“Students tell us when they’re done that 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
“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
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ACKNOWLEDGMENTS & THANKS

The creation, development and piloting of this Care Coordination course was made possible by a Health Workforce Re-Training Initiative grant from the New York State Department of Health.

Primary Care Development Corporation (PCDC) and 1199 SEIU Training and Employment Funds extend our deepest gratitude to Bronx Lebanon Hospital Center for providing the venue and the students including medical assistants, community health workers, case managers, and educators from their primary care staff to participate in the first pilot of the course. These front line staff members provided invaluable feedback and on-the-ground insight to the authors and trainers of this course regarding what skills, training and support care coordinators are most in need of today. In addition, Lutheran Medical Center and Maimonides Medical Center in Brooklyn, NY and Montefiore Medical Center in the Bronx, NY provided key input into the development and revision of curriculum.

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.

Thanks goes to Jennifer Chiu, and Herma Gebru, graduate students at the Columbia University Mailman School of Public Health and interns at PCDC at the time this course was being written. They served on the project team and provided invaluable support in the development of the classes.

A very special thank you goes to Cat Frazier, graphic designer, and at the time PCDC intern, who designed a beautiful looking product with limited time and resources.
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
1199SEIU 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,

Ronda Kotelchuck
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 increasingly are being asked to serve as a bridge between patients and providers. To accomplish this, front-line staff members require more advanced skills and training than they traditionally have received. Specifically, they 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, patient care technicians, certified nurse aides, 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 the students’ critical thinking skills by engaging them in discussion, individual exercises, and group activities. Students complete the course prepared to assist their patients in navigating the healthcare system, and to be strong, productive members of healthcare teams providing coordinated and patient-centered care.
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 and can be played 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
WELCOME & EXPECTATIONS

Note: Introduce yourself and discuss your background. Students should say something about their healthcare experience, if they have any. Talk about the class-inclusive approach, questions and discussion encouraged, interactive, etc.

POWERPOINT 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.
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”


**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

**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*

**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
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

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.

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

VIDEO: EYE TO EYE: DR. HAROLD FREEMAN

VIDEO DISCUSSION QUESTIONS
- 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.
- 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.
- 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.
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.

**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?

- Communication, good listener
- Resourceful
- Ability to be part of a medical team
- Ability to brainstorm and think creatively

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

**Knowledge**

- 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

**BREAK**

**VIDEO:**

- PATIENT NAVIGATORS - CENTER FOR ADVANCED DIGESTIVE CARE
- 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.

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

Go around 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
Divide the class into small groups of 4-5 students

- Ask students to make a list of all of the things that could make someone frustrated when accessing healthcare
- As a group brainstorm solutions to each of these frustrations
Tell the students: **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
15 HOMEWORK FOR NEXT CLASS

1. Write one page about a time when you, a friend or a family member had trouble navigating the healthcare system.

Some examples of this might be a time when:

• you couldn’t get a medical appointment quickly
• you didn’t understand medical instructions that were given to you or your family member
• you or someone you know had trouble getting medicine that you needed
• someone you knew had difficulty with their insurance or didn’t have insurance so they delayed going to the doctor
• a family member received a serious diagnosis, but took a long time to follow up to get care

Include how you think the situation could have been improved.
Be ready to share your story with the group.

2. Instructions: 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

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 the read the article, since these questions will be discussed in the next class.

http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande
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http://www.cdc.gov/socialdeterminants/Definitions.html

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Dohan, D. Schrag, D. Using Navigators to Improve Care of Underserved Patients. Wiley InetrScience, July 2005; 848-855


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


NIH fact sheets-health disparities:

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


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=DQhUllZ0N4&feature=related
Patient Navigators - Center for Advanced Digestive Care - Denise Miles
http://www.youtube.com/watch?v=fztTFZjKIXo&feature=related
Kings County Patient Navigators: Healthbeat Brooklyn
http://www.youtube.com/watch?v=DtkcnXrlzpc&feature=related
OBJECTIVES

- Define what a chronic disease is and how it relates to our healthcare system today
- Define coordinated care and patient-centered care
- Describe the new models of healthcare such as Health Homes, Patient-Centered Medical Home, ACOs where care coordination might staff might work
- Describe what it means to work as part of a medical team and describe how staff providing care coordination fit with the rest of the medical team
- Explain the Patient’s Bill of Rights

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

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<td>10 min</td>
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<tr>
<td>11</td>
<td>POWERPOINT WITH DISCUSSION: ETHICAL RESPONSIBILITIES</td>
<td>10 min</td>
</tr>
<tr>
<td>12</td>
<td>REVIEW HOMEWORK FOR NEXT CLASS, WRAP UP</td>
<td>5 min</td>
</tr>
</tbody>
</table>
2 HOMEWORK DISCUSSION: ATUL GAWANDE ARTICLE

- 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.”

- 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?

- 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?

- “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 patient navigator work?

- 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?

- “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?

3 STUDENT STORIES ABOUT TROUBLE NAVIGATING THE HEALTHCARE SYSTEM

- Ask for volunteers to read the stories
- Have the group brainstorm other solutions to the problems that students wrote
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.

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

What are some common chronic diseases in the United States today?
• Diabetes
• Hypertension
• Cardiovascular disease
• Asthma
• Depression/schizophrenia
• HIV and Hepatitis

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 patient navigators
• 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)?
• Similar to a Health Home
• Brings together multiple providers and organizations to deliver coordinated healthcare services
• Shared goal of improving quality of care, reducing costs, and improving patient experience
• Unlike a Health Home, does not have to focus only on chronically ill patients
VIDEOS:
WITHOUT A MEDICAL HOME (“BAD”)
WITH A MEDICAL HOME (“BETTER”)

BREAK

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?

POWERPOINT WITH DISCUSSION:
WHAT DOES IT MEAN TO WORK AS PART OF A MEDICAL TEAM?

How do you find out what your role and responsibilities are?
• Job description
• Who else is on the team?
• What do they do? What role do they play?
• What kinds of patients does your team care for?
• Does the rest of the team understand what your role is?

What does it mean to be a “team player”?
• Everyone on the team is valued
• All team members have something important to contribute
• Support each other, step in and help if someone needs help
• Listen to each other, respect each other
• All members share the goal of providing patient-centered, coordinated care

What does it mean to advocate for your patients?
• You may be the only person on the team who understands the challenges that a patient may be facing
  - Have you ever lived in a community similar to where your patients live?
  - Do you speak the same language that some of your patients do?
• Your role is to communicate the challenges your patients face to the rest of the team

Key Competencies:
• Understanding your role and responsibilities
• Being a “team player”
• Advocating for your patients
• Building relationships
Why is building relationships a key competency for staff who provide care coordination?

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

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 and “stand in their shoes”

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

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

- Takes primary responsibility for the patient
- Provides, facilitates and coordinates all patient care
- Care coordination staff facilitates 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 the team how care coordination can make things easier for them to do their job.
- Discuss the role of care coordination at team or staff meetings so that everyone is clear about their role

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

Being a staff member who provides care coordination means that you spend a lot of time working on maintaining professional relationships!
CARE COORDINATION TEACHER GUIDE

GROUP EXERCISE: CARE COORDINATION DUTIES QUIZ

Tell students to refer to their exercise book.

**Say to students:** 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
Say to the students: Have you ever been given a patient’s bill of rights in a health care center? Did you read it? Did you understand it?

Based on your students’ responses, be sure to highlight the following:

- 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 it or understand it.
- As a staff member providing care coordination, you want to be aware of the patient’s bill of rights in case you need to advocate for your patient.

Go around the room and ask students to take turns reading sections of the sample Health Center Patient’s Bill of Rights and Responsibilities in their exercise books.
SAMPLE

HEALTH CENTER PATIENT’S BILL OF RIGHTS AND RESPONSIBILITIES

Community Health Center (“CHC”) is committed to providing high quality care that is fair, responsive, and accountable to the needs of our patients and their families. We are committed to providing our patients and their families with a means to not only receive appropriate health care and related services, but also to address any concerns they may have regarding such services. We encourage all of our patients to be aware of their rights and responsibilities and to take an active role in maintaining and improving their health and strengthening their relationships with our health care providers.

We strongly urge anyone with questions or concerns regarding our “Bill of Rights and Responsibilities” to contact [INSERT POSITION AND NAME OF CONTACT PERSON(S)] who will be happy to assist you.

EVERY PATIENT HAS A RIGHT TO:

1. Receive high quality care based on professional standards of practice, regardless of his or her (or his or her family’s) ability to pay for such services.
2. Obtain services without discrimination on the basis of race, ethnicity, national origin, sex, age, religion, physical or mental disability, sexual orientation or preference, marital status, socio-economic status or diagnosis/condition.
3. Be treated with courtesy, consideration and respect by all CHC staff, at all times and under all circumstances, and in a manner that respects his or her dignity and privacy.
4. Be informed of the CHC’s Privacy Policies and Procedures, as the policies relate to individually identifiable health information.
5. Expect that the CHC will keep all medical records confidential and will release such information only with his or her written authorization, in response to court order or subpoenas, or as otherwise permitted or required by law.
6. Access, review and/or copy his or her medical records, upon request, at a mutually designated time (or, as appropriate, have a legal custodian access, review and/or copy such records), and request amendment to such records.
7. Know the name and qualifications of all individuals responsible for his or her health care and be informed of how to contact these individuals.
8. Request a different health care provider if he or she is dissatisfied with the person assigned to him or her by the CHC. The CHC will use best efforts, but cannot guarantee, that re-assignment requests will be accommodated.
9. Receive a complete, accurate, easily understood, and culturally and linguistically competent explanation of (and, as necessary, other information regarding) any diagnosis, treatment, prognosis, and/or planned course of treatment, alternatives (including no treatment), and associated risks/benefits.
10. Receive information regarding the availability of support services, including translation, transportation and education services.

11. Receive sufficient information to participate fully in decisions related to his or her health care and to provide informed consent prior to any diagnostic or therapeutic procedure (except in emergencies). If a patient is unable to participate fully, he or she has the right to be represented by parents, guardians, family members or other designated surrogates.

12. Ask questions (at any time before, during or after receiving services) regarding any diagnosis, treatment, prognosis and/or planned course of treatment, alternatives and risks, and receive understandable and clear answers to such questions.

13. Refuse any treatment (except as prohibited by law), be informed of the alternatives and/or consequences of refusing treatment, which may include the CHC having to inform the appropriate authorities of this decision, and express preferences regarding any future treatments.

14. Obtain another medical opinion prior to any procedure.

15. Be informed if any treatment is for purposes of research or is experimental in nature, and be given the opportunity to provide his or her informed consent before such research or experiment will begin (unless such consent is otherwise waived).

16. Develop advance directives and be assured that all health care providers will comply with those directives in accordance with law.

17. Designate a surrogate to make health care decision if he or she is or becomes incapacitated.

18. Ask for and receive information regarding his or her financial responsibility for the services.

19. 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 his/her insurance.

20. Request any additional assistance necessary to understand and/or comply with the CHC’s administrative procedures and rules, access health care and related services, participate in treatments, or satisfy payment obligations by contacting [INSERT POSITION AND NAME OF RESPONSIBLE PERSON(S)]

21. File a grievance or complaint about the CHC or its staff without fear of discrimination or retaliation and have it resolved in a fair, efficient and timely manner. [INSERT COMPLAINT PROCEDURES AND RESPONSIBLE PERSON(S)]

Taken from The National Association of Community Health Centers sample Patient’s Bill of Rights and responsibilities:

EVERY PATIENT IS RESPONSIBLE FOR:

1. Providing accurate personal, financial, insurance, and medical information (including all current treatments and medications) prior to receiving services from the CHC and its health care providers.
2. Following all administrative and operational rules and procedures posted within the CHC facility(s).
3. Behaving at all times in a polite, courteous, considerate and respectful manner to all CHC staff and patients, including respecting the privacy and dignity of other patients.
4. Supervising his or her children while in the CHC facility(s).
5. Refraining from abusive, harmful, threatening, or rude conduct towards other patients and/or the CHC staff.
6. Not carrying any type of weapons or explosives into the CHC facility(s).
7. Keeping all scheduled appointments and arriving on time.
8. Notifying the CHC no later than 24 hours (or as soon as possible within 24 hours) prior to the time of an appointment that he/she cannot keep the appointment as scheduled. Failure to follow this policy may result in being charged for the visit and/or being placed on a waiting list for the next visit.
9. Participating in and following the treatment plan recommended by his or her health care providers, to the extent he or she is able, and working with providers to achieve desired health outcomes.
10. Asking questions if he or she does not understand the explanation of (or information regarding) his or her diagnosis, treatment, prognosis, and/or planned course of treatment, alternatives or associated risks/benefits, or any other information provided to him or her regarding services.
11. Providing an explanation to his or her health care providers if refusing to (or unable to) participate in treatment, to the extent he or she is able, and clearly communicating wants and needs.
12. Informing his or her health care providers of any changes or reactions to medication and/or treatment.
13. Familiarizing himself or herself with his or her health benefits and any exclusions, deductibles, co-payments, and treatment costs.
14. As applicable, making a good faith effort to meet financial obligations, including promptly paying for services provided.
15. Advising the CHC of any concerns, problems, or dissatisfaction with the services provided or the manner in which (or by whom) they are furnished.
16. Utilizing all services, including grievance and complaint procedures, in a responsible, non-abusive manner, consistent with the rules and procedures of the CHC (including being aware of the CHC’s obligation to treat all patients in an efficient and equitable manner).

Have students read the summary of the key provisions of The Patient’s Bill of Rights from The Affordable Care Act and discuss what each part means.

HIGHLIGHTS OF THE PATIENT’S BILL OF RIGHTS IN THE AFFORDABLE CARE ACT

The Affordable Care Act puts consumers back in charge of their health care. Under the law, a new “Patient’s Bill of Rights” gives the American people the stability and flexibility they need to make informed choices about their health.

Coverage

• Ends Pre-Existing Condition Exclusions for Children: Health plans can no longer limit or deny benefits to children under 19 due to a pre-existing condition.
• Keeps Young Adults Covered: If you are under 26, you may be eligible to be covered under your parent’s health plan.
• Ends Arbitrary Withdrawals of Insurance Coverage: Insurers can no longer cancel your coverage just because you made an honest mistake.
• Guarantees Your Right to Appeal: You now have the right to ask that your plan reconsider its denial of payment.

Costs

• Ends Lifetime Limits on Coverage: Lifetime limits on most benefits are banned for all new health insurance plans.
• Reviews Premium Increases: Insurance companies must now publicly justify any unreasonable rate hikes.
• Helps You Get the Most from Your Premium Dollars: Your premium dollars must be spent primarily on health care – not administrative costs.

Care

• Covers Preventive Care at No Cost to You: You may be eligible for recommended preventive health services. No co-payment.
• Protects Your Choice of Doctors: Choose the primary care doctor you want from your plan’s network.
• Removes Insurance Company Barriers to Emergency Services: You can seek emergency care at a hospital outside of your health plan’s network.

From http://www.hhs.gov/healthcare/rights/index.html
Ask students the following questions:

1. **What is a pre-existing condition?**

   **ANSWER:** At a very basic level, a pre-existing condition is a physical or mental health condition, disability or illness that you had before you enrolled in a health plan.

   There is no one definition of a pre-existing condition. Health insurance issuers and employer plans use different definitions. Depending upon your condition, you may be denied coverage or charged a higher premium.

   Private insurance companies may choose to deny your application for health coverage because of a pre-existing condition, or agree to sell you a policy, but exclude coverage for benefits associated with certain pre-existing conditions. Or the insurance company may charge you more because of a pre-existing condition. What this means is that if you have a pre-existing condition, you may have been unable to obtain or afford coverage.

   The good news is that, under the Affordable Care Act, denying coverage or excluding benefits due to a pre-existing condition will no longer be allowed.

2. **Until what age can young adults receive coverage now under their parents’ insurance plan?**

   **ANSWER:** If you are under 26, you may be eligible to be covered under your parent’s health plan.

3. **What does it mean that “lifetime limits” are banned?**

   **ANSWER:** Before the health care law, many health plans set an annual limit — a dollar limit on yearly spending for your covered benefits. Many plans also set a lifetime limit — a dollar limit on your covered benefits during the entire time you were enrolled in that plan. You were required to pay the cost of all care exceeding those limits.

   Be aware that plans can put an annual dollar limit and a lifetime dollar limit on spending for health care services that are not considered “essential.”

4. **What does it mean that insurance company barriers to emergency services are no longer in place?**

   **ANSWER:** In the past, some health plans would limit payment for emergency room services provided outside of a plan’s preselected network of emergency health care providers. Or they would require you to get your plan’s prior approval for emergency care at hospitals outside its networks. This could mean financial hardship if you get sick or injured while away from home.

   The new rules prevent health plans from requiring higher co-payments or co-insurance for out-of-network emergency room services. The new rules also prohibit health plans from requiring you to get prior approval before seeking emergency room services from a provider or hospital outside your plan’s network.

From HealthCare.gov:
The last thing we want to cover in today’s class is the idea of ethical responsibilities. As you may have noticed in the last activity, the line can be unclear, but it is important to maintain an ethical relationship. It’s important to recognize that even if you feel inexperienced, patients will view you as the person of authority with all the answers. You therefore need to be careful about this responsibility and use your power in a way that empowers the patient. You must always remember to take the patient’s needs into account first and to do what is best for your patient.

It’s Important NOT to:
• Burden clients with your problems
• Meet your needs
• Insist on your solutions
• Exploit dependency

The Following are Strategies to Keep You in Check:

If you find yourself....
• Talking more than the patient
  Check yourself!
• Talking about your personal problems
  Check yourself!
• Suggesting your solutions or preaching to the patient
  Check yourself!
• In a position where the patient depends on you more than they should
  Check yourself!


HAND OUT PRINTED COPIES OR REFER STUDENTS TO THE LINK

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


Note: Students should know that many of the handouts and tools used in the class are intended to support their work with clients. Students should not feel obligated to read all of the handouts.
REFERENCES

Colonoscopy Patient Navigator Program Orientation Manual, NYC Health DOHMH

http://www.aafp.org/fpm/2000/0300/p47.html

Healthcare.gov: Patient’s Bill of Rights:


Colorado Patient Navigator Training Program:
http://www.patientnavigatortraining.org/

Core Value; Community Connections: Care Coordination in the Medical Home Patient-Centered Primary Care Collaborative, 2011

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

Medicaid Institute at United Hospital Fund, Implementing Medicaid Health Homes in New York: Early Experience
http://www.uhfny.org/publications/880881
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
▪ Print 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
# 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.

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

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
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)
**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 who are less active
  - Using cars, instead of walking
  - Watching more television and video games
- 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

**VIDEO: DIABETES MADE SIMPLE**
How is diabetes diagnosed?
- Fasting blood glucose (FBG)
  - $< 100$ (mg/dl) = normal
  - $100$ to $125$, pre-diabetes
  - $126$ or $> 125$ 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
o Podiatrist, infectious disease, neurologist:
  - For problems with nerve damage
  - High blood sugar can damage nerves leading to loss of sensation in feet and hands leading to infections, main cause of amputations in diabetics

o 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

**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

**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

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?

VIDEO: NDEP — GETTING READY FOR YOUR DIABETES CARE VISIT
SMALL GROUP EXERCISE: HELPING PREPARE A PATIENT FOR A DOCTOR’S VISIT

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

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

**Before the visit:**

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

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

What should patients bring with them to a healthcare visit?

What arrangements does a patient need to make regarding past medical records?
During the visit:

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

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

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

After the visit:

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

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

What should patients expect to be contacted about after a healthcare visit?
Preparing for a medical provider’s visit — checklist of things to do and ask the medical/care team

**Before the visit:**

✓ List of all doctors they have seen in the last five years, and type of doctor, including any emergency room visits or admissions to the hospital

✓ List of all medications they take or bring all pill bottles

✓ List of symptoms they’ve been experiencing

✓ Health diary

✓ Make sure that the doctor has their medical records

**What to do during the visit:**

✓ Ask questions

✓ Write down or record the answers

✓ Take home information

✓ Ask for written instructions
After the visit:

✓ Did they understand everything that was told to them at the visit?

✓ Call the provider’s office if they:
  • Have problems following the provider’s advice
  • Have any questions
  • Experience worsening of symptoms
  • Experience danger signs and symptoms
  • Have questions about taking their medications
  • Have problems with the medications
  • Had tests done and didn’t hear back about the results

✓ Write down any answers they get when they call and speak to someone at the provider’s office

✓ Do they have your number if they have questions?
WRAP-UP, QUESTIONS, HOMEWORK FOR NEXT CLASS:

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

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

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
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

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-Tudiaabetes
http://www.youtube.com/watch?v=29bng1H4XTS

NDEP | Getting Ready for Your Diabetes Care Visit
http://www.youtube.com/watch?v=r5gBffSrns4s
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.

MODULE 4
COMMON CHRONIC DISEASES — PART 2
HYPERTENSION/HIGH CHOLESTEROL/ASTHMA
Common Chronic Diseases — Part 2
Hypertension/High Cholesterol/Asthma

AGENDA

1. HOMEWORK REVIEW/FEEDBACK ON LAST CLASS 10 min
2. POWERPOINT WITH DISCUSSION: BASICS OF HYPERTENSION 5 min
3. VIDEO: MANAGING HYPERTENSION WITH LIFESTYLE CHANGES 15 min
4. POWERPOINT WITH DISCUSSION: BASICS OF HIGH CHOLESTEROL 5 min
5. GROUP EXERCISE: SATURATED FAT IN FOODS 15 min
6. GROUP EXERCISE: ROSA’S DILEMMA 5 min
7. BREAK 5 min
8. POWERPOINT WITH DISCUSSION: ASTHMA 10 min
9. VIDEO: LIVING WITH AND MANAGING ASTHMA 15 min
10. VIDEO DISCUSSION 5 min
11. SMALL GROUP EXERCISE: HEALTHY BEHAVIORS: DIET/EXERCISE/SMOKING QUIZ 22 min
12. WRAP-UP, QUESTIONS, HOMEWORK ASSIGNMENT 8 min

1. HOMEWORK REVIEW/FEEDBACK ON LAST CLASS

2. 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

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 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

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 at least 30 minutes most days
- Limit amount of alcohol you drink (< 1 drink a day for women, < 2 for men)
- Quit smoking
- Take your prescription medications as prescribed

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

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 is “good” cholesterol
- LDL: 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 makes your body make more triglycerides

What causes high blood cholesterol?
- Inactivity
- Obesity
- Diet high in saturated fat, trans fat and cholesterol
- Age
- Family history

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 blood 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, trans fat, and cholesterol
- Quit smoking
- Increase activity and exercise
- Lose weight
- Medications
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, or 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)
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

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
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
- Relieve 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

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

VIDEO: LIVING WITH AND MANAGING ASTHMA

What's a peak flow meter and what is it used for?
- Hand held device 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
**GROUP ACTIVITY: HEALTHY BEHAVIORS — DIET/EXERCISE/SMOKING QUIZ**

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

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

1. Examples of physical activity include:
   a. Walking at a brisk pace
   b. Using the stairs
   c. Watching television
   d. Riding a bike

2. Risk factors for diabetes and hypertension include:
   a. Cigarette smoking
   b. Being overweight
   c. Not being physically active
   d. Not managing stress well

3. For some people, asthma can be triggered by:
   a. Cockroaches
   b. Mold inside a house
   c. Plastic
   d. Pollen

4. Being more physically active can:
   a. Improve sleep
   b. Help reduce stress
   c. Help lose or maintain a healthy weight
   d. Give more energy

5. As a person gets older:
   a. They should reduce the amount of physical activity they do
   b. They can develop health problems if they are not physically active
   c. They are at greater risk for heart disease
   d. They are at lower risk for diabetes

6. Moderate high blood pressure may be controlled or lowered by:
   a. Reducing the amount of sodium in your diet
   b. Increasing how physically active you are
   c. Learning how to manage your stress
   d. Drinking lots of alcohol

7. The majority of the sodium that we eat and that 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. Greater than 110/60
   b. Greater than 70/50
   c. Greater than 140/90
   d. Greater than 135/88

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, doughnuts, 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: fats and oil that are solid at room temperature such as palm oil and coconut oil are high in saturated fat
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,
Homework for next class:


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?
REFERENCES

The Community Health Worker’s Sourcebook: A Training Manual for Preventing Heart Disease and Stroke,

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

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.
Module 5

Common Chronic Diseases — Part 3
Heart Disease/Stroke

AGENDA

1. HOMEWORK REVIEW/FEEDBACK ON LAST CLASS 10 min
2. POWERPOINT WITH DISCUSSION: OVERVIEW: HEART DISEASE AND STROKE 5 min
3. VIDEO: LIVING WITH AND MANAGING CORONARY ARTERY DISEASE 15 min
4. POWERPOINT WITH DISCUSSION: HEART ATTACK 5 min
5. POWERPOINT WITH DISCUSSION: STROKE 15 min
6. VIDEO: STROKE HEROES ACT FAST 5 min
7. SMALL GROUP EXERCISE: CULTURE AND CARDIOVASCULAR DISEASE 5 min
8. BREAK 10 min
9. POWERPOINT WITH DISCUSSION: TAKING MEDICATION 15 min
10. SMALL GROUP EXERCISE: HELPING PATIENTS TAKE MEDICATION 5 min
11. SMALL GROUP EXERCISE: JOB DESCRIPTION MATCHING GAME 3 min
12. HOMEWORK FOR NEXT CLASS 22 min

HOMEWORK REVIEW

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

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

3 VIDEO: LIVING WITH AND MANAGING CORONARY ARTERY DISEASE

4 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 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 that 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

Warning signs of a stroke:

- Symptoms can last 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 CY 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

VIDEO:
STROKE HEROES ACT FAST
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 among your patients and in their communities 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.
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 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
SMALL GROUP EXERCISE: HOW CAN STAFF PROVIDING CARE COORDINATION SERVICES HELP PATIENTS TAKE THEIR MEDICINES?

Say to class: Break into small groups and list all the ways in which staff who provide care coordination services 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.
**CARE COORDINATION TEACHER GUIDE**

### 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.

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<thead>
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<tr>
<td>1.</td>
<td>Primary Care Physician</td>
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<td>Specialist</td>
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<td>Nurse Practitioner, Nurse Midwife, Physician Assistant</td>
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<td>Administrator</td>
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<td>14.</td>
<td>Certified Diabetes Educator</td>
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<td>15.</td>
<td>Podiatrist</td>
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</table>
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 GRID

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

The ABCs of Hepatitis:

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
REFERENCES
The Community Health Worker’s Sourcebook: A Training Manual for Preventing Heart Disease and Stroke:

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:

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

Stroke Heroes Act Fast
http://www.youtube.com/watch?v=YHzz2cXBIGk
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

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<thead>
<tr>
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<th>Activity</th>
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<tbody>
<tr>
<td>1</td>
<td>HOMEWORK REVIEW/FEEDBACK ON LAST CLASS</td>
<td>5 min</td>
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<tr>
<td>2</td>
<td>POWERPOINT WITH DISCUSSION: HEPATITIS A, B, AND C</td>
<td>10 min</td>
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<tr>
<td>3</td>
<td>VIDEO: HEPATITIS C MADE SIMPLE: KNOW YOUR STATUS</td>
<td>7 min</td>
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<td>4</td>
<td>VIDEO DISCUSSION</td>
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<td>5</td>
<td>VIDEO: GEORGE’S STORY: HEPATITIS C</td>
<td>2 min</td>
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<td>6</td>
<td>VIDEO: SU WANG: FACES OF HEPATITIS</td>
<td>3 min</td>
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<td>7</td>
<td>VIDEO DISCUSSION</td>
<td>13 min</td>
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<td>8</td>
<td>POWER POINT WITH DISCUSSION: BASICS OF HIV</td>
<td>15 min</td>
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<td>9</td>
<td>BREAK</td>
<td>5 min</td>
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<td>10</td>
<td>VIDEO: FACES OF HIV: KAMARIA’S STORY</td>
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<td>VIDEO DISCUSSION</td>
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<td>12</td>
<td>VIDEO: LIVING WITH HIV</td>
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<td>13</td>
<td>GROUP EXERCISE: LIVING WITH HIV</td>
<td>25 min</td>
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<tr>
<td>14</td>
<td>HOMEWORK FOR NEXT CLASS</td>
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### HOMEWORK REVIEW/FEEDBACK ON LAST CLASS

### 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 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
- Alcohol/drug avoidance

www.cdc.gov/hepatitis

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

- Many people with lifelong chronic infection, many 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

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 tests
- If Hepatitis test is positive, usually more tests 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

VIDEO: HEPATITIS C MADE SIMPLE: KNOW YOUR STATUS

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 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.

POWERPOINT WITH DISCUSSION: BASICS OF HIV

What is HIV?

- Human Immunodeficiency Virus
- Virus that can lead to AIDS
- Destroys CD4 and 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
• HIV 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 feel anything 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
• Should begin if CD4 count is < 500, pregnancy, have Hep B

Treatment can be difficult
• May involve taking multiple pills at specific times every day for the rest of patient’s life
• 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
- Body 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

VIDEO: FACES OF HIV: KAMARIA’S STORY

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

VIDEO: LIVING WITH HIV
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?
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:

Web MD: A man with HIV infection:
http://www.webmd.com/hiv-aids/guide/man-hiv

Web MD: A woman with HIV:

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_kw8qHGTL

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

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.
  
AGENDA

1. HOMEWORK REVIEW 10 min
   HOMEWORK REVIEW
   POWERPOINT WITH DISCUSSION: CULTURAL COMPETENCE DEFINITIONS 5 min
2. VALUES CLARIFICATION EXERCISE 25 min
3. VALUES CLARIFICATION EXERCISE 25 min
4. POWERPOINT WITH DISCUSSION: CULTURAL IDENTITY 5 min
5. ACTIVITY: FROM MY PERSPECTIVE 15 min
6. BREAK 5 min
7. VIDEO: INCOMPETENT VS. COMPETENT CULTURAL CARE 10 min
8. VIDEO DISCUSSION 10 min
9. POWERPOINT WITH DISCUSSION: CULTURALLY COMPETENT INTERVIEW TECHNIQUES 15 min
10. ACTIVITY: CULTURAL COMPETENCY ROLE PLAY 15 min
11. 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?
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?
• Cultural Awareness: A general understanding of what another group is like and how it functions.

What is cultural sensitivity?
• 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
NOTE: 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.

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

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.

Say to the students: We know that there are many influences that shape who we are and how we see the world. For example, our language, our ethnicity or race, where we were born, where we live, our socioeconomic status, our age, our gender, etc. During this exercise, please take a moment and describe some of the influences that are specific to you — such as your place of birth, your age, your profession, your education, etc.

Discuss Questions:

- How do you think these influences affect your role as a staff member providing care coordination?
- How could this impact the healthcare of the patients you see?
- How can you make sure that these influences don’t negatively impact your work with your clients?
ACTIVITY: FROM MY PERSPECTIVE

Instructions: Using the graphic below, please fill in your specific cultural influences, such as religion (i.e. Jewish), age (i.e. 25), race (i.e. Black), education (i.e. Associate Degree) that have shaped who you are and your perspective in the world.
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


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.
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 and 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)

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.

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?”

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?
ACTIVITY: ROLE-PLAY — CROSS CULTURAL STRATEGIES IN PRACTICE

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

ROLE-PLAY: CROSS CULTURAL STRATEGIES IN PRACTICE

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?
ROLE-PLAY: CROSS CULTURAL STRATEGIES IN PRACTICE

PATIENT

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

Note to student: You will be asked many questions as part of this 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!

WRAP-UP, HOMEWORK FOR NEXT CLASS

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

HOMEWORK FOR NEXT CLASS

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.

REFERENCES
Missouri People to People Training Manual, 2008


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
Incompetent vs. Competent Cultural Care
http://www.youtube.com/watch?v=Dx4la-jatNQ
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
- Supplies for exercise:
  - Construction paper (4 colors)
  - Scissors
  - Envelopes
  - Marker
  - Tape for each student group (4 groups)
# Module 8

## Health Disparities

### AGENDA

| 1. Exercise: “Building a House” | 15 min |
| 2. Debrief: “Building a House” | 10 min |
| **Powerpoint with Discussion:** Health Disparities and Social Determinants of Health | 10 min |
| **Homework Discussion:** Broad Racial Disparities Seen in American’s Ills Article | 10 min |
| 5. Video: Unnatural Causes... Is Inequality Making Us Sick? | 5 min |
| 6. Video Discussion | 10 min |
| 7. Break | 5 min |
| **Video:** Living in Disadvantaged Neighborhoods is Bad for Your Health | 5 min |
| 9. Video Discussion | 10 min |
| **Powerpoint with Discussion:** The Role of Care Coordination in Reducing Health Disparities | 5 min |
| 11. Small Group Exercise: How Can Care Coordination Decrease Health Disparities? | 15 min |
| 12. Exercise Debrief & Powerpoint | 15 min |
| 13. Wrap-Up | 5 min |
GROUP ACTIVITY: BUILDING A HOUSE

The goal of this activity is to increase understanding of how patients and communities have different levels of resources and how this impacts patient and community health outcomes. This activity will ask students to work together in groups to create a “house”. Each group will be given a different “resource pack” to help them build a house. Some groups will have enough in their resource packs to easily build the house and others will not. Groups without enough resources will have to get creative in order to make their house (i.e. form alliances with other groups to share resources). Some groups might get frustrated because they don’t have what they need (especially compared to other groups) to build a house. Groups may ask you as the facilitator for help or guidance in building their houses. Your role is not to tell these groups how to build their houses, but rather connect their feelings and experiences with how their patients might feel when they experience situations without adequate resources.

For this activity, you will need to pre-assemble 4 “Resource Packs.” Different pieces of construction paper (as detailed below) will represent a roof, wall, door and window; and ultimately form a “Resource Pack.” Each student group will get a different kind of resource pack in order to create a “house.”

PRE-CLASS RESOURCE PACK ASSEMBLY INSTRUCTIONS:

Step 1:
Assemble construction paper as detailed below:
- 5 Roofs: Roofs are ½ a piece of construction paper, each labeled “Roof” (Color 1)
- 11 Walls: Walls are ¼ a piece of construction paper, each labeled “Wall” (Color 2)
- 6 Doors: Doors are 1/8 a piece of construction paper, each labeled “Door” (Color 3)
- 8 Windows: Windows are 1/16 a piece of construction paper, each labeled “Window” (Color 4)

Step 2:
Use construction paper pieces to create 4 Resource Packs:
- Resource Pack 1: 4 walls, 1 roof, 3 doors, 5 windows
- Resource Pack 2: 4 walls, 2 roofs, 1 door, 1 window
- Resource Pack 3: 2 walls, 2 doors, 1 window
- Resource Pack 4: 1 wall, 2 roofs, 1 window

Step 3:
Place each Resource Pack in an envelope and label with the corresponding number - 1, 2, 3, and 4
CLASS ACTIVITY INSTRUCTIONS:
Divide class into 4 groups. Each group will be given 15 minutes to build a house. Hand out one Resource Pack and a roll of tape to each group to build their house.

Tell the students: The goal of this activity is to build a “house.” Each group has been given a “resource pack” with items you will need to build your house. You will be given 15 minutes to do this. Houses will be rated based on how complete they are.

- For a “best quality” rating, your house must have at least: 4 walls, 1 roof, 2 doors and 4 windows
- For a “good quality” rating, your house must have at least: 3 walls, 1 roof, 1 door and 2 windows
- For a “baseline quality” rating, your house must have at least: 2 walls, 1 roof and 1 door

DEBRIEF OF BUILDING A HOUSE EXERCISE

ASK THE STUDENTS:
- What was it like trying to build your house without enough resources?
- Did you develop alliances and get other groups to share resources with you?
- What lessons can we learn from this activity about the ways that health disparities may impact our patients?
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.”


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”


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

As socioeconomic circumstances decrease, risk increases for:
- Mortality: risk of death
- Morbidity: risk of illness and injury
- Unhealthy behaviors
- Reduced access to health care
- Poor quality of care


CDC Health Disparities and Inequalities Report — United States, 2011

Health disparities can be seen as a constellation of risk factors and behaviors that occur more for some groups of people than for 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
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%).


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
VIDEO: UNNATURAL CAUSES...IS INEQUALITY MAKING US SICK?

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?

BREAK

VIDEO: LIVING IN DISADVANTAGED NEIGHBORHOODS IS BAD FOR YOUR HEALTH

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?

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


Provisions of the Affordable Care Act fund these strategies, all of which have been shown to be more successful when combined with care coordination services.
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.
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.
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 misperceptions 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 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, care coordination 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
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.”

Looking ahead, the opportunity for care coordination staff to reduce health disparities will be expanded and strengthened because the Affordable Care Act (ACA) will:
- Expand initiatives to increase racial and ethnic diversity in the health care professions
- Strengthen cultural competency training for all health care providers
- Require health plans to use language services and community outreach in underserved communities

**WRAP-UP**
REFERENCES

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


VIDEOS

Unnatural Causes...Is Inequality Making us Sick?
https://www.youtube.com/watch?v=uE7v5cHIHDQ

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 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
- PowerPoint file with videos 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 ABOUT CARE COORDINATION
   - 20 min

9. POWERPOINT WITH DISCUSSION: COMMUNICATING BY PHONE
   - 5 min

10. POWERPOINT WITH DISCUSSION: COMMUNICATING BY EMAIL
    - 5 min

11. VIDEO: KRISTIN BAIRD: SERVICE EXCELLENCE
    - 6 min

12. VIDEO DISCUSSION: WHAT IS GOOD CUSTOMER SERVICE?
    - 10 min

13. POWERPOINT WITH DISCUSSION: CARE COORDINATION, CUSTOMER SERVICE AND CONFLICT MANAGEMENT
    - 10 min

14. HOMEWORK REVIEW
    - 4 min

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?

VIDEO: POOR COMMUNICATION
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?

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

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 to 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

ACTIVITY: ACTIVE LISTENING

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?
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
- No standard definition for care coordination
- May involve ongoing discussion with your supervisor and the team
ACTIVITY: CREATING AN ELEVATOR SPEECH ABOUT CARE COORDINATION

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

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Say to the students: 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 Power Point 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 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?
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 nonverbal 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 calls 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?
- 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 and 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
- Patients may feel anxious for many reasons:
  - May be ill
  - May be worried they are ill
- Acknowledge the patient’s anxiety to the patient
- 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?

- HIPAA standards: patients provide authorization prior to the release of ANY information about them
- Ask to speak with the 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

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

### POWER POINT WITH DISCUSSION: 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 them instructions, directions, etc. in writing
- May be more convenient than the phone for some professionals

**Risks**

- Healthcare information is private and confidential
- Cannot send confidential messages 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

### VIDEO: KRISTIN BAIRD - SERVICE EXCELLENCE

**VIDEO DISCUSSION QUESTIONS**

- What does Kristin Baird say is the essence of customer service?
- Why is establishing and maintaining trust with patients such an important part of healthcare customer service?
- What are some examples of good customer service that you have seen where you work?
- What are some examples of not-so-good customer service where you work?
- Is customer service only about how each individual staff member behaves?
- What other things influence customer service?

### 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 so that we can provide good customer service
• 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 respectfully

What do we mean by “use empathy?”

Use Empathy
• Understand that the patient is your customer
• Sense and understand 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?

Manage your own emotions

**Practice:**
- Being aware of what emotions are coming up for you in certain situations
- Acknowledging to yourself what you are feeling
- What you need to do to manage them 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, seek out help
REFERENCES


Patient Safety and Quality: An Evidence-Based Handbook for Nurses, Chapter 32. Professional Communication
http://www.ahrq.gov/qual/nurseshdbk/docs/SeagoJ_PC.pdf

Patient Safety and Quality: An Evidence-Based Handbook for Nurses, Chapter 33. Professional Communication and Team Collaboration
http://www.ahrq.gov/professionals/cliniciansproviders/resources/nursing/resources/nurseshdbk/ODanielM_TWC.pdf

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?

Continuous and team based healing relationships-Safety Net Initiative

Conflict Resolution: What Nurses Need to Know, Pam Marshall

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

Hope for customer service in health care?

VIDEOS

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

Video: Kristin Baird - Service Excellence
http://www.youtube.com/watch?v=4GAPcsm3Cew
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

   POWERPOINT WITH DISCUSSION: HELPING PATIENTS ACCESS RESOURCES 15 min

   VIDEO: MORE THAN A PLACE TO LIVE: THE CORPORATION FOR SUPPORTIVE HOUSING 5 min

   VIDEO: HEALTH ANGELS: HELP FOR SOCIETY’S MOST VULNERABLE PEOPLE 5 min

   VIDEO DISCUSSION 5 min

   POWERPOINT WITH DISCUSSION: CREATING A RESOURCE DIRECTORY 20 min

   BREAK 5 min

   POWERPOINT WITH DISCUSSION: MAKING COMMUNITY CONNECTIONS 20 min

   EXERCISE: GETTING ORGANIZED TO PROVIDE CARE COORDINATION 30 min

HOMEWORK DISCUSSION


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.

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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
• 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
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 “promotoras” 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.

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 Health Information Tool for Empowerment
- 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

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

When paying a visit to a potential partner agency, what do you want to know? What would make you feel good about referring a patient to this organization?

- Ask yourself:
  - Is the facility clean?
  - Is the staff friendly?
  - Is the service free, and if so, to everyone?
  - Does the facility accept all types of health insurance?
  - Does the facility have payment options for people that cannot pay for the full service up front?
  - Would I want to go here?
- Revisit in a year to confirm whether or not the organization has changed and would still be considered a helpful place to direct patients
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: | | |

| Patient name and identification: | | |
| Date: | | |
| Reason for visit: | | |
| Barrier/concern identified: | | |
| Action to be taken: | | |
| Desired result: | | |
| Resolution and date: | | |
| Additional comments: | | |
REFERENCES


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
▶ Understand characteristics of common mental illnesses such as depression
▶ Understanding of basic risk assessment for depression and suicidal ideation

MATERIALS

• PowerPoint file with videos downloaded
### Basics of Mental Illness and Crisis Management — Part 1

<table>
<thead>
<tr>
<th></th>
<th>Activity</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>POWERPOINT WITH DISCUSSION: INTRODUCTION — CHRONIC DISEASE AND MENTAL HEALTH</td>
<td>5 min</td>
</tr>
<tr>
<td>2</td>
<td>POWERPOINT WITH DISCUSSION: MENTAL HEALTH AND HEART DISEASE</td>
<td>5 min</td>
</tr>
<tr>
<td>3</td>
<td>POWERPOINT WITH DISCUSSION: MENTAL HEALTH AND DIABETES</td>
<td>5 min</td>
</tr>
<tr>
<td>4</td>
<td>POWERPOINT WITH DISCUSSION: DEPRESSION</td>
<td>10 min</td>
</tr>
<tr>
<td>5</td>
<td>VIDEO: WHAT IS DEPRESSION?</td>
<td>5 min</td>
</tr>
<tr>
<td>6</td>
<td>VIDEO DISCUSSION</td>
<td>3 min</td>
</tr>
<tr>
<td>7</td>
<td>VIDEO: HOW IS DEPRESSION TREATED?</td>
<td>5 min</td>
</tr>
<tr>
<td>8</td>
<td>VIDEO DISCUSSION</td>
<td>3 min</td>
</tr>
<tr>
<td>9</td>
<td>BREAK</td>
<td>7 min</td>
</tr>
<tr>
<td>10</td>
<td>THE END OF THE DEPRESSION SPECTRUM – SUICIDAL IDEATION</td>
<td>5 min</td>
</tr>
<tr>
<td>11</td>
<td>ACTIVITY: MYTHS ABOUT SUICIDAL IDEALATION</td>
<td>10 min</td>
</tr>
<tr>
<td>12</td>
<td>VIDEO: STORIES OF HOPE &amp; RECOVERY - THE JORDAN BURHAM STORY</td>
<td>12 min</td>
</tr>
<tr>
<td>13</td>
<td>POWERPOINT WITH DISCUSSION: SUICIDAL IDEATION</td>
<td>10 min</td>
</tr>
<tr>
<td>14</td>
<td>PATIENT HEALTH QUESTIONNAIRE REVIEW</td>
<td>10 min</td>
</tr>
<tr>
<td>15</td>
<td>ACTIVITY: “PATIENT M” ROLE PLAY</td>
<td>15 min</td>
</tr>
<tr>
<td>16</td>
<td>ROLE OF CARE COORDINATION IN MENTAL HEALTH</td>
<td>5 min</td>
</tr>
<tr>
<td>17</td>
<td>WRAP-UP, HOMEWORK FOR NEXT CLASS</td>
<td>5 min</td>
</tr>
</tbody>
</table>

**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.

• 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.


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.

POWERPOINT WITH DISCUSSION: MENTAL HEALTH AND HEART DISEASE

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


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

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


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

VIDEO: WHAT IS DEPRESSION?

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

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 DISCUSSION
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 BREAK

10 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.
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.
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 nonjudgmental
- 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”
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 seem 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 a structured and brief screen.
ACTIVITY: “PATIENT M” ROLE PLAY

Ask the class to break into pairs. One student will be “Patient M” and the other student will be a health professional providing care coordination services. Have them read through their scenarios and begin.

Role-Play 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?

The Patient Health Questionnaire (PHQ-9)

Patient Name ____________________________ Date of Visit _______________________

<table>
<thead>
<tr>
<th>Over the past 2 weeks, how often have you been bothered by any of the following problems?</th>
<th>Not At all</th>
<th>Several Days</th>
<th>More Than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling asleep, staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself - or that you’re a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
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Column Totals _______ + _______ + _______

Add Totals Together _______________________

10. If you checked off any problems, how difficult have those 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

STUDENT EXERCISE BOOK
ROLE PLAY: THE PHQ-9

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

Health Professional

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

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

Today you are visiting M in her home for the first time. Even though its 4 PM, you notice that she is still in her bathrobe, her hair hasn’t been brushed and it doesn’t look like the apartment has been cleaned for weeks. You begin by asking her about the glucose checks.
ROLE PLAY EXERCISE: THE PHQ-9

Instructions: Divide into pairs. Decide who will role play as the “care coordinator” and who will role play as the “patient”. Take a moment to get into character and then begin.

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

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

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

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

National Institute of Mental Health

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.

MATERIALS NEEDED
▪ PowerPoint file with videos downloaded
# Basics of Mental Illness and Crisis Management — Part 2

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<th>Module 12</th>
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## AGENDA

1. **HOMEWORK REVIEW**  
   - 5 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**  
   - 5 min
7. **POWERPOINT WITH DISCUSSION: SOCIAL SUPPORT**  
   - 5 min
8. **ACTIVITY: IDENTIFY YOUR SOCIAL SUPPORT NETWORK**  
   - 20 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. **SOCIAL SUPPORT FOR THOSE WITH CHRONIC DISEASES**  
    - 5 min
12. **VIDEO: CLAUDIA AND SOCIAL SUPPORT**  
    - 10 min
13. **VIDEO DISCUSSION**  
    - 10 min
14. **SUMMARY & WRAP UP**  
    - 10 min

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**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.

VIDEO: LIVING WITH SCHIZOPHRENIA – ASHLEY’S STORY

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?

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”


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 diagnosed?
Schizophrenia is a mental disorder that is characterized by at least two of the following symptoms, for at least one month:
- Delusions
- Hallucinations
- Disorganized speech (e.g., frequent derailment or incoherence)
- Grossly disorganized or catatonic behavior
- A set of three negative symptoms (i.e. flat affect, no energy, inability to speak)
• To diagnose schizophrenia, a trained mental health professional conducts a face-to-face clinical interview, asking detailed questions about family health history and the individual’s symptoms.

• Though there isn’t a medical exam for schizophrenia, doctors typically order medical tests to rule out any health conditions or substance abuse that might mimic schizophrenia symptoms.

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.

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
**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 put 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.
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

<table>
<thead>
<tr>
<th></th>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Someone you can count on to listen to you when you need to talk</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Someone to give you good advice about a problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Someone to take you to the doctor if you needed it</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Someone to have a good time with</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Someone to help you understand a problem when you need it</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Someone to help you with daily chores if you are sick</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Someone to share your most private worries and fears with</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Someone to do something enjoyable with</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Someone to love and make you feel wanted</td>
<td>1</td>
<td>2</td>
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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.
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 assess 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):
  *More simplified and straightforward

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
Why is social support important for those living with chronic diseases?
Individuals with chronic diseases often need extra social support in order to follow their lifestyle recommendations. These lifestyle recommendations, often related to diet and exercise, are important in managing their disease. Studies have shown that there is a modest positive relationship between social support and chronic illness self-management.

Positive social support helps patients with chronic disease follow their lifestyle management, but negative social support can have a potentially negative influence on this as well (Gallant, 2003).

1. Who is Claudia’s social support?
2. Why does this make a huge difference in the healthcare arena?
REFERENCES


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

“Claudia – Social Support”
http://www.youtube.com/watch?v=k_3Ss9KZ6ks
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
### Basics of Mental Illness and Crisis Management — Part 3

#### Agenda

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
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<tbody>
<tr>
<td>1. PowerPoint with Discussion: Overview of Crisis Management</td>
<td>20 min</td>
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<tr>
<td>2. PowerPoint with Discussion: Coping Strategies</td>
<td>5 min</td>
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<tr>
<td>3. Activity: Coping Strategies Brainstorm</td>
<td>10 min</td>
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<tr>
<td>4. Activity Discussion</td>
<td>15 min</td>
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<tr>
<td>5. Group Activity: Crisis Management: Chronic Disease Diagnosis</td>
<td>20 min</td>
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<tr>
<td>6. Break</td>
<td>5 min</td>
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<tr>
<td>7. PowerPoint with Discussion: Crisis Management: Substance Abuse</td>
<td>20 min</td>
</tr>
<tr>
<td>8. PowerPoint with Discussion: Crisis Management: DV/IPV</td>
<td>20 min</td>
</tr>
<tr>
<td>9. Summary &amp; Wrap-Up</td>
<td>5 min</td>
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**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 he 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 (e.g. eviction)
Principles of Crisis Management

STEP 1. Provide reassurance and develop rapport through validation of the problem and use of active listening skills.

STEP 2. Evaluate the severity of the crisis and assess the patient’s mental, psychiatric, suicidal or homicidal, and medical statuses.

STEP 3. Ensure the safety of the patient and others through voluntary hospitalization, involuntary commitment, securing close monitoring by family and friends, or helping to remove the patient from a dangerous situation.

STEP 4. Stabilize the patient’s emotional status, explore options for dealing with the crisis, develop a specific action plan, and obtain commitment from the patient to follow through.

STEP 5. Follow up with the patient to provide ongoing support and to reinforce appropriate action.

As staff providing care coordination, what would be your role in crisis management?

STEP 1. Provide reassurance and develop rapport through validation of the problem and use of active listening skills.

STEP 2. Evaluate the severity of the crisis and assess the patient’s mental, psychiatric, suicidal or homicidal, and medical statuses. IN COORDINATION WITH CARE TEAM

STEP 3. Ensure the safety of the patient and others through voluntary hospitalization, involuntary commitment, securing close monitoring by family and friends, or helping to remove the patient from a dangerous situation. IN COORDINATION WITH CARE TEAM

STEP 4. Stabilize the patient’s emotional status, explore options for dealing with the crisis, develop a specific action plan, and obtain commitment from the patient to follow through. IN COORDINATION WITH CARE TEAM

STEP 5. Follow up with the patient to provide ongoing support and to reinforce appropriate action. IN COORDINATION WITH CARE TEAM

In crisis management, the role of front-line care-coordination staff is to begin the assessment process, provide support and then connect the patient to the care team.
Step 1: Provide reassurance and develop rapport through validation of the problem and use of active listening skills.

Step 2: Evaluate the severity of the crisis and assess the patient’s mental, psychiatric, suicidal or homicidal, and medical statuses.

Step 3: Ensure the safety of the patient and others through voluntary hospitalization, involuntary commitment, securing close monitoring by family and friends, or helping to remove the patient from a dangerous situation.

Step 4: Stabilize the patient’s emotional status, explore options for dealing with the crisis, develop a specific action plan, and obtain commitment from the patient to follow through

Step 5: Follow up with the patient to provide ongoing support and to reinforce appropriate action
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.

Refer to Student Exercise Book, “Coping Strategies Brainstorm.” Ask the students to report back on their responses.

Ask students: What are examples of positive and negative techniques of coping? Using this handout, write down some examples.

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

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):

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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 at 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 before?
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.
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

Who should you talk to about Alice?

Possible answers:

- Care team
- Supervisor
- Nutrition specialist
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

Don’t:
• 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.

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?**

**Don’t:**
- 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
SUMMARY & 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


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
▪ Increase understanding of how to conduct successful home visit assessments as part of chronic care plan
▪ Increase understanding of how to assess patient safety and conduct basic risk assessments
▪ Identify strategies to ensure personal safety of staff conducting home visits

MATERIALS NEEDED
▪ PowerPoint file with videos downloaded
# AGENDA

1. **EXERCISE:** OPEN FORUM: SHARED EXPERIENCES  
   - Duration: 20 min

2. **POWERPOINT WITH DISCUSSION:** PRINCIPLES OF HOME VISITING  
   - Duration: 15 min

3. **GROUP EXERCISE:** CASE STUDY – MR. DIAZ  
   - Duration: 15 min

4. **POWERPOINT WITH DISCUSSION:** HOW TO PLAN, CONDUCT AND DE-BRIEF HOME VISITS  
   - Duration: 20 min

5. **VIDEO:** NURSE HOME VISITING AT COMMONWEALTH CARE ALLIANCE  
   - Duration: 5 min

6. **VIDEO DISCUSSION QUESTIONS**  
   - Duration: 10 min

7. **POWERPOINT WITH DISCUSSION:** HOME VISIT BEST PRACTICES  
   - Duration: 20 min

8. **GROUP EXERCISE:** CASE STUDY – MS. JONES  
   - Duration: 15 min
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?
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.
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?
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.**
VIDEO: NURSE HOME VISITING AT COMMONWEALTH CARE ALLIANCE

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?

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.
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


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

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
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.
VIDEO: CIRCLE OF CARE: RETURNING HOME FROM THE HOSPITAL

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 how someone providing care coordination could help provide a smoother transition of care of patients recently discharged from the hospital?

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 percent.
- Communication failures between providers contribute to nearly 70 percent of medical errors and adverse events in health care.
- 68 percent of specialists receive no information from the referring PCP prior to referral visits, and 25 percent of PCPs do not receive timely post-referral information from specialists.
- Uninsured patients or those with Medicare or Medicaid are 60 percent more likely than those with private insurance to go to the ED for follow-up care instead of a PCP or outpatient clinic.

Getting to Impact: Harnessing health information technology to support improved care coordination December 2012

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.
- >1 medical error per discharge summary.

AHRQ: Data on Adult Care Transitions: 2010
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. After each statement, ask students to raise their hand if they think this happens at the place where they work. Then 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 Healthcare 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 Healthcare Innovation, Group Health Research Institute
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

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

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

Care coordination: what might your role be?

- Track referrals
- Proactively track and support patients as they go to and from specialty care, the hospital and the ER
- Monitor hospital and ER reports
- Follow-up with patients within a few days of an ER visit or hospital discharge
- 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:
Standardize the process

- 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

VIDEO: COACHING FOR SAFER HEALTHCARE TRANSITIONS

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
GROUP EXERCISE: HOW CAN SOMEONE 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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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
REFERENCES

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

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

Reining in Readmissions: Out-of-the-box strategies that get results, March 2011


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

VIDEOS

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

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

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

Coaching for Safer Healthcare Transitions
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
## AGENDA

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### 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

STUDENT EXERCISE BOOK

GROUP EXERCISE: POP QUIZ! PCMH MATCHING GAME

Say to class: Working in small teams, match the PCMH component with the definitions on the second page. Be prepared to report out to the group.

ANSWER KEY:

1. Care management
2. Care coordination
3. Evidence-based guidelines
4. ePrescribing
5. Care team
6. Quality Improvement and reporting
7. Care teamlet

C
E
A
F
G
D
B
A. A series of recommendations on clinical care, supported by the best available evidence in the clinical literature.

B. The smallest, most patient-centric model that pairs a clinician with a medical assistant (MA), community health worker or health coach. It works to provide a variety of services for a panel of patients and to help patients and their families manage their own chronic conditions within the context of their daily lives.

C. A set of patient-centered, goal-oriented, culturally relevant and logical steps to assure that the patient receives needed services in a supportive, effective, efficient, timely and cost-effective manner.

D. Systematic, data-guided activities designed to bring about immediate improvement in health care delivery in particular settings.

E. Sharing clinical information with others who are involved in delivering care to a given patient – the hospital, other physicians, and home health agencies in order to improve patient care and patient health outcomes.

F. A technology framework that allows providers to write and send prescriptions to a participating pharmacy electronically instead of using handwritten or faxed notes or calling in prescriptions.

G. Care of patients by a multidisciplinary team usually organized under the leadership of a physician; each member of the team has specific responsibilities and the whole team contributes to the care of the patient.
VIDEOS: EMR TECHNOLOGY IS LIFE CHANGING
ELECTRONIC MEDICAL RECORDS: HELPING DELIVER BETTER PATIENT CARE

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?

POWERPOINT WITH DISCUSSION: EHR AND QUALITY IMPROVEMENT

What is “Quality Improvement”?

“Doing the right thing, at the right time, in the right way, for the right person – and having the best possible results.” –Agency for Healthcare Research and Quality (AHRQ)

Ask the class to offer explanations/examples of what they think this statement means.

Ask how EHRs can contribute to quality improvement.

Overview of EHR and Quality

• EHR is a tool to achieve other goals
• Quality-enabled features enable providers and staff to:
  - Check whether interventions work
  - Compare outcomes across providers/care teams
  - Population management and registries
  - Consistent documentation (“structured data”)
  - Document clearly, then use reports to gather data

• What is “structured data”?
  ANSWER: Structured data is 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”?
  ANSWER: 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.

How do you use your EHR now?

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 screenshot of 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

EHRs can show data on an individual level:
• Track results for a patient over time
• These results can help providers manage care AND motivate patients

EHRs can show data on a practice level:
• Track performance by provider or care team across an organization
• Can average patient data across all patients and sort by provider/team

EHRs can show data by patient diagnosis/visit type:
• Allows health care staff to see a list of patients with specific conditions and risk levels – can provide a “snapshot”

Registries and Population Management

What is Population Management?

Population Management
Population management is identifying a target group of patients, identifying the specific health status and needs of that target group and then deploying interventions and prevention to improve the health of the target group.

Can you think of patients that we should conduct population management for?

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
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
  - Med. 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.*
VIDEO: VETERANS ADMINISTRATION ON THE “BLUE BUTTON”

VIDEO DISCUSSION

• How do the veterans in the video benefit with electronic access to their own medical data?

EXERCISE: RECAP ACTIVITY

Say to the students: Now we’ll take a few minutes for a recap activity. Pretend you are providing care coordination services to a patient who is coming in for diabetes management. How would you use the EHR to better support this work?

Specifically, how would you use the EHR...

• immediately before the provider visit?
• immediately after the provider visit?
• in-between visits?
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”
REFERENCES
Office of the National Coordinator for Health Information Technology
http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204
HIPAA
http://www.hhs.gov/ocr/privacy/index.html
HealthIT.gov
http://www.healthit.gov/
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=fmrgAjXHUU
Video: Veterans Administration on the “Blue Button”
http://www.youtube.com/watch?v=lGGnda44Yik
Video: Electronic Health Records: Privacy and Security
http://www.youtube.com/watch?v=SMUFa5amPKs
MODULE 17
NAVIGATING THE INSURANCE SYSTEM & HELPING THE UNINSURED

OBJECTIVES
▶ Increase basic understanding of Affordable Care Act (ACA)
▶ Increase basic understanding of Medicaid/Medicare/Managed Care
▶ Understand what it means to obtain referrals and authorizations
▶ Understanding how to reduce barriers to care for uninsured and insured patients

MATERIALS NEEDED
▪ PowerPoint file with videos downloaded
# Navigating the Insurance System & Helping the Uninsured

**AGENDA**

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**Affordable Care Act (ACA):**

The Patient Protection and Affordable Care Act (PPACA) – also known as the Affordable Care Act or ACA – is the landmark health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The legislation includes a long list of health-related provisions that began taking effect in 2010 and will “continue to be rolled out over the next four years.” Key provisions are intended to extend coverage to millions of uninsured Americans, to implement measures that will lower health care costs and improve system efficiency, and to eliminate industry practices that include rescission and denial of coverage due to pre-existing conditions.

As many healthcare reform changes will occur in 2014 and will continue to occur for years to come, it is recommended that facilitators research current developments and trends prior to teaching the class in order to inform the discussion. Please see some recommended websites below. State and city departments of health websites are usually good sources of information as well.

**Federal:**
The Kaiser Family Foundation:  
http://kff.org/  
The official site of the federal health insurance marketplace:  
https://www.healthcare.gov/  
U.S. Department of Health & Human Services ACA page:  
http://www.hhs.gov/healthcare/facts/timeline/index.html  
Medicaid ACA page:  
http://www.medicaid.gov/AffordableCareAct/Affordable-Care-Act.html

**For New York:**
The official New York health plan marketplace:  
https://nystateofhealth.ny.gov/  
Crain’s Health Pulse, a daily newsletter on the business of health care  
http://www.crainsnewyork.com/section/healthpulse

**INTRODUCTION: THE CHANGING WORLD OF HEALTH INSURANCE**

**Say to the class:**
• With the Affordable Care Act (ACA) much of what we know about health insurance is changing.  
• What have you heard about ACA? How will it change how people are insured in this country?  
• In this class, we are going to take a look at the changes that will be coming soon with ACA, as well as learn about how health insurance currently works.  
• Understanding the health insurance system and how you can get your clients covered may be one of the most important things you can do as a care coordinator.

**VIDEO: GET READY FOR OBAMACARE**

**Say to the class:** This video provides a great deal of important information about ACA very quickly, so we are going to take some time to discuss and make sure we got everything.

1. According to the Kaiser Foundation video, what are the 4 main ways Americans will “experience” healthcare in 2014?  
  **ANSWER:**  
  • Employer (50%)  
  • Government (33%) (Medicaid, Medicare)  
  • Buy My Own (10%)  
  • None (7%)
2. How will things change for people who get health insurance through their employers?

**ANSWER:**
- Not that many changes
- Caps on out-of-pocket expenses
- Free preventative care

3. What companies will be required in 2015 to cover health insurance for their employees?

**ANSWER:**
Companies with more than 50 employees

4. What will change for seniors on Medicare?

**ANSWER:**
- Not many changes
- Better coverage for prescription drugs and preventative care

5. How is Medicaid changing?

**ANSWER:**
Medicaid is expanding to cover more low-income Americans (up to 138% of the poverty level/ $15,856 for a single person)

6. What’s the catch?

**ANSWER:**
- Decisions to expand Medicare are state by state (governor)
- Depending on the state, there may be no Medicaid expansion, leaving the poorest people uninsured

7. Many Americans will still be left out of the employer or government sponsored health insurance plans. Where should these people look to for insurance coverage?

**ANSWER:**
Health Insurance Marketplaces
- A virtual “mega-mall” in which private insurances will compete with each other to offer individual coverage
- Bronze, Silver, Gold, Platinum levels of coverage

8. What are some of the services that all plans must cover?

**ANSWER:**
- Hospital visits
- Doctor visits
- Maternity Care
- Mental Health Care
- Prescription Drugs

9. What’s the advantage of buying insurance through these marketplaces?

**ANSWER:**
The federal government will provide most people with a tax credit to make these plans more affordable. (Up to 400% of the poverty level/ $78,120 for a family of 3)

10. Why should people get enrolled on a plan sooner rather than later?

**ANSWER:**
- Special enrollment periods
- Individual mandate: if you are not insured, you pay a fine
  - If individuals really can’t pay and can’t get insurance elsewhere, the penalty may be waived

**POWERPOINT WITH DISCUSSION:**
**HEALTH INSURANCE OPTIONS IN NEW YORK STATE**

_Say to class:_ As you heard in the video, many of the reforms in ACA are happening now and the majority of them will happen in 2014. However, it’s still helpful for you to have an understanding of how health insurance currently works, particularly in your state, as the way health insurance works can change state by state.
What is the difference between public and private health insurance?

**Commercial Insurance**
- Commercial health plans are bought individually or coverage can be extended through an employer-sponsored plan
- Charges premiums to its members

**Public Programs (state or federally sponsored)**
- Public health care plans are entitlement programs funded by the federal and state governments
- Group plans such as Medicare and Medicaid must include all eligible applicants regardless of their health condition
- Except for Medicare Part B, does not charge premiums to its members

**Uninsured Patients**
- Prior to ACA, many people were not eligible for private insurance because of previous medical conditions or were not able to afford it
- Post ACA, uninsured people will primarily be:
  a. low-income adults who live in states that did not opt for Medicaid expansion
  b. undocumented people
- Federally qualified health centers, public health clinics and public hospitals will continue to offer services to uninsured patients on a “sliding scale”

What do you know about Medicaid

**Medicaid in NYS**
- Eligibility – May be available to New York state residents who meet certain financial requirements, receive SSI or have high medical bills.
- Covered services – full range of necessary medical services.
- Medicaid Managed Care
  - Choosing a plan – most patients will select or be assigned to a Medicaid Managed Care Plan
  - Each plan is a different network and can have its own requirements and ways of making referrals

**Child Health Plus in NYS**
- Eligibility – NYS residents under the age of 19 who meet family income requirements. Premiums are dependent on family’s gross income.
- Enrollment – through a NYS Medicaid Office.
- Covered Services – full range of necessary medical services.

What do you know about Medicare?

**Medicare**
- Eligibility generally for people age 65 or older who (or whose spouse) has “40 quarters of covered employment”.
- 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
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
  - For example:
    - Ambulance services
    - Durable medical equipment
    - Mental health
    - Inpatient
    - Outpatient
    - Partial hospitalization
    - Getting a second opinion before surgery
    - Limited outpatient prescription drugs

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 Medicare drug coverage, 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
  - Co-payments or coinsurance
  - Costs in the coverage gap (i.e., the consumer has to cover what is not covered by Part D)
- Actual drug plan costs will vary depending on:
  - The drugs consumers use
  - The plan consumers choose
  - Whether consumers go to a pharmacy in their plan’s network
  - Whether the drugs consumers use are on their plan’s formulary
Note: Take a quick “poll” of the students’ experience with health insurance. Ask if they have ever felt confused about how to use their health insurance.

Say to the class: Even when we are fortunate to have health care coverage, we are unsure of how to use it. What information would have been helpful to you when you were confused?

What is the most important information for patients to know in order to use their insurance?
- Assigned primary care provider (PCP)
  - Is this the same primary care provider that is listed on their card?
- What services are covered under their plan
- What their patient responsibilities are
- Which services require a referral
- How to obtain a referral from their PCP
- How to obtain a pre-authorization

How can care coordination help patients become “educated insurance consumers?”
- Reinforce the importance of having an up-to-date PCP
- Get familiar with the health plans most commonly used by clients/patients
- Connect with the health insurance experts in their organization to get tips on how assist patients use their plans
- Spend time with patients to educate them on their insurance rights and responsibilities
- Clarify for patients their benefits and what services are covered
- Educate patients on when to request referrals or obtain prior authorizations
- Educate patients on ability to switch plans, providers or apply for additional benefits
- Help patients prepare for visits with new providers/specialists

VIDEO: WHAT IS THE DIFFERENCE BETWEEN A REFERRAL AND AN AUTHORIZATION?

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

VIDEO DISCUSSION

1. What is the difference between a referral and an authorization?
   **ANSWER:**
   - A referral is a recommendation from your health care provider (PCP) to receive services from another healthcare provider or specialist.
   - An authorization, or benefit certification means that certain medical services or pharmacy drugs need to be pre-approved by your PCP to be covered by your health plan.

2. Whose responsibility is it for following through on a referral?
   **ANSWER:**
   Patient

3. Whose responsibility is it for obtaining an authorization?
   **ANSWER:**
   It depends. According to this video, it is the provider’s responsibility to obtain pre-authorization for recommended services. However, some insurance plans are asking patients to be the ones responsible for obtaining pre-authorizations. The best way to know is to call the plan or become familiar with most commonly used plans.

4. How does it work at your health center? Who obtains pre-authorizations when a patient needs certain services?
# Samples of Commercial, Medicare and Medicaid Health Care ID cards

## Commercial Plans – Sample Cards

**UnitedHealthcare**

- **Health Plan ID**: 911-87726-04
- **Member ID**: 999999999
- **Group Number**: 123456

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## Medicare Plans – Sample Cards

**SecureHorizons**

- **Health Plan ID**: 911-87726-04
- **Member ID**: 999999999
- **Group Number**: 99999

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## Medicaid Plans – Sample Cards

**AmeriChoice**

- **Health Plan ID**: 911-86047-9X
- **Member ID**: 0090099376

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**Medicare Plan Details**

- **Phone**: 800-641-4047

**For Members**: 1-888-362-3358

**For Pharmacist**: 888-305-2443
**EXERCISE: INSURANCE CARD BASICS**

**Note to facilitator:** Refer students to the exercise books. Begin the discussion by asking patients to look at the sample insurance cards and identify the following:
- What number should a patient call to see if they need to obtain a pre-authorization?
- Is there a number for Rx benefits?
- Do you see their PCP? What about member number?
- What co-pays are due, if any?
- What other resources are referenced on the card?

**What should insured patients bring with them for their first appointment at a new health facility?**
- Every health facility is different, if possible call and ask what to bring
- May need to bring some or all of the following:
  - Insurance ID card
  - Co-payment
  - Referral or prior authorization
  - List of current medications
  - Medical history

**POP QUIZ: HEALTHCARE REFORM**

**Note to facilitator:** Refer students to the exercise books and ask them to complete the quiz on their own. When complete, read the questions out loud and ask students to respond as a group.
Pop Quiz! Healthcare Reform

1. Will the health reform law require nearly all Americans to have health insurance starting in 2014 or else pay a fine?
   A. No, the law will not do this
   B. Yes, the law will do this
   C. Don’t know

2. Will the health reform law allow a government panel to make decisions about end-of-life care for people on Medicare?
   A. No, the law will not do this.
   B. Yes, the law will do this.
   C. Don’t know

3. Will the health reform law cut benefits that were previously provided to all people on Medicare?
   A. No, the law will not do this.
   B. Yes, the law will do this.
   C. Don’t know

4. Will the health reform law expand the existing Medicaid program to cover low-income, uninsured adults regardless of whether they have children?
   A. No, the law will not do this.
   B. Yes, the law will do this.
   C. Don’t know

5. Will the health reform law provide financial help to low and moderate income Americans who don’t get insurance through their jobs to help them purchase coverage?
   A. No, the law will not do this.
   B. Yes, the law will do this.
   C. Don’t know

6. Will the health reform law prohibit insurance companies from denying coverage because of a person’s medical history or health condition?
   A. No, the law will not do this.
   B. Yes, the law will do this.
   C. Don’t know

7. Will the health reform law require all businesses, even the smallest ones, to provide health insurance for their employees?
   A. No, the law will not do this.
   B. Yes, the law will do this.
   C. Don’t know

8. Will the health reform law provide tax credits to small businesses that offer coverage to their employees?
   A. No, the law will not do this.
   B. Yes, the law will do this.
   C. Don’t know

9. Will the health reform law create a new government run insurance plan to be offered along with private plans?
   A. No, the law will not do this.
   B. Yes, the law will do this.
   C. Don’t know

10. Will the health reform law allow undocumented immigrants to receive financial help from the government to buy health insurance?
    A. No, the law will not do this.
    B. Yes, the law will do this.
    C. Don’t know
Answers:
1. B
2. A
3. A
4. B
5. B
6. B
7. A
8. B
9. A
10. A

Detailed Answers (on PowerPoint)

1. Will the health reform law require nearly all Americans to have health insurance starting in 2014 or else pay a fine?

B. Yes, the law will do this

Starting in 2014, most U.S. citizens and legal residents will be required to obtain health coverage, or pay a penalty. Some exemptions will be granted, for example, for those with religious objections or where insurance would cost more than 8% of their income.

2. Will the health reform law allow a government panel to make decisions about end-of-life care for people on Medicare?

A. No, the law will not do this

No such panels exist. While early versions of the law did contain provisions that would allow Medicare to reimburse physicians for voluntary discussions with patients about end-of-life, these provisions were dropped from the final legislation.

3. Will the health reform law cut benefits that were previously provided to all people on Medicare?

A. No, the law will not do this.

The law reduces payments to the privately administered Medicare Advantage plans, but they will still be required to provide all benefits that are covered by traditional Medicare.

4. Will the health reform law expand the existing Medicaid program to cover low-income, uninsured adults regardless of whether they have children?

B. Yes, the law will do this.

Medicaid will be expanded to cover nearly all individuals under age 65 with incomes up to 133% of the federal poverty level ($14,400 for an individual or $29,300 for a family of four in 2010).

5. Will the health reform law provide financial help to low and moderate income Americans who don’t get insurance through their jobs to help them purchase coverage?

B. Yes, the law will do this.

Individuals without access to affordable coverage who purchase coverage through the new insurance Exchanges and have incomes up to 400% of the federal poverty level will be eligible for premium tax credits based on their income.

6. Will the health reform law prohibit insurance companies from denying coverage because of a person’s medical history or health condition?

B. Yes, the law will do this.

Starting in 2014, all health insurers will be required to sell coverage to everyone who applies, regardless of their medical history or health status.
7. Will the health reform law require all businesses, even the smallest ones, to provide health insurance for their employees?
A. No, the law will not do this.

The law does not require employers to provide health benefits. However, it does impose penalties, in some cases, on larger employers (those with 50 or more workers) that do not provide insurance to their workers or that provide coverage that is unaffordable.

8. Will the health reform law provide tax credits to small businesses that offer coverage to their employees?
B. Yes, the law will do this.

In 2010, business with fewer than 25 full time equivalent employees and average annual wages of less than $50,000 that pay at least half of the cost of health insurance for their employees became eligible for a tax credit.

9. Will the health reform law create a new government run insurance plan to be offered along with private plans?
A. No, the law will not do this.

The law does not create a new government-run health insurance plan. The existing Medicaid program will be expanded to cover more low-income people, government regulation of the health insurance industry will be increased, and tax credits will be provided to make private health insurance more affordable for people.

10. Will the health reform law allow undocumented immigrants to receive financial help from the government to buy health insurance?
A. No, the law will not do this.

Undocumented immigrants are not eligible to receive financial help from the government to buy health insurance, nor are they eligible for Medicaid or to purchase insurance with their own money in the new exchanges.
Note to facilitator: If you have internet access, it is suggested you go online to these websites and explore search options on the sites with the students.

- Foundation for Health Coverage Education
- http://coverageforall.org/

Say to class: The Foundation for Health Coverage Education is an online resource that may be very useful in working with uninsured patients. Patients can go online and complete a 5 question quiz that helps them narrow down what programs they might be eligible for. Patients can then go ahead and complete the actual application through the links on this website. This website is helpful for patients anywhere in the country, not just in NYS.

- Health Information Tool for Empowerment
- www.hitesite.org

Say to class: In New York, we have another great resource, the Health Information Tool for Empowerment, or HITE website, HITE is an online resource for social workers, discharge planners, and other information and referral providers. Each listing includes the name, address, and phone number, but also information about intake procedures, languages spoken, hours of operations and directions. This is a particularly good tool for identifying resources for immigrant, undocumented or uninsured patients.

What should uninsured patients bring with them for their first appointment at a new health facility?

- 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)
HEALTH INSURANCE GLOSSARY MATCHING GAME (ANSWER KEY)

Instructions: Using their exercise books, ask the class to break into small teams to complete the exercise.

Working in small teams, match the health insurance term with the definitions on the second page. Be prepared to report out to the class.

1. Commercial Insurance — H
2. Fee for Service — F
3. Managed Care Plans — B
4. Medicaid Managed Care — D
5. Member Services Departments in Medicaid/Medicare Managed Care Plans — E
6. Networks — C
7. Prior Authorization — G
8. Primary Care Provider (PCP) — I
9. Referral — J
10. Sliding Fee Scale — A
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 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  In NYS most Medicaid patients are enrolled in this kind of plan (if they don’t select one, it will be assigned). The plans each have different panels of participating providers and hospitals. Patients enrolled in a plan will be required to use providers participating in that plan (with the exception of Emergency Rooms and Family Planning Services).

E  This is the patient/members point of contact with the Managed Care Plan. The phone number of the Members Services Department appears on the patients plan ID card and can provide assistance with finding providers, navigating the system, arranging transportation, selecting a Primary Care Provider or obtaining a replacement ID Card.

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.
REFERENCES
How to Prevent and Fix Medical Debt, A handbook for community advocates assisting New Yorkers with medical debt. The Legal Aid Society, updated 2.5.2010

RESOURCES

HITE website contains thousands of searchable Greater New York resources. Each listing includes the name, address, and phone number, but also information about intake procedures, languages spoken, hours of operations and directions.
www.hitesite.org

Coverage for All website contains information on all public and private health coverage options in all 50 states. You can click on links for your state and see options available. There is also an interactive eligibility quiz on the website that can identify resources available for a specific patient (depending on their age, income, healthcare requirements, etc.)
www.coverageforall.org/finder/everyoutcomepage.php?=26

VIDEOS

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

Referral vs Prior Authorization
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
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.
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.

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
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- Empathy

Over time, these approaches were studied, replicated, modified and enhanced to become the field of Motivational Interviewing.
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

All of this has led to an “explosion” of MI information:

- >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.

VIDEO: HOW NOT TO DO MOTIVATIONAL INTERVIEWING: A CONVERSATION WITH SAL

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?

BREAK

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?

Example
• 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?”
**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:*

<table>
<thead>
<tr>
<th>Repeating</th>
<th>Patient</th>
<th>Care Coordinator</th>
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<tr>
<td>(Used to diffuse resistance)</td>
<td>“I don't want to have a mammogram.”</td>
<td>“You don’t want to have a mammogram.”</td>
</tr>
</tbody>
</table>

| Rephrasing                     | “I want to have a mammogram but last time I did it, it hurt too much.”   | “Having a mammogram is important to you.” |
| (Slightly alters what the patient says to provide the patient with a different point of view) |

| Empathic reflection            | “You've probably never had to deal with anything like this.”            | “It's hard to imagine how I could possibly understand.” |
| (Provides understanding for the patient's situation) |

| Reframing                      | “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.” |
| (Helps the patient think about his or her situation differently) |

**Ask the class:** How did these reflections sound to you? Did they surprise you? How do you think they would make the patient feel?
# OARS Coding Sheet

<table>
<thead>
<tr>
<th>Open Questions</th>
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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.

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
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
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.
• 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.”

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.

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

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.
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.

**POWERPOINT WITH DISCUSSION:**

**BRIEF NEGOTIATED INTERVIEWING (BNI)**

**VIDEO:**

**BNI CASE EXAMPLE; DOCTOR A**

**BREAK**

**VIDEO:**

**BNI CASE EXAMPLE; DOCTOR B**

**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?

**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. 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)

10 GROUP ACTIVITY: 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**
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 ok 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.”
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?
     - 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?

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
     - 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.

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

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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?
REFERENCES


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

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

VIDEOS
BNI Case Example; Doctor A, Boston University, BNI-ART Institute

BNI Case Example; Doctor B, Boston University, BNI-ART Institute

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

Uploaded on Nov 25, 2009

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).
OBJECTIVES

▶ Understand what health coaching is and in what context a staff providing care coordination might provide it

▶ Describe what a care plan is and how it would be used by a staff providing care coordination and other care team members

▶ Know how to identify a 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
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.


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

Health coaching may be one of your responsibilities as a staff member who provides care coordination services.

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 hate 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
• Interdisciplinary Comprehensive Assessment
• Medical: H & P, including mental health, substance abuse and risk behavior needs.
  - Conducted by Primary Care Provider +/- behavioral health provider.
• Social needs/benefits: health insurance, housing, etc.
  - Conducted by nurse, social worker or care coordinator/care manager
• Logistics: family/social network, childcare, language, criminal justice, etc.
  - Conducted by care coordinator/care manager.
• May be different at different organizations

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 staff who provide care coordination and health coaching 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

VIDEO: COACHING PATIENTS FOR SUCCESSFUL SELF-MANAGEMENT (UP UNTIL 7:18 THEN PAUSE)

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?
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
- Med was not on their insurance formulary so pharmacy didn’t give it to them
- Med causes side effects
- Patient is worried that med may cause side effects/hurt them
- Patient doesn’t believe that med will really make a difference
- Patient forgets
- Medication regimen is too complicated
- Patient doesn’t want to begin to take 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

VIDEO: COACHING PATIENTS FOR SUCCESSFUL SELF-MANAGEMENT (FROM 7:18 TO THE END)

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?
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

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.
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?
REFERENCES

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

Bennett, H. MD, et al, Health Coaching for Patients With Chronic Illness: Does your practice “give patients a fish” or “teach patients to fish”?

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

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

Coaching patients for successful self-management
http://youtube/DmNBOVykeoM
MODULE 21
HEALTH COACHING & 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
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.)
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.
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 a 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?
EXERCISE: MAKING BEHAVIOR CHANGE ACTION PLANS WITH THE PATIENT

Dialogues and discussion activities reprinted here from with permission from Dr. Bodenheimer:

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.
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.

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.

VIDEO: HEALTH COACHING (MEDICATION RECONCILIATION) TECHNIQUES TO DELIVER PATIENT CENTERED CARE

VIDEO DISCUSSION

1. 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.

2. 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?

3. 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:
   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.
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 methods for monitoring performance, including performance indicators
▶ Understand how to assess opportunities for quality improvement
▶ Describe the relationship between care coordination work and quality improvement

MATERIALS NEEDED
- PowerPoint file with videos downloaded
Why is it important to measure or evaluate health outcomes?

Measuring and evaluating health outcomes helps us understand how well we are delivering our services and shows us where we can improve.

Pretend for a moment that, like groceries, you can shop for your healthcare at a store. You see these healthcare centers in the display case. Which one would you “buy”?
Instructions: Ask the class to take turns reading the following “products” aloud.

Which one would you “buy”?

- **Beginners Health Care Network**: Our providers are very smart and they know all the latest stuff in medicine because we all completed our training within the last 2 yrs. We know how to use technology but we don’t have any data that shows it benefits our patients. Give us a call and we will do a visit on the phone!

- **Excellent Health Care Services**: Our providers are proficient in medicine and our patients value our expertise. We have data that reflects our ability to improve patients’ health care outcomes. Give us a call! We would love to answer your questions about your healthcare needs.

- **Advanced Health Care Providers**: Our providers are intermediate level clinicians who use cutting edge technology to advance their healthcare services. Our multi-cultural providers and staff speak several different languages. Call us! We speak your language!

- **S.O.R.R.Y. D.O.C.S.**: Our providers available 24 hours a day seven days a week. Call us! We are open.

**Say to the class**: It’s hard to choose, isn’t it? In this day and age many of us make decisions on our purchases, based on how they are rated. Healthcare should be no different. If you can’t tell if the healthcare has been measured or if any kind of quality assurance is in place, you don’t know what you are getting and it’s hard to know what to “buy”.

2. **POWERPOINT WITH DISCUSSION: WHAT ARE PERFORMANCE INDICATORS?**

- In healthcare, several performance and patient satisfaction “indicators” exist to provide information on how well a center is delivering care.

- Monitoring these indicators regularly provides assurances to patients, regulators and researchers that care is being delivered safely with the intended results.

- What are some examples of a performance or patient satisfaction indicator?

  **ANSWER**: Patient satisfaction surveys, hospital re-admission rates, care given in timely/effective manner

  **Say to the class**: Now we’ll take a look at an interesting tool that consumers can use to “shop” for services by comparing important indicators such as patient satisfaction and hospital re-admissions.

  Website: Medicare Hospital Compare

  **Say to the class**: Besides allowing consumers/patients to compare hospitals by performance, this website can also allow you as a care coordinator to see how other hospitals and providers in your referral network are doing. Finally, if you work in a hospital, this tool can offer you a snapshot of how your own organization is doing - in other words, what is your organization’s standing in comparison with other hospitals?

  Medical Hospital Compare

  **Say to class**: This first screen shows how the consumer can locate a hospital by zip code and then come up with list of three closest hospitals.
Medical Hospital Compare

**Say to class:** This next screen shows a series of tabs that the consumer can click on, such as patient survey results, timely and effective care, readmissions/complications/deaths, use of medical imaging and so on. The consumer has clicked on timely & effective care and some options have dropped down, such as heart attack care and children's asthma.

Medical Hospital Compare

**Say to class:** This third screen shows what the consumer would see if they clicked on the timely and effective care tab for effective heart attack care. A comparison of the three nearest hospitals is listed with data on how often these clinical care services were performed.

*Which hospital has the best score for this clinical service?*

Now that we’ve seen some of these indicators, let’s talk about who comes up with these indicators and what constitutes quality care.

Who sets the standards in healthcare for what should be measured, how and when?

**Role of the Federal Government**

In the U.S., the federal government dictates policy on the regulatory requirements for healthcare businesses.

Examples:

- Obamacare
- Meaningful Use
- (CMS) Medicare

**Role of States**

Each state then decides whether they want to align with federal policy or make their requirements different.

*Say to class:* An example of this is medical resident hours. Medical resident work hours is a term that refers to the often lengthy shifts worked by medical interns and residents during their medical residency. The issue has become a political football in the United States, where federal regulations do not limit the number of hours that can be assigned during a graduate medical student’s medical residency. However in 2003, NYS regulations changed to cap the residency work-week at 80 hours.

**Role of Local Municipalities**

- Local municipalities even make considerations on healthcare regulations
  - For example, only the NYCDOH considers a completed colonoscopy as a screening for colorectal cancer. This regulation does not apply across NYS.

Another way the federal government determines performance indicators for healthcare is by requiring Federally Qualified Health Centers (FQHCs) to report UDS data.

**What is the UDS?**

**Uniform Data System (UDS)**

- The Uniform Data System (UDS) is a core set of information appropriate for reviewing the operation and performance of health centers.
**What Data Are Collected?**
UDS data tracks a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. UDS data are collected from grantees and reported at the grantee, state, and national levels.

**Who Reports UDS Data?**
The UDS is a reporting requirement for the following HRSA grantees (Health Resources and Services Administration), as defined in the Public Health Service Act:
- Community Health Center, Section 330 (e)
- Migrant Health Center, Section 330 (g)
- Health Care for the Homeless, Section 330 (h)
- Public Housing Primary Care, Section 330 (i)

_Say to the class:_ This screenshot shows the HRSA website with the primary health centers that receive HRSA federal funding. The UDS data for each of these centers can be seen on this website.

This next screen gives a closer look at the UDS data. For example, HRSA asks FQHCs to track the number of pregnant women who have a first prenatal visit in the first trimester. This is seen as an indicator of good prenatal care and therefore, health centers are asked to track and report this to HRSA.
EXERCISE: HOW DO YOU KNOW IF YOU ARE DOING A GOOD JOB?

Working in twos or small groups, take a few minutes to think about the work that you do now. What do you think would be a good measure of the work you do? What do you think is a good “indicator” of whether or not you are doing a good job? What are the kinds of things that you are responsible for and get done every day? How would this translate into a good outcome for your patients or clients? Take a few minutes to write some of these “indicators” down and be prepared to report back to the class.

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.

DISCUSSION QUESTIONS

- Was this a difficult exercise, or did these indicators come easily to you?
- Are these things being measured now? Is there information being collected on these indicators and if so, is it shared with you?
- If this information is not being collected, what is and do you think this helps your organization understand the quality of your work?

Say to class: Now we are going to shift gears and move from thinking about data collection to improving outcomes. In other words, what should we do with data once it has been collected? What if we see issues that need to be fixed? Let’s go through a scenario that maybe some of you are familiar with. If not, in the world of PCMH, this may be happening to you more in the future...

BREAK

VIDEO: COMPARING HEALTH CARE QUALITY: A ROAD MAP TO BETTER CARE
VIDEO DISCUSSION

1. What is the reason to collect data in a healthcare practice?
   
   **ANSWER:**
   To see how good the care is and use this information to make improvements

2. What do they mean by needing to collect data that is accurate? Why would the data not be accurate?
   
   **ANSWER:**
   Data needs to be captured in structured fields in the medical record, everyone must document in these structured fields including doctors, nurses, medical assistants, lab technicians etc. All data must be collected and documented in the correct place, otherwise data and reports will be inaccurate.

3. How did they use information to increase breast cancer screening for Somali women?
   
   **ANSWER:**
   Developed a focus group and asked the women what barriers they faced. This led to establishing same day appointments for screenings.

4. How did the general internists improve their pneumococcal vaccines for their diabetes 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.

Say to class: *Now we are going to shift gears and move from thinking about data collection to improving outcomes. In other words, what should we do with data once it has been collected? What if we see issues that need to be fixed? Let’s go through a scenario that maybe some of you are familiar with. If not, in the world of PCMH, this may be happening to you more in the future...*

BRAINSTORM: QI AT THE STAFF MEETING

Instructions: Guide the class through this activity by reading through the slides.

It’s time for your monthly staff meeting and the Medical Director says...

“*Since we are a federally qualified health center (FQHC) we have to report on many of our clinical services. We have noticed in our most recent data report that we are not doing well in weight screening.*”

“According to this report, only 47.14% of our patients are receiving weight screening.”

“*Since you all are seeing patients every day, I wanted to get your input. What should we do to fix this situation? How can we get this number up?*”

What would you suggest to the Medical Director?

**POSSIBLE ANSWERS:**
- Staff training
- Update the policy
- Put up poster reminders for staff
“Our diabetes A1c numbers are not good. 30% of our diabetic patients have very high levels of 10 or higher, 60% of patients have levels of 8 or greater. Normal is 7 or below.”

What would you suggest to the Medical Director?

**POSSIBLE ANSWERS:**
- Make a list of those patients
- Call them to see how they are doing
- Provide health coaching
- Do medication reconciliation
- Provide nutritionist visits
- Screen and treat for depression
- Offer same day appointments

**POWERPOINT WITH DISCUSSION: QUALITY IMPROVEMENT STRATEGIES**

While quality improvement can take many forms, the following strategy is recognized as one of the most successful:

**Fundamentals of a 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

If working... good!

If not working... do you still continue to perform the same activity?

Ask the class if they have ever been involved in any quality improvement initiatives and what those experiences were like.
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.

You have so impressed the Medical Director by your input at the last staff meeting that she has now asked for your help in 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
   – Done: The current 6-week postpartum visit rate is 25%.

2. Drill down of the data/define root cause of issues
   
   For this one, since you can’t do any background research, come up with a reason on your own:

3. Assess what can be done to achieve improvement

4. Put improvement in place

5. Check to see if it’s working

DISCUSSION QUESTIONS

• What kinds of reasons did you come up with for such a low return visit rate?
• How did you propose this be improved?

Say to the class: Data is key to good care coordination and good care. You will be using this data to determine what kind of follow up is needed for your patients. You also might be using data as part of quality improvement initiatives.

As care coordination staff, you are key to good data. By documenting your work well, you directly affect the quality of the data that your organization has and the quality of patient care.
REFERENCES

Health Resources and Services Administration (HRSA)
http://www.hrsa.gov/index.html

Medicare/Medical Hospital Compare
http://www.medicare.gov/hospitalcompare/

American Public Health Association
http://www.apha.org

Quality Improvement in Public Health: It Works!
http://www.apha.org/NR/rdonlyres/6CC21952-4A55-4E3F-BB51-1BA060BF60FE/0/QI_in_PH_ItWorks.pdf

VIDEOS

Comparing Health Care and Quality: A Road Map to Better Care
http://www.youtube.com/watch?v=5seWqqYBL4s
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. EXERCISE: A TIME WHEN YOU EXPERIENCED TROUBLE MAINTAINING BOUNDARIES
   20 min
2. POWERPOINT WITH DISCUSSION: PERSONAL BOUNDARIES
   20 min
3. VIDEO: DON’T BE AFRAID TO SET BOUNDARIES
   8 min
4. VIDEO DISCUSSION
   12 min
5. BREAK
   5 min
6. EXERCISE: VALUES CLARIFICATION
   35 min
7. POWERPOINT WITH DISCUSSION: PROFESSIONAL BOUNDARIES
   20 min
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?
__________________________________________________________________________________________
__________________________________________________________________________________________
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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 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.

10 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 will 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 when 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 ok, 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’s not ok.

3 VIDEO: DON’T BE AFRAID TO SET BOUNDARIES; JULIE HANKS, LCSW

4 VIDEO DISCUSSION QUESTIONS
Setting “boundaries will be offensive sometimes”
What does the therapist mean by this?
**ANSWER:** We may have to offend to take care of ourselves. Our job is to protect our emotional energy, not to make everyone around us happy.

“We are not responsible for other people’s emotions”
What does the therapist mean by this?
**ANSWER:** Being emotionally healthy means we are each responsible for our own emotions. “No one can offend you without your permission.”

What are the three different stances that the therapist lists? Which one is the healthy stance?
**ANSWER:**
• Doormat: people can walk all over you, value other people over yourself
• Sword: confuse setting boundaries with intentionally trying to hurt someone
• Lantern: “this is what I see”, illuminating the situation, value other people’s emotions and yourself, but understand that you are only responsible for your own emotions

According to the therapist, why are we so hesitant to tell people what is best for us?
**ANSWER:** We don’t want to push people away. We are afraid if we say what we need will hurt our relationships.

5 BREAK
**EXERCISE: VALUES CLARIFICATION**

*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.

(Note: version in Student Exercise Book does not list the answers.)

After each question and polling of student answers, have a discussion.

(Note: 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.)

- 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.

- 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.

- Hugging a patient is sometimes acceptable.
  
  **Answer:** Depends on the situation, can be appropriate in certain circumstances.

- Accepting a cash gift from a patient is sometimes ok.
  
  **Answer:** Accepting a cash gift is never acceptable in a work situation.

- 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.
• 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.

• 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.

• 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.

• 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.

• 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.

• 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.
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

What is the Connection between Personal and Professional Boundaries?
- Everyone has their own personal boundaries
- It’s important to be aware of your boundaries and those of others, such as your patients and co-workers in order to maintain positive relationships.
- Being aware of your workplace policies on professional ethics and professional boundaries will also help you maintain positive relationships with your co-workers and therapeutic relationships with your patients.

What do we mean by “crossing a boundary” in a professional situation?
- Times in which a professional does something that could be considered “unprofessional”. They can happen once or many times over a period of time.
- Repeated boundary crossings set up a pattern of behavior in which the relationship is no longer helpful to the patient.
- Breach of trust between the professional and the patient.
- Boundary crossings may also be thought of as a health professional being too little or too much involved in patient care.
- An extreme example of over-involvement could be sexual misconduct.
- Boundary crossings, or violations may occur when the professional is not aware of their own boundaries.
- They also may occur when the patient boundaries are “undefined.”
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.
REFERENCES

https://www.ncsbn.org/ProfessionalBoundaries_Complete.pdf

http://www.youtube.com/watch?v=FNCTl2SnO7w

https://www.ncsbn.org/ProfessionalBoundaries_Complete.pdf


http://www.nurses.ab.ca/pdf/Professional%20Boundaries%20Guidelines.pdf


VIDEOS

Video: Don’t be Afraid to Set Boundaries; Julie Hanks, LCSW
http://www.youtube.com/watch?v=fVmbVgYgcWc&feature=related
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
▶ Identifying 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

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<td>POWER POINT WITH DISCUSSION: CHALLENGES OF BOUNDARIES WHILE PROVIDING CARE COORDINATION</td>
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<td>EXERCISE: YOUR TRIGGERS AT WORK: PEOPLE, SITUATIONS-PART I</td>
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<td>12</td>
<td>FINAL CELEBRATION/ CERTIFICATE DISTRIBUTION</td>
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### 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.

POWER POINT WITH DISCUSSION:
CHALLENGES OF MAINTAINING CLEAR 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 staff who provide care coordination “keep it professional” with patients?

Know your role
- Be clear about your role so you can clearly communicate it to patients
  - Give patients a list of your duties when you first meet
  - Explain what you can and cannot do for them
  - this reduces your stress and patients’ stress because they know what to expect from you

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.

EXERCISE: YOUR TRIGGERS

AT WORK: PEOPLE, SITUATIONS — PART I

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.

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.
• However, it can be easy to overlook your own stress-inducing thoughts, feelings and behaviors.
  - For example, you may know that you are constantly worried about work deadlines.
  - But maybe it’s your procrastination that leads to stress around work deadlines

To identify your true sources of stress, look closely at your habits, attitude, and excuses:
• Do you explain away stress as temporary?
  - (“I just have a million things going on right now”) even though you can’t remember the last time you took a breather?
• Do you define stress as an integral part of your work or home life?
  - (“Things are always crazy around here”) or as a part of your personality (“I have a lot of nervous energy, that’s all”)
• Do you blame your stress on other people or outside events, or view it as entirely normal and unexceptional?

Does any of this sound familiar to you?

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:

- Avoid the stressor
- Alter the stressor

Change your reaction:

- Adapt to the stressor
- Accept the stressor

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”** – Know your limits and stick to them. Whether in your personal or professional life, refuse to accept added responsibilities when you’re close to reaching them.
- **Avoid people who stress you out** – If someone consistently causes stress in your life and you can’t turn the relationship around, limit the amount of time you spend with that person or end the relationship entirely.
- **Take control of your environment** – If the evening news makes you anxious, turn the TV off.
- **Avoid hot-button topics** – If you get upset over religion or politics, cross them off your conversation list.
- **Pare down your to-do list** – If you’ve got too much on your plate, drop the tasks that aren’t truly necessary to the bottom of the list or eliminate them entirely.
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.**
  - If something or someone is bothering you, communicate your concerns in an open and respectful way.
- **Be willing to compromise.**
  - When you ask someone to change their behavior, be willing to do the same. If you both are willing to bend at least a little, you’ll have a good chance of finding a happy middle ground.
- **Be more assertive.**
  - Don’t take a backseat in your own life. Deal with problems head on, doing your best to anticipate and prevent them.
- **Manage your time better.**
  - When you’re stretched too thin and running behind, it’s hard to stay calm and focused. But if you plan ahead and make sure you don’t overextend yourself, you can alter the amount of stress you’re under.

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.**
  - Try to view stressful situations from a more positive perspective. Rather than fuming about a traffic jam, look at it as an opportunity to pause and regroup, listen to your favorite radio station, or enjoy some alone time.
- **Look at the big picture.**
  - Take perspective of the stressful situation. Ask yourself how important it will be in the long run. Will it matter in a month? A year? Is it really worth getting upset over? If the answer is no, focus your time and energy elsewhere.
- **Adjust your standards.**
  - Perfectionism is a major source of avoidable stress. Stop setting yourself up for failure by demanding perfection.
  - Set reasonable standards for yourself and others, and learn to be okay with “good enough.”
- **Focus on the positive.**
  - When stress is getting you down, take a moment to reflect on all the things you appreciate in your life, including your own positive qualities and gifts.
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.
  - Many things in life are beyond our control — particularly the behavior of other people.
  - Rather than stressing out over them, focus on the things you can control such as the way you choose to react to problems.

• Look for the upside.
  - As the saying goes, “What doesn’t kill us makes us stronger.” When facing major challenges, try to look at them as opportunities for personal growth.
  - If your own poor choices contributed to a stressful situation, reflect on them and learn from your mistakes.

• Share your feelings.
  - Talk to a trusted friend or make an appointment with a therapist.
  - Expressing what you’re going through can be very cathartic, even if there’s nothing you can do to alter the stressful situation.

• Learn to forgive.
  - Accept the fact that we live in an imperfect world and that people make mistakes. Let go of anger and resentments. Free yourself from negative energy by forgiving and moving on.

5 EXERCISE: YOUR TRIGGERS AT WORK: PEOPLE, SITUATIONS — PART II

Say to the class: Now we will refer back to the “Triggers and Reactions” that you wrote down earlier. Keeping our discussions in mind now write down ideas for how you could react to these stressors differently in the future. Think about which of these you can’t change and where accepting and adapting might be the best tactic and think about which of these are situations you might be able to avoid or alter.

Instructions: Ask the class to report back on alternative ways of reacting to their triggers and stressors.
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.

**VIDEO: HUMOR IN THE WORKPLACE**

**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 below 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.
10 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?

11 EVALUATION COMPLETION

12 FINAL CELEBRATION/CERTIFICATE DISTRIBUTION
REFERENCES


Stress, Boundaries, and Burnout, M. Kirk Dougher, Power Point presentation, May 8th, 2009, Utah Association on Higher Education and Disability

https://www.ncsbn.org/ProfessionalBoundaries_Complete.pdf


VIDEOS

Humor and stress in the workplace http://www.youtube.com/watch?v=NgIxtkys_0&playnext=1&list=PLCD2CED7828F8148B&feature=results_main
CURRICULUM OVERVIEW

1. ORIENTATION: CARE COORDINATION BASIC SKILLS — PART 1

- 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

2. ORIENTATION: CARE COORDINATION BASIC SKILLS — PART 2

- Define what a chronic disease is and how it relates to our healthcare system today
- Define coordinated care and patient-centered care
- Describe the new models of healthcare such as Health Homes, Patient-Centered Medical Home, ACOs where care coordination staff might work
- Describe what it means to work as part of a medical team and describe how staff providing care coordination fit with the rest of the medical team
- Explain what the Patient’s Bill of Rights is

3. COMMON CHRONIC DISEASES — PART 1: DIABETES

- 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

4. COMMON CHRONIC DISEASES — PART 2: HYPERTENSION/ HIGH CHOLESTEROL/ ASTHMA

- 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
5 COMMON CHRONIC DISEASES — PART 3: HEART DISEASE/STROKE

• 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

6 COMMON CHRONIC DISEASES — PART 4: HEPATITIS/HIV

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

7 BIAS, CULTURE AND VALUES IN HEALTHCARE

• 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.

8 HEALTH DISPARITIES

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

9 BASIC COMMUNICATION SKILLS

• Understand why care coordination staff need excellent communication skills
• List best practices for communicating with patients in person, by phone and 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
10 ACCESSING PATIENT RESOURCES

• Explain the difference between patient resources that require a referral and those that don’t
• Discuss the role of staff who provide care coordination 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 staff providing care coordination can use to help patients access needed resources

11 BASICS OF MENTAL ILLNESS AND CRISIS MANAGEMENT — PART 1

• Understand connection between mental health and chronic disease management
• Understand role of care coordination in helping patients with mental illness
• Understand characteristics of common mental illnesses such as depression
• Understanding of basic risk assessment for depression and suicidal ideation

12 BASICS OF MENTAL ILLNESS AND CRISIS MANAGEMENT — PART 2

• 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

13 BASICS OF MENTAL ILLNESS AND CRISIS MANAGEMENT — PART 3

• 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
• Understand the characteristics of loss and grieving

14 HOME VISITS

• Increase understanding of how to conduct successful home visit assessments as part of chronic care plan
• Increase understanding of how to assess patient safety and conduct basic risk assessments
• Identify strategies to ensure personal safety of staff conducting home visits
15 TRANSITIONS OF CARE

• 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

16 ELECTRONIC HEALTH RECORDS

• Understand basics of Electronic Health Record system capabilities and use in care coordination/management
• Understand basics of Health Information Exchange and use in care coordination/management
• Understand the basics of HIPAA-related privacy and security

17 NAVIGATING THE INSURANCE SYSTEM/HELPING THE UNINSURED

• Increase basic understanding of Affordable Care Act (ACA)
• Increase basic understanding of Medicaid/Medicare/Managed Care
• Increase understanding of what it means to obtain referrals and authorizations
• Increase understanding of how to reduce barriers to care for uninsured and insured patients

18 MOTIVATIONAL INTERVIEWING — PART 1

• Increase basic understanding of the theory and techniques of Motivational Interviewing (MI)
• Increase understanding how MI techniques can be applied to management of chronic conditions

19 MOTIVATIONAL INTERVIEWING — PART 2

• Demonstrate basic understanding of the techniques of MI to facilitate positive client behavior change
• Increase understanding of how MI techniques can be applied within healthcare environment
• Understand what health coaching is and in what context staff providing care coordination might provide it
• Describe what a care plan is and how it would be used by staff providing care coordination
• Know how to identify a patient’s strengths and identify potential barriers they may face in following a care plan
• Explain how to use a care plan to coordinate care: Follow up on appointments, lab tests, medication adherence

• 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

• Define methods for monitoring performance, including performance indicators
• Understand how to assess opportunities for quality improvement
• Describe the relationship between care coordination work and quality improvement

• Describe the role professional boundaries have in helping patients
• Describe ways to maintain healthy boundaries
• List risky behaviors that lead to boundary violations
• Understand what professional boundaries are needed when providing care coordination and when to ask for help from care management team

• Understand the relationship between personal boundaries and burn-out
• Identify the benefits of stress-management as a staff member providing care coordination services
• Identifying strategies for wellness and stress reduction
• Reflect on the care coordination role
Primary Care Development Corporation and 1199 Training and Employment Funds are extremely grateful to the numerous video makers and organizations whose youtube videos we featured in our classes.

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