can know how and where to get screening and early detection services.
3. Care coordination staff can address any other barriers to screening, such as misconceptions about screening, cost, etc.

Now ask Group #2 to report back on their suggestions for how care coordination staff can assist in healthcare access and coordination. Then, review the following PowerPoint slides.

Health Care Access and Coordination

- Care coordination staff are "brokers" with the ability to confront health system and environmental barriers that tend to disproportionately burden racial and ethnic minorities
- Staff providing care coordination can play a critical role in coordinating access to a comprehensive continuum of services by:
  - Tailoring their assistance to help vulnerable patients identify a medical home
  - Facilitating communication and cooperation between providers
  - Providing the patient education and support necessary to increase access to care and their ability to comply with prescribed therapies

Ask Group #3 to report back on their suggestions for how care coordination staff can assist in insurance coverage and continuity. Then, review the following PowerPoint slides.

Care coordination staff such as medical assistants and patient service reps can help patients get and keep insurance

- Care coordination staff can play an important role in not only helping patients gain consistent access to insurance through publicly-funded programs such as Medicaid, but also in helping them to remain consistently insured

Care coordination staff can advocate on behalf patients against discrimination

- In addition, healthcare staff may advocate on behalf of patients who have historically experienced insurance discrimination, which is banned under the Affordable Care Act, so sicker individuals will no longer be excluded from coverage or charged higher premiums

Care coordination staff can help facilitate selection of plans and applications

- Finally, care coordination staff may play a role in advising patients—particularly those facing severe health literacy issues—regarding their selection of health insurance plans and in completing necessary applications

Now ask Group #4 to report back on their suggestions for how healthcare staff can help their patients receive culturally competent services. Then, review the following PowerPoint slides.

Care coordination services are ideal to address many of the disparities associated with diversity and culture because they foster trust and empowerment within the communities they serve

Care Coordination Roles within Cultural Competency

- Supportive Ally
- Bridge Between Worlds
- Cultural Translator
- Insider to the Healthcare System
- Empowering Advocate

The benefits of applying care coordination staff to address health disparities related to diversity and cultural competence are essentially "limitless"

11 POWERPOINT WITH DISCUSSION: HEALTH LITERACY AND LANGUAGE ACCESS

What is Health Literacy?

- The ability of patients to find, understand, and use health-related information to make good decisions about their medical care and personal health

Low health literacy is a common health disparity

- About one third of American adults have limited health literacy.
- Among many population subgroups, including older adults and some racial/ethnic minorities, the rate exceeds 50 percent, meaning that most individuals in those groups have limited health literacy.
- When you work in healthcare, it is likely that you will see patients every day who have limited health literacy.

From http://www.aafp.org/fpm/2014/0100/p14.html

Health Literacy and Health Outcomes

- Choosing a healthy lifestyle, knowing how to seek medical care, and taking advantage of preventive measures require people to understand and use health information.
- Given the complexity of the healthcare system, it is not surprising that limited health literacy is associated with poor health.

What are other ways that having poor health literacy could affect someone's behavior and decisions about their health?

What things do you think they might do, or not do?

Patients with low health literacy may:

- Use less preventive services
- Have less knowledge about how to care for any chronic conditions they have
- Have misinformation about the body as well as the nature and causes of disease
- May use the hospital for things that would be better treated in a doctor's office
- Feel shame or stigma and hide reading or vocabulary difficulties to maintain their dignity

From http://www.health.gov/communication/literacy/quick-guide/factsliteracy.htm

Example of low health literacy

Ms. Jones is told at her visit that her cholesterol is high. She is advised to change her diet and eat low cholesterol foods and return in 6 months. At her follow up visit 6 months later, her cholesterol is checked. It continues to be very high. When asked how her diet is going, she confides in the medical assistant that actually she doesn't know what cholesterol is or what foods contain it. She hasn't made any dietary changes since her last visit.

Example of low health literacy

Mr. Diaz's 3 year old son was diagnosed with strep throat. The nurse practitioner prescribed 2 teaspoons of an antibiotic twice a day for seven days. The antibiotic came with a dropper that indicated one line for a teaspoon and one for a tablespoon. Mr. Diaz didn't understand the difference and gave his son 2 tablespoons twice a day. Mr. Diaz's son was seen in the emergency room for severe vomiting and diarrhea the following week.

How could the healthcare staff have handled these situations more effectively?

Note to teacher: Possible answers:

- Make sure that a patient has understood what the doctor said to them:
  - Do you have any questions about what the doctor said to you?
  - Let's review the prescription - can you tell me what the medicine is, what it's for, and how much you are supposed to take?
- Offer translation services if English is not their primary language
- Connect patient to a nutritionist or other support staff if they have questions

What might be some of the challenges with linking patients with low health literacy to care?

Linkage to Care and Low Health Literacy

- Patients may not understand their condition and how to effectively manage it
- Patients may not be clear about which doctor they see for which issues
- If the patient is confused by what their doctor is saying, he/she may not adhere to treatment or understand the value of keeping appointments.

How can we help patients with low health literacy or low literacy?

Helping patients with low health literacy

- Use plain language, meaning communication that users can understand the first time they read or hear it
- Do not use jargon, and try and explain any medical terms

Helping patients with low health literacy

- Check for understanding with the patient-use the "teach back" or "show me" method
  - Just to make sure the doctor was clear, what is the plan for your care?
  - Can you show me how they want you to take your medication?
- Provide alternate means of communication - pictures, videos, etc.

12 EXERCISE: REVIEWING TREATMENT PLANS WITH PATIENTS

Instructions: The purpose of this activity is to allow students to practice explaining clinical treatment plans in simple language to the patient. Have students break into pairs. One person will play the role of the care coordinator and the other person will play the role of the patient. The "care coordinator" will 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. They will then switch roles and move on to a new treatment plan. If time allows, each student should practice being the care coordinator twice and the student twice. Note that students may have questions about what the clinical treatment plans mean, so be prepared to answer any questions or define terms.

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

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http://www.cdc.gov/minorityhealth/CHDIReport.html

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

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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

MODULE 9

BASIC COMMUNICATION SKILLS

OBJECTIVES

- Understand why care coordination staff need excellent communication skills
- List best practices for communicating with patients in person, by phone, and by email
- List best practices for communicating with an interdisciplinary team
- Discuss how body language and tone affect communication
- Describe what good customer service is
- Understand basic conflict management skills as needed to deliver excellent customer service

MATERIALS NEEDED

- PowerPoint file with video downloaded
- Index cards with "problems" written on them
- Print copies of homework article or refer students to link:
  "What Can Mississippi Learn from Iran?"
  http://www.nytimes.com/2012/07/29/magazine/what-can-mississippis-health-care-system-learn-from-iran.html

Basic Communication Skills

AGENDA

1.	POWERPOINT WITH DISCUSSION: WHAT ARE "EXCELLENT" COMMUNICATION SKILLS?	5 MIN
2.	VIDEO: POOR COMMUNICATION	5 MIN
3.	VIDEO DISCUSSION	12 MIN
4.	POWERPOINT WITH DISCUSSION: BASIC COMMUNICATION SKILLS	10 MIN
5.	EXERCISE: ACTIVE LISTENING	20 MIN
6.	BREAK	5 MIN
7.	POWERPOINT WITH DISCUSSION: COMMUNICATING AS PART OF AN INTERDISCIPLINARY TEAM	5 MIN
8.	EXERCISE: CREATING YOUR ELEVATOR SPEECH	20 MIN
9.	POWERPOINT WITH DISCUSSION: COMMUNICATING BY PHONE	5 MIN
10.	POWERPOINT WITH DISCUSSION: COMMUNICATING BY EMAIL	5 MIN
11.	EXERCISE: CONFLICT - HOW DO YOU SEE IT?	15 MIN
12.	POWERPOINT WITH DISCUSSION: CARE COORDINATION, CUSTOMER SERVICE, AND CONFLICT MANAGEMENT	10 MIN
13.	HOMEWORK REVIEW	5 MIN

1 POWERPOINT WITH DISCUSSION: WHAT ARE "EXCELLENT" COMMUNICATION SKILLS?

What is the single most common cause of patient complaints in healthcare?

- Lack of communication
- Poor, ineffective communication

Why do staff who provide care coordination, in particular, need excellent communication skills?

- Excellent communication skills are needed to help patients navigate the healthcare system

How do we do that?

Communication and relationships

- Want to understand the needs of our patients and barriers to care that they face
- Want to build strong relationships with other care team members, specialists, mental health providers, and community resources

What is good communication with a patient?

2 VIDEO: POOR COMMUNICATION

3 VIDEO DISCUSSION

Note: You may want to show the video and then reshow, pausing for discussion in the appropriate places.

What do you notice about how the medical professional introduces herself?
What impression does she give right from the beginning?

What do you notice about the choice of language the medical professional uses with the patient?

What kind of message does her body language send?
What kind of message does her tone send?

- **ANSWER:**
  Not professional, not really interested in what the patient is saying or going through (i.e. "your stuff, your situation") not appropriate, minimizes the serious nature of what the patient is going through, Tone sounds bored? Frustrated?

What kind of message does the medical professional send when she asks the patient if she is still feeling depressed?
How is this message being conveyed to the patient?

What does the medical professional say to the patient about her depression?
Why might she have said this? Is it helpful to the patient?

- **ANSWER:**
  She tells patient "You'll get over it, it's no big deal.

What other mistakes does this medical professional make?

- **ANSWER:**
  Doesn't listen to the patient, doesn't focus on the patient, body language, doesn't take patient seriously, judges the patient's situation, takes a phone call during the interview, seems only interested in talking to her so that she can finish her notes, the interview seems to be more about the medical professional and her needs than the needs of the patient

4 POWERPOINT WITH DISCUSSION: BASIC COMMUNICATION SKILLS

Use Active Listening

- Focus on the main ideas
- Be aware of both verbal and non-verbal messages
- Acknowledge and restate the patient's message

Speak Simply

- Use simple language
- Summarize your instructions or key points
- Explain things in a kind, understandable way
- Ask patients to repeat back what you said

Adapted from Colorado Patient Navigator Training program http://www.patientnavigatortraining.org/

Do's and Don'ts of verbal communication with a patient

- Do use the patient's name
- Don't interrupt the patient
- Don't give the patient unsought or unrelated advice
- Don't talk about yourself
- Don't tell the patient you "know how they feel"

Set up the ideal environment for communication

- Wear professional attire and maintain good hygiene
- Offer the patient a firm handshake and a warm greeting
- Sit down when speaking to the patient
- Ensure privacy when speaking to the patient

Be aware of what your body language conveys to the patient

- Maintain a distance of about one arm's length from the patient
- Maintain a posture that is relaxed, but attentive
- When seated, lean slightly forward and be still, but not motionless. Keep your hands visible

Be aware of what your gaze and facial expressions convey to the patient

- Maintain eye contact with the patient. This confirms your willingness to listen and acknowledge the patient's worth. (Note: different cultures interpret eye contact differently. Try to be aware of these differences.)
- Encourage the patient with affirmative head nods as opposed to listening without expression. This can help make the patient feel understood and empathized with.

Be aware of what your tone conveys to the patient

- Maintain an attitude that is warm and friendly
- Maintain an attitude of confidence and professionalism
- "Validate" what the patient says
  - "I can see how that would be hard"
  - "That sounds stressful"

Be aware of the patient's body language, tone, and nonverbal communications

- Recognize the different forms of nonverbal communication a patient may display
- Try to avoid making assumptions and try to confirm the proper interpretation of a patient's nonverbal behaviors
- Observe the patient's reactions toward you. This will provide feedback about your own nonverbal behaviors

Adapted from: Kelly McCorry Ph. D., L., Mason, J. Communication Skills for the Healthcare Professional, Lippincott Williams & Wilkens, 2011.

5 ACTIVITY: ACTIVE LISTENING

Facilitator instructions:

Before class, prepare index cards by writing the following problems, one per card:

- I was evicted from my apartment because I couldn't pay the rent.
- I am not testing my sugar because doing that hurts my fingers.
- I am hearing voices and don't want to see the doctor.
- My husband is drinking too much and beating me.
- I don't know how to get to my cardiology appointment.
- I need to refill my medication.
- I think I have a sexually transmitted disease.
- I believe that if I have surgery it makes my cancer spread.

Activity Instructions

Break students into pairs. One person in the pair will be the talker (patient) and the other a listener (care coordinator.) Give the talkers an index card with a problem on it.

This activity can be done in small groups with a report out on what they experienced, or ask for volunteer pairs to do the exercise in front of the class.

- **2 min:** The talker has to describe what the problem is, and what help they need, without explicitly saying what was written on the card.
  - Listener has to practice active listening skills.
  - Listener has to pay close attention to what is being said and what is not quite being said, and demonstrate their listening to the talker by their behavior.
- **1 min:** The listener should summarize the three or four main issues and needs that they have heard the talker (patient) express.
- **1 min:** Discuss how close the listener understood what the talker was trying to convey and what they needed.
- **1 min:** Review how well they demonstrated active listening behaviors. Did the talker (patient) feel listened to?

6 BREAK

7 POWER POINT WITH DISCUSSION: COMMUNICATING AS PART OF AN INTERDISCIPLINARY TEAM

Slides 2-8 in this section are adapted from: Patient Safety and Quality: An Evidence-Based Handbook for Nurses, Chapter 33. Professional Communication and Team Collaboration, pp 1-3

http://www.ahrq.gov/qual/nurseshdbk/docs/O'DanielM_TWC.pdf

Staff who provide care coordination will often work as part of a team. Being part of a team requires collaboration.

In the healthcare environment, what do we mean by collaboration?

- Assume complementary roles
- Work cooperatively together
- Share responsibility for problem-solving and making decisions to formulate and carry out plans for patient care

What is your experience of working as part of a team?

Effective teams are characterized by:

- Trust
- Respect
- Collaboration

When teamwork is working well:

- Everyone is working for the good of a goal
- Everyone has a common aim
- Everyone is working together to achieve that aim

What are the components of successful teamwork?

- Clear roles and tasks for team members
- Clear specifications regarding authority and accountability
- Respectful and non-punitive environment
- Regular and routine communication and information sharing
- Acknowledgment and processing of conflict

Understanding and communicating your role

- Role may be new to healthcare staff/patients
- If people do not understand what you do, you may quickly encounter problems.
- Important to be able to explain your role, and your scope of practice
- May involve ongoing discussion with your supervisor and the team

8 ACTIVITY: CREATING AN ELEVATOR SPEECH ABOUT YOUR ROLE

Say to the class: *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***

_____

_____

_____

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

Say to the class: *Now we are going to practice our elevator speeches. I need a few volunteers to be listeners/questioners and I need a few volunteers to explain what they do. Follow the script below.*
(also on the Powerpoint slide)

Script

Listener/Questioner: Hi I'm (name) I'm (say your title or make one up)

Care Coordinator: Nice to meet you. I'm (name). I'm the new care coordinator on staff here.

Listener/Questioner: Sorry. You're a what?

Care Coordinator: I'm a care coordinator.

→ INSERT YOUR "ELEVATOR SPEECH" FROM ACTIVITY HERE

- Ask the group how the care coordinator did.
- Did they speak clearly? Could you easily understand what they do?
- What was their body language saying while they were speaking?
- What message did their tone convey?
- Are there any ways that you think the speech or the way that it was conveyed could be improved?

9 POWERPOINT WITH DISCUSSION: COMMUNICATING BY PHONE

How is communication by phone different than in-person communication in the healthcare setting and why does this matter?

Communication that is not face to face carries risks

- Can't see the person
- Can't receive non-verbal communication such as eye contact, facial expression, or posture

Telephone Etiquette

- You represent the organization you work for
- A phone call may be the first impression that someone gets of you, or your organization
- Many of the relationships that are crucial to being an effective care coordinator will be established, and maintained by phone

"Special" types of call that may get routed to you

- Angry or anxious patient
- Family members or friends
- Other healthcare staff or organizations and community agencies

How do you handle an angry patient on the phone?

Handling an angry patient on the phone

- Emotions may be directed at you, but they are not necessarily because of you
- Patients can experience enormous frustration trying to navigate our healthcare system
- Patients may legitimately have a right to be upset - try not to take it personally

Handling an angry patient

- Listen carefully, do not interrupt, and acknowledge the patient's anger
- Remain calm: speak gently and kindly to the patient
- Tell the patient that you care, and want to help them
- Never make promises that cannot be kept
- Take careful notes/document the call
- Inform the appropriate provider/supervisor even after the problem has been resolved
- If you need to consult with someone else and get back to the patient, be sure to let the patient know when you will be calling back
- In some situations you may need to transfer the call to a supervisor.

How do you handle an anxious patient?

Handling an anxious patient

- There are many reasons a patient may feel anxious:
  - May be ill
  - May be worried they are ill
- Acknowledge the patient's anxiety
- Never minimize or make light of the patient's anxiety, feelings, or concerns
- Determine what types of support, if any, the patient has from family or friends

How do you handle friends and family who call to talk about a patient?

Calls from Friends and Family

- HIPAA standards: patients must provide authorization prior to the release of ANY information about them
- Ask to speak with patient if they are there to authorize you speaking with the family member or friend
- Tell the family member that you appreciate that they are concerned and trying to help, but that it's policy for patients to give authorization for any information to be released.

10 POWERPOINT WITH DISCUSSION: COMMUNICATING BY EMAIL

Tips for Communicating by Email

What are some benefits and risks associated with using email in healthcare?

Benefits

- Quick communication
- For some patients, it is a more reliable way to reach them
- Can send patients instructions, directions, etc. in writing
- May be more convenient than the phone for some healthcare professionals

Risks

- Healthcare information is private and confidential
- Cannot send health information via email without prior agreement by both the sender and the receiver, or need password protected system
- Email messages can sound cold and tone can easily be misinterpreted

Best Practices

- Know your organization's policy regarding sending emails and texts to patients
- Always assume that every single email that you write will be forwarded and read by other people besides who you sent it to
- ***Never send an email if you are in disagreement or feeling upset. Instead, wait until you are calmer, then pick up the phone or discuss the issue in person***

11 ACTIVITY: CONFLICT - HOW DO YOU SEE IT?

Activity instructions: This activity is intended to help students reflect on how they react to conflict and help them become more comfortable dealing with conflict in their role.

- Have each student fill out the activity sheet in their exercise book. Give them 5 minutes to do this.
- Then have them pair up and share their answers. Allow 5 minutes for this.
- Bring everyone back together for a group discussion for 5 minutes.

Discussion questions:

1. Were your partner's perspectives different from your perspective?
2. What were some things that you learned by considering another's perspective?
3. Does discussing conflict like this make it "less scary"? In what ways?
4. How can you apply what you learned in this activity to your role coordinating care for patients?

1. How do you define conflict?

_____

_____

2. What is your typical response to conflict?

_____

_____

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

12 POWERPOINT WITH DISCUSSION: CARE COORDINATION AND CUSTOMER SERVICE

Staff who provide care coordination are the ambassadors of good customer service.

What do we mean by this?

Care coordination is about making the experience of being a patient:

- Easier
- Better
- Less scary
- Less overwhelming

What are things that staff providing care coordination do that are a form of customer service?

Care coordination = customer service:

- Build trust with patients and families
- Assure that patients understand their care
- Make sure that providers and care team understand a patient's unique needs
- Support patient engagement in their care
- Increase patient satisfaction
- Improve patient outcomes

How do we continue to provide good customer service when there is conflict?

Deal with Conflict Constructively

- Recognize that it is normal and manageable
- Understand that it is a natural outcome of interacting with others
- Know that there are various approaches that can be used to handle it
- Expect it to happen

What can we do to help prevent and manage conflict?

Preventing and Managing Conflict

- Improve your communication skills
- Remember that practicing kindness is good customer service, and a business strategy
- Use empathy
- Manage your own emotions
- Be a professional
- Know when to seek help or get assistance

What do we mean by "kindness is good customer service, and a business strategy"

Kindness is good customer service, and a business strategy

- Your attitude counts
- Practice forgiveness and giving someone the benefit of the doubt
- Patients want to be cared for and will come back if they are treated with kindness and respect

What do we mean by "use empathy?"

Use Empathy

- Understand that the patient is your customer
- Build trust by sensing and understanding the emotions of your customer
- Being empathetic builds trust, and improves customer satisfaction because the patient feels that they have someone on their side

What does it mean to manage your own emotions?

Managing your own emotions

- Practice:
  - Being aware of what emotions are coming up for you in certain situations
  - Acknowledging to yourself what you are feeling
  - Knowing what you need to do to manage emotions in a healthy way and not direct them at patients or colleagues
- Find colleagues, friends, or a therapist to talk through difficult work situations and hard to handle emotions that are coming up

What does it mean to "be a professional" in terms of conflict and customer service?

Be a Professional

- Assume the positive about others and their behavior
- Assume that if someone is difficult to deal with that they are having something difficult going on in their life
- Assume it is about them and not about you (see practice forgiveness and giving someone the benefit of the doubt from previous slide)

Know when to seek help or get assistance

- You are not responsible for solving all problems
- If the patient is your customer and they are not happy, find other people who have the resources or authority to improve the situation
- Part of your role is connecting the patient with someone who can help them or with resources that they need,
  - if that is not you, then seek out help

13 HOMEWORK FOR NEXT CLASS

Read "What Can Mississippi Learn from Iran?"

Hand out printed copies or refer students to the link in their exercise books: http://www.nytimes.com/2012/07/29/magazine/what-can-mississippis-health-care-system-learn-from-iran.html

Homework questions for discussion (in Student Exercise Book)

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

- Did you like the article?
- What did you find interesting about the article?
- 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?
- In one word, how would you describe Ms. Cox's approach to care?
- How do Iranians boost primary care in rural Iran where there are a limited number of doctors?
- What are similarities between community health workers described in the article and staff who provide care coordination services?

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Patient Safety and Quality: An Evidence-Based Handbook for Nurses, Chapter 33. Professional Communication and Team Collaboration
http://www.ncbi.nlm.nih.gov/books/NBK2637

Addressing Chronic Disease through Community Health Workers
http://www.cdc.gov/dhdsp/docs/chw_brief.pdf

Community Health Workers: A Front Line for Primary Care?
http://www.nhpf.org/library/issue-briefs/IB846_CHW_09-17-12.pdf

Continuous and team based healing relationships-Safety Net Initiative
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.
http://www.institutik.cz/wp-content/uploads/2010/10/The-big-book-of-conflict-resolution-games.pdf

VIDEOS

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

MODULE 10

ACCESSING PATIENT RESOURCES

OBJECTIVES

- Explain the difference between patient resources that require a referral and those that don't
- Discuss the role of care coordination staff in helping patients to access resources
- Be able to use resource directories to find community, local and national resources
- Demonstrate effective skills and strategies for working with community agencies
- Describe tools that care coordination staff can use to help patients access needed resources

MATERIALS NEEDED

- PowerPoint file with videos downloaded
- Index cards with patient stories/ information for activity
- New York Times article"What Can Mississippi Learn from Iran?" for reference in homework review

Accessing Patient Resources

AGENDA

1.	HOMEWORK DISCUSSION	15 MIN
2.	POWERPOINT WITH DISCUSSION: HELPING PATIENTS ACCESS RESOURCES	15 MIN
3.	VIDEO: MORE THAN A PLACE TO LIVE	5 MIN
4.	VIDEO: HEALTH ANGELS - HELP FOR SOCIETY'S MOST VULNERABLE PEOPLE	5 MIN
5.	VIDEO DISCUSSION	5 MIN
6.	POWERPOINT WITH DISCUSSION: CREATING A RESOURCE DIRECTORY	20 MIN
7.	BREAK	5 MIN
8.	POWERPOINT WITH DISCUSSION: MAKING COMMUNITY CONNECTIONS	20 MIN
9.	EXERCISE: GETTING ORGANIZED TO PROVIDE CARE COORDINATION	30 MIN

1 HOMEWORK DISCUSSION

Ask students to take out their copies of the assigned homework article, "What Can Mississippi Learn from Iran?" http://www.nytimes.com/2012/07/29/magazine/what-can-mississippis-health-care-system-learn-from-iran.html?pagewanted=all

1. Did you like the article?
2. What was interesting about the article for you?
3. When Ms. Cox learns that Ms. Wells has been suffering from asthma symptoms at the beginning of the article, she suggests that perhaps something in the house is triggering asthma attacks. What resource does Ms. Cox find to follow up on this idea?

   ANSWER: Ms. Cox suggests the house be tested for mold. (pg. 2)
4. In one word, how would you describe Ms. Cox's approach to care?

   ANSWER: Personal

5. How did Iranians boost primary care in rural Iran where there are a limited number of doctors?

   ANSWER: The Iranians built "health houses" that could service 1,500 people who lived within an hour walking distance. Each house is equipped with examination rooms and sleeping quarters. The house is staffed by two community health workers that have been given basic training in preventative health care. They advise on nutrition and family planning, take blood pressure, keep track of who needs prenatal care, provide immunization, and monitor environmental condition like water quality.

6. What are similarities between community health workers described in the article and staff who provide care coordination services?

   ANSWER: Community health workers are concerned with non-clinical factors that impact patient health such as transportation and safety in the home. CH workers often do not have an advanced clinical degree and focus on preventive care issues.

Say to students: *This article highlights the potential for front line staff, such as community health workers, patient navigators and care coordination staff, to address underlying issues that might be missed by health care providers. These staff use knowledge of their patient population, knowledge of community resources and their ability to build connections that make real differences in the lives of their patients.*

2 POWERPOINT WITH DISCUSSION: HELPING PATIENTS ACCESS RESOURCES

What are patient resources?

- Services that are needed by the patient but are not directly available from the provider
- May be **clinical** and require a referral from the provider
  - Specialists
  - Social workers
  - Physical therapists
  - Procedures
  - Lab work
- May be **non-clinical,** also known as **community resources**, and do not require a referral from the provider
  - Community organizations
  - Housing services
  - Transportations services

For a patient in need of clinical resources outside of their primary care provider, how can care coordination staff assist?

Care coordination staff can:

(Patient-level)

- Make sure the patient has an appointment that will work for them
- Make sure the patient knows where to go
- Make sure the patient has the correct paperwork for the appointment
- Make sure the patient as any needed insurance authorizations before the visit
- Make sure the patient has a plan or way to get to the visit
- Make sure the patient made it to the visit
- Address any additional barriers that patient might have in following through on the referral

(Center-level)

- Ensure that any reports, notes, or test results from the visit get back to the primary care provider and into the patient's chart
- Document and track clinical referrals (What was the patient referred for? Did they make it? What was the outcome?) in a log to keep tabs on their patients across the facility.

For a patient in need of community resources outside of their primary care provider, how can care coordination staff assist?

(Patient-level)

- Assess what community resources might be most helpful to client
- Make patient aware of what services may be available to them
- Help patient fill out forms or apply for programs or assistance they would like to access
- Make sure the patient has an appointment that will work for them
- Make sure the patient knows where to go
- Make sure the patient has the correct paperwork for the appointment
- Make sure the patient has a plan or way to get to the visit
- Make sure the patient made it to the visit
- Address any additional barriers that patient might have in following through on the referral

(Center-level)

- Document and track community resource referrals (What was the patient referred for? Did they make it? What was the outcome?) in a log to keep tabs on their patients across the facility.

How is the role of care coordination staff different for helping patients access clinical vs community resources?

Care coordination staff **do not assess** patients to see what **clinical resources** they need. The primary care provider makes the referral and the role of the care coordinator is to make sure the patient can follow through.

Care coordination staff **can assess** what **community resources** might be most appropriate for the patient. Care coordination staff can make the referral and then follow-up to make sure the referral was successful.

Say to class: *The following videos are examples of programs that assess clients for the community resources they need and then connect them to these services. The first video takes a look at a client who needs community support after being in prison, while the second looks at low income families in South Texas.*

3 VIDEO: MORE THAN A PLACE TO LIVE: THE CORPORATION FOR SUPPORTIVE HOUSING

4 VIDEO: HEALTH ANGELS: HELP FOR SOCIETY'S MOST VULNERABLE PEOPLE

5 VIDEO DISCUSSION

- In the first video, what kinds of community resources were identified for this client?
- What do you think made this a "success story?"
- In the second video, what kinds of community resources were identified for these families?
- What kinds of skills and qualities did the "promatoras" have that helped them get their clients the services they need?

Say to class: *A common theme from these videos was the idea that community resources can empower clients and address difficult issues such as poverty and lack of employment. Another common theme was the importance of treating clients with respect – regardless of their circumstances.*
Because these clients felt respected, they were much more likely to trust and utilize the support that was offered to them. As we know that medical issues can often be related to underlying issues such as lack of nutritious food, affordable housing or quality education, the importance of community resources cannot be underestimated. Care coordination staff are key to making sure patients feel respected and get the community resources they need.

6 POWERPOINT WITH DISCUSSION: CREATING A RESOURCE DIRECTORY

To make a successful connection to clinical/ community resources for your patients, what is needed?

- Knowledge of what resources exist (i.e. resource directory)
- Relationships with the people and organizations in that directory

Resource Directory

- Care coordination staff need to know that resources are available in the community.
- Having an up-to-date resource directory, or list of key community resources is crucial

Pretend your supervisor has just given you the task of creating a new community resource directory for your center. What should you do?

1. Don't start from scratch: Find out if your health center has its own internal resource directory or directories
   - Ask your supervisor or co-workers if there are any official resource directories already in use.
   - Many staff have their own "go-to" lists that they use for specific kinds of referrals. Social workers, for example, might have a go-to list of valuable mental health or behavioral health resources.
2. Think about, and talk to others at your organization about the needs of the patients
3. Gather information for the directory
   - Search the internet
   - Contact local community collective organizations and review their resources and relevant information
4. Organize information into logical groupings that suit your patients' needs
5. Contact each organization to confirm services and placement within directory groups
6. If possible, develop a partnership agreement with certain community resources to strengthen collaborations

New York City Community Resource Highlight: HITE

- www.hitesite.org
- HITE is the **H**ealth **I**nformation **T**ool for **E**mpowerment
- Online resource for social workers, discharge planners, and other information and referral providers.
- Focused on assisting uninsured and low-income individuals get linked to community resources
- Screen for eligibility for public health insurance and assistance programs
- Can search under the following service categories
    - Dental/Optical
    - Financial Assistance
    - Health Care & Medicine
    - Immigrant Support
    - Mental Health & Substance Abuse
    - School Youth & Family Services
    - Social Services
    - Transportation
    - Wellness & Prevention

When creating your own go-to resource directory, what kind of information would be good to include?

- Name of organization
- Contact persons
- Address
- Telephone number
- Web site
- Brief description of the services offered
- Kinds of insurance accepted
- What should the patient bring to their appointment?
    - Does the patient need an ID? Proof of income?
- Languages spoken
- Directions via public transportation

7 BREAK

8 POWERPOINT WITH DISCUSSION: MAKING COMMUNITY CONNECTIONS

What do you want to establish with many (or all) of the organizations listed in your resource directory?

A relationship.

Having a personal relationship with someone at the organization is the best way to stay familiar with available services. Whether the organization is a homeless shelter, a food bank, or a youth mentor program, you will always benefit from knowing someone by name within the organization

Working with External Community Agencies

After you have found a list of organizations, service agencies, or general resources available in your community, you need to familiarize yourself with them in order to better assist your patients. In fact, it would be most beneficial to form contacts within organizations so that you can build a relationship with over time.

Depending on your organization, don't forget to make connections internally!

You might be working within a large multi-service organization or a hospital that has several departments. "Break down the silos" and familiarize yourself with everything your organization has to offer in order to better serve your patients. Just as you would reach out to external agencies, reach out to your co-workers and establish a referral relationship.

Pretend your supervisor has just asked you to reach out to a new social services agency in the neighborhood to see if they would be a good place to refer patients. What should you do?

- If they are on the web, look at the organizational website and the staffing list. Think about who you would want to refer the patient to (Social worker? Office manager? Referral specialist?)
- If there is no website, call the organization and ask to speak to the social worker or office manager.
- Introduce yourself as a staff person at your organization who is in charge of making patient referrals
- Briefly explain what you do and what your organization does
- Try and establish a contact at the organization that you can reach out to in the future
- Offer your help in the form of being a contact at your organization that they can reach out to if they need assistance
- Follow up with a thank you email and your contact information

9 EXERCISE: GETTING ORGANIZED TO LINK PATIENTS TO RESOURCES

Break students into pairs. One student is the patient and gets a card that has a story and information on it. The other student is the care coordinator and fills out the Intake Form. Students should fill out the potential problems/barriers to care as well.

After 10 minutes, announce that partners should switch roles.

Patients should feel free to make up other parts of their story or elaborate on the information that they receive.

After this exercise is complete, de-brief with the following questions:

- Was this a helpful form to keep you organized?
- How was it going through this with a patient?
- Is there anything that you think was missing from the form?

Stories/Information for Index cards

1. 25-year-old schizophrenic man, speaks English, has been homeless in the past, has been in jail once, lives with his mother now, reads at a 3rd grade reading level
2. 50-year-old woman with diabetes, speaks Russian, referred by her primary care doctor because she misses a lot of appointments
3. 67-year-old woman with hypertension and history of a stroke, needs rehabilitation to gain better control over her left leg and arm damaged by the stroke, seems easily confused
4. 40-year-old man with heart disease and depression, takes multiple medications, speaks only Spanish, does not have a green card
5. 17-year-old woman who has been in the ER 3 times this year, has learning disability and history of substance abuse, has difficult relationship with family and has been living at her boyfriend's house
6. 75-year-old woman, speaks only Spanish, has no insurance, suffers from depression and chronic back pain, lives alone and is visited infrequently by her family
7. 30-year-old man with severe asthma and history of substance abuse, currently living in a homeless shelter, speaks English but reads and writes Spanish

8. 45-year-old single mother with 4 children and no insurance, recently lost her job, recently diagnosed HIV positive, referred by infectious disease specialist to patient navigator

9. 48-year-old man with diabetes and recently diagnosed with lung cancer, works sporadically as a construction worker, has 3 children to support

10. 56-year-old woman who is paralyzed from the waist down after a recent stroke, on disability, her family lives in California, her neighbor helps her sometimes, she has trouble getting to medical visit

11. 55-year-old man recently diagnosed with diabetes, has been in the ER twice and hospitalized once this year for sky high glucose levels, speaks French, doesn't read or write in any language, doesn't understand what diabetes is or how to care for himself

12. 35-year-old single Hispanic woman, pregnant with her 4th child, suffers from asthma and high blood pressure, has one child with a disability, speaks Spanish only, has trouble getting to her visits

13. 68-year-old woman, uses a walker, suffers from hypertension, chronic headaches and bi polar disorder, often goes to the ER, misses medical visits, her son lives with her but doesn't work

14. 34-year-old woman recently diagnosed with ovarian cancer, has three children to take care of, speaks some English but reads/writes Spanish, doesn't understand what the treatment is or why she needs surgery, has missed the last two appointments with her oncologist, referred to the navigator by the social worker

15. 21-year-old man recently diagnosed with leukemia, has missed the last two visits with his oncologist, has no insurance and doesn't know if he is eligible for any, referred by social worker

16. 38-year-old woman with history of alcoholism and substance abuse, was recently beaten up by her boyfriend, living in a homeless shelter, has been to the ER repeatedly recently due to severe asthma attacks

17. 50-year-old woman with diabetes, insurance was recently cut off once she started working again, is confused about what paperwork needs to be filled out to reapply

18. 24-year-old man recently moved here from China, has no insurance, recently diagnosed with Hepatitis C and hypertension, has missed his last three visits, is worried about the bills he will receive if he sees a doctor, goes to the ER when he is too sick to go to work

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: _____

_____

_____

REFERENCES

CANCER CARE COORDINATION PROGRAM TOOLKIT, Kansas Cancer Partnership, September 2009,

www.cancerkansas.org under Health Care Professionals

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.

Meyer, H.S. (2005). Heath Vulnerability: Vulnerable Populations in the United States. JAMA, Vol 293, No. 15. Retrieved from
http://jama.jamanetwork.com/

Rains, J. (2012). How to Find Free (or Cheap) Health Resources. Retrieved from
http://www.wisebread.com/how-to-find-free-or-cheap-health-resources

Summers, N. (2012). Fundamentals of Case Management Practice: Skills for Human Services, 4th Edition. Belmont, CA: Brooks/Cole.

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

MODULE 11

BASICS OF MENTAL ILLNESS AND CRISIS MANAGEMENT - PART 1

OBJECTIVES

- Understand connection between mental health and chronic disease management
- Understand role of care coordination in helping patients with mental illness
- Describe characteristics of common mental illnesses such as depression
- Describe how to do a basic risk assessment for depression and suicidal ideation

MATERIALS

- PowerPoint file with videos downloaded

Basics of Mental Illness and Crisis Management - Part 1

AGENDA

1.	INTRODUCTION - CHRONIC DISEASE AND MENTAL HEALTH	10 MIN
2.	POWERPOINT WITH DISCUSSION: MENTAL HEALTH AND HEART DISEASE	5 MIN
3.	POWERPOINT WITH DISCUSSION: MENTAL HEALTH AND DIABETES	5 MIN
4.	VIDEO: WHAT IS DEPRESSION?	5 MIN
5.	VIDEO DISCUSSION	3 MIN
6.	POWERPOINT WITH DISCUSSION: DEPRESSION	10 MIN
7.	VIDEO: HOW IS DEPRESSION TREATED?	5 MIN
8.	VIDEO DISCUSSION	5 MIN
9.	THE END OF THE DEPRESSION SPECTRUM - SUICIDAL IDEATION	5 MIN
10.	ACTIVITY: MYTHS ABOUT SUICIDAL IDEATION	10 MIN
11.	BREAK	5 MIN
12.	VIDEO: STORIES OF HOPE & RECOVERY - THE JORDAN BURHAM STORY	10 MIN
13.	POWERPOINT WITH DISCUSSION: SUICIDAL IDEATION	10 MIN
14.	PATIENT HEALTH QUESTIONNAIRE REVIEW	5 MIN
15.	ACTIVITY: "PATIENT M" ROLE PLAY	20 MIN
16.	POWERPOINT WITH DISCUSSION: ROLE OF CARE COORDINATION IN MENTAL HEALTH	5 MIN
17.	WRAP-UP/HOMEWORK	2 MIN

1 INTRODUCTION – CHRONIC DISEASE AND MENTAL HEALTH

When thinking about helping patients with chronic disease, why is mental health important?

- Mental health and physical health are connected
- If patients are not mentally well, they will not be able to manage their physical health
- Mental health may be at the root of why a person has developed a chronic disease (i.e. diabetes)
- People who have chronic diseases combined with mental health illness have worse health outcomes overall

Chronic Disease and Mental Health:

- Can also help us, as health care professionals, understand why a patient might be acting in frustrating or self-destructive ways

Chronic Disease and Mental Health:

- Depression is projected to become the leading cause of disability and the second leading contributor to the global burden of disease by 2020.

World Health Organization. Mental Health and Brain Disorders: What Is Depression? www.who.int/mental_health/Topic_Depression/depression1.htm. Accessed September 1, 2012.

- It is estimated that the devastation caused by depression—defined as the number of years lost to death or disability—by 2020 will be surpassed only by heart disease.

National DMDA anticipate health care trends. Newsletter of the National Depressive and Manic Depressive Association 1998. Summer, p 1.

Chronic Disease and Mental Health:

- Recognizing that your patient might have a mental health illness and connecting them to supportive services is one of the most important things you can do in helping your patient manage their chronic disease.

2 POWERPOINT WITH DISCUSSION: MENTAL HEALTH AND HEART DISEASE

Some recent studies suggest that there is a connection between heart health and stress or depression.

Lett HS, Blumenthal JA, Babyak MA, Sherwood A, Strauman T, Robins C, Newman MF. Depression as a risk factor for coronary artery disease: evidence, mechanisms, and treatment. Psychosom Med. 2004 May-Jun;66(3):305-15.

What could be some reasons for this connection?

- Some common ways that people cope with stress, such as overeating, heavy drinking, and smoking are bad for the heart
- If you have stress or depression over a long period of time it can harm the heart
- The most common "trigger" for a heart attack is a stressful event, especially one involving anger
- After a heart attack or stroke, people with higher levels of stress and anxiety tend to have more trouble getting well
- Depression is common among people who have had a heart attack, heart surgery, or a stroke

If you sometimes feel depressed or have a lot of stress in your life, are you at a higher risk for heart disease?

- Possibly, but if you manage your stress and get help for your depression, your overall health will improve and your risk for heart attack goes down

3 POWERPOINT WITH DISCUSSION: MENTAL HEALTH AND DIABETES

Studies have also shown that there is a connection between diabetes and depression.

What could be some reasons for this connection?

- Diabetes can make depression worse because diabetes is chronic illness with a lot of worries
- Much of the treatment for diabetes is self-care, and people who are depressed may not take good care of themselves (don't exercise as much and may have other issues in terms of watching their diet, checking their blood sugar, and taking medications)
- People who are depressed have elevated levels of stress hormones such as cortisol, which can lead to problems with glucose or blood sugar metabolism, increased insulin resistance, and the accumulation of belly fat -- all diabetes risk factors
- Long-term stress and strain associated with diabetes management such as blood sugar control and treatment for complications can lead to decreased quality of life and increased probability of depression

Paul S. Ciechanowski, MD, MPH; Wayne J. Katon, MD; Joan E. Russo, PhD. Depression and Diabetes: Impact of Depressive Symptoms on Adherence, Function, and Costs. Arch Intern Med. 2000;160(21):3278-3285

4 VIDEO: WHAT IS DEPRESSION?

5 VIDEO DISCUSSION

What are some of the things that can happen to the brain when someone is clinically depressed?

ANSWER: Reduced levels of neurotransmitters (serotonin), smaller hippocampus (serotonin receptor). Serotonin affects mood regulation.

What are some of the different kinds of depression?

ANSWER: Major depression, dysthymia, adjustment disorder, seasonal affective disorder

6 POWERPOINT WITH DISCUSSION: DEPRESSION

How is clinical depression different from someone who occasionally feels depressed?

ANSWER: Length of time (i.e. two weeks and longer) and severity of symptoms

- Mental health occurs along a spectrum
- All of us have had symptoms of anxiety or depression at some point in our lives
- It is common to hear people say – "I'm so depressed, I'm so stressed out"
- However, clinical depression is different

What Causes Depression?

- Can be hereditary (can run in people's families)
- Painful loss
- Medical problems (stroke, cancer)
- Cause is sometimes unclear

What Causes Depression?

- Gender?
  - Depression is twice as common in women as in men
  - Unclear as to why
  - Changes in women's hormonal levels may play a part
  - **However,** men are less likely to admit being depressed
  - Doctors are less likely to suspect depression in men
  - Symptoms may present differently, so that diagnosis may be more difficult
  - Women usually feel hopeless/helpless
  - Men may feel irritable or angry

What does Depression Look Like?

- Feeling "blue," down, sad, angry
- Sleeping too much or too little
- No longer interested in the things that used to give pleasure
- Feeling guilty, worthless
- Lack of energy
- Eating too much or too little
- Suicidal ideation, thoughts of death

Besides these symptoms, how else might you tell if someone is depressed?

- Physical complaints (e.g., dry mouth, headaches, constipation, heavy legs/arms)
- Isolation – might not be returning phone calls or seeing friends/family anymore
- Helplessness
- Poor personal hygiene
- Psychosis (hallucinations: seeing/hearing things that others don't)

How is Depression Identified?

- Screening tools, such as the Beck Depression Inventory (BDI) and the Patient Health Questionnaire (PHQ) help identify depression
- However, these tools are NOT able to actually "diagnose" patients

How Is Depression Diagnosed?

- First step – physical exam
  - Rule out viral infection
- Second step – psychological evaluation
  - MD can do this, but will most likely refer to a psychiatrist or psychologist
  - Evaluation will include complete history of signs of depression – i.e. When did symptoms start? How long do they last? How bad? Previous treatment? Family history?
  - Assessment for substance abuse, suicidality

How Is Depression Treated?

There are two common types of treatment for depression:

- Medication
- "Talk" therapy
  - Cognitive behavioral therapy
  - Psychotherapy
  - Psychoanalysis

Can you think of other types of mental health treatment?

- Holistic
  - Yoga
  - Journaling
  - Art
  - Music
  - Dance
  - Physical exercise
- Spiritual
  - Ceremony,
  - Church
  - Prayer

7 VIDEO: HOW IS DEPRESSION TREATED?

8 VIDEO:

Are anti-depressants habit-forming? How long do they usually take to work?

ANSWER: No and sometimes up to eight weeks

Can therapy also affect how the brain functions?

ANSWER: Yes; can affect levels of serotonin

Besides medication and therapy, what else can help depression?

ANSWER: Exercise

9 POWERPOINT WITH DISCUSSION: THE END OF THE DEPRESSION SPECTRUM - SUICIDAL IDEATION

Say to the class: *As discussed, depression occurs in a spectrum, from mild to severe symptoms, which can happen for a short or long period of time. The severest symptom of depression is suicidal ideation, or having the desire to kill yourself.*

10 ACTIVITY: MYTHS ABOUT SUICIDAL IDEATION

Instructions: Ask students the following true or false questions:

True or False?

People who die from suicide don't warn others.

FALSE: Out of 10 people who kill themselves, eight have given definite clues to their intentions. They leave numerous clues and warnings to others, although some of their clues may be nonverbal or difficult to detect.

True or False?

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

FALSE: Asking someone if they're suicidal will never give them an idea that they haven't thought about already. Most suicidal people are truthful and relieved when questioned about their feelings and intentions. Doing so can be the first step in helping them to choose to live.

True or False?

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

FALSE: The highest rates of suicide occur within about three months of an apparent improvement in a severely depressed state. Therefore, an improvement in emotional state doesn't mean a lessened risk.

True or False?

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

FALSE: WRONG! Few people commit suicide without first letting someone else know how they feel. Those who are considering suicide give clues and warnings as a cry for help. In fact, most seek out someone to rescue them. Over 70% who do threaten to carry out a suicide either make an attempt or complete the act.

11 BREAK

12 VIDEO: STORIES OF HOPE AND RECOVERY - THE JORDAN BURNHAM STORY

13 POWERPOINT WITH DISCUSSION: SUICIDAL IDEATION

What are the warning signs for Suicidal Ideation?

Warning Signs

- Other signs of depression
- Suicidal talk
  - "I want to kill myself, I wish I could just die, Everyone will be better off when I'm gone…"
- Previous suicide attempts
- Preoccupation with death or dying
- Recent life crisis or trauma
- Gives away cherished possessions
- Not future oriented

If warning signs, ask:

- Have things ever gotten so bad that you thought about suicide?
  - Yes/No
- Are you thinking about suicide now?
  - Yes/No
- If yes, contact supervisor immediately
- Patient should not be left alone

If no, you can say:

- "If you ever feel that way, know that you can tell me and I will get you help."
- If no, you can still offer hotline information:
  - National Suicide Prevention Hotline
  - 1-800-273-TALK (8255)

Other Things to Keep in Mind

- Talk openly and matter-of-factly about suicide; be direct
- Be non-judgmental
- Be willing to listen and allow expression of feelings
- Seek support. Don't be sworn to secrecy. You are part of a team
- Offer hope, but don't just say that "everything's going to be fine"

14 PATIENT HEALTH QUESTIONNAIRE REVIEW (PHQ-9)

Refer students to the PHQ-9 in the Student Exercise Book and ask them to review.

Say to class: *In a few minutes, we are going to practice using one of the most commonly used tools to screen for depression: the Patient Health Questionnaire, or PHQ-9. This PHQ-9 is a set of 9 questions that have been used with many different kinds of patient populations and has a good track record of identifying people who might be depressed.*

It's important to remember that the PHQ-9 only screens for depression and does not diagnose. If someone scores "positive" on the PHQ, it does not mean that they have scored positive for a diagnosis of depression; it means that they have symptoms of depression and need to be referred to someone for a more comprehensive assessment.

As you can see, there is a list of symptoms that you should review with the patient and ask them how often they have been feeling these symptoms over the past two weeks. You are only asking about the last two weeks – this is not about whether or not they have ever had depression.

The skill in using the PHQ is making it seems like a conversation and not just a checklist. With time, it's possible to develop a style that allows you to use this tool as part of a dialogue with the patient. However, it's also important to not go "off book" with the PHQ so that it can remain structured and brief.

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 _____

A2663B 10-04-2005

15 ACTIVITY: PATIENT "M" ROLE PLAY

Ask the class to break into pairs. One student will be "Patient M" and the other student will be the "Health Professional". Each student should read the synopsis for their character and improvise based on the information they've been given.

The health professional will need to incorporate the PHQ-9 screening into his or her conversation with the patient.

Patient "M" can say whatever he/she wants based on the scenario.

After the teams have completed the role play, facilitate a group report out using these discussion questions:

- How did this exercise go?
- For the staff using the PHQ-9, how did this work for you?
- For the patients, how did it feel to be screened?

STUDENT EXERCISE BOOK

ACTIVITY: PATIENT "M" ROLE PLAY

Instructions: Divide into pairs. Decide who will role play as the "Health Professional" and who will role play as the "Patient." Take a moment to read the scenario 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.

ACTIVITY: PATIENT "M" ROLE PLAY

Instructions: Divide into pairs. Decide who will role play as the "Health Professional" and who will role play as the "Patient." Take a moment to read the scenario 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.

16 POWERPOINT WITH DISCUSSION: ROLE OF CARE COORDINATION

What is the role of the care coordinator for people with mental illness?

- Build rapport
- Build trust
- Build support systems in coordination with care team
- Help the patient stay on medication and keep appointments (i.e. troubleshoot)
- Offer strong support and encouragement for staying on medication
- Help the patient develop and achieve simple and attainable goals
- Keep track of patient symptoms – if you see something, say something

As a health professional providing care coordination, your role is to know what is "normal" for your patient, what is not "normal" and alert your care team as soon as you see things moving in the wrong direction.

17 WRAP UP/HOMEWORK

"Signs of Depression"; The Community Health Worker's Sourcebook, A Training Manual for Preventing Heart Disease and Stroke, Centers for Disease Control and Prevention; 6-13

"Four Steps to Understand and Get Help for Depression" The Community Health Worker's Sourcebook, A Training Manual for Preventing Heart Disease and Stroke, Centers for Disease Control and Prevention; 6-14

REFERENCES

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

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

MODULE 12

BASICS OF MENTAL ILLNESS AND CRISIS MANAGEMENT - PART 2

OBJECTIVES

- Understand characteristics of common mental illnesses such as schizophrenia
- Describe social support and the forms it can take
- Describe ways to help patients enhance their social support network
- Assess a patient's support system and identify and review areas where support is needed
- Describe the role of front-line care coordination staff in dealing with a patient crisis

MATERIALS NEEDED

- PowerPoint file with videos downloaded
- For activity "What Would You Do?" printed or written scenarios and some kind of container (hat, bowl, paper bag) for distributing to group

Basics of Mental Illness and Crisis Management - Part 2

AGENDA

1.	HOMEWORK REVIEW	10 MIN
2.	VIDEO: ASHLEY'S STORY	5 MIN
3.	VIDEO DISCUSSION	10 MIN
4.	POWERPOINT WITH DISCUSSION: SCHIZOPHRENIA	10 MIN
5.	VIDEO: CHOICES IN RECOVERY - PHYSICIAN'S PERSPECTIVES	15 MIN
6.	VIDEO DISCUSSION	10 MIN
7.	POWERPOINT WITH DISCUSSION: SOCIAL SUPPORT	5 MIN
8.	ACTIVITY: IDENTIFY YOUR SOCIAL SUPPORT NETWORK	10 MIN
9.	POWERPOINT WITH DISCUSSION: ASSESSING A PATIENT'S SOCIAL SUPPORT SYSTEM	5 MIN
10.	POWERPOINT WITH DISCUSSION: IMPROVING A PATIENT'S SOCIAL SUPPORT SYSTEM	5 MIN
11.	POWERPOINT WITH DISCUSSION: OVERVIEW OF CRISIS MANAGEMENT	20 MIN
12.	WRAP UP	5 MIN

1 HOMEWORK REVIEW

Note: In the previous class, students were asked to read two handouts and think about how they could be used to help educate patients about depression.

"Signs of Depression"
"Four Steps to Understand and Get Help for Depression"

Discussion Questions:

- When do you think would be an appropriate time to give your patients this information?
- Do you think this information is clear, or do you think you would need to provide additional explanations?
- How would you explain this information to your patient? What would you say in your own words as to why addressing depression is important?
- How would you feel explaining this information to patients? (for example, comfortable, anxious, unprepared)
- Is there any other information you would want your patient to have about how to understand and get help for depression?

Say to class: *In today's class we are going to learn about another kind of mental health illness: schizophrenia. Schizophrenia is a relatively common disorder, affecting about one out of 100 people. In fact, 1/5 of those receiving social security disability benefits are people with schizophrenia, and the disorder ranks ninth on the causes of disability throughout the world. Surprisingly, the disorder is more common than some diseases people hear more about, such as multiple sclerosis and Alzheimer's disease. Unfortunately, it's also widely misunderstood.*

2 VIDEO: LIVING WITH SCHIZOPHRENIA – ASHLEY'S STORY

3 VIDEO DISCUSSION

- Have any of you worked with a patient who has schizophrenia? Or perhaps know someone who has it?
- If yes, did Ashley's story sound familiar to you?
- If no, was there anything in her story that surprised you?

4 POWERPOINT WITH DISCUSSION: SCHIZOPHRENIA

It's safe to say that no mental disorder is more shrouded in mystery, misunderstanding, and fear than schizophrenia.

It has been called "the modern-day equivalent of leprosy"

- E. Fuller Torrey, M.D., Surviving Schizophrenia: A Manual for Families, Patients, and Providers.

Schizophrenia

- While 85% of Americans recognize that schizophrenia is a disorder, only 24% are actually familiar with it
- According to a 2008 survey by the National Alliance on Mental Illness (NAMI), 64% can't recognize its symptoms or think the symptoms include a "split" or multiple personalities.

What is Schizophrenia?

- A group of severe brain disorders in which people interpret reality abnormally.
- Schizophrenia may result in some combination of hallucinations, delusions, and disordered thinking and behavior.
- The word "schizophrenia" does mean "split mind," but it refers to a disruption of the usual balance of emotions and thinking.
- Schizophrenia is a chronic condition, requiring lifelong treatment.

Stigma

- Aside from ignorance, images of the aggressive, sadistic "schizophrenic" are plentiful in the media
- Stigma has a slew of negative consequences.
- Associated with reduced housing and employment opportunities, diminished quality of life, low self-esteem and more symptoms and stress (see Penn, Chamberlin & Mueser, 2003).

Substance Abuse Connection

- The relationship of schizophrenia to substance abuse is significant.
- Due to impairments in insight and judgment, people with schizophrenia may be less able to judge and control the temptations and resulting difficulties associated with drug or alcohol abuse.

Chronic Disease Connection

- It is not uncommon for people diagnosed with schizophrenia to die prematurely from other medical conditions, such as coronary artery disease and lung disease.
- It is unclear whether schizophrenic patients are genetically predisposed to these physical illnesses or whether such illnesses result from unhealthy lifestyles associated with schizophrenia.

What causes Schizophrenia?

- A complex interplay of:
  - Genetics, typically runs in families
  - Brain chemistry and structure, neurotransmitters are believed to play a role
  - Environment, early traumatic events, negative life events

What does Schizophrenia look like?

- Onset of schizophrenia is usually a gradual deterioration that begins in early adulthood – early 20s
- Loss of goals
- Loss of motivation
- Increased odd/eccentric behavior
- Increased isolation

Symptoms/Warning Signs of Schizophrenia

- Irrational, bizarre or odd statements or beliefs
- Increased paranoia or questioning others' motivation
- Becoming more emotionless
- Hostility or suspiciousness
- Increasing reliance on drugs or alcohol (in an attempt to self medicate)
- Speaking in a strange manner unlike themselves
- Inappropriate laughter
- Insomnia or oversleeping
- Deterioration in their personal appearance and hygiene

If You See Something, Say Something

While there is no guarantee that one or more of these symptoms will lead to schizophrenia, a number of them occurring together should be cause for concern, especially if it appears that the individual is getting worse over time.

This is **the ideal time** to act to help the person. (even if it turns out not to be schizophrenia)

How is Schizophrenia treated?

- Medicine
- A support network of family, friends, psychiatrists, psychologists, primary care providers, social workers, case managers, and other people with schizophrenia

5 VIDEO: CHOICES IN RECOVERY – PHYSICIAN'S PERSPECTIVES

6 VIDEO DISCUSSION

In this video, the psychiatrist talks about how she first focuses on establishing the "therapeutic alliance" when treating schizophrenic patients. What is the "therapeutic alliance"?

ANSWER: Respect, rapport and trust between a patient and a health professional who is trying to help them.

According to the psychiatrist, what's more important than the patient admitting or accepting that they have schizophrenia?

ANSWER: Finding a common goal that they can work on together (i.e. getting out of bed in the morning, getting a job, etc.)

Why does the psychiatrist say that "being on medication is not enough" for schizophrenic patients?

ANSWER: Patients should be living meaningful lives and therefore need things like vocational training, social support, therapy, integration into the community, a wellness plan, etc.

What does the psychologist say is the most important element of treatment?

ANSWER: Ownership of medication, wanting to be in treatment – which usually happens because someone they love or respect thinks this is a good idea.

What does the peer support program provide for people living with schizophrenia?

ANSWER: It lets them understand that they too can hold jobs, that they can be on medication successfully and lets them hear from someone who really understands where they are at.

From this video, how can you see care coordination working to help patients with schizophrenia?

ANSWER: Can help coordinate all of the multiple services and support systems that these patients need. Can help patients function independently by supporting the client to stay on medication, keep up with a wellness plan and access social support.

Say to the class: *Now we are going to take a closer look at this concept of social support. As we heard from the videos on schizophrenia, social support is one of the most important elements of treatment. However, social support is crucial for all of us, not just those of us with a mental illness.*

7 POWERPOINT WITH DISCUSSION: SOCIAL SUPPORT

What is Social Support?

Social support is defined as the "physical and emotional comfort given to us by our family, friends, co-workers and others. It is knowing that we are part of a community of people who love and care for us, and value and think well of us"

Who needs it?

We all do! We all need a social support network to depend on during the good times and the bad times (Fairbrother, 2004).

What types of social support are there?

Support can come in a variety of forms.
There are four main types (Fairbrother, 2004).

Emotional Support

- People give this type of support when they meet your emotional needs. This could be as simple as telling you they care about you and think well of you.

Practical Help

- People give this type of support to complete the basic tasks of day-to-day life, such as financial help or physical assistance.

Sharing Points of View

- People give this type of support when they want to offer an opinion on a situation. This allows you to think about a viewpoint you had not yet considered.

Sharing Information

- People give this type of support to provide factual information about an event that may be particularly stressful.

Fairbrother, 2004

8 ACTIVITY: IDENTIFY YOUR SOCIAL SUPPORT NETWORK

Say to the class: *Now we are going to take a few minutes to think about our own support network. This is an exercise that you can do in the future to help your clients or patients identify who is around them to help them and provide support. For this exercise, think about whether you have people in your life you can turn to when you just need someone to talk to. Is there someone who will take care of you when you are older? Using the handout, describe who is in your social support network; we will then discuss how these influences support you in your daily life.*

Refer students to their exercise books.

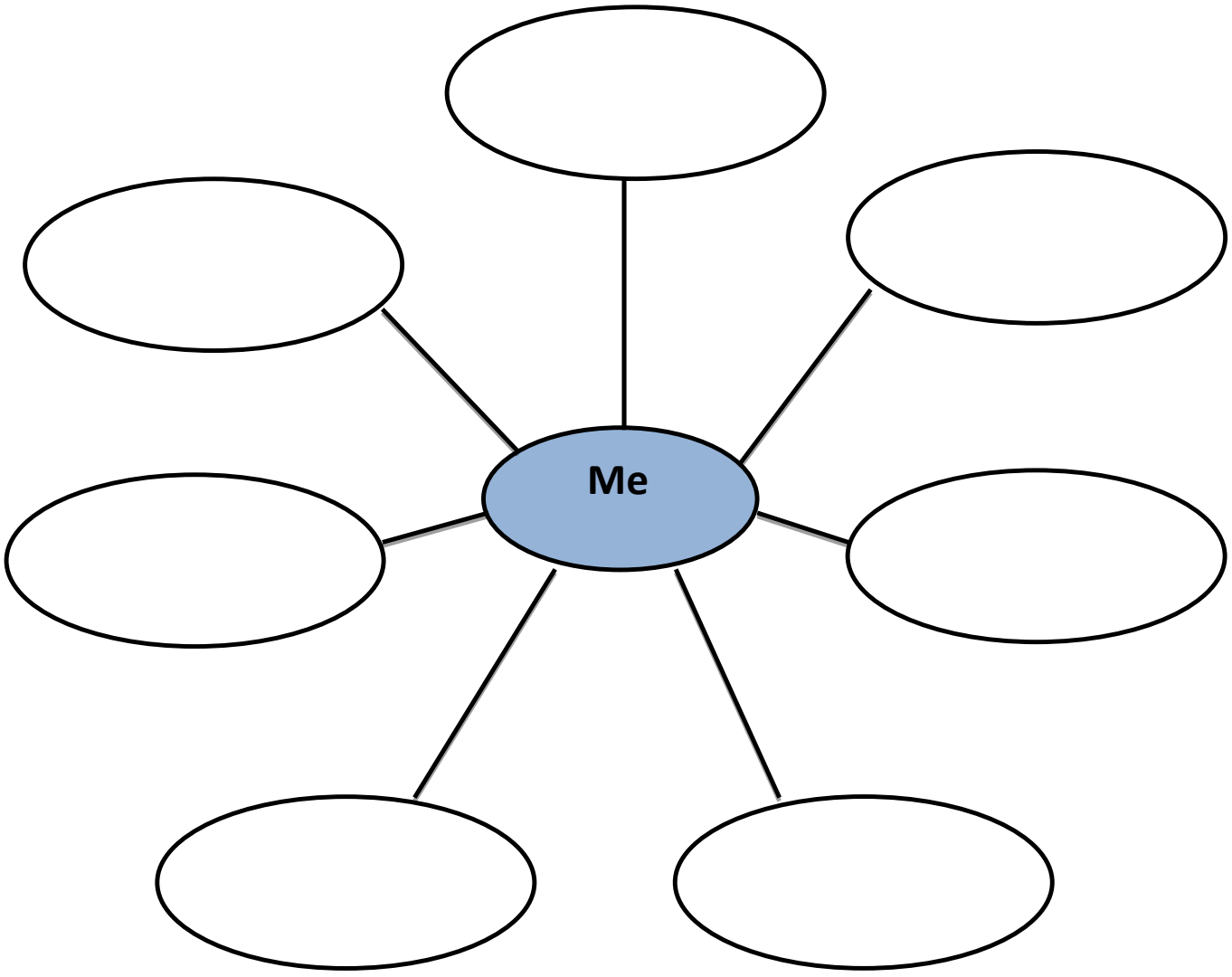
Discussion Questions:

1. Who did you write down as part of your social support network?
2. How do these individuals or influences support you in your daily life?

Say to class: *Notice that not one person will provide all your support needs. Different people provide different types of support.*

ACTIVITY: IDENTIFY YOUR SOCIAL SUPPORT NETWORK

Instructions: Describe who is in your social support network in the spaces provided on the handout and then we will discuss how these influences support you in your daily life.



EXAMPLE FOR ASSESSING A PATIENT'S SUPPORT SYSTEM

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.

9 POWERPOINT WITH DISCUSSION: ASSESS A PATIENT'S SUPPORT SYSTEM

Say to class: *When you first meet your client or patient, assessing their support system is a good first step in understanding how you can support them. To do this, there are several helpful tools you can use. These tools can be as simple as having the patient write down the numbers of those in their social support network or something more in depth as having a patient fill out a questionnaire to asses their level of social support.*

As you work with patients, you will sometimes find that you become part of your patient's support system. While this is to be expected, you should also keep in mind that as a professional, you will one day need to terminate this relationship or transition this patient to another professional. Using this tool to help capture the patient's support system at the beginning of your relationship will help you make this transition more successfully later on.

Here are a few examples of tools that health professionals use to assess a patient's support system.

Refer to:

Norbeck Social Support Questionnaire: http://nurseweb.ucsf.edu/www/ffnorb.htm (In Student Exercise Book)

Social Support Assessment Tool for those with a Specific Chronic Disease (i.e. Diabetes): http://www.diabetesinitiative.org/resources/topics/documents/8-LAC-SocialSupportToolEnglish_web.pdf

**More simplified and straightforward*

10 POWERPOINT WITH DISCUSSION: IMPROVING A PATIENT'S SOCIAL SUPPORT SYSTEM

If you find that your patient's social support network is not strong, how can we help the patient improve it?

Empower patients to:

- Not be afraid to take social risks
- Get more from the support you have
- Ask for help
- Make a plan
- Create new opportunities
- Let go of unhealthy ties
- Be a joiner
- Be patient
- Avoid negative relationships

When might a patient want to change his/her social support network?

- Not enough support
- Change in lifestyle
  - Parenthood
  - Divorce or death of a spouse
  - Behavioral problems
  - New hobby/activity
  - Sexual orientation
- Need for specialized knowledge or expert opinion
  - Formal support

11 POWERPOINT WITH DISCUSSION: CRISIS MANAGEMENT

What is Crisis?

- A crisis occurs when a person is confronted with a critical incident or stressful event that is perceived as overwhelming despite the use of traditional problem-solving techniques and coping strategies.
- Often it is not the event itself that causes the crisis; rather, it is the appraisal of the event as serious, uncontrollable, and beyond the patient's resources for coping that triggers a crisis response.

Perception is Key

Say to class: *It's important to keep in mind that while certain stressors or events can trigger a crisis, it is a person's perception about the situation and his or her coping ability to deal with the situation that determines how any particular person will react. Faced with the same fact situation, different people may react very differently.*

- Whereas one person might get upset, angry, or depressed, or even become out-of-control, another person in the same situation might not even experience the event as a significant problem. The way in which someone reacts to a problematic situation very much depends on such factors as the individual's genetic makeup, upbringing, past experience, personality, and learned coping strategies.

What kinds of events can trigger a crisis in someone's life?

- Developmental (i.e., life-transition events): Birth of child, graduation from college, midlife career change, retirement
- Existential (i.e., inner conflicts and anxieties related to purpose, responsibility, independence, freedom, or commitment):
  - Realization that one will never make a significant impact on one's profession
  - remorse that one has never married or had children
  - despair that one's life has been meaningless
- Environmental (i.e., natural or man-made disasters): Tornado, earthquake, floods, hurricanes, forest or grass fires
- Medical (i.e., a newly diagnosed medical condition or an exacerbation of a current medical problem):
  - Multiple sclerosis, HIV, infertility, myocardial infarction, cancer, medical problems that result in partial or total disability
- Psychiatric (i.e., actual syndromes and those that affect coping):
  - Depression or suicidal thoughts, events precipitating acute or post-traumatic stress disorder
- Situational (i.e., uncommon, situation-specific events):
  - Loss of job, motor-vehicle collision, divorce, rape

A combination of trigger events can also move someone from "coping" to "crisis"

- Fight with partner + Sick child + Diabetes = ?

Say to class: *A person may experience a crisis in reaction to a series of things that happen, rather than a single event. A person may be able to cope well enough with a single troubling event or situation, but may not be able to cope as well when several troubling things happen within a relatively short time. For example, if a man has a fight with his wife he may be upset for a while, but it is not necessarily a significant crisis for him. But if has to deal with a sick child, is dealing with a recent diagnosis of diabetes and then has a fight with his wife, the combination of these three circumstances may be so disturbing to him that he experiences an emotional crisis.*

As someone providing care coordination, what are the most common kinds of crisis you might see in your patients?

- Medical - dealing with a chronic disease diagnosis
- Psychiatric - depression, suicidal ideation
- Situational - unexpected events, violence, financial crisis, eviction

12 WRAP UP

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Kavan, M., Guck, T., Barone, E. A Practical Guide to Crisis Management. Am Fam Physician. 2006 Oct 1;74(7):1159-1164.

NYS Office for the Prevention of Domestic Violence
http://www.opdv.ny.gov/

National Network to End Domestic Violence
http://www.nnedv.org

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

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

VIDEOS

Living with Schizophrenia – Ashley's Story

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

Choices in Recovery – Physician's Perspectives

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

MODULE 13

BASICS OF MENTAL ILLNESS AND CRISIS MANAGEMENT - PART 3

OBJECTIVES

- Describe the role of front-line care coordination staff in dealing with a patient crisis
- Understand the difference between positive and negative coping strategies
- Understand the characteristics of substance abuse
- Understand the characteristics of domestic violence

MATERIALS NEEDED

- PowerPoint file with videos downloaded
- For activity “What Should I Do?” printed or written scenarios and some kind of container (hat, bowl, paper bag) for distributing to group

Basics of Mental Illness and Crisis Management - Part 3

AGENDA

1.	ACTIVITY: WHAT SHOULD I DO?	20 MIN
2.	POWERPOINT WITH DISCUSSION: COPING STRATEGIES	5 MIN
3.	ACTIVITY: COPING STRATEGIES BRAINSTORM	10 MIN
4.	ACTIVITY DISCUSSION	15 MIN
5.	GROUP ACTIVITY: CRISIS MANAGEMENT - CHRONIC DISEASE DIAGNOSIS	20 MIN
6.	BREAK	5 MIN
7.	POWERPOINT WITH DISCUSSION: CRISIS MANAGEMENT - SUBSTANCE ABUSE	20 MIN
8.	ACTIVITY: CRISIS MANAGEMENT - DV/IPV	20 MIN
9.	WRAP UP	5 MIN

1 ACTIVITY: "WHAT SHOULD I DO?"

Say to class: *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.*

For this next activity, I am going to ask you to pull out a slip of paper from this (hat, bowl, paper bag). On each slip of paper is a possible patient scenario in which a patient is experiencing a tough situation. Read this scenario aloud to the group. Think about how you might respond to this patient as a health professional and offer a suggestion. The discussion will then be opened up to the group and we will talk as a group about ways we could best address this situation. There is never one answer to these situations – but there are ways that you can handle these scenarios respectfully – which is always the goal when working with patients.

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.

KEY POINTS:

- Stay calm and respond with empathy and non-judgment.
- Share information clearly about what's expected in the clinic and why.
- Protect people's privacy by addressing issues discretely and privately whenever possible.
- Get backup: bring in social worker, practice manager, and/or trusted medical provider that knows the client to help with communication and containment.
- Follow-up: share what happened & any concerns with the care team for future assessment, be sure to connect the client with supportive resources for the issues that come up (via sm)
- Maintain safety in a way that the client feels respected and like they can come back to the clinic without shame.

Note to facilitator: Either write the scenarios below on separate slips of paper or make a copy of this page and cut these scenarios into strips. Then put these slips of paper in some kind of container (hat, bowl, paper bag) and distribute to the group. (Do not include the information in the purple boxes, those are notes for you to facilitate the discussion.)

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?

- Calmly & discretely ask her if she's ok and if she needs anything.
- Invite her to a private place and respectfully check in with her. Invite her to sit in an empty treatment room or office until she feels better. Bring her water, tea/coffee, or Kleenex. Put on a little quiet music if you can to create a safe space.
- If she appears to be in serious distress, bring in a social worker or CHW to sit with her, help her calm down, and make a counseling referral if needed.
- Share with her PCP/nurse what happened so they can do some more thorough mental health assessment and prescribe medication if needed.

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?

- Politely interrupt the patient's call and ask him to step outside to protect everyone's privacy.
- Ask him to put the call on hold and follow you to quiet space (hallway, unused office). Check in with him to make sure everything is ok and explain the clinic policy about phone calls (no loud ones in the waiting area) and creating safe space for all the clients.
- If you can't calm him down, ask him to end the call and have the practice manager or his provider come speak to him.

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?

- Listen, validate her feelings and calmly apologize. Thank her for waiting.
- Offer her realistic options: reschedule, wait for X amount of time (accurate estimate), offer water/snack/magazines, or that she can leave and you will call her cell when she's next in line to return to the clinic if possible.
- Ask her provider or the clinic manager to come out and explain to her about the cause of delay and how long she can expect to keep waiting.
- Calmly explain the clinic's grievance procedure & patient's rights to her if she wants to follow-up on her concerns.

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?

- Kindly and non-judgmentally ask her directly if she feels safe at home and if she needs any services or support. If she denies the issue, let her know the clinic is a safe place to bring up any safety issues she may have in the future.
- Pass on the information about what you saw to her provider or clinic social worker.
- If she has children in the home, check in with your staff social worker about whether there is need to for mandated reporting.

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?

- Stay calm and respond (don't react). Listen to his concerns and don't argue with him. Reiterate the policy & why it's in place (HIPPA, confidentiality, best patient care, etc.)
- Ask the client's provider and/or the staff social worker to come speak with the client & her partner in the waiting area.
- You can take the client back for her appointment and let her partner wait in the lobby until a trusted team member can talk with him. They will want to assess for domestic violence and offer some safety resources (DV hotline, shelter info, safety planning) to the client alone.
- If you or social worker think that denying the partner entrance to the appointment may put the client at risk for violence at home, ask her alone how she wants you to proceed. If she asks you to let the partner join the appointment, let him in and do the DV assessment if/when he leaves the room or later by phone.

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?

- Ask the client some basic questions (his address, day of the week, etc) to assess his mental capacity. If he appears too impaired, ask him to reschedule the appointment and ensure that he is not driving home from the clinic. You may need to call a taxi or his emergency contact to come get him, if he is not safe to drive.
- Some patients will always come to the clinic drunk, so if you want to treat them you have to work with their use. Smelling of alcohol shouldn't be a barrier to treatment, as long as his behavior with other clients and the staff is appropriate. If not, it's helpful to address the behavior itself (staggering, yelling, passing out) and not make accusations about substance abuse.
- Check in with his providers about if they are willing to see him or not. If you are unsure how competent he is, you may want to call a social worker out to do a more thorough assessment and decide if he should be seen and make referrals for substance use treatment or counseling if the client is interested.

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?

- Invite the parent and child into a quiet space (empty treatment room or office). Calmly and respectfully let the parent know it's not ok to hit her child in the clinic, as it is a safe place for all clients. Offer the Mom some water or tea and bring a toy for the kid if you have one. Let them stay in their own space until they both calm down. You may want to do this jointly with a social worker or trusted provider who knows this family.
- Follow up with a social worker on the team to find out if you will need to report the parent for physically disciplining her child. Ideally, the social worker can let the mom know that physical discipline is considered child abuse and offer her some parenting support resources to learn alternative ways to manage kid's behavior and her own stress.

2 POWERPOINT WITH DISCUSSION: COPING STRATEGIES

Say to the class: *When trying to manage a patient or client crisis, it is very helpful to have an understanding of their support systems and coping strategies. We discussed support systems in the last class; now we will spend some time discussing coping strategies.*

What are Coping Strategies?

Coping strategies are those strategies that reduce stress. It can come in two forms: adaptive or constructive coping (positive techniques) and maladaptive coping or non-coping (negative techniques). It is important to note that patients will develop their own mechanism for coping with stress (and their disease), but it may not always be the most beneficial.

3 ACTIVITY: COPING STRATEGIES BRAINSTORM

POTENTIAL ANSWERS TO ACTIVITY:

Positive Techniques (Adaptive or Constructive Coping):

- Seeking social support
- Keeping fit (nutrition, exercise, sleep)
- Hobbies

Negative Techniques (Maladaptive Coping or Non-Coping):

- Social avoidance
- Unhealthy or unsafe behavior
- Substance abuse

4 ACTIVITY DISCUSSION

Why do you think a patient would choose a negative coping strategy over a positive one?

- Sometimes a negative coping strategy can lead to a crisis itself. For example, binge drinking could create a crisis with a relationship or a job. As someone providing care coordination, how do you think you could address a patient's negative coping strategies before it got to a crisis point?
- How do you think you could reinforce or support a patient's positive coping strategies?

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):

- _____
- _____
- _____
- _____
- _____
- _____

5 GROUP ACTIVITY: CRISIS MANAGEMENT – CHRONIC DISEASE DIAGNOSIS

Say to the class:

- Many of you will be working with patients who have a chronic disease. You may work with them soon after they learn of their diagnosis, or you may work with them well after they got the news from their provider.
- If you are working with a client/patient soon after they learn of their diagnosis, you may be supporting them when the diagnosis feels like a "crisis."
- We are going to take a look a patient scenario together and think about an appropriate front-line care coordination response.

Note: The scenario below is on the PowerPoint slides. Ask students to take turns reading each scenario section and then ask for responses to each discussion question. Clarify that you will be asking students to figure out appropriate responses step by step.

Patient Scenario: Alice

Today is your first meeting with a client who very recently learned that she has Type 2 diabetes. Alice, a 30-year-old obese woman with two children, comes into your office to discuss how she can begin to manage her care. You ask her some general questions and she starts to break down and cry. She says that she is stressed out being a single mom with two young children, and can't imagine how she can do all the things she needs to do to take care of herself. She says she doesn't know how she can go on.

What's the first thing you could say in this kind of situation?

Possible answers:

- I hear that you are really worried about having diabetes, particularly about how this might affect how you can take care of your kids.
- Let me get you some tissues.
- Take all the time you need; we are going to figure this out together.

Alice Scenario Continued

Once Alice hears that you are listening to her, she begins to calm down. Her crying slows down. While you are concerned about the patient, you are most concerned about her statement, "I don't know how I can go on." You decide to screen her for suicidal ideation.

What questions should you ask?

Possible answers:

- I am concerned about something you said and I want to be sure I understand how you are feeling. Are you thinking about suicide? Are you thinking of hurting yourself? Have you ever tried to commit suicide?

Alice Scenario Continued

When you ask her these questions, Alice looks shocked and says no to both questions. She says she would never kill herself because she needs to be there for her kids. She says that she just feels really tired and overwhelmed. Since you are now no longer concerned about suicidal ideation (and you documented her answers in your notes) you would like to have the client talk more about the diagnosis.

What's something you could say at this point?

Possible answers:

- What does this diagnosis mean to you?
- Can you tell me more?

Alice Scenario Continued

Alice says that having diabetes means she has failed as an adult. She knows that she has not been taking good care of herself. Now she wonders if she can take good care of her kids. It's clear that Alice needs a lot of support.

What do you think you should ask about next?

Possible answers:

- Where do you get support from now?
- Are there people in your life who you can talk to and get help from?

Alice Scenario Continued

Alice says that she gets help from her mother and her sister, but that she and her mother disagree about a lot of things. She and her sister are close and her sister lives nearby. Her children's father is not in the picture anymore but has been providing child support.

What could you ask about next?

Possible answers:

- Coping strategies. For example:
    - How has Alice handled her stress in the past?
    - What does she do to relax?
    - What makes her happy?

Alice Scenario Continued

Alice says that cooking food for her family is relaxing and makes her happy. She also has a few shows on TV that she likes to watch. As you have been talking with Alice, you notice that she has relaxed and no longer appears to be so upset. It's time to start talking about how she can start managing her diabetes, and connect her to other support services.

What should you review with Alice as a way to move forward?

Possible answer:

- Her care plan.

Alice Scenario Continued

You review the care plan with Alice and ask her to come up with simple steps she can take to move forward on some of the care plan goals. You also provide a referral to the education and nutrition specialist. You make a plan to follow up with her in the next few days. Alice leaves.

Who should you talk to about Alice?

Possible answers:

- Care team
- Supervisor
- Nutrition specialist

6 BREAK

7 POWERPOINT WITH DISCUSSION: CRISIS MANAGEMENT - SUBSTANCE ABUSE

- Some of your patients or clients may be using substances as a coping mechanism to make themselves feel better
- Using "harm reduction" strategies may be helpful with these clients. For example, working with them to develop goals to reduce smoking, drinking or drug use but not quit, as they are not ready to quit completely
- As a care coordinator, you may see red flags that substance use is leading to a crisis in the patient's life. If this happens, bringing these observations to your care team will be crucial

What is substance abuse?

- Substance abuse can simply be defined as a pattern of harmful use of any substance for mood-altering purposes

What are some of the most commonly abused substances?

- An estimated 19.9 million people in the United States currently abuse drugs, according to the National Survey on Drug Use and Health (NSDUH)
- These drugs fall into nine categories including use of marijuana, cocaine, heroin, hallucinogens and inhalants; and the non-medical use of prescription-type pain relievers, tranquilizers, stimulants and sedatives
- However, cigarettes and alcohol are also "substances"

What could be some signs that your patient is abusing substances?

- Bloodshot eyes, pupils larger or smaller than usual
- Changes in appetite or sleep patterns, sudden weight loss or weight gain
- Deterioration of physical appearance, personal grooming habits
- Unusual smells on breath, body, or clothing
- Tremors, slurred speech, or impaired coordination

Behavioral Signs

- Missed appointments, drop in attendance and performance at work or school
- Unexplained need for money or financial problems, may borrow or steal to get it
- Engaging in secretive or suspicious behaviors
- Sudden change in friends, favorite hangouts, and hobbies
- Frequently getting into trouble (fights, accidents, illegal activities)

Psychological Signs

- Unexplained change in personality or attitude
- Sudden mood swings, irritability, or angry outbursts
- Periods of unusual hyperactivity, agitation, or giddiness
- Lack of motivation; appears lethargic or "spaced out"
- Appears fearful, anxious, or paranoid, with no reason

As staff providing care coordination, what should you do if you suspect your patient is abusing substances?

Do:

- Talk to your supervisor/care team
- Tell the patient what you see/smell (i.e. alcohol)
- Express concern
- Convey empathy
- Remain open and non-judgmental
- If appropriate, offer resources, i.e. AA

Do NOT:

- Attempt to punish, threaten, bribe, or preach.
- Take over their responsibilities, leaving them with no sense of importance or dignity.
- Hide or throw out drugs.
- Argue with the person when they are high.
- Feel guilty or responsible for patient's behavior.

8 POWERPOINT WITH DISCUSSION: CRISIS MANAGEMENT - DOMESTIC VIOLENCE/INTIMATE PARTNER VIOLENCE

- Some of your patients or clients might be in difficult or abusive family relationships.
- Particularly if you are doing home visits, you may be able to see some red flags that you could not see at the health center.
- However, it may take a long time for your patient or client to perceive their unhealthy relationships as a "crisis".
- Providing non-judgmental support and keeping the patient connected to support systems will be crucial.

What is domestic violence (DV) or intimate partner violence (IPV)?

- Domestic violence is a pattern of coercive, controlling behavior that can include physical abuse, emotional or psychological abuse, sexual abuse or financial abuse (using money and financial tools to exert control).
- Domestic violence is a pervasive, life-threatening crime that affects millions of individuals across the United States regardless of age, economic status, race, religion or education.

http://www.nnedv.org

What could be some signs that your patient is in an abusive relationship?

Behavioral Signs

- Seem afraid or anxious to please their partner
- Go along with everything their partner says and does
- Check in often with their partner to report where they are and what they're doing
- Receive frequent, harassing phone calls from their partner
- Talk about their partner's temper, jealousy, or possessiveness
- Be restricted from seeing family and friends
- Rarely go out in public without their partner
- Have limited access to money, credit cards, or the car
- Frequently miss appointments, work, school, or social occasions, without explanation

Physical Signs

- Have frequent injuries, with the excuse of "accidents"
- Dress in clothing designed to hide bruises or scars (e.g. wearing long sleeves in the summer or sunglasses indoors)

Psychological Signs

- Have very low self-esteem, even if they used to be confident
- Show major personality changes (e.g. an outgoing person becomes withdrawn)
- Depressed, anxious, or suicidal

As a staff person providing care coordination, what should you do if you suspect your patient is in an abusive relationship?

Do:

- Talk to your supervisor
- Ask if something is wrong
- Express concern
- Listen and validate
- Offer help
- Support his or her decisions

What should you NOT do?

Do NOT:

- Wait for him or her to come to you
- Judge or blame
- Pressure him or her
- Give advice
- Place conditions on your support

If your patient denies abuse, it's still ok to provide hotline information:

NYS Domestic and Sexual Violence Hotline

1-800-942-6906

Spanish language 1-800-942-6908

In NYC: 1-800-621-HOPE (4673) or dial 311

9 WRAP UP

- While a chronic disease diagnosis might cause a crisis for some of your patients, for others it won't.
- Positive coping strategies and strong support systems can affect how well a patient deals with a difficult situation.
- Some of your patients may have other unhealthy factors in their life that can become a crisis.
- Making the care team aware of "red flags" can help to either prevent or de-escalate the crisis situation.
- During crisis, showing non-judgmental support of your patient, as well as focusing on support systems and positive coping strategies will help your patient validated.

REFERENCES

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James RK, Gilliland BE. Crisis Intervention Strategies. 5th ed. Belmont, Calif.: Thomson Brooks/Cole, 2005.

Lazarus RS, Folkman S. Stress, Appraisal, and Coping. New York, N.Y.: Springer, 1984.

Kavan, M., Guck, T., Barone, E. A Practical Guide to Crisis Management. Am Fam Physician. 2006 Oct 1;74(7):1159-1164.

NYS Office for the Prevention of Domestic Violence
http://www.opdv.ny.gov/

National Network to End Domestic Violence
http://www.nnedv.org

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

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

MODULE 14

HOME VISITS

OBJECTIVES

- Define transitions of care
- Understand the relationship between care coordination and transitions of care
- List specific ways that staff providing care coordination can help support successful transitions of care

MATERIALS NEEDED

- PowerPoint file with videos downloaded

Home Visits

AGENDA

1.	EXERCISE: OPEN FORUM SHARED EXPERIENCES	20 MIN
2.	POWER POINT WITH DISCUSSION: PRINCIPLES OF HOME VISITING	15 MIN
3.	GROUP EXERCISE: CASE STUDY - MR. DIAZ	15 MIN
4.	POWERPOINT WITH DISCUSSION: HOW TO PLAN, CONDUCT AND DE-BRIEF HOME VISITS	20 MIN
5.	VIDEO: NURSE HOME VISITING AT COMMONWEALTH CARE ALLIANCE	5 MIN
6.	VIDEO DISCUSSION	10 MIN
7.	POWERPOINT WITH DISCUSSION HOME VISIT BEST PRACTICES	20 MIN
8.	GROUP EXERCISE: CASE STUDY - MS. JONES	15 MIN

1 EXERCISE: OPEN FORUM: SHARED EXPERIENCES

Begin by asking the class to divide into groups of 3-4 students. Ask the groups to assign one person to be the note-taker and discuss the following questions. If you have students in the class with home visiting experience, it is suggested that these students split among the groups.

After groups have had time to discuss their responses, ask each group to answer one question, going in order, until all questions have been answered. If other groups have thoughts/observations that have not been stated, ask them to contribute.

Discussion Questions

- 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 get out of 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 it's 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?

2 POWERPOINT WITH DISCUSSION: PRINCIPLES OF HOME VISITING

Purpose of Home Visits

- Identifies and reduces barriers to patient care
- Helps health professionals understand the "whole story" of what might be preventing the patient from being healthy
- Builds trust and connection
- Helps engage other caregivers in the home

Key Areas to Keep in Mind

Respect for the patient's home and privacy

- Remember that you are entering a person's home. Avoid making judgments about what you see, while also observing issues that could impact your patient's health.
- Discuss confidentiality with your patient. Let them know what specific situations you would need to discuss with your supervisor and care team, but also let them know that their confidentiality will be respected.

Home visits are strategic detective work

- While it's important to respect patient privacy and boundaries, home visits are a chance to see things that might be missed in a typical visit.
- This is your time to be creative and think of solutions to issues that might be presenting an obstacle to a patient's care plan.

Family dynamics

- One of the most useful things about a home visit is being able to understand how your patient fits into the family dynamics within a home.
- You may see that family members are allies to the patient; some family members might be obstacles to a patient's health.
- Particularly as you get to know your patient and the family, it's possible that family members might bring you into disagreements or ask you to take sides.
- Family members might also ask you for patient care coordination services for themselves.

What should care coordinators do in this situation?

Cultural dynamics

- Knowing and understanding your patient's cultural background can help prepare you for certain expectations, beliefs, or behaviors
- Some patients or family members will prefer you to address them formally, even if you are in their home. One approach is to address your patient formally and allow them to correct you if they want to be more informal. The patient who prefers you to be more formal will NOT correct you.
- The definition of "family" can be different for each of your patients. Some families might be nuclear, while some might include extended family or friends. Encourage the patient to tell you who they consider to be family.

Professional Boundaries

- Nowhere are professional boundaries more important than in home visits.
- Since you are in the home, the tone is more relaxed and informal - it can therefore be harder to maintain boundaries than in a clinic or a hospital.
- Particularly if home bound or sick, patients may not come to the door fully dressed.
- Patients may ask you to stay for dinner or offer gifts.
- Patients may have friends or family over that prevent you from conducting your home visit in a confidential manner.
- Patients, friends or family members may be using drugs or alcohol in the home.

What are some ways in which care coordinators can maintain professional boundaries in these kinds of situations?

ANSWERS

- *Dress:* Staff can ask patient to put on a robe and wait outside the door until the patient is fully dressed.
- *Dinner:* Staff can accept a glass of water or cup of tea but gently reinforce that they are here to make sure the patient is healthy and not here just for a social call.
- *Drugs/Alcohol:* Staff should reschedule home visit for another time and ask patient to not use alcohol/drugs, etc. at all home visits in the future.
- Staff should take some time with patient to outline expectations about how the patient and the care coordinator should interact and what they should expect during the home visit.

3 GROUP EXERCISE: HOME VISIT CASE STUDY – MR. DIAZ

Note: Direct students to their exercise books and ask for volunteers to read the case study aloud. Then ask the group the following questions (also in their exercise book)

- Can you identify the main red flags on this potential new home visit?
- Should this visit be conducted?
- If yes, how do you think a care coordinator should approach and resolve some of these issues?
- If you think this visit should not be conducted, why not?

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?

4 POWERPOINT WITH DISCUSSION: HOW TO PLAN, CONDUCT AND DE-BRIEF HOME VISITS

What kind of planning should be done prior to a home visit?

- Do your homework.
  - Look at the care plan. Discuss with your care team what your priorities should be when conducting the visit.
  - Look through medical records, case manager notes and social worker notes. Try and learn as much as possible about the patient before the home visit.
- Have a clear purpose and plan.
  - You should be able to identify the purpose of the home visit and be prepared to articulate that to the patient.
  - Preparing for the visit includes planning how to accomplish the purpose, including who needs to be there, topics to discuss, and issues that may arise.
- Gather your resources and tools.
  - Based on the needs of your patient, you should gather anything you think would be helpful to the patient, such as mental health resources, transportation options, food pantries, etc.
- Contact the patient.
  - Let them know you would like arrange a visit and get a time that works for them. Let them know the purpose of the visit, how long it will take and anything they should have on hand (medication, health insurance paperwork, etc.)
- Be safe.
  - Preparation also includes planning for staff safety, making decisions whether someone should accompany staff or deciding if the visit should occur elsewhere.

How can you conduct an effective home visit?

- Engage the patient.
  - While "small talk" should not be the only way you communicate with your patient, it can be helpful in building your rapport and relationship.
- State the purpose of your visit.
  - Visits should focus on a stated purpose, with a clear goal and flexible agenda.
- Use a standardized checklist or assessment tool.
- Establish and maintain professional boundaries
  - Professional boundaries should be maintained firmly AND sensitively.
- Assess patient safety
  - Regardless of the purpose, patient safety, stability, and well-being should be assessed (or reassessed) at every visit.
- End on time and let the patient know what's going to happen next.
  - Healthcare staff should conclude visits with summary statements and plans for next steps.

Documenting and Debriefing Effective Home Visits

- Using a standard checklist, tool or having a clear way to write notes will be crucial to good documentation.
- Once you are back in the office, document your findings in the appropriate database or EMR as soon as possible.
- De-brief the home visit to your supervisor in order to:
  - Discuss care plan related information
  - Develop your patient care coordination skills
  - Manage your feelings about your patients
  - Prevent burnout
- Finally, plan ahead for care team meetings and bring questions and agenda items to the meeting.

5 VIDEO: NURSE HOME VISITING AT COMMONWEALTH CARE ALLIANCE

6 VIDEO: DISCUSSION

- What kinds of care coordination skills was this provider using?
- How did the provider talk about her patient? How did she view this patient?
- From the patient's point of view, what was important to her about these visits and this provider?

7 POWERPOINT WITH DISCUSSION: HOME VISIT BEST PRACTICES

If Family is Present

- Acknowledge all family members.
- Knock, smile, make eye contact, and be pleasant.
- Introduce yourself and your role.
- Duration. At the start, state how long the overall visit will take, and during the visit you may want to state the length of particular tasks.
- Explain all processes and procedures so they know what to expect.
- Thank the family for inviting you into their home and for their time. Ask if there are any other questions before ending.

Boundaries and Roles

- Maintain a professional relationship. Becoming "friends" may make it difficult to talk about hard topics. Learn how to become both professional and personable.
- Respect personal space. Do not initiate touch unless necessary for the intervention. If touch is necessary, ask permission.
- Use self-disclosure sparingly to communicate understanding/build trust. The focus is not on you.
- Maintain confidentiality. While OK to discuss cases with supervisor as needed, do not share specifics or identifying information with friends or family.

Self-Care: Practical Tips Before You Go

- Keep dress simple - avoid jewelry, scarves, clothing that will attract unwanted attention.
- Wear safe footwear with closed toes.
- Take hand sanitizer.
- Avoid wearing scents as some people are sensitive.

Think Safety Before You Go

- Assess risks by phone before the visit (e.g.,animals, other persons in home).
- Ask clients to secure unruly pets.
- Ask clients to turn on lights, meet you at the door.
- If visit presents significant safety hazards, consider an alternative site to meet and/or take a buddy.
- If driving, be sure you have enough gas and a spare tire.
- Program the client's number into your phone.
- Identify safe routes within the neighborhood.
- Wear a name tag.
- Plan what you want to take into the home. Have items like laptops or backpacks locked away out of sight before arriving at your destination.
- Consider carrying clipboard, pepper spray, or a whistle.
- Carry important phone numbers with you.

Safety During the Home Visit

- Do not park in someone's assigned space, or block access to other cars.
- Keep hands free and car keys in hand.
- Walk with confidence. Do not walk through groups on street/sidewalk.
- Plan safe physical proximity in the home by positioning yourself between the client and the door. Sit near an exit or facing hallway to view other rooms. Sit on a hard chair or the edge of a soft chair to be able to get up quickly.

If There Are Safety Concerns

If a patient or family member becomes agitated or says things that make you uncomfortable:

- Respond calmly, using "I" statements.
- Acknowledge what they are saying.
- Redirect using matter of fact, simple, direct statements.
- Keep a physical distance of at least 3 feet.
- Do not reach out to touch the person, stand in front of the person, or turn your back to the person.
- Do not get up from a chair while the person is sitting. Do not try to leave too abruptly.
- Trust your instincts regarding impending danger.
- Do not reveal information about yourself or your family that could increase the risk of being harmed.
- If you feel threatened, remain calm but leave as quickly as possible.
- Report any incident to your supervisor.

Recognizing and Responding to Health and Home Safety Issues

Your health center/hospital should have an established procedure for how to report home safety issues. Examples of health/safety issues are:

- Neglect - unmet medical, dental, personal hygiene, or nutrition needs.
- Unsafe living conditions or injuries.
- Possible abuse – physical, sexual.
- Emotional abuse – name calling, making fun, putting the person down.
- Mental status – depression, anxiety, sleep deprivation.
- Financial abuse – taking money, not allowing the person to get or keep a job when one is desired.
- Caregivers - memory problems, confusion, inappropriate behaviors. Inappropriate behaviors of paid staff.

After you leave, be sure to make notes about any concerning observations or statements and make sure this information is communicated to your supervisor/ care team.

8 GROUP EXERCISE: HOME VISIT CASE STUDY – MS. JONES

Note: Ask the class to work with partners. Give them 15 minutes to read through the case study and discuss. Ask for volunteers to report back on what they discussed/decided.

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

MODULE 15

TRANSITIONS OF CARE

OBJECTIVES

- Define transitions of care
- Understand the relationship between care coordination and transitions of care
- List specific ways that staff providing care coordination can help support successful transitions of care

MATERIALS NEEDED

- PowerPoint file with videos downloaded

Transitions of Care

AGENDA

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

1 SMALL GROUP EXERCISE: CASE STUDY

Refer students to their exercise books. Have the class read the case study out loud or read it to them. Then break into small groups to brainstorm an answer to the question following the case study. Have groups report out on their answers and discuss.

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.

Say to the class:

What went wrong with this care transition? Make a list of everything that was a problem.

Possible discussion answers:

- Patient felt sick, but didn't know she could get a same day appointment.
- Patient admitted and discharged from the hospital, but there was no communication with her primary care provider.
- No information given to patient, or patient didn't understand what she was told, about her new medication regimen.
- The patient was advised to follow up with her primary care provider, but didn't.

2 VIDEO: CIRCLE OF CARE: RETURNING HOME FROM THE HOSPITAL

3 VIDEO DISCUSSION

- What is the patient most worried about when she gets home?
  - Taking care of herself
- What does the social worker say is the most important thing to do to be able to help the patient make a safe transition home?
  - Their concerns, their goals
- Even though this video discusses a specific care transitions program, did the video give you any ideas about what it is like for the patient going from the hospital to home and what are some things healthcare staff do to ease this transition?

4 POWERPOINT WITH DISCUSSION: CARE TRANSITIONS

What is a care transition?

- Movement of patients from one healthcare provider/setting to another
- Can be an extremely high risk time for patients

What are different types of care transitions?

- Hospital to home to primary care provider
- Hospital to nursing home or rehab facility
- Primary care to specialist
- Primary care provider to hospital
- Community based organization to primary care provider

Why are care transitions a high risk time for patients?

Care Transitions = High Risk

- If patient's different providers don't work together then care will be uncoordinated and confusing for patient.
- Patient may be too sick to adequately care for themselves, make appointments, or read instructions and medication labels.
- Language barriers and low literacy levels can add to the risk.
- Some patients have little or no family support or family/ friends who are working and unable to care for them.

Transitions of Care: Statistics

- Poor care coordination increases the chance that a patient will suffer from a medication error or other health care mistake by 140%.
- Communication failures between providers contribute to nearly 70% of medical errors and adverse events in health care.
- 68% of specialists receive no information from the referring primary care provider (PCP) prior to referral visits, and 25% of PCPs do not receive timely post-referral information from specialists.
- Uninsured patients or those with Medicare or Medicaid are 60% more likely than those with private insurance to go to the ED for follow-up care instead of a PCP or outpatient clinic.

Transitions of Care: Statistics

Centers for Medicare and Medicaid Services (CMS) Data states:

- 19% of patients had identifiable adverse events in the first 3 weeks home.
- 73% of older patients misused at least one medication.

AHRQ: Data on Adult Care Transitions: 2010

5 GROUP EXERCISE: POOR TRANSITIONS OF CARE

Refer students to their exercise books and ask them to look at the following list. Read the statements out loud or go around the room and have students read each line. As each line is read, ask the students to say why each of these scenarios is not good for the patient and for the healthcare team. Bring in the suggested discussion points on the following page to the conversation as needed

- 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

ANSWERS/DISCUSSION POINTS

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

- No relationship means communication is often poor, there may not be any agreement about when reports from consultations are supposed to be sent back to the primary care provider and no agreement on who is ultimately responsible for following up with patients and coordinating care.

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

- Important results and reports can be missed, leading to possible harm to patients and liability for the organization.

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

- Referral forms not filled out or inadequate information sent with referral, no relationship between primary care provider and specialist.

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

- Not patient friendly, additional costs, sets the stage for the patient to feel like the people caring for them either do not trust each other or do not coordinate care with each other.

Nobody at your organization knows when one of your patients was seen in the ER or is hospitalized.

- Hospital and primary care provider have no agreement or system for communicating when patients are seen in the ER, Primary care provider can't follow up, doesn't know if medications were changed, or new diagnosis made, patient often doesn't realize that their primary care provider doesn't know they went to the ER or were hospitalized.

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

- Again, lack of agreements or system of communication to track transitions for patients between hospital, nursing home, rehab facility and primary care provider or other specialists.

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

- No follow up or tracking system means that patients may feel overwhelmed and unsupported at home, may be confused about medications, may end up back in hospital soon after discharge.

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

6 BREAK

7 VIDEO: UNIVERSITY OF UTAH HEALTH CARE-TRANSITIONS PROGRAM

8 VIDEO DISCUSSION

What does the nurse navigator say she talks to the patient about when they are being discharged? What topics does she cover?

ANSWER:

- The exact process, how they will be monitored, who's going to call them, who is following up with them

What are the nurse navigator's tasks? Who does she have to work with to do her job?

ANSWER:

- Schedules all of the patient's follow up appointments and make sure that it is put in the discharge plan, then communicates with the care managers and primary care providers what the plan is for the patient.
- Hospitalists, nurses, providers and the patient

Say to class: *Care coordinators may also have a role helping the team to accomplish these tasks.*

What does the nurse navigator notice is the biggest change for patients since implementing this program?

ANSWER:

- Patients have more confidence in their medical home and their primary care provider.
- Reduced non-compliance by 50%.

The doctor in the video says, "One phone call can be the difference between life and death for a patient." What does he mean by this?

ANSWER:

- One phone call can catch any problems the patient has, assure that patients are ok, understand their plan of care, taking the correct medications, or reminded to come in for a follow up visit

9 POWERPOINT WITH DISCUSSION: HOW CAN HEALTHCARE STAFF HELP TO IMPROVE TRANSITIONS OF CARE FOR PATIENTS?

What can go wrong when a patient is discharged from the hospital?

- Patient confusion about:
  - New diagnoses
  - New treatment plan
  - New medications
  - Old medications
- Follow up call or visit to patient needed to clarify new medication plan

When a patient is supposed to come back to clinic?

- Patient may have trouble getting from home to clinic
- Follow up call to assess patient ability to return, set up transportation if needed

What might your role be?

- Track referrals
- Supporting patients as they go to and from specialty care, the hospital and the ER, such as arranging transportation
- Monitor hospital and ER reports for new admissions
- Follow-up with patients within a few days of an ER visit or hospital discharge and scheduling follow up appointments
- Make sure that someone has communicated test results and care plans to patients and their families
- Help patients identify sources of services, especially community resources that patients may not be aware of

Best Practices:

The healthcare organization may have a standardized process. For example, they may:

- Have a transitions of care tracking system with key milestones related to referral tracking
  - Patient referred to specialist
  - Appointment made
  - Patient called
  - Appointment kept
  - Consult report received
- Have a transitions of care tracking system with key milestones related to ER and hospital discharge
  - Notification received from hospital
  - Discharge summary obtained
  - Patient called
  - Follow up appointment made
  - Follow up appointment kept

10 VIDEO: COACHING FOR SAFER HEALTHCARE TRANSITIONS

11 VIDEO DISCUSSION

What does the son of the patient say that the family had to learn to do to help their mother transition home from the hospital?

ANSWER:

- Communicate better

What are the four key stepping stones for effective care transitions?

ANSWER:

- Effectively managing medications
- Carrying through with follow up care
- Watching out for worsening conditions/red flags
- Maintaining a personal health record for the patient

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

Refer students to their exercise books.

Say to class: *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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13 VIDEO: NORTHERN PIEDMONT COMMUNITY CARE

14 VIDEO DISCUSSION

What does the director at the beginning mean when he says that the different types of care are "silo-ed"?

ANSWER:

- Nobody is communicating or coordinating with any of the other providers

What does the nurse care manager say she spends most of her time doing with patients?

ANSWER:

- Educating them: about their meds, their bodies, their diagnoses, how they got to this point and how they can get out of where they are

What do they mean by they are providing a "proactive approach" to care?

ANSWER:

- They are reaching out to them before they are very sick, before they are going to the ER or the hospital

15 SUMMARY & WRAP-UP

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

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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

MODULE 16

ELECTRONIC HEALTH RECORDS

OBJECTIVES

- Understand basics of Electronic Health Record systems and use in care management/coordination
- Understand basics of Health Information Exchange and use in care management/coordination
- Understand the basics of HIPAA-related privacy and security

MATERIALS NEEDED

- PowerPoint file with videos downloaded

Electronic Health Records

AGENDA

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

1 POWERPOINT WITH DISCUSSION: ELECTRONIC HEALTH RECORDS SYSTEMS

What is an Electronic Health Record? (EHR)

- Computerized system for documenting patient's health information
  - Replacement paper chart, but can do much more
  - Can connect to labs, pharmacies, hospitals
  - All clinical staff can use it, not just providers
- Synonym: "Electronic Medical Record"
- Often used with Electronic Practice Management system (billing/scheduling)

Why Use an EHR?

- No more searching/waiting for paper charts
  - No need for file cabinets, rooms, etc.
  - Share info with team more easily
- Track a patient's results over time ("trending")
- Manage processes and tasks, like referrals and lab orders
- Track an entire population of patients
  - Answer questions like "How are my diabetic patients doing?"

EHR and Care Coordination

- Share important information with care team
- Facilitate information flow for a team (messages and "tasking")
- Patient care:
  - Assess and document barriers
  - Coordinate care, track referrals
  - Document phone calls, conversations, etc.
  - Easy access to patient education materials

EHR and Patient-Centered Medical Home

- Nearly all aspects of Patient-Centered Medical Home can be supported by EHR
  - Care management
  - Care coordination
  - Evidence-based guidelines
  - Care teams and "teamlets"
  - ePrescribing
  - Quality improvement and reporting

2 VIDEOS: EMR TECHNOLOGY IS LIFE CHANGING

ELECTRONIC MEDICAL RECORDS: HELPING DELIVER BETTER PATIENT CARE

3 VIDEO DISCUSSION

- What are some ways the patient's experience was improved through her providers' use of EHR?
- What are some benefits healthcare providers associate with the use of EHRs?

4 POWERPOINT WITH DISCUSSION: EHR AND QUALITY IMPROVEMENT

What is "Quality Improvement"?

"Quality Improvement (QI) consists of systematic and continuous actions that lead to measurable improvement in healthcare services and the health status of targeted patient groups."

- Health Resources and Services Administration (HRSA)

Ask the class to offer explanations/examples of what they think this statement means.

Ask how EHRs can contribute to quality improvement.

EHR and Quality Improvement

- EHR is a tool to achieve other goals
- Quality-enabled features enable providers and staff to:
  - Communicate with each other
  - Check lab and test results
  - Compare outcomes across providers/care teams
  - Easily remind patients of upcoming visits and tests
  - Document clearly
  - Produce reports to look at the health of a patient population or to see who may need particular services

Recording information in the EHR

What is "structured data"?

- Data that is entered into the EHR in such a way so that it can be pulled into a report later on.

What is "free text"?

- Refers to the way you can write a "note" in a specific patient record. This note will stay in the patient's record and can be very useful as a way of providing additional information about the patient, but it cannot be included in any standardized reports. This means that important information in a free text box can be missed on a standardized report.

Why does it matter how information is recorded?

Structured Data vs. Free Text

- To report on something, it must be captured clearly
- A piece of data in its own field is useful for reporting
- A piece of data in a "free text" field is not effective for reporting
- Example of free text:
  - "Patient's blood pressure is 130/80. Patient weighs 140 lbs."
  - "I referred patient to see Dr. Clark. Made appointment for Sept. 10."

Structured Data - Referral

Note: Show the screenshot of the referrals form and discuss its structured nature. All fields on this screenshot are "structured fields", which means the staff has to choose one option from a drop down box. There is no option to type in anything as "free text". All of this information can subsequently be pulled into a report.

EHRs and Quality Improvement

QI: Trending

- Track results for a patient over time
- These results can help providers manage care AND motivate patients

QI: Performance Reporting

- Track performance by provider or care team across an organization
- Can average patient data across all patients and sort by provider/team

QI: Registries

- Allows health care staff to see a list of patients with specific conditions and risk levels – can provide a "snapshot"

5 ACTIVITY: EHR MATCHING GAME

Direct students to the activity in their exercise books. Allow 5 minutes for students to complete the activity, and then spend 5 minutes reviewing the answers.

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

Term	Definition
1. Interoperability _____	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.
2. Electronic Prescribing _____	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.
3. Meaningful Use _____	C. The ability of two or more systems to communicate -- or exchange -- information and to use the information that has been exchanged.
4. Health Information Exchange _____	D. Functions that help you check your health, get feedback, and keep track of your progress to better manage your health.
5. Personal Health Tools _____	E. The movement of health information electronically across multiple organizations

Answer Key

(not in Student Exercise Book)

1. **C**
2. **B**
3. **A**
4. **E**
5. **D**

6 POWERPOINT WITH DISCUSSION: POPULATION MANAGEMENT AND EHRS

What is Population Management?

Population Management

Population management is an approach to care that uses information on a group of patients within a primary care practice or group of practices to improve the care and clinical outcomes of patients within that practice.

- Agency for Healthcare Research and Quality (AHRQ)

Population Management

- Using EHR data on its patient population, practices can:
  - Identify areas where services should be targeted
  - Create recommendations for patients and providers
  - Monitor quality measures
- Ensuring that each patient receives appropriate preventive and disease management services will improve the health of the patient population.

Population Management

For example:

- Target group: Patients with diabetes
- Health Status: Can be checked by routine hemoglobin A1c tests (also called HbA1c)
- Interventions and Prevention: Diet, exercise and medication

Registries and Population Management

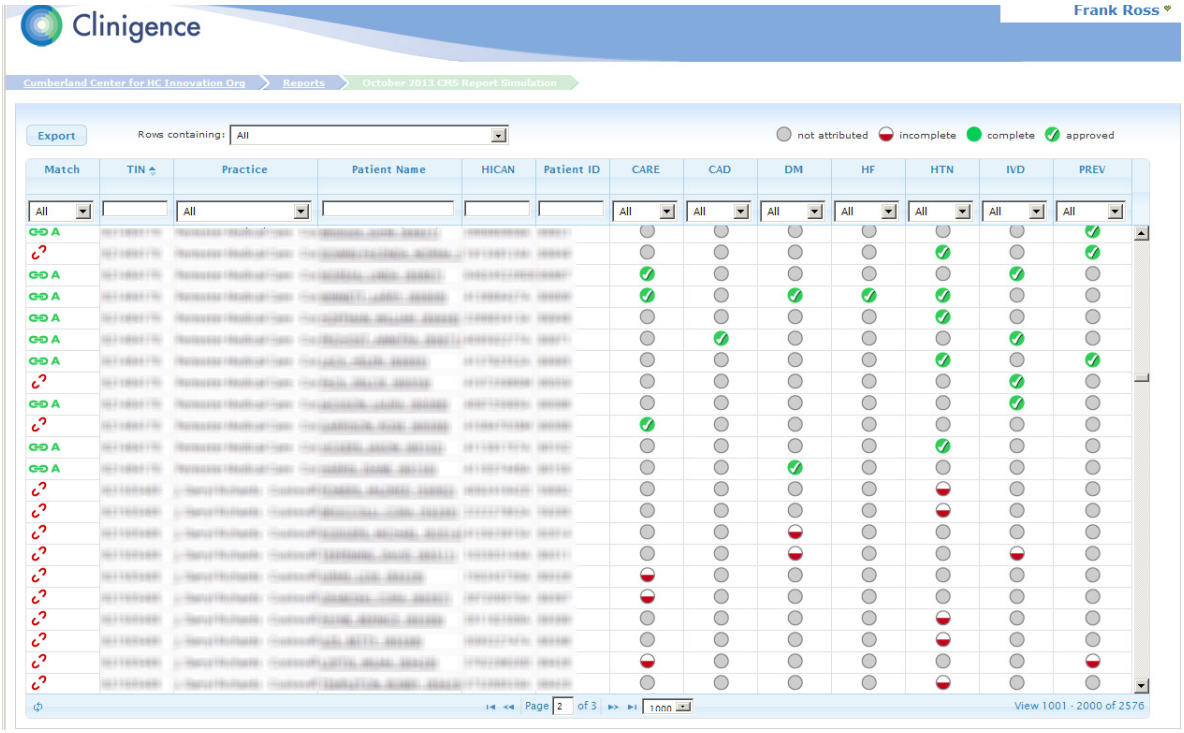
How could a patient registry help with population management?

Registries and Population Management

- A registry creates a list of patients with a specific condition
- A registry can identify targeted patients
- A registry can identify the patients in need of appropriate follow-up and interventions
- A registry can document the follow-up in the EHR
- A registry can track the outcomes over time

Registries and Population Management

Note to instructor: This is an example of a registry list in an EHR. Point out the information included and how it is easy to see which patients are up to date on screenings and which ones are not.



Using Registry Information

- Outreaching to patients to come in for overdue services
- Tracking quality measures
- Assist with case management for chronically ill patients

Say to class: *As care coordination staff, you will likely be using the registry function in the EHR to complete these activities*

Why is it important that demographic data is accurately collected and entered into the EHR?

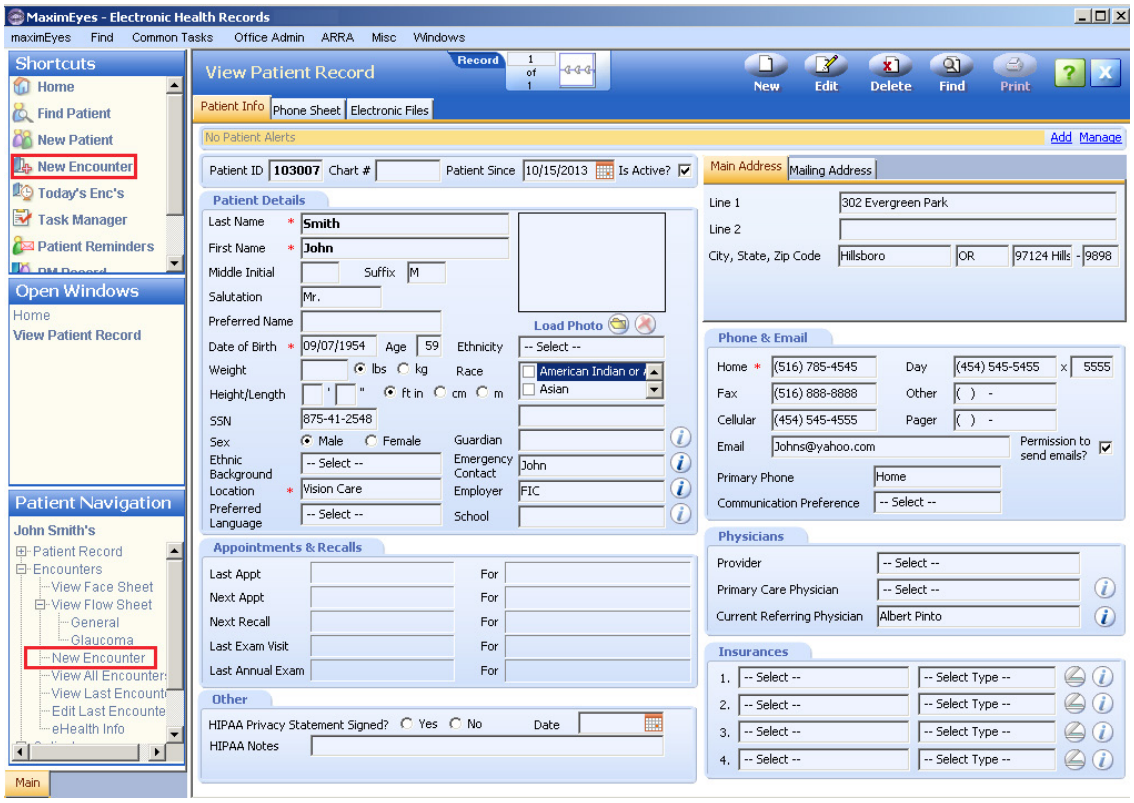
ANSWERS:

- Correctly identifying patients for a registry list
- Being able to successfully contact patients
- Avoid confusion with another provider who is treating the patient

Collecting Demographic Information

- As a best practice, the patient should be asked about any updates to this information at every visit.

Note to instructor: This slide includes a picture of where to record demographic data in an EHR. These are all structured fields. Note to the class that they may be documenting their encounters with a patient in a progress note, which is generally free text.



7 BREAK

8 POWERPOINT WITH DISCUSSION: HEALTH INFORMATION EXCHANGE

What is a Health Information Exchange? (HIE)

- The mobilization of healthcare information electronically across organizations within a region, community, or hospital system.
- HIE enables sharing patient data among different healthcare organizations
  - Hospitals, primary care providers, specialists, etc.
  - Health Homes / Accountable Care Organizations
- Data may include:
  - Alerts when patient is admitted to hospital
  - Medication list, problem list, surgical history
  - X-Rays, labs, transcribed reports
- You can better help the patient when you have better information

Health Information Exchange - Architecture

Say to the class: *This visual can help you see how providers and hospitals connect to a central hub, which is the HIE. Data travels between the hospitals and the clinics with the HIE in the middle.*

HIE and Patients

- For patients to have their data move through the HIE, consent is required.
- Moving forward, patients will either need to "opt-in" or "opt-out" of the HIE.

Note: Be careful not to get bogged down in a discussion of consent, as this is a topic that tends to receive a lot of focus the first time people hear about it in the context of HIE.

Can you think of some patient scenarios in which an HIE would help get them better care?

- Patient needs to go from their primary care provider to a specialist and back again
- Patient needs to be admitted to a hospital; expected or unexpected (emergency)
- Patient is traveling or moving

How does HIE help patients get better care?

- Can look up lab results so that tests don't need to be repeated
- Can be made aware of the patient's allergies and conditions that may impact treatment options
- Can see the patient's medications and dosages so that you aren't relying on the patient to remember

9 VIDEO: HEALTH INFORMATION EXCHANGE: MAKING A DIFFERENCE

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

10 VIDEO DISCUSSION

- What are the benefits associated with the use of HIE?

11 POWERPOINT WITH DISCUSSION: PATIENT PORTALS

What is a patient portal?

- An EHR feature that enables patients to view their records and interact via the web
- Helps engage patients in their care

12 VIDEO: PATIENT PORTALS: PATIENTS' PERSPECTIVE

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

13 VIDEO DISCUSSION

1. What are some of the common reasons why patients like to have access to a patient portal?

   ANSWERS: ease, can look up test results right away, fits lifestyle, improves communication with doctor

2. How did doctors and other healthcare staff use the patient portal to support their patients?

   ANSWER: reminders, had staff check-in on them to see how they were feeling and offer encouragement

3. What incorrect assumption did healthcare providers make about patients and access to the internet?

   ANSWER: they assumed most patients wouldn't have access to the internet, but they found that not to be true. Many patients at least have a smart phone and like using it to access their health information.

15 POWERPOINT WITH DISCUSSION: PRIVACY AND SECURITY

- What can go wrong when a patient's health information is stored electronically?
- How can healthcare organizations prevent these things from happening?

Basics of Privacy and Security

- Privacy and security of the patients' data is critical
- Healthcare providers are legally obligated to protect data
- Unauthorized access is illegal
- Privacy and security safeguards should be in place
- Healthcare Insurance Portability and Accountability Act (HIPAA)

How can you protect the privacy and security of your patient's health information?

- All users should have their own usernames and passwords
- Restrict access to data by role
- Keep servers in locked rooms
- Have computers "time out" when not in use
- Encrypt back-ups and store off-site
- Train employees on HIPAA
- Encourage a "security mindset"

16 VIDEO: ELECTRONIC HEALTH RECORDS: PRIVACY AND SECURITY

17 VIDEO DISCUSSION

- What are some key aspects of protecting patients' privacy and security?

18 SUMMARY AND WRAP-UP

REFERENCES

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

MODULE 17

NAVIGATING THE INSURANCE SYSTEM & HELPING THE UNINSURED

OBJECTIVES

- Review and discuss the basics of private health insurance plans and public insurance programs
- Review and discuss the Affordable Care Act (ACA)
- Understand what it means to obtain referrals and authorizations
- Understand how to reduce barriers to care for uninsured and insured patients

MATERIALS NEEDED

- PowerPoint file with videos downloaded
- Example insurance cards for activity

Navigating the Insurance System & Helping the Uninsured

AGENDA

1.	POWER POINT WITH DISCUSSION: WHAT IS HEALTH INSURANCE?	5 MIN
2.	VIDEO WITH DISCUSSION: WHY IS HEALTHCARE SO EXPENSIVE?	10 MIN
3.	POWER POINT WITH DISCUSSION: PUBLIC AND PRIVATE INSURANCE	20 MIN
4.	VIDEO WITH DISCUSSION: THE AFFORDABLE CARE ACT	20 MIN
5.	BREAK	5 MIN
6.	POWERPOINT WITH DISCUSSION: HELPING PATIENTS USE THEIR INSURANCE	5 MIN
7.	VIDEO WITH DISCUSSION: PRIOR AUTHORIZATIONS AND REFERRALS	10 MIN
8.	POWERPOINT WITH DISCUSSION: HELPING PATIENTS USE THEIR INSURANCE (CONTINUED)	10 MIN
9.	EXERCISE: HELPING YOUR PATIENTS NAVIGATE THE INSURANCE SYSTEM	15 MIN
10.	POWERPOINT WITH DISCUSSION: HELPING UNINSURED PATIENTS NAVIGATE THE INSURANCE SYSTEM	15 MIN
11.	SUMMARY & WRAP-UP	5 MIN

1 POWERPOINT WITH DISCUSSION: WHAT IS HEALTH INSURANCE?

Health Insurance

- Protects you from unexpected, high medical costs.
- It is a contact between you and an insurance company, where you buy a plan or policy and the company pays part of your expenses when you need medical care.
- Many people get health insurance from their employer or purchase it themselves ("private insurance")
- People can also get health insurance from the government ("public insurance")

Note to instructor:
For more information see: http://www.nlm.nih.gov/medlineplus/healthinsurance.html

Health Insurance

- Understanding the health insurance system and helping patients get covered may be one of the most important things you can do for patients
- As a Patient Service Representative (PSR) or Medical Assistant (MA) you will likely be helping patients to use their health insurance or directing them to where they can obtain health insurance

What has been your experience accessing or using health insurance? Was it easy or complicated? Why?

We need insurance because for most of us healthcare is not affordable. Why is the cost of healthcare so high?

2 VIDEO: WHY HEALTHCARE IS SO EXPENSIVE

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

Video Discussion:

1. What are some of the reasons why healthcare is so expensive?

2. What is the patient's perspective? How might the cost of care influence his or her decisions about when to get care and how much care to get?

Note to instructor:

Potential answers to Q1:

There are many factors that contribute to the cost of medical care. Common contributors to the high cost of medical care include:

- New and often expensive procedures, devices, & drugs
- Medical malpractice insurance
- The complexity of our medical system and our public policies have allowed for less competition and the charging of higher prices
- We consume A LOT of medical services and prescription drugs

Potential answers to Q2:

The high cost of care can be very overwhelming, confusing, stressful, and scary for patients. They fear that they may not be able to afford their care. The high cost of health care may cause some people to delay getting care until they are in dire need of it or not fully comply with a recommended treatment, such as not taking a full regime of medications.

Accessing Care

- Many patients do not realize that they may be eligible for public insurance programs and drug programs – some through pharmaceutical companies directly – that can help them afford needed care and medications.
- As a front line healthcare worker, you may be in a position to help connect or make patients aware of these options, so that they can access the care they need.

3 POWERPOINT WITH DISCUSSION: PUBLIC AND PRIVATE HEALTH INSURANCE

What is the difference between public and private insurance?

Private or "Commercial" Insurance

- Commercial health insurance plans are bought individually or coverage can be extended through an employer-sponsored plan
- The true cost of medical services are shared by employers, patients, and the insurance plan
  - Premiums are charged monthly to employers and/or individuals
  - Deductibles are paid by patients and go to the insurance company
  - Co-payments are paid by patients to medical providers

Public Health Insurance Programs

- Public health care plans are entitlement programs funded by the federal and state governments
- Often called "social insurance" because everyone pays in through taxes
- In the US, certain groups benefit:
  - Citizens over 65 years and certain permanently disabled persons (Medicare)
  - Individuals and families with low income levels (Medicaid)
  - Veterans (The VA Health System)
  - Native Americans on reservations

What do you know about Medicaid?

Medicaid

- Funded by both the Federal and State governments
- Each state has a unique Medicaid program but must meet minimum requirements set by the Federal government
- Programs can vary between states in terms of
  - Who is eligible
  - What services are covered
  - How much providers are paid for services
  - How people can sign up for the program
- Medicaid health benefits and other services are provided through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month payment for these services.

Say to class: *In your role as care coordination staff, it is important to have at least a basic understanding your state's Medicaid program, so that you can help patients better access and use their insurance.*

Note to instructor:
Managed care can benefit both the patient and the system. In theory, patients are more likely to get access to the care they need when they need it, because care is more coordinated and under the direction of a primary care provider. This can help keep costs down. Medicaid patients don't have to be in a Medicaid Managed Care plan but it is strongly encouraged. More information can be found here: http://www.medicaid.gov

Provider Networks

- A list of medical providers who accept a particular insurance plan.
  - Exist for public and private plans
- Not all healthcare organizations take all health insurance plans.
  - You will be provided a list of the insurance plans accepted by the healthcare organization where you work
- A patient can go "out of network" and see a doctor not covered by the insurance plan, but it will cost them more.

Note to instructor:
Whether a healthcare organization takes a particular insurance plan depends on if a contract has been signed with the insurance company.

It is important to be aware of which insurance plans your healthcare organization takes. If your organization does not take the patient's plan he/she may have to pay more.

Child Health Insurance Program (CHIP)

- CHIP is a public health insurance program run through Medicaid that provides comprehensive benefits to children up to age 19
- Like with adult Medicaid, states have the flexibility to design their own program, so benefits and eligibility can vary by state
- Since children are generally less costly, many states have more generous income eligibility limits for CHIP compared to adult Medicaid.
- Some states also cover pregnant women through CHIP as well as children and pregnant women who are "lawfully residing" in the state.

Note to instructor:
"Lawfully residing" is a fairly broad term that allows more categories of immigrants to be covered than other public health insurance programs.

For more information go to http://www.medicaid.gov/chip/eligibility-standards/chip-eligibility-standards.html

How to sign up for Medicaid

1. Understand the patient's eligibility – this will affect what health insurance plan he/she can apply for, where he/she can apply, and what documentation he/she will need to bring
    - Eligibility and documentation requirements can be found at your state's Medicaid office or department of health
2. Learn where the patient can sign up - some options include:
    - Your state's health insurance exchange set up through the ACA
    - Through a Medicaid Managed Care Organization
    - Local social services offices
    - Clinics and hospitals may also be able to help patients sign up for health insurance

What do you know about Medicare?

- Eligibility generally for people age 65 or older or people with qualified disabilities
- Funded by the Federal government
- Covered Services
    - **Part A** – Hospital (no premium, automatic at age 65)
    - **Part B** – Non hospital, outpatient care (premium, voluntary)
    - **Part C** – Parts A and B are offered in one package by a managed care company – Medicare Advantage
    - **Part D** – Prescription drugs

Note to instructor:
Qualified disabilities include end-stage renal disease, ALS or Lou Gehrig's disease, you get disability benefits from Social Security

Notes to instructor:

Part A

- Everyone on Medicare automatically has Part A
- No monthly premium for if you or your spouse paid Medicare taxes while working
- Medicare Part A covers:
  - Hospital care
  - Skilled nursing facility care
  - Nursing home care (as long as custodial care isn't the only care you need)
  - Hospice
  - Home health services

Part B

- Part B is optional.
- Most people pay a standard monthly premium amount. (In 2013, this is $104.90) However, if income is above a certain amount, consumers may pay more.
- Medicare Part B covers:
  - Preventive services (outpatient visits)
  - Medically necessary services

Part C

- Also known as **Medicare Advantage**, Part C is a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits.
- Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans.
- Most Medicare Advantage Plans offer prescription drug coverage (Part D).
- The "**advantage**" of this program is that it is a "fixed cost" to the consumer. No matter how their medical costs go up, their monthly payment stays the same.

Part D

- Medicare offers prescription drug coverage to everyone with Medicare.
- To get Part D, consumers must join a plan run by an insurance company or other private company approved by Medicare.
- **Each plan can vary in cost and drugs covered.**
- Consumer payments throughout the year can include:
  - Monthly premium
  - Yearly deductible
  - Copayments or coinsurance
  - Costs in the coverage gap (i.e., the consumer has to cover what is not covered by Part D)

Medicare and Medicaid

- Some people qualify for both Medicare and Medicaid – these people are often called “duals” or “dual eligibles”
- Medicaid can help pay for medical costs such as nursing home care, some personal care services, and paying for prescription drugs
- If a patient on Medicare is having trouble paying their medical bills, they may want to look into whether they are eligible for Medicaid benefits

Resource Review

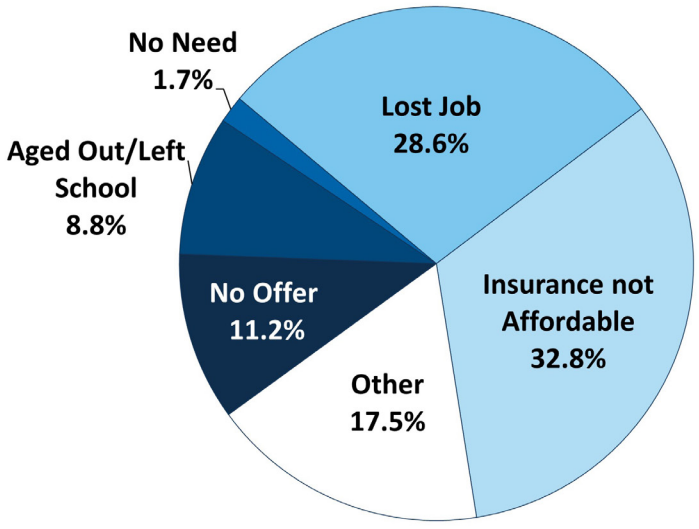
A helpful resource for your patients on Medicare or to see who might qualify and how to sign up for Medicare is:

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

Why might someone be uninsured?

Figure 3

Reasons for Being Uninsured among Uninsured Nonelderly Adults, 2013



SOURCE: KCMU analysis of 2014 National Health Interview Survey.

Note to instructor:

- 61% of adults said that the main reason they are uninsured is either because the cost is too high or because they lost their job, compared to 1.7% who said they are uninsured because they do not need coverage (Figure 3). Under the ACA, financial assistance is available to help many uninsured people afford coverage.
- Not all workers have access to coverage through their job. Most uninsured workers are self-employed or work for small firms where health benefits are less likely to be offered. Low-wage workers who are offered coverage often cannot afford their share of the premiums, especially for family coverage.
- Historically, Medicaid was only available to low-income children, parents, pregnant women, people with disabilities, and the elderly. While states have increasingly expanded eligibility for children over time, eligibility for parents remained much more limited before ACA coverage expansions.

Citation: http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

4 VIDEO WITH DISCUSSION: THE AFFORDABLE CARE ACT

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

Video Discussion

What are some of the changes to the health insurance market that will help more Americans get health insurance?
(answer on next slide)

- Insurers can't exclude people with pre-existing conditions or inflate prices if employees are sick
- Young people up to 26 can stay on their parents' insurance and get catastrophic insurance until they are 30
- Small businesses will get breaks on providing health insurance for employees
- Large business will be required to provide health insurance
- State-based insurance exchanges encourage competition (and lower prices) among health insurance plans

Note to instructor:
Excluding people with pre-existing conditions; imposing spending caps; and price inflation are some of the practices insurers used to reduce the impact of covering sick people. However, this prevented people from getting insurance or left them paying the bills once they had reached the spending limit. This often happened to cancer patients who were getting treatment and then learned they had reached their limit and their treatment was no longer covered by insurance. Women have been traditionally charged more for insurance, because of childbirth costs; however, this is viewed as gender discrimination.
It was also common for people in their 20s to not get health insurance, because of lack of employment that offered benefits or they felt they were healthy and didn't need it. Allowing them to stay on their parent's plan or just purchasing catastrophic coverage helps them get covered and adds more healthy people into the insurance pool.

What are some of the changes to the public insurance market that will help more Americans get health insurance?
(answer on next slide)

- State Medicaid programs will have the option to expand and cover low-income people
- Little change to Medicare
- Health insurance tax credits for laid-off workers
- People who don't have health insurance through their job will be able to purchase it through an "exchange" and may qualify for financial assistance (subsidies) from the federal government to afford the premiums

What are health insurance exchanges?

- State based entities where health insurance companies offer different health plans to consumers at competitive rates
- Plans must all follow the same set of rules and cover a basic set of services
- Most people who apply qualify for a tax credit that lowers the cost of coverage
- You can only apply during an open enrollment period or qualify for a special enrollment period due to a life change like a marriage, a birth, or loss of other coverage.
- You can learn more about these exchanges at http://www.healthcare.gov

Will people be required to have health insurance after 2014? What happens if they don't?
(answer on next slide)

- Yes, they will be required
- If they don't have it, they will have to pay a special tax.

Note to instructor:
This is to get more people covered and to encourage more healthy people to get insurance (to offset the costs of those who are sick)

Will undocumented immigrants be covered?
(answer on next slide)

In general, no – immigrants were excluded from participating in the exchanges in the ACA.

However, some states, like NY, have made exceptions and allow some immigrants to purchase insurance through the exchange or healthcare marketplace.

5 BREAK

6 POWERPOINT WITH DISCUSSION: HELPING PATIENTS USE THEIR INSURANCE

Helping patients use their insurance

- Using insurance is not always straightforward
- Sometimes needed services or drugs are not paid for by the plan (or "covered")
- The insurance company has an interest in making sure that healthcare resources are being used effectively
- You may be assisting patients get needed services covered by helping complete "referrals" and "pre-authorizations"
- Each healthcare organization has a different process, so be sure to ask your supervisor what is expected of you in regards to assisting patients with referrals and pre-authorizations.

Note to instructor: these terms are defined in the video that follows

7 VIDEO WITH DISCUSSION: PRIOR AUTHORIZATIONS AND REFERRALS

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

Video Discussion

- How are prior authorizations obtained?
- How are referrals obtained?
- What do patients need to understand about referrals and prior authorizations?

Note to Instructor:

- **Answer to Q1:** By calling the insurance company – they may ask to talk to the doctor directly to learn his or her reasoning for the procedure or treatment.
- **Answer to Q2:** By getting a form filled out and signed by the referring provider.
- **Answer to Q3:** That their medical costs for these procedures and treatments may not be covered without them

8 POWERPOINT WITH DISCUSSION: HELPING PATIENTS USE THEIR INSURANCE (CONTINUED)

How else can you help patients use their insurance?

Note to instructor:
Students may not know answer to this question but you can ask a follow-up question about how have healthcare staff helped them use their insurance

Provide "translation services"

- Insured patients may not understand how to use their cards
- Insured patients may not understand their benefits and what services are covered

Help patients be "educated consumers"

- Insured patients may not know how to request referrals or obtain prior authorizations
- Insured patients may not know how to switch plans or apply for additional benefits
- Insured patients may not know how to prepare for visits with new providers

Help patients advocate for themselves

- Insured patients may not know their rights and responsibilities
- Insured patients may not know how to or that they can appeal insurance denials

Help patients prepare for visits

- Insured patients may not know what to bring to their visits

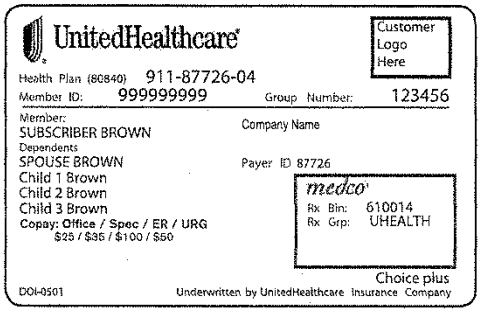
What should insured patients bring with them for their first appointment at a new health facility?

Insured patients should bring

- Every health facility is different, if possible patients should call and ask what to bring
- May need to bring some or all of the following:
  - Insurance ID card
  - Co-payment – the amount the insurance company expects the patient to pay to the healthcare provider at the time of the visit
  - Referral or prior authorization
  - List of current medications
  - Medical history

Samples of Commercial, Medicare and Medicaid Health Care ID cards

Commercial Plans – Sample Cards


UnitedHealthcare

Customer Logo Here

Health Plan (80840) 911-87726-04
Member ID: 999999999 Group Number: 123456

Member:
SUBSCRIBER BROWN
Dependents
SPOUSE BROWN
Child 1 Brown
Child 2 Brown
Child 3 Brown
Copay: Office / Spec / ER / URG
$25 / $35 / $100 / $50

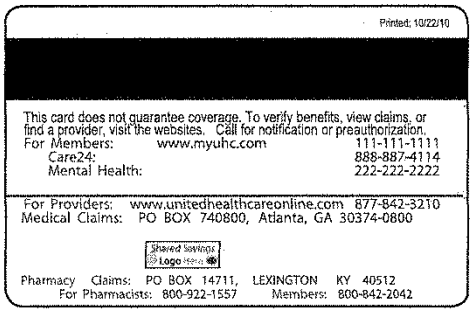
Company Name

Payer ID 87726

medco
Rx Bin: 610014
Rx Grp: UHEALTH

Choice plus

DOI-0501 Underwritten by UnitedHealthcare Insurance Company


Printed: 10/22/10

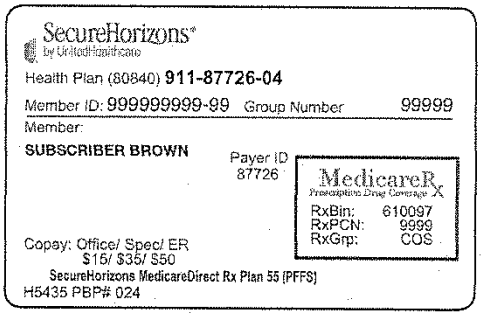
This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the websites. Call for notification or preauthorization.
For Members: www.myuhc.com 111-111-1111
Care24: 888-887-4114
Mental Health: 222-222-2222

For Providers: www.unitedhealthcareonline.com 877-842-3210
Medical Claims: PO BOX 740800, Atlanta, GA 30374-0800

Shared Savings Logo Here

Pharmacy Claims: PO BOX 14711, LEXINGTON KY 40512
For Pharmacists: 800-922-1557 Members: 800-842-2042

Medicare Plans – Sample Cards


SecureHorizons by UnitedHealthcare

Health Plan (80840) 911-87726-04
Member ID: 999999999-99 Group Number 99999
Member:
SUBSCRIBER BROWN

Payer ID 87726

MedicareRx Prescription Drug Coverage
RxBin: 610097
RxPCN: 9999
RxGrp: COS

Copay: Office/ Spec/ ER
$15/ $35/ $50

SecureHorizons MedicareDirect Rx Plan 55 (PFFS)
H5435 PBP# 024


In an emergency go to the nearest emergency room or call 911

This card doesn't guarantee coverage. To verify benefits, view claims, or find a physician, visit www.securehorizons.com or call member services Monday - Sunday 8:00 am to 8:00 pm

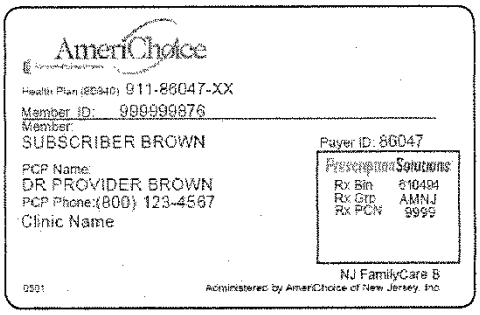
For Member Service: 1-866-579-8774 TDD 711

For Providers: www.unitedhealthcareonline.com/pffs 1-866-579-8611
Medical Claim Address: PO Box 31353 Salt Lake City, UT 84131-0353

UnitedHealthcare Medicare Solutions UHC

Pharmacy Claims: RX Solutions PO Box 6082 Cypress, CA 90630-0082
For Pharmacists: 1-877-889-6510

Medicaid Plans – Sample Cards


AmeriChoice

Health Plan (80840) 911-86047-XX
Member ID: 999999876
Member:
SUBSCRIBER BROWN

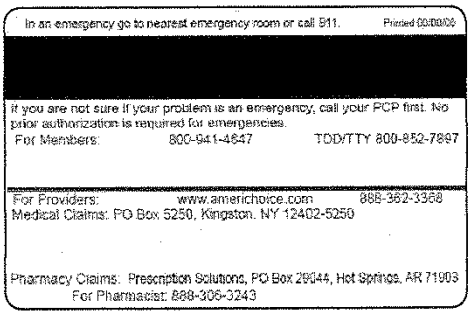
PCP Name:
DR PROVIDER BROWN
PCP Phone:(800) 123-4567
Clinic Name

Payer ID: 86047

PrescriptionSolutions
Rx Bin 610494
Rx Grp AMNJ
Rx PCN 9999

NJ FamilyCare B

0501 Administered by AmeriChoice of New Jersey, Inc.


In an emergency go to nearest emergency room or call 911. Printed 00/00/00

If you are not sure if your problem is an emergency, call your PCP first. No prior authorization is required for emergencies.
For Members: 800-941-4647 TDD/TTY 800-852-7897

For Providers: www.americhoice.com 888-362-3368
Medical Claims: PO Box 5250, Kingston, NY 12402-5250

Pharmacy Claims: Prescription Solutions, PO Box 29044, Hot Springs, AR 71903
For Pharmacist: 888-305-3243

9 EXERCISE: HELPING YOUR PATIENTS NAVIGATE THE INSURANCE SYSTEM

Note to instructor:
Refer students to the exercise books. Begin the discussion by asking patients to look at the sample insurance cards and identify the following:

- How a patient would call for a referral?
- How would they obtain an authorization?
- Where do they go for Rx (prescription) benefits?
- Who is their primary care provider (PCP)?
- What other resources are referenced on the card?

10 POWERPOINT WITH DISCUSSION: HELPING UNINSURED PATIENTS NAVIGATE THE INSURANCE SYSTEM

How can health professionals help uninsured patients access health insurance?

- Know what populations of patients may be eligible for insurance
- Understand why a patient may be uninsured
- Know who at your health center is an expert on coverage for the uninsured
- Maintain privacy and be respectful when talking with patients about obtaining insurance
- Know what resources exist for patients who cannot qualify for insurance (e.g., undocumented patients).

Uninsured patients and access to care

- No insurance does not necessarily mean no access to medical care
- Public health clinics and hospitals offer services to uninsured patients on a "sliding scale."
- Hospitals are not legally allowed to turn people away from the ER
  - However, Emergency care is not an ideal usual source of care
- Hospitals receive government funds to cover the costs of patients who cannot pay their medical bills

Note to instructor:
A patient with a chronic condition would not be best served by only receiving emergency care. Patients often present at the ER with exacerbated chronic conditions that could have been properly managed with a usual source of preventive care and chronic care management provided by a primary care clinician.

Sliding Scale Fees

- A " sliding scale" fee schedule identifies the amount a patient must pay for healthcare services based on their income, with those with higher incomes paying more and those with little or no income paying less or none
- Each healthcare organization has its own sliding scale fee values

Sliding Fee Scale

Revised as of January 1, 2010

Household Gross Annual Income	Therapy	Psychiatric Evaluation	Med Review	Group Therapy	In Home Assessment	In Home Therapy
$0-$5,000	$40	$75	$40	$25	$150	$150
$5,001-$10,000	$45	$85	$45	$25	$150	$150
$10,001-$15,000	$55	$85	$45	$35	$150	$150
$15,001-$20,000	$60	$100	$50	$40	$150	$150
$20,001-$25,000	$75	$125	$55	$45	$150	$150
$25,001-$30,000	$80	$140	$65	$50	$150	$150
$30,001-$50,000	$85	$145	$75	$75	$150	$150
$50,001-$70,000	$90	$160	$75	$75	$150	$150
$70,001-Above	$100	$170	$75	$75	$150	$150

What should uninsured patients bring with them for their first appointment at a new health facility?

Uninsured patients should bring?

- Every health facility is different.
- In non-emergency cases patients or their advocates should call the agency they'll be visiting prior to the appointment to determine exactly what they'll need.
- This may include:
  - Proof of income, age, residency
  - Proof of eligibility for services offered
  - Medical history (including current medications)
  - Sliding fee payment (if applicable)

Are immigrants eligible for health insurance?

Can immigrants access health insurance?

- Maybe - it depends on where you live. Each state has different policies regarding immigrants and the public benefits they can receive.
- Immigration status, income, and other criteria (such as age or condition) may impact whether an immigrant is eligible for public health insurance benefits
- In states that cover immigrants, getting health insurance will not affect their immigration status or be held against them if they apply to change or renew their status.
- Understanding your state's eligibility criteria for immigrants will help you support your immigrant patients access affordable healthcare services.

11 SUMMARY AND WRAP-UP

Summary

- Health insurance helps spread the costs of healthcare among large groups of people to make healthcare more affordable
- There is a private insurance market and public insurance programs
- The ACA seeks to increase the number of Americans with insurance
- There are many ways you can help patients with navigating their insurance including referrals, pre-authorizations, obtaining insurance, and preparing for visits.

Homework:

Health Insurance Glossary Matching Game

Say to class: *On your own or working in small teams, match the health insurance term with the definitions on the second page in your Student Exercise book. Use the answer key to check how well you did. Come to the next class with any questions you have!*

HEALTH INSURANCE GLOSSARY MATCHING GAME

Match the health insurance term with the definitions on the second page. Be prepared to report out to the class.

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.

Answer Key

1. Commercial Insurance — H; 2. Fee for Service — F; 3. Managed Care Plans — B; 4. Medicaid — D; 5. Medicare — E; 6. Networks — C; 7. Prior Authorization — G; 8. Primary Care Provider (PCP) — I; 9. Referral — J; 10. Sliding Fee Scale — A

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

MODULE 18

MOTIVATIONAL INTERVIEWING - PART 1

OBJECTIVES

- Increase basic understanding of the theory and techniques of Motivational Interviewing (MI)
- Understand how MI techniques can be applied to management of chronic conditions

MATERIALS NEEDED

- PowerPoint file with videos downloaded

Motivational Interviewing - Part 1

AGENDA

1.	POWERPOINT WITH DISCUSSION: WHAT IS MOTIVATIONAL INTERVIEWING?	10 MIN
2.	VIDEO: DR. WILLIAM MILLER: MOTIVATIONAL INTERVIEWING	5 MIN
3.	VIDEO DISCUSSION	10 MIN
4.	POWERPOINT WITH DISCUSSION: WHAT IS MOTIVATIONAL INTERVIEWING - CONTINUED	15 MIN
5.	VIDEO: HOW NOT TO DO MOTIVATIONAL INTERVIEWING: A CONVERSATION WITH SAL	5 MIN
6.	VIDEO DISCUSSION	10 MIN
7.	BREAK	5 MIN
8.	POWERPOINT WITH DISCUSSION: MOTIVATIONAL INTERVIEWING TECHNIQUES	15 MIN
9.	GROUP EXERCISE: REFLECTIVE LISTENING	15 MIN
10.	VIDEO EXERCISE: MOTIVATIONAL INTERVIEWING: A CONVERSATION WITH SAL	20 MIN
11.	VIDEO DISCUSSION	10 MIN

The next two classes will focus on the basic principles of Motivational Interviewing (MI). The goal of Part 1 is to introduce students to the main concepts of MI, while Part 2 will focus on the application of these concepts. You will see several tools in these classes, produced by the PACT Training and Technical Assistance Institute, a program of the Justice Resource Institute (JRI). These tools were initially developed to assist community health workers in the field in using Motivational Interviewing with their HIV positive clients. These clients often had co-occurring mental health and/or substance abuse issues. PACT community health workers found that using MI had a positive impact on the ability of these clients to make real behavior change.

You will see two specific PACT tools utilized in these two classes: 1) OARS Coding Sheet; and 2) Brief Negotiated Interview (BNI) Scoring Sheet. The OARS Coding sheet is intended as a peer review tool, in which colleagues are invited to watch each other conduct MI and "score" on how many times the interviewer used the MI techniques of open-ended questions, affirmative statements, reflective statements and summary statements. PACT community health workers used this tool as a way to share positive and constructive feedback with each other, as it is important to continually practice MI in order to improve. The BNI Scoring Sheet refers to a type of MI that was developed for emergency departments, with the goal of using specific MI techniques within a 5-10 minute session to effect behavior change. The BNI Scoring Sheet acts as a guide for interviewers to conduct this kind of brief behavior change session. While the BNI Scoring sheet uses the example of "drinking" as the focus for behavior change, these BNI steps can be used for any kind of problem behavior.

1 POWERPOINT WITH DISCUSSION: WHAT IS MOTIVATIONAL INTERVIEWING?

Say to the class: *Today's class and our next class will focus on Motivational Interviewing. This is a counseling strategy that is being used more and more in today's healthcare environment to help patients manage chronic disease. Have any of you heard of Motivational Interviewing or used it before?*

What is Motivational Interviewing?

- Motivational interviewing (MI) is a clinical method for helping people to resolve ambivalence about change by evoking internal motivation and commitment
- A skillful, clinical style for eliciting from patients their own motivations for making behavior change in the interest of their own health

The Story of Motivational Interviewing

- Originally came about as a different approach to substance/alcohol treatment
- 1970's treatment approach was to use counselors who were also in recovery to "confront" clients about their addiction and "make them" change
- When clients were confronted, their natural instinct was to defend themselves , thereby removing any desire to behave differently

Enter… Dr. William Miller

- Center for Alcoholism, Substance Abuse and Addictions
- Distinguished Professor of Psychology and Psychiatry at the University of New Mexico
- As a student in training, Dr. Miller "accidentally" discovered that other approaches could positively affect the behavior of addicted patients

What do you think some of these approaches were?

- Listening
- Empathy

Over time, these approaches were studied, replicated, modified and enhanced to become the field of Motivational Interviewing.

2 VIDEO: DR. WILLIAM MILLER: MOTIVATIONAL INTERVIEWING

3 VIDEO DISCUSSION

- In this video, Dr. Miller briefly talks about the difference between MI and other approaches to treating addiction. What was this main difference?
- Dr. Miller mentions that MI is both "client-centered" and "directive". How could these two approaches possibly be in conflict?
- What are some of the main techniques that Dr. Miller describes that helps MI be both "client centered" and "directive"?

4 POWERPOINT WITH DISCUSSION: WHAT IS MOTIVATIONAL INTERVIEWING? – CONT.

Largely due to the work of Dr. Miller in showing successful outcomes, a more common treatment philosophy for addiction is now:

- Rather than the job of the patient to be motivated for change….
- It's our job as health professionals to help people find the motivation for change that's already there within themselves

Because of its success, MI has expanded beyond the treatment of addiction

- MI has now been in the field for 30 years
- More than 200 clinical trials of MI have been published
- Used by health coaches working with patients with chronic diseases

Positive results for an array of target problems

- Cardiovascular rehabilitation
- Diabetes management
- Dietary change
- Hypertension
- Illicit drug use
- Infection risk reduction
- Management of chronic mental disorders
- Problem drinking
- Smoking
- Co-occurring mental health & substance abuse disorders

MI has also been found to be useful in primary care because it's:

- Relatively brief
- Verifiable (there are ways to know it's being delivered properly)
- Generalizable across problem areas
- Complementary to other treatment methods
- Learnable by a broad range of providers

MI also supports the philosophy of Patient-Centered Medical Homes (PCMH)

- In the world of Patient-Centered Medical Homes (PCMH) a patient-centered counseling approach is required
- Looking ahead, MI will not only be the right thing to do, but the thing you should do and get paid to do

All of this has led to an "explosion" of MI information

Besides the >200 randomized clinical trials…

- >1000 publications
- Dozens of books and videotapes
- 10 Multi-site clinical trials

How does someone learn how to do MI?

- Currently, no official certification for MI
- A complete training on MI is usually 1-2 days
- Many online resources and trainings exist
- However, in-person supervision or peer support groups is highly recommended as the way to achieve solid MI skills
- Practice

A complete training on MI includes learning eight stages:

1. The Spirit of MI
2. OARS
3. Recognizing change talk
4. Eliciting and strengthening change talk
5. Rolling with resistance
6. Developing a change plan
7. Consolidating client commitment
8. Engaging MI with other methods

For the purposes of today's class, we will be focusing on:

1. The Spirit of MI
2. OARS

The Spirit of MI – Collaborative

Collaborative Approach

- Clinical staff is not "above" the patient, telling them what to do
- Conversation is more equal, in which joint decision-making occurs

The Spirit of MI – Evocative

"Often healthcare involves giving patients what they lack…MI instead seeks to evoke from patients that which they already have."
(Rollnick, Miller & Butler, 2008)

- MI seeks to understand the patient's perspective by evoking their own good reasons and arguments for change.

The Spirit of MI – Honoring Patient Autonomy

"There is something in human nature that resists being coerced and told what to do. Ironically, it is acknowledging the other's right and freedom not to change that sometimes makes change possible."
(Rollnick, Miller & Butler, 2008)

- Clinical staff may inform, advise, even warn but ultimately it is the patient who decides what to do.
- Honoring this can help facilitate change.

Say to the class: *With motivational interviewing, as with other counseling techniques, it's often helpful to see how not to do it in order to better understand how to do it. We are now going to take a look at an example of a counseling session that is not done in the spirit of MI (collaborative, evocative, honoring patient autonomy) and see how this affects the patient and the provider's ability to facilitate positive behavior change.*

5 VIDEO: HOW NOT TO DO MOTIVATIONAL INTERVIEWING: A CONVERSATION WITH SAL

6 VIDEO DISCUSSION

- What kinds of approach or strategies did the health professional use that was not helpful to the client?
- How did the client feel as a result of this approach?
- What could the health professional have done differently to better engage the client?

7 BREAK

8 POWERPOINT WITH DISCUSSION – MI TECHNIQUES

One of the main strategies used in MI is OARS.

OARS uses four basic communication techniques in order to move the client along the path to change.

- Open-ended questions
- Affirmations
- Reflective listening
- Summary statements

What is an example of an open-ended question?

What is an example of a closed question?

Examples

- Closed
  - "Did you take your medicine last night?"
- Open
  - "Tell me what it's like for you fitting medicine into your day."

Ask the class: Can you see how these kinds of questions might feel different to a patient? How might a patient respond to the closed question if they did not actually take their medicine last night?

- ANSWER: The patient might lie. Or might feel that they failed and shut down from further questions.

Ask the class: What are the advantages of asking this question as an open question?

- ANSWER: The patient doesn't have to lie or feel pressure to respond one way or another. They can tell their own story and the navigator can get a better understanding of the challenges the client might be facing.

OARS: Open-ended questions

- Cannot be answered with a yes or no.
- Produce less biased data because they allow patients to "tell their story."
- Elicit important information that otherwise might not be asked.

Closed-ended questions often damage rapport, decrease empathic connections, and paradoxically end up taking more time.

What is an example of an affirmation?

OARS: Affirmations

- Statements of appreciation, which are important for building and maintaining rapport. Efforts to make changes are acknowledged, no matter how large or small.
  - *"I am impressed by how you kept to your plan of eating more vegetables this week."*

What is Reflective Listening?

OARS: Reflective Listening

- Involves taking a guess at what the patient means and reflecting it back, restating their thoughts or feelings in a slightly different way
- Helps to ensure understanding of the patient's perspective, emphasizes his or her positive statements about change, and diffuses resistance.
- Resistance occurs most often when patients experience a perceived loss of freedom or choice.
- Reflective responses move the interaction away from a power struggle and toward change.

Here is the basic framework of reflective listening:

- Open question:
  - "How was your day?"
- Reflect back to the client what you heard:
  - "So what I hear you saying is…"
- Check in with the client to make sure you understood correctly:
  - "Did I get that right?"

Besides making sure the patient feels heard, reflective listening can also highlight certain ideas or emotions the client might not be aware of.

Reflective listening techniques such as repeating, rephrasing, empathic reflection or reframing can help clients see situations differently.

OARS: Summary Statements

- Longer than reflections.
- Used to transition to another topic.
- Highlights both sides of a patient's ambivalence, or provide recap at strategic points to ensure continued understanding.

Example

"You have several reasons for wanting to take your asthma medication consistently; you say that your mom will stop nagging you about it and you will be able to play basketball more consistently. On the other hand, you say they are a hassle to take, and that they taste bad. Is that about right?"

9 GROUP ACTIVITY: REFLECTIVE LISTENING – BREAST CANCER SCREENING

Note: It is suggested that you ask the class for one volunteer to be the "patient" and another to be the "care coordinator" and then have them read the statements below:

	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."

Ask the class:

- How did these reflections sound to you?
- Did they surprise you?
- How do you think they would make the patient feel?

PACT Training and Technical Assistance Institute

OARS Coding Sheet

Open Questions 	
Affirmations 	
Reflections 	
Summaries 	

10 VIDEO EXERCISE: MOTIVATIONAL INTERVIEWING: A CONVERSATION WITH SAL

Refer students to the OARS coding sheet in their exercise books.

Say to the class: *Now we are going to have another look at the health professional and patient scenario that we saw before, but this time, we are going to see her using the OARS technique, as well as some other techniques that we will learn about more in the next class. As you watch the video, please use the "OARS Coding Sheet" to mark down how many times you see the health professional using open questions, affirmations, reflections and summaries. This coding sheet is used to provide supervision to health staff in the field to improve their motivational interviewing skills. Ideally, people conducting motivational interviewing should use these strategies throughout the session.*

11 VIDEO DISCUSSION QUESTIONS

- How did this health professional do? What kinds of MI techniques did you see her using and how often?
- What do you think was most successful about her interaction with Sal?
- Did you see the patient respond differently to the provider this time? How?
- How do you think you could begin to incorporate some of these techniques into the work you do now?

REFERENCES

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

MODULE 19

MOTIVATIONAL INTERVIEWING - PART 2

OBJECTIVES

- Demonstrate basic understanding of the techniques of Motivational Interviewing (MI) to facilitate positive client behavior change
- Increase understanding how MI techniques can be applied within healthcare environment

MATERIALS NEEDED

- PowerPoint file with videos downloaded

Motivational Interviewing - Part 2

AGENDA

1.	POWERPOINT WITH DISCUSSION: SPIRIT OF MI, OARS AND CHANGE TALK	15 MIN
2.	VIDEO EXERCISE: THE EFFECTIVE PHYSICIAN	15 MIN
3.	VIDEO DISCUSSION	10 MIN
4.	POWERPOINT WITH DISCUSSION: BRIEF NEGOTIATED INTERVIEWING (BNI)	10 MIN
5.	VIDEO: BNI CASE STUDY; DOCTOR A	5 MIN
6.	VIDEO: BNI CASE STUDY; DOCTOR B	5 MIN
7.	VIDEO DISCUSSION	10 MIN
8.	BREAK	5 MIN
9.	POWERPOINT WITH DISCUSSION: BNI STEPS	15 MIN
10.	GROUP ACTIVITY: MI/BNI PRACTICE SESSION	20 MIN
11.	MI/BNI PRACTICE SESSION DE-BRIEF	20 MIN

1 POWERPOINT WITH DISCUSSION: SPIRIT OF MI, OARS AND CHANGE TALK

Say to the class: During our last class, we learned about two main components of Motivational Interviewing: the "Spirit of MI" and "OARS". Today we are going to learn about one other main principle, "Change Talk" and then have a chance to put all this into practice. But first, let's take a minute to recap what we learned from the last class.

What are some of the main principles behind Motivational Interviewing?

- Patient-centered
- Goal-directed behavior change
- Helps resolve ambivalence
- Affirms patient/client autonomy
- Collaboration between patient and health professional
- Evokes patient's own reasons or motivation for change

What is OARS?

- Open-Ended Questions
- Affirmative Statements
- Reflective Listening
- Summary Statements

Say to class: And now we will move on to "change talk." Understanding "change talk" helps us understand how we can address a patient/client's ambivalence to change.

What is Ambivalence?

- Ambivalence is a conflict of ideas or attitudes: the presence of two opposing ideas, attitudes, or emotions at the same time.
- All of us have experienced change at some point our lives.
- Sometimes change is easy, sometimes it feels impossible.
- The place between knowing you should make a change and actually making the change is ambivalence.
- It's not an easy place to be, but it's a normal place to be before real change occurs.

Ask the class: Can you think of a time in which your clients/patients experienced ambivalence about a certain issue? How did that make them feel? How did that feel to you as someone who was trying to help?

- While it can be a very hard place to be, MI recognizes that ambivalence is a natural part of the change process.
- Moreover, MI recognizes that ambivalence has different stages.
- Being familiar with these stages can help health professionals understand how ready their clients are for change and how directive they can be.

What is "Change Talk"?

- Any client speech that favors movement in the direction of change
- Previously called "self-motivational statements"
- By definition linked to a particular positive behavior change target (for example, eating less, taking medication regularly, quitting smoking)

DARN – 4 examples of Change Talk

- Desire to change
  - I wish, I want, I would like
- Ability to change
  - I can, I could
- Reasons to change
  - If…..then
- Need to change
  - Need to, have to, got to

Ask the class: For example, if you were discussing smoking with a client and she said, "I would like to quit smoking, but I don't think I can," what kind of change talk would this be?

ANSWER: Desire

What if your client said, "I have got to quit smoking, since I am trying to get pregnant"? What kind of change talk would this be?

ANSWER: Need

What kind of change talk do you think is more predictive of the client actually taking steps to quit?

ANSWER: Need

How do you think you would use motivational interviewing with a client if they were using more "desire" change talk than "need" change talk? In other words, how would you use motivational interviewing with a client who was still showing a lot of ambivalence about changing but still showing that she wants to change?

ANSWER: Would encourage the client to talk more about why she is ambivalent with open-ended questions and reinforce any kind of change talk with positive affirmations but would not push the client in any way and would not consider the client ready for any action.

DARN

- Recognizing "change talk" is the more advanced stage of motivational interviewing.
- Using OARS is the first step.
- Listening for change talk and using it to inform how you use OARS is the real skill behind motivational interviewing.

DARN

- Studies have shown that change talk in a session predicts real change and positive outcomes
- Try to pick up on this language, reinforce and support it.
- Change talk is a cue for you to encourage the client to explore their reasons for change.
- Building on change talk should lead to a client making a commitment.
    - Example: "I will not smoke more than 2 cigarettes a day."

2 VIDEO EXERCISE: THE EFFECTIVE PHYSICIAN

Refer students to the OARS coding sheet in their exercise books.

Say to the class: Now we are going to take a look at a video with a pediatrician using motivational interviewing to address smoking. The physician does a really good job at picking up on the parent's "change talk" and uses it to guide her motivational interviewing strategies.

As you watch the video, please use the "OARS Coding Sheet" in your exercise book to mark down how many times you see the provider using open questions, affirmations, reflections and summaries, as we did in the last class. Additionally, write down any "change talk" that you hear from the parent.

3 VIDEO DISCUSSION QUESTIONS

1. How did this provider do? What kinds of MI techniques did you see her using and how often?
   ANSWER: Reflective listening, affirmations, reframing, summary statements, open questions

2. What kind of change talk did you hear from the parent?
   ANSWER: "Ok, this year I am going to quit smoking, but then something happens"
   "I know I've done it before and I know I can do it but it just seems really hard"

3. How did the provider respond when the parent started using change talk? What kinds of strategies did she use to explore the parent's ambivalence?
   ANSWER: Scale of 1-10, reflective listening, reframing, summary statements, pointing out discrepancies, open questions

4 POWERPOINT WITH DISCUSSION: BRIEF NEGOTIATED INTERVIEWING (BNI)

What do you think would be difficult about using motivational interviewing in healthcare?

- Might take too much time
- Might not know how to address serious concerns that come up
- Might get off track from the point of the session (i.e. diabetes management, medication adherence, etc)

MI can be practiced in many different ways.

- While it can be a 45 minute session with a client, it can also be a 5 minute intervention.

Brief Negotiated Interview (BNI)

The BNI, a specialized "brief intervention" for the medical setting, has foundations in motivational interviewing (MI) techniques.

Originally created for the emergency department in collaboration with Stephen Rollnick, PhD.

- Helps health care staff explore health behavior change with patients in a respectful, non-judgmental way within a finite time period.
- Intentionally designed to elicit reasons for change and action steps from the patient.
- Offers an algorithm, or "script," that guides staff through the health intervention.

Say to the class: *Now we are going to take a look at an example of BNI in practice – in a busy emergency room. The first scenario will show one doctor's approach to addressing problem drinking in his patient, while the second doctor will use BNI.*

5 VIDEO: BNI CASE EXAMPLE; DOCTOR A

6 VIDEO: BNI CASE EXAMPLE; DOCTOR B

7 VIDEO DISCUSSION

- What kinds of motivational interviewing techniques did Doctor B use?
- How did the patient respond differently to these doctors?
- What was Doctor B able to accomplish within this short amount of time?

9 BREAK

10 POWERPOINT WITH DISCUSSION: BNI STEPS

Students should refer to the Brief Negotiated Interview (BNI) Scoring Sheet (PACT Training and Technical Assistance Institute). Students can then reference this tool while you explain more in detail with the PowerPoint.

Say to the class: *Now we will look at BNI in more detail. Turn to your exercise book and look at the handout entitled: "Brief Negotiated Scoring Sheet."This is a tool used by community health workers to help their patients with behavior change. While this tool uses "drinking" as the example of the behavior that needs to be changed, this tool is flexible and can be used with any behavior that is having a negative health impact on your patient. The first step in this tool is to ask the patient about typical behavior patterns for them, so you can get to know more about them and what is normal.*

Suggestion: Ask the students to take turns reading each of the BNI steps.

BNI Steps

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?

How would you "ask for permission to talk about drinking" from a patient?

2. Pros & Cons

- What are the good things about drinking?
  - What are some more good things about drinking?
- What are the not so good things about drinking?
  - What are some more not so good things about drinking?
- Summarize in the patient's own words
- So where does that leave us?

Why do you think the pros and cons conversation starts with the good things about drinking (and not the bad)?

ANSWER: More often than not, patients/clients already know they are doing something "bad" and they expect you to criticize them about it. Asking them to talk about why they actually enjoy this "bad" behavior" and how it benefits them surprises the client and allows them to see you as an ally and someone to talk to, instead of someone who is judging them negatively.

3. Sharing Information and discussion

- Ask permission to share some information about safe drinking
- Share information
- What do you think of this information?

What kind of information would you share about the "safe drinking"?

ANSWER: Drinking 4 or more drinks for women and 5 or more drinks for men in 2 hours can put you at risk for illness or injury.

4. Assess readiness

- Use "the readiness to change" ruler
  - How ready are you to make a change?
  - Reinforce the positives
  - Why not less?
  - Ask about other reasons for changing
  - Ask about strengths and supports
  - Ask about past experiences

One strategy used in this video to address ambivalence was the "Readiness Ruler".

- This is like the "Pain Scale" used in hospitals.
- In MI, you can ask a patient: "On a scale of 1-10 with 1 being not ready at all and 10 being completely ready, how ready are you to change [X]?

This is a quick and effective strategy for helping you know where the client is at and where to focus MI.

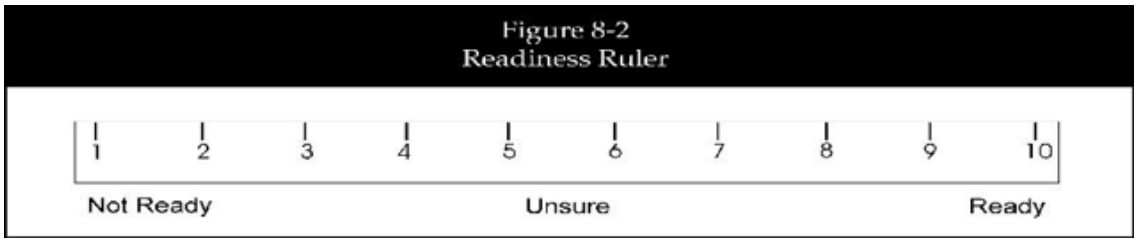
Why should you ask "why not less" when the client gives you a number on the readiness ruler?

ANSWER: Unless the patient says zero, this lets you focus on the positive. Even if they say 1, you can ask "Why not zero?" This encourages the client to focus on exploring the reasons for change.

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)

Figure 8-2
Readiness Ruler



10 GROUP ACTIVITY: MI/BNI PRACTICE SESSION

- Ask the class to divide into groups of three. One student will be a "Health Coach", one will be a "Patient" and one will be an "Observer."
- Once they know their role, refer them to the accompanying scenario in their exercise books. Have them read these scenarios carefully and then begin to role play.
- One way to conduct this role play is to ask each group to switch their roles after 10 minutes and then again after 10 minutes so that everyone has a chance to practice.
- Please give the groups a 5 minute time check and ask the Observers to give the Health Coaches their feedback about how often/well they used MI techniques.

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."*

PACT Training and Technical Assistance Institute

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)

11 MI/BNI PRACTICE SESSION DE-BRIEF

Discussion Questions

- For those of you who were the Health Coaches, how did this tool work for you? What did you find most useful? What felt the most difficult?
- For those who were the Patient, how did this feel to you? Did you feel listened to? Did you feel like you were able to make decisions for yourself?
- For those of you who were the Observer, what did you see as successful? What about the session was the most challenging?

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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).

MODULE 20

HEALTH COACHING AND PATIENT CARE FOLLOW-UP - PART 1

OBJECTIVES

- Understand what health coaching is and in what context healthcare staff might provide it
- Describe what a care plan is and how it would be used by staff providing care coordination and other care team members
- Know how to identify patient strengths and potential barriers they may face in following a care plan
- Know how to use a care plan to coordinate care: follow up on appointments, lab tests, medication adherence

MATERIALS NEEDED

- PowerPoint file with videos downloaded
- Printed copies of Health Coaching homework article or direct students to link http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2988157/pdf/11606_2010_Article_1508.pdf

Health Coaching and Patient Care Follow-Up Part 1

AGENDA

1.	POWERPOINT WITH DISCUSSION: HEALTH COACHING AND CARE PLANS	30 MIN
2.	VIDEO: COACHING PATIENTS FOR SUCCESSFUL SELF-MANAGEMENT	8 MIN
3.	VIDEO DISCUSSION	10 MIN
4.	POWERPOINT WITH DISCUSSION: THE SPECIFIC TASKS OF A HEALTH COACH	15 MIN
5.	BREAK	5 MIN
6.	VIDEO (SECOND HALF): COACHING PATIENTS FOR SUCCESSFUL SELF-MANAGEMENT	7 MIN
7.	VIDEO DISCUSSION	10 MIN
8.	EXERCISE: SETTING AGENDAS WITH PATIENTS	30 MIN
9.	HOMEWORK REVIEW	5 MIN

1 POWERPOINT WITH DISCUSSION: HEALTH COACHING AND CARE PLANS

What is health coaching?

- Helping patients gain knowledge, skills and tools and confidence to become active participants in their care so they can reach self-identified health goals.

From Health Coaching for Patients With Chronic Illness, Bennett H. MD, et al. http://www.aafp.org/fpm/2010/0900/p24.html#fpm20100900p24-ut1

2007 JAMA article states:

- 50% of patients leave without understanding advice given to them
- In only 10% of visits is the patient involved in the decisions made

Health coaching can improve patient understanding and engagement

What else can health coaching accomplish?

- Enhance the patient experience
- Improve clinical outcomes and quality of life
- Share work with care team so that everything does not have to be squeezed into a 15 minute visit:
  - Clinician can focus on complex clinical problems
  - Team members can focus on prevention and chronic care management

What specific tasks do coaches do?

- Help patients set agendas for clinician visits
- Make sure patient understands what the clinician would like them to do
- Determine whether patients agree with their care plans
- Provide self-management support
- Assist patients to improve medication understanding and adherence

Depending on your role, health coaching may be one of your responsibilities.

In terms of working with a patient, what is the most important thing for a health coach to remember?

Adopt a "collaborative approach" and not a "directive approach"

What is a directive approach?

- Telling patients what to do.

What is a collaborative approach?

- Ask patients what changes they are willing to make

What is the main way that you can provide a collaborative approach with your patients and not a directive one? What should you do?

- Ask them questions
    - Find out what they know - people don't like to be told what they already know
    - Find out who they are
    - Find out how much they are willing and able to do

Care Plans

- Document that shows a patient's complete plan of care including their medical, behavioral health, and social service needs
- Includes the patient's own goals for their care
- May list their diagnoses, medications, and plans regarding diet, nutrition, exercise, smoking cessation, follow up appointments, etc.
- Must be updated by the care team on a regular basis.

How does a care plan get put together?

- May differ depending on where you work
- May be started by the primary care provider and finished by health coach
- May be made after a case conference among program staff and medical providers
    - Care coordinator/care manager condenses assessments, creates goals and timelines for each, resulting in a comprehensive plan

How do healthcare staff use the care plan?

- Work under the supervision of the care coordinator or care manager to follow up on designated tasks
- Work with the patient to negotiate action plans for goals (health coaching)

What is an action plan?

Action plan - an agreement between caregiver and patients

- First, patient agrees on general goal
- Then, health coach and patient negotiate a specific action plan to assist in goal attainment

What is the difference between goals and action plans?

- Goals are more general
- Action plans are highly specific

- Goal: Lose 10 lb.
- Action Plan: “Drink water instead of soda”

- Goals may be more difficult to attain, and occur over a longer period of time
- Action plans: small specific manageable steps towards the goal

Why do we want to have patients set action plans?

Purpose of action plans

- Understand the specific steps involved in moving toward their goals
- Leave visit feeling confident about steps they can take now
- Leads to small successes
- Success increases patient’s confidence that he or she can continue to make positive life changes

What are specific coaching techniques that can be used to help patients reach their goals?

- Ask questions
- Develop a realistic action plan
- Follow-up to monitor progress

2 VIDEO: COACHING PATIENTS FOR SUCCESSFUL SELF-MANAGEMENT (PLAY UP UNTIL 7:18, THEN PAUSE)

3 VIDEO DISCUSSION

- Were there any “a-ha” moments while watching this coaching video?

- What were the differences between the way the coach approached the patient in the first scenario and the way she approached the patient in the second scenario?

- What worked well in the second approach?

- When the patient says that she can make a change by stopping eating all tortillas, what does the health coach say?

- What does the coach say that she will do to follow up at the end of the session with the patient?

4 POWER POINT WITH DISCUSSION: THE SPECIFIC TASKS OF A HEALTH COACH

What does it mean to help patients set the agenda for their visit with the clinician?

Helping patients set agendas for their visit with the clinician

- Patients concerns may be different from a clinician's but are equally important
- Want to find out about all their concerns, then negotiate what will be addressed when
- Phone call before the visit, or in person pre-visit when the patient is being triaged
- Let clinician know about patient's concerns: note in chart, during a huddle, in person communication

Make sure the patient understands what the clinician would like them to do.

Does the patient understand?

- Also known as "closing the loop"
- Means asking the patients to tell you if they understand what the clinician said
- Ask patients to repeat back what they understood
  - i.e. "Just to make sure the clinician was clear, can you tell me how you will take this medication?"

What does it mean to determine whether the patient agrees with their care plan?

Does the patient agree?

- For patients to make lifestyle changes and take prescribed medications they need to agree with what they are being asked to do
- Coach can ensure that they understand, agree with, and are willing and able to participate in the management of their chronic conditions

What can coaches do to provide self-management support for patients?

- Provide information
- Teach disease specific skills
- Promote healthy behaviors
- Impart problem solving skills
- Assist with emotional impact of illness
- Provide regular follow up
- Encourage patients to be active participants in their care

How can coaches assist patients to improve medication understanding and adherence?

- Reconcile patient medications
  - Compare list of meds clinician has prescribed with what patient is actually taking
- Confirm medication concordance
  - Patient understands how to take their meds
- Confirm medication adherence
  - Patient understands how to take meds and is actually taking them that way

How common is non-adherence?

Rates of non-adherence

- One third of patients take all their meds
- One third take some of their meds
- One third take none of their meds
- But not all of this is non-adherence

What would be some reasons that patients are non-adherent to their medications?

Reasons for non-adherence

- Patient has to pay for it and can't afford it
- Medication was not on their insurance formulary so pharmacy didn't give it to them
- Medication causes side effects
- Patient is worried that medication may cause side effects/hurt them
- Patient doesn't believe that medication will really make a difference
- Patient forgets
- Medication regimen is too complicated
- Patient doesn't want to begin taking something that they may have to take for the rest of their life

What are specific coaching techniques that can be used for effective medication adherence with patients?

Coaching Techniques for Effective Medication Adherence

- Keep asking the patient questions
- Make sure patient understands and agrees with medications
- Ask about barriers
- Follow-up phone call

5 BREAK

6 VIDEO: COACHING PATIENTS FOR SUCCESSFUL SELF-MANAGEMENT (FROM 7:18 TO THE END)

7 VIDEO DISCUSSION QUESTIONS

- Did you notice any "aha" moments in this video?
- What were the differences in approach between the physician assistant and the health coach?
- What specific questions did the health coach ask the patient about his medication?
- What does the coach do when he finds out that the patient is having side effects from his medication?
- What does the health coach do at the end of the visit to make sure that the patient understands how to take his medication?

8 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

Facilitator Instructions:

Have two students read each of the following dialogues and then have a discussion about each one.

- Ask questions such as:
- Was that a good discussion?
- What was wrong with it?
- What was right with it?

Tell students that there is room for them to write notes about the scenarios in their Student Exercise Books.

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

ANSWER: Not good. Patient's agenda in almost every case should come first.

EXERCISE: SETTING AGENDAS WITH PATIENTS

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.

ANSWER: Caregiver does a good job.

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?

ANSWER: This is the reality dialogue: too many agenda items for the 15 minute visit. The caregiver handles it fairly well.

EXERCISE: SETTING AGENDAS WITH PATIENTS

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.

ANSWER: This last dialogue demonstrates what happens if the agenda is not negotiated at the beginning of the visit. The cholesterol discussion took place before all possible agenda items were put on the table. As a result, a potentially urgent problem surfaced when the visit was already over.

9 HOMEWORK FOR NEXT CLASS

Hand out printed copies or direct students to the link and ask students to read 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.

- When does the health coach Victoria Ngo meet or interact with the patient?
- What things do Dr. Hammer and Victoria do to improve communication and anticipate how to best address patients' concerns?
- What might the health coach do between visits with patients?
- What operational challenges did Dr. Hammer and Victoria Ngo run into?
- In the stories presented, what are some of the strategies that the coaches use to foster trust with their patients?

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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

VIDEOS

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

MODULE 21

HEALTH COACHING AND PATIENT CARE FOLLOW-UP - PART 2

OBJECTIVES

- Increase understanding of the techniques of health coaching to aid in the completion of care plan goals
- Demonstrate basic understanding of health coaching techniques such as making behavior-change action plans with the patient, confirming the patient understands what the provider has asked them to do and medication reconciliation

MATERIALS NEEDED

- PowerPoint file with videos downloaded
- Index cards with medication order written on them for “Closing the Loop” exercise

Health Coaching and Patient Care Follow-Up - Part 2

AGENDA

1.	POWERPOINT WITH DISCUSSION: GAINING TRUST AS A HEALTH COACH	10 MIN
2.	HOMEWORK DISCUSSION	10 MIN
3.	POWERPOINT WITH DISCUSSION: PROVIDING HEALTH COACHING	15 MIN
4.	EXERCISE: MAKING BEHAVIOR-CHANGE ACTION PLANS WITH THE PATIENT	25 MIN
5.	BREAK	5 MIN
6.	POWERPOINT WITH DISCUSSION: PROBLEM SOLVING AS A COACH	5 MIN
7.	POWERPOINT WITH DISCUSSION: MEDICATION TRAINING	15 MIN
8.	VIDEO: HEALTH COACHING (MEDICATION RECONCILIATION)	5 MIN
9.	VIDEO DISCUSSION	10 MIN
10.	EXERCISE: CLOSING THE LOOP	20 MIN

1 POWERPOINT WITH DISCUSSION: GAINING TRUST WHEN YOU WORK AS A HEALTH COACH

We need to gain the trust of patients when we work as health coaches.

Why would a health coach need to gain the trust of patients?

- Patients may not understand the role of the health coach.
- Patients may not at first trust that the health coach or staff member providing coordination is reliable, accessible, will listen to their concerns, etc.

How do we gain the trust of patients?

- Clearly explain your role
- If you don't know the patient, ask the clinician if they can introduce you and explain what you do.
- Be reliable, follow through on what you say you will do.

You need to gain the trust clinicians when you work as a health coach.

Why might some clinicians have trouble understanding how to work with a health coach?

- Clinicians may be nervous about giving up some of the responsibility for a patient's care.
- Clinicians may be concerned about who is ultimately responsible.
- Clinicians may unrealistically think that they can do everything (i.e. solve complex medical problems and provide health coaching and coordinate care.)

Gaining trust of clinicians

- Have your role and responsibilities clearly defined
- Maintain clear, open channels of communication
- Be accountable and dependable
- Ask questions when you don't know something or need help

2 HOMEWORK DISCUSSION

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

ANSWER: Depends on what she and the clinician decide is needed. She may meet with them before the clinician visit to elicit patient concerns, set the agenda or confirm what medication patient is actually taking. She may sit in on the clinician visit, take notes, help translate, and ensure the visit runs smoothly. She may meet with the patient after the visit to "close the loop"-make sure the patient understands what the clinician said and develop behavior action plans.

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

ANSWER: They work as a teamlet with a group of patients assigned to them. They "huddle" for no more than 10 minutes at the beginning of the clinic session to discuss the day's patients.

What might the health coach do between visits with patients?

ANSWER: Phone calls to patients to see how they are doing, handle things that were previously handled by the physician like calling in a prescription refill based on a standing order, arranging home care, getting a letter documenting a patient's disability so that she can apply for financial assistance.

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

ANSWER: Workflow issues, physician cannot wait for coach to spend 10 minutes in a pre-visit coaching session, if coach is doing a 20 minute post visit session she is not available for pre-visit session before provider sees patient, constant huddling needed to work out flow and space issues.

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

ANSWER: 76-year-old Chinese patient wanted to see her doctor monthly but not enough appointment slots so health coach calls her frequently which alleviates some of her fears and reduces her desire for monthly doctor visits.

40-year-old Bangladeshi woman with diabetes did not like to talk on phone about her diabetes because it made her feel more stressed so health coach calls or visits her every few weeks to build trust.

Coach also works with overweight 10-year-old daughter on healthier eating choices.

Coach works with 64-year-old Vietnamese man who believes his BP is only high when he sees his doctor by getting him a home bp monitor. Patient then begins to take his meds when he sees that his bp is also elevated at home.

55-year-old African American woman gets derailed with her weight loss plan after a foot injury and her son's incarceration-regular phone calls from the health coach lead her to recommit to her exercise routine.

3 POWER POINT WITH DISCUSSION: PROVIDING HEALTH COACHING

Is health coaching always provided for all patients?

- Depends on the setting where you work
- You may work as a part of a large care team or as part of a team-let where you are assigned always to one provider and a set panel of patients
- Decisions about who receives health coaching can be made in team meetings, case conferences, or in daily huddles
- Main point: health coach, provider and other team members are communicating about what patients need

How does health coaching/care coordination help distribute work more efficiently and provide better care for patients?

The old way:

- Patient may drop in clinic needing:
  - a new prescription
  - help arranging home care
  - a letter documenting a disability in order to
  - apply for financial assistance
- How would this normally be handled? What staff would be involved?
  - Clerk might take a message
  - Patient would be sent home
  - Requests would be passed to physician
  - Physician would handle at the end of the day, after seeing patients

The new way:

- Health coach or care coordinator:
  - assists with getting authorization for prescription and calls the pharmacy
  - can arrange home care
  - has standard letter that documents disability
  - just needs a signature from the provider
- These are routine tasks that the organization expects and that health coach/care coordinator is prepared to handle

How can staff who provide health coaching/care coordination help a patient to have a productive appointment?

Having a productive appointment

- Does patient have all necessary information for the appointment?
- Does the patient need translation services?
- Have you discussed having the patient writing down their questions?
- If you are attending the visit, have you prepared the questions that you want to ask the provider?
- If you do not work in the same place as the primary care provider, do you have a contact at that organization who can help you coordinate care?

4 EXERCISE: MAKING BEHAVIOR CHANGE ACTION PLANS WITH THE PATIENT

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.

Have two students read each of the following dialogues and then have a discussion about each one.

Ask questions such as:

- Was that a good discussion?
- What was wrong with it?
- What was right with it?

Dialogue 1

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.

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.

5 BREAK

6 POWER POINT WITH DISCUSSION: PROBLEM SOLVING AS A COACH

Problem solving requires considerable ingenuity on the coach's part, trying to come up with a solution to the very real barrier the patient faces.

What are the steps you might follow to do problem solving with patients?

- Identify the problem (the most difficult and important step).
- List ideas to solve the problem.
- Pick one, try it for two weeks.
- Assess the results.
- If it doesn't work, try another idea.
- Utilize other resources (family, friends, professionals.)
- If nothing seems to work, accept that the problem may not be solvable now.

7 POWER POINT WITH DISCUSSION: MEDICATION TRAINING

What is medication reconciliation?

- Comparing the list of medicines the doctor has prescribed with the list of medicines the patient is actually taking

When do you do it?

- Before the visit so the provider knows which medicines the patient is actually taking.

Why does it need to be done?

- So the providers know the actual effects of the medication that they are prescribing.
- So the providers don't give more meds because they think they're not working when actually the patient is not taking them.

Who does medication reconciliation?

- Often, it is not done.
- Ideally a pharmacist would do it but usually not available.
- Many organizations experimenting with using medical assistants, nurses, health coaches, community health workers.

What are the two main tasks of medication reconciliation?

- Finding out what the patient is actually taking (detective work)-can be done by coach.
- Deciding what the patient should be taking-clinician function.

How do you do med-rec?

Medication reconciliation

- In a reminder phone call, ask patients to bring all medicine bottles.
- Print out the pre-visit medication list.
- Go over each medication on the pre-visit med list (or use bottles if patient brought them) and ask the patient the following questions:
  - Do you know the name of this pill?
  - Do you know what this pill is for?
  - Do you know how many milligrams it is?
  - How often should you be taking it?
  - Are you taking it?
  - If you are not taking it as the doctor prescribed, why not?
  - Do you need refills?

What should you do with the information you gather from the patient?

- Document in the appropriate place in the medical record.
- Make sure the clinician sees the information.
- Leave the pill bottles out for the provider to see if the patient brought them.

What is the coach's only real job when doing medication reconciliation?

- Get information from the patient.
- Do not advise patient.

8 VIDEO: HEALTH COACHING (MEDICATION RECONCILIATION) TECHNIQUES TO DELIVER PATIENT CENTERED CARE

9 VIDEO DISCUSSION

In the first video, what is problematic about the care coordinator/health coach responding to the patient's complaint that the medicine "makes her dizzy" by saying that "that's just part of the side effects?"

ANSWER: We have to work with patients. Patients who feel sick or have troubling side effects are unlikely to continue taking medication. Providers and the care team need to know and not judge if patients can't take certain medications. Coaches role is simply to listen and document what patient says not tell them what to do or judge.

What does the coach do differently in the video? How is his approach different?

ANSWER: First he asks permission to do medication reconciliation Then he starts by asking about each and every medication:

- What is the name of this medication?
- What is it for?
- How many milligrams is it?
- How are you supposed to take it?
- How are you actually taking it?

In the second video, when the care coordinator/ health coach finds out that the patient is only taking one pill twice a day instead of two pills twice a day, how does he respond to this?

ANSWER: Doesn't scold or judge, instead asks if it would be ok if he documents how she is taking the medication so the provider is aware.

10 EXERCISE : CLOSING THE LOOP

Divide the students into groups of two, with one person acting as the coach and one as the patient.

The teacher acts as the provider and tells the patient and coach the clinical advice that is written on an index card.

Examples of clinical advice to write on index cards are below:

- You are now taking 1 metformin two times a day; I would like you to start taking 2 metformin twice a day.
- You are now taking glyburide 5 mg twice a day: Your A1c is more under control so we are going to lower your dose to 2.5 mg twice a day.
- Please take one 81 mg Aspirin tablet every day to lower your risk of heart attack and one Hydrochlorothiazide 12.5 mg once a day to control your blood pressure.
- I would like to start you on Lipitor 10 mg daily. You need to come back in three months to have a liver function test done.

After you have told the advice to the coach and patient, give the card to the coach for their reference and don't show to patient.

Tell the coach to say:
"Do you remember what your doctor told you about your [fill in medication name]? Just to be sure your doctor was clear, how did she want you to take the [fill in medication name]?

"Alternatively, "How will you be taking your [medication name] starting tomorrow?"

The patient answers, and if incorrect, the coach corrects the patient, asks the patient to repeat the instructions again – until the patient gets it right.

DISCUSSION

Ask the trainees who were patients: *"How did it feel to be asked to repeat back the advice?" (to determine if the coach asked in a respectful manner)*

Ask the trainees who were coaches: *"Was it difficult to ask patients to repeat back the advice?"*

Note: Many coaches have difficulty asking patients to repeat back the advice, and have a tendency to ask "Did you understand the advice?" and if the patient says "Yes" the coach stops there. That is not closing the loop, and does not assess patient comprehension. We know that patients' lack of understanding of medication advice is a major contributor to patient non-adherence.

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Transforming the Role of Medical Assistants: A Key to an Effective Patient- Centered Medical Home.
www.pcmhri.org/files/uploads/Campanile_BP_Sharing_4.15.11.ppt

VIDEOS

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

MODULE 22

QUALITY IMPROVEMENT AND OUTCOMES

OBJECTIVES

- Learn basic methods for improving quality in the healthcare service environment
- Understand how coordinating care as a team can improve quality and support process improvement goals
- Learn about types of data used in quality improvement
- Describe the relationship between care coordination work and quality improvement
-

MATERIALS NEEDED

- PowerPoint file with videos downloaded

QUALITY IMPROVEMENT AND OUTCOMES

AGENDA

1.	POWERPOINT WITH DISCUSSION: INTRO TO QUALITY IMPROVEMENT	10 MIN
2.	VIDEO: COMPARING HEALTH CARE QUALITY: A ROADMAP TO BETTER CARE	5 MIN
3.	VIDEO DISCUSSION	5 MIN
4.	POWERPOINT WITH DISCUSSION: QUALITY IMPROVEMENT PROCESSES	10 MIN
5.	GROUP EXERCISE: QUALITY IMPROVEMENT FOR THE POSTPARTUM VISIT – PART 1	20 MIN
6.	POWERPOINT WITH DISCUSSION: STAFF ROLES AND TEAMWORK IN CQI	10 MIN
7.	BREAK	5 MIN
8.	VIDEO: CARE TEAMS IMPROVING QUALITY, ACCESS AND RELATIONSHIPS FOR PATIENTS	5 MIN
9.	VIDEO DISCUSSION	5 MIN
10.	POWERPOINT WITH DISCUSSION: CQI DATA	10 MIN
11.	POWERPOINT WITH DISCUSSION: PATIENT EXPERIENCE	10 MIN
12.	GROUP EXERCISE: QUALITY IMPROVEMENT FOR THE POSTPARTUM VISIT – PART 2	20 MIN
13.	WRAP UP	5 MIN

1 POWERPOINT WITH DISCUSSION: INTRO TO QUALITY IMPROVEMENT

Why is it important for a healthcare organization to monitor its performance?

Why monitor performance?

- Identify strengths and opportunities for service delivery improvement
  - e.g. 90% of our diabetic patients have had a foot exam in the last year but only 50% of our diabetic patients received an eye exam
- Identify disparities in access to services
  - e.g. only 40% of our female patients over 40 years with Medicaid have had a mammogram compared to 60% with private insurance
- Understand how our patients are doing
  - e.g. 70% of our patients diagnosed with hypertension have a blood pressure that is considered controlled (<140/90)

Note to instructor: these are some potential answers to the discussion question. The examples are included to illustrate these points. In the first example, highlight how the health center is doing well in one measure but not in another and making sure diabetic patients receive an eye exam could be something the health center wants to improve. In the second example, there is a disparity is services based on insurance status. This is a common disparity in care that the health center could take steps to help address by connecting Medicaid patients with mammography facilities that take Medicaid. The third example illustrates a measure that is some indicator of the health of a group of patients with a common diagnosis.

What is continuous quality improvement (CQI)?

Continuous Quality Improvement

- Process-based, data-driven approach for improving the quality of a product or service. It operates under the belief that there is always room for improving operations, processes, and activities to increase quality.

  --- Robert Wood Johnson Foundation
  - How are we doing? Can we do it better?

Why is CQI important in healthcare?

CQI and Healthcare

- Improve patient health outcomes
  - Are patients receiving the right care at the right time?
- Improve clinical performance
  - Medical errors are commonly caused by system or process failures (Institute of Medicine, To Err is Human).
  - These failures can be addressed if understood and monitored.

Why is care coordination important to improving healthcare quality?

Care Coordination and Quality Improvement

- As staff who provide care coordination, you play an important role in supporting patients get access to the services they need
- Ensuring that patients are able to get the right care at the right time in a culturally sensitive way can help to improve their health outcomes

2 VIDEO: COMPARING HEALTH CARE QUALITY: A ROAD MAP TO BETTER CARE

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

3 VIDEO DISCUSSION

How can collecting and reporting on quality data be a catalyst for change in the community and the health of patients?

ANSWER: Data can provide a community insight into how healthy is members are and the level of quality of healthcare services. These data can be a starting point for discussions about how to improve the health of a community and improve the quality of the healthcare services available.

What are some benefits of reporting quality data publicly?

ANSWER: In addition to being a catalyst for change in a community, providers and healthcare organizations can compare themselves against one another. This brings a competitive spirit among providers to improve quality, because no one wants to score poorly.

How did they use information to increase breast cancer screening for Somali women?

ANSWER: They developed a focus group and asked the women what barriers they faced. This led to establishing same day appointments for screenings

How did the general internists improve their pneumococcal vaccines for their diabetic patients?

ANSWER: They focused on the issues, worked with the whole care team, made it a campaign, engaged front desk staff and medical assistants, not just doctors.

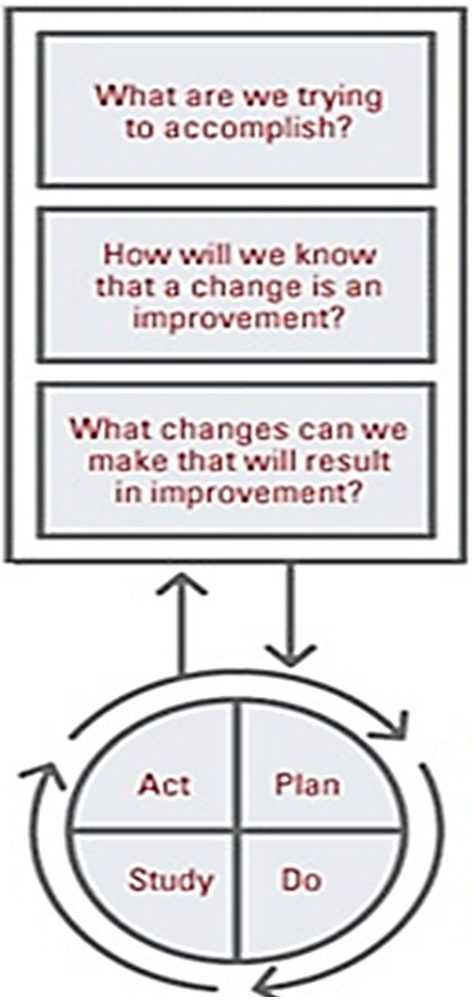
4 POWERPOINT WITH DISCUSSION: QUALITY IMPROVEMENT PROCESSES

What does a quality improvement process look like? What steps does it include?

Fundamentals of Quality Improvement Intervention

1. Get the Data – this informs you of the problem
   e.g., weight screening
2. Drill down of the data/define root cause of issues
   e.g., certain staff didn't know they were responsible for weighing patients
3. Assess what can be done to achieve improvement
   e.g., Staff training
4. Put improvement in place
   e.g., Train all staff that are responsible for weighing patients
5. Check to see if it's working
   e.g., Look at weight screening report one month after training

Note to instructor: This is a picture of a standard PDSA cycle. Highlight the importance of the steps before the PDSA cycle itself. These steps are commonly missed but are very important for having the PDSA cycle activities move an organization towards their goal, rather than getting stuck in endless PDSA cycles.



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.

Setting Aims

- After thinking through the root causes of the problem, setting an aim or goal is an important step in the quality improvement process.
- A goal will help keep staff focused and on the same page about what you are trying to accomplish for your patients.
- Using the "SMART" goal framework will help you come up with a clear goal:

SMART Goals

- **S** – specific (easy to understand and to the point)
- **M** – measurable (indicates a clear outcome or evidence that you have accomplished your goal)
- **A** – achievable (realistic that you can accomplish with the time and resources available)
- **R** – relevant (in-line with program's mission and vision)
- **T** – time-bound (includes a timeframe when the goal is expected to be reached)

Example: By January 1, 2016, increase the percentage of patients over the age of 65 years being offered a flu shot within the calendar year from 70% to 80%.

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

Teacher instructions: Ask the class to break into twos or small groups to complete this activity. Ask the class to be prepared to report back.

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.**

Discussion Questions:

1. What types of information did you identify to help you better understand the problem?
2. What did you come up with as possible root causes of this problem?
3. What SMART goal did you create? Did you find this process easy or difficult?

6 POWERPOINT WITH DISCUSSION: STAFF ROLES AND TEAMWORK IN CQI

Which staff are involved with quality improvement efforts at healthcare organizations?

Staff Roles

Everyone is involved

- Doctors, NPs, CNMs, PAs
- Nurses, LPNs
- MAs
- Front desk, Registrars
- IT, Operations and Administrative staff
- Social workers, case managers
- Care coordinators, patient navigators

Improving quality takes a team effort. Care coordination staff are part of that team.

Staff Roles: Data Collection

- Collecting and recording data is an important CQI role
  - Clinical data e.g. weight, blood pressure
  - Demographic data e.g. race & ethnicity, language spoken
- What is the connection between demographic data and patient outcomes?
- What is the connection between documenting clinical data and patient outcomes?

Note to instructor: Accurate demographic data can help healthcare providers identify and address disparities in care among their patients. Accurate contact information is important for easily contacting following up with patients. Clinical data, such as test results and progress notes, are important for monitoring and health of patients and when coordinating care among different healthcare providers that see the patient.

Importance of Accurate Data Collection

Example:

A patient on a care manager's panel recently had a change of address and phone number. The care manager documented this in the progress note after a meeting with the patient but forgot to update the patient's contact information in the EMR. A few months later, the patient's primary care physician received a notification that this patient had presented in the emergency room. When the office medical assistant reached out to schedule a follow-up visit she learned the phone number on file had become disconnected. As a result, the patient never received any care following the visit to the emergency department.

What was the missed opportunity here? How could have recording this data accurately and in the right place have helped the patient?

Staff Roles: QI Projects and New Processes

Example:

A health center would like to increase the number of diabetic patients who have a controlled Hemoglobin A1c and controlled blood pressure. Leadership decided that as a first step, they want that these patients to come in regularly to be seen and have self-management plans. They have asked all clinic staff – including care mangers – to assist with this.

What roles could the following staff have in this initiative?:

- Physicians
- Care managers
- Medical assistants/front desk staff

CQI and Team Based Care

- High functioning care teams essential in today's healthcare environment
- Effective teams are characterized by:
  - Shared goals
  - Clear roles
  - Mutual trust
  - Effective communication
  - Measurable processes and outcomes

Team Based Care and Care Coordination

Staff providing care coordination are an important member of the care team and greatly contribute to quality improvement efforts:

- Support collaboration with patients
- Patient is "known" and long term trusting relationship can be established
- Address the psychosocial context, including available financial support and resources, ability to self-manage and barriers to self-care
- Coordinate with other members of the care team, including the patient to facilitate communication and ensure that everyone is working towards the same goals

7 BREAK

8 VIDEO: CARE TEAMS IMPROVING QUALITY, ACCESS AND RELATIONSHIPS FOR PATIENTS

https://www.youtube.com/watch?v=YW75-IxF58E

9 VIDEO DISCUSSION:

Who is on the extended care team?

ANSWER: Physicians, MAs, nurse care managers, pharmacists, behavioral health, social workers, care navigators

How does the team-based model change the episodic care patients were receiving before? What does it take to deliver care in a coordinated way?

ANSWER: Mindset and communication is key to putting together the patient's story and ensuring that all providers are on the same page.

Where have they already started seeing quality improve as a result of care teams?

ANSWER: Patient satisfaction, staff engagement, and eventually expect clinical outcomes to improve.

10 POWERPOINT WITH DISCUSSION: CQI DATA

What is the difference between a "process" and "outcome" measure?

Process and Outcome Measures

- Process measures – assess how a program was implemented
  - e.g. The primary care provider referred 10 out of 15 eligible patients to the care management program.
- Outcome measures – assess achievement of a program's objectives
  - e.g. Of these 10 patients referred by the primary care provider, 5 consented into the care management program.

What is the difference between a preventive measure and clinical measure?

Preventive vs. Clinical Measures

- Preventive measures indicate how often patients are receiving services that can prevent or detect illness
  - e.g. 60% of adult patients have been screened for depression in the last year
- Clinical measures relate to a specific illness or chronic condition and can indicate whether patients are receiving services or the health status of a group of patients
  - e.g. 70% of our diabetic patients have an up-to-date A1C recorded in their chart; 60% of our diabetic patients have an A1C <9.

Note to instructor: depending on the objectives of the QI program, preventive measures could either be indicators or processes or outcomes. Clinical measures are usually considered outcome measures.

What are vulnerable populations?

"Those who are made vulnerable by their financial circumstances, place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability."

- Agency for Healthcare Research and Quality

Why is it beneficial to review quality improvement data for vulnerable populations?

- Vulnerable populations have characteristics that could lead to differences in access or quality of care.
  - e.g. only 30% of men over the age of 50 have had a colonoscopy in the last 10 years, whereas 60% of women over the age of 50 have had a colonoscopy in the last 10 years.

Understanding these disparities in care can help target where to focus quality improvement efforts and relate them to the needs of the community.

11 POWERPOINT WITH DISCUSSION: PATIENT EXPERIENCE

What is patient experience?

Patient Experience

"The sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care."

– The Beryl Institute

Examples:

- Did the patient feel respected and listened to by the staff and the doctors?
- Was the patient kept informed of changes in medications and lab or imaging results?
- Was the patient able to get an appointment when she felt she needed one?

Patient experience data is often considered an outcome measure.

Note to instructor: There is no common definition of patient experience. This one is from the Beryl Institute that focuses on patient experience in healthcare: http://www.theberylinstitute.org. The examples are sample questions that one could put on a patient experience survey.

Why does the patient's experience matter?

Value of Patient Experience

- Patients with a positive experience with the healthcare system are more likely to engage in care
- Engagement in care can lead to better health outcomes
- Healthcare organizations are evaluated on and sometimes get extra reimbursement for patient experience scores

Patient Experience and Care Coordination

- In your role as care coordination staff, you have many opportunities to improve your patient's experience
- Common reasons why patients may have a good or bad experience:
  - Treated with dignity and respect
  - Felt listened to and that their concerns were considered
  - Healthcare staff communicate clearly
  - Feels that healthcare staff cares about them
  - Can access care when they need it and care is not rushed

In your role, how could you help to improve the patient's experience in these areas?

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

Teacher Instructions: Ask the class to break into the same groups as they did for Part 1 of this activity. Ask them to be prepared to report back.

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.

Discussion Questions

- What interventions did you come up with to improve the rate of postpartum visits? Why did you choose this intervention?
- What process and outcome measures did you decide to use to measure if your intervention is successful? How were you defining "success?"

13 WRAP UP

- Continuous quality improvement (CQI) is an important process to ensuring that we are providing the best services we can to patients.
- A good CQI effort is data driven, well thought out and a team effort.
- All staff – particularly staff who provide care coordination – are key to successful quality improvement efforts.

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

MODULE 23

PROFESSIONAL BOUNDARIES - PART 1

OBJECTIVES

- Describe the role professional boundaries have in helping patients
- Describe ways to maintain healthy boundaries
- List risky behaviors that lead to boundary violations

MATERIALS NEEDED

- PowerPoint file with videos downloaded

PROFESSIONAL BOUNDARIES - PART 1

AGENDA

1.	POWERPOINT WITH DISCUSSION: PERSONAL BOUNDARIES	15 MIN
2.	EXERCISE: A TIME WHEN YOU HAD TROUBLE MAINTAINING BOUNDARIES	25 MIN
3.	POWERPOINT WITH DISCUSSION: 10 TIPS FOR SETTING BOUNDARIES	15 MIN
4.	VIDEO: TENSIONS BETWEEN PERSONAL AND PROFESSIONAL BOUNDARIES	5 MIN
5.	VIDEO DISCUSSION	15 MIN
6.	BREAK	5 MIN
7.	POWERPOINT WITH DISCUSSION: PROFESSIONAL BOUNDARIES	15 MIN
8.	EXERCISE: PROFESSIONAL BOUNDARIES IN HEALTHCARE	25 MIN

1 POWERPOINT WITH DISCUSSION: PERSONAL BOUNDARIES

What are personal boundaries?

- Guidelines, rules or limits that a person creates to identify what are reasonable, safe and permissible ways for other people to behave and how he or she will respond when someone steps outside those limits
- Built out of a mix of beliefs, opinions, attitudes, past experiences, and social learning
- Define you as an individual, outlining your likes and dislikes, and setting the distances you allow others to approach

Why are personal boundaries important?

- Establish you as an individual with your own needs
- Key to ensuring relationships are mutually respectful, supportive, and caring
- Allow you to take care of yourself by maintaining control of what you need to feel safe, secure, and appreciated
- Set the limits for acceptable behavior from those around you

What happens when someone has no boundaries?

- Exhaustion
- No Respect
- Resentment
- Exploding Anger

Why would someone have trouble with boundaries?

- Most people who have trouble with boundaries have good intentions
- They don't want to hurt or disappoint others
- They like to please others and make them happy
- They worry that if they set boundaries, they will lose friends or negatively alter relationships

What happens when someone has no boundaries?

- Often "blend" in with other people; it is hard to know their own desires and needs
- Can become exhausted taking care of other's needs; often get no respect for doing so.
- When they repress these feelings, they can become resentful and then explode in anger.
- However, there is a "happy medium", in which they can be considerate of others and considerate of themselves.

2 EXERCISE: A TIME WHEN YOU EXPERIENCED TROUBLE MAINTAINING BOUNDARIES

Students have 8-10 minutes to answer the following questions. Then have volunteers share their answers/ stories.

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?

_____

_____

_____

_____

Who was involved?

_____

_____

_____

_____

Why do you think it was hard?

_____

_____

_____

_____

How might you handle it differently next time?

_____

_____

_____

_____

3 TEN TIPS FOR SETTING BOUNDARIES

1. Get to Know People First

- Don't give total access to yourself when you first meet someone.

2. Be Selective in Sharing

- Keep some thoughts and feelings to yourself.

3. Tune Down Your Energy

- People with no boundaries are often overly enthusiastic and give people expectations that they can expect constant attention. Learn how to tune your energy up and down by "tuning down" your body language or tone of voice.

4. Speak Up About the Small Things

- Bad patterns develop over time and move from small issues to big issues. It's good to stop them early - not with anger, but with firmness.

5. No Pleading or Yelling

- Pleading or yelling can actually be seen as weakness. Remaining in control of your emotions means you will have more power and people wiill take you seriously.

6. Notice Your Feelings

- People with no boundaries often are more aware of other people's thoughts or feelings than their own. They are often only aware of their own needs when they are completely exhausted or drained.
- Be aware of your own feelings so you can address issues while they are "small."

7. Express Desires Positively

- People with no boundaries are afraid of hurting other people's feelings; saying things in a positive manner will help you say what you want, in the way that you want.

8. Limit Draining Conversations or Activities

- Limit anything in your life that is draining. Keep doing things that give you energy and vitality.

9. Don't Take Without Asking

- It may feel like sharing everything is okay, but over time this can become a lack of respect.

10. Respect for Physical Touch

- It is fine to be affectionate, but you need to be aware of how your affection is being received. If it's not being received positively, then it is not okay.

4 VIDEO: TENSIONS BETWEEN PERSONAL AND PROFESSIONAL BOUNDARIES

5 VIDEO DISCUSSION

What happens when the interpreter sits down next to the patient and waits for the appointment?
ANSWER: Patient shares personal information, seems needy, and wants to talk.

What does the interpreter do? How does he set the boundary? Does he do a good job?
ANSWER: Simply and kindly tells him that he is there to interpret, that the relationship is professional, and that he hopes the patient will understand.

What happens when they try to change the patient's address at the front desk?
ANSWER: Front desk staff talks to the interpreter and not the patient.

Why is it a problem for the interpreter when the patient asks for a ride? Why does he say it is illegal?
ANSWER: Can't take patient in your car while you are working, liability issues, favoritism issues.

Does the patient seem to have trouble with boundaries? What makes you think that?
ANSWER: Keeps asking for favors and help even after the interpreter has clearly explained what he can and cannot do.

What personal issues is the interpreter juggling that he doesn't share with the patient? Why doesn't he share that with the patient?
ANSWER: That he needs to pick someone up, maybe his son at school. Crossing a professional boundary to share personal issues may put burden on the patient to worry about the interpreter.

6 BREAK

7 POWERPOINT WITH DISCUSSION: PROFESSIONAL BOUNDARIES

What are Professional Boundaries?

- Rules that define the limits of professional behavior.
- Mutually understood, unspoken physical and emotional limits of the relationship between the patient and the [staff member]."
  (Farber et al., 1997)
- Professional boundaries separate therapeutic behavior from any behavior which, well intentioned or not, could lessen the benefit of care to clients, families, and communities.

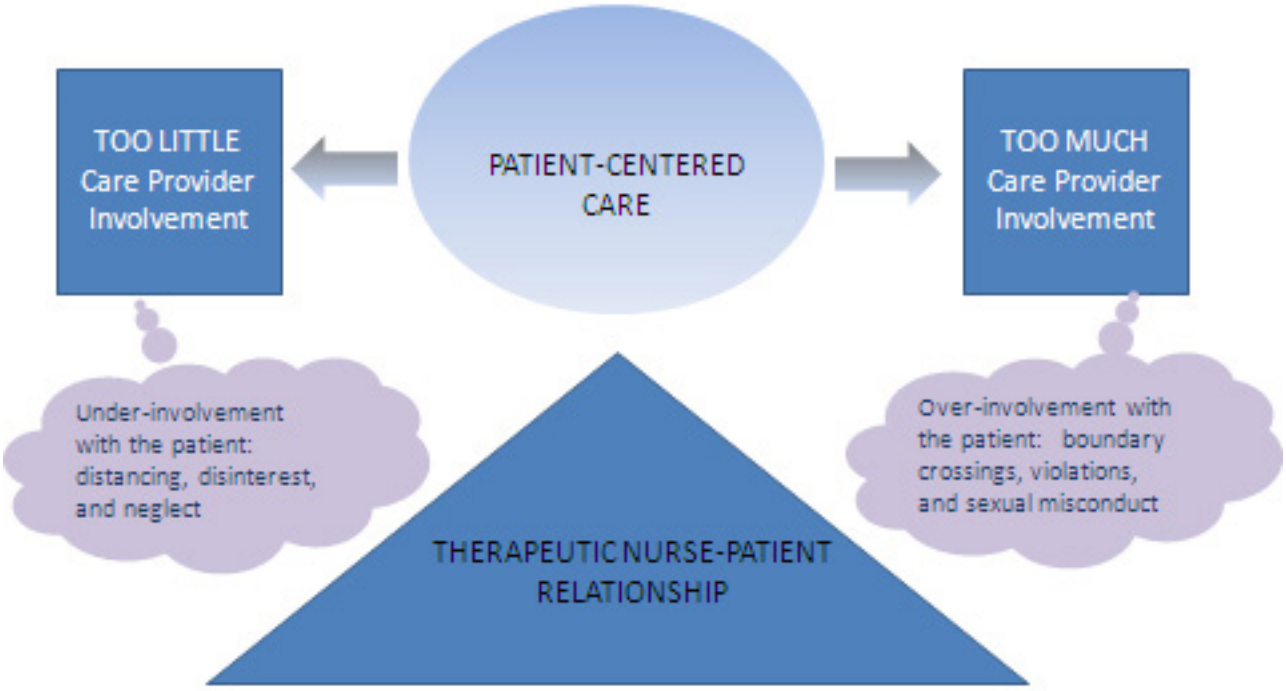
Why are Professional Boundaries important?

- Effectively establishing and maintaining professional boundaries is essential when providing healthcare
- Provide limits that enable the healthcare provider to interact with others in a professional setting
- Ensure a secure and therapeutic environment where the healthcare professional and patient are mutually respected

How are Professional Boundaries established?

- By law
- Set by licensing and/or certifying bodies
- Facility set policies
- Individually

A CONTINUUM OF PROFESSIONAL BEHAVIOR



Boundaries help protect the patient

- You as the healthcare worker have power.
- Boundaries help keep that power in check.
- Boundaries create standard ground rules so everyone knows what is expected and how to behave.

Boundaries help protect you

- Boundaries keep you clear about your role.
- As a healthcare worker it is easy to "burn-out" if you don't have clear boundaries.
- Boundaries allow you to take care of yourself so you can continue to care for others.

8 EXERCISE: PROFESSIONAL BOUNDARIES IN HEALTHCARE

Say to the class: *Especially in healthcare, professional boundaries can be difficult to maintain or can be unclear because of the level of intimacy that occurs between professionals and patients. Boundaries are not always black and white, and often you will need to seek guidance from a friend or supervisor about whether boundaries have been crossed.*

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.

After each question and polling of student answers, have a discussion.
This exercise would ideally be done with students standing up and moving to different corners of the room to visually show the differences in opinion but may be done sitting if space does not permit.
(**Note:** version in Student Exercise Book does not list the answers.)

1. Mark asks Jane if he can trade patient assignments so he can care for a patient he likes working with
   ANSWER: May depend on the situation.

2. Julie likes to grab a cup of coffee with one of her patients after work since she knows her from the neighborhood.
   ANSWER: Not really ok, if they really are friends then better to meet on a different day than her appointment and away from the health center.

3. Hugging a patient is sometimes acceptable.
   ANSWER: Depends on the situation, can be appropriate in certain circumstances.

4. Accepting a cash gift from a patient is sometimes ok.
   ANSWER: Accepting a cash gift is never acceptable in a work situation.

5. Flirting with a patient at work is alright if you are not obvious about it.
   ANSWER: Flirting with a patient in a work situation is never ok and could lead to charges of harassment.

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.

   ANSWER: You should not take sides with one patient over another no matter what you personally think.

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.

   ANSWER: This is not ok and can lead to problems with other patients and your co-workers.

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

   ANSWER: Although it depends on the situation, it could be misinterpreted as a sexual advance or patronizing if he only does this with female patients. In another context, it could be seen as warm or caring.

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.

   ANSWER: You should never ignore a patient who threatens to hurt you or do physical harm. Staff members must always take patients at their word and get immediate help from security, other staff members or the police. This boundary must be clearly established with patients.

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.

    ANSWER: Patients do need to talk, but this doesn't mean that staff should go over allotted time and make other patients wait or exhaust themselves by giving too much. It is important to model boundaries for patients. If a patient needs more time, set up another appointment or refer them to someone else.

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

    ANSWER: This is usually the case. Your professional judgment can be confused by your feelings for a friend, which could lead you to deliver less than optimal care.

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VIDEOS

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MODULE 24

PROFESSIONAL BOUNDARIES - PART 2 & WRAP UP

OBJECTIVES

- Understand the relationship between personal boundaries and burn-out
- Identify the benefits of stress-management as a staff member providing care coordination services
- Identify strategies for wellness and stress reduction
- Reflect on the care coordination role

MATERIALS NEEDED

- PowerPoint file with videos downloaded

PROFESSIONAL BOUNDARIES - PART 2 & WRAP UP

AGENDA

1.	POWERPOINT WITH DISCUSSION: THE RELATIONSHIP BETWEEN BOUNDARIES AND BURN-OUT	10 MIN
2.	POWERPOINT WITH DISCUSSION: CHALLENGES OF MAINTAINING BOUNDARIES WHILE PROVIDING CARE COORDINATION	10 MIN
3.	EXERCISE: YOUR TRIGGERS AT WORK	15 MIN
4.	POWERPOINT WITH DISCUSSION: STRESS MANAGEMENT	20 MIN
5.	BREAK	5 MIN
6.	POWERPOINT WITH DISCUSSION: HEALTH & WELLNESS	5 MIN
7.	EXERCISE: SIMPLE WELLNESS PRACTICES	10 MIN
8.	WRAP UP DISCUSSION	5 MIN
9.	EVALUATION COMPLETION	10 MIN
10.	FINAL CELEBRATION/ CERTIFICATE DISTRIBUTION	30 MIN

1 POWER POINT WITH DISCUSSION: THE RELATIONSHIP BETWEEN BOUNDARIES AND BURN-OUT

What does it mean to be burned out?

- No good days
- You feel overwhelmed and unable to meet constant demands
- You lose interest or motivation to do the job
- You begin to doubt that anything you do makes difference
- Caused by excessive and prolonged stress

How do boundaries relate to burn-out?

- Must be able to say “no” before we can wholeheartedly say “yes”
- Burnout often occurs when we have lost the ability to say no to people
- Especially as healthcare workers we can easily feel that we are not allowed to say “no”

Boundaries are proactive, not reactive - what does this mean?

Boundaries are proactive, not reactive

- A good boundary is set ahead of time, and is transparent
  - i.e. we have fifteen minutes for the visit, I am not able to do that but I will connect you with someone who can
  - it is not a patient's fault if they call you at 2 am to ask a question if you never told them during what hours they can and can't use the contact number that you gave them

It is our job to take care of ourselves, just as it is ultimately the patient's job to take care of him or herself.

2 POWER POINT WITH DISCUSSION: CHALLENGES OF MAINTAINING BOUNDARIES WHILE PROVIDING CARE COORDINATION

The following section was adapted From Colorado Patient Navigator Training Program, www.patientnavigatortraining.org

What are some aspects of care coordination work that may make it challenging to maintain boundaries?

- Work closely with patients
- Develop trust and learn a lot about patients' personal lives
- Line between personal and professional can become blurred

The tasks of care coordination often look very similar to "going above and beyond the call of duty." How could this turn into a problem?

- Avoid becoming personally involved with your patients
- Involvement beyond your professional role opens you to personal liability
- Involvement beyond your professional role establishes unrealistic expectations that can quickly get out of control

How can care coordination staff "keep it professional" with patients?

Know your role

- Be clear about your role so you can clearly communicate it to patients
  - Explain what you are able and not able to do for them
  - Everyone feels less stress when expectations are clear

In terms of information for patients - try to *keep it simple*

- Patients are easily overwhelmed by too much information
  - be sensitive to the type and amount of information they need
- Do not share other patients' stories or experiences
- Do not share or compare your personal health stories with theirs

Remember - ultimately patients are responsible for their own health

- Handle patients with patience
- Some patients will not use the information and resources you provide
- Others will choose to delay care or even refuse it

Recognize that some situations and types of patients may be particularly stressful and challenging for you, and be prepared for them.

3 EXERCISE: YOUR TRIGGERS AT WORK

Say to the class: *Everyone has particular situations and types of people that they find stressful and challenging. The important thing is to know ahead of time what these things are for you. (They are different for different people.) Take a few minutes to write these down.*

Some examples might be a patient bursting into tears, a co-worker getting angry at you, or a patient who repeatedly calls you and asks for more and more help from you.

Once you've written down a few of these triggers, think about how you would normally react to these situations.

Go around the room or ask for volunteers to share their triggers and typical reactions.

4 POWERPOINT WITH DISCUSSION: STRESS MANAGEMENT

We can't always change the situation but we can try and change our reaction to the situation.

Start at the Source

- Stress management begins with identifying the source of your stress.

Coping Strategies

- Once you have identified the source(s) of your stress, ask yourself, "How do I deal with it? What are my coping strategies?"
- Do you think your coping strategies are healthy or unhealthy, helpful or unproductive?
- Unfortunately, many people cope with stress in ways that compound the problem.

What are some unhealthy ways of "coping" with stress?

- Smoking
- Drinking too much
- Overeating or under eating
- Zoning out for hours in front of the TV or computer
- Withdrawing from friends, family, and activities
- Using pills or drugs to relax
- Sleeping too much
- Procrastinating
- Filling up every minute of the day to avoid facing problems
- Taking out your stress on others (lashing out, angry outbursts, physical violence)

4 A's of Stress Management

If your methods of coping with stress are not helping, it might be time to:

Change the situation:

- **A**void the stressor
- **A**lter the stressor

Change your reaction:

- **A**dapt to the stressor
- **A**ccept the stressor

Notes to teacher:

1) AVOID the stressor

- Not all stress can be avoided, and it's not healthy to avoid a situation that needs to be addressed.
- You may be surprised, however, by the number of stressors in your life that you can eliminate
- Can you think of any ways that you avoid stress in your life?

"Avoidance" strategies

- Learn how to say "no"
- Avoid people who stress you out
- Take control of your environment
- Avoid hot-button topics
- Pare down your to-do list

2) ALTER the Situation

- If you can't avoid a stressful situation, try to alter it.
- Figure out what you can do to change things so the problem doesn't present itself in the future.
- Often, this involves changing the way you communicate and operate in your daily life

If you have ever been in a stressful situation that you couldn't avoid, how did you change the situation to make it better?

"Altering" Strategies

- Express your feelings instead of bottling them up.
- Be willing to compromise.
- Be more assertive.
- Manage your time better.

3) ADAPT to the stressor

- If you can't change the stressor, **change yourself.**
- You can adapt to stressful situations and regain your sense of control by changing your expectations and attitude.

How have you adapted to stressors in your life?

What kind of thinking has helped you deal with stress better?

"Adapter" Strategies

- Reframe problems.
- Look at the big picture.
- Adjust your standards.
- Focus on the positive.

4) ACCEPT the things you can't change

- Some sources of stress are unavoidable. You can't prevent or change stressors such as the death of a loved one or a serious illness.
- In such cases, the best way to cope with stress is to accept things as they are.
- Acceptance may be difficult, but in the long run, it's easier than railing against a situation you can't change.

"Acceptance" Strategies

- Don't try to control the uncontrollable.
- Look for the up side.
- Share your feelings.
- Learn to forgive.

5 BREAK

6 POWERPOINT WITH DISCUSSION: HEALTH & WELLNESS

How does Health & Wellness relate to stress?

- Beyond managing how you deal with stress in the moment, you can also reduce stress in your life by **nurturing yourself.**
- Especially as caregivers, it's IMPORTANT to do this for ourselves.

What do you do to take care of yourself?

Healthy ways to relax and recharge

- Go for a walk.
- Spend time in nature.
- Call a good friend.
- Sweat out tension with a good workout.
- Take a long bath.
- Light candles.
- Savor a warm cup of coffee or tea.
- Play with a pet.
- Work in your garden.
- Get a massage.
- Curl up with a good book.
- Listen to music.
- Watch a comedy.

Healthy ways to relax and recharge

- **Set aside relaxation time.**
  Include rest and relaxation in your daily schedule. Don't allow other obligations to encroach. This is your time to take a break from all responsibilities and recharge your batteries.
- **Connect with others.**
  Spend time with positive people who enhance your life. A strong support system will buffer you from the negative effects of stress.
- **Do something you enjoy every day.**
  Make time for leisure activities that bring you joy, whether it be stargazing, playing the piano, or working on your bike.
- **Keep your sense of humor.**
  This includes the ability to laugh at yourself. The act of laughing helps your body fight stress in a number of ways.

7 EXERCISE: SIMPLE WELLNESS PRACTICES

Say to the class:

- *Working in partners, review the "Simple Wellness Practices" in your exercise book.*
- *Think about whether or not any of these practices are things you do now to take care of yourself or things you would like to do?*
- *Talk to your partner about one thing you would like to do more of and why.*
- *We'll ask for volunteers to share at the end.*

Note to Facilitator: The "Simple Wellness Practices" document on the next page was created by the PACT Project, Partners in Health and is reprinted here with permission from the PACT Project, Partners in Health

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.

8 WRAP-UP DISCUSSION

(Optional) review discussion:

- What is a care coordinator?
- What are some of the things they might do?
- Why do we need staff who provide care coordination?
- How are staff who provide care coordination helpful for chronic disease patients?
- What would be some of the benefits that an organization would hope to see by using staff who provide care coordination?

Course review discussion

Ask students to refer to their exercise book.

Say to the class: *Here is the list of all the classes and topics you have completed.*

- *Which topics seemed the most valuable to you?*
- *If you had to pick the most important thing that you learned in this class what would it be?*
- *Will you be able to use what you've learned in this class in your current position?*
- *What is exciting to you about the care coordination role?*
- *What do you think some of the biggest challenges will be?*
- *What other training would be helpful to be able to provide care coordination?*

9 EVALUATION COMPLETION

10 FINAL CELEBRATION/CERTIFICATE DISTRIBUTION

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